Maryland Hospital Palliative Care Program Report

Required under HB 581

October 20, 2015

Advisory Group Meeting

Definition and History of Palliative Care

- HB 581 and other definitions
- One of the first services health care providers offered, but only recently recognized as a specialty
- Consultation model: nationally and in MD
- Growth of hospital palliative care programs since 2000
  - Nationally, more than doubled between 2000-2010.
  - In Maryland, nearly all programs formally established since 2000.

Issues within the Specialty

- Challenges created by confusion with hospice care
- Lack of awareness and late referrals to palliative care
- Workforce shortages
- Limited resources

Evidence of Benefits and Cost Savings

- AMA highlighted challenges related to accurately measuring impacts of palliative care
- Two published studies on cost savings:
  - AMA reported savings between $1,700 and $4,900 per stay for palliative care patients
  - Health Affairs reported $6,900 in cost savings per stay for palliative care patients with Medicaid
- Carroll and Union Memorial submitted evidence of lower readmission rates
- Johns Hopkins and Union Memorial found greater patient and family satisfaction after palliative care consultation

Efforts to Standardize and Expand

- National: Efforts to promote expansion at hospitals in California; efforts to standardize screening processes in New York
- In Maryland, half of hospitals surveyed reported plans to add trained staff and provide more training
- Maryland's Comprehensive Cancer Control Plan includes chapter on improving access to palliative care
- HB 581 requires recommendations for statewide standards for hospitals

Maryland Palliative Care Programs

- Palliative care programs exist at 30 hospitals across the state
- One hospital Joint Commission certified.
- All 11 pilots report at least one staff member with palliative care credentials
- Also included: details on each pilot's staffing, relationship to hospice, integration with ED/ICU, and funding sources

HSCRC Study Questions

- Utilization
- Patient Demographics
- Patient Experience
- Charges for comparable flagged and unflagged medical/surgical patients

HSCRC Data Analysis

- Ratio to total medical/surgical discharges by pilot
- Percent that were referred to hospice (40%)
- Age groups (Palliative care patients skewed older)
- Ethnicity/Race (African American patients declined recommendations more frequently)
- Description of Major Diagnostic Categories by pilot
- Patient Disposition at Discharge (Palliative care patients expired more frequently)

Hospital Length of Stay

- Data adjusted for case mix differences across the pilot sites' medical/surgical discharges
- Patients who received palliative care consultations had longer stays
- Subgroupings provide additional insight:
  - Among flagged groups, patients referred to hospice (40%) had shortest average length of stay.
  - Patients who accepted palliative care had shorter average length of stay than those who declined at most pilots.

Charge Data

- Patients who receive palliative care consultations have longer average stays, so costlier total charges per stay
- Among flagged subgroupings:
  - Patients referred to hospice had lowest average charges per stay.
  - No consistent comparison across pilots for average charges per stay for those who accepted palliative care compared to those who declined recommendations.
  - For average charge per day, those who received palliative care consultations had lower average charge per day than those who did not. Patients who declined palliative care had lower average charge per day than those who accepted palliative care.

Recommendations on Best Practices and Minimum Standards

- Based on 2006 NQF-endorsed 38 “preferred practices,” reviewed by Advisory Group
- 37 “preferred practices” retained or modified for this particular use as “best practices”
- Of the 37 above “best practices,” 30 also recommended as minimum standards

Conclusions

- Demand for palliative care services is projected to grow
- The effect of palliative care is challenging to measure in a one year study of 11 diverse hospital programs
- Clear cost savings may not be apparent in HSCRC charge data for one hospital visit
- Other studies have shown that palliative care leads to lower readmission rates and charges, and increased satisfaction

Conclusions

- As more hospitals offer specialty palliative care programs, the need for standardization increases
- Standardization of practices would help to ensure a basic level of similar services across hospitals
- 11 diverse hospital pilots agreed on a list of practices that would help to ensure high quality, specialized palliative care programming
- Success relies upon hospital support for these programs to address a number of identified challenges

Next Steps

- Revise draft based on comments and additional material
- Develop final report – including Executive Summary
- Distribute final report to Advisory Group and Commissioners
- Presentation to Commission – November 19th
- Submission to General Assembly – December 1st