

By R. Sean Morrison, Jessica Dietrich, Susan Ladwig, Timothy Quill, Joseph Sacco, John Tangeman, and Diane E. Meier

DOI: 10.1377/hlthaff.2010.0929
HEALTH AFFAIRS 30,
NO. 3 (2011): –
©2011 Project HOPE—
The People-to-People Health
Foundation, Inc.

THE CARE SPAN

Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries

This Health Affairs PDF is provided for your personal noncommercial use and for limited distribution only. It may not be posted on any Web site. For additional distribution please see Health Affairs Reprints and Permissions information at www.healthaffairs.org

ABSTRACT Patients facing serious or life-threatening illnesses account for a disproportionately large share of Medicaid spending. We examined 2004–07 data to determine the effect on hospital costs of palliative care team consultations for patients enrolled in Medicaid at four New York State hospitals. On average, patients who received palliative care incurred \$6,900 less in hospital costs during a given admission than a matched group of patients who received usual care. These reductions included \$4,098 in hospital costs per admission for patients discharged alive, and \$7,563 for patients who died in the hospital. Consistent with the goals of a majority of patients and their families, palliative care recipients spent less time in intensive care, were less likely to die in intensive care units, and were more likely to receive hospice referrals than the matched usual care patients. We estimate that the reductions in Medicaid hospital spending in New York State could eventually range from \$84 million to \$252 million annually (assuming that 2 percent and 6 percent of Medicaid patients discharged from the hospital received palliative care, respectively), if every hospital with 150 or more beds had a fully operational palliative care consultation team.

R. Sean Morrison (sean.morrison@mssm.edu) is a professor in the Department of Geriatrics and Palliative Medicine at Mount Sinai School of Medicine, in New York City.

Jessica Dietrich is the director of research at the Center to Advance Palliative Care at Mount Sinai School of Medicine.

Susan Ladwig is a health project coordinator, Palliative Care Team, at the School of Medicine and Dentistry, University of Rochester, in Rochester, New York.

Timothy Quill is a professor of medicine, psychiatry, and medical humanities at the University of Rochester.

Joseph Sacco is the director of the Palliative Medicine Consultation Service at the Bronx Lebanon Hospital Center, in the Bronx, New York.

John Tangeman is the associate medical director at the Center for Hospice and Palliative Care, in Cheektowaga, New York.

Diane E. Meier is a professor in the Department of Geriatrics and Palliative Medicine at Mount Sinai School of Medicine.

Medicaid spending, excluding the \$87 billion in relief provided through the American Recovery and Reinvestment Act of 2009, increased by 9 percent (\$18 billion) in 2009—the highest rate of growth in more than a decade.¹ This increase occurred even though nearly every state adopted at least one new Medicaid policy that resulted in reductions to patient benefits and payments to health care providers.² It is estimated that annual Medicaid spending will increase from \$339 billion in 2010 to \$458 billion in 2020.^{1,3}

The national economy is expected to improve—although slowly—but state revenues are not. This means that enrollment in Medicaid, which swelled during the economic downturn, is likely to remain high. States will continue to be

challenged to maintain existing eligibility requirements, benefit levels, and provider payments.²

The escalating costs of the Medicaid system endanger not only the health of its enrollees, but also the health of the country's economy. Indeed, in its report, *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*, the Congressional Budget Office cites federal health care spending—which includes Medicare as well as Medicaid—as the “single greatest threat” to the stability of the US budget.¹

Past and present efforts to reduce Medicaid spending have focused on reducing provider reimbursement, tightening and reducing eligibility for programs, deploying Medicaid managed care programs with capitation, and devising formulary restrictions.³ Although Medicaid

is largely a state-managed system, a federal law assuring access to a basic platform of services gives states limited flexibility in determining the type and extent of services covered. Accordingly, there has been increased focus on delivery models, such as managed Medicaid, that promote care targeted to patients' needs and goals, and that limit the inherent incentives that exist in the fee-for-service environment to increase the quantity of care.⁴

Interdisciplinary palliative care programs may provide a way to improve quality and reduce costs for some of the sickest Medicaid patients and curb use of the most expensive treatments. Growth in the number and needs of chronically ill patients who are not clearly terminally ill has helped catalyze the development of palliative care as a specialty.

Palliative care aims to relieve suffering and improve quality of life for patients with advanced illness and for their families. It does so through assessing and treating pain and other symptoms; communicating about care goals and providing support for complex medical decision making; providing practical, spiritual, and psychosocial support; coordinating care; and offering bereavement services.^{5,6}

Palliative care is provided in conjunction with all other appropriate medical treatments, including curative and life-prolonging therapies. It is optimally delivered through an interdisciplinary team consisting of appropriately trained physicians, nurses, and social workers, with support and contributions from other professionals as indicated.⁵ In recent years, the number of palliative care programs in hospitals has grown rapidly, to the point where more than 60 percent of hospitals overall, and 80 percent of hospitals with 300 or more adult medical or surgical beds, reported the presence of a palliative care program as of 2010.⁷

Although palliative care can be delivered by specialists through a range of clinical models, the predominant delivery model in the United States (outside of hospice) is the hospital palliative care consultation team.^{8,9} Palliative care consultation, like other specialist consultation, is typically initiated at the request of the treating physician. Consultation teams communicate their recommendations back to the referring physician for implementation.¹⁰ Additionally, palliative teams focus on clarifying diagnoses and treatment options, helping patients and family members identify goals of care, and helping them select—in conjunction with their treating physicians—the treatments and hospital discharge options that meet those goals.^{6,10}

Palliative care consultation teams have been shown to improve quality of life for patients with

advanced illnesses and for their families^{10,11} and, in a recent study, to extend survival.¹² Furthermore, palliative care programs can reduce hospital costs by ameliorating pain and other distressing symptoms that increase hospital lengths-of-stay and cause medical complications; can reduce overuse of unnecessary, ineffective, or marginally effective services; and can develop transition plans that result in safe hospital discharges with lower likelihood of readmission.^{13–16}

To date, however, studies examining cost reductions have not focused specifically on patients enrolled in Medicaid. Our study was designed to help fill that gap, by exploring the effect of hospital palliative care consultation teams on hospital costs for a group of Medicaid patients in New York State.

Study Data And Methods

We used hospital administrative data to compare hospital costs of patients receiving palliative care consultations matched by propensity scores^{17–19} to patients receiving usual care for the period 2004–07.

SAMPLE Four diverse urban New York State hospitals—a community hospital, two academic medical centers, and a safety-net hospital—in one large and two midsize cities served as study sites. (See Exhibit 1 for hospital and palliative care team characteristics.) These hospitals were chosen because of their size (more than 350 beds and thus representative of the median for US hospitals); adequate numbers of annual Medicaid admissions (more than 5,000) to permit analyses and to obtain a sufficiently representative sample; and the presence of a mature (in existence for more than five years), interdisciplinary palliative care consultation team. Additionally, each team had participated in training sessions conducted by the Center to Advance Palliative Care²⁰ and therefore shared common care processes as recommended by the National Quality Forum's framework and preferred practices for palliative and hospice care quality.⁵

The patient sample included all adult patients with Medicaid as their primary and sole insurer, who had hospital stays ranging from six to forty-four days. People dually eligible for Medicare and Medicaid were thus excluded. Patients were included if they had been diagnosed with at least one of the following advanced diseases: metastatic solid tumor malignancies; central nervous system malignancies; metastatic melanoma; locally advanced head and neck cancer; locally advanced pancreatic cancer; HIV/AIDS (with at least one of the following secondary diagnoses: hepatoma, cirrhosis, cachexia, lymphoma, or

EXHIBIT 1
Characteristics Of Study Sites (Hospitals) And Their Palliative Care Consultation Teams, 2004–07

Characteristic	Hospital			
	A	B	C	D
Location	Buffalo, NY	Rochester, NY	New York City (Bronx)	New York City (Manhattan)
Type	Community hospital	Academic medical center	Safety-net hospital	Academic medical center
Number of beds	1,318	659	534	1,008
Number of admissions per year	65,757	30,922	23,231	50,338
Average number of adult Medicaid admissions per year	6,361	6,388	17,400	13,399
Team composition ^a	1 physician, 1 nurse practitioner	1.6 physicians, 2 nurse practitioners, 0.2 social worker, 0.2 psychologist	1 physician, 1 nurse practitioner, 1 social worker	2 physicians, 2 nurse practitioners, 2 social workers

SOURCE Authors' analyses of 2004–07 hospital administrative data. ^aIndicates the full-time equivalents of clinicians on the palliative care consultation team.

other cancer); congestive heart failure or chronic obstructive pulmonary disease, with either two or more hospitalizations in any six months of the study period or one or more intensive care unit admissions during the study period; and advanced liver disease with evidence of cirrhosis. Also included were people who had been in an intensive care unit for more than five days, regardless of diagnosis.

Researchers and clinicians generally consider these diagnostic and disease-stage criteria appropriate for palliative care, and the criteria have been used in other studies.^{21–26} Patients receiving palliative care were identified through administrative databases and billing records. Patients were classified as receiving palliative care if a consultation was requested by the patient's attending physician, the patient was seen and evaluated by the palliative care team for one or more visits, and at least one set of recommendations was made by the palliative care team for the primary team caring for the patient. The initial sample included 1,717 patients discharged alive and 495 patients who died in the hospital.

We used hospital databases to abstract patients' characteristics. Medical comorbidities were determined using the Elixhauser algorithm.²⁷

ANALYSES Costs were abstracted from the hospitals' cost accounting systems. We abstracted total costs for each subject for each hospital day and for the entire admission period. We aggregated costs into specific categories that included costs for staying in the intensive care unit, pharmacy and intravenous therapies, laboratory work, and diagnostic imaging.²⁸ All figures were converted to 2007 US dollars.

Patients were divided into two strata: live discharges and hospital deaths. We computed propensity scores for each patient within each stratum.^{17–19,29} We also used one-to-many matching with each stratum. For patients discharged alive from the hospital, we matched each patient receiving palliative care with one or more receiving usual care. For patients who died in the hospital, we matched each patient receiving usual care with one or more receiving palliative care, given that there were more palliative care patients than usual care patients in this stratum. All subsequent analyses included matched live discharges and matched hospital deaths.

Generalized linear models using normalized weighted data were estimated for all cost outcomes in dollars, and for intensive care unit lengths-of-stay in days. Multivariable logistic regression models using normalized weighted data were used to examine the likelihood of death in the intensive care unit (hospital decedents) and discharge to hospice (live discharges).

LIMITATIONS The generalizability of this study may be limited for several reasons: the small number of hospitals analyzed; the fact that all hospitals were located in the same state and were also urban; and the fact that the study was conducted before enactment of the Affordable Care Act of 2010, which had a notable affect on Medicaid enrollment. Additionally, we were unable to assess the effect of hospital palliative care services on total Medicaid spending because of New York State's restricted access to data on Medicaid costs occurring after hospital discharge.

There are also certain limitations associated with our analytic approach. First, unlike ran-

domization, propensity-score matching may fail to adjust adequately for unmeasured variables that could account for some group differences in hospital costs. Second, our sample was limited to four hospitals. The fact that we used relatively tight criteria for matching may have resulted in less precise cost estimates than in a larger sample. Third, we were unable to match ten palliative care patients, and these patients were excluded from analyses. Including the costs associated with these ten patients would have increased total costs in the palliative care group by 1.5 percent.

A full description of the methods is available in the online Appendix.³⁰

Results

All but six of the 296 patients (98 percent) who received palliative care and who were discharged alive were matched to patients in the group of 1,427 who received usual care and were discharged alive. In addition, 185 of 189 patients (98 percent) who died in the hospital and who received palliative care were matched to 149 patients who received usual care and who died in the hospital. (Detailed patient characteristics are available in the online Appendix).³⁰ There were no statistically significant differences in average lengths-of-stay between patients who received usual care or palliative care discharged alive (16.9 versus 17.2 days, $p = 0.45$) and those who died in the hospital (20.1 versus 19.3 days, $p = 0.45$).

HOSPITAL COSTS Overall, patients who received palliative care had significantly lower costs than patients who received usual care (Exhibit 2). Patients who were discharged alive and received usual care had adjusted average total costs of \$36,741, compared to \$32,643 for

patients who received palliative care. This represents an average difference of \$4,098 per admission ($p = 0.04$, which means that the results are not at all likely to be due to chance).

With respect to average total daily costs, palliative care provided to patients who were discharged alive was associated with an average net reduction of \$490 per day over the entire admission (\$2,744 per day for usual care patients versus \$2,254 per day for patients receiving palliative care, $p < 0.01$). For patients who were discharged alive and received palliative care, average savings of \$2,678 ($p < 0.001$) were also observed in intensive care unit spending per admission.

Cost reductions associated with palliative care were likewise observed among the patients who died in the hospital. Within this subset of the study population, patients who received usual care had average total hospital costs of \$68,804, compared to \$61,241 for those receiving palliative care. This represents an average difference of \$7,563 per admission ($p = 0.02$, also very unlikely to be due to chance).

With respect to average total daily costs, palliative care was associated with a net reduction of \$316 per day over the entire admission (\$3,503 per day for usual care patients versus \$3,187 per day for patients receiving palliative care, $p < 0.01$). Patients who were provided with palliative care and who also died in the hospital were seen to have lower intensive care costs (average reduction of \$2,641 per admission, $p = 0.06$) and lower average pharmacy costs (reduction of \$2,224 per admission, $p = 0.04$). In addition, patients who received palliative care spent an average of 3.6 fewer days in intensive care than did patients who received usual care ($p = 0.04$).

Receipt of palliative care was also associated with differences in the final care setting. Patients

EXHIBIT 2

Comparison Of Palliative Care And Usual Care Costs For A Single Hospitalization Of Adult Medicaid Enrollees, 2004–07

	Discharged alive			Died in hospital		
	Usual care	Palliative care	Net change	Usual care	Palliative care	Net change
Average total cost per admission	\$36,741	\$32,643	−\$4,098**	\$68,804	\$61,241	−\$7,563**
Average total cost per day	\$2,744	\$2,254	−\$490****	\$3,503	\$3,187	−\$316***
Average intensive care cost per admission	\$6,452	\$3,774	−2,678****	\$29,706	\$28,420	−\$2,641
Average intensive care length-of-stay (days)	5.8	5.3	−0.5	13.8	10.2	−3.6**
Average laboratory cost per admission	\$1,801	\$1,519	−\$282	\$4,885	\$4,777	−\$108
Average imaging cost per admission	\$1,697	\$1,478	−\$219	\$2,661	\$2,676	\$25
Average pharmacy cost per admission	\$2,719	\$2,705	−\$14	\$10,392	\$8,168	−\$2,224**
Percent discharged to hospice	1%	30%	29%****	— ^a	— ^a	— ^a
Percent dying in intensive care	— ^a	— ^a	— ^a	58%	34%	−24%**

SOURCE Authors' analyses of 2004–07 hospital administrative data. **NOTES** An expanded version of this exhibit, which provides confidence intervals and actual significance levels, appears in the Appendix (see Note 30 in text). ^aNot applicable. ** $p < 0.05$ *** $p < 0.01$ **** $p < 0.001$

who received palliative care and died in the hospital were significantly less likely than patients who received usual care to do so while in intensive care (34 percent versus 58 percent, respectively; odds ratio: 0.48; 95% confidence interval: 0.24, 0.95; $p = 0.04$). Compared to usual care patients, palliative care patients who were discharged alive were significantly more likely to receive hospice care in an appropriate setting (home, nursing home, or inpatient hospice) following hospital discharge (30 percent versus 1 percent, odds ratio: 13.5; 95% confidence interval: 7.4, 24.6; $p < 0.001$).

CONFIRMATORY ANALYSES Exhibits 3 and 4 display average daily total costs for people who were discharged alive and who died during their hospital admission. For patients who received palliative care, day 0 was the day of the palliative care team consultation; the six days before (days -6 to -1) and after (days 1 to 6) the consultation are plotted. For patients who received usual care, day 0 was a reference day representing the average day of consultation for patients receiving palliative care with hospital stays of similar duration. This reference day for patients who received usual care was day 5 of hospitalization for patients with lengths-of-stay of ten days or less, day 8 for those with lengths-of-stay of eleven to twenty days, day 12 for those with

lengths-of-stay of twenty-one to thirty days, and day 19 for those with lengths-of-stay of more than thirty days.

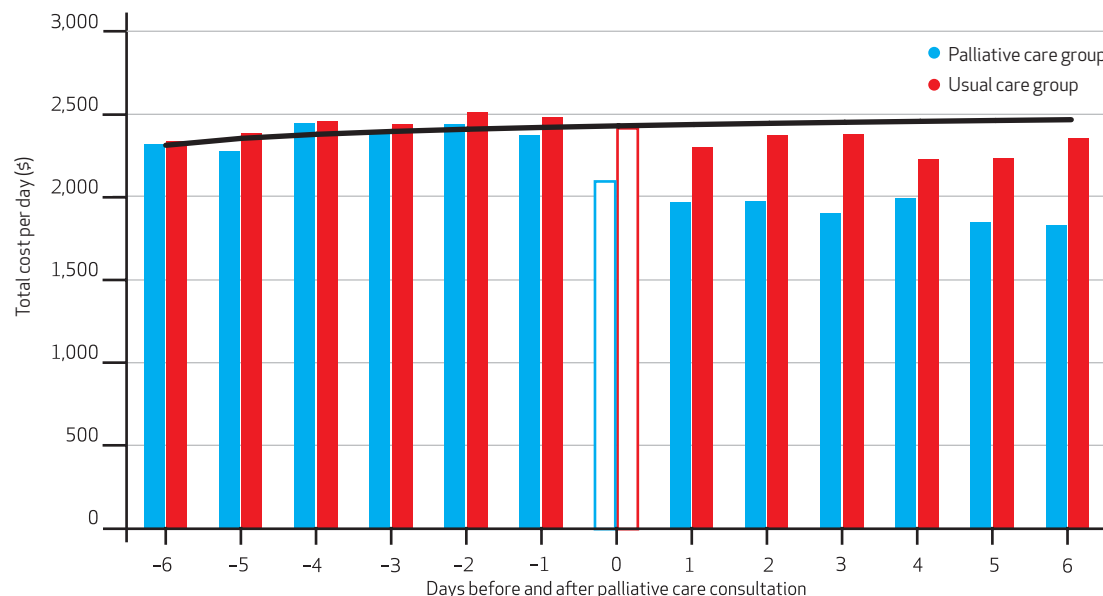
There were no statistically significant differences between the average costs per day for patients who received usual care and patients who received palliative care before day 0. Following day 0 and during the remainder of the admission, average daily costs for the usual care group remained stable, near the same values as before day 0. In contrast, palliative care was associated with a significant reduction in average daily hospital costs within one to two days after consultation. For patients discharged alive (Exhibit 3), average total costs per day decreased from \$2,551 before palliative care consultation to \$1,884 after consultation—a difference of \$666 per day ($p = 0.001$). For patients who died in the hospital, average total costs per day decreased from \$3,402 before palliative care consultation to \$2,558 after consultation—a difference of \$844 per day ($p = 0.001$) (Exhibit 4).

Discussion

Data from four diverse urban New York State hospitals suggest that palliative care consultation teams can lower hospital costs for Medicaid patients with serious and advanced illnesses. On

EXHIBIT 3

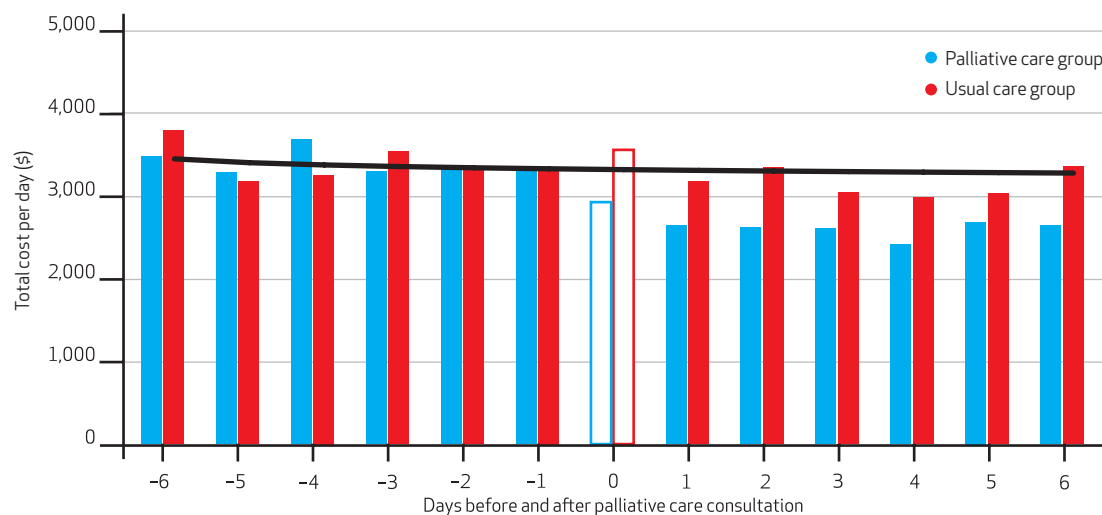
Average Total Hospitalization Cost Per Day, Before And After Palliative Care Consultation, For Patients Who Received Palliative Care And Were Discharged Alive



SOURCE Authors' analyses. **NOTES** The exhibit represents average daily costs before and after a reference day (day 0) for palliative care and usual care patients. Explanations of how reference days relate to various types of patients are in the text. The graphing line represents the regression curve of actual costs prior to palliative care consultation (day 0) and estimated costs (days 1-6), assuming palliative care consultation had not occurred.

EXHIBIT 4

Average Total Hospitalization Cost Per Day, Before And After Palliative Care Consultation, For Patients Who Received Palliative Care And Who Died In The Hospital



SOURCE Authors' analyses. **NOTES** The exhibit represents average daily costs before and after a reference day (day 0) for palliative care and usual care patients. Explanations of how reference days relate to various types of patients are in the text. The graphing line represents the regression curve of actual costs prior to palliative care consultation (day 0) and estimated costs (days 1–6), assuming palliative care consultation had not occurred.

average, patients who received palliative care in this study incurred \$6,900 less in hospital costs during a given admission than patients who received usual care. These reductions included \$4,098 in hospital costs per admission for patients discharged alive, and \$7,563 for patients who died in the hospital. Patients who received palliative care also had lower costs for intensive care and higher rates of referral to outpatient hospice programs.

Why are these results important? In 2008 Medicaid provided coverage for more than sixty million people, and total Medicaid spending was estimated to exceed \$339 billion—nearly equivalent to 2008 spending on Medicare.³ A joint federal-state responsibility, Medicaid now accounts for 16 percent of national health spending and is the primary safety net for the nation's poor.³¹ The Affordable Care Act of 2010 will depend upon expanded eligibility for Medicaid to extend insurance to a projected sixteen million of the estimated thirty-two million newly covered lives. Thus, it has been argued that “the fate of health care reform depends on the fate of Medicaid.”³²

In this context, it is notable that approximately 60 percent of all Medicaid spending is spent on acute hospital services³³ and that the sickest 5 percent of patients with Medicaid coverage, largely the elderly and disabled, account for fully 57 percent of total program spending.³⁴ Medicaid spending accelerated further by 7.9 percent

in 2009 because of a 10.6 percent increase in acute care spending on top of growing enrollment and rising costs.³⁴

In the “perfect storm” context of the 2008 economic recession—decreased state tax revenues, rapid growth in Medicaid enrollment, and inexorably rising medical costs—efforts are necessary to assure that the care provided to this high-risk, high-cost subset of the Medicaid population is as effective and efficient as possible.

NEW MODELS OF CARE, POTENTIAL SAVINGS

Faced with unavoidable cuts for Medicaid services, payers and health care institutions are under increasing pressure to develop models of care that improve quality, manage and coordinate care, and do so at lower costs. Data from this study support a new model for effective and efficient care for the seriously ill hospitalized Medicaid population: palliative care. In this study, four established hospital palliative care consultation teams cared for almost 4 percent of their hospitals' total Medicaid admissions, resulting in annual savings of almost \$820,000. If the services of a mature, interdisciplinary palliative care team on par with the teams at the four hospitals studied were offered at all 117 New York State hospitals capable of supporting such a team (that is, hospitals with more than 150 beds), New York State's Medicaid program could realize substantial savings.

It is difficult to determine exactly how many

hospitalized patients are potentially appropriate for palliative care consultation. However, estimates based on other studies range from 2 percent to 6 percent of the patients discharged from hospitals.³⁵ For hospitals in New York State large enough to support an interdisciplinary team of the type found at our four study sites, this translates into a potential pool of 12,317–36,592 hospitalized patients with Medicaid coverage who should be receiving palliative care each year.⁷

Using our finding of an average \$6,900 savings per admission, we estimate that the reductions in Medicaid hospital spending in New York State could eventually range from \$84 million to \$252 million annually (2 percent and 6 percent of Medicaid patients discharged from the hospital who received palliative care, respectively), assuming the presence of a fully operational palliative care team at every hospital with 150 beds or more. Such savings would probably be realized within five years if teams were appropriately trained and integrated within routine patient care, as was the case with the teams in this study.

REDUCING INTENSIVE CARE EXPENSES An important finding of this study was the reduction in intensive care spending. Other interventions have identified this site of care as a potential target for reducing the cost of hospitalization. What's more, patient surveys have indicated that most would prefer not to die in hospitals and not to die in an intensive care unit. Two previous studies using interventions that focused on identifying goals of care and treatment preferences found reductions in the use of intensive care for patients who died in the hospital.^{36,37} Similarly, nurse-based and interdisciplinary palliative consultations focused specifically on the intensive care setting have been seen to yield similar reductions in intensive care lengths-of-stay.^{38,39}

Our study expands and amplifies the results of prior studies by demonstrating that palliative care teams not limited to intensive care units can produce appropriate care matched to achievable patient and family goals, as well as savings, across hospital settings. These findings support the delivery of palliative care consultation to seriously ill hospital patients, regardless of location in the hospital. Finally, for the majority of patients in this study who survived hospitalization, palliative care teams not only were associated with lower costs, but also helped identify safe and sustainable discharge options in the community.

CONTRIBUTIONS OF PALLIATIVE CARE TO MEDICAID Palliative care teams are key contributors to the kind of planning, coordination, and communication across settings necessary to get an individual's postdischarge care plan right the

first time—for example, discharge with hospice services rather than standard home care for interested and eligible patients. Targeted access to coordinated palliative care among the sickest patients receiving the most expensive care could lead to savings for state Medicaid programs beyond the hospital costs evaluated in this study and could reduce pressures to cut other important Medicaid services. The contributions of palliative care teams are key to reducing readmissions, emergency department visits, and unnecessary inpatient and outpatient service, and they need further evaluation.⁴⁰

Development of palliative care services in other settings could also benefit Medicaid. For example, the rapidly growing dually eligible nursing home population represents 7 percent of the Medicaid population but accounts for 52 percent of Medicaid spending.⁴¹ Nursing home palliative care teams could deliver care consistent with patients' and family members' goals while reducing the costs associated with repeated hospital readmissions borne by public programs.^{42–44} Finally, alternative models for palliative care delivery at smaller (largely rural) hospitals that might not be able to support a full interdisciplinary team—for example, use of palliative care advance practice nurses—need to be developed and evaluated.

HOSPITAL GROWTH REFLECTS VALUE Hospital recognition of the benefits of palliative care in delivering patient-centered care (care that matches treatment to goals jointly set by informed patients and their care providers), along with substantial gains in efficiency, has led to linear yearly growth in the number of US hospitals reporting palliative care programs in the past ten years.⁴⁵ In 2010 more than 60 percent of American Hospital Association member hospitals reported having a palliative care program, compared to less than 10 percent in 2000.⁷ Despite this increase in the number of hospital programs, assuring that services reach all patients who might benefit will require adequate program staffing, integration of palliative care services into care settings beyond hospitals, and inclusion of palliative care into new delivery models such as accountable care organizations and medical homes.

IMPLICATIONS FOR POLICY MAKERS Finally, our data have a number of implications for policy makers. These include the following: strategies aimed at increasing access to quality palliative care across care settings through regulatory and accreditation requirements for hospitals, nursing homes, and home care services; investment in workforce incentives to assure availability of adequately trained and skilled providers; recognition of palliative care service delivery through

pay-for-performance schemes; development of quality measures—endorsed by the National Quality Forum and used by the Centers for Medicare and Medicaid Services—appropriate to a seriously ill patient population with multiple medical conditions; and inclusion of palliative care services in accountable care organizations and other new delivery and payment models.

Conclusion

In four New York State hospitals with mature, interdisciplinary palliative care consultation teams, hospital costs among patients enrolled

in Medicaid were significantly lower when they had consultations with the palliative care team that resulted in care planning guidance, pain and symptom management, and appropriate discharge planning transition management. These findings are consistent with previous work demonstrating a similar effect of palliative care teams on hospital costs among Medicare beneficiaries at eight diverse hospitals in a range of states and health care markets.¹⁴ Policy makers employing payment, regulatory, and quality levers could markedly strengthen access to palliative care for those Americans most in need, thereby benefiting patients, families, and payers alike. ■

This project was supported by the United Hospital Fund of New York, the Center to Advance Palliative Care, and

the National Palliative Care Research Center, and by a Mid-Career Investigator Award in Patient Oriented Research

(Grant No. K24 AG022345) from the National Institute on Aging to R. Sean Morrison.

NOTES

- 1 Congressional Budget Office. The budget and economic outlook: fiscal years 2010 to 2020 [Internet]. Washington (DC): CBO; 2010 Jan [cited 2011 Feb 11]. Available from: <http://www.cbo.gov/ftpdocs/108xx/doc10871/01-26-Outlook.pdf>
- 2 Smith VK, Gifford K, Ellis E, Rudowitz R, O'Malley Watts M, Marks C. The crunch continues: Medicaid spending, coverage, and policy in the midst of a recession [Internet]. Washington (DC): Kaiser Family Foundation; 2009 Sep [cited 2011 Feb 11]. Available from: <http://www.kff.org/medicaid/upload/7985.pdf>
- 3 Kaiser Family Foundation. Kaiser Commission on Medicaid facts: Medicaid and the uninsured [Internet]. Washington (DC): KFF; 2010 [cited 2010 Sep 10]. Available from: <http://www.kff.org/medicaid/upload/7235-04.pdf>
- 4 Holahan J, Yemane A, Rousseau D (Urban Institute, Washington, DC). Medical expenditures increased by 5.3 percent in 2007 led by acute care spending growth. Washington (DC): Kaiser Family Foundation; 2009 [cited 2010 Sep 10]. Available from: <http://www.kff.org/medicaid/upload/7978.pdf>
- 5 National Quality Forum. A national framework and preferred practices for palliative and hospice care quality [Internet]. Washington (DC): NQF; 2006. [cited 2011 Jan 27]. Available from: http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_PREFERRED_Practices_for_Palliative_and_Hospice_Care_Quality.aspx
- 6 Morrison RS, Meier DE. Clinical practice: palliative care. *N Engl J Med*. 2004;350(25):2582–90.
- 7 American Hospital Association. AHA hospital statistics. Chicago (IL): AHA; 2010.
- 8 Center to Advance Palliative Care. A guide to developing a hospital-based palliative care program. New York (NY): The Center; 2004.
- 9 Von Gunten CF. Secondary and tertiary palliative care in US hospitals. *JAMA*. 2002;287(7):875–81.
- 10 Manfredi PL, Morrison RS, Morris J, Goldhirsch SL, Carter JM, Meier DE. Palliative care consultations: how do they impact the care of hospitalized patients? *J Pain Symptom Manage*. 2000;20(3):166–73.
- 11 Ringdal GI, Jordhoy MS, Kaasa S. Family satisfaction with end-of-life care for cancer patients in a cluster randomized trial. *J Pain Symptom Manage*. 2002;24(1):53–63.
- 12 Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363(8):733–42.
- 13 Penrod JD, Deb P, Luhrs C, Dellenbaugh C, Zhu CW, Hochman T, et al. Cost and utilization outcomes of patients receiving hospital-based palliative care consultation. *J Palliat Med*. 2006;9(4):855–60.
- 14 Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008;168(16):1783–90.
- 15 Penrod JD, Deb P, Dellenbaugh C, Burgess JF Jr., Zhu C, Christiansen CL, et al. Cost and utilization effects of hospital-based palliative care consultation. *J Palliat Med*. 2010;13(8):973–9.
- 16 Smith TJ, Coyne P, Cassel B, Penberthy L, Hopson A, Hager MA. A high-volume specialist palliative care unit and team may reduce in-hospital end-of-life care costs. *J Palliat Med*. 2003;6(5):699–705.
- 17 Rubin DB. Estimating causal effects from large data sets using propensity scores. *Ann Intern Med*. 1997;127:757–63.
- 18 Rubin DB. Using propensity scores to help design observational studies: application to the tobacco litigation. *Health Serv Outcomes Res Methodol*. 2001;2:169–88.
- 19 Rubin DB, Thomas N. Matching using estimated propensity scores: relating theory to practice. *Biometrics*. 1996;52(1):249–64.
- 20 Center to Advance Palliative Care [home page on the Internet]. New York (NY): The Center; 2010 [cited 2010 Sep 10]. Available from: <http://www.capc.org>
- 21 Rabow MW, Dibble SL, Pantilat SZ, McPhee SJ. The comprehensive care team: a controlled trial of outpatient palliative medicine consultation. *Arch Intern Med*. 2004;164(1):83–91.
- 22 Casarett D, Pickard A, Bailey FA, Ritchie C, Furman C, Rosenfeld K, et al. Do palliative consultations improve patient outcomes? *J Am Geriatr Soc*. 2008;56(4):593–9.
- 23 Back AL, Li Y-F, Sales AE. Impact of palliative care case management on resource use by patients dying of cancer at a Veterans Affairs medical center. *J Palliat Med*. 2005;8(1):26–35.
- 24 Axelsson B, Sjoden PO. Quality of life of cancer patients and their spouses in palliative home care. *Palliat Med*. 1998;12(1):29–39.
- 25 Rosenfeld K, Rasmussen J. Palliative care management: a Veterans Administration demonstration project. *J Palliat Med*. 2003;6(5):831–9.

- 26 Santa-Emma PH, Roach R, Gill MA, Spayde P, Taylor RM. Development and implementation of an inpatient acute palliative care service. *J Palliat Med*. 2002;5(1):93-100.
- 27 Elixhauser A, Steiner C, Harris DR, Coffey RM. Comorbidity measures for use with administrative data. *Med Care*. 1998;36(1):8-27.
- 28 Birkenshaw C. UB-92 handbook for hospital billing with answers. Chicago (IL): American Hospital Association; 2005.
- 29 Rubin DB. The design versus the analysis of observational studies for causal effects: parallels with the design of randomized trials. *Stat Med*. 2007;26(1):20-36.
- 30 To access the Appendix, click on the Appendix link in the box to the right of the article online.
- 31 Kaiser Family Foundation. Medicaid today [slide on the Internet]. Washington (DC): KFF; 2010 Jul 26 [cited 2011 Jan 18]. Available from: <http://facts.kff.org/chart.aspx?ch=463>
- 32 Rosenbaum S. A customary and necessary program—Medicaid and health care reform. *N Engl J Med*. 2010;362(21):1952-55.
- 33 Kaiser Family Foundation. State variation and health reform section 6: Medicaid spending by service and population [Internet]. Washington (DC): KFF; [cited 2011 Jan 18]. Available from: <http://facts.kff.org/chart.aspx?cb=56&sctn=153&p=1>
- 34 Truffer CJ, Klemm JHeD, Hoffman ED, Wolfe CJ. 2008 actuarial report on the financial outlook for Medicaid. Washington (DC): Centers for Medicare and Medicaid Services; 2008.
- 35 Siu AL, Spragens LH, Inouye SK, Morrison RS, Leff B. The ironic business case for chronic care in the acute care setting. *Health Aff (Millwood)*. 2009;28(1):113-25.
- 36 Lilly CM, De Meo DL, Sonna LA, Haley KJ, Massaro AF, Wallace RF, et al. An intensive communication intervention for the critically ill. *Am J Med*. 2000;109(6):469-75.
- 37 Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DO, Blustein J, Cranford R, et al. Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. *JAMA*. 2003;290(9):1166-72.
- 38 Campbell M, Guzman J. Impact of a proactive approach to improve end-of-life care in a medical ICU. *Chest*. 2003;123:266-71.
- 39 Norton SA, Hogan LA, Holloway RG, Temkin-Greener H, Buckley MJ, Quill TE. Proactive palliative care in the medical intensive care unit: effects on length of stay for selected high-risk patients. *Crit Care Med*. 2007;35(6):1530-5.
- 40 Taylor DH Jr., Ostermann J, Van Houtven CH, Tulsy JA, Steinhauer K. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Soc Sci Med*. 2007;65(7):1466-78.
- 41 Kaiser Family Foundation. Medicaid's long-term care beneficiaries: an analysis of spending patterns [Internet]. Washington (DC): KFF; 2006 [cited 2011 Jan 18]. Available from: <http://www.kff.org/medicaid/7576.cfm>
- 42 Mitchell SL, Teno JM, Kiely DK, Shaffer ML, Jones RN, Prigerson HG, et al. The clinical course of advanced dementia. *N Engl J Med*. 2009;361(16):1529-38.
- 43 Huskamp H, Stevenson D, Chernew M, Newhouse J. A new Medicare end-of-life benefit for nursing home residents. *Health Aff (Millwood)*. 2010;29(1):130-5.
- 44 Meier DE, Lim B, Carlson M. Raising the standard: palliative care in nursing homes. *Health Aff (Millwood)*. 2010;29(1):136-40.
- 45 Center to Advance Palliative Care [Internet]. New York (NY): CAPC; c2011. Press release, Palliative care programs continue rapid growth in US hospitals becoming standard practice throughout the country: large and not-for-profit hospitals take the lead; for-profit hospitals lag behind; 2010 Apr 6 [cited 2011 Jan 1]. Available from: <http://www.capc.org/news-and-events/releases/04-05-10>
- 46 Higginson IJ, Finlay IG, Goodwin DM, Hood K, Edwards AG, Cook A, et al. Is there evidence that palliative care teams alter end-of-life experiences of patients and their caregivers? *J Pain Symptom Manage*. 2003;25(2):150-68.

ABOUT THE AUTHORS: R. SEAN MORRISON, JESSICA DIETRICH, SUSAN LADWIG, TIMOTHY QUILL, JOSEPH SACCO, JOHN TANGEMAN & DIANE E. MEIER



R. Sean Morrison is a professor at Mount Sinai School of Medicine, in New York City.

In this issue of *Health Affairs*, Sean Morrison and coauthors show that the use of palliative care consultation teams saves money when compared to usual hospital

care for Medicaid patients with serious and advanced illnesses. The current health care system is ill suited to the needs of these most vulnerable and costly patients and results in “tremendous suffering,” Morrison says. He and his coauthors hope that their study will help persuade policy makers that care for these patients can be improved by carefully assessing their needs and mobilizing care to meet their goals.

Morrison is a professor at Mount Sinai School of Medicine. He

serves both as the director of the National Palliative Care Research Center and as the vice chair for research at Mount Sinai’s Department of Geriatrics and Palliative Medicine. He received his medical degree from the University of Chicago and, in 2010, received a national leadership award from the American Academy of Hospice and Palliative Medicine.



Jessica Dietrich is the director of research at the Center to Advance Palliative Care at Mount Sinai School of Medicine.

Jessica Dietrich is the former director of research for Mount Sinai School of Medicine's Center to Advance Palliative Care. She received a master of public health degree from Columbia University.



Susan Ladwig is a health project coordinator at the University of Rochester, in Rochester, New York.

Susan Ladwig serves as a health project coordinator for the School of Medicine and Dentistry's Palliative Care Team at the University of Rochester. She received a master of public health degree from the University of Rochester Medical Center.



Timothy Quill is a professor at the University of Rochester.

Timothy Quill runs the University of Rochester Medical Center's Palliative Care Program and serves as director of the Center for Ethics, Humanities, and Palliative Care. He is also a professor of medicine, psychiatry, and medical humanities. He received a community leadership award from the American Academy of Hospice and Palliative Medicine in 2010. Quill received his medical degree from the University of Rochester.

Joseph Sacco is the director of the Bronx Lebanon Hospital Center's Palliative Medicine Consultation Service. He is an assistant clinical professor of family practice at the Albert Einstein College of Medicine. Sacco received his medical degree from the Mount Sinai School of Medicine.



John Tangeman is the associate medical director of the Center for Hospice and Palliative Care.

John Tangeman is the associate medical director of the Center for Hospice and Palliative Care, in Cheektowaga, New York. He received his medical degree from the State University of New York Upstate Medical Center.



Diane E. Meier is a professor at Mount Sinai School of Medicine.

Diane Meier serves as director of the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine, where she is also a professor in the Department of Geriatrics and Palliative Medicine. She was named a MacArthur Fellow in 2008. Meier received her medical degree from Northwestern University.