Palliative Care Programs Spread to 1 in 4 Hospitals

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The number of palliative care programs in U.S. hospitals grew from 632 in 2000 to 1,027 in 2003, an increase of 63%, according to results from a large study.

The study "demonstrates the increasing recognition by hospitals in the United States and those providing primary care for patients with advanced illness of the need for palliative care services," said Dr. R. Sean Morrison, the study's primary author.

"This is becoming part of what should be routine medical care. We have seen growth from a fraction of hospitals having hospital-based palliative care programs to where now 1 in 4 hospitals have a program. I'm not going to be satisfied until 100% of hospitals have [a palliative care program], but for patients and families, I think we're at the point where they do have access to this type of care. I think we are at a tipping point," said Dr. Morrison, vice chair of research in the department of geriatrics at Mount Sinai Medical Center, New York.

He and his associates obtained data from the 2001-2004 American Hospital Association annual surveys, which covered calendar years 2000-2003. The AHA's annual survey defines a palliative care program as "an organized program providing specialized medical care, drugs, or therapies for the management of acute or chronic pain and/or the control of symptoms administered by specially trained physicians and other clinicians; and supportive care services, such as counseling on advanced directives, spiritual care, and social services, to patients with advanced disease and their families."

The researchers identified all programs that self-reported the presence of a hospital-owned palliative care program and acute medical and surgical beds, and then used multivariate logistic regression to pinpoint factors that were associated with the presence of an adult palliative care program in the 2003 survey data (J. Palliat. Med. 2005;8:1127-34).

They found that hospitals in the Northeast, Pacific, and Mountain areas of the country are more likely than those in other geographic regions to have programs. The greater the number of hospital beds and acute care beds, the more likely a facility has a palliative care program. Similarly, being a Veterans Affairs hospital or a not-for-profit hospital increases the likelihood.

Among the factors associated with having a palliative care program are being a member of the American Association of Medical Colleges Council of Teaching Hospitals and being a cancer hospital approved by the American College of Surgeons.

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DR. MORRISON

"The fact that the American College of Surgeons would want to incorporate access to palliative care as one of their benchmarks of good care in a cancer setting is a sign that palliative care has been very successful in legitimizing its place in the continuum of medical practice," said Dr. Geoffrey P. Dunn, an Erie, Pa.–based surgeon who cochairs the ACS's Surgical Palliative Care Task Force.

"People are becoming increasingly aware that palliative care is an extension of the already well-known and very successful hospice programs in this country. As this study shows, there are more occasions where they will have the opportunity for those services. I think that's going to increasingly generate that expectation in care, whether it's at a cancer center or elsewhere," said Dr. Dunn.

Dr. Daniel B. Hinshaw, medical director of the palliative care consult team at the Ann Arbor (Mich.) VA Medical Center, said the increasing presence of palliative care programs in the nation's hospitals "gives us an opportunity to keep that message out there that this [component of care] is not just a matter of fighting disease. It's really about caring for the whole person who might have a bad disease," he said. "We may not always be able to cure their problem, but we should always try our best to provide comfort and relief of distress and symptoms."

For-profit hospitals, however, are significantly less likely to have programs, according to the study. Dr. Morrison said part of the reason may be the fact that palliative care programs started in academic medical centers and branched out to teaching hospitals. "The majority of teaching hospitals in the United States are still not-for-profit," he said. "I don't think there is a lot of communication [about palliative care programs] between the not-for-profit sector and the for-profit sector, but it's something we'd like to address."

Dr. Dunn called the current funding landscape for hospital-based palliative care programs "tenuous" even though numerous demonstration projects have shown them to be cost-effective. "What will be a challenge in 5-10 years will be the physician staffing of these [programs]," he said. "Very shortly the American Board of Hospice and Palliative Medicine is expecting to receive credentialing from the American Board of Medical Specialties. Once that happens, that is going to put a pretty narrow lock on the pool of people who are considered certified and qualified to run these programs. I'm concerned that with this rapid proliferation of programs, how are we going to fill the demand for physicians who have some degree of training in this to do it?"

Dr. Morrison's study noted that there were 1,892 certified palliative medicine physicians as of July 2005 and 5,500 certified palliative nurses as of March 2005. It also noted that the number of postgraduate palliative medicine fellowships increased from 17 in 2000 to 53 in 2005.

Dr. Morrison said that the cost of a hospital-based palliative care program is directly related to the size of the hospital. At Mount Sinai Medical Center, which is a 1,000-bed teaching hospital, the palliative care program consists of two full-time physicians, four full-time nurse-practitioners, two full-time social workers, and consultation with chaplaincy and physical therapy.

"The expense of the program is far outweighed by the cost savings to our hospital for having it," said Dr. Morrison, whose study was funded by the Robert Wood Johnson Foundation. "For a 300-bed hospital, the team is probably going to be a physician, a nurse, a social worker, and consultation with other core services. For a 50-bed rural hospital, it may be that the primary person is a nurse-practitioner with a part-time physician as backup in consultation with other services in the hospital."

To access a financial calculator that helps you estimate the cost of a palliative care program and the cost savings to your hospital, visit the Center to Advance Palliative Care's Web site at www.capc.org. Look for the "CAPC Impact Calculator" icon. ■

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A hospital nurse combs a terminally ill patient's hair. Terminal, or palliative, care aims to achieve the best possible quality of life for patients and their families.

Initiative Helps California Hospitals Implement End-of-Life Services

A California program has helped hospitals establish palliative care services, according to a recent study evaluating the program 1 year after its completion.

Given that more than half of people in the United States die in a hospital, end-of-life care is an important part of hospital services. The California Hospital Initiative in Palliative Services (CHIPS) program was designed to assist hospitals in organizing palliative care programs (Arch. Intern. Med. 2006;166:227-30).

Dr. Steven Z. Pantilat of the University of California at San Francisco and associates recruited all types of hospitals across California for the program. Interested hospitals had to demonstrate their readiness, obtain administration approval, and pay a $2,500 fee.

"The typical hospital participating in CHIPS was a large, not-for-profit, private hospital in an urban setting that had a hospitalist program," the investigators noted.

The 38 participating hospitals sent three-person multidisciplinary teams to a skills conference where they were paired with a CHIPS mentor. For 10 months, mentors consulted regularly with the teams. Between 8 and 11 months after the first conference, a reunion conference was held focusing on participants' needs, challenges, and successes. Two cohorts of hospital teams have completed the program.

A follow-up cross-sectional telephone survey was conducted 29 months after the initial conference for cohort 1 (18 months for cohort 2). By the time of the survey, of the 32 hospitals without a palliative care program, 19 had established new palliative care consultation services, a success rate of 60%. The six hospitals with existing services continued to offer them, giving an overall success rate of 66%. Urban hospitals and those with a hospitalist program were significantly more likely to establish new programs.

The investigators commented that "it takes time to implement a palliative care consultation service," suggesting that ongoing mentoring and assistance could be beneficial. In fact, 60% of the hospitals participating in the program helped other hospitals develop palliative care services.

—Melinda Tanzola