The Cost of Waiting:

Implications of the Timing of Palliative Care Consultation among a Cohort of Decedents at a Comprehensive Cancer Center

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Disclosures

• No relevant financial relationships or conflicts of interest to disclose
Objectives

1. Introduce metrics used to assess quality of medical care provided at the end of life

2. Discuss how quality outcomes differ between patients who received early vs. late palliative care consultation

3. Consider financial implications of early PC consultation at UCSF
Background

1. ASCO recommends that palliative care (PC) be offered alongside standard oncologic care for pts with metastatic CA and/or high symptom burden.

2. Multiple studies have demonstrated improved quality, cost savings, improved patient satisfaction with PC.

3. Limited data on how timing and setting of PC is associated with quality, intensity and cost of medical care at EOL in pts with advanced CA.
Research Question

• Among a population of patients who received regular care at an academic cancer center and who died of cancer, we sought to understand:

  o The overall rate of referral to specialty Palliative Care
  o Associations of Early (>90 days prior to death) versus Late (<90 days prior to death) provision of PC with overall quality of care as well as direct cost of medical care
  o The setting (inpatient vs outpatient) in which both Early and Late PC were delivered
Study Design: Retrospective Cohort

• Patients who received regular cancer care at UCSF
  o Died within 29 month study period
  o Cancer as known cause of death
  o At least 2 visits with UCSF oncology

• Looked at patients who had contact with specialty palliative care (PC)
  o Groups divided into Early (>90 days) and Late PC (>90 days)

• Evaluated clinical outcomes and overall cost in the 6 months preceding death
Too little, too late

- 922 patients identified
- Only 32% of patients had any contact with IP and/or OP PC services
- 10% received Early-PC (initial PC contact more than 90 days prior to death)
- 21% received Late-PC (initial PC contact 90 or fewer days prior to death)
Early-PC = Better Quality

Early-PC associated with better performance on EOL quality measures

*NQF measures
Average direct cost per patient for medical care in final 6 months of life

Early PC = Less Spending on Futile Care

<table>
<thead>
<tr>
<th>Direct Outpatient Costs</th>
<th>Direct Inpatient Costs</th>
<th>Total Direct Costs</th>
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<tbody>
<tr>
<td>Early PC</td>
<td>13,040</td>
<td>19,067</td>
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<tr>
<td>Late PC</td>
<td>11,549</td>
<td>25,754</td>
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</tbody>
</table>

p=0.006

p<0.001

p=0.86
Early-PC = less escalation in utilization

Average direct cost per inpatient admission by month, final 6 months of life
Early Palliative Care = Outpatient PC

- 91% of patients that only saw inpatient PC team received Late-PC
- 25% Late PC patients had any OP PC
- 84% of patients with OP PC received Early-PC
- 75% of patients where 1st PC contact was in OP setting received Early-PC
- Early PC allows for multiple contacts with palliative care over time
  - 78% of Early-PC patients had multiple contacts with PC services, compared to only 18% of Late-PC cases
Opportunities for earlier referral to PC

67% (137/204) of Late-PC patients had at least 2 office visits in months 6-4 preceding death

Late-PC = late referral, not late presentation to the cancer center

# Office Visits in months 6-4 preceding death

- 2: 30 cases
- 3: 33 cases
- 4: 34 cases
- 5: 19 cases
- 6: 7 cases
- 7: 6 cases
- 8: 5 cases
- 9: 2 cases
- 12: 1 case
Big picture findings

• Specialty Palliative Care is underutilized in advanced cancer patients at UCSF

• Early PC is associated with better clinical outcomes when compared to late PC

• Early PC associated with significant inpatient and overall cost savings

• Early PC is best delivered in the outpatient setting
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Questions?