The UNIVERSITY of VERMONT

James M. Jeffords Center's

Vermont Legislative Research Service

Palliative Care

According to Massachusetts General Hospital, palliative care is a form of medical treatment that helps both patients and families suffering through life threatening illnesses live as fully and as pleasantly as possible. Palliative care differs from hospice care in that palliative services are provided during any phase of an illness, instead of focusing exclusively on end-of-life care.[1] Palliative care is a growing form of medical treatment in the United States. In fact, several states have sought to bring palliative care into mainstream medical practice.[2] Approximately 53% of hospitals in the United States offer palliative care.[3] This report examines state initiatives, effectiveness, the costs and savings, and opposition and barriers to palliative care.

Palliative Care in the States

Researchers at the Center to Advance Palliative Care (CAPC)[4] have examined the availability of palliative care and graded states' palliative care programs.[5] The three states with an A grade are Montana, New Hampshire, and Vermont. On the other end of the spectrum, Alabama, Mississippi, and Oklahoma all received an F letter grade for their programs.[6] The map below

---

[1] Massachusetts General Hospital, "Palliative Care," accessed April 7, 2011, http://www.massgeneral.org/palliativecare.

[2] Matthew Geever, "Thinking Outside the Hospice: States Look To Expand Palliative Care Services," *National Conference of State Legislatures* 29 (2008): 524, accessed April 12, 2011, http://www.ncsl.org/default.aspx?tabid=14254.

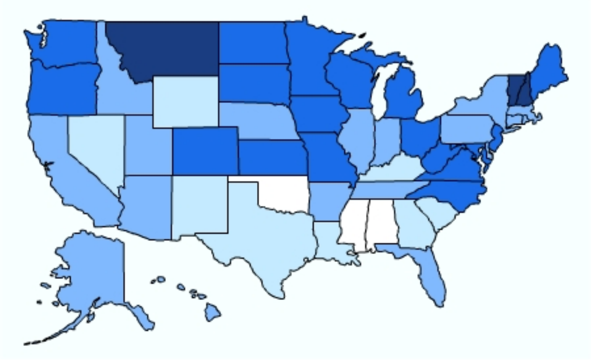
[3] Alicia Ault, "Hospitals Get a 'C' In Palliative Care," accessed April 12, 2011, http://www.ehospitalistnews.com/specialty-focus/pain/single-article-page/hospitals-get-a-c-in-palliative-care/f1f1a222f5.html.

[4] About CAPC from their web site http://www.capc.org/reportcard/acknowledgments: "Located at Mount Sinai School of Medicine, CAPC is a national organization dedicated to increasing the availability of quality palliative care services for people facing serious, complex illness."

[5] Benjamin Goldsmith, Jessica Dietrich, Qingling Du, and R. Sean Morrison, "Variability in Access to Hospital Palliative Care in the United States," *Journal of Palliative Medicine*, Volume 11, Number 8, 2008, accessed May 6, 2011, http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2008.0053.

[6] Center to Advance Palliative Care, "How Does Your State Rate?" accessed April 19, 2011, http://www.capc.org/reportcard/.

depicts which states have received which grades from the CAPC, and the bar chart below shows the prevalence of each grade.



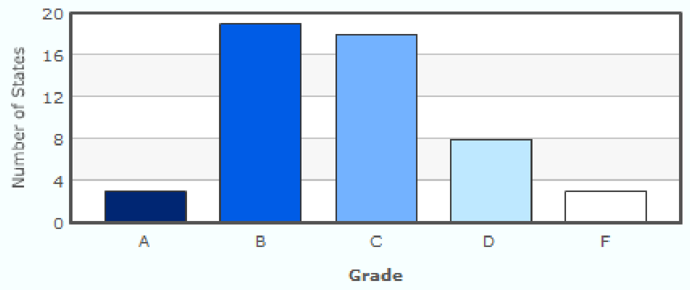


Figure 1. The map above displays the CAPC's state by state palliative care grades by color. The bar chart shows the prevalence of each of the grades.

Source: Center to Advance Palliative Care, "How does your state rate?" accessed April 13, 2011, http://www.capc.org/reportcard/home/VT/RC/Vermont.

Vermont

Despite being small and relatively rural, Vermont is one of the nation's leaders in access to palliative care.[7] Vermont was one of only three states that received an A grade from the Center to Advance Palliative Care because all mid to large hospitals (50 plus bed) and most (7 of 9) small hospitals have palliative care programs.[8]

---

[7] Dartmouth Hitchcock Medical Center, "New Hampshire, Vermont Lead Nation in Access to Palliative Care," last modified October 15, 2008, accessed April 19, 2011, http://www.dhmc.org/webpage.cfm?site_id=2&org_id=2&morg_id=0&sec_id=0&gsec_id=51860&item_id=51860.

[8] Center to Advance Palliative Care, "How does your state rate?" accessed April 13, 2011, http://www.capc.org/reportcard/home/VT/RC/Vermont.

Vermont has been proactive in supporting palliative care at the state level. In 2009, Vermont passed Act 25, a palliative care and pain management act. The purpose of this act was to expand palliative care and pain management services to as many Vermonters as possible.[9]

California

In 2006, California Governor Schwarzenegger signed the Nick Snow Children's Hospice and Palliative Care Act / Assembly Bill 1745.[10] This legislation established a new hospice and palliative care benefit for children. This statute contains provisions child will be provided with full palliative care only if:

- A physician decides that the pediatric patient has six months or less to live and;
- he child decides he/she wants to stop curative treatment.[11]

This legislation also created the Children's Medical Services (CMS), a branch to work alongside the Children's Hospice and Palliative Care Coalition, the Medi-Cal Waiver Analysis Section, and other policy makers in developing and evaluating the statewide palliative care waiver. The waiver has been implemented to inhibit the development of comprehensive Pediatric Palliative Care programs that promote the expansion of hospice type services and curative care concurrently. The intent is for an enriched quality of life for children suffering terminal illnesses, and their family members watching them helplessly. The cost neutrality associated with this legislation will foster reduced hospital stays, medical transports, emergency room visits, and expensive components while a child is protected under the CMS waiver.[12] In June of 2008, the Terminal Patients' Right to Know End-of-Life Options Act was enacted, providing patients with different options of care available from their doctor upon request. This legislation was the first providing terminally ill patients with full disclosure and counseling on all available legal and ethical end-of-life decisions. Another provision of this act stated that all health care providers that do not comply with the patients' choice must refer or transfer the patient to another facility.[13]

---

[9] Vermont Ethics Network, "Act 25 and the Palliative Care and Pain Management Task Force," accessed April 14, 2011, http://www.vtethicsnetwork.org/act25_task_force.html.

[10] California State Assembly Bill 1745, Chapter 330, Section 14132.74, accessed April 20, 2011, http://info.sen.ca.gov/pub/05-06/bill/asm/ab_1701-1750/ab_1745_bill_20060919_chaptered.html

[11] "Pediatric Palliative Care Program Overview," California Department of Health Care Services, accessed April 20, 2011, http://www.dhcs.ca.gov/services/ppc/ppc/Pages/ProgramOverview.aspx.

[12] "Pediatric Palliative Care Program Overview," California Department of Health Care Services.

[13] Diane E. Meier and Larry Beresford, "Palliative Care Professionals Contribute to State Legislative and Policy Initiative," *Journal of Palliative Medicine*, 11(2010): 1070-1073.

New York

In 2007 the New York State Assembly passed the Palliative Care Education and Training Act, a combination of two legislative proposals. This initiative was supported by $4.9 million of appropriations from the state budget to fund four main components:

1. Grants for undergraduate and graduate medical education in palliative care;
2. Specific locations noted for their excellence in palliative care;
3. Clearly identified resource centers for palliative care practitioners; and,
4. Appointment of a counsel overseeing the education and training for palliative care.

The above program is implemented by the New York State Task Force on Life and the Law, created in the 1990s to help the Commissioner of Health decide on the best practices in palliative care. The Hospice and Palliative Care Association of New York State (HPCANYS) also has an active palliative care advisory group that has been seeking to give coverage to palliative care providers. Palliative care was enacted in the New York State's hospice licensure law in 2002.[14]

Governor David Patterson signed the New York Palliative Care Information Act into law in August 2010. This law requires that physicians discuss palliative care and end-of-life treatment plans with terminally ill patients. Under this provision, if a patient has six or less months to live, a physician and/or nurse practitioner are required to provide plans of action highlighting the original prognosis, risks, and potential benefits for the patient. This law also includes the patients' legal rights to pain and symptom management at the end of life. Compared to California's statute, New York's law places more responsibility on the physician, making the law stronger and more regulated.[15]

Effectiveness

Dr. Jill A. Rhymes is a geriatric physician from Santa Fe, New Mexico. In her article "Barriers to Effective Palliative Care of Terminal Patients," Rhymes argues that an effective palliative care program requires two components. The first is the psychological and emotional care for the sick person and their family. The second component is pain relief, which is dealt with through medication. Both elements are essential to any palliative care program.[16]

---

[14] Diane E. Meier, Larry Beresford, "Palliative Care Professionals Contribute to State Legislative and Policy Initiative," *Journal of Palliative Medicine*, 11 (2010): 1070-1073, accessed April 23, 2011, http://www.liebertonline.com/doi/abs/10.1089/jpm.2008.9849.

[15] Alicia Ault, "New York State Mandates Counseling of Terminally Ill," *Family Practice News,* 40 (2010): 66, accessed April 23, 2011, http://www.familypracticenews.com/news/practice-trends/single-article/new-york-state-mandates-counseling-of-terminally-ill/34d870f6e1.html.

[16] Jill A. Rhymes, "Barriers to Effective Palliative Care of Terminal Patients," *Care of the Terminally Ill Patient*, 12 (1996): 407-416, accessed April 23, 2011, http://medicine.emory.edu/ger/bibliographies/pallative/bibliography5_files/Barriers_to_effective_palliative_care_of_terminal_patients.pdf.

A study performed at the King's College Hospital in London sought to assess the effectiveness of a hospital palliative care team. The study examined 125 hospital patients with malignant disease. The study assessed changes in symptom control, changes in patient insight regarding their diagnosis, and a variety of other factors. The results were promising for palliative care. The patients showed significant improvements in pain and understanding of their prognosis and diagnosis.[17] Another study in Palliative Medicine had the same objective and found similar results. The study found that compared to conventional care, there is evidence that palliative care improves patient satisfaction because they deal with patient and family needs.[18]

Saving Money

Hospitals

The journal *Palliative Medicine* released a study that sought to determine the cost of palliative care in hospitals. This observational study consisted of 3,321 hospitalized veterans with advanced disease. Eighteen percent of the population received palliative care and 82% received typical hospital care during the study. The study found that palliative care resulted in lower hospital costs. The average daily total hospital costs were $464 lower for the patients receiving palliative care. Furthermore, these patients were 43% less likely to be admitted to the Intensive Care Unit (ICU) during hospitalization than usual care patients.[19]

A recent multi-center study has shown that palliative care can save hospitals up to $300 a day because physicians, nurses, and other health-care providers use resources in a way that is more in line with the care a patient needs.[20] Another reason palliative care can save money is because providers receive feedback not only from the patient, but also from his or her family. Providers consult with the patient and their family in order to determine expectations and meet goals. Essentially, a family can determine whether or not a specific procedure is really in line with their goals for treatment, and decline such a treatment. This saves hospitals money because they are no longer prescribing unnecessary treatments and they can effectively shorten hospital stays.[21]

---

[17] John E. Ellershaw, "Assessing the effectiveness of a hospital palliative care team," *Palliative Medicine,* 9 (1995):145-152.

[18] Julie Hearn and Irene J. Higginson, "Do Specialist Palliative Care Teams Improve Outcomes for Cancer Patients? A Systematic Literature Review," *Palliative Medicine*, 12 (1998): 317-332, http://medicine.emory.edu/ger/bibliographies/pallative/bibliography77_files/Do_speacialist_palliative_care_teams_improve_outcomes_for_cancer_patients.....pdf.

[19] Joan D. Penrod, "Hospital-Based Palliative Care Consultation: Effects on Hospital Cost," *Journal of Palliative Medicine*, 13(2010): 973-979, accessed April 12, 2011, http://www.ncbi.nlm.nih.gov/pubmed/2064236.

[20] Debra Wood, "Palliative Care Teams Save Money," accessed April 12, 2011, http://www.amnhealthcare.com/News/news-details.aspx?Id=6886.

[21] Alicia Caramenico, "Palliative Care Could Save States Millions," accessed April 12, 2011, http://www.fiercehealthcare.com/story/palliative-care-could-save-states-millions/2011-03-08.

The Center to Advance Palliative Care suggests that hospitals benefit from palliative care programs in a variety of ways. They argue that palliative care lowers the cost for hospitals and payers. Palliative care programs have low implementation costs. Simultaneously, overall resource use and ICU utilization decreases. Palliative care programs also provide an effective approach for patients with the most needs within an inpatient population. They also suggest that an effective palliative care program eases the burdens on staff and increases retention for employees.[22]

States

State Medicare and Medicaid programs also stand to save money when palliative care is implemented. According to an article in the March issue of the policy journal *Health Affairs*, $6,900 could be saved in hospital costs for each patient per admission by providing them with palliative care. A Mount Sinai Hospital study estimated that the state of New York could save between $84 and $252 million annually in Medicaid payouts if palliative care was implemented at hospitals with 150 or more beds.[23] With this amount of savings, hospitals in New York would not have to cut certain Medicaid programs, but rather, would be able to use those savings to improve services. Another study conducted by researchers at Duke University found that patients who enter a hospice program can save Medicare $2,300 for each person.[24]

Opposition and Barriers

There have been substantial efforts attempting to thwart the expansion of palliative care in the United States. This opposition is due to a confusing linkage between the true definition of palliative care — which is unclear to many Americans, often just grouped with hospice care — and physician assisted suicide. The most common example used is Oregon, a state that has had legal provisions for physician-assisted suicide since 1997 through the "Death with Dignity Act." This legislation was later the model for Washington's "Death with Dignity Act," recently passed in 2008. It is argued that the legalization of assisted death is attributed to the substantial advances that Oregon has undergone in its palliative care programs. "Effective palliative care and hospice services may address many of the key reasons why patients request assistance in dying — such as loss of autonomy, dignity, and the ability to care for themselves in a home environment — and lead some to change their minds." [25]

---

[22] Center for the Advancement of Palliative Care, "Benefits to Hospitals," accessed April 19, 2011, http://www.capc.org/building-a-hospital-based-palliative-care-program/case/hospitalbenefits.

[23] Sean R. Morrison, Jessica Dietrich, Susan Ladwig, Timothy Quill, Joseph Sacco, John Tangeman, and Diane Meier, "Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries," *Health Affairs* 30 (2011): 3454-3463.

[24] Gale Scott, "Study: Dying Cancer Patients Need ICU Alternatives," *Crain's New York Business.com*, accessed April 14, 2011, http://www.crainsnewyork.com/article/20101119/FREE/101119824#.

[25] Robert Steinbrook, "Physician Assisted Death — From Oregon to Washington State," *New England Journal of Medicine* 359 (2008): 2513-2515, accessed April 17, 2011, http://www.nejm.org.ezproxy.uvm.edu/doi/full/10.1056/NEJMp0809394.

There are a few barriers that have kept palliative care out of mainstream medical news. The essential components in implementing a successful program include accessibility, availability, acceptability, and quality. Aside from these factors, the true barriers are the lack of awareness and political support, social and cultural issues regarding medical practice, and opiophobia — an inadequate education of doctors, nurses, and physician assistants in the field of pain management. To further complicate the issue, attitudes within the medical field and the low priority that palliative care receives from policy makers, health administrators, and educators in the field are all barriers that continue to halt the progress that palliative care has already started.[26]

Conclusion

Based on the evidence, palliative care is a rising sector of healthcare. Practicality appears to be a driving force in the enactment of palliative care programs — when a provider treats a patient for what that individual needs, they are offering a service not only to that patient but also the family of the patient. Increased communication between providers and patients broadens the scope of options and the patient has a voice in what happens next and also provides further insight to legal decisions at the end of life. Not only is palliative care beneficial for patients, but it also stands to save hospitals and states substantial amounts of money.

Prepared by Allyson Perleoni, Alexander Rosenblatt, and Max McNamara in response to a request from Representative Topper McFaun under the supervision of graduate student Kate Fournier and Professor Anthony Gierzynski on May 6, 2011.

Contact: Professor Anthony Gierzynski, 513 Old Mill, The University of Vermont, Burlington, VT 05405, phone 802-656-7973, email agierzyn@uvm.edu.

Disclaimer: This report has been compiled by undergraduate students at the University of Vermont under the supervision of Professor Anthony Gierzynski. The material contained in the report does not reflect the official policy of the University of Vermont.

---

[26] Liz Gwyther, Frank Brennan, Richard Harding, "Advancing Palliative Care as a Human Right," *Journal of Pain and Symptom Management* 38 (2009): 767-774, accessed April 19, 2011, http://www.sciencedirect.com.ezproxy.uvm.edu/science?_ob=ArticleURL&_udi=B6T8R-4X9D5B3-1&_user=1563816&_coverDate=11%2F30%2F2009&_rdoc=1&_fmt=high&_orig=gateway&_origin=gateway&_sort=d&_docanchor=&view=c&_acct=C000053744&_version=1&_urlVersion=0&_userid=1563816&md5=532f127a277b30a6d13086b3944c0ce4&searchtype=a.