

Unlikely Way to Cut Hospital Costs: Comfort the Dying

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Palliative-Care Unit Offers Painkillers and Support, Fewer Tests, Treatments Playing Santa in August

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Tom Smith

RICHMOND, Va. -- The palliative-care unit at Virginia Commonwealth University Medical Center offers plush carpeting, original watercolors and a kitchen for visiting families. A massage therapist drops by often, and a chaplain is available 24 hours. And there's High Anxiety, a fluffy white Lhasa apso that patients love to pet.

In an era of skyrocketing health-care costs, such perks might seem misplaced. In fact, it is all part of an approach that has helped VCU save millions of dollars in an area that is notoriously expensive: treatment of patients diagnosed with incurable illnesses.

Palliative care focuses on comfort, not cure. It tries to relieve a patient's physical and psychological distress, instead of preserving life at any cost. Though palliative care is standard practice in some countries, especially in Britain, it has been slow to catch on in the U.S., where many doctors prefer to use the latest technology or drug to prolong a patient's life, if only for a few months. Fewer than 20% of community hospitals in the U.S. use the approach, according to the American Hospital Association.

"It's counterintuitive to the high-tech American model of health care," says Sheldon Retchin, chief executive officer of the VCU health system.

Now, palliative care is getting new attention, not just because proponents view it as humane, but because it is usually cheaper than standard care. In 2002, there were palliative-care programs in 844 community hospitals, 18% more than in the previous year. In palliative programs, less money is spent on drugs, diagnostics, tests and last-ditch treatment.

At VCU, for instance, a typical five-day stint for a cancer patient cost \$5,312 in the palliative wing -- 57% less than it cost to house a similar patient elsewhere in the hospital. VCU officials calculate that the 11-bed unit, which opened in May 2000, saved the hospital \$1 million last year, when the palliative wing broke even for the first time.

As they spread, palliative-care programs promise to fuel the debate over how to ration the nation's limited health-care resources -- especially in the expensive last days of life in a hospital. The VCU unit has been chosen as a model for other hospitals by the Center to Advance Palliative Care, based at New York's Mount Sinai School of Medicine, which wants to popularize the concept by emphasizing both the humane and economic case for such care.

Though palliative care has been recognized as a medical specialty in Britain since 1987, it doesn't enjoy the same stature here. Most hospital CEOs in the U.S. are more familiar with making a profit by, say, installing a new CAT-scan machine. Others worry that palliative care could turn into a ploy for saving money off the backs of dying patients. Many physicians -- and patients -- simply don't like the idea of giving up until all possible avenues of treatment have been exhausted.

Even so, end-of-life care in the U.S. remains "woefully inadequate," according to a national study of such treatment, published last year in the *Journal of the American Medical Association*. One in four people who died didn't receive enough pain medication and sometimes received none at all, according to researchers at Brown University and the University of Massachusetts at Boston.

Ageing populations in the developed world will fuel demand for better end-of-life care: By 2030, the number of Americans over the age of 85 is expected to double to 8.5 million.

The roots of palliative care lie in the hospice movement, which got its start in Britain in the 1960s. The approach advocated regular use of opioids -- drugs derived from opium -- to control pain, and the easing of a

patient's mental distress as well. Widely used across England's state-funded National Health Service today, it is usually invoked early on in an illness and used in conjunction with life-prolonging treatments.

Palliative care in the U.S. sometimes overlaps with hospice care, but there are key differences. Both emphasize pain management and easing mental stress, rather than trying to cure a disease. But hospice care is often provided in a home setting, not in a hospital, and usually comes when a patient has less than six months to live. Palliative care can begin earlier, and involve some procedures to treat symptoms of the disease, such as blood transfusions and radiation treatment.

The seeds of VCU's palliative-care unit were sown in 1992 when Tom Smith, an oncologist at VCU, and a colleague, Patrick Coyne, who both had an interest in palliative care, briefly taught at a Tanzanian cancer hospital.

"I realized that I was teaching this halfway round the world and I should be teaching it in Richmond," Dr. Smith says. When he returned to Virginia, he broached the idea of a palliative unit at VCU. The medical center's response: First, prove there is a need for it.

CARE, NOT CURE

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital.

	Non-PCU	PCU
Drugs and chemotherapy	\$2,267	\$511
Lab	1,134	56
Diagnostic imaging	615	29
Medical supplies	1,821	731
Room & nursing	4,330	3,708
Other	2,152	278
Total	\$12,319	\$5,313

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.

Source: *Virginia Commonwealth University medical center*

In 1994, Mr. Coyne, a clinical nurse specialist, did a study of patient charts from around the hospital. On a typical day, he found there were about 30 patients with an incurable disease who suffered shortness of breath, nausea and other symptoms. Often, a patient's health "would be declining and declining, but doctors weren't picking up on it," he says.

Mr. Coyne then surveyed hospital physicians. The news wasn't encouraging. Virtually everyone said they'd support the idea of palliative care -- but only 1% said they'd actually want to be involved in the project. Dr. Smith says there were three reasons: Doctors said they were busy, they were reluctant to try something new, and few were eager to speak with patients about their approaching death. "Most doctors go into medicine to save everyone," he says.

VCU eventually agreed to back the project -- with one major condition. The medical center's finances were in a precarious state after coming under pressure from managed care and a number of uninsured patients. So the hospital's chief executive told Messrs. Coyne and Smith to find the bulk of the money themselves. Their plan had to accommodate the fact that up to 15% of VCU's patients didn't have health-care insurance, which meant that the hospital would have to swallow the cost.

With no official financial backing, the two men embarked on a fund-raising campaign. The duo at first teamed with a regional hospital system, but that fell apart over issues of who would control the program, Dr. Smith

says, resulting in a loss of two years work. The picture brightened in 1997, when the Jesse Ball Dupont Foundation in Jacksonville, Fla., provided a three-year, \$375,000 grant to establish a palliative wing at VCU. But it was only when a woman named Barbara Hughes walked into his office a few weeks later, that Dr. Smith knew his luck had truly turned.

Ms. Hughes was one of six women who sat on the board of Richmond's Thomas Hospice, which had recently closed its doors. During their meeting, Ms. Hughes said she'd heard about Dr. Smith's palliative-care project and wanted to help. She offered to back his plan with the hospice's entire endowment of \$660,000.

That was enough for the hospital to give Dr. Smith the green light in 1999 to start construction of a palliative-care wing in VCU's former outpatient psychiatry unit. Then, in August of that year, Hurricane Floyd battered the East Coast. Rainwater flooded the roof of VCU's pediatric unit, and the hospital was forced to temporarily move its younger patients to the outpatient psychiatry site -- delaying the opening of the palliative unit by eight months.

During that time, Ms. Hughes and other women volunteers of the renamed Thomas Palliative Care Foundation were undaunted. By tapping ties to friends in the Richmond business community, they managed to wangle big discounts on everything from beds and chairs to drapery and carpeting. They even persuaded local artists to donate watercolor paintings for VCU's new wing.

At the VCU palliative-care unit, doctors don't readily offer expensive chemotherapy, antibiotics, MRIs or CAT scans. "We may have a more frank discussion with the patient and family and say that chemotherapy is not going to help," Dr. Smith says. "So let's forego that and relieve your shortness of breath instead." When given the choice, he says, most patients agree.

Not all VCU doctors do, however. When it comes to referring terminally-ill patients to the palliative-care unit, some hesitate. "They see us as the death squad," says Mr. Coyne.

On a recent morning, Dr. Smith, who now heads the palliative-care unit, embarked on his rounds. One patient was a 76-year-old woman who had lung cancer and had recently suffered a second heart attack. Earlier that day, she had become delirious and thrown things around. Instead of calling Dr. Smith, a nurse followed an "agitation algorithm" -- a standard set of instructions drawn up by the unit's doctors -- and gave the patient two milligrams of the antipsychotic Haldol, and oxygen, to calm her.

Such algorithms allow nurses to provide patients with quick, cost-effective relief, says Dr. Smith. A more-expensive option in the case of a delirious patient would be to check for a stroke, by requiring a CAT scan. "We might have saved \$2,000 or \$3,000 just by having a plan," says Dr. Smith.

VCU says that X-rays, CAT scans, MRIs and other diagnostic imaging services are ordered for 10% or fewer palliative-care patients in the last five days of their lives, but for more than 62% of nonpalliative patients at the hospital. Similarly, lab tests are ordered for almost all nonpalliative patients, but for fewer than 20% of those in the palliative wing.

Such steps have had a dramatic effect on the unit's expenses. Based on data on cancer patients in 2001 and 2002, the five-day cost for X-rays, CAT scans, MRIs and other diagnostic services was \$29 per patient in the palliative-care unit. Similar costs for a cancer patient elsewhere in the hospital amounted to \$615.

Equivalent comparisons showed that the five-day cost of chemotherapy and other medicines was \$511 in the palliative unit, compared with \$2,267 elsewhere at VCU, and the cost of medical supplies was \$731 in the palliative unit, compared with \$1,821. Even the average daily cost of room and nursing in the palliative unit is roughly 14% less, because there are fewer nurses per patient.

Cost isn't the only factor. Palliative-care supporters say such treatment provides a more comfortable end to life. Of all Americans who die each year, half die in a hospital, according to the National Hospice and Palliative Care Organization, based in Alexandria, Va. The staff at VCU's palliative unit tries to ensure that patients spend their last days at home. "If your time is limited, you want to be in the familiar," says Valerie Cauthorne, a social worker at VCU.

One recent candidate was Andrew Turner, who suffered from sickle-cell anemia. While doctors in the palliative unit had managed to relieve his pain, the 56-year-old former shoe repairman wasn't expected to survive beyond a year or so. When his sister and son dropped by for a visit in December, Ms. Cauthorne felt it was time to broach the big question.

As Mr. Turner lay propped up in bed, Ms. Cauthorne turned to the sister and said: "Your brother's gotten to the point where it's more than likely he will not get any better. I can arrange for personal care at home -- are you OK with that?"

The sister paused, then said it was fine. So did Mr. Turner. "I understand," he said, and shut his eyes. His son, a policeman, didn't utter a word and left the hospital soon after.

Mr. Turner never made it home. He died in the palliative-care unit on Dec. 22. His family was with him.

Comfort is extended in other, unexpected ways. Some palliative-care patients in intense pain are given a drug called Dilaudid. One of the world's most powerful pharmaceutical narcotics, it commands a price of \$50 per pill on the streets, where it's sometimes known as "drugstore heroin." Because it's so potent, "most doctors simply wouldn't prescribe Dilaudid because they're not comfortable with it," says Dr. Smith.

To help cancer patients who suffer shortness of breath, the Thomas team pioneered a "misting device" that delivers pain medication directly to the lungs. The approach is now used elsewhere at VCU and at several hospices.

The palliative unit at VCU has also been the scene of bar mitzvahs, weddings and even a high-school graduation ceremony for a dying 17-year-old. One patient wanted to give her grandchildren Christmas presents before she died. So even though it was August, a doctor dressed up as Santa, someone put up an artificial tree and the nurses sang Christmas carols.

The first group of visiting doctors and hospital administrators interested in studying VCU's approach arrived last month. A group pays between \$750 to \$1,000 for a two-day visit -- but groups get a discount if any members are involved in a hospital's finances. That's because Dr. Smith says that in spreading interest in palliative care, it is as important to get to "the money men" and explain the cost benefits as it is to persuade doctors about the treatment's approach.

"Money talks," says Dr. Smith. "Unless you can make [a palliative-care unit] break even, it won't fly in today's health system."

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