



Case Statement for Palliative Care¹ in Health Care Reform

1. Our System is Failing

Our national health care system is failing patients every day. Far too often, adults and children who are in pain, suffering and in some cases dying, experience unrelieved physical, emotional and spiritual distress.² During this time of extreme vulnerability, patients and families need the support and assistance provided by palliative care teams to prevent and treat pain, ensure continuity of care, make informed decisions and meet their spiritual needs. It is well established that patients, families and caregivers benefit from this attention to body, mind and spirit; still, less than 53% of hospitals have palliative care programs.³

2. Palliative Care Represents the Future of Health Care

Palliative care must be an integral part of health care reform in our country. The imperative to improve quality, access and value is undisputed and making palliative care a national priority will reduce harm, reduce disparities and reduce waste. It represents what the future requires: comprehensive, holistic, patient- and family-centered care.

3. Quality Palliative Care is a Wise Use of Financial Resources

Palliative care involves the right level of care delivered in the right place at the right time. As operating margins shrink, it provides an appropriate and effective use of limited resources that translates into financial savings. Palliative care programs demonstrate improved patient/family satisfaction, lower readmission rates, reduced hospital costs per day and per hospitalization, and earlier referrals to hospice.

CAPC Leadership Site Data – Morrison et al research 2008⁴:

- Clear treatment goals, treatment in accordance with goals, improved quality
- Hospitals saved from \$279 to \$374 per day per PC patient
- Hospitals saved \$1,700 to \$4,900 on each admission of a PC patient
- Significant reductions in pharmacy, laboratory and intensive care costs means savings of >\$1.3 million/year for a 300-bed community hospital and \$2.5 million/year for average academic medical center

4. There are Serious Consequences to Inaction

A failure to address the need for palliative care will have serious consequences. New technology brings with it aggressive efforts to “do everything” to keep patients alive beyond reasonable hope of benefit, which will only prevail over humane, patient-centered care. In addition, persistent poor quality care during life-threatening illness and at the end of life continues to be a major driver for the call to physician-assisted suicide and legalization is sure to increase. Excellent palliative care offers a medical and spiritual balance between these extremes⁵, consistent with the inherent dignity of persons.

5. Palliative Care is Tied to Catholic Identity

Our Catholic health ministry’s commitment to the sick and dying is a hallmark of the Church’s healing mission.⁶ With all the advances in the art and science of palliative care, we are compromising our very identity if not providing it and advocating for its inclusion in health care reform.

6. Supportive Care Coalition is Doing Valuable Work⁷

The Supportive Care Coalition is comprised of 19 Catholic health organizations with facilities in 48 states. With a unified voice, it works to assure excellence in palliative and end-of-life care in all Catholic health care settings. Members collaborate to develop educational opportunities, establish quality standards, share and promote best practices, and engage in advocacy efforts. Since its founding in 1994, the Coalition has effectively identified and addressed barriers to the implementation of palliative care programs across the continuum of care and significant program growth has occurred. Despite this success, there is a great deal of work still to be done. Our goal is to ensure that every Catholic health ministry has palliative care as a part of its core services – so that we are known as much for palliative care as for our concern for the poor and vulnerable.

American Hospital Association Annual Survey⁸:

- Number of Catholic hospitals providing palliative care (through hospital, system or contractual arrangement) increased from 33% to 58% over the years 2001 to 2007

Supportive Care Coalition Member Organizations Represent:

- Approximately 450 acute care hospitals
- Approximately 166 long-term care facilities
- Approximately 24 long-term acute care hospitals

7. Support is Needed

Your leadership in supporting the advancement of palliative care efforts through inclusion in health care reform is critical. Thank you in advance for your commitment.

References

1. National Cancer Institute description of palliative care
"Care given to improve the quality of life of patients who have a serious or life-threatening disease. The goal of palliative care is to prevent or treat as early as possible the symptoms of the disease, side effects caused by treatment of the disease, and psychological, social, and spiritual problems related to the disease or its treatment. Also called comfort care, supportive care, and symptom management."
2. *Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)* (Robert Wood Johnson) (JAMA, 1996); *Approaching Death Improving Care at the End of life* (IOM, 1997); *Crossing the Quality Chasm: A New Health System for 21st Century* (IOM, 2001); *Improving Palliative Care for Cancer* (IOM, 2001); *Means to a Better End: A Report on Dying in America Today* (Last Acts, 2002); *When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families* (IOM, 2003); *Access to Hospice Care: Expanding Boundaries, Overcoming Barriers* (Hastings Center Report, 2003); *Describing Death in America: What We Need to Know* (IOM, 2003); *Improving Palliative Care: We Can Take Better Care of People with Cancer* (IOM, 2003); *Improving End of Life Care: Why Has It Been So Difficult?* (A Hastings Center Special Report, 2005); Supportive Care Coalition: Supportive Voice, Focus Group Work; *Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians*, Qaseem et al, *Ann Intern Med.* 2008; 148:141-146.
3. *2007 AHA Annual Hospital Survey*
4. Morrison, R.S. et al. *Cost Savings Associated With US Hospital Palliative Care Consultation Program*, *Arch Intern Med.* 2008; 168(16):1783-1790.
5. USCCB, *Ethical and Religious Directives for Catholic Health Care Services, 4th ed.*, Part Five, Introduction, Washington, 2001, at <http://www.usccb.org/bishops/directives.shtml>
6. Joseph Cardinal Bernardin, *A Sign of Hope: A Pastoral Letter on Healthcare*, Chicago: Archdiocese of Chicago (October 18, 1995), pp. 4-5, 7. Benedict XVI, "Message for the Fifteenth World Day of the Sick." *op. cit.* Benedict XVI, "Angelus," February 11, 2007; "Address to the Authorities and the Diplomatic Corps during the Apostolic Journey to Austria," September 7, 2007; "Address to Participants in the 22nd International Congress of the Pontifical Council for Health Pastoral Care," (November 17, 2007).
7. www.supportivecarecoalition.org
8. Catholic Health Association personal communication after analysis of AHA 2000 and 2007 Annual Hospital Survey.

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