Vol. ■ No. ■ ■ 2014 Journal of Pain and Symptom Management 1

Original Article

Clinic-Based Outpatient Palliative Care Before Hospice Is Associated With Longer Hospice Length of Service

Carl Scheffey, PhD, Matthew G. Kestenbaum, MD,
Melissa W. Wachterman, MD, MPH, MSc, Stephen R. Connor, PhD,
Perry G. Fine, MD, Malene S. Davis, MBA, MSN, RN, CHPN, and
J. Cameron Muir, MD, FAAHPM

Capital Caring (C.S., M.G.K., M.W.W., S.R.C., M.S.D., J.C.M.), Falls Church, Virginia; Veterans Affairs Healthcare System (M.W.W.), Boston, Massachusetts; and Pain Research Center (P.G.F.), University of Utah School of Medicine, Salt Lake City, Utah, USA

Abstract

Context. Outpatient nonhospice palliative care has been shown to provide many benefits to patients facing advanced illness, but such services remain uncommon in the U.S. Little is known about the association between clinic-based outpatient palliative care consultation and the timing of hospice enrollment.

Objectives. To determine whether there are differences in hospice length of service (LOS) between patients who were seen vs. patients who were not seen in an outpatient palliative care clinic before enrollment in hospice.

Methods. Using a retrospective study of medical records, a “prior palliative care clinic” group was formed of those hospice patients who had had a nonhospice clinic-based outpatient palliative care consult before hospice admission ($n = 354$). For those patients, “control” hospice patients without prior clinic-based palliative care were chosen who were matched by age, gender, median income of their zip code, and diagnostic group. Both groups were restricted to patients who died while enrolled in hospice. LOS for these two groups was compared using standard statistical methods of survival analysis.

Results. Prior palliative care clinic patients had a median LOS of 24 days, whereas control patients had a median LOS of 15 days (95% CI for difference between the medians 5–13 days). The difference between the LOS distribution curves was statistically significant by the log-rank test ($P < 0.001$).

Conclusion. Hospice patients who had clinic-based outpatient palliative consults before hospice enrollment tended, on average, to have a longer LOS in hospice than patients who did not. J Pain Symptom Manage 2014;■:■–■. *© 2014 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Address correspondence to: Carl Scheffey, PhD, Capital Caring, 2900 Telestar Court, Falls Church, VA 22042, USA. E-mail: cscheffey@capitalcaring.org

Accepted for publication: October 30, 2013.

0885-3924/$ - see front matter
http://dx.doi.org/10.1016/j.jpainsymman.2013.10.017

Key Words

Palliative clinic, hospice, length of service, outpatient palliative care

Introduction

Outpatient nonhospice palliative care improves control of pain and other symptoms, quality of life for patients and their families, disease survival, and resource utilization.[1–14] For these reasons, early use of palliative care services has been advocated, but the number of outpatient clinics in the U.S. remains very small.[15]

The subject of the present article is the impact of outpatient palliative care on another problem in advanced illness care: late referral to hospice. The national median hospice length of service (LOS) has been estimated as less than 20 days.[16] Late entry into hospice is associated with lower treatment satisfaction and greater unmet physical and psychosocial needs of the patient, along with unmet psychosocial and supportive needs of the family.[17,18] A small number of studies suggest that hospice LOS can be positively influenced by formal palliative care consultation. In a randomized controlled trial of inpatient palliative care, Gade et al.[19] reported that patients with prior palliative care had median hospice LOS about double that of controls. In a randomized controlled trial of early outpatient palliative care in patients with non-small cell lung cancer, Greer et al.[20] reported that patients assigned to palliative care who then received hospice care had a hospice median LOS more than double that of the controls. Based on these suggestive reports, we posit that the provision of outpatient palliative care in a general population of patients living with far-advanced disease leads to earlier hospice admissions, reflected in longer hospice LOS.

To examine the relationship between prehospice outpatient palliative care and hospice LOS, we drew from the patient population and electronic health records of Capital Caring (CC), a large nonprofit hospice and palliative care organization in the Washington, District of Columbia, area. In addition to traditional hospice and hospital-based palliative care consult services, the organization includes a system of outpatient clinics for nonhospice palliative care.

Methods

Description of the Clinics

For the purposes of this article, we defined an "outpatient palliative consult" as a formal patient/clinician encounter provided in one of the five outpatient palliative care clinics administered by CC. The clinics serve an economically and ethnically diverse area across northern Virginia and the District of Columbia. Three of the clinics lease one-half day per week of office space from local oncology practices, one clinic leases office space from a teaching hospital, and one clinic is located in a dedicated portion of CC's freestanding hospice inpatient unit. As most of these outpatient clinics share office space with oncology practices, a large portion of the patient population has a cancer diagnosis.[5] However, patients with other forms of advanced illness are welcome.

Referrals typically are initiated by community-based providers, although patients can self-refer. In the event of self-referral, CC administrative staff contact the patient's primary care provider to obtain a consult order before the patient is seen. Table 1 provides a summary of the characteristics of the patient population, including diagnostic categories and presenting problems.

Although patients in the clinic system present a heterogeneous mix of geography, socioeconomics, and diagnoses, all clinics function under a common set of policies and procedures. They are each staffed by a board-certified/board-eligible Hospice and Palliative Medicine physician and a nurse practitioner; all but one of the nurse practitioners are certified by the Hospice and Palliative Nurses Association. At each encounter, the patient is asked to complete a new Edmonton Symptom Assessment System tool, which drives the content and flow of the visit. In addition to symptom-related issues, clinic visits often comprise advance care planning and goals of care discussions. During these explorations, hospice is presented as an option if it is appropriate to do so, and the pros and cons of this intervention—like any intervention under consideration—are discussed. Based on time studies of entries in the electronic medical record, the average initial