

The Effects of Integrative Palliative Oncology on Health System Burden

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Background

Early integration of palliative care in oncology has been shown to benefit patients on an individual level, especially regarding mood and quality of life. These patients both have a difficult disease course – where palliative care can help with interpersonal, spiritual, physical, and care planning concerns – and represent a substantial burden on inpatient facilities like intensive care units and emergency departments. This study explores relationships between early palliative oncology, patient healthcare experience, and broader burden on the health system.

Methods

A retrospective chart review was performed comparing oncology patients at Parkview Regional Medical Center in Fort Wayne, IN. Cohort A (200 patients) received palliative care along with standard oncology care while cohort B (200 patients) received standard oncology care alone. Post-diagnosis emergency department visits, inpatient stays, and intensive care unit stays were compared. So were in-hospital deaths, referrals to hospice, and record of advance care planning documents.

Results

Two endpoints evaluated by Chi² analysis were statistically significant (p values <0.01): Cohort A was more likely than cohort B to be referred to hospice (79.5% vs 31.5%) and more likely to have advance care planning documents on file (38.5% vs 21%). Additionally, a T-test showed statistically significant difference (p=.001) for inpatient stays post-palliative care encounter versus patients who had no palliative care (1.75 vs 2.41).

Conclusion

This study shows correlation between integrated oncology care with patients filing ACP documents and being referred to hospice. Additionally, it finds that cancer patients who visit the palliative care office have fewer inpatient stays after their visit than those who don't visit at all.

Future Implications

Future studies in this area should explore the latter finding from new perspectives, perhaps focusing on the differences between palliative care visit promptly after diagnosis/staging and palliative care implemented long after diagnosis/staging or not administered at all.