33. von Gunten CF. Secondary and tertiary palliative care in US hospitals. *JAMA*. 2002; 287(7):875-881.
34. Rigby A, Krzyzanowska M, Le LW, et al. Impact of opening an acute palliative care unit on administrative outcomes for a general oncology ward. *Cancer*. 2008; 113(11):3267-3274.
35. Smith TJ, Coyne P, Cassel B, Penberthy L, Hopson A, Hager MA. A high-volume specialist palliative care unit and team may reduce in-hospital end-of-life care costs. *J Palliat Med*. 2003;6(5):699-705.
36. Casarett D, Pickard A, Amos Bailey F, et al. Important aspects of end-of-life care among veterans: implications for measurement and quality improvement. *J Pain Symptom Manage*. 2008;35(2):115-125.
37. Finlay E, Shreve S, Casarett D. Nationwide Veterans Affairs quality measure for cancer: the family assessment of treatment at end of life. *J Clin Oncol*. 2008; 26(23):3838-3844.
38. Stone M. An asymptotic equivalence of choice of model by cross-validation and Akaike's criterion. *J R Stat Soc Series B Stat Methodol*. 1977;39:44-47.
39. Rabow MW, Dibble SL, Pantilat SZ, McPhee SJ. The comprehensive care team: a controlled trial of outpatient palliative medicine consultation. *Arch Intern Med*. 2004;164(1):83-91.
40. Kuin A, Courtens AM, Deliens L, et al. Palliative care consultation in the Netherlands: a nationwide evaluation study. *J Pain Symptom Manage*. 2004;27(1): 53-60.
41. Manfredi PL, Morrison RS, Morris J, Goldhirsch SL, Carter JM, Meier DE. Palliative care consultations: how do they impact the care of hospitalized patients? *J Pain Symptom Manage*. 2000;20(3):166-173.
42. Delgado-Guay MO, Parsons HA, Li Z, Palmer LJ, Bruera E. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team. *Cancer*. 2009;115(2):437-445.
43. Kellar N, Martinez J, Finis N, Bolger A, von Gunten CF. Characterization of an acute inpatient hospice palliative care unit in a U.S. teaching hospital. *J Nurs Adm*. 1996;26(3):16-20.
44. Bascom PB. A hospital-based comfort care team: consultation for seriously ill and dying patients. *Am J Hosp Palliat Care*. 1997;14(2):57-60.
45. Abrahm JL, Callahan J, Rossetti K, Pierre L. The impact of a hospice consultation team on the care of veterans with advanced cancer. *J Pain Symptom Manage*. 1996;12(1):23-31.
46. VA stats at a glance. National Center for Veterans Analysis and Statistics. 2010. US Dept of Veterans Affairs Web site. http://www.va.gov/vetdata/docs/QuickFacts/population_quickfacts.pdf. Accessed June 29, 2010.

INVITED COMMENTARY

Identifying the Effective Components of Palliative Care

Palliative care is a new medical specialty that aims to improve quality of care for persons with serious and advanced illness through clear and direct communication between the interdisciplinary health care team, patients, and families; effective management of pain and other symptoms; coordination and continuity of care; and treatment aligned with patient and family goals.[1] Palliative care can be offered with life-prolonging therapies and is appropriate at any point in a serious illness. Benefits of palliative care include increased patient and caregiver satisfaction,[2] lower costs,[3] and improved quality of life and clinical outcomes.[4,5] Few studies, however, have compared different palliative care delivery models to assess their effect on outcomes.

Casarett and colleagues report on a propensity score matched survey of VA hospitals and nursing homes comparing family satisfaction with services provided by a palliative care consultation team vs a dedicated palliative care unit. The investigators surveyed family members of 5901 patients who died at one of 77 VA medical centers that offer both inpatient models of care. Family members of patients who received a palliative care consultation were more likely to report excellent care in the last month of life than were families of those who did not receive palliative care. Families of patients in the palliative care unit were even more likely to report excellent care when compared with families of patients who received a consultation. The palliative care unit group also scored highest in 3 of 4 process measures (do-not-resuscitate order at time of death, documented chaplain visit, and bereavement contact after the patient's death). The study was not designed to determine what services provided by the palliative care consultation team or the palliative care unit resulted in these improved outcomes.

The data provided by this study should be weighed with other factors when choosing the optimal palliative care model for a specific institutional environment. A dedicated unit offers direct control over implementation of clinical recommendations, the presence of skilled interdisciplinary staff, and a care setting designed for the needs of seriously ill patients. Under circumstances of difficult to-control symptom distress, family exhaustion, or lack of adequate community support services, a palliative care unit may provide the safest and highest quality of care. Drawbacks of a palliative care unit might include limited bed availability and decreased opportunity to promote palliative care practices throughout the hospital. A consultative team, in contrast, is less resource intensive, can deliver care to many more patients and family members, and may be able to promote the importance of the palliative care approach to a wider audience. The question for those planning a hospital palliative care program may not be whether to choose a dedicated unit or consultative services, but rather how to implement the best components of each. Despite the pressures for quick hospital discharge, some seriously ill and dying patients cannot be adequately cared for in the community. For these individuals, palliative care teams may need to provide primary management in the hospital, whether within various wards or a dedicated palliative care unit, as staffing and resources allow.

This study provides evidence that either of these 2 palliative care models can play a key role in improving the care of patients who die in hospitals and nursing homes. For well-established programs, the addition of a palliative care

unit to an existing consultative service will enable clinicians to offer a broader scope of care options to patients and families. However, in settings with limited program resources, the consultative approach, perhaps with adaptations based on the advantages of a specialized care setting, may be the most logical initial strategy. Studies are necessary to identify the effective components of the intervention and to understand how to match palliative care models to specific patient and family characteristics and needs.

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1. Morrison RS, Meier DE. Clinical practice: palliative care. *N Engl J Med*. 2004; 350(25):2582-2590.
2. Gelfman LP, Meier DE, Morrison RS. Does palliative care improve quality? a survey of bereaved family members. *J Pain Symptom Manage*. 2008;36(1): 22-28.
3. Morrison RS, Penrod JD, Cassel JB, et al; Palliative Care Leadership Centers' Outcomes Group. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008;168(16):1783-1790.
4. Casarett D, Pickard A, Bailey FA, et al. Do palliative consultations improve patient outcomes? *J Am Geriatr Soc*. 2008;56(4):593-599.
5. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363(8):733-742.

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Pike's Peak from Crystal Reservoir, Colorado Springs, Colorado (2010).

Courtesy of: David C. Plitt, MD, Internal Medicine, Clear Creek Medical Group, Denver, Colorado.