PALLIATIVE CARE UTILIZATION AND RESOURCE IMPACT AMONG HOSPITALIZED PATIENTS WITH ACUTE MYELOID LEUKEMIA AT END OF LIFE: A NATIONAL ANALYSIS, 2018–2022

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Introduction

Palliative care (PC) is essential for quality end-of-life (EOL) care in aggressive hematologic malignancies like acute myeloid leukemia (AML). Understanding PC utilization trends and its impact on health care resources, including costs, for patients with AML who die in hospital is critical.

Objectives

To analyze temporal trends in PC and do-not-resuscitate (DNR) order utilization, and to assess the association of PC with length of stay (LOS), hospital charges, and estimated national cost savings among hospitalized adult patients with AML at EOL.

Methods

Context: Palliative care (PC) is essential for quality end-of-life (EOL) care in aggressive hematologic malignancies like acute myeloid leukemia (AML). Understanding PC utilization trends and its impact on health care resources, including costs, for patients with AML who die in hospital is critical.

Objective: To analyze temporal trends in PC and do-not-resuscitate (DNR) order utilization, and to assess the association of PC with length of stay (LOS), hospital charges, and estimated national cost savings among hospitalized adult patients with AML at EOL.

Design: Retrospective analysis of nationally weighted data.

Setting: United States hospitals (National Inpatient Sample).

Patients or Other Participants and Intervention: Adult patients with AML who died during hospitalization (2018–2022), representing a national estimate of 31,480 decedents.

Interventions: Receipt of PC consultation.

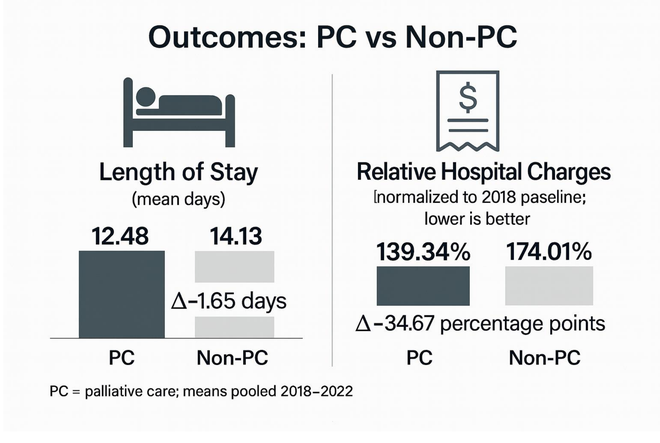
Main Outcome Measures: Annual utilization rates for PC, DNR, and concurrent PC plus DNR; mean LOS; mean relative hospital charges; estimated annual national hospital days and cost savings.

Results

Among hospitalized AML decedents, utilization trends for "any PC" (P=0.837), "any DNR order" (P=0.382), and concurrent "both PC and DNR" (annual percent change, 0.83%; P=0.158) were stable from 2018 to 2022.

Simultaneous PC and DNR was the most common pattern (46.5% overall). Despite stable utilization, AML decedents receiving PC (56.2% of the cohort) had significantly shorter mean LOS (12.48 vs 14.13 days; P<0.0001) and lower mean relative hospital charges (139.34% vs 174.01%; P<0.0001) compared with non-PC recipients.

Annually, extending PC to AML decedents not currently receiving it could lead to estimated national savings of over 4,551 hospital days and charge reductions exceeding $153.9 million (based on an average $55,805 difference per case; 2018 benchmark).



PC = palliative care; means pooled 2018–2022

Conclusions

Utilization rates of PC and DNR orders among hospitalized patients with AML at EOL remained broadly stable between 2018 and 2022.

However, the provision of PC was consistently associated with substantial reductions in length of stay and hospital charges, equating to significant potential national health care savings.

These findings underscore the profound value of PC in optimizing EOL resource use for patients with AML, highlighting an ongoing opportunity to improve care value even if broad utilization patterns have not markedly shifted.