PALLIATIVE CARE UTILIZATION TRENDS, SHIFTING CARE PATTERNS, AND RESOURCE IMPACT AMONG HOSPITALIZED PATIENTS WITH DIFFUSE LARGE B-CELL LYMPHOMA AT END OF LIFE: A NATIONAL ANALYSIS, 2018–2022

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Introduction

Documenting end-of-life (EOL) preferences, including do-not-resuscitate (DNR) orders, often occurs alongside palliative care (PC) consultation for patients with aggressive malignancies like diffuse large B-cell lymphoma (DLBCL). Understanding trends in such concurrent care planning is vital.

Objectives

To analyze temporal trends in the concurrent utilization of PC and DNR orders, and to assess the association of PC receipt with length of stay (LOS) and hospital charges among hospitalized patients with DLBCL who died.

Methods

Context: Documenting end-of-life (EOL) preferences, including do-not-resuscitate (DNR) orders, often occurs alongside palliative care (PC) consultation for patients with aggressive malignancies like diffuse large B-cell lymphoma (DLBCL). Understanding trends in such concurrent care planning is vital.

Objective: To analyze temporal trends in the concurrent utilization of PC and DNR orders, and to assess the association of PC receipt with length of stay (LOS) and hospital charges among hospitalized patients with DLBCL who died.

Design: Retrospective analysis of nationally weighted data.

Setting: United States hospitals (National Inpatient Sample).

Patients or Other Participants: Adult patients with DLBCL who died during hospitalization; an estimate of 18,795 decedents.

Interventions: Concurrent documentation of PC consultation and a DNR order (for trend analysis focus).

Main Outcomes and Measures: Annual rate and annual percent change (APC) for concurrent PC and DNR orders; mean LOS and relative hospital charges associated with PC receipt.

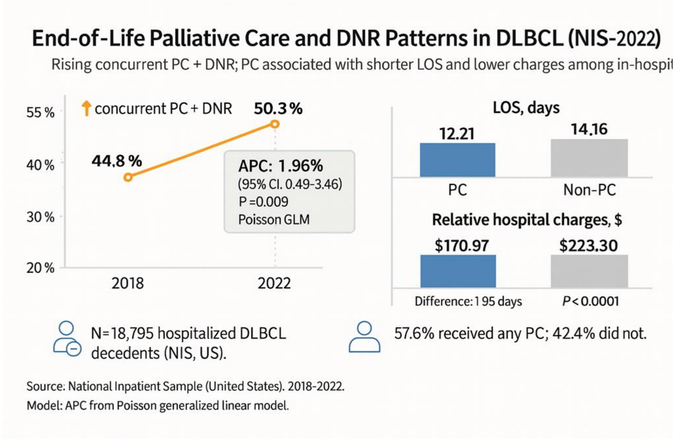
Results

A significant shift in EOL care patterns was observed among DLBCL decedents.

The proportion of patients receiving PC and a DNR order concurrently increased significantly from 44.8% in 2018 to 50.3% in 2022, with an estimated APC of +1.96% (95% CI, 0.49%–3.46%; P=0.009 via Poisson generalized linear model). This highlights an evolving approach to integrated EOL discussions.

Separately, regardless of DNR status, decedents receiving any form of PC consultation (57.6% of the cohort) experienced significantly shorter mean LOS (12.21 vs 14.16 days for non-PC recipients; difference, 1.95 days; P<0.0001) and markedly lower mean relative hospital charges ($170.97 vs $223.30; P<0.0001).

Extending PC to 42.4% of DLBCL decedents who do not receive it could yield over 3,100 hospital days savings and charge reductions nearing $87 million (2018 benchmark).



Conclusions

Between 2018 and 2022, there was a statistically significant increase in the concurrent utilization of PC and DNR orders for hospitalized patients with DLBCL at EOL, indicating an evolving landscape of EOL planning.

The provision of PC continues to be strongly associated with substantial reductions in hospital stays and charges.

These findings underscore the importance of PC in optimizing EOL care and reflect a trend towards patient-centered EOL preferences.