studies assessed psychological (respectively, n=24/32, 75%; 12/21, 57%) and physical (n=21/32, 66%; 11/21, 52%) symptom burden and patient quality-of-life (n=20/32, 63%; 10/21; 48%) outcomes, of which most favored the intervention arm.

Conclusions and Implications. There were notable differences in intervention content and delivery between SPC and PPC interventions. Both were associated with improvements in outcomes of seriously-ill patients. PPC interventions with different content and delivery mechanisms may be effective to meet some, but not all, palliative care needs of seriously-ill patients and their families.

Evaluating the Impact and Costs of Home-Based Palliative Care at the System Level (FR420C)

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Objectives

- Appreciate home-based palliative care's potential impact on patients at the end of life.
- Recognize utilization and cost benefits of home-based palliative care and apply economic evaluation to assess the value-for-money of palliative home care.

Original Research Background. While there has been increased investment in palliative care in Ontario, Canada, the evidence remains inconclusive regarding the cost-effectiveness and impact of home-based palliative care at a system level.

Research Objectives. To describe and understand the impact of home-based palliative care on place of death and healthcare cost in the last 3 months of life.

Methods. We conducted a population-based retrospective cohort study using health administrative data from Ontario's publicly funded home care program. We included adult decedents who died between April 2011 and March 2015. Regression analyses examined the relationship between receipt of home care (including service type, such as nursing), place of death (acute vs. non-acute) and healthcare cost. We calculated the incremental cost-effectiveness ratio (ICER) of palliative care, which is a measure of the added cost per unit of benefit (in this case, death diverted from an acute care facility).

Results. Decedents who received home-based palliative care in the last 3 months of life were less likely to die in acute care (OR = 0.248, $p<0.001$) and had lower estimated total healthcare cost (OR = 0.935, $p<0.001$) than those who did not receive home care services. Palliative visits by nurse practitioners demonstrated the largest effect on reducing the risk of acute care deaths (OR=0.948, $p<0.001$) and healthcare cost (OR= 0.982, $p<0.001$). Considering costs and benefits together, the ICER indicated that for every $0.25 invested in home-based palliative care, one hospital death is avoided.

Conclusion. Decedents who received home care, specifically care from palliative care nurse practitioners, were less likely to die in acute care and had lower healthcare cost.

Implications for Research, Policy, or Practice. One's dying experience could be improved by the receipt of home-based palliative supports, which require relatively minimal financial support, given the costs they offset and benefits they provide.

Same or Different? Comparing Cancer and Non-Cancer Patients Referred to Outpatient Palliative Care (FR420D)

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Objectives

- Describe key differences between cancer and non-cancer patients referred to clinic-based outpatient palliative care.
- Describe how the outpatient palliative care provided to cancer patients differs from that provided to non-cancer patients.

Original Research Background. While outpatient palliative care (PC) began primarily in cancer centers, outpatient PC increasingly serves patients with a wide range of diagnoses.

Research Objectives. Compare characteristics of patients with cancer and non-cancer diagnoses referred to clinic-based PC, and the care they receive.

Methods. Data were extracted from the Palliative Care Quality Network database regarding 3,569 patients seen by 27 clinic-based PC teams between 01/15/2016 and 07/17/2018.

Results. Overall 79.3% (n=2,766) of all patients referred to outpatient PC had cancer. Compared to patients with non-cancer diagnoses, patients with