

CIVHC PALLIATIVE CARE TASK FORCE REPORT

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CENTER FOR IMPROVING
VALUE IN HEALTH CARE

INTRODUCTION

In April of 2009, CIVHC convened a Palliative Care Task Force made up of members representing a spectrum of palliative care providers and experts in Colorado. The task of this group was to identify recommendations to improve access to high-quality palliative care (including end-of-life care) to all Coloradans who wish to receive it.

Before outlining the task force's recommendations, a few important considerations need to be identified. First is the need to clarify the difference between the terms "palliative care," "end-of-life care," and "hospice." The CIVHC Palliative Care Task Force maintains the distinction that "palliative care" refers to a continuum of care that improves the quality of life for patients and their families with chronic or advanced illness, or life-threatening injury. Palliative care prevents and relieves suffering through early identification, thorough assessment and expert treatment of pain and other challenges; physical, psychosocial and spiritual. Palliative care can be provided concurrently with other curative treatments, and can also be provided when a patient has chosen to discontinue curative treatments. This type of palliative care is more commonly referred to as "hospice" care. Although "hospice" and "end-of-life" care are often terms used synonymously, it is important to note that hospice care is one type of care that is available to patients at the end of life, however patients often receive medical care as they near the end of life that would not be considered hospice or palliative care. It is also important to note that palliative care is to be provided to patients and their families at any point when facing a chronic or advanced illness, or life-threatening injury.

Numerous hospitals, hospices, and community-based organizations in Colorado offer palliative care, however there is evidence that many individuals lack access to these services. Also, multiple studies have provided evidence that palliative care vastly improves patient satisfaction, increases the quality of care and contains health care costs. (See Palliative Care Research Review at civhc.org) Despite these facts, only hospice, (palliative care that is provided when curative treatments have been discontinued) is a defined benefit with a provider reimbursement mechanism. It is the underlying agreement among the members of the CIVHC Palliative Care Task Force that high quality palliative care, whether a patient is receiving concurrent curative treatment or not, should be available to all Coloradans as an important component of a highly functioning, patient-centered health care delivery system, and payments for palliative care services should be embedded within a new payment methodology that rewards high-value, coordinated, patient-centered care rather than volume of services.

GOALS

The following two goals have been identified by the CIVHC Palliative Care Task Force to serve as a framework for the group's recommendations:

- All Coloradans with advanced illness have access to high quality palliative care services when palliative care is consistent with their goals, values and preferences.
- All Coloradans with advanced illness have access to high quality hospice care when hospice care is consistent with their goals, values and preferences

RECOMMENDATIONS

DISCLAIMER:

These recommendations are aimed at improving care across the continuum of chronic and life threatening illness and at the end of life. The Task Force has not addressed the needs of people living with disabilities. The task force recommends that the needs of people living with disabilities in relation to palliative care be addressed by a CIVHC task force with specific expertise in the needs of the disability community.

The following recommendations represent strategies to support the goals articulated above.

RECOMMENDATION #1

Colorado to adopt, through regulatory means, the definition of and criteria for quality palliative care proposed by the CIVHC Palliative Care Task Force (adapted from the World Health Organization and the National Consensus Project on Quality Palliative Care) and use the definition for licensure and reporting.

Definition proposed by task force:

Palliative care improves the quality of life of patients and their families with advanced illness or life-threatening injury. Palliative care prevents and relieves suffering through early identification, thorough assessment and expert treatment of pain and other challenges; physical, psychosocial and spiritual.

Defining Features of Quality Palliative Care:

1. Affirmation of life and regard for dying as a normal process
2. Intent to neither hasten nor postpone death
3. Care throughout the continuum of illness which can be in conjunction with curative therapies
4. Availability of interventions early in the course of illness to assist with symptom management or advance care planning
5. Use of an interdisciplinary team approach to address the comprehensive needs of patients and families
 - a) assessment and management of patient's pain and other distressing symptoms
 - b) integration of the psychological and spiritual aspects of patient and family care
 - c) offering a support system to help patients live as fully as possible
 - d) offering a support system to help the family cope during the patient's illness and in their bereavement

Actions:

1. Ascertain process for regulatory adoption from CDPHE

2. Coordinate with the efforts of the Colorado Center for Hospice and Palliative Care Quality Committee to delineate and implement regulatory measures for palliative care
3. Begin process for Colorado to adopt the quality palliative definition learning from the approach taken in Wisconsin which resulted in regulatory change

Timeline: One year

Barriers Addressed:

Without a common definition of “quality palliative care,” we cannot determine if the goal or metrics are met.

RECOMMENDATION #2

Increase the percent/number of patients with advanced illness receiving high quality palliative care in all settings.

Actions:

- I. Data: Obtain a count of patients being served by palliative programs in Colorado
 - a) Utilize baseline data collected by the Colorado Center for Hospice and Palliative Care in Spring 2008 (hospital and hospice data) as preliminary data:

Hospitals

- Of the 84 hospitals contacted 21 (25%) report that they have a Palliative Care Program.
- Five (20%) of these hospitals provide their Palliative Care Program through a contract with a local hospice for these services.
- All of these programs use a consultation model, and one program serves only children.
- Eight (38%) of the reporting hospitals required hospice training or experience for the staff providing this service.
- Nine (42.8%) have either at least one physician or a nurse certified in Hospice and Palliative Care. Some have several certified providers.
- Three hospitals (14%) reported having an individual provide the service and the remainder use a team, although some noted the team did not meet regularly and was very informal.
- The oldest program is the one for children which began in 1999; two others began in 2003, with the remainder mostly starting in 2007. In addition at least three hospitals interviewed plan to start a program within the next year.
- The number of consults vary widely from 8-10/yr. to 720/yr. This seems to be related to how long the program has existed and the size of the population.
- The hospitals primarily bill for the M.D.’s time and utilize current staff for the other members of the team. Otherwise, hospitals don’t bill at all for the services.

Hospices

- Of the 48 hospices contacted 11 (23%) report that they have a Palliative Care Program.
- Six of the eleven stated that they provide consults; the others said “support, people services, whatever they need, or counseling”.
- Eight (73%) require the staff to have experience or training in hospice and palliative care.
- Eight (73%) have either at least one physician or a nurse certified in Hospice and Palliative Care. Three have more than one certified medical professional.
- All of the reporting hospices use a team to provide the service; sometimes it is just a team of two.

- The oldest program began in 1997, two others in 2003, and the remaining eight in 2006 and 2007.
 - The number of consults varies between 14/yr to 412/yr.
 - These organizations utilize a variety of payment options; sliding scales, grant money, donation, Medicare, and private insurance.
- b) Develop infrastructure for ongoing and expanded data collection from all healthcare entities providing palliative care to establish baseline data, processes for ongoing data collection and benchmarks.
 - c) Make routine reporting a requirement for palliative care licensure

Timeline: Obtain baseline data – 6 months; Develop infrastructure – 2 years; Reporting as a requirement for palliative care licensure – 2 years

2. Replicate and expand the analysis conducted in New York State which documented the impact of palliative care on costs for the Medicaid population, comparing costs between those who received a palliative care consultation and a matched sample of patients who did not receive palliative care.
 - a) Seek funding to replicate Medicaid analysis in Colorado, collaborating with Mt. Sinai group who conducted the NY state analyses
 - b) Expand analyses to other payers when the all payer database is established.

Timeline: Obtain funding: 6 months; Conduct analyses: 14-18 months; Expand to other payers: 2 – 3 years.

3. Work with payers (starting with CO Access/Medicaid) and employers to create payment mechanisms for comprehensive palliative care services

Timeline: 2 years

Barriers Addressed:

- No regular data collection on provision of quality palliative care services
- Reimbursement challenges
- Regulatory challenges
- Lack of timely access

RECOMMENDATION #3

Work with community partners, facilities and consumer groups on awareness and education of palliative care and hospice. Dovetail with other CIVHC groups to help with marketing campaign.

Actions:

1. Research Center to Advance Palliative Care (CAPC), Caring Connections, National Hospice and Palliative Care Organization, American Academy of Hospice and Palliative Medicine and other resources to develop a strategy for effective consumer engagement.
2. Link with Colorado Advance Directives Consortium and Colorado Center for Hospice and Palliative Care Advance Care Planning training efforts

Timeline: 6 - 12 months

Barriers Addressed:

Cultural – Public attitudes, beliefs, knowledge regarding palliative care and hospice.

Recommendation #4

Support the planning, implementation and evaluation of a series of palliative care demonstration projects.

- Such demonstration projects would provide the necessary planning and financing information needed to create economically viable palliative care programs.

These programs should demonstrate:

- 1) promotion of patient and family quality of life (i.e., assuring physical comfort, psychosocial and spiritual support and the provision of coordinated services across various sites of care);
- 2) improvement of quality of care across the trajectory (e.g., reduced emergency department visits, in-patient hospitalizations, and length of stay).

Actions:

1. Review evaluation of and findings from the 2002 Colorado Trust Palliative Care Initiative
2. Develop specific criteria for palliative care demonstration projects (see Pennsylvania recommendations as an example)
3. Support and assist in identifying funding for demonstration projects

Timeline: Review existing information and develop criteria – 6 months; Identify funding – 1 year

Barriers Addressed:

- Reimbursement challenges
- Differences between payers
- “Curative” vs. “palliative” treatments
- Lack of timely access

RECOMMENDATION #5

Create an expedited process for completing Preadmission Screening and Resident Reviews (PASRR) for hospice patients to address barriers for timely admission into hospice.

Actions:

1. Identify entity that regulates PASRR
2. Work with Dual Diagnosis Management (DDM) on identifying or creating a preferred procedure for processing PASRRs for hospice patients
3. Create education program for hospice and long-term care facilities

Link: Health Care Delivery Redesign Group

Timeline: 6 months

RECOMMENDATION #6

Increase access to palliative and hospice care for the pediatric population.

Actions:

1. Analysis of HCPF data on Medicaid pediatric palliative care waiver program to establish baseline.
2. Obtain data from Florida (only other existing pediatric palliative care waiver program) for comparison.
3. Gather data from hospices regarding their experiences with the Medicaid pediatric palliative care waiver program to inform reimbursement and efforts to expand programs and enrollment.

Timeline: 6 months

Barriers Addressed:

- Poor Medicaid reimbursement for pediatric palliative care services
- Limited access to pediatric palliative care services

RECOMMENDATION #7

Work with payers to establish preferred provider status and differential payment for health care entities that have palliative care programs that meet quality guidelines.

Actions:

1. Adopt quality palliative care standards per Recommendation #1
2. Work with payers to develop and implement

Timeline: 1 – 2 years

Barriers Addressed:

- Reimbursement challenges
- Access challenges

RECOMMENDATION #8

Increase the percent/number of long term care residents with advanced illness receiving hospice care.

Actions:

1. Investigate the Colorado Department of Public Health and the Environment (CDPHE) survey process: training of surveyors in hospice and palliative care; LTC survey that gives extra credit if palliative care present with the goal of eliminating remedial action for documented decline / debility in Long Term Care residents who are at the end of life.
2. Build on work done by the Colorado Center for Hospice and Palliative Care with the Colorado Health Care Association (CHCA) to develop a LTC/Hospice Palliative Care Best Practice

Timeline: One year

Barriers Addressed:

- Reimbursement challenges
- Regulatory challenges