

Background

People with serious or advanced illness often experience increases in symptoms coupled with a decrease in function. Traditional life-prolonging or curative care often does not meet a person's range of needs as illness progresses and/or people near the end of life. Fragmented care delivery and frequent transitions between care settings, unmet symptoms such as pain, and responsibilities put on family members and other caregivers create undue stress and burden.¹ Many people who would prefer to remain at home experience high-intensity care often in a hospital setting.²

Palliative care fills the gap between intensive curative care and supportive care to better meet patient need. *"Palliative care focuses on expert assessment and management of [symptoms including] pain...assessment and support of caregiver needs, and coordination of care [attending] to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness."*³ While hospice care is given only to people with six months or less to live, palliative care can be offered alongside life-prolonging or curative care.⁴ **Many of the aspects of palliative care, including the patient needs described above, can and should be managed within primary care with referrals to specialty palliative care when patient need increases beyond the capacity of primary palliative care.**

Provision of palliative care consistently shows improved outcomes for patients in both in- and out-patient settings.⁵ Palliative care has been associated with reduction in symptom burden, higher satisfaction with care, higher referrals to hospice, and lower days in a hospital.^{6,7} For patients with cancer, early delivery of palliative care has been associated with increased quality of life.⁸ Use of supportive services like palliative care is associated with a move for end-of-life care from in-hospital to home.⁹ Palliative care reduces caregiver stress and has been shown to reduce caregiver emotional and spiritual needs as well as increasing caregiver confidence.^{10,11} Those who receive palliative care earlier on in the course of their disease have been shown to live longer when compared to those who started palliative care later.¹²

Oncology care has been an earlier adaptor of providing palliative care, but access remains inconsistent within oncology and especially for other diagnoses. Palliative care is largely offered in larger, not-for-profit, urban hospital settings.¹³ In Washington State, 92% hospitals with greater than 300 beds have a palliative care program while 32% of those with fewer than 50 beds have a palliative care program.¹⁴ Among oncology patients within the Veterans Administration, 52% received palliative care and those who received care did so for a median of 38 days prior to death.¹⁵

Barriers to palliative care referrals include lack of resources, lack of knowledge about existing resources, lack of knowledge about palliative care, provider reluctance to refer (e.g., due to fear of upsetting patients or being perceived as abandoning patients), reluctance of the patient and family to be referred, and restrictive criteria for referral to palliative care.¹⁶ Further, the structures, processes, and definition of palliative care are

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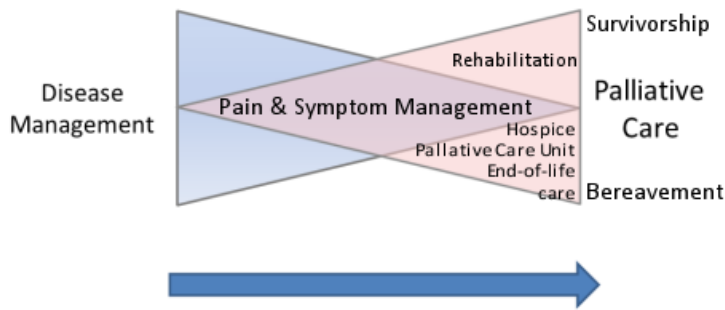
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often lacking. Poor or lack of reimbursement for palliative care services alongside life-prolonging and/or curative care also contributes to a lack of access.

Palliative care is focused on symptom management and for some is followed by rehabilitation and survivorship. For others, palliative care leads to hospice and end-of-life care as shown below in Figure X.

Figure X: Palliative Care Enhanced Model

Justis, Pat. Presentation to Palliative Care workgroup. April 12, 2019.



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Recommendations

Successful palliative care programs have common elements including: integrated teamwork, pain and physical symptom management, holistic care, caring providers, care that is timely and responsive, and patient and family preparedness.¹⁷ This workgroup acknowledges the great amount of work that has gone into defining palliative care within the National Consensus Project Guidelines and the American Academy of Hospice and Palliative Medicine: Payment Reforms to Improve Care for Patients with Serious Illness Patient and Caregiver Support for Serious Illness (PACSSI) bundled payment model and has endorsed and adapted these for Washington State. Further, the workgroup chose to focus on the functions of palliative care rather than assign specific clinical roles to allow greater adaptability based on local resources.

Focus Areas include:

- Increase in goals of care conversations¹⁸
- Outreach and increased awareness of palliative care including cultural competency and knowledge of cultural needs in the local community **and differences between primary and specialty palliative care.**
 - **Primary palliative care.** Care delivered within primary care to meet physical, functional, psychological, practical, and spiritual consequences of a serious illness. Advance care planning for end-of-life care should be part of primary palliative care as should discussions of the patient's goals of care. Providers should refer patients to specialty palliative care when needs cannot be met within primary palliative care.
 - **Specialty palliative care.** An interdisciplinary team led by a board-certified or board-eligible physician that includes a care coordination function, nursing staff, and is able to meet psychological and spiritual care needs (e.g., such as with social work or a chaplain). Advance care planning for end-of-life care should be done when necessary as patient needs may change over the course of a serious illness. Goals of care discussions should also be conducted early on and then again as needed.
- Increased consistency in how palliative care is implemented through endorsing the National Consensus Project for Quality Palliative Care National Coalition for Hospice and Palliative Care [Clinical Practice Guidelines for Quality Palliative Care, 4th edition](#) eight domains under which to organize quality palliative care including:
 1. Structure and Processes of Care (e.g., interdisciplinary team, assessment, care plan)
 2. Physical Aspects of Care (e.g., treatment of physical symptoms)
 3. Psychological and Psychiatric Aspects
 4. Social Aspects of Care (e.g., assessing and addressing social support needs)
 5. Spiritual, Religious, and Existential Aspects of Care
 6. Cultural Aspects of Care
 7. Care of the Patient Nearing the End of Life
 8. Ethical and Legal Aspects of Care Content (e.g., advance care planning)
- Financial support for the sometimes diffuse services that support members within palliative care through a per member per month palliative care benefit.

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- Defining a patient population for whom palliative care will offer benefit by adapting the criteria of the American Academy of Hospice and Palliative Medicine: Payment Reforms to Improve Care for Patients with Serious Illness Patient and Caregiver Support for Serious Illness (PACSSI) criteria.

Recommendations by Stakeholder Group

Patients and Family Members

Primary Care Providers

Primary Care Clinics

Hospitals

Specialty Palliative Care

Health Plans

Health Care Authority

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Patient Population

Table X: PACSSI Eligibility and Tiering Criteria

Tier	Diagnosis of Serious Illness (one of the below)	Function (one of the below)	Health Care Utilization
Tier 1: Moderate Complexity	One of the specified diseases, disorders, or health conditions in Table 2 below Three or more serious chronic conditions*	Non-Cancer: PPS of $\leq 60\%$ or ≥ 1 ADLs or DME order (oxygen, wheelchair, hospital bed) Cancer: PPS of $\leq 70\%$ or ECOG ≥ 2 or ≥ 1 ADL or DME order (oxygen, wheelchair, hospital bed)	One significant health care utilization in the past 12 months, which may include: - ED visit - Observation stay - Inpatient hospitalization Note: This criterion may be waived under certain circumstances specified below.
Tier 2: High Complexity	Same as above, Excluding dementia as the primary illness	Non-Cancer: PPS of $\leq 50\%$ or ≥ 2 ADLs Cancer: PPS of $\leq 60\%$ or ECOG ≥ 3 or ≥ 2 ADLs	Inpatient hospitalization in the past 12 months AND one of the following - ED visit - Observation stay - Second Hospitalization Note: This criterion may be waived under certain circumstances specified below.

Diagnoses

Option 1: A diagnosis of one of the following would meet the serious illness criterion:

- Metastatic Cancer
- Pancreatic, Gastrointestinal, Lung, Brain, Hematologic, or **Ovarian** cancers
- Heart Failure with Class III or IV level function under the New York Heart Association (NYHA) Functional Classification
- Heart Failure with a Left Ventricular Assist Device (LVAD)
- Advanced Pulmonary Disease (Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis)
- Advanced Dementia with stage 6 or 7 using the Functional Assessment Staging Tool (FAST) or ≥ 2 ADLs*
- Progressive Neurologic Disorder (e.g. Cerebrovascular Accident (CVA), Parkinson's Disease, Amyotrophic Lateral Sclerosis, Progressive Supranuclear Palsy)
- Hepatic Failure (Cirrhosis)
- Stage **IV** or **V** Renal Disease
- Protein-Calorie Malnutrition
- Cachexia

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- Hip Fracture (with functional decline)

Option 2 Diagnoses of three or more serious chronic conditions would also allow a patient to meet the serious illness criterion.

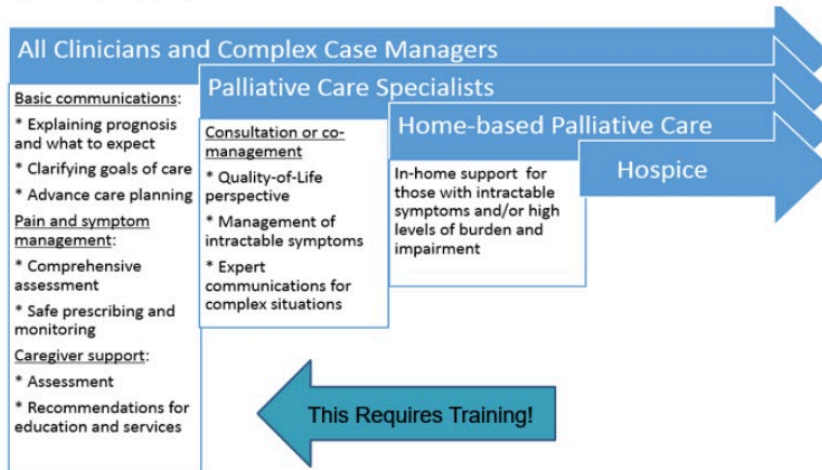
* Dementia as the primary illness would be confined to the moderate complexity group, as the rate of decline is often slow, and functional limitations occur significantly earlier in the course of an illness.

Work within Washington State

Justis, Pat. Presentation to Palliative Care workgroup. April 12, 2019.

Required element	Description
Interdisciplinary team	Have regular interdisciplinary team meetings.
Assessment and management of symptoms	Initial & ongoing, including physical and non-physical symptoms
Provider & care team education	Staff has sufficient & appropriate training relevant to roles on the team
Offer patient & family centered advanced care planning and goals of care	Have a policy/process to support patients in creating an advance directive if they do not have one
Care is accessible	May include access after hours, community-based resource support and services, care coordination, and continuity of care

Future State



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Quality Metrics

Source¹⁹

TABLE 1. DOMAINS AND METRICS IDENTIFIED BY STAKEHOLDERS FOR THE CAMBIA PALLIATIVE CARE METRICS PROJECT AND REPRESENTING STAKEHOLDERS' AND INVESTIGATORS' OPINIONS

Domain/ measure no.	Numerator	Denominator	Importance ^a (%)	Feasibility ^b (%)	Difficulty ^c
Service utilization					
1	No. of emergency room visits	Serious illness and last month of life	32	68	Low
2	No. of hospitalizations	Serious illness and last month of life	36	66	Low
3	Admitted to the ICU	Serious illness and last month of life	24	56	Low
4	Received chemotherapy	Metastatic cancer and last two weeks of life	18	44	Low
5	Readmissions in last 90 days of life (30 days; 7 days)	Serious illness	n/a	n/a	Low
Circumstances of death					
6	Died in an acute care hospital	Serious illness decedents	24	56	Low
7	Died in ICU	Serious illness decedents	24	50	Low
8	Hospitalized patients who die an expected death with an ICD deactivated	Inpatient deaths with an ICD	8	18	Medium
9	Not admitted to hospice	Metastatic cancer decedents	20	30	Medium
10	Fewer than three days in hospice	Serious illness decedents	26	32	Medium
Screening and assessment					
11	Received bowel regimen	Inpatients with serious illness who receive opiates	26	28	Medium
12	Screened for the presence and intensity of pain using a numeric pain score	Serious illness	52	40	Medium
13	Had comprehensive assessment completed (includes prognosis, functional assessment, screening for physical and psychological symptoms, and assessment of social and spiritual concerns)	Serious illness	54	14	High
14	Screened for shortness of breath	Serious illness	22	24	High
Patient needs and preferences					
15	Have an advance care plan or surrogate decision maker documented in the EHR or documentation that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	Serious illness	72	18	Medium
16	Documentation of patient's preferences for care (may include code status, preferences for general aggressiveness of care) has been considered or an attempt was made to identify them.	Serious illness	80	16	Medium
17	Discussion of emotional or psychological needs	Serious illness	48	12	High
18	Documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss	Inpatients with serious illness	46	14	High

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Colorado, Illinois, and Rhode Island include the HEDIS Care for Older Adults metric as a performance-based measure in their MLTSS or financial alignment demonstration contracts.

o HEDIS measure is defined as “the percentage of beneficiaries 66 years and older who have the advanced care planning, medication review, functional status assessment, and pain screening in one measurement year.”

Goals of American Academy of Hospice and Palliative Medicine: Payment Reforms to Improve Care for Patients with Serious Illness:

- Reducing pain and suffering patients experience due to their illnesses
- Reducing stresses and physical burdens on caregivers that can create or worsen their health problems
- Enabling caregivers to remain employed and productive
- Reducing the number of times patients visit Emergency Departments for symptoms or exacerbations of their health conditions
- Reducing the number of hospital admissions for exacerbations or complications of the patients’ health conditions
- Reducing the use of emergency transportation for ED visits and hospital admissions;
- Reducing the use of intensive care beds during hospital stays
- Reducing unnecessary office visits to specialists for routine follow-up care
- Reducing unnecessary and duplicative laboratory testing and imaging services
- Reducing the use of low-value treatment services and medical technologies that do not extend the patient’s life and may worsen the patient’s quality of life
- Avoiding the costs of maintaining medical devices that do not support or improve the patient’s quality of life
- Reducing the use of expensive post-acute care services such as skilled nursing facilities and home health services to address post-acute care needs that can be addressed at lower cost

ECOG Performance Status

Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.*

GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any self-care; totally confined to bed or chair
5	Dead

*Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol.* 1982;5:649-655.

Source: <https://ecog-acrin.org/resources/ecog-performance-status>

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