Master Plan for Aging (MPA) Recommendation Form

# #28

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## Page 1

**Q1** Issue Statement: [State the problem your recommendation will address. Insert links to reports where appropriate.]

Palliative care is specialized medical care that provides patients with relief from the symptoms, pain, and stress that often occur with serious illness. Palliative care can be delivered alongside curative treatment, and is appropriate at any age and at any stage of serious illness. While there is growing evidence regarding the positive impact that palliative care can have on patients, families, and utilization/cost outcomes, roadblocks such as inadequate workforce, confusion with hospice, and policies that limit services serve to deter people who could benefit from palliative care from receiving these services.

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| **Q2** MPA Framework Goal #: [Check which goal/s this recommendation addresses. View MPA Framework document] | **Goal 1: Services & Supports. We will live where we choose as we age and have the help we and our families need to do so.**<br>**,**<br>**Goal 3: Health & Well-being. We will live in communities and have access to services and care that optimize health and quality of life.** |
| **Q3** MPA Framework Objective #: [Check which objective/s this recommendation addresses. View MPA Framework document] | **Objective 1.1: Californians will have access to the help we need to live in the homes and communities we choose as we age.**<br>**,**<br>**Objective 1.2: Californians of all ages will be prepared for the challenges and rewards of caring for an aging loved-one, with access to the resources and support we need.**<br>**,**<br>**Objective 3.2: Californians will have access to quality, affordable, and person-centered health care through delivery systems that are age-friendly, dementia-friendly and disability-friendly.** |

### **Q4** Recommendation: [Explain your recommendation in one to two sentences.]

Develop and implement strategies that integrate palliative care concepts, competencies and clinical services in all health care settings – hospitals, clinics, nursing facilities, residential care, and through skilled home care; develop a standard way to report service provision so access and volume can be tracked; incorporate current best practices into care delivery, for example those put forth in the Clinical Practice Guidelines for Quality Palliative Care, developed by the National Consensus Project for Quality Palliative Care.

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### **Q5** Target Population and Numbers: [Describe groups of Californians impacted by this recommendation, with numbers if available.]

Californians who have life-limiting illness and those who die each year (~230,000) and their family and friends.

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### **Q6** Detailed Recommendation: [Insert detailed bullet points describing your recommendation.]

- Incorporate palliative care into public health and public education strategies and educate policy makers, healthcare providers and consumers about the role and value of palliative care and dispel myths which negatively impact utilization.
- Expand public policy efforts like SB 1004 (2014) and SB 294 (2017) to develop, implement and expand reimbursement for palliative care services.
- Implement palliative care reimbursement policies and quality measures within Medi-Cal and state employee health programs to promote high-value care.
- Adopt regulations that better define, standardize, and support palliative care delivery.

Ensure palliative care is “carved out” from new and existing opioid prescribing rules so that access to palliative care is not unnecessarily impeded.

- Promote evidence-based palliative care standards and practices across a variety of settings and for all age groups.
- Identify quality measures and reporting strategies to improve access to and quality of palliative care.
- Bring healthcare providers, payers and consumers together to inform policy and programmatic changes, and develop strategies to build capacity statewide.

Engage state public health agencies in heightening awareness of palliative on state websites and at local public health offices, developing referral resources for patients and families, and developing and disseminating educational materials.

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**Q7** Evidence that supports the recommendation: [Add links or summaries of research evidence that support the recommendation. Provide links or summaries of research evidence that support your recommendation]

According to a 2017 report by California Health Care Foundation, “Palliative Care in California: Narrowing the Gap,” both inpatient palliative care capacity for the entire state of California and outpatient palliative care are estimated to be sufficient to meet the needs of patients.

- Inpatient Palliative Care: While inpatient palliative care capacity has increased in recent years, statewide supply is still insufficient. Inpatient PC is nonexistent in 18 counties. Of the other 40 counties, 39 have inadequate supply, with 8 counties meeting less than 30% of the estimated need. In Riverside County, for example, the six identified programs can serve about 2,000 patients annually, only 17% of the estimated 11,770 patients in need.

- Community-Based Palliative Care: The 380 community-based PC programs in California can serve approximately 76,730 patients annually, about 40% of the estimated 191,000 Californians who need PC in the last year of life. While capacity has increased dramatically in recent years, supply is still insufficient. Community-based palliative care is nonexistent in 6 counties. Of the other 52 counties, 18 have limited supply, and are able to meet less than 30% of the estimated need. In Sacramento County, for example, the 16 identified programs can serve 2,610 patients annually, just 31% of the estimated 8,385 patients in need.

A randomized trial of in-home palliative care vs. usual care for terminally ill patients with a prognosis of 1 year or less found that the patients who received palliative care had significantly higher satisfaction with care, were more likely to die at home, were less likely to visit an ED, were less likely to be admitted to the hospital, and had lower health care costs. (Brumley 2007)

A randomized trial of interdisciplinary palliative care team consultation vs. usual care for hospitalized, seriously ill patients found that those who received palliative care had significantly higher satisfaction, fewer readmissions that featured ICU days, longer median hospice stays, and lower 6-month net costs of $4,855 per patient. (Gade 2008)

A randomized trial of early, concurrent palliative care vs. usual care for patients with lung cancer found that those who received palliative care had higher self-reported quality of life, less depression, received less chemotherapy in the final two weeks of life, had fewer hospitalizations in the last month of life and had nearly 3 months longer survival (11.6 mos. vs. 8.9 mos., $p<0.02$). Patients who received early palliative care also had a mean cost savings of $2,282 per patient in total health care expenditures during the final month of life compared to the standard care group. (Temel 2010, Greer 2012)

A 2011 analysis of data from the Health and Retirement Study and Medicare claims data showed that the cost of care for patients enrolled in hospice was significantly lower than cost of care for matched patients who did not utilize hospice. Savings ranged from $2,650 for patients enrolled in hospice for 1-7 days, to $6430 for patients enrolled for 15-30 days. (Kelley 2013)
On average, patients who received palliative care incurred $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care: $4,098 per admission for patients discharged alive; $7,563 for patients who died in the hospital. (Morrison, Health Affairs. March 2011)

An evaluation of the INTERACT quality improvement program, which uses communication tools, care paths and advance care planning tools to reduce preventable transfers from nursing homes to acute care hospitals, found a 17% reduction in hospital admissions, resulting in estimated annual net savings to Medicare of $117,300 for a typical 100-bed nursing home. (Ouslander 2011)

**Q8** Examples of local, state or national initiatives that can be used as an example of a best practice: [Provide any available links and sources.] Local: State: National: Other:

• National
o The National Consensus Project for Quality Palliative Care's Clinical Practice Guidelines for Quality Palliative Care, Fourth Edition (2018) detail best practices across eight key domains, ranging from management of physical symptoms, social aspects of care, cultural aspects of care, and care of the dying patient, among others. The guidelines are anchored in an extensive body of literature that document the vast array of superior patient outcomes associated with quality hospice and palliative care. The guidelines were developed by recognized experts representing a consortium of national palliative and hospice organizations, and carry the endorsement of dozens of stakeholder groups.
o The National Academy for State Health Policy (NASHP), with support from the John A. Hartford Foundation, recently convened a State Leadership Council on Palliative Care to better define how states can address these challenges. The council, composed of state medical directors, Medicaid and long-term care leaders, and other officials, identified contributors to the current low uptake of these services across community and hospital settings. These include a lack of state policy infrastructure, limited public and provider awareness of palliative care benefits, stigma, and workforce capacity.

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| **Q9** Implementation: [Insert actions state agencies, legislators, counties, local government, or philanthropy can take to move this recommendation forward. Some of the entities listed below may or may not be applicable to each recommendation.] State Agencies/Departments: [action to be taken by Governor or specific state agencies] State Legislature: [legislation needed to implement recommendation] Local Government: Federal Government: Private Sector: Community-Based Organizations: Philanthropy: Other: | **Respondent skipped this question** |
| **Q10** Person-Centered Metrics: [Individual measures of inputs or outcomes that can be used to measure the recommended action's impact on people.] | **Respondent skipped this question** |
| **Q11** Measuring Success: [Describe specific metrics that could be used to empirically measure the effectiveness of your recommendation] | **Respondent skipped this question** |
| **Q12** Measuring Success: [How would we know that the implementation of your recommendation is successful?] | **Respondent skipped this question** |
| **Q13** Data Sources: [What existing data can be used to measure success or progress?]: Existing data sources: [specify datasets, variables, and data owner/location] Suggestions for data collection to evaluate implementation of this goal when no data sources exist: | **Respondent skipped this question** |
| **Q14** Potential Costs/Savings: [insert any research, actuarial analysis or other evidence of the cost of this recommendation or potential savings] | **Respondent skipped this question** |

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| **Q15** Prioritization: [How would you prioritize your recommendation relative to other needs/priorities?] | **Respondent skipped this question** |

**Q16** Contact information:

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