

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

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

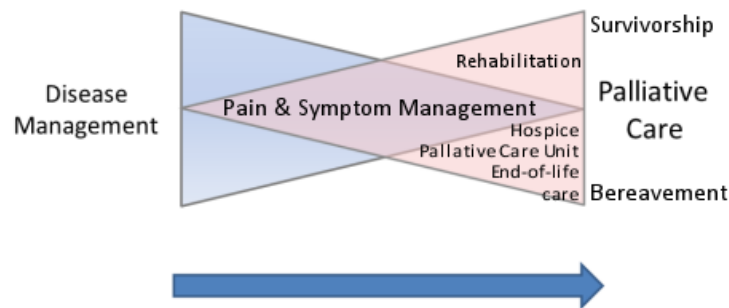
Oncology care has been an earlier adaptor of providing palliative care, but access remains inconsistent within oncology and especially for other diagnoses. Palliative care is largely offered in larger, not-for-profit, urban hospital settings.¹³ In Washington State, 92% hospitals with greater than 300 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 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.

Figure X: Palliative Care Enhanced Model

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Recommendations

Review of successful palliative care programs have found 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 chose to focus on the functions of care rather than assign specific clinical roles to allow greater adaptability based on local resources.

The National Consensus Project for Quality Palliative Care National Coalition for Hospice and Palliative Care [Clinical Practice Guidelines for Quality Palliative Care, 4th edition](#) presents 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)

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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

Quality Metrics

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

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