Center for Improving Value in Health Care (CIVHC) Palliative Care Task Force

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Center for Improving Value in Health Care

What is the Center for Improving Value in Health Care?

An interdisciplinary, multi-stakeholder entity created to identify and pursue strategies for health care quality improvement, consumer protection, and cost containment.

http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1249996141729

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Why was CIVHC created?

- From the Blue Ribbon Commission for Healthcare Reform (208): "...creation of an inter-agency, multi-disciplinary group to facilitate and implement strategies to improve quality and contain costs."
- Executive Order 005-08: "...develop a structured, well-coordinated approach to improving quality, containing costs, and protecting consumers in health care..."

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What will CIVHC do?

The Center will bring consumers businesses, health care providers, insurance companies, and state agencies together to develop recommendations for a long-term approach to identify, implement, and evaluate quality improvement strategies to ensure a better value and improved health outcomes in Colorado.

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Vision of CIVHC

To ensure Coloradans:

- the best individual experience
- the healthiest population
- the lowest cost per capita

Adapted from the Institute for Healthcare Improvement's Triple Aim initiative.

The "Triple Aim"

- **Improve Individual Experience**
- **Improve Population Health**
- **Control Inflation of Per Capita Costs**

The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society on the other hand needs these three aims optimized (given appropriate weightings on the components) simultaneously.

-Tom Nolan, PhD

Some System Components to Accomplish the Triple Aim

- Focus on Individuals and Families
- Strong "Primary Care" Services and Structures
- Population Health Management
- Cost Control Platform
- System Integration

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Palliative Care Task Force

- One of 5 CIVHC subcommittees
  (Others: Data, Consumer Engagement, Improving Delivery Systems, Aligning Benefits and Finance – structure in evolution)
- First meeting April 13, 2009

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Members

- **Julika Ambrose** - Ethics Committee of the Joint Venture of HealthOne and The Colorado Health Foundation (Co-Chair)
- **Martha Barton** - Pikes Peak Hospice and Palliative Care
- **Gayle Bereskin** - Agape Healthcare
- **Phyllis Graham-Dickerson** - Regis University
- **Brian Greffe** - The Children's Hospital
- **Dan Johnson** - Kaiser Permanente
- **Cordt Kassner** - Colorado Center for Hospice & Palliative Care
- **Jean Kutner** - University of Colorado Denver School of Medicine (Chair)
- **Jenny Nate** - Colorado Dept of Health Care Policy and Financing
- **Bev Sloan** - The Denver Hospice
- **Maureen Tarrant** - SkyRidge Medical Center
- **Tom Ventura** - CFMC
- **Christy Whitney** - Hospice and Palliative Care of Western Colorado (Co-Chair)
- **Mark Yarborough** - Center for Bioethics and Humanities, University of Colorado Denver Anschutz Medical Campus

Palliative Care Task Force Vision

"We envision health care capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, fully in synchrony with all of the resources that community, friends, and family can bring to bear at the end of life."

Taken from National Priorities Partnership (NPP) of the National Quality Forum (NQF) - "National Priorities and Goals: Aligning our Efforts to Transform America's Healthc[are]" November 2008

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Why End of Life Care?

- ~ 27% of Medicare's annual $327 billion budget goes to care for patients in their final year of life.
- States such as MN and MA have included end-of-life care as a major focus of their health care quality improvement initiatives.
- Individuals in CO deserve to make their own decisions when it comes to their care at the end of life and experience this time of their lives with dignity, comfort and high quality care.

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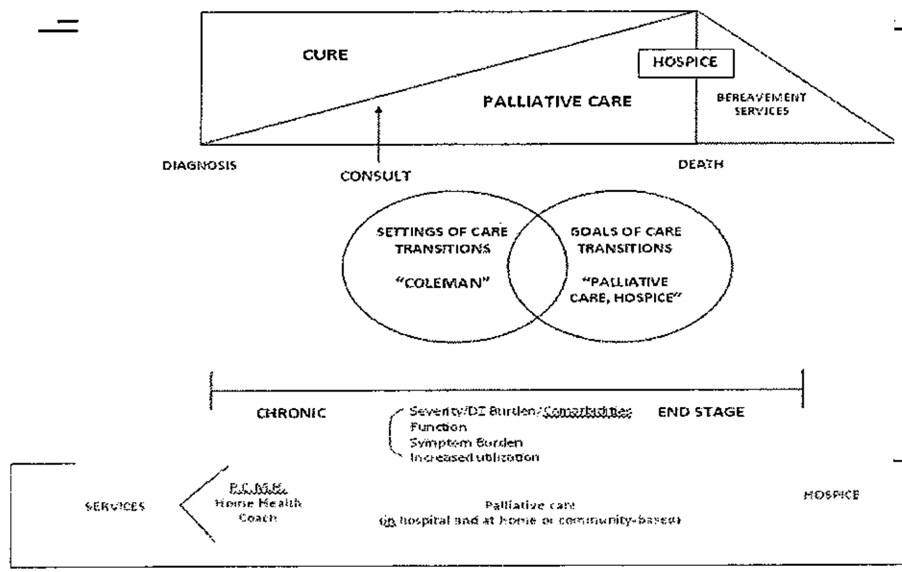
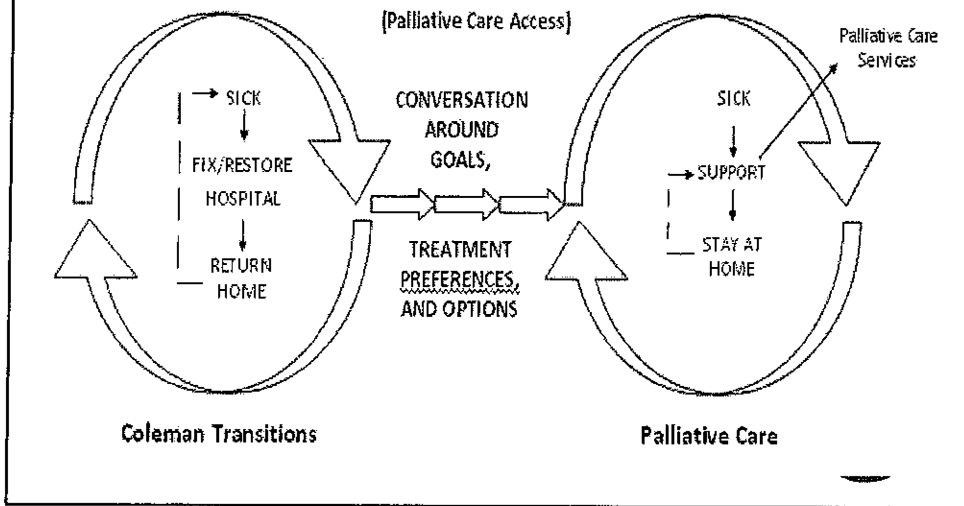
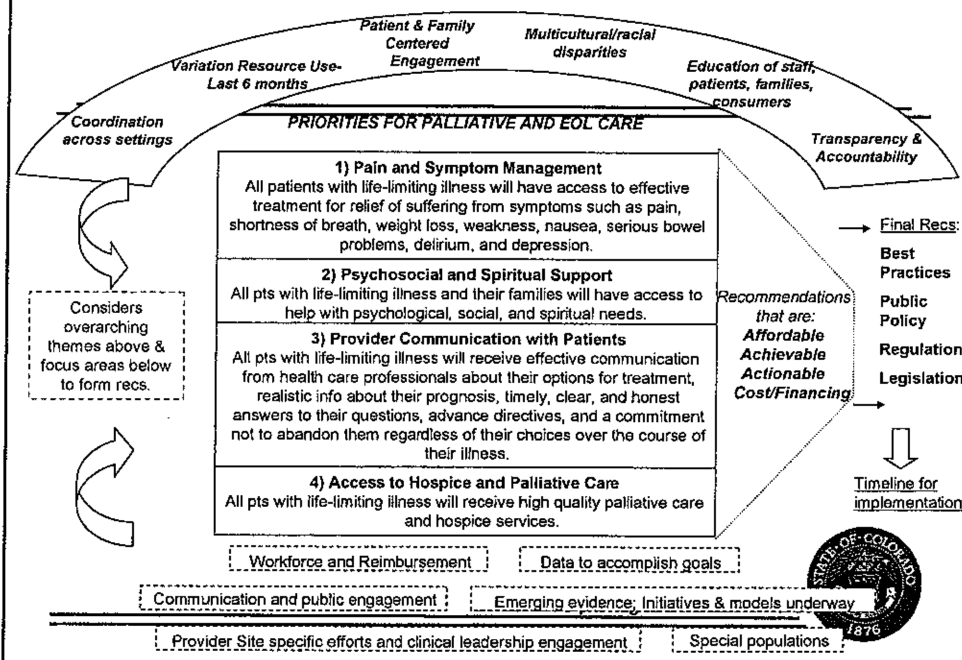
The Palliative Care Continuum




The Relationship Between Care Transitions and Palliative Care
(Palliative Care Access)
Palliative Care Services
SICK
FIX/RESTORE HOSPITAL
RETURN HOME
CONVERSATION AROUND GOALS,
TREATMENT PREFERENCES, AND OPTIONS
SICK
SUPPORT
STAY AT HOME
Coleman Transitions
Palliative Care


Palliative Care Task Force PRIORITIES
Patient & Family Centered Engagement
Multicultural/racial disparities
Variation Resource Use- Last 6 months
Education of staff, patients, families, consumers
Coordination across settings
Transparency & Accountability
PRIORITIES FOR PALLIATIVE AND EOL CARE
1) Pain and Symptom Management
All patients with life-limiting illness will have access to effective treatment for relief of suffering from symptoms such as pain, shortness of breath, weight loss, weakness, nausea, serious bowel problems, delirium, and depression.
2) Psychosocial and Spiritual Support
All pts with life-limiting illness and their families will have access to help with psychological, social, and spiritual needs.
3) Provider Communication with Patients
All pts with life-limiting illness will receive effective communication from health care professionals about their options for treatment, realistic info about their prognosis, timely, clear, and honest answers to their questions, advance directives, and a commitment not to abandon them regardless of their choices over the course of their illness.
4) Access to Hospice and Palliative Care
All pts with life-limiting illness will receive high quality palliative care and hospice services.
Considers overarching themes above & focus areas below to form recs.
Recommendations that are:
Affordable
Achievable
Actionable
Cost/Financing
Final Recs:
Best Practices
Public Policy
Regulation
Legislation
Timeline for implementation
Workforce and Reimbursement
Data to accomplish goals
Communication and public engagement
Emerging evidence; Initiatives & models underway
Provider Site specific efforts and clinical leadership engagement
Special populations
STATE OF COLORADO 1876

What does the CIVHC Palliative Care Task Force hope to achieve?

All Coloradoans with advanced illness have access to high quality palliative care.

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Potential Approaches to Increasing Access to Palliative Care in the Last 2 Years of Life (in development)

Data

- Explore statewide geographic variation in end-of-life costs among the Medicaid population (replicate Dartmouth Atlas approach for Medicaid beneficiaries)

Demonstration Projects

- Outpatient / home-based palliative care for dual eligibles
- Required palliative care consultations for patients in hospitals and nursing homes who meet certain triggers

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Potential Approaches to Increasing Access to Palliative Care in the Last 2 Years of Life (in development)

Payment Reform

- Require that all payers have a minimum palliative care and hospice benefit
- Direct Medicaid reimbursement for Room and Board for hospice patients in hospice or long-term care facilities

Standards

- Define standards for quality palliative care (following National Consensus Project)
- Require all nursing homes, hospitals, home care organizations to have palliative care and hospice available in-house or through contract

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Sample Metrics of Success

For patients with advanced illness in the last 2 years of life:

- Increased percentage receiving palliative care consultation
- Reduced hospitalizations, hospital days, ICU days, hospital readmissions and emergency department visits
- Increased percentage receiving hospice care
- Increased median hospice length of stay

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Additional Metric of Success

Increased number of quality palliative care programs in Colorado (hospital- and community-based)

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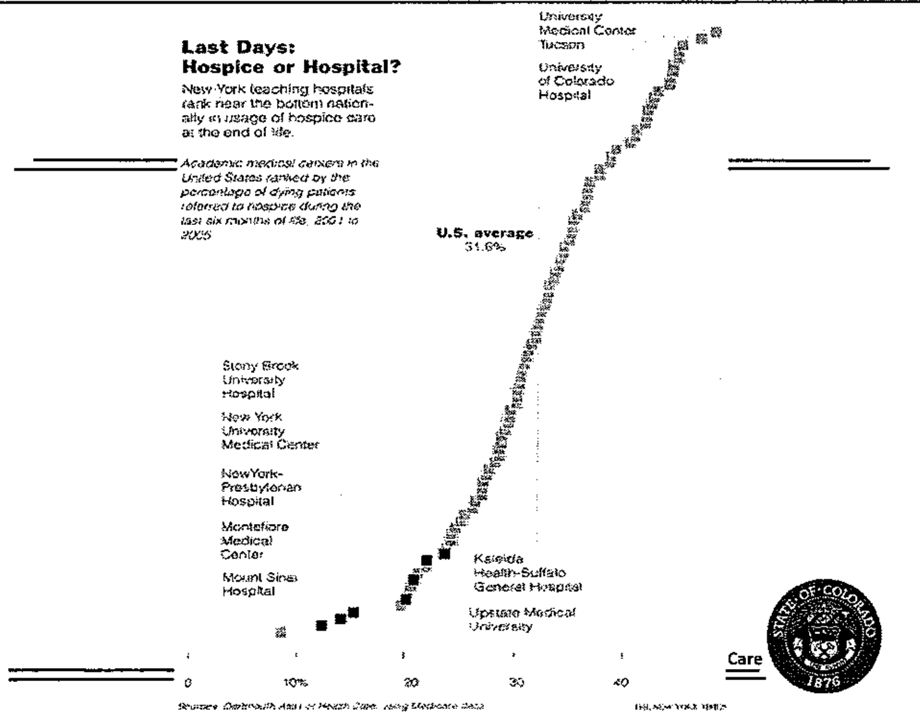

Strategic Approach

Assemble Task Force	April 2009
Define scope of the problem and priorities; Connect with similar efforts nationally	April – June 2009
Obtain charge from CIVHC Board	July – August 2009
Address Task Force Issue list	September – December 2009
Recommend action plan	By February 2010

CIVHC Task Force Issues to be Addressed

- Specific measurable goals and metrics
- Evidence-base
- Other relevant organizations
- Purchaser, provider, consumer roles
- Payment reform needs
- Implications for legislation / regulation
- Tools necessary for compliance
- Strategies to change behavior
- Barriers
- Data sources
- Cost reductions
- Funding needs
- Action plan

Questions and Discussion

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