Palliative Care in the Outpatient Setting

Questions for Deliberation: March 31, 2016 Public Meeting

Definitions

For the purposes of this New England CEPAC report/meeting, we use the following definitions:

Generalist Palliative Care

Generalist palliative care is typically provided by professionals who have some clinical experience and basic training in palliative care concepts but whose primary specialty is not palliative care, including primary care physicians, generalists, oncologists, nurse practitioners, and other disciplines. These providers conduct needs assessments, educate patients about their disease, and provide basic symptom management and psychosocial support. Generalist palliative care can be provided by individual providers or in conjunction with a multi-disciplinary team (e.g., social workers, chaplains, etc.); the main differentiating feature from specialty palliative care is the absence of a clinician with advanced training/certification in hospice and palliative care.[1]

Specialist Palliative Care

Specialist palliative care teams can be comprised of hospice and palliative medicine (HPM) board certified clinicians and advanced practice nurses with higher specialty education in palliative care. Specialist palliative care providers are those who have extensive training and experience in palliative care, and focus on those more complex aspects of disease management, including controlling refractory physical and emotional symptoms and worsening depression or anxiety; assisting with conflict resolution; identifying and communicating patients' goals and preferences for care; and counseling around issues of end of life planning and bereavement.[1]

References

1. Quill TE, Abernethy AP. Generalist plus specialist palliative care--creating a more sustainable model. *The New England journal of medicine*. 2013;368(13):1173-1175.

Voting Questions

Comparative Clinical Effectiveness

1. Is the evidence adequate to demonstrate that specialist palliative care delivered in the outpatient setting is superior to usual care for:

    a. *Improving quality of life?*
    Yes *No*
    b. *Reducing hospitalization and ED use*?
    Yes *No*

2. Is the evidence adequate to demonstrate that generalist palliative care delivered in the outpatient setting is superior to usual care for:

    c. *Improving quality of life?*
    Yes *No*
    d. *Reducing hospitalization and ED use*?
    Yes *No*

Comparative Value

Care Value

3. Given the available evidence, what is the *care value** of specialist palliative care in the outpatient setting vs. usual care in the outpatient setting?

    a. Low *b. Intermediate* *c. High*

Provisional Health System Value

4. Given the available evidence, what is the overall *provisional health system value*** of specialist palliative care?

    a. Low *b. Intermediate* *c. High*

* ***Care value*** is determined by looking at four elements: comparative clinical effectiveness, incremental costs per outcomes achieved, other benefits or disadvantages, and contextual considerations. Care value represents the long-term perspective, at the individual patient level, on patient benefits and the incremental costs to achieve those benefits.

** ***Provisional health system value*** represents a judgment integrating consideration of the long-term care value of a new intervention with an analysis of its potential short-term budget impact if utilization is unmanaged.