



Palliative Care: Barriers, Opportunities, and Considerations for Quality Improvement

Draft Background and Scope for Evidence Review

Background:

Palliative care is a management approach that provides symptom relief and comfort care to patients with serious or life-threatening illnesses, with the goal of improving quality of life for both patients and their families.¹ Unlike hospice care, which is typically restricted to individuals with a prognosis of survival of six months or less, palliative care can begin at diagnosis and is often provided along with treatment aimed at prolonging life, such as chemotherapy or radiation for cancer.² One of the primary objectives of palliative care is to help patients prioritize their goals of care, and may include conversations around advance care planning (e.g., a “living will”) depending the anticipated disease trajectory.³

Project Aim:

The focus for this assessment is the comparative effectiveness and value of outpatient palliative care services relative to “standard care” (i.e., treatment paradigms that do not include palliative services). Because it is expected that studies will vary substantially in terms of their entry criteria and definitions of the interventions, we will attempt to identify the components of palliative care programs most closely associated with treatment success. The review will also include an overview of lessons learned from national and regional experts to identify innovations and potential solutions, as well as an evaluation of the legal, regulatory, and financial landscape for palliative care in the New England states.

Scope of the Assessment:

The proposed scope for this assessment is described on the following pages using the PICOTS (Population, Intervention, Comparators, Outcomes, Timing, Settings) framework.

Population

The populations of interest will include all adults (>17 years old) with serious or life-threatening illnesses, including but not limited to advanced cancer, chronic obstructive pulmonary disease, and congestive heart failure.

Interventions

Interventions of interest will include those palliative care services provided either independently of, or in conjunction with, curative or life-prolonging treatment for serious and life-threatening illnesses. Studies which describe “hospice,” “end-of-life care,” “supportive care,” “comfort care,” or any such variation will be considered alongside studies with interventions specifically described as “palliative.”

Although we will include all studies regardless of their definition of the interventions, our focus will be on palliative care interventions that incorporate elements directed at both physical and psychosocial patient care, as both are considered essential and definitional components of palliative interventions.^{4,5} We will attempt to identify components of care across studies, with the goal of identifying those that may influence the direction of effect. We will also include studies describing “early” palliative care (as defined by initiation at or around the time of diagnosis) as compared to “late” interventions (e.g. initiated at or near the end of life) or no palliative services.

Comparators

Primary comparators of interest will be current models of “usual care,” which may take multiple forms.

Outcomes

Outcomes of interest will include the impact of palliative care on:

- Survival and mortality, including location of death
- Health resource utilization
- Symptom severity, including pain, breathlessness, fatigue, and nausea
- Patient, caregiver, and/or family psychological distress (e.g., stress, anxiety, depression)
- Ratings of patient, caregiver, family, and provider satisfaction
- Health-related quality of life
- Economic outcomes, including program start-up costs, costs per patient, potential cost offsets, and measures of cost-effectiveness

The review will include evidence drawn from all measures of these outcomes as reported in the evidence base, but will focus on those that are drawn from validated instruments.

Timing

Evidence on palliative care provided outside the hospital or nursing care facility setting will be gathered from the year 2000 onward, reflecting the timeline and evolution of palliative care in these settings.

Evidence on intervention effectiveness will be limited to higher quality randomized clinical trials or comparative cohort studies, of any duration.

Settings

While study participants could be identified in multiple settings, we will focus on palliative care programs delivered outside the hospital, including outpatient or home-based settings. Studies describing patients receiving palliative care in nursing facilities will also be excluded.

Economic Evaluation:

We will review the published literature for analyses that have examined the economics of palliative care programs. This may include studies of the cost to initiate and operate palliative care programs or specific components of such programs, analyses of the costs that are potentially offset through the use of such programs (e.g., reduced end-of-life medical costs), and cost-effectiveness analyses. Our report will summarize what is currently known in the literature about the economic impact of palliative care programs and components, the strength and validity of that evidence, and where gaps in knowledge still exist. Data permitting, we will also highlight those programs or program components best correlated with cost-offsets or favorable cost-effectiveness.

We will also explore the potential health system budgetary impact of outpatient palliative care programs over a near-term time horizon, utilizing published or otherwise publicly-available information on program planning, implementation, and ongoing treatment costs, any cost offsets, and the potential population eligible for such services. Multiple perspectives will be considered for this evaluation, including that of an accountable care organization as well as a third-party payer.

References

1. National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. Third ed 2013.
2. Kelley AS, Morrison RS. Palliative Care for the Seriously Ill. *The New England journal of medicine*. 2015;373(8):747-755.
3. Gillick MR. Rethinking the central dogma of palliative care. *Journal of palliative medicine*. 2005;8(5):909-913.
4. De Lima L, Bennett MI, Murray SA, et al. International Association for Hospice and Palliative Care (IAHPC) List of Essential Practices in Palliative Care. *J Pain Palliat Care Pharmacother*. 2012;26(2):118-122.
5. Gomes B, Calanzani N, Curiale V, McCrone P, Higginson IJ. Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Cochrane Database Syst Rev*. 2013;6:CD007760.