Palliative Care in the Outpatient Setting

Public Meeting – March 31, 2016
Agenda

- **Meeting Convened and Opening Remarks** | 10:00 AM- 10:15 AM
  - Steven Pearson, MD, MSc, President, Institute for Clinical and Economic Review

- **Presentation of the Evidence** | 10:15 AM- 11:30 AM
  - Sarah Emond, MPP, Chief Operating Officer, Institute for Clinical and Economic Review
  - Dan Ollendorf, PhD, Chief Scientific Officer, Institute for Clinical and Economic Review
  - Rick Chapman, PhD, MS, Director of Health Economics, Institute for Clinical and Economic Review

- **Public Comments and Discussion** | 11:30 AM-12:00 PM
  - Members of the public pre-registered to deliver oral remarks

- **Break for Lunch** | 12:00 PM – 12:30 PM

- **CEPAC Q&A with Experts/Deliberation and Votes** | 12:30 PM – 2:00 PM

- **Policy Roundtable** | 2:00PM-3:30 PM
New England CEPAC Overview

- A core program of the Institute for Clinical and Economic Review (ICER)
  - CEPAC is an independent panel that reviews objective evidence reports and holds public meetings to develop recommendations for how patients, clinicians, insurers, and policymakers can improve the quality and value of health care.

- Goal: To improve the application of evidence to guide practice and policy in New England

- Structure:
  - Evidence review from ICER
  - Deliberation and voting by CEPAC— independent clinicians, methodologists, and leaders in patient engagement and advocacy

- Supported by NESCO, regional private payers, regional provider organizations, and grant funding from the Laura and John Arnold Foundation
New England CEPAC Overview

- CEPAC recommendations designed to support aligned efforts to improve the application of evidence to:
  - Practice
    - Patient/clinician education
    - Quality improvement efforts
    - Clinical guideline development
  - Policy
    - Coverage and reimbursement
    - Medical management policies
    - Benefit design
TOPIC OVERVIEW

Sarah K. Emond, MPP
Chief Operating Officer
Institute for Clinical and Economic Review
Disclosures:

I have no conflicts of interest.

Key review team members:
Courtney Cunningham, MPH
Erin Lawler, MA
Context

- Palliative care is a multi-disciplinary management approach
  - Provides symptom relief and comfort care to patients with serious or life-threatening illnesses
  - Goal of improving QoL for both patients and their families
- Can be initiated at diagnosis and provided concomitantly with curative therapy
- Most commonly provided for advanced cancer patients in inpatient settings, but limited by capacity issues
- Interest in ways to increase access due to growing number of patients living with progressive diseases
Settings and Structure

- Palliative care services can be administered in hospitals, outpatient clinics, skilled nursing facilities, and in the home.
- Experts in the field have identified the outpatient setting as the new frontier in palliative medicine.*
- Two dominant types of palliative care:**
  - **Generalist:** led by providers who have some clinical experience and basic training in palliative care concepts but whose primary specialty is not palliative care.
  - **Specialist:** led by providers with higher specialty education and advanced training in palliative care who are able to treat more complex aspects of disease management.

Barriers

• **Workforce: Capacity, Education, and Training**
  - Estimated shortfall of 6,000-18,000 palliative care physicians in the U.S.
  - Extensive training requirements and limited fellowships available

• **Lack of Awareness Among Non-Specialist Providers**
  - Lack of training/education to be able to discuss and provide basic palliative care services

• **Patient and Family Knowledge of Palliative Care**
  - Stigma associated with end-of-life care
Barriers (2)

• **Availability of Data and Funding for Research**
  • Limited amount of comparative studies
  • Only 1% of the current NIH budget is dedicated to palliative care research

• **Geographic and Socioeconomic Disparities**
  • Dearth of palliative care providers in rural communities
  • Lack of access for minority populations due to issues around cultural competency

• **Billing**
  • Many providers have difficulty being reimbursed for palliative services (e.g., social workers, chaplains, etc.)
  • Reimbursements often cover only half of the costs for outpatient palliative care services
Opportunities

- **New Payment Methodology**
  - Integrated delivery systems operating under capitated or risk-bearing managed care payments

- **Use of Electronic Medical Records**
  - To encourage care collaboration among providers and identification of those patients who will benefit from palliative care

- **Patient and Provider Education**
  - Continuing education credits
  - Public education campaign
Opportunities (2)

- **Resources for Existing Providers and Health Systems**
  - CAPC’s Improving Outpatient Palliative Care program
  - VITALtalk program for promoting basic palliative care communication skills

- **Palliative Care Legislation**
  - Federal level: *The Palliative Care and Hospice Education and Training Act*
  - Regional level: MA and RI are studying barriers and ways to improve public awareness
EVIDENCE REVIEW

Dan Ollendorf, PhD
Chief Scientific Officer
Institute for Clinical and Economic Review
Disclosures:
I have no conflicts of interest.

Key review team members:
Shanshan Liu, MS, MPH
Anne Loos, MA
Karin Travers, DSc
Methods

- Review limited to higher quality RCTs and comparative cohort studies
- Studies conducted outside U.S. and Canada excluded
- All advanced diseases included
- Primary focus on “specialist” vs. “generalist” interventions
Study Selection (PICOTS)

- Population: adults 18 years or older
- Intervention: palliative care interventions that included both physical and psychosocial elements
- Comparators: usual/standard care
- Outcomes: QoL, resource utilization, symptom burden, mood, satisfaction, survival, costs
- Time Frame: January 2000-November 2015
- Setting: all outpatient settings (skilled nursing facilities excluded)
Selected Studies (13)

- Study characteristics
  - Relatively large (n>100), mostly RCTs using “modified” intent-to-treat design
  - Even mix of academic/community settings
  - Geographically-diverse

- 9 specialist, 4 generalist

- 5 in cancer only, 8 in mixed populations with cancer and other advanced illness (e.g., CHF, COPD)
## Strength of Evidence

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Specialized care</th>
<th>Generalist care</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>QoL</td>
<td>5 studies</td>
<td>2 studies</td>
<td>7 studies</td>
</tr>
<tr>
<td>Resource Use</td>
<td>7 studies</td>
<td>3 studies</td>
<td>10 studies</td>
</tr>
<tr>
<td>Survival</td>
<td>3 studies</td>
<td>1 study</td>
<td>4 studies</td>
</tr>
<tr>
<td>Symptom Burden</td>
<td>5 studies</td>
<td>2 studies</td>
<td>7 studies</td>
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<tr>
<td>Patient Satisfaction</td>
<td>3 studies</td>
<td>1 study</td>
<td>4 studies</td>
</tr>
<tr>
<td>Psychosocial and Spiritual</td>
<td>1 study</td>
<td>2 studies</td>
<td>3 studies</td>
</tr>
<tr>
<td>Mood</td>
<td>4 studies</td>
<td>2 studies</td>
<td>6 studies</td>
</tr>
<tr>
<td>Caregiver Outcomes</td>
<td>1 study</td>
<td>0 studies</td>
<td>1 study</td>
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</table>

**Key:**

- **High**
- **Moderate**
- **Low**
- **No evidence**
Quality of Life

- Measured in 7 studies
  - 4 showed improved QoL
    - 3 specialist, 1 generalist
    - All studies of cancer patients only
  - 3 showed equivalent improvements in QoL
    - 2 specialist, 1 generalist
Mood, Symptoms and Satisfaction

- Anxiety and/or depression measured in 6 studies
  - 4 showed improvement on one or the other (2 specialist, 2 generalist)

- Patient satisfaction measured in 4 studies
  - 3 showed improvement (all specialist)

- Symptom burden measured in 7 studies
  - 4 studies showed no impact (all specialist)
  - 3 studies showed benefits (2 specialist, 1 generalist)
    - Limited to discrete and disease-specific symptoms (e.g., shortness of breath in COPD)
Survival

- Measured in 5 studies
  - Intent of palliative care not to prolong life
  - 2 studies showed improvement in median survival (3-6 months) and rate of survival at one year (both specialist)
  - 1 trial showed improved 1-yr survival in early vs. delayed group (specialist)
  - 2 studies showed no difference in survival (1 specialist, 1 generalist)
Resource Utilization

- Measured in 10 studies
  - 7 showed benefits on at least one resource utilization outcome (5 specialist, 2 generalist)
    - Reductions in use of acute inpatient and/or ED services
    - Increase in home deaths and hospice utilization
Other Outcomes

- Evidence of outpatient palliative care impact on psychosocial, spiritual, and caregiver outcomes extremely limited
  - Some benefits observed re: improved spiritual wellbeing, increases in advance care planning, and improved depression and stress burden* for caregivers

*For a comparison of early vs. delayed palliative care
Overall Summary

- **Specialist**: moderate certainty that outpatient palliative care confers an incremental or better net health benefit relative to usual care (ICER evidence rating: B+)
  - Harms not reported in any study

- **Generalist**: small and inconsistent evidence base, but generalist approaches unlikely to be net harmful and produce at least comparable outcomes in available studies:
  - ICER evidence rating: Promising but Inconclusive (P/I)
Elements Associated with Success

- **Methods:**
  - Defined success as a statistically significant effect on any QoL measure in favor of the palliative care intervention
  - Compared the frequencies of various specific components of the interventions described in “successful” studies relative to those described in the “unsuccessful” studies
# Elements Associated with Success

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<tbody>
<tr>
<td><strong>Program Components</strong></td>
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<tr>
<td>Multidisciplinary Care Team</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Palliative Care Specialist</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Patient &amp; Family Education</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Advance Care Planning</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Monthly In-person Office Visit</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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*Unsuccessful Studies* vs. *Successful Studies*
COMPARATIVE VALUE ANALYSIS

Rick Chapman, PhD, MS
Director of Health Economics
Institute for Clinical and Economic Review
Disclosures:
I have no conflicts of interest.

Key review team members:
Dan Ollendorf, PhD
Methods

- Included higher quality RCTs and comparative cohort studies examining economics of palliative care programs in U.S. and Canada
- Same study selection criteria as for Evidence Review
  - Adults in palliative care programs in outpatient settings, compared to usual care (2000-2015)
Costs & Cost-Effectiveness

- 3 studies (including specialist and generalist interventions) found ~$6,000-$8,000 lower costs/patient with outpatient palliative care in patients with mixed diagnoses.
- No studies reported start-up/implementation costs, so full assessment of return on investment could not be performed.
- Recent review* found cost savings through reduced hospital admission rates, shift from high-cost settings (e.g., hospitals) to lower-cost settings (e.g., home health care).

Cost Burden & Unpaid Caregiving

- Studies employing societal perspective have found that much of the costs offset through reduced use of ED and hospital are shifted to the home setting and care provided by unpaid caregivers.

- Informal caregiving estimated to total nearly 70 hours per week, at annual replacement costs >$30,000*
  - Replacing informal care provided in U.S. in last year of life with home health aides estimated to require ~$1.4 billion

POTENTIAL BUDGETARY IMPACT
Potential Budget Impact: Methods

- Based on results from U.S.-based RCT*
  - Mean cost of $19,308 for palliative care and $30,816 for usual care, updated to 2014 dollars
  - Cost offsets of $11,508/patient enrolled in palliative care vs. usual care

- Estimated entire candidate populations for treatment**
  - Cancers: 585,000
  - COPD, CHF: 202,000
  - TOTAL: 787,000

**Expected LE < 12 months; numbers estimated using NCHS 2013 deaths by cause
Potential Budget Impact: Methods

- Evaluated 3 potential implementation rates: 10%, 25%, or 50% of eligible patients per year for 5 years
- Also evaluated 3 gradual implementation rates: 10%, 25%, or 50% at the end of 5 years
  - E.g., if 10% of patients assumed enrolled at 5 years, 2% of eligible patients enrolled in 1st year, 4% in 2nd, 6% in 3rd, 8% in 4th, 10% in 5th year
### Potential BI: Number of Patients Enrolled - 10% Assumption

<table>
<thead>
<tr>
<th>Full</th>
<th>Yr 1</th>
<th>Yr 2</th>
<th>Yr 3</th>
<th>Yr 4</th>
<th>Yr 5</th>
<th>Cum. Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>58,489</td>
<td>58,489</td>
<td>58,489</td>
<td>58,489</td>
<td>58,489</td>
<td>292,445</td>
</tr>
<tr>
<td>COPD/CHF</td>
<td>20,176</td>
<td>20,176</td>
<td>20,176</td>
<td>20,176</td>
<td>20,176</td>
<td>100,880</td>
</tr>
<tr>
<td>Total</td>
<td>78,665</td>
<td>78,665</td>
<td>78,665</td>
<td>78,665</td>
<td>78,665</td>
<td>393,325</td>
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<tr>
<th>Gradual</th>
<th>Yr 1</th>
<th>Yr 2</th>
<th>Yr 3</th>
<th>Yr 4</th>
<th>Yr 5</th>
<th>Cum. Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>11,698</td>
<td>23,395</td>
<td>35,093</td>
<td>46,790</td>
<td>58,489</td>
<td>175,464</td>
</tr>
<tr>
<td>COPD/CHF</td>
<td>4,035</td>
<td>8,071</td>
<td>12,106</td>
<td>16,142</td>
<td>20,176</td>
<td>60,531</td>
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<tr>
<td>Total</td>
<td>15,733</td>
<td>31,466</td>
<td>47,199</td>
<td>62,932</td>
<td>78,665</td>
<td>235,995</td>
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Results at 1 & 5 Years: Full Implementation

<table>
<thead>
<tr>
<th>Percent Enrolled</th>
<th>Immediate</th>
<th>Analytic Horizon = 1 Year</th>
<th>Analytic Horizon = 5 Years</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number Treated</td>
<td>Total BI (billions)</td>
<td>Cumulative Number Treated</td>
</tr>
<tr>
<td>10%</td>
<td>78,665</td>
<td>-$0.91</td>
<td>393,325</td>
</tr>
<tr>
<td>25%</td>
<td>196,655</td>
<td>-$2.26</td>
<td>938,275</td>
</tr>
<tr>
<td>50%</td>
<td>393,315</td>
<td>-$4.53</td>
<td>1,966,575</td>
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## Results at 1 & 5 Years: Gradual Implementation

<table>
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<tr>
<th>Percent Enrolled</th>
<th>Analytic Horizon = 1 Year</th>
<th>Analytic Horizon = 5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number Treated</td>
<td>Total BI (billions)</td>
</tr>
<tr>
<td>10%</td>
<td>15,733</td>
<td>-$0.18</td>
</tr>
<tr>
<td>25%</td>
<td>39,331</td>
<td>-$0.45</td>
</tr>
<tr>
<td>50%</td>
<td>78,663</td>
<td>-$0.91</td>
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</table>
Summary

- Outpatient palliative care appears to reduce overall costs of care through reduced use of hospital and ED services.
- However, much of this cost appears to be shifted to informal, unpaid caregiving.
- Costs studies also lack information on start-up and implementation expenses.
- Medical cost reductions of ~$2.7-$4.5 billion over 5 years possible even if only 10% of eligible patients opt for palliative care.
PUBLIC COMMENT
LUNCH
Meeting will resume at 12:30PM
Questions for Deliberation
Palliative Care in the Outpatient Setting
Comparative Clinical Effectiveness
Example Question

Is the evidence “adequate” to demonstrate that “intervention A” is superior to “comparator B” for patients with “condition X”?  
• Yes  
• No
Care Value Example Question

What is the care value of “intervention A” vs “comparator B”?

A. Low
B. Intermediate
C. High
Provisional Health System Value Example

Question

Assuming baseline pricing and payment mechanisms, what would be the provisional health system value of “intervention A”?  

A. Low  
B. Intermediate  
C. High
Practice Question

Who’s your prediction for the NCAA March Madness tournament winner?

A. Villanova
B. Oklahoma
C. Syracuse
D. UNC
COMPARATIVE CLINICAL EFFECTIVENESS
Specialist Palliative Care: QoL

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

Improving quality of life?

- Yes
- No
Specialist: Hospitalization and ED Use

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

Reducing hospitalization and ED use?

- Yes
- No
Is the evidence adequate to demonstrate that generalist palliative care delivered in the outpatient setting is superior to usual care for:

*Improving quality of life?*

- Yes
- No
Is the evidence adequate to demonstrate that **generalist palliative care** delivered in the outpatient setting is superior to usual care for:

*Reducing hospitalization and ED use?*

- Yes
- No
COMPARATIVE VALUE

CARE VALUE
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
COMPARATIVE VALUE

PROVISIONAL HEALTH SYSTEM VALUE
Given the available evidence, what is the overall *provisional health system value* of specialist palliative care?

A. Low  
B. Intermediate  
C. High
POLICY ROUNDTABLE
# Policy Roundtable Participants

<table>
<thead>
<tr>
<th>Policy Roundtable</th>
<th>Policy Roundtable</th>
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<tbody>
<tr>
<td><strong>Marie A. Bakitas, DNSc, NP-C, FAAN</strong>  &lt;br&gt;Professor, Marie O’Koren Endowed Chair  &lt;br&gt;School of Nursing/Department of Medicine,  &lt;br&gt;University of Alabama at Birmingham  &lt;br&gt;Associate Director, Center for Palliative and Supportive Care</td>
<td><strong>Diane E. Meier, MD</strong>  &lt;br&gt;Vice-Chair for Public Policy, Professor of Geriatrics and Palliative Medicine, and  Catherine Gaisman Professor of Medical Ethics, Icahn School of Medicine at Mount Sinai Hospital  &lt;br&gt;Director, Center to Advance Palliative Care</td>
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<tr>
<td><strong>Lori-Jane Higgins</strong>  &lt;br&gt;Caregiver, Data Collector for Palliative Care Research</td>
<td><strong>Rob Zavoski, MD, MPH</strong>  &lt;br&gt;Medical Director, Connecticut Department of Social Services</td>
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<tr>
<td><strong>Joseph Kozacheck, MD</strong>  &lt;br&gt;Senior Medical Director, Custom Care Unit, Aetna</td>
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Meeting Adjourned
Next Steps

- Final Report and accompanying materials expected in late April.
- Meeting materials and outputs: icer-review.org/meeting/palliative-care

For more information please visit
icer-review.org/programs/new-england-cepac