Medical Xpress

This type of care can sharply reduce medical costs, so why aren't doctors ordering it?

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Doctors can improve the quality of life for their seriously ill patients while also reducing the patients' medical expenses if they make use of one particular care model, so why aren't they using it?

The biggest hurdle might well be the words used to describe it, said Dr. Jeanine Ellinwood, who leads a team in the specialized field. People hear them, she said, and think immediately of hospice care.

It's not. It's palliative care, she said, and yes, there is a difference.

Hospice care focuses on making people comfortable in their last six months of life. Palliative care, however, aims to relieve the symptoms and stress of serious illness with the goal of improving quality of life, and it functions as an extra layer of support for patients and their families.

"We're still doing a lot of education of the clinicians that palliative care can occur way before someone chooses a comfort-care approach, which is what hospice support is," said Ellinwood, the medical director at El Dorado County, Calif.-based Snowline, which offers hospice and supportive care. "The hospice industry did a wonderful job, and we linked it with palliative care and used the lingo for a long time."

The distinction is critical, Ellinwood, insurers and researchers said, because when a patient goes into hospice, their specialists and physicians typically don't play as active a role in their care. That's not true with palliative care, where many patients are depending on their doctors to work aggressively to prolong their lives.

Snowline has played an integral role in keeping Natomas, Calif., resident Christine de Belen-Wilson's father out of the emergency room, de Belen-Wilson said, but getting her dad's pulmonologist to give palliative care a try wasn't easy.

"He didn't think that my dad, after being in and out of the hospital, needed palliative care," said de Belen-Wilson, a physician assistant. "It took several attempts to get folks in the medical community to

understand that he needs to have the support."

Servando de Belen has chronic obstructive pulmonary disease, or COPD, so oxygen doesn't always flow easily through his scarred lungs. His wife, Warlita de Belen, said that, before Snowline entered the picture, her husband was going to the emergency room two to three times a month.

Since the family started working with Snowline, she said, they haven't had one of those ordeals for about a year.

"It felt like we were alone," Warlita de Belen said. "It was just Christine who was helping us. Every time I had a problem, I'd call her. We had to bring him to the ER. He had a temperature, or this or that, and here comes Christine. His health has been more stable now."

More importantly for mother and daughter, they said, they feel as though they are again seeing the man their family knows and loves: the doting grandfather, the talkative card shark, the dedicated gardener and the amateur singer always ready for the karaoke box.

Snowline recently reviewed the hospital visits for patients in its palliative care program from Jan. 1, 2017 through May 1, 2018. Roughly 200 patients reported an average of 57 ER visits and 59 hospital stays in each of the three months prior to being admitted to Snowline's palliative care program. Three months after joining Snowline, though, ER visits had dropped to an average of seven per month for those 200 individuals and hospitalizations to an average of one.

What's even better, those patients reported significant drops in pain, anxiety and nausea after admission.

De Belen-Wilson credits her dad's success to an interdisciplinary team that actively manages all aspects of its patients' health. Her family has

benefited from Snowline's social workers, home health aides, chaplains, primary-care providers and nurse case managers. Snowline also offers music therapy and volunteers who provide respite to caregivers.

Provided along with curative treatments, palliative care emphasizes pain and symptom management, care management and coordination, assistance with treatment decisions, and 24-hour-a-day access to the palliative team's nurses and doctors.

De Belen said she has a high level of trust for Snowline's team, so her daughter is no longer the first call she makes anymore. The couple have become so much better able to cope, de Belen-Wilson said, that she's more likely to be upset that her mother didn't call her.

Currently, because many physicians and patients don't understand the benefits of palliative care, Snowline and many other support teams have the capacity to take more patients than they are getting. But, if everyone who qualified actually sought placement, there wouldn't be enough capacity to serve everyone who needs it, according to a report earlier this month from the Oakland-based California Health Care Foundation.

The philanthropic group, which works to improve health-care delivery, released data earlier this month showing that community-based palliative-care programs have only enough capacity to meet 33 percent to 51 percent of demand. Community-based palliative teams work in clinics and in patients' homes.

Even though many of the state's acute-care hospitals have their own so-called in-patient palliative care teams, they have only enough staff to meet 43 percent to 66 percent of the need for their service, according to the report.

This supply gap exists despite tremendous growth in the number of

palliative care operations all around California. Community-based programs have doubled in number to 380 between 2014 and 2017, the California Health Care Foundation reported, and the state's 356 acute-care hospitals offered 202 in-patient palliative care programs in 2017, up from 186 three years earlier.

The expansion has been fueled, in part, by SB 1004, a state law that required all managed-care health plans have palliative care services available for any Medi-Cal beneficiaries they serve.

Kaiser Permanente and the Department of Veteran's Affairs have long offered this service as part of an integrated health approach. Now, however, both Blue Shield of California and Health Net also have made a concerted push to add it. By the start of 2018, Blue Shield had partnered with community-based palliative care teams in all the state's 58 counties. The nonprofit health insurer also co-led creation of the California Advanced Illness Collaborative, a group that is attempting to bring consensus to the minimum services that palliative care providers must offer.

"We first wanted to ensure that we were covering the right services at the right time for patients and families facing serious illness," said Dr. Terry Gilliland, Blue Shield of California's chief health officer. "By standardizing the expectations for what makes a Blue Shield home-based palliative care provider, we were able to design a payment model that would allow for flexibility to provide the right care at the right time, cover staff that previously was unable to be reimbursed for their services, and also increase the understanding of the community about what they could expect when working with a palliative care team."

The lack of uniform standards may be another reason why physicians may not yet understand palliative care, said Kate Meyers, a senior program officer with the California Health Care Foundation. There is a

set of standards for hospice that is really predictable, she said, but that's not the case with palliative care.

"You've got tremendous differences in the scope of services, the type of disciplines involved in care delivery, the training those individuals have had," Meyers said. "Just everything you can imagine, there's probably a variation on, so it's entirely possible that maybe a type of palliative care that a particular referring provider was exposed to didn't align with what they would want for their patients or they didn't perceive it as helpful because it didn't match their expectations."

This will come as the industry matures, Meyers said.

The American Society of Clinical Oncology recently issued guidelines that palliative care should be offered concurrently with all appropriate disease-directed treatments for any patient with Stage 3 or 4 metastatic disease or any patient with a heavy symptom burden, said Kathleen Kerr, author of the California Health Care Foundation's recent report on palliative care.

There's no mention of prognosis at all, she said, so they are letting oncologists know that this type of care is not tied to end of life.

"Palliative care is focused on helping people function with a serious illness and live as best they can and cope as best they can with their serious illness, whatever stage it's at," Kerr said. "They may need palliative care at one point in time and then improve and not need it, and then they may need it again later."

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