State-by-State Access to Hospital Palliative Care

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Palliative care addresses the whole-person needs of people living with serious illness.

- Specialized care for people w/ serious illness
  - Relief of symptoms, stress – and communication
  - Delivered by an interdisciplinary team
  - Continuous, coordinated, care
  - Improves care quality
- Based on need, not prognosis
- Accompanies life-prolonging and curative treatments
- Goal: Improved quality of life for patient and family
Palliative care improves quality and lowers cost.

Numerous studies\textsuperscript{1-8} have found that palliative care:

- Reduces symptoms and pain
- Improves quality of life
- Reduces unnecessary emergency department visits, hospitalizations, and time spent in the intensive care unit
- Overall cost savings
2019 State-by-State Report Card

• To determine the prevalence of hospital palliative care
• To identify changes in prevalence and state performance over time
• To identify policy progress and gaps, and provide recommendations for policy change
Data Sources

• American Hospital Association Annual Survey Database™
• National Palliative Care Registry™
• Additional validation of hospital palliative care through CAPC databases, state palliative care directories, CAPC faculty, and web searches
Inclusions

• Hospitals with 50 or more beds
• Hospital types: nonfederal, general medical and surgical, children’s general medical and surgical, cancer, children’s cancer, heart, and obstetrics and gynecology hospitals
• Within the fifty states and the District of Columbia
• Responded to the AHA annual survey or the National Palliative Care Registry™
Limitations

• Prevalence only

• No data on quality, access, penetration, populations served (see National Palliative Care Registry, registry.capc.org, How We Work)

• No data on community settings (see mapping.capc.org and getpalliativecare.org)
Report Card Methods

States were assigned a grade based on the **prevalence** of hospitals (50+ beds) with palliative care

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>A</td>
<td>80% or more</td>
</tr>
<tr>
<td>B</td>
<td>60-79%</td>
</tr>
<tr>
<td>C</td>
<td>40-59%</td>
</tr>
<tr>
<td>D</td>
<td>20-39%</td>
</tr>
<tr>
<td>F</td>
<td>Less than 20%</td>
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</tbody>
</table>

Grades do not reflect quality, reach, staffing, size, or timeliness of palliative care programs nor do they include community palliative care or patient eligibility.
As of 2019, 72% of hospitals (50+ beds) report a palliative care team.
Disparities Remain

Access to hospital palliative care depends on geography and hospital characteristics.
Where you live matters.
The number of A states has increased from 3 in 2008 to 21 in 2019.

Three-quarters of states now have a grade of A or B.
Northeast has the best access to hospital palliative care. South has the worst.
Within states, access is not uniform.
Top 10

1. New Hampshire (A) 100.0%
1. Rhode Island (A) 100.0% [tie]
1. Vermont (A) 100.0% [tie]
1. Delaware (A) 100.0% [tie]
5. Connecticut (A) 95.8%
6. Maryland (A) 95.0%
7. Utah (A) 92.9%
8. Wisconsin (A) 92.7%
9. New Jersey (A) 91.8%
10. Massachusetts (A) 90.7%

Bottom 10

42. Kansas (C) 56.7%
43. West Virginia (C) 56.5%
44. Texas (C) 52.2%
45. Alaska (C) 42.9%
46. Arkansas (C) 41.2%
47. Alabama (D) 39.3%
48. New Mexico (D) 38.5%
49. Oklahoma (D) 37.5%
49. Wyoming (D) 37.5% [tie]
51. Mississippi (D) 33.3%

Rankings include the District of Columbia
## Hospital Characteristics as Predictors

<table>
<thead>
<tr>
<th>More likely to offer palliative care</th>
<th>Less likely to offer palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>94% of big hospitals (300+ beds)</td>
<td>62% of smaller hospitals (50-299 beds)</td>
</tr>
<tr>
<td>82% of non-profit hospitals</td>
<td>35% of for-profit hospitals</td>
</tr>
<tr>
<td>86% of children’s hospitals</td>
<td>60% of public hospitals</td>
</tr>
<tr>
<td>91% of Catholic church-operated hospitals</td>
<td>40% of sole community provider hospitals</td>
</tr>
<tr>
<td>98% of AAMC teaching hospitals</td>
<td>17% of rural hospitals</td>
</tr>
</tbody>
</table>
Factors other than state location may help explain the difference in grades.

For example...
Ownership

Top State: New Hampshire
100% are non-profit

Bottom State: Mississippi
Less than half are non-profit

Non-profit 100%

Non-profit 41%
Public 36%
For-profit 23%
Geography

Top State: New Hampshire
No rural hospitals

Bottom State: Mississippi
15% of hospitals are rural
Federal Activity

• The CHRONIC Act/Bipartisan Budget Act of 2018 enabled flexibility to offer supplemental benefits to sub-sets of Medicare Advantage enrollees, including people with serious illness.

• CMS/CMMI are launching the Primary Cares First Seriously Ill Population Option alternative payment model for community palliative care services.

• The Comprehensive Care Caucus, launched in the Senate by Sen. Rosen, Barrasso, Fischer, and Baldwin, to improve workforce, coordinated care, and caregiver support.
State Activity

- Palliative care requirements or standards incorporated into hospital, nursing facility, or home health regulations in 9 states

- MD CME required in 12 states on palliative care, pain and symptom management

- Many states reimburse palliative care services through Medicaid CPT codes; 2 explicitly support home-based palliative care

- Palliative Care Advisory Councils (or similar bodies) established in 28 states charged with increasing awareness of palliative care
## Important Gaps

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Workforce</td>
<td>Shortage of specialist palliative care clinicians</td>
</tr>
<tr>
<td>Payment</td>
<td>Inadequate FFS reimbursement for high-value yet time-intensive palliative care services</td>
</tr>
<tr>
<td>Quality</td>
<td>Lack of appropriate quality measures</td>
</tr>
<tr>
<td>Clinician Skills</td>
<td>No incentives for all clinicians to be trained in communication, pain/symptom management</td>
</tr>
<tr>
<td>Public Awareness</td>
<td>Lack of knowledge about palliative care and its benefits</td>
</tr>
<tr>
<td>Research</td>
<td>Insufficient NIH funding to create evidence base</td>
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</tbody>
</table>
The 2019 Report Card includes policy priority actions for multiple actors.
Federal Opportunities to Improve Access

Embed palliative care into existing programs

- e.g., Provider Training in Palliative Care Act; waive patient co-pays for palliative care (S. 1921)

New resources for workforce and research

- e.g., Palliative Care and Hospice Education and Training Act (S. 2080/H.R. 647)

Promote implementation of palliative care laws

- e.g., Advancing Care for Exceptional Kids Act (Public Law No: 116-16)
State Opportunities to Improve Access

Separate licensure for home palliative care

- E.g., California passed SB 294, clarifying that licensed hospices can provide non-hospice palliative care services

New resources to support workforce development

- E.g., Loan Assistance and Forgiveness Programs modeled on programs in other fields such as primary care or dentistry

Incorporate palliative care standards into existing regulations

- E.g., Maryland requires that hospitals with 50+ beds establish a hospital-wide palliative care program that meet certain criteria
Coming Soon: Palliative in Practice Blog

Take Action: Tips for Leveraging the 2019 State-by-State Report Card

Practical tips for understanding palliative care in your state, supporting policy changes, and influencing local leaders and funders

Available later in October 2019 at capc.org/blog/
To access the 2019 State-by-State Report Card and all findings, visit:

reportcard.capc.org
References

The Center to Advance Palliative Care

NATIONAL SEMINAR

NOVEMBER 14-16, 2019
Atlanta Marriott Marquis

Pre-Conference Workshops:
Boot Camp and Payment Accelerator

WEDNESDAY, NOVEMBER 13