

# Colorado Cancer Coalition Priorities: 2016-2018

## Option 9 of 10: Survivorship & End of Life Care: Palliative Care & End of Life Services

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Goal 10: Expanded availability of and access to palliative and end-of-life care services.

Objective 10.1: Increase palliative care and end of life services.

### → Strategies

- Assess number, type and credentials of current palliative and end-of-life care providers, particularly in rural and frontier counties.
- Partner with institutes of higher education and health care workforce development organizations, especially in rural areas, to prepare and recruit palliative and end-of-life care providers.
- Implement telehealth/tele-palliative care to increase access to palliative care services for rural and frontier counties.
- Assess reimbursement barriers and implement a plan to improve reimbursement and access to services.
- Educate the public and medical community regarding the differences between palliative, hospice and end-of-life care.
- Develop provider messaging on how to explain the relative benefits and risks of continued treatment vs. end-of-life care to terminally ill patients and their families, working with organizations like the Center for Improving Value in Health Care (CIVHC) or the Hospice and Palliative Care Association of the Rockies.
- Support research on the benefits of palliative care during chronic illness in addition to end-of-life stages.

### → Measures

	Data Source	Baseline	2020 Target
Hospitals providing palliative care services	2013 CIVHC Survey	26% <sup>##</sup>	80%
Hospices providing palliative care services at any stage of illness	2013 CIVHC Survey	36 <sup>#</sup>	50%
Rural/Frontier counties with hospital or hospice-based palliative care services	2013 CIVHC Survey	5	10
State grade on palliative care (among hospitals >50 beds)	2011 Center to Advocate Palliative Care	B	A

<sup>#</sup>Denominator of 99 hospitals. <sup>##</sup>Denominator of 53 hospice providers.

### → What we know about the problem

- Lack of understanding re: Palliative Care - quality of living, Hospice Care and End of Life Care - no further curative treatment - dying with dignity.
- Lack of knowledge re: use of multiple advance directive forms within one hospital.
- Lack of inpatient palliative care in rural communities, and a traveling nurse could come to your home.

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## → Why should CCC members prioritize this area of work?

Prioritization factors	Considerations	Notes
Likelihood of Population Impact	Targeting one hospital system at a time would impact hundreds and/or thousands, and the benefits are ongoing (not a one time event and done).	
Evidence of Feasibility	Evidence confirms palliative and hospice care allows people to die with dignity, and helps family process through their grief.	
Established Need	Less than one quarter of hospitals provide palliative care.	
Measurability	Easy to measure if palliative care, advance directives, no one dies alone, etc. are in place or not.	
Collective Impact	Once one hospital is integrated, their success can be replicated within their system, i.e., <i>SCL Health</i> or <i>Centura</i> , etc.	
Identified Gaps	Within St. Mary's we formed a Palliative Care Committee and realized there were four advance directives documents in use.	
Opportunities for Leveraging partnerships	Because of the wide net cast by the CCC, it's very realistic to work with one hospital and take what we learn to the next hospital system to minimize the effort and maximize the benefits to patients.	
Political/ community support	There is no one who benefits from restricting palliative or hospice care.	

**Would you or your organization commit to helping with this priority?**