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SILVER CHAIN GROUP SUBMISSION ON THE CONSULTATION PAPER ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2016-17

PROPOSED FUNDING MODEL TO PROMOTE REFORM OF PALLIATIVE CARE SERVICE MODELS

1 OVERVIEW

All Australians should be able to expect to die with dignity and have as much control as possible over the circumstances of their death. This includes being with the people they wish to be present and, whenever possible, being in the place of their choice[1]. Australian research consistently shows that between 60 and 70 per cent of Australians would prefer to die at home. However, in Australia, only approximately 14 per cent of people die at home, with the majority (54 per cent) dying in hospitals, or in residential care (32 per cent)[2]. The costs associated with dying in residential aged care facilities (RACFs) and hospitals total approximately $5 billion per year. As the number of Australians dying each year doubles over the next 25 years, these costs will become unsustainable in the longer term[2].

Being able to die at home, where consistent with the person's wishes, is considered to be the "gold standard" of community palliative care[2] and is the core objective of Silver Chain Group's Hospice Care Service (HCS). In Western Australia (WA) Silver Chain has provided community based palliative care services that include 24/7 palliative care support for patients and their families in their home since 1983. In 2014, approximately 2,000 Silver Chain clients receiving HCS died, with 65.9 percent dying at home[3]. Of these approximately 2,000 clients, 865 clients had a recorded choice of place of death as being home with 81.2 per cent supported by HCS to achieve that choice.

Silver Chain Group's HCS provides three specific service offerings:

1 Metropolitan Community Palliative Care Service: In home specialist palliative care to clients with 24 hour nursing and medical care available in the home.

2 Palliative Nurse Consultancy Service: A palliative nurse consultancy service to public/private hospitals and residential facilities where client care is managed by a registered nurse 24 hours each day. The service provides advice, assessment, procedures, staff education and telephone follow-up to meet the care needs of a specific client.

3 Palliative Rural Telephone Advisory Service: Specialist advice and knowledge provided over the phone 24/7 to rural service providers regarding managing the palliative care needs of a specified client.

The Silver Chain Group model differs from community palliative care models offered by other organisations in a number of ways, including its delivery across a whole metropolitan area, the engagement of General Practitioners to act as a link between community and primary care, the 24/7 nature of the service and the availability of personal care, home support and respite services.

[1] National Aged Care Alliance [NACA]. (2012). *Aged care reform series – Palliative care*. Retrieved from http://www.naca.asn.au/Age_Well/Palliative%20care.pdf
[2] Duckett, S. and Swerissen, H. (2014). Dying well. Grattan Institute: Melbourne, Victoria.
[3] Smith, J. (2015, January). Operational Research Series: Client choice of place of death. Perth, Australia: Silver Chain Group.

2 BACKGROUND

Ageing of the population combined with rising proportion of deaths from cancer (due to declining vascular deaths) are resulting in significant growth in demand for services by palliative care patients. A large number of hospital admissions and emergency department attendances in the last 90 days of life can be avoided if community based palliative care services are provided.

A palliative care approach supports person and family choice about the place of care, place of living and place of death. Overwhelmingly, people prefer to have some or all of their care in their home, and most have a preference to die at home, not in a hospital. Despite this, most Australians will die in a hospital where they are often cared for in non-palliative care beds, where staff may lack the specialised skills to care for a dying patient and support their family[4].

For success, a community based palliative care service needs to invest in engagement with the clinicians, patients and families as well as providing a high standard of care ranging from personal care to higher level clinical and psychosocial services and pain relief. Efficient and effective community palliative care provides broad-reaching multidisciplinary care to a defined population in collaboration with existing clinical supports.

Current Activity Based Funding (ABF) models create a perverse incentive for many health services to continue with status quo rather than move to a more fundamental community based palliative care model of care. A comprehensive and well subscribed community based palliative care model will inevitably impact hospital rebates from Emergency Department (ED) presentations and inpatient episodes of care. This perverse incentive supports existing models of care in much of Australia which result in a large number of palliative care patients dying in hospital despite the vast majority of patients and their families having a preference for their death to be at home.

There are several approaches that could be taken to funding a community centred palliative care service. Refinement of any methodology proposed in this paper will be necessary. Identification of the benefits of each methodology will require access to the national data sets**,** however Silver Chain has the skills and expertise necessary to undertake such analyses, with an internal research department consisting of experienced and nationally recognised academic researchers.

3 CHARACTERISTICS OF COMMUNITY CENTRED PALLIATIVE CARE SERVICE

To be effective, a community centred palliative care service must provide timely access to clinical and non-clinical services to patients and their families.

- Clinical services, including 24/7 access to in-home specialist nursing and where required, medical advice from General Practitioners (GPs) and specialists.
- Psychosocial support from social worker, councillors and/ or pastoral care.
- Non-clinical support, include support for activities of daily living.
- Education and patient/ family/ clinician engagement.

If a service provider is unable to offer this, then patients will turn to EDs and hospitals for this support.

[4] Duckett, S. and Swerissen, H. (2014). Dying well. Grattan Institute: Melbourne, Victoria.

To be cost effective, these services need to be implemented at scale for a defined population. This requires:

- A coordinated implementation program for transition from hospital-based to community-based palliative care support.
- Coordination between the different elements of care and a single point of contact for the patient and their family.
- A call centre with established protocols and trained staff
- A pool of skilled staff that can be rapidly deployed

To build at scale will require alignment of economic incentives to support structural change. As is evident in regions outside of WA, community palliative care is often piecemeal and incorporated with facility based services where the maintenance of the facility dominates the service model. This is both counter to patient preferences and economic sustainability of the public health system.

Palliative care patients access a large number of different services with different funding sources. These range from MBS, PBS, community nursing care through to utilisation of public hospital emergency and inpatient services. Silver Chain Group has demonstrated that comprehensive community-based palliative care delivered at scale reduces utilisation of admitted hospital and ED services. Typical costs saving over the last year of life for patients admitted to the service were $5,114 per patient in the period 2008-11. Given the high cost of providing hospital based services a funding approach that recognises the reduction in use of hospital services by these patients should be used to provide funding to the community centred palliative care service.

Diagram 1: Use of hospital services in the last 90 days of life – Oncology patients.

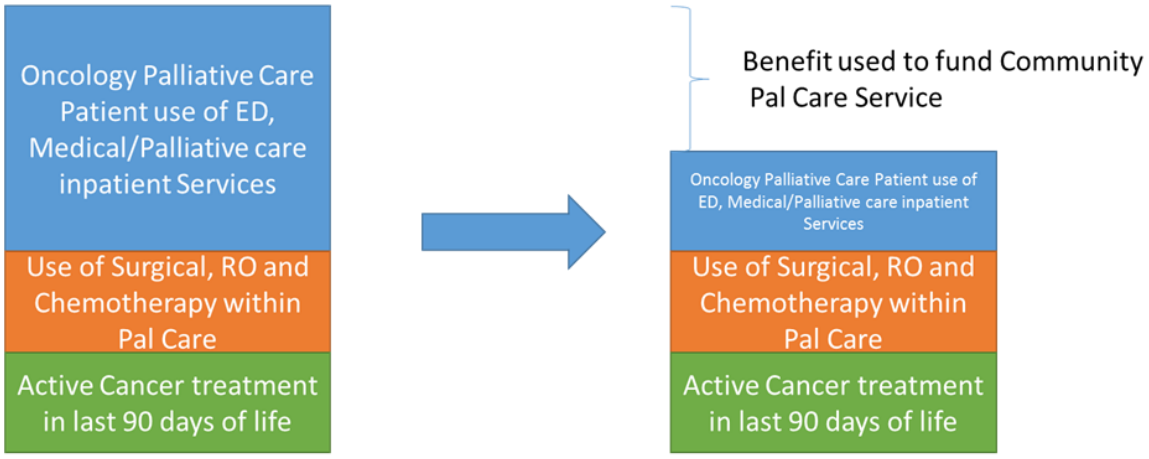

Diagram 1 illustrates a simple model of the use of hospital based services by oncology patients in the last 90 days of life. The implementation of the community based palliative care service will primarily reduce use of services for the many admissions that relate to providing supportive care. It is likely that the length of stay of patients when they transition from active treatment to palliative care will also be reduced due to improved access to services.

4 BUNDLED PAYMENTS FOR PALLIATIVE CARE

Bundled payments involves the various services and programs across multiple clinical settings for a patient may receive for the treatment of a specific medical condition being bundled into a single payment package. In theory, a bundled payment model ensures that both the payer and provider of healthcare share the financial risks, allows for greater flexibility in the timeframes for an episode and services covered, streamlines bureaucracy and reduces administrative overheads. Proponents suggest that the bundled payment model will lead to more judicious use of health services and improved care quality. However, there are a number of acknowledge challenges associated with the implementation of bundled payments, including[5]:

- Defining the bundles
- Defining the payment method and incentive structures
- Implementing quality measurement
- Defining accountability
- Engaging providers
- Care redesign

The above challenges were identified in a US context. In Australia, bundled payments face the added complexity of funding from multiple sources for a single patient, through Medicare, private health insurance and public hospital funding[6]

In the 2016-17 Consultation Paper, IHPA lists three examples of bundled pricing - uncomplicated maternity, stroke and joint replacement. These conditions are largely managed within an inpatient context, with a reasonably predicable care pathway, therefore avoiding many of the challenges outlined above. However, Silver Chain Group believes that a model palliative care delivered in a community setting can address the same challenges, with the addition of allowing for patient choice and improved patient outcomes, and therefore that there is a compelling argument to be made for IHPA to consider also creating a bundled episode of care payment for community-based palliative care.

For community-based palliative care to achieve the outcomes intended the funding must provide for the growth of, or establishment of, services that are robust with the necessary medical skills and expertise sitting in the community setting. This will require a fundamental shift from current structures. Defining the benefit based on a shift in practice within the targeted population of a geographic area avoids any cherry picking issues. It also creates the incentive for the provider of the community based palliative care services to engage all clinicians/ provider and a patient as it is the result achieved for the population that will determine if their program is being successful. The structure of episode bundle must be done in a way that changes in counting or classification methods cannot be manipulated and the true account of costs from a change in models of care are measured. Availability and quality of data as well as the potential to create perverse incentives need to be considered carefully when looking at the funding method.

[5] Hussey, P.S., Ridgely, M.S., & Rosenthal, M.B. (2011). The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems In Implementing New Payment Models. *Health Affairs*, 30 (11), p. 2116-2124.
[6] Health Policy Solutions (2011). *Literature Review: Efficiency, international best practice in ABF and future payment reform*. Retrieved from http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/future-payment-reform

It is suggested that IHPA considers undertaking a trial of bundled payments for palliative care within a defined patient group. For the best comparison based on national data, this defined patient group for a bundled palliative care trial should be oncology patients who have ceased curative treatment.

4.1 Trial of bundled payments for palliative care: Considerations

Defining the scope of the definition as services provided once curative treatment has ceased avoids any shifting of definitions as to what is palliative care. If this approach is used, a measure of hospital activity would include a number of patients that are in active (and expensive treatment) that is not the target of the community based palliative care program. Whilst there would be some patients that would commence receiving the community based palliative care prior to 90 days before death we would typically expect that the average length of stay would be around 90 days. (i.e. prognosis variation). The latter is probably only a small issue as it will just result in an underestimate of the benefits of the community based approach however likely addressed with volume (average length within Silver Chain Group's HCS is 81 days).

The issue of including high cost treatment (especially where some younger patients may receive very high cost care prior to death) is that a small number of these patients that are not the target of the community based palliative care program could if included in the inpatient care counted result in significant volatility in the funding indicator. An appropriate "outlier" policy might cover this adequately. Increased education of specialists and increased access to palliative care options may result in discussions with patients on their care moving to palliative care. This could result in some care that is currently classified as "acute care" in admitted patient data collections starting to be classified as "palliative care".

To promote health services focusing on shifting palliative care to community-based service a number of indicators could be published on a population basis:

	Outcome	**Outcome measure**
Patient outcome	Cared for and died at home	• % cared for and % who died at home vs. • % of deaths in hospital
Program outcome	Funding of care for patients who choose the program shifts to the community setting	• Rate of ED presentations • Rate of inpatient episodes • LOS inpatient episodes
System outcome	Reduction in cost of hospital services	• Cost of ED presentations • Cost of hospital services by palliative care oncology patients in last 90 days

6 NEXT STEPS

Silver Chain Group can assist IHPA to examine the available national data and how this demonstrates the differences in patient outcome and service cost where Silver Chain provides a comprehensive community-based palliative care service compared to other parts of Australia. The concepts in this paper and this analysis will help refine the measure that can be used to capture current costs in ABF terms that could be measured for reductions and those reductions recognised as providing an equivalent (or superior) service using a community based palliative care service model.