Clinical and satisfaction benefits of palliative care and hospice

- Control of symptoms: pain, fatigue, nausea, depression, anxiety, drowsiness, anorexia, dyspnea, insomnia, constipation
- Quality of life for patients and families
- Life expectancy
- Patient satisfaction with care
- Family satisfaction with care
- Family suffering

Utilization benefits of palliative care and hospice

- Acute care hospitalizations
- Emergency department visits
- Deaths in acute care facilities
- Aggressive care in final month of life
- Hospice utilization
- Hospice length of service
- Practice efficiency (oncology, primary care)

Better quality at lower cost ... so when are the quality and fiscal incentives aligned?

**Very strong incentive for all entities that benefit from lower health expenditures**
- Payers
- Global-budget integrated health systems: HMO-owned (e.g., Kaiser), Safety-net, Veterans Affairs
- Medical groups and health systems with full-risk contracts
- Accountable Care Organizations (Medicare Shared Savings Program ACOs and those sponsored by commercial plans)

**Strong incentive for hospital/health system-sponsored CBPC programs that target specific populations to reduce avoidable admissions**
- Programs targeting Medicare fee-for-service patients, where revenues could be impacted by provisions of the Affordable Care Act
  - To reduce exposure to CMS penalties for excessive readmissions among patients with heart failure, COPD, and pneumonia
  - To reduce avoidable utilization of acute care hospital services, for sites participating in the CMS Bundled Payment initiative
  - To reduce avoidable inpatient mortalities (30-day mortality measures added to CMS value-based purchasing program starting in FY2014)
- Programs for all patients with complex/serious illness (including cancer), to reduce non-beneficial utilization of acute care hospital services when:
  - Costs from such admissions typically exceed revenues (long or high-cost stays)

**Strong incentive to contract with or develop CBPC when utilization/operational measures may impact reputation or revenues**
- Cancer centers
  - To support accreditation and recognition (American College of Surgeons, US News and World Report)
  - To improve performance on NQF cancer care standards addressing over-utilization (ED visits and ICU stays in last 30-days of life, chemotherapy in last 14 days of life, hospice referral rates and length of hospice service)
- Patient-Centered Medical Homes, to improve adherence to standards addressing patient-centered care, comprehensive care, care coordination, and team-based care
- Hospitals and health systems, to improve performance on inpatient mortality and 30-day mortality measures

Developed by Kathleen Kerr & J. Brian Cassel, August 2013
With funding from the California HealthCare Foundation

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