Finding Common Ground: Quality and Fiscal Incentive Alignment for Community-Based Palliative Care

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 <u>lower health expenditures</u>

- 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 <u>target specific populations to reduce avoidable admissions</u>

- Programs targeting <u>Medicare fee-for-service patients</u>, 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 <u>all patients with complex/serious illness</u> (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 <u>utilization/operational measures</u> may impact reputation or revenues

- <u>Cancer centers</u>
  - 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)
- <u>Patient-Centered Medical Homes</u>, to improve adherence to standards addressing patient-centered care, comprehensive care, care coordination, and team-based care
- <u>Hospitals and health systems</u>, to improve performance on inpatient mortality and 30-day mortality measures

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