

# ADVANCING STANDARDS OF HIGH-QUALITY CARE FOR PATIENTS WITH SERIOUS ILLNESS IN AMERICA'S HOSPITALS



## A PROPOSAL TO CREATE A MEDICARE INCENTIVE PROGRAM FOR COMPREHENSIVE PALLIATIVE CARE SERVICES

### Summary

Patients with serious illness have inconsistent access to palliative care, which results in needless suffering, unnecessary spending, and excessive burden on caregivers. A new Medicare Palliative Care Incentive Program could promote access to palliative care services and adherence to national guidelines, thus improving patient experience and outcomes, as well as yielding significant benefits to participating hospitals.

### Background

At least 12 million adults and 400,000 children in the United States are living with a serious illness, including metastatic cancer, advanced dementia, heart failure, and frailty,<sup>i,ii</sup> and this number is expected to increase significantly over the next two decades.<sup>iii</sup> People living with a serious illness are the disproportionate users of our health care system: 911 calls, emergency department visits, hospitalizations, and skilled nursing facility admissions are commonplace. Yet despite high utilization and spending, this population often receives low-value, even distressing, service from our health care system.<sup>iv,v</sup> Consider the following:

- A recent survey of people living with serious illness<sup>vi</sup> found that 22% experienced hospital staff unresponsive to their needs and 23% received conflicting information from different health professionals.
- Symptoms are often un- or under-treated. For example, 64% of people with metastatic cancer report high levels of pain.<sup>vii</sup>
- Fewer than 50% of hospital patients with serious illness were ever asked what their personal preferences would be if a critical situation should arise.<sup>viii</sup>
- Serious illness takes an enormous toll on family caregivers. More than one in five cite adverse impacts on their own health<sup>ix</sup>, while formal studies conclude that caregivers face a 63% increased risk of mortality.<sup>x</sup>

It doesn't have to be this way. The evidence shows that reliable access to palliative care across America's health care system can ensure that our most complex patients receive high-quality, responsive care.

**Palliative care improves quality:** When hospital patients receive services from a specialty palliative care team, symptom burden is reduced and quality of life is improved by 66%, with improvements that can last for months.<sup>xi</sup>

**Palliative care reduces unnecessary spending:** On average, palliative care consultation is associated with reductions in direct hospital costs of more than \$3,000 per admission, and for the

sickest patients with four or more diagnoses, these cost savings are closer to \$4,800 per admission.<sup>xii</sup> Moreover, the provision of palliative care during a hospital stay reduces the rate of readmissions<sup>xiii</sup> and is expected to reduce post-acute spending through its role in avoiding potentially harmful procedures.

**People want palliative care:** A national poll<sup>xiv</sup> revealed broad nationwide support for palliative care services. Once informed about palliative care services, 74% responded that they would want this type of care for themselves or their families. A full 96% stated that palliative care should be available in every hospital.

While most Americans want palliative care available in their hospitals, significant gaps remain. Currently, the majority of hospitals with fifty or more beds do report having a palliative care team,<sup>xv</sup> but this availability is not evenly distributed. Access varies by state, by hospital tax status, hospital size, and other factors.

Even when specialty palliative care teams are available, adherence to standards for palliative care delivery also vary widely across the country. The [National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care, 4<sup>th</sup> edition](#), define the professionals that should be included in a specialty palliative care team – at least one physician, an advanced practice or other registered nurse, a social worker, and a chaplain. While the majority of hospitals do state that they provide palliative care services, more than 60% of these programs do not meet national quality guidelines<sup>xvi</sup>.

Considered all together: the size of the population with serious illness, the poor care now being delivered, the tremendous value that palliative care generates, and the wide disparity in palliative care availability and quality, creates an imperative to advance standards for palliative care in all US hospitals.

### **Proposal: A Medicare Palliative Care Incentive Program**

Given the established standards for hospitals the current demands placed on these vital institutions, it may not be feasible at present to add palliative care capabilities to Medicare conditions of participation or base accreditation requirements. Instead, a meaningful first step would be to **create a new Medicare incentive program** that financially rewards hospitals that meet standards for palliative care.

Therefore, we propose adding a Medicare value-based purchasing program for hospitals, akin to the current Hospital Readmission Reduction Program. A small withhold of Medicare revenue would fund the program, and hospitals would be able to earn a bonus payment by demonstrating palliative care access and quality through structural measures.

Unlike other Medicare value-based purchasing programs, performance under the palliative care program measures would be fully in the institution's control and not subject to variability driven by patient behavior or social determinants. Hospitals that perform well under this program would accrue benefits beyond the bonus payment, since evidence supports that their patients' experience

will improve and expenses per admission will decline. Moreover, by using structural measures, demonstration of performance would not impose undue burden on the facilities.

A similar program is now operating in the private sector. In 2015, Anthem introduced a palliative care measure for its network hospitals under its hospital quality incentive program,<sup>xvii</sup> and other private health plans are considering adopting similar approaches with their network hospitals. The Medicare incentive program would align both public and private payers. For reference, the Anthem measure details are attached.

The Medicare Palliative Care Incentive Program could operate as a demonstration for a period of time, and the Centers for Medicare and Medicaid Services could evaluate the impact on total Medicare expenditures. With widespread adoption of quality palliative care services across US hospitals, not only will patients be better served in our system, but we can expect a bending of the total cost curve.

---

<sup>i</sup> The Commonwealth Fund “High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?” August 2016

<sup>ii</sup> Field JF, Behrman RE. When children die: Improving palliative and end-of-life care for children and their families. Washington, DC: National Academies Press; 2003.

<sup>iii</sup> U.S. Department of Health and Human Services, Administration for Community Living (September 2014). “Administration on Aging (AoA) Projected Future Growth of Older Population.” Administration on Aging, Administration for Community Living, <https://www.acl.gov/aging-and-disability-in-america/data-and-research/projected-future-growth-older-population>

<sup>iv</sup> Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *Journal of the American Medical Association* 7 January 2004; 291(1):88-93.

<sup>v</sup> Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly* September 2011; 89(3):343-380.

<sup>vi</sup> Being Seriously Ill in America Today. The Commonwealth Fund, *The New York Times*, Harvard T.H. Chan School of Public Health. October 2018. <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/94/2018/10/CMWF-NYT-HSPH-Seriously-Ill-Poll-Report.pdf>.

<sup>vii</sup> Van den Beuken MHJ et al. Update on Prevalence of Pain in Patients With Cancer: Systematic Review and Meta-Analysis. *J Pain Symptom Manag* 22 April 2016; 51(6): 1070-1090.e9

<sup>viii</sup> Op cit Being Seriously Ill in America Today

<sup>ix</sup> AARP Public Policy Institute and National Alliance for Caregiving. Caregiving in the U.S. 2015 (2015)

<sup>x</sup> NIH Caregiver Health Effects Study 2008

<sup>xi</sup> Kavalieratos, D, J Corbelli, and D Zhang. “Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis.” *JAMA*, (2016): 316(20)

<sup>xii</sup> May P, Normand C, Cassel JB, et al. Economics of palliative care for hospitalized adults with serious illness: a meta-analysis. *JAMA Intern Med*. 2018 Jun 1;178(6):820–29. doi: 10.1001/jamainternmed.2018.0750.

<sup>xiii</sup> Adelson, K, J Paris, JR Horton, et al. “Standardized Criteria for Palliative Care Consultation on a Solid Tumor Oncology Service Reduces Downstream Health Care Use.” *J Oncol Pract*, (2017): 13(5)

<sup>xiv</sup> Public Opinion Strategies. “2011 Public opinion research on palliative care.” (April 2011).

<sup>xv</sup> *America’s Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation’s Hospitals*. Center to Advance Palliative Care and the National Palliative Care Research Center. September 2019

<sup>xvi</sup> Spetz, HA 2016

<sup>xvii</sup> Serious Illness Strategies. Center to Advance Palliative Care, August 2017

