



HEALTH DIMENSIONS GROUP

PALLIATIVE CARE AT THE INTERSECTION OF VALUE-BASED PAYMENT

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The increased importance of palliative care in a value-based environment and why acute and post-acute providers should care.

Familiar Term, Renewed Significance

Palliative care is not a newly introduced approach to care. The earliest record of the Latin word *palliate*, meaning to *conceal or alleviate symptoms without curing*, dates to the 14th century. Formally introduced in 1990 by the World Health Organization, palliative care is currently defined as an approach to care which improves quality of life for patients and their families facing advanced life-threatening illness through prevention, assessment, and treatment of pain and other physical, psychological, and spiritual problems.¹

The integration of palliative care is not only imperative in this expanding value-based care environment, but also essential for person-centered, compassionate care.

In 2011, the Joint Commission launched the Advanced Certification for Palliative Care program, which recognizes hospital inpatient programs demonstrating exceptional patient and family-centered care to optimize the quality of life for adult and pediatric patients with serious and advanced illness. By 2014, palliative care had grown to over 1,500 inpatient programs nationally.

Currently, more than 85 percent of hospitals with 300 or more beds have a palliative care program, 90 percent of teaching hospitals have palliative services, and 90 percent of National Cancer Institute (NCI) Designated Cancer Centers have palliative care, while 78 percent of non-NCI cancer centers have palliative care available.

While other support staff may be involved, palliative care uses a comprehensive and collaborative approach involving, at minimum, a team of four core disciplines comprising a physician or advanced practice provider, social worker, and chaplain, as designated by the Joint Commission.

Differentiating Palliative Care, Palliative Medicine, Hospice

It is important to distinguish palliative care from palliative medicine and hospice. *Palliative medicine* is specialized medical care for people with serious and advanced illness provided by a physician and advanced practice provider who specializes in this board-certified medical subspecialty. Palliative medicine becomes palliative care when a team practices and delivers the care, thereby bringing the interdisciplinary component versus the medical component alone.

Hospice is similar to palliative care in that they both use a team approach to medical care, pain management, and emotional and spiritual support which also caters to the needs of the patient's family members. Both palliative care and hospice cater to a patient population with advanced and life-threatening illness.

However, hospice focuses on care delivery at end of life, typically a patient's last six months or less, while palliative care is provided as appropriate and indicated throughout the disease trajectory of a patient. Another key distinguishing factor is that a patient receiving palliative care can pursue life-prolonging and curative treatments whereas a hospice patient must forgo any curative treatments.

From the payor perspective, hospice is a defined insurance benefit with clear payment streams, of which Medicare is the predominant payor. Payors for palliative care are much more varied and much less defined than hospice payors, presenting both challenges and opportunities for provider reimbursement. Because palliative care is commonly misunderstood by patients, families, and even practitioners, a more pragmatic definition of palliative care is "a medical specialty within a team plus supportive care" or simply "palliative medicine and supportive care."

Uniquely Positioned to Achieve the Triple Aim, the Palliative Care Value Proposition

The Triple Aim, developed by the Institute for Healthcare Improvement (IHI), provides an approach to optimizing health system performance which seeks to simultaneously: improve the patient experience of care, improve the health of populations, and reduce per capita health spending.ⁱⁱ Research indicates palliative care achieves all of these measures. Studies within the *Journal of Palliative Medicine* found that patients receiving palliative care experience improvements in symptom management and, specifically, significant reductions in anxiety, depression, fatigue, loss of appetite, and pain, as well as decreases in mortality and readmissions to the hospital.ⁱⁱⁱ

The 2010 landmark study published by the *New England Journal of Medicine* paved the way for a major shift in provider approach to palliative care, dispelling beliefs that palliative care should only be introduced during end-stage disease in patients.

The study found that introducing ambulatory palliative care early on for lung cancer patients, in conjunction with life-sustaining treatments, resulted in increased patient mood, quality of life, documentation of code status, as well as less aggressive end-of-life care, among other favorable outcomes. Most profound were the survival findings; the lung cancer patients receiving palliative care lived an average of 2.7 months longer than those receiving standard care.^{iv}

Palliative care has also been successful in its ability to reduce costs, with a recent study revealing a 40 percent decrease in health care costs (\$2,362 per day) when palliative care services are provided within the first 48 hours of a hospital admission.^v Thomas J. Smith, director of the Johns Hopkins Palliative Care Program, indicates annual patient savings of \$5,000 to \$7,000 when palliative care is incorporated into a patient's care program (2014). Palliative care holds the unique value proposition in its ability to address all dimensions of the Triple Aim.

Payment Reform Is Underway, Value Is at the Core

At the core of payment reform is provider ability to demonstrate value, expecting providers be increasingly at risk for the care, cost and outcomes of the patient populations they serve. Payment reform has presented providers with the ability to be rewarded financially for providing high-quality and cost-effective care, while imposing penalties on providers that do not meet performance thresholds.

Rapidly expanding value-based payment initiatives are motivating providers to better manage the care of the most medically complex patients across the entire care continuum. One of the key strategies providers are deploying to achieve the Triple Aim is integration of palliative care services. Palliative care offers an unparalleled solution by improving the patient experience, improving population health, and reducing spending.

Palliative Care as a Value-Based Payment Strategy

The promise of palliative care as a value-based payment strategy is a reality for many providers. Two approaches include:

- **Advocate Health's ACO**, in collaboration with BlueCross BlueShield of Illinois, focused efforts on strengthening and expanding palliative care medical leadership and education. Financial incentives are provided to primary care physicians to incorporate clinically appropriate use of palliative care, such as ensuring a patient's power of attorney for health care has been loaded into the electronic health record; education is provided to skilled nursing facility (SNF) partners; and a home care-to-hospice program was implemented. Based on these efforts, Advocate has reduced hospital readmissions, ventilator days, and SNF length of stay, while increasing hospice census and length of stay (2014).
- **Sharp HealthCare**, a large integrated health system based in San Diego, developed the Transitions Advanced Illness Management Program that uses a population-based approach with risk assessments and algorithms to identify people at the very beginning of an illness that would benefit from palliative services. Transitions program results have been exceptional, highlighted by a 94 percent reduction in emergency department visits. Because of the system's participation in innovative models of care and its strong managed care presence, Sharp's program does well in a risk-based environment including Medicare Advantage plans. Additionally, as an integrated system and owner of its continuum, Sharp realized a significant return on investment through the Transitions model.

Post-acute and senior care providers are particularly experienced in managing frail and medically complex patient populations and are uniquely positioned to integrate palliative care within post-acute care delivery. Under the Centers for Medicare and Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI) pilot, post-acute providers participating in Model 3 are financially at risk for specific diagnoses. A number of BPCI participants (SNFs and home health agencies) developed care pathways that integrate palliative care, including palliative care consults, as a means of quality improvement that enables these providers to more effectively manage readmissions, length of stay, and potentially avoidable costs and services.

House call programs (HCP) have also found tremendous value through integration with palliative care, and this growing strategy is evidenced by the palliative care HCPs offered by **Jewish Senior Life** and **Southern Ohio Medical Center**. **Northwell Health's** House Calls program (fka North Shore-LIJ House Calls), a participant in the CMS Independence at Home demonstration, approaches care in harmony with palliative care efforts, resulting in maximized quality of life with a reduction in costs. CMS recognized the HCP for its ability to care for the seriously ill with notable performance in cost-savings achievement and reductions in hospital readmissions.

Other providers that have implemented palliative care as a value-based care strategy include:

- **Aetna's Compassionate Care Program** offers value-based reimbursements (known as pay for performance or P4P) for enrolled members; outcomes include 81 percent and 86 percent decrease in acute days and ICU days respectively, increased customer satisfaction, and average cost savings of \$12,000 per member.
- **CareMore of WellPoint** offers extended covered benefits, including palliative care, for its Medicare population, which has resulted in continued increases in patient satisfaction and reductions in key acute care services.

- **Highmark** developed value-based contracts with hospitals and hospice agencies that support palliative care.
- **Excelsus BlueCross BlueShield of New York** provides enhanced payments to providers who have completed Medical Orders for Life-Sustaining Treatment (MOLST) training; payments are based on results related to the Excelsus Hospital Performance Incentive Program, and specific metrics are tied to provision of palliative care services.

In this era of value-based care with payment increasingly tied to outcomes, payors and providers will be continually challenged to deliver high-value care. The integration of palliative care is not only imperative in this expanding value-based care environment, but also essential for person-centered, compassionate care.

For more information on Health Dimensions Group, please visit www.healthdimensionsgroup.com.

i World Health Organization, 2004.

ii Institute for Healthcare Improvement, 2012.

iii Groh G, et al. J Palliat Med. 2013; Ornstein K et al. J Palliat Med. 2013; Bharadwaj, P, et al J Palliat Med 2016.

iv Temel JS et al. N Engl J Med 2010;363:733-742

v Bharadwaj, P, et al J Palliat Med 2016 Mar; 19(3):255-8. doi: 10.1089/jpm.2015.0234



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