

My year in Washington

or

Be at the Table or Be on the Menu!

or

**Palliative Care and Health Care Reform:
.....Connecting the Dots.....**

National Palliative Care Research Center

Kathleen Foley Retreat

Sundance, Utah

October 12, 2010

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Objectives

1. What's wrong with the U.S health care system?
2. How can it be fixed?
3. What are the relevant provisions of the Accountable Care Act of 2010 for palliative care and hospice?
4. Role of research, and researchers

Health care in the U.S. (aka the Wild West)

- What are the ends of medicine?
 - What should they be?
 - What are they in the U.S.?
- “To cure sometimes, relieve often, comfort always.”
- The problem: “The nature of our healthcare system- specifically *its reliance on unregulated fee-for-service and specialty care*- ...explains both increased spending and deterioration in survival.” Muenning PA, Glied SA. What changes in survival rates tell us about U.S. health care. Health Affairs 2010;11:1-9.

The Value Equation-1

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

Numerator problems

- 100,000 deaths/year from medical errors
- Millions harmed by overuse, underuse, and misuse
- Fragmentation
- EBM <50% of the time
- 50 million Americans (1/8th) without access
- U.S. ranks 40th in quality worldwide

The Value Equation- 2

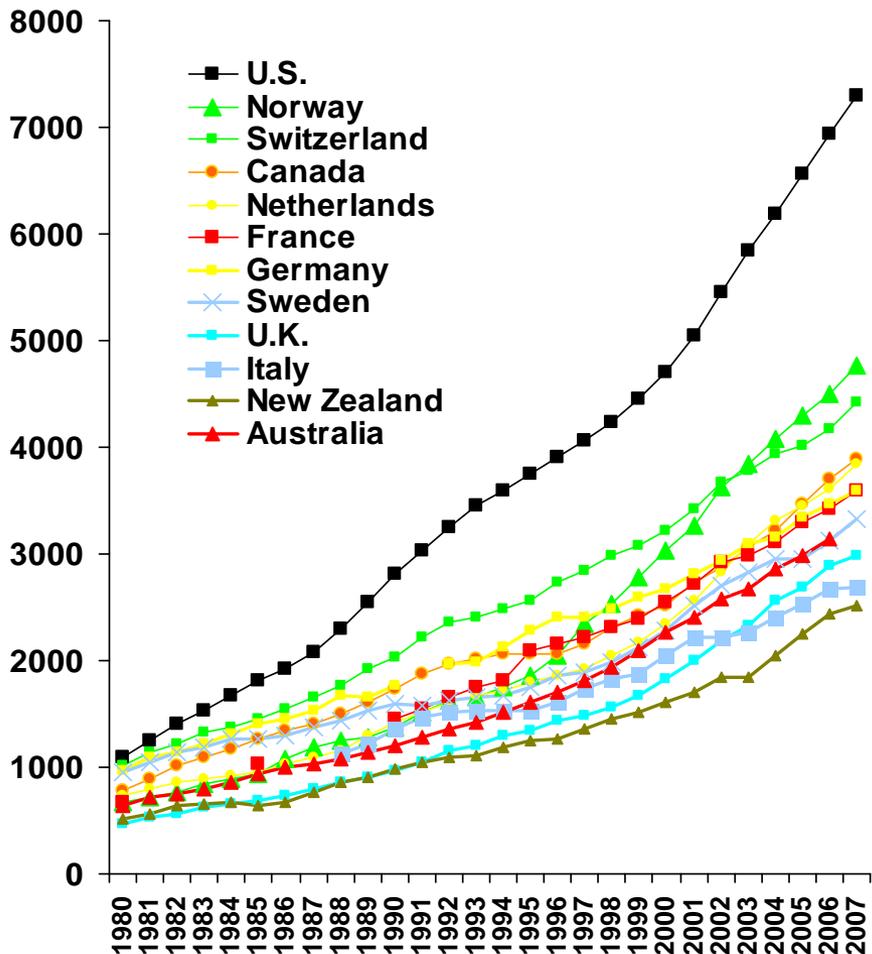
$$\text{Value} = \frac{\text{quality}}{\text{cost}}$$

Denominator problems

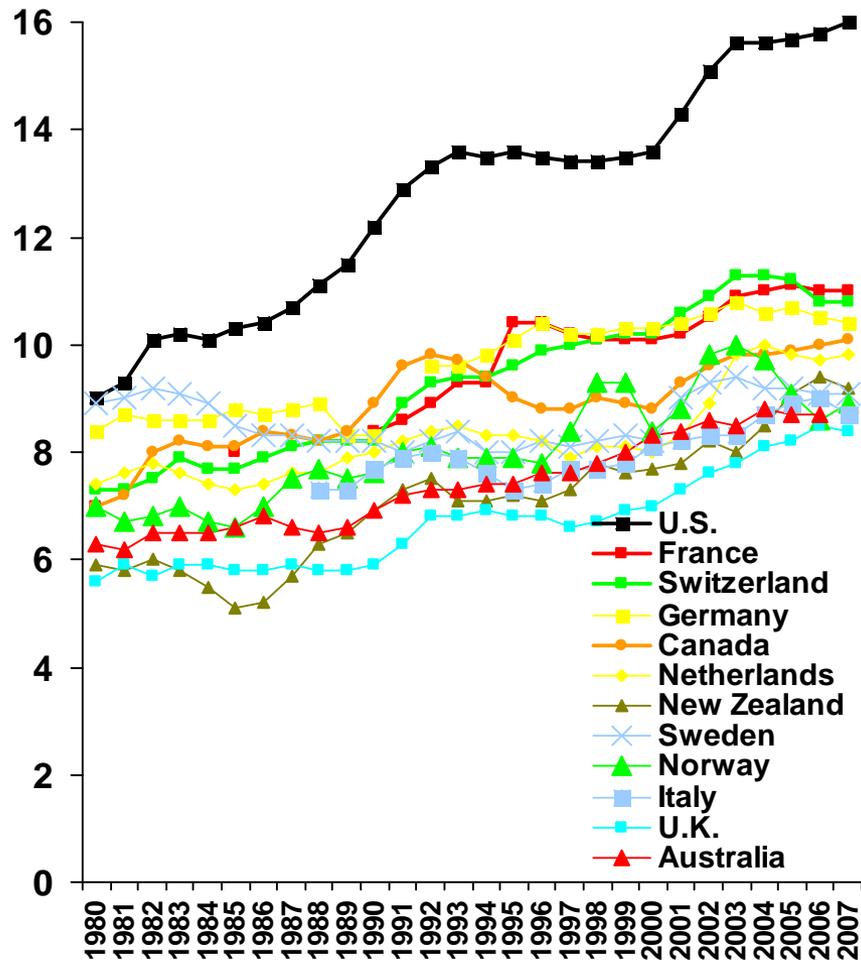
- Insurance premiums increased by 131% in the last 10 years.
- U.S. spending 18% GDP, >\$7,000 per capita/yr
- Nearing 50% of total State spending
- Despite high spending, 15% of our population has no insurance, and 50% are underinsured in any given year.
- Lack of health coverage contributes to at least 45,000 preventable deaths/year.
- Health care spending is the primary threat to the American economy and way of life.

Cost: International Spending on Health, 1980–2007

Average spending on health per capita (\$US PPP)



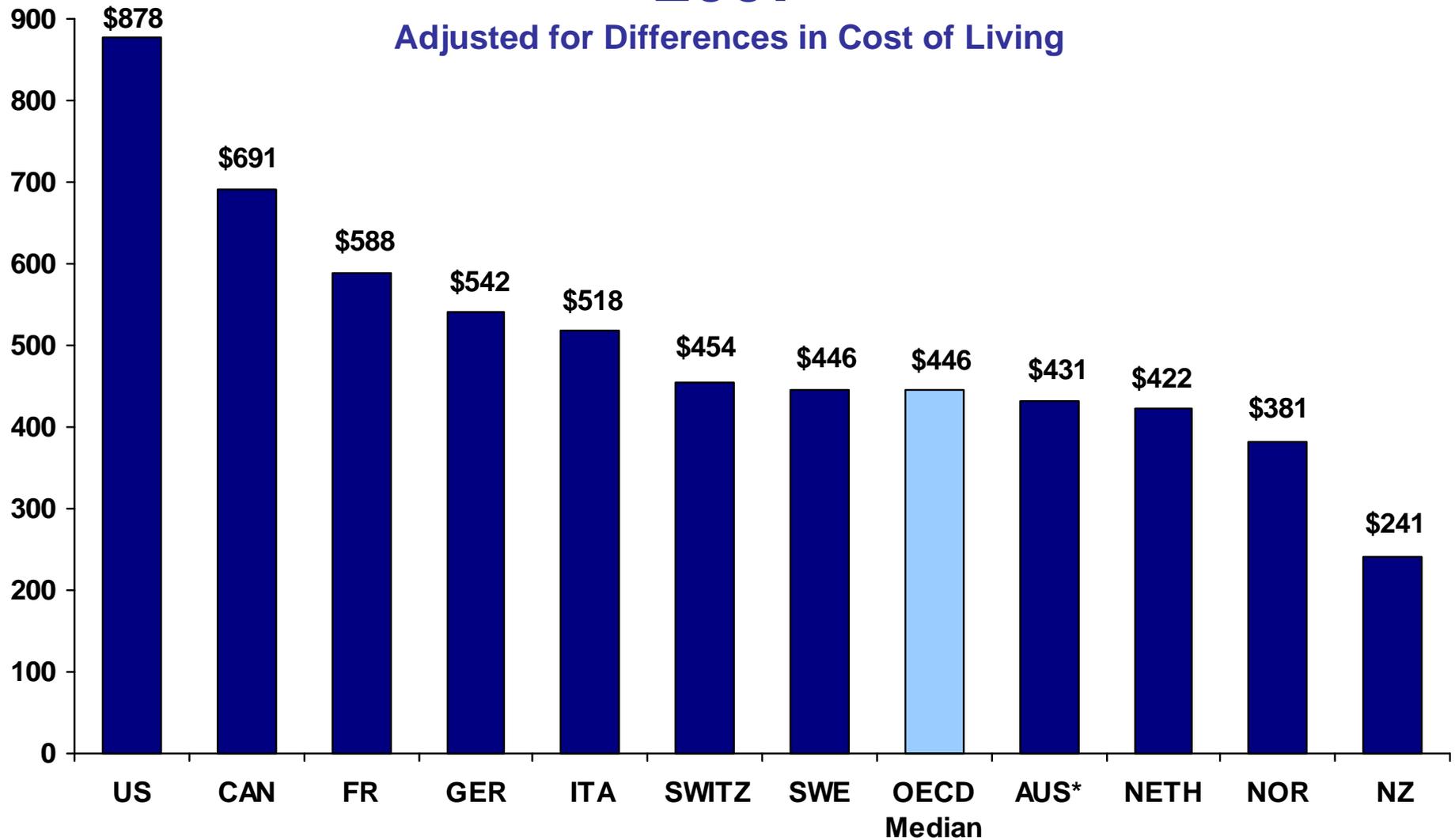
Total expenditures on health as percent of GDP



Cost: Pharmaceutical Spending per Capita, 2007

Dollars

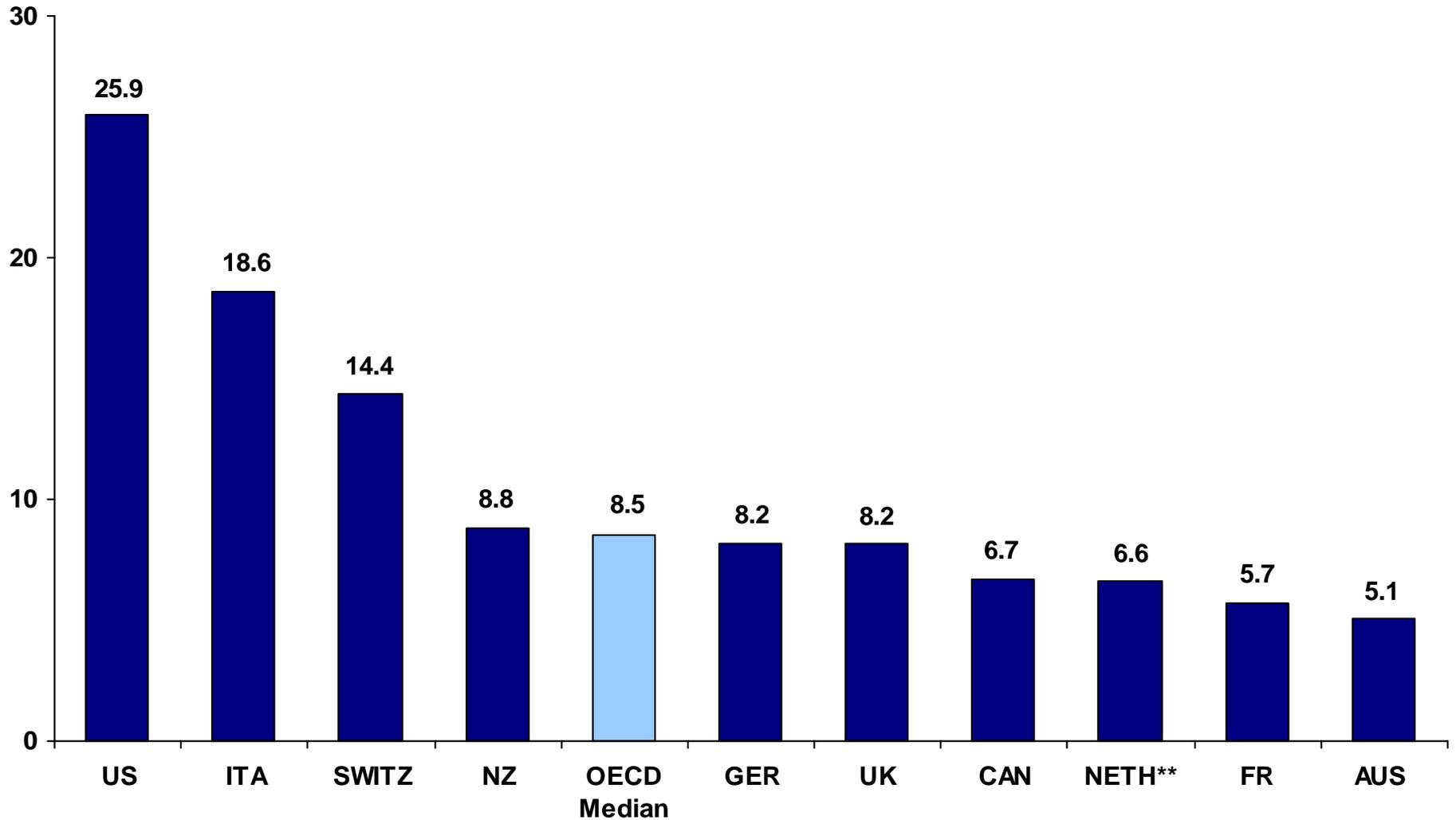
Adjusted for Differences in Cost of Living



* 2006

Source: OECD Health Data 2009 (June 2009).

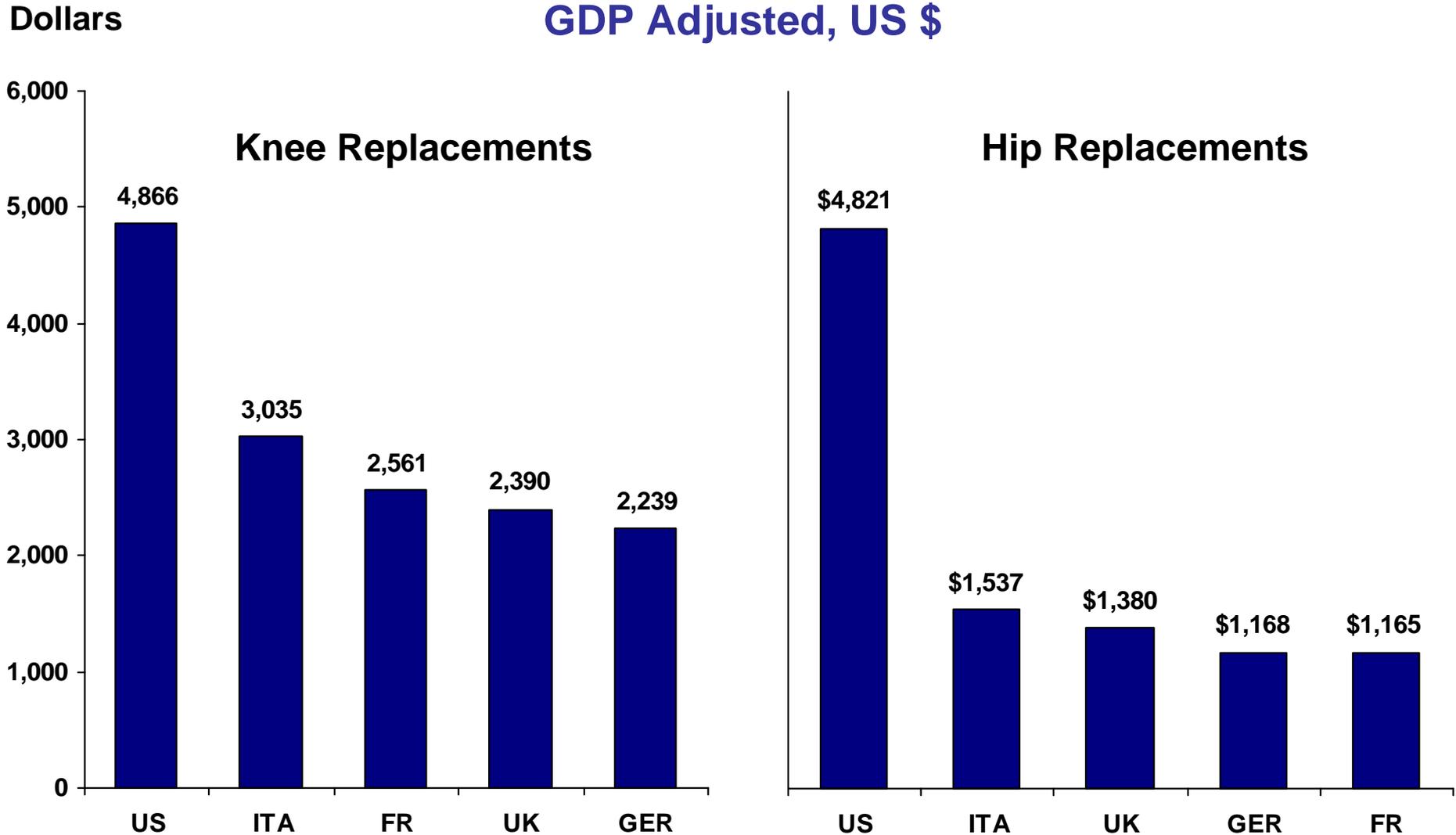
Cost and Capacity: MRI Machines per Million Population, 2007



** 2005

Source: OECD Health Data 2009 (June 2009).

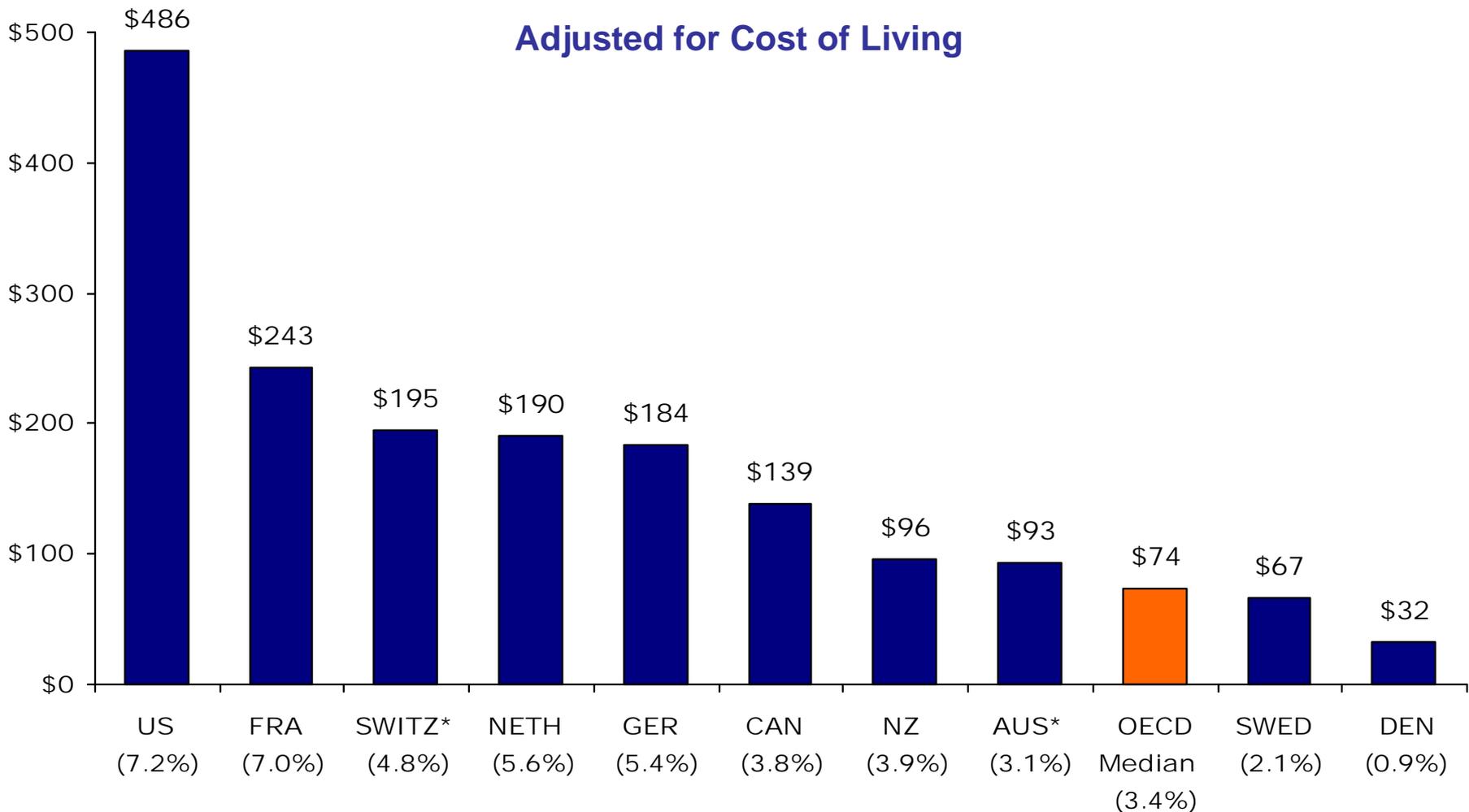
Cost: Knee and Hip Prostheses, 2004



Source: McKinsey & Company, Accounting for the Cost of Health Care in the United States, 2007.

Cost: Total Health Care Spending on Health Insurance and Administration per Capita, 2006

Adjusted for Cost of Living



(Percent of total health expenditure)
*2005

Note: Total health care spending on health insurance administration includes insurer costs only.
Data: Organization for Economic Cooperation + Development- Health Data 2008 (June 2008).

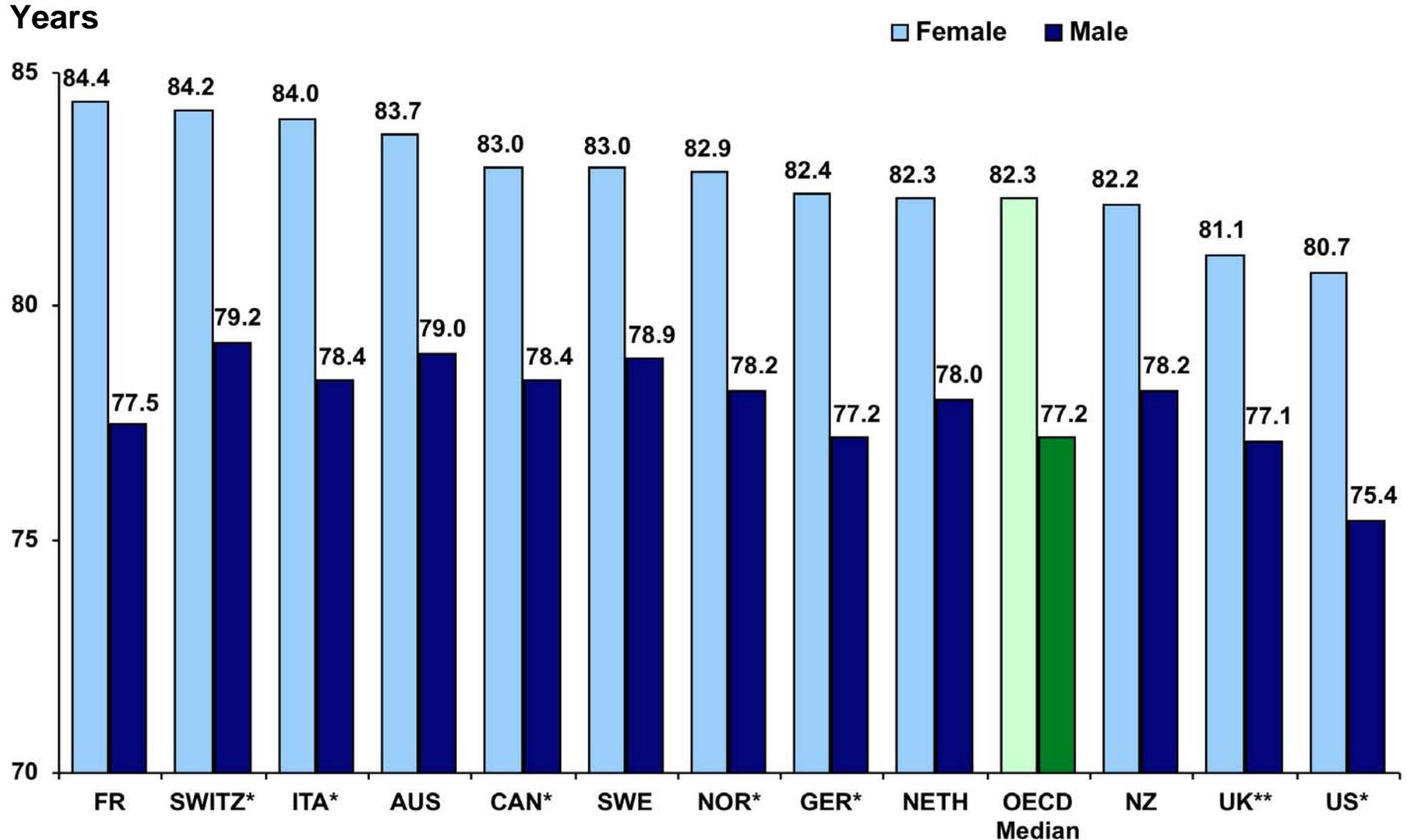
What is this money buying us?

Organization for Economic Development and Cooperation

Among OECD member nations, the United States has the:

- Lowest life expectancy at birth.
- Highest mortality amenable to health care.

Life Expectancy at Birth, 2007



* 2006

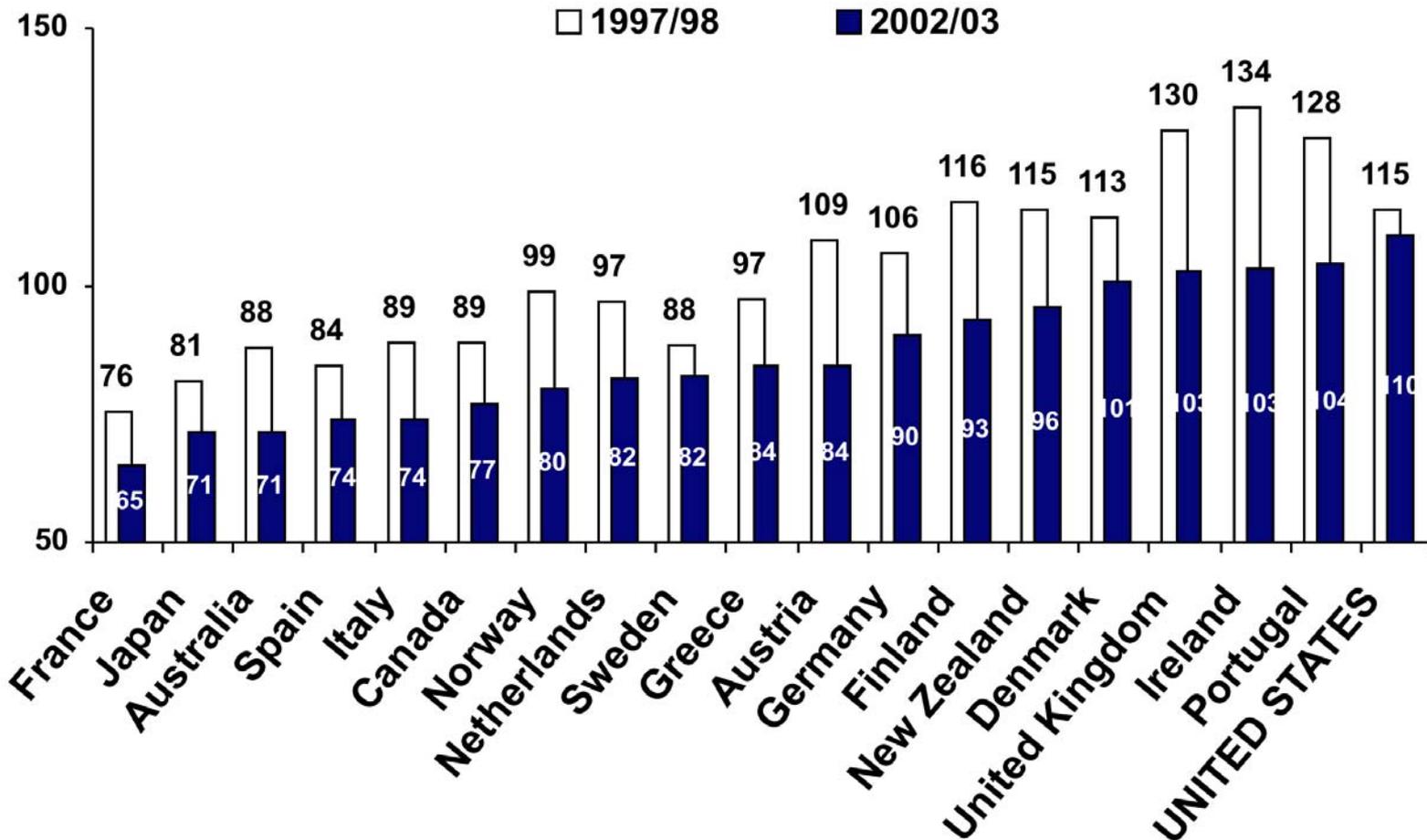
** 2005

Source: OECD Health Data 2009 (June 2009).

High Spending: Poor Outcomes

Preventable Mortality

Deaths per 100,000 population*



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C.M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs* Jan.-Feb. 2008, 27(1):58-71 analysis of World Health Organization mortality files.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

U.S. Health Care Policy's “Original Sin”

*“Providers and patients still largely determine what care is needed without a **budgetary framework to consider both benefit and costs**. This is the original sin of health policy and no reform can be adequate without addressing it.”* Steurle and Bovbjerg Health Affairs 2008;27:633-44.

What can be done?

Two options to “bend the cost curve.”

1. **Stop paying** for things that add little or no quality– i.e. don’t help patients at all or enough
 - Determine best yield per dollar via Comparative Effectiveness Research
2. **Capitation** or versions thereof- i.e. set a limit on what we will spend.
 - Accountable care, bundled payments, medical homes

Option 1: Paying for Value via Comparative Effectiveness Research

- Requires scientific comparison and willingness to implement the findings
- Means someone loses money
- Political football, labelled “rationing” and “death panels.”
- Death panel caricatures have made this topic politically untouchable.
- *“American political discourse is not yet mature enough to support realistic discussion about difficult subjects.”*

Option 2: Setting Limits

Putting our health care system on a budget:

- HMOs in 1990's reduced spending
- Modern "integrated systems" such as VA, Kaiser, Geisinger, Mayo, Cleveland Clinics also get more quality per health care dollar
- Characteristics of success: large delivery system, advanced IT, strong primary care infrastructure, and tight integration between physicians and the organizations.



"Because of your age, I'm going to recommend doing nothing."

Vocabulary List

with thanks to Bob Wachter

- Value Based Purchasing (VBP), see also pay-for-performance (P4P)
- “Bending the cost curve”
- Comparative effectiveness research (CER), see also NICE (Nat’l Institute for Health and Clinical Excellence)
- Dartmouth Atlas, see also McAllen, Texas
- Death panels, see also rationing, socialism
- Bundled payments, see also capitation
- Medical homes, see also capitation
- Accountable care organizations, see also HMOs, capitation

ACA Experimentation and the Value Equation

Accountable Care Act tests expansion of new delivery and payment models. All aim to improve the value equation by setting limits on spending.

1. Patient Centered Medical Homes
(aka Health Homes, Advanced Primary Care)
2. Bundled payment for an episode of care
3. Accountable Care Organizations

ACA Experimentation and the Value Equation-2

The ACA also tries to improve the value equation by improving quality:

- By investing in comparative effectiveness research so we get the most out of a dollar spent;
- By markedly increasing attention to the assessment of, and reward for, quality of care via Value Based Purchasing/Pay for Performance

New Models

Relevance to Palliative Care and Hospice

Accountable Care Organizations: ACOs are groups of providers receiving set fees to deliver *coordinated quality* care to a select group of patients (not a demo). Sec. 3022 of the ACA (Medicare Shared Savings Program) allows providers organized as ACOs that voluntarily meet quality thresholds to *share in the cost savings* they achieve for the Medicare program.

To qualify as an ACO, organizations must agree to be **fully accountable for the overall care of their Medicare beneficiaries**, have adequate participation of primary care and specialist physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.

New Models: Relevance to Palliative Care and Hospice

Bundled Payments

Provisions for both Medicare and Medicaid beneficiaries establish pilots to develop and evaluate paying a **single bundled payment for all services** -acute inpatient hospital, physician, outpatient, and post-acute care- for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, a plan is to be developed for its expansion.

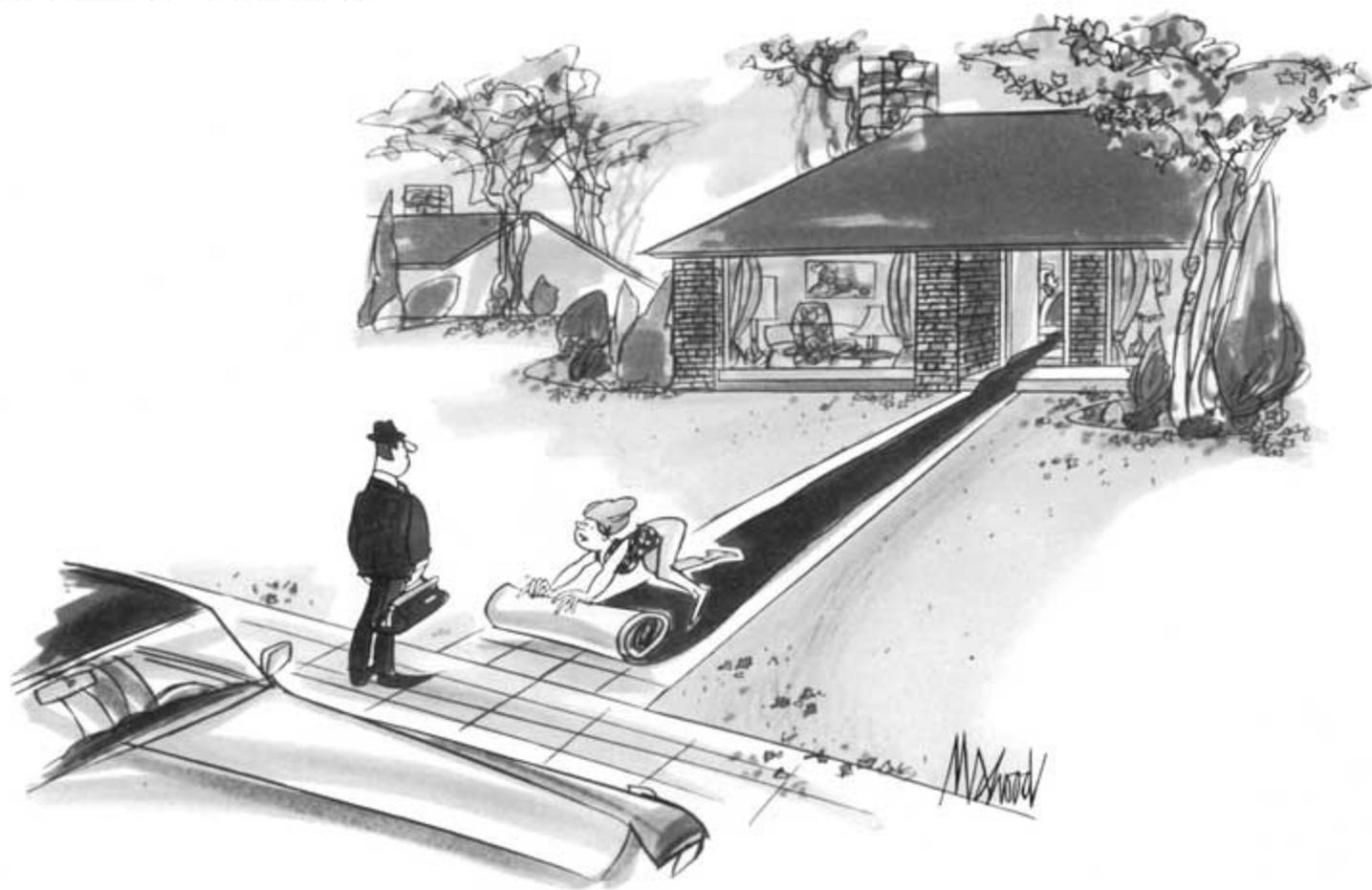
New Models:

Relevance to Palliative Care and Hospice

Medical Homes: defined as "an approach to providing comprehensive primary care that facilitates partnerships between individual patients and their personal providers and when appropriate, the patient's family."

The CMS Medicare demonstration provides a ***care management fee to physician practices serving "high need" patients***, who must use health assessment, integrated care plans, tracking of tests and providers, review of all medications, and tracking of referrals (Tier 1), and should develop an EHR, coordinate care across settings, and employ performance metrics and reporting (Tier 2).

Per member per month payment.



"It was good of you to come, Doctor."

New Models

Relevance to Palliative Care and Hospice

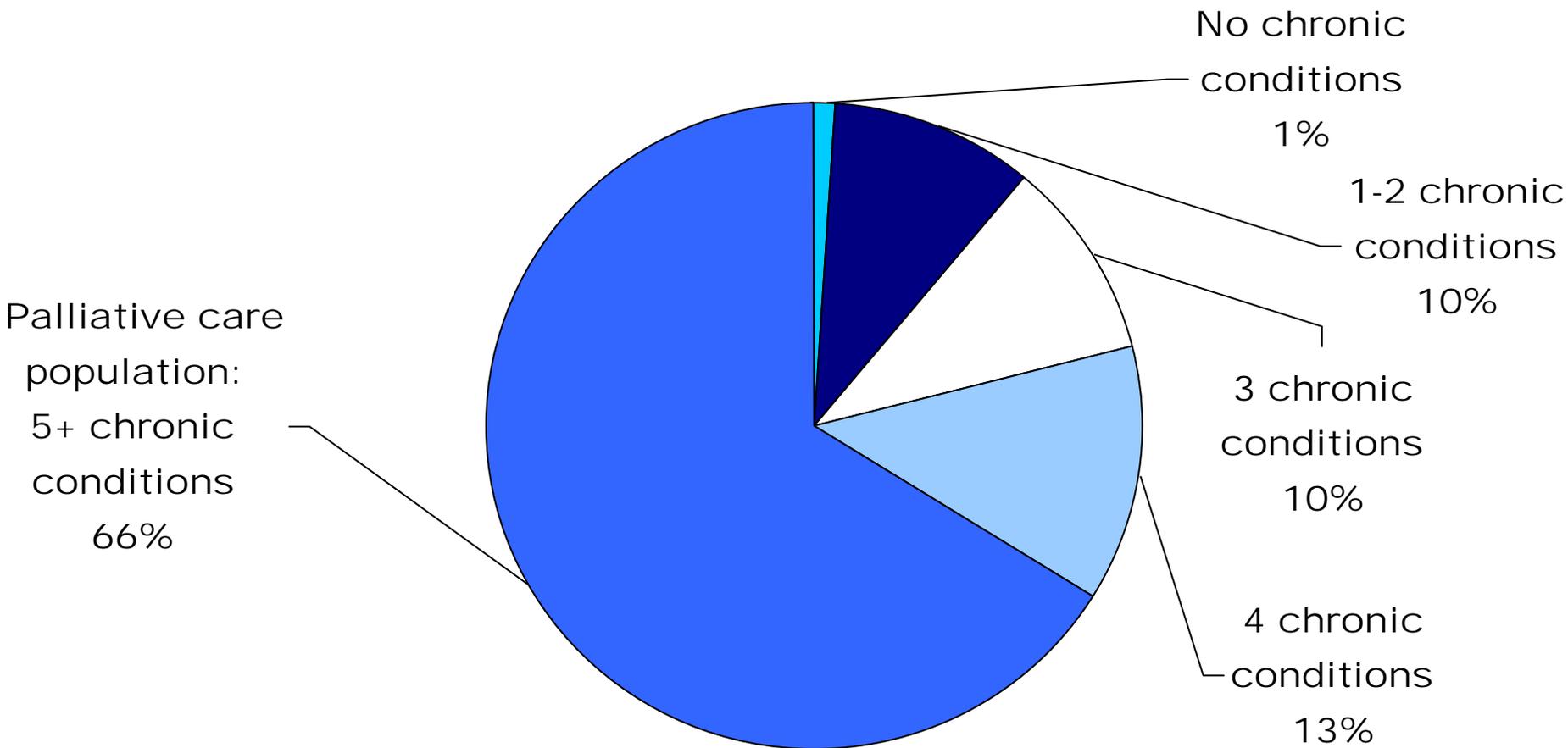
Independence at Home (Demo)

- Testing the provision of MD and NP-directed home-based primary care and care coordination across all treatment settings.
- Eligible beneficiaries: 2 or more chronic conditions, a nonelective hospital admission in last year, prior rehabilitation, and 2 or more functional dependencies.
- **Shared savings.**

Why is Palliative Care Important to Health Care Reform?

- >95% of all health care spending is for the chronically ill
- 64% of all Medicare spending goes to the 10% of beneficiaries with 5 or more chronic conditions
- Despite high spending, evidence of poor quality of care

The 10% of Medicare Beneficiaries Driving 2/3rds of Medicare Spending are Those with ≥ 5 Chronic Conditions



An Example: Grand Junction Colorado's Value Equation

Paying for Quality and Setting Limits

High quality, low cost care despite high-risk patient population.

Seven critical success factors:

1. Primary care docs in control
2. Pay for quality not quantity via shared savings
3. All-payer rate standardization
4. Regionalization of costly services
5. Limits on supply/capacity for costly services
6. Primary docs follow patients in hospital
- 7. Well integrated palliative care and hospice**

New Delivery and Payment Models Need Palliative Care

Delivery models targeted to the highest-cost, highest-risk populations-- those with multiple chronic conditions and functional impairment-- will be key to success at improving quality and reducing cost.

Who has the training and skills?

Who has demonstrated quality and cost impact for this population?

Policy Goal: Add palliative care and hospice to the eligibility/specifications/metrics for medical homes, accountable care organizations, and bundling strategies.

Why is Health Policy Important for Palliative Care?

Policy Change: Why Do We Need It?

Workforce

- No GME dollars for fellowship training
- No loan forgiveness for professionals training in the field
- No career development support for junior faculty in medical and other health professional schools
- No compensation for distinct effort/skill of palliative care practitioners

Evidence

- Inadequate NIH investment in the evidence base

Access

- No financial incentives for hospitals, nursing homes, providers to deliver palliative care
- No regulatory requirements for palliative care services
- Threats to Medicare Hospice Benefit

Policies to Improve Access

- 1. Financial incentives to doctors + nurses** to train in and provide palliative care
- 2. Financial incentives to hospitals/NHs** that provide palliative care (and penalties for those that don't)
- 3. Hospital/NH accreditation** requirements

Policies to Improve Quality

- 1. Standardization, metrics:** Palliative care programs meeting quality standards are a condition of accreditation/participation/payment.
- 2. Workforce is trained:** Faculty to teach workforce exist; loan forgiveness; CDAs; funding for palliative medicine/nursing fellowships.
- 3. Evidence exists:** NIH, AHRQ + VA fund research in palliative care.

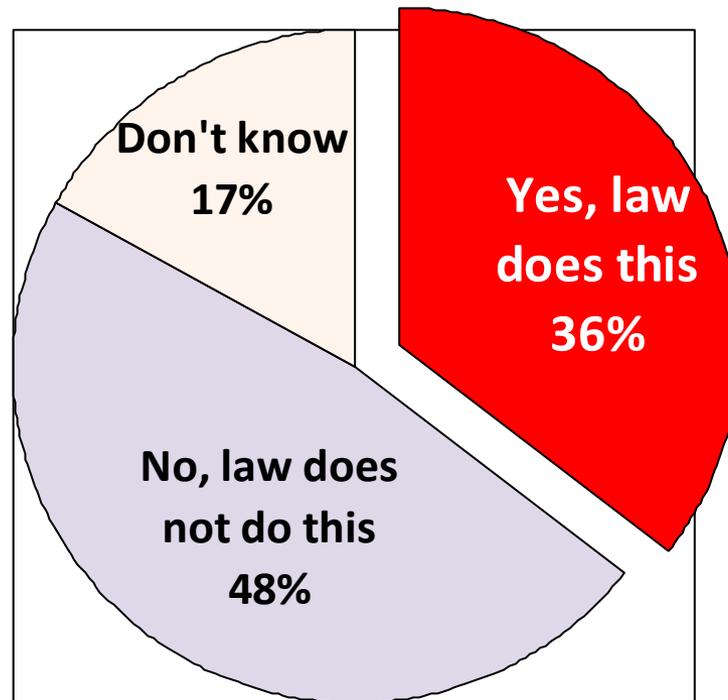
Palliative Care and Hospice Are in the Sweet Spot

- Improved quality
- Longer life
- Reduced costs
- So why aren't we on everybody's dance card?

Optics in Washington:

> 1/3 of all seniors say new health law includes a government panel to make end-of-life care decisions

To the best of your knowledge, would you say the new law does or does not allow a government panel to make decisions about end-of-life care for people on Medicare?



NOTE: Percentages do not sum to 100 percent due to rounding.
SOURCE: Kaiser Family Foundation *Health Tracking Polls*, July 2010.

Research to the Rescue! The Counter Message Palliative Care and Hospice can PROLONG Life

New England Journal of Medicine, August 18, 2010

419,193,994 impressions

**Helping cancer patients live better,
longer**

Cancer strategy: Easing the burden

Boston Globe (8/19/10)

NBC Nightly News (9/10/10)

Palliative care can help cancer patients live longer

USA Today (8/18/10)

Palliative Care Extends Life, Study Finds

The New York Times (8/18/10)

Study shows value of quality-of-life cancer care

The Washington Post (8/18/10)

New Studies in Palliative Care

National Public Radio, *The Diane Rehm Show (8/24/20)*

Study: Advanced Cancer Patients Receiving Early Palliative Care Lived Longer

The Wall Street Journal (8/18/10)

Clarity and Consistency of Language Needed

The message:

Palliative care and hospice are
about matching treatment to
patient goals.

Going to Scale

- Value Based Purchasing and Pay for Performance require standardization and quality reporting.
- Palliative care and hospice can be required elements of service delivery if their quality can be assessed.
- Therefore our integration into new delivery and payment models requires quality metrics.

Paying for Value

Assessing Quality in Hospice and Palliative Care

- CMS does not currently require quality reporting for hospice (unlike hospitals, NHs, CHHA, rehab providers) but it will be mandatory by 2014.
- Hospice-palliative care PEACE measures (N.C. QIO) in field testing (by iPRO, N.Y. QIO) for addition to CARE instrument now

<https://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage>

<http://www.cms.gov/QualityImprovementOrgs/>

- Joint Commission certificate program for hospital palliative care developed, not yet released
- NCQA considering development of palliative care program accreditation

Use Guidelines to Assure Quality and Standardization of Palliative Care

1. National Consensus Project for Quality Palliative Care – 2009 2nd edition
nationalconsensusproject.org
2. National Quality Forum *Framework and Preferred Practices for Hospice and Palliative Care* – 2007
3. CAPC program registry, CAPC metrics

Adherence will prepare you for the future release of-

- The Joint Commission *Palliative Care Certificate Program* or an NCQA equivalent
- And ultimately, for Value Based Purchasing, P4P, accreditation requirements, public reporting

Influencing Policy

“Democracy is the worst form of government except all those other forms that have been tried from time to time.”

Winston Churchill Nov. 11, 1947 in a speech to the House of Commons

Drivers of Policy Change

Effective lobbying by membership organizations + their members

Relationships with key Hill staff and members and (especially right now) HHS operating divisions

Unified Voice is crucial

- Hospice and Palliative Care Coalition
- AAHPM, CAPC, HPNA, NASW, NHPCO, NPCRC



"You can't spend your political life hiding behind being Canadian."

There is Hope!

Senate Report Language NIH

U.S. Senate's Labor-HHS Appropriations Committee called for a trans-Institute NIH strategy for increasing funding for palliative care research across disease types and patient populations.

“Palliative Care.-The Committee strongly urges the NIH to develop a trans-Institute strategy for increasing funded research in palliative care for persons living with chronic and advanced illness. Research is needed on: treatment of pain and common non-pain symptoms across all chronic disease categories, which should include cancer, heart, renal and liver failure, lung disease, Alzheimer's disease and related dementias; methods to improve communication about goals of care and treatment options between providers, patients, and caregivers; care models that maximize the likelihood that treatment delivered is consistent with patient wishes; and care models that improve coordination, transitions, caregiver support, and strengthen the likelihood of remaining at home.”

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<http://thomas.loc.gov/cgi-bin/bdquery/z?d111:S.3686:>

A skeptic, persuaded

- Write to NIH Director Dr. Francis Collins at nihinfo@od.nih.gov.
- Submit public comments when asked—they are taken extremely seriously in Washington.



crabford

What I did on my sabbatical, and why

Health and Aging Policy Fellowship

- Limitations of the academic model to do good, drive social change
- Limitations of private sector philanthropy in absence of public + policy commitment
- Recognition of my lack of knowledge about the policy world
- My goals:
 - Learn about the policy process
 - Nudge palliative care policy where possible

What I Did

- I met a lot of people
- January to June 2010: Senate HELP Committee
 - OAA
 - Rate setting
 - Pain management in NHs
- July to December 2010: Assistant Secretary for Planning and Evaluation- Disability Aging and Long Term Care Policy
 - Cross-HHS coordinating committee for the duals
 - Health Homes (Medicaid PCMH)
 - Policy options for palliative care and hospice in the NH
 - Multiple Chronic Conditions Strategic Framework
 - NHQR
 - NQF-NPP; NQF call for measures;
 - ...

What Else I Did (in Palliative Care)

Opportunities for Palliative Care and Hospice in the

ACA HR 3590

<http://thomas.loc.gov>

- Hospital Value Based Purchasing (3001)
- Hospital mortality reporting (MMA 501b)
http://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp
- Hospital readmission reporting (3025)
- National Health Care Workforce Council (5101-3)
- Medicare Hospice Concurrent Care Demonstration (3140)
- Concurrent Care for Children (2302)
- Center for Medicare and Medicaid Innovation (3021)
- Tests of new delivery and payment models, such as:
 - Accountable Care Organizations (3022)
 - Medical Homes, Health Homes, (2703)
 - Community health teams to support medical homes (3502)
 - Bundling (3023)
 - Care coordination for the dual eligibles (2601-2)
 - Independence at Home (3024)

Opportunities to Advance Palliative Care in ACA Implementation

1. Welcome to Medicare; Annual Wellness Visits should include regular review/update ACP/POLST
2. Meaningful Use, inclusion of meaningful, easy, timely availability of content of ACP/POLST;
3. New shared decision making program at AHRQ
4. Secretary's National Quality Strategy, out for public comment now
5. National Health Quality Report (AHRQ), inclusion of meaningful metrics;
6. PQRI physician quality reporting, need measures re timely referral palliative care and hospice, timely high quality ACP, POLST
7. Exchange Criteria, inclusion of hospice and palliative care as a COP;
8. NQF National Priorities Partnership, support efforts to include palliative care in the Secretary's National Quality Strategy;
9. NQF call for palliative care measures (November 2010), assure that appropriate measures are submitted, appropriate committee members nominated;
10. Quality reporting for hospice, mandatory as of 2014, measures being fielded now;
11. Workforce development, training for palliative care nursing/medicine;
12. CMS-ORDI and Hospice Concurrent Care and Transitional Care demos, assure design addresses continuum of palliative care;
13. Medicare National Coverage Determination process and Coverage with Evidence Development for ICDs, VADs, opportunity to refine informed consent/shared decision making options;
14. NBGH and palliative care as a condition of Preferred Provider Status;
15. ACO, PCMH, Health Home + bundling, explicit inclusion in specs and eligibility, inclusion of palliative care as a COP requires NQF endorsed measures prior to rulemaking;
16. US Preventive Services Task Force call for topics, ACP + PC as preventive measures
17. Legislative partners (Blumenauer, Levin, Baldwin, Wyden, Rockefeller) willing to press executive branch on behalf of palliative care
18. Essential Benefits (IOM Committee), inclusion of hospice and palliative care;