Assessing Progress in End-of-Life and Serious Illness Care

National Academy of Medicine
May 23, 2016

Policies & Payment Systems

NOTES—BREAKOUT SESSION 1

Barriers		
• **Lack of outcome data (patient/family experience is the outcome, family/proxy survey in population-wide way); denominator problem** • **HC system rewards interventions** • **Move from system focused on services to efficiency may burden caregivers** • **Culture in health care sees medical and social services as disconnected (Health plans often can't pay for social services)** • **Because many patients often receive many interventions before palliative care and hospice services, inability to show cost savings of these services** • **How to connect learning over past few decades, including of hospice development, with outpatient and community based care models and other care models** • **Number of board certified physicians (ratio of physicians to patients who need this type of care)**		
Solutions/Opportunities		
• **Data/information, patient/family experience is the outcome, family/proxy survey in population-wide way** • **Find where system rewards value** • **Make sure to avoid unintended consequences of cost shifting to caregivers** • **Harness data in health care to help identify patients who need conversations about services including palliative care and hospice (go beyond provider as gatekeeper)** • **Tie payment to patient choices for care (MA)** • **Change system to require opt-out of palliative care** • **Interdisciplinary models, incentivizing interdisciplinary care** • **Expand or enhance definition of provider depending on care needed** • **Policy review**		
Other		
• **Person-centered language (does our policy reflect this?)**		
Top Priority Action Items (limit to 3-5)		**Actor(s)**
1	Outcome measures: Build from surveys of family members/proxy; review surveys that have been done; implement population-wide/more broadly; Investment in quality measures (they require agreement on defining denominator)	CMMI CMS Private companies (transparency of models) States Academic medical centers Associations
2	Test financial models that deliver high-quality care that pay for patient-centered outcomes and reward interdisciplinary care (properly designed incentives, measurements, adequate	Private sector/Foundations Payers

	transparency, appropriate accountability)	
3	Tie payment to people's choices; Get care inconsistent with patient wishes listed as medical error (need for definition of medical error from federal level)	CMS Payers Congress
4	Change system to make palliative care services the default (comanagement);	
5	Well-defined accountability system	CMS (COP) Accrediting bodies (NCQA) Foundations