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

National Academy of Medicine
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Policies & Payment Systems

NOTES—BREAKOUT SESSION 2

Barriers

- **Field functions as circular firing squad, field is not unified, differing messages to policy makers and public (advocacy organizations)**
- **Don’t have a clear message or a clear definition of palliative care; public doesn’t understand “end of life” (translates to care at the bedside as well)**
- **Focus on “end of life” (pt-centered care, denominator problem)**
- **Medicaid draw down and long term service premium increases**
- **Lack of quality measures (needed for care and payment)**
- **Workforce shortage; knowledge of general workforce in this area**
- **Data/measurement: Knowing when there has been a palliative care encounter (not in claims data)**
- **System leaders don’t recognize that workforce doesn’t have training; EHR must be structured to capture correct items; Transparency and accountability**

Solutions/Opportunities

- **Unified message, unified language**
- **Commitment to developing the measures**
- **With move away from ffs and toward value, health systems are paying more attention to generalist training**
- **EHR: next year’s update will work toward sharing pieces of information**
- **Financial incentives/disincentives; monitoring for unintended consequences as new payment systems are tested**
- **Capture information about innovative models across sectors (private and public sector); transparency around models; evaluation of models/pilots**
- **Quality measures/data: mortality follow back study**

Other

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	Top Priority Action Items (limit to 3-5)	**Actor(s)**
1	Workforce: increase number of experts and build front line clinician competence (across disciplines); mid-career training pathways	ACGME LCME ACEN/CCNE CMS ABMS subboards State licensing boards (renewal) Health education schools (mid-career training) AAHPM/HPNA and specialty societies
2	Information exchange (EHR, registries for documenting	Federal (Certify EHRs)

	advanced care plans); goals of care being shared across providers; testing for user centered design	State (registries)
3	Learning health system for people with serious illness; validated measurement (link quality measures (first) to learning health care system and quality/accountability in payment system)	
4	As we create payment systems, monitor for harms (e.g., undertreatment, observation stays, management of dyspnea), celebrate benefits	
5	Ensure public and private financing mechanisms that work outside the hospital; develop payer best practices for providing high quality care	