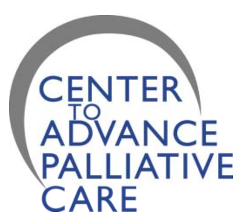
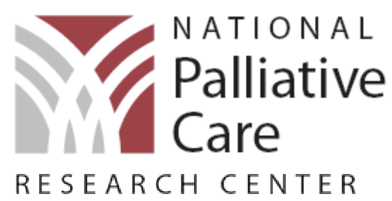
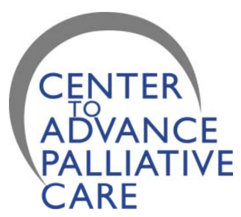




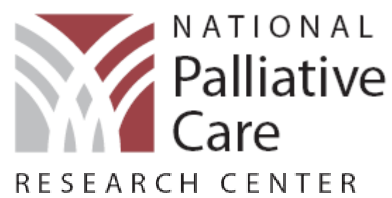
Palliative Care: Policy Initiatives to Improve Access, Improve Quality, and Reduce Costs

R. Sean Morrison, MD
Director, National Palliative Care Research Center
President-elect, American Academy of Hospice and Palliative Medicine
Hermann Merkin Professor of Palliative Care
Professor, Geriatrics and Medicine
Brookdale Department of Geriatrics & Adult Development
Mount Sinai School of Medicine
New York, NY
sean.morrison@mssm.edu
www.npcrc.org



- *Palliative Care: A Review*
- *Barriers Facing Palliative Care Implementation*
- *Policy Initiatives*

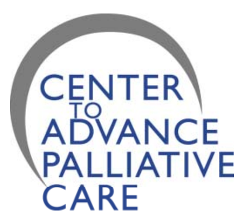
Palliative Care



***Palliative Care** means patient and family-centered care that optimizes quality of life* by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Palliative Care is *NOT End-of-Life Care* and is not dependent on prognosis

73 FR 32204, June 5, 2008 Medicare Hospice Conditions of Participation – Final Rule



Conceptual Shift for Palliative Care

Life Prolonging Care

Medicare Hospice Benefit

Old

Disease-directed Care

Palliative Care

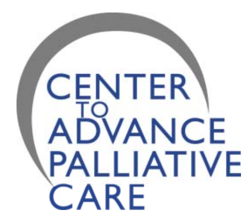
Hospice Care

Bereavement

New

Dx

Death



Estimated National Cost Impact For Medicare Enrollees

Estimated savings now based on palliative care services at 50% of U.S. hospitals (2007 penetration levels):

- Penetration of services to approximately 1.5% of all hospitalized patients

  -Direct cost savings = $1.2 billion/year

Estimated future savings based on palliative care services at >90% U.S. hospitals:

- Penetration of services to approximately 5% of all hospitalized patients

  -Direct cost savings = $4 billion/year

- Penetration of services to approximately 7.5% of all hospitalized patients

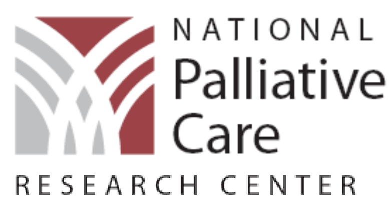
  -Direct cost savings = $6 billion/yr, $60 billion over 10 yrs

Estimates based on Morrison et al, Arch Intern Med, 2008; Siu et al, Health Affairs, 2009; Berenson et al, RWJF and Urban Institute, 2009. Assumes relatively high % of live hospital discharges (savings much greater for hospital deaths) & payer mix 40% Medicare

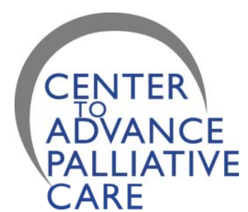
Barriers to National Implementation

- Workforce
- Access and Quality
- Evidence base
- Public and professional misconceptions

Policy Initiatives: Workforce

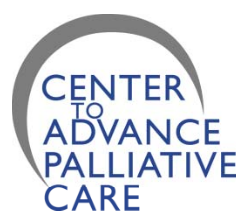


- Current problem:
  - 1 palliative medicine MD for every 31,000 people with serious advanced illness
  - 26 states + DC have no GME training programs in palliative medicine
- Near-term policy solutions
  - Lift GME cap to allow development and expansion of palliative care fellowship training programs
  - Loan forgiveness programs for palliative care physicians, nurses, and social workers
  - Palliative care academic career development awards (HRSA) to support clinician educators in palliative care
  - Mid-career training awards to support re-training of current workforce in new specialty
  - Mandatory CME training in primary-level palliative care prior to re-licensing

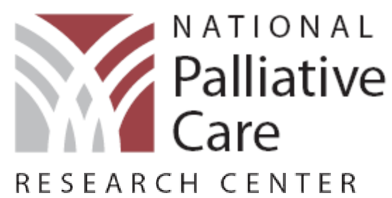


Policy Initiatives: Access and Quality

- Current problem
  - 50% of hospitals (27% of hospitals with over 300 beds) lack a palliative care program
  - Standards for palliative care programs are voluntary
  - Business model = cost savings + MD reimbursement (difficult to demonstrate and sustain)
- Near-term policy solutions
  - Medical home must include non-hospice palliative care
  - All hospital and nursing homes must have palliative care program that meets consensus standards as condition of accreditation
  - Hospital bonus payments linked to palliative care delivery with transition over 5 years to penalties for hospitals not providing palliative care (Medicaid and Medicare) Potential link to bundled payments
  - Adjustment of reimbursement scale for board-certified palliative medicine physicians and implementation of time-based coding for palliative medicine specialists to support time-intensive goals of care discussions and care coordination

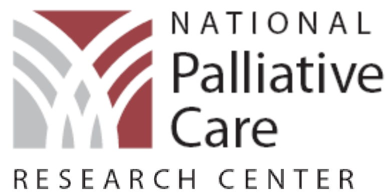


Policy Initiatives: Evidence base

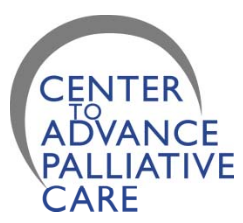


- Current problem
  - Inadequate evidence base to support appropriate symptom management (3 IOM reports, 2 NIH state of the science conferences)
  - <.1% of all NIH grants awarded for palliative care research (2001-2005)- orphan specialty at NIH
  - Lack of junior and mid-career investigators
  - Increasing regulatory barriers to appropriate opioid analgesic prescribing
- Near-term policy solutions
  - NIH/AHRQ reallocate 2% of current budget to focus on symptom relief, communication in the setting of serious illness, health services/comparative effectiveness research focused on patients with serious and advanced illness
  - Establish Office of Palliative Care Research modeled after OAR
  - Establish specific K24/K07/K23/K08 funding mechanisms in palliative care
  - Targeted research on harm reduction and diversion wrt opioids

Policy Initiatives: Public and Professional Misconceptions



- Current Problem
  - Palliative care is linked to “end-of-life” care in the minds of the public, professionals, and policy makers
  - Major barrier to ensuring access to high quality medical care for persons with serious and advanced illness
- Near-term policy solutions
  - Public/private social marketing campaign to rebrand palliative care, increase public demand, and promote effective bi-partisan legislation



Although the world is full of suffering, it is also full of the overcoming of it.

Helen Keller

Optimism 1903