Special Article

The Business Case for Palliative Care: Translating Research Into Program Development in the U.S.

J. Brian Cassel, PhD, Kathleen M. Kerr, BA, Noah S. Kalman, MD, MBA, and
Thomas J. Smith, MD, FACP, FASCO, FAAHPM

Massey Cancer Center (J.B.C., N.S.K.), Virginia Commonwealth University, Richmond, Virginia; Kerr Healthcare Analytics (K.M.K.), Mill Valley, California; and Johns Hopkins University (T.J.S.), Baltimore, Maryland, USA

Abstract

Specialist palliative care (PC) often embraces a "less is more" philosophy that runs counter to the revenue-centric nature of most health care financing in the U.S. A special business case is needed in which the financial benefits for organizations such as hospitals and payers are aligned with the demonstrable clinical benefits for patients. Based on published studies and our work with PC programs over the past 15 years, we identified 10 principles that together form a business model for specialist PC. These principles are relatively well established for inpatient PC but are only now emerging for community-based PC. Three developments that are key for the latter are the increasing penalties from payers for overutilization of hospital stays, the variety of alternative payment models such as accountable care organizations, which foster a population health management perspective, and payer-provider partnerships that allow for greater access to and funding of community-based PC. J Pain Symptom Manage 2015;■:■–■. *© 2015 The Authors. Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).*

Key Words

Palliative care, finance, health economics, payment reform, policy

Introduction

In his famous "Escape Fire" speech, Dr. Donald Berwick diagnosed the foundational problems with the U.S. health care system and articulated a vision for its transformation. He stated that for a comprehensive solution to succeed and be broadly adopted today, it must make sense from four distinct perspectives:

> Whatever "escape fire" [revolutionary innovation] we create has to make sense in the world of science and professionalism, in the world of the patient and family, in the world of the business and finance of health care, and in the world of the good, kind people who do the work of caring. I think the toughest part of this may be in terms of the business and financing of care. There is a tendency to assume that financial success—e.g., thriving organizations—and great care are mutually exclusive. However, we will not make progress unless and until these goals become aligned with each other." [emphasis added].[1]

This is certainly true of the field of palliative care (PC). The clinical-moral imperative that has driven innovators and practitioners in the field is necessary but insufficient for catalyzing and sustaining widespread investment in PC programs. Unless and until stakeholders—health system administrators, physicians, and payers—perceive a clear path to the financial viability of specialist PC programs, they will not support fully the development of such services.[2,3] Clinical leaders who have struggled for years to garner support for PC services can attest to the degree to which the misalignment of clinical and financial incentives has stymied the creation and expansion of specialist PC services. This phenomenon has been explored in at least one national study: in a survey of cancer centers in the U.S., financial issues were the most-often perceived barrier to PC program implementation.[4]

Address correspondence to: J. Brian Cassel, PhD, 1101 E Marshall Street, Box 980230, Richmond, VA 23298, USA. E-mail: JBCassel@VCU.edu

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The Clinical-Financial Disconnect

Why is there such misalignment between clinical and financial interests? The U.S. health care system is fundamentally rooted in a fee-for-service (FFS) model, where third parties compensate providers for each service delivered to patients. In such a system, there is a direct correlation between the quantity and intensity of health care provided and the amount of revenues collected by systems and individual providers—more activity (procedures, tests, and hospitalizations) results in more revenue. In contrast, the field of PC uses a "less is more" philosophy, where attention to patient and family needs and clarification of care goals often lead to reduced use of the most expensive health care services (such as inpatient admissions and emergency department [ED] visits) and increased use of less expensive services (such as home-based services).

With hospice, insurers cut through this obstacle by offering an entirely separate benefit that is mutually exclusive with continuation of disease-focused health care. The business case for specialist PC outside the hospice is more complex and more subtle, in part because PC needs to be provided concurrently with disease-focused therapies, rather than in the "either/or" forced choice inherent in the current regulations of the Medicare Hospice Benefit.

From the perspective of a hospital entrenched in the FFS reimbursement model, shifting activity away from hospital care does not make much financial sense. In a description of the Advanced Illness Management Program developed by SutterHealth, a program leader noted that although the intervention was successful in increasing hospice utilization, reducing hospitalizations and lowering costs of care, the misalignment of quality and financial incentives posed a serious challenge: "The current reimbursement system does not pay for Advanced Illness Management-type services, such as care coordination and hospital-to-home transition. Reduced hospitalizations cost Sutter hospitals more in lost revenue than they gain from dollar savings."[5]

The goal of this article is to help insurance and hospital executives, PC leaders, and policy makers to understand the extent to which the clinical/moral and financial imperatives for PC are actually aligned and the congruence between positive clinical and financial outcomes. Although numerous studies have documented the impact of PC on costs,[6–9] no prior article has presented a comprehensive assessment of the financial or business imperative for PC and how it could be aligned with the clinical/moral imperative. Drawing on the published literature and our technical assistance work with hundreds of PC programs over the past 15 years, we articulate the 10 principles that together create the economic rationale for specialist teams to provide an additional layer of support for patients (and families) facing progressive life-limiting diseases. These principles also refer to and reflect the increasing importance of the pay-for-quality movement that is slowing supplanting the FFS model.

The 10 Principles of the Business Case for PC

Principle 1: Persons with serious illness, especially those with progressive life-limiting diseases [and their families] are at risk for pain and suffering from multiple sources; PC helps prevent or improve those outcomes.

The business case for specialist palliative care (SPC) begins with the clinical case. Without a clinical imperative, there would be no need for a financial model; recall that the national Medicare Hospice Benefit followed (by eight years) the founding of the first hospice in the U.S. Voluminous evidence speaks to the extent to which patients with serious illness and their families suffer; there is equally strong and abundant evidence of how SPC services help to mitigate or even prevent that suffering.[10–16]

Principle 2: Persons with progressive life-limiting diseases often have heavy utilization of expensive health care services (e.g., ED visits, frequent and lengthy hospital admissions), some of which are avoidable. These use of patterns are often evident in the last months of life but may occur earlier in the disease course.

The literature on this, too, has become voluminous; three studies are worth highlighting. A recent study showed that one-half of older Americans go to a hospital ED in the last month of life; once there, three-quarters are hospitalized; and of those hospitalized, more than two-thirds die in the hospital.[17] For three major diseases, Medicare patients are increasingly receiving intensive care unit (ICU) care in the last month of life, and more than one-quarter of those dying in hospice care have received hospice for less than three days.[18] This utilization of hospital services at the very end of life would be acceptable if such care was aligned with patient and family preferences. Unfortunately, this is not the case: studies continue to show that the proportion of people who die in hospitals and nursing homes exceeds the proportion of those who identify these sites as their preferred location of death.[19] Worldwide, more than 80% of people want to die at home.[20]

Principle 3: Hospitalizations toward the end of life tend to be lengthy and costly; these can result in negative fiscal outcomes for hospitals and payers, in both FFS and risk-based revenue models.

Published studies have documented the duration and cost of hospitalizations near the end of life, which