Join us for upcoming CAPC events

➔ Other Upcoming Webinars:
  – Diffusing Innovation: Lessons from Palliative Care (Open to Non-Members):
    • Tuesday, March 6, 2018 | 1:00 PM ET

➔ Upcoming Improving Team Effectiveness Series Events:
  – Role Clarity for a Highly Effective Interdisciplinary Team:
    • Thursday, March 22, 2018 | 3:00 PM ET

➔ Virtual Office Hours:
  – Pediatric Palliative Care with Sarah Friebert, MD
    • February 20 2018 at 4:00 pm ET
  – Palliative Care Models in the Community with John Morris, MD, FAAHPM
    • February 21, 2018 at 2:00 pm ET
  – Measurement for Community-based Palliative Care with J. Brian Cassel, PhD
    • February 26, 2018 at 12:00 pm ET

Register at www.capc.org/providers/webinars-and-virtual-office-hours/
Objectives

➔ Articulate six proven strategies to improve the quality and value of care delivery for the seriously ill population

➔ Understand how to modify case management to serve this unique population

➔ Consider new benefits and services that help members avoid unnecessary emergency department visits and hospitalizations
Understanding serious illness

Individuals with serious illness – such as cancer, advanced heart disease, and dementia – face heightened risk of crisis hospitalization and preventable spending.

FIGURE 1: Percent of Six-Month Oncology Episodes with at Least One Admission or ED Visit

The opportunity: persistent high-spend

Of the top 5% of health care utilizers in the United States, only 11% are in their last year of life, with a full 40% facing year after year of high utilization.

The good news: health plans and ACO’s are implementing solutions

1. PROACTIVE IDENTIFICATION
   Finding high-need patients who need a different approach to care

2. ENGAGEMENT & ASSESSMENT
   Working with patients and families to identify burdens, goals, and gaps

3. SERVICES (BENEFITS)
   Addressing physical, psychosocial, and spiritual needs concurrent with treatment

4. PROVIDER NETWORK
   NETWORK COMPETENCIES
   Ensuring all clinicians have core skills
   ACCESS
   Ensure the network includes palliative care specialists

5. PAYMENT & INCENTIVES
   Financially supporting skill-building, access to palliative care, and caregiver supports

6. MEASUREMENT & EVALUATION
   Confirming the right structure and processes, and the delivery of high-value care

6 elements of a comprehensive strategy for simultaneously improving quality and reducing unnecessary spending
At the core are the principles and practices of palliative care

- Palliative care is specialized medical care for people with **serious illness**.
- It focuses on providing patients with **relief** from the symptoms, pain, and stress of a serious illness—**whatever the diagnosis or stage of the disease**.
- The goal is to **improve quality of life** for both the patient and the family.
- It is appropriate at any age and at any stage in a serious illness and **is provided along with regular disease treatment**.
Personalized Care Support
The Regence Palliative Care Program

Peggy Maguire
Senior Vice President
Corporate Accountability
and Performance

Lee Spears
Program Director
Personalized Care Support
Our Enterprise Palliative Care Focus

CAMBIA Health Foundation + Echo Health Ventures + Health Plans (Regence, BridgeSpan, Asuris)

2009 + 2011 + 2014

Community & Provider Focus
The Work of the Health Plan (the Personalized Care Support Program)
Regence is in partnership with GNS Healthcare to build and use its robust and dynamic machine learning algorithms in the identification of members who might benefit from palliative care (across diseases, lines of business, and all products).

Regence continues to mine its own data and develop companion predictive models targeting specific diagnoses and disease states for critical outreach.
Through Palliative Care Case Management, Regence tracks/measures:

- Timely outreach to members and resulting enrollment in case management
- Completion of an advance care plan
- Episodic quality indicators around being listened to and building confidence
- Satisfaction with care
Our mission is to provide palliative care services to anyone who might benefit from them in whatever setting they prefer.

Our benefits and services support the entire spectrum of palliative care needs, from birth to natural end.
PCS: Network Strength

➤ We review our provider network for percentage of hospitals with a palliative care team

➤ We track growth in the number of our community health contracts

➤ Regence has launched a consumer and provider outreach arm that works internally and externally to address support and training needs

➤ Regence tracks a number of metrics around the delivery of care (e.g., hospital readmissions, emergency room visits in last 30 days of life, LOS of inpatient stays in last 30 days of life, chemotherapy in last 30 days of life) to develop a broad picture of palliative care treatment in our 4-state footprint
PCS: Additional Work

- We continue to focus on the burden of caregivers through our benefit and services.

- In 2016, we launched a palliative care employee resource group to address the needs of seriously ill employees and employees serving as caregivers to loved ones.

- Regence has implemented a provider grief initiative to acknowledge feelings of loss and convey gratitude (from both family and staff).
Operational readiness does not equal network readiness; groom your champions

Bring your consumer partners in early

Update your risk management conversations
Elements of the Serious Illness Framework
The impact of integrating palliative care continues to be demonstrated

<table>
<thead>
<tr>
<th>AETNA MEDICARE ADVANTAGE COMPASSIONATE CARE PROGRAM</th>
<th>PROHEALTH ACCOUNTABLE CARE ORGANIZATION SUPPORTIVE CARE PROGRAM</th>
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<tbody>
<tr>
<td><strong>81%</strong> decrease in acute care days</td>
<td><strong>37%</strong> decrease in hospital admission rate</td>
</tr>
<tr>
<td><strong>86%</strong> decrease in ICU days</td>
<td><strong>20%</strong> decrease in ED visit rate</td>
</tr>
<tr>
<td><strong>HIGH</strong> member satisfaction</td>
<td><strong>HIGH</strong> patient satisfaction</td>
</tr>
<tr>
<td><strong>82%</strong> hospice election rate</td>
<td><strong>34%</strong> increase in hospice enrollment</td>
</tr>
<tr>
<td><strong>$12.6K</strong> in savings per person</td>
<td><strong>$12K</strong> in savings per person</td>
</tr>
<tr>
<td><strong>NO</strong> patient complaints in ten years</td>
<td><strong>90%+</strong> net promoter score</td>
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Other results:
- ✓ Reduced admissions, ED, and ICU use
- ✓ Improved quality of life and survival in lung cancer patients
- ✓ Reduced care giver burden
This framework provides a planning and implementation structure for a comprehensive strategy for simultaneously improving quality and reducing unnecessary spending.
1: Proactive Identification

**DIAGNOSIS**
- Cancer
- Advanced liver disease
- COPD w/oxygen
- Congestive heart failure
- Renal failure
- Advanced dementia
- Diabetes w/ complications
- ALS

**FUNCTIONAL IMPAIRMENT**
- Limitations in activities of daily living
  - eating
  - bathing
  - dressing
  - toileting
  - transferring
  - walking
- Significant memory loss
- DME-walkers, beds, home oxygen, etc.

**HIGH UTILIZATION**
- Hospital admissions, re-admissions, and length of stay
- Emergency department visits
- Poly-pharmacy
- Skilled nursing/rehab stays
- Multiple home care episodes

**TIPS:**
Targeting the highest need ensures best use of higher-intensity resources.

Claims alone are not adequate.

Source: Kelley AS et al. HSR 2017;52:113-131
2: Engagement and Assessment

SERIOUS ILLNESS ASSESSMENT DOMAINS

- Pain and symptom burden
- Psychological issues, including worry, stress, anxiety, and depression
- Caregiver burden and capacity
- Social, financial, and practical issues that interfere with effective care
- Spiritual concerns

TIPS:
Hiring and training of care managers is critical.

“Don’t ask what’s the matter with me; ask what matters to me!”
3: Services (Benefits)

An effective assessment identifies needed services:

- **24/7 and timely clinical response** for pain and symptom exacerbations
- **Caregiver training, support, and counseling** to equip families for the responsibilities placed on them
- **Assistance with activities of daily living, such as personal care supports**
- **Access to social and spiritual supports**, which can incorporate benefit changes and/or referral to high-quality resources in the community

**Example**: In 2019 Medicare Advantage plans can cover home adaptation and personal assistance for select enrollees

**TIPS:**

Review coverage, co-payment designs, and pre-authorization policies, including for practical supports.

A separate “palliative care benefit” may not necessarily be needed.
4: Provider Network

Not all seriously ill patients need specialty palliative care services. But all clinicians should have the core palliative care skills to support the range of needs.

- **LOW PALLIATIVE NEED**
  - Usual care with treating clinicians capable of effective communication and symptom management. Specialty palliative care consult(s) as needed.

- **MEDIUM PALLIATIVE NEED**
  - Treating clinicians regularly collaborate with specialty palliative care team, especially for intractable symptoms or complex family communications.

- **HIGH PALLIATIVE NEED**
  - Ongoing and active management by specialty palliative care team. The degree of palliative care team responsibility depends on patient need and treating clinician preference.

**TIPS:**

Identify and partner with specialty-level palliative care programs in your region.

Ensure primary care practices, care managers, and all network clinicians caring for the most complex have training.
5: Payment and Incentives

Best practice examples of value-based and alternative payment models for serious illness include:

- Additional “care management fees” to support psychosocial supports and/or infrastructure enhancements
- Direct salary support for palliative care specialists, including physicians, advance practice nurses, social workers, and chaplains
- Monthly case rates for a defined set of specialty palliative care services
- Shared savings, with shared risk if viable for the providers
- Enhanced fee-for-service rates for palliative care specialists or practices
- Flexibility to pilot innovative care interventions

TIPS:
There is a range of payment models – adopt the one(s) that best support the medical, psychosocial, and practical needs of the population.
6: Measurement and Evaluation

Aligning measures to organizational goals, across several dimensions, will support a more sustainable and wide reaching impact.

TIPS:
Beware of unintended consequences of well-intentioned measures in the seriously ill population.

Carefully consider the unique circumstances of a seriously ill population.
Download the full publication

Serious Illness Strategies for Health Plans and ACOs
www.capc.org/payers/strategies/

Thank you to the many contributors including CAPC’s Multi-Payer Workgroup participants.
Additional CAPC resources for health plans and ACOs

Visit [www.capc.org](http://www.capc.org) to learn more!
Learn more about CAPC’s offerings

➔ Online education in communication and symptom assessment/management for case managers
➔ Access to proven resources to build palliative care programs
➔ Call-in access to experts
➔ Opportunity to exchange ideas and lessons learned with others working to improve care
Questions?
Please type your question into the questions pane on your WebEx control panel.
Thank you!