Objectives

- Describe population health management and the key opportunities and requirements for providers in a population health, risk sharing payment system.
- Explain the importance of data and data analytics to gain access to contracts and to succeed in a population health system.
- Identify opportunities, best practices, key critical success factors and challenges to a successful population management program for home health and hospice providers.
Agenda

1. Population Health Management and Provider Opportunities
   • What is population health management and why is it the cornerstone of our emerging health care system?
   • What are the most popular ACO models?
   • Key requirements of Providers: Managing costs and quality
   • Risk sharing incentives and shifting accountabilities
   • Opportunities for Home Care and Hospice

Agenda (continued)

2. Data as a Key to Success
   • Importance of data analysis to managing population health and risk sharing environments
   • Key metrics required
   • How to utilize data to position your agency to be provider of choice
   • What to do if you are handicapped by a lack of available technology?
### Agenda (continued)

2. *A Providers Experience*
   - Getting started
   - Cost Concerns Driving Healthcare
   - What is Community-Based Palliative Care
   - Models of Care
   - Outcomes
   - Case Studies
   - Lessons Learned

### POPULATION HEALTH MANAGEMENT
Population Health Defined

“Population-focused health care... refers to assessing the health care needs of a specific population and making health care decisions for the population as a whole rather than for individuals. Populations being treated are made up of individuals who have one or more personal or environmental trait in common.”

*Loyola University New Orleans*

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Care Continuum Alliance: definition of population health improvement:

*The population health improvement model highlights three components: the central care delivery and leadership roles of the primary care physician; the critical importance of patient activation, involvement and personal responsibility; and the patient focus and capacity expansion of care coordination provided through wellness, disease and chronic care management*
### Population Health Characteristics

- Health care practitioners use similar treatment recommendations or guidelines for populations with a specific disease, injury or illness.
- Guidelines based on evaluating the effectiveness on a population of comparable patients or even one patient: balance between what works collectively for a population, and any individualization required.
- Aim to eliminate inequalities within subgroups of the population and empowering all.

### Population Health Characteristics

- Can focus on investing upstream
- Base decisions on evidence
- Apply multiple strategies to act on the determinants of health
- Collaborate across levels and sectors
- Increase accountability for health outcomes, and employ mechanisms to engage citizens to take part.
### Measurement

- Together, these characteristics point to the importance of an epidemiological approach to managing population health.
- Includes measuring inputs and outcomes, understanding how they are related, and setting priorities.
- As a result, measurement is a fundamental aspect of the population health perspective.
- The set of measures should operationally define each dimension of population health.
- But measurement of the factors that influence population health outcomes is challenging and an area where research is needed.

### Population Health Programs: Current Trends

- Coordinated Chronic care services
- Transitions of Care
- Payment Reform
- Med Pac recommendations
- Expanded Roles of Physicians
- HC Innovation Awards
- Dev. Of CBHC and Disease mgt programs
- Data and Interoperability
EMERGING HEALTHCARE:  
**DRIVING POPULATION HEALTH FOCUS**

Population Health in the Affordable Care Act

- The passage of the Patient Protection and Affordable Care Act (ACA) addresses population health:
  1. Provisions to expand insurance to improve population health by improving access to the health care delivery system which is a critical component of a community’s population health production system.
  2. Other provisions aim at improving the quality of the care delivered
  3. ACA seek to enhance prevention and health promotion measures within the health care delivery system by the promotion and implementation of ACOs to incentivize providers to take responsibility for population health outcomes
### “Dizzying Healthcare World”

<table>
<thead>
<tr>
<th>Accountable Care Organizations</th>
<th>Pre Acute Health Coaches</th>
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<tbody>
<tr>
<td>Process of Care Measures</td>
<td>Population Health</td>
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<tr>
<td>Pioneer Model</td>
<td>HIE/Connected Care</td>
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<td>Demonstration Projects</td>
<td>Redefining Partnerships</td>
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<td>Shared Risk</td>
<td>Data Analytics</td>
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<td>Bundled payments</td>
<td>Evidence Based Practice</td>
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<td>Value Based Purchasing</td>
<td>Patient engagement</td>
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<td>Readmission Reduction Program</td>
<td>Triple Aim</td>
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<td>Transitions in Care</td>
<td>Big Data</td>
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<tr>
<td>Chronic Care Mgt.</td>
<td>Post Acute emphasis</td>
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### “Dizzying Home Health and Hospice World”

<table>
<thead>
<tr>
<th>Increased Regulatory Scrutiny Consolidation</th>
<th>Rebasings HIS</th>
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<tbody>
<tr>
<td>Decreased Margins</td>
<td>CMS Innovation: Curative and Palliative</td>
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<td>F2F</td>
<td>Resource Capacity</td>
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<td>ICD 10?/ 11??</td>
<td>Management</td>
</tr>
<tr>
<td>Hospice Payment Reform</td>
<td>Data Analytics</td>
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<td>Oasis C-1</td>
<td>Efficiency and Effectiveness</td>
</tr>
<tr>
<td>Home Health Readmission Penalty</td>
<td>Triple Aim</td>
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<tr>
<td>Patient Facing Technology RACS, etc.</td>
<td>Big Data</td>
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<tr>
<td>Recalibration of HHRGs</td>
<td>Blurring of the Post Acute Silos</td>
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</table>
Common Themes?

- Declines in margins and revenues due to payment reform
  - Risk sharing
  - Bundled payments
- Shifting volumes to PAC, wellness and prevention focus
- Care model changes to:
  - Chronic care management
  - Managing populations longitudinally
  - Care coordination
- Accountability:
  - Quality and efficiency
  - Risk sharing
- Increasing dependence on technology

Accountable Care Organizations: Defined

ACOs are a group of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated care to their Medicare patients with the goal that patients, especially the chronically ill, get the right care at the right time, avoiding duplication of services and preventing medical errors.
Medicare ACO Programs Include

- Medicare Shared Savings Program
  → A Fee for Service Program: receive traditional FFS payments and be eligible for additional payments if quality and savings requirements are met

- Advance Payment Model
  → Supplementary incentive program for eligible providers in the Shared Savings Program

- Pioneer ACO Model
  → Population based payment initiative for health care organizations and providers already experienced in care across care settings

What do ACOs Want from their Provider Partners?

- Services and solutions that parallel the ACO’s goals
  → Manage high risk population
  → Maximize reimbursement
  → Reduction in acute admissions/readmissions

- Providers that can demonstrate with objective data the ability to provide cost effective care
  - Clinical accuracy, resource control

- Willingness to share risk
- Ability to provide required data
- Technology integrated into operations
Key to Success: Technology

**ONC for HIT: 10 year Vision**

- Need system wide transformation to achieve interoperable health IT, efficiencies and a “learning health system”
- Need to:
  - Improve capacity to capture clinical care delivery process
  - Increase integration of best clinical knowledge in care decisions
  - Involve patients
  - Improve care operations
  - Increase transparency
  - Increase Interoperability

Keys to Success: Business Intelligence

- Data: meaningful (KPI), exception focused
- Access where, when and how needed
- Supports fact based decision making
- Supports strategic positioning
  - Utilization focused
  - Clinical outcomes focused
- Analytic results interpretation to assist executives, managers, and clinicians in finding opportunities and driving improvements.
Why is HIE important?

- Supports efforts to reduce hospital readmissions
- Can help reduce duplicative testing – imaging and labs
- Administrative efficiencies
- Improve communication between all providers in the health care team
- Supports Meaningful Use, Primary Care Medical Homes, ACOs, etc.
- Advanced Directives
  >>>>>> Increased patient safety, satisfaction, and clinical outcomes

Start Maximizing the Benefits of Technology

- Raise the bar
- Enterprise system
  → Usage
  → Adoption rates
- Data Analytics and Business Intelligence
- Patient Monitoring
- Other patient engagement technology
- Interoperability/HIE
Technology: Current State Expectations

- A “enabler”: day to day and strategic
- Reflects best practice process and work flow
- Decision support: reflects evidenced based clinical practice
- Supports proactive versus reactive actions
- More than compliance with regs: supports audits and survey outcomes
- Error avoidance/risk reduction
- Maximizes technology: platforms, devices, tech tools, guides
- Easily adopted/user friendly

Positioning: Measurement and Analytics

- Importance of data analysis to managing population health and risk sharing environments
  → Key metrics required
- Operational Benchmarks for best practices for both back office and direct service.
  → Key Performance Indicators: Statistical, Operational, Financial
  → Continual monitoring of KPIs: Positive and negative trends
  → Benchmark against peers/competition
  → Relate to partners needs/wants/issues
<table>
<thead>
<tr>
<th>Data Analysis</th>
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<tbody>
<tr>
<td>• Retrospective and prospective cost trend analyses, benchmarking, and predictive modeling for targeted patient populations.</td>
</tr>
<tr>
<td>• Population segmentation with interpretation of clinical and financial risk analysis.</td>
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<tr>
<td>• Provider profiling that measures quality of care and cost efficiency.</td>
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<tr>
<td>• Identifying patient-specific gaps in care</td>
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<tr>
<td>• ID OFI and targeting outcomes</td>
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<tr>
<td>• Bundled payment analytics</td>
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A PROVIDERS EXPERIENCE

THE CRITICALITY OF COMMUNITY BASED PALLIATIVE CARE TO THE SUCCESS OF HEALTH REFORM THROUGH ITS IMPACT ON QUALITY AND COST
Cost Concerns are Driving Huge Changes in Healthcare Delivery

- 95% of all health care spending is for the chronically ill
- 22% of all Medicare spending goes to 1% of beneficiaries - the sickest and most complex with multi-morbidity and functional impairment.
- Health care is projected to reach 20% of GNP by 2021.
- The U.S. spends more for health care than any other developed country but does not have better outcomes.

Rising Illness Burden in an Aging Population

**Figure 1: Number of Persons 65+, 1900 - 2030 (numbers in millions)**

<table>
<thead>
<tr>
<th>Year (as of July 1)</th>
<th>1900</th>
<th>1920</th>
<th>1940</th>
<th>1960</th>
<th>1980</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
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<tr>
<td></td>
<td>3.1</td>
<td>4.9</td>
<td>9</td>
<td>16.6</td>
<td>25.5</td>
<td>31.2</td>
<td>35</td>
<td>54.8</td>
<td>72.1</td>
</tr>
</tbody>
</table>

US Admin on Aging, DHHS
Rising Illness Burden in an Aging Population

Illness Burden and Need for Care

- Patients with serious illnesses often experience high illness burden
  - Distress from poorly controlled symptoms
  - Distress from psychosocial and spiritual disturbances
  - Distress from loss of roles
  - Concrete needs in the home
  - Confusion in care coordination, communication, decision making, goal setting
  - Caregiver burden and financial stress
  - Fear about managing the period of active dying

Driver A et al., BMJ 2008,337,a2467
Illness Burden In A Complex Health Care System

- Providing health care services to patients and families is complicated by:
  - Evolving standards of care and best practices
  - Disparities in insurance status and access
  - Fragmented care
  - Patient/family expectations of care
  - Cure-oriented and disease-focused culture of medicine
  - High cost and misaligned incentives

Small Minority = High Cost

- Top 5% of Medicare Spend:
  - ◼ Population at the end of life (40%)
  - □ Population with persistently high costs (40%)
  - ■ Population with a discrete high-cost event

*Source: Aldridge, Kelley, 2013: IOM Commissioned Paper: Epidemiology of Serious Illness and High Utilization of Healthcare*
How Does Health Care Change For The Better?

**Pay for Quality – Not Volume**

**Palliative Care**

→ Patient Centered Medical Homes (PCMH)
→ Bundling of Health Care
→ ACO’s

*Adding palliative care targeted to the highest cost highest risk populations to the specifications for these new delivery and payment models is key to success at improving quality and reducing cost.*

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**Seeking Solutions: What is Palliative Care?**

- An interdisciplinary therapeutic model appropriate for all populations with serious or life-threatening illnesses, **the goal of which is to prevent and manage suffering and illness burden** for both patient and family from the time of diagnosis onward
Seeking Solutions: What is Palliative Care?

- The goal of Palliative Care is to improve quality of life for both the patient and the family.
- Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of specialist-level support.
- Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Specialist Palliative Care and Cost Avoidance

- Cost control is not an **objective** of specialist level palliative care but best practices leads to cost reductions & less costly care overall.
  - Informed, shared decision making based on medical realities and patient’s preferences/values.
  - Repeated goal setting
  - Advance care planning
Specialist-Level Palliative Care: U.S. Models

- Hospice
- Institution-based palliative care
- Community-based palliative care

Hospice in the U.S.

- Arguably the best benefit in health care
  - Care provided by interdisciplinary team including physician, nurse, social worker, chaplain and others
  - Care in the home with access to short-term acute inpatient care and continuous care in the home
  - Equipment, supplies, and drugs related to the illness at no cost
  - Bereavement services for the family
Hospice in the U.S.

- Nonetheless, benefits of hospice have not been fully realized
  → Median LOS ≈ 13 - 20 days
  → Late referral or no referral because
    - Linked to dying and out of the mainstream
    - Requires physician prognostication
    - Hospices limit admissions or care due to capitation
    - Unable to receive disease-modifying therapy

Community-Based Palliative Care

- Community-based programs are a new and challenging component in the continuum of specialist care
- Varied models and names
  → Upstream hospice
  → Home care-based or hospital-based or other
  → Home visit or telephonic or tele-health
  → Medical provider-led, nurse-led, or other models
  → Programs in Emergency Room Departments and ICUs
  → Programs for special populations, e.g., pediatrics
  → Disease management programs, e.g., CHF
Palliative Care: Key Concept

• **Palliative care can be:**
  
  → **Generalist-level care**: Best practices during the routine care of all patients with serious or life-threatening illness
  
  → **Specialist-level care**: Comprehensive, interdisciplinary care by professionals with special competencies

Specialist-Level Palliative Care: Key Elements

• Clinicians in any discipline
  
  → Specialist training and certification

• Services provided by an interdisciplinary team
  
  → Multidimensional assessment
  → Symptom control
  → Goal setting and advance care planning
  → Management of psychosocial or spiritual distress
  → Care coordination and referral
  → Care of the actively dying patient
  → Management of caregiver burden and distress
### Why is Specialist Palliative Care Growing?

- **Quality/Satisfaction drivers**
  - Reduced illness burden for the patient
  - Reduced illness burden for the family
- **Economic drivers**
  - Cost avoidance
  - Potential to help hospitals with length of stay, mortality statistics, and regulations with financial impact, e.g. 2-midnight rule, avoidable readmissions

### Who Will Pay for the Growth in Specialist Palliative Care?

- Hospitals will support inpatient services.
- Entities that assume risk by ‘managing lives’ through population health initiatives will support community-based palliative care.
  - Accountable care organizations
  - Patient-centered medical homes
  - Health homes
  - Organizations receiving bundled payments for episodes of care
  - Commercial managed care organizations (MCO’s)
# Palliative Care: Key Objectives

- **Palliative care promotes:**
  - Comfort through *symptom control*
  - Management of *psychosocial and spiritual distress*
  - Communication that supports *goal setting, shared decision making* and *advance care planning* with regard for culture, religion & other sources of variation
  - Availability of *practical help in the home*
  - Expert management of *active dying and its aftermath*
  - *Family support* while caregiving and when bereaved

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## Getting Started

- Improve your general knowledge about Managed Care (MCO’s) & Accountable Care (ACO’s).
- Become familiar with the language of MCO’s & ACO’s – *important to talk the language (refer to glossary)*
- Identify commonalities of the hospice & palliative care organization & the MCO & ACO’s.
- Become familiar with the laws (Federal & State) driving the push for MCO’s.
- Develop your own game plan for working with MCO’s & ACO’s in your community.
Getting Started

- Clarify your goals - some examples are: secure an agreement or improve turnaround time to payment.
- Identify how you will measure success. Some examples are: increase admissions from this payer by 10 percent by June.
- Do your homework before requesting a meeting with an MCO or ACO.
- Does the financial team of this MCO see the financial benefits to the health plan? If yes, you have allies within this organization.

Getting Started - Show Me The Data!

ROI – Return on Investment

- How to Demonstrate Financial Cost Savings using pre and post metrics:
  → Hospitalization rate as proxy
  → Hospice admissions as proxy
  → MLR
  → Total Medical Spend
  → Pharmacy
  → STAR Ratings
Getting Started

• Was there a particularly positive Member experience with your Hospice and/or Palliative Care Organization where this MCO was the payer? Create a 10 sentence case study to use as discussion points.

• Visit and research the organization’s website. Look for efforts around certain diseases (such as heart failure) or signs of efforts around re-hospitalizations or end of life care references.

• Call the MCO, ACO and describe your interest, ask to schedule a meeting with their key stakeholders in improving their ROI.

• Come to the meeting prepared; research, journal articles substantiating your proposal.

• Celebrate Success!

Moving to Contract

✓ Contracts are generally “Boiler Plate” & come from the plan, IPA, ACO.

✓ Hospice and/or Palliative Care organizations need to create a “Proposal”- outlines proposed program & your business terms.

✓ Recommend you start with a “Pilot”

✓ Once consensus is reached on elements of the clinical program & terms; review with legal

✓ Submit your Exhibit proposal to their contract.
MJHS Health System

- An integrated health system.
- 15 corporations
- Serves >45,000 each year
- MJHS Foundation
- Institute for the Innovation in Palliative Care
- Hospice and Palliative Care
- Centers for Rehabilitation & Nursing Care
- MJHS Home Care
- MJHS Adult Day Care Center
- Elderplan
- Homefirst
- Community Initiatives and Senior Housing Partnerships

MJHS Hospice and Palliative Care:
New Models of Community-Based Palliative Care

- Models of community-based palliative care
  - Interdisciplinary “high-touch” model
  - Acute palliative care
  - Transitional Pediatric Palliative Care
- Early intervention in a skilled nursing facility
- Special “Pilot” programs
### MJHS Palliative Care: Interdisciplinary “High-Touch” Model

- Contracted Capitated program with 2 MCO’s
  - Referral criteria: Serious illness with 2 or more hospitalizations during the prior year
  - Consultation model, working with PCP and care managers
  - Each patient undergoes initial comprehensive assessment by a palliative care physician or nurse practitioner

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### MJHS Palliative Care: Interdisciplinary “High-Touch” Model

- Patient assigned to an interdisciplinary team including a palliative care physician or nurse practitioner, a social worker & an RN Palliative Care Specialist
- Plan of care includes
  - Home visits by MD, NP and/or LCSW
  - Telephonic care management by RN
  - 24/7 telephone/ triage on-call center
  - Assistance with prescription medications if needed
  - Coordination with primary physician and case manager
  - Eligibility review to facilitate referral to hospice

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### MJHS Palliative Care: Interdisciplinary “High-Touch” Model

- **Year 1 results for MCO contract #1**
  - Number enrolled: 644
  - Number discharged due to stability or transfer to hospice: 163
  - Number of MD/NP home visits: 2218
  - Number of LCSW home visits: 871
  - Total number of care management calls: 9998

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### MJHS Palliative Care: Interdisciplinary “High-Touch” Model

- **Year 1 results for MCO contract #1**
  - Patients receiving >1 visit per month: 33%
  - Patients not receiving monthly visits: 19%
  - Patients utilizing 24 hour on-call services: 56%
  - Patients who were “no-show” for planned visit: 8%
  - Patients who “refused visits”: 21%
MJHS Palliative Care: Interdisciplinary “High-Touch” Model

• Year 1 results for MCO contract #1
  → Analysis of hospitalization rate performed on purposive sample of N=100 with multiple hospitalizations prior to enrollment
  → Compared pre-enrollment monthly hospitalization rate and post-enrollment monthly hospitalization rate for a 6 month period

Decline in monthly hospitalization rate
From pre- to post- enrollment: 87.5%*

*Data based on review of MJHS Hospice and Palliative Care records.
MJHS Palliative Care: Interdisciplinary “High-Touch” Model

• Year 1 results for MCO contract #2
  → N=147
  → Elderly population with chronic diseases and lower prevalence of severe illness

• Year 1 results for MCO contract #2
  → Analysis of Medical Loss Ratio* performed on full sample and subsamples with progressively higher MLR’s
  → Compared pre-enrollment total MLR over 3 months and post-enrollment monthly total MLR over 3 months

*MLR calculated without IBNR, Final Revenue from Risk Adjustments, part D reconciliation, risk corridor, manufacturer rebates, and federal insurance
MJHS Palliative Care: Interdisciplinary “High-Touch” Model

Changes in MLR for entire sample (N=147)

Changes in MLR for sample starting with MLR>130% (N=51)

Changes in MLR for sample starting with MLR>300% (N=25)

MJHS Palliative Care: Interdisciplinary “High-Touch” Model

- Early results from Press Ganey survey

→ 84% overall satisfaction at “good” or “very good”
MJHS Hospice and Palliative Care: 
Early Intervention with an ACO & SNF

• Model
  → Collaboration with a Medical Center’s ACO & key SNF’s.
  → Screening and early intervention
  → Goal is to identify and manage unmet needs for symptom control, patient/family support, or discussion about goals and advance care planning

MJHS Hospice and Palliative Care: 
Early Intervention with an ACO & SNF

• Screening
  → Patients placed into “tiers”
    • Tier 1: No acute needs → re-screen in one month
    • Tier 2: Acute need → consultation by palliative care physician or NP, with appropriate follow-up
    • Tier 3: Eligible for hospice services → consultation by palliative care physician or NP to address acute needs plus appropriate discussions with nursing home staff, patient and family about hospice
Expanding Community-Based Palliative Care Across the Care Continuum

• Conclusions

  → Community-based specialist-level palliative care will grow as a capitated care model or as a program ‘upstream’ from hospice

  • As a capitated model, it is advantageous for any partner engaged in a risk model for the care of patients with advanced illness
    – Government payers: Patient-centered medical homes, Health homes, Accountable care organizations
    – Commercial payers: Managed care organizations, clinical integration models

Opportunities for Palliative Care: Case Study

• 62 year old, Mandarin-speaking Chinese woman with Stage IV breast cancer
  → Metastases to lungs and skin with extensive wounds
  → PPS 50%
  → Prior treatment: mastectomy, radiation and multiple chemotherapy regimens.
  → Currently receiving chemotherapy because MD responded to pt/family request for “what else can be done”?

• Lives with husband and 20 year old son in private home
  → Hospital bed in living room but bathroom on the second floor
  → Partial assist all ADLs
  → Husband does daily wound care
Opportunities for Palliative Care: Case Study

- Consultation identified the following problems
  - Uncontrolled pain
  - Breathlessness (oxygen-dependent)
  - Fungating metastatic wounds that were malodorous, itchy and painful
  - Constipation
  - Anxiety
  - Uncertainty about plan of care that would avoid hospitalization

Opportunities for Palliative Care: Case Study

- Plan of care organized through home visits by a nurse practitioner & RN Palliative Care Specialist
  - Opioids for pain and breathlessness
    - Fentanyl and oxycodone
    - Pre-medication for dressing changes
    - Extra medication in a “Care Kit” left in the home
  - Other drugs for pain, itch, constipation, and anxiety
    - Dexamethasone
    - Lorazepam
    - Laxative regimen
Opportunities for Palliative Care: Case Study

• **Wound Treatment Plan**
  → Scheduled showers, with air or pat dry
  → 1% Hydrocortisone cream to inflamed skin
  → Metronidazole powder to open lesions
  → Vaseline gauze over open lesions
  → Cover with absorbent pads

Opportunities for Palliative Care: Case Study

• **Plan of care also included**
  → Discussion regarding treatment options & patient /family care goals.
  → Access to the Palliative Care 24-hour on-call triage service to avoid unnecessary use of emergency services.
  → Palliative Care Social Work Services to provide anticipatory guidance for the husband and son.
Opportunities for Palliative Care: Case Study

- **Plan of care also included**
  - Non-drug therapies for anxiety, pain and breathlessness
  - Discussion about use of 24-hour on-call service to avoid calling emergency services
  - Counseling of husband and son
  - Home visits by other disciplines
    - Chaplain
    - Social worker
    - Hospice Home Health Aides
    - Music therapist

Opportunities for Palliative Care: Case Study

- **Outcome**
  - Pain, breathlessness, anxiety and constipation greatly improved and/or resolved
  - Wound drainage and odor controlled
  - Anxiety improved
  - Aggressive disease modifying Chemotherapy discontinued.
  - Patient / Family Admitted to Hospice
  - *No calls to emergency services and no hospitalizations prior to death*
When Children Are Patients

Meet Samantha “Sammy”

Entering the Mainstream:
Pediatric Palliative Care Comes of Age

• “Sammy” was 6 when diagnosed with Stage 2 Neuroblastoma
• The MJHS Palliative Care Transitional Pediatric Consultation Team was called prior to Sammy undergoing surgery and starting chemotherapy in the hospital
• The Pediatric Oncologist introduced the Palliative Care Peds team to the Sammy and her family, as a resource for support prior to her discharge to home
• The MJHS Peds Palliative Care RN Specialist frequently collaborated with the Hospital team & family prior to discharge.
• Sammy was discharged home after being hospitalized for more than 3 months with a discharge plan to continue receiving outpatient Chemo & Radiation.
**Entering the Mainstream: Pediatric Palliative Care Comes of Age**

**Children are Not Small Adults......**

- Developmental differences among infants, children, and adolescents that affect diagnosis, prognosis, treatment strategies, communication, and decision-making processes, present challenges to adult providers who do not have training or experience in caring for children.

- The MJHS PC team was an added layer of care & focused on assessments and treatment of symptoms at home.

- Six months after her discharge to home, Sammy refused to get out of bed one morning because it “hurt” too much to move.

- The PC Pediatrician started an Analgesic PCA Pump and Sammy was able to start Radiation & another course of Chemotherapy.

---

**Entering the Mainstream: Pediatric Palliative Care Comes of Age**

*Pediatric palliative care affirms life by supporting the child’s and family’s goals for the future including hopes for cure, life prolongation and/or improvement in quality of life.*

- Sammy was able to return to school and finish the school year.

- She was D/C from our Peds PC Program after 12 months & continues to receive disease-modifying therapies.

- Sammy & her two sisters continue to attend weekly groups and are active participants in the MJHS “Art & Soul” Program.

- Since receiving the initial diagnosis, “Sammy” has required only one re-hospitalization for the treatment of sepsis.
Lessons Learned

• **Critical success factors**
  → Contracts Executed
  → Pilots Initiated
  → Cost Savings for MCO / ACO Achieved
  → Positive ROI Achieved

Lessons Learned

• **Challenges:**
  → Negotiating Rates **without History of Cost Savings**
  → Data Mining with MCO’s / ACO’s
  → Accessing Member Information
  → Resources Needed
  → Establishing Billing Mechanisms
  → Establishing Documentation Requirements
  → Credentialing of Community- Based Palliative Care Specialist
Lessons Learned

• Failures:

→ Willingness to be transparent with data results and obtain comprehensive ROI results.

→ Willingness to renegotiate a contract with Risk Sharing based on Cost Savings, until the Plan has experience with your results.

Questions

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In a study that sheds new light on the effects of end-of-life care, doctors have found that patients with terminal lung cancer who began receiving palliative care immediately upon diagnosis not only were happier, more mobile and in less pain as the end neared — but they also lived nearly three months longer.

The findings, published online Wednesday by The New England Journal of Medicine, confirmed what palliative care specialists had long suspected. The study also, experts said, cast doubt on the decision to strike end-of-life provisions from the health care overhaul passed last year.

“It shows that palliative care is the opposite of all that rhetoric about ‘death panels,’ ” said Dr. Diane E. Meier, director of the Center to Advance Palliative Care at Mount Sinai School of Medicine and co-author of an editorial in the journal accompanying the study. “It’s not about killing Granny; it’s about keeping Granny alive as long as possible — with the best quality of life.”

In the three-year study, 151 patients with fast-growing lung cancer at Massachusetts General, one of the nation’s top hospitals, were randomly assigned to get either oncology treatment alone or oncology treatment with palliative care — pain relief and other measures intended to improve a patient’s quality of life. They were followed until the end of 2009, by which time about 70 percent were dead.

Those getting palliative care from the start, the authors said, reported less depression and happier lives as measured on scales for pain, nausea, mobility, worry and other problems. Moreover, even though substantially fewer of them opted for aggressive chemotherapy as their illnesses worsened and many more left orders that they not be resuscitated in a crisis, they typically lived almost three months longer than the group getting standard care, who lived a median of nine months.

Doctors and patients “traditionally see palliative care as something extended to a hospitalized patient in the last week of life,” said Dr. Jennifer S. Temel, an oncologist and author of the paper. “We thought it made sense to start them at the time of diagnosis. And we were thrilled to see such a huge impact. It shows that palliative care and cancer care aren’t mutually exclusive.”

Dr. Atul Gawande, a Harvard Medical School surgeon and writer who just published a long article in The New Yorker about hospitalized patients’ suffering before death, called the study “amazing.”

“The field was crying out for a randomized trial,” he added.

Although the study could not determine why the patients lived longer, the authors and other experts had several theories: depression is known to shorten life, and patients whose pain is treated often sleep better, eat better and talk more with relatives. Also, hospitals are dangerous places for very sick people; they may get fatal blood infections, pneumonia or bedsores, or simply be overwhelmed by the powerful drugs and radiation attacking their cancer.

Saying the study was “of critical importance,” Dr. R. Sean Morrison, president of the American Academy of Hospice and Palliative Medicine, said it was the “first concrete evidence of what a lot of us have seen in our practices — when you control pain and other symptoms, people not only feel better, they live longer.”

There is sometimes tension between medical specialties, since surgeons and oncologists often view cancer as a battle, while palliative care specialists are seen as “giving up.”
Palliative care typically begins with a long conversation about what the patient with a terminal diagnosis wants out of his remaining life. It includes the options any oncologist addresses: surgery, chemotherapy and radiation and their side effects. But it also includes how much suffering a patient wishes to bear, effects on the family, and legal, insurance and religious issues. Teams focus on controlling pain, nausea, swelling, shortness of breath and other side effects; they also address patients’ worries and make sure they have help with making meals, dressing and bathing when not hospitalized.

Hospice care is intensive palliative care including home nursing, but insurers and Medicare usually cover it only if the patient abandons medical treatment and two doctors certify that death is less than six months away.

During the debate over President Obama’s 2009 health care bill, provisions to have Medicare and insurers pay for optional consultations with doctors on palliative and hospice care led to rumors, spread by talk-show hosts like Rush Limbaugh and Glenn Beck and by the former vice-presidential candidate Sarah Palin, that the bill empowered “death panels” that would “euthanize” elderly Americans.

Legislators eventually removed the provisions. In practice, Medicare and private insurers do pay for some palliative care, said Dr. Gail Austin Cooney, a former president of the palliative medicine academy. “But it’s piecemeal,” she said. “The billing is complicated, and for many physicians that’s enough of a deterrent to not bother.”

Dr. Cooney herself had such care along with surgery and chemotherapy for ovarian cancer in 2008.

“I decided I wanted every drop of chemotherapy they could give me, and it was very painful, dumping the drugs directly into my belly,” she said. She needed powerful painkillers, and also chose alternative-medicine options like acupuncture and “energy work” for nausea and fatigue.

“I’m rigid — I had my last chemo treatment on Christmas Eve because I wanted it on the day I was due for it,” she said. “But I couldn’t have completed the program without the psychosocial support.”

Palliative care experts now want to study patients with other cancers, heart disease, stroke, dementia and emphysema. But the National Institutes of Health is under budget pressure, and the other major source of money for medical research, the pharmaceutical industry, has little incentive to study palliative care. This trial was paid for by the American Society of Clinical Oncology and private philanthropy.

“Philanthropists tend to focus on curing cancer,” Dr. Temel said. “But we can’t ignore people who need end-of-life care.”

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NAHC Annual Meeting
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Emerging Healthcare Facts

**Population Health: Defined**

1. Care Continuum Alliance: definition of population health improvement:

   *The population health improvement model highlights three components: the central care delivery and leadership roles of the primary care physician; the critical importance of patient activation, involvement and personal responsibility; and the patient focus and capacity expansion of care coordination provided through wellness, disease and chronic care management*

2. The federal Agency for Healthcare Research and Quality (AHRQ) has developed a concept called “practice-based population health” (PBPH).

   *PBPH is “an approach to care that uses information on a group of patients within a primary care practice or group of practices to improve the care and clinical outcomes of patients within that practice.”*

3. Loyola University New Orleans

   *Population-focused health care... refers to assessing the health care needs of a specific population and making health care decisions for the population as a whole rather than for individuals. Populations being treated are made up of individuals who have one or more personal or environmental trait in common.”*

**Commonalities in Definitions:**

1. Population health is seen as more than the sum of individual parts or a cross-sectional perspective.
   - Upstream factors are included in the measurement of population health, for instance, not just health outcomes.
   - Holistic focus

2. The population health perspective requires the consideration of a broader array of the determinants of health than is typical in either health care or public health.
   - emphasis on health promotion and disease prevention as well as on interventions focusing on upstream factors rather than outcomes.
   - recognizes the role of health care and of personal prevention services as part of the population health production system

3. The population health perspective recognizes that responsibility for population health outcomes is shared but that accountability is diffuse.
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ACO Facts:

- Origin of the Accountable Care Organization
  March 23, 2010 Patient Protection and Affordable Care Act includes provisions designed to:
    - Improve Quality of Medicare Services
    - Support Innovation and the Establishment of New Payment Models in the Program
    - Better Align Medicare Payments with Provider Costs
    - Strengthen Program Integrity within Medicare
    - Put Medicare on a Firmer Financial Footing

- The number of ACOs in the United States now exceeds 600.
- All states and DC-CA, FL,TX have largest number
- The total number of ACO-covered lives is approximately 20.5 million.
- Physician-led ACOs:
  - Most are participating in MSSP, not the Pioneer ACO program
  - Less likely to include a hospital, federally qualified health center, or rural clinic
  - Less likely to provide emergency and post-acute care services
- ACOs that meet quality performance standards are eligible to receive payments for “shared savings”
- Who can Participate in an ACO?
  - ACO professionals in group practice arrangements
  - Networks of individual practices of ACO professionals
  - Partnerships or joint venture arrangements between hospitals and ACO professionals
  - Hospitals employing ACO professionals
  - Such other groups of providers of services and supplies as the Secretary deems appropriate
- ACO Participation Requirements:
  - Accountable for quality, cost, and overall care of Medicare beneficiaries assigned to it
  - Participate for not less than a 3 year period
  - Formal legal structure
  - Allows organization to receive and distribute payments for shared savings
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- Includes primary care ACO professionals sufficient for number of Medicare beneficiaries assigned to it
- Minimum of 5,000 Medicare beneficiaries to be eligible to participate in shared savings program
- ACO must provide the Secretary with information regarding participating professionals to support the assignment of Medicare FFS beneficiaries to the ACO, implementation of quality and other reporting requirements and determination of payments for shared savings
- ACO must have in place a leadership and management structure that includes clinical and administrative systems
- Define processes to:
  - Promote evidence-based medicine and patient engagement
  - Report on quality and cost measures
  - Coordinate care
- Use of Technology to include telehealth, remote patient monitoring, and other such enabling technologies
- Demonstrate to the Secretary that it meets patient-centeredness criteria such as use of patient and caregiver assessments or the use of individualized care plans

ACO Quality Measures:

- Under the CMS ACO initiatives, before an ACO can share in any savings created, it must demonstrate that it met the quality performance standard for that year.
- There are also interactions between ACO quality reporting and other CMS initiatives, particularly the Physician Quality Reporting System (PQRS) and meaningful use. There are 33 quality measures, which span four quality domains: Patient / Caregiver Experience, Care Coordination / Patient Safety, Preventive Health, and At-Risk Population.
  - Of the 33 measures, 7 measures of patient / caregiver experience are collected via the CAHPS survey, 3 are calculated via claims, 1 is calculated from Medicare and Medicaid Electronic Health Record (EHR) Incentive Program data, and 22 are collected via the ACO Group Practice Reporting Option (GPRO) Web Interface.
  - Preventive Health and At-Risk Population(8 Measures)
- Additional measures being monitored include:
  - Diabetes (1 measure and 1 composite consisting of five measures)
  - Hypertension (1 measure)
  - Ischemic Vascular Disease (2 measures)
  - Heart Failure (1 measure)
  - Coronary Artery Disease (1 composite consisting of 2 measures)

Other Reform Initiatives:
Bundled Payments for Care Improvement (BPCI)

• January 31, 2013, the Centers for Medicare & Medicaid Services (CMS) announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative, an innovative new payment model.

• Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care.

• These models may lead to higher quality, more coordinated care at a lower cost to Medicare
  o Model 1: Retrospective acute hospital stay only
  o Model 2: Retrospective acute and post acute episode
    ✓ Inpatient and all related services
    ✓ 30/60/90 episode periods
  o Model 3: Retrospective post acute care only
    ✓ begins within 30 days of an acute stay
    ✓ 30/60/90 episode periods
  o Model 4: Prospective acute care hospital stay only

Health Innovations Awards Program

• Test care delivery models to reduce costs and improve outcomes
• Reduce costs for Mcre and Mcd
• Improve care for populations with special needs
• Testing improved financial and clinical models for specific types of providers
• Linking clinical care delivery to prevention and population health
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GLOSSARY of TERMS

ACO - Accountable Care Organizations. An IDS with payer services.

ACO - Practitioners, insurance companies, HMOs, hospitals jointly assume responsibility for delivering medical care. Physicians and other providers would either work for or contract with these health plans.

Affordable Insurance Exchanges - Certain workers apply employer contributed funds to purchase a more affordable plan in the Exchange.

AHP - When an IDS operates one or more health insurance benefit products, or a managed care organization acquires a large scale medical delivery component, it qualifies as an Accountable Health System or Accountable Health Plan.

AHS - Accountable Healthcare System describes an IDS with a financing component. In the 1994 debate on health care reform, the proposed system of managed competition provided for an Accountable Health Plan that would have combined delivery and financing, and assumed accountability for patient care. ACOs are a more current term and Medicare is promoting this model for Medicare Managed Care.

Capitation - The method of payment in which the provider is paid a fixed amount for each person served no matter what the actual number or nature of services delivered. The cost of providing an individual with a specific set of services over a set period of time, usually a month or a year.

Carve-Out - Hospice is now a ‘carve-out’ for Medicaid and Medicare managed care. The payer separates, carves-out, the benefit and allows an outside organization to provide the benefit.

Case Management - Ensures continuity of services & access. Overcomes rigidity, fragmented services, and mis-utilization of resources. Matches the intensity of services with the patient's needs.

Choices Model – Medicare Palliative Care Demonstration – patients receive palliative care provided by hospices concurrently with curative treatments.

DSRIP – Delivery System Reform Incentive Payment program. For a list of DSRIP acronyms, go to https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_glossary.pdf

FIDA - Fully Integrated Duals Advantage program, i.e., NYS model for MLTC members eligible for both Medicaid and Medicare.

Formulary - A list of pharmaceuticals and dosages believed to be most useful and cost effective. Organizations develop a formulary under the aegis of a pharmacy and therapeutics
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committee.

HARP – Health and Recovery Plans, distinctly qualified specialized and integrated managed care product for individuals with significant behavioral health needs

HEDIS – Tool for measurement and reporting of clinical and quality outcomes

HMO - Health Maintenance Organization

IDS - Integrated Delivery Systems, i.e., Mayo, Geisinger, Kaiser, Guthrie

MAP - Medicare Advantage Program-Managed Medicare

MCO - Managed Care Organization

MCP - Managed Care Program

MLR – Medical Loss Ration

MLTCP - Managed Long Term Care Program-Generally Medicaid

MMCP - Medicaid Managed Care Program

MRT - New York State Medicaid Redesign Team

NCQA – National Commission for Quality Assurance

PCIP - Pre-Existing Condition Insurance Plan provides coverage options for uninsured because of a pre-existing condition until 2014. Pre-existing condition clauses ‘go away’ in 2014.

PMPM - Per Member Per Month is a revenue or cost for each enrolled member each month.

PPO - Preferred Provider Organization

SNP - Special Needs Plans. Medicare, Medicaid or dual eligible plans for the population with unique needs, i.e., Behavioral Health, HIV and/or Traumatic Brain Injury.

VBP - Value-Based Purchasing links provider payments to improved performance and holds health care providers accountable for both the cost and quality of care they provide. It aims to reduce in-appropriate care and identify and reward best-performing providers.