WHAT DOES IT TAKE TO SCALE HOME-BASED PALLIATIVE CARE?

LESSONS LEARNED (SO FAR) FROM AN IMPLEMENTATION EVALUATION OF THE ROLLOUT OUT OF HBPC IN THE BAY AREA

Gary Bacher, JD/MPA, Founding Member, Healthsperien
Torrie Fields, MPH, Senior Program Manager, Blue Shield of California
Mollie Gurian, JD/MPH, Director of Health Policy and Strategy, Healthsperien
IMPLEMENTATION EVALUATION TEAM

Valora Consulting
Organizational Development & Change Management
**Health plan cases**
What does it take to build a set of services for home-based palliative care?

- Business case
- Contracting
- Change management
- Internal work flow processes
- External policy environment

**ACO & Community-Based Palliative Care Provider Cases**
What does it take to create clinical and administrative capacity to deliver home-based palliative care?

- Business case
- Contracting
- Change management
- Internal work flow processes
- Coordination across sites
- Multiple payer partners
CONTEXT FOR GRANT
**THE PROBLEM:**

**“The Big Gap”**

<table>
<thead>
<tr>
<th>What People Want</th>
<th>What They Get</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Be at home with family, friends</td>
<td>Recycled through unwanted care settings</td>
</tr>
<tr>
<td>2. Have pain managed</td>
<td>Often unwanted, ineffective treatment</td>
</tr>
<tr>
<td>3. Have spiritual needs addressed</td>
<td>Often die in hospital, in pain and isolation</td>
</tr>
<tr>
<td>4. Avoid impoverishing families/being a burden</td>
<td>At great cost to families and the nation.</td>
</tr>
</tbody>
</table>
**MISMATCH IN CARE SETTING AND SOLUTION**

Palliative care -- specialized medical care for seriously ill patients that focuses on pain and symptom relief as well as psychosocial and spiritual support—is effective in improving pain and symptom control and quality of life, while decreasing healthcare utilization and costs of medical care.

Recent systematic reviews have concluded that patients and caregivers benefit when palliative care is provided in the home.

However, most palliative care programs are hospital-based, offering only episodic care.

This gap represents “a mismatch between the services patients and families need and the services they can obtain” because most seriously ill patients spend the majority of their last year of life at home.
CALIFORNIA: VALUE-BASED PAYMENT IN THE PRIVATE SECTOR

2015 data on participation in value-based pay for performance arrangements

<table>
<thead>
<tr>
<th>$500m paid out</th>
<th>200 Medical Groups and IPAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35,000 physicians</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 Plans</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>9 Million Californians</th>
</tr>
</thead>
</table>

[Image of healthcare plans and groups]
Sharp Program Helps Elderly San Diegans Get Medical Care At Home

Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care

Richard Storlency, MD, Anne Englund, PhD, MPH, Joaquina Lamont, BA, Raw Stolte, MD, Nora Musgrove, MD, Sherry Sato, MD, Jan McAdams, MSW, Krysta Hillery, BSN, RN, and Jorge Gonzalez, BA

Sutter Health’s AIM Engages Patients, Saving Millions in Chronic Care Costs

By helping patients better manage their advanced illnesses and connect with their primary care physicians, Sutter Health’s AIM program is improving quality of life and reducing unnecessary ED visits and hospitalizations.

California Goes Furthest

California has done more than other states to encourage palliative care. Since 2001, California has required most physicians to complete 12 hours of continuing education courses in pain management. And in 2014, it enacted a law making palliative care services available to the state’s Medicaid managed care population, which represents about three-quarters of the state’s Medicaid beneficiaries, or 10 million people.

The challenge now is to take the lessons learned from smaller scale initiatives (like pilots) in California and elsewhere to identify the most beneficial and cost-effective models for delivering palliative care and to scale and replicate them for wider dissemination and adoption.

Evidence for home-based palliative care program outcomes has come from integrated delivery systems – Kaiser and the VA.

While the evidence from integrated systems provides strong proof of concept, there is a dearth of information about how to translate this model to an open system with myriad players and new contractual relationships and regulations.
TRANSLATING HOME-BASED PALLIATIVE CARE INTO A NON-INTEGRATED ENVIRONMENT POSES CHALLENGES IN IMPLEMENTATION, FEASIBILITY, AND SCALABILITY, PARTICULARLY IN RELATION TO:

- Contractual arrangements
- State and federal regulations (particularly those related to the provision of services in the home), and
- Organizational cultures in both provider and payer institutions.

PARTICULAR INTEREST IN “COMMERCIAL ACO” ENVIRONMENT GIVEN OVERALL FIELD’S FOCUS ON POPULATION HEALTH

BOTH WHAT HAPPENS AND OTHER OPTIONS:

- The rationales, decision points and processes used to guide and evaluate plans, actions and consequences.
## PROJECT GOAL

One differentiating aspect of this work will be its interdisciplinary focus on:

- Identifying and addressing increasingly recognized but difficult to surface implementation and operational barriers
- If these barriers are left unaddressed, threaten efforts to replicate and scale HBPC programs and improve patient, family, and caregiver access to these programs

This information will be summarized into a set of tools for use by both payers and providers to achieve:

- Feasibility, replicability, and sustainability of these programs
- Widespread adoption of HBPC by the growing number of payers and providers who operate under these and similar alternative payment models
Blue Shield as an example of a health plan implementing a home-based palliative care program and is making organizational decisions about that program both internally and with provider partners.

Other health plans or partners may make different decisions.

*How and when* key decisions arise.

*What* considerations Blue Shield and partners have and are undertaking.

*Why* each party has and continues to make certain choices.

*Other* potential options.

This is an iterative and ongoing process.
STRUCTURING OUR WORK
OVERALL CONCEPT MAP

Core Issues
- Rationales
- Resolutions
- Tradeoffs

Context
- Internal
- External

Overall Healthcare Environment
ILLUSTRATIVE HEALTH PLAN STRUCTURE

C-Suite

Product, Provider Network, & Contracting

Shared Services

Medical Management

Contracting
Claims
Audit/Evaluation
Claims
Eligibility Services,
Payment Reporting

Actuarial
Health Informatics
IT
Legal
Sales/Marketing
Communications
Quality Improvement

Clinical Functions
Utilization Management
Case Management
Direct Services to Members and Employers
INTEGRATING PALLIATIVE CARE

Health Plan Goals → Departmental Goals → Global goals of a program or benefit (i.e. home-based palliative care)?

Stakeholder Goals → Provider Partner Goals → Impact of program (i.e. home-based palliative care)
EXAMPLE: BLUE SHIELD, THE ACO PROGRAM, AND THE “GOALS”
BLUE SHIELD’S PALLIATIVE CARE STRATEGY FOR ACOS

- 43 Accountable Care Organization agreements
- 25 counties
- Over 300,000 covered lives
- Palliative Care included as a fundamental strategic component of all ACO agreements (see clinical core 4)
- Home-based palliative care capacity will be a requirement by 2020
- Where we have an existing ACO, we expect palliative care be provided to all Blue Shield members, regardless of risk
Clinical Strategy: “Core Four”

1. Advanced Facility Care
   Optimal care delivery when in the facility

2. Home care
   Focuses on patients who are elderly, frail or too sick to regularly tolerate travel

3. High risk clinics
   Provide care to patients with comprehensive and complex needs

4. Care Management & Coordination
   Serves as the glue/safety net/traffic cop for all patients based on stratification

In conjunction with optimized primary & specialty care
HOW DO YOU GET TO IMPACT?:
FUNDING & SUPPORT FOR PALLIATIVE CARE

- Partnerships to educate and support palliative care throughout our delivery system, anchored in our existing ACO teams
  - Provided to all lines of business, regardless of risk arrangement

- ACO delivery transformation
  - Implementation support & up-front funding
  - Clinical training through reputable sources
  - Prospective member identification
  - PMPM case rate for outpatient & home-based models

- Home care design in a non-integrated environment
  - Partnerships between medical groups and home health or hospice agencies
  - Home-based teams not required to be led by a board certified physician in hospice & palliative medicine
WORKING WITHIN PLAN GOALS: ALIGNMENT WITH SHARED SAVINGS INCENTIVES

- Achievement of broadly aligned goals:
  - Improved patient and family experience
  - Improved quality of care
  - Reduced total cost of care
  - Reduced unwanted medical services
- Palliative care PMPM claims and implementation costs are built into the shared savings calculations as costs of healthcare
- Claims able to be tracked as professional fees, included in shared savings calculations
- Quality and satisfaction targets for additional achievement of quality incentive payment—increase the split of shared savings
- Full program evaluation provided through funding from PCORI (5 years), Stupski Foundation (2 years) & West Health Foundation (2 years)
ACO team example

Blue Shield Provides Multi-disciplinary Team to support ACOs
Palliative Care Program has to figure out how to operationalize within processes that already exist to support the ACOs
EXAMPLES OF MANAGING CHANGE: DEVELOPING A DME WORKFLOW

Issue: Health plan has a preferred DME vendor

• Many of the community based providers being contracted by Blue Shield are hospices who have their own pre-existing relationships for DME as they are responsible for it under their hospice per diem.

Issue: Building on existing relationships and contracts

• Between health plan and ACO partners
• Between health plan and community based providers (often as a hospice, but also physician group provider, hospital-based provider, or home health agency)
• ACO entity and community based provider
• Individual providers (ie primary care providers) and community based providers

Issue: 3 S’s

• Scale
• Speed
• Sustainability
EXAMPLES OF MANAGING CHANGE: DME PROCESS – HIGH LEVEL

**HMO**
- CBPC orders DME
- Medical Group auths DME
- Plan pays for DME

**PPO**
- CBPC orders DME
- Plan auths DME
- Plan pays for DME

**MA**
- CBPC orders DME
- Plan auths DME
- Plan pays for DME

**CBPC = Purple**
**Medical Group = Green**
**Blue Shield = Blue**
**Hospital = Orange**
### DME Process – Closer Look

#### Example of What Stupski Team Considers:
- **What decisions did Blue Shield make?**
  - Eg. having a preferred vendor
  - Having medical group auth at home level
- **Who is involved to make this process happen internally?**
- **What decisions did partners make?**
  - How does that impact ability to scale?
- **Evolution over time**
- **Evaluation of other options**

#### DME – Standard Items Used by SLH:
- Alternating Pressure Pump
- Bed Cradle
- Bed Rails - half
- Cane (Straight or Quad)
- Commode 3-in-1
- Concentrator Slpm
- E-Cylinder Backup & Cart
- E-Regulator
- Full Electric Bed (w or w/o extension)
- Somo Suction Unit
- Oxygen Conserving Device
- Shower Chair
- Suction Machine
- SVN Machine
- Transfer Bench
- Trapeze (bed mount or free standing)
- Walker (w or w/o seat)
- Wheelchair (16”, 18”, 20”, 22”, 24”)
- Wheelchair (Hemi, LW, High Back, Recl., Comp.)

#### Items Requiring Pre-authorization - Rental
- Bariatric Bed
- BIPAP
- CPAP
- Compressor 50psi
- Concentrator 10l
- Feeding Pump and Pole
- Geri Chair w/Tray
- Hoyer Lift (Manual)
- Low Air Loss Mattress
- Mobi Suction Unit
- Bed Alarm
- Floor Pads

#### Items Requiring Pre-authorization - Purchase
- APP Pad
- Commode Pail
- Cylinder Refill “E”
- Cylinder Refill “M6”
- Feeding Bags
- BIPAP or CPAP Mask

---

The information contained in this facsimile message may be confidential, proprietary and/or legally privileged information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any copying, dissemination, or distribution of confidential, proprietary or privileged information is strictly prohibited. If you have received this communication in error, please immediately notify the sender by telephone, 530-621-7829, and we will arrange for the return of the facsimile. Thank you.
THE WORK CONTINUES…
Scalability

- When a program is built sustainably, palliative care is treated as a standard service, monitored and evaluated in the same way.
- Built in standard claims processing, pharmacy expedited approval, and supplies/DME prior authorization approval systems to reduce administrative overhead.
- Removed prior authorization for enrollment; implemented audit process.

Trade-offs

- Not as close to our palliative care programs and providers.
- Increased up-front risk of inappropriate enrollment, duplication of services.

Stupski Team is:
1) Documenting these and other hypotheses being tested; and
2) Highlighting potential alternative options for plans and providers to test.
QUESTIONS?

Thank you

- Gary Bacher: gbacher@healthsperien.com
- Mollie Gurian: mgurian@healthsperien.com
- Torrie Fields: torrie.fields@blueshieldca.com