the Playbook

Better Care for People with Complex Needs

Strengthening the Payer-Provider Relationship for Value-Based Success in Home- and Community-Based Palliative Care

Sept 10, 2021, 12:00-1:30 pm ET

Made possible with support from the Seven Foundation Collaborative — Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, the Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation.

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Questions?

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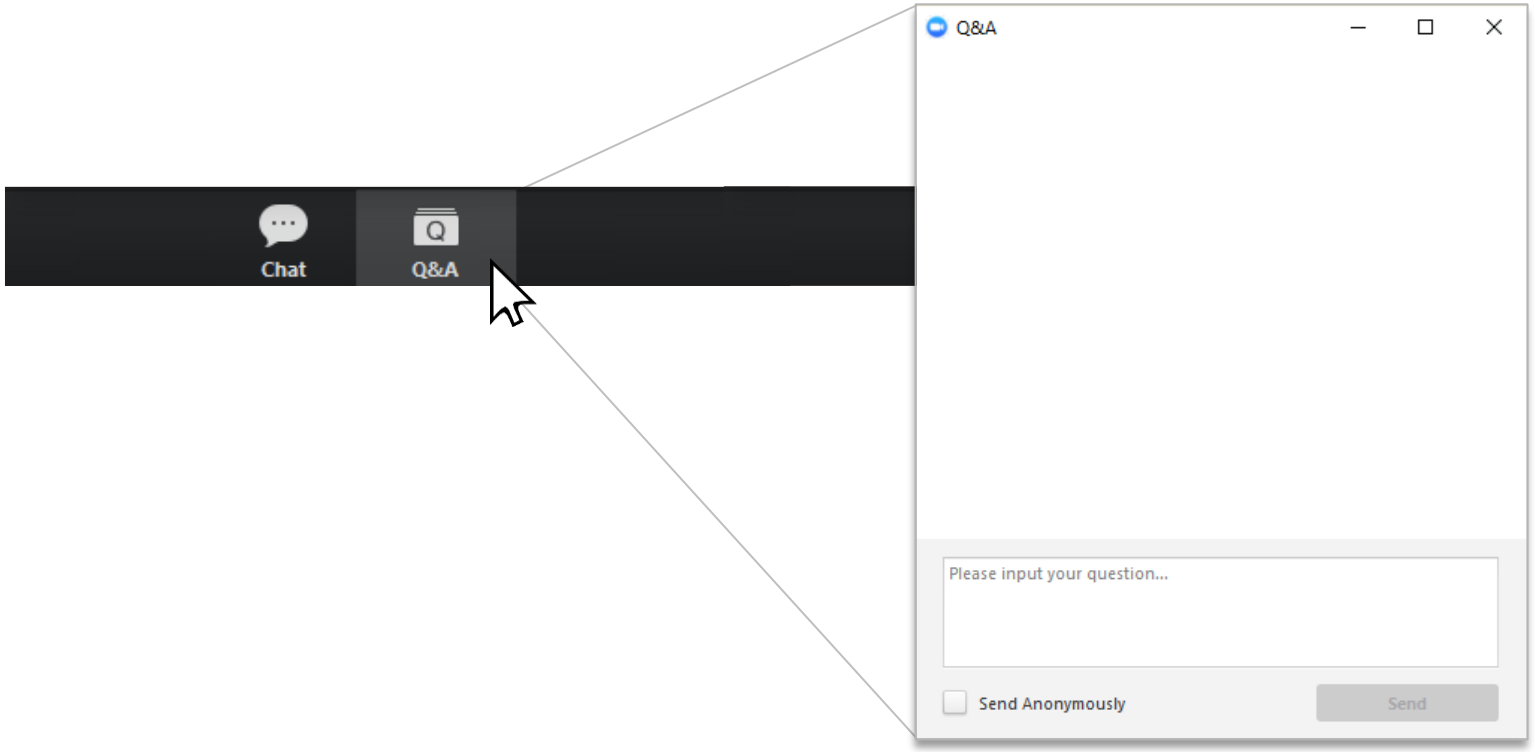

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Better Care for People with Complex Needs

Welcome & Introductions

About the Better Care Playbook

Robust online resource center offering the latest knowledge on evidence-based and promising practices for people with complex health and social needs

Provides practical how-to guidance to inform health system leaders, payers, policymakers and others on strategies to improve care for high-need, high-cost populations

Coordinated by the Center for Health Care Strategies through support from seven leading national health care foundations — **Arnold Ventures, The Commonwealth Fund, The John A. Hartford Foundation, the Milbank Memorial Fund**, **Peterson Center on Healthcare**, **the Robert Wood Johnson Foundation**, and **The SCAN Foundation**.

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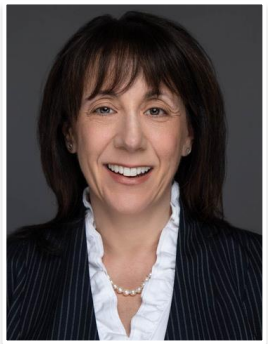
Agenda

- Welcome and Introductions
- Overview of Home-and Community-Based Palliative Care
- **Hosparus Health:** Defining and Growing a Palliative Care Service Line
- **Presbyterian Healthcare Services:** Integrating Palliative Care in Home and Community Care Models
- **Highmark Health:** Using Data to Drive Decision and Improve Quality in Palliative Care
- Implications for Payers and Providers and the Path Forward
- Moderated Q&A

Today's Presenters

Bethany Snider, MD, HMDC, FAAHPM
Chief Medical Officer
Hosparus Health



Emily Jaffe, MD
Executive Medical Director
Helion (Highmark Health)

Nancy Guinn, MD
Medical Director of Clinical Transformation, Population Health
Presbyterian Health Services

Torrie Fields, MPH
Founder and CEO
Votive Health

Overview of Home- and Community-Based Palliative Care

- Palliative care is aimed at providing relief from the symptoms and stress of serious illness
  - Can be provided in diverse care settings
  - Involves an interdisciplinary care team
  - Not dependent on patient prognosis but rather the patient's goals of care
- The need for home-and community-based palliative care is increasing:
  - US population is aging, as is the number of individuals with serious illness
  - Between 2011 and 2020, the prevalence of homebound adults aged 70 years or older more than doubled
  - Many patients prefer to be treated and to die at home

Evidence and Challenges

- Evidence of positive outcomes
  - » Fewer ED and hospital admissions
  - » Reduced overall cost of care
  - » High levels of patient satisfaction
  - » Increased access to palliative care
  - » Increased enrollment in hospice care

- Key challenges experienced by providers and payers
  - » Identifying the target patient population
  - » Determining a service model and coordinating care
  - » Developing a resilient and adaptive care team
  - » Building a financially stable service

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Defining and Growing a Palliative Care Service Line

Bethany Snider, MD, HMDC, FAAHPM

Chief Medical Officer, Hosparus Health

Pallitus Health Partners

A Division of Hosparus Health

Bethany Snider MD HMDC FAAHPM

SVP/Chief Medical Officer

PALLITUS™
HEALTH PARTNERS

PALLITUS
HEALTH PARTNERS

Pallitus Health Partners, a part of **Hosparus Health**, offers specialized palliative care for those with serious illness.

Specialized services include: expert symptom management, disease specific programs, advance care planning and care coordination.

Focused on strategic partnerships with payors and ACOs to improve quality of life at a lower cost to the system

Founded in **1978**

A **not-for-profit provider**

Served over **9000 patients** *in 2020*

Serving **Kentucky & Indiana**

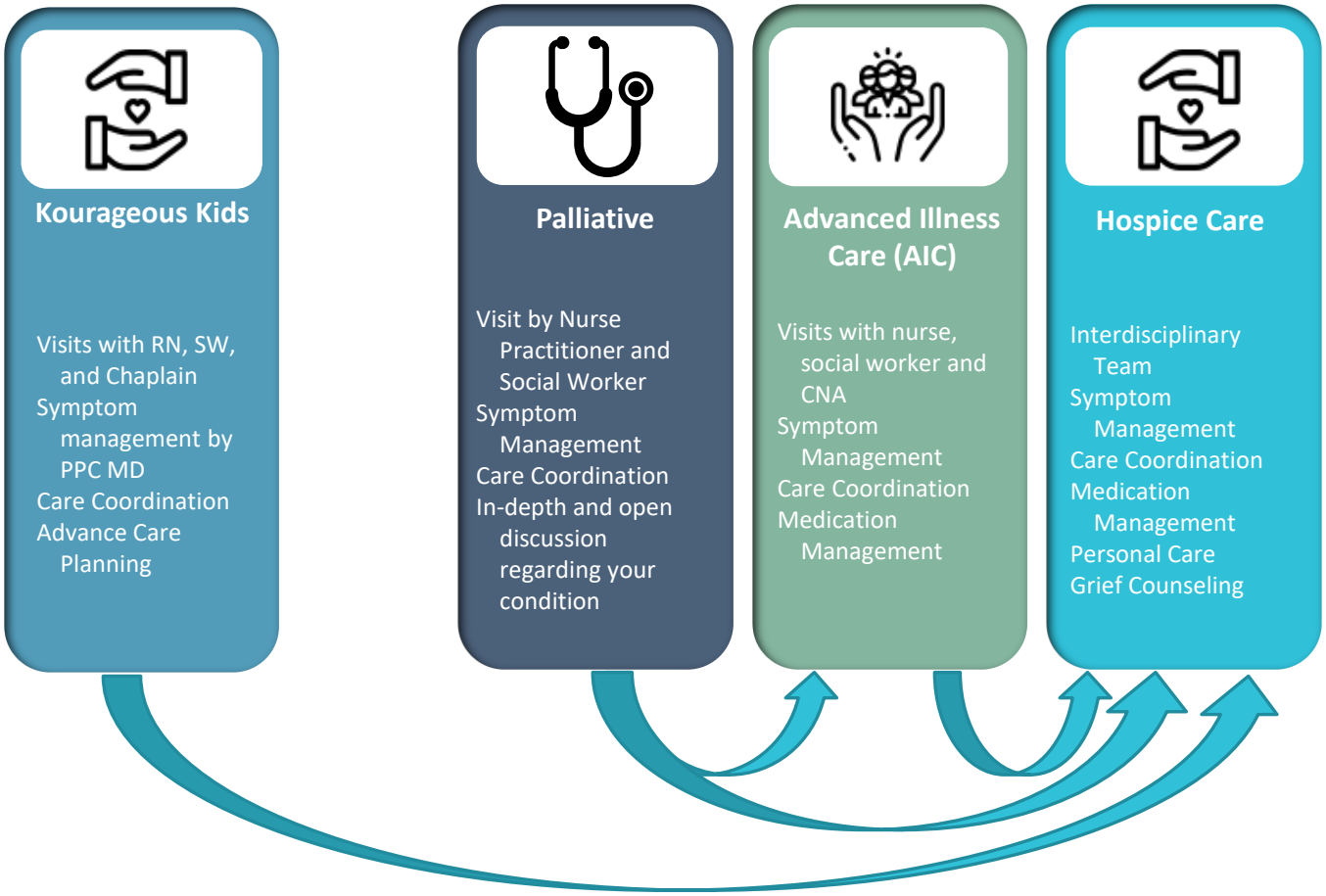
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

VBID Hospice Carve-In Participant

NPHI National Partnership for Hospice Innovation
The not-for-profit voice for advanced illness, hospice, and palliative care

NHPCO Member

Palliative Care Programs



Our Palliative Care Journey

PALLITUS HEALTH PARTNERS

2016

- Reinvested in palliative care
- Launched first value-based model with payor
- Launched first team-based model

2018

- Launched MD/NP Consult program and continued to expand team model geographically
- Ongoing negotiations for value-based models

2019

- MD/NP Consult program doubled # of patients served
- Launched second value-based arrangement but with health system and payor partnership (Advanced Illness Care)

430 Patients Served
Adult Palliative Programs

2020

- AIC program growing to serve more patients
- Redesign of community-based model due to data from consult and team-based models

2021

- Launched VBID program with Humana as a palliative and hospice provider
- AIC program demonstrates success both financially and clinically

AIC saving >50% in inpatient spend

Rebrand of palliative business led to exponential growth

Patient Experience Outcomes

PATIENT SATISFACTION

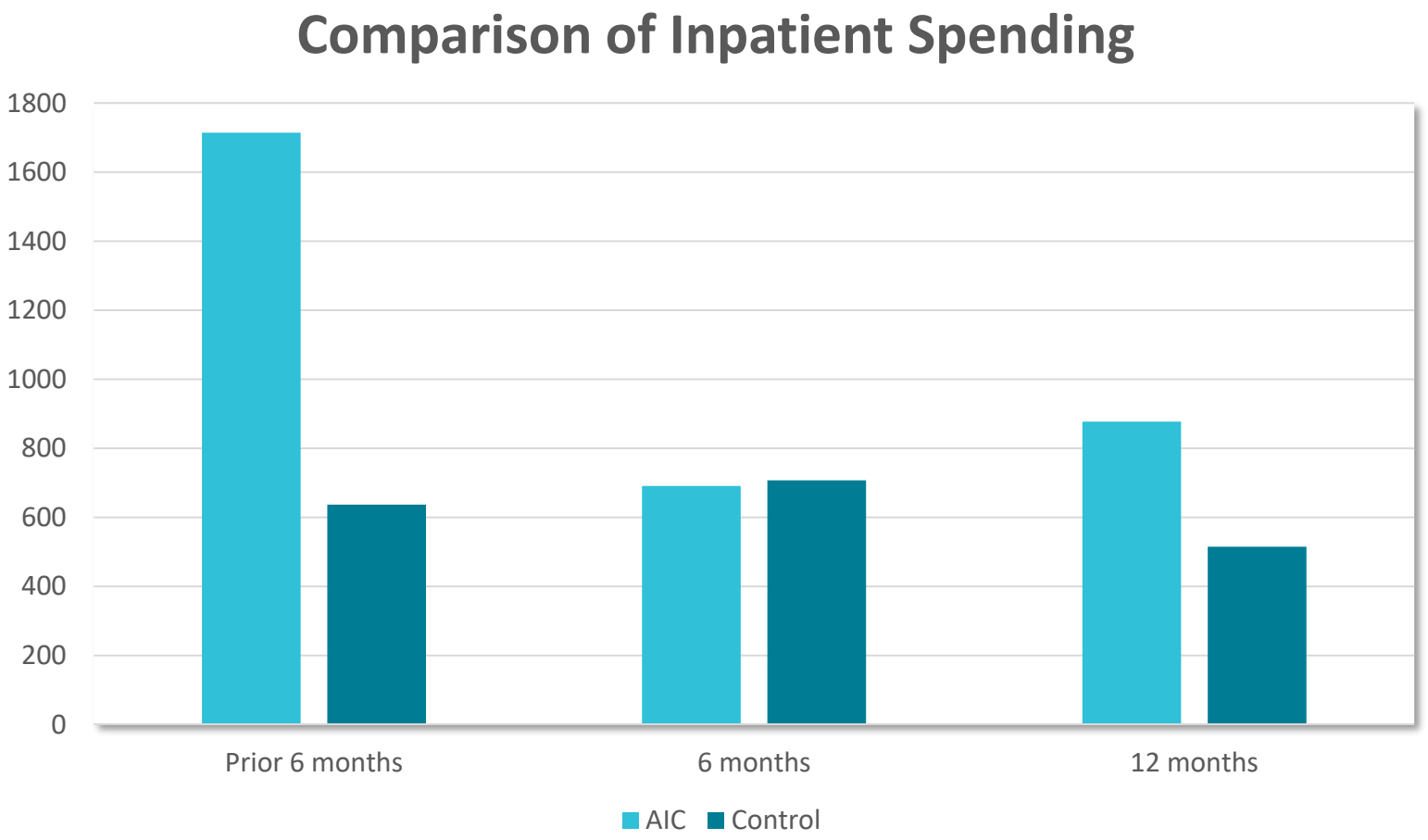
Impact on quality of life

	4 MONTH	6 MONTH	8 MONTH
IMPACT ON QUALITY OF LIFE:	84%	100%	100%
(1 TO 5) PT SATISFACTION:	4.8	5	5

PROGRAM TOTALS

	4 MONTH	6 MONTH	8 MONTH
IMPACT ON QUALITY OF LIFE:	85.8%	84.6%	93.9%
(1 TO 5) PT SATISFACTION:	4.7	4.5	4.7

Financial Outcomes



Over 50% reduction of inpatient spending that sustained for 12 months

Enhanced Services to Meet Outcomes

Specialty Disease Management Programs

Heart Connect

The Lung Care Program

Dementia Care

Telehealth via TapCloud

A virtual health platform that offers video, telephone, symptom tracking and electronic monitoring capabilities

Lessons Learned Through Innovation

1. Filling a need for population not served by hospice care
2. Strategic partnerships are critical with aligned incentives
3. Expert symptom management through co-management drives outcomes
4. Positive patient experience is enhanced with technology
5. Less healthcare utilization requires crisis management and addressing social determinants of health

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Integrating Palliative Care in Home and Community Care Models

Nancy Guinn, MD

Medical Director of Clinical Transformation, Population Health, Presbyterian Healthcare Services

Models of Care for Home-Based and Palliative Patients

Presbyterian Healthcare Services, New Mexico

Nancy Guinn, MD, Medical Director, Clinical Transformation, Population Health

PRESBYTERIAN

Presbyterian Healthcare Services

114 years in New Mexico

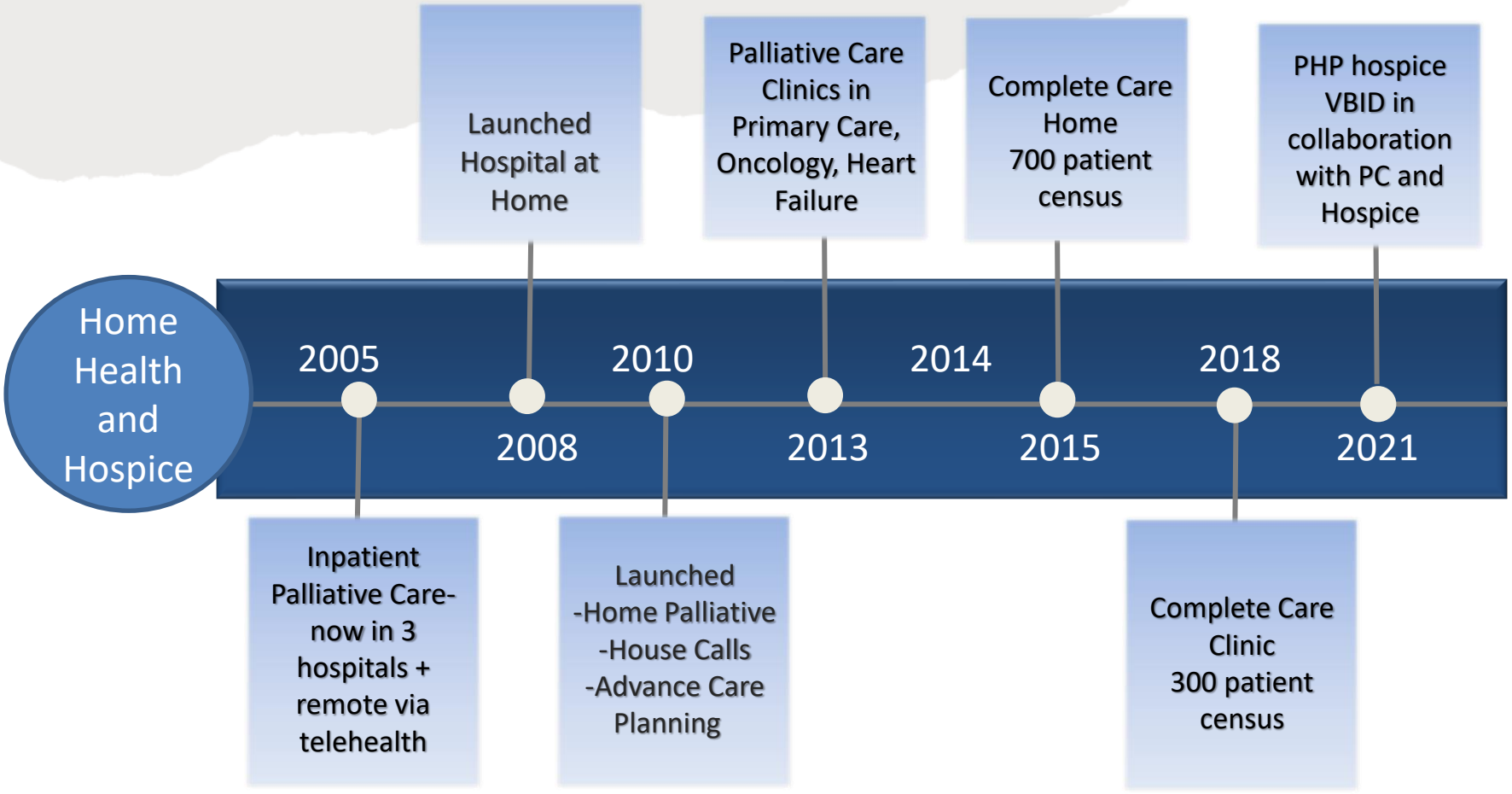
- Health Plan
- Delivery System with 9 hospitals and 32 clinics - (many rural)
- Medical Group with 1200 clinicians

Focus on Value-Based Care

- Health Plan since 1986
- Medicare Advantage Plan since 1998
- Largest MA and Managed Medicaid plan in the state
- Large population capitated to the Medical Group

- Largest not-for-profit healthcare system in New Mexico
- Serves 45% of all New Mexicans
- Accountable for total cost of care for large percentage of patients and members
- Transition over the last ten years from FFS mentality to focus on VB care and risk

Palliative and Home-Based Services



Palliative Services

- Inpatient
  - Multidisciplinary teams in 2 Albuquerque hospitals and 1 rural hospital
  - Telehealth for other hospitals
- Clinics
  - Embedded in Primary Care Clinics, Oncology, CHF Clinic
  - Telehealth Services now predominant
- Home
  - Specialized team in Presbyterian Home Health
  - Transitioning to a monthly PMPM for PHP for team-based services
- Teams
  - Include MD. RN, APN, SW, chaplaincy
  - MDs and APN's share hospice and palliative care for continuity, efficiencies and satisfaction
- Payment Models
  - FFS for provider visits
  - Episodic care for home health
  - Monthly payment for enrolled PHP patients

Complete Care

- Program
  - Cares for the 5-10% of our MA members with the highest disease burden and frailty. Offers primary care, urgent care and hospital-level care in the home.
  - Palliative focus – “no discharge” model to avoid care gaps
  - One number to call 24/7 with our own RN triage team
- Teams
  - Includes acute and care management RN’s, community health workers, physicians and APN’s, social workers, LPN’s, clerical staff.
- Home and Clinic
  - Home – 700 patient census
  - Clinic – 300 patient census
  - Programs collaborate in caring for patients in either setting
  - Advanced analytics used to search for and define possible patients, who receive invitation to join the program
- Outcomes
  - Total cost of care – savings of $700-1100 per patient/month
  - Hospitalization/Readmission rate 50% of predicted
  - Very high patient and family satisfaction
  - 85% of our patients die in their homes by choice
  - HCC capture very high

Funding sources for programs

- Providers, clinicians and support staff are part of Presbyterian Medical Group. While RVU's are budgeted and tracked, there is an implicit understanding that these programs will not break even. Most patients are capitated to PMG.
- Complete Care program receives PMPM from Health Plan for patients not capitated to Presbyterian Medical Group
- FFS from other payers for PC provider services
- New bundled payment model for PC services for patients
- Direct payments for HCC capture and for special group of providers who do HCC work for MA plan has helped underwrite programs in the past

Examples of demonstrating the value of programs to stakeholders (beyond cost savings)

Program Metrics

- Patient Experience
- Admissions, Readmissions, hospital mortality
- Hospice LOS or chemotherapy 21 days prior to death
- Advance Care Plans and Directives
- High-quality patient diagnoses

Value to payers and hospitals

- CAPHS, Medicare Stars
- Costs of care, VBP, HEDIS, Medicare Stars
- Cost of care, ASCO Cancer metrics
- Quality metric for many institutions
- HCC data – critical for revenue for MA plans

Lessons Learned

- Defining and understanding the needs of stakeholders is critical (referrers, payers, hospitals, patients and families, community groups, post-acute care)
- Networking and good stories are of high value as well as a crisp business plan
- Understand the key needs of the payers – palliative care offers value, but that value may be framed differently depending on the drivers
- Develop innovative care models with bundled payment models that will limit the risk for payers
- Remember that revenue may be more significant than cost-savings

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Using Data to Drive Decision and Improve Quality in Palliative Care

Emily Jaffe, MD

Executive Medical Director, Helion (Highmark Health)

Highmark Health

Palliative Care Approach for Patients with Advanced Illness

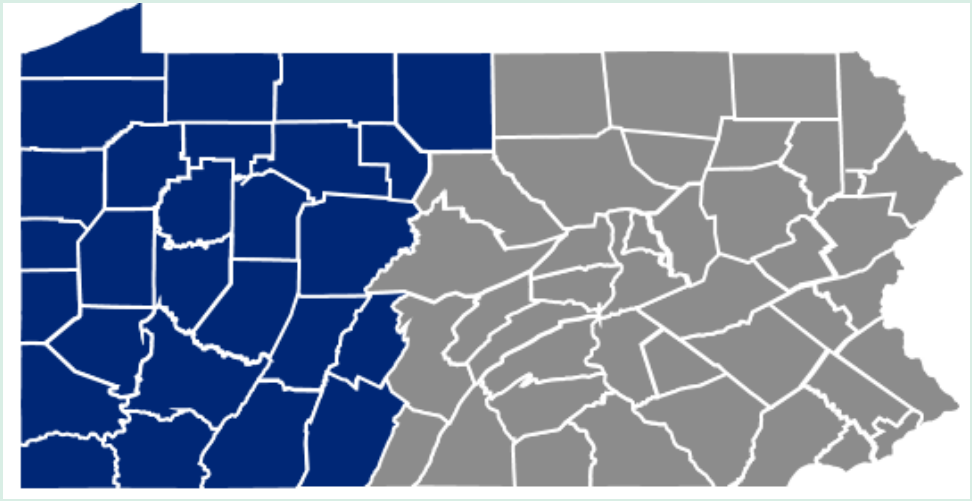
Agenda

1. Highmark Health Structure
2. Palliative Care Strategy
    - Illustrate Integration with ACP Completion
3. Insurance Inpatient Supportive Care Incentive Program
4. Next Steps

HIGHMARK HEALTH

Clinical Transformation Helion

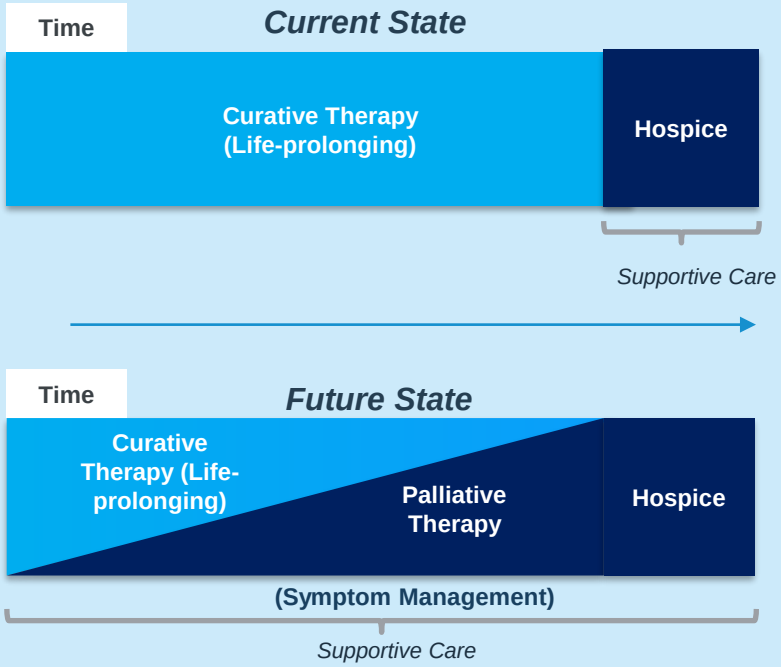
HIGHMARK



Allegheny Health Network

Supportive Care Approach

Supportive care programs are a foundational element of health system value-based care delivery



- Executive leadership approved a 3-year plan to advance an enterprise approach to standardize Palliative Care best practices across the AHN footprint and provide differentiated care to the Highmark MA members in WPA
- Ground-up program development requiring significant cultural transformation, contracting, recruiting, staffing, workforce retraining, workflow and infrastructure changes
- Nine initiatives were launched in 2019. Many reached or surpassed 2019 implementation plan goals.
- Program met or surpassed all metrics in Year 1
- Year 2, 2020, focused on programmatic expansion and earlier adoption in addition to COVID-19 interventions.

HIGHMARK HEALTH

Initiative: ACP Completion and Documentation

- Identification
- Timing
- Simplicity and partnerships
- Leverage Technology
- Continuity across care settings

Palliative Care Program: Five Key Pillars

Palliative care program has five key pillars to drive workforce and cultural transformations to provide the best end of life care

	Education	Leadership	Staffing	Data & Technology	Access Across Care Continuum
Pillar Description	*Widely available training for staff across the care continuum driving a culture of simultaneous curative and palliative care*	*Upper management palliative care Administrator and Clinical Lead with dedicated time for program implementation.*	*Align staffing models with industry best practices and measures clinical outcomes*	*Leverage data algorithms for ID & risk stratification; technology to optimize information sharing across the care continuum*	*Embed interdisciplinary care team across the care continuum*
In action for ACP	• **Center to Advance Palliative Care (CAPC) Online Training:** Best practices and clinical courses for frontline staff	• Key stake holders to influence primary care providers. • Incentives, quality, reinforcement	• Leverage ancillary staff in PCP office have early discussions, prep patients and charts	• **ePOLST:** Electronic & interoperable POLST (Physicians Orders for Life-Sustaining Treatment) accessible across care continuum (e.g. Vynca) • **EMR Integration**: Patient identification triggers for palliative care consults, best practice alerts, and quality metric reporting	• **Inpatient:** Team available to provide timely palliative consultations • **Home & Community Sites of Care:** Embed providers in Home Health, SNFs, and outpatient clinics with high palliative care volume (e.g. Cardiology, Oncology, CCSC) • **Care Management**: Trained care managers to identify and direct palliative care options

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Technology Partner and EMR

Identification/Timing: EMR

Inpatient trigger
Outpatient trigger: annual wellness
Health plan ID&S

Leverage Technology/Continuity: Vendor

Vynca

Simplicity and partnerships: Blended

ECCM
Vynca portal

Outcomes

POLST completion

Allegheny Health Network

HIGHMARK HEALTH

Highmark Inc. Hospital Quality Blue

History

- Inception
- Goals (ACP, drive volume)
- Rising thresholds and volume

Work group

- Participants
- Mission
  - "Collaborate with Highmark partners across the state …to encourage and reward providers to recognize members living with seriously illness and to partner with those members to adjust goals and treatment plans as appropriate."

Denominator

- Degenerative illnesses (comorbidities)
- Cancer (staging)
- Chronic diseases (utilization patterns)

Numerator

- Partners resources
- Flexibility
- Evidence of best practice

Outcomes

- Volume
- Claims
- QI collaboration

HIGHMARK

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Quality and Outcomes: Enterprise View

- **Hospital Quality Blue (VBR, provider partners):**

  Thresholds

- **ACP (hospitals, CIN, ECCM)**

  # POLST completed: who, what, where
  % full code, limited, CMO
  Consults accepted: who, what, where, why
  Outpatient trigger satisfied: tie to outcomes

Next Steps

- **Hospital Quality Blue (VBR, provider partners):**

  Continued refinement with clinical advisory group
  Create mechanisms to collaborate to improve access and care

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Reaction: Implication for Payers and Providers and the Path Forward

Torrie Fields, MPH

Founder and CEO, Votive Health

Question & Answer

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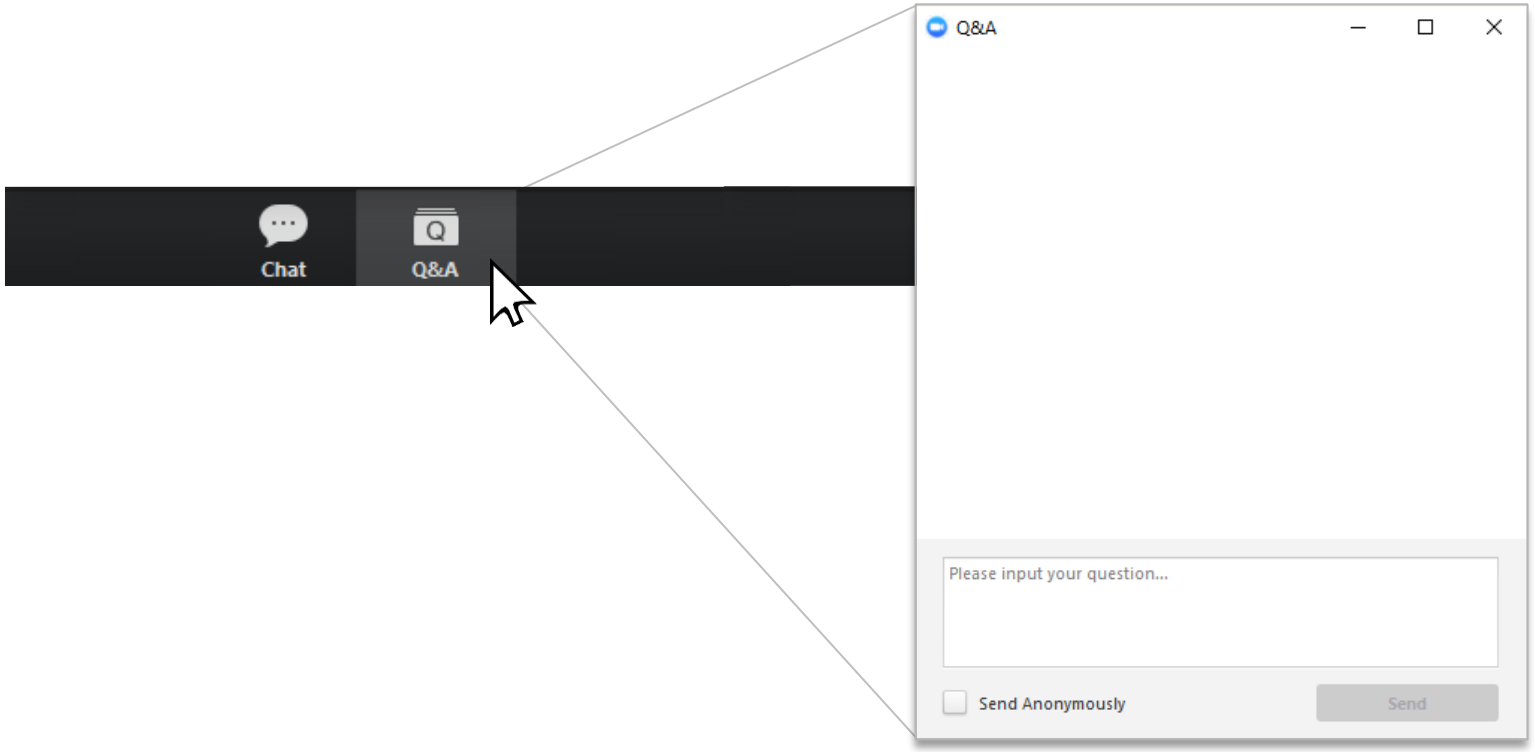

Additional Resources & Events

- **The Better Care Playbook Collection on Home – and Community-Based Palliative Care**
- **CAPC Payment Accelerator**

  Sept 23, 2021, 11:30AM – 5:30PM ET

  The CAPC Payment Accelerator, presented by CAPC and the Home Centered Care Institute (HCCI), helps organizations specializing in the care of high-need, seriously ill patients to understand and pursue value-based payment opportunities. Join us to learn how to build sustainable financial partnerships with health insurance plans, accountable care organizations, and others—both to secure initial support and operate effectively within value-based contracts. Visit the HCCI website to register.

Share Your Successes on the Playbook

- **Have you established a promising practice?**
- **Published a study about your complex care program?**

The Playbook welcomes content submissions to help spread best practices in complex care.

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Thank you!

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