Session 127 PD - Palliative Care: Improving Quality While Lowering Cost

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Stan Hornbacher
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Introduction to Palliative Care
What is 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.
- 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.
Palliative Care is best delivered concurrent with disease treatment
Who needs Palliative Care?

**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, etc.

**High Utilization**
- Hospital admissions, readmissions and length-of-stay
- Emergency Department visits
- Poly-pharmacy
- Skilled nursing/rehab stays
- Multiple home care episodes
People with serious illness are the top 5% of spenders

Source: Kaiser Family Foundation
What are the services provided?

• Expert pain and symptom assessment and management
• Assistance with decision-making, clarifying patient and family care priorities, and helping to match treatment and services to those goals
• Support to family caregivers with education, counseling, and/or respite
• 24/7 timely and competent clinical response to avert crises
Consider John

- On second line therapy for esophageal cancer
- Presents to ED for 3rd time in terrible pain (8/10), taking 5 gm of tylenol
- Wife doesn’t know how to help him -- 911 only option after 5pm
Before and After

Usual Care
- 3 calls to 911 in a 3 month period, leading to
- 3 ED visits and
- 1 hospitalization, leading to
- Hospital acquired infection
- 1 SNF stay with no change in symptom management
- Family distress

Palliative Care
- Effective pain treatment plan
- Advance care plan if 2nd line therapy fails
- 24/7 phone response to questions and concerns
- No 911 calls, ED visits, or hospitalizations in last 18 months
By improving quality of life, the costs of crisis are averted

<table>
<thead>
<tr>
<th>Setting</th>
<th>Results</th>
<th>Studies</th>
</tr>
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<tbody>
<tr>
<td>Office</td>
<td>In Primary Care: 20% fewer hospital admissions $117/day in oncology practice</td>
<td>(RTI 2006)</td>
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<td>(Greer 2016)</td>
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<tr>
<td>Home</td>
<td>48% to 56% reduction in hospital admissions</td>
<td>(Cassel 2016)</td>
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<td>(Lustbader 2016)</td>
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<td></td>
<td>36% lower costs in ACO model ($12,000 saved per patient)</td>
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<tr>
<td>Health Plan</td>
<td>22% lower medical costs ($12,000 saved per member on program)</td>
<td>(Krakauer 2009)</td>
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Blue Shield Business Case for Palliative Care
A Business Care for Palliative Care

- Building a business case includes overall potential impact, return on investment, and value of program
- Pilot Phase: Proving estimated savings and not expected savings

\[
\text{ROI (Value)} = \frac{\text{Total Revenue} - \text{Total Cost}}{\text{Total Cost}}
\]

**Costs to Blue Shield:** Claims expense, staffing to support, administrative impact, contracting time, analytic time, medical management and support, claims processing costs, external evaluation, initial implementation support and investment

**Impact:** “Site of service shifts” (from inpatient to home), increased care coordination, decreased pharmacy and SNF, increase in revenue (risk scoring), quality score increases, decreased CM support

**ROI:** Due to low overhead costs, increase in RAF scoring, and decrease in utilization of unwanted services, ROI for full program estimated to be 7:1.
Program development with value in mind

**Program Development**
- Set program eligibility criteria and pricing
- Defined services required to be provided by palliative care team, by setting
- Set operational budget, including direct and indirect costs
- Researched potential impact to savings and revenue, based on similar past programs and clinical literature

**Opportunity**
- Identified eligible members
- Calculated total at-risk dollars for eligible members
- Segmented dollars by benefit categories

**Analysis**
- Applied estimated 33% reduction in total health care dollars, found in clinical literature
- Applied ramp-up time and enrollment rate estimates (60% engagement after 3 years)
- Applied 70% confidence factor
- Subtracted program administration costs from gross savings
Patient eligibility requirements for palliative care

Blue Shield members are qualified for community-based palliative care services if they have a serious illness and begin to show signs of decline in health status or function.

**General Criteria**
- In remission, recovery from serious illness, or in the late stage of illness
- Documented gaps in care, including decline in health status and/or function
- Starting use of hospital and/or emergency department to manage illness/late state disease
- Not currently enrolled in hospice
- Illness is NOT psychiatric or substance-abuse related

**Diagnosis Categories**
Including but not limited to:
- Cancer
- Organ failure (e.g., heart, lung, renal, liver)
- Stroke
- Neurodegenerative disease (e.g., MS, ALS)
- HIV/AIDS
- Dementia/Alzheimer’s
- Frailty or advanced age
- Multiple comorbid conditions with exacerbated pain
Blue Shield Palliative Program Services

Blue Shield’s Palliative Care Program incorporates:
1. treatment decision support,
2. care plan development and shared decision making, and
3. pain and symptom management

Services include but are not limited to...
- Comprehensive in-home, multi-domain assessment by interdisciplinary team
- Development of care plan aligned with patient’s goals
- Assigned nurse case manager to coordinate medical care
- Home-based palliative care visits – in person and via video conferencing
- Medication management and reconciliation
- Psychosocial support for mental, emotional, social, and spiritual well-being
- 24/7 telephonic support
- Caregiver support
- Assistance with transitions across care settings
Innovative partnerships and payment

- Partnerships to educate about and support palliative care throughout our delivery system
- ACO delivery transformation
  - Clinical training
  - Implementation support
- Bundled payment for outpatient and home-based care
- Home care design in a non-integrated environment
  - Partnerships between medical groups and home health or hospice agencies
  - Dedicated case management and utilization management support
Policy Considerations & Trade-Offs

**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.
Modeling Price of Home-Based Palliative Care Services
Team was challenged in 2016 to develop a home-based palliative care rate model

**Alternative Payment model**
- NOT fee-for-service
- Preferably bundled case rate

**Actuarially Sound**
- Caregivers
- Services
- Typical protocol

**Marketable**
- Contracting
- Flexible
- Regional
Model relied on publications & case studies

California HealthCare Foundation, Up Close: A Field Guide to Community-Based Palliative Care
Kate Meyers, Kathleen Kerr, & J. Brian Cassel

Impact of an outpatient and home-based palliative care program on healthcare utilization and costs
J. Brian Cassel, Kathleen Kerr, Donna McClish, Nevena Skoro, Suzanne Johnson, Carol Wanke, Daniel Hoefer

Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care
Richard Brumley, MD., Susan Enguidanos, PhD., MPH., Paula Jamison, BA., Rae Seitz, MD., Nora Morgenstern, MD., Sherry Saito, MD., Jan McIlwanem MSW., Kristine Hillary, RNP., Jorge Gonzales, BA.

Effectiveness of a Home-Based Palliative Care Program for End-of-Life
Richard D. Brumley, M.D., Susan Enguidanos, MPH, David Cgerub, Ph.D
Who is providing the care?

What services are being provided?

What is a typical protocol?
Team of professionals providing care

- Physician
- Registered nurse
- Advanced practice nurse
- Social worker
- Chaplain, 24 hour nurse line, home health aide, etc...
- Other
## Services included in care

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<tr>
<th>Service</th>
<th>MD</th>
<th>RN</th>
<th>APRN</th>
<th>SW</th>
<th>other</th>
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<td>Home Visit with Physician</td>
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<td>✔️</td>
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<tr>
<td>Home Visit with Nurse</td>
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<tr>
<td>Home Visit with Social Worker</td>
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<tr>
<td>Telephone consultation with Nurse</td>
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<td>Palliative Care Team (PCT) conference</td>
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<td>chaplain, 24 hour nurse line, etc...</td>
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Typical home-based palliative protocol is 6 months, with most resources in the first 2 months
# Total 6 month resource base costs

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<tr>
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<th>Initial</th>
<th>Mth 1</th>
<th>Mth 2</th>
<th>Mth 3</th>
<th>Mth 4</th>
<th>Mth 5</th>
<th>Mth 6</th>
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<tr>
<td>Total</td>
<td></td>
<td>$1,099</td>
<td>$863</td>
<td>$600</td>
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<td>$600</td>
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<td>Notes</td>
<td>CMS RBRVS 2016 Sacramento, CA fees used in model</td>
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**Note:** CMS RBRVS 2016 Sacramento, CA fees used in model.

- Initial cost: $635
- Mth 1 cost: $1,099
- Mth 2 cost: $863
- Mth 3 cost: $600
- Mth 4 cost: $600
- Mth 5 cost: $600
- Mth 6 cost: $600

**Total cost:** $4,998 ($833 per month)
Palliative per month case rate

Per month resource based costs

$833

+ $125

15% for additional costs
(chaplain, 24 hour nurse line, etc.)

TOTAL PER MONTH BUNDLED CASE RATE

$958

Note: CMS RBRVS 2016 Sacramento, CA fees used in model
Flexible payment model

- Region factors were used
- Allow for rate negotiation w/ guardrails
Why the model is effective?

- Our contracting efforts began in Q1 & Q2 of this year
- Very little pushback on the rates
- Model is used for both hospice and medical group contracts
- Goal is to have statewide coverage in all 58 CA counties
- We are about 50% of the way there!
- Long term: filed network with tiering
Questions?