A Whole New World: Defining the Role of Hospice Care in a Transforming Health Care System

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SESSION EVALUATIONS

Available 5 minutes before close of session
Access Session Evaluations using your CONFERENCE MOBILE APP

STEPS TO COMPLETE YOUR EVALUATION WILL BE SHOWN AT THE CLOSE OF THIS SESSION
Objectives

• Learn how to utilize hospice and palliative care data to market quality and efficiency of care to ACO’s, MCO’s and hospital systems.
• Articulate the value proposition that hospice and palliative care represents to ACO’S, MCO’s and hospital systems.
• Identify a strategy to develop and market a strong, strategic partnership with hospitals, ACOs, and MCOs.

New Era of Healthcare

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Medicare Growth Impact

Number of Beneficiaries (in Millions)

Medicare Population Growth (Projections) – Source CMS

Medicare Growth

Projected Medicare Spending, 2013-2023

In billions:


Challenges Post Acute Care

- **Medicare Part A**
  - $203.1 billion gross fee-for-service spending in 2015

- **Medicare Part B**
  - $167.8 billion gross fee-for-service spending in 2015

- **Medicare Part C**
  - $149.8 billion in 2015

- **Medicare Part D**
  - $85.2 billion gross spending in 2015

Factors Impacting Change

Nine of 10 Medicare patients die of chronic disease, and caring for them in their final six months of life absorbs one-third of all Medicare dollars. During that time, more than a third of chronically ill Medicare patients are treated by 10 or more doctors.
Industry Landscape

Trends and Health Care Reform
Post Acute Care Impact
Reality Check
Operational Challenges
Change is swift
Expectations are high
Impact on Consumers
Redesign services - New Environment
Data=Quality!

Healthcare Challenges

- Government Unrest
- Reform initiatives
- Reimbursement Changes
- Increased Costs
- Regulatory Changes
- Performance Measures - Continuum
- External Oversight
- Providers who “play will stay”
Soaring Cost of Health Care

- 90 Million Americans Living with Serious Illness
- 5% seriously ill account for > 50% of health care spending
- Care in the last 2 months
- Economists call this a “cure at all cost” attitude
- Future
  - longer life spans and the aging of baby boomers
  - Double the number of Americans 65+ years
  - Triple the number of Americans 85+ years

Transformation of Health Care

The Vision

“To provide health care services and support to all consumers including health prevention, care coordination, and appropriate resource utilization. To promote quality of care to improve quality of life for our citizens. A commitment to processes that focus on education, consumer advocacy, clinical optimization of resources, patient safety, and technology to achieve superior clinical and financial outcomes with positive member and provider satisfaction.”

The Gaps

- Fragmentation & Silos of Care
- Growing Cost of Chronic Care
- Access to Care Options (24x7)
- Inconsistent Approaches
- Collaborative Team Practice
- Whole Person Care Approach
- Transitions of Care Facilitation
- Technology Advancements
- Regulatory/Gov’t Imperatives
- Premium increases, MLRs and provider Payment

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Health Care Reform

**Patient Protection and Affordable Care Act (PPACA)**
- Signed into effect March 23, 2010
- Reduce long term costs of health care
- *Link reimbursement to quality* outcomes
- Move from *Fee for Service to Bundled Payment methods*
- Person Centered Care
- Consumer engagement
- Access to data
- Strengthen the quality, accessibility, and sustainability of care

Three Pillars: The Future of Health Care

**Affordable Care Act**
- Quality and Performance
- Consumer Engagement and Satisfaction
- Compliance

National Quality Strategy
- HR 4302 and IMPACT
- QAPI
- HHS/CMS Strategic Plan/Triple Aim/Work Plans
- OIG - Work Plans/Compendium
- Fraud Prevention System

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Three Broad Aims of the National Quality Strategy

- Better Care, Healthy People/Healthy Communities, and Affordable Care

Six Strategies to Advance these Aims include:

1. Prevention and Treatment of Leading Causes of Mortality
2. Supporting Better Health in Communities
3. Making Care More Affordable
4. Making care safer by reducing harm caused in the delivery of care
5. Ensuring that each person and family members are engaged as partners in their care
6. Promoting effective communication and coordination of care

The Dynamic Force of Change

Foundation of New Delivery System

The ACA 2010

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Affordable Care Act Summary

- Overall approach to expanding access to coverage
- Individual mandate
- Employer mandate
- Expansion of public programs
- Premium and cost-sharing subsidies to individuals
- Premium subsidies to employers
- Health Insurance Exchanges

Affordable Care Act Summary

- Benefit design – changes to private insurances
- State roles
- Cost containment
- Improving quality/health system performance
- Prevention and wellness
- Long-term care
Hospital Readmission Penalties

77% of hospitals subject to the CMS 30-day Hospital Readmissions Reduction Program performed poorly and face some penalty

More than 1% will be subject to the maximum 3% reduction in 2016

Value-Based Purchasing

Value-Based Purchasing is a Key component of CMS’ Plan to achieve Triple Aim goals of Better Health, Better Care, Lower Costs

Value-Based Purchasing
Aligns providers
Ties quality to payment
Improves beneficiary experience and outcomes

CMS estimates $380 million in total savings
Value-Based Purchasing is REAL Today ...and Growing

Setting Specific
- Hospital Bonus 2012
- Hospital Readmissions 2012
- HH VBP 9 states January, 2016
- SNF October, 2018
- Hospice 2018
- Physicians 2020

Across Settings
- Accountable Care Organizations 2012
- Bundled Payments for Care Improvement (BPCI) 2013
- Comprehensive Joint Replacement (CJR) 2016

Community-Based Transitions of Care
- Section 3026 of the Affordable Care Act establishes Community-Based Care Transitions Program (CCTP)
- Provides $500 Million in grant funding to community-based organizations (CBOs) – either in partnership with hospitals or independently – to deploy evidence-based models to improve care transitions
- Goals
  - Improve transitions from inpatient hospital settings to other care settings or to home
  - Reduce readmissions for high-risk individuals
  - Generate savings to Medicare

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Accountable Care Organizations

- Connecting the “dots” between patients and health providers (now Next Generation ACO’s are being formed)
- Heart of National Strategy for Reform
- Seamless medical care
  - Reduce errors
  - Reduce Readmissions
  - Decrease costs
  - Increase quality and satisfaction
  - Safe care transitions
  - No restrictions for patient and providers...
  http://innovation.cms.gov/initiatives/ACO/
ACO and Partner Models

Medicare Shared Savings Program (cms.gov) - For fee-for-service beneficiaries

ACO Investment Model - For Medicare Shared Savings Program
ACOs to test pre-paid savings in rural and underserved areas

Advance Payment ACO Model - For certain eligible providers already in or interested in the Medicare Shared Savings Program

Pioneer ACO Model - Health care organizations and providers already experienced in coordinating care for patients across care settings

Next Generation ACO Models – allow flexibility – now being formed as of July 1, 2015.

http://innovation.cms.gov/initiatives/ACO/
Innovation Center

Delivery system and payment transformation

**Historical State** - Producer-Centered
- Volume Driven
- Unsustainable
- Fragmented Care
- FFS Payment Systems

**Future State** - People-Centered
- Outcomes Driven
- Sustainable
- Coordinated Care
- New Payment Systems and other Policies
  - Value-based purchasing
  - ACOs, Shared Savings
  - Episode based payments
  - Medical Homes and care management
  - Data Transparency

Source: CMS Innovation Center Update 11-2014

Payment Redesign

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

<table>
<thead>
<tr>
<th>Category 1: Fee for service — No Link to Quality</th>
<th>Category 2: Fee for Service — Link to Quality</th>
<th>Category 3: Alternative Payment Models on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>At least a portion of payments vary based on the quality or efficiency of healthcare delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by volume of services but opportunities for shared savings or risk sharing.</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment.</td>
</tr>
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IMPACT Legislation

*(Improving Medicare Post-Acute Care Transformation Act)*

- Standardized platform/assessment tool
- Quality Measures
- Performance Measures
- Public reporting of Data
- Care Compare Websites
- New Payment Models

Bi-partisan bill introduced in March, U.S. House & Senate; passed on September 18, 2014 and signed into law by President Obama October 6, 2014

Requires Standardized Patient Assessment Data for:
- Assessment and Quality Measures
- Quality care and improved outcomes
- Discharge Planning
- Interoperability
- Care coordination
Accountable Care Act Initiatives

Patient Centered Care - Making Informed Decisions
- Public Reporting of Data
- Quality Rating Sites
- Quality Ranking System
- Consumer Engagement

**Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, others coming soon!**

Accountable Care Act Initiatives

Home and Community Based Services
- Least Restrictive Environment
- Chronic Disease
- Community based care
- Decrease Cost
- Case Management

**Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, HME, Physicians, others coming soon!**
Accountable Care Act Initiatives

Safe Care Transitions – Patient Safety

*New Measurement*

- Care Transitions
- Patient Education
- Medication Reconciliation
- Transfer protected information

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, HME, Physicians, others coming soon!

Dementia Initiative

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living
Accountable Care Act Initiatives

Palliative Care and Hospice Integration
End of Life Care

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, Physicians

Technology and Impact on Healthcare
Telehealth
Electronic Health Record
Diagnostics
Virtual Health

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, HME, Physicians, others coming soon!

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Accountable Care Act Initiatives

Expand Medicare and Medicaid sharing of information between entities – DATA!

Acute, Skilled Nursing, Home Care, Hospice, HME, Physicians, others coming soon!

Accountable Care Act Initiatives

Corporate Compliance

Acute 
Skilled Nursing 
Home Care 
Hospice 
HME 
others coming soon!
Accountable Care Act Initiatives

Health Care Worker Impact

- Shortages – professional
- Shortages – nonprofessional
- National Care Giver Background Check

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, Physicians, others coming soon!

Quality Initiatives – Benchmark data, standards of practice, compliance and set expectations for reimbursement

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, HME, Physicians, others coming soon!
Summary Of Initiatives

- Sizeable Incentives
- Quality Measure Alignment
- Provider Engagement
- Performance Targets
- Data transparency
- Decrease LOS – Discharge to Community Measure
- Monitoring of VBP – external/OIG
- Review Measures with Providers
- Quality Improvement expectations – QAPI!
- Consumer Satisfaction and Surveys by external
- Public Data
- Performance Rankings

Overall Goal

- Improve overall quality
- Decrease costs
- Increase efficiencies
- Updated Regulations
- Partnership Collaboration
- Increased Clinical Competency
- Lowest Cost Setting
- Patient/Consumer Satisfaction
- “Play to Stay”
- QAPI – final rollout to all providers

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Hospice and Palliative Care Opportunity

“Our greatest opportunity to enhance value in U.S. health care is to improve quality of care for older adults with (likely incurable) serious illness.”

--ACO Business News, December 2013
The Wall Street Journal 2014

- $50 billion, about 10 percent of Medicare funds, is the annual spending on the last month of patients' lives
- 65% of health care spending goes toward the sickest 10% of patients
  - An average of $157,510 annually per patient
- 65% of poor-prognosis cancer patients are hospitalized during the last month of life
- 25% of poor-prognosis cancer patients use a hospital intensive care unit during the last month of life
- 30% of poor-prognosis cancer patients die in the hospital
- $5,000 to $7,000 annual savings per patient when palliative care is provided alongside usual care

Top 5 High Yield Targets for ACOs

1. Wellness/prevention
2. Chronic care management
3. Reduced hospitalizations
4. Care transitions
5. Multi-specialty coordination of complex patients

*Emphasis added to targets suitable to hospice and palliative care.
Hospice & Palliative Care Value Proposition

- Improved Quality of Life and Patient Experience
- Reduced Hospital Readmissions, ER Visits, Total Cost of Care

Hospice Research and Literature

- Hospice and palliative care improves quality of care for the seriously ill and reduces need for ER services and hospitalization
  - Reduces symptom distress
  - Enhance quality of life
  - Decrease spiritual suffering
  - Improve survival
Hospice Research and Literature

• Hospice and palliative care enhances family outcomes
  • Improved family satisfaction and quality of life
  • Decreased depression and anxiety
  • Better bereavement adjustment
  • Improved survival among spouses

• Improved quality of life associated with Hospice and Palliative Care leads to lower costs
  • Prevention of symptom crisis
  • Reduction of depression
  • Support of family caregivers
  • Person-centered care
Palliative Care Extends Survival

- Randomized Trial Lung Cancer Patients
  - Extended survival time of an average of 2.7 months in those receiving concurrent palliative care services
    - Fewer hospitalizations
    - Decreased rates of major depression (an independent predictor of mortality)
    - Prevention and treatment of distressing symptoms
    - Better family caregiver support

Palliative Care Reduces Costs

- A Study of 8 Hospitals with Mature Palliative Care Programs
  - Cost per day for palliative care patients was dramatically lower
- A Study of Medicaid Patients Receiving Palliative Care in 4 New York hospitals
  - Significant cost reduction associated with palliative care consultation
- Study findings are consistent across hospital types nationwide
High Patient Satisfaction

• Family Evaluation of Hospice Care
  • 93.5% Rate Hospice Care as “Excellent” or “Very Good”
  • 97.3% Would Recommend Hospice to Others

NHPCO, December, 2014

Hospice Enrollment Saves Money

• Icahn School of Medicine at Mt. Sinai
  • Most Common Enrollment Periods
    • 1 to 7 days; 8 to 14 days; 15 to 30 days; and 53 to 105 days
  • Within all enrollment periods studied, significantly lower rates of
    • Hospital and intensive care use
    • Hospital admissions
    • In-hospital deaths

*Health Affairs, March 2013*
Benefits of Hospice Care

“We know that hospice care addresses so many critical issues involving quality of care at the end of life and that hospice brings dignity and compassion when they are needed most. This new study reaffirms other reasons why hospice is the best solution for caring for the dying in a way that provides patient-centered care and is cost effective for the Medicare system.”

--J. Donald Schumacher, President and CEO, National Hospice and Palliative Care Organization.

ACO’s Want YOU!

• ACO’s will want to partner with Hospice and Palliative Care providers who can demonstrate:
  • Value (quality and cost reductions) with credible data (no more anecdotal evidence!)
  • Ability to lower hospital readmissions
  • Able to accept high volume of discharges to home
  • Evidence-based clinical pathways
  • Strong care coordination and care transition
Get In the ACO Game

• Develop relationships with hospitals, primary care physician groups, insurers/managed care providers
• Partnerships must be value-based – what value do you bring?
  • Earlier patient discharges from hospitals
    • Lowers hospital mortality rates
    • Shortens LOS in the hospital setting
  • Care management to reduce ED visits and Hospital readmissions
  • Cast reductions for post-acute episode of care
  • ↑ quality of life, ↑ patient/family satisfaction
  • Strong care coordination and care transitions

Successful ACO/Hospice Partnerships

Key Characteristics
• Rigorously target the high risk population and proactively offer palliative care services
• Use trained staff to elicit individualized patient goals that are then used to guide care plans
• Pay attention to the patient’s family and social support
• Provide expert symptom management and coordination of care
• Offer person-centered care with round-the-clock phone support and service intensity scaled to meet patient’s needs as they change over time
Recommended ACO Initiatives

- Awareness/Leadership/Urgency
- Model for forming/leveraging experience and ability to form partnerships across the care continuum
- Educators for Advance Care Planning
- Expertise in advance symptom management
- Leadership Best Practices
- Patient/Family Engagement and Education
- Provider Engagement and Education
- Avoidance of Expensive Drugs and Therapies

Awareness/Leadership/Urgency

- What is an ACO?
  - How to recognize one with a likelihood of success
- Opportunities and Risks
- Leaders as catalysts for transformative change
  - Act with confidence and a sense of urgency
Model for Forming/Leveraging Experience

Serve as a model for forming/leveraging experience and ability to form partnerships across the care continuum

- Model of Interdisciplinary Teamwork
- Importance of Seamless Transitions
- Care continuity models
  - Care team looks like a community of caregivers
  - Patient care is coordinated regardless of access to technology
  - The patient is at the center
  - The family is an integral part of the care team
  - Care extends from an inpatient setting all the way into the home and back again

Educator for Advance Care Planning

- Serve as educators for advanced care planning communication techniques
- Suggest triggers for identifying patients who would be most appropriate for goals of care discussions
Expertise in Symptom Management

Share experience and expertise regarding advance symptom management
• Pre-hospice bridge programs
• Advance Illness Management Programs
• Home-based palliative care services

Leadership on Best Practices

• Chronic disease management and end-of-life care
  • Patient-centered care customization
    • Lowers overall health care costs
    • Goals of care discussions lead patients to choose less invasive/aggressive care paths
    • Effective symptom management provides critical support and decreases excessive expenditures
    • Decreases hospital readmissions and LOS
    • Increases quality of life and life span
Leadership on Best Practices

Not sure where to start?
• Use the “Surprise” Question
  • Would you be surprised if this patient died in the next 12 months?
• Identify High Risk, High Cost Patients
  • Fragile
  • Utilize services that are high cost/low value
  • High reoccurrence of symptoms due to disease progression of psychosocial issues

Patient/Family Engagement and Education

• Partnership between patients and healthcare providers
  • Decisions respect patient goals and preferences
  • Provides education and support so that informed decision-making can occur
Provider Education and Engagement

Educate providers within the ACO
- Primary palliative care and appropriate referral triggers
- Communication skills that are effective for facilitating advance care planning and goals of care discussions
- Engaging providers around timely and appropriate completion of POLST types of documents for patients with significant disease burden.

Expense Avoidance

Avoidance of Expensive Drugs and Procedures with Marginal Value
- Opportunities for improved care and cost exist in pharmacy and procedure selection.
  - Polypharmacy and use of unnecessary procedures often adds to patient suffering
- Palliative care focuses on improving quality of life
  - Reduced symptom burden
  - Supportive care
- Value-based thinking benefits the patients both clinically and financially
- Value-based thinking benefits the shared savings
Getting the ACO to Pick You

Build Relationships
• Engage with local health systems

Have a Compelling Story
• Hospice and Palliative care providers have a great story to tell – Focus story on
  • Add-ons to the ACO’s existing activities
  • Synergies
  • Helping ACO meet quality and savings goals

Relevant Metrics

• Avoidance of admissions for CHF, COPD
• Critical care usage and costs
• Post-acute episodes of care cost reductions
• Laboratory and Imaging costs
• Pharmaceutical costs
• Chemotherapy in the last month of life
• Use of percutaneous feeding tubes in advanced dementia
Relevant Metrics

- Use of POLST in the last year of life
- Following/using hospice guidelines for the last six months of life
- Percentage constipated on pain meds
- Survey results – meeting the needs of patients and families
- Length of stay on hospice > 14 days
- Hospital readmission reduction
- Electronic information exchange

Implementation Strategy
Organization Change Capability

*Determine organization ability for change*

- Assess Readiness
- Care Transitions
- Data and Technology
- QAPI

Assess Organizational Readiness

**Assess Organization Systems**
- Corporate Programs and Outcomes
- Facility specific protocols

**Assess need to change**

**Benchmark internal systems for review**
- Current status
- Industry standards
- Best practice approach

**Identify opportunities**
Assess Organizational Readiness

Assess Clinical Readiness

Your Role
Industry initiatives
Market initiatives and expectations
Quality Outcomes
  • Payer and External Expectations
  • Consequences
Internal competency process
Right People and Right Roles

Data – Quality - Compliance

Increase communication
Efficiency and effectiveness
Collaboration with partners
Measure performance
Reduce redundancy
Determine roles and anticipated processes
Improve patient outcomes
Successful Care Transitions
Consumer Satisfaction
Achieve Goals and Vision – Sustainability!
The New Way to do Business
Redesign Training

- Clinical
- Reimbursement
- Diagnostic
- New Consumer
- Quality
- Data Outcomes
- Strategic Partners
- QAPI

Strategic Innovation

Creation of growth strategy
Creation of new products or services
Creation of business models that change the game
Generating significant value for new consumers, customers and the organization
Partnerships

Partnership and Collaboration
Acute care – clinical strategies
Diagnostics
Telemedicine
Performance Reviews
• Determine benchmarks
  – Internal
  – External entities

Partner Discussions

Establish a core committee
Develop and reinforce communication with referral sources
Establish your mutual goals – patient stability and management without readmission to hospital
Meet face to face to identify what each of you need to do to make it happen
C.R.E.A.T.E

Change agent – drive change through “collective” creativity
Refine and shape the culture
   (listen, appreciation and optimism)
Embrace the challenge
   Lead creativity and innovation
Acknowledge the essentials that should not change
Think BIG! Look to the “road” ahead
Energetic and Passionate – the fuel for change

Implementation and Innovation
For Sustainability

Preparation
Operational Readiness Assessment
Services
Internal Systems
Team composition
Increase clinical competencies
Validation and benchmark data
Excellent outcomes – quality and financial
   Evaluate, reposition, partner and implement
SESSION EVALUATIONS

FILL OUT SESSION EVALUATIONS IN THE CONFERENCE MOBILE APP TO EARN YOUR CEUs

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