Home-based Palliative Care:

A PLAYBOOK FOR HEALTH SYSTEMS TO OPTIMIZE CARE FOR ADVANCED ILLNESS
While there has traditionally been a clear distinction between the roles of healthcare providers and payers, a myriad of market forces over the past decade have blurred the lines between these two symbiotic partners. As they continue to evolve into each other’s space, they contribute to the significant transformation in America’s healthcare ecosystem.

Coupled with government and policy changes, increased economic pressures, adoption of value-based purchasing, and reimbursement issues, the hazy lines between providers and payers are changing the landscape of opportunity for capturing market share. Today, multiple entities are in the race to deliver quality, affordable healthcare. These include health systems, provider risk-bearing entities (i.e., Accountable Care Organizations, Integrated Delivery Networks), Medicare Advantage plans, Medicaid and dual eligible plans, Managed Long Term Services and Supports (MLTSS), commercial payers, self-funded organizations, and Administrative Services Only (ASO) contracts.

Interestingly, some industry observers coined the term “payviders” to describe this concept, which seems to be gaining traction as more providers move into value-based reimbursement. It is terminology that captures the spirit of provider organizations that are willing to take risk, as more groups begin to leverage their existing health plan relationships, enter into partnerships with one or more plans, or even start their own health plan.¹

Effectively Addressing the Impact of a Serious or Advanced Illness

This three-part series expands the understanding and analysis of the 12-18 month time period during the last stages of a serious or advanced illness and examines its impact on specific market audiences: payers, providers and the U.S. healthcare system, and consumers, patients and family caregivers.
However, in their quest to improve member outcomes and the patient experience, while lowering their expenses, both providers and payers encounter challenges that are magnified by the growing number of seniors – the group most likely to experience a serious or advanced illness and who are in need of long-term healthcare services. As a result, organizational leaders are beginning to recognize that this fragile, vulnerable population requires a more focused approach to effectively address the issues impacting cost and quality of care.

Confounding the entire situation is the sheer growth of the Medicare beneficiary population. Many seniors now rely upon private Medicare Advantage plans, totaling nearly 18 million and more than 40 percent of total Medicare beneficiaries in some states. Looking ahead, by 2050 the senior population is projected to grow by 135 percent, and aged 85+ is projected to increase by 350 percent.2

In their quest to manage the multitude of challenges confronting this defined population with extraordinary healthcare needs, especially seriously ill patients who are approaching the end-of-life (EOL), organizations are often hamstrung by a lack of specialized analytics, infrastructure and care management resources to effectively coordinate care. This becomes highly problematic for hospital systems and other provider-driven organizations that pursue risk arrangements with health plans. While they are expected to function more like payers, they are simply overwhelmed by the requirements for entering these contractual risk arrangements.

Yet, provider organizations continue to pursue these contracts. One industry analyst expects that providers will feel increasingly comfortable with assuming financial risk in exchange for larger incentives, as more than nine million Medicare beneficiaries will be covered by a total of 480 ACOs, including 99 new participants in the Medicare Shared Savings Program (MSSP).3 Furthermore, the number of ACOs participating in the Next Generation ACO Model launched by the CMS Innovation Center more than doubled from 17 last year to 45 in 2017. Of the 525 total ACOs serving Medicare beneficiaries, 87 are in risk-sharing arrangements that will result in financial losses if they fail to meet certain savings benchmarks.4

While operational efficiencies and cost containment are a key focus for these provider organizations, what remains at the heart of these efforts and in keeping with their missions are patient satisfaction, improved outcomes and enhanced quality of life for patients and their family caregivers.

“Organizations are simply overwhelmed by the requirements for entering these contractual risk agreements.”
Alternative Payment Models (APMs):

An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.⁵

Accountable Care Organizations (ACOs)

ACOs are groups of doctors, hospitals, and other health care providers, that come together voluntarily to deliver coordinated high quality care to their Medicare and other patient populations. The goal of coordinated care is to ensure that patients, especially the chronically ill, receive the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.⁶

At the end of the first quarter of 2017, industry analysts included 923 active public and private ACOs across the United States, covering more than 32 million lives. The increase of 2.2 million covered lives in the past year means that more than 10 percent of the U.S. population is now covered under an ACO.⁷

Health Care Payment Learning and Action Network (LAN) framework (category 3 and 4) which, in addition to shared-savings and shared-risk ACOs, include episode-based models and partially and fully capitated payments for patient populations. These trends have been reinforced by passage of the Medicare Access and CHIP Reauthorization Act (MACRA), which contains new incentives for many physicians to join APMs.

Note: While Medicare is the most prevalent sponsor of APMs, state Medicaid plans and commercial payers are also expanding a range of APMs. The LAN 2016 APM Measurement Effort found that in 2016, 25 percent of health care dollars were in category 3 and 4 payment models for commercial plans, Medicare Advantage, and Medicaid.
This series of white papers, the second of three, underscores the importance of specialized in-home palliative care within the framework of broader PHM programs and the pivotal role it plays in addressing the needs of the whole person and the family, improving quality of life for all. It can be provided along with curative treatment, offering services that effectively address the symptoms and stress of a serious or advanced illness. It is a meaningful option for organizations whether or not they choose to take risk since performance measurements are key indicators for STAR ratings that impact reimbursement.

**Optimizing Population Health Management**

The good news is that there’s growing awareness of the role of population health management (PHM) in preparing providers to take on risk contracts. For example, 95 percent of respondents to one survey rated population health as important for future success. Another 74 percent indicated that their organizations are operating a designated division, department or institute for population health programs.

Nevertheless, providers are discovering that most PHM programs lack the processes and components to effectively manage care that is specific to a serious or advanced illness population. As providers, they pride themselves on their robust capabilities for delivering healthcare and medical services, structuring a medical home or participating in data-sharing initiatives. By and large, however, they lack the training, expertise and resources to truly manage and coordinate care for individuals facing the burdens of a serious or advanced illness.

As providers strive to address the complex challenges associated with care for patients nearing end-of-life, they are discovering that this defined population requires a distinctive focus with greater specificity. Many are recalibrating their approach to PHM programs to include palliative care: specialized medical care for people with a serious or advanced illness and focused on providing relief from symptoms and stress. The goal is to improve quality of life for both the patient and the family. This level of care is fully described in an earlier white paper “Recalibrating Population Health Management to Include Community-based Palliative Care.”

In fact, a study in the New England Journal of Medicine shows palliative care can also help patients live longer. In a study of 151 patients with advanced lung cancer, those given early, concurrent palliative care survived 11.6 months, nearly three months longer than those who received standard medical care. Evidence also shows that, with or without curative treatments, a palliative approach offers the best chance of maintaining the highest possible quality of life for the longest possible time, according to the National Center for Biotechnology Information.

Today, organizations are viewing palliative care in the context of the larger continuum of care, and starting to see the value of moving their PHM programs from a generalized approach to one that is far more targeted to the specific needs of individuals with a serious or advanced illness.
For these reasons, the launch of Turn-Key Health’s innovative, specialized PHM solution, Palliative Illness Management (PIM™), is a welcome addition to the health system marketplace. PIM™ is a unique community-based model that identifies, engages and improves the member and caregiver quality of life. Turn-Key Health deploys a rapidly scalable solution by utilizing predictive analytics/AI for appropriate member identification and leveraging analytics and technology in three ways:

- Proprietary analytics are utilized to identify and stratify a patient’s likelihood of experiencing avoidable medicalization related to a serious or advanced illness.
- A custom palliative population health system manages patient populations, reports interventions, and standardizes care.
- Turn-Key utilizes its Palliative Activation Scale (PAS™) which is the measure of a patient’s propensity to adopt a palliative care approach, to improve quality of life and outcomes.

Historical and temporal claims encounter and clinical data are utilized for predictive modeling to identify patients who are at risk of a poor quality or experience avoidable medicalization in the last six to twelve months of life, leading up to a very short length of stay in hospice. Patients are also directly identified through case managers and clinicians within risk-bearing entities.

Turn-Key convenes, trains and manages networks of palliative care specialists to engage with members. Comprised mainly of palliative care trained nurses and social workers, the teams are also augmented by nurse practitioners and physicians, where medical intervention is needed. These teams utilize an interdisciplinary approach to manage populations, meeting weekly, and drawing in community-based resources to benefit the patient and decrease caregiver burdens.

Turn-Key serves as an extension of medical practices, enabling a palliative medical home model. Its palliative care teams provide supportive home-based assessments and interventions, communicating relevant information to the primary treating physician / medical home to foster better communication and to ensure that delivery is consistent with patient goals.

Bringing a standardized process of palliative care delivery through its proprietary platform, PIM provides a systemized approach across geographic regions to track and measure outcomes.

A Closer Look at the Issues: What’s Working vs. What’s Not Working

Knowing where to begin

Population health initiatives play an important role in healthcare delivery, and while many organizations have programs in place, they lack the capabilities to specifically address those patients with a serious or advanced illness. Few organizations have the capacity to develop programs specific to this defined senior population. As they assume financial responsibility for these patients and follow the path to value-based reimbursement, they will require methodologies to measure how shifting populations can impact incentive payments and quality metrics.
Advanced Illness & End-Of-Life Care

Health care systems worldwide are facing macro-scale changes involving advanced illness and end-of-life care that could affect both the quality of care and the quality of life for patients and their caregivers. For example, growth in mortality from cancer and Alzheimer disease, along with the increased prevalence of multiple morbidities for those near the end of life, raise questions about how the health system will provide adequate care and pain relief for patients, and addresses the needs of their caregivers—many of whom are unpaid family members. In addition, despite a growing tendency for people to prefer hospice and other lower-intensity options to cope with advanced illness and the relatively small share of excess spending that goes to individuals near the end of life, cost remains a concern. This is particularly true in the United States, where per capita medical spending in the last twelve months of life is $80,000—substantially higher than in comparable developed nations.

Costliest 5%

Contrary to popular belief, people in the last year of life account for a relatively small share of excess healthcare spending in the US, representing just 2 million (11%) of the 18.2 million people who are considered the high-cost population. In fact, another 500,000 people at the end of life are not among the costliest.

Causes of death

In 2015 heart disease was the leading cause of death in the United States, just as it was fifteen years earlier. But over that period, cancer mortality increased to the point where it nearly equaled heart disease mortality, which was in decline. Across Europe, pooled data (2006-13) showed variation in whether cancer or heart disease was the leading cause of death.

Caregivers

Family and friends are the predominant providers of end-of-life care with spousal caregivers being the most likely to provide assistance with no additional help. Nearly 9 in 10 caregivers for end-of-life patients were family members, or otherwise unpaid assistants.
Payers and provider organizations can take advantage of an end-to-end approach, offering a highly systemized, structured and standardized clinical program to guide the delivery of expert level palliative care to members with an advanced or serious illness.

A partnership with Turn-Key Health, for example, delivers the PHM components that allow organizations to quickly scale their programs for larger advanced illness populations. It is an opportunity that offers these risk-bearing organizations the proper infrastructure, staffing and resources to intervene when something is predicted to happen to a member, in advance of the last six months of life – prior to the delivery of unplanned treatment and avoidable medicalization, frequently offered by default.

Reimbursement Concerns

Payment mechanisms designed to spur advance care planning (ACP) have seen little uptake, despite its important role in serious or advanced illness care.

Specifically, only 14 percent of physicians have billed Medicare for counseling patients on EOL approaches—although most want to do so—according to a new survey.  

While many provider organizations can turn to their physician staff members as a resource for delivering ACP, this may not prove to be the best solution. Nearly 70 percent of physicians report that they have not been trained to discuss EOL care, and 73 percent of Medicare patients over the age of 65 have not discussed it with physicians.

Improving Patient Satisfaction

Clinicians and researchers widely acknowledge the importance of addressing not only physical pain and suffering, but also the need to attend to highly emotional and spiritual anxieties. As referenced earlier, community-based palliative care and discussions directed by specially trained nurses and clinical social workers empower individuals to influence decisions about their care and a voice in choosing to remain at home, according to the Dartmouth Atlas of Healthcare.
Let’s Talk: Physicians and EOL Conversations

Significantly, two-thirds of physicians who regularly see patients near EOL do NOT have specific training on EOL conversations. Among physicians most likely to discuss issues related to ACP with patients:

- 61% work in a hospital setting at least several times per week
- 62% had formal training on EOL conversations
- 63% were in a practice / health system with a system for assessing patients’ EOL wishes and goals

In contrast, PIM™’s Palliative Extensivists are particularly experienced and adept at conducting sensitive, meaningful conversations among patients, families and caregivers. These discussions result in shared decision-making that advances a clear understanding of what members and families view as important at the end-of-life. The PE’s help to align treatments to informed goals of care, avert costly, often unwanted interventions of questionable benefit, and mitigate avoidable over-medicalization.

Advance Care Planning

Advance care planning is generally defined as making decisions about the care one would want to receive if one becomes unable to speak for oneself. These are personal decisions to make, regardless of what one chooses, and the decisions are based on personal values, preferences, and discussions with one’s loved ones.

If one is in an accident or has an illness leaving that person unable to talk about their wishes, who will speak for that individual? In advance, that information can be communicated in a document to family, friends and healthcare providers - wishes and personal beliefs about continuing or withdrawing medical treatments at the end of life.

Advance care planning includes:

- Getting information on the types of life-sustaining treatments that are available.
- Deciding what types of treatment one would or would not want should one be diagnosed with a life-limiting illness.
- Sharing one’s personal values with loved ones.
- Completing advance directives to put into writing what types of treatment one would or would not want should one be unable to speak for oneself.

Source: National Hospice and Palliative Care Organization; https://www.nhpco.org/advance-care-planning
A Real Patient Story

Dwight, 90, lived at home with his wife. Over a period of six months, he made four visits to the Emergency Department (ED) and had two hospitalizations for falls and heart failure exacerbations. He was identified through Turn-Key Health’s predictive algorithm as a candidate to receive Palliative Illness Management™ (PIM™) services as a free benefit from his Medicare Advantage plan. Dwight’s last name has been redacted to protect his privacy.

The PIM™ program provides specialized case management services to health plan members who are identified through predictive modeling to be at risk of avoidable medicalization prior to death. These members receive home and phone visits from specially trained palliative care nurses and social workers from local community health organizations or hospices. They follow Turn-Key’s risk-based care pathways and document using Turn-Key’s palliative assessments embedded in a web-based platform.

Dwight’s home visit assessment by the PIM™ team nurse from Mount Carmel Hospice and Palliative Care program in Columbus, Ohio, revealed left shoulder pain, worsening shortness of breath due to heart failure, and declining ability to ambulate independently. The nurse arranged for Dwight to see his PCP the following day to evaluate his heart failure and pain symptoms, made recommendations for improved pain management, and set up a pill box for his meds.

The following week, the PIM™ social worker visited Dwight and his wife to address goals of care and assist in completing an advance directive that outlined a comfort approach to care if his health worsened, all in keeping with Dwight’s wishes. A DNR order form was provided for his next PCP visit.

Home health follow-up was arranged for medication management and a referral to Meals on Wheels was made to relieve meal preparation burden on his wife. The PIM™ team continued to monitor Dwight’s health and provided emotional support to his wife through intermittent calls and visits based upon his assessed palliative needs.

After three months on the program, Dwight had no further trips to the ED or hospital, his pain was under control, and he was taking his heart failure medications as prescribed. His wife appreciated the extra support and was able to get out of the house more often to visit family and friends.

Dwight’s story illustrates the ways in which new, innovative care approaches are improving outcomes for individuals and families with a serious or advanced illness. As health plans and providers in the U.S. take on greater accountability for those with a serious or advanced illness, they are recognizing the value of providing specialized community-based palliative care (CBPC). Palliative care programs successfully expand the goals of care toward comfort and quality of life when it is in keeping with the patient and family wishes, while avoiding costly, burdensome, unplanned treatment at the end-of-life.
A Structured Approach to Community-based Palliative Care

CBPC includes a variety of models of care designed to meet the needs of seriously ill individuals and their families, outside of the hospital setting.

Innovative approaches to CBPC within broader population health management (PHM) programs are addressing the medical, emotional and socio-economic burdens of an advanced or serious illness. The PIM™ model from Turn-Key Health was validated in 2015 at Mount Carmel Health System in Ohio and is now underway at other Medicare Advantage Plans and provider organizations.

Turn-Key Health’s predictive model focuses on high-opportunity member engagement. Utilizing payer claims data and leveraging a powerful form of Artificial Intelligence (AI) and Natural Machine Learning (NML), this approach proactively identifies members who will benefit from palliative care, rather than experience episodes of acute, over-medicalized or unplanned care at the end-of-life.

Research indicates that approximately half of all deceased Medicare beneficiaries in any year will undergo unplanned treatment in the last six months of life, including a small fraction that undergo appropriate, but expensive care. This model is designed to identify those members whose conditions and history are likely to result in care that is both expensive and ultimately futile.

Palliative Activation Scale (PAS)

A key differentiator of the Turn-Key PIM™ model is that it optimizes care quality to maximize the Palliative Activation Scale™ (PAS).

PAS is the measure of a member’s propensity to make healthcare choices that are in congruence with their personal goals of care. The PAS evaluates member clinical stability (i.e., symptom management, satisfaction), member engagement (such as completion of goals of care, advanced care planning, communication), and member alignment (i.e., psychosocial, family dynamics, and physician communication). PAS predicts behavior, as well as informs areas in need of improvement to maximize quality outcomes.

To maximize improvement in PAS, Palliative Extensivists in the PIM™ model utilize Turn-Key’s comprehensive, standardized, baseline and follow-up palliative phone and home visit motivational interviewing logic. They review symptoms, perform medication reconciliation, and discuss and documents goals of care. They guide advance care planning, provide psychosocial support and identify caregiver needs. These clinicians then create a palliative plan of care based upon patient goals, while providing ongoing support for enhancing home supports, providing patient education and assisting with patient decision-making.

“...highly structured and consistent clinical programming with ... monitoring and oversight are its keys to success...”
Focus on Care Coordination

Turn-Key has a national, proprietary network of specialized palliative care clinicians - comprised largely of nurses and social workers - that reside as a separate service within local hospice and palliative care organizations.

Focusing on palliative care outside the acute care setting, they address disease understanding, provide symptom control/treatment options, complete goals of care conversations, and provide advance care planning documentation. By aligning treatment with individual preferences, these clinicians improve member and caregiver satisfaction.

PIM™ focuses on improving member and caregiver satisfaction by enhancing care coordination and quality, improving knowledge and understanding, and establishing goals of care for shared decision-making. This results in quality of life improvement, a reduction in avoidable medicalization and unplanned care, and a decreased expense.

Members benefit from diminished symptom burdens and condition exacerbation through improved medication adherence.

Key Message: The PIM™ model effectively shifts the center of care to the home or community, placing the focus on care coordination and patient-centric services. Outcomes and results are measured and valued at a population level. Optimizing pre- and post-acute care, PIM™ reduces hospitalizations, re-admissions, and number of ICU days, resulting in a drop in the average claims cost per member per month.

Individuals with a serious or advanced illness who might otherwise go undetected by traditional means are identified earlier in the progression of disease, ensuring that gaps in care are recognized and closed.

Communication Enhancement

In addition to supporting shared decision making, the PIM™ model provides a significant benefit to the patient, caregiver, and treating physician by fostering more timely and accurate communication. This improvement is accomplished not only by opening channels of communication, but also through the surfaceing and prioritization of more important patient and caregiver issues.

The communication protocols within the PIM™ model address many different aspects of patient and caregiver status, but can be broadly categorized into three buckets: Clinical Events, Care Coordination and Non-Medical. The urgency of the issue dictates the mode and speed of communication back to the primary treating physician and/or to case management staff.

Clinical events identified by the PIM™ team member, in the home or telephonically, include such items as changes in status, cognitive function, functional status, risk level, and symptoms. Events may also include clinical utilization, such as acute care utilization – ER or hospitalization, or lack of utilization, such as missed appointments, missed medications, etc. These clinical events can be the precursor to further exacerbation and additional unplanned care for patients.

“...This model uses a ‘care pathways’ approach which defines the patient’s assessed risk level...”
Care coordination issues identified by the PIM™ team members are often identified in the patient home, and relate to gaps in care or excessive care that may lead to patient deterioration if left unaddressed. Many of the issues are difficult to identify without being in the patient home, and remain unaddressed in a typical home-based care environment. Issues such as the need for home health, DME, transportation support, social supports, pharmaceutical needs and others.

Non-medical events identified by the PIM™ team are equally important to communicate across the care continuum to improve quality of care for the patient and to decrease caregiver burden. Examples of these events that are communicated back to the primary treating physician, as well as the case management team, are advance care planning documents, goals of care, caregiver status changes, code status change, lack of social support, food insecurity, isolation, and risk of self-harm.

For each of these three communication buckets, it’s important to note that many of these items would remain undetected, unreported, or unaddressed without the PIM™ members in the home providing supportive palliative care to the patients and caregivers. The reach and frequency of the PIM™ team within the population are critically important to improving quality of life, while decreasing financial burden.

**Validated Results**

A one-year program at Mount Carmel Hospice and Palliative Care tested and validated PIM™ for seniors enrolled in a Medicare Advantage plan. There were 208 members enrolled in the program, compared to 800 members who were identified by the model but not enrolled. The overall reduction in healthcare expenditures was 34 percent.

- Lower hospitalizations: 32 percent
- Reduced hospital readmissions: 61 percent
- Reduced ICU days: 37 percent
- Earlier and appropriate election of the hospice Medicare benefit

Results from the program also demonstrated impressive clinical results:

- **98%** goals of care completion
- **97%** symptom satisfaction
- **4.8/5** stars satisfaction rating

Much like traditional health plans, provider organizations should seek scalable solutions like PIM™, which integrate with their existing PHM solutions to improve the quality of care for patients with a serious or advanced illness. Typically, these patients are frail and have multiple comorbidities requiring complex medication regimens and symptoms that make it difficult to cope with day-to-day living. Given the complexity of healthcare decisions facing those approaching end-of-life, CBPC care teams equipped with the right tools and training help to inform and support patient and family’s needs and expectations.
**Conclusion**

As a nation, lack of attention to the special needs of those with a serious or advanced illness is becoming a weighty issue that carries a billion-dollar price tag. For hospital systems, ACOs and MCOs that are tackling these challenges, functioning as both providers and payers, the introduction of specialized community-based palliative care has the potential to not only reduce the cost burdens, but to also support patients in their quest to remain in the home.

As payers and providers take dual roles in the healthcare ecosystem, they will find that innovative PHM solutions, such as PIM™, will enable them to monitor and improve the health of large groups of patients with a serious or advanced illness. Success lies in the provision of strict quality oversight and the training of palliative care specialists who are supported by a platform of uniform assessments, care protocols and dashboard reporting to monitor progress. Value will be tied to care quality and better outcomes, with an overall care coordination strategy playing an increasingly important role in fostering patient satisfaction.

Whether or not an organization opts to take on risk for Medicare Advantage members, it will be highly beneficial to implement a PHM strategy that offers a comprehensive solution that begins and ends with a patient-centric focus.

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Turn-Key Health, an Enclara Healthcare company, serves health plans, provider organizations and their members who are experiencing a serious or advanced illness. Its Palliative Illness Management™ (PIM™) model introduces a new, innovative option to improve care quality, address costs and reduce burdens associated with life-limiting illnesses.

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