Palliative care and serious disease management in primary care

National Academies of Sciences, Engineering, and Medicine Workshop on Integrating Palliative Care into Primary Care

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Transforming primary care

Transforming the healthcare system to better meet the needs of people with serious illness will require investment in primary care, providing time for shared decision-making, community integrated services, and better incorporation of palliative care into the care delivery model.

Health transformation

Our framework

1.0
SICK CARE SYSTEM

Goal: absence of acute disease

Mid-1800s to 1950s

2.0
COODINATED HEALTHCARE SYSTEM

Goal: absence of acute disease

1950s to 2020s

WE ARE HERE

3.0
COMMUNITY INTEGRATED HEALTH SYSTEM

Goal: optimize overall health

2020s & Beyond

Our philosophy

Relentlessly pursue fundamental changes in how healthcare is delivered to achieve the quintuple aim

1

Improve whole **population health**

2

Enhance **patient care** and **experience**

3

Improve **provider wellbeing**

4

Reduce **cost of health care**

5

Increase **health equity**

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Health Reimagined practice transformation solutions

Shared decision-making

Improves patient engagement and satisfaction by empowering patients to actively participate in their care planning and treatment

Virtual care

Establishes a platform for real-time virtual interaction between patients and their regular health professionals for diagnosis, treatment, and management of medical conditions

Community health advocates

Community Health Advocates work with—or on behalf of—patients to navigate the health system and connect them with community resources that address their social needs and reduce health inequities

Real-time claims settlement

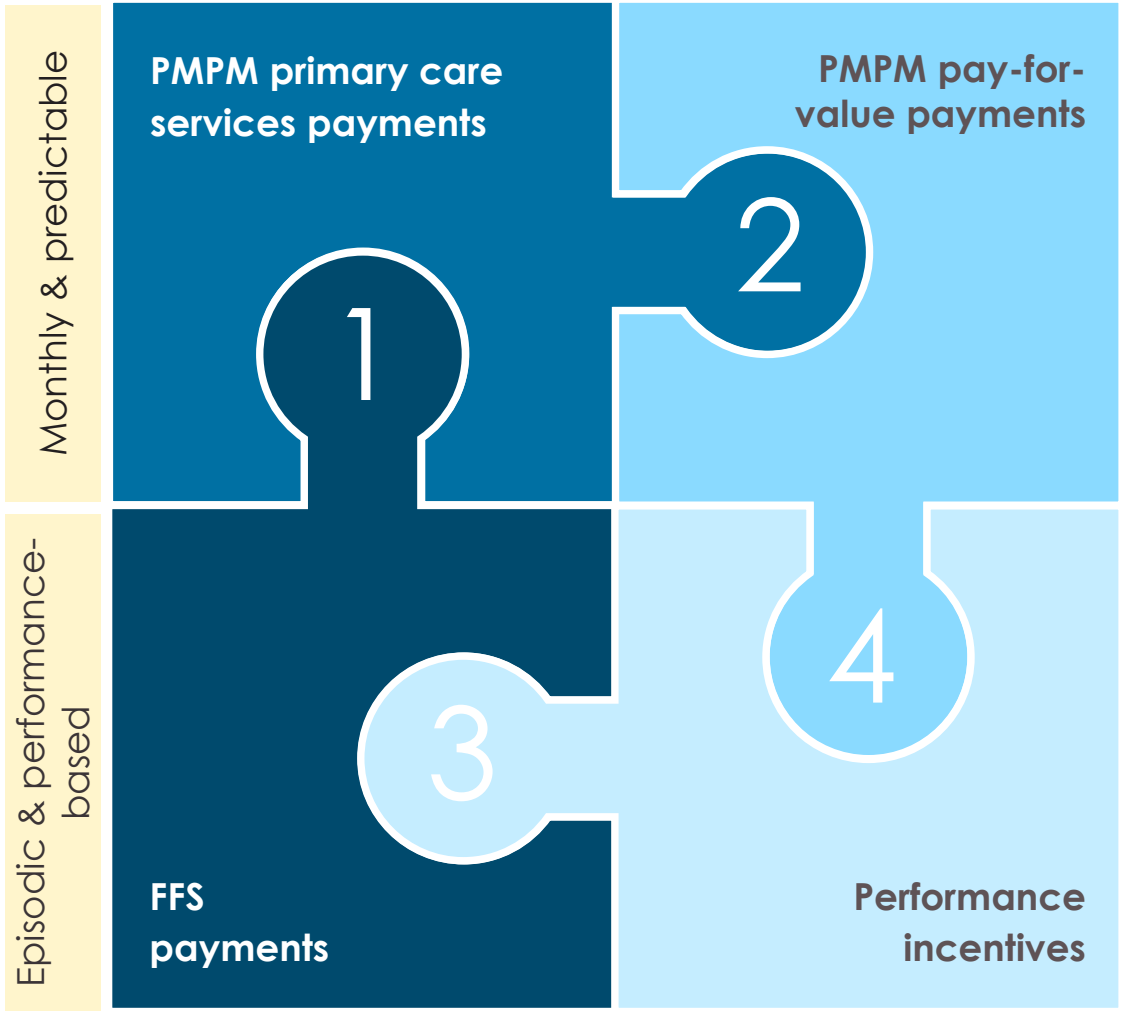
Using direct connection digital solutions, Blue Shield enhances the speed of claims processes from days to seconds

Payment transformation to support primary care

Payments for delivery of primary care services

Monthly advance payments for majority of codes used for standard primary care delivery. Service intensity & benefit adjusted.

Payments for codes/services not included in PMPM. Billed and paid fee-for-service (FFS).



Payments for pay-for-value services and performance outcomes

Monthly advance payments to support traditional and/or new approaches to care delivery and coordination.

Revenue opportunity tied to performance against targets in a minimum set of HEDIS measures, resource utilization measures and member satisfaction scores. Paid biannually.

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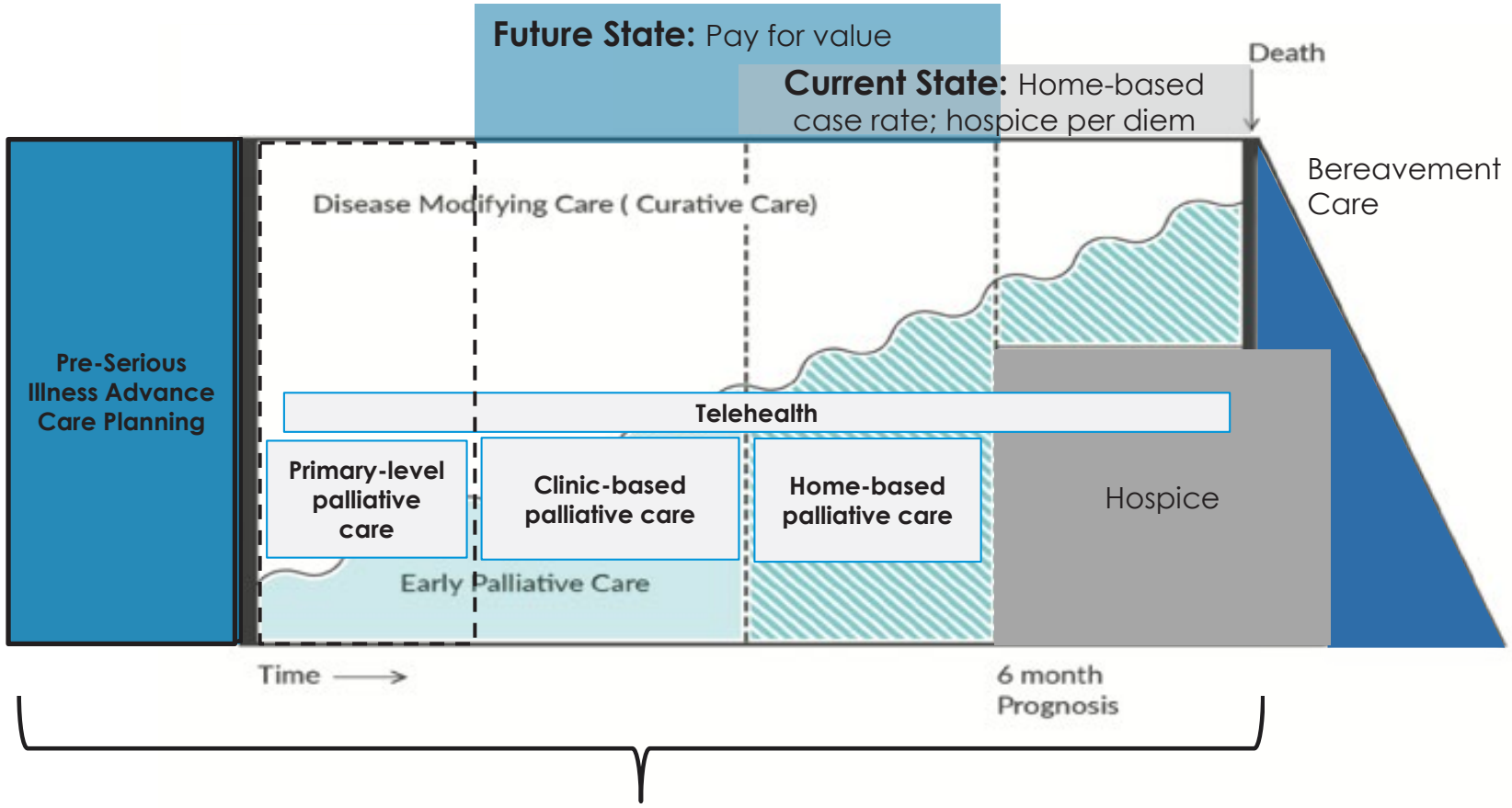
Blue Shield palliative care overview



Philosophy:

- Every member can engage in advance care planning and have their values, goals and preferences documented, shared and honored within the healthcare system.
- Every member who has a serious illness can participate across the palliative care continuum.

Home-based palliative care (HBPC) program overview

Designed to provide sub-specialty level palliative care and be an **extension of the care team into the home** for patients with serious medical conditions who:

- Have significant functional impairment that limits their ability to get to the office
- Have social determinateness that can't be effectively addressed in the office and interfere with optimal care
- Are struggling with adherence to the treatment plan

Members in the HBPC program are **not charged copays or co-insurance** for services provided as part of the program.

Providers are paid a **monthly case rate.**

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HBPC program patient eligibility requirements

General guidelines

- Have an advanced illness
- Use hospital and/or emergency room (ER) to manage illness
- Willing to attempt home and office-based management, when appropriate
- Not eligible for or declined hospice care
- Death within a year would not be unexpected
- Willing to participate in advance care planning discussions

Diagnosis categories

- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Advanced cancer
- Liver disease
- Cerebral vascular accident/stroke
- Chronic kidney disease or end state renal disease
- Severe dementia or Alzheimer's disease
- Other serious disease

Palliative care program services

Services include (but are not limited to):

- Comprehensive in-home, multi-domain assessment by interdisciplinary team
- On going discussion about the patient's priorities, values, and goals
- Symptom management
- Case management and coordination of care
- Assistance with transitions across care settings
- Medication review and reconciliation
- Psychosocial support for mental, emotional, social, and spiritual well-being
- Caregiver support
- Connection to community resources
- 24/7 telephonic support

Interdisciplinary team members

- Palliative Medicine Physician and Nurse Practitioner
- Nurse
- Social Worker
- Chaplain

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Early results

- Statewide network of 48 contracted providers who cover all of California.
  - In some remote areas, services are only available virtually (e.g., telemedicine)
- 3064 members served since January 2017
- Quality data
  - 52% of members have completed advance directives
  - 90% of members have designated a durable power of attorney for health care
- Utilization data
  - Per member per month cost for ED and hospitalizations
    - Median: $1,204 down to $45
    - Mean $3,996 down to $2,746
  - Inpatient visits per 1,000 went from 1,255 to 1,069
  - ED visits per 1,000 went from 1,034 to 851
- Member satisfaction data
  - Majority of members are satisfied or very satisfied with the program

"It has been an invaluable service and definitely took significant stress out of being ill so I could concentrate on being healthy."

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Future of home-based palliative care in primary care

- Leverage the lessons learned from implementation of home-based palliative care to create a **payment model** for interdisciplinary palliative care in the office setting with extension into the home by **video visit**
- Use the **shared decision-making** model as a resource for primary care physicians in integrating elements of palliative care earlier in serious disease management
- View palliative care integration into comprehensive primary care as a key step in the journey toward successful implementation of **pay for value**

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Thank you
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