# ACCOUNTABLE CARE COMMUNITIES COUNCIL

## Providing Palliative and Hospice Care in an ACO Network

On April 17th, 2014, the Accountable Care Communities Council convened to discuss how palliative and hospice care can improve the quality of care while reducing costs within an accountable care organization (ACO). During the call, experts from three Pioneer ACOs shared their experiences and illustrated approaches to using health IT to coordinate and manage palliative care services.

## Background

### Pioneer ACO Program

Over the past several years, the Centers for Medicare & Medicaid (CMS) has spearheaded a shift away from the traditional fee-for-service (FFS) model and towards a new value-based paradigm that emphasizes quality and coordination of care. In seeking to transform the payment and delivery of care, CMS has created different ACO models that strive to achieve the Triple Aim of better health, care, and cost containment. An ACO is generally comprised of a network of providers, hospital(s), and specialists that share responsibility to manage the care of a defined patient population across the continuum. Unlike the volume-based FFS reimbursement mechanism, providers within an ACO are reimbursed according to their performance. While similar models exist in the private sector based on independent quality measurements, ACOs participating in CMS programs can share the savings or losses experienced by Medicare to varying degrees for an assigned set of patients.

The Pioneer ACO Model was designed and launched by CMS on January 1, 2012 to study the impact of advanced payment arrangements among 32 organizations with prior experience in offering integrated, coordinated, and patient-centered care. While nine organizations subsequently dropped out of the Pioneer program due to the higher levels of risk, the remaining 23 Pioneer ACOs were able to generated $147 million in their first year.[1] These early adopters have been a weathervane for organizations that have been accepted into Medicare Shared Savings Program (MSSP) cohorts or that have been established in the private sector. The majority of ACOs are typically formed around the building blocks of primary and acute care. However, as ACO networks mature and expand to include outpatient care services, the coordination of patient-centered care across disparate settings becomes even more critical. Early evidence from the following three Pioneer ACOs suggests the importance of palliative care in achieving the Triple Aim.

### Palliative Care

Palliative care is a key component to effectively planning care and managing high-cost, seriously ill populations that experience distress, frailty, and progressive functional dependence on caregiver support. Acting to anticipate, prevent, and relieve suffering among patients, palliative care prioritizes the quality of life and autonomy of patients, caregivers, and family members. Typically, palliative care is delivered by a team comprised of a physician, nurse, social

> *"Palliative and hospice care are the cornerstone for transforming our system... it forces us to ask what can we do differently."*
> -- Tim Ihrig, MD, MA
> Trinity Regional Medical Center

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[1] www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-30.html

worker, therapist, dietician, and/or psychologist to meet the needs of patients and their caregivers. Palliative care provides an extra layer of support across the continuum, and goes beyond symptom management to also include physical, psychosocial, and spiritual dimensions. While similar in concept, hospice is only delivered to terminally ill patients (generally defined as those expected to die within six months). Palliative care contributes to approximately $1.2 billion in savings per year in the U.S., and hospice has been demonstrated to reduce spending, hospital service use, and in-hospital death significantly among Medicare populations for up to 105 days of hospital enrollment.[2]

## Case Studies

Summarized below are brief case studies of how Trinity Pioneer ACO, Beth Israel Deaconess Physician Organization, and Sharp HealthCare have used health IT to coordinate and manage palliative care services across their respective accountable care networks.

<u>Key Findings</u>

Common themes identified across the three organizations include:

- **A multi-disciplinary, team-based approach to palliative care** is key to achieving the best possible quality of life. Programs should be able to coordinate care transitions and deliver services in patient-centered settings such as home health or skilled nursing facilities.
- **You can't improve what you can't measure.** Programs should standardize shared quality metrics across an ACO network to reflect clinical objectives (patient symptoms, care requirements, etc.), operational (ER visits, hospitalizations, length of stay, transfers, discharges, etc.), financial, and patient-centered goals (POLST, completion of advance directives, patient/family satisfaction, etc.). Metrics should be continuously measured.
- **Identify and stratify patients according to risk of illness and need of palliative care.** Programs should develop multi-dimensional criteria such as patient pain and psychosocial symptoms; understanding of illness, prognosis, and treatment options; and stage of illness.
- **Health IT can improve the quality, cost, and coordination of palliative care** through tools that facilitate medication management, symptom monitoring, patient education, communication, and disease management.
- **Real-time access to and exchange of health information is critical to managing population health and delivering patient-centered care**, particularly among ACO networks that operate in disparate areas or across multiple facilities. But it is also one of the key challenges.
- **Establish a collaborative relationship with vendors to work through challenges.** While they may be missing elements specific to ACO metrics, continuity of care documents (CCDs) offer a standardized platform for EHR and health information systems to exchange data. Work with vendors to develop a framework with the key specifications (e.g. lab results) that may currently be lacking in Meaningful Use requirements.
- **Don't let perfect be the enemy of good.** Lack of interoperability can lead to gaps in palliative care across the continuum. Although organizational performance can be hindered by inability to

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[2] http://www.capc.org/costsaving_aim092008.pdf

transmit or access information, ACOs are encouraged to work with their current IT infrastructure and deploy simple solutions that deliver a high impact.

## TRINITY PIONEER ACO

The Trinity Pioneer ACO (TPA) network was formed by Trinity Regional Medical Center, UnityPoint Clinic, Berryhill Center, and UnityPoint at Home. Covering eight counties in northwest central Iowa, TPA is the most rural of the Medicare Pioneer ACOs. Since joining TPA, Trinity Regional Medical Center has implemented an integrated palliative care model across the network that has been able to consistently improve the quality of care and reduce costs among seriously ill patients. At the core of its approach has been a multi-disciplinary medical home that seeks to identify high-risk individuals upstream, engage and communicate with them and their families, and pinpoint patient-centered goals of care at the earliest opportunity. The systems-based approach has leveraged health IT to allow for real-time identification, assessment, and management of complex problems.

Outcomes of Integrated Palliative Care Program
Over the past three years, TPA palliative care services have achieved the following results:
- Length of stay has been reduced from 2 days to 1.5 days
- 40% reduction in ER visits and 80% reduction in hospital readmissions
- Cost savings of $800,000 in 1st year, $1.8 million in 2nd year, and $2.1 million in 3rd year
- 67% per-capita reduction in expenditures
- Top scores in patient satisfaction

Strategies for Success
The following initiatives were identified as vital to achieving the above outcomes:
- Promote timeliness of referrals to connect patients to the right service at the right time
- Conduct outreach to patients and their families to educate them about palliative care options; facilitate referrals to hospice; and provide holistic support to terminally ill patients
- Provide continuity of care across transitions to improve collaboration, communication, medication reconciliation, and medication management
- Move beyond basic health education and coaching to actively provide high-intensity case management beyond the four walls of care by leveraging telemedicine and partnerships with outpatient specialty clinics and skilled nursing facilities
- Develop standardized staffing metrics and an interdisciplinary team approach
- Standardize screening criteria and embed triggers for palliative care into practice in all settings
- Continuous measurement of operational, clinical, financial and patient satisfaction metrics.

## BETH ISRAEL DEACONESS PHYSICIAN ORGANIZATION

Beth Israel Deaconess Physician Organization (BIDCO) was originally formed by Beth Israel Deaconess Medical Center and the Harvard Medical School Teaching Hospital, and has since expanded to include other physician groups and organizations. Located in Eastern Massachusetts, BIDCO employs more than 80 staff members and contracts with 2,300 physicians, including approximately 550 primary care physicians and 1,700 specialists.

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Health IT Challenges

Due to the nature of operating an ACO network, BIDCO has encountered several challenges along the way that have hindered progress to date:

- Lack of clinical integration between electronic medical record and health information systems within and across organizations in the network.
- Lack of interoperability (BIDCO uses several primary care platforms in its medical center for approximately 40% of its physician members, a subscription-based cloud EMR among 40% of its members, and multiple systems among the remaining 20%).
- Lack of alignment between Meaningful Use quality measures and CMS ACO measures has made it difficult to efficiently measure, analyze, and improve performance
- Features required by hospice/palliative care and behavioral health programs don't always exist natively, leading to an in-house development approach

Strategic Approach: Keep It Simple

Rather than try to replace or redesign a fully integrated health IT infrastructure from the ground up, BIDCO has taken an incremental approach to improving its technology solutions. For example, after meeting with stakeholders in the hospital, physician groups, and patient community, it became clear that physicians and caregivers needed to be able to easily identify patients within the ACO program and view which extended care programs were available under coverage at the point of care. To achieve these objectives, an electronic member directory was deployed that visually flagged ACO patients in a caregiver's native EMR and clinical system. Accessible by all BIDCO affiliates, the query-based database can notify providers of high-risk ACO patients who are eligible to be enrolled into extended care programs such as palliative services. At a macro level, the Massachusetts Health Information Highway was also recognized as a critical feature that provided a trusted fabric and HISP in which information can be collected, exchanged, and accessed through a statewide master patient index and registry.

## SHARP HEALTHCARE ACO

Serving approximately 32,000 Medicare beneficiaries, Sharp Healthcare ACO (SHA) is part of the greater Sharp HealthCare integrated healthcare delivery system in San Diego County. The SHA network includes four acute-care hospitals, three specialty hospitals, 2,600 affiliated physicians, and two affiliated medical groups within the Sharp HealthCare System.

Integrating into an ACO

In 2007, a home-based palliative care program was designed to create different care pathways for seriously ill patients. Since then, Sharp HospiceCare has evolved to center evidence-based care around patient and family values, preferences, and goals. Sharp HospiceCare aims to seamlessly coordinate palliative care across the continuum through the following services:

- Advance care planning – shared decision-making program to engage patients and their families, reduce their distress, and achieve better outcomes
- Bridges Program – 30-day post-discharge readmission programs
- Transitions Program – interdisciplinary disease management for late stage illness
- Hospice Program – end of life care
- Bereavement, grief, and loss support

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Because the affiliated HMO and multi-specialty medical groups normally operate very differently with Medicare populations, SHA has found it critical to develop shared goals and outcomes that reflect competing priorities of organizations within the ACO network. Having already integrated its EHR system, Sharp HospiceCare has focused on streamlining its coordination and communication processes across the Bridges, Transitions, and Hospice programs. Each of the programs features telephonic care management, home visits, caregiver support, 24/7 access to a nurse, and varying degrees of additional support. The three programs also have a shared quality report card that includes key metrics.

Initial Experience in Integrated Palliative Care
Referrals to advance care planning have increased dramatically. Initially designed and launched in October, 2013 to improve outcomes for hospitalized CHF patients, the Bridges program coordinates care from admission to discharge between SHA's ambulatory care management and community medical group. Because Medicare patients are sometimes unaccustomed to being in a coordinated care plan, many may use the emergency room and hospital as a primary setting to manage symptoms. Accordingly, Sharp HospiceCare has taken an iterative approach to work upstream and improve quality, reduce costs, and engage patients earlier on in the process. The number of patients participating in the Transitions program has nearly doubled, with approximately 70-80% of them continuing on to hospice.

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