Patient Quality of Life Coalition
May 20, 2015

"Bottlenecks & Barriers reducing Patient Access to Palliative Care: Policy & Payment Implications"

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Agenda

- Current state of affairs –bottlenecks & financial hurdles
- Trends & Opportunities
- Overview of payment options
- Risks & Unintended Consequences
- Recommended Principles
- “No Regret” Strategies
- Implications for Public Policy

What is Palliative Care?

- Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.
- Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Essential concepts

- Palliative care teams focus on the “whole” – holistic – multisystem – including family –across settings
- Weaving the whole picture to achieve sustainable GOC takes TIME, TEAM, AND SKILL. This is often a “just in time” need.
- Patients often live in the “or else” bucket of treatment protocols and pathways…

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What does FFS pay for (partially)?

Gaps = time & timeliness, IDT, all non-direct patient care time, f/u

Medical Pain and Symptom Management	The Right Care, at the Right Place, at the Right Time	Psychosocial Support	Spiritual Support
Caregiver Support	Enhanced Communication and Shared Decision Making	Care Coordination and Communication between providers	Family Meetings and Conversations

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Positive Trends

- Culture is changing, tone has changed, lots of goodwill
- A “foothold” exists in most hospitals & some communities
- Quality measures (external to palliative care) are helping
- There is a thirst for recommendations & standards

Dilemma for Health Systems

- Living in one world, planning for next
- Norms re RVUs are deeply ingrained
- Want to support palliative care but can't get their heads around scope, scale, and impact…diffused.

Example of Costs

(example for illustration, representative but not actual data)

1 additional patient with complications

- ➔ Assume 1 week additional in hospital – at $1,000/day in direct costs (to hospital), $7,000 not offset by case payment
- ➔ Assume 1 week additional in hospital – at $2,000 in total costs, paid by payer, $14,000
- ➔ Assume 6 weeks in SNF at $450/day - $18,900

Which is relevant to whom?

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Current payment norms

- ➔ FFS rewards volume & drives single problem focus & proliferation of services

- ➢ Structural incentive to favor efficiency over effectiveness

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Efficiency vs. Effectiveness

- Option A – see every patient in office with billable provider; preschedule with average wait time of a month to ensure use of capacity
- Option B – use email, phone, non-billable team members for some of the contact, and possibly some home visits; maintain next day or same week appointment capacity & phone access 24/7. What is “cost” of maintaining access”?
- Value?

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Structural Payment Bottlenecks

- Institutional silos (hospital, hospice, home care, provider)
- Benefit structure ("subject to improvement" & hospice "either/or")
- Medical services vs. social service/ community support coverage

Intended Consequences

- "You get what you pay for"
- System intensifies the problem:
  - volume breeds volume
  - Solo (vs. IDT) and Silo (multi sub specialty)
  - Single problem vs. systemic
  - Medical/procedural vs. environmental
  - Notes go into E.H.R. – T.M.I. & T. L.C.

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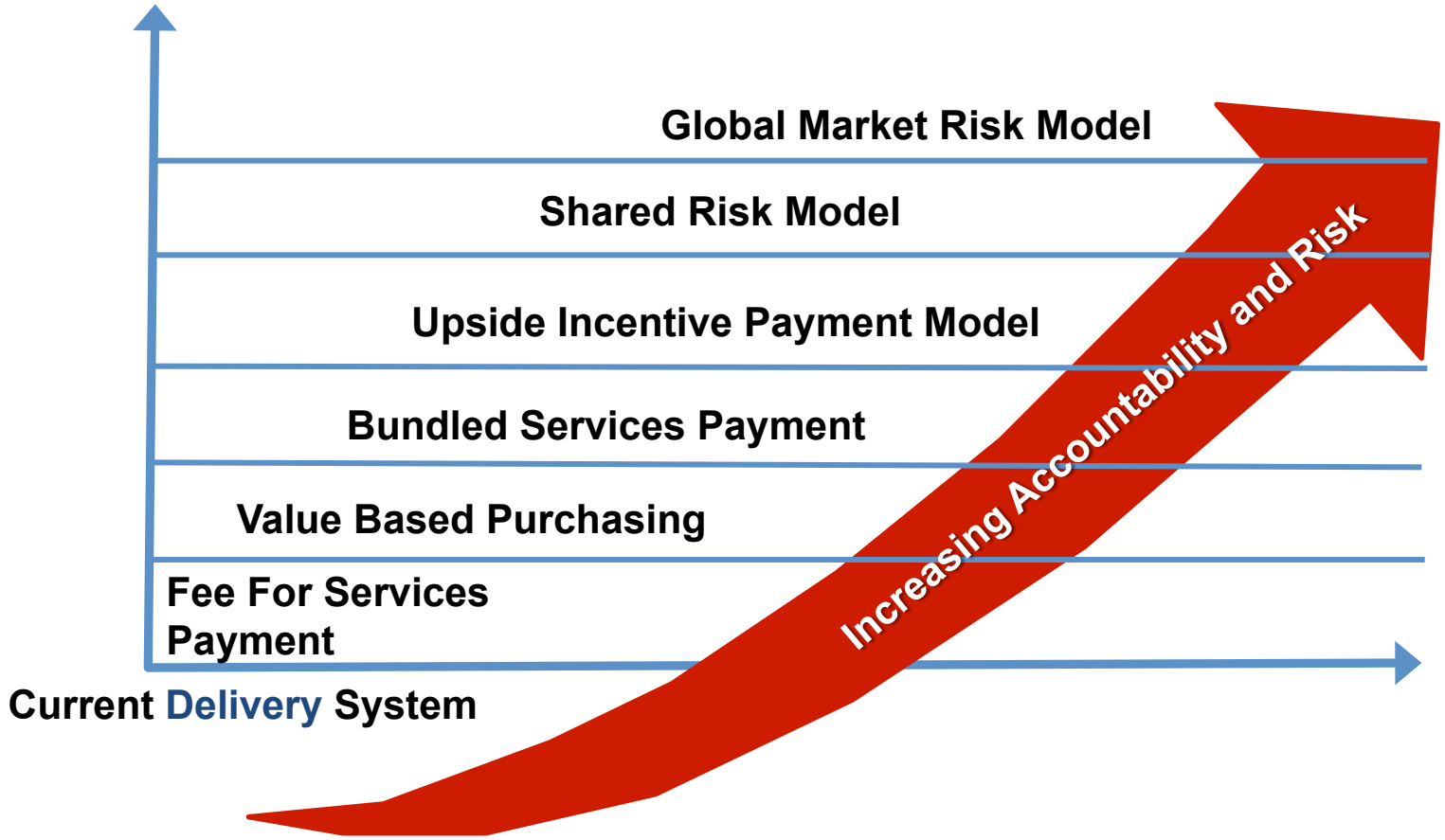
Movement Away from FFS



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Payment Options

- FFS (defined, narrow, countable)
- Bundled payments (“buckets” such as 1 hospitalization, 1 surgery, or episode of care)
- Capitation (and sub-capitation) – total cost of care (*at least theoretically)
- Incentives, Rewards, Penalties
- Per diems
- Outlier payments

Capitation Hurdles & Risks

- Effective control over all inputs? *Can you move around the deck chairs?*
- Timely Data?
- Patient buy-in?
- Willingness to pay for capacity and expertise vs. sub-cap ffs?
- How porous is your system?
- Market density / position

Bundled Payments – Creative Options for Palliative Care

- Single rate for IDT service, not tied to provider type (ex.: $250/home visit or $500 for GOC completed)
- Episode of care ($1000 per inpatient – if referred with criteria, or xxx per month in community wt criteria)
- Payment for portfolio of training activities

**examples are for illustration & not recommended rates.*

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Rewards & incentives

- Include palliative care training options in bonus pools for PCMH, primary care, specialty care
- Include nursing, SW, Care Managers, Navigators, etc.
- Reward inclusion of patients & families in advisory boards, workgroups, etc.

Training…training…training

- Community wide initiatives – ACOs or payers or systems could fund fellowships for mid-career folks, fund intensive short term training, fund outreach initiatives, provide access to on line training.
- **The process is the intervention – awareness stimulates access & use**

Challenges on “our” side

- Field is new – measures are “squishy”
- Great heart is not a substitute for good process, skills, and method (high variability)
- Training lags…big labor constraint
- Hard to define our denominator – appropriate high cost high risk patients

Characteristics preferred by payers & policy makers

- Clarity re target population & intervention
- Guardrails – measures of quality
- Consistency of service – scope, scale, definition
- Low risk of "bad actors" milking the system
- Low risk of expansion of demand based on attractiveness of service
- Mass customization – need to do it electronically & for high volume (low admin cost)
- Low risk of "good citizen penalty"

Risks – “no good deed goes unpunished”

- Without criteria to evaluate Q, open to manipulation (check off the box vs. GOC)
- Too much flexibility opens door to non-medical societal needs
- Without clear screening criteria, big denominator drives high costs (disproportionate to need)
- Adverse selection to some

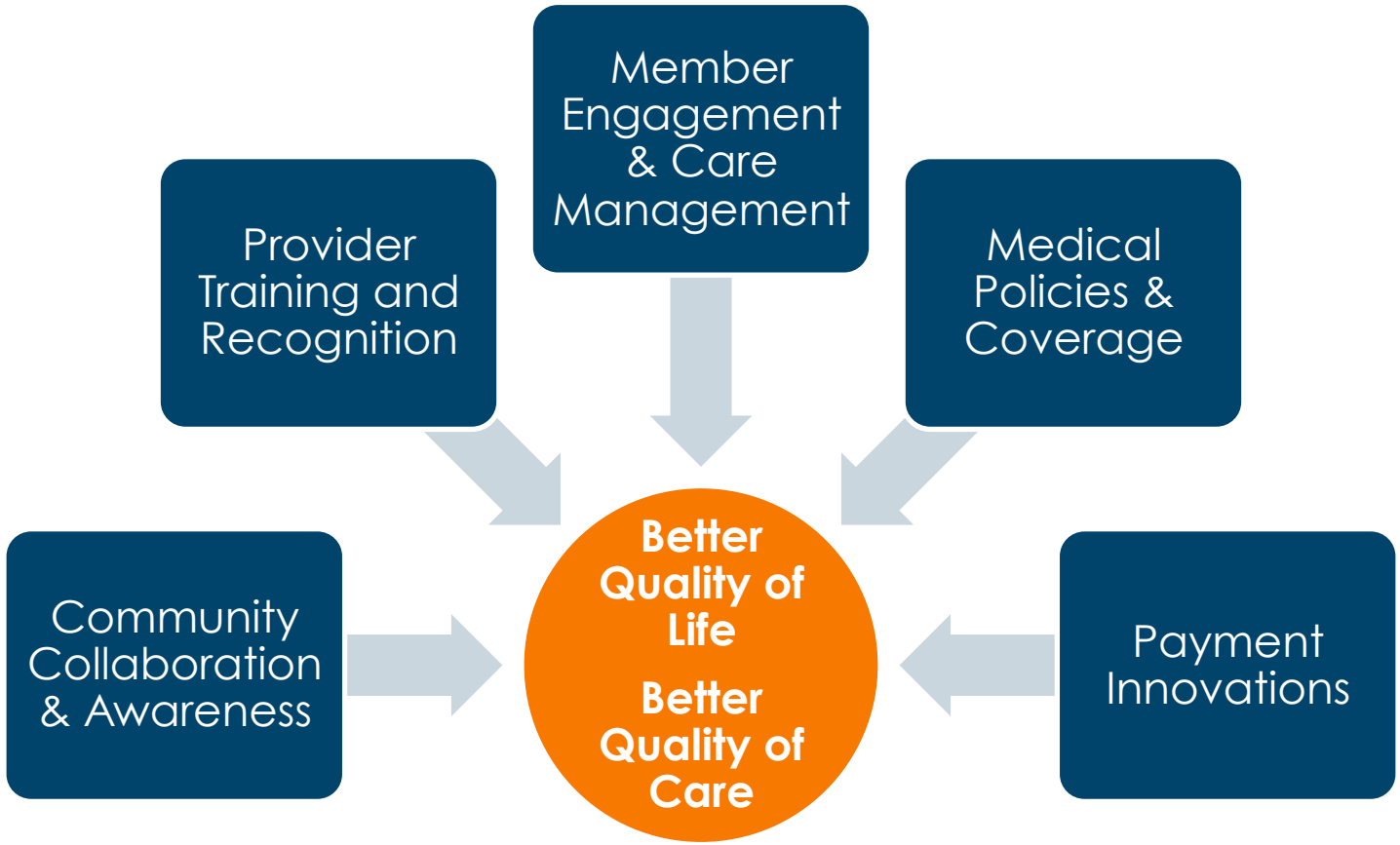
Risk Reduction Principles

- Resist the “tragedy of the commons”
  - Safety in consistent approaches
- Resist over-regulating metrics
  - Minimum becomes maximum (ex. Staffing)
- Reward communication & training
  - People want to do the right thing…
- Research & data – need for big picture Q outcomes & patient voice

Risks of "over-correcting" with Requirements

- "Noah's Ark" 2 x 2 (mandated IDT)
- Time as substitute for effectiveness
- Certification requirements may hurt rural markets / need match with training support
- **Minimum becomes maximum – "managing to the metric"**
- Penalizes creativity early in field development

How payers are supporting palliative care



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Innovative Payer Toolkit

www.capc.org/payers/palliative-care-payer-provider-toolkit/

- Predictors of successful payer-ACO-provider initiatives
- Case studies
- Checklists
- Worksheets
- Resources

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Important, and Hard

- How do we reward “availability and timeliness” vs. Volume?
- How do we measure “effectiveness” (so that creativity can flourish in solution sets)?

“No Regret” Actions

- Bonus Points, Rewards, Visibility for
  - Educational initiatives of all sorts
  - Community engagement activities
  - Process & systems that stimulate communication across lines
- “Hot Line” or “Concierge” option for teams caring for seriously ill to make just in time benefit exceptions & craft common sense solutions

Logical Payment Options

Option	Example
➔ Pay well for small “bundles”	➔ $1000/mo for up to 3 mo. For post d/c home & community support
➔ Pay for IDT roles (pilot)	➔ SW, Pharmacist, RN, etc
➔ ACO’s or MA to compensate health systems for comprehensive programs	➔ Full spectrum of services in place, with training, gets preferred rate

Summary

- You are all helping – by stimulating conversation & awareness
- Push for a few important things
- Education (broadly defined) and Engagement (across silos and professional turfs) create change
- Simple payment bundles done consistently can stimulate a lot of activity

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Thank You for the work you are doing!

Q and A

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