A Blueprint For Health Plans:

A Tool to Assess the Quality of Community Based Advanced Illness/Palliative Care

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Learning Objectives:

- Identify the critical elements of service delivery for each model
- Name three models of advanced illness/palliative care services delivery in non-hospital settings
- Appreciate how health plans can use this 'blueprint' as a roadmap for buying or building a sustainable model of advanced illness/palliative care service delivery

Providing the context

- Introduction to the Alliance of Community Health Plans
- Triple Aim Initiatives
- Medical Director's Committee Palliative Care Work Group

ACHP Mission

ACHP and its members

improve the health of the communities we serve

and

actively lead the transformation of health care

to

promote high quality, affordable care and superior consumer experience.

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ACHP Member Organization Attributes

Quadruple Aim: Focus on health of populations, optimal patient experience (outcomes, quality, satisfaction), affordability, and community benefit.

Community-Based: Build communities to better health. Loyal to our communities and inspiring loyalty in return.

Provider Partnerships: Partner closely with dedicated and contracted physician groups to improve health and health care delivery. Accept risk and share it with providers through payment strategies to achieve high performance and delivery system reforms.

Non-Profit Orientation: The community is the chief stakeholder in our plans' success. Make decisions that keep consumers healthy for the long-term. Provide community benefit.

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ACHP Members

Capital District Physicians' Health Plan	Albany, NY
Capital Health Plan	Tallahassee, FL
CareOregon	Portland, OR
Fallon Community Health Plan	Worcester, MA
Geisinger Health Plan	Danville, PA
Group Health	Seattle, WA
Group Health Cooperative of South Central Wisconsin	Madison, WI
HealthPartners	Minneapolis, MN
Independent Health	Buffalo, NY
Kaiser Foundation Health Plans and the Permanente Federation	Oakland, CA
Martin's Point Health Care	Portland, ME
New West Health Services	Helena, MT
Presbyterian Health Plan	Albuquerque, NM
Priority Health	Grand Rapids, MI
Rocky Mountain Health Plans	Grand Junction, CO
Scott & White Health Plan	Temple, TX
Security Health Plan	Marshfield, WI
SelectHealth	Murray, UT
Tufts Health Plan	Waltham, MA
UCare Minnesota	Minneapolis, MN
UPMC Health Plan	Pittsburgh, PA

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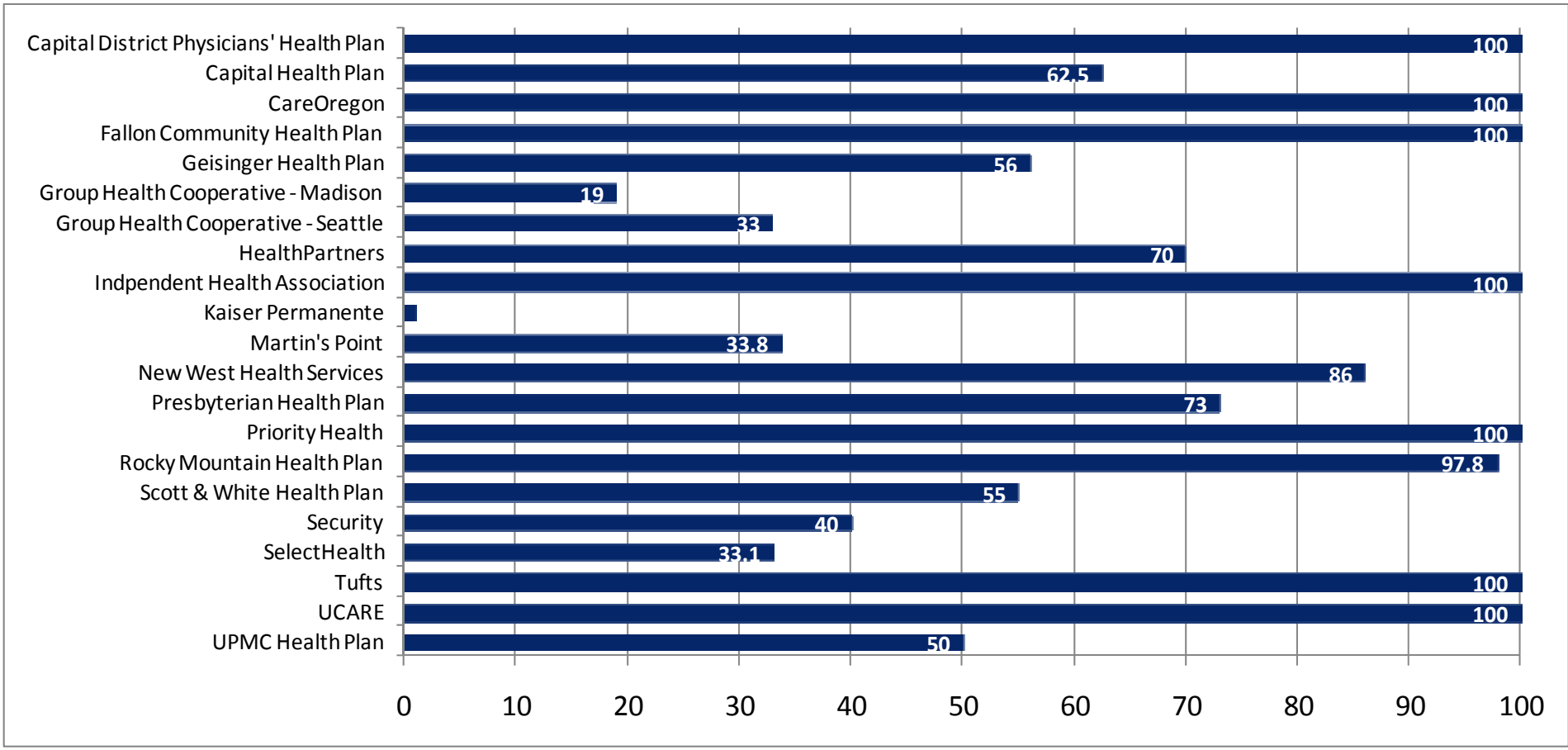
ACHP's Mixed Delivery Models

Percent of Members Aligned with Network PCPs (versus plan-owned/associated)



Source: a combination of self-reported data, direct member reports, and 2009 Interstudy data reflecting 2008 reporting

Plan-owned/associated PCPs include those employed by the same corporate parent organization, or those provider groups engaged in an exclusive delivery relationship with the health plan

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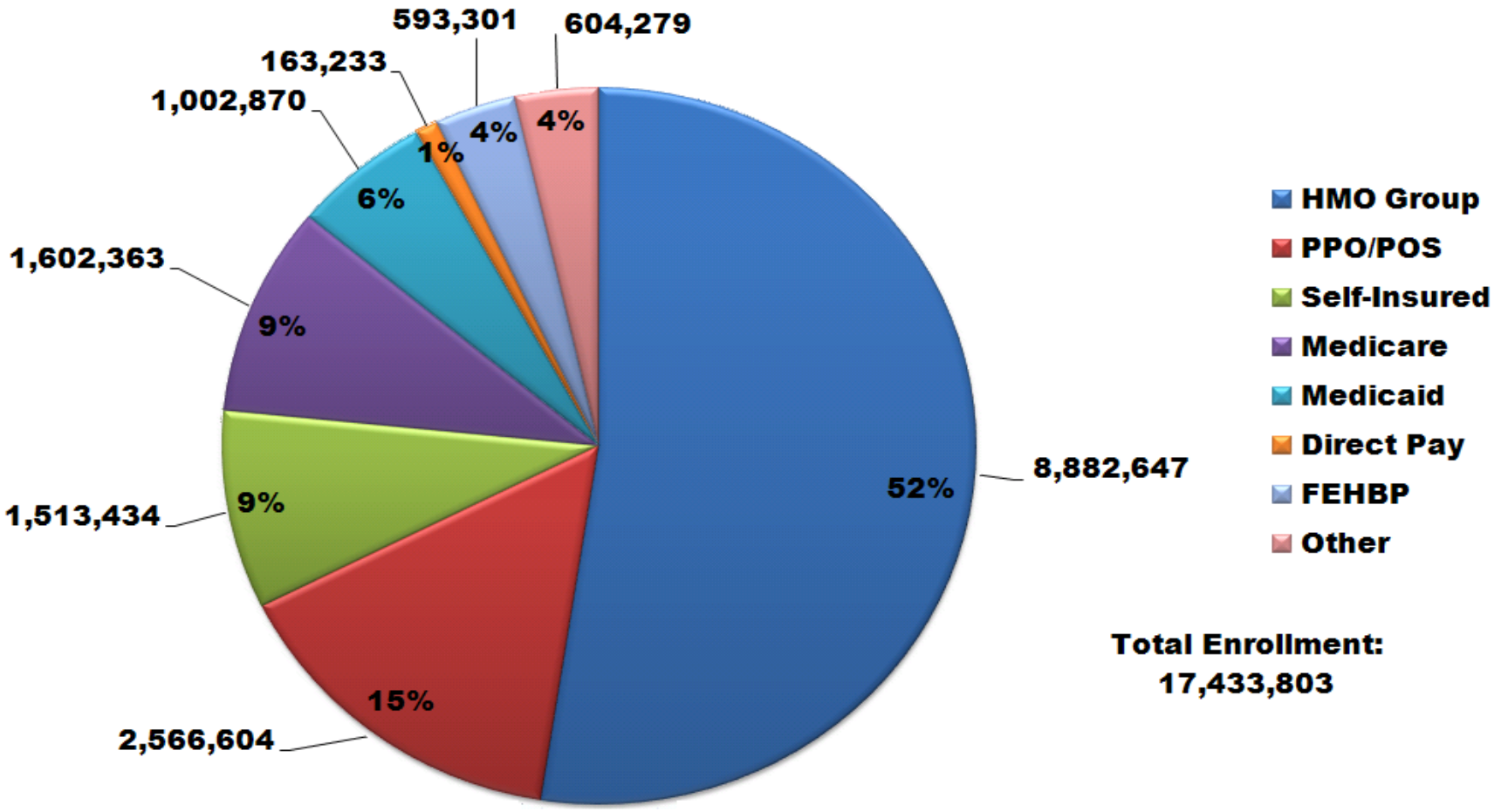
ACHP Total Membership Distribution



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NCQA's *Best Health Plans* – Proven Quality Rankings

On the 2010 *Best Health Plan* rankings, ACHP plans were:

- 9 out of the top 10 Medicare plans
- 6 out of the top 10 private plans
- 4 out of the top 10 Medicaid plans

Plan Name	Medicare	Commercial	Medicaid
CDPHP			6
Capital Health Plan	1	4	
Fallon Community Health Plan	3	8	1
Geisinger Health Plan	10	5	
Group Health Cooperative - SCW		7	
Kaiser Permanente	2,4,5,8	9	2
Security Health Plan	6		
Tuft's Health Plan	7	2	
UPMC Health Plan			10

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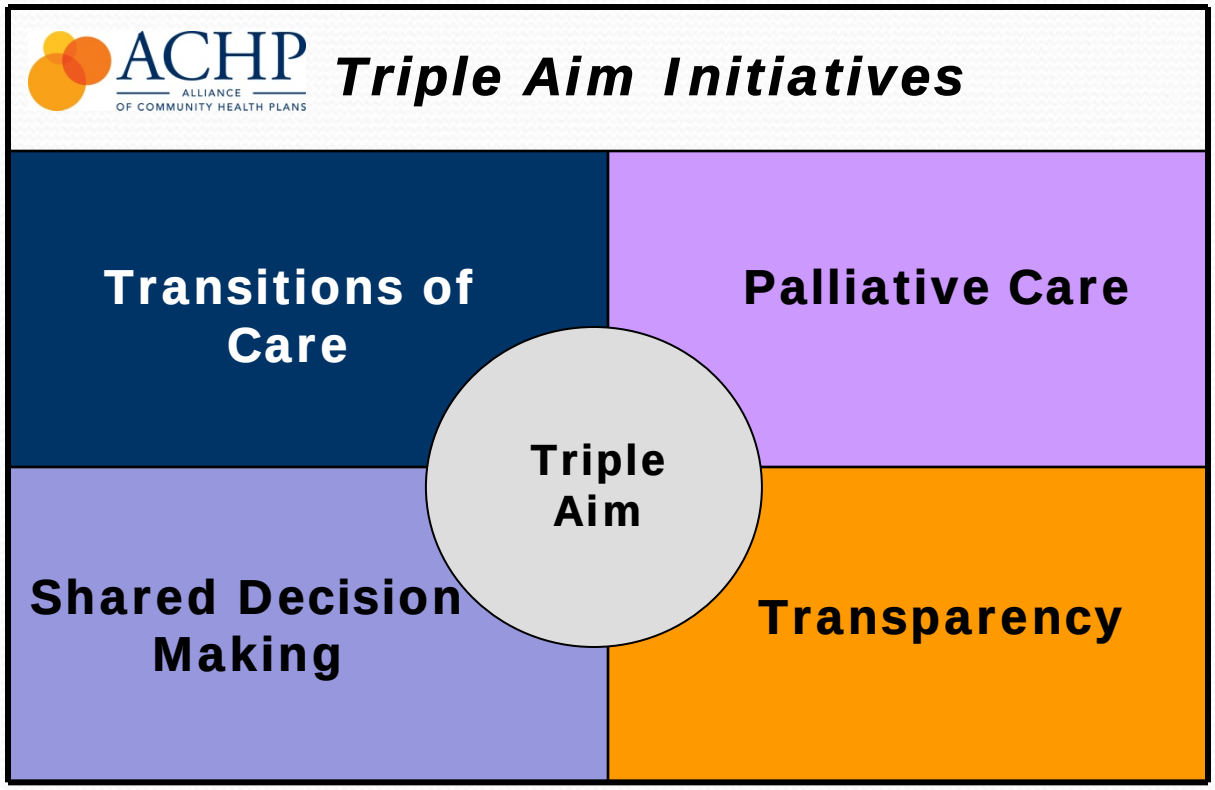
Triple Aim Initiatives

ACHP's Medical Directors are pursuing activities in key focus areas, with an aim towards determining actionable best practices that demonstrate reduction in costs, enhanced patient experience, and improved population health.



Palliative Care Work Group Operating Principles

- Start with a diagnosis of life-limiting illness and continue through end of life care.

- Address palliative care from a health plan perspective rather than a care system perspective

- Focus on non-inpatient palliative care

Elements of Advanced Illness/Palliative Care Services

- Started with the NQF list of 8 domains and 37 elements of advanced illness/palliative care
- Work group utilized a nominal group process to streamline the initial list
- Further prioritization identified elements that were ***critical, important,*** or ***non-essential*** to a delivery model

The Domains of Advanced Illness/Palliative Care Services

- Interdisciplinary team approach
- Access
- Symptom Management
- Patient and Caregiver Access
- Communication: Within care system
- Communication: To patients and families
- Documentation

Palliative Care Work Group Blueprint Process

- Categorize the different delivery models of advanced illness/palliative care services
- Identify and prioritize the critical elements of advanced illness/palliative care
- Define acceptable variations in the delivery of critical elements
- Create measurement set, and process for regular reporting

Blueprint snapshot

Palliative Care Core Components & Elements – Prioritized

The following table shows the prioritization of the elements for all three models of non-inpatient palliative care.

Component	Element	Ownership Model	Consultative Model	Telephonic Model
Inter-disciplinary team approach	Palliative care physician (or working towards board cert.), RN, Social Worker, Chaplain, pharmacist.			
	Team should be appropriately trained, credentialed and/or certified			
	Provide continuing education on the domains of palliative and hospice care to team members			
	Build partnerships with community clergy and provide education and counseling related to end of life care.			
	Establish or have access to ethics committee or ethics consultation across care settings to address ethical conflicts at the end of life.			
	Comments:			
Access	Provide access to palliative care that is timely and responsive to the patient and family.			
	Comments:			
Symptom Management	Assess, document and manage symptoms and side effects in a timely, safe and effective manner to a level that is acceptable to the patient and family.			
	Comments:			
Patient & Caregiver Education	Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.			
	Provide education and support to families and unlicensed caregivers based on the patient's individualized care plan to assure safe and appropriate care for the patient.			
	Comments:			

Three Models of Advanced Illness/Palliative Care

- "Ownership" Model
- Consultative Model
- Telephonic Model

"Ownership" Model

- **Description:**
  - A palliative care team assumes ongoing primary care and palliative care delivery responsibilities for the patient.
- **Advantages**
  - Palliative care delivery is in the hands of palliative care experts.
  - Ongoing care responsibilities allow for 24/7 access.
- **Disadvantages**
  - Removes patient from their primary relationship.
  - Costs of ongoing care are more significant because this model is labor intensive.

Consultative Model

- **Description**
  - Involves a team of palliative care experts that consult with the attending physician, primary care physician, or health care team.
  - Within this model, visits are typically limited and treatment would be recommended or implemented in collaboration with the referring physician and care team.

Consultative Model

- **Advantages**
  - Addresses major palliative care issues
  - Co-management could include 24/7 first call to palliative care team
  - Supports primary care physician/patient relationship & assists the PCP in being able to provide appropriate services to their severely ill patients

Consultative Model

- **Disadvantages**
  - May not provide 24/7 coverage.
  - Occasional difficulty in facilitating communication and feedback between teams.
  - Leaves ongoing care decisions to primary care/specialty physicians who may not be knowledgeable/ comfortable in supporting/ implementing palliative care recommendations.

Telephonic Model

- **Description**
  - The telephonic model uses predictive modeling and referrals from a health plan's network to identify patients for palliative care intervention.
  - This model links back to primary or specialty providers as part of the communication process
  - Addresses many, but not all of the issues delineated in the consultative or ownership model.
  - Interactions with the patient typically take place via telephone

Telephonic Model

- **Advantages**
  - Telephonic assessment and monitoring allows for reaching more patients more quickly.
  - Can be used in geographic areas where ‘on the ground’ resources are not available and is readily scalable.
  - Provides a flexible option to introduce important conversations that are not currently occurring.
  - Can be used in conjunction with or complementary to other delivery models.
  - Implementation costs are less than other models.

Telephonic Model

- **Disadvantages**
  - Conventional wisdom is that palliative care needs to be delivered in a face-to-face manner.
  - Lacks the comprehensive scope of other models
  - Effectiveness may be limited by inability to provide needed face to face contact.
  - No prior relationships with primary/specialty providers may hinder communication and needed follow through.

Defining the elements of Advanced Illness/Palliative Care

- ***Critical elements:***
  - *Considered essential for effective palliative care to be delivered.*
  - *These elements must be present in any non-inpatient palliative care program.*
  - *Without them, it could not be considered palliative care.*
- ***Important elements****:*
  - *Extremely relevant and will enhance the quality of palliative care.*
  - *Without these elements palliative care can still be effectively delivered.*
- ***Non-essential elements****:*
  - *Lower priority*
  - *Has a smaller impact on the quality of palliative care.*

A Tour of the Blueprint

A Blueprint For Health Plans:

How To Provide High Quality Community Based Advanced Illness/Palliative Care

March 2010

About ACHP

The Alliance of Community Health Plans (ACHP) brings together innovative health plans and provider organizations that are among America's best at delivering affordable, high-quality coverage and care to their communities. Drawing on years of experience, members collaborate to identify problems, share information and work toward solutions to some of health care's biggest challenges. Their work is the foundation for ACHP's advocacy on behalf of better health care nationally.

Palliative Care Core Components & Elements – Prioritized

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	Comments:			

Blueprint

Component	Element	O	C	T
Inter-Disciplinary team approach	Multi- disciplinary team			
	Training/credentialed			
	Continuing education			
	Partnerships with clergy			
	Ethics consultation accessible			
Access	Access to timely care			
Symptom Mgmt	Timely, safe, effective			
Patient/Caregiver Education	Disease, prognosis, interventions			
	Individual care plan			

Critical **Important** **Non-essential**

Blueprint

Component	Element	O	C	T
Communication within care system	Timely, thorough			
	Care plan based on thorough assessment			
	Advance directives documented throughout system			
Communication to patients and families	Periodic conferences			
	Communicate transition to actively dying stage			
	Reintroduce hospice			

Critical **Important** **Non-essential**

Blueprint

Component	Element	O	C	T
Documentation	Document as preferences change			
	Develop/implement social care plan			

Critical | Important | Non-essential

Health Plan Use of the Blueprint

- Created a consistent method of comparison among current health plan advanced illness/palliative care services programs.
- Used to help health plans decide on a ‘buy or build’ strategy for the delivery of advanced illness/palliative care services.
- Included as an ‘RFI’ request for evaluating potential contacted partners in the delivery of advanced illness/palliative care services.
- Used with existing palliative care providers and teams to set and clarify expectations

Benefit Design: Payment for Palliative Care

Plan Decision Point

If services delivered internally

↓

Must have method for analyzing cost in order to determine ROI
Must have method for assessing services

If services provided through home/community

↓

Must have method for analyzing ROI
Design a methodology to recognize care and pay appropriately

Benefit Design: Payment for Palliative Care

- What does the Member see and receive?
- What is the role for a palliative care benefit?
- Some plans have a benefit set of visits, or $$ value for this pre-hospice or in-lieu of hospice care.
- What is the role for education to the member about this approach to care and access to benefit?

Triple Aim Metrics and Measurement: The Next Challenge

- **Proposed Quality Metrics:**
  - Percent of decedents enrolled in hospice
  - Physician visits/patient
  - Percent of patients who die with advanced directives completed
  - Percent of patients with a referral to palliative care or hospice services before death

Triple Aim Metrics and Measurement: The Next Challenge

- **Proposed Experience/Satisfaction Metrics:**
  - Satisfaction surveys of patients prior to death
  - Satisfaction surveys of family members after the death of a loved one.

Triple Aim Metrics and Measurement: The Next Challenge

- **Proposed Cost Metrics:**
  - Percent of deaths occurring in hospital
  - Hospital days
  - Hospice days per decedent
  - ED visits
  - Total spend
  - Pharmacy utilization/costs

Thank you!

Discussion and Feedback