Volume 5, Issue 11 November 2018

Population Health NEWS

Symbiosis of Specialized Population Health and Systemized Palliative Care

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One of the most notable synergies in this current healthcare environment is the growing complement between two disciplines: *population health*, which focuses on improving the health of populations, with a special emphasis on reducing disparities in health outcomes and improving the value of health care, and *palliative care*, which focuses on improving the quality of life for patients and families facing the challenges of a serious or advanced illness.

Driving this relationship are two distinct market forces: 1) the maturity of traditional population health into specialized population health, with capabilities to specifically address a defined senior population with a greater likelihood of health problems and higher costs of care, and 2) the resulting transition from palliative care to *systemized* in-home palliative care within the framework of broader PHM programs.

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Taken together, this combination plays a pivotal role in addressing the needs of the whole person and the family, improving quality of life for all. Furthermore, as payers assume financial responsibility for these patients and follow the path to value-based reimbursement, they will benefit from the complementary and supportive roles of these disciplines.

The next steps to foster even greater collaboration involve PHM methodologies and continued innovation to achieve a systemized approach to palliative care.

Specialized Predictive Analytics

The need to determine member eligibility for in-home palliative care rests upon accurate patient Identification. Newer approaches utilize historic and temporal claims encounter and clinical data for predictive modeling. This identifies patients who are at risk of poor quality, over-medicalized care 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.

This type of technology platform leverages analytics in three ways. First, proprietary analytics are utilized to identify and stratify a patient's likelihood to prevent avoidable medicalization as it relates to a serious or advanced illness. Second, a custom palliative population health system manages patient populations, reports interventions, and standardizes care. Last, a Palliative Activation Scale (PAS™) is used to measure a patient's propensity to adopt a palliative care approach to improve quality of life and outcomes.

Palliative Activation Scale (PAS)

PAS™ optimizes care quality by measuring 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.

Systemized In-Home Palliative Care

As part of the transition to value-based care and reimbursement, payers 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. This process provides an ideal segue to the implementation of systemized palliative care beyond the hospital environment and into the home.

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One unique community-based model utilizes predictive analytics as described above to identify, engage and improve the member and caregiver quality of life. This approach deploys a rapidly scalable solution by utilizing predictive analytics/AI for appropriate member identification, 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.

To maximize improvement in PAS, this innovative model utilizes comprehensive, standardized, baseline and follow-up palliative phone and home visit motivational interviewing logic. Specially trained palliative care teams review symptoms, perform medication reconciliation, and discuss and document 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.

Comprised primarily of palliative care trained nurses and social workers, the palliative care 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.

This systemized and structured model serves as an extension of medical practices, enabling a palliative medical home model. 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 care delivery that is consistent with patient goals.

Bringing a standardized process of palliative care delivery that can be provided along with curative treatment, this represents a consistent approach across geographic regions to track and measure outcomes.

Impact of New CMS Changes for Supplemental Benefits

The evolution of specialized PHM and systemized in-home palliative care is expected to meet even greater receptivity given the recently finalized guidance and policies for the Medicare Advantage program from the Centers for Medicare & Medicaid Services (CMS). These changes will expand the supplemental benefits afforded to beneficiaries and include home-based palliative care, in-home support services and support for caregivers of enrollees to be included in the newly allowable supplemental benefits.

Additionally, CMS also reinterprets benefit uniformity rules. Beginning with 2019 applications, Medicare Advantage plans may tailor benefits for beneficiaries who are "similarly situated" and meet a set of clinical criteria. Starting with 2020 applications, CMS may offer waivers of benefit uniformity for benefits tailored to "chronically ill beneficiaries."

These changes reflect the inclusion of items and services that address certain "Social Determinants of Health" (SDoH). SDoH refers to a wide range of factors and conditions that are known to have an impact on healthcare, ranging from socioeconomic status, education and employment, to one's physical environment and access to healthcare.

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Previously, CMS did not allow an item or service to be eligible as a supplemental benefit if the primary purpose was for daily maintenance. CMS' reinterpretation of the statute to expand the scope of the primarily health-related supplemental benefit standard is an important step in encouraging value-based care.

This latest development aligns Medicare Advantage with commercial payers and states across the country that recognize the importance of addressing SDoH in achieving better health outcomes and lower costs. The newer, innovative model, as described earlier, leverages SDoH in the Palliative Activation Scale.

Looking Back – Looking Ahead

In 2016, a JAMA viewpoint suggested that combined approaches from palliative care and population health would improve care quality for elderly and frail populations. The authors were prophetic in forecasting that each discipline could learn from the other and that the incorporation of more social aspects of palliative care into PHM programs would be beneficial.

Since that time, the refinement of these disciplines and introduction of specialized population health and systemized in-home palliative care have become a reality. This symbiotic relationship is expected to flourish even more, given the new CMS policy providing greater opportunities to integrate evidence-based programs and other key community-based services and supports into Medicare Advantage plans.

Most Medicare Advantage plans have already developed a Plan Benefit Package for their 2019 application and are likely to offer supplemental benefits. In-home palliative care programs that result from specialized PHM are the expected winners in this evolving marketplace.