Healthcare Intelligence Network™ HIN.com

Guest Post: Innovative, Specialized Palliative Care Programs Help ACOs Improve Patient Care, Achieve Success in Medicare Shared Savings Program

September 13th, 2018 by Greer Myers

Under the new Medicare Shared Savings Program (MSSP), Accountable Care Organizations (ACOs) will be required to take on more risk as a rule of engagement and participation. The Centers for Medicare & Medicaid Services (CMS) is also shrinking the amount of time ACOs can be in an upside-only model to two years, putting additional pressure on ACO leaders to initiate changes. Currently, 82 percent of ACOs participating in the MSSP are in an upside-only model.

A structured, systematized approach to home-based palliative care: One of the most effective ways to manage and enhance care delivery for vulnerable, costly populations.

This has prompted many organizations to seek innovative strategies that will enable them to remain in the program and achieve success. One proven approach involves the adoption of a structured and systematized home-based palliative care program designed to identify patients with serious or advanced illness earlier in the disease process and offer them services outside of the hospital setting.

The palliative care team, primarily specially trained nurses and social workers, addresses the unique needs of the patient and family, taking into consideration their culture and values when developing a patient-centered approach to care. The team coordinates patient care across the continuum, which may include specialty care, acute, post-acute and community-based care needs.

For ACOs facing tight timeframes for implementing programmatic changes, this structured approach to community-based palliative care can be rapidly deployed in any geographic area and quickly scaled for larger populations.

Supporting the Medical Home

Home-based palliative care programs align with the medical home model through the provision of specialized care for people living with serious or advanced illness. Sharing priorities with the medical home, both emphasize the importance of care in the home, providing appropriate social services, clinical assessments and referrals, and partnering with physicians to deliver a solution that is patient-centered, data-driven and evidence-based.

A structured, systematized approach to home-based palliative care is one of the most effective ways to manage and enhance care delivery within this vulnerable, costly population. Quality controls and reporting are essential to improving quality and decreasing cost. Programs offering

modular continuing education to palliative care team members, as well as guided tools and electronic patient assessments, enable highly skilled clinicians to maximize the impact of member outreach, enrollment and engagement.

Palliative care teams extend the reach and frequency of patient engagement, establishing collaborative relationships and reporting with the medical home that further strengthen care coordination. This level of connectivity and interaction with the medical home represents a significant opportunity to affect quality and cost.

Advantages for Patients and ACOs

Populations burdened by a serious or advanced illness place incredible strain on ACO resources, compromising the organization's ability to improve care while generating shared savings under the MSSP model. By adopting the medical home/home-based palliative care approach, ACOs can turn this high cost population into an opportunity: improving quality and patient satisfaction while reducing cost and generating shared savings through reduced unnecessary hospital admissions, readmissions and ICU stays. Furthermore, this approach avoids over-medicalized care and high-cost services that may not align with the patient's goals of care.

Integrating home-based palliative care within the medical home model ensures that each member is treated with respect, dignity, and compassion. This leads to a better quality of life, thanks to strong and trusting engagement with specialized palliative care professionals. Overall, this integrated model aims to improve quality and care coordination, so that individuals access care in the right place, at the right time, and in the manner that best suits a patient's goals of care.

What's more, specially trained palliative clinicians act as an extension of the primary treating physician and strengthen the medical home. The palliative nurses and social workers establish goals of care, provide supportive home-based care and assess patient and caregiver status, reporting relevant information to the primary treating physician to fill gaps in care and better align goals with care received.

Innovation in the Real World

Let's consider a typical patient experience that is all too familiar: An 89-year old man with congestive heart failure (CHF) experienced five emergency room visits and five hospital admissions in one year before his condition worsened and he was intubated in the ICU. Prior to this, he had been seeing his cardiologist and primary care provider for adjustments to his medications, which he was unable to manage at home.

Now consider the vastly better approach of in-home palliative care: This same patient would have informed providers he did not want to go to the hospital or have intubation. When his health deteriorated, his social worker would have met with him and his family to discuss palliative care and supportive care options. He would have also been placed on the palliative care program with home visits made by palliative care specialists as needed. When the time came, his palliative care specialist would have evaluated hospice options with the patient and his family, and he would have died in the manner of his choosing – peacefully at home.

An innovative palliative care approach provides specialized patient/caregiver support and enhances communication with the primary treating physician. This facilitates a shared decision-making model, which results in better congruence between a patient's individual goals of care and medical care received. It is a recipe for improving quality of life and satisfaction with the care that is delivered.

About the Author:

Greer Myers

Greer Myers is the president, Turn-Key Health and executive vice president, chief development officer, Enclara Pharmacia. With more than 20 years of healthcare experience, Mr. Myers joined Enclara Healthcare in 2014, and maintains dual roles as its President of Turn-Key Health and its EVP of Corporate Development of Enclara Pharmacia. Bringing strengths in post-acute operations, mergers and acquisitions, pharmacy benefits management, strategy and business development, he also has strong vertical experience in payer, provider and healthcare IT verticals.