

INNOVATIONS IN SERIOUS ILLNESS CARE: WHY SHOULD HOSPICES INNOVATE??

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Because If They Don't, They Will Die...
Case: Ms. Valentine



Because If They Don't, They Will Die... Internal

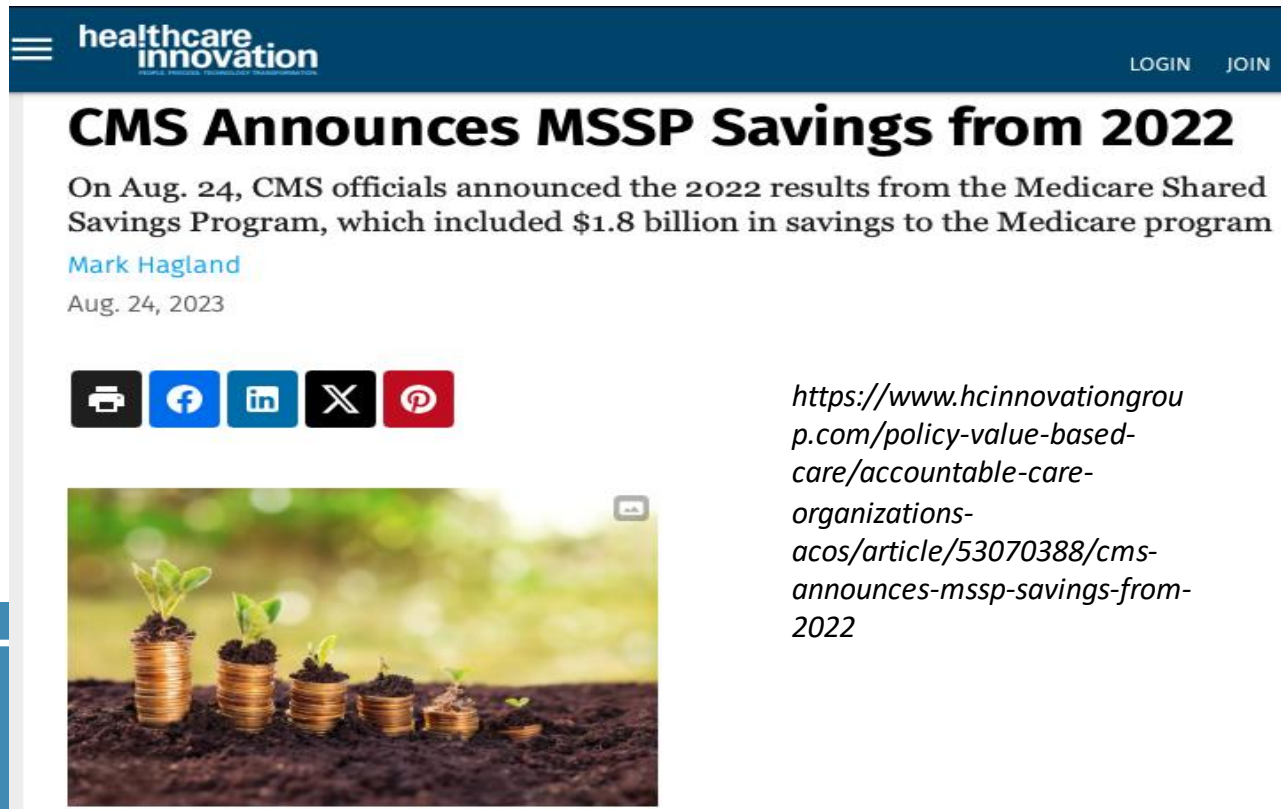
- Workforce challenges – exacerbated by the COVID pandemic:
 - Burnout and resignations
 - Staffing acute care:
 - Referrals
 - Contract beds and/or hospital IPU and/or own freestanding unit
 - Routine home care and continuous care
 - On call and weekends
- High “Churn” and Challenging incentives:
 - MLOS is generally down even further
 - Nursing home access has been limited;
 - Hospital mortality data; brink of death referrals
- Other “local” challenges?

Because If They Don't, They Will Die... External

- The healthcare payment landscape is changing
 - FFS → Value-based payment
 - Increasing risk on provider
- Medicare Advantage (MA) is growing rapidly (2022): (...more later)
 - 28 Million people are enrolled in MA (48% of eligible population)
 - \$427B (or 55%) of total federal Medicare spending (net of premiums)
- Medicare VBID “Carve-In” DEMO for Hospice benefit (extended through 2030)
 - Two “carve outs” to Medicare over the years: MHB and ESRD
 - ESRD benefit now “carved in”
 - Means the last remaining benefit “outside”

Because If They Don't, They Will Die... External

- ACO numbers and covered lives are growing rapidly (2022):
 - 63% of ACOs participating in MSSP received shared savings earnings
 - “Physician-owned ACOs did the best at achieving financial savings”
 - MSSP Program saved Medicare \$1.8 billion in 2022

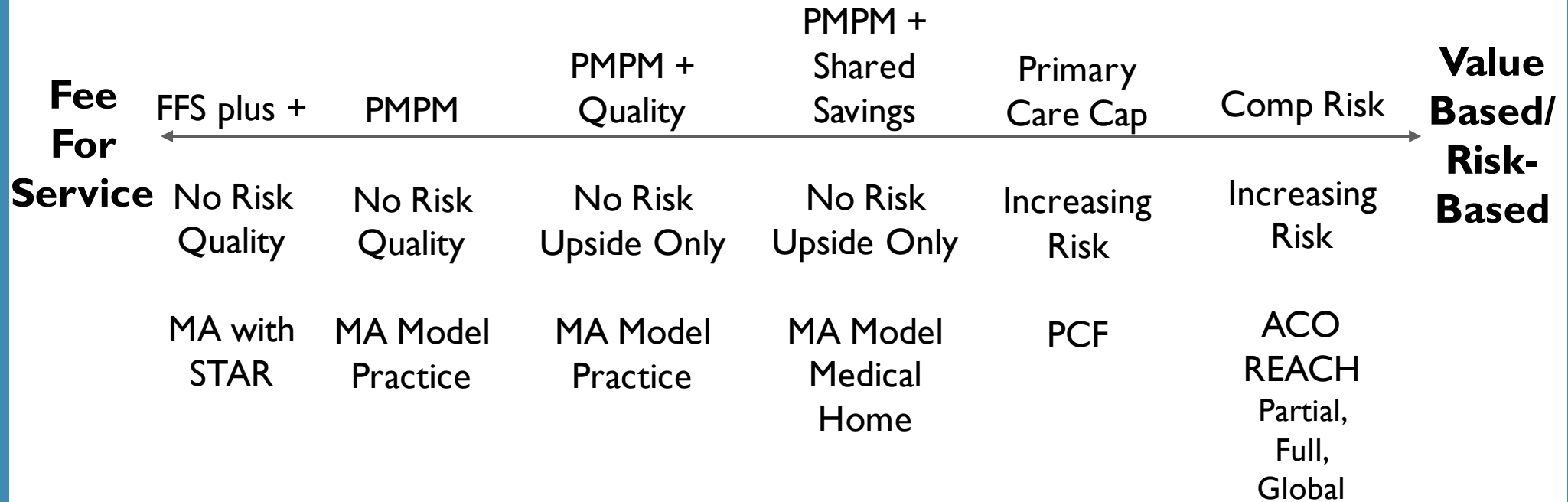


The screenshot shows a webpage from healthcare innovation. The header includes the logo and navigation links for LOGIN and JOIN. The main headline is "CMS Announces MSSP Savings from 2022". Below the headline is a sub-headline: "On Aug. 24, CMS officials announced the 2022 results from the Medicare Shared Savings Program, which included \$1.8 billion in savings to the Medicare program". The author is Mark Hagland, and the date is Aug. 24, 2023. There are social media sharing icons for print, Facebook, LinkedIn, X, and Pinterest. A URL is provided: <https://www.hcinnovationgroup.com/policy-value-based-care/accountable-care-organizations-acos/article/53070388/cms-announces-mssp-savings-from-2022>. At the bottom of the article preview is an image of small green plants growing out of stacks of coins on a dark surface.

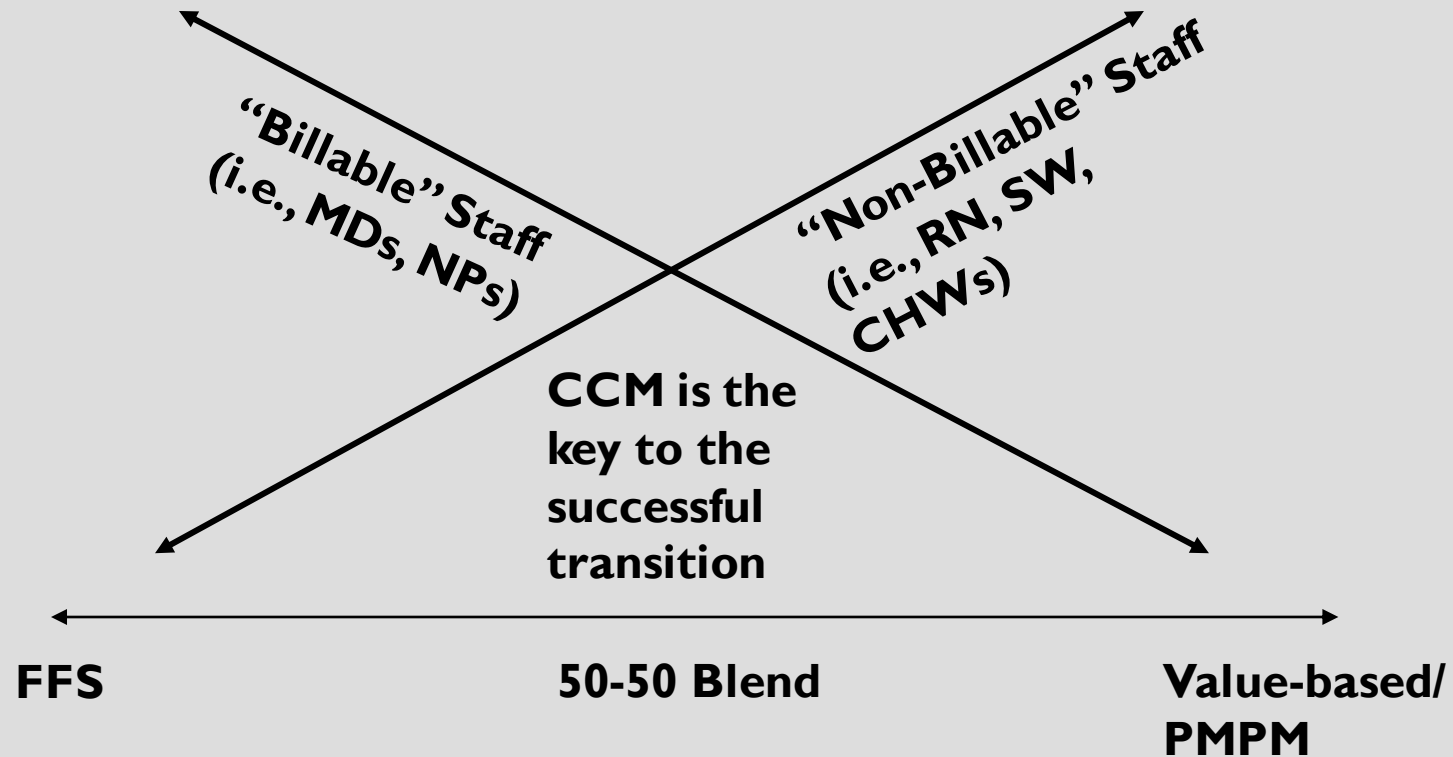
Because If They Don't, They Will Die... External

- ***CMS***: set a goal that “100 percent of people with Traditional Medicare will be part of an accountable care relationship by 2030”

A PAYMENT SPECTRUM



CONSISTENT CARE MODELING TOWARD VALUE



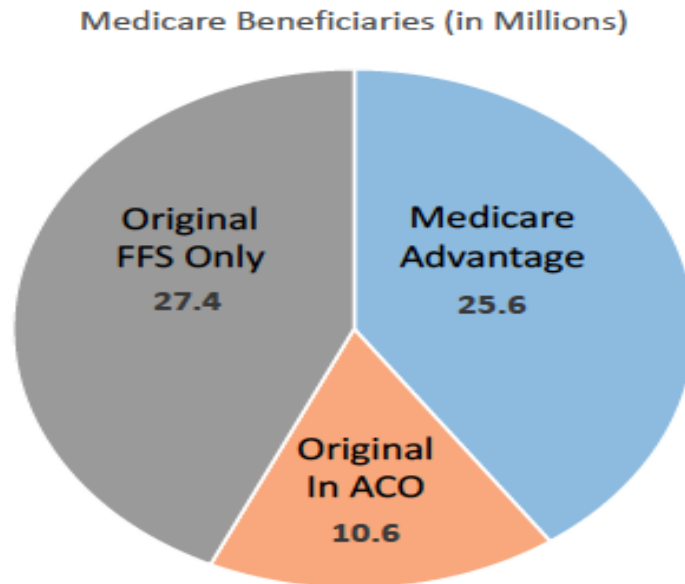
- For success in FFS-based models, emphasize billable staff and reduce nonbillable staff
- Moving to PMPM or with strong value-based models, flip this approach
- Ideal may be a care coordination model with medical oversight

CONFIDENTIAL: Not for Distribution

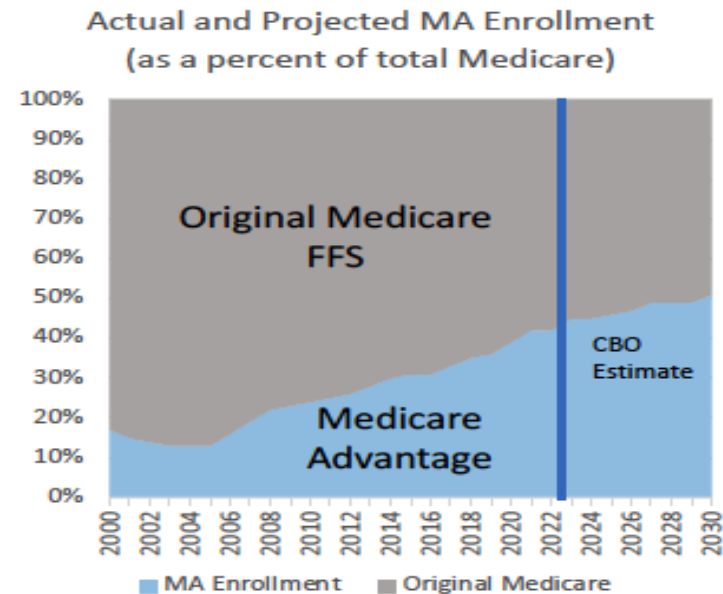
Medicare Advantage (MA) Is Growing Rapidly

Medicare Marketplace

Percent of Medicare Beneficiaries by Type of Enrollment, 2021

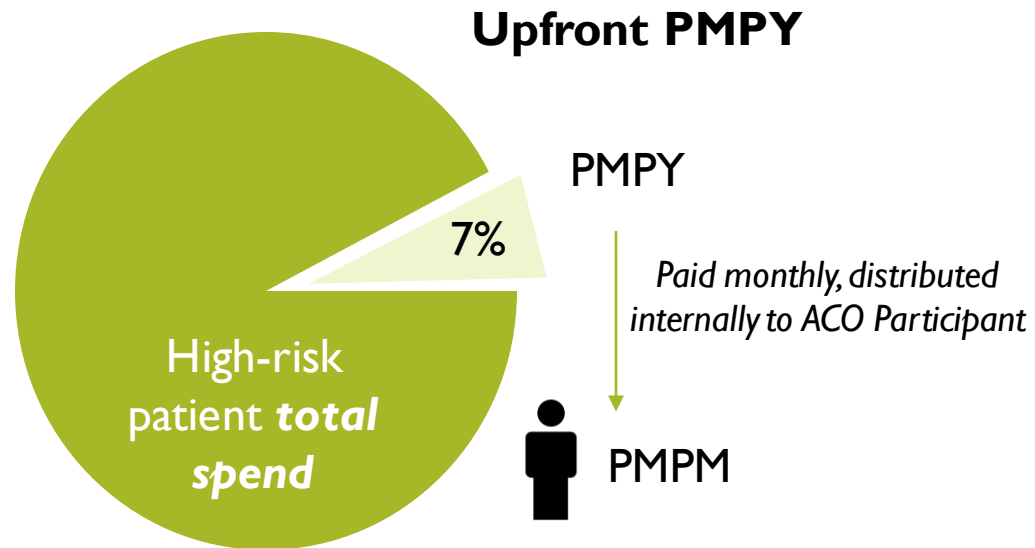


CMS. Fast Facts - November 2021;
MedPAC. Medicare Payment Basics: Accountable Care Organization
Payment Systems. Revised November 2021



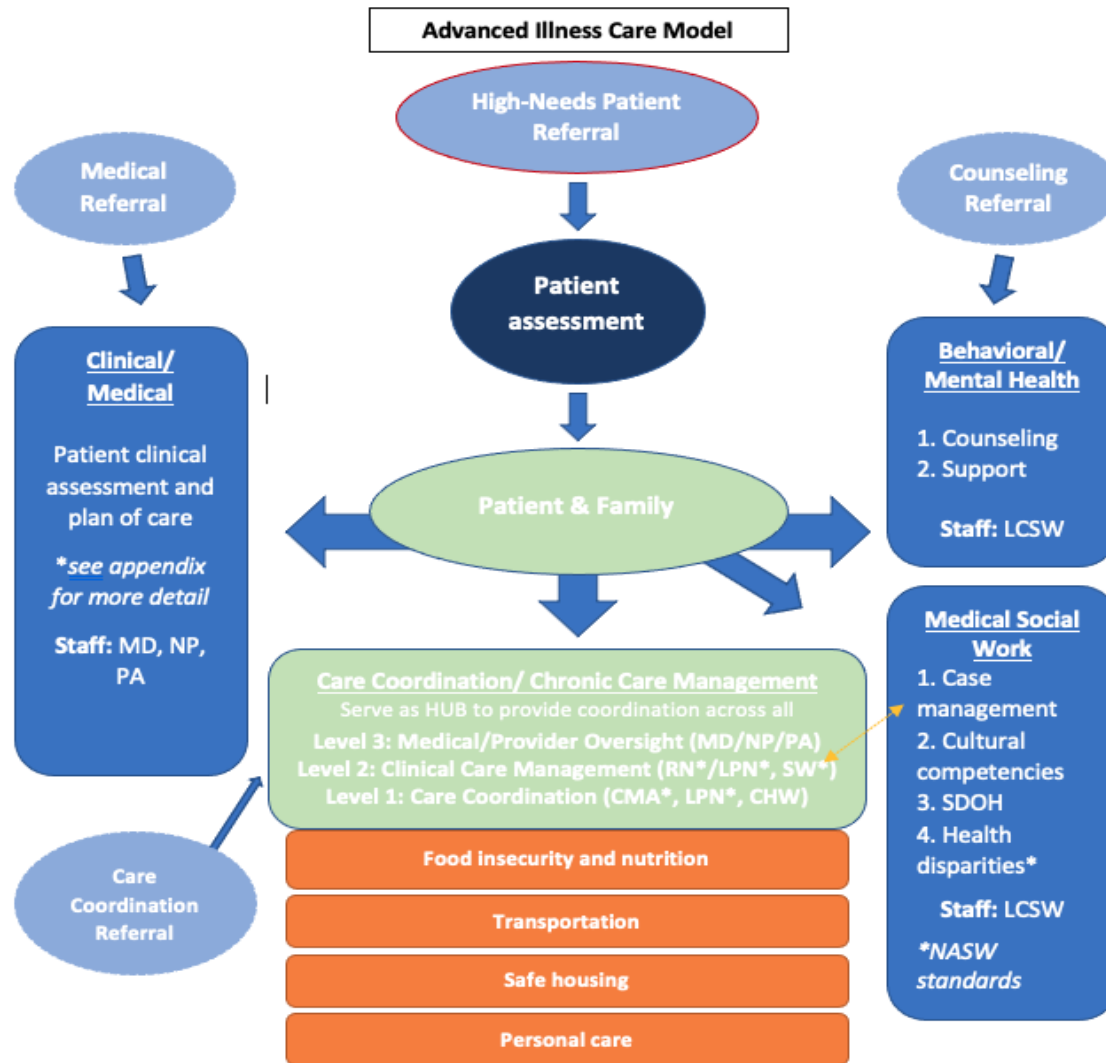
Kaiser Family Foundation. Medicare Advantage in 2021:
Enrollment Update and Key Trends. June 2021.

ACO numbers and covered lives are growing rapidly



- Model is total cost of care (TCOC) with significant risk
 - Professional: 50%:50%
 - Global: 100%:100%
- High Needs =~ \$35K/year
\$2,917/mo
- Hospice/mo =~ \$4,800/mo

AN ADVANCED ILLNESS CARE MODEL



Care AND Payment Model Innovations...

Diagnosis & Decline

Disease Trajectory

MD, NP, RN, SW, CNA
Volunteers, Increased DME,
Supplies, Bereavement

Complex Chronic

MD, NP, RN, SW, CNA
DME, Supplies

Accelerated
Decline

End of Life

Service Intensity

Care Navigation
Stay at Home Services –
supports **offered**
throughout progression

Home-Based, IDT Care:
MD, NP, RN, SW

End of Life
Intensity
accounted for as
an add on or as
part of PBP paid
overtime

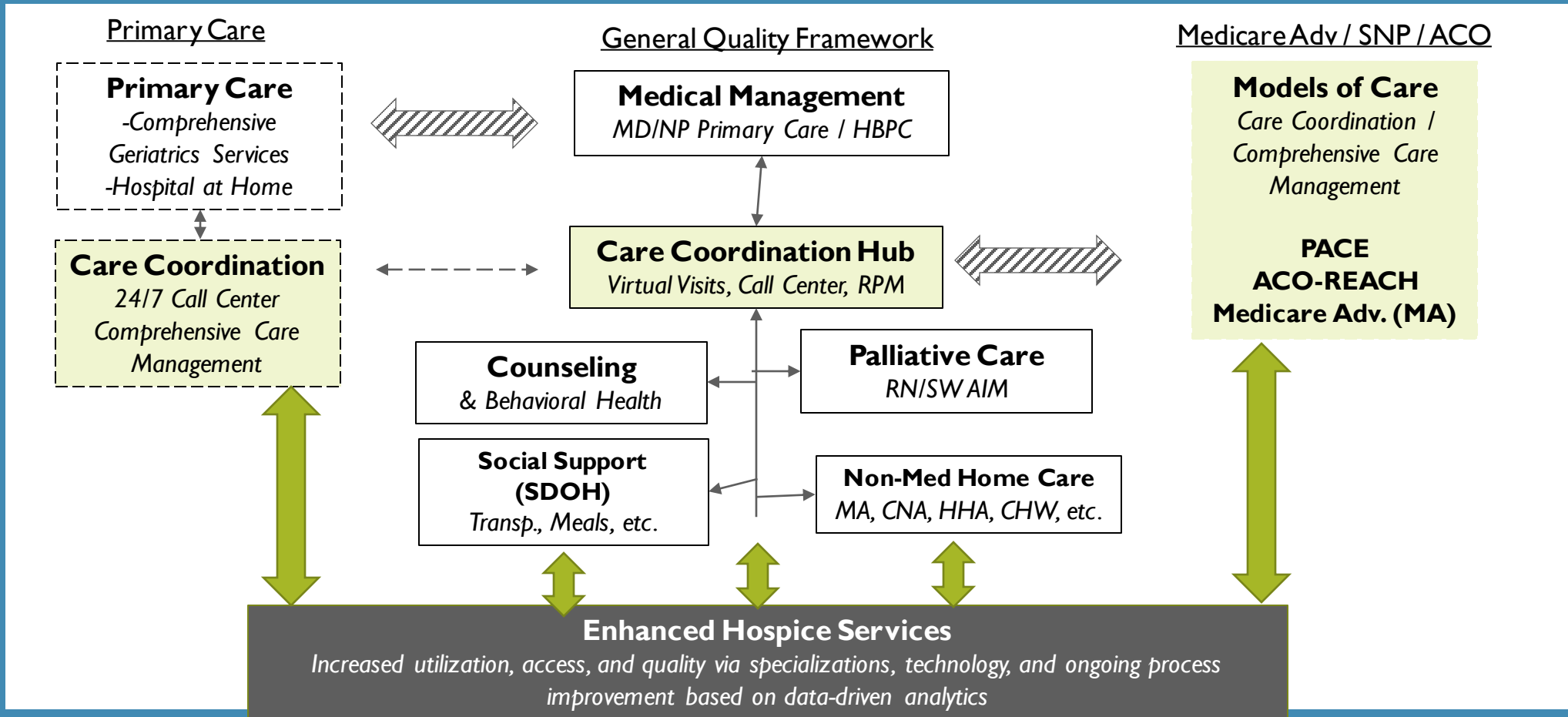


Population Based
Payment (PBP)

Payment Model

Death

Preparation for Risk Models: HPM: Moving from Wide Receiver to Quarterback



What Innovation is Already Occurring?

- Hospice – strengthening the “horizontal” core
 - Expanded hospice therapies/open access
 - Excellent counseling support and services
 - Into community including and beyond bereavement
 - Redefining volunteer support and services
 - Highly competent nursing care
 - Cardiac program – “game changer”
 - Clinical competence around advance cardiac care
 - Cardiology practice noticed
 - Strong medical leadership/engagement (provider/attribution)

What Innovation is Already Occurring?

- Palliative Care program as a part of the hospice entity
 - Beginning steps of “***strengthening the VERTICAL***”
 - Earlier and easier access
 - Used to be all hospital based
 - Now more:
 - Home
 - Nursing home
 - Office based (reference article on outpatient PC)

What Service Line Innovations are Occurring?

There are 4 to focus on:

- **Home-based primary care**
- **Focus on disparities and moving toward more health equity**
- **Care Coordination – essential blend of in person and virtual care**
- **EHR and Measurement and analytics underpin all of this.**

What Service Line Innovations are Occurring?

- Home-based primary care

- Wrap around primary care/palliative care
 - Thinking about the home-bound/home limited patients as a population
 - Data and analytics to measure
 - Models:
 - **PACE**
 - **CMMI** Direct Contracting/ACO REACH
 - Attribution
 - Total Cost of Care

What Service Line Innovations are Occurring?

- **Focus on disparities and moving toward more health equity**
 - Outreach to underserved populations
 - Community Health Workers/Certified Medical Assistants
 - Non-medical (social) determinants of health and cost:
 - Food insecurity/deserts and food preparation and delivery services
 - Transportation access
 - Other practical community supports and services

What Service Line Innovations are Occurring?

- Care Coordination – essential blend of in person and virtual care

- This may be the most essential population health strategy
 - Driving high value care
 - **ESPECIALLY IN A PERIOD OF STAFFING SHORTAGES**
 - **Incorporating in tele-visits and tele-counseling as well as well “friendly checks”**
 - CareMore experience
 - ***Volunteers - Double down on the hospice learnings!***
 - People with heart failure – EF 20% or less – have a prognosis of 3 years
 - How could care coordination work for someone?

Ms. Valentine's Care in 2024:



Ms. Valentine's Care in 2024:

- Ms. V's cardiologist asks "YOUR ORG Caring" to help support Ms. V in all ways at home (care coordination) after her initial cardiac event and diagnosis of CHF.
 - Education around disease, management, diet, activity
 - Cardiac rehab
 - Nutrition assessment and support
 - Transportation to PT/cardiac rehab
 - Symptom management
 - ***Advance care planning toward an order set (measured like the Domino's pizza delivery app)***

Ms. Valentine's Care in 2024:

- “YOUR ORG Caring” clinical resources are available to Ms. V 24/7 with provider oversight
- Telehealth services are provided for:
 - Friendly checks by volunteers; escalating up as appropriate
 - Clinical care coordination
 - Provider Oversight
- Home based care and coordination services are provided
 - These would be consistent with “wrap around primary/palliative care”
 - Would drive toward “preponderance of care” or attribution

Ms. Valentine's Care in 2024:

- Two years later she is home bound with ***significant frailty (measured)***, and thought to have a prognosis of months so the ***care coordination team asks*** for:
 - Hospice team visits to support the increased personal care and counseling needs of the patient and family
 - Hospice care is provided for ~3 months prior to her death
- She dies comfortably at home with her family around and
- Bereavement continues for her loved ones

What Service Line Innovations are Occurring?

- EHR and Measurement and analytics underpin all of this.

What Should Hospices Be Getting Into?

Hospices need to determine best approach(es):

1. Build out ALL of this advanced illness continuum themselves (it's a LOT!)
2. Partner with another program that is aligned in mission and goal that is significantly farther along this path, and/or has complementary assets, to be a part of a larger advanced illness organization
3. Integrate/Contract/Subcontract with a larger entity
 - a. ACO
 - b. Health System
 - c. Health Plan / Medicare Advantage (MA)