



TOOLS &
SUPPORT

The Palliative Care Initiative Community Care of North Carolina

By providing comprehensive case management services for those living with serious illness, Community Care of North Carolina and North Carolina's Medicaid agency empowered Medicaid enrollees to advocate for themselves and their goals for their care, improving their quality of life, and reducing costs to the program.

Case Study

The Palliative Care Initiative

A division of the North Carolina Department of Health and Human Services (NC DHHS), the North Carolina Division of Medical Assistance (DMA) is responsible for administering Medicaid coverage and services for the state of North Carolina, as well as leading health care innovation in the state. Over 2 million lives are covered under the state's Medicaid program, translating to over 14 billion dollars in health care expenditures. Looking for ways to decrease health care spending, the North Carolina legislature directed the DMA to seek opportunities without sacrificing the quality of care for enrollees. The DMA tasked Community Care of North Carolina (CCNC) with implementing a palliative care case management program for Medicaid enrollees with serious illness. This case study describes that program – the Palliative Care Initiative.

The following program description was developed by Catalyst for Payment Reform based on interviews with Jonathan Fischer, Assistant Professor at Duke University Department of Community and Family Medicine, Hospice and Palliative Care, and Consultant to NC Community Care Networks and Debbie Murray, Director of Population Health Outreach and Care Coordination Services at Community Care of North Carolina.

The Problem and Background

In the mid 1990's amid rising health care expenditures, the Secretary of the NC DHHS directed DMA to develop a plan to reduce costs with the long-term goal of promoting higher-quality, lower-cost care. The DMA looked to long-time partner CCNC to help them address this challenge.

While end of life care was an area of high health care spending, the DMA and CCNC found that high-value hospice services were significantly underutilized. The utilization rate of hospice care in the state was 40 percent at the time, similar to the national average. However, in the state's Medicaid population, utilization hovered around 20 percent. Given that the state's Medicaid population had a high prevalence of chronic disease and serious illness, it was likely that people in need of these services were not getting them and that presented a clear opportunity for both cost-savings and improved quality of life.

Designing the Strategy

To seize the opportunity, CCNC began a palliative care program called the "End of Life Care Initiative." The program sought to increase access to, and improve case management for, those living with a serious illness or chronic condition. Other goals were to improve access to palliative care services, promote more goals-of-care

conversations, and to reduce costs. An early program finding was that the name of the program did not help to empower patients to make choices about their own health care. In fact, the term ‘end of life care’ created a mental barrier for patients and family members, raising fear and potentially steering them toward costlier and potentially more invasive emergency care services, rather than toward the proactive care decisions that the program aimed to foster. Hence, CCNC renamed the program the “Palliative Care Initiative.”

Four core program elements

The Palliative Care Initiative focuses on case management for Medicaid enrollees and relies on four elements to improve care and outcomes for patients with serious illness and at the end of life. First, the program leverages **regional networks of local providers** partnered with social and community health organizations to coordinate patients’ care. CCNC holds statewide case manager trainings and established additional infrastructure in fourteen networks across the state for administrative support of the case management efforts. Second, the initiative relies on **evidence-based programs and protocols**, such as disease management programs and case management and pharmacy management tools, to aid providers in improving patient outcomes. Third, for patients discharged from the hospital, **case management and clinical support** helps providers ensure continuity of care. Lastly, **timely feedback on outcomes data** helps providers to assess, monitor, and improve care for patients with serious illness.

A focus on patient identification and needs assessment

Patient identification is key to the Palliative Care Initiative and the first step to successful case management. CCNC uses a combination of proprietary analytics based on patient condition(s), claims, discharges, care transitions, and care utilization patterns to identify potentially eligible patients. It then assigns risk scores and priority level and sends reports to regional case management staff for next steps and outreach. CCNC provides statewide support using its analytics system; however, regional case management staff have significant autonomy in implementation. For instance, depending on the relationship with primary care providers, some case managers hand over a list of potential patients and get feedback and confirmation from the providers to identify the appropriate candidates.

Once patients are identified by case managers, they conduct a comprehensive care needs assessment, including if there are palliative care needs. Depending on the patient’s needs and the skillset of the case manager, they may continue to manage symptoms and engage in goals-of-care conversations on their own, or with the patient’s primary care provider, as well as coordinate with local resources, look into hospice programs, and/or communicate with other members of the care team. The model is to identify, assess, refer, and continue case management. As patient needs evolve, so does case

A tool to prioritize program candidates

Identifying patients who were “high-risk” was not enough to ensure a return on investment in the program. CCNC required strategic targeting of patients likely to benefit from case management. Since 2011, CCNC has analyzed the spending and utilization trends of its case management program and in 2014 consolidated these data to create a single score that prioritizes patients using a tool they named The Complex Care Management Impactability Score™.

management support. The goals are to reduce preventable emergency department visits, prevent complications and readmissions, and improve outcomes to mitigate the associated costs of care.

CCNC noted that patient identification is an ever-evolving process. Over time, CCNC has progressed its focus from assessing patients who are “high-risk”—patients who were most likely to have an event—to identifying whether patients are “highly impactable,” meaning highly likely to benefit from care management.

“The payment structure had to encourage providers to change the conversation with patients from ‘what is the matter with you?’ to ‘what matters to you?’”

- Jonathan Fischer, MD
Duke University

A payment structure that supports case management

CCNC needed to consider which payment model would best support case management, improve quality, and reduce costs. This required payment high enough to cover services not covered under fee-for-service (FFS) models, such as extra time spent with patients and care coordination. CCNC’s payment approach was initially a per-member-per-month (PMPM) payment. The NC DHHS gave CCNC a contracted lump sum to distribute to primary care practices and the regional networks on a PMPM basis. As CCNC rolled out new initiatives under the Palliative Care Initiative, the PMPM increased to accommodate these new activities and implementation of the new programs.

However, the state gradually moved away from the PMPM model. To ensure appropriate distribution of payment, funding is now allocated based on cost metrics and success in achieving the goals of the triple aim.

CCNC facilitated the growth of additional palliative care services in the community by collaborating with local hospitals and other providers who deliver clinical services. To ensure efficient use of resources, CCNC first identified what was achievable within the scope of their program and what was required to spur new models of care and allocated resources accordingly.

Different payment models can impact the program’s success

CCNC recognized that reducing costs and improving quality would only be successful if implemented in concert with more fundamental changes to provider payment. Because programs such as home-based palliative care involve services for which billing codes do not exist, the existing FFS payment model created strong disincentives to the expansion of palliative care services. However, value-based payment systems that reward these high-value services can potentially allow these programs to be sustainable in the long-term.

Rolling out the model

CCNC tested new models of palliative care. The new models leveraged case managers to help patients and their families have goals-of-care and advance care planning conversations and to refer patients as needed to palliative care providers or hospice services. The models also included training primary care providers on advance care planning and palliative care, and assisting them in implementing a robust advance care planning program that meets PCMH standards.

Relying on a centralized call center

An integral component to the CCNC Palliative Care Initiative is a centralized population outreach and care coordination call center. Health Educators at the call center can assist with care coordination and make needed referrals for patients. Staff will communicate questions patients have about their care to members of the care team for continued management and support. Educators can redirect patients to appropriate care and help them avoid low-value care, such as inappropriate use of the emergency room. The call center staff also includes RNs who are certified as health coaches. The coaches work with patients to foster discussions about care decisions and personal preferences regarding the kind of care they want to receive. Coaches help patients create goals of care to share with their families and healthcare team members. Local CCNC network staff receive support from the central call center to help them assess, manage, and redirect palliative care patients. The call center staff uses information about patients from nightly data feeds, care management, provider referrals and monthly enrollment feeds to determine the most appropriate approach to outreach.

Program results

CCNC's Palliative Care Initiative demonstrated significant savings and better quality of care by improving care coordination, reducing stress on patients and caregivers, and enhancing the quality of life for patients and families. This was due, in part, to better case management leading to greater use of hospice care.

An evaluation of CCNC's programs found that Medicaid patients participating in the Palliative Care Initiative had fewer hospital days (an average of 0.5 fewer inpatient days per month), greater use of hospice services (an increase of 0.7 hospice days per month), and lower total healthcare spending in the time period leading up to their death. Average cost savings were \$1,661 per patient per month from the time the intervention started until end of life. In total, the initiative achieved an estimated \$2.0 million in savings across the 207 patients it serves.

CCNC recognizes that the default treatment plan in U.S. medicine is exhaustive use of tests and procedures, some of which may be unnecessary, unwanted, or both. CCNC wanted to "insert a pause" in the system and give patients and families the opportunity to consider what's important to them, discuss their values and goals of treatment, and help ensure that their care mirrors what they wish to receive. Palliative care—specifically the

case management component—enables families to choose less invasive and aggressive solutions, which are often less costly as well.

| Key Insights

CCNC found that creating a program budget, assessing the magnitude of the need, and establishing quantifiable goals is critical at the outset. The key is to create a model that can be perpetuated, propagated, and scaled. CCNC initially leaned on a third party to do the case manager training, but it became clear such training is best handled internally. In-house tools help ensure that existing resources are efficiently utilized.

In addition, the name and description of the program matters. The original name made the program look like it promoted ‘pulling the plug’ to save money instead of creating opportunities for patients to get the care that matters to them. CCNC found that calling the program the Palliative Care Initiative more effectively encouraged patients to take a proactive role in advocating for their own care decisions and planning for their long-term care.

Lastly, CCNC found that giving patients and their families a voice in their care has the side benefit of cost savings. A program like this does not need to lead with a cost savings agenda, but can focus on improving care, as the two go hand-in-hand.

| What's Next?

CCNC is always looking to evolve and improve its Palliative Care Initiative. It appears there are significant opportunities to leverage technology within the program to address the access issues inherent in North Carolina’s predominately rural geography. For instance, there may be opportunities to use telehealth for video consultations in areas where palliative care resources are not readily accessible.

About Community Care of North Carolina

CCNC is a national leader in transforming health care. The CCNC Program joins community-based care managers with local primary care physicians and diverse teams of health professionals to develop whole-person plans of care. Informed by statewide data and predictive analytics, The CCNC Program builds patient centered practice models, connects people to the right local resources and leads collaborations with health systems and public health. This proven population health management approach delivers better health outcomes at lower costs. For more information, visit <https://www.communitycarenc.org/>.