Pragmatic Principles to Achieve Bold Vision

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UAB Medicine Palliative Care
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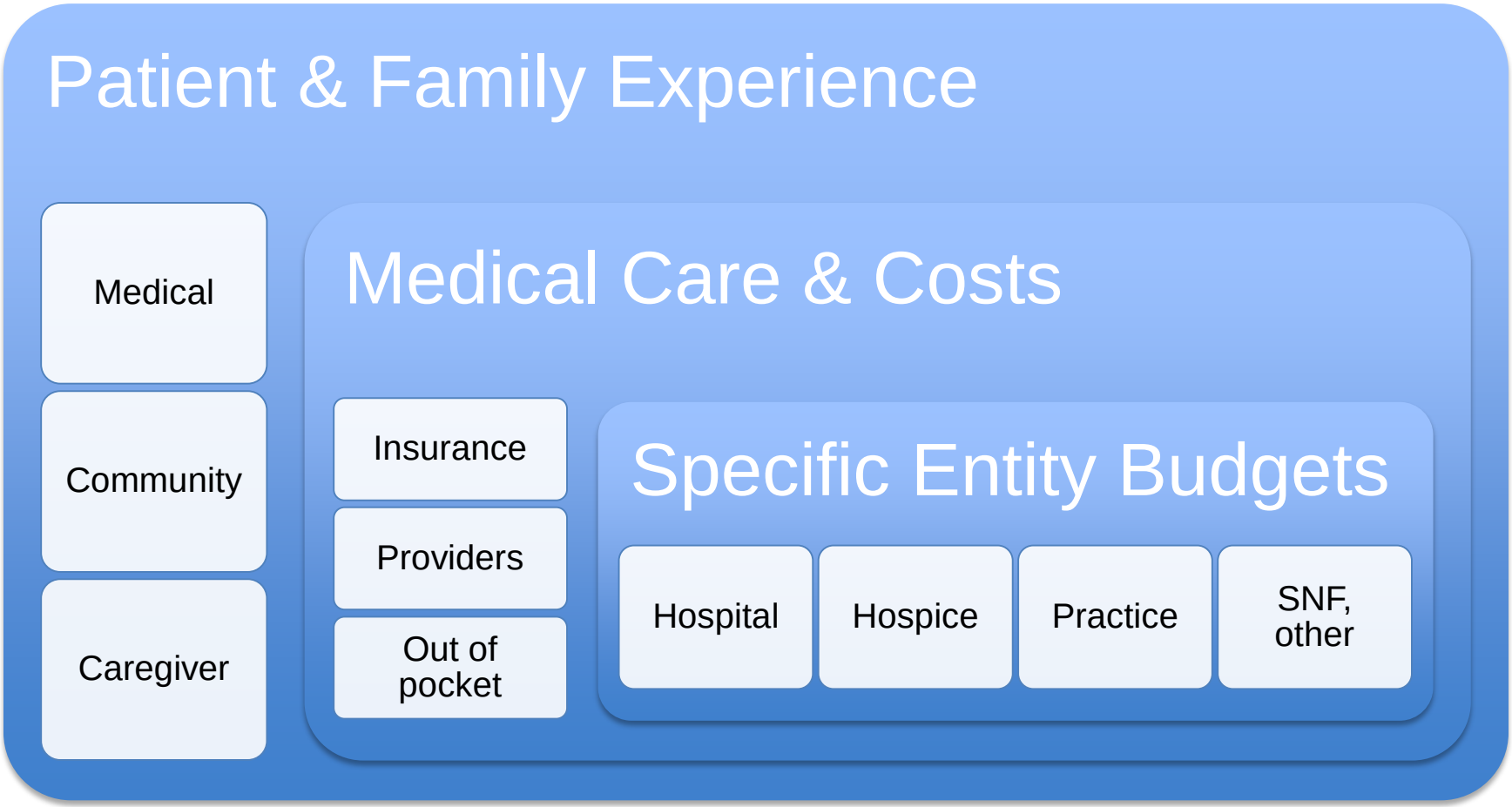
Disclosures

- No commercial disclosures
- Consultant to CAPC (Center to Advance Palliative Care) in NYC www.capc.org

Objectives

- Help you demonstrate leadership by planning comprehensively, with flexibility to implement incrementally
- Identify strategies to improve patient care through community partnerships
- Increase funding options through a broadened vision
- Identify solutions underway through discussion with others

Dilemma:
Alignment of design, investment, & benefit



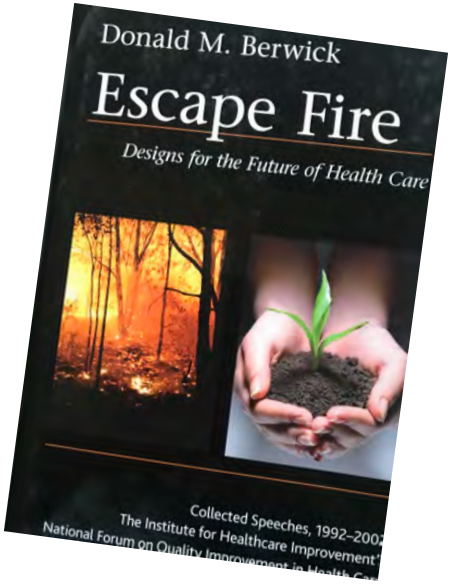
3 Non-Medical Factors that influence care outcomes

- Caregiver Support
- Financial circumstances / housing
- Transportation
- Functional decline

  - “Social determinants of health”

Think outside the box…

*"Why do we continue trying to make great health care out of disconnected, separately perfected fragments instead of weaving the fabric of experience that our patients need from us?"***



Don Berwick, **Escape Fire Designs for the Future of Health Care 2004, preface xi

Core Principles

*"Year after year I can find only three messages at the core: focus on the suffering, build and use knowledge, and cooperate."**

- Focus on the suffering (the patient)
- Build and use knowledge (improvement cycle + tech)
- Cooperate (build creative partnerships)

*Don Berwick, **Escape Fire: Designs for the Future of Health Care** 2004, Preface x.

How can YOU create change?

- Planning ≠ Direct Patient Care
- Engagement > Buy-in
- Success = Identifying Problems others can solve
- Missing link is often “cause & effect” knowledge
- Defining OPTIONS is better than defining solution
- Developing frameworks for training and supporting others can > “doing it yourself”

Dilemma

Which services, to whom?

Where to start?

Whether you can afford to provide a service will depend on program home, partners, payment methods, and translation of services into VALUE that matches up to specific entity ✳ interests.

Strategy = Needs Assessment

- ✓ Draft Plan,
- ✓ Test in Pilots
- ✓ Measure

Ask, Tell, Ask…

Needs Assessment Process:

A Means to Understanding Organizational Priorities

WHY are you considering this now?

What are the RISKS and OPPORTUNITIES for your organization?

Who are the community or health system stakeholders critical to success, funding, or achieving your goals?

How are you including the patient's voice?

Options for getting started?

Needs Assessment as a STRATEGY

- What keeps people up at night?
- How do they define “value”?
- What baseline data identifies gaps and opportunities?
- Who is already doing what?
- What is process for evaluation of plans?

Senior Leadership Pressures

- Decreasing revenues
- Increasing costs
- Competition – market & staff
- Changes: Pay for quality
- Expand footprint/Access
- Diversification
- Culture / habits

BUSINESS | HEALTH CARE | HEALTH

U.S. Hospital Profits Fall as Labor Costs Grow and Patient Mix Shifts

Decline points to new challenges for U.S. hospitals as more patients seek medical care in nonhospital settings

Implications of Emphasis on Population Health

- More value given for longer term & downstream costs (like SNF)
- Increased attention to “continuity” and “continuum” and “consistency”
- Pressure for full scale, reliable service, potentially in and out of hospital
- Preference given to clear “bundles” with defined processes & outcomes
- Pressure (hope) for prospective reliable ID of patients with needs through data

Service Options: Which Patients? Served Where? Implemented in what sequence?

Patient Focus	Where	Dilemma
By disease?	Hospital?	Patients move
By provider group?	Clinic?	Gaps between & across locations
By location?	Home?	People have more than one condition and needs change
By risk factors?	SNF?	
By payer or partner?		

Do’s and Don’ts of Needs Assessments & Partnership Strategies

DON’T “BAKE THE CAKE” YOURSELF

ASK OTHERS WHO TO INVITE; IT IS NOT YOUR PARTY

ALLOW TIME FOR THE PROCESS

SHARE CREDIT

MINIMIZE REDUNDANCY

DEFINE SERVICES NEEDED, THEN ID OPTIONS TO PROVIDE

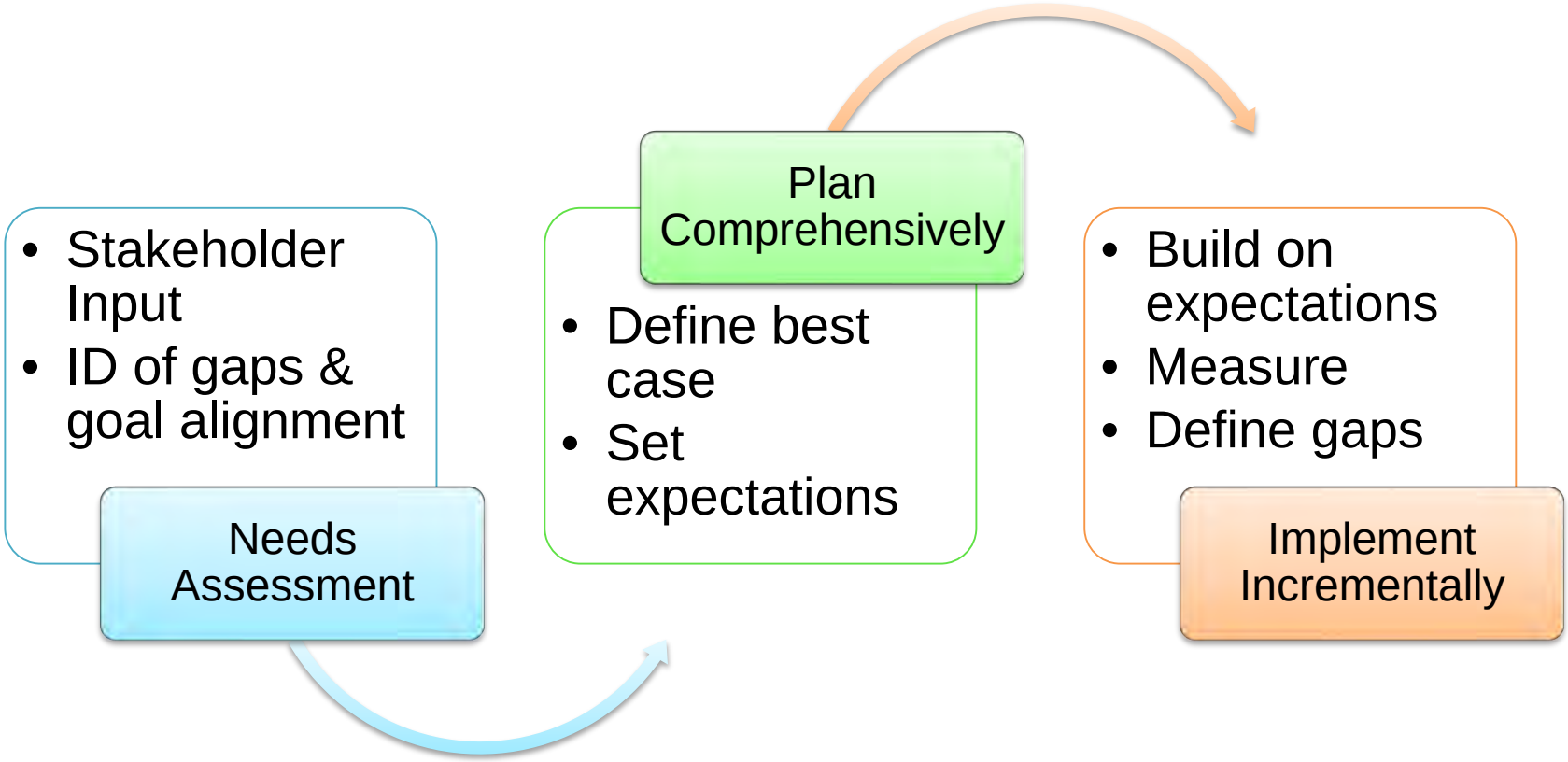
DO NOT START WITH ”GOOD WILL” THAT BECOMES UN-VALUED “FREE GOOD”

Reflections From Experienced Program Leaders

"The **single most common problem** encountered by palliative care programs is that they have **started services incrementally and reactively**. They want to meet a patient need…We respond with an incremental FTE...

Eventually the needs grow, the difficulty of juggling becomes problematic, and it is hard to get resources to sustain services. "

Key Principles of Planning



Financial Realities

Best care for complex patients is unlikely to be fully funded by FFS norms

It is likely to be cost-effective “in the big picture” but costly in the small picture (drives direct costs and diffused benefits)

Even risk bearing orgs like ACOs have difficulty reallocating costs.

Reality Check

- Leadership does not have your historical/baseline savings in a drawer…
- NEW savings matter more
- “Opportunity cost” approach highlights impact of cutting, maintaining, or expanding services
- Specificity of plans, target populations, baseline data, and measures help anchor investment decisions.

Value > Financial

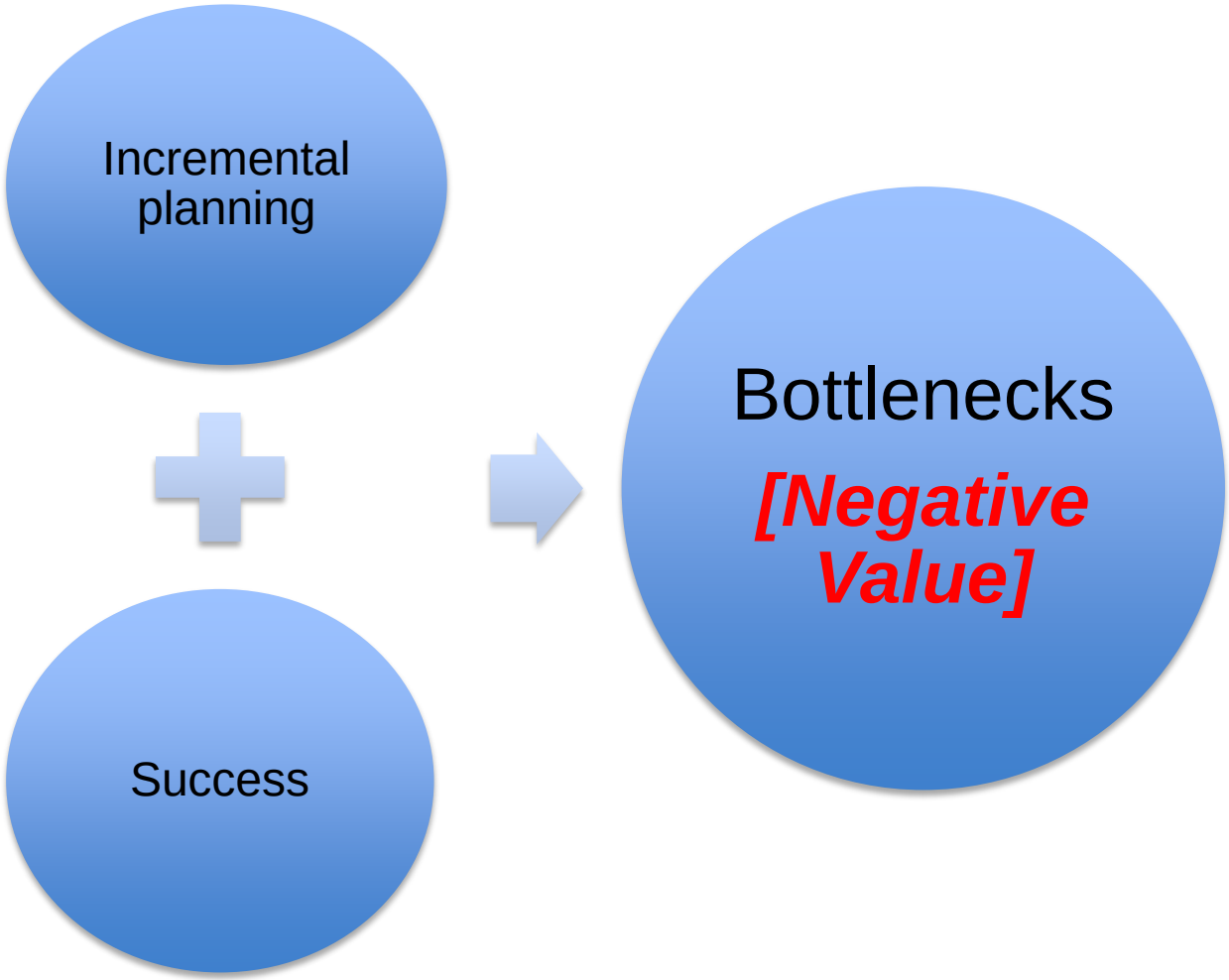
- **Reliability** (closed process, no gaps, smooth transitions & handoffs, no surprises)
- Effective direct timely communication of GOC wt. PCP & others
- **Access** (capacity, appointments)
- **SCALE** to have significant impact
- Partner organizations' loyalty
- Quality; performance on public indicators

Business Principles

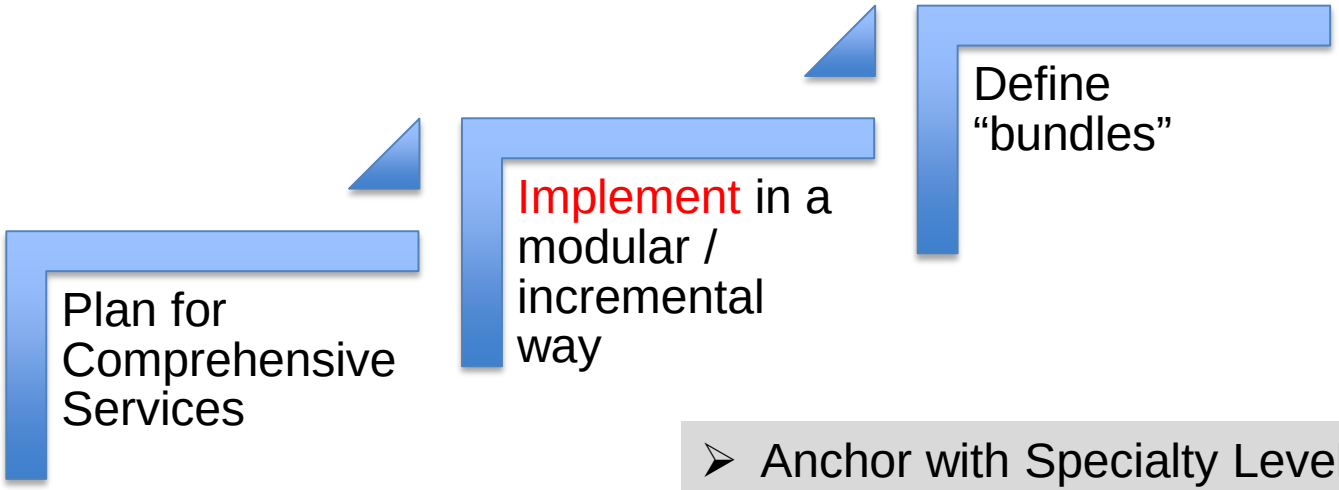
- If you can't define your services
  - Offer performance guarantees or standards (such as response time)
  - Know your costs & how scale impacts your costs

- It will be really hard to get paid appropriately.

Dilemma: Bottlenecks

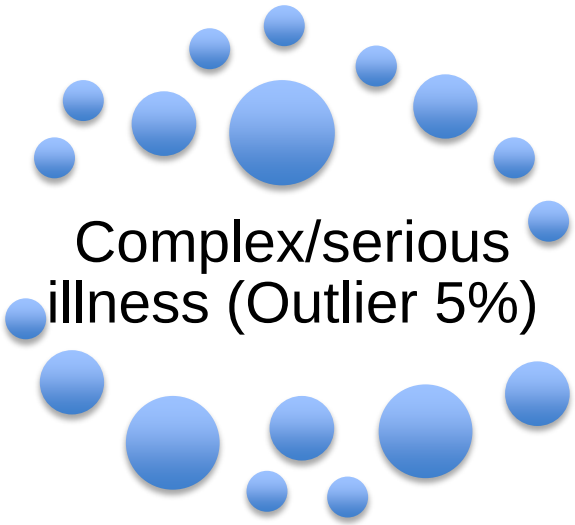


Recommended Approach



- Anchor with Specialty Level Capabilities
- Stabilize Services (Inpatient?) vs. spreading thin
- Consider "portfolio strategies" to achieve minimum critical mass for reliability & coverage

Define implementation “bundles”



Solutions?

Palliative Care

Bundles of defined services

Plan with full implementation in mind & make it as simple as possible

Balancing benefit & investment
(making service value explicit)

Example: Home Visit Program

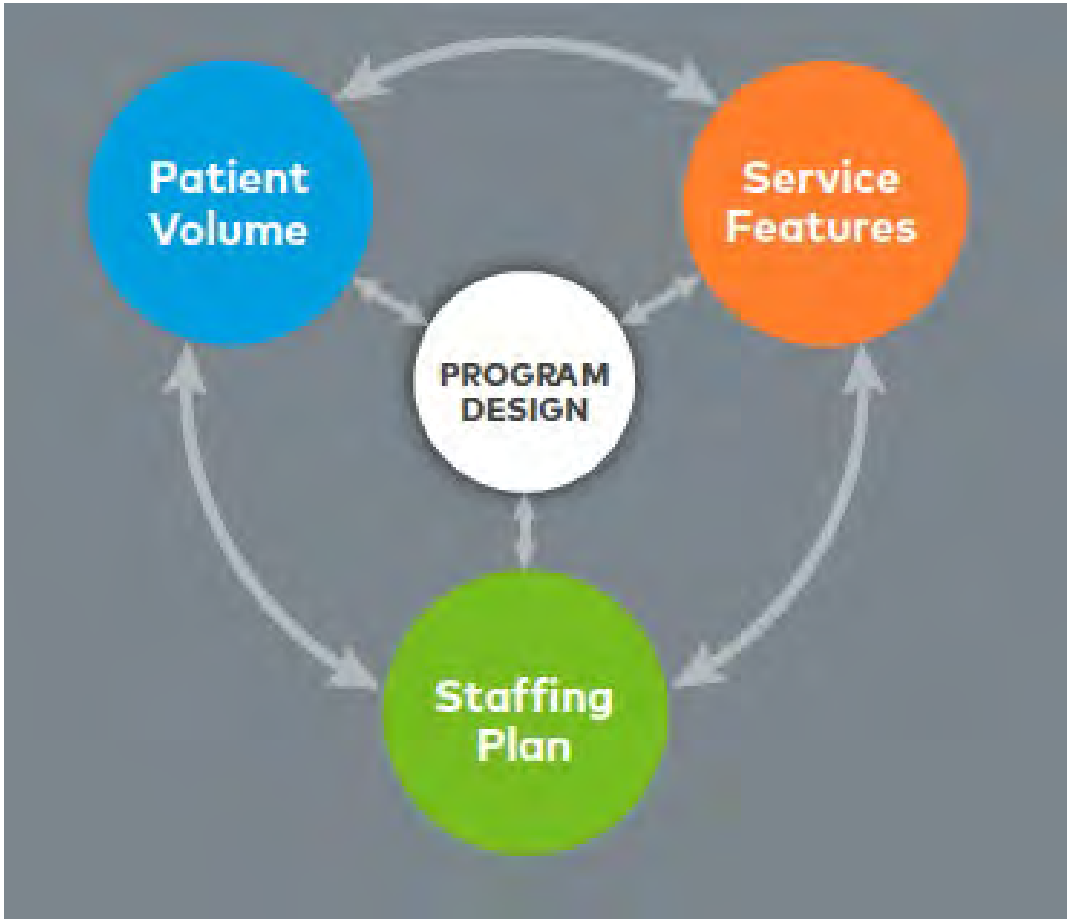
- ➔ 3 month post-discharge intensive support
- ➔ 3-6 visits, NP & SW + telephonic support
- ➔ Cost: assume approximately $2000 / patient
- ➔ Expected FFS billing net rev - $600 (+/-)

What are the *options for funding?*

ACO Environment? FFS system? Private Pay?

What is your "bundle"? Why?

Interactive Variables



Three Key Assumptions

- Which patients and how many will you plan to/be able to serve (and why)?
- What is your service model (and why)?
- What is your staffing plan (and why)?

Test your Constraints & Options

- Regulatory /legal environment for Home Care, Hospice, etc.
- Scope of Practice for APRNs
- Billability
- Partners & Payers
- Access to seamless E.H.R. across settings

Use Needs Assessment to **ID options** for partnerships to help design viable services!

Community Partners & Funding Strategies

Entities	
Hospital – Hospice – Home Care -Staff/ training/ call service/ home visits?	Shared by partners, purchased by entity at risk, or defined services paid by payor?
Volunteer orgs, Area Assoc. on Aging, Churches, State Agencies, 211 lines	How can roles be defined to create seamless access?
Local foundations or United Way Private donors CCRCs with resources Health system or payer foundations? Big employers with self funded plans?	How can new services demonstrate value to community? Options for startup funding vs. operational funding?

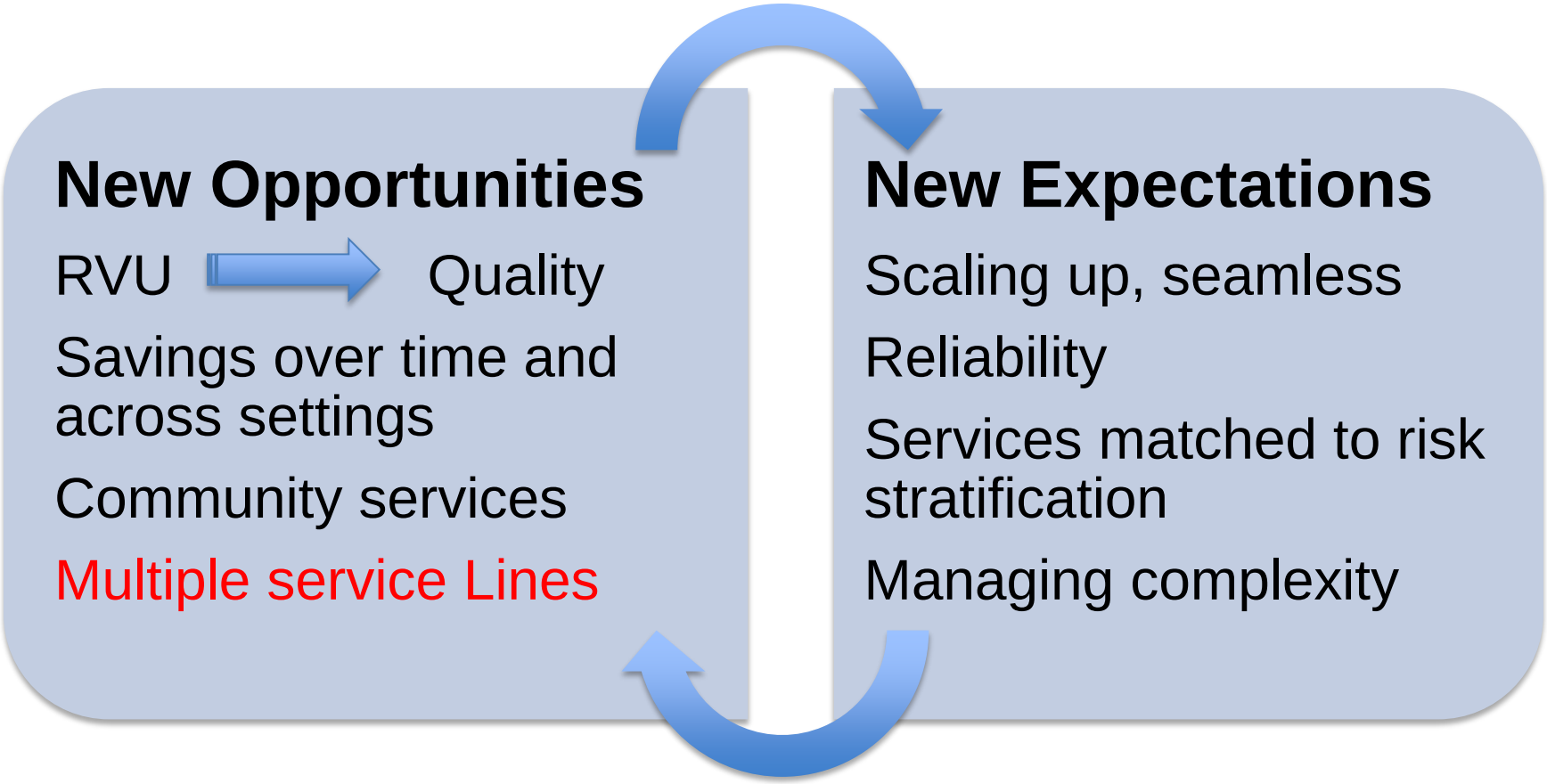
Discussion – Funding Strategies

Service you are considering	Who may fund? Why? How to use Needs Assessment to help connect the dots?

Food for Thought

- “Easier” to design in smaller places or where little is in place…
- Bold vision can break through for more support than tactical/incremental approaches…
- Difficult problems may have simple solutions…
- People with power and $ are also patients using the system as it is now…

Opportunities & Expectations (tied to Population Health)



Characteristics of Teams Equipped for Population Health

- Breadth (across settings)
- Depth & Capacity (IDT mix, FTEs)
- Systems' Support (Patient Identification, tracking, documentation, communication)
- Consistency of practice
- Reliability of processes, access
- Reliable feedback loops
- Management accountability
- Team Alignment and Health

Table Discussion

Question	Examples from discussion
Successes & Surprises?	
Failures, hurdles, and lessons learned?	
Current priorities/ efforts underway?	

Discussion

Summary

- Take the time to think ahead
- Consider multiple partners or collaborators
- **Do not shrink from designing a great program**
- Consider all work a “draft” and test as you go

CAPC Tools (capc.org)

- Implementation courses (100 & 500 series)
- Downloadable tools with courses (interview guides, budget templates)
- Virtual Office Hours
- Impact Calculator and National Registry
- Payment Primer & Serious Illness Guide