



Providing Early Palliative Care Interventions for Patients with Serious Illness

Sharp HealthCare's Approach

Domain: Care Coordination
Category: Access
Competency: CC.1.5 Ensure that palliative and hospice care services are available when deemed appropriate

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BACKGROUND

Sharp HealthCare's Transitions Program provides home-based palliative care for patients with advanced chronic illness, such as heart failure, COPD, dementia, and cancer. When the program was launched more than ten years ago, few health systems were thinking about outpatient palliative care, but the program's architects recognized a need for a service to help patients remain safely at home and avoid using the emergency department and hospital to manage symptoms and stresses of advanced disease. Daniel Hoefler, MD, a family physician and Sharp's Chief Medical Officer of Outpatient Palliative Care, describes seeing patients for whom he and the patient's specialists had done everything possible, but were nevertheless more likely to be admitted to the hospital than to attend their next outpatient appointment. Dr. Hoefler's strategy was to identify these patients early, support them in the home, and avoid hospital admissions altogether: a win-win for patients, families, and for the health system.

About Sharp HealthCare

Sharp HealthCare is a not-for-profit regional health care system with 4 acute care hospitals, 3 specialty hospitals, 5 urgent care centers, 3 affiliated medical groups, and a health plan.

Location: San Diego, California

Website: www.sharp.com

VBP Activity:

- Multiple capitated contracts with MA plans
- Pioneer ACO Program Jan 2012-Aug 2014 (~28k lives)
- NGACO Model since Jan 2017

APPROACH

Patients in Sharp HealthCare's Transitions Program receive palliative care in the home from a team of doctors, nurses, social workers, and spiritual support, each according to the patient and family's need. The program consists of four core components: 1) in-home medical consultations focusing on pain and symptoms; 2) ongoing prognostication of the inevitable consequences of disease progression and survival; 3) educational, psychosocial, and spiritual support for the patient's caregivers; and 4) skilled conversations to assist with treatment choices and advanced care planning. Unlike hospice, the Transitions Program is delivered concurrently with ongoing treatment. Patients continue to see their primary care physicians and specialists as usual, but also receive an added layer of support, with access to 24-7 telephone support from the Transitions nurses. The program's full-time staff currently includes four nurses, two social workers, one physician (Dr. Hoefler), and includes access to health care chaplains, and multiple physicians for interdisciplinary support.

Dr. Hoefler and his administrative counterpart, Suzi Johnson, launched the Transitions Program with an initial focus on home-based palliative care support for heart failure patients, a group they believed would experience immediate benefits. To secure the support of cardiologists, the program hired a cardiac nurse specialist and a hospitalist to conduct care management, and subsequently gave them palliative training. The launch was so successful that Transitions quickly expanded to serve other groups, including patients with dementia, COPD, cancer, cirrhosis, and geriatric frailty. A service for patients with late stage kidney disease is in development.

The Transitions Program maintained disease-specific staffing groups in its early years, but this became impractical as the program grew, and nurses are now zoned by region. Transitions cares for around 200 patients in the San Diego region, but will soon take on an additional 100 from Sharp's Next Generation ACO. The Program is looking closely at contracting with Medi-Cal managed care plans under a recent law (SB-1004) that mandates palliative care services for Medi-Cal patients based on criteria adapted directly from the Sharp Transitions Program.

Patients are identified by referrals from primary care providers, specialists, case managers, home health agencies, and skilled nursing facilities, using general and disease-specific criteria but no specific triggers. Assessments include measures of functional abilities, laboratory results (both general and disease-specific) and the program's "surprise" question, asking if clinicians would be surprised if the patient began using the hospital to manage advanced disease. While many other palliative care programs ask whether the referring clinician would be surprised if their patient died in the next 12 months, the Transitions Program has adapted the question to reach patients earlier in their disease process, with the goal to improve quality of life and avoid unnecessary utilization. Importantly, Transitions patients do not need to have a Medicare Part A skilled need, they do not need to be home-bound, and they do not need to have a time-limited life expectancy. A patient's primary care provider must agree to the referral to Transitions, and patients must continue to see their PCPs and specialists as needed.

The Transitions Program has two distinct phases: 1) an acute phase for new patients and those with changing circumstances and 2) a maintenance phase. In the acute phase, a registered nurse helps the patient articulate medical goals, such as pain management, while a social worker identifies and addresses the family caregivers' needs. During this phase, the patient receives weekly home visits from an RN for 4-6 weeks and weekly visits from a social worker for 1-3 weeks, as well as spiritual care as desired. When the patient and family's goals

have been met, the Transitions Program moves into the maintenance phase. In this phase, home visits continue less frequently, and case management continues through scheduled telephone calls.

The program is open to all Sharp HealthCare patients, including patients attributed to Sharp's ACO and traditional FFS patients. However, the large majority of Transitions patients are Medicare Advantage beneficiaries referred by medical groups affiliated with Sharp HealthCare, for which Sharp is fully at risk for hospital costs. Under capitated payment, the clinical and business cases for a proactive palliative care program are aligned. Transitions costs an average of \$642 per beneficiary per month, and patients are enrolled in the program for an average of 7 months.

RESULTS TO DATE

The Transitions Program has cared for more than 5,000 patients over the last ten years, successfully lowering hospital usage and health care expenditures with modest program costs and high rates of patient satisfaction. A recent study comparing Transitions patients with cancer, COPD, dementia or heart failure to a matched group found that the program cut hospital admissions by half.¹ For those patients that were admitted, the length of stay was cut by 50% or more, depending on the disease category. Hoefer says that hospital admissions for Transitions patients often result from falls as opposed to disease-related crises, and the program is developing new ways to reduce fall risk for their patients. The Transitions Program also produced other important reductions in utilization, such as significantly lower rates of ICU admission within 30-days of death. Transitions produced net savings per participant per month of \$4,258 for cancer, \$4,017 for COPD, \$3,447 for heart failure, and \$2,690 for dementia, equivalent to a return on investment between 4.2 for dementia and 6.6 for cancer.

TOOLS & VENDOR PARTNERS

The Transitions Program has not employed any specific data models or tools in its decade of caring for patients. Transitions uses a variety of disease-specific and functional criteria to assess whether patients are suitable for the program. For patients in the advanced stages of illness, however, Hoefer argues that no data model or tool can supersede the judgment of the physician and the patient's family. Indeed, check box-style assessments can miss crucial context for such patients, resulting in misinformation, particularly for dementia patients, for whom accurate prognostication is especially challenging.

CHALLENGES WITH IMPLEMENTATION

The foremost challenge faced by the Transitions Program in its early years was to overcome institutional and cultural barriers to delivering a new model of care. At the time, palliative care programs were largely confined to the hospital, and home-based care was restricted to hospice, while the bulk of patient needs fall between those two settings. Dr. Hoefer and Ms. Johnson recruited the support of two Sharp cardiologists to develop a program for the initial cohort of heart failure patients, but faced fierce opposition from other influential cardiac specialists concerned that Transitions would take over the care of their patients. The strategy, says Dr. Hoefer, was to build the program first and apologize later.

KEY LEARNINGS

- **Challenge assumptions** – Challenge the notion that in-home care for patients with serious illness needs to be preceded by a hospitalization. Moving care “upstream” has allowed Transitions to avoid thousands of unnecessary and harmful hospitalizations for its patients.
- **Prove your concept** – Transitions overcame cultural opposition to home-based palliative care by taking institutional risk to prove the concept, winning over specialists with its success.
- **Hire strategically** – Recruit staff that can help establish the relationships needed with patients and specialists; formal palliative training can be added later.

¹ Brian Cassel J, Kerr KM, McClish DK, et al. Effect of a Home-Based Palliative Care Program on Healthcare Use and Costs. Journal of the American Geriatrics Society. 2016;64(11):2288-2295. doi:10.1111/jgs.14354.

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