Best Practices Study Overview and Recommended Improvement Options

AZ Coalition to Transform Serious Illness Care
November 11, 2020

Arizona END OF LIFE CARE PARTNERSHIP
Anchored at United Way of Tucson and Southern Arizona

DISCERN HEALTH
a W2O company

AzHHA
Arizona Hospital and Healthcare Association

C-TAC
COALITION TO TRANSFORM ADVANCED CARE

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Project Background

Serious Illness in Arizona

Arizona has an opportunity to improve serious illness outcomes by focusing on community-based services and supports.

- C-TAC ACT Index results (2016) show that Arizona was ranked
  - 49th of 51 states on composite of "community" measures
  - 48th in ICU days per decedent (last 6 months of life)
- Access to care was the leading health priority for Arizonans identified in the 2016 – 2020 Arizona Health Improvement Plan.
- During the COVID-19 pandemic, ICU use increased, and an AZ Coalition survey found access issues exacerbated by social distancing.
- Even as patients seek more home-based services, community-based organizations must address new challenges in delivering care and supports.

Defining the Problem

People with serious illness and their families often experience acute events, seek crisis care, or choose institutional care because they have trouble **managing health conditions** and **adverse events** at home.

Patients with multiple comorbidities more likely to experience preventable hospitalization, often due to inability to manage symptoms.

Patients with multiple chronic conditions have 19-32% higher inpatient costs associated with longer hospital stays.

Patients with dependencies in three or more ADLs and/or cognitive impairment are more likely to be admitted to a nursing home.

About the Best Practices Study

Study conducted by Discern Health, authorized by the Arizona Coalition to Transform Advanced Care, and overseen by the Community Support Services Workgroup

Project Question

Which community services and supports should Arizona implement (or scale) to help people with serious illness manage health conditions and increase the number of days at home?

Intervention Requirements

- Supported with evidence for **impacting** days at home for people with serious illness
- **Relevant** to the mission of the AZ Coalition
- **Feasible** for implementation in AZ
- Leverage existing efforts, promote collaboration, and advance transformative ideas.

Community Support Services Workgroup

WORKGROUP PURPOSE

- Identify community services and supports to be investigated in a "best practices" study
- Determine the most effective measures for assessing improvements in care and outcomes for Arizonans with serios illness
- Oversee Best Practices Study

MEMBERS

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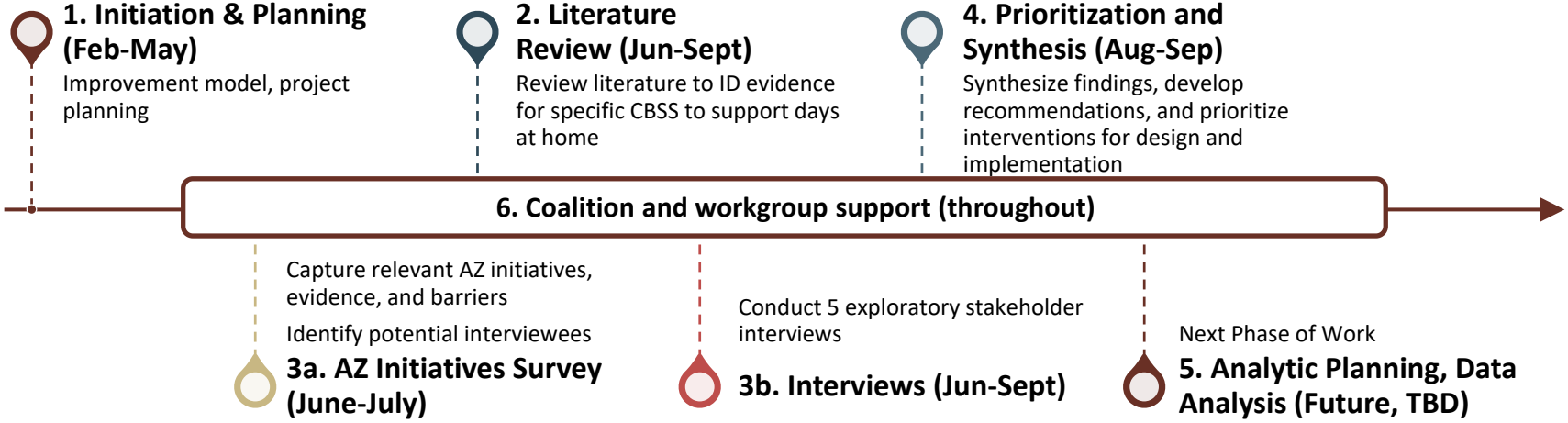
Thank You!

Thank you to the David and Lura Lovell Foundation for supporting our critical mission.

Additionally, we would like to acknowledge the AZ Coalition Steering Committee, Community Support Services Workgroup, and the project teams from AZHHA, the AZEOLCP, and C-TAC for their leadership and contributions to shaping the study approach.

Best Practices Study Project Timeline



Modified Approach due to COVID-19

- Use steps 1-3 to ID potential intervention options using survey, literature, and interviews; focus on moving towards implementation
- Voted to end this project after step 4 to move to the design phase of a broader intervention
- For more information on survey, literature review, and interview methodology, see Appendix.

Where We Are

Phase I	Phase II	Phase III
DEFINE	DESIGN	IMPLEMENT
▪ Best Practices Study & Define Intervention (Completed October 2020)	▪ Design Operational Details & Determine Baseline Metrics	▪ Implement Intervention via Pilot & Evaluate the Effectiveness

Project Milestones Achieved as of 9/24

- ✓ Selected "**community**" as area of focus using C-TAC ACT Index data
- ✓ Selected core **outcomes** (days at home, crisis care utilization, hospice days, patient/family satisfaction)
- ✓ Defined and listed "**community services and supports**"
- ✓ Developed **improvement model**
- ✓ Identified priority barriers: **health incidents** and **health conditions**
- ✓ Confirmed **Best Practices Study** design
- ✓ Revised approach based on **COVID-19** impact in Arizona
- ✓ Conducted **literature scan**
- ✓ Administered Steering Committee **survey**
- ✓ Conducted **5 interviews**
- ✓ Generated and discussed **recommended improvement options**
- ✓ **Voted on initial options,** compiled results
- ✓ Completed **Intervention Briefs, Survey Results, Literature Review Tracker, Interview Summaries, Summary Slides** (this deck), and **Recommendations Summary**
- ✓ **AZ Coalition Steering Committee voted to confirm final recommendation on 9/23/20**

Primary Recommendation

Primary Recommendation

Create a model for the seriously ill patient journey. At the center of this model is **Home and Community Based Palliative (HCBP)** care.

The model will also feature strong collaboration with primary care and community-based services and supports (CBSS), creating an integrated patient support network.

The model should serve people with serious illness in AZ, with a focus on high-cost, high-needs patients. The **target population** and method for identifying patients will be defined during design (phase II) and leverage prior research, existing programs, and scoring tools.

Key HCBP Model Components

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Component Considerations

Symptom and pain management	Interdisciplinary team	Coordination of care	Collaboration with primary care	Telehealth and tele-palliative
Connecting patients with CBSS	Promote palliative education for providers and communities	Advance care planning	Addressing social determinants of health, health equity	Support for care transitions
24/7 support	Family/caregiver support	Patient and caregiver education/coaching	Tools for self management	Services for pediatric population

HCBP Recommendation Rationale

- Evidence suggests an HCBP intervention will impact days at home by helping patients and families manage conditions and avoid crisis utilization from uncontrolled symptoms and acute events.

Survey

- **Current AZ programs exist** that can be leveraged in design and implementation.
- Some of these programs currently have value-based contracts with health plans.
- Programs also address needs and challenges from COVID-19 pandemic.

Literature Review

- Community-based palliative care models have resulted in **favorable outcomes:**
  - Reduced hospital admissions
  - Reduced ED visits
  - Reduced ICU days
  - Increased ability for patients to die at home (common care goal)
  - Reduced death in hospital
  - Long-term positive return on investment
  - Improved patient and family experience

Interviews

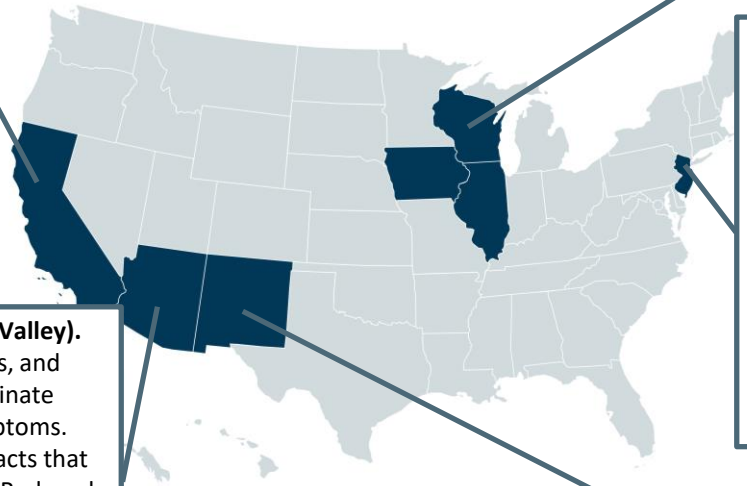
- **Now is the right time.** COVID-19 has highlighted disparities in access to care and CBSS.
- Increased interest from payers, patients, and providers to build a community-based palliative care model to help patients meet goals of care and generate cost savings.
- This environment increases the **feasibility** of success.

- Evidence also supports **home-based primary care**, but the AZ Coalition determined an intervention centered on palliative would fill a gap in supportive care and services for people with complex care needs. **Telehealth** and **ACP** can be key components of HCBP vs. stand-alone interventions.

Example HCBP Models from Survey, Literature Review, and Interviews

UnityPoint Health Palliative Care Services. Provides inpatient, clinic-based, and home-based palliative care across an integrated health system serving nine regions. In each region the palliative care program is co-led by a physician and clinical administrator. The palliative care program is a consultative service that supports other providers in caring for patients. **Outcomes**: 70–75% reduction in hospital utilization and variable direct costs in the six months following initial consult, compared to the 6 months prior to the consult.

Coalition for Compassionate Care of California and California Advanced Illness Collaborative. A joint collaborative that partners with payers to increase access to palliative care and improve care quality for people with serious illness in California. The Collaborative has developed consensus standards for community-based palliative care and is implementing a pilot program to test them with a cohort of health plans and CBPC providers. (Outcomes pending pilot intervention).



Meridian Care Journey. System-wide program provides palliative care in acute care hospitals, skilled nursing facilities, outpatient practices, and patient homes. Interdisciplinary teams operate across the continuum, serving individuals with chronic illness, with a focus on engaging with patients early in the disease course and assuring continuity over time and across settings. **Outcomes**: Percent of enrolled home-based patients re-hospitalized decreased from 23% to 16% within one year of implementation.

Arizona Palliative Home Care (AZPHC, Hospice of the Valley). A team of doctors, nurses, nursing assistants, chaplains, and social workers work with the patient's doctor to coordinate services and help patients manage their pain and symptoms. The organization currently has nine value-based contracts that include state Medicaid ran by Mercy Care. **Outcomes:** Reduced inpatient episodes by 56%, inpatient days by 57%, and ED visits by 49%. Reduced caregiver burden.

Casa de la Luz provides team-based wholistic in-home care, including social services and other supports (e.g., music therapist) to enhance quality of life for patients living with serious illness.

Project ECHO (Extension for Community Health Outcomes). Technology-enabled model for healthcare education began in New Mexico and deployed in several states and countries. teleECHO for palliative care delivers the skills and expertise of centralized palliative specialists to frontline PCPs working in diverse communities. **Outcomes**: Improved self-efficacy and knowledge of non-pain symptom management.

Potential Design Phase Tasks

Phase I: Define (complete)

- Selected measures of success (ACT Index)
- Conducted **Best Practices Study**
- Voted to select HCBP for Phase II-III

Phase II: Design

- **Part A:** Convene stakeholders, inventory programs, co-design care model
- **Part B:** Co-design payment model & pilot, calculate baselines

Phase III: Implement

- Launch the pilot (selected locations)
- Analyze data to evaluate pilot
- Determine network needs

Part A

Task 1 & 2

- **1a. Define Population**
  - Identify key stakeholders to add to CSS workgroup
  - Propose high-cost, high-needs population
  - Outline pop needs to be met w/program
- **1b. Inventory**
  - Survey AZ palliative programs to determine services, payment, capabilities, etc.
- **2. Conduct Interviews**
  - Interview local & national experts for more detail on programs

Task 3 & 4

- **3. Review Standards**
  - Review palliative standards & exemplary models
  - Concurrent w/ Task 1
- **4a. Crosswalk**
  - Compare population needs & standards to available AZ programs
  - Identify gaps in AZ
- **4b. Develop HCBP Principles**
  - Draft preliminary care model principles for convening review

Task 5 & 6

- **5a. Convene Stakeholders**
  - Providers, payers, patients, potential pilot partners, etc.
  - Concurrent w/ Task 1
- **5b. Co-Design Care Model**
  - Refine population definition
  - Co-design HCBP model
  - Define core set of palliative services & non-palliative CBSS
  - Align on KPIs to track overall measures of success
- **6. Report progress to Steering Com.**

Part B

Task 7

- **7. Design Payment Model**
  - Collaborate to design a value-based payment model
  - Address HCBP services & CBSS
  - Build in KPIs, (e.g., for cost & quality)
  - Draw from existing models in AZ & beyond

Task 8

- **8a. Build Infrastructure**
  - Create infrastructure for data sharing & collaboration
  - Concurrent w/ Task 7
- **8b. Calculate baselines**
  - Develop KPI specs.
  - Calculate local baseline rates
- **8c. Determine data collection process**
  - Concurrent w/ Task 9

Task 9

- **9a. Design Pilot**
  - Confirm 2-3 pilot sites across AZ
  - Select pilot quality measures
  - Design pilot and evaluation process
  - Summarize HCBP model design, pilot design, & baseline calculations
- **9b. Authorize pilot** (Steering Committee)

Which stakeholders should be included?

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Stakeholder Considerations

Patients and families	Health plans	Palliative and hospice providers	Primary care providers
CBSS providers	Hospitals (e.g., discharge planners, hospital-based palliative providers)	State officials, public payers	Experts in telehealth, geriatrics, developmental disabilities, dementia, pediatrics, social work
Emergency Medical Services	Health services researchers	Experts in performance measures and value-based payment models	Universities and education initiatives

Considerations for Success

What is needed to successfully design and implement the HCBP model?

- **Funding** to support convening, development of model, and peer network facilitation
- **Project team with expertise** in convening, clinical care, CBSS, payment models, and data to guide design efforts
- **Coordination/partnership building** across stakeholder groups and organization to spearhead efforts and hold participants accountable
- **Multi-stakeholder participation** throughout design and implementation processes
- **Buy-in** from payer, palliative, primary care, acute care, ACO, and other leadership
- **Time** to identify participants, convene stakeholders, develop model, and build peer network (if appropriate)
- **Partner commitment** to build palliative care workforce capacity, through training providers on providing palliative care and/or hiring new palliative care providers
- Plan to **engage additional providers** to offer palliative care (primary and specialty)

Considerations for Success (contd.)

- **Build on existing** models
  - Identify gaps (e.g., lack of alignment with primary care) to ensure this model represents an evolution.
  - Inventory existing palliative programs and connect the dots between existing CBSS efforts
  - Leverage existing partner networks, such as that convened by the AZEOLCP; use AZEOLCP pillars for framing
  - Leverage existing community and provider education efforts (Health Current, Project ECHO, university programs, etc.)
- Promote **state-level engagement** with palliative efforts by including state officials in AZ Coalition activities and considering a recommendation to the Governor's office to create a statewide palliative committee.
- Consider how the model will address the needs of underserved populations (e.g., without a payer source)

Recommendation Approval

During the 9/23/2020 Steering Committee Meeting, the AZ Coalition voted to move forward with next steps to seek funding and begin the HCBP design process.

Appendix: Detailed Findings

Appendix Contents

- **Slides in the Appendix synthesize key findings surfaced from the survey, literature review, interviews with key stakeholders, and the initial intervention options discussed with the Steering Committee.**
- **For more information on these findings, see supplementary documents:**
  - **One-page summary/press release (PDF doc):** "Arizona best practices study recommends home- and community-based palliative care initiative"
  - **Primary recommendation summary (PDF doc):** summarizes the primary recommendation that the Steering Committee selected to move forward
  - **Intervention briefs (PDF doc):** provides information about the evidence for impact/feasibility for different key intervention features
  - **Survey results (Excel doc):** includes the responses from the AZ interventions survey
  - **Literature review tracker (Excel doc):** summarizes articles identified from the literature review, including key results and intervention features
  - **Interview summaries (PDF doc):** summarizes discussions with key informants

Overview of Findings

Improvement Model Summary

The CSS Workgroup identified community-based solutions that could address barriers leading to more days at home:

Community-Based Solutions

- Telemedicine
- After-hours call center
- Advance care planning
- Transportation services
- Care coordination / case management
- Nutrition services
- Food delivery services / meal programs
- App for social support
- Health plan programs
- Employer-led support initiatives
- Support groups for families
- Low-cost respite services
- Home health agency visits
- Home-based primary care
- Community-based palliative care
- PACE programs
- Community healthcare workers top of license
- Family caregiver tax credits or wages
- Community partnerships
- Partnerships to obtain good food in rural markets
- Pharmacy / payer medication access or reconciliation
- Faith-based organizations
- Volunteer programs
- Volunteers / workers for home-based care
- E-visit verification, wearables, AI
- Telephone follow-up
- Emergency kit
- EMS onsite care
- Homemaker / custodial services
- Employer support for fam. caregivers

Barriers to Days at Home

- Family/ Caregiver burden
- Medication issues
- Social isolation
- Property maintenance issues
- Food-related issues
- Health incidents
- Health conditions/ functional impairment
- Financial issues

Healthcare Outcomes

Primary

- Days at Home

Secondary

- Hospice Days (leading)
- Crisis Acute Utilization (hospital, ICU, ED, readmissions)
- Patient / Family Satisfaction

Key Study Takeaways

Arizona has many people with serious illness not being fully served	• Struggling to manage conditions in their homes • Difficulty paying for care and may not be served by existing programs • May be impacted by other social determinants of health
Community-based palliative care and home-based primary care are options that meet different needs	• PCP quarterbacks care • Palliative is focused on symptoms and quality of life • Coordination between both is essential to ensure needs are met
AZ organizations already offer some needed services	• Challenges to meet demand due to limited funding, availability of trained providers, and difficulty scaling
Telehealth is a facilitator, especially during COVID-19	• Challenges to access and use, including knowledge and infrastructure
Innovative programs across the US have been funded through payer contracts or federal programs	• An example of such a programs includes the Independence at Home Demonstration Model through CMMI

Interventions and Features

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Surfaced evidence for four key interventions…

Advance Care Planning (ACP)

Community-Based Palliative Care (CBPC)

Home-Based Primary Care (HBPC)

Telehealth

…featuring crosscutting facilitators that help people manage conditions at home.

Care Coordination

Patient & Provider Training/Education

CHWs & Volunteers

Family Caregiver Support

Partnership & Coalition Building

These form the building blocks of improvement options for consideration.

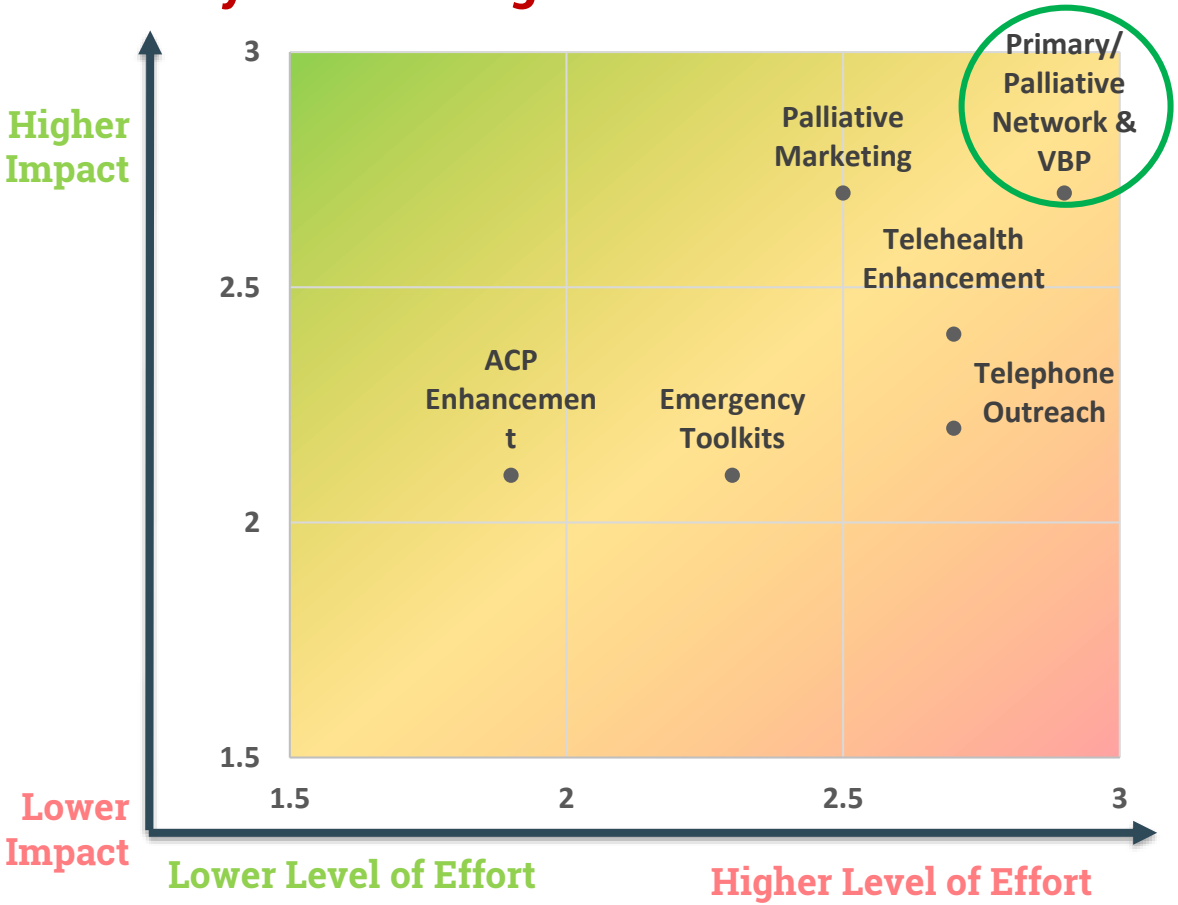
Updated Project Question

After conducting the literature review, survey, and interviews, we modified the guiding question to better reflect what we learned during the process. Changes are highlighted in light blue.

Updated project question: How can we leverage or expand existing community-based services and supports to:

- Advance top interventions,
- Serve the seriously ill and promote health equity in a socially distanced environment,
- Help people with serious illness manage conditions, and
- Increase days at home ?

Summary of Steering Committee Poll Results



Ranked Options*

1. Primary/Palliative Network & VBP
2. Primary Care and Care Coordination (Emergency Toolkits and Telephone Outreach)
3. Telehealth Enhancement and Support
4. Palliative Marketing
5. ACP Enhancement

*See Initial Options Discussed section for details on options ranked

Survey Results

About the Survey

- Adapted the study approach to reflect the experiences and lessons learned during COVID-19.

- Launched a survey of Steering Committee members and their broader networks (snowball approach) to capture:

Current AZ Initiatives

To deliver community services and supports that will help people at home during COVID-19 and beyond

Evidence

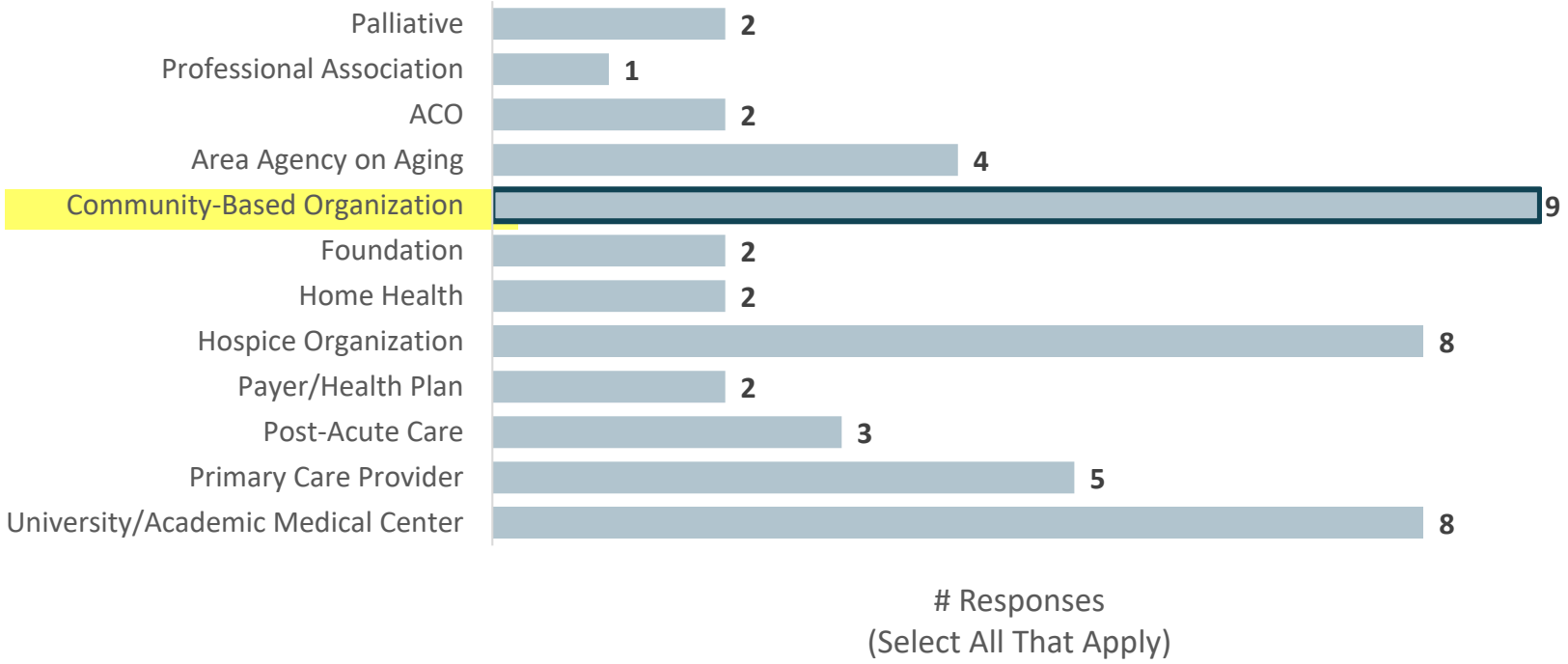
Being collected to assess the effectiveness of these initiatives

Barriers

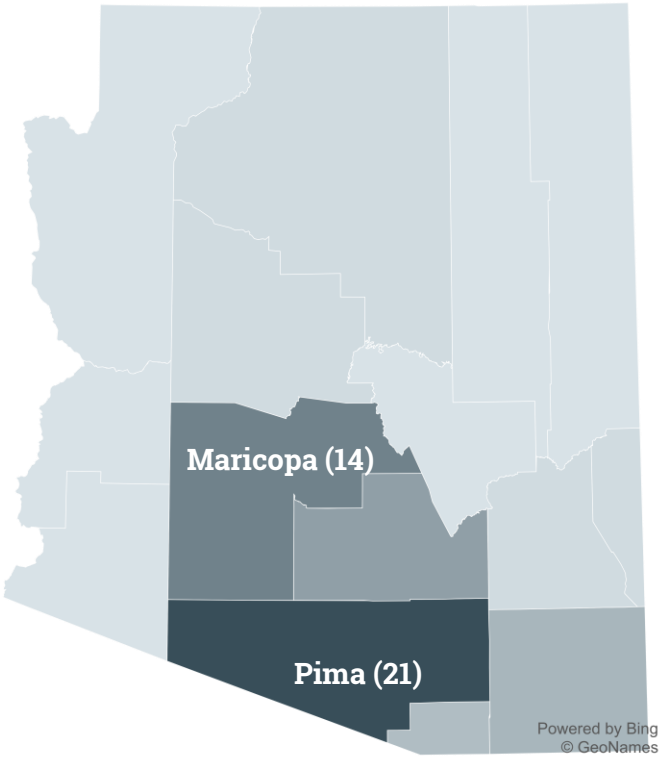
And how organizations are addressing those barriers

Survey Participants

Survey Participation by Organization Type (N=36)



Target Population



Many reported initiatives target residents of Maricopa or Pima County

- 3 initiatives includes participation from non-Arizona residents
- 4 initiatives span multiple counties state-wide (respondents not sure which counties)

Most initiatives reach between 1-400 participants per month

- 3 initiatives reach 751 – 2,000 participants
- 1 initiative reaches 2,000 – 10,000 participants

Target Population (cont'd)

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Initiatives target diverse populations. (N=36, select all that apply)

AGE	
Older Adults (65+)	25 initiatives
Adults (18-64)	14 initiatives
Children	8 initiatives

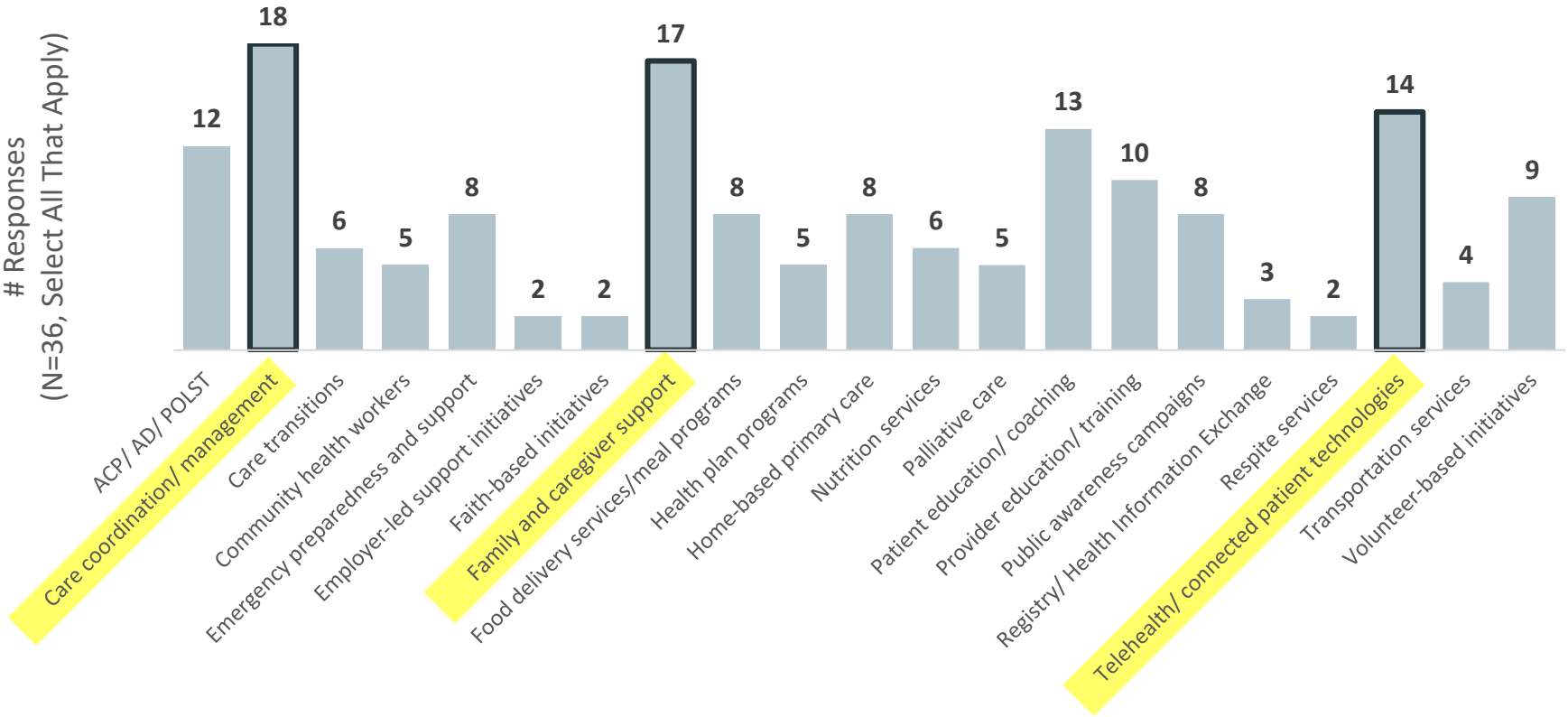
INSURANCE COVERAGE	
Medicare	24 initiatives
Dual-Eligible	18 initiatives
Medicaid	14 initiatives
Privately Insured	10 initiatives

2 initiatives address adults experiencing social isolation. 7 initiatives address specific racial or ethnic groups.

HEALTHCARE NEEDS	
2+ Chronic Conditions	22 initiatives
Serious Illness	20 initiatives
Hospice-Eligible	17 initiatives
People with Disabilities or Functional Limitations	17 initiatives
Family Caregivers	17 initiatives
Psychological or Behavioral Needs	14 initiatives
Single Chronic Condition	12 initiatives
SNF or Assisted Living	9 initiatives
People Who Are Hospitalized	9 initiatives

Initiative Components

Major Components of Initiatives



Barriers Identified

Barriers

- Accessibility challenges
  - Social distancing
  - Limited participant access to telehealth/technology
- Ability to track data
- Limited resources (PPE, staff, time)
- Lack of knowledge about available resources
- Financial viability (payer support)
- Number of people in need

Addressing Barriers

- Clinician recruitment
- Coalition building and strengthening partnerships
- Virtual communication and coordination
- U.S. Postal Service to reach patients
- Use of social media
- Participant outreach (e.g., making phone calls to community members)
- Increased telehealth flexibilities

Literature Review Results

About the Literature Review

- **Discern reviewed community-based interventions found on Google Scholar and PubMed databases and shared by project team***
  - 99 studies/articles with different intervention features (some articles contained more than one key intervention component):
    - ACP: 28
    - CHW: 7
    - CBPC: 42
    - Telehealth/telemonitoring: 19
    - HBPC: 19
    - Partnerships/coalitions: 13
    - Family/caregiver support: 16
- **Documented intervention, scope, population, outcomes, etc. from each study**

** Excluded international studies and studies before 2010.*

Interventions Identified

We identified the following interventions in the literature with evidence of outcomes of interest.

Community-Based Interventions	Outcomes
▪Community health worker-delivered services ▪Social worker-delivered interventions ▪Faith community partnerships ▪Telehealth and telemonitoring ▪Home-based care and facilitators of home-based care ▪Payer partnerships/ community-based palliative care benefits ▪Advance care planning ▪Integrated care (inpatient, outpatient, community) ▪Patient navigation ▪Support groups (e.g., for caregivers) ▪IDT to include community-based members ▪Patient and family education ▪24/7 support ▪Volunteer-led initiatives	▪Increased time at home ▪Improved quality of life (e.g., symptoms) ▪Increased ACP ▪Reduced emergency department visits and hospital readmissions ▪Improved symptom management ▪Reduced Medicare expenditures ▪Increased deaths at home ▪Improved patient and family satisfactions

Evidence for Interventions

Advance Care Planning

- **Promising interventions**
  - Integrated, interdisciplinary care team (i.e., blending of community and medical models) to deliver patient/family education and facilitate goals of care through advance care planning
  - Use of telehealth to deliver advance care planning
- **Outcomes**
  - Reduced crisis care utilization (e.g., hospitalization)
  - Reduced long-term care placement
  - Decreased expenditures (without an increase in patient mortality)

Community Health Workers

- **Promising Interventions**
  - Leveraging community health workers to deliver interventions: health education, counseling, patient navigation and case management, social support
  - Community health worker training and supervision
- **Outcomes**
  - Increased cancer screening and decreased cardiovascular risk (e.g., blood pressure, HbA1c, etc.)
  - Association with cost-effective and sustainable care
  - Improved self-reported quality of life
  - Improved transitions of care

Evidence for Interventions (contd.)

Community-Based Palliative Care

- **Promising Interventions**
  - 24/7 support (e.g., medical crisis prevention, urgent response, palliative nurse support)
  - Interdisciplinary, integrated home-based palliative care (e.g., faith, inpatient, outpatient, etc.)
- **Outcomes**
  - Improved patient and caregiver quality of life
  - Increased likelihood of dying in place of choice
  - Increased hospice utilization rate, longer length of stay

Telehealth and Telemonitoring

- **Promising Interventions**
  - Telepalliative care via remote patient visits to improve access
  - Telemonitoring (e.g., dementia care monitoring at home)
  - Telehealth patient education and caregiver support
- **Outcomes**
  - Lower health care costs in the last year & 3 months of life (Medicare A & B)
  - Reduced hospital admissions in the last month of life
  - Increased in hospice utilization rate, longer length of stay

Barriers and Facilitators

We also looked for evidence in the literature of things that might prevent interventions from being successful or help them be more successful.

Barriers to Success

- Economic **sustainability**
- Poor data **infrastructure**
- Lack of EHR systems and/or **interoperability**
- Conflict of interest with dominant healthcare **culture**
- Scarcity of healthcare **resources** and trained professionals
- **Referrals** to palliative care
- **Emotional toll** on care team

Facilitators of Success

- Strong internal/external **partnerships** (e.g., payers, faith community)
- Supportive **leadership**
- Strong **support** for care team members
- Robust **EHR**/**HIE** infrastructure (e.g., Health Current)
- Initiative **champions** (e.g., clinician champion, ACT Index Coach)

Interview Results

About the Interviews

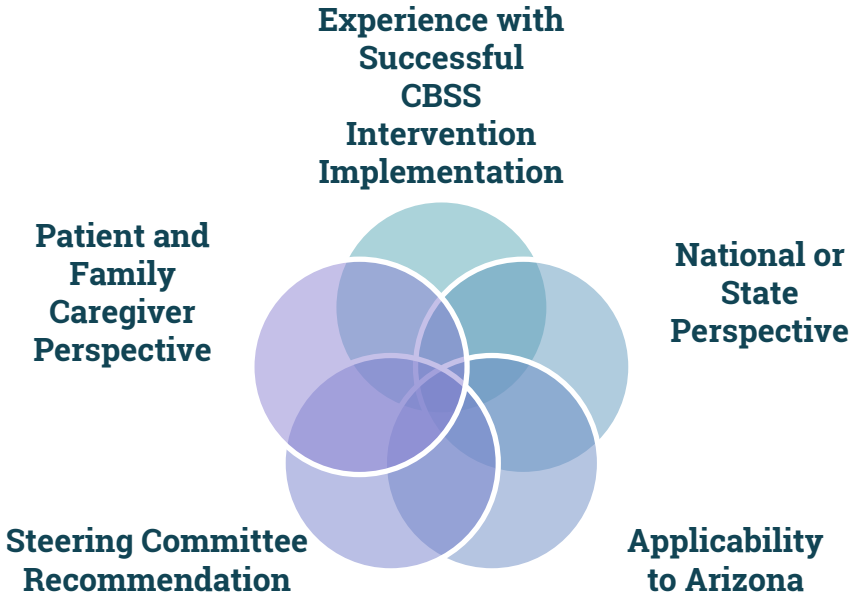
We conducted **five exploratory interviews** during Phase I to:

1) Identify community-based services and supports interventions in Arizona and beyond with **evidence of impacting people with serious illness** and their ability to manage their conditions at home
2) Understand **barriers to and facilitators of successful implementation** of community-based services and supports for the serious ill population, particularly in Arizona

We identified potential interviewees based on **selection considerations** (right) and developed a discussion guide.

Across interviews, we aimed to capture **diverse perspectives**.

Selection Considerations



Completed Interviews

Mindy Fain
(University of AZ)
Community-based primary care

Melissa Elliot
(Region 1 AAA)
Community-based services for older adults

Kim Shea & Chikal Patel
(University of AZ & Optum)
Telemedicine

Rachel Behrendt
(Hospice of the Valley)
Community-based palliative care

Katy Lanz
(TopSight Partners, NHPCO board)
National community-based program design and implementation

Barriers to Success

Interview #1
(Community-based primary care)

- Difficulty messaging to payers and making the value case
- Lack of shared definition of home-based primary care
- Lack of PCP training in palliative care
- Adapting telehealth for people where connectivity is a challenge
- Lack of patient fluency with technology

Interview #2
(Community-based services for older adults)

- Critical gap in care for people in their homes who need more support but cannot afford private care
- COVID-19-related barriers (e.g., social distancing, social isolation)
- Telephonic interactions may not be as effective as in-person or virtual
- Lack of access to smart technology
- Lack of patient fluency with technology

Interview #3
(Telemedicine)

- Adapting telehealth for people where connectivity is a challenge
- Telephonic interactions may not be as effective as in-person or virtual
- Lack of access to technology (e.g., smart phones or iPads)
- Lack of patient fluency with technology

Interview #4
(Community-based palliative care)

- Lack of skilled palliative care providers
- Lack of sustainable payments for palliative care
- Negative attitudes toward palliative care
- Impact of COVID-19 on decreased palliative care utilization

Interview #5
(National community-based program design and implementation)

- Lack of PCP training in palliative care
- Lack of communication and care coordination between primary and palliative care; lack of timely referrals to palliative
- Lack of patient engagement and education around palliative care

Facilitators of Success

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Interview #1
(Community-based primary care)

- Financial viability (venture capitalists are investing into home-based primary care)
- Organization agnostic models (i.e., not driven by a specific health plan or system)
- Address both social and healthcare needs, use translator for telehealth calls
- PCP "quarterbacks" responsibility for patient care

Interview #2
(Community-based services for older adults)

- Contract with health plans by establishing the value proposition (e.g., buy vs. build, demonstrated reductions in readmission rates)
- Use of volunteers willing to help seniors
- Use of "transition coaches" to coordinate care; also wellness checks
- Opportunity for state investment in HCBS

Interview #3
(Telemedicine)

- COVID-19 has increased payer and patient interest in telehealth
- Increased telehealth flexibilities and funding
- Use of volunteers and family members willing to help seniors use video conferencing
- Education for healthcare professionals re. telemedicine and billing/coding

Interview #4
(Community-based palliative care)

- Leveraging CNAs to provide support with activities of daily living
- Growing stakeholder interest in collaborative palliative care models
- Culturally competent care teams

Interview #5
(National community-based program design and implementation)

- Leveraging existing community infrastructure and resources to enhance delivery of community-based services and supports
- Centralized and enhanced coordination and communication
- Training clinical leaders on palliative care
- Adopting value-based models and sharing quality data
- Leveraging telehealth to deliver primary, palliative care

Initial Options Discussed

Recommended Options Prioritization Criteria

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Impact

- Evidence of improving patients' ability to manage conditions at home
- Ability to measure impact on quality outcomes (increase days at home and hospice days, decrease crisis utilization, improve patient/family satisfaction)

Level of Effort

- Feasible to implement and/or scale the intervention in Arizona
- Assess expected level of effort (high, medium, low) to design and implement

Relevance

- Relevant to addressing the population of people with serious illness in Arizona
- Consider health disparities and the impact of COVID-19

Primary and/or Palliative Network & VBP Model

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Study found evidence for impact of primary and palliative care delivered in the home. A collaborative network could leverage existing efforts and reach more people in need.

- **Convene providers, payers, patients, and other stakeholders to design a care model and associated value-based payment model**
  - Build on national consensus standards, prior research, and experience of other organizations
  - Consider elements of palliative and primary, or knit together
  - Align on specific population definition and how to ID patients
  - **Key features:** integrated care model, interdisciplinary team, care coordination, family/caregiver support, training, telehealth, etc.
  - Include relevant quality measures
- **Consider a phased approach: design, pilot implementation, evaluation, revision, scaling**
- **Create the foundation for a collaborative network of provider organizations**
  - Link existing organizations / providers and enable new ones
  - Offer resources for standards, training, data sharing, and evaluation

Community-based Palliative Care Marketing & Education

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Public and professional education is needed to correct misperceptions and promote palliative care

- **Public-facing Palliative Marketing Campaign**
  - Leverage existing research and social media analysis to develop public awareness campaign around palliative care
  - Align with Health Current campaign and others throughout the state
  - Target areas in the state will palliative services available first
  - Create “demand” while we build “supply”
- **On-Demand Training for Professionals about Palliative Options**
  - Leverage existing resources to identify or develop training modules on palliative care for clinicians in other disciplines (e.g., PCPs)
    - Define palliative care and distinguish from hospice
    - Community-based options
    - Identify patients
    - Refer appropriately
    - Have conversations introducing patients and families to palliative care
  - Load module to learning management systems and explore CME options
  - Conduct outreach across the state to promote availability and align with existing university curricula

2 Options in Primary Care & Coordination

These options would require collaboration across the coalition, partners, and potential funders (including health plans).

Create and Distribute Emergency Toolkits

- Develop and distribute emergency toolkits for patients and families
  - Have general and condition-specific toolkits
  - Include COVID-19 information
  - Allow organizations and care teams to customize
- Set up on website for downloadable version and link from partners across the state
- Potential for physical version
  - Includes a refrigerator magnet, masks, etc.
  - Could be mailed, leverage CHWs and/or volunteers, or leverage food delivery programs
- Controlled pilots in select counties to measure results; potential collaboration with organizations like Dispatch Health
- Could be accompanied by a media campaign or align with Health Current outreach campaign

Telephone Outreach Campaign

- Work with coalition members and volunteers to conduct broad phone-based outreach to people managing serious illness conditions in their homes
- ID at-risk individuals for outreach not covered by existing programs
- Develop or use existing warm hand-off/resource directory
- Implement a system to document/ incentivize follow-up and loop closure (build on existing efforts)
- Pilot in select counties and expand across the state, or think about targeting communities with the most need (e.g., rural)

Telehealth Enhancement and Support

This option would facilitate other programs but does not include providing care. Need for funding and lack of infrastructure in some areas may be barriers.

- **State-wide program to supply telehealth devices in home, SNFs, ALs, etc.**
  - Convene stakeholders to design program and determine how patients will be identified
  - CHW or volunteer-delivered technology install and training for patients
    - Collaborate with community organizations for a CHW train the trainer program
    - Promote technology and health literacy
  - Technical support for providers and patients for telehealth delivery
  - Future potential for internet hubs/ hotspot installation in collaboration with local companies

- **On-Demand Telehealth Training for Providers**
  - Identify or develop training modules for key provider types and/or CHWs on:
    - Best practices for engaging with patients via telehealth
    - Setting up and using devices and software
    - Billing and reimbursement
  - Load module to learning management system(s) and offer CMEs
  - Conduct outreach across the state to promote availability and leverage existing efforts
  - Potentially expand training beyond providers and CHWs (e.g., enhanced patient/caregiver education, other stakeholders, etc.)

ACP Enhancement

This option would align with the efforts of Health Current to collaborate on activities outside of the scope of that project.

- **Collaborate with Health Current in support of the collection of advance directives that currently exist in outside systems to merge with the HIE**

- **Develop or identify on-demand ACP training modules for healthcare professionals**
  - **Topics include:** Having quality ACP conversations, types of documents, Interpreting documents at point of care, billing and coding
  - Load module to learning management systems and explore CME options
  - Conduct outreach across the state to promote availability
  - Leverage existing efforts

Spotlight on Emergency Toolkits

Emergency Toolkits Description

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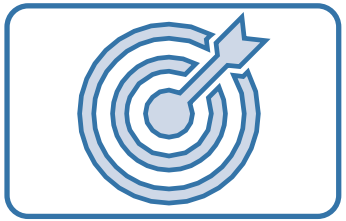
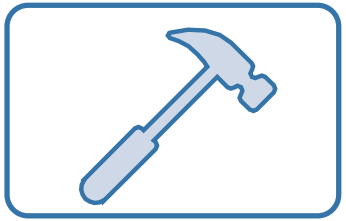


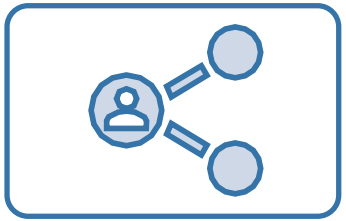
Determine the most appropriate population(s) for tailoring emergency toolkit development and identify the most effective ways to reach patients and families.

Deliverable: consensus on target population(s) and approach for dissemination



Develop emergency toolkits for patients and families with COVID-19 information and other critical information for people managing conditions at home

Deliverable: online and/or physical emergency toolkits



Distribute toolkits virtually, with the potential for a physical version that can be mailed or delivered via Community Health Workers, volunteers, or food delivery programs

Deliverable: virtual and/or physical dissemination of emergency toolkits

Potential Toolkit Components

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Considerations

Online Toolkit

- Virtual platform for dissemination
- Patient/family usability testing
- Social media strategy

Physical Toolkit

- Leveraging Community Health Workers, volunteers, or food delivery organizations to physically deliver toolkits
- COVID-19 PPE
- Technical support for setting up patients/families with telehealth devices

Both Toolkits

- Information available in multiple languages
- Contact information for patients/families to receive additional support
- Educational handouts, tailored to populations of focus – potential for targeting providers
- Organizations and care teams can customize the toolkits for specific populations or patients

Evidence for Impact and Effort

Survey

- Survey respondents identified organizations in Arizona that have current programs that can be leveraged in design and implementation:
  - **Nurses Network, Inc.** provides patients with COVID-19 Screening Tool Questionnaire, PPE, and patient education handouts from CDC
  - **Harbor Lights Hospice** provides PPE to family members so that they can care for their loved ones at home
  - **Legacy Foundation of Southeast AZ** developed a resource guide

Literature Review

- The findings from the literature review, enforced by discussion with CSS Work Group and Steering Committee members, suggest that that **one barrier to managing conditions at home is dealing with emergencies or crisis situations**.

- Articles identified in the literature review found that leveraging **Community Health Workers** trained to engage with patients and families during home visits can help reduce the probability of hospitalization.

Interviews

- **Emergency toolkits** were suggested as one option for reducing crisis care.

- **Need for support:** While there are some programs within Arizona that leverage Community Health Worker and volunteer support to deliver key services to seniors at home, there is a need for additional support to scale and sustain ongoing efforts.

Example Models from Survey, Literature Review, and Interviews

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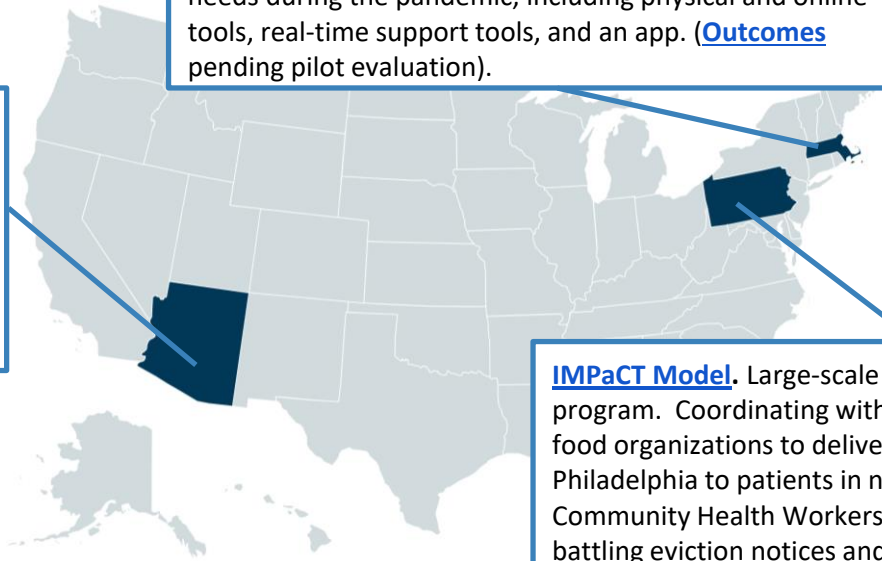
Palliative Care Program at Dana-Farber Cancer Institute and Brigham Women's Hospital (BWH). Developed a toolkit for nonpalliative clinicians caring for patients with palliative care needs during the pandemic, including physical and online tools, real-time support tools, and an app. (**Outcomes** pending pilot evaluation).

Region One Area Agency on Aging. Offers multiple programs delivering essentials to seniors living at home. Good2Home is a service that delivers household supplies and essential items to seniors in Phoenix.



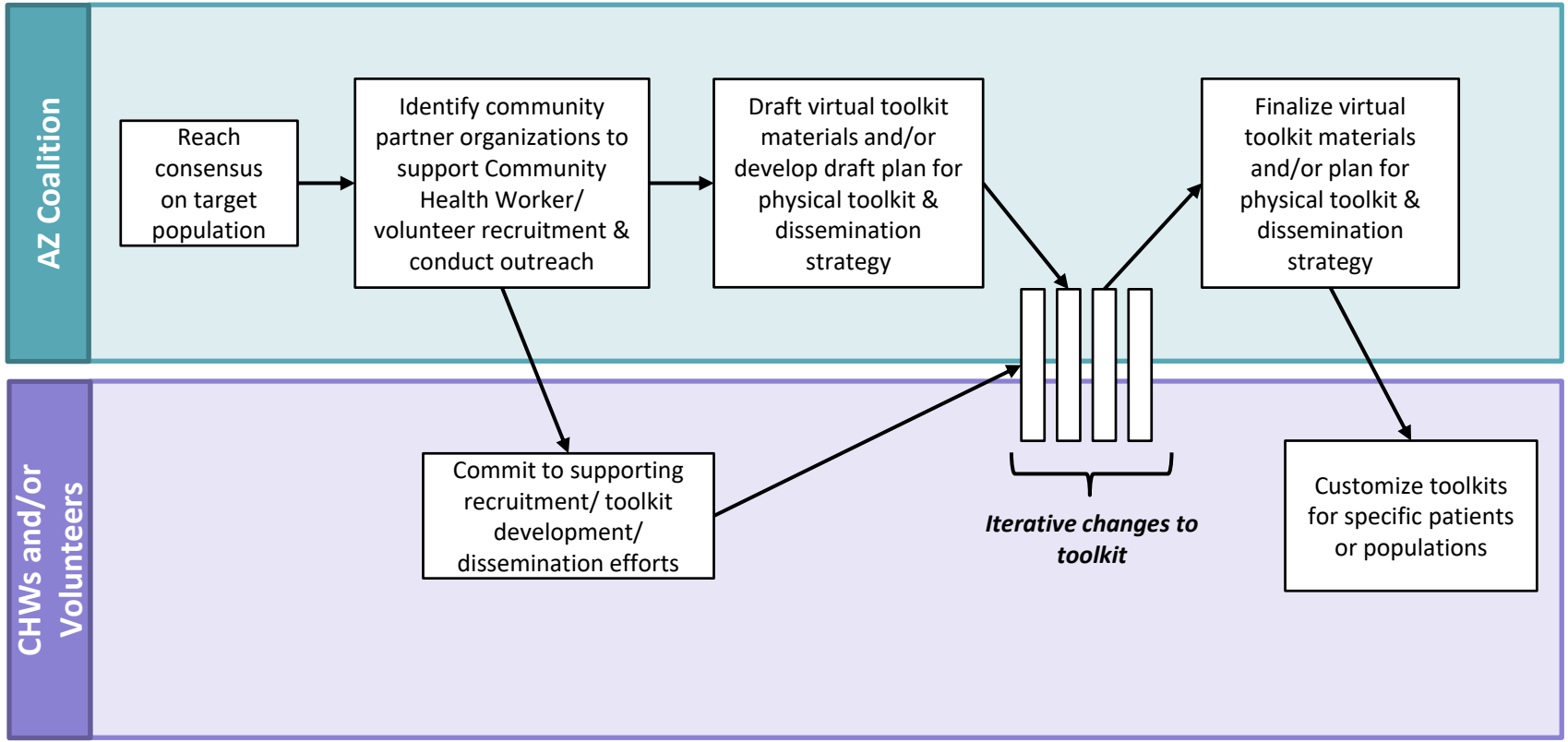
IMPaCT Model. Large-scale Community Health Worker program. Coordinating with the City of Philadelphia and local food organizations to deliver 100,000 meals across Philadelphia to patients in need during COVID-19. Community Health Workers also support patients with battling eviction notices and COVID-19 prevention strategies. **Outcomes:** The IMPaCT Model has reduced likelihood of hospital admissions, increased the quality of hospital discharge communication, and increased access to primary care to help keep people at home.

Implementation Considerations

What is needed to successfully implement this recommendation?

- **Funding** to support toolkit development and dissemination efforts, as well as physical toolkit supplies (if pursuing physical option)
- **Coordination/partnership building** across stakeholder groups and organization to spearhead efforts and hold participants accountable
- **Inclusive** approach to partnership to ensure that toolkits are tailored appropriately and effectively
- **Expertise** on clinical care to inform design
- **Community Health Workers and/or volunteers** to disseminate toolkits in-person and/or support efforts to disseminate toolkit virtually (e.g., via social media platforms)

Potential Design Phase Workflow



Thank You.

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