ARIZONA BEST PRACTICES: INTERVENTIONS ISSUE BRIEFS

Overview

Arizona's healthcare landscape is prime for using community-based services and supports (CBSS) to improve the quality of care and outcomes for people with serious illness. Results from the C-TAC ACT Index show that Arizona does not perform as well on a composite of "community" measures as other states, and Arizonans with serious illness are spending more time in the Intensive Care Unit (ICU) during the last six months of life. During the COVID-19 pandemic, ICU use continues to increase, and community-based organizations must address new challenges in delivering care and supports. However, Arizona is building a strong coalition of serious illness care providers and partners working across multiple initiatives to improve access to community support and goal concordant care for people with serious illness in Arizona. With this backdrop, the **Arizona Coalition to Transform Serious Illness Care,** with leadership from the **Arizona Hospital and Healthcare Association, the Arizona End of Life Care Partnership,** and the **Coalition to Transform Advanced Care** decided to focus on community-based services and supports.

In February 2020, the Arizona Coalition authorized Discern Health to begin a study designed to answer the following 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 they spend at home?**"

Through a review of the literature, a survey sent to the Arizona Coalition Steering Committee and further distributed to their contacts, and exploratory interviews with key informants, Discern surfaced evidence supporting four key interventions and five cross-cutting intervention facilitators that help people with serious illness manage their conditions at home. These interventions and facilitators are the "building blocks" underlying the recommendations for the Steering Committee to consider when deciding which options for improvement the Coalition should pursue for design and implementation. This document synthesizes evidence around impact and expected level of effort for each of these building blocks. The briefs explore promising features needed to serve people with serious illness, but we recognize that many current programs in this category do not have all these features.

Contents

Acknowledgements

CROSSCUTTING FEATURES

Several promising features emerged in many of the interventions reviewed that can support people with serious illness and their family caregivers in Arizona.

Care Coordination	Patient/ Provider Training/ Education	Community Health Workers (CHWs) and Volunteers	Family Caregiver Support	Partnerships and Coalition Building
Description				
Organizing patient care activities and sharing information among all participants of the care team, across care settings, in order to achieve more effective care[1]	Training and educating patients, caregivers, and providers to improve communication, build critical skills, and increase awareness about key issues	Leveraging lay community members who work either for pay or as volunteers in collaboration with local health and community organizations to deliver services to patients*	Providing mental, spiritual, emotional, and physical support to family members caring for patients with serious illness to improve their quality of life and reduce burden	Building state and local coalitions that include government agencies, payers, community organizations, healthcare providers, funders, and faith-based organizations to share best practices, and scale success
Programs with these Features within Arizona and in Other U.S. States				
UPenn Independence at Home Program (Pennsylvania): Home-based primary care program focused on coordinating care among nurse practitioners, physicians, and community agencies to provide supportive care to people with serious illness. **Outcomes:** Decreased use of hospital and emergency department (ED) services and 30-day hospital readmissions, improved follow-up from providers within 48 hours of hospital admission, discharge, or ED visit, and increased patient preference documentation.[2]	**Advanced Illness Management (AIM) at Sutter Health (California):** Home-based palliative coordinated care program that combines features of home health and hospice. Sutter trained all home health nurses as AIM care managers to educate patients and caregivers about their condition and facilitate advance care planning (ACP).[3] **Outcomes:** Produced savings to payers between $8,000 and $9,000 per person annually from reduced hospitalizations and ED use during the final months of life.[4,5]	**Region One, Area Agency on Aging (Arizona)** Community-based volunteer program delivering meals to seniors in the community facing food security threats during the COVID-19 pandemic. (Survey, no outcomes reported.) **Aging Brain Care (ABC) (Indiana):** A year-long, pre-post intervention employing lay CHWs trained to conduct and document ACP conversations with patients during home health visits with pre/post evaluation. **Outcomes**: ACP discussions were associated with a 34% lower probability of hospitalization.[1]	**Multiple Hospice Programs (Arizona, National):** The hospice care model includes wholistic in-home care and interdisciplinary support, including family/caregiver support and counseling and respite. For example, Casa de la Luz offers respite outside of the home and volunteer-led in-home respite. (Survey, no outcomes reported) **Pima Council on Aging (Arizona):** Virtual caregiver support groups; Education for Latino families via telenovelas portraying a family dealing with elder memory loss, questions, and discussion. (Survey, no outcomes reported.)	**Arizona End of Life Care Partnership (Arizona):** The EOLCP, anchored at the United Way of Tucson and Southern Arizona, is a partnership of organizations providing support, services, and education to improve end of life care in AZ. **David and Lura Lovell Foundation (Arizona):** supports work in several areas including end-of-life care and planning. They funded 12 AZEOLCP partners in 2020 and have been the primary funder for the **AZ Coalition to Transform Serious Illness Care**. **Coalition to Transform Advanced Care (National)**: Coalition of 160+ members dedicated to high quality of life for people with serious illness and their families.

Continued…

Care Coordination	Patient/Provider Education/Training	CHWs and Volunteers	Family Caregiver Support	Partnerships and Coalition Building
Impact and Evidence				
A systematic review focused on case management (includes care coordination) in chronic illness found that these programs overall decreased readmissions, length of stay, institutionalizations, ED visits, hospital visits, and costs. However, results were mixed.[10]	A survey of Nurse Practitioners indicated that the top need for improving end-of-life patient-provider communication is training.[6] A case manager education intervention resulted in 92% correct identification of patients meeting serious illness criteria to initiate ACP.[7]	A systematic review of interventions focused on CHWs to improve patient management of chronic conditions found that CHWs are effective implementers, particularly when partnering with underserved communities.[4]	Programs offering support to family caregivers have improved patient and family experience of care and self-reported ability to manage medications and symptoms. Programs featuring elements of family support also reduced hospitalizations and ED visits.[8,9]	The Robert Wood Johnson Foundation notes that stakeholder coalitions can maximize resource use and improve reach and engagement.[11] For instance, **Healthy Connections Prime in South Carolina**, a payer/provider collaborative, implemented a palliative care benefit for dual eligibles that increased palliative care utilization.[12]

***NOTE**: Arizona House Bill 2324 defines Community Health Worker as "a frontline public health worker who is a trusted member of the community, who serves the community or has an in-depth understanding of the community the worker serves, who serves as a liaison between health service providers or social service providers and community members to facilitate access to services and improve the quality and cultural competence of service delivery and who builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[13]

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Overview

Advance care planning (ACP) refers to the process of making health care decisions about the care one would like to receive in the event of a medical crisis. The ACP process can range from a conversation with a provider about life sustaining treatment options, to written protocols for transitions of care, to the formal completion of an advance directive (AD) that legally documents desired treatment.[1] An ACP conversation may include discussion of ADs, POLST, and other ACP documents, but this is not a requirement, and not needed to bill Medicare for ACP. ACP is often included in other programs (like palliative or hospice).

Promising Features and Infrastructure

☑ Communication with family and provider about goals of care and of life wishes
☑ Written protocols for transitions of care
☑ Coordination with PCP, palliative care, hospice, nursing home, emergency medical services, etc. to ensure ACP is delivered, documents accessible, and wishes followed
☑ Community health worker support to conduct conversations
☑ Patient/family engagement, education, and/or coaching
☑ Provider education/training
☑ Coalition building and community outreach/engagement
☑ Culturally tailored materials to support provider discussions
☑ Technology and infrastructure for telehealth consultations, document storage, and retrieval at the point of care
☑ Payer or health system support for long-term sustainability

Sample Programs within Arizona and in Other U.S. States

- **Provider Education and Advance Care Planning RN** **(Arizona)** ACP registered nurse (RN) works with providers at the clinic site to educate and increase Advance Directives and/ or help the patients with their life goals.[2] (Survey; no outcomes reported.)

- **Aging Brain Care (ABC)** **(Indiana)** A year-long, pre-post intervention employing lay community health workers trained to conduct and document ACP conversations with patients during home health visits with pre/post evaluation. **Outcomes**: ACP discussions were associated with a 34% less probability of hospitalization.[3]

- **Make a Plan, Share a Plan** **(Michigan)** Upper Peninsula Health Care Solutions, Inc. has partnered with the Upper Peninsula Health Plan (UPHP) and Honoring Healthcare Choices – Michigan to provide ACP through collaboration with community-based organizations. Providers can access ACP documents from a single web interface. ACP is delivered in-person and via telehealth. (Implementation ongoing; outcomes not yet published).

- **Respecting Choices** **(National)** Respecting Choices is an evidence-based, person-centered ACP model and curriculum. While originating at Gundersen Health System in **Wisconsin**, the model has been scaled, adapted, and spread nationally and internationally and is now a division of C-TAC Innovations. **Outcomes:** A systematic review found increased AD and POLST documentation along with patient-surrogate congruence.[18]

- **Advance Care Specialist Program** **(Indiana)** Trains nursing facility staff to educate other employees and implement procedures to support ACP for residents. The research team worked collaboratively with leaders from three partner companies (Signature HealthCARE, Miller's Health Systems, and Trinity Health System) who own and run nursing facilities to create and refine this program. **Outcomes:** Results from an early pilot showed improved patient/caregiver experience.[5]

- **Video Decision Aids (DAs) to Promote Advance Care Planning** **(Hawaii)** Patients received a single, 1-4-hour training on how to access and use a suite of ACP video DAs. **Outcomes**: After the intervention, ACP documentation among hospitalized patients with late-stage disease increased from 2% to 39.9%. DAs also associated with greater use of hospice and decreased costs.[6]

- **Telehealth-Centered Interventions (National, Michigan, California)** Several organizations such as Vynca, Vital Decisions, MyDirectives, WiserCare, and Priority Health have led telehealth-based ACP initiatives, often contracting with health plans to deliver ACP services.[19,20,21,22,23] **Outcomes**: Though varying across organizations, results included: higher completion of ACP documents, significant reductions in hospital admissions and ICU utilization, and improvements in overall cost savings.[19,20]
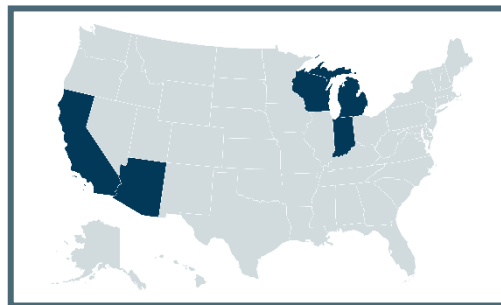
Implementation

Barriers to Success[7]

- **LACK OF DIVERSE WORKFORCE** that understands the cultural norms and expectations of the community with regards to life sustaining treatment.[8]
- **LACK OF CENTRALIZATION,** including inconsistent documentation habits, leads to poor access to ACP documents and undermines goal concordant care.[9]
- **LACK OF ADEQUATE REIMBURSEMENT** to incentivize providers (e.g., PCPs) to engage in ACP.
- **RESISTANCE TO ACP** due to misperceptions, cultural barriers, or discomfort with the topic.
- **LACK OF PROVIDER TIME** to have meaningful conversations and complete forms.[9]
- Conversations often occur **AT TIME OF CRISIS.**

Facilitators to Success[7]

- **STATE AND LOCAL COALITIONS,** including government agencies, multiple types of healthcare providers, community organizations, and insurers collaborating to promote ACP.
- **STATE/FEDERAL POLICIES AND INFRASTRUCTURE** conducive to data sharing and easy access to ACP documents at point of care and during transitions.
- **INTEROPERABLE DATA EXCHANGE** to support consistent documentation and availability.
- **VIRTUAL PLATFORMS** to support ACP via telehealth and promote interoperability.
- Standardized **PROVIDER TRAINING AND TOOLS** to support meaningful, culturally competent conversations.
- **HEALTH PLAN PAYMENT** for ACP services or value-based contracts.

Impact and Evidence

Potential Impact

- Early conversations around end-of-life care, goals of care, and ACP documentation can lower the likelihood of hospitalizations by 15%, decrease hospital deaths by 8.2%, and reduce emergency department visits by 7.1%.[10,11]
- The integration of ACP services into existing primary or palliative care interventions has the potential for long-term sustainability and cost savings of up $4,000 per member per month or expenses up to 45% lower when compared to usual care.[10,12,13]
- ACP integrated into existing care coordination paradigms with either the PCP and/or palliative care teams can improve symptom management and has been associatied with patient satisfaction rates of up to 96%.[14,15]
- ACP can increase the likelihood of dying in place of choice. 47% participants in one program that completed advance directives died in their homes (vs. 30% national ACT Index rate).[12,16]

COVID-19 Relevance

- New **PROCESS BARRIERS** such as difficulty collecting signatures from clients, as a result of social distancing.
- **TELEHEALTH** is likely to become common practice even after the COVID-19 pandemic, which may require training patients on how to use the technology.
- **PROVIDERS ARE STRAINED** due to the challenges of managing COVID-19, so it may be difficult to make time for ACP discussions. Not having specified medical goals in advance increases the burden on frontline providers and families combatting COVID-19 by creating confusion around medical decision-making.[17]
- Palliative and other providers skilled in ACP may have **LESS ACCESS** to nursing homes and other facilities to conduct ACP, but strain on crisis care services (like intensive care and ventilators) may **INCREASE DEMAND**.

Estimated Level of Effort (LOE)

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Low
Med
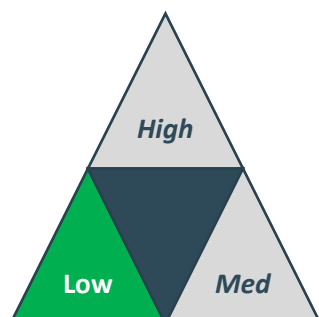
LOE Considerations

- **CENTRALIZATION OF DATA**: Providers and caregivers should seamlessly access patient medical history during any transition of care. Health Current, Arizona's health information exchange (HIE), is working to strengthen Arizona's AD registry.
- **INTEGRATION OF SERVICES**: ACP should be carried out in collaboration with the existing care team.
- **FUNDING AND REIMBURSEMNET**: While ACP is billable through Medicare fee-for-service, reimbursement is limited. ACP interventions may require additional sources of funding via a commercial payer or health system partner and/or value-based contract.
- **TECHNOLOGY**: In the COVID-19 environment, additional training and infrastructure may be needed to conduct ACP virtually.

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COMMUNITY-BASED PALLIATIVE CARE

Overview

Community-based palliative care (CBPC) refers to services delivered outside of a hospital setting that help patients manage pain and symptoms, maximize quality of life, optimize functions, and promote goal concordant care.[1] CBPC may be coordinated with a primary care provider (PCP), but palliative specialists, unlike most PCPs, are trained to provide supportive care to complex cases. CBPC is delivered by team of doctors, nurses, and other specialists who work together to provide an extra layer of support.[2] CBPC can be provided in patient homes, offices, nursing homes, and elsewhere, and can be provided alongside "curative" treatment.

Promising Features and Infrastructure

- ☑ Symptom management, advance care planning (ACP)
- ☑ Non-clinical support
- ☑ Support for care transitions
- ☑ Family/caregiver support; patient/caregiver education/coaching
- ☑ Emergency plans and "toolkits" to prepare patients and families
- ☑ Telehealth and outreach to assess symptoms and other needs between visits; includes telehealth devices and patient/caregiver and provider training for telehealth
- ☑ Palliative care training for providers/referral sources
- ☑ Coordination of palliative care providers, PCPs, and the broader care team (e.g., home health, nursing home, social worker, etc.)
- ☑ After hours call center with emergency support
- ☑ Payer or health system support

Sample Programs within Arizona and in Other U.S. States

- **Arizona Palliative Home Care (AZPHC, Hospice of the Valley)** (**Arizona**) Helps patients at any stage of chronic illness who are struggling with daily living and disease management. 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.[3] The organization currently has nine value-based contracts that include state Medicaid run by Mercy Care. **Outcomes:** Reduced inpatient episodes by 56%, inpatient days by 57%, and ED visits by 49%. Reduced caregiver burden.[4]

- **UnityPoint Health Palliative Care Services** (**Iowa/Illinois/Wisconsin**) Provides inpatient, clinic-based, and home-based palliative care across an integrated health system serving nine regions throughout Iowa, western Illinois, and southern Wisconsin. 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.[5]

- **Meridian Care Journey** (**New Jersey**) 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.[5]

- **Project ECHO (Extension for Community Health Outcomes)** (**New Mexico, now national/international**): Technology-enabled model for healthcare education began in New Mexico and has been deployed in several countries and states, including Arizona. 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.[6]

- **Aspire in Home Care** (**California**) A collaborative palliative care team works together to improve symptom management, patient-family communication, ACP, and care coordination with other medical professionals and support services. This includes 24/7 medical crisis prevention and urgent response. **Outcomes**: Supported patients were less likely to be hospitalized, more likely to have had ACP and complete advance directives, and more likely to use hospice care and for longer when compared to national benchmarks.[7]

- **Coalition for Compassionate Care of California and California Advanced Illness Collaborative** (**California**) 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 evaluation.)
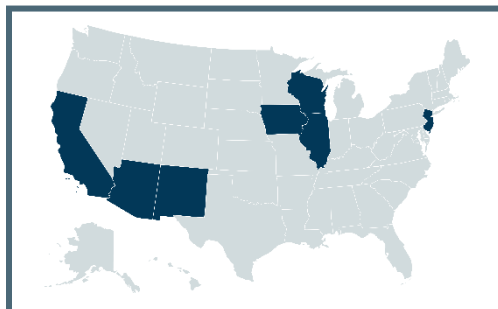
Implementation

Barriers to Success

- **MESSAGING:** Lack of standardized definition and range of delivered services means many patients and providers do not fully comprehend what palliative care entails. Confusion with hospice can lead to patient resistance and limit provider referrals.
- **FUNDING:** Paying for palliative care services can be a net loss for an organization when it is not offset by a robust funding stream. A CBPC intervention may require financial partnerships with health plans.

Facilitators to Success

- **VALUE-BASED CONTRACTS** with payers to fund and incentivize palliative programs
- Potential for a **"HUB"** to standardize processes, train practitioners, support contracting, and centralize data collection and evaluation
- **MEDICARE DEMOS** that create funding for palliative models delivered concurrent with curative treatment
- **MARKETING** to impact public opinion and address misconceptions of palliative care
- **TELEHEALTH** for virtual visits to save staff time, expand reach, and enable interdisciplinary collaboration

Impact and Evidence

Potential Impact

- Patients enrolled in one home-based program experienced a 35% reduction in hospital admissions, a 22% reduction in emergency department visits, and a 46% reduction in ICU days compared to non-participants.[5]
- One CBPC program found that 47% of decedents had died in their homes (a common care goal) during or after program participation.[8]
- Another CBPC intervention showed an 8.2% reduction in hospital deaths and a 7.2% reduction in ICU deaths.[9]
- A Medicare Advantage CBPC program with 212 enrolled patients reported that 98% had goals of care addressed and net cost savings of $24,000 per month/150 patients.[10]
- One CBPC program focusing on Medicare Advantage patients saw significant losses during the first year, but an overall positive 5.1% return on investment over the program's four years (including stop-loss insurance payments).[11]

COVID-19 Relevance

- New **PROCESS BARRIERS** have emerged, such as having to collect signatures from clients, as a result of social distancing.
- **SOCIAL ISOLATION AND FOOD INSECURITY** have spurred virtual care to connect patients with palliative services.
- **TELEHEALTH** is likely to become common practice even after the COVID-19 pandemic, which may require training seniors and other patients on how to use the technology.
- **AZ PROVIDERS**, like HOV, Casa de la Luz, Integrative Touch for Kids, and Banner Health have developed services for COVID-19 patients, optimized teleheatlh services, and developed COVID toolkits.

Estimated Level of Effort (LOE)
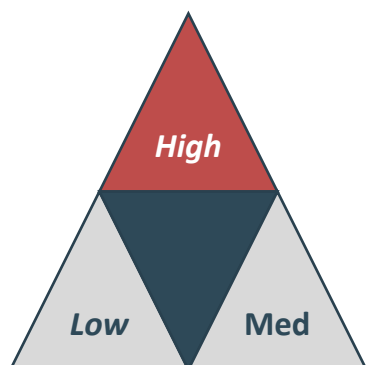
LOE Considerations

- **CENTRAL GOVERNANCE**: May need to build a hub for standardization, centralization of data collection to align and expand the reach of existing programs.
- **WORKFORCE COMPETENCY**: Not all providers have the necessary knowledge and skills to deliver palliative care. Educational programs and materials to properly train staff should be considered. (3-5 years).
- **FUNDING**: A successful model will require a consistent source of revenue to ensure long term sustainability. Either health plans, Medicare, Medicaid, or a combination will need to establish funding streams to make CBPC sustainable.
- **PUBLIC OPINION:** Prevailing perception that palliative care is synonymous to hospice. Both patients and providers need to receive proper training and guidance as to what each mean to promote CBPC referrals, access, and acceptance. Either new terminology or broad scale marketing efforts may help accomplish this.

High

Low *Med*

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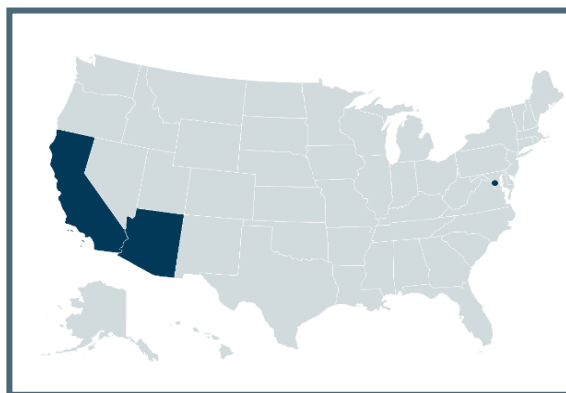
HOME-BASED PRIMARY CARE

Overview

Home-based primary care (HBPC) refers to a team-based approach in which a PCP (primary care provider; a physician, nurse practitioner [NP], or physician's assistant [PA]) coordinates specialty medical and non-medical services and offers primary care in patients' homes. HBPC providers may also deliver urgent care or palliative care but are not always trained specialists. PCPs can collaborate with palliative care physicians and other care and service providers to ensure patient medical and social needs are met for people with serious illness.[1-4]

Promising Features and Infrastructure

- ☑ Collaboration between PCP and palliative care physician where PCP directs care (PCP = care quarterback)
- ☑ Payer or health system support to fund
- ☑ Effective messaging to health plans and other payers
- ☑ Appropriate staff training, including PCP training in palliative care
- ☑ Coordination with broader care team and other needed services (e.g., nurse's aide or home health, social workers, medication management, other community-based services and supports)
- ☑ After hours call center with emergency support
- ☑ Telehealth visits and "wellness check" calls

Sample Programs within Arizona and in Other U.S. States

- **Medstar Washington Hospital Center Medical House Call Program (Washington, DC)** Offers 24-hour on call support for patients where home visits are made by doctors and nurse practitioners for primary and urgent care. Other services include in-home counseling and caregiver support by other staff. **Outcomes**: Over $8,000 in cost savings per patient per year from 9% reduction in hospitalizations and 10% reduction in emergency department (ED) visits.[5]

- **General Internal Medicine and Geriatric Primary Care (Arizona)** Provides acute, subacute and chronic primary care services to patients living at home, primarily through telehealth platforms that promote safety, support social distancing, and reduce unnecessary exposure.[6] (Survey; no outcomes reported.)

- **CareMore** (**National, in Arizona**): Medicare Advantage plan with a complex care management program that includes elements of home-based primary care support, including remote health monitoring and home visits. **Outcomes:** Programs have resulted in 20% fewer hospital admissions, 23% fewer bed days, 4% shorter length-of-stay, and 22% reduction in emergency department visits compared to traditional Medicare fee-for-service beneficiaries.[7,8]

- **Program of All-Inclusive Care for the Elderly (PACE)** (**National**) Comprehensive interdisciplinary care management that integrates primary and specialty care and includes a PACE center, home care, and care delivered at inpatient facilities. An interdisciplinary team of a primary care physician, nurse practitioner, clinic nurse, home health nurse, social worker, therapists, and transportation workers collaborates to deliver primary care in the home setting. The goal is to help the patient maintain health functioning and assist in advance care planning that aligns with individual goals of care. **Outcomes**: Reduced hospitalizations and long-term care placement, decreased expenditures without an increase in patient mortality.[9]

- **Landmark Health** (**National**) Partners with health plans, health systems, and provider groups to deliver in-home primary care to high-risk patients. Team members meet for a half day each week to discuss new patients and events that merit increased vigilance or stepped-up services to prevent or mitigate deterioration in patient condition. Landmark relies on risk-based contracts with health plans and health systems to provide services. **Outcomes**: Reduced medical costs typically incurred by patients with complex health conditions (i.e., 28% decrease in hospitalizations and 39% reduction in emergency room visits).[11,12]

- **Independence at Home** (**Select sites, national**) Center for Medicare and Medicaid Innovation demonstration value-based payment program for delivering home-based primary care to patients with multiple chronic conditions. Team includes physicians or NPs, PAs, pharmacists, social workers, and other staff. **Outcomes (Year 1-5)**: Significant reductions in hospital admissions and ED visits; no significant reductions in Medicare expenditures, but trend toward lower spending and small number of sites tested.[13,14]

Implementation

Barriers to Success

- **MESSAGING**: No universal definition of "home-based primary care" and many payers may not recognize the potential savings associated with this model.
- **EVIDENCE**: More evidence may be needed to sway adopters.
- **FUNDING AND REIMUBRSEMENT LIMITATIONS:** Traditional Medicare fee-for-service does not fully cover needed services. CMMI is exploring potential options in demonstration projects, but scale is limited.

Facilitators of Success

- **VENTURE CAPITALISTS** are investing more into home-based primary care.
- An **AGNOSTIC MODEL** that is not focused within a single organization or system may enable larger scale.
- **COLLABORATION** with other providers to offer comprehensive care and services may better meet patient needs, such as help with activities of daily living
- **TELEHEALTH** for virtual visits can save staff time, expand reach, and enable interdisciplinary collaboration.

Impact and Evidence

Potential Impact

- A primary care intervention in the hospital setting achieved reductions of up to 59% in inpatient care utilization and 37% in total medical expenditures. [8]
- Medicare Advantage plan members participating in HBPC intervention experienced 6% lower 30-day readmissions, 15% reduction in member per capita spending, and a 2.5 day length of stay shorter when compared to the traditional fee-for-service patients.[9]
- An evaluation of HBPC versus usual care demonstrated improved patient and caregiver quality of life for terminal and non-terminal patients for the HBPC group. [9]
- A systematic review of HBPC interventions found that HCBP reduces hospitalizations and hospital days, and may also reduce emergency and specialty visits. Frail or sicker patients are more likely than others to benefit from HBPC.[10]

COVID-19 Relevance

- New process barriers relating to **SOCIAL DISTANCING** have limited the PCP's ability to interact with patients.
- New challenges around **SOCIAL ISOLATION AND FOOD INSECURITY** have spurred new initiatives such as food delivery programs and virtual care.
- Given the new **TELEHEALTH ENVIRONMENT**, a lot of seniors do not have access to technology or do not know how to use it.

Estimated Level of Effort (LOE)

High

Low   **Med**
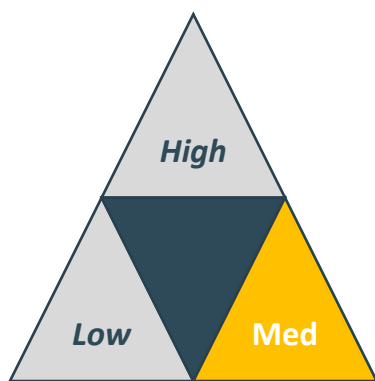
LOE Considerations

- **WORKFORCE COMPETENCY**: Pain and symptom management is a critical need for the serious illness population. PCPs may not have the necessary knowledge and skills to deliver palliative care or to coordinate care with the palliative care team. Consider educational programs and training materials to help connect HBPC with palliative care.
- **FUNDING**: A successful model will require a consistent source of revenue to ensure long term sustainability. Either health plans, Medicare, Medicaid, or a combination will need to pay for the services rendered.
- **INTEGRATION OF TELHEALTH**: Telehealth can enable "wellness calls" in between appointments, cut down on "windshield time", and allow co-visits with a social worker or other staff in person and a PCP on the phone.
- **GAPS IN CARE**: Many patients need help with managing symptoms, activities of daily living, medication reconciliation, housework, etc. Co-visits (PCP and social workers) can help assess for needs but may not be scalable. Care coordination is needed to connect patients with supports beyond primary care.

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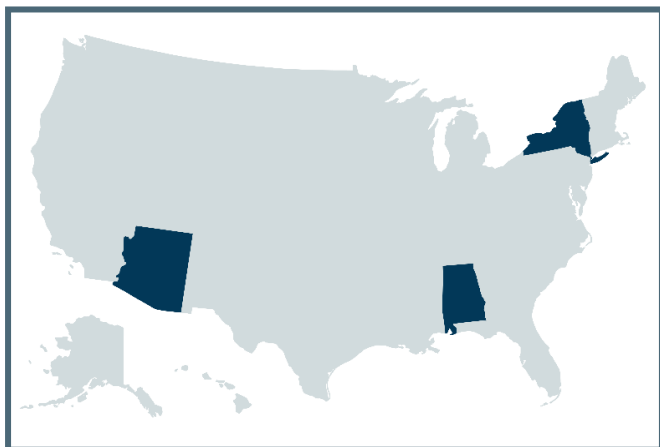
TELEHEALTH

Overview

Telehealth interventions connect people with chronic conditions and serious illness living at home to primary care providers (PCPs), palliative care providers, and other community-based services and supports. Telehealth can be conducted via asynchronous (or store-and-forward) video conferencing, synchronous virtual visits, remote patient monitoring, or telephone. Telehealth has the potential to expand care reach to rural areas but may be hampered by lack of infrastructure. During the COVID-19 pandemic, Medicare has increased the list of reimbursable services that can be furnished via telehealth.[1]

Promising Features and Infrastructure

- ☑ 24/7 access to support (depending on intervention)
- ☑ Patient access to telephone and/or (ideally) smart phone or other device
- ☑ Patient and provider high-speed internet access
- ☑ Availability of family caregiver, volunteer, or staff to coordinate telehealth set-up at patient home
- ☑ Can be a promising feature of other interventions: home-based primary care (HBPC), community-based palliative care (CBPC), advance care planning (ACP), and other community-based services and supports
- ☑ Can facilitate Family/caregiver support, care coordination, and collaboration (e.g., combined virtual visits)
- ☑ Payer or health system support

Sample Programs within Arizona and in Other U.S. States

- **University of Arizona College of Pharmacy, Telehealth Pharmacy Clinic** (**Pima County**): Provides pharmacy care via telephone to older adults with chronic conditions and polypharmacy. (Survey, outcomes not reported)

- **Integrative Touch for Kids, TeleFriend & TeleWellness** (**Maricopa & Pima County, other states**): TeleFriend program pairs an adult and a young person together to be friends with a hospitalized child or a child isolated at home. TeleWellness program pairs healers with children, their family, and providers to offer wellness tools for pain and stress management. (Survey, outcomes not reported)

- **Mountain Park Advance Directives** (**Pima County**): In response to COVID-19, provides telehealth visits with Medical Legal Partnership and Internal Medicine clinicians to assist patients with completing advance directives at home. (Survey, outcomes not reported)

- **ProHEALTH Care Support** (**New York**): Community-based palliative program serving seriously ill individuals through home visits, video-visits, and phone support, provided by teams comprised of nurses, social workers and palliative care physicians. Services are available to individuals in the medical group's ACO population and by contract to commercial payers. **Outcomes:** Location of death was home for 85% of enrolled decedents, compared to 25% for usual care. There was a 48% reduction in health care costs in the final month of life, compared to usual care.[2]

- **University of Alabama, Center for Palliative and Supportive Care** (**Alabama**): Telemedicine program that offers psychoeducational support to patients and family caregivers. Employs lay navigators who provide patients with information about cancer treatments, support in making informed care decisions, and emotional support and assistance. **Outcomes:** A recent analysis of the program showed that compared with non-participants, participants had fewer emergency department visits, hospitalizations, ICU admissions, and lower costs of care.[2]

NOTE: Telehealth is also a prominent part of several interventions described in the HBPC, CBPC, and ACP briefs.

Implementation

Barriers to Success

- **PATIENT ACCESS** to technology with the capacity for virtual visits.
- **PATIENT KNOWLEDGE AND UNDERSTANDING** of how to use technology for communicating with care team, community services, and caregivers.
- **LACK OF INFRASTRUCTURE** to support hi-speed internet and mitigate bandwidth issues.
- **INABILITY TO CONNECT VISUALLY** (i.e., via video), preventing care team from visually understanding a patient's situation/needs/experience.

Facilitators to Success

- Family caregiver, volunteer, or lay health worker **ABILITY TO TRAIN PATIENTS** on technology use.
- Organizations providing **DEVICES AND TECHNICAL SUPPORT.**
- **EXPANDED TELEHEALTH FLEXIBILITIES AND REIMBURSEMENT** via Medicare and other commercial payers during the COVID-19 pandemic (and in subsequent years).
- **INCREASED PAYER INTEREST** in telehealth given spike in utilization during COVID-19.[3]

Impact and Evidence

Potential Impact

- One community telepalliative intervention with access to 24/7 coverage demonstrated significantly lower health care costs in the last year and last three months of life for Medicare Part A and B beneficiaries, 34% reduction in hospital admissions in the last month of life, 35% increase in hospice utilization, and longer length of hospice stay.[4]
- Participants in a telephone-based care management intervention of over 900 patients and 300 family caregivers experienced a 29% decrease in home health episodes, 26% fewer skilled nursing facility days, and 13% fewer hospital admissions.[5]
- A medical house call intervention offering 24/7 phone support, coordinated care, in-home counseling and caregiver support, and respite care saw savings of over $8,000 per patient per year as a result of a 9% reduction in hospitalizations and a 10% reduction in emergency department vistis.[6]
- Recent studies suggest that patients and families are highly satisfied with virtual care.[3,7,8]
- A community-based telehealth intervention to identify hospice patient and caregiver needs found that participants had lower utilization of clinical services compared with non-participants.[8]

COVID-19 Relevance

- With people **SOCIALLY DISTANCING** during COVID-19, particularly those people with chronic conditions who may be more susceptible to the virus, telehealth has provided a way for isolated people to connect with providers and community-based services and supports.[9]
- Telehealth **FLEXIBILITIES AND PAYMENT** for services have been expanded as a result.
- The number of Medicare fee-for-service beneficiaries receiving telemedicine increased from ~13,000/week pre-COVID-19 to ~1.7 million/week in April.[3]

Estimated Level of Effort (LOE)

High

Low

Med
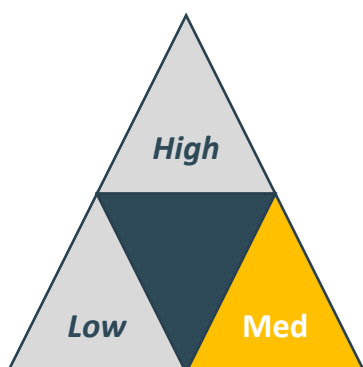
LOE Considerations

- **CONNECTIVITY**: Not all areas have a strong network, but in places that do, LOE would be minimal. Potential barrier for rural and tribal communities.
- **SCALABILITY**: Existing telehealth interventions within Arizona could be scaled to expand reach.
- **STAFFING:** Staff and/or volunteer support would be needed to train patients on technology and train community-based services and supports providers, if not already trained, on telehealth practices. Nursing and medical schools can incorporate telehealth into their curricula, and organizations can offer training on evolving billing/coding standards.
- **PAYER SUPPORT**: Successful interventions have had support from a payer or health system

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