CASE STUDY | May 15, 2019

Serious Illness Approaches by ACOs: Facey Medical Group

Robert Saunders, William Bleser

Summary

Background

Facey Medical Group, a large multispecialty practice in Southern California, identified a group of patients whose needs could not be met by traditional clinic visits. In short, there were patients with advanced chronic illness or serious diagnoses whose conditions were not well controlled, leading to significant hospitalizations and emergency department (ED) visits, but these patients did not yet need comprehensive hospice services. To improve these patients' function and experience, Facey launched a community-based palliative care program that provided home visits, after-hours access, education, regular telephonic check-ins, social work, and chaplaincy support. The program has started to show reductions in unnecessary hospitalizations and ED visits while improving patient satisfaction. This was implemented in the context of a number of shared- and full-risk contracts with commercial payers, including a commercial ACO contract focusing on community-based palliative care, which provided financial flexibility for a high-touch care approach and services not traditionally supported by fee-for-service payment.

Approach

Facey identifies potential patients to enroll using an in-house algorithm focused on specific diagnoses and utilization; this initial list is then reviewed by primary care physicians, who flag those patients with greatest need and can recommend high-need patients who were not included in the initial list. After a patient agrees to participate in the service, the palliative care team begins intensive services for the first three months to stabilize the person's conditions, educate them on their likely trajectory, and provide access and advice for exacerbations and crises. The palliative care team providing these services includes a palliative care-trained physician, nurse practitioner, nurse care managers, licensed clinical social workers, and chaplain, all organized by a clinical supervisor. After the patient is stabilized, comfortable, and safe, the program reduces the intensity of services and clinician check-ins based on patient need.

Key Learnings

Palliative care partnerships work. ACOs do not have to provide palliative care and other serious illness services in-house, but can deliver via partners.

Successful partnerships require close communication and coordination. Partner palliative care organizations need the ability to communicate at multiple levels—between clinicians, through charting in the electronic health record, and at operational leadership levels—which can help build trust and change culture in order to have greater service use.

Identifying seriously ill patients is challenging in claims and clinical data. Without data on people's function and caregiver situation, it is difficult to understand whether they need additional supports.

Internal champions can smooth adoption and early implementation. The palliative care program benefited from a senior leadership champion, who noted palliative care was the right thing to do; this helped the program launch and ensured the program continued as it was refining in its early years.

Technical details of evaluation (control groups, success measures) are difficult. Calculating the financial business case was challenged by identifying an appropriate control group, comparable to the community-based palliative care population, to assess key cost, utilization, and quality measures. Moreover, the ACO may want to capture "non-economic" benefits in terms of provider efficiency, provider satisfaction, and patient satisfaction.

Results to Date

Patients in the program have expressed satisfaction with quality, experience, and symptom management. Quality results include that all patients have discussed goals for emergency medical situations, a 70% reduction in hospital admissions, and a 55% decrease in ED visits in 2017. The program also reports additional benefits through provider satisfaction and efficiency, since the community-based palliative care team helps them more effectively manage an extremely complex patient population.

Tools & Vendor Partners

Facey implemented its community-based palliative care program through a partner organization, TrinityCare, which is a palliative care and hospice group. Both Facey and TrinityCare are affiliate organizations of Providence St. Joseph Health system. The Facey physicians still are the attending physician for the patients, and palliative care provides consultative and supportive services in addition to clinical treatments.

Challenges with Implementation

Given palliative care was implemented by a partner organization, a key challenge was communications and relationship building, especially in the early years of the relationship. A critical factor was the ability for the palliative care team to chart in the electronic health record, in order to show the services provided and communicate with the patient's other clinicians. Another implementation issue was coordinating palliative care with existing care management services to avoid duplication, which may confuse the patient and caregivers.

A major challenge, which happens for many other organizations, is the difficulty identifying seriously ill patients using existing data sources. In short, existing data sources do not easily show a person's daily function, their caregiver support, and their overall health needs. Given limited data, programs should involve clinicians in the final selection of patients, and will often have lower take-up rates due to flagging people who do not need palliative care services.

Facey Medical Group Details
Facey Medical Group operates a physician-group led Accountable Care Organization (ACO) with multiple commercial accountable contracts (shared- and full-risk). They have launched a community-based palliative care program with a partner organization (TrinityCare) to support their seriously ill patients.

Location: Headquartered in Mission Hills, CA; treats patients in the Los Angeles metro area

Website: **www.facey.com**

Detailed Case Study: Facey Medical Group

Overview

Facey Medical Group is a large multispecialty physician group practice in southern California. Through a partner organization, TrinityCare, they offer community-based palliative care for their seriously ill patient population, which helps patients with advanced chronic diseases to remain in their home and community. The ultimate goal is to develop trustworthy relationships with patients and their family caregivers, and to establish stability, comfortability, and safety for people living with serious illness to remain living in their home. Their palliative care team provides a high-touch approach to identify the patient's goals of care and unaddressed symptom, social, or spiritual needs; educate the patient and caregivers on condition trajectory and how to manage different situations; and provide 24/7 phone access when there are exacerbations or crises. Importantly, the model includes social work to link patients and caregivers to community and social services, such as transportation, senior centers, nutrition, legal support, or financial assistance. The program has shown improvements in patient satisfaction and experience, as well as reductions in unnecessary hospitalizations and emergency department (ED) visits.

Facey has multiple accountable care contracts, shared- and full-risk, with a variety of commercial insurers. One of their accountable care organization (ACO) contracts with BlueShield of California focuses on community-based palliative care. Overall, about 75% of their patient population is covered through such a contract, with most of those patients participating in Medicare Advantage. This level of risk both allows greater flexibility and motivation for Facey to develop new initiatives, such as implementing community-based palliative care, social work, or complex care management.

Facey chose to implement community-based palliative care through a partner organization as opposed to building infrastructure and hiring staff in-house. The advantages of this approach were that it allowed them to quickly start up and leverage existing expertise. Developing a functional partnership has required substantial ongoing communications on the program operations, the ability for the palliative care team to chart through the Facey electronic health record (EHR), and developing relationships with the Facey primary care physicians and care management teams.

Key Components of Care Model

Facey provides community-based palliative care through a partnership with TrinityCare, a home health, palliative care, and hospice group that is also an affiliate of the Providence St. Joseph Health system. At the time of interview, Facey and TrinityCare were in their third year of partnership. TrinityCare palliative care program provides services to Facey patients who have advanced illnesses, typically with significant utilization, who live in Los Angeles County and Orange County, and who are part of their ACO contracts (including shared- and full-risk)

Palliative Care Approach
The program is focused on delivering most care in the home, whether through in-person home visits or telephonic communications, and only rarely involving office visits. The program leaders view community-based palliative care as a blend of specialty palliative care, which focuses on symptom management, quality of life, and meeting goals of care, as well as home-based primary care, which provides medical care through home visits. The intensity of services varies depending on the patient's needs, as described below, with more services offered in the beginning, tapering off as the patient becomes more stable and comfortable.

The care team includes a specialty-trained palliative care physician, a nurse practitioner, 2 nurse care managers, 2 clinical social workers, a clinical supervisor, and a chaplain. This team provides all community-based palliative care and communicates with the primary care physicians, who continue to be the attending physicians for the patient's medical care. In this way, the palliative care service is more of a consultative role and in close partnership with the primary care physicians.

The care team huddles every morning about which patients are being seen that day (about 4 patients per day or fewer if they have new patients) and any changes in care plans, medical events, medications, or patient needs. They present on the cases from yesterday, what is going on, provide orders on what to do with each patient, and follow-up (e.g., social work or nursing follow-up to ensure the patient understood the treatment).

Short Overview of Facey Medical Group

Organizational Description

Facey Medical Group is a large multispecialty group with 700 physicians and 800,000 patients, and is an affiliate of the Providence St. Joseph Health (PSJH) system. One of Facey's ACO contracts focuses on community-based palliative care, but more broadly, approximately 75% of their patient population is in an accountable risk-bearing contract with a commercial payer, whether an ACO or full-risk managed care contract.

People in the Model

Serve people with serious medical conditions and significant hospitalization and ED usage through community-based palliative care services. The goal is to ensure patient goals of care have been recorded, patient symptom and social needs have been met, and patients are stabilized, comfortable, and safe.

Key Programs and Care Innovations

Facey has partnered with TrinityCare, another PSJH affiliate, to provide community-based palliative care to their seriously ill patient population. The services include 24-hour access to clinicians, social work and chaplaincy support, patient and caregiver education, and regular palliative care physician and nurse visits and calls.

Local Market and Context

Facey services Los Angeles County and Orange County in California, which are urban areas. As part of a larger health system, Facey has resource flexibility that smaller health care organizations may not have.

Evolution and Buy-In

Community-based palliative care was championed by the Facey Medical Foundation CEO, who emphasized that palliative care was the right thing to do. The TrinityCare and Facey team had deliberate communications in the early years to examine data, discuss operations, and identify communications for the full provider group. TrinityCare had recently received a grant to develop team-based palliative and hospice medicine competencies, the timing of which helped them be in the position to take on the community-based palliative care contract. Buy-in has been significantly improved by the ability of the palliative care team to document in Facey's EHR and communicate with a patient's clinicians that way.

Financing & Infrastructure

Facey supports the partnership by directly funding the staffing of the community-based palliative care team. The key infrastructure includes the data analysis to identify potential seriously ill patients. Furthermore, Facey had existing complex case management programs and additional social work support, which are now coordinated with the palliative care team.

Implementation Challenges

A major challenge is identifying seriously ill patients through existing claims and clinical data. The patient population has turned out to have lower mortality than expected, which has increased the length of time patients spend in the palliative care service and increased the overall census of patients served. Evaluating the impact of the program continues to be difficult in finding a comparable control group; identifying key cost, quality, and utilization measures; and capturing non-economic benefits like provider satisfaction.

Results and Key Outcomes

High patient satisfaction with quality, experience, and symptom management; all patients have discussed goals for emergency medical situations; 70% reduction in hospital admissions and 55% decrease in ED visits among patients in 2017.

Social workers help to connect patients with community services such as Los Angeles County Access Services (transportation), local senior centers, Meals on Wheels, elder law attorneys (if they need help creating wills or advanced directives), and charity organizations. Social work is critical to connect people and their families with community services, given the social drivers of health. More than 60% of community-based palliative care patients were outreached by social workers, and approximately half were getting in-person visits.

To ensure access, especially after traditional clinic hours, patients and caregivers have access to a 24-hour call center, and the call center routes calls straight to the palliative care physician if they require clinical intervention. The patients in the program also have access to virtual care services by referral.

The palliative care team spends considerable effort providing education, such as educating patients about their condition, what it means, what symptoms to look for, and what to do when symptoms occur. They also try to involve family members and caregivers as much as possible, which helps inform goals of care discussions and encourages patients and caregivers to feel confident in managing their condition, especially during exacerbations.

An example of an area where they have recently made progress is improving outcomes for urinary tract infections (UTIs). When undetected, UTIs can often progress to ED visits and hospitalizations. The palliative care team has focused on education and information about UTIs, especially to caregivers of patients with dementia. The team has also put standing orders for lab testing of urine samples in the EHR, so that patients can easily get tested if they show initial symptoms. The team has also set up a process where caregivers can bring the specimens to Facey, even without the patient, and then the palliative care physician can call in the prescription for the antibiotics if the test comes back positive.

Patient Identification

Facey identifies candidates for community-based palliative care using a two-step process. First, patients are flagged via an in-house algorithm that identifies people using a point system based on specific serious diagnoses and recent hospitalizations or ED visits. The algorithm relies on health care claims data, which Facey has through its shared- and full-risk contracts, along with EHR information. The list of diagnoses has evolved over time as Facey sees which patients had the best uptake for palliative care. For example, initially any patients with diabetes were flagged but now the algorithm looks for diabetes with complications, such as pressure ulcers.

After the initial list has been generated, it is sent to the patients' primary care physicians, who then review the list based on the "surprise question" (asking physicians whether they would be surprised if this patient passes away in the short term), if the patient has functional needs that require palliative care, or if the patient would accept this type of support. Clinicians can also recommend patients who were not flagged by the algorithm, but would be good candidates for the program given their function and needs. While useful, this step introduces the logistical challenge of getting busy providers to review the lists, and the Facey CEO has directly emailed reminders to providers to complete their review promptly.

The community-based palliative care team then contacts the patient to assess interest and needs. About half of the patients referred to the program end up enrolling, which is an improvement from earlier years. Some of the non-enrolling patients may not feel they are seriously ill, and some are surprised by the offer, since they are working or generally having normal function. They may have had an earlier hospitalization, but have since recovered, and believe their condition is well-managed. Other patients do not respond to multiple outreach attempts, perhaps because they do not feel seriously ill; others have already progressed to hospice care; and still others are seriously ill, but do not want palliative care services (perhaps due to caregiver support, cultural beliefs, or other reasons).

Despite considerable effort, it remains challenging to identify patients living with serious illness. The identification process has been improved through changes to the algorithm and by incorporating provider referrals (which are now 25% of the potential patient list and 50% of admissions to the program). Further improvements have come from encouraging primary care physicians to have a conversation with the patient prior to referring them to the service. With those warm handoffs, they have a much higher acceptance rate. After these changes, the current daily census is approximately 200 patients in the community-based palliative care program. The majority of patients in the program have advanced forms of congestive heart failure, chronic obstructive pulmonary disease, or diabetes (in addition to other comorbid conditions). The patients have functional limitations, but do not need extensive home health services or comprehensive hospice services.

This is a different patient profile than inpatient palliative care. TrinityCare's inpatient palliative care program is mostly comprised of patients with cancer malignancies; nearly 90% of the inpatient palliative care patient population has died within one year. TrinityCare assumed that they would see a similar patient population for their community-based palliative care. Instead, they saw more chronic progressive disease management for the community-based palliative care patient population, with much lower annual mortality (possibly around 4%) and approximately 15% referred to hospice each year (those patients referred to hospice tend to have longer hospice stays than people not in the program, which TrinityCare views as positive, given short hospice lengths of stay in California). More than half of TrinityCare's patients had been with them for 12+ months, and nearly one-fifth for 18+ months.

Stages of Palliative Care: Building and Maintaining the Relationship

The care model involves three stages. In the first stage ("Level 1" or "Assessment"), the palliative care physician visits the patient soon after enrollment and does a deep dive into their life, home, conditions, medications, and other factors. At this visit, the physician discusses the patient's goals for their care and life; these plans are recorded on Physicians Order for Life Sustaining Treatment (POLST) forms and advanced directives. In this first stage, there is a clinician encounter every week, with the physician visiting once a month, a nurse practitioner visiting two weeks after that, and a social worker and nurse contacting on the other weeks (in addition to follow-up contact as needed). The reason for such intensive services at the beginning is that the palliative care team has found that the first 90 days are critical for stabilizing the patient, and their hospital and ED utilization drop dramatically during that time frame.

> **The interviewed team emphasized that building a relationship with the patient is key, as that trust and communication helps prevent unwanted and unnecessary hospitalizations and ED visits.**

The relationship is critical because TrinityCare does not have an easy technological way to identify who is being hospitalized or in the ED through existing data sources. While they review for admissions every day, they rely on families and caregivers to call in order to know when a patient has visited the ED. By building a relationship with the patient and family, the patient and family often call the palliative care service first, who then advises them on the best course of action. As a result, most patient visits to the hospital or ED are based on the palliative care physician's recommendation.

At 3 months, there is a re-assessment of the patient, as well as family needs and goals. If the patient remains stable after 3 months, is showing improved communication and engagement with the care team, and is demonstrating appropriate healthcare utilization, then the patient moves to the second stage ("Level 2" or "Engagement"), where there will be a home visit at least once every 2 months by the provider, with nurse calls continuing biweekly and social worker contact continuing as needed.

If the patient remains stable and communicative after another 3 months (i.e., 6 months total in the program), then they move to the third stage ("Level 3" or "Sustain"), where they are visited by a provider every three months (with continued

regular nurse calls and social work involvement as needed). The 6-month marker is also driven by data, in that utilization continues to decline over the first 6 months.

If the patient has an acute condition, TrinityCare resets the level of service to provide more intensive care. In short, patients can move up and down levels, depending on their illness and need.

Implementing Care Models Inside an ACO

Facey is implementing the community-based palliative care program within contract arrangements with commercial payers, whether shared-risk ACO contracts or full-risk contracts. Approximately 75% of their patients are in an accountable contract where Facey bears the risk (either full or shared). Most of Facey's palliative care patients are in Medicare Advantage. In terms of technical specifications of their commercial contracts, typically the arrangement has benchmarks negotiated between the health plan, hospital, and clinical group, with risk set separately by line of business (e.g., hospital, pharmacy, professional). In these commercial contracts, Facey knows who all of their accountable care patients are, and the patients know they signed up for an accountable care product. The contracts also include provisions that mean Facey is not at risk if a small number of patients have very high expenditures in a given year, since the assumption is that insurance should bear the risk for unexpected or rare situations. These stop-loss provisions are based on a patient's actual cost compared to their historical cost, and Facey has a different level of upside or downside risk for patients with expenditures exceeding $100,000–150,000 per year.

In terms of results for their accountable care contracts, Facey has seen generally positive savings in terms of cost savings and quality. As a physician group, they have had less control over ED utilization, which is one area where community-based palliative care can be helpful.

Given the similarities between its accountable care models, similar palliative care approaches can be used. However, there are some technical details (such as quality measure reporting, risk arrangements, and attribution) that must be considered as palliative care programs are implemented under different arrangements (e.g., a preferred provider organization ACO contract versus a health maintenance organization ACO). Since Facey has a commercial ACO contract, the shared savings calculations are different than Medicare models and are changing over time. The organization notes that it can be hard to calculate their savings and difficult to assess how palliative care impacts these savings.

Tracking Success

Success was tracked in several ways. Patient experience was assessed through patient and family satisfaction surveys. Given the difficulties with measuring total cost of care, the organization has focused largely on utilization surrogates using claims data provided from their shared- and full-risk contracts. The main measures tracked include acute care utilization (hospitalizations, readmissions, bed days, length of stay), ED visits, urgent care visits, primary care visits, patients documenting their goals (POLST forms and advanced directives), and transitions to hospice.

> **Key results: 100% of enrolled patients discuss their goals through POLST forms and advanced directives. The team has also found high patient satisfaction with quality of care, symptom management, and patient experience with palliative care. For utilization, they saw a 70% reduction in hospital admissions and 55% decrease in ED visits among patients in 2017.**

Organizational Factors Necessary for Success

Implementing community-based palliative care within an accountable care framework requires numerous organizational competencies. Some specific organizational competencies for this program are shown below, which displays some of the specific actions and capabilities Facey and TrinityCare have built.

Establishing the Partnership

When Facey examined their seriously ill, high-need patient population, they identified what they could and could not deliver within their primary care infrastructure, and concluded that they needed palliative care. To develop the partnership, Facey and TrinityCare negotiated for 8 months around how to provide community-based palliative care services for Facey's patients, which included high-level leaders on both sides. Even though they are part of the same overarching corporation, this partnership still required building a relationship. They built in intentional communication, starting with a joint operating committee that met monthly at the beginning (and moved to quarterly as the program matured). The joint operating committee looked at data, talked through operations, and discussed communication opportunities for broader providers.

The regular meetings were critical early on because it allowed the palliative care partners to change their practice patterns in close to real time if they were not getting the outcomes they hoped for.

The Facey Medical Foundation President, Dr. Russo, was a key champion for palliative care across the organization. He believed palliative care was the right thing to do, with benefits that could be shown in patient quality of life and improved economic benefits. His leadership helped with cultural buy-in by physicians, care management teams, and others. For example, Dr. Russo presented to the Department of Medicine physicians about palliative care, including how it would be used at Facey, what patients would be involved, and how patients would be enrolled. He introduced the palliative care team to the clinicians to build trust, as well as to allow physicians to recognize the palliative care team. Dr. Russo returned to the clinical meeting yearly to update them on the palliative care services, show results, and discuss enrollment. Furthermore, he followed up with physicians who did not review the list of potential palliative care patients to encourage them to flag patients who would be good candidates for community-based palliative care. Having a key organizational leader as a champion for care delivery reform organizational change is a strategy echoed in the peer-reviewed literature, and was a key strategy for Facey.[1]

TrinityCare expressed that the timing of the partnership request from Facey was important. Less than a year prior to negotiations, TrinityCare received a grant from a local foundation, the UniHealth Foundation, to develop team-based palliative and hospice medicine competencies.[2] This grant provided key upfront capital for TrinityCare to invest in core competencies, and enabled them to be in the position to take on the community-based palliative care contract with Facey.

> **"Less than a year prior, our organization… received significant grant funding from a local philanthropic organization [for] launching community-based palliative care… so when [the ACO] approached us, we were… already about eight months into programming. And we were able to say, 'Yes.'"**

Another strategy used to build the relationship between the palliative care team and Facey was through annual provider satisfaction surveys sent to Facey primary care physicians or referring physicians.

These surveys were a vehicle to hear feedback from Facey primary care physicians and other physicians who referred to the palliative care service, including their experiences collaborating with the palliative care team. The people interviewed for this case study noted that palliative care should have the potential to improve primary care physician satisfaction. Primary care physicians may not be able to stabilize their seriously ill patients through traditional primary care, and a palliative care program can deliver services that those physicians want provided, but cannot offer themselves.

Facey's relationship with TrinityCare has been critical for the success of the program, as it has provided coordination and trust. In other situations, such as when the palliative care group partners directly with a payer, it can be difficult to implement since clinicians do not know the palliative care team and may not understand what services they are providing for their patients.

Strong Communications between Palliative Care and Clinicians

Implementing community-based palliative care with a partner organization requires seamless communication between all providers caring for a given patient. This can be challenging in a partnership model, since the two organizations may not work under the same EHR or data system. For the Facey/TrinityCare partnership, the TrinityCare palliative care team documents in the same EHR system (Epic) as Facey, so Facey primary care clinicians can see exactly what the palliative care team is doing, what the palliative care team's assessment is of a patient, and communicate with the palliative care team as needed. The charting also allows the community-based palliative care team to see appointments with the medical group, so that the first palliative care appointment does not take place the same week as the patient has multiple other appointments with Facey physicians.

Specific Organizational Competencies and Example Actions Used to Implement Serious Illness Care Model

Specific Competency[*]	Example Actions
Care Delivery	
Develop patient risk assessment strategy	Identified seriously ill patients with specific conditions and utilization in their claims and clinical data. Refined list by physician review and by allowing direct physician referrals to palliative care.
Offer access to palliative and hospice care services	Partnered with TrinityCare to provide community-based palliative care to their seriously ill population.
Governance	
Engage provider network	Internal champion presented palliative care overview, shared palliative care results, and introduced palliative care team to primary care physicians.
Finance	
Build systems to track performance	Regularly track changes in utilization, patient satisfaction, and primary care physician satisfaction of palliative care team.
Create structure for financial collaboration	Facey directly supports salaries of community-based palliative care team at TrinityCare.
Health IT	
Enable data sharing and access by care team	Palliative care team was able to chart in Facey EHR, and EHR also allowed for communications between palliative care team and primary care physicians.

[*] Competencies drawn from the *Accountable Care Atlas* published by the Accountable Care Learning Collaborative.

Aligning with Existing Services

Facey also considered how to align community-based palliative care with their other programs aimed at transitions and high-risk patients, since Facey has mature utilization management and case management functions. For example, Facey offers a complex case management program that engages patients with multiple ED and urgent care visits who have overall high utilization. Facey also has clinical pharmacists for managing patients with complex pharmaceutical needs, such as people taking biologics or oncologic drugs, as well as social workers.

Over the past few years, the community-based palliative care group has created stronger relationships with complex care management. Depending on a patient's needs, TrinityCare engages those services for a community-based palliative care patient, and they may also seek support from durable medical equipment, pharmacy, or other specialties. In other cases, the palliative care team and Facey's complex care management staff inform each other of patients they are working with for coordination purposes. Such coordination is facilitated by the fact that the community-based palliative care team charts in the same EHR as the medical group. There are limits to coordination, since complex care management can be required by (and specified in) plan contracts, so there may not always be flexibility in coordinating services.

The palliative care team does not manage all conditions or offer all services. For example, the palliative care team does not perform pain management, which is done through a Facey clinic. This was a deliberate decision to ensure opioids and other pain medicines are prescribed in a formal way. In addition, lab testing is difficult since the palliative care physician does not have the ability to draw blood and transport blood to the lab. Labs can be done by the home health service, but require coordination.

> Before working with TrinityCare, Facey worked with a different external palliative care partner. Even though the earlier partner employed many of the same team members, that collaboration was unsuccessful. Interviewees felt that this was largely because the previous partner worked in a different EHR system, which meant Facey providers could not see what care was occurring or easily communicate.

Implementation Challenges and Implications for Spread

One challenge has been measuring the impact of the community-based palliative care program. The overall trends for their palliative care patients are promising, with reduced hospitalizations, readmissions, ED, and urgent care visits (yet there is nuance in that the average length of stay has slightly increased, but coupled with total reductions in hospital admissions, this could be a sign of appropriate hospitalizations of severe cases). Although the palliative care programs now are showing greater declines in utilization than the control group, in early years the trends were very similar to the control group. This is partly due to the difficulty in identifying a "control group," particularly one with similar medical and functional needs. For this evaluation, the control group was drawn from patients flagged by the data-driven algorithm, but not enrolled in the palliative care program. Given the challenges in algorithms (as discussed earlier) and that many patients decline to participate because they do not feel seriously ill or have caregiver support, the control group may have different functional and care needs than the patients who joined the program.

In addition to control group challenges, the leaders who were interviewed emphasized a desire to be able to better capture "non-economic" benefits of their serious illness program. Such benefits include measures of success that are either difficult to measure in general, or are not traditionally measured, but that they feel they are important. Examples include provider satisfaction, provider efficiency, care effectiveness, patient goals of care achievement, and patient satisfaction. Leaders felt these measures were improved by the program, but they were not able to valuate these measures from a return-on-investment or business case standpoint. Better research in this area could benefit the field of palliative care.

One challenge is determining when a seriously ill patient is stabilized and no longer needs palliative care. Once palliative care patients reach "Level 3" of the program and remain there for 6 months (typically around 12 months into the program), Facey considers them to be stable enough to "graduate" from the program. Many patients, however, want to remain in the program because they appreciate the regular contact and support from the palliative care team. With limited resources, the challenge is targeting those patients with the greatest needs, and stable patients may take spots that could be used by new patients. Beyond graduating patients who have lesser needs, another possibility is to examine the list of patients who might be appropriate for hospice, since hospice provides more robust services than community-based palliative care.

There are some clinical nuances that challenge expanding community-based palliative care. For example, the palliative care team found that end-stage renal disease (ESRD) patients were not showing the same level of results as patients with other conditions. The leaders think this may be because of the unique care needs for ESRD, as well as the fact that such patients receive so much of their care through their dialysis facility and their nephrologist. Given that ESRD patients do not seem to be as improved by community-based palliative care, the team no longer includes such patients in this service.

Another implementation question is how to structure the financial arrangement of a partnership between an ACO and a palliative care partner. Currently, Facey funds the direct staffing costs for TrinityCare, although they are in negotiations regarding future arrangements. As an alternative to funding the direct costs of the palliative care team, an organization could provide a per member per month (PMPM) payment for those patients using the service. There are advantages and disadvantages to each approach. By funding the direct costs, the ACO bears the financial risk for the palliative care patients, but it also receives the savings. This may be challenging in the beginning when the palliative care enrollment is unclear. In contrast, a PMPM arrangement would provide a financial incentive to the palliative care provider to reduce unnecessary utilization, although the palliative care partner is now at risk if there are fewer palliative care patients and the revenue does not meet the salaries of the palliative care team.

Another question is how to determine the ideal size of a community-based palliative care program. Over the course of this program, the daily census has steadily increased and, with limited mortality, they have long-standing pa-tients. There is tension in continuing to provide services versus having space for new patients, which also raises the question of when the program should expand. In early years, the program expanded quickly, but the overall program has leveled off, and interviewees suggested that the growth would probably be slower going forward.

Policy Challenges

Interviewees mentioned that proper serious illness care is difficult to perform under traditional fee-for-service reimbursement and, in fact, might cause financial loss, primarily because fee-for-service is too inflexible and will not reimburse for certain crucial care team members (e.g., care coordinators or social workers), medical services (especially community-based palliative care for patients who do not need something as intensive as Home Health), or services focused on social drivers of health (e.g., home safety or transportation). By contrast, interviewees mentioned that an accountable care model, when implemented properly and with efforts to redesign care and accountability for cost and quality, generates enough savings to provide financial flexibility to provide ideal care for the seriously ill.

There are unique legal and regulatory constraints for ACOs in California, many of which are driven by regulations on health care organizations that take risk.[3–5] Key considerations include getting a license to bear risk, what entity holds that license, how shared savings can be distributed, and how the organization is governed.

Furthermore, California has a unique law requiring Medi-Cal managed care plans to provide access to palliative care ser-

Contextual Factors Affecting the Ability to Spread the Model	
Contextual Factors	**Description**
Institutional	Internal champion was critical for buy-in of palliative care among Facey physicians.
Local Market	Urban market provides a defined geography for home visits, which would be difficult to achieve in more diffuse geographies. Many payers offering shared- and full-risk contracts. Disease burdens and cultural expectations can vary widely across the region.
Regulatory	Commercial ACO and full-risk managed care provide financial flexibility that allow them to support services not typically reimbursed well by fee-for-service, such as home visits by palliative care team, social work, and other services. California law requires Medicaid managed care plans to offer community-based palliative care services, which affects the workforce, infrastructure, and overall environment for palliative care in the state.

vices, which has broader impacts on palliative care benefits among California's commercial insurers.[6]

While home visits are important, the model could be scaled further through telehealth services, as transportation takes considerable clinician time. Transportation is especially challenging in the Los Angeles region given traffic and urban sprawl; however, there are limitations on reimbursement and ability to deliver telehealth services.

Finally, Facey noted that pharmacy costs are a concern for this population, especially for specialty drugs (like biologics). Pharmacy costs jumped from 7–8% of total spending to a projected 40% by 2020. Such costs have implications, since the care interventions have little ability to affect those costs. Facey feels like this is one of their biggest cost challenges, and mentioned that a future ideal risk-based contract would include pharmacy as a risk-bearing entity. This is potentially a place for the broader field to investigate and innovate.

Summary

Facey Medical Group offers community-based palliative care for patients enrolled in commercial accountable care plans through a partner organization, TrinityCare. This high-touch model, with physician home visits and high-intensity services to stabilize a person's condition, allows patients to stay in their home comfortably and safely, avoiding unwanted and unnecessary hospital and ED care. Implementation is dependent upon internal champions who helped get clinician buy-in, changed the culture, improved communications between the palliative care team and the medical group (especially through charting in the same EHR), and improved patient identification. The Facey/TrinityCare partnership will continue to evolve, but has shown initial success in patient experience and utilization.

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Acknowledgments

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For more information about this brief, please contact
Robert S. Saunders, PhD at **Robert.Saunders@duke.edu.**

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