Innovations in the Carolinas

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Four Seasons, CMO, CIO
Disclosures

- Research Funding
  - AstraZeneca
  - Tabula Rosa
- Four Seasons Consulting Group – Principal
- Chief Innovation Officer – Teleios Collaborative Network
Objectives

- Describe the CMS Innovations Center and Four Seasons CMMI Project on the impact of community-based palliative care
- Explore the importance of using a Quality Data Assessment Collection Tool (QDACT)
- Demonstrate a patient centered telehealth app
- Understand Alternative Payment Model impact on hospice and palliative care agencies
- Learn about Project ECHO’s utility in palliative care
Creation of CMS Innovations Center

- Created through Affordable Care Act
- Designing, testing, and implementing new payment models
- Launched over 40 new payment models
- Goal – improve quality, lower costs, increase experience of care
- Funded 10 billion thru 2019, then 10 billion each decade
Figure 1
CMMI Payment and Delivery System Reform Models (2018)

ACO Models
- ACO Investment Model
- Next Generation ACOs

Medical Home Models
- Independence at Home Model
- Comprehensive Primary Care Plus

Bundled Payment Models
- Bundled Payments for Care Improvement (Models 2-4)
- Oncology Care Model
- Comprehensive Care for Joint Replacement Model

Source: Map data downloaded February 8, 2018 from CMS, "Where Innovation is Happening."
The Future of Healthcare

Conway, P CMS Health Care Delivery and System Reform, 3/24/15
The Solution - Payment Reform

- Fee for Service
  * Physician choice
  * Physician Accountability

- Pay for Performance
  * Outcomes-directed decision making
  * Physician Accountability

- Risk-sharing/ACOs
  Cost/quality-directed decision making
  Group Accountability

* Outcomes-directed decision making
* Physician Accountability

Quality Demonstration
MACRA Legislation

Medicare Access & Children’s Health Insurance (CHIP) Reauthorization Act of 2015

<table>
<thead>
<tr>
<th>Repeals Sustainable Growth Formula</th>
<th>Fee for Service</th>
<th>Alternative Payment Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Freezes Part B payments 2020-5</td>
<td>• MIPS</td>
<td>• ACOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bundled payments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Episodic care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CMMI models</td>
</tr>
</tbody>
</table>

In 2017, pure FFS accounted for only 37% of the market
Four Seasons’ CMS Innovation Project
CMMI Grant 9/2014-17

Scale model into 14 counties, delivered longitudinal across all care settings

- Improve healthcare outcomes
- Improve patient and family experience of care
- Reduce total cost of care
- Increase access to high quality care
- Developing/Testing a New Payment System
Scaling Palliative Care Across Western NC and Upstate SC

Western North Carolina

Upstate South Carolina

Figure 1 - Geographic area
Goals and Driver Diagram
Initial Challenges

- How do we define eligibility?
- How do we standardize care in all settings and various geographic locations?
- How do we deliver care to people who live remotely in mountainous regions of WNC?
- What type of interdisciplinary model is the best?
Defining Eligibility
A Monumental Task
Mary’s Story

Stage III breast cancer
72% 5 year survival rate

Palliative Care Intervention

- Symptom management - Nausea, vomiting, fatigue
- Family distress – 2 children in middle school/financial hardship
- Social worker – counseling, assist with Medicaid application
- Chaplain – spiritual support
Tom’s Story

End stage COPD
Prognosis 2-3 years
Recurrent ER visits

Palliative Care Intervention

- Goal: stay out of the hospital, die at home
- Symptom management of dyspnea
- Lives in rural area in WNC; little access to primary care
Doris’s Story

Advanced dementia
Prognosis 8-10 months
Behavioral issues, polypharmacy
2 hospitalizations/12 months
Daughter exhausted, stressed

Palliative Care Intervention

- Advance care planning (full code)/education of disease process
- Medication review with discontinuation of 5 meds
- Social worker and spiritual support
- Hospice referral after 2 months when patient clearly declining
CMMI Eligibility Criteria

Patients with life limiting illness in last 3 years of life presented often with:

- Serious Illness Diagnosis
- Functional Status Impairment
- High healthcare utilization
- Nutritional, cognitive, functional decline
- High symptom burden
- High caregiver burden
Four Seasons Model

Orange – only reimbursable service under FFS Medicare
The Palliative Care Referral Process

[Diagram showing the referral process for palliative care, including steps such as verifying insurance, initiating tracking, obtaining additional records, entering into system, determining CMMI status, calling the patient, referring to routine facility, notifying the provider, and handling patient packets and visits.]
# Visits Based on Risk Assessment

<table>
<thead>
<tr>
<th>PRIORITY OF VISIT</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition</td>
<td>Transition from hospital within last 2 weeks</td>
<td>Transition from hospital within last 15-30 days</td>
<td>No hospitalizations or ER visits within last 3 months</td>
</tr>
<tr>
<td>Symptom</td>
<td>Mod-Severity Symptoms: pain, dyspnea, constipation, N&amp;V</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Function</td>
<td>20% drop in PPS</td>
<td>10% drop in PPS</td>
<td>PPS stable but &lt;50%</td>
</tr>
<tr>
<td>Meds</td>
<td>• 3 or more medication changes within last week</td>
<td>• 1-2 medication changes within last 15-30 days (opioids, anti-psychotics, cardiac meds)</td>
<td>≤1 medication change within last 3 months</td>
</tr>
<tr>
<td></td>
<td>• Initiation of opioids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>• Sudden nutritional decline (5% weight loss in 3 months with BMI ≤ 21) • Albumin ≤ 2.5</td>
<td>• &gt;5% weight loss over last 2-3 months with BMI ≤ 21 • Albumin 2.5-3</td>
<td>≤5% weight loss in last 3 months</td>
</tr>
<tr>
<td>Infection</td>
<td>• Infection with systemic symptoms within last 2 weeks • ≥ Stage 2 pressure ulcer • Aspiration</td>
<td>• 2 infections within last 2 months • Stage 2 pressure ulcer within last 2 months</td>
<td>No infections within last 3 months</td>
</tr>
</tbody>
</table>

Bull, J Standardization and Scaling of a Community-Based Palliative Care Model, JPM 2017 Nov 20 (11) 1237-1243
Standardizing Care

The Initial Palliative Care Visit by MD, DO, NP, PA, and RN

PRE-VISIT
- Determine reason for consult
- Review H&Ps, meds, labs, x-rays, etc.
- Identify other agency involvement

RN
- Explain program and review New Patient Packet
- Review symptoms
- Reconcile meds and list allergies
- Obtain social history
- Do spiritual assessment
- Discuss ACP
- Identify goals
- Assess functional status and safety
- Assess VS, O2 sat, Ht/Wt, constitution, eyes, ENT, lymph, res, cardio, GI, GU, MS, skin, neuro, psych
- Formulate care plan with patient/family

MD, DO, NP, PA
- Explain program and review New Patient Packet
- Review symptoms
- Reconcile meds and list allergies
- Obtain social history
- Do spiritual assessment
- Discuss ACP
- Identify goals
- Assess functional status and safety
- Assess VS, O2 sat, Ht/Wt, constitution, eyes, ENT, lymph, res, cardio, GI, GU, MS, skin, neuro, psych
- Determine prognosis
- Formulate care plan with patient/family

POST-VISIT
- Determine Risk Level
- Complete visit documentation to include QDACP
- Forward copy of notes to facility and/or referer
- Collaborate with other members of IHR

Clinic
New Patient Packet at Sign-In
Quality Data Assessment Tool

<table>
<thead>
<tr>
<th>Consult Characteristics</th>
<th>12/01/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Assessment</td>
<td>12/01/2015</td>
</tr>
<tr>
<td>Referral Source</td>
<td></td>
</tr>
<tr>
<td>Primary Diagnosis for Consultation</td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>Primary Diagnosis Type</td>
<td>Peripheral vascular disease</td>
</tr>
<tr>
<td>Consultation Location</td>
<td></td>
</tr>
<tr>
<td>Admission Date</td>
<td>12/01/2015</td>
</tr>
<tr>
<td>30-day Hospital Readmission</td>
<td>Yes, 1 life-limiting illness-related hospitalization</td>
</tr>
<tr>
<td></td>
<td>Yes, 2 or more life-limiting illness-related hospitalizations</td>
</tr>
</tbody>
</table>

Four-Seasons
## Pain Assessment

On a scale of 0 to 10, zero meaning "no pain" and 10 meaning the "worst possible pain", indicate your current pain level.

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>As bad as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td></td>
<td></td>
<td>Patient unable to respond</td>
</tr>
</tbody>
</table>

- Unknown
- No
- Patient declines
- Yes - NSAI\D's or acetaminophen
- Yes - Weak opioids (e.g. tramadol, codeine, propoxyphene)
- Yes - Moderate/strong opioids (e.g. morphine, oxycodone, hydrocodone)
- Yes - Adjuvant medications (e.g. gabapentin, pregabalin, duloxetine, steroids)
- Yes - Methadone

### Do you currently take any medications for pain? (check all that apply)

#### Did medication status change during visit?

- Yes
- No
- Patient declines
- Yes - NSAI\D's or acetaminophen
- Yes - Weak opioids (e.g. tramadol, codeine, propoxyphene)
- Yes - Moderate/strong opioids (e.g. morphine, oxycodone, hydrocodone)
- Yes - Adjuvant medications (e.g. gabapentin, pregabalin, duloxetine, steroids)
- Yes - Methadone

### Do you currently take any medications for pain? (AFTER) (check all that apply)

#### Short-acting opioid available when long-acting opioid prescribed (AFTER)

- Not applicable/patient not on long-acting opioid

#### Intervention for Opioid-Induced Constipation Prevention (AFTER)

- Yes
## Quality Data Assessment Tool

### ADVANCE DIRECTIVES

<table>
<thead>
<tr>
<th>Preference for Resuscitation Status</th>
<th>Full Code</th>
<th>DNR/DNI</th>
<th>Mostly DNR/DNI with documented exceptions</th>
<th>DNR, not DNI</th>
<th>DNI, not DNR</th>
<th>Patient does not wish to discuss</th>
<th>Unknown</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Did resuscitation status change during visit?</strong> Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preference for Resuscitation Status (AFTER)</td>
<td>Full Code</td>
<td>DNR/DNI</td>
<td>Mostly DNR/DNI with documented exceptions</td>
<td>DNR, not DNI</td>
<td>DNI, not DNR</td>
<td>Patient does not wish to discuss</td>
<td>Unknown</td>
<td>Other (please specify)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existence of Advance Directives</td>
<td>No - has interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient unable to complete</td>
<td>Unknown</td>
<td>Other (please specify)</td>
</tr>
<tr>
<td></td>
<td>No - not interested</td>
<td>Yes, documentation or copy in medical record</td>
<td>Yes, but NOT documented in medical record</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of Healthcare Proxy</td>
<td>None</td>
<td>Spouse or significant other</td>
<td>Friend</td>
<td>Child</td>
<td>Legal guardian</td>
<td>Parent</td>
<td>Other family</td>
<td>Not sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patient does not wish to answer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other (please specify)</td>
</tr>
<tr>
<td>Has the ICD been deactivated prior to an anticipated death?</td>
<td>Yes</td>
<td>No</td>
<td>Not Applicable</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Measuring Quality – Global PC Quality Alliance
# Tracking of Palliative Care

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>5825</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Transitions</td>
<td>2190 (45%)</td>
</tr>
<tr>
<td>Palliative Care Deaths</td>
<td>794 (16%)</td>
</tr>
<tr>
<td>Palliative Care Discharges</td>
<td>2063 (42%)</td>
</tr>
</tbody>
</table>

Poor Functional Status of CMMI Patients

<table>
<thead>
<tr>
<th>PPS Score</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-60%</td>
<td>86%</td>
</tr>
<tr>
<td>70%</td>
<td>8%</td>
</tr>
<tr>
<td>80-100%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Total patients = 3263
Challenges Inform Innovation

- Rural Service Area
- Workforce shortage
- Knowledge basis
- Financial
- Infrastructure Issues
- Electronic health records
- MIPS reporting
Innovations

Telehealth
- Improved access to rural service areas
- Improved workforce shortage issues
- High patient/family satisfaction

QDACT
- Standardized quality metrics – validated tool
- Allowed for QI projects and opportunities for improvement
- Allowed for benchmarking of clinical and clinician data

Project ECHO
- Provided learning base community
- Networking
- Enhanced self-efficacy
TapCloud

99% OF HEALTH HAPPENS BETWEEN DOCTOR VISITS.

TapCloud connects patients and clinical teams between those visits.
TapCloud Platform

TapCloud Device Manager

TapCloud Clinical Rules Engine

TapCloud Dashboard and Alerts
- Alerts clinician to patients who need attention
- Monitors patient population
- Provides detailed real-time patient data

TapCloud Patient App
- Collects symptoms, pain level, and well-being
- Provides care plan
- Delivers reminders

Patient

TapCloud Communications
- Secure Messaging
- Secure Video
- Phone
- Hi-Res Photos

Clinician
Telehealth Intervention

TapCloud provides care plans, reminders, and critical health information to patients.

- **Patient Remote Monitoring**
  - Customized for each patient
  - Care plan, medication reminders
  - Symptom assessment

- **Clinical Dashboard**
  - Easy to read dashboard
  - Alerts to providers
  - Clinicians send messages
Customized Engagement

- Innovative word cloud
- Customized for each patient, each condition and medication.
- Sophisticated algorithms look for symptoms, medication side effects, positive and negative symptoms, emotional and physical issues
Clinical Dashboard

- Identifies high risk patients quickly
- Hover-over for details

Active Patients - View Case List

[Image of dashboard with patient information and alerts]

**Alert: Quick View - 3 Alerts**

Wed, 3/9 7:20 PM CST - **Symptom Alert**: Patient reported: Swollen Ankle

Wed, 3/9 7:22 PM CST - **Vitals Alert**: Device: **SCALE** reported: +2.7 lbs / 24 Hrs

Wed, 3/9 7:23 PM CST - **Vitals Alert**: Device: **Pulse Oximeter** reported: <87%
Interface with Clinicians

- Remote Patient Monitoring
  2953 check ins

- Clinical Dashboard
  2082 responses (1374 texts from patients with 1342 responses)

- 13,382 Pushed Messages
  Scheduling, medication reminders

## Quality Data Assessment Tool

### Results of TapCloud Patients

<table>
<thead>
<tr>
<th>Symptom</th>
<th>% with Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>82%</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>78%</td>
</tr>
<tr>
<td>Constipation</td>
<td>100%</td>
</tr>
<tr>
<td>Depression</td>
<td>90%</td>
</tr>
<tr>
<td>Well being</td>
<td>79%</td>
</tr>
</tbody>
</table>

Qualitative Analysis

Patients & Caregivers
- Increased Access
- Quick Response
- Improved Efficiency and Quality of Care

Clinicians
- Efficient Monitoring system
- Easy Medication Refills
- Avoidance of ER/hospital visits

Business Platform

- Customized to healthcare entity
- Designed with central database and discrete API’s
- Can serve as a patient portal for existing IT platform
  - Intouch Health – telehealth/robotics
  - DeltaRX – virtual pharmacy/PBM
  - SurvivorPlan – customized plan for cancer survivors
  - Safestart – surgical safety
  - Smart MD – dictation/EMR
Understand Impact of Alternative Payment Model for Palliative Care
Alternative Payment Model

- Unsustainable financial model under current fee for service reimbursement structure
- New E/M codes are helping but still fall short
  - Advance care planning
  - Non Face 2 Face prolonged service codes
  - Complex chronic care management codes
  - Transitional care management codes
- With new codes lose ~$160 month
<table>
<thead>
<tr>
<th>Role</th>
<th>Unreimbursed Services</th>
</tr>
</thead>
</table>
| Registered Nurse | Case management  
                      Education  
                      Coordination of care                          |
| Social worker | Counseling  
                      Assess psychosocial distress  
                      Social services (meals on wheels, Medicaid, etc.)  
                      Family and Social support                      |
| Chaplain     | Spiritual distress   |
| Bereavement  | Provide grief counseling                                   |
| Volunteer    | Companionship with patients  
                      Assist staff with duties                      |
| All          | Telehealth                                                  |
### AAHPM’s APM
Patient and Caregiver Support for Serious Illness

<table>
<thead>
<tr>
<th>Tier</th>
<th>Diagnosis of Serious Illness (one of the below)</th>
<th>Function (one of the below)</th>
<th>Health Care Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1: Moderate Complexity</strong></td>
<td>One of the specified diseases, disorders, or health conditions in Table 2 below</td>
<td><strong>Non-Cancer:</strong> PPS of ≤60% or ≥1 ADLs or DME order (oxygen, wheelchair, hospital bed)</td>
<td>One significant health care utilization in the past 12 months, which may include:</td>
</tr>
<tr>
<td></td>
<td>Three or more serious chronic conditions*</td>
<td><strong>Cancer:</strong> PPS of ≤70% or ECOG ≥2 or ≥1 ADL or DME order (oxygen, wheelchair, hospital bed)</td>
<td>- ED visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Observation stay</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Inpatient hospitalization</td>
</tr>
<tr>
<td><strong>Tier 2: High Complexity</strong></td>
<td>Same as above, excluding dementia as the primary illness</td>
<td><strong>Non-Cancer:</strong> PPS of ≤50% or ≥2 ADLs</td>
<td><strong>Note:</strong> This criterion may be waived under certain circumstances specified below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Cancer:</strong> PPS of ≤60% or ECOG ≥3 or ≥2 ADLs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: This criterion may be waived under certain circumstances specified below.*
Capitated Model AAHPM

- Tier 1 - $400/month
- Tier 2 - $650/month
- Risk adjustment for quality and Total cost of care
Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by State, 2017

National Average, 2017 = 33%

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.

SOURCE: Authors’ analysis of CMS State/County Market Penetration Files, 2017.
Medicare Advantage

- Continues to grow
- In NC 2013-2017 has grown by 11%; now 32% of all Medicare patients
- Multiple providers
- Increased contracting
Jefferson County – Medicare Advantage – 52%
CMS Regulatory Changes to MA

- April, 2018 CMS released CY19 call letter which
- Reinterpretation of “primary health-related” supplemental benefits
- Reinterpretation of uniformity requirement for MA plans

Shift will allow

1. New supplemental benefits
2. Possible different levels of cost-sharing with beneficiaries (uniformity requirement)
Chronic Care Act

- Passed Congress 2/2018 as part of Bipartisan Budget Act
- Developed in response to increased impact to Medicare of chronic illness
- Supplemental benefits goes into effect 1/2020 which *may not be limited to being primary health related benefits*
- Also increases Independence at Home benefit
- Increase SNP plans for MC beneficiaries
Opportunities

The Continuum of Palliative Care

Palliative care can be—and must be—available across all settings, offering an array of services in venues that matter most to patients and families, in ways that ensure smooth transitions between settings.

Filling the Gap

Point of Crisis

Community-Based Palliative Care

End of Life

Hospital Palliative Care

Office

Home

Long Term Care Settings

Center to Advance Palliative Care
Shifting Epicenter to Home

Death usually follows disease exacerbation.

Multiple hospitalizations

Death

Home

Office Visits

Hospice Care

Home Health

Rehab

Hospital

High

Low

Function
# Changing Landscape

<table>
<thead>
<tr>
<th>3rd party with Payors</th>
<th>Non Profit Collaborative</th>
<th>APMs</th>
<th>Healthcare Systems</th>
<th>Payors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspire</td>
<td>Ohio Hospice</td>
<td>Independence at Home</td>
<td>Northwell Health</td>
<td>Cambia</td>
</tr>
<tr>
<td>Landmark</td>
<td>Teleios (TCN)</td>
<td>ACOs</td>
<td>Ascension</td>
<td>Optum</td>
</tr>
<tr>
<td>Turnkey</td>
<td></td>
<td></td>
<td>Providence</td>
<td>BCBS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bon Secours</td>
<td>United</td>
</tr>
</tbody>
</table>
Quadruple Aim

- Patient Experience of Care
- Better Outcomes
- Lower Costs
- Care for the Clinical Team
Workforce Shortage

Kamal, Bull, Myers. Future of the Palliative Care Workforce: Preview to an Impending Crisis. The American Journal of Medicine 2017 130, 113-114
62% Burnout Rate – Hospice and Palliative Care Providers
Project ECHO (Extension of Community Healthcare Outcomes)

- Medical education – trains clinicians in rural/underserved areas to provide specialist-level services
- Specialists at a “hub” mentor and train clinicians in local communities “spokes” to manage a condition that was previously outside their area of expertise
- teleECHO sessions include case presentations/didactics, and promotes mentoring/knowledge sharing
Project ECHO

$750,000 Grant – The Duke Endowment
Awarded 11/2018 for 2 year period

Train at least 10 sites in NC and SC
Spoke and Hub Model

Use of QDACT, self efficacy and project satisfaction surveys
Project ECHO

Expand Provider Network
Primary Care NPs/PAs PC

Improve Skillset
Case base learning
Didactics

Enhance Outcomes
Symptom scores
Hospice transitions
Provider satisfaction and self efficacy

Funded by The Duke Endowment
In Conclusion

- Healthcare reform is here to stay
- Reform will be driven by Alternative Payment Models where risk is incorporated
- Hospice, while siloed in the healthcare system has a unique opportunity through community based palliative care and programs which care for the seriously ill
- Medicare Advantage is projected to increase its growth
In Conclusion

- Patterning with others to leverage opportunities for payor contracts and demonstrate ROI will become more important.
- Telehealth will offer solutions to increase access, improve care delivery, and assist with the workforce shortage issues.
- New education opportunities/platforms to train primary care physicians in general palliative care skills along with training advance practice practitioners in specialty PC will arise.
Questions?
jbull@fourseasonscfl.org