

Palliative Care Chat – Episode 19 - Interview with Timothy Cox

“CareFirst BlueCross BlueShield Blazing a New Trail in Home-Based Palliative Care”

- Dr. McPherson: Good morning. This is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast brought to you by the online master of science and graduate certificate program at the University of Maryland. I am delighted. I'm just simply delighted to introduce our guest today. It's Timothy Cox, who is senior director, home-based post-acute care evaluation and oversight at CareFirst, BlueCross BlueShield. Mr. Cox has a really interesting background and we were just chatting prior to hitting the record button that we have one thing in common. He attended Bucknell University, as did my sister and my niece. Clearly, a superior academic institution. Mr. Cox also has a JD from Widener University. He resides in Washington, DC. So not too far from me. I work in Baltimore.
- Dr. McPherson: Mr. Cox, what else is pertinent in your background? You've got a very lovely bio sketch here and you've got such a wonderful background. Before we jump into our topic, what else do you think is important for our conversation today?
- Mr. Cox: Well, thank you, Lynn. First of all, thank you for inviting me on your podcast. I am honored to speak about what I do at CareFirst and the benefits that our members have. About my background, I'm in my 33rd year of healthcare and really have spent all my adult life in post-acute care area. I did a regulatory stint for a while as a regulatory attorney for Sunrise Senior Living. I helped them go public and opened eight new states for them, in the regulatory sense of licensure process. Then also, I think the other highlight is I've worked for profit, non-profit, and including the federal government. Actually, at the time when Katrina hit, I was running the Armed Force Retirement Home. Without FEMA's help, I safely evacuated 432 seniors out of our Gulfport, Mississippi site and got them all up here.
- Dr. McPherson: Oh my goodness.
- Mr. Cox: Then rebuilt that site with the help of congress.
- Dr. McPherson: Oh my goodness. That is an amazing list of accomplishments.
- Mr. Cox: Thank you.
- Dr. McPherson: Why don't we, even though most of the people listening to this podcast probably do understand the difference, why don't you tell us from your perspective, the difference between palliative care and hospice care?

Mr. Cox: Sure. Palliative care is the ability for a group of caregivers, very holistically. It's not just focusing on medical. It's having therapies that could include music, aroma, rec-a. It includes spiritual health and it really deals with people with serious illness. It could be people who have cancer, but they're not typically going to die within the traditional Medicare guidelines of six months or less. Could be someone who has Parkinson's, someone has Lupus. Palliative care really looks at care coordination and symptom management at the base place the person wants that care, which is usually in their home. So-

Dr. McPherson: Obviously, you think palliative care could start way more quickly than, for example, hospice care?

Mr. Cox: Absolutely. It should start. Symptom management is really important because we tend to, with serious illness, wait until we have a crisis and then use the emergency room, which is really the last place we want people to go to. We really want them to be able to be proactive and as a healthcare provider and an insurance provider, we feel we can help instigate that care further upstream rather than waiting until there's a crisis.

Dr. McPherson: You may have noticed an interesting trend that I've noticed as well. Obviously, we have our online master of science degree in palliative care, and I am amazed at how many physicians I know who are actually emergency physicians by training, but they're moving closer and closer, and more and more into the palliative care realm. What the heck is going on with that, do you think?

Mr. Cox: Well, I think what's very interesting is that physicians realized that the care they can give at the emergency room is really just triage and that our healthcare system, we've set ourselves up to have the emergency room be where our primary care physicians act, and that shouldn't be the case. A majority of people look at the emergency room as their minute clinic. We need to reverse that. Colleagues who are, as you said, changing from emergency room physicians to look at palliative, they feel they can do more for that person by helping them control their health earlier on, rather than waiting until there's a crisis.

Dr. McPherson: I think ED Docs also see medical futility often, and perhaps they're the first one to really have that meaningful goals of care conversation with patients and their families. Do you think that could be what's at play here also?

Mr. Cox: That's a very good point. Oftentimes, people go because they don't know what other resources are out there. They haven't planned. They haven't talked about the quality of life that they want when they have an emergency or when their health continues to fail and at the crisis time, that's not the appropriate time to have that conversation.

Dr. McPherson: Absolutely. You were talking about process in palliative care. You do realize that the rest of the world really doesn't make this distinction between hospice and palliative care. I suspect that when you share with us what you're doing at

CareFirst, you'll be telling me about your efforts to actually bridge that gap between the two. Why don't you tell us a little bit about what you do at CareFirst BlueCross BlueShield?

Mr. Cox: Sure. Happy to. CareFirst, about seven years ago, started a program called Patient-Centered Medical Home. It was a model really to deal with the serious ill members, and who had a very high spend, and who were very sick, to be able to help them have a better quality of life at a place outside of the hospital. Perhaps it was just a living facility or perhaps at home with home care. One of the barriers that CareFirst saw is that getting people back home, traditional home care requirement that a person be home-bound was a barrier because being a commercial insurer, many of our members are younger. They wanted to go back to work, and even if they wanted to work part-time, they could no longer get, for instance, physical therapy at home because they no longer met that home-bound requirement.

Mr. Cox: CareFirst backed up and said, "Hey, you know what? We need to change this and go to the Insurance Commission and say, 'We want to be able to remove the home-bound requirement from our insurance policies because we feel the benefit-'"

Dr. McPherson: A bold move.

Mr. Cox: Yes. "We feel the benefit could be utilized at a much higher rate and keep people out of the hospital. Make sure they get their full compliment of services that they want." Because oftentimes, someone will go home. The moment they're not home-bound anymore, they stop the service, even though they could have used maybe two or three more weeks of physical therapy or occupational therapy or wound care. When those services stop prematurely, then we have a propensity to increase the chances that they'll come back to the emergency room, which we really don't want for their care or for their quality of life.

Dr. McPherson: I've been on the other end of that table, where I have sat in team meeting, and heard a hospice nurse report that, "I guess we're going to have to discharge this patient because she left the home to go visit her granddaughter." That's just so crazy.

Mr. Cox: It is so crazy.

Dr. McPherson: People should be allowed to lead their lives still.

Mr. Cox: Right.

Dr. McPherson: Oh my goodness.

Mr. Cox: That's the first thing that CareFirst did. The second thing they did is they removed the curative treatment barrier. Oftentimes, again, with the traditional Medicare benefit for hospice, you have to forgo curative treatment in order to get hospice, which means you couldn't even have a skilled service from a home care agency continue if you went on hospice. CareFirst, again, visiting members, visiting providers, when we looked at changing this benefit said, "Well, that seems ridiculous. If people want hospice because they are slightly ill and will eventually die because of that serious illness, but why should we have them have to choose?" Sometimes having that curative treatment is also helping manage the symptom better. We should allow the patient and their physician decide what clinically is best for them, not to say it's an either or.

Dr. McPherson: Wow. That's a bold move. That can't be commonly seen in the field. I think this is the first I've heard of it.

Mr. Cox: It is not commonly seen, Lynn. In fact, I have been speaking since I joined CareFirst in May. I've been speaking publicly, and it's amazing how many providers don't understand the difference and that our home-based services, our hospice and palliative care benefit is really an additional benefit that improves quality of life that gives our members an opportunity to have better care because it's more coordinated.

Dr. McPherson: That's wonderful. Well, selfishly-speaking since I work for the state, and I'm insured by you, could you share with me, what is CareFirst hospice and palliative care benefit?

Mr. Cox: Yes. Our hospice and palliative care benefit. We have two parts. One is the traditional benefit that is part of everyone's policy. The added benefit is through our program in home-based services, which causes that benefit to be enriched and on both sides. Home-based services, and all someone has to do is it's part of your employer contract with us, that they allow these additional benefits to be presented. We push the employer hard to include those benefits because what it does is it gives more flexibility and more compliment to the service.

Mr. Cox: For instance, on the home-based services side, your benefit would include that you don't have to be home-bound in order to get that home care. You want to go to work part-time. You had a care accident. You broke your leg. You need physical therapy. You want to go back to work. You can't get to your physical therapy appointment because they're only open until five. We will have a home care agency send a physical therapist at your house at seven o'clock at night. They can meet you after work. It gives you flexibility that you can continue to do that, so you're 100% repaired, not 80% repaired or not 50% repaired.

Mr. Cox: We know that benefit is saving cost for us, which obviously is important, but more importantly, it's giving that 100% quality of care that our member needs to be 100% recovered.

Dr. McPherson: Are most employers going along with this? Since you're pointing out, that by providing additional services, everybody is actually saving money.

Mr. Cox: Yes. We are and most employers do have that as part of their benefit, which is great.

Dr. McPherson: That is wonderful.

Mr. Cox: State of Maryland does have that, so you are covered by that.

Dr. McPherson: Yeah. There you go. Well, let's hope I don't break my leg anyway.

Mr. Cox: No, no. I don't wish that on you either.

Dr. McPherson: Thank you.

Mr. Cox: Then the second part is for hospice. Having a younger population having a serious illness, especially cancer, kidney failure, diabetes, that to be able to get curative treatment and palliative treatment, so you get that symptom management at your home. It's amazing how people are adverse first because most palliative care is provided through a hospice agency. When somebody hears hospice, it's like, "Oh, I'm giving up. You're not going to help me continue to live as long as I can." That's opposite of what palliative and hospice do. When people get into palliative care, they actually have a better quality of life and actually live longer than just continuing futile treatment.

Dr. McPherson: Right. That's been shown time and again.

Mr. Cox: It has.

Dr. McPherson: That is a real barrier though, using the word hospice. People are so afraid of that word. What you just described, how is this different from the traditional Medicare benefit?

Mr. Cox: Traditional Medicare benefit, you have to have a physician certify that you're going to die within six months or less because of your illness and also that you have to forego any curative treatment. That's pretty narrow. Now, there are some Medicare Advantage Programs that CMS has started, where through options, you can change that. There are some benefits out there now through Medicare Advantage, where it's getting closer to the CareFirst ideal, which is really important because people don't necessarily want to give up, especially if you're younger, but you are terminal. It may make the family feel better that you're still continuing with chemo on a very light treatment because it's still providing hope for that family.

Dr. McPherson: Yes, yes.

Mr. Cox: So we just don't want the member-

Dr. McPherson: That's the difficult-

Mr. Cox: I'm sorry. Go ahead.

Dr. McPherson: No, no, you finish, please.

Mr. Cox: What we don't want is just to treat the member, that part of us looking at the enriched benefit is that it really helps the member and their family.

Dr. McPherson: Sure. That's a really difficult decision to make. I know I prepare the new drug talk every year, and when it comes to the 15 chemotherapy drugs that were approved, and it's way over my head, but I look at those drugs, and the cost of those drugs, and I think, how useful are they really? I mean, does anybody really give the patient the information of, "Okay, you may live a month longer, but you may be throwing up three of those four weeks."? It's very difficult.

Mr. Cox: Right. It is. What part of my responsibility is, yes, to talk to providers to let them know what our benefit is, but also to talk to physicians to let them know that there are some alternative. What I tell our nurses, our members, when I'm speaking with them about making a difficult decision about going to palliative care and, or hospice is that it's called symptom management. Doesn't have to be hospice or palliative care. Where do you want your symptoms managed best? Not in the hospital. You want to be home.

Dr. McPherson: Absolutely.

Mr. Cox: I've talked to oncologist groups in our area and our area is all of Maryland, Northern Virginia, and all of DC. What they've said is, "Oh, just giving more information lets the patient and the family be more knowledgeable about what the alternatives are." It's not saying, "Don't choose this or that." It's saying, "Here's all the information so you can make a better informed choice for your care."

Dr. McPherson: That's pretty out of the box, I have to tell you. Most people don't get the full scoop. Some people don't want to full scoop. Difficult.

Mr. Cox: It is.

Dr. McPherson: Difficult.

Mr. Cox: It is. Part of the serious illness conversation that we're having, certainly statewide in Maryland, is just to be able to start that conversation and saying, "It's not anything to be afraid of." And really again, I can't emphasize enough that having the conversations while you're not in a crisis is so much more important.

Dr. McPherson: Oh, it's so true.

Mr. Cox: Because in a crisis, you're not hearing. You're reacting. You're not able to take the step back. Physicians naturally want to take care of us, so we rely on them to lead us, not necessarily for us to step back and absorb that information, and be able to make an informed choice.

Dr. McPherson: That is so true. You mentioned you're also responsible for home-based services. We've talked about the hospice Medicare Benefit. What are the significant differences from a traditional home healthcare benefit?

Mr. Cox: Very good question, so thank you. Again, CareFirst went out, which I think is so progressive, they went out, talked to members, talked to providers. What they found was, one, we talked about that home-bound requirement that's in the Medicare. Is that home-bound really restricts because most people go home. They recover. They're able to partially go back to work. Again, we're a commercial insurer, so most of our insurance is through employers. The goal is to get people back to work. They go back to work and then the home care agency traditionally would then have to drop the case.

Mr. Cox: We removed the home-bound requirement and we also enable the person to have skilled services, homemaker services. It's a home health aide service in their home, which usually, if you're not home-bound, you couldn't have any of those services provided in your home. You would have to go to an out-patient clinic to be able to get those skilled services. To give that flexibility to be able to people have them.

Mr. Cox: Also, we ask our partners to be able to be flexible. We had one time where a police officer was new to her diabetes, and didn't know how to use the glucometer, was on a day shift. The nurse from the home care agency said, "Well, if you have a private space to meet at the police station, I'll even meet you there."

Dr. McPherson: Oh my gosh.

Mr. Cox: The flexibility that we ask our partners to have to be able to meet our members where they need their care is really important. As that shows, the nurse was flexible enough to say, "Hey, it's easy to show you how to use this. It's going to take 15 minutes. If you have time and a private space at work, I'm happy to come to your workplace to be able to do that with you."

Dr. McPherson: Yeah. I personally think that we should let home care and hospice nurses rule the world because they are so awesome. They just are the salt of the earth.

Mr. Cox: They are. I guess I have a bias because I've been in the post-acute care world forever, but it takes a special person to be able to deal with death and dying,

serious illness, and the patients, the skill level that the nurses have, and physicians, that work in palliative care and hospice are so admirable for we do.

Dr. McPherson: They are. The nurses in particular are just so skilled at a work around. They will make this work come heck or high water.

Mr. Cox: Exactly right.

Dr. McPherson: So I have enormous respect.

Mr. Cox: They sure do. Yeah. They sure do.

Dr. McPherson: You've touched on this a little bit, but how did CareFirst come to first identify the need for these changes? This is pretty dramatic.

Mr. Cox: It is dramatic. CareFirst had a few providers, home care, actually come to a meeting and at that time, our CEO asked, "Tell me what are some of the barriers you see that are because of our policies that restrict you in doing your care." Which is a bold thing to ask because vendors sometimes don't want to speak up because obviously they get paid by us. On the other hand, they speak up, then they think, well, maybe they're a troublemaker. Well, our CEO took these discussions really to heart and several of the providers said they mentioned the barriers that we've been discussing, home-bound, restrictive care, flexibility, hours, having to be home during the day when someone works instead.

Mr. Cox: And so, he came back to his team and said, "I think we could do better. How do we give some flexibility to our programs? Yes, sometimes traditional home care is fine, but with a younger population that we serve, I think to have the flexibility would be better. And so, we went to our insurance commissions in the three jurisdictions where we serve and increased our benefit.

Dr. McPherson: I would argue it's not just younger people too. I think patients of all ages would really value this approach.

Mr. Cox: Absolutely. I think the more restrictive we are with where care is provided is not where we want to go. We all want the flexibility to be able to, whether it's dialing in and taking through our smartphone, doing FaceTime, whether it's a video chat. We want that flexibility to be able to get the care where we want it, which is when we want it, mostly being home. Or I have an hour for lunch. I can't drive to a midi-clinic, but I could talk to the nurse over the phone. I could do a video conference so I can see the nurse and she can see me or he can see me. I think the flexibility that we're trying to build into our benefit packages is being driven by consumer demand, regardless of age.

Dr. McPherson: That's wonderful. Yes. Some of these things you just mentioned, is that part of the focus for the future for CareFirst?

Mr. Cox: It is. It is part of the future for CareFirst.

Dr. McPherson: Wonderful.

Mr. Cox: Telehealth, obviously, is something being talked about, being utilized inconsistently, but we really see telehealth for being a primary motivation. Certainly, we don't have a Medicare product. So now when someone retires, they can't continue with CareFirst.

Mr. Cox: We have a new CEO, Brian Pieninck, and he has really asked us to evaluate our ability to participate in Medicare Advantage and Medicaid in the 2021 market year. We're currently working on evaluating how we could do that, how those policies would look for us. I think to be full-service and to be able to continue with somebody who's had our care, I've had CareFirst ever since being an adult, so going on my 59th year of age, I really appreciate having CareFirst for over 30 years. So I wouldn't-

Dr. McPherson: As I do for over 30 years.

Mr. Cox: Okay. I wouldn't want to not be able to have that option when I retire.

Dr. McPherson: Absolutely. You get on that because I'm not that far away.

Mr. Cox: Okay. I promise we're working diligently on it, evaluating that.

Dr. McPherson: There you go. Just one last question from me. This marvelous initiative, community-based palliative care. Are hospices eager to pick up this challenge?

Mr. Cox: They are, fortunately. They see that there's an added benefit for being able to get care out to persons earlier in their illness. The point is usually hospice. One of the things when I ran hospice organization, family members after their love one had died in hospice said, "Oh, gosh. I wish we would have gotten the service earlier." Anecdotally, everyone really likes the service and said, "Oh my gosh. It was so wonderful on being able to have our loved one at home. The care you provided out of the hospital, it was just exactly how our loved one wanted to die."

Mr. Cox: Now, getting into serious illness and helping people manage and being to say, "Okay. One size doesn't fit all. You don't have to be in a care plan and we don't have to see you every week. If we stabilize your Parkinson's, maybe we touch base with you once a month." It's those palliative care agencies now that are saying, "Hey, we can be flexible and develop care coordination for you, based on what you need at the place that you want it best, which is at home."

Dr. McPherson: That's so important. I think that's been the missing link for years in our continuum of care with serious illness, not just terminal illness. Obviously, you agree, yes?

Mr. Cox: I do agree with you, yes. That we really haven't been able to deal with that and like you said, so many of our colleagues outside of The United States have already designed programs that work that are home-based. That's where care will be is home-based. It's not going to be at the mini-clinic. It's not going to be in the emergency room. We'll be able to provide many more services at the home, which is the best place to serve most of them without an acute episode.

Dr. McPherson: Absolutely. Well, Mr. Cox, I'm very appreciative of your time and hearing about the amazing things that CareFirst is doing. Are there any last thoughts that you'd like to share with our listeners before we wrap up?

Mr. Cox: I just really appreciate Dr. McPherson having me on and talking about palliative care and love the energy you have. If people have questions, they can certainly find me at tim.cox@carefirst.com and happy to speak to anybody who has more questions about the services we provide.

Dr. McPherson: That's wonderful. Well, thank you so much again for your time. I would like to thank Mr. Cox for his valuable time and information. I personally am excited about this, both for myself and my family, but even more importantly for our more global community.

Dr. McPherson: Again, this is Dr. Lynn McPherson. This presentation is copyright 2019, University of Maryland. For more information on our completely online master of science and graduate certificates in palliative care or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.