Disclaimer

- I have no commercial interests to declare.

- I do have a long term relationship with the Center to Advance Palliative Care (CAPC) which is a non-profit organization affiliated with MSSM in NY.
  
  - [www.capc.org](http://www.capc.org)
Objectives

- Describe features of inpatient palliative care programs that enhance coordination & influence readmissions

- Discuss strategies to align investment and expected impact

- Identify strategies to leverage outpatient programs to impact avoidable readmissions
What is Palliative Care?

- Palliative care is specialized medical care for people with serious illness.

- It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis or stage of the disease.

- The goal is to improve quality of life for both the patient and the family.

- It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.
Service Design Options

Inpatient Consult Service

Inpatient Unit

Provider Home Visits

SNF Consult Service

Outpatient Specialty Clinics

Bridge Programs / Hospice

Outpatient PCP Clinics
The Accountable Care Act and other Federal government initiatives are seeking to address several challenges that regulatory and political leaders identified as needing attention.

### Major Provisions
- Medicaid Expansion
- Individual Mandate
- Employer Requirements
- Subsidies
- Minimum Loss Ratio
- Exchanges
- Minimum Benefit Levels
- Guaranteed Issue & Community-Based Rating
- Accountable Care Organizations CMMI Grants & Pilots
- Readmission Penalties

### Desired Impact
- Increase the number of insured
- Level the playing field
- Encourage innovation in care delivery
Characteristics of ACO/ shared risk (Ideal)

- Risk pool of total healthcare costs
- Flexibility about deployment
- Services not tied to billing norms – such as AIM
  - Use of interdisciplinary teams
  - Use of internet and telephone help
  - Lower panel size, more availability (24/7) is possible
  - Team work and shared roles
  - Consulting specialists can get paid without “doing procedures”
- Incentive to innovate re alternative use of capital for facilities (not “heads in beds”...)
Possibilities for much of the ideal; early pilots (Pioneer ACO as leader)
- Mixed model – *living in both worlds* (FFS vs. Full Risk); “facility fees”
- Often paying sub-contracted services with FFS methodology, even for at risk business
- Time lags, complexity
- Re involvement and buy-in of patients
Example of Costs
(example for illustration, representative but not actual data)

1 additional patient with delirium...

- Assume 1 week additional in hospital – at $1,000/day in direct costs (to hospital), $7,000
- Assume 1 week additional in hospital – at $1,600 in total costs, paid by payer, $11,200
- Assume 6 weeks in SNF at $450/day - $18,900
- Out of pocket $5000 deductible to family
- Total cost of care in a year of $100,000

Which is relevant to whom?
What is your “readmissions” Goal?

- Reduce 30 day rates for target (penalty) categories?
- Reduce 60 day or 90 day rates?
- Reduce all “avoidable” admissions from a narrow quality/regulatory standpoint?
- Re-design care system to provide care where patients want it, at the lowest total cost, in a safe and reliable manner?

- Be Realistic in matching investment with goals.
Complexities in Our Care Delivery System

Complexities lead to lack of coordinated and, at times, poor quality of care...not to mention a very confused consumer who may become frustrated and even disengaged.

**Medical Encounter**

1. Office Visit
2. Consultation Visit
3. Surgery
4. Post-Op Visit

**Hip Pain**

- MRI (prof)
- MRI (tech)
- Anesthesia
- Physical Therapy
- 3-Day Stay
- Pain Med

**Financials**

- Primary Care Doctor
- Surgeon
- Radiologist
- Anesthesiologist
- Hospital Outpatient
- Hospital Inpatient
- Pharmacy

1. Who “owns” the episode?
2. What was the cost of the episode?
3. Who is responsible for the final outcome?
Challenge: Defining “continuum”

- From patient’s perspective – all the places & providers that assist with their journey and the gaps in-between them

- From health system’s perspective – the providers and sites of care involved in delivery of medical services (usually constrained by payment and benefit rules)
  - May be limited to segments owned by system
  - Definition is changing with payment reform
Is this a patient-centered system??
Top 5 reasons for patient readmissions

- Patients may not fully understand what’s wrong with them
- Patients may be confused over which medications to take and when
- Hospitals don’t provide patients or doctors with important information or test results
- Patients do not schedule a follow up appointment with their doctor
- Family members lack proper knowledge to provide adequate care

Half of older Americans visited ED in last month of life and 75% did so in their last 6 months of life.

First, this population is not easily defined and is definitely not defined by prognosis.

- Functional limitation
- Dementia
- Frailty
- Serious illness(es)
  - Cancer, Severe Heart Conditions, etc.
- Family and social support needs
Practical Perspectives to Consider

- Many very sick people do not have transportation & cannot come alone; a clinic visit is a major hassle

- Handoffs of discharge orders, especially complex pharmacy are not nearly as smooth as people in the hospital think...

- Uncertainty about access and trust increases risk-reduction behavior, such as going to the ED

- Hospital problem solvers often do not know or walk in the shoes of community partners
Supportive Care/ Palliative Care

- Clinicians
- Shared Conversation of Goals and Plan of Care
- Patients and Families
Palliative care sees the person beyond the cancer treatment.

Palliative care treats the person as well as the disease.

It works.
How Palliative Care Reduces Cost

- Honest, timely communication re disease/prognosis
  - Establishing patient-centered goals
- Improved resource use matching patient preferences
  - Reducing bottlenecks in high cost units
- Improves throughput and fosters care consistency

The Conceptual Model:

Dedicated team ➔ Focus + Time ➔
Decision Making + Clarity + Follow through
Characteristics of Effective Palliative Care

**Clinical Skills:**
- Pain and symptom management
- Goal setting
- Care giver support
- Social & spiritual support

**Structural Services:**
- Targeting of those with serious illness
- Interdisciplinary team based care
- Flexible levels of care delivery intensity
- Flexible care settings and 24X7 access to care team
- Delivered concurrently or independently of curative or life-prolonging care
Most Important Characteristics

- Adequate, trained Interdisciplinary team well managed but not focused on RVUs
- Consistent service norms re call backs, orders, f/u
  Capacity to do proactive f/u post discharge and phone access for patients and professionals
- Co-management approach, engagement with PCPs and specialists; FEW points of contact for patient
- System supports for iterative Advance Care Planning, early and often
Opportunities for Impact

- Clinical Pharmacist on the team
- Psychologist / psychiatrist / Social Worker engaging community support structures for patient
- Coherent pain management strategies for the community
- Home based provider visit capabilities
- Telehealth options for proactive check ins to extend relationships and flag issues
- Consistency of communication across specialists...
## Examples of Impact on Value

<table>
<thead>
<tr>
<th>Topic / Outcome</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced admissions, crisis, ED use</td>
<td>Value depends on type of admission, payment environment, predictability. May be worth $10-$20k each, or may be a negative #</td>
</tr>
<tr>
<td>Reduced total cost of care per year per beneficiary</td>
<td>Impact on out of pocket costs, SNF, DME, RX, home care, Part B billing – value to whom?</td>
</tr>
<tr>
<td>Improved status, duration in research study, survival</td>
<td>May increase research effectiveness, future research $, patient participation</td>
</tr>
<tr>
<td>Accessibility / continuity relationships</td>
<td>May promote patient loyalty, reduce resource use, and help with market share.</td>
</tr>
<tr>
<td>Reduced crisis &amp; better time use for other specialists</td>
<td>Improved capacity (for new patients with $$$ treatment) and smoother operations, shorter waits</td>
</tr>
<tr>
<td>Reduced inpt mortality</td>
<td>Rankings may matter; alternative pathways to best care, use of hospice may be highly valued.</td>
</tr>
</tbody>
</table>
Example of Results Possible in an Integrated System

Service Use Among Patients Who Died from Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer While Enrolled in a Palliative Care Intervention or Receiving Usual Care, 1999–2000

Data: Adjusted service use rates were based on administrative records (Brumley, R.D. et al. JAGS 2007). SNF = skilled nursing facility.
Palliative Care in Addition to Usual Oncology Care

Allowed lung cancer patients to live almost 3 months longer than those who got usual oncology care.

Figure 3 Kaplan–Meier Estimates of Survival According to Study Group
Survival was calculated from the time of enrollment to the time of death, if it occurred during the study period, or to the time of censoring of data on December 1, 2009. Median estimates of survival were as follows: 9.8 months (95% confidence interval [CI], 7.9 to 11.7) in the entire sample (151 patients), 11.6 months (95% CI, 6.4 to 16.9) in the group assigned to early palliative care (77 patients), and 8.9 months (95% CI, 6.3 to 11.4) in the standard care group (74 patients) (P=0.02 with the use of the log-rank test). After adjustment for age, sex, and baseline Eastern Cooperative Oncology Group performance status, the group assignment remained a significant predictor of survival (hazard ratio for death in the standard care group, 1.70; 95% CI, 1.14 to 2.54; P=0.01). Tick marks indicate censoring of data.
Trends

- Home based services; blend with HouseCalls
- Hybrids of palliative care and geriatric models
- Small number of palliative care medical home models (experimentation)
- “Pain Phone” (expert to expert “just in time” advice)
- Telehealth interfaces with patient & family
- Palliative care as continuity link between inpatient and outpatient or home
New Approaches – Palliative Care Opportunities

- Innovative uses of Interdisciplinary Teams (ex. SW & KP-Colo; ex. Clinical pharmacist at Banner-Arizona)
- Uses of volunteers or non-clinical staff to do family contact and f/u
- “Urgent care” for cancer, CHF, etc. staffed by palliative care NP (Dana Farber pilot)
- Best linkages between POLST type initiatives and system of care
- Inpatient & outpatient continuity (Bellevue Hospital)
- Palliative Care Medical Homes (Peds, San Antonio)
Payer Engagement & Practices

• Payers (Private, Medicare Advantage, Medicaid Managed Care, Self Funded Large Employers) are interested in partnering for change

• Examples: BCBS / Excellus/Highmark, Aetna, United, HealthNet, and Others

• Approaches:
  • Benefit design (concurrent hospice, episodes of care, enhanced svc)
  • Payment incentives (Quality Measures, team based care, phone care, special rates)
  • Training, including of payer employees & case managers, or community based initiatives
  • Recognition for Jt. Commission or other quality indicators
  • Community partnerships & awareness (Excellus in NY, look at Colorado initiatives)
Key Metrics for Palliative Care Services

- Reliability of system – process measures of response, consistency of action, communication loops
- Access – time to first call or first visit, call and weekend coverage
- Volume – patients referred, patients seen; patterns of new vs. f/u, full documentation of Adv. Care Plans
- Utilization – readmissions, crisis, ED, specialty use
- Quality – process measures of assessment, pain management, satisfaction, etc.
Strategies to consider

- Proactive id of patients using IPAL ICU and ED tools [http://www.capc.org/ipal/](http://www.capc.org/ipal/)
- Move from Macro data on “readmissions” to profiling root causes with selected longer cases and readmissions (micro data)
- Plan for generalist training to build front line awareness and skills
- Use system resources to redesign processes of care for the seriously ill - create a “Custom Path”
Summary

- Results are best when “right patients” are identified proactively and early
- Services must be broadly and consistently available
- The payment environment is very conducive to palliative care contribution
- Impacting readmissions requires understanding root causes & rewiring services to be proactive, build relationship, and equip caregivers with “anticipatory confidence”....
Questions???
How well did this Learning activity meet the stated objectives?

1. Excellent
2. Good
3. Fair
4. Poor
5. N/A

1. Describe features of inpatient palliative care programs that enhance coordination & influence readmissions
2. Discuss strategies to align investment and expected impact
3. Identify strategies to leverage outpatient programs to impact avoidable readmissions
Evaluation Question #2

Amount of useful information and ideas provided:
1. Excellent
2. Good
3. Fair
4. Poor
5. N/A
Evaluation Question #3

Usefulness to my hospital of the information and ideas provided:

1. Excellent
2. Good
3. Fair
4. Poor
5. Not Applicable
Evaluation Question #4

Chance that the information and ideas provided will improve my effectiveness and results:

1. Excellent
2. Good
3. Fair
4. Poor
5. N/A
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