A Population Health Approach to Community-Based Palliative Care

Supportive Care Coalition Webinar

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Learning Objectives

- Describe design, implementation and outcomes of a population health community-based palliative care (CBPC) pilot project
- Discuss the predictive model used to identify candidates for the program
- Review lessons learned and key take-aways

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Designed to Address the Need for a New Care Paradigm

- Care is not congruent with people's wishes and is often aggressive even when the prognosis is poor
- Costs at the end of life are burdensome to patients, families, and society
- Care in the final months of life can be improved through the provision of better education, support, communication and coordination

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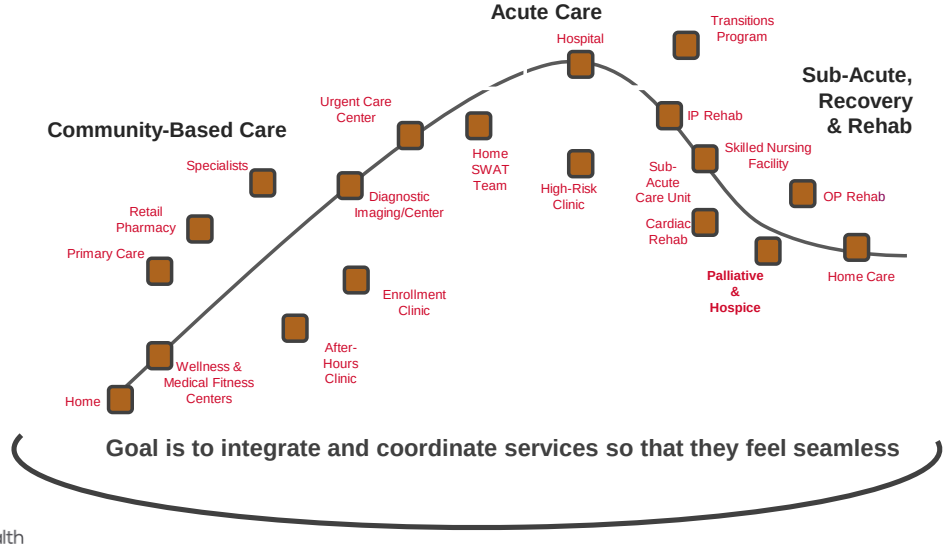
Caring Across the Continuum



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Population Health Approach to Advanced Illness Management

Project goal: to build a bridge to population and risk-based models that incentivizes high value care to support the transition to shared-risk and population-based models

"Prepared, engaged patients are a fundamental precursor to high quality care, lower costs and better health"

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The 2015 IOM Report, "Dying in America Improving Quality and Honoring Individual Preferences Near the End of Life"

Pilot Project Overview

1-year Trinity Innovation grant-funded demonstration to develop and test a new community-based advanced illness management (AIM) model

- Interdisciplinary team phone and home visit care management
- Sample- minimum of 150 seriously ill persons selected from a Medicare Advantage Plan using predictive analytics
  - 211 members enrolled
  - Location- Mount Carmel Palliative Care, Columbus OH
- Program timeframe- October 1, 2015-June 30, 2016 (9 mos.)

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Partnership with Turn-Key Health

Turn-Key Health is a national population health palliative care company who provided the following:

- Predictive analytics to identify health plan members for outreach and enrollment
- Engagement and communication strategies and support
- Structured clinical model with assessments and visit protocols
- Platform- clinical record, documentation, workflows and reporting
- Training and ongoing clinical support

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Project Innovations

- Data analytics used for patient selection
- Additional risk stratification methods to inform visit frequency
- Specialized web-based platform to promote care coordination, documentation and communication
- Standardized palliative care training, documentation, care protocols, and measurement
- Relationship with MA Plan to position for new value-based care models

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Measures of Success/Goals

- Engagement and enrollment benchmarks met
- Goals of care documented
- Satisfaction with symptoms
- Reduction in caregiver stress
- Patient and family satisfied with program
- Reduction of unplanned care (Emergency department visits and hospitalizations)
- Earlier adoption of the hospice benefit
- Lower cost of care

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Clinical Model Overview

Consultative Care Management Model

- Non-medical model staffed by palliative trained nurses and social workers employed by a hospice and palliative care organization
- Supported by structured phone and home visit assessments and protocols to develop one-to-one relationships with members and families
- Clinicians assess patient and family, develop plan of care, and organize the delivery of care
- Coordinate services with other providers based on the needs and goals of patient
- PC team does not write prescriptions, but recommend treatment and arrange for DME and/or referring to community services
- Serve as a liaison between patient, family, care team and health plan case managers
- Designed as an evidence-based scalable, cost effective model

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Core Components

- Care coordination
- Pain and symptom assessment
- Medication management/reconciliation
- Social support/caregiver support
- Facilitate communication and decision-making related to preferences for care and understanding of prognosis
- Assist with advance care planning (ACP)
- Provide referrals to community services and other agencies

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Pilot Project Staffing/Budget

Position	Position Description	FTE
Program Director	Administrative program oversight and supervisory support	.1
Nurse Navigator	Initial assessment, home visit and care plan support	2.0
Social Worker	Psychosocial assessment, support, advance care planning, and resource broker	1.5
Nurse Practitioner	Clinical consultation, Home visits, Care coordination	0.5
Physician	Oversight, consultation, IDT	0.25
Pharmacy Consultant	Pharmacist to conduct medication profile review	0.25
Turn-Key Health	Consultation, analytics, mobile palliative care platform	
Items	Laptops, phones for staff, call center technology, education, training	

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Training/Education

- Palliative care competency
- Goals of care / Respecting Choices Model ACP model
- On demand curriculum/webinars offered through CAPC
- Program policy & procedures
- Program guidelines/visit care pathways
- Software, clinical support tools, phone and home visit assessments, documentation and workflows
- Key program milestones/deliverables

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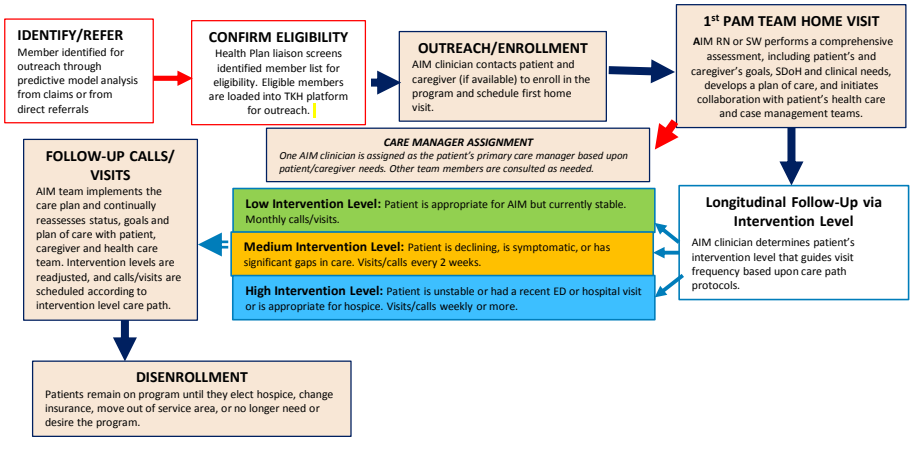
Clinical Model Workflow



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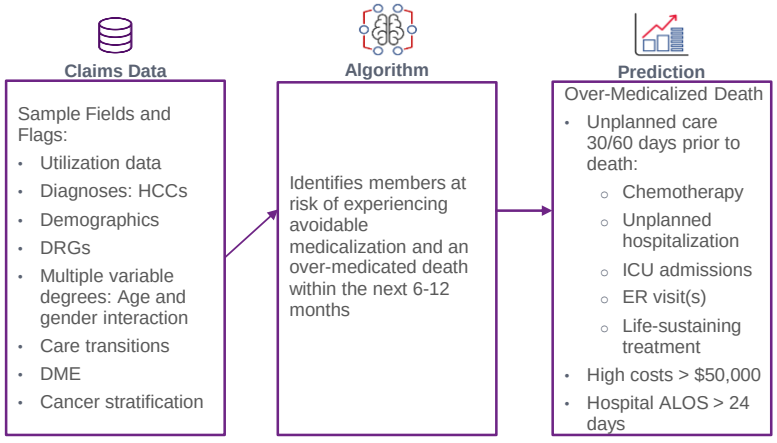
Patient Identification: Predictive Analytics



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Ongoing Patient Enrollment

We received monthly health plan claims to refresh and continuously identify and enroll members

- Payer provides member claims data
- TKH performs analysis and identifies members for the program
- Identified member file shared with Payer who sends introductory letter
- Members uploaded to the TKH platform for outreach and enrollment by clinical team

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Engagement & Communication Plan

To create program awareness and maximize enrollment

- Initial phone engagement strategies
- Introductory letters to members
- Education and promotion campaign provided to physician network, case managers, etc.
- Provider notification letter at member enrollment, including brief program description and contact information


Health Plan Logo Here

<Date>

<First Name> <Last Name>
<Address 1> <Address 2>
<City>, <State> <ZIP>

Dear <First Name>,

As a valued member, you have access to a new program that provides an extra layer of support for members and their families. Our (**Program Name**) program offers you an experienced care management team who will work with you to:

- Schedule home or phone visits with a nurse or social worker
- Coordinate care and appointments, especially if you see many doctors
- Address and manage pain and other symptoms
- Identify your unique needs to help you care for yourself at home

A nurse or social worker will be calling you in the coming weeks to explain how the (**Program Name**) can help you. You do not have to participate; we simply want you to know you have access to this new, free support program. Participating in the program will not affect your other healthcare benefits in any way.

If you would like to speak with a care manager sooner, please call 1-XXX-XXX-XXXX, 8 a.m. – 4:30 p.m., Monday through Friday.

We look forward to talking with you soon.

In good health,

<First and Last Name>
(**Program Name**) Care Manager
Registered Nurse

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Population Management Electronic Record

- Contains all patient information and captures all patient engagement activities including outreach, scheduling, assessment completion, care plan development and care coordination activities
- Assessments guide interactions and capture information to identify gaps in care and facilitate care planning and reporting
- Intervention levels inform care pathways/visit frequency
- Clinical dashboards highlight key metrics to prioritize tasks
- Real-time reporting facilitates member and program management

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Structured Palliative Assessments

- Medical and social history
- Key demographic and individual factors (race, language, communication barriers, etc.)
- Functional/ADL status
- Medication reconciliation
- Pain and symptom assessment
- Behavioral health screening
- Social support needs
- Social determinants of health (poverty, safety, health literacy, isolation, etc.)

- Veteran status
- Spiritual needs
- Home safety
- Disease-specific assessment/education
- Caregiver status
- Goals of care
- Advance care planning
- Physician engagement
- Access to care
- Acute care utilization/root cause analysis

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Follow-up Care Pathways

Low Intervention Level	Medium Intervention Level	High Intervention Level
Appropriate for program but currently stable	Declining health or functional status, symptomatic, or has significant care gaps or needs	Unstable, recent ED visit or hospitalization, or appropriate for hospice
• Symptoms controlled • Adequate medication adherence • Social support in place • Caregiver stress level low • High PCP engagement	• New or moderate symptoms • Medication adherence at risk • Low social support • Challenges related to SDOH • Caregiver stress level moderate • Missed PCP appointments	• Active/worsening symptoms • Medication non-adherence • Low social support or high SDOH needs • No caregiver or high caregiver stress • Recent ED visit/hospitalization • Meets hospice eligibility criteria
Clinician calls or visits monthly	**Clinician calls or visits every 2 weeks**	**Clinician calls or visits weekly and PRN**

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Patient Story

PB is an 88-year-old female with heart failure, arthritis, renal failure and glaucoma who lives alone. She experienced multiple falls, some resulting in ED visits and 2 hospitalizations for heart failure in the previous 6 months, largely due to poor medication adherence. She did not want to leave her home despite her failing health.

The nurse and social worker from the AIM team set up Meals on Wheels and monitored her weight, lung sounds, and pedal edema for signs of increasing heart failure. A neighbor agreed to fill her pill box weekly in between AIM team visits.

PB had no further ED or hospital admissions

3 months after enrolling in the AIM program and after a series of meetings with PB, she was admitted to hospice. She remained in hospice for 3 months before transferring to inpatient hospice care during her final two weeks of life.

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Key Pilot Program Outcomes

- Ability to identify and risk stratify population
- Patient engagement success
- Goals of care documentation
- Symptom status
- Medication reconciliation completion
- Patient care experience/program satisfaction
- Access to hospice and hospice LOS
- Hospital/ED use and cost of care

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Outreach and Engagement

- Called 701 of the top ranked members
- Successfully reached 82%
- Of those reached, 24% were not eligible due to a change in status
- 34% declined to participate in the initial call
- Of those who completed outreach (n= 241), 211 enrolled (net 56% engagement rate)

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Population Description

211 Members Enrolled

- 53% male
- 97% Caucasian
- 86% > age 80; (21% > age 90)
- 33% lived alone
- 87% PPS< 60; (49%< 50)

Primary Diagnosis

- CHF- 26%
- Pulmonary- 20%
- Coronary artery disease- 20%
- Other- 15%
- Cancer- 9%
- Dementia- 4%
- Neurological- 4%
- ESRD- 2%

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Timeframe: 9 months

Clinical Outcomes

Medication reconciliation performed	•97% (benchmark 95%) •73% of patients were on 8 or more medications
Goals of care documented	98% (benchmark 95%) 43% members changed code status
Satisfied with symptoms	98% satisfied (benchmark 80%)

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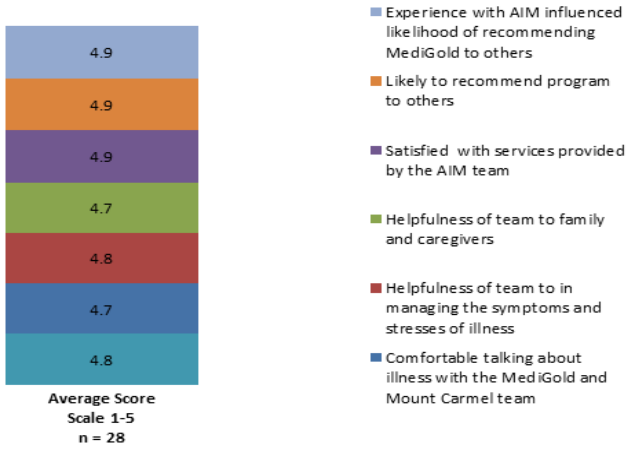
Patient/Family Satisfaction

Phone Survey responses from patients who had 3 or more visits



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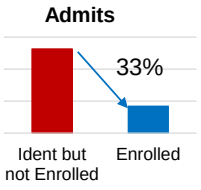
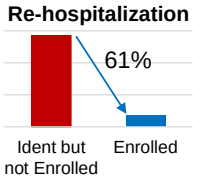
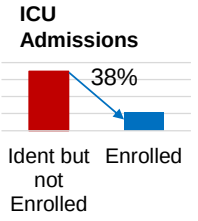
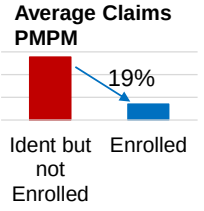
Utilization and Cost Outcomes

804 MA Patients (211 enrolled c/t 600 identified, but not enrolled who received standard health plan case management)









Overall, the study group had a **20% reduction in total medical costs** ($619 PMPM) with an estimated **total savings of $659,906** determined by multiplying the PPPM savings by the number of the study group's patient member months (n=1065).

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Hospice Length of Stay

	Baseline	Enrolled
Mean LOS	**49.7**	**51.5**
Median LOS	**12**	**52.1**

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Key Considerations

Be prepared to:

- Get a seat at the table if you plan to work with health systems; be part of the population health solution
- Describe the needs or problems your community palliative care program will address and how it differs from current case management or other population health programs
  - Plans, population health programs and specialized home care programs think they are already providing specialized palliative care
- Explain the ways in which your program is an innovative, disruptive or a breakthrough approach
  - Never assume that people know what palliative care is
- Explain how your program will integrate with current case management programs

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Key Considerations Cont'd

- Determine staffing mix and numbers
- Identify a target a population
- Engage participants and/or obtain referrals
- Measure the financial and non-financial benefits
  - Find an actuary who understands how to do this
- Develop a plan to overcome potential challenges that could delay implementation or impact the project
- Build it- can't just "add on" to existing Hospice or Home Care duties
- How will you sustain and replicate the model?

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Lessons Learned Resulting in Program Enhancements

- Predictive model refinements that include new interaction terms, oncology specific drugs, etc. for improved patient identification
- New platform for documentation, task tracking, workflow support and real-time patient dashboards
- Turn-Key Clinical Account Managers assigned to each team for training, clinical consultation and oversight
- Additional items such as SDOH screening questions added to assessments
- New policies and protocols to improve operational processes and attainment of clinical outcomes based upon best practice and evidence

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Discussion/Questions

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