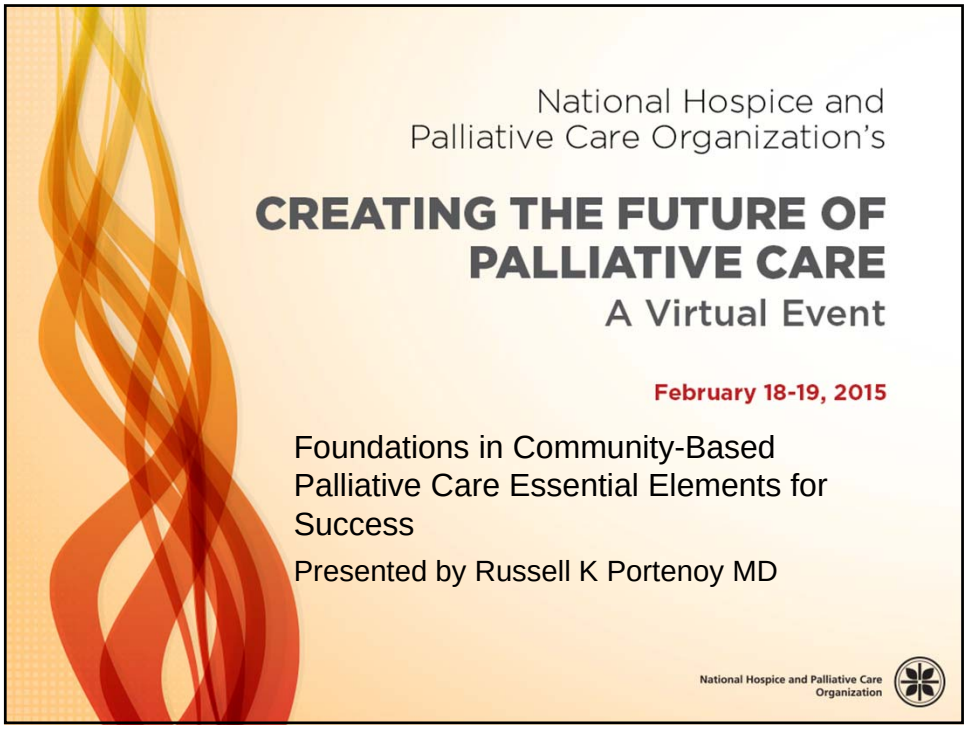


MJHS

Foundations in Community-Based Palliative Care Essential Elements for Success

Russell K Portenoy MD

Chief Medical Officer
MJHS Hospice and Palliative Care

Executive Director
MJHS Institute for Innovation in Palliative Care

Professor of Neurology
Albert Einstein College of Medicine

MJHS

Community-Based Palliative Care: Essential Elements for Success

- Developing consensus around key messages
  - Definition and objectives of palliative care
  - Value proposition for palliative care
- Issues in model building and sustainability

MJHS

Foundations in Community-Based Palliative Care

- Key messaging
  - What is palliative care?
  - What is specialist-level palliative care?
  - What is the value proposition for community-based palliative care?

Key Message: What is Palliative Care?

- An interdisciplinary therapeutic model appropriate for all populations with serious or life-threatening illnesses, **the goal of which is to prevent and manage suffering and illness burden for both patient and family from the time of diagnosis onward**

Key Message: What are the Core Objectives of Palliative Care?

- **Coordinate and implement interventions for physical, psychosocial and spiritual sources of distress or burden for the patient and family**
  - Multidimensional assessment → individualized care plan to reduce distress or burden
- **Engage in informed shared decision making about health care and related goals**
  - With consistent focus on individual preferences, culture and religion, and other sources of variation
  - With repeated goal setting and advance care planning

Key Message: What are the Core Objectives of Palliative Care

- **Coordinate care across providers and venues, and optimize access to specialized services, including hospice**
- **Expertly manage active dying and its aftermath**

Key Message: Expense Reduction is NOT An Objective

- Best practices are **not intended** to reduce the cost of disease-modifying care
- But this often occurs, and in aggregate, leads to savings for a payer
- **Business planning should project savings, BUT operational planning should not have workflows intended to reduce access to care**

Key Message: What is Specialist Palliative Care?

MJHS

- **Generalist-level palliative care**
  - Best practices of individuals or programs that may reduce patient/family burden, but are not implemented by specialists in palliative care
- **Specialist-level palliative care**
  - Best practices delivered by professionals with special competencies, demonstrated through documented training or certification
  - Includes multidimensional assessment and care
  - Includes interdisciplinary input or care

Specialist-Level Palliative Care: U.S. Models

MJHS

- Hospice
- Institution-based palliative care
- Community-based palliative care

Key Message: The US Has An Unique Version of Hospice

- The right 'hospice message' is part of key messaging about palliative care
- Hospice in the US is a health care system that can provide specialist-level palliative care for those with advanced illness
  - It **SHOULD BE DESCRIBED** as a government program, an federal entitlement, a low-cost managed care benefit, and a highly regulated industry
  - It **SHOULD NOT BE DESCRIBED** as a philosophy of care or a program of care for the dying

Key Message: Specialist Palliative Care Can be Distinguished

- Specialist-level palliative care is distinct from other types of supportive care
- Specialist-level care is likely to yield the best outcomes for a segment of the chronically-ill population
- Consensus view:
  - Specialist-level palliative care usually targets patients with advanced illness, who with their families manifest high distress, complex needs, and high health care utilization
  - The "sickest of the sick"

MJHS

Key Message: Specialist Palliative Care Can be Distinguished

- Challenges
  - Current consensus is not evidence-based
  - Focus on advanced illness and short life expectancy may also reflect the bias that palliative care is end-of-life care
  - Ability to identify the 'right patients' and 'defend' this model against competitor models requires demonstrating the value proposition for palliative care

MJHS

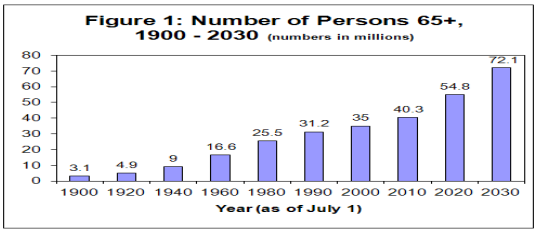
What is the Value Proposition for Specialist-Level Palliative Care?

- Key message
  - Palliative care can improve quality outcomes in the growing population with serious chronic illness
  - Palliative care can reduce aggregate cost for health care payers and the health system overall

What is the Value Proposition for Specialist-Level Palliative Care?

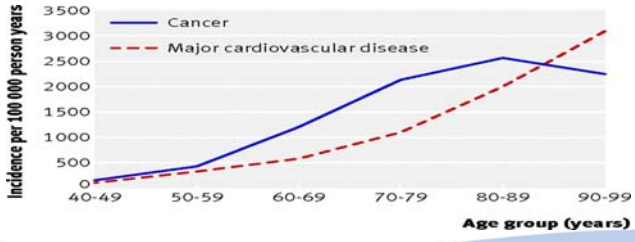
- Key message now supported by
  - Some data, including some high quality evidence
    - Most from institutions; some from community programs
  - Inferences based on population trends and current problems in the health care system

Population Trends: Rising Illness Burden With Age



US Admin on Aging, DHHS

>90% of deaths from chronic illnesses



Driver A et al., BMJ 2008,337,a2467

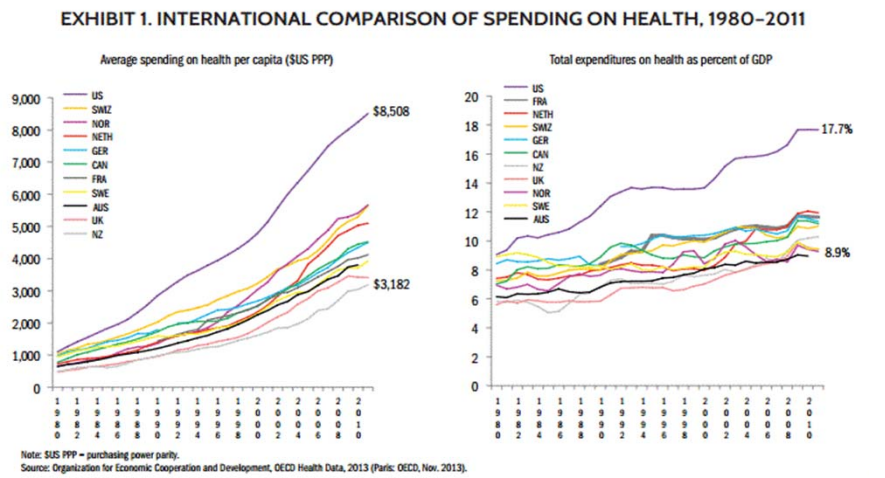
High Illness Burden In Chronic Illness

- Numerous studies in diverse populations
- High rates of distress from
  - Poorly controlled symptoms
  - Psychosocial and spiritual disturbances
  - Concrete needs in the home
  - Confusion in communication, decision making, goal setting
  - Caregiver burden and financial stress
  - Lack of preparation and support during active dying

Problems in the Health Care System

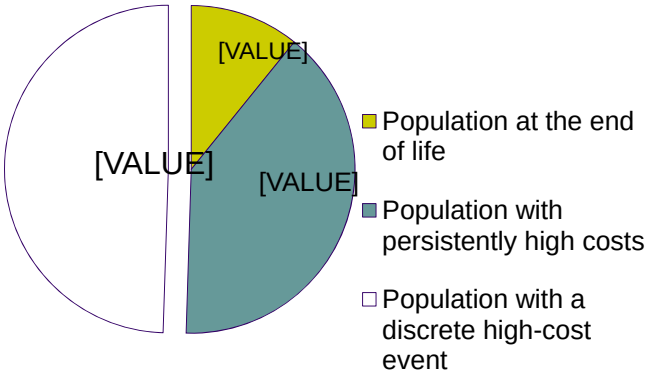
- In addition to high illness burden, care for the chronically ill is challenged by
  - Fragmentation and variation in practice
  - Disparities in access and insurance
  - Misaligned incentives for providers of care
  - Excessive cost and waste

Problem: Excessive Cost



5% of Medicare Patients = 50% of Medicare Spend

Half of the 50% is for the chronically ill



Source: Aldridge, Kelley, 2013: IOM Commissioned Paper: Epidemiology of Serious Illness and High Utilization of Healthcare

Problem: Much Health Care Spending is Unnecessary

- 2012 IOM Report: About 30% of health care expense in the US (>$750 billion/yr) is "unnecessary"
  - $210 billion in unnecessary services
  - $130 billion in services delivered inefficiently
  - $190 billion in excess administrative expenses
  - $105 billion in excessive prices
  - $75 billion in fraud
  - $55 billion in missed opportunities for prevention

Institute of Medicine, 2012

What is the Value Proposition for Specialist-Level Palliative Care?

- Key message
  - These trends—growing illness burden, high cost and unnecessary care—can be attenuated by specialist palliative care
  - There is growing evidence in support

Most Evidence Is From Institution-Based Programs

- Studies have limitations but suggest that access to palliative care specialists improves
  - Pain and symptom distress
  - Quality of life, satisfaction
  - Communication and decision making
  - Caregiver burden

El-Jawahri et al., J Support Oncol 2011;9:87-94; Ciemins E, et al.,JPM 2007;10:1347-1354: Hanson LC, et al., JPSM 2008;35:340-346; Gade G, et al., JPM 2008;11:180-190; Dy SM, et al., Evid Rep Technol Assess (Full Report),

Community-Based Specialist-Level Palliative Care

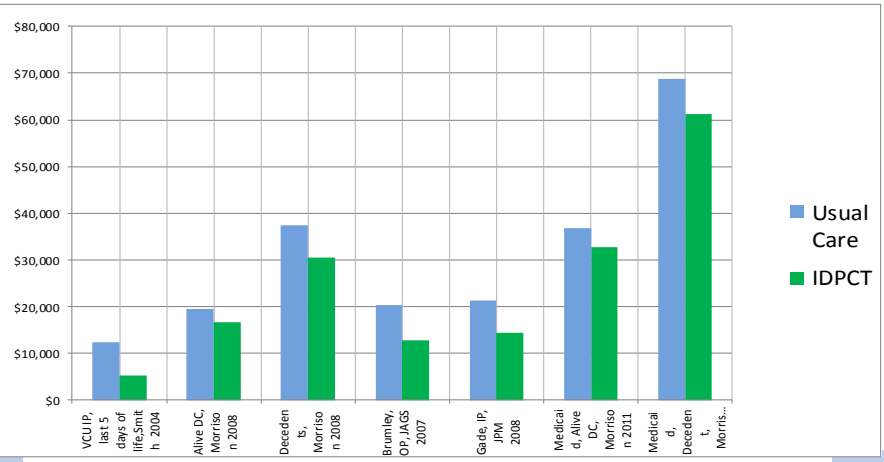
- Studies are still limited but also suggest improved clinical outcomes
  - Systematic review of 23 controlled studies of home-based palliative care
    - Higher likelihood of dying at home
    - Less symptom burden

Gomes et al, Cochrane Database Syst Rev. 2013Jun 6;6:CD007760

Cost Avoidance from Inpatient Palliative Care

MJHS

Studies Evaluating Cost Compared to Controls



Brumley et al, JAGS, 2007:55: 993-1000; Hughes MT, Smith TJ. The growth of palliative care in the United States. Annu Rev Public Health. 2014 Mar 18;35:459-75.

Cost Avoidance from Community-Based Palliative Care

MJHS

- Kaiser Permanente randomized trial of community-based interdisciplinary home-based palliative care program
  - Net mean savings of about $7000 per patient over 3 months ($95.30 vs. $212.80 per day, p=0.02)
  - Equal survival and better quality of care and communication among those receiving palliative care

Brumley et al, JAGS, 2007:55: 993-1000
Hughes MT, Smith TJ. The growth of palliative care in the United States. Annu Rev Public Health. 2014 Mar 18;35:459-75.

Cost Avoidance from Community-Based Palliative Care

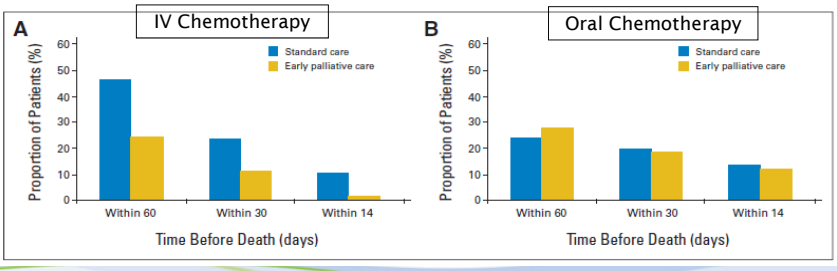
MJHS

- Highmark's Advanced Illness Service program
  - Medicare Advantage plan paying palliative care providers for up to 10 visits, with other services
  - Outcomes since 2011
    - 14% decline in acute care admissions in the last 6 months
    - 33% decline in acute care admissions in the last month of life
    - 30% decline in ICU admissions in the last 6 months of life
    - 48% decline in ICU admissions in the last month of life
    - 39% decline in ER visits in the last month of life

Cost Avoidance From Other Specialist Models

MJHS

- Randomized controlled trial of ambulatory specialist palliative care (N=151)
  - Patients with metastatic lung cancer received *either* usual care plus palliative care referral *or* usual care alone



Greer, JCO 30 (4) 2012, Temel JS. *N Engl J Med* 2010;363:733-42

Cost Avoidance From Other Models

MJHS

- Aetna's Compassionate Care Program
  - Hospice enrollment doubled 31% to 72%
  - 81% decrease in acute hospital days
  - 86% decrease in ICU days
  - High member and family satisfaction
  - Total cost reduction of more than $12K per member
  - Overall >22% savings in last 40 days of life

Krakauer R et all, Health Affairs, 2011; Spettell CM et al, JPM 2009;12: 827-832

Does Interdisciplinary Care Have Better Outcomes?

MJHS

- 200 patients in the Kaiser Permanente system referred to community PCS
  - First 100 seen solely by a palliative care RN
  - Second 100 seen by an interdisciplinary team
- Readmissions per patient six months after initial consultation dropped by half
  - 1.15 for RN consultation (probability 73%)
  - 0.7 for team consultation (probability 33%) (p=0.025)

Nelson C, et al. Perm J 2011 Spring;15(2):48-51

Specialist Palliative Care: Models and Sustainability

- The value proposition for specialist-level palliative care is well established for institution-based palliative care
  - Hospitals will support the cost because of a favorable impact on quality outcomes and cost at a time of steady shifting to value-based purchasing

Specialist Palliative Care: Models and Sustainability

- The value proposition for community-based care is less established and systems of care are only now emerging
- Work is needed to establish various models and confirm their sustainability in the changing health care system

Community-Based Palliative Care: Essential Considerations

MJHS

- Development of community-based palliative care requires that providers
  - Create care models that are feasible and meet the needs of patients and payers
  - Create models that are distinguished by professional expertise and other elements

Community-Based Palliative Care: Essential Considerations

MJHS

- Varied models
  - Administered through hospice agencies, home care companies, or hospital systems
  - Medical provider-led, nurse-led, or other models
  - Programs in specific venues, e.g. Emergency Dept's or other venues
  - Programs for special populations, e.g. pediatrics
  - Programs for specific diseases, e.g., CHF

Community-Based Palliative Care: Essential Considerations

- Development of community-based palliative care requires that providers
  - Understand the populations to be served so that models can target needs
  - Develop the model-specific process metrics and quality outcome metrics that can track implementation and its effects on patients and families

Community-Based Palliative Care: Essential Considerations

- Development of community-based palliative care requires that providers
  - Become prepared to help payers identify the target population using data mining or other approaches
    - Defining illnesses
    - Hospitalization and ED visit rate
    - Pharmaceutical spend
    - Clinical indicators, e.g. critical weight loss or the “surprise question”

Community-Based Palliative Care: Essential Considerations

MJHS

- Development of community-based palliative care requires that providers
  - Understand the financial imperatives of potential payers
    - Health care reform is shifting to population health management, value-based purchasing and shared risk
    - Payers—government and commercial MCOs, ACOs, PCMHs, Health Homes, others—are increasingly interested in cost reduction focused on the very ill segment of the chronically-ill population

Community-Based Palliative Care: Essential Considerations

MJHS

- Development of community-based palliative care requires that providers
  - Become prepared to propose pilot approaches with defined endpoints
    - Quality outcomes, e.g., symptom control and advance care planning
    - Quality ratings
    - Claims data for total expenditure, hospitalizations, ED visits, pharmaceutical spend, medical loss ratio
    - Hospice admissions

Community-Based Palliative Care: Essential Considerations

- Development of community-based palliative care requires that providers
  - Become prepared to explore various models of reimbursement
    - Enhanced fee for service
    - Fee for service plus administration charge
    - Capitation
    - Pay-for-performance or shared risk models applied to capitation or enhanced fee-for-service

An Example: Palliative Care Program of MJHS Hospice and Palliative Care

- MJHS
  - Largest not-for-profit provider in New York
  - 15 business units including
    - MJHS Hospice and Palliative Care
    - MJHS Institute for Innovation in Palliative Care
  - MJHS Hospice daily census about 820
  - MJHS Palliative Care daily census about 500

MJHS Hospice and Palliative Care: Five Models of Palliative Care

- Interdisciplinary, “High-Touch” Community Model
- Acute Palliative Care Community Initiative
- Early Intervention Nursing Home Model
- Pediatric Palliative Care and Hospice Model
- Hospital Consultation Model

MJHS Hospice and Palliative Care: Interdisciplinary “High-Touch” Model

- Model
  - Capitated program
  - Referral criteria developed with payers identifies the sickest patients
  - Consultation model, working with PCP and case managers
  - Each patient undergoes initial comprehensive assessment by a physician or nurse practitioner

MJHS Hospice and Palliative Care: Interdisciplinary "High-Touch" Model

- Model
  - Patient assigned to an interdisciplinary team including a physician or nurse practitioner, a social worker and a nurse clinical specialist
  - Plan of care includes
    - Home visits by MD, NP and/or LCSW
    - Telephonic care management by RN
    - 24/7 telephone on-call
    - Assistance with prescription medications if needed
    - Coordination with primary physician and case manager
    - Eligibility review to facilitate referral to hospice

MJHS Hospice and Palliative Care: Interdisciplinary "High-Touch" Model

- Model initiated in 2010
- More than 1700 patients served
- Overall 22% admitted to hospice

		Per Patient Per Month	
Type of Service Provided	Total	Mean (SD)	Median
NP/MD home visits	10,125	1.6 (3.4)	0.72
Social worker visits	4,992	0.74 (1.2)	0.4
Outgoing RN telephone calls	25,920	4.3 (10.9)	1.9
Outgoing social worker telephone calls	5,750	1.0 (2.0)	0.5
Incoming telephone calls	2,718	0.8 (2.6)	0.2

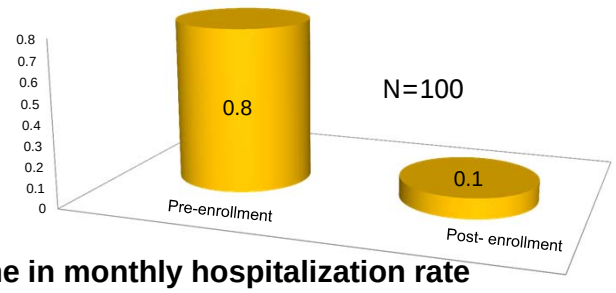
MJHS Hospice and Palliative Care: Interdisciplinary, "High-Touch" Model

- Year 1 results for contract #1
  - Patients receiving >1 visit per month: 33%
  - Patients not receiving monthly visits: 20%
  - Patients utilizing 24 hour on-call services: 46%
  - Patients who were "no-show" for visit: 8%
  - Patients who "refused visits": 21%

MJHS Hospice and Palliative Care: Interdisciplinary, "High-Touch" Model

- Year 1 results for contract #1
  - Analysis of hospitalization rate on purposive sample of N=100 with multiple hospitalizations prior to enrollment
  - Compared 6 months pre-enrollment with 6 months post-enrollment

MJHS Hospice and Palliative Care: Interdisciplinary, "High-Touch" Model



Decline in monthly hospitalization rate From pre- to post- enrollment: 87.5%*

*Data based on review of MJHS Hospice and Palliative Care records.

MJHS Hospice and Palliative Care: Community-Based Programs

- 2014 results from Press Ganey survey (N=118)
  - Likelihood to recommend: mean 89/100
  - Overall rating of care received: mean 89/100

Foundations in Community-Base Palliative Care

- Conclusions
  - The success of community-based palliative care in the changing health care system depends on many factors
  - Some of these factors will be strongly influenced by the response of the palliative care provider community

Foundations in Community-Based Palliative Care

- Conclusions
  - The provider community will need to articulate key messages
    - More clarity about the definition and objectives of specialist-level palliative care in diverse community contexts
    - More clarity about the importance and role of hospice
    - More specificity about the value proposition for specialist-level palliative care

Foundations in Community-Based Palliative Care

MJHS

- Conclusions
  - The provider community will need flexibility in
    - Building various models of care that address specific needs of patients and payers
    - Creating and evaluating various pricing and reimbursement models

Foundations in Community-Based Palliative Care

MJHS

- Conclusions
  - The provider community will need to improve data acquisition and analytics
    - About implementation processes and expected quality outcomes
    - Analytics that benchmark quality and financial outcomes, including hospice admissions
    - Skills in proposing pilots that provide data related to clinical and financial outcomes