Population Health and Palliative Care: A Natural and Synergistic Partnership

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Objectives

1) Describe value based care and population health in the context of serious illness.

2) Identify the strategies that effectively meet the needs of patients with serious advanced illness.

3) Describe approaches for enhancing care for people with complex care needs and measuring effectiveness of these approaches.

4) Identify tools for effecting change in your local environment.

A story you know…

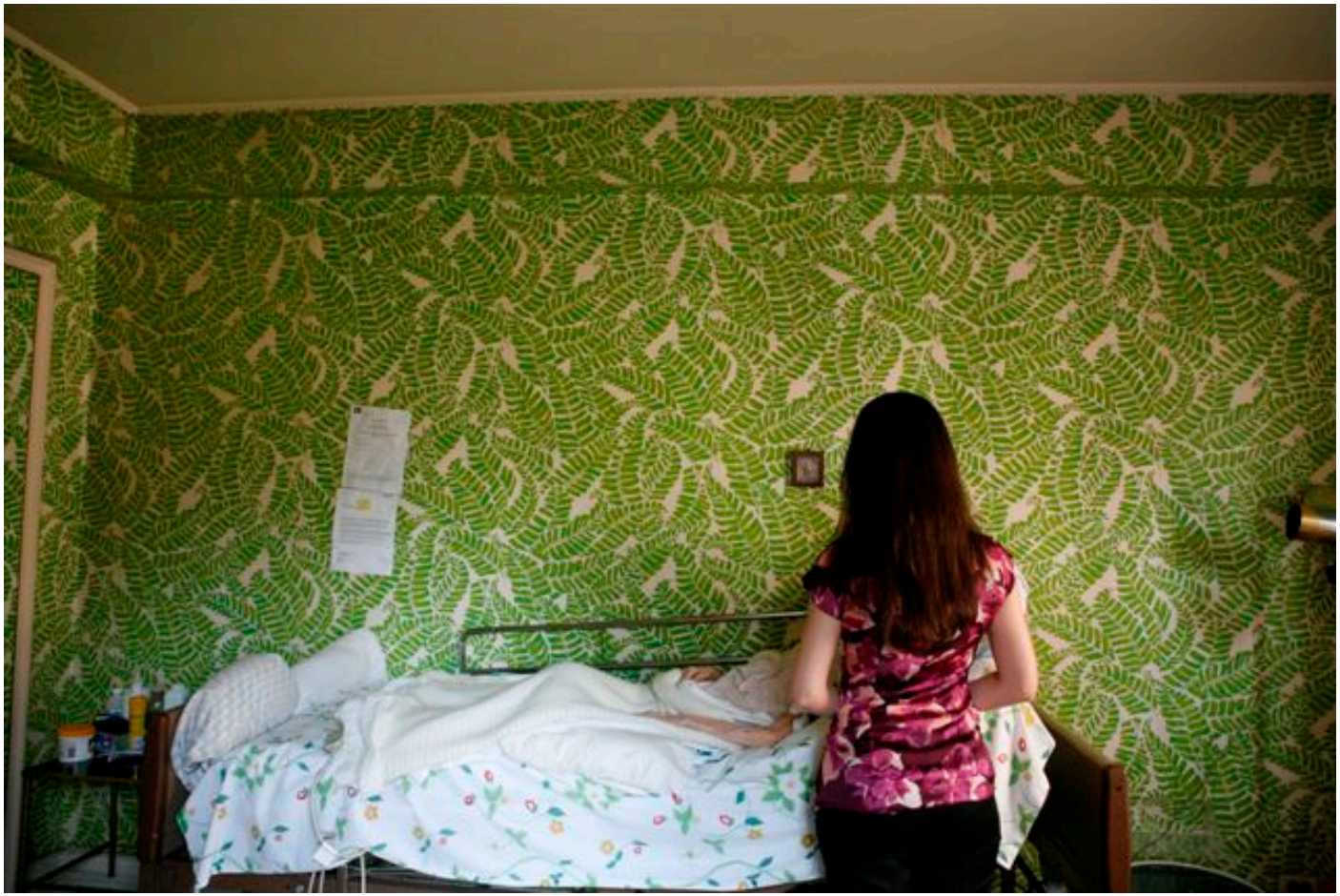


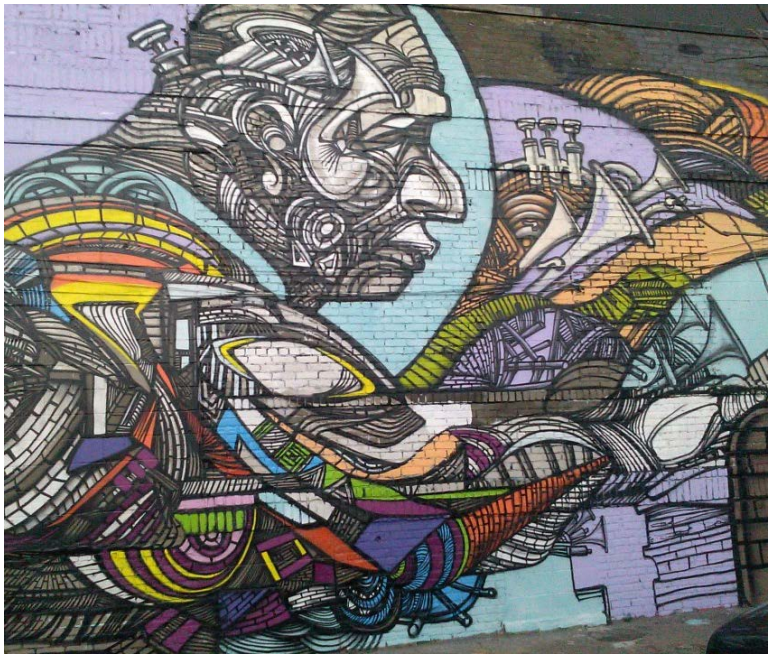
Photo courtesy A Blohm

Growth of Chronic Serious Illness

- 90 million Americans are living with serious illness
- This number will double over the next 25 years.
- 1/5 of all Medicare beneficiaries have 5 or more chronic conditions

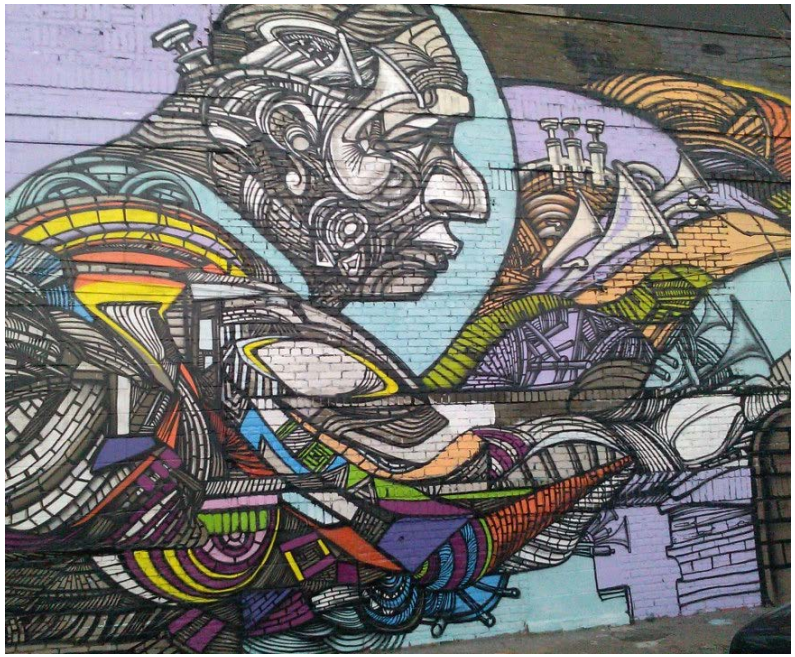
Implications of Chronic Serious Illness

- -Longer survival with advanced disease
- -High illness and symptom burden
- -Management complexity increased

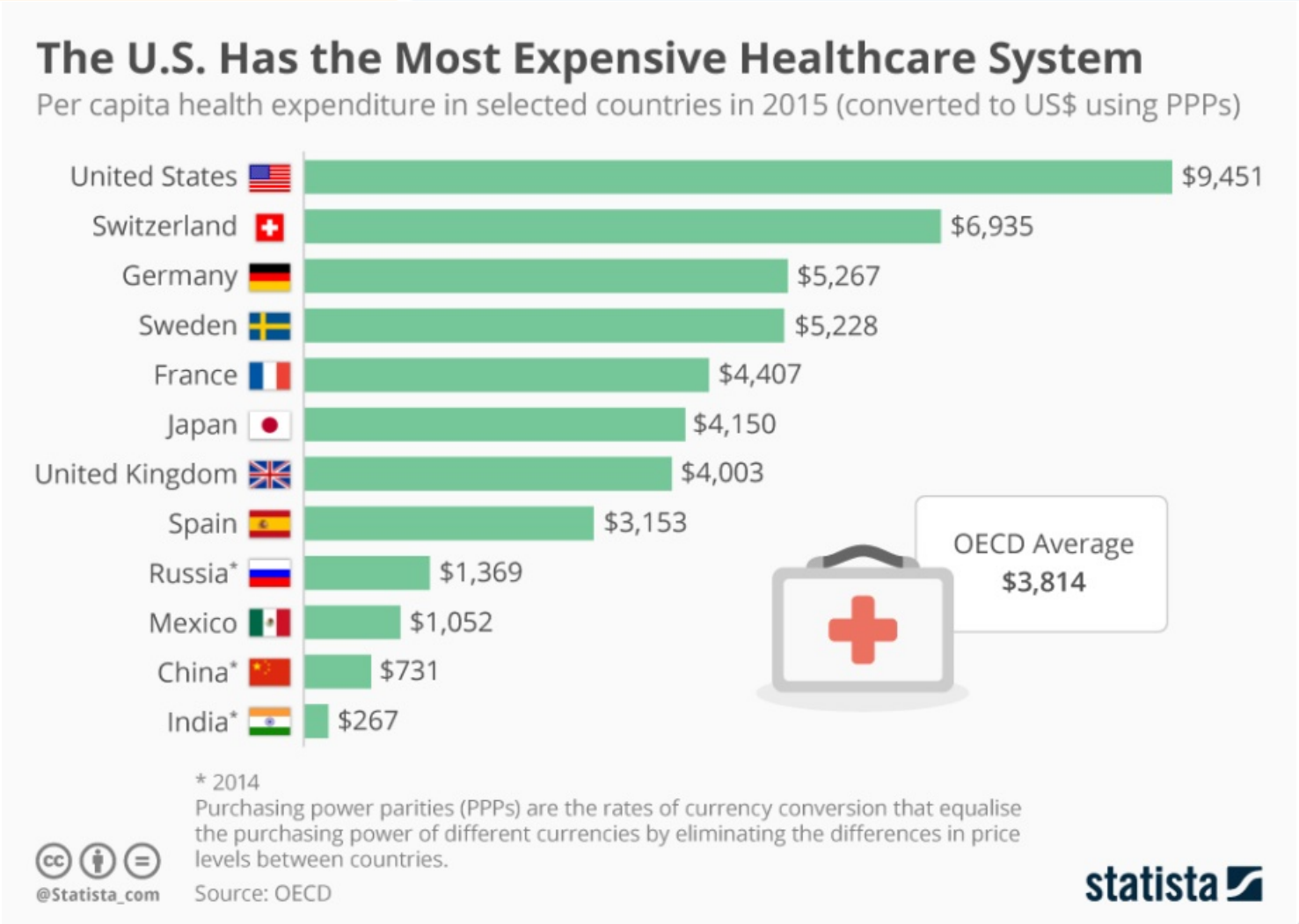


Management complexity leads to…

- Ongoing financial stressors from serious illness
- Multiple providers
- Dynamic goals and treatment preferences
- Conflicting/interacting treatment regimens



US Healthcare: High Cost



US Healthcare: Low Value

N.Y. / REGION

Fighting to Honor a Father's Last Wish: To Die at Home

By NINA BERNSTEIN SEPT. 25, 2014

Maureen Stefanides at NewYork-Presbyterian Hospital with her father, Joseph Andrey, waiting to move to a nursing home despite their efforts to arrange for 24-hour care at his apartment.

Victor J. Blue for The New York Times

“Value” in healthcare

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

$$\text{Quality} = \text{Access} \times \text{Outcomes} \times \text{Satisfaction}$$

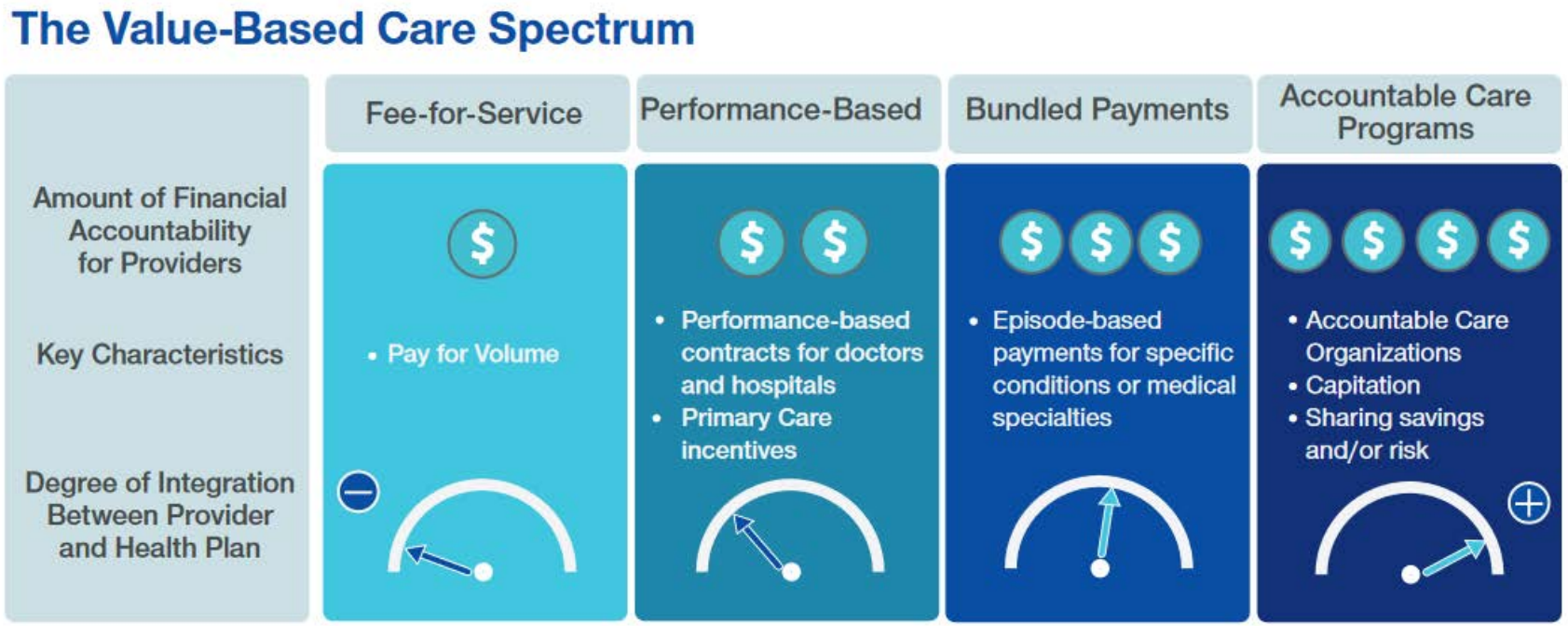
(Patient, Provider, Payer)

$$\text{Cost} = \frac{\text{Total Cost of Care (Entity)}}{\text{Volume}}$$

Value: From here to there….

Volume Based	Value Based
Payment: Fee-for-Service	**Payment**: Outcomes/cost based
Providers reimbursed for the **number** of things (e.g., lab tests, x-rays, procedures, etc.)	Providers reimbursed on the **outcomes** of things (i.e., was patient readmitted within 30 days? Did patient condition improve following intervention?)
Incentives: Do as much as possible to maximize reimbursement	**Incentives**: Do what is appropriate to optimize health and well-being
Focus: Individual patient episode that provides systems and practices with the greatest revenue	**Focus**: Outcomes across continuum of care with the lowest/most appropriate cost
Role of Provider: Siloed and not coordinated	**Role of Provider**: Team-based across care continuum

Value-based Care



https://www.uhc.com/content/dam/uhcdotcom/en/ValueBasedCare/PDFs/VBC-Spectrum-Infographic.pdf

Implications

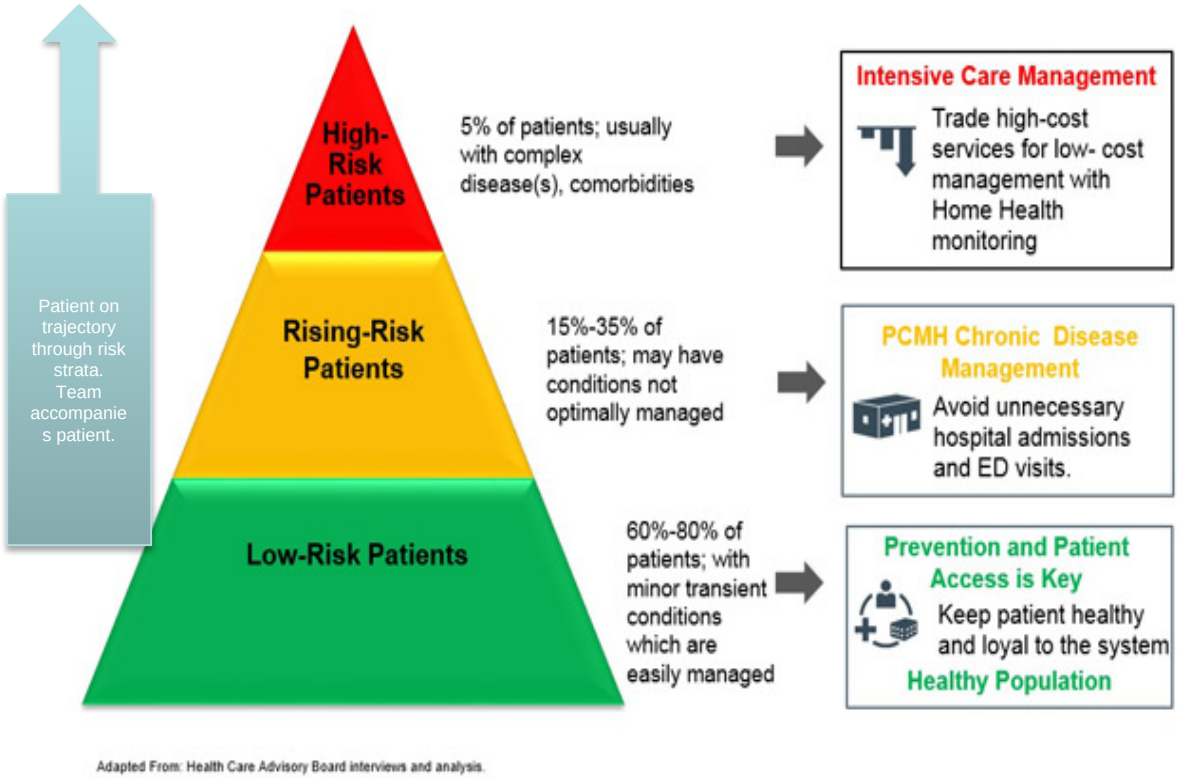
Past	Present
Treating Sickness / Episodic	Managing Populations
Fragmented Care	Collaborative Care
Specialty Driven	Primary Care Driven
Isolated Patient Files	Integrated Electronic Records
Fee for Service	Shared Risk/Reward
Payment for Volume	Payment for Value
Adversarial Payer-Provider Relations	Cooperative Payer-Provider Relations
"Everyone For Themselves"	Joint Contracting

Some definitions

Population health: The health outcomes of a group of individuals, including the distribution of such outcomes within the group

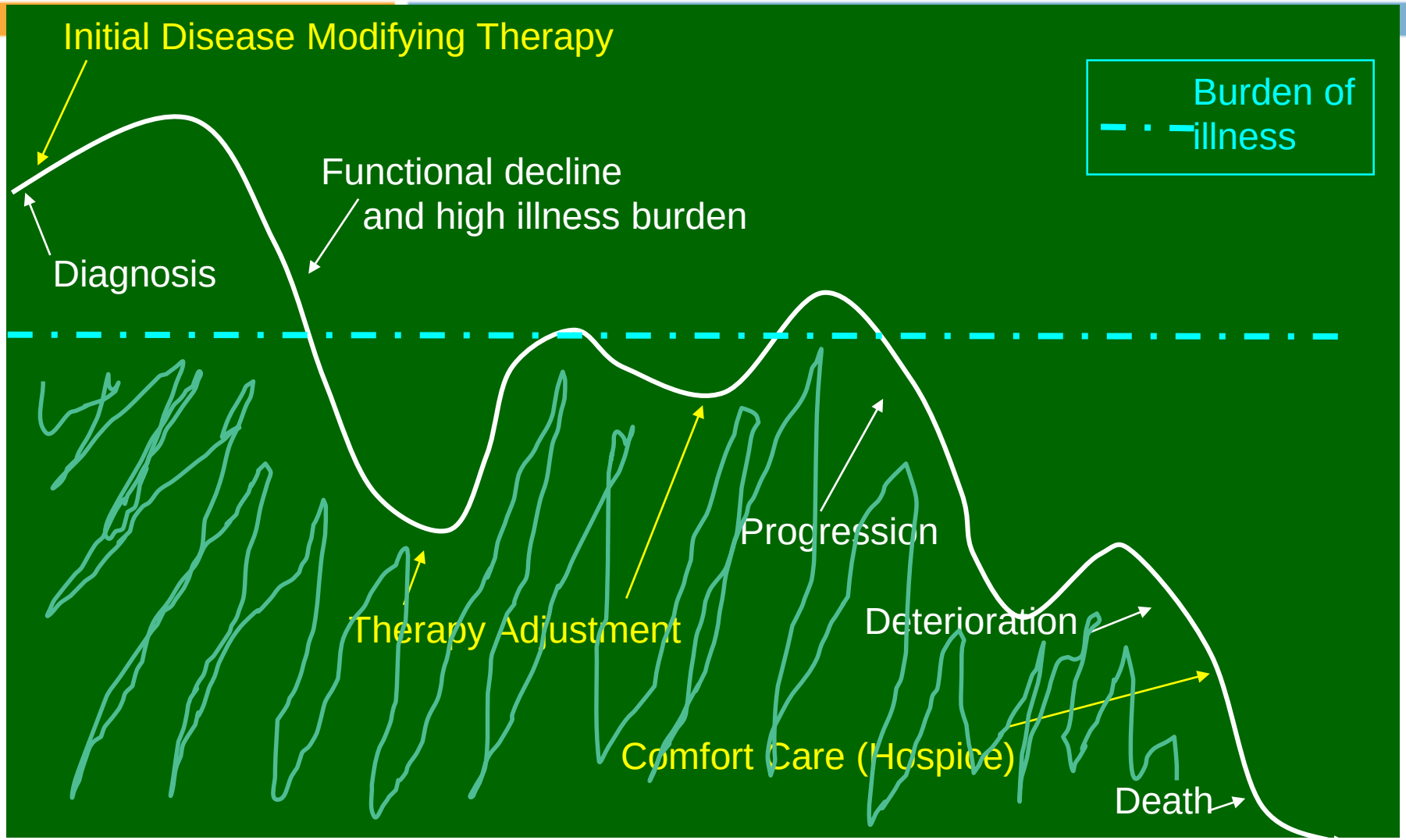
Population health management: Proactive and comprehensive interventions to help improve morbidity patterns and health outcomes of a defined population

Overall approach in population health



Adapted From: Health Care Advisory Board interviews and analysis.

Palliative Care and Complex Serious Illness



Palliative Care and Patient/Caregiver Satisfaction

Mortality follow back survey

palliative care vs. usual care (N=538 family survivors)

Palliative care superior for:

- emotional/spiritual support
- information/communication
- pain
- access to services in community
- care at time of death
- well-being/dignity
- care + setting concordant with patient preference
- PTSD symptoms

Teno J et al. J Am Geriatr Soc. 2011 Aug; 59(8): 1531–1536

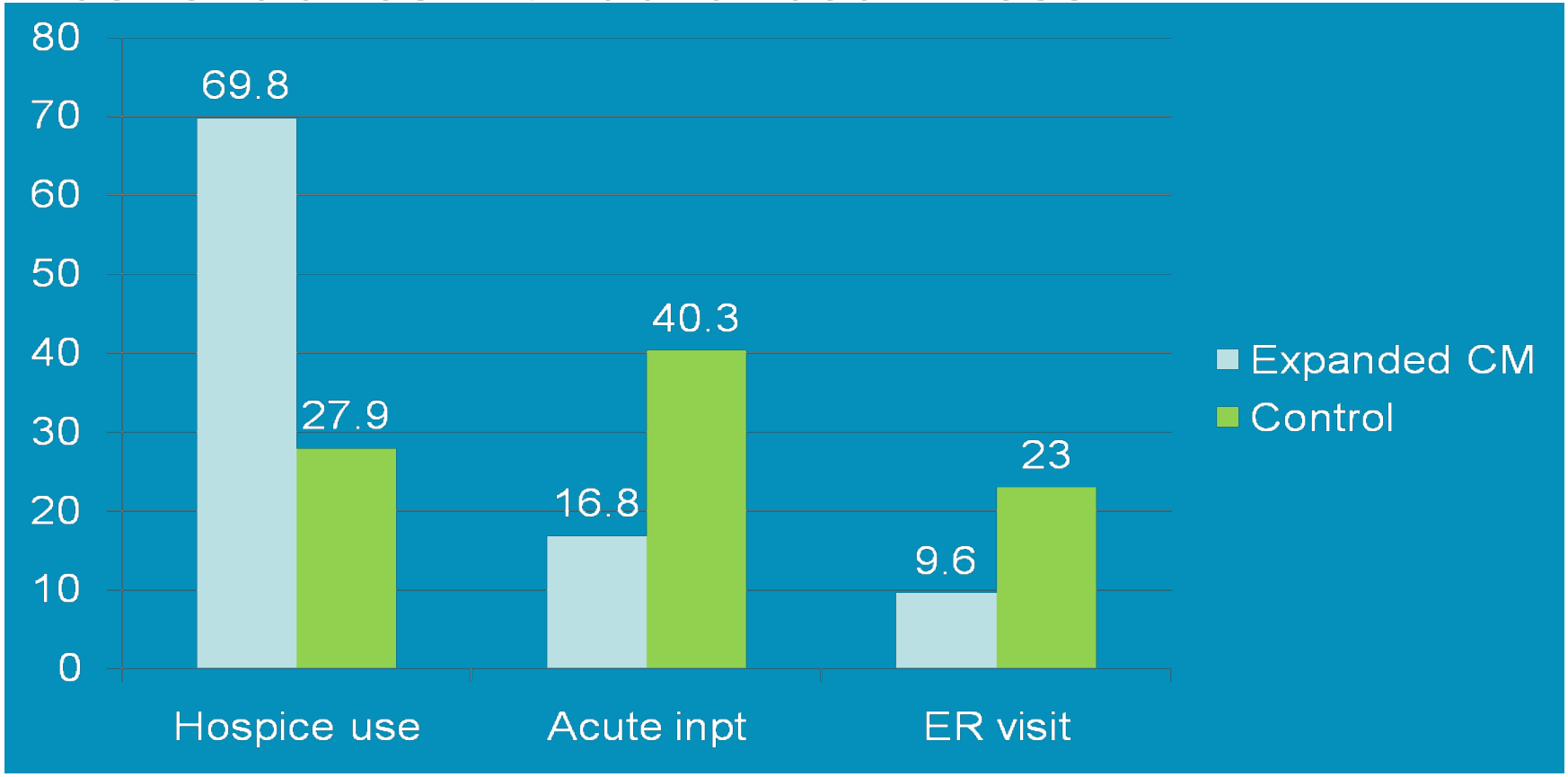
Palliative Care & Quality

- Prospective multicenter study of 332 seriously ill cancer patients
- Recall of occurrence of a prognostic/goals conversation was associated with:
  - Better quality of dying and death
  - Lower risk of complicated grief + bereavement
  - Lower costs of care
  - Less ‘aggressive’ care

Zhang et al. Arch Int Med 2009;169:480-8.
Wright et al. JAMA 2008;300:1665-73.

Palliative Care and Healthcare Utilization

"Expanded" hospice/CM services to 387 Aetna beneficiaries with advanced illness



Spettel et al. J Palliat Med. 2009 Sep;12(9):827-32

Person and Family Centered Care Strategies

- Ongoing risk identification stratification
- Triggers to increase interaction, frequency and intensity, with patients
- Promotion of wellness, function and QoL
- Development of relationship with patients and their support system
- Understanding needs of partners (IPCM, providers)
- Regular attention to informed choice and decision making
  - Best Case/ Worst Case
  - One size does not fit all
- Approaching care goals and preferences before patient is high risk
- Revisiting goals of care discussions at regular intervals

Care Management and Palliative Care

- Understanding range of Palliative Care capabilities
  - Simplest symptom management
  - Complex end of life care symptom management and support
- Assuring basic Palliative Care competency within Care Management work force
- Reasonable triggers for referral
- Early engagement for symptoms to both manage symptoms and promote relationship building and trust
- Increased direction from specialty Palliative Care as patient progresses
- Continued use of informed choice

Putting it together for the patient: Proactive Integrated Palliative Care Approach

ED use vs PCMH/PCP use

- Understanding symptoms
- Understanding options
- Rehearsal

Hospitalization

- Utilization of ICU
- LOS
- Disposition decisions
- Have discussions “before we need to”

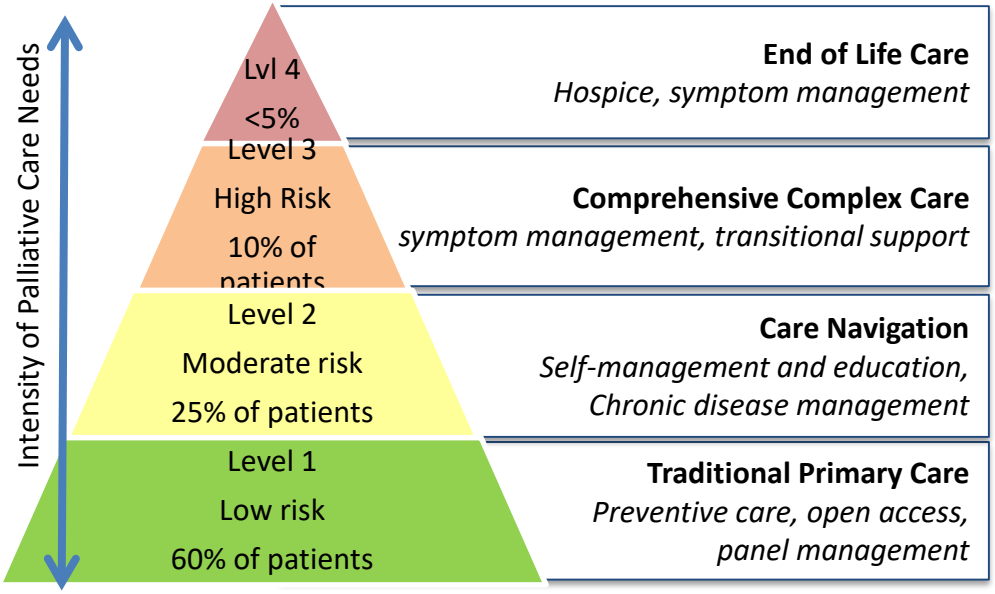
Adoption of Hospice benefit

- Early and non-emotional introduction of benefit and offerings
- ALOS in hospice for population

Utilization of Advance Directives

- POLST/MOLST
- Out of hospital DNR
- In hospital DNR/DNI, no ICU
- Organ Donation

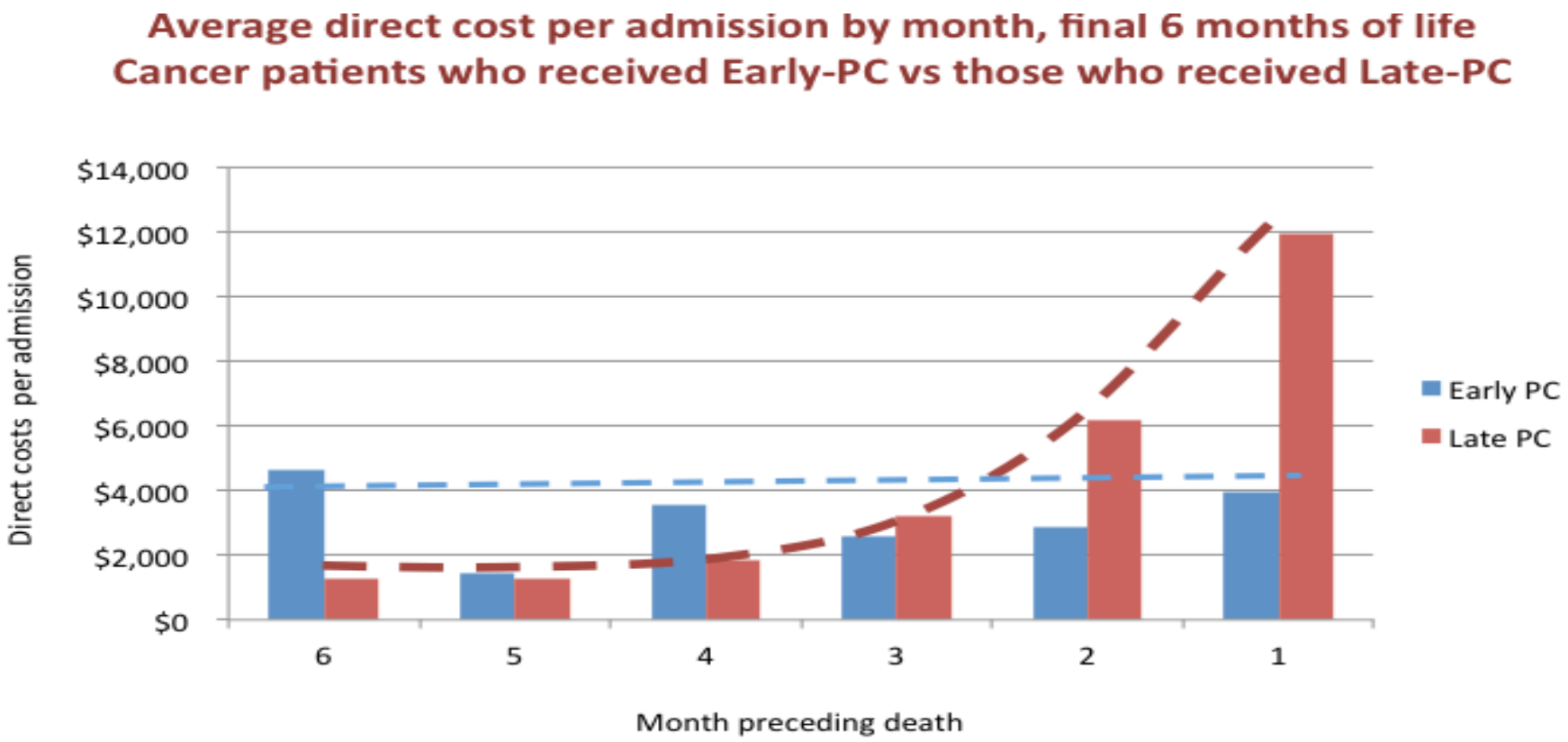
Population Health, Care Levels and Palliative Care



Advance Care Planning
Goal Setting
Symptom/well-being Support
Caregiver Support
PCP Support
Primary/Specialty Palliative Car

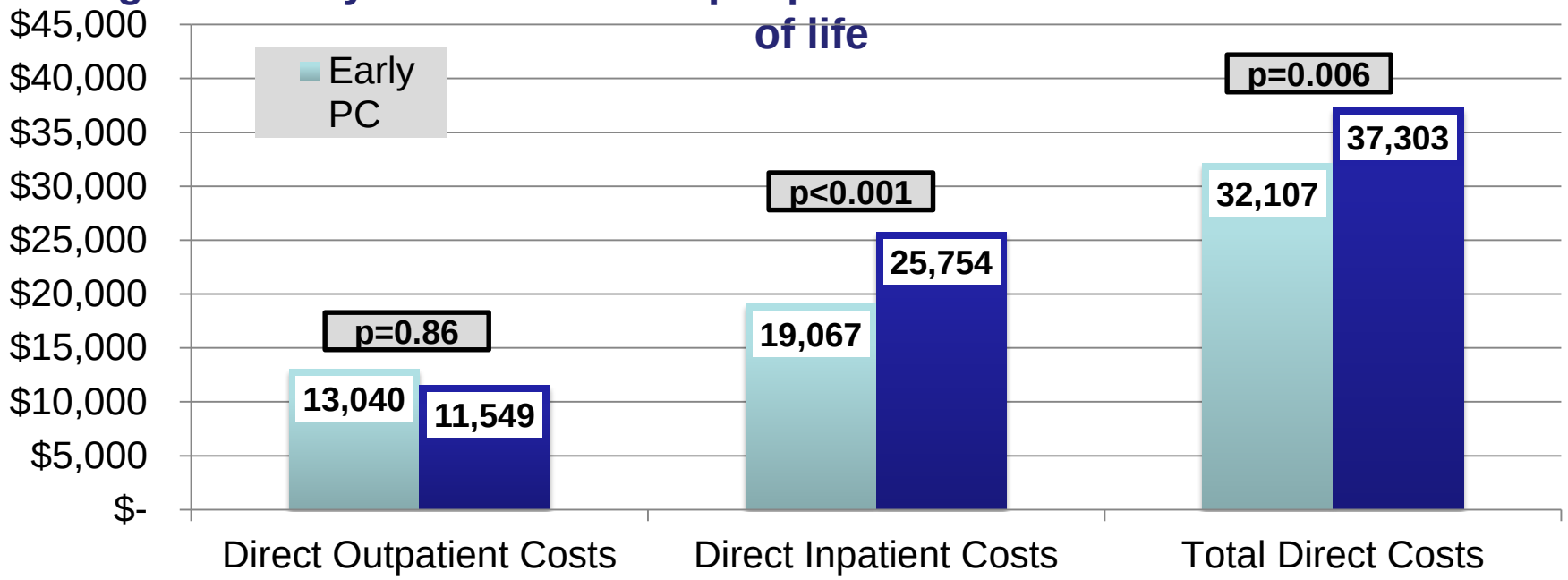
Advance Care Planning
Goal Setting
Primary Palliative Care

Level 2-3:
CbPalC in Outpatient Cancer Care



Level 2-3:
CbPalC in Outpatient Cancer Care

Average health system direct cost per patient for medical care in final 6 months of life



**Early PC = first contact with specialty service >90 days prior to death*

Scibetta C, Kerr K, Mcguire J, Rabow MW. *The Costs of Waiting: Implications of the Timing of Palliative Care Consultation among a Cohort of Decedents at a Comprehensive Cancer Center*. J Palliat Med. 2016 Jan;19(1):69-75.

Level 3-4:
The California BS Global Budget Pilot Project

- Pilot ACO in Sacramento area for 41,000 California Public Employees' Retirement System (CalPERS) employees/dependents enrolled in a Blue Shield HMO
- Focused review of the 5,000 patients accounting for 75 percent of total health care costs

Markovich P. HEALTH AFFAIRS. Sept 2012; 31: 1969–1976

Level 3-4:
The California BS Global Budget Pilot Project

- Coordinate pre- and postdischarge planning processes to avoid delays and readmissions
- Personalize care and disease management
- **Develop a comprehensive palliative care program across hospital, physicians, and care managers to engage patients and their families in end-of-life decisions**
- **Implement home-based medical care for high-risk, frail, elderly patients to improve their quality of life**

Markovich P. HEALTH AFFAIRS. Sept 2012; 31: 1969–1976

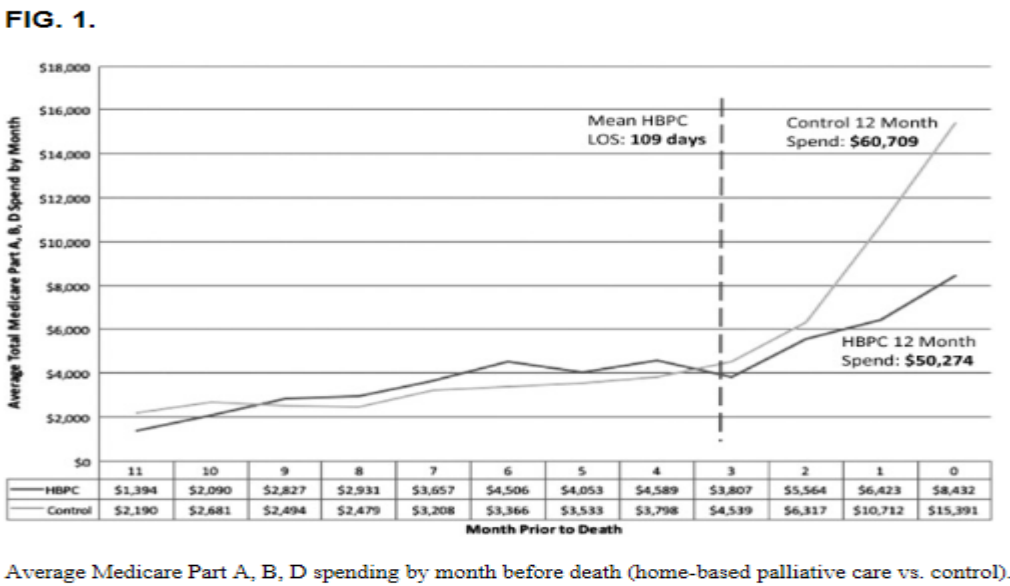
Level 3-4:
The California BS Global Budget Pilot Project

- Health care costs for CalPERS members ↓1.6 % from baseline amount (nonmembers: 9.9 % ↑).
- Inpatient days for CalPERS members ↓12.1 % (nonmembers: ↑ of 2.5%)
- Hospital readmissions within 30 days of discharge ↓ 15 %, from an already low 5.4 percent
- Extended hospital stays—those of twenty days or longer—↓ by 50 %

Markovich P. HEALTH AFFAIRS. Sept 2012; 31: 1969–1976

Level 4: Home-based Palliative Care

Cost per patient for Medicare parts A/B,/D final year of life was $10,435 lower for those receiving HBPalC compared to usual care

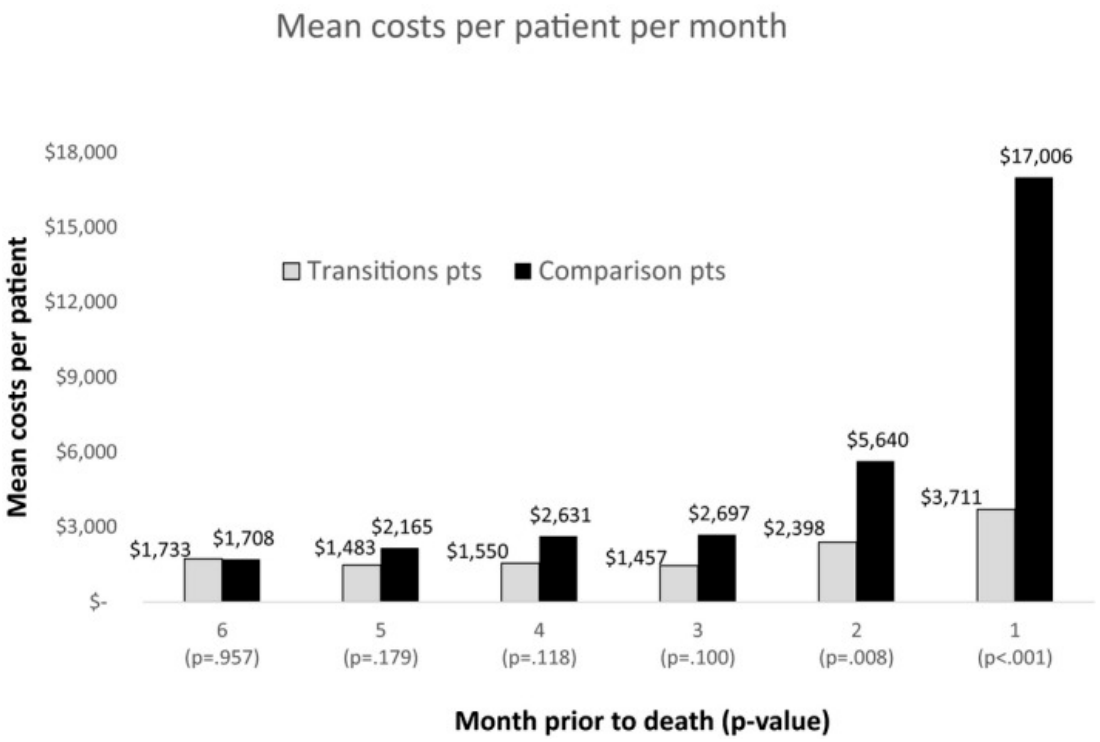


Average Medicare Part A, B, D spending by month before death (home-based palliative care vs. control).

Lustbader D et al. J Palliat Med. 2017 Jan;20(1):23-28

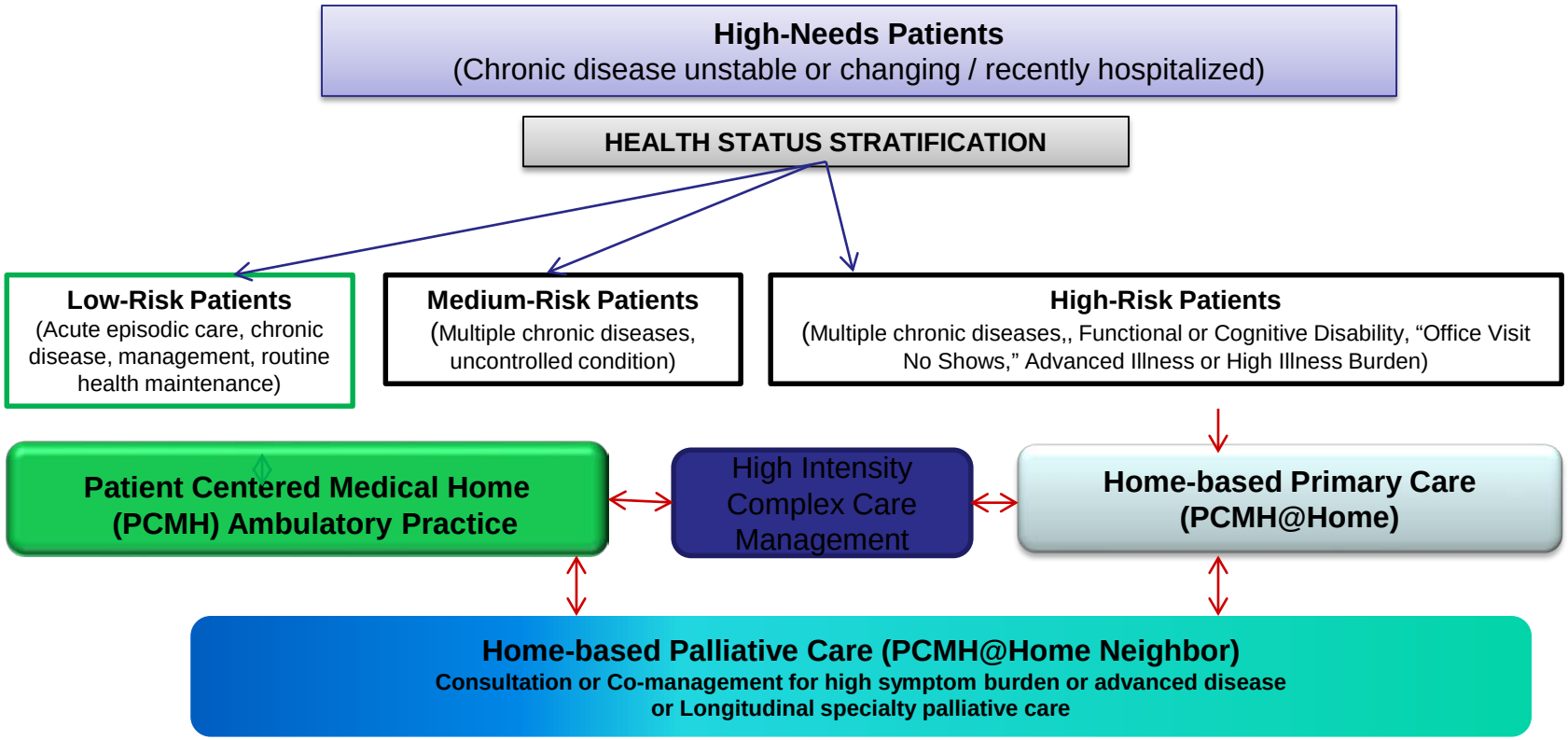
Level 4: Advanced Chronic Illness Care

- Four Pillars:
- in-home medical consultation
- ongoing evidence-based prognostication
- caregiver support
- advance healthcare planning



J Am Geriatr Soc. 2016 Nov; 64(11): 2288–2295.

Summary: Population Health and Palliative Care



Ritchie & Leff, JPSM 2017

Putting it together for the patient: relevant outcomes

Person/Caregiver Well-being

- Quality of life
- Symptom burden
- Treatment burden
- Goal alignment

Hospitalization

- Utilization of ICU
- LOS
- Disposition decisions
- Have discussions “before we need to”

Adoption of Hospice benefit

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Utilization of Advance Directives

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SO HOW CAN YOU EFFECT POSITIVE CHANGE IN YOUR LOCAL ENVIRONMENT?

Lay the Foundation

Understand the context

- What are current pressure points for my organization?
- What problems can palliative care solve for my organization?
- What is my organization currently doing in population health?
  - How is my organization defining its “population”?
  - What are the characteristics of the population that my organization serves/ is planning on serving?
  - What quality metrics has my organization prioritized?
- What are my organization’s strategic priorities?

Shape the message

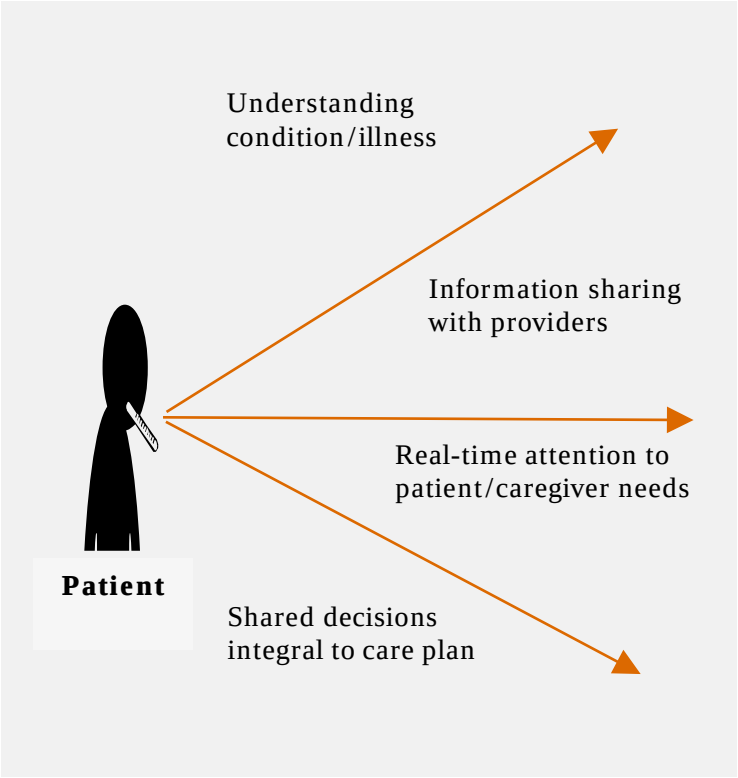
- **Identify:**
  - Key stakeholders
    - Potential supporters
    - Potential detractors
  - Existing resources to leverage
- **Clearly state goals, objectives, metrics, milestones, deliverables, timelines**
- **Know your audience**
- **Use language consistent with organizational context**
- **“Insider” review**

Person-centered palliative care strategies in population health management

Empowered Patients/Caregivers

Use of palliative care strategies in population health management:

- Delivers better patient experience (quality, satisfaction)
- Improves well-being of high need populations
- Reduces cost of care



Informed and educated patients/caregivers

Collaborative information gathering

Data capture of symptoms and distress

Dynamic shared decision making

Your turn – create an action plan

1)What is your organizational context? [or whom can you ask to find out?]

2)Who are your key stakeholders?

3)What existing resources can you leverage?

4)What is your message, tailored to your local environment?

5)What will you do in the next 90 days?

Summary

- The prevalence of chronic serious illness is growing at the same time value-based care is expanding
- These realities demand the use of palliative care principles and strategies
- Knowledge of population health principles and systems needs can offer new opportunities for palliative care integration
- Impact: better care for patients, caregivers and providers!