Implementing Community-Based Palliative Care in a Managed Care Environment

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Newport Beach, CA

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BACKGROUND
The Way We Die

The way people die has in large part changed significantly over the past several years. Our systems for dealing with chronic illness and death have not evolved to respond to new and changing realities to help us achieve quality end of life planning and care.
We Die Older

- Passage of Social Security Act, 1935
- Passage of Medicare & Medicaid, 1965
- First Baby Boomer Turns 65, 2011

Sources: Census.gov, CDC.gov, Data360.org; *Projected
We Die More Slowly

<table>
<thead>
<tr>
<th></th>
<th>1900</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at Death</td>
<td>46</td>
<td>78</td>
</tr>
<tr>
<td>Top Causes of Death</td>
<td>Infection</td>
<td>Cancer</td>
</tr>
<tr>
<td></td>
<td>Accident</td>
<td>Organ System Failure</td>
</tr>
<tr>
<td></td>
<td>Childbirth</td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dementia</td>
</tr>
<tr>
<td>Disability</td>
<td>Not much</td>
<td>Average 2-4 years before death</td>
</tr>
<tr>
<td>Financing</td>
<td>Private, Modest</td>
<td>Public, Substantial</td>
</tr>
</tbody>
</table>

Source: J. Lynn, 2015
How Americans Die
How Americans Wish to Die
How do we shift the cultural mindset from “more treatment is better” to “the right treatment and care, and no more”?

Triple Aim, IHI
Choosing Wisely Campaign
The Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost

Institute for Healthcare Improvement – IHI
Willie Sutton
% population - % cost

• 5% population generates 60% health care cost
• 49% catastrophic - only 1 year of high cost
• 11% costs are in the last year of life
• 40% consistently high cost – chronic disease

11% of 5% of population = 0.55% total population
11% of 60% of health care costs = 6.6% total cost
Palliative Care

Specialized medical care for people with serious illness. This type of care is focused on providing patients with relief from symptoms, pain, and stress from the serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment.
### Transition of Focus

<table>
<thead>
<tr>
<th>COMPLEX CASE MANAGEMENT</th>
<th>PALLIATIVE CARE</th>
<th>HOSPICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic and/or Complex Disease</td>
<td>End of Life 1-2 years and/or Chronic/ Complex Disease</td>
<td>End of Life 6 months</td>
</tr>
<tr>
<td>Concurrent with curative</td>
<td>Symptom Relief Concurrent with Curative</td>
<td>Symptom Relief NO Curative (for terminal illness)</td>
</tr>
<tr>
<td>PCP and Specialist</td>
<td>PCP, Specialist, and Palliative Consultant</td>
<td>Hospice Team including Physician</td>
</tr>
<tr>
<td>Complex Case Management (CCM) RN /SW</td>
<td>Integrated Team Approach MD/NP/RN/SW</td>
<td>Integrated Team plus aides, chaplain, plus respite benefit</td>
</tr>
<tr>
<td>Focus: Curative treatment by usual medical team with support for psycho-social issues</td>
<td>Focus: Transition from curative only to symptom management and goals of care</td>
<td>Focus: Symptom relief by the Hospice team with NO curative treatment of the terminal illness</td>
</tr>
</tbody>
</table>
Bereavement starts long before death

Curative is mostly managed by usual health care team – case management may help to coordinate
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IMPLEMENTATION
Home Based Palliative Pilot

- MD/RNP assessments in the patient’s home including Assisted Living Facilities, and Residential Care Facilities at least monthly
- Case manager (RN) assessment at least weekly
- Social Services assessment monthly
- Care coordinators
- Provide telephonic On Call 24/7
- Home visits 24/7
- Communicating with other CM Services

Often not a benefit but change is coming – paid per invoice
Program Implementation Process

CONTRACT DEVELOPMENT

- First began discussions mid 2013
- Contract finalized November 2014
- First patient admitted January 2015
Determine Major Referral Criteria

Utilization (using the hospital and ED to manage their condition)
- Two or more hospitalizations within the last six months
- Two or more Emergency Room visits within the last six months

Code Status
- DNR
- Artificial Nutrition

Diagnosis
- Prognosis of progressive 1 disease with a < 12-24 month life expectancy

Symptoms
- Has symptoms that are out of control

Support
- Psychological, financial, social (including caregivers) or other serious care planning issues related to illnesses

Top 1% (claims data)
EXCLUSIONS: **NOT** for REFERRAL  
(to the HN pilot programs)

- Dual risk
- Medicare primary
- Not in San Diego County
- Geographic barriers
- Currently in hospice
- Member/agent refusal
- Danger to providers
Determination of Referral Sources

- Data mining (claims based)
- Direct real time referrals
  - Health Net Case Managers
  - Health Net Medical Directors
  - Community PCP’s and Specialists
  - Dialysis Clinics
  - Emergency Departments
PROGRAM OPERATING STRUCTURE – JOINT DEVELOPMENT

• Clinical model – Tiers of care
• Interdisciplinary Team Process
  • Monthly meetings
  • Clinical reviews
  • Operational challenges discussion – Trouble shooting
  • Metrics review
• Key contacts(24/7)
• Prior authorization/vendors
• Pharmacy
• Communication flow with physicians, IPA/medical groups, facilities
• Collateral development
• Metrics
LIGHTBRIDGE INTERNAL IMPLEMENTATION PROCESS

- Medical Director
- Staffing
  - MD/NP
  - RN
  - SW
- Care Coordinator
- Scheduler
- Staff Training
- Program Marketing
- Data Analytics
- Finance
## Tiers of Care

<table>
<thead>
<tr>
<th>Palliative Level</th>
<th>Provider MD/NP/PA</th>
<th>RN/LVN</th>
<th>Social Worker</th>
<th>Patient Assistant</th>
<th>Monthly Case Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Intensity (I) Month one includes fully coded prospective assessment</td>
<td>At least monthly home visit in person or virtual</td>
<td>At least weekly home visits, supplemented by phone calls as needed</td>
<td>At least monthly home visit, supplemented by phone calls as needed</td>
<td>Phone contact and visits per team request</td>
<td></td>
</tr>
<tr>
<td>High Intensity (II) subsequent months</td>
<td>At least monthly home visit in person or virtual</td>
<td>At least weekly home visits, supplemented by phone calls as needed</td>
<td>At least monthly home visit, supplemented by phone calls as needed</td>
<td>Phone contact and visits per team request</td>
<td></td>
</tr>
<tr>
<td>Moderate Intensity (III)</td>
<td>At least monthly home visit in person or virtual</td>
<td>At least twice a month home visits, supplemented by phone calls as needed</td>
<td>At least monthly home visit, supplemented by phone calls as needed</td>
<td>Phone contact and visits per team request</td>
<td></td>
</tr>
</tbody>
</table>

### Quarterly Maintenance Program* Post Palliative Care Program Discharge

- **Low intensity with (IV) RN/SW visit once per quarter**: N/A  One RN or SW visit per quarter  Phone contact per team request
- **Maintenance Intensity (V) No RN/SW visit one phone call per month by Patient Assistant**: N/A  N/A  N/A  Two calls per quarter
Metrics

- LOB
- Diagnosis
- Source of referral (real time vs data mining)
- Mean time in palliative care
- Percent to hospice (immediate or subsequent)
- Mean and median time in hospice
- Death at home
- DNR in hospital
- POLST
  - Percent completed
  - Percent DNR
  - Percent full, limited, comfort care only
  - Percent tube feeding full, limited, none
Metrics-continued

- Resource utilization (scheduled and unscheduled)
  - MD/ NP visits
  - RN/CM visits
  - SW visits
  - Calls to members
  - Care coordination calls
- Services prevented (opportunity analysis)
- Dollar savings
- Admits before and after enrollment
- Patient satisfaction survey
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RESULTS
2015 Results
Palliative Care (46 referrals)

- Cancer 18
- Renal 9
- Neuro 5
- Cardiac 4
- Dementia 2
- Pulmonary 2
- HIV 1
- Other 5

- High risk referrals (data mined) 45.6%
- Real time direct referrals 54.4%
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Died in hospice</td>
<td>12/46</td>
<td>26.1%</td>
</tr>
<tr>
<td>Died not in hospice</td>
<td>5/46</td>
<td>10.9%</td>
</tr>
<tr>
<td>Alive in hospice</td>
<td>3/46</td>
<td>6.5%</td>
</tr>
<tr>
<td>Failure to engage</td>
<td>7/46</td>
<td>15.2%</td>
</tr>
<tr>
<td>Disenroll</td>
<td>6/46*</td>
<td>13.0%</td>
</tr>
<tr>
<td>Maintenance tier</td>
<td>2/46</td>
<td>4.4%</td>
</tr>
<tr>
<td>In process</td>
<td>1/46</td>
<td>2.2%</td>
</tr>
<tr>
<td>Current census</td>
<td>10/46</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

* 5 insurance change; 1 safety issue
## Palliative Care – 46 referrals

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Died</td>
<td>17/46</td>
<td>36.9%</td>
</tr>
<tr>
<td>Died at home</td>
<td>12/17</td>
<td>70.6%</td>
</tr>
<tr>
<td>Died in hospice</td>
<td>12/17</td>
<td>70.6%</td>
</tr>
<tr>
<td>Hospice</td>
<td>15/46</td>
<td>32.6%</td>
</tr>
<tr>
<td>Hospice initially</td>
<td></td>
<td>40%</td>
</tr>
<tr>
<td>Hospice during</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>Mean time in hospice</td>
<td></td>
<td>22.5 days</td>
</tr>
<tr>
<td>Median time in hospice</td>
<td></td>
<td>7 days</td>
</tr>
</tbody>
</table>
POLST - 25/32 active members = 78%
(Active = 46 - 7 non-engaged, 1 in process, 6 direct to hospice)

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full code</td>
<td>15/25</td>
<td>60%</td>
</tr>
<tr>
<td>DNR</td>
<td>10/25</td>
<td>40%</td>
</tr>
<tr>
<td>Full treatment</td>
<td>15/25</td>
<td>60%</td>
</tr>
<tr>
<td>Limited</td>
<td>5/25</td>
<td>20%</td>
</tr>
<tr>
<td>Comfort only</td>
<td>4/25</td>
<td>16%</td>
</tr>
<tr>
<td>Undecided</td>
<td>1/25</td>
<td>4%</td>
</tr>
<tr>
<td>Tube feeding</td>
<td>7/25</td>
<td>28%</td>
</tr>
<tr>
<td>Trial tube feed</td>
<td>8/25</td>
<td>32%</td>
</tr>
<tr>
<td>No tube feed</td>
<td>9/25</td>
<td>36%</td>
</tr>
</tbody>
</table>
Ethnicity

Caucasian 20
Hispanic 14 (7 primary language Spanish)
African American 4
Vietnamese 2
Other Asian 0
European 1
Native American 1
Unknown 4
Referral by LOB

Commercial 13 (28.3%)
PPO 1 (2.2%)
SHP (Medi Cal) 26 (56.5%)
Medi Medi 3 (6.5%)
Medicare 3 (6.5%)
Unit Cost Savings Rules – Opportunity Analysis

- Cost of admit, BD, ED, ambulance, SNF, subacute
- Omit savings for capitated services (e.g. ambulance)
- Enroll in hospice = 1 saved admit
- Death at home (w/o hospice) with DNR = 1 saved admit
- DNR in hospital = 3 days saved
- Vent in acute hosp d/c or DNR = 7 acute days 7 SNF days
- LTC trach/ vent d/c = saved 4 admits, 730 subacute days
- Do not save days if DRG
- Unsafe d/c or incomplete d/c order = 1 admit saved
- Expedite acute d/c = 3 day savings
- Expedite SNF d/c = 7 SNF days saved
- Early intervention resulting in admit = 7 days saved
## Unit Cost: All Commercial vs Top 1%* Commercial

<table>
<thead>
<tr>
<th>COMMERCIAL</th>
<th>ALL</th>
<th>TOP 1%</th>
<th>ALL</th>
<th>TOP1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>COST</td>
<td>COST</td>
<td>ALOS</td>
<td>ALOS</td>
<td></td>
</tr>
<tr>
<td>Acute admit</td>
<td>$25,000</td>
<td>$90,000</td>
<td>5.5</td>
<td>10.2</td>
</tr>
<tr>
<td>SNF admit</td>
<td>$5,000</td>
<td>$14,000</td>
<td>23.5</td>
<td>22.4</td>
</tr>
<tr>
<td>ED visit</td>
<td>$2,000</td>
<td>$3,700</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Top 1% includes catastrophic (e.g. trauma, burns, transplants, neonates, not just chronic and end of life*
Unit Cost
All Medicare vs Top 1% of Medicare

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>ALL</th>
<th>TOP 1%</th>
<th>ALL</th>
<th>TOP1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>COST</td>
<td></td>
<td>COST</td>
<td>ALOS</td>
<td>ALOS</td>
</tr>
<tr>
<td>Acute admit</td>
<td>$15,000</td>
<td>$28,000</td>
<td>5.9</td>
<td>9.5</td>
</tr>
<tr>
<td>SNF admit</td>
<td>$10,000</td>
<td>$13,000</td>
<td>19.2</td>
<td>24.0</td>
</tr>
<tr>
<td>ED visit</td>
<td>$700</td>
<td>$900</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Top 1%

Higher cost for admit, SNF, and ED
Longer LOS
Higher LOC
Higher DRG (? Stoploss, ? FFS)

Could be skewed higher due to catastrophic cases (e.g. trauma, burns, transplants, neonates)

Answer would be in a retrospective analysis after sufficient enrollment
<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Cost Per Admit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial HMO</td>
<td>$30,000</td>
</tr>
<tr>
<td>PPO</td>
<td>$20,000</td>
</tr>
<tr>
<td>Medicare</td>
<td>$15,000</td>
</tr>
<tr>
<td>MediCaid</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Savings

Opportunity Analysis
$1,284,557
$27,925/referral

Opportunity Analysis excluding 1 outlier case
$887,893
$19,302/referral
Success

54 yo trach vent, brain damage from intracerebral bleed; no chance of recovery; surgery planned for decubitus ulcer; daughters ages 18 and 22 not aware of prognosis; discontinued vent with support team

50 yo post abdom wound repair with mesh; open wound, recurrent infections, continued pain, imbedded mesh; told by surgeon mesh cannot be removed; referred to tertiary facility for surgery by bariatric surgeon
“Failures”

49 yo s/p multiple surgeries, short bowel, ostomy, chronic pain, substance abuse; unsafe environment; discontinue services due to unsafe neighborhood; decrease admits during enrollment

55 yo Vietnamese with metastatic liver cancer; converted to hospice; made comfortable at home; extended family visiting and “concerned” and called 911 (did not understand hospice); hospitalized but made DNR

74 yo pulmonary fibrosis, COPD; continued SOB, anxiety but patient opted for care at home; POA uncomfortable and called 911; member intubated but after patient’s wishes reviewed, vent d/c’d
Failure to Engage  15.2%

Refused  3
Unable to contact  2
Moved OOA  1
Changed insurance  1
Admits (23 graduates)
duration of measurement period before
equal to duration of enrollment

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admits before enrollment</td>
<td>28</td>
</tr>
<tr>
<td>Total admits during enrollment</td>
<td>25</td>
</tr>
<tr>
<td># mem w admits during &lt; adm before</td>
<td>5</td>
</tr>
<tr>
<td># mem w admits same during as before</td>
<td>3</td>
</tr>
<tr>
<td># mem w admits during &gt; adm before</td>
<td>4</td>
</tr>
<tr>
<td>No admits during or before</td>
<td>11</td>
</tr>
</tbody>
</table>
Q: WHERE’S THE BEEF?

A: Dave's HOT 'N JUICY CHEESEBURGERS

HERE'S THE BEEF:
we've gone back to the grill to make our classic cheeseburgers thicker, better and juicier than ever. They're made with fresh American beef and we've added new premium toppings and a buttered, toasted bun. The way it should be.
Clara Peller 1902-1987
10 Best Super Bowl Commercials

1. Eminem for Chrysler, 2011 – “What does this city know about luxury?”
3. Wendy’s, 1984 – “Where’s the beef?”
4. Budweiser, 2013 – Clydesdale Brotherhood
5. Old Spice, 2010 – “The man your man could smell like”
6. Apple, 1984 – introduced the Macintosh
7. Bud Light - Cedric the Entertainer, 2001 – “Why don’t you get something to cool this fire down?”
8. Honda, 2012 – “Matthew’s Day Off” spoof on Ferris Bueller
10. Audi, 2013 – “You can’t go to the prom without a date, right?”
What Does the Data Tell Us?
(aka “where’s the beef”)

• Highly successful on dollar savings
• Referrals are late in the course of illness (hospice data, time in palliative)- need more education/ marketing
• Low volume
  • 45.6% from claims; more data mining – other sources e.g. LTC, dialysis, oncology, ED UM reports
  • 54.4% real time; more marketing, education (LTC, ED, dialysis, etc)
• Low volume due to limited Medicare
• Only one county (? expand)
• 15% fail to engage – avoid the “H” word and the “P” word
• Reimbursement insufficient relative to resources consumed especially during start up (?contract; ?telemedicine)
1–3 metrics per palliative domain

Total 13 structural/ process metrics
  ◦ 6/13 process metrics
  ◦ 7/13 structural

9 outcomes metrics

Total of 22 metrics

Almost “maximal” per Kathleen Kerr criteria
Where do we go from here?

• Continue to try and expand program:
  • To other Health Net regions
  • To other community providers (non Health Net)
  • SB 1004
• Pilot televisits by physicians
• Explore ways to enhance cost effectiveness of program
• Continue to refine metrics
“You loved us, taught us, supported and encourage us and held our hand during this battle...You are an angel God sent to us in this storm.”

-Wife of a palliative care member
Discussion
8 Domains

National Consensus Project for Quality Palliative Care
Clinical Practice Guidelines for Quality Palliative Care

- Structure & Process
- Physical
- Psych
- Social
- Spiritual
- Cultural
- End of life care
- Ethical legal