The Role of Palliative Care in an ACO

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Objectives

• What is an ACO?

• Why is palliative care central to ACO success?

• Impact of palliative care on value = quality/cost

• Case study

• Success predictors

Is this a patient-centered system??
Value = \frac{Quality}{Cost}

The value equation...

What does this mean for the seriously ill with complex care needs?

**ACA Experimentation and the Value Equation**

Affordable Care Act tests expansion of new delivery and payment models. All aim to improve the value equation by *improving quality and setting limits on spending through versions of capitation and global budgeting.*

- Patient Centered Medical Homes (aka Health Homes, Advanced Primary Care)
- Bundled payment for an episode of care
- Accountable Care Organizations
- 30-day readmission, hospital mortality and satisfaction financial penalties
ACA Experimentation and the Value Equation-2

The ACA also tries to improve the value equation by improving quality:

- By investing in comparative effectiveness research so we get the most out of a dollar spent;
- By markedly increasing attention to the assessment and reward for quality of care via Value Based Purchasing/Pay for Performance
Managed care of the 80’s ≠ ACO’s

- More Knowledge
- More Data
- More Guidelines and Quality Metrics
- More Collaboration
- More Physician Control

Emanuel EJ. JAMA. 2012 Jun 6;307(21):2263-4

What is an ACO?

**Accountable Care Organizations**: ACOs are groups of providers receiving set fees to deliver *coordinated quality* care to a select group of patients.

Sec. 3022 of the ACA (Medicare Shared Savings Program) allows providers organized as ACOs that voluntarily meet quality thresholds to *share in the cost savings* they achieve for the Medicare program.

To qualify as an ACO, organizations must agree to be **fully accountable for the overall care of their Medicare beneficiaries**, have adequate participation of primary care and specialist physicians, define processes to promote evidence-based medicine, *report on quality and costs, and coordinate care.*
What does an ACO need to do?

• Manage quality outcomes and overall cost for a defined population, across a ‘continuum of care’

• Prospectively plan and administer budgets, organize resources, and distribute payments

• Be responsible for comprehensive, valid and reliable performance measures for at least 5,000 Medicare beneficiaries

• As of 2013 >450 ACOs in USA
“The future is here now. It’s just not very evenly distributed”*

• Roughly 40% of all Medicare beneficiaries are already in risk models as of 2013
  • Medicare Advantage >28%
  • ACO models >12%

*William Gibson, quoted in *The Economist*, 2003
Why Palliative Care for ACOs?

Because of the concentration of risk and spending in a small subset of patients, and the evidence that palliative care improves value for this group, palliative care principles and practices are central to improving quality and reducing cost--which are the purposes of an ACO.

Health Care Costs Concentrated in Sick Few—Sickest 10 Percent Account for 65 Percent of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2009

- 1% 10%
- 5%
- 22%
- 50%
- 65%
- 97%
- 50%
- 97%
- 100%

U.S. population Health expenditures

Annual mean expenditure

- $90,061
- $40,682
- $25,767
- $7,978

Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.
Mr. B

- An 88 year old man with mild dementia admitted via the ED for management of back pain due to spinal stenosis and arthritis.
- Pain is 8/10 on admission, for which he is taking 5 gm of acetaminophen/day.
- **Admitted 3 times in 2 months for pain (2x), weight loss + falls, and altered mental status due to constipation.**
- His family (83 year old wife) is overwhelmed.

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Mr. B

- Mr. B: “Don’t take me to the hospital! Please!”
- Mrs. B: “He hates being in the hospital, but what could I do? The pain was terrible and I couldn’t reach the doctor. I couldn’t even move him myself, so I called the ambulance. It was the only thing I could do.”

Modified from and with thanks to Dave Casarett
The Modern Death Ritual: The Emergency Department

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


Concentration of Risk

- Functional Limitation
- Dementia
- Frailty
- Serious illness(es)
Most of Costliest 5% have Functional Limitations

![Figure 4](http://www.cahpf.org/docuserfiles/georgetown_trnsfr ming_care.pdf)

**Dementia Drives Utilization**

Prospective Cohort of community dwelling older adults

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>No Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare SNF use</td>
<td>44.7%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Medicaid NH use</td>
<td>21%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Hospital use</td>
<td>76.2%</td>
<td>51.2%</td>
</tr>
<tr>
<td>Home health use</td>
<td>55.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Transitions</td>
<td>11.2%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

Callahan et al. JAGS 2012 20.
Dementia and Total Spend

- 2010: $215 billion/yr
- By comparison: heart disease $102 billion; cancer $77 billion
- 2040 estimates> $375 billion/yr

Hurd MD et al. NEJM 2013;368:1326-34.

Figure 1. Kaplan-Meier curves for differing grades of frailty for time to an adverse outcome. The patients were followed for up to 12 months, and their time to death or time to institutionalization (whichever came first) was recorded. Patients were divided into three groups based on their comprehensive geriatric assessment frailty index (mild, moderate, and severe frailty). The proportions of people who survived in the community are plotted against time.
Why do we have so much acute care spending in patients like Mr. B with multiple chronic conditions, functional and/or cognitive impairment, and frailty?

Low Ratio of Social to Health Services Expenditures in U.S.


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Home and Community Based Services are High Value

- Improves quality: People want to stay home.
- Reduces cost: Based on 25 State reports, costs of Home and Community Based LTC Services less than 1/3rd the cost of Nursing Home care.

Study: Having meals delivered to home reduces need for nursing home

10/14/2013 | HealthDay News

A study published today in Health Affairs found if all 48 contiguous states increased by 1% the number of elderly who got meals delivered to their homes, it would prevent 1,722 people on Medicaid from needing nursing home care. The Brown University study found 26 states would save money because lower Medicaid costs would more than offset the cost of providing the meals.
Palliative Care Models Improve Value

Quality improves
- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- MD satisfaction
- Care matched to patient centered goals

Costs reduced
- Hospital costs decrease
- Need for hospital, ICU, ED decreased
- 30 day readmissions decreased
- Hospitality mortality decreased
- Labs, imaging, pharmaceuticals reduced

Care gaps in current palliative care delivery models

Ideal Service Design

- Hospital Consult Service
- Inpatient Unit
- Home Visits/House calls
- Specialty Clinics
- Bridge Programs / Hospice
- NH Consult Service
- Primary care practices

Case Study of ACO-Palliative Care Integration

- *Sharp HealthCare in California*

Lots of others, for example:
- UnityPoint Health System in Iowa
- Banner Health System
- OSF System in Illinois
- Partners Health System in Massachusetts
- @HOMe program in Michigan
Thank you

• Suzi K. Johnson, MPH, RN: Sharp HealthCare
  http://www.sharp.com/hospice/transitions-advanced-illness-management-program.cfm

Key Questions

• **Targeting**: What screening methods are used to identify patients?
• **Continuity**: What cross-setting clinical and staffing model(s) assure access 24/7?
• **Symptoms**: Can the team effectively manage symptoms?
• **Goal setting**: Has the organization moved away from check-box advance directive forms to longitudinal advance care planning?
• **Family caregivers**: Are family needs for both medical and social support assessed and provided?
• **Dose flexibility**: Can the model adjust as needs change?
• **Metrics**: How is accountability and improvement measured?
Sharp Healthcare- Pioneer ACO Palliative Care System Strategy

1. Implement effective pathway for patients and families living with chronic progressive illness based on evidence
2. Align care plan with patient/family values, preferences and goals of care.
3. Assure coordinated seamless care among all clinicians in integrated system
4. Improve the overall healthcare experience

Sharp + Targeting: Prognostic Tools Help Determine Eligibility

- Use evidence-based prognostic criteria by disease type as guideline to help physicians recognize “the right time” to refer...
  - For example –
    - CHF – any patient hospitalized due to primary diagnosis. No further intervention planned
    - Late stage NYHA III, supporting criteria EF < 30 for systolic failure; significant comorbidities
Sharp Model: Four Evidence-Based Pillars

2. Evidence-based *prognostication*
3. Proactive *caregiver assessment and support*
4. Advance care planning – *goals of care discussions*, completion of documents

Home Care Management Model

**Care Management Team**
RN, MSW, Physician and Spiritual Care Services

**Active Phase**
Home visits and care coordination 4-6 weeks
RN averages 6 visits; MSW 1-2 visits,

**Maintenance Phase**
Regular phone communication/coordination, visits as needed; preparing for the future... eventually hand off to hospice
Care Management Approach

• Bimonthly IDT case conference
• Regular communication with Medical Group Case Managers (key stakeholder) regarding patient’s progress/condition
• Smooth, coordinated and seamless handoff to next appropriate program
  – Hospice
  – If patient condition improves, refer back to Medical Group Chronic Care Management

Sharp Metrics:
Key Performance Indicators

- Number of hospitalizations/ED visits
- Documentation of advance healthcare plan
- Timely referral to hospice
- System costs savings net of program costs
- Patient/family satisfaction
Sharp: Transitions Outcomes

- 100% completion of advance care planning, POLST
- Average enrollment time on Transitions Programs – 5 months
- 75% transfer smoothly to hospice
- Average hospice length of stay = 120 days (national average = 72 days)

Sharp Transitions Program Funding Support

Medicare Advantage
Pioneer ACO
Other Managed Care Contracts

Medicare Fee For Service DOES not pay for this program.
**Sharp Outcomes: Hospital+ED Utilization**

- **Pre-Transitions**: 160 ED visits, 60 Admissions
- **During Transitions**: 60 ED visits, 30 Admissions

57% reduction in ED visits and 54% reduction in Admissions for discharge HF patients (n=155) 2009-2010

**Sharp Outcomes: Total Cost of Care**

- **Pre-Transitions**: Average total cost of care is $50,000
- **During Transitions**: Average total cost of care is $28,500

43% reduction in total cost of care
Sharp: Next Steps

Value Proposition Expands to Cover:
  More chronic diagnoses – better care management and integration
  Provide care to patients in SNF/LTC
Expand Metrics Framework
  30 day hospital readmission reduction
Explore collaborative alignment/incentives for Medicare FFS population

Advising Your ACO

Assure inclusion of the model characteristics consistently linked to success in these studies:

1. Targeting
2. Goal setting
3. Family and social supports
4. Pain and symptom management
5. Flexible “dosing”
Key Characteristics of Effective Models 1: **Targeting**

![Graph showing the increase in resources as demand management (DM) and CCM-palliative care increase]

**Table 5** Distribution of ‘surprise question’ (SQ+) patients by main disease or condition

<table>
<thead>
<tr>
<th>Disease or condition</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>95</td>
<td>12.67</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>48</td>
<td>6.4</td>
</tr>
<tr>
<td>Chronic cardiac disease</td>
<td>79</td>
<td>10.53</td>
</tr>
<tr>
<td>Chronic neurological disease</td>
<td>42</td>
<td>5.6</td>
</tr>
<tr>
<td>Chronic hepatic disease</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Chronic renal disease</td>
<td>22</td>
<td>2.93</td>
</tr>
<tr>
<td>Dementia</td>
<td>176</td>
<td>23.47</td>
</tr>
<tr>
<td>Advanced frailty</td>
<td>238</td>
<td>31.73</td>
</tr>
<tr>
<td>Other chronic diseases/conditions</td>
<td>24</td>
<td>3.20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>750</td>
<td>100</td>
</tr>
</tbody>
</table>
Targeting on the Front Lines

Ask yourself:

• Would you be surprised if this patient died in the next 12 - 24 months?
• Does this patient have decreased function, dementia, progressive weight loss/frailty, >= 2 unplanned admissions in last 12 months, live in a NH or AL, have inadequate social supports, or need more help at home?

Key Characteristic 2: Goal Setting

• “Don’t ask what’s the matter with me; ask what matters to me!”
• Ask the person and family, “What is most important to you?”
• “Ultimately, good medicine is about doing right for the patient. For patients with multiple conditions, severe disability, or limited life expectancy, any accounting of how well we’re succeeding in providing care must above all consider patients’ preferred outcomes.”

Priorities for Care

Survey of Senior Center and AL subjects, n=357, dementia excluded, no data on function

Asked to rank order what’s most important:

Overall, independence ranked highest (76% rank it most important) followed by pain and symptom relief, with staying alive last.

Fried et al. Arch Int Med 2011;171:1854

Impact of Goal Setting through Advance Care Planning

- Prospective data on >3000 Medicare beneficiaries 1998-2007 (linked HRS, claims, and NDI)
- Advance care planning associated with lower Medicare spending, lower hospital death rate, and higher hospice use in medium-high Medicare spending regions of the U.S.

Key Characteristic 3:
Can We Deliver on People’s Goals? Not When Families are Home Alone

- 40 billion hours unpaid care/yr by 42 million caregivers worth $450 billion/yr
- Providing “skilled” care
- Increased morbidity/mortality/bankruptcy

aarp.org/ppi
http://www.nextstepincare.org/

Families Need Help if We Are to Honor People’s Goals

- Assess family capacity and willingness to provide care
- Match services to gaps
- Mobilizing long term services and social supports is the key to helping people stay home and out of hospitals.
Effective Care Coordination Models...

• Predictors of model success:
  – 24/7 phone access;
  – high-touch, consistent, and personalized care relationships;
  – focus on social and behavioral health determinants;
  – coordinated integration of social supports with medical services.

Payers Are Already Bringing the Care Home
Key Characteristic 4: Pain and Symptoms

Disabling pain and other symptoms reduce independence and quality of life.

HRS- representative sample of 4703 community dwelling older adults 1994-2006

Pain of moderate or greater severity that is “often troubling” is reported by 46% of older adults in their last 4 months of life and is worst among those with arthritis.

It’s Not Only Pain: Symptom Burden of Community Dwelling Older Adults with Serious Illness

*75% or more reported symptom as bothersome

Palliative Care - Needs for Care Are Dynamic, Not Linear...

...For when illness burden impacts the person or their loved one
Key Characteristic 5: Dose for Changing Risk

- *Early* advance care planning + communication on what to expect + treatment options + access.
- *As illness progresses*, ability to titrate dose intensity of services.  

### Trends

- Home based services
- Hybrids of palliative care and geriatric models
- Concurrent care in specialty areas such as cancer
- Palliative care as medical home for the most complex
- Telehealth
- Urgent care for cancer, CHF – staffed by palliative care NPs
- Generalist knowledge and knowledge/skill building & tools
- Payer interest in support (NBGH-CHF-CAPC project)
Take Home Messages

- **Target:** Target the at risk population and measure access in this denominator
- **Training:** Strengthen clinician’s core palliative care knowledge and skill
- **System Design:** Use triggers, bundles for access and quality
- **Measure:** Quality and cost metrics that matter to leadership
- **Families:** Explicit attention to social/medical needs and support
- **Goal setting:** Goals drive plan of care and service delivery
- **Flexibility:** Match service intensity to changing need; 24/7 access; care and communication across settings
- **What’s in a name?:** Don’t fret over what we call it. If supportive care works better than palliative care then supportive care it is.