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Adult Palliative Care in a Value Based Payment Model

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Frank

- Frank is an 87 year old man with dementia, heart failure and kidney disease
- Uses a walker to get around
- Frequent ER visits for weakness
- Avoidable hospitalizations
- His 86 year old wife and adult son are overwhelmed
- Prognosis is uncertain
- Not eligible for hospice

Frank lives with his 86 year old wife in a two story walk up and is a retired teacher.

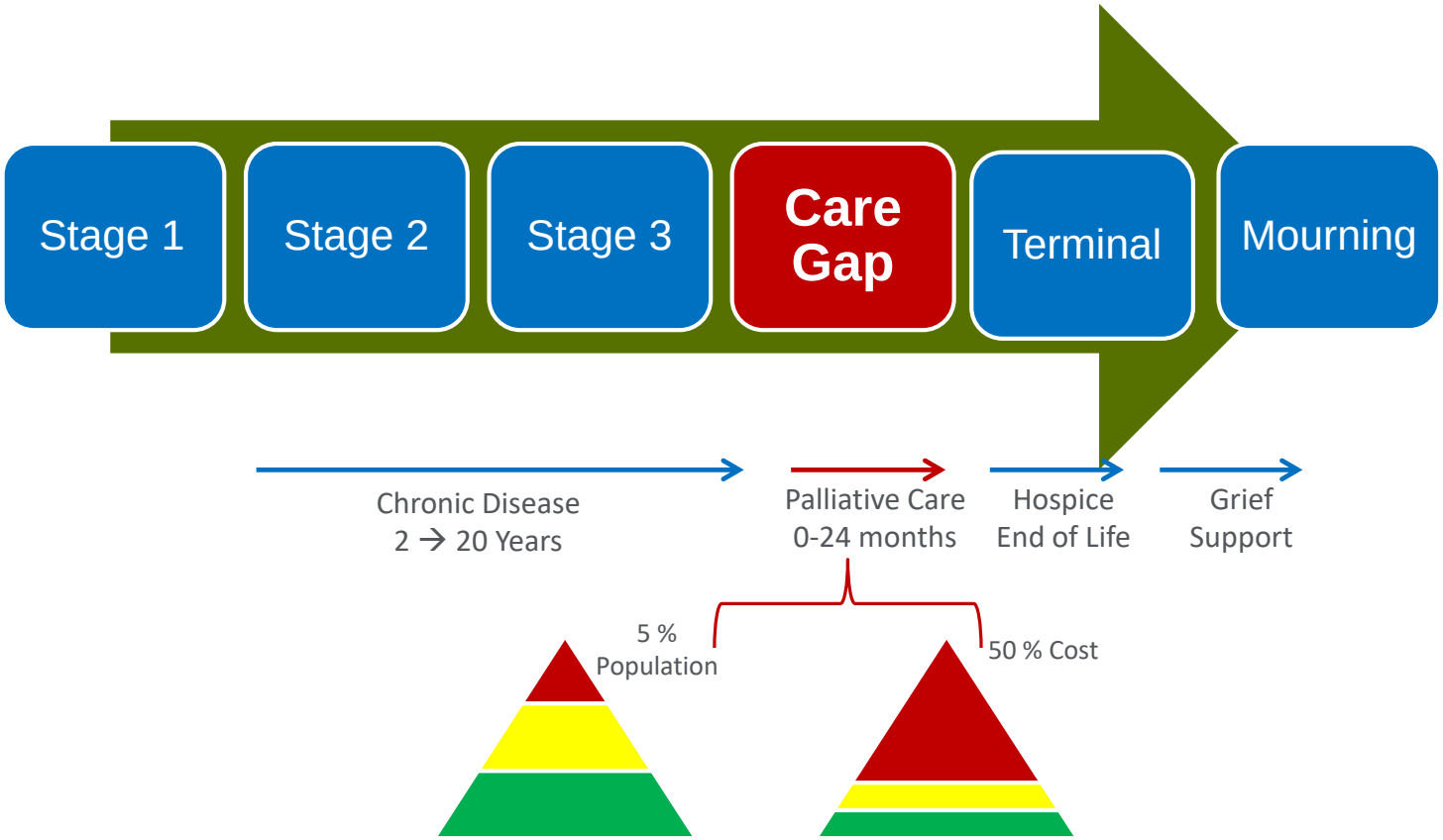
Usual Care

- Doctor's voicemail says "if this is any emergency, go to the nearest ER"
- Calls to 911
- Hospitalizations
- Family distress
- Progressive functional decline, confusion with each admission

Home-based Palliative Care

- 24/7 phone coverage, team based care, home visits
- Telemedicine visits with son
- Caregiver support
- Dinner - Meals on Wheels
- Friendly visitor program
- No ER visits, hospital admissions in 9 months

Health Care Gap for Adults with Advanced Illness



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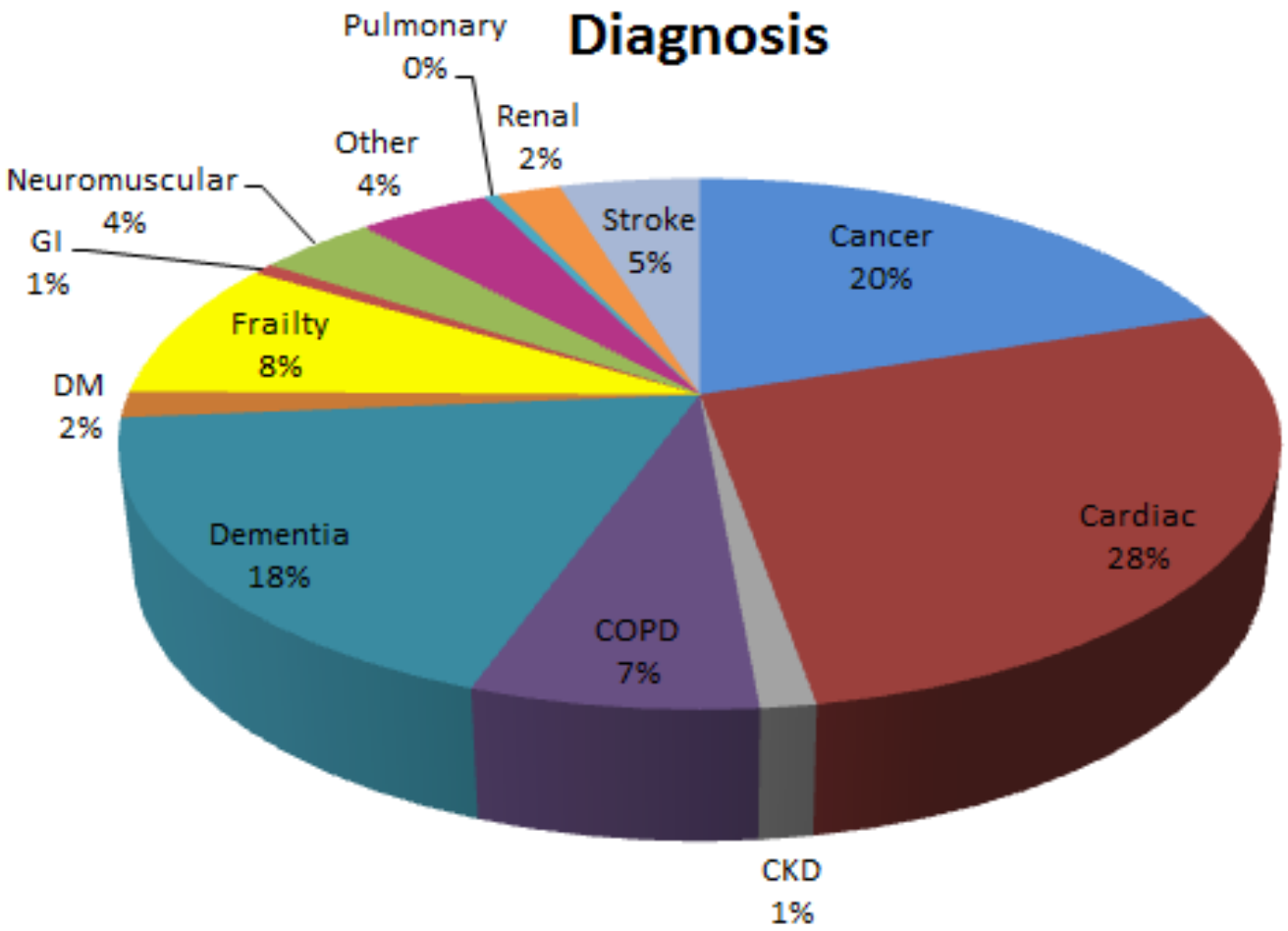
Ensure Palliative Care Needs Met: Data Driven Referrals

- Risk in waiting for physician referrals – too late
- Hot Spotter List - High spend and high need
- Can use health plan, CMS, ACO claims data
  - Utilization (e.g. ER, hospital admissions, SNF)
  - Frailty, functional impairment, disease burden
  - Risk scores, Charlson Comorbidity Index, LACE > 11

Palliative Care Triggers

- 5+ chronic conditions
- Advanced illness (e.g. Cancer, HF, COPD)
- Progressive disease
- CKD with debility
- Frailty or functional decline
- 2+ hospital admissions; ER visits


Diagnosis
Pulmonary 0%
Renal 2%
Other 4%
Neuromuscular 4%
GI 1%
Frailty 8%
DM 2%
Dementia 18%
COPD 7%
CKD 1%
Cardiac 28%
Stroke 5%
Cancer 20%

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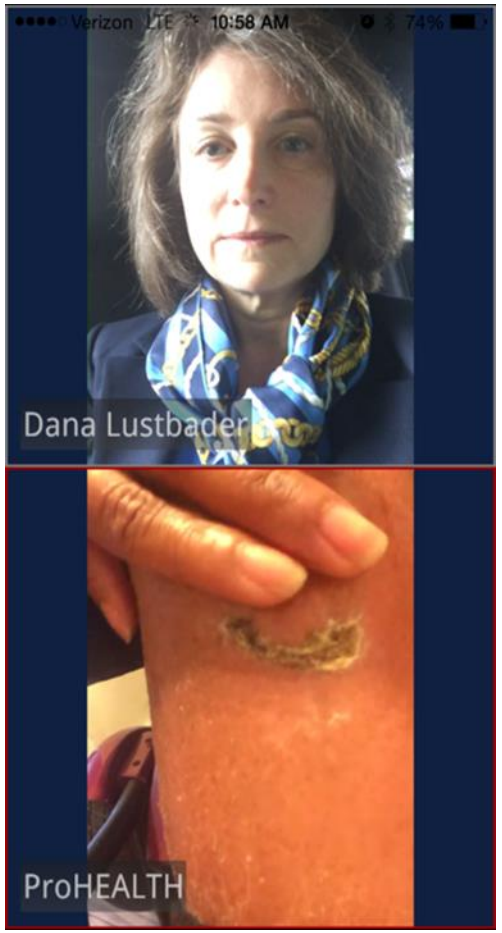
Staffing and Services

- Palliative Care Team
  - Pod = 0.5 MD; 3 RNs; 0.5 SW for 250 patients
- Cadence of encounters based on patient and family needs. Minimum of one house call per month.
- Services
  - House Calls
  - Video Calls – “telepalliative care”
  - 24/7 support
  - Volunteer Department

“Telepalliative Care” – Use Cases

- Acute Issue – patient has new distressing symptom, cough, infection, wound
- Advance Care Planning – can include other doctors, family members from around the world
- Scheduled F/U Visit – increased care access for remote and rural patients
- Caregiver Support – provide positive feedback and emotional support to stressed and undervalued family caregivers



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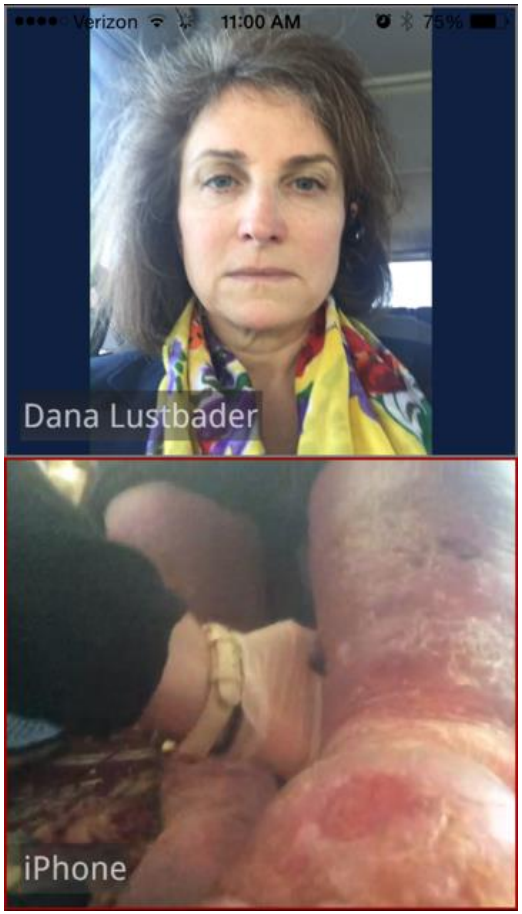
Telepalliative Care

Team Meeting



Urgent Issue

Routine Visit

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The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization

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- 651 decedents; 82 enrolled in a palliative care compared to 569 with usual care who died 2014-2016.
- Cost per patient during the final three months of life was $12,000 lower with palliative care than with usual care ($20,420 vs $32,420; p = 0.0002).
- Palliative care reduced hospital admits 34%.
- Cost savings about $2,100 PMPM for non decedents.

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Palliative Care Associated with $12,000 Cost Savings

Avg Part A, B, D Spend by Month Prior to Death	Control Group (N=569)	Palliative Care (N=82)	P-value
Month of death (Month #0)	$15,391	$8,432	**0.0002**
Month #1	$10,712	$6,423	**0.0154**
Month #2	$6,317	$5,564	0.8025
Last 3 months	**$32,420**	**$20,420**	**0.0002**
Month #3	$4,539	$3,807	0.8025
Month #4	$3,799	$4,589	0.0271
Month #5	$3,533	$4,053	0.0525
Last 6 months	$44,291	$32,869	0.0207

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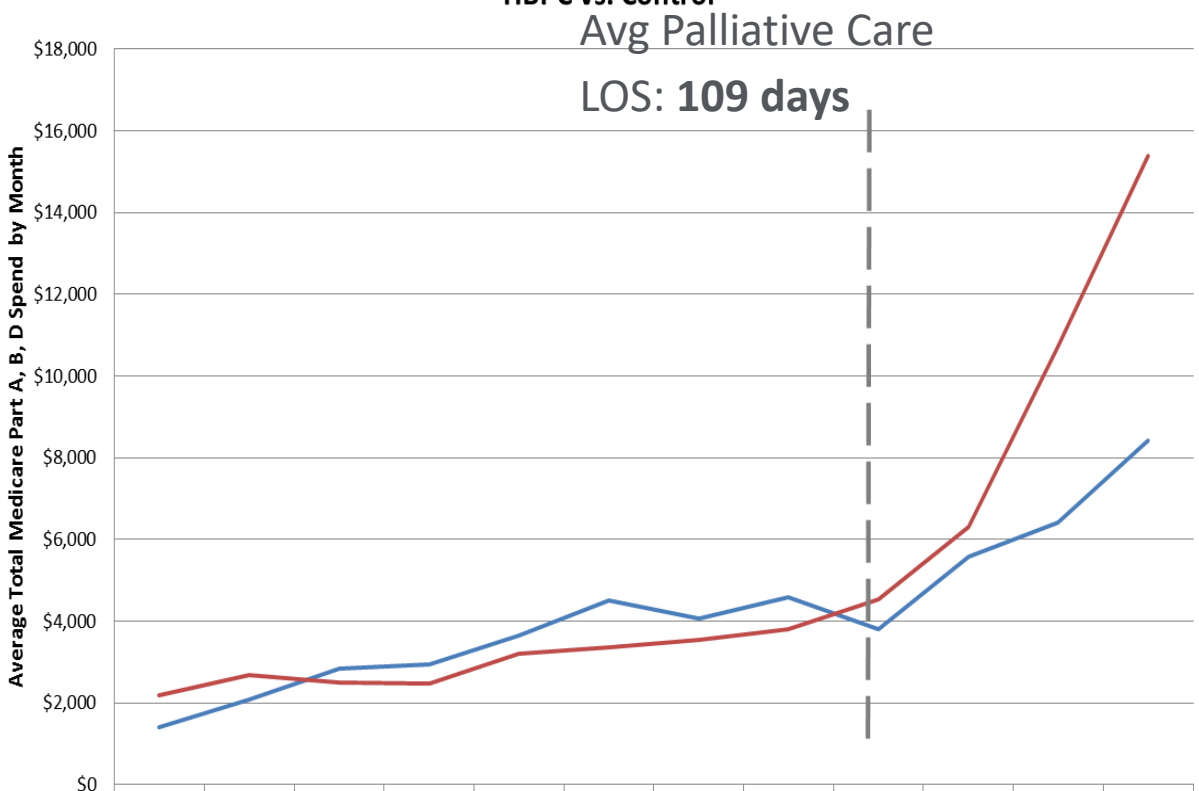
Table 2: Average Medicare Part A, B, D Spend by Month Prior to Death
HBPC vs. Control

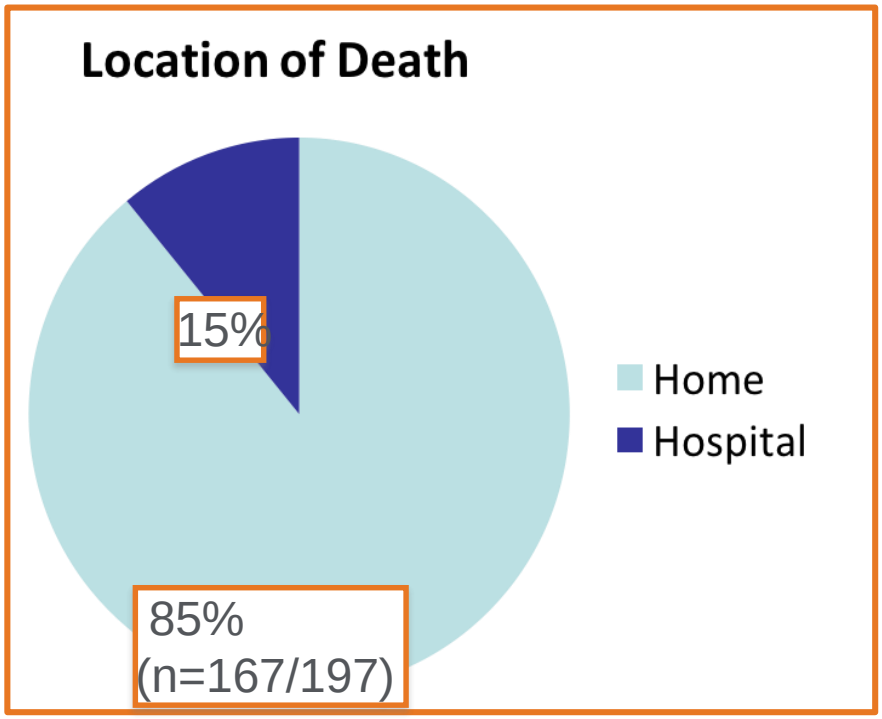


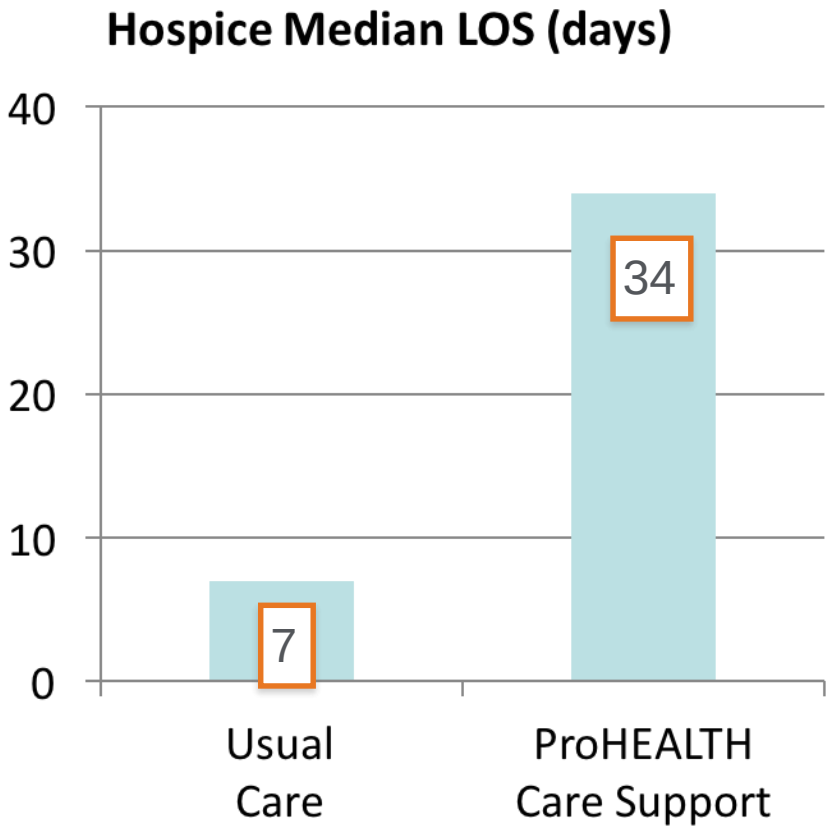
	11	10	9	8	7	6	5	4	3	2	1	0
HBPC	$1,394	$2,090	$2,827	$2,931	$3,657	$4,506	$4,053	$4,589	$3,807	$5,564	$6,423	$8,432
Control	$2,190	$2,681	$2,494	$2,479	$3,208	$3,366	$3,533	$3,798	$4,539	$6,317	$10,712	$15,391

Control 12 Month Spend: **$60,709**

HBPC 12 Month Spend: **$50,274**

Palliative Care Patients Who Died More Likely to be at Home with Longer Hospice LOS





How to help seriously ill people and their loved ones get palliative care?

- Fee for service is the enemy of high quality palliative care. It incentives high care intensity; often discordant with patient and family preferences.
- Speed up and reward full accountability for high quality palliative care through alternative payment models (APM) and measurement (patient and family experience).