Payer & ACO Palliative Care Strategies for Improving Care of Those with Serious Illness and High-Risk Populations

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Agenda

- Define palliative care and the opportunity for payers, ACOs, and providers
- Outline how payers and ACOs are supporting palliative care and steps to get started
- Review a case example: Banner Health System home-based palliative care

A National Perspective: Palliative Care and the Opportunity for Payers, ACO's, and Providers

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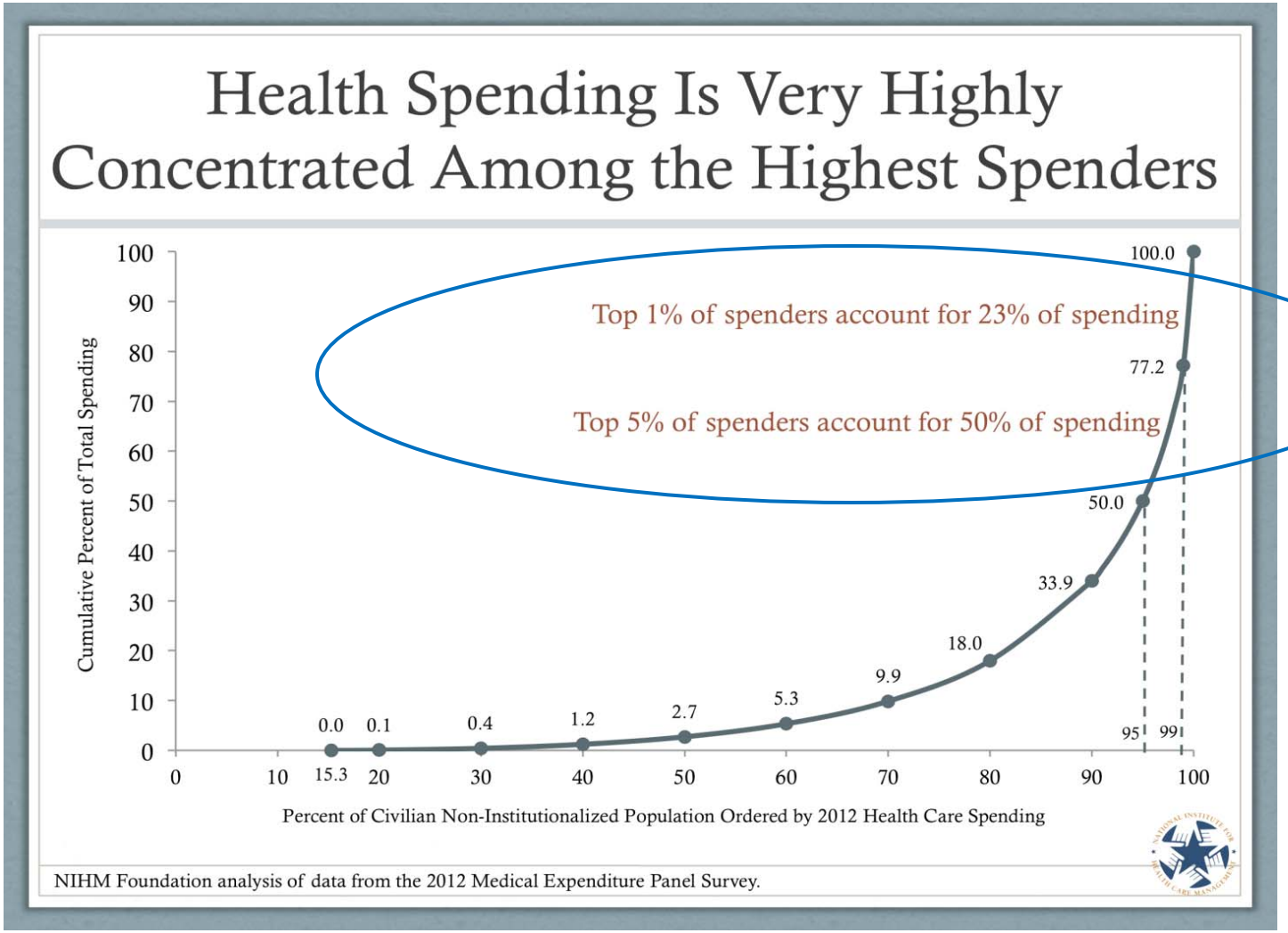
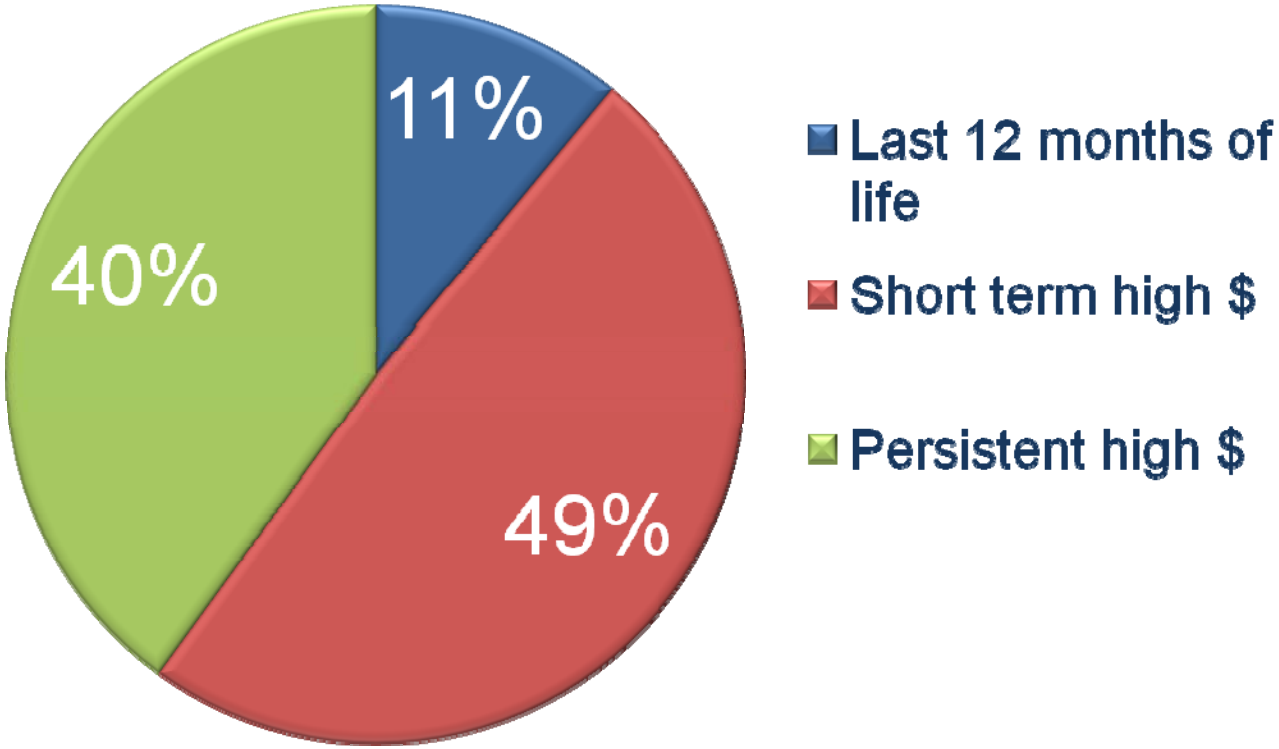
Concentration of Risk: The Opportunity for Payers, ACO's, and Providers



Who Are the Costliest 5% of Patients?



Source: IOM Dying in America Appendix E http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx

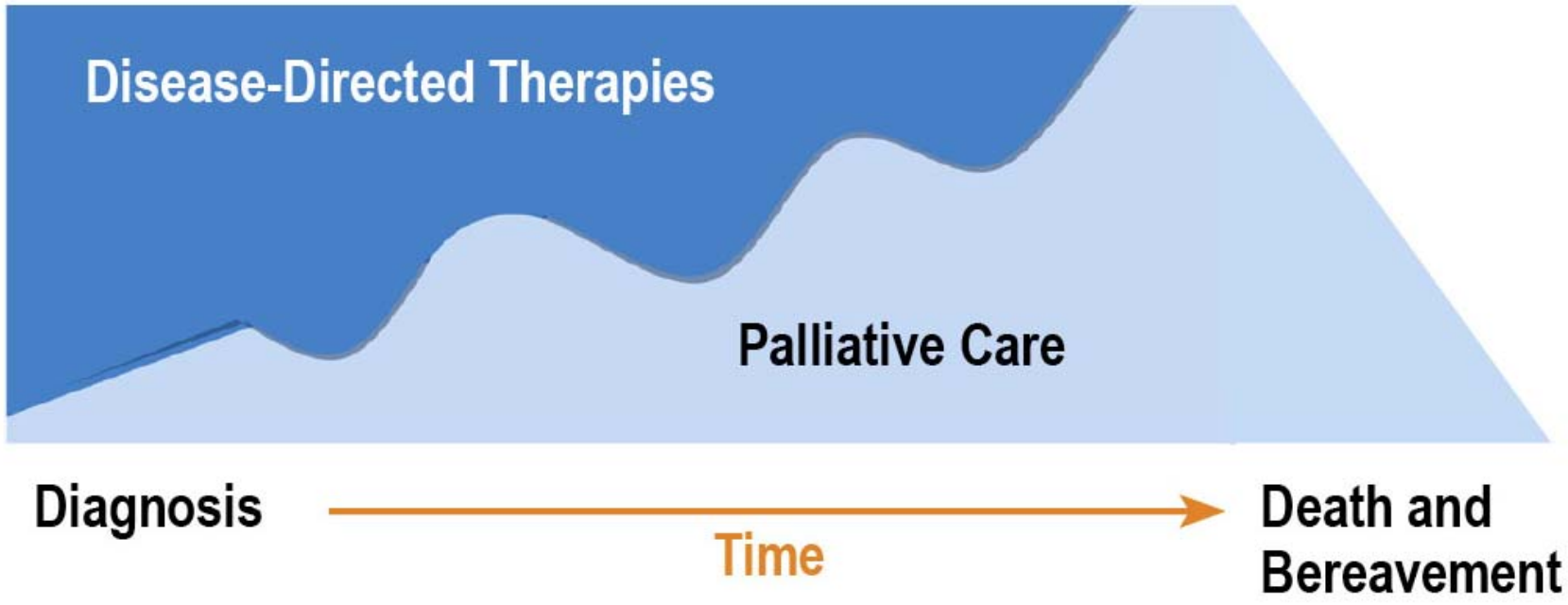
Who Are These Patients and How Effectively Are We Meeting Their Needs?

- Functional limitation
- Frailty
- Dementia
- Exhausted and overwhelmed family caregivers
- Social determinants
- +/- Serious illness(es)

What is Palliative Care?

- Palliative care is specialized medical care for people with **serious illness**.
- It focuses on providing patients and their families with **relief** from the symptoms, pain, and stress of a serious illness—**whatever the diagnosis or stage of the disease.**
- The goal is to **improve quality of life** for both the patient and the family.
- It is appropriate at any age and at any stage in a serious illness and **can be provided along with curative treatment.**

Palliative Care is Delivered Concurrent with Curative Treatment



Adapted from Morrison and Meier. N Engl J Med 2004;350(25):2582-90.

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What is the Impact of Palliative Care?

Quality:

- Relieves pain and symptoms
- Patients live *longer*
- Better family support

Cost:

- Setting & treatment aligned with patient goals
- Reduces 911 calls, ED visits, and hospitalizations
- Reduces unnecessary tests, procedures

Earlier Integration of Palliative Care Improves Outcomes For Patients

- 151 lung cancer patients randomized to usual care versus usual + palliative care consultation
- Compared to usual care only patients, palliative care patients were observed to have:
  - Significantly improved quality of life
  - Less depression
  - Fewer burdensome treatments
  - Improved survival: + 11 weeks

Temel et al, NEJM 2010

CAPC's Payer-Provider Toolkit

Sponsored by:

National Business Group on Health

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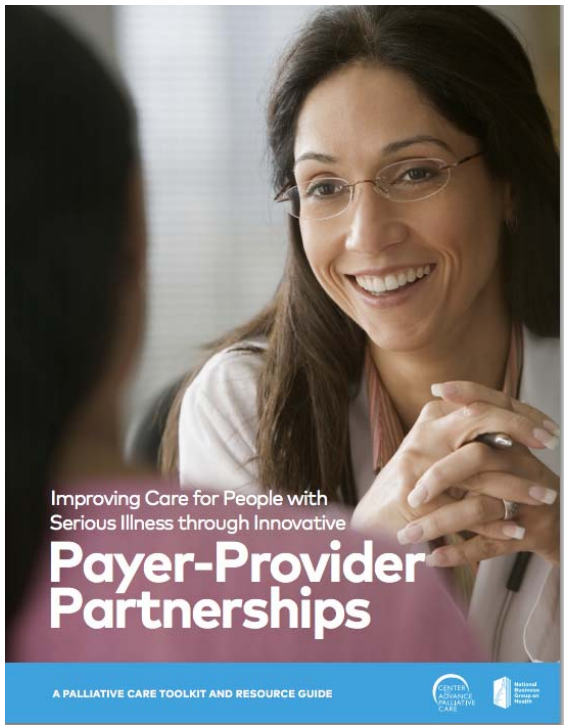

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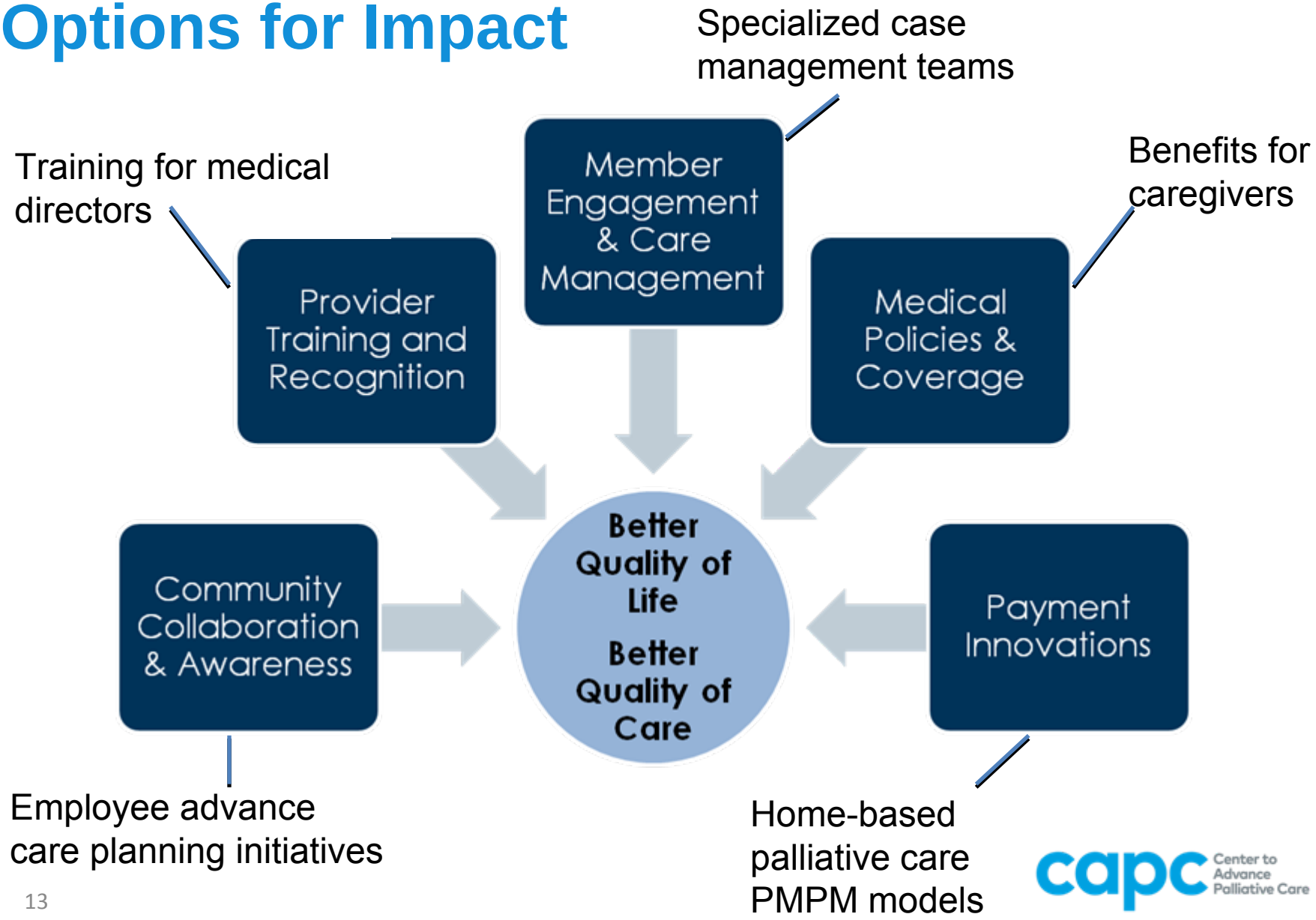
Payer and ACO Case Examples Demonstrate Options for Impact



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Designing Payer, ACO, and ACO-Like Programs Focused on Serious Illness

Targeting	• Develop criteria for identifying those with serious illness using claims and clinical data • Tip: Functional status is an important indicator
Services	• Identify quality palliative care network providers • Train clinical teams in skills of palliative care • Tip: Be able to offer psychosocial, spiritual, and practical (transportation) services
Payment	• Design payment models based on services needed • Tip: Expect to operate under multiple models
Evaluation	• Establish process for measuring impact • Include quality, experience, and cost indicators • Tip: Align program goals to organizational goals

Practical Tips for Getting Started: Conduct a Needs Assessment

1. **Identify the population and needs**
   - Case managers and medical directors
   - Palliative care and other providers
   - Members
   - Claims data and actuarial models
   - Community organizations
2. **Assess gaps, barriers and building blocks**
   - Training of clinical teams
   - Inventory benefits and coverage
   - Evaluate access to care and services
3. **Prioritize opportunities with leadership and the organization**
   - Align to leadership's goals
   - Evaluate actuarial and financial risk models and impacts

Home-based Palliative Care Case Example: Banner Health System

Stacie Pinderhughes, MD

Banner at a Glance

Banner Health®

- 29 Acute Care and Critical Access Hospitals
- Behavioral Hospital
- Banner Health Network
- Banner Network Colorado
- Banner Medical Group and Banner – University Medical Group with more than 1,500 physicians and advanced practitioners and more than 200 Banner Health Centers and Clinics
- Outpatient Surgery
- Banner – University Medicine division
- $5.4 billion in revenue, 2014
- AA- bond rating
- $457 million in community benefits, including $84 million in charity care, 2014

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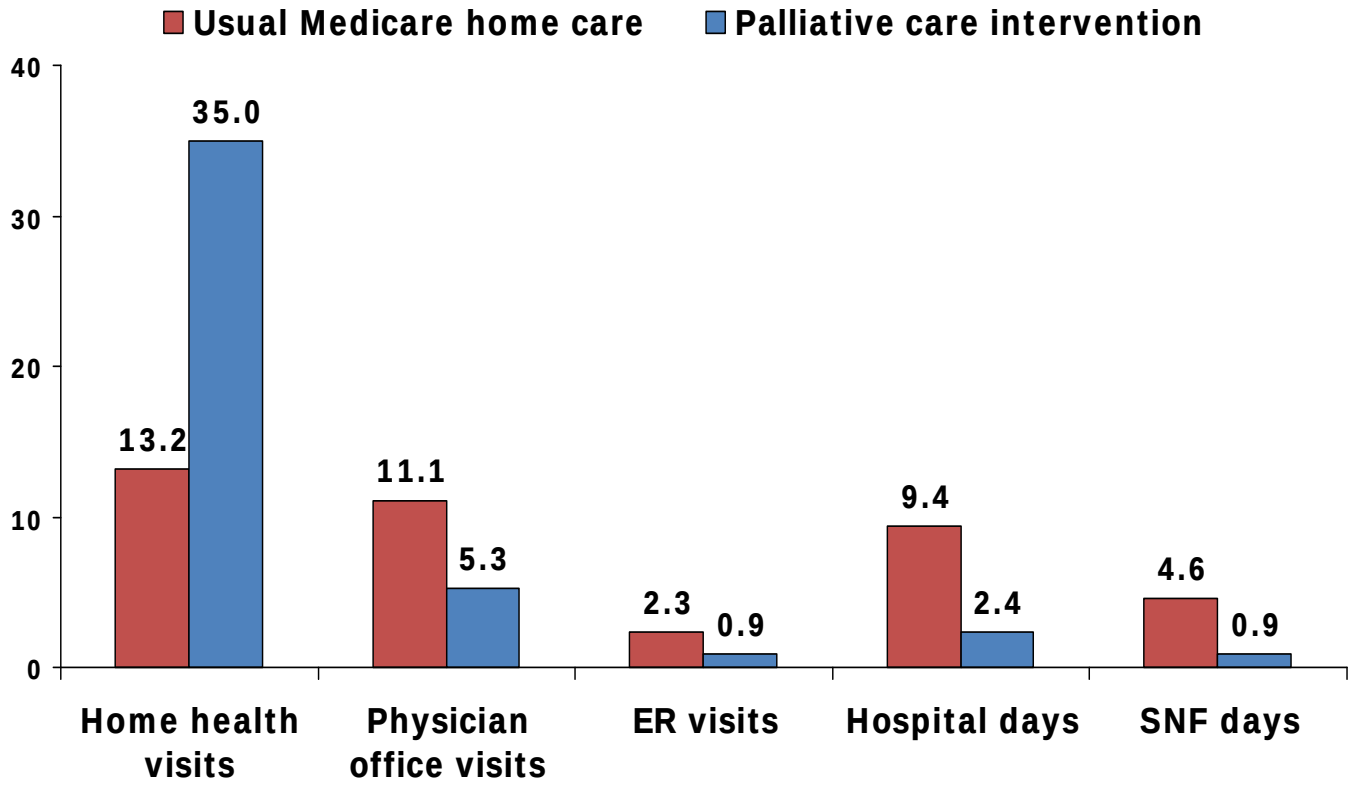
Why is Banner Investing in Home-based Palliative Care?

- ***System Priority***: Developing strategies to move from volume-based to value based care while developing models of care to meet consumer needs across the health care continuum.
- Banner Health Network (BHN): An ACO involving Banner employed physicians, private community physicians, governmental and commercial contracts involved in value based contracting.
  - Currently 20% of revenues in value based contracts
  - Current landscape: close to 700,000 lives under some type of value based arrangement
- Banner views Palliative Care as critical to being successful in new risk arrangements that drive a focus on individuals with serious illness.

Studies Demonstrate Impact of Palliative Care at Home for the Chronically Ill

Improves Quality, Markedly Reduces Cost. RCT of Service Use Among Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer Patients While Enrolled in a Home Palliative Care Intervention or Receiving Usual Home Care, 1999–2000.



KP Study Brumley, R.D. et al. JAGS 2007

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Banner Health: Key Elements of Quality Palliative Care Service Delivery

- Co-management with primary care physician
- Goal setting and advanced care planning
- Symptom management
- Disease specific prognostication
- Psychosocial assessment
- Patient and family education
- Practical and social supports
- Improve continuity across care continuum
- Pharmacy medication reconciliation
- Initial visit within 72 hours

Critical to Quality Palliative Care: Multidisciplinary Team

Our Home Based PC team includes:

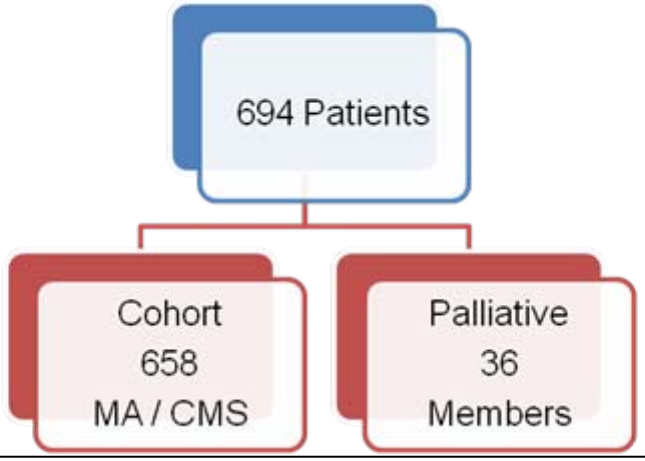
- ➔Physicians
- ➔Nurse Practitioners
- ➔Registered Nurses
- ➔Social Workers
- ➔Patient Care Coordinators
- ➔Chaplains (if requested)

Study Methods

- Population:
  - 3,171 CMS & Medicare BHN members were evaluated
    - 36 members participated in Palliative Care and were live discharged
    - 3,135 patients were in the palliative care comparison cohort
    - All members are expired as of the date of the analysis
- Control Approaches:
  - Patient expiration
  - Complex Chronic Dx Hx (15 Banner identified Dx)
  - HCC DX (Cancer)
- Study Period:
  - Up to 21 months of claims leading up to expiration
- Comparison Approach:
  - Claims expense, by type of claim, in indexed$_1$ claim months leading up to DOD.
    - Index month = DOD minus claim DOS
- Measures
  - Claims $ in months leading to death
    - Claims $/member/month

Complex Chronic Controlled Outcomes

$1,147 PMPM savings



Complex Chronic Indications Comparison

	$ / Claim	Total $ / Member		# claims / member	(UnPaired) T-Test	N		
<= 3 mo prior to DOD	$ 1,412	$ 11,358	Pall	8.04		36	$ 2,839	PMPM
	$ 3,202	$ 29,334	Cohort	9.16	0.00094 p-value	657	$ 7,334	PMPM
DOD - 4-6 mo	$ 1,770	$ 5,419	Pall	3.06		36	$ 1,806	PMPM
	$ 2,673	$ 14,626	Cohort	5.47	0.1090 p-value	476	$ 4,875	PMPM
DOD - 7-9 mo	$ 1,723	$ 4,089	Pall	2.37		31	$ 1,363	PMPM
	$ 2,444	$ 12,296	Cohort	5.03	0.1114 p-value	349	$ 4,099	PMPM
DOD - 10-12 mo	$ 1,142	$ 4,242	Pall	3.71		31	$ 1,414	PMPM
	$ 1,984	$ 8,846	Cohort	4.46	0.0629 p-value	248	$ 2,949	PMPM
> 12 mo prior to DOD	$ 1,403	$ 6,397	Pall	4.56		25	$ 800	PMPM
	$ 2,463	$ 16,857	Cohort	6.84	0.1937 p-value	172	$ 1,873	PMPM
Total	$ 1,499	$ 27,574	Pall	18.39		36	$ 1,313	PMPM
	$ 2,811	$ 54,132	Cohort	19.25	0.0498 p-value	658	$ 2,461	PMPM

$ 1,147 PMPM Savings

Complex Chronic = Banner INP Dx Hx of:
•Hypertension, CHF, CAD, cardiac arrhythmias, hyperlipidemia, stroke, arthritis, asthma, cancer, CKD, COPF, dementia, depression, diabetes, osteoporosis

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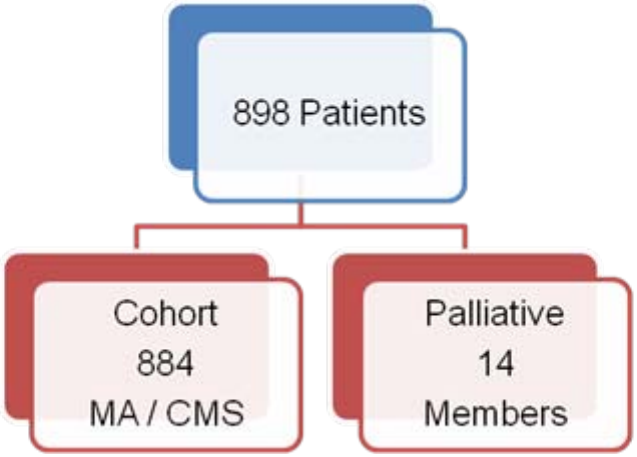
Cancer Controlled Outcomes

$4,432 PMPM
In last 3 months of life



Cancer Indication Comparison

	$ / Claim	Total $ / Member		# claims / member	(UnPaired) T-Test	N			
<= 3 mo prior to DOD	$ 1,057	$ 10,950	Pall	10.36		14	$ 2,738	PMPM	
	$ 2,601	$ 28,676	Cohort	11.03	0.01533 p-value	882	$ 7,169	PMPM	$ 4,432 *PMPM Savings*
DOD - 4-6 mo	$ 2,078	$ 13,357	Pall	6.43		14	$ 4,452	PMPM	
	$ 2,222	$ 16,379	Cohort	7.37	0.4020 p-value	657	$ 5,460	PMPM	
DOD - 7-9 mo	$ 1,915	$ 11,296	Pall	5.90		10	$ 3,765	PMPM	
	$ 1,993	$ 11,279	Cohort	5.66	0.9970 p-value	522	$ 3,760	PMPM	
DOD - 10-12 mo	$ 746	$ 4,273	Pall	5.73		11	$ 1,424	PMPM	
	$ 1,798	$ 9,576	Cohort	5.33	0.1800 p-value	371	$ 3,192	PMPM	
> 12 mo prior to DOD	$ 1,432	$ 10,658	Pall	7.44		9	$ 1,332	PMPM	
	$ 1,712	$ 13,747	Cohort	8.03	0.7178 p-value	277	$ 1,527	PMPM	
Total	$ 1,346	$ 42,584	Pall	31.64		14	$ 2,028	PMPM	
	$ 2,268	$ 55,772	Cohort	24.59	0.2172 p-value	884	$ 2,535	PMPM	

Cancer = All Claim Indications (HCCs):
Metastatic Cancer and Acute Leukemia (8), Lung and Other Severe Cancers (9), Lymphoma and Other Cancers (10), Colorectal, Bladder and other Cancers (11), Breast, Prostate, And other Cancers (12)

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Results & Recommendations

- Palliative Care Patients show statistically lower readmission rates than cohort patients in months leading up to expiration
  - (7.7% (T) vs. 22.6% (C)) – $p < 0.0001$
- Palliative Care Patients show statistically lower claims expense / inpatient claim than Cohort patients in months leading up to expiration
  - ($1,137 (T) vs. $5,946 (C)) - $p < 0.0001$
- Palliative Care Patients show statistically lower total claims expense per member in the last 3 months of life
  - ($9,843 (T) vs. $27,530 (C)) – $p = 0.002$

Results & Recommendations

- Palliative Care Patients with Cancer show statistically lower overall claims expense per member in the last 3 months of life
  - ($10,950 (T) vs. $28,676 (C)) – p = 0.015
  - Translates to $4,432 PMPM savings in last 3 months of life
- Palliative Care Patients with at least one chronic condition show statistically lower PMPM expense in months leading up to expiration
  - ($1,313 PMPM (T) vs. $2,461 PMPM (C)) – p = 0.049
  - Translates to $1,147 PMPM savings across all months leading up to expiration
- Clinical Recommendations: Continue to grow a robust Palliative Care program that can meet the needs of seriously ill individuals at home and in the community. Palliative Medicine must be viewed from the population health perspective.

Lessons Learned

- Plan for rapid program expansion; if you build it they will come
- Develop a realistic assessment of service area from program inception
- Develop precise and easily defined criteria
- Build EMR or electronic referral system from inception

Questions?