Incorporating “End of Life” Measures in to a Pay For Performance Contract

Integrated HealthCare Association

Los Angeles, CA

February 15, 2007

Jeff Levin-Scherz, MD MBA FACP

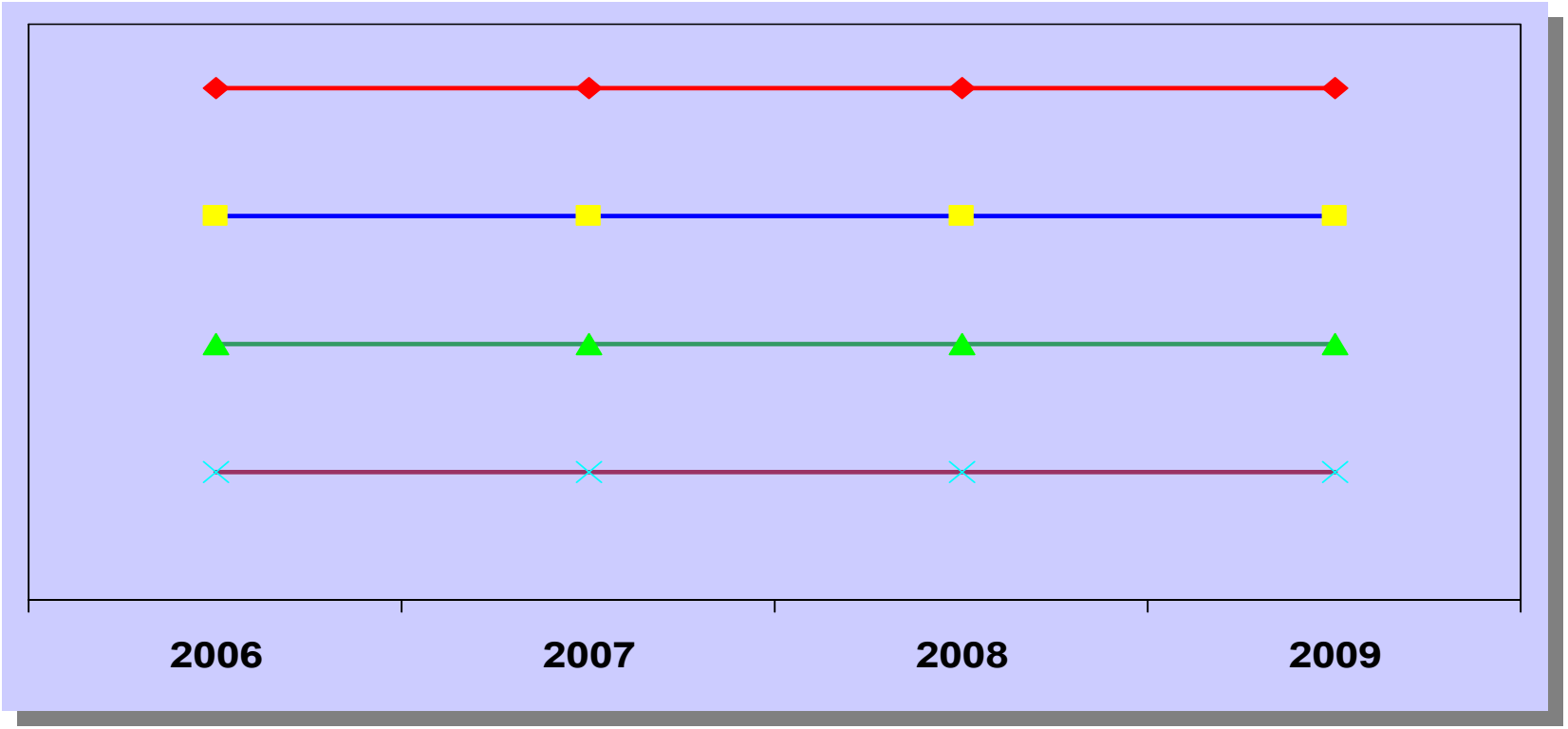
Partners Community HealthCare, Inc

jlevinscherz@partners.org

Learning Objectives

- Review how a health plan and a provider organization chose to make an intervention on end of life care
- Demonstrate current opportunity for improvement in our service area
- Examine potential metrics to assess appropriateness of end of life care
- Illustrate current plan to incorporate end of life care in 2007-2009 P4P performance metrics

BCBS –PCHI Contract, Fall,



Partners and BCBSMA have agreed to identify what should characterize care in 2009 (A,B,C,D), and work backwards, identifying what needs to happen in the preceding years. Withhold will be based upon hitting those goals in earlier years.

We live longer and suffer more disability and expense than in the past

A Century of Change (6)

	1900	2000
Life expectancy	47 years	75 years
Usual place of death	home	hospital
Most medical expenses	paid by family	paid by Medicare
Disability before death	usually not much	2 years, on average

Blue Cross Blue Shield of Massachusetts

Medicare spends 25% of its resources on patients in the last year of life, and 12.5% of its resources on last month of life

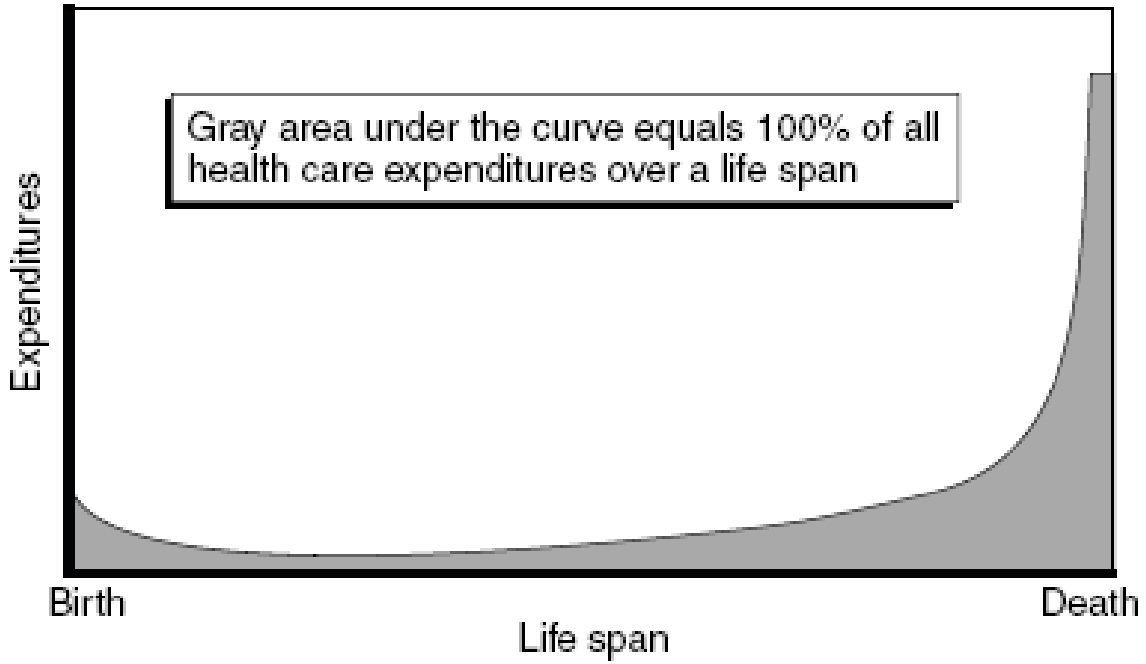
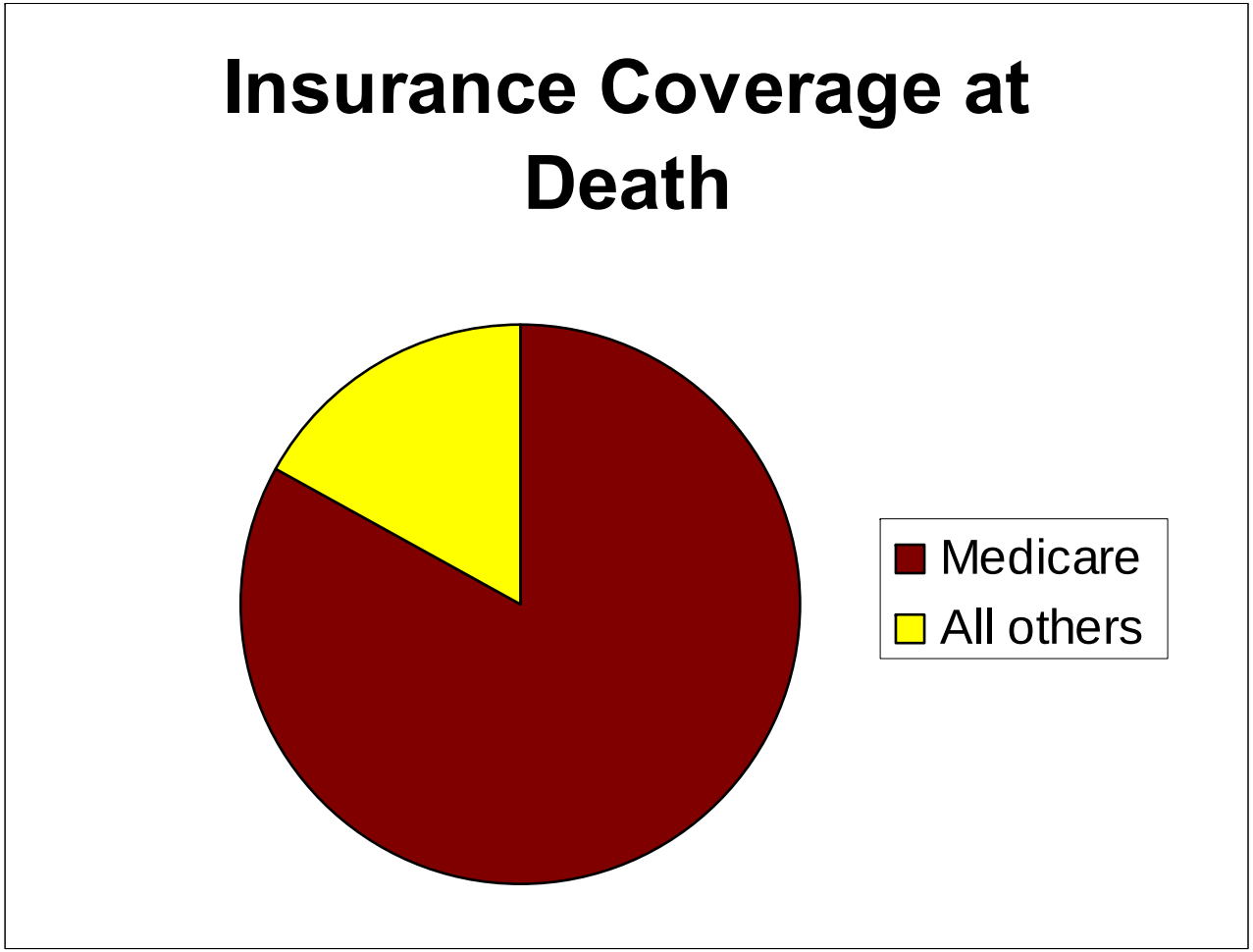


Figure 1. Americans' Current Health Care Expenditures Are Concentrated in the Final Part of the Life Span

Source: CMS Actuary

Medicare is the overwhelming insurer at time of patient death



Note 4.7% of Medicare population dies each year (MedPAC 2000).

Substantial Opportunities to Improve End of Life Care

- **Fragmentation of care**
- **Poor communication**
- **Few advance directives and advance care plans**
- **Inadequate pain management**
- **Late hospice and palliative medicine referrals, few for non-cancer**
- **patients**
  - **Confusing benefit sructures**
  - **Physician and patient and family misunderstanding**
- **Patients die in hospitals when they would prefer to be elsewhere**
- **Little information available on cultural sensitivity in end of life care**
- **Inadequate emotional support for patients and families**
- **Few incentives to promote physician performance in this area**

Source: Partners End of Life Workgroup, 2005

Joint Quality Initiative: Areas of Focus

1. EMR with Decision Support
2. Inpatient Safety
3. High Risk Patients
4. **End of Life**
5. Data Sharing

Mission is to “promote fundamental change in the way care is delivered/supported at both organizations.”

Blue Cross Blue Shield of Massachusetts

Goals of Partners/Blue Cross End of Life Initiative

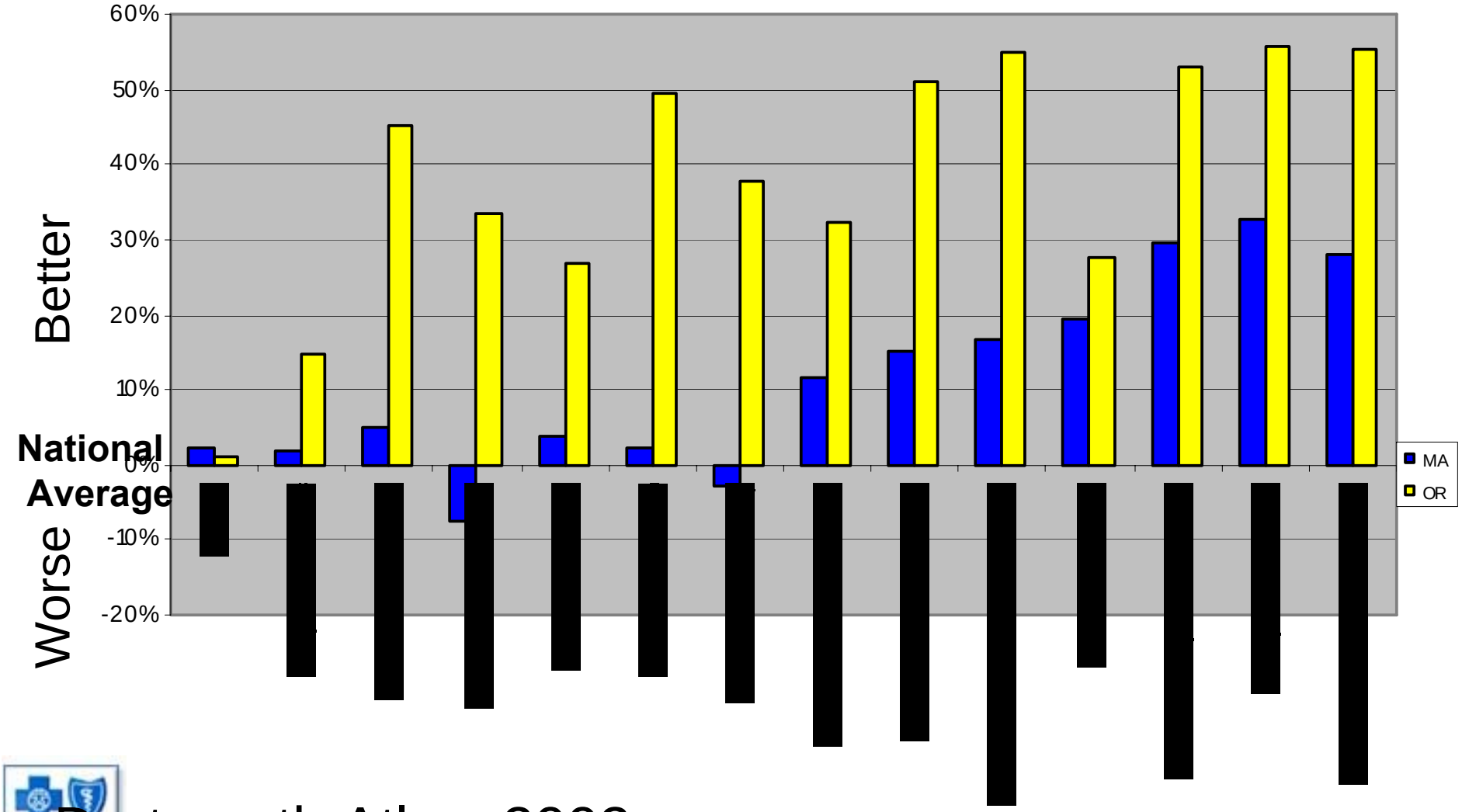
Measurably improve the care of those at the end of life, including:

- Improved quality of care and patient satisfaction
- Improved family and caregiver support and satisfaction
- Decreased percentage of deaths in hospitals
- Increased utilization of hospice, palliative care
- Better coordination of care through terminal illness

Scope: End of Life Care

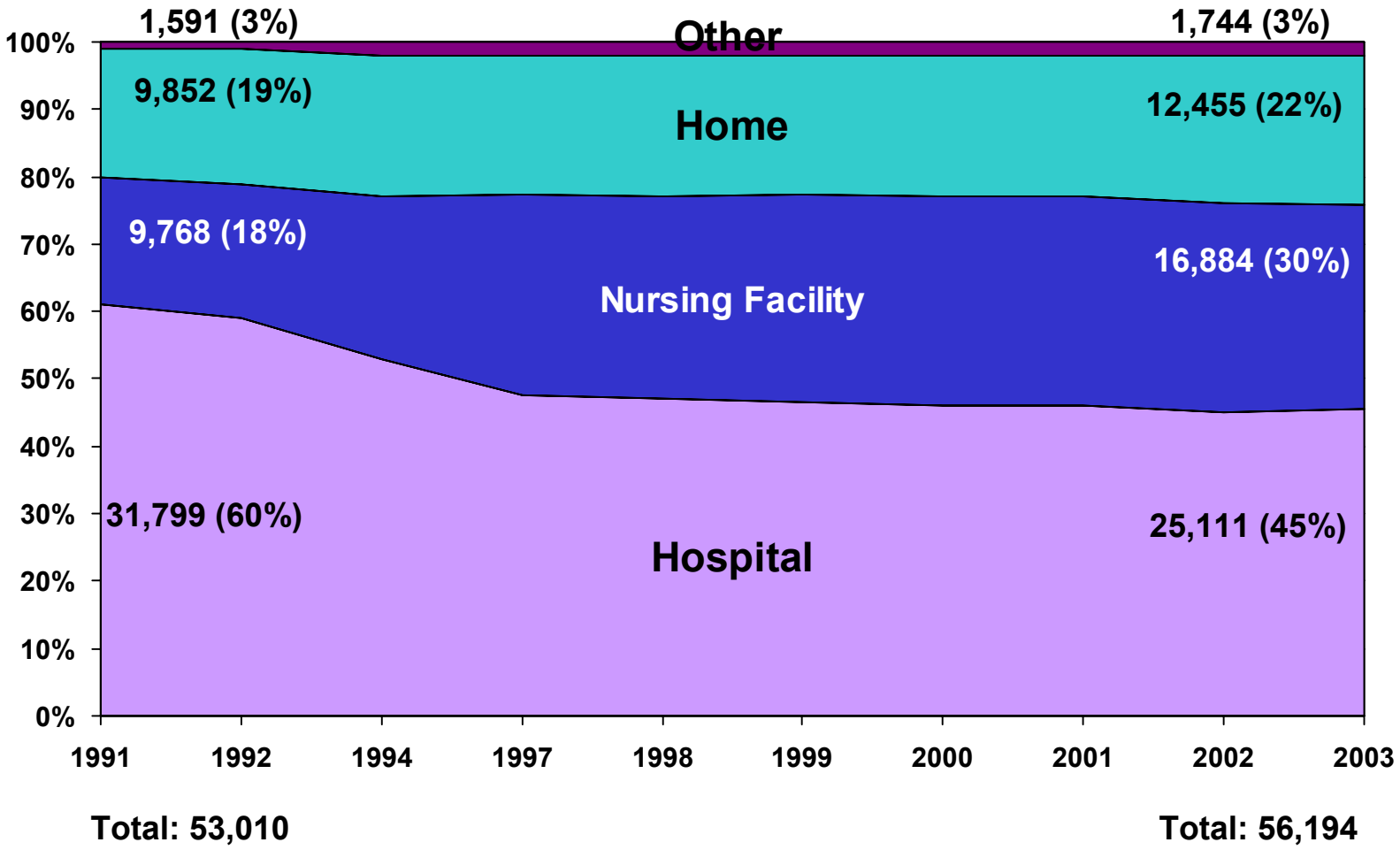
- Medicare beneficiaries AND commercial insurance enrollees
- Quality of care and patient satisfaction
- Family and caregiver support and satisfaction
- No incentives to increase “DNR” orders!

MA and OR compared to National Mean in End of Life Measures



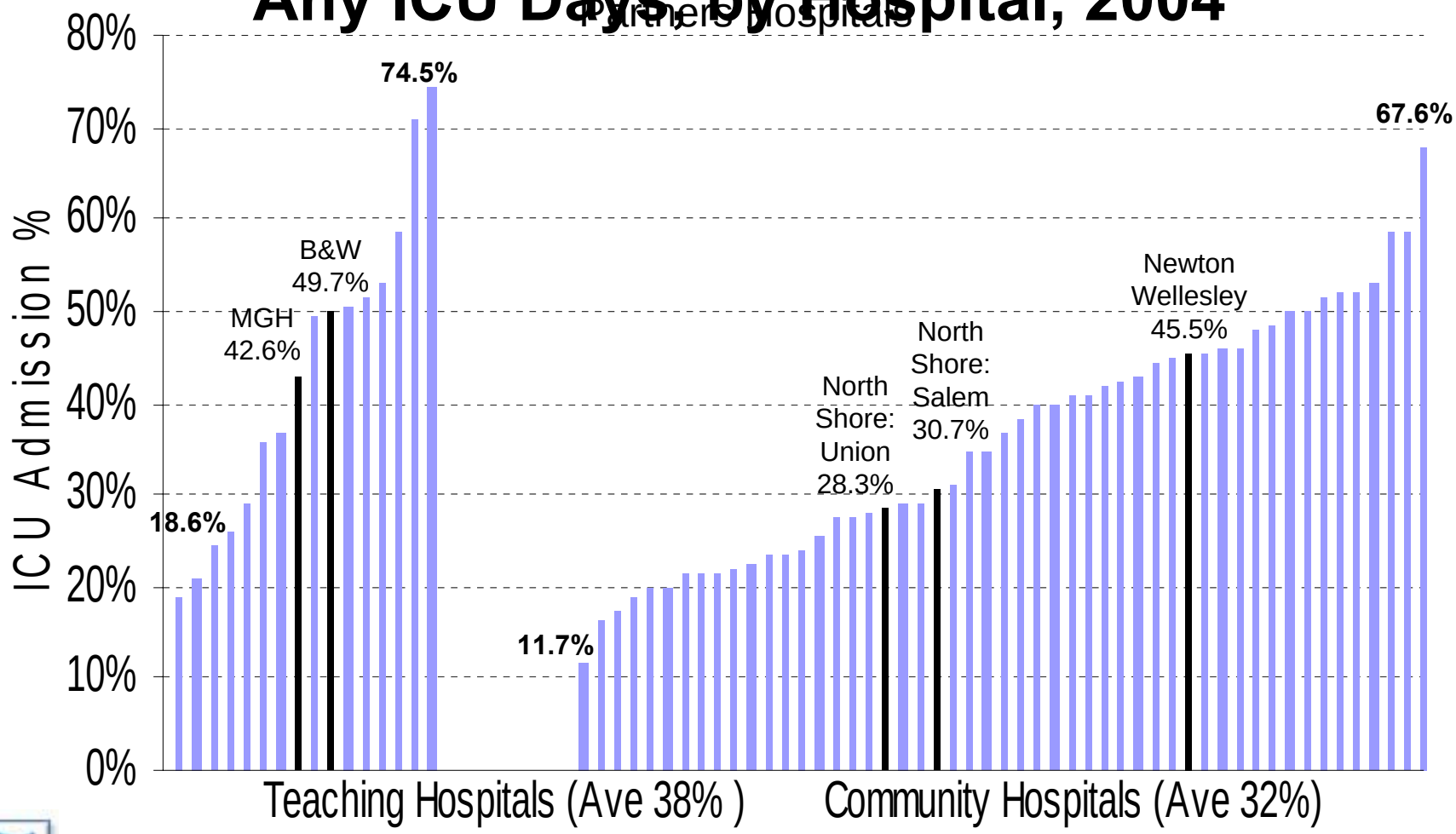
Dartmouth Atlas, 2002

Site of Death of Massachusetts Residents, 1991-2003



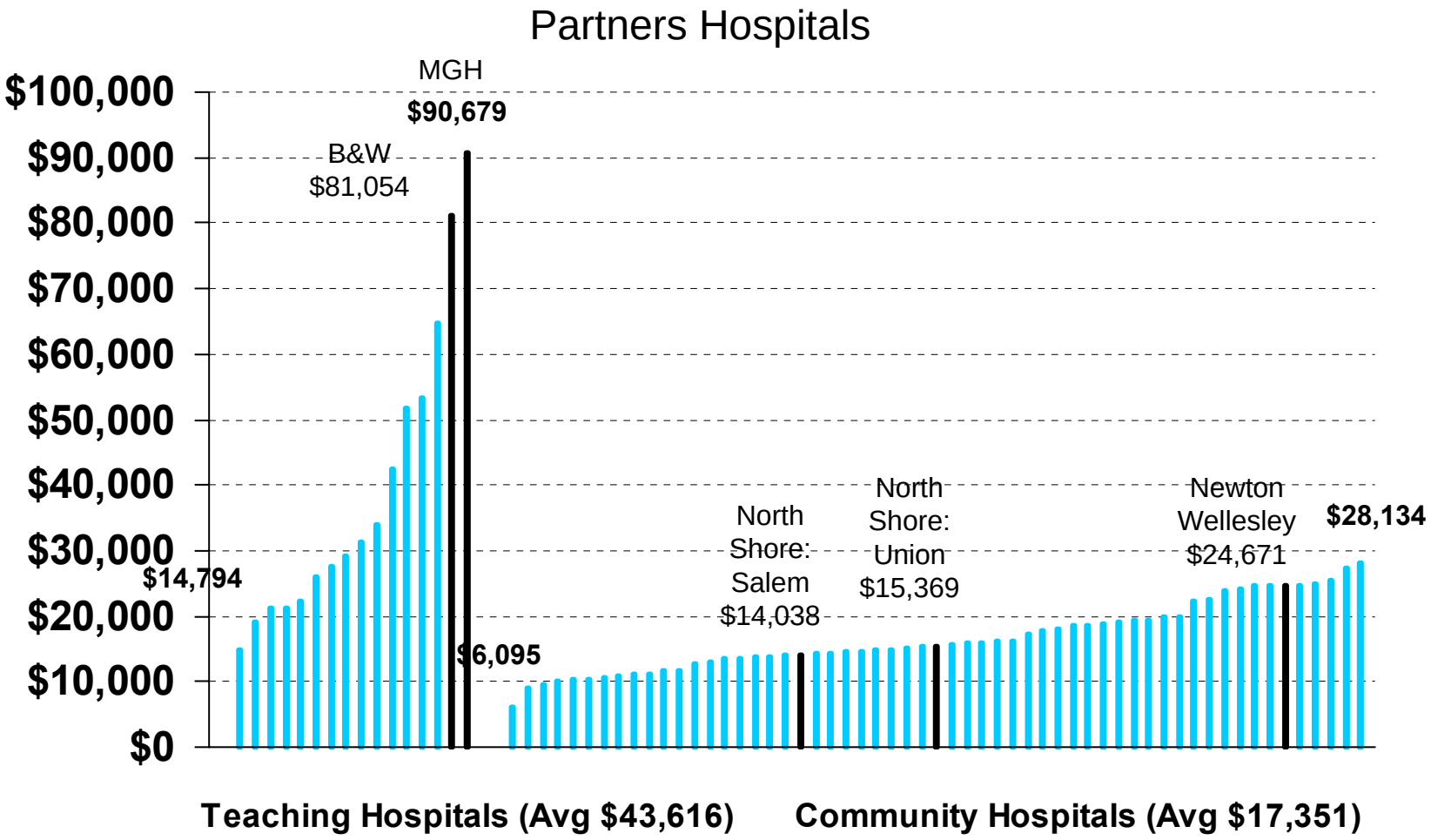
Source: Massachusetts Department of Public Health

Percent of Terminal Patients ≥ Age 80 with Any ICU Days, by Hospital, 2004



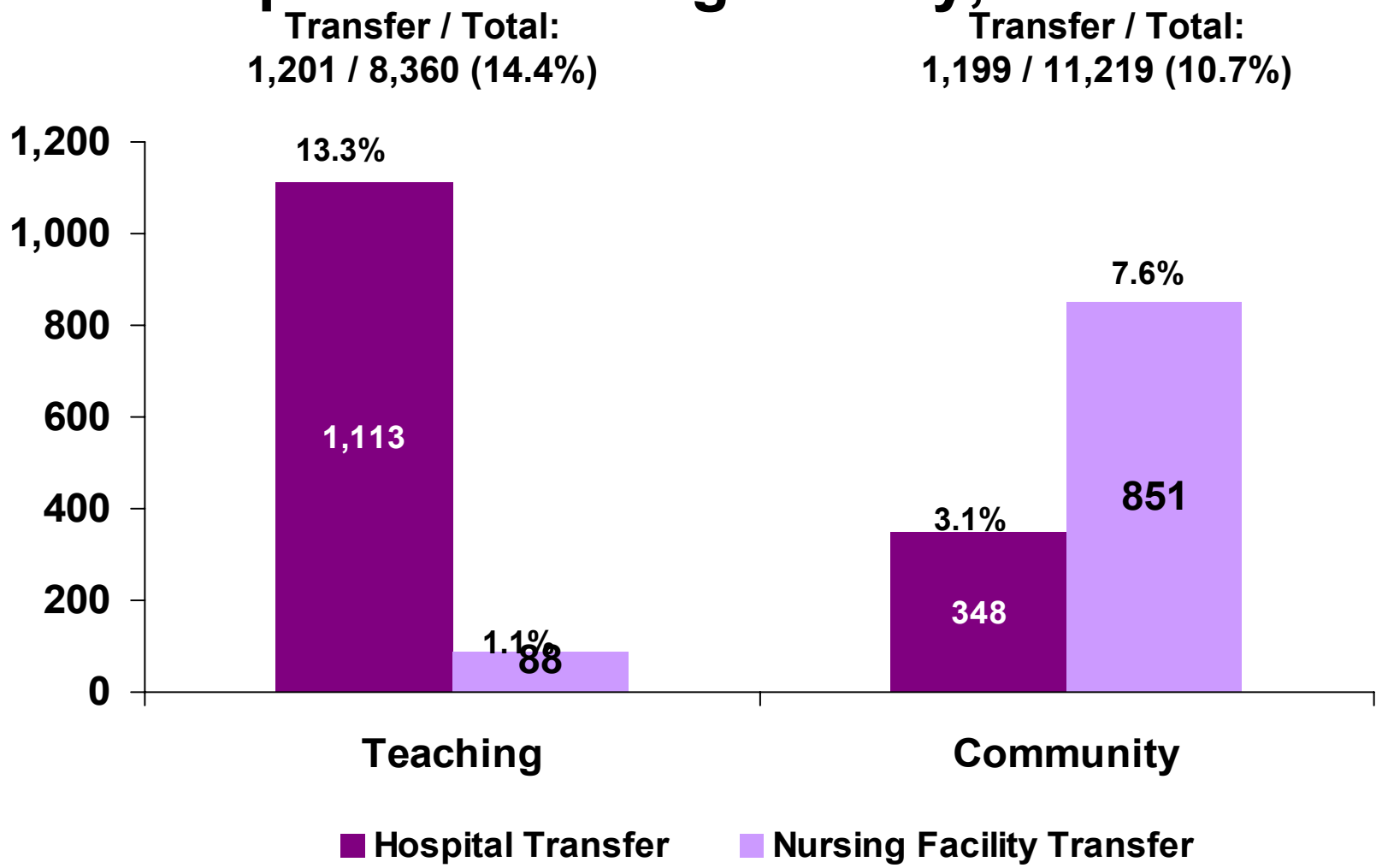
Source: Massachusetts Department of Public Health

Total Hospital Charge per Terminal Patient ≥ Age 80, by Hospital, 2004



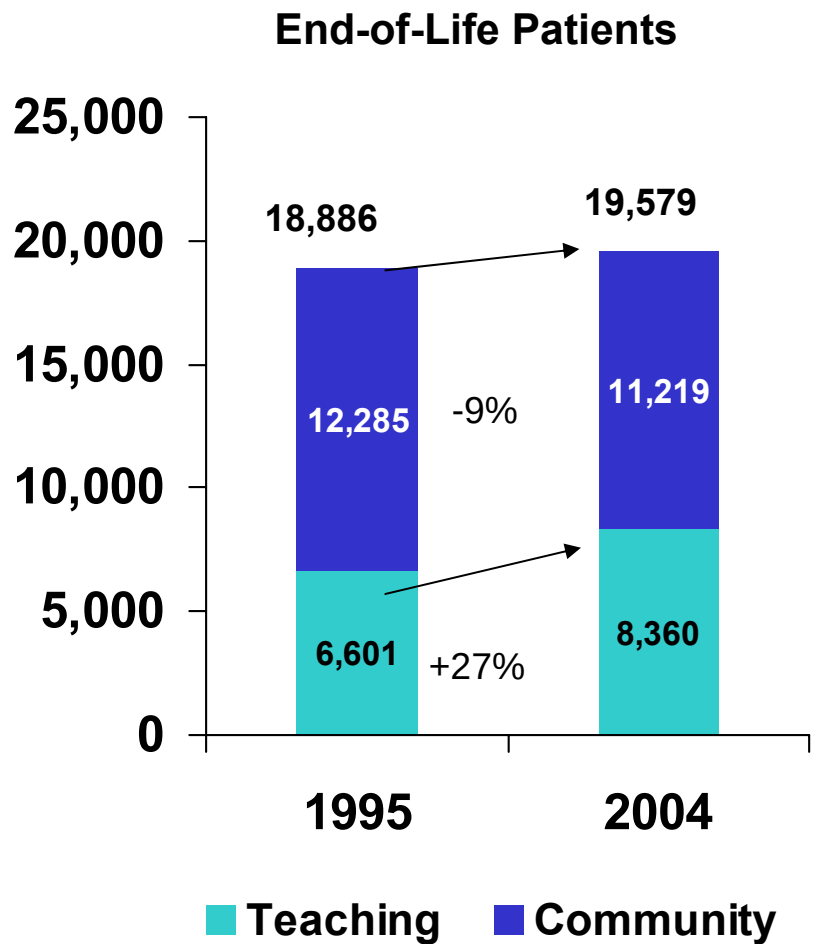
Source: Massachusetts Department of Public Health

Terminal Patients Transferred from Another Hospital or Nursing Facility, 2004



Source: Massachusetts Department of Public Health

The portion of deaths occurring in AMCs increased over last decade



Source: Massachusetts Department of Public Health

National Data: Many opportunities to improve

- **47% of physicians knew patient's preference re:CPR**
- **38% of patients who died spent at least 10 days in an ICU.**
- **50% of the patients who died in the hospital experienced moderate or severe pain at least half of the time during the few days of life.**

A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients
JAMA, 22 Nov 1995 pp 1591-1598

EXHIBIT 2
Physician Labor Input During The Last Six Months Of Life Among Medicare Chronic Disease Cohorts Loyal To Seventy-Nine Integrated Academic Medical Centers (AMCs), By Individual AMC And Labor Input Level, 1999–2001

	Standardized physician FTEs per 1,000 beneficiaries		
Academic medical center	**Total**	**Primary care**	**Medical specialists**
Very high			
New York University Medical Center	28.3	8.8	15.0
Robert Wood Johnson University Hospital (NJ)	19.8	4.3	12.2
Rush–Presbyterian–St. Luke's, Chicago (IL)	19.4	8.0	7.0
Hermann Hospital, Houston (TX)	18.3	4.6	10.0
Thomas Jefferson University Hospital, Philadelphia (PA)	17.9	5.6	8.9
Mount Sinai Medical Center, New York City	17.8	7.1	8.0
University of California, Los Angeles, Medical Center	16.9	3.5	10.1
Harper Hospital, Detroit (MI)	16.8	6.7	7.3
Sinai–Grace Hospital, Detroit (MI)	16.8	7.1	6.9
Presbyterian University Hospital, Philadelphia (PA)	16.6	5.9	7.1
Montefiore Medical Center (NY)	16.5	6.5	7.1
Westchester County Medical Center (NY)	16.3	6.8	6.1
Methodist Hospital, Houston (TX)	16.2	4.2	9.3
Georgetown University Hospital (DC)	16.2	3.4	9.2
Massachusetts General Hospital	15.3	6.3	5.5
Very low			
Mayo, Rochester (MN)	8.9	3.0	3.9
Grady Memorial Hospital, Atlanta (GA)	8.7	3.3	3.9
Froedtert Memorial Lutheran Hospital, Milwaukee (WI)	8.4	2.5	4.0
University Hospitals, Oklahoma City	8.4	1.8	4.5
University of Kentucky Hospital, Lexington	8.2	2.9	3.3
University and Children's Hospital, Columbia (MO)	8.1	3.3	2.5
University Hospital, Jackson (MS)	8.1	1.5	4.2
Strong Memorial Hospital, Rochester (NY)	8.1	3.8	2.4
Scott and White Memorial Hospital, Temple (TX)	8.0	2.7	3.7
Medical College of Virginia Hospital, Richmond	7.9	2.2	3.7
University of Wisconsin Hospital, Madison	7.8	2.2	3.6
Dartmouth–Hitchcock Medical Center, Lebanon (NH)	7.7	3.5	2.6
University of Utah Hospital, Salt Lake City	7.7	2.1	3.9
William Wishard Memorial Hospital, Indianapolis (IN)	7.6	3.1	3.0
University of Cincinnati Hospital (OH)	7.5	2.4	2.9
Medical College of Georgia, Augusta	6.0	1.8	2.8

…n, Thérèse A. Stukel, Chiang-hua Chang, and John E. Wennberg
…End-Of-Life Care At Academic Medical Centers: Implications For Future Workforce Requirements *Health Affairs*, March/April 2006; 25(2): 521-531.

Exploratory study on EOL care at Partners-Goals

- Method: Structured individual, in-depth interviews with
  - patients at the end of life and
  - family members of those who have died within the Partners Healthcare System.
  - Required referral from Partners physician

N = 44 family members and 13 patients

Selected Results

- 90% of patients and family members reported that it was clear who was directing their care
- Most patients and family members understood the severity of the illness
  - However, 3 patients did not understand that their illness was terminal, and 1/4 of family members hadn't known that the patient was at the end-of-life
- Over half were satisfied with the way the illness was explained. However, almost no one thought it was excellent, and about 20% were dissatisfied.
- About 3/4 of family members said communication among hospital staff was good (1/4 said "not good.")

Selected Results

- Most patients and family members said that pain was well attended to, yet 1/3 reported that patients lived with quite significant and frequent pain.
- Most family members and patients were satisfied with discharge planning – one in seven were <u>really dissatisfied</u>

Advance Care Plans

- More than half of family members and patients had health care proxy
- 1/3 of family members and 1/2 of patients had a DNR
- 1/3 of family members and patients reported having a living will
- 1/4 of family members reported that they were not provided information about advanced care (HCP, DNR, or living

Selected quotes

"…we didn't know who to go to. But there was a medical student that was involved with the case, and we used him as means of communication – which I don't think is acceptable…"

- Wife of elderly lung cancer patient

"These were (the doctor's) exact words to my mother. "We're gonna treat you with this chemo …And once you're done with those treatments, you're gonna go on with your life and you're gonna have a great life…(Her doctor) was very optimistic, very upbeat…not enough of reality."

- Family of elderly patient with ovarian cancer

"My only problem is that the information given is too simplistic….It is too little. Fortunately I'm the kind of patient who goes and gets lots of information on my own….But if I weren't the kind of patient.. I would not know much about my treatment."

Blue Cross Blue Shield of Massachusetts

"I'm told 'Don't worry about this…you're not going to die tomorrow. You know basically, 'don't be overly concerned.' My response is I'm not going to die today or tomorrow, but I'd like more information to help plan my life." *Patient with metastatic thyroid cancer*

"...sometimes it's almost invisible to us as to who is the patient because they are as sensitive to my husband and his needs as they are to me."

"She handed me his discharge summary and I'm readin' it over...and it was wrong! It was almost like it was a different patient! …They had him down as a diabetic; he wasn't. They had him down for havin' a stent... As far as I knew, he did not."

"My husband passed away on Sunday, the following Tuesday the family care doctor still hadn't found out about the death."
-Wife of colon cancer patient

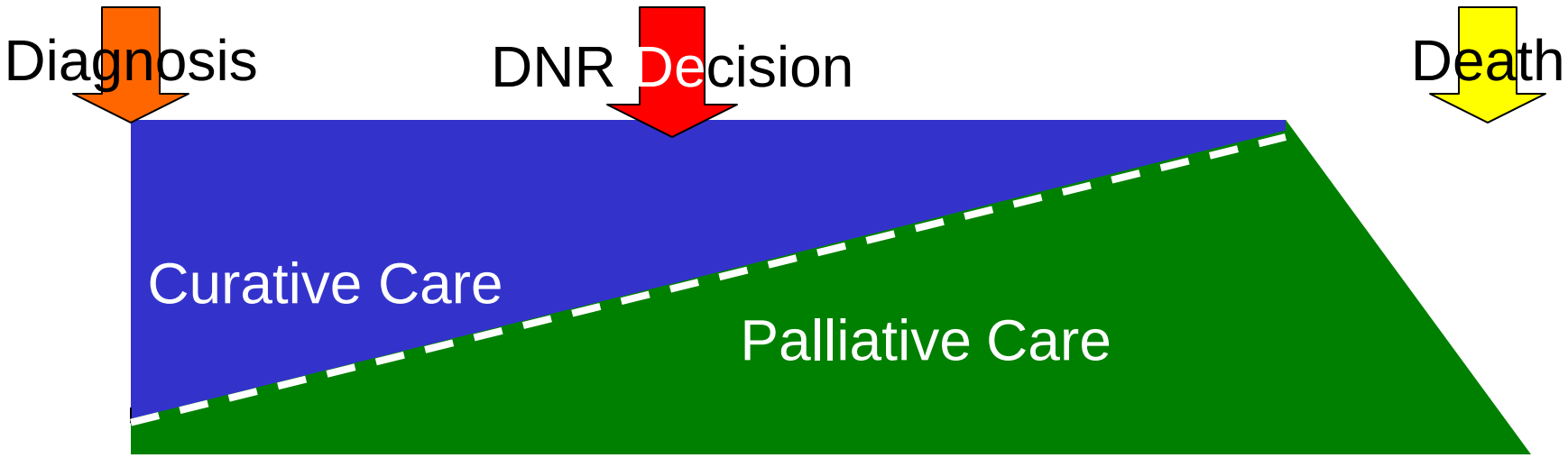
Blue Cross Blue Shield of Massachusetts

Lessons learned

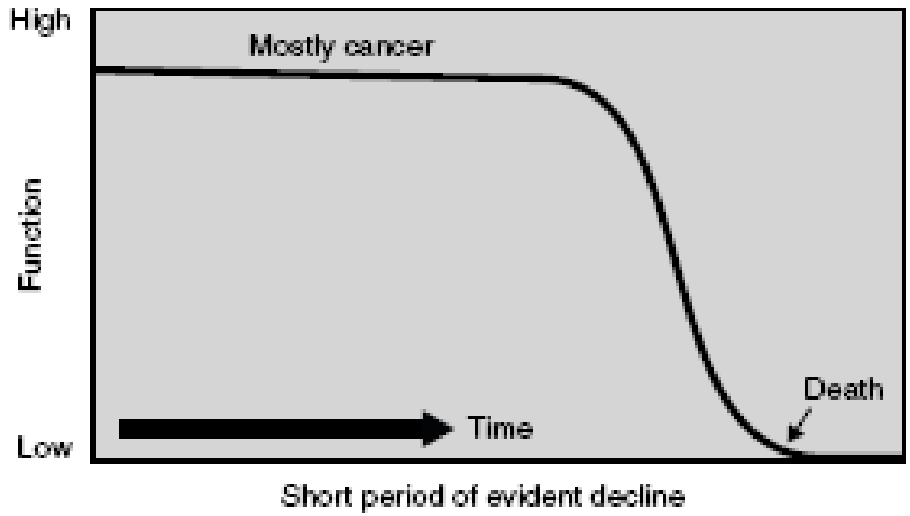
- End-of-life conversations are not occurring as frequently as they should be
- End-of-life conversations are occurring too late
- Death notification is not well coordinated

Traditional Conceptual Model of Care at the End of Life

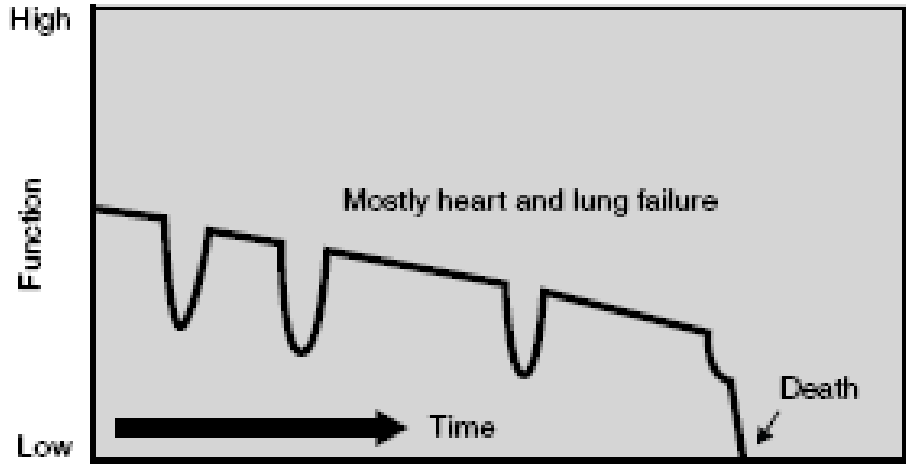
Concurrent Model: Curative and Palliative Care Coexist



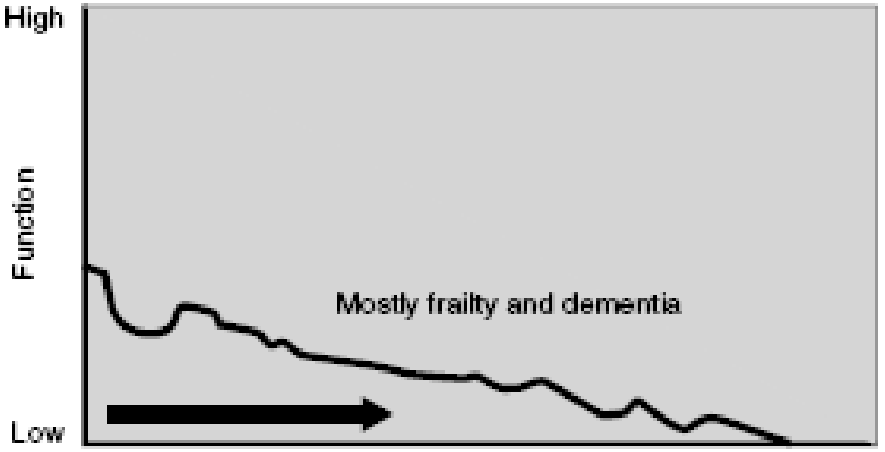
Different Disease Courses



Short period of evident decline



Long-term limitations with intermittent serious episodes



Prolonged dwindling

Rand, Living Well at the End of Life, 2003

How can we measure effectiveness of end of life care?

- Death in hospital
- Days in hospital
- ICU days
- Number of physicians seen
- Cost
- Hospice length of stay
- Advance care directives
- Patient and familly surveys

Some Evidence that Improved End of Life Care Can Lower Costs

Care, Not Cure

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

	NON-PCU	PCU
Drugs and chemotherapy	$2,267	$511
Lab	1,134	56
Diagnostic imaging	615	29
Medical supplies	1,821	731
Room & nursing	4,330	3,708
Other	2,152	278
Total	**$12,319**	**$5,313**

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.

Source: Virginia Commonwealth University medical center

THE WALL STREET JOURNAL.

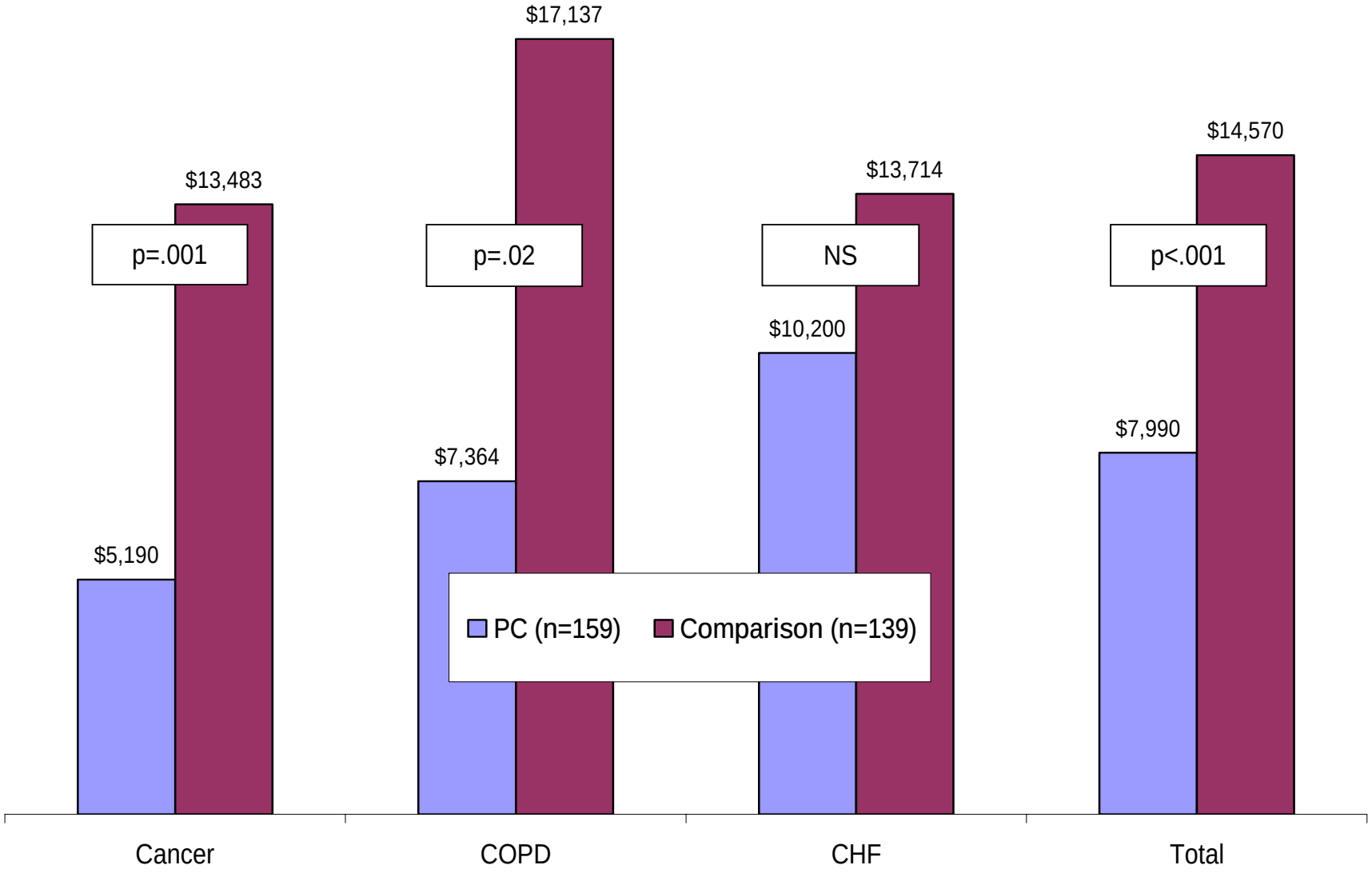
WEDNESDAY, MARCH 10, 2004 - VOL. CCXLIII NO. 48 - ★★ $1.00

Final Days

Unlikely Way to Cut Hospital Costs: Comfort the Dying

Blue Cross Blue Shield of Massachusetts

Kaiser Permanente: Palliative Care reduces cost



Brumley RD, Enguidanos S, Cherin DA. J Palliat Med. 2003 Oct;6(5):715-24.

Best Practices in Advance Care Directives

- Oregon: POLST
- LaCrosse, WI
  - Community-wide advance care directive effort
  - 85%of decedents had an advance directive,
  - 95% in the medical record
  - 98% life sustaining treatments avoided in accordance with patient wishes
- Veteran's Administration
  - Raised portion of seriously ill with advance directives from 50% to 70% in 3 months.

Lynne, J Ann Intern Med.2003;138:812-818.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders
for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes.
Any section not completed implies full treatment for that section.
Everyone shall be treated with dignity and respect.

Last Name	
First Name/ Middle Initial	
Date of Birth	

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): **Person has no pulse and is not breathing.**

☐ Resuscitate/CPR ☐ Do Not Attempt Resuscitation (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B *Check One*

MEDICAL INTERVENTIONS: **Person has pulse and/or is breathing.**

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C *Check One*

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.

Additional Orders: _____

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: **Always offer food by mouth if feasible.**

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

Additional Orders: _____

SUMMARY OF MEDICAL CONDITION AND SIGNATURES

POLST
Oregon

University HealthCare Consortium: Hospital Inpatient Care

Palliative Care Key Performance Measures

	Best decile performance (% of cases)	Best quartile performance (% of cases)
Documentation of patient status within 48 hours of admission	53.8	31.0
Plan for discharge disposition documented within 4 days of admission	73.1	64.3
Patient/family meeting within 1 week of admission	78.0	69.0
Discharge planner/social services arranged services required for discharge	90.0	81.0
Pain assessment within 48 hours of admission	100.0	100.0
Use of a numeric scale to assess pain	95.0	86.7
Pain relief or reduction within 48 hours of admission	85.7	81.5
Bowel regimen ordered in conjunction with opioid administration	75.6	66.7
Dyspnea assessment within 48 hours of admission	100.0	98.0
Dyspnea relief or reduction within 48 hours of admission	91.7	86.2
Psychosocial assessment within 4 days of admission	59.4	40.0

Figure 7 – Source: Patient-level data

From UHC 2004 Palliative Care Benchmarking Project

Individual patients who receive more of the key measures have shorter LOS and lower costs

Outcomes Based on Number of Key Performance Measures*

	0–3 (n = 7)	4–7 (n = 248)	8–11 (n = 147)
Average LOS (days)	16.4	16.2	12.7
Cost/case†	$33,079	$36,973	$25,053
Mortality	28.5%	19.8%	22.4%

Figure 2 – Sources: Patient-level data; CDB data

**Includes only the 402 patients eligible for all 11 key performance measures (i.e., patients reporting pain and dyspnea who were treated with opioids)*

†Cost analyses were performed on only the 391 cases with available cost data

From UHC 2004 Palliative Care Benchmarking Project

Blue Cross Blue Shield of Massachusetts

Partners Hospice Baseline

Number of Hospice Patients From Paid Claims					
	2001	**2002**	**2003**	**2004**	**2005**
HP1	-	-	-	121	132
HP2	38	60	38	71	70
HP3	38	43	38	51	53
Total	**76**	**103**	**76**	**243**	**255**

Partners –BCBSMA “End of Life” Measures in 2007-2009 Contract

- Inpatient
  - 2007: Do UHC chart review project
  - 2008: Implement QI projects to improve end of life care
  - 2009: Repeat UHC chart review and demonstrate improvement on 2 chosen measures

- Outpatient
  - 2007: Collect baseline for % of patients with certain diagnoses who have an advance directive
  - 2008: Implement program to increase this
  - 2009: Demonstrate measurable improvement in this metric

Blue Cross Blue Shield of Massachusetts

Current PCHI/PHS End of Life Efforts

- End of Life Workgroup established
  - Participation across facilities and disciplines Developing plans for regular metrics
  - Developing plans for identifying patients at high risk
  - Will likely develop intervention to include direct patient outreach
- IT developing plans for enterprise-wide repository of preferences for life-sustaining care
- Partners acquired a hospice organization

Conclusion

- There is huge variation in end of life care
- This issue is on health plan radar screens (although Medicare is by far the largest payer for terminal care)
- Contractual measure to improve end of life care will focus our attention on this important issue
- Metrics are key – and this contract will force us to better measure our progress

- Check back in 2010!

Appendix: Potential Metrics

Wennberg metrics

- Days spent in hospital per decedent during the last 6 months of life
- Days spent in intensive care units per decedent during the last 6 months of life
- Physician visits per decedent during the last 6 months of life
- Percent of decedents seeing ten or more physicians during the last 6 months of life

Other possible measures

- Average length of stay in hospice
- % of patients who have >=21 days in hospice care
- % of patients with selected diagnoses for whom a box is checked in EMR saying that “hospice is discussed”
- % of patients with selected diagnoses who are referred to the PHS end of life program
- % of patients with selected diagnoses who have a hospital stay in the last 30 (or 60) days of life

Appendix: Potential Metrics

Other measures cont

- % of patients with selected diagnoses who have an ICU stay in the last 30 (or 60) days of life
- % of patients with selected diagnoses who die in the hospital
- % of patients with selected diagnoses who have an ICU stay during a hospital admission during which they expire
- Number of patients with advance care plans
- % of patients with advance directives
- Decreasing the # of patients who die expected deaths as hospital inpatients
- Appropriate referral for selected diagnosis

Other ideas

- Patient and family surveys
- Surveys of attitudes toward hospice
- # of patients families accessing bereavement services

Appendix: Resources

- Mass Commission on End of Life Care **www.endoflifecommission.org**
- Americans for Better Care of the Dying **http://www.abcd-caring.org**
- Last Acts (RWJ funded) **www.lastacts.org**
- National Hospice and Palliative Care Organization **http://www.nhpco.org**
- Center for Palliative Care Studies **http://www.medicaring.org**

Additional Resources:

www.DyingWell.org

www.TheFourThings.org

www.CAPC.org

www.PromotingExcellence.org

www.Lifes-End.org