Coordinated Care for Advanced Illnesses: Evolution to an Innovative, Integrated Model

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North Texas Specialty Physicians

AMGA 2016 Annual Conference
Presentation Agenda

A Look at the Data

Overview NTSP Structure

Review Framework for Advanced Illness Strategies

Review Extensivist Model

Overview Palliative Care Pilot Program

Examination of Advance Care Planning Program
A Look at the Data
## National Data

### Improvement in care of chronically ill patients:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2007</th>
<th>2010</th>
<th>% Change 2007 to 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths among chronically ill patients</td>
<td>1,159,850</td>
<td>1,107,702</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Total Medicare spending (Parts A &amp; B) per patient, last two years of life</td>
<td>$60,694</td>
<td>$69,947</td>
<td>15.2%</td>
</tr>
<tr>
<td><strong>Hospital utilization, last six months of life</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All hospital days per patient</td>
<td>10.9</td>
<td>9.9</td>
<td>-9.5%</td>
</tr>
<tr>
<td>ICU days per patient</td>
<td>3.8</td>
<td>3.9</td>
<td>0.2%</td>
</tr>
<tr>
<td>Percent of deaths occurring in hospital</td>
<td>28.1</td>
<td>25.0</td>
<td>-11.0%</td>
</tr>
<tr>
<td>Percent of deaths that included an ICU admission</td>
<td>17.6</td>
<td>16.7</td>
<td>-5.5%</td>
</tr>
<tr>
<td><strong>Physician utilization, last six months of life</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All physician visits per patient</td>
<td>29.6</td>
<td>29.1</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Medical specialist per patient</td>
<td>15.1</td>
<td>14.8</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Primary care physician visits per patient</td>
<td>12.4</td>
<td>12.2</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Percent seeing 10 or more physicians</td>
<td>36.1</td>
<td>42.0</td>
<td>16.5%</td>
</tr>
<tr>
<td><strong>Palliative care, last six months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent enrolled in hospice</td>
<td>41.9</td>
<td>47.5</td>
<td>13.3%</td>
</tr>
<tr>
<td>Hospice days per patient</td>
<td>18.3</td>
<td>21.0</td>
<td>15.0%</td>
</tr>
</tbody>
</table>
National Data
Features distinguishing four programs that reduced hospitalizations for high-risk enrollees:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Among 4 programs that reduced hospitalizations</th>
<th>Among 5 programs that did not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition management - care coordinators:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Usually had timely notification of an admission to hospital/emergency department</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>• Contacted patient during hospitalization</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>• Requested copy of patient discharge instructions</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>• Used transition protocol and monitored for consistent use</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Medication management:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Had information about medications from source other than patient</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>• Consulted with pharmacist or program medical director when medication problems arose</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>
### National Data

Features distinguishing four programs that reduced hospitalizations for high-risk enrollees:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Number of Programs with Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Among 4 programs that reduced hospitalizations</td>
</tr>
<tr>
<td><strong>Face-to-face patient contact:</strong> more than 0.9 per month (based on data from first year of programs)</td>
<td>3</td>
</tr>
<tr>
<td><strong>Physician engagement and cooperation:</strong></td>
<td>4</td>
</tr>
<tr>
<td>• Care coordinators located near physicians, attended patient appointments, or saw physicians on hospital rounds</td>
<td>4</td>
</tr>
<tr>
<td>• Physician works with just 1 care coordinator</td>
<td>3</td>
</tr>
<tr>
<td>• Paid Physician</td>
<td>0</td>
</tr>
<tr>
<td><strong>Care coordinator had &quot;communications hub&quot; role with physicians</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Patient education: used behavior change model in addition to providing factual information</strong></td>
<td>3</td>
</tr>
</tbody>
</table>
A Look at the Data

Overview NTSP Structure

Review Framework for Advanced Illness Strategies

Review Extensivist Model

Overview Palliative Care Pilot Program

Examination of Advance Care Planning Program
NTSP – The Stats

900+ physicians
(specialty and primary care)

lead by physicians

capitation management since 1997

25+ North Texas cities

15,000 patients per day

strategic partner in NC

Cone Health System; Triad Health Network
NTSP – Aligning incentives

Primary care and specialty divisions measured by quality of care and efficiency at the division level

HEDIS | STARS
NTSP – Pieces of the Pie

care\n\ncare
Medicare Health Plans

SILVERBACK

Health\n\nCare

Sandlot

ntsp charitable fund

NORTH TEXAS RESPECTING CHOICES™
Our Mission

We are a physician-led organization committed to quality, fiscally-responsible health care through innovation and management for the benefit of our patients and physicians.

Our Vision

To create and manage superior healthcare models that enable physicians to best serve patients and to maintain their independence.
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Silverback Care Management

- **Preventative Health**: Wellness support and preventative services for health patients.
- **Disease Management**: Patients with single (or non-complicated) chronic conditions.
- **Case Management**: Patients with acute, time-limited medical needs.
- **Complex Care**: Patients with multiple, ongoing medical and social concerns.
Silverback RN Case Manager IDs patient at-risk for admission/readmission

Refers to MedStar MIH Program for enrollment

Series of in-home visits by specially trained paramedic
  ▶ Patient education
  ▶ Checklists

24/7 non-emergency access number for MedStar MIH provider
  ▶ Episodic needs

Address flag for 9-1-1 call
  ▶ Special response & treatment protocols
  ▶ Agreed to by NTSP & MedStar Medical Directors
MedStar Program – through September, 2015 YTD

<table>
<thead>
<tr>
<th>Number of Patients Identified</th>
<th>Number of Patients Enrolled</th>
<th>Number of Patients with Admit During Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>22</td>
<td>2</td>
</tr>
</tbody>
</table>

**ROI**

- MedStar cost $1K per member: 22K
- SilverBack RN cost: 71K (prorated)
- Anticipated savings 10K per hospital stay: 200K
- Ballpark savings impact: 107K

All 22 enrolled patients had ≥ 1 admission prior to enrollment

Case Study: Patient “RC” diagnosed with end stage MS. Institutional care for all of 2013. Through extensive social work intervention, able to coordinate patient’s discharge to home with services where patient actually improved physical functioning until his eventual decline and death. Patient expired at home with family per his wishes with MOST conversation/documentation.
Transitions of Care

30 DAY TOC PROGRAM

• Telephonic Outreach based on risk level
• Coordination of PCP follow up appointment within 7 days
• Medication reconciliation
• Post acute services Start of Care validation as warranted
• Home safety assessment
• Understanding / Compliance with discharge instructions
• Willing, able, available caregiver support
Transitions of Care
Measures of Success

- Enrollment

<table>
<thead>
<tr>
<th></th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count Members Eligible</td>
<td>72</td>
</tr>
<tr>
<td>Currently Enrolled in 30 day program</td>
<td>18</td>
</tr>
<tr>
<td>Currently identified for Enrollment</td>
<td>14</td>
</tr>
</tbody>
</table>

- Reductions in re-admission rate

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Current reporting month trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.6%</td>
<td>72</td>
<td>9.41%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

- 90% Compliant with follow up PCP appointment within 14 days

Transitions of Care Pilot Project – North Carolina Market
Health-e-Care

An integrated Primary Care Practice owned by NTSP

- 2 locations in Tarrant County
- 6 physicians (5 PCPs, 1 Podiatrist)
- 2 APRNs
- Developed to meet community needs; test and implement new models of care
Primary Care Support

Health-e Care – A primary care practice with an extensivist track – supported by multidisciplinary care team

PRIMARY CARE PRACTICE

EXTENSIVIST TRACK WITH EMPHASIS ON DUAL ELIGIBLES
Global Capitation

- Provides “funding” for management programs not reimbursed under FFS
  - Care Management
  - End of Life Programs (NTRC)
  - Quality clinics
  - Palliative Care Programs
Clinical Programs

- Serves NTSP as an incubator and implementer of new models of care enhanced by community partnerships
- North Texas Respecting Choices
- Palliative Care
- Extensivist Model including telehealth
A Look at the Data

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Extensivist Model

- Provide support system to PCPs
- Chronically ill and frail seniors receive all the necessary services to live an active independent lifestyle
- Avoid hospitalizations and other unnecessary acute episodes
CareMore model
“Hospitalization rate 24% below avg; hospital stays 38% shorter; costs 18% below average.”
NTSP’s Adapted Extensivist Model

- Chronic care model, overseen by Medical Director
- Goals are to improve care to NTSP’s high-acuity patients by:
  - Incorporating a multidisciplinary care model
  - Improving care coordination/communication with PCPs
  - Providing extended office visits with providers not typically available at primary care offices
Extensivist Clinical Team

- Board certified primary care physicians
- Advanced practice nurses, physician assistants
- Clinical pharmacists
- Advance care planning facilitators
- Social workers
- Care managers
- Other allied health care providers to ensure a multidisciplinary approach to care that is patient-centered and outcomes oriented
# Extensivist Services

## Current Services
- Physician, NP, & PA clinic visits
- Clinical pharmacy consultation
  - Medication reconciliation & adherence
  - Medication therapy management
- Care management & social services
- Advance care planning

## Future Services
- Nutrition counseling
- Diabetic counseling
- Disease specific education classes
- Mental Health
- Home visits
- Health risk assessments
Telehealth Pilot Parameters/Goals

- Telehealth pilot took place May through July, 2015
- Small patient population
- New telehealth platform
- Goal was to see if elderly chronically ill patients would use telehealth technology and determine lessons learned
Telehealth Pilot Results
(Patient Satisfaction)

Positive Feedback

- The interaction with and access to healthcare workers
- Liked entering the blood pressure/vitals and knowing the doctor had a record of the vitals so he didn’t have to track them to bring in
- Helpful to understand blood pressure tracking. Felt like someone cared
- Made me take my treatments more seriously
- Nice to be able to communicate with providers especially since she is home bound
- 95% of patients want to continue telehealth program

Improvement needed

- Video quality; the audio and video did not always stream continuously; it would freeze
- Manual entry of data
- Could not make comments on blood sugar reading to explain the circumstances
Telehealth Pilot Lessons Learned

• Patients WILL use it.

• Patients enjoyed using it and want to use it again. Duals have the potential to be more challenging

• Helped them engage in bettering their health; And just engage!

• Significant clinician time spent on video-chats when possibly monitoring via vitals submission would have worked fine

• Test software in advance
Extensivist Model Challenges

- Expansion to new location
- Anticipated large ACO population
- Funding (NTSP through Medicaid Waiver)
- Challenges with dual eligibles
- Community physician referrals
Extensivist Lessons Learned

• Have a dedicated referral mechanism
• Educate community physicians early and often
• Failed model the way we originally intended – adapt to changing market forces
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Examination of Advance Care Planning Program
“Palliative Medicine is specialized medical care for people with serious illness. It focuses on providing relief from pain, symptoms and distress of serious illness. It is a team based approach to care involving specialty trained doctors, nurses, social workers and other specialists focused on quality of life”

(CAPC)
Best Care Possible

Adapted from:
Percentage of Facilities that offer Inpatient Palliative Care Programs
Community-based palliative care

In 2012, the California HealthCare Foundation published *Next Generation of Palliative Care: Community Models Offer Services Outside the Hospital.*

- Hospice-Based
- Outpatient Clinics
- Medical Groups
- Integrated Delivery Systems
- Other: Long-term Care, Home Health
NTSP’s community-based approach

Two implementations:

CLINIC-BASED

HOME-BASED
NTSP’s community-based approach

THE CLINIC-BASED TEAM:

- Physician-lead team
- Social worker navigator (advance care planning facilitator)
- Clinical pharmacy
- Contracted with other specialty services (chaplain, mental health etc)
NTSP’s community-based approach

THE HOME-BASED TEAM:

Physician-lead team
Dedicated nurse to patient population
Social work
Chaplain
Respiratory Therapist
NTSP’s community-based approach

METRICS/GOALS:

✓ Increased patient satisfaction/engagement

✓ Reduction in hospital stays, ED visits and cost at the end of life (compare pre-, during- and post-discharged metrics)

✓ Percent of advance care planning conversations completed
Clinic-Based Palliative Care Program
Early Cost Findings

### Average Monthly Cost per Patient

<table>
<thead>
<tr>
<th></th>
<th>Avg PART A per Month</th>
<th>Avg PART B Cost per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to Palliative</td>
<td>$1,156.40</td>
<td>$720.84</td>
</tr>
<tr>
<td>Enrollment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>During Palliative</td>
<td>$256.22</td>
<td>$349.19</td>
</tr>
<tr>
<td>Enrollment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The chart visualizes the average monthly cost for patients before and during palliative enrollment for both PART A and PART B services.
Palliative Care Model Challenges

• Contractual processes on a new model – Funding and home care services
• Clinic staffing model
• Communication channels between entities
Palliative Care Model
Lessons Learned

- Comprehensive clinical and social needs assessment early
- Implementation specialist/project manager
- Staffing tracks clinical and social needs assessment data
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Examination of Advance Care Planning Program
Advance Care Planning: A time to Act

2011-2012 NTSP Board decision to improve end of life care for members

• 2012 – Study end-of-life problems and solutions
• 2013 – Contract with Gundersen Lutheran and begin implementation of North Texas Respecting Choices
• 2014 – Contracts completed with community partners and physicians
• 2015 – Full implementation and extension of program

Goal: Conversations and documentation to reflect patient preferences
Gundersen Lutheran (LaCrosse, WI) has been a 15+ year pioneer with POLST developing systems to increase advance care planning.

Gundersen’s results include:

- Individualized, person-centered planning discussions in a consistent and standardized manner across all care settings are increased.
- Patient and family satisfaction with ACP discussions is increased.
- Improving care through the use of MOST has resulted in a secondary gain of cost/utilization savings.
Unwanted hospitalizations in last six months of life were decreased.

<table>
<thead>
<tr>
<th></th>
<th>Unwanted Hospitalizations</th>
<th>Hospital Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Average</td>
<td>71.5%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Gundersen</td>
<td>59.5%</td>
<td>20.4%</td>
</tr>
</tbody>
</table>
Association between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and in-hospital death in Oregon

Proportion of each order with in-hospital death

- Comfort Measures Only (n=11,836): 6.4%
- Limited Additional Interventions (n=4,787): 22.4%
- Full Treatment (n=1,153): 44.2%
- No POLST in Registry (n=40,098): 34.2%

Fromme, Zive, Schmidt, Cook, Tolle (2014)
North Texas Respecting Choices Progress

- **Physician Champions**: Employed and aligned PCPs, Neph, Hosp, Onc, PCP
- **Care Partners**: Home health, Hospice, Skilled Nursing, Hospital, EMS
- **Active Facilitators**: 30 in the community (3 employed), 2 Instructors
NTRC Facilitator Education

ONLINE TRAINING
Complete Gunderson online training modules

CLASSROOM TRAINING
8-hr classroom training
Successful completion of role-play at end of day

PRACTICE MOST CONVERSATIONS
Recommend multiple practices using script
Enter practices on MOST log
Contact NTRC for competency checkoff and practices

COMPETENCY CHECKOFF
Perform one proctor session with skills checkoff within one month
Fax record of competency checkoff to NTRC

MOST CONVERSATIONS
Maintain log of MOST conversations and submit monthly to NTRC
Fax MOST documents to NTRC
MOST Conversation Measurement

2014 to 2015 MOST Conversation Improvements

<table>
<thead>
<tr>
<th>Year</th>
<th>% Declined</th>
<th>% Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>54%</td>
<td>42%</td>
</tr>
<tr>
<td>2015</td>
<td>12%</td>
<td>80%</td>
</tr>
</tbody>
</table>

362
MOST Conversation Measurement

MOST Quality Measurement

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNR</td>
<td>69%</td>
<td>81%</td>
<td>38%</td>
<td>50%</td>
</tr>
<tr>
<td>DNR/Comfort Intervention</td>
<td>62%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNR/Intermediate and Full Interventions</td>
<td>62%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Oregon

LaCrosse
**MOST Cost Comparison**

**Part A and B Cost in the last months of life - Average Cost per Patient**

<table>
<thead>
<tr>
<th></th>
<th>With MOST</th>
<th>WITHOUT MOST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PART A</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last 3 months</td>
<td>$7,163.37</td>
<td>$15,502.95</td>
</tr>
<tr>
<td>Last 6 months</td>
<td>$12,914.06</td>
<td>$23,146.05</td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last 3 months</td>
<td>$1,616.66</td>
<td>$2,713.69</td>
</tr>
<tr>
<td>Last 6 months</td>
<td>$2,669.62</td>
<td>$4,102.17</td>
</tr>
</tbody>
</table>
## MOST Utilization Comparison

### Hospitalizations in the last months of life - Average Hospitalizations per Patient

<table>
<thead>
<tr>
<th></th>
<th>Average Hospitalizations p/pt in last 3 months</th>
<th>Average Hospitalizations p/pt in last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>With MOST</strong></td>
<td>0.58</td>
<td>0.92</td>
</tr>
<tr>
<td><strong>Without MOST</strong></td>
<td>0.86</td>
<td>1.23</td>
</tr>
</tbody>
</table>
Advance Care Planning Challenges

- Care partner implementation
- Physician engagement (doing!)
- Facilitators – the right fit
Advance Care Planning Lessons Learned

- More education/training with physician – the introduction!
- Care partner agreements
- Diligent work with care partner to assist with implementation
- Start with EMS and hospital early!
Coordinated Care for Advanced Illnesses

Key Take-aways

- Coordinated care takes community-wide effort. Build partnerships!
- Measure early and often for quality and ROI
- Physician-led teams
- Employ evidence-based model adapted for market forces.