Innovative Medical Group
Models for Palliative Care

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OptumCare Medical Groups

- Consumers touched: 9.4M
- Markets: 55
- States served: 51
- Contracted payers: >80
- Employers: 25K
- Physicians: 22K
- Employed / contracted NPs, Pas, RNs: 7K
- Employed / contracted PCPs: 7K
- Primary / urgent care clinics: 500

OptumCare Statistics
A Gap and Solution in Our Health Care System

A patient in need

- Advanced Illness
- Often multiple conditions
- Declining functional status
- Missed office appointments
- Multiple hospitalizations
- Post-acute transitions
- Difficult care coordination
- Uncontrolled symptoms
- Social and family needs
- Unclear goals of care

A Solution: Community-based Palliative Care

- Specialized multi-professional care
- Expert symptom care
- Goals of care discussions and advance care planning
- Home based delivery
- Improved access and coordination
Value-based Care

Optimal care at home can be paid for from savings from avoided hospitalizations and burdensome post-acute care

- Right patient
- Right care
- Right place
- Right care teams
- Right skills
- Right systems
Escalating Costs at End of Life

End-of-Life Total Cost of Care

Quartile Analysis

Highest Quartile
$120,207

Second Quartile
$42,333

$46,297 (4X Higher)
Average Cost per Deceased Member

Costs ($)

$25,000
$20,000
$15,000
$10,000
$5,000
$0

Months Prior to Death

18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 0

*Medicare Part A and B spending, representative care delivery organization
End of Life Cost Driver: Multiple Hospitalizations

Total End of Life Cost by Hospitalizations

Average Cost Per Member

$24,497

Incremental Cost Per End-of-Life Admission*

*Medicare Part A and B spending, representative Medicare Advantage population
High-need, High-cost Patients
Chronic Illness and Functional Decline

Exhibit 1
Adults with High Needs Have Higher Health Care Spending and Out-of-Pocket Costs

- Average annual out-of-pocket spending
- Average annual health care expenditures

<table>
<thead>
<tr>
<th>Category</th>
<th>Out-of-Pocket Spending</th>
<th>Annual Health Care Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total adult population</td>
<td>$702</td>
<td>$4,845</td>
</tr>
<tr>
<td>Three or more chronic diseases, no functional limitations</td>
<td>$1,157</td>
<td>$7,526</td>
</tr>
<tr>
<td>Three or more chronic diseases, with functional limitations (high need)</td>
<td>$1,669</td>
<td>$21,021</td>
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</tbody>
</table>

Note: Noninstitutionalized civilian population age 18 and older.

From Commonwealth Fund pub. 1897, Vol. 26 (2016)
OptumCare  Community Based Palliative Care

PROGRAM DESIGN
• Multi-disciplinary specialist-level community (home) care for patients at highest risk of mortality, hospitalizations, and other complications

PROGRAM SUPPORT
• Patient identification Algorithm
• Program Design Collaboration
• Specialized Clinician Training
• Operations improvement
  – Shared resources
  – Lean process design
• Performance Measurement
  – Place of death
  – Matched cohort analysis
  – Experience measurement
Palliative Care in an ACO

Dana Lustbader, MD, FAAHPM
Chair, Department of Palliative Care
ProHEALTH, New York, an Optum Company
Frank is an 87 year old man with dementia, heart failure and CKD in ProHEALTH ACO

- Frequent ER visits for weakness
- Admitted 2x in 6 months for confusion
- High spend in ACO $67K in prior 12 months – Part A,B,D
- Algorithm found him from CMS claims
Setting – ProHEALTH NY, an Optum Company

- A large multispecialty group in New York metropolitan area with 900 providers serving over 1 million patients in a FFS world.
- Sweet Spot! - Also includes MSSP ACO and other shared savings arrangements with health plans.
- How do we pay for HPBC?
  - PMPM with local health plan
  - Shared savings in MSSP ACO and 5 other health plans
  - Fee for Service - “coffee budget”
- In 2016 we performed 6000 house calls, 8000 phone/video calls, served 700 patients, 200 decedents
- Location of death is home for 87%, saved $12K/decedent
Data Driven Referrals

• We don’t wait for physician referrals
• Hot Spotter - Top 5% spend
• ACO or health plan data
  – Utilization (e.g. ER, hospital admissions)
  – Frailty, functional impairment, disease burden
  – Risk scores, Charlson Comorbidity Index
ProHEALTH Staffing

• Palliative Care Team
  – Pod = 0.5 MD; 3 RNs; 0.5 SW for 250 patients
• Services
  – House Calls
  – Telephone Calls
  – Video Calls – “telepalliative care”
• Cadence of encounters is need based
  – LACE, health plan predictor for readmit, clinical decline
• 24/7 Telephonic and video call support
“Telepalliative Care” – Use Cases
Outcomes

• HBPC cost $12,000 less than usual care in final 3 months of life
• Reduced hospital admissions by 34% in final month of life
• Increased hospice enrollment 35% and median LOS 240%
Lessons Learned

1. Quality of life for people with serious illness and their family members is worse than we thought
2. Must track and reduce avoidable hospitalizations
3. Important to be at the table with health plans
WellMed Medical Management
Palliative Care Program

Elizabeth J. Glazier, MD, MPH
Chief, Department of Palliative Care WellMed
Setting - WellMed

• A Medical Service Organization for Medicare Advantage, global risk model and fully delegated focused on evidenced-based preventive healthcare with a unique stratification model that provides appropriate care at the right time.
• Texas, New Mexico, and Florida
• Providers – 655; Clinics 151
• Patients 286,000
• 48% growth since 2015
• Primary care driven model with some employed subspecialists
• 5 Stars - 2016 in Austin, Corpus Christi, El Paso, Rio Grande Valley
Palliative Care At WellMed: Current Offerings

- Markets: Tampa, Orlando, Rio Grande Valley, Corpus Christi, El Paso, Austin, San Antonio, Dallas
- Sites of care: Inpatient, SNF, home, palliative care clinic, embedded subspecialty clinics (oncology/cardiology)
- PCPs: Both employed and contracted
- BRIDGES program (home visits):
  - High risk patients
  - Bridges “maintenance”
- Telemedicine use for new/transition/urgent needs
Palliative Care Timeline at WellMed

San Antonio
Enrollments = 51

Tampa, El Paso and
Rio Grande Valley
Enrollments = 1956

Dallas
Current Active
Census = 2143

Corpus Christi
Austin
Enrollments = 635

Orlando
Enrollments = 3010
Patient Enrollment Process

Patient Appropriate for Palliative Care

In-Clinic, SNF, Inpatient Palliative Consult

Not eligible
Returns to PCP

Enrolled in Hospice
Home Hospice

Refuses Hospice, doesn’t meet criteria
Bridges Program
Palliative POD Structure

Clinical Model
Palliative Care Clinical Model

- MD
  - Initial Assessments
  - Follow up
  - Oversee patient responsibility

- NP
  - Supports initial assessments
  - Follow up care planning

- RN
  - Initial Assessments
  - Follow up care planning

- SW
  - Triggers
  - Telephonically
  - computer interface as part of care planning

- LVN
  - Provides program(s) information

- MA
  - Supports clinic
  - Informed patient outcomes and intake appointments

- 1 Lead + additional PCPs
- 1 NP / 125 patients
- 1 RN / 50 patients
- 1 SW / 250 patients
- 1 LVN / 200-250 patients
- 1 MA / 100 patients
- 1 Admin / 500

American Academy of Home Care Medicine
WellMed™
2016 Metrics

• Total Enrollment 3010 patients
• ALOS Palliative Care = 154 days
• Hospice ALOS = 155 days
• Hospice median LOS = 36 days
• Location of death = home 86% (95% in SA since 2013)
• Savings of 32% in the last 3 months/decedent
• Admissions/1000 = Decreased 39% in 2016
• Documentation of ACP = 62%
How to Find the “Right” Patient

• Band 4/5 of WellMed stratification model, CM/hospital/SNF referrals
• Optum High Risk list (frailty, HCCs, Charleson Comorbidity Index)
• Provider Referrals (PCP/Specialists)
• Presence at WellMed Functional PCCs by member of palliative team:
  – Clinics shut down once a week (1-2 hours)
  – Review of hospitalized/SNF/ER patients
Lessons Learned

• The needs of homebound patients or those with multiple chronic conditions are often not met with usual healthcare system, or clinic based practices.
• Consider quality metrics up front when designing a program.
• Understand local regulatory environment around advance care planning and home based care.
The Business Case for Palliative Care

Mitchell Mudra, MBA
Chief Operating Officer
Optum Center for Palliative and Supportive Care
Palliative Care Supports the Quadruple Aim

Improve Population Health (Outcomes)
Decrease Cost
Maximize Provider Satisfaction
Improve Patient & Family Experience

Quadruple Aim

Building Integrated Serious Illness Care Systems
Critical Success Factor: Patient Identification

Patients Facing Serious Illness:
• Top 2-3% of Seniors
• High Risk for:
  o Mortality
  o Frailty
  o Admission
• Clinical Conditions, including:
  o Advanced cancer
  o Heart failure stage IV
  o Advanced pulmonary disease, COPD
  o Dementia/stroke with functional impairment
  o Multiple chronic conditions and functional decline
Palliative Care Value – Medicare Advantage

MedEx

\[ S_1 = \text{Savings Pre-Hospice Election} \]
\[ S_2 = \text{Savings Without Hospice Election} \]
\[ S_3 = \text{Savings Post-Hospice Election} \]

Value Levers

1. Earlier Palliative Engagement
2. Palliative Performance
3. Optimal Hospice Engagement

\[ D_0 = \text{Date of Death} \]
\[ D_H = \text{Date of Hospice Election} \]
\[ D_p = \text{Date of Palliative Care Enrollment} \]
## Effect of Palliative Care on End of Life Costs

### Average Total Cost of Care

**PHNY 2015 Decedents**

MSSP ACO Decedents continuously enroll the last 12 Months of Life

PC = Decedents Enrolled in Palliative Care

Matched = Non-PC Decedents that Matched to PC Decedents

### Measure (Last 3 Months of Life) % Change

<table>
<thead>
<tr>
<th>Measure</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Admits/K</td>
<td>↓ 35%</td>
</tr>
<tr>
<td>Acute Days/K</td>
<td>↓ 36%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>↓ 15%</td>
</tr>
<tr>
<td>% Decedents IP Admit Last Month</td>
<td>↓ 28%</td>
</tr>
<tr>
<td>Percent Enrolled in Hospice</td>
<td>↑ 28%</td>
</tr>
<tr>
<td>Median Hospice LOS</td>
<td>↑ 215%</td>
</tr>
</tbody>
</table>

*Last 3 months of life (average enrollment period), includes cost of hospice care*
Business Model – Trade-Off Considerations

Model of Care
• Care Setting
• Team Composition
• Health Plan or Regulatory Requirements

Integrated Palliative Care versus “Bolt-On”
• Population Health
• Coordination of Care

Build versus Buy
• Risk Responsibility
• Startup Costs
  o Workforce and Training
  o Patient Enrollment Ramp
  o Technology / Systems
• Performance / ROI Expectations
DISCUSSION/QUESTIONS