

Context

ProHealth Physicians is a 390 provider, predominantly Primary Care, practice in Connecticut with responsibility for 32,000 Medicare (MSSP) lives and 13,500 Medicare Advantage lives. We are actively engaged in ACO and other shared savings programs with the goal of providing first rate care while containing cost. To this end we have instituted a program of identification, outreach and support for those with life limiting illness and their families to identify appropriate and realistic goals of care and then to facilitate achievement of those goals.



Program Design

Identification: We target patients with life limiting illness who have ill-defined goals of care or goals that are unrealistic for their disease and functional condition. This is approached through a referral and a case finding approach: Primary Care physicians, post-acute care coordinators and local specialists can refer to the program directly. In addition case finding using a frailty index which is part of the standard ROS for patients over 50 and billing and acuity data from our ACO contracts allows us to identify a group of potentially appropriate patients: those names are passed back to the PCP for referral.

Engagement: We encourage the PCP to reach out to the patient and family to discuss the referral and the program, advising them that someone will be contacting them to set up a visit. Our team (Hospice and palliative experienced APRN/RN) then reach out to the family to conduct one or more visits in the family's home with the key decision makers present: this may include family members close friends and long term caregivers. The format of the meeting is to explore the patient's and family's understanding of the condition and prognosis, the achievable goals of care and priorities for care in terms of those goals. There is no attempt to direct patients into a less aggressive level of care or particular outcome. Advance directives can be completed at these visits, and in conjunction with the PCP, Allow Natural Death orders (DNR) can be put into place where appropriate. Where appropriate, hospice referrals are facilitated, and patients and families are educated as to what hospice means and how it may help them as the disease progresses

Follow up: We remain in contact with the patients and families who may need continued support, either directly through this program or using other programs (Aetna Compassionate Care) until such time as they enroll in hospice, die, or no longer need support.

Future Plans: At this time we have not developed the second phase of our palliative program, which we hope to be able to do in the next 12 months. We plan to have an on call phone service that responds to the patients from this program with 24/7 coverage, and the ability to follow up in the form of an APRN home visit within 24 hrs. We anticipate our Palliative MD/APRN team taking over the primary care of a subset of these patients in the community.

Evaluation

Capture- We believe that up to 2% of our Medicare age population could benefit from this type of service. This is based on the premise that around 5% of this population will die in any given 12 month period, and that half of that number could be predicted, some of whom have already defined their goals and do not need this assistance.

Appropriateness- While prognostication up to a year before death is notoriously inaccurate, we would expect to see significant mortality in our referral base.

Effectiveness- While hospice referral is not the only way we help patients and families, we would expect to increase the utilization of hospice which should be demonstrable in the percentage of patients who are on hospice services at the time of death and an increase in the median hospice length of stay. (Avoidance of late hospice referrals)

Financial- In order to be able to provide this service there needs to be a financial model that supports the investment. Under shared savings or a total cost of care contract, the savings in avoidance of over-aggressive care should offset the cost of delivering the service.

Patient and family satisfaction- In doing a better job in identifying and meeting the patient and families goals of care, there is an expectation that satisfaction with care will improve.

Preliminary Results

As of 10/8/15

- 269 referrals received
- 90.7% referred patients were enrolled. 26 (9.7%) refused all offered services or were inappropriately referred
- 54 patients "active"- still being seen or in phone contact
- Average referral rate (2015) 23 patients per month
- Average duration of SAGE engagement 69 days
- Average number of visits per patient- 1.2
- Of those referred over 6 m ago, 44% have died

Of the 76 patients who have died after receiving services

- 45 died on hospice service (63%)
- Median hospice length of stay where death >28 days from referral - 47 days (average 63)

Feedback

Provider chart entry at the time of a condolence call: "She [the patient's wife] particularly appreciated the SAGE program which helped convince him that the hospice program was OK to try"

Family members: "How lucky were we to be connected to you when you first came to evaluate mom. Your calm and assuring manner and your respect for mom were so important. And then when you came...and we all realized the end was days away you, again, were calm and reassuring. And you checked in with us every few weeks."

From a primary care physician: "An invaluable resource for practicing physicians and families in addressing end of life issues and empowering patients"

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