# Improving access to community-based palliative care within an ACO: Lessons learned

UNC School of Medicine
UNC Palliative Care Program
UNC Senior Alliance
UNC Health Care

Kyle Lavin, MD, MPH[1,2], Christine E. Kistler, MD, MASc[1,3], Bob Gianforcaro, DO[4], Peter Leese, MSPH[5], Natalie C. Ernecoff, MPH,[6]
Laura C. Hanson MD, MPH[1,7]

[1]Palliative Care Program , University of North Carolina, [2]Department of Psychiatry, University of North Carolina [3]Department of Family Medicine, University of North Carolina, [4]UNC Senior Alliance, [5]University of North Carolina, [6]Department of Health Policy and Management, University of North Carolina, [7]Division of Geriatric Medicine, University of North Carolina

Topic: Risk Stratification and Dosing Services to Need

## INTRODUCTION

- Community-based palliative care (CBPC) enhances the value of health care for persons with serious illness
- Access remains dependent on clinician referrals
- Given their value-based focus, Medicare Accountable Care Organizations (ACOs) provide a potential opportunity for proactive and consistent palliative care referral

## AIMS

Within a Medicare ACO:

- To develop a risk scoring tool to screen for seriously-ill patients who may benefit from CBPC services
- To assess CBPC referrals using triggered electronic health record (EHR) alerts combined with use of the risk scoring tool

## METHODS

- SITE: ACO patients hospitalized in 3 hospitals in central North Carolina
- EHR REPORT: We developed an EHR weekly report of ACO patients who had a non-elective hospitalization and lived within the area covered by CBPC
- TRIGGERS FOR REFERRAL: We identified ACO patients for referral to CBPC using a risk scoring tool with 7 domains, based on current evidence for potential to benefit

## Risk Scoring Tool

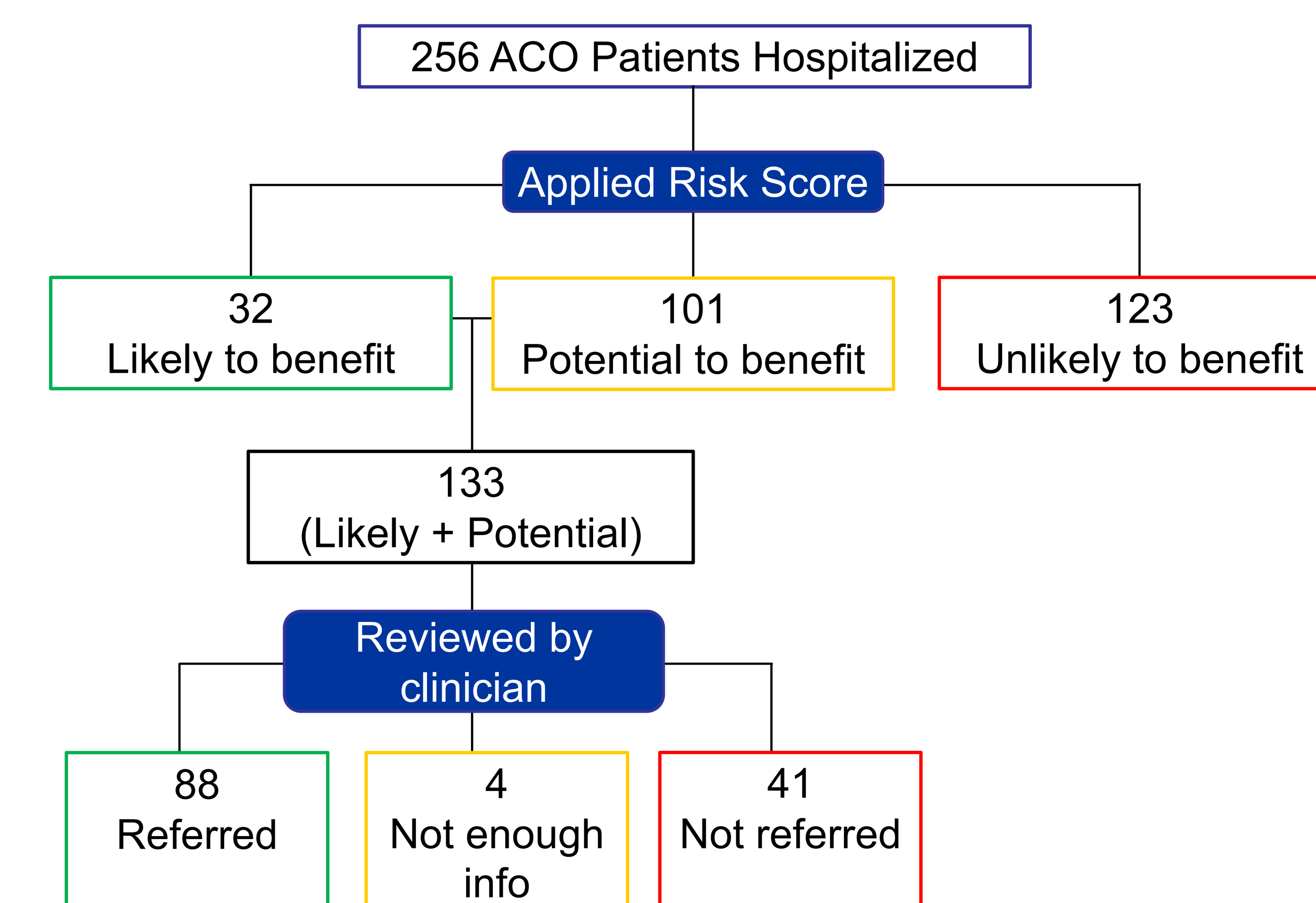
1. **Physical Domain/Serious Illness (1 point each)**
   a. Cancer (metastatic or hematologic)
   b. Renal failure, end stage
   c. Advanced dementia
   d. Advanced liver disease or cirrhosis
   e. Diabetes with severe complications
   f. Amyotrophic lateral sclerosis (ALS)
   g. Acquired immune deficiency syndrome (AIDS), CD4 < 100
   h. Hip fracture with significant neurodegenerative condition
   i. COPD or interstitial lung disease: home $O_2$ or admit reason
   j. Congestive heart failure, admit reason
2. **Utilization (1 point each)**
   a. 30 day readmission in last 6 months
   b. 3 unplanned hospitalizations in last 6 months
   c. More than 3 ER visits in last 6 months
   d. Hospitalization longer than 2 weeks in last 6 months
3. **Age**
   a. 76-85 years old (1 point)
   b. 86 and older (2 points)
4. **Functional Domain (1 point if any)**
   a. Fall within last 6 months
   b. Durable medical equipment ordered
   c. Receiving assistance with any activities of daily living (ADL)
5. **Existing Advance Care Planning in EHR (1 point if any)**
   a. No documented advance care planning note
   b. No documented advance directive (Living Will, HCPOA)
6. **Psychosocial Support (1 point if present)**
   a. Documented concern for lack of psychosocial support (e.g., financial strain, lack of transportation, etc.)
7. **Symptoms (1 point if present)**
   a. Uncontrolled symptoms (e.g., pain, depression, etc.)

**Scoring**: ≥ 5 points = Likely to benefit from CBPC, clinician reviews; 3-4 points = May benefit, clinician reviews; ≤ 2 = Unlikely to benefit

**Exclusion Criteria:**
- Primary diagnosis: Serious mental illness, personality disorder, or substance abuse
- Non-compliance as primary driver

## RESULTS

### Figure 1. Identifying ACO Patients in Need of CBPC




Within a Medicare ACO about 1/3 (34.4%) of recently hospitalized patients were referred to CBPC using a semi-automated screening process.

## CONCLUSIONS

- Combining triggered identification of ACO patients with an evidence-based risk tool provides a systematic and efficient method to identify those who have potential to benefit from CBPC
- This proactive approach may improve early and consistent referrals, and overcome barriers found in a provider-initiated referral-based system
- Future research is needed:
  - Automate the risk scoring system
  - Evaluate whether identified ACO patients actually benefit from community-based palliative care services

kyle_lavin@med.unc.edu