Across the Continuum and Beyond

Defining, Developing, and Integrating True Palliative Care Across the Healthcare Continuum

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My perspectives

➔ Physician
➔ Board Member
➔ Caregiver
➔ Educator
Objectives

1. Describe the development, implementation, integration and expansion of a community-based palliative care program (CbPC) within a Pioneer Accountable Care Organization

2. Apply a unique philosophical approach to care delivery and identify how it is essential to successful palliative care program initiation, growth and development.

3. Explain why challenging historical healthcare system assumptions of care delivery provides a framework for all programs to utilize and tailor to their culture and community to potentiate true palliative care success

4. Discuss development and utilization of metrics and data to measure program success and identify opportunities for improvement.

5. Cite and develop potential growth opportunities, as well as barriers to expansion within the CbPC setting
Bending the Cost Curve

U.S. is spending much more for older ages

Audience Polling

How much of all healthcare spending does the costliest 5% account for?

A. 20%
B. 30%
C. 40%
D. 50%
The costliest 5% account for 50% of all healthcare spending.

CBO May 2009 High Cost Medicare Beneficiaries www.cbo.gov
nchc.org/facts/cost.shtml
The costliest 15% account for 85% of all healthcare spending.
Current State:
A year in the Life of a Patient

- 6 Social Workers
- 13 Meds
- 5 Hospital Admissions
- 37 Nurses
- 22 Clinic Visits
- 19 Clinic Visits
- 5 Physical Therapists
- 6 Community Referrals
- 2 Nursing Homes
- 6 Weeks SNF Care
- 4 Occupational Therapists
- 2 Home Care Agencies
- 5 Months of Home Care
- 16 Physicians

Source:
Johns Hopkins, RWJ 2010 (G Anderson)
Health Care Costs
$3,542,200,000,000

GDP
2014

20%
Health Care Costs

$8,320,000,000,000 - 12,480,000,000,000

GDP 2045

60%
Value

Quality

Cost
Value

➔ Quality of Life

➔ Length of Life
Accountable Care

Alaska: No ACOs or prep activity
Hawaii: 1 private insurer
2 prep activity only

ACO sponsor
- Medicare / Medicaid
- Private insurer
- Both
- Prep activity only
Delivering Value
Disease Management Continuum

Clinical Integration

Screening/Prevention
Medical Home
Palliative Care
Hospice

Population Care Management
Disease Management System
Quality Indicators and Metrics
Financial Risk Arrangements

**Risk primarily carried by insurer**
- Fee for Service (FFS) Readmissions
- FFS with Pay for Performance

**Shared risk**
- Bundled Payments Heart Procedures

**Risk primarily carried by provider**
- Accountable Care Organization Medicare Population
- Capitation or Integrated Delivery Sys All Enrolled Members

Financial Risk Sharing Spectrum
Avoiding Risk is Antithetical to Care

→ Contractual only

→ Legal and financial at top

→ Patient not part of equation

→ No mechanism of care delivery
Pioneer ACO Service Area

Family Medicine Locations:
• Eagle Grove
• Fonda
• Fort Dodge (4)
• Humboldt
• Lake View
• Laurens
• Newell
• Pocahontas
• Sac City
• Storm Lake (2)
Pioneer ACO

- Midwest Region: Iowa
- 8-County Area: Rural
- Population of 120,000
- 10,000+ Pioneer Lives

- 8 Primary Care & 10 Specialty Clinics
- 40 Primary Care Physicians & 25 Specialists
- 5 Critical Access Hospitals
- 2 Dialysis Units
- Homecare coverage in all regions
Our Community

78 Million Baby Boomers Are Reaching Their 65th Birthday At The Rate Of 10,000 Per Day For The Next 20 years

<table>
<thead>
<tr>
<th>Selected Age Group</th>
<th>50+</th>
<th>55+</th>
<th>60+</th>
<th>65+</th>
<th>70+</th>
<th>75+</th>
<th>80+</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States Total</td>
<td>31.3%</td>
<td>24.2%</td>
<td>18.0%</td>
<td>12.9%</td>
<td>9.1%</td>
<td>6.1%</td>
<td>3.7%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Iowa</td>
<td>33.8%</td>
<td>26.6%</td>
<td>20.0%</td>
<td>14.8%</td>
<td>10.8%</td>
<td>7.6%</td>
<td>4.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Iowa - Ranked</td>
<td>9</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
## Population Demographics

### Risk and Chronic Conditions for 6,744 Beneficiaries

<table>
<thead>
<tr>
<th>Condition</th>
<th># of Patients</th>
<th>% of Total</th>
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</thead>
<tbody>
<tr>
<td>High Risk and Priority Risk</td>
<td>1,709</td>
<td>25.3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,725</td>
<td>25.6</td>
</tr>
<tr>
<td>Congestive heart Failure (CHF)</td>
<td>244</td>
<td>3.6</td>
</tr>
<tr>
<td>Coronary Artery Disease (CAD)</td>
<td>1,115</td>
<td>16.5</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>510</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Patients with Claims over $100K = 26 ($3.56M)
True Palliative Care

What is it?
Where we are now

Second Team
1.0 FTE ARNP
1.0 FTE RN
1.0 FTE LISW

June 2015
Current Palliative Care Services

- Inpatient Consult Service
- Care Facility Clinics
- Outpatient Clinic
- Emergency Department
- Community Clinics
- EMS
- Cancer Center
- Provider Home Visits
- Telemedicine

24/7 on-call access
Upstream Thinking

“Incident Command Model”
Patient Story

72 year old female: DM, Hypertension, CAD, CVA, Dysphagia, Aspiratory pneumonia, COPD, Atrial Fib, Respiratory Failure

Prior to Palliative Care  2009 - 2011
→ 27 Hospitalizations
→ 2 ED visits

Inpatient Palliative Care  2012
→ 7 Hospitalizations
→ 5 ED visits
Patient Story

Comprehensive Palliative Care 2013 - Present

➔ 4 Hospitalizations
➔ 3 ED Visits
Results

Rolling Readmission Rate = 6.53% for patients seen in Outpatient

Rolling 12 Month All Cause Readmit Rate
Sept 2011 - Feb 2014
Source: UnityPoint Health Internal EHR
## Results

<table>
<thead>
<tr>
<th>Measure</th>
<th>Results</th>
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</thead>
<tbody>
<tr>
<td>% of Zero Admissions</td>
<td>90%</td>
</tr>
<tr>
<td>Reduction in 30-Day Readmissions</td>
<td>40%</td>
</tr>
<tr>
<td>Days Hospitalized Per Consult</td>
<td>1.79</td>
</tr>
<tr>
<td>IPPC Consultation Rate</td>
<td>27%</td>
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</tbody>
</table>
Results

70% reduction per capita expenditures
## Results

<table>
<thead>
<tr>
<th>Trinity Palliative Care</th>
<th>2013 Overall Patient Satisfaction Mean Score</th>
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<tbody>
<tr>
<td></td>
<td>95</td>
</tr>
<tr>
<td>All Sites</td>
<td>89</td>
</tr>
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**Congratualtions to Palliative Care**

as the Press Ganey Patient Satisfaction top scorer for the UnityPoint Clinic – Fort Dodge Division

**Quarter 3, July-September 2013**

*Thank You* to the Palliative Care patients for responding with your opinion on the Press Ganey survey.
Metrics

→ Data is needed to prove the palliative case

→ Compare “apples to apples”

→ Identify gaps, opportunities

→ Enhance fiscal conversations
  – Cost avoidance / resource allocation / ???
Opportunities

Palliative Care & Advanced Care Collaborative
Inpatient Palliative Care RN

Start

Identify current PC hospital patients

PC consult on chart? Yes → F

No → Notify inpatient care coordinator/provider to request order

Quality for PC Navigator? Yes → Communicate with PC Navigator

No → Follow current PC process

Was PC order received on flagged pt? Yes → F

No → G

Rounds with pt through hospital stay

Communicate with navigator until transition

End
**Advanced Care Collaborative**

**Ambulatory Palliative Care**

**PC Office Staff**

1. Receives Referral Call
2. Sends to PC RN for Intake
3. Reviews provider and navigator schedule
4. Schedules initial consult
5. Appointment with provider and navigator?
   - Yes: Follow PC Navigator Process
   - No: Log reason both navigator and provider not together
5. If need appointment today, schedule today

- Long-term care
- PCP
- Specialty clinic
- Private (family/self)
- ED

**Send to manager to review barriers**
Advanced Care Collaborative

Ambulatory Palliative Care

Clinic PC RN

- Receives Clinic PC Referral
- Is Patient PC appropriate?
  - Yes: Qualify for PC Navigator?
    - Yes: Proceed to B
    - No: Sends to PC office staff for scheduling and normal process followed
  - No: Communicates back to referral source
Advanced Care Collaborative

Community Palliative Care

Start

- Receives Referral based on IDT on an existing PC patient
- Is Navigator on Pt Case
- Yes
- Collaborate with Navigator
- Determines frequency of direct patient care with Navigator
- Provides Direct Care
- Need for more intervention?
- Yes
- Schedule appropriate intervention
- No
- Follow current PC Community Process

Physical assessment of pt and home
- Identifies safety, day to day understanding, medications, goals of care
- PC provider
- PCP
- SN
- Chaplain
- ED
- Specialist
- Hospital
- Pharmacy
- Lab
- Nursing Home

G
Opportunities or Obstacles

➔ Boards represent systems as director plenipotentiary
  – having full power to take independent action

➔ Importance of clearly defined administrative structure
  – lead and support roles
The Solution is...
Understand, Manage & Thrive...
Paradigm Architecture

It’s About Behavior Change
It’s About System Design

Data

Human Dilemma Is Complex
Data Towards Accountability
Actionable Data
Predictive Modeling
Ambiguity and Improvisation

➔ Meet each patient where they are
➔ Meet each participant where they are
➔ Meet your system where it is
➔ Get comfortable with the “unknown”
➔ Embrace the chaos
➔ Patient first….the rest will follow
You have no choice if you don't know your options.

Palliative Care. A different voice in healthcare...so patients can find their own. ©

+ transcend medicine
Questions and Comments

→ Do you have questions for the presenter?

→ Click the hand-raise icon (👋) on your control panel to ask a question out loud, or type your question into the chat box.
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