Bridging Gaps in the Continuum of Care through Local Partnerships

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May 14, 2019

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Join us for upcoming CAPC events

- Upcoming Webinars:
  - **Understanding Key Principles (and Math) that Link Team Effectiveness and Staffing Plans**

    Thursday, May 30 at 12:30pm ET
  - **Billing and Coding for Advance Care Planning: How to Document Services Correctly to Reflect your Productivity**

    Tuesday, June 11 at 12:30pm ET

- Virtual Office Hours:
  - **Planning for Community-Based Care: Getting Started**

    Wednesday, May 15 at 12:30pm ET
  - **Training All Clinicians in Core Palliative Care Skills**

    Tuesday, May 21 at 1:30pm ET

Register at www.capc.org/events/

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NTSP Holding LLC Palliative Care Program

Our mission is to provide effective patient and family centered care, through an interdisciplinary team approach, that focuses on improved quality of life by providing relief from symptoms and stress of life-limiting illnesses.

About NTSP Holding LLC

- Independent Physician Association
  - Network of PCP’s and Specialists
- with:
  - Its own Medicare Advantage Plan
  - Care Management division, including Clinical Programs

Program History

- Started with DSRIP (Medicaid State Waiver)
- Main goal: improve care of seriously ill patients by managing symptoms
- Due to utilization reduction and medical expense savings, continued program without grant
- Gaps in care identified by clinical staff during crises, workflow breakdowns, etc.

Gaps in the Continuum of Care – the What?

- → Medication Issues
- → Crisis Management
- → Caregiver Stress
- → Social Isolation
- → Care Coordination
- → Economic Barriers

Gaps in the Continuum of Care – the Who and Where?

- PCP and Specialists
  - Communication between PCP and other providers
- Hospital
  - Discharge, transition to SNF
- Ancillary Services
  - Home health, DME, Meals on Wheels, Area agency on aging, Department of Aging and Disability Services, etc.
- Care Management
  - Transitions of Care, Social Work, Pharmacy, Community Paramedicine, Utilization Management

Partners in the Community

- Hospice Agency
  - Palliative Care Subsidiary
- EMS Agency
  - Community Paramedicine Program
- Emergency Pharmacy
  - 24/7 Crisis Medication

Contracting

- Legal agreements needed:
  - Non-disclosure, Business associate, Master services, Statement of work
- Clinical Protocols as part of SOW
- Workflows developed for program structure
- Implementation and OODA/PDSA
  - Routine IDT's for patient clinical evaluation
    - Gaps in workflow and process identified and worked on after by program managers and staff

Current Program Structure

- Referral Form and Screening Tool
  - Allows referrers to screen for appropriateness
  - Modify slightly for providers, e.g. Oncology specific, more user-friendly for PCP office staff
- Home vs. Clinic
  - Long-term symptom management, vs.
  - ACP and care coordination only

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Current Program Structure, continued

- EMS Backup
  - Community Paramedicine program
  - Established protocols applied to palliative care
- Electronic Symptom Management
  - Online and mobile application for symptom tracking, medication adherence, patient satisfaction

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Current Program Structure, continued

- 24/7 Pharmacy Support
  - General, COPD, CHF Kits "Care Paks"
  - Does not replace prescribed meds, only used in emergent situations
  - COPD Carepak example:

Drug	Quantity
Ipratropium bromide 0.02% in 3 ml saline (2.5 mg pre-packaged 20)	1 small box
Albuterol (0.083%) 2.5 mg in 3 mL saline	1 small box
Nasal Saline (1 bottle)	1 bottle
Dexamethasone sodium phosphate - 10 mg/ml vial	2 vials
Prednisone 20 mg	4 tabs
Nebulizer	1 unit
Syringes (25G, 1 in, 3 ml)	10 syringes

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Patient Story: J.M.

- Multiple hospitalizations
- Enrolled in Community Paramedicine program in July 2017
- Admitted to Home Palliative program in October prior to Community Paramedicine discharge
- No further hospitalizations
- In January 2018, transitioned to hospice

Patient Story: G.C.

- Multiple ED visits and hospitalizations related to falls and respiratory failure
- Enrolled in Community Paramedicine program as part of transition from SNF to home in January 2019
  - Safety education
- Enrolled in Palliative Care after referral from Community Paramedicine program
  - GOC and ACP, Coordination, Community referrals
- In April 2019, transitioned off program as Goals Met

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Program Results

- After implementation with partners, a per member per month (PMPM) cost reduction for 62.77% of patients enrolled greater than 1 month resulted in an overall PMPM reduction in Part A and Part B expenses of 26.93%.

Results: Outcomes

- Return on Investment
  - Utilization reduction
  - Medical expense savings in Part A and B (since at risk)
  - "Soft-money program"
- Patient/Family Satisfaction

Results: Lessons Learned

- ROI
  - Develop metrics that matter, and measure them
    - For Managed Care, reduced utilization/reduced costs of members
    - Patient Satisfaction with program
    - PCP Satisfaction with program (service offered by organization)
- Partners
  - Find partners to fill the gaps
    - They do what you can't, they do what you can't do well
    - Cheaper than internalizing?
  - Develop protocols prior to go-live
    - Revise as you go

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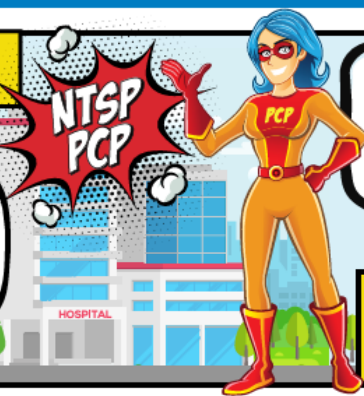
THE STORY BEGINS WITH A CHRONICALLY-ILL PATIENT BEING DISCHARGED AFTER MULTIPLE HOSPITALIZATIONS

PCP SAYS: "WHAT WE NEED IS A CARE DELIVERY TEAM THAT CAN HELP MANAGE SYMPTOMS OF CHRONICALLY-ILL PATIENTS ACROSS THE CONTINUUM OF CARE. I AM REFERRING YOU TO NTSP'S PALLIATIVE CARE PROGRAM."



THE PATIENT DIAGNOSED WITH CHF ENTERS THE CLINIC – BASED PALLIATIVE CARE PROGRAM AND IS MET BY A PHARMACIST WHO COMPLETES MEDICATION RECONCILIATION . . .

. . . SOCIAL WORKER DISCUSSES GOALS OF CARE, COMPLETES ADVANCE CARE PLANNING, HELPS COORDINATE CARE AND PROVIDES DISEASE EDUCATION.

MEANWHILE, THE PATIENT'S SYMPTOMS ARE WORSENING AND REQUIRE FREQUENT MEDICATION ADJUSTMENTS; NEW DIAGNOSES OF COPD AND CKD ARE MADE. THE PATIENT IS SEEING THE PCP FREQUENTLY AND IT'S BECOMING MORE DIFFICULT FOR THE PATIENT TO COME TO THE CLINIC TO SEE THE PHYSICIAN.

SOCIAL WORKER SAYS: "I KNOW YOU WANT TO FEEL BETTER AND I KNOW YOUR WIFE NEEDS HELP. SHE THINKS YOU WOULD BENEFIT FROM A WALKER. I THINK THE HOME-BASED PROGRAM IS WHAT YOU NEED."

BACK AT THE HOME-BASED PROGRAM, THE NURSE PROVIDES PRIMARY SYMPTOM MANAGEMENT. VISITS ARE MADE BY A CHAPLAIN, SOCIAL WORKER, NURSE PRACTITIONER AND PHYSICIAN. THE 24/7 URGENT ISSUES HOTLINE IS ACTIVATED.

24 HR HOTLINE

...THE CARE DELIVERY TEAM CONTINUES TO VISIT THE PATIENT AND AFTER 1 MONTH OF STEADY DECLINE IT IS DETERMINED THAT AN INCREASE IN PAIN CONTROL MEDICATION IS NEEDED. THE TEAM ALSO EVALUATES THE PATIENT'S GOALS OF CARE, AND POSSIBLE NEED FOR HOSPICE, AND AGREE TO DISCUSS THIS REGULARLY.

ON THE OTHER SIDE OF TOWN, THE COMMUNITY PARAMEDICINE TEAM RECEIVES A CALL FROM THE PATIENT AND RUSHES TO HIS HOME TO PROVIDE IV LASIX FOR ER AVOIDANCE.

TO THE RESCUE

FOR THE FORESEEABLE FUTURE, THE PATIENT CONTINUES TO RECEIVE VISITS FROM THE CARE DELIVERY TEAM AND THE PHARMACY IS CONTACTED TO PROVIDE IM LASIX AND STEROIDS TO HELP PREVENT HOSPITALIZATIONS.

AFTER IMPLEMENTATION, 65% OF PATIENTS ENROLLED IN THE PROGRAM FOR MORE THAN ONE MONTH RESULTED IN A 27% PMPM DECREASE IN PART A AND B MEDICAL EXPENSES.

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THE STORY CONTINUES...

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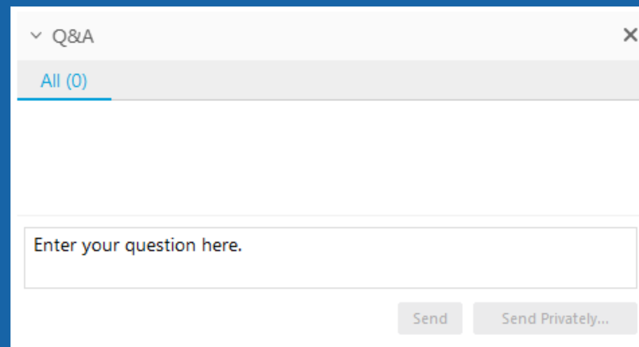
Questions?

Please type your question into the questions pane on your WebEx control panel.



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