Using Palliative Care to Improve Quality of Life and Financial Performance

June 23, 2021

hfma™

Speakers

- Brynn Bowman MPA, Chief Executive Officer, Center to Advance Palliative Care
- Susan Nelson MD, System Chair, Palliative Medicine and Supportive Care, Ochsner Health
- Jim Wentz, MBA, Chief Financial Officer, Ochsner Medical Center

Audience Poll: Palliative Care Experiences

- How many of you have had a personal experience with a palliative care team and a loved one?
  - Yes
  - No
  - Not sure

What is Palliative Care?

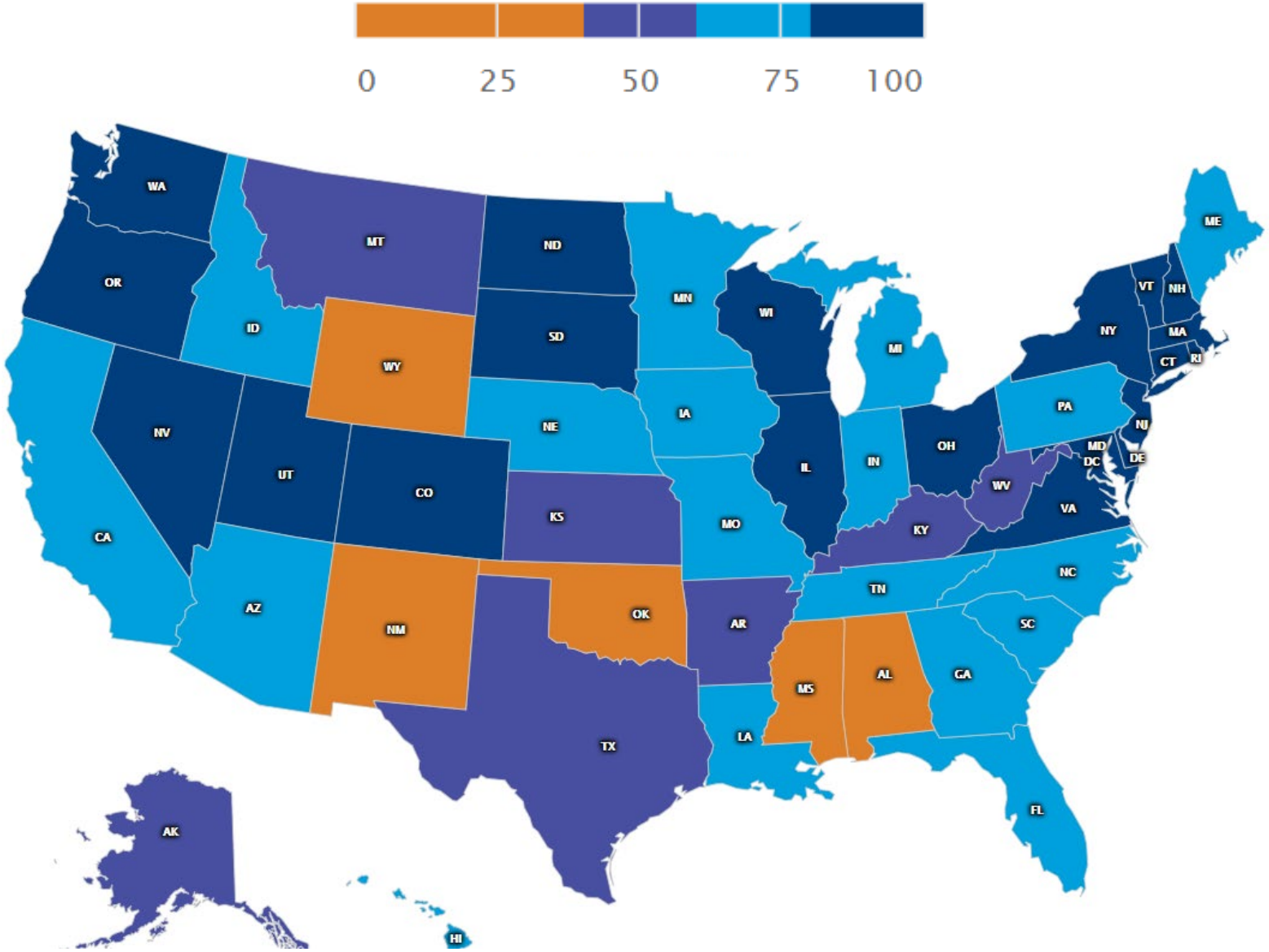
An interdisciplinary team-based specialty that:

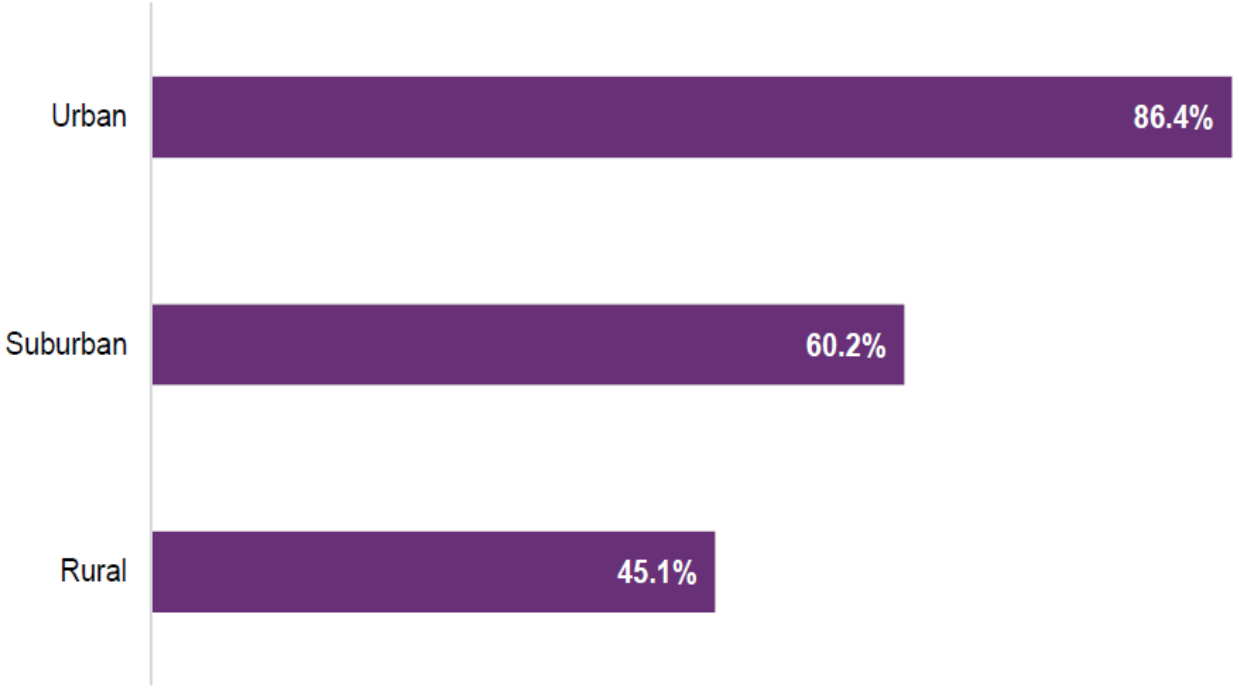
- Provides an added layer of support for relief of pain, symptoms, and stresses of serious illness
- Focuses on patient and family quality of life at the same time as curative or life-prolonging treatment:
  - Curable illness
  - Chronic illness
  - Progressive/terminal illness

What can go wrong for patients with serious illness?

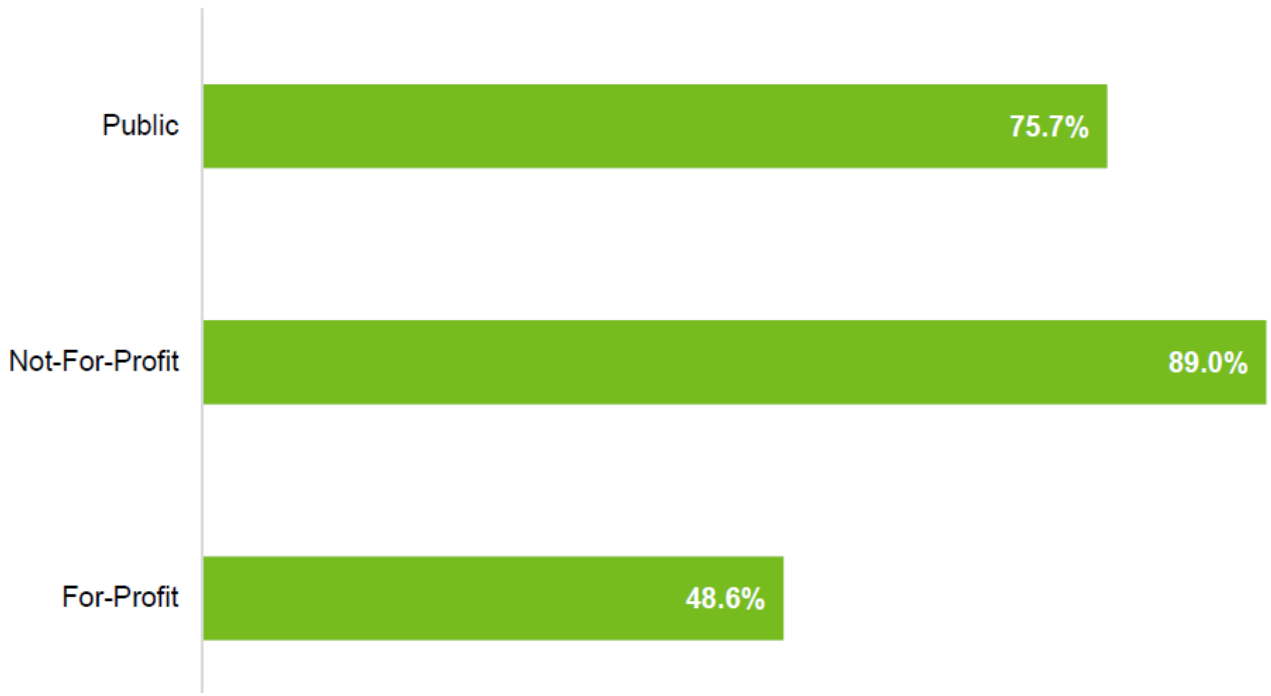
- Missing or inadequate conversations about what matters most to patients and families > gaps in care planning
- Uncontrolled symptoms leading to preventable ED visits and hospital stays
- Exhausted family caregivers
- Difficulty navigating care across clinical teams and through transitions, and…
- More patients in need

Hospital palliative care has seen dramatic growth over 20 years



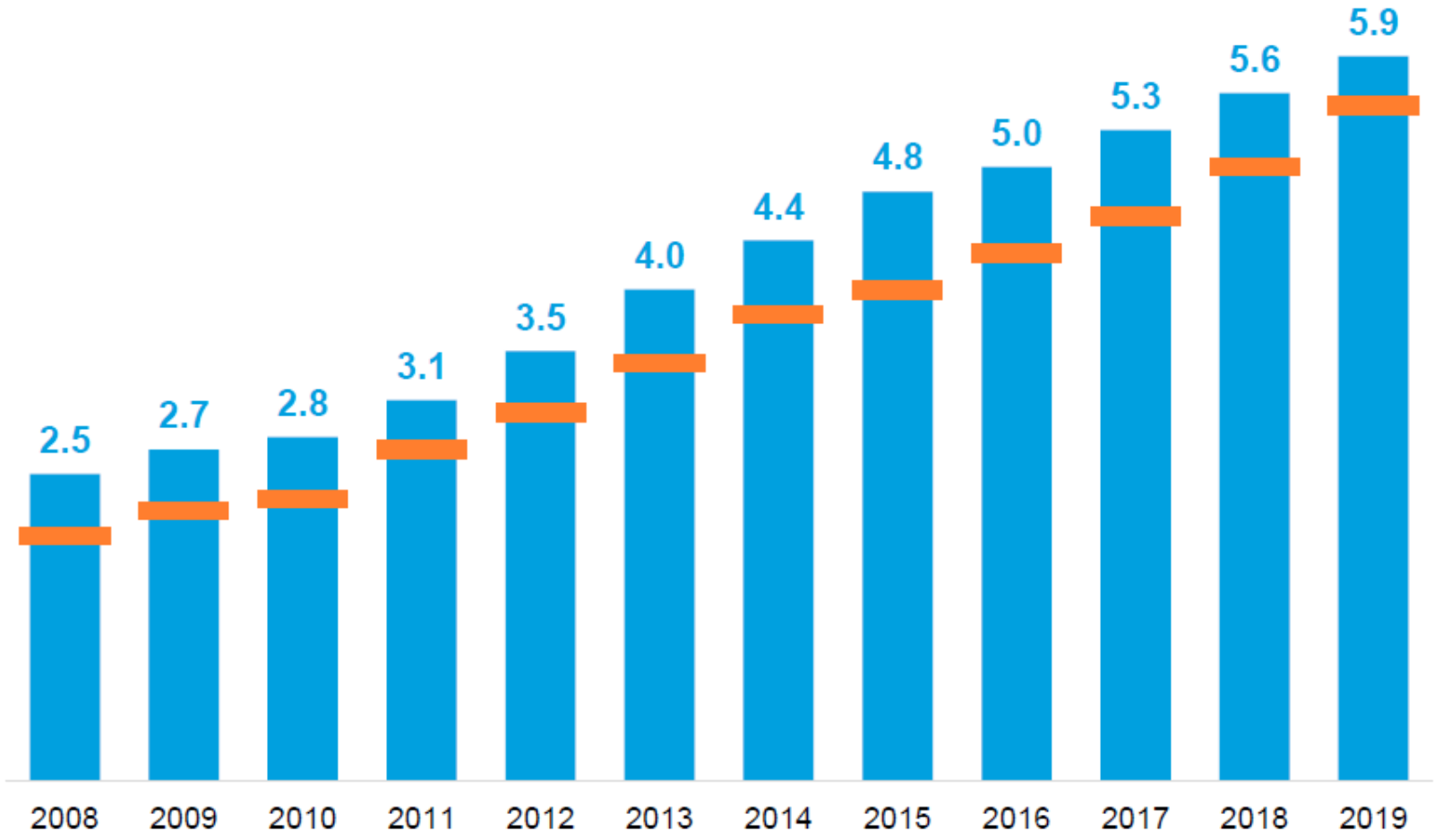


Prevalence by Hospital Setting, 2019

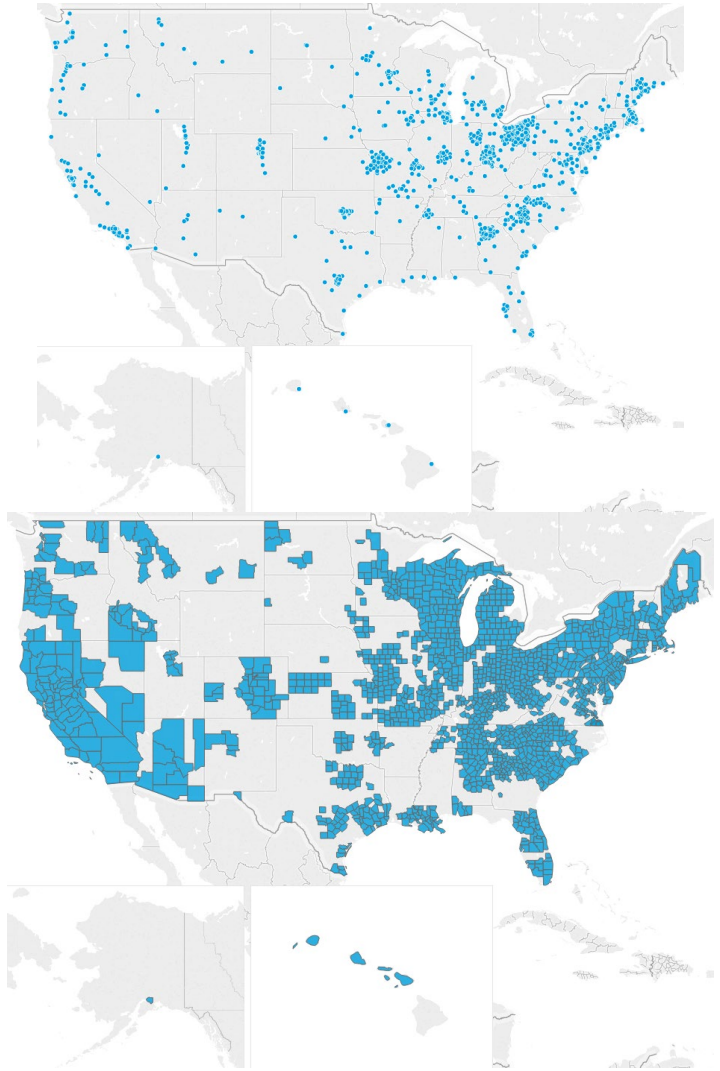


Prevalence by Hospital Type, 2019

Mean and Median Penetration Rates Over Time



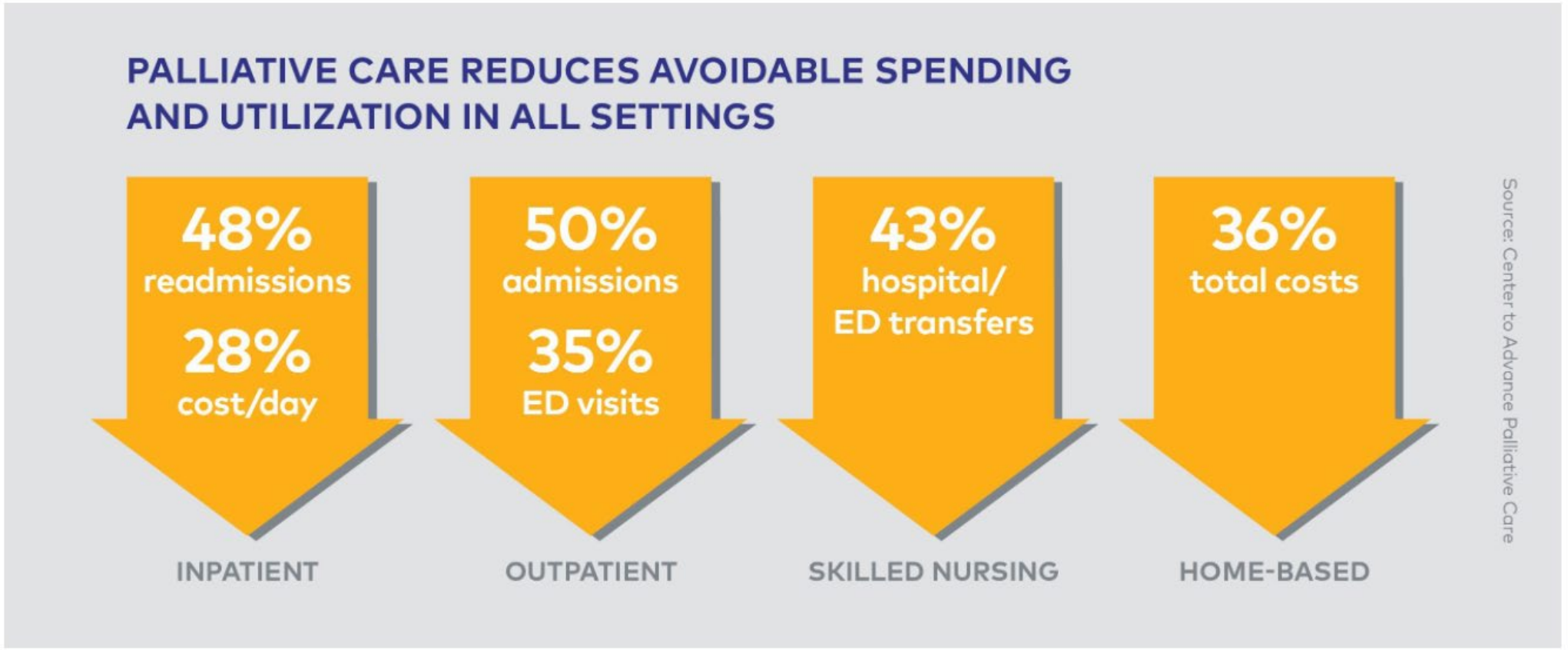
Palliative Care in community settings



Nearly 3,000 Office Practices and Long Term Care Facilities Served by Community Palliative Care

More than 1,500 Counties with an In-Home Palliative Care Presence

The Palliative Care Value Equation



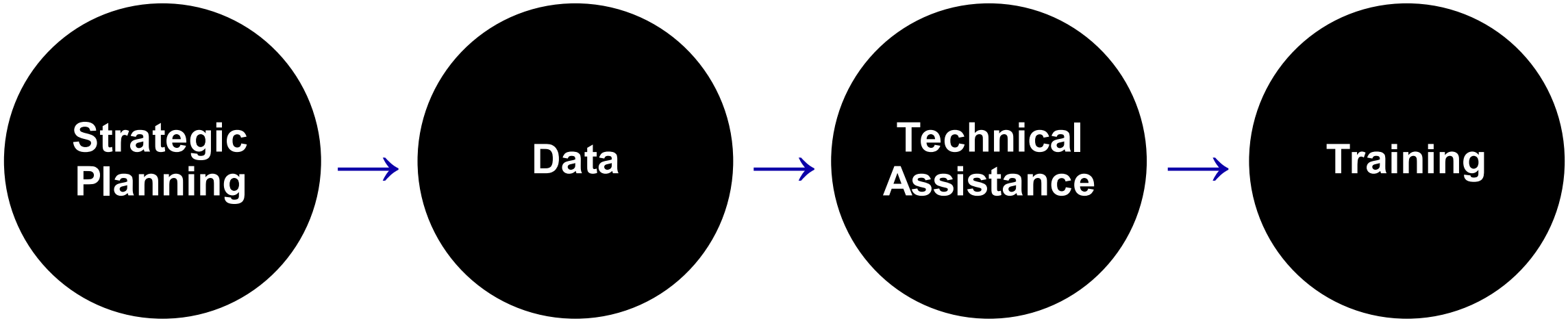
Planning for Organizational Impact

Interdisciplinary Palliative Care Capacity

Identifying the Population in Need

Clinician Training

How We Work:
CAPC Support for Palliative Care Strategies



Audience Poll: Palliative Care Experiences

- How many of you have a palliative care team at your facilities?
  - Robust program
  - No program
  - Not sure

Audience Poll: Scope of Organization

- My organization comprises (check all that apply):
  - Single hospital site
  - Multiple hospital sites
  - Tertiary services
  - Skilled nursing services
  - Home health services
  - Cancer center
  - Heart failure center

Ochsner Health

Our Mission is to Serve, Heal, Lead, Educate and Innovate

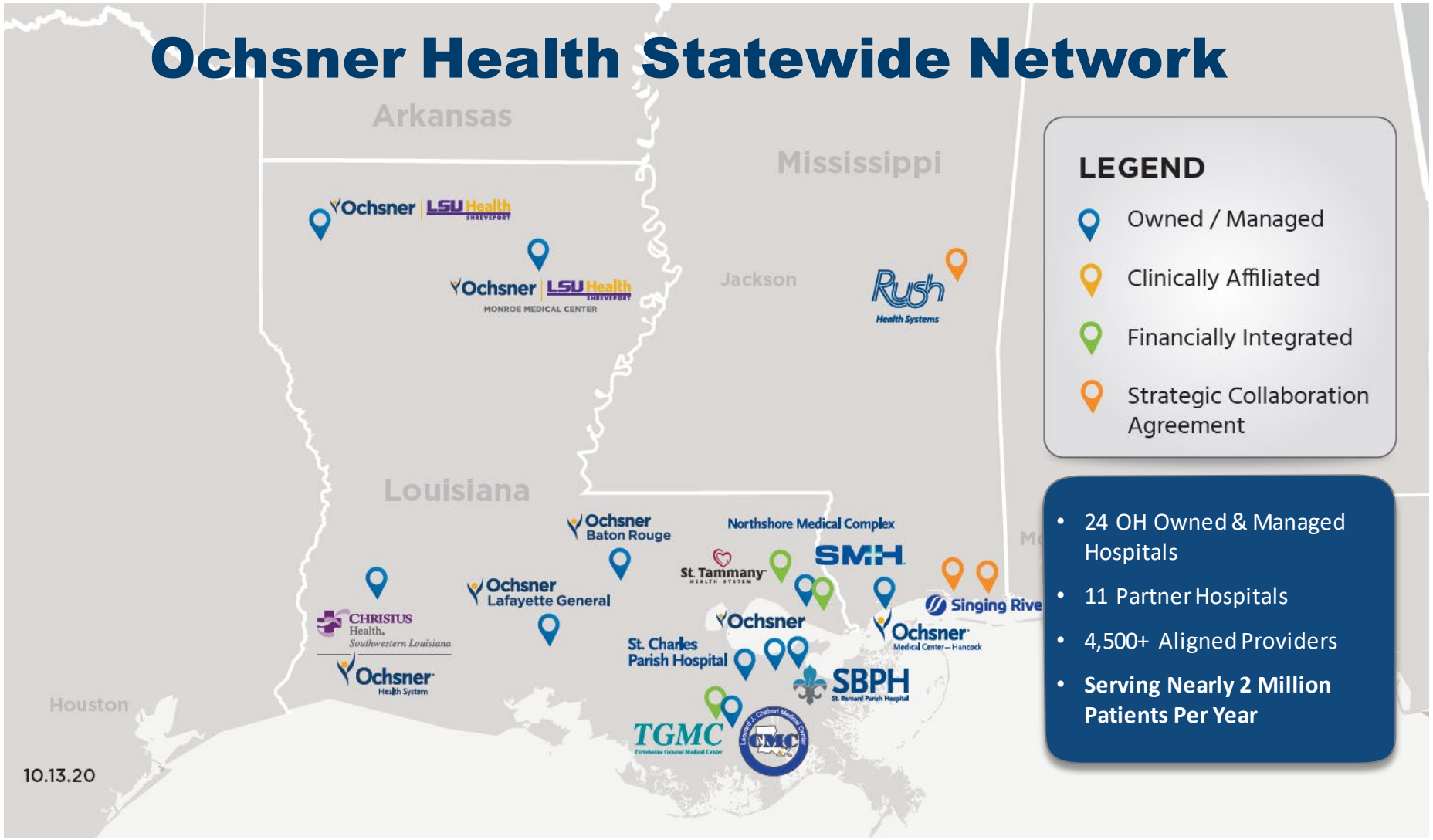
IMPACTING LIVES ACROSS LOUISIANA, THE NATION & THE WORLD

Our Vision

Ochsner will be a global medical and academic leader who will save and change lives. We will shape the future of healthcare through our integrated health system, fueled by the passion and strength of our diversified team of physicians and employees.

- ✓ Ochsner is the **Gulf South's Largest** Health System (Not-For-Profit)
- ✓ In 2020, Served **895,500** Patients From Across Gulf South, Every State, and 59+ Countries
- ✓ **24** Owned & Managed Hospitals, **11** Affiliated Hospitals and **5** Specialty Hospitals
- ✓ **230+** Health Centers & **25** Urgent Care Centers
- ✓ 1 U.S. News & World Report "Best Hospital" Specialty Category Rankings & 1 U.S. News & World Report "Best Children's Hospital" Specialty Category Rankings 2020-21
- ✓ **1,600+** Employed MDs & **3,000+** Aligned Providers in **> 90** specialties & subspecialties
- ✓ Largest Private Employer in the State with **26,000+** Employees
- ✓ **Largest Educator** of Medical Students, Residents, and Fellows in Louisiana
- ✓ **750+** Active Clinical Trials
- ✓ Payor mix -
  - ✓ 44% Medicare (about ½ managed)
  - ✓ 30% Commercial
  - ✓ 24% Medicaid
  - ✓ 2% Other

Ochsner Health Statewide Network



LEGEND

- Owned / Managed
- Clinically Affiliated
- Financially Integrated
- Strategic Collaboration Agreement

- 24 OH Owned & Managed Hospitals
- 11 Partner Hospitals
- 4,500+ Aligned Providers
- **Serving Nearly 2 Million Patients Per Year**

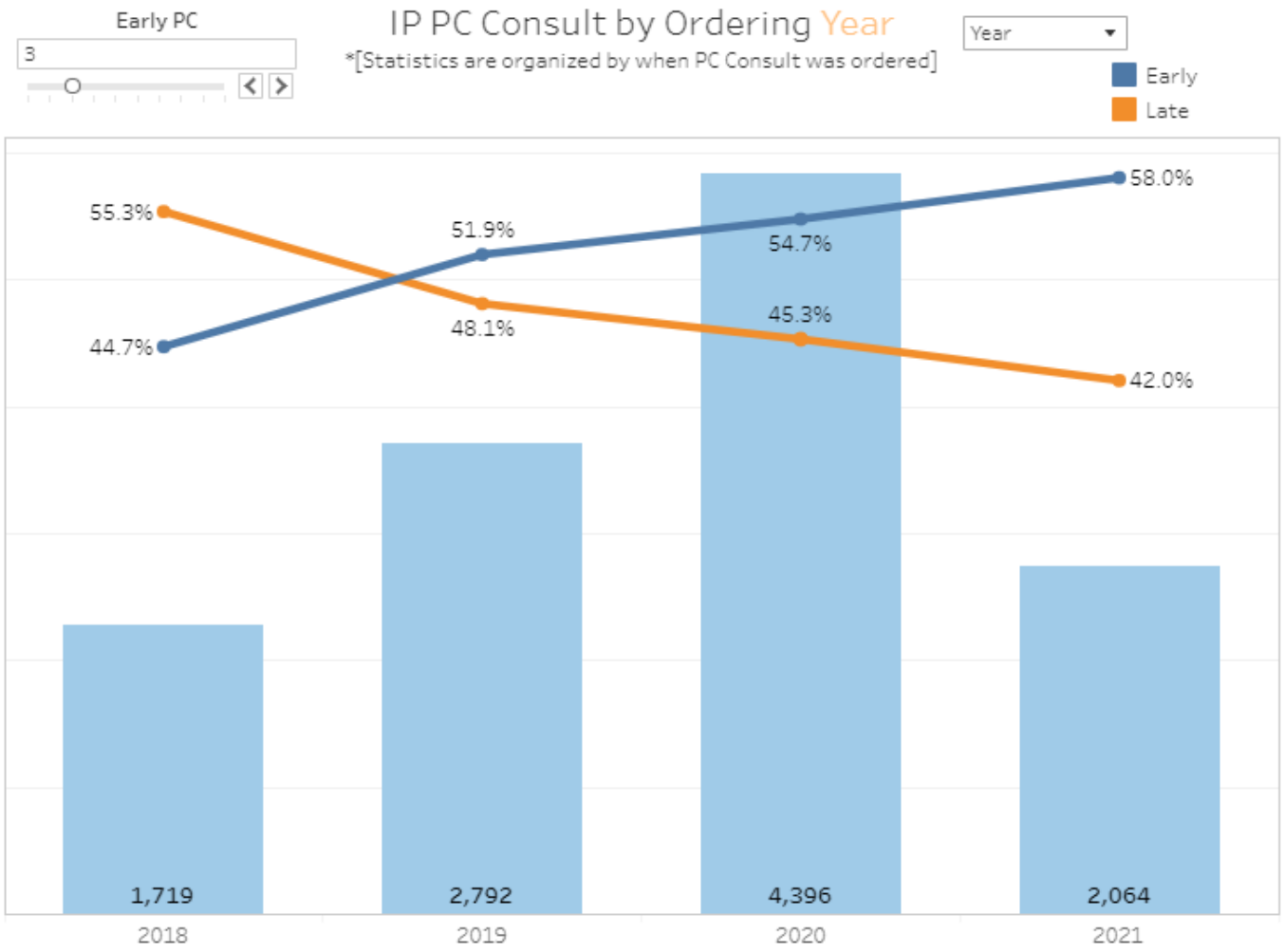
Palliative Care in Action: Jennifer T

- 58 y o woman who had a hysterectomy in March; found to have low grade sarcoma with surgical “cure”.
- 6 weeks later-came to ED due to back pain and inability to walk. Found to have near spinal cord compression from tumor.
- Seen by Radiation Oncology, Neurosurgery and Palliative Medicine.
- Pain pump started to manage pain; converted to oral long-acting medications with breakthrough meds and started on dexamethasone-a steroid to decrease inflammation and help with the spinal cord compression.
- Received urgent radiation and physical therapy consultation.
- Able to walk with cane and wanted to go home (48 hour stay) to await what other treatments would be helpful.
- Told every team that palliative medicine team helped the most to be able to get home!

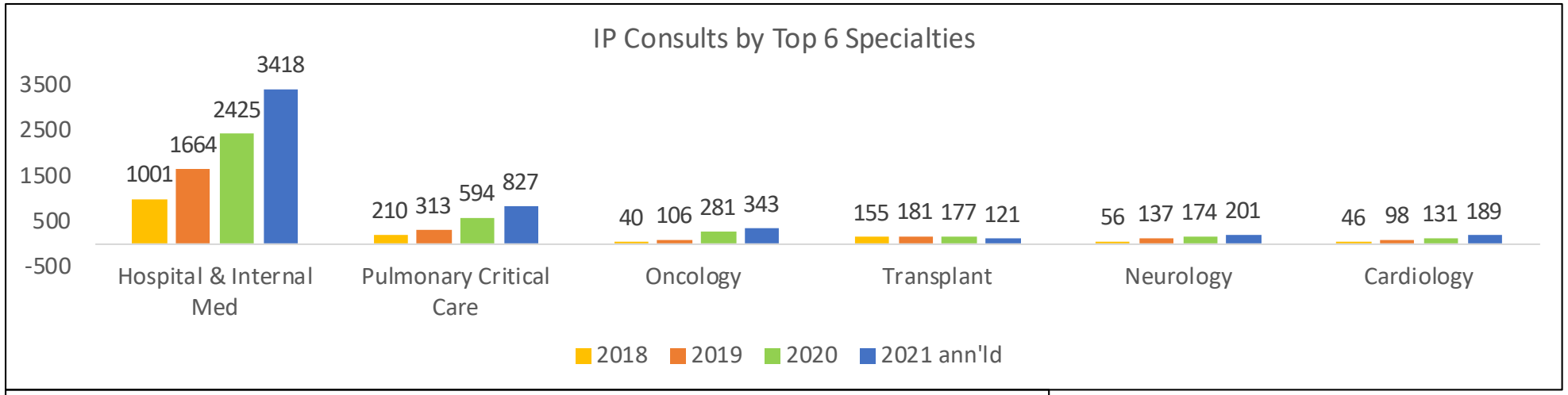
Staffing and Recruitment Update

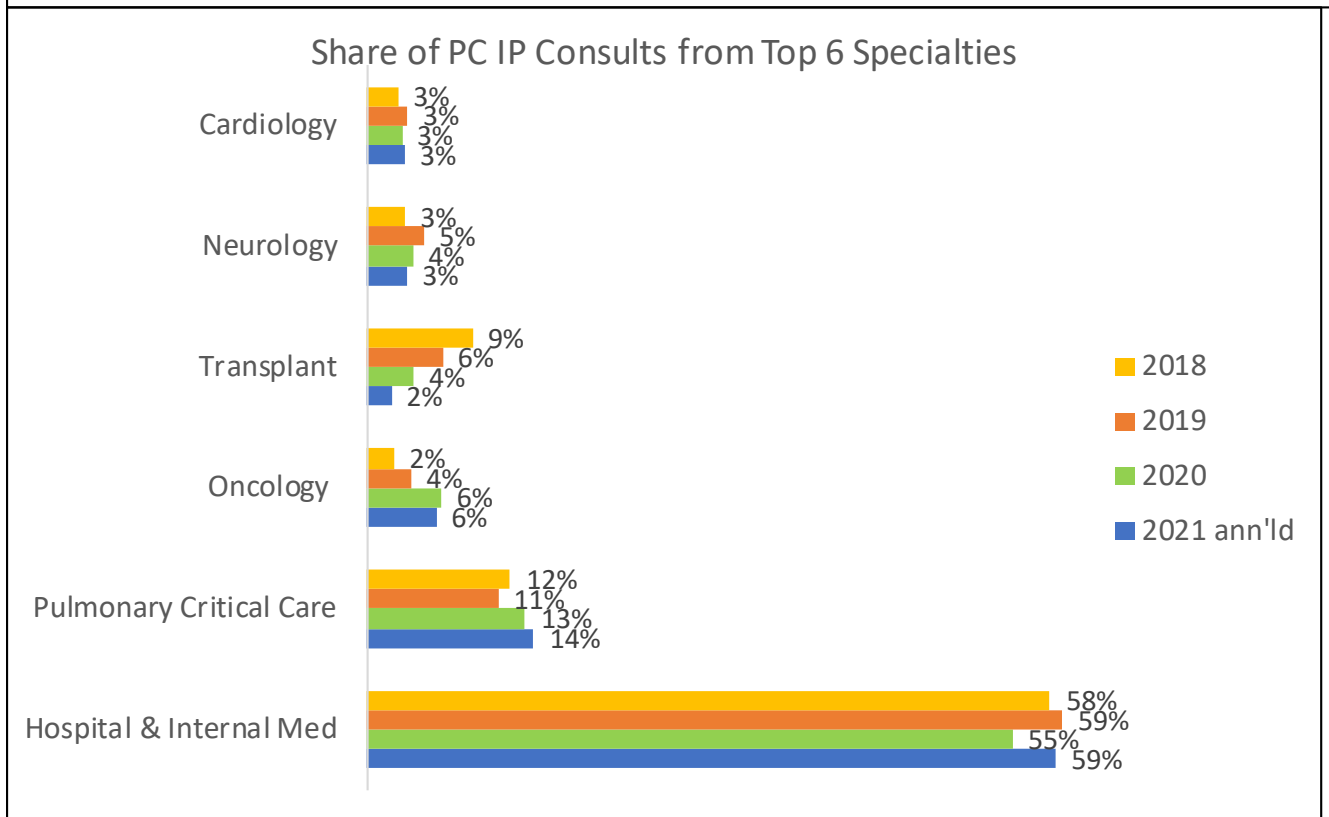
Campus	2015	2018	2021	Projected/ Recruitment
Baptist		1 RN	1 MD (.5); 1 APP	.5 SW- evaluating need
Baton Rouge			1 MD (.5 FTE); 1 APP; 1 RN; 1 LPN; 1 SW	1 MD; 1 APP- starts 6/28/21
Bayou				Handling internally; TBD
Kenner/ St. Charles		1 APP	1 APP	1 MD- offer made
Slidell/North Shore			1 MD (.4); 1 RN	MD starts 2022
St. Tammany Parish Hospital		1 APP	2 APP; 1 RN	1 SW
Jefferson Hwy	2 MD (.95 FTE); 3 APP (2.7 FTE); 1 SW	3 MD (2.4 FTE); 3 APP (2.7 FTE); 1 SW	6 MD (5.2 FTE); 3 APP (2.8 FTE); 1 RN; 3 SW; 2 MA *1 MD /1 SW peds pall care*	1 MD- interviews in process; 1 APP- West Campus- position in approval process; 1 APP- CHF; 1 APP-Hem/Onc; 1 APP- Brain Health; 1 CCLS- interviews in process
Lafayette General			1 MD	
West Bank		1 APP; 1 RN; 1 Chaplain	1 MD (.5); 2 APP; 1 RN; 1 Chaplain	1 SW- evaluating need
Shreveport			2 MD; 1 RN	1 APP starts 6/2021; 1 SW posted
TOTALS	**4.65 FTE**	**12.1 FTE**	**35.9 FTE**	**11 FTE**

Consults within 3 days



Palliative Care IP Consults





Impact of Home Visits (Poster in Appendix)

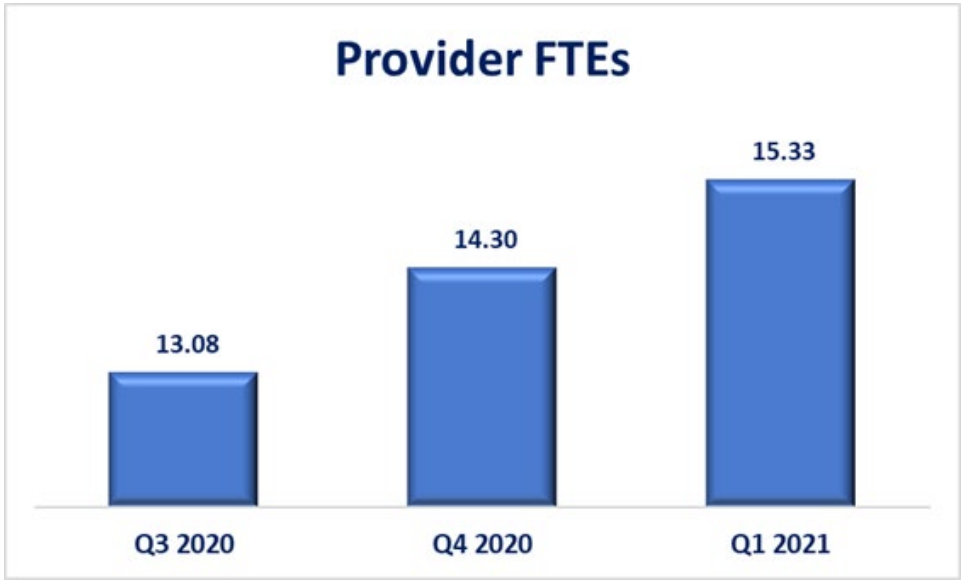
- Panel of 56 Medvantage patients
- Length of enrollment 1-15 months
- Multidisciplinary approach:
  - PCP
  - Home NP visits
  - Clinic based MA
  - Clinic based retail pharmacy
  - External Home Health staff
  - Mobile imaging technicians
- **Patients that utilized ED within 6 months prior to intervention: 75%**
- **Patients that utilized ED during the intervention: 9%**

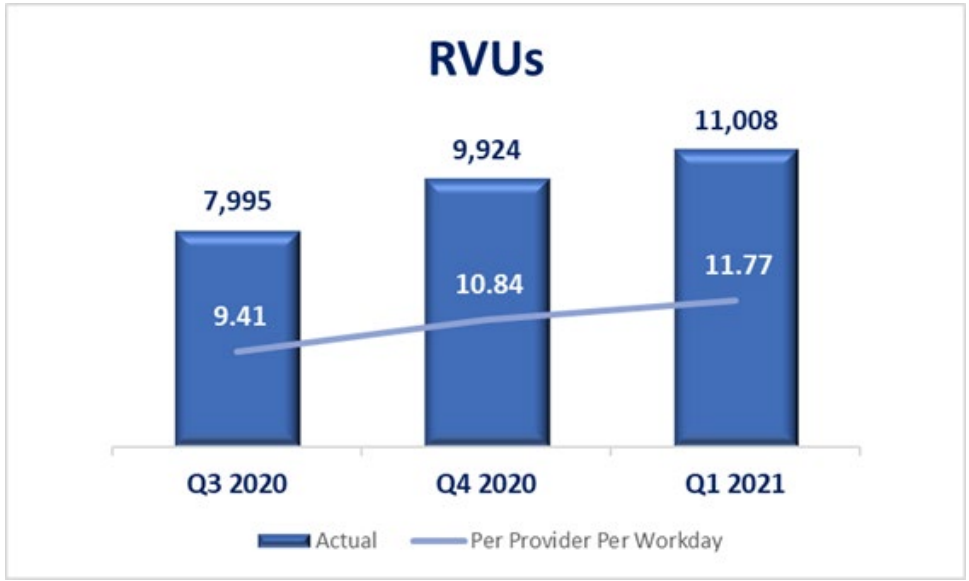
Impact of Multidisciplinary Primary Care (Poster in Appendix)

- Multidisciplinary Approach:
  - PCP
  - Case management
  - Social work
  - Pharmacy
  - Home Health
  - Palliative Care
- **Nationally: Hospice enrollment at time of death 48%**
- **Prior to partnership: 53.8%**
- **After partnership: 78.9%**
- **Of patients enrolled, 91.9% died in their homes**

Palliative Care – CFO Perspective

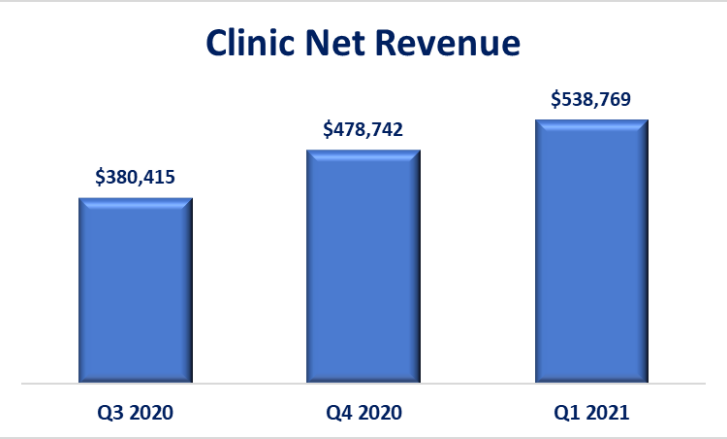
- **Why invest in Palliative Care?**
  - Even when fully productive, palliative care providers in isolation don't cover cost.
    - *Per provider we are subsidizing around $200K*
    - *Subsidy per RVU currently around $115*
    - *Medicare (including managed) payor mix about 70%*
    - *Commercial payor mix only about 15%*
    - *The Palliative care clinic is expected to lose about $2.9M at OMC this year*

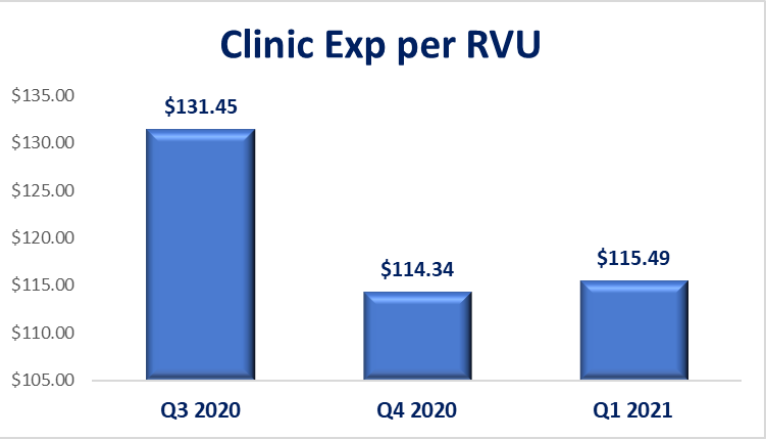


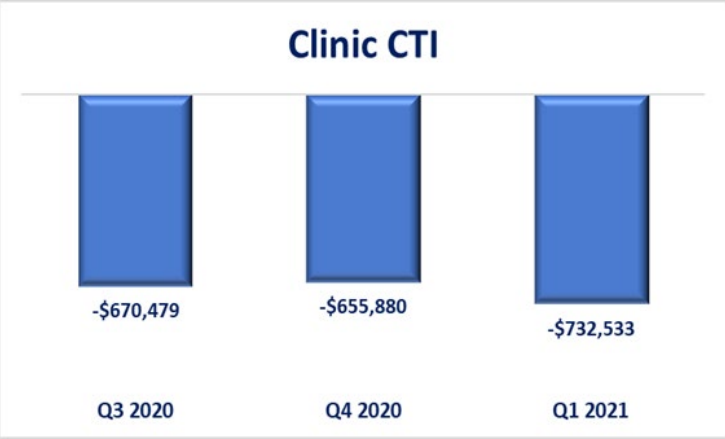


Palliative Care – CEO Perspective

- **Why invest in Palliative Care?**
  - To make matters worse, you won't make it up on volume.
  - More palliative clinic volume will drive higher losses, but as we continue to work on process, efficiency, and better utilization of advance practice providers, we do think we can improve the per encounter cost.







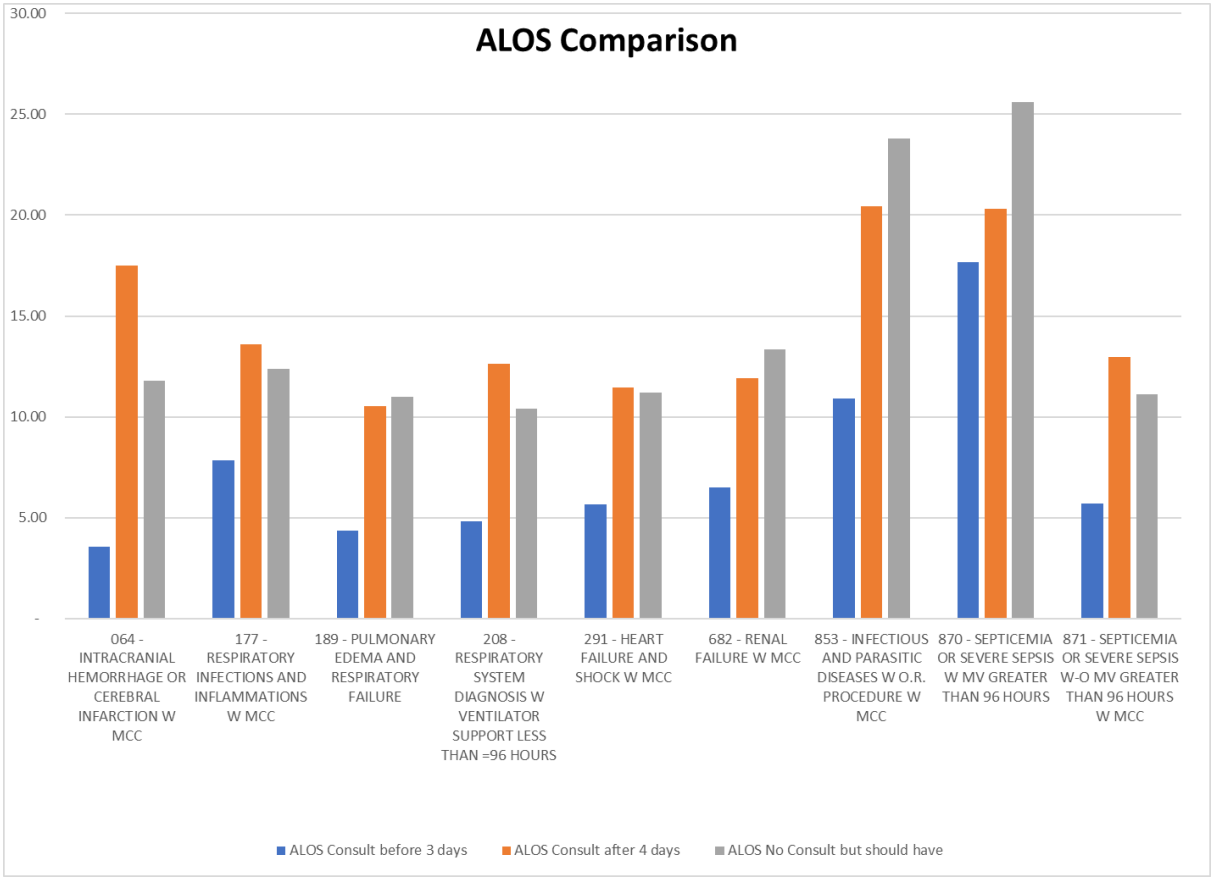
CFO Perspective

- We have a program
- How can we get the most out of it?
- Should we grow or should we try to right size?
- Does palliative care (really) lower LOS and cost of care?

Approach – Looked at top 10 DRGs for 2020 calendar year

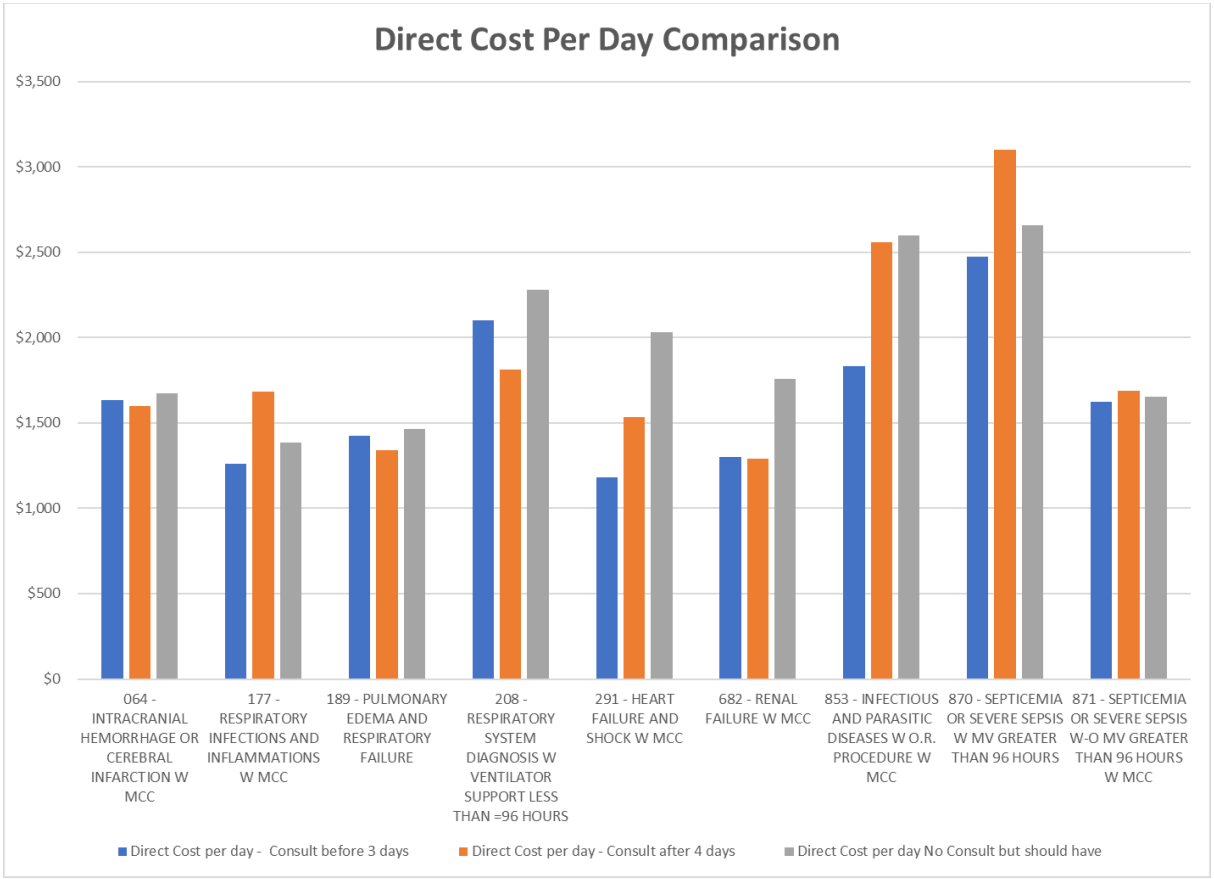
- Used 2020 instead of 2019 because of maturity of palliative care program
- Excluded primary COVID DRG
- Assumed all cases that palliative care consults needed them
- Compared:
  - All cases with palliative care consults within 3 days (industry standard)
  - Cases with palliative care consults after 4 days
  - Cases that should have had a consult but didn't (hospice discharge, deceased)
- Consults made on 13% of cases
- Cases made up about 40% of discharges at OMC for 2020

CFO Perspective: Value of Palliative Consults



Palliative care consults reduce LOS

CFO Perspective: Value of Palliative Consults



Palliative care consults on the average reduce the cost of care per day

CFO Perspective: Bottom Line – Realized Savings

Realized Savings	Consult after 4 days or should have been consulted	Consult before 3 days
Cases	908	757
Average LOS	14.57	6.57
Percent Reduction		*122%*
Average Direct Cost per Day	$2,080	$1,647
Percent Reduction		*26%*
Total direct cost savings if consulted within three days		**$9,586,215**
Total cost savings if consulted within three days		**$15,446,178**
Estimated Cost of Palliative Care Program		**2,900,000**

On just these DRGs the palliative care program generated a direct cost ROI of over 3.

CFO Perspective: Bottom Line – Unrealized Savings

Unrealized Potential Savings	Consult before 3 days	Consult after 4 days	No Consult but should have	Potential Total Savings Opportunity Palliative Care Program
Cases	757	627	281	
Average LOS	6.57	14.89	13.86	
Percent Reduction		*126%*	*111%*	
Average Direct Cost per Day	$1,647	$2,115	$1,997	
Percent Reduction		*28%*	*21%*	
Total direct cost savings if consulted within three days		**$7,340,374**	**$3,213,388**	**$10,553,763**
Total cost savings if consulted within three days		**$11,767,836**	**$5,183,980**	**$16,951,816**

On just these DRGs, if consults would have been done in accordance with industry standards, the palliative care program potentially could have generated an additional direct cost savings of $10.6M.

CFO Perspective

- The analysis of our top 10 DRGs showed that the palliative care program does drive value for the hospital
- *Think of a palliative care program in broader terms, to improve the overall efficiency of your resources:*
  - *Lowering LOS, Lowering Readmissions and OBS*
    - *IP, OP, ED and Clinic – remember the payor mix*
  - Less need for hospital-based providers AND nurses!
    - *Not to mention Capital cost as the population ages and drives the need for additional IP Beds*
  - *The numbers make sense for us even in a fee for service world; we are more excited about opportunity in a risk/value world*

CFO Perspective: Next Steps

- Expand the analysis to include additional DRGs
- Assess opportunities for palliative care to lessen unnecessary OBS, ED and clinic visits
- *Develop a process to ensure patients who need a consult get one*
  - *For palliative care to add value, the patient needs to have a consult, and the earlier the better.*
- *Assess the opportunity of the palliative care clinic to increase telemedicine visits*
- *Partner with the Ochsner Health Network to evaluate and assess the opportunities within our at-risk patients*

Audience Poll

- After hearing this presentation, what are your thoughts about a Palliative Care programs?
  - I need more information
  - I'll continue to support Palliative Care

What You Can Do on Monday

- If you have an existing service, meet with your Palliative Care Team Leader – ask what would most increase their impact?
- Evaluate your hospital's palliative care capacity vs. national averages
  - Resources from CAPC: "How We Work" and the Hospital Impact Calculator
- Run the data on patient need
  - Start with metastatic cancer, heart failure and COPD with O2

What You Can Do on Monday (cont'd)

- Learn about effective Palliative Care Program Operations
  - www.capc.org
  - 1,700 organizations are members – yours may be as well
  - Review tools and resources to create and operate efficient and effective programs
- Create a plan to expand palliative care's impact

Questions?

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Resources

- The Case for Hospital Palliative Care
- The Financial Impact of Palliative Care on Hospitals
- Recommended Standards for Hospital Palliative Care
- Serious Illness Strategies for Health Plans and ACOs

These and more are available at www.capc.org

The Impact of Home Visits by Physician and Nurse Practitioner in Decreasing ED Visits and Hospitalization for Homebound Patients

Ekan Ahmed MBBS[2]; Laura Pappas[3]; Richard Li[3]; Didi Ikeji[4]; Olivia Manayan, MPH[1]; Kathy Jo Carstarphen MD, MPH[2]
University of Queensland-Ochsner Clinical School[1], Ochsner Medical Center[2], Tulane University School of Public Health and Tropical Medicine[3],Tulane University[4]

Introduction

The MedVantage Clinic uses patient-centered & population health approaches to manage high-risk and geriatric patients. Comprehensive care is delivered and coordinated by an interdisciplinary care team composed of case management, social work, pharmacy, home health, and palliative care services.

Studies have shown that elderly patients are 4.4 times more likely to utilize ambulance services and 5.6 times more likely to be admitted to the ED/Hospital than non-elderly patients[1]. This disparity can effectively be addressed through home-based primary care.

Objectives

The purpose of this study is to determine whether MedVantage's home-based primary care program can reduce inappropriate ED visits for home-bound patients.

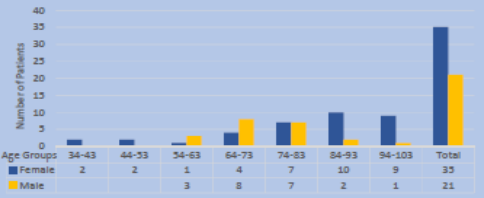


Figure 1. Patient demographics by age and sex

Methods

The intervention consists of PCP and NP home visits with home/bed-bound patients and their families. Staff consists of a PCP, LHC mobile NPs, a clinic-based MA, clinic-based retail pharmacy, external home health staff, and mobile imaging technicians. Appropriate assessments are communicated to all involved persons during visits. Other home-based care plans such as home health, palliative, and hospice care are coordinated with the patient's families.

To evaluate the impact of PCP and NP home visits, the percentage of enrolled homebound patients who utilized the ED each month was reviewed. Patients were enrolled between May 2018 and July 2019 for a total panel of 56 patients. The chart review was completed on 8/7/2019. Patients that were classified as homebound in the MedVantage Clinic at the Ochsner Primary Care and Wellness Health Center were included. The month a patient was enrolled in home-based primary care, they were counted as enrolled for the entire month. The month they were disenrolled, they were counted as enrolled for that month and excluded from future months. Females represented 62.5% of the patient sample and 96.4% were over the age of 54. Length of enrollment varied from 1 - 15 months with average enrollment at 5.5 months.

Descriptive information was collected through referral information under patient chart review. A manual chart review was performed for patients who fulfilled the inclusion criteria. Data collected include if a patient had visited the ED six months before they became enrolled in the study and for the entire time they were enrolled. A decrease in ED visits was expected after patients were established in the MedVantage Clinic home care program.

Figures

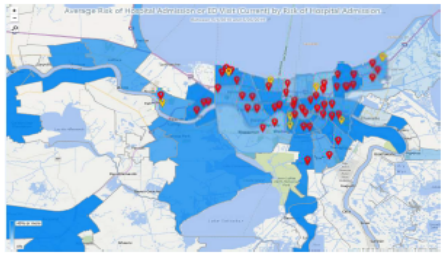
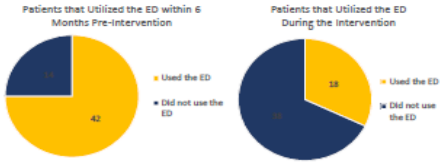


Figure 2. Average Risk of Hospital Admission or ED Visits for MedVantage Patients with pins indicating location of patients enrolled in HBPC. Yellow pins were deceased as of **May 2019**.



Figures 3 & 4. Data was collected retrospectively from patient charts looking at whether they had any ED visits six months before the intervention.

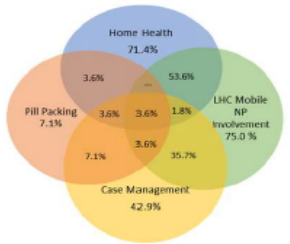


Figure 5. Percentage of services used by patients that were enrolled before **April 2019**

Results & Discussion

In May 2018, the MedVantage Clinic began enrolling patients in the home-based primary care program. 75% of enrolled patients utilized the ED in the six months prior to being enrolled in home-based primary care. The average number of ED visits was 2.52 in the six months prior to enrollment.

The average proportion of patient ED use during the study period was 9%, compared to 75% before the study period.

The results show a decrease in the proportion of enrolled patients utilizing the ED compared to six months before they became enrolled in the study. Slight fluctuations in the monthly data were expected due to the fact there was a rolling admission for this study and several patients transferred to hospice.

These findings demonstrate that home PCP and NP visits may reduce inappropriate ED utilization for homebound patients, which is consistent with the study objectives. Due to the differing lengths and periods of enrollment, the pre and post findings are not directly comparable and may show a greater impact from our intervention. However, disease maturation and new comorbidities may underestimate the overall primary care impact[2].

Another benefit of the intervention may be an increase in patient hospice enrollment. Out of the entire patient panel, 19.6% (n=11) of patients transferred to hospice during enrollment and 54.5% (n=6) of those patients transferred within three days of their first PCP home visit.

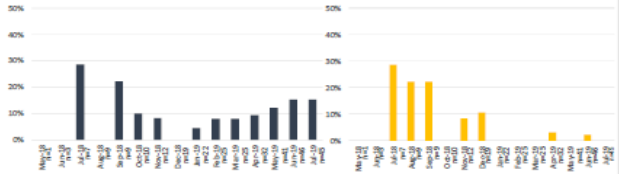


Figure 6. Proportion of patients who utilized the ED at least once during the month. This chart covers data for 56 patients that were enrolled **May 2018 to July 2019.**

Figure 7. Proportion of patients who transferred to hospice during the month. This chart covers data for 56 patients that were enrolled **May 2018 to July 2019.**

Conclusion

A multidisciplinary primary clinic that integrates home-based care for homebound patients is a model that may reduce hospitalization and unnecessary ED visits. PCP and NP home visits can play a valuable role in improving morbidity and mortality for bedbound patients and preventing costly hospitalizations. We found reductions in ED use during enrollment in home-based primary care as well as an increase in hospice enrollment among dying patients.

The results of this project should encourage providers, institutions, and insurance companies to facilitate the utilization of home visits by PCPs and NPs for patients in need. While efforts have been successful thus far, added infrastructure and specialized staffing would further increase program benefits and efficiency.

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The Impact of Multi-Disciplinary Primary Care Within the MedVantage Clinic on Hospice Enrollment at Death

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Introduction

The Medvantage Clinic is part of Ochsner Primary Care and Wellness and uses patient-centered and population health approaches to manage a high-risk, geriatric patient panel. Comprehensive care is delivered and coordinated by an interdisciplinary care team, that includes case management, social work, pharmacy, home health and palliative care services. The Medvantage clinic strives to start palliative and hospice care as early as possible to achieve the highest quality of end-of-life (EOL) care.

Thirty percent of Medicare costs are attributable to 5% of beneficiaries who die each year.[1] Previous studies have shown that most of the Medicare costs within the last year of life result from intensive life-sustaining care such as mechanical ventilation and dialysis.[2,3] Although most Americans prefer to die at home, over 20% of deaths still take place in the hospital.[4]

Hospice services are associated with improvements in both patient-centered outcomes and reduced healthcare costs.[3,5] Hospice services are also associated with less aggressive EOL care and death outside of hospital.[6] Hospice and home health services can alleviate some of the costs spent on hospital admission and EOL care. Hospice is considered a favorable model for quality compassionate care for patients and families facing a life-limiting illness.[3,7]

In March 2018 the MedVantage clinic partnered with the Louisiana Hospice and Palliative Care Group (LHC) to bring mobile nurse practitioners (NPs) to the homes of the sickest patients on the MedVantage patient panel. The mobile NPs collaborate with the MedVantage PCP to increase access to medical care that would not be possible with a single ambulatory physician. NPs help initiate and facilitate EOL care discussions, completion of advanced directives. Further the NPs respond to acute disease exacerbations and collaborate on solutions with the MedVantage PCP as patients decline during progression towards EOL care.

Methods

A retrospective chart review was performed to determine the percentage of Medvantage patients, both before and after partnership with LHC, who were enrolled in hospice at the time of death, compared to patients who died in hospital with similar age, comorbidities, cause of death, and insurance type. Exclusion criteria: living Medvantage patients. Inclusion criteria: deceased Medvantage patients.

Results & Discussion

Nationally, 48% of Medicare patients are enrolled in a hospice program at time of death. In comparison 70.6% of Medvantage patients (data collection performed from 10/2016-2/2019) are enrolled in hospice at their time of death.

Prior to Medvantage partnership with the LHC Ambulatory Palliative Care Program in March of 2018 (from 10/2016-3/2018), 53.8% of Medvantage clinic patients were enrolled in hospice at their time of death. Since partnering with LHC, a 25.1% increase in hospice enrollment among deceased patients has been observed – ultimately resulting in 78.9% enrollment among MV patients in the time period after the partnership with LHC (from 3/2018-2/2019, see Chart 1).

The Medvantage patient location, along with hospice status, at time of death was categorized as home, hospital, community, or unknown. The majority of patients (66.7%) died at home while receiving hospice care (See Chart 2). 91.9% of patients enrolled in hospice died in their home.

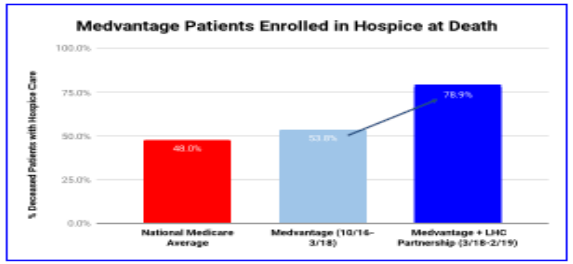

Chart 1: Impact of LHC ambulatory palliative care involvement in hospice initiation at death for Medvantage patients.

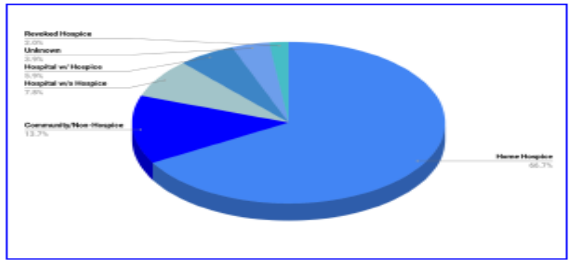

Chart 2: Medvantage patient location, and hospice status, at time of death.

Conclusions

For most patients and their families, dying in the home is optimal and also reduces healthcare costs, especially through prevention of hospitalization. By having early EOL care discussions with all patients, especially those who are homebound, we can form a treatment plan with realistic goals of care that are congruent with the patient's expectations of QOL at time at time of death. Utilizing a multidisciplinary team with mobile advanced practice palliative care providers and collaborative partnership with MedVantage Clinic, increases patient willingness to utilize hospice services. Implications for expansion of these services within a large hospital system may create sustainable use of Medicare funds, optimization of physician efforts, and improve family satisfaction with end of life care.

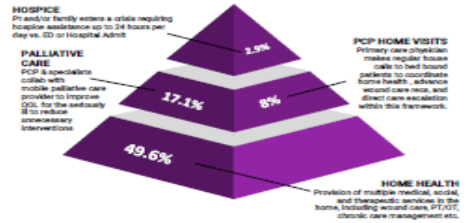

Figure 1 Distribution of home-based care model interventions.

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