End of Life Care in a Capitated System:
Lessons and Hope for the Future

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Commonwealth Care Alliance
Agenda

- Explore Current Hospice Model
- CCA Experience
- Where we believe we need to go
- Q & A
Traditional Hospice

Background

- Hospice started in 1971 in US, Medicare funded in 1983
  - Transfer of Medicare A benefit
  - Less than 6 months to live – two providers certify, can be re-certified
  - Primarily cancer focused, this has changed
  - 2012 – approx 15 billion industry
  - Per diem rate - $150/day – all inclusive
  - Different levels of care, 96.5% is Routine Home Care – NHPCO 2013
  - 2011 – approx 60 % of hospice expenditure on patient’s greater than 6 months - MedPAC
Traditional Hospice

Issues with Structure

- **Care Model: Inflexible, rewards longer stays, limits on patient focused care**
  - Per diem rate structure leads to enrolling patient’s as early as possible, keeping them as long as possible with as many days without service as possible.
  - Diagnosis of 6 months very vague in non-cancer patients – majority of patients on hospice for non cancer dx: dementia, FTT, CHF, others where 6 month dx unclear.
  - Black and white in care structure, no or very limited role for aggressive care, ability to blend care.
  - Lack of accountability if Hospice fails, patient hospitalized.
Traditional Hospice

Barriers for Patients

- Hospice means I am dying!
- All or nothing decision. Sense of abandonment. Primary Care Team not involved in most cases.
- Discussion very late in disease process.
- Duplicative to NH responsibilities.
- Limited benefit to patient.
  - Home health aid – limited hours
  - LPN predominant care
  - Usually once a week visit
  - SW, Chaplain, volunteers available not widely used
Traditional Hospice Facts and Figures

- 2012 – 35.5% of patients stayed on Hospice < 7 days
- Average length of service 2012 – 71.8 days
- 32% non for profit, 63% for profit, 5% gov – 2012
- Medicare pays approx 84% - holding steady
- Primary DX 2012
  - Cancer – 36.9%
  - Debility Unspecified – 14.2%
  - Dementia – 12.8%
  - Lung Disease – 8.2%
- Source: NHPCO’s Facts and Figures: Hospice in America 2013
Commonwealth Care Alliance
Pre Life Choices

- Lots of long stays! Very expensive!
- Primary care teams disengaged, not participating in care at end of life
- Sub specialist, hospital driven
- Patients dying away from home
- Limited advanced goals of care
- In short, we looked like everyone else!
Commonwealth Care Alliance’s Model
Life Choices Program

- Transition from a hospice model of care to an integrated model with end-of-life and palliative care services embedded in primary care model (‘‘End of Life Care is Normative Care’’)
  
  (Pilot started September 2009)

  - Widespread education programs with primary care teams
  - Direct consultations both live and virtual
  - Integration into BMC hospital service
  - Partnerships with VNA and hospice for a la carte services
  - MOLST form training for primary care teams
  - Culture change from default end of life care to quality of life focused care directed by patient and family goals
CCA Life Choices
Philosophy

- SeeSaw Approach weighted per patients wishes, clinical status
- Primary care teams lead care, utilize end of life services as consultants
- A la carte hospice services – we purchase in a fee for service arrangement of what we need, don’t buy what we don’t
- No need to have “the conversation”. Care at end of life evolves as a process, not an event
- Support from hospitalist and specialists who understand what we need to do
- We already have DME, PCA support as well as BH, SW – what more do we need?
  - 24/7 availability
  - Shared care model
  - Learning environment
Life Choices

Barriers

- Finding partners to work with in the community
- Avoiding the “feeding” of hospice
- Working with other hospitals to understand our model
- Explaining to patients the difference between our program, Medicare hospice
- Making sure we maintain a high level of quality of care
- Staff buy in, participation
- Swimming against the tide
# Preliminary Results

## Life Choices Program - Findings to-date

<table>
<thead>
<tr>
<th>Success Criteria</th>
<th>Baseline</th>
<th>Benchmark</th>
<th>Ultimate Target</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dying at home</strong></td>
<td>CY 2009</td>
<td>19%</td>
<td>45%</td>
<td>≥45%</td>
<td>19%</td>
<td>29.6%</td>
<td>37%</td>
</tr>
<tr>
<td>% dying at home</td>
<td>CY 2009</td>
<td>45%</td>
<td>≥45%</td>
<td>19%</td>
<td>29.6%</td>
<td>37%</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>ICU days at end of life</strong></td>
<td>CY 2009</td>
<td>2.72 days</td>
<td>2 days</td>
<td>≤2 days</td>
<td>2.72 days</td>
<td>1.49 days</td>
<td>1.53</td>
</tr>
<tr>
<td>Average # of ICU days per decedent in last 6 months of life</td>
<td>CY 2009</td>
<td>2.72 days</td>
<td>2 days</td>
<td>≤2 days</td>
<td>2.72 days</td>
<td>1.49 days</td>
<td>1.53</td>
</tr>
<tr>
<td><strong>Advance care planning</strong></td>
<td>CY 2008</td>
<td>56%</td>
<td>90%</td>
<td>≥90%</td>
<td>67%</td>
<td>59%</td>
<td>74%</td>
</tr>
<tr>
<td>% with evidence of advance care planning in medical record</td>
<td>CY 2008</td>
<td>56%</td>
<td>90%</td>
<td>≥90%</td>
<td>67%</td>
<td>59%</td>
<td>74%</td>
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<tr>
<td><strong>Cost Reduction</strong></td>
<td>CY 2009</td>
<td>$10,146</td>
<td>NA</td>
<td>NA</td>
<td>$10,146</td>
<td>$6,370</td>
<td>$7,528</td>
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<tr>
<td>Medical Costs PMPM in last 6 months of life (subset of population)</td>
<td>CY 2009</td>
<td>$10,146</td>
<td>NA</td>
<td>NA</td>
<td>$10,146</td>
<td>$6,370</td>
<td>$7,528</td>
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**Note:** TBD indicates that the target is not determined.
### Preliminary Results for BMC Inpatient Unit

#### Care Transitions Program - Findings to-date

**Pilot Results – Overall**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total # admissions</th>
<th>Admissions/1,000</th>
<th>30 day, All-Cause Readmission Rate</th>
<th>Average cost</th>
<th>% discharged to home</th>
<th>% with observation admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>171</td>
<td>357</td>
<td>19.9%</td>
<td>$11,585</td>
<td>76%</td>
<td>19.3%</td>
</tr>
<tr>
<td>2012</td>
<td>60</td>
<td>232</td>
<td>8.3%</td>
<td>$9,596</td>
<td>85%</td>
<td>33.8%</td>
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#### Comparison of Patients “On” vs. “Off” Pilot Service

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<th>Average cost</th>
<th>% discharged to home</th>
<th>% with observation admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Off</td>
<td>90</td>
<td>453</td>
<td>24.4%</td>
<td>$11,172</td>
<td>63%</td>
<td>16.5%</td>
</tr>
<tr>
<td>On</td>
<td>60</td>
<td>232</td>
<td>8.3%</td>
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Lessons Learned & Next Steps
Where we need to go (and why)

- Being better at what we do!
- Fully controlling care – EasCare pilot
- Continued education for everyone
- Growth to other care systems – Hospitals, NH, SNIFS, LTACHS, VNA, Home Care Providers
- Analysis with active PDSA cycle of program improvement
- Learn from our mistakes