Achieving Best Practices in Advance Care Planning and Hospice Referral:

A Collaborative Approach to Palliative Care in Ambulatory and Inpatient Settings

Marisol Arroyo
Khoi Luong, DO
Chris Philippou, MPH
Russell Portenoy, MD
Grace Wong, MBA/MPH

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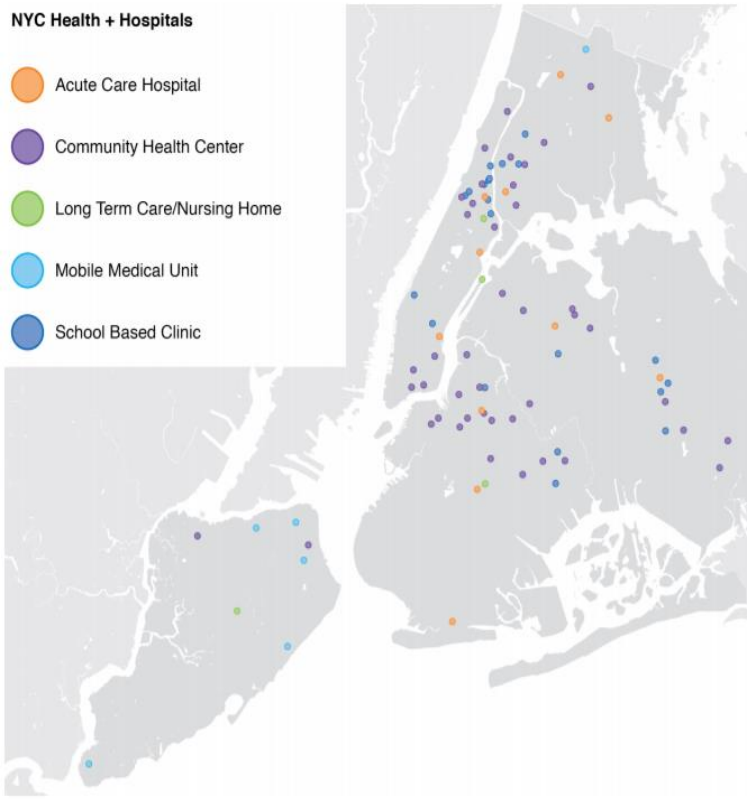

- Largest public health care system in the country
- Full continuum of care: 11 hospitals, 6 ambulatory centers, 5 post-acute sites, 70+ community clinics, home-based, and NYC correctional health care in detention- and jail-based settings
- 1.1m New Yorkers served annually (1 in 6) with +400k uninsured
- Provider of nearly 1/3 of emergency department encounters in NYC
- Nearly 1/3 of service area under 100% federal poverty level and life expectancy 2.3 years less than NYC average
- 1 in 10 patients meet palliative care SMC definition for this intervention

Case for palliative care, especially in aging populations

- The NYS population is aging at a historic rate with longer life expectancies and increased illness burden
- Health care costs are concentrated in groups of patients with severe medical conditions (SMCs); these are the groups who would benefit most from palliative care intervention
  - 25% of health care spend in last year of life (Medicare)
  - 30-50% of health care spend on patients with SMCs (Einav et al., 2018)
- Patients often enter through emergency departments and are admitted, though could be treated in more appropriate care settings with palliative care supports

Current Challenges:

- Capacity is limited in the community and post-acute setting
- Access further constrained for uninsured populations
- Fragmentation and lack of standardization of palliative care services
- Hospice is a federal/state benefit and while the best benefit in health care remains underutilized in NYS
  - NYS ranked 48th among states and Puerto Rico in hospice use by Medicare decedents
  - Hospice use too late with median LOS of 18 days compared to 24 nationally

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Core objectives of palliative care

- Ensure medically-appropriate, patient- and family-centered care through repeated goal setting and informed shared decision making
- Reduce physical, psychosocial, and spiritual sources of distress or burden and improve the quality of life for the patient and family living through serious illness
- Expertly manage and navigate active dying and its aftermath

OneCity Health and MJHS partnership

- In June 2018, a proposal on partnership between NYC H+H and MJHS on "Achieving Best Practices in Advance Care Planning and Hospice Referral: A Novel Collaborative Practice Approach"
  - Funded as a one-year evidence-based prototype by OneCity Health's Innovation Fund, the largest PPS innovation fund NYS-wide
  - Critical to the Innovation Fund as that we test prototypes to the most significant challenges in patients with SMCs with measurable outcomes and innovative, sustainable solution
- This prototype promotes two specific objectives tied to quality, satisfaction, and cost avoidance:
  - Improve access to goal-setting discussions and advance care planning for patients with SMCs
  - Improving awareness and access to appropriate use of the hospice benefit to optimize community-based end-of-life care
- Upon successful intervention, stated goal to expand this modular approach to other settings with high rates of patients with SMCs, including post-acute sites and specialty clinics

Prototype work plan

- Project timeline: 7/1/2018 – 6/30/2019
  - Final Report Due: 9/2/2019
  - Total Budget: $600,000
- July 2018 – Launched at:
  - Kings County Medical Center internal and geriatric medicine clinics
  - Gouverneur internal medicine practices
- February 2019: Launched through the inpatient care transitions program at Elmhurst Hospital

Target population

In any given year, 95,000 unique patients meet MJHS's criteria to qualify for Palliative Care Interventions*

- Approximately 4,100 patients are in our LTC facilities

Based on MetroPlus claims data:

- Top 4% patients meeting criteria incurred $2,432 PMPM
- Top 1% patients meeting criteria incurred $4,035 PMPM
- As compared to costs of all other patients, $236 PMPM

* See Appendix for eligibility criteria

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Prototype overview

- Trained palliative care clinical liaison embedded in a practice and linked to palliative care experts with the needed high-level clinical competency
- Proactive identification of patients with SMCs at-risk for avoidable utilization
- The patient and family journey:
  - Starts with initial outreach to and conversation with patient and/or family
  - Includes iterative discussions, hospice eligibility review, and communication with the patient‘s physician and care team
  - Encounter is documented and an advance directive is filed
  - If the patient is hospice -eligible and -appropriate, assistance is offered
  - Time-limited intervention offered until:
    - Goals are clarified and documented in the EMR
    - Advance directive is up-to-date and in the EMR, and/or
    - Hospice eligibility and appropriateness confirmed with patient and family

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Evaluation and results to date

- Three in four patients have new or updated advanced directives
- Nearly one in five eligible patients discussed hospice care with the care team, resulting in enrollments based on patient and family preferences
- Final evaluation to determine impact on quality and cost of care

	Ambulatory Practice 1	Ambulatory Practice 2	Inpatient Program
Duration	Start-up + 8 mos	Start-up + 7.5 mos	Start-up + 2 mos
Eligible Patients	415	194	16
Average Age	76.0 years, SD: 11.4	77.6 years, SD: 11.0	75.2 years; SD: 12.6
%Women	62.2%	61.9%	56.3%
Total Discussions	448	236	17
Updated/New Advance Directives	294	94	9
Hospice options discussed	59	21	1
Hospice enrollments	17	10	0

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Lessons learned

- Dedicated administrative resources to foster partnership and ensure that the practice has buy in at sites to implement a prototype that meets our defined aims, objectives, and standards in care
- Effectiveness depends on the Clinical Liaison's time availability (i.e. resources), cultural competence, and high-level palliative care clinical competency
- Requires a strong partnership trusted by front-line staff and administration, integration of new workflows into existing processes, and continual collaboration to identify patients
- Focusing resources to sites and practices with higher prevalence of patients with SMCs, such as post-acute care settings and advanced specialty clinics, will only enhance program effectiveness

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What's next?

Scaling to aging patients with SMCs residing in post-acute settings

- Post-acute service line has implemented and standardized use of advanced directives and Medical Orders for Life-Sustaining Treatment (MOLST), though an existing unmet need in palliative care supports
- Focus on selected nursing homes and the main hospital(s) that refer to them (the nursing home-hospital "dyad")
- Embedded clinician identifies patients at both the hospital (awaiting transfer) and nursing home
- Eligible patients receive the intervention
- Documentation and distribution of advance directives go to both hospital EMR and nursing home EMR

* See Appendix for information on post-acute service line

OneCity Health–MJHS modular, scalable solution

- Clinical dyad embedded in NYC H+H care team:
  - Clinical liaison
  - Palliative care-trained physician
- Project management and governance
- Data/analytics and evaluation support
- Annual budget:
  - Existing model: $300k / site / year
  - To scale model to all sites and reach highest need for palliative care services (7,000 patients with SMCs at 11 hospitals and 5 post-acute locations) – $4.8M / year

To discuss the prototype and partnership opportunities:

Grace Wong, MBA, MPH

COO and Chief Network Officer, OneCity Health

- Phone: (646) 694-7142
- Email: wongg3@nychhc.org

Chris Philippou, MPH

Development Officer, OneCity Health

- Phone: (646) 694-7128
- Email: philippc1@nychhc.org

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Appendix

MJHS palliative care intervention criteria

Characteristic 1: Comorbidities			
Condition	ICD10 Code	QOF rating	Positive Score
Atrial Fibrillation	I48	1	
Cancer	C00-C96, excludes C44	3	
COPD	J41-J44	2	
Dementia	G30, G31, F00, F01-F03	3	
Diabetes	E10-E14	1	
Epilespy (treated)	G40, excludes G40.4, G41	2	Sum of ratings > 3
Heart Failure	I11.0, I13.0, I13.2, I50	2	
Psychosis, Schizophrenia, Bipolar	F20, F22-F25, F28-F31, F32.3, F33.3	2	
Stroke or TIA	G45, I61-I64	1	
Chronic kidney disease	N18.3, N18.4, N18.5	2	
Chronic liver disease	K70.3, K74, K74.5, K74.6	2	

Characteristic 2: ADL Performance or Decline		
ADLs Rated	Score	Positive Score
Bathing, Personal Hygiene, Dressing, Upper Body, Dressing, Lower Body, Walking, Locomotion, Transfer Toilet, Toilet Use, Bed Mobility, Eating	Rating 0-6 for each ADL	Score > 3 for any ADL, OR "decline" for second item
Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago	Improved, Declined, no change, uncertain	

Characteristic 3: Hospitalizations or ED visits		
Utilization	Score	Positive Score
Inpatient Acute Hospital with Overnight Stay	# of times in past 3 months	≥ 1 IP or ≥ ED visit
ER Visit		

Post-Acute Care (PAC) Service Line Overview

Comprised of five skilled nursing facilities, a long-term acute care hospital and three adult day healthcare programs. There are a total of 2,099 inpatient beds in the SNFs and LTACH and 29,982 visits per year in the ADHCs.

Accomplishments:

- Implemented and standardized use of advanced directives and Medical Orders for Life-Sustaining Treatment (MOLST)
- Earned four & five Star Ratings awarded by CMS and Carter LTACH is Joint Commission accredited.
- Gouverneur and Seaview have been recognized by US News & World Report as one of the Best Nursing Homes in NY 2018/2019

Provider Name	Overall Rating
HENRY J CARTER SKILLED NURSING FACILITY	5
COLER REHABILITATION AND NURSING CARE	5
NEW GOUVERNEUR HOSPITAL S N F	5
SEA VIEW HOSPITAL REHABILITATION CENTER	5
DR SUSAN SMITH MCKINNEY	4

MOLST Implementation in the PAC

In 2018, the Post-Acute Service Line standardized the Advanced Directive Policy and Procedure and implemented the MOLST

- Multi-disciplinary workgroup reviewed all facility-specific Advanced Directives P&Ps and all Advanced Directives data
- Developed and implemented a standard education curriculum including Palliative Care education for all staff
- Educated residents/patients/families on MOLST and Palliative Care
- Developed standard metrics to measure effectiveness of the MOLST strategies implemented
- Identified MOLST Champions at each PAC site to assist with project roll-out

Since standardization and implementation, the Post-Acute Service Line has increased MOLST from 59% in Q1 2018 to 88% in Q1 2019.