Palliative Care through a Population Management Lens

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Disclosure

Dr. Bernacki has no conflicts to disclose

Objectives

• Describe population health management (PHM) and the intersections with palliative care
• Discuss the rationale, design and target populations for 2 programs designed to deliver earlier palliative care to specific subpopulations of patients within a PHM system
• Describe opportunities and challenges in implementing palliative care interventions across the spectrum of patient illness in PHM work
• Start an action plan to work with PHM at your institution
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Let’s Move Some Blood

Population Health Management 101
What Is Population Health?

- Historically, the term “population health” has been more commonly used in Canada than in the United States.
- A simple definition is “the health outcomes of a group of individuals, including the distribution of the outcomes within the group.”
- The Triple Aim defines 3 inter-dependent aspects:
  - Improving the health of a population
  - Improving the patients experience of care
  - Reducing the per capita costs of care for populations

  *David Kindig, MD, PhD, and Greg Stoddard, PhD - Models for Population Health, AJPH 2003
  **Don Berwick, Health Affairs - The Triple Aim: Care, Health and Cost, May 2008, vol. 27

Population Health Includes:

1. Health outcomes for a defined group that is at risk (based on agreement of metrics and measures of health)
2. Patterns of specific health determinants for the group at risk
3. Specific health policies and key interventions that link the above outcomes with the health determinants*

*Policies, process and procedures are developed at the organization or medical group or ACO level

Key Considerations

- Determinants of health may be both medical and non-medical (important in attribution and risk assessment)
- Population health determinants create a framework to drive policy development, research focus and resource allocation
- Measurement of population health includes consideration of the relative cost-effectiveness of resource allocation to multiple determinants of health and outcomes.
The Intersection of PHM and PC

Why does this matter? Why now?

- MACRA (MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015)
- The Quality Payment Program has 2 tracks you can choose from:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
Why do MACRA & MIPS Matter?

- Roughly 700,000 eligible clinicians across all specialties, HPM included, will enter MIPS in 2017 and receive payment adjustments in 2019.
- Need to understand what and how you or your institution will be reporting and make MIPS work in your practice setting.
- https://www.cms.gov/Medicare/Quality

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The Serious Illness Care Program

Mission:

To improve the lives of all people with serious illness by increasing meaningful conversations about their values and priorities
Serious Illness Care Program Components

- **Tools**
  - Serious Illness Conversation Guide
  - clinician reference guide
  - Patient & family resources

- **Education**
  - Reminder System
  - Conversation using the Guide
  - Documentation in EMR

- **Systems Change**
  - Patient Screening
  - Bedside manner
  - Communication using the Guide
  - Patient & family resources
  - Measurement and improvement (QI)

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Two examples of programs

- **iCMP:** Integrated Care Management Program (outpatient)
- **SAGE:** Speaking about Goals and Expectations (inpatient)

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Serious Illness Communication in integrated Care Management Program (iCMP)
Serious Illness Communication in iCMP

• Patient population and palliative care intervention
  • Primary care patients at high-risk of healthcare utilization
  • Primary palliative care communication intervention

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iCMP

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Study Objective and Design

Objective: Determine impact of implementation of the Serious Illness Care Program in primary care.

Setting: 14 primary care clinics participating in a high-risk care management program based in an accountable care organization

Study design: Prospective implementation trial

Methods: Chart review of deceased patient documentation

Frequency: % with documented conversation

Accessibility: % available in Advance Care Planning Module in EMR

Timing: Median days prior to death

Comprehensiveness: % with values and goals included
High-Risk Primary Care (iCMP)

- Opportunities
  - Passionate frontline clinicians
  - Program staffed with interdisciplinary and interprofessional team
  - Engaged and effective leadership from primary care, from palliative care, from population health management

High-Risk Primary Care (iCMP)

- Challenges
  - Patient identification
  - Very busy clinician workdays
  - Heterogeneous practice workflows
  - Complex, multimorbid patients with difficult to determine prognoses
Speaking about Goals and Expectations (SAGE)

**Rationale**

- In 2013, 350+ deaths in accountable care organizations (ACO) patients
- Among the high-risk pts who died without enrollment in care management...
- Among ACO deaths, 567 acute hospitalizations in the last 6 months of life.
  
  60% identified for care management, but only half were enrolled
  83% died or entered LTC before enrollment could occur
  Indicates opportunity to identify and engage patients earlier in end of life care planning in hospital

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SAGE: Inpatient Program

- Patient population and palliative care intervention
  - Hospitalized patients who are not making it to their outpatient providers
  - Primary palliative care communication intervention with significant social work input and leadership focused on care transitions

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SAGE

**Design**

- Patient identification
- Serious illness conversation
- Documentation & follow-up

Identification by care team or referral from hospital
SW consults with care team
Conversation by physician and/or SW using serious illness conversation guide
ACP module or note documentation, send to post-acute providers
Connect with resources post-discharge
SAGE

• Opportunities
  • Early goals of care conversations do work in the hospital setting
  • Doing the work across settings is critical for ongoing success
  • Leverages overlap between psychosocial needs and palliative care work in complex patients

Serious Illness Communication in iCMP

• Case

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The Serious Illness Care Program is a Quality Improvement intervention. You have been trained in how to have conversations, but how do you move from knowledge to implementing a program at your facility?

So now what? If you were to go back to your facility, what would you do first?

- Turn to your neighbor and discuss for 3 minutes

If you were to go back to your facility, what would you do first?
Know-do gap is due to multifactorial barriers.

- Common
- Often due to challenges in implementing the needed change:
  - Systems
  - Resources
  - Leadership
  - Knowledge
  - Motivation
  - Culture

It usually takes 17 years to translate research into actual care*

- Often it takes even longer for it to spread

We can do better

*Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century

It takes more than knowledge and skills to achieve systemic change.
It takes a roadmap.

Success in a step by step approach

- **Implementation steps**
  - Three phases:
    - Phase 1: Assessing, planning, & preparing
    - Phase 2: Testing & improving (start small)
    - Phase 3: Expanding and sustaining
  - Ongoing measurement and feedback
    - Are you reaching your goals?
- **Quality improvement methods**
  - Test, adapt, and refine your implementation

Implementing Palliative Care into Population Management

- Need to understand how to implement the program to achieve your goals.
- Series of steps: each needs
  - Planning
  - Action
  - Measurement to know if you are getting there.
- Planning, action, measurement throughout
Key phases

You are here, but don’t be discouraged!

Goals and Action Planning

SMART Goals

• **Specific**
  • Clear and precise

• **Measurable**
  • Able to be assessed or described in terms of quantity, quality, cost, or time

• **Attainable**
  • Realistic and achievable

• **Relevant**
  • Consistent with the activities and goals of the project

• **Time-bound**
  • There is a time limit
SMART Goals

1. Try the Serious Illness Conversation Guide on a small scale by recruiting a trusted clinician friend so we can both use the guide with 5 patients by August 15th, 2016.

2. Form a workgroup by assembling a team of 4 enthusiastic and invested colleagues, including a palliative care colleague and QI specialist, by 8/1/2016.

3. Workgroup will engage two key institutional leaders (e.g. CMO, CNO) to get support for the project by 9/15/2016.

An Action Plan Is...

- Detailed work plan that guides the implementation of the Serious Illness Care Program at your organization via the Roadmap
- A series of action steps that are needed to create the desired change

### Serious Illness Care Program Action Planning Worksheet

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<th>Name(s)</th>
<th>Organization</th>
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SMART goals and how you will measure them:

1. **Example:** Have 5 guided conversations with patients in _______________ clinic / hospital by August 15th, 2016.
   
   **Measure:** 5 documented conversations in the EMR.

2. **Example:** Identify 5 patients using the surprise question by _______________.
   
   **Measure:** __________________________________________________________________________________

3. **Example:** Check for an upcoming visit to schedule the conversation by _______________.
   
   **Measure:** __________________________________________________________________________________

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Take-home messages

- Form a multidisciplinary workgroup / team
- Engage leaders and colleagues face-to-face
- Consider: are we ready?
- Get the support / resources you need

Summary

- Understand the connections between palliative care and population management
- Consider partnering with your population management program and think broadly in your approach
- Interventions are context specific and individualized
- Take a step by step approach and choose SMART goals
- Choose your partners and collaborators wisely
Name(s) ____________________________  Organization ________________________________________

Do you have a population management team:  Yes  No
If so, who is on the team (e.g. Chaplain, SW, RNs, MDs) __________________________________________

Do you have a palliative care service:  Yes  No
If so, who is on the team (e.g. Chaplain, SW, RNs, MDs) __________________________________________

In what clinics units within your institution could you pilot an intervention? (top three)
________________________________________  __________________________________________  ___________________________

List two alternative ways to identify and target patients for advance care planning conversations?
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Who in your institution has QI expertise? _____________________________________________________________
Describe any past or current QI or other interventions undertaken in your institution to improve serious illness care.
______________________________________________________________________________________________

Do you have funding to implement changes in serious illness communication (vs. care)?  Yes  No
What leaders in your institution have an interest in improving serious illness care and have the ability to get you resources?
What will motivate them?
Person __________________________________________  ________________  _______________________
Motivation __________________________________________  ________________  _______________________
Identify 3 allies (people or organizations) who will support you in making change in serious illness communication:
________________________________________  __________________________________________  __________________________

List 2 resources and 2 anticipated barriers relevant to implementation of the serious illness care program at your institution.

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<th>Resources</th>
<th>Barriers</th>
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Palliative Care through a Population Management- Action Plan

What is your mission?

___________________________________________________________________________________________________
___________________________________________________________________________________________________

3 SMART goals and how you will measure them: (SMART goals are Specific, Measurable, Actionable, Relevant and Timebound)

   
   Measure: 5 documented conversations in the EMR.

   1. __________________________________________________________________________________
      Measure: __________________________________________________________________________________

   2. _____________________________________________________________________________________
      Measure: __________________________________________________________________________________

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<td>1.</td>
<td>Gain permission from administrator or clinician in _________ clinic to have guided conversations with patients.</td>
<td>July 1st</td>
<td>You</td>
<td>Someone with whom I have a good relationship</td>
<td>My reticence to bother people</td>
<td>Email granting permission</td>
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<td>Identify 5 patients using the surprise question?</td>
<td>July 14th</td>
<td>You</td>
<td>List of patients and information or clinician to inform prognosis.</td>
<td>No systematic way to identify patients</td>
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<td>Schedule time/place to meet with patients</td>
<td>July 21st</td>
<td>You</td>
<td>Admin assistance to find space at allotted time.</td>
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<td></td>
<td>Identify place in EMR to document conversations</td>
<td>July 28th</td>
<td>You</td>
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<td>Have first guided conversation</td>
<td>August 1st</td>
<td>You</td>
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