Acclivity
HEALTH

WHITEPAPER

Connected Care Communities

HOW THEY ARE IMPROVING END-OF-LIFE CARE

Introduction

Imagine a healthcare environment where end-of-life care is as integral to mainstream medicine as primary care. Where Hospice and Palliative Medicine (HPM) is a natural extension of the continuum of care and not a side option. Where primary care providers (PCPs), medical specialists, hospitalists, hospices, social workers, counselors, caregivers, and patients communicate openly and candidly about prognosis and treatment options and work together to manage advanced illness as a team.

Advanced illness management can't end with highly stressful, expensive, and painful therapeutics that do little more than prolong the process of dying. PCPs and specialists—trained to heal—need a better way to coordinate their patients' care with HPM physicians and nurses trained to ease the process of dying. When everyone involved in end-of-life care works well together, we can minimize the medicalization of death, improve the end-of-life experience, and ensure that every member of the care team is adequately reimbursed for the time they spend providing care.

> **"WE CAN'T CONTINUE TO SPEND THE MONEY THAT WE'RE SPENDING ON END-OF-LIFE CARE AND NOT BE HAPPY WITH THE CARE THAT WE'VE RECEIVED."**
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> **Carla Braveman, President & CEO**
> Hospice and Palliative Care
> Association of New York

Baby Boomers, the largest living adult generation in the United States, are bringing new expectations for what they will accept from their healthcare providers—including full transparency. They utilize technology to research their diseases and options, monitor their health, and cope with chronic illnesses. As they age, they are challenging physicians to provide greater candor, empower them with knowledge about their choices, and improve their end-of-life experience.

This whitepaper addresses the issues that affect the quality and cost of end-of-life care in the U.S. and introduces the concept of the Connected Care Community. The Connected Care Community, made up of physician groups, ACOs, and hospice organizations, is a new mechanism that provides both hospice organizations and physician groups with the tools and data they need to introduce hospice care, with all its palliative care benefits, to patients sooner in their end-of-life journey. Through Connected Care Communities, hospice organizations assist physician practices in managing patients with advanced illnesses by obtaining referrals further upstream, allowing physician practices to manage patient costs more effectively, reduce their uncompensated work burden, and match their patients' goals for their final months, weeks, or days.

Dying at Home

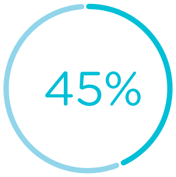
Prior to 1950, the majority of Americans died at home. Over the next decades, two things happened to move end-of-life care out of the home and into institutions: Advances in medicine enabled doctors to treat critical diseases like chronic diseases, prolonging life with medical interventions and reducing the number of sudden deaths; and hospitals recognized advanced illness management as an effective way to maximize profits.

Approximately 80% of Americans today say they do not want to spend their last days in a hospital.[1] They want to die peacefully in their own homes, surrounded by family and friends. Seven out of ten Americans die from a chronic illness.[2] But despite the fact that Medicare will pay for hospice as long as a patient meets eligibility criteria, and HPM is a recognized subspecialty by the American Board of Medical Specialties, almost 50% of patients die in a hospital, without the support of hospice.[3]

Hospice utilization is growing, with over 47% of Medicare decedents receiving some hospice care in 2017.[4] But while that growth is promising, referral to hospice still has a long way to go. A 4-year study of the Medicare 5% Limited Dataset (LDS) by the Society of Actuaries® showed "33% of FFS Medicare-eligible seniors with malignancies under active treatment were not enrolled in the Hospice program prior to their deaths." [5] Additionally, in 2016, 27.9% of patients referred to hospice had only 1 to 7 days of care prior to their deaths, and the median length of hospice utilization was only 24 days.[6]

WHERE MEDICARE DECEDENTS RECEIVED HOSPICE CARE IN 2016[6]

45%	**at home**
14.6%	in a hospice inpatient facility
32.8%	in a nursing facility
7.4%	in an acute care hospital



UNREALIZED POTENTIAL OF PALLIATIVE CARE

The benefits hospice and palliative care medicine provide are not being fully realized. These benefits include:

- Better quality end-of-life experience
- Longer potential life spans[7]
- Lower hospital readmission rates
- Significant cost savings
- Improved performance under value-based payment and contract models

Thirty years after the initial Academy of Hospice Physicians was founded, PCPs and specialists may not fully understand the value of hospice care or the right time to refer patients to hospice. Patients themselves are not aware of the services hospice can provide them.

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[1] Care of Chronic Illness in Last Two Years of Life - Dartmouth Atlas of Health Care. (2005). Retrieved from http://archive.dartmouthatlas.org/data/topic/topic.aspx?cat=1

[2] Center For Disease Control. (2009). The Power of Prevention: Chronic Disease ...The Public Health Challenge of the 21st Century[Pamphlet]. Author. Retrieved from https://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf

[3] National Center for Health Statistics. Worktable 309. Deaths by place of death. age, race, and sex: United States, 2005. Public-use data file and documentation. https://www.cdc.gov/nchs/data/dvs/Mortfinal2005_worktable_309.pdf

[4] Baxter, A., & Baxter, A. (2018, June 04). 2017 Hospice and Home Health Medicare Utilization Trends. Retrieved from https://homehealthcarenews.com/2018/06/2017-hospice-and-home-health-medicare-utilization-trends/

[5] Society of Actuaries; October 2018; Hospice Care Research: An Analysis of End-of-Life Costs for Terminally Ill Medicare Fee-for-Service (FFS) Cancer Patients; https://www.soa.org/Files/resources/research-report/2018/hospice-care-report.pdf

[6] Facts and Figures: Hospice Care in America(Rep.). (2017). National Hospice and Palliative Care Organization. Retrieved from https://www.nhpco.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf.v

[7] Connor, S. R., Pyenson, B., Fitch, K., Spence, C., & Iwasaki, K. (2007). Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window. Journal of Pain and Symptom Management,33(3), 238-246. doi:10.1016/j.jpainsymman.2006.10.010

The Costs of Underutilization

The American approach to advanced illness is too often fragmented and uncoordinated. Providers are spending more time treating patients in the last weeks or months of life than they can be reimbursed for. Despite spending nearly 18% of our gross domestic product (GDP) on healthcare—the highest expenditure in the world—we have a lower life expectancy than 20 other nations and our Quality of Death Index, measuring our ability to provide adequate palliative care services to every citizen, ranks 9th, below that of many other developed nations.[8]

By not taking full advantage of the services Hospice and Palliative Medicine can provide, not only are patients denied a substantial improvement in the quality of their lives, but our Medicare system is accruing costs for end-of-life care that could be used more effectively. In a recent study of cancer patients, those in hospice had medical costs that were 20%, on average, lower over the last six months of their lives than those not enrolled in hospice. The total cost savings per patient was nearly $12,000 (national average). In some regions, savings were as high as $25,000.[5]

Length of stay also has financial implications. In the above study, 37% of those patients enrolled in hospice were referred less than a week before death. Because per diem hospice costs are significantly lower than acute care costs, if patients had enrolled a few weeks earlier, the potential reductions in Medicare spending would have been 30%.

Studies indicate that by increasing public awareness of palliative care, normalizing conversations about death, and improving cooperation and coordination between physician groups and hospices, we can help patients with severe chronic illness receive the right care at the right time in the right place. When physicians help patients avoid hospitalization and enroll them in hospice, they not only improve quality of care, but also reduce their own work burden and increase their opportunities for value-based rewards.

A connected, collaborative, community-based care model delivers timely and appropriate care to patients, reduces healthcare costs, maximizes hospice benefits, and improves financial performance for all providers.

HOSPICE
Obtain patient referrals earlier in their advanced illness journey

PAYER
Ensure the most complex and costly care scenarios are in the hands of the right care team

PHYSICIAN
Refer costliest patients and better manage performance indicators

PATIENT
Experience complete transparency regarding health condition and treatment option

FAMILY
Access to an extended care team to be properly cared for and supported

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[8] Murray, S. (2015). The 2015 Quality of Death Index: Ranking Quality of Care Across the World[Pamphlet]. The Economist: Intelligence Unit.v. Retrieved from http://www.virtualhospice.ca/Assets/2015%20Quality%20of%20Death%20Index_20151013163458.pdf

Barriers to Hospice Utilization

If hospice provides the opportunity to help patients die well and is a benefit provided to Medicare recipients, why aren't more American patients dying in hospice?

One major challenge for both doctors and patients is that death is not a conversation we are comfortable having. Moving toward a system that includes palliative care as a natural extension of the care continuum requires a culture shift in the way we think and talk about dying. That takes time.

OTHER ISSUES LIMITING THE USE OF HOSPICE INCLUDE:

1. **Training:** With the exception of palliative care physicians, too few doctors in America are trained to help patients make end-of-life decisions. In fact, fewer than 10% of all medical schools offer education in the process of death. Many PCPs and chronic disease specialists still believe that by referring patients to hospice, they have failed and are abandoning them.

2. **Incentive:** Hospitals, physician groups, and specialists don't have enough time in their over-booked schedules to discuss their patients' goals and options. If they are still working under a fee-for-service model, they have no financial incentive to refer patients to palliative care. Since a death in the hospital affects quality measures, too often they will wait until a patient is actively dying to shift them to hospice so the death doesn't show up on their statistics.

3. **Integration:** PCPs lack real time access to patient data that could help them with care coordination. Their EHR systems often don't integrate with hospital or specialist practice systems and they aren't compensated for the extra time it takes to track down data and coordinate with other care providers.

4. **Prognostication:** Without relevant data, clinicians overestimate longevity by a multiple of 5, waiting too close to death to refer patients to hospice.[9]

5. **Knowledge:** Patients aren't given the information they need to make informed decisions about their care and are limited to the treatment options they're offered. Many do not have advanced directives to guide their care, and even when they do, they wait for their doctor's referral to hospice.

6. **Politics:** Politicians too often use healthcare benefits as a debate for their own political gain, adding to the chaos and confusion that has caused a state of disequilibrium in the industry.

7. **Referral Sources:** Hospice organizations are structured to enroll patients as soon as they are certified as terminally ill, but they rely heavily on hospitals for referrals. They have no way to determine independently when patients with advanced illnesses are eligible for hospice benefits.

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[9] Christakis, N. A., & Lamont, E. B. (2000). Extent and determinants of error in physicians' prognoses in terminally ill patients: prospective cohort study. The Western journal of medicine, 172(5), 310-3. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070876/

The Connected Care Community

Connection and care coordination are key to addressing the obstacles that limit the integration of palliative care and hospice into the healthcare system. In order to facilitate efforts toward better integration, Connected Care Communities offer an effective solution.

In a few areas in the United States, physician groups, physician-led ACOs, and hospice organizations within the same geographic areas have begun organizing themselves into Connected Care Communities to improve their ability to manage patient populations and provide appropriate and timely services in the right setting. These end-of-life Connected Care Communities have the power to:

- Offer a more holistic way to manage patients' pain and symptoms.
- Provide greater transparency of care options so patients and families can make informed decisions.
- Limit unnecessary treatments and reduce the cost of care through improved communication.
- Help physicians communicate better with patients regarding their cultural and personal beliefs related to death and dying.
- Honor patients' end-of-life wishes so they can experience their vision of a good death.

> **"THE TRUTH IS THAT A DOCTOR'S REFERRAL TO HOSPICE MAY LEAD TO A SUBSTANTIALLY BETTER QUALITY OF LIFE FOR WHAT IS OFTEN AN EVEN LONGER LIFE SPAN THAN THE PATIENT WOULD OTHERWISE EXPERIENCE WITH AGGRESSIVE CLINICAL TREATMENTS."**
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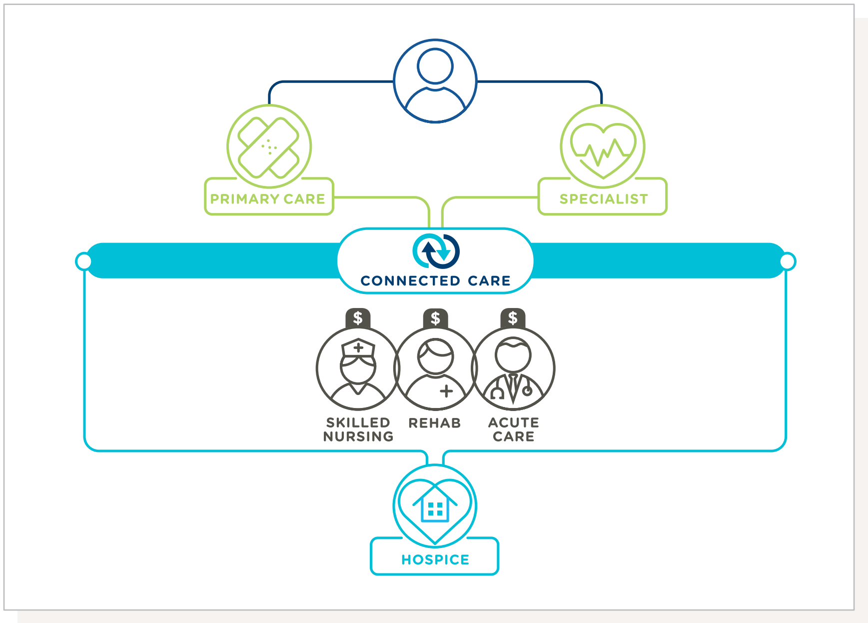
> **Duane Feger,**
> **Healthcare Economist**
> Acclivity Health Solutions



Hospice as Hub

Hospice organizations are considered the best entity to serve as a hub for their Connected Care Communities, based on their unique qualifications to provide a full depth and breadth of end-of-life services. Hospice adds significant value to the community because their professionals and volunteers are trained in the psychosocial aspects of the end-of-life journey and know when and how to start end-of-life care.

Value for Connected Care Community Partners

Currently, over half of most hospice organizations' referrals come from hospitals with little incentive to de-medicalize the dying process. PCPs may or may not have the time or opportunity to intervene if they question the patient's prognosis. However, when physician groups align with palliative care and hospice organizations in a formal community structure, these doctors can remain on the front line of their patients' care.

BENEFITS GO BEYOND IMPROVING QUALITY OF CARE. PARTICIPANTS WITHIN THE COMMUNITY CAN ADD VALUE TO THEIR OWN PRACTICES IN MULTIPLE WAYS:

1. **Collective Training:** Through the Community, all members can be trained in how to talk with patients about their prognosis and provide end-of-life care, so care is not only appropriate but consistent.

2. **Shared Decision Making:** PCPs, oncologists, cardiologists, nephrologists and other specialists within the community are not solely responsible for determining when to recommend a patient stop medical intervention. All physicians work with the same information and decisions can be made as a team, giving patients the assurance that it's the right time to focus on quality of life in lieu of curative treatment.

3. **Easy Access to Shared Data:** Using the same real-time data, accessible through a community portal, providers and hospice administrators can view all relevant patient information—from hospitalization to patterns in compliance to polypharmacy—in order to manage patient care. Hospice can recommend when patients should be transitioned based on the data, and PCPs can stay involved with their patients' treatment. The community can share the cost of integrating their EHR systems and avoid having to spend unreimbursed time tracking down patient records from providers and pharmacists.

4. **Timely Transition:** Physicians can identify patients needing advanced-illness care earlier in their care journey and transition costly patients to palliative, hospice, and advanced-illness care providers who are better equipped and reimbursed to deliver the appropriate care. By receiving referrals earlier, hospice organizations not only improve their daily census but can amortize substantial initial enrollment costs over a longer period to increase their profitability.

5. **Cost Management:** By coordinating services with hospice, providers can better manage the complex needs of patients with terminal illnesses in the most cost-effective way, saving those patients from over-medication, duplicate services, ER visits, hospital readmissions, and ineffective treatments. Additionally, they can help maximize the patients' use of their Medicare benefits for pain and symptom relief.

6. **Increased Patient Load:** When PCPs and specialists refer their highest-need patients to hospice earlier, they reduce the time treating complex medical issues and increase the number of patients they have time to treat.

7. **Bonus Dollars:** Physicians and ACOs whose compensation is tied to quality metrics can increase their bonus payments by keeping patient costs under control.

Requirements for Success

The first ingredient for a successful Connected Care Community is commitment to culture change that improves the end-of-life-experience for patients and their families. Financial incentives that reward improved value indices can also be a strong motivator.

As awareness of the advantages of Connected Care Communities grows, practices involved in advanced illness care may organically come together to collaborate. Practices with similar bonus structures are ideal partners for hospice organizations, since they can experience similar benefits from coordinated care.

Once a community has formed, it needs to invest in interoperable systems to facilitate communication and care coordination. These systems may include:

- A secure communications system for email and texting
- An integrated EHR system, so all members of the community share the same records
- An integrated care management system
- A population health analytics system that stratifies patients who are ready for palliative or end-of-life care
- Real-time data that reasonably predicts the probability of mortality within 6-month and 12-month increments

Once the Connected Care Community is operational, it will be far ahead of competing healthcare organizations and in a position to provide a real value for providers while empowering patients to live their lives to the fullest and meet death with a sense of comfort and dignity.

Insight-driven Advanced Illness Management for Connected Care Communities

In response to a growing interest in Connected Care Communities, Acclivity Health Solutions has developed a cloud-based platform to enable multidisciplinary collaboration regarding patients' prognosis, care options, and goals. The Acclivity platform combines analytics, including AI and machine learning, with care coordination and workflow management tools to empower truly informed, whole patient care.

Working with the platform's range of powerful and intuitive tools, healthcare providers and practice managers can access a holistic picture of the patient journey and identify which patients are at highest risk for utilization of non-beneficial treatment. Using real-time and claims data, they can develop and initiate an appropriate palliative care plan that moves patients away from costly, and often unnecessary, SNF, rehabilitation facilities, and acute care hospitals.

As a company with a resolute mission, Acclivity also serves as a consultant and catalyst to help form Connected Care Communities, providing the necessary resources to deliver high quality palliative care.

> **"THE ACCLIVITY PLATFORM HELPS HOSPICE ADMINISTRATORS COORDINATE WITH PROVIDERS BECAUSE IT TAKES ALL THE INFORMATION AND WRAPS IT UP IN MEDICAL PRACTICE SPEAK, MIRRORING THE OTHER TYPES OF DATA THAT DOCTORS CURRENTLY GET AND THE CONVERSATIONS THEY ARE ALREADY HAVING."**
>
> **Carla Braveman, President & CEO**
> Hospice and Palliative Care Association of New York

If you are interested in learning more about how you can develop or get involved in a Connected Care Community, please contact us at 904 580 4857 or email info@acclivityhealth.com.

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