

Optum California Outpatient Palliative Care Program Initiative

Submitted by: Optum California

Gold Winner

Category: Access to Palliative Care

Overview

In 2019, [Optum California](#) (Optum CA), a leading medical group in southern California, revamped its supportive care program, leveraging industry best practices to maximize access to high-quality palliative care for patients in their last year of life. Building on a foundational program launched in 2008, key new features of the enhanced program include a) adopting an outpatient focus (clinic and home visits), b) leveraging data science models to identify patients' 12-month mortality risk to engage patients earlier in their disease trajectory, c) forming a robust interdisciplinary team with a "Care Partner" role – a nonclinical, hired surrogate family member who helps the patient/family with care management, d) clearly defining and distributing discrete outcome metrics in monthly dashboards. Since January 2020, we've brought palliative care to 157% more patients in our 2 largest regions and achieved a 50-day LOS; today we are performing well against national benchmarks. Our budget was \$1 million with the main expense being clinician and non-clinician compensation/benefits.

Impact

The current healthcare system is dealing with an exponential increase in the cost of care along with fragmented care delivery, which has resulted in an unsustainable Medicare cost projection. In reality, 20% of the population uses 80% of healthcare dollars during the last couple years of their lives. Due to modern medicine and treatments, patients with chronic and serious illnesses are living longer and the average life expectancy for the general population is climbing. Also, medical literature has informed us that approximately 30-40% of ill patients die in the hospital or in nursing facilities. The Optum CA Palliative Care Program has demonstrated - through metrics and data analysis - that the program improves quality of life while maximizing efficiency and decreasing costs. Additionally, our program addresses population needs through an interdisciplinary team approach, focuses on patient-centered outcomes, quality of life, psychosocial wellbeing, and symptom management. By focusing on the highest costs and most fragile patient population, our program has become an essential and relevant strategy for addressing the current problems we face. The impact of our program on care quality is clearly demonstrated by early identification of and engagement with vulnerable patients. The 2019 program redesign has enabled Optum CA to effectively identify patients with a oneyear life expectancy and engage them with palliative care – our engagement rates have improved by 78% since 2018. This has resulted in a reduction in unnecessary hospitalizations, readmissions, ER visits, and inpatient deaths, along with an increase in both goals of care discussions and hospice conversions. By appropriately engaging these patients sooner and aligning on goals of care with patients and their families, we have discharged the appropriate patients to hospice - which both maximizes the benefit to patients and helps bend the cost curve – as evidenced by our 50-day hospice LOS. We have also been able to capture HCC codes more accurately which translates

to added revenue for our organization. This initiative has proven to have a significant impact on a large population of patients. We will continue to see an increase in the number of patients living with serious illnesses – including metastatic cancers, heart disease, heart failure, and advanced dementia – as these numbers are projected to increase over the next couple of decades; as such, there is a growing case for palliative care's role as an essential part of the healthcare delivery system.

Evidence-Base

At the outset, we identified that our success as a Palliative Care program would be indicative of our patients having the right experience at end of life, as they desire. We aligned on 2 key metrics to assess program success: Location of Death – Patient surveys and palliative care medical literature show that the majority of patients want to have a comfortable painless death, ideally in their homes and surrounded by their loved ones. We made delivering on this desire a guiding star of our program and focused on reducing inpatient deaths. Our current analysis of referrals and claims data shows that only 8% of patients who have enrolled in our clinic are dying in an inpatient setting. This is lower than our organization's performance as a whole and from our understanding of national statistics where 30-40% of patients die in inpatient settings. Hospice LOS – According to 2017 NAHPCQ data, 48% of patients discharged to hospice spend more than 30 days in hospice, even though this benefit is available to patients in the last 180 days of life. To maximize the number of patients that utilize this benefit, we focused on engaging patients and their families in discussions around goals of life and training our teammates around the benefits of hospice for patients. This allowed us to increase our mean hospice LOS to 50 days. We continually monitor this metric and reassess every death of a patient by asking ourselves: Was there any evidence (primary or secondary) when planning, which suggested that the project's solution, or critical components of it, would yield results? These metrics require contact with patients after they leave the clinic. The data is made available by monthly follow-up with patients and their families. These follow-ups allow us to check up on the patient, identify any concerns the patient has with the hospice agency and intervene accordingly. As other geographies think of using our model, this engagement-till-patient-death independent of discharge status from the clinic is key. Not only will you get good data, but it's the right things to do for the patients.

Feasibility

Funding the pilot: Development of this pilot started with benchmarking external organizations and synthesizing medical literature to gain a broader knowledge of what has worked or has not worked in this field of specialty. We took this, coupled with our own previous palliative care program learnings, into account and developed a redesigned palliative care program which detailed the staffing needed to be successful. As a centralized program which managed other High Risk programs, we were able to find efficiencies in other programs and use the savings of \$1.0M to develop a budget-neutral pilot. The ROI for this pilot also showed that we would be able to pay for the cost of the program if we were able to deliver desired results. Staffing: The full interdisciplinary team includes 1 physician, 1 nurse practitioner, 25 pharmacist, 1 nurse supervisor, 3 care partners, and 3 medical assistants. This team has capacity to see 300 patients at a time. Recruiting the right team members is imperative to the success of the program. We have found that recruiting Palliative Care certified clinicians with leadership qualities takes on average about 6 to 9 months. Depending on the target patient demographic, you may need to also target clinicians who can speak another language, which will likely extend your search to 12 months. The care partner is a specialized role whose

goal is to act as a highly effective “son or daughter” for our patients, driving patient engagement and enrollment. The skillset needed for this role is someone who has a high degree of emotional intelligence, and the ability to build rapport and trust early on with our vulnerable patients. This role also contributes to the interdisciplinary team meetings by communicating key socioeconomic factors about the patient that may not be gleaned during clinical visits. The Social Worker requires an LCSW in order to provide cognitive behavioral therapy, but we have found success with using MSWs who are close to completing their supervision hours and are about to sit for the licensing test. Implementation: Once you have a full team in place, the next step is to ensure they are trained properly. We have developed onboarding plans for each role, which includes meet-and-greets with key roles throughout the organization like lead hospitalists, care management teams, subspecialists and primary care physicians. It is also important to designate time to review the workflows in detail, as well as set up mock patient encounters to ensure the team understands what the flow should be. In the first few weeks of seeing patients, the lead clinician should shadow the provider and team to be able to provide feedback and coaching where necessary.

Scalability

Optum CA has a large footprint in health care in Southern California and has a layered leadership structure. This program is owned, operated, and budgeted by a central team that includes medical directors and operations directors who report to corporate executive sponsors. Engaging Regional Leaders: With Optum CA's leadership structure in mind, we recognized that the success of this program is partially dependent on regional buy-in and engagement. The program is implemented in local regions, each with their own leadership. Appointment of a Community Medical director and an operations counterpart is important as they will help to get the PCPs and sites engaged in referring patients and providing warm handoffs to the Palliative Care program. This is important so that your program is able to shorten the ramp-up period and ensure the team is fully utilized and able to increase their impact. Demonstrating Proof of Concept: Clear outcomes and measures of success were established prior to program start. We initially rolled out 2 programs in 2 different regions separated by a 3-month lag to allow for learnings and quick pivots. Those programs ran for 6 months allowing for data to be collected and analyzed. Initial outcomes were positive and shared with the corporate executives who gave the green light to further expansion.

At the end of 2020, the program began expansion into 3 additional regions. Developing the Tools to Enable Consistency: Successful scalability depends on several factors. Staying true to the vision of the program is critical as leadership in each region often have their own perspective on how the program should be utilized. Replicating culture and process in different regions with distinct team dynamics is also a tremendous hurdle to overcome. Activities that mitigate these challenges include regular communication with regional leadership, town halls with front-line clinicians to educate about enrollment criteria and program aims, monthly supportive care all hands meetings to align on workflows, regional nurse managers who own fidelity of the program in close supervision with the operations director, and a detailed handbook with role responsibilities and workflows. Proving COVID Resiliency: The COVID-19 pandemic accelerated adoption of telehealth which allowed for shared staffing models across broad geographies. We were able to start covering additional regions with existing clinician and care partner resources by offering phone and video visits. We could then add staffing when the program capacity was reached, keeping the program efficient and lean. Patients found these modalities more acceptable, given that they had become accustomed to using them in 2020. We were able to meet patients where there were...at home via telehealth! Many of these patients were high-risk for COVID-19 complications and providing these services remotely was

welcomed. The goals of care discussion, although not perfect, were able to be adapted to phone and video conversations.

Sustainability

In an effort to sustain our palliative care program, we need to have a steady flow of targeted patients into the program. To do this, we need to ensure continuous enhancement of data analytics to generate specific and sensitive lists of patients for the team to pursue. Additionally, maintaining engagement with PCPs and specialists is important to keep both the palliative care program and the appropriate patients top of mind. We can accomplish this by regular attendance at Group and IPA regional meetings to provide visibility to patient outcomes and success stories, as well as maintaining visibility to progress notes which outline the patients' care plan. The interdisciplinary team is set up to work in partnerships – the MD works closely with the NP, while the Social Worker is closely aligned with the Care Partner, following patients who do not have a behavioral health need. The Nurse Supervisor plays a key role in making sure that all workflows are being followed and that the team is documenting accurate data about enrollment and discharges. In addition to tactical management, the supervisor is also the pulse of the team, ensuring there are opportunities for team building and avoiding any breakdowns in communication, which can lead to teammate and patient dissatisfaction. As a part of the overall value-based organizational structure, our palliative care program has also integrated other organizational priorities within the daily workflow, like HCC capture, readmission reduction, and utilization reduction at end of life. Palliative care has synergistic correlation to affordability initiatives; setting goals to show how palliative care results contribute to overall affordable care goals is key to maintaining relevance to tight management of the bottom line.

Project Team

Linda Aoyama, MD
Supportive Care Medical Director for
North Optum CA
Optum California
Contact: laoyama@optum.optumcare.com

About the Challenge

The John A. Hartford Foundation Tipping Point Challenge is a national competition to catalyze the spread of skills, ideas, and solutions that will improve health care delivery for all people living with a serious illness. It is sponsored by the [Center to Advance Palliative Care](#) and [The John A. Hartford Foundation](#).

For more information, visit tippingpointchallenge.capc.org.