Optum Health

Integrating Primary Palliative Care in the Outpatient Setting

Background

- There are 90 million Americans living with serious illness and this number is expected to double within the next 25 years
- Approximately 68% of Medicare costs are related to people with ≥ 4 chronic conditions

Objective

- Incorporate palliative care into an outpatient setting to improve the quality of life for patient and the family

PRIMARY PALLATIVE CARE SOLUTIONS

Interventions

Flag Patients	Identified high-risk patients by flagging in the EMR using validated risk-score models (available in literature) that still allow room for clinical judgment
Educate Providers	Trained representatives from oncology, pulmonary, neurology, rheumatology, gastroenterology, podiatry, ophthalmology, internal medicine/family practice and surgery on having difficult conversations with tools like the Serious Illness Conversation Guide during incentivized 2-hour virtual sessions
Optimize EMR	Created a designated space in the EMR to easily document Serious Illness Conversations in the patient's medical record
Care Collaboration	Bridged the gap between primary care and community resources through virtual pallative care program and enhanced communication
Streamline Services	Made the transition to community services seamless by streamlining processes and services

Results

- 3021 Serious Illness Conversations with 2302 unique patients
- Serious Illness Conversation Occurred 314 days before death on average
- 74% conversations by PCPs
- Early data indicates that outcomes differ for decedents with a Serious Illness Conversation
- SIC decedents experienced less cost in the final 30 days of life ($18,843 vs. $19,952)
- Clinicians feel more confident in engaging patients in discussions around serious illness
- Since November 2019, 268 people trained via 32 sessions
  - 219 total providers
  - 176 MDs, 43 APPs, 14 Medical Students
  - 106 providers in IM/FP

Looking Ahead

Vision: To have a concierge program supporting palliative care and hospice referrals across the care continuum to provide guidance and support to physicians, patients, and their caregivers as they navigate services available for individuals with a life-limiting illness in a supportive care environment.

- ✓ Centralized process for referrals to community resources
  - Facilitates care management by dedicated Continuum RN, to support patient and provider through referral process
- ✓ Paperwork managed centrally
- ✓ Care management program designed with telephonic support and liaison role for external Palliative and Hospice providers
- ✓ Rejections to community services can be tracked

APPs, advance practice providers; EMR, electronic medical record; FP, family practice; IM, internal medicine; MD, medical doctor.