Healthcare and Community Collaboration: A Health Plan Model to Improve End-of-life Care

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VP & Medical Director, Geriatrics

October 24, 2006
“...along with burning flags and resisting the draft there is another un-American activity...dying...”

“...our Constitution upholds the rights of life, liberty and the pursuit of happiness...death is not there...”

Elizabeth Cohen
Author, news writer and columnist
EPEC, Binghamton, March 7, 2003
Objectives

- Recognize impact of ineffective advance care planning, pain management and late hospice referrals
- Illustrate opportunities for healthcare and community collaboration
- Define performance goals and track basic metrics
- Explain new benefit models
- Demonstrate results to date
End-of-life Care Costs

- **Total health care costs**
  - $1.4 trillion
  - 14% of the gross domestic budget (GDP) \(^i\)

- **End-of-life care costs**
  - 10-12% of total health care budget
  - 27% of Medicare budget \(^ii\)


\(^ii\) Emanuel, E.J. *Journal American Medical Association*, 275(24), 1996
Regional Variations in Medicare Spending

- Large regional variations in the percentage of deaths occurring in hospitals

- High-spending regions
  - more inpatient-based and specialist-oriented care
  - however, no improvement in
    - health outcomes, including mortality rates
    - quality of care
    - access to care
    - patient/family satisfaction

*Dartmouth Atlas*
End-of-life Care Cost Savings

- Dollars are wasted on unwanted, unnecessary and futile treatments
- Reducing amount spent on ineffective treatments will help reduce the total cost of end-of-life care
- Cost savings estimate: 3.3% of total costs
- 3.3% x $1.4 trillion = $59 billion

iii Terry Sanford Institute of Public Policy, Duke University. www.pubpol.duke.edu/courses/pps255s/2004/w-team-a/benefits.htm, 2004
Hospice Palliative Care (PC): symptom control, supportive care

Continuum of Care Model

Medical Management of Chronic Diseases
Integrated with Palliative Care

Bereavement

Progression of Serious Illness

Goals of Care shift

Diagnosis

Palliative Care (PC):
symptom control, supportive care

Hospice

Bereavement
Community-wide End-of-life/ Palliative Care Initiative

- **Advance Care Planning**
  - Community Conversations on Compassionate Care
- **Honoring Preferences**
  - Medical Orders for Life-Sustaining Treatment (MOLST)
- **Pain Management and Palliative Care**
  - Community Principles of Pain Management
  - CompassionNet
- **Education and Communication**
  - Education for Physicians on End-of-life Care (EPEC)
  - Community web site: [www.compassionandsupport.org](http://www.compassionandsupport.org)
Advance Care Planning

Traditional Advance Directives
**Advance Care Planning**

**Compassion, Support and Education along the Continuum**

- **Advancing chronic illness**
- **Chronic disease or functional decline**
- **Healthy and independent**
- **Maintain & maximize health and independence**
- **Multiple co-morbidities, with increasing frailty**
- **Death with dignity**

*Excellus*
Advance Directives

- **1991 - Patient Self-Determination Act**
  - 20% had a form of Advance Care Directive
  - 75% approved of a Living Will

- **2002 - Means to a Better End**
  - 15 -20% Americans have ACD
    - no significant change in a decade
  - 20% of LTC patients have ACD

- **2005 - Pew Research Center for the People and the Press**
  - 29% - Americans have ACD

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<sup>i</sup> Means to a Better End: A Report on Dying in America Today, November 2002
Question 3. What percent of patients with cancer, heart failure, COPD/emphysema or dementia have an Advance Directive or DNR order in place?
Community Data

- 40% seniors report physicians have not addressed Advance Care Planning

- 75% of deaths in Monroe County were 65+

EBCBSRR Senior Survey, 2001
Advance Care Planning Community Goals

- Document the designated agent (surrogate decision maker) in a Health Care Proxy for every patient in primary, acute and long-term care and in palliative and hospice care.

- Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as condition changes.

National Quality Forum, Framework and Preferred Practices
Quality Palliative Care & Hospice Care, 2006, Adapted for New York State
Advance Care Planning Community Goals

- Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital, i.e., the Medical Orders for Life-Sustaining Treatments—MOLST, a POLST Paradigm Program.

National Quality Forum, Framework and Preferred Practices for Quality Palliative Care & Hospice Care, 2006, Adapted for New York State
Advance Care Planning Community Goals

- Make advance directives and surrogacy designations available across care settings

- Develop and promote healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals

National Quality Forum, Framework and Preferred Practices for Quality Palliative Care & Hospice Care, 2006, Adapted for New York State
Community Resources
Advance Care Planning

- Advance Care Planning Booklet (English, Spanish)
- Advance Care Planning Poster and Tent card
- Behavioral Readiness “tools”
- Community Conversations on Compassionate Care (CCCC)
- Advance Care Planning Facilitator Training
- Life Choices Program

For these resources and more, visit
www.excellusbcbs.com
www.compassionandsupport.org
Total Number of ACP Booklets Ordered & Downloaded per Month
2005 - June 2006

# of Orders and Downloads

<table>
<thead>
<tr>
<th>Month</th>
<th>2005</th>
<th>2006</th>
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<tr>
<td>Jan.</td>
<td>4352</td>
<td>2942</td>
</tr>
<tr>
<td>Feb.</td>
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<td>617</td>
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<tr>
<td>Mar.</td>
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<td>2820</td>
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<td>Apr.</td>
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<td>3911</td>
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<td>Sept.</td>
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<td>Nov.</td>
<td>5021</td>
<td>4394</td>
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<tr>
<td>Dec.</td>
<td>8253</td>
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The graph shows the number of ACP booklets ordered and downloaded per month from January 2005 to June 2006.
Total ACP Booklet Web Downloads per Month

2005 - June 2006

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

2005 2006

Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec

241  314  4,652  4,819  2,668  685  725  1,682  1,981  1,550  1,432

876  584  467  312  690

20,000 18,000 16,000 14,000 12,000 10,000 8,000 6,000 4,000 2,000 0

Total Number of Downloads per Month

2005 2006
Functional Health Literacy

Cartoon: A person is reclining with feet on a table. The person says, "Just so you know..." Another person replies, "I never want to live in a vegetative state, dependent on some machine." The first person says, "If that ever happens, just unplug me, OK?" The second person says, "OK." Then, another scene shows the first person saying, "Hey!"
Community Conversations on Compassionate Care

- 1-2 hour facilitated workshop on advance care planning

- Goals
  - Increase comfort level in discussing death and dying
  - Increase conversations that lead to completion of an Advance Care Directive

A Community-wide End-of-life/ Palliative Care Initiative project
CCCC Facilitator Training Agenda

- **8-hour training**
  - Advance Care Planning Along the Health-Illness Continuum
  - The Patient Voice in End-of-life Transitions
  - Life-Sustaining Treatments
  - Medical Orders for Life-Sustaining Treatments (MOLST)... a POLST paradigm
  - CCCC workshop logistics
  - Facilitation training
Trainees receive

- comprehensive binder of information
- workshop “tools”
- facilitator resources
- CD-ROM, featuring the binder information in PDF format and CCCC PowerPoint presentation with facilitator speaking notes
CCCC Facilitator Training

- **Excellus BlueCross BlueShield support**
  - partnership with trainees to offer the CCCC workshop in the community and to facilitate 1 on 1 discussions
  - supplies workshop folders and booklets
  - collects post-workshop data
  - analyzes pre-and post-workshop data for partners
CCCC Results

- # 241 CCCC workshops
- # 5521 participants
- # 422 trained facilitators
Stages of Readiness to Complete

- See no need
- Recognize need, but have barriers
- Ready to complete
- Advance Care Directive reflects wishes
- Advance Care Directive needs update

Drs. Bomba and Doniger, 2002
Improvement in people with advance directives from 44% to 53% is statistically significant ($p < .01$).
<table>
<thead>
<tr>
<th></th>
<th>Have Advance Directives</th>
<th>Do Not Have Advance Directives</th>
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<tbody>
<tr>
<td>Internal Employees</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>UPitt* and STEP EMS** Attendees</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>EPEC Attendees</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>Facilitator Training Workshop Attendees</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>All Attendees Including Community Members</td>
<td>48%</td>
<td>56%</td>
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</tbody>
</table>

Data was collected immediately prior to the workshop using the Health Care Proxy Readiness form.

* Geriatrics Conference for Health Care Professionals, University of Pittsburgh  
** Emergency Medical Services conference, Rochester, NY
Counsel all individuals regarding completion of advance care directives

**Advance Directives:** Advance Care Planning is a process that requires conversation and results in the completion of an Advance Directive. An Advance Directive allows patient preferences and goals to drive care and to guide shared medical decision making in the event the patient is unable to communicate. Studies have demonstrated that physician counseling markedly increases the completion rate of Advance Directives.
Quality Management
Quality Indicators

- **All regions: baseline data collection 2004**
  - medical record recredentialing process
  - HEDIS sampling at Lifetime Medical Group
  - % of Advance Care Directives completed

- **WNY: Patient Management Reminder (PMR)**
  - ACP moved into Preventive Health
  - add stages of readiness to PMR
Is a completed Advance Care Directive in the patient’s medical record?

<table>
<thead>
<tr>
<th></th>
<th>Numerator*</th>
<th>Denominator**</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEDIS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buffalo Health Centers</td>
<td>62</td>
<td>1074</td>
<td>5.77%</td>
</tr>
<tr>
<td>Rochester Health Centers</td>
<td>80</td>
<td>1042</td>
<td>7.68%</td>
</tr>
<tr>
<td>Total</td>
<td>142</td>
<td>2116</td>
<td>6.71%</td>
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<tr>
<td><strong>Recredentialing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western New York</td>
<td>7</td>
<td>67</td>
<td>10.45%</td>
</tr>
<tr>
<td>Central New York, Southern Tier and Utica</td>
<td>12</td>
<td>421</td>
<td>2.85%</td>
</tr>
<tr>
<td>Rochester</td>
<td>29</td>
<td>257</td>
<td>11.28%</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>745</td>
<td>6.44%</td>
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</tbody>
</table>

* # of reviewed charts with a completed advance directive  
** # of charts reviewed
Advance Care Planning

Start

Assess Behavioral Readiness to Complete Directive

Provide Information on Advance Directives and Explore DNR Needs

Elicit Patient's Values and Preferences for End-of-Life Care

Encourage Designation of Health Care Proxy

Consider Introducing the Palliative Care Team

Discuss Palliative Care Options including Hospice

Encourage Patient to discuss wishes with family

Inquire about Desire for Organ Donation and/or Autopsy
Health Care Decision Employee Survey
2002 Results

- **6 question survey**
  - Knowledge
  - Self-reported completion rates
  - Demographics

- **Response**
  - 35% response rate (2272 of 6537 surveys)
  - 66% in 35-54 age range

- **Results**
  - 30% completed Health Care Proxy
  - 18% completed Living Will
  - 77% report understanding ACD
  - No difference based on medical background
Health Care Decision Employee Survey 2006

- **23 question survey**
  - Knowledge
  - Motivation and behavioral readiness
  - Self-reported completion rates
  - Demographics

- **Response**
  - 52% response rate (2133 of 4111 surveys)
  - 65% in 35-54 age range

- **Results**
  - 33.5% completed Health Care Proxy
  - 33.4% are ready to complete a HCP
  - 30% have identified barriers to completion
  - 17% completed Living Will
Results Comparison Between 2002 and 2006 surveys

Have you designated a HCP and completed a HCP form?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>2002</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>2006</td>
<td>33.5%</td>
<td>66.5%</td>
</tr>
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</table>
Advance Care Planning
Medical Orders for Life-Sustaining Treatment (MOLST)
POLST Paradigm Program

Paradigm of communication, documentation, and system responsiveness

POLST Paradigm, July 2006.www.polst.org
A decade of research in Oregon has proven that the POLST Program more accurately conveys end-of-life preferences and yields higher adherence by medical professionals.

Lee, Brummel-Smith, et al. JAGS. 2000; 48(10): 1219-1225
Schmidt, Hickman, Tolle, Brooks. JAGS. 2004; 52(9): 1430-1434
The POLST Program has been a key vehicle in Oregon’s successful efforts to increase the effectiveness of advance care planning and decrease unwanted hospitalizations at the end of life.

MOLST

- Created November 2003
- Adapted from Oregon’s POLST
- Combines DNR, DNI, and other Life-Sustaining Treatments
- Revised October 2005
- Incorporates NYS law
- Collaboration with NYSDOH
- Approved Inpatient DNR form
- Legislation passed
- Community Pilot
Goals of the MOLST Program

- Document an individual’s treatment preferences:
  - DNR
  - Intubation and mechanical ventilation
  - Other life-sustaining treatment
  - Future hospitalization and transfer
- Coordinate physician orders with patient preferences
- Communicate wishes across health care settings
- Improve EMS personnel’s ability to treat according to patient wishes
- Reduce repetitive documentation
MOLST
12/03 – 10/05
State of New York
Department of Health
Nonhospital Order Not to Resuscitate
(DNR Order)

Person's Name:___________________________________
Date of Birth: _____/_____/_____

Do not resuscitate the person named above.

Physician's Signature ___________________
Print Name ________________________
License Number ___________________
Date _____/_____/____

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart.

The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90 day period.

DOH-3474 (2/92)

Regional Pilot in Monroe and Onondaga Counties,
Approved NYSDOH, October 2005

Governor signed MOLST bill, October 11, 2005
Governor signed Chapter Amendment July 26, 2006
Monroe & Onondaga Counties Community Implementation Team

- Facilitate the implementation of the pilot
- Ensure adequate training
- Audit appropriate utilization
- Develop and track quality measures
- Establish standardized metrics
- Assist facility implementation throughout state
- Ensure the MOLST program moves beyond the pilot phase

To receive periodic email updates on status of MOLST pilot
Contact patricia.bomba@lifethc.com
Total MOLST Survey Response & Implementation Rates

Response Rate

- Hospital
- NH
- PACE
- Hospice
- ALP/AH
- ALP/EHP
- EHP
- AH

Implementation Rate
Community Resources
Medical Orders for Life-Sustaining Treatment (MOLST)

- MOLST 8-Step Protocol
- MOLST Guidebook
- MOLST Patient & Family Brochure (English, Spanish)
- Sample Facility Policies & Procedures
- Sample Facility Implementation Workplans
- Sample Facility Education Workplans
- MOLST Training Manual
- MOLST Train-the-Trainer Sessions
- MOLST Conferences

For these resources and more, visit
www.excellusbcbs.com
www.compassionandsupport.org
MOLST Order Form Comparison Between Original and Revised Form

# of Forms Ordered

Original Form 12/03 - 10/05

- 23710

Revised Form 11/05 - present

- 40381
Pain Management and Palliative Care
Community Principles of Pain Management
Prevalence

- **Pain is common**
  - leading reason people seek care
  - represents 80% of all physician visits
  - 25 million: acute pain due to injury or surgery
  - 50 million: chronic pain due to chronic or terminal illness
  - leading cause of disability

- **Pain is undertreated**
  - elderly, children, minorities, substance abusers
Economic Cost of Pain

- **Annual expenditures related to chronic pain**
  - NIH estimates $100 billion
  - medical expenses, lost income, lost productivity

- **Pain accounts for approximately**
  - 25% of all sick days
  - 21% of emergency room visits

- **Undertreated pain increases utilization and costs**
  - extended length of stay
  - increased ER visits
  - increased office calls
  - increased lengthy, unplanned office visits
  - repeat hospital admissions
  - lost income & insurance coverage
Impact on Quality of Life

- **Poorly managed acute pain**
  - medical complications (e.g. pneumonia, DVT)
  - prolonged recovery and LOS
  - progress to chronic pain

- **Undertreated chronic pain**
  - altered immune function
  - sleep disturbance
  - impaired functional ability (ADL’s, IADL’s)
  - impaired psychological function
  - compromised cognitive function
  - decreased socialization
  - impaired quality of life
Health Plan Interventions

- Clinical Guidelines
- Community Resources
- Educational Interventions
- Pharmacy Interventions
- Outcomes research study
  - decrease utilization
    - meperidine (Demerol®)
    - propoxyphene (Darvon®)
  - appropriate utilization
    - opioids
    - acetaminophen
- Disease and Case Management
Community Resources
Community Principles of Pain Management

- Provider Pain Clinical Guidelines Booklet
- Provider Pain “toolkit”
  - Laminated guide: Adult, Pediatric, Nurse
- Equianalgesic Opioid Pocket Card
- Patient Pain Guide (English, Spanish)
- Regional Pain Day: Enhancing Pain Management to Achieve Functionality
- LTC Pain Train-the-Trainers Symposium
- Education for Physicians on End-of-life Care (EPEC)

For these resources and more, visit
www.excellusbcbs.com
www.compassionandsupport.org
Outcomes Research Study

- Comparative retrospective analysis
- Population pre- and post implementation
- Primary objective
  - acetaminophen combination products
  - propoxyphene
  - meperidine
- Secondary objective
  - create an understanding of pain patients
Key Pharmacy Messages

- Clinical Rationale
  - APAP 4+ grams - liver toxicity
    - risk of combination and OTC products
    - use with alcohol
  - meperidine - unsafe and ineffective
  - propoxyphene - unsafe and ineffective
  - both meperidine and propoxyphene are on DeBeer’s Criteria of drugs to be avoided in elderly
Baseline Demographics

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<th>Dx Code</th>
<th>Description</th>
<th>% of Members</th>
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<tr>
<td>719</td>
<td>Other and Unspecified Disorders of Joint</td>
<td>22.4%</td>
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<tr>
<td>789</td>
<td>Other Symptoms Involving Abdomen and Pelvis</td>
<td>16.3%</td>
</tr>
<tr>
<td>724</td>
<td>Other and Unspecified Disorders of Back</td>
<td>15.6%</td>
</tr>
<tr>
<td>729</td>
<td>Other Disorders of Soft Tissue</td>
<td>12.0%</td>
</tr>
<tr>
<td>726</td>
<td>Peripheral Enthesopathies and Allied Syndromes</td>
<td>8.9%</td>
</tr>
<tr>
<td>715</td>
<td>Osteoarthrosis and Allied Disorders</td>
<td>7.7%</td>
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<tr>
<td>739</td>
<td>Nonallopathic Lesions, Not Elsewhere Classified</td>
<td>6.6%</td>
</tr>
<tr>
<td>784</td>
<td>Symptoms Involving Head and Neck</td>
<td>6.3%</td>
</tr>
<tr>
<td>723</td>
<td>Other Disorders of Cervical Region</td>
<td>6.0%</td>
</tr>
<tr>
<td>847</td>
<td>Sprains and Strains of Other and Unspecified Parts of Back</td>
<td>5.3%</td>
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</table>

(Members may have more than one diagnosis code, total may exceed 100% due to members being counted in more than one diagnosis.)
Propoxyphene Utilization:
RX/ 1,000 Members > 65

Prescriptions Per 1,000 Members


- Special Advisory Group Convened
- Pain Management Booklets Mailed
- Messaging to Pharmacies
- Pharmacy TIP Sheet Mailed

Compassion and Support at the End of Life

Excellus
Meperidine Utilization:
Rx/ 1,000 Members > 65

Prescriptions Per 1,000 Members

- Pain Management Booklets Mailed
- Pharmacy TIP Sheets Mailed
- Messaging to Pharmacies
- Special Advisory Group Convened

2001 FOURTH
2002 FIRST
2002 SECOND
2002 THIRD
2002 FOURTH
2003 FIRST
2003 SECOND
2003 THIRD
2003 FOURTH
2004 FIRST
2004 SECOND

Compassion and Support at the End of Life

Excellus
On-line Adjudication

- Follow four groups of patients in outcomes research study
- Track inappropriate dosing of OxyContin
- “Soft” messaging to pharmacist from health plan
  - “Drug not recommended in age >65”
- “Hard” messaging to pharmacist from health plan
  - claim not paid unless override code is given
- Quantity limits and therapeutic duplication edits
  - monitor appropriate usage of APAP and OxyContin
- Opioid mailings to providers twice annually
Innovative Palliative Care Benefit Models

CompassionNet
**Purpose:**

- To assist children with life-threatening illnesses to live as normally as possible, by providing their families access to a continuum of care, with the objectives of alleviating suffering and assuring quality services regardless of the site of care over the course of their disease. To support the independence, integrity, caregiving and other functions of the families/guardians of these children, by providing full access to services and resources that sustain effective coping and positive family dynamics.
<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Deaths (BCBSRA)</th>
<th>Deaths At Home</th>
<th>% of Deaths At Home with CompassionNet</th>
<th>Cost of Care Savings Avoided Terminal Hospitalizations ($46,000) (Milliman and Roberts, 2004)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>19</td>
<td>11</td>
<td>58%</td>
<td>$506,000</td>
</tr>
<tr>
<td>2004</td>
<td>16</td>
<td>8</td>
<td>50%</td>
<td>$368,000</td>
</tr>
<tr>
<td>2005</td>
<td>11</td>
<td>8</td>
<td>73%</td>
<td>$368,000</td>
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Innovative Palliative Care Benefit Models
Palliative Medicine Physician Reimbursement
Cumulative ABHPM Certified Physicians in the Health Plan Regions

Year Certified

Pre 2001  2001  2002  2003  2004  2005

Total # of Physicians

10  13  13  26  34  76
Education and Communication

Education for Physicians on End-of-life Care (EPEC)
Cumulative EPEC Participants Trained

Year

1000
800
600
400
200
0

# of Participants

2001 2002 2003 2004 2005 2006

42 190 255 440 669 762
EPEC Participant Satisfaction & Practice Behavior Results

Favorable Response Rate

Nov-03: 98% 93% 96% 100%
Mar-04: 98% 91% 95%
Apr-05: 96% 98%
Apr-05: 100% 95%
Mar-06: 95% 96%

Conference Rating
Practice Change
EPEC Participant Satisfaction & Practice Behavior Results

Favorable Response Rate

Nov-03: 98% 93%
Mar-04: 98% 91%
Apr-05: 96% 98%
Apr-05: 100% 95%
Mar-06: 95% 96%

Conference Rating
Practice Change
Education and Communication

Community Web site
www.compassionandsupport.org
THANK YOU

Patricia.Bomba@lifethc.com

www.excellusbcbs.com
www.compassionandsupport.org