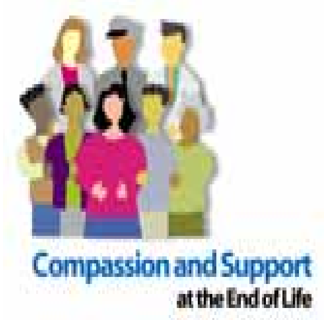
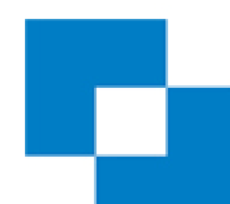
Healthcare and Community Collaboration: A Health Plan Model to Improve End-of-life Care

Patricia Bomba M.D., F.A.C.P.
VP & Medical Director, Geriatrics

October 24, 2006

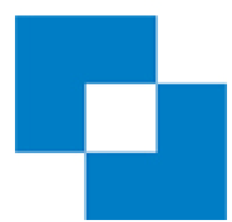


A nonprofit independent licensee of the BlueCross BlueShield Association



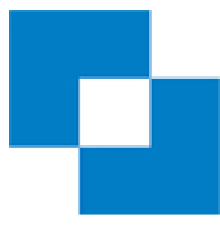
Compassion and Support
at the End of Life

Excellus



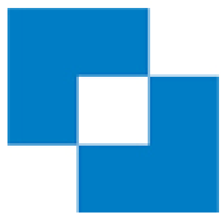
- "…along with burning flags and resisting the draft there is another un-American activity…dying…"
- "…our Constitution upholds the rights of life, liberty and the pursuit of happiness…death is not there…"

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



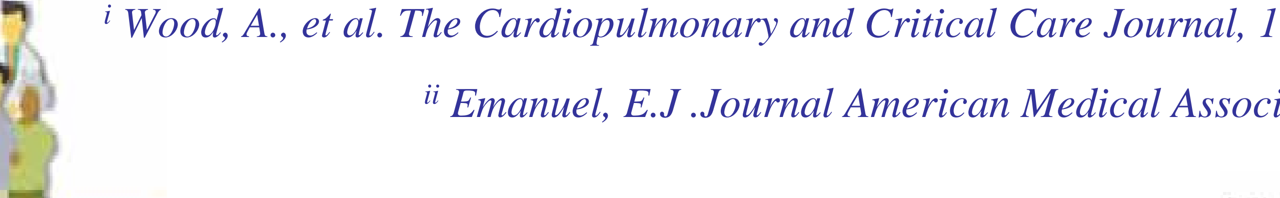
Objectives

- 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



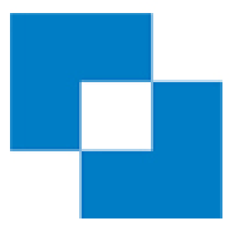
End-of-life Care Costs

- **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]



[i] *Wood, A., et al. The Cardiopulmonary and Critical Care Journal, 126: 1403-1406, 2004.*

[ii] *Emanuel, E.J .Journal American Medical Association, 275(24), 1996*

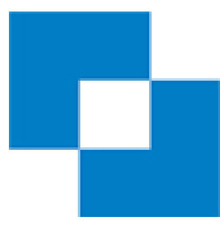


Regional Variations in Medicare Spending

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

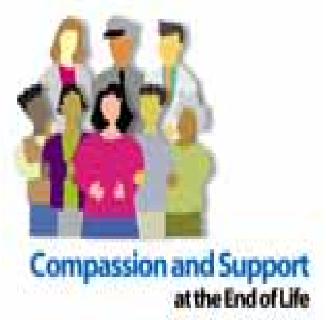
- **High-spending regions**
  - more inpatient-based and specialist-oriented care
  - however, no improvement in
    - health outcomes, including mortality rates
    - quality of care
    - access to care
    - patient/family satisfaction

Dartmouth Atlas



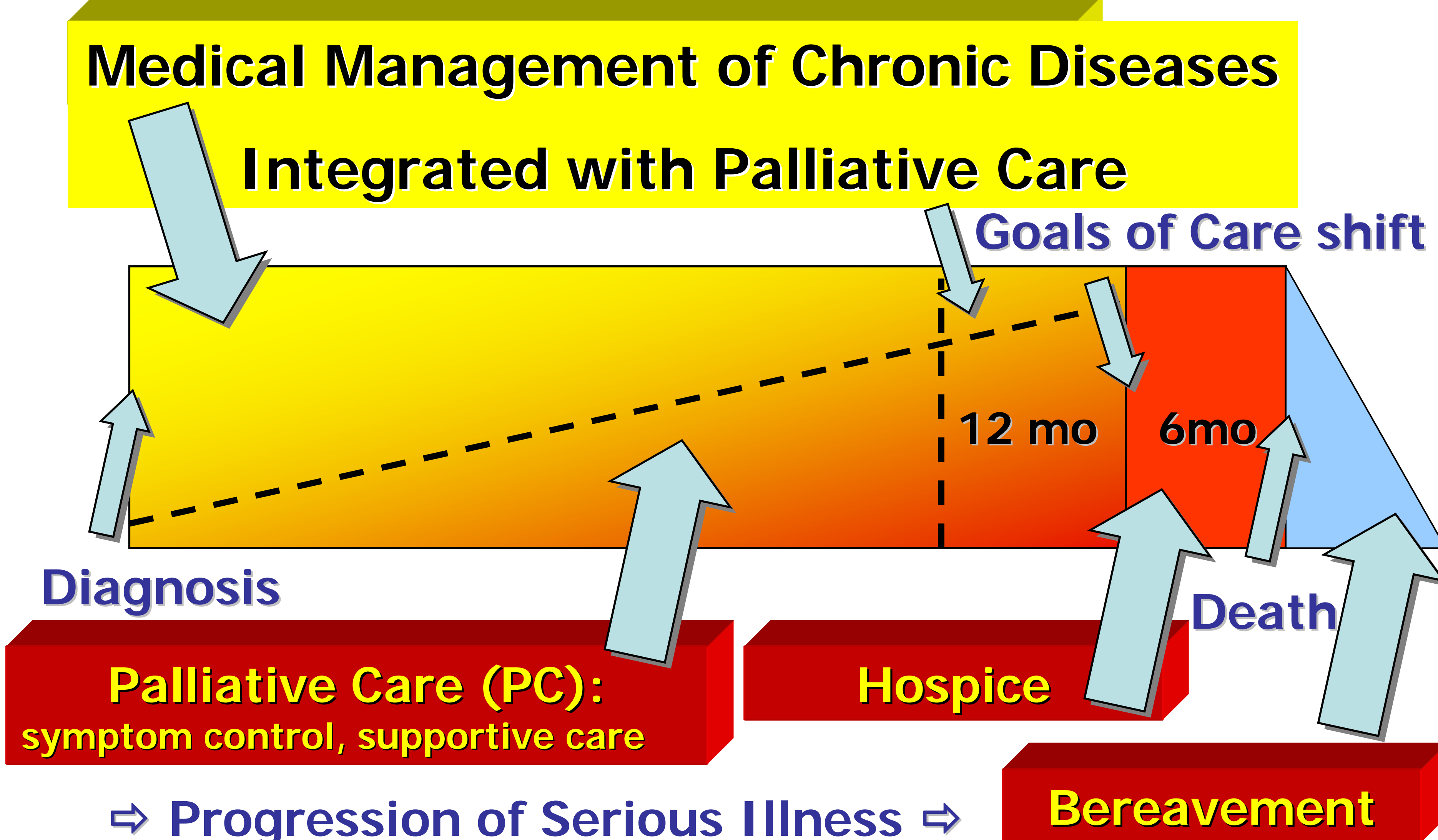
End-of-life Care Cost Savings

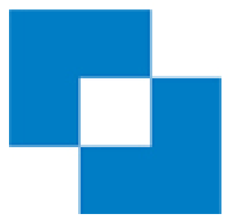
- Dollars are wasted on unwanted, unnecessary and futile treatments
- Reducing amount spent on ineffective treatments will help reduce the total cost of end-of-life care
- Cost savings estimate: 3.3 % of total costs [iii]
- 3.3% x $1.4 trillion = $59 billion



[iii] *Terry Sanford Institute of Public Policy, Duke University. www.pubpol.duke.edu /courses/pps255s/2004/w-team-a/benefits.htm, 2004*

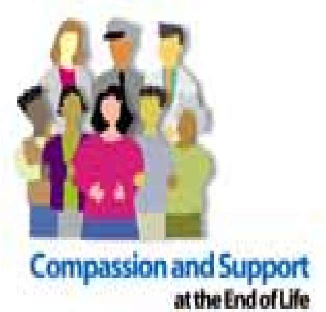
Continuum of Care Model





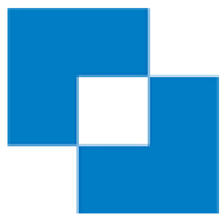
Community-wide End-of-life/ Palliative Care Initiative

- **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



Advance Care Planning

Traditional Advance Directives



Advance Care Planning

Compassion, Support and Education along the Continuum

Advancing chronic illness

Chronic disease or functional decline

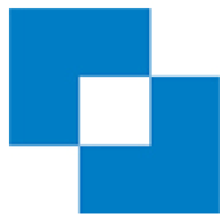
Multiple co-morbidities, with increasing frailty

Healthy and independent

Maintain & maximize health and independence

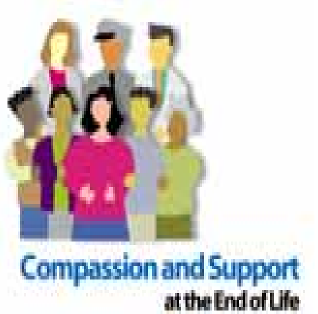
Death with dignity

Compassion and Support at the End of Life



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** [i]
  - 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** [ii]
  - 29% - Americans have ACD



[i] *Means to a Better End: A Report on Dying in America Today, November 2002*

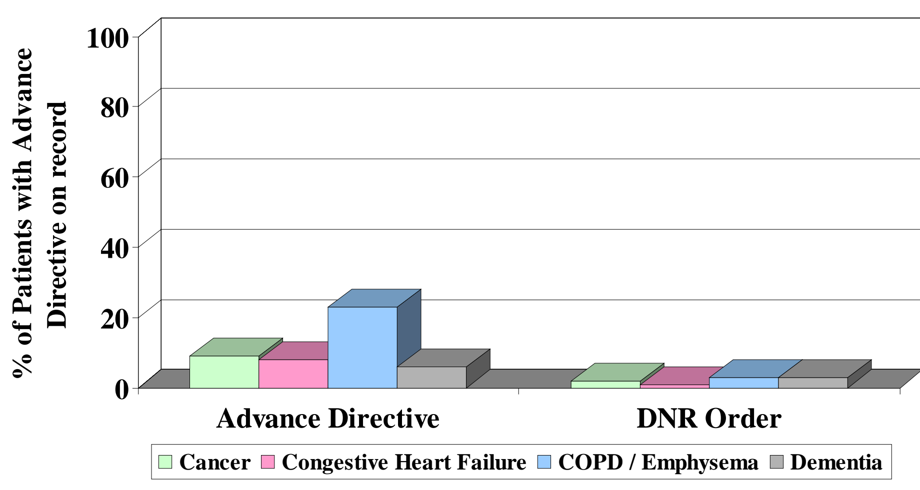
[ii] *The Pew Research Center for the People and the Press. More Americans Discussing and Planning End-of-life Treatment. January 5, 2006*

Advance Directives

HOME CARE PATIENTS WITH CHRONIC ILLNESS

End-of-Life Survey

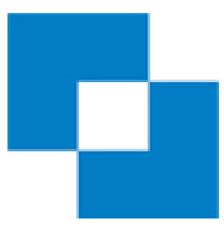
Percent of Home Care Clients with Chronic Illness having an Advance Directive or a DNR order



Question 3. What percent of patients with cancer, heart failure, COPD/emphysema or dementia have an Advance Directive or DNR order in place?

What percentage of patients with cancer, heart failure, COPD/emphysema or dementia has an Advance Directive or a DNR order in place?

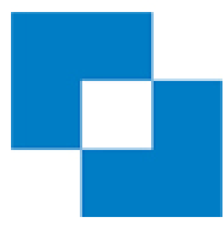
Community End-of-Life Survey Report
January 2001



Community Data

- 40% seniors report physicians have not addressed Advance Care Planning
- 75% of deaths in Monroe County were 65+

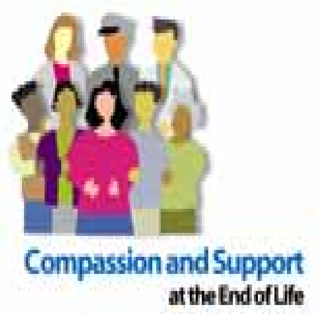
EBCBSRR Senior Survey, 2001



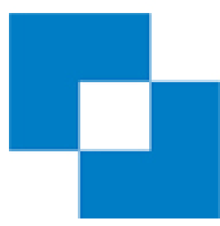
Advance Care Planning Community Goals

- **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

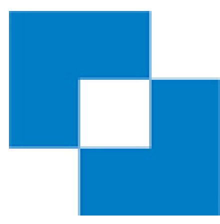


Advance Care Planning Community Goals

- **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

Compassion and Support at the End of Life



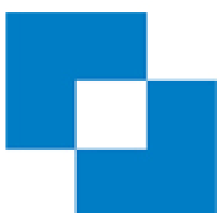
Advance Care Planning Community Goals

- Make advance directives and surrogacy designations available across care settings

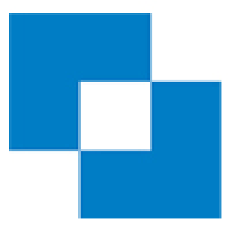
- Develop and promote healthcare and community collaborations to promote advance care planning and completion of advance directives for all individuals

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

Compassion and Support at the End of Life



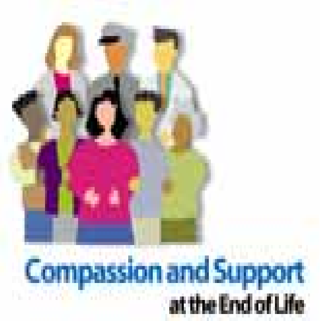
Advance Care Planning Campaign Rochester 2002



Community Resources

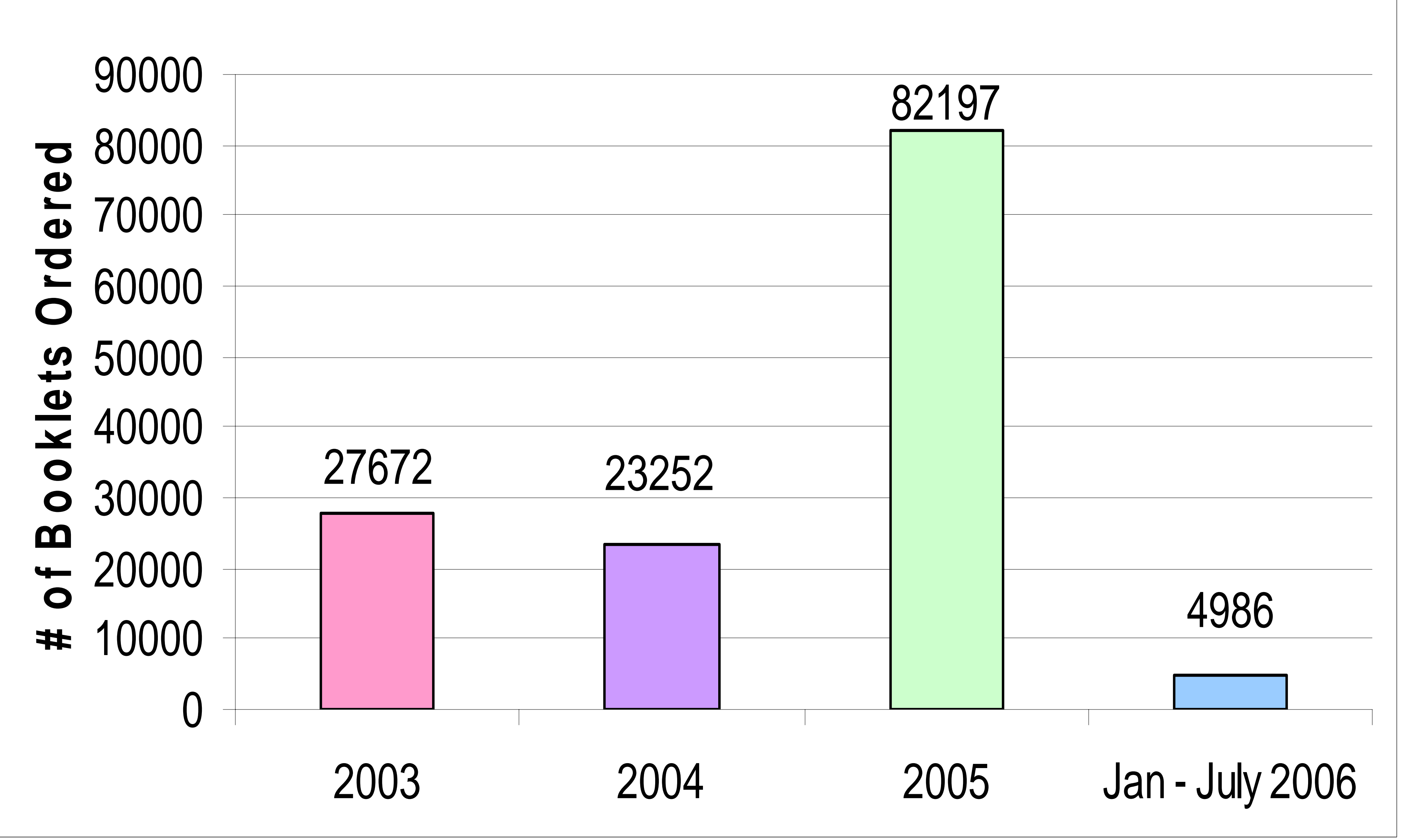
Advance Care Planning

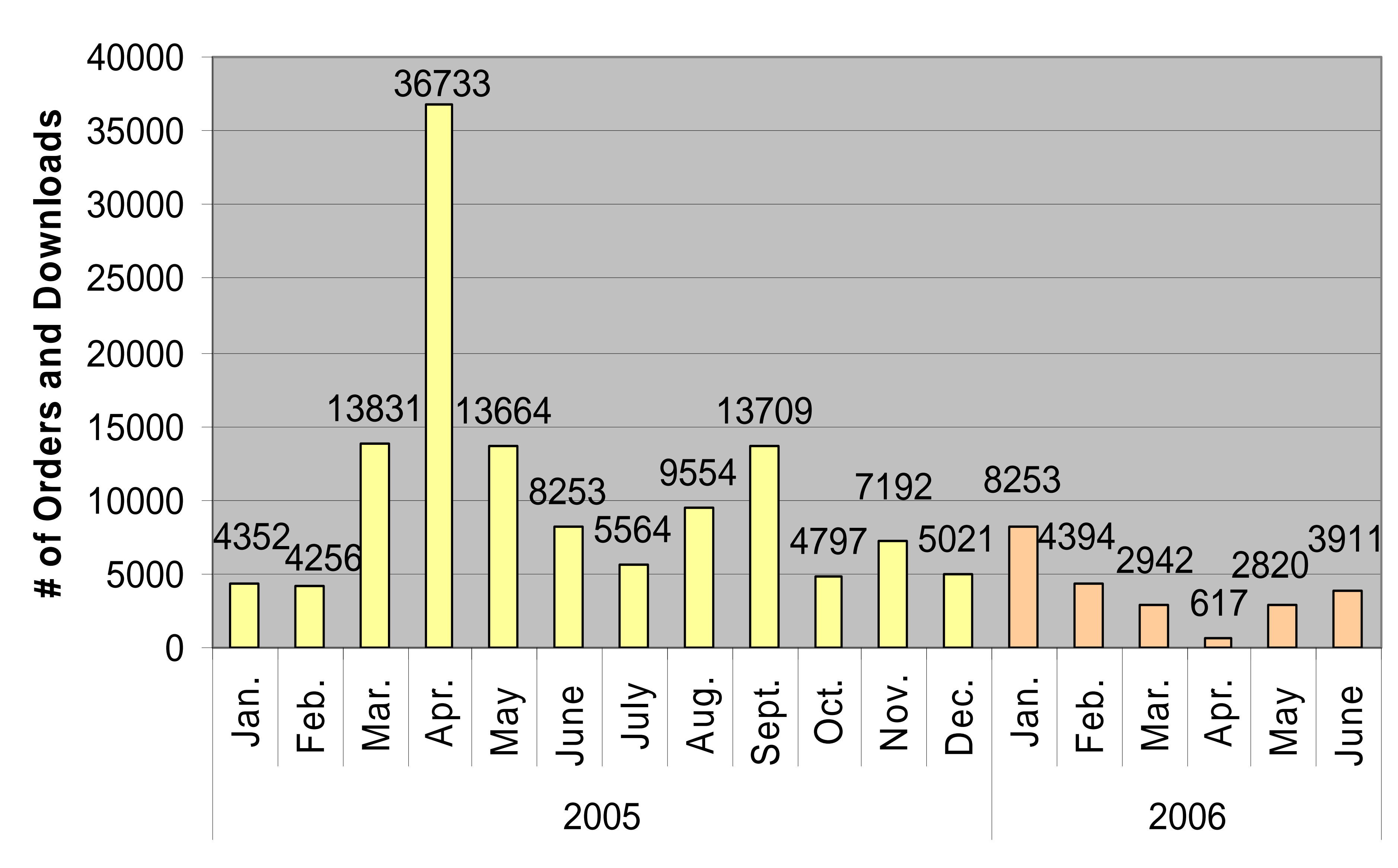
- Advance Care Planning Booklet (English, Spanish)
- Advance Care Planning Poster and Tent card
- Behavioral Readiness “tools”
- Community Conversations on Compassionate Care (CCCC)
- Advance Care Planning Facilitator Training
- Life Choices Program



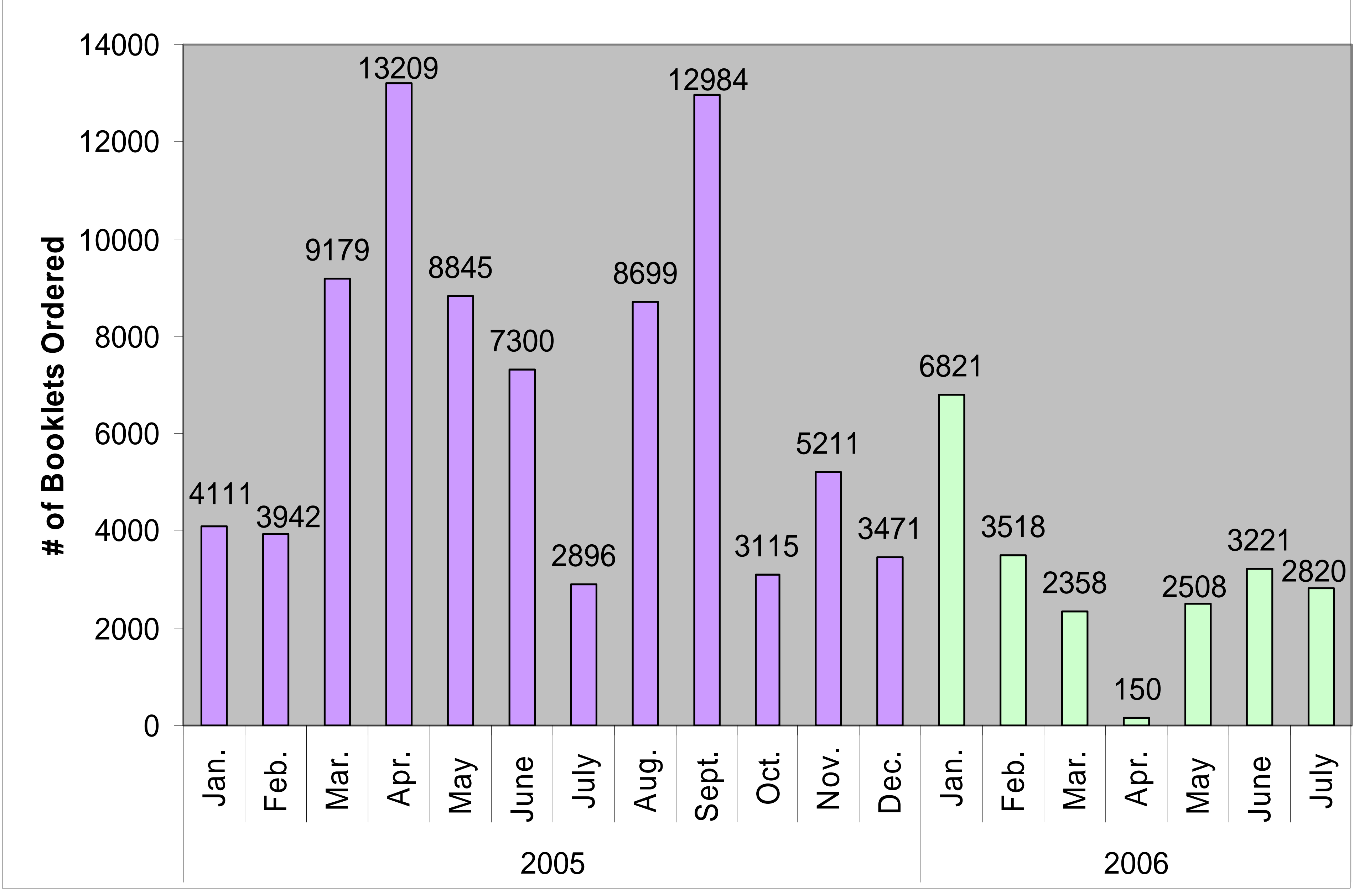
For these resources and more, visit
www.excellusbcbs.com
www.compassionandsupport.org

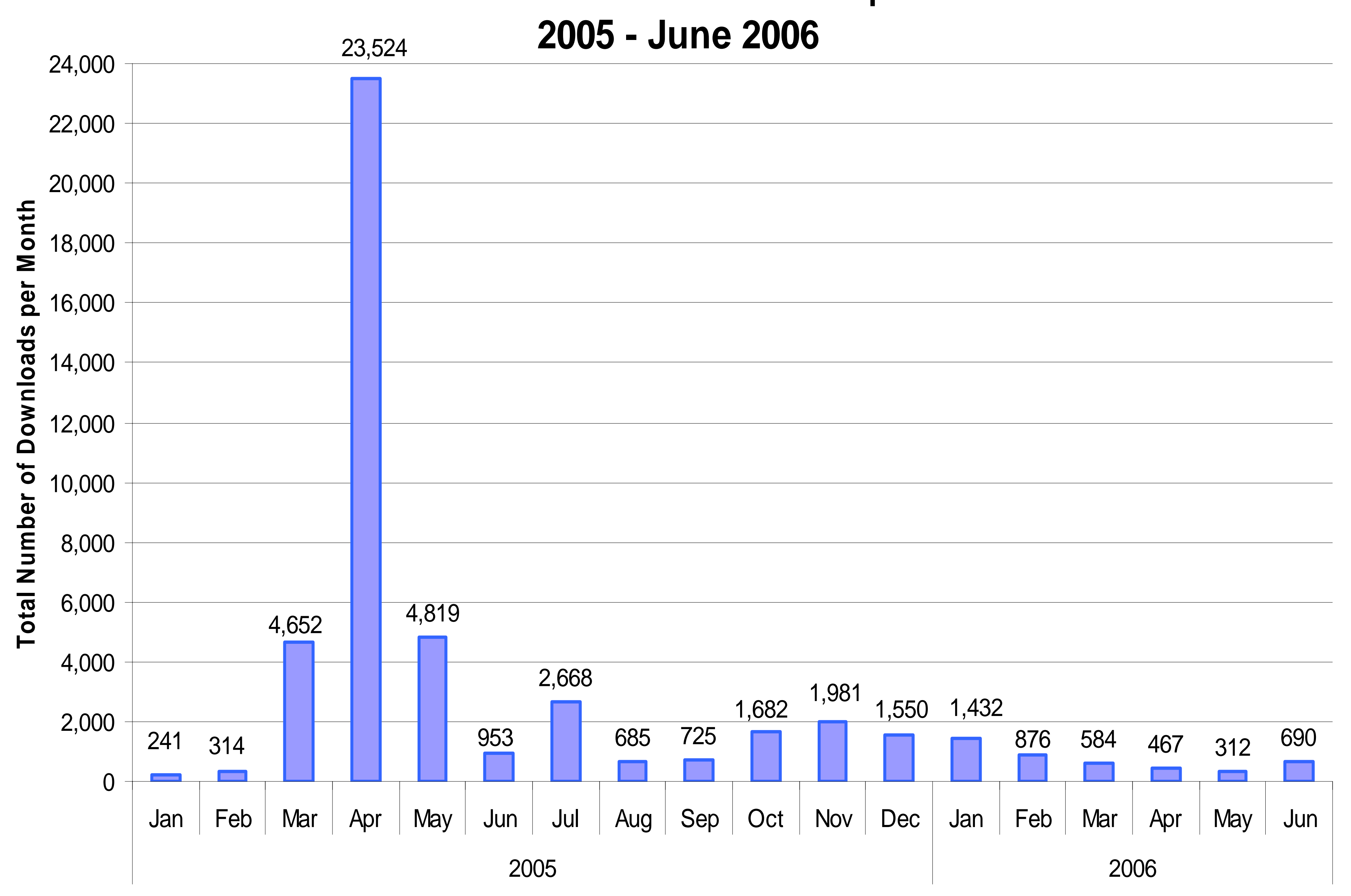
Total Number of ACP Booklets Ordered per Year
2003 - July 2006



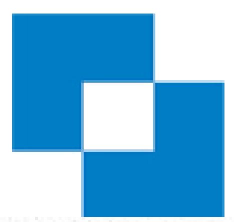


Total Number of ACP Booklets Ordered & Downloaded per Month
2005 - June 2006
# of Orders and Downloads
40000
35000
30000
25000
20000
15000
10000
5000
0
4352
4256
13831
36733
13664
8253
5564
9554
13709
4797
7192
5021
8253
4394
2942
617
2820
3911
Jan.
Feb.
Mar.
Apr.
May
June
July
Aug.
Sept.
Oct.
Nov.
Dec.
Jan.
Feb.
Mar.
Apr.
May
June
2005
2006

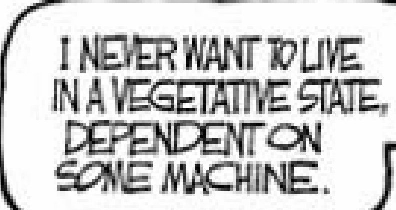

Total Number of ACP Booklets Ordered per Month
2005 - July 2006
# of Booklets Ordered
14000
12000
10000
8000
6000
4000
2000
0
4111
3942
9179
13209
8845
7300
2896
8699
12984
3115
5211
3471
6821
3518
2358
150
2508
3221
2820
Jan.
Feb.
Mar.
Apr.
May
June
July
Aug.
Sept.
Oct.
Nov.
Dec.
Jan.
Feb.
Mar.
Apr.
May
June
July
2005
2006

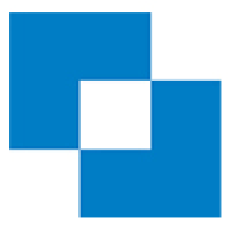


Total ACP Booklet Web Downloads per Month
2005 - June 2006
Total Number of Downloads per Month
24,000
22,000
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
241
314
4,652
23,524
4,819
953
2,668
685
725
1,682
1,981
1,550
1,432
876
584
467
312
690
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
2005
2006



Functional Health Literacy

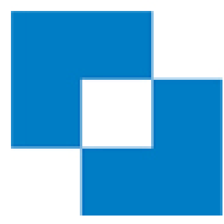




Community Conversations on Compassionate Care

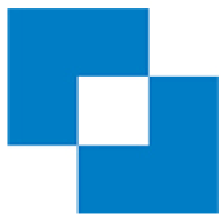
- **1-2 hour facilitated workshop on advance care planning**
- **Goals**
  - Increase comfort level in discussing death and dying
  - Increase conversations that lead to completion of an Advance Care Directive

A Community-wide End-of-life/Palliative Care Initiative project



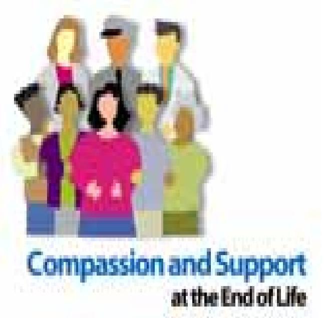
CCCC Facilitator Training Agenda

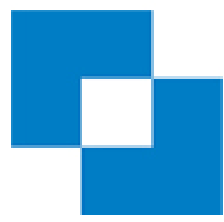
- **8-hour training**
  - Advance Care Planning Along the Health-Illness Continuum
  - The Patient Voice in End-of-life Transitions
  - Life-Sustaining Treatments
  - Medical Orders for Life-Sustaining Treatments (MOLST)… a POLST paradigm
  - CCCC workshop logistics
  - Facilitation training



CCCC Facilitator Training

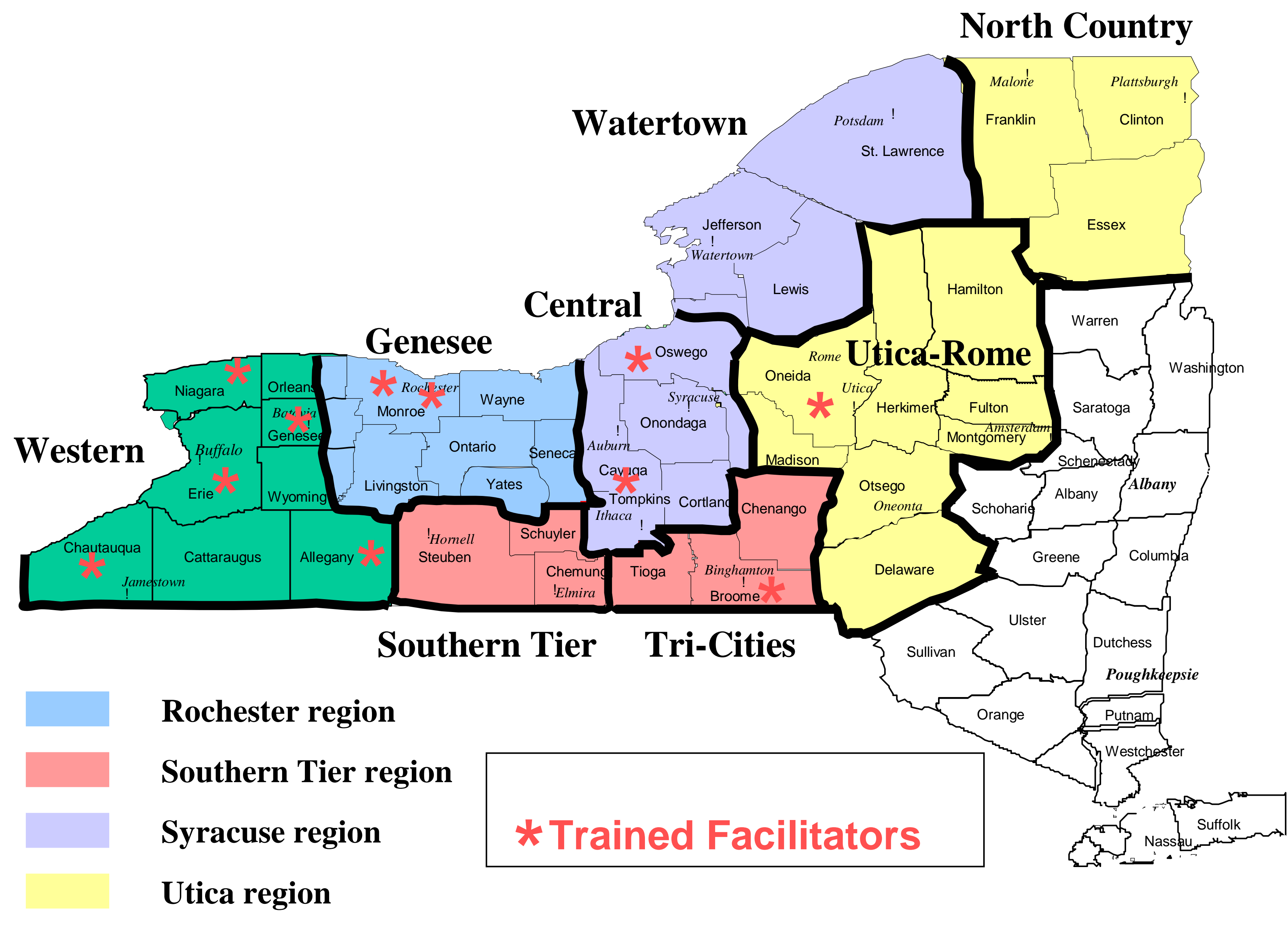
- **Trainees receive**
  - comprehensive binder of information
  - workshop “tools”
  - facilitator resources
  - CD-ROM, featuring the binder information in PDF format and CCCC PowerPoint presentation with facilitator speaking notes



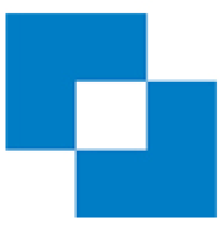


CCCC Facilitator Training

- **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

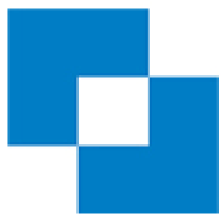


North Country
Watertown
Central
Genesee
Western
Utica-Rome
Southern Tier
Tri-Cities
Malone
Franklin
Plattsburgh
Clinton
Potsdam
St. Lawrence
Essex
Jefferson
Watertown
Lewis
Hamilton
Warren
Washington
Oswego
Rome
Oneida
Utica
Herkimer
Fulton
Saratoga
Amsterdam
Montgomery
Schenectady
Albany
Albany
Niagara
Orleans
Batavia
Genesee
Buffalo
Erie
Wyoming
Rochester
Monroe
Wayne
Ontario
Seneca
Livingston
Yates
Syracuse
Onondaga
Auburn
Cayuga
Tompkins
Ithaca
Cortland
Madison
Chenango
Otsego
Oneonta
Schoharie
Chautauqua
Jamestown
Cattaraugus
Allegany
Hornell
Steuben
Schuyler
Chemung
Elmira
Tioga
Binghamton
Broome
Delaware
Greene
Columbia
Ulster
Sullivan
Dutchess
Poughkeepsie
Orange
Putnam
Westchester
Suffolk
Nassau
Rochester region
Southern Tier region
Syracuse region
Utica region
Western region
* Trained Facilitators



CCCC Results

- # 241 CCCC workshops
- # 5521 participants
- # 422 trained facilitators



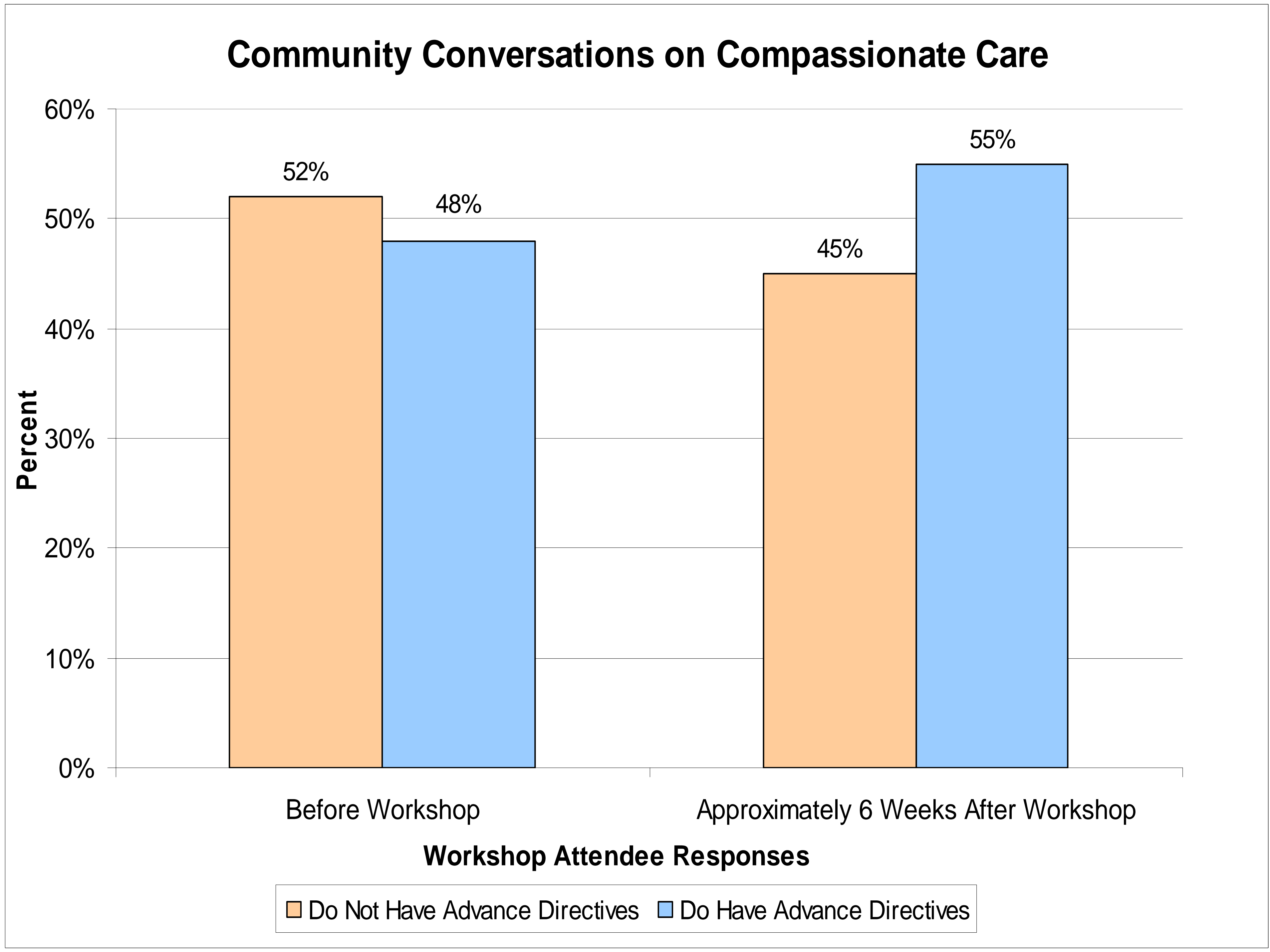
Stages of Readiness to Complete

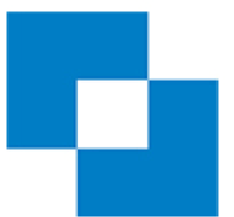
Staging Questions: Health Care Proxy Readiness

Drs. Bomba and Doniger, 2002

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

Compassion and Support at the End of Life


Community Conversations on Compassionate Care
60%
50%
40%
30%
20%
10%
0%
Percent
52%
48%
45%
55%
Before Workshop
Approximately 6 Weeks After Workshop
Workshop Attendee Responses
Do Not Have Advance Directives
Do Have Advance Directives



Health Care Proxy Readiness Form

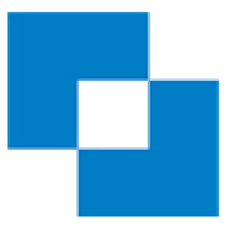
Baseline Statistics

	Have Advance Directives	Do Not Have Advance Directives
Internal Employees	30%	70%
UPitt* and STEP EMS** Attendees	38%	62%
EPEC Attendees	49%	51%
Facilitator Training Workshop Attendees	60%	40%
All Attendees Including Community Members	48%	56%

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

* Geriatrics Conference for Health Care Professionals, University of Pittsburgh

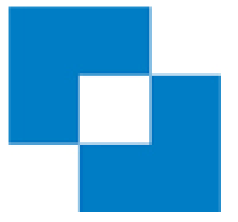
** Emergency Medical Services conference, Rochester, NY



Quality Management
Adult Preventive Health Guideline

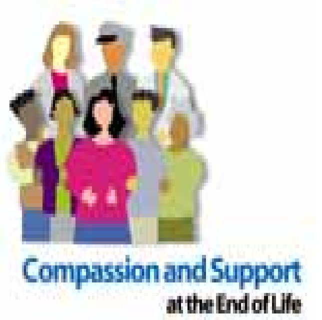
- **Counsel all individuals regarding completion of advance care directives**

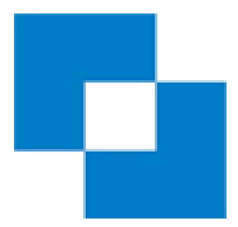
- **Advance Directives: Advance Care Planning is a process that requires conversation and results in the completion of an Advance Directive. An Advance Directive allows patient preferences and goals to drive care and to guide shared medical decision making in the event the patient is unable to communicate. 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



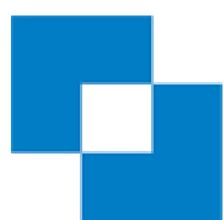


Is a completed Advance Care Directive in the patient's medical record?

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

* # 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

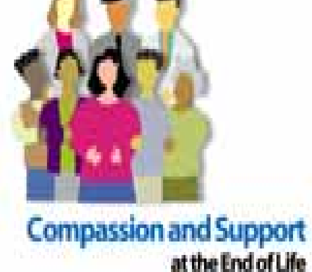
Encourage Designation of Health Care Proxy

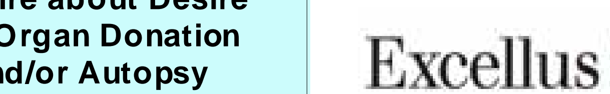
Inquire about Desire for Organ Donation and/or Autopsy

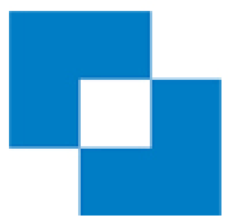
Encourage Patient to discuss wishes with family

Discuss Palliative Care Options including Hospice

Consider Introducing the Palliative Care Team

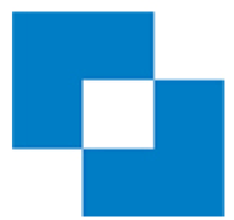






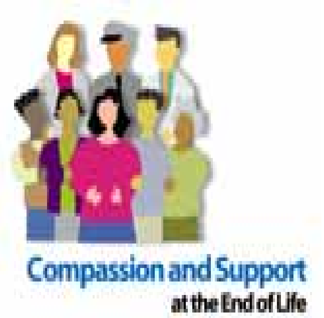
Health Care Decision Employee Survey 2002 Results

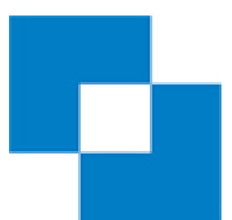
- **6 question survey**
  - Knowledge
  - Self-reported completion rates
  - Demographics
- **Response**
  - 35% response rate (2272 of 6537 surveys)
  - 66% in 35-54 age range
- **Results**
  - 30% completed Health Care Proxy
  - 18% completed Living Will
  - 77% report understanding ACD
  - No difference 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

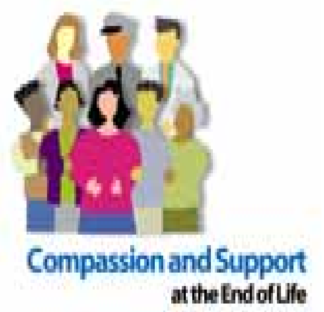


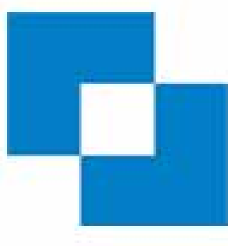


Results Comparison Between 2002 and 2006 surveys

Have you designated a HCP and completed a HCP form?

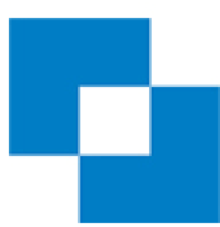
	Yes	No
2002	30%	70%
2006	33.5%	66.5%





Advance Care Planning

Medical Orders for Life-Sustaining Treatment (MOLST)



POLST Paradigm Program

D.C.

Endorsed Programs

Developing Programs

No Program (Contacts)

Paradigm of communication, documentation, and system responsiveness

POLST Paradigm, July 2006.www.polst.org

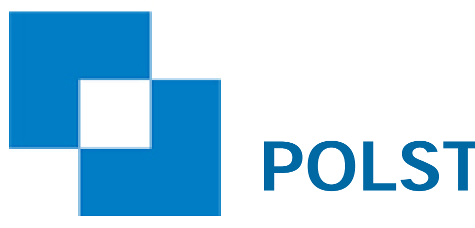
POLST

- **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

Meyers, et al. J Gerontol Nurs. 2004; 30(9): 37-46

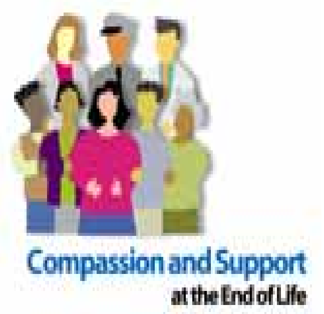
Schmidt, Hickman, Tolle, Brooks. JAGS. 2004; 52(9): 1430-1434



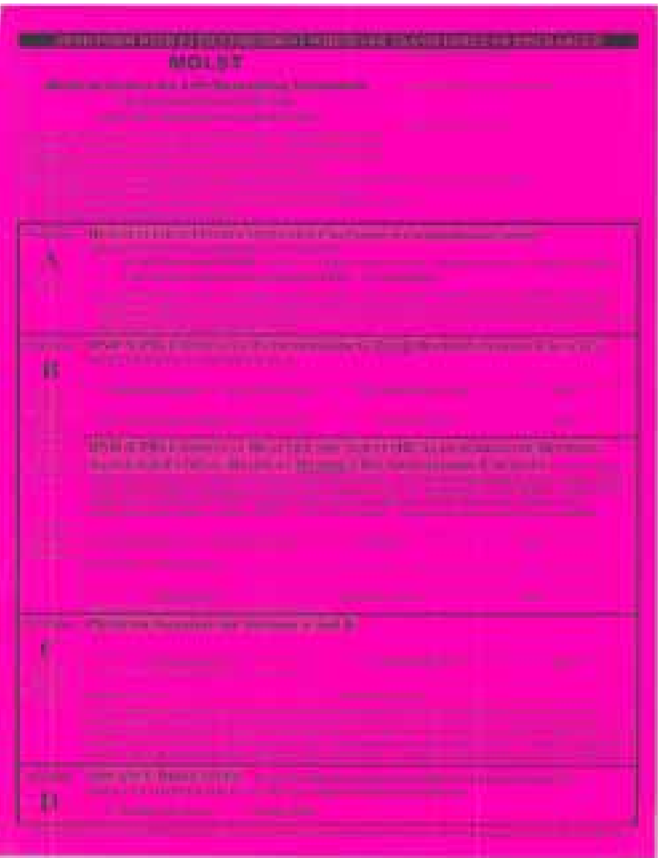
POLST

- **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.**

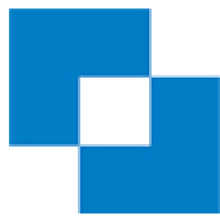
Tolle SW, Tilden VP. J Palliative Med. 2002; 5(2): 311-317



MOLST

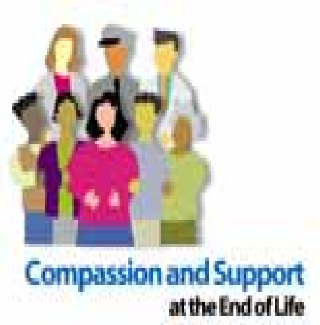

MOLST

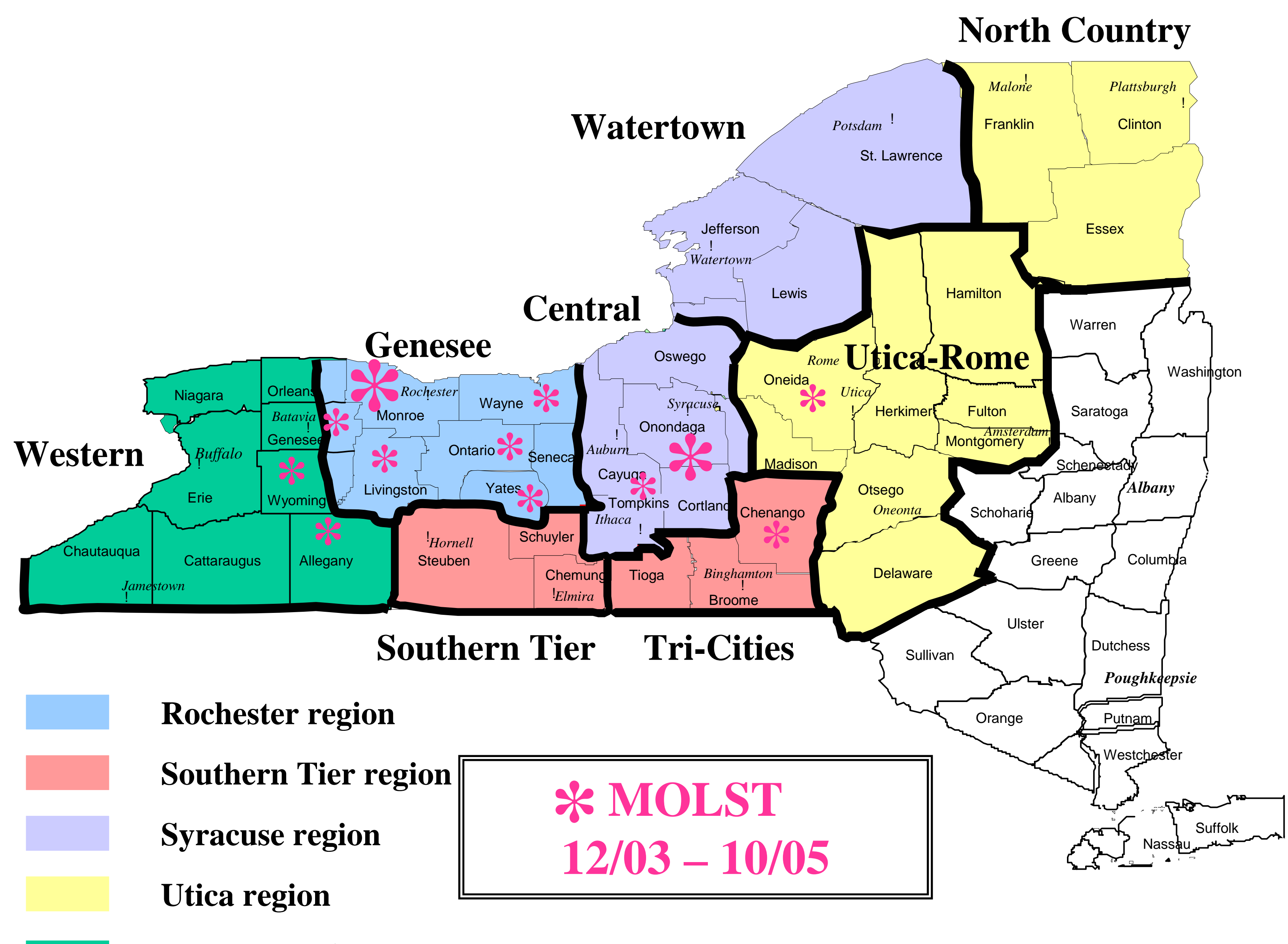
- Created November 2003
- Adapted from Oregon’s POLST
- Combines DNR, DNI, and other Life-Sustaining Treatments
- Revised October 2005
- Incorporates NYS law
- Collaboration with NYSDOH
- Approved Inpatient DNR form
- Legislation passed
- Community Pilot

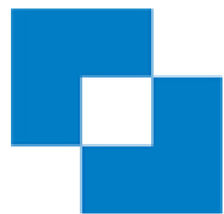


Goals of the MOLST Program

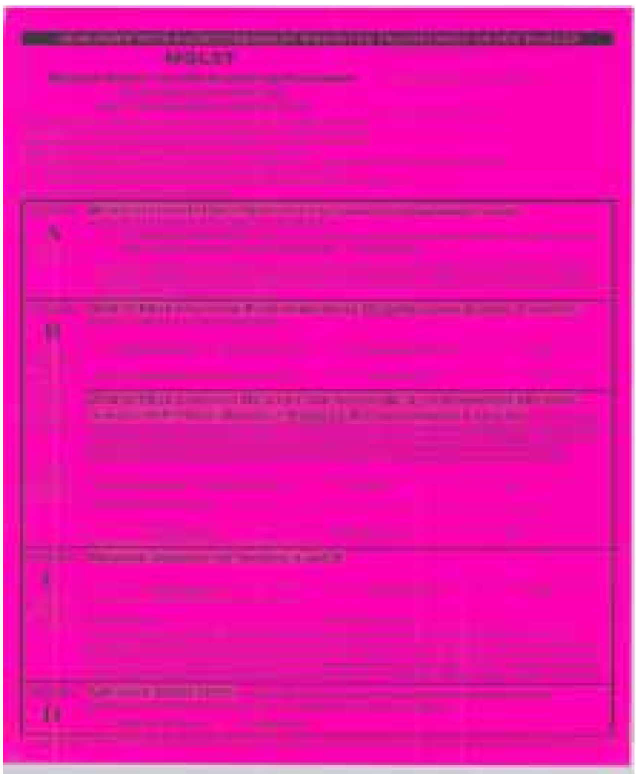
- **Document an individual's treatment preferences:**
  - DNR
  - Intubation and mechanical ventilation
  - Other life-sustaining treatment
  - Future hospitalization and transfer
- **Coordinate physician orders with patient preferences**
- **Communicate wishes across health care settings**
- **Improve EMS personnel's ability to treat according to patient wishes**
- **Reduce repetitive documentation**




North Country
Watertown
Central
Genesee
Western
Utica-Rome
Southern Tier
Tri-Cities
Malone
Franklin
Plattsburgh
Clinton
Potsdam
St. Lawrence
Essex
Jefferson
Watertown
Lewis
Hamilton
Warren
Washington
Oswego
Rome
Oneida
Utica
Herkimer
Fulton
Saratoga
Syracuse
Onondaga
Amsterdam
Montgomery
Schenectady
Albany
Albany
Madison
Auburn
Cayuga
Niagara
Orleans
Rochester
Monroe
Wayne
Batavia
Genesee
Buffalo
Erie
Wyoming
Livingston
Ontario
Seneca
Yates
Tompkins
Ithaca
Cortland
Chenango
Otsego
Oneonta
Schoharie
Columbia
Greene
Delaware
Chautauqua
Jamestown
Cattaraugus
Allegany
Hornell
Steuben
Schuyler
Chemung
Elmira
Tioga
Binghamton
Broome
Ulster
Sullivan
Dutchess
Poughkeepsie
Orange
Putnam
Westchester
Suffolk
Nassau
Rochester region
Southern Tier region
Syracuse region
Utica region
Western region
MOLST
12/03 – 10/05



MOLST Community Pilot



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 ____/____/____

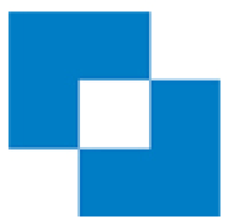
It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart.

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)

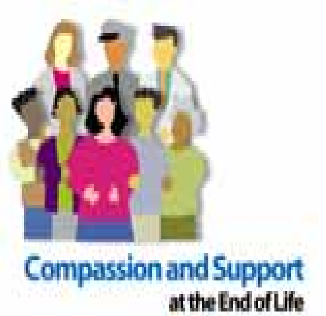
Regional Pilot in Monroe and Onondaga Counties, Approved NYSDOH, October 2005

Governor signed MOLST bill, October 11, 2005
Governor signed Chapter Amendment July 26,2006

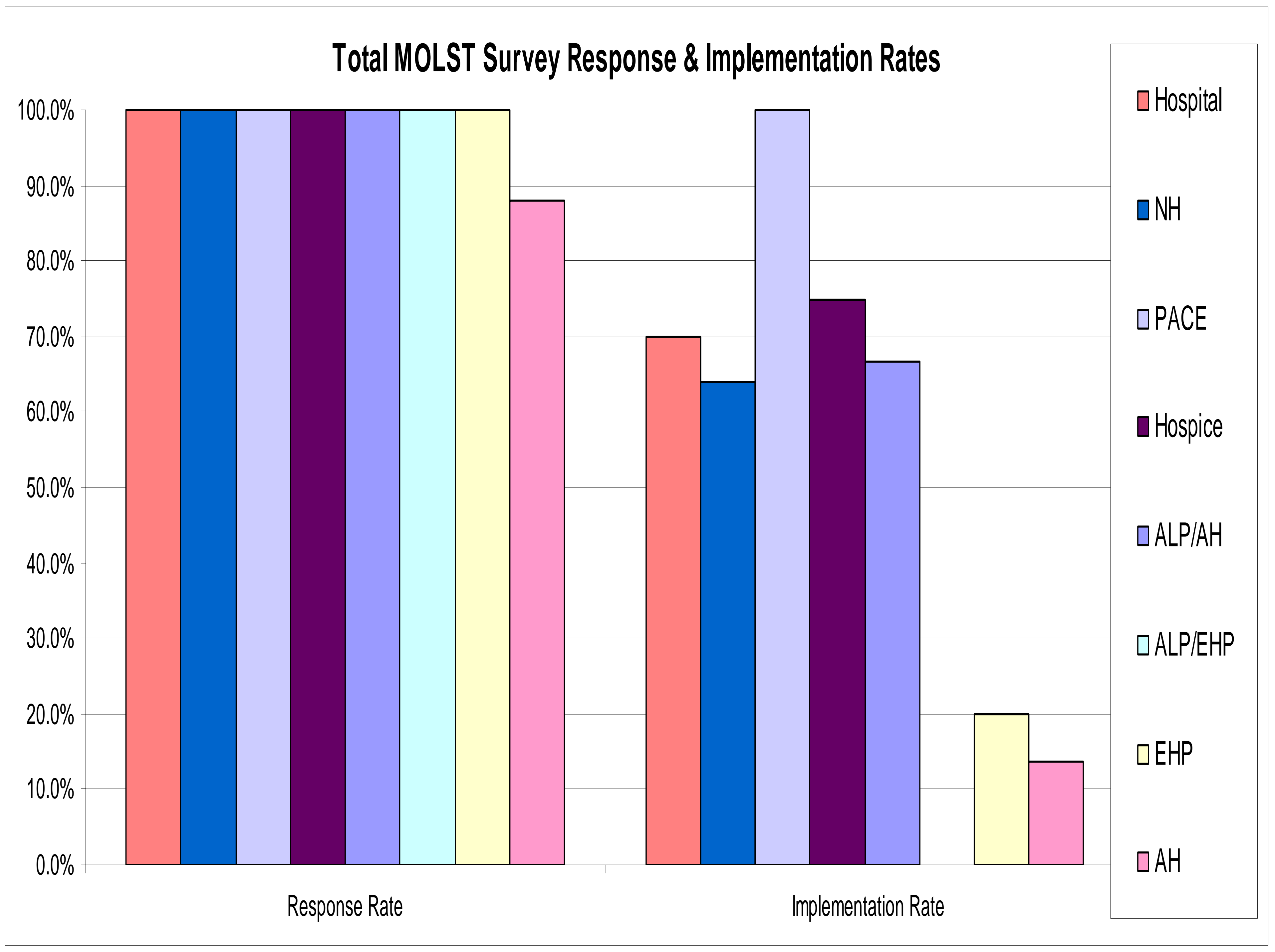


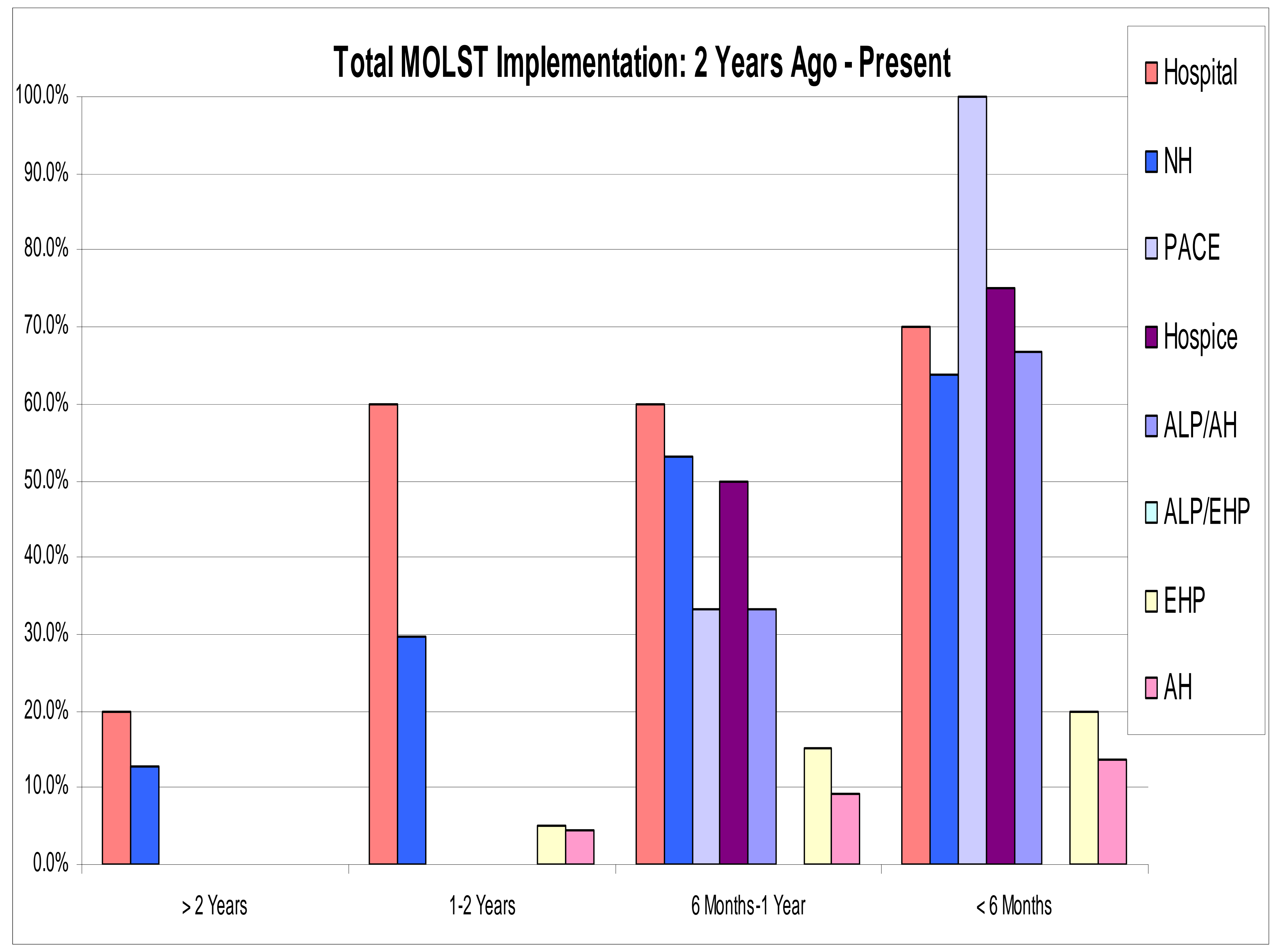
Monroe & Onondaga Counties Community Implementation Team

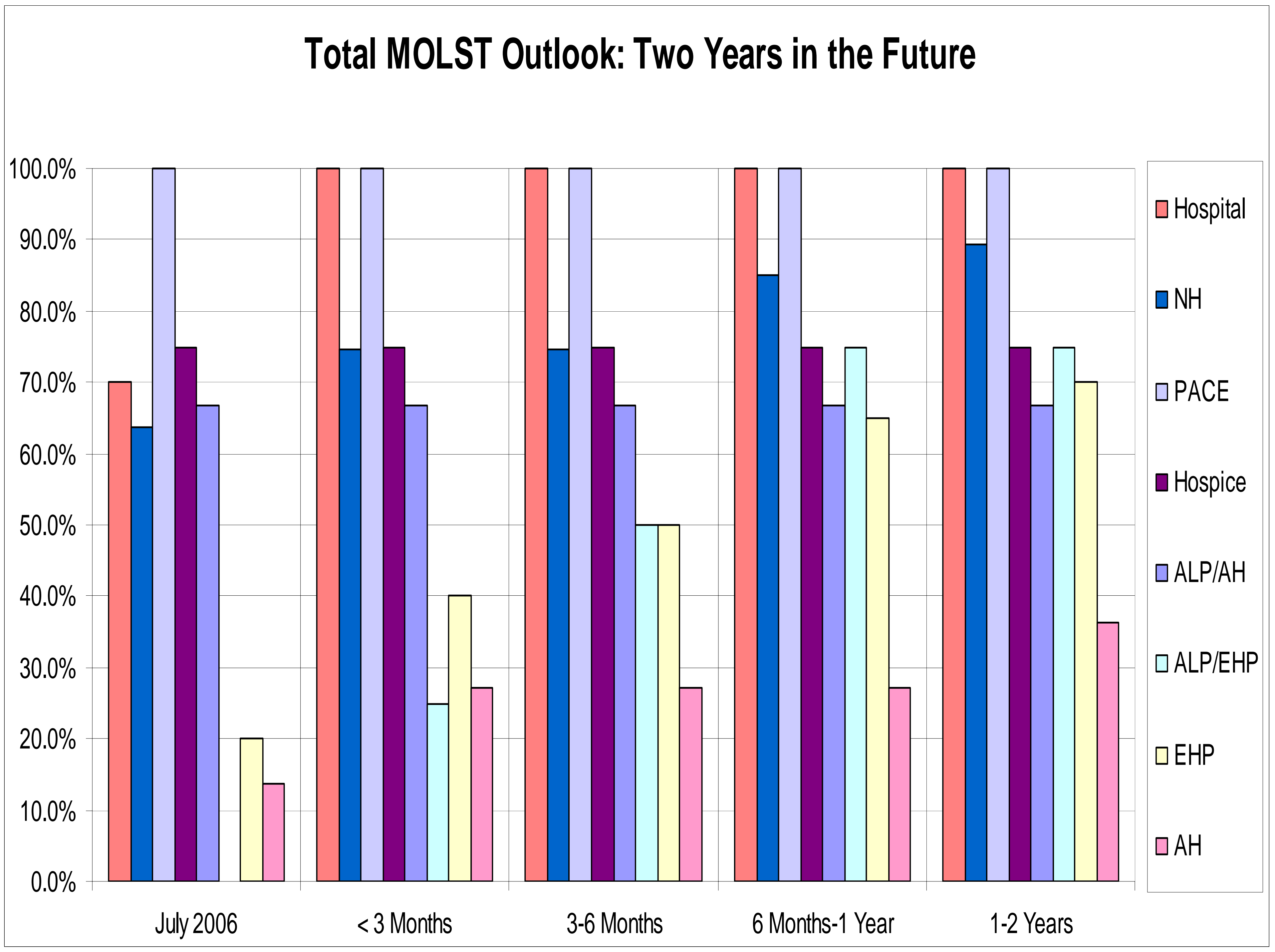
- Facilitate the implementation of the pilot
- Ensure adequate training
- Audit appropriate utilization
- Develop and track quality measures
- Establish standardized metrics
- Assist facility implementation throughout state
- Ensure the MOLST program moves beyond the pilot phase



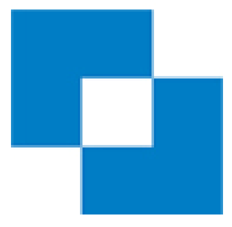
To receive periodic email updates on status of MOLST pilot
Contact patricia.bomba@lifethc.com


Total MOLST Survey Response & Implementation Rates
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Response Rate
Implementation Rate
Hospital
NH
PACE
Hospice
ALP/AH
ALP/EHP
EHP
AH


Total MOLST Implementation: 2 Years Ago - Present
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
> 2 Years
1-2 Years
6 Months-1 Year
< 6 Months
Hospital
NH
PACE
Hospice
ALP/AH
ALP/EHP
EHP
AH



Total MOLST Outlook: Two Years in the Future
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
July 2006
< 3 Months
3-6 Months
6 Months-1 Year
1-2 Years
Hospital
NH
PACE
Hospice
ALP/AH
ALP/EHP
EHP
AH



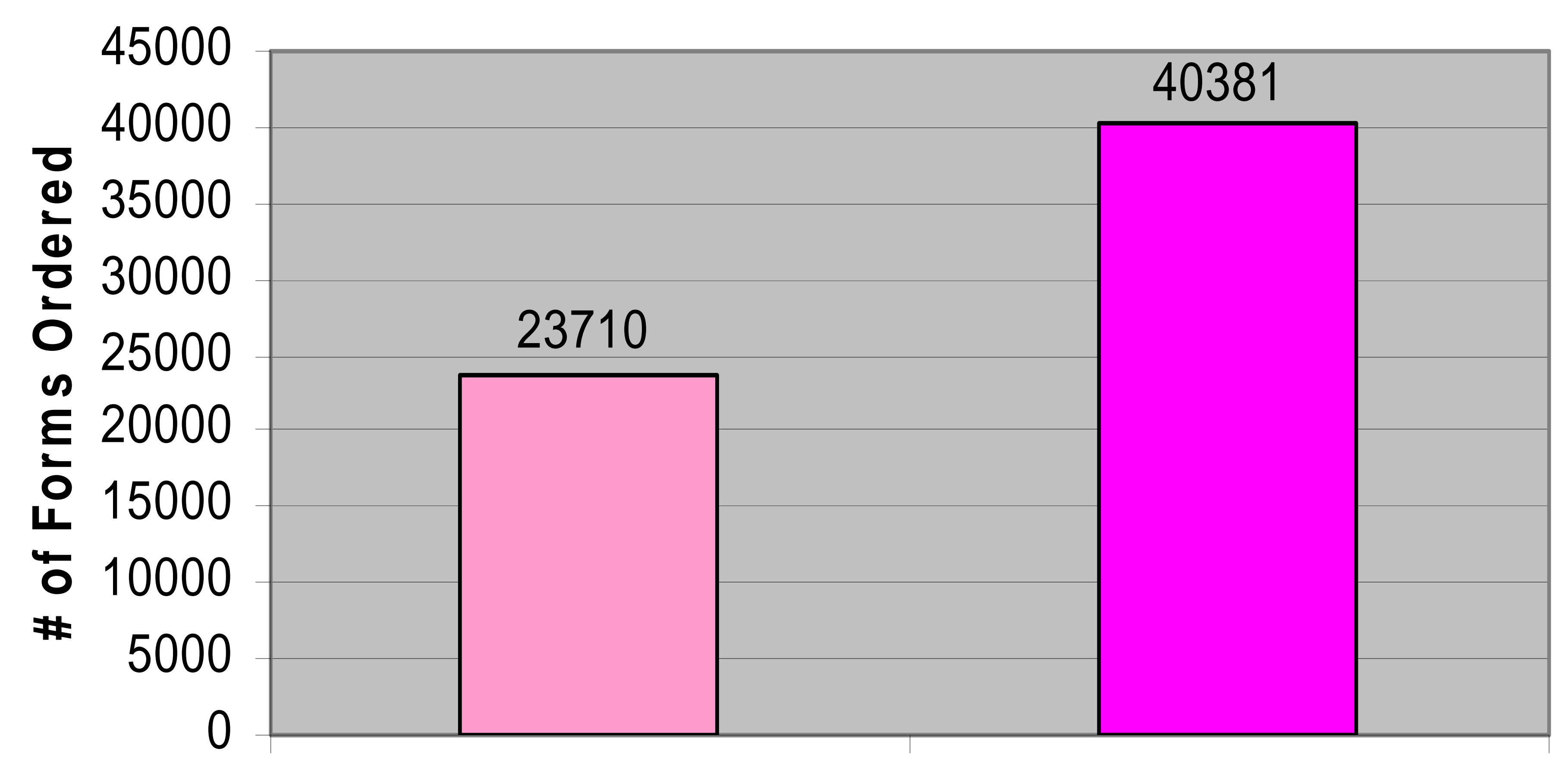
Community Resources

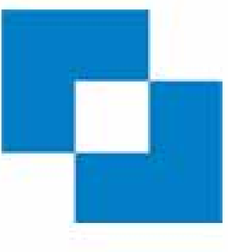
Medical Orders for Life-Sustaining Treatment (MOLST)

- **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

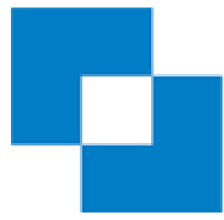
MOLST Order Form Comparison Between Original and Revised Form





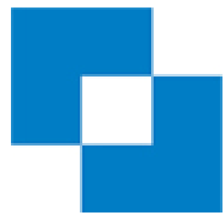
Pain Management and Palliative Care

Community Principles of Pain Management



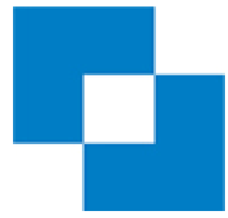
Prevalence

- **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



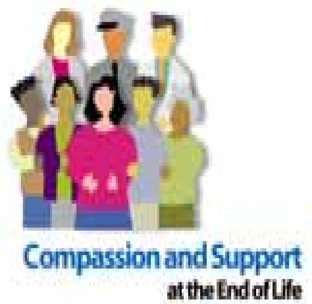
Economic Cost of Pain

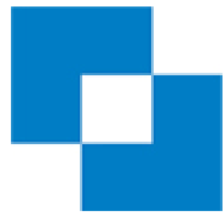
- **Annual expenditures related to chronic pain**
  - NIH estimates $100 billion
  - medical expenses, lost income, lost productivity
- **Pain accounts for approximately**
  - 25% of all sick days
  - 21% of emergency room visits
- **Undertreated pain increases utilization and costs**
  - extended length 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

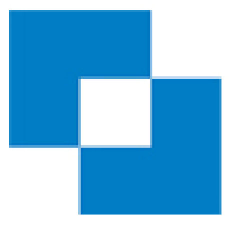
- **Poorly managed acute pain**
  - medical complications (e.g. pneumonia, DVT)
  - prolonged recovery and LOS
  - progress to chronic pain
- **Undertreated chronic pain**
  - altered immune function
  - sleep disturbance
  - impaired functional ability (ADL's, IADL's)
  - impaired psychological function
  - compromised cognitive function
  - decreased socialization
  - impaired quality of life





Health Plan Interventions

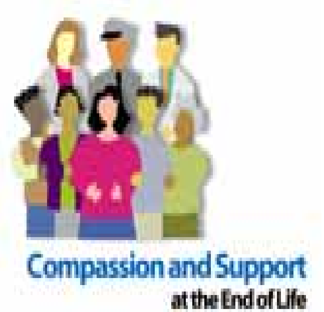
- **Clinical Guidelines**
- **Community Resources**
- **Educational Interventions**
- **Pharmacy Interventions**
- **Outcomes research study**
  - decrease utilization
    - meperidine (Demerol®)
    - propoxyphene (Darvon®)
  - appropriate utilization
    - opioids
    - acetaminophen
- **Disease and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



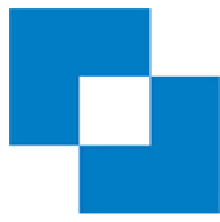
Community Resources

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)**

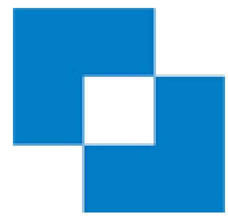


For these resources and more, visit
www.excellusbcbs.com
www.compassionandsupport.org



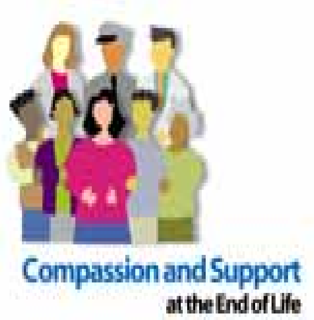
Outcomes Research Study

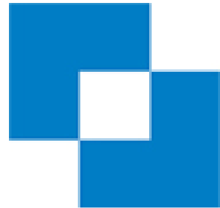
- **Comparative retrospective analysis**
- **Population pre- and post implementation**
- **Primary objective**
  - acetaminophen combination products
  - propoxyphene
  - meperidine
- **Secondary objective**
  - create an understanding of pain patients



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





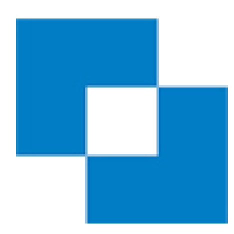
Baseline Demographics

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

(Members may have more than one diagnosis code, total may exceed 100% due to members being counted in more than one diagnosis.)

Compassion and Support at the End of Life

Excellus



Propoxyphene Utilization:

RX/1,000 Members > 65

Prescriptions Per 1,000 Members

450
400
350
300
250
200
150
100
50
0

Pain Management Booklets Mailed

Messaging to Pharmacies

Special Advisory Group Convened

Pharmacy TIP Sheet Mailed

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

Meperidine Utilization:

Rx/ 1,000 Members > 65

Prescriptions Per 1,000 Members

5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0

Pain Management Booklets Mailed

Special Advisory Group Convened

Pharmacy TIP Sheets Mailed

Messaging to Pharmacies

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

APAP Utilization:

RX >4grams/ 1,000 Members

Prescriptions Per 1,000 Members

5.0
4.5
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0

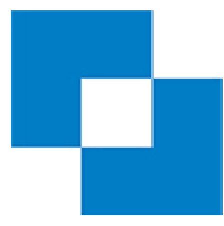
Special Advisory Group Convened

Pharmacy TIP Sheets Mailed

Pharmacy Edits Implemented

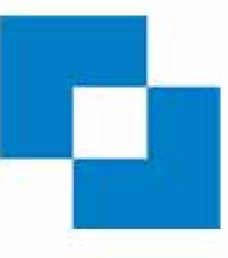
2001 FOURTH
2002 FIRST
2002 SECOND
2002 THIRD
2002 FOURTH
2003 FIRST
2003 SECOND
2003 THIRD
2003 FOURTH
2004 FIRST
2004 SECOND

Compassion and Support
at the End of Life



On-line Adjudication

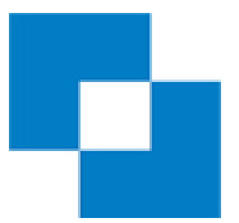
- **Follow four groups of patients in outcomes research study**
- **Track inappropriate dosing of OxyContin**
- **"Soft" messaging to pharmacist from health plan**
  - "Drug not recommended in age >65"
- **"Hard" messaging to pharmacist from health plan**
  - claim not paid unless override code is given
- **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

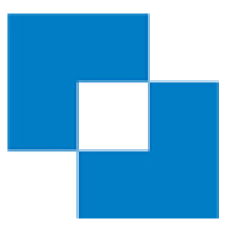
- **Purpose:**
  - To assist children with life-threatening illnesses to live as normally as possible, by providing their families access to a continuum of care, with the objectives of alleviating suffering and assuring quality services regardless of the site of care over the course of their disease. 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.



CompassionNet

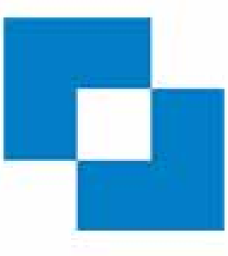
Growth

	2002	2003	2004	2005
BCBSUR	1	9	18	22
BCBSCNY	5	32	52	58
BCBSRA	69	84	137	143



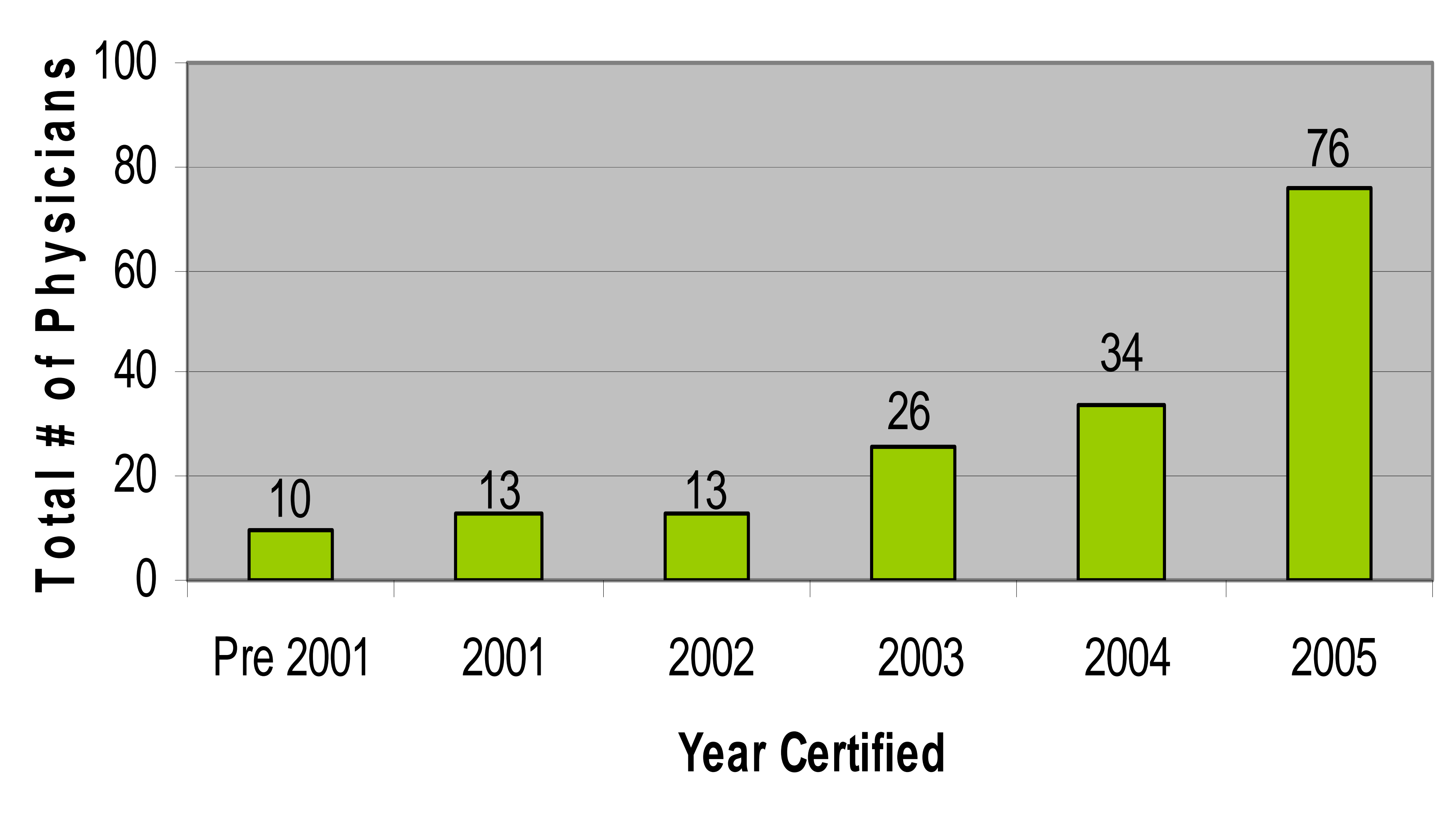
CompassionNet
Site of Death

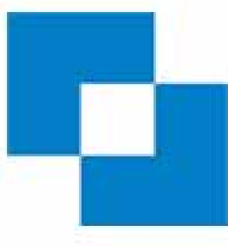
Year	Number of Deaths (BCBSRA)	Deaths At Home	% of Deaths At Home with CompassionNet	Cost of Care Savings Avoided Terminal Hospitalizations ($46,000) (Milliman and Roberts, 2004)
2003	**19**	**11**	**58%**	**$506,000**
2004	**16**	**8**	**50%**	**$368,000**
2005	**11**	**8**	**73%**	**$368,000**



Innovative Palliative Care Benefit Models

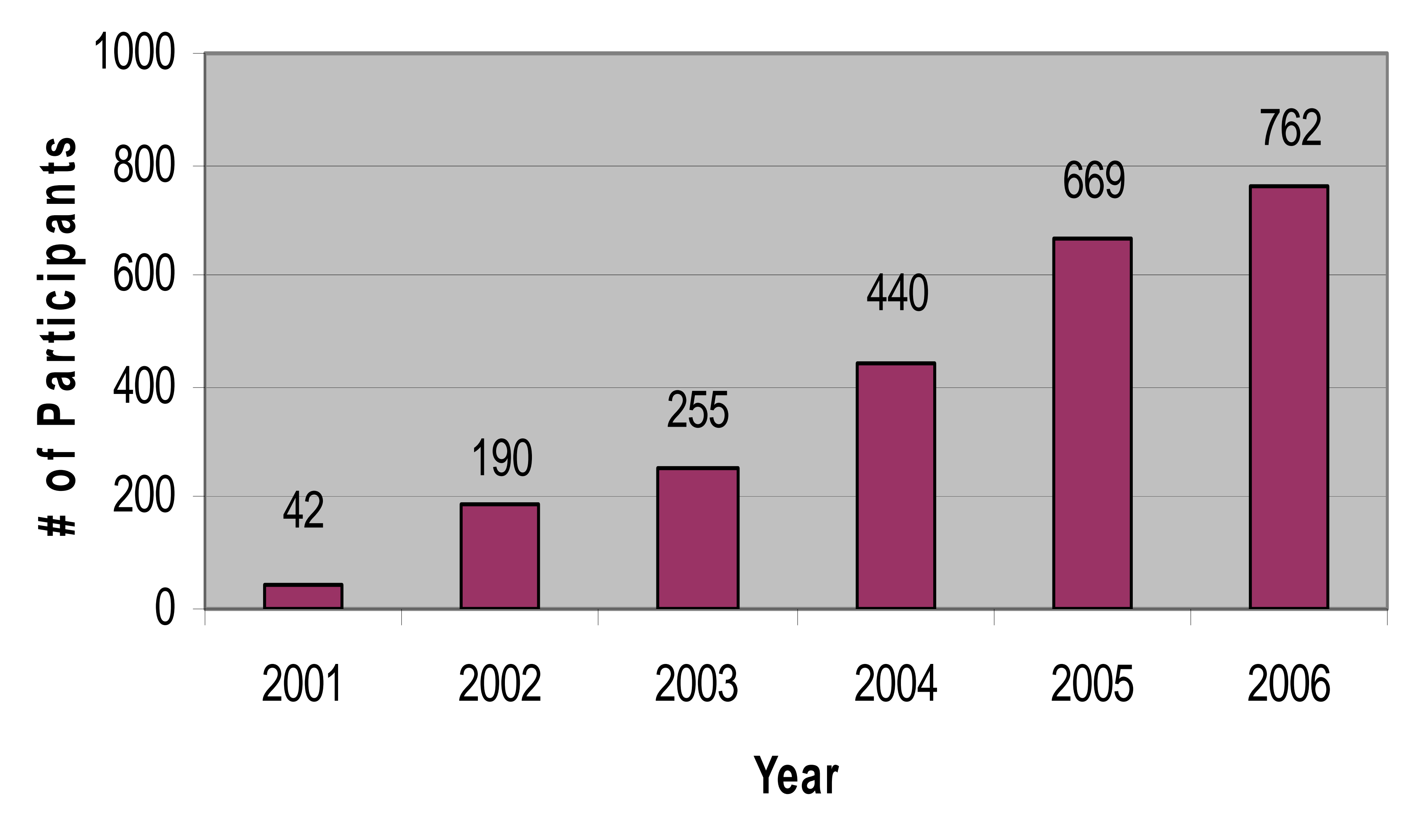
Palliative Medicine Physician Reimbursement

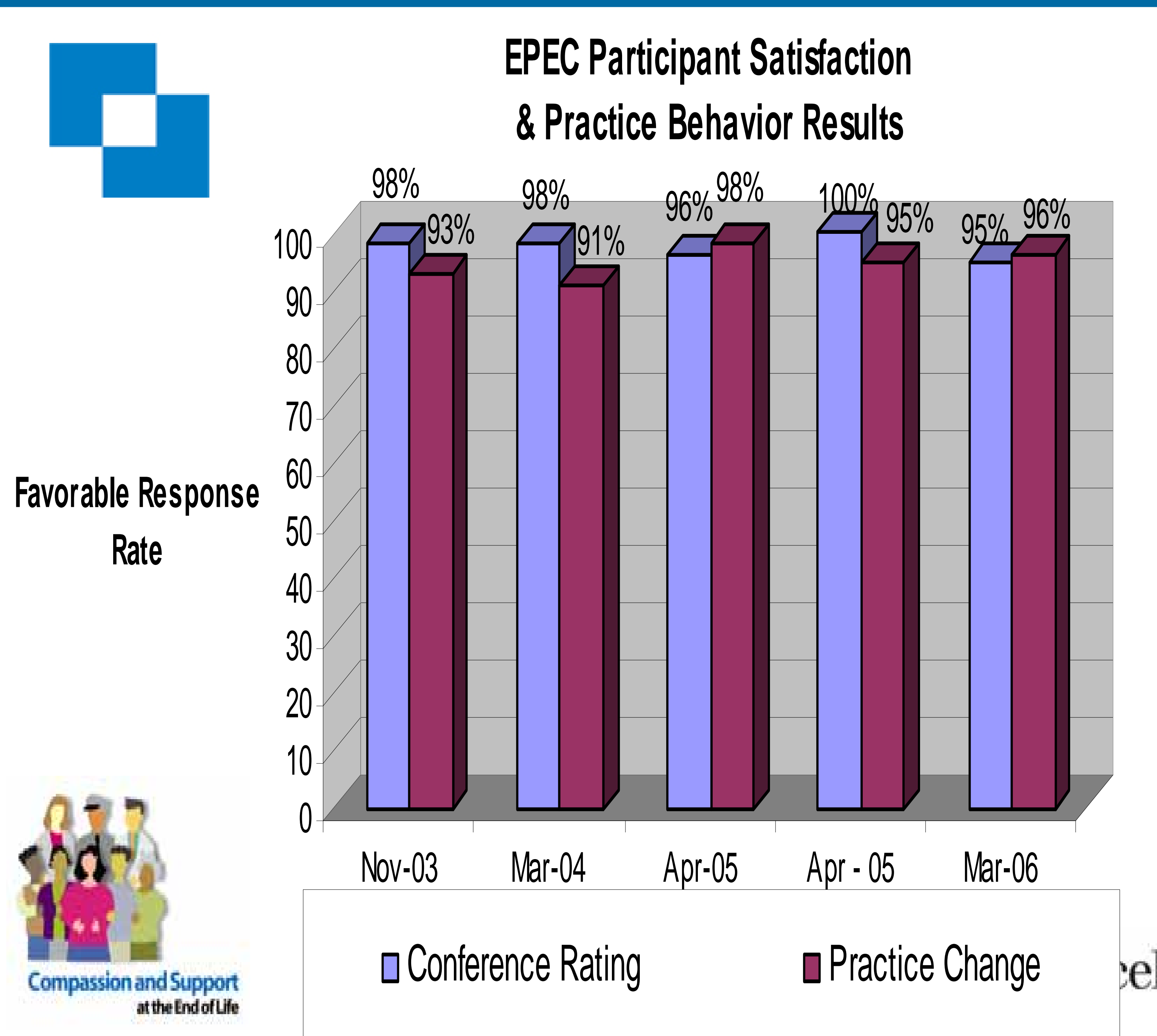

Cumulative ABHPM Certified Physicians
in the Health Plan Regions
Total # of Physicians
100
80
60
40
20
0
10
13
13
26
34
76
Pre 2001
2001
2002
2003
2004
2005
Year Certified



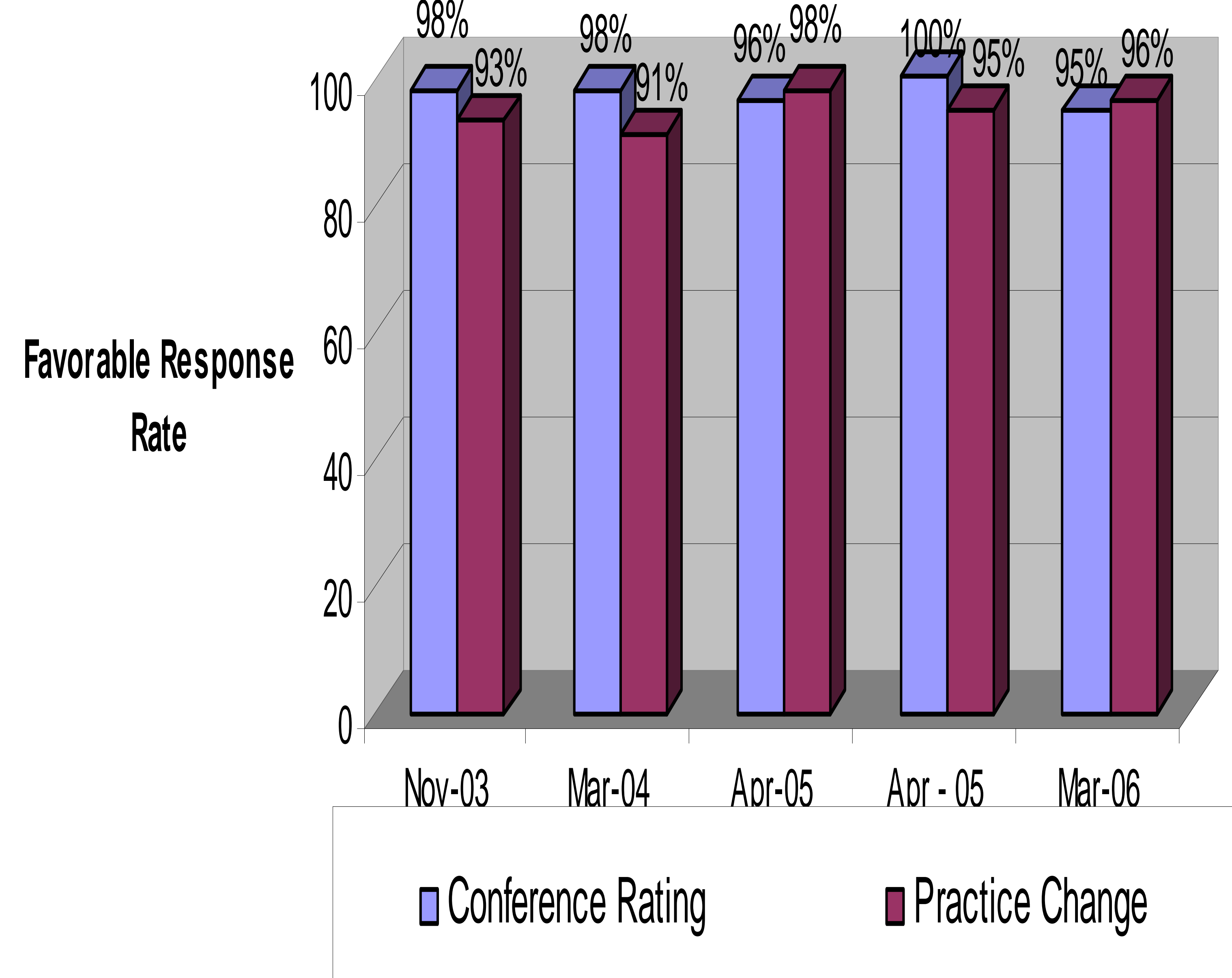
Education and Communication

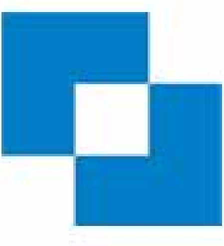
Education for Physicians on End-of-life Care (EPEC)


Cumulative EPEC Participants Trained
1000
800
600
400
200
0
# of Participants
42
190
255
440
669
762
2001
2002
2003
2004
2005
2006
Year


EPEC Participant Satisfaction
& Practice Behavior Results
Favorable Response Rate
100
90
80
70
60
50
40
30
20
10
0
98%
93%
98%
91%
96%
98%
100%
95%
95%
96%
Nov-03
Mar-04
Apr-05
Apr - 05
Mar-06
Conference Rating
Practice Change
Compassion and Support at the End of Life
cellus

EPEC Participant Satisfaction & Practice Behavior Results





Education and Communication

Community Web site

www.compassionandsupport.org

Blue on demand

THANK YOU

Patricia.Bomba@lifethc.com

www.excellusbcbs.com
www.compassionandsupport.org