Session 2E:
Practical Considerations for Developing a Palliative Care Program

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Palliative Care
Who-What-When-
Where-How-Why
Made Easy

Overview

INTRODUCTION

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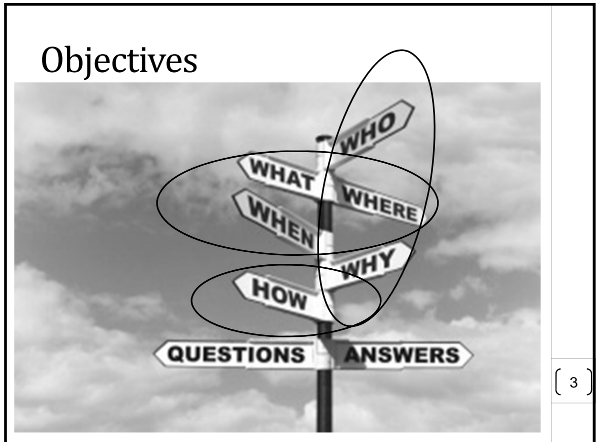
Objectives



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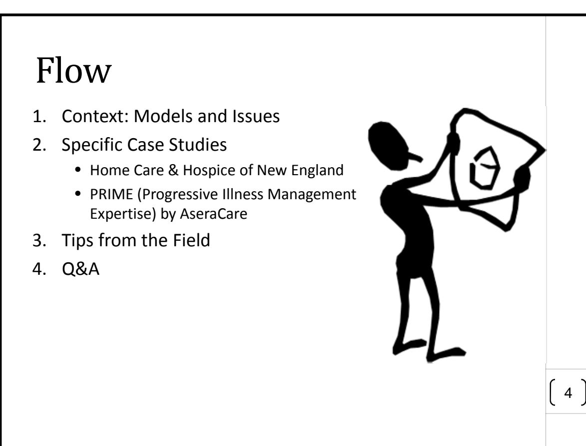
Flow

1. Context: Models and Issues
2. Specific Case Studies
   - Home Care & Hospice of New England
   - PRIME (Progressive Illness Management Expertise) by AseraCare
3. Tips from the Field
4. Q&A



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Caveats

- "If you've seen one palliative care program, you've seen one palliative care program."
- Regulations vary by state and by payer and are continually evolving – please don't take our comments as legal advice
- Beware of relying too much upon someone else's experience

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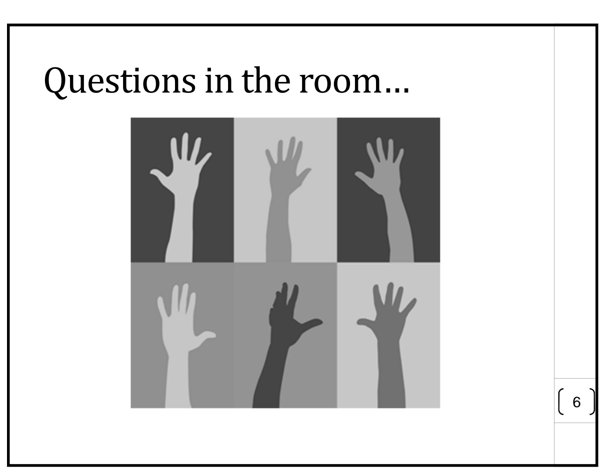
Questions in the room…



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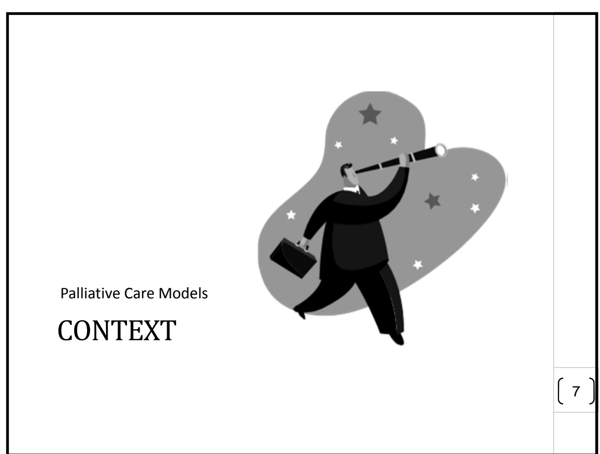

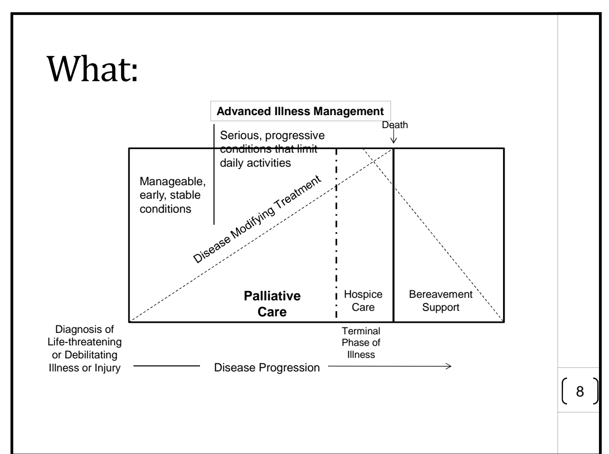

What is Palliative Care?

Center to Advance Palliative Care (CAPC)

Specialized care for ***people with serious illnesses***

- ***Focused on relief from the symptoms, pain, and stress*** of a serious illness
- goal is to improve ***quality of life*** for both the ***patient and the family***
- provided by a team of doctors, nurses and other specialists who provide an ***extra layer of support*** at any age and ***at any stage*** in a serious illness and can be provided along with curative treatment
- support patient and family, not only by controlling symptoms, but also by helping to ***understand treatment options and goals***

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What is Palliative Care?

Center to Advance Palliative Care (CAPC)

- The palliative care team provides:
  - Expert management of pain and other symptoms
  - Emotional and spiritual support
  - *Close communication*
  - *Help navigating the healthcare system*
  - *Guidance with difficult and complex treatment choices*

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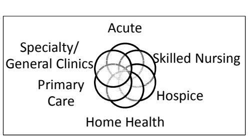
Variations



- Setting
- Task-specific (Advanced Directives vs P&SM)
- Disease-specific (Cancer vs CHF)
- Symptom-specific (Pain)
- Delivery method (Face to face, telephonic, video)

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What/Where

Common Options for Palliative Care Delivery

	Consultative	Integrative		
Setting	**Consult Service**	**Comprehensive Service ***	**Dedicated Unit**	**Case-Managed Team**
Acute	✓	✓	✓	✓
SNF/ALF	✓	✓	✓	✓
Clinic	✓			✓
Home	✓			✓
Typical Focus	Pain & Symptom Management (PSM)	PSM + Decision Support + Emotional/Spiritual Support	PSM + Decision Support + Emotional/Spiritual Support	PSM and/or Decision Support and/or Emotional/Spiritual Support

* internal or outsourced; includes QA/PI of palliative services, staff in-service education, compliance with accreditation, development of policies and procedures, serving on Committees, input to strategic planning related to palliative care

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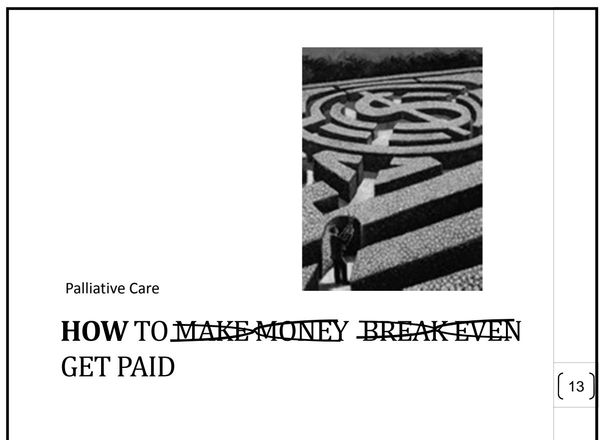
Palliative Care
HOW TO ~~MAKE MONEY~~ ~~BREAK EVEN~~
GET PAID
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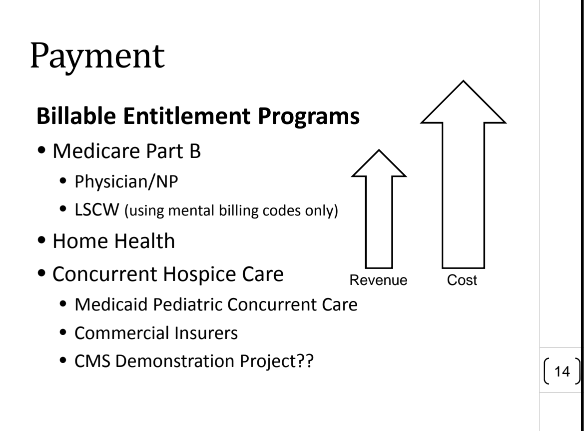
Payment
Billable Entitlement Programs
• Medicare Part B
• Physician/NP
• LSCW (using mental billing codes only)
• Home Health
• Concurrent Hospice Care
• Medicaid Pediatric Concurrent Care
• Commercial Insurers
• CMS Demonstration Project??
Revenue
Cost
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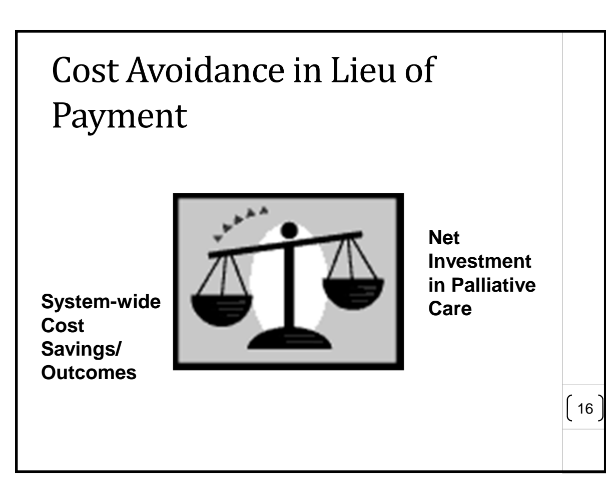
Payment (continued)
Entrepreneurial
• Contracts
• Commercial Insurer
• Hospital/Health System
• Innovation Award/ACO/Bundled Payment
• Philanthropic
• Research
• Foundations
• Private Pay Fee for Service (Concierge)
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Cost Avoidance in Lieu of Payment
System-wide Cost Savings/ Outcomes
Net Investment in Palliative Care
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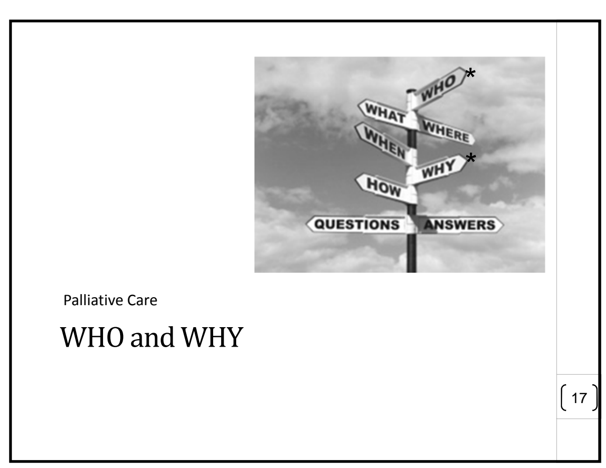
WHO*
WHAT
WHERE
WHEN
WHY*
HOW
QUESTIONS
ANSWERS
Palliative Care
WHO and WHY
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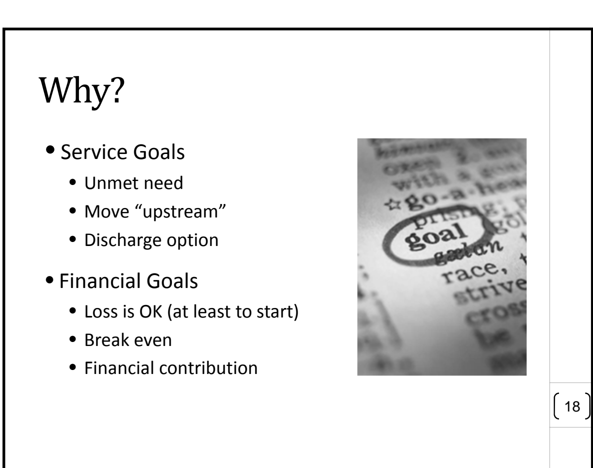
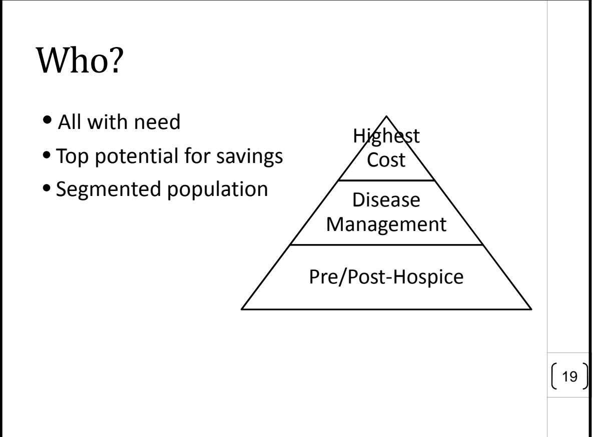
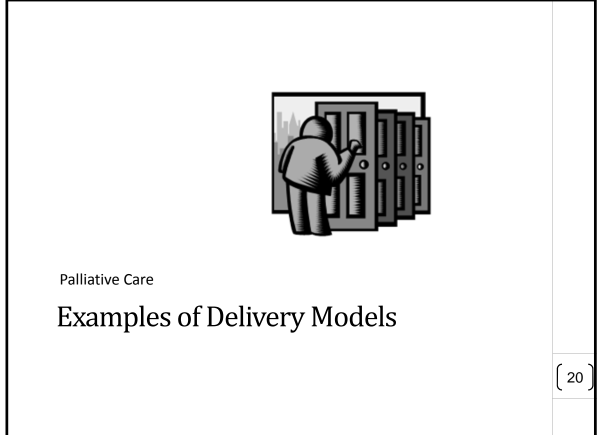
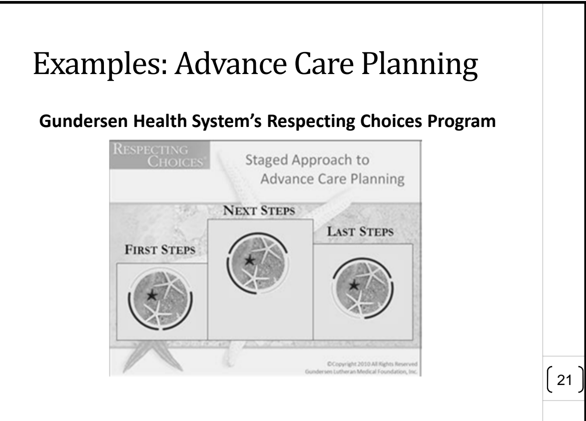

Why?
• Service Goals
• Unmet need
• Move "upstream"
• Discharge option
• Financial Goals
• Loss is OK (at least to start)
• Break even
• Financial contribution
goal
18







Example: UPHS CLAIM Project

University of Pennsylvania Health System CLAIM Project (Comprehensive Longitudinal Advanced Illness Management)

- Home Health-based program with supplemental disciplines
- Cancer
- Goal: reduce unnecessary end of life care costs and decreased quality of life
- Seed funding: Health Care Innovation Awards
- Long-term: Cost avoidance, outcome improvements

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Examples: Entrepreneurial Services

- Contractual arrangements by hospices/home health agencies to provide a combination of:
  - billable physician/NP services with
  - hospital payment for social work/chaplain and/or physician/NP administrative time
- Palliative care providers at risk for achieving savings through identification and care of high-cost chronic care patients (insurer or health system, ACO)

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Example: Lehigh Valley Health Network

- Optimizing Advanced Complex Illness Support (OACIS)
- Three-pronged service
  - OACIS Home-Based Consult Service
  - OACIS/Palliative Medicine Inpatient Consult Service
  - Palliative Care Outpatient Clinic (PCOC) – Cancer Center
- Medical Director, APNs, RN Case Manager
- Cost avoidance/improved outcomes

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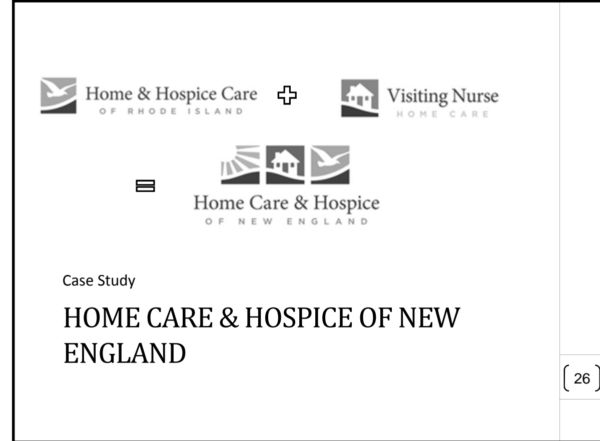

History

- **Home & Hospice Care of Rhode Island (HHCRI)**
  - Hospice ADC: 450's
  - Palliative ADC: 150
- **Visiting Nurse Home Care (VNHC)**
  - Home Care: 460's
- **Affiliation in 2012**
  - Financial strength, position for future HH/H affiliations
  - Care transitions among and between both organizations
  - Strong hospice; strong home care
  - Partnership opportunities: continuum of care

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Current Palliative Care Model

Location of Care	Staffing Model	Availability
Inpatient – Hospital Consultation *(contractual)*	MD / NP	Daily, 7-day week coverage
Inpatient – Hospital Consultation *(non-contractual)*	NP	M-F, as available
Outpatient - Hospital-Based Cancer Centers *(contractual)*	MD	Weekly
Long Term Care – Skilled Nursing Facilities	NP	M-F, dependent on relationship with Hospice
Academic - Brown University PC Fellowship	MD	One slot
Insurer - BCBSRI Hospital Initiative	MD / NP	With contracted hospitals

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Palliative Home Care

- **Establishment of Palliative Home Care Program**
  - **Internal:**
    - Home care patients with an advanced illness
    - Hospice patients who do not meet eligibility criteria
  - **External:**
    - Preferred provider for Rhode Island's only ACO, Coastal Medical (shared savings model)
    - Strategic hospital partner
    - Differentiator

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Palliative Home Care Model

- Establishment of PC business unit within home care
- Getting to Palliative Home Care
  - Time of Assessment
  - Utilization of predictive modeling data through SHP
  - Case Manager recognition
- Weekly case conference review, utilizing PC tool or template
- Education opportunity for Home Care RN Case Managers
- Hospice/PC Physician Leadership serve as liaison with Home Care
- House Calls by MD

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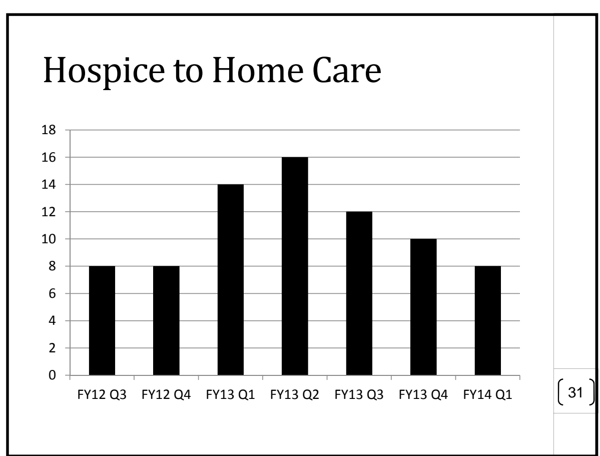
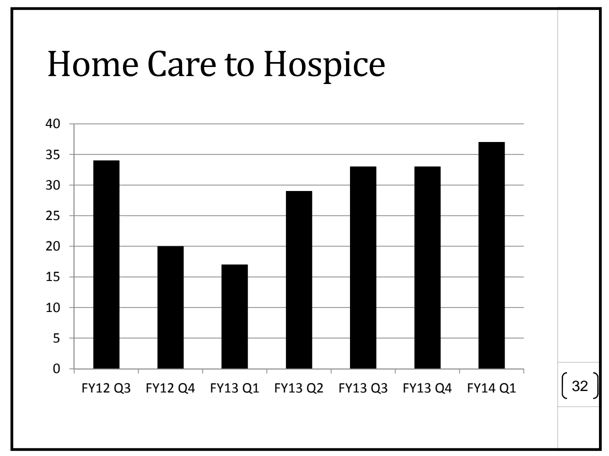
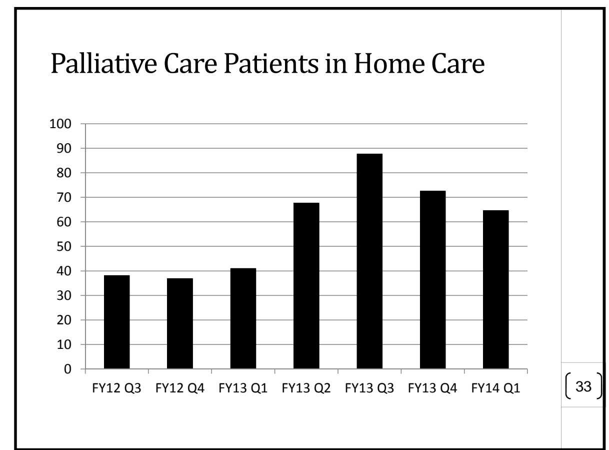
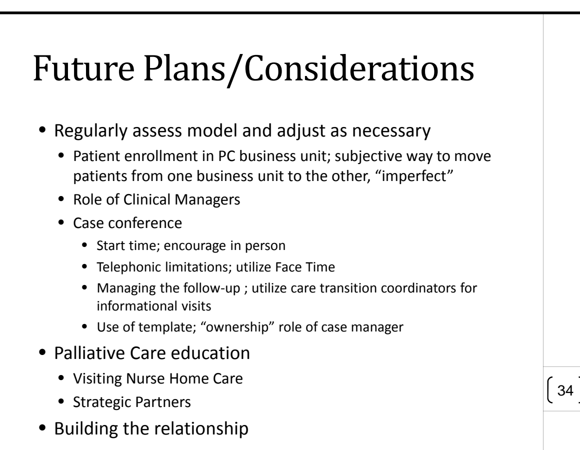

Hospice to Home Care
18
16
14
12
10
8
6
4
2
0
FY12 Q3
FY12 Q4
FY13 Q1
FY13 Q2
FY13 Q3
FY13 Q4
FY14 Q1
31


Home Care to Hospice
40
35
30
25
20
15
10
5
0
FY12 Q3
FY12 Q4
FY13 Q1
FY13 Q2
FY13 Q3
FY13 Q4
FY14 Q1
32


Palliative Care Patients in Home Care
100
90
80
70
60
50
40
30
20
10
0
FY12 Q3
FY12 Q4
FY13 Q1
FY13 Q2
FY13 Q3
FY13 Q4
FY14 Q1
33


Future Plans/Considerations
• Regularly assess model and adjust as necessary
• Patient enrollment in PC business unit; subjective way to move patients from one business unit to the other, "imperfect"
• Role of Clinical Managers
• Case conference
• Start time; encourage in person
• Telephonic limitations; utilize Face Time
• Managing the follow-up ; utilize care transition coordinators for informational visits
• Use of template; "ownership" role of case manager
• Palliative Care education
• Visiting Nurse Home Care
• Strategic Partners
• Building the relationship
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Comments/questions…
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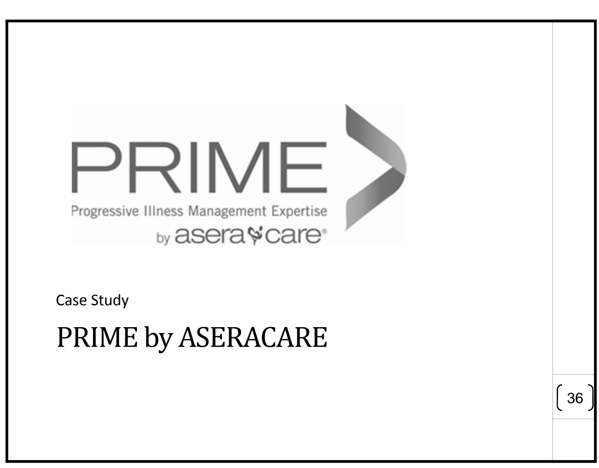
PRIME
Progressive Illness Management Expertise
by aseracare
Case Study
PRIME by ASERACARE
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History/Rationale

Program Development:

- Due diligence
  - 18 months (2010-2011)
- Identity
  - PRIME by AseraCare
- What Services
  - MD/NP Consultative Medical Model
  - NP Skilled Nurse Facility Service Model
  - NP Payor Medical Case Management Model

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History/Rationale

Program Launch:

- Inception November 2011
- 6 month pilot project
- Rapid expansion during 2012
  - 7 MD/NP Consultative Agencies
- Additional growth during 2013
  - 5 MD/NP Consultative Agencies
  - 1 NP Skilled Nurse Facility Agency (Pilot)

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Current Model

Target Population:

- Core
- MD/NP Medical Model (Community)
  - Seriously ill patients
  - End-stage disease trajectory

    1-2 years up stream from being clinically eligible for Hospice

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Current Model

Target Population:

- NP Skilled Nurse Facility Model
  - Chronically/Seriously ill patients
  - Rehab-to-Home

    2+ years up stream from being clinically eligible for Hospice
  - End-stage disease trajectory

    1-2 years up stream from being clinically eligible for Hospice
- NP Payor Medical Case Management Model
  - Risk stratified – cost avoidance

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Transitional Care

Patient-Caregiver Care Continuum

Disease Trajectory

Grief Trajectory

Palliative Medicine Supportive Care			Hospice Care	Bereavement Care
Curative/Restorative Care		High Risk of Futile Care		High Risk for Complicated Grief
Disease Presentation Stable/Unstable Self Management Educational Needs Monitoring	Life Altering/Life Limiting Periods of Decline and Stabilization Episodic, Chronic Acute Care, Community Based Care Needs (Home Health, Skilled Rehab, Outpatient Clinics)	Life Threatening Periods of Rapid Decline Critical Care Needs	Terminal	Increased Risk for Exacerbation of Illness Post Traumatic Stress Depression, Anxiety, Insomnia Mortality

Parker R; Hollis-Sells A; Twaddle M; Friend D. 2011. Used with permission

Current Model

Framework:

- Four Pillars
  - Pain and Symptom Management
  - Medication Reconciliation
  - Setting Management
  - Goals of Care
- Through Communication/Collaboration across care settings

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Current Model

Setting(s):

- Community based care/organization
- Home, Skilled Nursing Facilities, Long-term Care Facilities, Assisted Living Facilities, Personal Care Homes, etc.
- Acute/Long-term Acute Care (LTAC)
  - Selected agencies with specific relationships
  - Hospital privileges/credentialed
  - Participate in QAPI and other committees

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Current Model

Practice:

- Consults
  - 1438 (2012)
  - 4252 (2013)
- Practice
  - Unduplicated census 1430 (2013)
  - Initial/New Consults 1148 (2013)
- Setting Management
  - 93 patients (19%)
  - 292 patients (25%)

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Current Model

Core Staff:

- Board Certified MD
  Provider/Collaborative Agreement
- Advanced Practice Registered Nurse (APRN)
  Provider
- Licensed Clinical Social Worker (LCSW)
  DSM diagnoses
- Supportive Care Staff
  Social Worker, Spiritual Care Coordinator, Volunteer

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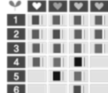
Statistics



Quality:

- Pain – 93% on a goal of 80%
- Dyspnea – 96% on a goal of 70%
- Anxiety – 91% on a goal of 70%
- Goals of Care – 93% on a goal of 98%
- Re-hospitalization – 0.4% on a goal of less than 5%

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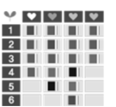
Statistics



Patient Satisfaction Survey:

- Partnered with Strategic Health Partners (SHP)
- Piloted 2013
- Full launch 2014

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Financials

- Evaluation & Management CPT Coding
- Revenue
  - Negative margin before Hospice Conversion
  - 40% of expense (2014 focus)
- Break-even model
  - Proforma builds month-over-month
  - Break-even within 12 months
- Consults per month
  - 18-22 Initial/New
  - 80-90 Subsequent/Established

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Integration with HH/Hospice

- AseraCare Hospice
  - Core business
  - Setting Management
  - 30% conversion rate
- Care Continuum
  - Across all settings over time
  - Home Health Agencies are an integral component
  - Acute Care
  - Specific partnerships

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Future Plans/Considerations

- Complement Hospice Agencies
- Projected growth for 2014
  - 8 MD/NP Consultative programs
  - 19 NP Skilled Nurse Facility programs
  - 3 NP Payor Medical Case Management programs
- Managed Care/Commercial Payors
  Case Management, member benefits
- Healthcare Systems
  - Acute, LTAC
  - Build community care continuum

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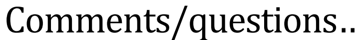
Comments/questions…



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Palliative Care

PLANNING AND DEVELOPMENT CONSIDERATIONS

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Issues in Financial Viability

- Incomplete payment mechanisms
- Optimal utilization of high-cost providers
- Over-extending services
  - Services provided
  - Patients served

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Tips

- Focus on local needs
- Assess local resources
- Look for creative leveraging of community resources
- When possible, shoot bullets first, then cannon balls

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Tips (continued)

- Think outside of legacy models
- Trust and compatible culture of partners ranked higher than logistics/systems by hospital executives
- Value of practice management

Palliative Care Models

Tips and Considerations from the Field

Resources & Acknowledgements

- Center to Advance Palliative Care - www.capc.org
- Palliative Care Center of the Bluegrass (Hospice of the Bluegrass) – Gretchen Brown, CEO
  - 1 of 8 CAPC Palliative Care Leadership Centers (PCLCs)
  - Physician practice model providing services in academic and community hospitals, NFs and outpatient clinic

Tips from the field

On Start-up and Partnering

- Pay attention to resistance - it may be well-founded and deserve further analysis
- No one knows what you will and will not do as a palliative care provider – tell them
- Don't claim outcomes (cost avoidance, readmission rates, patient/family satisfaction) without having documentation to prove it
- Your partner does not care/believe in cost avoidance findings from other providers – saying it louder won't help

Tips from the field

Especially for hospice providers…

- Avoid palliative care as 'hospice light' – it is exactly as it sounds – less - and not as good as should be expected
- Having the same provider offer both hospice and palliative care services contributes to the confusion
- Providers and consumers do not understand palliative care or hospice – saying one is not the other is not a clarification

Tips from the field

Diversify funding resources:

- Learn or buy Part B billing expertise; obtain the necessary provider numbers; be sure to have all your ducks in a row
- Train clinicians to bill effectively and collect early and often – they will hate the first part and like the second
- Fund-raise shamelessly – it's a skill set we already own

Tips from the field
Courtesy of Palliative Care Center of the Bluegrass

Physicians
- Remember that MDs are your most expensive staff, followed closely by NPs
- Set high expectations for productivity (8-10+ visits/day)
- MDs are your best marketers for PC
- Use NPs in NFs to extend MDs

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Tips from the field
Courtesy of Palliative Care Center of the Bluegrass

Payment
- Do not expect PC to generate a profit
- Do bill Part B and do it well (attention to accuracy and coding)
- Don’t give away PC - get a fair payment from hospitals
- Require hospital partners to measure the impact of PC

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Tips from the field
Courtesy of Palliative Care Center of the Bluegrass

Other
- Think twice about offering palliative home care
- Don’t provide PC to hospice patients or most of your discharged hospice patients

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Resources

- What is Palliative Care?, Center to Advance Palliative Care, 2012 http://www.getpalliativecare.org/whatis/
- Palliative Care Services: Solutions for Better Patient Care and Today’s Health Care Delivery Challenges, American Hospital Association, November 2012, http://www.hpoe.org/Reports-HPOE/palliative_care_services_solutions_better_patient_care.pdf
- Hospice and Palliative Medicine: What Are the Next Steps for a Match (National Resident Matching Program) (2012) *Signer* http://apps.aahpm.org/Default.aspx?TabID=251&ProductId=594

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Resources

- University of Pennsylvania School of Medicine. "Care At The End Of Life: Room For Improvement, Ideas For Change." *Medical News Today*. MediLexicon, Intl., 23 May. 2013. Web. 12 Aug. 2013. http://www.medicalnewstoday.com/releases/260840.php
- Palliative Care and Hospice Care Across the Continuum, Center to Advance Palliative Care, http://www.capc.org/palliative-care-across-the-continuum/

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Contact Information

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Comments/questions…

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