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

Diana Franchitto, Home Care & Hospice of New England
Amber Jones, Center to Advance Palliative Care
Bill Musick, The Corridor Group
Robert Parker, PRIME by AseraCare

Palliative Care

Overview
INTRODUCTION

Objectives
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

Flow

Questions in the room...

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
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

Variations

- Setting
  - Acute
  - Home Health
  - Hospice
  - Skilled Nursing Home
  - Primary Care
- Task-specific (Advanced Directives vs P&SM)
- Disease-specific (Cancer vs CHF)
- Symptom-specific (Pain)
- Delivery method (Face to face, telephonic, video)

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

Common Options for Palliative Care Delivery

<table>
<thead>
<tr>
<th>Setting</th>
<th>Consulate Service</th>
<th>Comprehensive Service</th>
<th>Dedicated Unit</th>
<th>Case-Managed Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SNF/ALF</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clinic</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Typical Focus

|---------------|-----------------------------------------------------|------------------------------------------|-----------------------------------------------------|--------------------------------------------------------|

* Internal or outsourced. Includes GAIN 1-2 education sessions, staff to staff education, in the hospital care management, development of policies and procedures, serving on committees, and in exchange planning relative to public use.
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??

---

**Payment (continued)**

**Entrepreneurial**
- Contracts
  - Commercial Insurer
  - Hospital/Health System
  - Innovation Award/ACO/Bundled Payment
- Philanthropic
  - Research
  - Foundations
- Private Pay Fee for Service (Concierge)

---

**Cost Avoidance in Lieu of Payment**

**System-wide Cost Savings/Outcomes**

---

**Why?**

- **Service Goals**
  - Unmet need
  - Move “upstream”
  - Discharge option
- **Financial Goals**
  - Loss is OK (at least to start)
  - Break even
  - Financial contribution
Who?

- All with need
- Top potential for savings
- Segmented population

Examples: Advance Care Planning

**Gundersen Health System’s Respecting Choices Program**

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

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)

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
Comments/questions...

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

Current Palliative Care Model

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

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

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
### 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

### Comments/questions...

---

**PRIME by ASERACARE**

Case Study

PRIME by ASERACARE
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

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)

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

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

Current Model

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

Transitional Care

Patient-Caregiver Care Continuum

Disease Trajectory

Grief Trajectory

High Risk of Public Case

High Risk For Complicated Grief

Curative/Rehabilitation Care

Supportive Care

Terminal Care

Disease Prevention/Acute Illness Management

Life threatening life limiting

Palliative Care and Rehabilitation

Acute Care, Chronic Disease Care, Home, Hospital, Extended Care

Goal Attainment

Advance Care Planning/End of Life Care

Purker R; Hollis-Solls A; Twaddle M; Friend D. 2011. Used with permission
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

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%)

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

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%

Statistics

Patient Satisfaction Survey:
- Partnered with Strategic Health Partners (SHP)
- Piloted 2013
- Full launch 2014

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
### 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

### 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

### Comments/questions...

### Issues in Financial Viability

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

### Tips

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

### Palliative Care

**PLANNING AND DEVELOPMENT CONSIDERATIONS**
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

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, NPs and outpatient clinic

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

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

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

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

Resources
• What is Palliative Care?, Center to Advance Palliative Care, 2012 http://www.getpalliativecare.org/whatis/

Contact Information
Diana Franchitto – President & CEO, Home Care & Hospice of New England
DFranchitto@hhcri.org
(401) 415-4201

Amber Jones – Palliative Care and Hospice Consultant, Center to Advance Palliative Care
ABJones@nycap.rr.com
(518) 465 - 6701

Bill Musick – Senior Associate, The Corridor Group
BMusick@corridorgroup.com
(888) 942-0405 (toll-free)

Robert Parker – Program Manager, PRIME by AseraCare
Robert.Parker@aseracare.com
(512) 422-2911
Comments/questions...