Palliative Care and Hospice in an Accountable Care Model

Key Strategies to a Successful Integrated Delivery System
Monique Reese MSN, ARNP, FNP-C, ACHPN
Timothy G. Ihrig, M.D., M.A.

Objectives

• Describe the formation and utilization of palliative care and hospice within an integrated delivery system
• Discuss strategies for tracking growth and development via metric-specific analysis of palliative care and hospice programs.
• Demonstrate the impact of expanding these services across the care continuum.
Case Study
PC Opportunities and Impact

Transitions in Care Concerns

- 1/3 of patients with chronic illness and hospitalization had no post discharge follow-up arrangements
- Less than ½ of PCPs were provided discharge information / medications
- 3% of PCPs are involved in discussions with hospitalists regarding patients’ discharge plans
- PCPs are infrequently notified that patient discharged

*“Coordinating Care – A Perilous Journey through the Health Care System” (T. Bodenheimer, MD NEJM 358 March 2008)
Readmissions

- 1 in 5 Medicare patients re-hospitalized within 30 days of discharge
- Half of these occurred before seeing outpatient physician (clinic follow up)
- Estimated cost 17.4 billion

*Jencks, Williams, and Coleman, NEJM 2009, Vol 360, 1418-1428

Table 2. Highest Rates of Rehospitalization and Most Frequent Reasons for Rehospitalization, According to Condition at Index Discharge

<table>
<thead>
<tr>
<th>Condition at Index Discharge</th>
<th>30-Day Rehospitalization Rate</th>
<th>Proportion of All Rehospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>21.0</td>
<td>Heart failure (8.6)</td>
</tr>
<tr>
<td>Heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many of these patients have</td>
<td>26.9</td>
<td>Heart failure (7.8)</td>
</tr>
<tr>
<td>palliative care needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>29.1</td>
<td>Pneumonia (26.1)</td>
</tr>
<tr>
<td></td>
<td>6.8</td>
<td>Heart failure (7.4)</td>
</tr>
<tr>
<td>COPD</td>
<td>22.6</td>
<td>COPD (36.2)</td>
</tr>
<tr>
<td></td>
<td>4.0</td>
<td>Pneumonia (11.4)</td>
</tr>
<tr>
<td>Psychoses</td>
<td>24.6</td>
<td>Psychoses (67.3)</td>
</tr>
<tr>
<td></td>
<td>3.5</td>
<td>Drug toxicity (1.9)</td>
</tr>
<tr>
<td>GI problems</td>
<td>19.2</td>
<td>GI problems (21.1)</td>
</tr>
<tr>
<td></td>
<td>3.1</td>
<td>Nutrition-related or metabolic (4.9)</td>
</tr>
</tbody>
</table>

Persistent Challenges for Quality Improvement

- Medication reconciliation
- Transitions
- Communication

*(from IHI Improvement Map gap exercise Dec 2010)*

Consequences of Inadequate Communication

For Patients facing Serious Illness:

- Physical and Emotional Suffering
- Lack of Support / Isolation
- Goal-inconsistent care
- Lack of Planning/Closure
Consequences of Inadequate Communication

For Families of Patients facing Serious Illness:
- Lack of Support
- Depression
- PTSD

For Healthcare Providers:
- Moral Distress
- Burnout
Consequences of Inadequate Communication

For the healthcare system:

- Disproportionate cost and resource use at the End-of-Life

Healthcare Reform Focus

- Better Care for Individuals
- Better Health for Populations
- Lower Cost
- TRIPLE AIM
Health Care Reform: Game Changing Options

- Hospice Concurrent Care Pilots (2012)
- Medicare Independence at Home demos
- Accountable Care Organizations (shared savings 2012)
- Bundled payments pilots (2013)
- Innovations Center (2011)

WHY PALLIATIVE CARE?

- “Palliative care teams are transforming the care of serious illness...”
- “They address the fragmentation of the healthcare system and put control and choice back in the hands of the patient and family”
- “…Palliative care is the key to delivering better quality, coordinated care to our sickest and most vulnerable patients.”

*Diane Meier, MD, director of Center to Advance Palliative Care
WHAT IS PALLIATIVE CARE?

Palliative care is *specialized medical care* for people with *serious illnesses*. This type of care is focused on providing patients with *relief* from the *symptoms, pain* and *stress* of a serious illness – whatever the diagnosis.

The goal is to improve *quality of life* for both the *patient* and the *family*.
WHAT IS PALLIATIVE CARE?

Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support.

WHAT IS PALLIATIVE CARE?

Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
SERIOUS ILLNESS

- Any disease/disorder/condition that is known to be life-limiting (e.g., dementia, COPD, chronic renal failure, metastatic cancer, cirrhosis, muscular dystrophy, cystic fibrosis) or that has a high chance of leading to death (e.g., sepsis, multi-organ failure, major trauma, complex congenital heart disease).

- NOTE: Medical conditions that are serious, but for which recovery to baseline function is routine (e.g., community-acquired pneumonia in an otherwise healthy patient) are not included in this definition.
**Goals of care**

- Physical, social, spiritual, or other patient-centered goals that arise following an informed discussion of the current disease(s), prognosis, and treatment options.

**Considerations**

- Palliative-care services are appropriate and should be available for all patients from the time of diagnosis with a life-threatening or debilitating condition.
- To ensure maximal benefit, these services should be integrated into all healthcare settings so that there is a continuum of care from diagnosis of a disease through the terminal phase.
Palliative Care Expertise

- **Primary palliative care** – All Healthcare Providers
  - Routine palliative care problems should be managed by staff involved in day-to-day care of the patient
  - Education in Integrated Chronic Care Disease Management can enhance primary PC
- **Secondary palliative care** – the Medical Specialty
  - Difficult to manage symptoms
  - Complex family dynamics
  - Challenging care decisions regarding the use of life-sustaining treatment
  - Certification and fellowship training for PC Team

Change in Service Design

Define “continuum” from different perspectives:
- Patient’s – all places & providers that assist with their journey and the gaps in between them
- Health system’s – providers and sites of care involved in delivery of medical services (Usually constrained by payment & benefit rules)
- Hospice’s – may only include services they can provide through shared resources

Copyright 2010 American Academy of Hospice & Palliative Medicine
Questions?

This concludes Part I

Session II

Dx ← LIFE PROLONGING CARE ----> Medicare Hospice Benefit
(Old)

Dx ← LIFE PROLONGING CARE → Hospice Care
(New) → Palliative Care

Define "continuum" from different perspectives:
- Patient's – all places & providers that assist with their journey and the gaps in between them
- Health system's – providers and sites of care involved in delivery of medical services (Usually constrained by payment & benefit rules)
- Hospice's – may only include services they can provide through shared resources

Bereavement

Copyright 2010 American Academy of Hospice & Palliative Medicine
Key Initiative #1

• Promote timeliness of referrals to Hospice
  – Connects patients to the right service at the right time
  – Provides holistic support to the terminally ill patient and their family
  – Prevents unnecessary ED visits and hospital admissions and readmissions
  – Connects families to bereavement services

Key Initiative #2

• Integrated PC program across the care continuum
  – Shared positions promote continuity of care during transitions across care settings
  – Shared IDT meeting promotes collaboration and improved communication regarding patients’ goals of care
  – Improves medication reconciliation and ongoing medication management
Components of Fully Integrated PC Program

- Inpatient consultation service (acute, ICU, ED)
- Outpatient practice (Home care, clinic, LTC)
- Geographical inpatient unit (could be inpatient unit and/or hospice house)

*I JOURNAL OF PALLIATIVE MEDICINE Volume 11, Number 9, 2008 © Mary Ann Liebert, Inc. DOI:10.1089/jpm.2008.0149

IHS Model of Palliative Care Delivery

- Systems-based approach
  - An organized, deliberate approach to the identification, assessment, and management of a complex clinical problem; including checklists (triggers), treatment algorithms, provider education, quality improvement initiatives, and changes in delivery and payment models.
PC Model Considerations

- Provider led vs. Nurse driven
  - Medical Specialty - similar to oncology or cardiology
  - Impact and Outcomes – symptom management, goals of care, prognostication, collaboration
  - Billable services – provider (physician and ARNP) visits are billable in all settings; LISW (or LCSW) billable in outpatient setting (psychotherapy only)

- Dyad Leadership
  - One Physician Leader with PC expertise, also provides a clinical role
  - One Administrative Leader with PC expertise, may oversee additional services (e.g. case management or hospice)
  - One Team across all sites of service – may contract across sites or dual-employ. Some members may be site specific. Providers cross all sites.
Opportunities for Palliative Care

Key Initiative #3

- Develop a standardized PC staffing metric
  - Identify Core PC IDT: physician, ARNP, RN, SW and adjuvant staff: chaplain, pharmacy, dietician, etc. to determine staffing needs
  - Staffing metric helps develop budget and identify when additional staff required
  - Productivity metric helps develop budget, supports program cost, and staff accountability
Staffing

- NQF Preferred Practice - Provide palliative and hospice care by an interdisciplinary team of skilled palliative care professionals. Including
  - Patient and family
  - physicians
  - nurses (ARNP and/or RN)
  - social workers (LISW and/or MSW)
  - pharmacists
  - spiritual care counselors
  - others who collaborate with primary health care professional(s)

IPPC Staffing Rules of Thumb

- For programs of 150 beds and up, REALLY a good idea to go with at least 1.5 FTEs, expect 200+new patients/year
- Capacity of NP, MD, MSW team with good ad hoc team support is 300-400 new/year
- Assume (very rough) 700-1000 visits per year per MD or NP provider (mix of new and f/u)
- For hospitals with 75-150 beds, consider beginning with a APN with physician back-up (Small hospital module, Appendix 2.7)

*L. Spraegens, CAPC consultant
IPPC Staffing Productivity Rules of Thumb

- New consults: 1-2 hours
- Family meetings: 1-2 hours
- Follow-up visits: 0.5 to 1 hour
- Example of typical day: 2 new consults, 1 family meeting, 3 follow-up visits = 4.5 to 9 hours of clinician time
- Depends on many factors

IPPC Estimating Referral Volume

A. 2 – 7% of hospital admissions
B. Consider other hospitals’ experience
C. Identify High Potential DRGs
   A. LOS > 2 days
   B. Fixed reimbursement (Medicare)
   C. Patients who die in the hospital

Review: top 10-20 DRGs national benchmark data for LOS cost per case
OPPC Staffing Model for ADC of 100 patients

- Physician = 0.2 FTE (administrative oversight and support for ARNP)
- ARNP = 1.0 FTE (assume 3 to 5 billable visits/day)
- LISW/MSW/RN = 2.0 to 3.0 FTEs
  - at least one LISW
  - assumes 4 to 6 visits/day with 50% of LISW visits billable
  - case load of 35 to 50 patients (mix of consultative in home care episode and primary care)

Key Initiative #4

- Standardize screening criteria (triggers) for PC consult and embed in each setting
  - Using standardized PC criteria identifies patients appropriate for PC services
  - Embedding triggers into practice in all care settings increases the potential for appropriate PC patients to be identified and served
  - Increasing PC consult volume increases ability for PC program to impact patient care delivery
Identifying Patients at High Risk

- Pain/symptom assessment
- Social/spiritual assessment
- Determination of patient understanding of illness, prognosis trajectory, and treatment options
- Identification of patient-centered goals of care
- Post-discharge transition of care

Primary Criteria

- Frequent clinic visits/ED visits/hospitalizations (more than one admission for same condition within 3 mos.)
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)
- Complex care requirements (e.g., multiple co-morbidities, functional dependency; complex home support for ventilator/antibiotics/feedings)
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)
- Need for Goals of Care and/or Advanced Care Planning discussion
PC SECONDARY CRITERIA

- Admission from long-term care facility
- Elderly patient, cognitively impaired, with acute hip fracture
- Metastatic or locally advanced incurable cancer
- Chronic home oxygen use
- Out-of-hospital cardiac arrest
- Current or past hospice program enrollee
- Limited social support (e.g., family stress, chronic mental illness)
- No history of completing an advance care planning discussion/document

Relationship Between Criteria

- **Primary Criteria** are global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative care needs.

- **Secondary Criteria** are more-specific indicators of a high likelihood of unmet palliative care needs and should be incorporated into a systems-based approach to patient identification if possible.
Extending PC Beyond Hospital

• Triggers should ensure fewer needs go unmet, prevent crises and hospitalizations for manageable problems, and improve quality of life (per *Journal of Palliative Medicine* editor-in-chief Charles F Von Gunten)
• However, recent findings that PC patients often report a lack of supportive information upon hospital discharge concern Von Gunten
• He urges primary care physicians and specialists alike extend the reach of PC by working to ensure smooth transitions between care settings

---

Palliative Care Patients

- Chronic Illness
- Pediatrics
- Geriatrics
- Palliative Care
- Inpatient Care

---
Key Initiative #5

• Provide education to billable staff and auditing of billing practices
  – Maximize billable services by improving billing practices (time and complexity)
  – Sharing audit results with providers identifies best practice and opportunities for additional education and support
  – Ensures compliance with laws and regulations

How do we pay for it?

• Medicare allows two physicians of like specialty to bill on the same day with the same CPT codes if they utilize different diagnoses.
• For Palliative Care Consultations that coincide with the date of the primary physician’s visit; the Attending Physician should bill the primary disease code and the Palliative Care Consultant bills codes related to symptoms.
PCC Team billing – who can?

• Physicians, *NPs or *CNS, *PAs - use CPT/ICD9
• *receive 85% reimbursable charges
• LISW’s/LCSW’s use DSM IV codes such as “Adjustment disorder”
• Many private insurance plans cover all visits with prior approval of the plan of care – ask for it!

Key Initiative #6

• Continue to develop PC metrics to include 4 domains and review monthly/quarterly/annually
  – Implementation of standardized use of ESAS, PC interventional tools, SBAR to support clinical metrics
  – Standardize policies and processes to support operational metrics
  – Standardize customer satisfaction tools
  – Standardize staffing/productivity and billing expectations, report percentage of PC patients converted to hospice and hospice volumes and ALOS/MLOS to support financial metrics
The Purpose of Measurement

- External and Internal quality assessment
- Demonstrate value
- Research/Exploratory Quality Improvement Initiatives

Metric Domains

- Operational
  - Does my program have the features required to provide high quality palliative care?
  - What metrics do I need to measure in order to demonstrate my program has these cores features?
- Clinical
  - Am I improving the clinical care of patients?
    - Symptom assessment scores, psychosocial assessment scores
  - Customer
    - Am I meeting the needs of patients and families?
      - Satisfaction survey data: patient, family, referring clinician
- Financial
  - Is my program fiscally responsible?
Metric Definitions Considerations

• Reporting frequency
• Timeframe
• Overall Criteria
• Database (manual entry) vs. data pull
• Database Elements
• HIPPA!

Metric Definition Components

• Source
• Measure
• Numerator
• Denominator
• Definitions
• Inclusions and Exclusions
• Additional Clarification
Consultation Volume

Number of Inpatient Visits with Palliative Care Consultations

Consultation Rate

Measure 1.c. Inpatient Palliative Care Consultation Rate

<table>
<thead>
<tr>
<th></th>
<th>Jul-11</th>
<th>Aug-11</th>
<th>Sep-11</th>
<th>Oct-11</th>
<th>Nov-11</th>
<th>Dec-11</th>
<th>Jan-12</th>
<th>Feb-12</th>
<th>Mar-12</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>12 mos</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>9.8</td>
<td>13.3</td>
<td>10.3</td>
<td>10.6</td>
<td>13.0</td>
<td>11.5</td>
<td>16.0</td>
<td>14.5</td>
<td>12.7</td>
<td>13.1</td>
<td>13.6</td>
<td>9.9</td>
<td>12.3</td>
</tr>
<tr>
<td>B</td>
<td>4.9</td>
<td>5.1</td>
<td>4.4</td>
<td>5.2</td>
<td>5.3</td>
<td>3.8</td>
<td>5.6</td>
<td>3.9</td>
<td>3.4</td>
<td>4.3</td>
<td>4.3</td>
<td>4.1</td>
<td>4.6</td>
</tr>
<tr>
<td>C</td>
<td>5.7</td>
<td>4.8</td>
<td>5.0</td>
<td>3.9</td>
<td>6.2</td>
<td>7.8</td>
<td>18.8</td>
<td>16.0</td>
<td>10.2</td>
<td>13.4</td>
<td>16.9</td>
<td>11.4</td>
<td>9.5</td>
</tr>
<tr>
<td>D</td>
<td>0.4</td>
<td>0.0</td>
<td>1.5</td>
<td>3.4</td>
<td>2.4</td>
<td>1.9</td>
<td>1.7</td>
<td>3.5</td>
<td>2.2</td>
<td>2.0</td>
<td>0.4</td>
<td>0.8</td>
<td>1.7</td>
</tr>
<tr>
<td>E</td>
<td>5.3</td>
<td>5.9</td>
<td>5.3</td>
<td>5.9</td>
<td>6.6</td>
<td>5.4</td>
<td>8.2</td>
<td>7.2</td>
<td>5.8</td>
<td>6.5</td>
<td>6.6</td>
<td>5.4</td>
<td>6.1</td>
</tr>
</tbody>
</table>

IHS 5.3 5.9 5.3 5.9 6.6 5.4 8.2 7.2 5.8 6.5 6.6 5.4 6.1
Discharges from OPPC

% of OP Palliative Care Patients Discharged Alive by Discharge Type

Readmission Rates for OPPC Patients

3b. Readmissions to Acute Inpatient Care (Excludes Referred from IPPC)

<table>
<thead>
<tr>
<th></th>
<th>Jul-11</th>
<th>Aug-11</th>
<th>Sep-11</th>
<th>Oct-11</th>
<th>Nov-11</th>
<th>Dec-11</th>
<th>Jan-12</th>
<th>Feb-12</th>
<th>Mar-12</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Rolling 12 Month Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5.1</td>
</tr>
<tr>
<td>D</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>E</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6.1</td>
</tr>
<tr>
<td>F</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>G</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IHS</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>11.0</td>
</tr>
</tbody>
</table>
Share Metrics with Key Stakeholders

- Identify internal and external stakeholders
  - Administrators/Leadership (system, regional, service lines, etc.)
  - Physicians (primary care, specialists)
  - Healthcare Service Partners (hospital, home care, hospice, clinic, nursing home, etc.)
  - Community Partners (Area Agency Aging, Churches/Parish Nurses, Community Groups, etc.)
  - State (HPCAI) & National (CAPC, NHPCO, AAHPM, etc.)

PC Expansion Opportunities

- Emergency Room
- Clinic
- Long Term Care
- Telemedicine
Best Outcome For Every Patient
Every Time

- Right Patient: Identify appropriate patients
- Right Time: Ensure timely referral
- Right Service: Coordinate Care