Objectives

- Understand the role of palliative care in the current health care environment
- Identify key components of a successful palliative care program to ensure sustainability
- Identify opportunities and barriers to expand palliative care services across the care continuum
Palliative Care Overview

- Specialized medical care for people with serious illness
- Interdisciplinary approach to care focusing on providing relief of symptoms, pain and stress of a serious illness in order to improve quality of life for the patient and family
  - Assessment and treatment of patient’s physical and emotional/spiritual distress
  - Communication and decision making with patients and their families to establish achievable patient-centered goals of care
  - Coordination of transitions of care and support for practical needs of patients and families

Why is Palliative Care needed?
Current state: A year in the Life of a Patient

- 6 Social Workers
- 13 Meds
- 5 Hospital Admissions
- 6 Weeks SNF Care
- 37 Nurses
- 22 Clinic Visits
- 19 Occupational Therapists
- 5 Physical Therapists
- 6 Community Referrals
- 2 Nursing Homes
- 16 Physicians
- 2 Home Care Agencies
- 5 Months of Home Care

Source: Johns Hopkins, RWJ 2010 (G Anderson)
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
About UnityPoint Health

- **System**
  - Integrated health system with physician-led team of professionals
  - Address patient’s health care in the most appropriate setting: whether that is *a clinic, a hospital or at home*
  - 280 physician clinics, 29 hospitals in metropolitan and rural communities and home care services throughout its 8 regions, provides care throughout Iowa and Illinois.

- **Palliative Care Service**
  - 8 integrated palliative care sites (inpatient and outpatient)

- **Patients served annually**
  - Inpatient- 4000 consults
  - Outpatient- 1000 consults

PC Relationships

- **Hospitals:**
  - PC recognized as essential component for co-management of the sickest and most complex patients served in hospitals - rather than just an “end of life” service line
  - Provide expert clinical consultation to colleagues, educate hospital staff and students
  - Integration into ICU and ED
  - Strive to integrate palliative care principles throughout institution, seeking to align with mission and improve key quality outcomes
    - Improving quality
    - Reducing variation in care
    - Reducing avoidable readmissions
    - Ensuring patient safety and satisfaction
    - Planning for bundled payment systems
PC Relationships

• Home Care:
  – Coordinate assessment and treatment of physical and emotional/spiritual distress, including pain, depression and SOB, and of family burnout and exhaustion, clarification of goals

• Hospice
  – Honor patient’s and their families wishes
  – Seamless transition of continuity of care for patient/ family
  – Earlier appropriate referrals providing more positive outcomes for end of life journey

• Physician Clinics
  – Patient centered medical homes increase demand for expertise in managing the sickest and costliest patients
  – Outpatient co-management clinic within a host clinic (cancer, pulmonary, cardiac)
  – Coordination of transitions of care and support
  – Decrease duplication and gaps in service

PC Relationships

• Nursing Facilities
  – Partner together to improve the quality and continuity of care for seriously ill, chronically ill
  – Patient centered care focused on pain and other symptoms
  – Superb communication and safe and effective transitions can offer solutions to the problems facing nursing home
  – Sufficient knowledge of best practices exists to support development of palliative care in nursing facilities
  – Intersect with existing quality improvement and culture change efforts to affect quality of life for most fragile and vulnerable
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.

Considerations

- Available from time of diagnosis
- Tailored to the needs of the patients and community served
- Integrated into all healthcare settings
- Attention to the culture of the care setting.
- Access to primary and secondary palliative care
- Maintain an interdisciplinary team
Primary Stakeholders

- Patients and families
- Hospitals: Board of Directors, executive leadership, administration, providers, staff
- Nursing facilities
- Physician primary and specialty clinics
- Regulatory bodies
- Third party payers

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)

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

- Patient Population/ PC screening criteria
- Staffing/ IDT
- Program Funding/Reimbursement
- Quality
- Metrics

PC Primary Criteria

- Uncontrolled symptoms (dyspnea, n/v, pain>5/10)>/=24 hours
- Complex care requirements ( age >/=70 with presence of 2 or more life threatening co-morbidities and declining functional status
- Need help with complex decision making and determination of goals of care and/or Advanced Care Planning discussion
- Frequent admissions ( 2nd ED/ hospital visit in last 6mo. for same diagnosis
- Patient ( esp. long term care resident) with DNR orders
- Specific ED, ICU, disease specific criteria available
The PC IDT

- Provider led- Palliative Medicine
- Skilled, competent professionals
- Consider on-going education/ training/ certification/ credentialing
- Interdisciplinary Team members
  - (physician, ARNP, RN, MSW, Chaplain, admin support, Dietician, Pharmacy, Therapy, and others who collaborate with primary healthcare professionals)
- Patient and amily Centric focus

Acute Site of Service Direct Care Staffing Options

<table>
<thead>
<tr>
<th></th>
<th>Consults/ bed</th>
<th>FTEs per 100 beds (MD/ ARNP)</th>
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<tbody>
<tr>
<td>Mean</td>
<td>1.4</td>
<td>.78</td>
</tr>
<tr>
<td>75 percentile of “moderate” size</td>
<td>2</td>
<td>1.02</td>
</tr>
<tr>
<td>600 beds at mean ratio</td>
<td>854 total consults</td>
<td>4.75 fte (.78*600/100)</td>
</tr>
<tr>
<td>600 beds at 75% ratio</td>
<td>1200 total consults</td>
<td>6.12 fte (1.02*600/100)</td>
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</table>
UnityPoint DM Integrated Model

<table>
<thead>
<tr>
<th>IPPC</th>
<th>FTE</th>
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<tbody>
<tr>
<td>ARNP</td>
<td>2 (1 Pediatric specialty)</td>
</tr>
<tr>
<td>RN (coordinator)</td>
<td>1</td>
</tr>
<tr>
<td>RN</td>
<td>1.1</td>
</tr>
<tr>
<td>OPPC</td>
<td></td>
</tr>
<tr>
<td>ARNP</td>
<td>2</td>
</tr>
<tr>
<td>RN (coordinator)</td>
<td>1</td>
</tr>
<tr>
<td>Dual</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td>0.2</td>
</tr>
<tr>
<td>Physician</td>
<td>0.9</td>
</tr>
<tr>
<td>Chaplain/ Counselor</td>
<td>1</td>
</tr>
<tr>
<td>LISW</td>
<td>1</td>
</tr>
<tr>
<td>Administration</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>11.2 FTE</td>
</tr>
</tbody>
</table>

OPPC Suggested Direct Care Staffing Model for ADC of 100 patients

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

- Diverse portfolio of resources
  - Direct hospital support (reducing high-cost, long-stay, inadequately reimbursed care that doesn't meet patient goals and values)
  - Philanthropy
  - Inpatient billing - fee for service for physician and ARNP
    - Time intensive, largely cognitive work, does cover much of program costs
    - Medicare allows two providers 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 provider’s visit; the Attending Provider should bill the primary disease code and the Palliative Care Consultants bill codes related to symptoms

Outpatient PC Reimbursement

- Physicians, NPs or Clinical Nurse specialists, Physicians Assistant’s use CPT/ICD9 and receive 85% RCC
- LISW’s/LCSW’s use DSM IV codes such as “Adjustment disorder”
- Some private insurance plans cover visits with prior approval of the plan of care
- Contracts for service- nursing facilities
- Pearl: V66.7 Secondary diagnosis code
  - Encounter for Palliative Care
  - A billable medical code that can be used to specify a diagnosis on a reimbursement claim.
  - NOTE: ICD-10-CM Diagnosis Code Z51.5 will replace V66.7 effective October 1, 2013
Quality

• 2006- National Quality Forum
  – Framework for Palliative and Hospice Care Quality Measures and Reporting
  – Within document, accepted the Clinical Practice Guidelines for Quality Palliative Care
    • Eight Domains
      – Structure and processes of care
      – Physical aspects of care
      – Psychosocial and psychiatric aspects of care
      – Social aspects of care
      – Spiritual, religious, and existential aspects of care
      – Cultural aspects of care
      – Care of the imminently dying patient
      – Ethical and legal aspects of care

Evidence Based Practice

• National Consensus Project for Quality Palliative Care and Corresponding NQF Preferred Practices (38)
  – Used 8 Domains and developed preferred practices for each
  – Ex: Guideline 1.1 (Structure and Processes of Care)
    • The timely plan of care is based on a comprehensive interdisciplinary assessment of the patient and family.
    • Guidelines used to create and sustain quality program-annual assessment, strategic planning, etc.
Metric Domains

- Operational
- Customer Satisfaction
- Metrics
- Financial
- Clinical

Operational Metrics

- New Consults and trend
- Consult rate as % of hospital admissions (natl av: 4-10%)
- F/u visits; ADC
- LOS pre- and post consult
- Discharge status
- Death as % of consults seen
- % of hospital deaths seen by palliative care
- Consults and f/u by provider
- Billed services by provider
- Hours of clinical time by providers
Clinical Metrics

- Pain/Symptom management impact
- Advance care planning/ IPOST
- Patient /family satisfaction with care
- Provider satisfaction with consult service

Clinical Outcomes

<table>
<thead>
<tr>
<th></th>
<th>IPPC</th>
<th>OPPC</th>
<th>IPPC</th>
<th>OPPC</th>
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<tbody>
<tr>
<td>PAIN</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>4</td>
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<tr>
<td>DYSPNEA</td>
<td>46% and 31%</td>
<td>49% and 26%</td>
<td>46% and 31%</td>
<td>49% and 26%</td>
</tr>
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Advanced Care Planning

Customer Satisfaction

- Who is customer?
- Consider surveys already in use
- Flag PC patients
  - Automatically have a control group
  - Is volume statistically significant?
  - Total response or specific response fields?
Financial Metrics

- Monthly costs per consult (costs/volume)
- Net billing revenue (overall and by consult)
- Annual “cost avoidance” impact
- % of consulted patients with re-admissions

**Total ED Visits & Hospitalizations**

<table>
<thead>
<tr>
<th>Month</th>
<th>PreConsult</th>
<th>PostConsult</th>
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<tbody>
<tr>
<td>Oct</td>
<td></td>
<td></td>
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<tr>
<td>Nov</td>
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<td>Dec</td>
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<td>Aug</td>
<td></td>
<td></td>
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<tr>
<td>Sep</td>
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</tbody>
</table>
Identified Barriers/ Challenges

Barriers
- Urban vs. Rural
- Community and Provider Culture
  - Still some misunderstanding with physician community by wrongly correlating it with hospice/end of life care
- Geographic areas (outpatient PC) and departments (inpatient PC)
- Resources

Opportunities for Palliative Care
- Inpatient Consult Service
- Outpatient Specialty Clinics
- Outpatient PCP Clinics
- Provider Home Visits
- SNF Consult Service
- Telemedicine
- Inpatient Unit
**Total Variable Direct Cost**

1,973 patients consulted for Palliative Care, broken down by site of service: Inpatient (1,767 patients) and Outpatient (206 patients)

Oct 2011-Sept 2012

- Sum of IP
- Sum of OP

**Total ED Visits and Hospitalizations**

1,973 patients consulted for Palliative Care, broken down by site of service: Inpatient (1,767 patients) and Outpatient (206 patients)

Oct 2011-Sept 2012

- Sum of IP
- Sum of OP
Goals of our PC services

• Demonstrate improvement in patients’ physical and psychosocial symptoms and reduce avoidable patient suffering and distress

• Improve patient and family centered care and optimize quality of life and satisfaction with their health care providers

• Prevent adverse events and lead to better outcomes, few readmissions and shorter hospital stays- transitioning patients to right level of care at right time

Best Outcome For Every Patient Every Time

- Right Patient
  - Identify appropriate patients

- Right Time
  - Ensure timely referral

- Right Service
  - Coordinate Care