Thinking Outside the Box of Medicare Hospice/Home Health: Palliative Care and Advanced Illness Management

Sharyl Kooyer, Sutter Care at Home
Bill Musick, The Corridor Group
Robert Parker, PRIME by AseraCare

INTRODUCTION
Objectives

Flow

1. Context: Models and Issues
2. Specific Case Studies
   - PRIME (Progressive Illness Management Expertise) by AseraCare
   - Advanced Illness Management Program – Sutter Care at Home
3. Q&A
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

Questions in the room...
Palliative Care Models

CONTEXT

What?

Advanced Illness Management

- Serious, progressive conditions that limit daily activities

Manageable, early, stable conditions

- Disease Progression

Disease Modifying Treatment

Palliative Care

- Diagnosis of Life-threatening or Debilitating Illness or Injury

- Hospice Care

- Bereavement Support

Terminal Phase of Illness

Death

Disease Progression
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

---

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*
Variations

- Setting
  - Acute
  - Skilled Nursing
  - Primary Care
  - Specialty/General Clinics
  - Hospice
  - Home Health

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

Palliative Care

HOW TO MAKE MONEY BREAK EVEN GET PAID
Payment

**Billable Entitlement Programs**
- Medicare Part B
  - Physician/NP
  - LCSW (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

Net Investment in Palliative Care

Palliative Care

WHO and WHY
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
Palliative Care

Examples of Delivery Models

Examples: Advance Care Planning

Gundersen Health System’s Respecting Choices Program

[Diagram showing Staged Approach to Advance Care Planning]
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

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
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)

Comments/questions...
Case Study

PRIME by ASERACARE

History

Program Development:

Due diligence
18 months (2010-2011)

Identity
PRIME by AseraCare

What Services
NP Consultative Medical Model
NP Skilled Nurse Facility Primary Care Service Model
NP Payer Medical Case Management Model
History

Program Expansion:

Community-based NP
16 programs in 9 states

Skilled Nursing Facility
5 programs in 3 states
10 programs in development

Payer Medical Case Management
1 Managed Medicaid payer

ACO, palliative outpatient clinics, hospital system partnership opportunities

Why

Poor Transitional Care

Care Silos
- Acute
- Skilled Nursing Facility
- Commercial/Managed Care Payers
- Physician/Physician Groups
- Community at Large
PRIME by AseraCare

Four Pillars:
- Pain and Symptom Management
- Medication Management
- Setting Management
- Advance Care Planning

PRIME by AseraCare

Core Staff:
- Advanced Practice Registered Nurse (APRN)
  - Provider
- H&P Board Certified MD
  - Collaborative Physician
- Licensed Clinical Social Worker (LCSW)
  - DSM diagnoses
PRIME by AseraCare

**Framework:**
- Patient-caregiver Care Continuum
- Communication and Collaboration
  - Healthcare Systems
  - PCPs
  - SNFs and SNF Attending
  - Home Health Agencies
  - Other care settings
  - NP as Community Case Manager

---

PRIME by AseraCare

**NP Community Model:**
- Across all settings
  - Seriously ill patients with progressive illness
  - High-risk for futile care
  - End-stage disease trajectory
    - 1+ years out from being clinically eligible for Hospice
NP Community Model

PRIME by AseraCare

NP SNF Model:
- Dedicated to individual SNF
  - Chronically/Seriously ill patients
  - Rehab-to-Home
  - 2+ years out from being clinically eligible for Hospice
  - Periods of decline and stabilization
  - Potential for high risk of futile care
  - Plus end-stage disease trajectory
NP SNF Model

NP Payer Model:
- NP Medical Case Management
  - Life altering, life limiting care needs
  - 4+ years up stream from being clinically eligible for Hospice
- Focus on high utilization of resources
- Patient self-management focus
- Risk stratified – cost avoidance

PRIME by AseraCare
NP Payer Model

Statistics

Practice:

- Initial/New Consults
  - 2664 (program to date July 31)
- Total Consults
  - 10,128 (program to date July 31)
- Hospice Conversions
  - 666 patients (program to date July 31)
  - 25% conversion rate (program to date)
  - 30% conversion rate (YTD 2014)
Statistics

Quality:
- Pain: 94% on a goal of 80%
- Dyspnea: 99% on a goal of 70%
- Anxiety: 98% on a goal of 70%
- Goals of Care: 98% on a goal of 100%
- Re-hospitalization: 1.3% on a goal of <5%

Financial

Reimbursement constraints:
- Fee-for-service
- Payer

Gaps in knowledge:
- Consumer confusion
- Industry confusion
Financial

Revenue:
- Break-even model
  - Proforma builds month-over-month
  - Break-even within 12 months
- SNF model
  - Easier model to break-even
  - Consolidated patient set

Financial

Revenue:
- Community consults per month
  - 18-22 Initial/New
  - 80-90 Subsequent/Established
- SNF consults per month
  - 60 Initial
  - 240 Subsequent
Financial

Revenue:
- Evaluation & Management CPT Coding
  - All three services lines
  - Payer model additional revenue through gain sharing
- Negative margin before hospice conversion
- Other - risk share, PMPM

Comments/questions...
Sutter Health / Sutter Care at Home

**Advanced Illness Management (AIM®)**
A Model for Palliative Care and Complex Care Management

Health Care Innovations Awards – Sutter Care at Home
Advanced Illness Management

“The project described was supported by Grant Number 1C1CMS331005 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.”

"The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies."
THE AIM JOURNEY: 2008 - PRESENT

• Imperative for AIM

• Model Design Characteristics

• Person Centered Care

• System Integration

• Impact on Care Outcomes

*The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.*

The ‘AIM’ Patient Experience

When I have Advanced Illness, this is how I’ll spend the last year of my life:

- Hospital
  - I’ll spend 17 days in the hospital, 12 in the ICU

- Home
  - I’ll take 18-30 medications; several times a day
  - I’ll make 54 trips to 9 different doctors and still not know who decides what

Additional Statistics

• Medicare will spend 28% of all their payments on a patient in the last year of life
• Medicare will spend ~$214M per year for 5,000 patients in the last year of life
• Patients have a 25% chance of receiving hospice care where they will spend 8 days on service before dying
• Patients in the last year of their lives represent 5% of the population that spends the highest amount of Medicare dollars and take the most time and resources from providers

Source: Data of Sutter Experience – “The Care of Patients with Severe Chronic Illness”, Dartmouth Atlas, 2006

*The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.*
The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
PERSON CENTERED CARE

- Teach Back
- Chunk and Check
- Motivational Interviewing
- Evidence-based Care Management
- Evidence-based Palliative Care

Clinician

Patient/Family

- Bubble Diagrams
- Stop Light Forms
- SMART Goals
- Medication Management
- POLST
- Mock Runs
- Personal Health Record

CLOSER LOOK AT INTEGRATION

1. Referral
2. Home Based Visits
3. Phone Visits
4. Critical Event
5. Discharge

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
STAFFING MODEL

- **AIM Team Members**
  - AIM Home Health
    - (HH RNs, MSWs, plus other disciplines)
  - AIM Transitions
    - (former Hospice RNs and MSWs)
  - AIM Hospital Based
    - (AIM Care Liaison, RN, former Hospice)
  - AIM Telesupport/Office Based Case Management
    - (RN – mixed experience)

- **Case Loads**
  - AIM Home Health: 13-17 pts
  - AIM Transitions: 15-20 pts
  - AIM Telesupport: 60-80 pts
  - AIM Administrator (also Hospice Administrator)
  - Leadership Team=HH, Hospice, AIM

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

AIM: TOTAL COST OF CARE

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
Examples of AIM Measures

Care at the End of Life
- % Transferred to Hospice
- % Died in Hospital
- Hospital Days in Last 6 months of life
- ED Use in Last 30 Days of Life
- ICU Use in Last 30 Days of Life
- LOS of Hospice Stay

Outcomes, Resources and Costs
- Inpatient and ED visit Rates per 100 patients
- 30, 90 and 180 Day Pre/Post Enrollment Utilization
  - Hospital
  - ED
  - ICU
  - ALOS in Hospice
- 90 Day Payer Impact, Hospital Cost Impact, Total Cost of Care
- Independent Research and Evaluation

Closer Look at Care Integration

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
IMPACT ON CARE

- Now serving 15 counties; enrolled more than 6,500 persons with advanced illness; 335 staff members trained
- Current census is 2,100+; 85,000 patient contacts last 12 months
- CMS awarded Sutter with a $13 million Innovation Challenge grant to fund the ongoing implementation and evaluation of the AIM program; Sutter provided $21.4 M
- Ongoing high patient and provider satisfaction.

Interim Results: 90 Day Pre/Post Cost Analysis
12 Months Rolling Q2 2013- Q1 2014
9 Out of 10 Sites Reporting
(Results not yet confirmed independently by CMS Evaluators)

Cost of Care Impact (N=1,544)

Cost of Care Impact Per Enrollee (N=1,544)

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
CHALLENGES

Time required to adopt and hardwire new clinical and care management skills

Regulatory & legal environment not aligned with health care reform innovation

Immediate demand for clinical, operation, and financial integration outpaced IS infrastructure

Resources and skills to perform specialty analytics in timely, consistent and reliable manner

Expanding Access to AIM Services and Evaluating the Model of Care

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

OPPORTUNITIES

Investment in infrastructure for broader complex care management

Participate in design or evaluation of model of care for persons with advanced illness

Develop new payment model to serve this complex growing population of patients

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
living in two worlds at the same time is challenging

Fee For Service

Value Based Population Reimbursement

What Questions Do You Have? I have time.

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
Health Care Innovations Awards

• “The project described was supported by Grant Number 1C1CMS331005 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.”

Resources

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


Resources


• Palliative Care and Hospice Care Across the Continuum, Center to Advance Palliative Care, http://www.capc.org/palliative-care-across-the-continuum/

• Improving Care for People with Serious Illness through Innovative Payer-Provider Partnerships, Center to Advance Palliative Care, http://www.capc.org/payertoolkit/

Contact Information

Sharyl Kooyer – AIM Program Director, Sutter Care at Home
KooyerS@sutterhealth.org
(916) 797-7856

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...

Compare & Contrast

- Targeting and Triggers*
- Interdisciplinary Team Composition*
- 24/7 Clinical Response *
- Integrated Medical and Social Supports*
- Concurrent Care*
- Setting-Specific or Agnostic?

* CAPC Essential Structural Characteristics of High-Value Palliative Care
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

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
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

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