Bridging The Gaps: Providing Transitional Care With Palliative Medicine

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Presentation Flow:

• The Issues/Problems
• Transitional Care
• Palliative Medicine Framework
• Current Programs
• Case Study
Bridging The Gaps: Proving Transitional Care With Palliative Medicine

Objectives:

• Discuss the need for patient-centered palliative medical care that follows the patient along their care continuum and care settings.

• Value and measure palliative medicine and how it can help bridge gaps in healthcare for patients

• Case Study of current models

The Issues/Problems
Issues/Problems

What are they?

• Health State?
• Unrealistic Expectations?
• Lack of Communication?
• Current healthcare structure?
• ??

Issues/Problems

In America, approximately:

• 76M people suffer from one or more types of coronary vascular disease
  • estimated cost of 286B annually
• 1.6M people will be diagnosed with cancer
  • estimated cost of 227B annually
• 5.4M people are living with Alzheimer’s
  • estimated cost of 200B annually

Issues/Problems

And the list goes on, approximately:

- 18.8M people diagnosed with diabetes mellitus
  - 174 billion dollars
- 149M people are obese
  - 190 billion dollars


Issues/Problems

Issues/Problems

The cost of chronic conditions requiring transitional palliative medical care has reached epidemic proportions

- Advanced illness accounts for 75% of medical dollars spent
- 32% of Medicare dollars spent is on individuals in their last two years of life
- The 23% of Medicare patients with >4 chronic conditions account for 68% of all Medicare spending.


Issues/Problems

Why?

- Current Models of Care do not guide evidence-based palliative practice
- Evidence-based practice not being implemented
- Inadequate fiscal mechanisms
- Definitions do not adequately describe the evidence-based practice
- We do not promote Goals of Care
Problems:

- Care silos
- Poor transitional care
  - Inadequate communication
  - Poor symptom management
- Reimbursement constraints
- Gaps in knowledge

Care Silos:

- Acute Care
- Commercial/Managed Care Payors
- Physician/Physician Groups
- Community at Large
- Skilled Nursing
Poor transitional care: We do not manage care, we create care needs.

A result of:
- Care silos
- Poor transitional care
- Inadequate communication
- Poor symptom management
- Reimbursement constraints
- Gaps in knowledge
Issues/Problems

Reimbursement constraints

• Fee-for-Service
• Payors have not adopted concept
• Lack of programmatic structure

Gaps in knowledge

• Regulatory
• Care silos
• Translation of evidence based protocols
• Cancer vs. non-cancer research
• Poor implementation of Goals of Care

Transitional Care
Transitional Care

Palliative Medicine as a Transitional Care Model
- Anticipate
- Manage
- Prevent
- Partner

How we support:
- Right Care, Right Setting, Right Time

Transitional Care

Why a transitional palliative medicine model?
- Treats the patient not the silo
- Provides a framework for:
  - Retooling the reimbursement system
Transitional Care

Throughout the trajectory of illness, palliative medicine providers optimize disease management through comprehensive assessment, symptom management, and supportive care to patients and caregivers.

This model of care enhances quality of life from the curative/restorative care stage through caregiver bereavement.

Framework

Palliative Medicine

• Specialized medical care for people with serious/chronic illnesses

• Provided by a team as an extra layer of specialized support

• Focused on relief from the physical and psychosocial symptoms of a serious illness
Palliative Medicine

- Help to improve quality of life for both the patient and the family
- Provided along with curative treatments

Palliative Medicine

- Uses an inter-professional team:
  - Comprehensive palliative assessments
  - Develops/Implements comprehensive medical care plans
  - Provides symptom and complex disease management
  - Improves function and quality of life across the continuum
  - Helps establish/re-establish Goals of Care
Framework

Palliative Medicine

• Trained to recognize when a patient:
  • Is experiencing a personal crisis
  • Is experiencing developmental impairment
  • Needs symptom and complex disease management
  • Needs help to improve function and quality of life across the continuum
  • Needs help establishing/re-establishing Goals of Care

Framework

Palliative Medicine

• Four Pillars:
  • Pain and Symptom Management
  • Medication Reconciliation
  • Setting Management
  • Goals of Care

• Through:
  • Communication/Collaboration across care settings
Framework

In Support of Silos:

• Acute Care
  • Support DRG management
  • Reduce LOS
  • Reduce avoidable re-hospitalizations
  • Community transitions

• Commercial/Managed Care Payors
  • Programmatic
  • Comprehensive
  • Care management

Framework

In Support of Silos:

• Physician/Physician Groups
  • Extend Care
  • Provide access
  • Collaboration
  • Communication across specialty support

• Community at Large
  • Transitional care needs
  • Right Care, Right Setting, Right Time
  • PCP extension
Framework

**In Support of Silos:**

- Skilled Nursing Facilities
  - Short-term
  - High risk for re-hospitalizations
  - Discharge follow-up
  - Medication reconciliation
  - Community transitions

**Current Models**
Current Palliative Models

Fee-for-Service - Medicare Part B:

- Physician/APRN
  - Fee-for-service
  - Evaluation & Management (E&M)
  - Multi-setting capability

- LSCW
  - Psychotherapeutic Management
  - DSM-IV diagnoses

Current Palliative Models

Home Health:

- Medicare Part A
- Bridge programs
- Regulatory constraints
- Silo of care

Concurrent Hospice Care:

- Medicaid Pediatric Concurrent Care
- Commercial Insurers
- CMS Demonstration Projects
Current Palliative Models

Transitional Care Programs:

• Health Coach/Navigator
  • Naylor
  • Coleman

• Healthcare Systems
  • Managed Care Networks

Current Palliative Models

Services:

• Setting Specific
  • Acute Care
  • SNF/ALF
  • Cancer Centers

• Task Specific
  • Pain Clinic
  • Advance Care Planning
  • Individual Disease

• Delivery Specific
  • Face-to-face
  • Telephonic/Web
Program Examples

- PRIME by AseraCare
- Gundersen Health System’s Respecting Choices Program
- Four Seasons Palliative Care Program
- Lehigh Valley OAICS Program
- Sutter Health’s AIM Program (Advanced Illness Management)
- Hospice of Michigan’s @HOMe Support Program
PRIME by AseraCare

Program Development:

• Due diligence  
  • 18 months (2010-2011)

• Identity  
  × AseraCare Palliative Care  
  × AseraCare Palliative Medicine  
  ✓ PRIME by AseraCare

• What Service  
  • Consultative Medical Model

PRIME by AseraCare

Program Launch:

• Inception November 2011

• 6 month pilot project  
  • Omaha, NE

• Rapid expansion during 2012  
  • 7 additional agencies

• Additional growth during 2013  
  • 3 agencies  
  • 2 agencies in development
PRIME by AseraCare

Target Population:

- Chronically and seriously ill patients
  - End-stage disease trajectory
  - Upstream from terminal diagnosis
    - 1-2 years
- Top Diagnoses:
  - Chronic Obstructive Pulmonary Disorder (COPD)
  - Cancer (cancer related symptoms)
  - Alzheimer’s
  - Cardiac (CHF, CVD, cardiac related symptoms)

Setting(s):

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

• Board Certified MD
  • Collaborative Agreement

• Advanced Practice Registered Nurse (APRN)
  • Provider

• Licensed Clinical Social Worker (LCSW)
  • DSM-IV diagnoses

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Supportive Care Staff:

• Social Worker
  • Support basic service support needs
  • Support transitional care decisions to Hospice
  • Provides community resource support to Provider

• Spiritual Care Coordinator
  • Provides community resource support to Provider

• Volunteer
  • Similar capacity to Hospice Volunteers
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Pearls:

• Advanced Practice Registered Nurse (APRN)
  • Multi-faceted use
  • Provider, Educator, Marketer

• Musts:
  • Clinical expertise
  • Extraverted
  • Self-starter
  • Communicator/Collaborator
  • Community vs. Clinic practice

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Pearls:

• Medicare 855
  • 30 day retro effective date

• Medicaid
  • State Specific
  • Managed Care Medicaid

• Managed Care/Commercial Payors
  • Credentialing
  • CAQH
  • Member Benefit
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Statistics:

• Quality
  • Pain – 96% on a goal of 80%
  • Dyspnea – 99% on a goal of 70%
  • Anxiety – 95% on a goal of 70%
  • Goals of Care – 96% on a goal of 98%
  • Re-hospitalization – 0.4% on a goal of less than 5%

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Statistics:

• Initial Consults
  • 486 (2012)
  • 656 (2013 – July)

• Subsequent Consults
  • 952 (2012)
  • 2289 (2013 – July)

• Practice
  • Unduplicated census 1005 (2013 - July)
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Statistics:

• Patient Satisfaction Survey
  • Partnered with Strategic Health Partners (SHP)
  • Developed Survey
  • Launched July 2013

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Financial:

• Evaluation & Management CPT Coding
• Break-even model
  • Proforma builds month-over-month
  • Break-even within 12 months
• Consults
  • 18-22 Initial Consults per month
  • 80-90 Subsequent Consults per month
• Revenue
  • Start-up mode
  • Less than budgeted
Integration:

• AseraCare Hospice
  • Core business
  • Setting Management
  • 30% conversion rate
    ✓ 103 (2012)
    ✓ 154 (2013 – 1st half)

Integration:

• Care Continuum
  • Across settings over time

• Home Health Agencies
  • Integral component

• Acute Care/LTAC
  • Specific partnerships
Future Considerations:

- Ongoing expansion
  - Complement Hospice Agencies
  - Urban and Rural

- Managed Care/Commercial Payors
  - Contracts
  - Member benefits

- Healthcare Systems
  - LTAC
  - Acute
  - Build community care continuums
Questions?