602. The Changing Landscape of Advanced Illness and Palliative Care

FINANCIAL MANAGEMENT CONFERENCE & EXPO

HOMECARE & HOSPICE
National Association for Home Care & Hospice

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602. The Changing Landscape of Advanced Illness and Palliative Care

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Continuing Education

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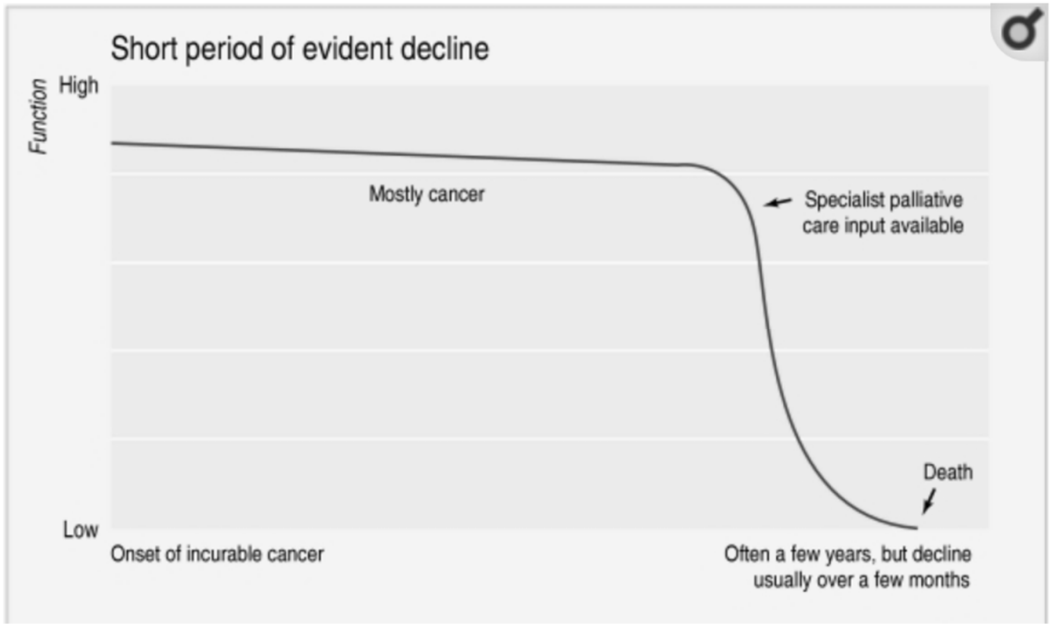
Commercial Support provided by Brightree, Excel Health Group, Healthcare Provider Solutions, and Simione Healthcare Consultants.

Objectives

- Discuss the goals for palliative and advanced illness management programs, incentives and payment models.
- Review nationally available data and research findings related to palliative care and advanced illness management
- Discuss the changing models for advanced illness management.
- Review a successful model in practice at a large health system
- Discuss financial incentives, payment models and lessons learned implementing an advanced illness management model.



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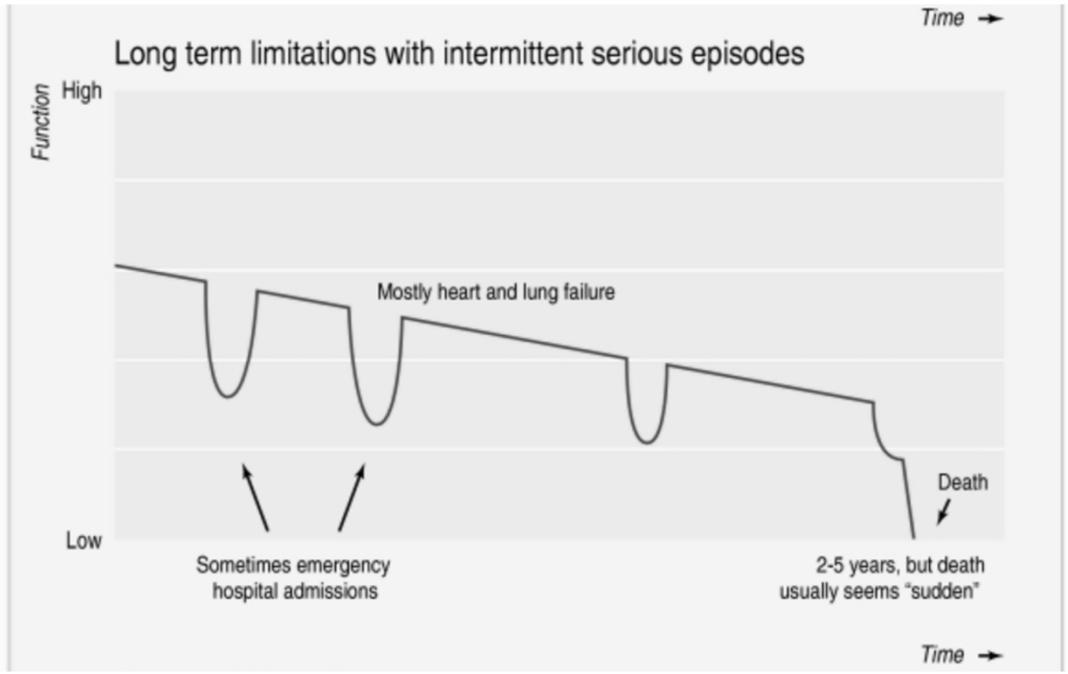

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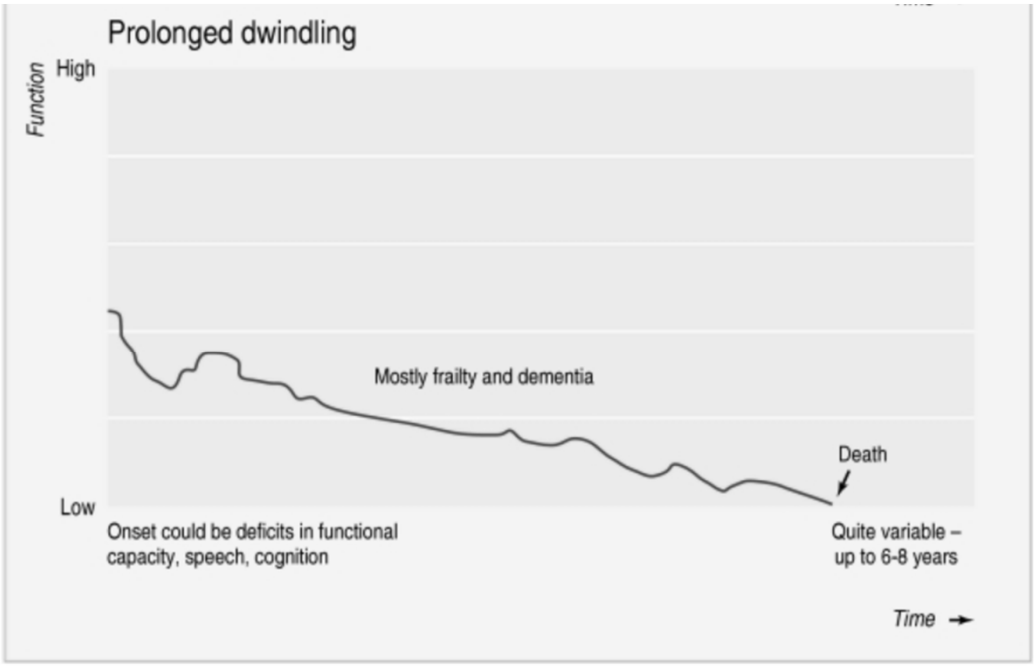

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Population

- Approximately 90 million Americans are living with serious, life-threatening illness.
- The aging population this number is expected to double in the next 25 years.
- Among the current Medicare population about nine out of ten deaths are associated with just nine chronic illnesses, including congestive heart failure, chronic lung disease, cancer, coronary artery disease, renal failure, peripheral vascular disease, diabetes, chronic liver disease, and dementia.

A 'Good Death'

- Most of us want to die at home in our own beds with familiar surroundings and our loved ones by our sides.
  - Dartmouth Atlas data – 55% of us die in the hospital – in-contrast to our wishes
  - Our health care is fragmented, not connected or coordinated
  - Many individuals with chronic illnesses have multiple specialty providers
    - No one provider is really overseeing all the care needs
    - No one is guiding the care to align with the individual desires at the end of life
  - Provider payer models are not aligned to incentivize good end of life care
  - Predictability challenging

One story - healthcare

- Fragmented care in chronic illness
- Multiple specialists
- No one physician or provider managing care
- Continuum managed by wife & himself
  - Bossy nurse daughter
- Last two years of life
  - Three hospitalizations
  - One SNF stay
  - Several falls
  - Multiple prescriptions
- No connection through MDs/ facilities/home health care
- Family advocated for palliative and end of life care
  -

Turning the Financial Incentives

- Chronic illness care for patients in their last 2 years of life represents over 1/3 of total Medicare spending
  - Most of these costs are related to physician and hospital fees associated with repeated hospitalizations.
- Acute Care based Palliative Care Models
  - Often programs barely cover direct costs
    - Provider reimbursement
  - Challenged to 'prove' cost savings to hospitals with reduced admissions and length of stay
    - Requires a deep understanding of the financial impact for hospitals profit/versus loss

Acute Care AIM Management Incentives

	Medicare Deaths	Medicare High-Risk Survivors[a]	All Other Medicare Admits	Total Medicare
Medicare Cases	396	1,030	7,469	8,895
% All Medicare cases	4 %	12 %	84 %	100 %
Total costs / case	$ 52,948	$ 49,109	$ 15,413	$ 20,986
Reimbursed / case	$ 48,347	$ 44,256	$ 15,440	$ 20,242
Net Margin[b] (sum)	$ -1,822,204	$ -4,998,219	$ 197,960	$ -6,622,463

Cassel, J. Brian., Smith, Thomas J., Journal of Pain and Symptom Management, *The Business Case for Palliative Care: Translating Research Into Program Development in the US, Elsevier Inc, Vol 50, No. 6 December 2015.*

Acute Care Financial Incentive

- Payers starting to shift from quantity to quality
  - Medicare based payments Value Based Purchasing
- End of life hospitalizations can impact hospital reimbursement and costs
  - May have death within 30 days
  - May have a negative net margin
  - May be a re-admission
- Palliative Programs are making inroads in proving their value
  - Reduction of costs
  - Expansion into clinics and community programs
- Evaluating the impact of better outpatient and community programs
  - Prevention of re-admissions enhancing the quality of care and earlier access to palliative care

Advanced Illness Management Models

- Acute Care facilities increased in palliative care programs
  - Since 2000 when less than 25% of hospitals in the US had palliative care programs there has been an increase to approximately 75% of hospitals with palliative care.*
  - Not all programs are alike or standard
    - MD/NP Consult services
    - Full team – MD/NP, RNs, SW, Chaplain
      - Hospice Like
    - Limited – SW or RN
      - Advanced care planning

- *CAPC ***Palliative Care Continues Its Annual Growth Trend, According to Latest Center to Advance Palliative Care Analysis:*** New York, NY (February 28, 2018)

Community Based Models

Home Health

- Shifting incentives for Home Health outcome measures additionally add to the attention for patient management
  - VBP currently 9 states with planned expansion to all states by 2022
  - Hospitalization
- Models of Advanced Illness Management and Palliative Care

Community Based Models

Hospice Care

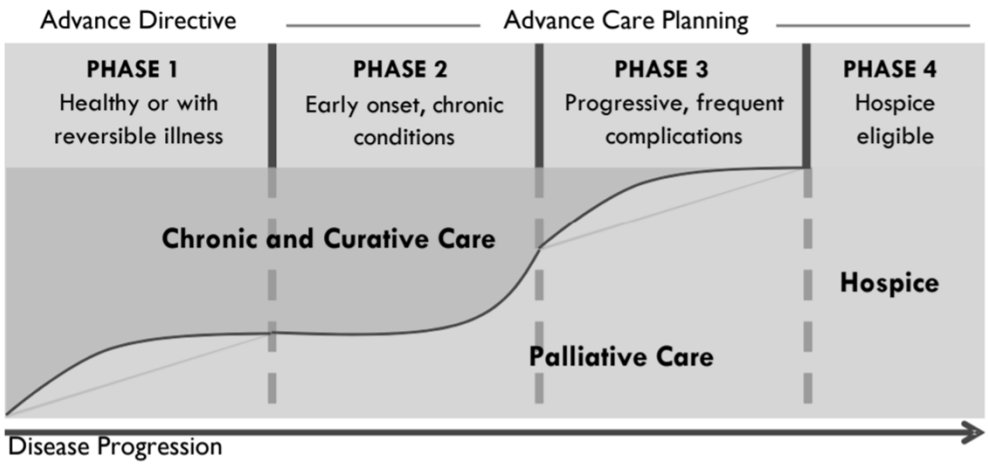
- Hospice Care incentives for advanced illness management and palliative care is to engage patient's earlier in their course of illness
  - Improve and capture market share
  - Increase patient's overall length of stay and benefit from hospice services
    - Past few years Length of Stay reductions challenge hospices

Emerging Models of Care

Health Systems

- Incentives with ACOs
- Risked based contracts
- Looking to Navigate patients through the health system.
  - Seeing this as emerging with large post-acute providers (Hospice, Home Health)
  - Retention of patients and families – market share
  - Patient and family engagement
  - Coordination of care – Target to meet the patient's goals for care

Advanced Illness Management



Source: AHA CPI analysis, 2012, with contributions from 2012 CTAC data and 2011 Center to Advance Palliative Care data.

Benefits of Advanced Illness Management

- Studies completed on the benefits of providing Advanced Illness Management Services
  - Patients experience better pain and symptom management
  - Improved patient and family satisfaction
  - Palliative Care improves the quality of life for patients
  - Less likely to have emotional issues and depression
  - Use of hospital inpatient day are less than the general Medicare population
  - Care is more aligned with patient and family wishes at the end of life

Holy Redeemer Home Care & Hospice

- Acute Care, Long Term Care, Senior Housing, MD practices, Home Care, Hospice, Private Care
- Home Care & Hospice – 9 locations in PA and NJ
- Hospital, MD practices and palliative care physician practice in PA
- Advanced Illness program in all locations
- Hospice in all but 1 location
- Physician home visit program embedded in PA location

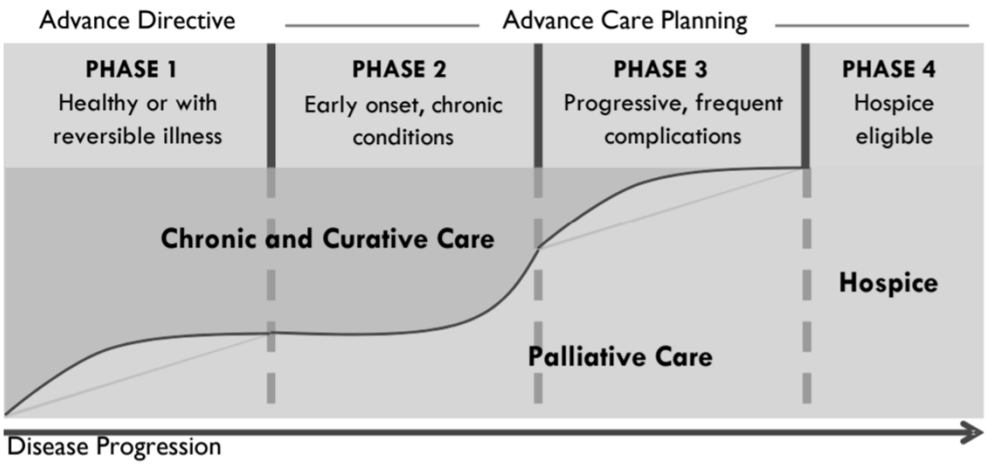
Is It Just Semantics?

- Palliative Care
  - Confusion with referral sources
  - Stigma of palliative care
  - Patient capture was less than expected
- Transitioned to Advanced Illness
  - Program growth
  - Referral source connection
  - Physician buy in
  - Staff buy in
  - Expansion of expertise

Home Care vs. Hospice

- Committed to Home Care model
- Hospice model falls short of meeting patient need
- Introduction of Palliative programs by hospice competitors
  - MD/NP focused
  - Reimbursement does not support goals of care
- Competitors referring to Advanced Illness program
- Partnering with Hospital Palliative Care programs – aligning goals of care and outcomes

Care Types & Competencies



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Identifying Advanced Illness Patient

- On referral, admission or during episode of care
- Use of risk assessment tools on admission and re-cert to determine frailty, palliative care status
- SHP scores for predictive analytics on potential for hospice transition and hospital readmission
- Predictive analytics – past experience and future use
- Initial expectation was that 25% of all home care patients would be categorized as Advanced Illness

Models of Care Vary

- Program continues to evolve
  - Staffing varies
  - Patient capture varies
  - % transitioned to hospice varies
  - Utilization of services varies
- Goal is continued program development
  - Fine tuning assessment tools, documentation, reports, outcome goals, staff competencies
  - Partnering with physician practices to manage complex patients
  - Developing a protocol for NP use in improving symptom management and supporting goals of reducing ER use and readmission rates
  - Revisit use of predictive analytics beyond current tools

Program Challenges

- Consistent patient capture and reporting
- Staffing
- Achieving standardization across all locations
- Introduction of NP role
- Physician partnership on goals of care - improving
- Competition – home care vs. hospice providers
- Continued issues with definition of “palliative”

Future State

- Federal and state programs expand to cover AIM through the continuum of care
- Incentives for quality, outcomes, and coordination of care
  - Management of care across the continuum
- More commercial/managed care involvement

Questions?

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