FOUR·SEASONS

Compassion for Life

Hospice • Palliative Care • Research • Elizabeth House

Palliative Care under a Value Based Reimbursement Model

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CMO Four Seasons

Objectives

- Describe palliative care
- Discuss benefits of palliative care
- Understand differences between hospice and palliative care
- Demonstrate costs of delivering care and challenges with current fee for service payment
- Discuss value based payment methods

What is Palliative Care?

- Specialized medical care for people with serious illness
- Focus on pain and symptom relief and improving quality of life
- Provides support for patients/families
- Appropriate at any stage of illness
- Team based care

Who Benefits from Palliative Care?

- **Serious Illness**
  - Moderate to severe COPD
  - Stage III/IV heart failure
  - Advanced liver or renal disease
  - Advanced cancer
  - Dementia
  - Frailty
  - 3 or more chronic diseases
- **Functional Decline**
- **High Healthcare Utilization – highest 5% Medicare recipients**

Palliative Care Given Alongside Curative Care

Mary's Story

Stage III breast cancer

72% 5 year survival rate

Palliative Care Intervention

Symptom management - Nausea, vomiting, fatigue

Family distress – 2 children in middle school/financial hardship

Social worker – counseling, assist with Medicaid application

Chaplain – spiritual support

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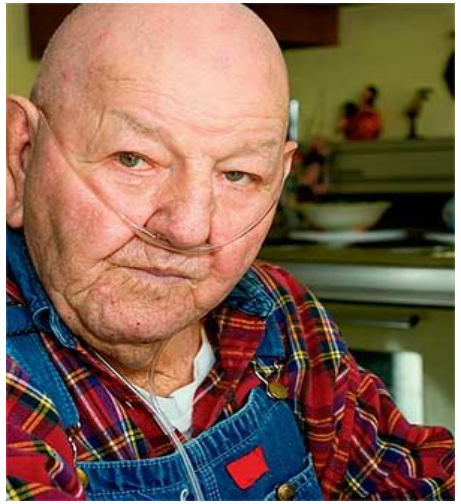

Tom's Story

End stage COPD

Prognosis 2-3 years

Recurrent ER visits/2 hospitalizations

Palliative Care Intervention

Goal: stay out of the hospital, die at home

Symptom management of dyspnea

Team based support 24/7

Social worker - set up meals on wheels

No ER visits/hospitalizations in past 8 months

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Doris's Story

Advanced dementia

Prognosis 8-10 months

Lives with daughter who has to quit work

Behavioral issues, polypharmacy

2 hospitalizations past 12 months (fall, pneumonia)

Daughter exhausted, stressed

Palliative Care Intervention

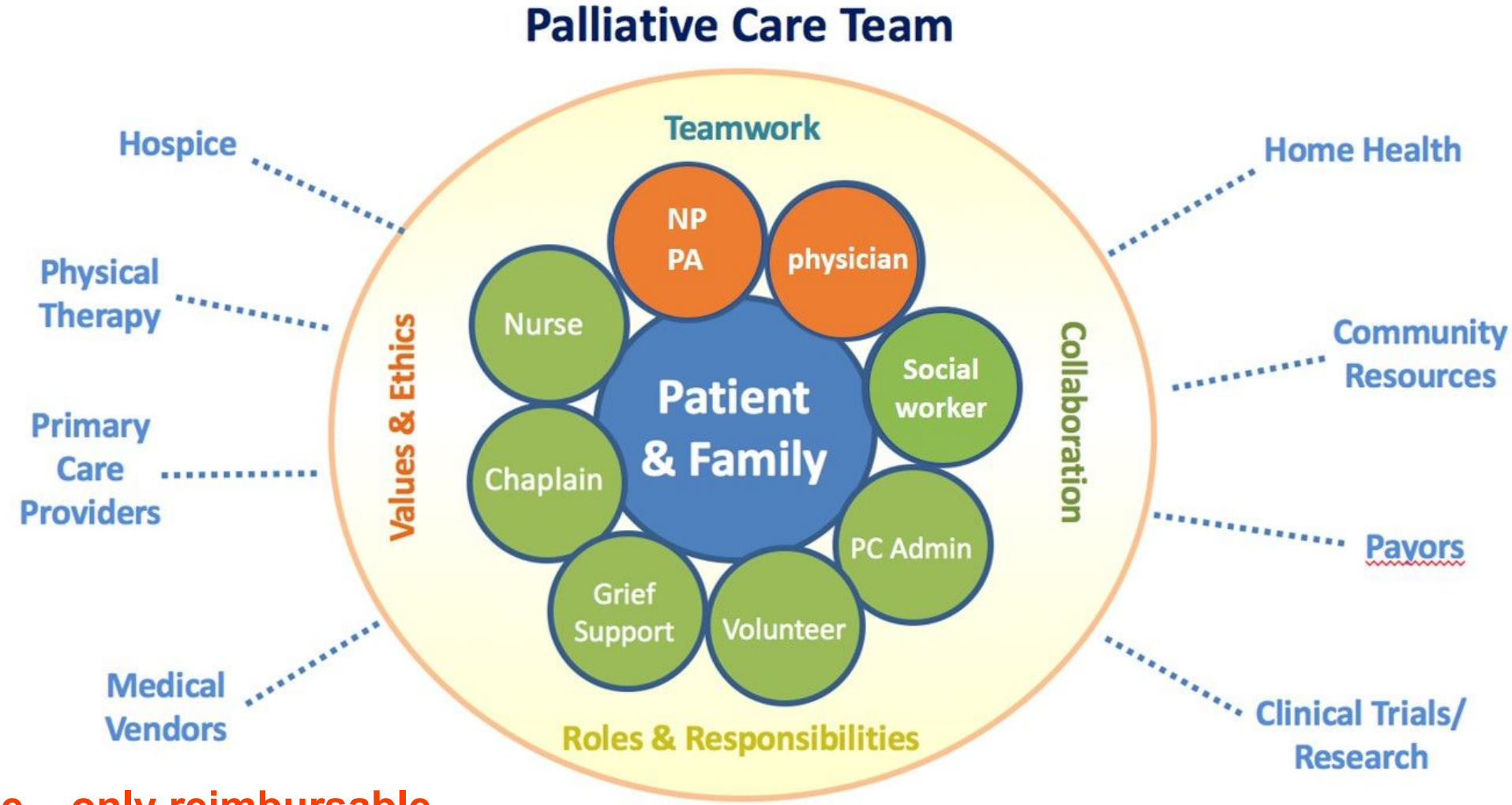
Advance care planning (was full code)/education of disease process

Medication review with discontinuation of 5 meds

Social worker and spiritual support

Hospice referral after 2 months when patient clearly declining

Who Delivers Palliative Care?



Orange – only reimbursable service under FFS Medicare

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What's the Benefit of Palliative Care?

- Palliative care associated with
  - Lower Hospital Readmissions and Emergency department visits
  - Higher transition to hospice care
  - Increased longevity
  - Improved quality of life and treatment of symptoms
- Palliative care reduces hospital cost
  - $4900 patients who died
  - $1700 patients discharged alive
- Palliative care associated with high family satisfaction

Nelson et al, Perm J, 2011; Enguidanos, JPM 2012, Temel, NEJM 2010
Adelson et al, ASCO 2013
Lustbader et al, JPM Vol 20, 2017

Impact of End of Live Conversations

N = 322	Had conversation	Did not have conversation
ICU Admission	4.1%	12.4%
Ventilator	1.6%	11.0%
Resuscitation	0.8%	6.7%
Chemotherapy	4.1%	6.7%
Outpatient hospice	76.2%	57.4%

Wright, A. A. et al. JAMA 2008;300:1665-167

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What's in the Syringe?

- Understanding values and goals of care of patients
- Open, honest conversations about prognosis and risks/benefits of treatment options
- Education on disease process and what the future holds
- Expertise in managing pain and symptoms
- Support in dealing with the stress of serious illness
- Psychosocial support
- Spiritual support
- Navigation and coordination

Differences - Hospice vs Palliative

	Hospice	Palliative Care
Life Expectancy	< 6 months	Any stage of illness
Treatment	Comfort	Curative or comfort
Care settings	All	All
Resources	Significant	Limited
Delivery model	Interdisciplinary Team	Interdisciplinary Team
Payment Model	Medicare Hospice Benefit	Medicare Part B E/M codes for providers

How is Palliative Care Currently Paid For?

- Under fee for service, reimbursement < cost of services
  - Hospital – program is subsidized
  - Post acute setting
    - Subsidized through grants/foundations/operations and delivered via:
      - Healthcare system
      - Hospice led organizations
      - Home health
- Medicare Advantage - often capitated payment models

THE CONTINUUM OF PALLIATIVE CARE

Palliative care can be — and must be — available across all settings, offering an array of services in venues that matter most to patients and families, in ways that ensure smooth transitions between settings.

FILLING THE GAP

POINT OF CRISIS

HOSPITAL PALLIATIVE CARE

COMMUNITY-BASED PALLIATIVE CARE

OFFICE

HOME

LONG TERM CARE SETTINGS

END-OF-LIFE

HOSPICE

Source: Center to Advance Palliative Care

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How Much Does it Cost to Deliver Community Based Palliative Care?

- Cost between $400-$650 month to deliver care depending on service needs and severity of illness
- Under FFS lose $250-$400 month

Challenge

- Unsustainable financial model under current fee for service reimbursement structure
- New E/M codes are helping but still fall short
  - Advance care planning
  - Non Face 2Face prolonged service codes
  - Complex chronic care management codes
  - Transitional care management codes
- With new codes lose ~$160 month

Role	Unreimbursed Services
Registered Nurse	Case management Education Coordination of care
Social worker	Counseling Assess psychosocial distress Social services (meals on wheels, Medicaid, etc.) Family and Social support
Chaplain	Spiritual distress
Bereavement	Provide grief counseling
Volunteer	Companionship with patients Assist staff with duties

Patient and Caregiver Support for Serious Illness

Tier	Diagnosis of Serious Illness (one of the below)	Function (one of the below)	Health Care Utilization
Tier 1: Moderate Complexity	One of the specified diseases, disorders, or health conditions in Table 2 below Three or more serious chronic conditions*	**Non-Cancer**: PPS of ≤60% or ≥ 1 ADLs or DME order (oxygen, wheelchair, hospital bed) **Cancer**: PPS of ≤70% or ECOG ≥2 or ≥ 1 ADL or DME order (oxygen, wheelchair, hospital bed)	One significant health care utilization in the past 12 months, which may include: - ED visit - Observation stay - Inpatient hospitalization *Note: This criterion may be waived under certain circumstances specified below.*
Tier 2: High Complexity	Same as above, excluding dementia as the primary illness	**Non-Cancer**: PPS of ≤50% or ≥ 2 ADLs **Cancer**: PPS of ≤60% or ECOG ≥3 or ≥ 2 ADLs	Inpatient hospitalization in the past 12 months AND one of the following - ED visit - Observation stay - Second Hospitalization *Note: This criterion may be waived under certain circumstances specified below.*

Payment Based on Need not Diagnosis!

- Tier 1 – Moderate Complexity
  - $400/month*
- Tier 2 –High Complexity (Require higher assistance for daily living activities)
  - $650/month*
- Optional Bundled with Shared Savings
  - $400/month
  - Most programs can't take the financial risk

* Based on cost of care

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Alternative Payment Model Allows Flexibility

Tom

- Medical Management
- Telehealth – virtual visits by NP/social worker
- Tracking of symptoms via TapCloud – RN reviews symptoms daily; antibiotics given during flare-ups
- Social worker provides help with medication assistance programs
- Social worker helps DME needs

Mary

- Medical management – behaviors
- RN case management
- Volunteer support – build ramp to help when wheelchair needed
- NP visits 1-2 x months
- Counseling by social worker
- Meals on wheels and Medicaid application by social worker

With Alternative Payment Model could also consider…

- Transportation
- Medication assistance
- Electricity/Housing
- Nursing Aides
- Safety Issues
- Caregiver issues

Questions?

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