eHEALTH INITIATIVE
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Accountable Care Communities Council

Palliative & Hospice Care in an ACO Paradigm

Thursday, April 17

2:00-3:00pm ET

Reminder:

- Please mute your line when not speaking (* 6 to mute, *7 to unmute)

- This call is being recorded

Agenda

- Welcome and introduction
- Case study presentations
  - Tim Ihrig, MD, MA
    Medical Director, Palliative Care Services
    UnityPoint Health Trinity Regional Medical Center
  - Bill Gillis
    Chief Information Officer
    Beth Israel Deaconess Care Organization
  - Suzi Johnson, MPH, RN
    Vice President
    Sharp HospiceCare
- Q&A / General Discussion

Co-Chairs

Council is chaired by:

- **Anshu Choudhri**, MHS
  Director, Legislative and Regulatory Policy
  Office of Policy and Representation
  BlueCross BlueShield Association

- **Rebecca Molesworth**
  Manager
  Solution Management
  Truven Health Analytics

Speakers

Today we have case study discussions presented by:

Tim Ihrig, MD, MA
Medical Director, Palliative Care Services,
UnityPoint Health Trinity Regional Medical Center

Bill Gillis
Chief Information Officer
Beth Israel Deaconess Care Organization

Suzi Johnson, MPH, RN
Vice President
Sharp HospiceCare

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Palliative Care and Hospice in an Accountable Care Model

Key Strategies to a Successful Integrated Delivery System

Timothy G Ihrig, MD, MA
Ihrig MD & Associates
tim@ihrigmd.com

Board of Governance

Unity Point Health Accountable Care Organization;

Regional Organized System of Care TRMC

Medical Director Palliative Care

Trinity Regional Medical Center

Incentive for Healthcare

Reactive	Focused	Predictive
Visitor	Patient	Person
Symptomatic	Episode	Overall Health
Acute Needs	Most Common Conditions	Community Health Characteristics
Services & Supplies	Packaged Treatments	Management of Well Being
Unit Based	Efficiency Based	Outcome Based
No Financial Risk	Partial Financial Risk	Full Financial Risk

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WHAT IS PALLIATIVE CARE?

Palliative care is **specialized medical care** for people with **serious illnesses**. This type of care is focused on providing patients with **relief** from the **symptoms**, **pain** and **stress** of a serious illness – whatever the diagnosis.

WHAT IS PALLIATIVE CARE?

The goal is to improve **quality of life** for both the **patient** and the **family**.

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RELATIONSHIP TO HOSPICE

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Serious Illness

- Any disease/disorder/condition that is known to be life-limiting (e.g., dementia, COPD, chronic renal failure, metastatic cancer, cirrhosis, muscular dystrophy, cystic fibrosis) or that has a high chance of leading to death (e.g., sepsis, multi-organ failure, major trauma, complex congenital heart disease).
- NOTE: **Medical conditions that are serious, but for which recovery to baseline function is routine (e.g., community-acquired pneumonia in an otherwise healthy patient) are not included in this definition.**

Goals of care

- Physical, social, spiritual, or other patient-centered goals that arise following an informed discussion of the current disease(s), prognosis, and treatment options.

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Palliative Care Expertise

- **Primary palliative care – All Healthcare Providers**
  - Routine palliative care problems should be managed by staff involved in day-to-day care of the patient
  - Education in Integrated Chronic Care Disease Management can enhance primary PC
- **Secondary palliative care – the Medical Specialty**
  - Difficult to manage symptoms
  - Complex family dynamics
  - Challenging care decisions regarding the use of life-sustaining treatment
  - Certification and fellowship training for PC Team

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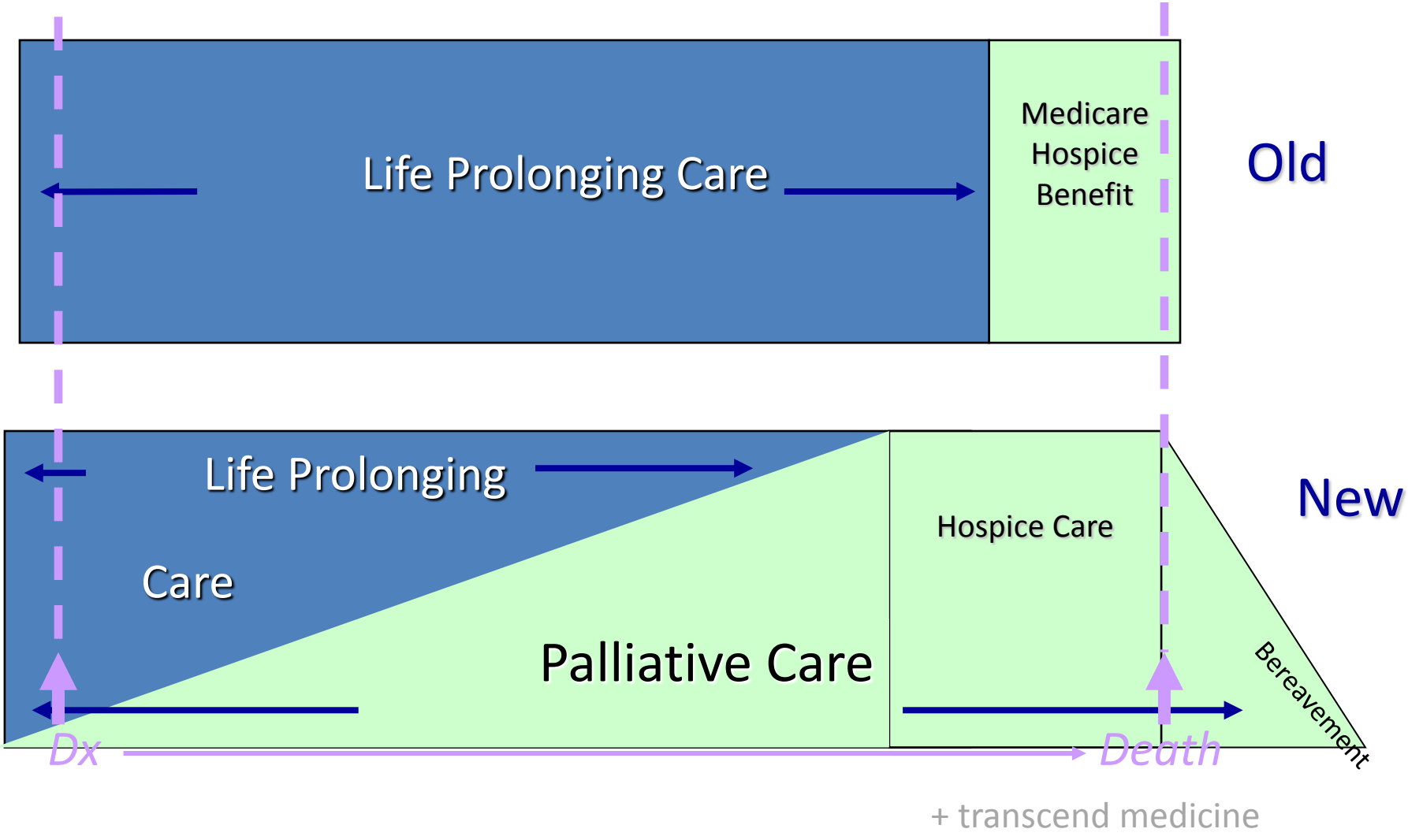
Change in Service Design



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Disease Management

Targeted Population	Stable patients with one of the following chronic conditions . Diabetes, CHF, Coronary Artery Disease and COPD
Resource	My Health Help Disease Management team nurses
Estimated percent of population engaged	10-12%
Identification of patients	Via claims data, physician referral or referral from another care management program
Focus of interventions	Education and support. Compliance with physicians plan of care
Program is delivered to patients	Telephonic
Physician involvement	Support for program Reinforce value of engagement
Referral pattern	To AMT or Palliative Care
Length of time in the program	Ongoing

Results of Integrated Palliative Care Program

Inpatient reduction in LOS and case margin:

Post Palliative Consult < 2 days

$800,000 (first year)

$1.8 million (second year)

$2.1 million (third year)

94% No Hospital Admissions

67% per capita expenditures

90% Outpatients to Hospice

10% of attributable lives

Key Initiative #1

- Promote timeliness of referrals to Hospice
  - Connects patients to the right service at the right time
  - Provides holistic support to the terminally ill patient and their family
  - Prevents unnecessary ED visits and hospital admissions and readmissions
  - Connects families to bereavement services

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Key Initiative #2

- Integrated PC program across the care continuum
  - Shared positions promote **continuity of care during transitions across care settings**
  - Shared IDT meeting promotes collaboration and improved **communication** regarding patients' goals of care
  - Improves **medication reconciliation** and ongoing medication management

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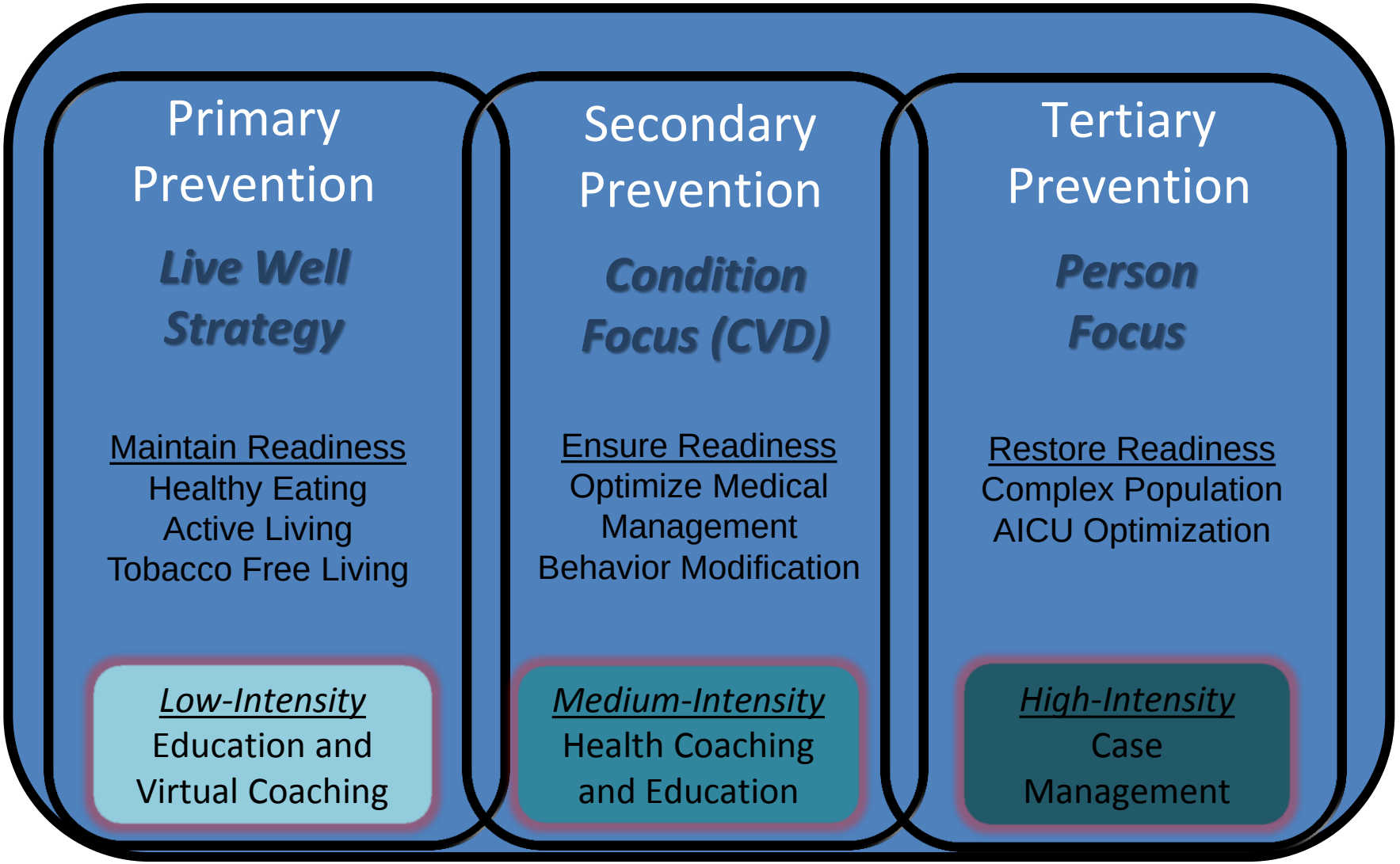
Integrated Health Strategy



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IHS Model of 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.

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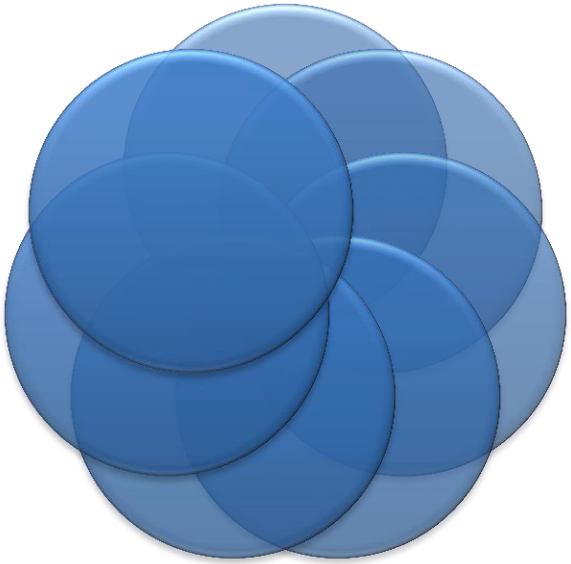
Opportunities for Palliative Care

Inpatient
Consult Service

Outpatient
Specialty
Clinics

Telemedicine



Outpatient
PCP Clinics

Inpatient Unit

Provider Home
Visits

SNF Consult
Service

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Key Initiative #3

- Develop a standardized PC staffing metric
  - Identify Core PC IDT: physician, ARNP, RN, SW and adjuvant staff: chaplain, pharmacy, dietician, etc. to determine staffing needs
  - Staffing metric helps develop budget and identify when additional staff required
  - Productivity metric helps develop budget, supports program cost, and staff accountability

Staffing

- NQF Preferred Practice - Provide palliative and hospice care by an interdisciplinary team of skilled palliative care professionals. Including
  - Patient and family
  - physicians
  - nurses (ARNP and/or RN)
  - social workers (LISW and/or MSW)
  - pharmacists
  - spiritual care counselors
  - others who collaborate with primary health care professional(s)

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Key Initiative #4

- Standardize screening criteria (triggers) for PC consult and embed in each setting
  - Using standardized PC criteria identifies patients appropriate for PC services
  - Embedding triggers into practice in all care settings increases the potential for appropriate PC patients to be identified and served
  - Increasing PC consult volume increases ability for PC program to impact patient care delivery

Identifying Patients at High Risk

- Pain/symptom assessment
- Social/spiritual assessment
- Determination of patient understanding of illness, prognosis trajectory, and treatment options
- Identification of patient-centered goals of care
- Post-discharge transition of care

Primary Criteria

- Frequent clinic visits /ED visits/hospitalizations (more than one admission for same condition within 3 mos.)
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)
- Complex care requirements (e.g., multiple co-morbidities, functional dependency; complex home support for ventilator/antibiotics/feedings)
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)
- Need for Goals of Care and/or Advanced Care Planning discussion

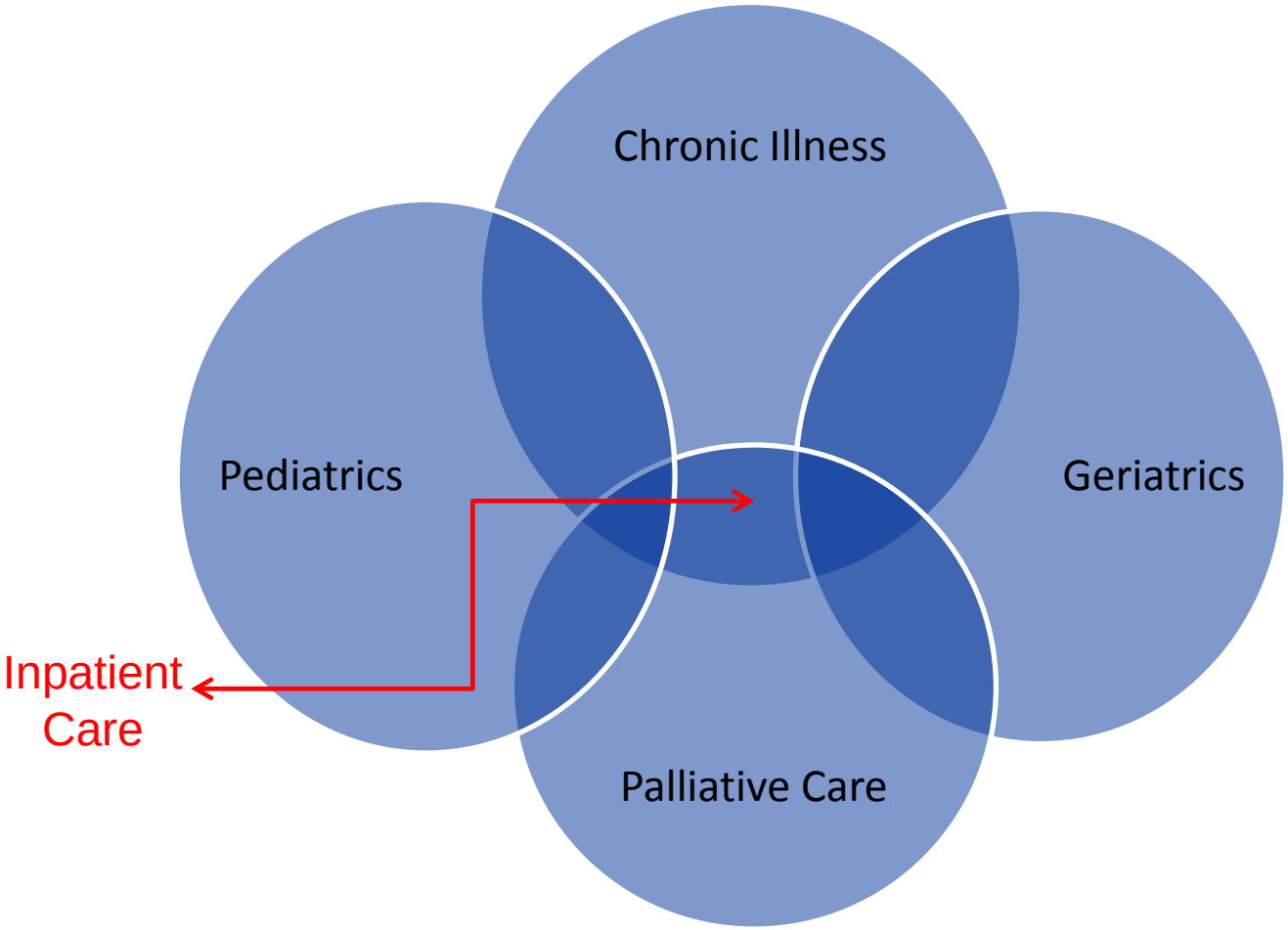
PC SECONDARY CRITERIA

- Admission from long-term care facility
- Elderly patient, cognitively impaired, with acute hip fracture
- Metastatic or locally advanced incurable cancer
- Chronic home oxygen use
- Out-of-hospital cardiac arrest
- Current or past hospice program enrollee
- Limited social support (e.g., family stress, chronic mental illness)
- No history of completing an advance care planning discussion/document

Relationship Between Criteria

- **Primary Criteria** are global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative care needs.
- **Secondary Criteria** are more-specific indicators of a high likelihood of unmet palliative care needs and should be incorporated into a systems-based approach to patient identification if possible.

Palliative Care Patients



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Key Initiative #5

- Provide education to billable staff and auditing of billing practices
  - Maximize billable services by improving billing practices (time and complexity)
  - Sharing audit results with providers identifies best practice and opportunities for additional education and support
  - Ensures compliance with laws and regulations

How do we pay for it?

- Medicare allows two physicians 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 physician's visit; the **Attending Physician** should **bill** the **primary disease code** and the **Palliative Care Consultant bills** codes related to **symptoms**.

PCC Team billing –who can?

- Physicians, *NPs or *CNS, *PAs - use CPT/ICD9
- *receive 85% reimbursable charges
- LISW's/LCSW's use DSM IV codes such as "Adjustment disorder"
- Many private insurance plans cover all visits with prior approval of the plan of care – ask for it!

Key Initiative #6

- Continue to develop PC metrics to include 4 domains and review monthly/quarterly/annually
  - Implementation of standardized use of ESAS, PC interventional tools, SBAR to support clinical metrics
  - Standardize policies and processes to support operational metrics
  - Standardize customer satisfaction tools
  - Standardize staffing/productivity and billing expectations, report percentage of PC patients converted to hospice and hospice volumes and ALOS/MLOS to support financial metrics

Metric Domains

- Operational
  - Does my program have the features required to provide high quality palliative care?
  - What metrics do I need to measure in order to demonstrate my program has these cores features?
- Clinical
  - Am I improving the clinical care of patients?
    - Symptom assessment scores, psychosocial assessment scores
- Customer
  - Am I meeting the needs of patients and families?
    - Satisfaction survey data: patient, family, referring clinician
- Financial
  - Is my program fiscally responsible?

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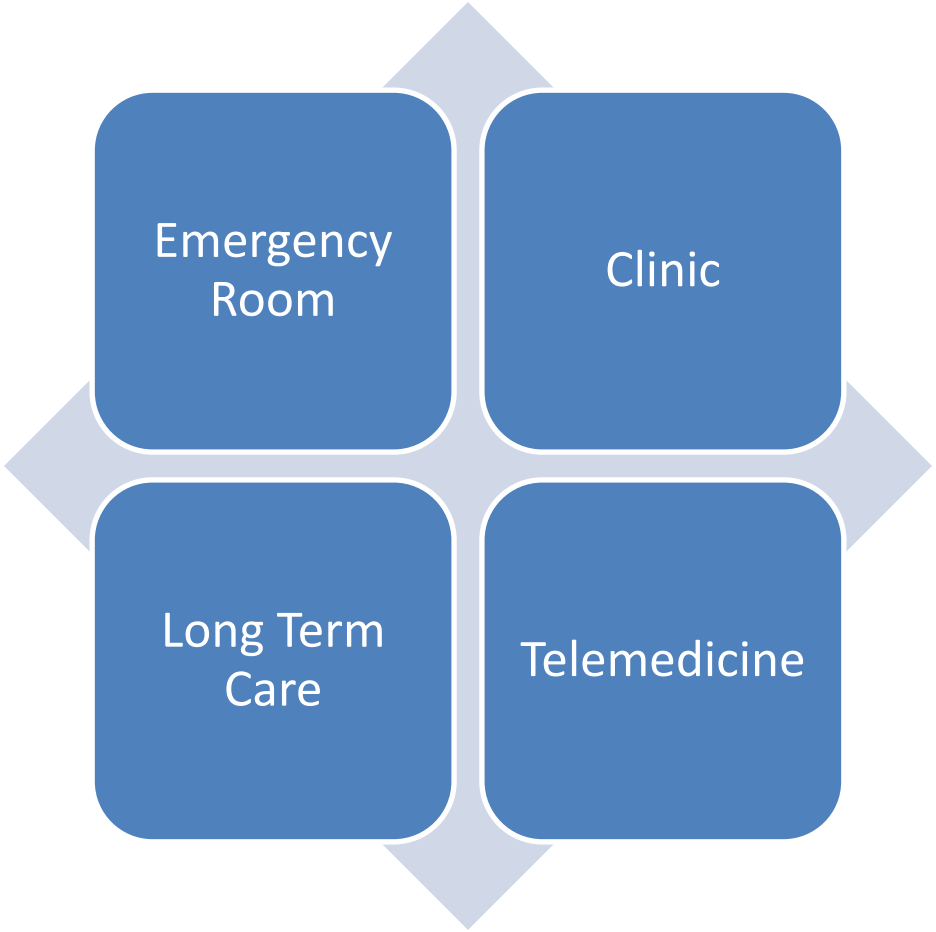
PC Expansion Opportunities



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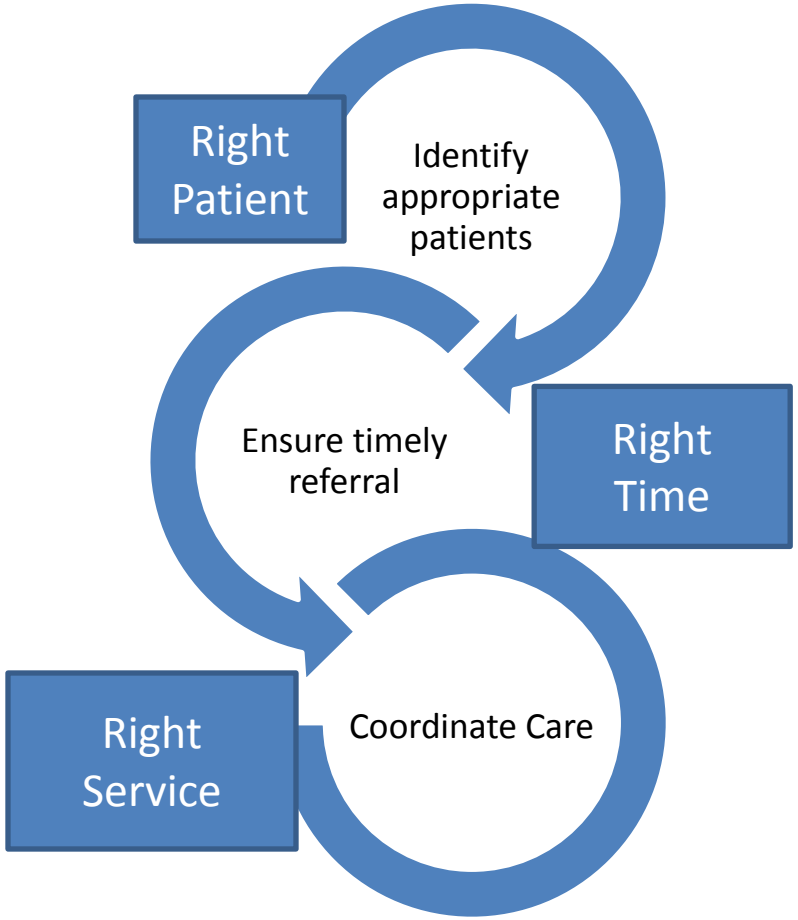
Best Outcome For Every Patient Every Time



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Beth Israel Deaconess
CARE ORGANIZATION LLC

Affiliated with
Beth Israel Deaconess
Medical Center

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

The Electronic Integration of Extended Care Programs

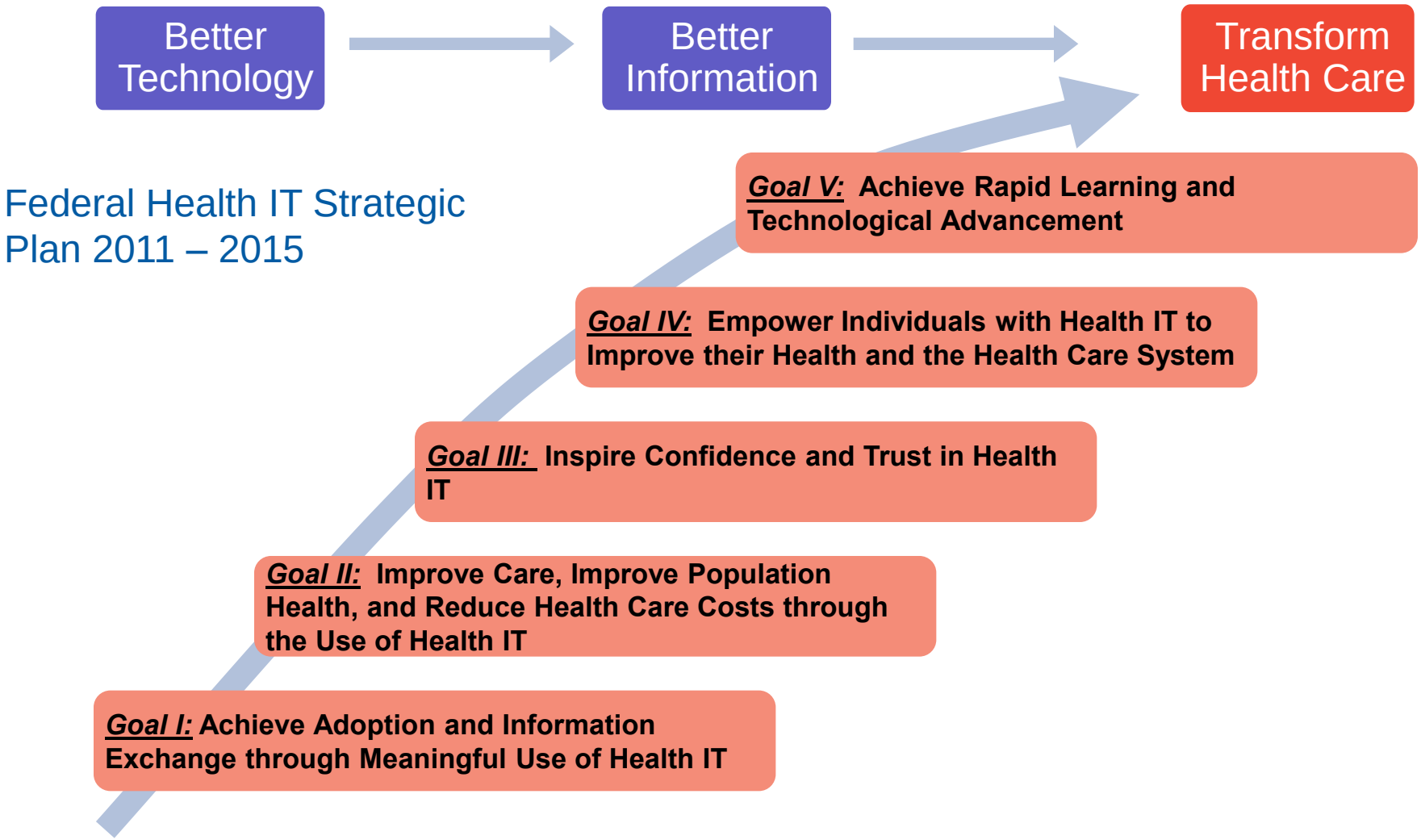
Beth Israel Deaconess Care Organization

April 17, 2014

About BIDCO

- BIDCO is a value-based, physician and hospital network and an Accountable Care Organization (ACO).
  - Located in Westwood, Mass.
  - Employs more than 80 staff members
  - Contracts with 2,300 physicians, including nearly 550 primary care physicians and more than 1,700 specialists
  - Contracted by Centers for Medicare and Medicaid Services as a Pioneer ACO
- Our highest level goal is to promote the best quality and value of care to patients, providers, health insurers, and employers.

Our charge to date…



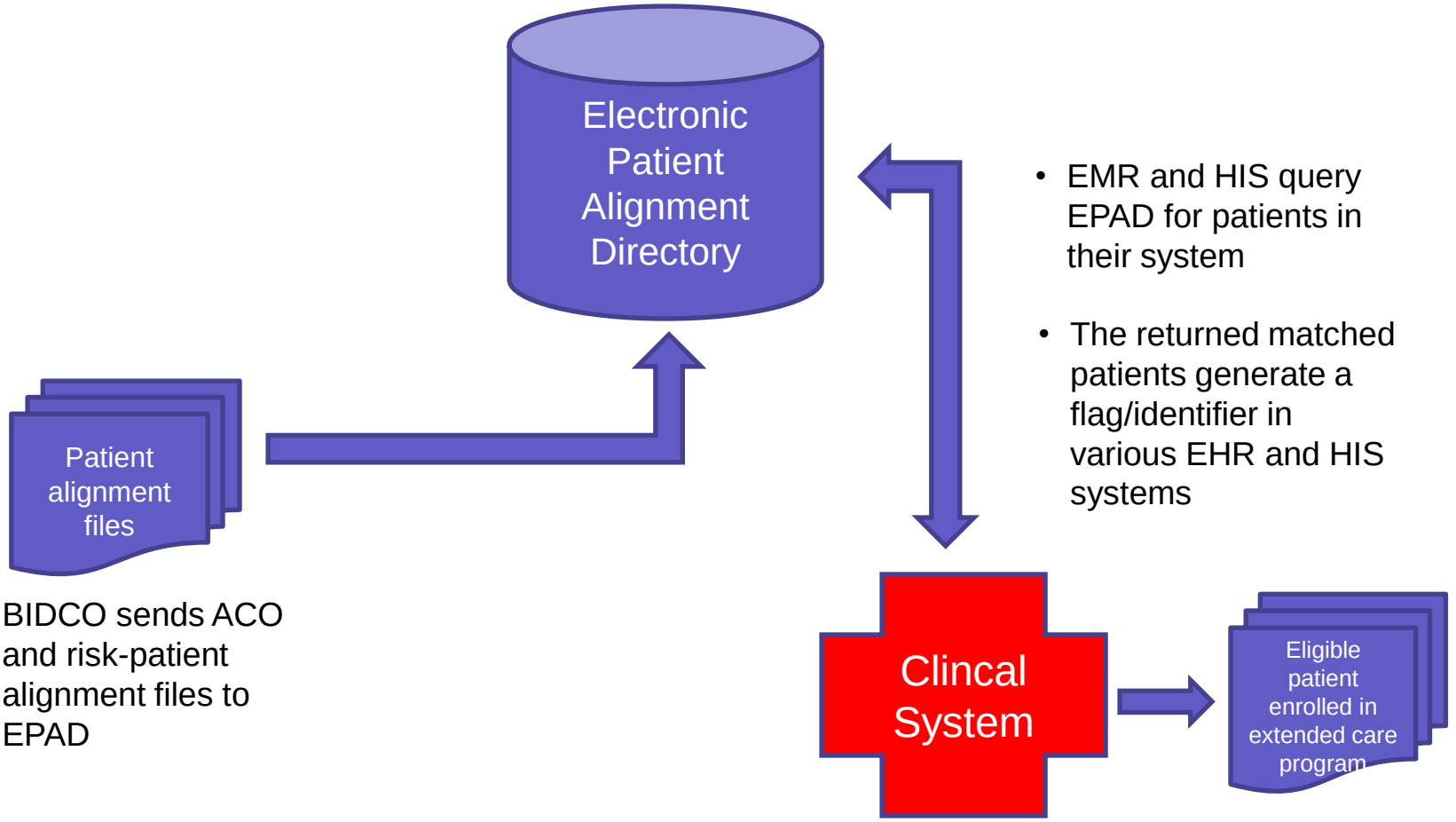
Challenges

- Lack of clinical integration between clincal systems and care organizations
- EHR vendors focused on Meaningful Use (MU) Certification
  - ACOs and MU quality measures not aligned
- Extended care programs have limited representation in MU and ACO quality measures
- Hospice, palliative, and behavioral health programs generally driven by ACOs, care systems, and care providers
- Delivering quality extended care programs while controlling costs in a risk-contract world

BIDCO: One approach

- Provide physicians and caregivers a method to easily identify patients and available extended care programs
  - Create Electronic Member Directory
    - Single source of truth: Dynamically updated data store that contains all aligned risk-contract members
    - Data store accessible by all BIDCO affiliates
  - Visually “flag” ACO and risk-contract patients in caregivers’ native EHR and clinical system
  - Visually identify extended care program availability at point of care

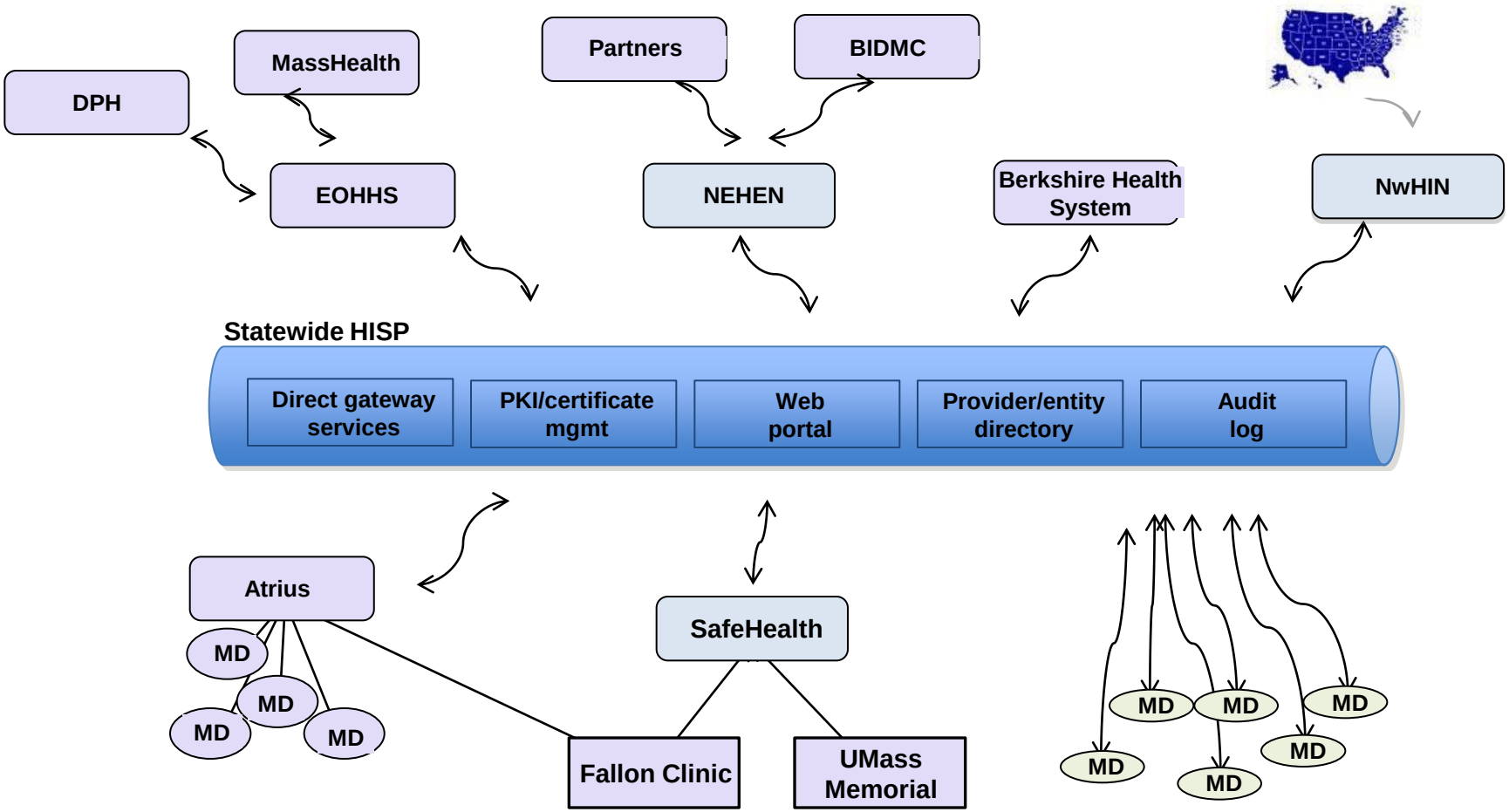
Identifying ACO and risk-contract patients at point of care



- BIDCO sends ACO and risk-patient alignment files to EPAD

- EMR and HIS query EPAD for patients in their system
- The returned matched patients generate a flag/identifier in various EHR and HIS systems

Future state: Real-time, seamless clinical integration



Palliative Care in an ACO Environment

Suzi K. Johnson, MPH, RN
Vice President
Sharp HospiceCare

SHARP Hospice Care

Malcolm Baldrige National Quality Award 2007 Award Recipient

Sharp Health Care

- Not-for-profit serving 3.1 million residents of San Diego County
- Grew from one hospital in 1955 to an integrated health care delivery system
  - Fully integrated information technology systems and infrastructure
  - Centralized system support services (business development, clinical effectiveness, compliance, facilities development, contracting, finance, human resources, information technology, internal audit, marketing and communications, risk management, strategic planning, supply chain management, etc.)
  - Over 25 years experience in managing care under a population-based payment structure; over 280,000 individuals covered through population-based health plan contracts alone
- Largest health care system in San Diego with highest market share
  - 2 affiliated medical groups, 4 acute care hospitals, 3 specialty hospitals, 3 skilled nursing facilities, a health plan, 21 outpatient clinics, 5 urgent care centers, home health, hospice, and home infusion programs, etc.
  - Only health system in San Diego to increase market share each of the past 11 years
- Largest private employer in San Diego
  - 15,000 employees, 2,600 affiliated physicians (none employed), 2,000 volunteers

Program Goals

1. Design and implement a more effective care pathway for patients and families living with chronic progressive illness using an evidence based approach

2. Align patient/family values, preferences and goals of care with care actually received.

3. Provide a coordinated seamless approach to care among all care providers within integrated system

4. Move patient/family along the care continuum with seamless handoffs and coordination

5. Improve the overall healthcare experience

Palliative Care Continuum

Shared Decision Making

30 day post hospital Discharge Readmission strategy

Late Stage illness management disease specific

End of life care

Grief Loss Support

Our Partner Medical Groups

- Sharp Rees-Stealy
  - Staff model HMO
  - PCP driven
  - Highly structured
- Sharp Community Medical Group
  - IPA (Independent Physicians Association)
  - Loosely affiliated
  - Specialty driven

Integration and Working Together

- All stakeholders have access to EHR
- Development of shared goals and outcomes
  - Understanding compliance requirements of medical groups and vice versa
- Identifying and engaging other care providers to simplify coordination and communication for patients, families, i.e. home health services, skilled nursing facility care, etc

Funding for Palliative Care

- Full Risk Medicare Contracts, e.g. Medicare Advantage
- Pioneer ACO
- Other Managed Care Contracts
- Medicare Fee For Service DOES not pay, however some services can be billed through Medicare Part B

Process and Outcome Measures

Care Management Elements

	Bridges	Transitions	Hospice
Prognostic Criteria Required		X	X
Evidence Based, Standardized care interventions	X	X	X
Advance Care Planning Completion of Document	X	X	X
RN Home Visits and Telephonic Care Management	X	X	X
MSW Home Visits and Telephonic	X	X	X
Caregiver Support	X	X	X
Spiritual Care Support		X	X
Hospice Aide/Personal Care			X
24/7 Access to RN	X	X	X

Shared Quality Metrics and Report Card

	Bridges	Transitions	Hospice
Completion of Advance Directive/POLST/Goals of Care	X	X	X
ER Visits	X	X	X
Hospitalizations	X	X	X
Length of Stay	X	X	X
Symptom Management	X	X	X
Transfer/Discharge to next level of care	X	X	X
Patient/Family Satisfaction	X	X	X

Advance Care Planning

The Role of Advance Care Planning in an Integrated Delivery System

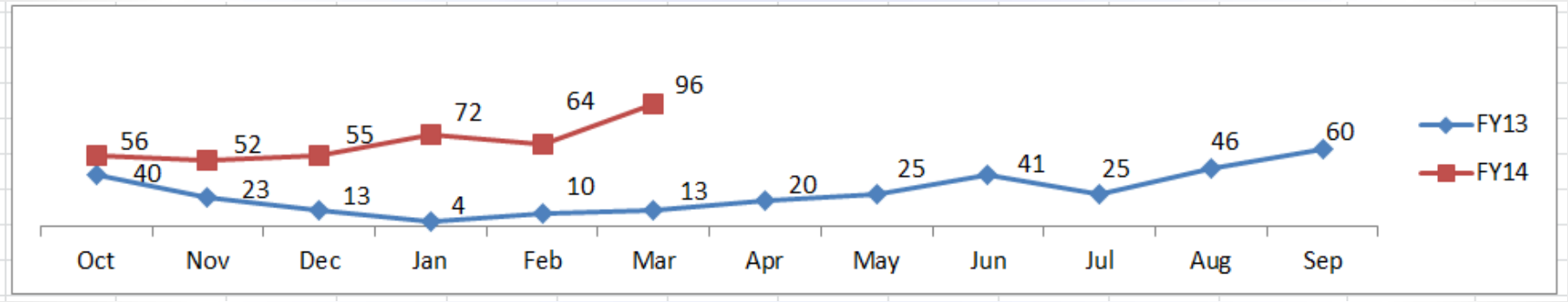
- Improve correlation between patient centered goals and care received
- Improve patient/family compliance through proactive engagement as part of “their” healthcare team
- Reduce patient/family distress including moral guilt, financial burden and caregiver stress through proactive planning
- Reduce use of unnecessary and/or unwanted medical care/interventions
- Achieve the goal of better care, improved quality, and reduced costs

A Standardized Methodology for Patient Engagement

- Standardized, evidence based tools and resources
- Standardized system-wide training
- Centralized referral process
- Flexible scripting with standardized elements
- Facilitation of informed healthcare decision making among all parties, including healthcare providers.
- Patient's goals and preferences align with treatment and care.

Bridges

ACP Referrals



FY13ACP Referrals by Month FY14 ACP Referrals by Month

Bridges

Hospital Discharge Readmission Strategy

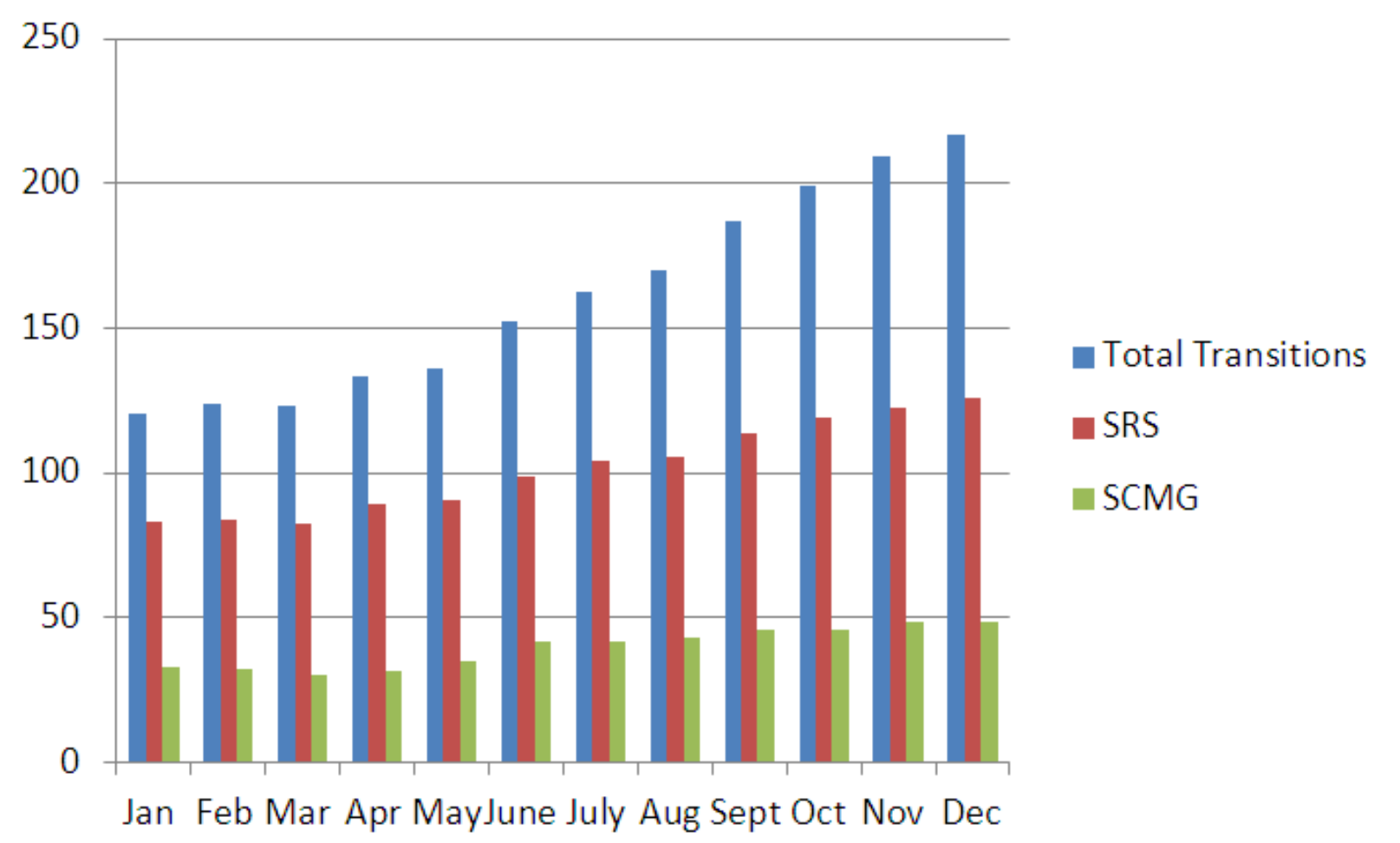
- A care model designed to improve outcomes for Pioneer ACO patients hospitalized with a diagnosis of CHF
- Designed in collaboration with Sharp Community Medical Group (SCMG) IPA
- Coordinate closely with SCMG Ambulatory Care Management from Bridges admission through “warm” transfer to ACM upon Bridges discharge

Transitions

Transitions

- A comprehensive care delivery model designed to manage patients with late stage illness in their preferred environment of care using the expertise of skilled healthcare providers through an interdisciplinary team approach

Transitions - Census Growth 2013



Recently Published

- To learn more about the Transitions program, read our recently published article:

CHRONIC DISEASE CARE

408 JCOM September 2013 Vol. 20, No. 9 www.jcomjournal.com

Development and Preliminary Evaluation of an Innovative Advanced Chronic Disease Care Model

Daniel R. Hoefer, MD, Suzi K. Johnson, MPH, RN, and Miriam Bender, PhD, RN

J Clin Outcomes Manage 2013 September;20(9):408-418

Thank you

General Discussion

- Historically, palliative care services have had a slow uptake; is this changing with value-based care?
  - What is the business case for ACO networks to integrate palliative care?
  - From a HIT perspective, what barriers and challenges exist?
    - What factors should ACO leadership consider as they consider expanding?
- Q&A / General Discussion

Next Steps

- Audio recording and slides will be available online at http://ehidc.org/issues/accountable-care/accountable-care-council-materials

- Next meeting: May 15, 2014
  Behavioral Health

- Upcoming topics in the spring:
  - Home health / skilled nursing facilities
  - ACO Survey
  - 2020 Roadmap

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FORUM INFO AVAILABLE AT:
http://ehidc.org/events-landing/daf-2014

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- Cutting Edge Data & Analytic Technologies & Practices

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Thanks for participating!