FINANCES OF PALLIATIVE CARE

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Learning Objectives:
- Distinguish and identify the unique needs of one's organization as it relates to a functional palliative care program.
- Implement a cost-efficient, outcome-driven palliative care program

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Objective

- Improving Quality & Cost Efficiency Through a Collaborative Palliative Care Program

What We Know

- Without PC Service
  - Patients receive unnecessary/unwanted medical, pharmalogical and diagnostic interventions

- PC Service should
  - Identify patient & family needs from multiple perspectives
    - Patient /family
    - Primary/Specialty Physicians
    - Case Management/Discharge Planning
    - Patient Ability to adhere to Discharge Planning (Difficult w/o true collaboration)
The Concerns are Valid

- “Coordinating Care – A Perilous Journey through the Health Care System” (T. Bodenheimer, MD. NEJM 358 March 2008)
- 1/3 of pts with chronic illness and hospitalization had no post discharge follow-up arrangements
- Less than 1/3 of PCPs were provided discharge information / medications
- 3% of PCPs are involved in discussions with hospitalists re pts d/c plans
- PCPs are infrequently notified that pt discharged

Readmissions

- 1 in 5 Medicare patients re-hospitalized within 30 days of discharge
- Half of these occurred before seeing community physician
- Estimated cost 17.4 billion

*Jencks, Williams, and Coleman
NEJM 2009, Vol 360, 1418-1428

<table>
<thead>
<tr>
<th>Condition at Time of Discharge</th>
<th>30 Day Readmit Rate</th>
<th>Most Commonly Attributed to Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>21.6</td>
<td>Heart Failure (8.6), Pneumonia (10.3)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>28.1</td>
<td>Pneumonia (29.1), Heart Failure (17.4)</td>
</tr>
<tr>
<td>COPD</td>
<td>27.6</td>
<td>COPD (26.1), Pneumonia (21.4)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>24.6</td>
<td>Psychosis (62.7), DKA (32.3)</td>
</tr>
<tr>
<td>UTI/infections</td>
<td>19.2</td>
<td>UTI/infections (52.0), Influenza (15.3)</td>
</tr>
</tbody>
</table>

Rehospitalizations among Patients in the Medicare Fee-for-Service Program, Stephen F. Jencks, M.D., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H. NEJM 2009;360:1418-1428 April 2, 2009
We All Recognize the Benefit

Service Use Among Patients Who Died from Heart Failure, Chronic Obstructive Pulmonary Disease, or Cancer While Enrolled in a Palliative Care Intervention or Receiving Usual Care, 1999–2000

Data: Adjusted service use rates were based on administrative records. SNF = skilled nursing facility. (Brumley, R.D. et al. JAGS 2007)

Palliative Focus

Palliative care is a comprehensive approach to serious illness which aims to improve quality of life by focusing on:

- Symptom Management
- Prognosis
- Treatment options
- Goals of care and advance care planning
- Physical, emotional, and psychological suffering
- Functional capacity
- Bereavement needs

Regardless of the Model

- Same goals
  - Pain and symptom control
  - Avoid inappropriate continuation of the dying process
  - Provide the patient and loved ones with a sense of control
  - Relieve burdens on family
  - Improve Quality
  - Reduce Unnecessary Cost
Goal

- Create a hospital based palliative care program coupled with a collaborative partnership that includes a robust outpatient palliative care service.
- Aimed at addressing an important part of the continuum of illness: those patients who are facing incurable, life-limiting chronic and/or acute life threatening illness.
**+ Approach**

- Coordinated, comprehensive, multidisciplinary approach to patients which focuses on discussion of prognosis, treatment options, goals of care, patients’ personal goals and spirituality, as well as relief of emotional, psychological, and physical suffering. Through this approach, the palliative care team will add a valuable, new, patient-focused service.

**+ Familiar graphic:**

- Majority of Initial PC Referrals

**+ We Need a Change**

- Initial PC Referral
Target Patients

- Patients with advanced illness who are in the final months to years of life, the final stages of life.
- Oncological patients with advanced, metastatic solid organ cancers, with symptoms and functional impairment, e.g. metastatic non-small cell lung cancer.
- Non-oncological diseases, that is most easily conceptualized as end stage organ failure, including congestive heart failure (CHF), COPD, end stage renal disease, end stage liver disease, and stage brain disease (dementia).

Indicator/Trigger Tools

- e.g. end stage heart failure (CHF), sepsis, massive MI and reperfusion therapy inappropriate due to patient preferences, other terminal illness, or unrelated severe decline in functional status:
Program Options

- Hospital based consult service.
- Hospital based comprehensive service.
- Comprehensive Partnership.

Program Options

- Hospital based consult service consisting of
  - Physician
  - Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant

Program Options

- Hospital based comprehensive service consisting of
  - Physician
  - Nurse Practitioner
  - Social worker
  - Chaplain
  - Eventual RN case manager
Program Options

- Comprehensive Partnership
  - Physician
  - Nurse Practitioner
  - Social worker/Case Manager
  - Chaplain
  - RN case manager

Program Outline

- Job descriptions and Staff Credentialing
  - How to reach the service
  - M-F initially or 7 day coverage?
  - 90 day period for APN or additional physician to be credentialled

- Identify Palliative Committee/Task Force
  - Development of PC Triggers and Metrics for Data Collection

- Solidify Education Timeline for Clinical Specialty and Departments

- Internal PR (Introductory Letter from CMO)

- Meet IT/BI department involvement in reporting capabilities

- Development of Marketing/PR materials to support the initiative

Program Outline

- Assess staff’s ability to differentiate between Hospice and Palliative Care; tailor education to meet educational need

- Review triggers for PC, and for Hospice
  - Introduction of triggers into collaborative care rounds

- Communicate objectives of the program
  - (ICU LOS reduction, Reduction in readmissions, reduced mortality, Patient/family satisfaction)

- Review current high risk areas
  - Diagnoses/DRGs
  - Particular patient demographics (Such as certain feeder nursing homes)
  - Specific Physicians or Specialty
  - Specific Units
**PC Service**

- The service will be available for consultation when assistance is needed with:
  - Discussing medical treatment options/goals of care
  - Reviewing prognosis
  - Relieving suffering caused by physical symptoms
  - Dealing with the multifaceted emotional, spiritual, psychological, and social challenges faced by patients with an acute life-threatening condition or a chronic, life-limiting illness
  - Helping to mediate discordance in goals of care between the medical team and patient/family
  - Providing bereavement services
  - Caring for patients whose death is imminent

**PC Service Operation**

- Weekend and evening phone coverage will be offered for urgent consults, if physician staffing during this first year of operations allows for this. Seasons Call center can provide support for after hours and weekend consults.
- The service will follow the practice guidelines set forth by the National Consensus Project “Clinical Practice Guidelines for Quality Palliative Care.”
- A focused effort to educate hospital staff on palliative medicine and hospice care will be an ongoing goal of the program. This will be a particularly important initiative early on and help serve initial marketing needs.

**PC Service**

- Working closely with the community based providers, the consult service will become involved in the care of appropriate patients who require admission to the hospital.
- While the service’s focus will be the preferences and comfort of its patients, the service will also strive to:
  - Ensure the judicious use of laboratory and radiologic testing
  - Discontinue medications and other therapies that are inconsistent with a patient’s care plan
  - Play a central role in discharge planning and ensure that the transition for its patients is expedited, seamless and efficient
Impact – Clinical Quality

- Based on the experience of other programs, we believe the following clinical outcomes can be anticipated:
  - Improved management of patients’ physical symptoms, with resultant improved scores on pain and other symptom assessment
  - Increased attention to assessment and management of psychological symptoms
  - Improved psychosocial and spiritual support for patients and their families
  - Improved patient and family satisfaction through improved communication and patient-focused care
  - Enhanced coordination of care between all involved providers
  - Increasing appropriateness of care by adhering to a patient’s goals
  - Improved quality of life through comprehensive, patient-focused care

Ancillary Impact

- Reduced use of ancillaries
- Decreased hospital mortality rates by selecting patients who are appropriate for inpatient hospice
- Decreased resource utilization at the end-of-life, resulting in greater similarity with the practices of the nation’s top-performers
- Increased attention to Joint Commission standards regarding pain management
- Added support and education surrounding palliative care-related Pay-for-performance measures

Evaluating the Outcomes

- Clinical Outcomes Data
  - Patient characteristics (medical record number, age, sex, primary and secondary diagnoses, MS-DRG, date of consult)
  - Referral source (specialty) and patient location
  - Daily census/Monthly volume of new patients
  - Patient discharge status: % of patients who die as inpatients or discharged to hospice
  - Impact on pain and other symptom scores/functional status
  - Number and type of palliative care interventions
  - Advance care planning/DNR discussions
  - Number of DNR orders
  - Transfers out of ICU
  - Patient and family satisfaction/Referring physician satisfaction
### LOS Comparison Data
Like DRG n=181

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>Reg LOS</th>
<th>LOS - Patients on PC</th>
</tr>
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<tbody>
<tr>
<td>IP HOME OR SELF CARE</td>
<td>18.83</td>
<td>14.18</td>
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<tr>
<td>EXPRIE - HOSPICE/ATTORNEY</td>
<td>20.64</td>
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<tr>
<td>IP AMA</td>
<td>9.00</td>
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<tr>
<td>IP HOME HEALTH CARE</td>
<td>20.01</td>
<td>13.03</td>
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<tr>
<td>IP HOSPICE HOSPITAL</td>
<td>15.08</td>
<td>7.04</td>
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<td>IP HOME HEALTH CARE</td>
<td>20.58</td>
<td>13.03</td>
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<tr>
<td>IP TRANS TO NH FOR SKILLED CARE</td>
<td>23.06</td>
<td>13.03</td>
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<tr>
<td>IP TRANS TO SHORT TERM GEN. HOSP.</td>
<td>22.06</td>
<td>11.67</td>
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<tr>
<td>Grand Total</td>
<td>19.89</td>
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### LOS Comparison Data
Like DRG/ICU only n=112

<table>
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<th>Discharge Disposition</th>
<th>Reg LOS</th>
<th>LOS - Patients on PC</th>
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<tbody>
<tr>
<td>IP HOME OR SELF CARE</td>
<td>20.00</td>
<td>26.13</td>
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<tr>
<td>EXPRIE - HOSPICE/ATTORNEY</td>
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<td>IP AMA</td>
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<td>IP HOME HEALTH CARE</td>
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<td>IP HOSPICE MEDICAL FACILITY</td>
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<td>IP LONG TERM CARE HOSPITAL</td>
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<td>IP REHABILITATION</td>
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<td>IP TRANS TO NH FOR SKILLED CARE</td>
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<td>IP TRANS TO SHORT TERM GEN. HOSP.</td>
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<td>Grand Total</td>
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Utilization Comparison Data

### ICU Patients

<table>
<thead>
<tr>
<th>Imaging/Diagnostic</th>
<th>PC Patients</th>
<th>Non-PC Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT Scan</td>
<td>26%</td>
<td>60%</td>
</tr>
<tr>
<td>EKG</td>
<td>32%</td>
<td>80%</td>
</tr>
<tr>
<td>MRI</td>
<td>4%</td>
<td>11%</td>
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<tr>
<td>Nuclear medicine</td>
<td>4%</td>
<td>10%</td>
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<tr>
<td>Ultrasound</td>
<td>20%</td>
<td>49%</td>
</tr>
<tr>
<td>X-Ray</td>
<td>54%</td>
<td>85%</td>
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</table>

<table>
<thead>
<tr>
<th>Imaging/Diagnostic</th>
<th>PC Patients</th>
<th>Non-PC Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Utilization</td>
<td>Qty/Patient</td>
<td>Qty/Patient</td>
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<tr>
<td>CT Scan</td>
<td>3.17</td>
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<tr>
<td>EKG</td>
<td>2.94</td>
<td>4.64</td>
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<tr>
<td>MRI</td>
<td>2.80</td>
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<tr>
<td>Nuclear medicine</td>
<td>1.10</td>
<td>1.25</td>
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<tr>
<td>Ultrasound</td>
<td>1.36</td>
<td>1.84</td>
</tr>
<tr>
<td>X-Ray</td>
<td>6.33</td>
<td>10.59</td>
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ICU Compliance with Initiative

Patients with Positive Screens Receiving PC Consults
Impact of PC Consult on 30-Day Readmissions Stratified by Number of Risk Factors

Percent of Patients Admitted as Full Code Who Changed to DNR

Sample ROI Assessment

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The Seasons Difference

- Experience in building a Collaborative Hospital-based Palliative Programs nationally. Hospitals with capacity between 200 and 700 beds.
- Currently collaborating with Tenet Healthcare (Chicago, the NE Region, Detroit, Southern California) and Tenet’s National Palliative Care leadership (Dr. Robert Zalenski)
- >85% Employed physicians are board certified and/or fellowship trained in Hospice and Palliative Medicine.
- Robust outpatient program to provide palliative services through the continuum of care.
- Ability to staff and implement a program quickly given current staffing ability, support materials already developed; including palliative triggers, CE approved education/training, data collection tools, call center ability to triage after-hours consults
- Open Access Hospice Program
  - Palliative Radiation, TPN, IV, Cardiac drips, Ventilators
- Hospice Inpatient Center experience

The Seasons Continuum of Care

- Open Access Hospice Requirements:
  - Palliative Care
  - Non-curative treatment
  - Termination of curative treatment
  - Active terminal illness
- Traditional Hospice Requirements:
  - 6 months of life expectancy
  - Medical condition(s) is terminal
  - Active terminal illness
  - Curative treatment appropriate
- Other Services:
  - Hospital Team
  - Pharmacy
  - Physician

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