Palliative Care Financial Stability in the post-COVID Healthcare Era

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Learning Objectives

1. Identify some of the key issues in building / growing a Palliative Care team in the time of COVID

2. Explore the range of financial support in Tele-Palliative Care (TelePC)

3. Discuss key operational / clinical steps that can be implemented to improve access to care

4. Highlight “low-hanging fruit” data and quality metrics that you can collect and highlight now

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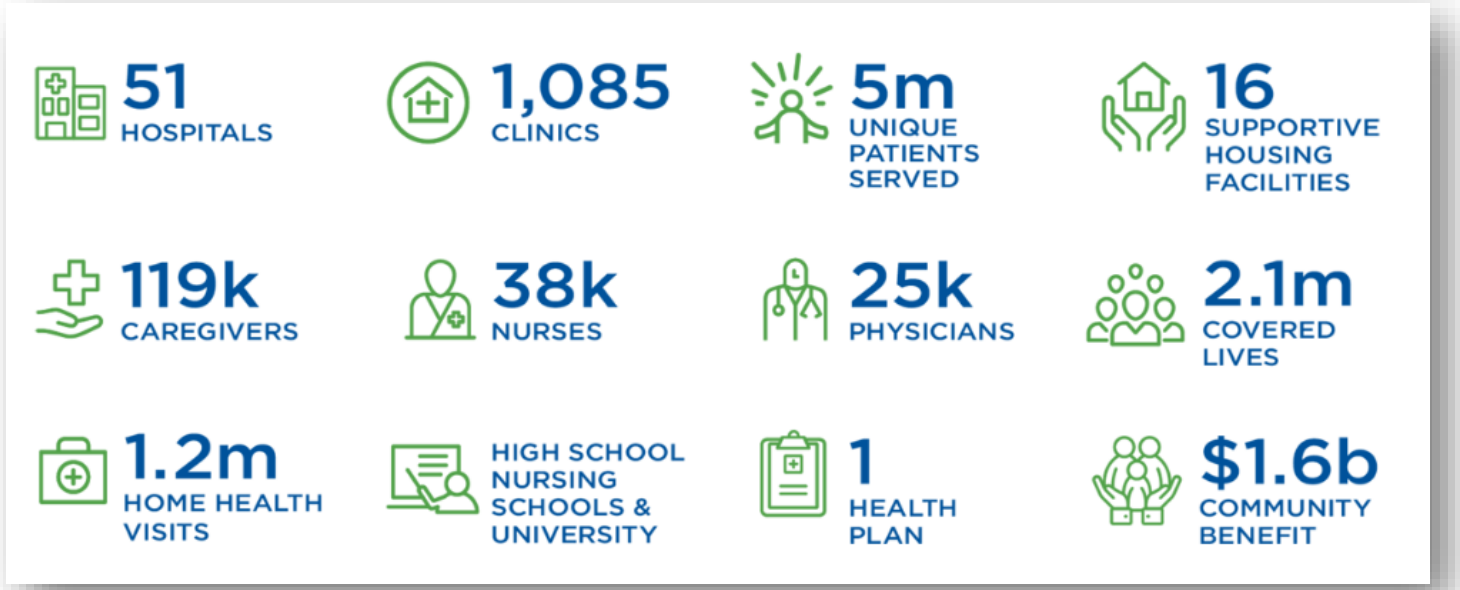
We are a team of health care leaders, clinicians, and change agents who serve a 50+ hospital system, across seven states in improving care and healthcare access to the most vulnerable.

"At the Institute for Human Caring, we believe that whole person care is essential to helping patients, families, and caregivers experience the best care possible. This requires attending to the body, mind and spirit."



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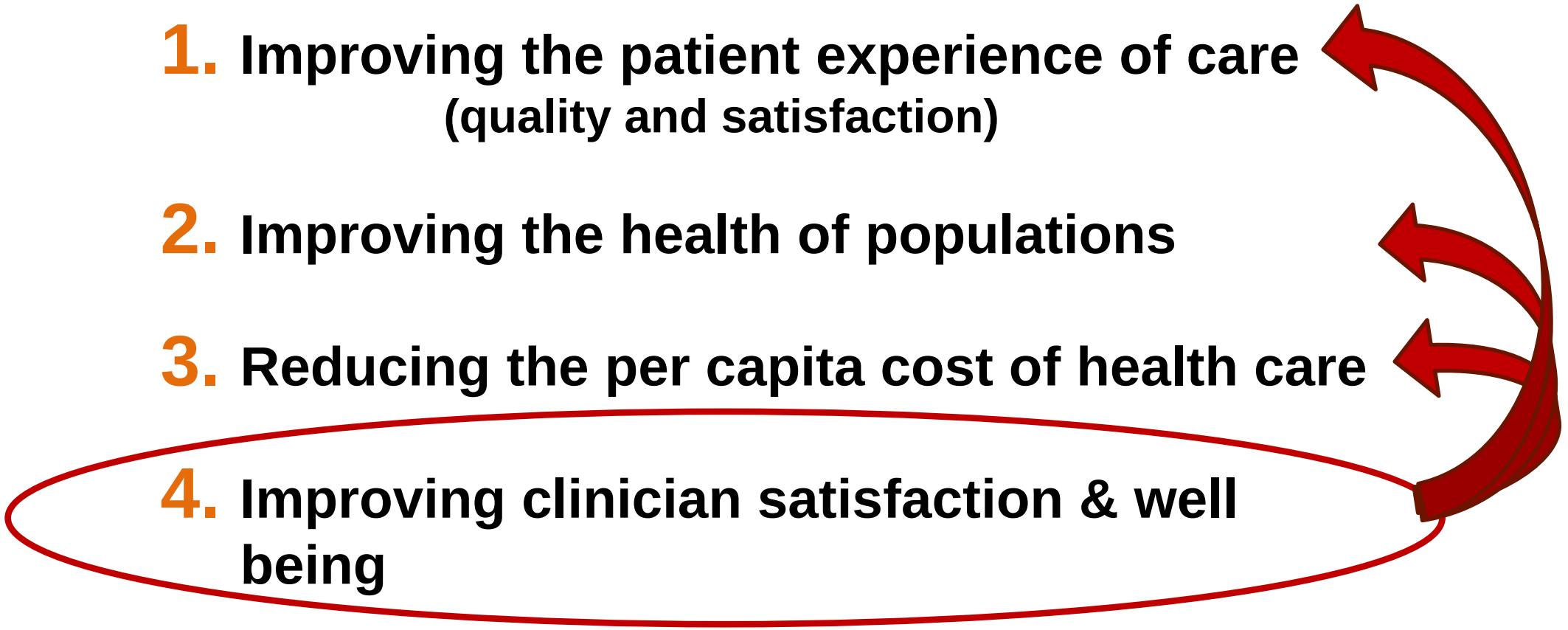
Quadruple Aim

1. **Improving the patient experience of care**
   (quality and satisfaction)
2. **Improving the health of populations**
3. **Reducing the per capita cost of health care**
4. **Improving clinician satisfaction & well being**



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TelePC visits exploded after March 2020

With COVID-19 changes, so came some required adaptation in Acute Palliative Care

We identified three High-Priority Use Cases:

- Hospitalized Patients in Isolation
- Interprofessional Collaboration
- Family Meetings

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Palliative Care TelePC and COVID-19

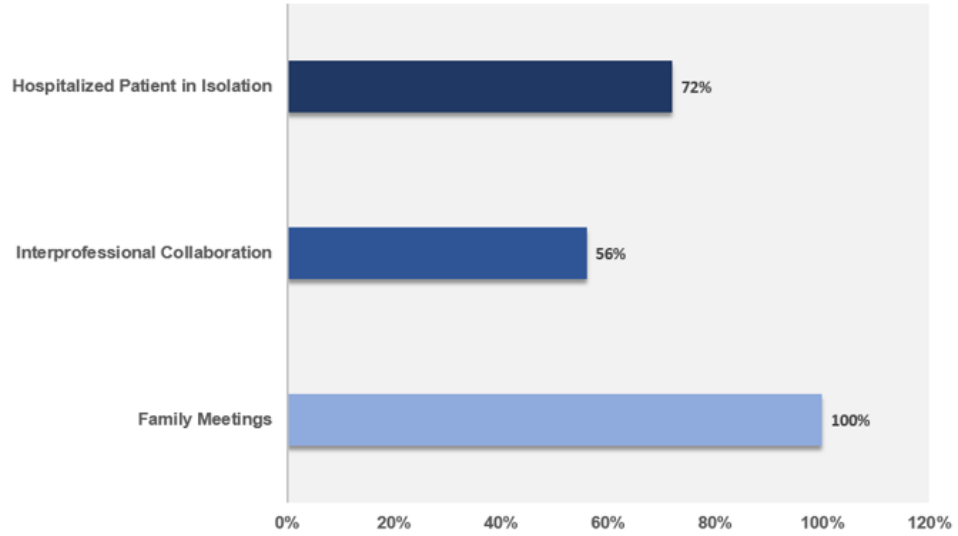
- Formed COVID-19 response team to bring together resources, support, and best-known practices
- Drafted EOL visitation recommendation
- Created tele-PC resources for technology access, documentation, and billing/coding

Priority Care Scenarios

→ **18** ministries are using tele-PC for patients in isolation

→ **14** ministries are using tele-PC for interprofessional collaboration

→ **25** ministries are using tele-PC for family meetings



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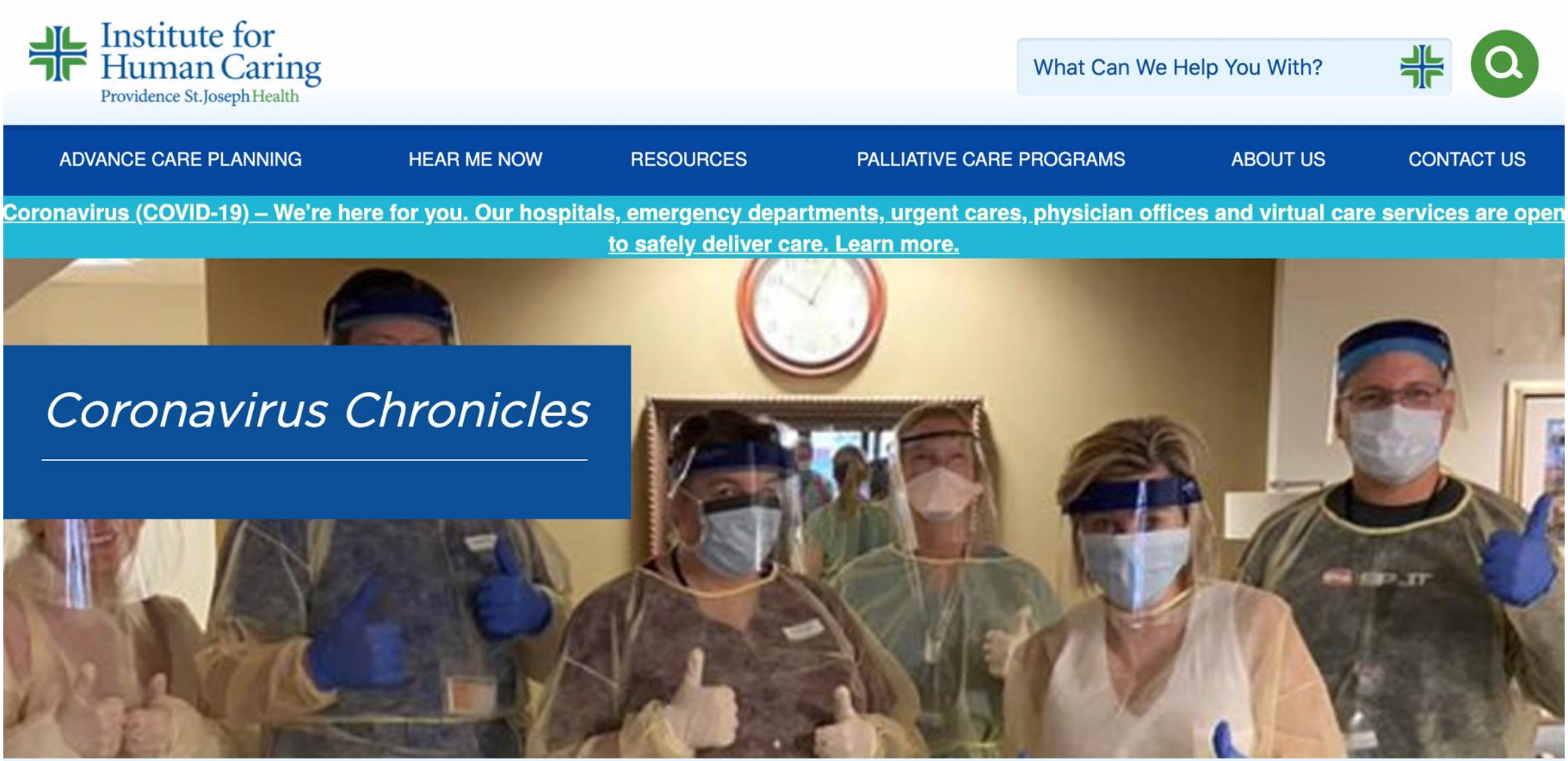
Palliative Care – Pivoting in Response to Covid-19

- **Tele-Palliative Care**
  - Daily PC COVID Planning/Response Huddles
  - Weekly PC Leadership meetings - Compile and define best practices to facilitate sharing across system

- **Tele-Palliative Care**
  - Develop resources: instructions for caregivers and patients, policy/billing & iPad fact sheets, EHR documentation templates, FAQs, and tip sheets
  - Coding and billing for TelePC in context of current pandemic waivers, and future sustainability
  - Develop program design and proforma for launch of TelePC to support PC teams across the system in launching and utilizing TeleHealth platform

Coronavirus Chronicles



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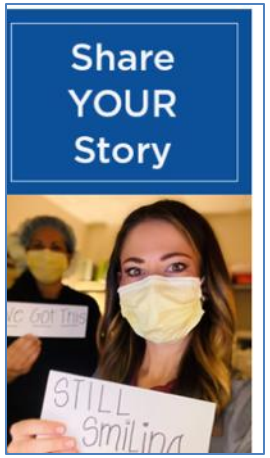
Coronavirus Chronicles

The **Coronavirus Chronicles** is a storytelling and listening project to capture experiences from caregivers, patients and others during the 2020 pandemic.

The Coronavirus Chronicles offers a safe space for you to share heartfelt images, art, audio, video and text stories during this surreal - and often scary - moment in history.

Things to Talk About

- **What gives you hope?**
- **What concerns or frustrates you?**
- **What are you not doing now that you miss the most?**
- **What incident occurred that you'll forever remember – or would rather forget?**
- **What are your coping strategies?**
- **What did you do for or tell a patient or loved one that made their day better?**
- **What advice would you give your future self?**



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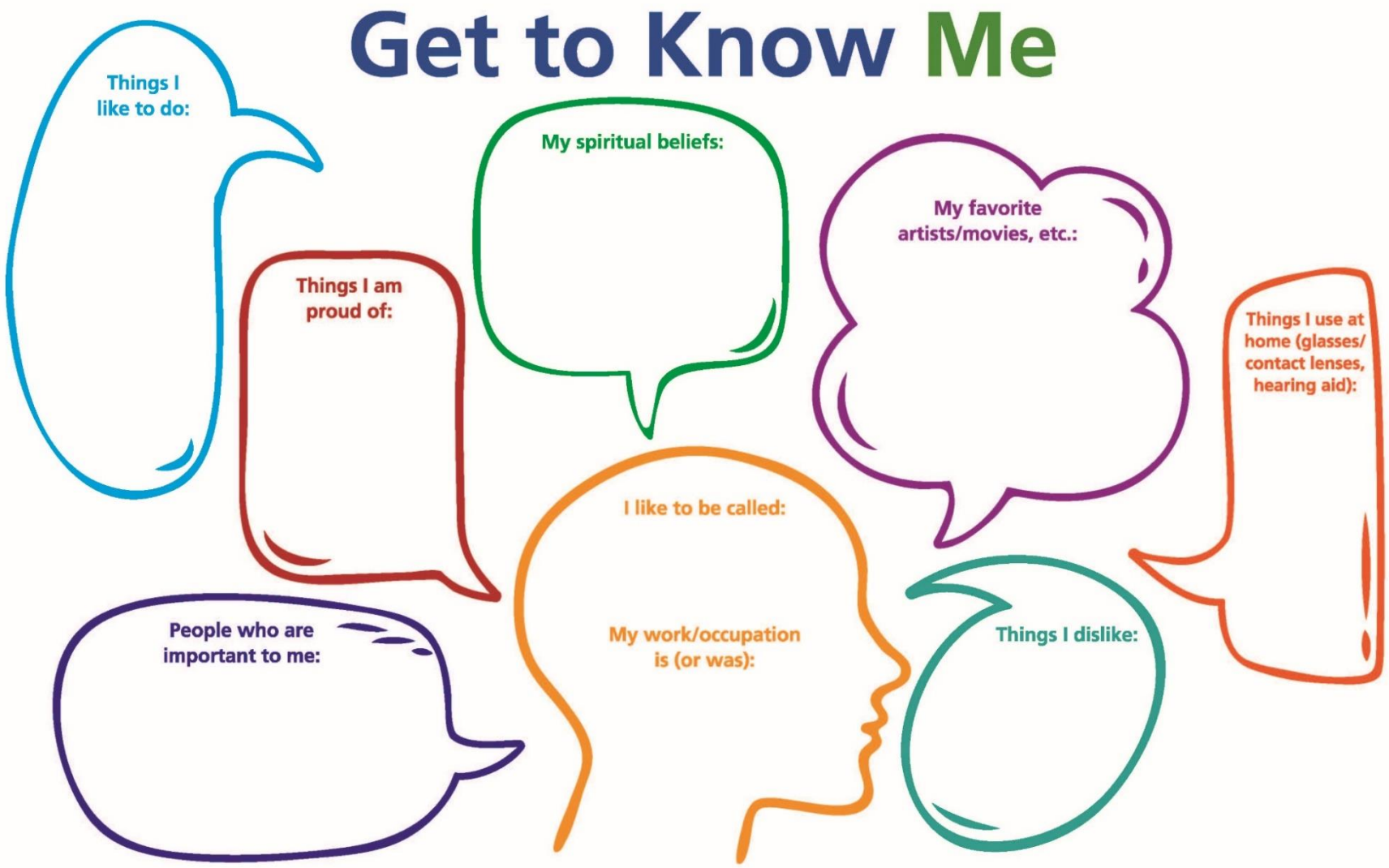
Our Patients are people



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CMS changed the rules

- **Telehealth visits during COVID response are considered as an in-person visit.**

  Telehealth visits are paid at the same rate as regular, in-person visits during pandemic.

- **Established relationship for New patients not required.**

  Normally you cannot complete nor bill for a new patient telehealth services, but HHS will not be auditing this during the COVID-19 response.

- **You may conduct telehealth appointments from anywhere.**

  The new waiver eliminates the need for caregivers to be at a medical facility or physician's office; patients can receive tele-health services from their homes or any setting of care.

- **HIPAA compliance standards have been suspended for platforms like Facetime and Skype.**

  HIPAA compliant platform is still recommended, but CMS has committed to waive penalties for HIPAA violations for health care providers serving patients in good faith through everyday communications technologies, such as **FaceTime** or **Skype**, regardless of whether the patient has symptoms/diagnosis of COVID-19. **Telephonic communication**, while not ideal, is also allowed.

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CMS will allow reimbursement

- Medicare will **reimburse** for tele-health services as an in-person visit.
- Medicare payments for audio-only telephone evaluation and management (E/M) visits **(CPT codes 99441-99443**) are now equal to payments for comparable office or outpatients visits with established patients **(CPT codes 99212-99214)**.
- **CMS has waived the video requirement for select services.** As a result, Medicare beneficiaries can use audio-only telephone visits to receive advance care planning (CPT Codes 99497-99498).

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Acute Consult (inpatient & SNF)

2020 Physician Fee Schedule - Palliative Care						
Visit	**CPT**	**SHORT DESCRIPTION**	**Threshold Time**	**CMS Allowable**	**wRVU**	**tRVU**
InPatient Consult			Minutes			
Level 1	99221	Initial hospital care	30	**$109.81**	1.92	2.86
Level 2	99222	Initial hospital care	50	**$148.65**	2.61	3.86
Level 3	99223	Initial hospital care	70	**$218.55**	3.86	5.7
Level 1	99231	Subsequent hospital care	15	**$42.37**	0.76	1.11
Level 2	99232	Subsequent hospital care	25	**$78.14**	1.39	2.05
Level 3	99233	Subsequent hospital care	35	**$112.63**	2.0	2.93
Prolonged Services (Acute with Patient)			Minutes			
1st Hr	99356	Prolonged service inpatient	31-75	**$100.37**	1.71	2.6
Addl 1/2	99357	Prolonged service inpatient	76-105	**$101.22**	1.71	2.61
Prolonged Services (non-patient facing)			Minutes			
1st Hr	99358	Prolong service w/o contact	31-75	**$120.99**	2.1	3.15
Addl 1/2	99359	Prolong serv w/o contact add	76-105	**$59.10**	1.0	1.52
Advance Care Planning			Minutes			
1st 1/2 Hr	99497	Adv care plan first 30 min	16-45	**$85.61**	1.5	2.4
Addl 1/2	99498	Adv care plan addl 30 min	46-75	**$80.62**	1.4	2.11

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Tele Health Acute Consult (inpatient, ED, & SNF)

2020 Physician Fee Schedule - Palliative Care						
Visit	**CPT**	**SHORT DESCRIPTION**	**Threshold Time**	**CMS Allowable**	**wRVU**	**tRVU**
TeleHealth Consult			Minutes			
Level 1	G0425	Inpt/ed teleconsult	30	$106.74	1.92	2.86
Level 2	G0426	Inpt/ed teleconsult	50	$145.26	2.61	3.86
Level 3	G0427	Inpt/ed teleconsult	70	$215.68	3.86	5.7
Level 1	G0406	Inpt/tele follow up	15	$41.45	0.76	1.11
Level 2	G0407	Inpt/tele follow up	25	$77.26	1.39	2.05
Level 3	G0408	Inpt/tele follow up	35	$111.01	2.0	2.93
Prolonged Services			Minutes			
1st Hr	G0513	Prolong prev svcs, first 30m	31-75		0.59	1.64
Addl 1/2	G0514	Prolong prev svcs, addl 30m	76-105		0.59	1.65
TeleHealth Pharmacy Consult			Minutes			
G0459	G0459	Telehealth inpt pharm mgmt		$43.52		
Advance Care Planning			Minutes			
1st 1/2 Hr	99497	Adv care plan first 30 min	16-45	**$85.61**	1.5	2.4
Addl 1/2	99498	Adv care plan addl 30 min	46-75	**$80.62**	1.4	2.11

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Phone Calls

2020 Physician Fee Schedule - Palliative Care						
Visit	**CPT**	**SHORT DESCRIPTION**	**Threshold Time**	**CMS Allowable**	**wRVU**	**tRVU**
Interprofessional Internet/EHR Collaboration			Minutes			
5-10 Min	99446	Interprofessional Collaboration	5	**$19.44**	0.35	0.51
11-20 min	99447	Interprofessional Collaboration	11	**$39.30**	0.7	1.01
21-30 min	99448	Interprofessional Collaboration	21	**$58.73**	1.05	1.52
>31 min	99449	Interprofessional Collaboration	31	**$78.28**	1.4	2.02
>5 min	99451	Written Intrprof/Intrnet/EHR	5	**$39.83**	0.7	1.04
>16 min	99452	Intrprof ph/intrnet/ehr rfrl	16	**$39.83**	0.7	1.04
Telephone E&M			Minutes			
Level 1	99441	Telephone Consult-physician	5-10	**$51.07**	0.48	1.27
Level 2	99442	Telephone Consult-physician	11-20	**$83.32**	0.97	2.09
Level 3	99443	Telephone Consult-physician	21-30	**$120.43**	1.5	3.06
Level 1	98966	Telephone Consult-non physician	5-10			
Level 2	98967	Telephone Consult-non physician	11-20			
Level 3	98968	Telephone Consult-non physician	21-30			

Moving into value-based reimbursement

- High performing Palliative Care teams cover ~50% of their expenses with billing.
- In a fee-for-service model only the provider's service is reimbursed.
- High quality Palliative Care benefits the patient and family!

- **The financial benefit of PC is primarily realized by the payer >> the Hospital/System**

Why do they Consult Palliative Care

- **Overall: Presence of a Serious, Chronic Illness**
  - Declining ability to complete activities of daily living
  - Weight loss
  - Multiple hospitalizations
  - Difficult to control physical or emotional symptoms related to serious medical illness
  - Patient, family or physician uncertainty regarding prognosis or goals of care
  - Requests for futile care
  - DNR order conflicts
  - Use of tube feeding or TPN in cognitively impaired or seriously ill patients
  - Limited social support and a serious illness (e.g., homeless, chronic mental illness)
  - Patient, family or physician request for information regarding hospice appropriateness
  - Patient or family psychological or spiritual distress
- **Intensive Care Unit Criteria**
  - Admission from a nursing home in the setting of one or more chronic conditions (e.g., dementia)
  - Two or more ICU admissions within the same hospitalization
  - Prolonged or difficult ventilator withdrawal
  - Multi-organ failure
  - Consideration of ventilator withdrawal with expected death
  - Metastatic cancer
  - Anoxic encephalopathy
  - Consideration of patient transfer to a long-term ventilator facility
  - Family distress impairing surrogate decision making
- **Oncology Criteria**
  - Metastatic or locally advanced cancer progressing despite systemic treatments with or without weight loss and functional decline;
  - Karnofsky < 50 or ECOG > 3
  - Progressive brain metastases following radiation
  - New spinal cord compression or neoplastic meningitis
  - Malignant hypercalcemia
  - Progressive pleural, peritoneal or pericardial effusions
  - Failure of first – or second-line chemotherapy
  - Multiple painful bone metastases
  - Consideration of interventional pain management procedures
  - Severe prolonged pancytopenia in the context of an untreatable hematological problem (e.g., relapsed leukemia)
- **Emergency Department Criteria**
  - Multiple recent prior hospitalizations with same symptoms/problems
  - Long-term-care patient with Do Not Resuscitate (DNR) and/or Comfort Care (CC) orders
  - Patient previously enrolled in home or residential hospice program
  - Patient/caregiver/physician desires hospice but has not been referred
  - Consideration of ICU admission and or mechanical ventilation in a patient with:
    - metastatic cancer and declining function
    - moderate to severe dementia
    - one or more chronic diseases and poor functional status at baseline

- **Distressing Symptoms**
- **Unclear Goals**
- **Questions**
- **Unmet need**

Population management organizations have used the indicators noted in the table below to identify the population in need of palliative care:

DIAGNOSIS	FUNCTION	UTILIZATION	COMBINATION RISK SCORES
• Cancer • Advanced liver disease • COPD with oxygen • Heart failure • [illegible]ure • Parkinson's Disease • Advanced dementia • Diabetes with complications • ALS • Other neurological conditions (egg. stroke, head trauma, intracranial hemorrhage) • Diagnoses indicative of decline, including: sarcopenia, cachexia, weight loss, decubitus ulcers, and/or difficulty walking • Combine diagnosis information into the Charlson Comorbidity Index (CCI)[3]	• Formal functional assessment results (see Section 2: Assessment) • Durable medical equipment ("DME") orders or prior authorizations[4], particularly: o home oxygen o wheelchair o home hospital bed • Transportation orders • Personal care orders • History of falls • Declining ability noted (Nursing, Social Work, or Case Manager notes – search for key words)	• Multiple hospital admissions • Multiple emergency department (ED) visits • Hospital length-of-stay greater than 7 days • ICU stays • High-burden treatment (egg bone marrow transplant, ventricular assist device) • Increased frequency of utilization of ED and/or hospital • Polypharmacy • Skilled nursing stay(s) • Certified home health agency use • High volume helpline callers	• Medicare Advantage Risk Adjustment Factor (RAF) or Hierarchical Clinical Conditions (HCC) score • Hospital One-Year Mortality Risk ("HOMR")) • "LACE" Index Scoring Tool[5]

In addition to diagnosis, functional limitations, and high utilization, **social determinants of health and personal factors** are also commonly used in identifying those appropriate for palliative care services. For example:

- Advanced age (over 75 or 85 years)
- Living alone/lack of nearby family
- Low self-reported quality of life
- Overwhelmed family caregivers
- Frequent missed appointments
- Dual eligibility or Medicaid insurance

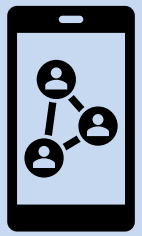
GetPalliativeCare.com

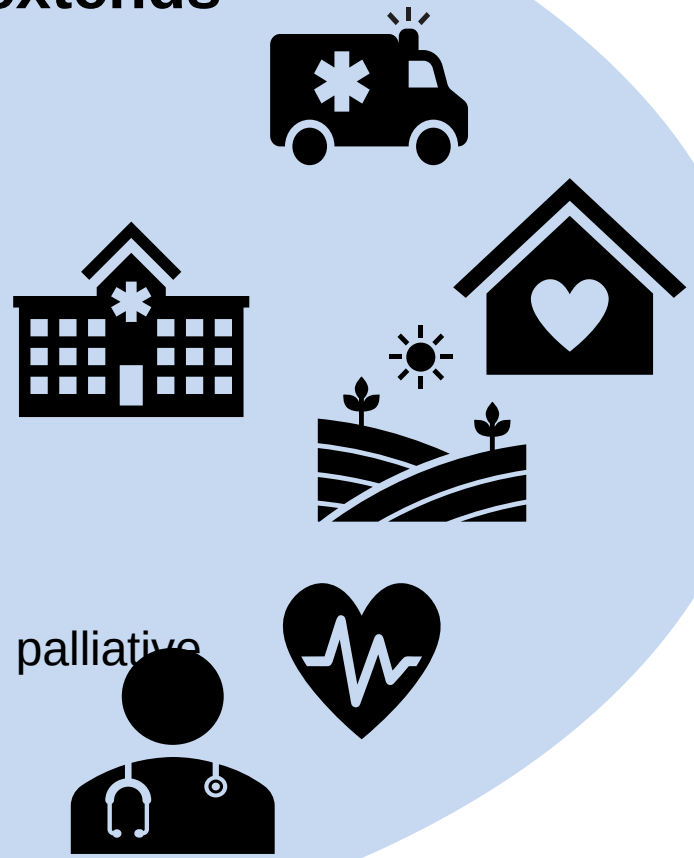
CAPC.org

Where do we Consult Palliative Care

Palliative Care Need extends into the community:

- Tertiary Medical Centers
- Emergency Departments
- SNF, ALF, AFH
- Critical Access Hospitals
- Rural Hospitals
- Primary Care Clinics
- Specialty Clinics
- Home visits
- Free-standing or embedded palliative care clinics





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Models of Palliative Care

Consultation Only

- Recommendations
- Guidance
- Very quick Handoff

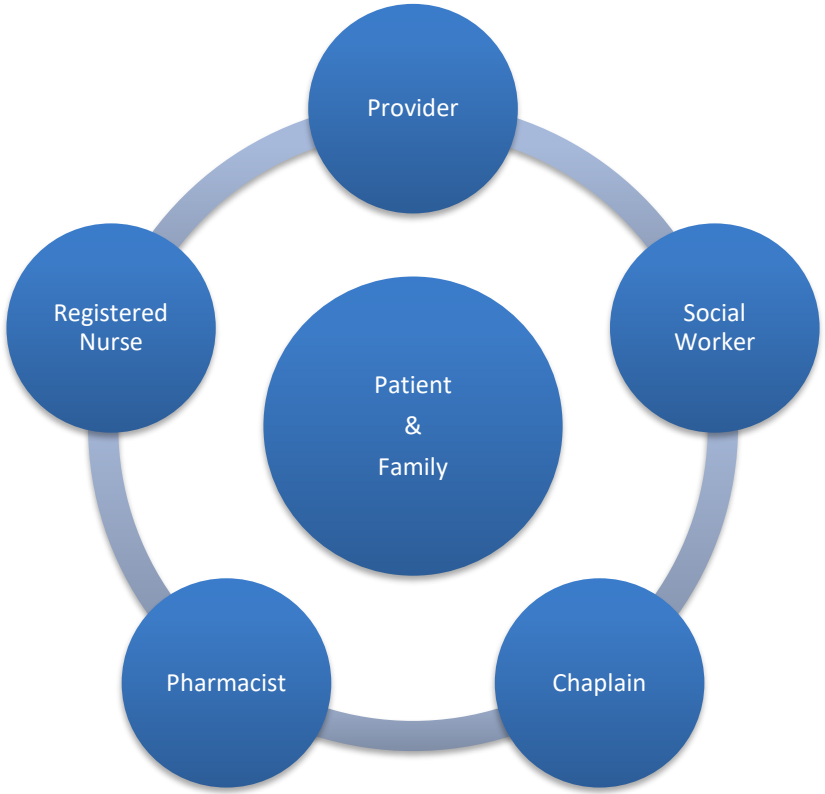
Co-Management

- Recommendations
- Collaboration & Guidance
- Cooperation on RX and day-to-day management
- Handoff after needs are met

Palliative Care Unit

- PC Provider assumes attending role and primary responsibility
- Manages/Directs all care
- No Handoff

Interdisciplinary Team



The foundation of the interdisciplinary team (IDT) is the identification of a common goal, and the shared approach to achieve this goal.

The IDT takes care of patients and their families, instead of diseases and conditions.

The team approach allows all care givers to function at the top of their license, and to support each other in delivery of very difficult care.

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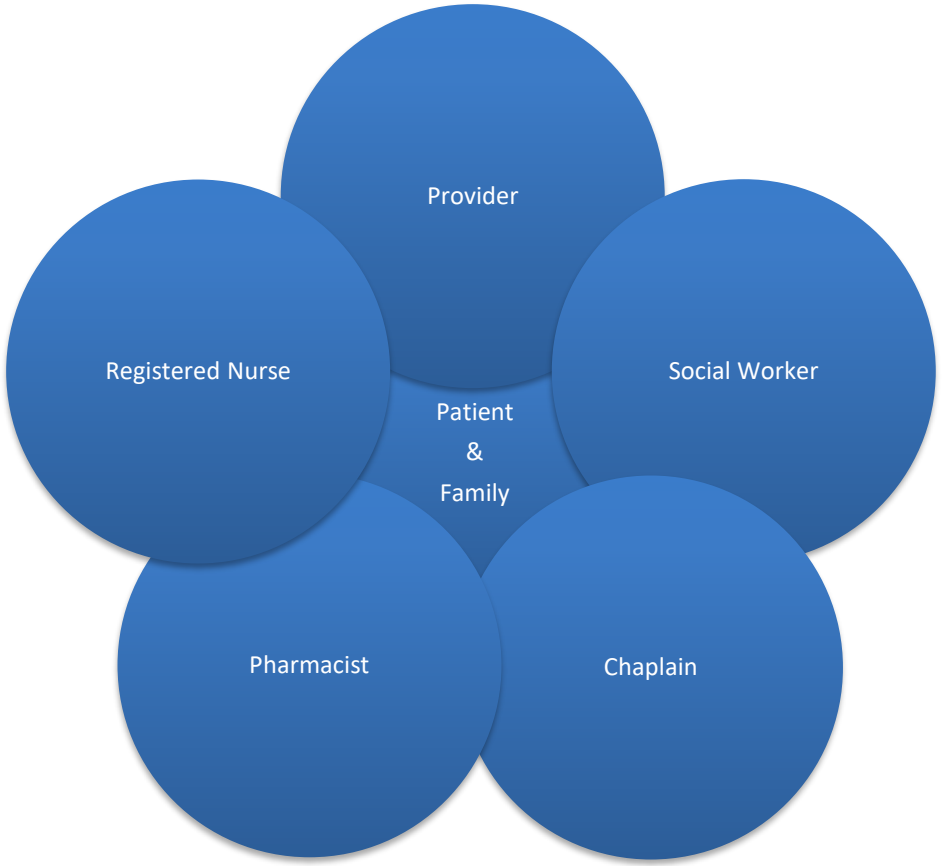
Interdisciplinary Team



Serving at the top of one's license improves patient care and improves caregiver satisfaction.

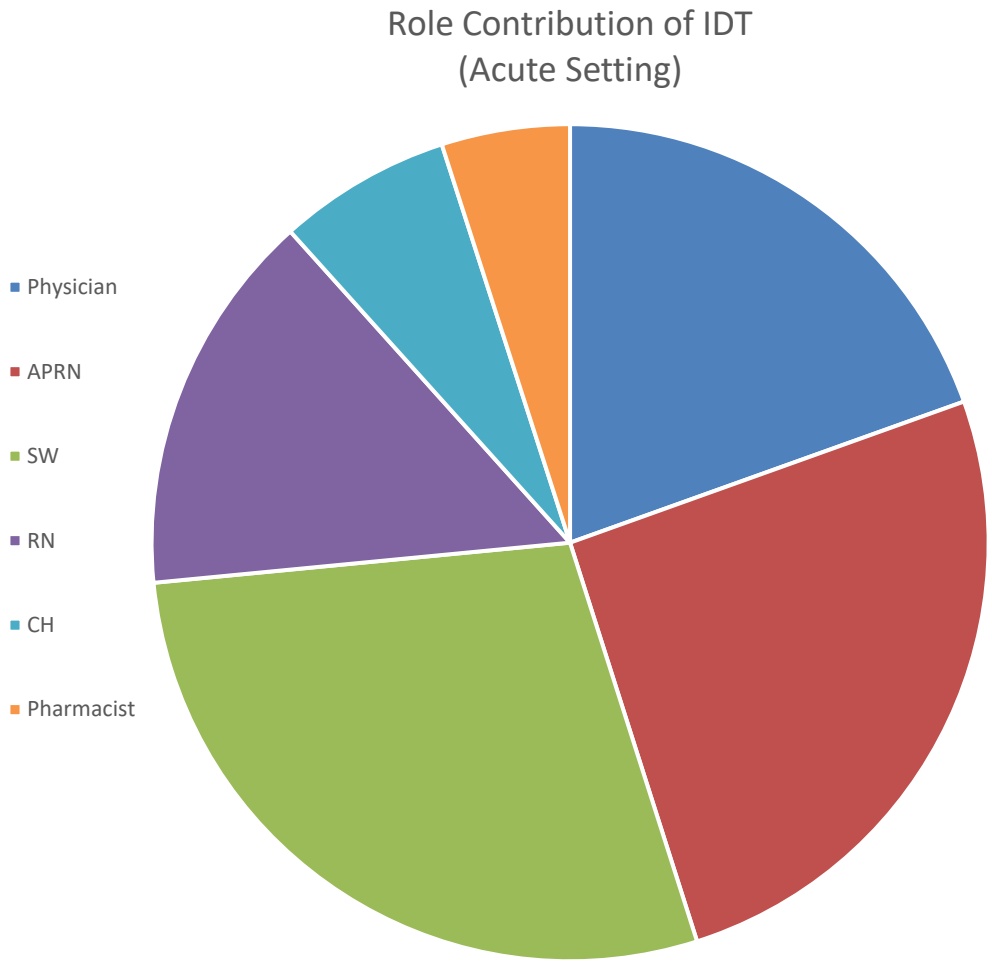
The foundation of the interdisciplinary team (IDT) is the identification of a common goal, and the shared approach to achieve this goal.

The IDT takes care of patients and their families, instead of diseases and conditions.

The team approach allows all care givers to function at the top of their license, and to support each other in delivery of very difficult care.

The overlap of role in the achievement of this common goal fills in the gaps for the patient and family.

Interdisciplinary Team Roles



Example 1: 125 bed hospital,
annual acute admission volume: 10,000
Full IDT

Requests for Consult	750
Provider Touches	2438
SW Touches	2775
RN Touches	1500
Chaplain Touches	675
Pharmacist Touches	710

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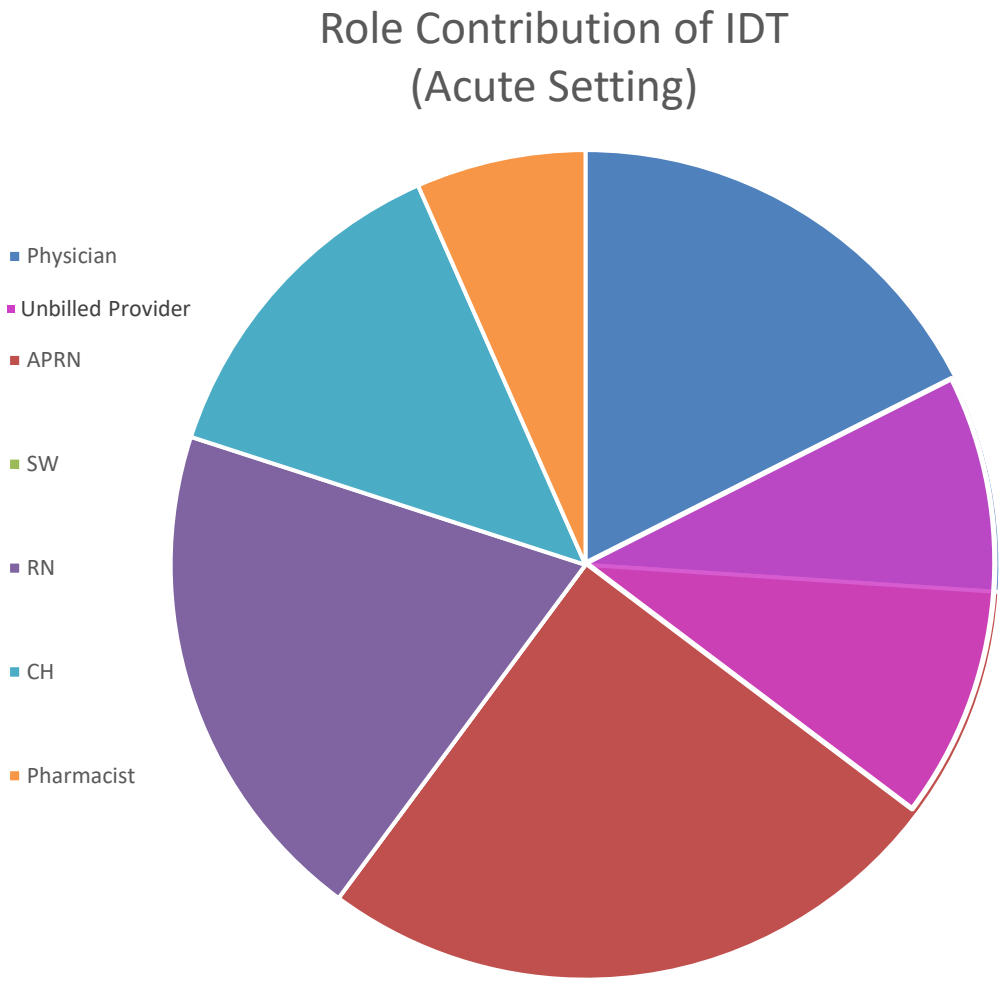
Interdisciplinary Team Roles

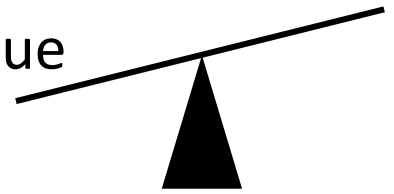


Example 2: 125 bed hospital,
annual acute admission volume: 10,000
Incomplete IDT

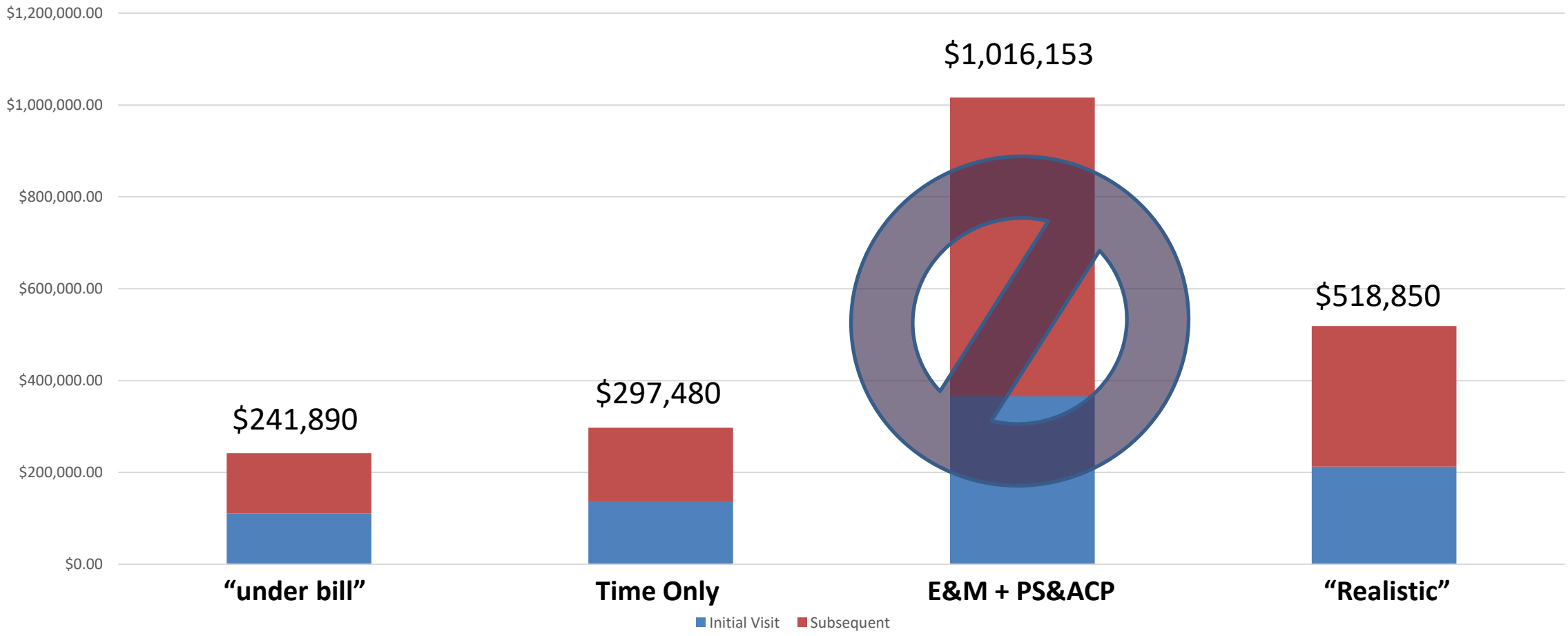
Requests for Consult	~~750~~ 600
Provider Touches	~~2438~~ 1050
SW Touches	~~2775~~ 0
RN Touches	~~1500~~ 2000
Chaplain Touches	~~675~~ 800
Pharmacist Touches	~~710~~ 850

~ $80,000
saved in salary

$104,000
↓ revenue



Billing Practices



Estimated billing for 750 Consults with approx. 1688 Follow-up visits

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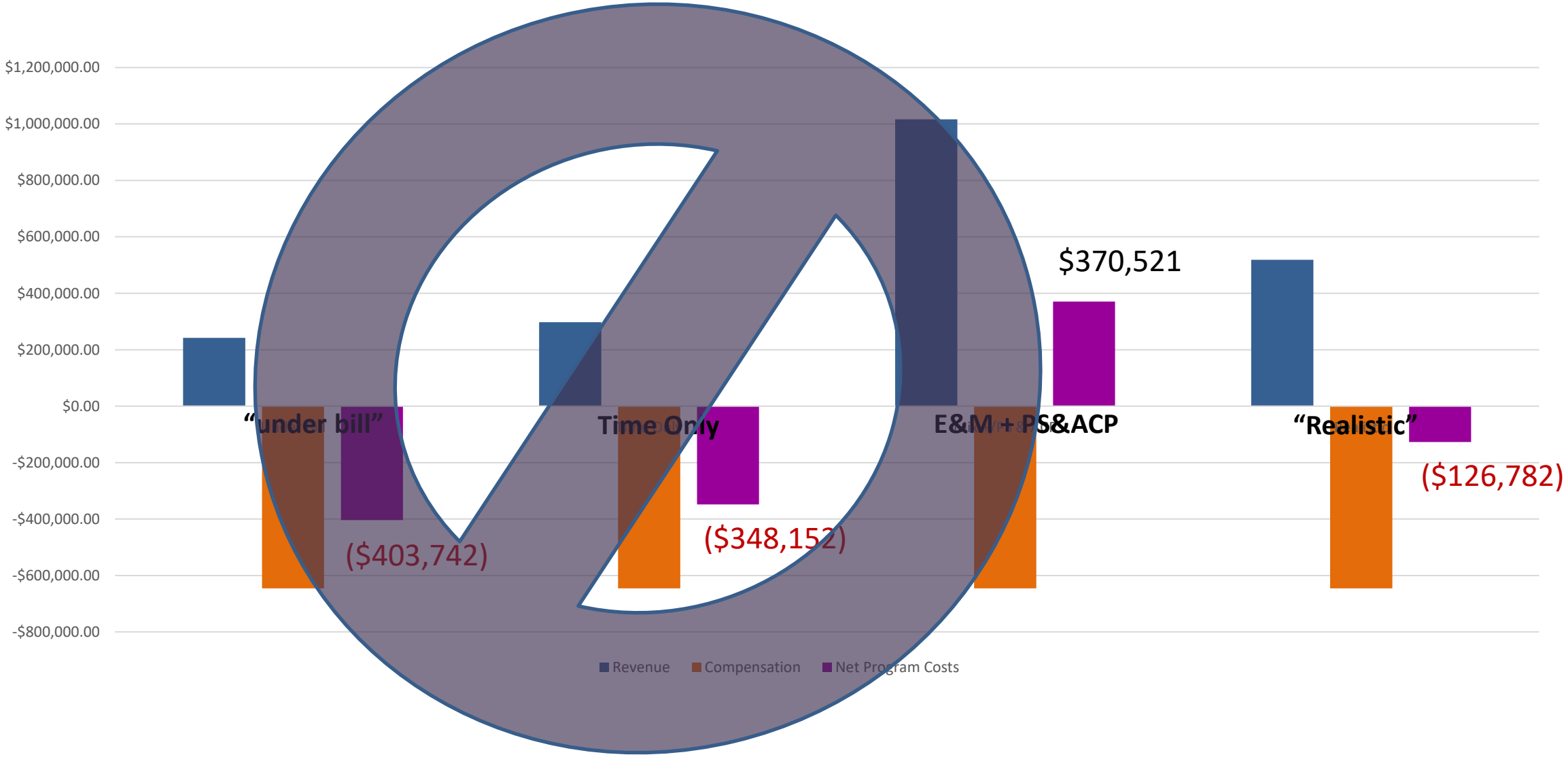
IDT Compensation vs Billing Practices



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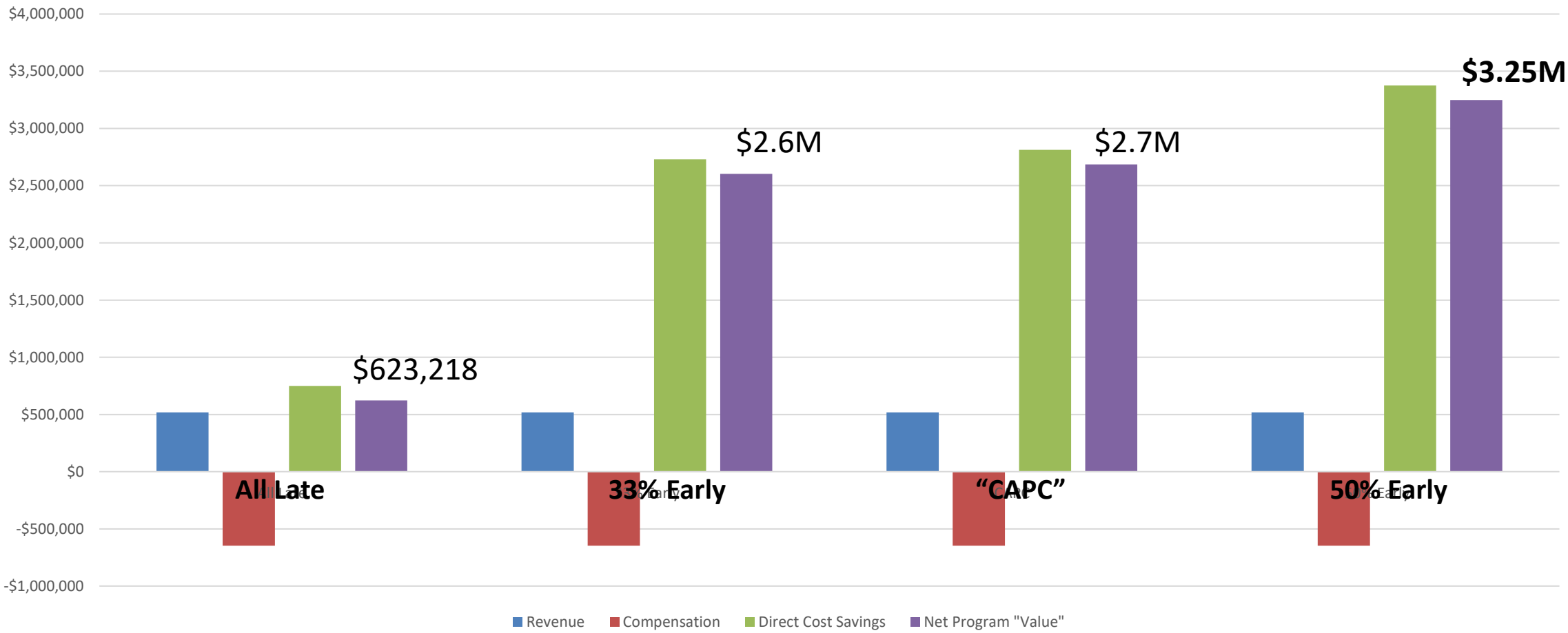
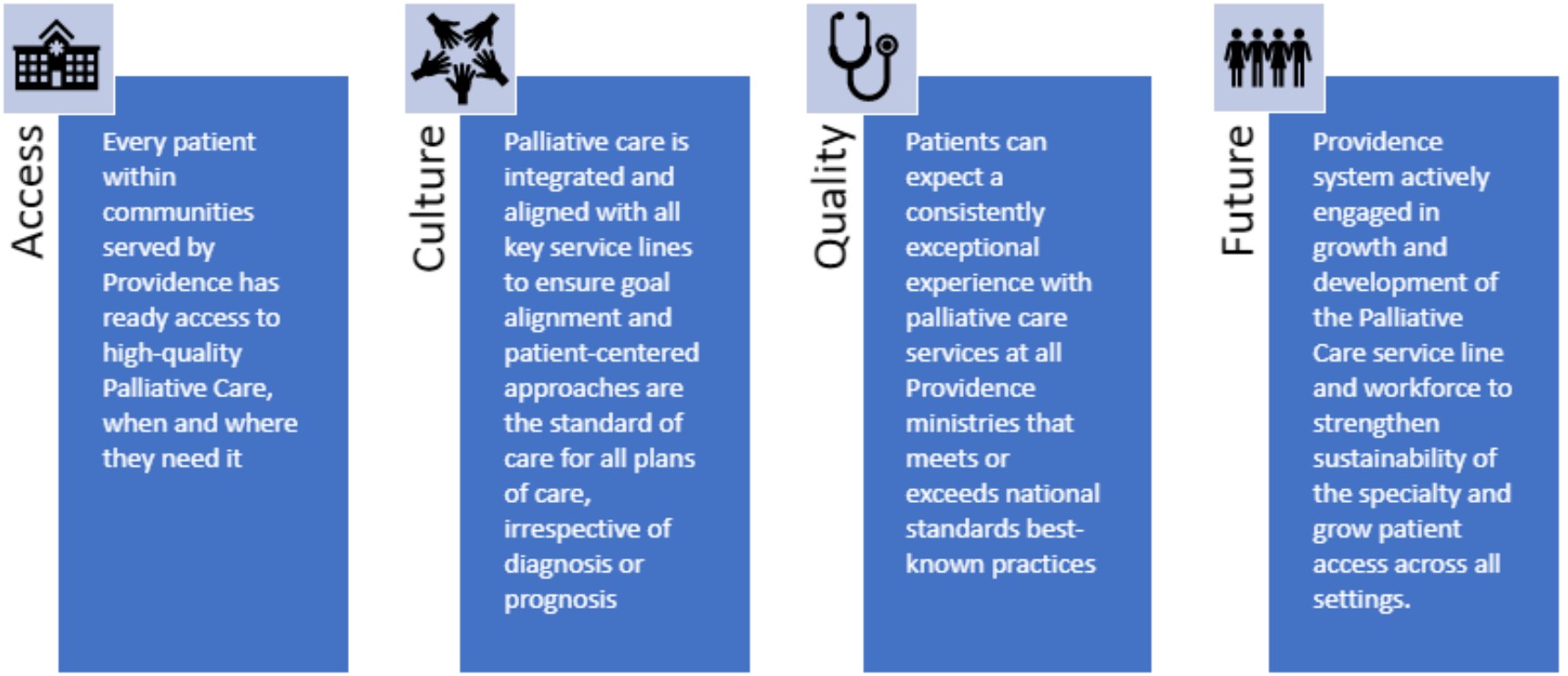
Direct Cost Savings



Estimated billing for 750 Consults with approx. 1688 Follow-up visits
3.8 FTE Patient-Facing Caregivers (Providers, SW, Chaplain, Nurse, and Pharmacist)

Vision for Palliative Care in Providence

24/7/365 access
to specialty palliative care services
for every patient who needs and wants it



Palliative Practice Group Recommendation

Full IDT at all ministries with >10,000 annual admissions or ADC >100

- Modified full-team in ministries between 50 – 100 ADC
- Explore alternate delivery models (telehealth) in ministries <50 ADC

To achieve min 10% penetration at all ministries. >8.5% in 5 years

- Full IDT for 10000 admissions (min)=2.0 Provider, 1.6 MSW , 1.0 RN, 0.75 Chaplain, + admin

Targeted Performance Improvement with RCV Sites to Move Toward Consistent System-wide Targets by 2022

All should be seen as a suite of balancing metrics

Access: First ensure patients can get palliative care

Early Impact: Then work to see PC consults earlier in hospitalization

Sustainable: Comprehensive 7 day coverage

PC Penetration

Target: All sites to work toward **at least 10%** by 2022. Incremental targets by year.

Early PC

Target: All sites to work toward **at least 50%** by 2022. Incremental targets by year.

7 day/week, sick, and vacation coverage

Turning attention to ensuring consistent access and service line coverage (which will aid in increasing penetration and early consultation)

Un-Met Need: Maintain as a learning metric for purposes of focusing existing palliative care resources where need is greatest. Not currently tracked for specific targets/performance.

Operating model and organization structure to support future state

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Driving toward success: Proposed measures to manage to

- **PC infrastructure:** # or % of ministries with PC teams meeting the recommended staffing
- **Earlier PC engagement:** % of early PC consults, within 1 day of admission
- **Goal-aligned care:** percent of ICU stays of five or more days with a goals of care note in the electronic health record
- **Overall PC access:** PC penetration rates, by ministry

Enhanced alignment of care with patient wishes and overall quality of care…

And meet the needs of seriously ill people by making PC more accessible

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What's driving success for sites that are at or near targets?

- **Ensuring appropriate team size to match patient need**
- **Active presence at ICU and other service-line rounds**
- **Expanding coverage to 7 days / week**

- Optimizing team function: assignments, workflows, and role clarity
- Shared team goals, clarity on targets, and data tracking
- Regular updates and alignment with leadership
- Building indicators/triggers for referral to PC (partnering with key referring groups)
- Establish PC Committee/formal change leadership forum to maintain attention and focus
- Operational Improvement Plan focused on PC with project management support
- Team involvement in problem solving to improve performance

Close participation with, and support from, service leaders across Acute Care settings is key to continue Palliative Care optimization!

Key Operational Steps

2020 PC Optimization Metrics

Integration with...	Oncology	Cardiology	Critical Care	Hospital Medicine	Emergency Medicine
PC Rounds daily w/			✓		
Daily chart review or review patient list w/			✓		
Agreement on patient criteria w/	✓ (some)	✓ (Chiefs)	✓	✓	

Weekend & After-Hours Coverage				
	On site for new admit consults	On call for new admit consults, on site as needed	Available by phone only on admit	After hours phone coverage
Provider	✓			
Other	✓ (Nurse)			

Service Availability & Triage			
At min. recomm. staffing	Expanding team	Full IDT	Daily PC IDT Huddle
		✓	✓

Proactive Patient Identification & Earlier PC Consults				
Auto-indicators built into EMR	Daily review of new admissions	Daily review of admits previously seen by PC	Other patient-level criteria (Ex: RRT / Code called, 30-day readmits, delirium, patients w/ > 5d LOS)	Regularly monitor time from admission, to referral, to PC consult
✓ (Cancer MHL)				

Key Operational Recommendations:

- Service-line Partnerships & Integration
- Service Coverage & Availability (7 days/week)
- Workforce / Interdisciplinary Team
- Proactive Identification to ensure Early PC

View full de

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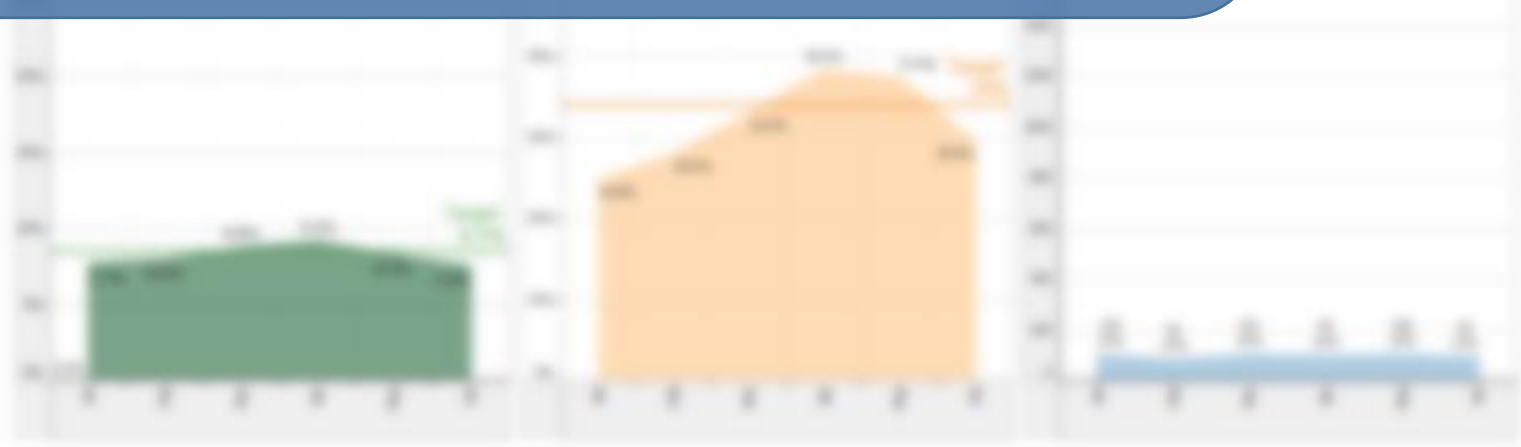
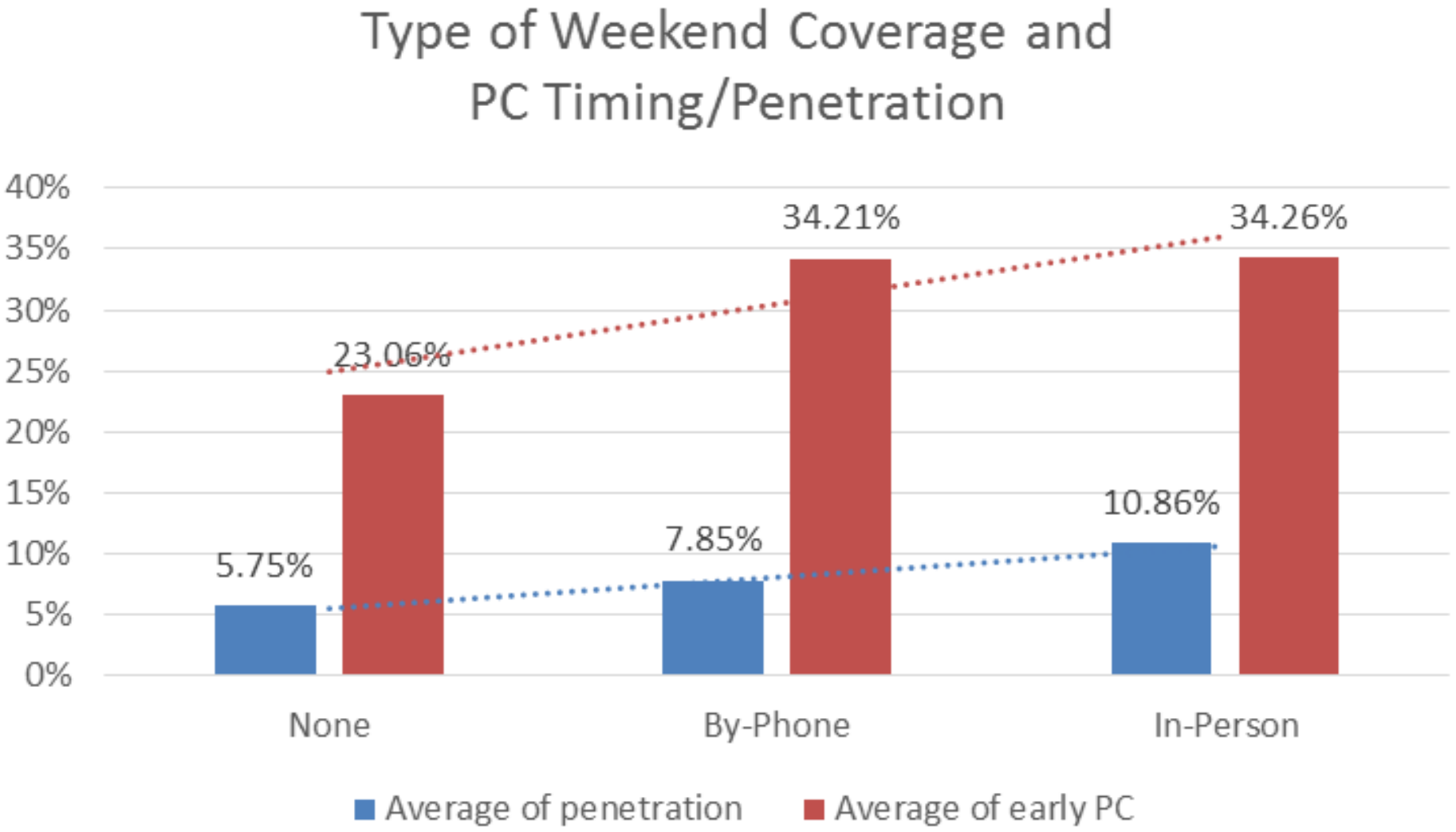
s/gallery/gallery-instituteforhumancaring

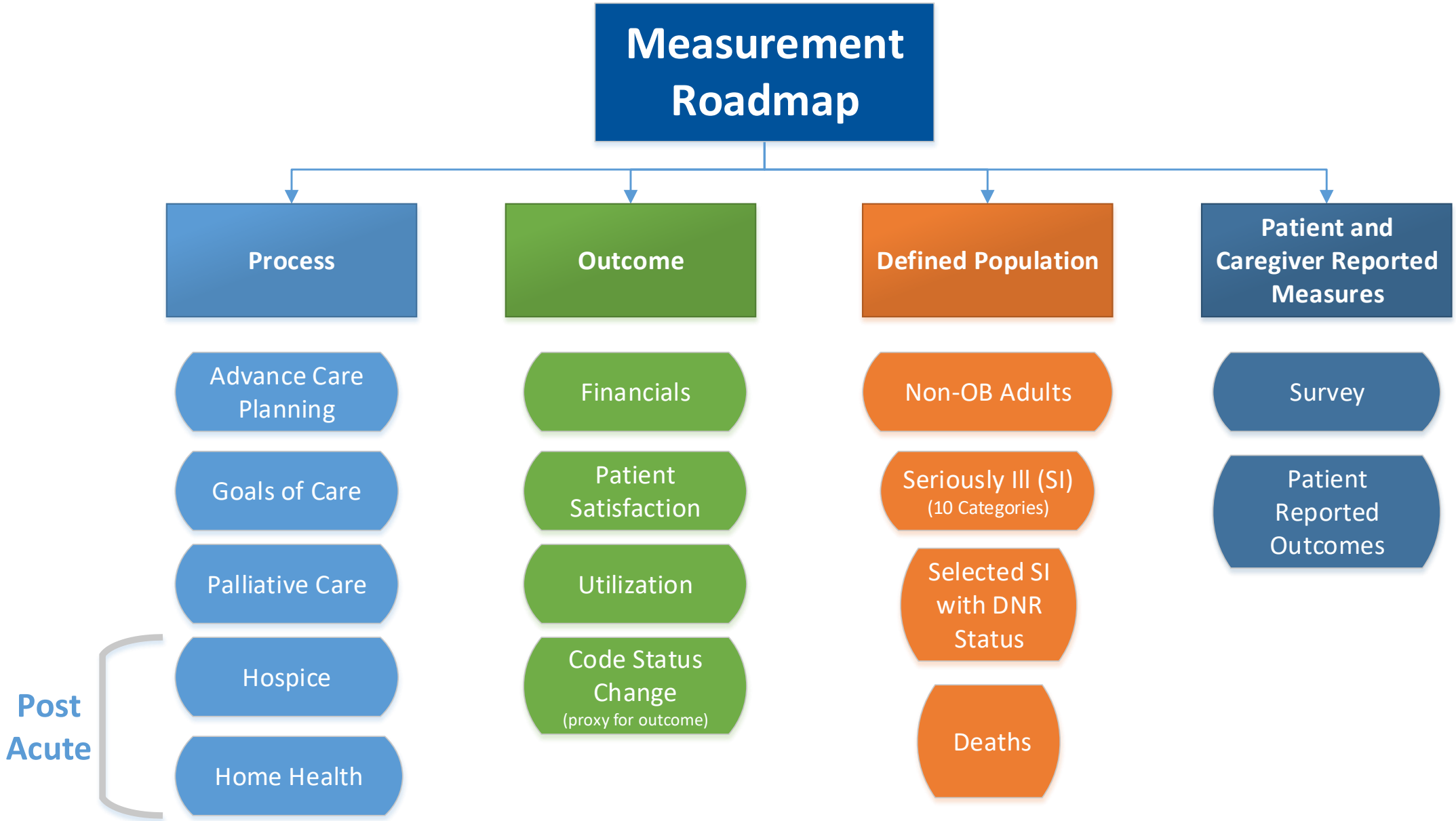
Select "RCV PC Optimization"



Increasing weekend PC coverage impacts access and availability



Measurement Roadmap



Measuring Palliative Care Readiness for Optimization

Example Metrics

Team Optimization

METRICS TO DETERMINE WHETHER STAFFING IS OPTIMAL

- Full IDT present
- 75% complete FTE for each discipline
- Penetration rate
- Admin support
- 24/7 coverage

Established Collaboration

METRICS TO DETERMINE ENGAGEMENT WITH OTHER TEAMS

- Oncology
- Cardiology
- Critical Care
- Hospice
- Other (Neuro, Renal, GI, etc.)

Identification Mechanisms

METRICS TO DEMONSTRATE/OPTIMIZE HOW PATIENTS ARE SELECTED

- Referral triggers
- Rounding in other departments
- Daily huddles
- Weekend rounds

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Discussion & Questions

Key Resources to Guide Best Practices

- NCHPC-NCP Guidelines
- Joint Commission - Palliative Care
- Bree Collaborative - Palliative Care
- ASCO Guidelines - Palliative Care
- JACC-PC in Heart Failure
- AAFP-PC Best Practices
- ACC-Palliative Care for Geriatric Cardiology Patients
- ACS-Palliative Care

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Unmet Needs for Hospitalized Seriously Ill

Categories of Disease for Chronic Serious illness:

- Malignant Cancer, Leukemia
- Chronic Pulmonary Disease
- Coronary Artery Disease
- Congestive Heart Failure
- Peripheral Vascular Disease
- Severe Chronic Liver Disease
- Diabetes with End Organ Damage
- Renal Failure
- Dementia
- Neurological