Palliative Care & Hospice

Same kind of different as need

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Who is Here and Why?

**Personal**
- Discipline
- Employer
- PC Program - Yes / No
- Location – Rural, Semi-rural, Metropolitan

**Goals for attending**
- Inquisitive: Learn more about Palliative Care
- Improve personal skills or an existing program
- Thinking about starting a program
- Planning a program
Outline

Overview of Hospice vs Palliative Care
Understanding of services
  History
  Comparison
  Trends
    1. Specific Populations
    2. Population Health
Goals
Principles
  1. Principles of Palliative Care
  2. Principles guiding policy
Entertaining starting or expanding Palliative Care Services
Considerations
  Coverage for services
  Methods
  Mechanisms of Care
  Payments
Resources / Supplements
Introduction

Palliative Care & Hospice are integrally linked, often provided by the same people - a singular provider, physician / extender team, or an Interdisciplinary Team. The extent of care delivered varies greatly, as does the understanding of care coverage, whether by the public, the medical system, and even by the providers themselves.

In this presentation we will explore the trends of hospice & palliative care in our current system, particularly as is delivered in this southwest region of the US. We will discuss similarities and differences, identify principles and some overlaps and gaps in coverage, and discuss opportunities to meet those needs. We will also identify possible future areas applying this mode of caring, and deliberate on how to develop various methods to address these.
Integrated model

Diagnosis

- Specific disease treatment
- Supportive Care

Death

- Palliative care
- Terminal care
- Bereavement

Complexity vs prognosis -- Flexible, shared, cooperative

Integrated model
ORIGINS

• International

• Domestic

Palliative care programs early on were rare and developed primarily within larger healthcare institutions, while hospice care developed within the community as free-standing, primarily volunteer programs. Over time, these programs gradually evolved from individual, grass roots efforts to a cohesive movement that aims to relieve suffering and improve quality of life for those who are living with, or dying from, an illness.

The practice of hospice palliative care in Canada, began in the 1970s and has evolved rapidly. The term "hospice palliative care" was coined to recognize the convergence of hospice and palliative care into one movement that has the same principles and norms of practice.

The history of hospice care in the USA dates to the 1960’s and is well known.
In 2006, the National Quality Forum (NQF) issued a report detailing 38 Preferred Practices for Palliative and Hospice Care Quality. Applying the following definitions:

• **Palliative care** refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

• **Hospice care** is a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition. It also supports family members coping with the complex consequences of illness, disability, and aging as death nears. Hospice care further addresses the bereavement needs of the family following the death of the patient.
Definition of Palliative Care

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems—physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
Definition of Palliative Care

CAPC Definition

Palliative care is specialized medical care for people with serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

Close Communication

The palliative care team will also spend time talking to you and listening. They will make sure you understand all of your treatment options and choices. By deeply exploring your personal goals, the palliative care team will help you match those goals and options. They will also make sure that all of your doctors are coordinated and know and understand what you want. This gives you more control over your care.

A Partnership of Palliative Care Team, Patient and Family

Palliative care teams are specialists who work together with you, your family and your other doctors. They provide an extra layer of support when you need it most. In addition to treating your symptoms, the palliative care team spends as much time as necessary communicating with both you and your family. They support you every step of the way.

Talking to Your Doctor
Which is which?
Hospice vs Palliative Care
<table>
<thead>
<tr>
<th>Question</th>
<th>Palliative Care</th>
<th>Hospice Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who can receive care?</td>
<td>Anyone with a serious illness, regardless of life expectancy, can receive palliative care</td>
<td>Someone with a life-threatening illness and a life expectancy of six months or less. Talk with your physician.</td>
</tr>
<tr>
<td>Can I continue to receive treatments to cure my illness?</td>
<td>You may receive <a href="http://familycomforthospice.org/palliative-care-vs-hospice/">palliative care</a> and curative care at the same time</td>
<td>Treatments and medicines aimed at relieving symptoms are provided by hospice. The goal is comfort not cure.</td>
</tr>
<tr>
<td>Does Medicare pay?</td>
<td>Certain treatments and medications may be covered by Medicare and private insurers.</td>
<td>Medicare pays all charges related to hospice. Most private insurers also have a hospice benefit.</td>
</tr>
<tr>
<td>Does Medicaid pay?</td>
<td>Certain treatments and medications may be covered</td>
<td>In most states, Medicaid pays all charges related to hospice</td>
</tr>
<tr>
<td>Does private insurance pay?</td>
<td>Certain treatments and medications may be covered</td>
<td>Most private insurers have a hospice benefit</td>
</tr>
<tr>
<td>How long can I receive care?</td>
<td>This will depend upon your care needs, and the coverage you have through Medicare, Medicaid or private insurance</td>
<td>As long as you meet the Medicare’s criteria of an illness with a life expectancy of months not years</td>
</tr>
</tbody>
</table>
| What organization provides these services?   | • Hospitals  
• Hospices  
• Nursing Facilities  
• Healthcare Clinics | • Hospice organizations  
• Hospice programs based out of a hospital  
• Other healthcare organizations |

Adapted from NHPCO 2016.  
http://familycomforthospice.org/palliative-care-vs-hospice/
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<th>Question</th>
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<th>Hospice Care</th>
</tr>
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<tbody>
<tr>
<td>Who provides these services?</td>
<td>Doctors, nurses, social workers, therapists and spiritual counselors.</td>
<td>A hospice team that consists of a medical doctor, nurse, social worker, chaplain, volunteer, home health aide and others.</td>
</tr>
</tbody>
</table>
| Where are services provided?   | • Home  
• Assisted living facility  
• Nursing facility  
• Hospital                | • Usually, wherever the patient resides. In their home, assisted living facility, nursing facility, or hospital.  
• Some hospices have facilities where people can live, like a hospice residence, or receive care for short-term reasons, such as acute pain or symptom management. |
Hospice vs Palliative Care

Who, What, Where, Why?

• Who
  • Has access?
  • Is eligible?
  • Provides services?
  • Pays?

• What
  • Distinguishes the service?
  • Is the difference?

• Where
  • are services available?
    • Country, region, location of service?

• Why
  • are services available/not available?

• Why
  • is third party payment available/not available?
TRENDS

National Palliative Care Registry

-Overview in U.S. hospitals from 2008 to 2015.

• **Penetration** - defined as % of hospital admissions seen by palliative care team.
  • increased by 85 percent, from 2.6 (2.3-2.8) to 4.8 percent (4.4-5.1).

• **Staffing** –
  • + growth of palliative care interdisciplinary teams:
    • hospitals with 500 or more beds, the interdisciplinary team has nearly doubled—from 3.7 full-time equivalent (FTE) staff to 6.9 FTE;
    • hospitals with fewer than 150 beds report an increase of only 32 percent, from 2.2 FTE in 2008 to 2.9 FTE in 2015.
TRENDS

National Palliative Care Registry

Since 2008, the Registry has been an essential resource for hospital palliative care programs and has contributed to the expansion of access to palliative care. For specific programs, Registry data have helped to make the case for program development, staffing and value.

Over the past few years, palliative care has moved from predominantly hospital- and hospice-based programs toward service models that reach across the care continuum.

With palliative care’s expansion, programs more in the community settings with programs in long-term care, home health, clinics and office practices.
TRENDS

The Palliative Care Quality Network

- Four Years, 71 Palliative Care Programs, and 48,000 Patient Consultations

Data
1.) Describe patients referred to inpatient palliative care services
2.) Describe the processes of care of inpatient palliative care teams in the course of usual patient care
TRENDS

The Palliative Care Quality Network

Patients:
  • Average age 72 years (median=74)
  • Were significantly debilitated (mean PPS =35.2).
  • Diagnoses:
    • cancer (32.8%),
    • cardiac/vascular (12.3%) disease,
    • pulmonary (11.0%) diseases.
  • Common reasons for referral to PC
    • goals of care discussions (73.1%),
    • pain management (20.2%),
    • providing support for patient/family (20.0%).
TRENDS

The Palliative Care Quality Network

Symptoms (Of patients with moderate to severe symptoms) :
- 68.5% reported improved pain from the 1st to 2nd PC assessment
- 78.4% reported improved nausea,
- 65.9% reported improved dyspnea
- 65.7% reported improved anxiety.
TRENDS

The Palliative Care Quality Network

PC Team work:
• Referred to PC an average of 4.7 days (median=2) after hospital admission
• Followed by the PC team for an average of 5.0 days (median=3.0)
• A surrogate decision maker was identified for 95.2% of patients seen by PC
• Average 1.2 family meetings with the PC team (median=1)
• 44% clarified code status
• 45% had a MOST/POLST form completed
• 3.1% completed an advance directive
• 3/4 were discharged alive
• 48.2% discharged to home
• 38.0% arranged for hospice.
TRENDS

Palliative Care in Specific Disease Types

Since the goal of palliative care is to improve quality of life, PC is more often applied to many specific disciplines and/or specific disease processes.

Focusing on the symptoms of both the disease and the treatment, palliative care helps with a wide range of issues, of the disease itself, the treatments for disease, and the factors affecting day to day living.

Focused education is provided, and discussions empowering the patient to have more control over care by improving understanding of dz/tx and choices for treatment.
Specific Diseases

- ALS
- Alzheimer’s Disease
- Breast Cancer
- Bone Marrow Transplant
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Colon Cancer
- Congestive Heart Failure
- Dementia
- Head and Neck Cancer
- HIV/AIDS
- Huntington’s Disease
- Kidney Disease
- Liver disease
- Lung Cancer
- Multiple Myeloma
- Multiple Sclerosis
- Ovarian Cancer
- Pancreatic Cancer
- Parkinson’s Disease
- Prostate Cancer
- Pulmonary Fibrosis
- Pulmonary Artery Hypertension
- Sickle Cell Anemia
- Stroke
- Leukemia and Lymphoma
TRENDS

POPULATION HEALTH

· Population health management seeks to harness the efforts of health care delivery systems, public health agencies, community-based organizations, and many other entities to improve health outcomes in the communities* they serve.

· Palliative care improves value in ACOs and other integrated care delivery networks by increasing high-quality care and decreasing costs for the sickest patients.
TRENDS

POPULATION HEALTH

• Large impact by ACA; unproven – not well tested prior
• Commercial payers
• Medicare ACOs
• Medicare Advantage
• Bundled payments, the next iteration
• How do these populations differ and what are the implications for program design?
• Why should palliative care be engaged with population health management?
• Post-acute care strategy
• The role for palliative care in comprehensive post-acute care strategies
• Complex care, panel management and measurement / Extensivist model
• Innovative approaches for addressing the needs of patients with complex care needs
• Palliative care's role in facilitating panel management
• Selecting relevant processes and outcome measures
• Effecting change
• Identifying key partnerships
GOALS

• Hospice palliative care aims to relieve suffering and improve the quality of living and dying.

• Hospice palliative care strives to help patients and families:
  • address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears
  • prepare for and manage self-determined life closure and the dying process
  • cope with loss and grief during the illness and bereavement.

• Hospice palliative care aims to:
  • treat all active issues & prevent new issues from occurring
  • promote opportunities for meaningful and valuable experiences, personal and spiritual growth, and self-actualization
GOALS

• Hospice palliative care is appropriate for any patient and/or family living with, or at risk of developing, a life-threatening illness due to any diagnosis, with any prognosis, regardless of age, and at any time they have unmet expectations and/or needs, and are prepared to accept care.

• Hospice palliative care may complement and enhance disease-modifying therapy or it may become the total focus of care.

• Hospice palliative care is most effectively delivered by an interdisciplinary team of healthcare providers who are both knowledgeable and skilled in all aspects of the caring process related to their discipline of practice.
PRINCIPLES

• Holistic approach
• Patient centered
• Partnership with team members
• Goal oriented care, contradistinct from disease oriented problem-focused care
• Identify patient preferences
• Utilize multidisciplinary team approach to address the needs of patients and their families
• Assist in establishing goals
• Integrate the psychological and spiritual aspects of patient care
• Provide a Continuum of Care
• Access all potential resources
PRINCIPLES

• Offer support system
  • to help patients live as actively as possible until death
  • to help the family cope during the patient’s illness and in their own bereavement
• Affirm life, & regard dying as normal process
• Intend neither to hasten nor postpone death
• Enhance QOL, and possibly influence the course of illness
• Provide relief from distressing symptoms, notably pain
• Address distressing clinical complications
• Is applicable early in the course of illness, in conjunction with other therapies that are intended to modify disease, such as chemotherapy or radiation therapy
• Flexibility in location of service

• Skilled Communicators / Communication
PRINCIPLES GUIDING POLICY

1. Patient / Family Focused.

- As patients are typically part of a family, when care is provided, the patient and family are treated as a unit.
- All aspects of care are provided in a manner that is sensitive to the patient’s and family’s personal, cultural, and religious values, beliefs and practices, their developmental state and preparedness to deal with their morbidities and the dying process.
2. High Quality

All activities are guided by:

- ethical principles
- standards of practice for each discipline
- policies and procedures that are based on the best available evidence or opinion-based preferred practice guidelines
- data collection/documentation guidelines that are based on validated measurement tools.
3. Safe and Effective

All palliative care activities are conducted in a manner that:

- is collaborative
- ensures confidentiality and privacy
- is without coercion, discrimination, harassment or prejudice
- ensures safety and security for all participants
- ensures continuity and accountability
- aims to minimize unnecessary duplication and repetition
- complies with laws, regulations and policies in effect within the jurisdiction, host and hospice & palliative care organizations.
PRINCIPLES GUIDING POLICY

4. Accessible*

Patients and families have equal access to palliative care services:

· wherever they live
· at home, or within a reasonable distance from their home
· in a timely manner.

* depending on the model
PRINCIPLES GUIDING POLICY

5. Adequately Resourced

- The financial, human, informational, physical and community resources are sufficient to sustain the organization's activities, and its strategic and business plans.
- Sufficient resources are allocated to each of the organization’s activities.
PRINCIPLES GUIDING POLICY

6. Collaborative
   · Each community’s needs for palliative care are assessed and addressed through the collaborative efforts of available organizations and services in partnership.

7. Knowledge-Based
   · Ongoing education of all patients, families, caregivers, staff and stakeholders is integral to the provision and advancement of quality palliative care.
8. Advocacy-Based

· Regular interaction -with legislators, regulators, policy makers, healthcare funders, other palliative care providers, professional societies and associations, and the public- is essential to increase awareness about, and develop, hospice palliative care activities and the resources that support them.
PRINCIPLES GUIDING POLICY

9. Research-Based

· The development, dissemination, and integration of new knowledge are critical to the advancement of quality palliative care. Where possible, all activities are based on the best available evidence.

· All research protocols comply with legislation and regulations governing research and the involvement of human subjects in effect within the jurisdiction.
So, you are considering starting a Palliative Care program?
WHY?

.... Are you crazy?
The Look of Palliative Care
Who, What, Where, Why?

- **Who**
  - Has access?
  - Is eligible?
  - Provides services?
  - Pays?

- **What**
  - Distinguishes the service?
  - Is the difference?

- **Where**
  - are services available?
    - Country, region, location of service?

- **Why**
  - are services available/not available?

- **Why**
  - is third party payment available/not available?
Futility has become a great subject, full of opportunities.

Mason Cooley
1. **IDENTIFY:**
   - the needs
   - *potential stakeholders / partners
   - the market
   - resources
     - Leaders
     - Players
     - Referral sources
     - Consultants
     - Information
     - Financial**

2. **STRATEGIZE**
   - Key stakeholders
   - Key leaders
   - Internal consultants
   - External consultants
How to approach starting / expanding PC services

*Potential stakeholders / partners:
  • Physician Groups: Single-Specialty, Multi-Specialty, Focused-Specialty
  • ACO’s
  • Risk-bearing contract holders
  • LTC companies / facilities
  • Hospitals
  • Hospital Systems
  • Insurance companies
  • PACE program (Program for All-inclusive Care for the Elderly)
  • AAA (Area Agency on Aging) Programs
How to approach starting / expanding PC services

Swimming in cash? ......
How to approach starting / expanding PC services

3. DO YOUR HOMEWORK!
4. RECONVENE Strategy group
5. CHOOSE YOUR MODEL/s
   • Partners *In-pt
   • Funding *Out-pt
   • Locations of service
   • Office-based
6. DEVELOP BUSINESS PLAN
7. ENGAGE KEY PLAYERS
8. CHOOSE SYSTEMS
9. *MAKE THE ARGUMENT
10. DECIDE ON METRICS
11. POLICY & PROCEDURES
How to approach starting / expanding PC services

9. **MAKING THE ARGUMENT**
   
   Reduced costs / utilization
   
   Inpatient
   
   ICU,
   
   Re-hospitalizations
   
   ALS
   
   ED
   
   Tests and Procedures
   
   Improved care
   
   Pleased customers ^
   
   ACP performance ^
1. Palliative Care in the Home: A Guide to Program Design
The essential reference for those planning and starting home-based palliative care programs.
The Guide outlines a process for designing a program that provides the highest quality care...

2. Payment Primer: What to Know about Payment for Palliative Care Delivery
Published by CAPC 2017
https://media.capc.org/filer_public/bd/1c/bd1c2882-3f66-4de8-9dd0-929252f85271/capc_payment_primer12017.pdf
PART 1  About Health Insurance

• The Traditional Payment Model
• Risk, Managing Risk and Shifting Risk to Providers
• Government Health Insurance Programs
• Commercial Insurance
• Payer Cost Structure and Why It Matters

Health plans need to categorize expenses, and are under pressure to minimize administrative costs; they also often face regulatory constraints
Part 2  Value-Based Payment and Alternative Payment Models

• What Is Value and What Is Value-Based Payment?
• Alternative Payment Models
Providers should be familiar with the most common types of alternative payment models (APMs). There are three models, ACOs, PCMHs, and OCMs, where palliative care fits well
• Value-Based Payment Under MACRA’s Quality Payment Program
The Quality Payment Program has inherent incentives for APM participation, but because of limited opportunities and the downside risk involved, clinicians should be familiar with the alternative—the Merit-based Incentive Payment System (MIPS)
• Considerations for Taking Risk
Part 3 How Palliative Care Adds Value

• Accountability for Quality and Palliative Care
  High-quality palliative care can improve quality measures, which in turn increases their revenue

• Financial Impact of Palliative Care
  Palliative care can reduce unnecessary spending and improve risk adjustment. Providers should be able to communicate their own performance to payers and at-risk provider groups

• Putting it All Together
  Palliative care providers need to make the case for financial support by providing data on their quality and cost impact
Part 4  Key Success Factors and Key Takeaways

• Key Success Factors
Providers will not be able to secure sustainable financing without data, the right relationships, and skilled legal and financial professionals

• Key Takeaways
There are many important details to understand about payment and value; this document ends with the some of the fundamentals
RESOURCES


2 National Consensus Project for Quality Palliative Care, Clinical Practice Guidelines for Quality Palliative Care (National Consensus for Quality Palliative Care, 2004), www.nationalconsensusproject.org.

3 Center to Advance Palliative Care, Crosswalk of Joint Commission Standards and Palliative Care Policies: Procedures and Assessment Tools (New York: Center to Advance Palliative Care, 2007), www.capc.org
RESOURCES

• NHPCO
• AAHPM
• https://getpalliativecare.org
• CAPC - Center to Advance Palliative Care
  • Payment Primer: What to Know about Payment for Palliative Care Delivery
  • Palliative Care in the Home: A Guide to Program Design
    $85.00 (plus shipping and handling)
    15% CAPC member discount
Take OFF !!
Supplements

https://getpalliativecare.org
CAPC - Center to Advance Palliative Care
Payment Primer: Outline  CAPC 2017
Pediatrics
ACP Notations
Palliative Care (pronounced pah-lee-tiv) is specialized medical care for people with serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

1. WHERE DO I RECEIVE PALLIATIVE CARE?
   Palliative care can be provided in a variety of settings including the hospital, outpatient clinic and home.

2. DOES MY INSURANCE PAY FOR PALLIATIVE CARE?
   Most insurance plans, including Medicare and Medicaid, cover palliative care. If you are not sure, talk to your primary care provider to find out if you are covered.

3. HOW DO I KNOW IF PALLIATIVE CARE IS RIGHT FOR ME?
   Palliative care may be right for you if you or your loved one is facing a serious illness, whether it is a new diagnosis or living with an existing diagnosis. It can help you manage symptoms, improve quality of life, and support you in making decisions about your care.

4. WHAT ABOUT EXPECTANCY?
   Palliative care can be provided at any stage of illness and at any time, even before a diagnosis of a serious illness. It can help you manage symptoms, improve quality of life, and support you in making decisions about your care.

5. HOW DO I GET PALLIATIVE CARE?
   Palliative care can be provided in a variety of settings, including hospitals, clinics, and at home. It can also be provided through hospices or other specialized palliative care programs.

6. SUPPORT TOOLS
   Palliative care can be provided in a variety of settings, including hospitals, clinics, and at home. It can also be provided through hospices or other specialized palliative care programs.

7. WHERE DO I FIND MORE INFORMATION?
   Palliative care can be found at many hospitals, clinics, and through hospices or other specialized palliative care programs. You can also find more information by talking to your doctor or other healthcare provider.

https://getpalliativecare.org
The future of health care payment is here. Value-based payments—methods of paying for health care which reward quality and cost-effectiveness—had reached 38% of all US health care payment by the end of 2015. In 2016, health plans changed their payment arrangements with providers at an even more rapid pace.

Value-based payments are a prime opportunity to assure access to quality palliative care for our sickest and most vulnerable patients. Fee-for-service historically has not adequately supported home-based care or time-consuming patient interactions; but as payment models change, the business case supports giving the right services at the right time to the right population in the right setting.

This is an opportunity for palliative care to be integrated as part of standard care for those with serious illness. Shifting from volume-based payment models to alternative payment models creates an environment where improving quality and patient experience while ensuring appropriate utilization of costly health care services is not only desired but required—and palliative care has a strong track record on all three counts. By providing expert pain and symptom management, psychosocial support and skilled communication with patients and families, palliative care can help ensure avoidance of unnecessary Foreword 2 capc.org emergency department visits, hospital admissions and unwanted procedures. Not only is unnecessary cost reduced, but palliative care also improves the patient experience and facilitates patient informed choice.

Challenging as it is to move from the familiar system of fee-for-service, value-based payment provides the best opportunity to match care provided to the actual needs of patients with serious illness. For example, there are now a number of palliative care organizations that contract directly with Medicare Advantage plans for fixed monthly payments and shared savings in return for the care and management of the health plans’ sickest and most complex members. Without these contracts, these palliative care programs would not be financially viable.

So how can palliative care leaders make the most of this opportunity? In order to be effective messengers for the integration of palliative care into population management and alternative payment models, palliative care providers first require a basic understanding of health insurance, value-based payment and the new incentives at play in health care delivery._
PART 1        About Health Insurance

The Traditional Payment Model

Understanding the challenges of fee-for-service provides context to the need for changes in our payment models

Risk, Managing Risk and Shifting Risk to Providers

Depending on who is managing the risk, there are common mechanisms that are used to ensure appropriate utilization and spending

Government Health Insurance Programs

Medicare and Medicaid cover the majority of complex, high-need patients. Knowing how they work—and the trend toward privatization—lays the groundwork for palliative care payment

Commercial Insurance

A single insurer does not offer the same benefits to all of its members. Providers need to realize the range of insurance products sold and how a plan might vary benefit design to encourage certain patient behaviors

Payer Cost Structure and Why It Matters

Health plans need to categorize expenses, and are under pressure to minimize administrative costs; they also often face regulatory constraints
Part 2  Value-Based Payment and Alternative Payment Models

What Is Value and What Is Value-Based Payment?
Getting to value means improving quality and controlling cost, and doing both is necessary for sustainability under value-based payment

Alternative Payment Models
Providers should be familiar with the most common types of alternative payment models (APMs). There are three models, ACOs, PCMHs, and OCMs, where palliative care fits well

Value-Based Payment Under MACRA’s Quality Payment Program
The Quality Payment Program has inherent incentives for APM participation, but because of limited opportunities and the downside risk involved, clinicians should be familiar with the alternative—the Merit-based Incentive Payment System (MIPS)

Considerations for Taking Risk
Accepting risk is not to be taken lightly, and requires providers to assess their readiness and to secure risk limitation options
Part 3 How Palliative Care Adds Value

Accountability for Quality and Palliative Care

High-quality palliative care can improve quality measures, which in turn increases their revenue.

Financial Impact of Palliative Care

Palliative care can reduce unnecessary spending and improve risk adjustment. Providers should be able to communicate their own performance to payers and at-risk provider groups.

Putting it All Together

Palliative care providers need to make the case for financial support by providing data on their quality and cost impact.
Part 4 Key Success Factors and Key Takeaways

Key Success Factors

Providers will not be able to secure sustainable financing without data, the right relationships, and skilled legal and financial professionals.

Key Takeaways

There are many important details to understand about payment and value; this document ends with some of the fundamentals.
Part 4 Key Success Factors and Key Takeaways

- Patients that need palliative care are increasingly sitting in Medicare Advantage, Medicaid Managed Care and Accountable Care Organizations.
- Palliative care providers primarily care for beneficiaries of Medicare and Medicaid. Increasingly, these programs are either being privatized and run by health insurance plans, or else delegated to at-risk providers (such as Accountable Care Organizations), or both. It is unlikely that this privatization trend will stop anytime soon. Privatization creates new opportunities for palliative care providers to partner with payers to assure sufficient funding—to supplement or replace traditional fee-for-service.
- Quality drives revenue for health insurers and at-risk providers.
- Quality measures are important to health insurance plans and at-risk providers for both care quality and financial reasons. Quality scores are publicly available and impact both revenue and market position. For Medicare Advantage plans, revenue also depends on accurate risk adjustment. High-quality palliative care should positively impact a number of the key quality metrics as well as risk scoring, making palliative care providers valuable partners.
- Cost-effectiveness is another key value of palliative care.
- Health insurance plans are interested in solutions that improve the predictability of their medical loss ratio (MLR = medical costs/total premium). Palliative care can help stabilize medical costs by supporting the sickest and most complex members to remain stable in their homes and communities and avoiding preventable and costly crises. A program lacking its own cost or utilization data can turn to the wealth of literature on palliative care’s cost-effectiveness.
- There are viable ways to be paid without fee-for-service.
- Alternative payment models (APMs) are models that base payment on quality and/or cost outcomes. Common examples of APMs include shared savings (and sometimes losses), bundled payments, and case rates (PMPMs).
- Assuming downside risk is not for all.
- Alternative payment may or may not require that a provider take on financial risk. Assuming financial risk requires significant population management capabilities and infrastructure. Before considering, assess financial reserves, risk tolerance, the strength of other provider relationships and the strength of data management. Also rely upon lawyers and actuaries—“don’t try this at home”—and ensure that protections such as risk corridors, stop-loss and outlier exclusions are well-defined.
- Data are essential for any value-based payment relationship.
- Working with health insurance plans and at-risk providers requires a commitment to collecting data, and using that data to make the case and cultivate relationships.
WHO Definition of Palliative Care for Children

Palliative care for children represents a special, albeit closely related field to adult palliative care. WHO’s definition of palliative care appropriate for children and their families is as follows; the principles apply to other pediatric chronic disorders (WHO; 1998a):

- Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family.
- It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease.
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centres and even in children's homes.
Pediatrics

• Pediatric Concurrent Care
  • Learn about the Concurrent Care for Children provision in the Affordable Care Act (ACA) – Briefing and Implementation Toolkit available from NHPCO.

• Pediatrics Professional Resources
  • Access NHPCO’s Pediatric Standards of Practice, Facts and Figures and other resources.
Pediatric palliative and/or hospice care is both a philosophy and an organized method for delivering competent, compassionate and consistent care to children with chronic, complex and/or life-threatening conditions and their families. This care focuses on enhancing quality of life, minimizing suffering, optimizing function and providing opportunities for personal and spiritual growth. Planned and delivered through the collaborative efforts of an interdisciplinary team with the child, family and caregivers as its center, pediatric palliative and/or hospice care can and should be provided along with concurrent disease-modifying therapy, when disease-modifying therapy is appropriate, or as the main focus of care, when disease-modifying therapies are no longer effective and comfort measures are of the utmost importance. This care is achieved through a combination of active and compassionate therapies intended to comfort and support the child, as well as family members and other significant people in the child’s life. Effective management of pain and other distressing symptoms, together with psychosocial and spiritual care, are of critical importance beginning at diagnosis and continuing throughout the entire course of a child’s life and for their families beyond the child’s death. Therapies take a holistic approach, assisting children and families in fulfilling their individual/unique physical, psychological, educational, social and spiritual goals while remaining sensitive to developmental, personal, cultural and religious values, beliefs and practices. How pediatric palliative care/hospice care is different from care for adults.

Pediatric palliative or hospice care differs from care delivered to adults in several important ways. First, children with palliative care needs range in age from prenatal to young adult. In fact, some adults over the age of 21 are still considered part of this population because they have conditions monitored by pediatric subspecialists or have developmental and/or physical challenges are better served by pediatricians. Teams must thus be able to care for patients with wide-ranging diagnoses whose understanding of illness and decision making changes significantly throughout the developmental spectrum. There are significant differences between what is effective for adult patients versus pediatric patients on a number of dimensions, including: • trajectories of illness • effective pain/symptom management interventions • clinical models of care delivery, • funding mechanisms • research paradigms • educational initiatives • communication strategies • ethical concerns • staffing ratios and management.
Pediatrics

Impact of the ACA

For many years, healthcare professionals and families with children living with life-limiting or life-threatening conditions had few options for Medicaid coverage when children were very seriously ill. Parents in all but a few states were faced with forgoing curative treatments for their children to be eligible for hospice services. Or conversely, they were not eligible for beneficial interdisciplinary hospice services while getting curative treatment.

The Patient Protection and Affordable Care Act (ACA) changed that situation. It requires all state Medicaid programs to pay for both curative and hospice services for children under age 21 who qualify. On March 23, 2010, President Obama signed ACA into law enacting a new provision, Section 2302, termed the “Concurrent Care for Children” Requirement (CCCR).

Section 2302 states that a child who is eligible for and receives hospice care must also have all other services provided, or have payment made for, services that are related to the treatment of the child’s condition.1

This provision affects children who are eligible for Medicaid or the Children’s Health Insurance Program (CHIP). In its simplest form, implementation of this provision could be accomplished by the state Medicaid agency eliminating any provider claims that deny or delay concurrent curative care and hospice claims.
Pediatrics

Impact of the ACA

Significant Barriers Remain

While Section 2302 addresses what has been a significant barrier to enrollment of children into hospice care, this new requirement in section 2302 does not remove the major remaining barriers to providing a more expansive pediatric palliative care program, which are:

• Physicians must still certify that that child is within the last six months of life, if the disease runs its normal course.

• Children who qualify for this benefit remain limited to the existing array of Medicaid hospice services and other existing Medicaid services covered by a state. However, a child may be simultaneously enrolled in other programs that provide supplemental services such as home and community-based service (HCBS) waivers.
Pediatrics

Options to Address Barriers and Expand Pediatric Palliative Care

There is significant interest in providing children who are eligible for hospice with more expansive programs and services than are currently provided under the hospice benefit. There is also considerable interest in providing more expansive supportive services to children with life-limiting or life-threatening conditions who are not eligible for Medicaid hospice services, but who would greatly benefit from palliative care services earlier in their disease. While states cannot provide fewer services than stipulated by Medicaid, states are certainly free to expand the scope of services paid for by Medicaid, and expand the number of children who might be eligible for those services. There are options for states that permit them to provide services that are more expansive than basic hospice services and to forgo the requirement that eligibility is limited to children who have a life expectancy of six months or less. These options are available at a state’s discretion and must be approved by the Centers for Medicare & Medical Services (CMS). If a state wants to provide more expansive services and eligibility, there are two basic mechanisms for implementing those programs and services: 1. State plan amendment 2. Medicaid waiver.
a. “Advance Care Planning” NOTES
   i. ACP conversations
      1. Includes patient/family understanding of illness, decision-making preferences, hopes & fears, definitions of quality of life, future goals, preferences for funeral arrangements, etc
   ii. “Goals of Care” Conversations / Family Meetings
      1. Includes discussions about prognosis, goals, treatment decisions, code status, etc
   iii. “Death” notes
      1. Includes information related to patient’s death (death pronouncement, autopsy, etc)
b. “Advance Care Planning” DOCUMENTS
   i. MOST/POLST
   ii. Surrogate designations (MPOA, Guardian, family, etc)
   iii. Durable Power of Attorney for Health Care
   iv. Advance Directive (Living Will)
   v. Other ACP forms, e.g.
      1. State-specific forms
      2. Five Wishes, Will to Live, etc.
c. “CODE STATUS”
   i. Options for these physician orders vary by state and Institution
      1. E.g. Full-Presumed, Full-Confirmed, DNR/DNI

http://aahpm.planion.com/EvalCenter/AAHPM/Blobs/22835_1_TH332_After_the_Conversation.pdf