Various Models of Palliative Care

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Objectives

• Describe different models of care
• Understand roles of various team members
• Discuss productivity expectations which vary by care settings
• Discuss key performance metrics of clinicians
• Highlight Partners in Care PC Program
Program Design

- Why Palliative Care
- Local Advocates
- Getting Started
- Business/ Financial Plan
- Data
- Quality
PC Design for Alignment

- Align with mission and vision
- Who is the Payer?
- Who are the stakeholders?
- What are you trying to accomplish?
- What does success look like?
- How much strategic capital are you willing to invest?
- Are you willing to sustain an ongoing loss?
Who are the Local Advocates

• Hospitals
• Outpatient clinics
• Primary Care
• Healthcare system
• Nursing homes/ALFs
• Home health
• Payors
What is the Primary Payor Source?

- Fee for service
- Capitation
  - Commercial
  - Medicare Advantage
  - Medicaid
  - APM model
- ACOs
Model of Palliative Care

Dependent on:
• Geography
• Culture
• Target Patients
• Staffing
• Services
• Care delivery setting
Staffing Plan - Design

- Consult volume
- Geography
- 24/7 call
- Growth strategy
- Educational needs – orientation/mentoring/billing
- Provider mix
Staffing Palliative Care

Principles

• Interdisciplinary Team

• Person/family centered care
  • Medical
  • Psychosocial
  • Spiritual

• Right care by right person at right time
Staffing

Hire New Staff
- Pros - dedicated staff; broader pool
- Cons – need recruitment plan, onboarding

Hire Existing Staff
- Pros - Understand organization culture; quick onboarding
- Cons – require pc training and mentorship

Share Staff
- Pros – less costly, can ramp up as need increases
- Cons – require training, may feel pulled and not as committed
Hospital Palliative Care

- Under promise and Over deliver
- 1:1 Physician APP model
- Hospitalist collaboration
- Care Management collaboration
- Focus on Outcomes important to Stakeholders

24/7 vs 5 days?
Shared staff?
Who owns? Hospital, hospice, healthcare system
Who leads? APP SW physician RN
Community Palliative Care

• Tremendous variation
• Who is payer?
• Team composition
  • 4 APP/1 physician
  • Other disciplines – RN/SW/chaplain/pharmacy
• Shared staffing?
Continuum of Palliative Care staffing and reimbursement.

Consultative Model

Co-management Model

Home Medical Model

Medical Provider (NP, PA, MD)

Registered Nurse

Social worker

Full IDT

Fee for Service

Alternative Payment Models

Full Risk
Palliative Care Team

- Physician/Clinical Ops Director
- Advance Practice Practitioners (NPs/PAs)
- SW
  - Chaplain
  - Nurse
  - Nurse Assistant
  - Lay Navigator
  - Pharmacist
  - PT/OT/SLT
  - Administrator
  - Program Director

Core Team

Ad-Hoc Team
Team Composition

Percent of Programs Reporting the following Staff Disciplines, 2017

- Physician: 83.6%
- APRN: 80.1%
- Social Worker: 67.7%
- Chaplain: 55.6%
- RN: 48.1%
- Support Staff: 35.2%
- Administrator: 29.4%
- Medical Director: 27.4%
- Pharmacist: 9.5%
- Fellow: 8.4%
- PA: 6.1%
- Hospice Liaison: 4.9%
- Nutritionist: 4.3%
- Music/Art Therapist: 4.3%
- Ethics: 4.0%
- Childlife Specialist: 4.0%
- PT or OT: 3.2%
- Massage Therapist: 2.9%
- Resident: 2.3%
- LPN: 1.4%
- Psychologist: 1.2%
- Doula: 0.9%

Core Interdisciplinary Team

National PC Registry
Community PC Roles

- **RN**
  - Triage, phone, Visits- goals, ACP, Education
- **AP**
  - Visits for symptoms, goals, ACP, prescriptions
- **SW**
  - Counseling, ACP, Community Resources
- **MD**
  - Medical supervision, MD communication
- **Admin**
  - Schedule, phone, billing
- **Chaplain**
  - Spiritual support
Staffing Challenges

- Huge demand for all clinicians
- High turnover in APP positions
- Most PC fellows enter hospital PC
- Cost has increased as supply is low
- May take a year to find a qualified clinician!
Think Outside the Box

• Local recruitment of physicians (often well respected in your community)
• Offer sign on bonus/moving expenses
• Bonus after 1-2 years
• Creative hours – 4 day workweek/job sharing
• Competitive benefits
• Offer education – invest in pc trainings
Expect to invest in education!

- Four Seasons PC Immersion Course
  - [https://www.fourseasonsconsultinggroup.com/](https://www.fourseasonsconsultinggroup.com/)
- CAPC
- PCEP – Harvard Course
- PC Now (Fast Facts)
- California State Institute for Palliative Care
  - [https://csupalliativecare.org/programs/](https://csupalliativecare.org/programs/)
Onboarding New Providers

- Communication Skills
- Prognostication
- Billing/Coding
- Quality measurement
Care Settings

- NPs/PAs assigned to specific care settings, according to expertise
- Hospital
- Home care
- ALF
- SNF/NH
- All are trained to 2 settings, and rotate through hospital for call
Program Director’s Role

• Provide Leadership and Direction
• Continuous quality improvement
• HR issues
• Oversight of data collection
• Help departmental agency communication
• Relationship building with referral sources
• Role in community awareness and education
Role of Physician

- Often provides clinical director and oversee
- Leadership skills
- Outreach/marketing – advocates for good EOL care
- Strong educator
- Good team player
- Enjoys outpatient setting
- MD/DO communication
- Joint visits on complex patients
Role of the Advance Practice Practitioner

- Strong clinical skills
  - Especially in use of opioids
  - Prognostication skills
- Need to operate autonomously
- Good communication skills
- Seen as team player with NH and ALF staff
- Need to be good educators
- Good time management skills
- Important to have at least 2 years experience
Role of RN

- Triage
- Phone contact
- Advance care planning
- Education
- Visits
- Follow-up from APPs and physician visits
Role of Social Worker

- Higher caseload than hospice
- Need for brief, solution-focused/crisis intervention and resource procurement
- Strong assessment skills
- Advance care planning
- Good relationship skills to work with facility staff at various NH/ALF
- Acceptance of limitation of the scope of PC SW services
Role of Social Worker

- Knowledgeable about community resources
- Identifies and teaches patients/families how to access systems
  - Prescription assistance programs
  - Meals on Wheels
  - Medicaid
- Good communication skills
- Good boundary setting
Role of Chaplain

• Assist patients to connect to spiritual resources in the community
• Counseling to address existential suffering
• Acceptance of limitation of the scope of PC chaplain services – not same intensity as in hospice
• Often this is PRN or outsourced
Administrative Role

- Phone support
- Scheduling
- HR - personal, credentialing, call schedules
- Hospice coordination
- Data management
- Reports
Role of Administrative Support

- Medical Records
- Credentialing for providers/payors
- Scheduling
- Obtaining consent before visits allowed
- Communication with referral sources regarding admission/discharge of pts
- Utilize and develop billing sheet
- Data management/reports
- Billing/coding
- Human Resource Issues
Role of Scheduling

• Dedicated PC scheduler
  – 1 scheduler for 4-5 providers
  – NH and Home
  – Zone scheduling for minimal drive time

• Time per visit
  - 90 min new and 45 min follow up (home)
  - 60 min new and 30 min follow up (clinic)
  - Flexible scheduling in facilities (depending on # patients/facility)
General Guidelines in CBPC

• 1 physician to 4 APPs (know state requirements)
• 1 SW to 3 APPs
• PRN chaplain
• Admin support
## Mid Size Program Staffing ADC = 300

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Staffing Details</th>
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<tbody>
<tr>
<td>FFS</td>
<td>1 MD/DO, 3 APPs, 1 SW, PRN chaplain, 1-2 Admin</td>
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<tr>
<td>Capitated Plan</td>
<td>1 MD, 1 APP, 2-3 RNs, 1 SW, PRN chaplain, 1-2 Admin</td>
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<tr>
<td>ACO</td>
<td>1 MD, 3 RNs (case management), 1 SW, PRN chaplain, 1-2 Admin</td>
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Productivity - Clinicians

- 6 hours clinical, 2-3 hours admin
- Depends on other responsibilities
  - Time for IDG (4 hours week or .1 FTE)
  - Education of facilities/referral source
  - Nonbillable time on coordination of care

Most clinicians DON’T bill their salaries
Managing Outpatient Caseloads

• Visits/day
  • 4-5 home visits/d
  • 6-8 facility (SNF/ALF) visits/d
  • 10-12 clinic visits/d

• Caseloads
  • 60-80 home/APP
  • 100-120 facility/APP
<table>
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<tr>
<th>PC Billing Clinicians</th>
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<tr>
<td><strong>Physician</strong></td>
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<td>- Oversite role</td>
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<td>- Rarely bill 50% of salary</td>
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<td><strong>Advance Practice Practitioners</strong></td>
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<tr>
<td>- Education role</td>
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<tr>
<td>- Bill between 70-120% of salary</td>
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<tr>
<td><strong>Social Workers</strong></td>
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<td>- Can bill for counseling</td>
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<tr>
<td>- Generally bills &lt; 10% of salary</td>
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Productivity

- Full time clinical APP, fully onboarded
- Average billing $140-160/visit (depends on setting)
- APPs in CBPC usually bill 90-130k
- Rural settings – geography restricts # visits/day
Clinicians’ Key Performance Metrics

**Finance**
- Revenue billed/year
- # encounters billed/year
- Average billing/visit

**Growth**
- # new patient referrals
- Expand into new county with x # patients/year
- Start specific program, i.e., dementia with x % new patients/year

**Compliance**
- 90% correct codes (audit sample each month)
- % pass rate from ADRs (additional data requests)
- 90% documentation completed within 48 hours
### Clinicians’ Key Performance Metrics

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Performance Metrics</th>
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| **Quality** | • 70% pain improvement (moderate-severe)  
               • 90% advance care planning completion  
               • % Hospice transitions |
| **Service** | • 90% high referral satisfaction  
               • 95% patients would recommend to others |
| **People**  | • 85% high - Internal satisfaction scores of PC dept  
               • Team based score |
Billing and Coding - Education

- Recognize the importance of continued education
- Educate physicians/NPPs as new hires!
- Regulations change frequently – have a plan to keep up with changes
- Develop templates that meet coding criteria
- Use billing/coding master guide sheets
Assessing Providers

- Track code by providers – see who are your outliers on both ends
- Obtain current Medicare E/M data from your Medicare Administrator Contractor for your state and medical specialty
- Develop benchmarks for your agency
Our Palliative Care Model

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Palliative Care Medical Director
Bend, OR
Partners In Care

- Home health and hospice agency 1979
  - Only IPU east of Cascade Mountains
- Non-profit

- Late hospice referrals prompted development community-based palliative care in 2014
  - Consulting FSFL
  - AAHPM mentorship grant
Partners In Care Palliative Care

- Out-patient palliative care started 2014
- MD embedded in BMC oncology clinic

Results
- ALOS hospice increased 126% from 26 days to 59 days
- More hospice referrals
- Improved pain and dyspnea scores
- 92% of patients discussed advance care planning
- 64% had a completed POLST
- 100% patient and provider satisfaction
Sustainability

• MD billing
• Increased Hospice referrals/ LOS
• Grant funding
  – PacificSource Community Foundation
  – COIPA
  – OR Community Foundation
• Pilot Program Pacific Source
  – $500/ PS client
Based on nurse-led program at Everett Clinic started 15 years ago by Providence Hospice.

Palliative Care RNs embedded in multiple sites (mostly primary care) to see patients with serious illness to coordinate complex care needs.
Our Goal

- **Create** cultural transformation
- **Model / teach** palliative care so primary care develops skills and provides primary palliative care
  - Discussions about serious illness
  - EOL discussions
  - Care goals
  - Keep patient goals in mind when delivering care
    - Tests, treatments
  - Improved symptom management
Target Population

Patient Triggers

– Life expectancy < 2 years
– Recent hospitalizations
– Recurrent ER visits
– Need care goal discussion
  • Multiple comorbidities
  • Provider/patient disagreement
– Symptom management (related to serious illness)
Our Evolution

- Different Vision
- **Palliative Care Consults**—versus Care Management
  - Advance care planning
    - Goals of care
    - Advance directives
    - POLST
    - Hospice discussion
  - Symptom management
  - Anticipatory guidance
- **Education**
  - Patients and providers/staff
### Patient Visits: January 1, 2017 – July 31, 2019

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<tr>
<td>Unique Patients</td>
<td>260</td>
<td>226</td>
<td>102</td>
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<tr>
<td>Total Clinic Visits</td>
<td>236</td>
<td>315</td>
<td>17</td>
</tr>
<tr>
<td>Total Home Visits</td>
<td>242</td>
<td>40</td>
<td>110</td>
</tr>
<tr>
<td>Total RN Visits</td>
<td>478</td>
<td>355</td>
<td>127</td>
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Diagnoses – PC RN Visits

January 2017 - July 2019

- Neurologic: 32%
- Cardiac: 27%
- Pulmonary: 14%
- Cancer: 17%
- Other: 10%

Referrals to Hospice
82

Palliative Care to PIC Hospice
151 patients (25.7%)

Advance Care Planning
(on initial visit)
74%

Referrals to Home Health
91

Hospice ALOS
(based on 151 patients)
67.4 days

Provider Satisfaction
4.6/5
Successes – PC RN Visits

Hospice Utilization / ALOS

- Mosaic Medical: 73 Days
- High Lakes: 63 Days
- Home Visits: 78 Days
More success...

**Improved Patient Care**

- Increased advance care planning
- Higher hospice utilizations
- Impact on hospitalizations, ER visits

Increased provider acceptance / awareness

Increased patient understanding of palliative care
CHALLENGES: FUNDING

- RNs can’t bill, not working with our providers
- Increased hospice referrals / LOS

- PacificSource covers cost of RN visit
  - $150 new patient / $100 f/u visit

- Grant funding
  - COIPA – 300 nurse visits 2019-2020
  - Collecting data and hope to prove value to other payors

- APM pilot
Challenges: STAFFING

• Program Director
  – Slow growth
  – Business partnerships

• Nurse Practitioner

• Balancing growth and ability
  – Heart failure clinic
  – SNF outreach
  – Post-acute care continuum
Challenges: Patient Access

• Home health patients – SHP list

• Outreach
  – Education PCPs/ specialists
  – Community talks/ education

• Triage
  – Right person for right job
FUTURE STEPS

- SNF visits
- Heart failure clinic
- ? Back to neurology
- Post-acute care continuum
- ACO

- Primary Care Clinic partnership
  - Goal: train providers (MD, RNs, CHW, BH) to provide primary palliative care
Future Steps

• FINANCIAL
  – Grant support
  • Joint application with primary care with focus primary palliative care throughout community
  – ? ACO
  – Payor contracts, stipends
  – NP program growth
  – ? RN billing with team expansion (ACP codes)
Summary

• Multiple models of palliative care
  – Consultative
  – Co-management
  – Home medical

• Staffing and reimbursement dependent on the model chosen and risk assumed
  – Every team member should work to the top of their skillset
Summary

• Choose alliances/ care setting dependent on community need

• Start slow – do not over-promise

Most programs are in state of evolution and have to be fluid to adapt to the local - and global - climate.