Understanding a Model for Contracting and Implementing Community-based Palliative Care Services

Objectives: You should be able to …

- Understand components of a model developed by the Alliance of Community Health Plans (ACHP) that may be used by health plans as base program requirements to engage in contracts to provide palliative care services.
- Identify the process used by one palliative care provider to approach and engage Minnesota health plans in contracting to provide palliative care services.

Who we are…

- From Allina (the health system)
  - Sandy Schellinger, RN, Program Director, Palliative Care
- From UCare (the insurer)
  - Barry Baines, MD, Associate Medical Director

- An independent, nonprofit health plan founded in 1984
- Recognized as one of the state's leading health maintenance organizations
- Serves nearly 200,000 Minnesotans and Wisconsinites with health coverage plans:
  - Medicare
  - Minnesota Care and Medical Assistance
  - Special Needs Plans

Work Group Operating Principles

•Start with diagnosis of life-limiting illness and continue through end of life care.

•Addressing palliative care from a health plan perspective, not care delivery perspective

- Focused on role of plan in working with care system to develop an effective approach to palliative care, and to provide oversight and support to such an approach

•Focused on non-inpatient palliative care

Presentation Outcomes

- Summary of work to date
- Present Palliative Care Blueprint

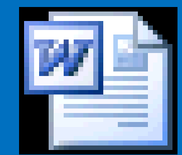
Palliative Care Workgroup: Goals & Status

	Goals	Status
Palliative Care	▪Understand plans' experiences with palliative/end-of-life care programs (key elements, metrics, successes, challenges, lessons learned) ▪ID best practices (both within ACHP plans and nationally) ▪Create measurement set, and process for regular reporting ▪Determine and answer questions regarding structure and implementation issues ▪Create "blueprint" of recommendations and metrics	✓Created inventory and collected information on plans' hospice and palliative care work ✓Agreed on operating principles ✓Developed high level Triple Aim measurement set ✓Assess pros/cons of three different palliative care delivery models ✓Prioritized critical elements for delivery models ✓Developed draft blueprint of key elements for any palliative care approach

Blueprint: Table of Contents

Introduction	About ACHP Triple Aim Initiative Palliative Care
Models	Ownership Consultative Telephonic
Key Components & Elements	Prioritization of Elements Acceptable Variations for Critical Elements Other Elements ▪ Ownership ▪ Consultative ▪ Telephonic
Measurement	Proposed Measure Set
Suggested Resources	Vendors Articles Other Resources

Reviewing the Blueprint



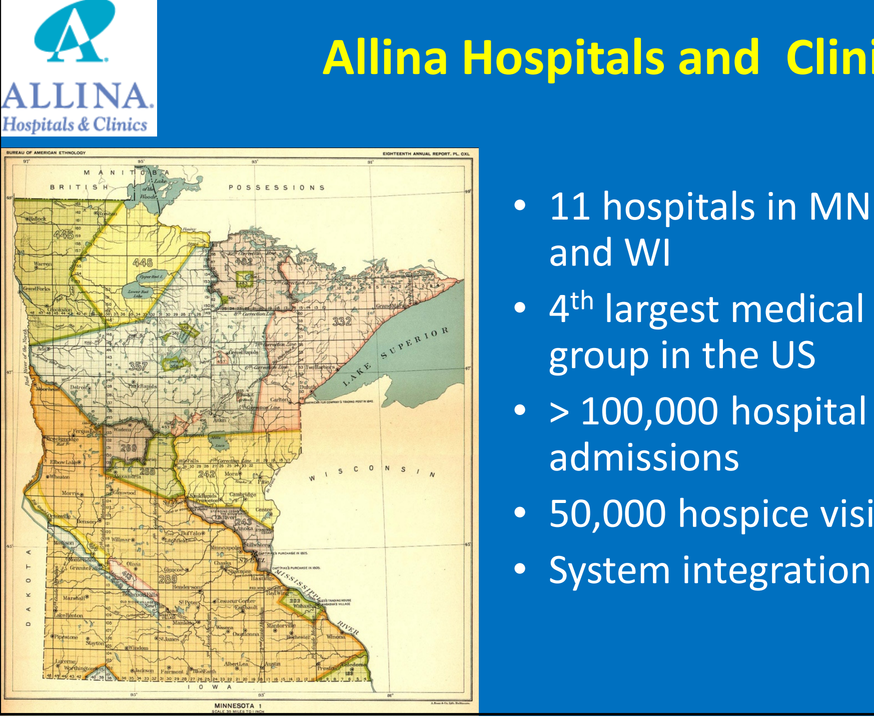
Microsoft Word Document

Next Steps

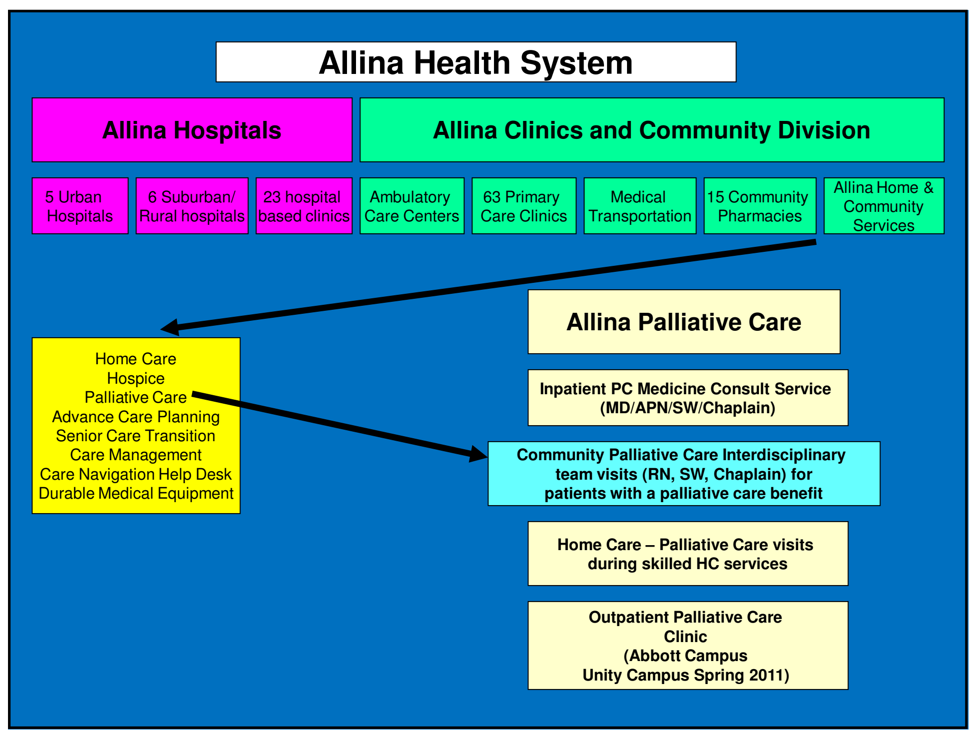
- For ACHP Work Group:
  - ✓ Begin test collection of measurement data

- For UCare:
  - ✓ Leverage Stratis Rural Palliative Care Initiative participants to expand Palliative Care services to rural areas employing the consultative model
  - ✓ Expand metro (consultative model) and non-metro (telephonic and consultative models) palliative care service accessibility

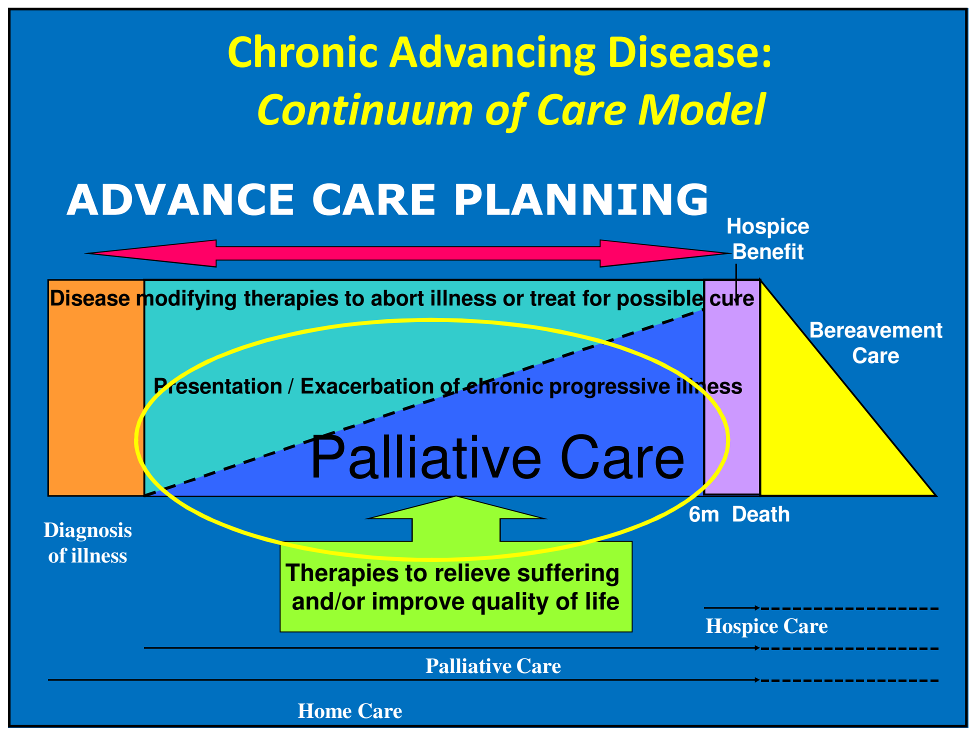
Allina Hospitals and Clinics



- 11 hospitals in MN and WI
- 4th largest medical group in the US
- > 100,000 hospital admissions
- 50,000 hospice visits
- System integration


Allina Health System
Allina Hospitals
Allina Clinics and Community Division
5 Urban Hospitals
6 Suburban/ Rural hospitals
23 hospital based clinics
Ambulatory Care Centers
63 Primary Care Clinics
Medical Transportation
15 Community Pharmacies
Allina Home & Community Services
Home Care
Hospice
Palliative Care
Advance Care Planning
Senior Care Transition
Care Management
Care Navigation Help Desk
Durable Medical Equipment
Allina Palliative Care
Inpatient PC Medicine Consult Service (MD/APN/SW/Chaplain)
Community Palliative Care Interdisciplinary team visits (RN, SW, Chaplain) for patients with a palliative care benefit
Home Care – Palliative Care visits during skilled HC services
Outpatient Palliative Care Clinic
(Abbott Campus
Unity Campus Spring 2011)

Allina Community Based Palliative Care
Born as an access issue: short LOS in hospice
Care according to National palliative Care guidelines and National Quality Framework preferred Practices for Hospice and Palliative Care.



Allina Community PC

- Current State
- Caseload 188 patients
- 28 counties
- 9-16 visit consult benefit
  - Average LOS 254 days
  - Median LOS 131 days
  - Disposition at time of transition
    - 55% d/c to hospice
    - 21% d/c goals met
    - 24% died while receiving PC

Allina focus for system integration

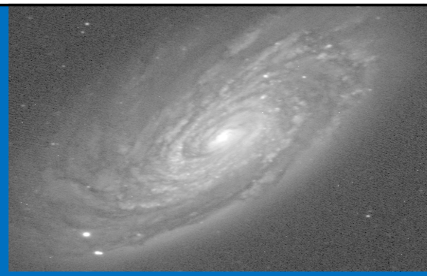
- **Timely advance Care Planning**
- **Optimal Transitions of care**
- **Congestive Heart Failure**
- **Optimal Access to End of Life Care**

…all these initiatives are supported by a strong palliative care presence across the continuum…

How did the health plan and palliative care system come together?

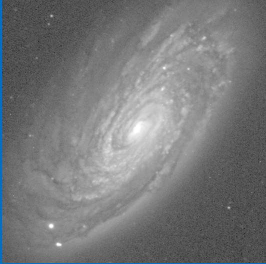
- Previous collegial relationships in EOL initiatives
- Metro-wide palliative physicians' group had been meeting for eight years
- Health plan CMO had developed similar program in the mid 1990's at another health plan

Alignment of the stars: Clinical



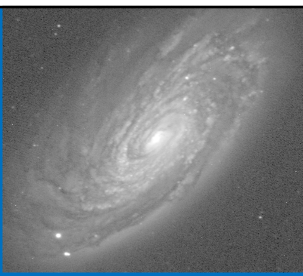
- Shared vision of patient-centered care for frail persons facing advanced illness and chronic illness
- Comfort with and respect for the IDT model of patient/family support
- Increasing media attention on the poor quality of end of life care most individuals received.

Alignment of the stars: Operational



- Health plan mission supports innovative partnerships
- Health plan set measurable goals to improve end of life care.
- Delivery system with expertise and strong drive to innovate

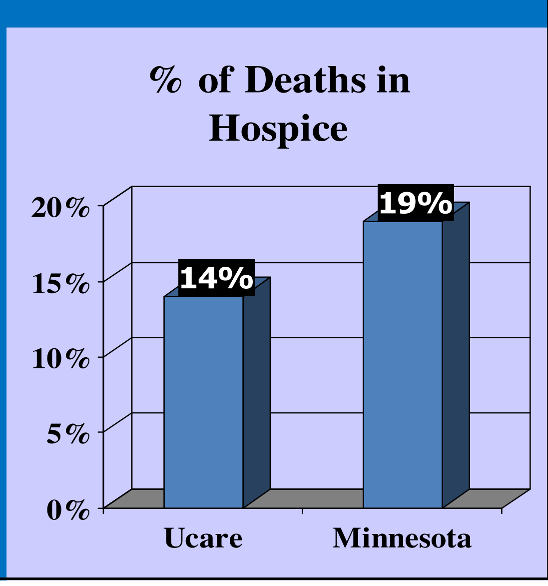
Alignment of the stars: Financial

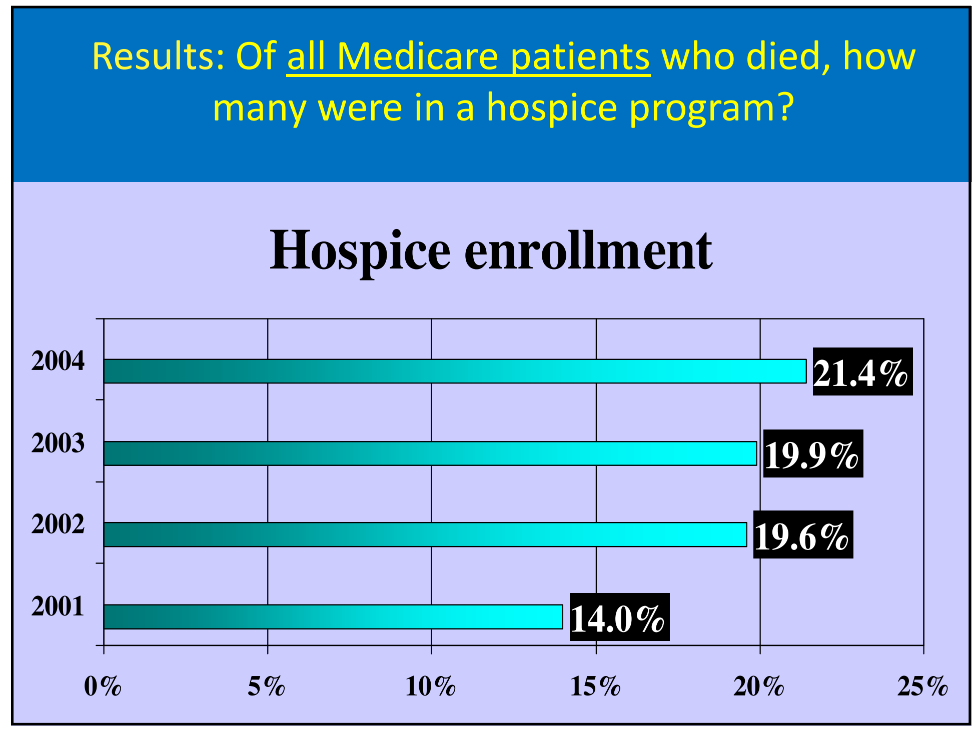


- Health plan took full risk for the Medicare patients
- Willingness to pay the costs of a 6-visit model, with the ability to approve additional visits
- Discovery that patients not in hospice incurred higher costs, 1, 3, and 6 months before death.

Why did UCare become interested in this?

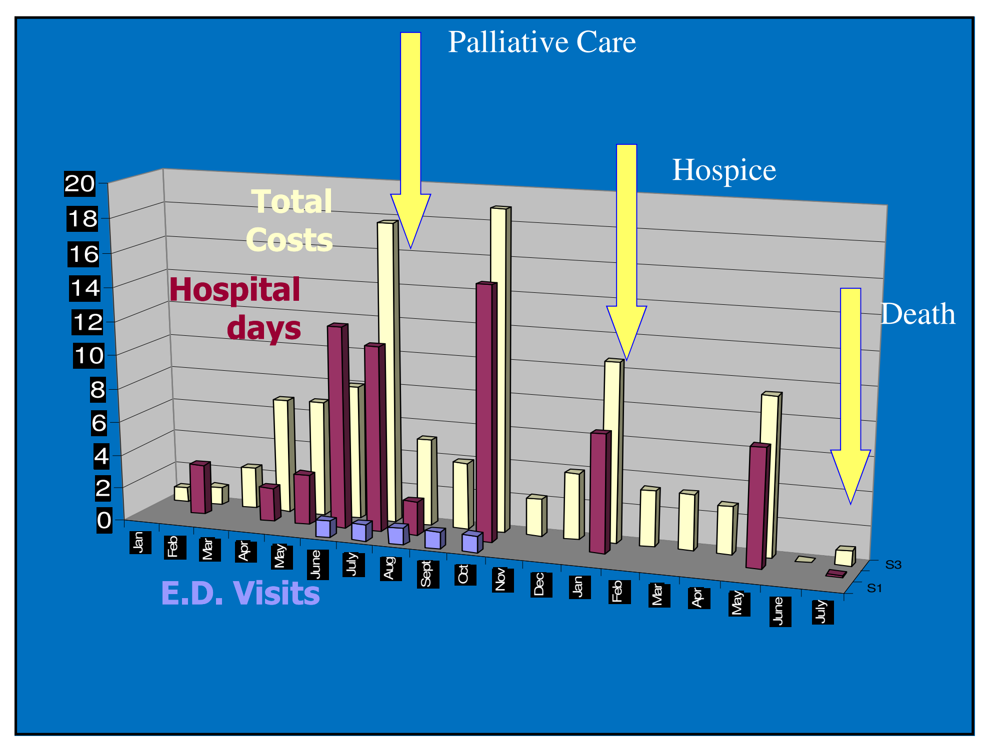
- CMO interested in palliative care and hospice, is currently a hospice medical director
- Desire to improve the quality of end of life
- Poor track record of hospice referrals

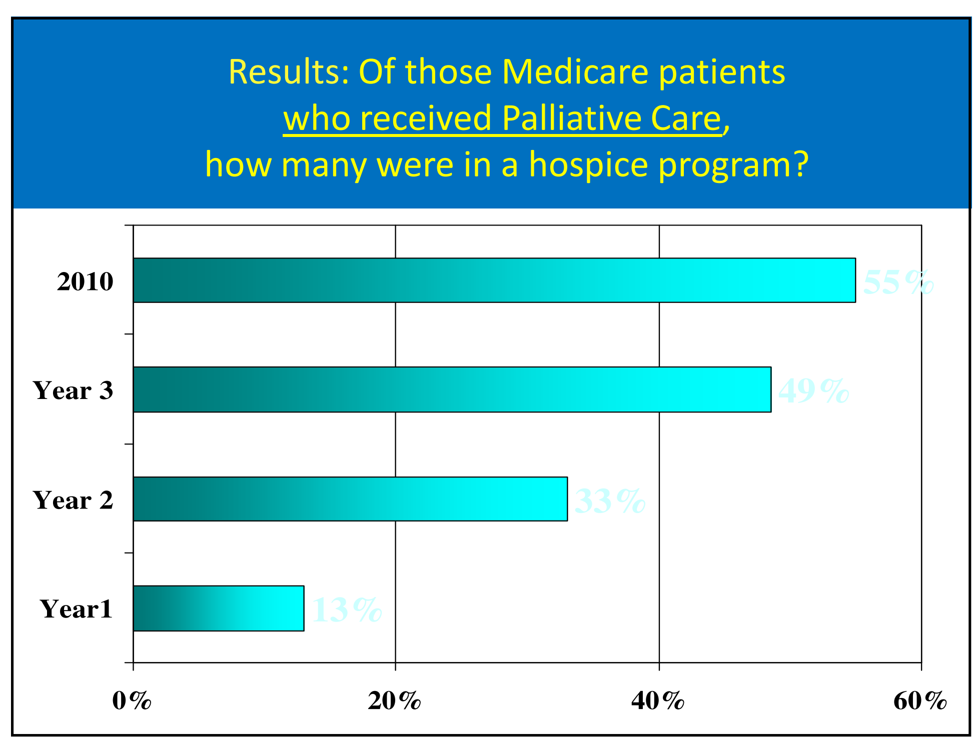


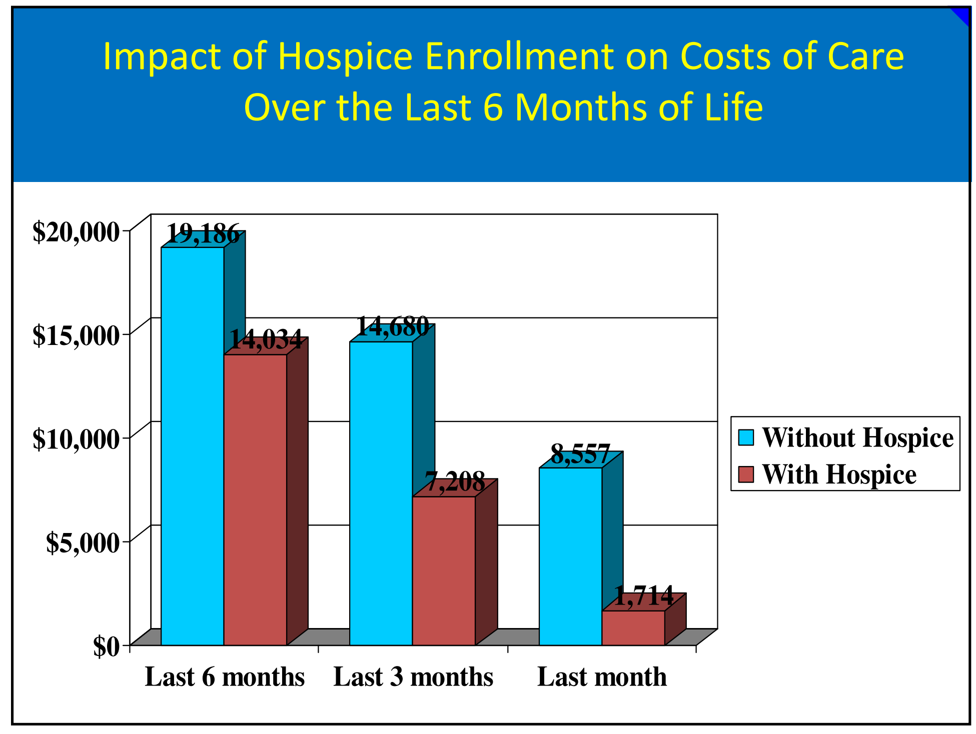


Metrics

- Patient Satisfaction
- Enrollment in Hospice before death
- Cost of care in the last 6, 3, & 1 month before death.
  - Reduced hospital and ED visits
  - Avoidance of non-beneficial care


Palliative Care
Hospice
Death
Total Costs
Hospital days
E.D. Visits
20
18
16
14
12
10
8
6
4
2
0
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
July
S3
S1


Results: Of those Medicare patients
who received Palliative Care,
how many were in a hospice program?
2010
Year 3
Year 2
Year1
55%
49%
33%
13%
0%
20%
40%
60%



Steps to contracting for PC services

- Develop a business model - Engage the financial person(s) at your facility
  - Identify the focus for your program, services and disciplines provided, what gaps exist and how this service will meet stated goals, i.e. make the case
  - Identify measurement that demonstrates the benefit of palliative care
    - % referred to hospice program or increase in LOS
    - Symptom scores
    - Patient/family/staff satisfaction
    - Cost savings due to fewer hospitalizations

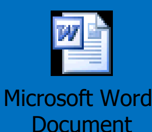
Steps to contracting for PC services

- Other items to address:
    - Understand that PC nurse visits are not as productive as a home care nurse visit (take more time at visit and follow up)
        - 2.5 visits per day
    - Determine if palliative care will be provided to those not covered by this proposed benefit (suggest including legal counsel in this discussion)
    - Ask –"How many patients would we commit to keeping in PC without being reimbursed?"

Steps to contracting for PC services

- Prepare insurance plan presentation – use PowerPoint, start with a story
    - Define palliative care and the people most appropriate for services,
        - i.e. symptoms out of control, have frequent emergency department visits, caregiver stress, and those not responding to the current therapy.
    - Identify palliative care benefits –
        - i.e. improved patient care with symptom management, quality, access to end of life resources (how you work with hospice), cost of care at end of life, etc.
    - Describe your program -
        - identify your services
        - Assessment and symptom management, counseling and spiritual care, volunteers, etc.

Sample contract language



- Purpose of program
- Covered services and interventions
  - Eligibility criteria
  - Discharge Criteria
  - Location of services
- Products covered
- Reimbursement
  - Visit fee structure
  - Mechanisms for billing
- Services, supplies and associated expenses NOT covered
- Legal Terms

Palliative Care visit fee:

- Hours of Professional staff = hourly rate X professional time
- RN/SW/Chaplain –
  - Initial consult/family meeting 90 minutes
  - Follow up visit – 60 minutes
  - Travel – 45 minutes
  - Documentation and follow up coordination – 30 minutes
  - Pre-post admin duties – 45 minutes
- .5 hours clerical = X $/visit
- Administrative costs for billing data gathering = X $/session
- Total cost of ACP session plus 10% EBIDA = X $/session

Contact Information

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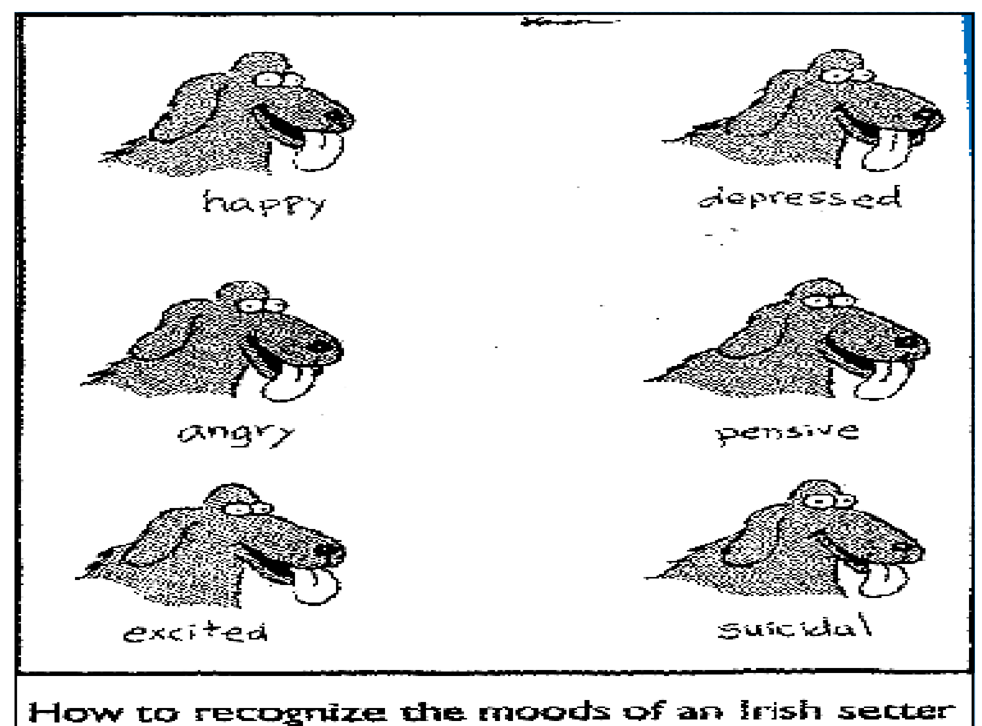

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