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

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

Allina Clinics and Community Division
- 5 Urban Hospitals
- 6 Suburban/Rural Hospitals
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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.
Chronic Advancing Disease: 
*Continuum of Care Model*

**ADVANCE CARE PLANNING**

- **Disease modifying therapies to abort illness or treat for possible cure**
- **Presentation / Exacerbation of chronic progressive illness**
- **Therapies to relieve suffering and/or improve quality of life**
- **6m Death**
- **Bereavement Care**
- **Hospice Benefit**

**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

% of Deaths in Hospice

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Results: Of all Medicare patients who died, how many were in a hospice program?

Hospice enrollment

- 2004: 21.4%
- 2003: 19.9%
- 2002: 19.6%
- 2001: 14.0%

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
Results: Of those Medicare patients who received Palliative Care, how many were in a hospice program?

- Year 1: 13%
- Year 2: 33%
- Year 3: 49%
- 2010: 55%
Impact of Hospice Enrollment on Costs of Care Over the Last 6 Months of Life

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

- Dr. Barry Baines, MD
  - Email: bbaines@ucare.org
  - Tel: 612-676-3606
- Sandy Schellinger, RN BSN CHPN
  - sandy.schellinger@allina.com
  - Tel: 612-262-7063

How to recognize the moods of an Irish setter