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Compassion for Life

Hospice • Palliative Care • Research • Elizabeth House

CMMI Project
Demonstrating the Value of Palliative Care

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CMO Four Seasons

Objectives

- Discuss components of palliative care
- Demonstrate the benefits to dementia patients
- Discuss payment reform in hospice and palliative care

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Four Seasons

Located in Hendersonville, NC

Retirement community

25% population over 65 years old (compared to 13%)

High dementia population – number 1 referring diagnosis for both hospice and palliative care

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Why Palliative Care?

- **Need to improve care for seriously ill patients**
- **Aligned with Mission of providing exceptional end of life care**
- **Provide care across the continuum of care settings**
- **Unsustainable financial model under current reimbursement structure**

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Palliative Care Services Focus on…

- Symptom management
- Prognostication
- Advance care planning
- Establish goals of care
- Educate patients on their disease process
- Spiritual and psychosocial support
- Assist with community resources
- Coordination of Care
- Help patients navigate the healthcare system

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Mary's Story

74 year old black female with advanced dementia, living with her daughter at home

- major behavioral issues – combativeness, agitation
- polypharmacy
- hospitalized 2 times in past 12 months (fall, pneumonia)
- daughter quit work to provide care - exhausted & stressed
- no advanced care planning

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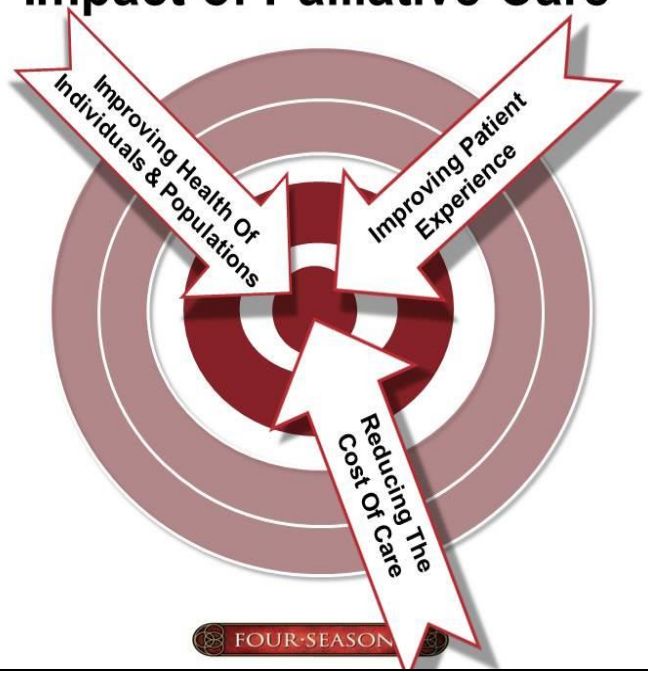
Impact of Palliative Care



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CMS Innovations Grant

- Scale model into 14 counties, delivered longitudinal across all care settings
- Track Quality
- Define Costs
- Test innovation – Tele-palliative care
- Developing/Testing a New Payment System

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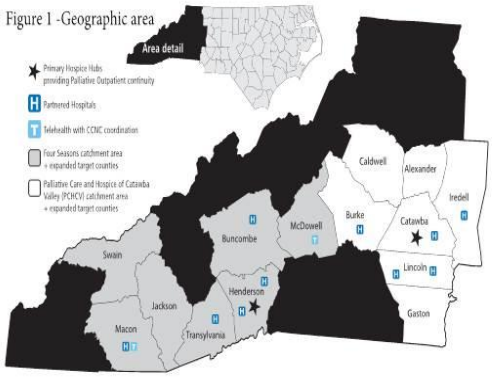
Four Seasons Expanding Palliative Care Across Western NC and Upstate SC

Western North Carolina



Upstate South Carolina

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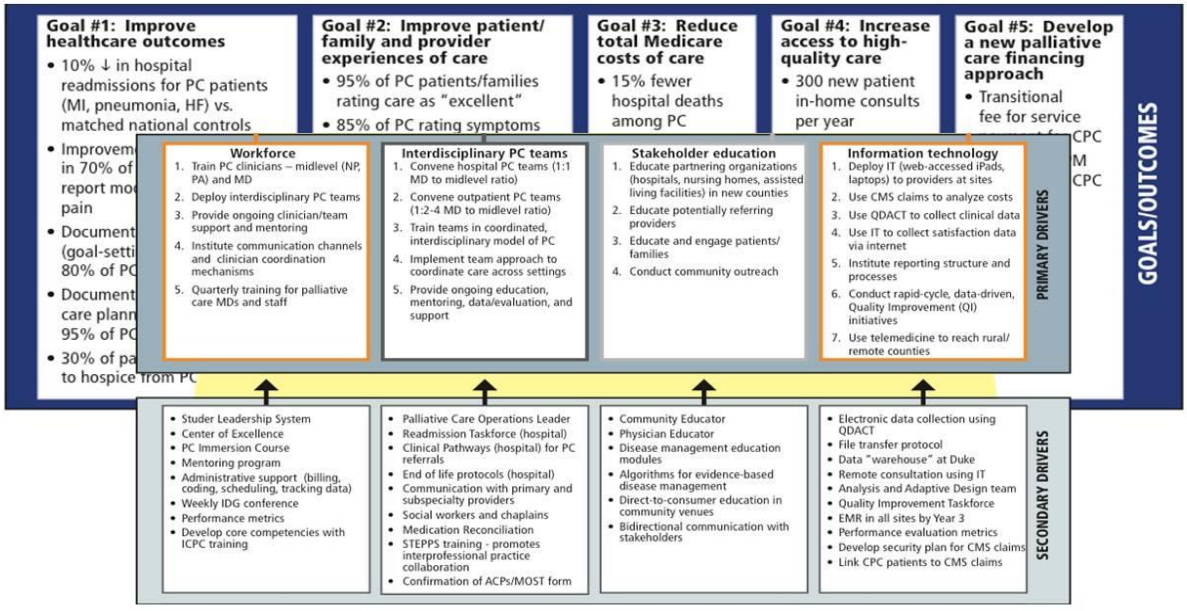
Goals and Driver Diagram



Eligibility

- Medicare Age Eligible
- Patients with life limiting illness in last 3 years of life
- Uncertainty of appropriateness of therapy (curative, palliative, hospice)
- Excludes 54% of palliative care patients (younger, Medicare Advantage, etc)

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Screening Tool for Palliative Care Referrals

Significant Risk Factors: check all that apply

Clinical Opinion

Would you be surprised if this patient died in the next year?

☐ No

Physical Limitations

- ☐ Needs Assistance with Activities of Daily Living
- ☐ Severe functional decline
  - PPS* ≤ 50%
- ☐ Non ambulatory
- ☐ Physical Disability
  - Legally Blind
  - Hard of Hearing
- ☐ Debility
  - BMI ≤ 21
  - PPS* ≤ 40%
- ☐ Fall Risk

Utilization of Resources

- ☐ Frequent hospitalizations
  - > 2/year
- ☐ Frequent ER visits
  - > 2/year
- ☐ Multiple provider visits
- ☐ Polypharmacy
  - > 5 meds
- ☐ High risk medication
- ☐ Recent Sentinel Event
  - Fall with injury
  - Pneumonia or Sepsis
  - Fracture
  - Hospitalization
  - New onset delirium

Social Determinants

- ☐ Depression
- ☐ Low health literacy
- ☐ Homeless
- ☐ Limited access to care
- ☐ Transportation Issues
- ☐ Low income
- ☐ Substance Abuse
- ☐ Lack of caregiver support
- ☐ Recent loss of spouse

Serious Illnesses *check if any apply*

- ☐ Dyspnea at Rest
  - NYHA Class IV
  - Ejection Fraction ≤ 15
  - CHF with elevated BNP
  - Symptomatic at rest
  - Maximally treated with medications
- ☐ End Stage COPD
  - FEV1 (subscript) <30%
  - Oxygen sats < 88% room air
  - On Oxygen
  - Dyspnea at rest
- ☐ > 3 Comorbidities
- ☐ End Stage Dementia
  - Fast Stage 7A or greater
  - Aspiration Pneumonia
  - Recent Fracture
- ☐ End Stage Liver Disease
  - PT > 5 or INR > 1.5
  - Albumin ≤ 2.5
  - Ascites
  - Hepatorenal syndrome
- ☐ End Stage Renal Disease
  - GFR ≤ 15 cc/min
  - Albumin < 3.5
- ☐ CVA
  - Dependent on ADLs
  - 10% weight loss
- ☐ ALS
  - Vital Capacity < 30%
  - On oxygen
- ☐ Metastatic Cancer
  - Metastatic disease
  - PPS* < 70%
- ☐ Frailty Syndrome

Patient can be referred to palliative care with a LACE Score > 12

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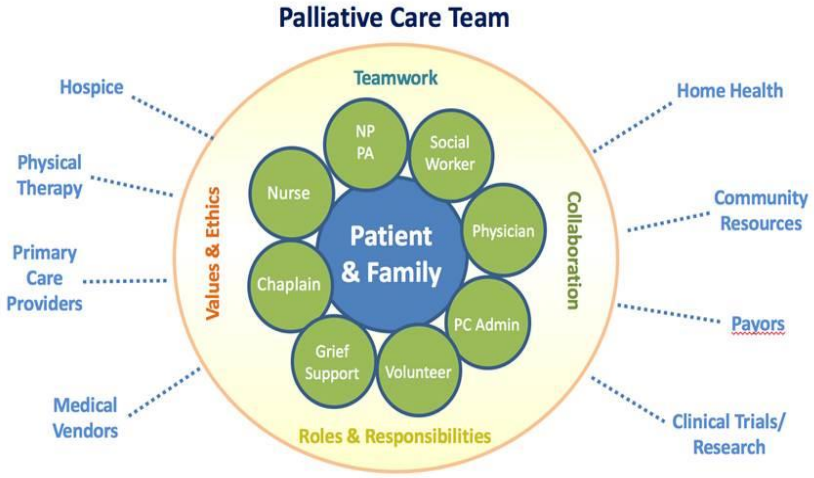
Four Seasons Palliative Care Model

Mission – Co Creating the Care Experience



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Standardizing Care

- Developing good processes/procedures
- Data collection
- Data analysis/tracking
- Quality improvements
- Measuring satisfaction

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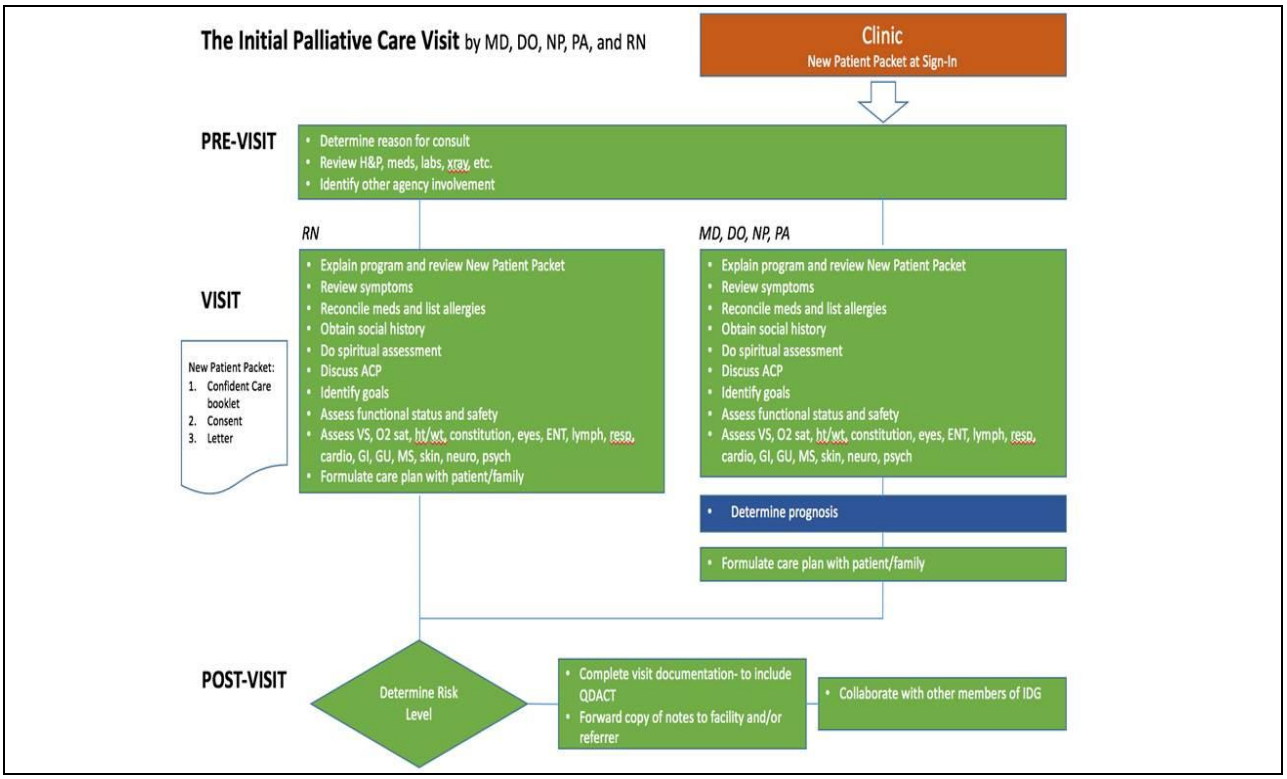

RISK ASSESSMENT

PRIORITY OF VISIT	High	Medium	Low
Transition	Transition from hospital within last 2 weeks	Transition from hospital within last 15-30 days	No hospitalizations or ER visits within last 3 months
Symptom	Mod-Severe Symptoms: pain, dyspnea, constipation, N&V		
Function	20% drop in PPS	10% drop in PPS	PPS stable but <50%
Meds	• 3 or more medication changes within last week • Initiation of opioids	1-2 medication changes within last 15-30 days (opioids, anti-psychotics, cardiac meds)	≤1 medication change within last 3 months
Nutrition	• Sudden nutritional decline (5% weight loss in 1 month) with BMI ≤ 21 • Albumin ≤ 2.5	• >5% weight loss over last 2-3 months with BMI ≤ 21 • Albumin 2.5-3	<5% weight loss in last 3 months
Infection	• Infection with systemic symptoms within last 2 weeks • ≥ Stage 2 pressure ulcer • Aspiration	• 2 infections within last 2 months • Stage 2 pressure ulcer within last 2 months	No infections within last 3 months

PSYCHOSOCIAL RISK ASSESSMENT

RISK	High	Medium	Low

Psychosocial	• Sudden cognitive changes
	  • Delirium
	  • Confusion
	• Mental health diagnosis accompanied by disruptive verbalizations/behaviors. Concern for patient or caregiver safety.
	• Suicidal ideation, especially with plan. Despair.
	• Signs/Symptoms of abuse/neglect. Unsafe situation for patient.
	• Caregiver decompensation. Immediate safety concerns.
		• Anhedonia- flat affect and not participating in ≥ 3 activities
		• Significant losses in last 2 years. Unresolved grief issues.
		• Depression.
		• Expresses fear/anxiety about money, worried about caring for family, concerned about paying for services
		• Caregiver stressed, showing some signs of burnout, but no immediate danger to patient or caregiver. Placement issues.
		• Transition to hospice- pt/family require psychosocial support in making decision for hospice care. Complex family dynamics.
			• Caregiver available and adequate to manage patient care. May need some self-care strategies or information on community resources.
			• Advance care planning needs.

Quality Data Assessment Tool

ADVANCE DIRECTIVES

Preference for Resuscitation Status	(•) Full Code ( ) DNR/DNI ( ) Mostly DNR/DNI with documented exceptions ( ) DNR, not DNI	( ) DNI, not DNR ( ) Patient does not wish to discuss ( ) Unknown ( ) Other (please specify)
Did resuscitation status change during visit?	Yes ⇕	
Preference for Resuscitation Status (AFTER)	( ) Full Code (•) DNR/DNI ( ) Mostly DNR/DNI with documented exceptions ( ) DNR, not DNI	( ) DNI, not DNR ( ) Patient does not wish to dicuss ( ) Unknown ( ) Other (please specify)
Existence of Advance Directives	( ) No - has interest ( ) No - not interested (•) Yes, documentation or copy in medical record ( ) Yes, but NOT documented in medical record	( ) Patient unable to complete ( ) Unknown ( ) Other (please specify)
Presence of Healthcare Proxy	( ) None ( ) Spouse or significant other ( ) Friend (•) Child ( ) Legal guardian	( ) Parent ( ) Other family ( ) Not sure ( ) Patient does not wish to answer ( ) Other (please specify)
Has the ICD been deactivated prior to an anticipated death?	( ) Yes ( ) No ( ) Not Applicable ( ) Unknown	

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PC Tracking

Enrollment	N = 2450 Total	N = 522 Dementia
Hospice Transitions	700 (33%)	181 (35%)
Palliative Care Deaths	237 (11%)	59 (11%)
Palliative Care Discharges	665 (31 %)	141 (27%)
Active PC Caseload	457 (24.3%)	141 (27%)

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Story tells….

- 50-60% die within 1 year (80% from data 2 years ago)… PC moving upstream
- 33% discharged after acute episode; of these ~ 10% readmitted

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Dementia

Challenges

- Difficult to prognosticate
- Slow disease trajectory
- High caregiver distress/burnout
- Often stabilize/improve with supportive services

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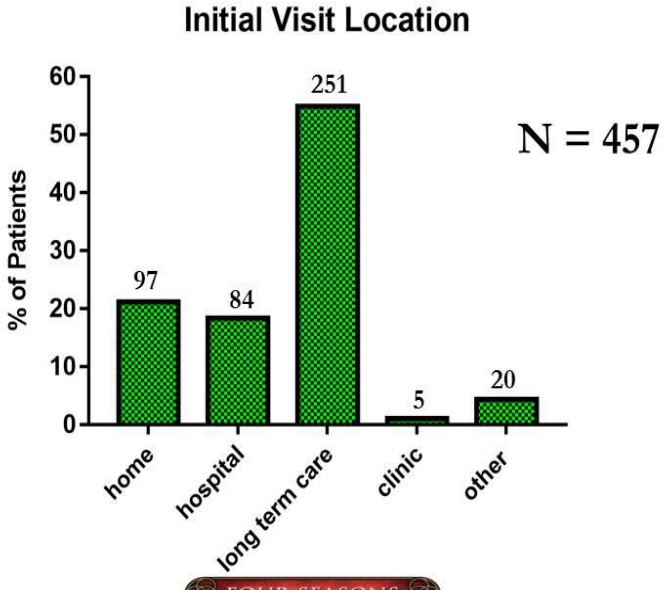
Palliative Care – Dementia CMMI patients



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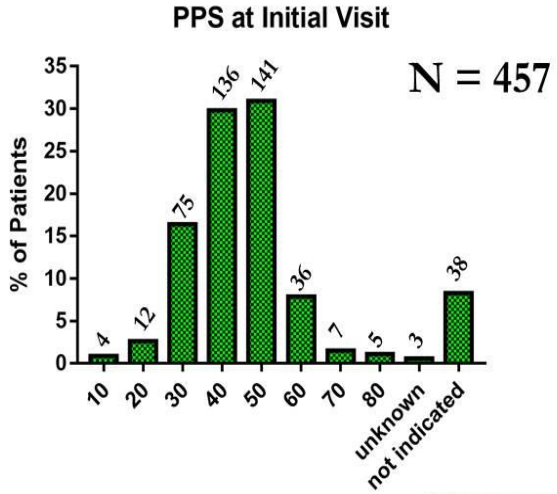
Functional Status of PC Dementia Patients



Palliative Performance Scale (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Conscious
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or some housework, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Mainly sit/lie	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy, or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy, or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy, or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death	–	–	–	–

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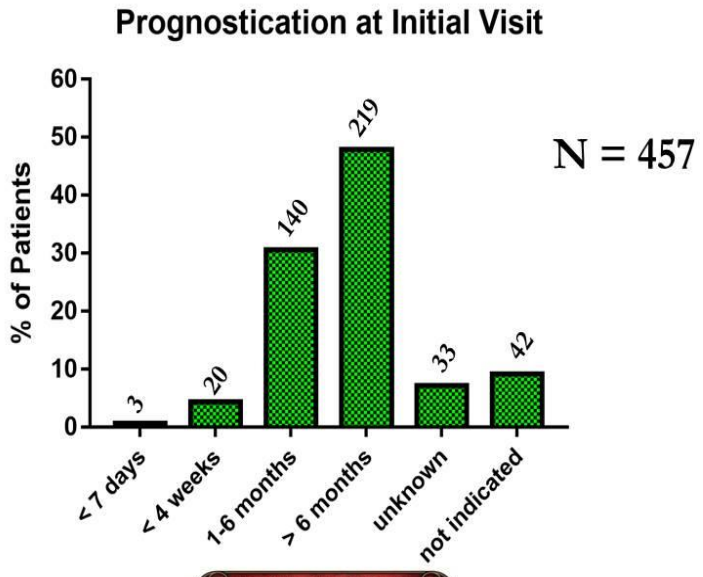
Prognostication by Clinicians



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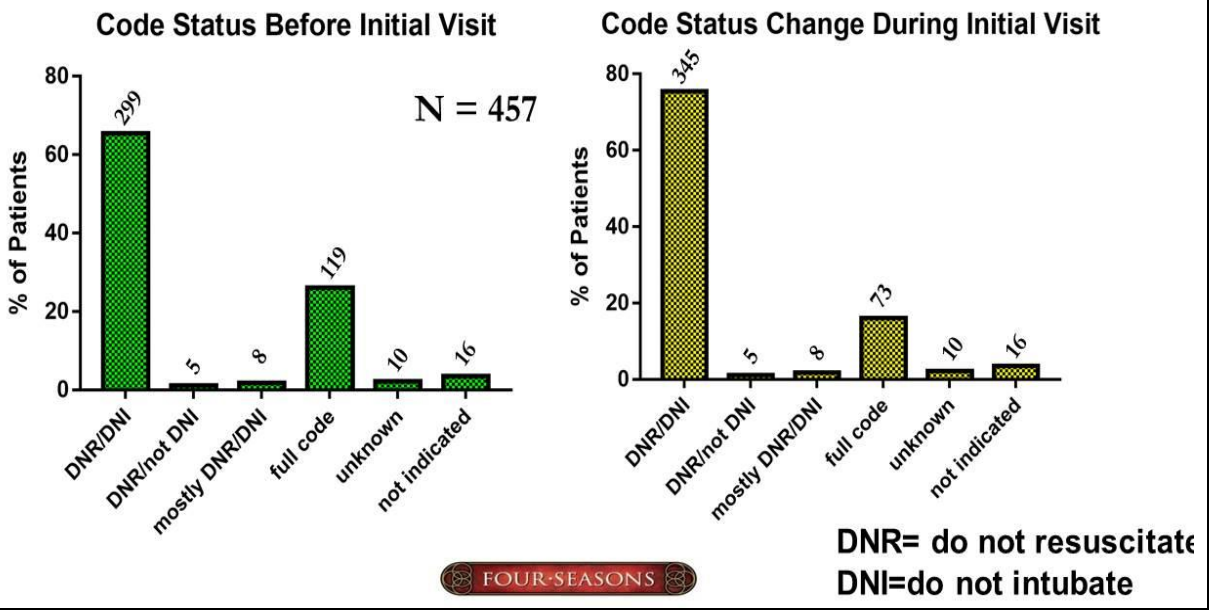
Code Status – Dementia Patients - PC



DNR= do not resuscitate
DNI=do not intubate

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Policy Issues

- Lack of long term care benefit
- Little reimbursement for other disciplines
- New Care Management codes
  - Advance care planning
  - Transitional care codes
  - Chronic care codes

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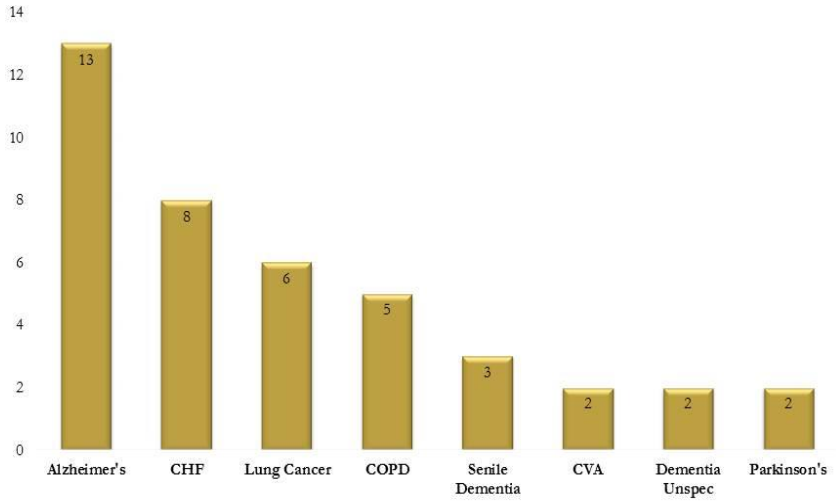
Diagnosis Hospice Claims 2015



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Differences - Hospice vs Palliative

	Hospice	Palliative Care
Life Expectancy	< 6 months	Any stage of illness
Treatment	Comfort	Curative or comfort
Care settings	All	All
Resources	Significant	Limited
Delivery model	Interdisciplinary Team	Interdisciplinary Team
Payment Model	Medicare Hospice Benefit	Medicare Part B E/M codes

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How to Pay for Services?

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Developing Alternative Payment Approaches

Covered Services

- Advance care planning
- Goals of care (3 meetings)
- Social work, chaplain, patient family volunteers
- RN case management and care coordination
- Not covered (hospitalization, primary care, specialty care)

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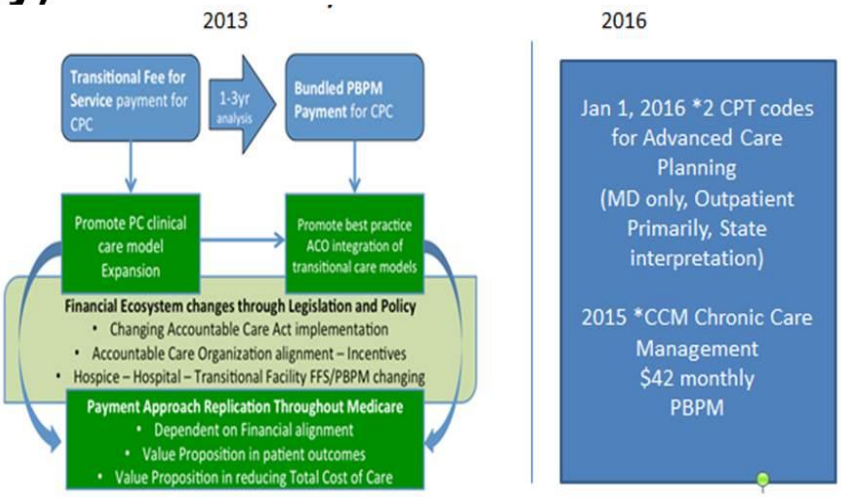
As the World Turns (Grant submission to today)



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Questions Around Payment Approaches

Challenges for Evaluation

- Medicare Part A vs Part B – increase Part B while reducing Part A costs
- PBPM payment 30/60/120
- Bundled payment (60/120 days) Who holds?
- Care management codes (increase Part B bucket)
- Changes in hospice payment (two tiered payment, Service Add on)

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Susan's Story

82 year old white female with end stage dementia admitted to the hospital with second episode of aspiration pneumonia

- wandering, behavioral issues
- feeding issues – considering PEG tube
- lives with son and his wifej who are overwhelmed

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Questions?

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