Roundtable on Quality Care for People with Serious Illness

Session 2: Financing and Payment Innovations: Challenges, Impact and Lessons Learned from Fee-for Service and Value-Based Payment Arrangements

BSWH Journey Towards Value in Serious Illness Care

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Supportive and Palliative Care

See fact sheets for both

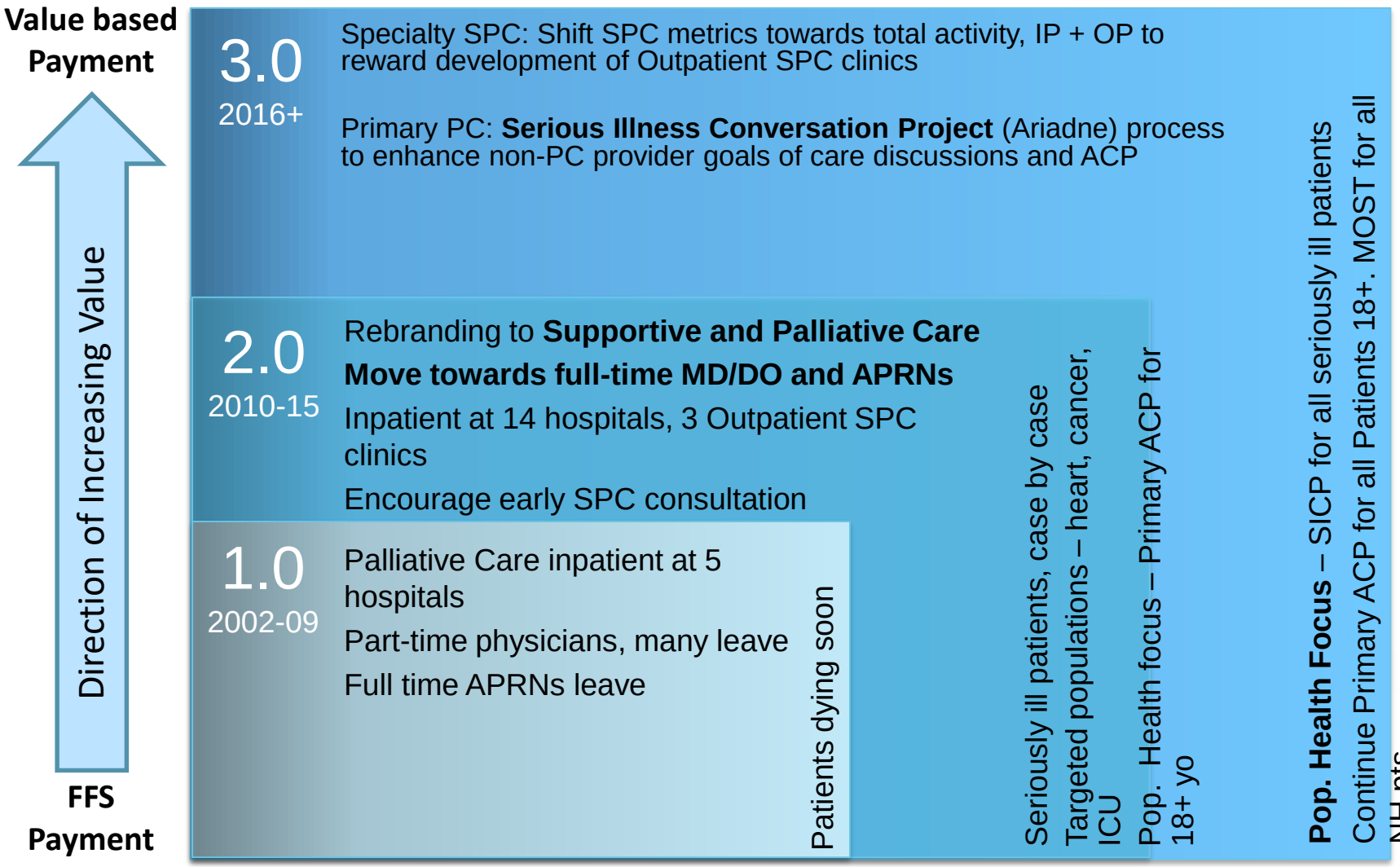
- Largest not-for profit health care system in Texas:
  - 44 counties with 9.5 million people, 34,500 square miles (Maine)
  - 5.8 million patient encounters, 208,000 hospital admissions, 548,000 covered lives
  - 48,000 + employees, 9600 + physicians, 5385 licensed beds
  - $10.8 billion assets, $8.4 billion total operating revenue
- Supportive and Palliative Care (SPC) Service Line
  - CAPC/Joint Commission model, board certified physician led teams at 14 hospitals with 100+ non-obstetric beds.
  - 19 board certified palliative medicine physicians, 17 APRNs, SW, Pastoral Care, Child Life, ST/PT/OT/MT/AT
  - 24,369 SPC patient visits (FY17)
  - 81.7% live discharge, 34.1% with hospice
  - 28.6% of hospital deaths seen by SPC

Pre - Palliative Care, 1976- 2001

- First hospices in Dallas, 1978. No financial benefit to hospitals.
- Multidisciplinary Clinical Ethics Committee, 1983.
  - Ethics consults grow from 5 (1985) to 150/year (2002)
  - Several million dollars/year *charge reduction* (limiting “futile” interventions)
  - Served only ≅ 0.5% of non-OB admits.
  - Good for payer, bad for hospital in FFS world.
- In-hospital SNF, response to DRGs, 1987 - 97.
  - 30 bed unit within 1000 bed hospital.
  - 6-bed Palliative Care Unit on SNF planned 96-97.
  - SNF closes first. *Other space utilization more financially advantageous!*

Lessons learned: Financial incentives must align.

Evolution of Palliative Care at BSW



PC 3.0
SPC process goal added to EIP.
FY18 projected consults 7656, $21M cost savings.

PC 2.0
Prep for Value Based payment. Better cost savings data. Merger. SPC structure goal added to Executive Incentive Plan (EIP).

PC 1.0
Limited cost savings data and limited expansion by hospital leaders.

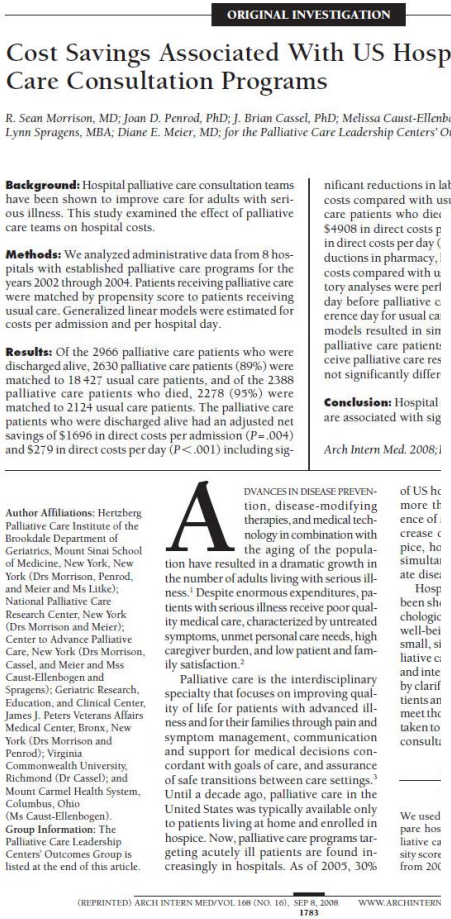
PC 1.0 (2002-2009)

- Second effort to start PC begins 2002
  - Nursing and Clinical Ethics leadership.
  - Part time service, limited funding contingent on cost savings.
  - Savings demonstrated by 2006, ***but many leaders don't believe the data and will not start or expand PC programs***.
    - Only 5/10 hospitals have PC programs.
    - Growth stagnates at 1% of hospital admissions, mostly acute death and dying. Loss of physician and APRN staff.
  - By 2009, some leaders thinking of a value based payment world.
    - Recognize much treatment near the end of life is non-beneficial, not desired by patients, and our limited palliative care programs can help.

Lessons learned: Data leaders can't ignore is critical.

PC 2.0 (2010-2015)

Overcoming skepticism about finances of PC



ORIGINAL INVESTIGATION

Cost Savings Associated With US Hospital Palliative Care Consultation Programs

R. Sean Morrison, MD; Joan D. Penrod, PhD; J. Brian Cassel, PhD; Melissa Caust-Ellenbogen, MS; Ann Litke, MFA; Lynn Spragens, MBA; Diane E. Meier, MD; for the Palliative Care Leadership Centers' Outcomes Group

Background: Hospital palliative care consultation teams have been shown to improve care for adults with serious illness. This study examined the effect of palliative care teams on hospital costs.

Methods: We analyzed administrative data from 8 hospitals with established palliative care programs for the years 2002 through 2004. Patients receiving palliative care were matched by propensity score to patients receiving usual care. Generalized linear models were estimated for costs per admission and per hospital day.

Results: Of the 2966 palliative care patients who were discharged alive, 2630 palliative care patients (89%) were matched to 18 427 usual care patients, and of the 2388 palliative care patients who died, 2278 (95%) were matched to 2124 usual care patients. The palliative care patients who were discharged alive had an adjusted net savings of $1696 in direct costs per admission ($P = .004$) and $279 in direct costs per day ($P < .001$) including significant reductions in laboratory and intensive care unit costs compared with usual care patients. The palliative care patients who die
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Conclusion: Hospital
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Arch Intern Med. 2008;

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Group Information: The Palliative Care Leadership Centers' Outcomes Group is listed at the end of this article.

ADVANCES IN DISEASE PREVENtion, disease-modifying therapies, and medical technology in combination with the aging of the population have resulted in a dramatic growth in the number of adults living with serious illness.[1] Despite enormous expenditures, patients with serious illness receive poor quality medical care, characterized by untreated symptoms, unmet personal care needs, high caregiver burden, and low patient and family satisfaction.[2]

Palliative care is the interdisciplinary specialty that focuses on improving quality of life for patients with advanced illness and for their families through pain and symptom management, communication and support for medical decisions concordant with goals of care, and assurance of safe transitions between care settings.[3] Until a decade ago, palliative care in the United States was typically available only to patients living at home and enrolled in hospice. Now, palliative care programs targeting acutely ill patients are found increasingly in hospitals. As of 2005, 30%

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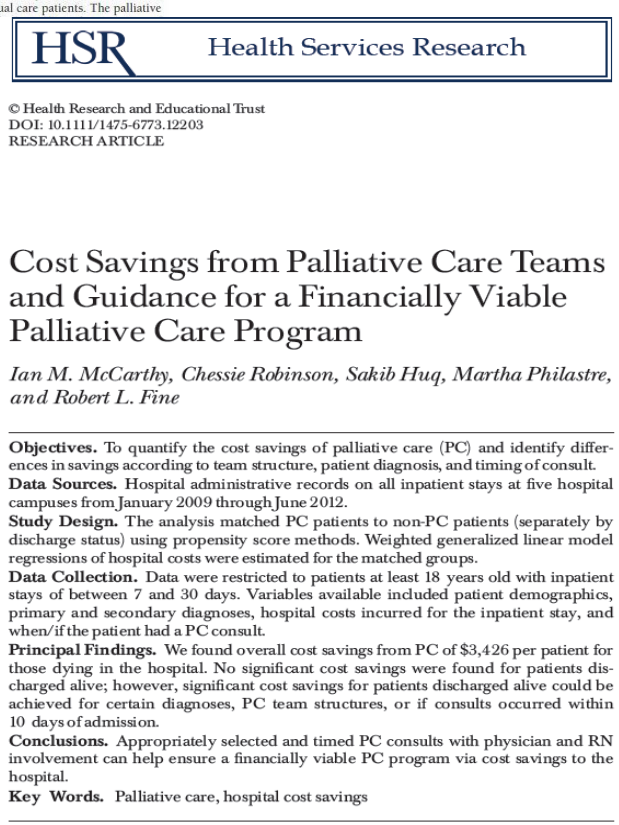

HSR Health Services Research

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RESEARCH ARTICLE

Cost Savings from Palliative Care Teams and Guidance for a Financially Viable Palliative Care Program

Ian M. McCarthy, Chessie Robinson, Sakib Huq, Martha Philastre, and Robert L. Fine

Objectives. To quantify the cost savings of palliative care (PC) and identify differences in savings according to team structure, patient diagnosis, and timing of consult.
Data Sources. Hospital administrative records on all inpatient stays at five hospital campuses from January 2009 through June 2012.
Study Design. The analysis matched PC patients to non-PC patients (separately by discharge status) using propensity score methods. Weighted generalized linear model regressions of hospital costs were estimated for the matched groups.
Data Collection. Data were restricted to patients at least 18 years old with inpatient stays of between 7 and 30 days. Variables available included patient demographics, primary and secondary diagnoses, hospital costs incurred for the inpatient stay, and when/if the patient had a PC consult.
Principal Findings. We found overall cost savings from PC of $3,426 per patient for those dying in the hospital. No significant cost savings were found for patients discharged alive; however, significant cost savings for patients discharged alive could be achieved for certain diagnoses, PC team structures, or if consults occurred within 10 days of admission.
Conclusions. Appropriately selected and timed PC consults with physician and RN involvement can help ensure a financially viable PC program via cost savings to the hospital.
Key Words. Palliative care, hospital cost savings

- We sought to duplicate the Morrison study on cost savings with hospital based PC consultation
  - Would we get the same results as Morrison?
  - Does PC lower direct costs in hospitals with already high hospice utilization?
  - Does timing matter?
  - Does discharge status matter?
  - Does primary disease matter?
  - Does team structure matter?

PC 2.0 (2010-2015)

- Does PC lower direct costs in high hospice hospitals pre-PC?
  - Baylor had high hospice utilization pre-PC. **"Why build PC?"**

(Data from DAHC, 2003-2007)

	% Hospice enrollment	Hospice LOS	Hospice impact factor*
U. S. Average	36.9	13.9	513
Morrison Academic Hospitals	32.3	11.6	375
BHCS Academic Hospital	**49**	**18.5**	**907**
Morrison Community Hospitals	44.9	19.7	885
BHCS Community Hospitals	**56.9**	**20.6**	**1172**

  - Hospice enrollment 52% & 27% higher at BHCS academic and community hospitals.

Lessons learned: PC generated cost savings even in our high hospice utilizing system.

*Hospice Impact Factor = % hospice enrollment as raw whole number x hospice length of stay.

PC 2.0 (2010-2015)

- Discharge status and timing important to cost savings at Baylor.
- Overall cost savings only for discharged deceased of $3246.
- Earlier consults yielded significant savings and critical for discharged alive patients.

Estimated Savings (Loss) from PC Consultation		
	Discharged Alive	Discharged Deceased
Days 1 - 9	$2550	$9579
Days 10-14	($1644)	$8017
Days 15 or more	($5363)	$3313

Lessons learned: Late consults yield less or even no financial benefit.

- Patients and families miss clinical benefits of early PC

PC 2.0 (2010-2015)

- Primary diagnosis matters!

Cost Savings from PC Consultation		
	Discharged Alive	Discharged Deceased
Cancer	Yes	Yes
Cardiovascular	Yes	Yes
Pulmonary	No	No
Infection	No	Yes

Lessons learned: Take all seriously ill patients referred, but "market" more to cancer and cardiovascular services.

Lessons learned: PC team structure matters! Greatest cost savings seen in hospitals with more complete teams. Hospitals with the least physician presence had worst financial performance.

PC 3.0 (2016 and Beyond)

- Staying on top of our finances.
  - CAPC Impact Calculator at https://www.capc.org/impact-calculator/
    - BSWH FY18 (Q1 annualized): Admissions (excluding OB/Neonatal) 150,564 at 14 hospitals
      Inpatient SPC consults 7656
      CAPC direct cost savings/case $3,274

Description	Estimate 1	Estimate 2
Est. avg. cost/FTE	**$160,000**	**$180,000**
Est. team cost	$5,760,000	$6,480,072
Collections from billing	$2,577,086	$2,577,086
Net Investment needed	$3,182,914	$3,902,886
Cost savings before investment	$25,065,755	$25,065,755
Annual Direct Cost Savings (Savings – Investment)	**$21,882,830**	**$21,162,858**

Similar values if use previously published BHCS data applied to annualized 1192 discharged deceased and 6262 discharged alive, adjusted for timing of consults.

Lessons Learned

To Provide the best Serious Illness Care

- Hospice is essential but not sufficient by itself.
  - Until more rule flexibility such as ability to maintain disease modifying treatment and not be time limited (6 months), it will remain a relatively late service.
- Clinical Ethics is essential but not sufficient by itself. Medicine is a moral endeavor using science as a tool to reach certain ends.
  - Clinical ethics can set and help maintain a moral foundation for serious illness care but can't meet the practical needs of patients, family, or staff.
- Palliative Care, appropriately managed provides significant direct cost savings and multiple evidence based benefits to patient and family:
  - Enhanced symptom control
  - Less non-beneficial treatment
  - Better advance care planning
  - Less complicated grief and PTSD among surviving family members
  - Enhanced survival in some illnesses
  - Lower costs

Commitments Regardless of Reimbursement

Unit of treatment must be patient and family

- Commitment to quality patient care
  - Joint Commission Certification
  - Robust data (40 + items) at each hospital with 100+ adult beds
    - Timeliness of service
      - Mean time admission to SPC consult: 4.16 d (range 2.5 - 7.1)
      - Median time admission to SPC consult: 2 d (range 2 - 4)
    - Care planning
      - One or more new advance directives: 32.5% (range 20.3 – 45.4%)
      - Code status change in 51%
    - Palliation
      - Pain improvement: 95.3% (range 92.3 – 100%)

- Commitment to quality family support
  - Serving families means serving the children of seriously ill adults
  - Child Life Specialists if trained can serve the children of seriously ill adults
    - FY17: 1392 families with 2521 children served

PC Truths Regardless of Reimbursement

Providing high quality PC is human labor intense

- Cannot fund comprehensive primary and specialty level palliative care from professional revenue alone. Cost savings are essential! We believe Value Based payment will better support PC.
  - Specialty palliative care is more challenging in smaller institutions. Breakeven point for a single PC physician + APRN team is approximately 100 non-OB beds.
    - Physician and APRN are in essence solo.
  - Palliative care is team based, but only the physician and APRN can charge for the service. (SW, Pastoral Care, Child Life cannot)
  - Palliative care generally serves the sickest 5 – 10% of hospitalized patients. ***Complexity = Time***, but current reimbursement (even with ACP codes), does not adequately cover this time, especially at tertiary care facilities.

Lessons Learned

To Provide the best Serious Illness Care

- All health care is local, even in the same organization!
  - Culture eats strategy for breakfast, lunch, and dinner, especially in an arena as sensitive as serious illness care.
    - It's a long way from Central Texas to DFW!
    - We don't know yet how to provide SPC team service in rural areas.
  - Higher case mix index and social complexity facilities require larger SPC teams. ***Complexity = Time.***
- Data is important:
  - Qualitative data (heart) - pain relief, care planning.
  - Quantitative data (head) - service growth, timing, financial.
    - External benchmarks, such as those from CAPC are helpful.
- **<u>Aligning leadership incentives helps!</u>**
  - Clinical + Administrative leadership required with objective standards for quality, clear performance goals, clear strategy to reach the goals, and routine outcome reporting.

The Impact of Value Based Payment

- The transition from FFS to Value is challenging. An administrator subsidizing PC wants to see a direct return on investment to that administrator's bottom line.
  - What source of funds subsidizes the PC program?
  - Which organizational location accrues cost savings?
- Even within value based payment systems, palliative care needs to continually demonstrate its contribution to value and that may be harder as we expand the skill set of non-PC doctors through programs like the Serious Illness Conversation Project.

Recommendation

Payers, both governmental and commercial, should reward organizations/providers who demonstrate palliative care competency and quality if expanded PC capacity is desired.
Value Based Payment will not solve all the challenges of SPC.

Questions/Comments

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