# Listening Session 1: *Relationship between Payment Features and Care Transition Innovations*

**Presenters:**

***Subject Matter Experts***

- **Cheri A. Lattimer, RN, BSN** – Executive Director, National Transitions of Care Coalition
- **Diane Sanders-Cepeda, DO, CMD** – Senior Medical Director, UnitedHealthcare Retiree Solutions
- **Diane E. Meier, MD, FACP** – Founder, Director Emerita and Strategic Medical Advisor, Center to Advance Palliative Care

# Listening Session 1: *Relationship between Payment Features and Care Transition Innovations*

**Cheri A. Lattimer, RN, BSN**

Executive Director

National Transitions of Care Coalition

# Relationship Between Payment Features and Care Transitions

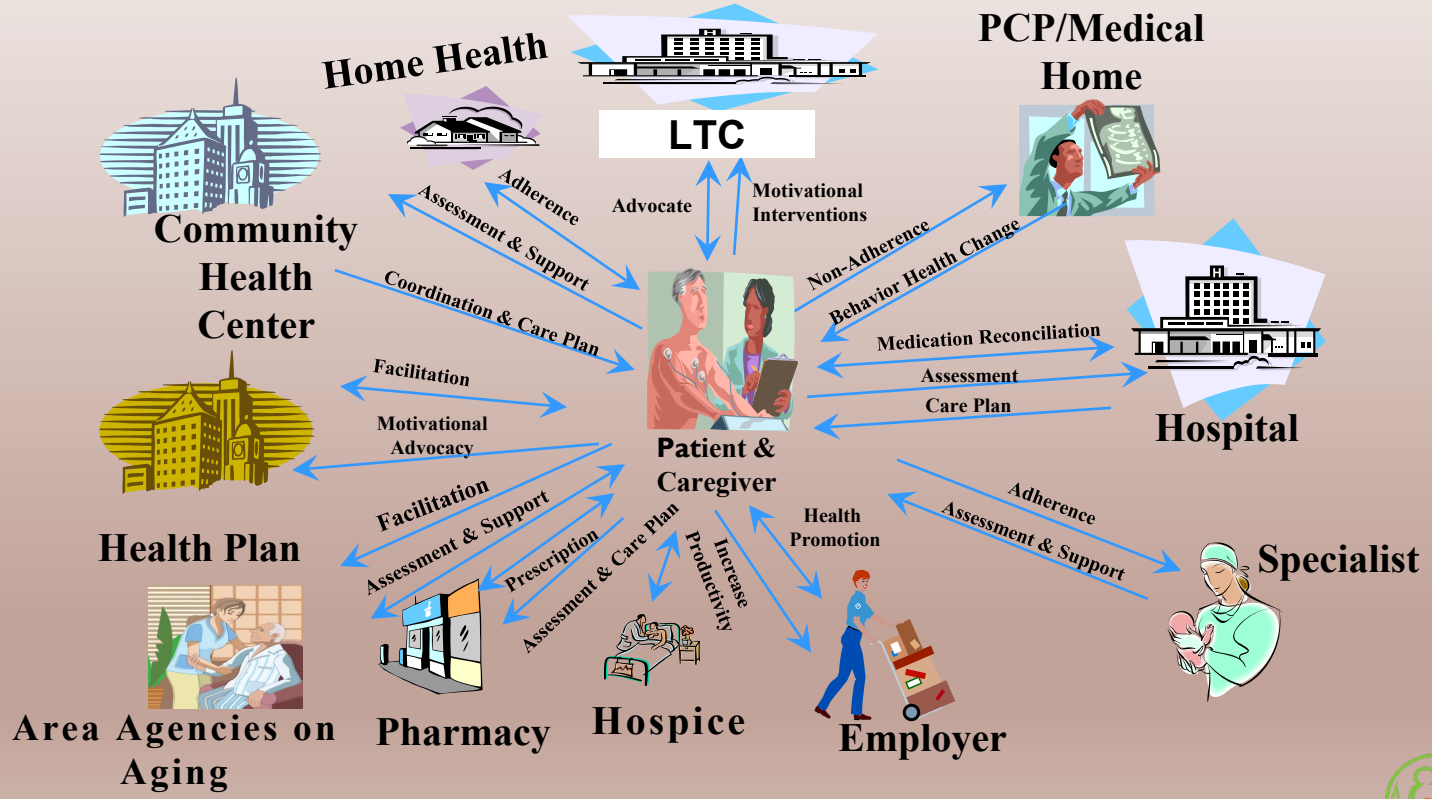
Presented by Cheri Lattimer, RN, BSN
Executive Director, National Transitions of Care Coalition (NTOCC)

# The Role of Transitions of Care (ToC)

- We have been addressing the issues surrounding ToC for ~20 years[1]
- ToC refers to the movement of patients from one healthcare practitioner or setting to another, due to changes in their conditions and care needs during a chronic or acute illness or an episode of care (AHRQ)[2]
- We continue to see gaps and barriers at three levels:[3]
  - Systems level barriers
  - Clinical level barriers
  - Patient level barriers


1. NTOCC, https://www.ntocc.org, accessed March 24, 2023;
2. AHRQ, https://ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html. Accessed March 29, 2023
3. Khanna S et al. The Adv Gastroenterol. 2022; 15:17562848221078684.

# It is Complicated but Only By Working Together as a Collaborative Team Addressing *ALL* the Care Needs of the Patient & Family Caregiver Can We Improve This Process




Developed by NTOCC

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# Seven Essential Intervention Categories For Designing Transition Strategies for Patients & Caregivers Across the Continuum

**Patient & Identified Family Caregiver Engagement /Education**

Nursing or social work case managers need to conduct an assessment including SDOH and develop educational plan which is shared with care team and transferred to the next care setting

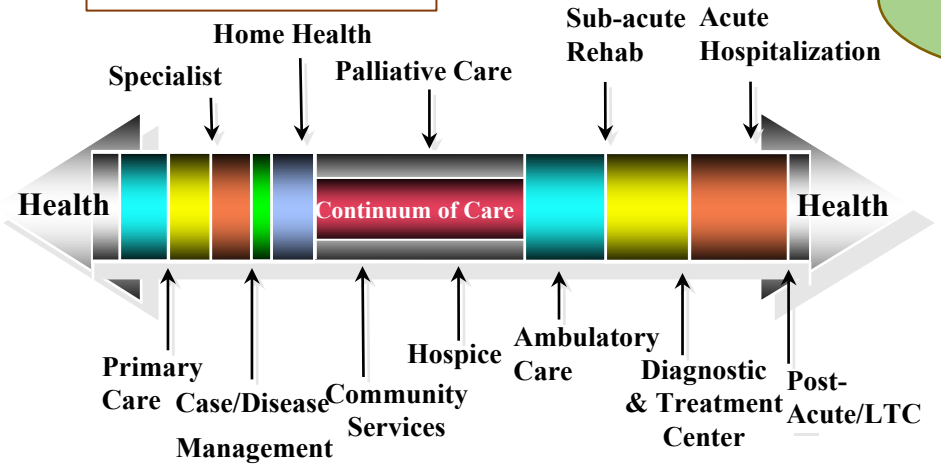
**Medication Management Services & Coordination**

Conduct & complete a comprehensive patient and caregiver medication intake and needs assessment, develop a medication plan which is shared with the collaborative care team

**Transition Planning**

**Physical Health, Mental Health/SUD, Social Determinants of Health Triune**

Providers need to assess the whole individual. Ensure complete assessment of all areas to avoid missing crucial factors that may significantly affect others; they are not separate domains but integrated.




Collaborative care planning & implementation, use shared decision making with patient & family incorporating findings of the patient assessment including Social Determinants of Health

**Information Transfer**

**Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum**

Identify interdisciplinary care teams: MD, Pharmacist, APN RN, SW, CM, allied health, community health workers, and community agencies to ensure that a healthcare provider is responsible for the care of the patient at all times

**Follow-Up Care**

Ensure timely access to medications and key healthcare providers & communicate importance to patients and their identified family caregiver

Implement bi-directional communication with provider to provider at the next level of care and provide information to the patient and family caregiver

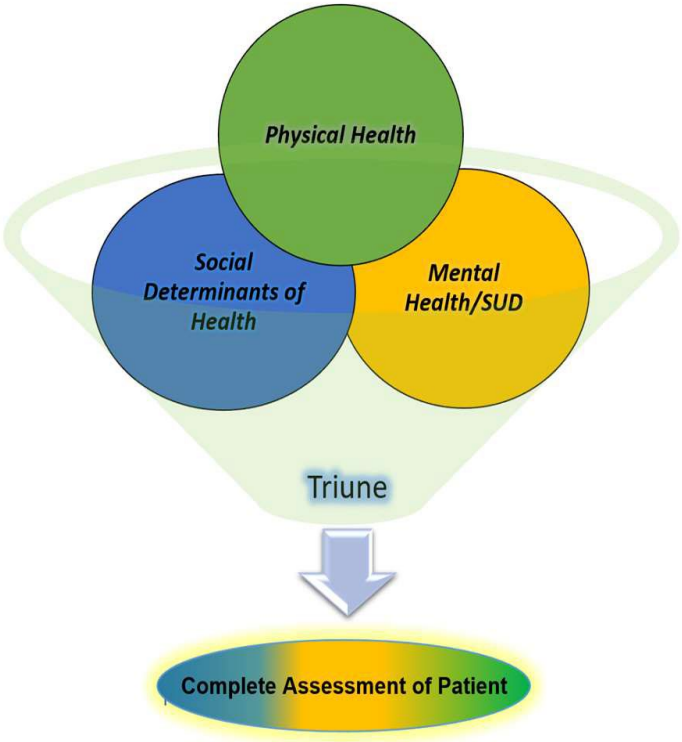


NTOCC, https://static1.squarespace.com/static/5d48b6eb75823b00016db708/t/625ed8dd72c19b5acc0b4e76/1650383070550/Care+Transition+Bundle+Graphic.pdf

# Care Transition Bundle #7

## PHYSICAL HEALTH, MENTAL HEALTH/SUD AND SDOH

- Patient's assessments must include all three domains
- Failure to do so leads to missed opportunities to identify important factors that may affect other areas.
- These are not separate domains but integrated and together will impact the outcome and transition journey of the patient and their identified caregiver
- Be sure to communicate the outcome of the assessment to the next level of care






NTOCC, https://static1.squarespace.com/static/5d48b6eb75823b00016db708/t/625ec7834a90de6335434515/1650378628414/2022+NTOCC+7+Elements.pdf

# Transitions of Care – Services & Reimbursement Gaps & Barriers

1) Timely notification and information to providers at discharge/transitions
2) Coordination between Specialist and PCP for use of TCM codes coordination – only 1 provider can bill
3) Some providers feel the reimbursement codes do not cover the administrative (documentation & billing) and services cost
4) Timely access/appointment to PCP & Specialist for follow up care
5) Rural areas timely access to providers may be very limited
6) TCM codes are used by one provider during the 30 days after discharge/transition
7) Medication reconciliation and management – pharmacists support
8) Transition follow-up with patient and their family caregiver often unclear at discharge
9) TCM codes and CCM code coordination suboptimal – one provider must use the codes – yet we ask the care team among the various levels of care to interact and coordinate
10) Patient assessments may not be inclusive of medical, behavioral/SUD, SDOH
11) TCM coordination in FFS vs. ACO, IDS, Value-based Payments
12) Accountable healthcare providers who can bill for TCM/CCM


1. CMS Medicare Learning Network, MLN908628 August 2022
2. AAFP, https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management.html#:~:text=TCM%20Coding,within%20seven%20days%20of%20discharge
3. Medical Economics, https://www.medicaleconomics.com/view/transitional-care-management
4. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FAQ-TCMS%20031716-compare.pdf
5. www.NTOCC.org

# Considerations For Improving Transitional Care

- Enhance TCM codes to apply to more than 1 provider during the 30-day period after discharge/transitions
    - Consider Hub Provider – PCP, Specialist
    - Secondary Transition Provider – Specialist, PCP
- Ease requirements for billing
- Enhance CCM to apply to multiple providers for complex chronic patients
    - Bridge code for handover TCM/CCM
- Develop payment models that support collaborative practice and care coordination as a team across the continuum
- Integration of pharmacists with CCM reimbursement
- Identify additional providers of care – i.e., pharmacists, registered nurses
- Collaborative practice agreements – process structure, scope of work, billing, reimbursement

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# Thank You

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# Questions

# Listening Session 1: *Relationship between Payment Features and Care Transition Innovations*

**Diane Sanders-Cepeda, DO, CMD**

Senior Medical Director

UnitedHealthcare Retiree Solutions

# Relationship between Payment Features & Care Transition Innovations

PTAC 6/2023: Driving Innovation to Improve Transitions of Care

Diane Sanders-Cepeda, DO CMD

UnitedHealthcare Retiree Solutions

Senior Medical Director

United Healthcare

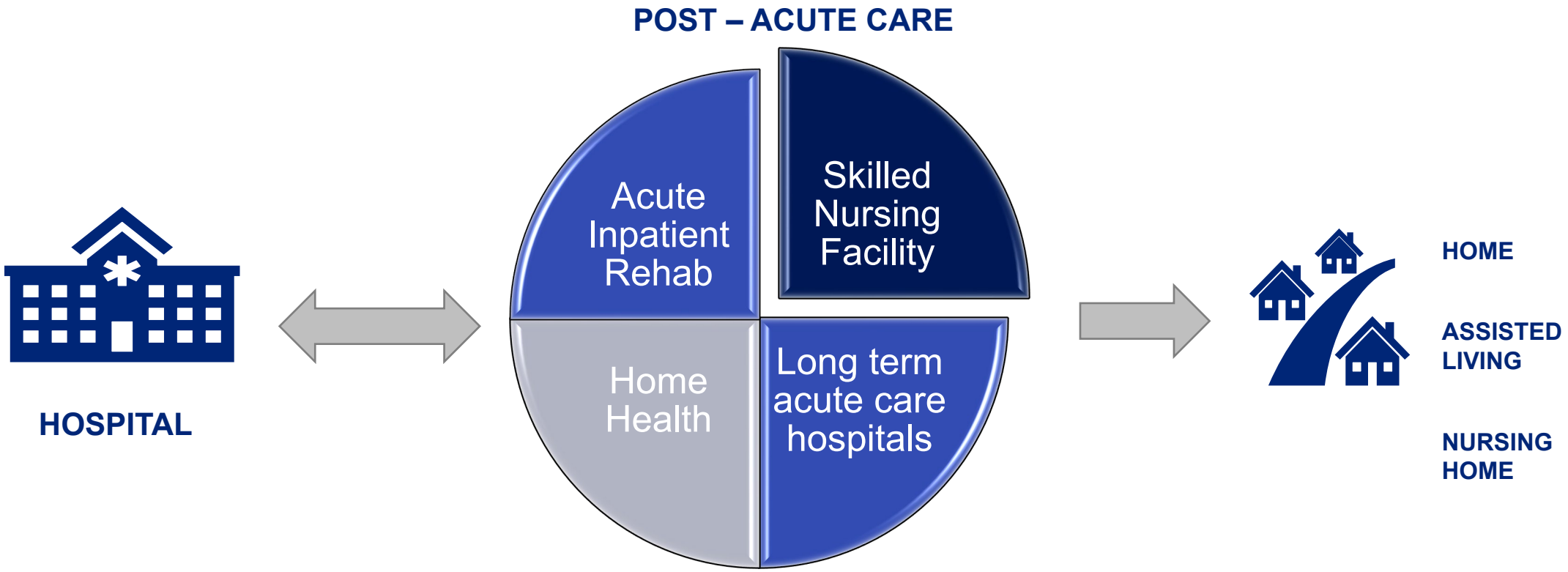
# Agenda

Address barriers impacting Care Transitions

Describe Infrastructure challenges in Post-Acute & Long-Term Care settings

Consider Innovations for Provider partnership & Care Delivery

# The Post-Acute & Long-Term Care Landscape



# Skilled Nursing Facility Challenges

**Geography**

- state, county, neighborhood

**Hospitals**

- where are they admitting from, what population are they serving

**Competitive landscape**

- how many other SNFs*, AIRs*, LTACHs*

**Payment models**

- Medicaid beds, Managed Care, ISNPs*, IESNPs*

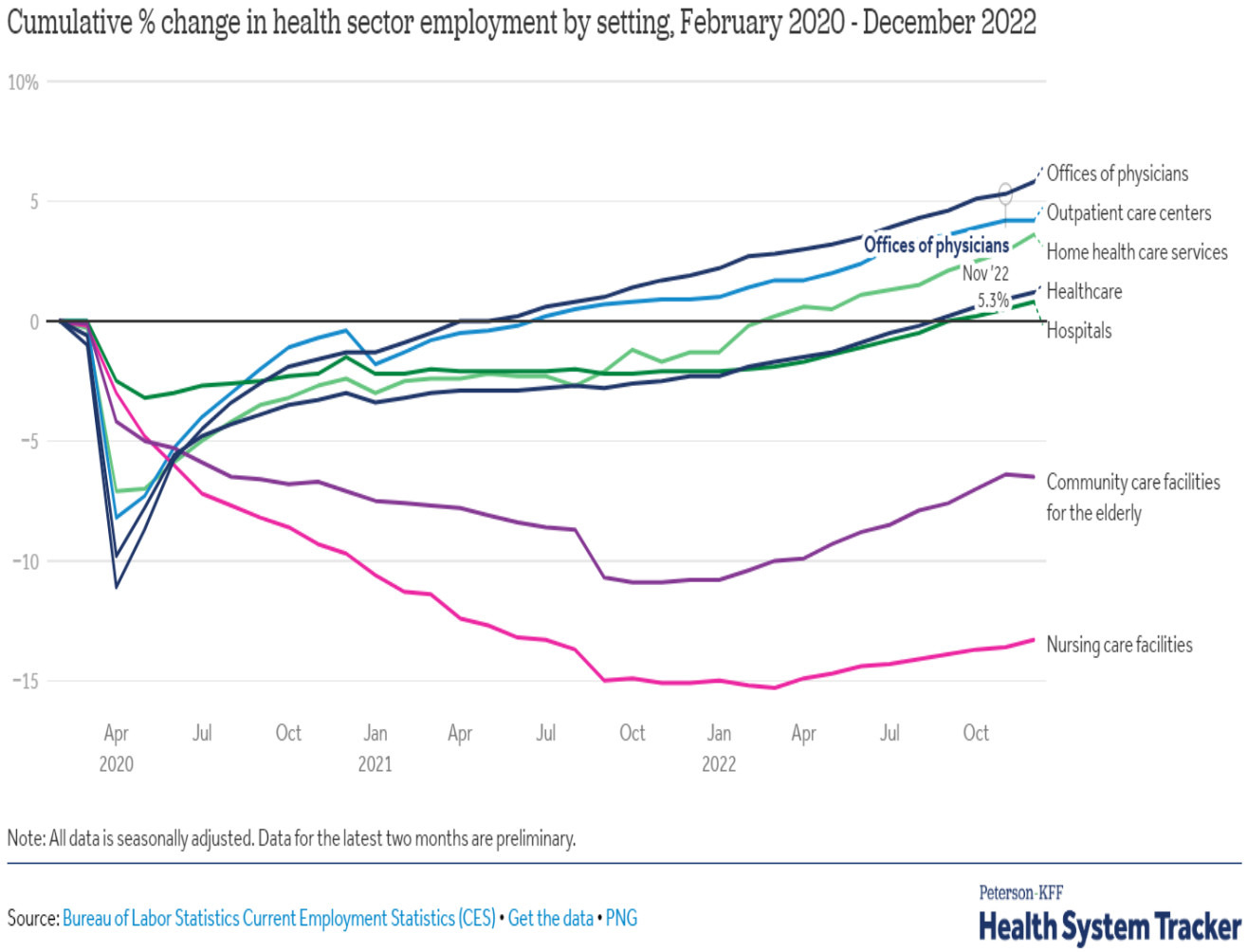
Medpac.gov – The Medicare Payment Advisory Commission



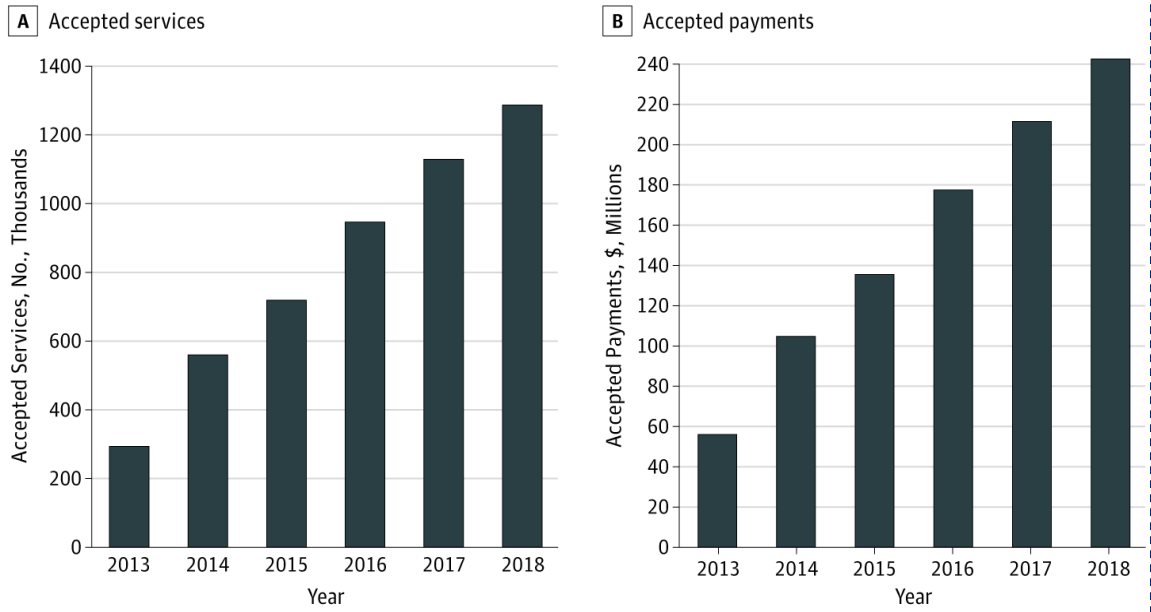
*SNF – skilled nursing facility; AIR – acute inpatient rehabilitation; LTACHs- Long term acute care hospitals; ISNPs – Institutionalized special needs programs: IESNPs – Institutional-equivalent special needs programs

# SNF Barriers to overcome

- Lack of Resources
- Technology Challenges
- Staff Shortages
- Variability??



# Trends in Utilization of Transitional Care Management in the United States

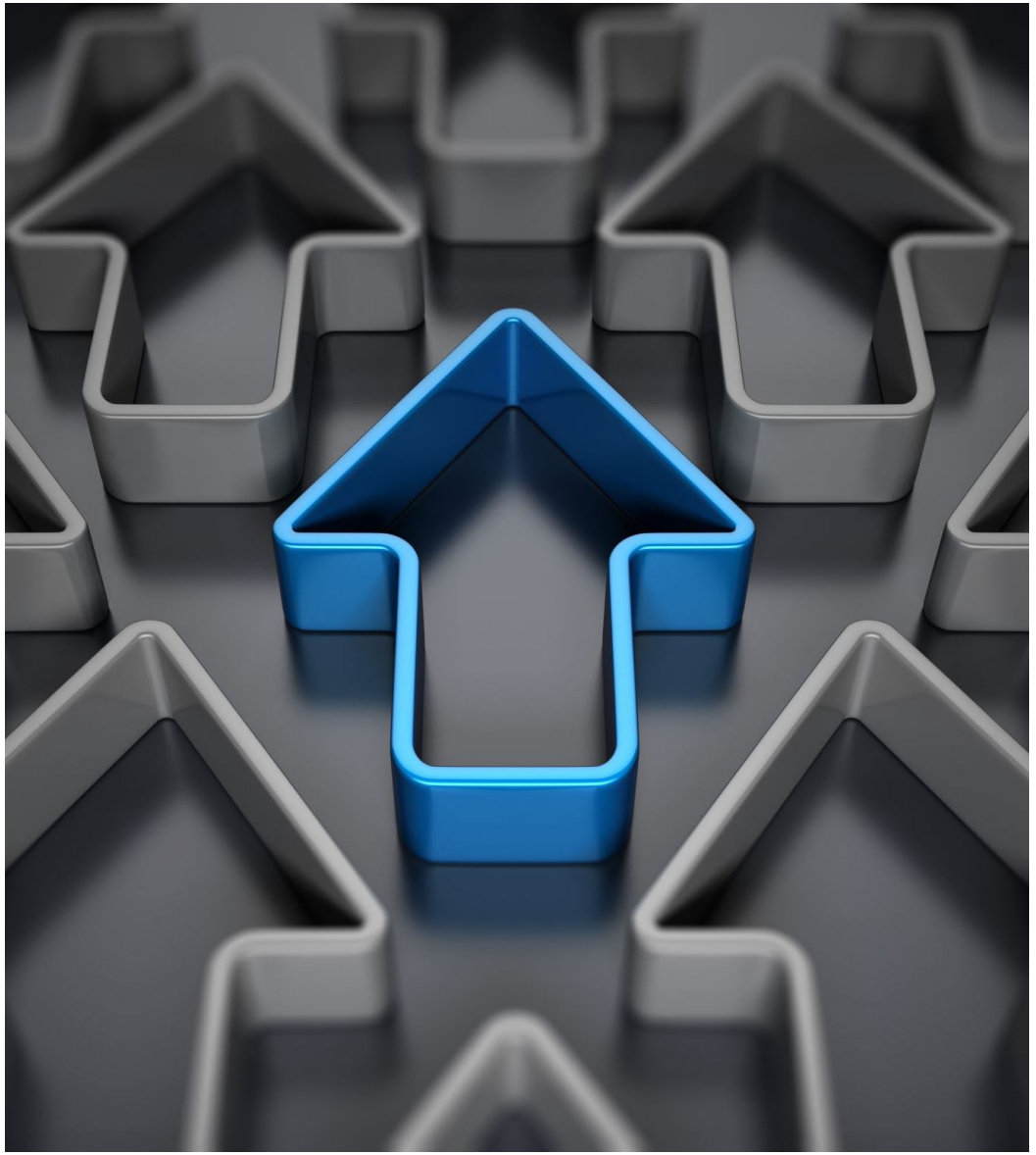



Trends in Transitional Care Management Use and Payment From 2013 to 2018

JAMA Netw Open. 2020;3(1):e1919571. doi:10.1001/jamanetworkopen.2019.19571

# Value Based Care – Care Transitions Innovations

- Provider Partnerships & Incentives
- Care Coordination & Navigation
- In-Home Care & Services
- Social Risk Intervention



# Questions

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**Diane E. Meier, MD, FACP**

Founder, Director Emerita and Strategic Medical Advisor

Center to Advance Palliative Care

# *Relationship between Payment Features and Care Transition Innovations for Patients with Serious Illness*

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June 12, 2023

“Serious illness” is a health condition that carries a high risk of mortality AND either negatively impacts a person's daily function or quality of life, OR excessively strains their caregivers. Mar 1, 2018

National Institutes of Health (.gov)

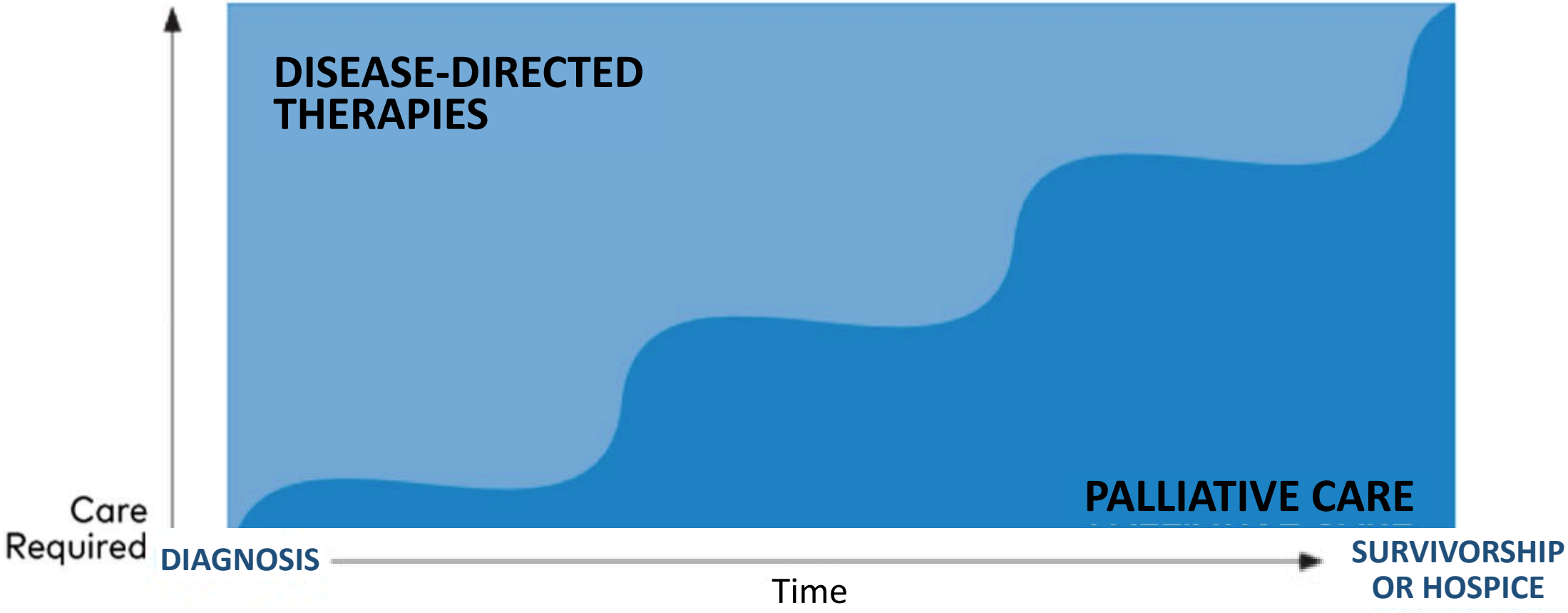
https://www.ncbi.nlm.nih.gov › articles › PMC5756466

## Identifying the Population with Serious Illness - NCBI

# *A Caution on Language*

- The repeated phrase “transitions to palliative care, comfort care, or end-of-life care services” falsely equates the three terms and yields the opposite of the intended result → **drives patients and clinicians away**.
- Palliative care is ***“specialized medical care for people living with a serious illness, focused on providing relief from the symptoms and stress of the illness. It is an added layer of support, working in partnership with other providers and is provided along with curative and life-prolonging treatment.”***
- Nothing in the definition of palliative care includes stopping treatments, and access to palliative care is based on need, not on prognosis.

CMS definition: "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs ..." (CMS, 42 CFR 418.3)



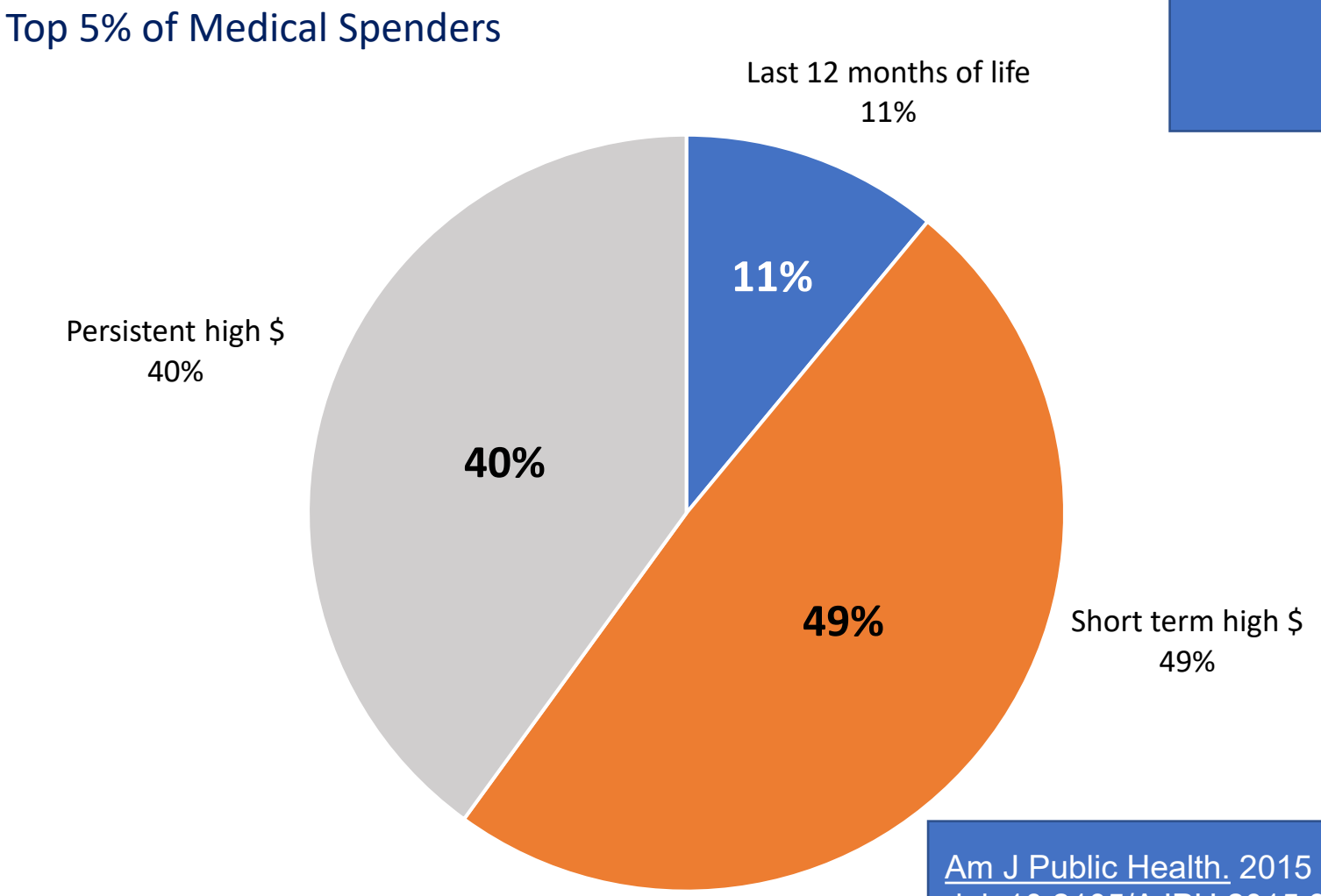
# *Example: Bundled Payments for Care Improvements in Sub Acute Rehab used an embedded palliative care consultant, described as "key to improving value"*

High percentage of Sub Acute Rehab patients die within 90 – 180 days, 28% within 1 year

**"The only way we were able to sell the idea *(of the embedded palliative care consultant)* to clinicians was that it's not 'giving up' and it's not 'end-of-life.'"**

## Most high-cost high-need patients are not near the end of life

## Only 11% of the highest cost patients are in the last year of life.




Am J Public Health. 2015 December; 105(12): 2411–2415.
doi: 10.2105/AJPH.2015.302889
Aldridge MA, Kelley AS. The Myth Regarding the High Cost of End-of-Life Care

# *Untreated symptom distress drives preventable utilization*

| Cancer ED Visit Primary Diagnosis (Within the top 10 Diagnoses) | % of Total Visits | Median Reimbursement |
|---|---|---|
| Pain | 27.2% (36.5%) | $1,127 |
| Dyspnea | 6.2% (10.2%) | $1,115 |
| Dehydration | 3.3% (6.5%) | $1,160 |
| Fatigue | | $544 |
| All Other Preventa<br>Distress | | $292-1,314 |

**102% increase from 2012-2019 in the number of patients – with any illness – visiting an ED because of pain**

(Tabriz, JAMA Open, 2022)

anattoni, J Oncol Pract, 2018

https://www.capc.org/training/introduction-to-palliative-care-for-health-professionals/

# Debbie's quality of life changed with the addition of palliative care.

Before palliative care:

- Disabling pain due to chemotherapy side effects
- Depression, functional decline, inability to work, social isolation, and suffering
- Family distress
- Multiple 911 calls for pain crises, followed by three ED visits and hospitalizations
- Devastated by being accused of drug seeking by ED staff

After palliative care:

- Pain well-controlled
- Resumed work, family role, and going to church
- 24/7 phone access to clinicians
- Ongoing relationship with palliative care team for 10+ years
- Support from social worker, chaplain, yoga and art therapists
- No 911 calls or ED visits in 10+ years

**Not dying!**

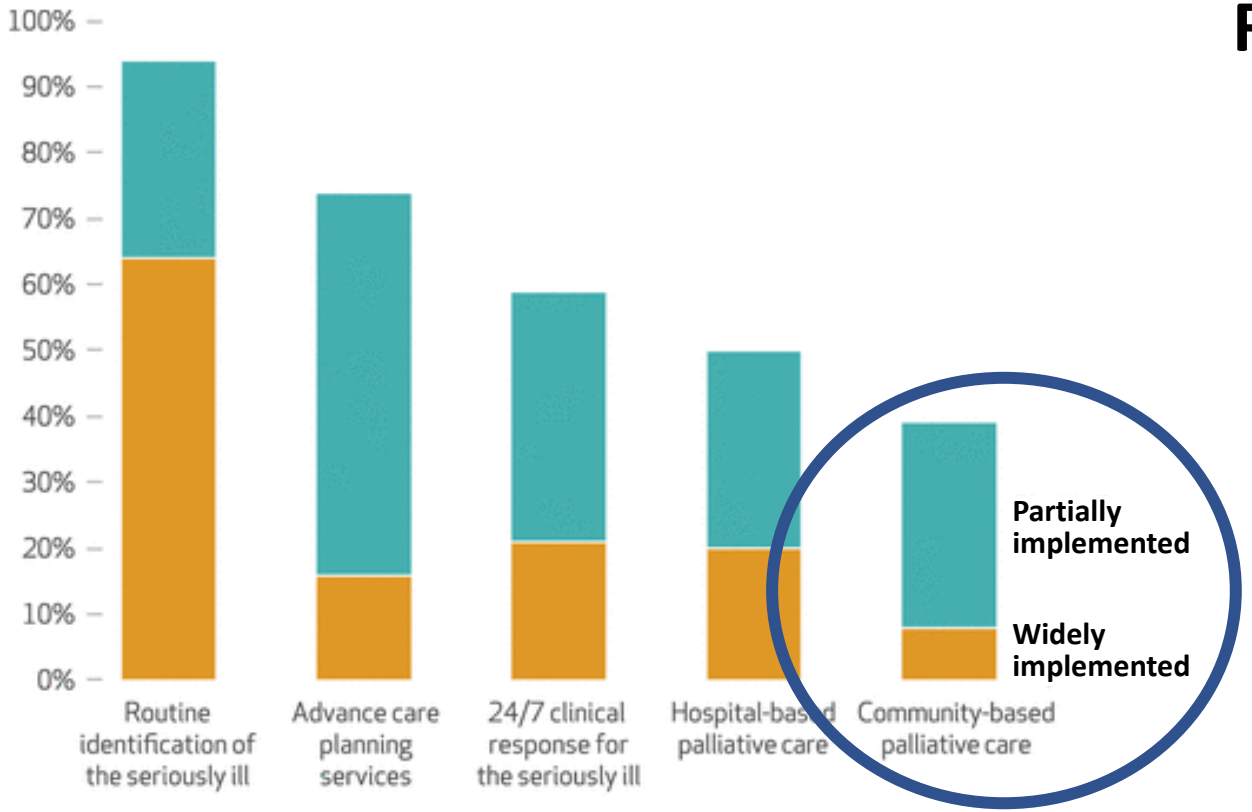
# *Integration of Palliative Care Across Levels of Care*

## •Integration. Not transition.

- **Goal should not be to "transition" from curative care to palliative care**, but to ensure early integration of palliative care in treatment planning and managing symptoms and side effects.
- Most serious illness is chronic.
- No one wants to die, and everyone wants treatment that might prolong their life or improve its quality.
  - This is true for all of us but is especially important for Black and other minoritized patients, given prior experiences.

# *APMs already implicitly incentive palliative care, but providers are slow to 'connect-the-dots'*

**Exhibit 1** Percent of ACOs that implemented serious illness identification or care strategies, by strategy type and breadth of implementation, 2018




Bleser, Health Affairs, 2019

## Recommendations

- **Explicit** requirements for access to, screening for, and utilization of palliative care
- Quality incentive for access to and screening for palliative care
- Eliminate prognosis as an eligibility criterion for 'concurrent hospice'

# *Early Identification of High Cost- High Need Patients*

- **The great majority are not dying.**

**Goal should be early identification** of high-cost/need patients, 90% of whom are not in the last year of life.

- As many as 80% of Medicare hospitalizations are for people with a serious illness diagnosis (https://www.westhealth.org/resource/a-practical-guide-to-implementing-a-home-based-palliative-care-program/)
- Most SNF and LTC residents would be considered seriously ill (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4834838/ )
- In primary care, about 5-10% of the total population would be considered seriously ill. (https://www.commonwealthfund.org/publications/issue-briefs/2016/aug/high-need-high-cost-patients-who-are-they-and-how-do-they-use)

# *Require screening for palliative care needs*

- Functional impairment
- Cognitive impairment
- Symptom distress
- Caregiver burden
- Frailty
- SDOH (housing, food insecurity, poverty)
- Psychiatric co-morbidity
- Recurrent hospitalization/ED visits

**High-need high-cost population**

- Those screening in → mandatory palliative care consultation and/or co-management
- Quality measure reflecting proportion screened and referred

# *Relationship Between Palliative Care and High Value Care Transitions*

A. The misconception on the part of clinicians, policy makers, and patients that conflates palliative care with end of life is the major barrier to access.
   - Linking to prognosis is the surest way to reduce access. *"It's too early until it's too late."*

B. Routine discharge from hospital to post-acute rehab (61% in one JAMA study) without prior clarification of achievable goals is often a low-value care transition
   - 28% of patients dead within 1 year (70% if cancer, 64% if stroke with fn'l impairment, 25% if non cancer)
   - "Rehabbed to death" when what is needed is palliative care, with eventual referral to hospice

https://www.ahajournals.org/doi/10.1161/JAHA.121.024327; https://link.springer.com/article/10.1186/s12916-021-01912-x; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4706779/; https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2727848

# *Recommendations to Incentivize High-Value Care*

- Use new NQF-endorsed Patient Reported Outcome Measures to incentivize high-quality care transitions:
  - #3665 – Patients' Experience of Feeling Heard and Understood
  - #3666 – Patients' Experience of Receiving Desired Help for Pain
- Explicit requirement/quality incentives for screening for and referral to palliative care during ED visits/hospital stays
- Require access to palliative care specialists and screening for needs in all (post acute care, hospital, ED, cancer center, ESRD) settings

# *There is Precedent: CMS Requires Palliative Care for Ventricular Assist Devices*

"The team must include, at a minimum:

- At least one physician with cardiothoracic surgery privileges and individual experience implanting at least 10 durable, intracorporeal, left ventricular assist devices over the course of the previous 36 months with activity in the last year.
- At least one cardiologist trained in advanced heart failure with clinical competence in medical- and device-based management including VADs, and clinical competence in the management of patients before and after placement of a VAD.
- A VAD program coordinator.
- A social worker.
- **A palliative care specialist."**

https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=298

# *The main takeaway*

- A strong and consistent evidence base indicates that palliative care – delivered from the point of diagnosis, well before a patient is near the end of life – improves quality of life, reduces caregiver and clinician burden, and reduces avoidable utilization and spending.

- In contrast, linking palliative care to hospice or end of life care results in reduced and delayed utilization because both patients and clinicians reject it. We cannot legislate acceptance of or timing of death and we shouldn't try.

- **Stop** linking palliative care to a transition away from life prolonging treatment if we want to improve care transitions and high value care in people with serious illness.

- **Add** mandatory screening for palliative care needs, referral, and inclusion of palliative care specialists in the care of those who 'screen in' as high-need/cost.

# *Appendix*


- Dio Kavalieratos1,2, et al. Homeward Bound, not hospital rebound: how transitional palliative care can reduce readmission. Heart 2016 Jul 15;102(14):1079-80. doi: 10.1136/heartjnl-2016-309385.
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