Value Based Care in COVID-19 Era

Our HealthCare Responsibility

J. Armando Díaz, MD
Internal Medicine

Personal story

Internal Medicine Private practice (24 yrs)

OutPt/InPt care setting (28-128-512-6144)

3 LVN, 2 Receptionist, 1 Manager/Care Coordinator/Psychologist/Wife, outside billing.

Hybrid Medicine (Personal In-patient care/Hospitalist)

Medical Functions

- Board Member of ALLIANCE ACO
- Medical Director for Harbor Hospice, Victoria TX
- X-FIT Founder Servicing Free Community Fitness (7 Yrs)
- Board of Trustees -Victoria Medical Foundation (IPA)
- Chief of Staff -Citizens Medical Center
- EHR Committee Chairman -CMC
- Pharmacy & Therapeutics Committee Chairman
- Volunteer of the year YMCA

Vulnerable patients ($$$$)

Nursing Home Patients

Assisted Living Patients

Confined at home (bedridden, wheelchair, immobile)

Immunosuppressed

> 60 yrs of age

TABLE. Hospitalization, intensive care unit (ICU) admission, and case–fatality percentages for reported COVID–19 cases, by age group —United States, February 12–March 16, 2020

Return

Age group (yrs) (no. of cases)	%*		
	Hospitalization	ICU admission	Case-fatality
0–19 (123)	1.6–2.5	0	0
20–44 (705)	14.3–20.8	2.0–4.2	0.1–0.2
45–54 (429)	21.2–28.3	5.4–10.4	0.5–0.8
55–64 (429)	20.5–30.1	4.7–11.2	1.4–2.6
65–74 (409)	28.6–43.5	8.1–18.8	2.7–4.9
75–84 (210)	30.5–58.7	10.5–31.0	4.3–10.5
≥85 (144)	31.3–70.3	6.3–29.0	10.4–27.3
Total (2,449)	20.7–31.4	4.9–11.5	1.8–3.4

My story, my patient.

88 yr male

Dementia, Immobile.

Wheelchair Bound

URI

Bil, Multifocal Pneum...

DNR

Dx, Tx, in facility.

Results = $ Cost Death

My story, my other patient.

- 100 yr old
- CHF, 20% EF, living at home compensated
- Partially Independent
- No Advanced Directives (family resistance)
- Admitted to acute care x 1week, Post Acute Medical x 4 weeks
- Discharged to die 1 day later (sudden death)
- Results=$$$$ Cost Death

HealthCare Network Mission

Provide high quality care

Intelligent/Wise care

Planned care

Advanced Care Planning

Advanced Directives

DNR/Palliative Care/HOSPICE CARE

End of life expenditures

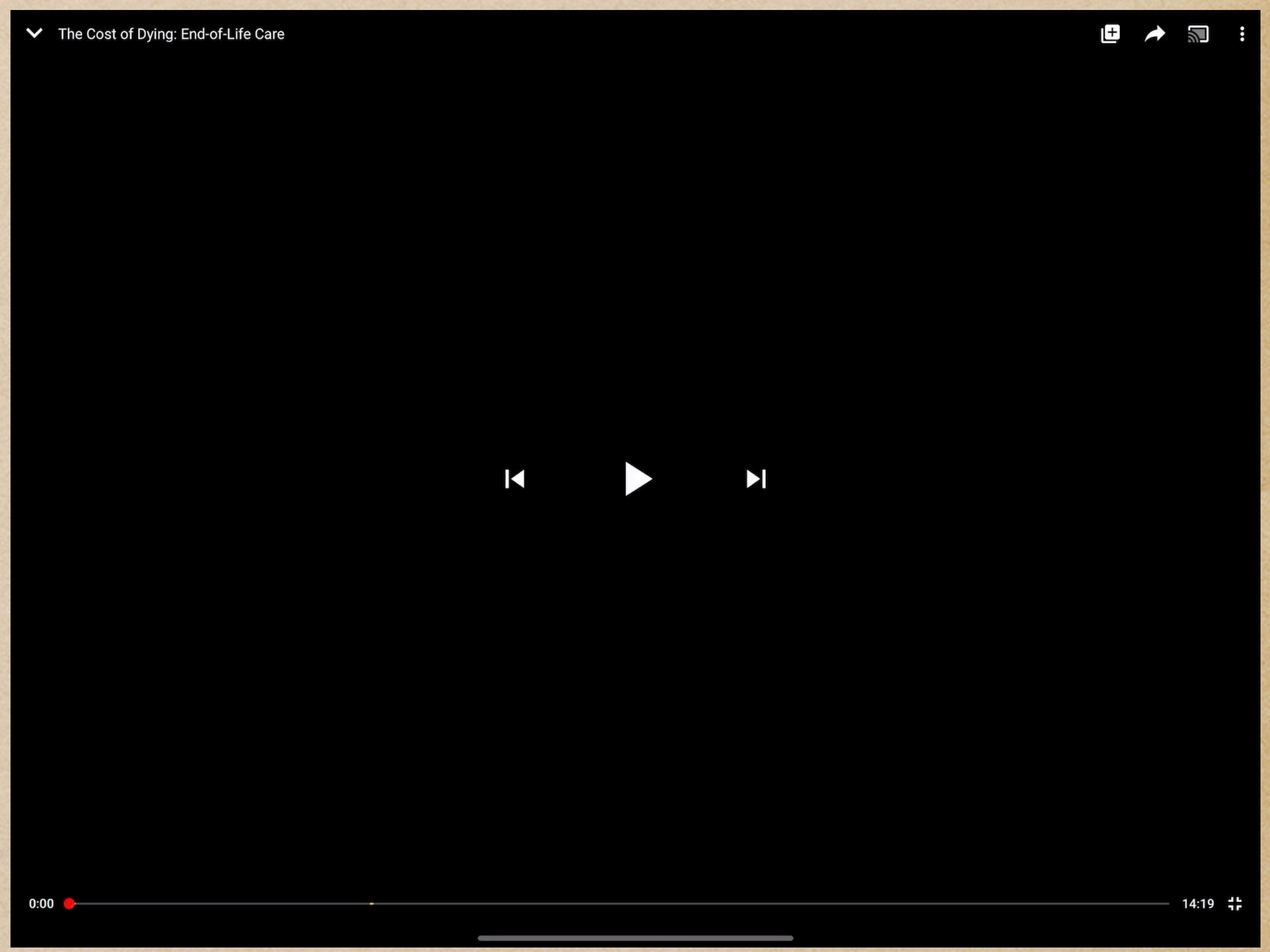
$10,000/ ICU day

7/10 Americans prefer to die at home

75% of pts. die in a hospital or NH

20% Americans die in ICU

60% of HC cost = 5% of MC beneficiaries



Please note: To access this recorded webinar, including this videos, visit the Catalyst Resource Page

Medicare Financial Reward

- 99497 Advanced Care Planning 1st 30 min = $86.00
- 99498 Advanced Care Planning 2d 30 min = $75.00
- TOTAL = $161.00 (1hr end of life conversation)
- MD or other qualified healthcare provider (both)
- https://www.capc.org

DAVID PEREIRAS—GETTY IMAGES

It's Time to Get Serious About End-of-Life Care for High-Risk

WHAT IS VOLUNTARY ACP?

Voluntary ACP is a face-to-face service between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care. As part of this discussion, the provider may talk about advance directives with or without completing relevant legal forms. An **advance directive** is a document that appoints an agent and/or records the person's wishes about their medical treatment based on personal values and preferences, to be used at a future time if the individual is unable to speak for themselves. "Advance directive" is a general term that refers to various documents such as a living will, instruction directive, health care proxy or health care power of attorney. State attorney generals' offices post forms on their websites.

PATIENT ELIGIBILITY

Medicare pays for ACP as either:

- An optional element of a patient's Annual Wellness Visit (AWV)
- A separate Medicare Part B medically necessary service

There are no limits on the number of times you can report ACP for a given patient in a given period. When billing this patient service multiple times, document the change in the patient's health status and/or wishes regarding their end-of-life care.

When a patient elects to get ACP services outside of the AWV, we encourage practitioners to notify the patient that Part B cost sharing applies as it does for other physicians' services.

99497-Advanced Care Planning -30 min
99498-Advanced Care Planning -60 min
1158F-Advanced Care Planning (in-House)
ICD-10. Z71.89 Health Counseling

$86.00
$86.00 + $75.00

Revenue for ACP

- 4 encounters/day x $161= **$644.00** day
- 20 encounters/week x $161 = **$3,200** week
- 80 encounters/month x $161 = **$12,800** month
- $12,800 x 11 months = **$140,800 year**

High 'End of Life" Expenditures

- Disease oriented treatments
- Failure to identify patients treatment preferences (www.choosingwisely.org)
- Lack of integrated healthcare information/networking.
- Unable to reliably predict death.
- Lack of Advanced Care Planning, Advanced Directive (Living Will, instruction directive, health care proxy, health care power of attorney, POLST, etc (https://www.nhpco.org/wp-content/uploads/Texas.pdf)
- Delaying cost efficient healthcare resources (HBPC/Hospice)
- https://www.capc.org/toolkits/capc-payment-accelerator-building-a-financially-sustainable-palliative-care-service/

Home Health & Hospice Industry COVID-19 Public Policy & Advocacy

www.NAHC.org (National Association for a home care and hospice)

www.NHPCO.org (National hospice and palliative care organization)

www.PQHH.org (partnership for quality home health care)

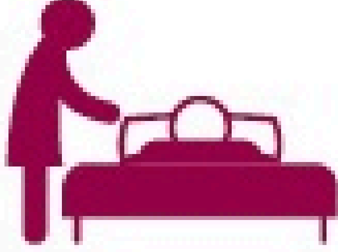
www.AXXESS.com

Palliative Services

- Paid by insurance, self
- Any stage of disease
- Same time as curative treatment
- Typically happens in hospital

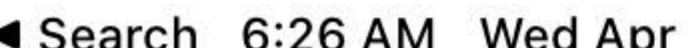
In Common

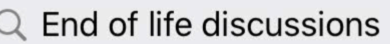
- Comfort care
- Reduce stress
- Offer complex symptom relief related to serious illness
- Physical and psychosocial relief



Hospice Services

- Paid by Medicare, Medicaid, insurance
- Prognosis 6 months or less
- Excludes curative treatment
- Wherever patient calls home





THE GLOBE AND MAIL

CHANNELS

Rodale's Organic Life

The Times of London

Outdoor Life

Cottage Life

Taste of Home

SEE MORE CHANNELS

TOPICS

Book discussion club

End-of-life care

End-of-life (product)

Discus throw

Debate

SEE MORE TOPICS

CANADA

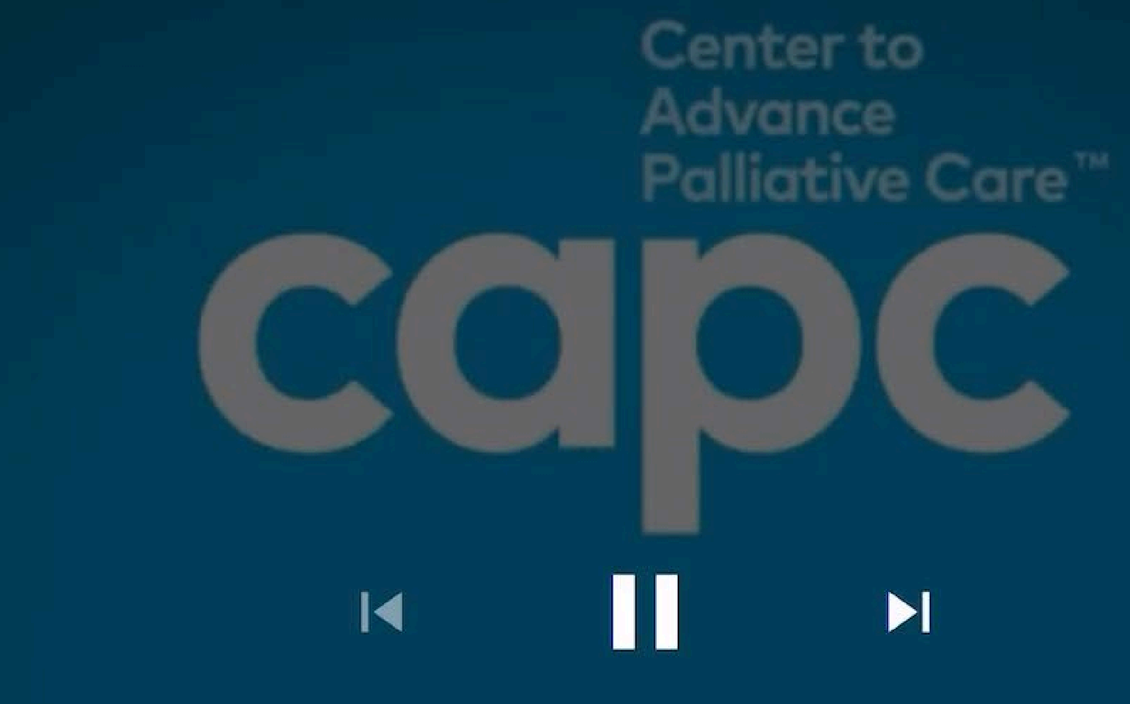
Canadians urged to plan ahead for end-of-life decisions as toll from COVID-19 builds

WENCY LEUNG

PUBLISHED MARCH 30 2020, 5:39PM

Hospital staff dressed in protective equipment standby as a patient is taken out of an ambulance at Toronto's Mount Sinai Hospital on March 29, 2020.
CHRIS YOUNG/THE CANADIAN PRESS

Home-Based Palliative Care: Benefits for ACOs and Health Plans



Home-Based Palliative Care:
Benefits for ACOs and Health Plans

Please note: To access this recorded webinar, including this videos, visit the Catalyst Resource Page

0:01 2:33

ACP ▶ HBPC → Hospice

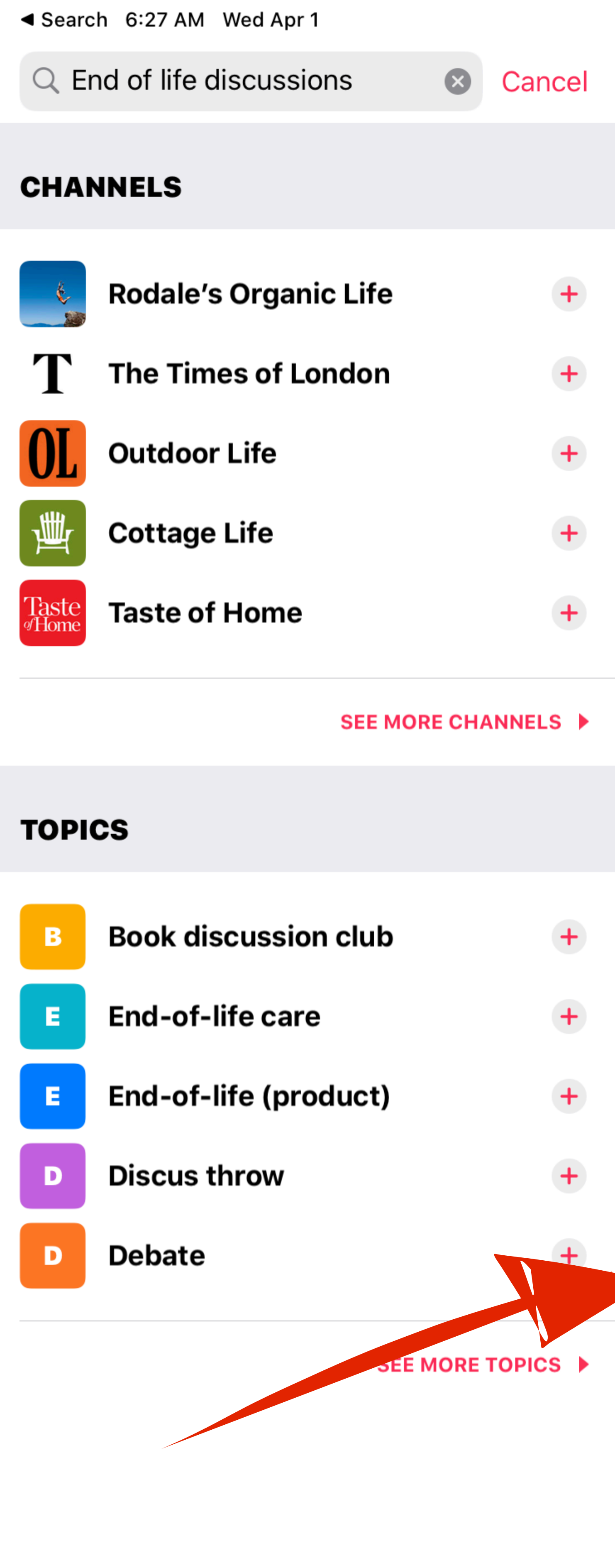
20 pts x $12000=

$240,000 HC Savings

$240,000 x 100 MD's=

$24,000,000

Healthcare Savings



hospital beds and 295,000 ICU beds. Because the country is not likely to meet these needs in time, we must prepare for this emotional and physical onslaught in other ways. Practically, this means we should identify those at highest risk from serious illness and death and then discuss with them whether, in a worst-case scenario, they would want hospitalization and use of a ventilator in the ICU, which could reduce the impending need for rationing care based on who will most likely benefit from mechanical ventilation. We need to be able to communicate effectively with them and their families early on to understand their wishes and be able to provide high quality palliative care in the ICU and eventually hospice.

Ideally, palliative care starts early, at the time someone is diagnosed with a life-limiting condition. But the speed and severity of COVID-19 will make that difficult. In order to meet that challenge, we need to build the capacity for more palliative care to be provided at scale. With a looming dwindling of hospital-based resources, this will also require putting critical infrastructure in place now for hospice programs to deliver medications that relieve suffering for patients in nursing facilities and in their own homes.

Aware of this reality, doctors have even started addressing their own end of life wishes and sharing them publicly to encourage others to do the same. Dr. Rana Awdish, an ICU physician at Henry Ford Health System and author of *In Shock*, wrote on Twitter how she and her colleagues came up with and shared their plans if they were to get sick. They discussed their kids and their pets and their emergency contacts. But they also talked about how they'd rather die at home than be in the hospital and traumatize their own colleagues who would then have to care for them. Even trainees are having these important conversations. For example, residents at Massachusetts General Hospital decided to complete advance directives and assign health care proxies during their shifts at work. Perhaps through taking back control in even the smallest way, our own fears and anxieties about the unknown can be lessened, and maybe even our anticipatory grief.

To some, it might seem a bit morbid or feel like fear-mongering to have these conversations

Medicare Revenue Tools

- Chronic Care Management (**$$$$**)
- Transitional Care Management (99496-**$237.11** 99495-**$175.76**)
- Annual Wellness Visit G0438 **$168.23** G0439 **$119.16**
- Welcome to Medicare (IPPE) G0402 **$125.68**
- Advanced Care Planning (99497-**$86.00**. 99498-**$75.00**)
- Shared Savings Program (improved care, lower expense, share savings)
- Remote Physiologic Monitoring-RPM **(20 min-$51.63, add 20 min-$42.53)**
- Principal Care Management **(30 min. MD $78.68, 30 min. CT $39.70)**
- TeleHealth, E-Visits & Check Ins (March 6th, 2020)

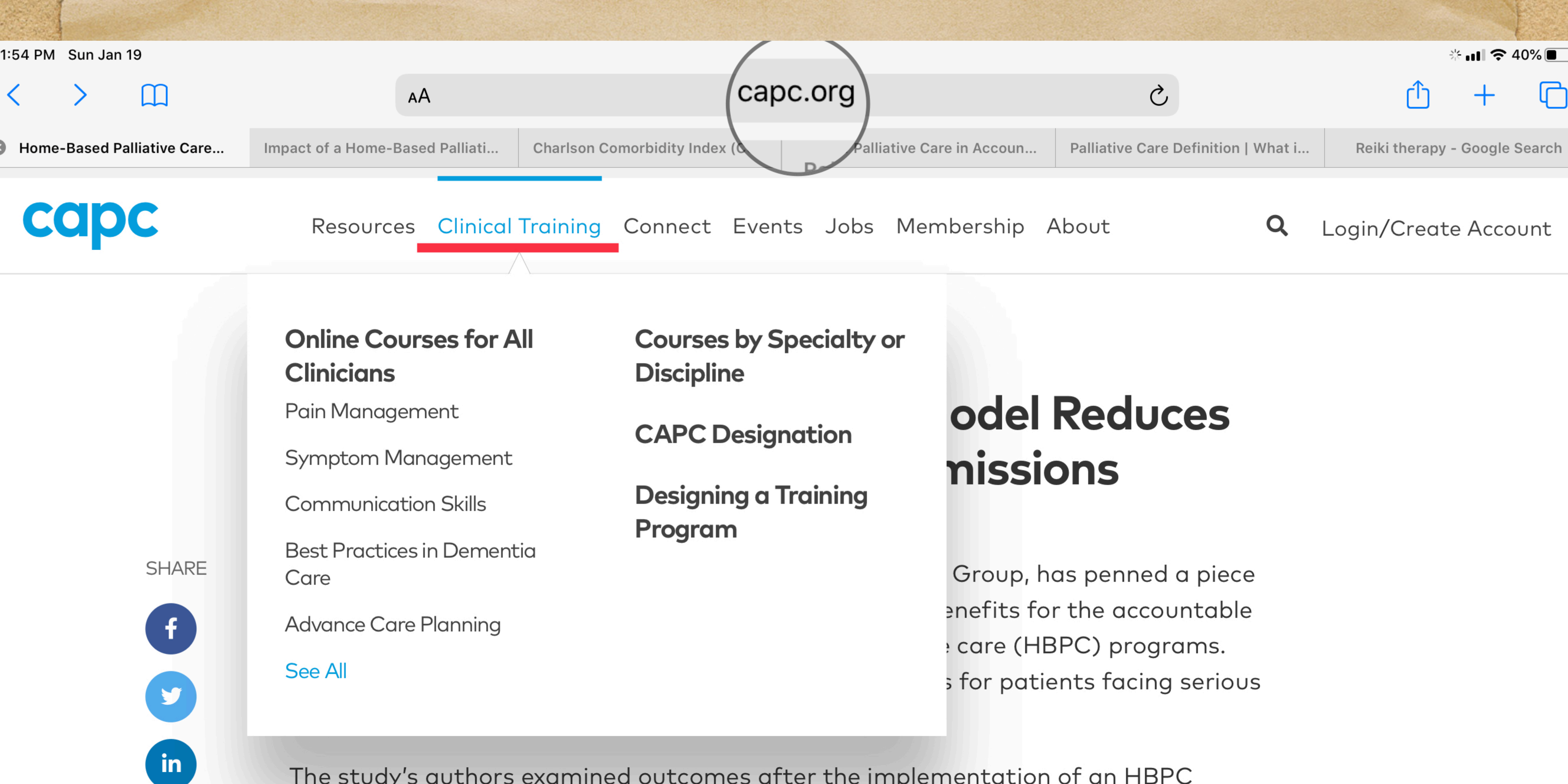
Chronic Care Management

- 99490–20 minutes – **$40.71**
- G2058 –20 additional minutes – **$37.89 ($75.78)**
- 99491– 30 minutes – **$81.54**
- 99487– 60 minutes – **$89.14**
- 99489– 30 additional minutes - **$44.57**

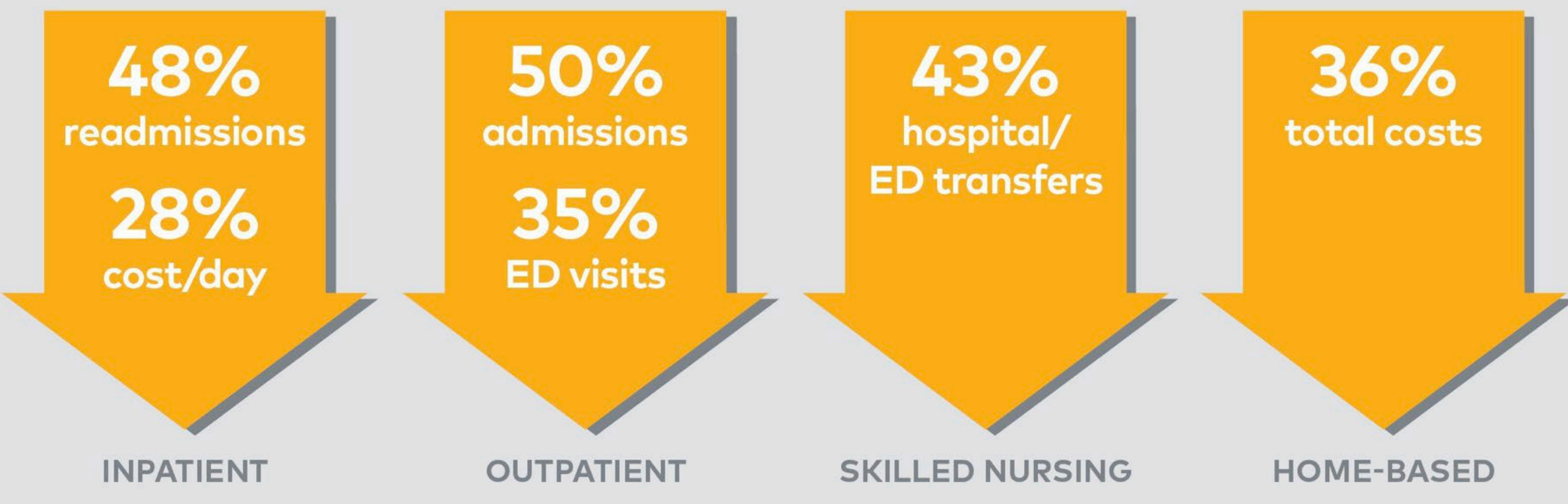
TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

Other CMS Reimbursement tools

- Depression screening
- Alcohol screening
- Alcohol abuse counseling
- Opiate risk counseling
- Cognitive impairment screening
- Care plan creation and management



The study's authors examined outcomes after the implementation of an HBPC program within a Medicare Shared Savings Programs (MSSP). The study focused on 651 patients in a New York metropolitan between October 1, 2014, and March 31, 2016. 569 did not receive palliative care and 82 were enrolled in the HBPC program. Click here to read the full study.



Center to Advance Palliative Care

CAPC.ORG

Home Based Palliative Care Model (HBPC)

- Reduces ACO Costs
- Reduces Readmissions
- Reduces Admissions
- Reduces ER Visits
- Increases Hospice utilization
- Improves Pt satisfaction
- Increases likelihood of dying at home (87%)

Modern Palliative Care

The nature of suffering & the goals of Medicine

- The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Failure to understand the nature of suffering can result in medical intervention that, (though technically adequate), not only fails to relieve suffering but becomes a source of suffering itself.
  Eric J. Cassell, MD, MACP