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White Paper: Building a Continuum of End of Life Care in Whatcom County: An Assessment of the Financial Landscape

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Overview

The goal of the End of Life Financial Issues and Sustainability Task Force was to design a care payment strategy which would support the phased build out of the full continuum of services needed to provide appropriate services and choice for End of Life in Whatcom County.

In order to further develop and appropriately finance a full continuum of End of Life services, the following six principles should serve as a guide: services should be targeted both to those who are dying as well as those with a progressive, debilitating disease; dollars should follow patient needs, not program needs; financial support should be provided for non-medical services; payment models should support the most efficient use of financial resources; the financing system should be sustainable in the long-term; pilots and transition funding should be considered in the short-term.

While the majority of medical services, including those in End of Life care, are reimbursed in a Fee-for-Service manner, other payment models such as pay for coordination, bundled payments, pay for performance, shared savings, and capitation may provide more innovative and patient-centered models for providing End of Life services. A number of existing clinical programs have shown promise in utilizing these innovative models to provide End of Life services, including Medicare Special Needs Plans, Partners in Palliative Care, and Life Passages. Elements of each of these models could be combined to develop a continuum of End of Life services in Whatcom County.

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Goal

The stated goal for the work of the End of Life Financial Issues and Sustainability Task Force was to design a care payment strategy which would support the phased build out of the full continuum of services needed to provide appropriate services and choice for End of Life in the Whatcom Community.

Note: Currently the majority of funding for End of Life care comes through the traditional medical system, and as such, the Finance Task Force focused our efforts researching potential financial models and opportunities in that area. We realize that the development of a financing structure that will support a full continuum of services will require multiple and varying types of financing. Given that other Task Forces were examining areas such as Culture, Clinician Training, and Advance Care Planning, we did not want to duplicate research, but at the same time would need the resulting Plans from those Task Forces to build out a full financial strategy. As such, this report primarily addresses how to finance the medical portion of End of Life services. We would recommend a Phase II process that combines the resulting reports from all the Task Forces, from which the Finance Task Force could work to develop a financial strategy for the full continuum of End of Life services.

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This White Paper is one of five working papers, each of which covers a different content area and was developed by a separate Work Group. These papers were used to inform the development of the Blueprint for Community Excellence at End of Life. As such, this White Paper is not to be viewed as a formal or standalone document, but rather as supplemental and expanded material for those who may be interested in additional information and content in a specific area. If there are any discrepancies between this paper and the Blueprint, the Blueprint represents the final decision of the Steering Committee.

WHITE PAPER

Introduction

It is important to think about financing a continuum of End of Life (EOL) services in terms of what we are trying to accomplish. The old saying “each system is perfectly designed to get the results it gets” has been proven over and over again. The End of Life Financial Issues and Sustainability Task Force developed a set of six principles that they believe should guide the process of developing and financing a continuum of EOL services in Whatcom County. They are as follows:

SIX PRINCIPLES FOR FINANCIAL SUSTAINABILITY

Scope of Program
Services should be targeted both to those who are dying and also to those with a progressive, debilitating, chronic disease that will eventually be fatal.

Dollars follow patient needs, not program needs
The appropriate set of services will be offered to qualifying persons. Services will follow the patient’s situation in order to ease transitions among providers and improve continuity of care. Benefits will follow patients, not the rules of each service provider.

Non-medical services are crucial
Support should be provided for non-medical services such as advance care planning, social services, and family caregiver support, as these are essential elements of a comprehensive financing approach.

Efficient use of resources
Payment models should support the most efficient use of financial resources, and, where possible, incentivize wider use of longer term strategies such as advance care planning and culture change.

Financing system is sustainable
Philanthropy and grant funding are vital to spur innovation and to fill certain gaps in funding. At the same time, more core support needs to evolve through insurance vehicles such as Medicare in the form of global payments for bundles of end of life services.

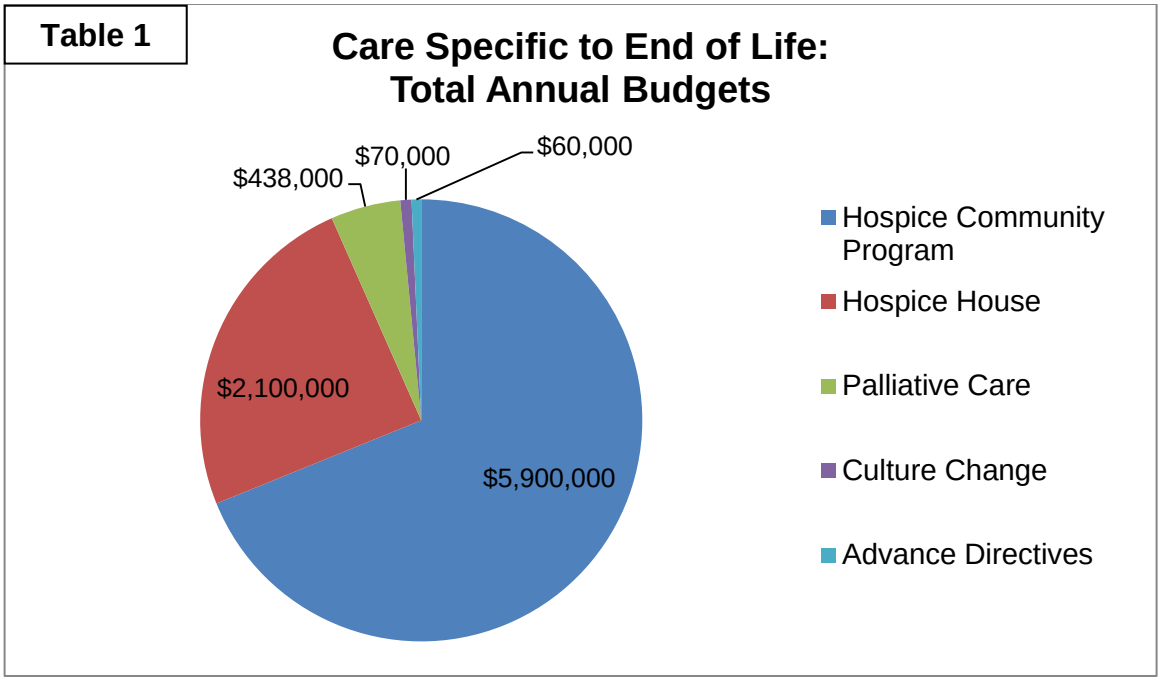
Transition is difficult
At this time nearly all financing is through fees-for-services, limited time grants, and philanthropy. Shifting to all-inclusive payment models will be disruptive to existing provider-based services. Therefore, to moderate disruption, limited scale pilots and transitional funding approaches (e.g., bundled payments leading to Accountable Care Organization-like models) are indicated over the next several years.

In thinking about what payment models would be preferable to finance an EOL system, we should consider how each of the models supports these attributes.

Current Financial Landscape in Whatcom County

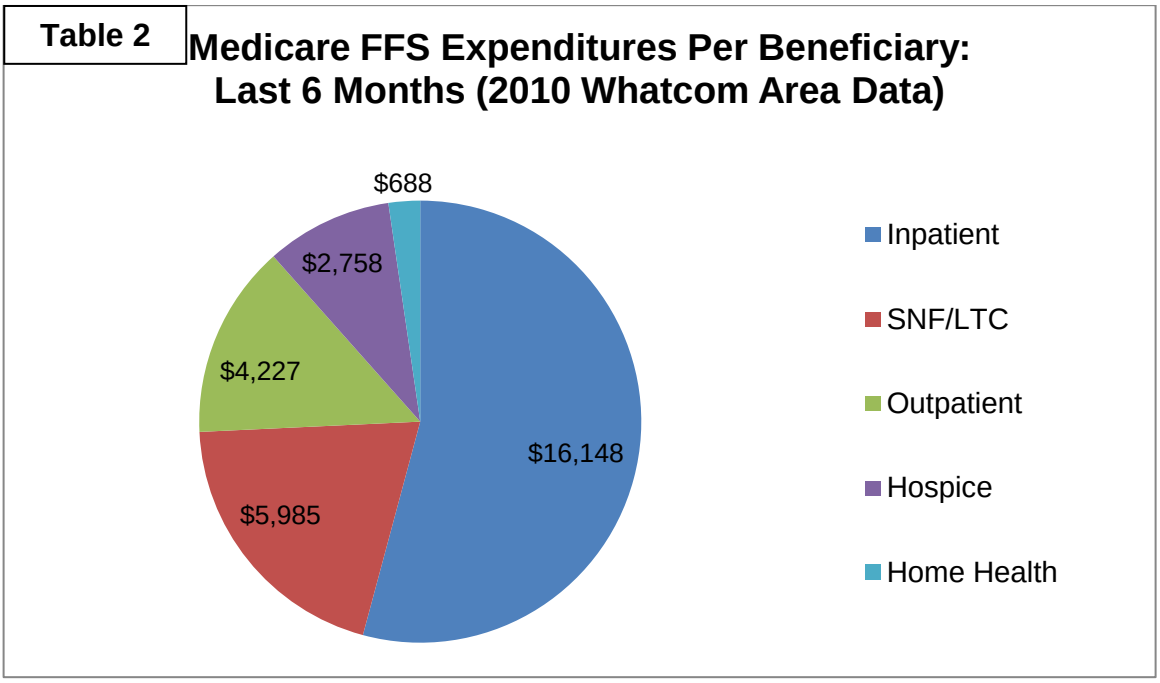
An estimated $8,568,000 is spent annually on Whatcom County's current EOL system, of which 93% is devoted to hospice care (Table 1).

Table 1



Each year about 1,300 Medicare beneficiaries in Whatcom County die, and the total local estimated spending per Medicare Fee-For-Service (FFS) beneficiary in the last six months of life is $29,806 (Table 2).

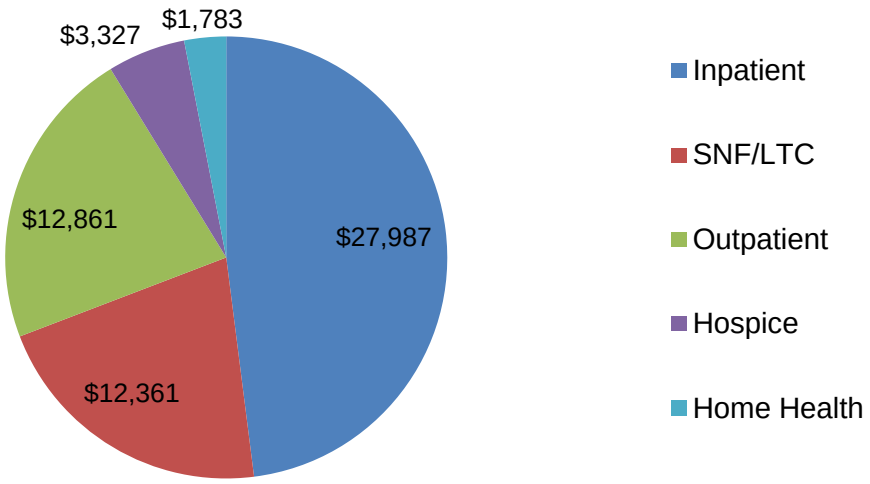
Table 2



The total spending in the last two years of life is $58,319, highlighting the fact that spending drastically increases in the last months of life (Table 3).

Table 3

Medicare FFS Expenditures Per Beneficiary: Last 2 Years (2010 Whatcom Area Data)



This amounts to a total estimated cost of $38,747,800 for all medical services for people at the end of life each year. As the population continues to age, these costs will grow. As such, the community will need to identify funding sources and alternative payment models to effectively and sustainably fund a continuum of EOL care.

While the majority of this nearly $39 million in annual EOL expenditures is spent on inpatient and nursing home care, numerous surveys have shown that most patients would prefer to die at home. Though much could be written on this topic, in short, it is clear that a large proportion of current spending is on care and services that may be unwanted, while funding for desired services is lacking. As such, it will be important to finance a continuum of care that fully addresses patients' wishes. In addition, it will be critical to find ways to gradually transition the payment system in order to reduce the negative impact on hospital revenue.

At present the prevailing payment models in Whatcom County for these services are (1) a per diem inclusive rate for hospice services, (2) fees for services for most palliative care services, and (3) contributions and budgeting from PeaceHealth and Family Care Network for developmental activities and to fill in the gaps where fees and per diems are inadequate to cover costs. These payment methods have a number of flaws. First, they do not nearly cover the full cost of services. Many of the payment methods are unstable and require continuous effort to renew. Thirdly, none of these methods focus on patient needs across a whole continuum of services. The closest method to achieving a continuum of care approach is the hospice per diem payment, which does include a comprehensive range of services. The problem, however, only a subset of the population is eligible- those with a terminal diagnosis within six months. Conceptually, something like that needs to be

in place to finance those with a longer prognosis, and it also needs to be linked to and paid for by shifting care from the inpatient to the less expensive outpatient setting.

Payment Models Around the Country

The following diagram illustrates the payment models that will be described in this section, arranged on a continuum from least to most global.

Fee for Service
Fee for service (FFS) involves reimbursement for specific, individual services provided to a patient. Each specific service, procedure, or intervention provided is billed and paid for. This incentivizes "productivity" in the sense of providing more services in order to maximize revenue. The vast majority of medical services are currently paid for in this manner.

Pay for Coordination
This model involves payment for specified care coordination services, usually to certain types of providers, such as primary care providers or care managers. This is often utilized in a medical home model, where the medical home receives a monthly payment (typically in the range of $2-8 per member) for the delivery of care coordination services that are not otherwise provided and reimbursed. This model increases flexibility in how care is delivered and is intended to reduce unnecessary and inefficient care through supporting care between visits in more cost-effective ways. Washington State's Health Home Program, which provides care coordination services to high risk Medicaid patients, is one example of this payment model.

Bundled/Episodic Payments
In a bundled payment system a provider is reimbursed on the basis of expected costs for a clinically-defined episode of care. The payment is a lump sum payment that covers the acute event or chronic condition advent and a specified amount of time following the initial event. This is a "middle ground" between FFS and capitation- unlike FFS, bundled payments discourage unnecessary care and encourage coordination across providers; unlike capitation, bundled payments do not penalize providers for caring for sicker patients. The Centers for Medicare and Medicaid Services (CMS) has a major Medicare demonstration program on bundled payments. Payment under the CMS hospice program is a form of bundled payment in which one rate is paid for all services received. In this case the rate is a daily rate. In Whatcom County, Avamere and the Eagle Hospitalist group have CMS bundled payment demonstrations.

Pay for Performance
In Pay for Performance (P4P) payment models, financial rewards are offered to providers who achieve defined and measurable goals related to care processes and outcomes. The measures for this model are most often related to quality and efficiency and work to reward explicitly measured dimensions of performance. The Center to Advance Palliative Care (CAPC) has developed a repository of operational metrics which include assessment and management of physical/psychological/spiritual symptoms, establishment of patient-centered goals, support to patient and family caregivers, and management of transitions across sites. Aetna has P4P contracts for physician group practices in which Aetna case managers are embedded. These contracts include incentive payments for meeting quality outcomes related to hospital admissions and hospital days per 1,000 members, as well as quality processes such as primary care visits within 30 days of hospital discharge. In addition, Excellus, a regional payer serving upstate New York provides enhanced payments to clinicians who complete a Medical Orders for Life-Sustaining Treatment (MOLST) training course for ACP discussions for patients with serious illness. Excellus also includes palliative care measures in their hospital performance incentive program.

Shared Savings
A shared savings program is a provider payment approach in which the provider group is able to "earn" a share of any savings resulting from its efforts. Savings are usually calculated at the health insurance premium level and the cost before and after the intervention are both measured. The provider gets a pre-negotiated share of the savings (e.g., 50%) if the budget reduction target is met.

Using a Palliative Care example, assume that your program is serving 100 patients who each use $10,000 annually in health services. Thus the premium level budget is $1,000,000. Assume that the total claims cost for these 100 patients is only $500,000 yielding a savings of 50%. In this example, the provider group gets an incentive (shared savings) payment of $250,000 (50% of 50%). Note that this has nothing to do with the actual cost of providing palliative care services, as these are simply one small part of total claims expense. The most prominent example of the Medicare Shared Savings Program (often called the ACO program) which has over 150 participating communities.

Capitation/Per Member Per Month
In a capitated payment model, a provider organization is given a set amount of money for each enrolled person assigned to it, per period of time, whether or not that person seeks care. The specific amount of money in the individual capitation payment is the actuarially determined average cost of the services per person. One type of capitation is a global capitation, or "per member per month" (PMPM) in which a provider provides services and is reimbursed PMPM for the entire population. This incentivizes strategies that emphasize early and preventive care and careful management of utilization in order to reduce the need for acute care services.

Existing Programs Using Innovative Payment Models

This section highlights a number of programs in End of Life care, primarily those that are clinical in nature. Each program is briefly described, the financial structure highlighted, and applicability to Whatcom County discussed.

PACE Program
PACE stands for Program of All-Inclusive Care for the Elderly. It is a Medicare and Medicaid program that assists people in meeting their needs in the community rather than going to a nursing home or other care facility. PACE organizations can provide services in the home, community, or at the PACE center. Patients are eligible if they have Medicare or Medicaid, are over the age of 55, live in the service area of a PACE organization, need a nursing-home level of care, and are able to live safely in the community with the help of PACE.

PACE Programs cover all of the services and care covered by Medicare and Medicaid if they are authorized by the health team. Some of the covered services include adult day primary care, dentistry, emergency services, home and hospital care, laboratory services, meals, medical specialty services, nursing home care, nutritional counseling, occupational and physical therapy, prescription drugs, preventive care, social services and social work counseling, and transportation to a PACE center.

A given PACE Program receives a capitated amount of money from the state (for Medicaid patients) and federal (for Medicare patients) governments. Each PACE site bears 100% financial risk for the complete care to its locked-in census. Patients who have Medicaid do not pay a monthly premium for the long-term care portion of services, but patients who are on Medicare do pay a monthly premium for long-term care services, as well as for Part D drugs.

There is never a deductible or copay for any service or drug approved by the PACE team.

There are 81 PACE Programs across the country, but the only PACE Program in Washington State is in Seattle- Providence ElderPlace.

For our purposes, a PACE program is probably overly complex to set up and administer and may not be able to flex up to a full population demonstration. While this is a really innovative and valuable program, its applicability has been limited. One issue is that the administrative rules to apply and manage the program are complex and likely require substantial start-up funds. Secondly, the population eligible to participate, by statute and regulation, is fairly narrowly defined. On the other hand, one major advantage is that there is considerable flexibility to use dollars to follow the needs of the patients enrolled, because it operates at the insurance or premium level.

Medicare Special Needs Program
Medicare Special Needs Plans (SNPs) are a subset of Medicare Advantage Plans available to patients with specific diseases or characteristics. They are generally available to individuals with Medicare Parts A and B, and a given plan is available to individuals who have certain severe or disabling chronic conditions, live in a nursing home, require nursing care at home, or are Medicaid/Medicare dual eligible. The plan receives 100% of the premium dollar.

The SNP provides all hospital, medical health, and prescription coverage, essentially combining Medicare Parts A, B, and D into one plan. Depending on the plan, additional services specific to the population may be covered as well.

Two Medicare SNPs currently operate in Whatcom County. Community Health Plan of Washington (CHPW) operates a plan for dual eligible patients (i.e., patients who are eligible for both Medicare and Medicaid). United Health Care, through its Optum subsidiary, operates a plan for institutionalized persons. Optum intends to launch a plan for dual eligibles in the near future. Enrollment in these plans is currently quite small. Total enrollment in both plans appears to be about 200 persons as of July 2014.

As of this writing WAHA staff have not had time to completely explore possible relationships with these two plan sponsors. However both Optum and CHPW have previously informally expressed an interest in developing a business relationship. Advantages of partnership with an SNP plan are multiple: (1) the plan already is capitated and has control of payment for the entire continuum of services; (2) incentives are aligned since the plans' goals are to reduce unnecessary hospitalizations; and (3) the plans are struggling to gain market share, so an alliance is a possible strategic fit.

Outpatient Palliative Care

The Center to Advance Palliative Care defines Palliative Care as specialized medical care for people with serious illness. It is focused on providing patients with relief from the symptoms, pain, and stresses of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. This kind of care can be offered in both inpatient and outpatient settings. Two examples of innovative programs that include an outpatient palliative care component are through Kaiser Permanente and Sutter Health. Local examples include The Everett Clinic's partnership with Providence Hospice and Homecare of Snohomish County, and Life Passages of Oregon.

Kaiser Permanente's In-Home Palliative Care Program

Kaiser Permanente's (KP) TriCentral Palliative Care Program is an outpatient service for patients with a prognosis of 12 months or less. Patients are assigned a palliative care physician who coordinates care from various health providers.

The five core components of care are an interdisciplinary team approach, home visits by all team members, ongoing care management to fill gaps in care, telephonic support 24/7, and advance-care planning.

A randomized controlled trial of this program showed increased patient satisfaction, increased numbers of patients dying at home according to their wishes, and decreased costs, ED visits, and inpatient admissions.

The Kaiser Program is unlikely to have direct applicability in Whatcom as this insurer does not operate here. Its close cousin, Group Health, operates here as a conventional insurance company and does not own facilities as it does in Central Puget Sound. The value of studying Kaiser is thus in examining their service delivery pattern as an example of how services would be organized if the FFS incentives were eliminated

Sutter Health AIM Program

Advanced Illness Management (AIM) through Sutter Health in northern California is a home-based program established to ease the transitions between curative and comfort care for seriously ill patients. This program utilizes a branded system approach and is available only through the Sutter Health plan. AIM attempts to fill the gap between home health and hospice services, which is often a gap in care where patients "fall through the cracks." Patients are eligible for AIM if they have clinical, functional, or nutritional decline; multiple hospitalizations or ED visits in 12 months; and are clinically eligible for hospice but have chosen to continue treatment or have otherwise chosen not to go on hospice.

AIM provides a comprehensive approach to care management by moving the focus of care for advanced illness out of the hospital and into the home/community setting. An interdisciplinary team provides care coordination and supports a patient's personal health goals. The emphasis is on tracking patient goals and preferences over time as illness progresses. Sutter Health also has an inpatient palliative care program, and AIM staff work with patients there to clarify and document their personal values and goals in order to develop a care plan. Given the emphasis on moving care from the hospital to community setting, in theory this type of program would be strongly supported by payors – for which it would save money – but not by hospitals, for which it would decrease revenue.

The AIM program has expanded over time, and there are currently AIM teams across 12 counties in northern California, coordinating care with 17 hospitals and multiple medical groups, serving 800 patients per day. This program has shown cost savings of $2,000 per patient per month on average, as well as improved patient, family, and physician satisfaction.

The Sutter program is an excellent example of how a corporate health care provider (like PeaceHealth, for example) would probably organize palliative care services if it were in a competitive environment, like Northern California, in which managing total cost of care and improving care outcomes were incentivized by third party payors. In our judgment, this environmental shift in Washington is unlikely to fully take hold within the next two years. Without the change in incentives, a program like Sutter's would be a financial disadvantage to our providers.

Partners in Palliative Care

Partners in Palliative Care is a 10 year old program operating in Snohomish County as a contractually linked partnership between Providence Health & Services and The Everett Clinic, a network of independent physician clinics. There are currently 1,358 patients in the program across seven clinics. The origin of the program was to address the concern that patients leaving hospice for "extended prognosis" had no services while many other patients were coming onto hospice too late. This program does not bill for services. Staffing consists of seven Registered Nurses (RNs) plus a cadre of "program assistants" playing supporting roles. Staff serve mainly as care coordinators and operate largely telephonically with caseloads of about 200 per full time employee. Referrals come in informally from the associated clinics as this program is largely based in primary care. Physicians who think a patient may have a prognosis of less than two years may refer that patient for care management services. There are no physician palliative consults, volunteers are not utilized, and referrals to home health services are fairly sporadic. Medical services are mainly delivered by linking back to the primary care clinics.

Financially, the costs are “absorbed” by the two partners with Providence paying the salaries of most of the RNs and Everett Clinic providing management services. The vast majority of patients are Everett Clinic patients. The program is “cost justified” by increasing average length of stay (ALOS) on the hospice program. The program states that ALOS has increased from 20 to 90 days, which, in their view, has more than offset the cost of the program. Everett Clinic has about 30% of its patients in risk arrangements, and the proportion is rapidly increasing. Similar data for Providence are unknown, but this corporation has stated intent to completely shift to risk arrangements.

Parts of this model may be applicable to Whatcom. The ideas of creating a partnership, folding in care management work, and increasing Hospice ALOS appear relevant. However, it is unlikely here that any “partners” are going to finance $300-400,000 in staff expense without more clearly linked incentives.

Life Passages

Life Passages is a program of PeaceHealth in Eugene, Oregon that began in 2012 and is the most developed outpatient Palliative Care program in the PeaceHealth system. To date the program has served 240 patients, and the program’s core activity is care management/care coordination. Life Passages employs several staff, including an MSW, an RN, a volunteer coordinator, and clerical staff. The bulk of services, however, are provided through volunteers, and this has been a key to sustainability. Originally grant funded, the program now has some core funding from PeaceHealth and is investigating opportunities to negotiate insurance contracts as well as to pursue additional grant funding. It is not yet clear that the program has been able to obtain stable long term funding.

The financial rationale for the program has been to try to demonstrate reductions in emergency room and hospital use, as well as to appropriately move patients into hospice earlier, where revenues are greater.

Due to the corporate connection, Life Passages is an obvious target for replication and/or extension into Whatcom. From a staff point of view we see at least two issues to address. First, the program as currently organized seems to mainly be a PeaceHealth branded effort, raising issues of whether it could and/or should successfully incorporate non-PeaceHealth providers. Second, depending upon the success of current insurance negotiations, the program appears overly reliant on grants and on corporate subsidy. The financial model is not yet robust.

SWOT Analysis

Community Strengths Related to End of Life Financing

- The Hospice Foundation is a great asset to the community, and it has contributed greatly to developing the Hospice portion of a care continuum.
- For a community the size of Whatcom County, there is far better than average philanthropic health funding. A good example is the RiverStyx Foundation which has provided funds for much of the local innovation.
- A core group of people understand the evolving reimbursement environment and what needs to happen to position the community and these services for that transition.
- The PeaceHealth System appears philosophically committed to End of Life excellence; it also has enough market size to potentially move the rest of the community if so desired.
- The community culture appears to be strongly moving in an aligned direction.
- There is a relative wealth of community resources such as WAHA, the Palliative Care Institute, and other organizations which can both prompt and organize the kind of change often difficult to foster in large organizations.
- Whatcom County has a number of respected clinical professionals in the EOL arena who work tirelessly and holistically to meet the needs of and to broaden the continuum of care available to their patients.

Community Weaknesses Related to End of Life Financing

- Almost all funding is oriented around Hospice; there is little funding for outpatient palliative care, advance directives work, or culture change.
- Funding is siloed, and until recently there has been little coherent focus on building a complete system and continuum of EOL services.
- While committed philosophically, PeaceHealth tends to be a conservative factor in that there is not yet a complete EOL system vision or an active implementation plan for adapting to payment reform.
- The Insurance Environment has not been characterized by innovation. There are also relatively few players with whom to partner—Regence, Group Health, CHPW—all of whom have major strengths and weaknesses.

Community Opportunities Related to End of Life Financing

- The Whatcom Community has a multiple year history of being able to innovate and lead change in medical and health care organization and delivery.

- The general environment including the evolving State level financing policy and the beginnings of third party payor and Medicare experimentation with payment reform are very encouraging counterbalancing factors.

- As a community with a single hospice that is well-respected, Whatcom County has the opportunity to maximize the positive aspects of hospice care, while avoiding some of the less desirable elements that tend to emerge in a community with multiple competing hospice organizations.

Community Threats Related to End of Life Financing

- The possibility of Palliative Services fragmenting into competing entities presents a financial threat, because a community of this size will be fortunate to adequately support one solid continuum of services. The existence of two entities would create redundancy, not be a wise use of resources, and ultimately be too small to be sustainable.

- There currently does not exist a trusted entity that could develop the vision for a complete EOL system and convene all the relevant players in order to execute the plan.

Task Force Recommendations

WAHA staff developed a set of relatively specific recommendations which articulated a path to change service delivery and financing of the medical end of the continuum. These are included as Appendix A, but were not adopted or supported by the Finance Task Force. As the recommendations were detailed and complicated, they needed far more time for assessment than the Task Force had available. Additionally, there was some sentiment among Task Force members that a different, more step-wise process of gaining support from key institutional decision-makers would be needed.

Thus, the recommendations that follow do not constitute “end prints” for implementation. Rather they are intended to articulate a general vision combined with a set of process steps geared toward creating a sharper and more politically-supportable structure in the future.

The overall vision and recommendation of End of Life Financial Issues and Sustainability Task Force is to position Whatcom County for the shift towards capitated or other total cost of care payment models, and do so in a way that is both sustainable and does not result in a sudden decrease in revenue for the hospital. Towards that end, we make the following recommendation:

- Create a Task Force, convened by WAHA, that has high level involvement from PeaceHealth, Family Care Network, insurers, and other providers and community members in order to:
    - Plan for a move toward population-based models that will enable the provision of a full continuum of End of Life services.
    - Plan for pilots and philanthropic relationships which will position our community for the shift in payment models. A key principle will be to serve the people in our community and preserve the sustainability of our providers. Two ways this could happen are as follows:
        - Evaluate opportunities for grants and philanthropic support for End of Life projects in the short-term.
        - Engage key players in Whatcom County to participate in a County-wide pilot for a continuum of End of Life services in the long-term.

APPENDICES

Appendix A

What follows is a set of recommendations to articulate a path to change service delivery and financing for End of Life Care in Whatcom County. This is merely a starting point for discussion and will require additional time and assessment by and with community partners to fully articulate a path forward.

1. There needs to be an overall ongoing coordinating structure/entity
    a. Rationale:
        i. We will be better off if we cooperate rather than compete
        ii. There are not enough resources to support a competitive structure
        iii. Patients will benefit most for a seamless, coordinated structure
    b. A straw man proposal for such a structure is included in Appendix B
    c. This structure needs to be negotiated with the work being done by the outpatient palliative care subgroup
2. The community needs to develop a pilot structure which will demonstrate the value of an integrated program in terms of cost, quality, and satisfaction; to do so, some sort broad financial structure will be needed
    a. Rationale:
        i. Funding disconnected from outcomes will be unsustainable
        ii. A funding source closer to the payor is most desirable to allow flexible uses of money
        iii. Without some kind of global budgeting approach, sustaining each of the continuum pieces individually is more difficult
    b. Likely prospects:
        i. Medicare special needs plan
        ii. Medicare ACO
        iii. Apply for a CMS bundled payment demonstration
        iv. Create an entirely new category of CMS demo
        v. Conceptualize a demo through the Group Health Medicare Advantage plan for persons referred with a life expectancy of two years or less
    c. Much more work and research is ahead of us on this work which would ultimately coalesce into a business plan
3. Conventional funding needs to be secured in the short term for crucial pieces of the continuum build out. Braided funding is preferable
    a. Priority areas:
        i. Volunteer system and structure
        ii. Care management lite
        iii. Intensive case management
        iv. ACP
        v. Culture change
        vi. Sustained funding of the medical portions of this system

b. Again, these thoughts are preliminary and need more build out including cost estimates
c. Possible sources:
    i. PeaceHealth
    ii. Foundation grant
    iii. RiverStyx
    iv. Hospice Foundation

Appendix B

Structuring Palliative Care in Whatcom County
An Interim, Transitional Vision

Whatcom Palliative Care Partners

Coordinating Committee oversees development of an ongoing continuum of care

Inpatient Palliative Care Services

Owned by: PH, as now
Funded by: same as now
Services: same as now

Whatcom Hospice: Inpatient/Outpatient

Owned by: PH, as now
Funded by: same as now
Services: same as now

Outpatient Palliative Care

Includes palliative consults, care management, Intensive Case Management, volunteer services, and ACP work

- PH and FCN provide consults
- WAHA provides case finding
- WAHA provides most care management and ICM services

Community Culture Evolution

- WWU Institute: training
- Informal groups (e.g., Death Café)
- WAHA to assist

1. The Coordinating Committee is an ongoing planning body staffed by WAHA. The charge of the committee is to:
    a. Build out an appropriate continuum of care
    b. Make sure all the subparts are working well together and are maximizing synergies
    c. Oversee overall continuum of care performance regarding a) cost, b) quality, c) satisfaction, and d) reducing downstream expense
2. A possible membership structure for the Coordinating Committee could include (11 people)
    a. Bree Johnston, M.D. (Medical Director and Chair)
    b. Meg Jacobson, M.D.
    c. Larry Thompson (or other WAHA)
    d. Rep to be appointed by PHSJMC management
    e. Director of Hospice
    f. Rep to be appointed by FCN
    g. Rep from Hospice Foundation
    h. Rep from RiverStyx
    i. Rep from WWU
    j. Rep from complementary care
    k. At-large consumer representative (Culture)
    l. Dan Murphy (Northwest Regional Council)
3. At least initially this Coordinating Committee is not incorporated; it functions as an informal body
4. The Coordinating Committee also directly oversees the Outpatient Palliative Care Program
5. Outpatient Palliative Care Program functions under a series of interlocking contracts for services
6. Outpatient Palliative Services (Note: this is one potential way to organize services and is meant to be a starting place for discussion)
    a. Management services: WAHA (does not include billing)
    b. Physician/ARNP consults: PH and FCN with services billed by home organization; contracts specify service offerings
    c. Palliative services (TBD) by social workers, RNs: PH by contract will provide specific staffing
    d. Case finding (registry and enrollment): by WAHA into integrated database; this is intended to be population management
    e. Care Management (light coordination and linkage to ACP and hospice): managed by WAHA through volunteers- needs 1FTE Rn for clinical consults and 1 FTE for tracking, scheduling, volunteer coordination
    f. Intensive Case Management: by contract to WAHA; 1 pod for the most complicated patients
    g. ACP: uses existing WAHA program; existing program accepts referrals

WAHA is a 501(c)(3) nonprofit organization with a mission *to connect people to health care and to facilitate transformation of the current system into one that improves health, reduces costs, and improves the experience of care*. The WAHA Leadership Board includes consumers and community leaders from the nonprofit, business, and governmental sectors, as well as many local healthcare organizations.

If you have questions or comments regarding this report, please contact Mary Ann Percy at mpercy@hinet.org or 360-788-6526.

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