

# FLORIDA HOSPICE

& PALLIATIVE CARE ASSOCIATION

presents

## KID'S BIG WIN: Concurrent Care for Children- Florida Implementation

With Panelists:

- *Stacy Orloff, Suncoast Hospice*
- *Terry Eason, Community PedsCare (Community Hospice of NE Florida)*
- *Jennifer Holler, Covenant Hospice*
- *Barbara Hengstebeck, Agency for Health Care Administration*



## SECTION 2302

# PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) The Health Care Reform Law

### SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”; and

(2) by adding at the end the following new subparagraph:  
“(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made.”.

(b) APPLICATION TO CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by inserting “(concurrent, in the case of an individual who is a child, with care related to the treatment of the child’s condition with respect to which a diagnosis of terminal illness has been made” after “hospice care”.



# CONCURRENT CARE

- Signed into law March 23, 2010 by President Obama
- Applies to children:
  - Covered by Medicaid and Children's Health Insurance Program (CHIP)
  - With a 6 month prognosis and eligible for hospice services
  - From birth to age 21



# REQUIREMENTS

- When child elects hospice care under Medicaid or CHIP:
  - **Does not waive** the child's right to be provided with, or to have payment made for, services that are related to the **treatment** of the child's condition, for which a diagnosis of terminal illness has been made.
  - Services covered and **paid for separately** from those provided under the child's hospice benefit
- State is now required to pay for medically necessary curative services, even after election of the hospice benefit by or on behalf of children receiving services



# NATIONAL PERSPECTIVE

- National Hospice and Palliative Care Association
  - Pediatric policy phone calls
  - Website resources
  - Networking with other states



# FLORIDA

- Concurrent Care task force
  - FHPCA
  - AHCA
  - CMS
- Pilot project
  - Evaluating payment to all providers
  - Collaborative process



# COMMUNITY PEDSCARE

(COMMUNITY HOSPICE OF NORTHEAST FLORIDA)

## ○ Historical Data

- Enrolled first Concurrent Care patient in August, 2013
- Total of 3 patients received Concurrent Care
- 2 patients remain currently enrolled in Concurrent Care



# CASE STUDY

## ○ Concurrent care census

- < 6 month old with Edwards syndrome (Trisomy 18) and complex congenital heart disease (Tetralogy of Fallot, right ventricular hypertrophy, large ventricular septal defect, and multiple other cardiac abnormalities).
- 6 year old with recurrent progressive pontine brain stem glioma receiving curative-focused chemotherapy.





# COMMUNICATION STRATEGIES

## ○ Internal

- Concurrent Care process developed for hospice care staff education and reference
  - **Eligibility defined**
    - Medicaid recipient
    - Birth to age 21
    - Any end-stage diagnosis
    - Prognosis 6 months or less
    - Hospice physician review of case
    - Discussion of concurrent care option with child's primary care physician/specialist (referring/treating physician)
    - Meet with parents to discuss this new option
- **Talking Points** compiled for hospice staff use to best and most easily explain care to the family
- **Education** to Finance, Pharmacy and DME departments



# COMMUNICATION STRATEGIES (CONT.)

## ○ External

- Face-to-face presentation to key physicians from hematology/oncology practice
- Hospice medical director discussions with other key providers on a case-by-case basis (cardiovascular group)
- Case-specific conversations with external care providers involved in patient care, i.e. shift nursing, medical equipment providers, infusion therapies
- Presentation to program's professional advisory board



# TRANSITION

- All staff remain the same when patients transition from one pediatric program to another.
  - Formal discharge from one care program into another.
  - No transition in staff for patients and families.
  - Smooth transition into different care model.
  - Hospice-supplied medications, DME easily implemented.



# CHALLENGES

- Initial internal education to pediatric team.
- Clear understanding of care – conceptually and technically.
- Consistent messaging to physician office staff involved in any aspect of the patient's care.



# SUCSESSES

- While the child remains hospice appropriate, the parents have been able to pursue potentially disease-altering, life-prolonging interventions and consultations for their child.
- While pursuing/receiving curative interventions, hospice care has embraced and supported the child and family through times of disease progression, positively impacting the child and family's quality of life.
- The duality of care and focus has afforded the hospice care team the ability to offer families hospice support and care without the parent having to make the difficult choice regarding discontinuation of services already in place.



# COVENANT HOSPICE

## ○ Historical Data

- Enrolled first Florida Concurrent Care patient in 2012
- 2-Current patients participating in Concurrent Care
- Covenant has cared for children under the CCR in Florida and Alabama
- Year to Date Covenant Hospice has cared for 8 children under Concurrent Care
  - Discharges have been due to death, moved out of service area, transitioned to PIC:TFK, or no longer hospice eligible



# CASE STUDY- “EVA”

- Seven day old female born with Trisomy 18
- Referral and admission
  - Referral from hospital
  - IDG received pediatric consult upon admission
- Coordination of Care
  - New DME provider contract for pediatric DME supplies
  - Collaboration with hospital on discharge planning
- Collaboration with Providers for care planning
  - Ongoing collaboration between all providers
  - Communication with CMS regarding billing questions
- Discharge



# COMMUNICATING WITH PROVIDERS

- Proactive approach to education, instead of reactive to issues
- Developed education resources and presentations for community health providers
- Reached out to our local pediatric physicians and children's clinics
- Reinforced to providers the need for early referral





# COMMUNICATING WITH FAMILIES

- Interdisciplinary approach
  - Physician
  - Referral source
  - Hospice
  - Family
  - DME providers
- Open and clear discussions
  - alleviate fears/ misconceptions reduce feelings of abandonment
- Communicate choice (“and” not “or”)
  - increase of services for the child and family



# NEWLY IMPLEMENTED PROCEDURES

- Updated admission procedures
  - Referral Forms
  - Notification of Pediatric Hospice Admission
- Developed a Pediatric Consultation Program
  - Provides Pediatric consultation and support to IDG and families
  - Collaboration between in-house Pediatric experts and the IDG
  - Regular communication through IDG meetings
  - Provide on-call pediatric staff
- Updated Notification of Death Checklist Form
  - Includes Pediatric Consultation Program if the patient is a child



# CHALLENGES

- Misconceptions of care in the medical community
- Traditional Hospice mindset
- Differences in caring for children versus adults
- Billing responsibilities
- Reinforcing the importance of IDG collaboration with outside providers



# SUCCESSSES

- Implementation of additional in-house pediatric support services for the hospice IDG
- Connection to needed services for the families
- Seamless transitioning from Hospice to PIC:TFK, and vice versa
- Comprehensive care for all needs
- Removed the “foregoing curative care” barrier



# BILLING CONSIDERATIONS: WHO BILLS FOR WHAT

- Importance of the Plan of Care
  - Hospice is responsible for providing items and services on the Hospice Plan of Care
  - Other Providers will bill for items and services on their Plan of Care
  - All providers for the child must work together to coordinate the child's care and avoid duplication



# BILLING CONSIDERATIONS

- Other healthcare providers
  - Hospitals - Hospital billing for inpatient admissions related to the terminal diagnosis: curative vs. palliative
  - Physician practices
  - DME, pharmacy, etc.



# BILLING CONSIDERATIONS FOR AREA OFFICES

- Hospices will continue to send Election Statements to Area Offices
- New Election Statement for Under 21 – will be in new Hospice Handbook
- Don't dis-enroll CMS children – see FOM email dated 7-8-2013



# OTHER CONSIDERATIONS

- Medicaid Managed Care
- Concurrent Care Tracking for hospice providers





# CONCLUSION

- Kids' Big Win in Florida
- Full implementation of concurrent care begins now!
- Additional questions? Need resources?



# Q&A

