



**Supporting the Continuum of Palliative
Care: A Resource Hub for State
Policymakers**

August 20, 2019



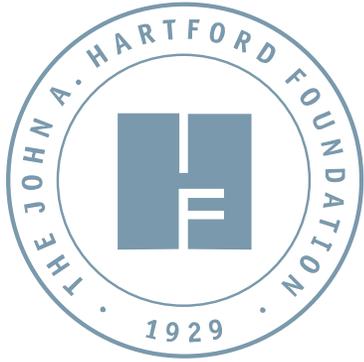
Supporting the Continuum of Palliative Care: A Resource Hub for State Policymakers



Welcome, Introductions, and Overview

Kitty Purington, NASHP

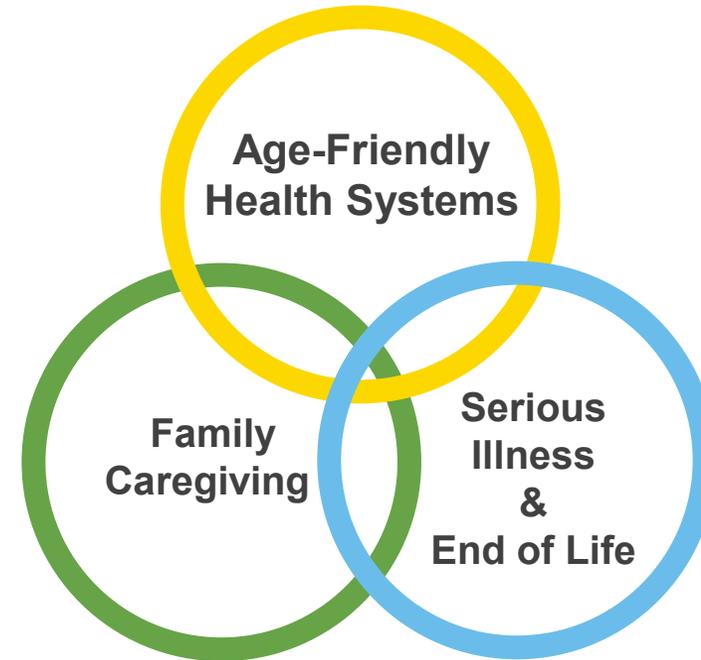
Scott Bane, The John A. Hartford Foundation



The John A. Hartford Foundation

Dedicated to Improving the Care of Older Adults

Scott Bane
Program Officer



Priority Areas

Who We Are



The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults

Improving the Health of Older Adults

\$ 585,000,000

amount invested in aging
and health since 1982

\$13,880,000 + in Palliative Care & EOL



Palliative Care

- **Focuses on improving the quality of life for people facing serious illness:**
 - Pain & symptom management
 - Communication & coordinated care
 - Appropriate from time of diagnosis
 - Can be provided w/ curative treatment

Resource: Center to Advance Palliative Care
www.CAPC.org



NASHP: Supporting the Continuum of Palliative Care

Goal of Grant

Improve access to and the quality of hospital and community-based palliative care services

Approach

- Review palliative care activity & policies in states
- Convene State Leadership Council on Palliative Care
- Develop briefs for State Health Policymakers
- Provide technical support to states
- Disseminate findings and resources



The John A. Hartford Foundation
Dedicated to Improving the Care of Older Adults



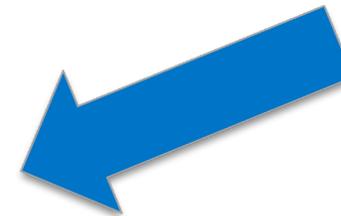
NASHP's Palliative Care Work



NASHP received funding from [The John A. Hartford Foundation](#) to conduct a 26-month project focusing on opportunities and challenges for states to advance palliative care programs/policies.

Goal of this project: to support state leaders in their work to expand access to, and quality of, palliative care.

- Convene state leaders
- Understand current state activity
- Develop resources and recommendations
- Provide support to states that are working on these issues



Why Palliative Care?



What is palliative care?



- Interdisciplinary, patient- and family-centered health care that addresses the physical, mental, social, and spiritual well-being of seriously ill individuals
- Provided in facility, outpatient, community, or home settings
- Provided alongside curative care, if desired by patient (distinct from hospice)
- Not limited to individuals with a terminal illness

Palliative Care & States



Palliative care and the Triple Aim:

- Improving the individual experience of care;
- Improving the health of populations; and
- Reducing the per capita costs of care for populations.

Alignment of state policy goals to foster high quality, value-driven care for high-cost-high needs populations, such as:

- Patient-centered care models;
- Value-base purchasing;
- Long-term services and supports rebalancing.

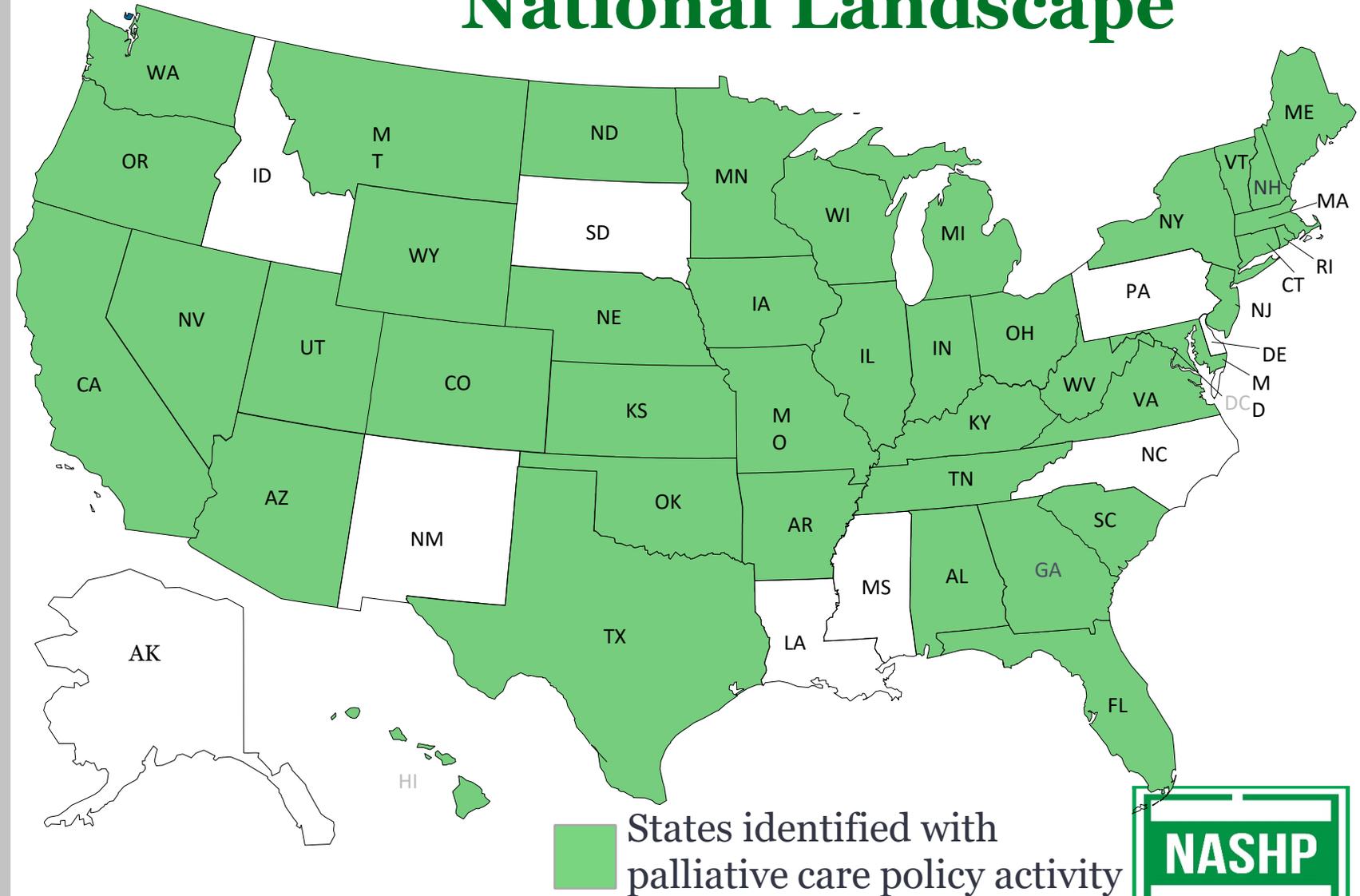


National Scan Finding:
While the majority of states have not developed a comprehensive policy strategy, many states are taking steps to increase access to and quality of palliative care.

Domains of Policy Activity:

- Implementing regulation;
- Instituting public insurance coverage and reimbursement;
- Promoting public awareness.

National Landscape



Recommendations



Identify quality measures and reporting strategies to improve access to and quality of palliative care

Develop strategies to build capacity

Promote evidence-based standards and practices across a variety of settings, and across the lifespan

Identify opportunities to align with delivery system reforms and innovations

Define palliative care services and standards; distinguish from hospice

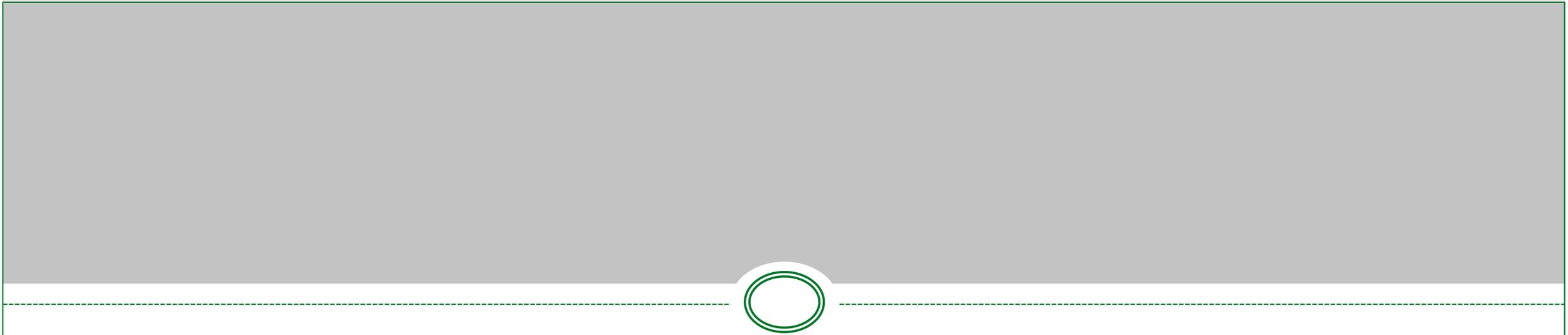
Educate policy makers, primary and specialty providers, and the public

Develop sustainable reimbursement

Resources



- [Palliative Care: A Primer for State Policymakers](#)
- [Advancing Palliative Care for Adults with Serious Illness: A National Review of State Palliative Care Policies and Programs](#)
 - Appendix A: [Scan of State Regulations for Adult Palliative Care Activity](#)
 - Appendix B: [Scan of State Medicaid Programs for Adult Palliative Care](#)
- Webinar: [Advancing Palliative Care for Adults with Serious Illness: A National Review of State Palliative Care Policies and Programs](#)



Increasing Access to Quality of Palliative Care: Laying the Groundwork

Dr. Martha Twaddle, Northwestern Medicine



The Evolution and Expansion of Palliative Care in Health Care

The Integration of Palliative Care, Community and Population Health

**Martha L. Twaddle MD FACP FAAHPM
HMDC**

Medical Director, Palliative Medicine & Supportive Care
Northwestern Medicine – North Region
Associate Professor of Medicine,
Northwestern Feinberg School of Medicine



This educational activity is being presented without bias or conflict of interest by the planners and presenter.

Objectives for This Discussion

- Discuss the continuum of Palliative Care
 - how it integrates with Population and Public health approaches integral to healthcare re-alignment
 - and how it so effectively contributes the Triple Aim
- Discuss PC's vital role in healthcare delivery systems to support the seriously ill through “community-based” models.
- Illustrate and consider models to integrate PC and its competencies into systems of care to avoid “chance encounters”.

What is Palliative Care?

- **Palliative Medicine** = Specialized medical care for people with serious illness(es)
- **Palliative Care** = Team-based (interdisciplinary), focused on improving quality of life for patients AND their families by providing:
 - Expert symptom management
 - Emotional and spiritual support
 - Guidance in navigating the healthcare system
 - Assistance with difficult medical decisions

...What is Palliative Care?

- Any serious diagnosis, particularly those that are progressive and complex, or life-threatening
- Any age
- Any stage of illness
- Team = Partnership with treating physicians & clinicians
- Extra layer of support and a care coordination
- Provided alongside curative treatment

Palliative Medicine & Supportive Care

Different from Hospice

- Hospice is a form of palliative care supported by a specific insurance benefit that people are eligible to use when they are terminally ill.
- Hospice provides palliative care for terminally ill patients with ≤ 6 mos to live.
- Hospice patients:
 - ✓ Must sign on to (elect) their hospice benefit
 - ✓ Must be 'certified' by physicians as being eligible.
 - ✓ Must allow the hospice team to serve as the care managers.



What population do we serve? How do we identify them?

Utilizing a method **sensitive** enough to identify most of the target population, but **specific** enough to focus on those **who can benefit from supportive interventions**.

It is increasingly clear that any program's ability to improve care value is **critically reliant on targeting the right patients—not too many, not too few, but the right ones**.

Meier 2016



Our Population.....

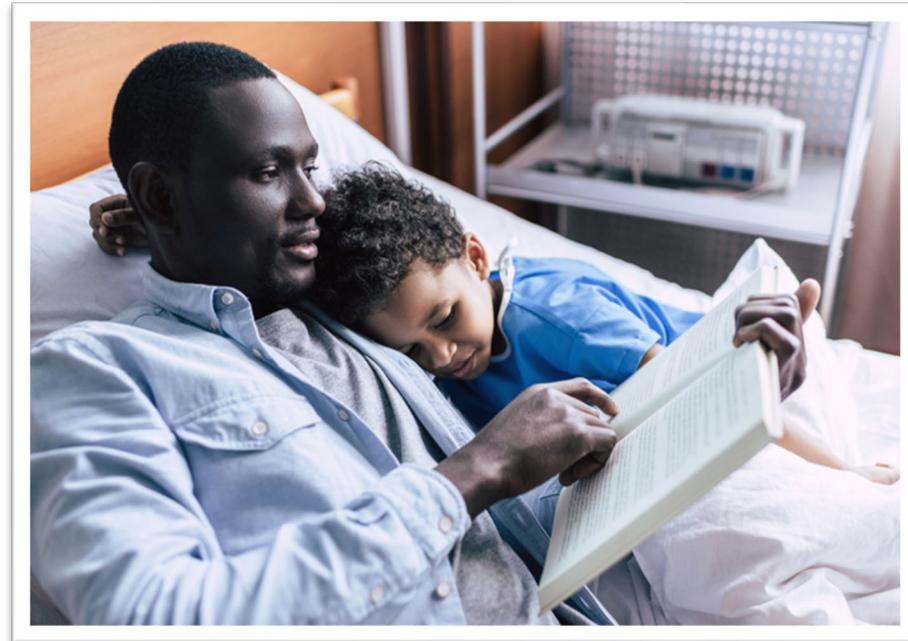
- ✓ Beyond those who are dying
- ✓ The very ill
- ✓ Aging, frailty
- ✓ Chronically ill with debility
- ✓ The seriously ill for whom our health care system is potentially rich with resources but **who need help**

navigating its fractured structure to make sense of all the choices – some of which are non-beneficial.



Identifying those who need our care...

Inclusive of all people living with **serious illness**, regardless of setting, diagnosis, age or prognosis



Serious Illness Definition

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 caregiver.*

*Kelley, AS, Bollens-Lund, E. Identifying the population with serious illness: the “denominator” challenge. *Journal of Palliative Medicine*. Volume: 21 Issue S2: March 1, 2018.

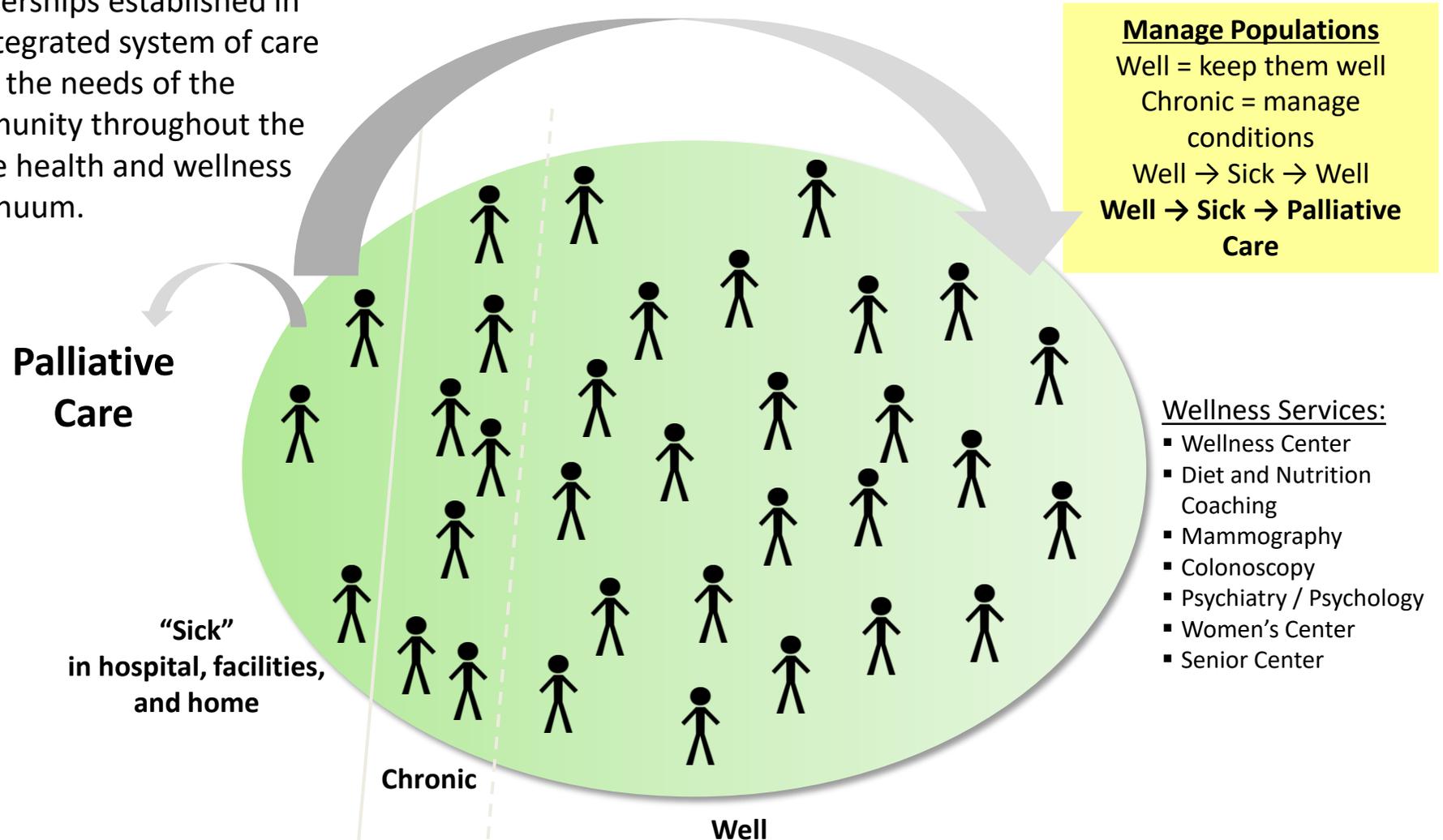


Systematic Approach

- ...to caring for people with serious illness
- Utilizing Population, Public, Community, Preventative Health approaches
- Right sized and matched to need
- Scalable - Increasing the Populations served
- Not just the patient, but the caregiver

Palliative Care supports Population Based Health

The services and partnerships established in an integrated system of care meet the needs of the community throughout the entire health and wellness continuum.





Caregiving Increases Mortality Risk

Nurses Health Study: *prospective study of 54,412 nurses*

- ❖ Increased risk of MI or cardiac death: RR 1.8 if caregiving >9 hrs/wk for ill spouse

Lee et al. Am J Prev Med 2003;24:113

Population based cohort study 400 in-home caregivers + 400 controls

- ❖ Increased risk of death: RR 1.6 among caregivers reporting emotional strain

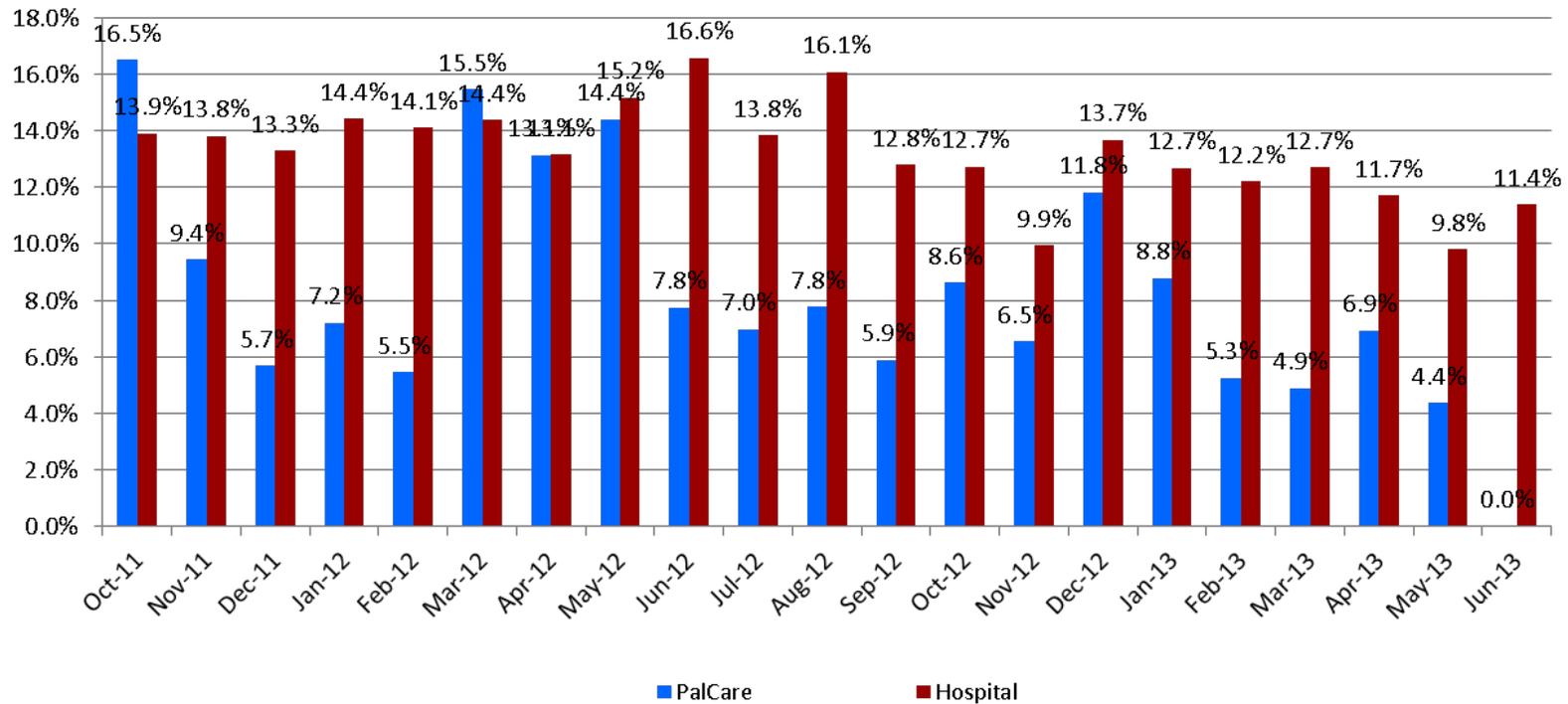
Schulz et al. JAMA 1999;282:2215.



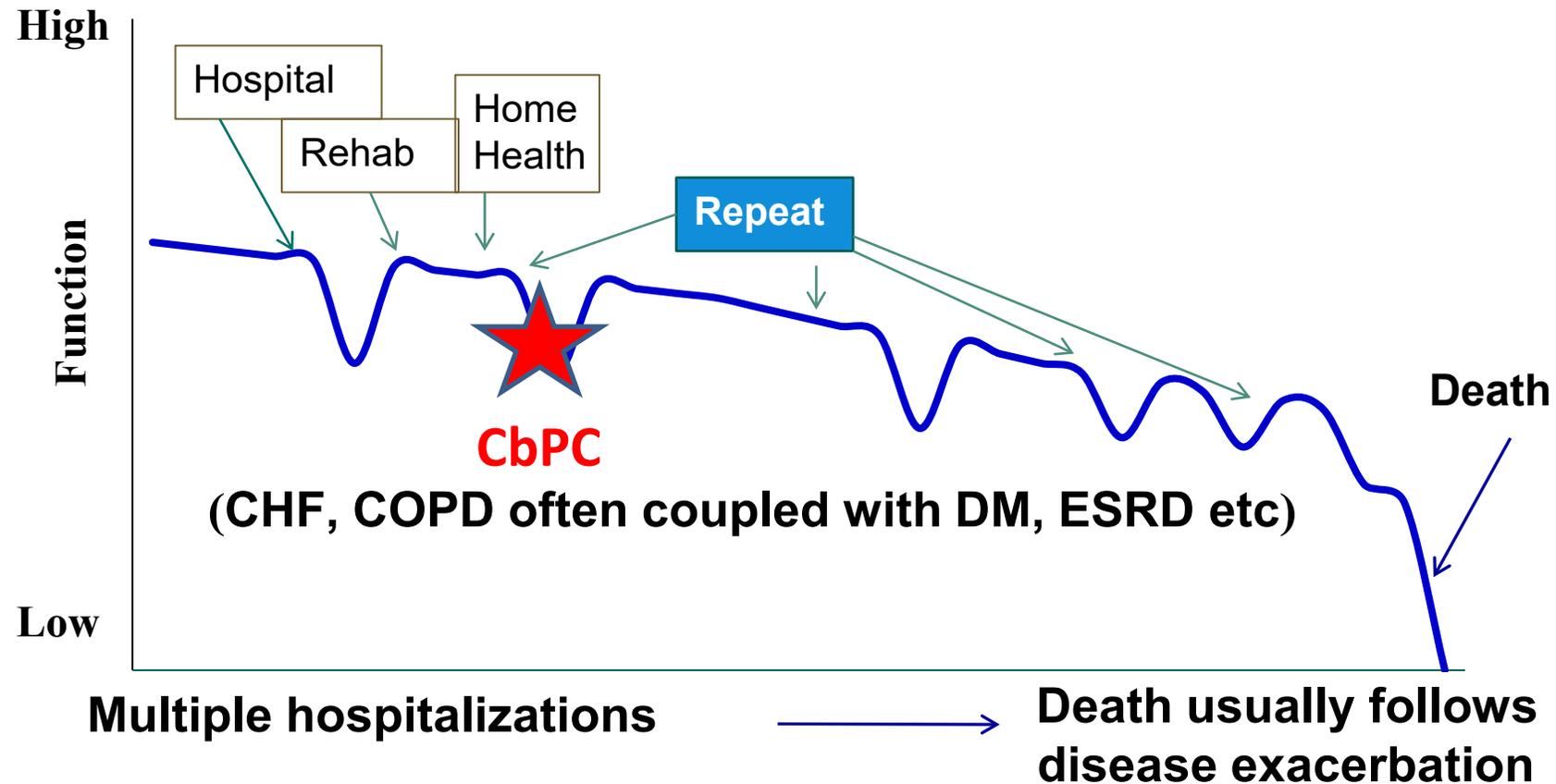


Impact on Hospital 30 Day Re-admissions

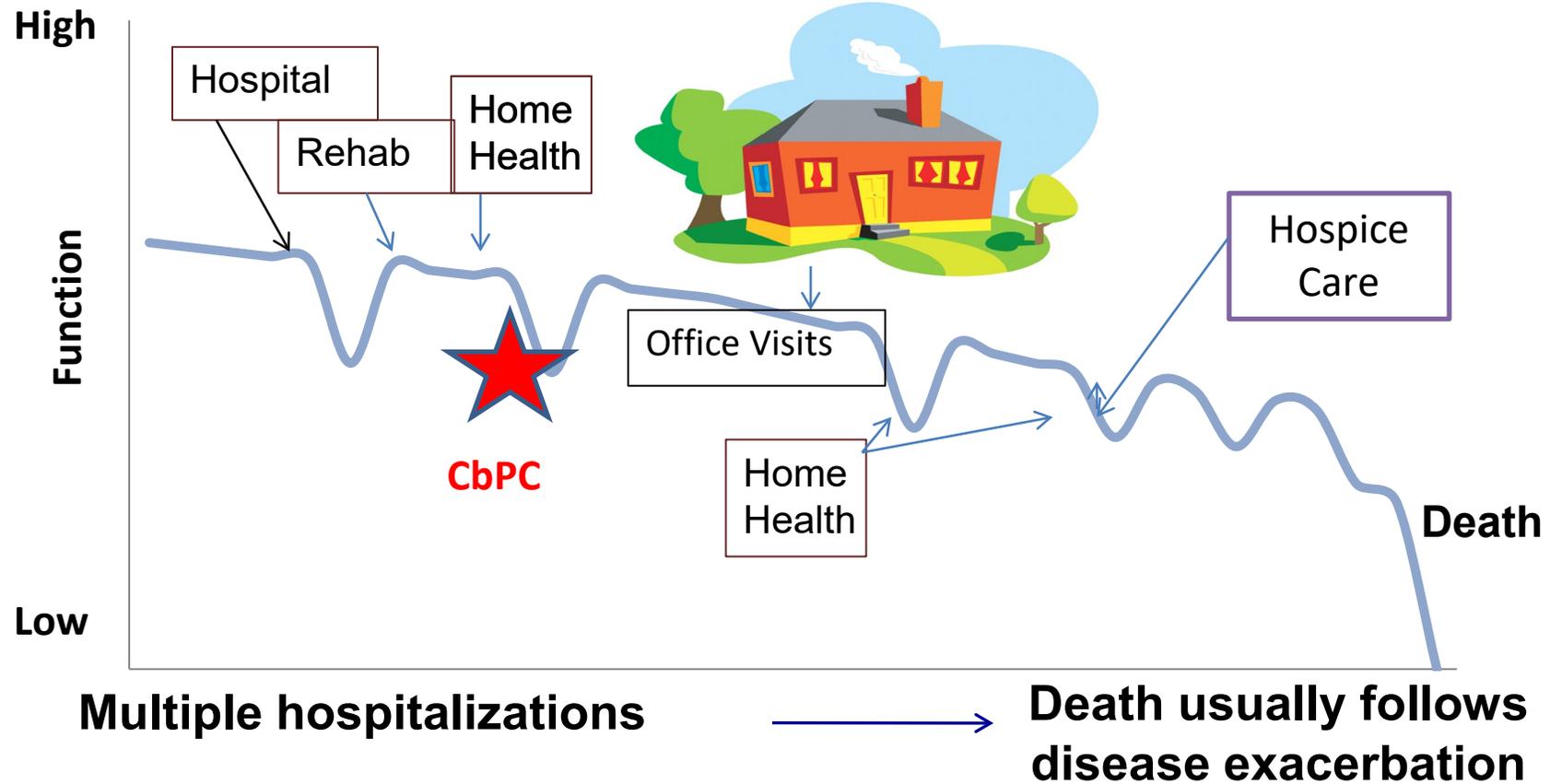
Readmissions - Pal Care vs. Hospital (Medicare Only)



Changing the Epicenter to the Community

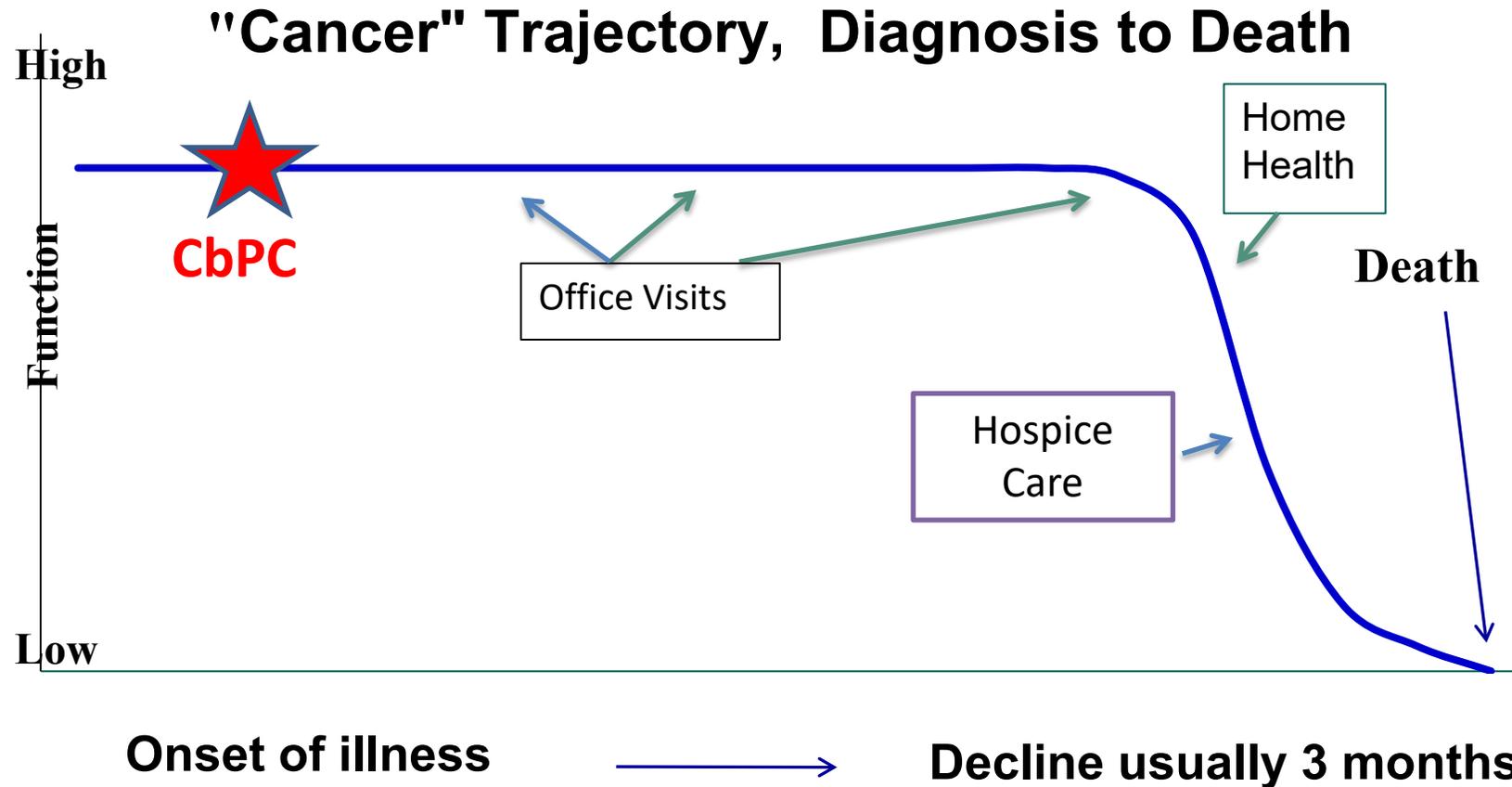


Community-based Palliative Care (CbPC)



CbPC Time frame – particularly targeting the last year or two of life.

Supportive Model for Cancer Care





Early Palliative Care for Patients with Metastatic Non-Small Cell Lung Cancer

Temel JS et al. N Engl J Med 2010;363:733-742

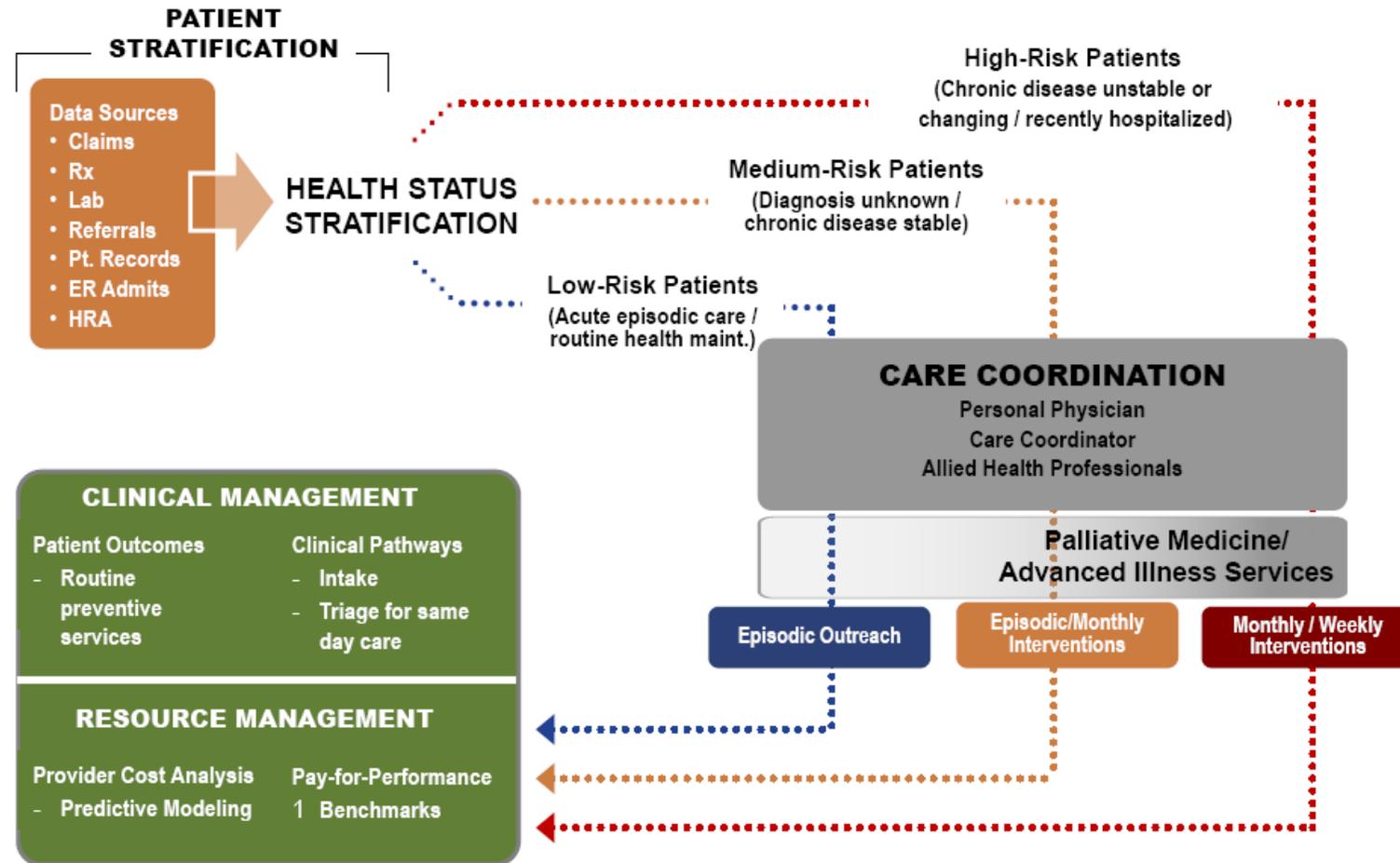


The NEW ENGLAND
JOURNAL of MEDICINE

The Results

- Early ambulatory palliative care, in conjunction with life-sustaining treatments, for patients with metastatic NSCLC is associated with:
 - Improved mood
 - Improved QOL
 - More documentation of code status
 - Less aggressive EOL care
 - Improved survival

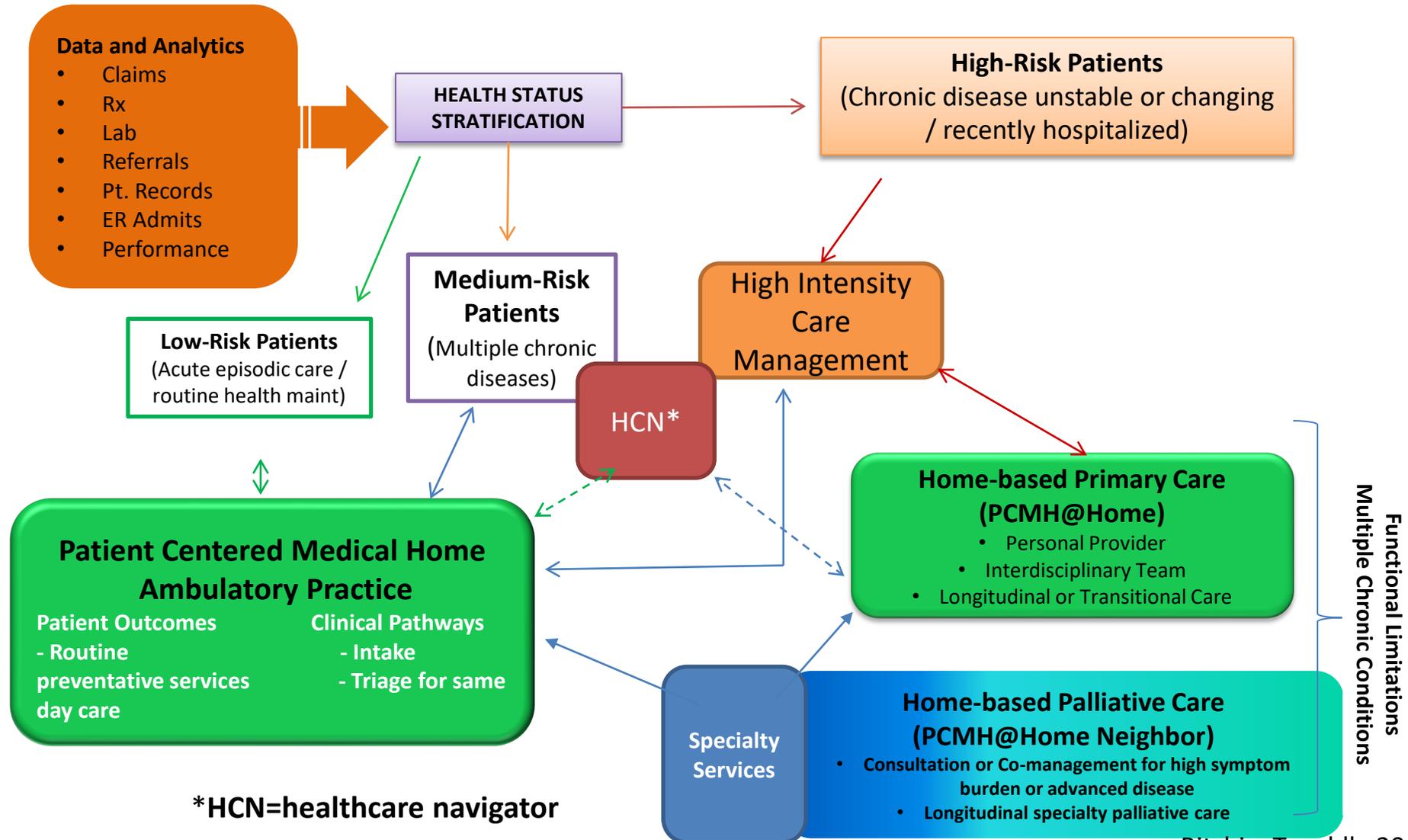
Medical Home Coordinated Care Model Featuring Palliative Med / Advanced Illness Services Component



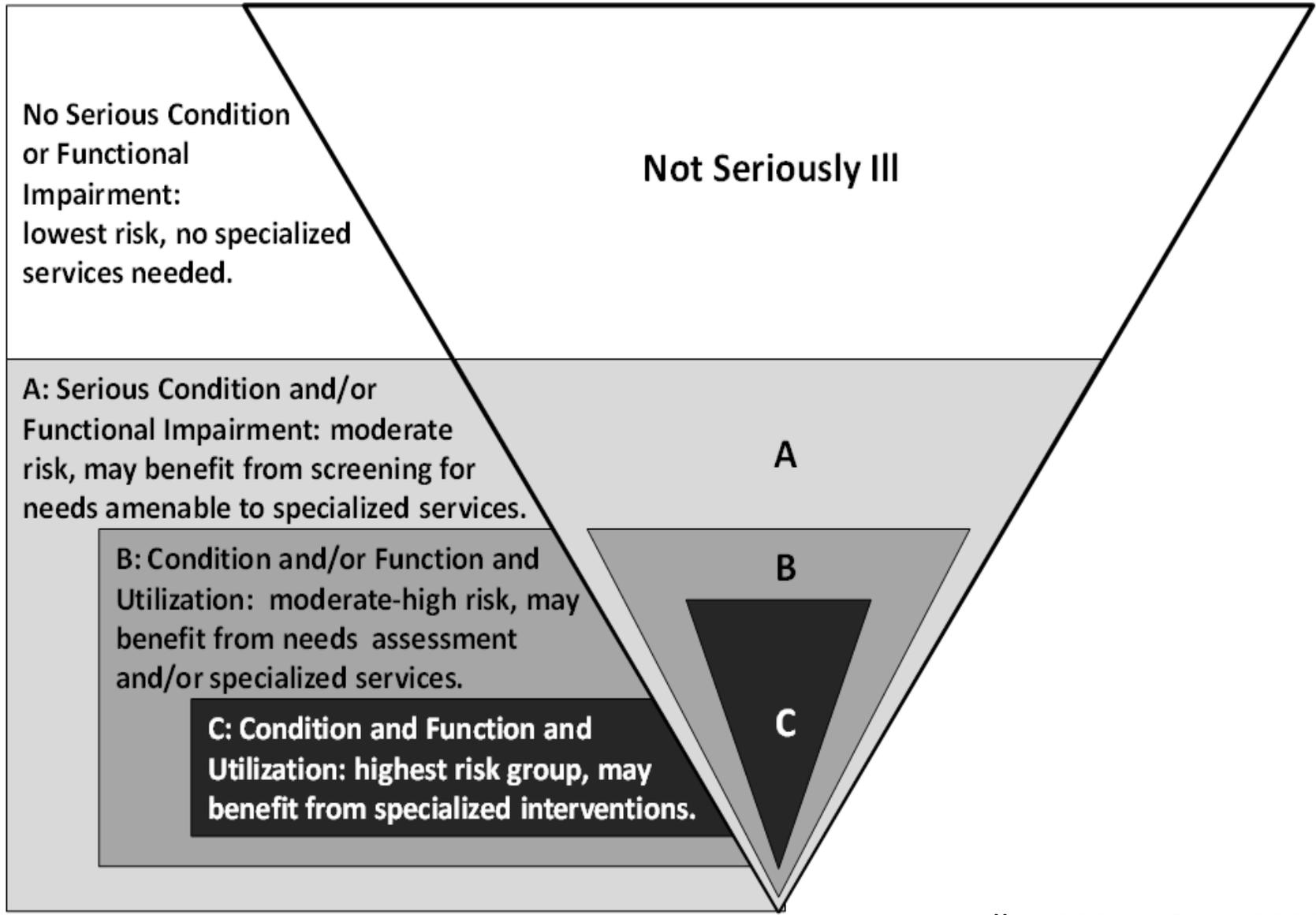
Adapted from SSB Solutions AHA-CIO Discussion Document March 2012

Neighborhood: Home-based Primary & Palliative Care

Population Health, PCMH@Home & PCMH@Home Neighbor



*HCN=healthcare navigator



1-year outcomes	Not Seriously Ill (or “Comparison group”)	Category A Serious condition and/or functional impairment	Category B Serious condition and/or functional impairment AND utilization	Category C Serious condition AND functional impairment AND utilization
Number of Subjects	6,280	5,297	3,151	1,447
Hospitalization	12%	33%	44%	47%
Total Medicare costs (mean)	\$7,789	\$20,566	\$26,349	\$30,828
Mortality	2%	13%	19%	28%

Improving the U.S. Health Care System Requires Simultaneous Pursuit of Three Aims:



- improving the experience of care,
- improving the health of populations, and
- reducing per capita costs of health care.

Berwick DM, Nolan TW, Whittington, J. Health Aff May 2008 vol. 27
no. 3 759-769.

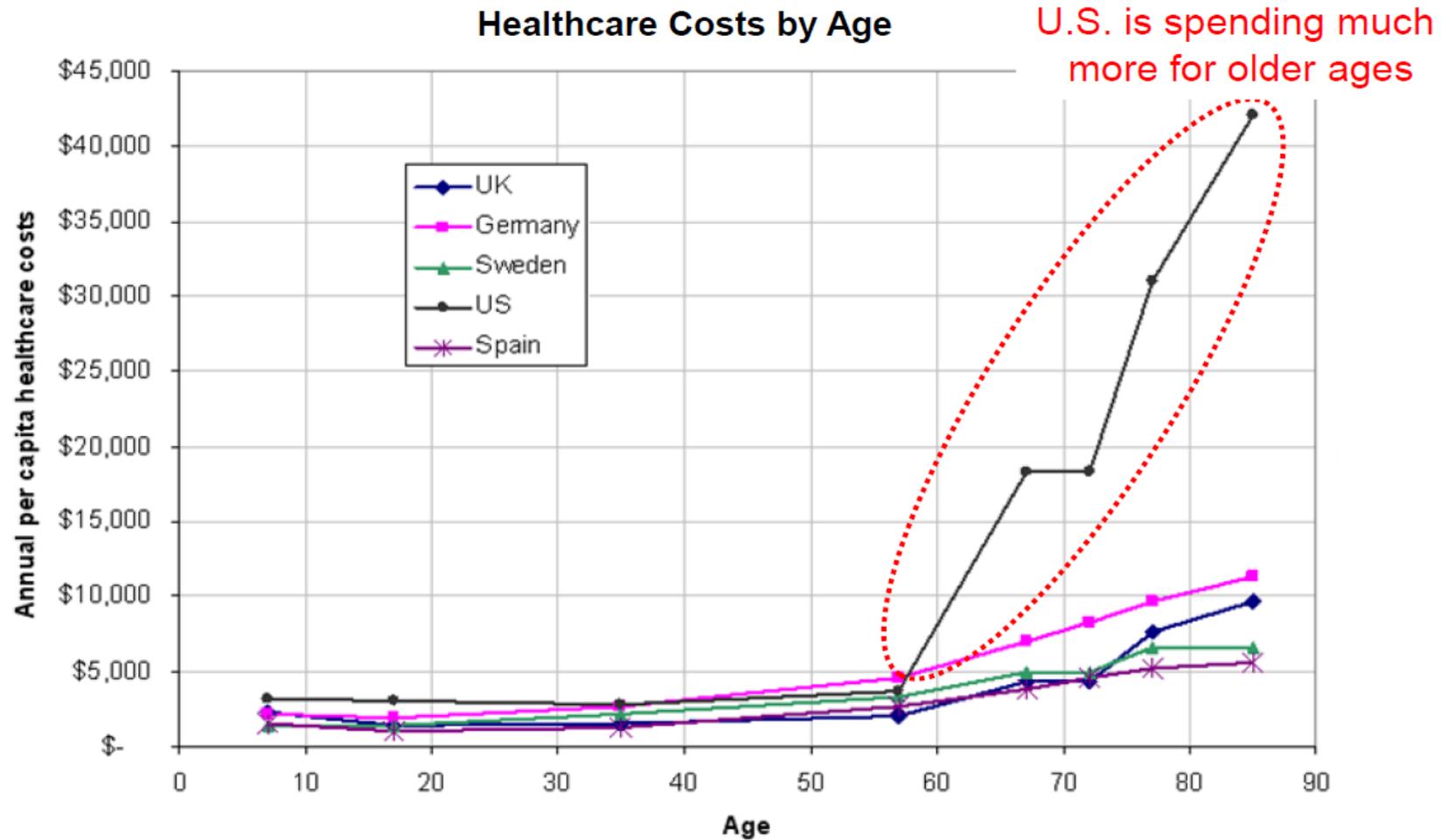
Palliative Care is Uniquely Effective in Achieving the Triple Aim

Outcomes of Palliative Care:

- Reduction in symptom burden
- Care concordant with pt/family wishes
- Improved patient and family satisfaction
- Reduced costs



Costs by Age Categories

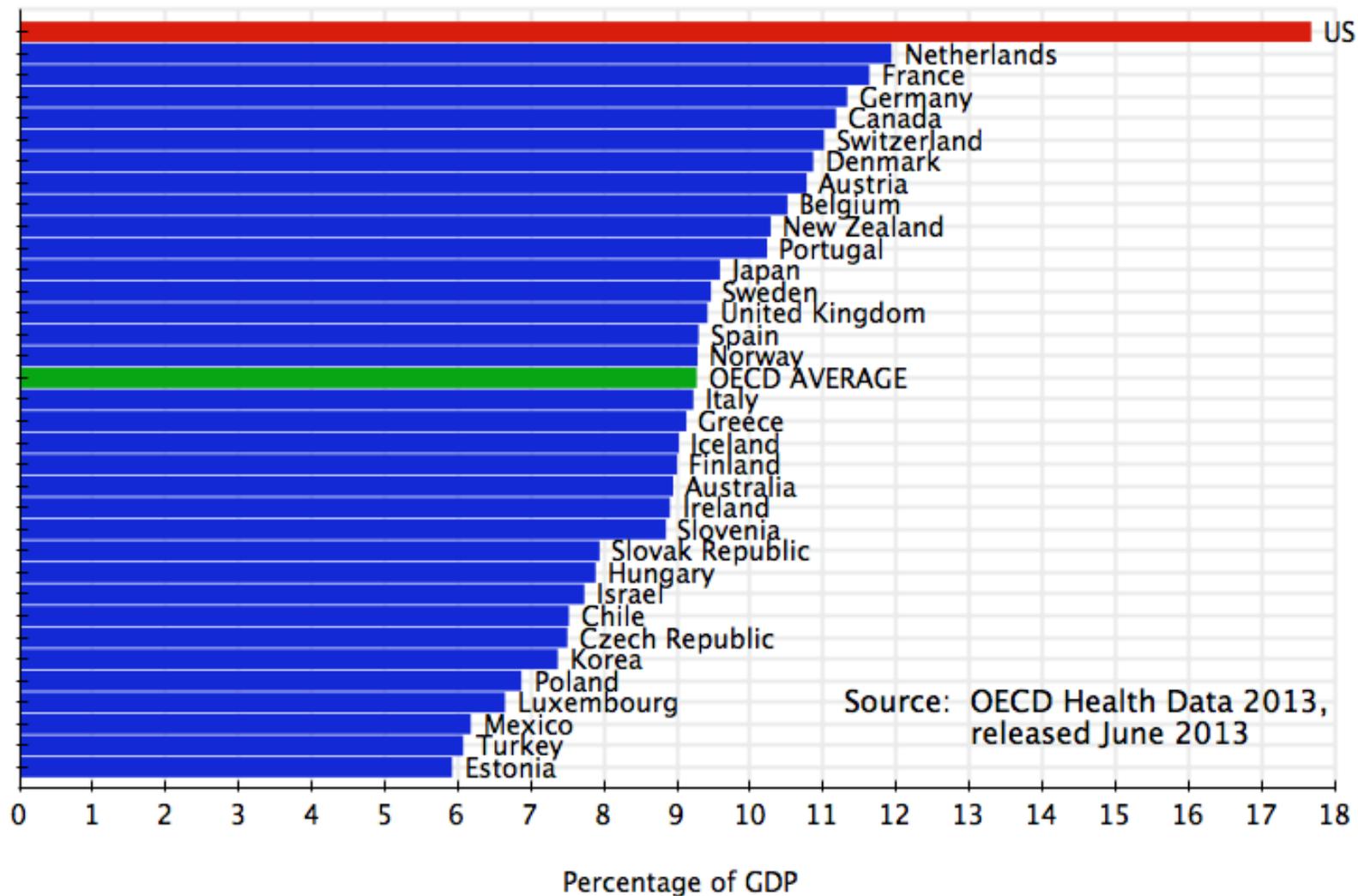


Source: Fischbeck, Paul. "US-Europe Comparisons of Health Risk for Specific Gender-Age Groups." Carnegie Mellon University; September, 2009.

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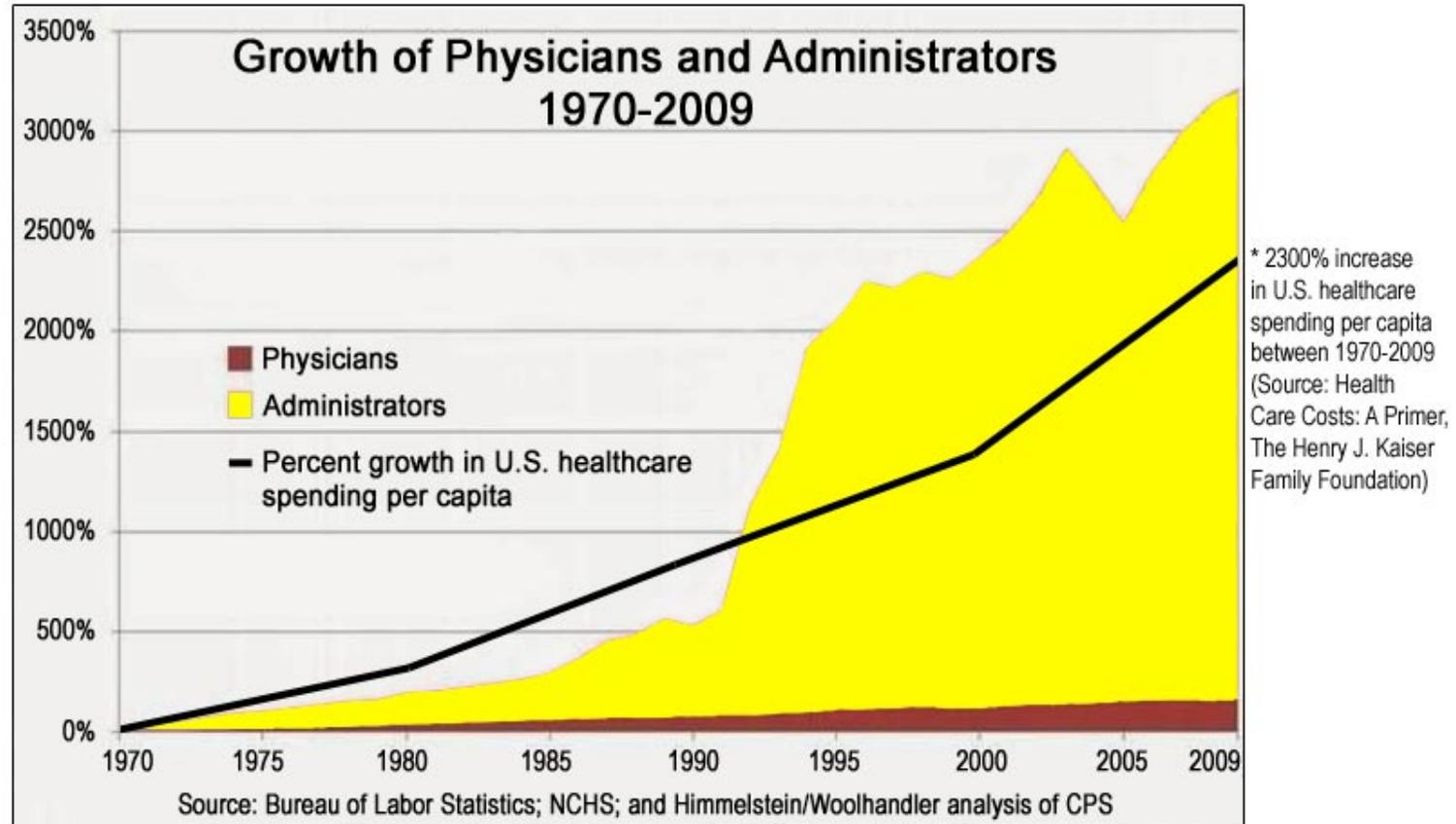
KaufmanHall

Health Expenditures as Percentage Share of GDP OECD Member Countries – 2011 or nearest available year



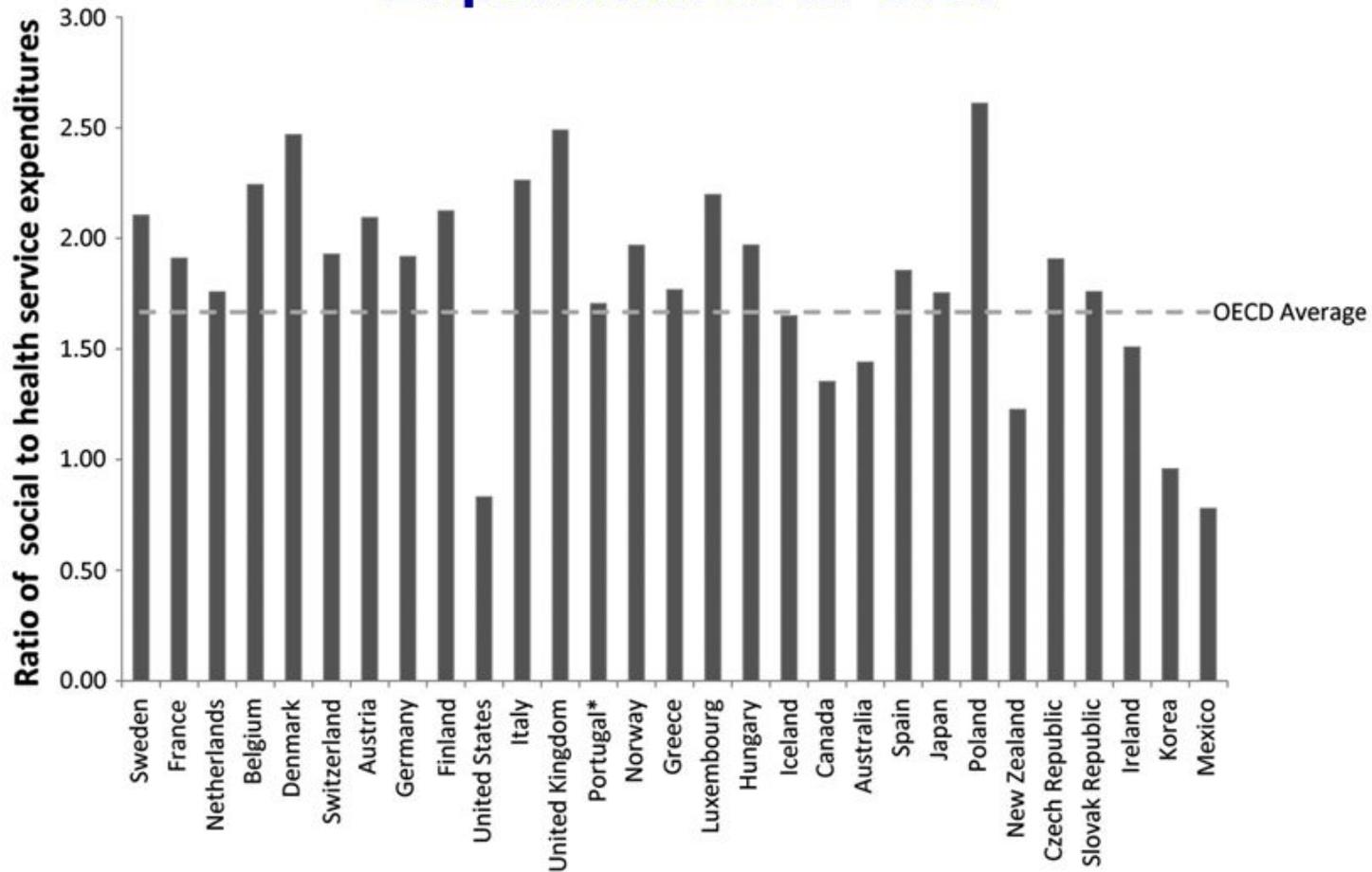


2300% increase in US healthcare spending per capita between 1970-2009



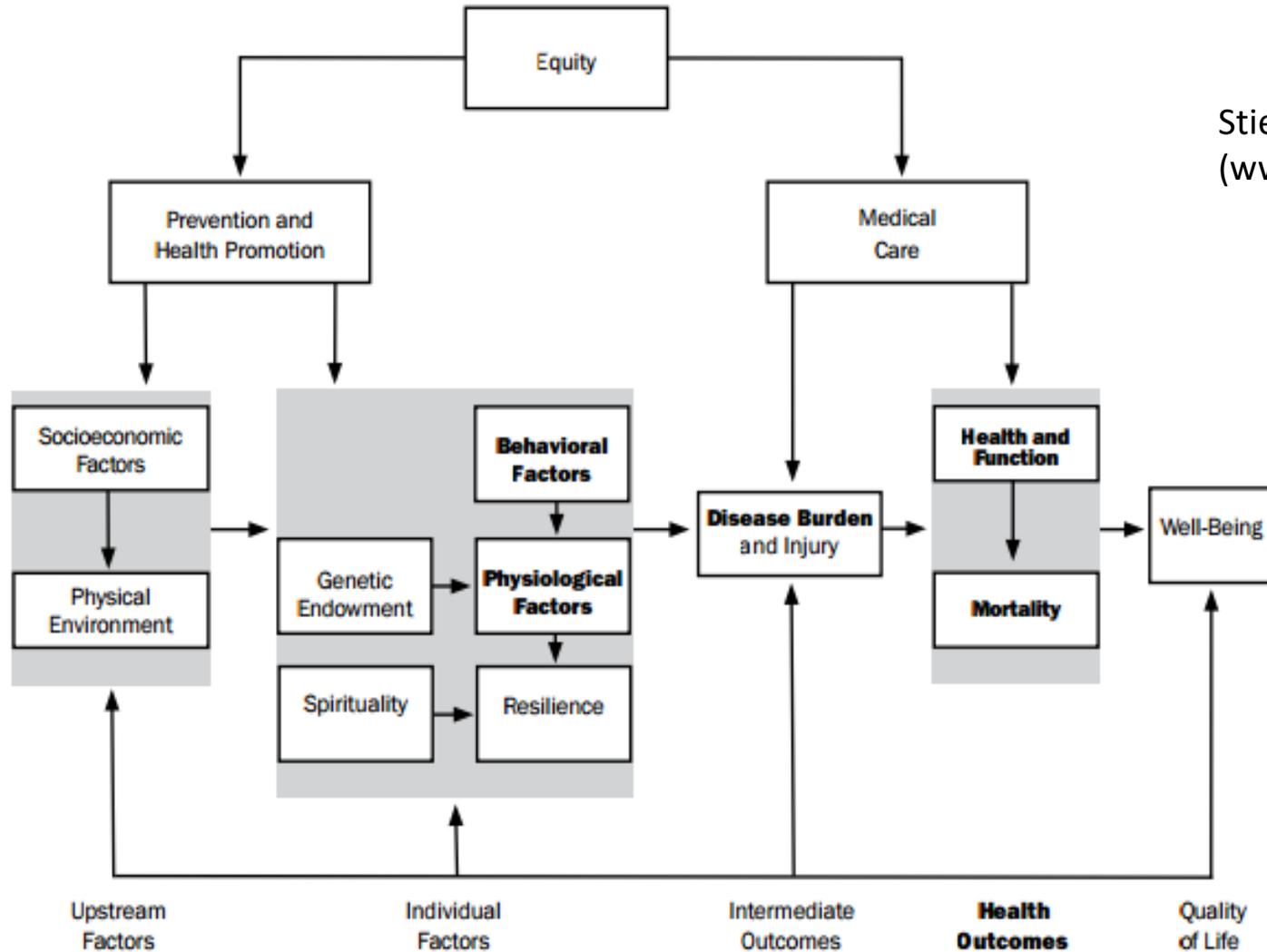
“It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication, somehow think that we can afford to pay for doctors, hospitals, medication, and a government bureaucracy to administer it.” –Thomas Sowell

Low Ratio of Social to Health Service Expenditures in U.S.



Bradley E H et al. *BMJ Qual Saf* 2011;20:826-831

Figure 1. A Model of Population Health



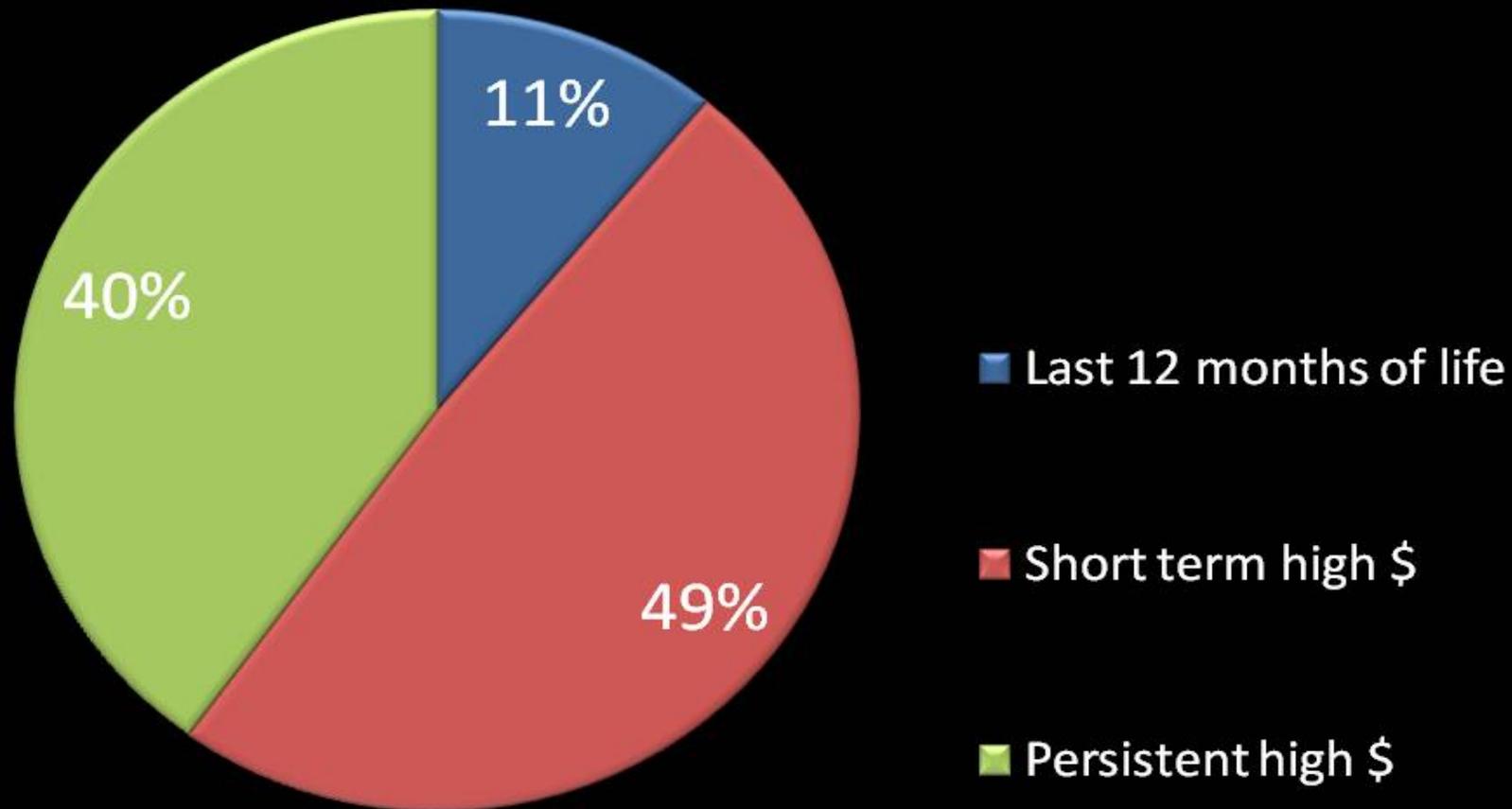
Stiefel M: IHI; 2012.
(www.IHI.org)

Note: Measures of population health in the Triple Aim measurement menu in Table 1 appear in **bold** text in Figure 1.

Costliest 5% of Patients

IOM Dying in America Appendix E

<http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>



Transforming 21st Century Care of Serious Illness

Change from:	Change to:
Terminal	Advanced Chronic
Prognosis weeks-month	Prognosis months to years
Cancer	Condition (frailty, fn'l dep, MCC)
Disease	All chronic progressive diseases
Mortality	Prevalence
Cure vs. Care	Synchronous shared care
Disease OR palliation	Disease AND palliation
Prognosis as criterion	Need as criterion
Reactive	Screening, Preventive
Specialist	Palliative/Geriatric Care/Generalist level
Institutional	Community
No regional planning	Public health approach
Fragmented care	Integrated care

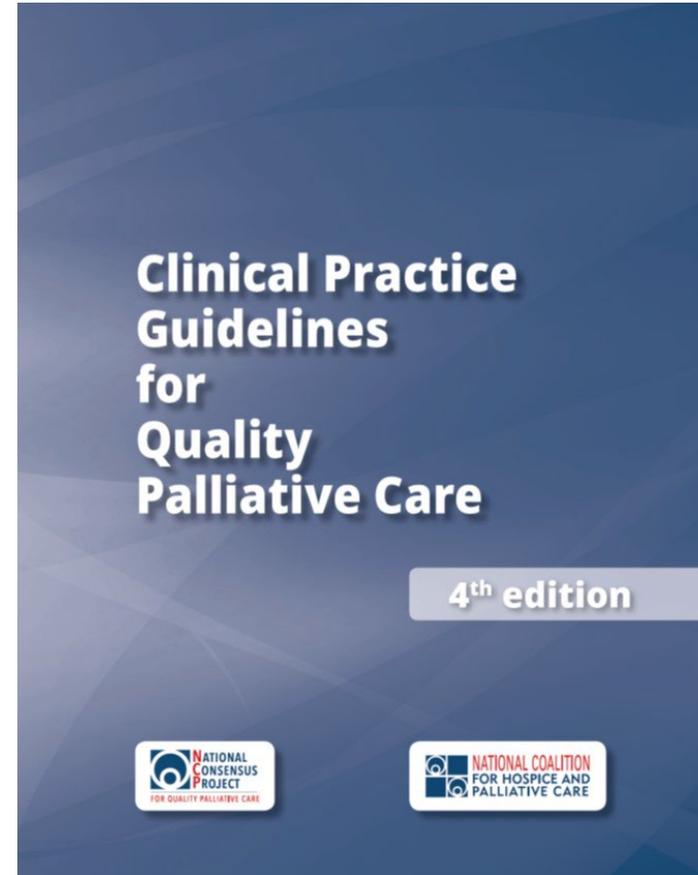
Importance of Palliative Care

Interdisciplinary team expertise

- **Support for transitions** of care for high risk patients across sites of care
- **Active care management** to meet patients and families needs and thus prevent unnecessary inpatient/ED utilization
- Filling gaps in existing community services – or **coordinating the gaps**

The 4th edition

- **For all people with serious illness, regardless of setting, diagnosis, prognosis, or age**
- Increased attention to caregiver strain
- Screening and assessment in all Domains
- Attention to the vulnerability of the seriously ill when moving across settings of care.
- Funded by the Gordon and Betty Moore Foundation
- Published by the National Coalition for Hospice and Palliative Care
- NCP leadership consisted of 16 national organizations
- **Endorsed by almost 90 National Organizations like ACS, AHA, AMA....**



Population Health + Pal Care

Potent opportunity for health care delivery systems, public health agencies, community-based organizations, and many other entities to **work together** to improve health outcomes in the communities they serve.

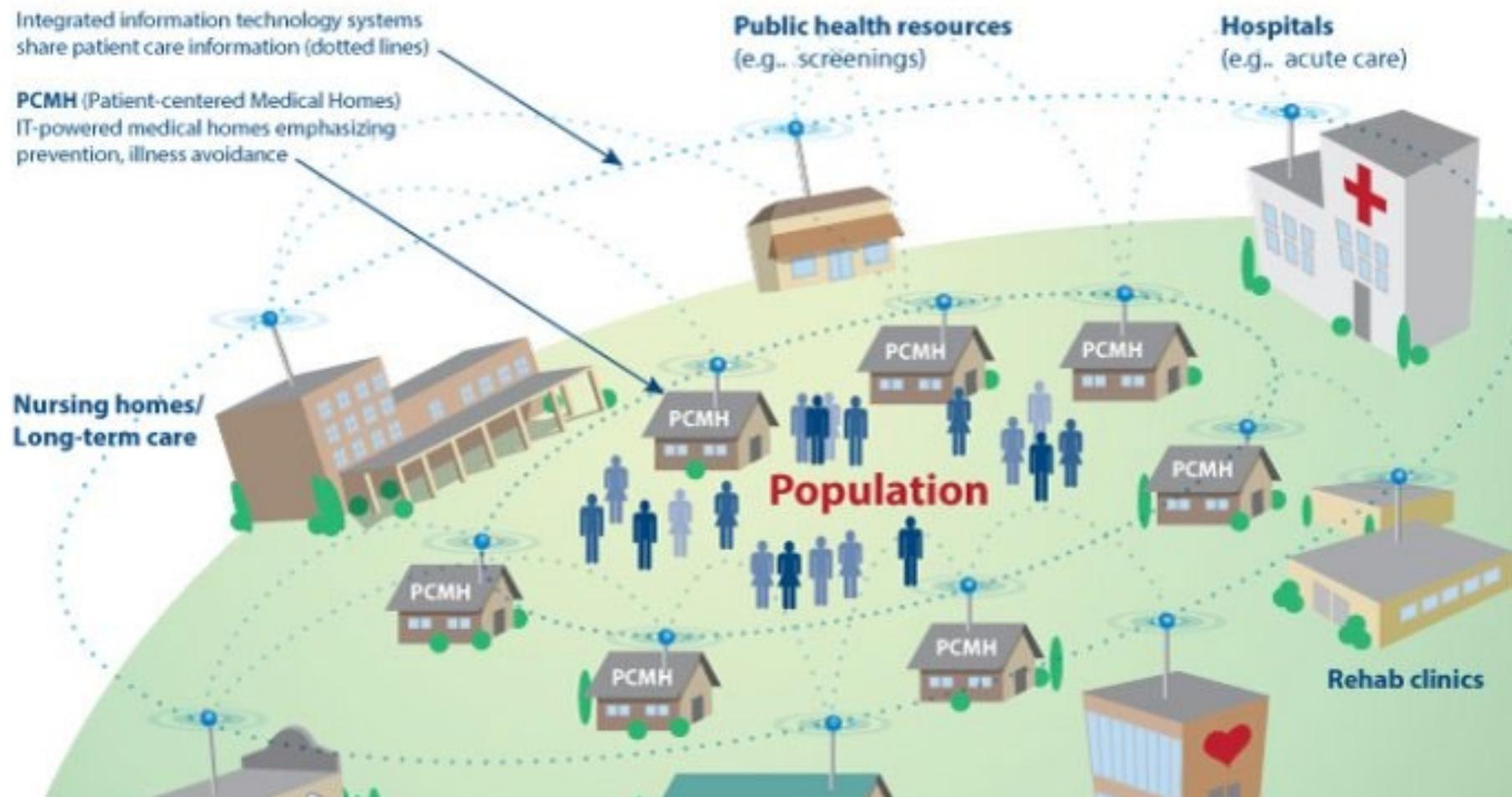
M. Stoto, Academy Health 2013

For the seriously ill – PC interdisciplinary teams may serve as **population health integrators**

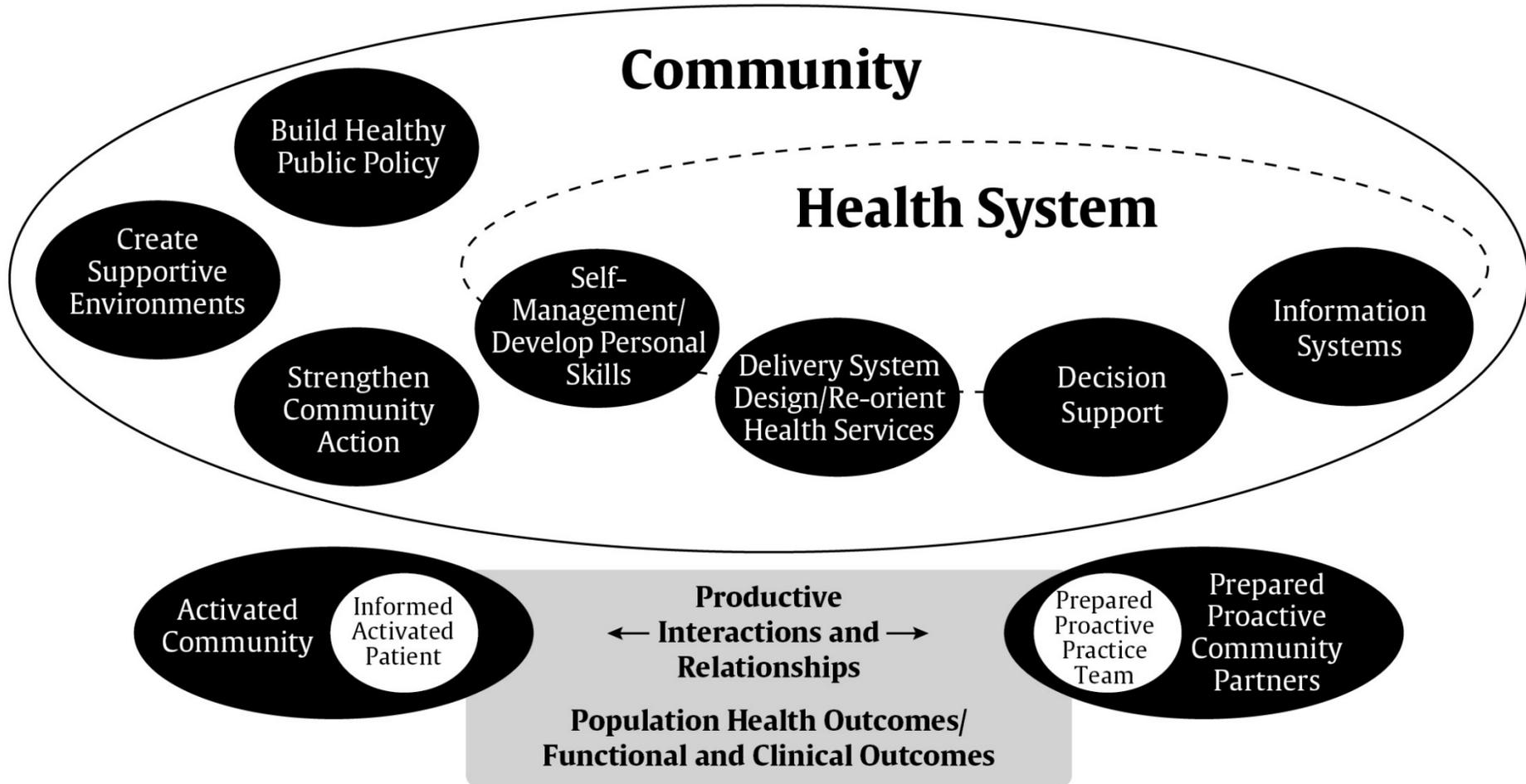
Population Health Management

Integrated information technology systems share patient care information (dotted lines)

PCMH (Patient-centered Medical Homes)
IT-powered medical homes emphasizing prevention, illness avoidance



The Expanded Chronic Care Model: Integrating Population Health Promotion



Improving the U.S. Health Care System Requires Simultaneous Pursuit of ~~Three~~ Four Aims:



- improving the experience of care,
- improving the health of populations,
- improving the work life of health care providers, including clinicians and staff, and
- reducing per capita costs of health care.

Berwick DM, Nolan TW, Whittington, J. Health Aff May 2008 vol. 27 no. 3 759-769.

Summary

- Palliative Care is uniquely effective in meeting the Triple Aim for seriously ill people and their families.
- PC has a vital role in contributing to the development of Population and Public Health (Community Health) approaches in healthcare models.
- PC's expertise as an interdisciplinary model is relevant and of great value as a Population Health Integrator.
- It is imperative that we know who we are here to serve – that our truth north is caring for seriously ill people and their families.
- It is imperative as well that we are supported and sustained in this vital work.

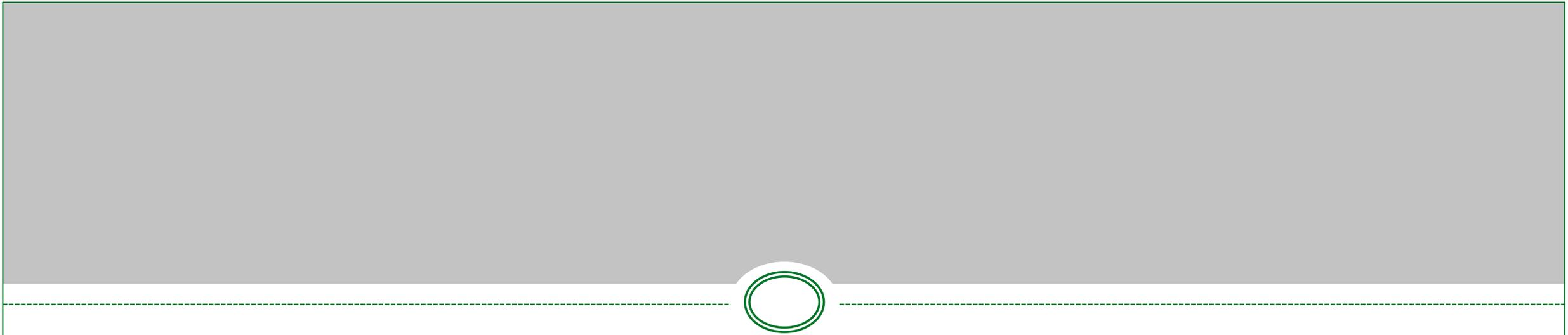
We do not learn from
experience... we learn
from reflecting on
experience.

- John Dewey



Break

10:30-11:00am



Building Effective Delivery Systems: Sustainable Reimbursement Models

Torrie Fields, Blue Shield of California

Anastasia Dodson, California Department of Healthcare Services





Lessons learned (so far) from developing and implementing home- based palliative care

Torrie Fields, MPH, Senior Manager, Blue Shield of California

The challenge we can meet together

The challenge

- Millions of Americans live with serious illness...a group that is expected to double in the next 25 years.
- Young or old, they can live for many years or only months.
- While diverse, they will require extensive care at various points in their illness.
- Programs to serve them are not widely available or well-coordinated.

How we will meet it

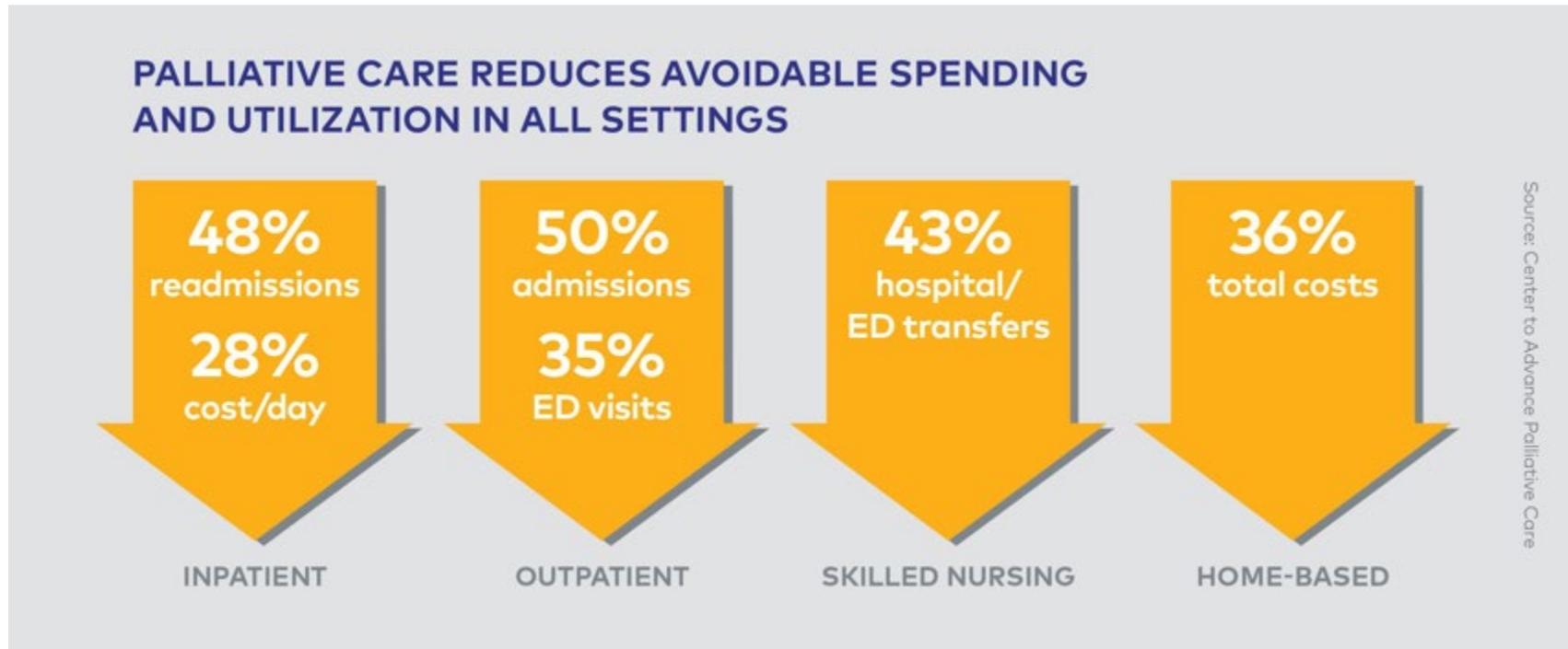
- Blue Shield provides eligible members **high-quality palliative care** that helps those with serious illness receive the care they want and need.



Palliative care = great care and good business

Meets the “Triple Aim”

- Improving patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing health care costs

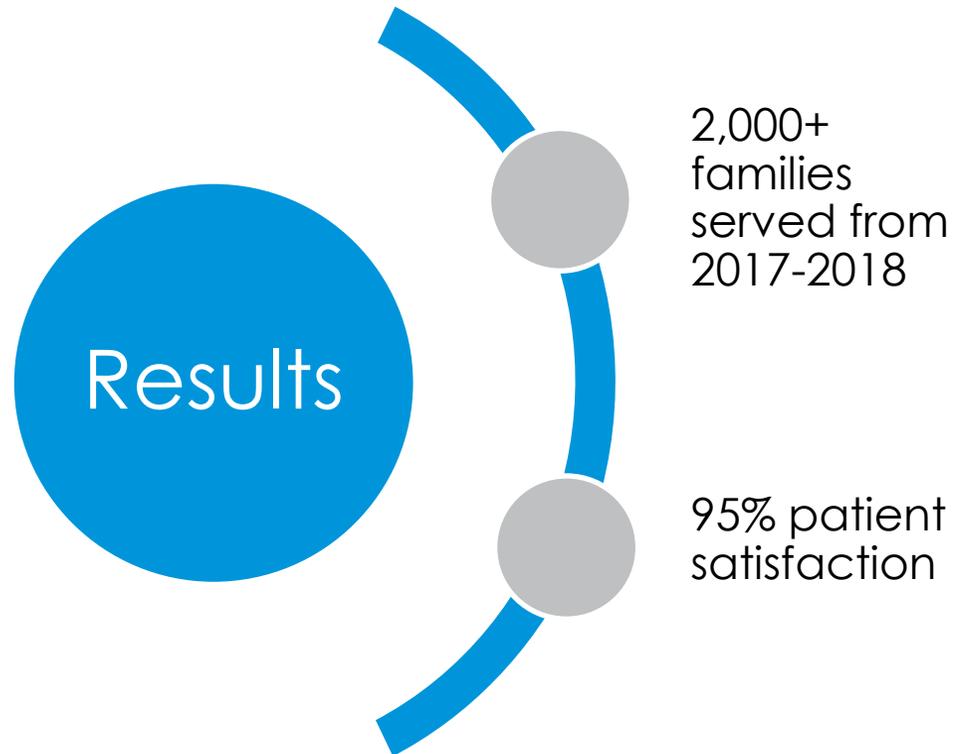


CAPC- <https://www.capc.org/tools-for-making-the-case/downloadable-tools/>



Blue Shield's palliative care program summary

Improving the lives of people with serious illness.



Palliative Care Program Overview

- Palliative Care Case Management Program
- Caregiver Support
- Advance Care Planning
- Referrals to community-based palliative care providers
- Personal Care Services for Trio ACO Members

California state-wide provider network

- More than 40 contracted home-based palliative care programs, across all California counties
- Outpatient palliative care programs in all metropolitan service areas
- Telemedicine-enabled palliative care programs for rural members
- Inpatient palliative care programs in all tertiary hospitals



Blue shield's palliative care program

- Services
 - Help with pain and other problems
 - 24/7 access to help and support
 - Help with making treatment decisions and arranging medical care
 - Help with coordinating medical care and communicating with doctors
 - Support for the family
 - Meal delivery and transportation, in some cases
- Settings- Throughout California wherever the person needs or wants
 - In their home
 - In clinics in all metropolitan areas
 - In all large hospitals
 - Via phone or video in rural areas
 - In many nursing homes



Who's on Blue Shield's palliative care team?

- Specially-trained:
 - Doctors
 - Nurses
 - Social workers
 - Chaplains
 - Home health aides
 - Other specialists



Palliative care patient eligibility criteria

Palliative care is a **standard medical service** offered to all members with primary Blue Shield coverage except those who carry FEP PPO, Shared Advantage, or Medicare supplemental insurance (Medigap).

General Criteria	Diagnosis Criteria
<ul style="list-style-type: none">• Have a serious illness• Have documented gaps in care, including decline in health status and/or function• Use hospital and/or ER to manage illness• Not currently enrolled in hospice• Illness is NOT psychiatric or substance use disorder-related	<ul style="list-style-type: none">• Included but not limited to:• Cancer• Organ failure (e.g., heart, lung, renal, liver)• Stroke• Neurodegenerative disease (e.g., MS, ALS)• HIV/AIDS• Dementia/Alzheimer's• Frailty or advanced age• Multiple comorbid conditions with exacerbated pain



Overcoming Barriers to Adaptation

- Team-based approach is fragmented
 - Integration of different agencies in IDT
 - Issues with data sharing and transfer of charting
 - Organizational names can be a deterrent to patient and physician, strengthening bond between palliative care and hospice
 - Palliative care is often a second service line under another type of licensure that can restrict provision of care by provider (ex. CA SB 294)
- Sustainability
 - Development of a financial model for providers that works with other value-based payment models
 - Funding is difficult to secure for evaluation of new models
- Replication
 - Commercial implementation without market share
 - Need to streamline reimbursement and coding for providers
 - Need to streamline clinical and operational requirements



Payment for Palliative Care Comes in Many Forms

PAYMENT MODEL	Description
Specialized fee schedule	Paid a higher % of Medicare, in recognition of quality/cost contributions. Some commercial health plans develop codes for “non-billable” staff
FFS with shared savings/losses	Shared savings (or losses) based on meeting specific cost or quality targets
Flat fee or “Bundle”	Fixed payment for palliative care team’s co-management over a fixed period of time (eg, during a home health episode or over three months)
Case rate (PMPM)	Monthly fixed payment per “enrolled” member/patient per month



Quality Incentive Payments Provide Even More Flexibility

Incentive Model	Description
Shared Savings	Splitting total cost of health care savings based on quality percentage payouts
Quality lump sum payment	Per beneficiary payment based on overall practice performance
Fee-for-service tier enhancements	Increasing the percent of Medicare payment based on quality scores



Payment is Shifting Beyond FFS to “Value-Based Payment (VBP)”

$$\text{value} = \frac{\text{quality}}{\text{cost}}$$

- Quality measures and/or actual spending are used at least in part to determine the amount a provider is paid
- Many VBPs are *add-ons* built on a FFS architecture – bonuses, penalties, and/or reconciliations happen at the end of each time period



Setting Performance Measures and Targets

- Measures should be negotiated with private payers
- Limit the use of performance measures to only those your program can influence
- Performance measures should be balanced between:
 - Cost and Utilization
 - Patient and Family Satisfaction
 - Quality of Care
- Ensure targets account for the level of illness in this population
 - Resource can will be high
 - Satisfaction is low when the patient feels sick
- **Limit the administrative burden of data collection and reporting**
 - Suggest using existing Registries



Prevalent APM is the “Case Rate” Payment

- Single monthly payment for a defined set of services
- Often requires 24/7 availability
- Onus on palliative care program to stratify their patient population to manage service delivery within fixed payments
- Often need to find operational efficiencies (e.g., telehealth, “outsourcing”)
- Does not necessarily require taking on additional risk



Value-Based Payment Improves Quality



- Blue Shield has established a **per member per month (PMPM) case rate** to support the Program's interdisciplinary team approach.
- Members in the Program are **not charged copays or coinsurance** for services provided as part of the Program.
- Members are also flagged in Blue Shield's internal systems to expedite coordination and authorization of services they may need.



Summary and Lessons Learned

- Licensure and other regulatory barriers can limit capacity of providers to provide this service.
- Enrollment growth is slow and building relationships takes time
- Referral sources must be varied to account for low enrollment or exposure to these types of services. People often don't know what palliative care is
- Innovative hospices and home health agencies are best positioned to provide home-based palliative care, due to setting and team composition
- Implementation is slow and other barriers will arise
 - Applying hospice regulations to your palliative care program
 - Change from per diem to care coordination
 - Lack of exposure to commercial plans & contracting
 - Slower than average pace for contracting and payment, utilization management
- The start-up cost of a program is much greater than the sustainable cost, when enrollment growth stabilizes the practice. Start-up support must be considered



blue  of california





Palliative Care in California's Medicaid Program

Anastasia Dodson, Associate Director
California Department of Health Care Services
NASHP Conference, August 2019



Presentation Overview

- New State Law: Senate Bill 1004
- Policy Development & Data Analysis
- Stakeholder Engagement and Partnership
- Provider Training
- Implementation



New State Law

- California Senate Bill (SB) 1004 signed by Governor Brown in 2014
- Required the California Department of Health Care Services (DHCS) to “establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.”

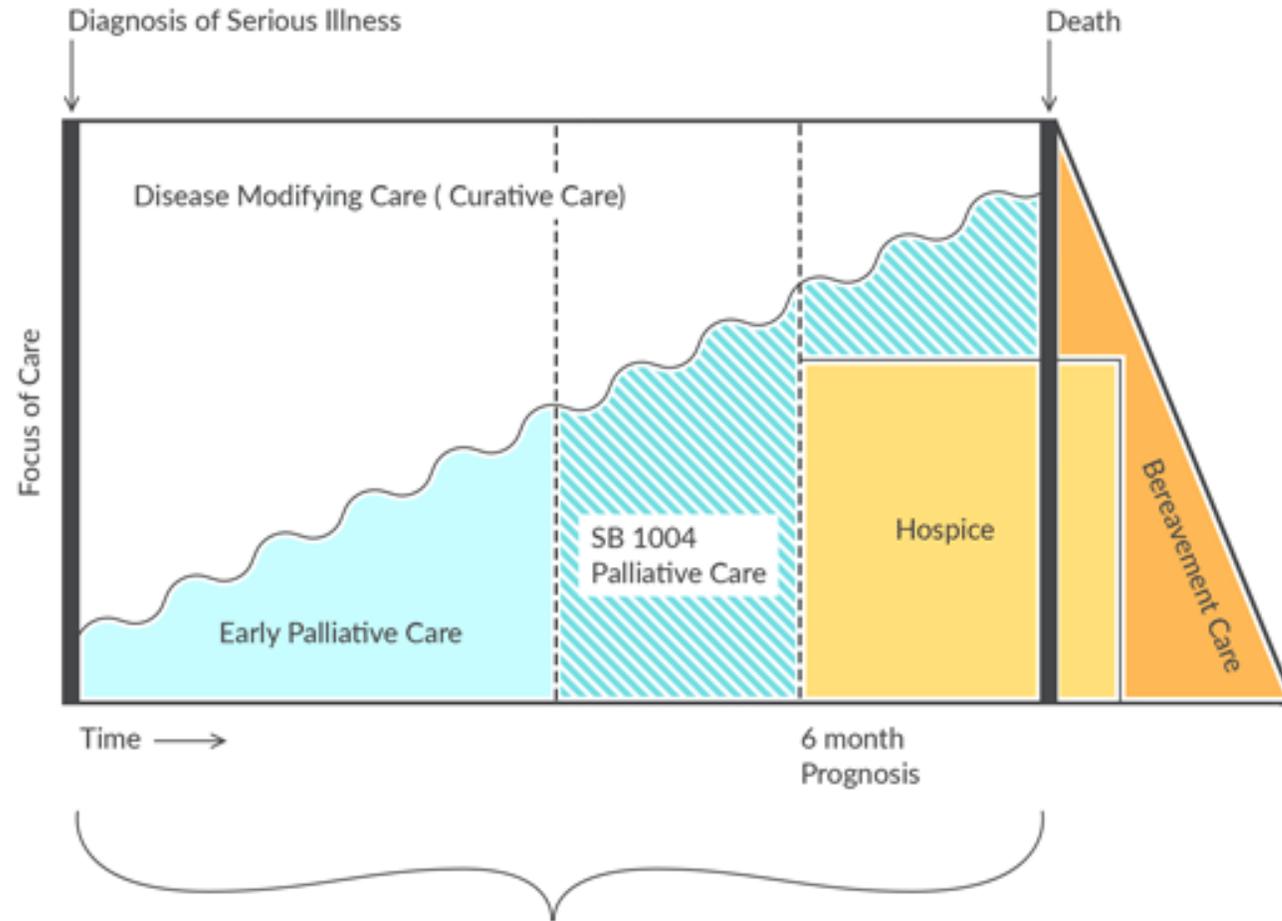


Policy Development

- Leverage Existing Palliative Care Models in California
- Research Coding, Conditions, Services, Fiscal Impact, Results
- Consider Managed Care and Fee-for-Service Delivery Systems
- Began Policy Development in 2015, with Implementation in 2017



SB 1004 Care Model



Advance Care Planning can occur at any time, including the POLST* form for those with serious illness.

Design adapted from the National Consensus Project for Quality Palliative Care.
*POLST: Physician's Orders for Life Sustaining Treatment



Most Frequent Causes of Death for Medi-Cal only* Decedents in 2013

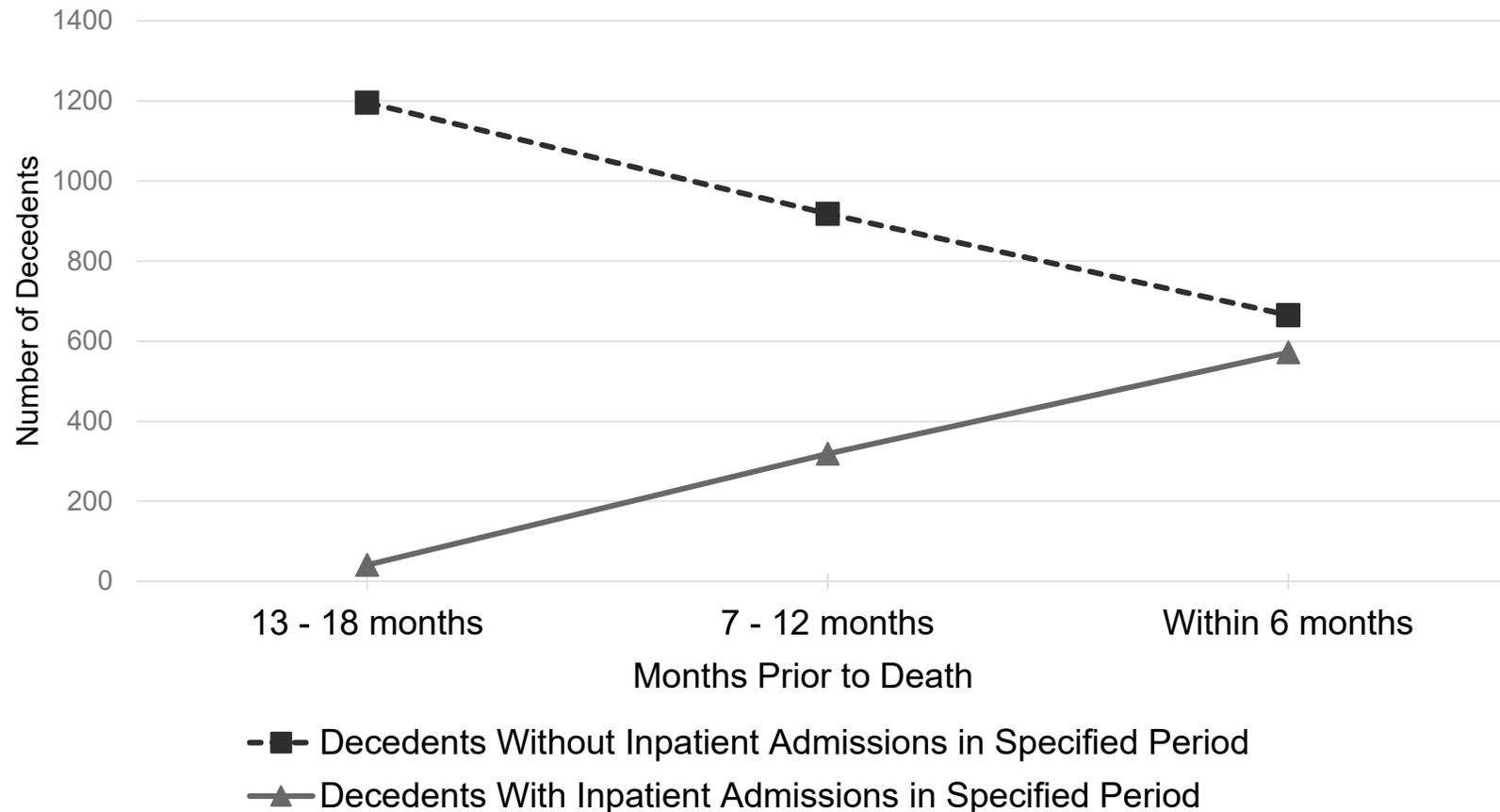
- **Cancer (28.2%)**
- Injury/Accidents (15.6%)
- **Heart disease (14.4%)**
- **Liver disease (6.4%)**
- Stroke (3.9%)
- Diabetes Mellitus (3.4%)
- **Chronic lower respiratory disease (3.3%)**
- Influenza/pneumonia (1.6%)
- Other diseases not included above (23.2%)

*Excludes Dually Eligible Medicare-Medi-Cal Beneficiaries



Inpatient Utilization

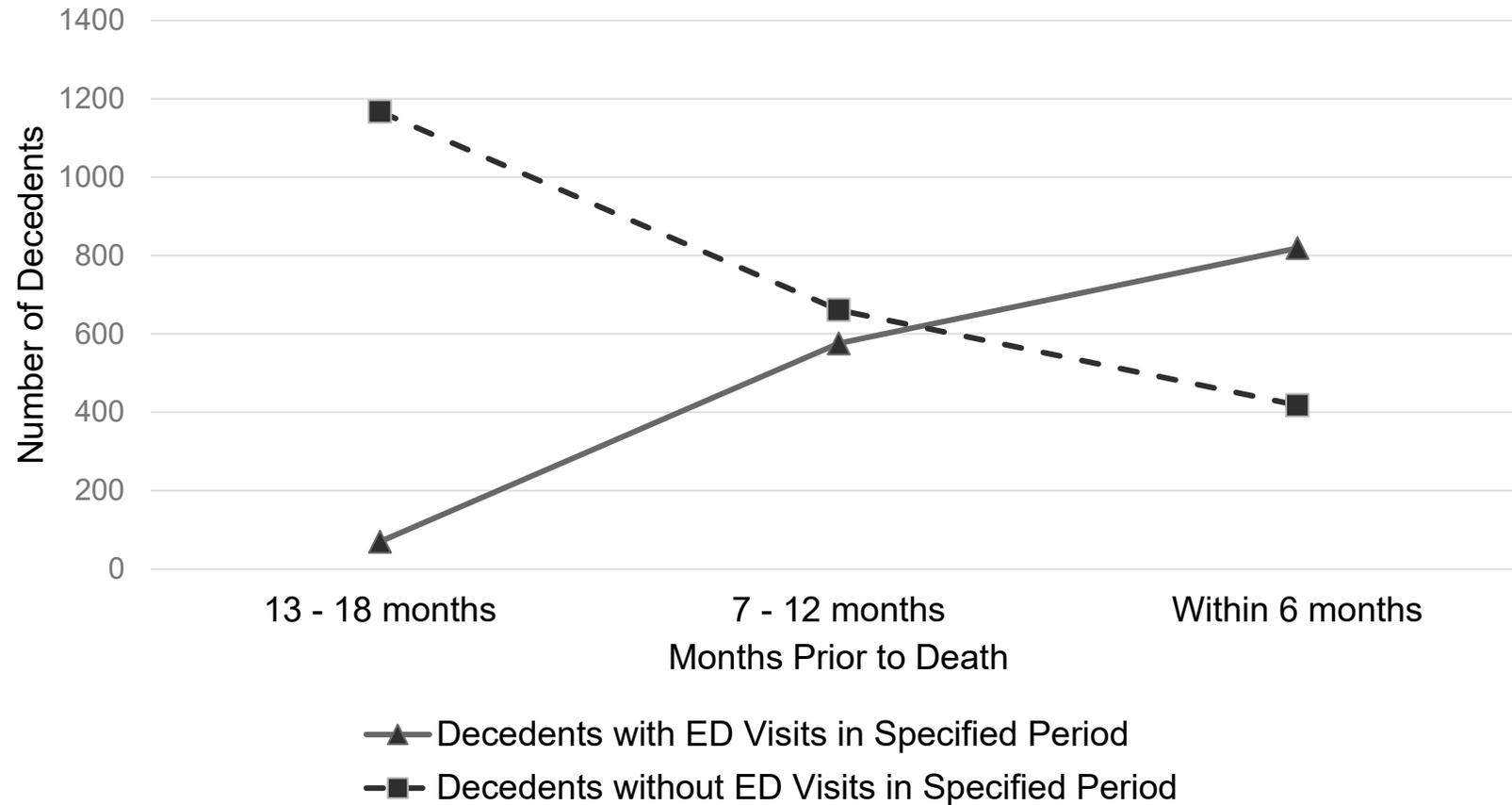
Hospital Inpatient Utilization Among August 2015 Medi-Cal only Decedents (1,237 individuals)





Emergency Department Visits

Emergency Department Visits Among August 2015 Medi-Cal Decedents (1,237 individuals)





SB 1004 Eligible Conditions

- Four eligible conditions, and patient must meet both General and Disease-Specific Criteria for any of these conditions:
 - Cancer
 - Congestive Heart Failure (CHF)
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Liver Disease
- These four conditions are the minimum; Medi-Cal managed care plans (MCPs) may authorize palliative care for patients with other conditions.



SB 1004 Palliative Care Services

1. Advance Care Planning
 2. Palliative Care Assessment and Consultation
 3. Plan of Care
 4. Pain and Symptom Management
 5. Mental Health and Medical Social Services
 6. Care Coordination
 7. Palliative Care Team
 8. Chaplain Services
 9. 24/7 Telephonic Palliative Care Support
(recommended)
- Access to Curative Care/Disease Modifying Care



Palliative Care Billing Codes

Palliative Care Service	Billing Codes
Advance Care Planning (Inpatient/Outpatient [I/O] and Hospital [H])	Evaluation and Management (E&M) codes 99497 (reimbursable twice a year before <i>Treatment Authorization Request</i> [TAR] override) & 99498 (reimbursable once a year before TAR override)
Palliative Care Assessment and Consultation (I/O)	E&M codes for counseling
Palliative Care Assessment and Consultation (H)	E&M codes 99341 – 99350 for MD/NP, or Home health for RN/LPN
Pain and Symptom Management (I/O)	Prescription drugs, physical therapy (TAR)
Pain and Symptom Management (H)	Home health physical therapy
Mental Health Services, Discharge Planning (I/O)	Individual and group psychotherapy, hospital or Nursing Facility Level B discharge planning
Mental Health Services and Caregiver Assessment/Support (H)	Medical social services within home health
Plan of Care (I/O)	E&M codes
Plan of Care (H)	Home health or E&M codes 99341 – 99350
Care Coordination (I/O)	E&M codes
Care Coordination (H)	Home health or E&M codes 99341 – 99350
Palliative Care Team (I/O)	E&M codes 99366 and 99368
Palliative Care Team (H)	Home health or E&M codes 99341 – 99350



Stakeholder Engagement and Partnership

- DHCS SB 1004 Website and Email: SB1004@dhcs.ca.gov
- Draft policy paper posted for public comment
- Several Stakeholder Meetings in 2015 and 2016
- Discussions with Providers, Managed Care Plans, Researchers, Advocates



Stakeholder Engagement and Partnership (cont'd)

- **California Health Care Foundation (CHCF):** Wide range of online materials and resources, as well as grants and in-person technical assistance events.
- **Coalition for Compassionate Care of California:** Consumer and provider resources on advance care planning and palliative care. Also frequent webinars and training programs.
- **California State University, Institute for Palliative Care:** Instructor-led and self-paced online training for health care professionals, as well as patients and families.



Provider Training

- Broad need for more training, in both:
 - Primary Palliative Care
 - Specialty Palliative Care
- State Budget in 2017-18 and 2018-19 included funds for provider training in palliative care.



Implementation

- Policy launched January 1, 2017 in Fee-for-Service and Managed Care Delivery Systems
 - Provider Bulletin with Codes
 - Managed Care All-Plan Letter
 - Managed Care Plan Palliative Care Start-Up Funding
- Managed Care Plan Performance Measures and Results
 - Collecting Provider Participation Info, and Referrals and Enrollment/Disenrollment Data
 - Results similar to other palliative care programs



Resources

- California Department of Health Care Services, SB 1004 Website:
<https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx>
- Medi-Cal Provider Bulletin: http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_26508.asp
- Medi-Cal Managed Care All-Plan Letter:
<https://www.dhcs.ca.gov/formsandpubs/Documents/MCDAPLsandPolicyLetters/APL2018/APL18-020.pdf>



Questions?

Thank you!

Contact: Anastasia.Dodson@dhcs.ca.gov



Building Effective Delivery Systems: Quality and Capacity Building

Pete Liggett, South Carolina Department of Health and Human Services

Dr. Doug Fish, New York State Department of Health

Medicaid, Healthcare Integration & Palliative Care

Pete Liggett, Ph.D., Licensed Psychologist
Deputy Director, Long Term Living
South Carolina Department of Health & Human Services

Palliative Care Benefit

- The South Carolina Medicaid program does not expressly cover a benefit titled, “Palliative Care”
- However, dually eligible (Medicare/Medicaid) can access palliative care through their Medicare benefit – for FFS beneficiaries this is difficult to navigate
- Our Medicare-Medicaid Plan MCOs cover palliative care for duals as D-SNPs using the Medicare benefit
 - SC has approximately 92,000 “Duals”
 - 15,000 enrolled in our duals demonstration
 - 1.1 million beneficiaries total

How does Palliative Care Happen

- Services can be cobbled together for any Medicaid beneficiary meeting medical necessity for...
 - Not yet hospice level
 - Pain management
 - Behavioral and mental health services
 - Incontinence Supplies
 - Home Health
 - Children's Private Duty Nursing
 - Community Choices 1915(c) Home & Community Based Services Waiver (e.g., Personal Care, Environmental Mods, Respite, etc.)
 - Any other state plan services

How does Palliative Care Happen

- Palliative Care was introduced in our Duals Demo as a “New” benefit under the demonstration.
- Center for Advanced Palliative Care provided input on messaging of benefit in 2018 member material to promote quality of life
 - Prior Language included:
 - “Advanced illness”
 - “Life-threatening injury”
 - “End-of-life”
 - New Language includes:
 - Specialized medical care for “people with serious illnesses”
 - Goal is to “improve quality of life for both the patient and family”
 - Provides “extra layer of support” to patient’s doctors
 - “Appropriate at any stage of serious illness”; can be “provided together with curative treatment”

Challenges

- Palliative care is not a well understood healthcare construct in South Carolina because it is not expressly covered.
 - Providers
 - Beneficiaries
- Palliative care IS understood by a limited number of palliative care providers who stay busy with a limited patient load
- Palliative care has had strong advocacy from the pediatrics community

The Jump to Hospice

- Hospice becomes the bundled treatment of choice
 - ...and is supposed to include an array of services including personal care and other HCBS-like services.
- However...
 - The Hospice benefit is state plan only and is an MMP carve-out
 - For 1915(c) participants, they cannot receive many of the most popular services (e.g., personal care, adult day health care, respite)
- Beneficiaries must weigh the pros and cons of using hospice.

Going Forward

- H. 4935 created the “Palliative Care and Quality of Life Study Committee.”
- Exploring the state of palliative care in SC including:
 - Education/training for healthcare professionals
 - Resources for the public
 - Services and care settings
 - Reimbursement
- By December 31, 2019, the study committee shall submit to the Governor and the General Assembly a report on the state of palliative care in South Carolina with findings and recommendations.





Department
of Health

Integrating Palliative Care in Delivery Systems

New York State DSRIP Palliative Care Projects

Agenda

- Introduction to NYS Delivery System Reform Incentive Payment (DSRIP) Program
- Overview of Palliative Care Projects
 - Project Design
 - Assessment
 - Key Takeaways
- Promising Practices
 - United Hospital Fund Report and Performing Provider System (PPS) Examples
- Palliative Care & Value Based Payment

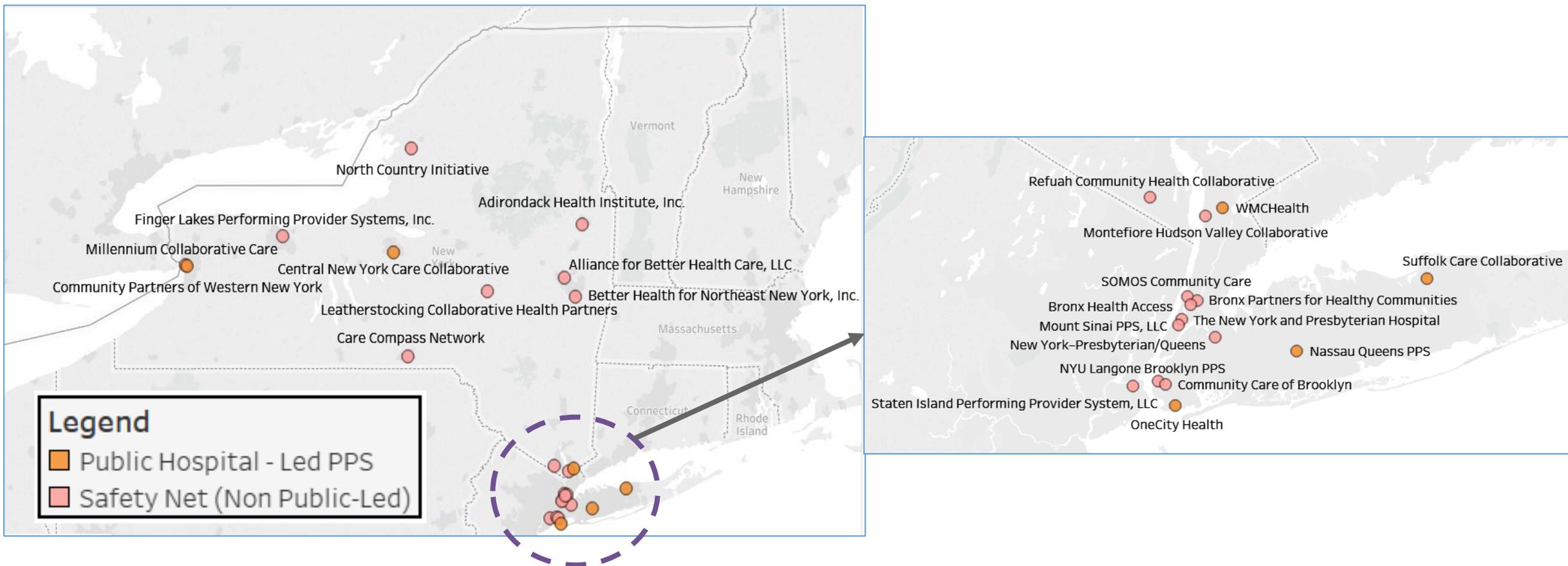
New York State DSRIP Program

August 2019

The 2014 MRT Waiver Amendment and New York State's DSRIP Goals

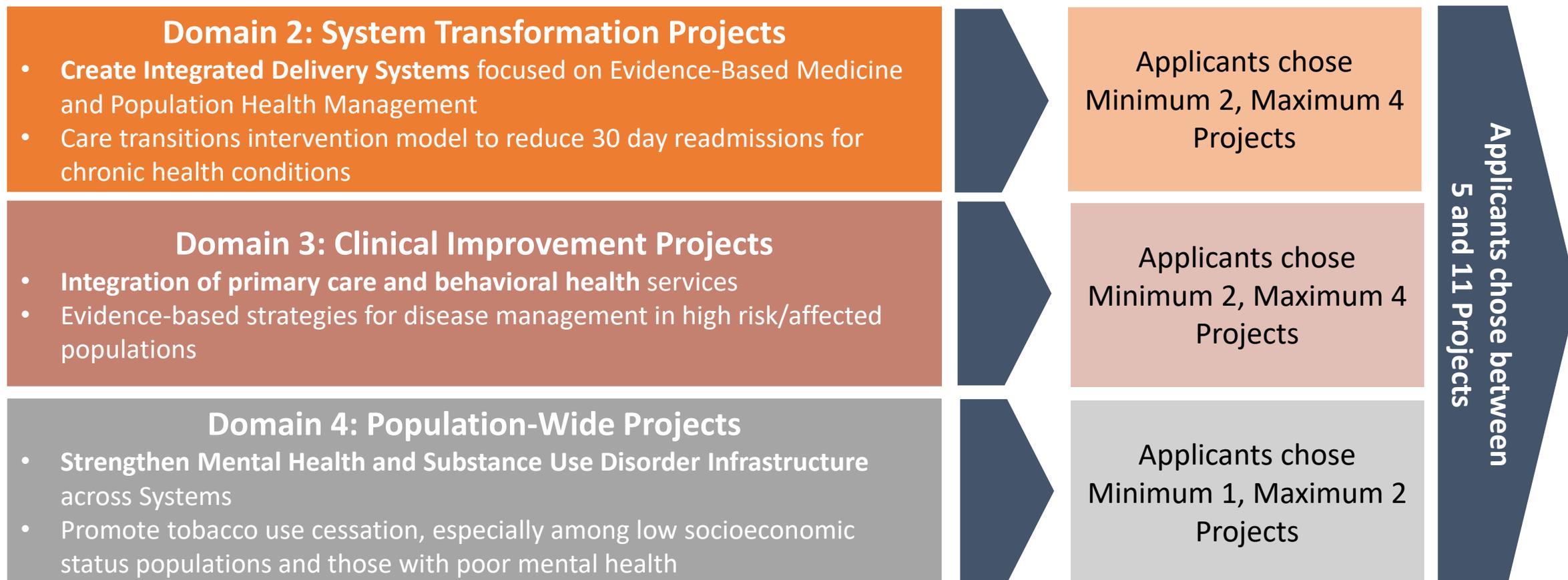
- In April 2014, Gov. Andrew M. Cuomo announced that New York State and CMS finalized the MRT Waiver Amendment
- Allowed the State to reinvest \$8 billion of \$17.1 billion in Federal savings generated by MRT reforms
 - **\$6.4 billion designated for fulfilling DSRIP Goals:**
 - ✓ **Reduce avoidable hospital admissions and emergency department use by 25% over the next 5 years**
 - ✓ **Preserve and transform the State's healthcare safety net system**

25 DSRIP Performing Provider Systems (PPS)



August 2019

Each PPS was able to select between 5 and 11 projects across 3 domains*



August 2019

*Project 2.d.i is described as ***“Implementation of patient and community activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care,”*** which PPSs could select as their 11th project.



Department of Health

11 PPS Chose a Palliative Care Project

Integration of Palliative Care into the PCMH Model (3.g.i)

- Alliance for Better Health Care
- Central New York Care Collaborative
- Leatherstocking Collaborative Health Partners
- Adirondack Health Institute
- OneCity Health
- Community Care of Brooklyn
- The New York and Presbyterian Hospital
- Care Compass Network
- Community Partners of Western New York

Integration of Palliative Care into Nursing Homes (3.g.ii)

- Staten Island PPS
- The New York and Presbyterian Hospital/Queens

“Palliative care...is an *integrated* specialty, it’s not another swim lane, so to speak.”

~ *Martha L. Twaddle, MD*¹

¹ Abbasi, J New Guidelines Aim to Expand Palliative Care Beyond Specialists. *JAMA*. 2019;322(3):193-195. doi:10.1001/jama.2019.5939

Palliative Care Projects

Project 3.g.i: Integration of Palliative Care into the PCMH Model

Project 3.g.ii: Integration of Palliative Care into Nursing Homes

August 2019

Palliative Care Projects' Aim & Measure

- **Projects aim to further integrate palliative care** into patient-centered medical home (PCMH) practices and nursing home settings.
- A tool was selected *to measure access to palliative care services* for patients most in need, *not* to evaluate the outcomes associated with palliative care interventions.
- Both projects use the **Integrated Palliative Care Outcome Scale (IPOS)**, a standardized screening tool to identify which patients are most in need of palliative care interventions.

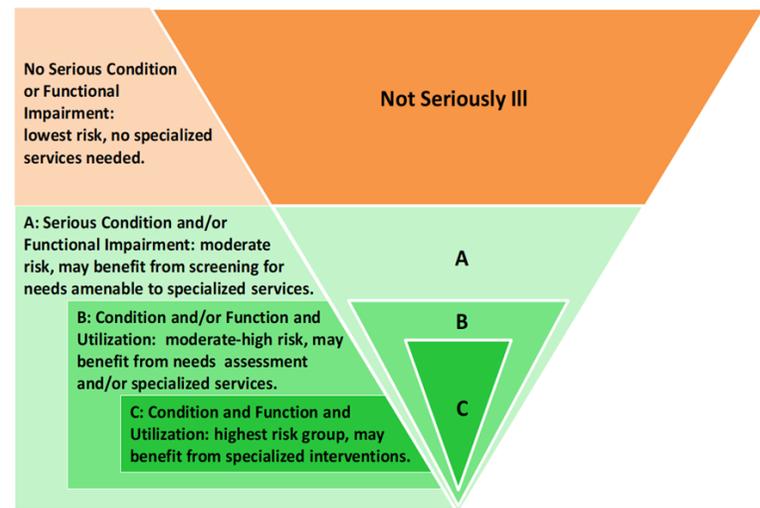
Palliative Care Project Requirements

Beyond increasing access, the project seeks to drive provider organizations to find the “right patient” in order to...

- Reduce burden – not all high-cost/high-need patients need palliative care

- Emphasize the use of screening tools, many of which can draw from data in the Electronic Health Record

Figure 1: Three Definitions of Serious Illness, Ranging from Broad to Restrictive



Kelley AS, et. al., Identifying Older Adults with Serious Illness: A Critical Step toward Improving the Value of Health Care, *Health Services Research* 18 MAR 2016

... this secondary goal drove several project implementation requirements including to:

- Require project managers to identify & engage appropriate providers;
- Develop partnerships with community-based resources;
- Develop and/or adopt clinical guidelines agreed to by all partners;
- Train staff to increase role-appropriate competence in palliative care skills;
- Engage with Medicaid Managed Care to address coverage of services; and
- Monitor progress through a quality committee.

History of Measure Selection

- **Initial measure choice was Uniform Assessment System – NY (UAS-NY), but an issue was identified early on:**
 - Very little overlap between PPS target population for Palliative Care and the population captured in UAS-NY Long-Term Care and Community-Based programs
 - Measures available in UAS-NY addressed pain management, depression, and advanced directives, but did not include other areas relevant to goals for palliative care. The assessment also took 4 hours to complete per patient
- **Updated the measure, choosing the IPOS**
 - The state needed a mechanism through which standardized data could be captured, results could be accounted for, & incentive dollars could be paid out.
 - A literature search was performed, and the POS tools emerged as most closely aligning with program intents.

Why the Integrated Palliative care Outcome Scale (IPOS)?

- What is the tool?
 - A 10-item questionnaire to assess patient's physical symptoms, psychological, emotional, and spiritual needs
 - Widely used in palliative care projects across the US and internationally
- Moving from POS to IPOS
 - DOH collaborated with the Cicely Saunders Institute to better understand the benefits of IPOS
 - Greater focus on symptom identification & less emphasis on look-back period
- Correlation between the survey tool and P4P measure
 - Three questions measure across four domains in projects 3.g.i and 3.g.ii, and a fifth (Pain) was added:
 - Physical symptoms
 - Depression
 - Peacefulness
 - Completion of advance directives

Crosswalk between POS/IPOS & Project Measures

POS	IPOS
Q1. Over the past 3 days, have you been affected by pain?	Q2. Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick one box that best describes how it has affected you over the past week:
Q2. Over the past 3 days, have other symptoms e.g. nausea, coughing or constipation seemed to be affecting how you feel?	
Q7. Over the past 3 days, have you felt that life was worthwhile?	Q5. Have you been feeling depressed?
Q8. Over the past 3 days, have you felt good about yourself as person?	Q6. Have you felt at peace?

IPOS Implementation

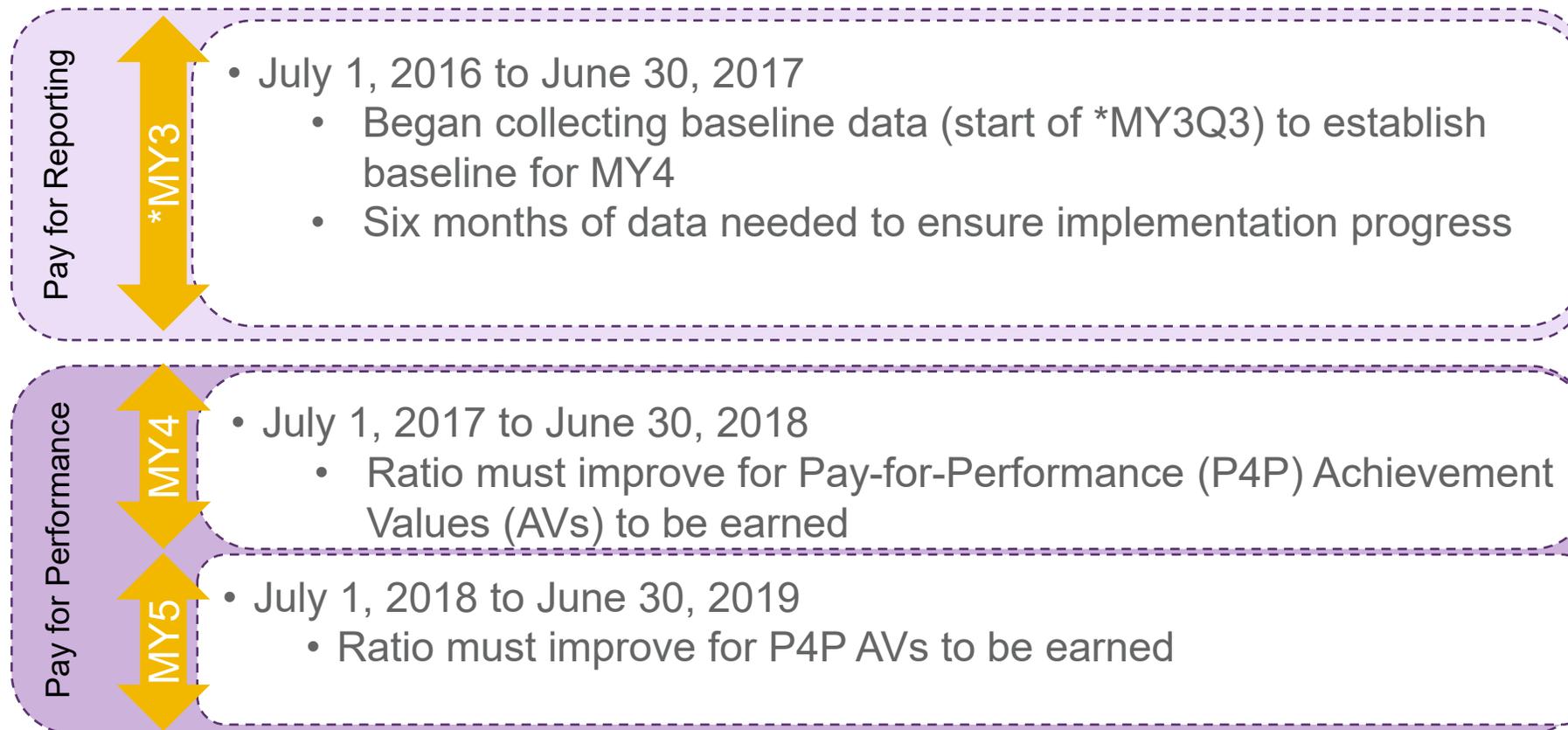
Versions

- Two of the three versions of the IPOS acceptable:
 - the patient version (self-administered or administered by a family member/caregiver) and
 - the staff version

Frequency of administration

- After baseline established, assessments should be conducted at least every six months
- Assessments should be additionally administered when a patient:
 - Enters a palliative care treatment regimen (or as soon as possible if already participating)
 - Experiences a significant change in patient status (defined as changes to the patient's care plan, such as hospitalization, changes in home care needs, independent living status)

Implementation Timeline



Audit Protocol:

- During MY3-5 PPS must audit 10% of all completed assessments
- Self-audit done - if lower than 75% accuracy, a full audit of all completed assessments by the independent assessor would be triggered

*MY - Measurement Year

August 2019

A Forum for Shared Learning was Established

The Center for Advanced Palliative Care (CAPC)
and the
Hospice and Palliative Care Association of New York State
(HP-CANYS)
established a DSRIP Palliative Care Forum

- Convene PPSs implementing 3.g projects
- Share challenges, solutions, lessons learned
- Provide resources to support implementation
- Highlight NYS Hospices' available expertise
- Draw on best practices in other parts of the country



- Telephone town-halls and discussion groups



- Webinars to share best practice and implementation efforts



- Program updates and policy changes

August 2019

Assessing Project Progress

Performance Questions

- **Q2.** Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick one box that best describes how it has affected you over the past week:
- **Q5.** Have you been feeling depressed?
- **Q6.** Have you felt at peace?
- **Q11.** Check all advance directives known to have been completed:

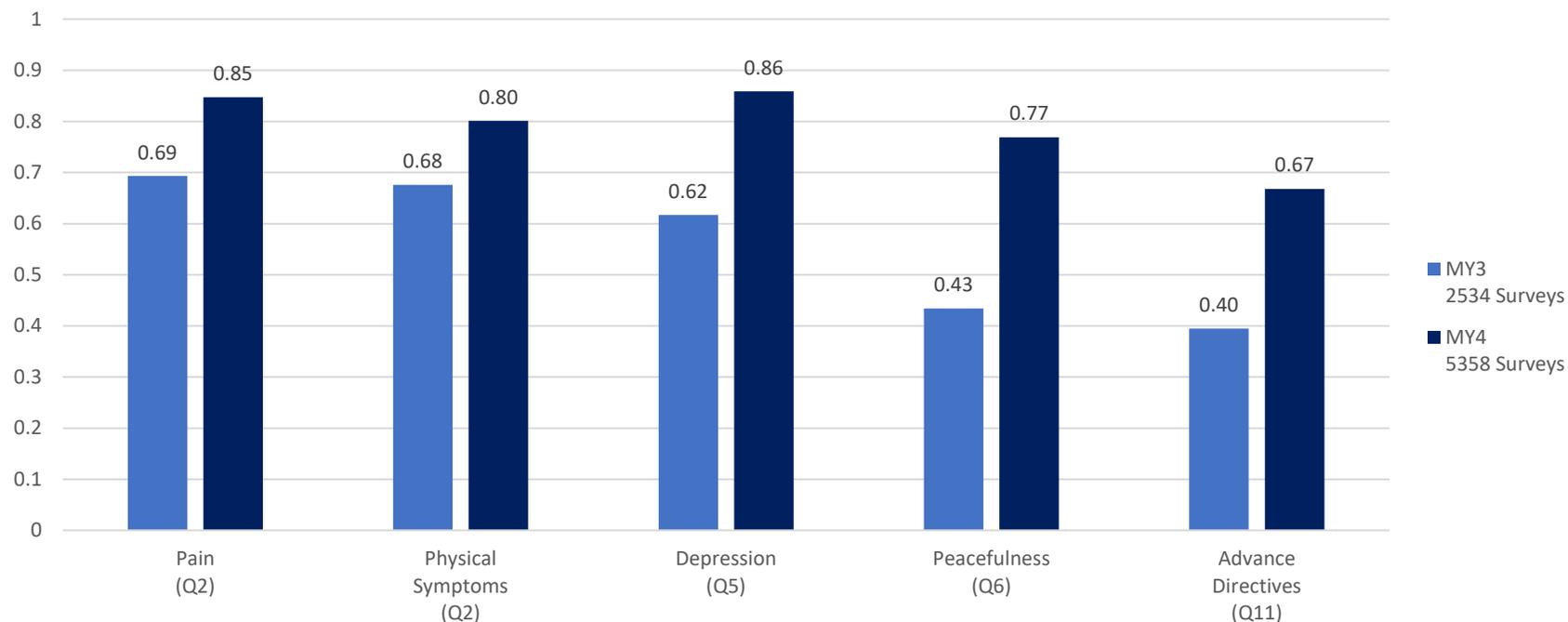
Assessment Method and AVs

- Five measures: Pain (Q2), Physical symptoms (Q2), Depression (Q5), Peacefulness (Q6), and completion of advance directives(Q11) align with an IPOS question
- Numerator is # of patients offered or provided an intervention for the “symptom”
- Denominator is # of patients whose response to the assessment indicated the need for such intervention
- Achievement Value is earned if ratio of current measurement year result to baseline is greater than 1

IPOS Measure Results

July 2016 – June 2018 (MY3 – MY4)

- All 5 measures improved at statewide level
- All 11 PPS earned Achievement Value indicating improvement on at least one of the measures



August 2019

Project Key Takeaways

- PCMH can be an opportune setting to identify those patients most appropriate for palliative care
 - Patient has an established relationship with a trusted provider
 - PCMH focuses on cultural competency and health literacy, especially important for sensitive palliative care consultations
 - Resources are in place (care coordinators/managers) to manage care plans
- Need to be realistic about the time needed to engage in dialogue on palliative care and advance directives
- Access to Medicare claims data needed to analyze full benefit
- Misconceptions persist
 - Some may view a palliative care referral as an indication that the treatment (or the treating provider) has failed
 - On-going patient and provider education is needed

Promising Practices & Paying for Value-Based Care

August 2019

UHF Report on DSRIP Promising Practices

Press Release: NEW YORK, NY—July 16, 2019—Four years into a groundbreaking overhaul of its Medicaid program, New York has laid the groundwork for improving health care access, quality, and costs well beyond 2020 if it continues to expand on the practices implemented to date, according to a report released today by United Hospital Fund (UHF) and funded by the New York State Department of Health.

- Link to full press release: <https://uhfnyc.org/news/article/nys-medicaid-reform-efforts-can-improve-health-care-outcomes-well-beyond-2020/>
- Link to report: DSRIP Promising Practices: Strategies for Meaningful Change for New York Medicaid - <https://uhfnyc.org/publications/publication/dsrip-promising-practices/>

NY Presbyterian Queens PPS¹

- Partnership between New York Presbyterian Queens PPS and Silvercrest Nursing Home
 - Silvercrest's hospital readmission rate was one of the highest among the 27 SNFs that formed the PPS' long-term care committee. The committee sought to improve readmission rates and other long-term care related quality metrics.
- Implemented a Palliative Care educational program using CAPC modules and in person sessions with NPs to educate patients, families and providers at Silvercrest.
 - Increased awareness and understanding of “Goals of Care consultations” and relevance of such consultations to reducing readmissions.
- Developed SNF protocols for common clinical decisions around evaluation, management, and transport and by implementing more systematic palliative care referrals.
- The PPS reports that, as a result of these activities, Silvercrest's hospital readmission rate decreased from 31% (in January-March 2018) to 23% (in April-November 2018)

¹ New York Presbyterian Queens PPS. February 2019. DSRIP Learning Symposium Poster. Available at: http://www.dsriplearning.com/documents/presentations/posters/RPPH23_Hospital%20and%20Skilled%20Nursing%20Facility%20Collaboration%20to%20Reduce%20Palliative%20Services%20Related%20Readmissions.pdf

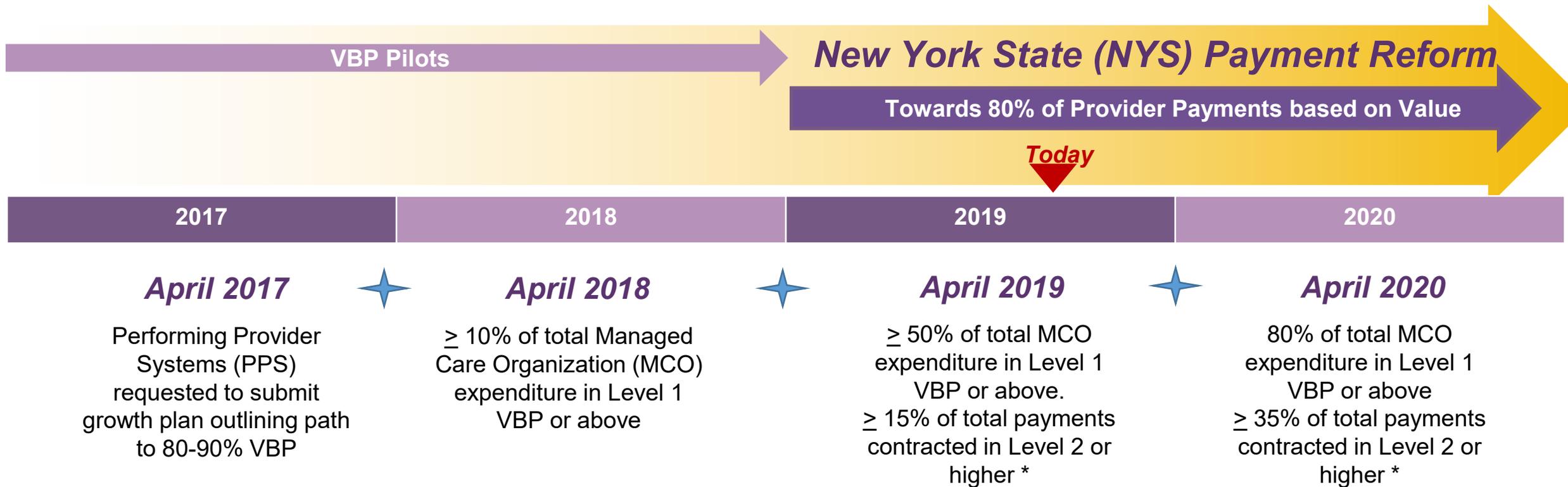
State University of New York (SUNY) Upstate MAX Project²

- SUNY Upstate anchors the Central New York Care Collaborative (CNYCC) PPS
- MAX = “Medicaid Accelerated Exchange” model for rapid cycle continuous improvement
- Project focused on high utilizers
 - Unmet palliative care needs were found to be a driver of high utilization
 - Developed care pathways that included warm-handoffs to Health Homes, home care agencies, and other community partners, and developed improved process for inpatient palliative care referrals
- From March to May of 2017, reduced high utilizer inpatient admissions by 15%

² New York State Department of Health. 2018. MAX Series Case Studies, January-July 2017. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/max/docs/2017-jan-jul_max_case_studies.pdf

Palliative Care and Value Based Payment

- Financial incentives provided through DSRIP have increased access to palliative care.
- Palliative Care would be incorporated into a value-based payment model.



August 2019



Questions

August 2019

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Department
of Health



State Strategies for Promoting Palliative Care and Increasing Awareness

Stacie Sinclair, *Center to Advance Palliative Care*

Ginny Weir, *Bree Collaborative*

Increasing Access to Palliative Care – Current Landscape and Opportunities

Stacie Sinclair, MPP, LBSW
Senior Policy Manager
Center to Advance Palliative Care

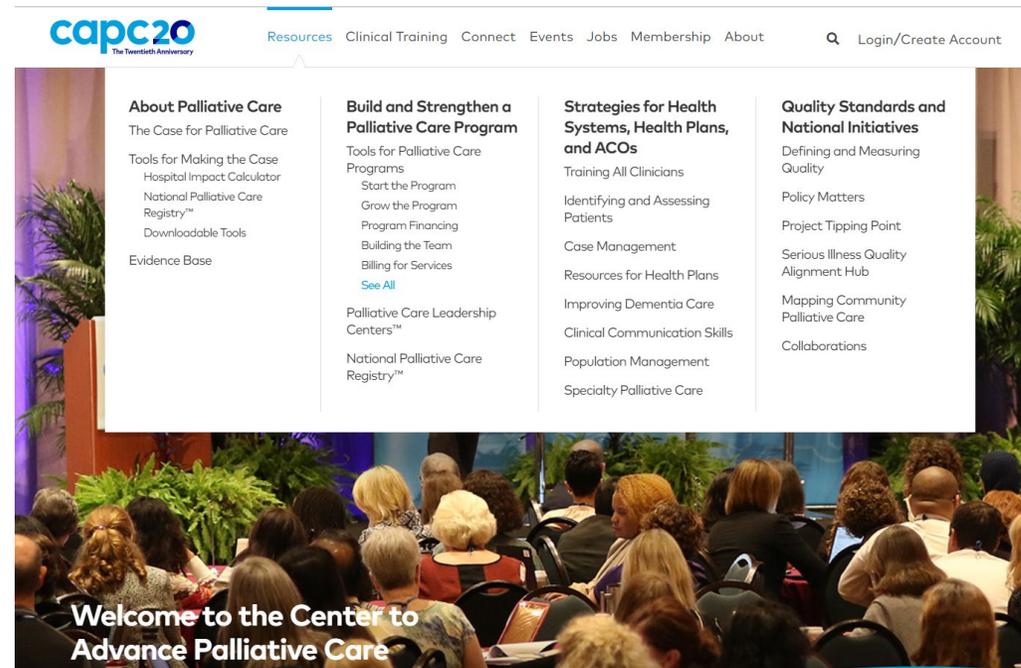


About CAPC

- The Center to Advance Palliative Care (CAPC) is a national, member-based organization that supports hospitals, health systems, hospices, payers, and other health care organizations with the implementation and integration of palliative care
- We do this by:
 - Providing training, tools, and technical assistance
 - Serving as a convening, organizing, and dissemination force for the field
 - Promoting public awareness of palliative care
 - Collecting and providing essential metrics

Our Strategies to Scale Palliative Care Access Nationwide

- Operational Training
- Clinical Training
- Research
- Payment
- Policy
- Public Awareness



Palliative Care Barriers

- It is estimated that fewer than 5% of people living with a serious illness who could benefit actually receive care informed by palliative care principles and practices
- Barriers include:
 - Lack of training of frontline clinicians in the core skills of communication, symptom management, and family support over time
 - Unreliable financing
 - Deficits in the specialist workforce
 - **Persistent misunderstanding of palliative care**
 - Lack of oversight, particularly in home-based palliative care

Starting Point: Messaging Palliative Care

CAPC Public-Facing Definition Supported by Public Opinion Research	National Consensus Project Definition	CMS Definition
<p>Palliative care (pronounced pal-lee-uh-tiv) is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.</p> <p>Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient’s other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient’s prognosis. This care is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.</p>	<p>Interdisciplinary care delivery system designed for patients, their families and caregivers</p> <p>Beneficial at any stage of a serious illness</p> <p>Anticipates, prevents, and manages physical, psychological, social, and spiritual suffering to optimize quality of life</p> <p>Delivered in any care setting through the collaboration of many types of care providers</p> <p>Improves quality of life for both the patient and the family through early integration into the care plan</p>	<p>“Palliative care” means 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 and to facilitate patient autonomy, access to information, and choice.</p>

Key Challenge – Messaging Palliative Care (2011)

General Public

- Majority of public does not know what palliative care is; from 2011 polling:
 - Plurality of adults 25+ did not recognize the term
 - Phrase “palliative care and supportive services” viewed more positively than “palliative care” alone
 - Often confused with “hospice” and “end-of-life care”
 - How palliative care is defined has a big impact on how people feel about palliative care
- Once informed, 92% of consumers felt positively about palliative care and reported a high likelihood of wanting to access if they or a loved one had a serious illness

Clinicians

- Also have misconceptions regarding palliative care and end-of-life care (“You’re not ready for palliative care”); alternately
 - Think services are limited to advance care planning or pain clinic services
 - Think they are already providing this kind of care
 - Limited understanding of how palliative care can contribute
- Leads to late or inappropriate referrals
- Requires persistence, data on referred patient outcomes (time-consuming)

2019 National Survey - Methodology

- National telephone survey: A total of 800 adults age 25+ oversampling to reach n=347 65+ years
- National online survey: 252 patients with a serious illness and 262 family caregivers of patients with serious illness
- National online survey: 317 physicians who treat patients with serious illness (207 hospital-based/110 non-hospital-based)

2019 National Survey – Public

→ Palliative care is still relatively unknown among the general public

PALLIATIVE CARE IMAGE RATING (Scale: 1=very unfavorable, 50=neutral, 100=very favorable)	Adults Age 25+		Adults Age 65+	
	Palliative Care		Palliative Care	
	<u>2011</u>	<u>2019</u>	<u>2011</u>	<u>2019</u>
Mean Rating	57	60	62	62
%Not Able to Rate	42%	38%	50%	42%

2019 National Survey – Public

- Initial impressions of palliative care are positive to neutral
- Patients and caregivers report higher levels of familiarity than the general public

PALLIATIVE CARE IMAGE RATING (Scale: 1=very unfavorable, 50=neutral, 100=very favorable)	Adults Age 25+	Adults Age 65+	Patients	Caregivers
Mean Rating	60	62	59	57
%Not Able to Rate	38%	42%	9%	10%

2019 National Survey – Public

- Sub-groups least familiar with palliative care are men, rural residents, those in lower income households and with lower levels of education. Those sub-groups who have the most favorable opinion of palliative care initially are older women and adults with higher levels of education.

**Top Sub Groups –
Unable to Rate Palliative Care (Adults)
(38%)**

Men Less than College	50%
Men Income Less than \$60K	46%
High School or Less	45%
No Serious Illness in Household	44%
Rural	44%
Some College	44%
Republicans	44%
Income \$40K-\$60K	44%
Men	43%

**Top Sub Groups –
% Rating 80-100 Palliative Care
(Adults)
(19%)**

Post Graduates	34%
Women Ages 45-64	28%
Women College+	27%
Women Ages 65+	26%
Republican Women	26%
Women	24%
Homemakers	24%
Pacific Region	24%
Strong Democrats	24%
Retired	23%

2019 National Survey – Public

→ Use of the previous definition has a significant positive impact on how the public feels about palliative care

PALLIATIVE CARE IMAGE RATING (Scale: 1=very unfavorable, 50=neutral, 100=very favorable)	Adults Age 25+		Adults Age 65+		Patients		Caregivers	
	%Rating 80-100	Mean	%Rating 80-100	Mean	%Rating 80-100	Mean	%Rating 80-100	Mean
Initial Rating	19%	60	21%	62	29%	59	24%	57
Informed Rating	49%	72	51%	74	51%	73	51%	73
Net Difference	+30	+12	+30	+12	+22	+14	+27	+16

2019 National Survey – Public

→ More than eight in ten consumers say they would be likely to consider palliative care for themselves or a loved one if they had a serious illness.

<u>Likely to Consider Palliative Care</u>	Adults Age 25+	Adults Age 65+	Patients	Caregivers
%Very Likely	62%	61%	41%	51%
%Total Likely	90%	87%	86%	89%
%Total Not Likely	8%	8%	14%	11%

2019 National Survey – Public

→ After hearing the palliative care definition, substantial majorities of consumer audiences agree with these premises about palliative care:

<i>%Total Agree – Ranked by Patients</i>	Adults Ages 25+	Adults Ages 65+	Patients	Caregivers
Palliative care treatment options should be fully covered by health insurance.	90%	90%	96%	93%
It is important that patients with a serious illness and their families be educated that palliative care is available to them together with curative treatment.	97%	93%	96%	93%
Doctors who treat patients with a serious illness should refer these patients to palliative care when the patient is experiencing difficult-to-manage pain or other symptoms	87%	86%	94%	93%
Palliative care should be available to patients with a serious illness based on a patient's need, not based on their prognosis.	87%	87%	93%	90%

2019 National Survey – Public

- Palliative care messages that score well with the public:
- Providing the best **quality of life**
 - **Relief from symptoms, pain, and stress**
 - Appropriate at **any age** and providing the care **alongside curative treatment**
 - **Matching treatment options to patient goals**
 - A **team approach** to care
 - Providing an **extra layer of support**

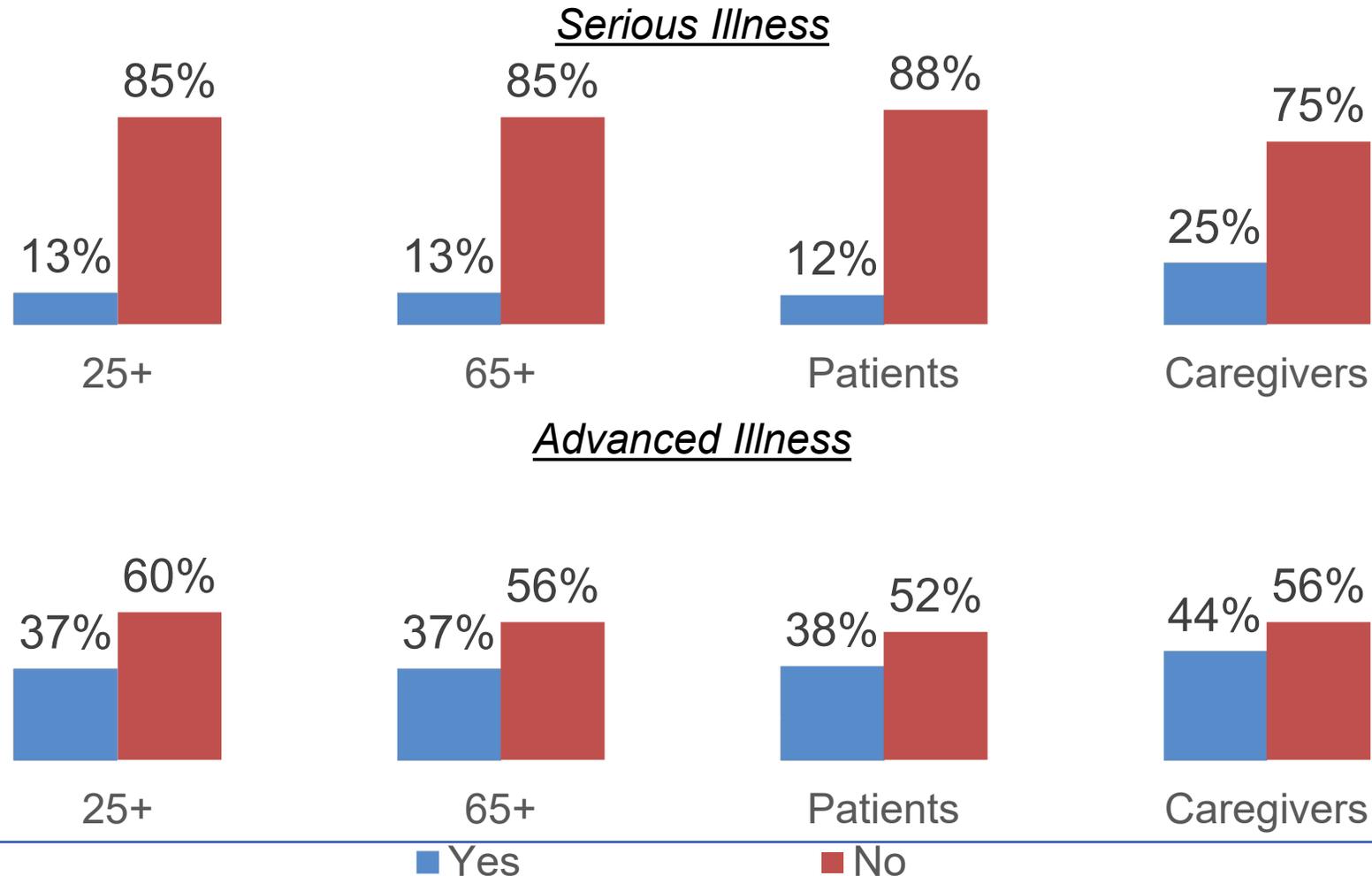
2019 National Survey – Public

	Pre-Definition (Average)	Post-Definition (Average)	Post-Messages (Average)
Age 25+	60	72	81
Age 65+	62	74	81
Patients	59	73	81
Caregivers	57	73	79

[0: very unfavorable 50: neutral 100: very favorable]

2019 National Survey – Public

→ Data continue to show that palliative care should be positioned as care for patients with serious illness but NOT advanced illness. Advanced illness is perceived to be more closely aligned with terminal illness



2019 National Survey – Public

- How we talk about palliative care influences perceptions of palliative care
- Attitudes become significantly more favorable as people are educated
- The more educated consumers become, the more likely they are to say they would consider palliative care for themselves or a loved one (this is particularly true among patients and caregivers)

2019 National Survey – Physicians

→ Physicians who treat patients with serious illness are much more familiar with palliative care and have much more favorable views of palliative care than the general public, patients and caregivers.

INITIAL PALLIATIVE CARE IMAGE RATING (Scale: 1=very unfavorable, 50=neutral, 100=very favorable)	Adults Age 25+	Adults Age 65+	Patients	Caregivers	Physicians
Mean Rating	60	62	59	57	82
%Rating 80-100	19%	21%	29%	24%	72%
%Not Able to Rate	38%	42%	9%	10%	0%

2019 National Survey – Physicians

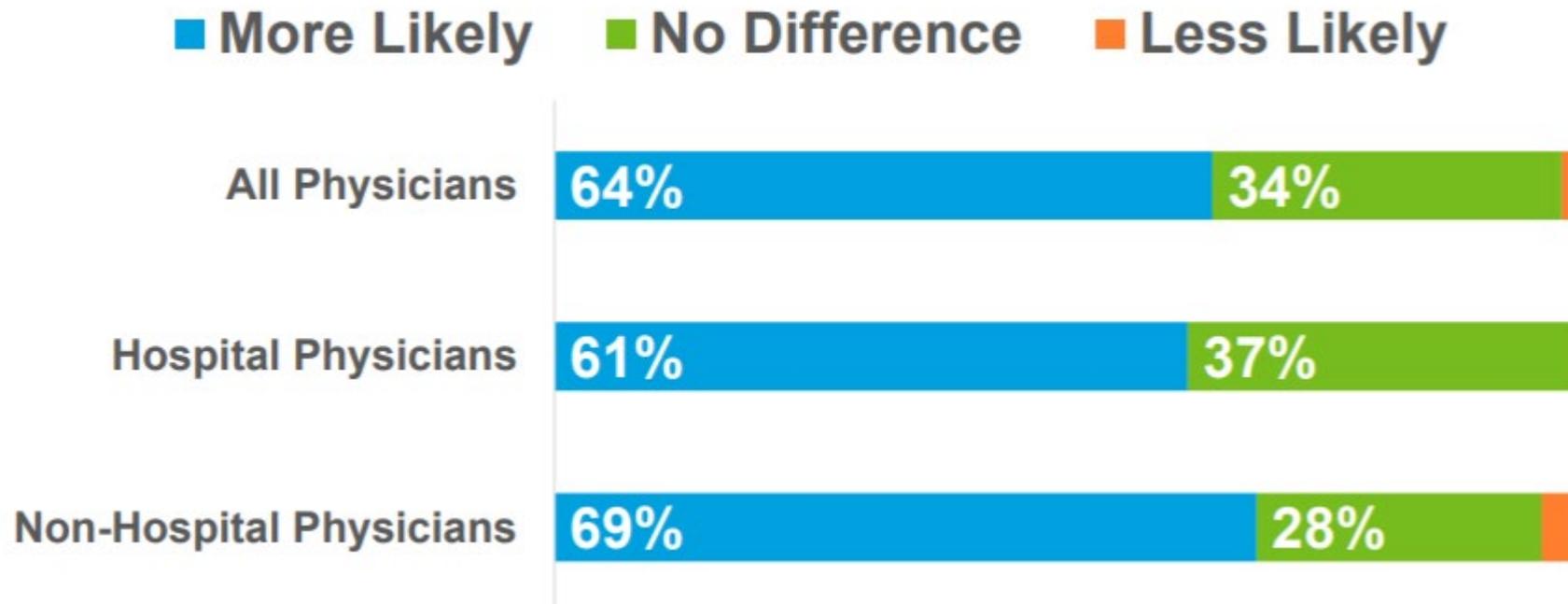
- Unfortunately, downstream referral criteria:
- Illness no longer curable, or no viable treatment options available – the priority is comfort
 - Patient has a prognosis of less than six months
 - Patient has a terminal illness
 - Patient has frequent hospitalizations or ICU stays
 - If they ask for palliative care
 - When pain medications are no longer effective
 - When a patient has worsening symptoms or heart failure

2019 National Survey – Physicians

	1 st Choice	Combined Choice
Patients not wanting palliative care	17%	40%
Physicians not being comfortable talking with patients and families about palliative care	17%	41%
Physicians view palliative care as ONLY end of life care	14%	44%
Lack of or inadequate palliative care services and professionals available	10%	31%
Lack of awareness about what palliative care options are available for patients	10%	31%
Competing treatment priorities, needing to address and treat serious illness first	9%	25%
Lack of knowledge about the criteria used to determine when to refer patients to palliative care	6%	25%
Lack of knowledge and familiarity with palliative care	6%	23%
Physicians concern that palliative care providers are not experts in all serious illnesses	4%	11%
Not sure if palliative care is covered by insurance	3%	11%
Physicians feel referring to palliative care would give up control of the patient's care	3%	17%
Other	1%	1%

2019 National Survey – Physicians

→ After reading the definition of palliative care, physicians were more likely to say they would refer



2019 National Survey – Physicians

→ Messages that resonated:

- The palliative care team devotes **time to intensive family meetings and patient/family counseling** which helps relieve burdens on referring physicians' time.
- Palliative care **improves patient and family satisfaction** with their care. Patients receiving hospital-based palliative care rate the quality of care higher than patients who do not receive palliative care.
- Palliative care leads to **better outcomes** including improvement in symptoms, quality of life, patient satisfaction and reduced caregiver burden.
- Palliative care **improves the quality of life** for patients and families struggling with **serious illnesses that they might live with for years**, including heart and lung disease, complications of diabetes, cancer, and kidney and Alzheimer's disease.
- The palliative care team provides specialist-level **consultation** with the **complex physical and emotional symptoms** patients experience, including difficult-to-treat pain, depression, anxiety, fatigue, shortness of breath, constipation, nausea, loss of appetite, and difficulty sleeping.
- Palliative care **reduces ICU utilization and decreases 30-day re-admission** rates by 48% for inpatient and 50% for 31 outpatient care.

2019 National Survey – Physicians

→ Nearly all physicians agree that:

<i>Ranked by %Strongly Agree</i>	%Strongly Agree	%Total Agree
Palliative care treatment options should be fully covered by health insurance	80%	93%
It is important that patients with a serious illness and their families be educated that palliative care is available to them together with curative treatment	75%	94%
Palliative care should be available to patients with a serious illness based on a patient's need, not based on their prognosis	60%	94%
Doctors who treat patients with a serious illness should refer these patients to palliative care when the patient is experiencing difficult-to-manage pain or other symptoms	53%	91%

South Dakota Focus Groups

- In 2018, HRSA awarded South Dakota funding to establish a palliative care network under its “Rural Health Network Development Planning Grant Program;” leads:
 - Avera Sacred Heart Health Services
 - American Cancer Society
 - Regional Health Rapid City Hospital
- Among several deliverables, the team conducted six focus groups to better understand the needs and views of palliative care among patients and providers

Perceptions of Palliative Care In SD

Prominent Issues

- Palliative care is a poorly understood concept by healthcare team members, patients, family members and caregivers, leading to prevention of services offered by healthcare teams and acceptance of such services by patients, family and caregivers
- Lack of resources, including insufficiently trained staff, and a resistance to offer complete services due largely to payer reimbursement constraints inhibits palliative care services spreading statewide
- A large inattention to the toll of both enduring a serious illness and the stress of caring for an individual.

Perceptions of Palliative Care In SD

Primary Themes

- Poor conceptual understanding and awareness
- Need for guidance toward the development of a complete and holistic statewide palliative care model
- Insufficient resources to implement complete care model in all SD communities
- Disparities in the availability and provision of care services in rural SD communities
- Need for relationship and connection with a palliative care team
- Secondary effects of palliative care on patients/family/ caregivers and healthcare team members

2019 National Survey – Conclusions

- Continued message confusion – why is this the case?
 - Proximity of words can be dangerous
 - Social media 101 – don't define something by what it's not (provide positive messages instead)
 - Hospice has a much clearer brand
- Support efforts to stay on message
 - When people see audience-tested definitions and messages, they want palliative care
 - Reinforce the definition by not introducing it at the same time as end-of-life language. Make it clear that palliative care is based on need, not prognosis
 - Message discipline and alignment is essential to improve awareness and favorability of palliative care

Takeaway – Public Messaging

	25+	65+	Patients	Caregivers
The goal of palliative care is to relieve suffering and provide the best possible quality of life	29%	30%	49%	45%
The palliative care team spends time with a patient and their family to help match treatment options to their goals	23%	25%	17%	26%
It helps coordinate a patient's care and helps them navigate the medical system	19%	17%	12%	13%
Studies have shown that patients who receive it live longer	18%	11%	21%	18%
It is appropriate at any age and at any stage in a serious illness	18%	17%	15%	15%
It is about treating the patient as opposed to the disease	17%	16%	16%	21%
It provides patients with relief from symptoms, pain, and stress	16%	13%	31%	26%
It is available to patients with a serious illness regardless of their prognosis	14%	13%	16%	10%
It is a team approach to provide an extra layer of support	12%	10%	10%	11%
It can be provided together with curative treatment	9%	10%	10%	10%
None Of These	3%	3%	1%	3%

Takeaway – Provider Messaging

<i>Ranked by Much More Likely</i>	Much More Likely	Total More Likely
The palliative care team devotes time to intensive family meetings and patient/family counseling which helps relieve burdens on referring physicians' time.	66%	92%
Palliative care improves patient and family satisfaction with their care. Patients receiving hospital-based palliative care rate the quality of care higher than patients who do not receive palliative care.	65%	95%
Palliative care improves the quality of life for patients and families struggling with serious illnesses that they might live with for years, including heart and lung disease, complications of diabetes, cancer, and kidney and Alzheimer's disease.	65%	91%
Palliative care leads to better patient and caregiver health outcomes including improvement in symptoms, quality of life, patient satisfaction and reduced caregiver burden.	65%	92%
The palliative care team provides specialty-level assistance with the complex physical and emotional symptoms patients experience, including difficult-to-treat pain, depression, anxiety, fatigue, shortness of breath, constipation, nausea, loss of appetite, and difficulty sleeping.	63%	91%
Palliative care reduces ICU utilization and decreases 30-day re-admission rates by 48% for inpatient and 50% for outpatient care.	62%	92%

Messaging Do's and Don'ts

DO	DO NOT
<ul style="list-style-type: none"> • Use field-supported definition and messaging • Use “Palliative care is based on need, not prognosis” 	<ul style="list-style-type: none"> • Do not define palliative care by how it is not hospice, or how it is different from hospice • Do not use end of life language when describing palliative care
<ul style="list-style-type: none"> • Living with a serious illness 	<ul style="list-style-type: none"> • End of life, death, dying
<ul style="list-style-type: none"> • Palliative Care • Pal Care (with one “l”) 	<ul style="list-style-type: none"> • PC • Pall Care
<ul style="list-style-type: none"> • Palliative care specialist • Non-palliative care specialist 	<ul style="list-style-type: none"> • Primary • Generalist
<ul style="list-style-type: none"> • Serious illness • Illnesses such as . . . • Care of serious illness 	<ul style="list-style-type: none"> • Advanced illness/advanced illness care • Serious illness care
<ul style="list-style-type: none"> • People/person living with a serious illness 	<ul style="list-style-type: none"> • The seriously ill
<ul style="list-style-type: none"> • Skills in x, y, z (e.g., complex pain and symptom management, communication skills, etc.) 	<ul style="list-style-type: none"> • Primary palliative care skills

GetPalliativeCare.org

The screenshot shows the homepage of GetPalliativeCare.org. At the top, there is a navigation bar with the logo "GET PALLIATIVE CARE" in orange and blue. To the right of the logo are menu items: "What Is It", "Is It Right for You", "How to Get It", "Blog", and "Resources". Below the navigation bar is a large photograph of an elderly woman and a young girl smiling together. Overlaid on the right side of the photo are two buttons: a blue button that says "Access the Provider Directory" and a purple button that says "Handout for Patients and Families" with a document icon. Below the photo is a paragraph of text: "Are you or a loved one living with a serious illness? Palliative Care can help. Palliative care is specialized medical care focused on relieving the symptoms and stress of a serious illness. It is appropriate at any age and at any stage, and you can have it along with curative treatment. The goal is to improve your quality of life." Below this text is a section titled "The Latest" with sub-links for "Articles & Stories", "Videos", "Podcasts", "Webinars", and "News". There are two article cards displayed. The first card is titled "Living Well With Lung Cancer – Palliative Care Can Help", dated August 14, 2019, and written by Andrew Esch, MD. The second card is titled "Coping Strategies and Resources for Family Caregivers", dated August 5, 2019, and also written by Andrew Esch, MD.

GET PALLIATIVE CARE

What Is It ▾ Is It Right for You How to Get It ▾ Blog ▾ Resources ▾

Access the Provider Directory

Handout for Patients and Families

Are you or a loved one living with a serious illness? Palliative Care can help. Palliative care is specialized medical care focused on relieving the symptoms and stress of a serious illness. It is appropriate at any age and at any stage, and you can have it along with curative treatment. The goal is to improve your quality of life.

The Latest

Articles & Stories Videos Podcasts Webinars News

Living Well With Lung Cancer – Palliative Care Can Help
AUGUST 14, 2019
By Andrew Esch, MD

Coping Strategies and Resources for Family Caregivers
AUGUST 5, 2019
By Andrew Esch, MD

Stacie Sinclair, MPP, LBSW
Senior Policy Manager
stacie.sinclair@mssm.edu
www.capc.org

THANK YOU!

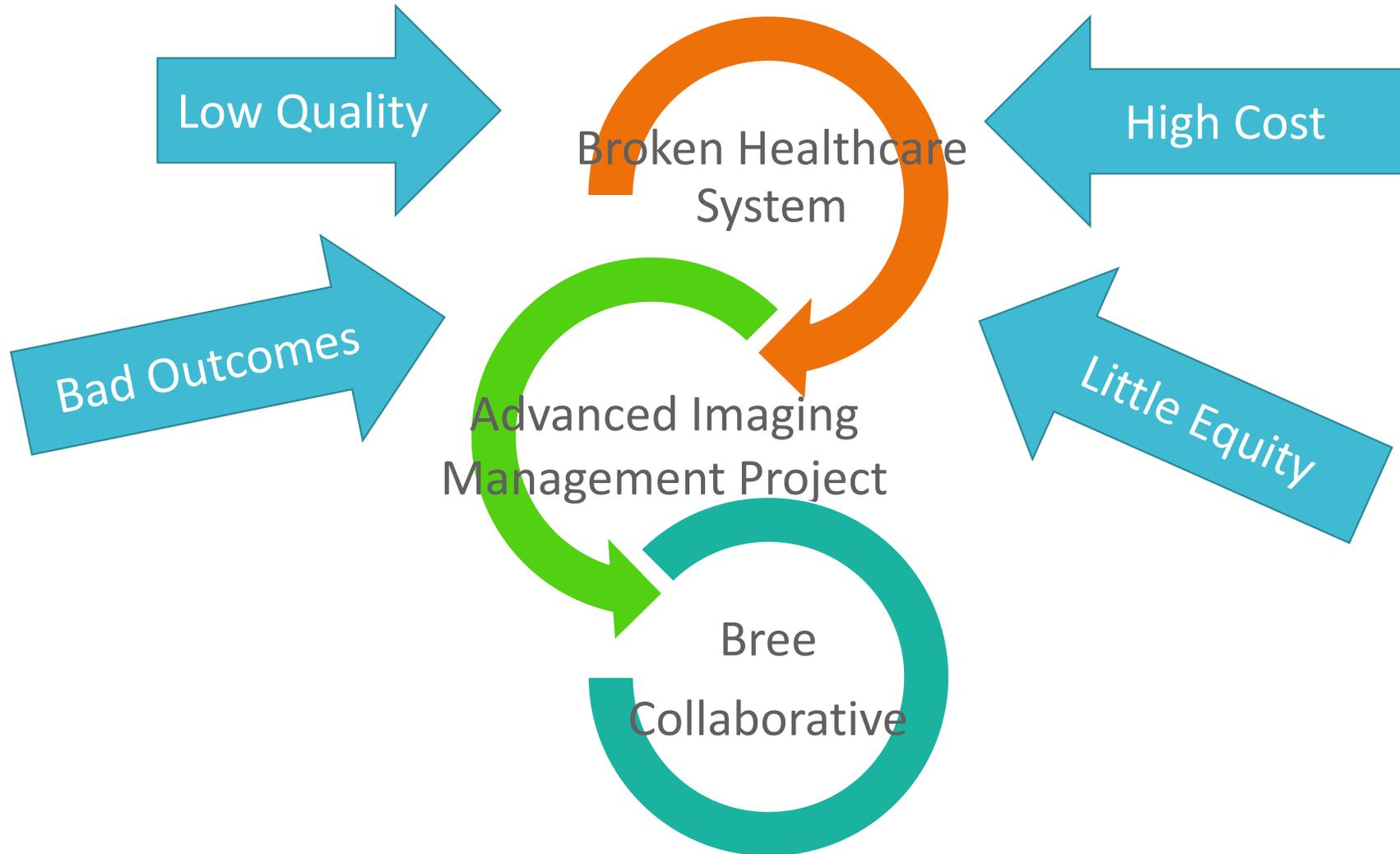
Collaborative Evidence- Based Guideline Development: Palliative Care

Ginny Weir, MPH
Director, Bree Collaborative



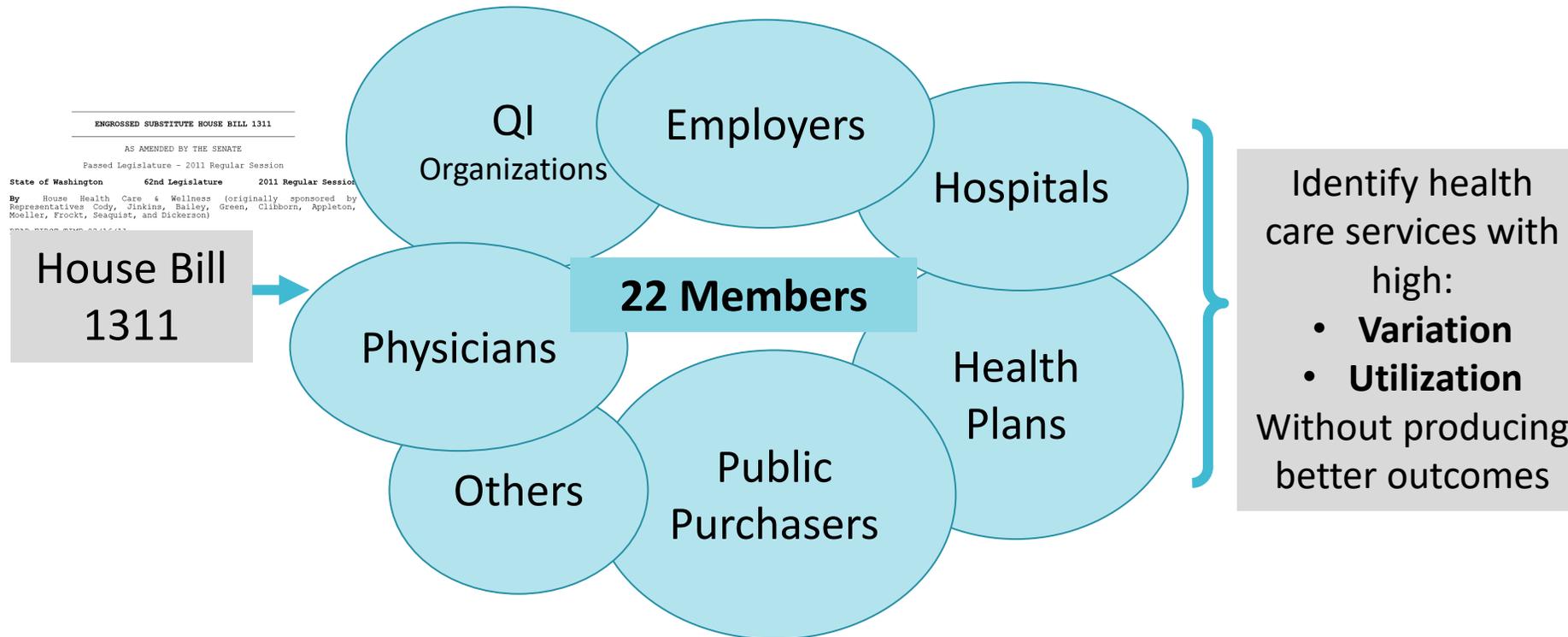
Background

2011 Health Care Environment

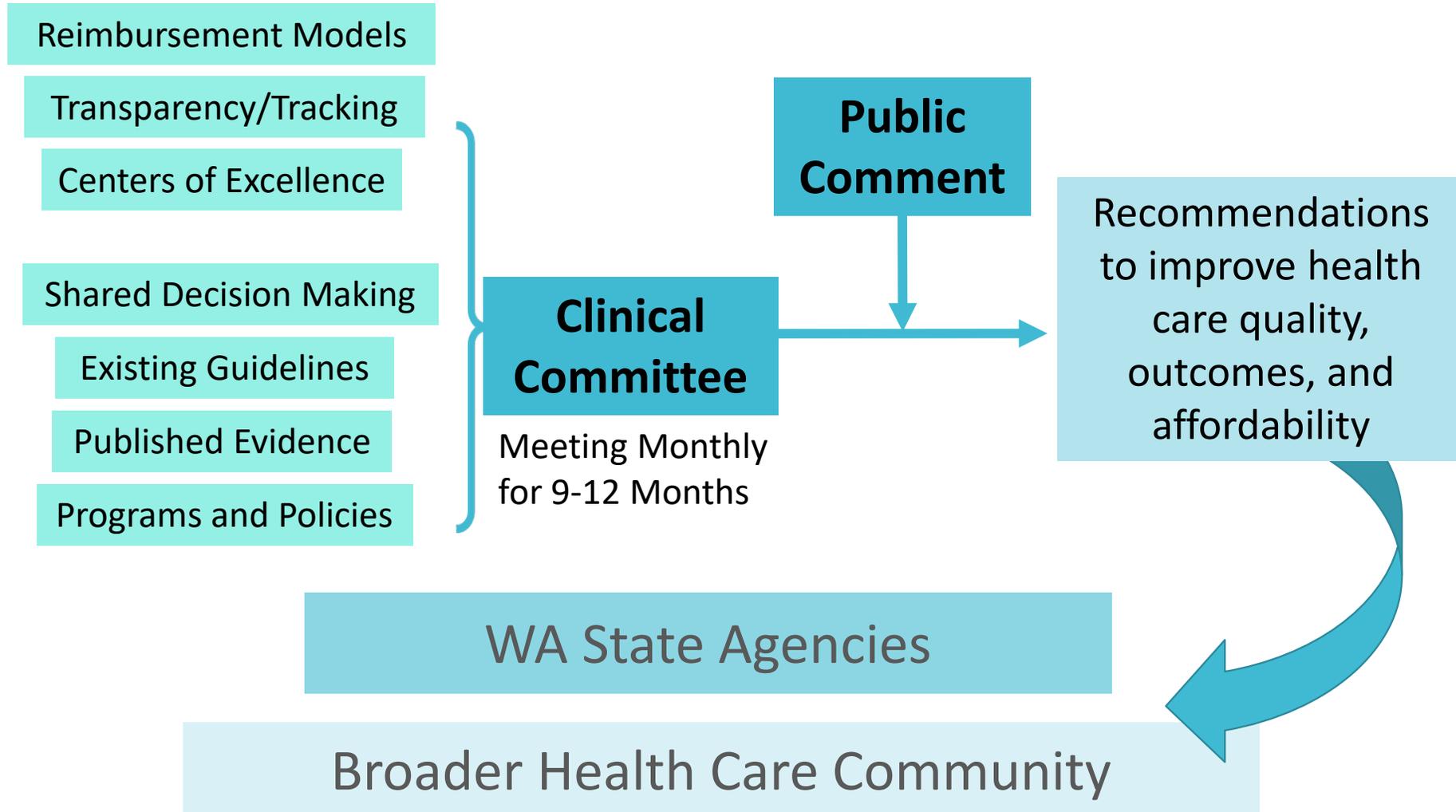


Background

Members and Topic Selection



Developing Recommendations



Diverse Topic Areas



- Addiction and substance use disorder screening and intervention (2014)
- Advance care planning for the end-of-life (2014)
- Alzheimer's disease and other dementias (2017)
- Bundled payment models and warranties:
- Total knee and total hip replacement (2013, 2017)
- Lumbar fusion (2014, 2018)
- Coronary artery bypass surgery (2015)
- Bariatric surgery (2016)
- Collaborative care for chronic pain (2018)
- Data collection on appropriate cardiac surgery (2013)
- Hospital readmissions (2014)
- Hysterectomy (2017)
- Integrating behavioral health into primary care (2016)
- LGBTQ health care (2018)
- Low back pain management (2013)
- Maternity bundled payment model (2019)
- Obstetric care (2012)
- Oncology care (2015)
- Opioid prescribing metrics (2017)
- Opioid prescribing in dentistry (2017)
- Opioid prescribing for postoperative pain (2018)
- Opioid prescribing for chronic pain (2019)
- Risk of violence to others (2019)
- Shared decision making (2019)
- Suicide care (2018)
- Treatment for opioid use disorder (2016)
- Prescribing antipsychotics to children and adolescents (2016)
- Palliative Care (2019)
- Prostate cancer screening (2015)

Why Palliative Care?

Selected Summer 2018

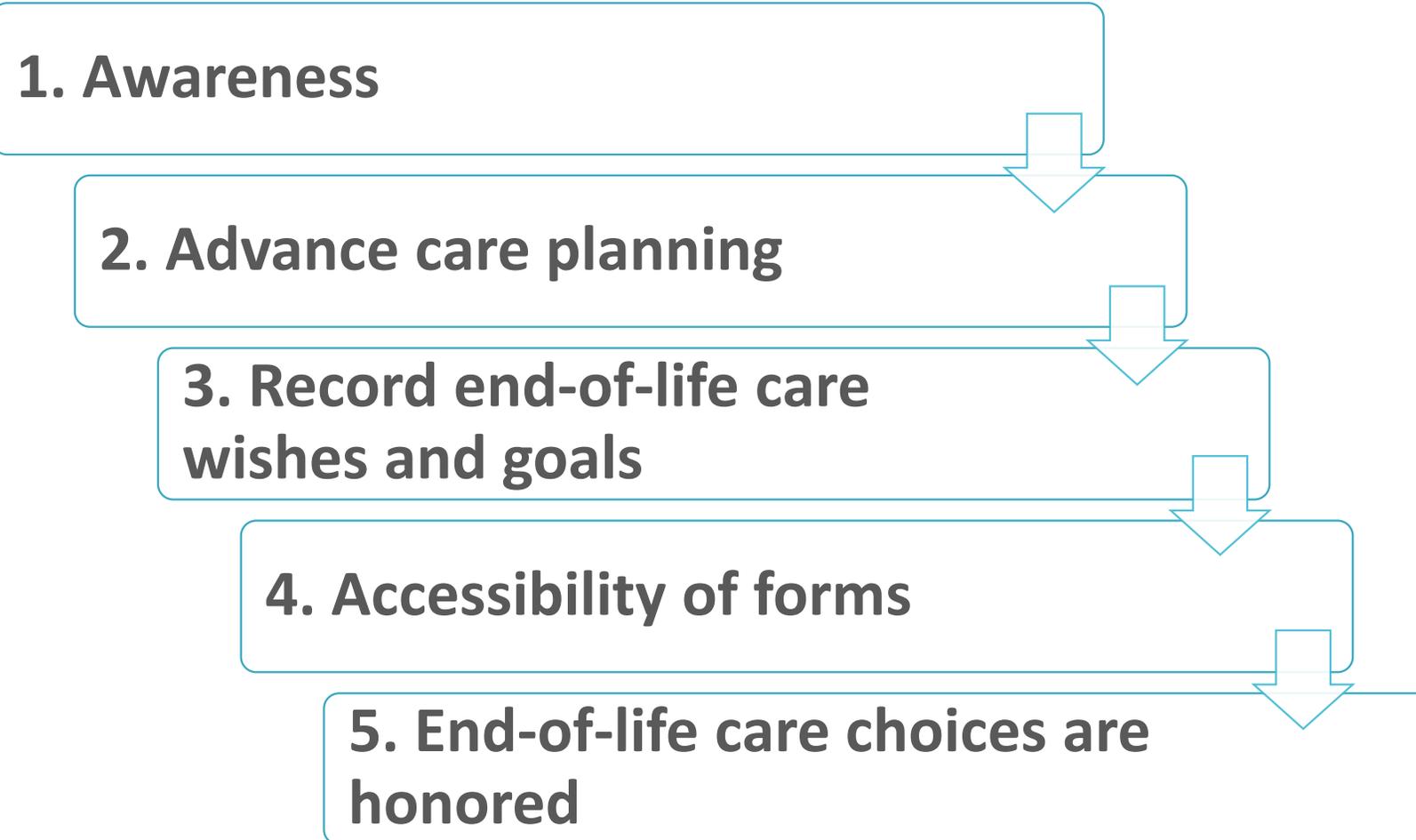


Variation	Patient Safety Issue	Cost	Proven Strategy	Unique Bree Role
Data	Shared-decision making	Equity Issue	Other Notes (e.g., community support, Choosing Wisely)	

- Ask from community members
- Alignment with WA state priorities

End-of-Life Care Recommendations

Developed 2014



Alzheimer's Disease and Other Dementias

Developed 2017



1. Diagnosis
2. Ongoing Care and Support/Management
3. Advance Care Planning and Palliative Care
4. Need for Increased Support and/or Higher Levels of Care
5. Preparing for Potential Hospitalization
6. Screening for Delirium Risk Prior to Surgery

Recruiting Workgroup Members



- Balance of individual clinical expertise and representation of clinicians working within large health systems
- Inclusion of **community voice**
- **Health plan voice**
- Iterative process – identifying gaps in expertise – new members

Workgroup Members



- Chair: John Robinson, MD, SM, Chief Medical Officer, First Choice Health, Bree Collaborative Member
- Lydia Bartholomew, MD, Senior Medical Director, Pacific Northwest, Aetna
- George Birchfield, MD, Inpatient Hospice, EvergreenHealth
- Raleigh Bowden, MD, Director, Okanogan Palliative Care Team
- Mary Catlin, MPH, Senior Director, Honoring Choices, Washington State Hospital Association
- Randy Curtis, MD, MPH, Director, Cambia Palliative Care Center of Excellence, University of Washington Medicine
- Leslie Emerick, Legislative Consultant, Home Care Association of Washington
- Ross Hayes, MD, Palliative Care Program, Bioethics, Rehabilitation, Pediatrician, Seattle Children's
- Greg Malone, MA, MDiv, BCC, Palliative Care Services Manager, Swedish Medical Group
- Kerry Schaefer, MS, community member
- Bruce Smith, MD, Medical Director of Providence Hospice of Seattle, Providence Health and Services
- Richard Stuart, DSW, Psychologist, Swedish Medical Center - Edmonds Campus
- Stephen Thielke, MD, Geriatric Psychiatry, University of Washington
- Cynthia Tomik, LICSW, Manager, Palliative Care, Evergreen Health
- Gregg Vandekieft, MD, MA, Medical Director for Palliative Care, Providence St. Peter Hospital
- Hope Wechkin, MD, Medical Director, Hospice and Palliative Care, EvergreenHealth

Developing the Guidelines Reproducible Process



- Identify problem(s)
- Develop framework
 - Clear, based in evidence
- Inclusions v exclusions
- Guideline has to be attractive to clinicians, payers, and patients
- Collaboration always means compromise

Identifying Problems



- Unmet patient need
- Fragmented care
- Unwanted high-intensity care
- Lack of common understanding
- Lack of resources
- Lack of referrals
- Lack of financial support
 - Diverse services, not all clinical

Framework Focus Areas

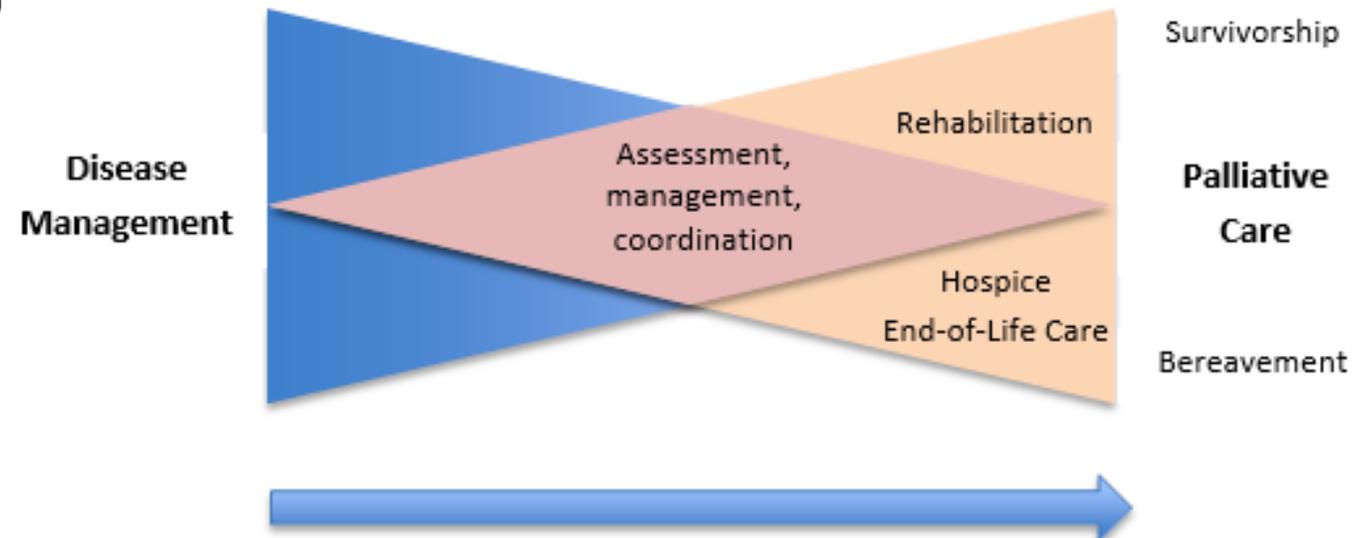


- Common definition
- Cultural awareness and understanding of local community
- Advance care planning
- Goals of care conversations
- Defining primary and specialty palliative care
- Per member per month palliative care benefit

Common Definitions



- Serious illness is a condition that *“negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress... [and] carries a high risk of mortality”*



Source: Kelley AS. Defining "serious illness". J Palliat Med. 2014 Sep;17(9):985.

Source: Adapted from Hawley PH. The bow tie model of 21st century palliative care. J Pain Symptom Manage. 2014 Jan;47(1):e2-5.

The power of metaphor



Palliative Care

For comfort, clarity, and quality of life

People with serious illnesses can feel as if they're on a "medical train." One test or treatment quickly leads to the next, and many people can soon feel as though the train is speeding down the tracks. They're not sure how they got there or what comes next.

An EvergreenHealth Palliative Care consultation is like a stop at a train station. It's a chance to get off the medical train, get comfortable, and plan the rest of the journey.

First, you and your care provider will discuss your symptoms – whether it's pain, fatigue, shortness of breath or anything else – and will work together to make sure those symptoms are being managed as well as possible.

Second, you'll look at the "map" of your medical care together, you'll clarify what "track" of medical treatment you're on, and you'll begin to plan for what lies ahead. Sometimes, after looking at the map, people decide to change course, and other times they choose to stay on the same track, based on who they are and what's most important to them. Your palliative care provider will help to clarify the course of your medical care by working to ensure that everyone involved in your care is reading the same map.



"It was hard to think about what was ahead for me and my family. I felt overwhelmed, and I didn't know where to start. Palliative Care helped me find my way."

"I had pretty bad nausea and pain with cancer treatment. Palliative care helped get my symptoms under control, so I could get my life back. Along the way, we clarified what was most important for the future."

"We're worried that Mom is nearing a point where she can't make her own decisions. How do we talk to her about her wishes? We need to know what's important to her, so that we can speak for her when she can't."



Palliative Care

For Comfort, Clarity, and Quality of Life

INPATIENT CONSULTATION SERVICE
12040 NE 128th St, Kirkland, WA 98034
425.899.3224

OUTPATIENT CLINIC
12303 NE 130th Lane, Coral 550, Kirkland, WA 98034
425.899.3224

Evergreenhealth.com/palliative-care

DR. ROBERT
BREE
COLLABORATIVE

Meeting Patient Need



- Meeting physical, functional, psychological, practical, and spiritual consequences of serious illness
- **Primary palliative care**
 - Assessment and management
 - When to refer
- **Specialty palliative care**
 - Assessment and management
 - Interdisciplinary team
 - Care coordination function
 - Access

Clinical Visit(s)

Assessment and Management



- Goals of care conversations including around hospitalization
 - Advance care planning
 - Cognitive impairment
 - Medical care – symptoms that impact quality of life
 - Caregiver needs
 - Behavioral health (i.e., depression, anxiety, suicidality, others)
 - Functional needs
 - Spiritual care
- + Care Coordination
- + Access

Financial Support



- Defined services + quality metrics
- Defining the seriously ill patient population
- Based on CMS Seriously Ill Population (SIP) Alternative Payment Model Option
 - First visit
 - Monthly per patient payment
 - Additional per-visit payment for face-to-face clinician visit

Answering our Charter's Aim



To develop best practice recommendations for palliative care regarding:

- Assessment of patients with serious illness for primary and/or specialty palliative care need,
- Care delivery frameworks, and
- Payment models to support delivery of care.

Lessons Learned



- Bottom-up approach
- Guideline development v implementation
- Patient voice
- Standardization v individualized medicine
- Involve **primary care**

Questions?



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