

Community-Based Palliative Care: Lessons on Standardization and Scaling

Session #3 of 3: Building on California's Efforts to Drive Consistency and Quality in Palliative Care

February 9, 2022



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Housekeeping

- This webinar is being recorded.
- Information on how to access the recording and slides from this webinar will be emailed to you in a few days.
- Post questions and comments in the chat box at any time.

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About us.



- ✓ Founded in 1998
- ✓ Collaborative approach
- ✓ Committed to improving serious illness care

Thank you to our co-sponsors



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Community-Based Palliative Care: Lessons on Standardization and Scaling



- ✓ January 26, 2022, 11:00am-12:00pm PST
Community-Based Palliative Care Standards: Rationale and Impact
- ✓ February 2, 2022, 11:00am-12:00pm PST
Affordability and Sustainability of Palliative Care Services across Medicaid, Medicare, and Commercial Insurance
- February 9, 2022, 11:00am-12:00pm PST
Building on California's Efforts to Drive Consistency and Quality in Palliative Care. *How payers, providers, and policymakers can leverage what was learned about developing or implementing standards for community-based palliative care.*

<https://coalitionccc.org/CCCC/Our-Work/2022-CAIC-Webinar-Series.aspx>

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Series Presenters



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Today's Session



- Brief review of the standards for community-based palliative care
- Reflections on development
- Reflections on implementation
- Reflections on evaluation
- Questions and discussion

The webinar is being recorded.

The presentation slides and a link to the recording will be distributed to session registrants.

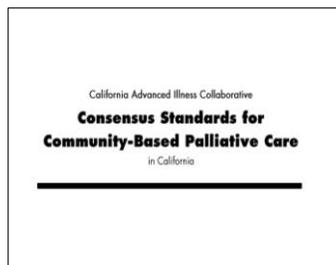
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Consensus Standards for CBPC Delivery



- 2016: CCCC convened development team – the California Advanced Illness Collaborative (CAIC) – including payers, CBPC providers, policy advocates, researchers
- March 2017: Standards released
- Intended to specify **minimums** acceptable to any payer or provider
- Intended to inform contracting for **home-based** palliative care
- Generally aligned with Medi-Cal palliative care mandate (SB 1004)



<https://coalitionccc.org/CCCC/Our-Work/CAIC.aspx>



<https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx>

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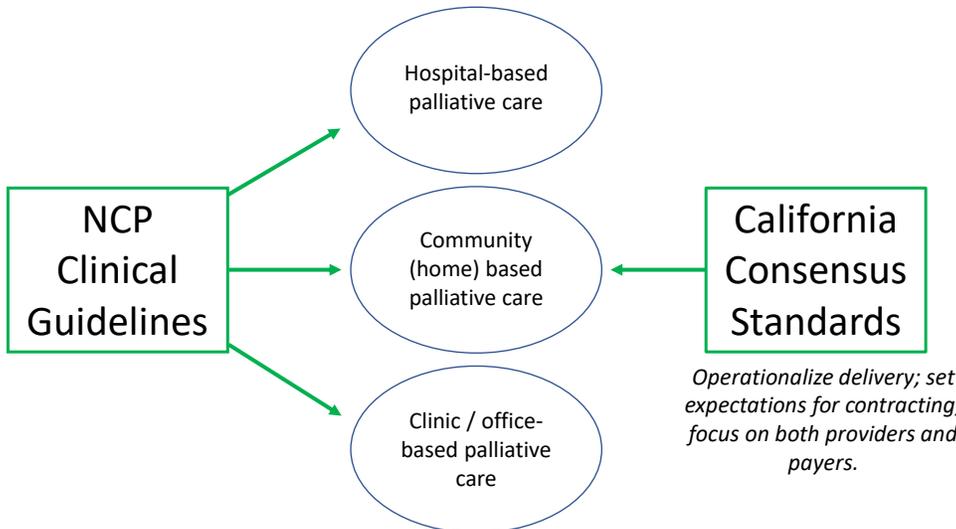
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What the Standards Address



** Not addressed in Medi-Cal palliative care (SB 1004) guidance*

In Addition to Clinical Guidelines



Demonstration Project 2018-2021



Goals: Implement standards with payers and providers. Evaluate outcomes and variation in care delivery. Determine if the Standards make it easier for payers and providers to develop and implement contracts that increase access to quality, sustainable CBPC services.

Features:

- Participants assembled in 2018
- Multiple payers and providers delivering CBPC in Sacramento and/or Los Angeles
- Contract requirements met or exceeded the Standards or SB 1004 requirements
- Many but not all providers had contracts with multiple participating payers
- Claims analyses focus on new palliative enrollees Jan 2019-Mar 2020
- Qualitative data collection and group activities through Dec 2021
- Project led by CCCC, funded by CHCF, supported by evaluation team and advisory group

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A Few Demonstration Findings



1. Standards were largely successful in promoting delivery of team-based care that aligned with NCP guidelines and other descriptions of best practices
2. Evaluation revealed variation in how the Standards were enhanced and implemented
3. Mix of manageable and problematic variation; measurement and reporting was the area with the most problematic variation
4. Preliminary assessment of fiscal outcomes showed positive results, with variation across insurance types and plans
5. Variation in fiscal outcomes was likely the result of implementation choices

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LESSONS RELATED TO DEVELOPING STANDARDS

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Standards Are Needed



“We need to take a multifaceted approach to ensure home-based palliative care programs are to some extent standardized, and held accountable for the care they provide. It is critical for the future of home-based palliative care, and for patients’ and families’ health and safety, that when an organization says, *“Yes! We have a home-based palliative care program!”* that patients, families, referring clinicians, and payers know what they are getting.”

“Yes! We Have a Home-Based Palliative Care Program!”.
Calton BA, Ritchie C. JAGS 2019 Jun;67(6):1113-1114.

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Assemble a Diverse Team



- Payers
- Palliative care providers
- Academics
- Philanthropy
- Government officials
- Palliative care advocacy organizations
- Specialists that care for seriously ill individuals
- The voice of patients and caregivers

A neutral 3rd party (like CCCC or CHCF) can play an important role



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Define a Floor and Optional Enhancements

- Aim for defining a floor
 - Based on the California experience, both payers and providers will build on that
- Specify enhancement options
 - (Medi-Cal Standards did this)
- Put emphasis on “what”, not necessarily “how”
- Recommendations should be evidence-based, and acceptable to payers and providers



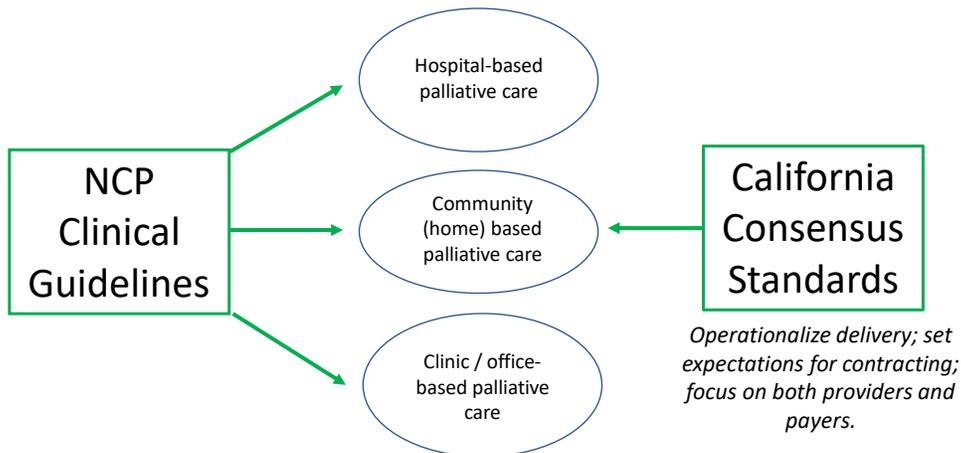
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Be Clear on the Role of Standards



Be mindful of the difference between palliative care as an essential aspect of care for all seriously ill individuals vs. a health plan **benefit** that provides home-based palliative care for a specific population



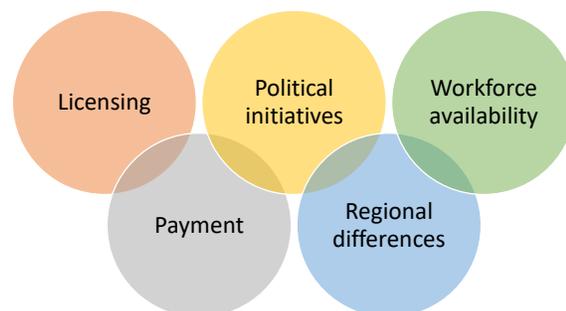
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Be Mindful of Context



- Be aware of state/federal programs and policies that standards need to align with
- Be aware of regional differences that might impact uptake and feasibility (i.e., workforce availability in rural vs. metropolitan areas)
- Make sure the standards are flexible enough to accommodate variation



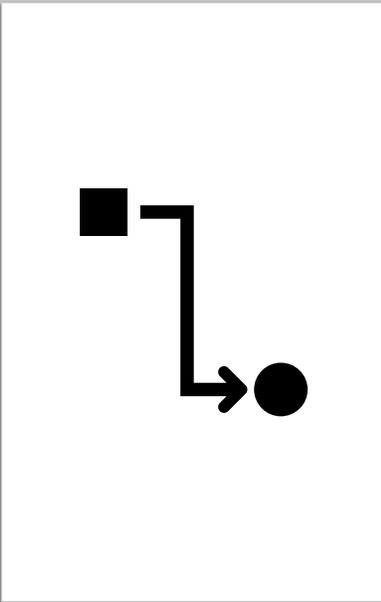
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Be Mindful of Process

- Project management
- Influential leadership
- Encourage open communication and strive for regular meetings
- Brainstorming by video or phone has limitations
- This takes time & reaching consensus can be difficult
- Consider how organizations make decisions



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Questions about developing standards?

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LESSONS RELATED TO IMPLEMENTING STANDARDS

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Outcomes are Driven by
'What' and 'How'



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Standards are a Starting Point



	Enhancements to "What"	Choices for "How"
Eligibility	<ul style="list-style-type: none"> Add specific diseases? Relax dx-specific criteria? 	<ul style="list-style-type: none"> How to identify potentially eligible members Method for verifying eligibility Strategies for promoting referrals Member engagement strategies
Services	<ul style="list-style-type: none"> Add specific services? 	<ul style="list-style-type: none"> Requirements for frequency and mode of contact by specific team members Require use of specific screening and assessment tools
Staffing/Providers	<ul style="list-style-type: none"> Add specific team members? Specific training requirements? Requirements for individual or organizational certification? 	<ul style="list-style-type: none"> How to find and vet providers Whether to support provider training

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Starting Point (continued)



	Enhancements to "What"	Choices for "How"
Measurement / Reporting	<ul style="list-style-type: none"> Require participation in national registry? Add process or outcome measures? 	<ul style="list-style-type: none"> Content, format, method and frequency of reporting by providers Does plan share data with provider? Method for assessing fiscal outcomes Plan or provider to gather PROs? Joint rounding/meetings to supplement data reporting? Regional or plan-specific quality collaborative?
Payment Model	<ul style="list-style-type: none"> Use of tiered payment model 	<ul style="list-style-type: none"> Payment amount Incentives linked to process or outcome measures Supplemental payment for high-utilizers

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Demonstration Project Implementation Supports



- In-person and virtual meetings
- Developed Universal Referral Form
- Qualitative and quantitative evaluation of standards in practice
- Cross-provider review of patient/family experience assessments

PALLIATIVE CARE REFERRAL & SCREENING TOOL
Created by the Coalition for Compassionate Care of California in collaboration with health plan partners:

Referral Date

PATIENT INFORMATION

Patient Name: _____ Date: _____
 Last First
 Phone #: _____ Address: _____ City: _____ Zip: _____
 ID/ICN Number: _____ Male _____ Female _____ Date of Birth: _____ Age: _____
 Language / Ethnicity: _____ Name of PCP: _____
 Health Plan: _____ LOB: Medicare Medi-Cal Commercial PPO
 Location: Hospital SNF Home Other: _____

REFERRING/ATTENDING PROVIDER:

Provider Name: _____ Specialty: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____ Office Contact: _____

____ Patient meets basic eligibility/screening guidelines or other health plan specific diagnostic criteria for a full Palliative Care Service Evaluation (see reverse side).
 ____ Current referral prompted by:
 Patient is using the hospital and ER to manage symptoms
 Uncontrolled symptoms related to underlying disease (e.g., pain, shortness of breath, vomiting)
 Inadequate home, social, family support.

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Implementation Supports for Medi-Cal Standards



PILOT TEST	• Test the standards and disseminate findings
MONITORING	• Monitor uptake and promising practices
PEER LEARNING	• Create peer-peer learning opportunities
TECHNICAL ASSISTANCE	• Offer practical /focused /flexible technical assistance that makes progress possible
RESOURCES	• Create or collate tools and resources that feature data, documents and approaches used by plans and providers, + access to external resources

In all of the above, highlight how palliative care aligns with other state / plan programs, and support integration

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Pilot Test



Partners in Palliative Care Pilot

Pilot Lays Foundation for Medi-Cal Palliative Care Benefit

Executive Summary
Partnership HealthPlan of California (PHC) piloted an intensive outpatient palliative care program – Partners in Palliative Care (PHC) – with four organizations that began in September 2015. An evaluation of the pilot showed several differences from palliative care programs in other populations and other settings. These differences include a much higher burden of psycho-social issues and surprising challenges, such as a lower than expected completion of advance care planning documentation. A financial analysis of the first six months of the pilot showed approximately \$3 in hospital cost savings for every \$1 spent on the palliative care program. These results will help health plans and potential palliative care providers construct programs and contracts that meet the requirements of California Senate Bill (SB) 1004 which mandates establishment of an outpatient palliative care benefit for Medi-Cal beneficiaries.



End-of-Life Care for Medi-Cal Beneficiaries

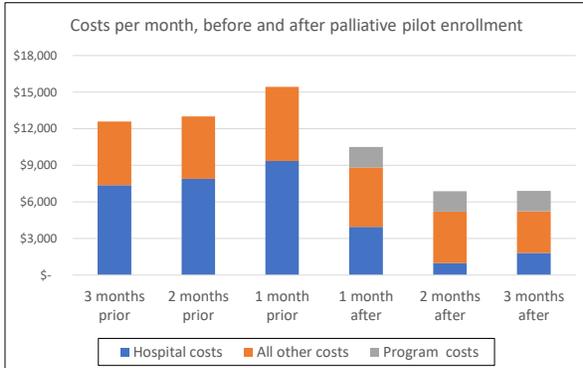
Hospice care is a benefit for Medi-Cal members; however, it is clear from both state data and a UCSF study that hospitalization is common at the end of life. [State of California data from 2013](#) showed that 37 percent of Medi-Cal members died as hospital inpatients.

A UCSF safety-net study from 2010 to 2013 showed:

- 76% of safety-net patients were hospitalized in the last six months of life.
- 45% were hospitalized in the last month of life.
- 33% died in the hospital.
- 21% had multiple admissions in the last month of life.

Prior to the Partners in Palliative Care pilot, PHC contracted with hospice and palliative care physicians who could conduct visits with patients in the home and hospital setting. Palliative care provided in the inpatient setting and less intensive outpatient advance care planning activities were covered prior to the pilot, but more intensive outpatient palliative care services were only available to those enrolled in hospice.

“Even with the costs of the program included, the total cost of care was 33 to 50 percent less for PHC members that received palliative care, primarily due to a marked decrease in hospital days while enrolled in the program.”



http://www.partnershiphp.org/Providers/Quality/Documents/Strategic%20Initiatives%202017/PHC%20Palliative%20Care%20Program%20Summary_3_23_17.pdf

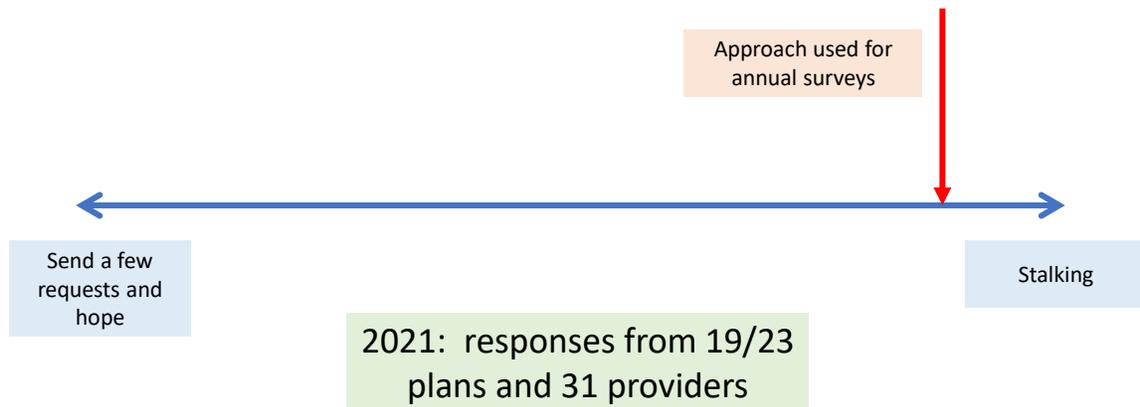
Monitor with Annual Surveys



- Separate but similar surveys for plans and providers
- Track referrals and enrollments
- Document range of plan approaches to payment model, eligibility, required services
- Characteristics of providers
- Challenges and focus areas for TA/resources

- Plans and providers curious about collective experiences
- CHCF/CCCC really interested in identifying challenges and opportunities to help

Effort Required to Achieve High Response Rate



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Promote Peer-Peer Learning with Convenings

- Forum for reporting out survey results
- Chance for peer-peer learning
- Showcase innovations developed by plans and providers
- Booster shot of visibility for PC program



Objectives

Participants will:

- Examine progress and challenges delivering SB 1004 palliative care services reported by Medi-Cal managed care health plan and palliative care provider organizations.
- Discuss considerations, dependencies, and decision points for plans and providers regarding maintaining, expanding, or reducing use of virtual/remote visits over time.
- Learn about innovative practices used by Medi-Cal palliative care providers and plans to improve access to, quality of, and impact of their palliative care programs.
- Discuss Medi-Cal palliative care provider and MCP experiences delivering services that meet or exceed the All Plan Letter (APL) requirements, and learn how various approaches including promising practices impact program volume, care quality and program sustainability.

Day 1 Agenda: April 27, 2021, 9:00 AM - 12:00 PM Pacific Time

9:00 AM	Welcome
9:05 AM	State of SB 1004 Palliative Care: Looking Back – Looking Forward <i>Part A: Reports from Plans and Providers on Volume and Quality</i> Presenters: Anne Kinderman, MD, Director, Supportive & Palliative Care Service Zuckerberg San Francisco General Hospital; Kathleen Kerr, BA, Kerr Healthcare Analytics
9:40 AM	Reflection Exercise
9:45 AM	State of SB 1004 Palliative Care: Looking Back – Looking Forward <i>Part B: How Care is Delivered and Reflections on Sustainability</i> Presenters: Kathleen Kerr and Dr. Anne Kinderman Q&A

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Plan-Specific Meetings Can Be Helpful

Medi-Cal Managed Care Plan Learning Community

- Monthly opportunities for plans to interact (Zoom meetings)
- Open sessions
 - Do you have 'X'? How do you do 'Y'? Anyone else struggling with 'Z'?
- Focused (practical) sessions
 - Presentation of tool, data, case example, etc. + discussion
 - ***Wherever possible link to CalAIM, a new massive Medi-Cal initiative***



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Offer Individual and Group Technical Assistance

Plan-Provider Technical Assistance Workshops



Estimating the number of eligible individuals and appreciating baseline utilization patterns and costs in the final year of life



Estimating the Cost of Care Delivery



Assessing Palliative Care Capacity and Launching Palliative Care Services



Gauging and Promoting Sustainability and Success



Strategy Exchange to Address Common Challenges

“Feel much better prepared after the workshop.”

“Content was very clear and helpful. Attendee questions were also helpful in clarifying”

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Create and Curate Resources

Palliative Care in Medi-Cal (SB 1004) Resource Center

Senate Bill 1004 (SB 1004) is the California law that requires Medi-Cal managed care plans to provide access to palliative care. Explore CHCF's collection of tools and resources aimed at helping organizations implement, sustain, and improve programs providing palliative care to Medi-Cal enrollees under SB 1004.

Material presented in workshops was transferred to this web site

<https://www.chcf.org/resource/sb-1004/>

Summarize and Disseminate Promising Practices

SB 1004 PROMISING PRACTICES
June 2019

Identifying Eligible Patients

Background
Many Medi-Cal and palliative care identifying patient SB 1004 PC as th SB 1004. This summary an and PC provider- identify eligible p

SB 1004 PROMISING PRACTICES
Engaging Patients

Background
Once Medi-Cal manag palliative care (PC) pro have identified potent someone will need to t team. Approaches to a way vary, with different strategies, and workfo of all approaches is to identify eligible patients who topic summary outlines and strategies that pla organizations can use t engagement with PC.

SB 1004 PROMISING PRACTICES
Referral Processes

Background
Referral processes can have a huge impact — positive or negative — on the proportion of eligible patients who eventually receive services. This summary outlines considerations and strategies that Medi-Cal managed care plans and palliative care (PC) provider organizations can use to engage referring providers and reduce the barriers to referrals and enrollment in SB 1004 PC services.

Common Challenges and Barriers

Referring Provider Barriers

- Providers misunderstand what PC is, or don't appreciate its value.
- Providers are concerned that PC referral equates to limiting treatments for a patient, or that it will "take the patient away" from their care, or, conversely, they have unrealistic expectations that the PC provider will be able to take over all care for the patient. It is surprisingly common for providers to think that PC is the same thing as hospice.
- Providers are too busy — they forget to refer, lack the time to have serious (three conversations with patients, and/or can't spend time learning about new programs.
- Providers are hard to reach; they might not read emails or newsletters.
- Providers may be unfamiliar with the PC organization and therefore might hesitate to refer patients to it.

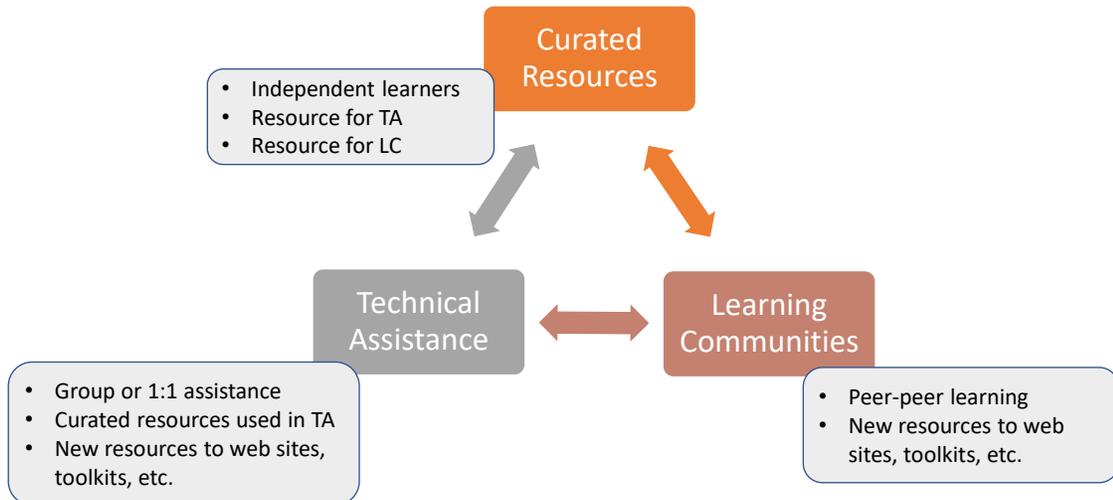
Referral Workflow Barriers

- Providers may not know patients well enough to refer them (for example, a patient who has been assigned but never seen, or has not been seen for an extended period).
- Providers stop-referring due to frustration that only certain patients qualify.
- Providers don't see how a referral can be beneficial to them and think referring the patient will increase their workload, especially if they are expected to manage medications or facilitate delivery of services the PC team recommends.
- Neither the plan nor the PC organization may have access to the clinical information needed to confirm disease-specific eligibility criteria for SB 1004.
- PC organizations and referring providers are unsure who to contact at the plan to refer patients and to address problems when they arise.
- PC organizations that are accustomed to providing hospice or clinic-based services may be unfamiliar with the authorization and administrative processes they need to work effectively with plans.

- Challenges and Barriers
- Brief descriptions of 4-7 strategies (rationale and considerations)
- Key lessons learned
- Medi-Cal specific, but generalizable

<https://www.chcf.org/resource/sb-1004/>

Create a Flexible Ecosystem of Supports



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Questions about implementing standards?

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LESSONS RELATED TO EVALUATING STANDARDS AND SERVICES

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Evaluation Aspects



Provider evaluation efforts

- Patient/family experience
- Self-assessment of some process and outcome measures

Payer evaluation efforts

- Compliance (eligibility, services)
- Enrollment duration
- Self-assessment of fiscal inputs and outputs

CCCC evaluation efforts

- Convened meetings for review and feedback about each domain
- 3rd party interviews with payers & providers
- Enrollment & claims data acquired, pooled, and analyzed by 3rd party

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Evaluating Acceptability of Standards

- Acceptability is subjective, so important to ask stakeholders
- This is independent of quantitative results
 - A higher cost of care may be acceptable to some payers
 - Some plans may be fine with breaking even, some may have specific ROI expectations
 - Some providers may be fine with breaking even; some may expect a specific margin
- Also behavioral: do payers and providers continue, or drop out?



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Challenges in 3rd-Party Fiscal Evaluation



Goal: All four payers would extract and transmit data to evaluation team in order to have a shared view of volumes, duration, costs of care

- One payer (out of 4) was not able to come to agreement on data sharing
- Asked all payers to acquire beneficiary death dates, 2 did
- Asked payers if they had records on beneficiaries who were referred for services but did not receive, 2 said yes
- Format of data did not allow for easy computation of number of hospitalizations and bed days
- Challenges with capturing costs of care when there is delegation or capitation

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Patient / Family Perspective



- A lot of variation in providers' assessments of patient experience
- Recommend use of new "Serious Illness Survey for Home-Based Programs" developed by RAND
- Some insights gleaned from proportion disenrolling due to patient choice
- Encourage efforts to evaluate patient / family outcomes

Serious Illness Survey for Home-Based Programs

by Rebecca Anhang Price, Melissa A. Bradley, Danielle Schlang
 Related Topics: Chronic Diseases and Conditions, Health Care Delivery Approaches, Palliative Care, Patient Experience, Patient-Centered Care, Survey Research Methodology

Citation Synops (print-friendly) View related products
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LEARN MORE

Access the survey materials

Community-based programs that provide care for seriously ill individuals in their homes have grown rapidly. Although measuring, monitoring, and incentivizing high-quality care is critical for seriously ill individuals, before 2020, no standardized measures had been developed for programs that provide care to the seriously ill.

Experts in care of the seriously ill have highlighted the importance of quality measures that assess the person- and family-centeredness of care. Surveys of seriously ill individuals and their family members are an essential means of understanding whether care is person- and family-centered.

RAND Corporation researchers, in close collaboration with Oregon Health and Science University and Yale University, developed and field-tested a survey to assess the care experiences of individuals who receive care from programs that provide serious illness care to patients in their homes. The goal of this work was to develop survey-based measures that assess the quality of care provided by these programs.

ACCESS THE SURVEY MATERIALS

<https://www.rand.org/pubs/tools/TLA1547-1.html>

Document Details

Copyright: RAND Corporation
 Availability: Web-Only
 DOI: <https://doi.org/10.7246/TLA15471>
 Document Number: TL-A1547-1
 Year: 2021
 Series: Tools

Explore

Related Topics

Chronic Diseases and Conditions
 Health Care Delivery Approaches
 Palliative Care

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Innovate, Implement, and Disseminate



- Continue to innovate!
- Field needs evidence to support improving, sustaining, scaling home-based medical services and case-rate contracts
- Feedback loops: key findings from process and outcome measures can foster early identification of implementation issues and promising practices
- Make standards and findings easily accessible to all



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Key Recommendations

Development

- Seek and incorporate input from a diverse group
- Define a floor and optional enhancements
- Balance specificity with need to accommodate regional and other variation

Implementation

- Provide a range of implementation supports for payers and providers
- Collect and share information about promising practices
- Create opportunities for peer-peer learning

Evaluation

- Assess acceptability, feasibility, impact, and sustainability
- Consider linking standards to a validated patient experience survey
- Make standards and evaluation findings easily accessible to all

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Questions and Discussion

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Acknowledgments



The CCCC team gratefully acknowledges the contributions of the health plans and palliative care providers that participated in the demonstration project, who shared their data, wisdom, perceptions, and recommendations.

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2022 Annual Summit – Register today!

Emerging Stronger: Creating a New Normal

May 4 – 5, 2022

San Francisco Airport Hyatt Regency



Register today at CoalitionCCC.org/Summit!

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2022 CCCC Webinar Series

Thursday, February 24

Caregiver Support: A Vital Component of Palliative Care

Teresa "TV" Vaughn, MPT, MHA
Caroline Etland, PhD



Thursday, March 24

Why the Right Words Matter When Talking about Serious Illness Care

Anna Gosline

Wednesday, April 13

Kimberly D. Acquaviva, PhD, MSW, CSE

Wednesday, June 15

"Can We Still Have a Child After You're Gone?" Navigating the Challenges of Reproductive Planning with Terminally-Ill Patients – Joanna Sharpless, MD

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To learn more about this work and download a copy of the
Consensus Standards for Community-Based Palliative Care,
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