Community-Based Palliative Care: Lessons on Standardization and Scaling

Session #1. Community-Based Palliative Care Standards: Rationale and Impact

January 26, 2022
Housekeeping

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

- Founded in 1998
- Collaborative approach
- Committed to improving serious illness care
Thank you to our co-sponsors
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 Business Lines. When services met or exceeded the Standards, were the financial outcomes sufficient to make community-based palliative care services sustainable for payers and providers?

• 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.
Series Presenters

J. Brian Cassel, PhD
Palliative Care Research Director
Associate Professor, VCU School of Medicine

Kathleen Kerr
Transforming Care Partners

Judy Thomas, JD
CEO, Coalition for Compassionate Care of California
Agenda

• Rationale and historical context
• Review California Consensus Standards and Medi-Cal requirements for community-based palliative care (CBPC)
• Review 5 areas addressed in the Standards
  • Assess effects and impact on variation
  • Review plan and provider experiences
• Conclusions and reflections
• Discussion

The webinar is being recorded.
The presentation slides and a link to the recording will be distributed to session registrants.
Looking Back to 2016

NATIONAL CONTEXT

• Community-based (in-home) palliative care (CBPC) an emerging treatment model
• National consensus guidelines and other documents that describe best practices available
• Growing body of literature showing positive outcomes
• No federal requirements or standards for CBPC

CALIFORNIA CONTEXT

• State law (SB 1004, 2014) requiring access to CBPC for Medi-Cal (Medicaid) enrollees signed but not yet implemented
• Some early-adopter health plans and other at-risk entities offering CBPC to members/patients

CLINICAL VARIATION

• Contracts for delivering CBPC varied significantly in eligibility criteria, services, provider qualifications, reporting requirements, payment model, length of expected engagement
• Some provider organizations were offering palliative care that did not feature best practice structures and processes (IDT, full scope of services, training, etc.)
## Consequences of Variation

### PALLIATIVE PROVIDERS
- Managing multiple contracts with different requirements
- Extremely difficult from operational perspective

### PLANS
- Time-consuming contracting process
- Uncertainty re what to offer to members or require of providers, appropriate payment model, how to assess impact/quality

### REFERRING PROVIDERS
- Uncertain what getting if refer a patient to CBPC, or if hear patient is getting CBPC

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Impediment to development, sustainability, use and spread of CBPC

Would consensus standards help?
CCCC Consensus Standards for CBPC

- Released March 2017
- Development team, the California Advanced Illness Collaborative (CAIC), included payers, CBPC providers, policy advocates, researchers
- Based on current understanding of best practices
- 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)
Demonstration Project

Goal: 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:

• Multiple payers and providers delivering CBPC in Sacramento and/or Los Angeles
• Contract requirements met or exceeded the Standards or SB 1004 requirements (as appropriate per line of business)
• Many but not all providers had contracts with multiple participating payers
• Project led by CCCC, funded by CHCF, supported by evaluation team and advisory group
• Participants assembled in 2018, claims analysis period Jan 2019-Mar 2020, qualitative data collection and group activities through Dec 2021
Payer Participants

• 4 health plan participants
• 3 operating in both Sacramento and LA
• 2 Medi-Cal (SB 1004) only
• 2 offering CBPC across multiple lines of business
• Payers had 5-27 CBPC provider partners in the two regions
• Range of CBPC experience:
  • 2 began offering CBPC upon implementation of SB 1004 (Jan 2018)
  • 2 with multi-year efforts to develop benefit / create statewide networks
Provider Participants

• 11 provider participants
• Range 1-3 payer partners (that were participating in the project)
  • Many also had contracts with additional payers (plans, medical
groups, ACOs) that did not participate in the project
• None delivering care in both LA and Sacramento
• Range <10 to >400 CBPC patients annually
• Range 1 to >10 years experience delivering CBPC
Evaluation

Questions
• Do the Standards facilitate provision of CBPC services?
• Are the financial outcomes sufficient to make CBPC services sustainable for payers and providers?
• Do patients and families value the CBPC services they received?

Data sources
• Plans provided demographic, PC enrollment, and claims data
• Providers shared tools and data used to assess patient experience of care
• Plans and providers shared oral and written information regarding policies, practices, and experiences delivering CBPC
Questions?
What the Standards Address

• Intended to set minimums, but invited to do more (expected variation)
• Specify “what” but not “how” (expected variation)

* Not addressed in Medi-Cal palliative care (SB 1004) guidance
# Hoped for Effects of Setting Minimum Standards

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**If hoped for effects not achieved could be result of:**

- Failure to adhere to the Standards
- Flaws in the Standards
- Implementation issues/choices not addressed in the Standards
Assessing Variation

Possible causes of variation

- Enhancements (expected)
- Implementation issues not addressed in the Standards (expected)
- Failure to adhere to the Standards
- Flaws in the Standards

Manageable variation

- Example: Expanded eligibility criteria, enrolled more appropriate patients with wider range of illnesses

Problematic variation

- Example: Extensive reporting requirements that require double data entry, extra data collection by clinical staff

- Consider extent to which achieved hoped for effects
- Consider possible cause and significance of variation noted by plans and providers
Eligibility

- General criteria/qualifications
- 4 specific diseases – cancer, COPD, heart failure and liver disease
- Detailed clinical criteria for each specified disease; verify advanced illness
- Consensus Standards (but not SB 1004 APL) includes “Other diagnoses, which either singly or in combination are indicative of progressive illness, with a <12-month life expectancy if the disease follows its natural course”
Eligibility: Operational Variation

Who is eligible

• Some plans added eligible diagnoses: stroke, end-stage liver disease, severe dementia
• Some eliminated specific criteria clinical criteria (do not need MELD score for liver disease, or EF for CHF)

Eligibility verification

• Range of approaches: PC provider completes assessment and can enroll member directly vs. review and authorization by plan staff
Eligibility: Plan Experiences

Do the eligibility criteria in your contracts effectively identify the members who would benefit from CBPC?

• Agreement **missing some important diagnoses** (dementia/other neuro, CKD) **but plans feel they usually** accept seriously ill members with other conditions

• Operationally, **may be too inclusive:**
  o Some issues with inappropriate referrals for those with chronic illness and needing pain management
  o Some enrollees are more “advanced illness” rather than true palliative (answer to the surprise question is “yes”, we would be surprised)

• **Challenges with implementation:** clinical requirements for enrollment (severity of illness) were not monitored closely and resulted in enrolling numerous members that are not the target population for CBPC
Eligibility: Provider Experiences

Do the eligibility criteria in your contracts effectively identify the patients who would benefit from CBPC?

• Minority feel effective and inclusive:
  o “The criteria appropriately screen out patients who may be better served by either behavioral health or psychiatry. Otherwise, the eligibility criteria are inclusive.”

• Most feel missing patients and too restrictive:
  o “We are missing ESRD patients who would benefit profoundly from our services”
  o “Sometimes we have bedbound patients that would benefit from our services that somehow don’t meet criteria”
Eligibility: Reflections

Hoped for effects?

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- Agreement missing important dx but disagreement if limiting access
- Suggested add of PPS score to better target appropriate patients within specified diseases
- Implementation issues created too loose access

Presence and significance of variation

- Expected, manageable variation from enhancing access (adding dx, relaxing criteria)
- Problematic variation (too loose access) from implementation issue
Required Services*

**Assessment**
1. A comprehensive palliative care assessment
2. Individualized care plan
3. Assessment of caregiver needs

**Clinical Services**
1. Visits from / contacts with an interdisciplinary team
2. Medication management and reconciliation
3. Availability of symptom management services 24 hours/day, 7 days a week
4. Advance Care Planning discussions and appropriate documentation
5. Caregiver education on aspects of in-home care.

**Care Coordination and Communication**
1. Collaboration with patient, family and other treating medical providers.
2. Care coordination to assist eligible member in navigating of the medical system
3. Coordination with health plan partner to support palliative care patient access to appropriate services
4. Education on hospice services.

*Items in red not addressed in Medi-Cal palliative care (SB 1004) guidance
Visit frequency by discipline specified

- For example, “2 RN visits per month” or “PC team prescribing clinician sees patient at least once every 3 months and when GOC change”

Mode of contact specified

- For example, “4 contacts per month, one of which must be in-person”
Services: Plan Experiences

*How well do the services required in your contracts match the types of supports members and families need?*

- In general, pleased, “They match well and help facilitate a holistic approach to care”
- Spiritual support seen as an important add (not required for SB 1004)
- Required 24/7 phone access seen as an important add (not required for SB 1004)
- Members and families can benefit from more caregiver services (not required for SB 1004)
Services: Provider Experiences

Do the services required in your contracts match the types of supports patients and families need?

• Agreement aligned with patient/family needs
• Several referenced implementation issues:
  o “We are being asked to provide more visits/contacts than patients/families may want. In some instances, being encouraged to discharge patients from services, versus meeting them where they are with fewer contacts each month.”
  o “Contracts can dictate type of support and frequency of visits by discipline, versus being guided by needs of the patient. We often deliver additional services (beyond contract requirements) which may also be related to a desire to fulfill our mission.”
Hoped for effects?

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- Plans and providers feel services match patient/family needs
- Good alignment with national consensus guidelines

Presence and significance of variation
- Problematic variation from implementation choices related to specifying frequency and mode of contact
Staffing/Providers

Palliative Care Providers:
Community-based palliative care is delivered by an interdisciplinary team appropriately trained and prepared, the members of which have demonstrated competency in palliative care. The interdisciplinary team should, at minimum, consist of the following disciplines:

- Physician (medical doctor, doctor of osteopathy), board certified in a related field (e.g. palliative care, internal medicine, family practice, geriatric or pediatric medicine, etc.)
  The physician role may include direct clinical care or be limited to program oversight.
- Registered nurse
- Social worker
- Spiritual care professional*

*Recommended but not required in Medi-Cal palliative care program
Staffing/Providers: Operational Variation

- Variation in requirements (plans) and use (providers) of different disciplines
  - Use of community health workers and home health aides
  - Physician in program oversight vs. direct clinical care role
- Requirement that provider organization be certified in palliative care
Staffing: Plan Experiences

Are you satisfied with the Staffing (which disciplines) and Training/Certification requirements featured in your contracts?

• In general, satisfied but some training deficits identified:
  o “Some vendors would benefit from further training on the scope of palliative care and being able to differentiate from hospice. It would also be helpful for them to learn about how to communicate with the PCP and share information.”
Are the requirements for Staffing (which disciplines are involved in care) and Training/Certification featured in your contracts feasible for your organization?

Most organizations were mostly satisfied
  
  o “The staffing works for us. We utilize a chaplain routinely and to great benefit of our patients. We have an experienced team and are working towards certification”

Some concerns about required effort
  
  o “Individual contract requirements for meetings/trainings are a significant time commitment and can at times interfere/compete with patient care.”
Hoped for effects?

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- Delivering team-based care
- Partial requirement of certification in CBPC

Presence and significance of variation
- Manageable variation from implementation choices related to disciplines on team
- Manageable variation in certification requirements
Questions?
Measurement & Reporting*

Process Measures

- **Number of patients enrolled** in palliative care
- **Duration of patient enrollment**
- **Proportion of palliative care patients who transition to hospice**
- **Documentation of advance care planning conversation**, including Advance Healthcare Directive or POLST, where appropriate. Should documentation not be completed due to patient choice or readiness, the following must be completed:
  - Documentation of a surrogate decision maker or absence of surrogate decision maker AND notification to the individual that they have been selected as the surrogate decision maker
  - Documentation of conversations or attempts to discuss advance care planning

Outcome Measures

- **Patient and family satisfaction**
- **Inpatient utilization and ED utilization rates**
- **Hospice length of service**
  - Total days at home in the last 6 months of life (excludes inpatient days in an acute care facility, an inpatient rehabilitation facility, a skilled nursing facility, or an inpatient hospice unit.

*Medi-Cal guidance does not address measurement and reporting*
Measurement and Reporting: Operational Variation

Tools and practices for assessing patient and family experience of care
• Tools featured 4-24 items
• Varied in timing and frequency of distribution
• Significant variation in question focus areas
• Significant variation in formatting and phrasing within and across tools
• Many sites had very small numbers of returned surveys, some with zero for entire quarters

Data reported to plan
• No data shared beyond claims submitted by provider vs. weekly reporting that summarizes encounters and resulting care plans

Audits of services and processes
• Routine audits of quality indicators (note reviews) vs. no plan assessment of process measures (monitoring of outcome measures only)
Measurement and Reporting: Plan Experiences

- Do you feel that information you ask palliative care providers to collect and share is appropriate?
- Do you feel these data provide an accurate picture of provider contributions to patient care?

Some felt their practices were acceptable
- “The three groups of data we obtain for measuring quality are discharge disposition, hospital utilization, and care planning documentation completion. Other useful measurements are length of stay on program and referral sources, which are gathered during the enrollment process. I believe these measurements are appropriate for our palliative care providers.”

Some deficits identified
- Some plans noted they do not have and would value patient/member satisfaction data
- One plan felt data requirements were too burdensome for providers
- One plan felt currently available data are inadequate:
  "I do not feel the data are an accurate picture of vendor contributions to patient care. I would like to see measurements focused on palliative care provider utilization (# of visits, which clinicians visited); care coordination; and patient/caregiver measurements around pain/symptom management, goals of care conversations, program satisfaction"
Measurement and Reporting: Provider Experiences

• Do you feel that information you are asked to gather and share with your health plan partners is appropriate?
• Do you feel these data provide an accurate picture of your contributions to patient care?
• Is the level of effort devoted to data collection and reporting sustainable for your providers and organization?

Some felt feasible and acceptable

• “We have very robust rounds with our health plan partners. We also collaborate well between rounds. I believe that they see the great efforts that our team makes and the benefit to the patients”.
• “This varies from plan to plan, but for the most part, data collection is reasonable and necessary.”

Some concerns about burden, pertinence and sustainability

• “The administrative requirements are burdensome with some payors and involves more manual processes than is reasonable – often duplicative in nature. The requirements for each contract are different, the frequency varies along with the information requested. There is little consistency.”
• “It does not feel that the current level of information drills down to the quality of care.”
• “The data is in general appropriate and reflects the quality of care delivered. However, [reporting] the number of visits, calls, consults, and IDT meetings is very time consuming and unlikely to be sustainable or realistic at our current rate of growth.”
Measurement and Reporting: Reflections

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- Incomplete adherence
- Mixed perceptions re meaningful and feasible
- Concerns about burden

Presence and significance of variation
- Problematic variation from enhancements, adherence, implementation issues and specifics in the Standards
Payment Model*

Payment Models:
Enrolled palliative care members will continue to be eligible for existing services as appropriate under their health plan. Community-based palliative care has demonstrated cost-effectiveness, often by shifting site of care to home and ambulatory settings, as opposed to inpatient care. It is recommended that outpatient palliative care payment models emphasize value-based reimbursement.

These value-based payments should consider the following value-based payment principles:

1. A process by which payers and providers align the needs and acuity of the patient and the services covered.
2. Per enrolled member-per month case rate to cover all community-based palliative care services and providers included in the care team, possibly tiered.
3. Payment incentives for quality and utilization management.

* Not addressed in Medi-Cal palliative care (SB 1004) guidance
Payment Model: Operational Variation

• Formal tiers of service with different payment amounts vs. assuming a distribution of acuity/need and a single payment amount

• Supplemental payments in addition to PEMPM for high utilizers
Payment Model: Plan Experiences

- Is the payment mechanism for palliative care services in your contracts (monthly case rate, for example) appropriate?
- Is there adequate alignment between the cost of delivering palliative care and the impact on the total cost and quality of care?

Case rate universally endorsed:

- “Monthly case rates work. We have occasional exceptions for which we will pay extra fee for service charges for “extraordinary” intensity of services”

Alignment between cost and impact was less clear

- One plan expressed **concerns about alignment**: “I do not feel there is adequate alignment between the case rate and the impact on total cost and quality. The plan will benefit from a more defined approach regarding which members are eligible and a utilization management process to ensure appropriate enrollment and adequate services are provided during enrollment.” *(Implementation issue)*

- One plan **did not feel they had enough data** to assess impact on fiscal outcomes: “Once the service expands, we will be able to measure this but at this point it is not recognized for cost avoidance.”
Payment Model: Provider Experiences

- Do you feel that the payment mechanism for palliative care services in your contracts is appropriate?
- Is the amount of payment you receive enough to make delivering palliative care sustainable for your organization?

Case rates preferred but concerns about sustainability

- “The reimbursement needs to be more to be a profitable program.”
- “Case rate is the better payment model. Case rate varies and, in some instances, it is difficult to provide excellent PC services with a lower case rate.
- “Most contracts require care delivery models that exceed reimbursement sustainability”
Payment Model: Reflections

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- Case rates universally used and endorsed
- Provider concerns about adequacy of payment amount
- Mixed and evolving perceptions of ROI for plans

Presence and significance of variation

- Manageable variation from implementation choices related to payments for high-utilizers
- Problematic variation related to payment amount, which is not addressed in Standards and reflects implementation choices
Conclusions and Reflections

1. It is possible to develop and implement minimum standards that are applicable across lines of business

2. Standards were largely effective in achieving hoped for effects and reducing problematic variation

3. Plans and providers have differing perspectives on the strengths and limitations of different aspects of the Standards (dialogue is recommended)

4. Plan and provider preferences and practices (the “how”) are as important as the specifics in the Standards (the “what”); implementation issues that are not addressed in the Standards created problematic variation

5. Measurement and reporting is the area with the most persistent, problematic variation
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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Questions and Discussion
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Emerging Stronger: Creating a New Normal

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2022 CCCC Webinar Series

Thursday, February 24
Caregiver Support
A Vital Component of Palliative Care

Teressa “TV” Vaughn, MPT, MHA
Caroline Etland, PhD

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To learn more about this work and download a copy of the *Consensus Standards for Community-Based Palliative Care*, go to CoalitionCCC.org/CAIC

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