INTEGRATING PALLIATIVE CARE INTO POPULATION MANAGEMENT:

A Toolkit for Health Plans and Accountable Care Organizations

Serious Illness Framework: Six Essential Strategies

PROACTIVE IDENTIFICATION
Finding high-need patients who need a different approach to care
1

ENGAGEMENT & ASSESSMENT
Working with patients and families to identify burdens, goals, and gaps
2

SERVICES & BENEFIT DESIGN
Addressing physical, psychosocial, and spiritual needs concurrent with treatment
3

PROVIDER NETWORK
NETWORK COMPETENCIES
Ensuring all clinicians have core skills
ACCESS
Ensuring the network includes palliative care specialists
4

PAYMENT & INCENTIVES
Financially supporting skill-building, access to palliative care, and caregiver supports
5

MEASUREMENT & EVALUATION
Confirming the right structure, processes, and delivery of high-value care
6

How to use this Toolkit

These resources can serve as a roadmap for organizing the programs, benefits, providers, and metrics needed to improve care for those with serious illness. Full implementation within a payer organization will likely involve stakeholders from across the organization, each of whom can use the guidance in this document to modify existing workflows, policies, and procedures.

Specifically, the sections can be used by staff in the following units:

	Proactive Identification	Engagement and Assessment	Services and Benefit Design	Provider Network	Payment and Incentives	Measurement and Evaluation
Accountable Care	X	X	X	X	X	X
Care Planning		X	X			
Case Mgt*		X	X			
Communications/Mktg	X		X			
Contracting				X	X	X
Credentialing				X		
Data Analytics	X					X
Finance			X		X	X
Innovation Team	X	X	X	X	X	X
Joint Operating committee			X	X		X
Medical Mgt	X		X	X		
Network Account Mgt				X	X	X
Patient/ Member Education		X	X			
Population Health	X	X	X	X	X	X

Practice Mgt	X	X	X			
Product Design			X	X	X	
Provider Relations				X	X	
Quality Assurance	X	X	X	X	X	X
Strategic Planning	X	X	X	X	X	X
Utilization Mgt		X	X			

* including titles such as care management, care coordination, health coaching, patient navigation

The integration of palliative care into health plans and ACOs is continuing to evolve. It is expected that, as more is learned and new models continue to develop, this toolkit will continue to evolve. CAPC encourages our members to contact us with feedback on what has worked well, what has not, and lessons learned, so that we all can continue to improve the quality of life of those with serious illness.

capc Center to Advance Palliative Care

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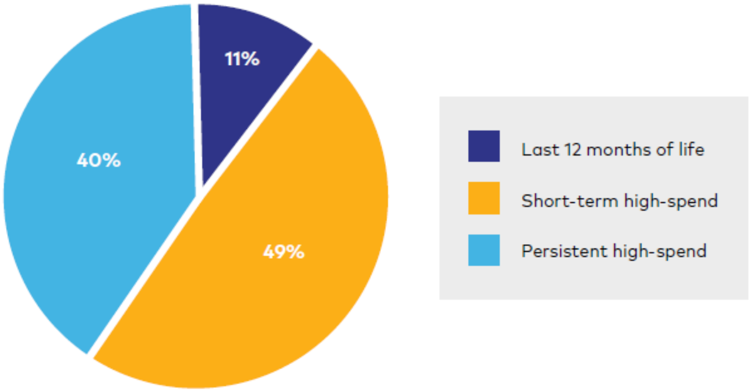
“Moving beyond a ‘one size fits all’ model of care for persons with serious illness and efficiently targeting resources to those who need and will benefit from them the most are critical steps in providing appropriate, value-driven care to this population.” Amy S. Kelley, MD, Mount Sinai Health System

What it is and Why it’s Important

With limited resources, health plans and health systems must target palliative care resources to the appropriate sub-population, but there is not yet a clear consensus of how to define the “seriously ill population.” We know there are important indicators, but no single indicator alone is sufficient.

- Diagnosis is insufficient. There are people with stage IV cancer who are fully functional with minimal distress, while others lack a life threatening diagnosis and still return repeatedly to emergency departments with a high symptom burden.

- High spend is also inadequate. While the preponderance of those in need for palliative care services will likely be in a payer's high-cost claimant list, nearly half of the top five percent of costly patients face issues that resolve within the year and return to a typical spending pattern[1], as illustrated in the figure below:



- Prognosis is a poor identifier of need for palliative care. Individuals with unmet palliative care needs often rely on the emergency department and hospital to manage their needs year-after-year. The same National Academy of Medicine analysis shows that only 11% of the highest cost individuals are in the last 12 months of life.
- Clinician opinion, such as "Would you be surprised if this patient died in the next x months?" is sometimes used as an alternative to data, but studies are conflicting on whether clinician opinion correlates to patient level of burden and distress, or even mortality.

Despite these challenges, identifying the right population for an extra layer of palliative care services and supports is the necessary first step in giving people the right care at the right time in the right setting.

Best practices in Identification

Start by Collecting Relevant Data

There is general consensus that identifying the population in need of palliative care relies on **a combination of three indicators:**

1. **Diagnosis**
2. **Limitations in activities of daily living ("ADLs" – eating, bathing, dressing, transferring, toileting, walking)**
3. **Past utilization data**

A recent article by Amy S. Kelley and her team at Mount Sinai found that combining at least one of ten selected diagnoses, together with both impairment in one or more activities of daily living (ADL impairment) AND one or more hospital or SNF admissions in the prior year in Medicare beneficiaries prospectively predicted the high-spenders with a mean annual Medicare spend of about $31,000 -- more than 50% higher than a diagnosis-driven algorithm alone[2]. The combination of all three factors identified a population with a 50% likelihood of hospitalization and a 22% risk of death in the subsequent year.

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[1] Institute of Medicine Consensus Report, "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life." Appendix E (September 17, 2014); Aldridge MA and Kelley AS, "The myth regarding the high cost of end-of-life care," *Am J Public Health* 2015 December; 105(12): 2411–2415

[2] 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

Some organizations seek a population with a higher risk of mortality – at least 25% to 40% in one year – requiring a more sophisticated identification algorithm. That said, a good deal of suffering and avoidable utilization can be ameliorated in the population that is further "upstream."

Population management organizations have used the indicators noted in the table below to identify the population in need of palliative care:

DIAGNOSIS	FUNCTION	UTILIZATION	COMBINATION RISK SCORES
• Cancer • Advanced liver disease • COPD with oxygen • Heart failure • Renal failure • Parkinson's Disease • Advanced dementia • Diabetes with complications • ALS • Other neurological conditions (egg, stroke, head trauma, intracranial hemorrhage) • Diagnoses indicative of decline, including: sarcopenia, cachexia, weight loss, decubitus ulcers, and/or difficulty walking • Combine diagnosis information into the Charlson Comorbidity Index (CCI)[3]	• Formal functional assessment results (see Section 2: Assessment) • Durable medical equipment ("DME") orders or prior authorizations[4], particularly: ○ home oxygen ○ wheelchair ○ home hospital bed • Transportation orders • Personal care orders • History of falls • Declining ability noted (Nursing, Social Work, or Case Manager notes – search for key words)	• Multiple hospital admissions • Multiple emergency department (ED) visits • Hospital length-of-stay greater than 7 days • ICU stays • High-burden treatment (egg bone marrow transplant, ventricular assist device) • Increased frequency of utilization of ED and/or hospital • Polypharmacy • Skilled nursing stay(s) • Certified home health agency use • High volume helpline callers	• Medicare Advantage Risk Adjustment Factor (RAF) or Hierarchical Clinical Conditions (HCC) score • Hospital One-Year Mortality Risk ("HOMR")) • "LACE" Index Scoring Tool[5]

In addition to diagnosis, functional limitations, and high utilization, **social determinants of health and personal factors** are also commonly used in identifying those appropriate for palliative care services. For example:

- Advanced age (over 75 or 85 years)
- Living alone/lack of nearby family
- Low self-reported quality of life
- Overwhelmed family caregivers
- Frequent missed appointments
- Dual eligibility or Medicaid insurance

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[3] Charlson ME, Charlson RE, Peterson JC, et al., "The charlson comorbidity index is adapted to predict costs of chronic disease in primary care patients," *Journal of Clinical Epidemiology*, 8 Dec 2008; 61(12)

[4] Faurot KR, Jonsson Funk M, et al. "Using claims data to predict dependency in activities of daily living as a proxy for frailty" P*harmacoepidem Drug Saf* Jan 2015;24(1):59-66

[5] Van Walraven C, Dhallia IA, Bell C, et al., "Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community," CMAJ 2010 Apr 6;182(6):551-7

Putting all the relevant data together into a predictive algorithm is then the “art” of identifying patients for palliative care. Private companies are available to partner with health plans and ACOs to collect the appropriate data and run it through their proprietary algorithms to identify the sub-population in need of palliative care. For example, Optum (see Case Studies, below) has an algorithm that successfully incorporates DME authorizations to identify a population that has greater than 50% mortality in any one year, a focus of importance to their organization. Currently, there are a range of algorithms and processes in use, and no clear calculation has yet emerged as the most effective.

Adding in Clinical Opinion

While predictive data algorithms can be fairly accurate, sole reliance on predictive analytics can create other concerns. Claims algorithms often include both false positives (e.g., a high cost hospitalization for coronary artery bypass grafting followed by an uncomplicated and full functional recovery) and false negatives (e.g., an older adult with spinal stenosis and disabling low back pain but no “serious illness” diagnosis), and rarely capture caregiver burden, which is an important predictor of spending and decline[6]**.** Moreover, lags in claims and data analysis can be mitigated with a proactive process of clinician input; for example, one program found that 35% of patients identified had died by the time the list of high need members was generated.

Incorporating clinician opinion can be done in one of two ways:

- Start with clinician identification of patients in their panel. Some programs use the “Surprise Question:” “For which patients would you not be surprised if they died in the next 12 months?” Sharp Healthcare (see Case Studies in Section 3: Services) asks the question more pointedly in this way: “for which patients would you not be surprised if they started to use the hospital as a tool to manage decompensations from the inevitable progression of their chronic illness in the next 12-24 months?” The lists of patients that are created by treating clinicians should be followed by a confirmatory data screen.
- **Start with data-generated lists which are then reviewed with the treating clinician(s)**[7]. This is an effective way to balance sensitivity and specificity. Such a review is also an opportunity to partner directly with the treating provider to ensure the right match of additional services to clinician-identified needs (egg, clinician notes frequent missed appointments due to lack of transportation) and to encourage engagement of the patient/member in the care plan, because their clinician recommended it.

Getting started

Consider relying on existing identification processes

Identification may come from several existing sources. All too often complex algorithms are created where appropriate risk identifiers already exist. For example, as noted in the table above, some organizations believe that the LACE (**L**ength of stay; **A**cuity of admission; **C**omorbidities; **E**mergency Department utilization) score[8] (intended to assess readmission risk) or the risk of mortality scores from hospital discharge data are sufficient. In addition, people with serious illness are often already identified in algorithms for eligibility for complex care management or as part of case management program; as a further cut, case managers can be asked to identify the clients that they are worried about or for whom they have arranged additional supports like personal care or home-delivered meals.

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[6] Ankuda CK, Maust DT, Kabeto MU, et al. “Association Between Spousal Caregiver Well-Being and Care Recipient Healthcare Expenditures” JAGS, 2017

[7] Colbert J and Ganguli I, *To identify patients for case management, look beyond Big Data*, Health Affairs Blog, April 19, 2016

[8] Van Walraven, 2010

Practical considerations for Implementation

1. Use caution when incorporating clinical opinion into the identification process

When programs rely too heavily on treating physicians to identify patients in need of palliative care, some patients who can benefit are overlooked, while some patients who are referred are really not appropriate. There is often "recall bias," where a clinician may not think of a patient they have not seen in a while, perhaps because that patient has been relying on urgent care for symptom crises. A recent study of a common tool to solicit clinician opinion – asking the treating provider "would you be surprised if this patient died in the next year?" – failed to identify most deaths that occurred in the following year[9]. Clinicians are notoriously over-optimistic on prognostication[10] and tend to identify patients for palliative care very late in the disease process, if at all. Further, as noted above, most patients requiring palliative care services are not in the last 12 months of life, and using "the surprise question" or clinician referral can fail to identify them in time to affect change. While the treating providers usually have the best understanding of the patient's situation, both their prognostication ability and their understanding of the benefits of palliative care for high need patients are not yet where they should be to rely primarily on clinical opinion.

2. Functional impairment data will often need confirmation.

While identifying the population in need of palliative care requires information about functional limitations, this data is not always easily available. The table above provides guidance on what proxies, such as DME orders, can be used to indicate ADL limitations. Note that some functional assessments used in post-acute settings, such as the Functional Independence Measure (FIM), are meant to be used to assist in rehabilitation planning and evaluation, and are not the best source of functional impairment for a population facing persistent gradual functional decline. Whenever possible, functional assessments – such as the Karnofsky Performance Status Scale or the Palliative Performance Scale – are recommended, and such assessments could be completed once a population has been screened for diagnosis and utilization indicators (see Section 2: Engagement and Assessment.)

Considerations for Pediatrics

A good approach to identifying the population that should have access to pediatric palliative care professionals and services was published in the New England Journal of Medicine in 2004[i]:

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[9] Lakin JR, Robinson MG, Bernacki RE, Estimating mortality for high-risk primary care patients using the 'surprise question' *Journal of the American Medical Association* December 2016; 176 (12)

[10] Glare P, Virik K, Jones M, et al. A systematic review of physicians' survival predictions in terminally ill cancer patients *BMJ* 2003; 327 :195

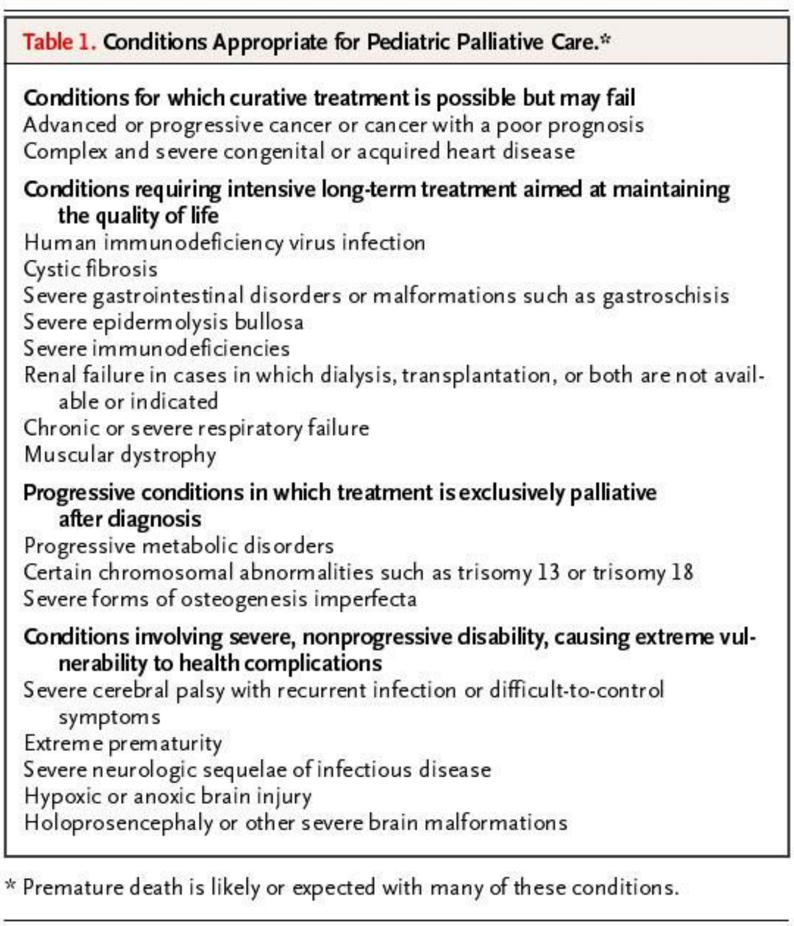

Table 1. Conditions Appropriate for Pediatric Palliative Care.*
Conditions for which curative treatment is possible but may fail
Advanced or progressive cancer or cancer with a poor prognosis
Complex and severe congenital or acquired heart disease
Conditions requiring intensive long-term treatment aimed at maintaining the quality of life
Human immunodeficiency virus infection
Cystic fibrosis
Severe gastrointestinal disorders or malformations such as gastroschisis
Severe epidermolysis bullosa
Severe immunodeficiencies
Renal failure in cases in which dialysis, transplantation, or both are not available or indicated
Chronic or severe respiratory failure
Muscular dystrophy
Progressive conditions in which treatment is exclusively palliative after diagnosis
Progressive metabolic disorders
Certain chromosomal abnormalities such as trisomy 13 or trisomy 18
Severe forms of osteogenesis imperfecta
Conditions involving severe, nonprogressive disability, causing extreme vulnerability to health complications
Severe cerebral palsy with recurrent infection or difficult-to-control symptoms
Extreme prematurity
Severe neurologic sequelae of infectious disease
Hypoxic or anoxic brain injury
Holoprosencephaly or other severe brain malformations

* Premature death is likely or expected with many of these conditions.

In most pediatric palliative care programs, children with cancer make up less than 20% of the patients, with the bulk of patients being children with genetic, neurodevelopmental or congenital disorders. A potential indicator of pediatric need is DME orders, such as g-tubes or home ventilators.

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[i] Himelstein, BP JM Hilden, AM Boldt, D Weissman Pediatric Palliative Care*, N Engl J Med* (2004); 350

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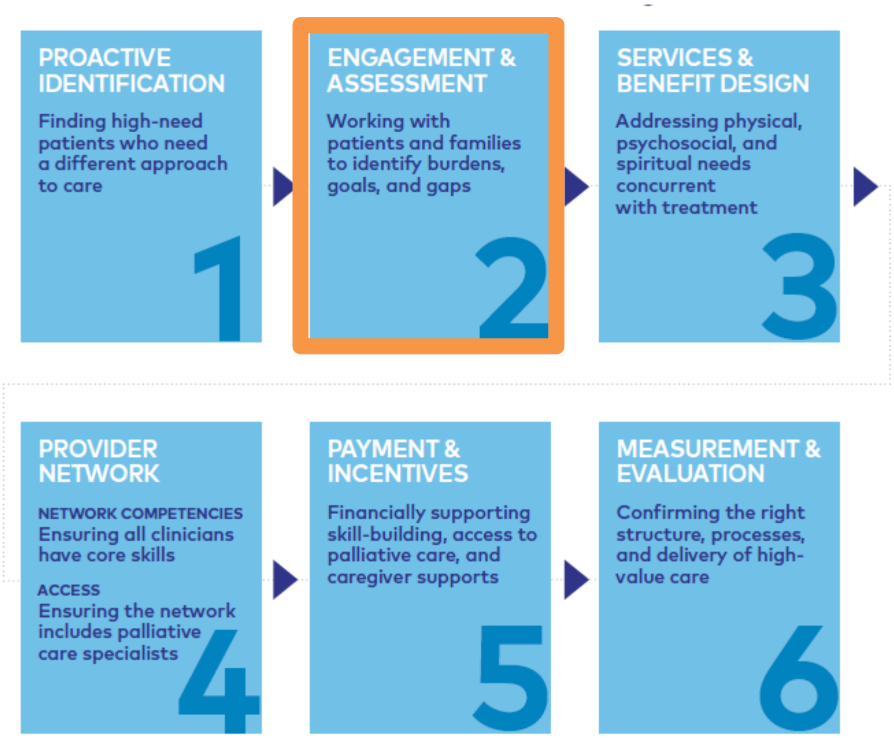
ENGAGEMENT AND ASSESSMENT



"Even the best palliative care will be of little use without the ability to engage patients to understand their needs and preferences." Randy Krakauer, MD

What it is and Why it's Important

While there is a science to identifying individuals with serious illness, there is an art to defining their needs and the shared-decision-making required to address them. Best practice in health plan and ACO case management requires that the staff responsible for outreach and assessment must have the skills to:

- Hold meaningful conversations to understand values and goals, and help individuals translate those into treatment preferences and priorities
- Assess needs and distress across the full range of physical-psycho-social-spiritual spheres
- Determine what is really needed to support the entire family, taking into account practical and financial considerations

Too often case management focuses on physical needs and adherence to the treatment plan prescribed by the treating clinicians, but such an approach is often insufficient for the populations facing significant symptom burden and life-threatening illness. A different set of communication and assessment skills are needed for the seriously ill population.

Note that the term “case management” as used in this guidance encompasses nurse case management, care coordination, health coaching, patient navigation, and all other patient guidance and support.

Best practices in Engagement and Assessment

A. Case manager hiring and training

Successful engagement is dependent on the ability of the case manager to create a trusting relationship and to build on it to provide expert support and assistance. This requires:

- the ability to gather the individual and family’s “back-story”
- knowledge about course of and expectations of the illnesses
- knowledge of the types of support available and how to mobilize it

In hiring case managers, the following qualifications should be sought out:

- Human warmth and interest in the stories and circumstances of other people
- Positive and optimistic attitude
- Educated and have real experience in either nursing, social work, gerontology, or psychology
- Strong capabilities to assess, plan, coordinate, and monitor services
- Resourceful and creative in identifying and covering social and medical services
- Excellent advocacy skills with a community-based mindset
- Interest and ability in meaningful advance care planning conversations
- Able to assist patients and families in thinking through choices, rather than explaining what to do
- Utilize a patient and family centered approach
- Case management certification preferred.

The strongest serious illness case management programs look for staff members that are eager to work with this population.

Even well-qualified case managers will need extensive training to do this job well. Training should encompass all the likely concerns and issues facing individuals with serious illness and their families; role-playing is an effective mechanism for this. Training is also necessary in expected disease progression and treatment options (and their various pros and cons). Clinical knowledge of the more common illnesses – cancer, dementia, heart failure, COPD, and end-stage kidney disease – must be strengthened in training, so that case managers can hold conversations about expectations without referring the patient and family back-and-forth to multiple sources.

Skills in motivational interviewing and “cultural humility” round out the full slate of competencies needed. Selection and training might be followed by a period of review and mentoring by experienced case managers. If telephonic, calls should be recorded and reviewed carefully for a minimum of two weeks after hire. Ongoing mentoring not only allows the new hire to continue to hone their knowledge and skills, but also allows the plan or ACO early indication of whether the new hire can truly be comfortable in assisting patient and family decision-making without making recommendations or “steering” the conversation.

Health plans including Kaiser Permanente and Aetna have found improved quality, satisfaction and cost from a strong team of well-trained case managers.[1] There are a growing number of training courses and resources available to strengthen case manager communication and assessment skills specific to supporting those with serious illness, including those available through the Center to Advance Palliative Care (CAPC) – consider the curriculum guide for case managers as a starting point to develop a training program.

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[1] Randall Krakauer, Claire M. Spettell, Lonny Reisman, and Marcia J. Wade, Opportunities to Improve the Quality of care for Advanced Illness, *Health Affairs,* 28, no.5 (2009): 1357-1359.

B. Engagement skills and processes

As noted above, successful case management of the seriously ill depends on forming meaningful connections with people, and comfort in holding difficult conversations. Effective conversations simply cannot be had by reading a script or through a smart phone application. A barrage of questions, checklists, or flow charts can be overwhelming and limit the opportunity to more thoroughly identify needs. ***The bottom line: allow sufficient time for case manages to make a deep human connection, and success will follow.***

Whenever possible, treating providers should be contacted before contacting the patient. This not only enables the case manager to gather as much background information as possible, but also to obtain the clinician's buy-in for additional support.

Other successful engagement strategies include:

- Contacting someone shortly after a hospitalization or emergency department visit
- Starting the conversation by asking the individual's permission to discuss their situation with them
- After that, start by asking what the individual/family already know – do not make any assumptions that they are aware of their state of illness or prognosis
- Ask what is worrying them most about their situation, and then use the response to guide next questions
- Emphasize that the goal is to maximize their quality-of-life while they are going through this difficult illness
- Being "present" when someone is in an emotional or difficult place
- Being well versed in describing palliative care services, sometimes without using the term "palliative care," and always making sure not to confuse palliative care with end-of-life care or hospice
- Asking open-ended questions to discern the person's or families' understanding of the illness, their concerns and priorities (rather than going through a yes/no checklist or conversation)
- Incorporating Motivational Interviewing/Appreciative Inquiry techniques to improve activation and self-management.

Consider this example, excerpted from a case note:

Wife stated member passed away with Hospice. Much emotional support given to spouse. She talked about what a wonderful life they had together, their children, all of the people's lives that he touched - they were married 49 years last Thursday and each year he would give her a piece of jewelry. On Tuesday when she walked into his room he had a gift and card laying on his chest, a beautiful ring that he had their daughter purchase. She was happy he gave it to her on Tuesday - on Thursday he was not alert . . .Also stated that Hospice was wonderful, as well as everyone at the doctor's office, and everyone here at [the health plan]. She tells all of her friends that "when you are part of [this health plan], you have a lifeline." Encouraged her to call CM with any issues or concerns. Closed to Case Management.

The depth of the human connection between this case manager and the person's wife is obvious. This level of engagement resulted from a program that was entirely telephonic. Clearly this case manager has combined training, experience and empathy. She took the time to assess and understand the clinical issues, and the psychosocial issues. This is one of many such examples that illustrate why a palliative care-based case management program can be effective and produce real satisfaction and impact. What might have been the result had this case manager merely read scripted material or focused on adherence?

C. Assessments

The needs of seriously ill patients and their family members will vary enormously. Comprehensive assessment across all aspects of well-being – physical, psychological, social, spiritual, and financial – will help to ensure that the services made available to the person and family align with their needs.

Best practice suggests that symptom burden and functional status should be assessed initially, as these can also serve as screening for level of palliative care need. Even the most sophisticated identification processes will result in "false positives," and physical assessment will reveal whether function is truly impacted.

The following are the more common physical assessment tools.

Assessment Needed	Key Assessment Tools
Symptom Burden	• Pain Assessment and Documentation Tool (PADT) • Condensed Memorial Symptom Assessment Scale (CMSAS) • Edmonton Symptom Assessment Scale (ESAS) • National Comprehensive Cancer Network Distress Thermometer
Functional Status	• Karnofsky Performance Status Scale • Palliative Performance Scale • Australia Modified Karnofsky Scale • Meets Home Health Homebound Definition: needs supportive devices, special transportation, or assistance of another person to leave the home; or leaving the home is medically contra-indicated

From these assessments, a person can be risk-stratified into Low, Medium and High Need:

- Low Need -- Patients with low symptom burden or minimal functional impairment; serious but stable illness.
- Medium Need -- Physical symptoms are severe or are unstable, or function is greatly compromised, impeding self-care.
- High Need – Significant symptom burden along with functional limitations

The level of need can dictate whether palliative care needs can be met by the treating provider team, specialty palliative care consultation, ongoing palliative care co-management, or specialized palliative care programs, often home-based. See Section 3: Services, for how to match level of need with services.

For those individuals within the Medium and High Need categories, additional assessment should follow, to enable a holistic response to the individuals' needs. The table below describes the additional assessments that a clinical team can provide in order to assess appropriateness for certain services.

Assessment Needed	Why Assess?	Assessment Tool
Depression	Depression and psychological distress commonly co-occur with serious illness, and are treatable	• PHQ-9
Caregiver Burden	Family members shoulder tremendous direct care responsibilities, with significant physical, emotional, functional, and financial consequences.	• Zarit Burden Interview (ZBI-12)
Social Needs	Social determinants such as housing, food insecurity, trauma, illiteracy, and poverty strongly impact health status and utilization.	• Limited consistent assessment tools are used. Some health plans and ACOs are developing their own tools referencing

		resources such as the Institute of Medicine’s publications on caring for those with serious illness.[2]
Spiritual Needs	Questions of meaning, purpose, and connection to a faith community are of high priority to most individuals with serious illness.	- Beck Hopelessness Scale

Referrals to appropriate services or supports can then follow these assessments. Again, please see Section 3: Services, for more detailed information on services.

Getting started

1. Start by evaluating case management skills and processes already in place.

Prior to designing and implementing a case management program that will help care for people with serious illness, it is important to assess what you already have in place with regard to both training for case managers and support for those with serious illness. The remaining steps would be addressing the gaps, rather than building entire programs.

2. Integrate palliative care training into existing training.

Most complex case management programs use motivational interviewing as the basis of the services they provide. Determine where palliative care principles like psycho-social-spiritual assessment, goals of care discussions, and advance care planning can fit into the existing training protocols. For example, CAPC training for case managers in communication skills can be added to help case managers shift the conversation focus from promoting adherence to clarifying values and preferences.

In addition ensure that clinical skills training for palliative care is also supplemented by operational training. This may take coordination with utilization management to develop workflows for authorizing services individuals with serious illness may need more frequently. By coupling clinical skills and operational training, case managers can apply their skills directly to the care covered by an individual’s particular benefits.

3. Assess technology and data resources.

It is recommended that in addition to assessing training potential and plans, a technology and data assessment also be completed. A technology assessment should include the case management platforms that are used to keep track of cases and the pathways that may form between an analytics team, outreach, case management, and utilization management. For example, in order to track people in need of palliative care services by their treating providers, the system should have a place to flag such people and document their goals of care. Documented goals of care and any advance care planning should also be available to network providers.

Practical considerations for implementation

1. Assessments should be done for specific purposes, not for the sake of complete assessment.

Keep in mind that overburdening the individual or family caregiver with too many assessments leads to frustration and exhaustion. Assessments should be brief, appropriately prioritized and timed, requiring coordination internally and, where possible, with the treating providers.

2. Weigh the pros and cons of telephonic or in-person case management

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[2] Institute of Medicine, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life” September 17, 2014

Some contend that for managing the complex and highly-variable needs of the seriously-ill population, telephonic case management is insufficient, yet there is good evidence that, when executed correctly, telephonic is just as effective as in-person. Plans and ACOs should consider the culture of their organizations, their relationships with treating providers, and the cost-benefit of in-person case management when deciding on the best approach. A health plan or ACO can combine or adopt variations of these alternatives as well.

OPTIONS	Advantages	Disadvantages
Telephonic	• Economies of scale • Greater flexibility to extend hours for access • Some people may prefer telephonic due to convenience, greater accessibility if unable to travel, or personal issues (embarrassment in sharing details face to face)	• More challenging to build trusting relationships with people via telephone • Difficult to assess social, housing, food, family dynamics that influence care • Limited access to treating providers or ability to directly deliver needed services (e.g. not able to write a prescription)
Practice Embedded or In-Person	• Able to build strong relationships with clinicians • Access to clinical record • Face-to-face interactions with patients and clinicians can improve engagement	• May be pulled from case management duties to cover day-to-day clinic duties • Less flexibility in case management staffing • Overhead costs (space, travel) • Requires patient's ability to travel unless this is part of a home-based model

3. Evaluate whether a dedicated case management team would be appropriate

Whether building or buying case management services, one key design decision that health plans and ACOs will need to make is whether to develop a dedicated case management team just for people with serious illness, with specially trained case managers who have well-honed skills in communication and assessment. The table below summarizes the options:

Case Management Approach	Short Description	Considerations
Dedicated case management team	Specially trained team with assigned caseload that meet internal criteria for serious illness.	• Allows team to work together as a unit, building team processes like morning huddles to review cases with medical directors. • Opportunity to enroll members in a specific case management program, providing opportunities to manage enhanced benefits based on the unique needs of the patient and track outcomes. • More flexibility in managing caseloads to allow adequate time for complex case management • Important to collaborate and cross-train with other case managers in high-cost, complex care teams to avoid duplication and member confusion.
Integrate with existing case management teams	Train all case managers in the core principles and practices of palliative care.	• Must ensure that all case managers have access to training in pain and symptom assessment and goals of care and understand the basics of palliative care and the needs of those with serious illness. • Must ensure all case managers are empowered and have the necessary support to take the time necessary to address member needs. • Limits the ability to develop consistent experiences, offer enhanced benefits, and in some cases demonstrate outcomes.
Referring to network providers for case	Refer those with serious illness to network providers with available case	• Some health plans and ACOs are electing to provide claims and other program support to network providers who are then taking on the case management role for those with serious illness. This often requires contract amendments, and often new payment models.

management	management expertise and services.	- For those health systems that are providing their own case management, it is recommended that the health plan clearly define criteria for high quality services, such as designated training, outreach response times, and tracking of certain palliative care metrics. - Important to collaborate and cross-train with other case managers in high-cost, complex care teams to avoid duplication and member confusion.

4. Coordinate with member/patient education vehicles

Regardless of how a health plan or ACO elects to implement its case management services, there is an important role they can play in educating their entire population on this topic. Member/patient education vehicles can be used to explain what palliative care is, and also encourage family conversations on wishes and values. Resources might also include information on how to communicate someone's wishes to their treating provider.

Some health plans and ACOs have launched targeted campaigns to educate their members – regardless of health status – on family discussions. For example, Blue Cross Blue Shield of Massachusetts promoted The Conversation Project (www.theconversationproject.org) to an employer group and a New York State ACO adopted Respecting Choices (www.respectingchoices.org), encouraging family discussions about their values and planning ahead. Payers can promote publicly available educational materials such as those available at www.getpalliativecare.org to members so they can learn what palliative care is and its role in supporting those with serious illness.

Considerations for Pediatrics

Just as case managers working with adults would need strong knowledge in the clinical conditions faced by the target population, the same is true for those case managers working with children – they would need to understand the perinatal, neonatal, and pediatric conditions. In addition, further training is needed to ensure that case managers have the skills to help parents in their anticipatory grief and in communicating with healthy siblings and extended family.

Assessment tools for the psychosocial needs of seriously ill children or their parents are limited. The PedsQL "a modular approach to measuring health-related quality of life (HRQOL)," with surveys based on age and a proxy survey for parents. In addition, a consensus process has resulted in assessment standards, which health plans and ACOs can use to create their own assessment tool(s).

For more guidance, two resources for case managers working with pediatric populations are included in the Additional Resources section: a) CAPC's Pediatric Palliative Care Field Resource Guide may be a helpful resource; and b) provider resources available through the Courageous Parents Network.

INTEGRATING PALLIATIVE CARE INTO POPULATION MANAGEMENT:

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SERVICES AND BENEFITS

“Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge.” Institute of Medicine, Dying in America 2014

What it is and Why it’s Important

Palliative care encompasses a range of services that address symptoms and stresses of serious illness, delivered by an interdisciplinary team, and often coordinated with additional service providers. Key members of palliative care teams are the clinicians – physicians and advanced practice practitioners – who provide medical services that are medically necessary and already covered through traditional medical benefits, including Medicare Part B. In other words, palliative care is not a new service that needs a new, distinct benefit.

However, there are often limits put in place*, and there are also non-medical services that seriously ill patients need which are often not included in standard benefit packages. For these reasons, health plans and ACOs

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* For example, hospice care is a well-known and comprehensive delivery model of palliative care that many health plans make available, but too often health plans unnecessarily replicate the same restrictions that exist in the Medicare hospice benefit: requiring two doctors to certify a prognosis of six months or less to live, and that the patient agrees to forgo coverage for disease-modifying treatment. As explained further below, commercial hospice benefits do not need to follow these same restrictions and individuals and the plan often benefit when these restrictions are modified.

should take steps to evaluate the benefits and services available, so that appropriate palliative care services are available to the right patients.

Health plans and ACOs must also recognize that palliative care is additive to existing medical services and treatments, and should be available regardless of diagnosis or stage of illness. At diagnosis, patients need initial discussions about the benefits and drawbacks of treatment options and what to expect in the future, as well as preliminary advance care planning. They will also need pain and symptom management while they pursue disease-directed therapies, to maximize function, independence, and quality of life for as long as possible.

Best practices in Matching Services to Needs

While the specific services provided will depend on a person's need, there are certain key service capabilities that are fundamental to the care of all persons with serious illness:

1. **Expert pain and symptom management**
2. **Meaningful 24/7 clinician availability**
3. **Shared decision making using expert communication skills, including:**
   a. **Explaining what to expect with disease progression and treatment options, in terms that the patient and family can understand**
   b. **Eliciting patient and family caregiver concerns and priorities**
   c. **Advance care planning processes**
4. **Family caregiver support, including emotional support and personal care supports for the patient**
5. **Ability to mobilize practical social supports**

Below are examples of detailed service needs by risk category (low to high in terms of severity/intractability), presented in line with the domains of the National Consensus Project Guidelines for Quality Palliative Care.

1. Physical Symptoms: Pain, Dyspnea, Nausea

Low	Medium	High
• Palliative care consult • Treatment recommendations to treating provider • Patient and family self-care teaching • Palliative care in-home medication ("comfort") pack in case of urgent need (eg low dose opioids for dyspnea crisis)	• Continued palliative care specialist consults • Self-care teaching and tools, as for Low Need • Home-based nursing and social work for member and family education, medication reconciliation, home safety and social supports assessment • Some home-based therapies (e.g. PT, OT) • Home adaptations as needed (e.g., air conditioning, gait assist devices, grab-bars etc.) • Palliative care in-home medication ("comfort") pack in case of urgent need	• Home-based primary and palliative care, inclusive of physician, nursing, social work, and spiritual care; or • Ongoing palliative care specialist co-management, if not serving in the primary clinician role • Home adaptations • Complementary services (e.g., massage or acupuncture) • Family caregiver supports such as respite care, counseling, support groups • Palliative care in-home medication ("comfort") pack in case of urgent need

2. Functional Symptoms: Impairments in Activities of Daily Living (ADLs) and Instrumental ADLs

Low	Medium	High
• Durable medical equipment (DME), as needed	• Home environment safety assessment and follow-up	• Personal care services (home health aide)

• Outpatient therapy, as needed	• Home adaptations as needed (eg, grab bars) • Home-based physical and/or occupational therapy • Personal care (home health aide), limited	• Housekeeping and other home environmental supports • Home-based therapy; may be compensatory instead of restorative

3. Psychological Symptoms: Depression, Anxiety, Trouble Coping

Low	Medium	High
• Linkage to community supports • Psychopharmacology • Referral to psychological and/or psychiatric services for both member and family caregivers	• Linkage to community supports • Psychopharmacology • Referral to psychological and/or psychiatric services for both member and family caregivers • Substance use counseling, as needed • Counseling facilitation services, such as transportation or home visits	• Linkage to community supports • Psychopharmacology • Referral to psychological and/or psychiatric services for both member and family caregivers; and/or • Home-based counseling • Family counseling, in the home • Substance use counseling, as needed

4. Social and Economic: Food, Transport, Environmental Supports, Friendly Visiting

Low	Medium	High
• Benefits and entitlements assistance • Linkage to community supports	• Benefits and entitlements assistance • Linkage to community supports, with follow-up • Linkage to financial assistance, with follow-up	• Benefits and entitlements assistance • Linkage to community supports • Psychological counseling • Food, transport, safety, and housing services as needed • Linkage to financial assistance, with follow-up

5. Spiritual, Religious, and Existential: Chaplaincy, Structured Worship

Low	Medium	High
• Linkage to spiritual supports in the community	• Linkage to spiritual supports in the community, with follow-up • Chaplain “consult”	• In-home Chaplain visits, as needed

6. Caregiver Support: Training, Trouble coping, Respite

Low	Medium	High
• Caregiver linkage to community supports	• Caregiver psychological counseling • Caregiver spiritual counseling • Supplemental caregiver education	• In-home respite care or respite stay in a care facility • Personal care services for the patient • Caregiver counseling and education

Many organizations have created home-based palliative care programs to deliver the full range of services, varied according to level of need. See Case Studies, including ProHealth, Sharp and Kaiser Permanente.

Best practices in Coverage and Benefit Design

Modifying and Adding Health Plan Benefits

Recall that some palliative care services are already covered under Part B codes as medical services, and some members – through luck or their own self-advocacy – will already be accessing pieces of what they need. However, to have a broader impact, health plans should **conduct a comprehensive review of all existing benefits and policies available to a person with serious illness** to ensure adequate coverage of their holistic medical, home health, pharmacy, skilled nursing, and behavioral health needs.

A comprehensive benefit review should start with the services listed in in ***Best Practices in Matching Services to Needs***. For some needs – such as home health care, medical supplies, DME, or specialist visits – a health plan may cover the services necessary, but would need to evaluate and potentially amend its policies that impact access to those services, such as:

- Can co-payments be eliminated, or deductibles waived for certain services, such as palliative care specialist consultations?
- Can the home care benefit eligibility be modified, to cover home visiting services of nurses, social workers and other professionals for those identified as having a serious illness, regardless of meeting "homebound" or "skilled need" criteria?
- Can performance guarantees of turn-around time for delivery of supplies and durable medical equipment be added to network provider contracts?

For other needs, a health plan will need to evaluate and potentially change prior authorization requirements, utilization limitations, or benefit periods, or consider development of additional benefits. For example:

- Can in-home respite care and/or adult day care be made available for members with overwhelmed family caregivers?
- Can the home health benefit be modified to enable personal care services for members who need assistance with "instrumental activities of daily living" (e.g. food preparation)?
- Can marriage and family counseling be made available to seriously ill members and their families without utilization limitations?
- Can home adaptation be added as a benefit for those authorized under certain circumstances?

Reconsider utilization criteria and limits to coverage even for those services that may rarely be used. Developing coverage maximums and eligibility criteria for these services and documenting them as part of medical policy allows for increased timeliness and appropriateness of responses by utilization managers and medical directors while also mitigating the risk of allowing individual or single case considerations to be extended to those without a defined need. This not only improves the patient, family, and provider experience through transparency in coverage determinations, but also decreases time and resources spent reviewing appeals and grievances from seriously ill people and their family caregivers.

The examples in the table below illustrate the types of review of benefit coverage and policies, as well as potential changes:

Needed Service	Covered Under a Standard Benefit?	Suggested Policy Determinations/Eligibility Criteria
Palliative care consultations	Yes	Eliminate cost-sharing for visits billed by palliative care specialists, as well as for all billed advance care planning conversations.
Durable medical equipment (DME)	Yes	Ensure that urgent supplies and DME (e.g. breathing apparatuses, compressors, etc.) are covered under a performance guarantee, requiring all contracted vendors to deliver supplies in less than 8 hours.
Home environment safety assessment and follow-up	No	Cover service by specified service providers licensed with the state to perform home assessments for all individuals with moderate functional impairment.
Home adaptations or modifications (e.g., grab bars)	No	Cover service for all individuals with moderate functional impairment up to a specified dollar amount.

Home-based physical and/or occupational therapy	Yes	Ensure that all individuals with moderate functional impairment can access services and not simply those who are determined homebound. Ensure that services provided can be both restorative and rehabilitative in nature.
Personal care services	Sometimes	Cover a defined number of home health aide hours per week for all individuals with significant functional impairment. Cover non-emergency transportation for members meeting eligibility criteria.
Respite services for family caregivers	No	Ensure that individuals living at home and meeting the nursing facility level of care who have a primary caregiver providing greater than 16 hours per month of primary caregiving have access to a defined number of hours of in-home respite and/or a specified number of adult day care days per week.
Access to a Spiritual Professional	No	Ensure that certified healthcare chaplains are covered. Getting started with this benefit can focus on advance care planning visits.
Marriage and Family Counseling	Yes	Eliminate utilization limitations. Consider elimination of cost-sharing.
Personal Emergency Response System	No	Ensure that all individuals who meet the following criteria have coverage for a basic monitoring device: Spends most of time at home alone; dependent for more than 3 ADLs; legally blind; have had a recent fall resulting in hospital stay; is at high risk for falls.

Improved coverage policies should reflect the urgency of a serious illness and can improve care transitions across settings and decrease gaps in care, such as those monitored as part of the Medicare Advantage Star Ratings. For example, a program that would authorize limited coverage for home maintenance can help decrease an individual's risk for falls. In addition, programs that allow for home health aides or cover instrumental activities of daily living can improve medication adherence and therefore reduce readmissions due to non-compliance.

Not All Modifications Need Be Benefits

Consider that improvements for seriously ill members can be done through network development as well. Noted above is the suggestion that medical supply and DME providers be held to performance guarantees for quick turn-around. Additionally, while phlebotomy is a standard service covered by an individual's medical benefit, individuals with serious illness may have limited mobility and be unable to access outpatient laboratory services. The same is true for mobile laboratory and imaging services. Mail-order and on-demand pharmacy delivery are also essential when caring for the seriously ill.

Some additional services can be provided through the structure of a health plan program, such as Case Management, rather than filing it in the product. While the services provided may not have as much transparency or visibility as a defined benefit, a program offered through a case management department rather than directly through a member's benefits may be an even more effective way to engage seriously ill members in decision-making (see **Section 2: Engagement and Assessment**).

Hospice Benefit Considerations

Some commercial health plans have revised their hospice coverage policies to remove the limitations that exist in the Medicare hospice benefit, enabling hospice care to be delivered concurrently with treatment, and modifying authorization requirements to remove barriers and improve access to the necessary skills and supports available in hospice.

Specific changes to the commercial hospice benefit have included:

- Removal or revision of the 6-month-prognosis requirement to access hospice benefits. Some plans have extended eligibility for hospice services to a period of 12-months, and a few have considered removing a time-bound prognosis for eligibility.
- Allowance for concurrent care provided alongside hospice, including total parenteral nutrition, wound care, palliative chemotherapy, palliative radiation, etc.
- Allowance for concurrent disease treatment provided alongside hospice, including for cancer, cardiac disease, and COPD.
- Revision of discharge criteria to decrease the number of live discharges from hospice to remove or extend requirements for re-authorization for people who are enrolled in hospice longer than one year and stabilized due to the care they receive in hospice.

According to the health plans that have modified their hospice benefits in these ways, they have found these changes help to increase the hospice election rate while greatly reducing hospital readmission rates for individuals who otherwise would have been discharged from, or ineligible for, hospice. In addition, these changes have increased access to grief and bereavement resources for caregivers both prior to and after the death of their family member. By extending these services through concurrent care provisions or extended eligibility determinations, plans have seen an improvement in patient and family satisfaction and a reduction in grievances made by family members of people with serious illness.

Getting started

1. Starting with the comprehensive review

Creation and expansion of new benefits can take years to develop and implement, especially if they are constructed as formal benefits within an insurance product. At a minimum, health plans should review current payment and coverage policies that would affect people with serious illness the most. When revising and documenting policies for those with serious illness, begin by assessing coverage determinations using two questions:

1. Would changing coverage determinations or authorization processes keep the person with serious illness out of the hospital or from needing a higher level of care?
2. Is the policy or process set up in a way that can accommodate urgent needs, especially after- hour requests and crises?

By identifying gaps in coverage, gaps in process, and barriers to receipt of care in line with treatment preferences and then reviewing access to needed services under current benefit design, areas for improvement are identified.

A relatively simple step involves revision to cost sharing requirements, such as the removal of a co-payment or coinsurance for advance care planning conversations or palliative care consultations, as noted above. From there, benefit limitations can be addressed, such as changes to the home care, and hospice benefit. Lastly, additional defined benefits for those with serious illness may be included as part of a broader benefit design, such as personal care, nutritional services, caregiver support, and/or social services and supports.

2. Benefit additions should start with a pilot

For new benefits or services offered, pilot the benefits with a smaller population or a specific product to gain experience with how the benefit will be used. Once the assumptions in the benefit design and pricing have been tested, subsequent implementation of the new benefit or service can be expedited and medical expense can be better predicted.

Practical considerations for implementation

1. The importance of data

Changes in coverage, payment policies, or authorization processes will often require a clinical and actuarial assessment to ensure consistency with evidence-based care and to assess the impact on medical costs and premiums. Utilization, cost, and outcome data are necessary to quantify the total impact of proposed changes and can also be used to proactively identify emerging trends in patient or caregiver needs.

2. Consider distinct benefits for pediatric palliative care and services

Children and their families with serious illness need specialized services to address physical symptoms, functional needs, and psycho-social-spiritual stresses. For example covering Child-Life Specialists, family transportation, creative arts therapists, and caregiver/sibling counseling is especially critical in these cases.

The Affordable Care Act includes a provision that all Medicaid beneficiaries under 18 years old are allowed to access hospice benefits without forgoing any curative treatment. Hospice entails home-based specialty palliative care services along with emotional and spiritual support for the child and family.

3. Limitations on Medicare Advantage Plans

Medicare Advantage plans are often limited by federal regulation in what can be added as a new benefit. For example, the Medicare uniformity requirement precludes varying benefit design within a Medicare Advantage plan based on health status or other enrollee characteristics. Consult your compliance team for benefit changes in this line of business.

4. Education on existing benefits

Some health plans are working to educate their members and providers about existing covered benefits that can be accessed for people with serious illness. While many services that would benefit those with serious illness are already covered by a health plan, patients and providers alike are often not aware of what is available. A prime example is a consultation by a billable palliative care specialist, which is a covered benefit under most medical plans; yet because “palliative care” is not a defined benefit, some assume that palliative care specialist visits are not covered. Thus, it is critical that benefit clarification and navigation be improved so that providers and those facing serious illness know what is available to them and how to access those services.

One good place to start is by educating case managers about existing covered benefits that can meet the individual’s needs (e.g., palliative care specialist visits, home health for skilled needs, mental health counseling services). Communications that clarify existing benefits for network providers is another important aspect.

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PROVIDER NETWORK

"Our program is designed to help individuals with advanced illness receive high-quality care that honors priorities and preferences, and to lessen the burden on critically ill patients and their families." Andrew Dreyfus, Blue Cross Massachusetts CEO

What it is and Why it's Important

Health plans and ACOs need a provider network with the skills, knowledge, and capacity to provide the range of services needed to care for those with serious illness. The network requires two essential features:

1. All network providers who commonly care for the seriously ill – including primary care, oncology, cardiology, nephrology, neurology and other specialty services – must have demonstrated training and competency in basic pain/symptom management and communication skills.

2. Certified specialty palliative care providers must be reliably available for the most complex patients. This includes access to home-based palliative care programs for the most complex, functionally impaired, or debilitated patients.

Compared to the size of the population in need (roughly 16 million people per year) there is a shortage of specialty trained palliative care providers. The great majority of people with serious illness will have to get their needs for pain and symptom management, meaningful conversations and advance care planning, care coordination, and family and social supports from their treating clinicians. Unfortunately, most have never received such training during undergraduate and graduate medical and nursing education. Therefore, all relevant network physicians, nurses, social workers, therapists, and pharmacists require mid-career training in core palliative care skills, and health plans and ACO leadership can both incentivize and facilitate the development of these skills.

Specialist palliative care clinicians should be available to their colleagues for advice and consultation, and for co-management when patients face complex situations, intractable symptoms, and overwhelmed caregivers (see "Engagement and Assessment" section for more information about risk-stratification).

Best Practices in Enhancing the Existing Network's Core Palliative Care Skills

The table below summarizes the distinction among treating providers delivering core palliative care, consulting specialty palliative care, and specialized services, clarifying why the network requires all levels:

Low Palliative Need	Medium Palliative Need	High Palliative Need
Usual care possibly with specialty palliative care consult(s)	**Collaborative specialty palliative care services**	**Ongoing and active management by specialty palliative care team**
Usual care by treating provider with training in communication, care coordination, family support, and symptom management	Specialty palliative care available for ongoing consultation and in response to crises	Home-based services likely. Primary care responsibility may be diverted to palliative care team.
The treating providers should be trained in the knowledge and skills of safe and effective symptom management and communication. Ongoing specialty palliative care is unlikely to be needed.	Specialty palliative care consultation or co-management is appropriate when a focused problem arises, such as intractable symptoms, or an overwhelmed caregiver.	Complex cases often require the ongoing involvement of the specialty palliative care team. Care is some combination of usual and palliative care. The degree of the palliative care team responsibility assumed depends upon availability, individual and family need, and treating clinician preference.

Skills Needed by Treating Clinicians

Clinicians that regularly treat patients with serious illness should have the knowledge and skills to provide basic palliative care, such as holding meaningful conversations about prognosis and goals of care, or providing safe and effective pain and symptom management. Health plans and ACOs can incentivize and recognize those network providers who attain these essential skills:

Essential Clinical Skills	
Pain and symptom management	Symptom distress is the number 1 cause of 911 calls, ED visits, and unnecessary hospitalizations[1]. Effective management of pain and symptoms is a prerequisite to sustainable care in the home, clinic, or other non-acute settings, as well as to achieving person-centered goals of care. Clinicians need skills in pain and symptom assessment and management, skills not adequately taught in medical and nursing school and residency curricula.

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[1] Nipp, RD, El-Jawahri, A, Moran, SM, et al., "The relationship between physical and psychological symptoms and health care utilization in hospitalized patients with advanced cancer," *Cancer,* December 2017; 123: 4720–4727

Goal setting	Communication and listening skills are required to share an individual's prognosis, translate potential treatment side effects, risks and benefits, capture the person's and, when appropriate, family's, concerns and priorities, and to communicate those goals to all members of the care team. Few clinicians feel they have the right training, and often express discomfort in these conversations[2].
Practical and social supports	Treating providers should be able to identify and address practical and social issues (such as literacy; language barriers; access to food, transportation and safe housing; family caregiver exhaustion or incapacity; and mental and behavioral health issues) that may undermine effective care. These must be documented as gaps in care or treatment in order to ensure services matched to these needs.

The role of the health plan and ACO in ensuring these skills cannot be understated. There is a significant gap in our medical system's skills that all parties – educators, payers and providers – must work together to address. **Health plans and ACOs should consider providing access to and incentivizing core palliative care skills training for targeted groups of providers -- such as primary care, oncology, cardiology, nephrology, and neurology – at no cost to the provider as a quality assurance activity or as a strategic investment.** Hospital staff – hospitalists, nurses, and other professionals – are another key target audience for palliative care training.

To ensure the competencies of the targeted practices, plans and ACOs must provide all team members access to this training, including billing (i.e. MDs, NPs, and PAs) and non-billing (i.e. social workers, chaplains) providers, case managers, and even administrators. Plans and ACOs should reinforce skills training by ensuring access to specialist level palliative care experts to support clinicians as they begin to gain skill and confidence in these newfound skills. Additional aspects of network competency would include investments in infrastructure, such as building triggers and easy access to advance care plan documentation in the electronic health record (EHR).

Several health system ACOs have used the provider network training strategy to achieve their outcomes. For example, Integra Community Care Network, a partnership among Care New England, Rhode Island Primary Care Physicians Corporation, and South County Health, provided geriatrics and palliative care training to their primary care physicians in delivering serious news and holding goals of care conversations, which were well-received by the physicians.

In conjunction with investment in professional development and training, health plans and ACOs can expedite the acquisition of core palliative care skills through financial incentives. Examples in this area include:

- Financial incentives to providers with certain palliative care designations (e.g., The Joint Commission advanced certification in palliative care for hospitals; The Joint Commission palliative care certification for hospices and home care agencies; CAPC designation for clinicians; practices with on-site VitalTalk coaches; practices completing the Ariadne Labs Serious Illness Care Program for communication skills)
- Financial incentives for providers who can demonstrate competency, either through the designations above, formal palliative care sub-specialty certifications, or demonstration of training completion. For example, Anthem established a standard for all network hospitals to have a palliative care training program, and uses this as a component of its quality incentive program (see case study in Additional Resources, below).

Palliative Care Skill Training Resources

There are many great programs and resources available for palliative care training for the non-specialist. See below for a partial list of training options.

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[2] Perry Undem Research, "Conversation starters: research insights from clinicians and patients on conversations about end-of-life care and wishes, November 2016

Platform	Training Audience	Format/Usability	CME/CEU	For the palliative care program	For the non-palliative care specialist
CAPC (Center to Advance Palliative Care)	All frontline clinicians who work with seriously ill patients	Clinical curriculum and operational online curriculum, webinars, virtual office hours, tools, annual National Seminar	CME/CEU credits for physicians, physician assistants, nurses, case managers, social workers (including NY) and LPCs	Palliative Care programmatic support, clinical training, toolkit for palliative care programs across settings	Clinical training in communication, pain and symptom management, care coordination and family caregiver support
EPEC (Education for Physicians in End-of-life Care)	Physicians and other health care professionals who are engaged in palliative care education and clinical practice	Conferences, grand rounds presentations, medical school curricula, seminars, self-study courses	CME for MD, CEU for RN, SW coming soon	Clinical training	Clinical training
ELNEC (End-of-Life Nursing Education Consortium)	Undergraduate and graduate nursing faculty, CE providers, staff development educators, specialty nurses in pediatrics, oncology, critical care and geriatrics and other nurses with training in palliative care	Online courses, national and regional training sessions, conferences	Nursing CE	Clinical training for educators	Clinical training for nurses
CSU (California State University Institute for Palliative Care)	Nurses, social workers, chaplains and other healthcare professionals	Virtual faculty-led cohorts, certificate programs, chaplaincy training and self-paced courses online	All courses offer CE; some offer BRN, BBS and CME hours	Clinical and program development training	Clinical training
AAHPM (American Academy of Hospice and Palliative Medicine)	Physicians and physicians-in-training	In-person and online education, resources, products and textbooks	CME/MOC for physicians	Clinical, hospice regulatory training	
HPNA (Hospice and Palliative Nurses Association)	Hospice and palliative educational products and services for all levels of nursing	Conference and e-learning (70 online courses), online resources	Nursing CE	Clinical, operational, and leadership training	
Vital Talk	Communication	Face-to-face	CME for online	Communication	Communication

	skills training for clinicians	training and train the trainer courses, online course with CME, mobile app	course	training for clinicians	training for clinicians
University of Colorado, Denver	Nursing, physicians, physician assistants and pharmacists	Online and some face-to-face courses.	Palliative care interprofessional graduate 36 credit hour master's and 12 credit hour certificate programs	Clinical, some operational training	Clinical, some operational training
University of Washington – Cambia Palliative Care Center of Excellence: Graduate Certificate Program	Health professions students or practicing physicians, nurses, social workers, chaplains and other health care professionals	Online plus a 3-day weekend face-to-face	15 credit graduate certificate program over 9 months	Clinical, some operational training	Clinical, some operational training
Palliative Care Education and Practice (PCEP), Harvard Medical School	"For palliative care specialists, champions and educators, as well as generalist and specialist physicians and nurses who wish to gain additional competencies in palliative care by enhancing their skills in communication, teaching and clinical practice."	Two 1-week in-person training program; adult and pediatrics tracks	CME for physicians	Clinical and operational training	Clinical and operational training
Four Seasons Center of Excellence	Physicians, RNs, nurse practitioners, physician assistants, clinical nurse specialists and social workers	40-hour intensive in-person training	40 hours continuing education	Clinical and operational training including program design	Clinical training
Serious Illness Care Project	Physicians, RNs, nurse practitioners, social workers, risk management	2.5-day face-to-face training course	Nursing, social work, medical and risk management CE credits	Multicomponent educational and implementation plan for improving occurrence, quality, and actionability of	Multicomponent educational and implementation plan for improving occurrence, quality, and actionability of

				serious illness conversations	serious illness conversations

Best Practices in Building the Specialized Palliative Care Provider Network

Board certified palliative care professionals are needed for the most complex cases, and should be available in the right individuals' care team to the extent they are available. The role of the health plan and/or ACO is to identify and contract with certified palliative care specialists to ensure members/patients have access to these resources.

Identifying Palliative Care Specialists in Your Geographic Area

Certified palliative care providers are often already contracted with a payer but not recognized as a "palliative care" specialist in network directories, as they tend to be listed under their primary specialty, such as internal medicine, geriatrics, or oncology. In fact, providers with specialty-level training and certifications in palliative care -- including physicians, nurse practitioners, and social workers – are often not listed as such in credentialing databases because palliative care is their sub-specialty and not their primary specialty. Efforts to identify palliative care providers through claims systems are also difficult, as there is not a distinct diagnosis or procedure code that is consistently used by palliative care specialists – although identifying the clinicians that consistently bill for "symptom" codes (e.g., dyspnea) over "disease" codes (e.g., malignant neoplasm of the lung) may yield some possibilities.

Health plans and ACOs often need to take additional steps to locate specialty palliative care providers and programs for their network. Some resources to assist include:

- Getpalliativecare.org with a palliative care provider directory by city and state
- Lake Group Media, for a fee, can create mailing lists from the American Board of Medical Specialties database, which includes palliative care as a sub-specialty
- Health system and hospital websites often list providers by specialty, including palliative care
- National Hospice and Palliative Care Organization - identified hospices that may also deliver non hospice palliative care

In particular, the National Hospice and Palliative Care Organization lists state-level organizations and associations through which health plans and ACOs can work to identify community-based palliative care programs operating under the corporate umbrella of a hospice. There are also private companies that focus on providing care to the most complex patients, and plans and ACOs may contact them directly. These companies can provide care in all settings, and include organizations such as Aspire Health, Turn-Key Health, CareMore Health, and Optum Supportive Care.

In some cases, specialized palliative care may be a department or division within an existing network health system or hospital, and will not require a separate contract. In addition, many hospices and home health agencies within a health plan's or ACO's existing network are able to provide inpatient or outpatient palliative care services under their existing license, but capacity may be limited due to inadequate financial support for these services. A health plan or ACO can expand or amend these hospital or hospice provider contracts to enable palliative care services in the additional setting(s). Several health plans in California, including Blue Shield of California and Partnership Health Plan have used amendments to existing network provider contracts to expand palliative care to additional settings (see Case Studies, below).

Providing Access to Home-based Palliative Care for the Most Complex Individuals

Home-based palliative care is appropriate for those who face significant and complex disease burden and/or symptom distress with a high degree of dependency upon family caregivers whether undergoing disease treatment or not. In many cases, home-based palliative care is a layer of support for those who are not yet eligible for or who choose not to elect hospice.

For the right subset of patients, home-based palliative care can result in significant quality improvements and cost savings[3]. For example, ProHealth, a division of Optum and a Medicare Shared Savings Program participant, created a home-based palliative care program as one of its strategies to manage their high-need/high-cost patients, working in collaboration with the patient's existing team to extend services and supports into the home, and available 24/7 (see ProHealth case study, below).

Keep in mind that home-based palliative care is often an unlicensed service with little regulatory oversight, and the plan or ACO must be prepared to hold home-based programs accountable to quality standards.

Ensuring the Quality of the Specialty Palliative Care Provider Network

While specialized palliative care services can improve the quality of care and quality of life for people with serious illness and their families, not all palliative care providers or programs are created equal. Maintaining the quality of the network palliative care providers across settings is critical to sustaining outcomes over time, and to upholding a standard of care provided to all individuals with serious illness, regardless of setting.

Health plans and ACOs should anchor standards of care for serious illness to nationally recognized guidelines for palliative care. The National Coalition for Hospice and Palliative Care (NCHPC) has developed the National Consensus Project for Quality Palliative Care (NCP) to define guidelines for appropriate palliative care delivery. These clinical standards can be used to hold providers and programs accountable for the quality and scope of the clinical services they provide to people with serious illness and their families.

Payers do not need to reinvent the wheel when developing standards of care or credentialing high-quality palliative care programs. There are credentials, certifications and standards developed for individual providers and for palliative care programs that assist in identifying and designating a high-quality provider. The table below summarizes available credentialing or certification examples for palliative care programs and providers:

Program or Provider Type	Credentialing or Certification Examples
Inpatient Palliative Care Programs	• The Joint Commission (TJC) Advanced Certification for Palliative Care
Community-Based Palliative Care Programs	• The Joint Commission's Community-Based Palliative Care Certification • The Accreditation Commission for Health Care Distinction in Palliative Care • Center to Advance Palliative Care Designation in Pain Management, Symptom Management, and Communication Skills

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[3] Lustbader, D, M Mudra, C Romano, et al. "The Impact of a Home-based Palliative Care Program in an Accountable Care Organization." *J Palliate Med*, (2016): 20(1); Cassel, JB, KM Kerr, DK McClish, et al. "Effect of a Home-based Palliative Care Program on Healthcare Use and Costs." *J Am Geriatr Soc,* (2016): 64(11).

Physicians	• Board Certification in Hospice and Palliative Medicine • Vital Talk Clinician and Facilitator Training • Education in Palliative and End-of-Life Care (EPEC) certification • Center to Advance Palliative Care Designation in Pain Management, Symptom Management, and Communication Skills
Nurses	• Certification in Hospice and Palliative Nursing (CHPN) • Vital Talk Clinician and Facilitator Training • End-of-Life Nursing Education Consortium (ELNEC) certification • Center to Advance Palliative Care Designation in Symptom Management and Communication Skills
Social Workers	• Certification in Hospice and Palliative Social Work • Advanced Certification in Hospice and Palliative Social Work • Social Work Certification in Palliative and End-of-Life Care
Chaplains	• Board Certification in Palliative Care Chaplaincy
Case Managers	• Center to Advance Palliative Care Designation in Palliative Care Communication Skills

Getting Started

1. Identify existing palliative care programs already in the network.
The first step to building a high-quality palliative care provider network is to identify existing palliative care providers and programs within a plan's existing contracted network. As noted in the section above, this often requires external data sets or directories (such as hospital and health system, and hospice websites, getpalliativecare.org provider directory) that can help to crosswalk existing providers, regardless of contracted facility type or licensure, with those who are listed elsewhere as providing palliative care. Again, consistent billing of symptom codes may be another source of existing in-network palliative care providers.

Once providers already in the plan's network are identified, then assess the capacity, scope, and quality of their services. Be sure to look for and identify inpatient, office, cancer center, dialysis center, skilled nursing facility, and home-based programs.

2. Establish standards of care for palliative care programs.
After current in network palliative care providers (if any) have been identified and gaps in the network capacity, scope, and/or quality have been identified, the plan or ACO should establish a standard of care that palliative care programs should maintain, in accordance with the National Consensus Project for Quality Palliative Care (NCP) guidelines. These standards will change depending on the setting where palliative care is provided and the credentials of the clinician. While there are not enough board certified clinicians to meet the care needs of people with serious illness and their families, inpatient and community- based palliative care programs should demonstrate progress toward achieving designation, credentialing, or certification in palliative care.

3. Create financial incentives for selected network providers to obtain core palliative care skills
As discussed above, targeted providers should include those specialists and practices most often caring for the seriously ill, including hospital staff. A variety of training opportunities exist, and the health plan or ACO can

modify its existing quality incentive programs to encourage such training. Steps would include the health plan or ACO supporting the cost of such training, and/or investing in on-going provider supports.

Practical considerations for Implementation

1. Establish network contract "essentials" to ensure access to palliative care services

Contracts and contract amendments for specialty palliative care should, of course, align with the role that the provider or program is expected to play. Some key elements to consider for the contract include:

- Inclusion of comprehensive assessment as a covered service, as assessment enables matching services to needs, essential to the effectiveness of specialty palliative care
- Specify coverage of telephonic and telemedicine services if required
- Specify inclusion of 24/7 telephone coverage and set standards for timely response to patient calls
- Establish a payment model and rate sufficient for the services included, including consideration of the costs of 24/7 response and travel time for home-based programs (see Section 5: Payment and Incentives)
- Establish evaluation metrics to ensure quality and compliance (see Section 6: Measurement and Evaluation)

2. Rely on national credentialing and accreditation bodies to ensure network quality

Because there are quality guidelines and certification standards for both inpatient and community-based palliative care, health plans do not need to devote time and resources to setting up new models of credentialing. When achievement of the plan's credentialing standards by the palliative care provider network is required in order to receive or renew a contract for reimbursement, the quality of the network's palliative care providers will be maintained and improve over time, without increased administrative overhead. Include process measures tracking progress towards credentialing as it may take time for programs to attain the necessary external credentials. Progress toward these goals can include evidence of staff training, CAPC designation, or board certification for individual members of the palliative care team.

3. Set standards within existing risk-bearing or quality contracts

Where a plan has an existing contract that can produce shared savings or quality incentive payouts, embed standards for palliative care as a process measure, such as rates of documentation of advance care planning conversations in the target population. Ensure that any clinical programs for serious illness, including oncology bundled payment programs or high-risk clinics, also have standards that reinforce the integration of palliative care alongside treatment. For example, oncology bundled payment programs should follow the Medicare Oncology Care Model quality measures, which include rates of assessment of pain and having a pain plan of care documented; a private health plan or ACO contract can also specify criteria for patients to receive a palliative care consult.

As process measures are achieved, new measures can be put into place, improving the quality of care provided within these types of arrangements and allowing the health system and network capacity to strengthen over time towards achieving measurable value outcomes under the agreement. These process measures can be used as a vehicle to improve both the access to and quality of palliative care within a plan's networks with the confidence that these improved processes can result in achievement of the outcomes set forth in the agreement. Examples of process measures can include: percentage of individuals with serious illness who have had a documented advance care planning conversation; percentage of individuals with serious illness who have enrolled in a palliative care program; number of primary care providers with continued education in pain and symptom management or serious illness conversations.

Considerations for Pediatrics

Given that seriously ill children and their families require additional services and special expertise, health plans and ACOs will need to speak with their network providers to find out if they indeed have the skills and customization needed for the pediatric seriously ill population. For example, health plans and ACOs should be aware that not all medical equipment suppliers service seriously ill pediatric patients; much equipment must be sized appropriately. Network development resources will likely be needed to find appropriate hospitals, home care agencies, skilled nursing facilities, professionals, and suppliers.

To start, health plans and ACOs can consult the Courageous Parents Network map, to find self-identified pediatric palliative care programs. Palliative care programs listed on getpalliativecare.org are asked to specify the age groups that they care for. Neither of these give a complete listing of pediatric palliative care specialists and programs, but they can give network developers a starting point.

Child Life Specialists should hold certification (Certified Child Life Specialist, CCLS) issued by the Association of Child Life Professionals. Health plans and ACOs can provide financial incentives for network providers to include certified child life professionals in their services for seriously ill children.

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INTEGRATING PALLIATIVE CARE INTO POPULATION MANAGEMENT:

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PAYMENT AND INCENTIVES

"The future is here now. It's just not very evenly distributed." William Gibson*, The Economist,* 2003

What it is and Why it's Important

What doesn't get paid for doesn't get done. This truism of medical economics continues to apply despite the growth of value-based payment models. The high prevalence of palliative care in hospitals and in hospices in this country can be traced to the fact that there is a rational business model supporting both. In contrast, access to palliative care for the great majority of the seriously ill who are neither hospice-eligible nor hospitalized remains a matter of luck. In order to strengthen access to quality palliative care for high-need/high-cost patients, payment must provide a secure and sustainable basis for such care in patients' homes, doctors' offices, cancer centers, dialysis units, and long term care settings.

There are two parts to payment. The first is payment for specialty palliative care and interdisciplinary care teams in community settings. New payment models are needed because traditional fee-for-service payment does not adequately reimburse for specialty palliative care, comprising the time-intensity of skilled clinician conversations over time, the required access 24/7 for crisis management, the essential nature of the interdisciplinary care team for such a complex population, and the creation and sustainability of the reliable community partnerships necessary to address food, housing, transportation, and social needs.

The second part is financial incentives. Payment is a powerful mechanism for payers to accelerate the preparation of the healthcare workforce in care of people with serious illness. As noted in Section 4: Provider Network, the great majority of practicing clinicians have had little or no training in pain and symptom management, expert communication skills, and coordinated care over time and across settings. Payers can expedite the adoption of core palliative care knowledge skills, along with the integration of palliative care specialists, through targeted financial incentives.

Best practices in Specialty Palliative Care Payment

In general, value-based payment models align well with specialty palliative care, as both seek to avert crises and unnecessary emergency department visits, hospitalizations, and low-value interventions like intubations in the ICU for end-stage dementia patients. Listed in the table below are a range of payment models that have been used by health plans or health systems to support high-quality palliative care teams:

Payment Models Currently in Use to Support Specialty Palliative Care Services	
Enhanced Fee-for-Service	• Enhanced fee-for-service, such as 200% of Medicare, to enable interdisciplinary team care. A national Medicare Advantage plan has piloted this for palliative care services in oncology practices. • Additional service codes to pay for the traditionally “non-billable” professionals such as social work, chaplaincy, and pharmacists. A health plan in Texas has created a code for social work advance care planning conversations. • Risk-adjusted payments for case management services, such as in the Medicare Comprehensive Primary Care Plus model. • It is possible to create tiered fee schedules, with higher fees paid for clinicians or programs holding certain palliative care certifications.
Lump Sum Payment	• Stipend or per-session payment for a specialty palliative care clinician or team. An ACO in Kentucky uses this to provide their patients access to specialty palliative care. • Salary and benefit support for the palliative care team, commonly used by risk-bearing health systems to enable access to palliative care services. • Start-up or implementation funding for program development and/or training. Blue Shield of California has used this to rapidly expand network capacity (see Case Studies).
Case Rate	• Payment on a per-enrolled-member-per-month basis for a set of palliative care services. ○ The rate typically encompasses the services of an interdisciplinary palliative care team, including physician, nursing, social work, and chaplaincy. ○ Specific additional services may be included such as medications, home nursing, personal care, and some durable medical equipment. ○ Specific outlier provisions, time limits, or risk adjustment payments are typically included. • Case rates are used by many health plans, typically to pay for palliative care services that include in-home visits and 24/7 response. See the Advanced Alternative Payment Model proposals in the Additional Resources Section for models under consideration by Medicare.
Episode Rate	• Payment of a single price for a defined set of palliative care services over a defined period of time. As with case rates, services typically include in-home visits and 24/7 response. Ongoing services and payment are possible either by re-authorizing the episode or moving to a lower case rate for ongoing support in the following months. ○ Episodes paid by HealthFirst in New York are for three months (see Case Studies). ○ Sharp Healthcare’s program includes six-weeks of in-home services, followed by ongoing telephonic support.

"Combination" Payment Model	Case rate or episode rate, combined with shared savings, shared risk, and/or quality incentive payments.

The payment model selection should consider the claim system's capabilities to support alternative payments, as well as the accounts receivable capabilities of the providers in the network. If either party is unable to administer the preferred model, enhancements to fee-for-service should be considered while the systems are adjusted.

Best Practices in Incentive Payments that Promote Palliative Care Skills or Integration

The table below highlights best practices in financial incentives that have successfully encouraged the adoption and integration of palliative care.

Payment Incentives Currently In Use to Promote Palliative Care Skill Development and/or Integration of Palliative Care Services	
Practice-level Incentives	• Fee-for service with a periodic reconciliation for bonuses, based on: ○ Documentation of pain/symptoms and plans to address within targeted timeframes. ○ Measures related to occurrence and documentation of advance care planning conversations. ○ Improvement in accuracy and comprehensiveness of coding and documentation. ○ Reductions in end-of-life utilization, such as hospital days or ICU stays ○ Increases in end-of-life hospice utilization. ○ Member satisfaction scores above a certain threshold. • Two-sided payment adjustments, with bonuses for achievements such as those listed above, with penalties for less-than-targeted outcomes.
Hospital Incentives	• Higher payments for achievement of The Joint Commission Advanced Certification in Palliative Care or sufficient progress towards those standards. • Ongoing payment bonuses dependent upon the rate and timeliness of specialty palliative care consultations. • Increased annual rate increases based on TJC certification or proof of specific palliative care capabilities and processes. This is a strategy used by Anthem to promote network hospital palliative care capacity (see Case Studies).
Bundled or Episode of Care Payments	• Set a target price for certain episodes of care, requiring the inclusion of palliative care specialists and services. Examples of episodes appropriate for the bundled payment-with-palliative-care-requirement include: ○ Oncology care episode ○ CHF or COPD hospitalization ○ Skilled Nursing Facility episode • A national Oncology management vendor is using this strategy with all partnering practices.

Getting Started

Whatever the degree of penetration of value-based and alternative payment models in support of access to community-based palliative care, there are initial steps that all payer organizations can take to ensure sufficient financing for palliative care services, as follows:

1. Create incentives for appropriate referrals and goals of care conversations.
The best way to begin paying for palliative care is to begin incentivizing accountable providers for appropriate referrals to palliative care and/or documentation of a goals-of-care conversation for those patients identified as seriously ill (see Section 1: Identification). This could include adding an incentive payment to a contract with, say, an oncology practice that completes certain assessments on patients. Not only do these efforts incentivize timely and appropriate goals of care conversations with seriously ill patients, they also allow tracking of the effect advance care planning has on the member's subsequent care trajectory.

2. Assess whether existing payments and/or incentives may already promote access to palliative care.
Payment comes after other serious illness strategies are defined. Before tackling payment, a health plan should define who the target population is and what services they will be expected to utilize. Depending on the program, current payment models may be sufficient, or may need slight adjustments to align incentives. For example, if the serious illness program targets individuals undergoing cancer treatment and oncology bundled payment already exists, the bundled payment can be modified to require specialty palliative care consultations and/or elevate an incentive payment for documented goals of care conversations. In another example, primary care providers may already be receiving a higher tiered payment if they have certification as a Patient-Centered Medical Home, and the plan can highlight guidance on how palliative care capabilities meet the requisite standards.

3. **Consider starting with hospitals, building on existing hospital palliative care teams.**
As above, hospital stays are already paid for, but a health plan or ACO's members may not have access to any palliative care services under current conditions. To incentivize palliative care consultations for appropriate members, consider adding process measures, such as: timing (earlier is better) and occurrence of palliative care consultations for eligible hospitalized members; occurrence of advance care planning documentation in the electronic medical record or in physician claims; or rate of referral to, and timeliness of, hospice referral (again, earlier is better). Also, hospitals with an inpatient palliative care team that meet certain criteria, such as breadth of the interdisciplinary team or ratios of palliative care team FTEs to beds, might be contracted within a narrow network. These adjustments provide an opportunity to tier financial payouts based on the presence, utilization, and timeliness of palliative care services.

4. **Pilot payment for community-based palliative care with an existing provider**.
If you are aware of palliative care providers in your market area, consider beginning a small pilot to pay for outpatient or home-based palliative care services using a preferred starting payment model to support the time of the non-billable interdisciplinary team members. Use pre-existing data and published outcomes to determine patient eligibility and model out potential cost of pilot and savings. Start small and continue to evaluate; successful pilots can then incrementally add diagnoses, geographical areas, services, and quality requirements.

Note that you can process case rates for palliative care by creating an S-code for the pilot.

Practical considerations for implementation

1. Seek to align risk-adjustment methodologies and quality thresholds across providers.
Implementation is simplified and quality is more reliable if payers work towards consistency in the underlying structures, including risk-adjustment and quality thresholds, across all providers in the network, and not just the palliative care specialists. Otherwise, issues may arise when the palliative care providers are working towards outcomes that are not on the treating provider's "radar." For example, if palliative care providers are measured on the rate of advance care planning conversations, their colleagues in other specialties such as oncology and cardiology should be held to the same measures so that all efforts align to improve advance care planning, and no one works at cross-purposes. Developing a consistent set of risk-adjustment methodologies and

performance expectations will ensure both quality of care for those with serious illness and improve the ability to administer payment and provider network designs.

2. Carefully consider the metrics used in pay-for-performance.

Value based payment requires linking payment to outcomes. However, measure selection should incentivize services aligned with the patient and family's needs and priorities. For example, an excess focus on reducing 30 day readmissions or ED visits may create perverse incentives preventing some very sick and complex patients from receiving necessary and appropriate care in those settings. Similarly, driving towards adherence to HEDIS measures often incentivizes unnecessary and inappropriate preventive services, such as colonoscopy, that make no sense in patients with end stage dementia or progressive life threatening disease, and may even be dangerous. See more in Section 6: Measurement and Evaluation.

3. Consider using creative "bridge" or "investment" payments.

Making the transition from a fee-for-service to an alternative payment model often requires an upfront investment in infrastructure necessary for providers to deliver on value. For example, managing a population requires an investment in reliable after hours telephone responsiveness, health information technology, analytics, and sometimes case management. Investments may also be needed in telehealth/telemedicine, particularly to optimize access and cost appropriateness. Recognizing that the benefits of these provider investments often accrue to the health plan or ACO, some are partnering with palliative care providers to subsidize the initial financial investments required, including Blue Cross/Blue Shield of Massachusetts, ProHealth, Anthem, and others (see Case Studies across the sections).

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MEASUREMENT AND EVALUATION

"Ultimately, good medicine is about doing right for the patient. For patients with multiple conditions, severe disability, or limited life expectancy, any accounting of how well we're succeeding in providing care must above all consider patients' preferred outcomes." Reuben and Tinetti, *NEJM*

What it is and Why Measurement is Important

Health plans and ACOs need to determine whether their seriously ill population is getting care of appropriate and high quality that is based on a comprehensive needs assessment and that matches service delivery to those needs. Ensuring quality is the responsibility of health plans as required by their accreditation, and payers are therefore in a position to advance best practices and the integration of palliative care through measurement linked to financial incentives (see also Section 5: Payment). Plans and ACOs also need to determine whether the strategies they've implemented to improve the quality of care for their seriously ill population have achieved and continue to achieve the desired results.

Plans and ACOs may seek to evaluate satisfaction and patient experience, metrics to which they are held accountable themselves, and/or reductions in avoidable utilization. With the vast menu of quality measures available and the increasing burden of measurement, plans and ACOs need to pinpoint meaningful measures of quality care for those facing serious illness.

Best Practices in Measurement and Evaluation

When evaluating palliative care interventions, it is important to remember that palliative care improves value by attending to symptoms, stresses, value, and preferences. While outcomes such as reductions in unnecessary utilization often result from this approach, exclusive measurement of cost or utilization may result in unintended consequences, such as creating perverse incentives to under-treat. Best practice requires that, in addition to measures of patient and family experience of care, structure and process metrics are included to evaluate adherence to evidence-based guidelines and quality of care. The table below provides examples of measures that have been used by health plans, health systems, ACOs and others to evaluate the care of the seriously ill.

Measurement Area	Example Measures
Internal Project Milestones (structure)	• % of plan or ACO staff with palliative care skill training (e.g., relevant board certifications; CAPC designation; completion of VitalTalk or Ariadne Labs programs) • Network adequacy of palliative care specialty teams or programs • Completion of relevant benefit or authorization changes • # of people using a specific benefit or service
Clinical Capabilities and Provider Network Access (structure)	• % of network providers completing palliative care skill training (e.g., relevant board certifications; CAPC designation; completion of VitalTalk or Ariadne Labs programs) • Availability of 24/7 coverage (both home-visiting and telephonic) in the provider network • Timeliness of access for new patients • % of network hospitals with or pursuing The Joint Commission Advanced Certification in Palliative Care* • % of community palliative care programs with or pursuing certification, such as the Joint Commission Certification in Palliative Care*, or the Accreditation Commission for Health Care (ACHC) Distinction in Palliative Care*
Clinical Quality of Care (process)	• Rate of assessment completions, if data available ○ includes functional status, PHQ-9, physical symptoms including pain, psycho-social needs, and caregiver burden • Rate of goals of care or advance care planning discussions (measured through claims and/or EHR documentation) • Rate of documentation of a health care agent/proxy/surrogate • Rate of advance care planning documentation completion • Timeliness of response to calls from patient or family; frequency of visits
Satisfaction / Experience (outcome)	• Patient likelihood to recommend the relevant service(s) • Family caregiver likelihood to recommend the relevant service(s) • Performance on the shared decision-making questions on the CAHPS • Performance on the provider communication questions on the CAHPS • Days at home in last 6 months of life
Utilization and Cost (outcome)	• Emergency department visits per 1000 members • Hospital admissions and/or inpatient days per 1000 members • All-cause 30-day hospital re-admission rates • Hospice utilization rates and/or hospice length-of-stay • % of people with cancer receiving chemotherapy in last 14 days of life • Total cost of care in the last 6 months of life

***See Additional Resources for link to site**

It is important to endeavor **not to add burdensome new measures for a specific effort where existing measures will suffice**. Utilize measures that can be calculated from claims data, existing survey mechanisms, or simple EHR queries. To underscore this point, consider a recent analysis estimating that it now costs each physician an estimated *$40,000 per year* to collect and report quality measures, in large part due to the lack of uniformity in measure requirements across payers[1].

Getting Started

1. Consider certifications as the vehicle for structure, process, and some outcome measures.
Successful demonstration of knowledge, skills or care processes can be evidenced by clinician palliative care board certification, clinician designation of successful completion of additional training by educational entities such as the Center to Advance Palliative Care (CAPC), and The Joint Commission Advanced Certification for Palliative Care for hospitals. Such evidence of quality care processes and skill provides reassurance to a health plan or ACO that its contracted palliative care services are indeed of measurably high quality. NCQA's Patient-Centered Medical Home recognition also includes a number of standards and measures relevant to quality of shared decision-making and comprehensive assessment; this type of recognition may be a good starting point for palliative care competencies in primary care settings. Rather than reinventing the wheel, use existing and externally validated measures of quality as requirements for network or contract eligibility.

2. **Inventory organizational priorities**.
Access to palliative care can achieve many of a health plan's or ACO's own quality goals, and the palliative care program's evaluation should align with those priority goals. For example, re-admission and ED visit reduction, net promoter score improvement, and diagnosis capture may be additional appropriate measures of the contribution of palliative care services to quality. **Whenever possible, use measures for which your organization is already accountable**.

Practical considerations for Implementation

1. Beware of unintended consequences

As noted above, measurement may create incentives that conflict with patient-directed care or create unintended incentives to under-treat. For example:

- Weight loss as an indicator of poor quality in a nursing home may lead to an increase in unnecessary or unwanted tube-feeding in a patient with advanced dementia and ongoing functional decline.
- Targeting a specific rate of hospice utilization can lead to inappropriate or ineligible referrals and high rates of hospice disenrollment. These cause burdensome transitions, fragmentation and discontinuity; a 2014 study found that of those patients who are discharged alive from hospice, one-quarter were hospitalized within 30 days[2].
- Setting unachievable expectations for complete elimination of distressing symptoms is unsafe and unrealistic in a complex, seriously-ill population, and may lead to over-medication, drug interactions, and adverse effects
- Incentivizing on the completion of a POLST or Advanced Directive document, as opposed to incentivizing conduct and documentation of goals of care conversations per se, can lead to provider focus on completing

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[1] Casalino LP, Gans D, Weber R, et. al.; US physician practices spend more than $15.4 billion annually to report quality measures, *Health Affairs,* March 2016 , 35(3): 401-406

[2] Teno Joan M., Plotzke Michael, Gozalo Pedro, and Mor Vincent. A national study of live discharges from hospice, *Journal of Palliative Medicine*. October 2014, 17(10): 1121-1127

the document rather than on meaningful discussion, pressuring the person with serious illness to make decisions prior to feeling ready to do so.

- Seeking to aggressively drive down hospitalizations and emergency department visits for people with complex and serious illness is unsafe and unrealistic, and may lead to a perception of rationing care for those being served rather than aligning with the person's needs, goals, and preferences.
- Similarly, a directional measure such as "days spent at home in the last 90 days of life" is a measure of quality of care for many patients and families, but there will always be a subset of the population that requires hospital care when medical needs are intensive and significant, and the days-at-home measure may not be appropriately applied for those patients' and families' wishes.

2. Carefully consider the unique circumstances of a seriously ill population

- Measurement that is based on self-reported outcomes (e.g., levels of pain) cannot be easily or inexpensively tracked, as compared to, say, lab results like hemoglobin A1c levels run from an EHR report. Work with your analytics team to identify relevant proxies for clinical information that could be identified through claims. For example, look at presenting diagnosis on an ED visit or inpatient admission to determine presence of symptoms as precipitant of a 911 call.
- Beware of "survey fatigue." The seriously ill population is not only going through difficult health and family strain, but is typically in contact with a lot of providers, many of whom are also conducting satisfaction surveys as part of regular practice. Consider suppressing surveys or creating a more direct and personal survey approach (e.g. a follow up call by a nurse)
- Measuring satisfaction and experience of care in this population is difficult for three reasons: 1) small numbers of individuals make statistical significance challenging; 2) it is difficult to establish a satisfaction or experience baseline; and 3) sick and stressed populations may skew towards dissatisfaction and adverse experiences, despite excellent care by a palliative care program.