INTEGRATING PALLIATIVE CARE INTO POPULATION MANAGEMENT:
A Toolkit for Health Plans and Accountable Care Organizations

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.

[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.

[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

[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.