

# CHCF Palliative Care Innovation Forum — Meeting Summary

## May 17, 2016

### Context and Objectives

*Kate O'Malley, CHCF*

Through this forum, the California Health Care Foundation (CHCF) aimed to support health plans and providers as they prepare for implementation of Senate Bill 1004, which requires Medi-Cal plans to ensure access to palliative care services for Medi-Cal beneficiaries.

This session introduced key concepts on developing workforce strategies to support the provision of palliative care, through three modalities:

- **Contracting** for specialty palliative care through external organizations
- **Building** specialty palliative care services
- **Training** to increase the primary palliative care skills of the workforce overall

### Brief Tutorial: Why Do We Need “Palliative Care Everywhere”?

*Dr. Anne Kinderman, San Francisco General Hospital*

- Palliative care (PC) is interdisciplinary patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. PC moves the framing on advanced illness from “there’s nothing more we can do” to “we will give you the best care possible” at every stage of a serious illness.
- PC focuses on support for decisionmaking and advance care planning, symptom management, care coordination, spiritual care, and assessment and management of psychosocial needs. While other providers and programs may address parts of that, PC brings it all together.
- Gaps include:
  - People often have access to palliative care in hospitals, and access to hospice when their disease is advanced, but community-based palliative care services offered concurrently with disease-directed therapies are insufficient.
  - Hospice recipients in California are disproportionately white.
  - Median hospice length of service is only about 17 days.
- Research has shown the benefits of community-based PC:
  - Increase in quality of life for patients
  - Increase in patient satisfaction
  - Better performance on quality metrics
  - Decrease in hospitalizations, emergency department (ED) visits
  - Longer hospice length of service, greater proportion dying at home
  - May be associated with longer life expectancy in some cases
  - Early PC association with less escalation in utilization than late PC
- Medi-Cal recipients have unique needs due to income instability, housing instability, psychosocial issues, language and cultural barriers, transportation challenges, etc.

- Plans and providers need to think creatively about how to achieve their goal — how can you build on existing services? Think outside the box (e.g., telehealth, partnering with community health workers, delivering services in alternative settings).
- Need to build primary palliative skills, develop access to specialty services, and include “cultural brokers” in our workforce to engage different populations.

## **PC Service Design Cues: Developing Solutions Based on Needs**

*Kathleen Kerr, Kerr Healthcare Analytics*

A useful framework for assessing PC needs and designing solutions for filling the gaps stems from concepts developed by Don Berwick (IHI, CMS) — solutions must make sense from these perspectives:

- **Science and professionalism:** Evidence-based care, aligned with consensus best practices
- **Patient and family:** Centered on their needs and preferences
- **Business and finance:** A rational investment for systems and payers
- **Providers:** Helpful, accessible, sustainable (a rational investment of time and energy for individuals)

As health plans and provider organizations assess their current assets and gaps when planning improved access to palliative care, they can use this lens: Is the solution addressing and aligning each of these elements?

### ***Science and professionalism***

- Consensus best practices have been described in multiple resources.
- Core components of quality end-of-life care have been articulated.
- Resources describe essential clinical skills and structures that payers and providers should have in place to deliver PC.

### ***Patient and family***

- Studies and surveys have examined what is most important to patients and families — services can be created with these priorities at the center.
- Understanding the needs, priorities, and limitations of the patient population you intend to serve is essential to designing a program to meet their needs.

### ***Business and finance***

- The business case for PC is anchored in cost reduction and avoidance.
- Payers and providers need to understand current expenditure patterns and believe that those patterns are modifiable.
- The top 5% (highest expense patients) account for 60% of spending; of that top 5%, 11% are at end of life and 40% have persistently high costs — many of these patients would be appropriate for and benefit from PC services.
- Community-based PC has been shown to reduce costs.

### ***Providers***

- For referring/generalist providers: PC needs to save them time or be time-neutral; have clear inclusion criteria that fit into existing workflows; have clear scope (what the specialty service does and how it adds value for them and for patients); have proof that it helps; and show respect for the existing relationship with the patient.

For specialty PC providers: Must be adequately compensated, have time to do the work, allow them to work within their scope, and have reasonable expectations about outcomes.

## **Workforce Development from a Payer's Perspective: Launching a Palliative Care Program**

*Torrie Fields, Blue Shield of California*

### ***Building on existing assets***

- Health plans should begin by assessing what they already have and what they can grow. With a limited workforce in specialty PC, consider ways to build skills and capacities of generalists who are passionate about advanced illness care.
- First step is understanding the landscape:
  - Identify and analyze the population of interest (retrospective claims analysis using death data to assess cost of care at end of life); prognostication approaches to understand who may benefit from PC (e.g., using National Committee for Quality Assurance criteria, disease-specific categories, utilization).
  - Find entities doing similar work and leverage current literature showing impact of PC.
  - Perform an internal stakeholder analysis to assess who already has related experience (e.g., case managers with experience in home care) or who wants to build skills in PC.

### ***Five basic levers payers can use to increase access to PC***

- Provider training and recognition
- Care management / case management
- Medical policies and coverage
- Payment innovations — making sure services and incentives match
- Community collaboration and awareness — including social services for vulnerable members

### ***Basic elements of a needs assessment***

- Identify the population and needs (providers and patients).
- Assess gaps and barriers (clinical teams, benefits and coverage, access to care and services).
- Prioritize opportunities with leadership and the organization (align with leadership's goals, evaluate actuarial and financial risk models and impacts).

### ***Assessing impact of services***

- Measures depend on the audience for whom you are measuring. Research? Quality Improvement? Accreditation? Funding?
- Make sure what you want to measure is feasible to measure — use what you're already collecting.

### ***Key lessons learned from payer perspective***

- Leverage existing resources — align PC program with organizational strategy; play to your strengths.
- Obtain leadership commitment.

- Build relationships — take the time to meet frequently with partners.
- Don't under- or overestimate the role of data — data exchange and standardization among partners are critical.
- Stage your growth and build — be prepared to go fast but manage the expansion; avoid overpromising and under-delivering.

## **Panel 1 — Contracting: Increasing Capacity Through External Solutions**

*Moderator: Carl Bouthillette, CHCF*

- **Aspire Health:** Brad Smith plus customer: Dr. Chip Chambers, Cigna HealthSpring
- **ResolutionCare:** Dr. Michael Fratkin plus customer: Dr. Scott Endsley, Partnership HealthPlan
- **Collabria Care:** Carol Williams plus customer: Dr. Scott Endsley, Partnership HealthPlan

### [Aspire Health](#) and [Cigna HealthSpring](#)

#### **Drivers for collaboration**

- Payers identifying the need to improve end-of-life care
  - Cigna found very high costs associated with the day of death — they knew they had a problem and knew palliative care was a solution — but didn't know how to address community-based services.
- Providers with ability to provide community-based PC services
  - Aspire sets up specialty physician practices that provide non-hospice community-based PC, currently in 12 states; Aspire is rapidly growing, with plans to expand to California in September 2016.

#### **Key success factors of partnerships**

- Education and culture change
  - The Aspire/Cigna partnership centers around the primary physician — ideally, they are the ones to introduce the program to the patient. Therefore, a massive educational campaign was needed — over the course of 30 months, Aspire and Cigna provided education on PC to every physician associated with Cigna HealthSpring across Tennessee. As a result, while they do use claims data to identify potential patients, they have a qualitative screening process of those lists by the provider organizations, and most referrals come from the providers.
- Close working relationships and trust
  - Cigna and Aspire have worked together to build trust with the physician groups — when the program was originally presented to them, some recoiled because the providers didn't know them or trust them with their patients. They have built that trust over time.
  - Aspire sends primary providers a succinct, one-paragraph summary to tell them everything they need to know about the care of that patient.
  - Close communication and regular touch-points between Aspire and Cigna have been key, enabling problem-solving around specific patient issues and general program strategies.
  - If not building PC services yourself, finding a trusted, skilled partner is essential.

### [ResolutionCare](#), [Collabria Care](#), and [Partnership HealthPlan of California](#)

ResolutionCare and Collabria Care are two of the four provider sites that participated in a six-month community-based palliative care benefit pilot with Partnership HealthPlan of California (PHC) and Partners in Palliative Care, and in the CHCF Payer/Provider Partnerships planning grant and implementation grant.

#### **Drivers for collaboration**

- Payers identifying the need to improve end-of-life care
  - While PHC has developed a portfolio of efforts related to advanced illness care, “Offering and Honoring Choices,” before these pilots, palliative care had not been a part of the health plan’s service model. They knew there was a huge gap in capacity for community-based PC in many of the rural Northern California counties they serve and were looking for different strategies to fill that gap.
- Providers with ability to provide community-based PC services
  - Dr. Fratkin of ResolutionCare had been providing palliative care services for years but was struggling with an under-resourced program. As models for payer/provider partnerships for PC showed potential for building out a fully-resourced PC program, ResolutionCare jumped at the opportunity to partner with PHC to provide in-person, telemedicine, and videoconference-based care to take care of people in their homes.
  - Collabria Care (formerly Napa Valley Hospice and Adult Day Health) added palliative care services in 2011.

#### **Key success factors of partnerships**

- Global payment and start-up support
  - PHC provides a per member per month (PMPM) global payment to each of the four provider groups, tiered based on whether they provide in-home skilled nursing services, with incentive programs related to ED and hospital utilization and Physician Orders for Life-Sustaining Treatment (POLST) completion. They also provided some start-up funding to offset the costs of ramping up services. These funding models have supported the provider organizations in building the teams and services they need to support patients and families effectively.
- Reporting and communication
  - Throughout the pilot, PHC had the four provider organizations participate in regular conference calls (one-on-one and combined), submit worksheets reporting patient data, and share real-life stories of how this work is playing out in the field. This communication has helped keep the pilot on track, helped with identifying issues and enabling course-correction, and built relationships among the provider groups and between the providers and PHC.

#### **Lessons learned**

- **Referral processes are harder than you think** — The simpler you make the process, the better. With multiple programs available from the health plan (e.g., complex case management), referring providers may have trouble differentiating.
- **Medi-Cal beneficiaries have unique needs** — Medi-Cal only (as opposed to dual Medi-Cal/Medicare) are typically younger than other PC patients, may not be ready to embrace PC,

and have more psychosocial issues that staff may not have the experience or skills to manage appropriately. Many times the patients' core issues weren't medical; they were social and financial. This underscores the need for robust social work support, education of providers on psychosocial needs, as well as additional outreach, education, and preparation of patients to help them open up to the idea of palliative care. The type of outcomes we can expect may also need to be adjusted (e.g., death at home may be more difficult to impact if home supports are not there).

- **Technology does not need to be a barrier** — Regarding tele-PC, Dr. Fratkin has found that once initial setup issues are addressed, the technology really disappears, and provider and patient are able to truly connect.
- **Finding the right staff and supporting them with training is essential** — What qualifies prospective staff most is compassion and the view that PC is a human enterprise — that what is happening is not a medical problem; it is a human experience. Organizational support/sponsorship of training and certification programs shows commitment to staff skills.

## **Panel 2 — Building Your Own: Increasing Capacity by Developing a Specialty Palliative Care Service**

*Moderator/panelist: Dr. Mike Rabow, University of California, San Francisco (UCSF)*

- **Sharp HealthCare:** Suzi Johnson
- **University of California, Irvine:** Dr. Solomon Liao

### **Drivers and program structure**

- [UCSF Symptom Management Service](#) is based in UCSF's cancer center, and began with the help of a single, powerful oncologist who was interested in the services being offered by the PC team. "Sibling rivalry" effect drove others in cancer center to seek out the services. It's important to understand who wants what within your organization — power structure and flow of funds.
- [Sharp HealthCare's Transitions program](#) was implemented in 2007. Its aim was to take hospice principles and move them upstream, to provide an alternative to using the ED or hospital to manage disease. Four pillars of the program: in-home consultation, evidence-based prognostication, caregiver support, goals of care conversation. It is a nurse-led case management model and also includes social work, spiritual care, and oversight by the chief medical officer for palliative care.
- [UC Irvine's outpatient palliative care program](#) started eight or nine years ago, and began as a posthospital follow-up service. Now they see 150 patients per month, in 5.5 days of clinic per week, and have added a heart failure PC clinic. Planning to double by next year to 5 days/week due to expected influx of CalOptima (Medi-Cal) patients.

### **Developed and staffing programs based on needs and assets**

- The Sharp team thought up front about what problem they were trying to solve. They saw heart failure as low-hanging fruit — high rates of hospital admissions and low rates of hospice use. As they developed the program, they considered what a referring provider would want: evidence-based medicine (in the referral criteria and outcomes metrics) and confidence that PC providers had competence in the disease (skilled, experienced staff; commitment to training; highly structured algorithms for visits).

- UC Irvine is challenged by the need to staff up their service to double capacity — it can be difficult to hire talented, certified providers. It's committed to training existing staff and the future workforce; for example, those in the PC fellowship program.
- UCSF also has a PC fellowship program — Try hard to keep them on staff after fellowship. Also leverage staff that are not PC-certified; for example, all the social workers in the cancer center are considered part of the PC team (and identify themselves that way) even if not PC-certified.

### **Addressing staff burnout**

Data shows that risk of burnout for PC physicians is higher than for any other physician specialty. Lots of new programs are being developed, but programs also fold — burnout is probably a piece of this.

- UC Irvine has PC physicians rotate off to do other things (e.g., general medicine) and bring in per diem coverage to help lighten weekend load for PC team members. Team-building activities (e.g., retreats) can also be useful. Consider offering career-planning support and access to a sounding board for challenges or frustrations.
- Sharp tries to provide staff with tools and support they need so they stay satisfied.
- UCSF tries to identify what the team can do every day, every week, every month, and every year to protect against burnout. They hold regular team meetings focused on patients and on team self-care. These meetings start with a poem and end with a gratitude practice.

### **Panel 3 — Training: Increasing Capacity Through Training in Primary Palliative Care**

*Moderator: Anne Kinderman, San Francisco General Hospital*

- **Stanford Health Care:** Sandy Chan
- **ECHO Palliative Care (ResolutionCare Fund):** Amy Bruce plus customer: Katie Stollmeyer, Six Rivers Medical Center, Mad River Hospital System
- **California State University (CSU) Institute for Palliative Care:** Helen McNeal plus customer: Sheri Keahey, Providence Health & Services

Since we will never be able to address all palliative care needs through specialty palliative care, we need to build the skills of primary providers (primary care and specialists). Many options and approaches for training exist; a few examples were explored during this panel.

#### **Stanford Health Care**

- Palliative Care Always, a free online course, was developed as an interdisciplinary training module to build skills of primary providers (and patients and families) on supporting people with serious illness from diagnosis to death. It includes didactic information delivered from different members of the interdisciplinary team (IDT), and then shows that provider actually delivering the care to a standardized patient (actor).
- The first run of the course was January-May 2016; as each IDT member was featured in the didactic portion in a particular week, they were also available for communication with participants online that week. The course is set to run again starting in September 2016.
- In the first run of the course, about 76% were health care providers, 24% other. Among providers, about 30% were nurses, 15% physicians, about 15% social workers, and 7% worked in spiritual care. All participants got the same curriculum.

- To assess impact, Stanford Health Care will examine changes in attitudes (through pre- and post-tests at three and six months), uptake of PC principles, qualitative analysis of discussion blog, and PC skill sets (e.g., symptom management, goals of care). They are still analyzing the data.

#### ECHO Palliative Care (ResolutionCare Fund)

- ResolutionCare Fund began delivering the Project ECHO model as a way to spread the knowledge of PC specialists: “moving knowledge, not people.” In rural settings, this has been a more practical approach to training than expecting participants to travel for in-person classes.
- Currently, seven Federally Qualified Health Centers and Indian Health providers participate; attendees include all levels of providers and staff. The same content is delivered no matter the participants, creating an equal learning field. The training happens in real time (not through a recorded session), so all participants are learning together as a group. Participants have said they feel less isolated connecting with each other and with specialist providers every other week.
- Participants were asked to complete surveys after each session about whether they learned something useful, if they think they could teach it to others, etc. Results from their first seven-month session have not yet been analyzed. Anecdotally, Ms. Stollmeyer said she found the sessions to be “incredible”; they have given her tools for managing a high-risk population, decreasing her stress and increasing her confidence.
- Looking ahead, ResolutionCare Fund would like to offer Project ECHO Palliative Care to primary care providers across the state, and would like to work with skilled nursing facilities and cancer centers.

#### CSU Institute for Palliative Care

- The training approach of the CSU Institute for Palliative Care (IPC) is centered on the notion that the best way to reach busy health care professionals is through programs they can do whenever convenient. Most of their training courses are online; some are face-to-face. Some online courses are self-paced (participants can do them on any timeline); others are asynchronous instructor-led courses, meaning they are offered on a specific timeline a few times a year. These training groups become a community; alumni groups keep them connected.
- Providence Health & Services saw challenges with palliative care providers having a standard knowledge basis, and liked the IPC asynchronous instructor-led courses because they made participants stick to a timeline, with specific modules and homework each week. They have sent their palliative care nurse practitioner, registered nurses, chaplain, and social workers through IPC courses and now see it as a standard for any staff coming in to the PC department.
- Courses for primary palliative care include Palliative Care for Care Managers and the What Every . . . Needs to Know About Palliative Care (discipline-specific courses on primary palliative care for doctors, nurses, chaplains, social workers, and all other health professionals). The new Care Excellence course is focused on case management education, for new and experienced case managers.
- Looking forward, the institute aims to expand their offerings in primary palliative care and pediatrics, and expand access to palliative care more broadly by focusing on educating future health professionals and community members.