

Plans in Progress: CHCF Payer-Provider Partnerships for Palliative Care

December 2015

While health care provider organizations, payers, and the health policy community increasingly recognize the deficiencies in care for people with serious illness and the robust evidence of the benefits of palliative care, growth of community-based services — those offered outside the acute care hospital and prior to enrollment in hospice — has been stunted by the lack of sufficient, defined funding streams.

To address this challenge, the California HealthCare Foundation (CHCF) engaged 10 pairs (or triads) of payer and provider organizations in a six-month planning process to identify sustainable approaches for delivering high-quality, community-based palliative care to patients with serious illness.

CHCF made planning grants to these entities to support this effort:

1. California Pacific Medical Center with Sutter and Brown & Toland (San Francisco)
2. CareCHOICES Hospice and Palliative Services with Health Net (Orange County, Long Beach, and South Los Angeles)
3. Community Regional Medical Center with Humana (Fresno)
4. LightBridge Hospice & Palliative Care with Health Net (San Diego)
5. Optum Palliative and Hospice Care with UnitedHealthcare (Orange County)
6. Partnership Health Plan with various palliative care providers (Northern California)
7. Rady Children's Hospital with Health Net (San Diego)
8. SCAN Health Plan with MemorialCare Medical Group and Monarch (Orange County)
9. UCLA with Anthem (Los Angeles)
10. UCSF with Hospice by the Bay and Blue Shield (San Francisco)

By the end of the planning period, each team had developed an implementation plan that detailed the target patient population, model of care, funding approach, and metrics.

This document describes the variety of approaches developed by the payer-provider teams and may provide food for thought for other organizations considering similar partnerships.

Patient Population

What patients will be targeted to receive specialty palliative care, and how will they be identified?

Critical to the success of any specialty palliative care intervention is defining which patients the palliative care team will serve. If teams cast too large a net, using criteria that yield too many patients or patients that are unlikely to benefit from palliative care, they will overwhelm their services and dilute their impact on clinical and fiscal outcomes. If targeting criteria are too restrictive, teams may miss opportunities to reach patients whose physical or psychosocial distress they could effectively address, as well as opportunities to prevent avoidable hospitalizations or emergency room visits.

There is no one "right" way to define which patients are appropriate for palliative care — teams use different approaches based on variations in program goals, clinical resources, and available data. Among the Payer/Provider Partnership planning grant teams, criteria for targeting patients for their palliative care services included combinations of these variables:

Estimated life expectancy: Ranges from "one year or less" to "18 months or less" to "12 to 24 months." Some teams plan to use explicit prognostic criteria to estimate life expectancy, while others expect to rely on (subjective) provider assessments, or a combination of the two.

Diseases: Some services plan to accept patients with any chronic or serious illness, provided there is evidence of specific comorbidities or debility / functional decline. Other services will target specific conditions or combinations of conditions, including metastatic cancer (may specify certain types of cancer), chronic obstructive pulmonary disease, congestive heart failure, cirrhosis, dementia, and frailty syndrome.

Age: Used by some teams to narrow the patient population, such as under age 18 for pediatric patients, or age 90 or above.

Utilization: Some teams plan to use history of emergency department (ED) and hospital use, such as two or more visits/admissions over six months, or same-diagnosis admission within 30 days.

Geography: Most specify the cities or counties that a given provider will serve.

Teams developed a range of strategies for implementing the above criteria, including:

Database search: Some teams plan to use payer claims data to identify patients who are high utilizers of high-acuity services such as the hospital or ED, and some will use predictive modeling tools to assess risk of mortality or readmission.

Chart review: Often used as a supplement to a palliative care team member using a database search as a starting point in patient screening. This step is often needed if non-coded values, such as functional status, are used in determining eligibility.

Referral: Referrals from primary care and specialty providers, health plan nurses and case managers, hospital discharge planners, as well as self-referrals from patients and families.

Model of Care

What services will be provided to patients, by whom, and where?

The term "palliative care" can mean different things to different people. As payers and providers collaborate to improve access to palliative care services, they must reach agreement on the model of care, clarifying issues such as:

- **Services to be provided:** May include assessment and management of physical and psychological/psychiatric symptoms, emotional and spiritual issues, social and functional issues; assessment and documentation of patients' values and wishes, including goals of care

discussions and advance care planning documentation; case management; and coordination of transitions across settings and providers

- **Intensity and duration:** How frequently and for how long patients are seen by different members of the interdisciplinary team, defining different tiers of care depending on patients' needs
- **Staffing:** Composition of interdisciplinary team, role of different team members in providing services
- **Location:** Where services will be provided, such as a stand-alone clinic; a clinic-based service embedded or colocated with another medical specialty; at a patient's residence (may include private homes, assisted living facilities, nursing facilities); by telephone or videoconference; or across settings
- **Outreach:** How the service will engage providers and/or patients and families to inform them of the available services

Among the Payer/Provider Partnership planning grant teams, models of care vary across all of the elements above. Some trends include:

Home-based services: A majority of the teams plan to provide exclusively or predominantly home-based palliative care services, some in coordination with inpatient palliative care services, often augmented with phone-based or videoconference interactions between providers and patients. The one team planning to provide exclusively clinic-based services (plus phone support) will be embedded in an oncology clinic.

Interdisciplinary care: Palliative care services will be provided by interdisciplinary teams, including some combination of physician, nurse practitioner, registered nurse, social worker, and less frequently, chaplain, pharmacist, or patient care attendant. Some will involve other types of care providers within their organizations, outside of the core palliative care team (such as psychologists, grief counselors, and massage therapists). Some plan specific intervals and/or touchpoints for different members of the care team to interact with patients, such as having the nurse or social worker do an initial screening, the physician or nurse practitioner do the initial care visit, and the nurse care coordinator providing ongoing care.

Tiers of care: Defining different tiers of care based on patient acuity and needs, with variation in the intensity and duration of services, which disciplines are involved, and care setting. These may range from weekly visits by a physician or nurse practitioner for the patients with greatest need, to semimonthly or monthly phone calls from a social worker or nurse case manager for more stable patients.

Outreach: Includes a variety of methods to educate providers about services, including group and one-on-one meetings, use of brochures or newsletters (for providers and patients/families), referral forms or triggered consults that identify appropriate patients, and general education about palliative care and advance care planning aimed at providers as well as patients and families.

Funding Approach

How will payers compensate providers for palliative care services?

Partnerships between payers and providers to increase access to palliative care services must include payment models that enable both parties to sustain the partnership over time. Payment models will vary based on the type of palliative care services provided, the staffing model, the anticipated impact on care quality and total health care costs for the targeted patient population, and the degree of risk each party currently has or is willing to take on for the target patient population.

The planned funding approaches of the teams vary widely, illustrating the need for flexibility in this new and dynamic field. Teams' planned initial approaches include:

- Enhanced fee-for-service, where payments for individual encounters are increased to reflect involvement of team members such as nurses, chaplains, and social workers, as well as greater length of individual encounters
- Per-member-per-month payments, which would cover all specialist palliative services offered to a member or a subset of services (for example, all community-based services)
- Tiered monthly bundled service rate based on patient characteristics and needs
- Shared-savings or shared-risk arrangements
- Combined approaches, such as a per-member-per-month base payment for one specific set of services, fee-for-service payments for additional sets of services, and shared savings based on key quality indicators
- Additional "pay for reporting" incentives that reward collection and reporting of detailed process and outcome data
- Additional "pay for performance" incentives that reward positive outcomes

Teams will evaluate and potentially adjust their funding approaches over time based on pilot phase experiences.

Metrics / Monitoring Impact

How will partners assess the impact of their palliative care services?

To understand the impact of their palliative care services on care quality, utilization of health services, and fiscal outcomes, payer/provider partners must agree on a set of metrics they will collaboratively monitor. This metrics strategy will vary based on the goals of the palliative care program from both the payer and provider perspectives, data availability, and analytic resources but should generally include a balanced portfolio of indicators that feature:

- **Structure metrics:** What is in place to serve patients and families; team composition, training, and availability (including, for example, program staffing, services offered, and locations, settings, and availability of services)
- **Process metrics:** Describe the who, what, where, when, and why of the service; for example:

- Who: Which patients were seen? What proportion of the potential population was seen?
- What: What did the palliative care team do? Pain management, advance care planning, spiritual support?
- Where: Where were services provided?
- When: When were services provided, relative to time of diagnosis, time of death, or time of referral?
- Why: What were the reasons that palliative care was asked to help? Were these appropriate?
- **Outcome metrics:** Describe the impact of clinical contacts:
 - On patients: For example, what was the impact of palliative care on pain scores and other symptom scores?
 - On families and care teams: For example, how satisfied were families with the services provided?
 - On institutions: For example, the impact of palliative care on hospital use. Are costs reduced? Are there fewer in-hospital deaths?

The top 10 metrics proposed by the CHCF Payer/Provider planning grant teams included:

- Proportion of patients completing Advance Care Plan / POLST forms
- Use of palliative care service (number of individuals referred, enrolled, refused; time on service; number of encounters, number of encounters by discipline, number of different locations of encounters [for example, clinic, home, phone])
- Hospital (number of admissions, number of readmissions, approved days)
- Emergency Department (number of visits)
- ICU (number of days)
- Hospice (referral rate, acceptance rate, length on service)
- Patient/family satisfaction scores
- Management of pain and other symptoms
- Site of death (percentage dying at home, percentage dying in preferred location)
- Referring provider satisfaction / likelihood of using service again