Experiences Implementing Palliative Care

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Objectives

- Learn about variation in approaches plans and providers have used to implement Medi-Cal palliative care

- Consider plan and provider experiences offering palliative care that meets or exceeds the Medi-Cal requirements, and how those experiences align with or differ from your own experiences

- Learn about and share promising practices that may optimize implementation

Standards for Delivering Community-Based Palliative Care

State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: December 7, 2018

ALL PLAN LETTER 18-020
SUPERSEDES ALL PLAN LETTER 17-015

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PALLIATIVE CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their obligation to provide palliative care to their members pursuant to Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014) and under their contract relative to the provision of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.[1] The requirements discussed in this APL specifically apply to Medi-Cal managed care members who are not dually eligible for Medicare and Medi-Cal.

BACKGROUND:
SB 1004 requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to MCPs for the delivery of palliative care.[2] Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the MCP contracts and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

California Advanced Illness Collaborative
Consensus Standards for Community-Based Palliative Care

I. Patient Identification ("Eligible Member"):

Eligibility is based on general and disease-specific criteria. Patients should meet <u>all</u> general eligibility criteria and <u>at least one</u> of the disease-specific criteria. It is acknowledged that some patients who would likely benefit from palliative care may not meet all of the specified criteria. Additional patients who may benefit from palliative care services may be included in the palliative care program at the discretion of each individual health plan payer.

NOTE: <u>**Qualifying patients may continue disease-directed treatments concurrently with palliative care services.**</u>

A. General Qualifications (must meet all):

1. Patient in the late stage of illness with decline in health status and/or function.
2. Patient is starting to use the hospital and/or emergency department to manage their advanced illness/late state disease.
3. Patient and family are assessed for appropriateness for in-home/outpatient disease management, reside or will reside in a safe living environment, are willing to receive palliative care, and consent to treatment by a palliative care team.
4. Patient not currently enrolled in hospice.
5. Patient's primary diagnosis for eligibility is NOT psychiatric or substance-abuse related in nature.

The California Advanced Illness Collaborative (CAIC) Pilot Project

- Four payers and ten providers delivering palliative care in Sacramento and/or Los Angeles

  - Managed Medi-Cal, Medicare Advantage and Commercial populations

- Contracts for delivering palliative care meet or exceed the SB 1004 All-Plan Letter (APL) requirements or CAIC Standards

- Pilot led by CCCC, funded by CHCF

- Evaluation Questions

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

Assessing Variation and Experiences

- Gathered data about how plans and providers have operationalized SB 1004 requirements
- Gathered opinions about how things are going
  - Oral and written information shared by participants in surveys, interviews and group meetings
- Focus on five key elements of implementing contracts for delivering palliative care

Eligibility	Services	Staffing/Care Model
Payment Model	Measurement and Reporting	
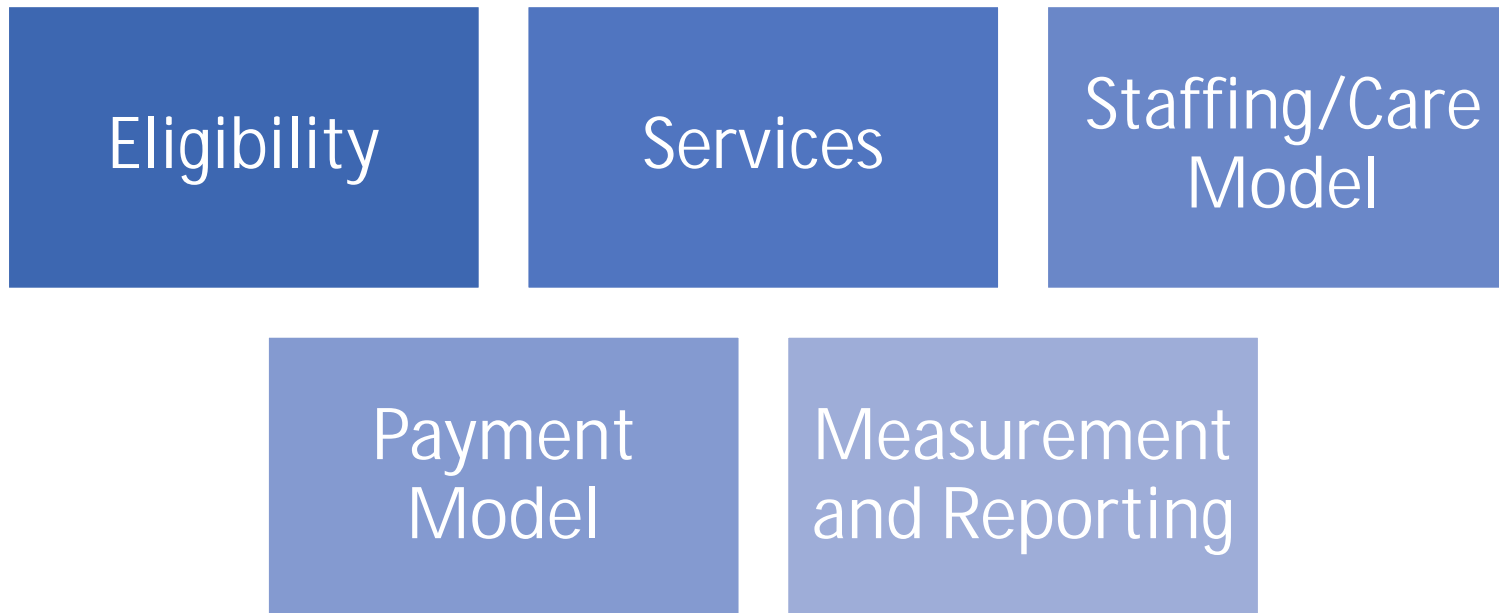
Session Structure

- Review information about variation and experiences with the 5 key implementation areas
  - Where possible consider plan/provider approaches to operationalizing specific SB 1004 requirements
- Small group discussion
- Return to large group for report out

Eligibility Criteria

General Criteria	Qualifying Diagnosis	Evidence of Advanced Disease
• Using hospital / ED to manage illness • Death within a year would not be unexpected • Willing to participate in ACP • Etc.	• Cancer • COPD • CHF • Liver disease	• Utilization criteria • Bio-markers

At minimum, plans must ensure access to palliative care to individuals with advanced cancer, COPD, heart failure and liver disease who meet both general and disease specific criteria

Eligibility: Operational Variation

- Specific inclusion of other eligible diagnoses: stroke, end-stage liver disease, severe dementia
- Relaxing criteria based on biomarkers that serve as evidence of advanced disease

How might this variation impact:
- Number of referrals?
- Referrer confusion re who is eligible?
- Palliative supports needed by enrollees?
- Outcomes?

Eligibility: Plan Experiences

- *Do the eligibility criteria in your contracts effectively identify the members who would benefit from palliative care?*
- *Are the criteria identifying any members who do not need palliative care?*
- *Do the criteria exclude any important patient groups?*

- Agreement that as written missing some important diagnoses (dementia/other neuro, CKD) but also noted that plans usually accept seriously ill members with other conditions
- Operationally, may be too inclusive:
  - Some issues with inappropriate referrals for those with chronic illness and needing pain management
  - Some enrollees are more "advanced illness" vs. palliative care (answer to the surprise question is "yes, we would be surprised")
  - Might be helpful to include the palliative performance score in criteria

Eligibility: Provider Experiences

- *Do the eligibility criteria in your contracts effectively identify the patients who would benefit from palliative care?*

- *Are the criteria identifying any patients who do not need palliative care?*

- *Do the criteria exclude any important patient groups?*

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

- Most feel missing patients and too restrictive:

  o "Sometimes we have bedbound patients that would benefit from our services that somehow don't meet criteria"

  o "The eligibility criteria should be broader. Many patients with neurological diagnosis and heart conditions could benefit from palliative care"

  o "We are willing to help in the vetting of patients if needed. We feel that many patients who would benefit from our services are still not getting them."

Services

1. Advance Care Planning
2. PC Assessment & Consultation
3. Plan of Care
4. Interdisciplinary PC Team
5. Care Coordination
6. Pain and symptom management
7. Provide or refer to mental health and medical social services

- *(24/7 telephonic support)*
- *(Chaplain Services)*

Services: Operational Variation

- Specific inclusion of spiritual care as a required service
- 24/7 availability requirement

How might this variation impact:
- Cost of care delivery?
- Referring provider understanding of what PC is?
- Outcomes?

Services: Plan Experiences

- *How well do the services required in your contracts match the types of supports members and families need?*
- *Are there additional services that members and their families seem to need?*
- *Do you feel that the SB 1004 APL require any services that members may not need?*
- *Have any of the required services seemed difficult for your vendors to provide?*

- In general, pleased, "They match well and help facilitate a holistic approach to care"
  - Important to partner with care management or other plan departments to obtain additional services for very complex members
- Spiritual support seen as an important add, even though not a required service for SB 1004
- Required 24/ 7 phone line also an important addition
- Members and families can benefit from more caregiver services (not required for SB 1004)

Services: Provider Experiences

- *Do the services required in your contracts match the types of supports patients and families need?*
- *Do you routinely deliver services that are not in your defined scope because patients and families need them?*
- *Do you feel that you are required to deliver some services that patients and families may not need?*
- *Are any of the required services difficult for you to deliver?*

- Most felt services they provide are needed by patients and families, but some gaps remain
  - "The services that we provide are in line with what patients and families need. What we are missing is more consistent access to mental health providers and substance use facilities and specialists. We definitely take on a lot the social and behavioral health issues because our patients cannot access them due to availability and Covid."
  - Bereavement support after the death of a patient (is missing)
- One provider cautioned against a too-rich benefit:

  "Sometimes offering too much under palliative care, like home health aide services, may discourage patients from electing hospice care"

Staffing/Care Model

Providers

- Plans may contract with any qualified PC provider, based on the setting and needs of a beneficiary
- DHCS recommends using providers with current palliative care training and/or certification

Organizations

- Hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care

Staffing/Care Model: Operational Variation

- Requirement that provider organization be certified in palliative care (CHAP or TJC)

- Visit frequency (by discipline) specified
    - For example, "2 RN visits per month" or "PC team prescribing clinician sees patient at least once every 3 months and when GOC change"

How might this variation impact:
- Quality of care?
- Referring provider attitude towards PC?
- Plan ability to assemble a PC-provider network?

Care Model: Plan Experiences

- *Are you satisfied with the Staffing (which disciplines), Care Model (how often specific disciplines are required to deliver services) and Training/Certification requirements featured in your contracts?*
- *Do you feel these requirements promote delivery of the right care at the right time?*
- *Do you feel they ensure quality care?*

- In general, satisfied but some deficits identified:
  - Some vendors would benefit from further training on the scope of palliative care and being able to differentiate from hospice. It would also be helpful for them to learn about how to communicate with the PCP and share information.
- *Payment model supports care model:*

  > "By paying a case rate, we give our vendors flexibility on which services are provided. For example, the vendor may substitute an extra social work visit for a nursing visit if medically appropriate."

Care Model: Provider Experiences

- *Are the requirements for Staffing (which disciplines are involved in care), Care Model (how and how often specific disciplines are required to deliver services) and Training/Certification featured in your contracts feasible for your organization?*
- *Do you feel that they promote delivery of the right care at the right time?*
- *Do you feel they ensure quality care?*

Most organizations were mostly satisfied

- o The staffing works for us. We utilize a chaplain routinely and to great benefit of our patients.
- o Our staffing and care model often exceed the contractual requirements.
- o Most contracts allow for the necessary delivery of services. Plans tend to be very flexible in authorizing additional visits when requested.

Some issues were identified

- o We are being asked to provide more visits/contacts than patients/families may want.
- o Individual contract requirements for meetings/trainings are a significant time commitment and can at times interfere/compete with patient care.
- o Contracts can dictate type of support and frequency of visits by discipline, versus being guided by needs of the patient.

Measurement/Reporting

Information Plans Are Gathering From Contracted Palliative Care Providers

Metric	% Getting Data
Discharge status for enrolled patients, (e.g. transition to hospice or death)	67%
Timeliness or amount of service delivered • number of days between referral and first contact • number of visits/month	61%
Assessment or management of physical symptoms	61%
Assessment or management of psychosocial needs	61%
Assessment or management of spiritual needs	61%
Assessment or documentation of member goals or advance care planning	61%
Member satisfaction	22%
Information is not requested from vendors	17%

19

Measurement/Reporting: Operational Variation

Data reported to plan

- No data shared beyond claims submitted by provider vs. weekly reporting that summarizes encounters and resulting plans

Audits of services and processes

- Routine audits of quality indicators (note reviews) vs. no plan assessment of process measures (monitoring of outcome measures only)

How might this variation impact:
- Resource investments by plan and providers?
- Quality of care?

Measurement: Plan Experiences

- *Do you feel that information you ask palliative care vendors to collect and share is appropriate?*
- *Do you feel these data provide an accurate picture of vendor contributions to patient care?*
- *Do you feel the provided data have been useful to your organization?*

Some aspects acceptable

- Reports of visits and calls gives us a quantitative measure of care given. Rounds with the vendors gives us an assessment of the quality of services delivered. Plan has the utilization data.
- The three groups of data we obtain for measuring quality are discharge disposition, hospital utilization, and care planning documentation completion. Other useful measurements are length of stay on program and referral sources, which are gathered during the enrollment process. I believe these measurements are appropriate for our palliative care providers.

Some deficits identified

- Two plans noted they do not have and would value patient/member satisfaction data
- One plan felt data requirements were too burdensome for providers
- One plan felt currently available data are inadequate: "I would like to see measurements focused on palliative care provider utilization (# of visits, which clinicians visited); care coordination; and patient/caregiver measurements around pain/symptom management, goals of care conversations, program satisfaction"

Measurement: Provider Experiences

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

Some aspects acceptable

- This varies from plan to plan, but for the most part, data collection is reasonable and necessary.

Some deficits identified

- Data collection is possible but special reports have to be created so it is an added factor when contracting

- The administrative requirements are burdensome with some payors and involves more manual processes than is reasonable – often duplicative in nature. The requirements for each contract are different, the frequency varies along with the information requested. There is little consistency.

- It does not feel that the current level of information drills down to the quality of care.

- The data is in general appropriate and reflects the quality of care delivered. However, [reporting] the number of visits, calls, consults, and IDT meetings is very time consuming and unlikely to be sustainable or realistic at our current rate of growth

Payment Model

Payment mechanisms featured in SB 1004 palliative care contract(s)
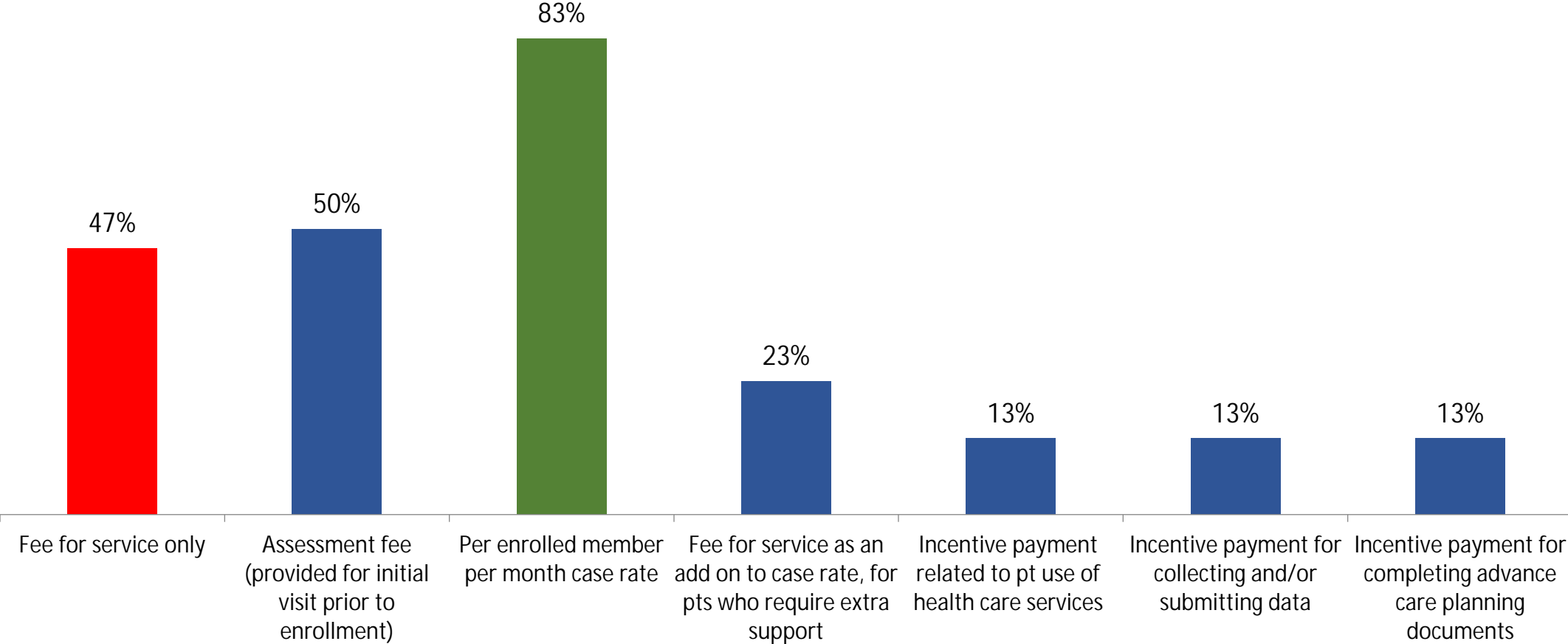
Payment Model: Operational Variation

- Formal tiers of service with different payment amounts vs. assuming a distribution of acuity/need and a single payment amount
- Supplemental payments in addition to PMPM for high utilizers

How might this variation impact:
- Amount of service delivered?
- Sustainability for providers?
- Fiscal outcomes for plans?
- Plan-provider relationships?
- Administrative burden for claims processing?

Payment: Plan Experiences

- *Is the payment mechanism for palliative care services in your contracts appropriate?*

- *From the plan perspective, is there adequate alignment between the cost of delivering palliative care and the impact on the total cost and quality of care?*

Case rate universally endorsed:

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

- The monthly case rate enables provider flexibility with care delivery.

Alignment between cost and impact was less clear

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

Payment: Provider Experiences

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

Case rates preferred but some concerns about sustainability

- Given the amount of time we spend, as a team, managing these patients, there may be cases where additional funding should be considered but we are generally satisfied.
- The reimbursement needs to be more to be a profitable program.
- Case rate is the better payment model. Case rate varies and, in some instances, it is difficult to provide excellent PC services with a lower rate.
- Most contracts require care delivery models that exceed reimbursement

Small Group Discussion

1. Which implementation area would you like to modify your own organization's approach to, and why?
   a. Eligibility
   b. Services
   c. Staffing/care model
   d. Payment model
   e. Measurement/reporting

   For provider organizations, most modifications would require engaging plan partners

2. What promising or successful practices have you used or heard about in any of these areas that you wish were used more widely?

- Random assignment to small groups
- Address two questions + general discussion if time allows
- Return to large group for Rapid Report Out