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Recommendations for Implementation of SB 1004

Expanding Palliative Care for Medi-Cal Beneficiaries

Palliative care is specialized, team-based care that focuses on providing relief from the symptoms and stresses of serious illness. Palliative care improves the quality of life for both patients and their families. Unlike hospice, palliative care is appropriate at any age or any stage of a serious illness. It is delivered across a variety of health settings, from acute hospital to outpatient clinics, skilled nursing facilities and homes, through a team-based approach which can include physicians, nurses, chaplains, social workers, and others.

Increasingly, health care professionals and consumers are recognizing the benefits of palliative care for seriously ill patients.

SB 1004, which passed the legislature in 2014 with overwhelming and bipartisan support, is designed to expand access to palliative care services for beneficiaries of Medi-Cal managed care plans, which serve more than half of all people in the Medi-Cal program.

Under SB 1004, the Department of Health Care Services is required to:

- Establish standards regarding palliative care services
- Develop inclusion criteria for palliative care services
- Provide technical assistance for plans to ensure delivery of palliative care services

The Coalition for Compassionate Care of California is a statewide coalition of organizations, institutions, healthcare providers, state agencies and individuals working together to promote high-quality, compassionate end-of-life care for all Californians. Since 1998, CCCC has developed and implemented a wide variety of programs and projects to improve care for those with serious or terminal illnesses.

CCCC has a successful track record for bringing together diverse groups with an interest in palliative and end of life care – government agencies, health care providers, policymakers, educators, community groups, consumers and other stakeholders. We know how to develop consensus, create a shared vision and move forward in a way which supports successful implementation.

In developing the following recommendations, CCCC worked in coordination with several other thought-leaders in this area. (Appendix A.)

Our recommendations are based on three over-arching themes:

- **The System Must Be Flexible** – There is tremendous diversity in California in terms of patient populations, practice settings, and resource availability. For this reason, there needs to be considerable flexibility in how different plans meet the palliative care needs of their members. However, diversity of need must be met by appropriately trained, resourced, and qualified palliative care providers. Optimal care delivery will require triaging individuals with the most complex and challenging needs to receive services from the most highly-trained and experienced providers. All palliative care services must be of adequate and verifiable quality.
- **Workforce Shortages Must Be Addressed** – With the aging of the population, there is a growing disparity between the number of patients who could benefit from palliative care and the number of subspecialty (“specialist”) palliative care providers. For this reason, there must be flexibility in how palliative care is delivered, reserving subspecialty palliative care for the members with the highest and most complex needs, and emphasizing training of generalist providers to meet the basic palliative care needs of the majority of members. Very likely, palliative care specialists will be needed to provide training, direction, and supervision to generalists who will provide the majority of palliative care services.
- **Quality Outcomes Must Be Defined and Tracked** – Given the Bill's mandate that plans achieve the goal of enhancing access to palliative care without increasing costs, there is the potential for members to perceive that receiving palliative care would lead to a *loss* of services. For this reason, it will be important to track and report outcomes that demonstrate improved quality of care, including adherence to member preferences, in addition to program impact on health care utilization patterns.

CCCC offers the following key recommendations:

1. DHCS should specifically define what constitutes a “palliative care service”; given the necessary and expected variation in how services will be delivered across plans and regions, this will likely be a list of minimum required service components, evidence of quality monitoring, and personnel qualifications and certifications, rather than a description of one or two comprehensive “approved” models.
2. A quality monitoring program should be developed iteratively, with input from the Department, plans, providers and palliative care experts.

3. DHCS should allow for flexibility in how individual plans determine members' eligibility for services, prioritizing members with the highest illness/symptom burden and those in the last 1-2 years of life.
4. Given the complexity of funding issues, we would recommend initially piloting services for members insured with only Medi-Cal. This would allow plans to begin services more quickly, realize the anticipated cost savings and enable program growth and sustainability, with an intent to extend services to dually eligible beneficiaries over time and in collaboration with CMS.
5. Technical assistance offered to plans should include developing and disseminating gap analysis tools that will help plans understand what specialty palliative services are currently available to members, opportunities for leveraging existing non-palliative programs to meet members' needs, where new specialist services are needed, and how to deliver education and other supports to non-specialist providers.
6. DHCS should disseminate examples of community-based palliative care models, representing a wide variety of team structures and care settings.
7. Plans should be given maximum flexibility in determining the payment models that are most suitable for a variety of palliative care interventions.
8. Technical assistance provided to plans should include instruction in different methods for assessing palliative care programs' impact on health care utilization and total health care costs.
9. We recommend a 5-step, multi-year implementation plan that provides opportunities for plans to develop, pilot, assess, and expand palliative care services with assistance from peers and DHCS.

ESTABLISHING STANDARDS FOR PALLIATIVE CARE

Legislative language in SB 1004 defines palliative care as, "Specialized medical care and emotional and spiritual support for people with serious advanced illnesses," and underscores that it is "appropriate care for any age and for any stage of serious illness, along with curative treatment." It emphasizes "relief of symptoms, pain, and stress of serious illness," as well as the "improvement of quality of life for both the patient and family."

The Centers for Medicare and Medicaid Services (CMS) have endorsed the following definition: "Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice."ⁱ

Core Components

Key components of high-quality palliative care have been identified by the National Consensus Project for Quality Palliative Careⁱⁱ, and include guidelines and criteria addressing eight domains of care. With that in mind, we recommend that core components of palliative care include:

- Interdisciplinary team-based approach to patient and family care;
- Comprehensive and ongoing assessment of symptoms and burden of illness (physical, emotional, social, spiritual/existential), impacting patients and their caregivers;
- Skilled interventions to address identified areas of distress/suffering;
- Assessment of patients' values, wishes, and preferences, particularly related to developing and implementing treatment plans that are aligned with patient and family preferences addressing setting and intensity of care.

RECOMMENDATION I: Core Components

Core components of palliative care services should include:

- Coordinated, interdisciplinary, ongoing assessment and management of:
 - Physical symptoms and mental health
 - Emotional and spiritual/existential impact of illness (coping)
 - Social and functional impact of illness
- Routine assessment and documentation of patients' values and wishes, particularly related to health care decisions
- Routine visits to document patients' wishes regarding specific medical treatments, transferrable across systems (e.g. completion of advance directive and POLST forms)

The core components of palliative care can be provided by trained generalists or certified subspecialists, depending on available resources and patients' needs, *provided that there is accountability for the quality of palliative care that is provided.*

Quality Metrics

Given the certain variation in population needs and plan/affiliated provider choices in how palliative services will be delivered, we do not recommend that the Department require plans to use a very limited set of specified metrics when monitoring the quality of palliative care delivered.

RECOMMENDATION II: A Menu of Quality Metrics

The Department should consider endorsing a menu of metrics that plans and affiliated provider organizations can choose from. The choices of metrics should include items that speak to the use of palliative services, as well as structure, process and outcome metrics, with an eye to ensuring that services offered address the full spectrum of core palliative care domains.

The menu should be developed as a collaborative effort that features input from plans, provider organizations and palliative care experts. The department could mandate that each plan (and the plan could mandate that affiliated provider organizations) monitor a given number of each type of metric (e.g. six structure metrics, two process metrics, two outcome metrics).

Metrics that address reach and use of palliative services could include items such as:

- Number of individuals receiving specialist services
- Type(s) of services utilized
- Number of contacts per members that receive services
- Timing of initial offering of primary and/or specialist palliative care services, in relation to date of death

Structure metrics could include items such as:

- Proportion of providers or supervisors with advanced training in palliative care
- Accessibility of specialist services (i.e., 24/7, or more restricted)
- Disciplines on a specialist team
- Settings in which palliative care is offered (clinics, home, SNF, etc.)
- Availability of materials describing hospice, advance care planning and other key concepts that are available in the languages that are predominantly used by a plan's members

Process metrics could include items such as:

- Proportion of individuals who receive a comprehensive palliative care assessment within a certain time period following referral for specialist services
- Number of individuals with surrogate decision maker identified and documented
- Proportion of individuals who screen positive for moderate or severe pain who receive treatment within 24 hours

Outcome metrics should address patient, social (caregiver/family) and cost/utilization outcomes, such as:

- Concordance between care preferences and treatment received
- Reduction in severity of physical, psychological, and spiritual symptoms

- Family satisfaction with medical decision-making support
- Use of the emergency department and acute care hospital
- Total cost of care in a defined period (before/after initial palliative care contact, or the final 6 months of life, etc.)

An overarching quality monitoring program that includes a smaller number of possible measures and a limited number of mandatory measures could be developed in 2-3 years, after programs have had the opportunity to pilot metrics, address data access or data quality issues that might impede collection or analysis of data, and determine through experience which measures are of greatest value to all involved stakeholders.

Metrics assessing access to and use of inpatient palliative care should be distinct from measures assessing access to and use of community-based services, as these are likely to be delivered by different providers. Similarly, metrics for pediatric palliative care should be distinct from measures used for adult services.

Inclusion Criteria

SB 1004 charges DHCS with providing "guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services."

There are a number of methods that plans could use to proactively identify individuals who could benefit from palliative care. The method that an individual plan would choose could be based on a variety of factors, including the availability of key data, the availability of clinicians willing and able to screen patients for eligibility, and the degree to which palliative care is already integrated across the system or region.

RECOMMENDATION III: Flexible Inclusion Criteria

We recommend that DHCS define the specific qualifying diseases for palliative care services, and then allow plans to determine their own methods for identifying members with the greatest need.

Possible methods to identify members who would benefit from palliative care could include:

- Claims-based methods:
 - Identify members with specific life-limiting disease(s): for example, advanced cancer, heart failure, COPD, liver disease, kidney disease, HIV, dementia, or frailty
 - Develop specific qualification criteria based on utilization patterns (e.g. threshold number of emergency department visits and/or hospitalizations in specified time period)
 - Patients who meet both criteria could be screened for palliative care needs

- Clinical triggers, such as functional assessments or prognostic indices relevant to specific disease states (e.g. Karnofsky performance status)
- Provider referral, with outreach and education to help providers identify members likely to die in the next 1-2 years

Plans could use a combination of these methods to identify eligible members.

We favor the use of clinical triggers to identify patients *before* they reach a certain threshold utilization pattern or when clinicians determine that a member might be eligible.

Technical Assistance

RECOMMENDATION IV: Gap Analysis

Plans should be supported in conducting gap analyses to determine what types of supports and services are already available to eligible members and where gaps exist, across need categories (including social service needs) and types of patients.

Support (technical assistance) in this area would include process descriptions, templates and checklists. Findings across regions and plans will certainly vary, as will decisions regarding how gaps will be addressed, but the process for conducting a gap analysis need not vary, and developing tools that plans can use will make this process as comprehensive and efficient as possible.

Creating mechanisms for plans to share gap analysis experiences and findings will almost certainly be helpful and promoting such activity should be a component of DHCS technical assistance.

Clinical & Payment Models

The landscape of community-based palliative care services is rapidly evolving, and includes a wide variety of clinical models that use interdisciplinary teams to deliver the core elements of palliative care (see above) across a wide variety of settings. Exemplary health care systems have demonstrated that in order to meet patients' needs and maintain cost-neutrality, it is important to have a variety of levels of service available to meet patients' needs as efficiently as possible.

As mentioned above, given shortages in the palliative care workforce, plans should consider how to most effectively triage the palliative care needs of their members, emphasizing generalist-level palliative care services for the majority of members, and reserving specialty-level palliative care services for members with the greatest needs.

RECOMMENDATION V: Utilize Community-Based Models

SB 1004 emphasizes the concurrent hospice care model, exemplified in the Pediatric Palliative Care Benefit. While hospice providers have the clinical skills that position them to provide palliative care, the recently completed survey of California palliative care providers note that only 22% of community based palliative care was provided by hospices. To ensure palliative care access, we believe that a variety of community-based palliative care service models should be available to health plans, including:

- Telephonic or video-enabled case management
- Clinic-based palliative care co-management or consultation
- Home-based palliative care consultation
- SNF and residential care facility-based consultation

Provided that they are able to demonstrate evidence of high-quality care, plans should be able to determine which members should receive generalist-level palliative care services vs. specialty-level palliative care services, in various care settings.

RECOMMENDATION VI: Payment Models

Plans should have maximum flexibility in devising payment models to support access to enhanced palliative services.

Options that existing payer-provider partnerships have used 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 (i.e., all community-based services.)
- Shared savings or shared risk arrangements

Plans should be encouraged to experiment with incentives or dedicated payments to non-specialist providers who are being asked to assume responsibility for offering primary palliative care.

Plans should consider offering incentive payments to provider groups that achieve meaningful benchmarks, such as: the proportion of individuals with advanced disease whose surrogate decision makers have been identified and documented, the proportion of individuals with advanced disease with whom providers have discussed advance care planning, the number of individuals with advanced disease who have received comprehensive palliative care assessments (addressing physical, psychological, social, spiritual distress, for example); or adherence to a palliative care quality monitoring plan.

RECOMMENDATION VII: Assessing Impact

Plans should be supported in assessing program impact on utilization of health services and total cost of care amongst individuals who received palliative care.

Such support should include developing and sharing analytic approaches to assessing impact across patient groups and delivery models for both specialist and primary palliative care. For this topic, the Department should consider sponsoring educational opportunities that will allow analytic staff from each plan to familiarize themselves with a variety of approaches to this work.

Because different methods for assessing impact will be both optimal and feasible across plans, the Department should not mandate a single approach for conducting such assessments.

The Department should gather cost and utilization impact from all plans, for the purpose of assessing the extent to which new palliative care programming is achieving the goal of cost neutrality, for individual plans and for the state.

An essential prerequisite to any assessment effort is ensuring that plans have ongoing, timely access to date of death data. Without these data, plans and affiliated provider groups will face nearly insurmountable challenges in analyzing impact, determining patterns of using palliative care services, and appreciating how many individuals who might have benefited from palliative care did not receive such services.

Implementation

Given the diversity of health plans across California, with some plans already actively identifying patients in need of palliative care services and providing enhanced palliative care benefits, and other plans that are relatively unfamiliar with palliative care and at present offer limited access to subspecialty palliative care services for members, it will be important to provide both accountability and flexibility in the implementation of the SB 1004 across the state.

RECOMMENDATION VIII: Implementation Phases Based on Experience

Plans relatively unfamiliar with palliative care should begin with a (1-yr) *Planning Phase*, which would address the following key considerations:

- Conduct a gap analysis to identify core palliative care needs that are not being addressed and consider which existing services (primary care, case management, disease specific programs, complex case management programs, etc.) might be leveraged/enhanced to help address needs, in addition to promoting access to specialist palliative care services

- Identify local champions/stakeholders to help in planning, implementation, and post-implementation monitoring/quality improvement
- Identify opportunities for training and development of local practitioners in primary palliative care
- Agree to a strategy (or strategies) for identifying appropriate patients:
 - Claims-based
 - Clinical triggers
 - Clinician referral
 - Hybrid
- Determine how access to services will be financed, with an expectation that in some locales multiple models will need to be utilized
- Develop mechanism to recognize/track which members received palliative care
- Choose which metrics will be tracked to demonstrate quality of services provided

Programs that have already engaged in planning for palliative care services could choose to skip the *Planning Phase*.

RECOMMENDATION IX: Pilot with Medi-Cal Recipients Only

After planning is complete, plans could move into a (1-yr) *Piloting Phase* to test a proposed model for a defined subset of members.

- **Given the additional payer complexities of dual-eligible members , for the pilot phase we would recommend piloting services for members insured with only Medi-Cal. This would allow plans to realize the anticipated cost savings and enable program growth and sustainability.**
- The size and scope of the pilot could be determined by each plan and its partners, available resources and perceived needs of members.

RECOMMENDATION X: Assessment Phase

After a *Piloting Phase*, plans could move into a (6-month) *Assessment Phase* to allow for strategic planning and quality improvement:

- Incorporate lessons learned from Pilot Phase to improve care delivery (quality and efficiency)
- Develop a strategic plan for expansion of the program pilot, to serve a larger number of members

After the *Planning, Piloting, and Assessment* phases, programs would continue to expand services to reach additional members, and continue reporting on quality measures.

RECOMMENDATION XI: Develop Education & Support

Throughout implementation, it will be critical to support the plans through access to education and training resources:

- Resources for plan leadership regarding program development and assessment
- Resources for generalist clinicians to provide primary palliative care
- Resources for developing palliative care "champions" with additional training to implement local education and QI initiatives
- Resources for selecting and monitoring quality metrics, including impact on the patient experience of care and impact on utilization and costs
- Resources for facilitating development of local palliative care specialists across a variety of disciplines (e.g. certification programs through the CSU Institute for Palliative Care)

As emphasized above, it would be especially useful for the Department to develop mechanisms for all plans, regardless of developmental stage of palliative care programming, to come together to share experiences, lessons learned, promising practices and outcomes.

Appendix A: Contributors

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ⁱ Federal Register 2008 - 73 FR 32204, June 5, 2008.

ⁱⁱ National Consensus Project for Quality Care; Clinical Practice Guidelines for Quality Palliative Care, Second Edition. 2009 <http://www.nationalconsensusproject.org/guideline.pdf>