

California Advanced Illness Collaborative

Consensus Standards for Community-Based Palliative Care

in California

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*The Standards will be tested in a multi-payer/multi-provider pilot starting in January 2018. The pilot will be funded by the **California Health Care Foundation (CHCF)**, which works to ensure that people have access to the care they, when they need it, at a price they can afford. Visit www.chcf.org to learn more.*

INTRODUCTION

Palliative care is patient- and family-centered care that prioritizes quality of life by anticipating, preventing and treating the symptoms and stress associated with serious illness. Generally, palliative care is provided by an interdisciplinary team of physicians, nurses, social workers, chaplains and other specialists that works together to address the physical, intellectual, emotional, social and spiritual needs of patients and families. Palliative care can be provided alongside curative treatment, regardless of patient age, diagnosis or stage of serious illness. Community-based, or in-home palliative care (CBPC) has been shown to improve patient quality of life, reduce symptom burden, and increase patient and family satisfaction while reducing the cost of medical care towards the end of life.¹⁻³

Why the Standards were developed

In 2016 the Coalition for Compassionate Care of California (CCCC) and Blue Shield of California convened individuals with expertise in palliative care, payment and policy advocacy, and health services research to form the “California Advanced Illness Collaborative” (CAIC). The mission of the CAIC is to improve the quality of care delivered to Californians with advanced illness, with an initial strategy of increasing access to palliative care.

CAIC members, including individuals affiliated with provider organizations and health plans that were early adopters of CBPC, noted that the absence of standards for delivering CBPC created difficulties for both payers and providers, and ultimately impeded the development, sustainability and spread of CBPC services. Members noted that CBPC providers with multiple health plan partners are often faced with implementing contracts that differed radically in terms of scope, staffing, eligibility requirements, and more. Further, in the absence of an agreed upon model for delivering CBPC, payers found themselves needing to negotiate each contract from scratch, repeatedly revisiting foundational issues that are standardized for established clinical services such as home health and hospice. To address these challenges, the CAIC developed a set of standards that are intended to facilitate development of contracts for delivering CBPC services. These standards build off of prior work in California led by the California Health Care Foundation (CHCF).⁴

What the Standards are based on

The CAIC Standards are based on the current understanding of best practices for CBPC, as put forth by multiple national organizations. Most notably, the National Consensus Project’s Clinical Practice Guidelines 3rd edition (with the 4th edition in process and due out in 2018),⁵ along with the Center to Advance Palliative Care (CAPC),⁶ Coalition to Transform Advanced Care (CTAC)⁷, American Association of Hospice and Palliative Medicine (AAHPM), and others. The National Academy of Medicine (formerly the Institute of Medicine)⁸ provided not only groundwork for best practices for palliative care, but specifically in nursing.⁹ Additionally, the work of both the American Geriatric Society (AGS)¹⁰ and SCAN Foundation inspired the work toward person-centered and person-driven care that underlies palliative care. The CAIC goal was to operationalize some aspects of existing policy documents and guidelines that address best practices in CBPC, elements that are often included in service delivery contracts. The Standards also reflect the real-

world experiences of the CAIC advisory group, and have been reviewed and commented on by other interested individuals and organizations.

Expected use

The Standards put forth a MINIMUM set of services that are to be delivered to a precisely defined patient population. The goal of the Standards is to identify a floor, based on best practices, which should be acceptable to any payer or provider. The minimum set of services are generally aligned with the terms of SB 1004, the California law that as of January 2018 will require Medi-Cal Managed Care health plans to ensure beneficiary access to palliative care.¹¹ In practice, it is expected that contracts for delivering CBPC may include a broader set of services, a wider team of providers and additional patient populations. Similarly, the CAIC expects the listed MINIMUM metrics will be supplemented with other indicators that are of interest to payers, providers, or other stakeholders.

While some specified services can certainly be delivered in a clinic/office or acute care facility, in general the Standards are intended to be used when developing contracts for delivery of home-based palliative care, with the expectation that some provider-patient contacts could be delivered via phone or video-visits.

The Standards focus on the ‘what’ aspects of CBPC—target population, minimum required team members, minimum services, and so on. The Standards do not address the processes to be used to deliver the specified services to the specified population. We expect that ‘how’ details such as staffing ratios, frequency of contacts, distribution of phone and in-person visits, and similar service delivery specifics will vary (appropriately) across providers, payers, and regions. We believe that accepted, operational Standards as proposed in this document for the ‘what’ will reduce the time, energy, and frustration consumed by the current CBPC contracting process and will facilitate the wider dissemination of high-quality CBPC.

Development team and process

The CAIC was initiated and co-chaired by Dr. Marcus Thygeson, MD, former Chief Health Officer of Blue Shield of California and Judy Thomas, JD, Chief Executive Officer of the Coalition for Compassionate Care of California (CCCC). Together, they convened healthcare researchers, providers and health plan representatives as a CAIC Planning Group, which developed the *Standards*.

The *Standards* were publicly released in March 2017 at the Coalition for Compassionate Care 9th Annual Summit as a panel discussion by Judy Thomas, JD, Dr. Marcus Thygeson, Dr. James Mittelberger, (Director and Chief Medical Officer, Center for Palliative and Supportive Care, OPTUM) and Jill Mendlen, RN (Founder and CEO, LightBridge Hospice & Palliative Care and LightBridge Medical Associates).

The Standards were published on the CCCC website on March 21, 2017, with public comment and feedback requested. This document incorporates and addresses the feedback we received.

Beginning January 2018, the Standards are being tested in a multi-payer/multi-provider pilot, funded by the California Health Care Foundation. Visit the CCCC website for further information about this pilot (www.coalitionccc.org).

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11. For more information, see the SB1004 web page maintained by the California Department of Healthcare Services: <http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx> (accessed October 2017)

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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 all general eligibility criteria and at least one 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: **Qualifying patients may continue disease-directed treatments concurrently with palliative care services.**

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.

B. Disease-Specific Clinical Criteria:

1. Advanced Cancer:

- Stage 3 or 4, locally advanced or metastatic cancer; leukemia or lymphoma
AND one of the following:
 - Karnofsky Performance Scale (KPS) score \leq 50 (KPS 50 = Capable of only limited self-care, confined to bed or chair $>$ 50% of waking hours) or ECOG Grade of 3 or higher
 - Patient has already received two lines of standard chemotherapy
 - Patient not a candidate for or declines further disease-directed therapy

Advanced Cancer

<u>Option 1:</u> Stage 3 or 4, locally advanced or metastatic cancer; leukemia or lymphoma <u>AND</u> KPS score \leq 50 or ECOG Grade of 3 or higher	<u>Option 2:</u> Stage 3 or 4, locally advanced or metastatic cancer; leukemia or lymphoma <u>AND</u> Patient has already received two lines of standard chemotherapy	<u>Option 3:</u> Stage 3 or 4, locally advanced or metastatic cancer; leukemia or lymphoma <u>AND</u> Patient not a candidate for or declines further disease-directed therapy
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2. **Congestive Heart Failure (CHF):**

- Any patient who has been hospitalized at least once with CHF as the primary diagnosis

OR

- Patient meets New York Heart Association (NYHA) Class III or IV criteria **AND one** of the following:
 - Ejection Fraction < 30 for systolic failure
 - Significant comorbidities, such as coronary artery disease, renal disease, diabetes, dementia, or poor biomarkers including rising BNP, pro-BNP, hsCRP, BUN/Creatinine (assessed when patient is in their best compensated state)

Congestive heart failure: three eligibility options

<u>Option 1:</u> Any patient who has been hospitalized with CHF as the primary diagnosis	<u>Option 2:</u> NYHA Class III or IV AND Ejection Fraction < 30 for systolic failure	<u>Option 3:</u> NYHA Class III or IV AND Significant comorbidities, such as coronary artery disease, renal disease, diabetes, dementia, or poor biomarkers including rising BNP, pro-BNP, hsCRP, BUN/ Creatinine (patient is in their best compensated state)
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3. **Chronic Obstructive Pulmonary Disease (COPD):**

- 24-hour oxygen requirement at greater than or equal to 3 L/minute

OR

- Severe airflow obstruction: FEV1 < 35% predicted **AND** 24-hour oxygen requirement at less than 3L/minute

COPD: two eligibility options

<u>Option 1:</u> 24-hour oxygen requirement \geq 3 L/minute	<u>Option 2:</u> FEV1 < 35% predicted AND 24-hour oxygen requirement < 3L/minute
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4. **End-Stage Liver Disease:**

- Irreversible Liver Damage
AND BOTH of the following:
 - Albumin < 3.0
 - INR > 1.3

PLUS one of the below:

- Ascites
- Subacute (Spontaneous) bacterial peritonitis
- Hepatic encephalopathy
- Hepatorenal syndrome
- Recurrent esophageal bleeds

OR

- Model for End Stage Liver Disease (MELD) score of greater than 19 (MELD Score: <https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator/>)

End-Stage Liver Disease: two eligibility options

<p><u>Option 1:</u> Irreversible liver damage with serum albumin < 3.0 and INR > 1.3</p> <p><u>AND one of:</u></p> <ul style="list-style-type: none"> • Ascites • Subacute bacterial peritonitis • Hepatic encephalopathy • Hepatorenal syndrome • Recurrent esophageal bleeds 	<p><u>Option 2:</u> (MELD) score >19</p>
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5. Other diagnoses, which either singly or in combination are indicative of progressive illness, with a <12 month life expectancy if the disease follows its natural course

AND one of the following

- Two or more ER visits within past 6 months
- Two or more non-elective hospitalizations within past 6 months
- Two or more non-elective hospital readmissions with past 30 days,

AND one of the following:

- Impaired Functional Performance based on the Palliative Performance Scale (PPS) ≤ 50%
- Current admission prompted by:
 - Uncontrolled symptoms related to underlying disease e.g. pain, shortness of breath, vomiting **AND/OR**
 - Insufficient home, social or family support

II. Essential Services

Community-based palliative care programs are expected to offer the following minimum set of services:

A. Assessment

1. A comprehensive palliative care assessment, to include physical, psychological, social, and spiritual needs, and functional status. This must include ongoing assessment of need for community-based palliative care services.
2. Development of an individualized care plan to identify problems and document a plan of care to address symptom management, goals of care, care coordination and to provide an extra layer of support.
3. Assessment of caregiver needs, making appropriate referrals to community-based services such as support groups, caregiver respite, and grief/bereavement services.

B. Clinical Services

1. In-person or telehealth/telemedicine visits or telephonic contacts by an interdisciplinary team. Services shall be adjusted to meet patient needs for care.
2. Medication management and reconciliation.
3. Availability of symptom management services 24 hours/day, 7 days a week.
4. Advance Care Planning discussions and appropriate documentation, including identification of surrogate decision maker and completion of POLST forms, where appropriate and desired.
5. Caregiver education on aspects of in-home care.

C. Care Coordination and Communication

1. Collaboration with patient, family and other treating medical providers.
2. Care coordination to assist eligible member in navigating of the medical system, including navigating transitions across settings and benefits, in collaboration with health plan partner.
3. Coordination with health plan partner to support palliative care patient access to appropriate services as necessary and appropriate for eligible member, in a timely manner.
4. Education on hospice services.

III. Palliative Care Providers:

Community-based palliative care is delivered by an interdisciplinary team appropriately trained and prepared, the members of which have demonstrated competency in palliative care. The interdisciplinary team should, at minimum, consist of the following disciplines:

1. Physician (medical doctor, doctor of osteopathy), board certified in a related field (e.g. palliative care, internal medicine, family practice, geriatric or pediatric medicine, etc.) The physician role may include direct clinical care or be limited to program oversight.
2. Registered nurse
3. Social worker
4. Spiritual care professional

Programs may also include additional clinical and non-clinical staff, such as:

1. Pharmacists
2. Advanced practice clinicians (physician assistant, advanced practice nurses such as those defined by the CA Board of Registered Nursing, e.g.: nurse practitioner or clinical nurse specialist)
3. Home health aides
4. Community health workers
5. Care coordinators
6. Volunteers – faith-based or community-based

IV. Disenrollment Criteria:

Patients are no longer eligible for community-based palliative care services under the following conditions:

1. Hospice enrollment
2. Death
3. Change in insurance eligibility
4. Improvement of condition or functional status extended outside eligibility criteria
5. Client living conditions are found to be unsafe for staff contact, and no alternative can be found
6. Patient moves out of palliative care provider's service area
7. Patient chooses to disenroll

V. Payment Models:

Enrolled palliative care members will continue to be eligible for existing services as appropriate under their health plan. Community-based palliative care has demonstrated cost-effectiveness, often by shifting site of care to home and ambulatory settings, as opposed to inpatient care. It is recommended that outpatient palliative care payment models emphasize value-based reimbursement.

These value-based payments should consider the following value based payment principles:

1. A process by which payers and providers align the needs and acuity of the patient and the services covered.
2. Per enrolled member-per month case rate to cover all community-based palliative care services and providers included in the care team, possibly tiered.
3. Payment incentives for quality and utilization management.

Measurement & Reporting:

Community-based palliative care programs shall have the ability to measure and report the following suggested process and outcome measures as evidence of services and quality of care provided:

A. Process Measures

1. Number of patients enrolled in palliative care
2. Duration of patient enrollment
3. Proportion of palliative care patients who transition to hospice
4. Documentation of advance care planning conversation, including Advance Healthcare Directive or POLST, where appropriate. Should documentation not be completed due to patient choice or readiness, the following must be completed:
 - a) Documentation of a surrogate decision maker or absence of surrogate decision maker AND notification to the individual that they have been selected as the surrogate decision maker
 - b) Documentation of conversations or attempts to discuss advance care planning

B. Outcome Measures (if available)

1. Patient satisfaction and family satisfaction
2. Inpatient utilization and ED utilization rates
3. Hospice length of service
4. Total days at home in the last 6 months of life (excludes inpatient days in an acute care facility, an inpatient rehabilitation facility, a skilled nursing facility, or an inpatient hospice unit)