

Improving Care for People with
Serious Illness through Innovative

Payer-Provider Partnerships

A PALLIATIVE CARE TOOLKIT AND RESOURCE GUIDE



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Foreword

“We, payers and providers alike, have an opportunity to collaborate to advance palliative care programs and principles that can truly transform our nation’s health care system, and improve outcomes and experiences for all Americans with a serious illness, and their families.

At Cambia Health Solutions, we are adopting many of the strategies included in this toolkit to improve care for our members. We are developing and implementing a comprehensive approach to palliative care service delivery, including both benefit expansion and specialized care management for members with a serious illness.

We believe these initiatives will greatly enhance quality while creating a community of care that ensures that each person’s values and goals of care are expressed, understood and honored.”

Mark Ganz, JD, President and CEO Cambia Health Solutions

Introduction

There is increasingly wide recognition of the need to improve quality of care for those with serious illness. One of the major strategies in this trend is palliative care, an emerging medical specialty focused on improving overall quality of life for people with serious illness and their families.

Multiple studies have shown that palliative care services result in less symptom distress and longer patient survival, as well as better patient and family quality of life. These improvements in quality result in the reduced need for crisis interventions and hospitalizations, thus enabling patients to spend more time enjoying what matters most to them, while also markedly reducing total health care spending. In order to improve access to this high-value care, payers, providers and communities are working together to find new ways to deliver and finance palliative care.

Purpose and Audience

This toolkit is meant to serve as a reference guide for organizations that lead the financing of health care (including commercial insurers, self-funded employers, and federal and state government agencies) and for providers working in shared risk arrangements. In sum, the *Palliative Care Toolkit*:

- **Defines palliative care** and demonstrates its importance to improving value in health care.
- **Identifies opportunities** to integrate palliative care into payer programs and products.
- **Provides tools and resources** to payers, employers and providers, including palliative care quality standards and best practices, and checklists to support opportunities and action within payer organizations.
- **Demonstrates what payers are doing** to advance palliative care through profiles and case examples.

1. Definitions & Rationale

Understanding serious illness, what palliative care is and why palliative care is important is necessary in order to develop the most effective programs. This section provides definitions and frameworks designed to help understand and organize the many opportunities that payers, providers and communities have to improve care for those with serious illness.

A System in Crisis

What Is Palliative Care?

Specialist-Level Palliative Care: Dominant Delivery Models

Why Is Palliative Care Important?

Ensuring Value: Essential Features of Successful Palliative Care Programs

Palliative Care Strategies for Payers

A System in Crisis

As of 2011, the top 5 percent of health care spenders accounted for an estimated 60 percent of health care costs.¹ This costliest 5 percent of health care spenders consists of three groups of patients: those who are in their last year of life (11 percent); those who have high acute care needs one year, but return to baseline in subsequent years (49 percent); and finally, those who will live for years with a serious illness and during that time have consistently high health care costs (40 percent).²

This last group of individuals, who are very ill year after year but not predictably dying, represents the highest-leverage opportunity for improving value in the health care system.

Over the next several decades, the U.S. health care system anticipates a steep rise in the number of people living with serious illnesses and functional impairments. This is due both to changing demographics and advances in medicine that allow people to live longer, despite their illnesses and conditions. These two factors have caused the Institute of Medicine (IOM) to declare that the cancer care system is “in crisis”³—meaning that it is unable to meet the needs of the population. One of the answers, the IOM report states, lies in the broad application of palliative care principles and practices—combining the focus on disease

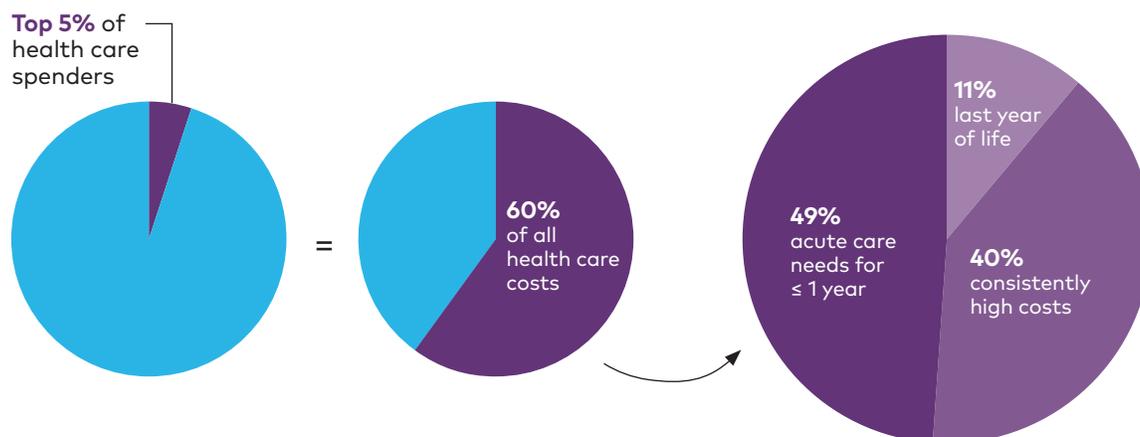
treatment with the added layer of communication, care and support that patients and families need to live well during serious illness. The IOM’s prescription for meeting the needs of people with cancer is equally applicable to other major illnesses and conditions.

Many payers have worked to bring palliative care to their members, and have seen excellent returns on that effort. With regard to those enrolled in the Aetna Compassionate Care™ (palliative care) program, for example, very high satisfaction was reported from both members and their families; hospice election increased to more than 80 percent of participants; acute care inpatient days decreased by 82 percent; and intensive care unit days decreased by 88 percent.

“If there is an opportunity to impact at the intersection of quality and cost, this is the mother lode.”

Randall Krakauer, MD; Director of Medical Strategy, Aetna.
Wall Street Journal, February 23, 2014

CHART Health Care Spending



What Is Palliative Care?

Palliative care is specialized medical care for people with serious illness. It focuses on providing patients with relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. It is appropriate at any age and at any stage of a serious illness and can be provided along with curative treatment.

At diagnosis, patients need initial discussions about the benefits and drawbacks of treatment options and what to expect in the future, as well as preliminary advance care planning. They will also need pain and symptom management while they pursue disease-directed therapies, to maximize function, independence and quality of life for as long as possible. All providers who care for patients with serious illness, including oncologists and cardiologists, should have the skills to provide this type of care—referred to as generalist palliative care. A growing movement is underway to improve generalist palliative care skills among these providers.

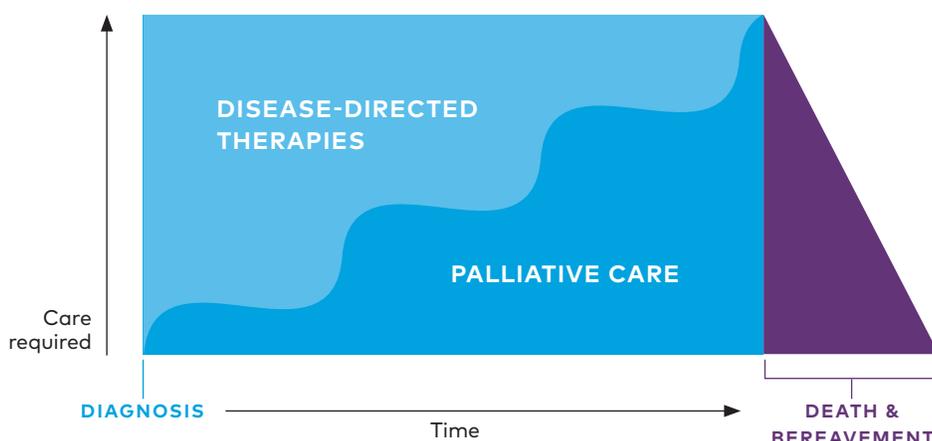
The progression of illness often results in the increased need for expert or specialist-level palliative care. Specialist palliative care consultation is delivered concurrently with ongoing treatment, by a palliative care team working alongside a patient's regular doctors. Typically, a palliative care interdisciplinary team is composed of a physician board-certified in hospice and palliative medicine, an advanced practice nurse, a social worker and a chaplain,

who together provide palliative care and support to patients and their families. Though the dominant setting for palliative care delivery (outside of hospice) in the United States is the hospital, this type of care can be provided in any setting—and both nationally and globally there is a rapidly growing focus on community-based palliative care—delivered in patients' homes, nursing homes, office practices and cancer centers.

FEATURES OF PALLIATIVE CARE

- Focuses on the relief of pain, symptoms and stress of a serious illness.
- Palliative care providers work alongside a patient's other providers, delivering treatment concurrently with disease-directed therapies.
- Eligibility depends on symptom burden, functional dependencies, family and social support needs, and requirements for clear information about options and what to expect.
- Earlier use ensures better quality of care and minimizes the need for crisis care.

CHART Illness Progression



ABOUT PALLIATIVE CARE

Hospice and palliative medicine was recognized as a subspecialty of 10 medical specialties in 2007. Certification in the subspecialty requires a one-year fellowship. There is also specialty certification for nurses, chaplains and social workers.

Specialist-Level Palliative Care: Dominant Delivery Models

Specialist palliative care is provided in a range of delivery models. The three descriptions offered below give an overview of palliative care in the hospital and community settings.

Hospital palliative care

Hospital palliative care teams either provide consultation to the attending physician or assume primary oversight of care, depending on the preferences of the referring physician. The palliative care team is often called upon to treat intractable pain and symptoms; communicate with patients, families and other treating providers in order to match treatment options with the patient's goals of care; or to help create care plans that enable safe discharge to minimize the risk of readmission. In the consultation model, the palliative care team does not assume primary responsibility for the patient and the family; rather, in addition to ongoing disease-specific treatment, it provides an extra layer of support to address the needs of the whole person and the family.

Community-based palliative care

Community palliative care includes a range of delivery models designed to meet the needs of seriously ill individuals and their families, outside of the inpatient or hospital setting. Palliative care may be provided in the patient's home, a nursing home, an assisted living facility, or an outpatient clinic such as a physician's office, dialysis unit or cancer center. Community-based palliative care models include, for example, advanced illness management (AIM) programs, supportive care programs embedded in cancer centers, and "post-acute" transitional care programs. These care models are developing rapidly in an effort to meet the needs of the sickest and costliest patients—who must otherwise resort to 911 calls, emergency department visits, and hospitalizations for problems that could and should have been addressed safely and effectively in the community.

Hospice

Hospice care is a well-known and comprehensive delivery model of palliative care, but it is often limited to terminally ill patients. The Medicare hospice benefit defines hospice eligibility as appropriate for patients when two doctors certify a prognosis of six months to live if the disease follows its usual course, and the patient agrees to forgo Medicare coverage for disease-modifying treatment.

Why Is Palliative Care Important?

While ostensibly designed to serve the needs of patients, our health care system often fails to assess and respond to the top concerns of patients and their families.

As the goals and values of seriously ill patients are not consistently elicited, the services delivered tend not only to neglect patients' most pressing concerns, but all too often add to their burdens. Patients with serious illness report significant and untreated pain and other symptoms, and high levels of depression, anxiety and worry about the future. They are often unable to get clear answers from their providers and have no place to turn other than 911 when crises arise. Precious time that should be spent at home with loved ones is lost in waiting rooms, hospital beds and emergency departments. We can and should do better by these patients, and palliative care is a proven solution to these gaps in the system.

"For the secret of the care of the patient is in caring for the patient."

Francis Peabody, MD. Lecture to the 1925 graduating class of Harvard Medical School

People want palliative care

Once informed about what palliative care is, the overwhelming majority of people report that they would want it for themselves and their families. According to a 2011 public opinion poll conducted by Public Opinion Strategies:⁴

- 95 percent of respondents agree it is important that patients with serious illness and their families be educated about palliative care.
- 92 percent of respondents say they would be likely to consider palliative care for loved ones if they had a serious illness.
- 92 percent of respondents say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families.

Palliative care improves the quality of health care

In every setting in which it has been tested, palliative care improves care quality for the sickest and most vulnerable patients across all diseases.⁵ Patients report a higher quality of life, less pain and fewer symptoms, and higher satisfaction with their care. Families and caregivers likewise experience less stress and psychological debility, and greater satisfaction with the care received by their loved one. Not surprisingly, when the patient and family both find their needs are being met, they no longer rely on 911 calls and hospitals to manage the patient's illness.

Palliative care consistently reduces costs for the highest-risk, highest-need population

By better matching treatment plans to patient goals and providing support where it is needed, palliative care has been shown to reduce the need for unnecessary and unwanted services. Palliative care reduces health care utilization precisely because it addresses the root causes of acute care utilization—poorly managed pain and symptoms, and overwhelming caregiver stress and burden. Expert management of symptoms and support for beleaguered families leads to a reduction in 911 calls, ED visits, hospitalizations and ICU stays, as well as in unnecessary diagnostic imaging and therapies that provide no benefit and may instead cause harm.

Ensuring Value: Essential Features of Successful Palliative Care Programs

What should payers look for? Best practices in palliative care.

Palliative care is designed to improve the quality of life for people with serious illness while ensuring the care that such patients receive is aligned with their goals and preferences. The most effective models succeed due to several key features. The tables below describe the essential clinical skills required to deliver high-value palliative care, and the essential structural components of an effective palliative care program. These characteristics can guide payers' provider training and recognition initiatives; support the evaluation of new care management programs; and inform the design of benefits offered to members.

These key characteristics are derived from a review of the science of effective care coordination, the National Quality Forum's framework and preferred practices for quality palliative care, the National Consensus Project for Quality Palliative Care guidelines, and presentations at national palliative care conferences.

TABLE 1

Essential Clinical Skills for Palliative Care

Pain and Symptom Management

Effective management of pain and symptoms is a prerequisite to sustainable care in the community, as well to achieving patient-centered goals of care. Providers need skills in pain and symptom assessment and management.

RATIONALE

- Symptoms such as disabling pain, fatigue and depression reduce independence and quality of life.
- Poorly managed symptoms lead to immobility, depression, weight loss, family distress and high acute care utilization.
- Symptom distress is the number one reported reason for 911 calls and ED visits.

EXAMPLES OF PRACTICE

- Expert training and skill in safe, effective and appropriate use of pain (opioid) and other symptom medications.
- Expert management and prevention of side effects.

Goal Setting

Communication and listening skills are required to capture the patient's and, when appropriate, family's preferred outcomes, and to communicate those goals to all members of the care team.

RATIONALE

- Determining what matters most to the patient is the bedrock of an effective care plan.
- Goals-of-care documentation supports the continuity of care in alignment with patient and family priorities across all settings and providers.

EXAMPLES OF PRACTICE

- Asking the patient and family about what is most important to them, and documenting the conversation(s).
- Conducting a spiritual and cultural assessment.
- Effectively documenting and transmitting the plan of care across settings—such as using, when appropriate, POLST⁶ or MOLST⁷ forms (representing, respectively, physician or medical orders for life-sustaining treatment).

Family Caregiver Support

Clinicians should have the ability to assess and address family and caregiver capacity and needs, and to provide training and support to caregivers when needed.

RATIONALE

- Family caregivers are an extension of the clinical care teams, conducting wound care, complex medication management and daily support for activities of daily living.
- Stressed or poorly supported family caregivers are more likely to call 911 when crises arise.

EXAMPLES OF PRACTICE

- Assessing family capacity and willingness to provide care.
- Use of assessment tools like the Covinsky Family Impact Survey.

Practical and Social Supports

Providers should be able to identify and address practical and social issues (such as literacy; language barriers; access to food, transportation and safe housing; and mental and behavioral health issues) that may undermine effective care.

RATIONALE

- Practical and social issues can greatly reduce the quality of life of people with serious illness; such issues in fact are the underlying root cause of much preventable acute care utilization.

EXAMPLES OF PRACTICE

- The provider assesses practical and social issues, and is able to identify, refer and coordinate with social services in the patient's community. Social services should in turn be available to address housing, transportation, pharmacy and resource problems.

PALLIATIVE CARE SKILLS IN ACTION

The importance of assessing practical and social issues should not be overlooked. In the course of one palliative care hospital consultation, a palliative care nurse identified that the reason a patient was repeatedly hospitalized for shortness of breath was that she lacked an air conditioner, causing her to have difficulty breathing in South Carolina's hot and humid summer months. The palliative care team talked to the local insurer, who purchased a \$300 air conditioner for the patient. As a result, hospitalizations for dyspnea were no longer necessary for this patient.

TABLE 2

Essential Structural Characteristics of High-Value Palliative Care

This table describes the **elements of successful palliative care models** that increase the likelihood of **improving quality** and thereby **reducing costs**. Some of these requirements, such as targeting and identifying patients most likely to benefit from palliative care, present an obvious opportunity for payer-provider collaboration.

Targeting and Triggers

It is essential to identify those individuals with functional and/or cognitive impairment, frailty, high pain and symptom burden, high family caregiver burden, poorly assessed and documented goals of care, and poor care coordination, as well as those who suffer from high psychosocial stress.

RATIONALE

- Multiple studies identify targeting services to the highest-risk group as key to realizing improved value, better quality and lower cost.
- Care service intensity needs vary over time and require regular reassessment in order to best titrate the level of care to the patient's needs.

EXAMPLES OF PRACTICE

- A computer algorithm that identifies high-risk patients from administrative and clinical data sources.
- Documentation of functional and/or cognitive limitations in the electronic health record (EHR) to identify patients in need.
- Routine documentation of replies to the question, "Would you be surprised if this patient died in the next 12 to 24 months?"
- Physician engagement and referral into a palliative care program.

Interdisciplinary Team-Based Care

The interdisciplinary team usually includes a physician, social worker and advanced practice nurse; it may also include chaplains, physical and occupational therapists, and others as needed. The team addresses the full range of medical, family, psychosocial and spiritual issues.

RATIONALE

- An effective interdisciplinary team will ensure consistent coordination between all medical specialists, as well as social and spiritual services.
- Chaplains and social workers are better trained to address the social and spiritual support crises that precipitate 911 calls and hospitalizations. Ongoing care of complex, seriously ill persons and their exhausted family caregivers involves intense emotional labor and persistence addressing multiple contributors. No single discipline can handle this alone.

EXAMPLES OF PRACTICE

- The existence of team members from various disciplines, preferably with training and/or board certification in palliative care.
- Structured, regular communication among team members and with all other involved medical, social support and community providers is crucial to prevent crises and ensure consistent goal-concordant care.

24/7 Meaningful Clinical Response

The program should have the capacity to support and provide meaningful and responsive care 24 hours a day, 7 days a week, to the degree of intensity that suits the patient's needs—with the ability to be quickly adjusted as needs vary.

RATIONALE

- Given the complexity and often intense pain or symptom distress in this population, 24/7 access is necessary to avert 911 calls.
- If meaningful clinical response is not available when patients experience crises, they will call 911 and seek care in emergency departments.
- The ability to "dial up" or "dial down" services based on changes in the condition or goals of care ensures the most effective and efficient care possible.

EXAMPLES OF PRACTICE

- Staff capacity to respond to crises, including the ability to send providers to the home if needed.
- 24/7 telephone support by clinicians with appropriate training and skill.
- The ability to promptly schedule appointments with patients as needed.
- The availability of decision support tools and protocols to assist hotline staff with triage and clinical support.

Integrated Medical and Social Supports

The provider is aware of social supports in the service area, and has the capacity to refer to these organizations.

RATIONALE

- Poor mobilization of social supports leads to medical care for issues that are inherently socially determined or practical, such as access to transportation and food, language and literacy barriers, or unsafe living conditions.

EXAMPLES OF PRACTICE

- The provider is appropriately networked with social services in the given service area.

Concurrent Care

Services are available concurrently with or independent of curative or life-prolonging care.

RATIONALE

- The patient's condition and identified care needs should determine the need for palliative care, not prognosis.
- Earlier delivery of palliative care services is associated with better quality of life and survival, as well as lower hospital admissions and hospital mortality.

EXAMPLES OF PRACTICE

- A palliative care consult occurs routinely upon the diagnosis of a serious illness.
- Psychosocial support and training on what to expect and how to handle behavioral and symptom distress problems is provided to family caregiver(s) early in the course of illness for a patient with dementia and other high caregiver-burden illnesses.
- Triggers or checklists are used to identify patients likely to benefit from palliative care.

TABLE 3

Palliative Care Strategies for Payers

There are many opportunities to integrate palliative care into payers' existing strategies, including benefit design, provider recognition or care management. Most options can fit into one or more of **five main categories for improving access to palliative care**. This table defines these five categories and gives examples of best practices.

Community Collaboration and Awareness

Work with community partners (including providers, churches, medical societies and health systems) to build awareness of palliative care and its benefits; strengthen policies, and change public and professional culture regarding shared decision making; and advance care planning together with concurrent palliative care models.

EXAMPLES OF PRACTICE

- Join local and national coalitions advocating for palliative care, MOLST or workforce competency in palliative care.
- Create and distribute materials on advance care planning and palliative care; include links to Web resources (such as GetPalliativeCare.org).
- Disseminate member guides on how to talk to a doctor about what is most important and what to expect from an illness.
- Promote community support for caregivers by listing resources such as transportation services, Meals on Wheels, and "friendly visiting" programs (provided by churches and senior centers).
- Provide resources to employers and employees on advance care planning and palliative care.

Provider Training and Recognition

Provide incentives and public recognition for providers pursuing training in palliative care and demonstrating palliative care practices (such as routine documentation of goals-of-care discussions).

EXAMPLES OF PRACTICE

- Offer incentive payments to physicians and other providers who complete continuing medical education related to communication skills, goals-of-care discussions, care planning, and pain and symptom management.
- Offer providers training in palliative care practices and standards.
- Support training for nonprofessional community members in advance care planning, such as the Respecting Choices model in La Crosse, Wisconsin.
- Designate those hospitals that have earned The Joint Commission's Advanced Certification for Palliative Care as preferred providers or centers of excellence.

Member Engagement and Care Management

Integrate palliative care practices into member engagement resources and demand- and care-management programs.

EXAMPLES OF PRACTICE

- Include advance care planning in member health risk assessments.
- Include information in member booklets about palliative care and how to access it (GetPalliativeCare.org).
- Train care managers in palliative care practices, including goals-of-care discussions and culturally sensitive counseling.
- Offer videos for members on how to have goals-of-care discussions with providers, or what to expect in a range of serious illnesses (see, for example, the video support tools of ACP Decisions at acpdecisions.org/videos).

Medical Policies and Coverage

Ensure that palliative care and related services are appropriately defined as medically necessary, and that benefit designs cover palliative care and related services.

EXAMPLES OF PRACTICE

- Include a palliative care consultation as a standard benefit with no copay, if applicable.
- Permit members to elect hospice care earlier, or to receive hospice care concurrently with disease treatment.

Payment Innovations

Offer payment and incentives to providers that integrate palliative care practices and demonstrate associated quality outcomes.

EXAMPLES OF PRACTICE

- Offer incentive payments for receipt of palliative care consultation; conduct and document goals-of-care discussions and subsequent care plans; document advance care plans; and meet quality measures related to palliative care.
- In risk contracts, develop per-member, per-month community-based palliative care delivery and payment models, requiring providers to demonstrate structural and clinical capacity, as detailed in Tables 1 and 2.
- In high-risk populations, include receipt of palliative care consultation as a quality measure linked to payment.
- Reimburse for palliative team-based care (e.g., social worker or chaplain time).
- Provide discrete reimbursement codes for palliative care and complex care, which take into account the additional time required for these services.

2.

An Action Plan for Payers: Tools & Resources

This section is dedicated to providing payers with checklists, tools, worksheets and references that can be helpful in assessing the opportunities to integrate palliative care principles and practices. These resources are a starting point, and they should be customized according to the payer and the needs of its members.

Getting Started Checklist

A quick reference guide or work plan that can be used by the payer to organize a team in developing a comprehensive set of programs to support those with serious illness.

Payer Self-Assessment Checklist

A checklist and self-assessment for payers to assess current approaches to palliative care and opportunities for expansion.

Provider Recognition and Training Examples

A short list of ideas for payer recognition and incentives to encourage providers to develop skills and programs that address the needs of those with serious illness.

National Palliative Care Guidelines, Standards and Resources

A quick reference guide for the identification of national resources for quality standards and guidelines on caring for those with serious illness.

Sample Opportunity Evaluation Worksheet

A sample worksheet to evaluate and prioritize opportunities for implementing programs or products that improve quality of care for those with serious illness.

Getting Started Checklist

The following quick reference guide may serve payers as a work plan in developing a comprehensive set of programs to support those with serious illness.

Needs Assessment

NOTES AND CONSIDERATIONS

ACTION ITEM 1

Size the population:
Who could benefit?

- Run claims reports and analyses to identify those at risk for or currently experiencing serious illness.
- Review referral, authorization and case management reports.
- Interview both in-hospital and telephonic case managers.
- Meet with area providers that have palliative care programs or that manage populations with complex, serious illnesses (e.g., geriatric, cardiology, pulmonary or oncology practices).
- Meet with area employers to identify impacts on employers.

ACTION ITEM 2

Identify providers:
Who delivers high-quality care?

- Survey top providers serving a large portion of membership to identify those that treat patients with serious illness.
- Search publicly available program information on providers in the payer market that have palliative care programs (e.g., GetPalliativeCare.org, The Joint Commission, American Hospital Association).
- Meet with area palliative care programs or other teams that manage populations likely to have complex, serious illnesses (e.g., geriatric or oncology practices).

ACTION ITEM 3

Identify community resources:
Which resources exist?

- Identify social program resources in the payer market.
- Meet with local skilled nursing facilities, home care agencies or hospices.
- Identify political, legislative, insurance regulatory or other public policy efforts related to advance care planning or programs for seriously ill persons.

Self-Assessment

EXAMPLES OF PRACTICE

ACTION ITEM 4

Conduct a review of current payer programs, policies and products.

- Review the payer's employee benefits and training curricula.
- Ensure the provider network includes specialized palliative care providers.
- Review medical policies, utilization management programs and benefit designs for inclusion of palliative care resources.
- Assess case management and care management training modules for inclusion of palliative care skills and knowledge.

Develop a Plan and Implement

EXAMPLES OF PRACTICE

ACTION ITEM 5

Brainstorm and assess ideas.

- Identify top-priority markets, conditions, providers or populations.
- Estimate the population affected.
- Assess risks and barriers.
- Seek input from experts.

ACTION ITEM 6

Implement.

- Processes vary by payer. Key recommendation: leverage expertise and resources in provider networks and communities.

Payer Self-Assessment Checklist

Opportunities to integrate palliative care practices into a payer's products and programs encompass a range of options. Taken together, these approaches lead to the development of a comprehensive palliative care payer program.

Community Collaboration and Advocacy

Build public, professional and policy-maker awareness of the importance of palliative care principles and practices.

PALLIATIVE CARE FEATURES

- Provide members with a dedicated serious illness resource website.
- Collaborate with other stakeholders in the state to advocate for favorable advance care planning policies, such as those related to POLST or MOLST forms.
- Offer caregiver support by listing relevant community resources, such as transportation services or programs like Meals on Wheels.

Provider Training and Designations

Provide training and tools to clinicians, and publicly recognize or designate those whose care adheres to palliative care principles and practices.

PALLIATIVE CARE FEATURES

- Offer providers tools and training in conducting and documenting goals-of-care conversations with patients; palliative performance assessment; and pain and symptom management.
- Establish provider network access standards for palliative care specialists.
- Designate and recognize providers that meet palliative care standards of practice, including safe and effective pain management practices and regular documentation of goals-of-care discussions.

Member Engagement and Care Management

Integrate information about palliative care and its benefits into member engagement resources, and train care management teams in palliative care principles and practices.

PALLIATIVE CARE FEATURES

- Include questions about advance directives on annual health assessment tools.
- Ensure that providers document the functional status of patients.
- Create algorithms and programs that effectively identify seriously ill members in need of palliative care.
- Train care managers to identify which individuals may need the added layer of support of a community palliative care or advanced illness management program.
- Provide access to dedicated in-person, telephonic or digital care coordination experts, who are trained in assessing and meeting patient needs by engaging with patients, family caregivers and providers.

Medical Policies and Coverage

Ensure that palliative care and related services (such as advance care planning discussions) are defined as medically necessary. Design member benefits and provider reimbursements to reduce financial and awareness barriers to palliative care services.

PALLIATIVE CARE FEATURES

- Medical policies should cover palliative care home visits for both physicians and non-physician team members.
- Benefits should include hospice and palliative care services offered concurrently with medical treatment, even if a reasonable limit is placed on those services.
- Preauthorization policies should support early and ongoing, as-needed engagement of palliative care services.

Payment Innovations

Offer payment and incentives to providers that integrate palliative care practices and demonstrate associated quality outcomes.

PALLIATIVE CARE FEATURES

- Establish reasonable payment fees for palliative care specialists to include palliative care team members, such as social workers, chaplains and dedicated care coordination service professionals.
- As part of provider payment innovation efforts, incorporate measures of adherence to palliative care standards and the achievement of specific related outcomes (such as the conduct and documentation of goals-of-care conversations; assessment and treatment of distressing symptoms; safe opioid practices; appropriate and timely hospice referrals; and routine assessment of and support for family caregiver needs).
- Include all providers (i.e., primary care, hospice, specialist and palliative care providers) and care delivery team members in payment innovation program incentives for the outcome measures listed above.

Provider Recognition and Training Examples

Payers can help improve quality of care for members with serious illness by recognizing and rewarding those providers that have integrated palliative care principles and practices into their care delivery systems. The table below lists examples of such integration of palliative care into payer recognition programs.

Advanced Training or Certification

- Recognize network health care providers that have been trained, credentialed or certified in palliative care clinical skills.
- Examples include The Joint Commission's advanced certification in hospital palliative care as well as online training opportunities and/or palliative care board certification for doctors, nurses and social workers.

Centers of Excellence

- Designate providers to serve as palliative care centers of excellence.
- Selection would be based on meeting quality outcomes (such as reductions in 30-day readmissions and hospital mortality; patient experience scores; and hospice referral rates) and achieving advanced levels of certification in palliative care.

Value-Based Contracting

- Pay providers for meeting specific palliative care–related outcomes (such as documenting goals-of-care discussions, controlling pain or conducting caregiver needs assessments), achieving advanced certification levels, or completing training and/or board certification in palliative care.
- Incentivize physicians without specialty training in palliative care to complete additional education in palliative care principles and practices, and to incorporate the concepts into their practice workflows.

Tiered Networks

- Offer richer benefits (e.g., lower or no copays) to members who select a provider or health system that has met specific outcomes, achieved advanced certification or completed training in palliative care (as described above).

Narrow Networks

- Require in-network providers to meet specific outcomes, such as advanced certification in hospital palliative care or completion of provider training and/or board certification in palliative care.

National Palliative Care Guidelines, Standards, Training and Resources

There has been significant growth in the recognition of and research into palliative care standards, measures and guidelines, and in palliative care training resources for professionals. Although not a complete listing, the resources below may be used to guide the creation and direction of palliative care programs.

Agency for Healthcare Research and Quality (AHRQ)

ahrq.gov

→ **Standards** This national clearinghouse of quality standards and measures includes guidelines on palliative care: guideline.gov.

American Academy of Hospice and Palliative Medicine (AAHPM)

aahpm.org

→ **Training** Resources are available at aahpm.org.

→ **Finding Providers** Physicians board-certified in hospice and palliative medicine can be found at aahpm.org.

American Board of Internal Medicine (ABIM)

abim.org/maintenance-of-certification

→ **Training** ABIM offers palliative care Practice Improvement Modules (PIMs) that apply toward physicians' maintenance of certification requirements.

American Hospital Association (AHA)

aha.org

→ **Finding Providers** The AHA collects self-reported information about whether a hospital has a palliative care program. AHA data can be accessed through several windows at aha.org.

American Society of Clinical Oncology (ASCO)

asco.org

→ **Standards** ASCO develops and endorses clinical standards and measures specific to clinical oncology, including a 2012 provisional clinical opinion stating that palliative care should be offered from the time of diagnosis: asco.org.

Center to Advance Palliative Care (CAPC)

capc.org

→ **Training** As of 2015, CAPC offers online clinical skills training for generalist providers, in addition to its operational tools, implementation support and technical assistance for palliative care development.

→ **Finding Providers** Listings of hospitals with palliative care programs are available at GetPalliativeCare.org; and a state-by-state assessment of hospital availability of palliative care can be found at capc.org.

Coalition for Compassionate Care of California (CCCC)

coalitionccc.org

→ **Training** CCCC offers training resources for advance care planning.

Commission on Cancer (CoC)—of the American College of Surgeons (ACoS)

facs.org/cancer

→ **Standards** This accreditation organization for cancer centers has included palliative care as a requirement for its accreditation. See standard 2.4 of the CoC program standards at facs.org.

Compassion and Support

compassionandsupport.org

→ **Training** Compassion and Support offers free online training resources for advance care planning and implementation of Medical Orders for Life-Sustaining Treatment (MOLST), pain management and other aspects of palliative care.

→ **Resources** This group also offers resources on New York laws and legislation around palliative care, and general palliative care resources.

EPEC (Education in Palliative and End-of-life Care)

epec.net

→ **Training** EPEC provides online and in-person training for physicians and caregivers in palliative care principles and practices.

End-of-Life Nursing Education Consortium (ELNEC)— of the American Association of Colleges of Nursing (AACN)

aacn.nche.edu/el nec

→ **Training** ELNEC provides online and in-person training for nurses in core palliative care competencies, including pediatrics, geriatrics and oncology populations.

End of Life / Palliative Education Resource Center—of the Medical College of Wisconsin

eperc.mcw.edu/EPERC.htm

→ **Training** EPERC offers resources on common palliative care challenges for clinicians, including numerous Fast Facts documents available at eperc.mcw.edu.

Hospice and Palliative Nurses Association (HPNA)

hpna.org/Default2.aspx

→ **Training** HPNA offers online training in palliative care principles and practices for nurses.

National Consensus Project for Quality Palliative Care (NCP)

nationalconsensusproject.org

→ **Standards** The NCP has released three editions of comprehensive practice standards and quality guidelines for palliative care.

National Quality Forum (NQF)

qualityforum.org

→ **Standards** The NQF has developed a consensus-based framework and preferred practices in palliative care, available at qualityforum.org.

→ **Measures** The NQF has also endorsed 14 palliative care-specific measures in 2012, which can be found at qualityforum.org.

PalliTALK—of the University of Wisconsin School of Medicine and Public Health

medicine.wisc.edu/hemonc/pallitalk

→ **Training** PalliTALK provides in-person communication training courses to clinicians caring for patients with serious illness.

Respecting Choices—of the Gundersen Health System

[gundersenhealth.org/
respecting-choices](http://gundersenhealth.org/respecting-choices)

→ **Training** Respecting Choices is an advance care planning program. Resources for online and in-person training of community-based facilitators are available at gundersenhealth.org; and train-the-trainer programs for community-based conduct-of-care planning conversations can be found at gundersenhealth.org.

The Joint Commission (TJC)

jointcommission.org

→ **Standards** As part of its Advanced Certification for Palliative Care for hospitals, TJC has created a list of standards based on national consensus documents. A presentation of these standards can be accessed at capc.org.

→ **Finding Providers** A current listing of TJC-certified palliative care programs can be found at qualitycheck.org.

VitalTalk

vitaltalk.org

→ **Training** VitalTalk provides online and in-person communication training for clinicians caring for patients with serious illness, as well as train-the-trainer courses.

Sample Opportunity Evaluation Worksheet

This worksheet may be used to evaluate and prioritize opportunities for implementing programs or products that improve quality of care for people with serious illness. Although intended primarily for illustrative purposes, the examples below include opportunities to consider.

SAMPLE OPPORTUNITIES

- A. Incent primary care providers to be trained in the competencies of palliative care.
- B. Join national workgroups to develop standards and guidelines.
- C. Develop an employee program to increase awareness of advance care planning.
- D. Require providers to submit codes to capture services for the seriously ill (to enable better targeting).
- E. Lead a community-based pilot to increase access to home-based palliative care.

EVALUATION

Rank each opportunity in each criteria group using a scale from 1 to 5:

1 = Low

5 = High

NUMBER OF MEMBERS

- Total membership directly or indirectly affected.
- Percentage of total membership directly or indirectly affected.
- Target memberships that have indicators for serious illness.

A	B	C	D	E

QUALITY OF CARE

- Improved member/patient satisfaction.
- Reduced unnecessary hospitalizations or ED visits.
- Percentage of providers demonstrating basic competencies in the principles and practices of palliative care.
- Increased documentation of goals of care.

A	B	C	D	E

TOTAL COST OF CARE (per episode or per patient)

- Estimated cost savings from the potential avoidance of unnecessary care or services.
- Cost/benefit analyses.

A	B	C	D	E

RISK ASSESSMENT

- Regulatory requirements.
- Legal or contractual considerations.
- CMS compliance.
- Public or political perception.
- Adverse selection considerations.

A	B	C	D	E

OPERATIONAL FEASIBILITY

- Ability to identify appropriate collaborating providers.
- Availability of staff with both the expertise and the time to implement programs or modify technology (e.g., IT programmers, benefit configuration coders).
- Lead time required to implement solutions.
- Readiness of community organizations.
- Required training or expertise of existing staff.

A	B	C	D	E

3.

Payer Profiles & Case Examples

This section profiles some of the payers who have taken a comprehensive approach to enhancing access to palliative care, and includes case examples of some key design elements of payer programs and payer-provider partnerships.

Payer Profiles

A number of innovative payers have successfully integrated palliative care principles and practices across benefit designs, member services and community outreach efforts. This section profiles three payers as exemplars of comprehensive approaches that address the needs of people with serious illness, across the five payer strategy categories (see page 12).

- **Aetna**
An overview of Aetna's multi-strategy approach, including its Compassionate Care Program.
- **Excellus BlueCross BlueShield**
An overview of Excellus's approach, including its extensive work in community advocacy and its pediatric palliative care program, CompassionNet.
- **Highmark Inc.**
An overview of Highmark's efforts and programs, including the Advanced Illness Services program.

Palliative Care Program Designs

The following case examples illustrate how payers and providers are addressing three common issues. Each of the program design sections provides an overview of the issue and why it's important, with a few examples of how payers and providers are designing programs to address the given challenges.

- **Focusing on Those in Need**
Case Examples: Highmark, BCBSMA.
- **Provider Quality Recognition and Training**
Case Examples: Highmark, Blue Cross and Blue Shield of North Carolina.
- **Paying for Specialist Community-Based Palliative Care**
Case Examples: Aetna, North Shore-LIJ Health System, Hospice Care of California.

Aetna

Aetna is a national health care benefits company that offers a broad range of traditional and consumer-directed health insurance products and related services. Aetna's long-standing Compassionate Care program focuses on improving care for those with serious illness. This program incorporates case management, member engagement and clinical partnerships. Aetna's leadership has also striven to improve access to palliative care through federal advocacy for upstream and concurrent hospice benefits.

PROGRAMS AND PRODUCTS

Community Collaboration and Advocacy

As a result of improved member satisfaction and reduced costs with concurrent hospice and disease-directed care, Aetna has advocated for a similar expansion of the Medicare hospice benefit in Congress, and has asked permission to provide concurrent hospice services to their Medicare Advantage members at no expense to Medicare. Aetna has also applied to the Center for Medicare and Medicaid Innovations (CMMI) to conduct a demonstration of concurrent hospice care for Medicare beneficiaries. Based on its own experience, Aetna argues that this benefit change will reduce costs and improve member satisfaction, and has offered to take on full risk for this demonstration.

Aetna has an advanced illness website with caregiver resources available at [aetna.com](https://www.aetna.com).

Aetna works with clinical and advocacy groups to improve care of serious illness. It is a founding member of the Coalition to Transform Advanced Care (C-TAC), which is developing a model community-based palliative care management program (the Advanced Care Project). Aetna and its provider partners plan to participate in this program. Dr. Randall Krakauer, Aetna's director of medical strategy, is a board member and co-chair of the C-TAC Clinical Models Committee.

Provider Training and Designations

Aetna medical directors conduct outreach to hospitals and other medical audiences, providing grand rounds and educational presentations on management of advanced illness. These CME-approved presentations are undertaken to improve care of advanced illness generally, drawing on the experiences of Aetna and others in this area.

RESULTS

For the 1% of all Medicare Advantage members enrolled in the Compassionate Care program, there is:

- An **82% hospice election rate**.
- An **81% decrease in acute days**.
- An **86% decrease in ICU days**.
- High **member and family satisfaction**.
- A total cost reduction of more than **\$12,000 per member**.

Member Engagement and Care Management

Aetna offers complex care management to those members with serious illness who are enrolled in the Compassionate Care program. As part of that effort, specially trained nurses and social workers support members and their family caregivers, providing needs assessment, care coordination, shared decision making and goals-of-care discussions, patient and family education, and psychosocial care.

The selection and training of case managers is key to this program's success. These highly personal relationships in which trust is developed over time cannot be mechanized or scripted.

Although care management was initially telephonic, Aetna gradually moved to partner with physician practices to provide embedded care managers. This collaborative care model has proven to be more effective than remote case management alone, as clinicians and care managers work together to better identify and serve patients in need.

Medical Policies and Coverage

Aetna offers concurrent hospice and disease-directed treatment in commercial plans for members with a prognosis of up to 12 months, in contrast to the standard Medicare hospice benefit requirements of a prognosis of 6 months and the willingness to forgo disease-directed therapies.

Payment Innovations

For the physician group practices in which Aetna has embedded case managers, it has also implemented value-based contracts. These contracts include a per-member, per-month incentive payment contingent on meeting certain quality outcomes, including the number of hospital admissions and hospital days per 1,000 members, and quality process criteria like follow-up visits for primary care within 30 days of discharge from a hospital.

“[Reading case managers’ notes] dramatically illustrates the need for end-of-life assistance, the too common absence of such assistance, and the almost desperate gratitude this engenders. We have dedicated ourselves to providing this help.”

Randall Krakauer, MD. *Invictus: Increasing Patient Choice in Advanced Illness and End-of-Life Care.* *Frontiers of Health Services Management.* Spring 2011.

Excellus BlueCross BlueShield

Excellus is a regional payer serving upstate New York. It is also a regional and national leader in advocating increased use and adoption of advance care plans, and the development of the Medical Orders for Life-Sustaining Treatment (MOLST/eMOLST) forms. Through the funding of the organization Compassion and Support and its website, Excellus provides training and educational resources to providers, medical practices, and patients and their families.

In recognition of its commitment to honoring the choices of patients and families, Excellus has received 15 national awards for its leadership, including the 2009 BlueWorks Award for Best Practices in Empowering Consumers and Providers; it was also a finalist for the 2008 BlueWorks Award for its Community Conversations on Compassionate Care and Medical Orders for Life-Sustaining Treatment Programs Program.

PROGRAMS AND PRODUCTS

Community Collaboration and Advocacy

A leader in the area of community collaboration and advocacy, Excellus has initiated and funded six community projects on care planning and pain management. These projects have resulted in a wealth of resources, free and available to all on the website CompassionAndSupport.org.

Excellus educates its employees about advance care planning and provides advance care planning resources.

Provider Training and Designations

Excellus offers courses to train physicians and other professionals across New York in advance care planning discussions (including the use of MOLST, and the principles and processes essential for shared decision making). It also provides incentive payments to credentialed physicians and other providers who have completed CMEs related to goals-of-care and MOLST discussions.

Information on advance care planning, palliative care and pain management is integrated into provider touch points, by dissemination of community guidelines developed in collaboration with regional clinician experts, provider training opportunities and provider toolkits offered at no charge.

Member Engagement and Care Management

Excellus includes a health care proxy readiness survey in its health risk assessment for all members, and integrates advance care planning into the member rewards program. Advance care planning and palliative care are integrated into disease management, case management and complex case management protocols.

RESULTS

- **Increased health care proxy completion rates:** 42% of persons 18 years of age and older across 39 counties; and 47% in the Rochester region (2008) versus a 20% national completion rate, as a result of the Community Conversations on Compassionate Care program.
- **Nearly 60%** of Excellus BCBS employees have completed health care proxies.
- Excellus **leads in the development and implementation of NY MOLST and New York's eMOLST**—the first electronic form and process documentation system in the nation that also serves as the state registry.

Care managers approach counseling based on behavioral readiness assessment using an interactive clinical pathway—either Advance Care Planning: Life Expectancy Greater than One Year or Advance Care Planning: Life Expectancy Less than One Year.

For children, Excellus developed CompassionNet (see below). Dedicated care managers are trained by Lifetime Care, which provides palliative care services in collaboration with pediatric palliative care specialists.

Medical Policies and Coverage

Excellus offers its pediatric population (21 years and younger) a comprehensive home-based palliative care program called CompassionNet. This program is available to children with a potentially life-threatening condition, and their families. The program provides comprehensive pain and symptom management, enhanced care planning and communication, and support for families, including counseling for siblings. Providers available for support include CompassionNet care managers and an interdisciplinary palliative care team for management of medical issues. The palliative care teams and case managers are employed by Lifetime Care, an affiliated hospice and home care agency, and are available to conduct home visits as necessary. CompassionNet care managers arrange community resources as needed.

Payment Innovations

Excellus provides enhanced payment to clinicians—physicians, nurse practitioners and physician assistants—who have completed a MOLST training course for advance care planning discussions for patients with serious illness. The time-based counseling model is applicable for members of all ages identified as appropriate for advance care planning discussions, for all lines of business, in all clinical settings. The model includes coverage of non-face-to-face time needed for telephone calls to distant family members and development of a care plan to support MOLST. The typical requirements of documentation for prolonged service codes are eliminated.

Palliative care measures are included in the Excellus Hospital Performance Incentive Program (HPIP). Quality measures align with the degree of penetration of palliative care provision to at-risk hospitalized patients. Examples include the number of palliative care consults; formalization of a palliative care program to include staff education; facilitation of appropriate early referrals to palliative care; and conducting family meetings for medical ICU patients at the time of admission.

“A dedicated physician and system champion can influence payment innovation with a committed health plan, as well as engage providers, lead community collaboration, legislative advocacy and empowerment to achieve culture change.”

Pat Bomba, MD, FACP; Vice President and Medical Director, Geriatrics, Excellus BlueCross BlueShield.

Highmark Inc.

Highmark is a regional payer organization that serves members throughout Pennsylvania, Delaware and West Virginia. It offers unique palliative care services to its Medicare Advantage members and supports hospital palliative care through value-based contracts.

In 2013, Highmark won first place and received the Gold Fine Award for its Advanced Illness Services program. Milton Fine, chairman of The Fine Foundation, stated, "This year's winners show a deep commitment to putting patients first in end-of-life decisions. Through ingenuity and teamwork, they partner with patients and families to ensure patient dignity and that patients' preferences for how they want to live out the end of their lives are honored." For this program, Highmark was also awarded the 2012 Best of Blue Clinical Distinction Award and the 2012 BlueWorks Award, both from the Blue Cross and Blue Shield Association.

PROGRAMS AND PRODUCTS

Community Collaboration and Advocacy

Highmark has engaged extensively in the community, serving on the national POLST paradigm task force, and as a leadership member of the Coalition for Quality at End of Life, an initiative housed at the Jewish Healthcare Foundation of Pittsburgh. This coalition comprises health systems, providers, payers, citizens and government agencies.

Provider Training and Designations

Highmark has dedicated "clinical transformation consultants" who work directly with providers to promote best practices throughout the hospital network and offer education on strategies for increasing palliative care consults and ICU bundle compliance (a bundle constitutes documentation of resuscitation status, health care proxy and family meetings).

Member Engagement and Care Management

Highmark plans to offer online resources and tools for members with serious illness, focused on understanding treatment options and developing goals of care.

For those enrolled in the Advanced Illness Services program (see below), services are provided in tandem with a "health coach" case

manager employed by Highmark. Clinical health coaches experienced in the care and management of advanced illness engage members, family caregivers and physicians to facilitate discussions on available end-of-life options. This communication supports the discussion of the program and includes collaboration and

RESULTS

The following applies to members enrolled in the Highmark Advanced Illness Services Program:

- **95%** would refer friends and family.
- **79%** hospice election rate.
- **85 day** average length of stay in hospice; **29 day** median stay.
- **14% decrease** in acute care admissions in the last six months.
- **33% decrease** in acute care admissions in the last month of life.
- **30% decrease** in ICU admissions in the last six months of life.
- **48% decrease** in ICU admissions in the last month of life.
- **39% decrease** in ER visits in the last month of life.

coordination with hospice providers. The health coach monitors the provision of services available to confirm that members' needs are being met and ensure ongoing member satisfaction.

Medical Policies and Coverage

Through its Advanced Illness Services program, Highmark offers its seriously ill Medicare Advantage members coverage for 10 home-based palliative care visits. This includes palliative care physician consultation, medical team conferences, and nurse and social worker visits. Members are eligible for the program if they meet certain general or disease-specific triggers. (For more information on criteria for patient identification, see Focusing on Those in Need, page 27)

Payment Innovations

Highmark utilizes value-based contracts to support palliative care. Highmark's Quality Blue incentive program supports hospital palliative care by providing incentive payments to hospitals based on these key metrics:

- The percentage of patients receiving a palliative care consult in the hospital (per 100 admissions).
- Patients who have documentation of resuscitation status on or before day one.
- Patients who have documentation of ICU efforts to identify the medical decision maker on or before day one of the ICU admission.
- An interdisciplinary family meeting conducted on or before day five of the ICU admission.

Highmark's Advanced Illness Services program reimburses hospice agencies to provide interdisciplinary (non-hospice) palliative care home visits for its members at a special fee-for-service reimbursement rate that accounts for the additional time required. The palliative care visits from the hospice agency are reimbursed via procedure codes that permit providers to bill for eligible services. The program includes a lifetime limit of 10 visits by a palliative care-trained social worker or registered nurse, who comes to the home as needed to provide patient and family education, consult about goal setting and care planning, and connect patients and families with community resources. The program provides 24/7 telephonic or in-home access to a palliative care team in case of unmanageable pain and symptoms. The type of outreach chosen is at the discretion of agency staff. Palliative home visits allow for early intervention, ongoing coordination of care with providers, and timely access to information to assist members and families with:

- Communication and complex decision making related to goals of care.
- Advance care planning.
- Control of pain and other symptoms.
- Psychological and practical support for patients and family caregivers.
- Referrals to community services.

“Numerous studies have shown that people with palliative care and the opportunity to discuss treatment goals actually live longer and have a higher quality of life. This is really about a community effort.”

Judith S. Black, MD, MHA; Senior Medical Director of Senior Markets, Highmark.
Pittsburgh Business Times, November 29, 2013.

Focusing on Those in Need

What is it?

An essential feature of effective palliative care models is the presence of an identification strategy that focuses the right level of care and resources on the right patient population. This section addresses screening strategies designed to identify individuals who require specialty-level palliative care in the hospital and in the community. This is an area in which payer-provider partnerships are particularly important, as effective targeting requires both administrative claims information from payers and clinical information from providers.

Many targeting systems have a screening-review-referral structure. First, patients are screened via keyword diagnosis searches, utilization or other administrative data elements to generate a list of people who may need palliative care. This list can be generated either by the payer or the provider. A clinician (usually a nurse) then reviews these patients' medical records and, using clinical judgment, proceeds to discuss potential referrals with the primary provider who knows the patient. However, a screening process based solely on claims data will capture only a minority of patients who need palliative care. It is critical to work with providers to encourage referrals based on clinical data like functional impairment and a negative response to the question, "Would you be surprised if this patient died within the next year or two?"

While there is no algorithm to capture the entire population that may need palliative care, there are several characteristics that may predict need and utilization. These are:

- A negative response to the "surprise question": "Would you be surprised if this patient died within the next year or two?"
- Frequent ED visits and hospital admissions.
- Admissions prompted by difficult-to-control or recurrent physical or psychological symptoms, or by inadequate home, social and family support capacity.
- Complex care requirements (wound care, home medical technology, medication management).
- Decline in function, altered mental status, dementia, difficulty eating or drinking, frailty or unintended weight loss.
- High-need conditions, including congestive heart failure, metastatic cancer, chronic obstructive pulmonary disease, stroke or organ failure.

Why is it important?

A successful targeting strategy serves two functions: it identifies those who need palliative care services, and enables appropriate program referrals. Without properly identifying the population that needs palliative care, payers may be offering an unnecessary and high-cost intervention to a population that will not benefit; and without routine screening for the identification of appropriate patients, high-need and high-risk patients may not receive the palliative care they need.

A CENTRAL PROBLEM: FUNCTIONAL IMPAIRMENT

The greatest predictor of need for palliative care services is a decline in functional status and an associated increased need for help at home. However, providers do not routinely collect and code functional status. Effective screening for palliative care requires the routine assessment of function in all patients. Payers should ask providers to record functional status with claims or other medical authorization documentation. Functional status assessment tools include the Palliative Performance Scale. For additional tools, see npcrc.org.

CASE EXAMPLES

Highmark Inc.

Highmark's Advanced Illness Services (AIS) program is a specialized palliative care model to support Medicare Advantage members with life-threatening illness. The program helps members understand their medical conditions in order to make informed health care decisions. Uniquely qualified and trained professionals provide emotional support, facilitate decision making, support effective communication with physicians and arrange referrals to community support resources. The program provides 100 percent coverage for a lifetime limit of 10 visits. The services are available to eligible Medicare Advantage members at no additional cost.

SCREENING CRITERIA AND METHODS

Predictive Modeling Tool The predictive modeling tool used to identify patients includes the following variables, or claims screening criteria:

- Gender.
- Age.
- Medicare risk score.
- Specific medical conditions, including cardiorespiratory failure or shock; metastatic cancer and acute leukemia; dementia or cerebral degeneration; endocrine, metabolic and nutritional disorders; disorders of the vertebrae or spinal discs; and high-potency opioid analgesics.
- Utilization data, such as the number of ED visits, ICU admissions, hospital admissions and chemotherapy visits.

Physicians, Health Coaches and Home Health Triggers Physicians and health coaches also identify patients who may be appropriate for AIS. Triggers include:

- Negative response when asked, "Would you be surprised if this patient died within a year?"
- Two or more hospital admissions within six months, with functional decline.
- Psychosocial distress in a patient who has a life-threatening illness.
- Uncontrolled symptoms in a patient who has a life-threatening illness.
- Guideline met for hospice eligibility, but "not yet ready."
- Consideration of percutaneous endoscopic gastrostomy tube placement.
- The following comorbid conditions (i.e., disease-specific triggers):
 - Stage-3 or stage-4 cancer.
 - Stage-3 or stage-4 congestive heart failure and signs of fluid overload.
 - Chronic obstructive pulmonary disease: oxygen-dependent state; low body mass index or weight loss; poor functional status.
 - Stroke: inability to take oral nutrition; change in mental status; aspiration.
 - Renal failure: signs of uremia (itching, confusion) or edema in a patient not on dialysis.
 - Liver failure: encephalopathy refractory to medications; coagulopathy; renal dysfunction.

Blue Cross Blue Shield of Massachusetts

BCBMA, in collaboration with Massachusetts General Hospital (MGH) and Brigham and Women's Hospital (BWH), studied the provision of incentive payments to hospitals to increase the number of palliative care consultations for high-risk patients. BCBS defined the high-risk population in need of palliative care, and hospitals identified eligible patients accordingly. Consultation rates in this target population tripled following the initiative: from 16 percent to 46 percent at MGH, and from 15 percent to 48 percent at BWH.⁸

SCREENING CRITERIA AND METHODS

Definition of "High-Risk Patients" Patients over 18 with a length of stay in the hospital of four days or longer, and presenting either:

- Acute cohort criteria—not admitted to the hospital within the previous 12 months but judged likely to die during target hospitalization; or
- Chronic cohort criteria—admitted twice in the previous 12 months for one of 26 high-risk diagnosis-related groups.

Provider Quality Recognition and Training

What is it?

The “dose” of palliative care required varies by patient and family need, setting, and stage of disease. All providers caring for high-risk patient populations need training in the core principles and practices of palliative care, including safe and effective pain and symptom management; expert communication about the realities of the illness and what to expect; and skilled coordination and continuity of care across the long course of an illness. To promote the spread of these skills among frontline clinicians, payers are recognizing providers that have received additional training or board certification in the competencies of palliative care.

Payers can help improve quality of care for members with serious illness both by recognizing and rewarding the provision of quality palliative care and by encouraging members to seek care from such “preferred” providers.

Why is it important?

Payers have an opportunity to support the wider adoption of palliative care by assisting members and their families in locating providers that have demonstrated either completion of palliative care skills training, or development of delivery models aimed at achieving the best quality of care and outcomes for those with serious and complex illness. Payers can change how they reimburse providers based on the achievement of key milestones in the delivery of high-quality palliative care. They may also choose to provide financial incentives to make the necessary investments in training, systems and staff, toward ensuring that quality palliative care is effectively delivered to those patients at highest risk who are most likely to benefit.

Case examples

A number of payers have integrated palliative care into their provider-recognition and value-based payment programs, using industry-standard criteria. Despite the challenges of defining and measuring best quality of care, the ongoing collaboration among payers and providers demonstrates the growing recognition of the importance of improving quality of support for those with serious illness. Two exemplars are described below.

CASE EXAMPLES

Highmark Inc.

Highmark is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. Highmark and its diversified businesses and affiliates operate health insurance plans in Pennsylvania, Delaware and West Virginia.

PROGRAM OVERVIEW

Program Description Value-based hospital contracting program that incentivizes hospitals to meet palliative care program outcome metrics.

Who Is Eligible? All in-network hospitals.

Examples of Program Requirements and Measurements

- Percentage of patients who had a palliative care consult (measured against established targets).
- Percentage of patients admitted or discharged from a long-term care or skilled facility with a POLST or MOLST form.
- Percentage of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of medical ICU admission.

Value-Based Payment Models Hospital payment rates for future years will be calculated from Highmark claims data and based on meeting predetermined measured target ranges. These targets will be specific to the increase of hospital palliative care consults for targeted populations, and for the initiation of POLST or MOLST for patients discharged to either a nursing or long-term acute care facility.

Sources for Palliative Care Practice Standards National Quality Forum (NQF), *Journal of Palliative Medicine*, Agency for Healthcare Research and Quality (AHRQ).

Process for Collaborating with Providers

- Use of industry-standard quality measures.
- Ongoing input from physician and hospital advisory groups.
- Ongoing communication with participating hospital program leaders.

Blue Cross and Blue Shield of North Carolina

Blue Cross and Blue Shield of North Carolina delivers innovative health care products, services and information to more than 3.84 million members, including approximately 1 million served on behalf of other Blue plans.

PROGRAM OVERVIEW

Program Description Recognition program that offers value-based payment to primary care and community-based oncology practices that meet all program requirements, including the completion of training in palliative care clinical skills, and the active integration of those skills into practice.

Who Is Eligible? All in-network community-based primary care and oncology practices.

Examples of Program Requirements and Measurements

- Cultural competency and advanced illness management training.
- Oncology providers ensuring:
 - Measurement of patient functional status.
 - Measurement of patient experience.
 - Development of cancer treatment plan to include:
 - Documentation of goals-of-care discussions.
 - Palliative care and hospice referrals.
 - Documentation of survivorship care plans.
 - Integration and use of a decision support tool, or evidence-based treatment pathway that provides comprehensive resources for treatments derived from peer-reviewed literature and oncology associations.

Value-Based Payment Models

- Primary care practices are eligible to receive an enhanced fee schedule based on meeting quality elements and completing required training.
- Oncology practices are eligible for an enhanced fee schedule if they complete required training; demonstrate the integration of advanced illness management and palliative care clinical skills into their practice; and successfully meet quality measures.

Sources for Palliative Care Practice Standards EPEC (Education in Palliative and End-of-life Care), National Committee for Quality Assurance (NCQA), National Comprehensive Cancer Network (NCCN).

Process for Collaborating with Providers

- Use of industry-standard quality measures.
- Ongoing input from physician and hospital advisory groups.
- Ongoing communication with participating hospital program leaders.

Paying for Specialist Community-Based Palliative Care

What is it?

Though generalist palliative care can and should be provided by all clinicians, specialty-level palliative care may be necessary to support the primary teams caring for high-risk individuals whose needs exceed the capacity and training of most frontline providers. These patients are often in the last few years of life (though notably not yet dying or eligible for hospice care) and need special attention to goals-of-care planning, psychosocial and family caregiver support, and pain and symptom control to remain safely at home.

Community-based palliative care can enable these individuals to remain at home and prevent needless 911 calls, ED visits and hospitalizations.

This is achieved through:

- Expert and responsive pain and symptom management, supported by 24/7 telephone access to a trained clinical team.
- Routine and standardized discussions on goals of care and goal-oriented care planning over time.
- Attention to practical, family and psychosocial issues that may affect a patient's health and need for additional services.

Community-based palliative care can be delivered by outpatient clinics, patient-centered medical homes, or hospice or home care agencies that have the appropriate skills and licensing.

Why is it important?

When we ask patients what matters most to them, many report that they want to be at home, free of pain and able to maintain independence for as long as possible.⁹ However, unless there is support in the community to help these individuals with spikes in pain or symptoms, or to assist family caregivers with daunting psychosocial or practical issues, people will have no choice but to return to the hospital. Community-based palliative care provides the assistance and support necessary for patients to live safely and comfortably at home. Palliative care has been shown to reduce hospital admissions and ED utilization, and payers are building on this evidence base to serve their highest-risk populations. Indeed, while preventative health such as obesity reduction campaigns may improve quality of life in the long term, payers will not see a return on this investment until decades into the future. In contrast, investment in palliative care for high-risk populations has been shown to yield improved quality and lower costs in the first month.¹⁰

CASE EXAMPLES

Aetna

Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities.

PROGRAM OVERVIEW

Description As part of its Compassionate Care program, Aetna offers a specialized nurse care management program. Specially trained case manager nurses engage members and family caregivers in discussions of advance care planning; coordinate medical, community and social support services; and provide emotional and psychosocial support to both the patient and the family.

Aetna also offers a “liberalized” hospice benefit to its commercial population. Patients are eligible for hospice with a physician’s estimated prognosis of 12 months. For some commercial group plans, members are not required to forgo disease-directed treatment as a condition of receiving hospice.

Payment Model Hospice per diem; care managers employed and trained by Aetna.

Outcomes In the Medicare Advantage population, hospice election tripled to more than 80 percent of decedents, acute care days decreased by 82 percent, intensive care days decreased by 88 percent, and members and families reported high satisfaction.

Tips/Advice from Innovator The consistent relationships, personal touch and palliative care training of the nurse care managers is the backbone of the program. Nurses and social workers are carefully selected according to their clinical experience, interest in the field, compassion and ability to relate well to people. They are then trained utilizing online resources and, as a key part of the program, mentored by professionals with a long record of success in care managing.

North Shore-LIJ Health System

North Shore-LIJ Health System includes 16 award-winning hospitals and nearly 400 physician practice locations throughout New York, including Long Island, Manhattan, Queens and Staten Island.

PROGRAM OVERVIEW

Description The Advanced Illness Management (AIM) program of the North Shore-LIJ Health System provides home-based primary and palliative care to frail elderly patients with multiple chronic conditions and functional impairments. Services include regular and on-demand home visits by doctors and nurse practitioners, 24/7 telephone response with remote access to EMR at all hours, social worker assistance with psychosocial issues, and a rapidly deployable community paramedic program for patients with new or worsening symptoms.

Payment Model In addition to the traditional fee-for-service model, North Shore-LIJ’s AIM program has leveraged four alternate payment models: full-risk, shared-risk, shared-savings and care-management fees. Of these, only the care-management fee results in prospective payment, whereby the program is paid a per-member, per-month rate to manage care for high-risk patients. For the remaining three models, payment is retrospective through the analysis of paid claims. For shared-savings models, there is only an upside potential; for shared-risk and full-risk models, there are both upside and downside possibilities.

Identification of patients for the AIM program vary by payer and payer arrangement. Most payers provide lists of high-risk patients that are generated through proprietary risk stratification algorithms. Payers typically provide initial outreach and education to members regarding the AIM program, followed by AIM outreach and enrollment. One payer allows for independent case finding through the use of hospital case managers, practice managers or home care nurses.

Outcomes North Shore-LIJ’s AIM program has seen a 37 percent reduction in annual hospital admissions for its enrolled population, and high patient satisfaction. In the event of a hospitalization, the program coordinates with the inpatient team within 48 hours on over 85 percent of cases. Upon discharge from the hospital or emergency department, the program visits patients at home within 48 hours in 94 percent of cases. An advance care plan is documented in the medical record in over 90 percent of all patients. See medpagetoday.com.

Tips/Advice from Innovator The key to reduction in admission rates is achieving a high-quality on-demand clinical response. Patients need to have phone calls returned in near real time, and visits need to be same-day or next-day. When working with third-party payers, enrollment of members can be difficult, as members are not familiar with the services and will not necessarily understand the benefit. Many have existing relationships with providers that they do not want to disrupt.

Hospice Care of California (HCC)

Hospice Care of California (HCC) is a licensed hospice that provides non-hospice home-based palliative care services through contracts with six different regional risk-bearing independent practice associations (IPAs). The mission of Hospice Care of California is to advance, support and provide a community-based palliative care program—serving patients of IPAs and their families. HCC envisions a seamless, integrated and coordinated care system.

PROGRAM OVERVIEW

Description Hospice Care of California has developed a community-based palliative care (CBPC) program that serves risk-bearing IPAs in California. Services include an on-call registered nurse, available 24/7, who has access to patient and family information. An additional palliative physician, registered nurse, licensed vocational nurse, social worker and chaplain are available to provide home visits if needed.

Payment Model HCC contracts a per-visit rate for services delivered to the home. For those patients who are referred to the program, five visits are preauthorized—generally three registered nurse visits and two social worker visits. In addition to the fee-for-service payments for these visits, the IPA provides a small per-member, per-month administrative fee to HCC, which covers team review, 24/7 call support and provision of various reports to the IPA—including documentation on advance care planning, utilization, pain and symptom status, and patient satisfaction, as well as summaries of clinical issues and patient needs.

Outcomes HCC collects data on pain and symptom management; patient and family satisfaction; advance care planning; numbers of hospitalizations, readmissions and ED visits; communication; physician satisfaction; and the perceived effectiveness of the palliative team. Detailed reports of outcomes are provided to the IPAs on a quarterly basis, and outcomes to date have been overwhelmingly positive.

Tips/Advice from Innovator HCC has put effort into clarifying the roles of the palliative team and IPA staff. As IPAs tend to have their own case managers, it is important to identify a main point of contact for the patient. HCC emphasizes the importance of training staff on the unique needs of the population. For example, many of the individuals enrolled in HCC's program speak only Spanish; it has therefore been crucial that outreach occur in the patients' own language. Likewise, it has been important to identify barriers to effective care management, such as cultural variability in the perception of the role of primary care physicians versus that of the emergency room.

4. Appendix

Select Published Literature

Toolkits and Monographs

Complex Care Management Toolkit. California Quality Collaborative, California HealthCare Foundation; April 2012. Available at calquality.org.

- This toolkit provides a wealth of resources for designing and implementing a complex care management program, from identifying the population in need to patient engagement and enrollment strategies.

A Better Benefit: Health Plans Try New Approaches to End-of-Life Care. California HealthCare Foundation; April 2013. Available at chcf.org.

- This landscape report describes efforts by some of California's health plans to develop improved palliative care benefits for their members with serious illness.

Palliative Care Quality and Efficiency Gains

Enguidanos S, Vesper E, Lorenz K. 30-day readmissions among seriously ill older adults. *J Pal Med*. 2012 Dec;15(12):1356–61. doi: 10.1089/jpm.2012.0259.

- Those discharged with home palliative care were 3.7 times less likely to be readmitted than those discharged to home without palliative care, and five times less likely to be readmitted than those discharged to nursing facilities.

Gelfman LP, Meier DE, Morrison RS. Does palliative care improve quality? A survey of bereaved family members. *J Pain Symp Manag*. 2008 Jul;36(1):22–8. doi: 10.1016/j.painsymman.2007.09.008.

- Sixty-five percent of palliative care patients' family members reported that their emotional or spiritual needs were met, as compared to 35 percent of usual care patients' family members (P = 0.004).

Kelley AS, Deb P, Du Q, Aldridge Carlson MD, Morrison RS. Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths of stay. *Health Affairs*. 2013 Mar;32(3):552–61.

- For each patient enrolled in hospice 53 to 105 days before death, Medicare saved an average of \$2,561 per patient, as compared to a matched, non-hospice control.

Morrison RS, Dietrich J, Ladwig S, et al. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs*. 2011 Mar;30(3):454–63.

- Compared to usual care patients, those who received a palliative care consultation in the hospital were significantly more likely to receive hospice care in an appropriate setting (home, nursing home or inpatient hospice) following discharge (30 percent versus 1 percent).

Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008 Sep 8;168(16):1783–90.

- For patients receiving palliative care during an inpatient admission, there was an average cost reduction of \$1,700 per admission for live discharges, and of \$4,900 per admission for those who died in the hospital.

Penrod JD, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. *J Palliat Med*. 2010 Aug;13(8):973–9.

- Patients who received a palliative care consultation during an in-patient admission were 43.7 percent less likely to be admitted to the ICU than patients receiving usual care, and daily total direct costs were \$464 a day lower for those receiving palliative care.

Riolfi M, Buja A, Zanardo C, Marangon CF, Manno P, Baldo V. Effectiveness of palliative home-care services in reducing hospital admissions and determinants of hospitalization for terminally ill patients followed up by a palliative home-care team: a retrospective cohort study. *Palliat Med*. 2014 May;28(5):403–11. doi: 10.1177/0269216313517283.

- Patients enrolled in a palliative home-care program had fewer hospital stays (0.4 versus 1.3 admissions) and shorter stays (4.4 versus 19.6 days) in their last two months of life than did patients receiving usual care.

SELECT PUBLISHED LITERATURE

Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non–small-cell lung cancer. *N Engl J Med*. 2010 Aug 19;363(8):733–42.

- For patients with newly diagnosed metastatic non–small-cell lung cancer who received early palliative care, median survival was longer than for those who received usual care (11.6 months versus 8.9 months).

Care Models and Payer Programs

Brumley R, Enguidanos S, Jamison P, Seitz R, et al. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. *J Am Geriatr Soc*. 2007 Jul;55(7):993–1000.

- Patients who received in-home palliative care (delivered by an interdisciplinary team providing pain and symptom relief), patient and family education and training, and an array of medical and social support services reported greater improvement in satisfaction with care than those receiving usual care; they were also more likely to die at home rather than in hospital. In addition, in-home palliative care subjects were less likely to visit the emergency department or be admitted to the hospital than those receiving usual care, resulting in significantly lower costs of care for intervention patients.

Claffey TF, Agostini JV, Collet EN, Reisman L, Krakauer R. Payer-provider collaboration in accountable care reduced use and improved quality in Maine Medicare Advantage plan. *Health Affairs*. 2012 Sep;31(9):2074–83.

- This study describes a collaborative care model (which includes care management and palliative care) developed by Aetna and the independent practice association NovaHealth. Results included 50 percent fewer hospital days per 1,000 patients, 45 percent fewer admissions, and 56 percent fewer readmissions than statewide unmanaged Medicare populations.

Hoefer DR, Johnson S, Bender M. Development and preliminary evaluation of an innovative advanced chronic disease care model. *J Clinical Outcomes Manag*. 2013;(20)9:408–18.

- This study describes Sharp HospiceCare's Transitions Advanced Illness Management program—a model of caring for an advanced heart failure population, which provides aggressive palliative services concurrently with disease-directed treatment. Results included a significant decrease in hospitalization rate (from 32 percent to 17 percent) and a significant decrease in ED visit rate (from 57 percent to 31 percent). The average total cost of care decreased significantly during enrollment (from \$73,025 to \$46,588).

Hopp FP, Trzcinski E, Roth R, et al. Cost Analysis of a Novel Interdisciplinary Model for Advanced Illness Management. *Am J Hosp Palliat Care*. 2014 Feb 21. doi: 10.1177/1049909114523827.

- This study evaluated cost outcomes for patients in the @HOME Support home-based palliative care program. It found that for those over 65 years of age who received the services, there was an average per-month cost reduction of \$3,400.

Kerr CW, Tangeman JC, Rudra CB, et al. Clinical Impact of a Home-Based Palliative Care Program: A Hospice-Private Payer Partnership. *J Pain and Symptom Manag*. 2014 Apr 16. doi: 10.1016/j.jpainsymman.2014.02.003. Accepted manuscript.

- This study evaluates the clinical impact of a home-based palliative care program, Home Connections, implemented as a partnership between a nonprofit hospice and two private insurers. Seventy-one percent of participants completed actionable advance directives after enrollment, and the site of death was home for 47 percent of those who died during or after participation in the program. Six of eight symptom domains (anxiety, appetite, dyspnea, well-being, depression and nausea) showed improvement. Patients, caregivers and physicians gave high program-satisfaction scores (from 93 percent to 96 percent).

SELECT PUBLISHED LITERATURE

Krakauer R, Spettell CM, Reisman L, Wade MJ. Opportunities to improve the quality of care for advanced illness. *Health Affairs*. 2009 Sep–Oct;28(5):1357–9.

- For those in Aetna's commercially insured populations who were enrolled in the Compassionate Care program, the increase in hospice election and decrease in acute care services was estimated to represent a net medical cost decrease of 22 percent as compared to a historical control group.

Lynn J. Reliable and sustainable comprehensive care for frail elderly people. *JAMA*. 2013 Nov 13;310(18):1935–6.

- This featured *JAMA* Viewpoint discusses the need for health system redesign to improve care for frail elderly people, noting, inter alia, that many services should be brought to the individual's residence, and that the system should encompass long-term supports and services.

Meier DE, Thar W, Jordan A, Goldhirsch SL, Siu A, Morrison RS. Integrating case management and palliative care. *J Palliat Med*. 2004 Feb;7(1):19–34.

- This article describes an academic, care management and health plan partnership between the Icahn School of Medicine at Mount Sinai, Franklin Health (a care management organization) and BlueCross BlueShield of South Carolina to design and test a program integrating care management and palliative care. Preliminary programmatic results indicate that combining palliative care with the case management approach was a logical, feasible and effective strategy to improve the care of seriously ill patients living in the community.

Meyer H. Changing the conversation in California about care near the end of life. *Health Affairs*. 2011 Mar;30(3):390–3.

- This article discusses Sutter Health's Advanced Illness Management program, including preliminary data on cost and quality.

Parikh R, Kirch RA, Smith TJ, Temel JS. Early specialty palliative care—translating data in oncology into practice. *N Engl J Med*. 2013 Dec 12;369(24):2347–51.

- This sounding board presents the clinical, economic and political case for providing earlier specialty palliative care, and proposes initial priorities for clinicians and policymakers to achieve the integration of palliative care across all populations with serious illness.

Sweeney L, Halpert A, Waranoff A. Patient-centered management of complex patients can reduce costs without shortening life. *Am J Manag Care*. 2007 Feb;13(2):84–92.

- This study describes and evaluates intensive patient-centered management—a type of palliative care program that involves education, home visits, frequent contact and goal-oriented care plans. Those receiving palliative care had 38 percent fewer inpatient admissions, 36 percent fewer inpatient hospital days, and 30 percent fewer ED visits. Overall costs were reduced by 26 percent.

Williams R, Krakauer R. The Challenge of Non-Communicable Diseases and Geriatric Conditions. *Global Population Ageing: Peril or Promise?* World Economic Forum, 2012.

- This chapter discusses the importance of payer-provider collaboration and of providing advanced illness management services in efforts to improve value in health care. Features Aetna's Compassionate Care program.

Targeting Patients in Need

Gómez-Batiste X, Martínez-Muñoz M, Blay C, Espinosa J, Contel JC, Ledesma A. Identifying needs and improving palliative care of chronically ill patients: a community-oriented, population-based, public-health approach. *Curr Opin Support Palliat Care*. 2012 Sep;6(3):371–78.

- This article describes the importance of early identification of patients with unmet palliative care needs to assure that they receive appropriate quality of care and mitigate unnecessary costs. Using a public health approach, the authors describe targeting criteria (dementia, frailty, functional decline) to find and treat patients with advanced care needs, and argue that the use of these tools in community-based care is key to ameliorating the quality and cost issues associated with patients with advanced disease.

SELECT PUBLISHED LITERATURE

Paris J, Smith C, Horton J, Adelson K, Morrison RS. Standardized criteria for integrated palliative care consultation on the solid tumor oncology service (S752). *J Pain Symptom Manag*. 2014;47(2):497–8.

- This three-month pilot program, developed by the Icahn School of Medicine at Mount Sinai in New York, evaluated the use of standardized criteria to identify patients with advanced solid tumors for palliative care consultation and the resulting outcomes. The criteria for palliative care consultation included any of the following: stage-4 solid tumor, stage-3 pancreatic or lung cancer, hospitalization within the prior 30 days, prolonged hospitalization (for more than 7 days), or uncontrolled symptoms, including pain, nausea, shortness of breath, delirium and psychological distress. Application of the standardized criteria increased palliative care consultations (from 41 percent to 82 percent) and the use of hospice services (from 14 percent to 25 percent), and lowered 30-day readmission rates (from 36 percent to 17 percent), suggesting improved quality and reduced costs.

Weissman DE, Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the Center to Advance Palliative Care. *J Palliat Med*. 2011 Jan;14(1), 17–23. doi: 10.1089/jpm.2010.0347.

- In this article, the authors (representing the Center to Advance Palliative Care) describe a consensus-building process to develop criteria and tools that support a system-change approach to address the identification of patients at risk for unmet palliative care needs. The authors outline the components of the consensus process and present the two checklists developed by the panel, including one assessment for the time of admission and a second assessment to be used as part of daily rounds.

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2. Ibid.
3. *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*. Institute of Medicine; September 10, 2013. Available at iom.edu.
4. *2011 Public Opinion Research on Palliative Care: A Report Based on Research by Public Opinion Strategies*, April 2011. Available at capc.org.
5. Smith S, Brick A, O'Hara S, Normand C. Evidence on the cost and cost-effectiveness of palliative care: a literature review. *Palliat Med*. 2014 Feb;28(2):130-50.
6. POLST is an advance care planning process for seriously ill or frail individuals designed to ensure shared medical decision making. POLST is based on conversations between the patient, his or her family, and health care professionals that focus on establishing the person's goals for care and the treatments they do or do not want based on those goals. The result is a set of medical orders that is honored in all settings.
7. The names of similar forms in different states vary: MOLST (Medical Orders for Life-Sustaining Treatment); MOST (Medical Orders for Scope of Treatment); POST (Physician Orders for Scope of Treatment); LaPOST (Louisiana Physician Order for Scope of Treatment); COLST (Clinical Orders for Life-Sustaining Treatment); IPOST (Iowa Physicians Orders for Scope of Treatment); TPOPP (Transportable Physician Order for Patient Preference). See polst.org.
8. Bernacki RE, KoDN, Higgins P, Whitlock SN, Cullinan A, Wilson R, Jackson V, Dahlin C, Abraham J, Mort E, Scheer KN, Block S, Billings JA. JPM Improving Access to Palliative Care through an Innovative Quality Improvement Initiative: and Opportunity for Pay-for-Performance. *J Palliat Med*. 2012; 15: 192-9.
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