# Community-Based Model Programs for the Seriously Ill

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*Prepared for the Gordon and Betty Moore Foundation by Kathleen Kerr*

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## Executive Summary

For decades providers and financers of health care have experimented with approaches to improving care delivered to individuals with serious illness, defined as those who have a poor prognosis and are likely in the last stage of life, experience functional impairment, and are at risk for cycling in and out of the hospital. The goal of this project was to identify examples of programs that are serving seriously ill individuals, and to gather information about how those programs are structured, staffed and financed.

For the current purpose, we held that a serious illness program (SIP) would include the following essential components:

**Team-based approach**: services delivered by an interdisciplinary team of professionals;
**Goal-based approach**: care is centered on patient goals, which are documented in a care plan;
**Comprehensive care**: access to curative care, disease-management, palliative care, and social supports;
**Coordinated services**: among providers, across settings and over time;
**Transition supports**: including timely transfer of information about patient goals and preferences;
**Accessible services**: including during nights and weekends, to address crises and urgent needs;
**Concordant care**: delivered services are aligned with patient values, goals and preferences;
**Home-based care**: services and supports that promote care delivery in the home;
**Family-oriented care**: structures and processes that provide a central role for family caregivers;
**Caregiver support**: assessment of and attention to caregiver coping and needs;
**Measurement**: an organized, comprehensive approach to assessing the quality of care.

We used a layered approach to find model programs. We sent inquiries to dozens of individuals with expertise in palliative care, geriatrics, health services research and similar fields who would likely have knowledge of serious illness programs. We reviewed programs that had been recognized by the American Hospital Association's *Circle of Life Award*, as well as programs described at national meetings that focus on palliative care, hospice care and advanced illness care. We considered programs that participated in demonstration projects aimed at improving care for seriously ill individuals, such as the *Independence at Home* program, and reviewed documents describing innovative approaches to advanced illness care / community-based palliative care developed by advocacy groups and trade organizations. Finally, we reviewed recent editions of peer-reviewed journals that focus on serious illness care, such as the *Journal of Palliative Medicine* and the *Journal of the American Geriatrics Society*.

From among the hundreds of programs that were identified[1] we selected 12 that completely or mostly offer the essential components of serious illness care, and whose successes and challenges appear to be representative of broader trends for further study. All are caring for at least 200 patients a year and have been operational for at least two years. In addition to seeking geographic diversity, we selected programs that were built off of a range of "bases" – such as health systems, hospices and medical groups – and that

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[1] As a companion to this report, we created a list that includes information on 100 programs offer some or all of the essential serious illness program components.

are integrated with or dependent on a range of financing and care delivery models such as Medicare Advantage plans and Accountable Care Organizations. Case studies for 8 of the 12 are included below, following discussion of information gathered for all 12.

*12 Model Serious Illness Programs*

| Organization and Program Name | Base (notable feature) | State(s) |
|---|---|---|
| University of Alabama Birmingham<br>*Center for Palliative and Supportive Care* | Health System<br>(program in south central United States) | Alabama |
| Palo Alto Medical Foundation<br>*Palliative Care and Support Services* | Medical Group<br>(cross-setting teams) | California |
| Sharp HealthCare<br>*Transitions* | Health System<br>(Medicare Advantage population) | California |
| The Denver Hospice<br>*Optio Health Services* | Hospice<br>(partnership with integrated health system) | Colorado |
| UnityPoint Health<br>*UnityPoint at Home* | Health System<br>(collaboration with the health system's Population Health programs) | Iowa / Illinois / Wisconsin |
| Hackensack Meridian Health<br>*Meridian Care Journey* | Health System<br>(integration across a complex system) | New Jersey |
| ProHealth<br>*ProHEALTH Care Support* | Medical Group<br>(services for an ACO population) | New York |
| Four Seasons Compassion for Life<br>*Community Palliative Care* | Hospice<br>(regional integration) | North Carolina |
| Lehigh Valley Health Network<br>*Optimizing Advanced Complex Illness Support (OACIS)* | Health System<br>(coordination with social service programs) | Pennsylvania |
| Virginia Commonwealth University Health System<br>*Center for Advanced Health Management* | Health System<br>(health home for complex patients) | Virginia |
| Harborview Medical Center (University of Washington)<br>*Palliative Care Services* | Health System<br>(services in a safety-net system) | Washington |
| Yakima Valley Memorial Hospital<br>*Compass Care* | Health System<br>(program in a rural area) | Washington |

For each serious illness program we interviewed and solicited written information from clinical and / or administrative leaders that described each program's strategy for delivering the core components of serious illness care. We asked leaders about factors that promoted the development and sustainability of their programs, as well as factors that challenged their success. We also sought their input on resources that would help to promote development of similar services or enhance the sustainability, quality or

growth of their own services. Though the profiled programs are quite diverse, interviews revealed a number of common themes.

**Success factors:**  Most informants noted the importance of <u>internal and external partnerships</u>. Relationships with community and national philanthropic organizations, as well as partnerships with researchers (within or external to their organizations) were often instrumental in launching or sustaining programs. Hospice-sponsored programs noted the importance of learning how to partner with health systems and payers. Internal partnerships, such as embedding programs in cancer centers or leveraging system-wide efforts related to advance care planning, were also identified as success factors. For health system programs in particular,<u> supportive organizational leadership</u> was felt to be critical. <u>Efforts to support care team members</u> through education, mentorship programs for new providers, and team wellness programs were all listed as mechanisms for nurturing clinical teams, maintaining morale and preventing burnout and turnover. Several informants noted the importance of having <u>an electronic health record (EHR) that could share information across settings</u>.

**Challenges:**  <u>Economic sustainability</u> was a common worry, particularly for health system and hospice sponsored programs. Several programs felt <u>tracking metrics was an area of weakness</u>, resulting from suboptimal informatics (IT) infrastructure, scarce IT and analytic personnel resources, and / or lack of familiarity with methods for assessing outcomes for the serious illness population. <u>EHR systems that could not integrate or share information across settings</u> posed a significant challenge for some programs, especially those that operate outside of a health system umbrella. <u>Conflict with the dominant health care culture</u> was also referenced, and some informants mentioned a need to improve their programs' relationships with important specialty clinical services, such as oncology. <u>Workforce shortages</u> made hiring qualified providers a continuing challenge. <u>Maintaining standardized operational approaches in the setting of program growth</u> was a challenge encountered by several programs, in particular organizations that are looking to spread and sustain programs across diverse markets. <u>Leaders that operate programs in safety net systems and in rural areas noted a number of distinct challenges</u>, including a general scarcity of health care services and trained professionals, and the difficulty of offsetting the socioeconomic issues such as poverty and addiction that compound the stresses and challenges of serious illness for patients and families.

**Resources to promote growth and sustainability:**  Program leaders identified several supports that would promote development of new programs, or that would facilitate the sustainability, improvement and growth of existing programs. These included <u>leadership training</u>, in particular guidance on how to navigate "start-up" issues that are commonly encountered when creating new services. Most informants endorsed the need to <u>create opportunities for program leaders and staff to collaborate with peers</u>, to share best practices and lessons learned. Most program leaders expressed strong interest in efforts aimed at creating <u>care delivery standards</u>, as well as the need to <u>identify feasible, meaningful metrics</u> that would assess program quality and impact. Multiple programs saw a need for <u>resources that would support analytic and informatics staff</u> in meeting program needs related to communication, documentation, and quality monitoring. Many also referenced the need for <u>supports that would promote payer-provider partnerships</u>, as well as <u>policy changes that would create well-defined and easily accessed payment sources</u> for team-based, home-based serious illness services. Many described a need for <u>training in how to achieve culture change</u> within a large organization, as well as methods for promoting better collaboration and integration with specialty clinical services. Incorporating <u>telehealth capabilities</u> was identified as an opportunity, rather than a challenge, and several noted an interest in receiving guidance on best practices, security issues, and billing considerations.

## Community-Based Model Programs for the Seriously Ill

For decades providers and financiers of health care have experimented with approaches to improve care for individuals with serious illness, defined as those who have a poor prognosis and are likely in the last stage of life (which could last for years), experience functional impairment, and are at risk for cycling in and out of the hospital. Innovations have focused on different aspects of care, ranging from expanded hospice benefits that allow for concurrent provision of certain types of disease-directed treatments, to interdisciplinary teams that provide home-based palliative care. Some innovations have focused on the needs of a particular subset of seriously ill individuals – for example persons with advanced cancer; others have focused on specific care settings – such as acute care hospitals or nursing homes.

Ideal care for the seriously ill population could be described as follows:
- Goal-based care that is concordant with patient and family wishes;
- Comprehensive care, including concurrent access to appropriate disease-directed and restorative treatments, palliative care, end-of-life care, and social supports;
- Home-based care, including access to supports that allow individuals to remain in their homes;
- Coordinated care, where care plans and other information follow patients across settings;
- Rapid access to services, including during nights and weekends;
- Access to extra support before and immediately after care transitions;
- Family-oriented care, including support for family caregivers.

The primary goal of this project was to identify programs that are delivering such care, and to gather information about the strategies they are using to meet the needs of seriously ill individuals. Towards this end, we adopted the following objectives:

- To identify several serious illness programs that completely or mostly offer the core features of quality serious illness care, and that represent a range of care delivery/financing approaches;

- To describe each program's strategy for delivering essential components of serious illness care, and to assess the extent to which they are able to deliver each component;

- To gather information from the leaders of these programs about the factors that promoted the development and sustainability of their services, as well as factors that challenged their success;

- To elicit input from program leaders about resources that would have made program development easier, and resources that would help to sustain, improve or expand their services;

- To gather information that would inform an approach to a conducting a national assessment of the prevalence and characteristics of serious illness programs.

**ESSENTIAL ELEMENTS OF SERIOUS ILLNESS CARE**
Though many types of organizations offer services to seriously ill individuals, there is no common definition of a serious illness program, nor are there any national standards that address required structures and processes. For the current purpose, we held that an ideal serious illness program would include the following essential elements:

**Team-based approach**:  services, including comprehensive assessments, are delivered by an interdisciplinary team of professionals with expertise in assessing and managing the physical, emotional, spiritual and practical needs of patients and families;

**Goal-based approach**:  patient needs, values, goals and preferences are elicited and recorded, and are incorporated into a comprehensive care plan, which is updated regularly;

**Comprehensive care**:  concurrent access to curative and restorative care, palliative and end-of-life care, spiritual care, and to social supports and services;

**Coordinated services**:  structures and processes that promote delivery of coordinated care and services, among providers, across settings and over time;

**Transition supports**:  structures and processes that optimize transitions across settings, with a focus on ensuring access to and transfer of information about patient needs, goals and preferences;

**Rapid access to services**: including during nights and weekends, to address crises and urgent needs;

**Concordant care**:  structures and processes that ensure that the delivered services and supports are aligned with patient and family needs, values, goals and preferences;

**Home-based care**:  services and supports, including use of telehealth and other technologies, which promote care delivery in private residences or wherever the patient is living;

**Family-oriented care**:  structures and processes that provide a central role for family caregivers, as dictated by the needs and preferences of the patient;

**Caregiver support**:  assessment of caregiver coping and needs, with provision of or referral to appropriate social and spiritual supports;

**Measurement**:  an organized, comprehensive approach to assessing care quality, with an emphasis on assessing concordance between patient preferences and actual care delivered, as possible.

These components are consistent with or, in some instances, more extensive than goals and standards put forth by organizations that focus on the seriously ill population, such as the Center to Advance Palliative Care (CAPC), the Coalition to Transform Advanced Care (C-TAC), the National Consensus Project for Quality Palliative Care (NCP), and the National Comprehensive Cancer Network (NCCN).

**PROGRAM IDENTIFICATION AND DATA GATHERING**

We used a layered approach to identify programs. We sent inquiries to dozens of individuals with expertise in palliative care, geriatrics, health services research and similar fields who would likely have knowledge of serious illness programs. We reviewed programs recognized by the American Hospital Association's *Circle of Life Award*, which recognizes excellence and innovation in the delivery of hospice and palliative care. We considered programs described at national meetings that focus on palliative care, advanced illness care, and supportive care for cancer patients, such as the annual conferences sponsored by the Center to Advance Palliative Care (CAPC) and the Coalition to Transform Advanced Care (CTAC). We considered programs that have or continue to participate in federal demonstration projects aimed at improving care for seriously ill individuals, such as the *Independence at Home* program and the *Community-based Care Transitions Program*. We reviewed documents describing innovative approaches to advanced illness care and community-based palliative care developed by advocacy groups and trade organizations, such as the *Payer-provider Toolkit* developed by CAPC, and the *Field Guide to Community-Based Palliative Care developed by the* California Health Care Foundation. Finally, we reviewed recent editions of peer-reviewed journals that focus on palliative care and geriatrics care, such as the Journal of Palliative Medicine and the Journal of the American Geriatrics Society.

We found that while many organizations offer at least several of the essential components of serious illness care and include "seriously ill individuals" in their target populations, none called themselves a "serious illness program," preferring instead the more commonly used labels of "palliative care," "advanced illness care," "home-based primary care," or "supportive care." Thus, we looked for programs that had the essential structures and features of a SIP, no matter what they called themselves. Further, though some essential components of serious illness care are offered through a variety of interventions - such as complex care management programs embedded in primary care practices, or hospital-based palliative care consultation services - we excluded from consideration programs that do not offer on-going home-based care. Further, in selecting programs we favored those that had demonstrated sustainability, where non-recurring grant support or philanthropy did not comprise the bulk of program funding.

From among the hundreds of programs that were identified, we selected 12 that completely or mostly offer the specified essential elements, and whose successes and challenges appear to be representative of broader trends. All are caring for at least 200 patients a year and have been operational for at least two years. In addition to seeking geographic diversity, we selected programs that were built off of a range of "bases" – health systems, hospices and medical groups – and that are integrated with or dependent on a range of financing and care delivery models, such as the Medicare hospice benefit, Medicare Advantage health plans, and Accountable Care Organizations (ACOs).

For each program we interviewed and solicited written information from clinical and administrative leaders that described each program's strategy for delivering the core components of serious illness care. We asked leaders about factors that promoted the development and sustainability of their services, as well as factors that challenged their success. We also sought their input on resources that would help to promote development of similar services or enhance the sustainability, quality or growth of their own services.

**ENTITIES THAT SPONSOR SERIOUS ILLNESS PROGRAMS**

**Health plans:** Some health plans promote access serious illness care by offering care management and advance care planning supports, adopting benefit designs that pay for home-based care, or by sponsoring care delivery innovations. For example, CareOregon, a non-profit health plan serving about 250,000 Medicaid and Medicare members, offers an open access community-based palliative care benefit, and is running a pilot where specialty palliative care teams are embedded in an oncology practice and an FQHC. These palliative care services work in collaboration with primary and specialty providers, and with plan programs that offer behavioral health services and an array of social supports.

**Health systems:** For health systems in particular, serious illness care is commonly offered as a constellation of services that together represent an advanced illness care strategy that crosses care settings and clinical service lines. For example, in their Minneapolis market Allina Health offers an inpatient palliative consult service; a palliative care clinic; a home-based palliative care service; a system-owned hospice; embedded geriatrics care in transitional care units, nursing homes and assisted living communities; a medical home for individuals with complex conditions; advance care planning classes offered at multiple clinics; oncology social workers and "healing coaches" embedded in a cancer center; and a lay navigator program embedded in a several primary and specialty clinics.

**Hospices:** Many organizations which began as hospices now offer an array of serious illness services. Gilchrist Services, which began as Gilchrist Hospice Care, now offers several programs for individuals with advanced or terminal illnesses. *Gilchrist Greater Living* offers cross-setting medical care to older patients with serious conditions and functional decline. *Support Our Elders* offers home-based care with a focus on advance care planning, anticipatory guidance about expected disease progression, medication management, and 24/7 on-call support. An interdisciplinary *Inpatient Palliative Care* consult service sees patients at two local hospitals. The *Transitions* program offers navigation support, respite care, and end of life planning to individuals who graduate from hospice or are not eligible for hospice. *Grief and volunteer support* is available to families of hospice patients and the community at large.

**Medical groups:** Many multispecialty practices, particularly those that assume risk for the cost of care or those that participate in shared savings alternative payment models, have developed dedicated serious illness services. For example, ProHEALTH Care is a multispecialty medical group of some 900 providers; *ProHEALTH Care Support* is a specialty practice within ProHEALTH, that provides palliative care to ProHEALTH patients through home visits, telemedicine, and phone support.

**Specialty organizations:** Emerging evidence that specialty services can have a positive impact on clinical and utilization outcomes have created a niche for specialty serious illness care organizations. These organizations contract with health plans, health systems and medical groups to offer specialty care to individuals with advanced illness. Aspire Health maintains a network of specialty community-based palliative care practices that provide comprehensive medical care for patients facing a serious illness in 19 states. The organization has targeted programs for Medicare Advantage, Managed Medicaid and commercial health plans, as well as ACOs, IPAs, MSOs and oncology practices.

**Partnerships:** The breadth of needs commonly seen among individuals with serious illness, and the fact that supports need to be available across settings, has led some organizations to enter into partnerships, where organizations combine their expertise to deliver comprehensive, cross-setting, longitudinal care to seriously ill individuals and their families. For example, the Palmetto Kidney Care Alliance is an End-stage-renal-disease (ESRD) Seamless Care Organization (ESCO) participating in the CMS Comprehensive ESRD Model demonstration. The ESCO includes four organizations: Gentiva Health Services, Dialysis Clinic, Inc., Spartanburg Nephrology Associates, and Spartanburg Regional Health District Services.

**TWELVE MODEL PROGRAMS**

The 12 profiled programs operate in 12 states. Two are sponsored by hospices, two by medical groups, and eight by health systems. One operates in a rural, geographically isolated area, and one has features specially designed to serve a homeless population. One program holds responsibility for delivering all health care to a population of seriously ill individuals; all others offer serious illness care in collaboration with other providers (within or external to their organizations) who maintain responsibility for providing primary care and disease-directed treatments. Programs care for as few as 200 patients and as many as 7,700 annually. Most programs offer services across multiple sites, including acute care hospitals, nursing homes, clinics, and patient homes. Nearly all of the programs offer some form of distance support, including video visits with physicians or telephone contacts with nurse or social worker staff that focus on case management and care coordination. Profiles of eight of the 12 programs, which describe their clinical models, target patients, funding sources and other details, are included on pages 32-81.

*12 Model Serious Illness Programs*

| Organization, Base Type, SIP Name | Description |
|---|---|
| Organization:  University of Alabama Birmingham (Alabama)<br><br>Base Type:  Health system<br><br>SIP Name:  Center for Palliative and Supportive Care | An array of palliative and supportive services available to individuals with cancer and other serious illnesses. Core components include an inpatient palliative care consultation service, a dedicated palliative care unit, supportive care and survivorship clinics, a telemedicine program that offers psychoeducational support to patients and family caregivers, and a lay navigator program. Mature integration with an NCI designated cancer center, where programs that launched with research funding have been integrated into clinical practice. |
| Organization:  Palo Alto Medical Foundation (California)<br><br>Base Type:  Medical Group<br><br>SIP Name:  Palliative Care and Support Services | Interdisciplinary team offering concurrent specialty palliative care to medical group patients with serious illnesses. Patients are seen in any setting, including private residencies, nursing homes, clinics and acute care hospitals. Care is coordinated across providers and settings, and with family caregivers. Service focuses on discussions of underlying disease processes, goals of care, developing care plans, advance care planning, symptom management, and emotional support for patients and families. |
| Organization:  Sharp HealthCare (California)<br><br>Base Type:  Health System<br><br>SIP Name:  Transitions | Specialty palliative care provided to Medicare Advantage members with advanced chronic illness who are beginning to use the hospital as a tool for managing their illness. The program is built on four pillars: in-home consultation, evidence-based prognostication, caregiver support, and advance care planning. Nurse/social worker teams, under the supervision of a physician, provide in-home and phone-based support to address physical and emotional distress, and to proactively prepare patients and families for expected disease progression, with the goal of keeping patients in their homes if that is their preference. |

| Organization, Base Type, SIP Name | Description |
|---|---|
| Organization:  The Denver Hospice (Colorado)<br><br><br>Base Type:  Hospice<br><br><br>SIP Names:  Kaiser Special Services, Kaiser Palliative Care at Home, Optio Health Services | Palliative care provided through three home-based programs, two of which are partnerships with integrated health system Kaiser Permanente. *Kaiser Special Services* is led by social workers and focuses on clarifying goals of care for people with advanced illness and transitioning them to a care plan and services that support those goals. *Kaiser Palliative Care at Home* is operated under a home health license, and offers home-based palliative care from an interdisciplinary care team. For non-Kaiser patients, the *Optio Palliative Care at Home* model offers home visits by a team that includes nurse practitioners, social workers and patient navigators, with office-based triage support from RNs. |
| Organization:  UnityPoint Health (Iowa / Illinois / Wisconsin)<br>Base Type:  Health System<br><br><br>SIP Name:  UnityPoint at Home | Inpatient, clinic-based, and home-based specialty palliative care offered across an integrated health system serving nine regions throughout Iowa, western Illinois and southern Wisconsin. In each region the palliative care program is co-led by a physician and clinical administrator, and consultative care is provided by interdisciplinary teams. A system-wide clinical administrator oversees the regional programs, and works to facilitate sharing and adoption of best practices and consistent approaches to quality monitoring. The system has designated palliative care as one of 14 essential competencies for population health. |
| Organization:  Hackensack Meridian Health (New Jersey)<br><br><br>Base Type:  Health System<br><br><br>SIP Name:  Meridian Care Journey | System-wide program that provides palliative care in acute care hospitals, skilled nursing facilities, outpatient practices and in patient homes. Interdisciplinary teams operate across the continuum, serving individuals with chronic illness, with a focus on engaging with patients early in the disease course and assuring continuity over time and across settings. Services are supported by an electronic health record that is available across all system sites, which alerts the care team and case managers if an enrolled patient engages with the health system at any point of access. |
| Organization:  ProHEALTH (New York)<br><br><br>Base Type:  Medical Group<br><br><br>SIP Name:  ProHEALTH Care Support | Specialty palliative program serving seriously ill individuals through home visits, video-visits, and phone support, provided by teams comprised of nurses, social workers and palliative care physicians. Services include pain and symptom management, support clarifying goals, care plan development, support for caregivers, and 24/7 phone availability. The program has explicit processes for coordinating care and communicating with all involved providers. Volunteers affiliated with the program offer Reiki massage and friendly visiting. Services are available to individuals in the medical group's ACO population, and by contract to commercial payers. |

| Organization, Base Type, SIP Name | Description |
|---|---|
| Organization:  Four Seasons Compassion for Life (North Carolina)<br><br>Base Type:  Hospice and palliative care organization<br><br>SIP Name: Community Palliative Care | Specialty palliative care provided in hospitals, nursing homes, assisted living facilities, patients' homes, and outpatient clinics. Hospice services are also available, including a 19-bed inpatient hospice residence. The care model features interdisciplinary collaboration and the integration of palliative care into the regional health care system, continuity of care across transitions, and longitudinal, individualized support for patients and families. In addition to clinical care, educational programs, consulting, and mentoring are offered through a Center of Excellence. |
| Organization:  Lehigh Valley Health Network (Pennsylvania)<br><br>Base Type:  Health System<br><br>SIP Name:  Optimizing Advanced Complex Illness Support (OACIS) | Specialty palliative care offered in inpatient, clinic and home settings. The program is conceived of as the "safety net" for people with serious illness cared for across the health system, and works in partnership with patients' primary or specialty care providers in a co-management model. The program has grown significantly since launching in 2006, and palliative care was recently designated as one of the Network's mission goals, making this type of care one of the organization's top priorities. |
| Organization:  Virginia Commonwealth University Health System (Virginia)<br><br>Base Type:  Health system<br><br>SIP Name:  Center for Advanced Health Management | Health home for individuals with complex illness, which follows patients over time and across settings. Core components include office-based medical care; longitudinal primary care in the home for those who are less mobile; nurse practitioner home visits for post-acute and post-ambulatory care needs; physician-driven nursing home care with 24/7 coverage; inpatient geriatric consult service; intensive care management; home-and office-based social work services including counseling; behavioral health including medication management and psychotherapy; a dedicated pharmacist; specialty palliative care and hospice services; and telemedicine services, including home monitoring and video-visits. |
| Organization:  Harborview Medical Center (University of Washington)<br><br>Base Type:  Health System<br><br>SIP Name:  Palliative Care Services | Array of well-integrated and well-coordinated palliative and supportive care programs available in a safety-net system, which serves an ethnically and linguistically diverse population. Services include specialty inpatient palliative care, clinic and home-based palliative care, and a program for homeless individuals with serious illness (providers will see patients in shelters or any other location, following patients over time and across care settings, including into the hospital.) Robust educational and research endeavors are coordinated through a palliative care center of excellence. |

| Organization, Base Type, SIP Name | Description |
|---|---|
| Organization: Yakima Valley Memorial Hospital (Washington)<br><br>Base Type: Health System<br><br>SIP Name: Compass Care | Multi-component program operating in a culturally diverse and geographically isolated rural area. Program includes two tiers of home-based palliative care (medical and "non-medical" models), home hospice, a hospice house, and a complex advance care planning initiative. Specialty palliative care is well integrated with the cancer center, system-wide care coordination programs and home health services; spiritual care services enjoy close partnership with community clergy and faith organizations. |

**FEATURES OF THE 12 PROGRAMS**

Defining and identifying the target patient population

The 12 programs use a variety of definitions for their target populations, and a range of methods for identifying patients and promoting appropriate referrals. Definitions generally reference a combination of patient characteristics, symptom burden, utilization indicators, evidence of functional decline, and / or prognosis, with varying levels of specificity. For example, the UnityPoint program is intended to serve, "individuals with a life-limiting condition where death in the next 12 months would not be surprising, with frequent hospital admissions, or difficult-to-control physical or psychological symptoms, or complex care requirements, or feeding intolerance, or unintended decline in weight, or decline in function." For some programs age restrictions (e.g., must be over age 65), insurance type (e.g., must be Medicare Advantage plan member), or inclusion in an ACO population are also incorporated into inclusion / exclusion criteria. Some components of some programs are limited to individuals with specific diseases, for example survivorship clinics for cancer patients.

Methods for identifying eligible patients include relying on referrals from primary or specialty care providers, or using information gleaned from encounter or claims data, such as presence of claims that feature International Classification of Diseases (ICD) diagnosis codes indicative of high severity of illness. Many programs use both methods (referrals and "chase lists" of patients identified through claims or encounter data) in a hybrid patient identification strategy. Programs that serve an ACO population or that have contracts with commercial payers commonly use more precise inclusion criteria that completely or mostly rely on systematic analysis of claims data intended to proactively identify individuals at risk for hospitalization, death or high costs.

As a rule programs require a referral from the patient's primary care physician or a specialist who has assumed that role, and many SIP leaders described extensive, on-going efforts to orient potential referring providers to the scope of their programs and the benefits they bring to patients and families. The presence of uncontrolled symptoms or complex psychosocial issues were often referenced as triggers for referral, as were general indicators of decline that would be easy for referring providers to utilize; "patients who are beginning to use the hospital to manage progressing illness," or "would you be surprised if this patient could no longer come in to the clinic or died in the next 12 months?" One hospice-based program used hospice eligibility as a reference point for referral, and defined their target population as "patients who are anticipated to be appropriate for hospice in the next year or two."

Patient and family willingness to engage with the SIP or adopt the SIP's approach to care was a focus area for some programs. The Sharp Transitions program specifies as a condition of enrollment that the patient

and family should be willing to engage in advance care planning and to attempt in-home disease management strategies coordinated by the Transitions team instead of first going to the emergency department. In recognition of the difference between "empaneled" and "engaged", the Virginia Commonwealth University Center for Advanced Health Management (VCU CAHM) program stations outreach workers in system emergency departments. These individuals are available to talk to patients who have been empaneled to the health home, may have never used the center for care, and have presented to the ED for issues that may be better addressed in a clinic setting. The outreach workers connect with these patients, explain what the CAHM program has to offer, and can set up an appointment and transportation support on the spot.

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*There is significant variation in how serious illness programs define their target patients. Sharp Health Care's Transitions program uses a detailed and comprehensive set of eligibility criteria, whereas the Palo Alto Medical Foundation's Palliative Care and Support Services program has a more flexible approach.*

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| Sharp Transitions | PAMF Palliative Care and Support Services |
|---|---|
| • Likely to or has started to use the hospital or ED to manage their late stage disease<br><br>• Patients should be evaluated in their best compensated state<br><br>• Patients should have received maximal medical therapy (per Medicare definition)<br><br>• Life expectancy of about 2 years or less<br><br>• Diagnosis of cancer, CHF, Cirrhosis, COPD, dementia, or frailty syndrome<br><br>   – 2-3 disease-specific criteria for each condition (cancer stage, MELD score, ejection fraction, oxygen requirements etc.)<br><br>• Patients and families should:<br><br>   – Be willing to attempt in-home disease management by the Transitions team instead of first going to the ED<br><br>   – Be willing to participate in ACP<br><br>   – Have a Medicare Advantage plan | Individuals with an expected prognosis of 1-2 years who have a PAMF physician (primary care or specialist), who would benefit from extra support |

Core Services
With the exception of the VCU CAHM program, which operates as a health home for seriously ill patients, all programs deliver serious illness care in a consultative or co-management model. Average length of service for clinical programs ranges from several months to several years.

The intent of all 12 programs is to ensure that seriously ill individuals get the supports and services they need. They achieve this end by prioritizing interventions that are often missed, delivered too late in the disease course, or delivered in too low a dose in the course of usual care delivery. As detailed in Figure 1, all programs offer eight cores services aimed at supporting patient and family needs for symptom control, medication management, accessing and understanding medical information, clarifying goals, advance care planning support, and assistance with coping. Most programs also have explicit practices that support patients as they transition across settings. All deliver care in patient homes, and most offer care in multiple settings. Many are either accessible to patients 24 / 7 or utilize a range of strategies for expanding access to ensure availability during night and weekend hours, such as partnering with affiliated urgent care centers. While all hospice-sponsored SIPs offer bereavement services, this practice was not universal across programs sponsored by medical groups or health systems.

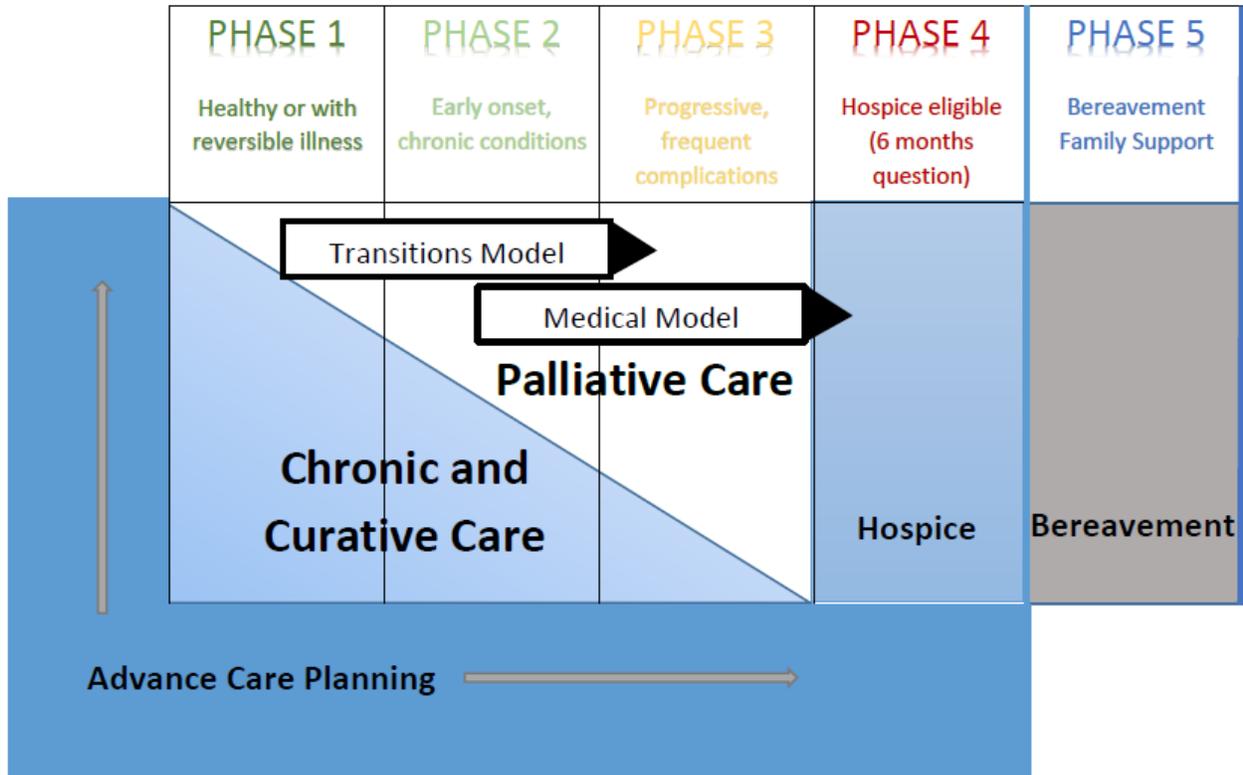*Proportion of programs offering 11 core services*
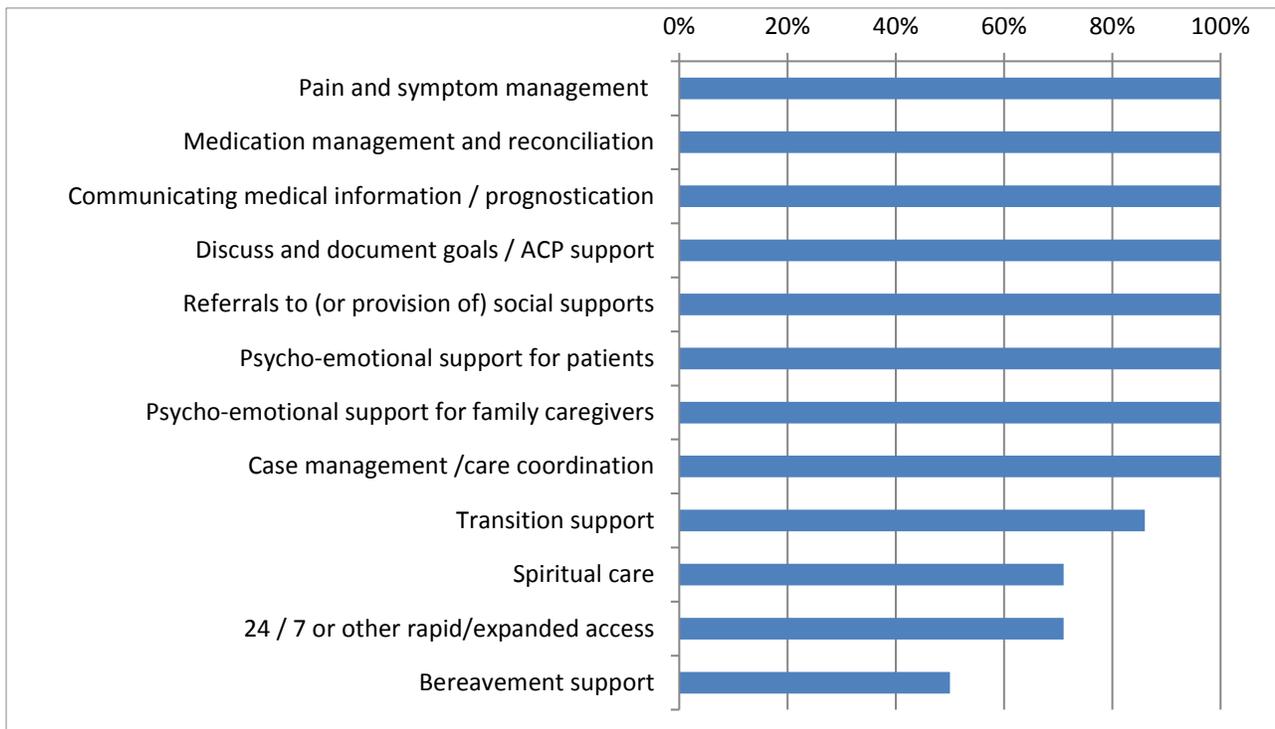


Most programs adjust the amount of service delivered according to patient needs. For example, Hackensack-Meridian's home-based palliative care program assigns patients to one of three acuity levels, and this stratification guides the frequency of contact. All patients receive at least one "touch" per month, either an in-home visit or a phone assessment, which are more substantive than just a brief social/check-in call. Patients in level three (the sickest/highest-need patients) require a minimum of one face-to-face visit per month; level two requires one face-to-face visit every other month; and so on.

For health system-sponsored SIPs patients have access to system-wide programs such as case management, care navigation, home health, and chaplaincy services that support both seriously ill individuals and other types of patients. The degree to which such services are considered to be part of the SIP (vs. components of the larger organization) varies across programs. For example, the Compass Care program at Yakima Valley Memorial Hospital oversees a system-wide advance care planning program, as well as a department of clinical ethics, home health services, specialty palliative care offered in multiple

settings, spiritual care, a hospice, a hospice residence, and bereavement services. Bundling all these services in an advanced illness service line is not surprising, but it is not necessarily typical.

***Serious illness services available at Yakima Valley Memorial Hospital***

| PHASE 1 | PHASE 2 | PHASE 3 | PHASE 4 | PHASE 5 |
|---|---|---|---|---|
| Healthy or with reversible illness | Early onset, chronic conditions | Progressive, frequent complications | Hospice eligible (6 months question) | Bereavement Family Support |

Transitions Model

Medical Model

**Palliative Care**

**Chronic and Curative Care**

Hospice

Bereavement

**Advance Care Planning**

The Interdisciplinary team

*Team composition*

All 12 programs are interdisciplinary and use a core team of physicians and / or advanced practice nurses, registered nurses, social workers, and spiritual care professionals in different configurations. It is quite common for those configurations to vary across settings (hospital, clinic, nursing home, patient home), and for health systems to have variable staffing across regions. Many programs also employ pharmacists, medical assistants, counselors/behavioral health professionals, community health workers, and lay navigators. Programs often work in tandem with staff employed by the nursing homes, health systems and clinics where enrolled patients receive care; for example a SIP team may collaborate with pharmacists employed by a hospital, social workers employed by the nursing home, or physical therapists employed by a cancer center. Volunteers perform a variety of services, including Reiki massage, friendly visiting, helping patients use iPads to complete surveys in clinic waiting rooms, and providing emotional support to family caregivers.

*Team training*

Nearly all programs report extensive investment in team development and offer staff a range of training and enrichment activities. Trainings focus on effective team functioning, communication skills, clinical skills, and advance care planning support skills, among other topics. Several programs require that new staff participate in clinical and communication training programs, such as the End-of-Life Nursing Education Consortium (ELNEC) training for nurses or the web-based courses in symptom management and

communication skills offered by CAPC. Many programs require that clinicians become certified in hospice and palliative care, as appropriate for their discipline, within two years of hire. In addition, several programs have extensive orientation programs for new hires, such as mandatory mentoring / proctoring and shadowing experiences.

*Team interactions*

All programs invest significant time in interdisciplinary team (IDT) communications, and most report spending multiple hours per week in IDT meetings. Scheduled meeting frequency ranged from daily to twice monthly, supplemented with on-going daily communications conducted via videoconferencing, telephone calls or text messaging to address clinical and care coordination issues. Meeting topics typically include case review, care coordination, medical literature review, and program metrics review. Most programs also incorporated into their meetings practices aimed at promoting self-care and team well-being, such as starting each meeting with a "check-in" exercise. Many programs have annual retreats / gatherings that focus on enhancing coping skills or managing issues associated with caring for seriously ill patients, such as strategies for avoiding compassion fatigue. Several programs noted the importance of having centralized, shared staff offices, a resource that was seen to promote both interdisciplinary communication and team well-being.

Some programs time meetings to enhance continuity of communication before and after the weekends. For example, every Monday morning the ProHEALTH team holds a 30 minute "Good Morning Monday" call to review any urgent issues that came up over the weekend.

Documenting goals and preferences

For all programs, care is centered on understanding patients' goals, values and preferences and how those change over time, with accompanying focus on developing and disseminating care plans that reflect those goals.

All programs document goals of care and care plans in an EHR, some of which were specially designed for the SIP. Typically, entries are available to SIP program staff across settings, meaning SIP care teams in one setting can see what has already happened with patients who were cared for by a different SIP team in another setting, which greatly enhances continuity and efficiency. For some system- and medical group-based programs, the EHR is accessible to affiliated primary and specialty providers. For programs that have less sophisticated or integrated EHRs, SIP staff rely on phone, fax and email communications to loop in other providers who are involved in patient care.

Several programs have developed standardized processes and templated forms for common aspects of clinical care, such as initial visit, follow-up visit, psychosocial assessment, and spiritual care. For one SIP, every form used in clinical care contains required questions about goals of care and advance care planning, to ensure that these essential topics are assessed and documented initially and on an ongoing basis. Forms include prompts such as checkboxes to indicate whether goals / ACP issues were addressed, whether any follow-up is required, and whether an advance care plan is on file.

Many programs described processes for completing and disseminating portable medical order forms that specify patient preferences – such as the New York State Medical Orders for Life Sustaining Treatment Form (MOLST). Several programs feature these forms in their quality assessment programs. For example, the ProHEALTH program has a formal process to review all hospital admissions. For those patients who had a

MOLST stating they would not want future hospital admissions, the team does an analysis of what went wrong (i.e. caregiver decision, lack of adequate plan for symptom management, and so on).

Several health systems have enterprise-wide structured advance care planning (ACP) programs, typically modeled after Respecting Choices™ and similar programs. Sharp Health Care has a dedicated ACP department, which serves as a repository for tools, resources, training, and subject matter expertise in all aspects of ACP and POLST, which are available to all Sharp providers.

Care Coordination
All 12 programs engage heavily in monitoring needs and coordinating care for their patients. As the Lehigh Valley team leader put it, "The program sees itself as the safety net for seriously ill patients cared for throughout the system – once a patient is on their census, we keep close tabs on them and work to address their needs across settings."

Common care coordination activities include fielding/triaging calls from providers, families, and patients; facilitating information exchange about patient goals, care plans, and clinical status among providers, patients and families; and monitoring transitions across settings. In some programs the care coordination role is always managed by a specific team member, usually a nurse or social worker, though some SIPs a more flexible approach and assign responsibility for care coordination / case management according to the patient's primary needs (i.e., if needs are primarily psychosocial, the social worker would be the primary case manager; if needs are primarily physical, the advance practice nurse would be the primary case manager). The University of Alabama (UAB) team includes both a health system-based nurse navigator and a community-based community health advisor who work together to ensure that patients are supported through transitions into and out of the health system.

The specific processes used to fulfill care coordination goals often reflect the extent of support available from the program's IT infrastructure. Some EHRs allow users to flag patients being followed by the SIP, and some (health system) EHR's include features that send notifications to SIP teams if one of their patients presents to the ED, is on observation status or is admitted to the hospital, is discharged from the hospital, or is transferred to hospice. In the absence of such IT supports, SIP and other providers use phone, fax, email and video-visits to keep each other apprised of changes in patient clinical status or location of care. SIPs that operate in multiple settings see this as conveying significant continuity and care coordination benefits. For example, some 85% of patients that receive inpatient palliative care from Four Seasons are subsequently followed by their community-based program, with a defined hand-off process between settings and a structured risk-assessment process to identify acuity and key needs. The Hackensack-Meridian program has a similar process; if a patient has been followed by the inpatient palliative care team and is being discharged to a skilled nursing facility (SNF), an order for palliative care in the SNF is placed automatically.

Several programs report rounding and meeting with affiliated clinical services, such as oncology practice staff and intensive care unit (ICU) staff. One program even holds a regular community IDT meeting to discuss the most complex patients and strategies for supporting those patients in their preferred care setting. These regional meetings include the palliative care teams from each setting, discharge planners from the region's hospitals, hospice staff, home care staff, the local PACE program, and representatives from community social service agencies.

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**THE PROS AND CONS OF VARIATION**

Though all 12 programs have a common goal of delivering comprehensive, coordinated care to seriously ill patients and their families, they employ a range of strategies to achieve that goal, and differ in important ways. Some significant areas of variation include:

- How they define the population they wish to serve/eligibility criteria;
- The scope of service, and degree to which they offer a fixed, tiered or flexible intervention;
- The settings in which care is offered;
- Frequency of contact, method of contact (in-person / phone/ video) and length of service;
- The disciplines on care teams and staffing ratios;
- Training and certification requirements for core staff;
- Data collection practices and metrics used to assess program quality and outcomes;
- Payment model and payment amount for clinical services.

Such variation is certainly understandable, given regional differences in practice culture, the degree to which collaborating services attend to the essential elements of serious illness care, and availability of workforce to staff growing services. Without question this variation reflects innovation, and the flexibility needed secure support from a diverse pool of stakeholders. Over time, however, such variation might prove to be an impediment to scaling and spreading effective models. SIP providers that contract with multiple health plans, health systems or ACOs might have 8 contracts that call for 8 different sets of services, with different minimum service requirements, staffing requirements, metrics, and payment amounts. Not surprisingly, many program leaders articulated a need for care delivery standards, which would in turn standardize and simply the contracting process.

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<u>Engaging with and supporting families and caregivers</u>
Caregiver engagement and support is an integral part of all programs, which typically view patients and families as a single unit of care. The dominant attitude is that engaging with families and caregivers is critical to understanding patient goals and preferences, and to creating a workable care plan. As a rule, family members are engaged in the process of care planning if that is the preference of the patient.
All organizations described efforts to make it as easy as possible for families to engage with care teams, and to have a central role in care planning. Many programs hold family meetings late in the day, in early morning hours or on weekends to accommodate working families. All use phone or videoconferencing to engage family members who do not live nearby or who are unable to leave work to attend a family meeting. Most programs reference using interpreters, at least in clinic and hospital settings, and others have intentionally built bi-lingual/bi-cultural staffs.

Most programs use EHR templates that allow for documenting the name and contact telephone number for the patient's medical decision maker, and some allow staff to note the presence and identity of family members and caregivers involved in family meetings.
None of the programs have a specific frequency or set of triggers for care planning meetings or family meetings – they are simply an integral part of their services and as one leader described, "happen everywhere all the time."

For most programs, screenings, assessments, interventions or referrals for caregivers are a routine part of the social worker's role during initial and follow-up visits. Specific supports include offering one-on-one

counseling to caregivers (separate from the patient), virtual visits through videoconferencing with caregivers, and routinely asking caregivers what they are most worried about with respect to their own well-being. At UAB, family members have access to the psychology and counseling resources housed in the cancer center. Visits with these professionals primarily focus on the impact of illness on relationships and the family dynamic, the emotional impact of serious illness, preparation for death, and emotional and behavioral coping skills for the demands of caregiving.

Many programs offer support groups for people with advanced illness and their families. The Hackensack-Meridian SIP sponsors a support group for caregivers of people with dementia, during which program staff are available to attend to patients, freeing caregivers to participate in the meetings.

In some cases, SIP counselors are available to talk to family members as part of bereavement support after a death; other programs utilize bereavement staff employed by an affiliated hospice, or refer families to bereavement programs run by hospices in the community.

All programs report working with multiple community partners to provide support for families and caregivers, and in most cases these connections have been fostered by and the social workers and chaplains on the team. Typical community partners include private duty nursing agencies, county transportation agencies, in home psychotherapy groups, and caregiver volunteers, among others. Local parish partners were also mentioned as valued resources for caregiver and spiritual support.
Some programs have patient/family/community advisory groups that review palliative care team polices and educational materials, and most programs administer family satisfaction surveys as part of a quality monitoring program.

Collaborators
Program leaders identified multiple collaborators, including individuals and services affiliated with their parent organizations, as well external entities such as medical groups, nursing homes, assisted living facilities, social service organizations and faith communities. Nearly all referenced the importance of seeking and nurturing positive, collaborative relationships with the primary care and specialist physicians with whom they co-manage patients. Outpatient and hospital-based case management teams, Patient Centered Medical Home care coordinators and other care navigators were also frequently referenced as important partners.

In addition, most programs described partnering with home health agencies and hospices, as many SIP patients use both services. For example, ProHEALTH team members often partner with home health nurses and aides to manage clinical issues. When needed, the teams stagger the visit schedule of the home health nurse and ProHEALTH nurse, to maximize the number of days per week that include a home visit. Additionally, the home health nurse can conduct a virtual visit with the ProHEALTH physician when the home health nurse identifies a clinical issue that warrants physician input.

Health system leaders were also described as important partners, especially in systems that are pursuing population health strategies. Many programs described partnerships with community organizations that help support patients in their homes, including physical therapy agencies that can help with home assessments and equipment issues, and social service agencies that can help get home services for people who have limited resources but do

*Constellation of Services -* Health systems use a range of interventions, usually in combination, to meet the needs of seriously ill individuals. Many of these interventions are well-described in the peer-reviewed literature and other sources, and have been deployed widely. In some circumstances, improving serious illness care could focus on the quality of coordination and communication across these interventions, the extent to which the services are adequately staffed with appropriately trained individuals, and the extent to which patients who would benefit from such services can access them.

| | |
|---|---|
| Home-based primary care | • Offered in private residences, nursing homes, and assisted living facilities |
| Specialty geriatric services | • Offered in hospitals, clinics, senior centers, private residencies, nursing homes, assisted living facilities and transitional care units |
| Specialty palliative care | • Offered in hospitals, clinics, rehabilitation facilities, private residences, nursing homes and assisted living sites |
| Specialty care units for elderly or seriously ill patients | • Examples include ACE units, dedicated palliative care units, senior emergency rooms and hospice facilities |
| Care /case management services for serioulsy ill individuals | • Often embedded in specialty care centers, primary care practices, or offered by health plans or medical groups |
| Navigation / coaching programs | • Lay or clinical staff available to help patients and families navigate the health care system |
| Transition management programs | • Structured programs that support individuals as they transfer across care settings |
| Advance care planning programs | • Trained individuals guide patients and families through the process of clarifying and documenting preferences |
| Social supports and services | • To assist with a broad range of needs; examples include home-delivered meals, transportation, personal care, friendly visiting, legal assistance, and housing |
| Spiritual care programs | • For patients and families / caregivers; could be offered in partnership with local faith organizations |
| Support programs for families / caregivers | • Programs that address practical, educational or emotional needs; examples include respite services, support groups, or bereavement programs |
| Complementary and integrative medicine services | • Such as massage, meditation or hypnotherapy |
| Hospice or similar end of life services | • Interidsicplinary support to individuals in the final stage of terminal illness, usually delivered in the patient home |

not qualify for Medicaid's supportive services. The Lehigh Valley team described how the local Area Agency on Aging assists with a variety of supportive services, and how local parishes have provided valuable spiritual support to patients and families. The program also partners with a Community Time Bank, through

which program patients or family members can offer or receive different kinds of volunteer services. This unique program provides practical assistance for SIP patients and families (when receiving help) and a sense of satisfaction and engagement (when giving help).

The leaders of the Four Season's program noted that their 12-year academic partnership with Duke University has been an important factor in the program's growth and ability to build a robust approach to quality monitoring. Several programs endorsed the importance of affiliations with professional organizations that focus on palliative and supportive care, such as the American Academy of Hospice and Palliative Medicine (AAHPM), CAPC, the National Hospice and Palliative Care Organization (NHPCO), the Hospice and Palliative Nurses Association (HPNA), and the Palliative Care Research Collaborative (PCRC).

Quality monitoring

Most programs have a designated staff member who is responsible for extracting, analyzing and summarizing data, and generating quality assessment reports. Program leaders typically report findings quarterly to various executive, medical staff and quality oversight committees of the larger organization. All programs routinely track operational metrics such as number of patients served and discharge disposition, and most review utilization metrics such as proportion referred to hospice, number of hospital admissions and ED visits. Several administer referring provider and patient / family satisfaction surveys, which were often developed locally.

Some care teams meet monthly to review metrics, and some described specific processes for engaging clinical teams in quality reviews. The Four Seasons program reviews all inpatient and outpatient palliative care deaths to determine if there were barriers to hospice referral (such as skilled nursing status, goals not aligned with hospice care, family refusal) or if it was a sudden, unexpected event. The program also tracks cases where the care that was delivered did not match MOST (Medical Orders for Scope of Treatment) form specifications, as well as instances where the MOST form was not available at the patient's final care setting. Similarly, ProHEALTH conducts an interdisciplinary review of each hospital admission; the team does a deep dive on the specifics of the case, and then all team members vote on whether they think that hospitalization could have been avoided.

Nearly all program leaders have found it very difficult to track patient-reported outcomes such as pain or symptoms through their EHRs, and most were relatively unsatisfied with their quality monitoring programs. This sentiment was not shared by the Harborview team, which has an extensive enterprise-wide clinical data warehouse and dedicated analyst / programming staff to develop input templates and extraction processes specifically designed to meet the needs of the SIP. Similarly, Four Seasons, whose informatics capabilities have been developed in partnership with Duke University, uses its custom-made daily patient interface / documentation tools to collect a large amount of data, which are used to assess a broad set of quality metrics. Elements of their data collection process have been approved by the Centers for Medicare and Medicaid Services (CMS) as a qualified clinical data registry (QCDR) for the Physician Quality Reporting System (PQRS).

*Selected metrics and quality indicators used by the 12 SIPs*

| Operational metrics | Utilization / fiscal metrics |
|---|---|
| **Operational metrics**<br>• Number of referrals and number of patients (actually) seen<br>• Average length of time followed by service<br>• Number of MD, NP, RN, SW, chaplain visits and phone contacts<br>• Wait times for initial visit<br>• Distribution of major diagnoses<br>• Distribution of discharge dispositions (death, transfer to hospice, dis-enrolled, etc.)<br>• Referring provider identity/clinical specialty<br>• Reason for referral<br>• Patient location at time of referral<br>• Clinical staff/support-staff ratio<br>• Work RVU's, work RVUs/FTE<br>• Billing revenue by provider and by FTE | **Utilization / fiscal metrics**<br>• Admits/1000 members<br>• ED visits/1000 members<br>• Hospital admissions by provider/nurse team<br>• ED visits by provider/nurse team<br>• Average hospital length of stay per admission<br>• Proportion of patients referred to hospice<br>• Mean/median hospice length of service<br>• % Decedents hospitalized in the final month of life<br>• In-hospital deaths<br>• Re-hospitalization rates<br>• Total cost of care per decedent compared to usual care decedents |
| **Process metrics**<br>• Goals of care developed/documented<br>• Portion of patients that receive ACP interviews<br>• Proportion with advance care plan documented<br>• % patients who completed POLST forms<br>• Proportion where surrogate decision maker identified<br>• Various indicators of care quality based on the Outcome and Assessment Information Set (OASIS) data<br>• Instances where care delivered did nto match MOST specifications | **Clinical metrics**<br>• Pain assessed<br>• Pain addressed<br>• Shortness of breath assessed<br>• Shortness of breath addressed<br>• Nausea assessed<br>• Nausea addressed<br>• Initial vs. follow up pain score<br>• Initial vs. follow up dyspnea score<br><br>**Patient / family / referring provider satisfaction**<br>• Pt/family satisfaction as measured by the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)<br>• Responses to program-designed patient/family satisfaction surveys<br>• Responses to program-designed referring provider satisfaction surveys |

Financing

Programs utilized a range of revenue sources and financing strategies, and most programs had multiple funding streams. Programs that relied on traditional fee-for-service (FFS) professional billings reported covering 50-80% of direct costs with clinical revenues, and needed to secure grant funds, philanthropy or support from the parent organization to fully cover the costs of an interdisciplinary intervention. Programs that contract with commercial payers typically receive a monthly payment for each individual enrolled in the program, a compensation model that is well-suited to supporting an interdisciplinary team. Programs affiliated with health systems or medical groups that hold risk for patient/member health care costs were

fully or mostly funded by the parent organization, justified by reductions in health care costs that are typically realized when patients receive intensive home-based support.

Funding options had on impact on clinical models and patient inclusion criteria. Programs for which FFS billing was the dominant model for generating clinical revenue were more likely to make greater use of physicians and nurse practitioners in care delivery, and the one program that relies on the home health benefit as a revenue source stipulates that patients be homebound.

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### *FINANCING OPTIONS FOR TEAM-BASED, HOME-BASED SERIOUS ILLNESS CARE*

**Support from parent organization**
- For health systems, can be justified by quality/operational value if the SIP is able to demonstrate reductions in inpatient deaths, hospital admissions (in the setting of high-occupancy rates), or re-hospitalizations
- For some hospice-sponsored programs, the SIP services may lead to more frequent and earlier referrals to hospice, for patients that are open to the hospice care model
- Many organizations see SIPs as offering care that is aligned with the larger mission of the organization, and are willing to support such programs, even with no proof of fiscal impact

**Traditional FFS billings**
- Mostly using Evaluation and Management (E & M) codes for services delivered by physicians and NPs caring for patients across settings (hospitals, patient homes, clinics, nursing homes.)
- Some programs also bill off Care Management Codes and Advance Care Planning codes
- Billings typically cover 50-80% of direct staffing costs for physicians and nurse practitioners

**Health plan contracts**
- For Medicare Advantage, Medicare Advantage Special Needs Plans, Medicaid Managed Care populations, and all manner of commercial business lines
- Contracts commonly allow for per-enrolled-member-per-month payments, designed to cover a specified set of palliative and supportive services delivered by an IDT
- Tiered services are common, with payment variation based on services provided (e.g., with or without skilled nursing) and patient acuity
- Some contracts stipulate incentives related to utilization benchmarks (no hospital admissions or ED visits in a specified period), member responses to satisfaction surveys, or even incentives related to submitting data describing service provision and findings from comprehensive assessments

**Shared savings and shared risk**
- Both Medicare and commercial ACO's use SIPs as a strategy to improve quality and reduce costs.
- SIPs are also used liberally in integrated health systems that operate on global budgets, and within care delivery organizations that carry full risk for costs of care (such as a PACE program)

**CMS Demonstrations/Innovation programs**
- Many programs have been launched with funding from a variety of CMS demonstration/innovation programs, including Independence at Home, the Oncology Care Model, the ESRD Care Model, the Community-Based Care Transitions Program, the Medicare Care Choices Model
- Some organizations have transitioned from grant support to contracts with health plan payers

**SUCCESS FACTORS**

Program leaders noted several factors that they perceived as having contributed to the success of their programs. Most informants noted that <u>internal and external partnerships</u> had been key to the development, sustainability and growth of their services. Leaders perceived that increased efficacy and durability resulted from supplementing their clinical programs with formal educational offerings, and, in some cases, partnerships with researchers within or external to their organizations. Close relationships with community and national philanthropic agencies were also referenced as a critical strategy for promoting program growth. Hospice-sponsored programs noted the importance of learning how to partner with health systems and payers. Internal partnerships, such as embedding programs in cancer centers, or leveraging system-wide efforts related to advance care planning or care coordination, were also listed as success factors. Several leaders noted the importance of engaging with national organizations such as CAPC or the National Hospice and Palliative Care Organization (NHPCO), to access educational resources and to create peer networks. For health system programs in particular, <u>organizational leadership</u> that understands the value of the serious illness program and its alignment with the organization's future in population health and value-based care was noted as a key success factor.

<u>Efforts to support care team members</u> through education, mentorship programs for new providers, and team wellness programs were all cited as mechanisms for nurturing clinical teams, maintaining morale and preventing burnout and turnover. <u>Self-staffing strategies</u>, such as having a palliative medicine fellowship program or a training program for nurse practitioners, were referenced as effective tools for replenishing program staff when turnover occurred, or for finding staff to support planned growth.

Several noted the importance of having an <u>EHR that can share information across settings</u>. Such systems support care coordination efforts, promote delivery of care that is concordant with patient preferences, and allow access to data needed to demonstrate the program's impact on quality and costs, which was endorsed as a prerequisite for sustainability and growth.

| | | |
|---|---|---|
| Internal and external partnerships | Diversifying beyond clinical work into education, research | Supportive organizational leadership |
| Supportive environment for care team members | Self-staffing strategies | EHR that can share information across settings |
| Focus on patients and family needs | Focus on referring provider needs | Ability to demonstrate economic impact |

Designing a program that is <u>appreciated by both patients and families and referring providers</u> was referenced as another success factor. All programs described program features aimed at identifying and meeting the needs of patients and families, and multiple programs described processes that were explicitly designed to respect the authority and primacy of referring providers.

Finally, <u>being able to demonstrate the economic efficacy</u> of the program was referenced as a critical contributor to program success.

**BARRIERS AND CHALLENGES**

Our informants identified a number of ongoing challenges facing their programs. Economic sustainability was a common worry, particularly for health system and hospice sponsored programs. As interpretations of hospice eligibility have narrowed, the serious illness programs are caring for more patients with chronic, deteriorating conditions over a longer period of time. Payment models have not kept up, and the <u>absence of a reliable and adequate payment stream</u> remains a significant challenge for many programs. Some health system-based programs referenced the challenge of sustaining and growing services when their parent organizations were navigating a transition from a revenue model anchored in episodic, fee-for-service payments, to one that was anchored in population health and alternative payment models. In such an environment, avoiding a preventable admission (a common result of improved serious illness care), could have a positive or negative net fiscal impact; in some instances reduced utilization would represent an avoided loss or cost, in others, lost revenue.

While several programs counted measurement as an area of strength, others felt that <u>tracking metrics was an area of weakness</u>, often hampered by suboptimal informatics (IT) infrastructure, scarce IT and analytic personnel resources, and an absence of familiarity with methods for assessing performance indicators or clinical and fiscal outcomes for the serious illness population. <u>Obtaining data describing patient experience of care</u> was noted as a particular challenge. <u>EHR systems that could not integrate or share information across settings</u> posed a significant challenge for some programs, especially those that operate outside of a system umbrella. Oftentimes programs could access a good deal of detailed information that had been collected by their staff, but these data were not available, for example, to staff at local hospital emergency departments.

<u>Continued conflict with the dominant health care culture</u> was also referenced. Engaging community-based private physicians to refer to their programs was a challenge for many, and some informants mentioned a need to improve the program's relationship with important specialty clinical services, usually oncology.

Leaders that operate SIPs partially or entirely in <u>rural areas noted a number of distinct challenges,</u> including a general scarcity of health care services, workforce issues, an absence of technology infrastructure needed to implement telehealth programs, an older often isolated population, and socioeconomic issues such as poverty and substance abuse that compound the stresses and challenges of serious illness for patients and families. Similarly, the one program operating in <u>safety-net system had to contend with a number of particular challenges,</u> notably the need to address the abundant and complex social issues facing their patients – substance abuse and mental illness, social isolation, housing and physical safety, to name just a few – while addressing concurrently issues related to serious illness, such as care coordination, advance care planning and symptom management.

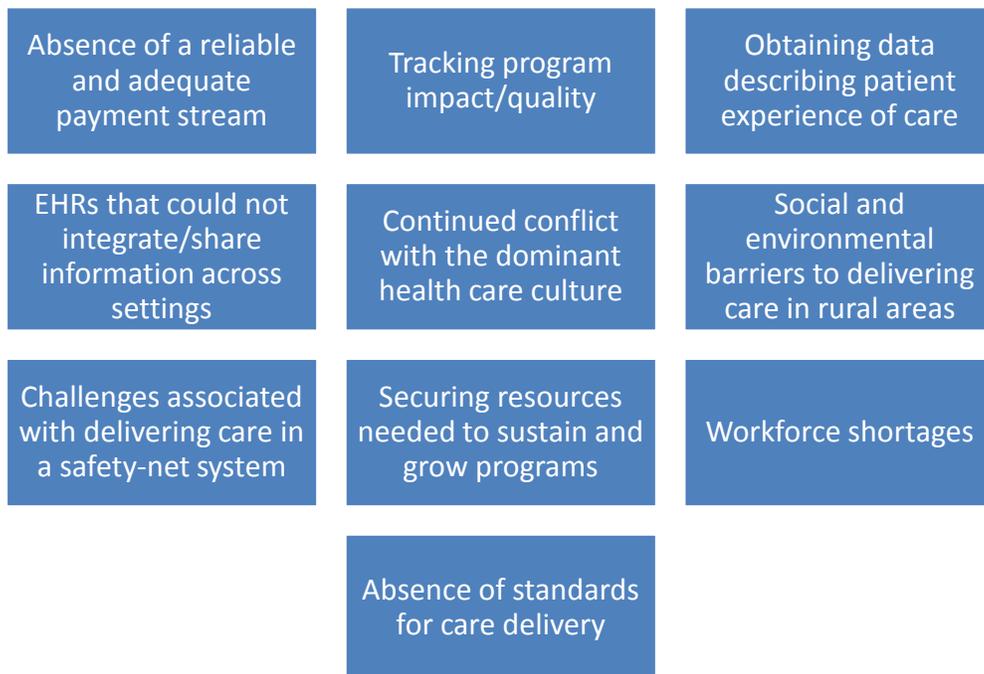> ### Serious illness care in the safety-net
>
> *Providers delivering serious illness care to a safety-net population face an extensive set of distinct challenges. The prevalence of such issues has implications for SIP staffing (e.g., need for abundant social worker effort), training (expertise in substance abuse and mental health care), and assumptions about indicators of care quality (some programs and payers use hospice referral rate as an indicator of quality, but for patients who do not have a home or caregiver, transfer to hospice might not be possible or even desirable.)*

- *High prevalence of substance abuse and mental illness*
- *Socially isolated patients*
- *Mistrust of medical system, providers*
- *Unsafe living situation*
- *Cultural barriers*
- *Communication barriers*
- *Limited health literacy*
- *Limited resources to cover additional medical expenses*

- *Illness discovered late in disease course (as a consequence of access issues)*
- *Access to food, medication*
- *Impaired cognitive function*
- *Staff/provider burnout*
- *Limited social/emotional support*
- *Unstable housing*
- *Limited caregiver support*
- *Absence of transportation / funds to purchase transportation*

Though all profiled programs are well-established, allocation of resources continued to be a challenge for many. Many felt pressured to expand their programs to new patient populations, but an absence of a clear revenue model that would support such expansion remained a barrier. Several noted that even in the setting of adequate funding, workforce shortages made hiring qualified providers a continuing challenge. The intensive workload and emotionally draining nature of the work for care team members create high risk for burnout and turnover, and program leaders noted the need to balance the potentially conflicting priorities of creating programs that were maximally accessible to patients and families while also crafting job descriptions for staff that accommodated work-life balance and promote team well-being.

An absence of tested standards for care delivery was a challenge encountered by several programs, in particular health system-sponsored programs that are looking to spread and sustain programs across diverse markets. An absence of standards was also seen as a barrier for hospice-sponsored SIPs, which were often confronted with the daunting task of managing contracts that called for different sets of services, staffing models, metrics and payment amounts.

*Barriers and challenges*

| Absence of a reliable and adequate payment stream | Tracking program impact/quality | Obtaining data describing patient experience of care |
|---|---|---|
| EHRs that could not integrate/share information across settings | Continued conflict with the dominant health care culture | Social and environmental barriers to delivering care in rural areas |
| Challenges associated with delivering care in a safety-net system | Securing resources needed to sustain and grow programs | Workforce shortages |
| | Absence of standards for care delivery | |

**RESOURCES TO PROMOTE GROWTH AND SUSTAINABILITY**

Program leaders identified several supports that would promote development of new serious illness programs, or that would facilitate the sustainability, improvement and growth of their own programs. These included underline leadership training, in particular guidance on how to navigate "start-up" issues that are commonly encountered when creating new services, or expanding existing services across patient populations, markets or to new payer partners. Exposure to and training in programs that increase efficiency, such as LEAN, was also suggested.

Overwhelmingly, our informants endorsed the need to create opportunities for program leaders and staff to collaborate with peers, to share best practices and lessons learned. Regional or topical collaboratives would be an important adjunct to current opportunities to learn about developments in the field, such as annual conferences. While most program leaders and many of their staff attend such gatherings regularly, few of those events offer opportunities for discussion or to develop longitudinal relationships with peers to explore challenges and solutions.

The majority of program leaders expressed strong interest in efforts aimed at creating care delivery standards, as well as the need to identify feasible, meaningful metrics that would assess adherence to standards and program impact.

Multiple programs noted the difficulties associated with suboptimal IT systems, and saw a need for resources that would support analytic and informatics staff in creating EHR capacity that supports serious illness program workflows and communication needs, as well as data collection and extraction strategies that support quality assessments and rapid cycle improvement efforts.

Many also referenced the need for supports that would promote payer-provider partnerships, as well as policy changes that would create well-defined and easily accessed payment sources for serious illness services. Options for financing interdisciplinary programs that serve patients with traditional Medicare fee-for-service insurance coverage was noted as a particular need.

Many described a need for training in how to achieve culture change within a large organization, as well as methods for promoting better collaboration and integration with specific clinical services such as oncology.

Incorporating telehealth capabilities into their programs was identified as an opportunity, rather than a challenge, and several noted an interest in receiving guidance on best practices, security issues and billing considerations.

*Resources to promote SIP growth and sustainability*

| | | |
|---|---|---|
| Care delivery standards | Opportunities to collaborate and connect with other SIPs | Nationally endorsed feasible, meaningful metrics |
| Well-defined and easily accessed payment sources | Training programs in:<br>•Leadership<br>•Organizational efficiency<br>•Telemedicine<br>•Culture change<br>•Payer-provider partnerships | EHR that supports:<br>•Clinical workflows<br>•Cross-setting and cross-organizational communication functions<br>•Quality assessment needs |

**CONSIDERATIONS FOR ASSESSING PREVALENCE AND CHARACTERISTICS OF SIPs NATIONALLY**

Documenting the prevalence and characteristics of SIPs is a complex proposition. Sponsoring organizations may be hospices, health systems, medical groups, specialty organizations that provide a range of post-acute services, and even health plans. These entities have different types of licenses and are affiliated with a range of professional and trade organizations, meaning there is no single organization all SIPs belong or report to.

Further, sponsoring entities employ a wide range of programs and services to meet the needs of seriously ill individuals and their families; ACE units and bereavement services, system-wide ACP programs and care management services, lay navigation programs and interdisciplinary specialty palliative care services, to name just a few. Health system leaders in particular might consider these types of programs and services to be part of a strategy for meeting the needs of individuals with serious or advanced disease, but they may or may not conceive of them as a distinct "program." For this reason, surveys and interviews should be explicit in defining both the types of interventions that would "count" as being part of a serious illness program (complex case management, specialty palliative care, etc.) as well as the competencies or focus areas of interest. A medical group operating in a rural region may well have integrated the essential elements of serious illness care into their practice, but may hesitate to endorse the idea that they have a distinct serious illness program.

Given the diversity of sponsors and variability of components within a SIP, a layered strategy for identifying programs is almost certainly needed. Membership lists for a range of academic, trade and quality organizations should, when combined and reconciled, yield a good sampling of programs sponsored by health systems, hospices and specialty organizations. A "pre-survey" could be used to determine the identity of the individual(s) within an organization who would be best informed about serious illness services, and could include questions about any organizations the system/plan/medical group contracts with to deliver serious illness care.

*Potential sources for identifying serious illness programs*

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Professional and trade organizations member lists
- American Geriatrics Society
- Center to Advance Palliative Care (CAPC)
- National Hospice and Palliative Care Organization
- Coalition to Transform Advanced Care
- National Comprehensive Cancer Network
- American Society of Clinical Oncology
- American Academy of Home Care Medicine

Surveys and registries
- Hospitals / health systems responding to the American Hospital Association annual survey
- Organizations that contribute to the CAPC registry
- Quality Oncology Practice Initiative sites
- Palliative Care Quality Network sites
- Global Palliative Care Quality Alliance members

Accreditations Certifications and Awards
- Hospices certified by The Joint Commission, the Accreditation Commission for Health Care, or Community Health Accreditation Program
- Commission on Cancer Certified Cancer Centers
- Commission on Cancer certified Oncology Medical Homes
- Organizations that have been recognized by the Circle of Life Award
- Hospitals with Advanced Certification in Palliative Care from The Joint Commission
- Entities with Community-Based Palliative Care Certification from The Joint Commission
- NICHE exemplar sites
- Planetree designated sites

CMS Demonstration/Innovation program participants
- Participants in the Medicare Care Choices Model
- Participants in the Oncology Care Model
- Participants in the ESRD Care Model
- Organizations participating in CMS-sponsored accountable care organizations
- Independence at Home sites

Special units or care delivery organizations
- PACE programs
- ACE units

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Regional Approach

It might be useful to conduct one or a series of focused regional assessments of prevalence and characteristics of SIPs, prior to embarking on a national survey. Exploring the availability of serious illness services in a few representative cities or regions (large metropolitan, suburban, rural, across different regions) would yield useful information about the composition, governance, quality and accessibility of SIPs. At the same time, such a project would improve our understanding best practices for identifying SIPs,

and which individuals/job titles within a range of organization types (health plans, health systems, medical groups, etc.) would be best positioned to report on the structures and operations of their programs.

An important feature of such an investigation would be to consider access from the perspective of patients and families who need support:

- Which services are open to individuals with a range of insurance coverages (Medicare FFS, Medicare Advantage, dually-eligible, Medicaid, and commercial coverage)?
- Which services are available to individuals of different ages?
- Which services are available to individuals with different diseases (cancer, pulmonary disease, heart disease, dementia/frailty, renal disease, or liver disease)?

Programs tend to be unevenly distributed, across regions and populations. A Medicare beneficiary with advanced heart failure living in Manhattan would have a choice of providers of home-based serious illness care; a Medicaid beneficiary with advanced liver disease living in rural California might have no options at all. Exploring prevalence and characteristics by region, insurance coverage and disease could highlight such disparities.

# PROFILES OF EIGHT MODEL SERIOUS ILLNESS PROGRAMS

# Sharp HealthCare's Transitions Program (California)

## PROGRAM AT A GLANCE

*The Transitions program provides specialty palliative care to Medicare Advantage members with advanced chronic illness who are beginning to use the hospital as a tool for managing their illness. The program is built on four pillars: in-home consultation, evidence-based prognostication, caregiver support, and advance care planning. Nurse/social worker teams, under supervision of a physician, provide in-home and phone-based support to address physical and emotional distress, and to proactively prepare patients and families for expected disease progression, with the goal of keeping patients in their homes if that is their preference.*

**Base organization:** Sharp HealthCare, a non-profit integrated health system with four acute-care hospitals, three specialty hospitals, three affiliated medical groups and a health plan

**Year SIP launched**: 2007

**Patient population**: Medicare Advantage members with advanced chronic illness. The most commonly seen primary conditions are heart failure (40% of all cases), COPD (25%), dementia (20%), and frailty (10%).

**Service volume and duration**: about 300 individuals served annually; duration of engagement of 5-7 months, depending on disease group

**Team composition**: Clinical team comprised of registered nurses, social workers, and chaplains, with oversight from a medical director

**Finance model/revenue sources**: Fully supported by the health system, justified by significant reductions in total health care costs for served patients (Sharp is at full risk for this population)

**Selected outcomes**
Patient/family experience of care
- 88% would recommend to others
- 83% taught to manage medications and symptoms

Hospice utilization
- 84-91% hospice enrollment rate (depending on disease)
- Median hospice length of service 15-41 days (San Diego county median LOS = 17 days)

Outcomes for 369 Transitions patients, compared to 1075 matched patients who received usual care
- PMPM costs were $2690-$4,200 lower (varied by disease group)
- 11% of Transition patients with CHF died in the hospital, vs 59% of patients receiving usual care
- 8% of Transition patients with COPD died in the hospital, vs 63% of patients receiving usual care

**Program leaders:** Daniel Hoefer, MD, Chief Medical Officer for Outpatient Palliative Care; Suzi Johnson, MPH, RN, Vice President, Sharp Hospice Care

## To learn more

For a thorough description of the Translons program see: Hoefer DR et al. Development and Preliminary Evaluation of an Innovative Advanced Chronic Disease Care Model. Journal of Clinical Outcomes Management. 2013:20(9);408-18.

For a description of fiscal/utilization outcomes see: Cassel JB et al. Effect of a Home-Based Palliative Care Program on Healthcare Use and Costs. Journal of the American Geriatrics Society 64(11)·September 2016

**PROGRAM PROFILE**

Sharp HealthCare is an integrated health system based in San Diego, California. The system operates four acute-care hospitals, three specialty hospitals, three affiliated medical groups, and a health plan.

Sharp's *Transitions* program provides home-based palliative care for Medicare Advantage members with advanced chronic illness who are beginning to use the hospital as a tool for managing their illness. The program is built on four pillars: In-home consultation, evidence-based prognostication, caregiver support, and advance care planning. Patients remain under the care of their primary or specialty care physician and can continue receiving disease-directed care, with additional support provided by the Transitions program. Care is provided by nurses and social workers, with supervision and consultation from a physician, as well as access to spiritual care from the program's chaplain. The program admits about 300 patients per year.

At the core of the Transitions model is proactive medical and psychosocial care management for patients and families, where care team members help patients and families understand and prepare for the progression of disease through the lens of "not *if* it will happen, but *when*." This "anticipatory guidance" promotes meaningful and practical advance care planning, prevents or mitigates crisis situations, and helps patients continue to live at home when that is their preference. A recent study of program outcomes found that the majority of Transitions patients are never hospitalized in their last year of life.

The target population includes patients with congestive heart failure, chronic obstructive pulmonary disease, advanced stage cancer, end-stage liver disease, advanced dementia, and geriatric frailty syndrome. Patients need not be home-bound or have a skilled need to enroll in the program, though a prognosis of two years or less is required. The patient and family should be willing to attempt in-home disease management strategies and interventions coordinated by the Transitions team instead of first going to the emergency department, and be willing to participate in advance care planning.

**Identifying and engaging with patients**
The majority of referrals come from Sharp HealthCare's outpatient primary care and specialty providers, with occasional referrals from hospital providers or case managers. Patients and families can self-refer, but this is uncommon. Eligibility is determined by disease-specific criteria, biometric markers, and functional status.

The program's approach to managing patients with dementia and frailty – diseases which typically progress relatively slowly – is to focus on patients who are starting to use the hospital to manage decompensation (as indicated by infections, falls, etc.) The goals for these patients are similar to those for the other disease groups: help the patient and family anticipate and prepare for what's coming, keep the patient at home for as long as possible if that is their preference, and transition the patient to hospice care when that care model would better meet their needs. The program has identified the clinical pathways that dementia and frailty patients typically follow and the specific indicators of disease progression, which are used to help families and referring providers recognize when the last phase of life is beginning for these patients. While the overall trajectory for these diseases is longer than the other diseases targeted by the program, the underlying principles of evidence-based prognostication and anticipatory guidance are the same.

**Core services**
Transitions services are provided in two phases:

1) **Active Phase**:  Patients receive nursing services about once a week for four to six weeks, along with social worker visits once or twice in that same time period. These visits are quite structured; the nurses use an assessment algorithm that addresses lifestyle, medication management, symptom assessment, recognition of symptoms and what to do when symptoms arise, activity, diet, completion of POLST forms, and more. The social worker provides structured psychosocial assessments and care planning support. These visits engage both patients and their families, with a focus on aligning the medical and psychosocial care plan with the way the patient actually lives – understanding what will work in the context of that person's values, goals, and priorities.

2) **Maintenance Phase**: For most patients this starts approximately 6 weeks after enrollment. Services include phone calls from the nurse or social worker approximately every other week, a home visit from the nurse every four to six weeks, and periodic visits by the social worker or program chaplain, as necessary.

During both phases, the Transitions team works in tandem with the patient's primary or specialty care provider, sharing information and working collaboratively on developing, implementing and revising the care plan. While the primary or specialty provider remains responsible for delivering primary care and disease-directed treatments, the Transitions team can make recommendations about medical management issues based on patient priorities and their palliative care perspective.

Core services provided by the Transitions team include:
✔ Goals of care discussions and documentation / advance care planning support
✔ Pain and symptom management (in the form of recommendations to primary physician)
✔ Medication management and reconciliation(in the form or recommendations to primary physician)
✔ Communicating medical information / prognostication support
✔ Psycho-emotional support for patients
✔ Psycho-emotional support for family caregivers
✔ Case management /care coordination
✔ Referrals to community resources for assistance with social and practical needs
✔ Spiritual care
✔ Transition support

If patients' stabilize or improve, they are moved back to the medical group's chronic care management team, medical group home visit program, or other supportive services.  As patients decline again, they often come back to Transitions or are admitted to hospice. The goal is to keep the patient engaged in the community-based care continuum, even when not with the Transitions program.

Ninety percent of Transitions patients transition to hospice, likely due to the program's attention to providing education about hospice, and it's focus on preparing patients and families for "what's coming next."  All Transitions nurses can do a hospice admission/intake themselves to provide continuity, and then hand the patient off to the hospice case manager and team.

Transitions patients have access to nurse support 24 hours a day, seven days a week, through Sharp's hospice nurse call center. These nurses have access to information on Transitions patients in the EHR, and can advise patients by phone, contact a physician on call if the issue exceeds the nurse's scope of practice, or can make an after-hours home visit if necessary.

**Interdisciplinary team training and interactions**

The Transitions team meets twice a month, for about two hours each time, to review all new admissions, to highlight any pressing problems with patients, and to run through every patient on service to identify medication issues, goals of care issues, and anything that needs to be done in the near-term for particular patients. The team discusses frailty and dementia patients at one of these meetings, and heart failure, COPD, and liver disease patients at the other meeting. If there are issues that require immediate attention, a team member will call the primary or specialty care physician during or right after the team meeting; for less urgent issues, the nurse will call or e-mail the provider soon after.

All program nurses are Hospice and Palliative Care certified, as is the medical director.

**Documenting patient goals and preferences**

Identification and documentation of patient and family preferences, values, and goals – and development of care plans that align with those goals – is at the core of Sharp's care model. Over time, this has evolved into a system-wide structured advance care planning (ACP) program, inspired by and modeled after Respecting Choices and similar programs. The ACP department houses tools, resources, training, and subject matter expertise in all aspects of ACP and POLST, which are available to all Sharp providers.

For the Transitions program, goals of care and care plan details are documented in the service EHR (AllScripts), which is used by all Transitions care team members. At this time, Sharp HealthCare does not use a single EHR platform, and the platform used by the Transitions team is not inter-operable with the platforms used in other system care areas. Transitions team members have read-only access to their patients' system medical records, so the team can see if a patient has an advance directive on file, review medical information, and so on. Patients' primary providers get extensive paper reports from Transitions on a regular basis, which the primary providers scan into their EHRs. For urgent issues, the Transitions team calls or e-mails primary providers directly. When patients complete advance directive or POLST forms, those are sent to their primary or specialty care physician to sign and upload into the system EHR, making them accessible to medical group providers, and to staff working in the system's acute care hospitals and emergency departments.

**Engaging with and supporting families and caregivers**

Caregiver engagement and support is an integrated part of the Transitions program process of understanding patient and family goals and preferences, and creating a workable care plan.

The Transitions EHR has a location to document name and contact information of family caregivers involved in caregiving or care planning. The program primarily uses phone communication with family members who do not live nearby; however, videoconferencing technologies are used occasionally. Care team members can meet with family members outside of routine business hours, but the ability to do so depends on the availability of individual staff.

***Aggressive Care to Prevent Readmissions***

*The program has an intense focus on recognizing when a patient is at risk of being admitted to the hospital, which triggers an equally intensive focus on managing exacerbations in the home. The program medical director states, "When the last year of life approaches, we treat our patients so aggressively, so proactively and are so mindful of their goals, that they never need to see the inside of a hospital...ever. If it is true that patients are afraid of dying but not death, then we just made that part of life a whole lot better."*

The program uses a structured processes for assessing the needs and well-being of caregivers, in particular the caregivers of patients with dementia and frailty. Though the Transitions program does not run its own caregiver support groups, they can refer family caregivers to other Sharp or community-based groups and resources. The program does provide some pre-bereavement supports, but most bereavement services are provided through hospice.

**Quality monitoring**
The program does not have a regular schedule or format for assessing quality indicators. Intermittently, program leaders assess:
- Productivity assessments by provider and discipline
- % patients who completed advance directives or POLST forms
- Proportion of patients who transfer to hospice
- Average length of stay on Transitions
- Patient/family satisfaction
- Utilization and fiscal outcomes

**Collaborators**
Key internal collaborators include Sharp's primary care physicians, who provide the majority of referrals; specialists, who also refer or advocate that the primary provider refer; and outpatient and hospital-based case management teams, who are often also working closely with these patients and with primary care. The program also partners effectively with Sharp's skilled nursing program (Sharp Extended Care). Opportunities remain to partner more closely with Sharp's home health program.

**Successes and success factors**
Program leaders identified the following areas of excellence:

- Honestly discussing prognosis – one Transitions nurse estimates that about 90% of patients referred to Transitions do not know that their diseases are terminal; in some cases their primary physician may have tried to convey this, but their efforts were not effective. Lack of understanding of the terminal nature of their disease frequently leads patients to treatment choices they would not have otherwise chosen.

- Offering care consistent with realistic, patient-centered goals (as compared to provider- or hospital-centered goals).

- Providing full disclosure about what the healthcare industry can and cannot do for the patients, to help patients and families make informed choices.

- Exceeding the triple aim -- lowering the cost of healthcare while improving care for the patient and community, and also improving care of the caregiver and family.

Factors that have contributed to the program's success include appreciation by patients and families, who report through surveys and ad hoc communications that they love the program, largely because care is brought to them and they have an alternative to calling 911 when they need help. Referring providers also appreciate the program, as they do not have to see their patients as often and when they do, they find that care has been well- managed. The program is also intentionally designed to respect the authority and primacy of referring providers. Another success factor is the fact that the program is economically effective, resulting in a significant reduction in total cost of care.

**Opportunities and challenges**

When asked about opportunities and challenges, program leaders mentioned a need to expand the range of diagnoses served, and to better engage with system oncologists, to increase referrals from that source. And while they have had some success educating their colleagues on what palliative care is and the benefits of palliative care, this work is ongoing.

A broader, ongoing challenge is the current culture in health care of "if you're broken, we will fix you," a stance that is at odds with the Transitions care philosophy, which emphasizes an understanding and acceptance of the natural and predictable progression of chronic illnesses.

**Resources to promote development of similar services**

All features of the program are replicable, especially in capitated systems, or in the setting of any financing model that incentivizes lowering overall costs (as opposed to maximizing revenues.)

Program leaders advise that others looking to develop similar programs should "do their homework and talk to other programs." Education in prognostication and geriatric psychology were also recommended, as was engaging with state and national organizations that have an interest in serious illness care, such as CAPC or CTAC.

KEY FEATURES

✓ Prognostication that focuses on preparing patients and families for the next step in expected disease progression, as opposed to life expectancy
✓ Structured intervention that features two phases, with specific goals and activities for each
✓ Focus on educating and supporting caregivers of patients with dementia

# Lehigh Valley Health Network OACIS / Palliative Medicine Program (Pennsylvania)

## PROGRAM AT A GLANCE

*Lehigh Valley Health Network's Optimizing Advanced Complex Illness Support (OACIS) / Palliative Medicine program provides specialty palliative care in inpatient, clinic and home settings. The program is conceived of as the "safety net" for people with serious illness cared for across the health system, and works in partnership with patients' primary care or specialty care providers in a co-management model. The program has grown significantly since launching in 2006, and palliative care was recently designated as one of the Network's mission goals, making this type of care one of the organization's top priorities.*

**Base organization:**  Integrated, non-profit health system comprised of three full service hospitals, a children's hospital, community health centers and community clinics, home health and hospice services.

**Year SIP launched**:  Inpatient and home-based palliative care services 2006, clinic-based service 2012

**Patient population**:  The home-based service sees patients who have experienced multiple hospital admissions, have uncontrolled symptoms, those with complex psychosocial issues, and those whose health condition is making it difficult to use clinic-based services. The program most often sees individuals with cancer (30% of all referrals), cardiac conditions (30%) and pulmonary conditions (30%).

**Service volume and duration**:  about 4,400 annually, across settings; average duration of engagement for individuals seen by the home-based program of about 280 days

**Team composition**:  Clinical team comprised of physicians, advanced practice nurses, registered nurses, social workers, and medical assistants

**Finance model/revenue sources**:  Major revenue sources include fee-for-service payments, some institutional support from the Lehigh Valley Health Network, and support from a Highmark quality initiative, which incentivizes reaching certain palliative care quality benchmarks.

**Selected outcomes**
Inpatient setting (2,500 consultations in 2015/2016):
- Preferred setting of care documented in 90% of cases
- Surrogate decision maker documented in 96% of cases
- Code status clarified in 90% of cases

Outcomes among 369 patients with advanced complex illness, 18 months pre/post enrollment in the OACIS home-based service
- 44% decrease in number of hospitalizations
- 60% decrease in total inpatient days for all hospitalizations
- 31% decrease in variable cost for all hospitalizations
- 31% decrease in probability of any 30-day readmission

**Program leader:**  Donna Stevens, Program Director

**To learn more** The OACIS program recently published a report of their fiscal and utilization outcomes. See: Lukas L, Foltz C, Paxton H. Hospital Outcomes for a Home-Based Palliative Medicine Consulting Service. Journal of Palliative Medicine, 2013; 16(2):179-184.

**PROGRAM PROFILE**

Lehigh Valley Health Network is an integrated care delivery system based in Allentown, PA. It is comprised of three full service hospitals, a children's hospital, community health centers and community clinics, and offers home health and hospice services. The medical staff includes some 1,300 physicians, including more than 600 who are employed by the Network.

The Network's Optimizing Advanced Complex Illness Support (OACIS) / Palliative Medicine program provides specialty palliative care services in inpatient, clinic, and home settings. The program is conceived of as the "safety net" for people with serious illness cared for across the health system, working in consultation to and partnership with patients' primary care or specialty care providers in a co-management model.

The **home-based service** sees a variety of complex patients who are struggling, as evidenced by multiple hospital admissions, uncontrolled symptoms, or complex psychosocial issues or family dynamics. The service is also aimed at patients whose health condition is making it difficult to come in for office visits with their provider.

The **palliative care clinic** is embedded in the cancer center, so the population is primarily (90%) oncology patients, along with a small number of non-cancer patients who are experiencing troubling symptoms.

The **inpatient consult service** is typically called in when an attending physician is "getting stuck." This could mean the patient is at a crossroads in their disease course and the attending physician does not feel they have the time or skills to talk with the patient and family in depth about care options and preferences, or they need help with eliciting goals and developing a care plan that meets those goals. Approximately 90% of referrals are to address goals of care or to develop symptom management care plans.

Overall, the OACIS/Palliative Medicine program views referring providers as their customers -- if the provider is having difficulty meeting the needs of a seriously ill patient, these services can be a source of support and assistance.

**Identifying and engaging with patients**

The **home-based service** uses disease-specific and general criteria to help referring providers identify the most appropriate patients. About 70% of the patients are referred by primary care practices (by providers, community care teams, PCMH teams, and others), and about 30% are referred by oncologists and other specialists. If the referral comes from any group other than primary care, the OACIS team proactively contacts the primary care provider, to ensure there is no opposition to or concern about the OACIS team's involvement with the patient. While patients and family members cannot self-refer, if they inquire about the program they are encouraged to ask their primary care provider for a referral.

Nearly all referrals to the **palliative care clinic** come from oncologists and oncology care team members. The top three referral sources for the **inpatient service** are general medicine (hospitalists), oncology, and cardiology, with requests coming from physicians, nurses, case managers, and other care team members. Similar to the other settings, patients and families can ask the attending physician to request a palliative care consult, but cannot self-refer.

The program aims to support patients across multiple care settings as their needs change, on an ongoing basis. Some patients access palliative care in only one setting, some in all three. For example, a patient with advanced-stage cancer may be referred to the palliative care clinic by their oncologist. At the initial appointment, which typically takes place within 14 days of referral, a nurse practitioner performs a full history and physical assessment, begins to elicit goals, and begins to develop a plan of care. All notes are documented in the electronic medical record (Epic), so the information flows back to the referring oncologist and primary care provider, and is available to anyone on the care team across inpatient, outpatient, and home settings. If the patient feels it is burdensome to come in to the clinic, and they live in the catchment area for the home-based palliative care service, they can be transferred to that program. NP's can follow patients from the clinic into the home setting, which enhances continuity of care and the development of trusting relationships.

In the home-based program, an NP typically conducts the initial visit alone, but for particularly complex cases may be joined by the social worker. An initial home visit / assessment can take anywhere from one to three hours, and includes history and physical (for new patients), and assessment of patient symptoms, home environment, support resources, and family dynamics. The timeline for follow-up visits varies widely depending on patient need – for example, for oncology patients, the first follow-up visit may be within two weeks; for organ failure, it may be within one to three months; and for dementia, it may be three to six months. Overall, frequency of visits is based on patient need.

**Core services**
Inpatient consults focus primarily on goals of care discussions and pain and symptom management. For community programs, core services include:
- ✔ Goals of care discussions and documentation / advance care planning support
- ✔ Pain and symptom management
- ✔ Medication management and reconciliation
- ✔ Communicating medical information / prognostication support
- ✔ Psycho-emotional support for patients
- ✔ Psycho-emotional support for family caregivers
- ✔ Case management /care coordination
- ✔ Referrals to community resources for assistance with social and practical needs
- ✔ Transition support

Spiritual care is primarily addressed through partnerships with local parishes (though the inpatient program does have access to chaplaincy.) Some limited transportation supports are available through the Lehigh Valley Health Network, and other home-based supportive services are available through some community groups.

If patients stabilize visits can become less frequent, but patients stay in the program for ongoing co-management between palliative care and primary (or specialty) care providers. For patients whose conditions worsen and needs become more intense, many are transitioned to hospice.

The inpatient service is available 24 hours a day, 7 days a week (in-person during the day and by telephone at night). Home and clinic-based services have limited availability outside of business hours.

**Interdisciplinary team training and interactions**
OACIS/Palliative Medicine care team members are expected to sit for their specialty exams within two years of joining the team. New staff members are also required to take online courses through the Center to Advance Palliative Care (CAPC). Team members also sit in on the learning sessions offered by the organization's Hospice and Palliative Medicine Fellowship program, as well as the monthly meetings of the Palliative Medical Scholars program (run by the palliative medicine fellows), which provides primary palliative care education to the wider community of Lehigh Valley staff.

Palliative care team members are all located in one office space, which has helped significantly with team communication. All of the care teams meet frequently to discuss current cases, patients that are transitioning between settings, and core metrics. The inpatient team meets in-person every morning, typically for 30 minutes but sometimes for up to an hour. The home-based team meets in-person three times per week (twice for 30 minutes, once for one hour). The teams start every gathering with a check-in to focus and connect team members. Program leaders note that this substantial investment in team meeting time has not affected their teams' ability to achieve productivity goals (and perhaps has enhanced performance because of clear and frequent communication about patient needs). Program leaders cited the value of these meetings for both clinical care and team wellness.

**Documenting patient goals and preferences**
The care plan and patient's goals of care are documented and continually updated in the EHR; all disciplines document in the EHR in their discipline-specific notes sections. In addition, the team is working on developing a template for an advance care planning tab within Epic that can be easily accessed and updated across care settings (inpatient, ED, outpatient, and home). They have also developed a family meeting template for Epic, which is used in the inpatient setting.

The program does not have a specific frequency or set of triggers for care planning meetings or family meetings – they are simply an integral part of their services and "happen everywhere all the time." Family meetings are a natural part of the inpatient and home-based services, where families are usually present for many interactions with the clinical teams. In the clinic setting, family meetings are planned as a routine part of care, based on patient situation and needs.

**Care coordination**
The program sees itself as the safety net for seriously ill patients cared for throughout the system – once a patient is on their census, they keep close tabs on them and work to address their needs across settings. Patients' primary care and specialty providers are viewed as the most important collaborators for the palliative care team, and the team relies on the EHR and ongoing verbal communications to keep providers informed. There are currently no alerts or "push" mechanisms activated within the EHR to notify providers when a palliative care patient changes care settings or has a significant change in clinical status. The care team keeps each other updated about these types of changes through their frequent team meetings and through manual tracking.

Care coordination is managed by support staff comprised of registered nurses and a medical assistant, who field/triage calls from providers, families, and patients, and assist NPs in transitioning patients to hospice or the hospital when that is indicated. As needed, outpatient RNs call patients between NP home visits, to check on health status.

If a palliative care patient is admitted to the hospital, the home-based RN can see the patient in that setting for a continuity visit and to connect with the inpatient palliative medicine team.

**Engaging with and supporting families and caregivers**
The team social worker provides some caregiver support and connection to community resources. Local parish partners are valued resources for caregiver and spiritual support.

While family engagement is a core part of the program's approach to care, they do not currently have dedicated family/caregiver support resources beyond their social worker. While they would like to accommodate working families and do occasionally hold after-hours family meetings, they struggle with after-hours care generally, as they strive to balance being accessible to patients with having job descriptions and work hours that promote team wellness. They do engage family members by phone, but not via videoconferencing.

**Quality monitoring**
The program has a designated team member responsible for assessing metrics, which are analyzed and reviewed with the larger team on a monthly basis. Program metrics are reported up through the Department of Medicine quality leadership, as well as to the Associate Chief Medical Director.

Routinely monitored metrics / quality indicators:
- Number of referrals and number of patients (actually) seen
- Distribution of major diagnoses
- Distribution of discharge dispositions
- Access indicators (such as wait times for initial visits)
- Goals of care developed/documented
- Length of service
- Satisfaction with program
- Utilization Outcomes
  - Program income
  - Work RVU's, work RVUs/FTE
  - Staffing/support staff ratio
  - Billing revenue/FTE
- Various analyses of fiscal impact
- For the inpatient service specifically
  - Advance Care Planning/Advance Directive completed
  - Surrogate decision maker identified
  - Length of consult
  - Transition out of ICU
  - Transition to hospice
  - Code Status Change

**Collaborators**
Internally, the most important collaborators are the referring providers and staff – the palliative care teams need to truly partner with these colleagues to deliver the best care to their shared patients. Case management/care management programs are also important collaborators; with multiple specialized or home-based support services available to patients, communication with other departments is essential to

making sure the patients get what they need and know who to go to for what. Other important internal partners include psychiatry, since mental health can be a significant issue, as well as home health and hospice, since many palliative care patients utilize those services at some point.

Externally, the program partners with various community agencies to support patients in their homes whenever possible. For example, the local Area Agency on Aging assists with a variety of supportive services, and local parishes have provided valuable spiritual support to patients and families. The program also partners with a local Time Bank program to enable their patients or family members to offer or receive different kinds of volunteer services, which can provide practical assistance to the palliative care patients and families (when receiving help) and a sense of satisfaction and engagement (when giving help).

**Successes and success factors**
Self-identified areas of excellence include their program team, their clinical expertise, their partnership and collaboration both within the team and with referring providers, the effectiveness of their messaging about their service, and the buy-in they have achieved among diverse stakeholders within the Lehigh Valley Health Network. Their continuing growth has been supported by their efforts to identify and come to know the needs of key stakeholders/partners. The team also noted that the equal footing of the program's administrative and clinical leadership has helped ensure that the program has developed in a sustainable way. The strength of the program is evidenced and assisted by its designation as part of the Network's mission goals.

**Opportunities and challenges**
The program has struggled with creating a network-wide perspective on and commitment to advance care planning. Program leaders began offering training in advance care planning across their health system using the Gundersen Health System "Respecting Choices" model, but to date it has not been adopted widely. And while the program has secured additional resources over time, funding / support continues to be a challenge, given the number of patients that could benefit from their services if more staffing resources were available.

KEY FEATURES

✓ Effective internal collaborations, with referring providers, case managers, psychiatry, home health and hospice
✓ Effective external collaborations, with the Area Agency on Aging, local parishes, and a community volunteer Time Bank (where patients and families can secure or offer services)
✓ Enterprise level buy-in, including designation as one of the organization's top priorities

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**Growth over time**
*The inpatient service has grown 60% over the last two years, during which time palliative care was designated as one of the Network's mission goals. In the last year, the program has added one NP, one RN, and one social worker to the home-based service. The volume of the clinic and home-based programs is restricted only by staffing – when new providers are added to the service, their census fills quickly.*

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# ProHEALTH Care Support (New York)

## PROGRAM AT A GLANCE

*ProHEALTH Care Support is a specialty palliative program serving seriously ill individuals through home visits, video-visits, and phone support, provided by teams comprised of nurses, social workers and palliative care physicians. Services include pain and symptom management, support clarifying goals, care plan development, support for caregivers, and 24/7 phone availability. The program has explicit processes for coordinating care and communicating with all involved providers. Volunteers affiliated with the program offer Reiki massage and friendly visiting. Services are available to individuals in the medical group's accountable care organization population, and by contract to commercial payers.*

**Base organization:** ProHEALTH Care, a multispecialty medical group of 900 providers in the New York metropolitan area, with over 200 locations across New York City and Long Island.

**Year SIP launched**: 2014

**Patient population**: Seriously ill individuals identified through systematic analysis of claims data, provided by CMS on a monthly basis for the ACO members, or by contracted health plan partners. Major disease groups include heart failure/cardiac conditions (28% of cases), cancer (20%), and dementia/neurodegenerative diseases (18%).

**Service volume and duration**: about 700 annually; average duration of program enrollment of 6 months

**Team composition**: Clinical teams comprised of physicians, registered nurses, and social workers; volunteers offer Reiki massage and friendly visits

**Finance model/revenue sources**: About 70% of program support comes from the medical group, justified by reductions in health care costs for enrolled ACO patients. Other income is derived from contracts with payers (about 25%), and fee-for-service professional billings (about 5%).

**Selected outcomes**
- Hospice median length of service of 34 days for enrolled patients, compared to 7 days for usual care
- Location of death was home for 85% of enrolled decedents, compared to 25% for usual care
- 48% reduction in health care costs in final month of life, compared to usual care
- Analysis of ACO performance in 2015 showed that, compared to a cohort of similar patients:
  - Acute admits/1000 members was 43% lower for enrolled patients
  - Acute hospital days/1000 members was 54% lower for enrolled patients
  - Median hospital length of stay was 29% lower for enrolled patients
  - % Decedents hospitalized in the last month of life was 47% lower for enrolled patients

**Program leader:** Dana Lustbader, MD, Chair, Department of Palliative Medicine

**Useful reference**
An analysis of ProHEALTH Care Support impact on utilization and fiscal outcomes was recently published in the Journal of Palliative Medicine. See: Lustbader Dana, Mudra Mitchell, Romano Carole, Lukoski Ed, Chang Andy, Mittelberger James, Scherr Terry, and Cooper David. *The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization.* Journal of Palliative Medicine. January 2017, 20(1): 23-28. doi:10.1089/jpm.2016.0265

**PROGRAM PROFILE**

ProHEALTH Care is a multispecialty medical group of some 900 providers, with over 200 locations across New York City and Long Island. *ProHEALTH Care Support* provides palliative care to ProHEALTH patients through home visits, telemedicine (videoconferencing), and phone support. Care is provided by nurse/social worker teams with oversight by and clinical consultation with palliative care physicians. Volunteers affiliated with the program offer Reiki massage and friendly visiting. About 75% of patients served by the program are part of ProHEALTH's Medicare Shared Savings Program Accountable Care Organization (MSSP ACO), which has a total of about 32,000 patients. The remaining 25% of served individuals are members of commercial insurance plans that have fee-for-service, per-enrolled-member-per-month case rate, or shared savings arrangements with ProHEALTH.

ProHEALTH operates in a predominantly fee-for-service market where patients often see multiple physicians from different systems, and where these physicians often do not communicate with each other about the patient's care. In this environment, ProHEALTH Care Support leaders have found their program to be in perfect alignment with the ACO's goals of delivering well-coordinated, high-quality care that improves patient outcomes and costs less than usual care.

**Identifying and engaging patients**
Initially, ProHEALTH Care Support relied on referrals from physicians, but found this to be an unreliable approach to identifying appropriate patients in their system. Today, patients are identified through systematic analysis of claims data, provided by the Centers for Medicare and Medicaid Services (CMS) on a monthly basis for the ACO members, or provided by contracted health plan partners. The program uses an algorithm to identify individuals who are likely to have unmet palliative care needs, using criteria such as recent escalation in emergency department (ED) visits; orders for durable medical equipment (DME) that may signal advancing illness or frailty (e.g., home oxygen, home hospital bed, walker, wheelchair); Hierarchical Condition Category (HCC) codes that signal morbidity or mortality risk (e.g., bedsores, metastatic cancer, sepsis); disease burden as measured by the Charlson Comorbidity Index; and frequent hospital admissions. The algorithm produces a mortality risk score and a hospital admission risk score for each patient. Scores derived from claims data are supplemented with medical record data that assess frailty and functional decline. The program uses a screening tool that assigns points based on age, functional status, living situation, health care utilization, diagnosis, and prognosis, with a threshold score for considering home-based palliative care. In addition, some referrals for ACO patients come directly from ProHEALTH physicians. The most frequent diagnoses among patients in the program are cardiac issues, cancer, COPD, and dementia. Seventy percent of the patients have five or more chronic conditions.

Once patients are identified, ProHEALTH Care Support reaches out to the patient's primary care provider via a templated e-mail. The email notes that this is a high-risk patient who may benefit from support in the home; the provider is invited to "opt out" if they prefer the ProHEALTH Care Support team not contact the patient. If the provider does not opt out, the engagement team will call the patient, explain that they are from ProHEALTH and they work with the patient's doctor, and ask for permission to arrange for a home visit from a team nurse.

**Core services**
Once a patient is enrolled in the program the first visit is conducted by a nurse, in the patient's home. Nurse home visits continue once a month on average; the social worker may make a home visit on a

subset of about 10-20% of patients in a given month.  In-person visits are supplemented with video-visits, for patients who have more acute issues and are able to use a phone, tablet, or computer. Nurses will also sometimes use the videoconferencing technology when they are doing a home visit and want to show another team member something in the moment. Videoconferencing is used with about 20-25% of patients, based on their ability to use the technology and the presence of needs that require a visual check-ins.

Care team members are accessible by phone or videoconference 24 hours a day, 7 days a week, but are not available for in-person home visits after hours. The team uses several strategies to anticipate and reduce the need for after-hours care, including Friday afternoon "tuck-in" calls from the nurse for the highest acuity patients, to make sure all medications are available, needs have been addressed, and to discuss what to do if certain symptoms arise. The on-call provider on the weekend can then proactively call or videoconference with that patient to check in.

When patients have an engaged primary and/or specialty care physician, they continue to receive primary care or disease-directed therapies from those providers, with collaboration from the ProHEALTH Care Support team. For patients without an engaged provider, or for whom getting in to the clinic to see their provider is difficult, the ProHEALTH Care Support team takes on a more active primary care role.

Other core services include:
- ✓ Goals of care discussions and documentation / advance care planning support
- ✓ Pain and symptom management
- ✓ Medication management and reconciliation
- ✓ Communicating medical information / prognostication support
- ✓ Psycho-emotional support for patients
- ✓ Psycho-emotional support for family caregivers
- ✓ Case management / care coordination
- ✓ Referrals to community resources for assistance with social and practical needs.

Spiritual care is not a core service of the program, as most patients who wish to receive spiritual care rely on their own local faith communities.

As patients' conditions worsen, many transition to hospice: about 57% of program patients who die do so under the care of hospice; those who die under care of ProHEALTH Care Support (not hospice) often do not have a hospice-certifiable diagnosis or they do not want to stop some disease-directed therapies. Some patients who stabilize are transitioned back to usual care or case management. Each quarter, the team reviews their entire patient census to identify any patients whose core issues have been addressed and who are functioning well (e.g., minimal or no assistance needed with activities of daily living, gets out of the house regularly, no ED visits or hospital stays in last six months, strong caregiver support). The team communicates with the patient and family, as well as the primary physician and practice care coordination staff (if present) to discuss the disenrollment and address any concerns.  About 10% of patients are returned to usual care each quarter.

**Interdisciplinary team training and interactions**
Services are provided by nurse/social worker teams, with oversight by and consultation with physicians. Each care team "pod" is comprised of one physician, three nurses, and one social worker, which manages

a panel of about 275 patients. Each nurse manages about 80-90 patients, and is viewed by the team as the "CEO of their own company" with responsibility for their patient panel. All team members are enrolled in CAPC online training programs and have strong palliative care clinical skills, and all attend one palliative care conference per year.

All interdisciplinary care team members meet every Monday morning by videoconference for 30 minutes (a "Good Morning Monday" call) to review any urgent issues that came up over the weekend. They also meet in-person every Tuesday and Friday for 90 minutes, to review urgent issues, tough cases, hospital admissions, and which patients they will be referring to hospice that day. For each hospital admission, the team does a deep dive on the specifics of the case, and then all team members vote on whether they think that hospitalization could have been avoided; those deemed avoidable are tracked for each nurse.

Weekly, the physician, social worker and nurse meet to review the sickest patients in that nurse's panel. The nurse selects the top five to ten cases he or she is most worried about for discussion. During these sessions, the physician will electronically refill medications, call other providers, review documentation in the electronic health record (EHR) and offer input on care issues. The social worker will also have input.

**Collaborators**

ProHEALTH Care Support team members often partner with home health nurses and aides to manage clinical issues. When needed, the teams stagger the visit schedule of the home health nurse and ProHEALTH Care Support nurse, to maximize the number of days per week that include a home visit. Additionally, the home health nurse can conduct a virtual visit with the ProHEALTH Care Support physician when the home health nurse is with the patient and identifies a clinical issue that warrants physician input.

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### *Interdisciplinary Team Interactions*

*Every Monday morning the entire IDT participates in a "Good Morning Monday Teleconference Call" to review urgent issues that came up over the weekend. They also meet in-person every Tuesday and Friday, to review urgent issues, tough cases, hospital admissions, and imminent/expected hospice referrals. When an enrolled patient is hospitalized, the team does a deep dive into the specifics of the case, and then all team members vote on whether they think that hospitalization could have been avoided.*

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The program has strong relationships with area hospices and an established referral process that has resulted in a 96% conversion rate for those referred to hospice.

Other important partners are two ProHEALTH Urgent Care centers staffed with Family Medicine physicians who are experienced in managing the needs of frail older adults. During non-business hours, the ProHEALTH Care Support team can send patients to these urgent care centers to address time-sensitive (but not emergency) needs, such as doing an X-ray or draining an abscess.

**Documenting patient goals and preferences**

ProHEALTH Care Support uses the same EHR system as the rest of ProHEALTH's providers. While this system is oriented around billing and coding rather than capturing the complexities of patient care, the team has developed templates to help guide care processes and to document goals of care and the care

plan. One such template serves as a checklist to guide and document conversations about goals, preferences, and values. The template is based on the Serious Illness Communication Guide developed at Ariadne Labs. All care team members can document in the EHR, and these notes are available to all providers across ProHEALTH.

Because ProHEALTH's EHR is not inter-operable with other local hospitals' or health systems' EHRs, communication with outside providers about patient care issues primarily takes place through phone calls. Patient preferences regarding resuscitation and future hospital admissions are documented on the New York State Medical Orders for Life Sustaining Treatment Form (MOLST). The completed MOLST is placed on the refrigerator in a white envelope with the 24/7 telephone number for ProHEALTH Care Support. The MOLST is generally completed by the third home visit.

There is a formal process to review all hospital admissions. For those patients who had a MOLST stating they would not want future hospital admissions, the team does an analysis into what went wrong (i.e. caregiver decision, lack of adequate plan for symptom management, and so on).

**Care coordination**
The nurse is responsible for care coordination for his or her panel of patients, and communicates with all ProHEALTH Care Support team members and the patients' other providers about care needs and transitions between settings. While there are no automated methods by which the nurse is alerted to a patient's change in location of care (e.g., admission to hospital), the relationships between patients/families and their assigned nurses are so strong that the patient or family would typically contact the nurse themselves to share news about an ED visit or hospital admission.

**Engaging with and supporting families and caregivers**
The name and contact telephone number for the patient's medical decision maker is documented in the EHR. The program's use of videoconferencing as a core component of care offers a means of connection and communication with family members who do not live nearby, or who live locally but are unable to leave work to attend a family meeting. A large part of the social workers' role is to support family caregivers, including offering one-on-one counseling to caregivers (separate from the patient), virtual visits through videoconferencing with caregivers, and routinely asking caregivers what they are most worried about with respect to their own well-being. Some community-based support groups are available and care team members sometimes refer caregivers to these.

**Quality monitoring**
A data analyst is responsible for metrics and reporting for the program. The program tracks hospital admissions by provider and by nurse; ED visits by provider and by nurse, patient satisfaction and family/caregiver satisfaction; and cost of care. All metrics are reported to ProHEALTH executive leadership every quarter.
Metrics tracked quarterly:
- Admits/1000 members
- ED visits/1000 members
- Hospital length of stay
- % Decedents referred to hospice
- Mean/median hospice length of service
- % Decedents hospitalized in the final month of life

- Total cost of care per decedent compared to usual care decedents
- Satisfaction survey responses

**Successes and success factors**

The ProHEALTH Care Support medical director cites the "outstanding care team" as the greatest determinant of the program's success. She notes, "The level of passion and dedication of our nurses and social workers is above anything I've ever seen. They all 'love their job' and often call patients during off hours."

Another success factor has been a very supportive physician-led leadership team, which makes it easy to quickly implement adjustments and innovations.

**Opportunities and challenges**

Program leaders note that it has been difficult to achieve rapid scaling of the model to cover a larger service area.  Workforce shortages and competition in the market for talented palliative care providers have been on-going challenges.

**Resources to promote development of similar services**

Program leaders note that development would have been easier if they had had more expertise and experience with starting a new clinical enterprise. Advice for others looking to develop similar programs includes leveraging CAPC resources, getting leadership training, and collaborating with others who are building home-based palliative care services.

KEY FEATURES
- ✓ Use of physician video-visits to supplement home visits by nurses and social workers
- ✓ Partnership with urgent care centers to provide services in off-hours
- ✓ Formal process for reviewing hospital admissions, to identify causes and assess adherence to patient wishes, as documented in MOLST forms

# Four Seasons Compassion for Life Community Palliative Care Program (North Carolina)

## PROGRAM AT A GLANCE

*Four Seasons Compassion for Life provides specialty palliative care in hospitals, nursing homes, assisted living facilities, patients' homes, and outpatient clinics. Hospice services are also available, including a 19-bed inpatient hospice residence. The care model features interdisciplinary collaboration and the integration of palliative care into the health care system, continuity of care across transitions, and longitudinal, individualized support for patients and families. In addition to clinical care, educational programs, consulting, and mentoring are offered through a Center of Excellence.*

**Base organization:** Non-profit hospice and palliative care organization serving western North Carolina, including rural areas

**Year SIP launched**:  Hospice services in 1981; palliative care services in 2003

**Patient population**: For non-hospice services, individuals with any serious illness who are experiencing medical or functional decline, emotional distress and/or have frequent ED visits or hospitalizations. The most commonly referred patients are those with dementia (22% of cases), COPD (14%), and CHF (10%)

**Service volume and duration**: For non-hospice services, about 1,400; average duration of service for community programs of about 295 days

**Team composition**: Clinical teams are comprised of physicians, advanced practice nurses or physician assistants, registered nurses, social workers and chaplain/spiritual care professionals (with chaplaincy support provided by hospital staff in the inpatient setting)

**Finance model/revenue sources**:  For non-hospice services, the majority of revenues (75%) are from fee-for-service professional billing. Remaining support comes from the parent organization (about 10%), grant funds (about 10%), and philanthropy (about 5%).

**Selected outcomes**
Among palliative care patients and families served January 2015-June 2016:
- 63% had an advance directive after an initial palliative care visit
- 94% had a documented code status
- 90% had a healthcare proxy identified
- 86% rated palliative care as excellent
- 85% rated symptom management as excellent
- 84% rated delivered care as consistent with the patient's wishes
- 98% would recommend the service to others

**Program leader:**  Janet Bull, MD, Chief Medical Officer

**Disseminating innovation**

In 2014 Four Seasons, in conjunction with Duke University, received a $9.5 million Centers for Medicare and Medicaid Innovation award to expand their cross-setting model of palliative care to 10 additional counties in North Carolina

**PROGRAM PROFILE**

Four Seasons Compassion for Life provides hospice and palliative care services in western North Carolina. The palliative care program began in 2003 as an effort to support patients across the continuum of care. Today, the program provides interdisciplinary, consultative care in hospitals, skilled nursing facilities, assisted living facilities, patients' homes, and outpatient clinics. Across these care settings, the target population includes individuals with any serious illness who are experiencing medical, functional, or emotional distress and/or have frequent ED visits or hospitalizations. Given the older-than-average population in this geographic area (over 25% of people are aged 65 years or older), and the high rates of tobacco use, the most commonly referred patients are those with dementia, COPD, and CHF.

In the inpatient setting, Four Seasons currently staffs two hospital-based palliative care programs. At one of these hospitals, the palliative care service sees about 10% of all hospital admissions; in the other hospital, they see about five to six percent of all admissions. The care teams include physicians, nurse practitioners or physician assistants, and social workers, with access to hospital chaplains.

In community-based settings (clinic, home, SNFs, assisted living facilities), the care teams include physicians, NPs or PAs, nurses, social workers, and chaplains.

**Identifying and engaging with patients**

Four Seasons has developed written materials that help cue providers about appropriate referrals to palliative care. The organization has also offered community providers extensive education, delivered in group settings and one-on-one, regarding the benefits of palliative care and how to identify appropriate patients. Most referrals to the community-based programs come from physicians and NPs, with occasional referrals from home health or social service agencies. Patients and families can self-refer, but this is not very common; if Four Seasons does receive a self-referral, they will connect with the patient's primary provider to collaborate.

In the inpatient setting, palliative care consults typically take place within 24 hours of referral. For the community-based programs, after a referral is made a nurse will call the patient to do an initial assessment to determine their risk level and key issues. If the patient is coming from the inpatient palliative care service, or if the referring provider notes it is a "stat" referral, this assessment happens as soon as possible, with the goal to see the patient in-person within 48 hours. If it is determined that the patient would best be served by hospice, the palliative care team will work to transition the patient to that service. In the clinics and in home settings, the initial in-person visit is typically made by the NP, PA, or physician. Frequency and duration of follow-up visits depend on the patient's risk level and needs; a high-risk patient may be seen once or twice a week; lower risk patients would be seen much less frequently (at four to six week intervals).

**Core services**

The palliative care team works collaboratively with the patient's primary or specialty care provider to create and implement a care plan based on the patient's goals and preferences. While the primary or specialty provider remains responsible for delivering primary care and disease-directed treatments, the palliative cares team will make recommendations about medical management issues.

Core services provided by the palliative care team include:
✓ Pain and symptom management
✓ Medication management and reconciliation
✓ Goals of care discussions and documentation / advance care planning support
✓ Communicating medical information / prognostication support
✓ Psycho-emotional support for patients
✓ Psycho-emotional support for family caregivers
✓ Spiritual care
✓ Transition support
✓ Care coordination
✓ Referrals to community resources for assistance with social and practical needs
✓ Bereavement support

Of the community-based palliative care patients, about 35% transition to hospice as their condition progresses, and about 10-12% die while on the palliative care service. About 35% of patients are discharged from palliative care when their conditions stabilize. The average length of service in the community-based programs is about eight to ten months.

Across settings, palliative care patients are supported 24 hours a day, 7 days a week; in the vast majority cases after-hours needs can be addressed by phone, but if a visit is needed it will take place.

**Interdisciplinary team training and interactions**
The inpatient palliative care teams have daily team huddles and regular team meetings. The community-based teams meet for 1.5-2 hours every week to review cases, discuss care coordination issues and identify next steps for high-risk patients.

Four Seasons invests extensively in team development. The organization has a Health Resources & Services Administration (HRSA) grant for investigating interprofessional practice collaboration. The grant supports efforts to define team member roles and responsibilities and effective team functioning; providing TeamSTEPPS® training (Strategies and Tools to Enhance Performance and Patient Safety), which focuses on communication and teamwork; implementation of specific communication approaches and tools such as SBAR (Situation, Background, Assessment, and Recommendation); individual and team goal development; and use of Studer leadership training.

All providers are trained through a 40 hour Palliative Care Immersion Course. Goals of care and communication skills are taught and an experiential learning environment builds skills through role plays. New clinicians also have a two month mentoring period.

**Documenting patient goals and preferences**
Four Seasons' approach to palliative care is centered on identifying patients' goals and helping them to develop care plans that reflect those goals, in collaboration with primary care and specialty providers. Currently, all palliative care team members use a hybrid electronic health record system including CareCloud (billing, demographics and document repository), Quality Data Assessment Collection Tool (to document assessments and interventions for each visit), Outlook (for scheduling), and dictation to document visit notes, patient preferences/goals, and the care plan. Team notes are faxed to patients'

primary and specialty providers. Four Seasons works with a number of hospitals, nursing homes, assisted living facilities, and community providers, and there is currently no way for their various electronic systems to interface with Four Seasons' EHR. The organization has engaged a vender to build an EHR template that will integrate data from patient visits, care plans and goals, and the data points that Four Seasons collects in QDACT for quality monitoring.

**Care coordination**
Approximately 85% of patients that receive inpatient palliative care from Four Seasons are subsequently followed by their community-based palliative care program, with a defined hand-off process between settings and a structured risk-assessment process to identify acuity and key needs. Different care team members take the lead in care coordination, depending on the patient's key issues (e.g., medical, emotional, or psychosocial).

*Innovations for rural communities*
*Four Seasons serves a number of rural, low-income counties, where there are numerous challenges to providing regular hospice care home visits. In November 2016, Four Seasons received an award from the Hillman Innovations in Care Program (Principal Investigator: Michelle Webb, MSN, RN, CHPCA.) The grant will support development of a program to provide telehospice services to people in western North Carolina.*

**Engaging with and supporting families and caregivers**
Palliative care team members (especially social workers and chaplains) work with multiple community partners to provide support for families and caregivers. The palliative care teams engage family members in the process of care planning if that is the preference of the patient; and because so many of their patients have dementia, family engagement and partnership is essential. The program has a monthly support group for people with advanced illness and their families, and the same team that provides bereavement services to families of patients who die on hospice is also available to palliative care families. In addition, Four Seasons has a Patient and Family Advisory Group, which reviews palliative care team polices and educational materials.

While the palliative care program does not currently have specific processes to screen/assess/refer caregivers, they are in the process of creating caregiver educational materials, with modules that address coping skills, meditation, and grieving. They also currently have a research study that enrolls patient/family dyads, with the intent to better understand how to support caregivers as they help their loved ones deal with cancer pain.

The organization has focused on making it easier for families to engage with the palliative care teams, and to have a central role in care planning. Team members frequently have family meetings late in the day or early morning hours to accommodate working families. In the hospital setting, this may occur during weekend hours. In addition, they have begun a telehealth program that uses videoconferencing for patient visits, and the expectation is that this technology will also be a useful means of connecting with families.

**Quality monitoring**
Four Seasons has a robust quality monitoring program and uses their daily patient interface / documentation tools to collect data.  Elements of their data collection process have been approved by the Centers for Medicare and Medicaid Services (CMS) as a qualified clinical data registry (QCDR) for the Physician Quality Reporting System (PQRS).

Regularly tracked metrics include:

- Transitions to hospice, deaths while being followed by the palliative care service, hospice deaths (among patients who were followed by the PC service), length of service, and billing by provider

- QDACT Assessment Tool: this tool includes Edmonton Symptom Assessment System scores, prognostication data, Palliative Performance Scale findings, results of spiritual assessment, caregiver burden assessment, referring provider identity and reason for referral, place of referral, disposition, readmissions to hospital, advance care planning questions, and reason for discharge from service. These data are analyzed in a number of ways, to inform understanding of program patients, referral practices, adherence to best practices, and care outcomes.

All inpatient and outpatient palliative care deaths are reviewed to determine if there were barriers to hospice (such as skilled nursing status, goals not aligned with hospice care, family refusal) or if it was a sudden, unexpected event. The program also tracks cases where the care that was delivered did not match MOST (Medical Orders for Scope of Treatment) form specifications, as well as instances where the MOST form was not available at the patient's final care setting.

**Collaborators**
Program leaders state that Four Seasons' most important partners are the entities they serve and the providers that refer patients to the service, including hospitals, nursing homes, assisted living facilities, and community physicians. In addition, home health agencies are important partners both for potential referrals and as co-providers, as many patients use both services. Finally, the program's ongoing academic partnership with Duke University over the past 12 years has been an important factor in the program's growth and ability to build a robust approach to data analytics; Duke is also Four Season's partner for their current CMMI Innovation Grant.

**Successes and success factors**
Program leaders identify several areas of excellence, including data collection and quality monitoring; their focus on patient and family goals of care; efforts to support care team members through education; a mentorship program for new providers; and wellness programs for providers and staff to help prevent burnout. A success factor has been the development of the palliative care program as a core service that aligns with and helps fulfill the overall mission and vision of the organization.

**Opportunities and challenges**
When asked about challenges and areas for improvement team leaders noted delivering care in rural settings; the inability to exchange information across EHR systems; and the diverse needs of a wide variety of stakeholders. The intensive workload and emotionally draining nature of the work for care team members was also noted as a challenge that carries significant consequences, as losing one member can cripple the team's ability to function well. To address this challenge, the organization places a high priority on self-care, and emphasizes that team members cannot say yes to everything and still maintain team wellness.

**Resources to promote development of similar services**
Program leaders note that development would have been easier had they had access to a functional EHR that integrates hospice and palliative care data. They note that organizations looking to develop similar palliative care programs would benefit from familiarizing themselves with LEAN processes, to increase

efficiency. They also recommend their own Palliative Care Immersion Course, which helps standardize care, or similar educational offerings available from national organizations.

KEY FEATURES

- ✓ Interdisciplinary specialty palliative care delivered across the continuum
- ✓ Robust data collection system and quality monitoring program
- ✓ Investment in team training and wellness

# Hackensack Meridian Health Meridian Care Journey (New Jersey)

**PROGRAM AT A GLANCE**
*Meridian Care Journey is a system-wide program that provides palliative care in acute care hospitals, skilled nursing facilities, outpatient practices and in patient homes. Interdisciplinary teams operate across the continuum, serving individuals with chronic illness, with a focus on engaging with patients early in the disease course and assuring continuity over time and across settings. Services are supported by an electronic health record that is available across all system sites, and to affiliated physicians, which alerts the care team and case managers if an enrolled patient engages with the health system at any point of access.*

**Base organization:** Hackensack Meridian Health is a non-profit integrated health network in New Jersey, which includes community and academic hospitals, outpatient care sites, skilled nursing facilities, assisted living facilities, and home health and hospice services.

**Year SIP launched**: Inpatient and SNF-based services 2011; home-based 2012; clinic-based 2015

**Patient population**: Population varies by care setting. For the home-based program, the most commonly seen diseases are heart failure (38%) and COPD (25%); in the nursing home-based program, the most common conditions are heart failure (23%) and cancer (17%); in the clinic setting, the most common conditions are cancer (40%) and heart failure (22%)

**Service volume and duration**: about 6,300 individuals served annually, across the system; average duration of engagement with patients receiving home-based services is about a year

**Team composition**: Clinical teams comprised of physicians, advanced practice nurses or physician assistants, registered nurses (only for the home-based program) social workers and chaplains/spiritual care professionals

**Finance model/revenue sources**: The majority of program revenues (65%) have come from per-member-per-month payments, initially from CMS as part of a demonstration project, now transitioning to commercial payers. Remaining support comes from the parent organization (about 21%), and fee-for-service professional billing (about 14%)

**Selected outcomes**
- Advance care planning discussions were documented in the EHR for more than 91% of enrolled patients receiving home-based services
- Overall patient and family satisfaction with the program is greater than 90%
- For patients enrolled in the home-based program, a 35% reduction in hospital admissions, a 22% reduction in emergency department visits and a 46% reduction in ICU days (vs. historical data)
- Percent of enrolled home-based patients re-hospitalized decreased from 23% in program year 1 to 16% in program year 2

**Program leader:** Amy Frieman, MD, Medical Director, Palliative Care Services

**Recognition from the field**
In 2016 the Meridian program received a Citation of Honor from The Circle of Life Awards, which recognizes innovative palliative and end-of-life care programs offered by hospices, hospitals, health care systems, long-term care facilities, and other direct care providers.

**PROGRAM PROFILE**

*Note: Meridian Health has recently undergone a merger and is now Hackensack Meridian Health; this summary addresses the programs that have been in place at Meridian Health, pre-merger.*

Meridian Health is an integrated health network in New Jersey, comprised of community and academic hospitals, outpatient care sites, skilled nursing facilities, assisted living facilities, and home health and hospice services. With their recent merger to become Hackensack Meridian Health, they now have 11 hospitals and over 6,000 physicians within their system. This summary addresses the services that were developed at Meridian Health, which program leaders aim to expand across the new, larger system over time.

Meridian's palliative care program was developed to serve the full continuum of care, with specialty palliative care services available in each of Meridian's seven hospitals and five skilled nursing facilities, as well as in outpatient clinics and patient homes.

In the inpatient setting, dedicated palliative care teams serve patients with any diagnosis, primarily to provide goals of care discussions, pain and symptom management, or assistance with transitions to hospice. Inpatient palliative care team members include physicians, advance practice nurses, social workers and chaplains. Out of the seven Meridian Hospitals, three (Jersey Shore University Medical Center, Riverview Medical Center, and Ocean Medical Center) have received The Joint Commission's Advanced Certification in Palliative Care, with a fourth hospital applying this year.

Meridian also has palliative care teams in each of their five SNFs; some care teams are shared between SNFs. Their palliative care patients in SNFs tend to be older than those seen in the inpatient setting, and have a wide variety of diagnoses.

The outpatient palliative care practice strives to be a "practice without walls," bringing care as close to patients as possible to make it easier to access services. These clinics exist in various locations up and down the New Jersey coast near Meridian's medical centers, and include free-standing clinics, as well as services that are embedded in oncology and other specialty group practices. The palliative care clinics see patients with any serious illness, including cancer, heart failure, chronic obstructive pulmonary disease, and dementia; to date, the majority of referrals have come from oncology. As the system embarks on a $128 million re-design of cancer care, it is expected that palliative care will be integrated into new multidisciplinary cancer centers, as these are developed.

The home-based program has until recently functioned as a Medicare demonstration project, where Meridian was paid a per-member-per-month care management fee to provide home-based palliative care on an ongoing basis. Throughout the course of the demonstration project, the program served about 3,700 patients in their homes. Care teams of nurse practitioners, nurses, social workers, and chaplains cared for these patients along with the primary care or specialty physician. About 75% or referrals came from primary care, and about 25% from specialty practices, with the most common disease group being cardiac, followed by pulmonary, followed by cancer.

The inpatient, SNF, and outpatient palliative care services are all co-management models, where the palliative care teams work in collaboration with the patient's primary physician (whether that be a primary care or specialty care physician) and also manage some medical issues directly. At this time, the home-based program is a pure consultative model, where the care team makes recommendations to the primary provider, but does not write orders or prescriptions themselves.

**Identifying and engaging with patients**
In the inpatient setting, most referrals come from hospitalists and intensive care unit physicians, and require a physician order.

Palliative care in the SNF setting began as a means of continuing palliative care for patients who had received inpatient palliative care, but SNF staff soon requested access to palliative care for their general patient population as well. Referrals to palliative care in the SNF require a physician order.

Anyone can refer to the **outpatient palliative care service**, including self-referral from patients or families.

Under the demonstration project, the **home-based palliative care program** served people ages 65 and older who had Medicare Part A and Part B (not managed care), who were not enrolled in hospice, and had been assigned a Medicare Severity-Diagnosis Related Groups (MS-DRG) or International Classification of Diseases (ICD) diagnosis code indicative of high severity of illness. For patients meeting eligibility criteria, the palliative care program asked for authorization from the patient's primary or specialty care provider before enrolling the patient, with the provider having the option to decline the service. It is expected that eligibility criteria for the home-based program will evolve, as the program transitions to engaging with commercial payers.

**Core services**
The palliative care teams aim to address all eight domains of palliative care described by the National Consensus Project for Quality Palliative Care. Primary care and disease-directed treatments remain the responsibility of the primary or specialty care provider.

Across settings, the palliative care teams offer the following supports and services:
- ✓ Pain and symptom management
- ✓ Medication management and reconciliation
- ✓ Goals of care discussions and documentation / advance care planning support
- ✓ Communicating medical information / prognostication support
- ✓ Psycho-emotional support for patients
- ✓ Psycho-emotional support for family caregivers
- ✓ Spiritual care
- ✓ Case management and care coordination
- ✓ Transition support
- ✓ Referrals to community resources for assistance with social and practical needs
- ✓ Bereavement support

For the home-based program, patients are stratified into one of three acuity levels, and this stratification guides the frequency of contact. All patients receive at least one "touch" per month, either an in-home

visit or a phone assessment, which are more substantive than just a brief social/check-in call. Patients in level three (the sickest/highest-need patients) require a minimum of one face-to-face visit per month; level two requires one face-to-face visit every other month; and so on. On average, patients receive more than four touches per month.  Overall, about 60% of the home-based care team's touches are face-to-face, the rest are by phone. Under the demonstration project, patients were not discharged from the program unless they transitioned to hospice, changed to managed care insurance, no longer wanted to participate in the program, or died. About 25% of the program's patients die annually, and the average length of service has been about 400 days. Going forward, it is expected that the focus will shift to patients with a prognosis of one year or less, which is likely a sicker group than served currently by this program.

In the inpatient setting, referrals often occur late in the course of illness and the majority of patients either transition to hospice, to a sub-acute setting, or die.

In the SNF and clinic settings, it is rare for palliative care patients to improve so much that they are discharged from the service. Patients whose conditions worsen often transition to hospice.

The inpatient and SNF teams are available 24/7 by phone.  The outpatient and home-based programs currently do not provide 24/7 coverage.

**Interdisciplinary team training and practices**
Staff are required to complete CAPC's online symptom management and communication training modules as part of the orientation process. New hires participate in an intensive proctoring process that includes shadowing experiences in different care settings and with different disciplines. Clinicians are asked to become certified in hospice and palliative care, as appropriate for their respective discipline, preferably within two years of hire.

Each care team meets in person at least weekly to review cases, discuss medical literature, and support each other. In the inpatient and clinic settings, team members communicate about cases and work together routinely, including doing family meetings together. The home-based teams, while more geographically dispersed, are also in very frequent contact by phone and text messaging. In addition, the entire palliative care team (including staff from inpatient, SNF, clinic and home-based services), meets every other month. They have an annual self-care retreat and have begun holding a day-long gathering focused on compassion fatigue.

The program provides ongoing education addressing advance care planning and other palliative care topics through CME/CEU lectures made available to the wider audience of Meridian physicians, nurses and social workers.

**Documenting patient goals and preferences**
A central part of the program's mission is to understand their patients' goals, values, and preferences, and how these change over time. Across care settings, the palliative care teams use standardized processes and forms for common aspects of clinical care, such as initial visit, follow-up visit, psychosocial assessment, and spiritual care. These processes and forms are documented in an EHR developed specifically for the palliative care service (PC EHR), which interfaces with the system's inpatient EHR. The PC EHR is used by the inpatient, SNF and home-based teams (but not currently by the clinic-based

palliative care practice). Every form used in clinical care contains required questions about goals of care / advance care planning, to ensure that this essential topic is assessed and documented initially and on an ongoing basis. Forms include prompts such as checkboxes to indicate whether goals / ACP issues were addressed, whether any follow-up is required, and whether an advance care plan or POLST form is on file. They also include narrative sections that document goals of care discussions.

All palliative care team members document assessment findings and care plans in the palliative care-specific EHR. Goals of care are routinely documented there, and advance directive documents are scanned into the EHR, regardless of where care was delivered (home-based PC team members use hand-held scanners which can be used outside the office setting).

Because all of Meridian's palliative care teams document in the same system, care teams in one setting can see what has already happened with patients who have received palliative care in another setting, which greatly enhances continuity and efficiency.

**Care coordination**
A member of the palliative care team is identified as the primary case manager for each patient, based on the patient's primary needs (i.e., if needs are primarily psychosocial, the social worker would be the primary case manager; if needs are primarily physical, the advance practice nurse would be the primary case manager).  Palliative care providers are automatically notified on a daily basis if any of their patients go to the ED, are on observation status or admitted to the hospital, are discharged from the hospital, are transferred to hospice, or die.

Because the palliative care program operates across the continuum, services can be coordinated to facilitate smooth transitions across settings. For example, if a patient has been followed by the inpatient palliative care team and is being discharged to a SNF, an order for palliative care in the SNF is placed automatically. If an inpatient palliative care patient is discharged to home, they may be referred to the clinic-based palliative care service, as needed.

**Engaging with and supporting families and caregivers**
Family members are a core part of care planning discussions if that aligns with patient preferences. The palliative care service provides a wide variety of support groups, including a support group for caregivers of people with dementia, during which program staff are available to attend to patients, freeing caregivers to participate in the meetings. Social work has also been a strong and growing program component; the home-based program went from one social worker to five, in recognition of the value this discipline conveys to patients and families.

## Helping patients plan ahead

*"They helped me face my mortality, which I was very afraid of. Now, I have all this support and feel so much better. I've made all the decisions for my living will with my two girls and other family members. We're all on the same page now that we've completed my living will. I was able to face it.  I'm not afraid anymore. I probably would've put off the living will knowing my nature. I was afraid that if they took me in and I didn't want to be resuscitated they [the health system] wouldn't help me. The [Care Journey] staff assured me that it wouldn't be like that. It helped clear my mind.  I found that extremely helpful. I feel they're my advocate."*

*- Meridian Care Journey patient*

The program is frequently in phone contact with families who do not live locally, and team members can also be available after business hours, to accommodate working families.  The EHR documents the names of family caregivers. Screenings, assessments, interventions or referrals for caregivers are a routine part of the social worker's role during initial and follow-up visits.  The social workers have also built a network of partnerships with community groups. These include private duty nursing agencies, county transportation agencies, in home psychotherapy groups, and caregiver volunteers, among others.

Overall, more than 90% of surveyed families report being satisfied with the program.

**Quality monitoring**

The program employs a data analyst who uses data stored in the PC EHR to generate quality dashboards for all care settings. Inpatient palliative care programs report up to their respective hospital quality committees and executive leadership committees.

Metrics that are tracked monthly:
- Proportion of patients with:
  - Advance care planning discussion documented
  - Advance care planning document on file
  - Pain assessed
  - Pain addressed
  - Shortness of breath assessed
  - Shortness of breath addressed
  - Nausea assessed
  - Nausea addressed
- Patient/Family Satisfaction
- Number of MD, NP, RN, SW, chaplain visits
- Number of MD, NP, RN, SW, chaplain phone touches
- Bereavement packet sent

**Collaborators**

Within the Meridian system, key collaborators include home care and hospice, as many palliative care patients need these services at some point. A liaison from Meridian's hospice can make home visits with the home-based palliative care team, to help make transitions to hospice easier. Other key partners include Meridian's oncology and cardiology service lines, which have closely collaborated with the palliative care program and developed standing orders for palliative care consults in some settings. The palliative care program has made concerted efforts to educate the system's physicians about what palliative care is and how it can help them and their patients, including 20 continuing medical education lectures delivered in the two months following program launch. Health system leaders have also been important partners, especially as the health system has continued to move towards a population health, value-based approach to care.

Externally, a number of community partners help to support patients in their homes, including physical therapy agencies that can help with home assessments and equipment issues, and social service agencies that can help get home services for people who have limited resources but do not qualify for Medicaid's supportive services.

**Successes and success factors**

Program leaders see managing transitions across the continuum as a strength, with specialty palliative care available across settings and information on assessments and care plans available to all providers through the EHR.  Another strength is their focus on family support and family-oriented care.

In terms of factors contributing to success, participating in the Medicare demonstration project was critical to the growth of the home-based program. In addition, having the ability to collect metrics that demonstrate the program's impact on quality and cost, and organizational leadership that understands the value of palliative care and its alignment with the organization's future in population health and value-based care, have been key success factors.

**Opportunities and challenges**

Program leaders referenced engaging community-based private physicians to refer to palliative care as an on-going challenge, along with receiving referrals earlier in the disease process, and finding qualified providers as the program grows.

**Resources to promote development of similar services**

Program  leaders noted that CAPC recently released a guide to home-based palliative care, including information on staffing, core services, and metrics, that would have been helpful to Meridian's palliative care leaders, and would be helpful to others looking to build similar models.

KEY FEATURES
- ✔ Robust systems for eliciting and documenting patient goals and preferences
- ✔ EHR that notifies the team if a program patient presents to the ED or is admitted to the hospital
- ✔ Robust process for managing transitions

## The Denver Hospice / Optio Health Services (Colorado)

**PROGRAM AT A GLANCE**
*Palliative care provided through three home-based programs, two of which are partnerships with integrated health system Kaiser Permanente. Kaiser Special Services is led by social workers and focuses on clarifying goals of care for people with advanced illness and transitioning them to a care plan and services that support those goals. Kaiser Palliative Care at Home is operated under a home health license, and provides palliative care services from a full interdisciplinary care team: physician, nurse, social worker, chaplain, and pharmacist. For non-Kaiser patients, the Optio Palliative Care at Home model offers home visits from a team that includes nurse practitioners, social workers and patient navigators, and office-based triage support from Registered Nurses.*

**Base organization:** Non-profit hospice and palliative care organization serving seriously ill patients and their families in 9 Colorado counties.

**Year SIP launched**: Kaiser Special Services 2005; Kaiser PC at Home 2007; Optio PC at Home 2008

**Patient population**: Common diagnoses include cancer, chronic obstructive pulmonary disease, congestive heart failure, ALS and HIV.

**Service volume and duration**: Approximately 900 patients served annually, across programs; average duration of engagement ranges from 56 days for Optio PC at Home, to 125 days for Kaiser Special Services

**Team composition**: Clinical teams comprised of physicians, advanced practice nurses, registered nurses, social workers, chaplains and patient navigators, used in different configurations across the three programs.

**Finance model/revenue sources**: About 20% of program support comes from fee for service professional billing, 40% comes from contracts with payers, and small amounts come from non-recurring grants and donations. Remaining programs costs (33-50% in a given year), are covered by the parent organization.

**Selected outcomes**

- 5 Star (out of 5) Rating on the HCAHPS Patient Satisfaction Survey
- HHCAHPS Honor Award winner 2 years in a row

**Program leaders:** Janelle McCallum, President, The Denver Hospice & Optio Health Services; Tim Bowen, President and CEO, Care Synergy Network

**Excellence from the patient perspective**
In 2016 Optio Health Services, for the second consecutive year, was recognized with a Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Honors award, which recognizes home health agencies that provide quality care as measured from the patient's point of view. HHCAHPS Honors recipients include those agencies score above the national average on at least eighty-five percent of the HHCAHPS satisfaction measures.

**PROGRAM PROFILE**

The Denver Hospice provides hospice and palliative care services to patients with advanced illnesses and injuries throughout nine Colorado counties–from Boulder to Castle Rock and from Golden to Bennett. Optio Health Services, the palliative care arm of The Denver Hospice (TDH), provides palliative care services under three home-based programs, two of which are partially funded by and operated as partnerships with integrated health system Kaiser Permanente.

Kaiser Special Services is led by social workers and focuses on clarifying goals of care for people with advanced illness and transitioning them to a care plan and services that support those goals. The social worker team lead can bring in a nurse or chaplain as needed. Patients in this program receive an average of 2.5 home visits from a social worker to define and document goals of care, and are then transitioned back to their primary or specialty provider, to Kaiser Colorado's palliative care clinic, the Kaiser Palliative Care home-based palliative care program, or to hospice.

**Kaiser Palliative Care at Home is operated by TDH / Optio under a home health license, and provides** palliative care services from a full interdisciplinary care team, including physician, nurse, social worker, chaplain, and pharmacist. Patients receiving these services must be home-bound. This model includes home visits from the physician and other team members as needed (including an initial joint visit with the physician and nurse.) Enrolled patients can continue to receive concurrent disease-directed care. Target populations for both Kaiser programs are patients with cancer, chronic obstructive pulmonary disease, congestive heart failure, ALS or HIV. Referrals for the two Kaiser programs come from Kaiser providers, typically from hospitalists or other inpatient providers, or clinic-based care teams.

Non-Kaiser patients are served by Optio Palliative Care at Home, a specialty palliative care service provided by nurse practitioners, social workers and patient navigators. The target population for this program includes patients who are anticipated to be appropriate for hospice in the next year or two. Patients can have any serious illness with associated physical or emotional needs, generally excluding patients with non-malignant pain and psychiatric illnesses. Referrals can come from any inpatient or community-based provider, or patients and families can self-refer. Home visits can take place in private residences (which is the case for about 80% of cases), or in assisted living or skilled nursing facilities.

**Core services**
All referrals come in to The Denver Hospice / Optio Health Service's admissions department, which works with both the hospice and palliative care sides of the organization. TDH/Optio encourages simultaneous referrals for both hospice and palliative care, so that admission staff has flexibility in working with the patient to determine which program is most appropriate.

For Kaiser Special Services, the social worker conducts all visits, with assistance from nurse and chaplain colleagues as needed. For Kaiser Palliative Care at Home, the initial visit is conducted by the physician and nurse together the vast majority of the time, and follow-up visits are conducted by different team members depending on the patient's and family's needs. For Optio Palliative Care at Home, the nurse practitioner conducts a full assessment after the admissions visit, and manages care on an ongoing basis or brings in other care team members for follow-up visits as needed.

When patients in the three programs meet the eligibility criteria for hospice and are emotionally ready for and accepting of hospice, they are transitioned to hospice. If patients stabilize (or in the case of Kaiser Special Services, when they have worked through the process of identifying and documenting goals of care), they get discharged back to their usual provider or chronic care management program, or in the case of two Kaiser programs they may transition into Kaiser's palliative care clinic.

Kaiser Special Services focuses on goals of care discussions and documentation / advance care planning, as well as psycho-emotional support for patients and families and spiritual care when appropriate.
For Kaiser Palliative Care at Home and Optio Care at Home, primary care and disease-directed treatments remain the responsibility of the primary or specialty care provider.  Core services provided by these palliative care teams include:

✔ Goals of care discussions and documentation / advance care planning support
✔ Pain and symptom management
✔ Medication management and reconciliation
✔ Communicating medical information / prognostication support
✔ Psycho-emotional support for patients
✔ Psycho-emotional support for family caregivers
✔ Case management /care coordination
✔ Referrals to community resources for assistance with social and practical needs
✔ Spiritual care
✔ Transition support

All of Optio's programs have accessibility 24 hours a day, seven days a week, available through phone contacts or in-person visits, if needed.

**Interdisciplinary team training and interactions**
Optio has a robust collaborative culture, borne from the organization's roots in hospice and home health. All programs meet formally every two weeks, but communicate about patient status and needs routinely outside of these meetings.  Team members have office space in the same location, which also facilitates team interaction and communication.

**Documenting and acting on patient goals and preferences**
For all of Optio's palliative care programs, working with patients and families to clarify goals of care and determine appropriate next steps to achieve those goals is a core activity. Goals, care plans, and advance directives are documented in Optio's EHR (AllScripts), and are discussed at interdisciplinary team meetings, which include both Optio care team and Kaiser home-based palliative care team members. For the Kaiser Palliative Care at Home and Optio Palliative Care at Home programs, goals and care plan are revisited over time. All Optio palliative care team members are able to document in Optio's EHR, and while this system is not interoperable with Kaiser's EHR, providers from both organizations can send and receive secure e-mails and Optio has read-only access to Kaiser's EHR for their shared patients. Kaiser's ED physicians do not have access to Optio's documentation unless a Kaiser team member uploads the material into Kaiser's EHR.

For non-Kaiser patients in the Optio Palliative Care at Home program, team members document in Optio's EHR and the nurse practitioner faxes the encounter notes to the primary physician.

**Care coordination**

In the Kaiser programs, Optio and Kaiser providers collaborate closely to keep each other apprised of changes in patient clinical status or location of care, though this is done manually on a case-by-case basis (not through automated systems). The Kaiser EHR system contains a flag to indicate if a patient is enrolled in an Optio palliative care program.

If Kaiser patients are admitted to the hospital, they may then be followed by Kaiser's inpatient palliative care team.

Optio's care teams work with patients' other providers to coordinate care and facilitate smooth transitions. There is not a specific Optio care team member with a formal care coordination role.

*Optimal care requires attending to clinical and practical needs of patients and families. Program leaders point to a recent case where the TDH team was able to attend to the needs of an indigent, Spanish-speaking family. In the span of a few weeks, the program's Spanish-speaking Patient Navigator arranged for a transition to safer and better housing, as well as a range of social support services– critical complements to the care coordination and pain and symptom management provided by other team members. In the words of the family, "We could never have managed this time without you."*

**Engaging with and supporting families and caregivers**

Caregiver engagement and support is an integrated part of the process and plan of care for all Optio programs, as patients and families are considered one unit of care. The Denver Hospice has extensive caregiver support and bereavement staff and resources, all of which are available to all Optio families. Optio's EHR templates document the presence and identity of family caregivers. Team members can be available to meet with family after business hours to accommodate working families.

**Quality monitoring**

Optio's quality and compliance department oversees quality monitoring for both hospice and palliative care. Their partners at Kaiser Permanente also track quality metrics, timeliness of care, service failures, as well as Outcome and Assessment Information Set (OASIS) and CAHPS performance. Optio's program leaders feel that grant-making organizations could make a substantial impact on the ability of serious illness programs to develop and track quality metrics focused on outcomes, rather than processes.

Metrics/Quality Indicators:

- Pt/Family Satisfaction Survey results based on HHCAHPS (publicly reported)
- Quality of Patient Care Survey results based on OASIS data (publicly reported)
- Portion of patients that receive advanced care planning interviews
- Re-hospitalization rates
- Percent of patients who transition from palliative care to hospice

**Collaborators**

The most important collaborators for Optio are the hospitals and health systems that are their main referral sources, and the payers that they contract. In addition, Optio partners with other organizations that help support patients in their homes, such as home health, private-duty non-medical support services, and community organizations such as Meals on Wheels, the Red Cross, and Project Angel Heart that help keep patients safe at home and assist with issues like transportation and getting patients the medications they need.

Another important collaboration is with the Care Synergy Network, the parent organization of TDH, which includes three other not-for-profit affiliates that all provide hospice and palliative care. Launched about a year and a half ago, the Care Synergy Network provides back office, mission-support services to their affiliate organizations, such as IT, finance, contracting, quality, and compliance. Centralizing these functions aims to help these non-profit providers achieve some efficiency to aid their sustainability and growth.

**Successes and success factors**

Program leaders note Optio's success in delivering a high-quality care experience through a collaborative model with Kaiser Permanente.  Another strength is their proactive approach to patient care, reaching out to patients to help prevent crises and help prepare them for next steps in their care, and their willingness to take care of patients regardless of their insurance status / ability to pay. Another strength has been their willingness to change their model over time to adapt to a changing payment landscape.

Their long partnership with Kaiser has been instrumental to their success in palliative care, and has been characterized by two-way communication and motivation for developing and implementing new collaborative care models and benefits.

Optio leaders feel that their overall care model is replicable and scalable if there was a viable long-term economic model.  While Optio's partnership with Kaiser is unique, the model of an insurer paying a hospice organization to provide non-hospice palliative care is replicable.

**Opportunities and challenges**

Opportunities for improvement include better tracking of outcome metrics, doing even more robust caregiver support, and possibly building telehealth capacities over time.  The ongoing challenge for Optio is economic sustainability – as interpretations of home health and hospice eligibility have narrowed, Optio's palliative care program is caring for more patients with chronic, deteriorating conditions over a longer period of time, without the structure or payment mechanisms of home health and hospice.  A reliable and adequate payment stream for palliative care remains a significant challenge.

**Resources to promote development of similar services**

Economic stability and well-defined payment sources would have made program development easier and would help to spread and sustain the program.

KEY FEATURES
- ✓ Multiple programs to accommodate different funding options

✓ Partnership with an integrated health system, where program staff coordinate care across settings with the health system's specialty palliative care teams
✓ High patient and family satisfaction with the program

# University of Alabama Birmingham, Center for Palliative and Supportive Care (Alabama)

## PROGRAM AT A GLANCE

*The University of Alabama Birmingham, Center for Palliative and Supportive Care offers an array of palliative and supportive services to individuals with serious illness cared for by the health system. Core components include an inpatient palliative care consultation service, a dedicated palliative care unit, supportive care and survivorship clinics, a telemedicine program that offers psychoeducational support to patients and family caregivers, and a community health advisor training program. In addition to clinical programs, the center is active in educational and research arenas.*

**Base organization:**  Large academic health system offering a full spectrum of specialty and primary care; the system operates 1100+ acute care beds, an NCI designated cancer center, and 6 community clinics

**Year SIP launched**:  psychoeducational coaching for patients and families (ENABLE) 1999; palliative care clinics 2001; inpatient consult service 2004; inpatient palliative care unit 2006; lay navigator program (Patient Care Connect at UAB) 2013

**Patient population**:  The program sees individuals with a wide range of serious illnesses; common conditions include COPD (17% of all patients), heart failure (12%), and cancer (10%).

**Service volume and duration**: about 2,500 annually, across programs; average duration of engagement in community settings of several months

**Team composition**: Clinical teams comprised of physicians, advanced practice nurses, registered nurses, social workers, chaplains, counselors and a music therapist

**Finance model/revenue sources**: About half of program income comes from fee-for-service professional billings, 30% is provided by the health system, and 20% comes from donations

**Program leaders:**  Rodney Tucker, MD, Director, UAB Center for Palliative and Supportive Care; Marie Bakitas, DNSc, APRN, Associate Director, UAB Center for Palliative and Supportive Care

### Improving care with lay navigators

Patient Care Connect, a program initially funded by a CMMI Health Care Innovation Challenge Grant, is a central component of cancer care at UAB. The program employs lay navigators who provide patients with information about cancer treatments, support in making informed care choices, emotional support and assistance with overcoming common barriers to accessing cancer treatment.  A recently published analysis of the program showed that compared with matched non-navigated patients, patients participating in the program had fewer emergency department visits, fewer hospitalizations, fewer intensive care unit admissions and lower costs of care.

For more information see:  Gabrielle B. Rocque, MD; Maria Pisu, PhD; Bradford E. Jackson, PhD; et al. Resource Use and Medicare Costs During Lay Navigation for Geriatric Patients With Cancer. JAMA Oncol. Published online January 26, 2017. doi:10.1001/jamaoncol.2016.6307

**PROGRAM PROFILE**

The University of Alabama at Birmingham (UAB) Health System is an academic health center located in Birmingham, Alabama. The system has over 1,100 acute care beds and an NCI designated cancer center. It is the largest academic medical center in Alabama and one of the largest in the United States, offering a full spectrum of specialty and primary care.

The UAB Center for Palliative and Supportive Care was formed in 2000, as a joint effort between the School of Medicine and School of Nursing. From its inception, the Center has focused on an interdisciplinary approach to proving comprehensive palliative care, integrating care from physicians, nurses, social workers, chaplains/pastoral care, and psychology. In addition to clinical care delivery, the Center also focuses on community education and outreach, advancing knowledge through research and educating health care providers and trainees in primary and specialty palliative care.

Today, the core components of the clinical program include:

- **Inpatient consult** service at all UAB hospital facilities (two campuses), the Birmingham VA hospital, and the Children's Hospital of Alabama

- **Inpatient palliative care units** at UAB (12 beds) and the VA (10 beds)

- Palliative care **clinics**, including Supportive Care and Survivorship Clinics housed in the UAB ambulatory practice building and at the VA, and palliative care clinics embedded in HIV and heart failure practices

- An **emerging home-based model** that can provide continuity of care for patients who have received care from the inpatient or clinic programs (if they live within a 50-mile radius), with the intention to reach new patients by partnering with UAB's existing geriatrics home visit program

- **ENABLE**, a telemedicine program that offers psycho-educational support to patients and family caregivers

- Community health advisor model, **Patient Care Connect**, which trains and employs lay health advisors/ navigators to support patients with cancer.

In addition, UAB's insurance product, VIVA, has a contract with Aspire Health, a specialty organization that offers home-based palliative care. The UAB palliative care program refers patients with appropriate insurance to Aspire, if they live outside of catchment area for UAB's own home-based palliative care service.

Two clinical services, ENABLE and Patient Care Connect, were developed with major research funding. ENABLE (Educate, Nurture, Advise Before Life Ends) is a telehealth support program that was initially launched at the Norris Cotton Cancer Center at Dartmouth-Hitchcock, in Lebanon, New Hampshire. At UAB, the model uses nurse coaches to help empower patients and their caregivers and to improve their quality of life. The intervention includes an initial in-person standardized assessment by a palliative care physician or nurse practitioner, followed by four to six phone sessions with nurse coaches focused on problem-solving, communication, symptom management, advance care planning, and life review/conflict resolution (the latter sessions use the Outlook model developed by Karen Steinhauser, et. al. at Duke). The coaches also use a self-paced educational curriculum, "Charting Your Course," (CYC) with patients and caregivers during these sessions. Ongoing monthly phone follow-up continues after the initial structured

sessions. The goal of the CYC curriculum, based on Wagner's' Chronic Illness Care model, is to promote self-management and decision support to create activated, empowered patients. Activated, informed patients: 1) ensure clinicians are aware of their personal values, life circumstances, and expectations for care, 2) seek needed information and support for self-care management, and 3) feel empowered to participate in decision-making.

Since 2012, UAB has been engaged in a research project, first as a pilot and now as a randomized controlled trial, to compare the outcomes of patients with heart failure and their caregivers who are exposed to usual heart failure care versus usual heart failure care plus ENABLE: CHF-PC (Comprehensive Heartcare For Patients and Caregivers). The ENABLE: CHF-PC program is embedded in UAB's Advanced Heart Failure Clinic and Transitional Care Clinic, a HRSA-funded, nurse-run clinic for uninsured and underinsured heart failure patients recently discharged from UAB Hospital, and the Birmingham VAMC. Eligible patients are identified and recruited into the study through systematic screening of patients being seen in these clinics; these include those aged 50 and older, with a diagnosis of New York Heart Association (NYHA) stage 3 or 4 heart failure, or American College of Cardiology (ACC) stage D.  While the ENABLE model is structured as primarily phone-based, some patients who have unreliable phone access participate in in-person coaching sessions when they come in to the clinic to see their provider.
UAB is also running an implementation research study through a grant from the American Cancer Society, focused on implementing ENABLE as standard of care for people with cancer. UAB is one of four sites in this study (the Birmingham VA is another.) At UAB, ENABLE if offered to newly diagnosed leukemia patients who are undergoing initial inpatient treatment and can participate in several ENABLE coaching sessions while they are in the hospital, with remaining sessions offered post discharge.

UAB's Comprehensive Cancer Center also runs the Patient Care Connect program, which was developed with the support of a $15 million CMMI Innovation Grant.  In this model, trained non-clinical patient navigators are employed by the health system to provide coaching and support to adults aged 65 or older who have cancer. The goals of the program are to improve the quality of life of people with cancer and their families, to support patients and families as they go through treatment and consider different care options, to reduce the use of ineffective therapies (e.g., chemotherapy in the last two weeks of life), and to maximize appropriate use of health care resources, including reducing ED visits and unnecessary hospital and ICU days.

**Identifying and engaging with patients**
UAB's inpatient, clinic and home-based services seek to serve patients with serious illness whose primary or specialty care providers would respond "no" to either of the following questions:

- Would you be surprised if this patient could no longer come in to the clinic or died in the next 12 months?
- Would you be surprised if this patient is admitted to the hospital three times in the next 12 months?

In the inpatient setting, the top three referral sources are Oncology, Pulmonary and General Medicine (Hospitalist) services, with nearly all referrals coming from physicians. Referrals to clinic and home-based services come most frequently from oncology, cardiology, pulmonary and HIV providers, along with some referrals from case management. Patients and families can self-refer to community services, but a physician order is required in the inpatient setting. Across these care settings, the most commonly

referred patients are those with cancer, heart failure, pulmonary conditions (e.g., COPD), and neurological issues. The inpatient consult service also sees trauma patients, and the community services see a number of patients with frailty/multi-comorbidity.

For the inpatient and community-based PC services, all referrals go through Palliative Care Coordinators (nurses), who triage referrals. In the inpatient setting, the initial visit is done by an NP, PA, or attending physician/fellow.  In the clinic setting, initial visits are conducted by the NP, PA, or attending/fellow. Frequency and staffing of follow-up visits are determined by patient need, and may include NP, PA, attending/fellow, psychologist, dietician, chaplain, massage, and physical therapy, as needed.

Some patients cared for by the inpatient service are referred to the clinics at discharge, some are referred to the home-based service and many are discharged with hospice. For about 20% of hospice referrals the palliative care physician continues to follow the patient as the attending of record.

**Core services**
Across care settings, palliative care teams provide consultative services to the referring provider, and co-manage some problems such as pain and other symptoms or emotional distress.

Core services include:
- ✓ Goals of care discussions and documentation / advance care planning support
- ✓ Pain and symptom management
- ✓ Medication management and reconciliation
- ✓ Communicating medical information / prognostication support
- ✓ Psycho-emotional support for patients
- ✓ Psycho-emotional support for family caregivers
- ✓ Case management /care coordination
- ✓ Referrals to community resources for assistance with social and practical needs
- ✓ Spiritual care
- ✓ Transition support
- ✓ Bereavement support

Volunteers help patients navigate iPad-based surveys in the outpatient clinic, check on patients while they are waiting to be seen, and provide emotional support to patients and caregivers.

All palliative care patients have access to phone support from a palliative care physician 24 hours a day, 7 days a week.

For ENABLE, the nurse coach focuses on coaching patients and their caregivers to advocate for themselves, as well as focusing on goals of care / advance care planning, psycho-emotional support for patients and caregivers, and helping patients and caregivers prioritize, assess and report their symptoms in order to get their needs met by their providers.  There are times when the nurse coach identifies or hears about symptom issues in the moment and intervenes to provide relief, but the overall focus is helping the patient and family to problem-solve to get what they need.  Heart failure patients and their caregivers participating in the study are followed for 48 weeks. If they have continuing needs they may also be followed by palliative care providers at UAB or in their home community. For the cancer

population, follow-up care by other palliative care providers will occur as determined by patient/caregiver need*.*

**Interdisciplinary team training and interactions**
The overwhelming majority of the program's physicians are Board Certified in Hospice and Palliative Medicine. Nurses are encouraged to become certified in Hospice and Palliative Care, but this is not required. Most of the program nurses are ELNEC trained.

Every interdisciplinary palliative care team meets once or twice a week to discuss patient issues; the ENABLE nurse coaches also participate in these IDT meetings, when possible. In addition, in the inpatient setting the consult and palliative care unit teams huddle each morning and round on all service patients. The Palliative Care Coordinator serves a single point of contact for the care team and the referring providers.

**Documenting and acting on patient goals and preferences**
The palliative care teams use standardized EHR templates to document notes from new consults and follow-up visits, in both inpatient and outpatient settings. This includes standardized approaches to eliciting and documenting patient goals, preferences, and values, and a separate template process related to discussions of code status.  All team members can document in the EHR (except for the psychology students that work with the team, whose notes are vetted by their clinical directors before being entered in the record). Visit notes and documentation of goals and preferences are accessible to UAB's emergency department providers, but these providers would need to look for this information in the clinic notes (goals are not flagged or made more prominent for palliative care patients in the EHR).

**Care coordination**
The nurse Palliative Care Coordinators in inpatient and outpatient settings play the lead role in care coordination and helping to facilitate smooth transitions and information exchange between providers. The care team uses the EHR documentation template and message center to coordinate care with their patients' primary and specialty care providers if they are within the UAB system, which the vast majority are. The EHR also has a patient portal that enables the care team and referring providers to communicate with patients. Team members also call patients' other providers to keep them posted of any changes in clinical status or care setting.

Cancer patients cared for in the clinic and home-based programs are supported by both a health system based nurse navigator, and a community based community health advisor who work together to ensure that patients are supported through transitions into and out of the formal health system, whether that is the cancer treatment center or the hospital.

**Engaging with and supporting families and caregivers**
The palliative care EHR templates used in both the inpatient and outpatient settings include sections for family / caregiver information, and it is standard practice for the care team to develop an understanding the patient's support system. The care team can also provide distress screening and psychological and pastoral supports to caregivers, as needed. Team members routinely connect by phone with family members who are unable to participate in family meetings in person.  The program's counselors are also available to talk to family members as part of bereavement support after a death.  Interpreters are available in both the hospital and clinic settings.

The ENABLE model is centered on both the patient and the caregiver as a unit, so support of family caregivers is integrated into every aspect of that model.

**Education and outreach**

All Medicine Residents rotate through the palliative care program and receive training in breaking bad news, appreciating patient goals of care, shared-decision making and similar skills. The program also trains UAB Case Management and Social Services staff in these areas.

**Quality monitoring**

The Director and Associate Director meet with key administrative stakeholders once or twice a year to discuss progress, strategy, and to review quality metrics.  Individual medical directors at the various clinical sites also report statistics and metrics through their respective quality and patient experience councils.

Some routinely monitored metrics include ratio of observed vs expected deaths in the PC unit, number of direct admits to the PC Unit from ED, and admissions to the PC unit within 24 hours of hospital admission.

While the program routinely tracks operational metrics such as number of patients served and discharge disposition, program leaders have found it very difficult to track patient-reported outcomes such as pain or symptoms through their EHR. Their ambulatory program uses a stand-alone database to track patient-reported outcomes, but these data are not linked or imported into the larger system medical record.

**Collaborators**

Important collaborators include system providers who refer patients and lead clinical programs throughout the system, as well as educational faculty. A Community Advisory board that represents stakeholders outside of UAB has offered valuable input, and collaborations with health system administrative leaders and the system's payer product, VIVA, have been crucial. Affiliations with external entities that focus on palliative and supportive care, such as AAHPM, CAPC, NHPCO, HPNA, and PCRC have also been important

**Successes and success factors**

When asked about success factors program leaders cite investing in a fellowship training program and a focus on philanthropic development. They state further that partnership between the School of Medicine and the School of Nursing, and centering those efforts in the Center for Palliative and Supportive Care, has helped the program maintain strategic alignment across a wide array of programs and focus areas.

When asked about areas of excellence program leaders mention the breadth of their clinical services and their training programs, which engage some 100 unique learners per year from the schools of medicine and nursing. Leaders also note that they enjoy tremendous support from hospital and health system administration, and generous support from the community in terms of philanthropy. Leaders also felt that their status as one of CAPC's designated Palliative Care Leadership Centers has been tremendously beneficial to the program.

**Opportunities and challenges**

Tracking clinical quality outcomes has been an ongoing challenge. Leaders also struggle to manage requests to expand community services to new clinical areas, such as transplant and heart failure, while

endeavoring to maintain adequate staffing for existing services. They report that some staffing challenges have been overcome by fulling embracing the advanced practice provider model and allowing those staff to practice to their full scope.  A robust fellowship program and a training program for nurse practitioners have also created a reliable stream of new team members.

**Resources to promote development of similar services**
For others who are looking to develop new services, UAB leaders recommend pursuing a diverse revenue stream that includes income from educational, research, technical assistance and clinical work. They recommend developing relationships with national and regional philanthropies, investing in a Community Advisory Board and nurturing a close relationship with Development offices.

KEY FEATURES

- ✓ Integration of disease directed care and palliative care, especially for cancer patients
- ✓ Using a strong research program to fund, develop and deploy service innovations
- ✓ A Palliative and Supportive Care Center, jointly led by the School of Medicine and School of Nursing, that focuses on clinical care delivery, research, community education and outreach, and educating health care providers and trainees in primary and specialty palliative care

# UnityPoint Health Palliative Care Services (Iowa/Illinois/Wisconsin)

**PROGRAM AT A GLANCE**
*The UnityPoint Health program provides inpatient, clinic-based, and home-based palliative care across an integrated health system serving nine regions throughout Iowa, western Illinois and southern Wisconsin. In each region the palliative care program is co-led by a physician and clinical administrator, and consultative care is provided by interdisciplinary teams. A system-wide clinical administrator oversees the regional programs, and works to facilitate sharing and adoption of best practices and consistent approaches to quality monitoring. The system has created a Care Model that defines 14 competencies for population health, with palliative care as one of those competencies.*

**Base organization:** UnityPoint Health, a non-profit integrated health system with 35 owned or network hospitals, 280+ clinics, and over 30,000 employees.

**Year SIP launched**: Inpatient and home-based palliative care 2005, clinic-based service 2010

**Patient population***:* Individuals with potentially life-limiting conditions who have frequent hospital admissions, difficult-to-control physical or psychological symptoms, complex care requirements, decline in function, feeding intolerance, or unintended decline in weight

**Service volume and duration**: about 7,700 individuals served annually; average duration of service for community programs of about 76 days

**Team composition**: Clinical teams comprised of physicians, nurse practitioners, registered nurses, social workers and chaplains/spiritual care professionals

**Finance model/revenue sources**: The majority of program support comes from the parent organization (about 80%), justified by cost avoidance achieved in both inpatient and community settings. Remaining support (about 20%) from fee-for-service professional billing

**Selected outcomes (across regions)**
- 40% - 70% reductions in pain and shortness of breath scores within 24-72 hours after consult
- Three regions exceed the target of 10 % consultation rate in the hospital site of service (5 regions exceed the national benchmark of 7%)
- Three regions have achieved the target of a pre-consult median length of stay of 2 days
- 70–75 % reduction in hospital utilization and variable direct costs in the 6 months following initial consult, compared to the 6 months prior to the consult

**Program leader:** Pam Yockey, Executive Director of Palliative Care

**Leading the way in spiritual care**
In 2016 the HealthCare Chaplaincy Network (HCCN) named UnityPoint Health-Des Moines' four hospitals as recipients of the "Excellence in Spiritual Care Award." The award recognizes commitment to optimally addressing patients' spiritual and religious needs, as evidenced by adherence to HCCN's Standards of Excellence in Spiritual Care. The Standards include processes such employing an interdisciplinary approach to spiritual care, engaging in quality improvement projects, and the strategic deployment of chaplaincy care resources.

**PROGRAM PROFILE**

UnityPoint Health provides inpatient, clinic-based, and home-based palliative care across an integrated health system serving nine regions throughout Iowa, western Illinois and southern Wisconsin. In each of these nine regions, the palliative care program is co-led by a physician and clinical administrator, and consultative care is provided by interdisciplinary teams. A system-wide clinical administrator oversees the regional programs, and works to facilitate sharing and adoption of best practices and consistent approaches to quality monitoring. While the program strives to have a standardized approach, some variation in program operations and management exist across regions and sites of service.

UnityPoint participates in Accountable Care Organization (ACO) networks in most of its regions, covering more than 360,000 lives. Participation in ACOs has been a benefit for the palliative care program overall, as a team-based, multi-setting palliative care model can be difficult to sustain financially under a fee-for-service revenue model. The program has found that palliative care has had a positive impact on quality of care, the patient and family care experience, and overall health care utilization.

As UnityPoint invests further in population health through participation in ACOs and other mechanisms, they have created a Care Model that defines 14 competencies for population health, with palliative care as one of those competencies. As their health system is straddling two different reimbursement worlds, with ACOs on one side and traditional fee-for-service on the other, the palliative care program strives to remain focused on its core mission of improving patient care and aligning patients' goals with their plan of care, no matter the payment model.

The palliative care program provides specialty consult services in all of UnityPoint's regional hospitals, in patient homes and in long-term care settings across all regions, and in clinic settings in about half of their regions. The program has transitioned from a nurse-driven model to a medical model over the last several years, with interdisciplinary teams of physicians, nurse practitioners, nurses, social workers, and chaplains operating in all settings. Different regions approach staffing differently; for example, one region may assign the social worker to follow patients across settings to assist with continuity through transitions, with this role being filled by a nurse in another region.

**Identifying and engaging with patients**
About 90% of program patients have their first contact with the inpatient service. Anyone can refer to the program, though an order from the patient's primary or specialty provider will be sought, as part of consultation etiquette. Consistent with evidence in the medical literature, an internal study found that when patients are referred to palliative care within 36 hours of hospital admission there is a substantial positive impact on clinical outcomes, hospital length of stay, and cost of that episode of care. These findings have helped influence referrals in the inpatient setting. The program would like to move more referrals upstream into the community settings, and it is working to educate outpatient care coordinators and others on how to identify patients that could benefit from palliative care.

The target population is individuals with a potentially life-limiting condition where death in the next 12 months would not be surprising, with frequent hospital admissions, or difficult-to-control physical or psychological symptoms, or complex care requirements, or feeding intolerance, or unintended decline in weight, or decline in function. Those screening elements are assessed at the time of admission and are

part of EHR templates. During a hospitalization, additional referral prompts include Intensive Care Unit length of stay greater than or equal to seven days; lack of clear goals of care or documentation of goals; or disagreements or uncertainty among the patient, staff, and/or family concerning major medical treatment decisions, resuscitation preferences, or use of non-oral feeding or hydration.

**Core services**
Across UnityHealth the palliative care program is a consultative service that complements and supports other providers in caring for patients. In all settings, primary care and disease-directed treatments remain the responsibility of the primary or specialty care provider.

Because currently most referrals to palliative care come from the inpatient setting, the palliative care team plays an important role in identifying services and supports patients will need after discharge and connecting them to those services, including home-based or clinic-based palliative care, or home health, or hospice.

Core services provided by the palliative care team include:
- ✓ Medication management and reconciliation
- ✓ Pain and symptom management
- ✓ Goals of care discussions and documentation / advance care planning
- ✓ Communicating medical information / prognostication support
- ✓ Psycho-emotional support for patients
- ✓ Psycho-emotional support for family caregivers
- ✓ Spiritual care
- ✓ Transition support
- ✓ Care coordination
- ✓ Referrals to community resources for assistance with social and practical needs

24/7 on-call coverage is not yet available in all regions.

In addition to in-person visits, program physicians have begun to offer video-visits. In some cases, these occur when the team's nurse or social worker is conducting a home visit and is able to help the patient connect by videoconference with the provider in the clinic.

For clinic-based and home-based services, the length of time that patients are followed by palliative care depends on what the referral was for – in some cases the main issue can be addressed in one visit, in other cases the team is mainly facilitating a transition to hospice, in other cases continued monitoring over several months is warranted. If patients don't require the palliative care team's services or would be better served by another program, the team works to transition them off service.

If a hospice patient improves and is discharged from hospice, they are automatically routed into home-based or clinic-based palliative care for ongoing support.

**Interdisciplinary team training and interactions**
The program expects staff to achieve certification in palliative care and hospice within two years of hire. They strive to hire physicians that are certified, but will hire physicians that are mid-to late-career with the expectation that the individual will seek appropriate palliative care education.

Within each region, palliative care teams from all three settings meet as one interdisciplinary team (IDT) weekly or bi-weekly to discuss cases. Many teams also have a daily huddle. One region's best practice is to hold a regular community IDT meeting to discuss the most complex patients and strategies for supporting those patients in their preferred care setting. These regional meetings include the palliative care teams from each setting, discharge planners from the region's hospitals, hospice staff, home care staff, the local PACE program, and representatives from community agencies.

**Collaborators**

The palliative care teams work in close collaboration with UnityPoint's Patient Centered Medical Home care coordinators and other care navigators within the health system. They also collaborate with specialty services such as cardiology, oncology, pulmonology, and nephrology, with an emerging relationship with specialty pharmacy.

**Documenting and patient goals and preferences**

As UnityPoint began to develop a system-wide approach to palliative care, program leaders across regions shared information on their operational approaches, strengths, and opportunities for improvement. With this information, and based on the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, program leaders worked to standardize care processes, including approaches to eliciting goals, preferences, and values. Since then, due to program growth and staff turnover, the consistency of these approaches has eroded somewhat, which has motivated system-level program leaders to create a shared governance structure for the palliative care program, with workgroups focused on issues like compliance, care processes, education, and quality monitoring. Care team members from all regions are participating in those workgroups to redefine structures and processes of care, and to move towards greater standardization across the system.

Generally, goals of care and the care plan are documented by all team members in the EHR. The inpatient and clinic settings use the same EHR system (Epic); the home-based program has not yet migrated to Epic, but will in the future. A specific palliative care tab/navigator in the EHR enables all team members to document on the same flowsheet, which prompts particular clinical assessment processes, and the medical provider (physician or nurse practitioner) can pull information from that palliative care flowsheet into their own progress note in the medical record. Care team members can also look at changes in flowsheet data points over time to track changes in patient clinical status.

While information on goals of care / care plan is available to primary, specialty, and ED providers in the EHR, it can take some digging to access the information. This should be improved with the creation of a common care plan; another one of UnityPoint's identified 14 competencies for population health. The common care plan will follow the patient across all sites of service and will provide more easily accessible links to palliative care progress notes and goal-related documents such as advance directives or POLST forms. The common care plan will also include a patient-facing portal that contains aspects of the care plan and will allow patients to update their goals themselves.

The system has implemented Gundersen's Last Steps program, and is in the midst of implementing Gundersen's First Steps system-wide. Advance care planning is seen to be foundational to the system's population health strategy and is prominently displayed in the common care plan.

**Care coordination**

Typically, PC nurses and social workers fulfill the care coordination or care management activities for their team. With palliative care services available in inpatient, clinic, and home settings, the program aims to support patients with advanced illness wherever they are.  Communication with patients' other providers takes place via phone and/or fax, as well as via telehealth video visits in the nursing home. All palliative care patients are flagged in the EHR, so if a patient is seen in the ED or is admitted to the hospital, providers are prompted to notify the Palliative Care department. Palliative care team members can also opt to receive automated notifications if a PC patient goes to the ED or is admitted. There are also daily reports on ED visits and hospitalizations available to PC teams.

Another one of the system's 14 competencies in population health is standard transition of care processes; as these are developed and implemented, this will standardize the steps that need to happen as patients transition from one care setting to another to ensure continuity and coordination.

| A community approach to serious illness care |
| --- |

*One region's best practice is to hold a regular "community IDT" meeting to discuss the most complex patients and strategies for supporting those patients in their preferred care setting. These regional meetings include the palliative care teams from each setting, discharge planners from the region's hospitals, hospice, home care, the local PACE program, and representatives from community agencies.*

**Engaging with and supporting families and caregivers**
The program uses phone or videoconferencing to engage family members who do not live nearby, and team members can be available to meet family after business hours. Interpreters are used as needed. Program EHR templates document presence and identity of family members and caregivers involved in

family meetings.  Some regions have patient/family/community advisory groups, but not all.  All regions refer families to the bereavement program facilitated by affiliated hospices.

**Quality monitoring**
UnityPoint approaches quality monitoring and analysis of the palliative care program from a system-wide perspective, with consistent EHR flowsheets for documentation that enable consistent data collection across all regions and care settings.

The PC Metrics Report is run quarterly, and includes a summary of progress toward achieving executive scorecard targets related to palliative care. The clinical administrator is responsible for reviewing the preliminary report to ensure data integrity. Executive leadership at the system and regional levels receive the report, and findings are presented annually or bi-annually at regional and system level meetings.

Tracked metrics include:
- Proportion of individuals in the community program with advance care plan documented
- Initial vs. follow up pain score
- Initial vs. follow up dyspnea score
- Consultation rate among hospitalized patients
- Pre-consult length of stay for hospitalized patients
- Hospice length of service

- Proportion of patients referred to hospice
- Fiscal impact

**Successes and success factors**

Program leaders identified several areas of excellence, including the ability to measure palliative care metrics across the care continuum and regions, a well-developed home-based care model, and early efforts in telehealth.

**Opportunities and challenges**

Several ongoing challenges were identified, chief of which was maintaining standardization of operational approaches as the program grows and matures. Securing patient satisfaction data has also been difficult; the program has not wanted to create a separate satisfaction survey for palliative care, but has had a difficult time adding pertinent questions to existing surveys that are distributed to health system patients.

**Resources to promote development of similar services**

Program leaders emphasized informatics (IT) as a critical focus area for other organizations looking to develop system-wide palliative care programing. Critical resources include clinical care teams that appreciate the value of data collection, robust IT infrastructure, and analytic resources. The clinical team needs to provide high-quality documentation both for clinical communication with other providers and to ensure that data inputs exist for key program metrics; the IT infrastructure needs to be able to support standardized care processes and the ability to pull out key data; and analytic resources are needed to help build dashboards to understand the impact of the program.

KEY FEATURES
- ✓ Palliative care identified by the system as one of 14 competencies for population health
- ✓ "Community IDT" meetings, where representatives from multiple organizations collaborate to meet the needs of complex patients
- ✓ Attention to building informatics capacity needed to support clinical care, coordinated care across settings, and data for assessing metrics

# 100 SERIOUS ILLNESS PROGRAMS

## 100 Serious Illness Programs

For decades providers and financiers of health care have experimented with approaches to improve care for individuals with serious illness, defined as those who have a poor prognosis and are likely in the last stage of life (which could last for years), experience functional impairment, and are at risk for cycling in and out of the hospital. Innovations have focused on different aspects of care, ranging from expanded hospice benefits to improve end-of-life care, to complex case management interventions aimed at improving care coordination and access to clinical and social services. Some entities have focused on the needs of a particular subset of seriously ill individuals – for example cancer patients; others have focused on specific care settings – such as acute care hospitals or nursing homes.

Ideal care for this population could be described as follows:
- Goal-based care that is concordant with patient and family wishes;
- Comprehensive care, including concurrent access to appropriate disease directed and restorative treatments, palliative care, end-of-life care, and social supports;
- Access to home-based care, and to supports that allow individuals to remain in their homes;
- Coordinated care, where care plans and other information follow patients across settings;
- Rapid access to services, including during nights and weekends, to address crises and urgent needs;
- Access to extra support before and immediately after care transitions;
- Family-oriented care, including support for family caregivers.

These features and focus areas are consistent with recommendations forth by organizations that focus on the seriously ill population, such as the Center to Advance Palliative Care (CAPC), the Coalition to Transform Advanced Care (C-TAC), the National Consensus Project for Quality Palliative Care (NCP), the American Society of Clinical Oncology (ASCO), and the National Comprehensive Cancer Network (NCCN), among others.

The diversity of organizations that offer serious illness care (health systems, medical groups, hospices, etc.), the range of settings in which care is delivered, and the heterogeneity of the serious illness population (in terms of age, disease, and life expectancy) means that there is no single repository of information describing the prevalence and characteristics of serious illness programs operating in the United States. The purpose of this project was to identify <u>a representative sample of organizations</u> that offer services designed to meet the needs of seriously ill individuals.

We used a layered approach to identify organizations. We sent inquiries to dozens of individuals with expertise in palliative care, geriatrics, oncology, health services research and similar fields. We reviewed programs that had been recognized by the American Hospital Association's *Circle of Life* Award, as well as sites that had received accreditation or certification from The Joint Commission (advanced certification in hospital or community-based palliative care), the Commission on Cancer (cancer center or Oncology Medical Home accreditation) or the National Committee for Quality Assurance (case

management accreditation). We reviewed programs described at national meetings that focus on palliative care, advanced illness care, and supportive care for cancer patients, such as the annual conferences sponsored by CAPC, C-TAC, and ASCO. We considered programs featured in the Agency for Healthcare Research and Quality Innovations Exchange, and those that had or are participating in federal projects aimed at improving care for seriously ill individuals, such as the Independence at Home Demonstration, the Community-based Care Transitions Program, the Medicare Care Choices Model, the Oncology Care Model, and the Comprehensive ESRD Model. We reviewed documents describing innovative approaches to advanced illness care / complex case management / community-based palliative care developed by advocacy groups and trade organizations, such as the Payer-Provider Toolkit developed by CAPC, and the Field Guide to Community-Based Palliative Care developed by the California Health Care Foundation. Finally, we reviewed recent editions of peer-reviewed journals that focus on palliative care and geriatrics care, such as the Journal of Palliative Medicine and the Journal of the American Geriatrics Society.

Our review identified hundreds of organizations that use a range of interventions, usually in combination, to meet the needs of seriously ill individuals. Many of these interventions have been studied rigorously, are well-described in the peer-reviewed literature and other sources, and have been deployed widely.

1. Home-based primary care, offered in private residences, nursing homes, and assisted living facilities;

2. Specialty geriatric services, offered in hospitals, clinics, senior centers, private residencies, nursing homes, assisted living facilities and transitional care units;

3. Specialty palliative care, offered in hospitals, clinics, rehabilitation facilities and patient homes, including private residences, nursing homes and assisted living sites;

4. Specialty care units for elderly or seriously ill patients, such as ACE units, dedicated palliative care units, senior emergency rooms and hospice facilities;

5. Care management services specifically for seriously ill individuals;

6. Navigation / coaching programs that help patients and families navigate the health care system;

7. Transition management programs that support individuals as they transfer across care settings;

8. Structured advance care planning (ACP) programs, such as Respecting Choices;

9. Social supports and services, such as home-delivered meals, transportation,  personal care, friendly visiting, and so on;

10. Spiritual care programs for patients and families / caregivers;

11. Support programs for families / caregivers such as respite services, support groups, or bereavement programs that address practical, educational or emotional needs;

12. <u>Complementary and integrative medicine services</u>, such as massage, meditation or hypnotherapy;

13. <u>Hospice</u> or similar end of life services.


The 100 Serious Illness Programs (SIPs) listed below each offer some combination of these interventions and are representative of the types of programs that are operating nationally. In addition to seeking geographic diversity, we selected programs that were built off of a range of "bases" – health systems, hospices, medical groups, etc. – and that are integrated with or dependent on a range of financing and care delivery models, such as Accountable Care Organizations (ACOs), or Fully Integrated Dual Eligible Medicare Advantage Special Needs Plans. Some SIPs serve any individual with serious illness; others are available only to a subset of patients, based on disease, age, or type of insurance coverage. Several of the identified programs offer a combination of services that could meet nearly all of the needs of seriously ill individuals; others have a narrower focus, and would need to partner with other organizations to assure optimal care delivery.
The list is organized by the type of sponsoring entity, or "base":

- **Health plan (5 SIPs):** including national providers of insurance products and local health plans; all pay for or provide some component of serious illness care, such as case management, advance care planning supports, or home-based palliative care.

- **Health system (42 SIPs):** all offer inpatient palliative care and at least one type of community-based palliative care (home-based or office/clinic-based), in addition to primary care and specialty disease-directed services. In some instances an entire health system is listed, in other cases an individual hospital, clinical service or specialty care center is highlighted. For health systems in particular, serious illness care is commonly offered as a constellation of services that together represent an advanced illness care strategy that crosses settings and clinical service lines.

- **Hospice (15 SIPs):** all offer at least one non-hospice service, such as home-based palliative care.

- **Medical group / practice (12 SIPs):** where the serious illness program is a distinct service offered to a subset of group's patients. For example, ProHEALTH Care is a multispecialty medical group; ProHEALTH Care Support is the specialty palliative care service operated by ProHEALTH Care.

- **Partnership / consortium (13 SIPs):** where at least two distinct organizations are collaborating to provide (or improve) serious illness care. For example, the Palmetto Kidney Care Alliance is an End-stage-renal-disease (ESRD) Seamless Care Organization (ESCO) participating in the CMS Comprehensive ESRD Model. The ESCO includes four organizations: Gentiva Health Services, Dialysis Clinic, Inc., Spartanburg Nephrology Associates, and Spartanburg Regional Health District Services.

- **Specialty organization (13 SIPs):** where the primary focus of the organization is offering serious illness care. For example, CarePartners is a private, non-profit healthcare organization that offers rehabilitation services, home health, adult care, hospice and specialty palliative care.

Note that our intent was to identify SIPs, not to assess the quality of care being delivered. Future efforts could focus on the processes used by these programs, and their impact on clinical and other outcomes.

## 100 Serious Illness Programs

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Aetna | Health Plan | National provider of health insurance products; offers an advanced illness case management program (Compassionate Care℠) that focuses on advance care planning, emotional support, pain management, clarifying goals, and use of hospice | Multiple |
| CareOregon | Health plan | Non-profit health plan serving Medicaid and Medicare recipients in the state of Oregon; open-access outpatient palliative care benefit; pilot program of embedded nurse/social worker palliative care teams in a specialty oncology practice and a Federally Qualified Health Center(FQHC) | OR |
| Commonwealth Care Alliance | Health Plan | Non-profit care entity providing integrated health care and related social support services to Massachusetts Medicaid beneficiaries and dually eligible individuals with complex needs (Fully Integrated Dual Eligible Medicare Advantage Special Needs Plan); focuses exclusively on the most complex and expensive beneficiaries; care model features enhanced primary care and care coordination capabilities; comprehensive services, including end-of-life care, delivered by interdisciplinary teams that provide care in homes, clinics, and other settings | MA |
| Highmark, Inc. | Health Plan | National provider of health insurance products; offers home visits to seriously ill individuals (AIS Home Visit Program) in Medicare Advantage plans; focus on symptom management, goals of care/advance care planning, care coordination and education about disease | PA |
| Partnership Health Plan | Health Plan | Medicaid managed care plan offering a community-based palliative care benefit that provides pain/symptom management, 24/7 telephonic support, advance care planning, case management, assessment of caregiver needs, and transition support | CA |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| AllinaHealth Abbott Northwestern Hospital - Minneapolis | Health system | Non-profit health system that offers a suite of services for seriously ill individuals, including specialty palliative care available in multiple settings; embedded geriatrics care in transitional care units, nursing homes and assisted living communities; a medical home for individuals with complex conditions; advance care planning classes offered at multiple clinics; a lay navigator program (LifeCourse); and hospice care. Pioneer ACO site | MN |
| Banner Health | Health system | Integrated non-profit health care system offering full range of primary and specialty care, including geriatrics, inpatient palliative care, home-based palliative care, home health and hospice services. Pioneer ACO site | AZ |
| Baylor University Medical Center | Health system | Academic medical center with wide range of specialty services; specialty palliative care offered in acute care hospital, outpatient clinics and hospice units operated by community partners. Participating in MSSP ACO program | TX |
| Bon Secours Richmond Health System | Health system | Integrated health system working with affiliated multi-specialty medical group to provide palliative care in hospital and clinic settings; regional advance care planning initiative and multi-component primary palliative care educational programming. Participating in MSSP ACO program | VA |
| Boston Medical Center Section of Geriatrics | Health system | Geriatric services provided by academic medical center. Program includes ambulatory practice, geriatric assessment program, home-based primary care, medical services offered in nursing homes and rehabilitation facilities; program that provides comprehensive medical, social and legal support to elders at risk for homelessness. Participant in the CMS Independence at Home Demonstration and MSSP ACO program | MA |
| Care New England Health System | Health system | Integrated health system with palliative care integrated into all aspects of an ACO; collaboration with geriatrics and mental health; specific services include inpatient palliative care consult service, outpatient palliative care clinic, home-based palliative care, and hospice services. Participating in MSSP ACO program | RI |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Christiana Care Health System | Health system | Private not-profit regional health system; inpatient palliative care service; interdisciplinary home-based primary care service that provides chronic disease management, health and social assessments, referrals to social supports, and end-of-life care coordinated with hospice. Participant in the CMS Independence at Home Demonstration and MSSP ACO program | DE |
| Cleveland Clinic | Health system | Non-profit regional health system that offers inpatient and clinic-based palliative care and hospice services embedded in a comprehensive cancer center. Participant in the CMS Independence at Home Demonstration and MSSP ACO program | OH |
| Cook County Health & Hospitals System | Health system | Safety-net health system that offers inpatient palliative care, outpatient palliative care clinics, a home visit assessment program, and collaborations with community-based hospice programs | IL |
| Department of Veterans Affairs, New York/New Jersey Healthcare Network (VISN3) | Health system | Care delivery network offering palliative care services in hospitals, community living centers, and patient homes through collaboration with local hospice agencies; specialist geriatrics care including home-based primary care | NY / NJ |
| Eskenazi Health / Sidney & Lois Eskenazi Hospital | Health system | Integrated health system with inpatient and clinic-based specialty palliative care; specialty geriatric care including an ACE unit, house calls program, and a care coordination / case management program for low-income seniors (GRACE). Participating in MSSP ACO program | IN |
| Fairview Health Services | Health system | Non-profit health system offering inpatient, clinic-based and home-based palliative care, and hospice services. Regional advance care planning initiative (Honoring Choices). Comprehensive geriatric services including care coordination, primary care medical services embedded in assisted living and skilled nursing communities, transitional medical care, and transportation services. Participant in Medicare Care Choices Model | MN |
| Florida hospital | Health system | Non-profit health system offering specialty palliative care in hospital and home settings, and hospice services. | FL |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Gundersen Health System | Health system | Not-for-profit integrated delivery system offering interdisciplinary advanced disease coordination program that includes care coordination services, primary care services, home health care, palliative care, pastoral care, hospice discussion, and social worker services | WI |
| Hackensack Meridian Health | Health system | Integrated system-wide program that offers palliative care in acute care hospitals, skilled nursing facilities, outpatient practices and in patient homes. Participating in MSSP ACO program | NJ |
| Harborview Medical Center (University of Washington) | Health system | Safety-net hospital with array of palliative and supportive care programs, including specialty inpatient palliative care, clinic and home-based palliative care, and a dedicated program for homeless individuals with serious illness | WA |
| Intermountain Healthcare | Health system | Non-profit regional health system offering specialty palliative care in hospitals, clinics, patient homes and nursing facilities, and hospice services; specialty case management program where care managers within primary care clinics work with patients who have long-term chronic diseases (Care Management Plus) | UT |
| Lehigh Valley Health Network | Health system | Non-profit health system that offering interdisciplinary specialty palliative care services in inpatient, clinic and home settings. Participating in MSSP ACO program | PA |
| MD Anderson Cancer Center | Health system | NCI designated comprehensive cancer center offering a range of supportive services in hospital and clinic settings; focus areas include advance care planning, spiritual care, psycho-oncology, support groups, resources for caregivers/families | TX |
| Medstar Washington Medical Center | Health system | Academic medical center offering inpatient specialty palliative care, office-based geriatric primary care, specialty hospital-based geriatric service, and an eldercare medical house call program. Participant in the CMS Independence at Home Demonstration and MSSP ACO program | DC |
| Mount Carmel Health System | Health system | Community hospital–based health system offering inpatient specialty palliative care consult service, three dedicated inpatient units, and home-based palliative care. Participant in Medicare Care Choices Model and Next Generation ACO program | OH |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Mount Sinai Medical Center Brookdale Department of Geriatrics and Palliative Medicine | Health system | Geriatric and palliative care services available from academic medical center, including mobile acute care for the elderly; a visiting doctors program for patients with complex, serious illnesses who have difficulty leaving their homes; primary medical care at an affiliated nursing home; specialty palliative care in hospital, home and clinic settings; and hospice services. | NY |
| Northwell Health | Health system | Health system-based palliative care service providing care to patients at outpatient clinics, in patient homes, in long term care settings. Participant in the CMS Independence at Home Demonstration and MSSP ACO program | NY |
| OSF HealthCare | Health system | Regional health system using comprehensive care management, an advance care planning program and specialty palliative care services (available in hospitals, clinics and patient homes), and hospice to optimize care for seriously ill patients | IL / MI |
| Presbyterian Healthcare | Health system | Non-profit health system offering a full range of primary and specialty services; Hospital at Home program; palliative care program serving adult patients in home, assisted living and office settings | NM |
| Providence Hospital | Health system | Urban medical center offering specialty palliative care in the acute care hospital and at an affiliated nursing home/rehabilitation center; specialty geriatrics care | DC |
| Providence Little Company of Mary Medical Center Torrance | Health system | Non-profit health system that offers in-patient palliative care, outpatient/home-based palliative care, close collaboration with an affiliated hospice; Providence Institute for Human Caring promotes advance care planning programs, primary palliative care education, quality assessments and integration efforts related to palliative care across multiple ministry markets | CA |
| Sharp HealthCare | Health system | Integrated health system offering inpatient palliative care and hospice services and a home-based palliative care service for Medicare Advantage members with advanced chronic illness who are beginning to use the hospital as a tool for managing their illness. | CA |
| St. Joseph Mercy Oakland | Health system | Non-profit community teaching hospital offering specialty inpatient palliative care and outpatient supportive care case management. Senior services including an ACE unit, senior ER, NICHE designation and a care transitions program. Participating in MSSP ACO program | MI |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Summa Health System Akron Campus | Health system | Integrated health delivery system offering specialty inpatient palliative care consultation, dedicated palliative care unit, palliative care clinics, and hospice services; specialty geriatric care including NICHE designation, ACE unit, geriatric care in outpatient clinics and extended care facilities, dedicated senior emergency room, physician house calls program. Participating in MSSP ACO program | OH |
| Susquehanna Health | Health system | Integrated non-profit health system offering specialty supportive and palliative care in hospitals, clinics and nursing homes, home hospice services and a hospice facility; regional advance care planning initiative. Participating in MSSP ACO program | PA |
| Sutter Health Advanced Illness Management (AIM) | Health system | Advanced illness management program that follows seriously ill patients across settings; emphasis on care coordination, symptom management and advance care planning | CA |
| UCSF Helen Diller Family Comprehensive Cancer Center | Health system | NCI designated comprehensive cancer center offering hospital and clinic-based palliative care, a suite of supportive services for patients and families, including integrative health; lay support program (Patient Support Corps) assists patients with preparing for and documenting visits with oncologists | CA |
| UnityPoint Health | Health system | Non-profit health system that provides inpatient, clinic-based, and home-based palliative care across nine regions. Affiliated PACE. Participant in Medicare Care Choices Model and Next Generation ACO | IA / IL / WI |
| University Hospitals Seidman Cancer Center | Health system | Supportive services offered at NCI designated comprehensive cancer center, including inpatient and outpatient palliative care, social work support, mental health services, integrative oncology services, cancer rehabilitation services, nutrition services, spiritual care, pharmacology consultations and referrals to community resources. CMMI award to test multi-faceted intervention for complex cancer care | OH |
| University of Alabama Birmingham (UAB) Health System | Health system | Large academic health system with an array of services available through Gerontology, Geriatrics and Palliative Care Division, including a palliative care consult service, acute palliative care unit, supportive and survivorship clinics, community health advisor training program, and palliative care telemedicine | AL |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| | | program for rural populations; multiple geriatric specialty programs including an ACE unit and home-based primary care | |
| University of Iowa Hospital and Clinics | Health system | Academic medical center with inpatient and clinic-based palliative care; geriatric medicine program; NICHE Exemplar status | IA |
| University of Pennsylvania Penn Presbyterian Medical Center | Health system | Academic medical center with specialty palliative care offered in hospitals, clinics and patient homes; hospice services. ACE unit and house calls program. Participant in the CMS Independence at Home Demonstration | PA |
| University of Pittsburgh Medical Center | Health system | Academic medical center offering inpatient and outpatient palliative care, palliative care in skilled nursing facilities, and hospice services; robust geriatrics program including in-home support program offering medical and social services and supports, and care coordination | PA |
| University of Virginia Health System | Health system | Academic medical center offering inpatient palliative care and outpatient palliative care embedded in a cancer center and CHF clinic; services are integrated with home health and hospice agencies. Participating in MSSP ACO program | VA |
| Virginia Commonwealth University Health System Center for Advanced Health Management | Health system | Health home for individuals with complex illness; services include office-based medical care, longitudinal primary care in the home, nurse practitioner home visits for post-acute and post-ambulatory care needs, physician-driven nursing home care with 24/7 coverage, inpatient geriatric consult service, intensive care management, home-and office-based social work services including counseling, behavioral health including medication management and psychotherapy, dedicated pharmacist, specialty palliative care and hospice services, and telemedicine services | VA |
| Yakima Valley Memorial Hospital (Virginia Mason Memorial) | Health system | Non-profit, rural system that offers two tiers of home-based palliative care, home hospice, a hospice house, and a complex advance care planning initiative. Specialty palliative care is well integrated with cancer center, system-wide care coordination programs and home health services; spiritual care services offered in partnership with community clergy and faith organizations. | WA |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Capital Caring | Hospice | Hospice and palliative care organization offering home-hospice, hospice provided in inpatient centers, outpatient and home-based palliative care, counseling services for patients and caregivers; offers daily check-in phone calls to monitor patient and caregiver well-being | VA |
| Care Dimensions | Hospice | Hospice and palliative care organization that offers a continuum of clinical care for patients with advanced and life-limiting illnesses, as well as support for families and caregivers. Home-hospice care, a free-standing hospice facility, specialty palliative care offered in hospitals, private residencies, nursing homes and an outpatient clinic; specialized hospice care for cardiac conditions, respiratory conditions, dementia, and for the developmentally disabled. Participant in Medicare Care Choices Model | MA |
| Care Partners | Hospice | Non-profit health care organization offering rehabilitation, home health, adult care, palliative care and hospice, including a hospice facility. Palliative care delivered in private residences, nursing homes, and assisted living sites. | OR |
| Collabria Care | Hospice | Non-profit organization that offers home-hospice care, home-based palliative care, and chronic condition services including a day program, a caregiver respite program and care giver support services | CA |
| Four Seasons Compassion for Life | Hospice | Non-profit hospice and palliative care organization that offers interdisciplinary, consultative care in hospitals, skilled nursing facilities, assisted living facilities, patients' homes, and outpatient clinics; home hospice and a 19-bed inpatient hospice facility | NC |
| HopeWest Hospice | Hospice | Non-profit hospice and palliative care organization offering hospice services in homes, nursing facilities, assisted living facilities and at a hospice center; palliative care program that allows patients and families to choose from a range of medical and social supports and services; specialized program for cancer patients; program for individuals who graduate from hospice. Participant in Medicare Care Choices Model | CO |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Hospice and Palliative Care of St. Lawrence Valley | Hospice | Non-profit organization offering home hospice services, palliative care in homes and hospitals, and a home support program that offers medical case management, nursing consultation and social work services to qualifying patients with a serious illness who were recently hospitalized | NY |
| Hospice of Michigan | Hospice | Non-profit hospice and palliative care organization offering hospice in homes, hospice in facilities, and home-based palliative care; advanced illness management program offers interdisciplinary home-based services including symptom and pain management, disease management, medication assistance, care coordination, and 24/7 access for urgent needs. Participant in Medicare Care Choices Model | MI |
| Hospice of the Bluegrass | Hospice | Non-profit hospice and palliative care organization that provides hospice care, palliative care in hospitals, patient home and clinic settings, and private duty nursing. Partnership with local health systems to provide pre-discharge assessments and care planning for complex patients at risk for readmissions; participant in the Community-Based Care Transition Program (CCTP) | KY |
| Hospice of the Valley | Hospice | Non-profit hospice and palliative care organization offering specialized disease specific services for dementia, cancer, CHF and lung disease; palliative care units to accommodate short stays aimed at symptom management; outreach program for individuals with advanced illness that provides education about the disease to patients and family caregivers, referral to community resources, help preparing living wills and medical power of attorney forms, healthcare advocacy, and 24/7 and telephone support | AZ |
| Kansas City Hospice & Palliative Care | Hospice | Non-profit organization offering home-hospice, a hospice house, home-palliative care, clinic-based palliative care, and a counseling service for patients and families | MO |
| MJHS | Hospice | Integrated not for profit health system offering a spectrum of health care services including rehabilitation, home care, palliative and hospice care, long term care and various health plans for Medicare and Medicaid eligible individuals. Community-Based Palliative Care (CBPC) Certification from The Joint Commission. Participant in Medicare Care Choices Model. | NY |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| The Center for Hospice & Palliative Care | Hospice | Non-profit organization offering hospice and palliative care. Home hospice and an inpatient hospice facility. Home-based palliative care; palliative medical consultations available via home visits and in hospitals. Case management program for seriously ill individuals. | NY |
| The Denver Hospice | Hospice | Non-profit organization offering hospice services, plus palliative care provided through three home-based programs, two of which are partnerships with integrated health system Kaiser Permanente. | CO |
| Unity | Hospice | Non-profit organization offering hospice and palliative care; services include home hospice, residential hospice, home-palliative care; partnerships with hospitals and nursing facilities; Participant in Medicare Care Choices Model | WI |
| Center for Cancer and Blood Disorders | Medical group / practice | Oncology practice, Commission on Cancer accredited Oncology Medical Home participating in the CMS Oncology Care Model program. | TX |
| Compass Oncology | Medical group / practice | Oncology practice with a palliative medicine specialist; an embedded nurse/social worker palliative care team offers supplemental support to practice patients enrolled in one of the state's Coordinated Care Organizations | OR |
| Doctors Making Housecalls | Medical group / practice | Medical practice that provides a suite of home-based medical services including comprehensive primary care, acute/urgent care, and geriatric specialty care. Participant in the CMS Independence at Home Demonstration | NC |
| Health-Care Partners | Medical group / practice | Medical group that offers primary and specialty care, including in-home medical and palliative care management for frail and homebound patients; complex care and disease management service that provides long-term, whole-person care for patients with diabetes, COPD, CHF, CKD, depression, dementia, cancer, and organ transplant; specialty clinics and care management service featuring intensive one-on-one physician/nurse-patient care planning for the highest risk, most complex patients. Participating in MSSP ACO program | CA |
| Monarch HealthCare | Medical group / practice | Independent Practice Association that provides primary and specialty care; MonarchCares® program offers disease management, care management, medication review, after-hospital care, home visits for home bound patients and palliative care | CA |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| New England Cancer Specialists | Medical group / practice | Oncology practice; Commission on Cancer accredited Oncology Medical Home participating in the CMS Oncology Care Model program. Multiple providers with certification in hospice and palliative care | ME |
| New Mexico Cancer Center | Medical group / practice | Oncology practice; Commission on Cancer accredited Oncology Medical Home participating in the CMS Oncology Care Model program. Providers with expertise in hospice and palliative care, and integrative medicine. | NM |
| Northwest Georgia Oncology Centers | Medical group / practice | Oncology practice; Commission on Cancer accredited Oncology Medical Home participating in the CMS Oncology Care Model program. | GA |
| Oncology Hematology Care | Medical group / practice | Oncology practice; Commission on Cancer accredited Oncology Medical Home participating in the CMS Oncology Care Model program. Multiple providers with certification in hospice and palliative care | OH |
| Palliative Care Consultants of Santa Barbara | Medical group / practice | Physician owned practice that provides hospital, hospice, and outpatient palliative care physician services. Extensive community engagement including creation of three successful, sustained community collaborations (partnering with a health system, hospices, a cancer center and a local philanthropy) to meet the needs of the chronically ill and dying residents of the Santa Barbara Community. | CA |
| Palo Alto Medical Foundation | Medical group / practice | Medical group that offers interdisciplinary, concurrent specialty palliative care. Patients are seen in any setting, including private residencies, nursing homes, clinics and acute care hospitals. Care is coordinated across providers and settings, and with family caregivers. | CA |
| ProHealth Care | Medical group / practice | Multispecialty medical group with a specialty palliative care service that features home visits and phone support from nurses and social workers, video-visits from physicians, and Reiki massage and friendly visiting provided by volunteers. Participating in MSSP ACO program | NY |
| Alameda County Care Alliance + Kaiser Permanente | Partnership / consortium | Network of churches that offers spiritual support, caregiver support, assistance with advance care planning and assistance navigating the health system to individuals with advanced illness; collaboration with integrated HMO-owned health system | CA |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Beaumont Health + The Senior Alliance, Area Agency on Aging 1-C | Partnership / consortium | Health system with inpatient and clinic-based specialty palliative care; partnership with an elder services agency to provide pre-discharge assessments and care planning for complex patients at risk for readmissions; participants in the Community-Based Care Transition Program (CCTP) | MI |
| CareChoice Cooperative | Partnership / consortium | Consortium of 20+ organizations that provide elder housing and services; collective implementation of best practices aimed at improving quality of care and life for residents; focus areas include implementation of INTERACT, improving transitions, utilization of POLST, palliative care, and pain management | MN |
| Community Care of Southern Piedmont | Partnership / consortium | Regional partnership of primary care providers, hospitals, departments of social services, and community organizations offering services to Medicaid and dually-eligible individuals; services offered in medical home model; one of 14 similar physician-led networks participating in the statewide Community Care of North Carolina (CCNC) initiative. Offers transition management services, chronic disease management, case management and a palliative care initiative. | NC |
| Congregational Health Network-Methodist Le Bonheur Healthcare | Partnership / consortium | Partnership between a network of faith organizations and a health system serving a largely African American and lower income patient population. Church members who are hospitalized at one of the health system's hospitals can receive support in their transition from hospital to home, through hospital-employed health navigators and church-based volunteer liaisons | TN |
| Hallmark Health + Somerville-Cambridge Elder Services | Partnership / consortium | Health system with inpatient and home-based specialty palliative care + elder services agency offering care management, community living supports, caregiver supports; partnership to provide pre-discharge assessments and care planning for complex patients at risk for readmissions; participants in the Community-Based Care Transition Program (CCTP); | MA |
| Music City Kidney Care Alliance | Partnership / consortium | End-stage-renal-disease (ESRD) Seamless Care Organization participating in the CMS Comprehensive ESRD Model. Participants include a hospice and a specialty palliative care provider group | TN |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Palmetto Kidney Care Alliance | Partnership / consortium | End-stage-renal-disease (ESRD) Seamless Care Organization participating in the CMS Comprehensive ESRD Model. Participating health system offers specialty palliative care service and palliative care trained providers | SC |
| Phoenix-Tucson Integrated Kidney Care ESCO | Partnership / consortium | End-stage-renal-disease (ESRD) Seamless Care Organization participating in the CMS Comprehensive ESRD Model. Partner organization Banner Health has extensive palliative care resources. | AZ |
| Presbyterian SeniorCare / Family Hospice and Palliative Care | Partnership / consortium | Partnership between a senior living and care organization and a hospice and palliative care organization; provides comprehensive palliative and end of life care to nursing home residents | PA |
| Providence Health and Services / The Everett Clinic | Partnership / consortium | Serious illness program offered by network of provider organizations; employs an interdisciplinary team-oriented approach to offer medical care, pain management, and emotional and spiritual support; case management, coordination and referrals to community resources, advance care planning, and companionship and support from volunteers. Participant in Medicare Care Choices Model, and MSSP ACO program | WA |
| Rogosin Kidney Care Alliance | Partnership / consortium | End-stage-renal-disease (ESRD) Seamless Care Organization participating in the CMS Comprehensive ESRD Model. Health system partners have extensive specialty palliative care services | NY |
| Southeast Alabama Medical Center + Southern Alabama Regional Council on Aging (SARCOA) | Partnership / consortium | Health system with inpatient specialty palliative care; partnership with an elder services agency to provide pre-discharge assessments and care planning for complex patients at risk for readmissions; participants in the Community-Based Care Transition Program (CCTP) | AL |
| CarePartners | Specialty organization | Private, non-profit healthcare organization that offers rehabilitation services, home health, adult care, hospice and specialty palliative care. | NC |
| Community Care PACE | Specialty organization | Program of All-Inclusive Care for the Elderly (PACE) that provides comprehensive, coordinated  medical and social services to frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. Program includes palliative care and end-of-life care. | WI |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Gilchrist Services | Specialty organization | Non-profit organization that offers a suite of services to individuals with serious illness, including primary medical care offered in offices, nursing homes, assisted living facilities and rehab centers; enhanced medical care coordination; case management and volunteer support; interdisciplinary specialty palliative care; hospice services; services to support caregivers and loved ones. Participant in Medicare Care Choices Model | MD |
| HouseCall providers | Specialty organization | Non-profit organization that provides home-based primary care to individuals with chronic conditions. Transition management program, specialty palliative care program, and hospice services. Participant in the CMS Independence at Home Demonstration | OR |
| Jewish Family and Children's Services Seniors at Home | Specialty organization | Non-profit offering a range of social and medical services including home care, palliative and end-of-life care, skilled nursing, care management, spiritual care and caregiver support | CA |
| Midland Care | Specialty organization | Not-for-profit, community organization providing a suite of services for seriously ill and elderly individuals, including hospice care, home health, home-based palliative care, a PACE program, in home support services, caregiver support programs, elder housing including assisted living sites. | KS |
| Mountain Empire Older Citizens, Inc. | Specialty organization | Area Agency on Aging offering a wide range of services including a PACE program and a care transition support program | VA |
| Partners in Care Foundation | Specialty organization | Non-profit that offers a suite of services that address the health and social needs of elderly and disabled individuals, including medication reconciliation; psychological, functional needs, and safety assessments; case management services; and palliative care | CA |
| ResolutionCare Network | Specialty organization | Specialty palliative care program that offers home visits from nurse, social worker, chaplain and community health worker staff, supplemented with video-visits from a palliative medicine physician. | CA |
| Senior CommUnity Care | Specialty organization | Rural Program of All-Inclusive Care for the Elderly (PACE) that provides comprehensive, coordinated  medical and social services to frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. Program includes palliative care and end-of-life care. | CO |

| Base (SIP parent organization) | Base type | Description | State(s) |
|---|---|---|---|
| Senior Life LeHigh Valley | Specialty organization | Program of All-Inclusive Care for the Elderly (PACE) that provides comprehensive, coordinated medical and social services to frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. Program includes palliative care. | PA |
| Visiting Nurse Service of Northeastern New York | Specialty organization | Non-profit, teaching, home healthcare agency. Care Choices Program provides home-based services to seriously ill individuals; services delivered by interdisciplinary team; focus on screening and assessments, care plan development, symptom management, care coordination and supporting patients in medical decision-making. | NY |
| WellMed Medical Management | Specialty organization | Health care delivery / medical management organization that provides interdisciplinary community-based palliative care to individuals with chronic, life-limiting conditions. The initial evaluation includes geriatric and palliative care assessments conducted in the patient's home or in a subspecialty palliative care clinics. The program focuses on effective symptom management, care coordination and comprehensive advanced care planning. | TX / FL |