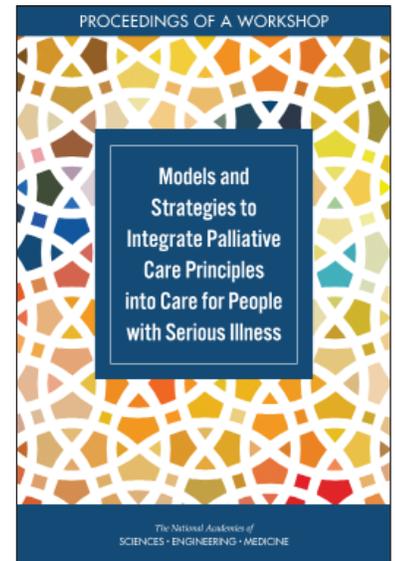




October 2017

Workshop  
HIGHLIGHTS

## Models and Strategies to Integrate Palliative Care Principles into Care for People with Serious Illness



With support from a broad coalition of sponsors, the National Academies of Sciences, Engineering, and Medicine's Roundtable on Quality Care for People with Serious Illness hosted a workshop, Models and Strategies to Integrate Palliative Care Principles into Care for People with Serious Illness on April 27, 2017 in Washington, DC. The webcast and workshop presentations are available online.<sup>1</sup>

### PROVIDING HIGH-QUALITY COMMUNITY-BASED CARE TO PEOPLE WITH SERIOUS ILLNESS

Remarkable developments in health promotion and disease prevention and treatment have led to significant improvements in life expectancy over the past century. Nonetheless, most Americans will experience a substantial period of time living with serious illness. Those living with serious illness can be found across the age spectrum, from pre-birth to the frail elderly, and in a broad range of care settings.

Palliative care, explained Diane Meier, director of the Center to Advance Palliative Care, is specialized medical care that focuses on providing relief from the symptoms and stress of serious illness, with the goal of improving quality of life for the person facing serious illness, as well as their family. Meier explained that while such care is often accessible in hospice and hospital settings, there is a significant gap in access to palliative care because the overwhelming majority of people with serious illness are living in the community, at home, in assisted living, or in nursing homes. Meier emphasized that in order to meet the needs of people of all ages and in all stages of serious illness, palliative care needs to be available across all settings in the community, offer an array of services in venues that matter most to patients and families, and in ways that ensure smooth transitions between settings.

The workshop aimed to highlight innovative models of community-based care for people with serious illness, across patient populations and care settings. Meier highlighted the core principles of palliative care that are common characteristics of the models of care featured at the workshop, including 24/7 access to care, accurate identification of high-risk patients, attention to social determinants of health, professional skill in managing pain and symptom management, use of interdisciplinary teams, and caregiver support.

<sup>1</sup> See <http://www.nationalacademies.org/hmd/Activities/HealthServices/QualityCareforSeriousIllnessRoundtable/2017-APR-27.aspx> (accessed October 20, 2017).

## MODELS FOR SERIOUS ILLNESS CARE ACROSS THE AGE SPECTRUM

Pediatric palliative care programs work with children, from the preborn to toddlers to adolescents and even young adults, while also helping families care for a child with serious illness, explained Kathy Perko, director of the Bridges Palliative Care program at Oregon Health & Science University Doernbecher Children's Hospital in Portland, OR. The focus is on relieving suffering and improving quality of life, and in some cases palliative care can be as simple as providing a child with two sets of books—one at home and one at school—so they do not have to carry their books back and forth. One of the keys to good pediatric palliative care is an interdisciplinary team, because such care requires a broad range of knowledge and expertise, explained Perko. Along with her colleagues, she created the Bridges Palliative Care program, which features an interdisciplinary educational program, webinars, telehealth, support calls for nurses and other palliative and hospice care staff, and regular calls with families, as well as an annual conference. Deborah Lafond, co-director of PANDA Palliative Care Team at Children's National Health System in Washington, DC, described the primary palliative care program she and her colleagues developed, which pairs the acute care clinicians who have extensive pediatric experience, with community providers of hospice care for adults. Lafond noted that these pediatric palliative care programs provide seamless coordinated care and offer parents and families better choices in the type and setting of care provided to their seriously ill children.

Dana Lustbader, chief of the Department of Palliative Care at ProHEALTH described her organization's multi-specialty, home-based adult palliative care program that initially focused on seriously ill patients within a Medicare Shared Savings Program Accountable Care Organization (ACO), and then expanded to patients within other care models. Services provided include in-home, team-based palliative care with 24-hour telephonic support, telepalliative care/virtual visits, and caregiver support for individuals with multiple, complex, chronic conditions. Rather than wait for referrals from care providers in the organization, Lustbader and her colleagues actively identify high-risk patients within the ACO via an algorithm developed to analyze claims data. While there are limitations to using a claims-based algorithm to find people who would benefit from palliative care, Lustbader said the data can reveal important markers. For example, an order for a hospital bed is highly predictive of a patient dying within one year. Coupled with other indicators, such as having a chronic disease like chronic obstructive pulmonary disease (COPD) and being on home oxygen, such markers enable Lustbader to identify and support patients with very high needs. Lustbader pointed out

that ProHEALTH's home-based palliative care program has resulted in reduced hospitalizations and lower per capita health care costs.

Another adult palliative care program discussed at the workshop is the Medicare Care Choices Model, which was introduced by the Centers for Medicare & Medicaid Services (CMS) in 2014 as a five-year pilot effort to enable patients to receive disease-directed treatment while simultaneously receiving hospice-like support. Laura Patel, Chief Medical Officer of Transitions LifeCare in Raleigh, NC, explained that the model was designed to explore whether offering care without restrictions on other treatment would entice more people to choose this type of support, and if so, what impact such support has on patient satisfaction, health care quality, and utilization. The model, Patel explained, is based on the interdisciplinary framework of hospice and focuses on care coordination, shared decision-making, and symptom management. Patel explained that they refer to the program as "hospice light or palliative care heavy" because it offers more than the consultative fee-for-service palliative care approach, yet is not as comprehensive as traditional hospice care. Medicare pays a per person, per month rate and enrolled members receive 24/7 access to nurses, including home visits in the middle of night if needed, using on-call hospice staff.

## ADDITIONAL INNOVATIVE PROGRAMS DISCUSSED AT THE WORKSHOP

Another CMS innovative program is the Independence at Home (IAH) Demonstration. Eric De Jonge, executive director of Medstar Total Elder Care, described how home-based primary care teams implement palliative care principles such as treatment of symptoms and suffering, 24/7 access to care, establishing clear goals of care according to patient and family preferences,<sup>2</sup> and coordination of care across the lifespan and care settings. De Jonge noted that the care team comprises a physician, nurse practitioner, and a social worker that coordinate the delivery of all of the services the patient and family need in the home, including social services and home aides, physical and occupational therapy, medications and equipment, diagnostics services, and rehabilitation services.

De Jonge explained that the IAH Demonstration is a shared savings model; Medicare reimburses De Jonge's program on a fee-for-service basis, but if the program meets six quality metrics and reduces total cost per capita by 5 percent compared to expected costs, they are able to share the savings. He pointed to CMS data that indicate the national IAH Demonstration saved an aggregate of nearly \$33 million over the first two years of operation and health care providers received incentive payments totaling \$16.7 million.

<sup>2</sup>The importance of identifying, understanding, and addressing patient and caregiver preferences was explored in depth during the Roundtable on Quality Care for People with Serious Illness' December 2016 workshop on Integrating the Patient and Caregiver Voice into Serious Illness Care. The Proceedings of the Workshop is available at <http://www.nap.edu/24802> (accessed October 5, 2017).

Michael Fratkin, chief executive officer of ResolutionCare, discussed how his organization provides home- and community-based palliative care services to seriously ill people in remote, rural areas of Northern California by partnering with health insurers and plans with value-based payment arrangements. The ResolutionCare team delivers care either through in-person meetings in the home or community or through video conferencing technology, supported on occasion by its community health workers. Fratkin explained that approximately 8 percent of the program's clients are in nursing homes or assisted living facilities and, because the program has a contract with the local community hospital, it can provide seamless continuity of care for its patients when they are hospitalized. Fratkin highlighted ResolutionCare's extensive use of telemedicine drawing on smartphones and cloud-based computing to provide relational and longitudinal care.

Commonwealth Care Alliance (CCA) in Boston, MA is a not-for-profit, full-spectrum care system, health plan, and delivery organization focused exclusively on beneficiaries dually eligible for Medicare and Medicaid. CCA's chief of innovation, John Loughnane, explained that CCA was the first organization in the United States to use risk-adjusted premiums to create an integrated payer and care delivery model, and currently serves more than 20,000 members with complex medical, behavioral, and social needs. Clinical innovations include a community-based program that responds to urgent care needs and provides highly intensive care in the member's setting of choice at any time of day using specially trained paramedics. This program, according to Loughnane, has prompted the state of Massachusetts to develop regulations designed to encourage more of what he calls "community-powered medicine" across the state.

Another model discussed at the workshop, Landmark Health, is a mobile medical group that provides risk-based intensive patient-centric 24/7 in-home care for chronically ill patients with complex needs. Landmark's co-founder and chief medical officer, Micheal Le, described Landmark's interdisciplinary clinical model, which integrates behavioral, social, and palliative care and provides 24/7 triage capability, pre-911 calls, and in-home urgent visits when clinically indicated. Le explained that Landmark has coined the term "complexivist" to refer to these expert medical teams that provide in-home care. Landmark partners with health plans to share risk based on a prepayment/capitated payment model. Le said that Landmark's outcomes include positive impact on quality measures, reduced hospital utilization, lower costs, and high patient satisfaction rankings.

David Wensel, medical director of Midland Care in Midland, Kansas, discussed his organization's Program of All-Inclusive Care for the Elderly (PACE). As Wensel described it, PACE is

a comprehensive, fully-integrated community-based model of care including primary, palliative, and hospice for frail elderly adults at least 55 years old and certified at nursing home level of function. Payment is based on a monthly capitated rate adjusted for the frailty of the patient population. Palliative care is an integral part of the PACE model, and every team member is cross-trained in palliative medicine and end-of-life care.

Sachin Jain, chief executive officer of CareMore, described how its model provides coordinated care through care teams and neighborhood care centers with a focus on three areas: prevention of disease through sub-acute services and fitness centers; chronic care through disease management programs; and acute care through case managers and "extensivists," or internists who see the patient in the hospital and follow them through post-discharge to ensure continuity of care. A guiding clinical philosophy at CareMore, explained Jain, is to never waste any patient "touches," which enable staff to better manage patients' chronic diseases and build stronger relationships with their patients. Jain shared CareMore's clinical results, which include reduced hospital admissions, shorter hospital stays, and fewer congestive heart failure and COPD admissions than the Medicare average. Jain emphasized that the model is only as strong as the people who do the work, referring to staff as the "secret sauce."

Teresa Toland, chief executive officer of Tandem365, noted that her organization was formed in Michigan in 2013, when five care provider organizations—four faith-based continuing care retirement communities and an ambulance service—came together to form an independent collaborative to assist hospitals, doctors, family members, and individuals in need of health care services not traditionally provided as part of health system benefits. The partners all had strong reputations in the community for providing excellent care, an important factor for establishing contracts with insurance companies to provide services for their clients with complex medical needs. Toland noted that Tandem365's navigators, nurses, and social workers see their job as connecting the dots for their clients, which requires them to engage constantly with the community to arrange for supportive services.

## CONCLUDING REMARKS

In her closing remarks, Meier said she was inspired by the success, impact, and spread of the innovative care models detailed by workshop speakers. She said that an important next step is to make the types of programs explored in the workshop the standard of care rather than the exception.

**DISCLAIMER:** This Workshop Highlights was prepared by **Laurene Graig** as a factual summary of what occurred at the workshop. The statements made are those of the rapporteur or individual workshop participants and do not necessarily represent the views of all workshop participants; the planning committee; or the National Academies of Sciences, Engineering, and Medicine.

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For more information, visit <http://www.nationalacademies.org/SeriousIllnessCareRT>.

*Models and Strategies to Integrate Palliative Care Principles into Care for People with Serious Illness: Proceedings of a Workshop* can be purchased or downloaded from the National Academies Press, 500 Fifth Street, NW, Washington, DC 20001; (800) 624-6242; <http://www.nap.edu>.

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