CALIFORNIA HEALTHCARE FOUNDATION

Increasing Palliative Care Capacity in CA Communities

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21 members of the Palliative Care Action Community (PCAC)

Affiliations:

- 5 from single hospital or small health systems
- 7 from regional hospitals or large health systems
- 4 from home health or hospice agencies
- 5 from medical groups or specialty palliative care practices

Program settings

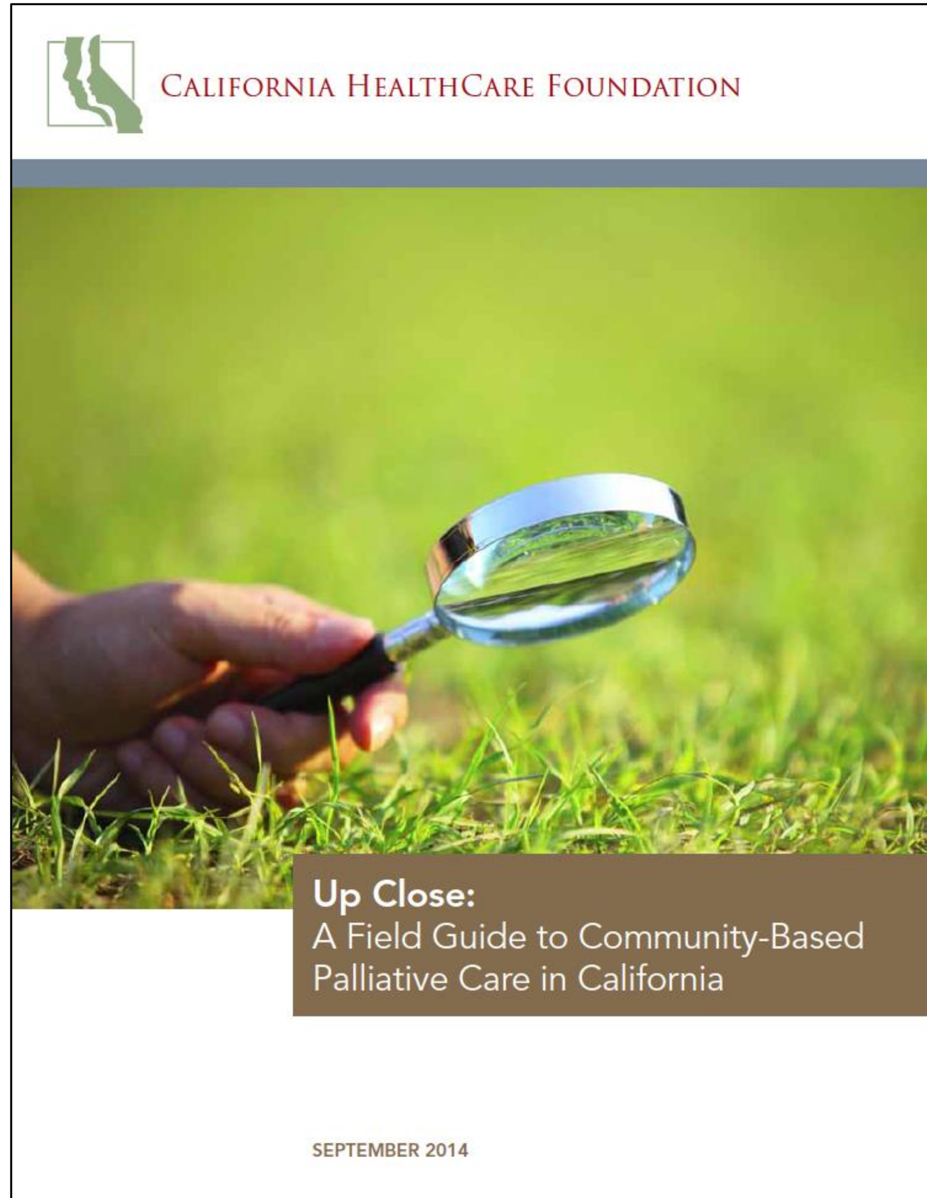
- Clinic -- 13
- Home -- 14
- Distance/phone support -- 8

Infrastructure for Shared Learning

- Focus on peer-to-peer learning and networking
- Monthly in-person or virtual learning sessions for one year
- Discipline- or topic-specific subgroups

The “Field Guide”

- Describes PCAC members’ programs, challenges, and promising practices
- Available at www.chcf.org



Field Guide Contents

- Examples of approaches to providing CBPC
- Practical information on how PCAC members are doing things: “Promising Practices”
- Case studies
- Descriptions of innovative models
- Other resources

Models of Community-Based PC

- Definitions
- Patient populations
- Types of services and service structure
- PC team's role in relation to other providers
- Approaches to pre-visit, initial visit, and follow-up care

Teamwork

- Care team composition
- Sample staffing allocations
- Sample visit volume
- Staffing strategies
  - Sharing staff between PC services
  - Providing support outside regular hours
- Team functionality
  - Communication and training

Partnering with Other Care Providers

- Rationale
- Approaches to building partnerships
- Supporting appropriate referrals
- First steps in working together
- Balancing responsiveness with service capacity
- Addressing resistance or disagreements

Coordination and Transitions

- Partnering with related services
  - E.g., complex case management; disease-specific or setting-specific social worker support; home care
- Transitioning patients back to usual care
- Transitions to hospice

Measuring Opportunities and Impact

- Rationale
- How teams can assess impact: Opportunity Analysis and Supportive Care Calculators
  - Which measures are tracked
  - Which patient populations can be examined
  - What types of data are needed
  - Process
  - Examples of how programs use these tools

Tools to Assess Impact on Quality and Cost

- **Opportunity Analysis** – look at utilization patterns in final 6 to 12 months of life; compare outcomes with and without PC; examine differences related to timing of initial PC contact
- **Supportive Care Calculators** – estimate impact and ROI using data from Opportunity Analysis and other operational and financial assumptions

Quality Improvement

- PCAC members developed aim statements
  - Increase referrals to PC clinic by 5 new MDs across at least 2 specialties
  - Establish processes to support smooth transitions from inpatient to outpatient PC services
  - Patients with moderate to severe pain will have pain reduced by 50% by second clinic visit
  - 80% of patients with incurable illness will have goals-of-care discussions and completed POLST forms

Case Studies

- Profiles of 4 programs
    - Stanford Health Care
    - Palliative Care Center of Silicon Valley
    - Hoag Hospital
    - Palo Alto Medical Foundation

CHCF Payer-Provider Partnerships

- Increase access to palliative care in the community
- 6 month planning grants of $50,000/team
- Selected through competitive proposals
- October 2014 – March 2015
- 2 meetings and technical assistance

Partners

Lead agency	Partner
1. California Pacific Medical Center Foundation	Brown and Toland/Sutter
2. Community Regional Medical Center	Humana
3. LightBridge Hospice & Palliative Care	HealthNet
4. Optum Palliative Care & Hospice	UnitedHealth
5. Partnership Health Plan	Various hospice-based palliative care providers
6. Rady Children's Hospital	HealthNet
7. SCAN Health Plan	MemorialCare Medical Group and Monarch
8. St. Michael Hospice	HealthNet
9. UCLA	Wellpoint
10. UCSF	Blue Shield + Hospice by the Bay

Areas of Focus

1. Identifying the patient population
   - By diagnosis
   - By prognosis
   - By utilization patterns
   - Scores on predictive modeling tools

2. Determining the model of care and staffing
   - Mostly home based with interdisciplinary team
   - Clinic based

Area of Focus

3. Funding approaches vary

- Per member per month (PMPM)
- Shared savings
- Varied monthly case rate
- Base payment plus service payment plus shared savings
- Other: P4P; reimbursement incentives

Areas of Focus

Measuring Impact

Process:

- Advance Care Plan / POLST (#/% completed)

Outcomes - Utilization:

- ED and hospital (# of visits, admissions, readmission, LOS); ICU (# of days)
- Hospice (referral rate; conversion rate; length on service)
- Palliative care service (#enrolled; length on service; # of encounters by discipline and locations)

Areas of focus

Measuring Impact

Outcomes – Experience:

- Patient / family satisfaction
- Pain and symptoms
- Site of death (% dying at home; % dying in preferred location)
- Provider satisfaction

Palliative Care Resources

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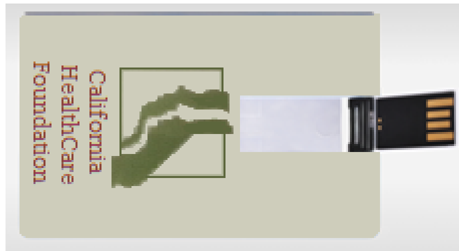

Experience of one PPI team

Partnership Health Plan