

**Palliative Care and Quality of Life
Interdisciplinary Advisory Council**

May 9, 2024

12:00 - 1:30 PM

Online Meeting via Zoom

<https://www.zoomgov.com/j/1609839491?pwd=NU1UZzBIM1Z6Y1E3NitQdmEvZ3F4QT09>

AGENDA

PALLIATIVE CARE AND QUALITY OF LIFE INTERDISCIPLINARY ADVISORY COUNCIL

May 9, 2024

12:00 - 1:30 PM

Virtual Meeting Via ZoomGov

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All times are approximate

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|-------------|----------------------------------------------------------------------|-----------------|
| I. | Call to Order, Roll Call, Minutes Barb Hansen, Vice Chair | 12:00 PM |
| II. | Palliative Care Program Rules & Training Resources | 12:10 PM |
| III. | Public Comment | 1:15 PM |
| IV. | Adjourn | 1:30 PM |

MINUTES

Palliative Care and Quality of Life Interdisciplinary Advisory Council

Virtual via ZoomGov

December 14, 2023

Members Present: Jamie Newell, Barb Hansen, Bob McCauley, Julia Victoria-Salve, Linda DeSitter, Seiko Izumi, Ryan Weller and Andrea Cano

Members Absent: Glen Patrizio

Staff Present: Mark Altenhofen

Guests: Summer Boslaugh, Carolyn Campbell

Call to Order

The meeting was called to order by Jamie Newell, Chair, at 12:05 PM. A roll call was conducted, and a quorum was established.

Minutes Approval

Minutes were approved unanimously. Linda made the motion to approve; Seiko 2nd; Aye- 8, Nay – 0, Abstain - 0

Staff Report

Mark provided a brief update on the status of the HB 2981 RAC process and the outreach that OHA Staff have done with CCO's on alternative or value-based payment models for the new palliative care program. Jamie shared how frustrating the delayed roll out of implementing HB 2981 has been for stakeholders.

OHA Staff Outreach on Value Based Payment

Mark introduced Summer Boslaugh and Carolyn Campbell, OHA Transformation Center staff who have been conducting outreach to CCO's. Summer described the work they have been doing to better understand how palliative care is being paid for currently within CCO's and how care is being delivered in different parts of the state. She also discussed what has been working and not working for CCO's. Carolyn summarized the interviews she conducted with CCO representatives and said that many are accepting and processing palliative care claims, but don't have any formal programs established. She also said that many CCO's are not offering all the services detailed in HB2981, especially around 24/7 telephone support and spiritual services. Carolyn also discussed how difficult it is to find trained and qualified providers in the rural areas of Oregon. She went on to describe how palliative care is primarily

available in hospitals at this time for many CCO's and that sustainable funding is a challenge for home based programs. Carolyn and Summer said they received a lot of interest in exploring creative ways to provide palliative care in rural areas, including through the use of telehealth or community health workers. Summer talked about the program that House Call Providers is offering in the Portland Metro region and their value-based payment model, although they understood this would be difficult to duplicate in rural areas. Summer and Carolyn then opened up the discussion to the council asking what they feel is working or not working with regard to providing palliative care services in Oregon. Linda described the program she directed for Providence Health System over the past ten years and how they worked very hard to implement community based palliative care in multiple different ways. She went on to say how the focus of their program was to engage patients in their homes with visits from social workers to help prevent unnecessary hospitalizations. Barb talked about how frustrating it has been to have to wait for this program to begin and that CCO reluctance or hesitation shouldn't have much weight on the conversation about getting the rules out because this is already in statute. She said the reimbursement is supposed to be mutually worked out with each palliative care provider and the CCO's could still to pay on a fee for service basis if that is what they want to do. Barb went on to say that organizations can't hire staff until they know when the program is going to start. Seiko said it will be very important to account for the non-billable providers in this service and that they are paid as well. Bob wanted to highlight the fact that palliative care is not the same for everybody from his perspective working in a pediatric specific population. He went on to say how the number of adults who need palliative care dwarfs the number of children who do, and at the same time, kids have unique needs. Bob believes that unless there is a pediatric specific emphasis somewhere in the rules, we are going to default to the greatest need and kids are going to be left out of the mix. He referred to an innovative program in upstate New York that is utilizing a monthly based payment model based on prognosis and that they're able to staff up a pediatric palliative care program that covers a wide geographic catchment area. Bob thinks that the uniqueness of the pediatric population might lead to a specific payment model based on children and prognosis when the life expectancy is not anticipated to go beyond 21 years of age. Barb added that she does not think there is any language in HB 2981, as it was passed, that prohibits it being applied to pediatric patients. She also thinks there needs to be statewide education for both CCO's and providers on this topic and there is an issue of concurrent care that kids can be on both hospice and curative care at the same time.

Summer provided an overview of how the state of Washington has been using a bundled payment methodology to provide interdisciplinary palliative care services along with fee for service reimbursement of medical providers. She provided an example of how a physician and nurse bill utilizing standard CPT & HCPCS codes and then the other members of the palliative care team bill using the bundled payment. Hospital stays and DME are not included in the team-based service model. Barb said it sounds very complicated to have a hybrid model, very high maintenance, and labor intensive for both the CCO and someone out of the palliative care program to manage. She then commented on how it would be nice to standardize the referral and recertification process. For instance, if a palliative care program gets a referral to see a patient, do they have to get reauthorized or recertified every 30 days, 90 days or six months? Barb said maybe that needs to be included in the rules, then went on to say that comments were submitted about the draft rules, but stakeholders never heard anything back, no feedback at all from OHA. Linda said that she didn't think the hybrid model would actually deliver the results CCO's want, which is to prevent unnecessary ER visits or hospitalizations. She went on to say that she supports Barb's comments on standardization and that it would be nice to have a dashboard where data from billing claims could be collected and programs could compare themselves to one another. Summer described the challenges Washington faced when trying to get everyone on the same page regarding measurement of both the clinical and financial outcomes and that she would send out

their findings to the group. Barb expressed her appreciation for the work Summer and Carolyn have been doing and wanted them to know that her frustrations were more about the delay in the rule making process than the good work they've been doing. Jamie also voiced her appreciation for the work being done by the Transformation Center at OHA.

HB 2981

Barb thought it would be helpful for the council to consider developing a list of resources to put on the website to help providers when the rulemaking for HB 2981 is finished and the program starts. For example, she said it would be helpful to come up with a list of training resources to help providers meet the required 16 hours of training in palliative care. There is such a shortage of certified palliative care providers in the state. She said maybe the council could include access to virtual training or webinars. Jamie said she agrees, but recalled how the experience with creating the health facilities document went nowhere and how it will be important to have a clear understanding how work the council is doing will actually be productive. Linda and Barb discussed ways of increasing the motivation for CCO's to come up with a payment model and how to assess if patients are actually receiving care via the program. They wondered who at OHA will be assessing the implementation and what outcome measures will they be tracking. Linda asked about ways to influence political leaders to help make sure the program is successful. Mark said the council can advise the Director of OHA or add educational material to the website to help influence the program and engaging political representatives would need to be done outside of the scope of the council's work or representation. Jamie said it would be helpful to focus the next meeting on creating some resources for the PCAC website to help with the roll out of HB 2981.

Adjournment

Meeting adjourned at 1:20 PM. Next meeting is scheduled for May of 2024, time and date to be announced.

Palliative Care and Quality of Life Interdisciplinary Council

Palliative Care Program Training Resource List

May 2024

Clinical team members are required to have a minimum of 16 hours of palliative care training. **If a clinician has a certificate from a palliative care training program, no additional training is required.**

[Should the council website more clearly define what is meant by “a certificate from a palliative care training program?”]

Training in may include the following:

[Does the council want to provide more information or better define the following training categories to help guide providers in decision making?]

- Advance Care Planning conversations including discussion of POLST and/or Advance Directive
- Palliative Care Assessment including: [Any recommendations on protocols, tools or screening instruments?]
 - Patient assessment
 - Social needs screening
 - Home safety assessment
 - Caregiver assessment
 - Spiritual assessment
 - Functional assessment
- For Physicians, NPs, PAs and RNs:
 - Basic pain and symptom management [Guidelines or standards of care?]
 - Expected disease trajectory. [Examples?]

Additional recommended training:

- Trauma informed care
- Social determinants of health
- Boundaries – [What does this mean or look like in practice?]
- Motivational interviewing

[Any additional information to include on the website that would be useful for providers?]

Palliative Care and Quality of Life Interdisciplinary Council

Palliative Care Program Training Vendors or Sources

Example Listing on Website – Criteria may include:

- Name of Course
- Vendor or Source of Training
- Brief description or summary of course
- Type of training – webinar, conference, in person, books, journal articles or audio resources.
- Time requirement
- CME or CEU's hours
- Cost (Free or \$)
- Contact information / website links for registration

[Is there any other information that would be helpful to add/remove?]

Resources can be sent via email to: mark.g.altenhofen@oha.oregon.gov

Definitions

- (1) "Assessment" means procedures by which a practitioner of the healing arts identifies strengths, weaknesses, problems, and needs to determine a member's need for palliative care services.
- (2) "Interdisciplinary Team" means a team of individuals working together in a coordinated manner to provide palliative care services, which may include the family-patient unit. An interdisciplinary team is composed of the following individuals who are trained or certified in palliative care:
 - (a) A registered nurse;
 - (b) A social worker; and
 - (c) A physician or primary care provider, or specialty care provider;(d) In addition to (a-c) above, the interdisciplinary team may include one or more of the following palliative care program personnel:
 - (A) Licensed Practical Nurse;
 - (B) Certified nurse's aide;
 - (C) Home health aide;
 - (D) Hospice aide;
 - (E) Community health worker;
 - (F) Occupational therapist;
 - (G) Physical therapist;
 - (H) Trained volunteer (faith or community based);
 - (I) Spiritual care professional;
 - (J) Advanced practice clinicians; and
 - (K) Licensed or credentialed mental health professionals including:
 - (i) Licensed psychiatrist;
 - (ii) Licensed psychologist;
 - (iii) Psychiatric nurse; and
 - (iv) Qualified Mental Health Professional.
- (3) "Palliative care services" means comfort services that focus primarily on reduction or abatement of physical, emotional, social, functional deficiency and spiritual symptoms of serious illness.
- (4) "Primary caregiver" means the person designated by the patient or the patient's representative to assume responsibility for care of the patient as needed. If the patient has no designated primary caregiver and is unable to designate one, the interdisciplinary team shall designate a primary caregiver.
- (5) "Portable Orders for Life-Sustaining Treatment (POLST)" means the formal written medical orders for life-sustaining treatment signed by a physician, naturopathic physician, nurse practitioner or physician assistant that helps identify the types of medical treatment a patient will receive during their palliative care.
- (6) "Prognosis" means the probable outcome of a disease over a given period of time.
- (7) "Residential care facility" has the meaning given that term in ORS 443.400.
- (8) "Serious Illness" means a disease, injury, or other physical, cognitive or mental condition that is life-limiting.
- (9) "Skilled nursing facility" has the meaning given that term in ORS 442.015.
- (10) "Symptom management" means assessing and responding to the physical, emotional, social, functional and spiritual needs of the patient and their family.

System of Care

- (1) A Coordinated Care Organization (CCO) shall maintain a network to provide a community or home-based Palliative care benefit for its members.
- (2) A residential care facility or a skilled nursing facility is not subject to the rules for the Palliative Care Program established for CCOs in providing or arranging palliative care services for residents of the facilities.
- (3) A provider of palliative care services under the program and a CCO shall determine the reimbursement paid for services by mutual agreement.

Eligibility for the Palliative Care Service

- (1) A patient qualifies for palliative care services under the program if they:
 - (a) Have been diagnosed with a serious illness that has a negative impact on the patient's quality of life or the quality of life of their primary caregiver; and
 - (b) Palliative care is ordered by the patient's primary care or other specialty care provider.
- (2) If Medicare or other insurance is available it must be billed before billing Medicaid.

Plan of Care

- (1) A written plan of care must be established and maintained for each patient eligible for palliative care services, and the care provided to a patient must be provided in accordance with the plan.
- (2) The plan of care is developed and updated as directed by the patient accessing palliative care services or the patient's representative, in collaboration with the members of the interdisciplinary team (IDT).
- (3) The plan of care includes the following:
 - (a) A comprehensive palliative care assessment to include physical, psychological, social, spiritual needs, and functional status. This also requires on-going assessment of need for community-based palliative care services.
 - (b) Assessment of caregiver needs, including appropriate referrals to community-based services such as support groups, caregiver respite, and grief or bereavement services.
 - (c) A documented plan to manage symptoms and coordinate care in accordance with the patient's needs and goals;
 - (d) An ongoing assessment of pain, other physical symptoms, functional status, and psychological symptoms using available standardized tools.

Provider Qualifications for Palliative Care Program

- (1) Providers must be credentialed per CCO requirements as is required for Home Health, Hospice, or outpatient palliative care provider requirements.
- (2) Members of the Interdisciplinary team (IDT) must be trained or certified in palliative care with documentation of a minimum of 16 hours of palliative care training for those who are not certified.
 - (a) Training topics will include, but are not limited to:
 - (A) Advance Care Planning conversations including discussion of POLST and/or Advance Directive.
 - (B) Palliative Care Assessment, including Patient assessment; Social needs screening; Home safety assessment; Caregiver assessment; Spiritual assessment; Functional assessment; and Risk assessment.
 - (C) Basic pain and symptom management;
 - (D) Expected disease trajectory for Physicians, Naturopathic Physicians, Nurse Practitioners, Physician Assistants and Registered Nurses.
 - (b) Additional recommended training topics include:
 - (A) Trauma informed care;
 - (B) Social determinant of health issues;
 - (C) Professional boundaries;
 - (D) Motivational interviewing.

Palliative Care Team and Services

(1) The Palliative Care Program must designate an Interdisciplinary team who provide or supervise the care and services offered to the patient. Members of the Interdisciplinary team interact on a regular basis and have a working knowledge of the assessment and care of the patient/family unit by each member of the team. The interdisciplinary team is responsible for:

- (a) Development of the plan of care;
- (b) Provision or supervision of palliative care services;
- (c) Review and updating of the plan of care for each patient receiving palliative care; and
- (d) Establishment of policies governing the day-to-day provision of palliative care services.

(2) Palliative care services shall include:

- (a) Palliative care assessment;
- (b) Advance care planning including a discussion regarding completing a POLST and/or Advance Directive;
- (c) Case management and care coordination provided by a registered nurse or other qualified member of the interdisciplinary team;
- (d) Symptom assessment and management;
- (e) Transitional care management;
- (f) Behavioral health and social work services;
- (g) 24-hour clinical telephone support;
- (h) Spiritual care services;
- (i) Education with the patient and their caregivers, including:
 - (A) Aspects of in-home care, including the safe use of medications, and storage and disposal of medications in the home setting;
 - (B) Goals towards the patient being more self-reliant and when to seek higher level of care;
 - (C) When to contact Emergency Medical Services (EMS);
 - (D) Hospice services availability and eligibility;
 - (E) Bereavement support and services availability.

(3) The palliative care services, as determined and provided by an interdisciplinary team, must be provided in the patient's choice of residence.

Requirements for Coverage

(1) To be covered, Palliative care services must meet the following requirements:

- (a) A referral from a patient's primary care or other specialty care provider must be given for palliative care services;
- (b) The patient or the patient's representative must elect Palliative care services;
- (c) The services provided must be consistent with the plan of care.

Disenrollment Criteria

(1) Patients are no longer eligible for community-based palliative care services under the Palliative Care Program if the patient:

- (a) Enrolls in hospice;
- (b) Dies;
- (c) Is no longer enrolled in Medicaid;
- (d) Experiences improvement of their condition or functional status causes them to no longer meet eligibility criteria;
- (e) Lives in conditions that are found to be unsafe for staff contact, and no alternative can be found;
- (f) Chooses to disenroll;
- (g) Moves out of a palliative care provider's service area;

- (h) Engages in behavior that is disruptive, abusive, or is considered a health and safety concern to the patient or a member of the IDT, to the extent that delivery of care to the patient, or the ability of the agency to operate effectively, is seriously impaired.
- (i) Lives in a home where others engage in behavior that is disruptive, abusive, or is considered a health and safety concern to the patient or a member of the IDT, to the extent that delivery of care to the patient, or the ability of the agency to operate effectively, is seriously impaired.

Consensus Standards for Community-Based Palliative Care in Implementing HB 2981 June, 2022

Introduction

Palliative care is patient- and family-centered care that prioritizes quality of life by anticipating, preventing, and treating the symptoms and stress associated with serious illness. HB 2981, passed by the Oregon legislature in 2021 and signed into law effective January 1, 2022, requires that the Oregon Health Authority, through the Community Care Organizations (CCOs) offer palliative care to their Medicaid members.

The law defines palliative care as being provided by an interdisciplinary team, including medical providers, nurses, social workers, chaplains, and other specialists as needed. Palliative care can be provided alongside curative treatment regardless of patient age, diagnosis or stage of illness. Community-based palliative care has been shown to improve patient's quality of life, reduce symptom burden, and increase patient and family satisfaction while reducing the cost of medical care.

Learning from some of the challenges a similar law in California has faced in adoption and operationalization, a group of representatives from community-based palliative care providers, a CCO, and the Oregon Hospice and Palliative Care Association met to outline suggested standards to be used in implementing HB 2981. With permission, these standards are based on California's standards, the National Consensus Project's Clinical Practice Guidelines, and guidelines from the Center to Advance Palliative Care (CAPC), and the American Association of Hospice and Palliative Medicine (AAHPM).

The goal of these suggested standards is to determine a minimum set of services and training necessary for implementation of community-based palliative care under HB 2981.

I. Patient Identification

| Advanced Illness Care Eligibility Screening Tool | |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Section 1: DIAGNOSIS - Patient has at least one of the following</p> | <p>Cardiac Disease</p> <ul style="list-style-type: none"> - Systolic Heart Failure with Ejection Fraction (EF) of $\leq 50\%$ or - Diastolic Heart Failure/Pulmonary Hypertension or - Valvular Diseases where surgical intervention is not an option <p>Liver Disease</p> <ul style="list-style-type: none"> - End stage liver disease (ESLD): Patients with Ascites, Esophageal Varices +/- GIB, Encephalopathy, Hepato-Renal Syndrome, or Spontaneous Bacterial Peritonitis <p>Renal Disease</p> <ul style="list-style-type: none"> - CKD Stage 4 or ESRD on HD with ED/hospital utilization for symptoms related to the disease such as anorexia or dyspnea or edema or NV and/or having issues with dialysis intolerance and recurrent venous access complications, or pain from calciphylaxis <p>Respiratory Disease</p> <ul style="list-style-type: none"> - Interstitial Lung Disease or Idiopathic Pulmonary Fibrosis or - COPD - GOLD Stage 2-3 +/- oxygen supplementation with dyspnea at rest and/or on exertion and/or - Comorbidities such as having recurring pneumonia or have other associated respiratory issues such as obstructive sleep apnea using CPAP or BiPAP with worsening symptoms <p>Neurodegenerative Disease</p> <ul style="list-style-type: none"> - ALS - all referrals from the ALS clinic - Parkinson's Disease, Multiple Sclerosis, or Huntington's Chorea with a Palliative Performance Score (PPS) of $\leq 50\%$ with palliative symptom management needs <p>Cancer</p> <ul style="list-style-type: none"> - Definitive diagnosis based on biopsy +/- metastases & symptomatic or - Presumptive diagnosis without biopsy but symptomatic but not pursuing further evaluations for various reasons such as having contraindications or have other severe medical problems or due to advanced age but not yet ready for hospice level of care <p>Cerebral vascular accident (CVA)/Stroke or dementia</p> <ul style="list-style-type: none"> - Decreased ability to take oral nutrition, or rapid change in mental status, decreased functional status PPS($\leq 50\%$), aspiration pneumonia or history of aspiration pneumonia <p>HIV/AIDS</p> <ul style="list-style-type: none"> - CD4+ Count < 25 cells/mcL, albumin < 2.5, wt loss, PPS $\leq 50\%$ <p>Frailty</p> <ul style="list-style-type: none"> - Decrease in weight and/or function with 2 falls and/or infections in last six months <p>Multiple chronic conditions/comorbidities with ≥ 2 ED visits or 1 hospitalization in the last 6 months related to symptom management, chronic disease management, or acute event contributing to more rapid decline in health (PPS $\leq 50\%$).</p> |

| | |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Section 2: UTILIZATION - The patient meets at least one of the four criteria</p> | <ul style="list-style-type: none"> - Two or more ER visit in the last 6 months - One or more hospitalization in the last 6 months - Fall with injury but refused transfer to ED - Current admission prompted by: <ul style="list-style-type: none"> o Uncontrolled symptoms related to underlying disease (e.g. pain, shortness of breath, vomiting, confusion) and/or o Inadequate home, social, family support |
| <p>Section 3: FUNCTION - The patient meets at least one of the six criteria</p> | <ul style="list-style-type: none"> - Decline in function, feeding intolerance, frequent falls, or unplanned weight loss - Complex care needs: dependent on one or more ADLs, complex home support for care (oxygen, medications, insulin) - High risk factors/gaps in care: low health literacy, medication non-adherence, frequent no show to appointments, cognitive impairment, houselessness, homebound. - Pt declined hospice enrollment. - Complex goals of care: conflict amongst patient/family regarding GOC, patient declines to engage in GOC/ACP activities |
| <p>Section 4: EXCLUSIONS - The patient meets all listed criteria</p> | <ul style="list-style-type: none"> - The primary diagnosis explaining the above is not psychiatric in nature. May consider patients who meet palliative care criteria with active psychiatric symptoms with additional screening. - The primary diagnosis explaining the above is not related to active substance use disorder (SUD). May consider pts who meet palliative care criteria with active SUD with additional screening. - This referral is not related to primary pain management. - The patient is not currently enrolled in hospice. |

II. Essential Services

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

A. Assessment

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

4. Ongoing assessment of pain, other physical symptoms, functional status, and psychosocial symptoms using standardized tools as available.

B. Plan of Care

1. Development of an individualized care plan to identify problems and document a plan of care based on the patient's needs, values, goals, strengths, and limitations to address symptom management, goals of care, care coordination and to provide an extra layer of support.

2. Advance Care Planning discussions, anticipatory guidance, and appropriate documentation, including identification of surrogate decision maker and completion of POLST forms, where appropriate and desired.

3. IDT meetings to assess the effectiveness of interventions and the palliative care plan.

C. Clinical Services

1. In-person or telehealth/telemedicine visits or telephonic contacts by an interdisciplinary team. Services shall be adjusted to meet patient needs for care.

2. Medication management and reconciliation. When patient care includes the treatment of physical symptoms with opioids, assessment for the need of a bowel regimen.

3. Symptom management services 24 hours/day, 7 days a week. Support can be telehealth.

4. Education with the patient and the caregiver(s):

- on aspects of in-home care, including the safe use of the prescribed medications, storage, and disposal in the home setting
- with the goal of patient being more self-reliant by the time of live discharge
- on the process of calling 911 if death occurs
- on hospice services.

5. Collaboration with the primary care provider for referral for rehabilitation therapies when indicated, including, but not limited to physical, occupational, and speech-language therapies.

6. Consideration of referral for complementary and alternative medicine services for the treatment and management of symptoms, if covered benefit, and recommendation in consideration of access to such services.

7. In the likelihood of imminent death of the patient, IDT provides information regarding bereavement support services and recommends community resources for bereavement follow-up as indicated.

8. Facilitate continuity of care during patient's discharge from the palliative care program or transfer of care to a health care facility or other health care provider.

D. Care Coordination and Communication

1. Collaboration with patient, family, legal decision medical maker, and patient's providers.

2. Care coordination to assist eligible member navigation of the medical system, including transitions across settings, benefits, and collaboration with health plan partner.
3. Coordination with health plan partner to support palliative care patient access to appropriate services and DME as necessary.

III. Palliative Care Providers

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

1. Physician (medical doctor, doctor of osteopathy) The physician role may include direct clinical care or be limited to program oversight.
2. Registered nurse
3. Social worker
4. Spiritual care professional/chaplain

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

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

IV. Training Requirements

Clinical team members are required to have a minimum of 16 hours of palliative care training. If a clinician has a certificate from a palliative care training program, no additional training is required.

Examples of topics to require to be included:

- Advance Care Planning conversations including discussion of POLST and/or Advance Directive
- Palliative Care Assessment including:
 - Patient assessment
 - Social needs screening

- Home safety assessment
- Caregiver assessment
- Spiritual assessment
- Functional assessment
- For Physicians, NPs, PAs and RNs:
 - Basic pain and symptom management
 - Expected disease trajectory

Additional recommended training:

- Trauma informed care
- Social determinant issues
- Boundaries
- Motivational interviewing

V. Disenrollment Criteria

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

1. Hospice enrollment
2. Death
3. Change in insurance eligibility
4. Improvement of condition or functional status extended outside eligibility criteria
5. Client living conditions are found to be unsafe for staff contact, and no alternative can be found
6. Patient moves out of palliative care provider's service area
7. Patient chooses to disenroll
8. Consider discharge for cause if the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient, or the ability of the agency to operate effectively, is seriously impaired.

VI. Measurement and Reporting

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

A. Process Measures

1. Number of patients enrolled in palliative care
2. Duration of patient enrollment

3. Proportion of palliative care patients who transition to hospice
4. Documentation of goals of care conversation, including Advance Healthcare Directive and POLST, anticipatory guidance, value based shared decision making where appropriate, selection of surrogate decision maker and preferences for end-of-life care
5. Documentation of timely follow up of transitional care support from acute care or skilled facility
6. Individualized Care Plan

B. Outcome Measures (if available)

1. Patient and caregiver satisfaction
2. Inpatient utilization rates
3. Emergency department utilization rates
4. Goal concordant care

VII. Payment Models

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

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

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

HB 2981 Standards Work Group

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Kevin Hohnbaum
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Community Engagement Meeting for Palliative Care New Rule – HB 2981
4/2/24 – Engagement Questions

Section 1 – Definitions

- There is inner mixed use through out the document of “client”, “individual”, and “patient”, need consistency. **Updated all to patient.**
- #2 Interdisciplinary team, states directed by the individual. Who is the individual?
 - Changed “An interdisciplinary team is directed by the individual and composed of the following individuals who are trained or certified in palliative care:” to:
 - An interdisciplinary team is composed of the following individuals who are trained or certified in palliative care:
- Is “trained or certified” going to be better defined?
 - The answer is provided further down in the document.
- #8 Serious Illness - Would there be any benefit in adding “cognitive” to be included. **Added**
- #3 & #10, We would like to add the words functional deficient because of how the population is defined in literature, it is the best way to pull out the population in question. **Added**
- #2 – line (iv) Mental Health Professionals, are you speaking of LPC, LCSW, and LMFT? Professional representation.
 - Yes, this would be staff enrolled as a Mental Health Provider (type 33). This can be clearly defined within the contract the CCO’s have with their Palliative Care providers.
 - In HB 2981, the only required disciplines are Nurse, Social Worker, and a Provider that is in an oversight role only.

Section 2 -System of Care

- No comments

Section 3 – Eligibility for the Palliative Care Service

- Is there a time limit on Palliative Care?
 - That limit would be established by the CCO’s.
The usual time limit is 2 years, but stated further in the meeting, pediatric patients tend to receive palliative care longer.
- What does #2 mean, residential care facility, skilled nursing facility are not subject to the rules?
 - The OAR does not require these facilities to provide palliative care services. These facilities have services they would provide per their contract. CCO’s can choose to contract with providers for additional services.
 - Under the law, the facilities lobbied they did not want to be required to provide palliative care. It would not be included in their bundled rate, allowing them to be exempt.
 - Palliative care teams can see patients in any setting.
- Under the eligibility, it appears a patient cannot request services for themselves. If a CCO identifies a member that can benefit from palliative care services, would they need to reach out to the primary car provider for a referral?
 - The law requires an order, and the palliative care providers will need to work closely with the CCO in these cases to create a process for referrals.

Section 4 – Plan of Care

- Who is responsible for what? Who is completing the plan of care, the CCO or the Palliative Care team?
 - The CCO's are responsible for implementing the program. The CCO would contract with their Palliative Care provider and that team would create the Plan of Care for the patient.

Section 5 – Provider Qualifications for Palliative Care Program

- In Eastern Oregon there is a limited work force. Do we have to include language of 16 hours of training?
 - Yes. Most CCO's are looking to the model created by Housecall providers. It was stated to direct the requirements in the contract the CCO has with the providers. It was stated there is free training available on CAPS. The 16 hours was designed for deal with disease trajectory and symptom management. Stated in the law, there are 2 identified providers needed, the providers listed were suggestive.
- What does that mean if providers are not certified?
 - The certification is going to be dependent on the CCO contract and their requirements for the palliative care team.
 - It was stated there is certification available thru training classes for hospice, palliative care nurse, similar to social workers and chaplains. If those staff already have it, it would be notated within their files in case it was requested for verification.
 - There is not a specific time for completion called out. That again is between the CCO contract with the palliative care team.

Section 6 – Palliative Care Team and Services

- Is the IDT team within the CCO or within the palliative care providers?
 - It is the palliative care providers.

Section 7 – Requirements for Coverage

- Is it only the patient that can elect palliative care? This can be problematic.
 - Language has been changed to include patient representative.

Section 8 – Disenrollment Criteria

- Concerns about letter (e) "Lives in conditions that are found to be unsafe for the staff contact, and no alternative can be found;"
 - Team safety is the most important thing and providers must be judicious of the CCO's funding around this. If the team is unable to engage with them, such as no phone, no showing to appointments, there have to be reasons to discharge the client.
 - Working with the CCO's, the provider should be able to identify whether a patient would benefit from palliative care interventions.

Secondary questions:

- What data will be collected and presented to the state to show efficacy and is OHA taking responsibility for collecting the data or how is the evaluation part of all this going to happen?
 - Any requirements for data or evaluations would be directed by the CCO within their contract.
 - OHA will include the CCO requirements per their contract with the state.

- Is there a due process if a patient is discharged for safety reasons?
 - The CCO's should have an appeal process.

- What will be the process of providing utilization management in these kinds of palliative care models?
 - Housecall providers have created their own document. The consensus document from a palliative care leaders, CCO's from around the state participated in the process to come up with the document to inform the rules.
 - The disenrollment is from the palliative care program, not the CCO.