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	
Section 1: DIAGNOSIS - Patient has at least one of the following	Cardiac Disease - Systolic Heart Failure with Ejection Fraction (EF) of ≤50% or - Diastolic Heart Failure/Pulmonary Hypertension or - Valvular Diseases where surgical intervention is not an option Liver Disease - End stage liver disease (ESLD): Patients with Ascites, Esophageal Varices +/- GIB, Encephalopathy, Hepato-Renal Syndrome, or Spontaneous Bacterial Peritonitis Renal Disease - 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 Respiratory Disease - 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 Neurodegenerative Disease - ALS - all referrals from the ALS clinic - Parkinson's Disease, Multiple Sclerosis, or Huntington's Chorea with a Palliative Performance Score (PPS) of ≤50% with palliative symptom management needs Cancer - 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 Cerebral vascular accident (CVA)/Stroke or dementia - Decreased ability to take oral nutrition, or rapid change in mental status, decreased functional status PPS(≤50%), aspiration pneumonia or history of aspiration pneumonia HIV/AIDS - CD4+ Count <25 cells/mcL, albumin <2.5, wt loss, PPS ≤50% Frailty - Decrease in weight and/or function with 2 falls and/or infections in last six months 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 ≤50%).

Section 2: UTILIZATION - The patient meets at least one of the four criteria	- 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:
	  o Uncontrolled symptoms related to underlying disease (e.g. pain, shortness of breath, vomiting, confusion) and/or
	  o Inadequate home, social, family support

Section 3: FUNCTION - The patient meets at least one of the six criteria	- 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
Section 4: EXCLUSIONS - The patient meets all listed criteria	- 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 choses 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.

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