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NAMCP MEDICAL DIRECTORS SPOTLIGHT GUIDE:
Palliative Care in Oncology

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NAMCP Medical Directors Spotlight Guide: Palliative Care in Oncology

Dawn Holcombe, MBA, FACMPE, ACHE and Barry Kinzbrunner, MD, FACP, FAAHPM

The Oncology Landscape: How Palliative Care Trends and Issues in Oncology will Affect Medical Directors of Purchasers, Plans, and Providers, and NAMCP Strategies to Address These Issues

Summary

The mission of the NAMCP Medical Directors Oncology Institute is to open the lines of communication between medical directors in managed care and practicing oncologists to help them jointly better navigate and understand what is happening in managed care and the day to day management and practice of oncology. This guide presents an overview of palliative care in oncology, as well as the challenges and issues for physicians and oncology management from the health plan perspective. It discusses palliative care in the context of quality and payment reform, the business of oncology, and issues and strategies for plans and purchasers seeking solutions for oncology management. The guide presents activities and initiatives within the NAMCP Oncology Institute to support medical directors from purchasers, plans, and provider systems, and to eventually achieve greater collaboration that should lead to improved patient outcomes in oncology.

Introduction

This Medical Directors Guide from the NAMCP Oncology Institute reviews the current state of palliative care in oncology and addresses the range of programs and policies, as well as implications of those components of cancer treatment related to the management of oncology. Oncology treatment, quality, value and costs are among the top concerns for health plans and purchasers, yet most medical directors in those venues are not oncology-trained specialists. There is great interest and increased discussion about the use of palliative care in oncology, but too often plans and purchasers also seek a context in which to evaluate potential policy, risk management and value of care being provided for their members. Members of the NAMCP Medical Directors Oncology Institute have asked for assistance in terms of a context from which to consider oncology management options, to take a look at the resources that NAMCP can offer, and to develop oncology policy strategy related to palliative care.

Health Plan Considerations for Oncology Palliative Care – the Growing Impact of Quality Focus

“The Centers for Medicare and Medicaid Services projects that U.S. health-care spending will reach \$4.3 trillion and account for 19.3 percent of the nation’s gross domestic product by 2019. Although cancer care represents a small fraction of overall health-care costs, the cost of cancer care is rapidly increasing, now estimated to reach \$158 billion in 2020 — an increase of 26 percent over just a decade.

These expenditures are driven by the increasing prevalence of cancer due to the overall aging of the population and the introduction of costly, but hopefully more effective, new drugs as well as improved techniques in radiation therapy and surgery, resulting in more patients continuing on treatment for longer periods of time. Also contributing to rising costs are physician reimbursement models that reward the quantity rather than the quality of care delivered, the often inappropriate use of tumor-directed therapy near the end-of-life, and the sometimes desperate hopes and unrealistic expectations of patients and family members that lead clini-

cians to offer certain options despite lack of clear evidence of clinical benefit.¹”

Written by Richard L. Schilsky, MD, FACP, FASCO, Chief Medical Officer of the American Society of Clinical Oncology in 2015.

Escalating cancer expenditures are a major challenge that takes a significant toll on society, patients, providers, payers and employers. Just as the causes of these rising costs are multifactorial, as delineated above in Dr. Schilsky’s comments, strategies aimed at effectively managing these costs are multifactorial as well, and have become part of a wide national discussion on quality and value for cancer treatment. Quality measurement and improvement have been components in just about every payment reform model proposed by Congress, the Center for Medicare & Medicaid (CMS), physicians, health care systems and private payers and employers. Organizations as varied as CMS, the Commission on Cancer, the Community Oncology Alliance, the National Quality Forum, the Agency of Healthcare Research and Quality, and the American Society of Clinical Oncology have published or endorsed quality metrics that cover a wide variety of cancer services. Common to all of these is the presence of some measures related to palliative care, end-of-life care,² and pain management, which is often used as a marker for quality patient management.

Most medical directors for health plans and employers are not medical oncologists. Although very concerned about costs and policy issues for cancer, they are not always certain of what questions to ask and where some of the less obvious issues lie. This guide reviews common background, concerns and issues that medical directors might want to address when embarking on a policy for oncology palliative care.

Medical Director Concerns and Questions

The following are topics and questions beginning to be raised by medical directors of plans, purchasers and plans regarding oncology palliative care:

- How can I measure quality in cancer care, and what is the impact of palliative care, end-of-life care, and pain management?
- What are the standards for palliative care?
- Where and when does palliative care become part of the choices for oncology care and treatment?
- What are the differences between palliative care and hospice care?
- What choices do my members have to make, and who is helping them to make those choices?
- What resources are available to patients, providers and payers for understanding palliative care?

- How do I define costs of palliative care in oncology and what are the key variable points? How are these costs being managed and by whom?
- What is the impact of drugs in the management of palliative care?
- What are considerations for health benefits design for palliative care?

These questions are all being factored into choices, within a cancer center or a health plan, that are being made about the management of palliative care in oncology that affect the cost, quality and access of cancer care. In these choices, it is useful to be aware of the many variables involved, while deciding how oncology care will be managed. The National Association of Managed Care Physicians (NAMCP) is developing tools and support for the decision-making challenges that face its members.

The Impact of Palliative Care on the Quality and Costs of Oncology Care

Cancer and the treatment of cancer causes symptoms and side effects. The current model of medical care in the United States does not meet the needs of many patients with advanced illness, including cancer. Additionally, the costs of cancer care to society, employers, purchasers, and patients are significantly rising. The Agency for Healthcare Research and Quality (AHRQ) estimates that direct medical costs of cancer care are now at \$88.7 billion annually.³

Cancer and the treatment of cancer causes a wide range of significant and serious symptoms and side effects. The costs of managing these symptoms and side effects can be high, both physically and mentally for patients, and financially for patients, providers and payers. There is a general consensus that better management of patient side effects, suffering and pain can result in better quality of life and even lower total costs of care, but there is still great variation in the degree and timing of such interventions. As a result, both the quality and costs of care, particularly for people with advanced illness, are central issues in the debate of health care reform.

Patients with cancer make up a significant portion of those people who have a high symptom burden and/or advanced illness. Of all patients with metastatic cancer, nearly half have incurable disease, but they can live for years after the initial diagnosis.⁴ Since the 1990’s, when advances in diagnosis and treatment started surging, many organizations have addressed the role that palliative care plays in comprehensive cancer care – during both curative treatment and end-of-life management. There have been wide ranging definitions of what constitutes palliative care, and what should be the standard for strate-

Exhibit 1: Challenges to the Delivery of Palliative Care Across the Cancer Care Continuum

In this report, the committee utilizes the term palliative care and adopts the National Quality Forum's definition: "patient-centered and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice" (NQF, 2006, p. 3). The committee conceptualizes palliative care as an added layer of support that can be delivered concurrently with other therapeutic treatment modalities to improve quality of life for cancer patients.

A lack of awareness about palliative care and definitional challenges reduce patients' access to palliative care across the cancer care continuum. A recent survey found that 70 percent of the public had no knowledge of palliative care, but once informed, 95 percent of respondents agreed that patients with serious illness should be informed about palliative care (Center to Advance Palliative Care, 2011).

Although the general public has little knowledge about palliative care, clinicians often conflate palliative care with hospice care (Center to Advance Palliative Care, 2011; Meier, 2012). Thus, clinicians often neglect recommending palliative care until late in the cancer care continuum. Studies suggest that some oncology clinicians prefer the term supportive care as opposed to palliative care, and if the name were changed, clinicians would be more likely to refer patients earlier in the cancer care continuum (Dalal et al., 2011; Hui et al., 2013; Wentlandt et al., 2012). However, others have asserted that changing the name risks even more confusion: "Rather than changing the name from 'palliative care,' risking ambiguity and confusion, we believe that improved communication is key to appropriate engagement with palliative care services" (Milne et al., 2013)

"Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis" Box 3-4, Page 123, Laura Levit, Erin Balogh, Sharyl Nass, and Patricia Ganz, Editors; Committee on Improving the Quality of Cancer Care: Addressing the Challenges of an Aging Population; Board on Health Care Services; Institute of Medicine, National Academy of Sciences, publication 2013, last accessed on July 20, 2015 at http://www.nap.edu/download.php?record_id=18359.

gies and goals, so it is difficult for benefits managers and payers to clarify what should be covered and when.

The Institute of Medicine wrote in its 2013 report on the state of quality in cancer care, "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis," how important palliative care is in the cancer continuum, but also how poorly it is integrated into current care patterns:

"There is strong evidence to support the provision of palliative care throughout the cancer care continuum. Early palliative care referral has been associated with improved symptom management (Bandieri et al., 2012; Temel et al., 2010), increased survival time (Temel et al., 2010), lower utilization of aggressive end-of-life care (Greer et al., 2012; Temel et al., 2010), and more accurate patient expectations regarding long-term prognoses (Temel et al., 2011). Despite these benefits, clinicians often do not refer their patients to palliative care until the last 2 months of life (Cheng et al., 2005; Osta et al., 2008). At one comprehensive cancer center, fewer than half of patients received a palliative care consultation before they died, and palliative care consultations occurred late in the disease process (Hui et al., 2012). Inclusion of palliative care in the cancer care plan will help improve patient access to palliative care across the cancer continuum. Addressing palliative care needs is also critical for high-quality end-of-life care."⁵

Roles and Definitions of Palliative Care

Cancer treatment addresses the comprehensive disease of cancer. Patients with cancer will need support and management of the consequences of both

the treatment and the disease. Distinctions between the types of support and management can make a difference in determining coverage and payment policy (Exhibit 1).

The verb "*palliate*" comes from the Latin "*palliare*" meaning "to cloak," and according to the Oxford English Dictionary (1975), "*palliate*" in the context of health care means "to alleviate the symptoms of a disease." Applying this definition to its current context, "palliative care" can be defined in its most basic sense as any care which has its primary goal the relief of pain and other symptoms, as opposed to "curative" or "disease-directed" care, which has as its goal the cure or control of the diseases that are causing those symptoms. It must be emphasized that "palliative care" and "curative" or "disease-directed care" are not mutually exclusive, and in many situations, the same interventions may result in significant improvement in patient symptoms and also result in a cure or remission of the patient's primary disease process. While, in the last decade, physicians have been able to become board certified in the specialty of palliative care, the reality is that palliative care has been practiced for centuries, and still can be delivered as part of the normal care process by a primary care physician, an oncologist, or any other health care provider and should be included in the care of cancer patients through the entire care continuum, i.e. from diagnosis until the end-of-life.

Not to be confused with palliative care, end-of-life care can best be defined as a subset of palliative care confined to patients who are in the last several

weeks to months of life and, up until the last three decades or so, has been delivered primarily as part of general medical services. Therefore, interventions may include those with “curative” or “disease directed” goals, even though, as the patients are in the last several weeks or months of life, such goals are unlikely to be achieved. However, with the advent of the Medicare Hospice Benefit in 1982, increasing numbers of patients have been receiving end-of-life care from a hospice program (which is usually covered as a separate and identifiable benefit and site of care delivery). Like other forms of end-of-life care, goals of care in hospice are palliative and primarily focused on relief of pain and other symptoms. Patients choosing hospice care are more likely to recognize that “curative” or “disease directed” care options will not be effective at achieving their goals of care or they have decided not to pursue those options because the side effects and changes in quality of life outweigh the benefits of treatment.

Patients who receive palliative care under a hospice benefit, such as that provided by Medicare, must meet specific eligibility requirements for hospice, but palliative care in other settings is not as tightly constrained. As the largest national payer, Medicare pays for most of hospice care delivered in the United States through the Medicare hospice benefit.⁶

Because the impact of palliative care in the treatment of cancer can be so widespread and cost effective, it is important for medical directors from purchasers, plans and provider systems to understand the breadth of the term “palliative care,” and the many arenas in which it can become part of the patient’s care process. Palliative care may or may not be an identifiable service, but can be performed and billed under a wide range of traditional physician service codes. It may not be separately identifiable from the ongoing care process, but should be integrated as early as possible into the management of patients with serious illness, like cancer, that can dramatically affect quality of life and increase costs for unmanaged symptoms and side effects.^{7,8,9}

The American Cancer Society

The American Cancer Society states that palliative care (supportive care) is care that focuses on relieving symptoms caused by serious illnesses like cancer. It can be given at any point during a person’s illness to help them feel more comfortable.¹⁰

American Society of Clinical Oncology

“Palliative care is any treatment that focuses on reducing a person’s symptoms, improving quality of life, and supporting patients and their families. Any person, regardless of age or type and stage of cancer,

may receive palliative care. Ideally, palliative care is part of a person’s treatment starting at diagnosis, and it can be given at the same time as disease-directed treatment or on its own.”¹¹

National Consensus Project for Quality Palliative Care

The National Consensus Project (NCP) for Quality Palliative Care¹² defines palliative care broadly as patient and family – centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice. Features of palliative care philosophy and delivery include:

- Care is provided and services are coordinated by an interdisciplinary team;
- Patients, families, palliative and non-palliative health care providers collaborate and communicate about care needs;
- Services are available concurrently with or independent of curative or life-prolonging care;
- Patients’ and family hopes for peace and dignity are supported throughout the course of illness, during the dying process, and after death.

World Health Organization

In 1990, the World Health Organization defined palliative care as “the active total care of patients whose disease is not responsive to curative treatments. Many aspects of palliative care are also applicable earlier in the course of the illness.” Initially, palliative care evolved as a general approach to care for end-stage and dying cancer patients. As patients with serious illness, like cancer, began living longer with their disease, the demarcation between living and dying patients became less clear. The need for ongoing, early management of the disease and its symptoms, pain and stresses led to refined definitions. By 2012, the concept of palliative care evolved into specialized medical care for people with serious illnesses, that focused on providing patients relief from symptoms, pain and stress, and to improve quality of life for the patient, without any expectation of “cure.” Patients with these serious illnesses could transition into hospice and end-of-life care, but palliative care is now considered appropriate at any age and at any stage in a serious illness, and can be co-managed with curative treatment.¹³

Certifications for Physicians in Palliative Care

While the functions of palliative care can be and are performed by primary care physicians and/or medical specialists, physician certification in hospice

and palliative medicine has been of significant importance in establishing the legitimacy of palliative medicine as a medical subspecialty.

American Board of Hospice and Palliative Medicine (ABHPM):

Leadership in the American Academy of Hospice and Palliative Medicine (AAHPM), seeing the need to establish physician credentials in Hospice and Palliative Medicine, formed an independent board, the ABHPM, which began offering physician certification examinations beginning in 1996. These examinations were offered yearly until 2006, when the American Board of Medical Specialties recognized Hospice and Palliative Medicine as a subspecialty, and began to offer its own examination. At that point, the ABHPM was disbanded.

American Board of Medical Specialties (ABMS) Subspecialty Certification in Hospice and Palliative Medicine:

In 2006, the ABMS recognized the subspecialty of Hospice and Palliative Medicine under ten participating boards: Internal Medicine, Family Medicine, Anesthesiology, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Surgery, Pediatrics, Emergency Medicine, Radiology, and Obstetrics and Gynecology. This certification exam was first offered in 2008. There was a “grandfathering” period through the 2012 examination to allow physicians who were board certified from the ABHPM and/or who were already working in the field to obtain subspecialty certification without any additional formal training. Going forward, in order for a physician to become certified in Hospice and Palliative Medicine, she or he must complete a 12 month fellowship in hospice and palliative medicine from an Accreditation Council of Graduate Medical Education (ACGME) accredited training program.

American Osteopathic Association (AOA) Bureau of Osteopathic Specialists Certification of Added Qualification (CAQ) in Hospice and Palliative Medicine

The American Osteopathic Association (AOA) Bureau of Osteopathic Specialists approved a Certificate of Added Qualification (CAQ) in Hospice and Palliative Medicine, under the following osteopathic boards: Family Medicine, Internal Medicine, Neurology & Psychiatry, and Physical Medicine & Rehabilitation.¹⁴ As with the ABMS, the AOA allowed a “grandfathering” period through the 2013 examination, and going forward, a 12 month AOA approved fellowship is required to sit for the examination.

Hospice Medical Director Certification Board (HMDCB):

Established by the AAHPM in 2012, the HMDCB was established to create a certification examination for hospice medical directors that would be separate and distinct from the certifications provided through the ABMS and AOA. Designed primarily to establish competence in the roles of hospice medical physician and hospice as opposed to the role of medical specialists in palliative medicine, the first examination was administered in 2014. It should be noted that despite these differences, the HMDCB examination may be seen as an alternative certification option for midcareer physicians who desire to enter the hospice and palliative medicine field without fellowship training.¹⁵

Palliative Care – Standards and Resources

The following are key associations involved in the clinical and operational management of oncology. These are mostly membership or advocacy based organizations, and many have developed essential clinical tools and resources related to palliative care, hospice care, and pain management for private and hospital-based oncology physicians, as well as patients.

- American Academy of Hospice and Palliative Medicine, <http://aahpm.org/>
- American Cancer Society, www.cancer.org
- American Hospice Foundation, www.americanhospice.org
- American Society for Clinical Oncology (ASCO), www.asco.org
- CancerCare, www.cancercare.org
- Caregiver Action Network, www.caregiveraction.org
- Caring Connections from the National Hospice and Palliative Care Organization, www.caringinfo.org
- Center to Advance Palliative Care, www.capc.org, www.getpalliativecare.org
- Hospice Association of America, www.nahc.org/haa
- Hospice Education Institute, <https://www.hospiceworld.org/>
- Joint Commission, http://www.jointcommission.org/certification/palliative_care.aspx
- International Association for Hospice and Palliative Care, www.hospicecare.com
- National Cancer Policy Board, “Improving Palliative Care for Cancer”, <http://www.nap.edu/catalog/10147/improving-palliative-care-for-cancer-summary-and-recommendations>
- National Comprehensive Cancer Network (NCCN[®]), www.nccn.org

Exhibit 2: Examples of Components in a Patient-Specific Cancer Care Plan

Plan utilizing patient-centered communication and shared decision making, the cancer care team should collaborate with patients to develop a cancer care plan.

Examples of components in a patient-specific cancer care plan include:

1. Patient information (e.g., name, date of birth, medication list, and allergies)
2. Diagnosis, including specific tissue information, relevant biomarkers, and stage
3. Prognosis
4. Treatment goals (curative, life-prolonging, symptom control, palliative care)
5. Initial plan for treatment and proposed duration, including specific chemotherapy drug names, doses, and schedule as well as surgery and radiation therapy (if applicable)
6. Expected response to treatment
7. Treatment benefits and harms, including common and rare toxicities and how to manage these toxicities, as well as short-term and late effects of treatment
8. Information on quality of life and a patient's likely experience with treatment
9. Who will take responsibility for specific aspects of a patient's care (e.g., the cancer care team, the primary care/geriatrics care team, or other care teams)
10. Advance care plans, including advanced directives and other legal documents
11. Estimated total and out-of-pocket costs of cancer treatment
12. A plan for addressing a patient's psycho-social health needs, including psychological, vocational, disability, legal, or financial concerns and their management
13. Survivorship plan, including a summary of treatment and information on recommended follow-up activities and surveillance, as well as risk reduction and health promotion activities

SOURCES: IOM, 2011a; IOM and NRC, 2005.

"Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis" Box 3-3, Page 120, Laura Levit, Erin Balogh, Sharyl Nass, and Patricia Ganz, Editors; Committee on Improving the Quality of Cancer Care: Addressing the Challenges of an Aging Population; Board on Health Care Services; Institute of Medicine, National Academy of Sciences, publication 2013, last accessed on July 20, 2015 at http://www.nap.edu/download.php?record_id=18359.

- National Quality Forum: A National Framework and Preferred Practices for Palliative and Hospice Care Quality, A Consensus Report, <http://www.rwjf.org/content/dam/farm/reports/reports/2006/rwjf13081>
- Oncology Nursing Society (ONS) www.ons.org
 - Patient website: www.palliativedoctors.org
 - Professional website: <http://aahpm.org>

The Impact of Reforms: Value-Based, Payment, and Performance Reforms Influence on the Role of Palliative Care – Driving Better Patient Management, and Palliative Care in the Process

Palliative care is the quintessential definition of patient focused care. It seeks to understand the goals and needs of the patient, and to adjust the treatments and choices to match those goals. Traditional health care is built more around disease-focused care, the selection and administration of treatments that have as their goal to induce a cure or remission of the disease that is afflicting the patient. Health care reforms in both the private and public sectors seek to push health care from volume (visit and procedure) driven care towards value based care that addresses what was and can be done for the patient, rather than what occurred in a billable visit. This presents a challenge for health care providers and payers alike. None of the billing systems (or specific codes) address a palliative care focus where time is spent understanding patient

needs and situations, and then tailoring care to meet those needs. Additionally, most electronic health records systems that have been developed to date lack the necessary fields to support tracking and monitoring of the detailed patient assessments required for the delivery of palliative, patient focused care.

Despite these challenges, pilot programs involving care management, payment for performance, and shared savings are in process, and are starting to integrate more of the functions of palliative care earlier into the care process. As these models move from small pilot into established programs, so will the integration of palliative care and pain management move into the mainstream of practice operations and care delivery.

Center for Medicare & Medicaid Improvement Oncology Care Model – A Key Driver

Some value based programs, such as the Center for Medicare and Medicaid Improvement (CMMI) Oncology Care Model (OCM) lay out specific requirements for patient case management and patient navigation as part of the criteria for a proposed new payment model for oncology practices.¹⁶ The OCM requires that participating practices develop and share a comprehensive cancer care plan with their patients, as defined by the Institute of Medicine (IOM) in their 2013 report "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis". Many of the 13 elements identified by the IOM (Exhibit 2) will require palliative

focused care and reporting – despite the technology challenges caused by most electronic health records systems not having fields to enter and analyze trends related to those elements.

The OCM program began a multitude of discussions among oncology care providers about how they would modify care delivery in order to achieve tangible savings for the Medicare program, and additional savings to share with CMS. Many of those discussions centered on patient care management, and the impact that management, not just of symptoms and side effects, but also of patient expectations and goals for their cancer care, can have on the outcomes and total costs of care. This focus on patient care management for a five year national program covering half or more of all cancer patients, will become a game-changer for discussions around early intervention and application of palliative care management.

Center for Medicare and Medicaid Services Physician Quality Reporting System (PQRS)

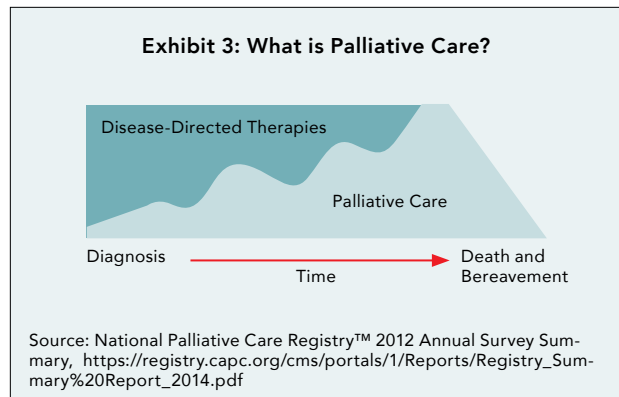
The Center for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS) sets forth quality measures that address patient-centered and caregiver-centered experience outcomes, communication and care coordination as part of the CMS evaluation of practice performance. Some of the PQRS measures may also be considered palliative care outcomes measures, such as the Plan of Care for Pain and Pain Intensity Quantified (National Quality Foundation Measure #2100). Practices are evaluated under the PQRS program for their success on such measures, which itself will spur a deeper practice focus on palliative care components.

Private Insurers

Several private insurers are exploring quality programs that may have components linked to palliative care. For example, Aetna has recently developed pilot programs with about 15 oncology practices that are tied to specific operational and care delivery requirements, and result in payments for additional care management through the delivery of care plans, survivorship plans, and informed consent, among other elements. One detailed requirement focuses on pain assessment. Aetna seeks validation that practices are connecting with patients and assessing pain levels during treatment. Management of pain is one of many elements of palliative care, and a good beginning to integration of more palliative care elements into the daily management of cancer care.

Oncology Medical Home

Most patient centered medical home models are focused on primary care, but in recent years two



major initiatives have arisen in the specialty oncology community. Dr. Barbara McAneny, a private community oncologist in New Mexico, was awarded a \$19.8 million, 2013 CMMI Innovation grant to develop an oncology medical home project in seven community practices across the country. This “COME HOME” project (www.comehomeprogram.com) focuses on better triage of patients and management of symptoms and side effects to avoid hospitalizations and emergency room visits.

The Community Oncology Alliance (COA) has also been working on the Oncology Medical Home concept (www.medicalhomeoncology.org) bringing together physicians, NAMCP member payers, and patients to build an Oncology Medical Home certification and reviewing quality measures, patient satisfaction, and patient focused requirements. COA is working with the American College of Surgeons’ Commission on Cancer to establish an oncology medical home certification for interested oncology practices.

Accountable Care Organizations and Clinically Integrated Care Networks

As accountable care organizations (ACOs) and Clinically Integrated Care Networks evolve from a primary care focus into a full care continuum focus, there will be increasing attention to the role, quality, and costs of managing the specialty of oncology and cancer care. Demand for better patient management and early integration of palliative care patient management will rise at the ACO and care network level and in those oncology centers working within the networked structure.

Overview and Monitoring of Existing Programs/ Collaborations in Market – Resources and Policy Evolution

Growing Standardization and Resources Over the Last Three Decades

Medical oncology was established as a specialty on

Exhibit 4: ASCO Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care

PURPOSE: An American Society of Clinical Oncology (ASCO) provisional clinical opinion offers timely clinical direction to ASCO's membership following publication of potentially practice-changing data from major studies. This PCO addresses the integration of palliative care services into standard oncology practice at the time a person is diagnosed with metastatic or advanced cancer.

CLINICAL CONTEXT: Palliative care is frequently misconstrued as synonymous with end-of-life care. Palliative care is focused on the relief of suffering, in all of its dimensions, throughout the course of a patient's illness. Although the use of hospice and other palliative care services at the end-of-life has increased, many patients are enrolled in hospice less than three weeks before their death, which limits the benefit they may gain from these services. By potentially improving quality of life (QOL), cost of care, and even survival in patients with metastatic cancer, palliative care has increasing relevance for the care of patients with cancer. Until recently, data from randomized controlled trials (RCTs) demonstrating the benefits of palliative care in patients with metastatic cancer who are also receiving standard oncology care have not been available.

RECENT DATA: Seven published RCTs form the basis of this PCO.

PROVISIONAL CLINICAL OPINION: Based on strong evidence from a phase III RCT, patients with metastatic non-small-cell lung cancer should be offered concurrent palliative care and standard oncologic care at initial diagnosis. While a survival benefit from early involvement of palliative care has not yet been demonstrated in other oncology settings, substantial evidence demonstrates that palliative care — when combined with standard cancer care or as the main focus of care — leads to better patient and caregiver outcomes. These include improvement in symptoms, QOL, and patient satisfaction, with reduced caregiver burden. Earlier involvement of palliative care also leads to more appropriate referral to and use of hospice, and reduced use of futile intensive care. While evidence clarifying optimal delivery of palliative care to improve patient outcomes is evolving, no trials to date have demonstrated harm to patients and caregivers, or excessive costs, from early involvement of palliative care. Therefore, it is the Panel's expert consensus that combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden. Strategies to optimize concurrent palliative care and standard oncology care, with evaluation of its impact on important patient and caregiver outcomes (eg, QOL, survival, health care services utilization, and costs) and on society, should be an area of intense research.

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See more at: <http://www.institutequality.org/asco-provisional-clinical-opinion-integration-palliative-care-standard-oncology-care#sthash.Mba93Ak.dpuf>

the early 1970s. Cancer then was a dire diagnosis, leading to hospitalizations for both treatment and symptom management until the early 1990s, when the development and approval of newer anti-neoplastic agents allowed for more outpatient cancer treatment. By 1998, oncologists were becoming increasingly capable of providing comprehensive cancer care as a continuum from diagnosis to treatment to care at the end-of-life (Exhibit 3). Most clinicians considered palliative care as a component of end-of-life care, to make the patient as comfortable as possible during the last stages of the cancer journey. To assist oncologists in providing such comprehensive care, ASCO published two special articles: "Cancer Care at the End-of-life," and a companion article "Consensus Statement of Recommendations for High Quality Cancer Care Developed by the American Federation of Clinical Oncologic Societies."¹⁷

In "Cancer Care at the End-of-life", the authors noted that "provision of optimal end-of-life-care requires access to and the availability of state-of-the-art palliative care rendered by skilled clinicians, but-tressed when necessary, by palliative care experts."¹⁸ As cancer care continued to evolve in the following decade, numerous further statements were issued

by many global organizations advocating for palliative care to become more a part of the full cancer care continuum, and to be integrated earlier in the treatment process. The importance of hospice care was also recognized by ASCO in 1998 as a "widely available, but underutilized, excellent model for delivering end-of-life-care." Over the next decade, the use of hospice services more than doubled¹⁹

Numerous standards, resources and recommendations now exist for the delivery and provision of palliative care, yet the implementation of these services is still inconsistent. Most formal palliative care programs are found in larger academic centers, while the hospital cancer centers and private medical practices may be more likely to integrate components of palliative care, including pain assessment and management. Formal palliative care programs are now reported in 100 percent of the U.S. News 2014-2015 Honor Roll Hospitals, 100 percent of the top 20 National Institute of Health (NIH) funded medical schools, 97 percent of the Council of Teaching Hospitals and Health Systems® member organizations, and 87 percent of the NCI's designated comprehensive cancer centers.²⁰

Variation in the scope of the palliative components (i.e. physician, nurse practitioner, nurse, social

Exhibit 5: Representative ASCO QOPI Measures Related to Palliative Care and Pain Management		
Module	Measure #	Measure
Core	3	Pain assessed by second office visit NQF Endorsed #0383/#384 (adapted)
Core	4a	Pain intensity quantified by second office visit (includes documentation of no pain) NQF Endorsed #0384 (adapted)
Core	5	Plan of care for moderate/severe pain documented NQF Endorsed #0383/#0384 (adapted)
Core	6	Pain addressed appropriately (defect-free measure, 3, 4a, and 5)* NQF Endorsed #0383 (adapted)
Core	6a	Pain assessed on either of the two most recent office visits NQF Endorsed #0383/#0384 (adapted)
Core	6b	Pain intensity quantified on either of the two most recent office visits NQF Endorsed #0383/#0384 (adapted)
Core	6c	Plan of care for moderate/severe pain documented on either of the two most recent office visits NQF Endorsed #0383/#0384 (adapted)
Core	6d	Pain addressed appropriately on either of the two most recent office visits (defect-free measure, 6a, 6b, and 6c) NQF Endorsed #0383/#0384 (adapted)
Core	6e	Pain addressed appropriately by second office visit and during most recent office visits (defect-free measure, 6 and 6d) NQF Endorsed #0383/#0384 (adapted)
Core	24	Patient emotional well-being assessed by the second office visit
Core	25	Action taken to address problems with emotional well-being by the second office visit
Core	25a	Documentation of patient's advance directives by the third office visit (Test Measure)
EOL	35	Pain assessed on either of the last two visits before death NQF Endorsed #0383/#0384 (adapted)
EOL	36a	Pain intensity quantified on either of the last two visits before death (includes documentation of no pain) NQF Endorsed #0383/#0384 (adapted)
EOL	37	Plan of care for moderate/severe pain documented on either of the last two visits before death NQF Endorsed #0383/#0384 (adapted)
EOL	38	Pain addressed appropriately (defect-free measure, 35, 36a, and 37) NQF Endorsed #0383/#0384 (adapted)
EOL	39	Dyspnea assessed on either of the last two visits before death
EOL	40	Dyspnea addressed on either of the last two visits before death
EOL	41	Dyspnea addressed appropriately (defect-free measure, 39 and 40)
EOL	42	Hospice enrollment NQF Endorsed #0215 (adapted)
EOL	43	Hospice enrollment or palliative care referral/services NQF Endorsed #0215 (adapted)
EOL	44	Hospice enrollment within 3 days of death (Lower Score – Better) NQF Endorsed #0216 (adapted)
EOL	44a	Hospice enrollment and enrolled more than 3 days before death (defect-free measure, 42 and inverse 44) NQF Endorsed #0216 (adapted)
EOL	45	Hospice enrollment within 7 days of death (Lower Score – Better) NQF Endorsed #0216 (adapted)
EOL	45a	Hospice enrollment and enrolled more than 7 days before death (defect-free measure, 42 and inverse 45)* NQF Endorsed #0216 (adapted)
EOL	46	For patients not referred, hospice or palliative care discussed within the last 2 months of life NQF Endorsed #0215 (adapted) EOL 47 Hospice enrollment, palliative care referral/services, or documented discussion (combined measure, 43 or 46) NQF Endorsed #0215 (adapted)
EOL	47a	Percentage of patients with invasive malignancy who died in known location: private residence with hospice/palliative care(Test Measure)
EOL	47a1	Percentage of patients with invasive malignancy who died in known location: private residence without hospice/palliative care (Test Measure)
EOL	47b	Percentage of patients with invasive malignancy who died in known location: licensed hospital with hospice/palliative care (Test Measure)
EOL	47b1	Percentage of patients with invasive malignancy who died in known location: licensed hospital without hospice/palliative care (Test Measure)

EOL	47c	Percentage of patients with invasive malignancy who died in known location: ICU with hospice/palliative care (Test Measure)
EOL	47c1	Percentage of patients with invasive malignancy who died in known location: ICU without hospice/palliative care (Test Measure)
EOL	47d	Percentage of patients with invasive malignancy who died in known location: extended care facility with hospice/palliative care (Test Measure)
EOL	47d1	Percentage of patients with invasive malignancy who died in known location: extended care facility without hospice/palliative care (Test Measure)
EOL	47e	Percentage of patients with invasive malignancy who died in known location: other location with hospice/palliative care (Test Measure)
EOL	47e1	Percentage of patients with invasive malignancy who died in known location: other location without hospice/palliative care (Test Measure)
EOL	48	Chemotherapy administered within the last 2 weeks of life (Lower Score – Better) NQF Endorsed #0210
http://www.institutequality.org/sites/institutequality.org/files/QOPI%20Spring%202015%20Measures%20Summary.pdf		
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worker, chaplain) is widespread, regardless of the site of care. The following review of some of the more common sources of standards, resources and recommendations will be useful to managed care medical directors in assessing and evaluating programs available to their own members.

ASCO Provisional Clinical Opinion (PCO) Guidance and Quality Oncology Practice Initiative (QOPI®) Standards

Both ASCO and its members have developed several statements and models on palliative care integration since the first ASCO statement in 1998. These resources are readily available on-line in the ASCO web site at <http://www.asco.org/practice-research/palliative-care-oncology>.

One of the strongest statements in support of the value of palliative care intervention in combination with standard cancer care at the time a person is diagnosed with metastatic or advanced cancer, is the Provisional Clinical Opinion (PCO) issued by ASCO in March 2012. In this PCO, for the first time, ASCO was able to reference major clinical studies that showed not only the benefits of palliative care, but more importantly, did not show harm to patients or caregivers, or excessive costs related to the palliative care choices (Exhibit 4).

ASCO has developed an Institute for Quality (IQ) to promote quality, value, and accountability in cancer care. Two key components of the IQ are the ASCO Quality Oncology Practice Initiative (QOPI®) program – an oncologist-led, practice-based quality assessment and improvement program, and the QOPI® Certification Program (QCP™), which recognizes medical oncology and hematology/oncology practices that are committed to delivering the highest quality of cancer care. Several of

the quality assessment and benchmarking measures are related to management of pain and end-of-life care (Exhibit 5).

ASCO held the first of what are becoming annual meetings – the Palliative Care in Oncology Symposium, in 2014. The second was held in October 2015 (<http://pallonc.org/>). With most presenters coming from larger healthcare facilities, the focus of the 2015 Symposium is to explore the patient experience, approaches to patients, and to share best practices on the integration of palliative care into the oncology care continuum. With more than 20 planned exhibitors, the interest in this Symposium highlights the importance that palliative care is achieving in the oncology community.

ASCO has also developed several virtual learning and video initiatives, published an extensive library on palliative care for physicians, and has created several patient resources, on topics including Advanced Care Planning (<http://www.cancer.net/navigating-cancer-care/advanced-cancer/advanced-cancer-care-planning>) and palliative care (<http://www.cancer.net/navigating-cancer-care/how-cancer-treated/palliative-care>), available with other resources on the ASCO patient focus web site, www.cancer.net™).

Center to Advance Palliative Care

The Center to Advance Palliative Care (www.capc.org) is a national organization dedicated to increasing the availability of quality palliative care services for people living with serious illness. CAPC provides hospitals, health systems, hospices, payers and other healthcare organizations with the tools, training, technical assistance and metrics needed to support successful implementation and integration of palliative care. CAPC serves as a convening, organizing and dissemination force for the field, col-

laborating with leaders, innovators and partners to foster connection and cross-fertilization. CAPC also promotes public awareness through the site, getpalliativecare.org and collects and provides essential metrics through the National Palliative Care Registry (<https://registry.capc.org/cms/>). Payers and patients can also identify which hospital palliative care programs are available in their area through a free published service found at the Get Palliative Care website (<http://getpalliativecare.org/providers/>).

Joint Commission Accreditation

The Joint Commission established an accreditation program in 2011 for hospital inpatient palliative care programs that offer a minimum of a full time 24 hour palliative care service that is available to all inpatients (not just those in oncology). Accreditation reviews address advanced training in palliative care, patient and family engagement, and compliance with evidence-based guidelines for treatment choices and care processes.

National Cancer Institute

The National Cancer Institute (NCI) is the federal government's principal agency for cancer research and training. It is part of the National Institutes of Health (NIH), which is one of 11 agencies that make up the Department of Health and Human Services (HHS). The NCI has created a wide resource of consumer-friendly publications on various topics of cancer: the disease, medications and treatments, and specific interventions and approaches at its website (www.cancer.gov). In particular, it addresses the topics of palliative care in sections on patient coping and managing their disease, but it also has a specific page on Palliative Care in Cancer (<http://www.cancer.gov/about-cancer/advanced-cancer/care-choices/palliative-care-fact-sheet>), which addresses a number of basic questions about palliative care that employers and managed care organizations may find useful for their employees and members.

National Cancer Policy Board and Institute of Medicine

The National Cancer Policy Board (NCPB) and the Institute of Medicine (IOM) gather eminent members of appropriate professions to examine policy matters pertaining to the health of the public. The IOM has issued several publications on the state of quality in oncology, each time making recommendations and setting standards. Unfortunately, their assessment over time is that the needle hasn't moved too far or fast enough. Two key reports from the NCPB and the IOM were published over a decade apart, and identified significant gaps in care that per-

sisted. The 1999 "Ensuring Quality Cancer Care" report (<http://www.nap.edu/catalog/6467/ensuring-quality-cancer-care>) included a recommendation to "ensure quality of care at the end-of-life, in particular, the management of cancer-related pain and timely referral to palliative and hospice care."²¹ In 2013, a follow up IOM report, "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis" (<http://www.nap.edu/catalog/18359/delivering-high-quality-cancer-care-charting-a-new-course-for>) pointed out that care is often not patient-centered, that many patients do not receive palliative care to manage their symptoms and side effects from treatment, and that decisions about care often are not based on the latest scientific evidence. In 2001, a report that specifically focused on the palliative care situation: "Improving Palliative Care for Cancer" was published, and identified seven general barriers that still exist today:

- The separation of palliative and hospice care from potentially life-prolonging treatment within the healthcare system, that is both influenced by and affects reimbursement policy;
- Inadequate training of health care personnel in symptom management and other end-of-life skills;
- Inadequate standards of care and lack of accountability in caring for dying patients;
- Disparities in care, even when available, for African Americans and other ethnic and socioeconomic segments of the population;
- Lack of information resources for the public dealing with palliative and end-of-life care;
- Lack of reliable data on the quality of life, and the quality of care of patients dying from cancer (as well as other chronic diseases);
- Low level of public sector investment in palliative and end-of-life care research and training.²²

The conclusions and recommendations from the 2001 NCPB "Improving Palliative Care in Cancer" set out the direction for most of the drivers, standards, and key players that we see now in the palliative care space.

1. NCI should designate certain cancer centers, as well as some community cancer centers, as centers of excellence in symptom control and palliative care for both adults and children.
2. NCI should add the requirement of research in palliative care and symptom control for recognition as a "Comprehensive Cancer Center."
3. The Center for Medicare and Medicaid Services (CMS) should fund demonstration projects for service delivery and reimbursement that integrate palliative care and potentially life-prolonging treatments throughout the course of the disease.

4. Private insurers should provide adequate compensation for end-of-life care.
5. Organizations that provide information about cancer treatment (NCI, the American Cancer Society, health insurers and pharmaceutical companies) should revise their inventories of patient – oriented material, as appropriate, to provide comprehensive, accurate information about palliative care throughout the course of the disease.
6. Best available practice guidelines should dictate the standard of care for both physical and psycho-social symptoms. Care systems, payers, and standard-setting and accreditation bodies should strongly encourage their expedited development, validation, and use. Professional societies, particularly the American Society of Clinical Oncology, the Oncology Nursing Society, and the Society for Social Work Oncology, should encourage their members to facilitate the development and testing of guidelines and their eventual implementation, and should provide leadership and training for non-specialists, who provide most of the care for cancer patients.
7. The recommendations in the NCPB Report, “Enhancing Data Systems to Improve the Quality of Cancer Care” should be applied equally to palliative and end-of-life care as to other aspects of cancer treatment.
8. NCI should convene a State of the Science meeting on palliative care and symptom control.
9. NCI should establish the most appropriate institutional locus (or more than one) for palliative care, symptom control and end-of-life research, possibly within the Division of Cancer Treatment and Diagnosis.
10. NCI should review the membership of its advisory bodies to ensure representation of experts in cancer pain, symptom management, and palliative care.²³

National Hospital and Palliative Care Organization

The National Hospital and Palliative Care Organization (NHPCO) (<http://www.nhpc.org/>) offers resources, education and advocacy for its members representing hospice and palliative care programs and professionals. Like ASCO, it offers a self-assessment tool for quality measures. These quality measures are focused on aspects of hospice care and palliation of patient’s symptoms and side effects.

National Quality Forum

The National Quality Forum (NQF) issued a con-

sensus report in 2006 on “A National Framework and Preferred Practices for Palliative and Hospice Care Quality (<http://www.rwjf.org/content/dam/farm/reports/reports/2006/rwjf13081>)”. This report set forth intended standards for NQF preferred practices aligned with the Institute of Medicine’s six dimensions of quality (safe, effective, timely, patient centered, efficient, and equitable). The preferred practices cover the structure and processes of care, physical aspects, psychological, social, spiritual and cultural aspects of care, as well as care of the imminently dying patient, and the ethical and legal aspects of care. The NQF report also sets forth Quality of Cancer Care Performance measures, National Voluntary Consensus Standards for Symptom Management, and End-of-Life care measures in cancer patients.²⁴

Vitaltalk Resources

Vitaltalk Resources (www.vitaltalk.org) is a non-profit organization with the mission of nurturing healthier connections between patients and clinicians. They offer courses, e-learning, and one page guides on traditionally difficult topics including “Talking About Dying”, “Transitions/Goals of Care”, “Discussing Prognosis”, “Serious News”, and “Responding to Emotion: Respecting”.²⁵

Growth in Programs

Palliative care programs vary widely. This presents a challenge for patients and payers, both in terms of what care is provided and what coverage is needed to ensure appropriate care at the appropriate time.

As a general guide, there are 6 major skill sets (which do not necessarily correlate to billing codes reflected on claims forms) that comprise complete palliative care:

1. Communication
2. Decision making
3. Management of complications of treatment and the disease
4. Symptom control
5. Psycho-social and spiritual care of the patient and the family,
6. Care of the dying.²⁶

Patient and family needs for these various skills will rise and fall during the care process, and will probably be delivered by a variety of professionals over the course of the patient’s illness. Often the care being provided may not be specifically labeled “palliative care” nor even by a more specific term such as pain management. Rather, the services and counseling may be part of multiple different care teams fielded by a hospital, physician office, employer, insurer, or a hospice. Those professionals

touching the patient may range from physicians, to nurses, to social workers, or other staff. This lack of uniformity in providing such care to patients often proves challenging to an employer or payer seeking to ensure and manage costs and appropriate care.

A further challenge comes for patients, physicians and payers related to coverage of palliative care for patients nearing the end-of-life, who often require a myriad of supportive services such as intensive pain and symptom management, psycho-social and spiritual counseling, and significant personal care services. For patients whose physicians can determine that they have a prognosis of six months or less, hospice becomes a viable care option as hospices under the Medicare Hospice Benefit offer the comprehensive supportive services that patients near the end-of-life require. (For further discussion of hospice care and the Medicare Hospice Benefit, see “Hospice Care” below). For patients for whom hospice is not a viable option, however, available services tend to be much more limited due to the fact that funding for palliative care is primarily through physician consultation services, various palliative care initiatives developed by payer/providers (see “Payer Provider Initiatives in Palliative Care” below), and reductions in the cost of care (see below “The Impact of Palliative Care”).

The Impact of Palliative Care

A 2012 review of the progress of palliative care approaches notes that the majority of patients, including those with cancer, report inadequate discussions with their physicians regarding goals of care and prognosis. Poor satisfaction with multiple areas of communication in the setting of serious illness, and that upwards of 30 percent of Medicare beneficiaries with cancer die in the hospital, not infrequently with intensive care and chemotherapy services in that last month of life.²⁷

Because the range of palliative services can reach from beginning of treatment into end-of-life care, the studies and findings on the impact of palliative care often focus on specific segments of that process. Consistently, the intervention of palliative care has been found to have a positive effect on symptom control and cost of care, but we still have much more to learn about the details and impact of palliative care management. Palliative care can take many different forms and be applied to patients in a variety of ways (Exhibit 6).

Also in 2012, the Agency for Healthcare Research and Quality (AHRQ) issued a report on the results of the Kaiser Permanente’s home-based palliative care program, which not only increased patient satisfaction but also reduced emergency department visits

and inpatient admissions and costs. Average costs for palliative care patients with cancer were 35 percent lower than the usual care patients, 67 percent lower for palliative care patients with chronic obstructive pulmonary disease and 52 percent lower for palliative care patients with congestive heart failure.²⁸

Reduced hospital costs were also reported in a review of 2004 – 2007 Medicaid patients at four New York state hospitals. On average, patients who received palliative care incurred \$6,900 less in hospital costs during a given admission than a matched group of patients who received usual care. Consistent with the goals of a majority of patients and their families, palliative care recipients spent less time in intensive care, were less likely to die in intensive care units, and were more likely to receive hospice referrals than the matched usual patients. The Care Span report estimated that the reductions in Medicaid hospital spending in New York State would eventually range from \$84 million to \$252 million annually if two percent to six percent respectively of Medicaid patients discharged from every hospital with 150 or more beds received palliative care from a fully operational palliative care consultation team.²⁹

There is no doubt that palliative care intervention can improve patient satisfaction as well as patient quality of life, and reduce total costs of care. The challenge for payers is understanding when and where palliative care is being administered, and correspondingly, how to support and encourage it in diverse delivery settings.

Delivery Models for Palliative Care and their Impact on Payers

Clinical Delivery Models Defined by ASCO

There are basically three clinical delivery models (defined in 2008 by ASCO) that patients and payers are likely to encounter in oncology palliative care.³⁰

The first model is care provided primarily by a physician and his or her practice team – classified by ASCO in 2008 as a “**Solo Practice Model**”. The physician and his or her nurses and staff provide the cancer assessment and treatment, as well as the psycho-social and clinical management of the patient’s symptoms and side effects. The effectiveness of palliative care in the Solo Practice Model is dependent upon the available resources and training in palliative conversations and management. Funding for the palliative care is billed as evaluation and management encounters with the patient, and not separately distinguishable from oncology professional services as palliative care. Such encounters are based upon time and complexity, and billed as visits to a physician or physician extender, like a nurse practi-

Exhibit 6: The Path Palliative Care Can Take for a Patient

This excerpt from *The Oncologist* illustrates the wide path that palliative care can take for one patient.

Patient Story

“Mr. S was a 52-year-old man seen as a new outpatient at our cancer center. He had recently been diagnosed with stage III non-small-cell carcinoma of the lung with a three centimeter nodule in the right lower lobe and hilar and mediastinal adenopathies. After initial evaluation, the patient was started on a combined regimen of radiation therapy, chemotherapy, and targeted therapy. At the time of the initial evaluation, the thoracic medical oncologist referred the patient to the supportive care center, where a full assessment was conducted by a palliative medicine team. During the initial assessment by the supportive care team, the patient was found to have chest pain, nausea, moderate dyspnea, and severe fatigue. He was prescribed slow-release morphine, senna, and metoclopramide to treat these symptoms. In addition, the patient underwent expressive supportive counseling with one of the palliative trained counselors and was prescribed increased physical activity as well as exposure to natural light for the management of fatigue and insomnia.

Over the next two months, the patient was seen on the same day by the medical oncologist at the thoracic center and the palliative medicine specialist at the supportive care center. Because of progressive disease in the mediastinum and chest wall, the patient started second-line therapy. At the supportive care center, the patient was found to have increased fatigue and sedation. The patient was prescribed methylphenidate, and the patient’s wife and child received counseling.

One month later, the patient developed back pain caused by bony metastases to the lumbar spine and was started on palliative radiation therapy. In addition, because the patient continued to experience sedation and had begun to experience myoclonus, the opioid was switched to methadone, the laxative dose was increased, and the patient was provided with a disabled parking placard, occupational therapy, and a home safety evaluation.

Two months later, because his disease had progressed, the patient was referred by the thoracic oncologist to our institution’s Center for Targeted Therapy for consideration of experimental treatment in a phase I clinical trial. On the same day as his first phase I pretreatment evaluation, the patient was seen at the supportive care center. The doses of his opioid and antiemetic were adjusted, a corticosteroid was added for the management of fatigue and pain, and the methylphenidate dose was adjusted.

After two courses of targeted therapy in the trial, the patient was found to have progressive disease. At that point, because of deterioration in his performance status, the patient and his family chose to discontinue treatment. On the same day, the patient was assessed at the supportive care center and was found to have delirium with mild psychomotor agitation and hallucinations as well as increased pain intensity. The primary medical oncologist and the palliative care physician agreed that the patient would be admitted to the palliative care unit under the care of a palliative care physician. During the patient’s five-day stay in the unit, he underwent opioid rotation and parenteral hydration, he was given haloperidol for agitation and antibiotics for pneumonia, and a family conference was conducted. The patient’s delirium resolved, and he was discharged home with hospice care; his symptoms remained well controlled until his death three weeks later.

Mr. S received medical oncology and palliative care simultaneously from almost the moment of diagnosis to death. In a recent randomized controlled study of 151 patients with advanced lung cancer, Temel et al. observed that patients allocated to palliative care referral with standard care had a better quality of life (as shown by their Functional Assessment of Cancer Therapy – Lung scores), less depression (as shown by their Hospital Anxiety and Depression Scale scores), and a longer median survival time (11.6 months versus 8.9 months) than patients receiving just standard care. Palliative care has also been found to improve symptom control and reduce the cost of care. However, very few patients in cancer centers and acute care facilities receive the type of care Mr. S did.”

Reference: E. Bruera, S. Yennurajalingam, “Palliative Care in Advanced Cancer Patients: How and When?”, *The Oncologist*, first published online in the *Oncologist Express* on Jan. 17, 2012, last accessed on 8/21/2015 at <http://theoncologist.alphamedpress.org/content/17/2/267.full>.

tioner, or (more often) not billed at all, and provided before, during or after chemo administration or as after-hours telephonic management, which are usually not billable services. Physicians may choose to provide such counseling or services themselves, or use other professional staff such as nurses, counselors, or other staff trained for such conversations, but most often such counseling or additional services are not billable. The payment reform pilots being performed with Medicare and private payers that include a “management fee” for disease management, provide funding through that management fee for more intense patient management such as these palliative care services.

The second palliative care delivery model presented by ASCO is the **Congress Practice Model**, where a treating oncologist will refer patients to multiple consultants for management of their symptoms and needs, in addition to the treatment being provided in the oncologist office. An oncologist might make referrals under this model to pain specialists for pain management, to psychiatrists for emotional distress, to other specialists like pulmonologists for respiratory difficulties, or neurologists or gastrointestinal specialists, or to social workers or chaplains for psycho-social, family and/or spiritual distress.

These services will be separately billable, however, the payer may not recognize that they are for

“palliative care”. Rather, such services are likely to be billed to the payer as medical encounters by the physician specialists, or from a hospital or other independent agency for the psycho-social or spiritual supportive services. Patients can be physically and mentally challenged by the process and logistics of receiving care in this model, because of the issues involved with coordination and transportation to multiple points in the health care system. Gaps in communication are more likely with each additional referral, and might even result in conflicting care plans from different consulting specialists. Payers will not necessarily be able, through their tracking and billing systems, to connect the multiple service referrals to a coordinated palliative care effort by the treating oncologist.

The third clinical delivery model of palliative care defined by ASCO was the **Integrated-Care Model**, which involves the oncologist and a supportive/palliative care team. When the supportive/palliative care team is trained and broad enough in depth, the oncologist is able to focus on treating the patient, with confidence that the team will address the physical symptoms and psycho-social and spiritual concerns. There may still be referrals to other specialists for specific issues, but the coordination between the team members and the treating oncologist and ease of access for the patient is likely to be far greater and thus of higher value and less stressful than less coordinated care.

The integrated care model is more likely to be found in a hospital or academic medical center setting, because there is a mechanism for funding the supportive care services that are not individually billable as part of the facility costs – an option not available to the independent physician practice without recompense for disease management. Payers are more likely to see formal “palliative care” departments and programs in the integrated care model setting, so the palliative care process for patients will be more identifiable and obvious. Payers will also likely see services billed from board certified and specially trained palliative care providers – although the codes used may be the same as other physician services, and the payer may not be aware of the physician’s additional palliative specialization and training.

Palliative Care Case Manager Programs

In addition to these clinical delivery models, patients are now often being touched by **numerous other health care teams** (funded by payers, employers, accountable care organizations, specialty pharmacies, or pharmacy benefits managers) going by the titles of care or case managers, patient navigators, or patient coordinators.

While the intent of these programs is to have these health care teams coordinate patient care with the treating oncologist and other physicians, oftentimes such coordination is lacking, leading to gaps in communication, or confusing or even conflicting guidance for the patient. Some of these care teams are asked to provide some degree of palliative care consultation and guidance to their patients – and payers will want to know that appropriate coordination is occurring with the treating physician, which, as already stated, may not be the case in actual practice.

Hospice Care Models

No discussion of palliative care models would be complete without describing hospice care, that, in essence, is palliative care for the dying patient. In large part defined by the Medicare Hospice Benefit, which was originally passed by the Congress in 1982, hospice programs are charged with providing comprehensive end-of-life care to terminally ill patients. Patient eligibility for hospice is based on certifications provided by the patient’s attending physician and the hospice medical director that the patient has a life expectancy of six months or less if the illness the patient suffers from runs its natural course. Hospices are paid a flat daily rate for routine home care, which includes a comprehensive array of services: nursing services, medical direction and physician care plan oversight, medical social services, pastoral counseling, bereavement counseling, home health aide and homemaker services, drugs and biologicals, durable medical equipment and other medical supplies, laboratory and diagnostic studies related to the care and treatment of the terminal illness and related conditions, dietary counseling, and physical, occupational, speech therapy when indicated. It should be noted that for patients who reside in a nursing home (NH) or adult facility (ALF), the NH or ALF is considered the patient’s home for the purpose of the hospice benefit.

If patients require a higher level of care for the management of acute pain or other uncontrolled symptoms, hospices may manage such patients by providing either continuous home care, that is reimbursed on an hourly basis for up to 24 hours per day, or general inpatient care in a hospice inpatient unit or in a hospital with which the hospice has a contract, and that is reimbursed at a daily rate significantly higher than the rate for routine home care. It should be noted that for Medicare patients enrolled in a Medicare managed care program who are admitted to hospice, reimbursement of hospice services under the Medicare Hospice Benefit is “carved out,” meaning that Medicare reimburses the hospice provider directly. The managed care provider’s respon-

sibilities are limited to providing care to the patient that is determined to be unrelated to the patient's terminal illness, and reimbursement for such services is provided on a fee for service basis. For commercial patients, managed care providers and other payers can negotiate directly with hospice providers, although in most cases, such agreements parallel the Medicare Hospice Benefit in both services provided and the reimbursement for such services.³¹

While hospice care is a goal for many payers, who view it as a less costly alternative to end-of-life care that occurs in palliative care inpatient units, or with continued anti-neoplastic therapy until close to the actual end-of-life, there are two key issues that may affect oncologist referral and utilization of hospice services.

As already mentioned, the Medicare Hospice Benefit requires that the attending physician and hospice medical director certify that a patient has a life expectancy of six months or less. Physicians are often reluctant to predict a patient's life expectancy with any degree of certainty, with studies demonstrating that physicians often make these determinations inaccurately.^{32,33} Guidelines to help physicians identify potentially eligible hospice patients have been published³⁴, and include general criteria that apply to all patients (cancer and non-cancer diagnoses) and cancer specific criteria. General criteria include evidence of progressive disease, declining performance status, declining nutritional status, and an understanding of the patient's goals of care, and the benefits versus risks of any available disease-directed therapy that might help the patient. Specific criteria related to various cancers divide the various malignancies into five categories based on their relative responsiveness to various anti-neoplastic agents in the face of advanced metastatic disease, although with some of the newer available agents this classification may be somewhat outdated. Additionally, keeping in mind that the prediction of a prognosis of six months or less is based on probability and is not an exact science, the first six months of the Medicare Hospice Benefit is divided into two 90 day periods. Prior to the end of each period (prior to days 90 and 180) if the patient continues to survive, the hospice medical director is charged with re-evaluating the patient's life expectancy and must recertify that the patient's prognosis remains six months or less. At the end of six months (180 days) if the patient is still alive and has been recertified as still being terminally ill (which includes a face-to-face encounter), the patient may remain on the hospice program, with required re-evaluations of prognosis by the hospice medical director (including a face-to-face encounter) every 60 days.

The second major issue that may affect oncology

referral to hospice relates to the potential utilization of anti-neoplastic therapy while a patient is on a hospice program. It must be pointed out that while the Medicare Hospice Benefit states that patients who elect hospice are required to forgo curative care, the reality is that for patients with advanced metastatic cancer, there is no curative care, and any anti-neoplastic therapy that is being provided is for life-prolonging and/or palliative treatment. If the goal of care is to prolong the patient's life significantly beyond six months, one could argue that based on the patient's goals of care and the patient's life expectancy if the treatment is effective, the patient would not be eligible for hospice. However, when the therapeutic goal is to palliate symptoms, one can make a sound argument that for certain individual patients, such therapy may be appropriate care even for a patient with a prognosis of less than six months, and therefore, it may be appropriate to provide such interventions in a hospice setting.

One challenge that hospices face in being able to provide these agents is the ability of hospice nurses, many of whom are not oncology trained, to properly recognize and manage the toxicities and side effects of these interventions. Therefore, it is incumbent upon the oncologist and the hospice to ensure that hospice nurses caring patients receiving anti-neoplastic therapies in a hospice setting are properly trained to manage the potential toxicities and side effects of any such treatment. A second challenge relates to cost. As anti-neoplastic agents in this setting would be related to the palliation of the terminal illness in this situation, the hospice is required under the conditions of the Medicare Hospice Benefit to provide such medications. Hospices, as mentioned above, are reimbursed at a flat daily rate, and many anti-neoplastic agents are very costly. Therefore, the hospice may not have the available funding to provide these agents to oncology patients on a frequent basis. However, many hospices will consider anti-neoplastic interventions on a case-by-case basis, and, therefore, it is recommended that any oncologist who is considering treating a patient near the end-of-life with anti-neoplastic therapy, and is also considering a hospice referral, discuss the patient's situation with the hospice medical director.

Based on 2011 data, NHPCO estimates that approximately 44.6 percent of patients who died in the U.S., died in a hospice program³⁵, with an average length of stay of 72.6 days and median length of stay of 18.5 days. This suggests that the majority of hospice patients are receiving care for a very short length of time. Additionally, despite the concern that has been raised regarding patients remaining on hospice for too long a period of time, only

11.5 percent of hospice patients receive care for more than 180 days.³⁶ Among the drivers for short hospice lengths of stay are the two issues discussed above, physician concerns regarding accurately predicting patient prognosis, and the difficulties that hospices have in providing anti-neoplastic therapies to patients for whom such care remains medically appropriate.

Medicare Care Choices Model

In an attempt to address the second of the issues stated above, CMS initiated a demonstration project in 2014 entitled the “**Medicare Care Choices Model.**” This model allows participating hospice providers to enroll patients who are hospice eligible with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and HIV/AIDs but are not ready to elect hospice due to their treatment plan or other factors, in an alternative program under which they would receive somewhat more limited support services from hospice, while still being able to receive traditional medical treatments from their various providers.

There are currently about 140 hospices nationwide who are participating in this program. Hospice services that are required include nursing, psychosocial, and spiritual assessments leading to the development of a comprehensive care plan, a patient centered goals of care plan, case management, hospice aide and homemaker services, as well as other counseling and support services. Once the initial evaluations are completed, follow-up can be provided telephonically, although visits may be required under certain circumstances. All other services, including physician services, medications, medical equipment and supplies to name a few, continue to be provided through traditional Medicare and secondary insurance coverage. Continuous care and general inpatient care are not included in this program, so if a patient experiences an acute problem requiring hospitalization, they either can access the acute care hospital as usual, or, if they so choose, they may elect the full hospice benefit (that the model projects they may be more likely to do as they are already familiar with hospice staff) that would give them access to either continuous home care or general inpatient care.

While this program theoretically will allow advanced cancer patients who are hospice eligible and still benefiting from anti-neoplastic therapy to continue to receive active treatment while benefiting from some hospice services, there are some significant limitations to this program that raises serious doubts as to its potential success. Firstly, since the model is limited to hospice eligible patients, meaning the patient must have a life expectancy of six months or less, it does not address physician con-

cerns regarding the ability to predict patient prognosis, thereby continuing to deny patients who are undergoing active treatment and whose prognosis is unclear from receiving supportive services that they may need. Secondly, unlike the full Medicare Hospice benefit, which is reimbursed at a flat daily rate, the reimbursement for the Medicare Care Choices Model has been set a flat monthly rate which is significantly lower than current hospice reimbursement. This has raised serious concerns that the reimbursement, as currently set, is insufficient to cover the costs of services that the hospice is required to deliver to patients under this model. Despite these concerns, initial interest in participating in this program among hospices was great enough that CMS expanded the number of participating hospices from 30 to 140, and extended the duration of the model from three years to five years.³⁷

Examples of Current Palliative Care Initiatives in the Clinical Delivery Models

There is such variation in palliative care application and programming that it would be useful to share examples of how palliative care may be addressed in some of the specific models that have been identified earlier in this Guide. Payers might want to consider their organization’s policies for coverage relative to each model, and explore whether there may be opportunities for enhanced policy configuration around palliative care services and coverage.

Solo Practice Model Examples

As mentioned earlier, the solo practice clinical delivery model is the most difficult to identify, because palliative care components will be combined with patient management and care, and will not usually be separately billed and identifiable from other professional services. Practices may use a combination of physicians, physician extenders, oncology nurses, and other staff to monitor, counsel and support patients throughout the cancer care process, as part of the ongoing care provided to the patient, rather than providing the care under a formal palliative care program. Patients and their families are often provided with information on pain and symptom management, and the depth of any further discussions regarding patient choices, functional status, psycho-social care, quality of life, or even assessment of the caregivers is dependent on the individual skills and strengths of the professionals working in the practice.

There are standards and measures, including some for palliative care and symptom management available in the private practice setting, and hundreds of practices perform self-assessments on these standards

Exhibit 7: Core and End-of-Life Measures

Core Measures

- #3 Pain assessed by second office visit
- #4 Pain intensity quantified by the second office visit
- #5 For patients with moderate to severe pain, documentation that pain was addressed
- #6 Effectiveness of pain medication assessed on visit following new narcotic medication
- #7 Constipation assessed at time of, or at first visit following, new narcotic medication
- #21 Chart documents patient's emotional well-being was assessed within one month of first visit to office
- #22 For patients identified with a problem of emotional well-being, the chart documents that action was taken within one month

End-of-Life Measures

- #35 Pain assessed on the second to last or last visit before death
- #36 Pain intensity quantified on second to last or last visit before death
- #37 Dyspnea assessed on second to last or last visit before death
- #38 Action taken to ease dyspnea on the second to last or last visit before death
- #39 Patient enrolled in hospice before death
- #40 Patient enrolled in hospice or referred for palliative care services before death
- #41 Patient enrolled in hospice within three days of death
- #42 Patient enrolled in hospice within one week of death
- #43 For patients not referred in last two months of life, hospice or palliative care discussed
- #44 Chemotherapy administered within last two weeks of life

Reference: B. Bell, MD, L. Harris, et al., "Integrating Palliative Care into a Medical Oncology Practice", *Oncology Issues*, Association of Comprehensive Cancer Centers, July – August 2014, last accessed on August 25, 2015 at https://acc-cancer.org/oncology_issues/articles/JA14/JA14-Integrating-Palliative-Care-into-a-Medical-Oncology-Practice.pdf

twice each year, seeking benchmarking comparisons and best practices. While these self-assessment results are not reported externally, practices can and do share that they participate in these quality efforts. Medical Directors may wish to seek practices that either participate in the ASCO Quality Oncology Practice Initiative™ (QOPI®) measures program and especially those who have sought certification in the ASCO QOPI Certification Program™ (QCP) program as practices who consistently manage to a documentable level of quality and outcomes. QOPI and QCP participation is open to any US-based hematology-oncology practice, and ranges from single oncologist practices to large academic medical centers. By the summer of 2015, there were over 260 practices that had received QOPI certification across the country, a current listing of QOPI Certified practices is available at <http://www.institute-forquality.org/qcp/certified-practices>. Certification requires an overall quality score of 75 percent or higher on at least 26 measures from the QOPI program, as well as additional chemotherapy safety and medical records documentation standards. There are five separate measurement areas (Breast, Colorec-

tal, Non-small Cell Lung Cancer, End-of-life, and Symptom/Toxicity) included in the ASCO QOPI program.³⁸

ASCO QOPI™ Measures – Over 360 practices³⁹ participated in the Spring 2015 data collection period for ASCO's QOPI. Practices conduct chart reviews and report results against various QOPI measures, including specific measures for palliative care and pain management. These results are reported within the ASCO QOPI structure, and practices receive benchmarking reports as to their success rates for compliance with the measure compared to other practices also participating in QOPI. The benchmarking results are kept private and not made available to the general public, so managed care does not have ready access to these measures. However, managed care may inquire and recognize or reward practices that do participate and report on these measures in the QOPI process. Some of the ASCO QOPI measures that practices can use track palliative care and pain management components (Exhibit 7).⁴⁰

One example of Solo Practice palliative care is that which happened in a 1,000 physician private

national oncology network, The U.S. Oncology Network (USON). In May of 2015, Arizona Oncology, a practice in USON, announced a new offering of palliative care to patients in Tucson and southern Arizona. Two palliative care nurse practitioners will work closely with a multi-disciplinary team of medical professionals to coordinate patient care at all stages of illness, provide help and support, establish individualized plans of care, provide support for complex pain and symptoms, and work with patients on psycho-social and spiritual needs.⁴¹

This is a typical approach in private practice to integrating palliative care into patient care, whether it is early in the patient's journey or primarily for patients with advanced disease. The services are provided to the patient, but are indistinguishable from other patient care services on the billing claim forms sent to a payer. Managed care providers will not be aware of these separate palliative care initiatives based on the claims data they receive.

Congress Practice Model Examples

As described earlier, this clinical delivery model is a complex model that also is difficult for payers to track as identifiable palliative care. A treating physician, whether in private practice or in a hospital based practice, will solicit services or make referrals for patients for components of palliative care. These services would most often include consultative guidance to patients and their families regarding the palliative choices available at various stages of care. Physicians may choose to refer patients to specific services for a variety of reasons:

- Their own comfort level with having those difficult conversations about recognizing that there may be a point when the patient would prefer to stop aggressive treatment;
- The possibility that patients and their families would "hear" the messages about palliative care options better from another specialist than from their treating physician from whom they may only want to hear optimistic, curative messages even when a cure is no longer possible;
- Or for dedicated symptom management and guidance that augment the resources available in the treating physician's practice.

Many hospices and formal palliative care programs at large hospital or academic health centers offer classes, services, counseling and care to patients and their families. These programs actively seek referrals from both physicians and payers to their programs. The Center to Advance Palliative Care™ (CAPC) has created Policies and Tools that include checklists and guides for when such referrals might be appropriate (Exhibit 8).

Managed care plans will observe such referrals occurring from claims data that shows multiple claims for services coming from diverse providers for cancer patients. Such consults could be very beneficial to the overall management of the patient and their symptoms and choices. Palliative care is sometimes also referred to as Supportive Care.

As one example of a Congress Practice Model – The Supportive Care Clinic in Spartanburg, S.C. has a team that includes a palliative care physician, two nurse practitioners, a registered nurse, and a licensed clinical social worker. The Spartanburg Regional Hospital's palliative care program decided to name its own outpatient palliative care unit the "Supportive Care Clinic," based on MD Anderson research that showed that increased and earlier referrals, as well as decreased clinician stress around referrals, were associated with the name "supportive care," rather than palliative care.⁴²

There is very close integration between the Spartanburg Regional Hospital's Supportive Care Clinic (SCC) and the private medical oncology practice in the area, with the SCC occupying physician space within the practice and using the practice's electronic medical records system for registration, documentation and billing. This allows all providers to access the most current medical records. Two Advance Practice Registered Nurses (APRNs) from a private medical oncology practice participate on the staff, scheduling for the SCC, which facilitates consultations and referrals. Advance palliative care education and training for the office staff was provided by the hospital's inpatient palliative care team prior to opening the SCC.

The palliative care referral is integrated, but separate, from the treating medical oncologist's services. Once a referral is made to the SCC, the palliative care Registered Nurse (RN) conducts pre-certifications and mails a new patient pack containing a Patient Questionnaire, Drug Contract, Brief Pain Inventory, and Consent to Treat. In the SCC clinic visits, the patient is first seen by the APRN, who conducts interviews and completes their history and medical profile (including an ESAS Scale, a PHQ-9 depression call and a Distress Scale.) This is followed by a visit with the social worker to gather additional information. The full team reviews the patient's profile, and plans the next steps in the patient's management. The patient then sees the Palliative Care Medical Director, who conducts a medical assessment, and discusses a care plan with the patient based upon the patient prognosis and five domains:

1. Understanding Goals of Care and Prognosis
2. Physical Symptoms

Exhibit 8: Criteria in Use at Leading Palliative Care Centers

The following criteria have been suggested or are in actual use at leading palliative care centers. Some hospitals use this material solely in marketing, while others have established these as defining criteria for automatic consultations.

General Referral Criteria

Presence of a serious illness and one or more of the following:

- New diagnosis of life-limiting illness for symptom control, patient/family support
- Declining ability to complete activities of daily living
- Weight loss
- Progressive metastatic cancer
- Admission from long-term care facility
- Two or more hospitalizations for the same illness within three months
- Difficult-to-control physical or emotional symptoms
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding appropriateness of treatment options
- Patient or family requests for futile care
- DNR order uncertainty or conflicts
- Uncertainty or conflicts regarding the use of non-oral feeding/hydration in cognitively impaired, seriously ill or dying patients
- Limited social support in setting of a serious illness (e.g., no family support system, lives alone, homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

Intensive Care Unit Criteria

- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., advanced dementia)
- Two or more ICU admissions within the same hospitalization
- Prolonged or failed attempt to wean from ventilator
- Multiorgan failure
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision making
- Coma or PVS lasting more than two weeks

Cancer Criteria

- Metastatic or locally advanced cancer progressing despite systemic treatments Karnofsky < 50 or ECOG > 3
- Brain metastases, spinal cord compression or neoplastic meningitis
- Malignant hypercalcemia
- Progressive pleural/peritoneal or pericardial effusions

Neurological Criteria

- Folstein Mini Mental Score < 20
- Feeding tube being considered for any neurological condition
- Status epilepticus > 24 hours
- ALS or other neuromuscular disease considering mechanical ventilation
- Any recurrent brain neoplasm
- Parkinson's disease with poor functional status or dementia
- Advanced Alzheimer's or other dementia with poor functional status and one or more hospitalizations for infection in the last six months
- Coma or PVS lasting more than two weeks

"Referral Criteria: From the Center to Advance Palliative Care™ Policies and Tools for Hospital Palliative Care Programs: A Crosswalk of National Quality Forum Preferred Practices," https://media.ccapc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf

3. Psycho-social and Practical Issues
4. Spiritual and Cultural Issues
5. End-of-life, Advanced Care Planning and Hospice.

Follow-up visits with the physician include reassessments of the Edmonton Symptom Assessment Scale (ESAS), the Distress Scale, and any needed labs and prescriptions. Quality goals for the SCC include a 15 percent decrease in pain scores, a 25

percent decrease in distress scores, and a 20 percent decrease in total ESAS scores from the average first visit scores to the average last visit scores.

As a result of the development process, the SCC team suggests the following conceptual model of a successful palliative care program. There must be a culture that incorporates trust, (between providers and between the provider and the patient) awareness, coordination of the palliative care process, and value. There must be a strong infrastructure that

focuses on the staff, finances and physical space, as well as measurement of the care being delivered, that aligns the infrastructure between the palliative care program and its referral base. Successful completion of the culture and the infrastructure will yield outcomes such as High-Value Care.⁴³

Integrated Care Model Examples

As described earlier, the integrated care delivery model is the most comprehensive and formal of the clinical delivery models for palliative care. These models can still look quite different from each other. Several hospitals and academic medical centers have fully integrated palliative care models, often with both inpatient and outpatient components, to accommodate their own patients and those in active treatment elsewhere who may be referred for components of palliative care services. Most formal palliative care programs are found in larger academic centers, while the hospital cancer centers and private medical practices may be more likely to integrate components of palliative care, including pain assessment and management.

Fierce HealthCare reported in 2012 on the growing perspective from hospitals that palliative care provides a positive return on investment. “Whether you work in a 400-bed hospital or a 100-bed hospital, a palliative care program is likely to pay for itself in both reduced costs and increased patient satisfaction,” said Raymond Hino, CEO of Mendocino Coast District Hospital in California.⁴⁴ The University of Rochester (N.Y.) Medical Center found palliative care intervention in 2007 saved 1,400 ICU patient days at an average of \$450 a day.⁴⁵

A 2011 survey by the Center to Advance Palliative Care (CAPC) reported that 1,568 (about 63 percent) of 2,489 hospitals (with at least 50 beds) surveyed had palliative care teams.⁴⁶ Much of the growth in hospital palliative care programs has been supported by the Palliative Care Leadership Centers™ (PCLC), established by the CAPC and the Robert Wood Johnson Foundation in 2004. The PCLC claims to have trained over half of the nation’s hospital palliative care programs by providing intensive, operational training and year-long mentoring for hospital palliative care programs at every stage of development and growth.⁴⁷

Nine Pioneer Programs in Palliative Care

While palliative care programs are found in most hospitals and academic medical centers, the focus, infrastructure, and impact of these programs still vary widely. Managed care organizations will want to investigate the individual programs that are available in their market areas to determine the local variability. A key resource for NAMCP member medical direc-

tors for understanding the depth and breadth of these programs might be a Robert Wood Johnson Foundation report, published in October 2000 that profiled nine pioneer programs in palliative care. These profiles still stand today as a good perspective on the infrastructure, issues, barriers, and focus involved in developing and maintaining a palliative care program. This report may be accessed at <http://www.milbank.org/uploads/documents/pppc/0011pppc.html>.

While each of the programs took a different path in definition, structure, and even funding of their programs, the report identified four common essential characteristics that would still be of value for managed care medical directors today in evaluating palliative care services and benefit coverage, particularly integrated palliative care programs in hospital settings:

1. Palliative care programs should be constructed around an interdisciplinary team, including at least a doctor, nurse, social worker, pharmacist, and chaplain.
2. Patients, families, and physicians should discuss goals and preferences and should plan the care together.
3. Palliative care should reach patients throughout the hospital, should encourage collaboration across clinical and administrative boundaries, and should foster respect for patients’ and families’ wishes.
4. Palliative care programs should provide bereavement services for families and staff members.⁴⁸

The nine pioneer programs in palliative care cited and reviewed in detailed case studies in the Robert Wood Johnson Foundation report noted above included:

1. Balm of Gilead Center, Cooper Green Hospital in Alabama
2. Beth Israel Deaconess Medical Center/Care Group in Massachusetts
3. Harry R. Horvitz Center for Palliative Medicine, The Cleveland Clinic, in Ohio
4. Massachusetts General Hospital Palliative Care Service, in Massachusetts
5. Palliative Care Program, Medical College of Virginia Campus of Virginia Commonwealth University, in Virginia
6. Pain and Palliative Care Service, Memorial Sloan Kettering Cancer Center, in New York
7. The Lilian and Benjamin Hertzberg Palliative Care Institute, Mount Sinai School of Medicine, in New York
8. Palliative Care and Home Hospice Program, Northwestern Memorial Hospital, in Illinois
9. Comprehensive Palliative Care Service, Uni-

versity of Pittsburgh-UPMC, in Pennsylvania

Payer Provider Initiatives in Palliative Care

Payers and Providers are already jointly exploring initiatives to bring palliative care in a more formalized and timely fashion to patients, including patients with cancer. Some of the following examples illustrate resources or examples used by payers for both providers and patients to encourage utilization of palliative care approaches and decision making for all patients with serious illness, not just those with cancer care. The consistent message across all these examples is that although there are many options available, the support and activity itself related to palliative care with both providers and patients seems to always yield some degree of benefit and results, both in quality of care, patient satisfaction, as well as costs of care, particularly at end-of-life.

Aetna Compassionate CareSM Program

In 2005, Aetna launched a pilot program, called Aetna Compassionate CareSM, to provide support and services to members facing life-threatening disease. Previously, when members chose hospice, like the Medicare program, their Aetna benefits required that they discontinue “curative care.” The Aetna Compassionate CareSM allowed members to enroll in hospice while continuing with the treatment of their disease. The pilot quickly rolled out on a national level, supported by specialized nurse case management services, and a dedicated website with online tools and information about living wills, advance directives, and tips on how to begin discussions about personal wishes at the end-of-life. The pilot results indicated a decrease in emergency room and intensive care use, coupled with an increase in hospice services.⁴⁹ In 2011, Dr. Randall Krakauer, MD, FACP, FACR, and Vice President and National Medical Director for Medicare Strategy at Aetna, reported that 81 percent of the Medicare members in the Compassionate Care program elected hospice care, with the remaining 18 percent dying in acute or sub-acute facilities. Aetna also saw an 82 percent reduction in acute days, and an 88 percent reduction in intensive care days for these members, with a corresponding high level of member and family satisfaction.⁵⁰ In the 2014 CAPC NBGH Toolkit, Aetna reported a total cost reduction of more than \$12,000 per Medicare Advantage member enrolled in the program.⁵¹

CAPC “Improving Care for People with Serious Illness through Innovative Payer-Provider Partnerships: A Palliative Care Toolkit and Resource Guide”
The Center to Advance Palliative Care (CAPC) and the National Business Group on Health (NBGH)

have developed a toolkit specifically to serve as a reference guide for those payers and providers seeking to understand the opportunities, to provide tools and resources, and to share what others are doing to advance palliative care. The “Improving Care for People with Serious Illness through Innovative Payer-Provider Partnerships: A Palliative Care Toolkit and Resource Guide” (CAPC NBGH Toolkit) is available for download at https://www.capc.org/media/filer_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-provider toolkit-2015.pdf.

In addition to identifying essential clinical skills for palliative care (Pain and Symptom Management, Goal Setting, Family Caregiver Support, and Practical and Social Supports), the CAPC NBGH Toolkit identifies essential structural characteristics of High-Value Palliative Care:

- Targeting and Triggers – to identify those individuals most in need of services
- Interdisciplinary Team-Based Care – to address the full range of medical, family, psychosocial and spiritual issues
- 24/7 Meaningful Clinical Response – to meet patient’s needs as quickly as appropriate
- Integrated Medical and Social Supports – to identify and utilize appropriate available support structures
- Concurrent Care – so that curative or life-prolonging care is still available concurrently or independently of palliative care⁵²

One example in the CAPC NBGH Toolkit cited the importance of including the practice and social issues affecting patients. A palliative nurse consultation identified the lack of an air conditioner at a home in the hot South Carolina months as a key factor in a patient’s repeated hospitalizations for shortness of breath. Coordination between the palliative care team, the provider and the payer led to the payer’s purchase of a \$300 air conditioner for the patient, and the subsequent cessation of hospitalizations for dyspnea.

Excellus BlueCross Blue Shield Compassion and Support at the End-of-life Program

Excellus BlueCross BlueShield (Excellus BCBS) has offered an all-inclusive pediatric palliative care program called CompassionNet for over 15 years, in affiliation with Lifetime Care Home Health and Hospice. Families enrolled in the program have access to a pediatric palliative care team composed of a nurse, nurse practitioner and a pediatric physician. The program covers additional services, equipment and supplies in full.⁵³ Excellus BCBS worked with

the Medical Society of the State of New York to sponsor and create 30 second public service announcements (PSAs) that were aired across New York demonstrating that “conversations change lives,” and the importance of advance care planning for all people 18 years and older. Excellus BCBS also provides a Compassion and Support library of audio and video on its website (at http://www.compassionandsupport.org/index.php/resource_directory/compassion_and_support_video_library) that includes Community Conversations on Compassionate Care (CCCC) on the benefits of the advance care planning process, as well as Medical Orders for Life-Sustaining Treatment (MOLST) videos for both patients and providers. According to a case study in the CAPC NBGH Toolkit, Excellus BCBS has increased their member’s health care proxy completion rates (42 percent for people 18 years and older across 39 counties, and 47 percent in the Rochester region in 2008 compared to a 20 percent national completion rate), in part due to the CCCC resources and member utilization of those resources. Nearly 60 percent of the Excellus BCBS employees have themselves completed health care proxies, and the MOLST and electronic version of the MOLST resources are leading the nation with the first electronic form and process documentation system for MOLST in the country. Excellus BCBS offers enhanced payment to providers who have completed the MOLST training, and tracks palliative care quality measures in its hospital performance incentive program. Some of the measures for which hospitals are rewarded include the number of palliative care consults, formalization of a palliative care program including staff education, facilitating appropriate early referrals to palliative care, and providing family meetings at the time of admission for medical ICU patients.⁵⁴

Highmark

Highmark is a regional Blue Cross and Blue Shield payer that is also widely recognized for its pro-active support of palliative care through provider (hospital based) contracting. In 2013, Highmark announced that members will receive ten free consultations with an Advanced Illness Services palliative care team, without co-pays or deductibles.⁵⁵ Since the Advanced Illness Services (AIS) program (<https://www.highmark.com/hmk2/newsroom/presskits/seniorMarketsSeriouslyIll.shtml>) began in 2011 for Medicare Advantage members and their families, Highmark has seen an increased hospice enrollment and median length of stay in hospice, as well as reduced emergency room visits, reduced acute hospital admission and readmission rates (especially in the

Intensive Care Unit) and reduced chemotherapy administration in the last two weeks of life.⁵⁶ Specifically, Highmark has seen the following results for members enrolled in the AIS program. A 33 percent decrease in acute care admissions in the last month of life, a 38 percent decrease in ICU admissions in the last month of life, and a 39 percent decrease in ER visits in the last month of life. Highmark also uses quality measures in its value-based contracting with local providers to support palliative care. Some of the measures used in these contracts include:

- The percentage of patients receiving a palliative care consult in the hospital (per 100 admissions).
- Patients who have documentation of resuscitation status on or before day one.
- Patients who have documentation of ICU efforts to identify the medial decision maker on or before day one of the ICU admission.
- An interdisciplinary family meeting conducted on or before day five of the ICU admission⁵⁷

Regional Collaborations in Palliative Care

When integrated into serious illness throughout the care process, attention to managing patient side effects and symptoms, as well as clarifying their goals and expectations for treatment, can yield significant benefits for the quality of life patients feel, as well as reducing the resource burden on the total healthcare system and those who pay for the care. Growing diverse interest in health care reform has led to the rise of regional collaborations related to quality care, with an increasing focus on palliative care both during serious illness as well as at the end-of-life. Examples of some regional collaborations follow, which may lead to ideas of what organizations medical directors might want to approach to develop similar initiatives in their own areas.

Honoring Choices Virginia

The three health systems in the Richmond, VA area embarked on a joint venture – “Honoring Choices Virginia”⁵⁸ in late 2014 to train and educate health care professionals to make sure patients’ wishes about end-of-life care are documented and honored. The program links Bon Secours Richmond, HCA Virginia Health Systems and Virginia Commonwealth University Health System with the Richmond Academy of Medicine, and began in nine sites, with plans to expand to nine more within the first six months. Honoring Choices Virginia uses the “Respecting Choices” curriculum developed by Gundersen Health System in La Crosse, WI (<http://www.gundersenhealth.org/respecting-choices>)⁵⁹ to train facilitators to initiate crucial conversations with patients and families about how to articulate

what is important to them about life and death decisions. Nathan Kottkamp, a member of the Honoring Choices Virginia board, also founded National Healthcare Decisions Day (April 16 of each year), to inspire and empower patients and providers about the importance of advance care planning.

Nevada Cancer Coalition

The Nevada Cancer Coalition (NCC) is a statewide partnership of more than 75 individuals representing over 40 public and private organizations throughout Nevada, working together on the goals and objectives outlined in the State of Nevada Cancer Plan. The Nevada Cancer Control Summit agenda in September 2015 included a targeted discussion on enhancing survivorship programs for patients and managing cost and quality through enhanced payment models in cancer care.⁶⁰

Seattle Area Palliative Care Quality Measurement Summits

A May 2015 Palliative Care Quality Measurement Summit in Seattle, WA drew more than 100 stakeholders (oncologists, researchers, social workers, data analysts, statisticians, hospital administrators, policymakers and patient advocates) from around the state of Washington and beyond. The summit was one of a series of community meetings intended to address how to increase value and decrease the human and financial cost of cancer care. It was co-sponsored by the University of Washington's Cambia Palliative Care Center and the Hutchinson Institute for Cancer Outcomes Research (HICOR). During the summit, presentations of oncology metrics (from the currently available but limited data sources of non-Medicare data covering 2007 to early 2014), profiled a rough picture of a western Washington cancer patient's last 90 days of life. Attendees understood that the metrics were based on incomplete data and not yet ready to develop interventions and eventually policy, and moved on to discuss the benefits of early palliative care, and possible ways to increase access and education for patients. By the end of the summit, a sense of what palliative care should look like evolved, but without clarification of how it should be provided and funded. The summit concluded that active palliative care should include shared decision making, clear and sensitive communication about prognosis, improved emotional and symptom management support (especially after hours), patient mentorship, engagement with caregivers, and ongoing discussions about treatment goals and priorities with payer participation to ensure these needs are met.⁶¹

Health Economics and Payment Models in Palliative Care, and Impact on Payers

Palliative care, both when introduced early in the treatment of serious disease and in preparation for the end-of-life, has been proven to have a positive impact on patient quality of life, satisfaction, engagement and achieves a reduction in total costs of treatment and utilization of higher cost facilities and treatments. The challenge for payers is that the diversity of implementation of palliative care makes it difficult to create one specific policy approach to encourage and support palliative care. At a larger hospital or academic center, palliative care may be more intense patient management by the treating provider, or a series of referrals for additional services, or counseling, or a formal intensive counseling and guidance program. Payers wishing to encourage and support palliative care will need to create a series of supportive policies and programs to cover the scope of palliative care services, as well as reach out to both patients and providers with education, information and support for the palliative care process. Internal and external payer policy and benefits design will want to ensure appropriate coverage and payment for documentable high quality palliative care furnished across multiple settings and by a range of providers.

There are a number of healthcare reform initiatives that will potentially have an impact on the growing availability and deeper integration of palliative care (Exhibit 9).

Medicare programs and reforms are clearly in the lead for these initiatives, and the challenge with Medicare programs is that they may not offer payment levels to sustain the initiatives, in general practice or even for the duration of the pilot programs. Some of the initiatives in process include:

- Medicare payments for chronic management
- Medicare shared savings programs
- Accountable Care Organization development (both Medicare and private payers)
- Bundled payment efforts and initiatives
- Medicare hospice payment policies
- The Medicare Oncology Care Model and other initiatives it may prompt with private payers
- Center for Medicare and Medicaid Services Innovation Center grants for individual palliative care related projects⁶²
 - Four Seasons Compassion for Life, North Carolina, “Increasing Patient and System: Value with Community Based Palliative Care”
 - Innovative Oncology Business Solutions, Inc., “Community Oncology Medical Homes” (COME HOME)

Exhibit 9: Perspectives on Palliative Care from the Field

Perspectives on Palliative Care from the Field: Candid comments from Thomas J. Smith, MD, FACP, FASCO, FAAHPM, Director of Palliative Medicine, Johns Hopkins Medical Institutions, Professor of Oncology, Sidney Kimmel Comprehensive Cancer Center, Harry J. Duffey Family Professor of Palliative Medicine – 9/18/2015

Q. What would you most want employers' medical directors and health plans to know about the importance of palliative care coverage and the value of such services and coverage to the patient, the providers, and the payers?

A. Palliative care is one of the few parts of health care that truly fulfills the "triple aim": better quality of life, better quality of care, and lower costs (really). Now there is mounting evidence that early palliative care contributes to longer survival in randomized trials, in multiple diseases.

We got into this field to reduce symptoms, including pain, distress, and lack of communication. We have multiple randomized trials that show better symptom control, quality of life, depression/anxiety, more knowledge of the illness (prognostic awareness), and markedly less care giver distress. Betty Ferrell's recent lung cancer study showed dramatic effects on quality of life, as well as caregiver distress.

We next showed that quality of care changed, especially around the end of life. Fewer hospitalizations, trips to the ER, admissions, ICU admissions, unless necessary to fix something fixable. This comes from having a plan in place, usually home hospice that prevents such trips and keeps people where they want to be — at home.

We next showed that as a consequence of these changed patterns, IN EVERY SINGLE STUDY TO DATE, palliative care, provided concurrently with usual care, reduced costs - even with the cost of the team factored in. Kaiser Permanente (KP) did two large randomized trials and showed that the care was better, patients and families were more satisfied, and it saved KP \$5,000 to \$7,000 per person. So, they made it their standard of care.

Finally, there are increasing data that early palliative care leads to longer or at least equal survival:

- 2009 Bakitas cancer *JAMA* plus three to six months, NS
- 2010 Temel lung cancer, plus three months, significant
- 2014 *Lancet Oncology*, Zimmermann, markedly better symptoms QOL, = survival
- 2014 Higginson dyspnea, months, significant
- 2015 Bakitas, cancer, *JCO*, months significant
- 2015 Ferrell, lung cancer, *JPSM*, plus six months, NS
- 2015 Sidebottom, *CHF*, major improvement in QOL and symptoms, = OS
- 2015 Higginson, *MS*, (due out soon)

Again, not a single study showing worse survival. So I am replacing my "Member, Death Panel B" tattoo with "Palliative Care – better care at a cost we can afford". Take Kaiser Permanente's lead and pay for interdisciplinary teams.

Q. What emerging trends do you see occurring in the growth of palliative care (in private practices, hospital systems, and formal programs in large systems and academic centers)?

A. More outpatient programs – IF we can train enough people, and IF, we can figure out a way to pay for them. It's hard to make a living as a slow internist.

More teaching of palliative care specialty skills to other practitioners. Maybe the use of the palliative care Tattoo (goes on inner left forearm to help with difficult conversations.) and how to use the concepts we know work from the many randomized trials without every one needing to see pall care. Not rocket science. Use the checklist concept. Use the TAME concept.

Q. If you had an employer or health plan medical director in front of you, what insights would you want to share, and what counsel or guidance would you want to give them about palliative care for cancer?

A. It works. It will improve your patient's care, and your families' situation. It will save them and you time, angst, and money, and may allow them to live not only better but longer.

- University Hospitals Case Medical Center, Ohio "Evidence Conformant Oncology Care"
- Trustees of the University of Pennsylvania, "Comprehensive Longitudinal Advanced Illness Management" (CLAIM) – home care

- services for patients with cancer
- Suttercare Corporation, California, "Advanced Illness Management (AIM)"
- The Rector and Visitors of the University of Virginia, "Proactive Palliative Care and Pal-

Keys to Successful Oncology Palliative Care Programs

The wide range of palliative programs and care delivery models require flexibility in the definition of best practices and keys to success on oncology palliative care programs.

Payers should look for providers that have expressed an interest in the topic, and show initiative in broaching the subject with patients. The skills that providers – of any delivery system size – should demonstrate in a documentable and trackable manner include:

- Assessing, monitoring and managing pain symptoms and side effects in cancer patients, at a minimum near end-of-life, but more ideally throughout the patients’ journey with cancer.
- Communication and listening to the patient regarding the setting of goals and expectations. Discussion of what is most important to them, and identification of choices they are willing to make at different points of the disease. Documentation of such choices for the plan of care in advanced care planning and medical orders for life-sustaining treatment.
- Communication and provision of support for the family and caregivers. Assessing the family capacity and their own levels of support for the choices made by the patient.
- Assessing, monitoring, and supporting the need for and use of practical social and environmental intervention, particularly where practical solutions to needs and problems would affect the patient’s quality of life.

Few palliative care initiatives will find success without collaboration with providers and engagement of patients. Payers will find the most success in seeking out collaborative partners in their local markets, and using such partnerships to build consensus and broad support for the concepts and tools of shared decision making and palliative care support for their patients with serious illnesses, including cancer.

Outcomes and Measures Progress in Palliative Care Programs

There are a number of outcomes and measures that have been proposed for determining quality and progress in palliative care programs, but these are tempered by the data collection systems and electronic medical records programs available to providers today. Some data points, such as hospitalization, emergency room and hospice admissions and utilization, as well as utilization of referred palliative

care and hospice services, may not be readily available to providers, depending on their delivery model and depth of communication and data sharing by collaborative partners in payers and other providers. Regional programs such as the one in Seattle, WA that was described earlier in this guide have admitted that no matter how much data they have been able to collect and analyze, it is still not sufficient or reliable yet to serve as a basis for policy and change.

With that caveat of insufficient data collaboration and collection, there have been some resources that are setting forth quality measures and standards for palliative care programs. Payers considering utilization of these measures as reference points for discussions with potential provider partners will want to use them only as a starting point, recognizing that surrogates, such as provider participation in accreditation, certification and quality programs, might have to suffice for outcomes measures until all parties agree that available data collection and analysis processes become suitable for development of more complex outcomes measures. General first measures start with days in hospice in last one to three months of life, patient pain management, patient symptom management, admissions to the ER in last one to three months of life, admissions to the ICU in last one to three months of life, and chemotherapy administration in last one to three months of life. Surrogate measures may include recognizing provider participation in quality, certification, accreditation or board specialization programs.

Outcomes measures for end-of-life care are difficult in that they end up being hindsight measures. There are some general measures that, if measured regularly for all patients, can yield useful information about end-of-life care trends in retrospect: Patient comfort measures, patient safety monitors and assessments, meeting of patient and family preferences, health-related quality of life, continuity of care and care coordination, patient and family experience, and bereavement outcomes.⁶³ Existing resources for Palliative Care Quality Measures include:

- American Society of Clinical Oncology QOPI[®] and QPC[™] programs (<http://www.asco.org/quality-guidelines/asco-institute-quality-iq>)
- Association of Community Cancer Centers measures for integrating palliative care into medical practice (https://acc-cancer.org/oncology_issues/articles/JA14/JA14-Integrating-Palliative-Care-into-a-Medical-Oncology-Practice.pdf)
- Joint Commission Certification practice guidelines

- Center to Advance Palliative Care (www.capc.org)
- CMS programs, which include components of outcomes measures related to palliative care and pain management (<http://innovation.cms.gov/initiatives/oncology-care/>)
- B. Kinzbrunner, MD, J. Policzer, MD, End-of-life Care: A Practical Guide, published by McGraw Hill Medical (<http://www.amazon.com/End-Life-Care-Practical-Second-Edition/dp/0071545271>)
- Hutchinson Institute for Cancer Outcomes Research and the Cancer Surveillance System (<http://www.fredhutch.org/en/labs/phs/projects/cancer-surveillance-system.html>)
- Joint Commission Performance Measurements Requirements for Palliative Care (http://www.jointcommission.org/certification/performance_measurement_requirements_palliative_care.aspx)
- National Consensus Project Guidelines for Quality Palliative Care (http://www.nationalconsensusproject.org/Guidelines_Download2.aspx)
- National Hospice and Palliative Care Organization Performance Outcomes Measures (http://www.nhpc.org/performance_measures)
- National Palliative Care Registry (<https://registry.capc.org/cms/Reports.aspx>)
- National Quality Forum's Preferred Practices for Palliative and Hospice Care (<http://www.rwjf.org/pr/product.jsp?id=18736>)

Next Steps – Implications for Purchaser Choices

Purchasers interested in starting and supporting palliative care components in their local markets may want to start by identifying potential collaborators and partners:

- Research the resources identified in this guide, such as the National Palliative Care Registry, and local members of Palliative Care Leadership Centers, and the Center to Advance Palliative Care.
- Seek out local physicians who are certified in hospice and palliative medicine from the American Academy of Hospice and Palliative Medicine
- Identify practices that participate or are certified through the ASCO QOPI or QCP programs
- Reach out to the local oncology groups and cancer centers and ask about their interest in palliative care and collaboration

Once potential collaborators and partners have been identified and the current environment related to palliative care in the local market has been as-

essed, it will be possible to consider some of the many opportunities available for payers to move forward with palliative care initiatives.

Payer Opportunities for Palliative Care Initiatives

Payers can and often do take the lead in initiating palliative care components into benefit design, member education and resources, case manager conversations, and integration with existing or encouraging emerging provider programs. CMS is clearly setting forth targets of payment reform and care delivery reform that include components of palliative care conversations and support from early in the care process through to end-of-life. Private payers, like Aetna, Highmark and some of the Blue Cross Blue Shield organizations have started to integrate components in various contract and quality measure programs. The challenge for payers is that there is no one model for palliative care, only a combination of components, and so the opportunities for payers are more diverse, and tend to be supportive in nature. Payers can take initiative in a variety of different directions, all of which will build toward a comprehensive palliative care program over time (Exhibit 10).

The CAPC and NBSGH Payer Provider Toolkit suggests some strategies⁶⁴ (which are included in the following categories), with some examples for ideas:

Community Collaboration and Awareness

Identify community partners for collaboration in creating and raising awareness of palliative care and its benefits, as well as shifting cultural acceptance and movement toward shared decision making and advanced care planning.

- Join local and national coalitions advocating for palliative care and advanced care directives such as MOLSTs
- Disseminate materials on palliative care and how to talk to doctors about patient and family expectations and goals to members, employees and the community.
- Support referrals to community organizations, and the organizations themselves, that provide resources to patients such as transportation, visiting and counseling programs, and food and expenses support such as foundations and Meals on Wheels, etc.
- Start with your own employee population for palliative care education and support of initiatives

Medical Policies and Coverage

Payers should review their medical policies and coverage, including edits for professional services

Exhibit 10: Perspectives on Palliative Care from the Field: Palliative Anti-Neoplastic Therapy: What a Health Plan Medical Director Needs to Consider

Candid comments from Barry M. Kinzbrunner, MD, FACP, FAAHPM, Executive Vice President and Chief Medical Officer, VITAS Innovative Hospice Care, Miami, FL, 9/18/2015

In my roles as a medical oncologist and as a hospice medical director, I was occasionally challenged by an oncology colleague who, upon referral of a hospice eligible patient (prognosis of six months or less) to the hospice program, would request that the hospice agree to allow the continuation of palliative anti-neoplastic therapy (chemotherapy and/or radiation therapy) for the patient. This required that, as hospice medical director, I discuss the planned treatment with the referring oncologist and, ultimately, make a decision about whether the oncologist's request was appropriate for the patient to receive in a hospice setting. To assist me in coming to a conclusion, I developed a set of guidelines that I would review with the oncologist, and in most situations, after working through the issues, the treating oncologist and I would be able to agree on a treatment plan for the specific patient.

While, in the context of hospice, such requests were and remain relatively rare, health plan medical directors experience similar scenarios with much more frequency. While there are various oncology treatment guidelines (i.e. NCCN, ASCO, U.S. Oncology) that are available to assist health plan medical directors in determining appropriate anti-neoplastic therapies in many situations, for patients with advanced cancer who are or should be receiving palliative care, the utilization of such palliative interventions should be individualized in keeping with the concept that palliative care is patient-centered. While the guidelines that I utilized as a hospice medical director were intended to look at the appropriateness of palliative anti-neoplastic therapy through the lens of hospice, it is my belief that these guidelines can serve health plan medical directors in assessing the appropriateness of palliative anti-neoplastic interventions for patients under their health plan irrespective of whether or not the patient is hospice eligible.

Guidelines for Considering the Appropriateness of Palliative Anti-Neoplastic in Advanced Cancer Patients

- What are the patient's goals of care and are they compatible with the proposed intervention?
- What is the goal or expected outcome of the proposed intervention?
- What is the probability that the planned intervention will be efficacious?
- How significant are potential toxicities, side effects, complications, and/or post-intervention discomfort for the patient?
- What is the patient's baseline level of function?
- What is the life expectancy of the patient?

Limited space prevents me from expounding in detail on each of the guideline questions listed above, however, further discussion can be found in the reference below.

I do have one final suggestion. While I have no doubt that any health plan medical director can and should be able to have these conversations with the oncologists treating their patients, with the ever evolving and changing field of medical oncology, it is suggested that health plan medical directors who do not have an oncology background hire an experienced medical oncologist who is willing and able to have these conversations with his or her colleagues. With both physicians possessing the same knowledge base and therefore understanding the benefits and risk of any proposed palliative intervention, there is a much greater likelihood that an agreed upon treatment plan will be arrived at that will provide the most palliative benefit to the individual patient whose care is being discussed.

Reference: B.M. Kinzbrunner and N. Weinreb, "Diagnostic Tests and Invasive Procedures in End of Life Care," Chapter 18 in B.M. Kinzbrunner and J.S. Policzer, *End of Life Care: A Practical Guide*, 2nd ed. New York: McGraw Hill, 2011, pp.443-470.

and referrals, to ensure that palliative care and related services are able to be provided, as medically necessary, in the variety of delivery models that are possible. Benefits designs should cover palliative care and related services in the variety of delivery models as well. Policy should recognize that extended professional consultations and referrals for additional services and counseling are a recognizable component of palliative care, and may indicate appropriate and desired utilization rather than over-utilization.

- Consider adding palliative care consultation(s) and services in any of the known delivery models as a standard benefit with no co-pay or co-insurance, if applicable.
- Consider coverage that permits hospice care and services earlier in the care process, and to

receive hospice care and services concurrently with disease treatment.

Member Engagement and Care Management:

Integrate a palliative care focus and seek out best practices into member engagement materials and resources as well as any care management programs for members and provider performance incentives.

- Include advance care planning choices in member health risk assessments
- Provide members with information about palliative care in member booklets, videos, audio support, and online resources, including how to access it and engage in conversations with their providers (including resources at www.americanhospice.org, www.cancer.net, www.cancer.org, www.cancercare.org, www.capc.org.)

org, www.capc.org, www.caregiveraction.org, www.caringinfo.org, www.getpalliativecare.org, <http://www.gundersenhealth.org/respecting-choices>, www.palliativedoctors.org, and www.vitaltalk.org

- Train those who interact with members (care managers, providers, case managers, patient navigators) in palliative care practices, including goals-of-care discussions, social and cultural issues, and culturally sensitive counseling.

Payment Innovations:

Payers should review their payment policies and both provider and member incentives to encourage utilization and integration of palliative care services and practices, as well as measurement and documentation of associated quality outcomes.

- Consider offering incentive payments for palliative care consultations, conducting and documenting goals-of-care discussions and related subsequent and advanced care plans, and meeting quality measures related to palliative care
- Review certification and accreditation programs and consider offering incentive payments for provider participation in such programs as a surrogate for individual reporting and meeting incentive obligations such as those indicated above
- In risk based contracts, add per-member, per-month community based palliative care delivery and payment models, with appropriate documentation and proof of performance as indicated in both of the above noted situations
- Cover additional management and palliative care provided by providers, teams and formal palliative care centers, including services such as social work, chaplain, nutrition, home assessments, home counseling, etc.
- Identify discrete reimbursement coding options for palliative and complex care, which recognize the time and additional services required with and for the patient and their families.

Provider Training and Recognition:

Support providers in providing such services by recognition and provision of additional training in palliative care and utilization and documentation of palliative care resources, tools and programs, whether directly or through referral.

- Offer incentive payments to physicians and other providers who complete continuing medical education related to communication skills, goals of care discussions, advanced care planning, difficult conversations, and pain and symptom management

- Support providers who commit to utilization of known external resources such as Vitaltalk and the Gundersen Health System Respecting Choices models (but not limited to just those)
- Recognize providers that have sought and earned accreditation or certification or leadership and participation in programs such as the ASCO QOPI® and QPC™ initiatives, the Joint Commission's Advanced Certification for Palliative Care, the Palliative Care Leadership Centers™, ABMS and AOA physician board certification in hospice and palliative medicine HMDCB hospice medical director certification, or other such programs as shall be developed.

Checklists for Payers Intending to Move Forward with Palliative Care Initiatives

Follow the checklists and self-assessment suggestions made by the CAPC and NBGH Toolkit for Payers and Providers to build a work plan for comprehensive palliative care programs and integration of palliative services for member's care (Exhibit 11).

There are full checklists to be found in the CAPC and NBGH Toolkit for Payers⁶⁵, but the basic steps will include:

1. Assessing the potential population: who could benefit?
2. Identifying relevant providers/collaborators. Who delivers quality care? Who is known to deliver palliative care?
3. Identifying community resources and potential partners/collaborators. What resources exist? How much are they utilized?
4. Conduct a self-assessment of current payment and coverage policies, programs and products for both members and providers.
5. Consider options, opportunities, risks, barriers, priorities, and goals.
6. Bring in collaborators and partners to set priorities and implement desired changes in steps.

Incorporation of palliative care program components for members with serious illness will yield positive and measureable results and benefits at many stages of the care process. Some of the programs may already be in place in local markets for individual payers, and progress may be as simple as identifying opportunities, and removing barriers. Other programs will take more intensive effort and collaboration/partners will be essential. The downside to integration of palliative care program components will be the time and resources expended to achieve better communication and support of such programs with both providers and patients, but palliative care pro-

Exhibit 11: Perspectives on Palliative Care from the Field: Payer and Employer Opportunities to Support Those with Serious Illness

Candid comments from Diane E. Meier, MD, FACP, Director, Center to Advance Palliative Care (CAPC), New York, NY 9/22/2015

As the primary financers of health care in the U.S., private and public payers and employers play a critical role in expanding access to quality palliative care to support those with serious illness such as cancer. Studies continue to demonstrate the impact of quality palliative care on patient and family caregiver needs and quality of life as well as costs. Through effective goals of care communication and by addressing pain and symptom management, there is a reduction in unnecessary hospitalizations, 911 calls, emergency room visits and suffering. To further advance care for those with Stage IV cancer, dementia and other serious illnesses we need to change how payers and providers work together to design a health care system that ensures patients get the care they need throughout the course of treatment they have chosen.

Through CAPC's work with payers, providers and other health care organizations, we have identified several important steps that leaders within payer organizations can take to build or expand efforts to support the members, employees, families and care givers.

1. Ensure leadership commitment to the value of palliative care. Without the support of leadership to focus on the needs of those with serious illness, and a willingness to take a comprehensive approach to addressing those needs, it will be difficult to have a meaningful impact on both the quality and cost of caring for the most complex populations. The reality is that making changes to benefit or payment policies, training curricula, information systems and provider networks requires time and resources that are often difficult to find or hard to justify within a health plan or an employer benefit. The pressure on payer leaders to reduce cost, provide high quality customer service and maintain stable provider networks often means that a strong business case is necessary to make any changes. The business case for expanding access to palliative care starts with aligning to the goals of leadership and the organization.

2. Ensure understanding of, and training in, palliative care principles and practices. One of the biggest misconceptions is that palliative care is only appropriate at end-of-life. This is not true. Palliative care, also known as palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness - whatever the diagnosis. It is critical to ensure that leaders, case managers, medical directors, benefit designers, regulatory leaders and others understand what palliative care is, for whom it is appropriate and what services are needed to support those with serious illness.

3. Develop effective payer-provider partnerships. Identifying those most in need and providing the services that are necessary to reduce unwanted hospitalizations and 911 calls requires having both clinical and structural services available such as 24/7 access to a physician or advanced practice nurse to manage pain and home visits by social workers. Through its care managers or predictive analytics, payers often have access to data and information that would help providers better identify those facing functional decline or other indicators for the need for palliative care. Providers have direct access to clinical information about their patients and often do not know that there are benefits or resources that are available to these members. It is critical for payers to work directly with providers in their regions to identify those most in need, to locate palliative care specialists and resources, and to redesign policies, processes and systems that will ensure patients have access to the care they need.

4. Expand access to palliative care in the community. While access to palliative care in hospital settings has grown substantially over the past 15 years, the need for palliative care in the home, office, long-term care and other settings is growing. While the hospice benefit provides access to palliative care outside of the hospital setting, it often requires that patients forgo curative treatment. Designing case management programs, payment policies and benefits that enable palliative care home visits by doctors, advanced practice nurses, social workers and chaplains will help ensure the patient and family care giver have the support they need to effectively manage pain and symptoms and adequately address their social needs.

We are encouraged by the leadership role that payers and employers are taking nationally to address the needs of those with serious illness. In addition, more national standards have been developed to integrate palliative care into our care delivery system. For example, The Joint Commission offers Advanced Certification in Palliative Care and the American College of Surgeons has established palliative requirements for cancer center accreditation. It is through both payer and provider actions that we will have the impact necessary to improve the quality of life for those diagnosed with cancer and other complex and vulnerable populations.

For more information download CAPC's Payer-Provider Toolkit https://media.capc.org/filer_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-provider toolkit-2015.pdf

grams have consistently proven that when they are embraced and integration occurs with patient engagement, the results far outweigh the down-sides.

NAMCP Medical Director's Oncology Institute Strategies and Initiatives

Clearly, there are many rapidly changing elements involved in the management of palliative care in on-

colony whether from the perspective of the payer, the provider or the patient. Under the guidance of Dr. Ron Hunt, President of NAMCP (www.namcp.org) and of Blue Cross Blue Shield of Georgia, and Dr. Bill Williams, Executive Vice President, NAMCP is dedicated to improving communications between those diverse perspectives for the goal of improving patient outcomes. The Oncology In-

stitute Executive Leadership Council, headed by Dr. Alan Adler of Independence Blue Cross Blue Shield, has created a strategy and plan for addressing the interests and needs of the NAMCP members. They continue to move forward with these initiatives, and to solicit feedback from members and to support the industry at large in order to better improve patient outcomes in oncology. For medical directors, the value equation is a function of benefits over costs, and by moving forward with purchasers, plans, and physician medical directors, the hope is to be able to improve benefits, enhance communications and collaborations, and to reduce costs of care overall.

Interactive Discussions

NAMCP sponsors a discussion group for the members of the Oncology Institute for addressing specific or general oncology issues, questions, and concerns. Besides the breadth of organizations involved in the NAMCP as members, there are several Corporate Partners now engaged in discussions and providing resources related to oncology care through the Oncology Institute. NAMCP has also engaged an oncology consultant with deep experience in the issues and perspectives of plans, employers and physicians, as a resource to the organization and its members for oncology strategy.

Oncology Education

One first step is to survey the members twice annually for their key interests and concerns. As a follow-up to the members' request for more information on trends in oncology such as palliative care management, sessions have been added to the programs presented at NAMCP conferences, and this "NAMCP Medical Directors Spotlight Guide: Palliative Care in Oncology" was developed to serve as a resource. The NAMCP Medical Director's Guide: Oncology, (<http://jmcmpub.org/pdf/medical-directors-guide-on-oncology/>) was produced in 2013.

Oncology Research Studies

NAMCP is also actively engaged in projects to identify and analyze research data on oncology issues, in order to facilitate informed policy decision-making and actions among its members.

Oncology Resources

NAMCP presents a focused Oncology Track at each spring and fall national conference to discuss both clinical advances and trends in oncology management. In addition, the NAMCP Oncology Institute website provides tools and resources for medical directors, as well as patient resources and tools.

NAMCP has entered into discussions for poten-

tial collaborations with key oncology provider organizations such as ASCO and NCCN. The Community Oncology Alliance (COA) and NAMCP conducted a study on the cost variations between site-of-service delivery models (of increasing importance given the trend toward hospital acquisition of private practices).⁶⁶ Exploring the concept of the oncology medical home is another project with COA (that includes palliative care components), to see if there is potential for the concept that could bring value to the plans, physicians and patients, thus reducing costs by bringing greater efficiency to the process.

NAMCP also completed a study that tracked the impact on drug costs of different drug delivery models.⁶⁷

Other potential studies for NAMCP members will be to explore collaborative evidence-based oncology management and decision-making. These studies could be intended to see if this type of project could develop a mutually accepted model to explore existing variation (or not) from evidence-based treatments and serve as a rallying point for collaboration for further oncology based initiatives in those markets. If successful, better tracking of evidence-based treatment could result in reduced overhead costs, for both plans and physicians, including lower costs for oversight processes like prior authorizations, and better care for the patients and system at large. Those interested in any of these studies or in suggesting other initiatives may contact Katie Eads, in the NAMCP office at keads@namcp.org.

Conclusion:

Cancers are very complex diseases, and the management of the quality and costs of cancer care is of great importance to purchasers, plans, physicians and patients. Many health plans have not yet adopted significant oncology management processes, but are increasingly concerned about how changes in the marketplace will affect them and the members they cover. These changes include:

- Management of palliative care and integration of palliative care components throughout the patient's disease as well as at end-of-life.
- Site of service shifts.
- Depth of the oncology pipeline.
- Lack of detailed information about oncology treatments in relation to evidence.
- Prices of drugs.
- Lack of predictability of costs for a disease that can both be fatal and chronic.

Oncology physicians are concerned about federal and private payment and coverage policy, the access

issues their patients are facing through benefit design and oncology management processes, and how to prove the quality of their care in a challenging technology environment.

Purchasers (employers) are concerned about the impact of health costs and benefits on their own organization's financial viability, as well as the impact that cancer will have on their employee population.

Patients are concerned about whether their physician can afford to treat them in their preferred site of service, about whether they can afford the appropriate oncology treatment given drug prices and benefit design, and the daily mental and physical challenges of battling cancer.

All these differing perspectives still ultimately have the admirable goal of wanting to see the right treatment, delivered to the right patient at the right time in the right setting, at the right cost.

The role of palliative care becomes central to most of these concerns, since the management of the disease, the symptoms and side effects, communication and mutual understanding of patient goals and expectations for quality of life and treatment choices, the complete assessment and support of psychosocial and spiritual needs of the patient and their families, mutual decision-making; and care of the dying are all connected to the quality, satisfaction and ultimate cost of the cancer care for patients. Palliative care does provide benefit and value in cancer care, and purchaser medical directors have a number of resources available to help create programs and policy that support the integration and utilization of palliative care for cancer patients, even when the current delivery models for palliative care are diverse, complex and confusing.

NAMCP as an organization is uniquely positioned to encourage mutual information sharing, discussion, collaboration, and analytics among its diverse membership of purchasers, plans, and providers. NAMCP has also been able to initiate collaborative discussions with other key oncology organizations to bring a comprehensive set of perspectives to the discussion table. With the increasing activities of the NAMCP Oncology Institute, there are great opportunities for all involved to effect significant change and reform in the oncology space, while enhancing quality of care and patient outcomes even as they reduce overhead burdens and costs.

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