



NAMCP Medical Directors Spotlight Guide: Palliative Care in Oncology – Second Edition 2021

How Palliative Care Trends and Issues in Oncology Can Affect
Medical Directors of Purchasers, Plans, and Providers



JOURNAL of MANAGED CARE MEDICINE

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Mission Statement

The mission of the National Association of Managed Care Physicians (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 the growing trends in 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. This guide is part of a series of 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.

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NAMCP Medical Directors Spotlight: Palliative Care in Oncology – Second Edition 2021

How Palliative Care Trends and Issues in Oncology Can Affect Medical Directors of Purchasers, Plans, and Providers

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Abstract

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, 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. Most medical directors for health plans and employers are not medical oncologists. Although 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.

Cancer and the treatment of cancer causes a wide range of significant and serious symptoms and adverse events. The costs of managing these symptoms and adverse events can be high, both physically and mentally for patients, and financially for patients, providers, and payers. 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. 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 it 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, which can dramatically affect quality of life and increase costs for unmanaged symptoms and adverse events.

Hospice is comfort care without curative intent: The patient no longer has curative options or has chosen not to pursue treatment because the adverse events outweigh the benefits. Palliative care is comfort care with or without curative intent. On average, palliative care consultation is associated with reductions in direct hospital costs of more than \$3,000 per admission, and for the sickest patients with four or more diagnoses, these cost savings are closer to \$4,800 per admission. Incorporating standardized access to palliative care services for patients with serious illness has the potential to save hundreds of millions of dollars per year.

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

Abstract (continued)

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

Palliative care does provide benefit and value in cancer care, and purchaser medical directors have many 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 possibly confusing.

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 consider resources that the 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 stated that U.S. health-care spending bill grew to \$3.6 trillion in 2018 or \$11,172 per person, and projects expenditures to reach \$6.2 trillion and account for 19.7 percent of the nation's gross domestic product by 2028.¹ More than 1.8 million new cancer cases are expected to be diagnosed in 2020 (excluding noninvasive cancers or basal or squamous cell skin cancers). About 606,520 Americans are expected to die of cancer in 2020, but the overall age-adjusted annual cancer death rate continues to decline from its peak in 1991 (a drop of 29% from 1991 to 2017), attributed to

reductions in smoking and improvements in early detection and treatment.

Many patients with newly diagnosed cancers will survive their disease. One estimate is that the number of cancer survivors could grow from about 15.5 million in 2016 to 20.3 million by 2026 – a 31 percent increase over the decade.² Although cancer care represents a small fraction of overall health-care costs, the cost of cancer care is rapidly increasing, projected in part due to an aging population, population growth, increasing numbers of cancer survivors, and rising costs of therapies. The national cost for cancer-related medical services and prescription drugs is expected to rise about one third (from \$183 billion in 2015 to \$246 billion by 2030) due to population changes alone. Costs vary by cancer site and stage. Overall annualized costs per patient were highest in the end-of-life stage followed by initial and then continuing phases of care.³

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, 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 and Medicaid (CMS), physicians, health care systems, private payers, and employers. Organizations as varied as CMS, the Commission on Cancer (CoC), the Community Oncology Alliance (COA), the National Quality Forum (NQF), Center to Advance Palliative Care (CAPC), the Agency of Healthcare Research and Quality (AHRQ), the American Academy of Hospice and Palliative Medicine (AAHPM), and the American Society of Clinical Oncology

(ASCO) have published or endorsed quality metrics that cover a wide variety of cancer services. Common to these is the presence of some measures related to palliative care, end-of-life care, and pain management, which are often used as markers for quality patient management.

Most medical directors for health plans and employers are not medical oncologists. Although 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 understandings, 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 and 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, which 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 Impact of Palliative Care on the Quality and Costs of Oncology Care

Cancer and the treatment of cancer causes symptoms and adverse events. The current model of medical care in the United States (U.S.) 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. *Cancer costs can be measured in terms of direct medical costs for all health expenditures as well as indirect costs such as lost earnings and productivity from missed work. The Agency for Health Care Research and Quality estimates that U.S. cancer-related direct medical costs were about \$80.2 billion (52% from outpatient care and 38% from inpatient care.) The American Cancer Society researchers estimated that more than \$94 billion in U.S. earnings were lost in 2015 due to cancer death.*⁴

Cancer and the treatment of cancer causes a wide range of significant and serious symptoms and adverse events. The costs of managing these symptoms and adverse events can be high, both physically and mentally for patients, and financially for patients, providers, and payers. There is a consensus that better management of patient adverse events, 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 with advanced illness. ASCO notes that “The primary argument for palliative care has always been to improve care for patients and families. However, a compelling case can be made that palliative care is better care at a cost we can afford; palliative care in most studies has reduced the total cost of care, often substantially. Not a single study, randomized or observational, has shown that cost is increased.”⁵ 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 strategies 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: Charging a New Course for a System in Crisis,” about 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 two 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”⁶

Roles and Definitions of Palliative Care

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

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 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 adverse events 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 U.S., through the Medicare hospice benefit.⁷

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, which can dramatically affect quality of life and increase costs for unmanaged symptoms and adverse events.⁸⁻¹⁰

Defining Palliative Care

Palliative care can have two separate but inter-related pathways.¹¹

- **Palliative care** is compassionate comfort care that provides relief from the symptoms, physical and mental stress of a serious or life-limiting illness. Palliative care can be pursued at diagnosis, **during curative treatment and follow-up**, as well as end of life.
- **Palliative/hospice care** is increasingly considered to be compassionate comfort care (as opposed to curative care) for people facing any terminal illness with a prognosis of six months or less, based on their physician’s estimate of

the disease progression, this is reassessed if the period goes beyond six months.

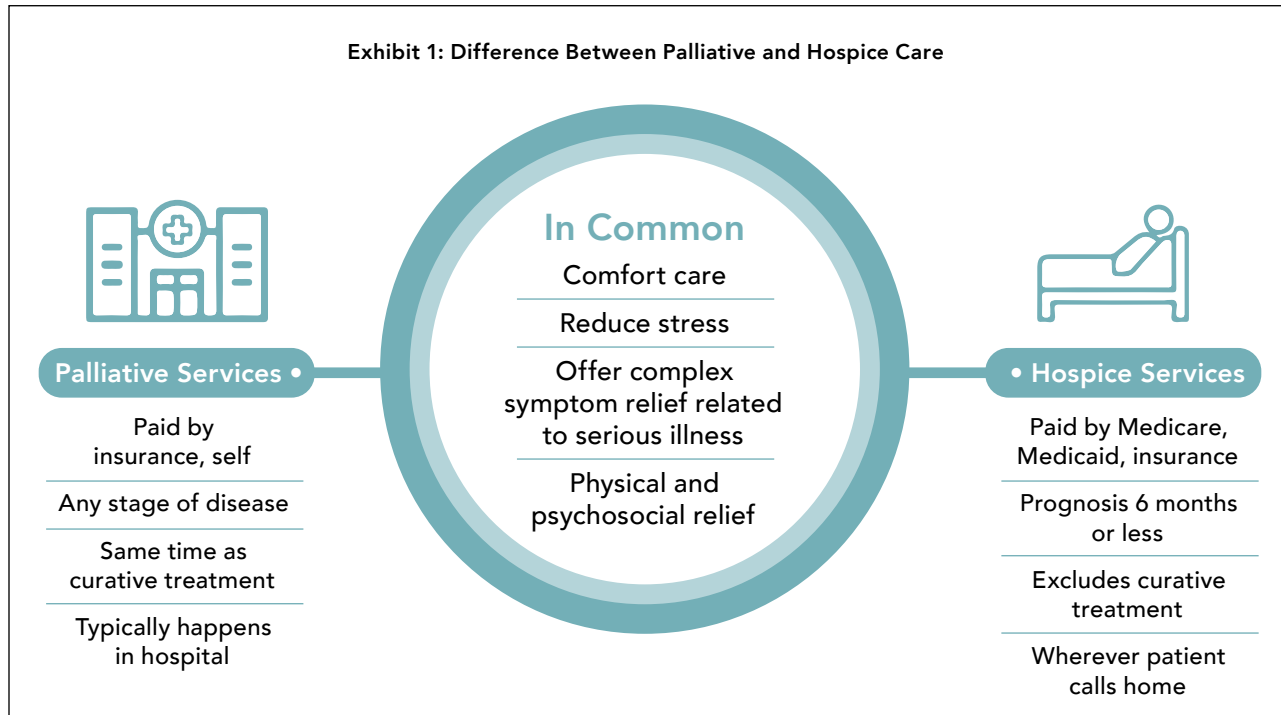
What is the Difference Between Palliative and Hospice Care?

The palliative/hospice care pathway is often what is considered top of mind when hearing the phrase palliative care, which is thought of as pre-hospice care; care that patients and their family receive prior

to admission to a hospice or end-of-life program.

“While the objective of both hospice and palliative care is pain and symptom relief, the prognosis and goals of care tend to be different. Hospice is comfort care without curative intent; the patient no longer has curative options or has chosen not to pursue treatment because adverse events outweigh the benefits. Palliative care is comfort care with or without curative intent.”¹²

Exhibit 1: Difference Between Palliative and Hospice Care



Source: “Palliative Care vs. Hospice: What’s the Difference?”, VITAS Healthcare web page, last accessed Mar. 24, 2021 at <https://www.vitas.com/hospice-and-palliative-care-basics/about-palliative-care/hospice-vs-palliative-care-whats-the-difference>.

The palliative care pathway challenges us to look beyond the stereotypical pre-cancer scenario and go to the place where palliative care originated. This care pathway focus is on clinicians managing a patient through curative and/or maintenance treatment, improved symptom management and supportive care. Palliative care works best when started during the treatment process and coordinated with cancer treatment. When utilized in that fashion, those patients usually have less severe symptoms and adverse events, improved quality of life, and feel better during their treatment. This inter-related pathway approach to palliative care can be utilized at any age and for any type and stage of cancer or other conditions.

Palliative eligibility is begun at the discretion of the physician and patient at any time, at any stage of illness, terminal or not, whereas **hospice eligibility**

requires that two physicians certify that the patient has less than six months to live if the disease follows its usual course.¹³

- Coverage for comfort-focused palliative care varies by provider and insurance plan, each time patients and providers must check what is not covered and whether there are co-pays, out-of-pocket costs, or other charges.
- Medicare Part B and Medicaid cover some types of palliative care, but there still might be co-pays for some treatments and medications that are not covered.

Organizational Definitions Vary Somewhat THE AMERICAN CANCER SOCIETY

The American Cancer Society (ACS) states that palliative care (supportive care) is focused on improving the quality of life for people living with a

serious illness like cancer. It can be given at any time from the point of diagnosis, throughout treatment, and beyond.¹⁴

AMERICAN SOCIETY OF CLINICAL ONCOLOGY

The American Society of Clinical Oncology supports the National Consensus Project definition of palliative care: “Palliative care means 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.”¹⁵

CENTER TO ADVANCE PALLIATIVE CARE

The Center to Advance Palliative Care (CAPC) describes palliative care as a team approach to improving quality of life for people living with serious illness. It focuses on providing relief from the pain, symptoms, and stress of a serious illness for both the patient and family. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. At a minimum, a palliative care program should provide expert pain and symptom management, effective communication with patients and families to support autonomous decision making for medical treatment, care priorities, screening, and support for the emotional, social, and spiritual needs of patients and their families.¹⁶

INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE

During 2018, the International Association for Hospice and Palliative Care (IAHPC) developed a palliative care definition with input from over 400 IAHPC members from 88 countries. Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers.¹⁷

Palliative care:

- Includes, prevention, early identification, comprehensive assessment, and management of physical issues, including pain and other distressing symptoms, psychological distress, spiritual distress, and social needs. Whenever possible, these interventions must be evidence based.
- Provides support to help patients live as fully as possible until death by facilitating effective communication, helping them and their families determine goals of care.

- Is applicable throughout the course of an illness, according to the patient’s needs.
- Is provided in conjunction with disease modifying therapies whenever needed.
- May positively influence the course of illness.
- Intends neither to hasten nor postpone death, affirms life, and recognizes dying as a natural process.
- Provides support to the family and the caregivers during the patient’s illness, and in their own bereavement.
- Is delivered recognizing and respecting the cultural values and beliefs of the patient and the family.
- Is applicable throughout all health care settings (place of residence and institutions) and in all levels (primary to tertiary).
- Can be provided by professionals with basic palliative care training.
- Requires specialist palliative care with a multi-professional team for referral of complex cases.

NATIONAL INSTITUTE ON AGING

The National Institute on Aging notes that palliative care is helpful at any stage of illness and is best provided from the point of diagnosis. Palliative care is a resource for anyone living with a serious illness, such as heart failure, chronic obstructive pulmonary disease, cancer, dementia, Parkinson’s disease, and many others.¹⁸

WORLD HEALTH ORGANIZATION

The World Health Organization defined palliative care as an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial, or spiritual. Palliative care is explicitly recognized under the human right to health. It should be provided through person-centered and integrated health services that pay special attention to the specific needs and preferences of individuals.¹⁹

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 and other medical professionals’ certification in hospice and palliative medicine has been significant 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

Physicians have different pathways to certification depending upon their primary board or experience. In 2006, the ABMS recognized the subspecialty of Hospice and Palliative Medicine under 10 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, for physicians to become certified in Hospice and Palliative Medicine, they must complete a 12-month fellowship in hospice and palliative medicine from an Accreditation Council of Graduate Medical Education (ACGME) accredited training program. The American Osteopathic Association (AOA) Bureau of Osteopathic Specialists approved a Certificate of Added Qualification (CAQ) in Hospice and Palliative Medicine (HPM), under the following osteopathic boards: Family Medicine, Internal Medicine, Neurology and Psychiatry, and Physical Medicine and Rehabilitation.²⁰ 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. While the AOA has five Boards that co-sponsor the Certificate of Added Qualification (CAQ) in HPM, those that complete the ACGME/AOA fellowship in HPM and are certified by a primary board of the AOA, are eligible to sit for the HPM certification exam. The AAHPM has developed products, courses, and resources to help prepare for the exam, which are available on their website.²¹

CENTER TO ADVANCE PALLIATIVE CARE (CAPC)

The Center to Advance Palliative Care (CAPC) offers program certification for palliative care programs. Certification has been available to nurses since 1994. Currently, hospice and palliative certification is now also available to nursing assistants (CHPNA), registered nurses (CHPN), advanced practice registered nurses (ACHPN), pediatric nurses (CHPPN), bachelor’s level social workers (CHP-SW) and master’s level social workers (ACHP-SW), a new certification for experienced Advanced Palliative Hospice Social Workers (APSHSW-C) became available in 2019. Chaplains may seek the Board-Certified Chaplain – Palliative Care and Hospice Advanced Certification (BCC-PCHAC) and chaplains, pastoral supervisors and pastoral psychotherapists may seek College of Pastoral Supervision and Psychotherapy (CPSP) certification. Thanatology: Counseling in Death and Bereavement certification is available for death education counselors, as well as Perinatal Loss Counselor Certification.²²

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 an alternative certification option for midcareer physicians who desire to enter the hospice and palliative medicine field without fellowship training.²³

The Impact of Reforms: Value-Based, Payment, and Performance Reforms Influence on the Role of Palliative Care

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 pilots 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 AND MEDICAID IMPROVEMENT ONCOLOGY CARE MODEL

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. 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 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.

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

Information in a Cancer Care 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 psychosocial 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 September 10, 2020 at http://www.nap.edu/download.php?record_id=18359.

The OCM program spurred many discussions among oncology care providers about how they would modify care delivery to achieve tangible savings for the Medicare program, and additional savings to share with CMS. A number of those discussions centered on patient care management, and the impact that management, not just of symptoms and adverse events, 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, has become a game-changer for discussions around early intervention and application of palliative care management.

The OCM program began on July 1, 2016 and was to have continued for five years. The program was extended for one year until June 30, 2022 due to the disruption of the health care system created by coronavirus disease 2019 (COVID-19).²⁴ A 2019 report (based on on-site visits and interviews of 13 of the 138 participating OCM practices) on the results of the first 18 months of the program showed limited impact on the rates of emergency department visits or hospitalizations overall but did indicate about 1 percent cost savings related to end of life care. All the 13 interviewed practices provide some sort of patient navigation under the program, including the following specific activities that touch upon key aspects of palliative care management:

- Engaging with new patients at or before the first appointment to orient the patient to the practice and identify any psychosocial or financial issues.
- Educating patients about treatment adverse events and whom to call about urgent issues.
- Calling patient on cycle one/day one to check on adverse events and additional follow-up for patients on especially toxic regimens.
- Referring patients to support services (e.g., counseling support groups spiritual counseling/chaplain, dietician services) or to community services (e.g., transportation housing support).
- Ensuring referrals are added to medical charts sending oncology notes to outside providers and helping patients schedule appointments within and outside the practice.

The OCM program asked practices to utilize palliative care and advanced care planning, especially related to end-of-life care. The 2020 report noted OCM practices are hiring more palliative care specialists and enhancing access to palliative care which did help OCM practices reduce hospital use in the last month of life which decreased Medicare Part A payments for dying patient's last episodes of care.²⁵

CENTER FOR MEDICARE AND MEDICAID SERVICES PHYSICIAN QUALITY REPORTING SYSTEM (PQRS) AND QUALITY PAYMENT PROGRAM

The Center for Medicare and Medicaid Services (CMS) Physician Quality Reporting System (PQRS) set forth quality measures that address patient- 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 were evaluated under the PQRS program for their success on such measures, which itself was hoped to spur a deeper practice focus on palliative care components.²⁶ This reporting program ended in 2016. Medicare replaced this and other programs with the Quality Payment Program beginning in 2017, which is mandatory, and covers most Medicare providers.

The Quality Payment Program included a new all specialty Merit-based Incentive Payment System (MIPS) The MIPS program collects data on quality and claims. Practices must report on at least six from among hundreds of measures in different categories. There are three MIPS Quality measures that relate directly to Pain or Palliative care: #342 – Pain Brought Under Control Within 48 Hours, #143 – Oncology: Medical and Radiation – Pain Intensity Quantified, and #144 – Oncology: Medical and Radiation – Plan of Care for Moderate to Severe Pain.²⁷

PRIVATE INSURERS

Private insurers are also exploring quality programs that may have components linked to palliative care. For example, Aetna offers the Aetna Compassionate CareSM program to offer members support and guidance on treatment options, pain management and planning at end-of-life.²⁸ Management of pain and advanced care planning are part of many elements of palliative care, and a good beginning to integration of more palliative care elements into the daily management of cancer care.

CIGNA,²⁹ Humana,³⁰ and other private payers are more often referencing palliative care support and services on their patient access websites. Some of these are still tied more to end-of-life care than ongoing supportive care during the patient's full cancer journey.

Medicare Advantage plans were provided the opportunity to expand benefits by the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act (CHRONIC) passed by Congress in 2018. By 2020, smaller regional health plans offering Medicare Advantage models in

modest geographic areas like Ohio, Pennsylvania, Minnesota, Washington State and Oregon began offering in-home palliative care. Larger health plans were expected to begin expansion of such services in subsequent years. In Florida, a 2019 Florida Tax Watch Report suggested that the Florida legislature should develop a regulatory framework to define services and reimbursement for palliative care, predicting that home-based palliative care could reduce societal health care costs by \$1 to 3 billion within 20 years.³¹

ONCOLOGY MEDICAL HOME

Most patient centered medical home models are focused on primary care, but major initiatives have also 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) focused on better triage of patients and management of symptoms and adverse events to avoid hospitalizations and emergency room visits. The COME HOME program resulted in a significant 8.1 percent savings relative to Medicare six-month average spending (\$32,866), as well as a significant 10.2 percent reduction in emergency department visits per 1,000 patients per six-month period.³²

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. A 2019 study found that ACOs are utilizing strategies to identify individuals with serious illness, but far fewer are implementing specific care strategies (such as palliative care) for this population once it is identified. Just 13 percent of integrated health systems, 3 percent of hospital-led ACOs, and 9 percent of physician-led ACOs identified palliative/hospice care as a priority for improving efficiency and reducing costs.³³

Resources and Policy Evolution

GROWING STANDARDIZATION AND RESOURCES OVER THE LAST THREE DECADES

Medical oncology was established as a specialty on 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. Most clinicians then 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.

Numerous standards, resources and recommendations now exist for the delivery and provision of palliative care earlier in the patient's journey with cancer, 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.

As of 2019, 72 percent of hospitals with fifty or more beds report a palliative care team, up from 67 percent in 2015 and 7 percent in 2001. These hospitals currently serve 87 percent of all hospitalized patients in the U.S., an increase from 82 percent in 2015. Significant regional variation persists, with penetration highest in New England and lowest in the south-central states. Large nonprofit hospitals in urban centers remain the institutions most likely to provide access to a palliative care team.³⁴

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

AMERICAN SOCIETY OF CLINICAL ONCOLOGY (ASCO)

Both the American Society of Clinical Oncology (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 <https://www.asco.org/practice-policy/cancer-care-initiatives/palliative-care-oncology>.

In 2017, ASCO published an updated Guideline: The Integration of Palliative Care into Standard Oncology Care. ASCO additionally provides education materials, workshops, policy statements, and quality measures for health care professionals on their website. ASCO recommends that “inpatients and outpatients with advanced cancer should receive

dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.”³⁵

Exhibit 3: Integration of Palliative Care Into Standard Oncology Care

American Society of Clinical Oncology Clinical Practice Guideline Update

Guideline Question

Should palliative care concurrent with oncology care be standard practice?

Target Population

Patients with advanced cancer and their caregivers.

Target Audience

Oncology clinicians, patients, caregivers, and palliative care specialists.

Methods

An Expert Panel was convened to update clinical practice guideline recommendations based on a systematic review of the medical literature.

Key Recommendation

Patients with advanced cancer, whether patient or outpatient, should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referring patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer caregivers of patients with early or advanced cancer to palliative care services.

Specific Recommendations

Patients with advanced cancer should be referred to interdisciplinary palliative care teams (consultation) that provide inpatient and outpatient care early in the course of disease, alongside active treatment of their cancer:

Type: evidence-based, benefits outweigh harms

Evidence quality: intermediate

Strength of recommendation: strong

Palliative care for patients with advanced cancer should be delivered through interdisciplinary palliative care teams with consultation available in both outpatient and inpatient settings:

Type: evidence-based, benefits outweigh harms

Evidence quality: intermediate

Strength of recommendation: moderate

Patients with advanced cancer should receive palliative care services, which may include referral to a palliative care provider. Essential components of palliative care may include:

- Rapport and relationship building with patients and family caregivers
- Symptom, distress, and functional status management (e.g., pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation).
- Exploration of understanding and education about illness and prognosis.

(continues)

- Clarification of treatment goals.
- Assessment and support of coping needs (e.g., provision of dignity therapy).
- Assistance with medical decision making.
- Coordination with other care providers.
- Provision of referrals to other care providers as indicated.

For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement within eight weeks of diagnosis:

Type: informal consensus, benefits outweigh harms

Evidence quality: intermediate;

Among patients with cancer with high symptom burden and/or unmet physical or psychosocial needs, outpatient cancer care programs should provide and use dedicated resources (palliative care clinicians) to deliver palliative care services to complement existing program tools:

Type: evidence-based, benefits outweigh harms

Evidence quality: intermediate

Strength of recommendation: moderate

For patients with early or advanced cancer for whom family caregivers will provide care in the outpatient setting, nurses, social workers, or other providers may initiate caregiver-tailored palliative care support, which could include telephone coaching, education, referrals, and face-to-face meetings. For family caregivers who may live in rural areas and/or are unable to travel to clinic and/or longer distances, telephone support may be offered;

Type: evidence- based

Evidence quality: low

Strength of recommendation: weak

Qualifying Statement

This guideline uses the National Consensus Project definition of palliative care: "Palliative care means 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." ASCO believes that cancer clinical trials are vital to inform medical decisions and improve cancer care and that all patients should have the opportunity to participate. Patients in clinical trials may benefit from the support of palliative care.

Additional Resources

More information, including a Data Supplement with additional evidence tables, a Methodology Supplement with information about evidence quality and strength of recommendations, slide sets, and clinical tools and resources, is available at www.asco.org/palliative-care-guideline and www.asco.org/guidelineswiki. Patient information is available at www.cancer.net.

ASCO launched a symposium in 2014 that was dedicated to palliative care, but due to the growing recognition in the last decade of the importance of treating the whole patient, ASCO held its last free-standing symposia themed around supportive and palliative care in September 2019. Moving forward, the ASCO approach to treating cancer in the “whole patient” and going beyond consideration of not just the disease, but also the patient’s goals and values, comorbidities, environment, and family members is expected to lead to the integration of palliative and symptom management into standard oncology care. ASCO will integrate research findings and best practices in palliative care into sessions presented at the ASCO Annual meeting and other ASCO specialized meetings, to bring advancements in the field of palliative medicine to a wider audience.³⁶

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.³⁷

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.³⁸

THE CENTER TO ADVANCE PALLIATIVE CARE

The Center to Advance Palliative Care (CAPC) (www.capc.org) is a national organization dedicated to increasing the availability of quality palliative care services for people living with serious illness. The 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. The CAPC serves as a convening, organizing and dissemination force for the field, collaborating with leaders, innovators, and partners to foster connection and cross-fertilization. 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/>). In the fall of 2020, a new national registry for the collection of palliative care data launched. This one national registry is called the Palliative Care Quality Collaborative (PCQC) and is a consolidation of the former National Palliative Care Registry™, the Palliative Care Quality Network (PCQN), and the Global Palliative Care Quality Alliance (GPCQA).³⁸

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). 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 (<https://www.cancer.gov/about-cancer/advanced-cancer/care-choices/palliative-care-fact-sheet>), which addresses several 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 has not moved 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 persisted. The 1999 “Ensuring Quality Cancer Care” report (<https://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.”³⁹ A 2016 workshop explored the relationship between palliative care and health literacy, and the importance of health literate communication in providing high-quality delivery of palliative care (<https://www.nap.edu/catalog/24646/health-literacy-and-palliative-care>).

edu/catalog/21839/health-literacy-and-palliative-care-workshop-summary.)

In 2013, a follow up IOM report, “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis” (<https://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 adverse events from treatment, and that decisions about care often are not based on the latest scientific evidence.

In 2001, a NCPB report that specifically focused on the palliative care situation: “Improving Palliative Care for Cancer” (<https://www.nap.edu/catalog/10147/improving-palliative-care-for-cancer-summary-and-recommendations>) 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, which 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.⁴⁰

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 psychosocial symptoms. Care systems, payers, and standard-setting and accreditations 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, their eventual implementation, and should provide leadership and training for the 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.⁴¹

NATIONAL HOSPITAL AND PALLIATIVE CARE ORGANIZATION

The National Hospital and Palliative Care Organization (NHPCO) (<http://www.nhpco.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 adverse events. CaringInfo, a program of NHPCO, provides free resources (<https://www.nhpco.org/patients->

and-caregivers/) to help people make decisions about end-of-life care and services before a crisis.

VITALTALK RESOURCES

Vitaltalk Resources (www.vitaltalk.org) is a nonprofit 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.”⁴²

Publications as Resources for Palliative Care Conversations

- D. Gramling, R. Gramling, “Palliative Care Conversations”, 2019, Walter de Gruyter, Boston/Berlin, ISBN 978-1-5015-1268-1
- Dr. K. Patel, “Between Life and Death”, 2020, Penguin Random House India, ISBN 978-0670093977.
- CAPC Designation status in Communication – provides clinicians with techniques needed to discuss serious news and prognosis, have effective conversations about goals of care and advance care planning, and facilitate decision-making in family meetings. CAPC Communication Skills Unit – information found on the CAPC website at <https://www.capc.org/training/communication-skills/>.

What to Look for in Palliative Care Programs

Palliative care programs vary widely. That 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 to what to look for, there are six 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. Psychosocial and spiritual care of the patient and the family
6. Care of the dying⁴³

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, psychosocial 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 because 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 “The Impact of Palliative Care”) below.

PALLIATIVE CARE FOR PATIENTS AND THEIR FAMILIES AND/OR CAREGIVERS

As patients and their families undergo life altering treatments, physicians need to focus on managing the symptoms and adverse events they already know patients will encounter or have been encountering prior to the first medical visit.

For example, there are some cancer diagnoses that can have a more devastating clinical presence than others. Often when a patient with lung or esophageal cancer presents to the doctor for the first time, 75 to 80 percent of the time they have already lost 10 to 15 pounds and they are tired and debilitated. For these patients to survive the treatment regimen for that lung cancer, they are going to need focused symptom management and supportive care. The aim of the palliative care team is to improve the quality of life for both patients and their families. This form of care is offered alongside curative or other treatments patients are receiving.

Another often unknown aspect is that palliative care often follows the patient well after treatment. Often cancer treatments will have “late events” which can last for 3 to 24 months and sometimes

longer. Palliative care specialists can help treat late events of treatment. This is a vital part of survivorship care, it is not enough to beat cancer, patient will need to manage adverse events many years into the future and sometimes forever.

It is essential to note that palliative care is not just for the person going through treatment but for the family and caregivers. Loved ones often provide important physical, practical, and emotional support to the person with cancer. Caregivers can also experience fear, stress, anxiety, depression, and frustration. Palliative care can help caregivers balance providing care while also improving their own quality of life.

Palliative care can be especially important for patients who are 65 years or older. Older adults can have more physical adverse events, especially from chemotherapy. The older body might not recover as quickly from surgery as in the past. These patients may be concerned about items that relate to living on their own, how will treatment affect their memory, and overall quality of life. The palliative care team can assist with everyone's specific needs.

THE IMPACT OF PALLIATIVE CARE ON SYMPTOMS AND COSTS OF CARE

A 2012 review of the progress of palliative care approaches notes that “most patients, including those with cancer, report inadequate discussions with their physicians regarding goals of care and prognosis, and 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.”⁴⁴

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.

POTENTIAL SAVINGS RELATED TO PALLIATIVE CARE INTERVENTION

On average, palliative care consultation is associated with reductions in direct hospital costs of more than \$3,000 per admission, and for the sickest patients with four or more diagnoses, these cost savings

What Effects of Illness Can Palliative Care Address?

A serious illness affects more than just the body. It touches all areas of a person's life, as well as lives of that person's family members.

Palliative care can address these effects of a person's illness.

Physical Problems: Symptoms or adverse events can include:

- Pain
- Fatigue
- Exercise
- Trouble sleeping
- Breathing problems, including shortness of breath
- Loss of appetite, and feeling sick to the stomach

Palliative care support may include:

- Medicine
- Nutritional Guidance
- Physical Therapy
- Occupational Therapy
- Sleep specialists
- Pain specialists
- Integrative therapies

Emotional, Social, and Coping Problems: Patients and their families face stress during illness that can lead to fear, anxiety, hopelessness, or depression. Family members may take on care giving, even if they also have jobs and other duties. Patients may wish for assistance speaking to their loved ones or caregivers about how they feel or what they are going through.

Treatments may include:

- Counseling
- Support Groups or other activities, including yoga, creating art, and volunteering.
- Family Meetings
- Referrals to mental health providers

Practical Problems: Some of the problems brought on by illness are practical, such as money- or job-related problems, insurance questions and legal issues. A palliative care team may:

- Explain insurance, billing, costs of care, complex medical forms or help families understand treatment choices.
- Provide or refer families to financial counseling.
- Help connect patients to resources for transportation or housing, medical leave, disability payments, free or low-cost medicines.

Spiritual Issues: When people are challenged by illness, they may look for meaning or question their faith. A palliative care team may help patients and families explore their beliefs and values so they can move toward acceptance and peace.

Source: “What is palliative care?” MedlinePlus webpage, U.S. National Library of Medicine, References Arnold RM. Palliative care. In: Goldman L, Schafer AI, eds. Goldman-Cecil Medicine. 26th ed. Philadelphia, PA: Elsevier; 2020:chap 3 Rakel RE, Trinh TH. Care of the dying patient. In: Rakel RE, Rakel DP, eds. Textbook of Family Medicine. 9th ed. Philadelphia, PA: Elsevier Saunders; 2016:chap 5. Schaefer KG, Abrahm JL, Wolfe J. Palliative care. In: Hoffman R, Benz EJ, Silberstein LE, et al, eds. Hematology: Basic Principles and Practice. 7th ed. Philadelphia, PA: Elsevier; 2018:chap 92.

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are closer to \$4,800 per admission. Incorporating standardized access to palliative care services for patients with serious illness has the potential to save hundreds of millions of dollars per year.⁴⁵ Palliative care intervention was reported in a 2017 study to reduce total healthcare costs, after the intervention, by as much as 28 percent. The economic effect of the palliative care depended on the timing of the consult. Palliative care consultation within seven days of death decreased healthcare costs by \$975, whereas palliative care consultation more than 4 weeks from death decreased costs by \$5,362.⁴⁶

Reduced hospital costs were also reported in a 2004 to 2007 review of 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 most 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 2 percent or 6 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.⁴⁷

A 2019 report on the impact of a population health community-based model of palliative care showed a statistically significant 20 percent reduction in total medical costs (\$619 per enrolled member per month), a 38 percent reduction in intensive care unit admissions, a 33 percent reduction in hospital admissions, and a 12 percent reduction in hospital stays.⁴⁸

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

There are two general approaches to palliative care provision in oncology. Primary palliative care is the foundational symptom management, shared decision making, and coordination of psychosocial and community services that comprises routine, comprehensive oncologist-delivered care. Some

patients with more complex needs require secondary or consultative palliative care, which is delivered by an interdisciplinary team of palliative specialists typically composed of physicians, nurses, social workers, and chaplains. Teams may also include the disciplines of counseling, nutrition, pharmacy, and rehabilitation. Specialty palliative care follows patients throughout expected transitions in the community, for example from a hospital to a skilled nursing facility, thereby providing a centralized care plan across the disease continuum.⁴⁹

THREE 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, each with different visibility and implication for claims activity.⁵⁰

The first model is care provided primarily by a physician and his/her practice team; classified by ASCO in 2008 as a “**Solo Practice Model**”. The physician and his/her nurses and staff provide the cancer assessment and treatment, as well as the psychosocial and clinical management of the patient’s symptoms and adverse events. 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 practitioner, 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 psychosocial, 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 psychosocial 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 then able to focus on treating the patient with confidence that the team will address the physical symptoms and psychosocial 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 payment 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 outside of the patient/physician care relationship (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, which, 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 four basic levels of care to meet the clinical needs of 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.

1. Routine Hospice Care (RHC) is the most common level of hospice care, provided at the patient’s residence.
2. Continuous Home Care (CHC) is care provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. CHC services must be predominately nursing care, supplemented with caregiver and hospice aide services, and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.
3. Inpatient Respite Care (IRC) is available to provide temporary relief to the patient’s primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long-term care facility that has sufficient 24-hour nursing personnel present.
4. General Inpatient Care (GIP) is provided

for pain control or other acute symptom management that cannot feasibly be provided in any other setting. GIP begins when other efforts to manage symptoms are not sufficient. GIP can be provided in a Medicare certified hospital hospice inpatient facility or nursing facility that has registered nursing available 24 hours a day to provide direct patient care.⁵¹

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 “carve(d) out,” meaning that Medicare reimburses the hospice provider directly. 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.⁵²

Based on 2018 data, the National Hospice and Palliative Care Organization (NHPCO) estimates that approximately 50.7 percent of Medicare decedents were enrolled in one day or more of hospice care at their time of death, with over half (51.5%) dying in the home at the RHC level of care. Over half (53.8%) of these patients were enrolled in hospice for 30 or fewer days. Almost a third (29.6%) of the 2018 Medicare decedents had a principal diagnosis of cancer. Patients with a principal diagnosis of cancer showed an average length of hospice enrollment of 45.6 days, with a median of 18 days.⁵³

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 to 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. Among the drivers for short hospice lengths of stay could be 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.

CHALLENGES FOR MOVING CANCER PATIENTS INTO HOSPICE CARE

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.^{54,55} Guidelines to help physicians identify potentially

eligible hospice patients have been published,⁵⁶ 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, and 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 reevaluating the patient’s life expectancy and must recertify that the patient’s prognosis remains six months or less.

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 the Medicare Hospice Benefit states that patients who elect hospice are required to forgo curative care. The challenging 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.

Another 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 adverse events of these interventions. Therefore, it is incumbent upon the oncologist, and the hospice to ensure that hospice nurses caring for patients receiving anti-neoplastic therapies in a hospice setting are professionally trained to manage the

potential toxicities and adverse events of any such treatment.

One additional 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.

MEDICARE CARE CHOICES MODEL

To address the second of the issues stated above, CMS initiated a five-year demonstration project in 2015 entitled the “Medicare Care Choices Model (MCCM).” This model allows participating hospice providers to enroll patients who are hospice eligible with advanced cancer, 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 82 hospices nationwide who are participating in this program, a decrease from a high of 140. In June 2020, the model was extended one additional year through 2021.⁵⁷ A February 2020 report on the first few years of the program noted that low enrollment in those years limited the ability to assess the impact of the model on Medicare expenditures and other outcomes at the end-of-life.⁵⁸

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 (which the model projects they may be more likely to do as they are already familiar with hospice staff) which 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 concerns 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 MCCM 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 initially extended the duration of the model from three years to five years.⁵⁹ The MCCM was extended for one additional year during the COVID-19 pandemic, and will end for all participating hospices in 2021, with evaluation and reporting to take another further two to three years. Hospices to date report losing money on the model. However, they see it as an important investment in innovation.⁶⁰

Understanding Current Palliative Care Initiatives in the Clinical Delivery Models for Payer Opportunities

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, psychosocial 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.

PRACTICE CERTIFICATIONS

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 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 participate in the ASCO Quality Oncology Practice Initiative (QOPI®)⁶¹ 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 hematology-oncology practice across the world, and ranges from single oncologist practices to large academic medical centers. By the summer of 2020, there were over 300 practices that had received QOPI certification, and a current listing; an interactive map of QOPI Certified practices is available at https://www.google.com/maps/d/viewer?mid=1uROz9-xM_8xfbYnd17WkRn_OR5k&ll=40.3578111772134%2C-47.78678080045665&z=4.

SCO QOPI™ MEASURES

Oncology practices in the United States and several other countries conduct chart reviews and report results against more than 140 QOPI measures⁶²,

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 public, so managed care does not have ready access to these measures. However, managed care may inquire and recognize and/or reward practices that do participate and report on these measures in the QOPI process.

One example of Solo Practice palliative care is that which happens in a 1,000-physician private national oncology network, The U.S. Oncology Network (USON). As of 2020, Arizona Oncology, a practice in USON, offers palliative care to patients in at several locations in Tucson and southern Arizona. Palliative care nurse practitioners 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 psychosocial and spiritual needs.⁶³

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, but rather will learn of the palliative care focus of individual oncology groups by interaction and collaboration toward value-based initiatives.

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 such as 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 even 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 4: Suggested Criteria in Actual Use at Leading Palliative 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 nonoral 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

Source: "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," last accessed on September 10, 2020 at https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf

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 beneficial to the overall management of the patient and their symptoms and choices. Palliative care is sometimes also referred to as Supportive Care.

One example of a Congress Practice Model: The Supportive Care Clinic in Spartanburg, SC. 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.⁶⁴

There is 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 record system for registration, documentation, and billing, which allows all providers to access the most current medical record. Two Advance Practice Registered Nurses (APRNs) from 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 Edmonton Symptom Assessment Scale (ESAS), 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,
3. Psychosocial and Practical Issues,
4. Spiritual and Cultural Issues, and
5. End-of-life, Advanced Care Planning and Hospice.

Follow-up visits with the physician include reassessments of the 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) and awareness and 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, and that also 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.⁶⁵

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.

The likelihood of a hospital having a palliative care team increases with hospital size. A 2019 Report Card by the Center to Advance Palliative Care (CAPC) reported that 94 percent of U.S. Hospitals with more than 300 beds now have a palliative care team, compared to 62 percent of hospitals with fifty to 299 beds. Tax status also appears to be a strong predictor of the presence of a palliative care team. Eighty-two percent of nonprofit hospitals, 60 percent of public hospitals, and only 35 percent of for-profit hospitals (up from 23% in 2015) report palliative care programs.⁶⁶

DUKE UNIVERSITY SCHOOL OF MEDICINE (ONE EXAMPLE OF A HOSPITAL BASED PALLIATIVE CARE PROGRAM)

Duke offers a palliative care program (<https://www.dukehealth.org/treatments/palliative-care>) intended to help patients experience relief from the pain, symptoms, and stress of serious illness. No matter what the patient's age or stage of illness, the Duke team works closely with patients and their doctors to help navigate care and understand treatment options. The goals of the palliative care program are to help patients gain physical, emotional, and psychological strength, and to ensure that patients and their families experience the best possible quality of life. The Duke program offers services to patients who are inpatients or outpatients and works closely with the Duke HomeCare and Hospice to arrange for post-hospital care at other facilities or in the patient's home.

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 directors for understanding the depth and breadth of these programs might be a Robert Wood Johnson Foundation report⁶⁷, 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 and structure, 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.⁶⁸

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/CareGroup 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, University 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 under

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.

CAPC "IMPROVING CARE FOR PEOPLE WITH SERIOUS ILLNESS THROUGH INNOVATIVE PAYER-PROVIDER PARTNERSHIPS: A PALLIATIVE CARE TOOLKIT AND RESOURCE GUIDE"

The 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://media.capc.org/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 Toolkit⁶⁹ 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 care.⁷⁰

One example cited in the CAPC NBGH Toolkit is the importance of including the practice and social issues affecting patients: One palliative nurse consultation identified the lack of an air conditioner at 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.

AETNA

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.⁷¹ 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.⁷² 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.⁷³

EXCELLUS BLUECROSS BLUE SHIELD

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.⁷⁴ ExcellusBCBS 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 <https://www.excellusbcbs.com/health-wellness/advanced-care/cccc-program>) 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% for people 18 years and older across 39 counties, and 47% in the Rochester region in 2008) compared to a 20 percent national completion rate, this 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 Intensive Care Unit (ICU) patients.⁷⁵

HIGHMARK BLUE CROSS BLUE SHIELD

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 10 free consultations with an Advanced Illness Services palliative care team, without co-pays or deductibles.⁷⁶ Since the Advanced Illness Services (AIS) program (<https://hbs.highmarkprc.com/Care-Management-Programs/AIS-Home-Visit-Program>) 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 ICU) and reduced chemotherapy administration in the last two weeks of life.⁷⁷ 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 medical decision maker on or before day one of the ICU admission
- And an interdisciplinary family meeting conducted on or before day five of the ICU admission⁷⁸

PRIORITY HEALTH

Priority Health is a Michigan based nonprofit health plan that started around 2012 to identify patients which could benefit from palliative care services, including medical and nonmedical services. This initiative (www.tandem365.com) creates a consortium of long-term care facilities that work together to provide home-based care. The Tandem365 initiative reported results in 2017 of a 38 percent decrease in inpatient stays, a 52 percent decrease in emergency department visits, a 35 percent decrease in total cost of care, fewer specialty care visits, and a return on investment of as much as four to one. Priority Health also partners with Aspire Health to provide strategies for patients with serious illnesses to relieve symptoms and pain, assistance with treatment decision making, and offering emotional and spiritual support to patient and caregivers.⁷⁹

REGENCE HEALTH CARE

Regence offers health plans in Idaho, Washington, Oregon, and Utah, has had a palliative care program since 2015. They offer advance care planning, care coordination, team conferences among palliative care providers, in-home counseling, provider training to engage patients/families in end-of-life care planning, and increased access to services. The program's services include nurse care management, increased staffing and training, an emphasis on patient values needs and desires, caregiver and psychosocial support, and provision of non-medical needs, such as transportation and food. Within the first two years of the program, 67 percent of those in palliative care were enrolled in hospice care at their time of death, which was considered a success indicator for transitioning patients from palliative care to hospice care at the right time.⁸⁰

Most Regence health plans include coverage for palliative care through a Personalized Care Support Program. This benefit covers:

- Specialized adult and pediatric palliative care case management: Assistance with care coordination and benefit navigation with specially trained nurses and social workers
- Home health medical: Assistance with activities

of daily living

- Home health psychosocial support: Individual, family, and marriage counseling
- Caregiver support: Case managers work with the member's caregiver even if the caregiver is not a Regence member
- Goals of care/advance care planning (ACP) conversations: Provider reimbursement for conducting and documenting goals of care conversations with their Regence patients

Regence health plans also offer additional resources, including two advanced care planning videos on Questions, and Broaching the topic of ACP. Other resources include flyers and brochures on Palliative Care, Personalized Care Support and Benefits, Palliative Care Incident to Services and Virtual Care reimbursement policies, a Guide for Caregivers: Take Care of Yourself, Too, and information on Advanced Care Planning.⁸¹

SHARP HEALTHCARE

Sharp HealthCare, a San Diego based integrated regional health care system, created a palliative care program called Transitions. One of the primary objectives of this program was to prevent members from relying on hospital care as a tool for decompensation management of chronic illness. The Transitions program helps to teach providers how to identify such patients early. Such advanced intervention can help to reduce emergency department visits, facilitate advanced care planning, improve quality of care, decrease deaths in hospital, increase use of hospice, and reduce ICU and hospital lengths of stay. Besides advance care planning, the Transitions program combines comprehensive, in-home patient and caregiver education about disease processes, proactive medical, medication and lifestyle change management, and evidence-based prognostication.⁸²

Regional Collaborations in Palliative Care

When integrated into serious illness throughout the care process, attention to managing patient adverse events 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.

DELAWARE VALLEY

PALLIATIVE CARE COLLABORATIVE

The Delaware Valley Palliative Care Collaborative (DVPCC) began in 2015 as a network of regional palliative care providers. By 2019, the DVPCC counts 150 members that come from 31 hospitals, hospices, and other organizations across the Delaware Valley. Future growth and expansion may include obtaining not-for-profit status, development of mentoring and regional intensive palliative care skills courses, and supporting fellowship programs across care delivery settings.⁸³

HONORING CHOICES VIRGINIA

The three health systems in the Richmond, VA area embarked on a joint venture – “Honoring Choices Virginia”⁸⁴ (www.honoringchoices-va.org) 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 (<https://respectingchoices.org/>)⁸⁵ 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 NCC partners with the Nevada Comprehensive Cancer Control Program (NCCCP) and the cancer control community to draft and implement five-year plans to guide activities to prevent cancer, detect cancer earlier, improve treatment and increase survivorship. The 2016 – 2020 Nevada Cancer Plan Goal 3.2 directly addresses the need to increase the number of education opportunities on palliative care for

adults and pediatrics from zero to six, and, to that end, a Palliative Care Council was established in 2017 to identify and create educational materials for patients and family, as well as a one hour required continuing medical education credit for clinicians. The NCC maintains a list of state palliative care resources at; (<https://nevadacancercoalition.org/survivorship/palliative-care>).⁸⁶

SEATTLE AREA PALLIATIVE CARE INITIATIVES

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 into a discussion of 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.⁸⁷ The Cambia Palliative Care Center of Excellence at the University of Washington was launched in 2012 and in 2020 has a newly defined goal of seeing that palliative care has an integral and prominent role in healthcare – regionally nationally and internationally – for seriously ill patients and their families.⁸⁸

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 to achieve 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.** 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 at a larger hospital or academic center. **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 many healthcare reform initiatives that will potentially have an impact on the growing availability and deeper integration of palliative care.

Exhibit 5: A Patient's Story

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

"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 3-cm 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 2 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. [1–3] 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 [1]. Palliative care has also been found to improve symptom control [2, 4, 5] and reduce the cost of care [6–10]. However, very few patients in cancer centers and acute care facilities [11] receive the type of care Mr. S did."

Source: 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 September 10, 2020 at <http://theoncologist.alphamedpress.org/content/17/2/267.full>.

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 over the last decade 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 projects⁸⁹
 - 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)
 - 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 Palliative Radiation Model”

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 adverse events 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.**

Standards and Resources for Palliative Care Programs

There are several 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 initial measures could include 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.**⁹⁰

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. The variety of unique approaches illustrate the challenges for payers to identify, let alone support, when palliative care is being delivered by providers across the care continuum.

- Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services: Effective Health Care Program: Assessment Tools for Palliative Care, May 4, 2017, <https://effectivehealthcare.ahrq.gov/products/palliative-care-tools/technical-brief-2017>
- American Academy of Hospice and Palliative Medicine, <http://aahpm.org/>
 - Quality Measures: <http://aahpm.org/quality/quality-guidelines>
- American Cancer Society: The ACS has a web page devoted to Palliative Care, which shares materials on understanding palliative care, as well as managing treatments and adverse events of cancer.⁹¹ <https://www.cancer.org/treatment/treatments-and-side-effects/palliative-care.html>
- American Society for Clinical Oncology (ASCO), <https://www.asco.org/practice-policy/cancer-care-initiatives/palliative-care-oncology>
- B. Kinzbrunner, MD, J. Policzer, MD, End-of-Life Care: A Practical Guide: Second Edition, ISBN-13: 978-0071545273, published by

McGraw Hill Medical. <https://www.amazon.com/End-Life-Care-Practical-Second-Edition/dp/0071545271>

- CancerCare, https://www.cancercare.org/tagged/palliative_care
- Cancer.net, <https://www.cancer.net/coping-with-cancer/physical-emotional-and-social-effects-cancer/what-palliative-care>
- CaregiverAction Network, www.caregiveraction.org
- Hospice Foundation of America, <https://hospicefoundation.org/>
- Center to Advance Palliative Care, www.capc.org, www.getpalliativecare.org
- Outcomes and Measures Toolkit: <https://www.capc.org/toolkits/measurement-best-practices/>
- Hutchinson Institute for Cancer Outcomes Research: Community Cancer Care in Washington State: Quality and Cost Report 2019. © 2019 Fred Hutchinson Cancer Research Center, Seattle, WA. <https://www.fredhutch.org/en/research/institutes-networks-ircs/hutchinson-institute-for-cancer-outcomes-research/reports.html>
- Joint Commission Performance Measurements Requirements for Palliative Care <https://www.jointcommission.org/measurement/measures/palliative-care/>
- Joint Commission, <https://www.jointcommission.org/accreditation-and-certification/certification/certifications-by-setting/hospital-certifications/palliative-care-certification/>,
- International Association for Hospice and Palliative Care, <https://hospicecare.com/what-we-do/projects/consensus-based-definition-of-palliative-care/definition/>
- National Cancer Policy Board, National Academies Press, "Improving Palliative Care for Cancer and other publications", <https://www.nap.edu/search/?term=PALLIATIVE+CARE+CANCER>
- National Coalition for Hospice and Palliative Care, <https://www.nationalcoalitionhpc.org/about/>
- National Comprehensive Cancer Network (NCCN®), www.nccn.org
- National Hospice and Palliative Care Organization, <https://www.nhpco.org/palliativecare/>
- National Quality Forum, Palliative and End-of-Life Care 2015 – 2016, http://www.qualityforum.org/Palliative_and_End-of-Life_Care_Project_2015-2016.aspx
- Oncology Nursing Society (ONS) www.ons.org, <https://www.ons.org/acq-search?search=palliative+care>

Next Steps – Implications for Purchaser Choices

Purchasers and payers 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, as well as local members of Palliative Care, Leadership Centers, and the Center to Advance Palliative Care members and registry participants.
- Seek out local physicians who are certified in hospice and palliative medicine from the American Academy of Hospice and Palliative Medicine.
- Identify cancer centers and 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, the current environment related to palliative care in the local market has been assessed, 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 6: A Provider Perspective on Palliative Care in Oncology

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 – September 18, 2015 interview with Dawn Holcombe

Question:

What would you most want medical directors of employers 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?

Answer:

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. And 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 caregiver 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 – home. We next showed that because 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.

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Finally, there are increasing data that early palliative care leads to longer or at least equal survival:
2009 Bakitas cancer JAMA + 3 to 6 months, NS
2010 Temel lung cancer, + 3 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, + 6 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.

Question:

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)?

Answer:

More outpatient programs – IF we can train enough people. And IF we can figure out a way to pay for them.
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 everyone needing to see pall care. Not rocket science. Use the checklist concept. Use the TAME concept.

Question:

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?

Answer:

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.

The CAPC and NBGH Payer Provider Toolkit suggests some strategies⁹² (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 Medical Orders for Life-Sustaining Treatment (MOLST).
- 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 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, 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 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

Payers can 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.

There are full checklists to be found in the CAPC and NBGH Toolkit for Payers⁹³, 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.

Exhibit 7: Palliative Anti-Neoplastic Therapy: What a Health Plan Medical Director Needs to Consider

Perspectives on Palliative Care from the field:

Candid comments from Barry M. Kinzbrunner, MD, FACP, FAAHPM, Executive Vice President and Chief Medical Officer, VITAS Innovative Hospice Care, Miami, FL, September 18, 2015 interview with Dawn Holcombe

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, US 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, adverse events, 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 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: BM Kinzbrunner and N Weinreb, "Diagnostic Tests and Invasive Procedures in End of Life Care," Chapter 18 in BM Kinzbrunner and JS Policzer, End of Life Care: A Practical Guide, 2nd ed. New York: McGraw Hill, 2011, pp.443-470.

Incorporation of palliative care program components for members with serious illness will yield positive and measurable 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 programs have consistently proven that when they are embraced and integration occurs with patient engagement, the results far outweigh the downsides.

Exhibit 8: Payer and Employer Opportunities to Support Those with Serious Illness

Perspectives on Palliative Care from the field:

Candid comments from Diane E. Meier, MD, FACP, Director, Center to Advance

Palliative Care (CAPC), New York, NY September 18, 2015 interview with Dawn Holcombe

As the primary financiers 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 caregivers.

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, who is appropriate for it 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 caregiver 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-providertoolkit-2015.pdf

Conclusions

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 adverse events; 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 several 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.

NAMCP Medical Director's Oncology Institute Strategies and Initiatives

Clearly, there are many rapidly changing elements involved in the management of palliative care in oncology 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, the NAMCP is dedicated to improving communications between those diverse perspectives for the goal of improving patient outcomes. The Oncology Institute Executive Leadership Council, headed by Dr. Alan Adler, recently from Independence Blue Cross Blue Shield and now a private consultant, 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 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

The 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. The 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 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 2020 Second Edition" was developed to serve as a resource. The NAMCP Medical Director's Guide: Oncology, (<http://jmcpmpub.org/pdf/medical-directors-guide-on-oncology/>) was produced in 2013.

ONCOLOGY RESEARCH STUDIES

The NAMCP is also actively engaged in projects to identify and analyze research data on oncology issues, to facilitate informed policy decision-making and actions among its members. The NAMCP Medical Directors Institute 2018 Oncology Profile Study: The Importance of Patient Management, Total Overall Costs of Care, Patient Acuity and Provider Collaboration for Managing Oncology costs, a pivotal review of the oncology landscape may be accessed here: <http://jmcpmpub.org/wp-content/uploads/2018/12/NAMCP-Oncology-Profile-Study.pdf>.

ONCOLOGY RESOURCES

The NAMCP presents a focused Oncology Track at each spring and fall national Managed Care Forum 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.

The NAMCP has entered discussions for potential collaborations with key oncology provider organizations such as ASCO and NCCN. The Community Oncology Alliance (COA) and the 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.⁹⁴ The NAMCP also completed a study that tracked the impact on drug costs of different drug delivery models.⁹⁵

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 Will Williams, in the NAMCP office at wwilliams@namcp.org.

AUTHORS' BIOGRAPHIES

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Sheryl A. Riley, RN, OCN, CMCN has over 30 years practical experience advocating for and caring for cancer patients. Ms. Riley serves as the Chief Nursing Officer for Beacon Advocates, based in St. Petersburg, Florida, and has recently helped to execute COVID-19 Recovery Centers in New Jersey. A visionary for value-based care innovations between brokers, employers, health plans and providers, she has spoken and written extensive articles on innovative care management solutions. She may be reached at srilocn7@gmail.com.

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