## 3.g.i Integration of Palliative Care into the PCMH Model

**Project Objective:** To increase access to palliative care programs in PCMHs.

**Project Description:** Per the Center to Advance Palliative care, "Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment." (http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc)

Increasing access to palliative care programs for persons with serious illnesses and those at end of life can help ensure care and end of life planning needs are understood, addressed and met prior to decisions to seek further aggressive care or enter hospice. This can assist with ensuring pain and other comfort issues are managed and further health changes can be planned for.

**Project Requirements:** The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the attachment: **Domain 1 DSRIP Project Requirements Milestones and Metrics,** which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Integrate Palliative Care into appropriate participating PCPs that have, or will have achieved NCQA PCMH certification.
2. Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.
3. Develop and adopt clinical guidelines agreed to by all partners including services and eligibility
4. Engage staff in trainings to increase role-appropriate competence in palliative care skills.
5. Engage with Medicaid Managed Care to address coverage of services.
6. Use EHRs or other IT platforms to track all patients engaged in this project.

### Project Response & Evaluation (Total Possible Points – 100):

**1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (Total Possible Points – 20)**

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

According to an article by Morrison, Dietrick, Ladwig, et al, on average, Medicaid patients who received palliative care incurred $6900 less in hospital costs during a given admission than a matched group of patients who received the usual care. Within Western New York,

only 15 % of the Medicaid population utilized palliative care services in an 11 month period. This reflects an opportunity for significant improvement. The community needs assessment (CNA) indicates that the leading cause of death is Cardiovascular Disease followed by Chronic Obstructive Pulmonary Disease (COPD) or other conditions of the lung. Overall, Western New York has a 24% higher incidence of cardiovascular disease than the rest of New York State. Some of the most significant concerns for cardiovascular health were seen in Niagara County, which was ranked in the bottom quartile for prevention metrics, and performed worse than the state on hospital admissions for all categories of cardiac-related chronic disease including angina and ischemic heart disease, congestive heart failure, coronary atherosclerosis, and hypertension. The most seriously ill patients incur the highest costs – in 2009 the sickest 5% of patients in the United States accounted for greater than 50 % of health care spending, with a large proportion spent in the last year of life, often on hospital and /or ICU care. . Disease and disability become more prevalent during the later decades of life, directly bearing on health care need and consumption. Poor health can also create barriers to health care. Almost one out of six individuals across the region, about 243, 400 in all, are age 65 and up. The majority live in Erie county (59%) but comparatively high proportions live in Niagara, Chautauqua, and Genesee counties. There is at least one hospice service location in every county. Catholic Medical Partners, the Project Management Team for CPWNY PPS, currently has approximately 60% of its practices recognized as NCQA Level 3 Patient Centered Medical Homes (PCMH). Community Partners of WNY will work with current assets of Sisters of Charity Hospital, Catholic Medical Partners, Catholic Health home care/hospital palliative care program and the local Hospice Programs. Current assets include registered nurses, social workers and others who work collaboratively to identify and address the needs. As more patients are identified, staffing will be expanded proportionately.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

Geographically, target populations will be identified in the following order: in Erie County will be within the first 6 months; in Niagara County during the second 6 months and in Chautauqua County over the next 6 months. This project will be fully implemented within 2 years. The target population is patients with cardiovascular diseases and COPD as identified in the CNA and will be identified within PCMH practices with the largest Medicaid population. Additionally, patients living at home or in alternative settings like assisted living and long term care will also be focused upon. Social needs will be identified and addressed within the context of individual cultural and ethnicity beliefs and on chronic illness, interventions on symptom management/pain control and the dying process.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Existing programs have established staff to patient ratios that will be are utilized for the implementation of this project. Current assets that are mobilized include physicians, registered nurses, social workers, spiritual care staff and other community outreach staff. Proving support for meaningful discussion within the PCMH practices will start the process on an outpatient basis rather than after an admission to the hospital, thereby decreasing hospital admissions. Existing staff will be utilized and additional staff will be added incrementally based upon the volume of the identified target population. Community resources needed will be Hospice and Palliative Care Certified Clinicians, home health aides, assistive devices to maintain home living, faith community support, social services department case workers and care managers. Additionally, initial and on-going training will be provided by partner organizations for the PCMH offices via webinars.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The most significant challenge is understanding the word Palliative Care by both the target population as well as groups of physicians and other care providers. Palliative care has been associated with "death" and not the care of the living in attainment of quality in everyday life. Plan to overcome this perception: phone call campaign as well as a faith based approach in communities, libraries, shelters, clinics and food pantries. Other challenges include the continued growth of PCMH office which will be addressed via the use of the clinical transformation team from the Sisters of Charity Hospital Project Management Team. All interventions will be culturally and ethnically sensitive so insure the competency of the staff addressing issues with patients.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve overlapping service areas. If there are no other PPSs within the same service area, then no response is required.

There is no plan to coordinate with other PPS as this is not a collaborative project. That said, CPWNY partners have been working on a community wide approach to palliative care through workshops and provider meetings and we expect this collaborative work will continue.

**2. <u>Scale of Implementation</u> (Total Possible Points - 40):**

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information:

***Please use the accompanying Speed & Scale Excel document to complete this section.***

**3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):**

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information:

***Please use the accompanying Speed & Scale Excel document to complete this section.***

**4. Project Resource Needs and Other Initiatives (Not Scored)**

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

| Yes | No |
|---|---|
| ☐ | ☒ |

**If yes:** Please describe why capital funding is necessary for the Project to be successful.

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b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

| Yes | No |
|---|---|
| ☐ | ☒ |

**If yes:** Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

***Please note:*** *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
|---|---|---|---|---|
| | | | | |

| Name of Entity | Medicaid/Other Initiative | Project Start Date | Project End Date | Description of Initiatives |
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c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

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**5. Domain 1 DSRIP Project Requirements Milestones & Metrics:**

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

**a. Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

**b. Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.