

Serious Illness Care Task Force Meeting 5 Summary

North Carolina Institute of Medicine

630 Davis Drive, Suite 100

Morrisville, NC 27560

July 12, 2019

10:00am-3:00pm

Co-Chairs in attendance: Jonathan Fischer

Members in attendance: Mary Bethel, Nathan Boucher, Vicky Bovail, Ken Burgess, Wendee Cutler, Linda Darden, Anne Elmore, Glenn Field, Debbie Futrell, Beth Golding, Charles Hardy, Mark Hensle., Donna Lake, Kristen Lakis, Saberna Lea, Deb Love, Ellie McConnell, Adrienne Mims, Christopher Morrisette, Debi Nelson, Susan Nestor, Carla Obiol, Laura Patel, Melanie Phelps, David Sevier, John Smith, Linda Spragens, Keith Stirewalt, Charlotte Sweeny, Lynne Templeton, Stan Walters, Ellie Ward

Steering committee members in attendance: Cindy Morgan, Cathy Sevier

Guests in attendance: Scott Lofland, Michelle Xue

Speakers: Lori Taylor, Sally Sterns

NCIOM staff in attendance: James Coleman, Michelle Ries, Adam Zolotor

Meeting Agenda

DISCUSSION OF RECOMMENDATIONS

Facilitator:

Michelle Ries, MPH

Project Director

North Carolina Institute of Medicine

The first session of the day was focused on revising Task Force recommendations. The goal for this session was to start refining the recommendations with additional details.

For each recommendation, each point was considered:

- Did we accurately capture Task Force discussion on this topic and the will of the Task Force?
- Is this actionable and feasible? Is it the right action at the right time?
- Is this a priority recommendation? (Alternately, can we eliminate if we do not have consensus)
- Who is the lead entity (or co-entities) who would be responsible? Who are partners?
- What are the resources needed? Does this impact feasibility?
- Does this recommendation reflect principles of health equity?

- How will we know if we have achieved success?

Below are key points and comments from the discussion.

Advance care planning recommendations:

1.

- Need full-frontal discussion on why 2-witness signature and notary requirement are for the prevention of fraud
 - What do we absolutely need to protect the integrity of the process and to protect vulnerable individuals?
- We are one of the four states that require both 2 witnesses and notaries.
 - 2 witnesses are not the problem, but the requirement of notaries is a barrier.
 - Fact --- there just aren't that many notaries around
 - We don't need both a requirement of two witnesses and a notary.
 - Idea—have an option for either signature of 2-witnesses or a notary
 - We need to look at best practices in other states.
- We need to look into other technologies for verifying identities.
- Combine a. & b. in recommendations, and reorder to evaluate how to reduce the barrier for having 2 witnesses and notary.
 - Have multiple options for people to verify documents, like you have to do with a passport
 - Have cafeteria plan of options.
 - So many have to be verified to complete it.
- This recommendation needs to be focused on the protection of the individual and be mindful of the fact that technologies will change.
- How much of a problem is fraud in other states?
 - Not a huge issue in other states
- Notaries are supposed to ask a lot of questions.
 - Does the person know what they are signing?
 - Do they understand it?
 - However, most notaries are legal assistants and don't ask the needed questions.
- In developing a cafeteria plan of options, we need to look at what other states are doing.
 - We need electronic options.
- Nothing in documents truly protects patients from undue influence.
- We need a working group to develop a 21st century approach.
- Another big issue is that many of these documents never get seen.
- These documents should not just be completed when we are dying and under the influence of medicines. Should be filled out by healthy people.
 - When someone is dying, should be more focused on a plan of care
- Explore reciprocal decisions.
- Don't need B. for recommendation 1
- 1c.. we keep

2.

- Office of emergency services needs to accept electronic versions of MOST forms
 - Needs to make recommendation around this

3a.

- Is there consensus around increased use of electronic documents?
- Not foregoing old-fashioned methods; using electronic versions mainly for transferability and storage

- This recommendation is more about storage
 - Even though the purpose is storage and connectivity, we don't want to drop the notion of multiple forms of entry.
 - The cost-shifting occurs when only using paper, and there is a great risk of that when only using paper.
 - Maybe completion language goes to Recommendation Number 1.
 - For all recommendations, we need to broaden health systems to post-acute care settings.
 - Individuals own the documents, not systems.
 - We need to tease out the consumer's role in this as the owners of the documents.
 - This is about the patient:
 - Are we doing this with the patient or for the patient?
 - How do we address this to patients?
 - There is some language revising we need to do "in order to ease the administration burden on patients."
 - We should be using people-first kind of language.
 - We need to build in language to emphasize the person's wishes.
- 4.
- We are being too narrow with just targeting hospitals and health care systems. Most of the documents are used in long-term care facilities. We need to include them.
 - We need recommendations for reaching people outside of the HIPAA wall.
 - Get people to sign these documents before they get sick.
 - HB 441
 - Giving multiplicity options for broadband.
 - We may not need to address broadband issues.
 - Maybe revise the terminology broadly.
 - 3B.
 - Needs legitime change
 - We have to remember the patient.
 - Ask patients at the point of care, what are their current advance care directives.
 - * Currently required to be scheduled by joint regulations or legislation.
 - We need to make a decision about the role of the state registry in recommendations.
 - We need to invest in the registry.
 - Make it more inter-operable.
 - Needs multiple pathways.
 - We need a single point of truth; state registry can be a single pint of truth.
 - The way state registry works right now doesn't work for healthcare settings
 - Our goal is to make it easier for people to make their wishes known.
 - People need the opportunity to define what they want before they're seriously ill.
 - Potential partners to bring in are hospital software vendors
 - Sate registry needs tweaks.
 - However, the main problem is people are not even completing the documents.
 - Also, the registry has a low participation rate..

FRAMING REMARKS: PAYMENT FOR SERIOUS ILLNESS CARE

Lynn Spragens, MBA
 CEO
 Spragens & Associates

In this session, Ms. Spragens provided context for serious illness care payment models, challenges and opportunities for payment models and incentivization, and principles and considerations when developing recommendations. She also talked about how we need to empathize removing barriers in many of our recommendations, a desirable characteristic for recommendations, and the importance of making changes across silos.

[Spragens Presentation](#)

OVERVIEW OF PAYMENT STRUCTURES AND BCBS NC PALLIATIVE CARE REIMBURSEMENT MODEL

John Smith, MD

Lead Medical Director

BlueCross BlueShield of North Carolina

Lori Taylor

Senior Strategic Advisor, Care Redesign

BlueCross BlueShield of North Carolina

In this session, Dr. Smith and Ms. Taylor talked about payment structures and the BlueCross BlueShield (BCBS) NC palliative care reimbursement pilot, Care360. In their presentation, they provided an overview of BCBS' serious illness journey from 2009 to 2017, which involved the development of a workgroup that came up with the cCre360 model. They explained that the Care360 model pilot was developed as an innovative approach to paying for interdisciplinary care teams. Care teams in the pilots typically included physicians, nurses, social workers, spiritual leaders, and 24/7 support staff. Expected outcomes of the pilots included improved quality of life and reduced the amount of unwanted care for all enrollees. After talking about the development of goals of Care360, Dr. Smith and Ms. Taylor went into the details of those enrolled in the pilot and key learnings and challenges. When the pilot launched, 200 members were enrolled. There is a current enrollment of 80 members. From the lower enrollment number, the Care360 team infers that many of those initially enrolled were referred too late and transitioned to Hospice. Main challenge mentioned by Ms. Taylor and Dr. Smith includes developing a referral method for getting members into the pilot before they need to transfer to Hospice.

Presentation Questions/Comments (select):

- Task Force needs to define what palliative care and hospice care are
- Because of the low number of palliative care physicians, a palliative care payment model won't solve the whole problem.
 - Primary care providers who provide palliative care could be included in a model to address the lack of specialized palliative care providers.
- What is the typical composition of the Care360 team?
 - Foundation supportive care
 - Physician is quarterback
 - On the core team, one member must be certified in palliative care.
- Would be much better to have one design so providers can learn it.
 - Have to start them by using the pilot
- There are not enough home-based palliative care groups in the state.
- Providers and the community need to understand what palliative care is
 - A lot of stigma around the name palliative care
- Look at the Grace model for dementia care.
 - The patient should be considered a key member of the care team.
- We need to be careful that we just redefine hospice and put it in a different label.

- What is team collaborative training like? How do you prepare the team?
- VA allows their patients to receive palliative and curative care at the same time.

MEDICARE FINANCING OF HOSPICE AND PALLIATIVE CARE

Sally Stearns, PhD

Professor of Health Policy and Management

Gilling's School of Global Public Health

University of North Carolina at Chapel Hill

In this session, Dr. Stearns presented via webinar on Medicare payment for serious illness care. The goal for this session was to develop a shared understanding of the services that Medicare pays for (including hospital and SNF care but also new rules regarding: HCBS through Medicare Advantage plans), how they pay, and innovations in Medicare payment models that are showing promise in improving quality of and/or reducing costs of serious illness care. Dr. Stearns began by providing an overview of Medicare hospice benefits, payment categories and rates, as well as key ongoing challenges and approaches. Ongoing challenges and approaches include long stays for Medicare beneficiaries eligible for hospice care in hospitals and the high rates of return from live discharge.

Presentation Questions/Comments (select):

- Are there differences in the rate of return between for-profit and nonprofit facilities?
- Higher rate of return with for-profits
 - 60 percent rate of return with for-profits
 - Longer stays
 - More patients in nursing homes
 - Many for-profit hospice care centers keep patients longer and charge more for Medicare
- Continued high frequency of short stays

[Stearns Presentation](#)

MEDICAID FINANCING AND PAYMENT FOR HOME AND COMMUNITY BASED SERVICES

Sabrina Lea

Associate Director

NC Medicaid, Long Term Supports and Services

NC Department of Health and Human Services

In this session, Ms. Lea provided context and data on Medicaid payment for serious illness care and for home and community-based services. The goal of her session was to develop a shared understanding of how/ Medicaid pays for services, who is covered, and opportunities for recommendations to expand or enhance services. To begin her presentation, Ms. Lea covered the vision for NC Medicaid Managed care, and the average demographics of those enrolled in Medicaid programs. After talking about the vision for managed care and info about Medicaid enrollees, Ms. Lea went over some of the Medicaid related programs for serious illness care such as LTSS in the NC Medicaid, CAP, and PACE programs.

Presentation Questions/Comments (select):

- What is the waiting list of CAP programs?
 - CAP program for people with developmental disabilities has the longest waiting list.
 - Waitlist in the thousands.
 - Allocation of slots is at the county level. A lot of counties are using their slots

- CAP program for disabled adults has a 3000-person waiting list, but there are about a thousand slots open
- CAP-c has no waiting list
- LTSS: system initiatives for 2019-2020
 - Opportunities to improve
 - Improved customer experience
 - Improved quality
 - Increased compliance
- The LTSS unit administers two 1915 © waivers.
 - North Carolina does not have a palliative care clinical policy.
 - A lot of the services provided under these waivers could be used to provide palliative care services.
- What is the PACE program?
 - Provides comprehensive medical and social services to certain frail, elderly people (participants) still living in the community
 - Only Medicaid dollars for this are for personal care services. Average spent is \$10,000
- Hospice and CAP-da combined is a great way of providing fully integrated care.

Lea Presentation

DISCUSSION OF RECOMMENDATIONS (CONT.)

Facilitator:
 Michelle Ries, MPH
 Project Director
 North Carolina Institute of Medicine

The final session of the day was a continuation of the recommendation discussion from the morning. Key points and questions raised are below;

- What is the definition of palliative care services?
 - Many different definitions
 - Maybe survey Task Force members on what is the best definition of palliative care
 - The issue with definition is that it is often too broad and vague
 - Is palliative care the same thing serious illness management?
- We need to produce a list of things to define.
 - Serious illness care
 - Advance care planning
 - What else should we add?
- If we marry the CAP program with palliative care, we would need palliative care workforce training for CAPda workers.
- Tie in advance care information into some sort of annual requirement that most NC residents have to do.

- There may be something that can be done to identify those at the frontline levels who needed the services through some sort of service or annual care.
- When developing definitions, we may need advice from non-clinicians to ensure that we are using simple and engaging language
- When we define palliative care, we have to define it further down the service delivery line than just physicians.
- What can we do to ensure the quality of care?
 - Some of what we will be talking about next month are some quality measures.