

# PALLIATIVE CARE BLUEPRINT

## MARCH 2010

### **About ACHP**

The Alliance of Community Health Plans (ACHP) brings together innovative health plans and provider organizations that are among America's best at delivering affordable, high-quality coverage and care to their communities. Drawing on years of experience, members collaborate to identify problems, share information and work toward solutions to some of health care's biggest challenges. Their work is the foundation for ACHP's advocacy on behalf of better health care nationally.

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## **Introduction**

### **About ACHP**

The Alliance of Community Health Plans (ACHP) brings together innovative health plans and provider organizations that are among America's best at delivering affordable, high-quality coverage and care to their communities. Drawing on years of experience, members collaborate to identify problems, share information and work toward solutions to some of health care's biggest challenges. Their work is the foundation for ACHP's advocacy on behalf of better health care nationally. See the appendix for a list of all ACHP members, and a list of the ACHP Palliative Care workgroup members.

### **Defining Palliative Care**

Keeping health care affordable has always been a core priority for ACHP member plans. With health care reform on the national agenda, the ability to bend the medical cost curve is even more critical. As part of a broader set of initiatives, ACHP commissioned a work group to determine best practices for non-inpatient palliative care. The work group defined palliative care as *patient and family-centered care that optimizes quality of life, treats physical symptoms, and identifies and alleviates suffering. The continuum of illness involves addressing physician, intellectual, emotional, social and spiritual needs, and facilitating patient autonomy, access to information and choice.* ([NQF: A National Framework for Preferred Practices for Palliative and Hospice Care Quality](#))

This toolkit has been created for health plans that are considering developing a non-inpatient palliative care program or contracting with a vendor for such services. Other efforts that the ACHP palliative care workgroup has aligned with during the creation of this blueprint are the National Quality Forum and the Institute for Clinical System Improvement.

## **Non-Inpatient Palliative Care Models**

As part of the information gathering process, three basic models of palliative care were identified: Ownership, Consultative and Telephonic. What follows is a brief description of the models and advantages and disadvantages of each model. These models are not necessarily mutually exclusive in terms of their application and implementation .

### **Ownership Model**

In the ownership model, the palliative care team assumes ongoing primary care and palliative care delivery responsibilities for the patient. The inter-disciplinary team focuses on the patient and family, with care provided by a core team consisting of a physician, nurse, and social worker, all with expertise in pain control, other symptom management, and psychosocial intervention (Kaiser Permanente, *The Tri-Central Palliative Care Program Toolkit*, Brumley and Hillary, 4). The core team is responsible for coordinating and managing care across all settings and providing assessment, evaluation, planning, care delivery, follow-up, monitoring, and continuous reassessment of care to improve outcomes (22, Brumley).

<b>Advantages</b>	
	Palliative care delivery is in the hands of palliative care experts
	Ongoing care responsibilities allow for 24/7 access
<b>Disadvantages</b>	
	Removes patient from their primary relationship
	Costs of ongoing care are more significant than a consultative model

## Consultative Model

The consultative model involves a team of palliative care experts that consult with the attending physician, primary care physician, or health care team. Within this model, visits are typically limited and treatment would be recommended or implemented in collaboration with the referring physician and care team. Issues this model addresses include: ascertaining patient's understanding of their illness, identifying goals of care and treatment preferences, advance care planning, addressing physical, emotional, and spiritual issues.

Advantages	
	Addresses major palliative care issues
	Minimizes costs for health plan
	Support primary care coordination
	Co-management could include 24/7 first call to palliative care team
	Supports primary care physician/patient relationship & assists the PCP in being able to provide appropriate services to their severely ill patients
Disadvantages	
	Model may not provide 24/7 coverage
	Occasional difficulty in facilitating communication and feedback between teams
	Leaves ongoing care decisions to primary care/specialty physicians who may not be knowledgeable/ comfortable in supporting/ implementing palliative care recommendations
	Challenge of co-mgmt between specialists and primary care (particularly with focus on 12 chronic conditions)

## Telephonic Model

The telephonic model uses predictive modeling and referrals from a health plan’s network to identify patients appropriate for palliative care intervention. This model links back to primary or specialty providers as part of the communication model and addresses many, but not all of the issues delineated in the consultative or ownership model. Interactions with the patient typically take place via telephone. Some face-to-face meetings may also be included in this model, particularly at the initial stages of the consultation.

Measurement may also be more critical in this model, especially of patient experience.

Advantages	
	Telephonic assessment and monitoring allows for reaching more patients.
	Can be used in geographic areas where ‘on the ground’ resources are not available and is readily scalable.
	Provides a flexible option to introduce important conversations that are not currently occurring
	Can be used in conjunction with or complementary to other delivery models
	Implementation time is shorter than other models
	Costs are less than either of the above models <b>(need to check on this)</b>
	May reduce pressures inherent in other models, which tend to be impacted more by scheduling and availability issues (both providers and patients/families)
Disadvantages	
	Conventional wisdom is that palliative care needs to be delivered in a face to face manner.
	Lacks the comprehensive scope of other models
	Effectiveness may be limited by inability to provide needed face to face contact.
	No prior relationships with primary/specialty providers may hinder communication and needed follow through.

## **Identifying Key Elements for Palliative Care Models**

The proposed elements in this blueprint are based on the National Quality Forum's preferred practices across eight essential domains: structure and processes of care; physical aspects of care; psychological and psychiatric aspects of care; social aspects of care; spiritual, religious and existential aspects of care; cultural aspects of care; care of the imminently dying patient; ethical and legal aspects of care.

The work group adopted these domains, and the elements within, into the following core components:

- Interdisciplinary team approach
- Access
- Symptom Management
- Patient and Caregiver Access
- Communication: Within care system
- Communication: To patients and families
- Documentation

The elements have been broken down into three categories, described below:

***Critical*** elements are considered essential for effective palliative care to be delivered. These elements must be present in any non-inpatient palliative care program. Without them, it could not be considered palliative care.

***Important*** elements are extremely relevant and will enhance the quality of palliative care, but without this element palliative care can still be effectively delivered.

***Non-essential*** elements are lower priority and have a smaller impact on the quality of palliative care.

One element, related to providing professional interpreter services was deemed a basic necessity of health care, not confined to palliative care. Therefore, we removed this element from our list, and are recommending that any health plan ensure these services are provided. In addition, providing culturally sensitive materials in the patient's and family's preferred language is recommended.

## Palliative Care Core Components & Elements – Prioritized

The following table shows the prioritization of the elements for all three models of non-inpatient palliative care.

Component	Element	Ownership Model	Consultative Model	Telephonic Model
<i>Inter-disciplinary team approach</i>	Palliative care physician (or working towards board cert.), RN, Social Worker, Chaplain, pharmacist.	Green	Green	Red
	Team should be appropriately trained, credentialed and/or certified	Green	Green	Green
	Provide continuing education on the domains of palliative and hospice care to team members	Yellow	Yellow	Yellow
	Build partnerships with community clergy and provide education and counseling related to end of life care.	Yellow	Yellow	Yellow
	Establish or have access to ethics committee or ethics consultation across care settings to address ethical conflicts at the end of life.	Red	Red	Red
	Comments:			
<i>Access</i>	Provide access to palliative care that is timely and responsive to the patient and family.	Green	Green	Yellow
	Comments:			
<i>Symptom Management</i>	Assess, document and manage symptoms and side effects in a timely, safe and effective manner to a level that is acceptable to the patient and family.	Green	Green	Yellow
	Comments:			
<i>Patient &amp; Caregiver Education</i>	Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.	Green	Green	Green
	Provide education and support to families and unlicensed caregivers based on the patient's individualized care plan to assure safe and appropriate care for the patient.	Green	Green	Green
	Comments:			
<i>Communication within Care</i>	Ensure upon transfer between healthcare settings, there is timely and thorough communication of the patients' goals,	Yellow	Yellow	Yellow

**Green = Critical**

**Yellow = Important**

**Red = Non-essential**

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Component	Element	Ownership Model	Consultative Model	Telephonic Model
<i>System</i>	preferences, values and clinical information so that continuity of care and seamless follow up are assured			
	Formulate, utilize, and regularly review a timely care plan based on a comprehensive Interdisciplinary assessment of the values, preferences, goals, and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.			
	Document and translate the patient's treatment goals and preferences, advance directives and surrogacy designations into useful information and ensure or make best efforts to see that this information is transferred across all care settings.			
	Comments:			
<i>Communication – To Patients &amp; Families</i>	Conduct periodic patient and family care conferences with appropriate members of the interdisciplinary team to provide information, to discuss goals of care, disease prognosis, realistic treatment options, advance care planning, and to offer support.			
	Recognize and document the transition to the active dying phase, and communicate to the patient, family, and staff the expectation of imminent death.			
	Health care professionals should present hospice and palliative care options to all patients and families when death within a year would not be surprising and should reintroduce the options, including hospice, as the patient declines.			
<i>Documentation</i>	Document the patient/surrogate preferences for goals of care, treatment options, and setting of care in a timely manner and as conditions change.			
	Develop and implement a comprehensive social care plan that addresses the social, practical, and legal needs of the patient and caregivers, including but not limited to relationships, communication, existing social			

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Component	Element	Ownership Model	Consultative Model	Telephonic Model
	and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, and access to medicines and equipment.			
	Comments:			

**Green = Critical**

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## Variations in Delivery of Palliative Care Critical Elements

In order to assist with creating a palliative care program, the following tables include acceptable variations for the elements. There are some elements for which variations are acceptable and the work would still be considered effective, patient-focused palliative care. For other elements, there are no acceptable variations.

We only noted variations for elements deemed critical. If an element is less than critical, the assumption is that variations are acceptable. We have left space in this blueprint for you to note your own variations for the important and non-essential elements.

In this table, O=Ownership, C=Consultative and T=Telephonic.

Element	O Variations	C Variations	T Variations
<b>Interdisciplinary Team Approach</b>			
Palliative care physician (or working towards board certification), RN, Social Worker, Chaplain, pharmacist.	Green	No variation	Green
Team should be appropriately trained, credentialed and/or certified	Green	No variation	Green
<b>Access</b>			
Provide access to palliative care that is timely and responsive to the patient and family.	Green	Access to someone on the team required 24/7.	Yellow
		A clear goal for this model is that the care team, patients and families know how to access care 24/7. If this is not present, there should be	

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Yellow = Important

Red = Non-essential

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Element	O Variations	C Variations	T Variations
		a plan for how it can be accomplished.  <i>A plan for handling crisis situations should be created with patient and care team in advance to avoid unnecessary rescue care.</i>	
<b>Symptom Management</b>			
Assess, document and manage symptoms and side effects in a timely, safe and effective manner to a level that is acceptable to the patient and family.	No variation	No variation	
<b>Patient and Caregiver Education</b>			
Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.	No variation	No variation	No variation
Provide education and support to families and other caregivers based on the patient's individualized care plan to assure/advocate for safe and appropriate care for the patient.	No variation	No variation	No variation
<b>Communication Within the Care System</b>			
Document and translate the patient's treatment goals and preferences, advance directives and surrogacy designations into	No variations in content.  ID who palliative team has a minimum responsibility to	No variations in content.  How this information is made available may vary,	ID who palliative team has a minimum responsibility to get information to (AD, SD)

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Element	O Variations	C Variations	T Variations
useful information and ensure or make best efforts to see that this information is transferred across all care settings.	get information to (AD, SD)	but it must be transferable and applicable across care settings.  ID who palliative team has a minimum responsibility to get information to (AD, SD)  These functions are crucial to the success of any palliative care program.	
<b>Communication – To Patients &amp; Families</b>			
Conduct periodic patient and family care conferences with appropriate members of the interdisciplinary team to provide information, to discuss goals of care, disease prognosis, realistic treatment options, advance care planning, and to offer support.	No variation	No variations on content, how care conferences are arranged is negotiable with primary care team.	
Health care professionals should present hospice and palliative care options to all patients and families when death within a year would not be surprising and should reintroduce the options, including hospice, as the patient declines.	No variation	No variation	No variation
<b>Documentation</b>			

Green = Critical

Yellow = Important

Red = Non-essential

Element	O Variations	C Variations	T Variations
Document the patient/surrogate preferences for goals of care, treatment options, and setting of care in a timely manner and as conditions change.	<p>No variation</p> <p>Assessment may need to unfold over period of time, depending on where patient/family is.</p>	<p>No variation</p> <p>Assessment may need to unfold over period of time, depending on where patient/family is.</p>	<p>No variation</p> <p>Assessment may need to unfold over period of time, depending on where patient/family is.</p>

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## Variations in Delivery of Palliative Care Elements: Important & Non-Essential Ownership Model

If an element is less than critical, the assumption is that variations are acceptable. We have left space in this blueprint for you to note your own variations for the important and non-essential elements.

Component	Description of Ideal Situation	Variations
<b><i>Important Elements for Ownership Model</i></b>		
<i>Inter-disciplinary team approach</i>	Provide continuing education on the domains of palliative and hospice care to team members	
<i>Communication within Care System</i>	Ensure upon transfer between healthcare settings, there is timely and thorough communication of the patients' goals, preferences, values and clinical information so that continuity of care and seamless follow up are assured	
	Formulate, utilize, and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals, and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.	
<i>Communication – To Patients &amp; Families</i>	Conduct periodic patient and family care conferences with appropriate members of the interdisciplinary team to provide information, to discuss goals of care, disease prognosis, realistic treatment options, advance care planning, and to offer support.	
	Recognize and document the transition to the active dying phase, and communicate to the patient, family, and staff the expectation of imminent death. <i>*one plan said they consider this only critical to hospice</i>	
<i>Documentation</i>	Develop and implement a comprehensive social care plan that addresses the social, practical, and legal needs of the patient and caregivers,	

Component	Description of Ideal Situation	Variations
	including but not limited to relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, and access to medicines and equipment.	
<b><i>Non-Essential Elements for Ownership Model</i></b>		
<i>Inter-disciplinary team approach</i>	Build partnerships with community clergy and provide education and counseling related to end of life care.	
	Establish or have access to ethics committee or ethics consultation across care settings to address ethical conflicts at the end of life.	

## Variations in Delivery of Palliative Care Elements: Important & Non-Essential Consultative Model

If an element is less than critical, the assumption is that variations are acceptable. We have left space in this blueprint for you to note your own variations for the important and non-essential elements.

Component	Description of Ideal Situation	Variations
<b>Important Elements for Consultative Model</b>		
<i>Inter-disciplinary team approach</i>	Provide continuing education on the domains of palliative and hospice care to team members	
	Build partnerships with community clergy and provide education and counseling related to end of life care.	
<i>Communication within Care System</i>	Ensure upon transfer between healthcare settings, there is timely and thorough communication of the patients' goals, preferences, values and clinical information so that continuity of care and seamless follow up are assured	
	Formulate, utilize, and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals, and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.	
<i>Communication – To Patients &amp; Families</i>	Recognize and document the transition to the active dying phase, and communicate to the patient, family, and staff the expectation of imminent death.	
	Provide professional interpreter services and culturally sensitive materials in the patient's and family's preferred language.	
<b>Non-Essential Elements for Consultative Model</b>		
<i>Inter-disciplinary team approach</i>	Establish or have access to ethics committee or ethics consultation across care settings to address ethical conflicts	

Component	Description of Ideal Situation	Variations
	at the end of life.	
<i>Documentation</i>	Develop and implement a comprehensive social care plan that addresses the social, practical, and legal needs of the patient and caregivers, including but not limited to relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, and access to medicines and equipment.	

## Variations in Delivery of Palliative Care Elements: Important & Non-Essential Telephonic Model

We only noted variations for elements deemed critical. If an element is less than critical, the assumption is that variations are acceptable. We have left space for you in this blueprint to note your own variations.

Component	Description of Ideal Situation	Variations
<b>Important Elements for Telephonic Model</b>		
<i>Inter-disciplinary team approach</i>	Provide continuing education on the domains of palliative and hospice care to team members	
	Build partnerships with community clergy and provide education and counseling related to end of life care.	
<i>Access</i>	Provide access to palliative care that is timely and responsive to the patient and family.	
<i>Symptom Management</i>	Assess, document and manage symptoms and side effects in a timely, safe and effective manner to a level that is acceptable to the patient and family.	
<i>Communication within Care System</i>	Ensure upon transfer between healthcare settings, there is timely and thorough communication of the patients' goals, preferences, values and clinical information so that continuity of care and seamless follow up are assured.	
	Formulate, utilize, and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals, and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.	
<i>Communication – To Patients &amp; Families</i>	Conduct periodic patient and family care conferences with appropriate members of the interdisciplinary team to provide information, to discuss goals of care, disease prognosis, realistic treatment options, advance care	

		planning, and to offer support.	
		Recognize and document the transition to the active dying phase, and communicate to the patient, family, and staff the expectation of imminent death.	
<i>Documentation</i>		Develop and implement a comprehensive social care plan that addresses the social, practical, and legal needs of the patient and caregivers, including but not limited to relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, and access to medicines and equipment.	
<b>Non-Essential Elements for Telephonic Model</b>			
<i>Inter-disciplinary team approach</i>		Palliative care physician (or working towards board cert.), RN, Social Worker, Chaplain, pharmacist	
		Establish or have access to ethics committee or ethics consultation across care settings to address ethical conflicts at the end of life.	
<i>Communication within Care System</i>		Convert the patient's treatment goals and preferences into usable medical information and ensure that the information is transferred across care settings.	

## Measurement

### Proposed Palliative Care Measure Set

While measuring palliative care, particularly from the Triple Aim lens of patient experience, population health, and reduced cost trend, can be a challenge, we believe it's also a critical element of any program.

Research has shown that effective palliative and hospice care not only significantly reduces health care costs at end of life, but can also enhance patient's and family member's experience as well.

The measure set here is still a proposal, and the ACHP workgroup will continue to refine it, and begin a data collection process throughout 2010-2011.

*All metrics should be captured at months 24, 12, 6, 3, and 1 prior to death. Palliative care metrics will only focus on patients who die having been diagnosed with one of the 12 Chronic Conditions identified by the Dartmouth Atlas as associated with a high probability of death. A comparison population should also be established. (See appendix page 23 for 12 Chronic Conditions).*

Metrics	
Cost	Percent of deaths occurring in hospital
	Hospital days
	Hospice days per decedent
	ED visits
	Total spend
	Pharmacy utilization/costs
Quality/Process	Percent of decedents enrolled in hospice
	Physician visits/patient
	Percent of patients who die with advanced directives completed
	Percent of patients with a referral to palliative care or hospice services before death
Experience/Satisfaction	Satisfaction survey (both patient, prior to death, and family members, post death) Example: Perception of survivors on patient's level of comfort/symptom control <b>Add other examples</b>

### Metrics Defined

1. *Percent of deaths occurring in hospital* – Percent of plan's members who die in the hospital. Purpose of this metric is to demonstrate decrease in this number post implementation of palliative care services, and see a converse increase in metrics 3 and 4.
2. *Hospital Days* – Includes med/surg/ICU, but excludes behavioral health inpatient facilities.
3. *Hospice Days/Decedent* – number of days any decedent spends in hospice in last two years of life.

4. *ED visits* -- Number of times decedent visits ED during last two years of life.
6. *Total spend* – Total cost of care in last two years of life excluding pharmacy (through either death, or for MA – enrollment in hospice)
7. *Pharmacy Utilization in last two years of life.*
8. *% of decedents enrolled in hospice at time of death* – Percentage of members who die in hospice.
9. *Physician visits/patient* – Total number of outpatient visits with a physician or mid-level clinician in last two years of life. Report separately primary care and specialty care.
8. *Percent of patients who die with advanced directives completed*
9. *Percent of patients with referral to palliative care or hospice services before death*
10. *Patient/family experience* – measures patient’s experience with palliative care in last six months of life (includes level of comfort and symptom control), as well as family members’ experience with patient’s palliative care experience in last six months of life.

## **Suggested Resources**

### **Vendors**

#### **ACP Decisions**

ACP Decisions is a series of video narratives designed to educate patients about advance care planning. It serves as a patient-centered tool to inform patients about their choices at end of life. The video narratives have been tested in the research arena before being distributed to wider audiences. More information about ACP Decisions can be found at [www.acpdecisions.com](http://www.acpdecisions.com).

#### **Care Support of America (CSA)**

The Care Support of America program, also known as Advanced Illness Coordinated Care (AICC) to the public and physicians, is introduced by plan correspondence. Patients and family are paired with their own experienced registered nurse for individual assessment and care. CSA nurses are specially trained to rapidly develop highly effective working relationships that engage patients and families in strengths-based problem-solving. More information about Care Support of America can be found at [www.caresupportofamerica.com](http://www.caresupportofamerica.com).

#### **Vital Decisions**

Vital Decisions provides a patient counseling program that gives options for end-of-life care to patients that have become seriously ill. Through a series of telephone conversations, the consultants review the patient's medical situation and help develop a plan to address the patient's health care decisions. More information about Vital Decisions can be found at [www.vitaldecisions.net](http://www.vitaldecisions.net).

#### **Votiva Health**

Votiva Health was created by health care professionals experienced in hospice, case management health plan operations, pharmacy services, and disease management. They provide end of life counseling and help to build awareness about hospice and palliative care services. Votiva Health has been useful for health plans by helping providers and health care teams identify candidates for hospice or palliative care programs. Through case management support they are able to provide higher quality care for patients and family members. More information on Votiva Health's services can be found at [www.votivahealth.com](http://www.votivahealth.com).

## **Suggested Resources**

### **References**

#### **[Aging with Dignity – Five Wishes](#)**

*Five Wishes* helps to start and structure important conversations about care in times of serious illness.

#### **[POLST Program](#)**

Physician Orders for Life-Sustaining Treatment is a form that specifies the types of medical treatment that a seriously ill patient wishes to receive. The link below is an example of the POLST form used in CA.

#### **[National Quality Forum – Palliative Care Priority](#)**

NQF seeks to identify and endorse (outcome, process, and/or structural) measures and patient experience of care surveys that specifically address nursing home quality measures for public reporting and quality improvement.

#### **[Center to Advance Palliative Care](#)**

The Center to Advance Palliative Care (CAPC) provides health care professionals with the tools, training and technical assistance necessary to start and sustain successful palliative care programs.

### **Published Articles**

[Use of Video to Facilitate End-of-Life Discussions with Patients with Cancer: A Randomized Controlled Trial \(Journal of Clinical Oncology\)](#)

[Cost Savings Associated With US Hospital Palliative Care Consultation Programs \(Archives of Internal Medicine\)](#)

[Health Care Costs in the Last Week of Life \(Archives of Internal Medicine\)](#)

[Hospice Care Saves Money for Medicare, New Study Shows \(NHPCO\)](#)

[Hard Choice for a Comfortable Death: Sedation \(NY Times\)](#)

[A Comprehensive Case Management Program to Improve Palliative Care \(Journal of Palliative Medicine\)](#)

[Effects of a Program for Improving Shared Patient Decision Making During Terminal Illness \(Aetna Informatics\)](#)

## **Appendix**

### **12 Chronic Conditions**

1. Cancer (solid tumors, e.g., lung, breast, colon, liver, kidney, brain)
2. Lymphoma or leukemia
3. Chronic pulmonary disease
4. Chronic artery disease
5. Congestive heart failure
6. Peripheral vascular disease
7. Severe chronic liver disease
8. Diabetes with end-stage organ damage
9. Chronic renal failure
10. Nutritional deficiencies
11. Dementia
12. Functional impairment

## ACHP Member Organizations

<b>Capital District Physicians' Health Plan</b>	(Albany, NY)	
<b>Capital Health Plan</b>	(Tallahassee, FL)	
<b>CareOregon</b>	(Portland, OR)	
<b>Emblem Health</b>	(New York, NY)	
<b>Fallon Community Health Plan</b>	(Worcester, MA)	
<b>Geisinger Health Plan</b>	(Danville, PA)	
<b>Group Health</b>	(Seattle, WA)	
<b>Group Health Cooperative of South Central Wisconsin</b>	(Madison, WI)	
<b>HealthPartners</b>	(Minneapolis, MN)	
<b>Independent Health</b>	(Buffalo, NY)	
<b>Kaiser Foundation Health Plans and the Permanente Federation</b>	(Oakland, CA)	
<b>Martin's Point Health Care</b>	(Portland, ME)	
<b>New West Health Services</b>	(Helena, MT)	
<b>Presbyterian Health Plan</b>	(Albuquerque, NM)	
<b>Priority Health</b>	(Grand Rapids, MI)	
<b>Scott &amp; White Health Plan</b>	(Temple, TX)	
<b>Security Health Plan</b>	(Marshfield, WI)	
<b>Tufts Health Plan</b>	(Waltham, MA)	
<b>UCare Minnesota</b>	(Minneapolis, MN)	
<b>UPMC Health Plan</b>	(Pittsburgh, PA)	

## Workgroup Members

ACHP Health Plan	Name	Title
Capital Health Plan	Nancy Van Vessem, MD	Chief Medical Officer
Capital District Physicians Health Plan	Kirk Panneton, MD	Medical Director for Senior Services
Care Oregon	Margaret Rowland, MD	Chief Medical Officer
Fallon Community Health Plan	Seth Lewin, MD	Senior Medical Director
HealthPartners	Tom Von Sternberg, MD	Associate Medical Director, Geriatric Programs, Hospice and Home Care
Independent Health	Kathleen Mylotte	Associate Medical Director
Kaiser Foundation Health Plan & Hospitals	Helene Martel	Elder Care Practice Leader, Care Management Institute
Priority Health	John Fox	AVP Medical Affairs
Security Health Plan	Edward Krall	Director, Behavioral Health
UCare	Barry Baines*	Associate Medical Director
UPMC Health Plan	Cynthia Rosenberg Michael J. Culyba	Senior Medical Director for Medicare Vice President, Medical Affairs
ACHP	Lynne Cuppernull Vanessa Levine	Director, Clinical Learning & Innovation Research Associate

\*Work group leader