
Clinical Utilization Review Board (CURB)

July 20, 2016

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PRESENT:

Board: Michel Benoit, MD, Jessica MacLeod, NP, Paul Penar, MD, Michael Rapaport, MD, Norman Ward, MD, Nels Kloster, MD

DVHA Staff: Kristy Allard, Evan Welsh, Thomas Simpatico, MD (moderator), Scott Strenio, MD

Guests: Melissa Kamal, Melissa Moore, Chrissy Racicot, Monica Ogelby, Zail Berry, Josh Plavin, Bob Gramling, Stephanie Kilaga, Samantha Haley, Debbie Austin

Absent: Ann Goering, MD, John Matthew, MD, David Butsch, MD

HANDOUTS

- Agenda
- Draft minutes from 5/18/2016 Meeting
- Palliative care executive summary
- Palliative CURB guide
- Overview of legislation impacting Dept. of Vermont Health Access(DVHA)

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:35 pm.

1.0 Introductions

2.0 Review and Approval of Minutes

The minutes from 05/18/2016 meeting were reviewed and approved as written.

3.0 Updates

CURB Membership

Dr. Kloster and Dr. Rappaport have been approved for full 3 year terms. DVHA is looking for a new member to fill a vacant spot. DVHA is currently looking at a few candidates and will have more information at the next meeting.

Opiate Updates

DayOne Suboxone Transition (DOST) has begun doing inductions. A new Hub has been approved and is opening in Franklin county with Bay Area Addiction Research and Treatment (BAART). There will be more concrete details around the new Hub in the coming weeks.

The Vivitrol Pilot is still ongoing and is creating a connection between corrections and the community.

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The next CURB meeting will contain another update on both the DayOne and Vivtrol Pilot from Sanchit Maruti or William Kiethcart, and Tony Follund.

Legislative Updates

Board members were provided a listing of new legislation from the most recent session that will have an impact on DVHA. Members were advised to read through this at their discretion to obtain a better understanding of the current legislation around Vermont Medicaid.

One of the larger impacts from the legislative session was the allocation of \$200,000 to DVHA to explore the utility of acupuncture as an adjunctive therapy for chronic pain management. This now allows Medicaid to pay for acupuncture services if they are related to chronic pain, where it previously did not pay. Robert Davis from the Vermont Association of Acupuncture & Oriental Medicine as well Carlos Pino and Ahmed Haque from the University of Vermont Medical Center(UVMMC) Pain Medicine and Magdalena Naylor from the UVMMC Mind & Body Medicine Clinic will be working together on this expansion. The likely outcome is that Medicaid will pay for acupuncture as a benefit. There is still work outstanding on who will be eligible to receive this benefit. The acupuncture services have the potential to be expanded into the opiate area as well. Some things to look for are: what DVHA can do to quantify and compare the impact and is it improving member care. The current timeline for this new service is slated for the next few months to start seeing utilization and there should be further updates by the next CURB meeting.

Discussion: Prospective study of population utilizing acupuncture services, using a smaller sample. This would help understand the impact and evidence of the usefulness and cost of this type of service. Using a definitive criterion, for example placebo vs treatment to determine the outcomes. What limits will there be on types of pain patients?

4.0 New Business/Updates

Palliative and Hospice Care

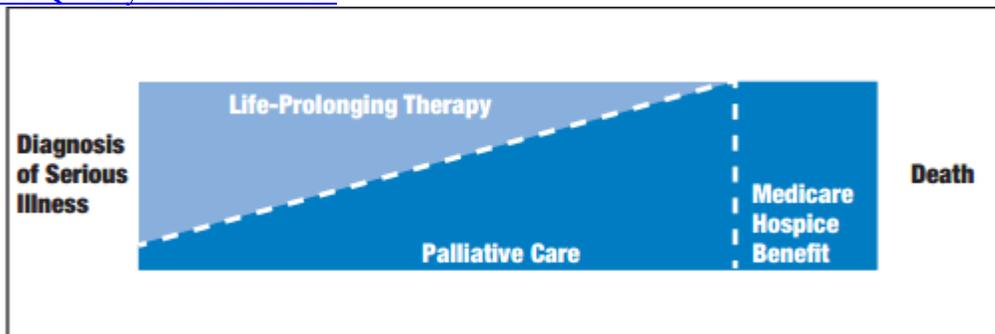
There is a national, including Vermont, interest in palliative care. It has the opportunity to improve care while reducing costs. There is evidence to support that it can improve end of life care while still reducing costs. There is activity some in Vermont, currently, surrounding palliative care. The biggest question is if palliative care does provide the triple aim then why is not it a larger topic. Palliative as a CURB topic was spurred by a few articles by the Institute for Clinical and Economic Review (ICER). They provide models to bring experts from both the economical and medical side together to create useful information to help guide payers and providers. The link to one such article is as follows: <http://goo.gl/BjgsXC>

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Palliative care is an approach that provides symptom relief and comfort to patients. These patients usually have a serious or life-threatening illness. The goal of this type of care is to improve the patients well-being including quality of life for both them and their families. The one major difference between palliative and hospice care is the ability to continue life prolonging treatment while receiving palliative care. Unlike hospice care, it can begin at diagnosis. However, palliative care can move to hospice as part of a continuum of care. One item from hospice that could be followed is that: hospice started as a benefit then moved into full programs to meet the need after initiation.

Below is a diagram showing the trajectory of care regarding palliative and hospice care timelines. It is a good reference to see the progression of care from diagnosis into palliative care and finally into hospice. The chart is from the [National Consensus Project for Quality Palliative Care](#).



While we have data that shows a potential cost savings for palliative care the current state makes it difficult to separate “true” palliative care from hospice. DVHA has data on the costs of the under 18 population using vouchers to identify them. Vouchers are used to determine who is eligible for a service. While the adult population is found by using palliative care diagnosis codes (ICD-9 V667 and ICD-10 Z515). One problem that arises from these codes is the lack of monetization associated with the codes. Another issue is that the diagnosis codes can be used loosely and are not always used.

Quantifying the data surrounding palliative care currently is not exact and is a barrier to creating metrics on the current utilization and costs.

The current barriers to palliative care are:

- Insufficient palliative care workforce
- Lack of training and knowledge surrounding palliative care
- Low awareness by non-specialty providers of what is available
- Socioeconomic barriers to services
- Geographic issues relating to availability in rural areas
- Lack of large scale funding
- Complex billing and reimbursement policies regarding palliative care services
- Difficult to quantify metrics and utilization

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The opportunities are:

- The ability to define and utilizes new payment methods
- Integrating e-records to coordinate care
- The expansion of resources to meet the need
- New legislation creating a better environment

The following topics and discussions surrounding them are from people working in palliative in Vermont and their perspective on its current state and where it can go in the future.

Blue Cross Blue Shield(BCBS) Perspective- Josh Plavin, MD

Providers do not understand the benefits of palliative care until they witnessed the outcomes of the service. Many would say they have always done this, since they are primary care providers, they consider it part of their job. They would then resist the palliative care programs because they couldn't see the added benefit of this service. Both as a cost avoidance and quality of care improvement.

Palliative/Hospice Care programs and Supportive Care Pilot program (the later has been ongoing for 2 years). The palliative care program provides a dedicated case manager to the members enrolled. Some of the goals of the program: addresses the gaps in care while providing pain management, ensuring that the member dies in the place of their choice, evaluate the benefits of additional programs, differentiate that this care is not the same as hospice but can act as a bridge to hospice. The program requires no PA or diagnosis. However, providers still need to submit procedure codes even though the service is bundled. This is the way they found to track the services and what works best. Having no requirements on what is included allows the program to "carve out" the services that are needed on a case by case basis. BCBS does not have the hard stop between hospice and palliative care that Medicare does. As a result of this the member feedback is that they feel less constrained knowing they have the ability to continue life prolonging care.

The hospice program at BCBS looks into the early identification for those in need of end of life care. One way they are doing this is by looking at those in the palliative care and supportive care programs. BCBS is striving to increase hospice lengths of stay while ensuring advance planning surrounding the care. The challenge is identifying the members early to provide them with this benefit. Once identified BCBS has a three-tiered program designed for the levels of care a patient can receive.

The supportive care pilot while known as palliative care has a wider focus of "providing comfort to people of all ages with serious, chronic or life threatening illnesses." It consists of multidisciplinary teams which allows the program to address a wide range of member needs. The supportive care services are paid by bundled daily per diem rate. One question arises from this is: Can the bundle be split and billed services billed individually? The program was designed by BCBS Vermont with their client along with the Visiting Nurse Association (VNA) of Vermont. With this service the client drove the need. The eligibility for the

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program is determined by the presence of chronic or life threatening or serious illness that also have 1 of 5 “qualifiers” which are as follows:

- Difficult to manage physical and psychological symptoms
- Decline in function, feeding intolerance, or unintended decline in weight
- Uncertainty regarding prognosis
- Poor response to usual treatment methods or burden of treatment outweighing benefit
- Two or more hospitalizations or ER visits within 6 months

The one drawback to the supportive care program at BCBS is the lack of utilization in the current programs with only 4 members currently in the program.

One major takeaway is the hospice programs success. This includes an increase in early referrals and increase in lengths of stay in hospice care, and better patient satisfaction. From end of life counseling and strong service coordination BCBS has report that 97% of members have been able to die in their place of choice. Through a comparison with members who did not receive hospice a \$50,000 difference in cost of care was found.

Discussion: What services are the most valuable form the palliative care benefit? There is currently one case manager who handles the 4 members. Is it a best practice to have members consult with a palliative care specialist as well as specialist in the diagnosis when the member is diagnosed? If palliative care saves money and improves care while prolonging life compared to not having palliative care, then there is no reason not to expand palliative care.

Physician Perspective- Zail Berry, MD

Palliative care history stemmed from the hospice movement in the 1970’s. This movement expanded the Medicaid benefit for hospice services which in turn did not fully meet the needs of the patients. This gap was the driving force in the start of palliative care asking the question “why do members only receive service when dying?”

Currently throughout Vermont 100% of hospitals have a palliative care program. UVM Medical Center currently has 3 doctors and 4 nurse practitioners as well as a part time social worker in their palliative care program. The problem arise is that not all these programs are on an equal level of training and resources in their palliative care program. This is causing a disparity between areas in regards to what is palliative care and what is offered for palliative care.

Some additional issues that have come up in the physician area are:

- Poor access to physician level palliative care
- Regional differences in quality and access
- Palliative care beginning after diagnosis and not earlier
- Palliative “label” being applied to liberally

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- Providers perception about palliative care and referring patients to a palliative care service or program
- Systems outside of the hospital for care are met with financial barriers

There are solid takeaways on areas to improve in or move towards. One is the education and training on the benefits of palliative care. As second area is discussing the prognosis with members and providing them with the options of can come out of a palliative care program. Another is the benefit that can be had through telemedicine. Telehealth partnered with home health agencies can greatly help to improve the access and quality of palliative care throughout Vermont.

Discussion: How do you measure palliative care and if it is successful or not? Palliative care has not had a history of being marketed to the community well. Providers do not want to hand over their control of a member to another for palliative care. This barrier is stopping providers working with palliative care specialists to improve quality of care. There needs to be a stronger emphasis on prognosis discussions between providers and members. This can help get palliative care into the discussion.

Pediatric Palliative Care(PPC)- Monica Ogelby, MSN CPNP APRN

As a result of the Current Care Act of 2010 pediatric palliative care became more accessible compared to the adult population. The Current Care Act allows for children to gain hospice benefits earlier and without releasing the option of curative treatment. This provided the ground work Vermont has now with its pediatric palliative care program. Vermont Medicaid has covered this group for ~4 years'. The PPC model is fee for service where the hospice care was unbundled and care was chosen out of that group to be provided as PPC. The billing system relies on a voucher as a tool to determine eligibility for members to receive this service. The voucher is method in which Medicaid uses to pay for the service. The PPC also utilized the VNA to help facilitate the program. The program provides 2 conferences a year that focus on the education of the community around pediatric palliative care.

While this type of model can be applied to the adult Medicaid population there are some questions and barriers. The first being the billing process, what is the appropriate bundled services and the appropriate bundled rate? The second is that the program would need backing from other insurers as well. Which brings the question up on what is stopping insurers in regards to this? Next is that palliative care is usually considered outside the norm of physician care.

Discussion and Next Steps

People live longer with palliative care versus those who only receive curative or life prolonging treatment. There are indications that palliative can save money in a variety of situations. The care can help avoid additional member harm in end of life scenarios. With these benefits why is there not a higher usage of this type of care? Should this be approached in a similar way to the opiate campaign, using a public health approach? There are psychological barriers around palliative care and would such an approach help remove them? Making availability to palliative easier could alleviate some of these concerns.

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There are next steps on how the CURB and DVHA can move forward with expanding palliative care:

- Encouraging a stronger education into end of life care during medical schooling
- Determining the best point to begin palliative care
 - Is there a way to trigger when a patient history suggests palliative care would be best?
 - This would allow services or mediations to be directed to patients earlier
 - Trigger system did not work well with the PPC
- Examine coding surrounding palliative care
- Gathering indicators from both Aetna and the American Academy of Hospice and Palliative Medicine, through Bob Gramling.
- How can the medical home model impact palliative care and how can it work? It has potential to build the relationship with providers and palliative care specialists.
 - Examine St. Johnsbury as an example, they are beacon for medical home model in Vermont and are doing palliative care referrals
 - Mary Ready and Joyce Stoverton are two providers who have been examples of this system working
 - Primary care acts as a “gatekeeper” for these services and when they are appropriate
- Figuring out who provides this service and what the system is for recommendations.
- Defining the differences between primary and specialty palliative care
- Virtual group meetings to create a to-do list of what actions need to be taken and follow up meetings on progress
- Policy recommendations regarding reimbursement and place of care
 - Currently Palliative care has been inpatient focused
 - It could benefit from a medical home model paired with telehealth
 - Telehealth could strengthen the usage and quality of palliative care
- Research the Palliative Care Task Force and their annual reports through the Vermont Ethics Network
- ICER has their own policy topics that coincide with many of the topics discussed, these are areas that DVHA and CURB can investigate
 - Coverage policies that justly compensate providers
 - What is the economic incentive?
 - Alternative delivery options ex. telehealth
 - Flexibility on care delivery
 - Outpatient care key component of medical home models
 - Build quality assurance measures
 - Do not approach care as one size fits all

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- Provider training and awareness to palliative care

Palliative care will be a continuing topic for the upcoming CURB meetings. This will allow for updates into the progress and the ability for the CURB to make further recommendations regarding palliative care.

Adjournment – CURB meeting adjourned at 8:15 PM

Next Meeting

Suggested agenda items:

- Palliative care recommendations and update
- DayOne update
- Vivitrol update

September 21, 2016

Time: 6:30 PM – 8:30 PM

Location: Department of Vermont Health Access, Williston, VT