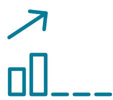
3 INTEGRATION

Integrate palliative care across all lines of business, in all settings, and with other medical and social services frequently used by people with serious illness.

Health plans can enhance access to high-quality serious illness care and optimize the appropriate utilization of existing services by providing palliative care across lines of business. This integration should also span a care continuum that includes home-based primary care, care management, disease management, as well as incorporating outpatient clinics where individuals with serious illness, like those in oncology clinics, already receive care.

Facilitating collaboration among these services enables patients to transition seamlessly to the support that aligns with their evolving needs, reducing the risk of both over- and under-serving patients. This approach also fosters improved coordination among treating providers and establishes palliative care as the standard of care for people with serious illness.

ACTION ITEMS

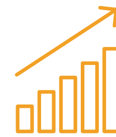


THE ESSENTIALS

At the very least, start here

PROGRESSING FURTHER

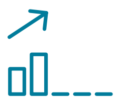
Take the next steps



SETTING THE STANDARD

Strive for excellence

3 INTEGRATION



THE ESSENTIALS

A Within the plan: Offer palliative care across all lines of business and foster connections between palliative care and aligned plan programs.

Offer palliative care across all lines of business.

Share palliative care infrastructure, staff, and educational programs across lines of business to promote consistency and efficiency.

B Across the provider network: Promote integration of palliative care into aligned medical services and support collaboration between palliative care providers and the network of medical and social services used by seriously ill members.

Ensure network capacity to offer palliative care in all settings where seriously ill members seek care, leveraging both in-person and telephone or video visits.

When necessary, **mentor and support** organizations that are newer to delivering palliative care and encourage collaboration between newer and more experienced providers in the network.

Use contracting requirements and incentives to encourage the integration of palliative care into other inpatient, outpatient, and home-based services that are used by seriously ill members. For example, offer a bundled payment for outpatient oncology visits if the care model includes palliative providers.

3 INTEGRATION

PROGRESSING FURTHER

A Within the plan: Offer palliative care across all lines of business and foster connections between palliative care and aligned plan programs.

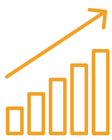
Establish connections between palliative care and other plan programs and services available to members with serious illness, such as Complex Care and Long-Term Services and Supports.

B Across the provider network: Promote integration of palliative care into aligned medical services and support collaboration between palliative care providers and the network of medical and social services used by seriously ill members.

Promote connections and collaboration between palliative care providers and other medical and social services commonly used by members with serious illness, such as home-based primary care, complex care management, care navigation, and behavioral health.

Ensure that palliative care providers deliver services to eligible members residing in assisted living facilities and nursing homes, including those who are receiving post-acute short term skilled care and those with longer stays. Require intensified attention (i.e., mandatory home visit within 48 hours) during a resident's transition back to home.

3 INTEGRATION



SETTING THE STANDARD

A Within the plan: Offer palliative care across all lines of business and foster connections between palliative care and aligned plan programs.

Evaluate outcomes for the entire seriously ill population, rather than solely at the service level, to gain insight into care gaps and the combined impacts of all services.

B Across the provider network: Promote integration of palliative care into aligned medical services and support collaboration between palliative care providers and the network of medical and social services used by seriously ill members.

Undertake or participate in a study of the effects of integration, and disseminate the findings to guide the development and adoption of the most promising models.

3 INTEGRATION

Table 3: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Report	Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models (Center to Advance Palliative Care)	Example actions for building palliative care capabilities at the payer level and among network providers.
Case Study	Embedded RN-Led Clinics in Primary Care Practices (Center to Advance Palliative Care)	Example of embedding palliative care with another clinic service.
Webinar	The Intersection of CalAIM and Palliative Care (MCP Palliative Care Learning Community Webinar)	Review of how palliative care intersects with Medi-Cal transformation.
Report	Medical Care at Home Comes of Age (California Health Care Foundation)	Description of various home-based care models.

THANK YOU

For more information, please contact us:

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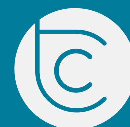
This toolkit was developed with the generous support of the California Health Care Foundation



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