DEVELOP A PLAN

Once organizational buy-in for investing in palliative care is secured, the next step involves assessing your current state and then developing a comprehensive strategy and implementation plan that leverages your existing position. This section outlines seven essential elements to consider when constructing a robust palliative care strategy. These elements draw from insights gained through palliative care projects supported by the California Health Care Foundation over the past decade, including in-depth interviews with leaders as part of the resource titled "California's Palliative Care Evolution: Celebrating Progress and Shaping the Future".

TRANSFORMING CARE PARTNERS

CRAFT THE STRATEGY

Within this section of the toolkit, specific action items for each of the seven elements are detailed based on your plan's current state: "**The Essentials**" for those starting out, "**Progressing Further**" for those that have the basics covered, and "**Setting the Standard**" for those who are ready to build cutting-edge programs and contribute to strengthening the broader field of palliative care. These actions are cumulative. Following the actions, you'll find links to resources designed to accelerate learning and implementation efforts.

The information is specifically tailored for internal champions at health plans seeking to expand or optimize their palliative care program. For plans without an existing palliative care program, additional resources can be found in Appendix Two.

1

Payment

Adopt a bundled payment model for home-based and outpatient palliative care.

Learn More →

2

Quality

Adopt policies and practices that adhere to minimum standards and improve quality of care.

Learn More →

CRAFT THE STRATEGY

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.

Learn More →

4
Uptake

Increase utilization of palliative care.

Learn More →

5
Equity

Ensure palliative care reaches and meets the needs of communities of color and other historically marginalized populations.

Learn More →

6
Workforce Capacity

Increase the number of clinicians with generalist palliative care skills and encourage use of generalist palliative care when specialty palliative care is not needed.

Learn More →

7
Family Caregiver Support

Assess the needs of family caregivers and provide them with training and resources to support the care needs of seriously ill members.

Learn More →

1 PAYMENT

Adopt a bundled payment model for home-based and outpatient palliative care.

Payers should adopt a bundled payment model for home-based and outpatient palliative care. In a bundled payment model, a single payment covers the delivery of a specified set of services, by a multidisciplinary team, over a defined period of time. Bundled payments create incentives for delivering the optimal palliative care model, making it feasible and sustainable for providers to offer high-quality palliative care. In contrast, fee-for-service payment models do not cover the cost of the full interdisciplinary team, including nurses, chaplains, care navigators, social workers, or the extensive coordination activities required to deliver services.

A 2023 survey of Medi-Cal managed care plans conducted by the Coalition for Compassionate Care of California found that 67% of the 14 responding plans reported using a bundled payment model for home-based palliative care.[5] Furthermore, the Consensus Standards for Community-Based Palliative Care in California (including home and outpatient palliative care), which were developed by a collaborative of health plans, provider organizations and health services researchers, also endorse bundled payments as the preferred payment model.[6]

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

5   State of Medi-Cal Palliative Care: Findings from the Annual Plan and Provider Surveys.

6   Consensus Standards for Community-Based Palliative Care in California

1 PAYMENT

THE ESSENTIALS

Adopt a bundled payment model that covers the effort of the entire interdisciplinary team needed to deliver all specified outpatient and home-based palliative care services across lines of business and markets.

Compensate palliative care providers for initial assessments, irrespective of whether patients ultimately enroll.

PROGRESSING FURTHER

Use program design tools such as tiers of service (i.e., higher payment for more complex cases) and guidance on use of telehealth (e.g., allow telephone or video visits in some circumstances) to ensure intervention intensity matches member needs while remaining sustainable for the plan and palliative care provider.

Offer performance-based incentives related to data collection, important care processes (e.g., surrogate decision maker identified) or outcomes (e.g., member experience or decreased unplanned hospitalizations).

SETTING THE STANDARD

Participate in evaluations of the economic impact of using a bundled payment for outpatient and home-based palliative care services to increase awareness among plans and policymakers that this is economically sustainable.

1 PAYMENT

Table 1: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Report	Palliative Care in Medicaid Costing Out the Benefit: Actuarial Analysis of Medicaid Experience (National Academy for State Health Policy)	Guidance on how to price a bundled payment.
Report	Home-Based Palliative Care Payment and Delivery Models for Short-Term Interventions (Center to Advance Palliative Care)	Guidance on payment approaches for short-term palliative care needs, such as during a transition to home after hospital, hospice, or to another care team.
Survey	2023 survey of MCPs and palliative care providers (Coalition for Compassionate Care of California)	Survey of 14 Medi-Cal managed care plans (MCPs); includes a question regarding payment mechanisms used for home-based palliative care.

2 QUALITY

Adopt policies and practices that adhere to minimum standards and improve quality of care.

Palliative care has the potential to yield improved clinical outcomes, better member experience of care, and lower cost of care. However, health plans can only attain these outcomes if they offer high-quality palliative care to their members. Palliative care is still a relatively new field compared to other medical specialties, with wide variations in services offered and quality achieved by palliative care providers. Health plans can enhance the likelihood of achieving improved outcomes by adopting policies and practices that adhere to minimum standards and encourage continuous improvement.

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

2 QUALITY

THE ESSENTIALS

Ⓐ Monitor program performance and implement improvements

Monitor program performance across all aspects of the quintuple aim (patient experience, patient outcomes, reducing costs, care team well-being, health equity) and disseminate the findings to provider partners to support quality improvement and promote appropriate referrals.

Ⓑ Adopt policies and practices that reduce variation in staffing models and scope of services delivered

Develop internal minimum standards based on the National Consensus Project Clinical Practice Guidelines and the Consensus Standards for Community-Based Palliative Care in California (see "Resources" below). Ensure that minimum standards specify capabilities that drive health, and experience and economic outcomes, such as a requirement that the clinical care team be available by phone, have access to health records, and can make visits when necessary on a 24/7 basis.

Define qualifications and training prerequisites for the palliative care team and establish certification/ accreditation prerequisites for palliative care provider organizations.

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2 QUALITY

PROGRESSING FURTHER

A Monitor program performance and implement improvements

Require providers to participate in the Palliative Care Quality Collaborative (PCQC), which collects data on quality and provides feedback to help providers improve performance.

Regularly engage with palliative care providers to identify areas for improvement.

B Adopt policies and practices that reduce variation in staffing models and scope of services delivered

Ensure consistent implementation of minimum standards across lines of business and markets.
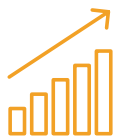
SETTING THE STANDARD

A Monitor program performance and implement improvements

At regular intervals, **re-assess monitoring activities** and update approaches to reflect current opportunities.

B Adopt policies and practices that reduce variation in staffing models and scope of services delivered

Participate in national efforts to establish minimum standards and associated measures for palliative care.

2 QUALITY

Table 2: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Consensus Standards	CAIC Consensus Standards for Community-based Palliative Care in California (Coalition for Compassionate Care of California)	Outlines minimum requirements for eligibility, scope of services, provider qualifications, measures, and payment models. It can be used as a starting point for developing minimum standards.
Consensus Guidelines	National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th Edition (National Coalition for Hospice and Palliative Care)	Detailed description of recommended practices for palliative care to inform benefit design.
Database	Palliative Care Quality Collaborative	Monitor and benchmark quality of care delivered by palliative care providers.
Report	Recommendations for Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness (PDF) (National Coalition for Hospice and Palliative Care)	Measures a plan might use to assess quality of palliative care program.

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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 →

3INTEGRATION

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.

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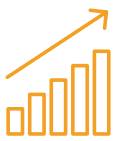
Establish connections between palliative care and other plan programs and services available to members with serious illness, such as Complex Care and Long-Term Services and Supports.

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.

4 UPTAKE

Increase utilization of palliative care.

Uptake of palliative care, along with its associated benefits, only happens when people with serious illness understand what palliative care is, how it can complement their other medical services, and the ways to access it.

Health plans can play a pivotal role in generating and sustaining this demand through community engagement efforts that raise awareness and establish trust in palliative care. They can also educate case managers and health care providers about the benefits of palliative care and implement systems for identifying people who could benefit from these services.

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

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4 UPTAKE

THE ESSENTIALS

Use inclusive eligibility criteria. For example, expand the eligible population for home-based palliative care services beyond the minimums specified in Medi-Cal policy guidance.

Provide training to clinical and non-clinical plan staff regarding the benefits of palliative care, and how to effectively communicate its value.

Implement a four-part approach to identify appropriate members:

Utilize claims and administrative data to proactively identify individuals with serious diagnoses and unmet symptom burden or insufficient social supports.

Integrate member identification into the workflows of plan care managers.

Collaborate with hospital-based clinicians and staff, including discharge planners.

Promote referrals from healthcare providers who care for a substantial number of seriously ill members, such as oncologists or cardiologists.

Offer resources that describe palliative care using culturally appropriate phrasing and, when necessary, in multiple languages.
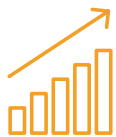
4 UPTAKE

PROGRESSING FURTHER

Incorporate community engagement activities into the palliative care strategy, such as regular talks at senior centers, faith-based organizations, adult day programs, and similar settings.

Assist palliative care providers in marketing their services to non-palliative care providers within the network.

Inform other essential groups responsible for the care of seriously ill members (e.g., hospital discharge teams, oncology practices) about the value of palliative care, the specifics of the plan's program, the referral process, and effective methods for introducing palliative care to patients.

SETTING THE STANDARD

Partner with other plans to conduct community and provider education related to palliative care to maximize reach within markets that have multiple plans.

4 UPTAKE

Table 4: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Toolkit	Care Managers: Addressing the Unique Needs of Patients with Serious Illness (Center to Advance Palliative Care)	Online courses and resources to help care managers meet the needs of members with serious illness.
Online Course	Essential Care Management Training for Health Plans (Care Excellence)	Foundational, advanced, and leadership training for care managers working at health plans. Online and in-person offerings.
Video Series	Introducing Palliative Care Video Series (Coalition for Compassionate Care of California)	Video series and supporting materials to help case managers and clinicians become more comfortable with describing palliative care or responding to common questions or concerns about palliative care when offering it to their members or patients.
Memo	Recommendations for Identifying the Population with Serious Illness (Center to Advance Palliative Care)	Brief description of strategy for a data-based approach to identifying members who might benefit from palliative care.
Online Course	Palliative Care for Care Managers (California State University Shiley Haynes Institution for Palliative Care)	Online course for care managers that introduces palliative care, evidence-based therapeutic approaches, determining who qualifies, and effectively communicating options with members.

5 EQUITY

Ensure palliative care reaches and meets the needs of communities of color and other historically marginalized populations. This includes considerations based on race/ethnicity, language, gender identity, sexual orientation, age, income, geographic location, diseases, disabilities, and social needs such as housing status.

Considerable inequities in health and health care persist for diverse populations, including those with serious illnesses. A 2019 statewide survey in California revealed disparities among people of color and low-income individuals regarding the absence of crucial conversations about medical preferences, experiences of discrimination when seeking healthcare, and levels of trust in healthcare providers.[7]

The field of palliative care is still in the early stages of learning how to ensure it reaches and meets the needs of communities of color and other under-served populations. Even as new knowledge is being developed, health plans can take steps to identify and address inequities, such as analyzing data to identify areas of disparity, listening to community needs, and tailoring programs to meet those requirements. Additionally, health plans can hire or contract with more clinicians who reflect the diversity of the community being supported.

ACTION ITEMS

THE ESSENTIALS
At the very least, start here →

PROGRESSING FURTHER
Take the next steps →

SETTING THE STANDARD
Strive for excellence →

7   Help Wanted: Californians' Views and Experiences of Serious Illness and End-of-Life Care. California Health Care Foundation, October 2019.

5 EQUITY

THE ESSENTIALS

Prioritize contracting with providers and hiring plan staff who have characteristics in common with your members.

Initiate or expand internal diversity, equity, and inclusion (DEI) activities to address how internal and external work cultures and practices contribute to inequities, and explore ways to bring about positive change.

Regularly evaluate enrollment and service outcomes to identify disparities associated with member characteristics, including race/ethnicity, language, gender identity, sexual orientation, age, income, geographic location, diseases, disabilities, and social needs, such as housing status.

PROGRESSING FURTHER

Engage with diverse communities to learn more about their needs and preferences for palliative care using methods like focus groups and interviews.

Utilize incentives to motivate providers to pursue DEI goals, such as favoring network providers who share characteristics with member populations.

Contract with community-based organizations that provide non-medical, culturally responsive, supportive care programs (e.g. lay navigation, emotional and spiritual support) to ensure responsiveness to the needs of specific populations.
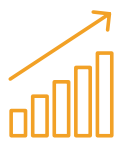
SETTING THE STANDARD

Develop, evaluate, and disseminate additional strategies to reduce disparities in access to and outcomes of care.

Consider requirements or incentives to improve care quality for the most-studied domains of inequities (pain management, communication about goals of care, etc.).

5 EQUITY

Table 5: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Blog	How Medicare Advantage Could Address Pain Inequities For Black Patients Living With Serious Illness (Health Affairs)	Health Affairs blog with actionable steps for Medicare Advantage plans to address disparities in pain management for Black members.
Toolkit	Health Equity in Palliative Care Toolkit (Center to Advance Palliative Care)	Curated tools and resources to improve the quality of serious illness care provided to historically marginalized and under-served patient groups.
Report	Equitable Access to Quality Palliative Care for Black Patients: A National Scan of Challenges and Opportunities (Center to Advance Palliative Care)	Report summarizing challenges, opportunities, and possible interventions to improve equity.
Report	Improving Access to and Equity of Care for People with Serious Illness (The National Academies Science, Engineering, and Medicine)	Summary of workshop proceedings providers can use to deepen understanding of challenges, opportunities, and possible interventions to improve equity.
Toolkit	English/Chinese Glossary of End-of-Life Care Terms (Chinese American Coalition for Compassionate Care)	Tool plan providers can use when communicating with Chinese-speaking individuals about palliative and end-of-life care.

6 WORKFORCE CAPACITY

Increase the number of clinicians with generalist palliative care skills and encourage use of generalist palliative care when specialty palliative care is not needed.

Despite an increase in the number of specialty palliative care clinicians and the emergence of more pathways for pursuing a career or training in specialty palliative care, a workforce shortage of specialty palliative care clinicians is likely to persist over the next 20 years.[8] Additionally, some seriously ill patients' needs can be met by basic palliative care interventions which do not require a palliative care specialist or a full interdisciplinary team. Given these considerations, generalist palliative care (also known as "primary palliative care") has been gaining momentum as a complement to specialty palliative care. Generalist palliative care skills used in communication and symptom management enable front-line clinicians to administer basic palliative care comfortably and competently. If made widely available, generalist palliative care would ensure that a minimum level of palliative care is accessible to anyone who would benefit—and allow specialty palliative care services to focus on more complex situations.

ACTION ITEMS

THE ESSENTIALS
At the very least, start here →

PROGRESSING FURTHER
Take the next steps →

SETTING THE STANDARD
Strive for excellence →

8   Lupu D, Quigley L, Mehfoud N, Salsberg ES. The Growing Demand for Hospice and Palliative Medicine Physicians: Will the Supply Keep Up? J Pain Symptom Manage. 2018 Apr;55(4):1216-1223. doi: 10.1016/j.jpainsymman.2018.01.011. Epub 2018 Feb 2. PMID: 29410071.

6 WORKFORCE CAPACITY

THE ESSENTIALS

Disseminate information on available generalist palliative care educational programs to non-palliative care physicians who care for people with serious illness (cancer, heart failure, renal failure, chronic obstructive pulmonary disease, etc.) and geriatricians.

PROGRESSING FURTHER

Pay for generalist palliative care training for nurses and other clinicians who care for people with serious illness.

SETTING THE STANDARD

Incentivize process improvements to support generalist palliative care (e.g., creating easy access to documentation of goals of care conversations within the electronic health record).

6 WORKFORCE CAPACITY

Table 6: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Report	The Case for Improving Symptom Management and Communication Skills (Center to Advance Palliative Care)	Succinct outline of rationale for improving symptom management and communication skills for all providers who care for seriously ill patients.
Report	Clinical Training Recommendations for All Clinicians Caring for Patients with Serious Illness (Center to Advance Palliative Care)	Recommendations and links to courses to build generalist palliative care skills.
Toolkit	Essential Skills and Supports for All Clinicians Treating Serious Illness: Building Generalist Palliative Care Capabilities Across Services and Settings (California Health Care Foundation)	Cases studies and resources that can inform design of a generalist palliative care initiative.
Report	Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models (National Coalition for Hospice and Palliative Care)	Example of incorporating generalist palliative care capabilities into population-based strategy/policy.
Training Program	End-of-Life Nursing Education Consortium (End-of-Life Nursing Education Consortium)	Nurse education program that uses a train-the-trainer model to scale palliative and end-of-life care clinical skills.
Training Program	VitalTalk	Serious illness communication skills training appropriate for all clinicians who care for seriously ill patients.

7 FAMILY CAREGIVER SUPPORT

Assess the needs of family caregivers and provide them with training and resources to support the care needs of seriously ill members.

Caregivers of people with serious illness are often overwhelmed and experience significant levels of stress and burden, which can directly impact their ability to provide quality support to the people in their care. Currently, most specialty palliative care teams address some caregiver needs through the team's social worker, but often these supports are not comprehensive and/or are highly dependent on individual social worker knowledge, skills, and competing priorities.

Whether administered by a health plan itself or through requirements for contracted palliative care teams and other providers, offering a more comprehensive and consistent additional layer of support to family caregivers has the potential to improve member outcomes. These outcomes may include reducing emergency room visits and hospitalizations, addressing medication-related issues, and ultimately, improving member satisfaction. Supported caregivers also contribute to helping members stay at home, thereby reducing the need for skilled nursing facility placement.

Additionally, caregiver support programs provide the added benefit of improving outcomes for the caregiver, who might also be a member. This includes a decrease in caregiver depression and anxiety, prevention of injuries, and better management of the caregiver's own chronic conditions.

Caregiver support can manifest in various forms tailored to the specific needs of caregivers. This may include resource navigation and problem solving, emotional support and counseling, social-emotional skills training, medical skills training, respite, financial aid opportunities, and bereavement support.

7 FAMILY CAREGIVER SUPPORT

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

THE ESSENTIALS

Ensure the health plan adopts a structured approach to supporting family caregivers of seriously ill members. Family caregiver support can be delivered by palliative care providers, community organizations, or with health plan internal resources. This support could include assessment, navigation, medical and non-medical skills training, and respite.

Require contracted palliative care providers to have a structured and comprehensive approach to supporting family caregivers. Consider the effort required to do this work when calculating payment amount for palliative care providers.

Ensure that family caregiver support resources, whether delivered by the palliative care team or other partners, **are cataloged** and easily accessible to caregivers and all relevant contracted providers.
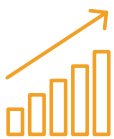
7 FAMILY CAREGIVER SUPPORT

PROGRESSING FURTHER

Require contracted palliative care providers to reassess caregiver needs on a regular basis (e.g., Zeit Burden survey administered every 60-90 days).

Develop a comprehensive suite of caregiver programming, either administered through the health plan or through a provider network (beyond palliative care providers), to fill gaps in existing programs.

Ensure that programs incorporate culturally and linguistically tailored support, preferably through partnerships with trusted community-based organizations.

Develop and implement a mechanism to collect feedback on caregiver support interventions to facilitate quality assessment and improvement.

SETTING THE STANDARD

Offer a respite benefit for family caregivers of seriously ill members.

Ensure that the suite of caregiver programs incorporates flexibility and variety to address the full spectrum of caregiver abilities and needs at different points along the caregiver journey.

7 FAMILY CAREGIVER SUPPORT

Table 7: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Assessment Tools	Caregiver Assessment Tools (Family Caregiver Alliance)	Examples of caregiver assessment tools used by state agencies.
	Zarit Burden Interview	Widely used assessment tool. 22- or 12-question caregiver burden assessment that can be self-administered or administered by trained staff as an interview.
	Caring for the Caregiver (Center to Advance Palliative Care)	List of six caregiver assessment tools.
Database of Programs	Best Practice Caregiving Database (Benjamin Rose Institute on Aging and Family Caregiver Alliance)	Over 40 evidence-based dementia-focused Caregiver Support interventions, some with extensive implementation support and many that also support caregivers of people with other conditions.
Program Example	Veterans Affairs (VA) Caregiver Support Program	The VA provides an example of more comprehensive offerings to caregivers through their Program of General Caregiver Support Services and Program of Comprehensive Assistance for Family Caregivers.
Payment Model	Guiding an Improved Dementia Experience (GUIDE) Model	Medicare dementia-focused care model that includes care coordination and care management, caregiver education and support, and respite services.

APPENDIX TWO

Resources to Help Health Plans with the Basics of Starting a Palliative Care Program

The Center to Advance Palliative Care (CAPC), the Coalition to Transform Advanced Care (C-TAC), and California Health Care Foundation (CHCF) have excellent resources to help health plans that are in the early stages of building a new palliative care program.

Resources to Help Health Plans with the Basics of Starting a Palliative Care Program

Develop a Plan Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Toolkit	**Payer Provider Toolkit** (Center to Advance Palliative Care)	Toolkit including getting-started checklists, self-assessment checklist, and case studies featuring health plan programs.
Toolkit	**Serious Illness Strategies** (Center to Advance Palliative Care)	Outlines three key strategies for offering palliative care including proactive identification, engagement and assessment, and home-based supports.
Caregiver Support Program Example	**Designing and Implementing Community-Based Palliative Care: A Guide for Payers** (Coalition to Transform Advanced Care)	A toolkit for health plans offering community-based palliative care (home and clinic/outpatient), including tips in designing a program, payment and finance, network-building and management, and program operationalization.
CMS Alternative Payment Model	**Essential Elements of Medi-Cal Palliative Care Services** (California Health Care Foundation)	A toolkit for Medi-Cal managed care plans and palliative care providers

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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