

The Lewin Group
Palliative and Hospice Care for Persons with Disabilities
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Jessie Micholuk: Thank you, and good afternoon, everyone. Welcome to the Disability-Competent Care webinar on *Palliative and Hospice Care for Persons with Disabilities*. My name is Jessie Micholuk, and I'll be getting us started today.

Should you have any questions, now or throughout the presentation, please feel free to enter them into the Q&A feature in your platform. We will be addressing your content-related questions during the discussion portion of this webinar.

The Lewin Group under contract with the CMS Medicare-Medicaid Coordination Office (MMCO), partnered with Christopher Duff and other disability practice experts to develop the 2018 Disability-Competent Care webinar series. This webinar series builds on the 2017 DCC Webinar Series that introduced the Model of Care and its 7 Foundational Pillars. You can view this series and related resources at the Resources for Integrated Care website.

As I mentioned, the webinar will be interactive with 45 minutes of presenter-led discussion and then followed by a 15 minute presenter and participant question-and-answer session. We are pleased to be able to offer credits for continuing education units and continuing medical education for this webinar. You can see the accreditation information on your screen now.

To receive the credit, the post-test must be completed through the CMS' Learning Management System with a score of 80 percent or higher by midnight on March 26, 2018. Further information is also available at the Resource for Integrated Care website.

This webinar is supported through the Medicare-Medicaid Coordination Office to help beneficiaries enrolled in Medicare and Medicaid have access to seamless, high quality health care that includes the full range of covered services in both programs.

To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, the Medicare-Medicaid Coordination Office is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar. To learn more about current efforts and resources, you can visit our website, <https://resourcesforintegratedcare.com/>.

Now, I will hand the presentation over to Chris Duff.

Chris Duff: Thanks, Jessie. I would also like to thank everyone for joining the third session of the 2018 webinar series. I am a Disability Practice and Policy Consultant who's been working with the Lewin Group to develop the Disability-Competent Care model and all the related webinars and materials.

I will be joined today by group leaders that I will introduce in the order of their presentation. First will be Judi Lund Person, Vice President for Regulatory and Compliance at the National Hospice and Palliative Care Organization (NHPCO).

I normally do not read the mission of organizations, but I really like their mission and vision. The mission of NHPCO is to lead and mobilize social change for improved care at the end of life. Their vision is a world where individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

Judi served for 22 years as the President and CEO of the Carolina Center for Hospice and End of Life Care, the state hospice organization for North and South Carolina. There she helped communities establish hospices and provided training and guidance on the Medicare/Hospice benefit in the early days.

She was also a member of the advocacy group that worked to pass the Medicare Hospice benefit in Congress in 1982 and was instrumental in preparing hospices to begin accepting Medicare reimbursement in the mid-'80s.

The second presenter is Kelly Ambrose, who is a Certified Hospice and Palliative Nurse. CareOregon started in 1994 as a safety net health plan with members primarily in and around the Portland, Oregon area.

One of their current plans is CareOregon Advantage Plus targeting persons dually eligible for both Medicare and Medicaid. Kelly is the manager of the Advanced Illness Care program at CareOregon Housecall Providers. She has 15 years experience working with complex patient populations in community settings. Palliative care has been one of her primary focuses for the last five years.

I would like to quickly review the learning objectives for this webinar. First is to know the fundamentals of hospice and palliative care and to know what differentiates the two.

Second, to learn about the historical context for why many persons with disabilities are often fearful of end of life discussions, and third is to learn some techniques and approaches for talking about hospice and palliative care options with your participants with disabilities.

Today, we will start off with a basic introduction of hospice and palliative care. Judi will then discuss the resistance of many persons with disabilities bring to any discussion of the end of life care. While all of us have some trepidation, this population often has had challenging conversations about their health and health care with medical professions which leads them to a higher level of fear.

The presentation will lead to a presentation on what is involved in hospice care overall and especially for persons with disabilities. Ms. Hayes, from CareOregon, will talk about their palliative care programs and a home-based primary care service they've incorporated into their model.

So with that, I will turn it over to Judi.

Judi Lund: Thank you so much, Chris. It's great to be with all of you, and I'm really looking forward to our discussion today and also to your questions. Let's start on the next slide with what is hospice care.

So, it is a program of care that provides support to patients who are nearing the end of life. Usually the marker in the current definition of hospice is if a patient, or in our discussion today, if a participant is in the end stages of their disease. Not the disability disease, but some other disease that is now going to be more considered a terminal diagnosis.

So, six months or less is usually the marker that we use, but we're also very, very committed to the highest possible quality of life for whatever life is left for any participant. We're very committed to making sure that whoever that participant has family.

I know sometimes when we work with patients in nursing homes and hospice care, the family is really the roommate or the care staff. We've got the same commitment, no matter where the participant starts. We have some focus on not just physical care for the beneficiary, but also care for the family. To offer support, palliative care services are provided throughout the process of dying.

So, what is palliative care? Over the last 8 to 10 years, palliative care has really grown all over the country. It started out focused on inpatient services with a focus on comfort and with a focus on making sure that the patient has all their needs in the hospital.

Now, palliative care is provided wherever a participant might be, so the same with hospice but in a broader context. We are looking at focusing on providing relief from symptoms; providing a goal of improving quality of life for the participant and their family.

Just like in hospice, we have a team of folks who are providing the care: physicians, nurses, social workers, and other providers. The providers could be an aide or a music therapist, but I think the key here is palliative care does not have that six month prognosis requirement. It's also not a benefit that has reimbursement coming from the Medicare program.

So, you can kind of see the difference between palliative care for wherever a participant might be in their disease process and then hospice care for a patient who is nearing the end of life and in that six-month prognosis requirement.

A participant may receive palliative care or hospice care wherever they prefer. If they are in their own home, in a group home, assisted living facility, or a nursing home, all of those places are options for where care can be provided.

I wanted to talk just for a minute about the dually eligible beneficiaries. Both Medicare and Medicaid cover hospice services.

Of course Medicaid is always a last resort, but it is very much a coordinated effort on who pays for what things. This is important for the hospice care side of the discussion because palliative care is not specifically paid for as a benefit under either Medicare or Medicaid.

Now, we say that, but then we also have a lot of experimentation and innovation going on among the states. In some states, such as California, there is the possibility that palliative care services will be available to the Medicaid population in California. Actually, California is leading the way for a lot of the coverage of services for participants.

We also see some palliative care being designed by Medicare Advantage plans or other health plans as well as commercial insurance carriers for participant and their families.

So, let's talk just a little bit on the next slide about the issues I think that we all are worrying about with the fear of palliative and hospice care within the disability community.

In the 1800s, individuals with disabilities were in asylums. They were out of sight and out of mind in facilities and big institutions.

There have certainly been a lot of advances over the last years, especially over the last 30 to 40 years. I think many of us who've been around a little while remember especially the Americans with Disabilities Act, and how important a lot of the work was in the '80s and '90s, even in the '70s to get the disability community in a new and much more visible place.

However, I think there's also a lot of concern about hospice patients and talking about hospice in the disability community, so I really wanted to address some of that as well.

We hear a lot of stories about participants with severe disabilities and maybe even health care professions have said, "This patient will never get better. They're in a persistent vegetative state," and sometimes that participant may progress to lead a life with quality and a life that's worth living.

I think the concern that many patients have as they are dealing with the healthcare system are magnified for the participant who has a long-term disability. If you are talking about your illness, which is a long-term and chronic illness, then you are having a different conversation when that illness begins to pop up as a terminal illness or as an illness at the end of life.

If we are looking at advanced serious illness where palliative care might be involved, palliative care might be the thing that the participant might choose and continue to have through the rest of their life.

Hospice is also an option, but even in the communities where patients and their families are looking at services across the board, sometimes that H word is very concerning to many patients. In the disability community, we all know that there's a lot more sensitivity about anything that might indicate that the patient or the participant is not recognized as still having quality of life to live.

Let's talk about having that end of life discussions. We are more focused on end of life discussions since physicians are now able to be paid for having advance care planning discussions with patients.

We are part of this new environment where talking about what your plan should be for the end of life is something all of us are much more tuned into than we used to be.

In the context of a participant with a long-term disability, this is a lot more challenging and a lot more difficult. Many hospices are very tuned into person-centered care. That is the highlight of a lot of the work that a hospice interdisciplinary team can do. I think very concerning is the question of how will the disease of the participant with a long-term disability be recognized by the hospice team?

If a participant has a trusted care provider, that is the place to start. That is the place to start about how to plan for what life should be like as they near the end of life. That health care provider may be able to bridge that discussion with the hospice provider or the palliative care provider.

We will talk now a little bit about how hospice care gets provided in the community and maybe there's some ways that participants can use some of this information to identify participants and their families that might need hospice care.

49.6% of Medicare beneficiaries who died in 2016 used hospice. That's just astounding. Even as I worked in hospice for a very long time, it's astounding that that's what our number has grown to.

I think the thing that I want to make sure of is that we're talking about the really wide diversity of diseases. In the early days of hospice, we expected that most people who used hospice services would have cancer.

So, a lot of our early modeling was 90% cancer, 10% all other diagnoses. Well now you can see just from this list here, that cancer beneficiaries in this data with cancer were not even 30% of our patient population.

It is important for us to really think about hospice as available to a participant with any particular disease that might be the disease that is causing a terminal event.

This is also true in the Medicaid benefit, and in many of the private insurance benefits as well. The reimbursement is paid by the day, so, it does not matter what services are provided; it is the day of care.

In Medicare and in Medicaid, we have four levels of care. Routine home care is what most people get; delivered wherever the participant is. To a participant in a group home, assisted living, and nursing home; you name it, we provide care in that setting.

If a participant has a symptom that is urgent and doesn't require a hospitalization, there is a possibility that a hospice would be able to provide what they call continuous health care. That is somebody who would be in the home, nurse or aide services, for at least 8 hours in a 24-hour

period. That way, the participant does not have to go to the hospital or make any kind of change, but the urgent medical issue can be addressed at home.

If that's not possible, then inpatient care could be provided; that is called general inpatient care. Then respite, which you can see is used by some of our patients as well. Respite care would be for a stay in a nursing home mostly while the family members rest and take a break from the caregiving for the participant or the beneficiary.

So, how does a patient get to hospice? That is an important thing, and certainly a little bit of a, "If I needed hospice care, what would I do?" I wanted to spend a little bit of time talking about what happens when a participant is at the place where there is a disease that's going to be moving down the very serious route and could be six months or less prognosis.

The participant would have the discussion or obtain a physician's note indicating a life-limiting illness. We are so hopeful that the physician would have the conversation with the participant about the difference between their disability and whatever it is that's happening now to make them not chronically ill, not seriously ill, but now terminally ill.

This is another place where that trusting relationship with someone who knows the participant well, who knows what their needs are, and can be an advocate is really going to be important. Now, I want to talk just for a minute about the physician.

The participant has the opportunity to choose what we call an attending physician. That could be their primary care provider, but really, it could be any physician that they choose to be their attending physician.

Between that person and the hospice physician or hospice medical director, the team of two physicians make the determination about agreeing that this participant is ready for hospice and qualifies for hospice care.

The nurse and other interdisciplinary team members, and we'll talk about the team in just a minute, they conduct an initial and comprehensive assessment. What are the medical needs of the patient? What are the social needs? What kinds of things does the family need? What kinds of things should be provided for in terms of the spiritual issues or the counseling issues? How do we help the participant and their family deal with the anticipatory grief that now this is whatever disease it is is moving toward a prognosis that is not forever and and is different from their disability?

The interdisciplinary team develops the hospice care plan. That would be any services. That could include the hospice aide for personal care. It could be hospice social worker to come and help with some counseling services. It could be the chaplain to talk about spiritual issues.

I know in my own situation, I was the caregiver for a neighbor. He had lung cancer. His biggest need was to talk to the chaplain because he'd been in the Korean War and he was afraid that when he died, God would not forgive him for what he did during the Korean War. It always

sticks with me because we think about the medical needs, but we don't necessarily think about all the other things that that participant is dealing with as they're approaching death.

This is a really good list of all the possible services that a hospice might be able to provide and would be providing in a way that is identified specifically for the participant and their family.

I want to note that I keep on talking about the participant and their family because this is a benefit that is not just for the participant, it is also for the family members. Physical, occupational, and speech therapy definitely, but I also want to call your attention to the massage, art, and music therapy, which has gotten very popular for many of our patients. There are some life-changing experiences that music therapists can bring to patients as they're nearing the end of life.

Now, we've added here at the bottom, the in-home para-professional care. That would be like personal care services. Depending on the state, also often able to be provided separate and apart, but coordinated with the hospice services like Medicaid personal care services. That is something to check on in the state where you're participants live, but certainly that's something that is also very important to this patient population.

Here are some of the things that the interdisciplinary team does. They're looking at pain and symptoms. They're looking at emotional support and anticipatory grief. They're making sure, and this is an important one, that medicine and durable medical equipment, medical supplies that're related to that participant's terminal illness are provided and paid for by the hospice.

This is one of those unique benefits in Medicare and in Medicaid where it is 100% paid for by hospice. For the services of the illness, there should be no cost to the participant or their family.

They're going to work with the family and any other care providers on how to continue to provide care to the patient. As the participant gets weaker, as the disease progresses, the hospice nurse or the hospice social worker will be there to help understand what's going on with the disease process and what to expect next.

We talked a little bit about that short-term inpatient care. Just really also we need to be aware that most of hospice care is not provided in the inpatient setting. There is a lot of focus on doing as little as we can in the inpatient setting. Making sure it's available, but also keeping patients at home. Keeping participants at home with their loved ones as much as possible is what our goal would be.

Then, bereavement support and counseling to family members, to staff, to partners, to other friends after the death of the participant. That can continue for a year or even 13 months so that you get past that one year anniversary.

Finally, coordinating with other personal care services that are in the home because of the participant's disability. Making sure that that coordination is smooth. That everybody has ongoing conversation about that. That is the place where paying attention to what's available at the state level is going to be really important.

As I was thinking about this presentation, I wanted to think two different ways. The hospice provider who is tuned in, and I would say the vast majority of hospice providers are very interested in providing good services to participants with disabilities.

I think that is an education opportunity on both sides. The hospice should be listening to what kinds of needs participants with disabilities might have. What's related to their disability? What new things are happening because of a new or worsening disease process?

I think we all have work to do in this area. The encouragement I have to anybody who's working with participants is to provide as much listening as possible. To make sure that whatever services are provided take the participants, and their caregivers, and their family into account so that all of the care planning that's done allows a participant to be as able to do as much as they can.

As Chris and I were talking about this session, we also began talking about what we could do in the same area for hospice providers to have better experience and better knowledge about how to care for participants with disabilities.

We are very interested in doing that. We are very interested in making sure that the end of life stage of life is as comfortable and as high quality as possible. So, with that, I will turn it over to Kelly.

Kelly Ambrose: Thank you, Judi, and thank you, Chris. I'm grateful to have the opportunity to be here today to talk to you all about CareOregon's palliative care programs. CareOregon is a non-profit health plan that serves about 250,000 Oregonians. We serve Medicaid, Medicare, and dually eligible members with about 11,000 dually eligible beneficiaries.

Our mission is cultivating individual well-being and community health through shared learning and innovation. Our vision is health communities for all individuals, regardless of income or social services.

So, I wanted to frame the conversation today with an experience of a member that we've worked with recently whose experience is similar to a lot of members that we work with. We are going to refer to this gentleman as Paul.

Paul is a 50 year-old dually eligible beneficiary with CareOregon. He had metastatic cancer. He had a long history of behavioral health issues. In fact, he was disabled with his mental illness. He also had multiple chronic conditions and had been in public programs or relying on public programs, a safety net for most of his adult life.

He recently lost a job. He had addiction issues. He was divorced. He was estranged from his family. He was socially isolated, and as he described it, and I'm always amazed by what people can share with us when they let us into their lives, that his life became a slow downward spiral. He just couldn't catch a break anywhere along the way.

Through the process of diagnosis and treatment, he would leave AMA. After aggressive treatment that was not working for him, he rejected hospice. He thought of it as giving up.

Even in the face of no further care to therapy, he expressed a fear of losing his independence. At every step of the way, he was resistant to discussing hospice or palliative options with the specialty care team in the hospital.

As far as speaking to the fears of the disability community with thinking about palliative care programs, these people have had to fight all their lives. They are survivors, so the thought of giving up isn't really part of their makeup.

They also have a lot of fears around changes in their approach to their treatment because they've had a lot of contact with the medical system and have been often let down by the medical system. There is a significant lack of trust.

This next slide is really speaking to our population. What we know about people facing serious illness is that it helps us to serve them if we can consider their past history and experiences.

What we know from child and adult traumatic experiences is that it can lead to altered brain development, emotional and cognitive functioning issues, associated morbidities like anxiety and depression, lifestyle related problems like smoking leading to COPD, substance abuse.

In Oregon, if you are homeless or living with severe mental illness, and I suspect this is the case in most states, your life expectancy is decades shorter than someone without one of these programs. There are several studies that definitively show the correlation between the social determinants of health and chronic illness and disabilities.

At CareOregon, we first started approaching care recognizing that these past experiences were going to affect how people could engage in their healthcare and with their health plans, and developed a program called the Health Resilience Program. It was, and is, a team of social workers that connected with people in the community where they live, where they recreate in their clinics, where they get care to engage them with a specific skill set to lead to hopefully better adherence, lower utilization, and just engagement with their treatment plan.

These are clinicians that are trained in motivational interviewing and understand a trauma-informed approach. We need to find out what's really important to members that we work with in order to understand the best way to serve them. So again, it's focusing on what people's experiences are and what's important to them.

When people aren't following a treatment plan, it's important to use motivational interviewing skills to ask questions. Open-ended questions are best. What do you understand about the plan? How might you like things to be different?

Then, even getting into something like, fill in the blank. "How does smoking interfere with the things you like to do?" We find these things out about people, and we really try to support their goals no matter where they are and what they want.

It's a collaborative process. The therapeutic relationship is really treated like a partnership. Now, traditional palliative care is focused on meeting the needs of the seriously ill beyond curative medical treatment.

It is about trying to improve quality of life and reduce suffering in every way possible. Physician Diane Meier defined palliative care as three core domains, symptom management, which could be pain, shortness of breath, anxiety. Also, we need to focus on goals of care. What do people understand about their situation? Their prognosis? What's important to them? Then care coordination. In complex illness, it is so easy to become lost in a maze of specialist facilities, services, and so forth.

Now, imagine being uncertain of one's prognosis with no one asking you your goals, having your major symptoms like pain, and also be trying to navigate the healthcare system. It's a path that no one should have to walk alone.

So, our CareOregon population that's served by palliative care, it skews younger than you might think for a healthier able-bodied person or people without such significant trauma in their history. 63% of the patients that we serve are under the age of 65. The bulk of the participants are middle aged, and they are middle aged people often dying from the diseases of old age.

As palliative care has advanced as a priority in the U.S. healthcare, it's been focused on the elderly in terms of who it serves. That makes a great deal of sense since the majority of people dying from chronic illness are above age 65.

However, as the field has evolved, it's been clear that there are other significant areas of critical needs that must be addressed in their own specific contexts. A good example is when we had the emergence of pediatric palliative care in the '90s to meet the needs of children and families and now it has now evolved to other populations and specialized work. That is the work we do in the safety net population.

Similar to pediatric palliative care in the '90s, it is a response to a specific set of challenges concerning vulnerable often traumatized low income populations. I'm going to give you a little overview of the work we do with these members.

Since 2010, CareOregon has focused on providing outpatient palliative care to its vulnerable members as a dedicated program. The program started as a benefit being administered by two Portland area hospices.

We gave them a program outline, and they were contracted to provide these services with a significant amount of oversight from CareOregon palliative care program management. Our patients were strictly in the outpatient palliative care program, not the hospice. In fact, the majority of CareOregon palliative care patients will decide never to go to hospice.

What we learned over the years is that relationship matters. As we know from the trauma literature is that relationships provide the ability to regain trust and security and that is so essential to overcoming traumatic life experiences.

In our model, while we do the core traditional palliative care activities, at the heart of it is high intensity involvement by our nurses and social workers to create this foundation above all else.

As we've learned, without this kind of foundational relationship, the rest of the work does not go well. This work evolved from just strict hospice and providing this care on a contract so we experimented with our own programs by embedding our staff into an oncology practice and into a safety net primary care clinic. At this point, we have brought most of that back in house with our own staff and with our program Housecall providers.

Traditional palliative care services have always focused on symptom management and initially through these palliative care consult programs. In the hospitals, outpatient palliative care clinics are the brick and mortar clinics where we found palliative care specialists.

In our safety net palliative care services, we offer all these additional supports to meet participants' other issues that they could be facing with housing, behavioral health, food and security, drug and alcohol treatment. We also, like I said earlier, really focus on what the patient's lived experience is.

We provide our programs primarily right now through our Advance Illness Care Program. Through our new program at Housecall Providers and our Advance Illness Care Program, we work with providers, other providers in the community, specialists, and primary care providers. We provide some wrap around supports with nursing and social work. We also provide chaplain and pharmacy support.

This interdisciplinary team works with the patient's primary care and specialty providers in the community. We focus on symptom management, care coordination, and really working on goals of care with individuals.

The program at Housecall Providers, this is a home-based primary care practice that CareOregon acquired last year. It includes 24 primary care providers, which includes 19 advanced practice nurses serving over 1400 patients in the Portland Metro area.

The goal of CareOregon acquiring this practice was to create a more robust safety net focused Housecall practice in the Portland area. When people come on to Housecall Providers, they have their wrap-around support and their interdisciplinary team all in one place, which includes a new primary care provider for them in that practice.

So, when we introduce these programs to individuals, I feel like we've had a lot of success. We don't pitch it as palliative care. We call it Advanced Illness Care initially, and we talk to people about the extra layer of support that this kind of service can provide. That we can work with their providers in the community, and we can help them navigate the challenges that they're facing and support them no matter what their goals are.

Often, people move from Advanced Illness Care to the Housecall Program. Some people come directly on to the Housecall Program from CareOregon. Again, we're really focusing on the services that we provide than actually the language of what we call it.

I find the people that refuse are usually the people that don't want somebody in their home or seeing them in their doctor's offices. Maybe they're not really engaging in the physician's office, but I think we have great success just pitching it as an extra layer of support.

Not as many of our patients go to hospice, only 30% of CareOregon members actually die on hospice. That's compared to in 2014; around 47% of Medicare patients utilized hospice at the end of their life.

Effective palliative care does improve the quality of life, especially with our safety net population, if we focus on the social determinants of health and developing these care partner relationships.

These strong relationships within the care team enable important and difficult conversations around hospice and palliative care. I would say with this population there's a lower percentage of them that actually do complete POLST and advance directives, especially those people with disabilities that have a fear of end of life and what it means to put your wishes down on paper.

I think because of the relationship we establish with individuals, we're able to have those difficult conversations where they haven't been able to happen before. A missing piece in safety net palliative services has been services for people that are homeless at the end of their life.

CareOregon is partnering with one of our largest mental health and housing providers in Portland to build another campus in Portland that will house an inpatient palliative unit with 10 beds for actively dying hospice patients as well as housing for palliative patient population. We hope to just get more creative with who we can serve once we have those services in place; really this care is successful. It's just all about the relationships.

So, we get back to Paul, and although Paul refused hospice care, we understood his resistance. We understood where he was coming from with that. We continued to engage him with care options that could meet his needs and continue to work with him and provide him with our version of hospice lite, which does not include after hours or weekend care, but pretty robust care during the week.

Although Paul's medical treatment was complicated with his disabilities and behavioral health issues, the relationships that were developed offered him crucial support. Some of the wins I would say with his care would be his reconnection with his family. I think family reunification's some of the most rewarding work that we do. Oftentimes even finding family members that will take patients in at the end of their life where they can receive end of life care.

This is what happened with Paul. He passed away peacefully at a family member's home. He did not go on hospice, but his symptoms were managed. When these people let us in, they share the

most amazing things. He expressed that before, he felt like he was falling. That he was in a spin, and now, he was not. So, while we can't solve a lifetime of trauma in our palliative care program, we can try to chart a new course around trust, support, and love.

In healthcare, I'm not sure there is a less appreciated factor than the therapeutic relationship. It's free. It doesn't have side effects. It can have profound effects on the small things that can make all the difference like medication compliance, keeping appointments, and patient engagement. We've designed our program so that therapeutic relationships can be developed with frequent visits by our dedicated team. I feel like we've done a really good job with that, and I feel very lucky to get to do this work.

Last concluding thoughts, I would say again relationship, relationship, relationship. I can't express enough how important training for clinicians, and motivational interviewing, and a trauma-informed approach to care will find success with this population. Thank you.

Chris Duff: Thank you, Kelly and Judi. I appreciate it very much. We have received many questions, and I will get through as many of them as I can. First question I would like to ask both Judi and Kelly, "Is palliative care provided for chronic pain management?"

Judi Lund: Chronic pain management could be provided by a palliative care specialist absolutely.

Chris Duff: Another way of looking at it is what's the difference between palliative care and chronic pain management?

Judi Lund: You go ahead, Kelly.

Kelly Ambrose: Well, I would say in our program, it is a little different in that we don't have a prescriber in our program. However, we can try to work with a provider in the community around chronic pain management, whether it's a specialty palliative provider, someone's primary care provider, or another specialist in the community.

Chris Duff: Great. Judi, did you want to kick back in?

Judi Lund: I would just add maybe one thing that chronic pain management might be one of the reasons you would ask for palliative care. Many chronic issues, including chronic pain, are reasons to access palliative care.

Kelly Ambrose: There are a lot of palliative programs that if that is the only reason for seeking palliative care, they may defer and not take that patient into the clinic or their program.

Chris Duff: So, if there's confusion, does the conversation need to go back to the person's primary care doctor. Most people we have on the phone here are probably care managers or people from plans. How do they sort that through?

Kelly Ambrose: Well, we don't take a patient on our program; I always reach back to the referring provider and discuss all the issues. If there are other issues involved besides just a provider's reluctance to maybe provide that chronic pain management, I help identify resources that might be more appropriate in the community.

At the palliative care practice I work with up at Oregon Health Science University, especially with cancer patients, primarily the symptoms they're working with are related to their pain.

Chris Duff: Right. Okay.

Another question came in specifically asking about the IDT in hospice and an IDT that may be present with a person who's on the developmental disabilities waiver. How do the two teams interface?

I would even go a little broader and say there may be an IDT from some other source, like out at the primary care clinic. The question becomes one of how does hospice interface with an existing IDT working with the participant?

Judi Lund: Well, it's a really, really good question. What we see in hospice practice around the country is that the hospice is now going to focus on that patient's terminal illness. Everybody's going to be working together.

I know when we provide interdisciplinary teams in any setting, we're always looking for how do we communicate and collaborate with other provider and other teams. We make sure that we're all addressing the things that need to be addressed, but the hospice's focus is on that terminal illness and what is needed for that.

Chris Duff: Understandable. One last question, and this is to Kelly. I want you to know that I struggled with this myself, so it is a great question. It comes from Therese from PACE Program in Southwest Michigan. Can you provide more specifics on what Advance Illness Care is versus your Housecall Care?"

Kelly Ambrose: Well I would say that they're very similar. What we focus on in our palliative care programs is symptom management, care coordination, and goals of care.

We have some of those difficult conversations with patients understanding what they want for their care. Sometimes we are able to talk about what they want for their care at the end of life or we focus on who we can identify as surrogate decision makers. Even though people may be able to discuss with us what they want, they may not want to put it down in a POLST form or an advanced directive.

With that, care is provided with social workers or nurses. We have outreach workers that are community health workers. We help people navigate complex health situations. We help people access disability benefits. We get people connected to specialists in the community they might need.

With the Housecall practice, my team, the Advance Illness Care team, often gets a lot of the social stuff a little buttoned up, but if they're having difficulty accessing care in a brick and mortar type clinic for whatever reason, whether it's a physical disability, or it's anxiety that has them house bound, or something else, we then bring people over to the Housecall provider's primary care practice, where they still get all those other things, but they also get their primary care provider wrapped into that as well.

Chris Duff: Great. Thank you very much. I appreciate that. We had a few other questions, and we will get back to people individually outside of the webinar, and we will post those questions and answers. Now, I'm going to have to turn it over to Jessie to wrap it up.

Jessie Micholuk: Thank you, Chris. Thank you, everyone, for attending today's webinar and your contributions to our discussion. As Chris said, please feel free to send any additional questions either via the platform or to our email address at the end of these slides. We'll be sure to follow up and post those questions and answers on our website following today's presentation.

I'd also especially like to thank our presenters for today, Judi Lund Person and Kelly Ambrose. Thank you for your contributions. Our next webinar in this series will be held next Wednesday, March 14th, and we'll be discussing *Supporting Participants with Complex Behavioral Health Needs*.

Again, for more information on obtaining those CEUs or CMEs, you can look at CMS's learning management system document that's on our Resources for Integrated Care website and the link is provided on your screen here.

As always, your input is essential to developing new trainings and resources. Please answer our brief survey that will appear automatically on your screen when this webinar ends. You can send, as I said, any additional comments to our inbox. That's RIC@Lewin.com.

Again, thank you for attending today, and have a good rest of your day.