California Health Care Foundation
SB 1004 Technical Assistance Series
Overview of Topic 3: Assessing Capacity and Launching Services
Self-Guided Materials for Plans and Provider Groups

The information below is intended to help those who could not attend the in-person workshops to further prepare for implementing SB 1004 services. You can also review the Topic 3 webinar recording and view a PDF of the slides from the Topic 3 workshops (which provide more visuals to illustrate the content below) on the CHCF website at www.chcf.org/SB1004.

Objective 1: Describe the conditions and supports required to optimize the delivery of SB 1004 palliative care.

Before you launch palliative care services, it is important to be aware of the environmental conditions and programmatic decisions that will impact the ability of palliative care providers to deliver SB 1004 palliative care.

Environmental conditions describes the larger reality of palliative care in the United States, such as:

- The palliative care needs of Medi-Cal members will be far greater than the minimum services required under SB 1004 — for example:
    - Members with prognosis > one year but significant symptom burden
    - Members with another serious illness (other than the four eligible conditions)
    - Dual eligible members
- Palliative care needs are dynamic, and different team members will take the lead in different situations. For example, needs for symptom management, emotional support, spiritual support, advance care planning, prognostication, and clarification of goals and values will wax and wane through the course of illness. Palliative care teams can be most efficient when they have the flexibility to have different team members take the lead in managing patients' needs.
- There is a shortage of palliative care–trained specialists from all disciplines (e.g., one certified palliative care social worker for every 4,200 terminally ill Californians).
- The Medicaid (Medi-Cal) population will stretch the resources of palliative care providers in ways that are different from patients with Medicare or commercial insurance. These patients are often younger and have significant financial and social challenges that will require more attention to meet basic needs (e.g., communication, housing, food, caregiver support).

Recommendations based on the environmental conditions above:

- Both MCPs and provider groups should have a plan for how they will address the palliative care needs that are identified, outside of the mandates of SB 1004 (e.g., expand eligibility criteria, identify other programs that could support members not eligible for SB 1004).
- Allow flexibility in which provider disciplines see patients at which frequency, since patients' needs are dynamic and often difficult to predict.
- Reserve specialist resources for the most complex patients, and help frontline providers/organizations to incorporate palliative care principles into normal workflows.

- MCPs can help their palliative care partners by connecting them with other resources to attend to members' complex psychosocial needs (e.g., substance use treatment programs, case management, transportation services).

In order to optimize chances that SB 1004 services will benefit members and that palliative care providers will continue to be able to deliver these services, there are some key principles to consider:

- Refer the right patients. Since the palliative care needs of members will be far greater than the minimum SB 1004 eligibility criteria, some plans may choose to significantly expand their eligibility criteria; however, referring too many members for specialty palliative care may result in overuse of your limited resource of palliative care specialists, when routine palliative care could have adequately addressed the members' needs. Conversely, if too few patients are referred, you may miss opportunities to improve members' end-of-life experience and there may be an increase in unnecessary end-of-life care costs.
    - Suggestion: Discuss expected volume among payer-provider partners and consider some expansion of eligibility criteria; work collaboratively to screen members for eligibility before referral to palliative care.
- Refer patients at the right time. Studies suggest that palliative care can have greater benefit when it is started earlier (at least three months before patients die); however, providers will often only think to refer patients for palliative care in their final weeks of life. In a Medi-Cal population, patients may seek care inconsistently or late in the disease course, which makes patient identification and early referral even more challenging.
    - Suggestion: Identify key places in the health care system where patients can be identified by medical providers (e.g., ED, complex care management, acute care) and social service providers (e.g., case management, social workers, navigators). Proactive patient identification strategies will also be important (see Objective 3, below).
- Provide the right supports for palliative care providers. As stated above, palliative care programs can be most efficient when they have flexibility in how they deliver care; MCPs can work to accommodate that flexibility. Additionally, palliative care providers often need support for education and training, either related to palliative care (if they are not specialists) or to care for the psychosocial complexities of Medi-Cal patients. Lastly, the MCP helping to manage some of those complex psychosocial needs will free the palliative care providers to focus on delivering the core SB 1004 services, which they are best trained to deliver.

ACTIVITY: Complete the accompanying worksheet, Connecting Palliative Care Partners. The intention of this worksheet is to leverage the resources and connections of both the MCP and palliative care provider, to understand which programs and services can be offered to patients to supplement SB 1004 palliative care — so please share your ideas from this worksheet with your MCP/provider partner(s)!

Objective 2: Outline approaches to assess the palliative care capacity of local providers and to identify any gaps in readiness to deliver SB 1004 palliative care.

We can think of capacity in multiple ways. Likely the thing that most people associate with "capacity" is the number of patients a provider can see, which is an important aspect of capacity. However, there are other key characteristics that speak to an organization's ability to provide high-quality palliative care services, which point toward its overall readiness to provide these services. To that end, we recommend considering several aspects of readiness:

- Awareness and Experience
    - Context of Serious Illness — How in-depth is the organization's understanding and experience caring for patients with serious illness, particularly Medi-Cal or similarly vulnerable patient populations? The context of serious illness includes:
        - Impact on patients — physical, emotional, social, financial, legal, etc.
        - Impact on families/caregivers — physical, emotional, social, financial, legal, etc.
        - Range of needs of patients and families/caregivers — in vulnerable populations, this also includes things like supporting wishes to return to friends/family who live far away, developing a plan for progressive support for homeless or marginally housed individuals, etc.
    - Awareness of Resources — To what extent does the organization already collaborate with community and other clinical partners who are equipped to assist in the care of psychosocially complex patients? (Palliative care providers outside of safety-net health systems, some of whom are accustomed to short lengths of stay on-service for patients, may be unaware of the spectrum of programs available to meet the longer-term needs that are likely to be present in the Medi-Cal population.)
        - Community partners
            - Social services and nonprofit organizations
            - Faith-based organizations
        - Other clinical partners
            - Behavioral health
            - Homeless health
- Core Competencies — Does the organization's team members have special training and experience with managing more challenging and complex situations related to:
    - Assessment and management of:
        - Pain
        - Nonpain symptoms
        - Psychosocial needs/distress
        - Spiritual needs/distress
    - Evidence-based prognostication
    - Assessment of patient/family goals and applying them to medical decisionmaking
    - Facilitating advance care planning
    - Evaluating hospice eligibility and referring as needed
- Organizational Readiness
    - Structures and Relationships

    - Flexibility in care delivery — As mentioned in Objective 1, the needs of seriously ill patients are dynamic and often difficult to predict. The palliative care team will need to be flexible in terms of time allocated for visits and disciplines involved in visits, depending on the patient's most pressing needs. If an organization has difficulty allowing for this flexibility, it will challenge the team's ability to be as efficient as possible.
    - Addressing patient needs after hours — What happens when a patient or caregiver has a question or unmet need after hours? Will he or she reach the organization's voicemail, call 911, or have access to a support line?
    - Connection to likely referring providers (e.g., primary and specialty care groups, complex care management teams) — Which groups is the organization connected to? To what extent does the organization already communicate with and outreach to these groups, beyond simply receiving referrals?
  - Team Composition
    - Which disciplines are included on the team? (SB 1004 requires a physician, nurse(s), and a social worker, and recommends a chaplain.)
    - What do the team members do? Do they have other responsibilities? It is common for teams to launch with only partial FTE staff until demand increases; in these situations, how available will the various team members be if they have other responsibilities?
    - To what extent do team members work together or separately? Interdisciplinary work can be done separately, but there is then a critical need to routinely communicate with other team members, beyond simple charting, to ensure that a patient's needs are being met and appropriate services are delivered in a timely manner.
  - Standard Procedures/Workflows
    - Clinical assessments done routinely — Are clinical assessments done at predictable, standardized points in the patient's care, or just when needs arise?
    - Tools used — Does the organization use standardized, validated tools to do their assessments (symptoms, psychosocial needs, spiritual needs)?
    - Proactive vs. reactive patient identification — Does the organization already do outreach to identify patients earlier in their illness course or wait until referrals are made?
  - Time for Nonclinical Activity
    - Continuing education — Does the organization support its clinicians to receive continuing education in palliative care (i.e., paid time off, covering costs for conference registration and travel)?
    - Quality assessment and improvement activities — Is there dedicated time and/or staff for reflecting on organizational outcomes (i.e., developing and sharing reports that reflect on outcomes)? What quality-improvement initiatives has the organization undertaken in the last year? Is the organization part of any quality collaboratives in palliative care?

        - Data collection and reporting — How is time allocated for data collection and reporting (i.e., is there "protected time" for clinicians or a dedicated staff person assigned to these tasks)?
        - Network development — To what extent does the organization dedicate time and effort to developing connections with community partners and understanding the landscape of supportive services available?
    - Ability to Expand
        - Current capacity — To what degree is the organization already staffed to take new referrals? What is the volume of referrals that could be accepted in a month? What is the current interval (time) from referral to first contact with a patient?
        - Near-term capacity — If referrals were to increase (by an estimated amount), how much time would it take for the organization to increase its capacity to take on the added volume?
        - Factors influencing ability to grow/maintain growth — Are there any logistical or organizational characteristics that influence a program's rate of growth (for example, in safety-net systems, budgeting decisions are often made only at one or two time points in the year)?

All these characteristics can serve as a checklist to evaluate a palliative care provider's readiness to start and sustain high-quality palliative care services for Medi-Cal patients. Given the breadth of this list, it is to be expected that there will be areas of strength and weakness for all organizations, even the most well-established and effective. We recommend using this checklist as an informational tool — either externally (with your palliative care partners), or internally (for palliative care providers) — to be aware of these areas of strength and weakness, and to discuss ways to address any identified gaps.

After the review of an organization's readiness to deliver palliative care services has been performed, the next step is to discuss opportunities to address any identified gaps. There are both internal and external strategies for filling gaps. Internal strategies include hiring new staff or training/reallocating existing staff. External strategies involve outsourcing the work to an outside partner. Different organizations will take different approaches depending on their resources and other priorities, as well as the available external partners. With that allowance for organizational variation, see the following table for some common approaches to addressing specific gaps.

Organizational Characteristic	Strategies to Address Identified Gaps
Core Competencies	Train existing staff Hire new staff Defer to specialty providers
Awareness and Experience	
Context of Serious Illness	Train existing staff
Awareness of Resources	Share resources, make connections
Organizational Readiness	
Structures and Relationships	Evaluate capacity to restructure Share resources, make connections
Team Composition	Reallocate existing staff Hire new staff
Standard Procedures and Workflows	Leverage lessons learned from other initiatives (e.g., what worked in other QI or program development)
Time for Nonclinical Activity	Explore avenues to support QI, professional development
Ability to Expand	Reallocate existing staff Hire new staff

Following a discussion about identified gaps and potential strategies to address them, the MCP and provider both must come to a conclusion regarding identified gaps: either the provider can fill it, the MCP can fill it (or assist in filling it), or the gap is unlikely to be filled in the near term. Both organizations will need to come to their own conclusions as to whether any unmet gaps will prevent moving forward with the partnership, or whether the partnership can move forward, recognizing that these gaps exist.

ACTIVITY: Use the Gap Analysis Worksheet to evaluate the readiness of your organization (palliative care providers) or your palliative care partners (MCP).

Objective 3: Discuss strategies to optimize referral of eligible members.

Once the MCP and provider are aware of potential gaps, the next step in preparation is to start developing policies and workflows to prepare for members being referred for SB 1004 services. Some steps in this process have already been carried out, since the MCPs submitted their Policies & Procedures to DHCS in November 2017. However, beyond those general policies, MCPs and their provider partners will likely need to do more planning to determine how the referral process will work. One of the biggest components of this process is patient identification. In order to optimize the benefits of palliative care for patients, proactive patient identification is recommended, rather than relying solely on primary and specialty care providers to be aware of and refer their patients for SB 1004 services.

When preparing to identify and refer patients/members for SB 1004 services, it is important to attend to the unique features of the Medi-Cal population. These population characteristics suggest that modifications to typical palliative care approaches may be necessary.

- Characteristics that impact patient identification
    - Patients (more) often present with late-stage illness, or present intermittently — As a result, there is little time for palliative care to get involved, particularly if patient identification relies solely on primary and specialty care providers. It may be helpful to consider implementing triggers for consultation, at time of diagnosis, when there is progression to a late stage of illness, or when the patient is hospitalized or comes to the ED for the second time in six months (for complications of an SB 1004 diagnosis).
    - Some patients will be unable to engage with the health system in traditional ways — As a result, the patients who recognize functional decline first may be outside of the health care system. For this subset of patients, referrals from social service or case management may become a critical component of early patient identification.
- Characteristics that impact patient acceptance of referral
    - Some patients may mistrust the medical system — As a result, patients may be less willing to accept new and unfamiliar services, if their introduction to those services is on a call from an unknown provider or organization. For this subset of patients, "warm hand-offs" and in-person introductions can be helpful to transfer trust from existing providers to new providers.
    - Cultural or linguistic barriers are common — If program materials or services are available only in English, patients may be fearful about accepting palliative care services. Having cultural or linguistic ambassadors can be a powerful way to bridge these gaps.

To optimize patient identification and referral in this population, we recommend the following:

1. Outreach and education to potential referring providers
2. Outreach and education to members/patients
3. Proactive patient identification

Strategy 1: Outreach and education to potential referring providers

Since the eligibility criteria for SB 1004 include both specific clinical criteria and patient/surrogate agreement, it is critical to partner with health care providers who have access to clinical information and who have greater trust with their patients, many of whom have never heard of palliative care. Whether you decide to wait for spontaneous provider referral of patients, or to proactively identify patients, this level of screening for clinical eligibility will be necessary. For this reason, providers need to be informed about the availability of SB 1004 services, and how they can be accessed.

At the same time, there are important considerations for approaching providers. First, it is critical to appreciate the pressures that providers are facing to see a larger number of patients, perform more services and screenings, and thoroughly document their encounters — in the same (or a shorter) amount of time. For this reason, to gain the buy-in of busy providers, it is very important to help alleviate some of the stress of caring for seriously ill patients. Second, if the referral process is too cumbersome, it will discourage providers from referring. Third, many providers want to take better care of their seriously ill patients but haven't received enough education or training to do so confidently. Last, busy providers may miss communications about new services if they come only through one mechanism (e.g., email newsletter).

For all these reasons, we suggest the following approach to provider outreach and education:

1. Identify key partners you want to reach out to:
    a. Providers with access to clinical information who can help with gauging prognosis and getting patient trust
        i. Specialty care clinics (cardiology, pulmonology, hepatology, oncology)
        ii. Primary care
        iii. High-risk patient care providers (e.g., complex care management, health homes, whole-person care teams)
    b. People/organizations who may recognize functional decline earlier than providers
        i. Social workers
        ii. Case managers
        iii. IHSS workers
        iv. Community health workers, patient navigators
        v. Other community partners (e.g., meal delivery services, housing programs)
2. When you meet with your key partners, focus on these goals:
    a. Listening more than talking/informing, so you understand how to gain providers' buy-in (i.e., promote recognition that palliative care services will meet the needs they identify as challenging). Example questions might include:
        i. What do you wrestle with most when caring for seriously ill patients?
        ii. What additional support(s) would be most valuable to you in caring for seriously ill patients?
        iii. What additional support(s) would be most valuable to your seriously ill patients?
        iv. Are there services (clinical or social) with smooth referral processes? What works well?

b. Identify potential palliative care "champions" — Our experience is that you will find people in every system for whom supporting patients with serious illness is a point of pride or professional passion, even if they have never pursued in-depth training or certification in palliative care. These people have tremendous capacity to help in identifying and referring patients in their unique care settings.

c. Provide education opportunities
    i. Basics of SB 1004 — eligibility, how and when to refer, services provided
    ii. Continuing education opportunities for them to learn more about palliative care (e.g., CSU Institute for Palliative Care online learning modules)

Strategy 2: Outreach and education to members/patients

Some organizations, particularly MCPs, have expressed hesitancy about reaching out to members to educate them about palliative care services, or to directly offer services to eligible members. However, there is abundant evidence that patients and families are very receptive to palliative care once they are educated about it. In 2011 public opinion surveys found that 70% of surveyed adults stated that they were "not knowledgeable" about palliative care; however, after being informed, nearly all stated that they would want these services available for themselves or a loved one and strongly believed that insurers should pay for these services. For this reason, MCPs and providers should feel comfortable in approaching patients/families to educate them about palliative care.

What strategies might be helpful to reach out to vulnerable patient populations?

- Focus on relationship-building with trusted community organizations (e.g., churches, community centers, neighborhood organizations).
- Leverage the experience of organizations that focus on improving palliative care for minority communities (e.g., Chinese American Coalition for Compassionate Care, Familias en Accion).
    - Some organizations can offer small-group education sessions to train providers to deliver culturally sensitive care.
    - See if you can access education materials that have already been developed.
- Train/hire members of the community to help with patient outreach (e.g., hospice/palliative care volunteers, navigators, promotoras, community health workers).
- Develop culturally/linguistically concordant staff/teams (especially important for the initial information call/visit from the palliative care program).
- When using printed materials, use best practices in health literacy (e.g., fifth-grade reading level or below), available in multiple languages.
- Capture stories of patients/family members, particularly if they are willing to serve as spokespeople at events, to explain the personal benefits of palliative care.
- Key messages to convey about palliative care:
    - It helps provide the best possible quality of life for a patient and their family.
    - It helps patients and families manage the pain, symptoms, and stress of serious illness.
    - It is a partnership of patient, medical specialists, and family.
- Although the greatest effort at member/patient outreach is warranted at the outset of the program, it will be important to continue education/outreach efforts on a regular basis, since patients may not be as interested/engaged until they or a loved one becomes seriously ill.

Strategy 3: Proactive member/patient identification

What strategies might be used to proactively identify members eligible for SB 1004 services? Different payer-provider partnerships have used different strategies, which fall into three main categories:

- Payer identifies potentially eligible members — This can be accomplished by regular reviews of authorization or claims data. Claims data might be used to identify members with one of the four SB 1004 diagnoses, a certain number of hospitalizations or ED visits, and/or particular orders for durable medical equipment (e.g., oxygen, hospital bed, bedside commode). Since claims data returns weeks or months after the event, some plans are using authorization requests to identify members in real-time.
  - This strategy is useful in that it is relatively low effort and should be fairly complete in its capture of eligible members; however, these analyses are likely to overidentify members and include those who aren't actually eligible for SB 1004. If no further screening is done before referral to palliative care providers, it is likely that the palliative care providers will expend significant effort for little return of enrolled members, which will likely be unsustainable.
- Provider identifies potentially eligible members — In addition to spontaneous referral when providers recognize a need for palliative care (which is likely to occur late), some health care systems have implemented clinical triggers to prompt palliative care referral. Examples of such triggers include a new diagnosis (or progression to more advanced stage of illness) or a clinical event (e.g., hospitalization, ED visit, failure of second-line cancer treatment). Another strategy is to build in time for providers to review their patient panels on a routine basis to determine if any patients could benefit from palliative care services.
  - This strategy is useful in that the eligibility screening is completed before referral, and patients may be more likely to follow through if their providers endorse the benefits of palliative care. However, this approach is likely to underidentify members eligible for SB 1004.
- Hybrid payer-provider member identification — In this approach, payers run routine queries to identify potentially eligible members and then share those lists with their clinical partners (primary and specialty care providers with access to clinical information). Clinicians then determine which of the MCP-identified patients meets criteria, and refers them to the palliative care provider.
  - This strategy is likely to be the most accurate and comprehensive, but it requires buy-in from a larger group of stakeholders and is more labor-intensive.

In addition to patient identification and referral strategies, MCPs and their provider partners will need to develop workflows related to data collection, analysis, and reporting. More of this will be covered in Topic 4.

ACTIVITY: Complete the Patient Identification and Referral Workflows worksheet. This exercise (done collaboratively among stakeholders from the MCP and provider group) will help to clarify the processes related to patient identification, referral workflows, and patient and provider outreach.

Objective 4: Describe lessons learned about patient referral from existing Medi-Cal palliative care programs.

During the workshops we highlighted one palliative care provider (Outreach Care Network) and one MCP (Health Plan of San Joaquin) that are already providing palliative care services for Medi-Cal members/patients. See webinar slides to learn more about these organizations.

Lessons learned from Outreach Care Network:

- It's (very) important to hire local providers who are culturally/linguistically concordant with patients (though this can definitely be a challenge in rural areas — telemedicine can help).
- Particularly for palliative care providers with multiple contracts, need to reinforce with staff the differences in requirements and services for different patient populations.
- Staffing a patient/family advice line can be critical to avoid unnecessary admissions ("outside triage will send your patient to the hospital") and to provide consistency in care quality (aim for "2 AM is the same as 2 PM").
- Focus on the mission/vision and doing the right thing for the patient.

Lessons learned from Health Plan of San Joaquin (HPSJ):

- To make things manageable, they started with a limited number of inpatient facilities and outpatient clinics, and focused education there. Once the program was up and running, they have expanded to cover many more facilities and clinics.
    - HPSJ focuses on direct provider education and outreach to promote palliative care services and generate referrals.
    - As the program has grown, the education has become more targeted (e.g., stressing importance of prompt responses when patients need meds, equipment, etc.).
- Referral information is confirmed and consolidated before it's sent to palliative care provider partners, to help maximize the efficiency of their palliative care partners.
- Plan-providers have biweekly operations meetings to make adjustments to the program as it continues to grow.
- Connecting with patients can be challenging (e.g., incorrect phone numbers, mistrust), so they focus on making connections with the patients while they're in the hospital.
- When transportation is a barrier for patients, they assist with transportation.
- It's critical to choose the right palliative care partners, and it's particularly helpful to find organizations that are willing to collaborate, innovate, and adjust as needed to make it work.

Take-home points:

- Critical to work with providers who have ready access to clinical information.
- Iterative process is helpful in improving information flow between payer and provider.
- Important for palliative care team to be aware of other resources available to patients who don’t meet criteria.
- Important to recognize the cost to palliative care group of determining if member is eligible and will (and can) accept services.