Topic 3:
Assessing Palliative Care Capacity and Launching Palliative Care Services

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Where are we now?

- **Sep. 2014**: SB 1004 signed by Gov. Brown
- **Sep. 2016**: DHCS released SB 1004 policy paper
- **Oct. 2017**: Final All-Plan Letter Released
- **Jan. 2018**: Implementation

T1 and T2 events are indicated.
Building blocks for implementing community-based palliative care

- Estimating member/patient need
- Estimating costs for delivering services
- Evaluating current capacity for palliative care
- Developing a strategy to expand services
- Gauging and promoting sustainability and success
Building blocks for implementing community-based palliative care

- Estimating member/patient need
- Estimating costs for delivering services
- Assessing capacity for palliative care & launching services
- Gauging and promoting sustainability and success
- Lessons learned and adjusting programs

Topic 3 technical assistance materials will be posted online in February: www.chcf.org/sb1004
Workshop Objectives

• Describe the conditions and supports required to optimize the delivery of SB 1004 palliative care

• Outline approaches to assess the palliative care capacity of local providers, and to identify any gaps in readiness to deliver SB 1004 palliative care

• Discuss strategies to optimize referral of eligible members

• Describe lessons learned about patient referral from existing Medi-Cal palliative care programs
Agenda

• Welcome and Introductions
• SB 1004 review/updates
• Conditions and supports to optimize SB 1004 delivery
• Assessing capacity to deliver palliative care, identifying gaps
• BREAK
• Referral strategies
• Lessons learned about patient/member referral
• Summary and closing
Introductions

• Organization
• Your name
• Your job title
• Your current or expected role in relation to SB1004 Palliative Care

• QUESTIONS
  • Have you gotten any SB 1004 referrals yet?
  • What is making you anxious as implementation starts?
  • Which components of implementation are still in development?
SB 1004 Updates

• Lots has happened since October...
  ◦ Oct 2017: Final All-Plan Letter (APL) released
  ◦ Nov 2017: Plans submitted Policies & Procedures
  ◦ Dec 2017
    ◦ DHCS webinar with draft reporting requirements
    ◦ Policy update published
      ◦ http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_26508.asp
  ◦ Jan 2018: Implementation!

DHCS SB 1004 page:
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx
SB 1004 All-Plan Letter

• No changes to eligibility criteria

• Required services
  ◦ Dropped requirement for chaplain services (encouraged)
  ◦ Clarification of what is (not) in plan of care

• Requirements for plans
  ◦ MCPs must have a process to identify the beneficiaries eligible for palliative care, including a provider referral process.
  ◦ MCPs must inform and educate providers regarding availability of the palliative care benefit.

• Implementation: Jan 1, 2018
SB 1004 Reporting Requirements

• Dec 4 webinar hosted by DHCS reviewed draft reporting requirements

• Reporting domains
  • Patient level – assess program growth, patterns of program use, disenrollment reasons
  • Requests – where care is being delivered, trends in approvals/denials
  • Network adequacy – what types of providers are delivering SB 1004 PC, in which care settings

• DHCS responses
  • There is no comprehensive list of palliative care CPT codes. MCPs should determine their own data collection methodology for palliative care.
  • Patient-level data will be required
  • DHCS discussing whether individual providers (vs. provider group) will need to be listed
  • Reporting schedule, final template TBD
SB 1004 Policy Update

- No age restrictions on who can get SB 1004 Palliative Care (kids eligible)
- If needs decrease, level of support provided may decrease, but patient still needs to be reassessed periodically
- DHCS recognizes that regional needs may vary -- MCPs can propose alternative eligibility criteria to DHCS (but can’t be more restrictive than DHCS criteria)
- Encourages partnerships with specialty providers (e.g. cardiology, oncology) to support “early [non-SB 1004] palliative care”
- $244,000 allocated for provider education
- MCPs will be required to provide list of members who received SB 1004 svcs
Education Support

- California State University’s Institute for Palliative Care – education offering
- DHCS has approved limited number of users per system to access online education modules
- Modules
  - Provider-specific, clinically-focused
  - Program development
- How to apply: https://csupalliativecare.org/education/sb1004/
- Available until DHCS funds run out (first-come, first-served)
Agenda

✓ Welcome and Introductions
✓ SB 1004 review/updates

• Conditions and supports to optimize SB 1004 delivery
• Assessing capacity to deliver palliative care, identifying gaps
• BREAK
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• Summary and closing
Conditions and Supports to optimize SB 1004 palliative care delivery

• Important context
  ◦ Palliative care needs
  ◦ Palliative care structures
  ◦ Palliative care access
  ◦ Medi-Cal population

• Key ingredients for optimizing service delivery
  ◦ Right patients
  ◦ Right time
  ◦ Right supports
#1: The palliative care needs of your members/patient population will be far greater than what is required by SB 1004
SB1004 Population in Context

- Patients with SB1004 conditions
- SB1004 eligible patients
- Eligible patients who are referred/identified
- Patients who are eligible for, willing and able to accept SB 1004 services
- Patients who would benefit from PC

Eligible patients who are referred/identified

Patients who are eligible for, willing and able to accept SB 1004 services

SB1004 eligible patients

Patients with SB1004 conditions

Patients who would benefit from PC
SB1004 Population in Context

- Other high-risk patients
- Other-insured (including duals)

Patients who would benefit from PC

GAP

Patients who are eligible for, willing and able to accept SB 1004 services
Palliative Care Context

#1: The palliative care needs of your members/patient population will be far greater than what is required by SB 1004

IMPLICATION:
You need to plan for how you will address the gap between need and SB 1004 eligibility (providers, patients/members will ask!)
#2: Palliative care needs are dynamic and different interdisciplinary team members will take the lead in different situations
Team magic
Patient referred

August

Interdisciplinary assessment in clinic

September

Frequent communication with providers at Medical Respite

October

November

Continuity/support visits by SW, chaplain

December

January

Inpatient admission, anticipatory grief and social needs addressed

Symptom crisis, goals of care meetings

February

Hospice referral

Team Magic
### Transdisciplinary care

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<thead>
<tr>
<th>Task</th>
<th>Nurse Practitioner</th>
<th>Social work</th>
<th>Chaplain</th>
<th>Physician</th>
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Palliative Care Context

#2: Palliative care needs are dynamic and different interdisciplinary team members will take the lead in different situations

IMPLICATION:
Need to allow for flexibility in different ways teams will use interdisciplinary members, and to recognize that non-billing providers often play key roles
#3: Palliative care specialists are a scarce resource
Access to Specialty Palliative Care in SF Health Network

SF Health Network
- Ambulatory Care
- Transitions
- Laguna Honda Hospital (SNF)
- San Francisco General Hospital
- Primary Care
- Behavioral Health
- Maternal, Child, Adolescent Medicine
- Jail Health
- Acute Care
- SNF
- Specialty Care
Palliative Care Specialists are scarce

• In 2010, estimated physician shortage of 6,000-18,000 just to staff existing services appropriately (Lupu, 2010 J Pain Symptom Management)

• Certified/designated PC workforce in California (2012 data, CSU Institute for Palliative Care)
  ◦ 914 physicians
  ◦ 89 NPs
  ◦ 975 RNs
  ◦ 146 CNAs
  ◦ 43 SWs
  ◦ 171 chaplains
Are there enough specialty PROGRAMS?
#3: Palliative care specialists are a scarce resource

**IMPLICATION:**
Need to reserve specialist resources for most complex patients, help frontline providers/organizations to incorporate palliative care principles in normal workflows
Palliative Care Context

#4: Medi-Cal population will stretch palliative care programs in unique ways
Experience at ZSFG Palliative Care Clinic

• Mean age of patients: 61

• Diverse
  ◦ 33% Asian, 27% Caucasian, 19% African-American, 18% Latino
  ◦ 39% have Limited English Proficiency

• Challenging social situations
  ◦ 10% Homeless, 15% Marginally housed

• Reasons patients could not be seen in clinic
  ◦ 20% (especially) hard to reach
  ◦ 26% had series of no-shows
ZSFG Response to Unique Patient Needs

• Key (non-traditional) partnerships
  ◦ Homeless advocates/providers
  ◦ Case managers
  ◦ Patient navigators
  ◦ Interpreter services

• Inpatient-outpatient hybrid care delivery model

• Set clear expectations for patient outreach and sign off

• Team member(s) with mental health training

• Developing telehealth services in partnership with home health agency
Palliative Care Context

#4: Medi-Cal population will stretch palliative care programs in unique ways

IMPLICATION:
Need to build connections with key community and system supports to address the complex psychosocial needs of this population; social work support is critical
Right Patients

• TOO BROAD
  ◦ Pal Care Team overwhelmed/cannot meet demand
  ◦ Pal Care Team wastes time evaluating patients who aren’t eligible

• TOO NARROW
  ◦ Miss patients who could have benefitted
  ◦ May be difficult for pal care program to be sustainable without economies of scale

• JUST RIGHT
  ◦ Patients 6-12 months prognosis
  ◦ Pre-screened for eligibility or screening process is collaborative
Right Time

• Palliative Care can have greater impact when contact starts >90 days before death

• Many Medi-Cal patients will present late, or inconsistently
  ◦ Patient identification/triage
  ◦ Late presentation → Referral from time of diagnosis
  ◦ Recognition of disease progression may be recognized by other health and social service providers
  ◦ Where are the key points in the system where patients can be identified?
Right Supports

• Structures
• Education & Training
• Connection to additional Resources
Addressing the Gap

Expand Eligibility

Right patients
Right time
Right supports

Frontline ("primary") palliative care
Key Ingredients: take aways

• SB 1004 benefit is great, but several other supports are needed to ensure that your palliative care partner(s) can do the work
  ◦ Right patients
  ◦ Right time
  ◦ Right supports

• Need to think about how you will address the gap of patients/members who need palliative care and who will get SB 1004 services
  ◦ Expand eligibility
  ◦ Support frontline providers in delivering frontline palliative care
Intersection with Other Programs

- SB 1004
- Whole Person Care
- Health Homes
- Coordinated Care Initiative
- PRIME
Intersection with Other Programs

• Health Homes for Patients with Complex Needs
  ◦ Medi-Cal program
  ◦ Allows for creation of integrated “health homes” to provide comprehensive, coordinated medical care, mental health care, and social services, to address the complex needs of highest users of health care resources
  ◦ [http://www.dhcs.ca.gov/services/Documents/HealthHomesforPatients_Final.pdf](http://www.dhcs.ca.gov/services/Documents/HealthHomesforPatients_Final.pdf)

• Whole Person Care
  ◦ Medi-Cal program
  ◦ 5-year, up to $1.5 billion federally funded pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes
  ◦ [http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx](http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx)
## Intersection with Other Programs

<table>
<thead>
<tr>
<th></th>
<th>SB 1004</th>
<th>Health Homes</th>
<th>Whole Person Care</th>
</tr>
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<tbody>
<tr>
<td>Where it comes from</td>
<td>2014 CA legislation</td>
<td>ACA section 2703</td>
<td>Medicaid 1115 waiver</td>
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<tr>
<td></td>
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<td>2013 CA legislation (AB 361)</td>
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<tr>
<td>Mandatory?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Eligibility</td>
<td>• General</td>
<td>• Highest risk 3-5% of</td>
<td>“HUMS”</td>
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<tr>
<td></td>
<td>• Utilization</td>
<td>Medi-Cal population</td>
<td>Defined by organizations</td>
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<td></td>
<td>• Prognosis</td>
<td>likely to improve with</td>
<td>Subpopulation examples:</td>
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<tr>
<td></td>
<td>• Pt willing</td>
<td>support</td>
<td>Homeless</td>
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<tr>
<td></td>
<td>• Disease-specific</td>
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<td>Incarcerated</td>
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<td></td>
<td>• CHF</td>
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<td>Substance use</td>
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<td>• COPD</td>
<td></td>
<td>treatment</td>
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<td></td>
<td>• Cancer</td>
<td></td>
<td>Mental health</td>
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<td>• ESLD</td>
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HUMS: Highly Utilizing Medication Systems

Subpopulation examples:
- Homeless
- Incarcerated
- Substance use treatment
- Mental health
### Intersection with Other Programs

<table>
<thead>
<tr>
<th>Services included</th>
<th>SB 1004</th>
<th>Health Homes</th>
<th>Whole Person Care</th>
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</thead>
</table>
|                   | • Advance care planning  
|                   | • PC Assess & Consult  
|                   | • Plan of Care  
|                   | • Pain, symptom mgmt.  
|                   | • Mental Health and Medical Soc Svc  
|                   | • Care Coordination  
|                   | • PC Team  | • Comprehensive care management  
|                   |                   | • Care coordination  
|                   |                   | • Health promotion  
|                   |                   | • Comprehensive transitional care  
|                   |                   | • Individual and family support  
|                   |                   | • Referral to community and social support services  | Defined by organizations  
|                   |                   |                   | Goals: coordination of health, behavioral health, and social services  
|                   |                   |                   | Improve well-being  
|                   |                   |                   | More efficient use of resources  |
| Requires plan-provider partnership | Yes | Yes | Yes |
| Payment mechanism | Can bill for some svcs; Relies on cost avoidance | Funds allocated for participating groups | Grant funds |
How are you thinking about triaging members to one program vs. another, or coordination among programs?
Work in Small Groups

CONNECTING PALLIATIVE CARE PARTNERS worksheet
Agenda

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  • BREAK
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• Lessons learned about patient/member referral
• Summary and closing
Are you/partners ready to deliver palliative care?
Are you/partners ready to deliver palliative care?

- Awareness & Experience
  - Context of Serious Illness
  - Awareness of Resources

- Core Competencies

- Organizational Readiness
  - Structures & Relationships
  - Team composition
  - Standard procedures/workflows
  - Time for non-clinical activity
  - Ability to expand
Awareness & Experience

• Context of Serious Illness
  • Impact on patients
  • Impact on families/caregivers
  • Range of needs of patients and families/caregivers

• Awareness of Resources
  • Community partners
    • Social services & non-profit organizations
    • Faith-based organizations
  • Other clinical partners
    • Behavioral health
    • Homeless health
Awareness & Experience

• Core competencies in palliative care
  ◦ Assessment & management of
    ◦ Pain
    ◦ Non-pain symptoms
    ◦ Psychosocial needs/distress
    ◦ Spiritual needs/distress
  ◦ Evidence-based prognostication
  ◦ Assessment of patient/family goals and applying them to medical decision-making
  ◦ Facilitating advance care planning
  ◦ Evaluating hospice eligibility & referring as needed
Organizational Readiness

• Structures & Relationships
  ◦ Flexibility in care delivery
  ◦ Addressing patient needs after hours
  ◦ Connection to
    ◦ Primary care groups
    ◦ Specialty care groups
    ◦ Complex care management groups/Special Populations
Organizational Readiness

• Team composition
  ◦ Which disciplines are included on the team?
    ◦ Physician
    ◦ Nurse(s)
    ◦ Social worker
    ◦ Chaplain
  ◦ What do the team members do? Do they have other responsibilities?
  ◦ To what extent do team members work together or separately?
Organizational Readiness

• Standard procedures/workflows
  ◦ Clinical assessments done routinely
  ◦ Tools used
  ◦ Patient identification – proactive or reactive?
Organizational Readiness

• Time for non-clinical activity
  ◦ Continuing education
  ◦ Quality assessment & improvement activities
  ◦ Data collection & Reporting
  ◦ Network development
Organizational Readiness

• Ability to expand
  ◦ Current capacity
  ◦ Near-term capacity
  ◦ Factors influencing ability to grow/maintain growth
Are you/partners ready to deliver palliative care?

- Awareness & Experience
  - Context of Serious Illness
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Gap Analysis Example: Alameda Alliance

• QUESTIONS:
  ◦ Who is currently providing palliative care in Alameda County?
  ◦ Who might be able and willing to serve as SB 1004 providers?

• Alameda context
  ◦ Alameda Alliance serves 270,000 members
    ◦ Initially estimated 2,200 members may be SB 1004 eligible
  ◦ Network
    ◦ Alameda Health System: 5 hospitals + 4 wellness centers
    ◦ 4 additional hospitals, 8 CHCN clinics
    ◦ Several unaffiliated FQHCs + solo providers
    ◦ Several community hospice organizations
Gap Analysis Example: Alameda Alliance

**Approach**

- Hired a project manager to spearhead efforts
- Created list of potential palliative care partners
- Developed and implemented surveys of potential provider/community partners
  - Palliative care specialist groups
  - Hospice organizations
  - Primary care & other community-based organizations
- Performed interviews/focus groups with key stakeholders
- Report on findings
  - Identified SB 1004 partners
  - Identified gaps in palliative care capacity
Gap Analysis Example: Alameda Alliance

• Analysis Findings
  ◦ 163 surveys distributed, approximately 51 returned (38 providers)
    ◦ Hospitals, Hospice organizations
    ◦ Community-based organizations, primary care
  ◦ Different perceptions of what it means to provide palliative care
    ◦ Frontline (“primary”) vs. specialty palliative care
    ◦ Training/experience of providers
Gap Analysis Example: Alameda Alliance

• Analysis Findings
  ◦ Mixed excitement/interest and some hesitancy
  ◦ General themes: complexities of caring for high-need population for longer—need dedicated SW/case mgmt help, costs of providing IDT, address diversity issues—culture, language, health care experiences; look to Alliance for leadership/support in delivering SB 1004
  ◦ Hospital needs: additional staff to manage referrals, increased partnership with community providers, clarity on appropriate referrals (e.g., diagnosis, stage of illness)
  ◦ Primary care provider needs: training, access to pc specialists for consults, collaboration among providers, expanded time and funding to manage/see palliative patients
  ◦ Community-based organization needs: resources, greater partnership with health care
Gap Analysis Example: Alameda Alliance

• How this work has influenced SB 1004 planning
  ◦ Helped to provide (much) greater detail on organizational readiness to deliver services
  ◦ Who Alliance will contract with
  ◦ What gaps & concerns exist in partner organizations, frontline providers

  ◦ Helped to identify strong frontline palliative care providers
    ◦ Potential referral sources
    ◦ May be able to help address palliative care need outside of SB 1004 eligibility (farther upstream)

  ◦ Helped to identify areas of need (e.g. education, networking)

Presenting findings at Palliative Care Summit on February 2
Addressing Gaps in Readiness
Addressing Gaps in Readiness

- **Review/share**: Review/share concerns about gaps with your payer/provider partner
- **Discuss**: Discuss opportunities/strategies to fill the gap
- **Evaluate**: Evaluate likelihood that gap can be filled in timely manner
Review with partner(s): Gaps in Readiness?

- Awareness & Experience
  - Context of Serious Illness
  - Awareness of Resources

- Core Competencies

- Organizational Readiness
  - Structures & Relationships
  - Team composition
  - Standard procedures/workflows
  - Time for non-clinical activity
  - Ability to expand
Addressing Gaps: Strategies

Internal
• Hire new staff
• Train existing staff

External
• Outsource to partner
Review with partner(s): Ways to Fill in Gaps?

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<tr>
<th>Organizational characteristic</th>
<th>Strategies to address</th>
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<tbody>
<tr>
<td>Core Competencies</td>
<td>Train existing staff</td>
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<td>Train existing staff</td>
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<td>Awareness of Resources</td>
<td>Share resources, make connections</td>
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Review with partner(s): Ways to Fill in Gaps?

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<td>Organizational Readiness</td>
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<td>Structures &amp; Relationships</td>
<td>Evaluate capacity to restructure</td>
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<td>Share resources, make connections</td>
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<tr>
<td>Team composition</td>
<td>Reallocate existing staff</td>
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<td>Reallocate existing staff</td>
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<td>Hire new staff</td>
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Evaluate

- Awareness & Experience
  - Context of Serious Illness
  - Awareness of Resources

- Core Competencies

- Organizational Readiness
  - Structures & Relationships
  - Team composition
  - Standard procedures/workflows
  - Time for non-clinical activity
  - Ability to expand

Partner able to fill in gaps

Collaboration possible to fill in gaps

Partner won’t be able to fill in gaps
Discussion

• Have you been able to do any gap analysis work?
  ◦ If so, what have you learned?
  ◦ If not, are there partners you especially want to reach out to?

• What are the questions that remain, in terms of you or your partners’...
  ◦ ...readiness to deliver SB 1004 palliative care?
  ◦ ...ability to fill in identified gaps?

RESOURCE: Gap Analysis Worksheet
BREAK
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- Referral strategies
- Lessons learned about patient/member referral
- Summary and closing
Moving from Planning to Implementing

- Estimating need
- Estimating costs
- Identifying partner(s)
- Developing contracts, agreements
- Developing policies and procedures
- Developing workflows
  - Patient identification and referral
  - Review and authorization/denial
  - Data collection, reporting, review
Patient Identification & Referral

• Preparation
• Workflows and Policies
• Patient outreach
Preparation: Provider Education & Outreach
Preparation: Provider Education & Outreach

• Identify key partners
  ◦ Access to clinical information, can help with prognosis, patient trust
    ◦ Specialty care clinics (cardiology, pulmonology, hepatology, oncology)
    ◦ Primary care
  ◦ People/organizations who may recognize functional decline earlier than providers
    ◦ Social work
    ◦ Case management
    ◦ IHSS workers
Helping Providers to Move Palliative Care “upstream”
Preparation: Provider Education & Outreach

• Explore with stakeholders
  ◦ What do you wrestle with most, when caring for seriously ill patients?
  ◦ What additional support(s) would be most valuable to you, in caring for seriously ill patients?
  ◦ What additional support(s) would be most valuable to your seriously ill patients?
  ◦ Are there services (clinical or social) with smooth referral processes? What works well?

• Identify potential palliative care champions

• Education
  ◦ SB 1004 basics
  ◦ Suggest CME in palliative care (e.g. CSU courses)
ZSFG Approach to Provider Education

Needs assessment
• Workflows
  • Referral
  • Pt identification
• Education
• Support
Tool to Provide “Early” Palliative Care

http://www.chcf.org/publications/2015/08/weaving-palliative-care
Workflows

Who needs to be involved
- Plan
- Providers
- Community

How & when will communication happen?
Who are the point people?
Workflows, cont.

• For plans, many considerations are likely similar to other new programs

• For palliative care providers, processes may be very different

• Patient population & service considerations
  ◦ Needs may be acute (implications for how rapidly patients need to be seen)
  ◦ The people/organizations that first recognize decline may not be the ones with all of the clinical information – will require partnership
  ◦ Each organization likely has own preferred communication method/style
  ◦ May be difficult to separate psychosocial contributors and medical causes for decline
  ◦ Anticipate that providers will likely have little bandwidth for reviewing patient panels proactively – may need to build in opportunities to review potentially eligible patients
Workflows

- Patient identified
- Patient referred
- Patient seen
- Data collected
- Data reported
Considerations for Patient Identification

Attend to unique patient population

Proactive approach
Considerations for Patient Identification: Attend to Unique Patient Population

Medi-Cal population

- Patients (more) often present late in illness course
- Some will be unable to engage with providers in typical ways
- Mistrust of medical system
- Cultural/language barriers

Strategy suggestions

- Develop mechanisms to identify patients at time of diagnosis
- Partner with trusted providers/organizations to identify eligible patients (medical, social service, community)
Considerations for Patient Identification: Proactive Approach

• Typically systems have a reactive approach to palliative care referral
  ◦ Since (more) Medi-Cal patients will present late, it can be more challenging to identify them in time to get the most benefit from palliative care services
  ◦ Referring providers may have lingering misconceptions about when palliative care is appropriate

• For SB 1004 referral, it will be important to shift to a more proactive approach to patient identification
Proactive Approaches to Patient Identification

Payer Strategies

Provider Strategies

BOTH
Proactive Approaches to Patient Identification

Use claims data to look for potentially eligible patients
- Examples: dx, DME, utilization, costs

Set routine intervals for patient identification

Develop workflow for pushing information to providers

Payer Strategies
Develop clinical triggers to identify patients
  ◦ New diagnosis
  ◦ New event

Perform routine reviews of patient panels

Palliative Care participates in case conferences
Proactive Approaches to Patient Identification

Payer strategies likely to OVER-identify

Provider strategies may UNDER-identify

Combination strategy requires most effort, but is likely best for identifying the right patients
What other workflow issues would be helpful to discuss?
Patient Identification & Referral

✓ Preparation
✓ Workflows and Policies
• Patient outreach
What are your concerns or questions about reaching out to patients/members to tell them about SB 1004 palliative care services?
What do we know about patient interest in palliative care?

- 2011 report by Public Opinion Strategies (commissioned by the Center to Advance Palliative Care) – 800 adults
  - 70% reported that they were “not knowledgeable” about palliative care
  - After palliative care was described/explained
    - 92% said they would recommend it for a loved one (somewhat or very likely)
    - 92% said it was important that these services would be available for people with serious illness (somewhat or very important)
    - 86% said that discussions about palliative care should be covered by insurance
    - 95% agreed that patients/families should be educated about palliative care

Clarifying what palliative care is makes all the difference
What do we know about vulnerable patients and palliative care?

• Less access to hospice care (African Americans, Latinos)
  ◦ Less likely to get frontline ("primary") palliative care (Chuang, 2017 J Pain Symptom Mgmt.)

• Focus groups, research with African-Americans suggest that personal recommendations are better than media
  ◦ Suggest outreach to churches, hospitals, SNFs (vs. printed advertisements, PSAs)
  ◦ Word of mouth from previous patients, employees, volunteers
  ◦ Recommendation from trusted providers

• Key messages
  ◦ 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.
Strategies other groups have used

- Small-group education to providers, community members
  - Chinese American Coalition for Compassionate Care
  - Familias en Accion
- Train/hire members of the community
  - Hospice/palliative care volunteers
  - Navigators, promotoras, community health workers
- Culturally/linguistically concordant staff/teams (especially in info visits/call)
- For materials used, best practices in health literacy, available in multiple languages
Recommendations: Patient/Member Outreach

- The biggest issue is clarifying what palliative care is -- patients/families want it once they know what it is
- Focus on people/relationships more than materials (but can’t forget them)
  - Who are your vulnerable patients/members?
  - Who are the trusted community advocates for those patients/members?

Key messages

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.
Work in Groups & Discussion

RESOURCE:
Patient Identification and Referral Workflows
Agenda

- Welcome and Introductions
- SB 1004 review/updates
- Conditions and supports to optimize SB 1004 delivery
- Assessing capacity to deliver palliative care, identifying gaps
- BREAK
- Referral strategies
  - Lessons learned about patient/member referral
  - Summary and closing
Examples of organizations with patient identification processes

- Partnership Health Plan
- Health Plan of San Joaquin
- Outreach Care Network
Medi-Cal Palliative Care

Outreach Care Network
Questions/Discussion
Lessons Learned about Patient Identification & Referral

• 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 (can) accept services
Agenda

- Welcome and Introductions
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• Summary and closing
Review of objectives

• Describe the conditions and supports required to optimize the delivery of SB 1004 palliative care
  ◦ Understanding context will help you make wise decisions about program design/adjustment
    ◦ Need >>> SB 1004 eligibility
    ◦ Interdisciplinary work is dynamic, need to accommodate flexibility, non-billing providers
    ◦ Palliative care specialists are a scarce resource – use wisely
    ◦ Alternate care models may be needed for Medi-Cal population
  ◦ Key ingredients for optimal palliative care delivery
    ◦ Right patients
    ◦ Right time
    ◦ Right supports
Review of objectives

• Outline approaches to assess the palliative care capacity of local providers, and to identify any gaps in readiness to deliver SB 1004 palliative care
  ◦ Beyond specified SB 1004 partners, it is critical to develop a network of supportive care providers, to meet the complex needs of the Medi-Cal population
  ◦ Different lenses to explore capacity for delivering SB 1004 services
    ◦ Review required services
    ◦ Assess clinical, structural, and operational factors which contribute to organizational readiness
  ◦ Strategies to address identified gaps
    ◦ Train existing staff
    ◦ Hire new staff or reallocate existing staff
    ◦ Outsource to external partner
Review of objectives

• Discuss strategies to optimize referral of eligible members
  ◦ In order to provide most benefit for patients and have financial sustainability, it will be critical to develop proactive patient identification strategies between trusted providers and MCPs
    ◦ Provider strategies, Payer strategies, both
  ◦ Account for and get ahead of:
    ◦ Possible provider misperceptions of palliative care – make case for benefits
    ◦ Limited provider bandwidth
  ◦ Patients don’t know what palliative care is – you shouldn’t be afraid to offer it to them
Review of objectives

• Describe lessons learned about patient referral from existing Medi-Cal palliative care programs
  ◦ 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 (can) accept services
Building blocks for implementing community-based palliative care

- Estimating member/patient need
- Estimating costs for delivering services
- Assessing capacity for palliative care & launching svcs
- Gauging and promoting sustainability and success
- Lessons learned and adjusting programs

Webinar: March 2018
Workshops: April 2018
Workshops: June 2018
Suggestions for Topic 4: Gauging and Promoting Sustainability and Success

• What questions do you have about data collection and reporting (besides final answer from DHCS on exact requirement)?

• What are the areas you’ll be looking at to gauge whether the program is successful?
Acknowledgements, and final questions

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• Michelle Schneidermann & Monique Parrish at Alameda Alliance
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• Sheila Kirkpatrick & Mary Vergilio from Outreach Care Network

Questions about the SB1004 technical assistance series?
www.chcf.org/sb1004
Glenda Pacha gpacha@chcf.org

Questions about SB 1004 requirements?
◦ http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx
◦ SB1004@dhcs.ca.gov