California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

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

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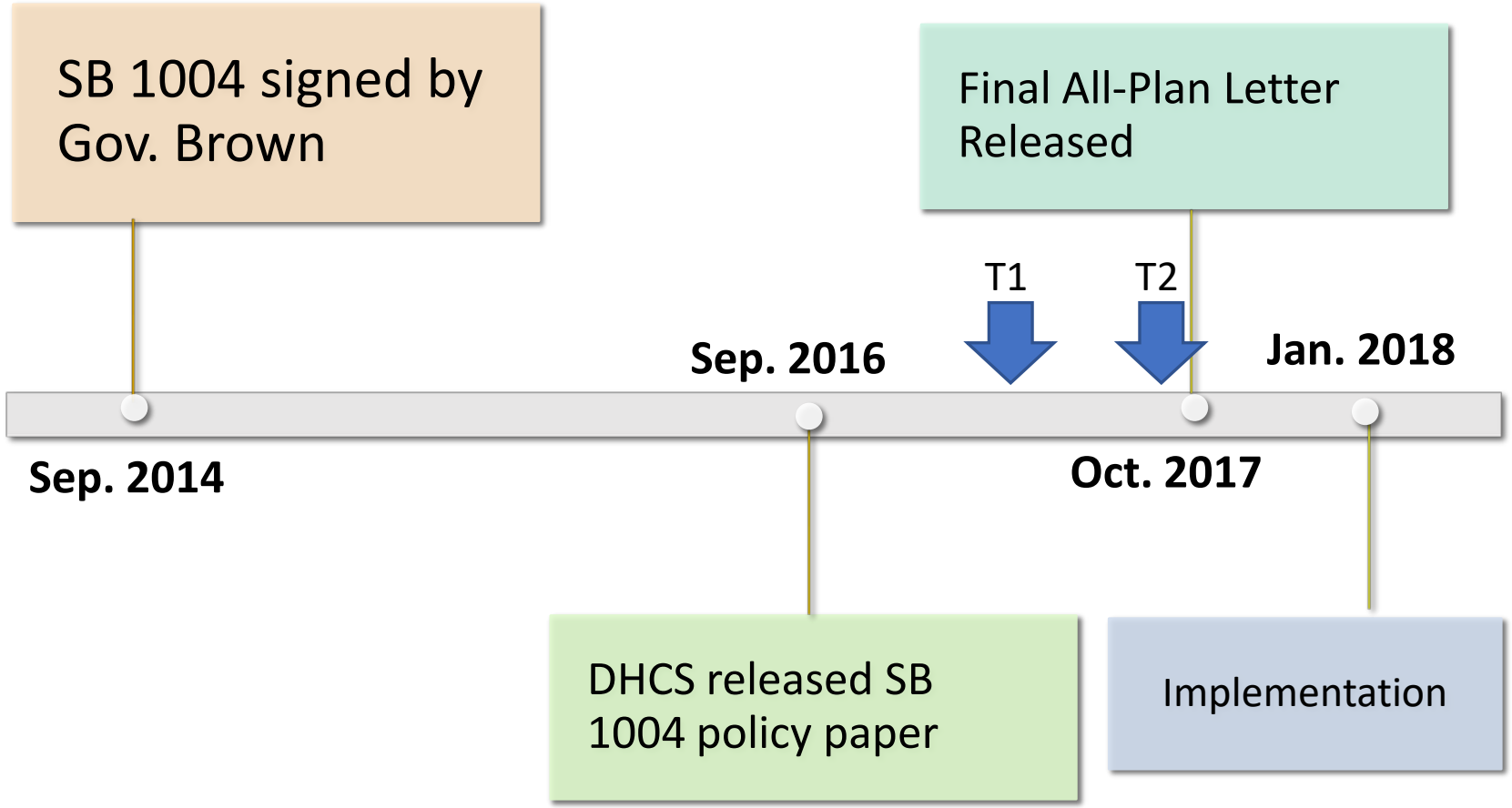
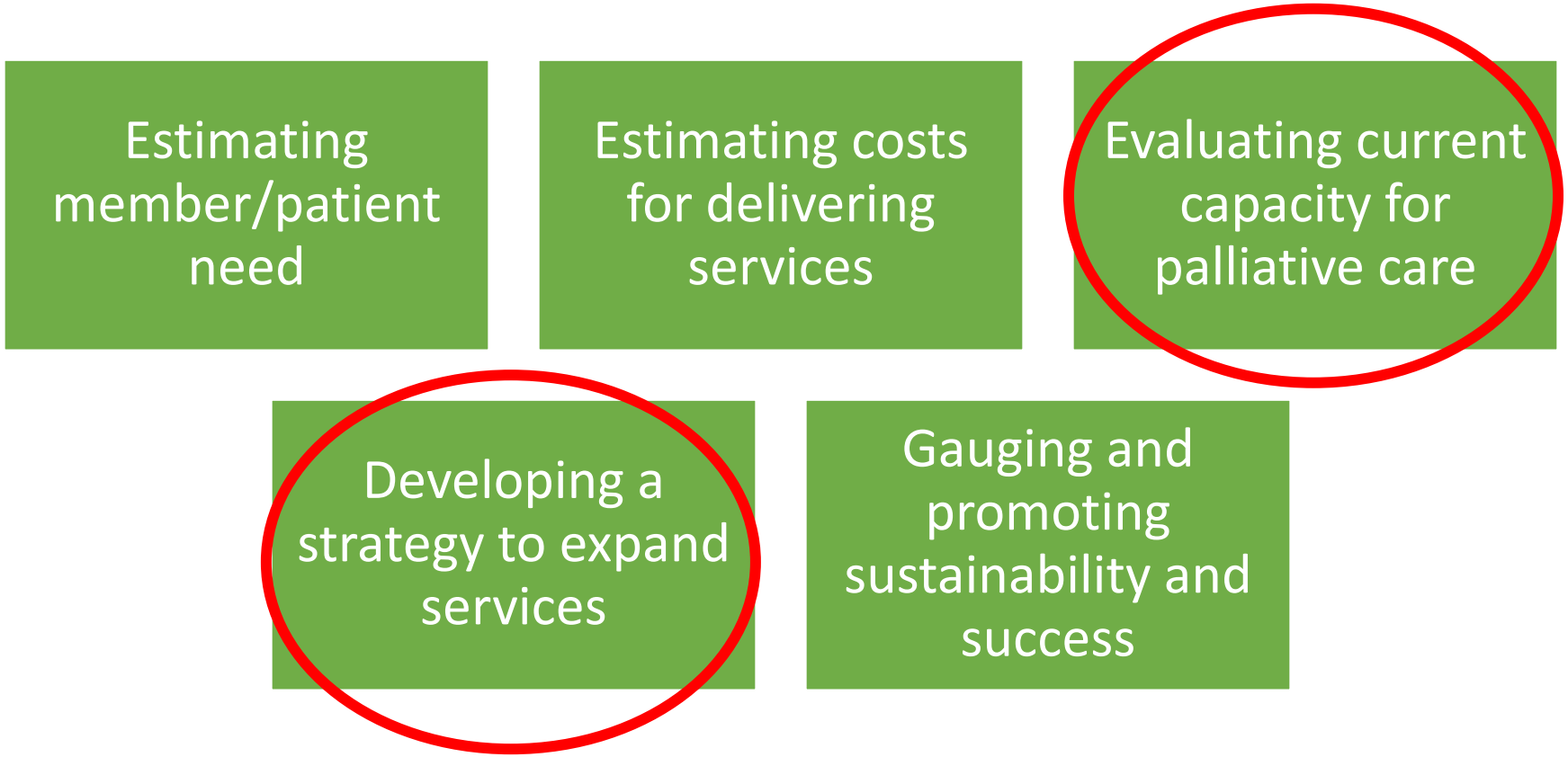
Where are we now?



Building blocks for implementing community-based palliative care



Building blocks for implementing community-based palliative care

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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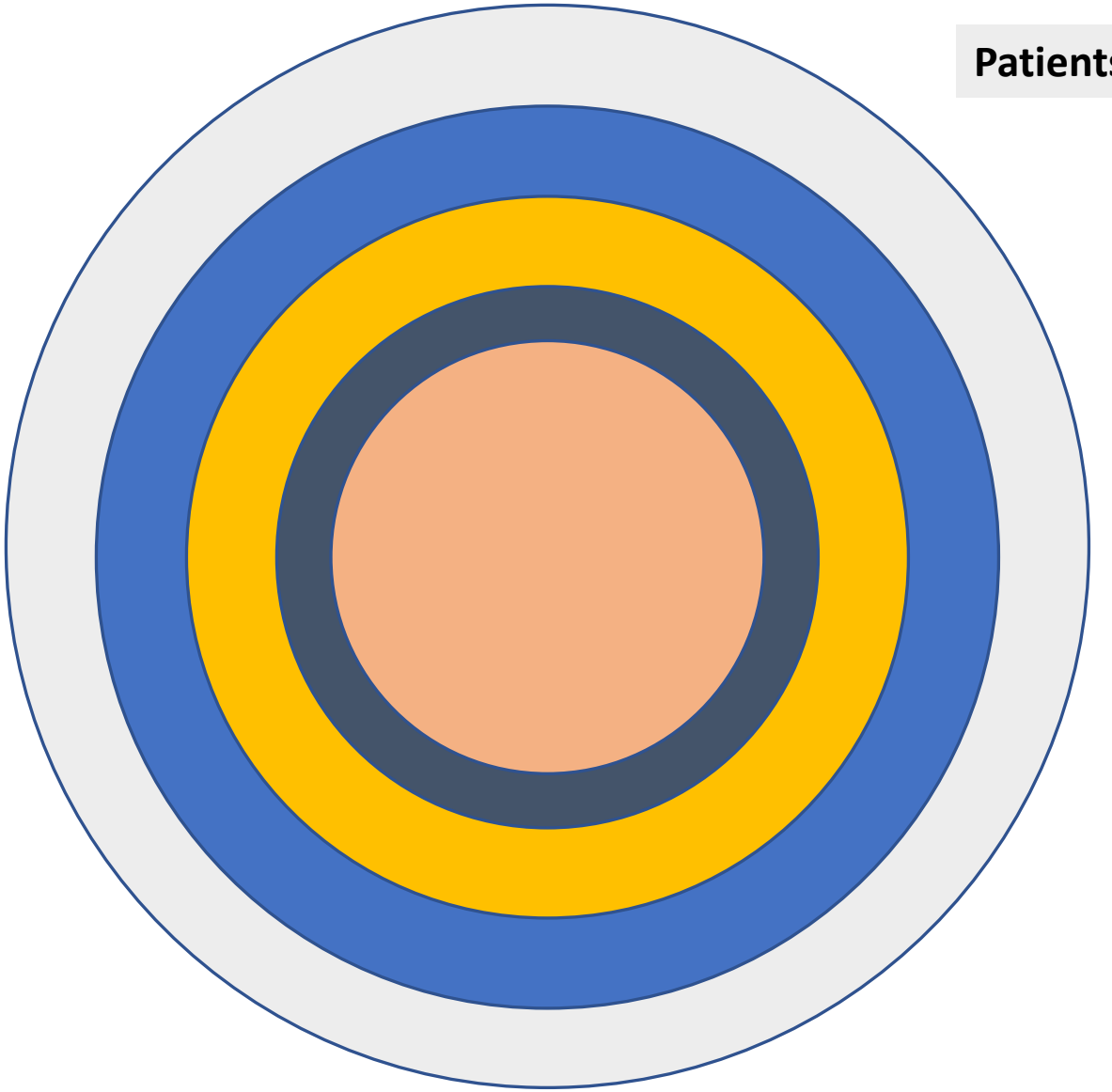
Conditions and Supports to optimize SB 1004 palliative care delivery

- 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

Palliative Care Context

#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 who would benefit from PC

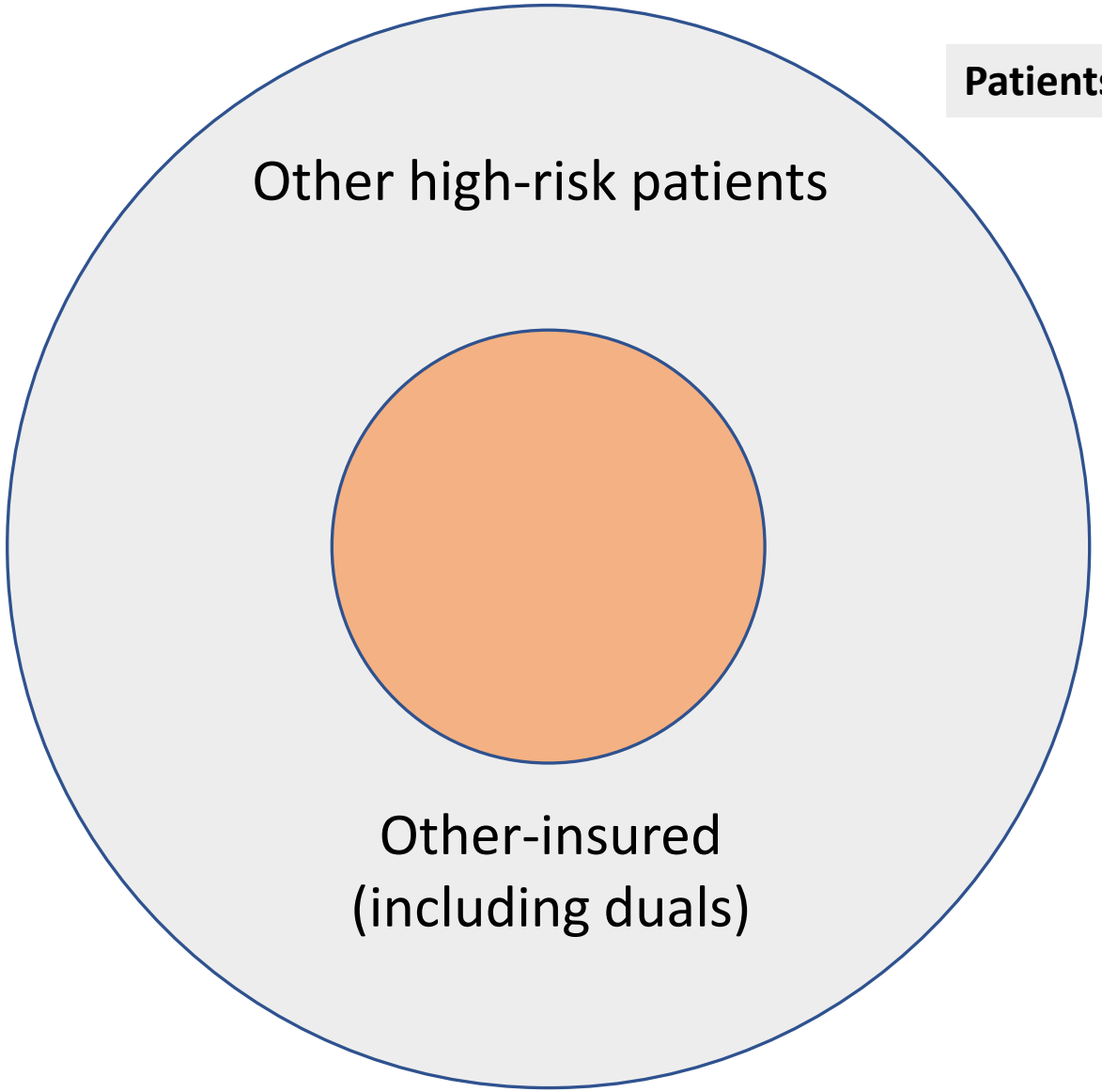
Patients with SB1004 conditions

SB1004 eligible patients

Eligible patients who are referred/identified

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

SB1004 Population in Context



Patients who would benefit from PC

GAP

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

Palliative Care Context

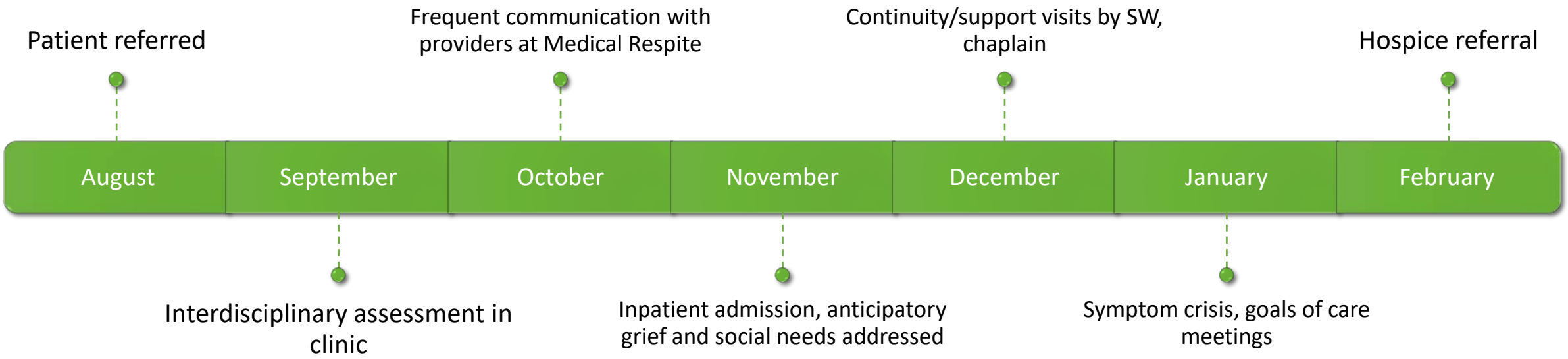
#1: The palliative care needs of your members/patient population will be far greater than what is required by SB 1004

IMPLICATION:
You need to plan for how you will address the gap between need and SB 1004 eligibility (providers, patients/members will ask!)

Palliative Care Context

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

Team magic


Patient referred
Frequent communication with providers at Medical Respite
Continuity/support visits by SW, chaplain
Hospice referral
August
September
October
November
December
January
February
Interdisciplinary assessment in clinic
Inpatient admission, anticipatory grief and social needs addressed
Symptom crisis, goals of care meetings

Team Magic

Transdisciplinary care

Task	Nurse Practitioner	Social work	Chaplain	Physician
Advance Care Planning	✓	✓	✓	✓
Symptom Management	✓✓	✓	✓	✓✓
Plan of Care	✓	✓	(✓)	✓
Mental Health and Medical Social Services		✓	(✓)	
Care Coordination	✓	✓	(✓)	✓
Data collection	✓	✓	✓	✓
Patient calls	✓	✓	✓	✓

Palliative Care Context

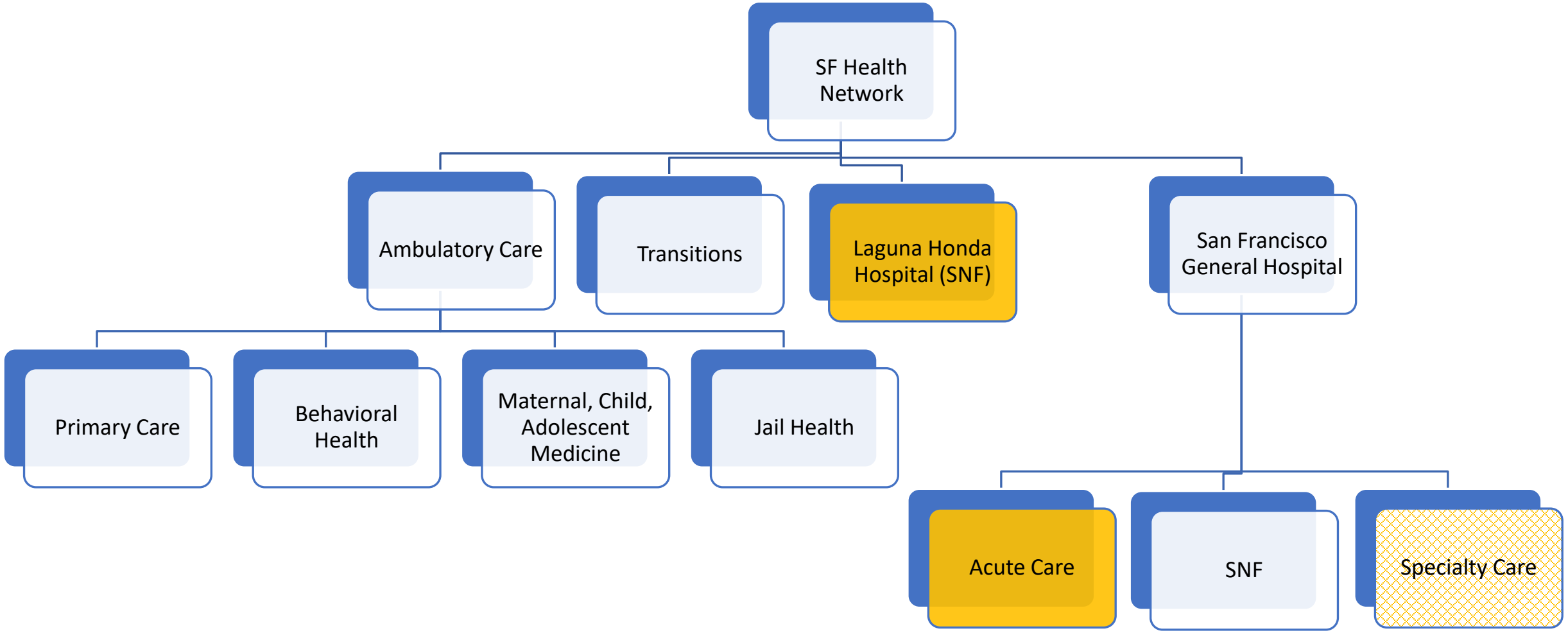
#2: Palliative care needs are dynamic and different interdisciplinary team members will take the lead in different situations

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

Palliative Care Context

#3: Palliative care specialists are a scarce resource

Access to Specialty Palliative Care in SF Health Network



Palliative Care Specialists are scarce

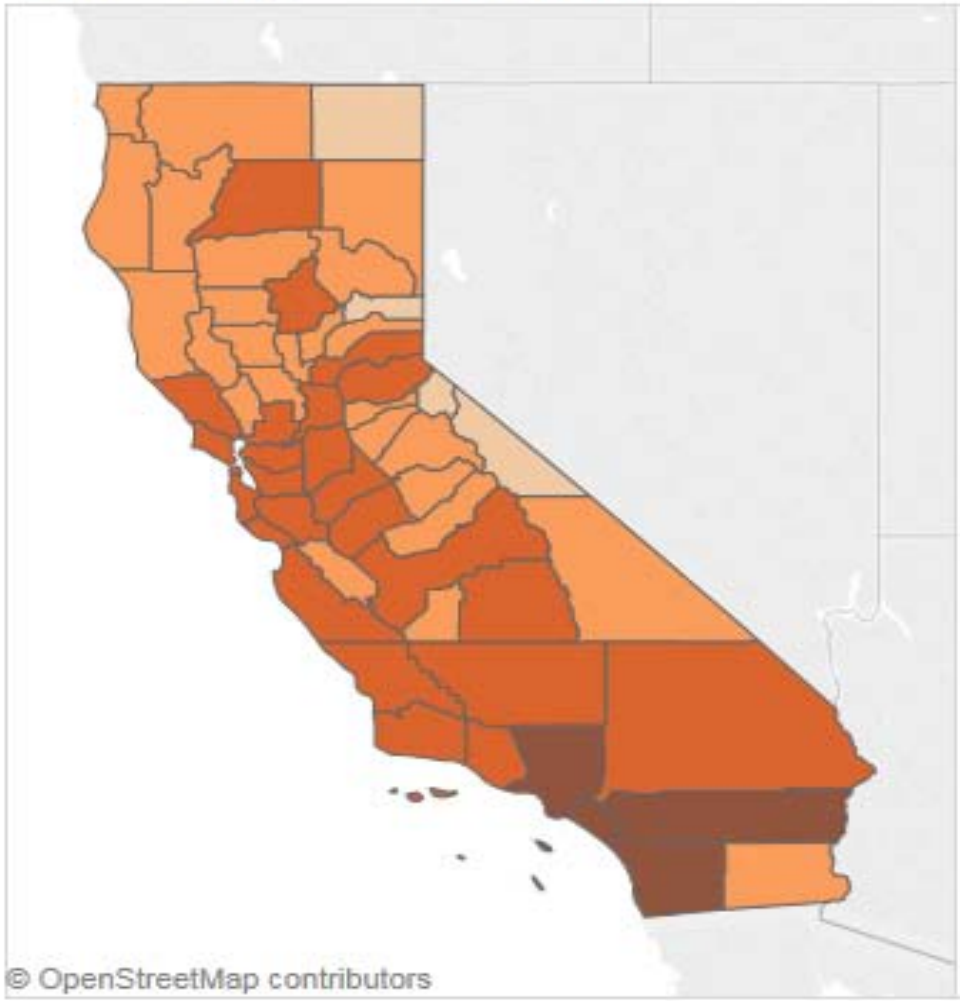
- In 2010, estimated physician shortage of 6,000-18,000 just to staff *existing services* appropriately (Lupu, 2010 J Pain Symptom Management)
- Certified/designated PC workforce in California (2012 data, CSU Institute for Palliative Care)
  - 914 physicians
  - 89 NPs
  - 975 RNs
  - 146 CNAs
  - 43 SWs
  - 171 chaplains

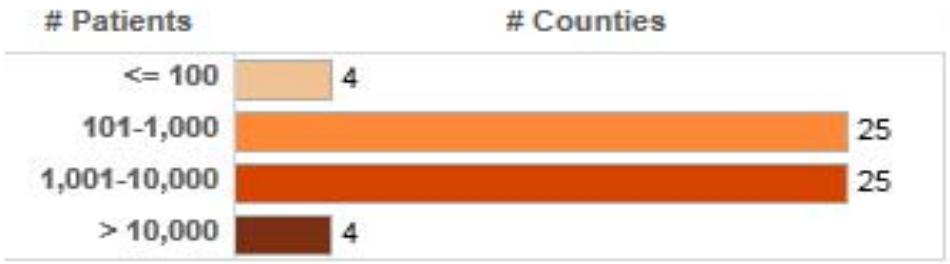
Are there enough specialty PROGRAMS?

http://www.chcf.org/publications/2015/02/palliative-care-data

Estimated Palliative Care Need

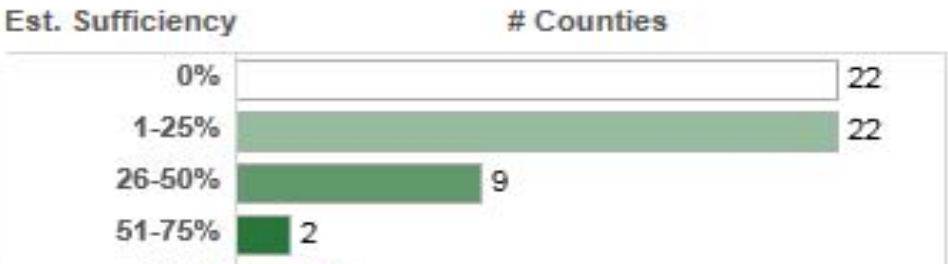
Patients Needing PC in the Last Year of Life





Estimated Community-Based PC Sufficiency

Community-Based PC Capacity as % of Need



Palliative Care Context

#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

ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

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

Key Ingredients for Palliative Care

Right patients

Right time

Right supports

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

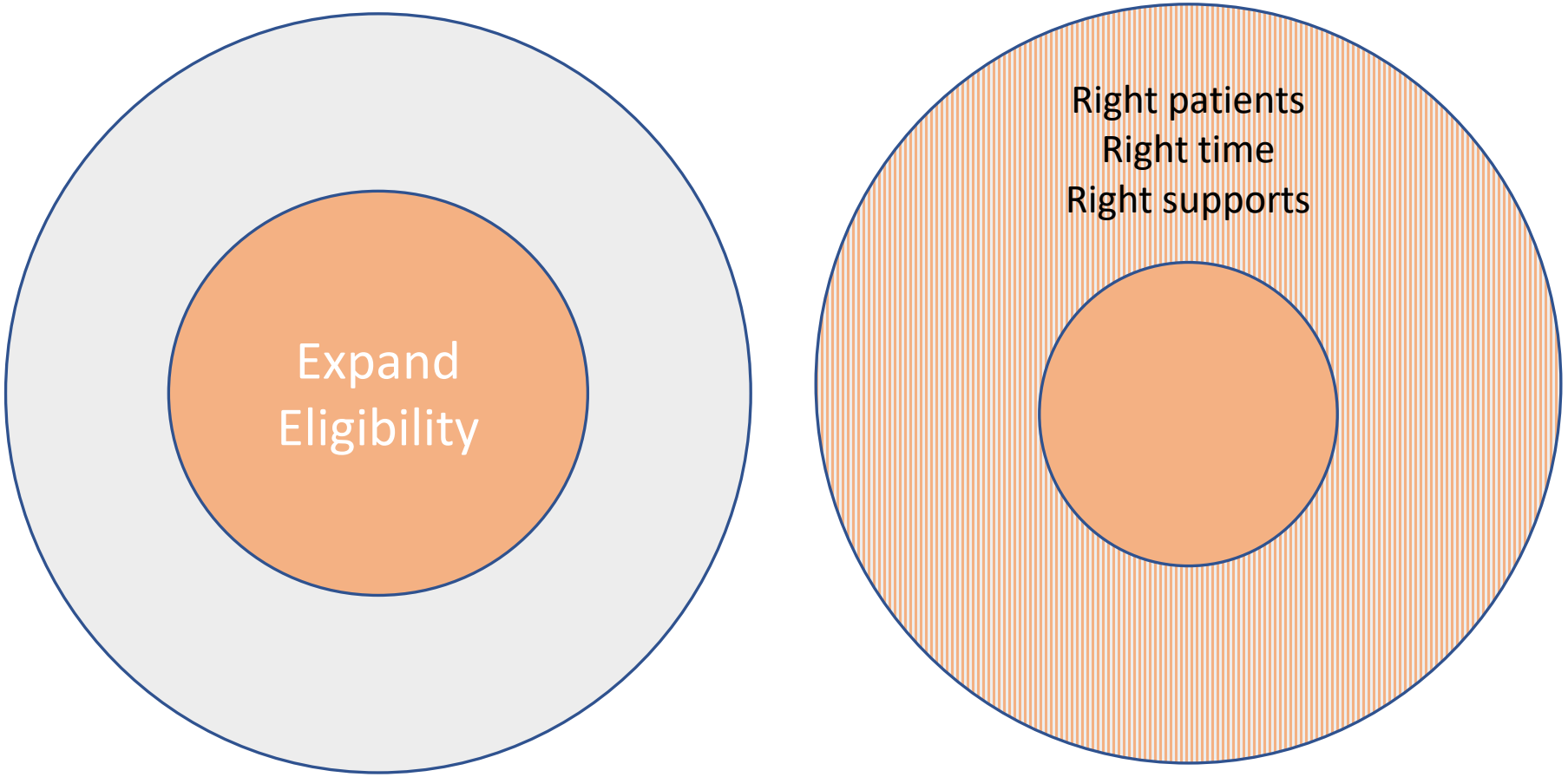
Right Time

- 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



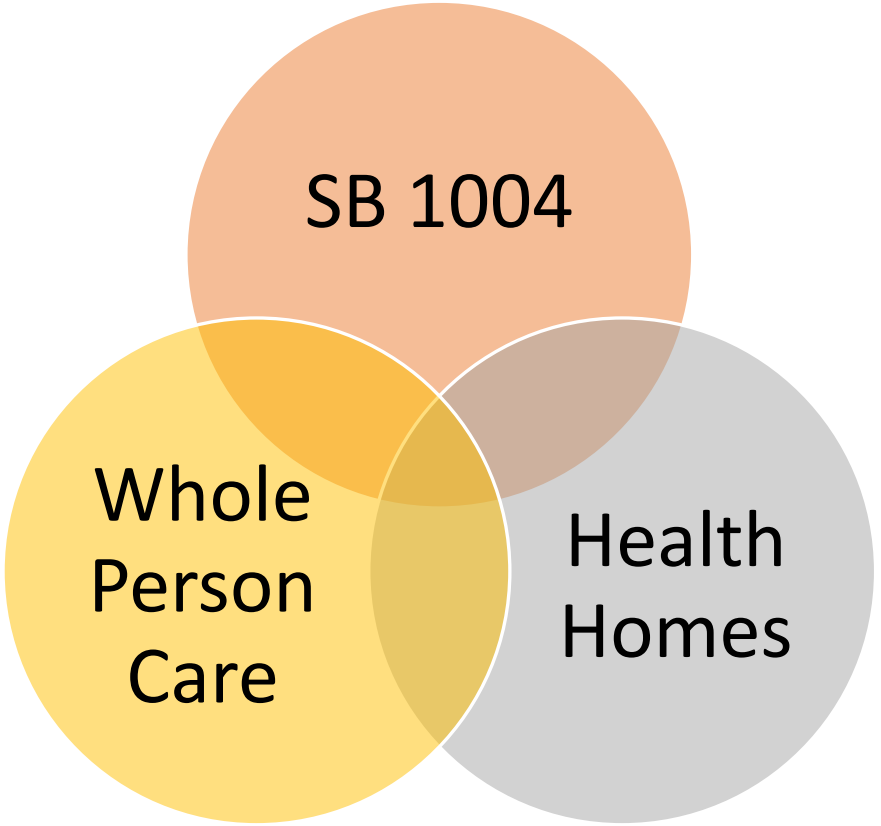
Frontline (“primary”) palliative care

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

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
- 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

Intersection with Other Programs

	SB 1004	Health Homes	Whole Person Care
Where it comes from	2014 CA legislation	ACA section 2703 2013 CA legislation (AB 361)	Medicaid 1115 waiver
Mandatory?	Yes	No	No

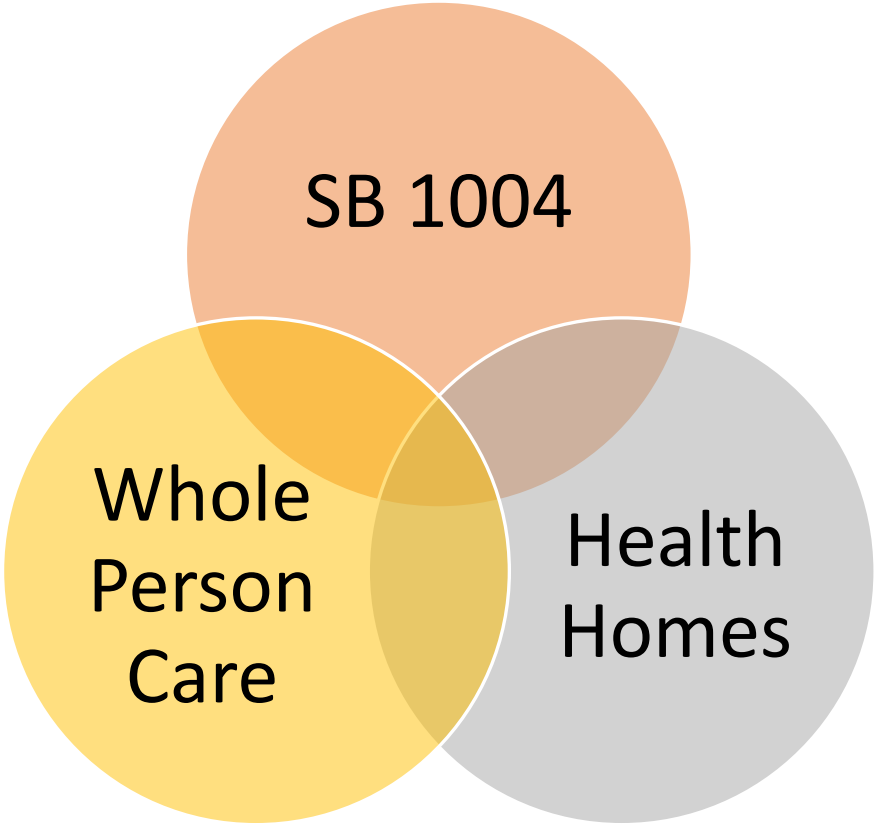
Eligibility	• General
	  • Utilization
	  • Prognosis
	  • Pt willing
	• Disease-specific
	  • CHF
	  • COPD
	  • Cancer
	  • ESLD
		• Highest risk 3-5% of Medi-Cal population *likely to improve with support*
		• High acuity and/or complexity
		• 3+ chronic medical conditions, 1+ psychiatric
			"HUMS"
			Defined by organizations
			
			<u>Subpopulation examples</u>:
			Homeless
			Incarcerated
			Substance use treatment
			Mental health

Intersection with Other Programs

	SB 1004	Health Homes	Whole Person Care
Services included	• 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

Intersection with Other Programs

How are you thinking about triaging members to one program vs. another, or coordination among programs?



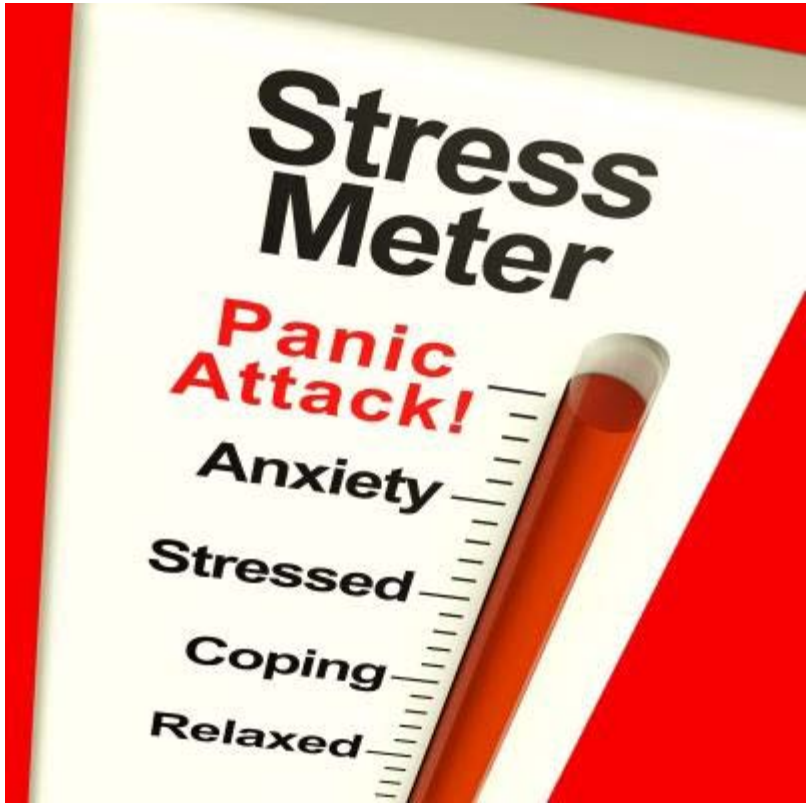
Work in Small Groups

CONNECTING PALLIATIVE CARE PARTNERS worksheet

Agenda

- ✓ 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

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?

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  - ❑ Team composition
  - ❑ Standard procedures/workflows
  - ❑ Time for non-clinical activity
  - ❑ Ability to expand

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

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

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

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

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

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

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

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

Addressing Gaps in Readiness

Addressing Gaps in Readiness

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?

Organizational characteristic	Strategies to address
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

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

Organizational characteristic	Strategies to address
Organizational Readiness	
Structures & Relationships	Evaluate capacity to restructure Share resources, make connections
Team composition	Reallocate existing staff Hire new staff
Standard procedures/workflows	Leverage lessons learned from other initiatives
Time for non-clinical activity	Explore avenues to support QI, professional development
Ability to expand	Reallocate existing staff Hire new staff

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

Agenda

- ✓ Welcome and Introductions
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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

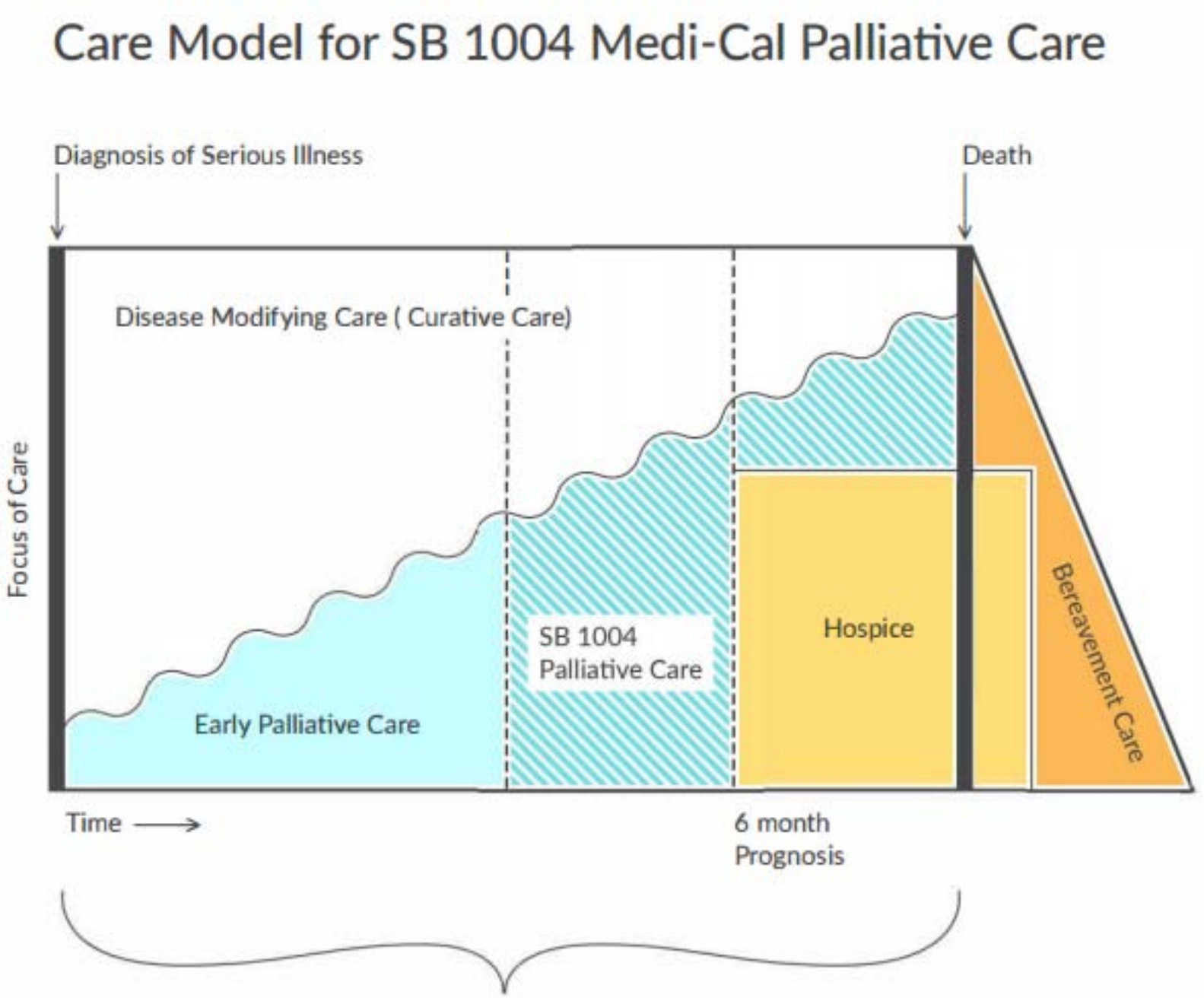
- Preparation
- Workflows and Policies
- Patient outreach

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

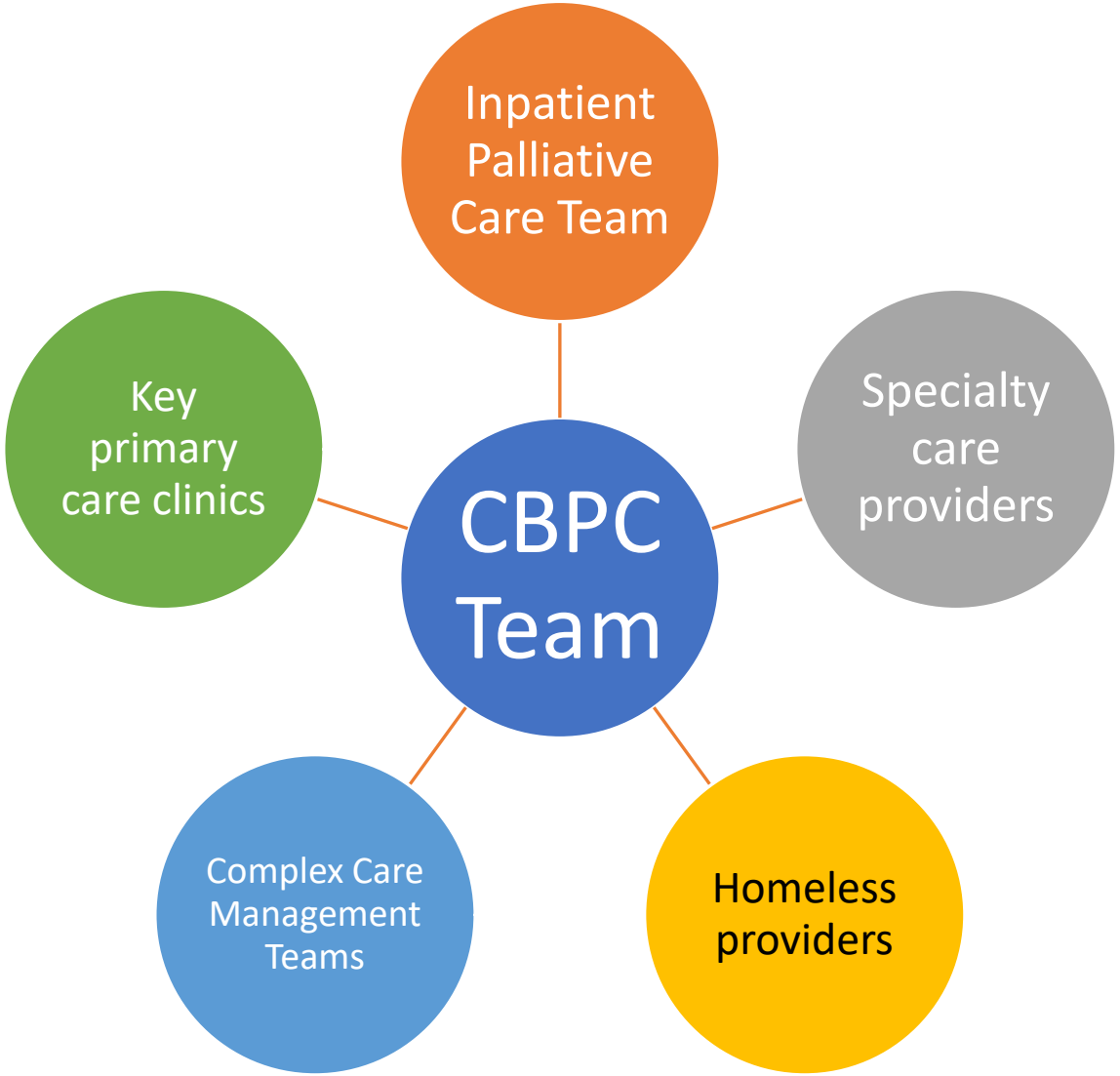
Helping Providers to Move Palliative Care “upstream”



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

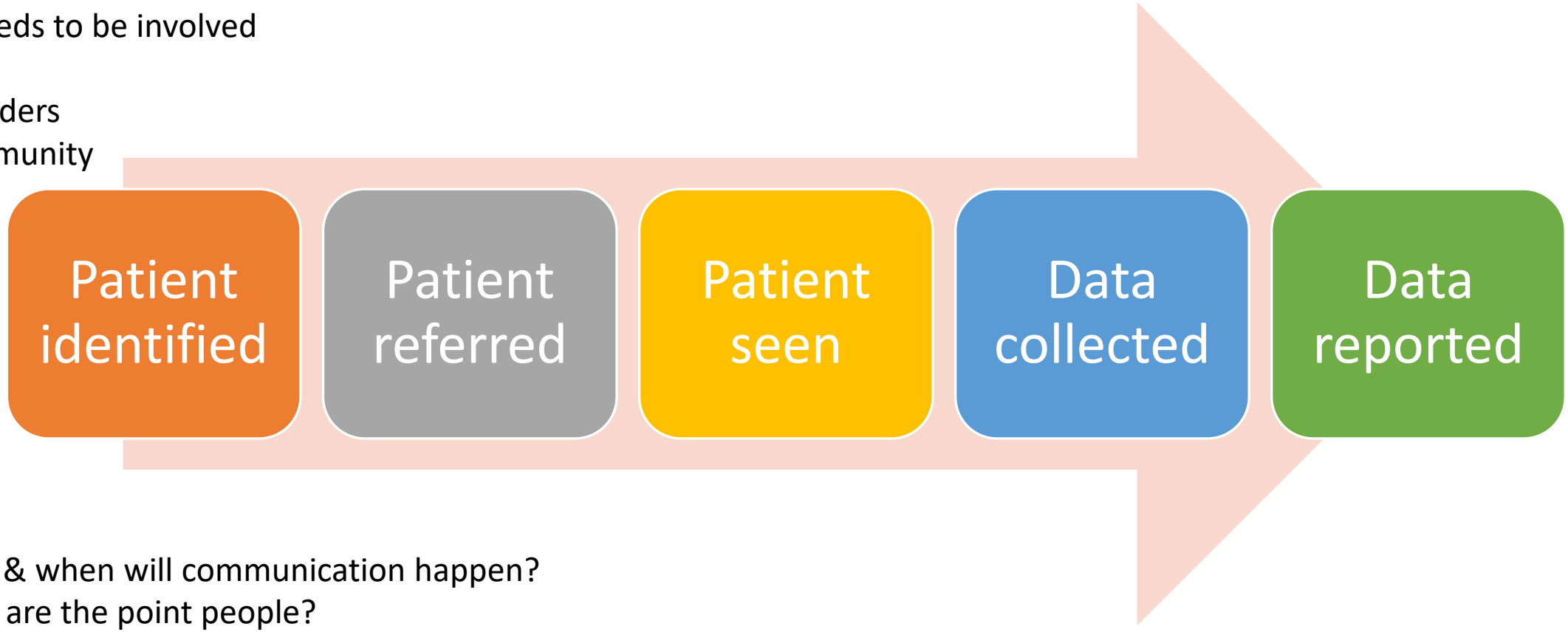
Tool to Provide "Early" Palliative Care

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

Workflows

Who needs to be involved

- Plan
- Providers
- Community

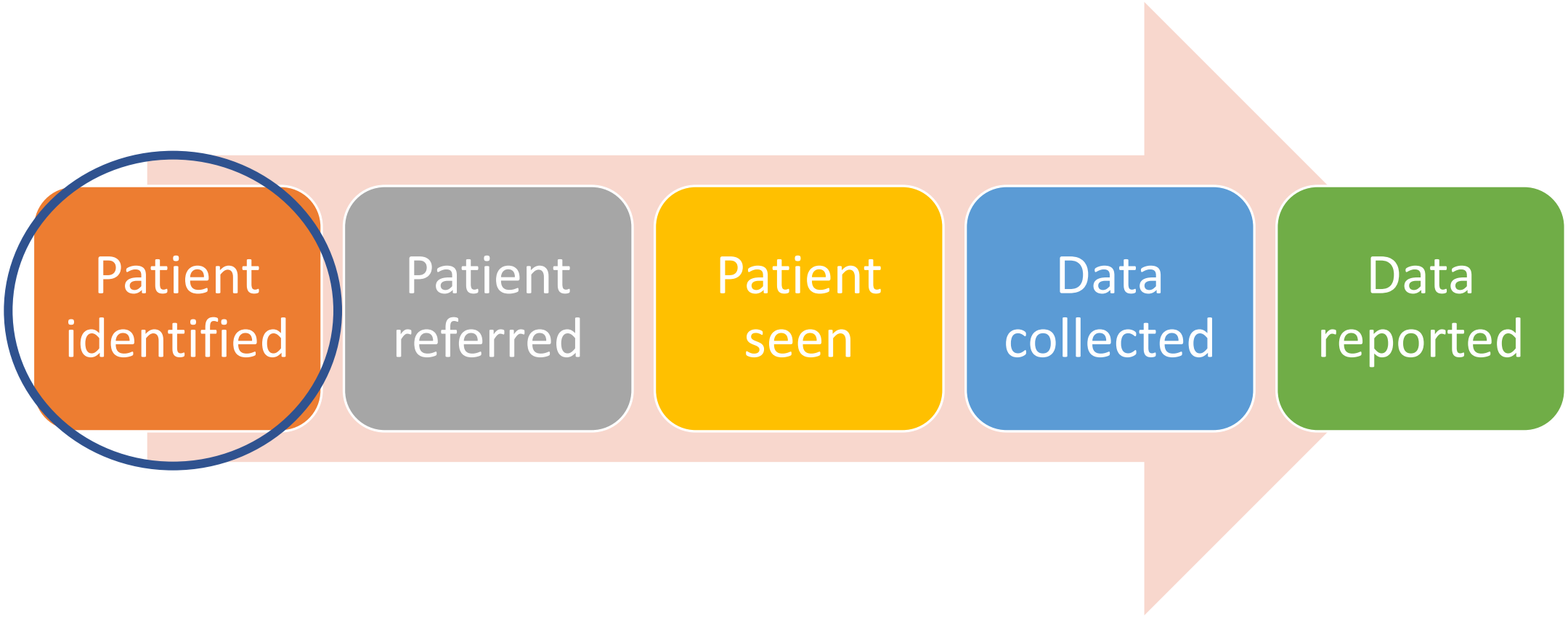


How & when will communication happen?
Who are the point people?

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

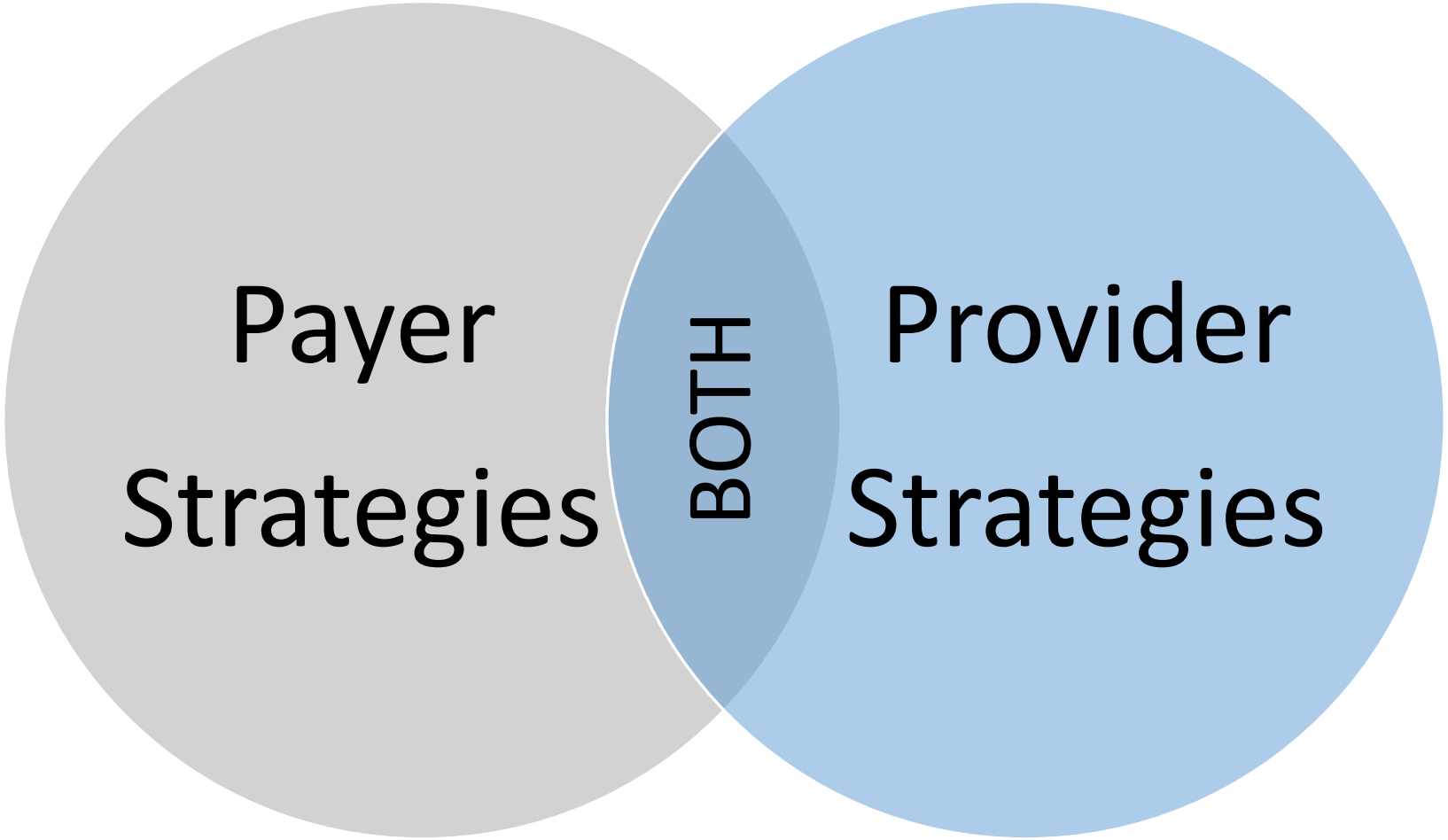
Strategy suggestions

- 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



Proactive Approaches to Patient Identification

Payer Strategies

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

Proactive Approaches to Patient Identification

Develop clinical triggers to identify patients

- New diagnosis
- New event

Perform routine reviews of patient panels

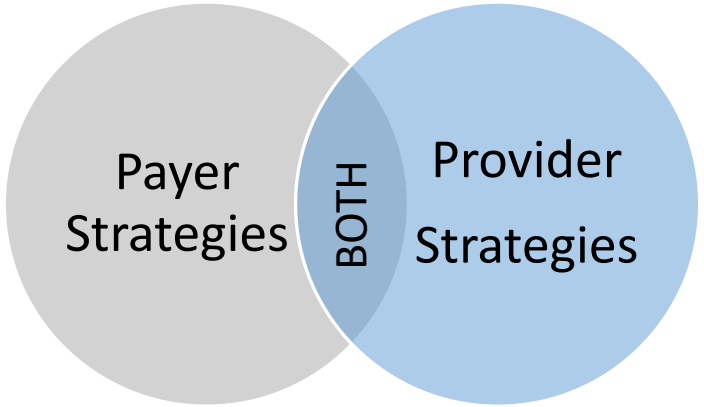
Palliative Care participates in case conferences

Proactive Approaches to Patient Identification

Payer strategies likely to OVER-identify

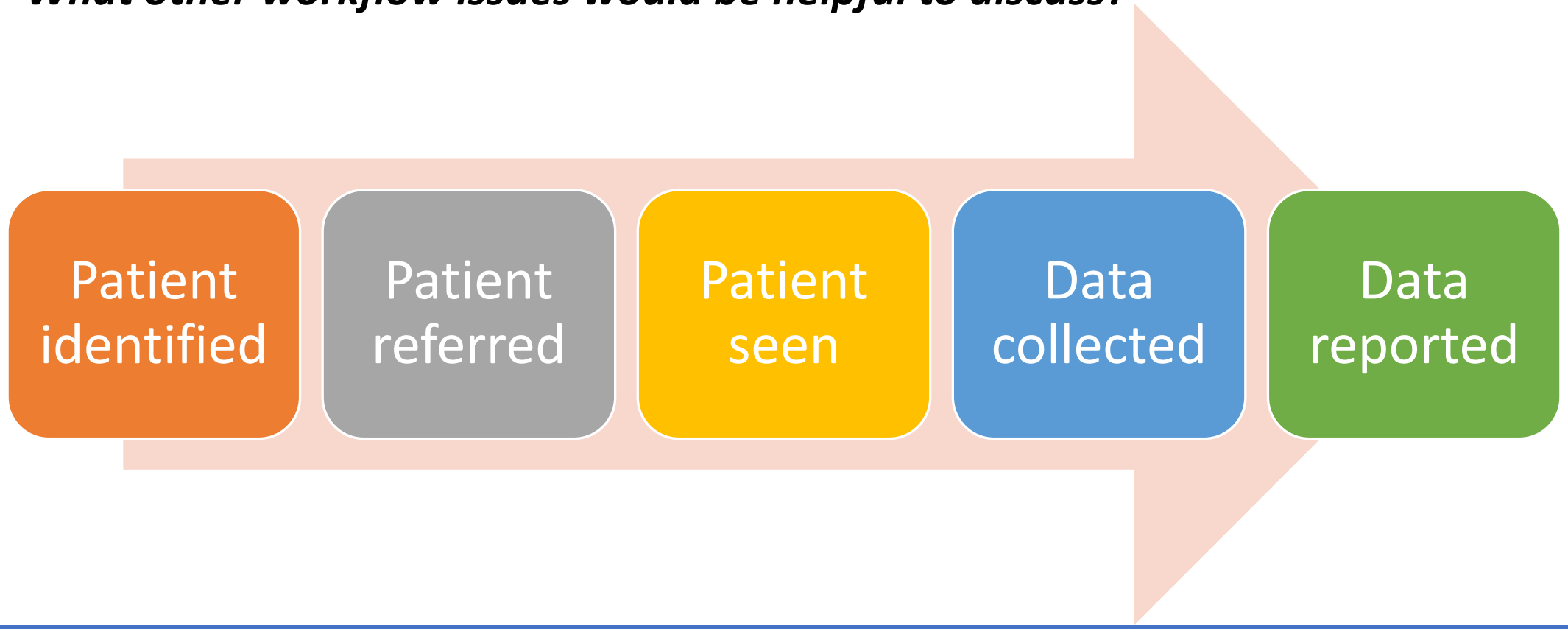
Provider strategies may UNDER-identify

Combination strategy requires most effort, but is likely best for identifying the right patients



Workflows

What other workflow issues would be helpful to discuss?



Patient Identification & Referral

- ✓ Preparation
- ✓ Workflows and Policies
- Patient outreach

Patient/Member 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

Health Plan of San Joaquin

COMPANION
HOSPICE, HOME HEALTH & PALLIATIVE CARE
Enhancing Quality of Life

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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- ✓ Lessons learned about patient/member referral
- **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

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

Thanks to colleagues who shared their knowledge, wisdom and experiences

- Michelle Schneidermann & Monique Parrish at Alameda Alliance
- Lakshmi Dhanvanthari & Maria Aguglia from Health Plan of San Joaquin
- 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