Variables That Impact the Cost of Care Delivery

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SB 1004 Palliative Care

SB 1004 (Hernandez, Chapter 574, Statutes of 2014) requires the Department of Health Care Services (DHCS) to "establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services"

Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Palliative care may be provided concurrently with curative care and does not require the beneficiary to have a life expectancy of six months or less.

Policy documents, contact information for DHCS available at SB1004 web site:

http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Revised implementation date: January 1, 2018

Information in this slideset reflects content of the October 2017 All Plan Letter (APL)

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

Workshop objectives

1. Become familiar with SB 1004 required services, providers, settings
2. Appreciate service model and contract features that influence the cost of delivering SB1004 palliative care
   a) Variables related to patient care
   b) Operational/administrative variables
3. Consider strategies to promote alignment between payment and costs
4. Consider issues that contribute to the quality and success of (new) payer-provider partnerships

Workshop structure

- Review SB 1004 required services, providers, settings
- Explore variables that impact the cost of delivering care
- Begin "Decision Points" worksheet
- Case presentation by Linda J. Gibson, President & CEO, Collabria Care
- Review a few lessons learned from CHCF's Payer-Provider Partnership Initiative
- Review and closing

Palliative Care Definition

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

SB 1004 population

General and disease specific criteria

- Qualifying diagnoses: COPD, advanced cancer, heart failure and advanced liver disease
- Evidence of advanced disease
- Patient and caregiver / family preferences

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Seven required services

1. Advance Care Planning
2. PC Assessment & Consultation
3. Plan of Care
4. PC Team
5. Care Coordination
6. Pain and symptom management
7. Mental Health and Medical Social Services

- (Chaplain Services)
- (24/7 telephonic support)

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Advance care planning

Advance care planning for beneficiaries enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment forms.

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

PC assessment and consultation

The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:

- Treatment plans, including palliative care and curative care
- Pain and medicine side effects
- Emotional and social challenges
- Spiritual concerns
- Patient goals
- Advance directives, including POLST forms
- Legally recognized decision maker

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Plan of care

A plan of care should be developed with the engagement of the beneficiary and/or his or her representative(s) in its design. If a beneficiary already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A beneficiary's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.

See APL and DHCS web site for most recent policy documents
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PC team

The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of beneficiaries and their families and are able to assist in identifying sources of pain and discomfort of the beneficiary. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team includes, but is not limited to, a doctor of medicine or osteopathy (Primary Care Provider if MD or DO), a registered nurse, licensed vocational nurse or nurse practitioner (Primary Care Provider if NP), a social worker, and a chaplain.

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Care coordination

A member of the palliative care team should provide coordination of care, ensure continuous assessment of the beneficiary's needs, and implement the plan of care.

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Pain and symptom management

Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address beneficiary pain and other symptoms. The beneficiary's plan of care must include all services authorized for pain and symptom management.

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Mental health and medical social services

Counseling and social services must be available to the beneficiary to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate.

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Chaplain services

DHCS recommends that MCPs provide access to chaplain services as part of the palliative care team.

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Settings and providers

MCPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings.

MCPs must utilize qualified providers for palliative care based on the setting and needs of a beneficiary so long as the MCP ensures that its providers comply with existing Medi- Cal contracts and/or APLs. DHCS recommends that MCPs use providers with current palliative care training and/or certification to conduct palliative care consultations or assessments.

MCPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care.

See APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Discussion

- From a clinical perspective, what are your thoughts on the required services, settings and providers?

- From an operational / administrative perspective, what are your thoughts on the required services, settings and providers?

Variables that impact the cost of care

Required activities

- Assemble IDT

1. Advance Care Planning
2. PC Assessment & Consultation
3. Plan of Care
4. Pain and symptom management
5. Care Coordination
6. Referrals to mental health and social services
7. (Spiritual support)
8. (24/7 telephonic support)

The “what” is specified, the “how” is not

- Staffing model
- Frequency / types of encounters
- Process for verifying eligibility
- Documentation and communication requirements
- Billing processes
- Authorization processes

Specific services, several possible providers

Required Service	Possible providers
Advance Care Planning	Could be done by MD/DO, NP/PA, nurse, social worker, chaplain or trained lay person
Palliative Care Assessment and Consultation	Could be done by nurse/social worker team, or might require input from physician, nurse, social worker and chaplain
Care Coordination	Could be MD/DO, NP/PA, nurse, or social worker; could be facilitated by case manager employed by health plan

Achieving balance

Scope of services and cost of delivery

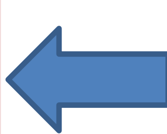
Payment amount

Outcomes that justify investment

Variables that drive costs

Cost components

- Direct care effort
- Operational costs
- Indirect costs



Cost drivers

- PC population and care environment
- Provider organization characteristics, preferences and resources
- Payer policies, preferences and resources

Some cost drivers are fixed and some reflect choices (issues that can be negotiated between the payer and provider)

See 23 Factors handout

COST DRIVERS

Patient population attributes that impact your service model and effort (poverty, isolation, mental health needs, complexity, etc.)

Patient selection/acuity
- Eligibility criteria (late-stage or less advanced?)
- Disenrollment criteria (probability of stable patients remaining on service)

Volume and duration
- Number of eligible patients in your service area
- Number of patients referred, screened, and enrolled
- Length of time (months) that patients are enrolled

Scope
- Services from your team (goals of care, ACP, symptom management, etc.)
- Services from others (plan, community organizations, medical group)

Service Model
- Care modalities and settings (home, office, phone, video)
- Interdisciplinary staffing

Variable (per patient) care team effort
- Frequency of contacts by modality and discipline
- Length of those contacts
- Travel time
- Charting and communication/coordination work
- IDT meeting time

Variable (per patient) organizational costs
- Travel costs
- Screening, enrollment, and dis-enrollment efforts

Administrative efforts and indirect costs
- Reporting effort
- Care team training costs
- Meetings with others (e.g., sit in on plan's high-utilizer meeting)
- Marketing services to referring providers

COST CALCULATIONS

Calculate direct care costs

Cost per patient per month

Multiplied by average enrollment duration

Cost per patient over the course of their enrollment

Multiplied by number of patients

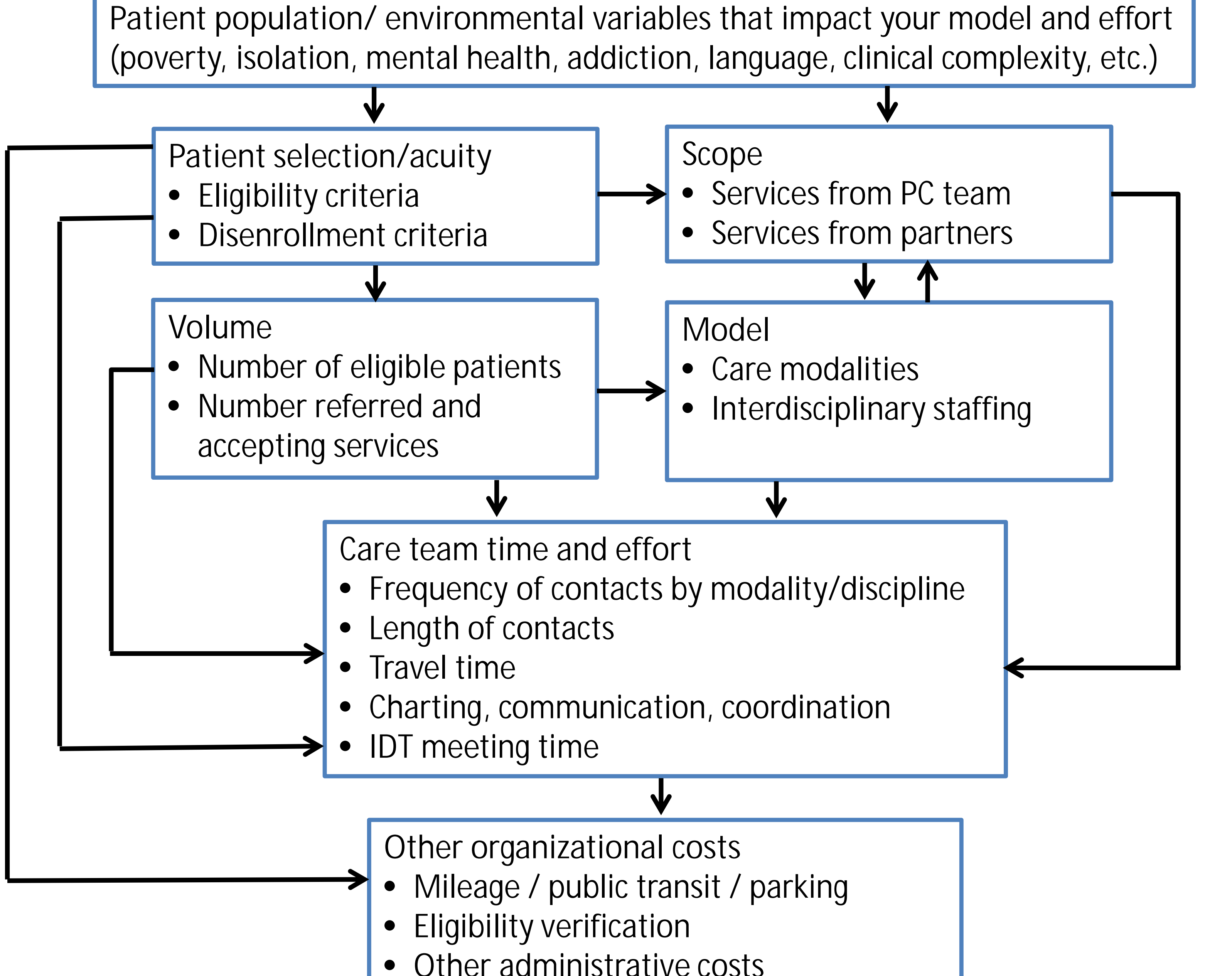
Direct costs of care per year

Operational costs to implement and administer contract per year

Indirect costs

Annual, per month, and per patient costs of delivering specified services

Cost drivers are all inter-dependent



Drivers and decision points

Population

- Target population is complex: mental health issues, poverty, substance abuse, linguistic diversity, high prevalence of presenting with late stage disease, high prevalence of food / housing insecurity, safety issues, etc.

Scope

- Which services the PC team will provide
- Expected collaboration with other organizations, including the health plan

Multi-organization efforts are common

Organization	Role
HPSJ	• Funding, plus support from Clinical Analytics, Case Managers, Social Workers, pt transportation costs
San Joaquin General Hospital	• Primary and specialty care, plus inpatient and clinic-based palliative care
Community Palliative & Hospice Care	• Home-based palliative care, with ability to transition to hospice as appropriate
Hospice of San Joaquin	• Home-based palliative care, with ability to transition to hospice as appropriate
Axispoint Health	• Telephonic case management, analytics to identify patients, and "feet on the street" (member engagement)
Beacon Behavioral Health	• Mental health services

Drivers and decision points

Model

- Disciplines on the team
- Frequency of providing different types of services, by discipline, by modality / setting (clinic/office, vs patient home, vs telephone/video)
- Strategy for ensuring 24/7 access (triage service, leverage hospice staff, pay staff call), if you will provide this

Care team communication effort

- Frequency of IDT and other internal provider organization meetings
- Presence/frequency of meetings with external organizations (participate in clinic rounds, health plan case management meetings, etc.)

Drivers and decision points

Operational factors

- Effort required to screen, enroll and dis-enroll patients
  - DC criteria impact need for on-going authorizations and probability of some enrolled patients experiencing periods of stability
  - Lots of screened patients who are ineligible = lots of uncompensated effort for provider organization
- Strategies for promoting referrals
- Strategies used to orient/engage patients and families to the PC service

Drivers and decision points

Operational factors

- Effort required to gather and submit data needed for payer case review/on-going authorization for services/severity rating
- Effort required to secure authorizations for DME, medication re-fills etc. (single point of contact in plan, or chasing PCP to get permission?)
- Metrics required to report to plan and proportion that are not simple extractions from EHR
- Process for submitting claims; provider and payer billing infrastructure

Eligibility criteria: Variables – Implications - Options

Variable or circumstance	What this may mean for your services and costs	Options
You or your payer/partner specify very stringent disenrollment criteria (e.g., as soon as a patient stabilizes)	• Frequent assessments to confirm continued eligibility • Brief duration of enrollment • Confusion among referring providers and patients/families	• Negotiate broader criteria • Negotiate minimum number of months for initial enrollment • Consider tiered services and payment for stable patients vs active / unstable patients

Identifying eligible patients: Variables – Implications - Options

Variable or circumstance	What this may mean for your services and costs	Options
• Payer/partner is unable to help to identify potential patients	• Your team will spend considerable time educating providers and marketing services • Actual number of referrals may be dramatically lower than number of eligible patients	• Negotiate assistance from payer/partner for identifying appropriate patients • Quantify effort required to generate / screen referrals; incorporate into negotiated price • Partner with medical group leadership to promote / incentivize appropriate referrals

Scope:
Variables – Implications - Options

Variable or circumstance	What this may mean for your services and costs	Options
The breadth of required services exceeds the capacity / training of your organization, but you have formed no collaborative relationships with other organizations	• Your team works in isolation from other service providers in community • You feel responsible for meeting all the needs of your patients • You try to do everything, and you are not compensated to do everything	• Form collaborative relationships and partnerships with other service providers in the community • Set limits for your team • Set reasonable expectations with your payer/partner that some other providers will have to address some needs (be specific)

Authorization processes: Variables – Implications - Options

Variable or circumstance	What this may mean for your services and costs	Options
Considerable effort required to secure authorizations for DME, prescription approvals, refills, etc.	• Ties up clinical staff on the phone	• Negotiate exception to some rules while patients are enrolled in PC • Identify single point of contact at plan or within medical group to handle such requests

Mandatory minimums:
Variables – Implications - Options

Variable or circumstance	What this may mean for your services and costs	Options
You (or your payer/partner) mandate frequent visits per patient per month	• High cost per patient per month • Some patients may not make themselves available for visits at predictable intervals, which reduces revenues for provider	• Negotiate other approaches – contacts via phone, other media • Suggest high-frequency initial phase followed by maintenance phase • Create process to waive requirement for certain patients

24 / access:
Variables – Implications - Options

Variable or circumstance	What this may mean for your services and costs	Options
You want to ensure patients/families have 24/7 access to providers	• Paying providers for this may not be feasible	• Teach patients/families to recognize when symptoms and distress are starting to escalate, for earlier intervention • Provide 24/7 call only for subset of high-need or high-risk patients, or for limited time(s) • Leverage existing hospice staff to triage calls

Decision Points Worksheet

Take a few minutes to complete the Decision Points worksheet

For each cost driver category identify issues/circumstances that may impact the cost of delivering care, then consider options your organization has for reducing effort / costs

Start-up / ramp-up costs

- Gap between revenues and salary costs while building referral base
- Developing (new) workflows, developing data collection strategies
- Training new staff in palliative care

Key points

- APL specifies (minimum) eligibility, services, providers
- The “what” is fixed; the “how” is up to you
- Costs will be driven by the population and care environment, as well as payer and provider policies / preferences / resources
- Some cost drivers are fixed, but many are flexible; contract terms will reflect negotiated choices
- Know your costs and cost drivers and experiment with different choices if there is a gap between your expected effort / costs and payment offered

Six steps to aligning costs and revenues

1. Understand the population and environment
2. Identify the palliative (and other) services needed
3. Decide on a clinical model
   a) Who on your team will do what, how frequently, and in which settings
   b) Appreciate what partners (external organizations) will do
4. Appreciate effort beyond direct patient contact required to deliver quality care and attend to operational matters
   a) Effort driven by your organization
   b) Effort driven by your partners
5. Do the math
6. If there is a gap between the cost of care delivery and available payment, chat with your payer partner and revisit choices/decisions made in steps 3-4

Questions and discussion

Costs of Care Delivery
California Healthcare Foundation

SERVING NAPA COUNTY SINCE

1 9 7 9

2015 LEADERSHIP AWARD WINNER
COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

2,600
UNDUPLICATED SERVED IN 2016

KEY SERVICE LINES

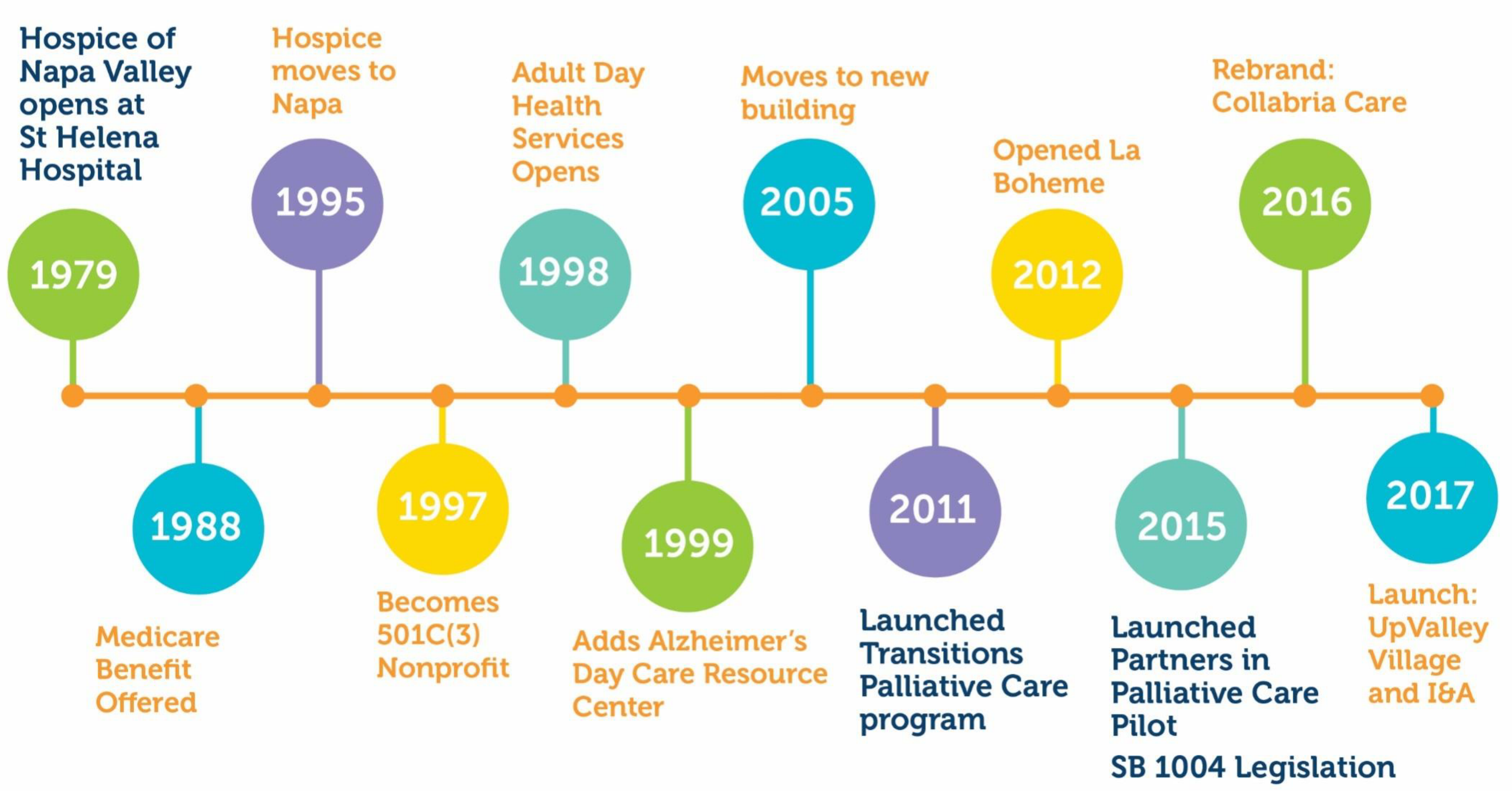
1. PALLIATIVE CARE (2011)
2. HOSPICE (1979)
3. ALZHEIMER'S & DEMENTIA CENTER / CBAS (1998)

VOLUNTEER 14,000 HOURS

~2016~

PATIENT 63,000 VISITS

ORGANIZATION HISTORY



Transitions of Aging

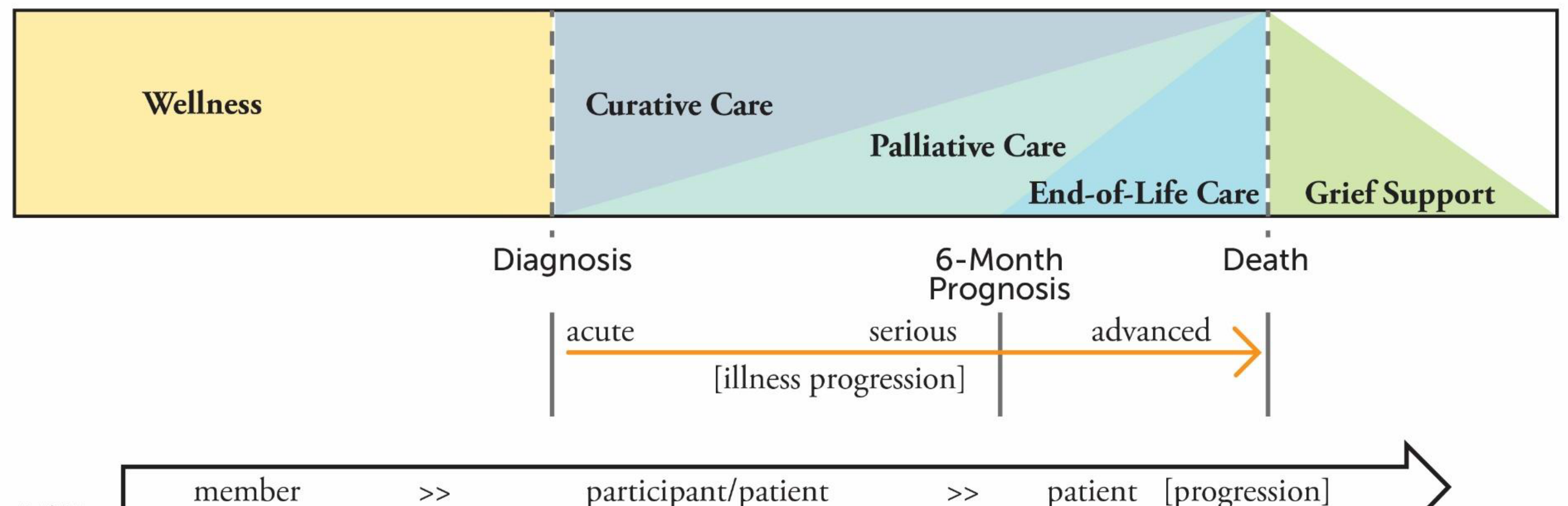
Wellness Programs
Education Programs
UpValley Village
Mind Boosters
Honoring Choices N.V.
Information & Assistance

Serious Illness

Day Program
Adult Day Healthcare
Alzheimer's Specialty Programs
Palliative Care
Family Consultations
Caregiver Support

End-of-Life Care

Hospice Care
Caregiver Support
Grief Support
Family Consultations



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Eligibility – Blue Shield

The Patient has an advanced disease/ disorder/condition that is known to be life-limiting	• Stage 3 or 4 Cancer • NYHA Class 3 or 4 CHF • COPD • Stroke • End-Stage Liver Disease • Chronic Kidney Disease • Severe dementia

The Patient meets at least ONE of FOUR Criteria	• 1 or more ED visits in past 12 months
	• 1 or more hospitalizations in past 12 months
	• Hospital readmission in past 12 months
	• Current admission prompted by:
	    • Uncontrolled symptoms related to underlying disease
	    • Inadequate home, social, family support

Eligibility – Blue Shield

The Patient's Palliative Performance Scale rating is <=70%	
The Patient meets at least TWO of SIX Criteria	• Decline in function • Complex care requirements • High risk factors: low health literacy, medication non-adherence, etc • Would you be surprised if the patient died within one year? • Patient declined Hospice enrollment • Complex Goals of Care
The Patients meet ALL these criteria:	• The patient is going home, to assisted living at hospital D/C • The patient does NOT live in a long-term care facility • The primary diagnosis explains the above is NOT psychiatric in nature

Eligibility – Partnership Healthplan

- Any patient who is likely to or has started to use the hospital as a means to mange late stage disease
- Patient evaluated in their best compensated state
- Patient has received maximum medical therapy
- Life expectancy of about 1 year
- Stage 3 or 4 cancer
- Congestive Heart Failure
- End Stage Liver Disease
- COPD
- Patients and families agree to attempt in-home disease management prior to going to the ED, and participate in ACP

Outpatient Palliative Expected Services

SERVICES	STAFFING	SETTING
Initial Assessment	Nurse or Social Worker	Home Preferred
24/7 Telephonic Support	After Hours Triage	Phone
Pain/Symptom Management	Primary Care, Medical Director, NP and Nurse	Home and Phone
Advance Care Planning	Social Worker	Home Preferred
POLST (when appropriate)	Social Worker	Home Preferred
Acute Management Plan	Nurse or Social Worker	Home and Phone
Assess Caregiver Support Needs and refer and/or provide support	Nurse, Social Worker, Home Health Aide	Home and Phone
Warm hand-offs from Hospital and Hospice	Nurse or Social Worker	Community Based
Case Management	Social Worker	Home and Phone

Palliative Care Payment Methodology Blue Shield

Service	Criteria	Rate
Palliative Care Services Evaluation	One time	100% of CMS
Palliative Care Service	Monthly	$ xxx

Partnership Health Plan of California

Service	Criteria	Rate
Engagement Fee	Up to 7 days of care	$ xxx
Enrolled Member (home) (2 RN visits / month)	Per Member every 14 days	$ xxx
Enrolled Member (SNF or LTAC)	Per Member every 14 days	$ xx
Quality Bonus ACP/POLST	One time	$ xxx
Quality Bonus No Hospitalization	Monthly	$ xxx

Collabria Care Model

Resource	Frequency
Registered Nurse	Two visits / month / patient
Social Worker / Community Health Worker	Two visits / month / patient
Spiritual Care	Shared with Hospice
Volunteer RN	Weekly check in call / patient
Intake Team	Shared with Hospice
After Hours Call	Outsourced – Per call rate
Medical Director	Four hours / month / 50 patients
Business Coordinator	10 hours / week / 25 patients

RN Case load = 25
Social Worker / CHW = 40

Palliative Care Proforma – Partnership Health Plan 2017

Description	Per Patient Per Month	One Time Per Patient	All Patients Annual	All Patients Per Day	Per Patient Per Day
Revenue					
One Time Engagement Fee		$ xxx	$ xxx	$ xxx	$ xxx
Patient Bundled Fee	$ xxx		$ xxx	$ xxx	$ xxx
Quality Bonus ACP/POLST		$ xxx	$ xxx	$ xxx	$ xxx
Qty. Bonus Hospitalization	$ xxx		$ xxx	$ xxx	$ xxx
Total Revenue	$ xxx	$ xxx	$ xxx	$ xxx	$ xxx
Expenses					
RN @ $xxx/hr. /FTE	$ xxx		$ xxx	$ xxx	$ xxx
CHW @ $xxx/hr. / FTE	$ xxx		$ xxx	$ xxx	$ xxx
SW @ $xxx/hr. / FTE	$ xxx		$ xxx	$ xxx	$ xxx
Prgm. Coord. @ $xxx/hr. /FTE	$ xxx		$ xxx	$ xxx	$ xxx
Benefit Expense xx%	$ xxx		$ xxx	$ xxx	$ xxx
Total Staffing	$ xxx		$ xxx	$ xxx	$ xxx

Palliative Care Proforma - 2017

Description	Per Patient Per Month	All Patients Annual	All Patients Per Day	Per Patient Per Day
Other Expenses				
Medical Director	$ xxx	$ xxx	$ xxx	$ xxx
Mileage (staffing)	$ xxx	$ xxx	$ xxx	$ xxx
Administration Costs	$ xxx	$ xxx	$ xxx	$ xxx
Other Expenses	$ xxx	$ xxx	$ xxx	$ xxx
Total Other Expenses				
Indirect Costs (Overhead)	$ xxx	$ xxx	$ xxx	$ xxx
Total Expenses	$ xxx	$ xxx	$ xxx	$ xxx
Profit / (Loss)	$ xxx	$ xxx	$ xxx	$ xxx
Profit Margin	$ xxx	$ xxx	$ xxx	$ xxx

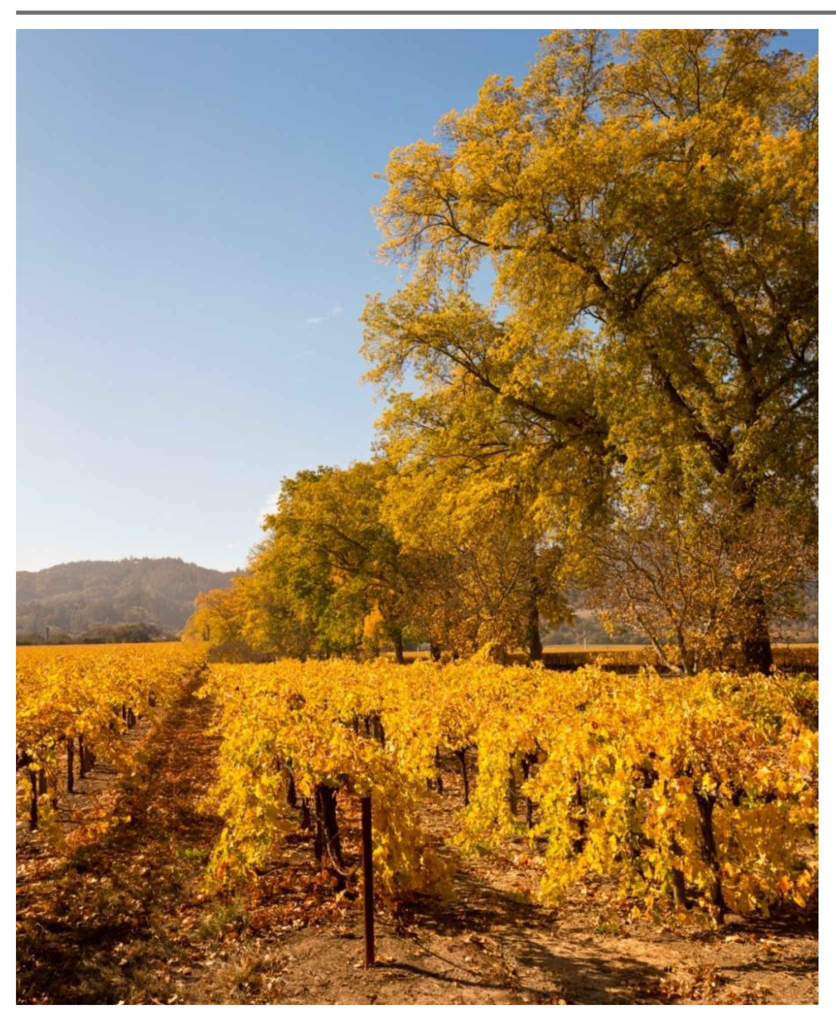
Lessons Learned

- Know your market
- Plan for program start up costs – takes a long time to ramp up to break even
- Be clear about services provided and frequency of services
- Have a plan for discharge / Hospice admission
  - To date, MediCal members have shorter stays in Hospice
- Plan for high utilization of social services
- Referrals are hard to find – good relationships with referral sources is essential

Cost Containment

- Consider use of Community Health Worker
  - Extends social worker
- Consider use of volunteers
- Consider use of Palliative Nurse Practitioner when patient is eligible for Hospice, but not ready
- Add a clerical / billing resource to keep track of difference in contracts
- Pay attention to scope creep
- Ask a partner to help cover start up costs

Contact Information



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Lessons learned from payer-provider partnerships

Learning from others

- California Health Care Foundation Payer-Provider Partnership initiative
- 6 teams of payer and provider organizations
- Providers: large academic medical centers, hospices, and a specialty palliative care practice
- Payers: national insurers, regional insurers, a Medicaid managed care plan
- 6 month planning process, yielding operational and financial plans for delivering CBPC
- 24 month implementation phase, where contracts were executed and clinical services were delivered

Payers and providers who participated in the initiative identified lessons learned from developing and enacting an agreement to deliver CBPC.

Five lesson areas

1. Initial engagement
2. Promoting appropriate referrals
3. Services / operational issues
4. Relationship issues
5. General advice

Initial engagement

Be prepared to get info

- Size and geographic footprint of payer partner
- What populations the payer serves / population profile
- # Patients likely eligible
- Expectations re: service levels, number of visits, etc.
- Infrastructure and resources of the health plan (case managers, data systems, staff to support ancillary service authorizations, etc.)

Be prepared to give info

- Geographic catchment area
- Referral relationships
- CBPC experience
- CBPC care model (e.g., nurse-led, physician-led, team members, case mgmt., telehealth)
- Capacity to take on new patients

Initial engagement

- Take the time (meet in person)
- Make sure there is a common understanding of ....
  - What palliative care is
  - Goals / what hoping to achieve
  - What success looks like
  - Each organization's priorities and pressures

Promoting appropriate referrals

- Data mining vs provider referrals vs hybrid
- Creating and maintaining referring provider relationships

Services / operational issues

- Fixed or flexible
- Collaborative vs full control
  - Authorizations, med refills

Relationship issues

- REALLY important (don’t be the last to know)
- Aim for building trust and being flexible, not us vs. them
- Listening and transparency are valued highly
- Collaborative problem solving is valued highly

General advice

- It will cost more and take a lot longer than you think
- Perceived need and number of (actual) referrals might not match up
- Even small volumes need a full infrastructure
- More than one payer partner is (probably) better

Review and closing

Workshop objective #1

Become familiar with SB 1004 required services, providers, settings

1. Advance Care Planning
2. PC Assessment & Consultation
3. Plan of Care
4. PC Team
5. Care Coordination
6. Pain and symptom management
7. Mental Health and Medical Social Services

- (Chaplain Services)
- (24/7 telephonic support)

Workshop objective #2

Appreciate service model and contract features that influence the cost of delivering SB1004 palliative care, including variables related to patient care as well as operational/administrative variables

See: 23 Factors handout

- Environment / region
- Population characteristics / eligibility criteria
- Scope of service
- Care model
- Communication / coordination
- Engaging patients/families and referring providers
- Operational effort

Workshop objective #3

Consider strategies to promote alignment between payment and costs

- Consider adjusting administrative and clinical aspects of program that are modifiable (policies, preferences, practices of payer and provider)
- See: Decision Points worksheet

Workshop objective #4

Consider issues that contribute to the quality and success of (new) payer-provider partnerships

Initial engagement	Invest in the beginning
Promoting appropriate referrals	Shared responsibility
Services / operational issues	Integration / collaboration
Relationship issues	Nothing more important
General advice	It's hard, but worth it

Acknowledgements, and final questions

Thanks to colleagues who shared their knowledge, wisdom and experiences

- J Brian Cassel, PhD and the team working on the CAPC Accelerator initiative
- The payers and providers and project staff that participated in the CHCF Payer-Provider initiative

Questions about the SB1004 Technical assistance series?

- Glenda Pacha gpacha@chcf.org
- www.chcf.org/sb1004