

The two Topic 5 workshops featured opportunities for participants – representing a mix of health plans and palliative care provider organizations – to share their approaches, challenges, and lessons learned related to 5 specific topics:

- A. Staffing Models (providers only)
- B. Areas of Plan-Provider Collaboration (plans only)
- C. Strategies to Identify Eligible Patients/Members (mixed discussion)
- D. Strategies to Engage Patients/Members (mixed discussion)
- E. Strategies to Engage Referring Providers (mixed discussion)

Notes from small group discussions on each of these topics are presented below.

A. Staffing Models

1. Which disciplines on your team (usually) participate in delivering each required service?

There was significant variation in how different teams answered this question. Some have only 1-2 team members responsible for some of the services (e.g. only RN does pain/symptom management, only social worker does referrals to mental health/social services), while others reported that “everyone” is involved in many of the required services (e.g. advance care planning, plan of care, care coordination, pain/ symptom management). Some felt that particular disciplines were very useful (e.g. NP, LVN) while other teams did not report having these disciplines involved in the program. Take-away: variation in approaches to staffing models suggests that there is an opportunity to change your approach over time, as your program’s needs change.

2. Have you considered adjusting your approach to delivering services? If so, why? If not, should you?

- Most common response: telehealth
 - Also listed as a way to increase efficiency without changing disciplines on the team
- Other responses
 - Reevaluate core team members: RN/Community Health Worker (CHW)/Palliative Care Coordinator vs. RN/LVN
 - Leverage CHW (could do more of SW role)
 - NP – would help to solidify program (policies, procedures, care plans)
 - Would like to use more RN
 - Chaplain – tap into patient’s faith community

Key take-aways

- Most common responses
 - Telehealth – increase quality and increase efficiency; “Telehealth is the future”
 - Use NPs for face-to-face, MDs for telehealth
 - Add or expand role of CHW (take on some of Social Work scope)
 - Move personnel to roles that fit their niche, especially MDs and NPs

- Other responses
 - Move toward standardizing care
 - Increase coordination with DME company, through plan and IPA
 - Think about/focus on sustainability

B. Areas of Plan-Provider Collaboration

1. In which areas does your plan collaborate with Palliative Care (PC) Provider partners?
 - Creating content for newsletters
 - Educational events for primary care providers (PCPs)/specialists
 - Site visits (quarterly, or at another regular interval)
 - Billing support
 - Marketing to members/patients and referring providers
 - Monthly calls
 - Medical director-PC medical provider collaboration
 - Constant/regular CM/UM coordination with PC providers
 - Created off-hour authorization process for PC
 - Round (Interdisciplinary Team [IDT] meeting) with vendors every two weeks
 - Monthly operational meetings to discuss processes (distinct from IDT/case reviews)

2. Are there any areas where collaboration has likely resulted in improved quality of care (efficacy, safety, timeliness, efficiency, etc.)?
 - Efficiency of Concurrent Care Review (CCR) processes
 - Clearly defined point of first contact
 - More timely referrals to mental health programs

3. Are there any areas where collaboration has possibly increased the cost of care delivery for PC providers (required significant time investment)?
 - Incentives built into PC provider contracts increase costs
 - Plan staff time needed to support program is costly, but needed because new program

4. Are there any areas of collaboration you might consider adjusting, adding or eliminating in the next six months?
 - Overall effort to increase traction/number of patients identified/collaboration
 - Streamline referral process
 - Joint visits between Health Homes care provider and home health team
 - Inpatient UM nurse and PC providers
 - Figure out process for getting referrals turned around in timely fashion
 - Efforts to make potential patient lists as clean as possible (to increase cold call yield)

Key take-aways

- Plans and providers should partner to conduct patient and referring provider education
- Single point of contact in plan is valued by PC team
- Focus efforts on connecting PCPs and PC providers
- Regular communication on operations and cases (IDT) work is important
- Taking on aspects of patient identification is helpful
- Responsiveness to PC providers / maximizing plan accessibility to PC providers is important
- Getting PC provider pertinent member/patient contact and clinical information is important

C. Identifying Eligible Patients/Members

1. What strategies have you used to identify eligible members/patients?

- Specialists/PCPs identify patients
- PC provider SW/RN round in hospitals
- Hospital-based PC providers identify patients
- Claims reports showing utilization in previous 6-12 months and diagnosis – plans or PC providers do outreach based on list
- Plan CM/SW conduct outreach
- Plan sends lists of potential patients to providers
- “Lunch and learn” sessions with PCPs/others, ask them to identify patients
- Inpatient CCR team identifies
- Educating plan staff working in appropriate business units (authorizations, case managers, med review unit) re PC service and inviting to refer
- Referrals from health plans, chronic care managers and PCPs
- Engaging social services team
- Home health team identifies
- Patients invited to self-identify/self-refer

2. Which identification strategies have been most effective, and why?

- Referrals from inpatient PC teams and outpatient (clinic-based) PC services
- Cold calling using list of potential patients from plans
- Plan direct outreach to members
- PC provider works directly with Medi-Cal clinic – accesses EHR to identify patients
- (CBO) PC physician rounding at hospital – target patients preparing for discharge
- Leveraging existing strong relationships – asking PCPs and specialists to refer
- Combining strategies works best
- Nursing pain management identifies (due to relationship with patient)
- Home health team identifies – they are in the home
- SNF staff identify

3. Which identification strategies have not been effective, and why not?

- Cold calling from claims data/risk report lists and reports from EMRs
- Working with (plan or provider) partner to make calls on list (shared responsibility)
- Relying on PCPs and specialists to refer
 - Expecting PCPs/specialist to identify after being educated through “Lunch and Learn” sessions

4. What additional identification strategies might you implement in the next 6 months?

- IT build for proper data collection to support patient identification
- UM case managers identifying and referring patients
- Going live with Health Homes (hoping will be a source of referrals)
- Relationship building to help PCPs and specialists identify patients
- Linking to / leveraging aligned plan programs (like chronic case management)
- Increased internal education (at plan), especially new hires
- Continuing education for specific provider groups and hospital staff
- Outreach to FQHCs to engage PCPs
- Outreach to SNFs

5. Are there any patient identification strategies that you have been using that you might discontinue?

- List culling and cold calling

Key take-aways

- Holistic approach required – focus on adding strategies vs eliminating strategies
- Cold calling is least effective
- Relationships/relationship building is key
- Coordination across aligned programs is key
- Physician to physician outreach works best (medical director outreach to medical provider)
- Health plan UM staff can alert PC team staff to do assessment
- PC physicians rounding in hospital is especially effective
- Make sure PC team is not perceived to be hospice team

D. Strategies to Engage Patients/Members

1. What strategies have you used to inform members/patients about palliative care service availability?

- Most common responses
 - Letters, general mailings
 - Warm hand-offs from hospital/SNF, or from case manager/plan/referring provider
 - Direct phone calls (though some organizations noted that there is a barrier in that patients may not return calls)

- Offer education sessions (e.g. Being Mortal screenings, information sessions in target facilities like low-income housing or senior living facilities, advance care planning sessions)
- Direct communication with PCPs
- Cold calling to patients
- Less common responses
 - “Work through existing relationships”
 - Hospital discharge follow-up
 - Videos online
 - Press releases, news stories

2. Which have been the most effective strategies for informing members/patients about palliative care service availability, and why?

- Most common responses
 - Warm hand off to establish relationship → higher conversion rates
 - Meet patient in hospital/SNF
 - Patient informed/educated by plan before PC provider calls
 - “Have someone with a relationship reach out”
 - Physician-to-physician (PC physician to referring physician)
 - Informational visits (particularly if initial call to patient fails)
 - Face-to-face contact
 - Adult day health centers
 - Specific case manager dedicated to program discusses program with patients upon referral
 - Education for this person re: PC
 - (Provider education so they have correct/clear information when educating patients)
 - See notes in Engaging Referring Provider section, below
- Less common responses
 - Send targeted letter to patient (describing program) before calling
 - Word of mouth
 - Dedicated, local outreach coordinators
 - Specific messaging
 - Emphasize partnership with referring provider and PC org
 - Emphasize nothing being taken away
 - Emphasize safety of home visits
 - Workshops, community outreach (e.g. film screenings)
 - Use opportunity to engage patients who are evaluating other services (e.g. home health, hospice)
 - Collaborate with other health plan depts

3. What additional patient/member outreach strategies are you considering implementing in the next 6 months?

- Broad advertising strategies
 - Additional events/health fairs
 - Social media marketing
 - Mailings with co-branding (plan and provider)

- Text messages and calls from plans with automated recording
- Target specific populations
 - Forums in different languages
 - Partner with community organizations (churches, shelters) at plan facilities
- Work with hospital-based providers
 - Weekly liaison visit to round in hospital
 - Work with discharge case managers
- Get out in the community – engage CHWs
 - Broaden outreach to other facilities
- Inform/engage internal staff within the organization (other departments/lines of business)
 - Leverage internal contacts
 - Continued internal education for how to do patient outreach (provide words and phrases to use to describe the service)
- Other ideas
 - Asking providers, “When is the time for palliative?”
 - More education to providers and home health companies
 - Have (PC) CHW spend part of time in clinic (FQHC) to build relationships, review with providers if any patients need services
 - Offer medically-tailored meals
 - Telehealth/tele-doc
 - Focus on caregiver needs, not just patients

4. What factors have been the most important, in terms of encouraging eligible members/patients to accept palliative care services, and why?

- Most common responses
 - Building trust, making sure they’re informed
 - Education
 - Key messaging
 - Defining “supportive care” and clarifying that other services continue
 - Extra support
 - Promoting 24/7 call line
 - Approach without pressure – reassure that it’s their choice
 - Leverage motivational interviewing techniques to understand barriers and potentially overcome them – “engage in question and answer”
 - Patient-centered approach
 - Offer to make a follow-up call to allow patient time to think about enrolling (take off pressure of decision-making in first call)
 - Work from what patient’s needs are, how we can apply services to need
 - Personally connecting with patients, ideally in-person
- Other responses
 - Single point of contact (health plan)
 - Bilingual, bicultural
 - Warm hand-off
 - Pre-outreach before services are really needed (e.g. at member enrollment in plan)
 - Monitoring for SB 1004 diagnoses on hospital admissions (coordination with plan)

5. What have been the biggest barriers to having members/patients accept palliative care services, when they're eligible for them?

- Most common responses
 - Misunderstand/confuse hospice and PC
 - Cultural differences and/or language barriers
 - Fear of losing their PCP
 - Fear of losing other services they value (e.g. participating in clinical studies, home health services they like)
- Other responses
 - Follow-up calls take time – limited bandwidth
 - Not getting in the door -- “cut off before can provide full info”
 - Suspicion, lack of trust
 - Sense that home services invade privacy
 - Too many calls from providers

Key take-aways

- Education
 - Direct interaction with members
 - Motivational interviewing, clarifying misunderstanding/misinformation, reassuring the patient they aren't losing anything, they're gaining (x, y, z), home visits are safe, etc.
 - Educate members about PC services before they're needed (e.g. make it part of plan enrollment) – mailings, phone calls, community outreach
 - Educating referring providers is important in building trust with patients
- Informing patients/members
 - Introductory letter helpful with identification; co-branding provider with provider and plan is key
 - Partner with community outreach teams that typically focus on other services (e.g. hospice) to have them include disseminating info on PC program
- Engaging patients/members who are (likely) eligible
 - Relationship btw “asker” and member/patient matters
 - Helps when plan works through case mgmt. list
 - Identifying the family's decision-maker/addressing cultural issues
 - Meet the patient where they are
 - Culturally and linguistically appropriate materials
 - Couple with other benefits (e.g. medically-tailored meals)
 - Focus on caregiver needs
- Barriers
 - Competition with home health
 - Cultural challenges (e.g. dying at home, language, beliefs about “giving up”)

E. Engaging Referring Providers

1. What strategies have you used to inform providers about palliative care service availability?

- Most common responses
 - Education for providers
 - In-service in office or telephonically seems to work (and webinars)
 - Quarterly meetings (make an announcement about program), or provider staff meetings
 - Orientation for making referrals (processes)
 - Outreach to SNFs
 - Newsletter
 - Email or fax blast
 - Brochure for providers (or resources asking about PC)
 - Provider-to-Provider, ideally face-to-face, regarding specific patient
 - Identify and leverage champions (physician AND non-physician)
 - Cold calls (to providers or nurses)
- Other responses
 - Engage multiple departments
 - “Focus on always being in the back of MD’s minds”
 - Website information
 - Target high-volume clinics

2. Which have been the most effective strategies for informing referring providers about palliative care service availability, and why?

- Most common responses
 - 101 provider education
 - Information directly from plan case mgmt.
 - Face-to-face visits with MDs, staff – “have their full attention”
 - Clear communication to provider
 - Particularly physician-to-physician
 - Have a specific contact person for palliative care who can describe the program clearly and effectively
 - Outreach about a specific member
 - Key messages
 - Use “supportive care” language, including extra support for physicians
 - Discuss what PC org can offer patient when [referring provider] isn’t available, “we’re your extension; we’re the eyes and ears in the home”
 - Emphasize partnership, not competition or taking business away
 - Help make life easier for them, in addition to difficulty around pain mgmt. in the setting of opioid concerns/restrictions
 - Identify and work with champions, build relationships
- Other responses
 - Intake dept follows up on referrals that were placed
 - Work with frontline office staff
 - Go to case review meetings (e.g. tumor board)

3. What additional referring provider outreach strategies are you considering implementing in the next 6 months?

- Education efforts
 - Educate/train internal staff (e.g. case managers) -- designate staff to educate providers in the community
 - Target specific providers (e.g. case managers, CHWs, hospital-based providers), groups (e.g. high-volume offices, home health), or patients (e.g. missing appointments or other signs of high needs)
 - Emphasize "consult" concept
- In-person outreach
 - One-on-one relationship building
 - Building trust with referring providers
 - Participate in clinic staff meetings
 - Go to office with list of pts who may be eligible (from that clinic)
- Strategies to increase efficiency
 - Provide PC education (appropriate level) to staff who are doing outreach to PCPs re PC program; have PC clinicians accompany liaison staff when doing outreach
 - Increase collaboration with plan
 - Go to case review meetings (e.g. tumor board)
 - Support providers in reaching out to pts (e.g. mail pamphlets to providers)
 - Focus on settings where care transitions happen (e.g. hospice, home health, SNFs)

4. What factors have been the most important, in terms of encouraging providers to refer patients for palliative care services, and why?

- Referral etiquette
- Contact providers re: specific pts -- "making it real"
 - Plan case manager does outreach to both PCP and patient
- Ease referral process and "encourage them to refer anyone who seems to need support then we can place them in appropriate program" (Don't "cherry pick" pts)
- Share outcomes: patient and provider satisfaction with services (past experiences), other key metrics (e.g. DRG, LOS, meeting patient needs)
- Buy-in from key stakeholders (MD champion, group leadership)
- Education on differentiating factors and benefits, how PC supports their patients
 - Find common goals between PCP and PC provider
 - Support providers in addition to patients
 - Emphasize capacity to reach home-bound pts

5. What have been the biggest barriers to having providers refer patients for palliative care services, when they're eligible for them?

- Most common responses
 - MDs are busy (short on time and attention)
 - Lack of awareness and/or understanding about PC
 - Confusion that patient already getting home health (think it's the same thing as PC)

- Lack of understanding re: eligibility criteria
 - Don't know how to talk to pts about PC
 - Confusion that patient will have to stop disease-directed treatments
 - Provider fear that org will push patient into hospice or take patient away
 - Suspicion, "How did you get my patient's info?"
- Other responses
 - Organizational competition within a community
 - MDs are hard to reach
 - Unclear criteria
 - Providers sometimes don't know patient well
 - Difficulty with either PCPs or specialists referring

Key take-aways

- Education – either 1 on 1, or telephone/web-based in-service; repeated information; health plan staff targeting providers
- Leverage existing (and build new) relationships, using a variety of approaches
- Make referral process easy (or easier)
- Emphasize value added
 - Act as support to providers as well as patients
 - Increase capacity of the care delivery system (solution for provider)
 - Partnership, with clearly defined roles of who does what
- Physician-to-physician conference on patients
- Focus on key clinics/PCPs