California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

SB1004 Technical Assistance Series: Topic 5: Strategy Exchange to Address Common Challenges

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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

Objectives

- Develop strategies to address common implementation challenges, informed by the experiences of peers who are administering and delivering SB 1004 services
- Review strategies that plans and providers are employing to identify eligible patients
- Highlight promising approaches to engaging patients and referring providers
- Explore the range of staffing models that providers are using to deliver SB 1004 palliative care
- Explore different ways plans are collaborating with palliative care providers on operational and clinical processes

Outline

- Status of Services
- Staffing Models
- Plan Engagement
- Strategies for Identifying Patients/Members
- Strategies for Engaging Patients/Members
- Strategies for Engaging Referring Providers

Where is the information coming from?

Survey responses

Workshop notes

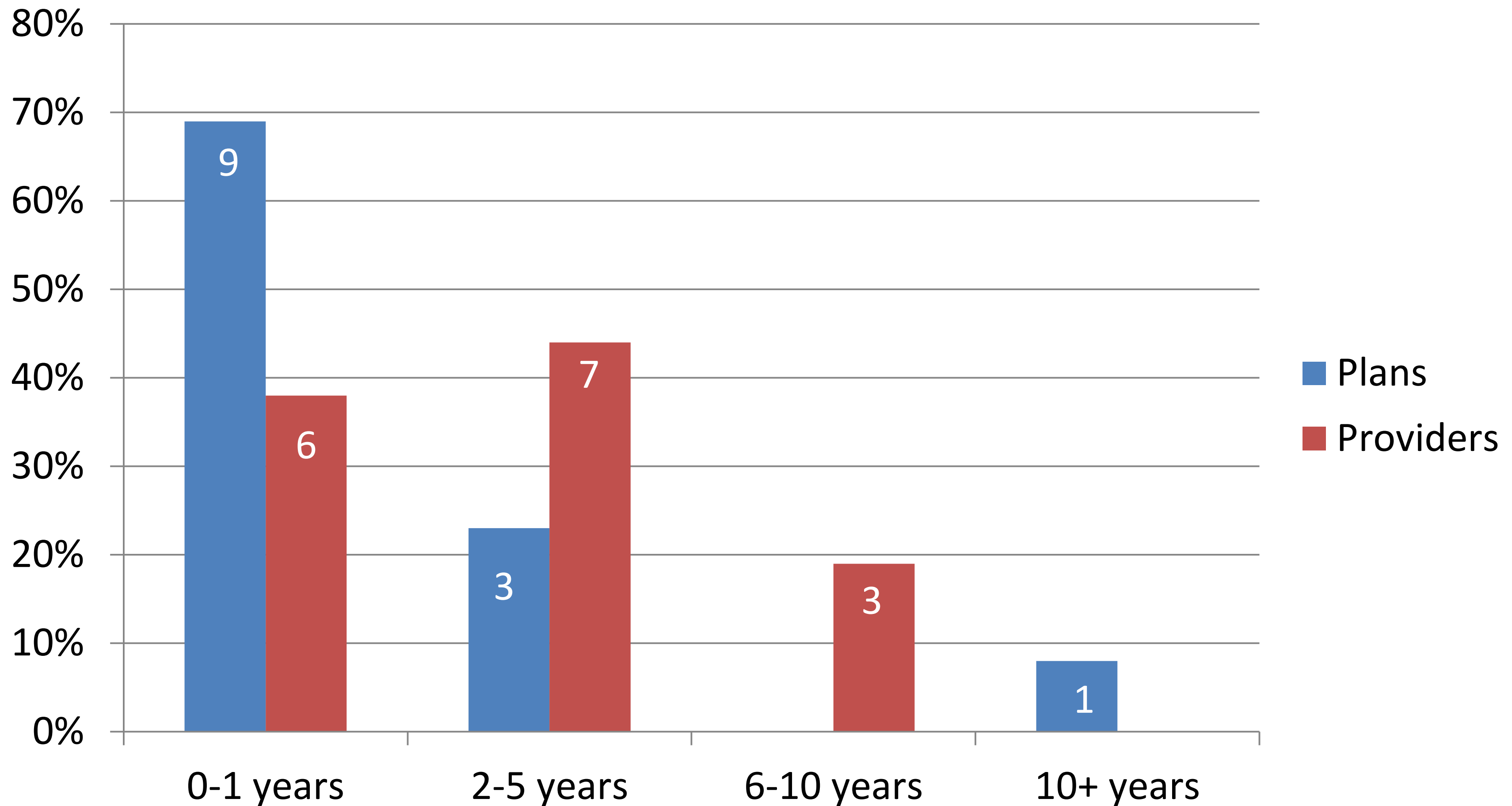
Materials from Topics 1-4

Survey and Workshops

- Main focus areas
  - Information about services and partnerships
  - Program implementation topics
    - Staffing model
    - Plan approaches to collaborating with providers
    - Patient/member identification
    - Patient/member engagement
    - Referring provider engagement
- Participation
  - Survey: 13 plans, 16 provider organizations responded
  - Workshop: approximately 60 participants

STATUS
OF SERVICES

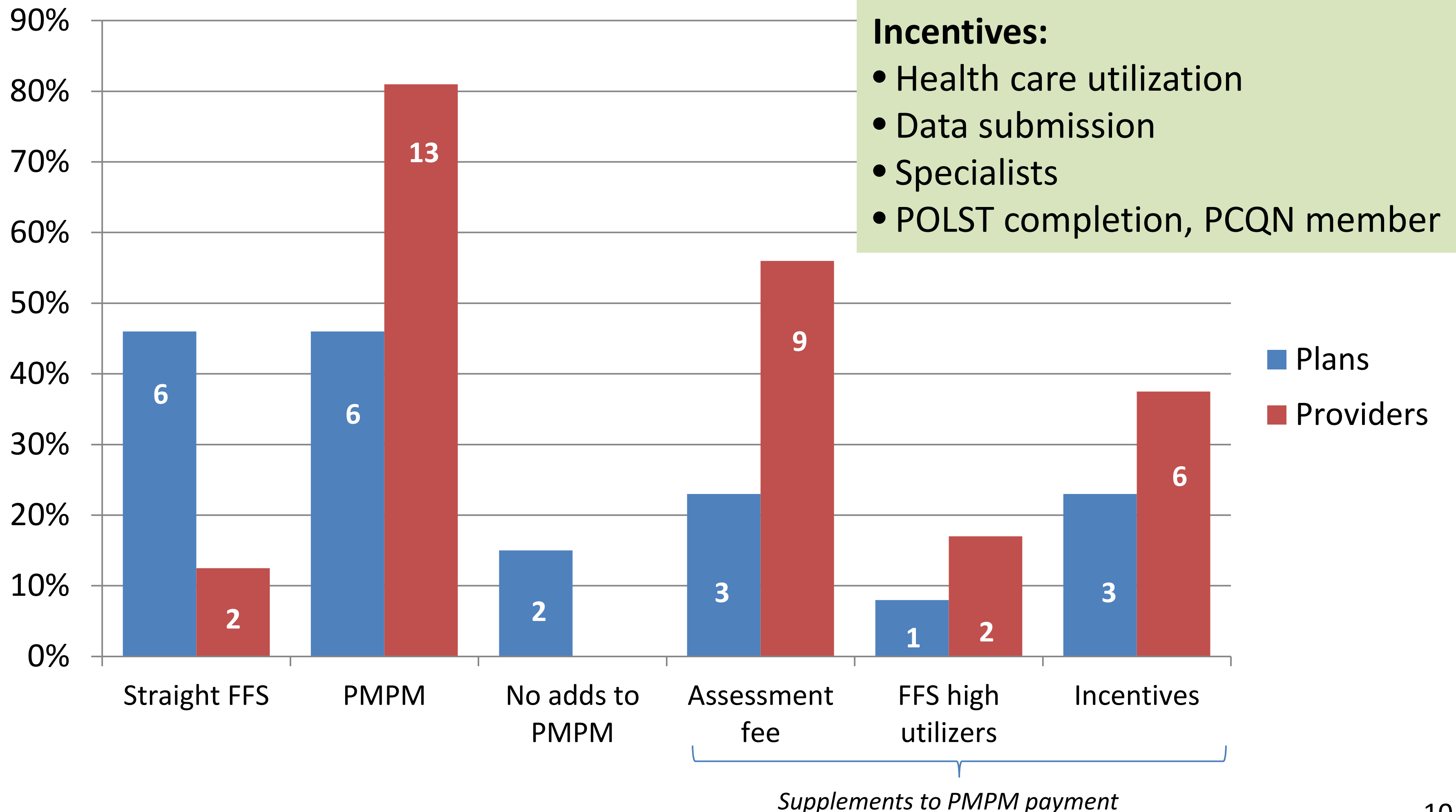
Survey Results: Partnership information



Survey Results: Partnership information

- **How many SB 1004 partners do you have?**
  - Plans: Range 1-10 (majority have ≤ 3)
  - Providers: Range 1-3 (majority have 1)
- **Additional services required by plans**
  - No additional services required (38%)
  - 24/7 phone support (54%)
  - Direct spiritual care services (46%)
  - Direct medication prescription (23%)
  - Formal caregiver assessment (15%)
  - Other home health services (8%)

Survey Results: Partnership information



Survey Results: Required/reported data

Data element	Plans requiring	Providers reporting
% Referred patients who receive PC services	62% (8)	56% (9)
% Pts with AD or POLST completed	38% (5)	75% (12)
% Pts with ACP discussed	31% (4)	62% (10)
Use of tele-visits	38% (5)	50% (8)
# Days between referral and initial visit	38% (5)	43% (7)
Pt/family satisfaction	31% (4)	44% (7)
Assess/impact physical symptoms	23% (3)	62% (10)

Survey Results: Required/reported data

Data element	Plans requiring	Providers reporting
% Pts for which spiritual assessment is completed	15% (2)	38% (6)
% Pts for which functional assessment is completed	8% (1)	31% (5)
Assessing, managing, or impacting emotional or spiritual distress	23% (3)	56% (9)
% for which medication reconciliation is completed within 72h of hospital discharge	0	38% (5)
NONE	15% (2)	0

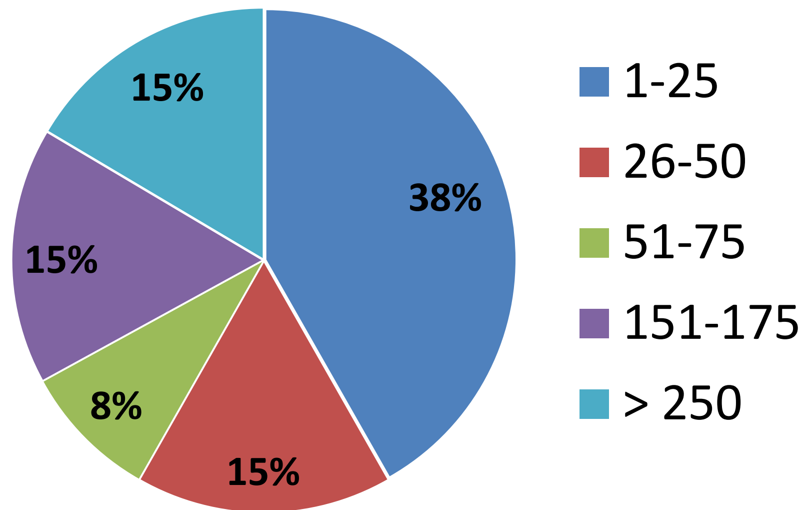
Survey Results: Palliative Care Quality Network membership

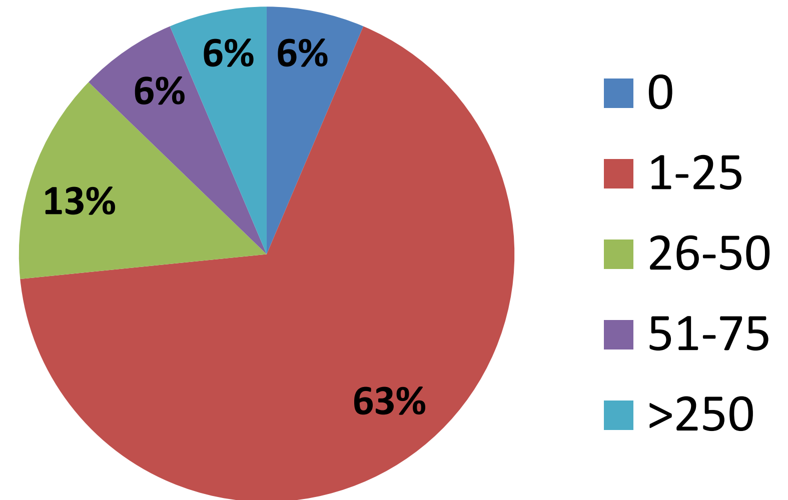
- **Does your plan require PCQN membership?**
  - Yes (23%)
  - ✓NO (69%)
  - Unsure (8%)

At least 2/3 of plans that require PCQN membership help cover cost

- **Does your (provider) organization belong to PCQN?**
  - ✓Yes (50%)
  - Considering or In Process (17%)
  - No (6%)
  - Don’t know (6%)

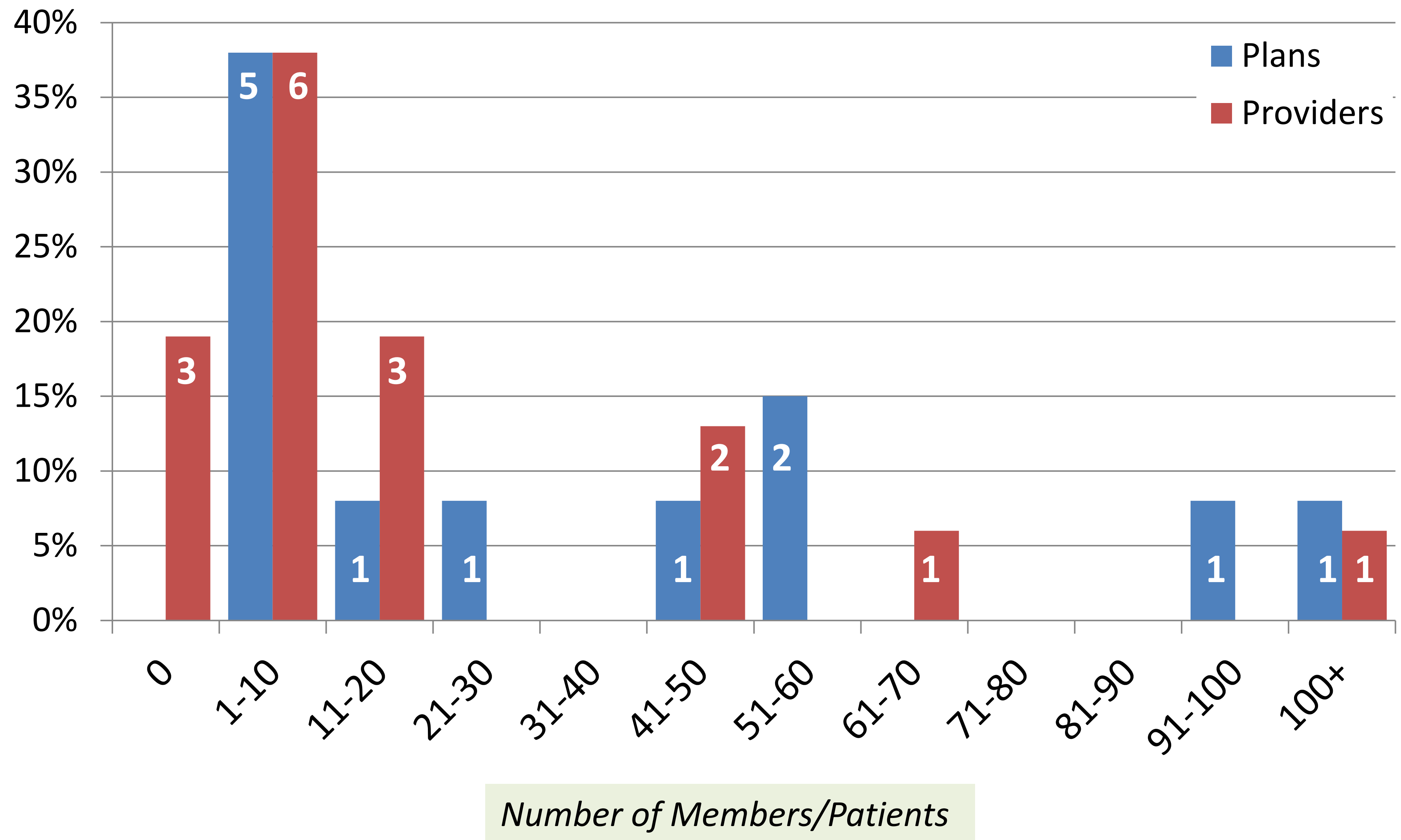
Survey Results: Patients referred since Jan 2018





62% of plans expanded the SB 1004 eligibility criteria

Survey results: Members/pts receiving services



Status of Services: Reflections

- For several plans & providers these services are new, and a small number of pts have received services so far (with a few notable exceptions)
  - 75% of providers report seeing 20 pts or less
- Plans are evenly split between FFS and PMPM case rate for reimbursement
- Nearly 2/3 of plans require additional services beyond those outlined in the All-Plan Letter
- 62% of plans expanded the eligibility criteria

STAFFING MODELS

Staffing Models: Introduction

SB1004 Required (and recommended but Optional) services to be delivered by an interdisciplinary team:

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)

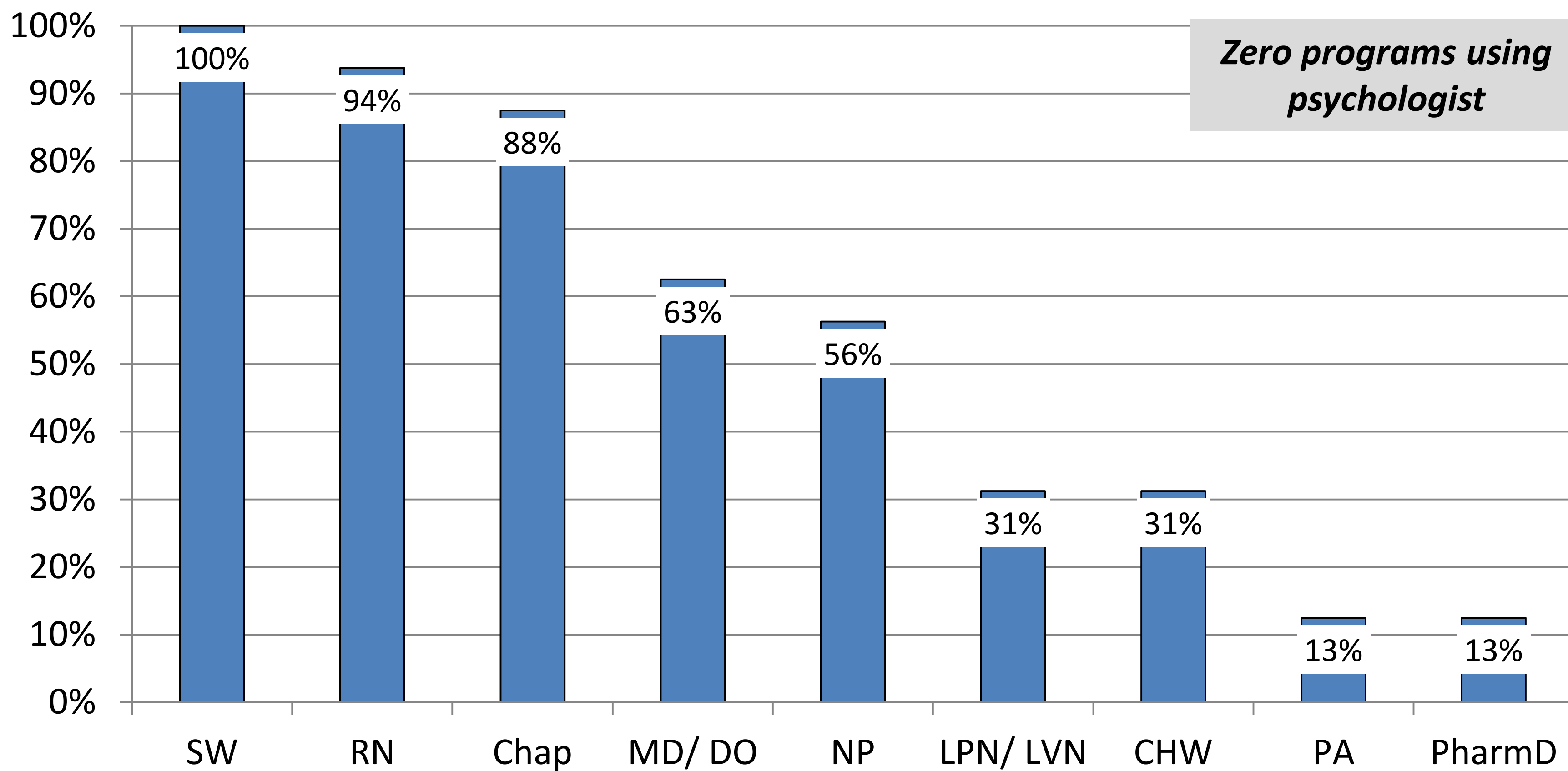
Staffing Models: Introduction

Many disciplines can participate in (at least) some aspects of most services

Required Service	MD/DO	NP	RN	SW	Chap
Advance Care Planning	✓	✓	✓	✓	✓
Palliative Care Assessment and Consultation	✓	✓	✓	✓	✓
Plan of Care	✓	✓	✓	✓	✓
Pain and Symptom Management	✓	✓	✓		
Care Coordination	✓	✓	✓	✓	✓
Mental Health and Med Soc Svcs	✓	✓	✓	✓	✓

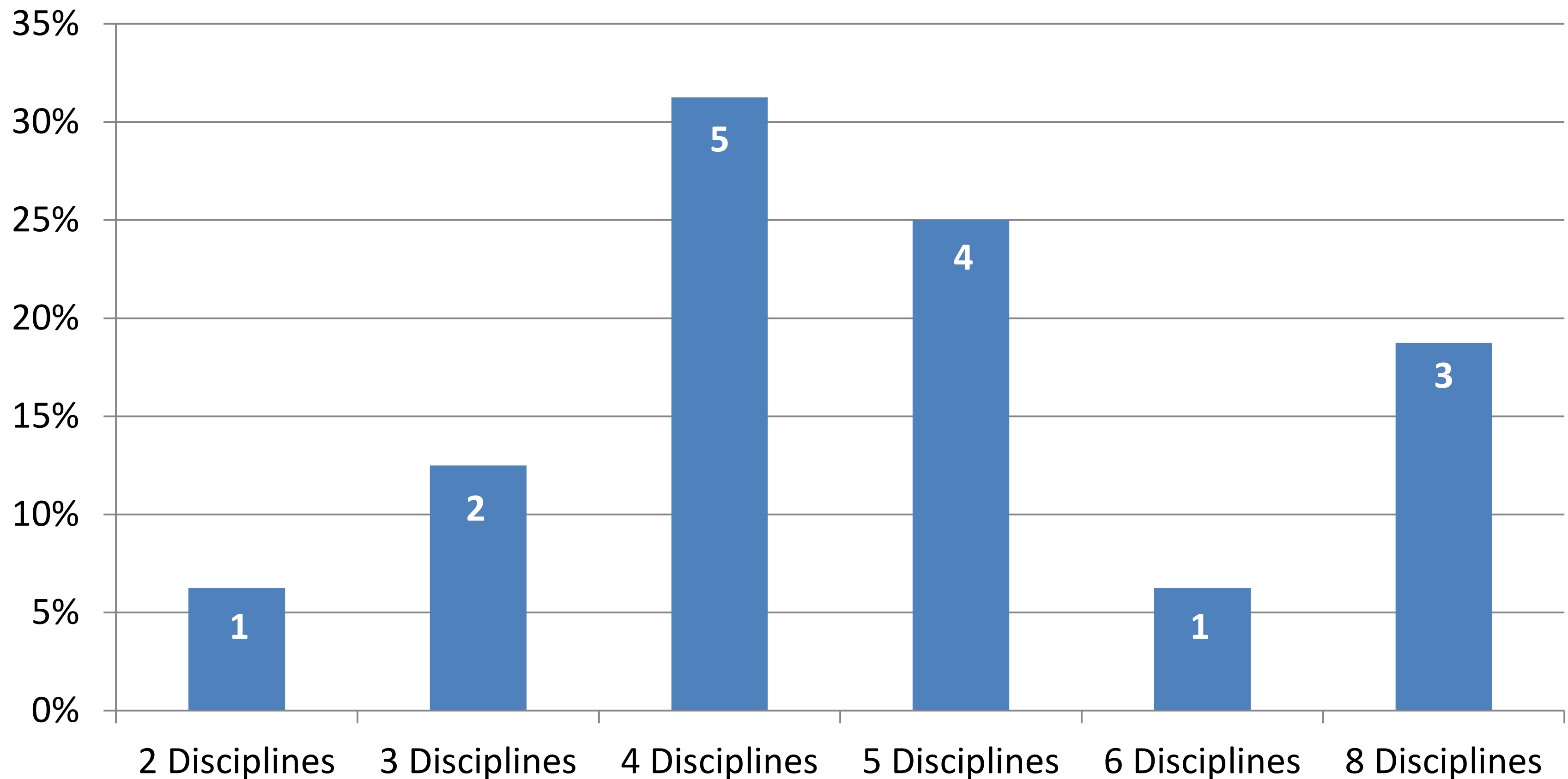
Survey Results: Proportion providers using each discipline

Disciplines directly involved in patient care on the PC Team (n=16)



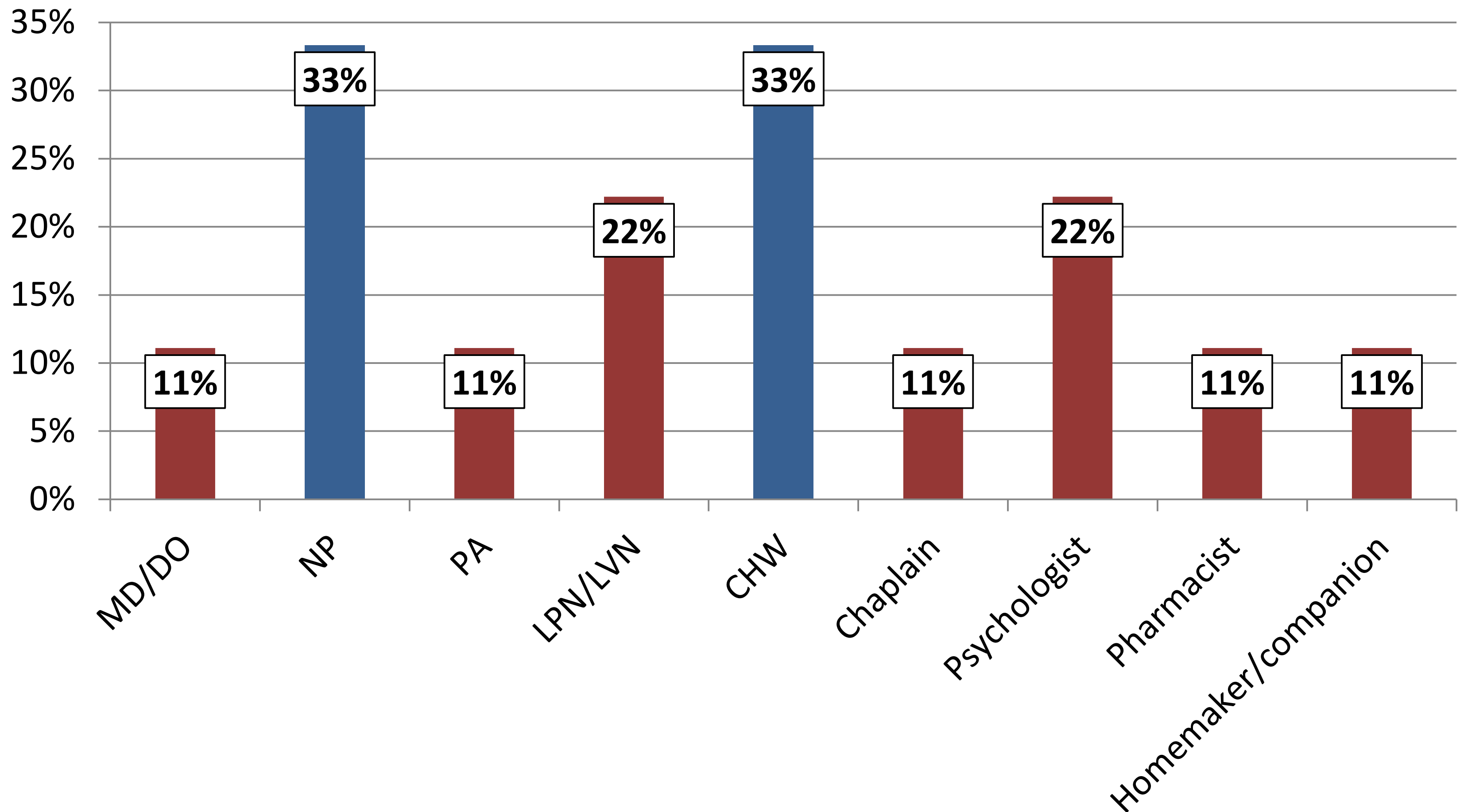
Survey Results: Number of disciplines on team

Range 2-8 of 10 possible disciplines (n=16 provider organizations)



Survey Results: Staffing Models

Which discipline(s) would you most want to add? (n=9)



Staffing Models: Reflections

- Teams are appropriately interdisciplinary
- Almost all use RN and SW but beyond that significant variation in team composition
- Potential drivers of variation
  - Custom/culture?
  - Expedience?
  - Feasibility (recruiting and retention)?
  - Quality?
  - Efficiency?
- Worth thinking about why using current model, and how model will work as volumes increase over time

PLAN-PROVIDER COLLABORATIONS

Plan-Provider Collaboration: Introduction

- In most cases, delivering SB1004 PC is a team sport (collaboratively delivered by plan-provider)
- We have heard from you there is variation in areas / intensity of collaboration

Survey Results: Plan-Provider Collaboration

12 plans rated intensity of involvement in 8 processes

	Frequent direct plan involvement	No plan involvement
Identifying eligible members	33%	8%
Educating members about PC benefit/program	**0%**	**8%**
Referring provider education	17%	0%
Plan participates in IDT case reviews	33%	17%
Care coordination/case management	25%	17%
Securing authorizations for services / meds / supplies	42%	8%
Referrals to social services	25%	8%
Referrals to mental health services	25%	8%

Survey Results: Variation in level of involvement by plan

	# areas (of 8) with frequent involvement	# areas (of 8) with no involvement
Plan 1	6	0
Plan 2	6	1
Plan 3	5	0
Plan 4	2	0
Plan 5	2	0
Plan 6	1	0
Plan 7	1	0
Plan 8	1	3
Plan 9	0	0
Plan 10	0	0
Plan 11	0	2
Plan 12	0	3

Plan-Provider Collaboration: Reflections

- Collaboration can serve several purposes
  - Quality assurance/quality improvement
  - Better coordination
  - Lower burden on provider
  - Monitor plan expenditures
  - Education (plan to provider, and provider to plan)
- Significant variation so opportunities to reassess practices
- It is perhaps worthwhile for partners to share perspectives on the value of each type of collaboration
  - Add or remove areas?
  - Increase or decrease intensity?
  - Ramifications of collaboration, or lack thereof?

IDENTIFYING ELIGIBLE PATIENTS/MEMBERS

Identifying Eligible Patients/Members: Introduction

Three types of criteria, hard to find in a single data source

	Claims and authorization data	Electronic health records	Screening / assessment findings
Qualifying diagnoses	✓	✓	✓
Evidence of advanced disease	(✓)	✓	(✓)
Patient & family preferences		(✓)	✓

www.chcf.org/sb1004 -- Topic 1: Estimating number eligible patients

Survey Results

What strategies have you used to identify potentially eligible patients?

	Plans (n=13)	Providers (n=16)
Primary & specialty providers asked to refer directly to PC providers	100%	81%
Non-physician staff at clinics/hospitals/physician offices asked to refer directly to PC providers	85%	56%
Members self-refer	62%	44%
Plan id's pts through claims data, sends list to PC providers	54%	63%
Plan id's pts enrolled in other programs (complex care management) sends list to providers	54%	31%
PC providers participate in rounds at local hospitals	31%	13%
Staff in social service organizations (shelters) asked to refer directly to PC providers	15%	19%
PC providers participate in rounds at local clinics	8%	13%

Most effective strategies

- ✓✓ Plan Case Managers and UM nurses identify
- ✓✓ PC team participates in clinic and hospital rounds
- Data mining of high cost, multiple co-morbidity patients
  - Use claims as a starting point, and then use case managers/social workers to filter further
- Cold calls can work
  - Case managers and social workers calling on behalf of the physician to describe the program
- Plan sends list of patients to PCP/Specialists
- Primary/specialty providers identify (best when PCP involved)
- Inpatient PC team or other hospital providers identify
  - [CBPC Provider meets Member at bedside]
- Affiliated home health agency identifies
- **[None]**

Least effective strategies

PLANS

- Relying on PCP and Specialist referrals
  - ✓✓ Presenting at provider education meetings (“lunch and learn”)

✓✓ Providing lists to PC Providers (for cold calls)

- Identifying high-risk/acutely ill members in concurrent review
- Working with other community partner organizations

PROVIDERS

✓✓ Cold calling members from lists provided by health plans

> ***“Information is often incorrect, members are suspicious, lack of medical information and barriers to obtaining this from PCP”***

- Referrals from Physicians / Clinics / Self-Referrals
- **[Waiting for referrals to come in]**

Identifying Eligible Patients/Members: Identification assets

- Claims data
- Plan staff & programs
- SB1004 PC providers
- Primary & specialty providers
- Non-physician staff
- Hospital PC teams
- Home health agencies
- Community agencies
- Members/pts

Identifying Eligible Patients/Members: Reflections

- Lots of variation … so many of you may have additional strategies to try
- Some strategies that were flagged as being most effective in survey or at workshop were also flagged as being least effective
  - How a strategy is employed matters: By whom, how, when … all impact efficacy
- General rejection of having PC Providers cold call members/patients from lists generated by claims data
- Most see benefit of adding strategies vs. eliminating any, even those that have not yet been effective

STRATEGIES TO ENGAGE PATIENTS/MEMBERS

Patient/Member Engagement: Introduction

- Major topics:
  - How to inform members/patients about the availability of services
  - How to increase the likelihood that eligible patients/members will accept services
- Issues covered in Topic 3
  - Informing patients about palliative care
    - Challenges with Medi-Cal population
    - Suggestions for addressing challenges

Engaging Patients/Members: Introduction

- Topic 3 content reminders
  - Informing patients about palliative care
    - Most patients are unaware of what palliative care is
    - When informed, the vast majority say they would want it personally or for a loved one
    - For vulnerable patient populations:
      - Significant disparities in access exist
      - Word of mouth (former patients, staff, trusted organizations) is an important way to inform them of services
      - Leverage advocacy organizations for resources to address language, cultural barriers

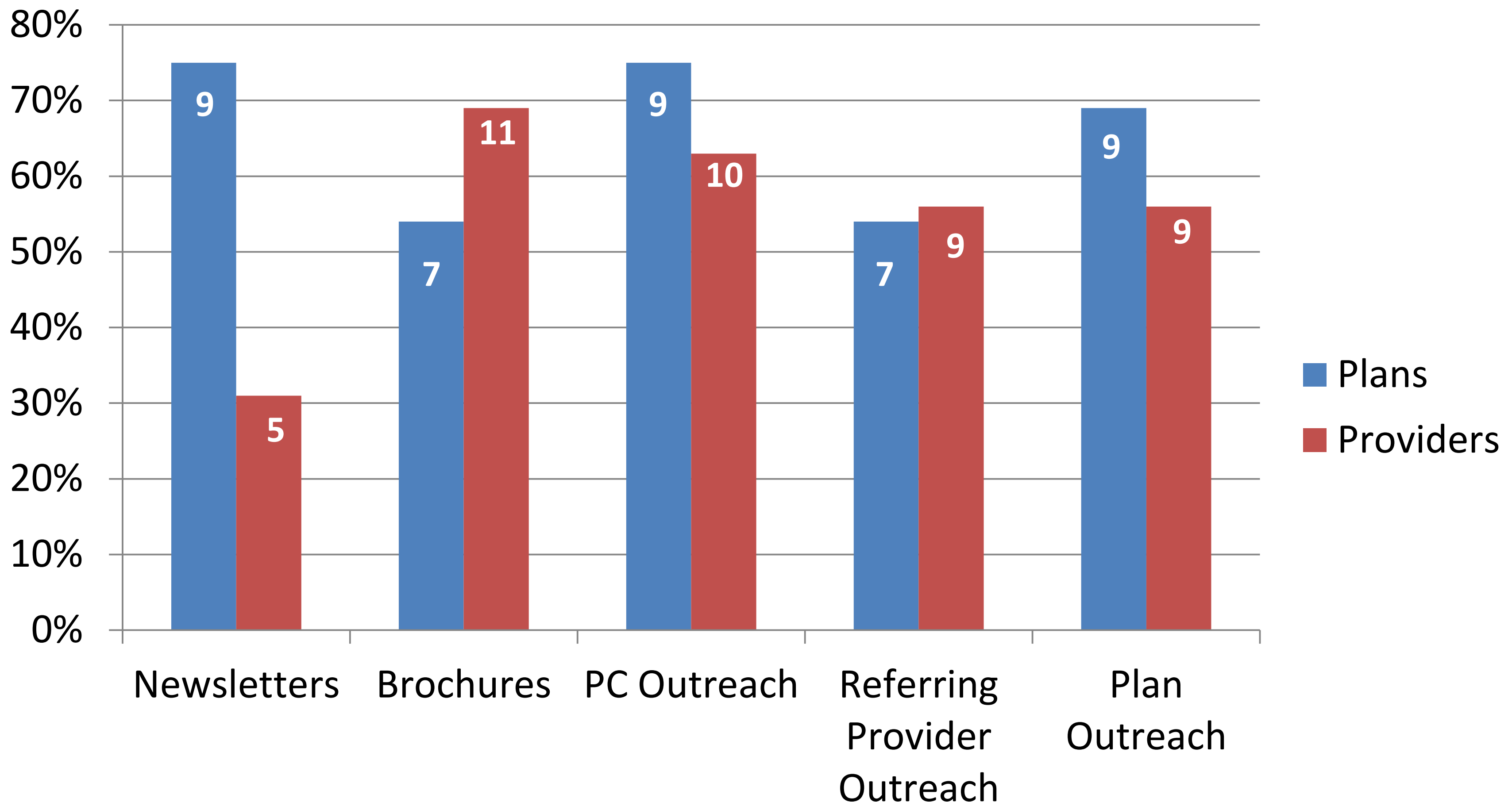
www.chcf.org/sb1004 -- Topic 3: Assess Capacity and Launch Services

Engaging Patients/Members: Introduction

- Topic 3 content reminders
  - Explored challenges of Medi-Cal population
    - Language, cultural barriers
    - Challenging social situations (isolation, homelessness)
    - Late presentation with advanced illness (timeline is compressed)
  - Recommendations for addressing challenges
    - Partner with trusted providers (navigators/CHWs, PCP, specialist) & trusted organizations
    - Develop system for identifying patients at time of diagnosis/progression

Patient/Member Engagement: Informing About Palliative Care

What strategies have you used to inform members/patients about PC availability?



Patient/Member Engagement: Are Patients Informed?

- Have Medi-Cal patients/members contacted you to ask about palliative care services?
  - Plans: 17% Yes (2 orgs)
  - Providers: 33% Yes (6 orgs)

Patient/Member Engagement: Biggest challenges

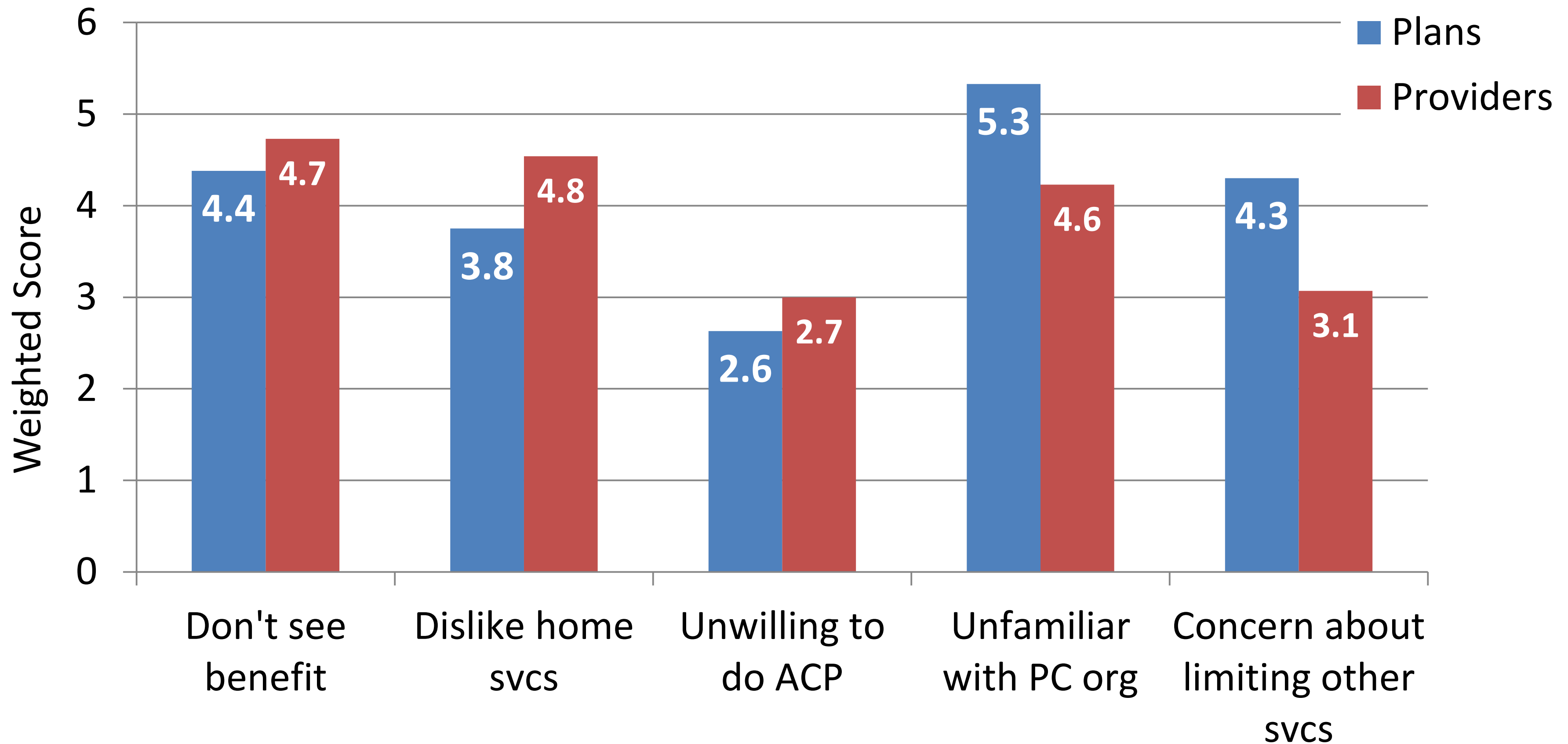
- Plans
  - Low volumes of members who read newsletters, otherwise hard to contact because of social issues
  - Lack of time for outreach/education (have been invested in developing infrastructure)
- Providers
  - Difficulty getting information from plans, or integrating with plan case management
  - ✓✓Patient instability (moving, lose phone, homeless)
  - Time investment

Survey Results: Engaging Patients/Members

Provider comment

"The amount of time cold calling patients takes - usually [a] call made by a clinician who can also obtain medical history - enough to determine eligibility. All of this time (1-2 hrs/patient) might be completely unreimbursed if the patient, or PCP, declines involvement in the program. The marketing outreach overhead right now is cost prohibitive to trying to build the program."

Patient/Member Engagement: Reasons members/pts decline services



Patient/Member Engagement: What works best?

- **Face-to-face** (or at least direct)
- Time -- building rapport, trust, providing education
- Follow-up calls (takes pressure off 1st call)
- Meet pt in hospital/SNF
- Co-branding on materials (PC org and Plan)
- Support from referring provider
  - Warm handoffs (provider-to-provider)
  - Letter or call from plan before PC provider calls
  - How provider explains service makes a difference
- Consistent case mgr contact at plan (easier to ensure consistent message)
- Addressing pt's immediate needs first

Patient/Member Engagement: Reflections

- More patients are finding out about services than might have been expected
- Psychosocial factors have a big impact on providers' ability to engage with patients
- Emphasize strategies to transfer trust (introductory letters, warm hand-offs)
- "Getting in front of the patient" is key
- Some reasons patients/members decline services may be amenable to education

STRATEGIES TO ENGAGE REFERRING PROVIDERS

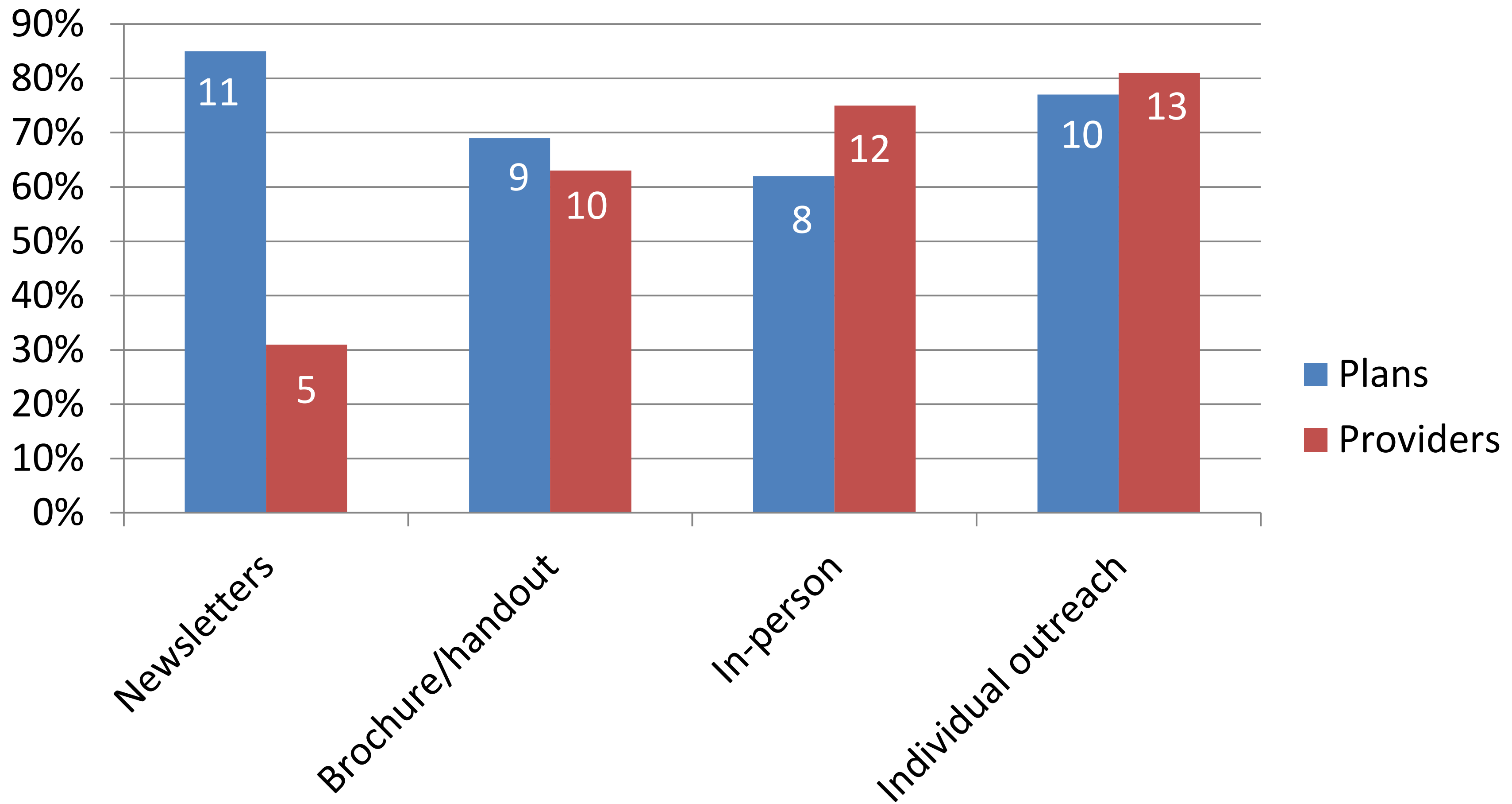
Referring Provider Engagement: Introduction

- Topic 3 content reminders:
  - Key providers to involve for referrals:
    - Clinicians with access to clinical information
    - Providers with frequent contact (e.g. case managers, navigators, CHWs, social service providers)
  - Referring Provider needs assessment
    - Importance of understanding providers' needs and constraints, competing priorities, workflows
    - Identifying your palliative care champions
    - Education needs

Referring Provider Engagement: Introduction

- Major topics:
  - How are organizations reaching out to referring providers?
  - What are the barriers to engaging providers?
  - What are the most effective strategies so far?

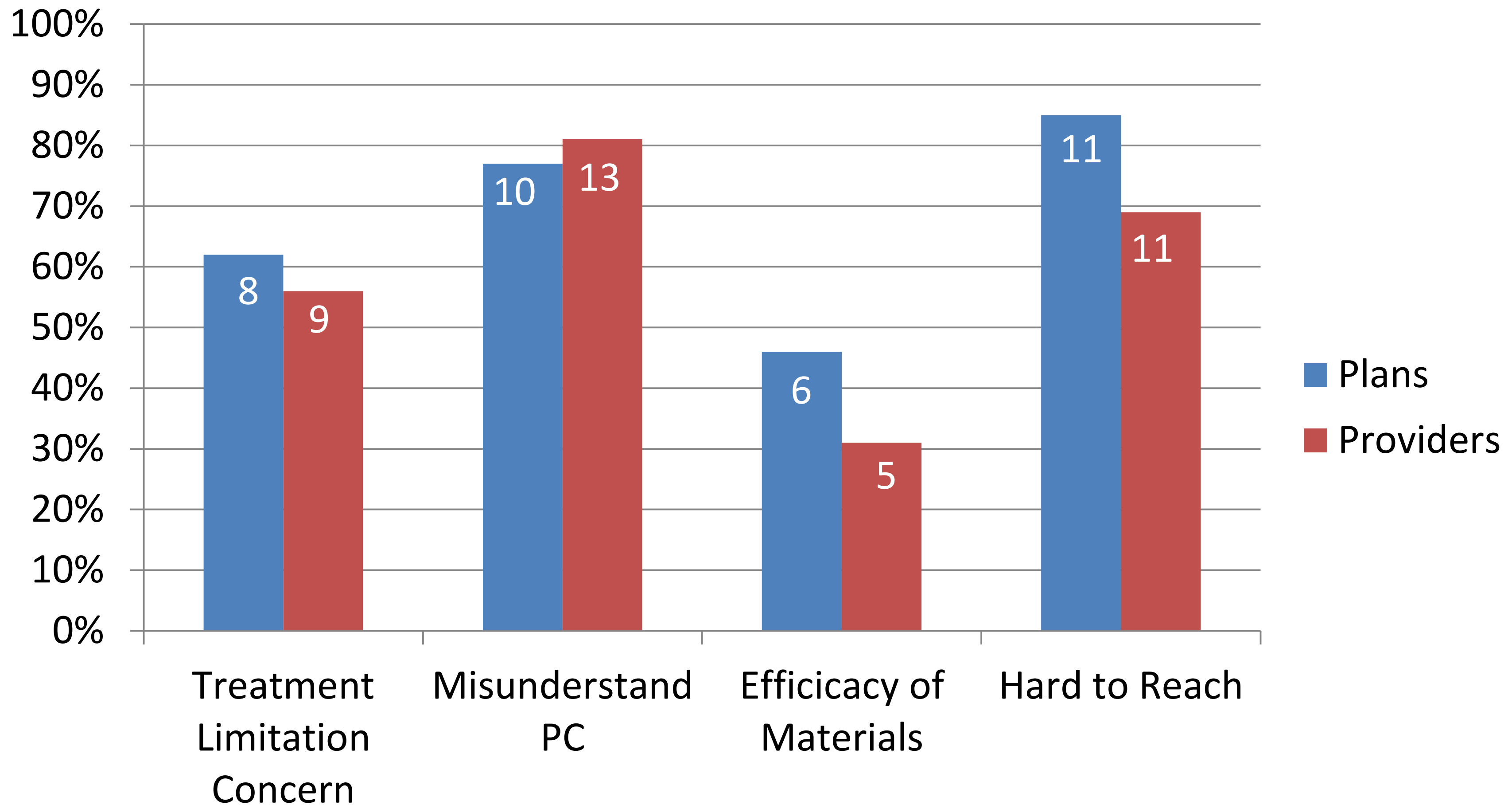
Engaging Referring Providers: Strategies used



Survey Results: Which providers have you engaged?

- Attempts to engage providers:
  - PCPs (100% plans, providers)
  - Specialists (90% plans, 91% providers)
  - Case managers/CHWs (90% plans, 91% providers)
  - Inpt palliative care (80% plans, 81% providers)
  - Social workers (60% plans , 81% providers)
  - RNs (50% plans, 55% providers)
  - Chaplains (10% plans, 27% providers)
  - Other: Office mgr/staff, ED physicians & hospitalists

Engaging Referring Providers: What are the biggest barriers?



Engaging Referring Providers: What are the biggest barriers?

- Themes

✓✓✓Lack of time/focus (for education, and for serious illness conversations with patients)
  - Lack of understanding (benefit, what pal care is)
  - Limited access/contact (e.g. won’t return calls, don’t read newsletters)
  - Referring providers want to be able to refer all pts who need pal care, not just Medi-Cal
  - Expectation (or fear) that palliative care team will take over care (or try to “sell” hospice)
  - Some providers don’t know pt well

Survey Results: Biggest barriers to provider engagement

Plan response

"The most effective strategies seem to be fairly resource heavy (time/energy/staff/etc). We've had staff go out to clinics; we've invited our pall care providers to small gatherings of providers doing complex care management. This is a difficult strategy to sustain, particularly when there are other competing priorities for time/resources."

Engaging Referring Providers: What are the most effective strategies?

- **Face-to-face meetings**
- **Doc-to-Doc conversations** about specific pts
- Key messaging – extra support for physician

  "We're the eyes and ears at home"

  "We're available when your office is closed"
- Engaging office staff and non-physician providers, especially to get physician time
- SW coordinates with hospital dc planner
- Personal connection/provider receptive to palliative care

Engaging Referring Providers: Reflections

- Time is a huge factor, for <u>everyone</u> (referring providers, plans, and PC providers)
  - Hard to get time with referring providers
  - Face-to-face (or doc-to-doc) strategies are frequently identified as effective, but time-consuming
- Participants highlight not just education but awareness and practical aspects (making referrals easier)
- Most organizations have focused on physicians, case managers for outreach
- Think about meeting providers' needs, value added – "extra support for physicians"

KEY POINTS

Staffing Models

- Significant variation in team composition … not just one right way
- Reflect on why you are using your current staffing model
- Consider/anticipate how model will work as volumes increase over time, or what you will do if you need to operate more efficiently

Plan-Provider Collaboration

- Variation in which areas plans are engaged in and in intensity of involvement
- Seek partner perspective on current collaboration practices
  - Time investment
  - Value-added
- Reflect on what might be gained/lost if practices are modified

Identifying Eligible Pts/Members

- Plans and providers should share responsibility and assets
- Strategies that were seen as most effective by some were seen as least effective by others: "how", "when" and "by whom" impact efficacy
- Consider new twists on old methods
  - Plan sends list of potentially eligible members to PCP's / specialists, vs to PC provider teams

Engaging with patients/members

- Emphasize strategies to transfer trust (introductory letters, warm hand-offs)
- “Getting in front of the patient” is key
- Some reasons patients/members decline services may be amenable to education

Engaging with referring providers

- Time is a huge factor, for <u>everyone</u> (referring providers, plans, and PC providers)
- Education, awareness and practical aspects (making referrals easier) are all important
- Think about meeting providers' needs, emphasize value added – "extra support for physicians"
- Start with your friends (providers that are receptive to palliative care)and leverage personal connections

Acknowledgements and resource links

Thanks to our colleagues from health plans and provider organizations who completed the surveys, and to all of the individuals who participated in the workshops.

- SB 1004 Questions
  - http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx
  - SB1004@dhcs.ca.gov
- Technical Assistance Series: kmeyers@chcf.org
- Technical Assistance resources: www.chcf.org/sb1004