



## SB 1004 PROMISING PRACTICES

# Identifying Eligible Patients

### Background

Many Medi-Cal managed care plans (MCPs) and palliative care (PC) providers consider identifying patients who are eligible for SB 1004 PC as their most persistent and difficult SB 1004 implementation challenge. This summary outlines the strategies that plans and PC provider organizations can use to identify eligible patients.

For more SB 1004 resources, go to [www.chcf.org/sb1004](http://www.chcf.org/sb1004).

### Common Challenges and Barriers

- ▶ There are three elements to SB 1004 eligibility — having one of four specified diagnoses, evidence of advanced disease, and patient willingness to engage in advance care planning — and it is very difficult to find all that information in a single data source. Thus, verification of eligibility is usually a multistep process that takes a lot of time and effort.
- ▶ There is no standard definition of a “PC-appropriate” population, and SB 1004 criteria are unique, so there are few completely transferable, established approaches to adopt. Further, the majority of California’s Medi-Cal MCPs have expanded access to SB 1004 PC either by relaxing some of the criteria related to evidence of advanced disease or by adding disease groups. This variation means that a patient identification strategy used by one MCP may not work (without modification) for any other MCP.
- ▶ Claims-based approaches to identifying patients are relatively new and have yet to be perfected; inaccurate, outdated, or incomplete data can undermine the utility of lists of potential patients.
- ▶ Patient lists based only on primary diagnosis can yield far more people than are actually eligible, creating a significant amount of screening work; on the other hand, algorithms that are too restrictive (screening based on high use of health care services, plus high costs, plus presence of multiple comorbidities, for example) can fail to identify a large number of eligible patients.
- ▶ SB 1004 is a new benefit that creates access to a clinical service that is often misunderstood by primary and specialty providers, patients, and even health plan staff. As a result, plans and PC providers need to invest significant effort in teaching all involved parties what PC is generally, followed by specific information about SB 1004 PC eligibility criteria.
- ▶ All strategies require a significant investment of time, both in start-up and maintenance phases.
- ▶ Time is in short supply for safety-net primary and specialty care providers, which often limits the efficacy of identification strategies that rely on these providers to recognize and refer eligible patients.

# Strategies for Identifying Patients

Strategies that plans and PC provider organizations commonly use to identify eligible patients are described below. Most organizations prefer to use a combination of approaches rather than relying on just one.

## 1 Use claims, encounter, and authorization data to generate lists.

**Rationale.** Plans have access to claims, encounter, and authorization data, and most plans use these data to generate lists of potentially eligible patients, which are then further screened by staff from the plan or the PC provider organization.

EXAMPLES:

- ▶ Plan builds an algorithm that accesses data from the prior 6–12 months to create a list of potentially eligible members. Variables included in such algorithms may include primary and secondary diagnoses, risk score for mortality or admission, number of comorbidities, use of health care services like hospital admissions or emergency department visits, nursing home admissions, authorizations for certain types of durable medical equipment or drugs, and/or total cost of care.
- ▶ Plan staff review a list of patients who were recently admitted to an acute care hospital, screening for those with eligible diagnoses and other evidence of advanced disease.

**Partner involvement.** Plans generate the lists, and in some instances plan staff do all follow-up screening to verify eligibility, including outreach to primary or specialty providers. Alternatively, plans may do little or no screening before delivering the list to a PC provider organization, which will then cold-call patients and, as needed, reach out to primary or specialty providers to further assess eligibility.

**Things to consider.** Though most plans and PC providers rely on this identification strategy, all agree that it entails significant staff time for relatively low numbers of patients identified and then engaged. Lists tend to include many patients who are not eligible for SB 1004; lists based on claims data tend to include outdated or inaccurate patient contact information, and the lag between claims processing and list generation can result in delayed identification of a member who has urgent support needs. That being said, this approach is very common, and many are experimenting with ways to correct for over- or under-identification. A few plans are piloting approaches that include primary and specialty providers in the screening process, based on the assumption that those providers have the best and most up-to-date understanding of which patients would likely benefit from SB 1004 PC.

## 2 Ask primary and specialty care providers to identify patients.

**Rationale.** In most cases, primary and specialty providers who take care of seriously ill patients are in the best position to make assessments of SB 1004 eligibility and to recognize unmet or escalating needs for support.

EXAMPLES:

- ▶ Primary and specialty providers are oriented to the SB 1004 program through in-person educational sessions and are invited to identify eligible patients within their own practices. Orientation is conducted by the plan, the PC provider, or (ideally) both.
- ▶ PC provider teams regularly visit clinics that care for large numbers of seriously ill patients, and work with primary and specialty providers to identify eligible patients.

**Partner involvement.** Best when plans and PC providers collaborate in outreach and education.

**Things to consider.** Safety-net providers have very little time, an often incomplete or inaccurate understanding of PC, and very often no familiarity with SB 1004. Some fear that enrolling patients in a PC program will increase their own workloads, take the patient away from their care, or limit patient access to other services. All of these issues need to be addressed if primary and specialty providers are expected to participate in the patient identification process. While there are significant challenges and inconsistent results from this strategy, when a provider has or acquires a good understanding of PC and the SB 1004 benefit and a good relationship with the plan and/or contracted PC providers, this can be a very successful means of identifying eligible patients.

### 3 Review patients enrolled in other health plan programs.

**Rationale.** Most plans offer multiple programs for seriously ill individuals, and enrollment in such programs, like complex case management, often occurs well before a member becomes eligible for SB 1004 PC. Plan staff who deliver these services are in a good position to identify eligible patients, and the trusting relationships that some case managers have with patients can be leveraged to promote patient acceptance of services.

EXAMPLE:

- ▶ Plan case management and utilization management staff are trained to recognize signs that a member might benefit from and be eligible for SB 1004 PC.

**Partner involvement.** Plans take the lead here, but it can be useful for PC providers to support such strategies by helping to educate plan staff on PC and best practices for presenting the SB 1004 benefit to potentially eligible patients.

**Things to consider.** Most plan staff will need training in PC concepts, and workflows may need to be adjusted to allow adequate time for screening.

### 4 Seek referrals from other services that care for seriously ill populations.

**Rationale.** Seriously ill patients often use many different types of health and social services. If they are oriented to SB 1004 eligibility criteria, providers and staff across settings can help with identifying patients.

EXAMPLES:

- ▶ PC provider team participates in hospital rounds for appropriate services/units and helps assess eligibility for SB 1004, with a particular focus on patients who are preparing for discharge. This approach also allows for a direct handoff from the hospital team to the PC provider.
- ▶ Inpatient PC teams and outpatient (clinic-based) PC services are invited to refer patients to the SB 1004 PC provider.
- ▶ PC provider works directly with a clinic that cares for large numbers of Medi-Cal members (e.g., a Federally Qualified Health Center) and collaborates with clinic staff to use electronic health record data to identify eligible patients.
- ▶ Pain management teams, which often know patients' needs well, are invited to refer.
- ▶ Home health teams, which have information about how patients are coping in the home environment, are invited to refer.

**Partner involvement.** Best undertaken by both plans and PC providers initially, with PC providers taking the lead once strategies are implemented.

**Things to consider.** It will take time to educate and build relationships with providers and staff from all these services. In most cases, ongoing structured interactions yield better results than a single educational event. Plans and PC providers should regularly remind partners to refer and, when possible, create processes that make referrals easy.

## Key Lessons Learned in Identifying Patients

- ▶ Combining strategies from each of the four categories works best.
- ▶ Plans and PC providers should be mindful of the quality and reliability of the strategies that are employed. For example, is the strategy standardized, and do those tasked with identifying patients have the training, skills, and resources they need? Plan and PC providers should search for and address flaws in implementation before abandoning a strategy.
- ▶ Building relationships with providers and staff from multiple care settings and services is essential.
- ▶ Discipline-specific outreach often works best (e.g., medical director outreach to medical provider, nurse to nurse), helping to identify patients within different scopes of practice.
- ▶ To encourage earlier patient identification, plans and PC providers should ensure that those tasked with identifying and referring eligible patients understand the differences between PC and hospice.

## The Authors

Anne Kinderman, MD, Zuckerberg San Francisco General Hospital; Kathleen Kerr, Kerr Healthcare Analytics.

## About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit [www.chcf.org](http://www.chcf.org).