Topic 4: Engaging Patients & Providers

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Kathleen Kerr
Kerr Healthcare Analytics

Anne Kinderman, MD
Director, Supportive & Palliative Care Service
Zuckerberg San Francisco General Hospital
Associate Clinical Professor of Medicine, UCSF

Review: What Is SB 1004?

- [Senate Bill 1004](#) (2014) requires Medi-Cal managed care plans (MCPs) to ensure access to palliative care (PC) services for eligible patients

- Implemented January 1, 2018 for adult patients, expanded to include pediatric patients in 2019

- All Plan Letter (APL) describing plan requirements available at:

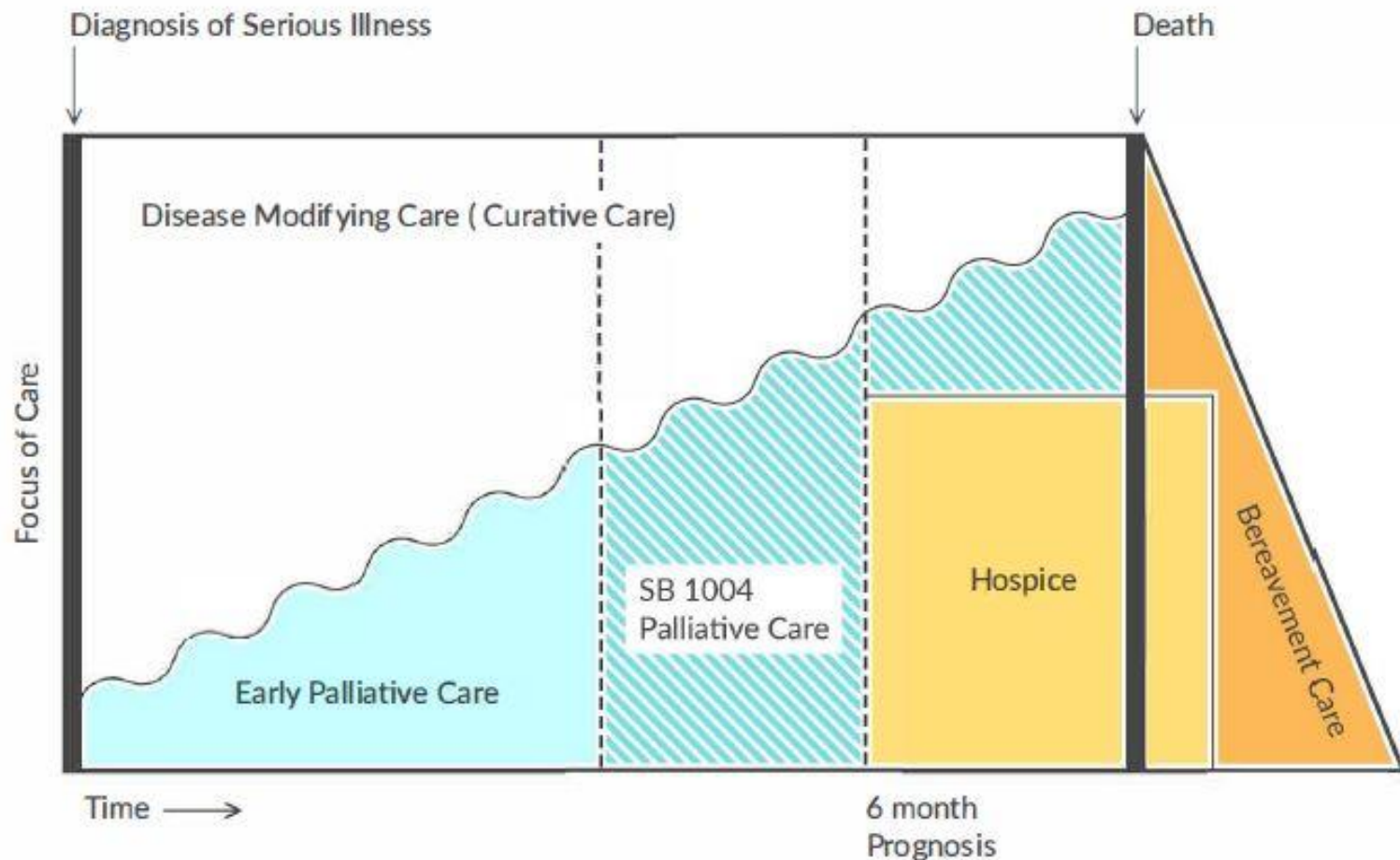*http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx*

*For more information about palliative care and SB 1004 see Topic 1 in this series, **SB 1004 Basics***

Topic 4 Objectives

- Review common challenges and barriers to engaging with eligible patients
- Review strategies plans and PC providers are using to engage patients
- Review common challenges and barriers to engaging providers who might refer eligible patients
- Review strategies plans and PC providers are using to engage referring providers
- Review options for optimizing referral processes

Palliative Care as Defined in SB 1004

Diagnosis of Serious Illness

Death

Focus of Care

Disease Modifying Care (Curative Care)

SB 1004 Palliative Care

Hospice

Early Palliative Care

Bereavement Care

Time →

6 month Prognosis

Advance Care Planning can occur at any time, including the POLST form for those with serious illness.

SB 1004 Eligibility Criteria

At minimum, plans must ensure access to palliative care to individuals with advanced cancer, COPD, heart failure, and liver disease who meet both general and disease-specific criteria.

| General criteria |
|---|

Disease-specific criteria

Cancer	COPD	Heart failure	Liver disease

Sources for Data and Recommendations

- In March 2019, CHCF surveyed 22 Managed Care Plans (MCPs) and 59 PC providers about their experiences implementing SB 1004 in 2018.

  - 14 plans (64%) and 29 PC providers (49%) responded to the survey.

  - Several survey questions focused on engaging with patients and referring providers.

- Survey responses are presented in this topic, along with information gathered from plans and PC providers that participated in a variety of CHCF SB 1004 implementation support activities.

Key Implementation Processes
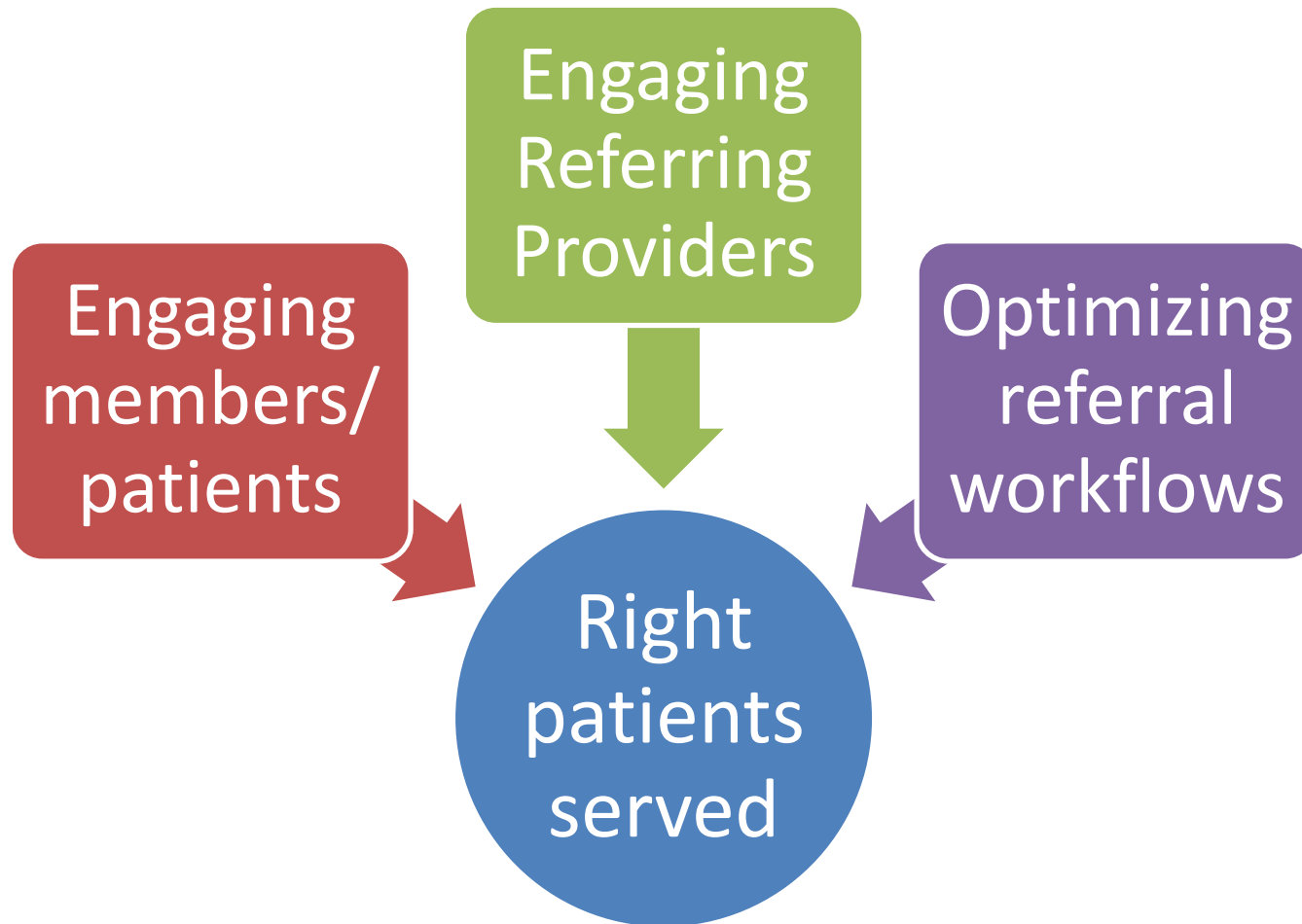
Common Barriers to Engaging with Patients

- Many patients are unfamiliar with or misinformed about PC; many assume that PC and hospice are the same thing.
- Some patients may receive diagnoses late in their illness course, limiting opportunities to provide early PC.
- Patients may not have a trusted (or even assigned) primary care or other provider who can recommend or introduce PC services.
- Barriers that are disproportionately prevalent in the Medi-Cal population:
  - Language barriers (limited English proficiency)
  - Cultural barriers (e.g. avoiding discussing end-of-life issues)
  - Psychosocial barriers (e.g. homelessness or unstable housing, lack of transportation, lack of consistent telephone access, mental illness and/or substance use disorders)

Common Barriers to Engaging with Patients

- PC providers may have a limited ability to make the multiple calls and contacts required to engage this population, particularly if such effort is not reimbursed.
- After PC is introduced, patients may decline services for a variety of reasons:
  - Lack of trust or familiarity with the PC provider organization
  - Patient receives conflicting messages regarding PC from other providers
  - Benefit of PC services is unclear — why would this help me?
  - Fear that enrolling in PC program may limit access to other services, including other home health services
  - Reluctance to allow outside providers to enter the home

Survey: Biggest Patient Engagement Challenges

- Plans
  - ✓✓ Incorrect contact information
  - – Cultural barriers
  - – Misunderstanding PC and hospice
  - – Competing priorities at the plan
- Providers
  - ✓✓ Incorrect contact information
  - ✓✓ Misunderstanding PC and hospice

Survey: Top Reasons Members/Patients Decline Services
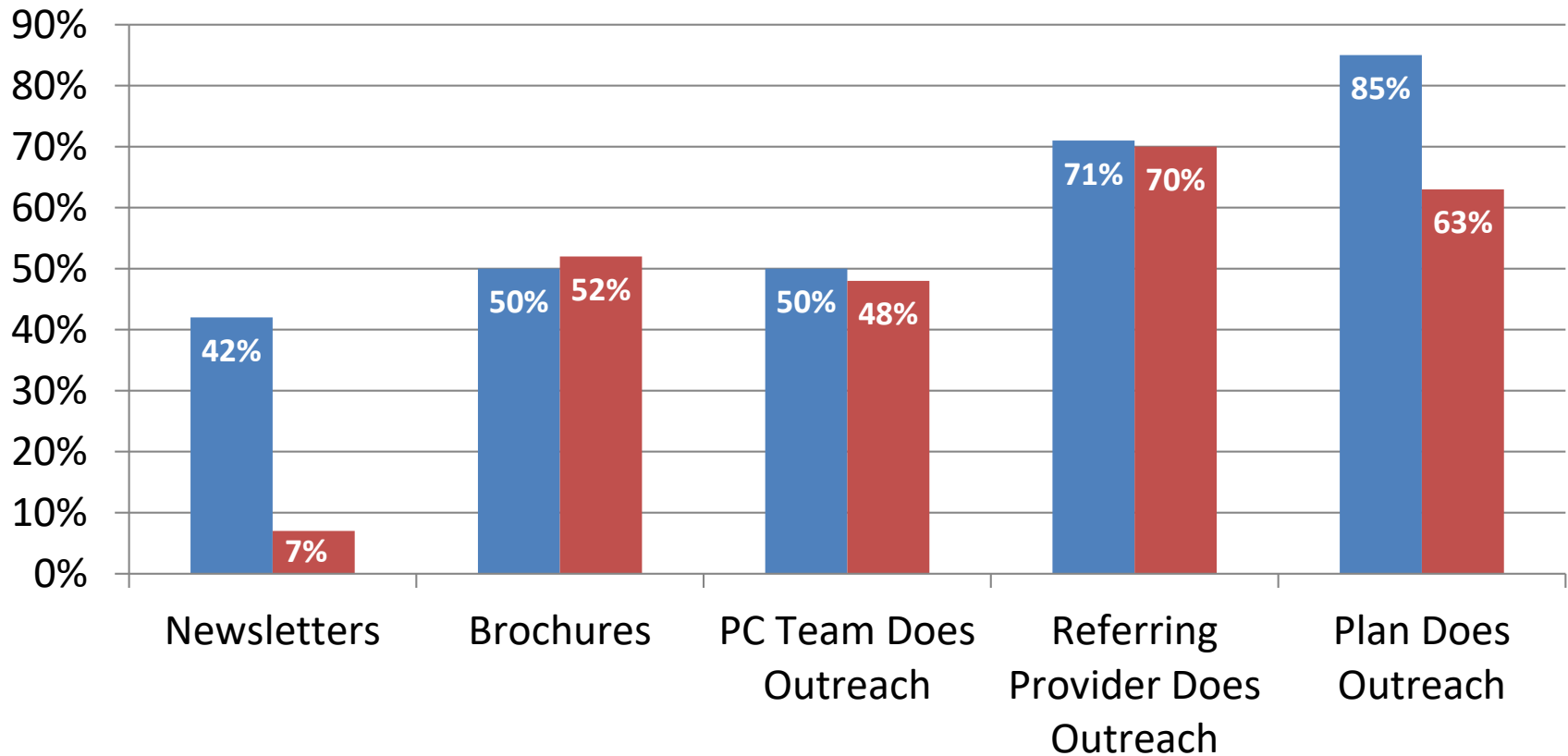
Areas of Agreement

1. Lack of familiarity with PC org
2. Doesn't see benefit of services

- Plans think patients worry about limiting care; PC orgs don't cite this as a big barrier
- Other barriers: Cultural norms, family resistance, mental illness, defer to referring provider, already getting other services (overwhelmed), pattern of disengagement

Survey: Engaging Patients

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

Legend: ■ Plans ■ Providers

Strategy	Plans	Providers
Newsletters	42%	7%
Brochures	50%	52%
PC Team Does Outreach	50%	48%
Referring Provider Does Outreach	71%	70%
Plan Does Outreach	85%	63%

Survey: Patient/Member Engagement – Most Effective Strategies

- ✓✓ Referrals/encouragement from plan case managers
- Referring provider introduces/promotes service
- Familiarize patient with PC provider (e.g. warm handoff)
- ✓✓ Emphasize benefits: included in your benefits (no additional cost), extra layer of support, 24/7 access to live person, help managing symptoms
- Face-to-face visits with patient/member

"Inpatient palliative care hand-offs to outpatient services seem to be the most effective; the other most effective strategy is having somebody the patient/family [trusts] (PCP, complex care case manager, etc.) explain and promote services – emphasizing the potential value/synergy of palliative care in combination with attempts at curative treatments."

Plan

Recommendation:
Be Intentional in Messaging

Pay attention to the face of the program, and the message to patients

- <u>Rationale</u>: First impressions can be powerful. Because many patients are unfamiliar with PC (or have misperceptions about it), it is important to convey a clear and consistent message regarding its benefits.

- <u>Examples</u>:
  - Use a single person (or small group) to perform patient outreach and education regarding the PC program.
  - Prioritize hiring staff who reflect the community you seek to engage.
  - Emphasize the "extra layer of support" provided by PC to counteract the concern that other services may be taken away.

- <u>Things to consider</u>: These approaches may require initial investment in staff training and recruitment, and some ongoing investment will likely to be needed to maintain proficiency, train new staff, and so on. But, if the messaging is high-quality, efforts in this area may have significant positive impact on patient engagement.

Recommendation: Provide Proactive Outreach and Education

Provide proactive community outreach and education

- <u>Rationale</u>: Patients may be more open to accepting PC if they have heard of it *prior to* the time they become eligible for services.

- <u>Examples</u>:
    - Film screenings in low-income housing communities
    - Staff education at senior living facilities
    - Community advance care planning workshops

- <u>Things to consider</u>: This strategy enables organizations to reach groups (rather than individuals), and may lead to some referrals, but it requires sustained effort and investment to be effective.

Recommendation: Collaborate in Developing Written Materials

Develop written materials thoughtfully and collaboratively

- Rationale: Written materials are an easy way to reinforce program messaging, particularly if they are developed with a target patient population in mind.

- Examples:
    - Cobrand materials with logos of the health plan — which patients may be more familiar with — and the PC organization.
    - Translate written materials into language(s) spoken by target population.
    - Review materials for health literacy, targeting a fifth-grade reading level.

- Things to consider: Developing appropriate materials requires an initial investment, then minimal ongoing effort. The impact of written materials varies but may be worth the small investment required.

Recommendation:
Use Face-to-Face Contact

Engage patients through direct — ideally face-to-face — contact

- <u>Rationale</u>: Since patients are often unfamiliar with PC concepts, services, and providers, direct (and often repeated) contact may be needed to introduce the program.

- <u>Examples</u>:
  - Spend time eliciting the patient's specific needs and highlight ways that PC services can help meet them.
  - Leverage motivational interviewing techniques to overcome fears and concerns.
  - Remove decision-making pressure by offering follow-up contact to discuss again, rather than forcing a decision at the first meeting.

- <u>Things to consider</u>: Arranging and carrying out an in-person introduction or multiple contacts requires significant time; however, plans and providers consistently cite the importance of this strategy, particularly with the Medi-Cal population.

Recommendation:
Work to Establish Trust

Work to establish trust with the patient

- <u>Rationale</u>: Many patients have had limited access to health care or have past experiences that have made them skeptical of new services; as a result, they may be hesitant to accept PC services.

- <u>Examples</u>:
  - Whenever possible, facilitate an introduction (ideally a warm hand-off) between a trusted provider (e.g. primary care provider, case manager, community organization) and the PC provider.
  - Send a letter to eligible patients from the plan or a trusted provider introducing the program before the PC provider calls for the first time.
  - In coordination with the plan and referring provider, address the patient's immediate needs (e.g. food, transportation, etc.) either before or while enrolling them in PC.

- <u>Things to consider</u>: This strategy often requires higher up-front investment (e.g. coordinating warm hand-offs, addressing immediate needs), but can potentially make a big difference in increasing patients' receptivity to services.

Key Points

- Tailor messages and materials to the unique needs, cultures, and groups in your service area.

- Strategies that work well in some areas and populations may be less effective in others, for a variety of reasons — consider investing in multiple approaches at once.

- Focusing on relationship- and trust-building with patients can require significant up-front investment but can make all the difference in patient acceptance of services.

Useful Resource

Promising Practices for Engaging Patients, which is available in this section of the SB 1004 Resource Center, summarizes strategies plans and providers use to engage with potential patients.

Key Implementation Processes
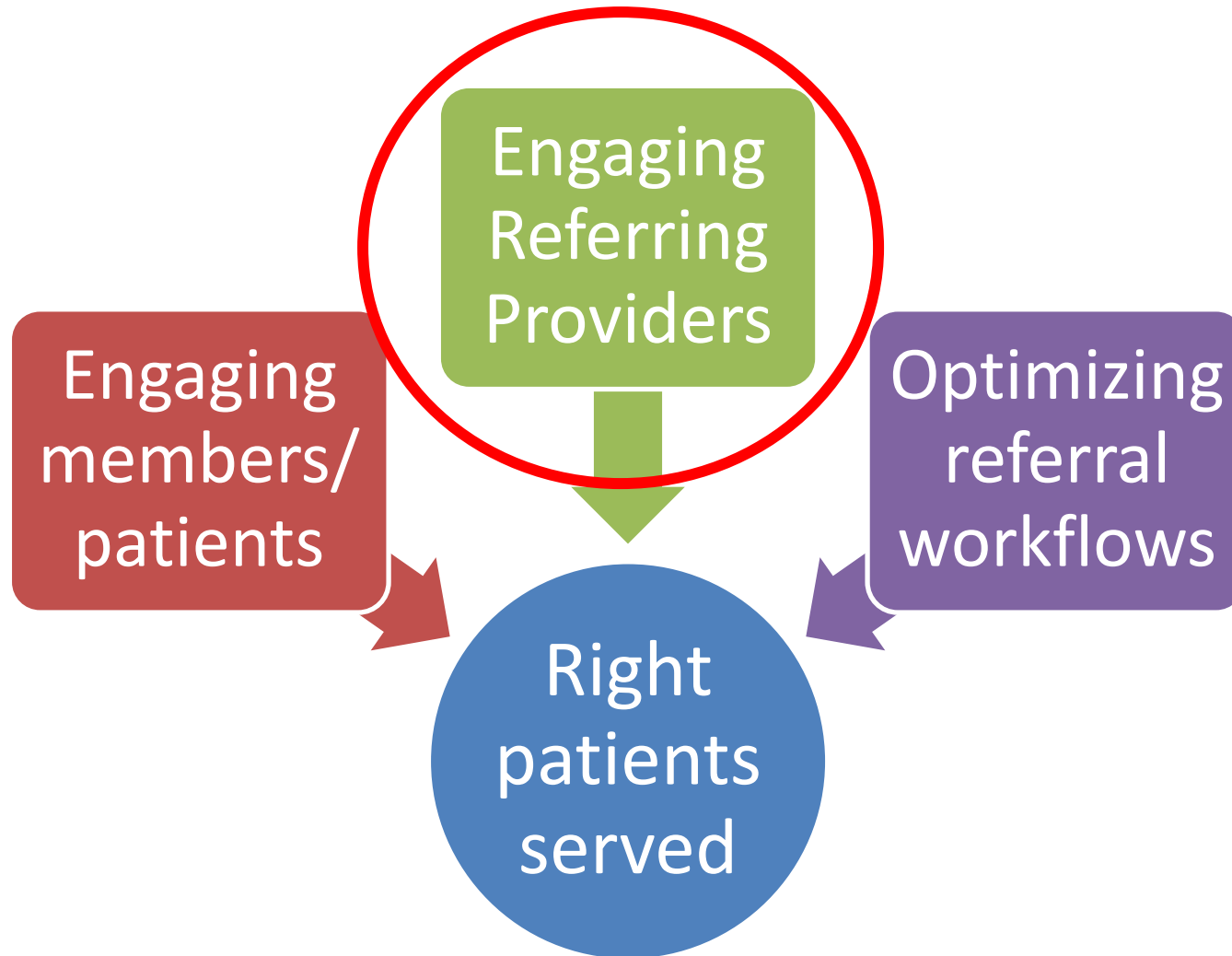
Common Barriers to Engaging Referring Providers

- Providers misunderstand what PC is, or don't appreciate its value.
- Providers are too busy — they forget to refer, lack the time to have serious illness conversations with patients, and/or can't spend time learning about new programs.
- Providers are hard to reach, or don't read e-mails or newsletters.
- Providers may be unfamiliar with the PC organization and therefore might hesitate to refer patients to it.
- Providers may not know patients well enough to refer them (for example, a patient who has been assigned but never seen, or has not been seen for an extended period).
- Providers stop referring due to frustration that only certain patients qualify.
- Providers don't see how a referral can be beneficial to them and think referring the patient will increase their workload, especially if they are expected to manage medications or facilitate delivery of services the PC team recommends.

Survey: Biggest Barriers to Provider Engagement
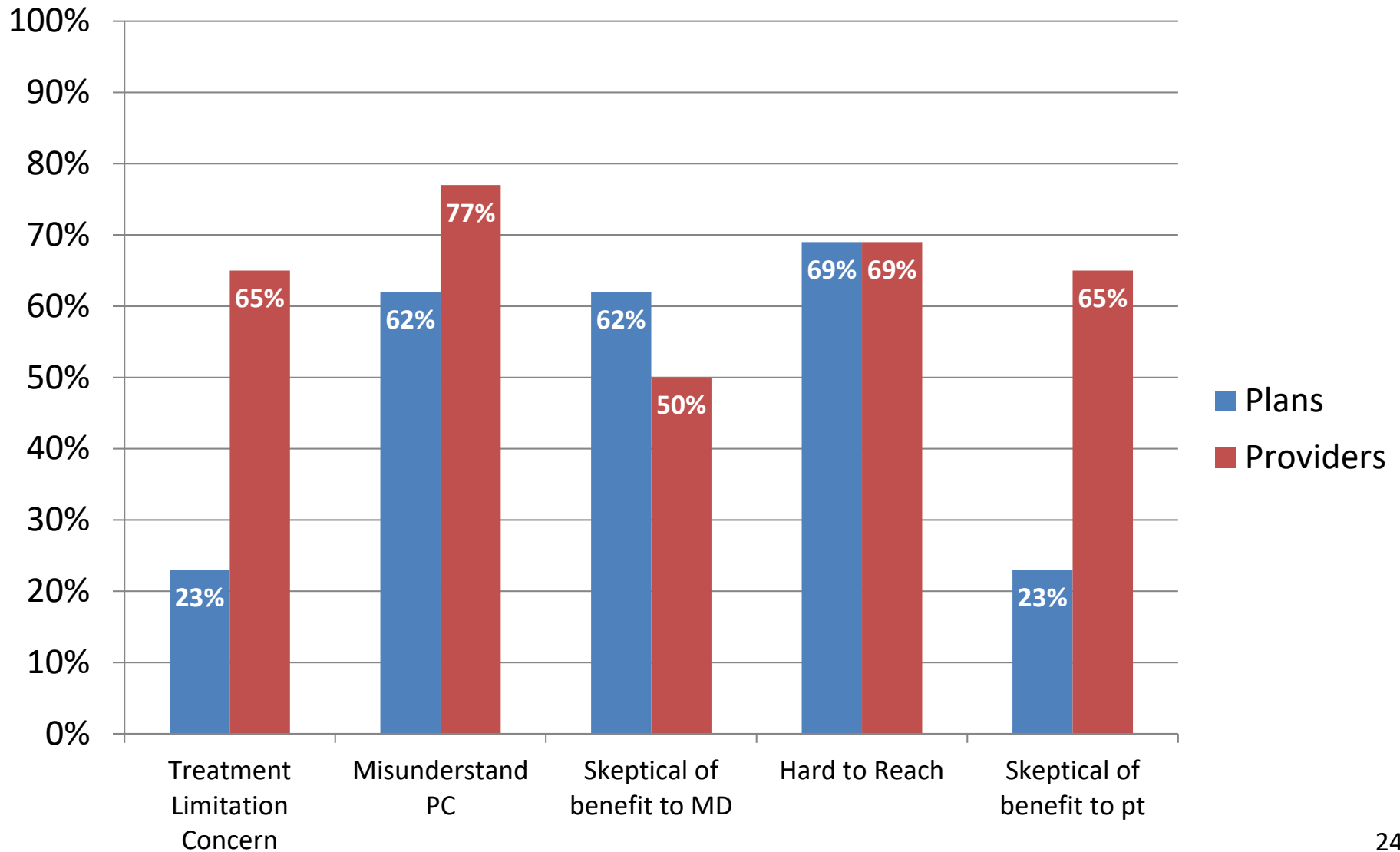
Survey: Biggest Barriers to Provider Engagement

- Plans
  - Limited/no resources for provider engagement, or feel ill-equipped to do this without clinical partner
  - Hard to get word out in large provider network
  - Referring providers see cases infrequently and forget about PC resources
  - **["We don't do this."]**

Only 23% of Plan respondents reported having specific outreach strategies or referral workflows with FQHCs or community clinics to encourage referrals for palliative care

Survey: Biggest Barriers to Provider Engagement

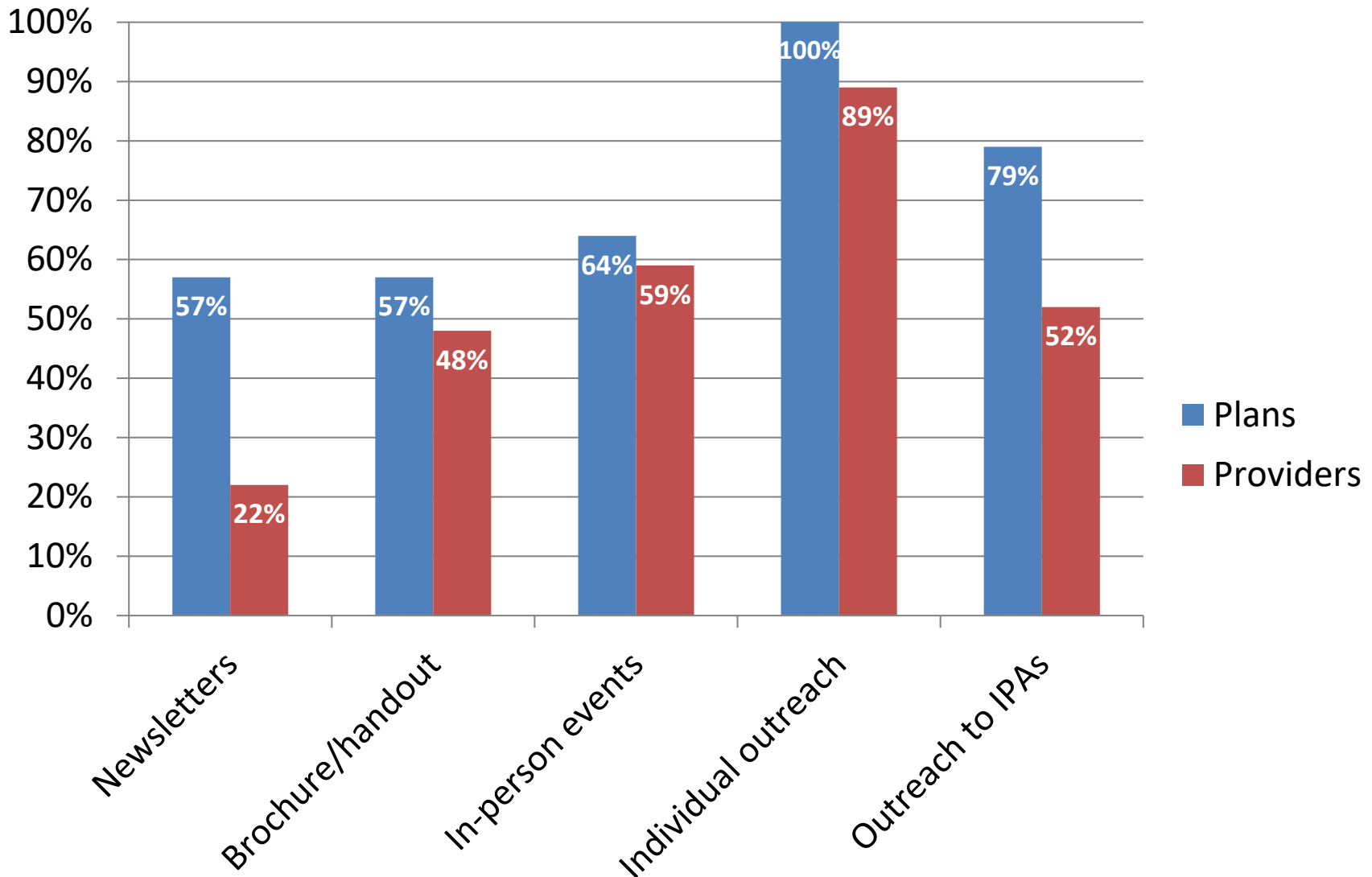- PC Providers
  - Primary and specialty providers want to refer other patients (e.g. Medicare patients, other diagnoses); frustrated that they can't

    "Some providers won't refer because [they] won't do this based on insurance."

  - Misconceptions about what PC is → think they're already doing it, or that it's the same as hospice
  - Can't access them/they don't have enough time

Survey: Strategies to Engage Referring Providers

Survey: Which Providers Have You Engaged?

Plans and PC providers have conducted outreach with a wide range of individuals who provide services to SB 1004 eligible patients, including:

- Case managers/CHWs (86% plans, 81% providers)
- PCPs (79% plans, 74% PC providers)
- Specialists (71% plans, 59% PC providers)
- Inpt palliative care (64% plans, 55% PC providers)
- Social workers (64% plans , 59% PC providers)
- FQHCs/CHCs (64% plans, 26% PC providers)
- RNs (57% plans, 55% PC providers)
- Chaplains (14% plans, 11% PC providers)
- Other: IHSS orgs, faith-based orgs, hospital CM

Most Effective Strategies to Engage Referring Providers

- Plans
  - Suggestion from plan staff
  - Peer-to-peer
  - Education; target specific teams (CCM, HH, FQHC)
  - Facilitating trust between provider and PC org
- Providers

✓✓Education (in-person)
  - Direct communication; provide follow-up

"If a provider has had a patient on service they often refer again."

Engaging Referring Providers: Reflections

- Emphasis on individual outreach over materials; effective but time-consuming and very difficult in large networks (targeted outreach may help)

- Misconceptions regarding PC continues to be a big barrier

- Varying degrees of plan involvement in engaging referring providers

- Access to referring providers is likely to continue to be a barrier – building on positive experiences is key

Recommendation: Focus on Relationships

Focus on building relationships

- <u>Rationale</u>: Since the palliative care organization may be unknown to referring providers, referrals will be slow until providers know about and trust the organization.

- <u>Examples</u>:
  - Prioritize face-to-face interactions between referring and PC providers (many see this as an especially effective strategy)
  - Leverage health plan relationships with primary care providers and specialists to introduce PC organizations and services
  - Identify PC champions in key clinics, hospitals, community programs

- <u>Things to consider</u>: Relationship-building can require significant time investment (particularly in large geographic areas), but most well-established programs view this as an essential process.

Recommendation: Make Direct Contact About Specific Patients

Make direct contact about specific patients, provider-to-provider.

- <u>Rationale</u>: Doing this creates opportunities for building trust and delivering education in a focused way regarding a specific person the referring provider is already invested in.

- <u>Things to consider</u>: Effort depends on referral volume; organizations see this contact as being very impactful in early stages of program or when working with new referring providers and groups.

Recommendation:
Be Flexible, Creative, and Persistent

Be creative, flexible, and persistent.

- <u>Rationale</u>: Providers are busy and have many competing priorities, so getting frequent face-to-face time solely for education may be difficult.

- <u>Examples</u>
  - Engage non-physician staff to get information to physicians
  - Participate in patient care conferences to offer input and identify eligible patients.
  - Conduct telephone- or web-based education to maximize efficiency.
  - Follow up repeatedly; routine communication is almost always needed.
  - Share PC program outcome data (e.g. patient satisfaction, avoiding emergency department visits).
  - Focus on benefits for *referring provider*, as well as patient and family (e.g. "we can be your eyes and ears in the home").

- <u>Things to consider</u>: The effort required varies depending on the outreach frequency, strategy, and region; the impact can be significant when thoughtfully targeted (e.g. focus on high-volume provider groups or those that care for many high-risk patients).

Key Implementation Processes
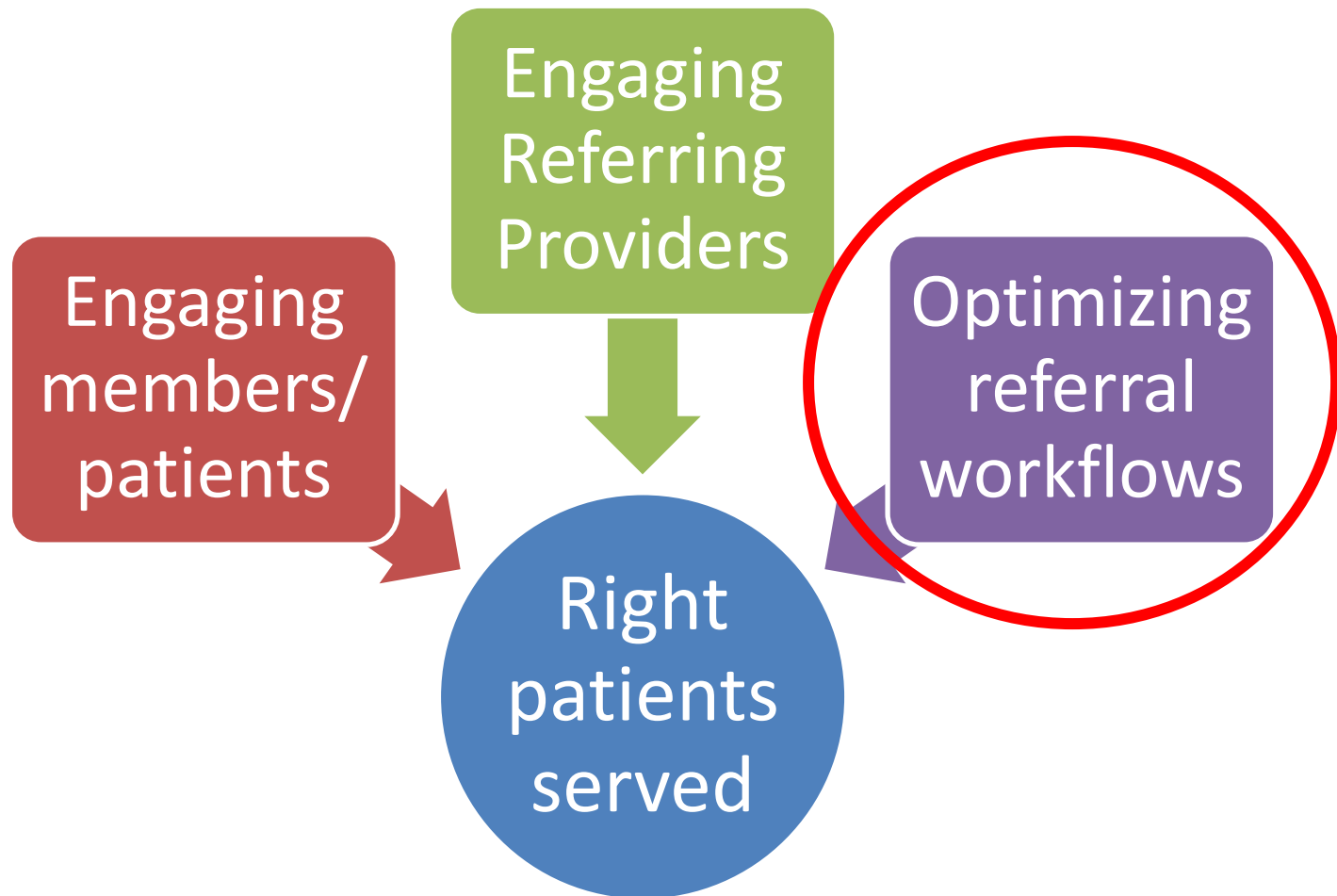
Common Referral Workflow Challenges

- Neither the plan nor the PC organization may have access to the clinical information needed to confirm disease-specific eligibility criteria for SB 1004.

- PC organizations and referring providers can be unsure who to contact at the plan to refer patients and address problems when they arise.

- PC organizations that are accustomed to providing hospice or clinic-based services may be unfamiliar with the authorization and administrative processes they need to work effectively with plans.

- Referred patients often have urgent needs, but the plan authorization process may not be rapid enough to appropriately meet those needs.

Optimizing the Workflow: Routine Meetings

Conduct routine meetings between plan and provider organizations.

- Rationale: This helps to identify and remove patient-level or operational barriers before they become huge problems. High-performing plan-provider partnerships often view optimizing the referral process as an iterative exercise, with adjustments expected over time.

- Things to consider: The time and effort involved varies depending on how — and how often — meetings are held. For high-performing, established programs, this collaboration is often seen as a critical component of their success.

Optimizing the Workflow: Single Point of Contact

Identify a single point of contact at the plan for SB 1004 referrals and questions.

- Rationale: Ensures that appropriate referrals are authorized in a timely manner and provides a liaison between other plan divisions, members, and PC organizations.

- Things to consider: May require staff reallocation and/or training investment up front; otherwise, requires minimal ongoing investment.

Optimizing the Workflow: Make the Process Easy

Make the referral process easy for referring providers.

- <u>Rationale</u>: If referrals are too time-consuming, confusing, or slow, providers may be less likely to refer their eligible patients.

- <u>Examples</u>:
  - Empower non-provider office staff to complete the referral.
  - Allow primary care and specialist providers to directly refer patients to the PC program, eliminating the authorization process entirely.

- <u>Things to consider</u>: Investment in this area requires relatively little effort with potentially significant impact.

Optimizing the Workflow: Consider Pre- or Retro-Authorizations

Develop a pre- or retro-authorization process for patients with urgent needs.

- Rationale: Patients are often referred at transition points (e.g. hospital discharge) when they are particularly vulnerable to rapid decline. To have the greatest impact, palliative care organizations should be equipped and supported (including appropriate compensation) to deploy rapid interventions to stabilize new patients.

- Things to consider: Investment in this area requires relatively little effort with potentially significant impact.

Useful Resource

Promising Practices in Referral Processes, which is available as a download in this section of the SB 1004 Resource Center, summarizes strategies for engaging with referring providers and optimizing referral workflows.

Key Points: Engaging Patients

- Pay attention to the face of the program, and the message to patients.

- Provide proactive community outreach and education.

- Develop written materials thoughtfully and collaboratively.

- Engage patients through direct — ideally face-to-face — contact.

- Work to establish trust with the patient.

Useful Resource: **Promising Practices for Engaging Patients**

Key Points: Engaging Referring Providers

Investments in relationship-building between referring providers and the PC organization —through education sessions, case reviews, and outreach about specific patients — can promote appropriate patient referrals.

- Focus on building relationships.
- Make direct contact about specific patients, provider-to-provider.
- Be creative, flexible, and persistent.

Useful Resource: **Promising Practices in Referral Processes**

Key Points: Optimizing Referral Workflows

Optimizing the referral and process can make all the difference in whether providers decide to refer patients, and whether the PC organization can meet patients' urgent needs.

- Conduct routine meetings between plan and provider organizations.
- Identify a single point of contact at the plan for SB 1004 referrals and questions.
- Make the referral process easy for referring providers.
- Develop a pre- or retro-authorization process for patients with urgent needs.

Useful Resource: **Promising Practices in Referral Processes**

Check Out All of the
SB 1004 Resource Center Topics

1. SB 1004 Basics

Includes basic information about SB 1004 requirements, as well as survey data collected from health plans and provider organizations describing early experiences implementing SB 1004

2. Patient Population

Includes a review of eligibility criteria, characteristics of the eligible patient population, and strategies for identifying eligible patients

3. Services, Costs, Payment

Includes a review of required services, staffing models used by PC providers, payment models, variables that impact cost of care delivery, and strategies for increasing efficiency

4. Engaging Patients & Providers

Reviews strategies for engaging patients, strategies for engaging providers who might refer eligible patients, and options for optimizing referral processes

5. Optimizing for Success

Includes a review of the factors that promote success in launching and sustaining PC programs

6. Quality and Impact

Reviews data that health plans report to DHCS, approaches to quality assessment in PC, and tools and resources for plans and providers to support improvement efforts

7. Webinars

Provides an archive of the recorded webinars from CHCF's 2017-18 SB 1004 Technical Assistance Series