



California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Topic 5: Optimizing for Success

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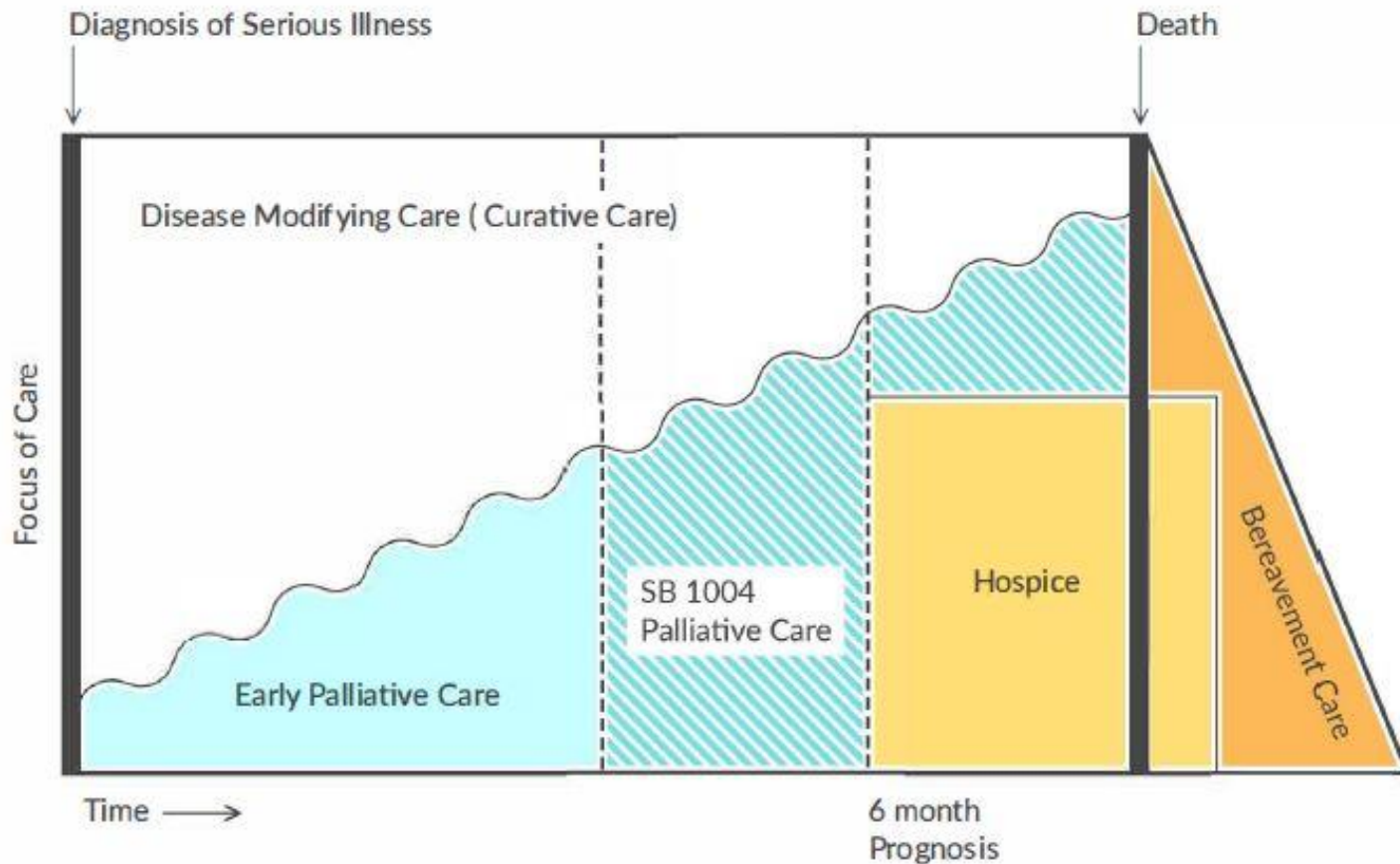
Review: What Is SB 1004?

- [Senate Bill 1004](#) (2014) requires Medi-Cal managed care plans (MCPs) to ensure access to palliative care 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***

Review: Palliative Care as Defined in SB 1004



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

Source: [DHCS Palliative Care and SB 1004](#)

Review: SB 1004 Population

General and disease-specific criteria

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

See California Department of Health Care Services (DHCS) website for All-Plan Letter (APL) and most recent policy documents:

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

*For more information about eligibility requirements
see Topic 1 in this series, **SB 1004 Basics***

Review: Seven Required Services

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

Optional: *DHCS recommends—but does not require—that plans provide access to chaplain services as part of the palliative care team. Further, DHCS notes that plans may authorize additional palliative care that is not described above, at the plan’s discretion. An example of an additional service is a telephonic palliative care support line, separate from a routine advice line, which is available 24 hours a day, seven days a week.*

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

Topic 5 Objectives

- Describe the conditions and supports required to optimize the delivery of palliative care
- Outline approaches to assess the palliative care capacity of local providers, and to identify any gaps in readiness to deliver SB 1004 palliative care
- Review recommendations for promoting program sustainability

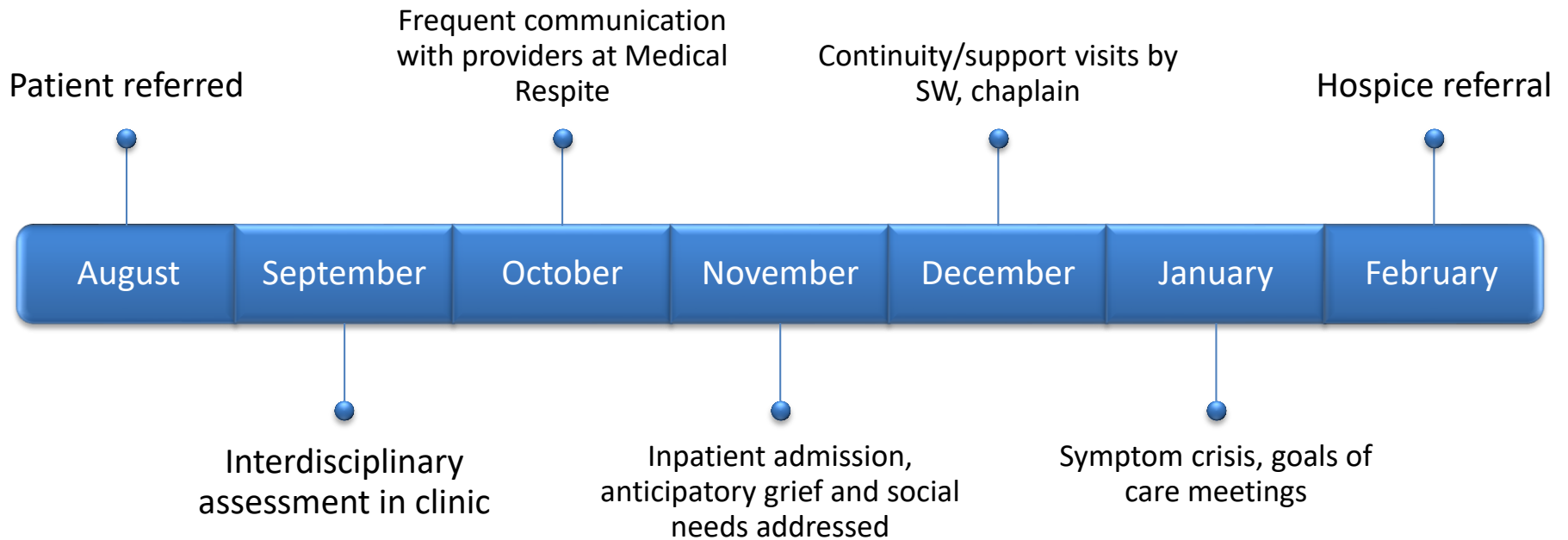
Conditions and Supports to Optimize SB 1004 Palliative Care Delivery

It is important to be aware of the environmental conditions and programmatic decisions that will impact the ability of palliative care providers to deliver SB 1004 palliative care.

- Important context
 - Palliative care needs and delivery models
 - Palliative care access
 - Medi-Cal population
- Key ingredients for optimizing service delivery
 - Right patients
 - Right time
 - Right supports

Palliative Care Context

#1: The needs of seriously ill individuals are dynamic, and different interdisciplinary team members will take the lead in different situations.



Typical patient course

Transdisciplinary Care

Task	Nurse Practitioner	Social work	Chaplain	Physician
Advance Care Planning	✓	✓	✓	✓
Symptom Management	✓✓	✓	✓	✓✓
Plan of Care	✓	✓	(✓)	✓
Mental Health and Medical Social Services		✓	(✓)	
Care Coordination	✓	✓	(✓)	✓
Data collection	✓	✓	✓	✓
Patient calls	✓	✓	✓	✓

Palliative Care Context

#1: The needs of seriously ill individuals are dynamic, and different interdisciplinary team members will take the lead in different situations.

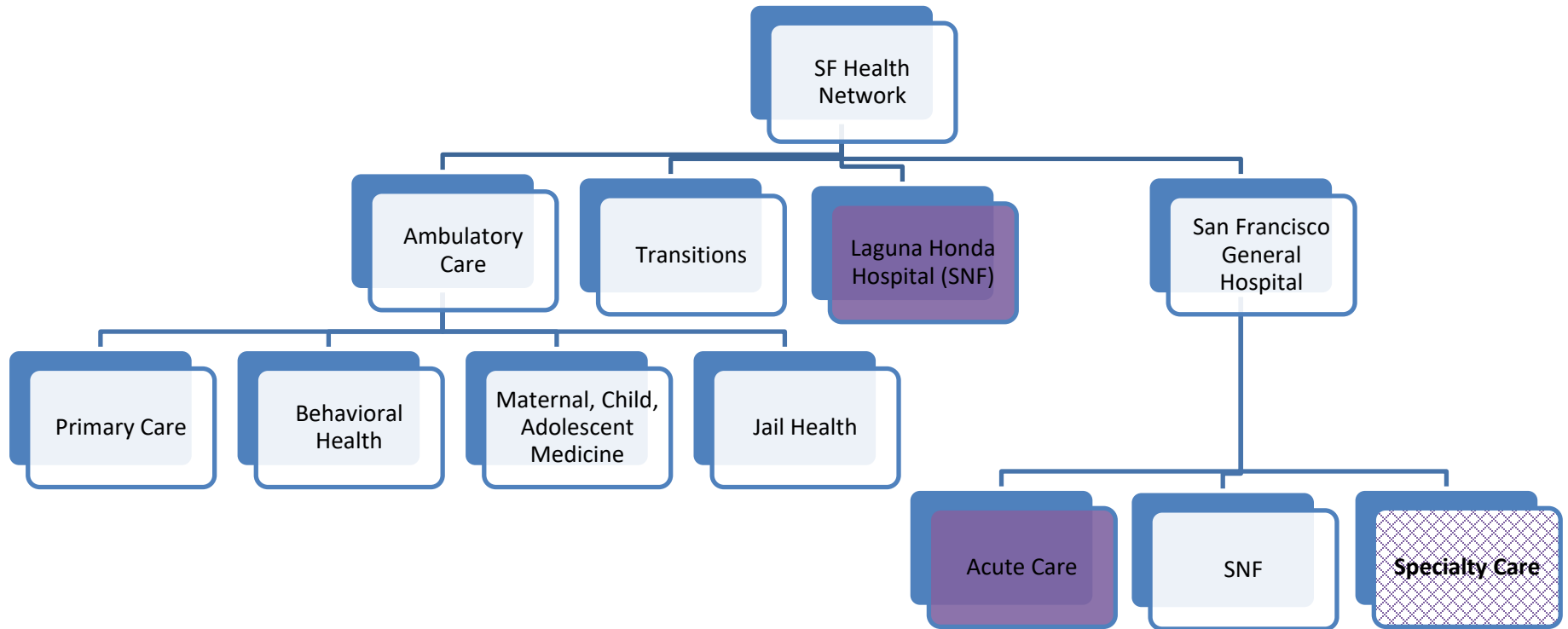
IMPLICATION:

Need to allow for flexibility in how teams will use interdisciplinary members, and to recognize that non-billing providers often play key roles.

Palliative Care Context

#2: Palliative care specialists are a scarce resource.

Access to Specialty Palliative Care in San Francisco Health Network



Palliative Care Specialists Are Scarce

- In 2010, estimated physician shortage of 6,000-18,000 just to staff *existing services* appropriately (Lupu, 2010 J Pain Symptom Management)
- Certified/designated PC workforce in California (2012 data, CSU Institute for Palliative Care)
 - 914 physicians
 - 89 NPs
 - 975 RNs
 - 146 CNAs
 - 43 SWs
 - 171 chaplains

Palliative Care Context

#2: Palliative care specialists are a scarce resource.

IMPLICATION:

Need to reserve specialist resources for most complex patients, help frontline providers/organizations to incorporate palliative care principles in usual workflows.

Palliative Care Context

#3: Medi-Cal population will stretch palliative care programs in unique ways.

Experience at ZSFG Palliative Care Clinic

- Mean age of patients: 61
- Diverse
 - 33% Asian, 27% Caucasian, 19% African-American, 18% Latino
 - 39% have Limited English Proficiency
- Challenging social situations
 - 10% Homeless, 15% Marginally housed
- Reasons patients could not be seen in clinic
 - 20% (especially) hard to reach
 - 26% had series of no-shows



ZSFG Response to Unique Patient Needs

- Key (non-traditional) partnerships
 - Homeless advocates/providers
 - Case managers
 - Patient navigators
 - Interpreter services
- Inpatient-outpatient hybrid care delivery model
- Set clear expectations for patient outreach and sign off
- Team member(s) with mental health training
- Developing telehealth services in partnership with home health agency

Palliative Care Context

#3: Medi-Cal population will stretch palliative care programs in unique ways.

IMPLICATION:

Need to build connections with key community and system supports to address the complex psychosocial needs of this population; social work support is critical.

Key Ingredients for Palliative Care

Right patients

Right time

Right supports

Right Patients for SB 1004 PC

- **TOO BROAD**
 - PC team overwhelmed/cannot meet demand
 - PC team wastes time evaluating patients who aren't eligible
- **TOO NARROW**
 - Miss patients who could have benefitted
 - May be difficult for PC program to be sustainable without economies of scale
- **JUST RIGHT**
 - Patients with life expectancy of approximately 12 months
 - Pre-screened for eligibility or screening process is collaborative

Suggestion: Partners work collaboratively to screen members for eligibility before referral to palliative care.

Right Time

- Palliative Care can have greater impact when contact starts >90 days before death.
 - Many providers will only think to refer patients for palliative care in their final weeks of life.
 - Many Medi-Cal patients will present late, or inconsistently.
 - Some health and social service providers can help recognize disease progression.

Suggestion: Identify key places in the health care system where patients can be identified by medical providers (e.g. ED, complex care management, acute care) and social service providers (e.g. case management, social workers, navigators) relatively earlier in the disease course.

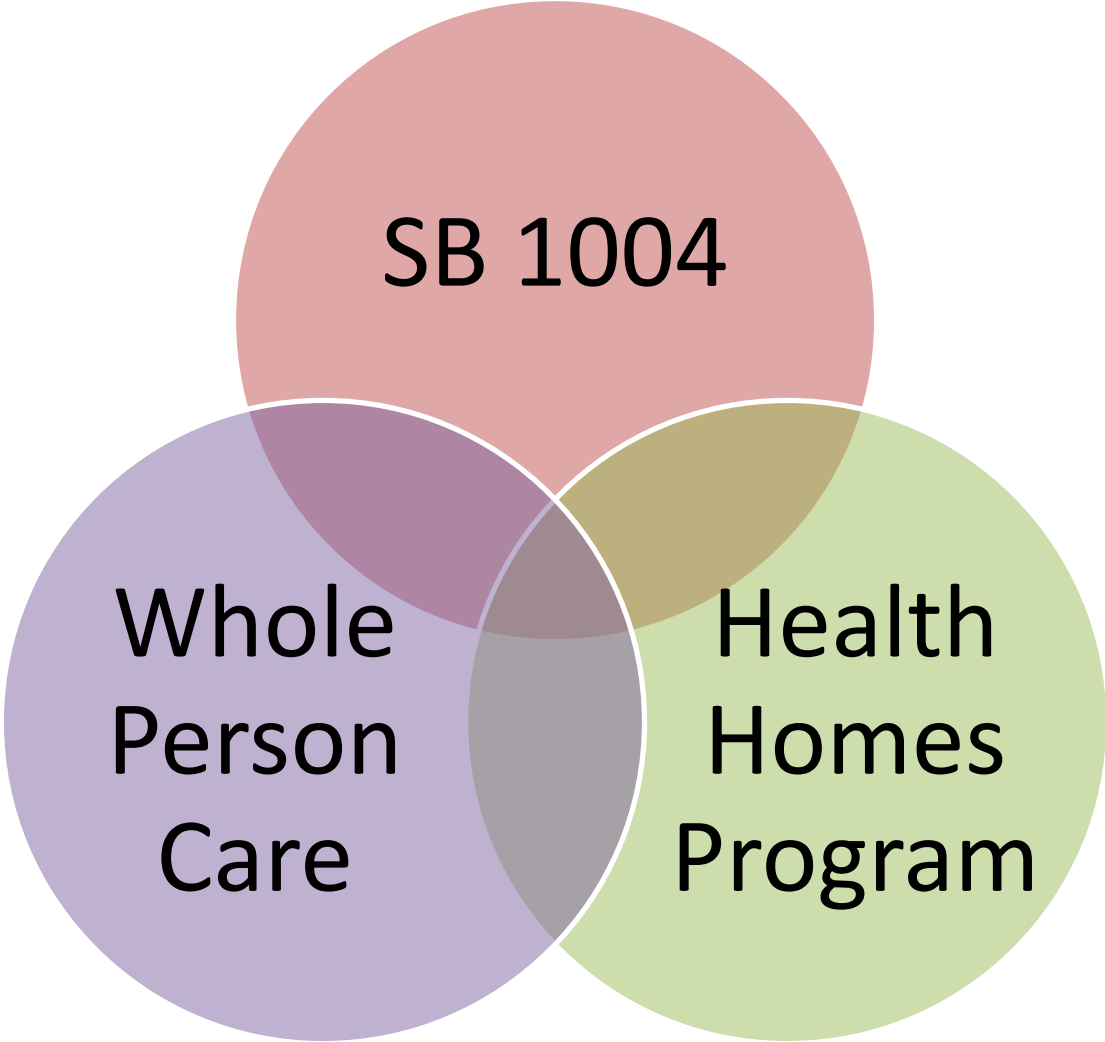
Right Supports

- Structures
 - Flexibility (appointment duration, frequency, disciplines involved)
 - Payment that is aligned with effort / cost of delivering care
- Education and Training
 - Generalists need help with higher-level PC issues.
 - Those doing hospice or that are new to delivering specialty PC to the Medi-Cal population may need other training.
- Connection to additional resources
 - What other support services from health plan or community organizations would help lighten the load and would help PC team focus on issues where they have expertise.

Key Ingredients: Take-aways

- SB 1004 benefit is great, but several other supports are needed to ensure that palliative care partner(s) can do the work.
 - Right patients
 - Right time
 - Right supports
- Plans and PC providers should consider how they will address the needs of patients/members who need palliative care but do not meet SB 1004 eligibility criteria.
 - Expand eligibility
 - Support (non-PC) providers in delivering generalist / primary palliative care

Intersection with Other Programs for Medi-Cal Beneficiaries



Intersection with Other Programs for Medi-Cal Beneficiaries

- Health Homes Program for Patients with Complex Needs
 - Lead entities are Medi-Cal managed care plans
 - Allows for creation of integrated “health homes” to provide comprehensive, coordinated medical care, mental health care, and social services, to address the complex needs of highest users of health care resources
 - http://www.dhcs.ca.gov/services/Documents/HealthHomesforPatients_Final.pdf
- Whole-Person Care Pilots
 - Lead entities are city/county agencies and public hospital systems
 - 5-year, \$3 billion (including \$1.5 billion in federal funds) pilot program to test initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes
 - <http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>

Intersection with Other Programs

	SB 1004	Health Homes	Whole Person Care
Where it comes from	2014 CA legislation	ACA section 2703 2013 CA legislation (AB 361)	Medicaid 1115 waiver
Mandatory / statewide?	Yes	No	No
Eligibility	<ul style="list-style-type: none"> • General <ul style="list-style-type: none"> • Utilization • Prognosis • Pt willing • Disease-specific <ul style="list-style-type: none"> • CHF • COPD • Cancer • ESLD 	<ul style="list-style-type: none"> • Highest risk 3-5% of Medi-Cal population likely to improve with support • High acuity and/or complexity • 3+ chronic medical conditions, 1+ psychiatric 	<p>“HUMS” Defined by organizations</p> <p><u>Subpopulation examples:</u> Homeless Incarcerated Substance use treatment Mental health</p>

Intersection with Other Programs

	SB 1004	Health Homes	Whole Person Care
Services included	<ul style="list-style-type: none"> • Advance care planning • PC Assess & Consult • Plan of Care • Pain, symptom mgmt. • Mental Health and Medical Soc Svc • Care Coordination • PC Team 	<ul style="list-style-type: none"> • Comprehensive care management • Care coordination • Health promotion • Comprehensive transitional care • Individual and family support • Referral to community and social support services 	<p>Defined by organizations</p> <p>Goals: coordination of health, behavioral health, and social services → Improve well-being More efficient use of resources</p>
Requires plan-provider collaboration	Yes	Yes	Yes
Payment mechanism	Can bill for some svcs; Relies on cost avoidance	Funds allocated for participating groups	Grant funds

Connecting Palliative Care Partners

Use the **Connecting Palliative Care Partners Worksheet**, which is available in this section of the SB 1004 Resource Center, to leverage the resources and connections of both the MCP and palliative care provider to understand which programs and services can be offered to patients to supplement SB 1004 palliative care.

Assessing Capacity to
Deliver Palliative Care and
Identifying Gaps

Checklist for Readiness to Deliver PC

- Awareness and Experience
 - Context of Serious Illness
 - Awareness of Resources
- Core Competencies
- Organizational Readiness
 - Structures & Relationships
 - Team composition
 - Standard procedures/workflows
 - Time for non-clinical activity
 - Ability to expand

Awareness and Experience

- Context of Serious Illness
 - Impact on patients
 - Impact on families/caregivers
 - Range of needs of patients and families/caregivers
- Awareness of Resources
 - Community partners
 - Social services and non-profit organizations
 - Faith-based organizations
 - Other clinical partners
 - Behavioral health
 - Homeless health

Awareness and Experience

- Core competencies in palliative care
 - Assessment and management of:
 - Pain
 - Non-pain symptoms
 - Psychosocial needs/distress
 - Spiritual needs/distress
 - Evidence-based prognostication
 - Assessment of patient/family goals and applying them to medical decision-making
 - Facilitating advance care planning
 - Evaluating hospice eligibility and referring as needed

Organizational Readiness

- Structures and Relationships
 - Flexibility in care delivery
 - Addressing patient needs after hours
 - Connection to:
 - Primary care groups
 - Specialty care groups
 - Complex care management groups/Special Populations

Organizational Readiness

- Team composition
 - Which disciplines are included on the team?
 - Physician
 - Nurse(s)
 - Social worker
 - Chaplain
 - What do the team members do? Do they have other responsibilities?
 - To what extent do team members work together or separately?

Organizational Readiness

- Standard procedures/workflows
 - Clinical assessments done routinely
 - Tools used
 - Patient identification – proactive or reactive?

Organizational Readiness

- Time for non-clinical activity
 - Continuing education
 - Quality assessment and improvement activities
 - Data collection and reporting
 - Network development

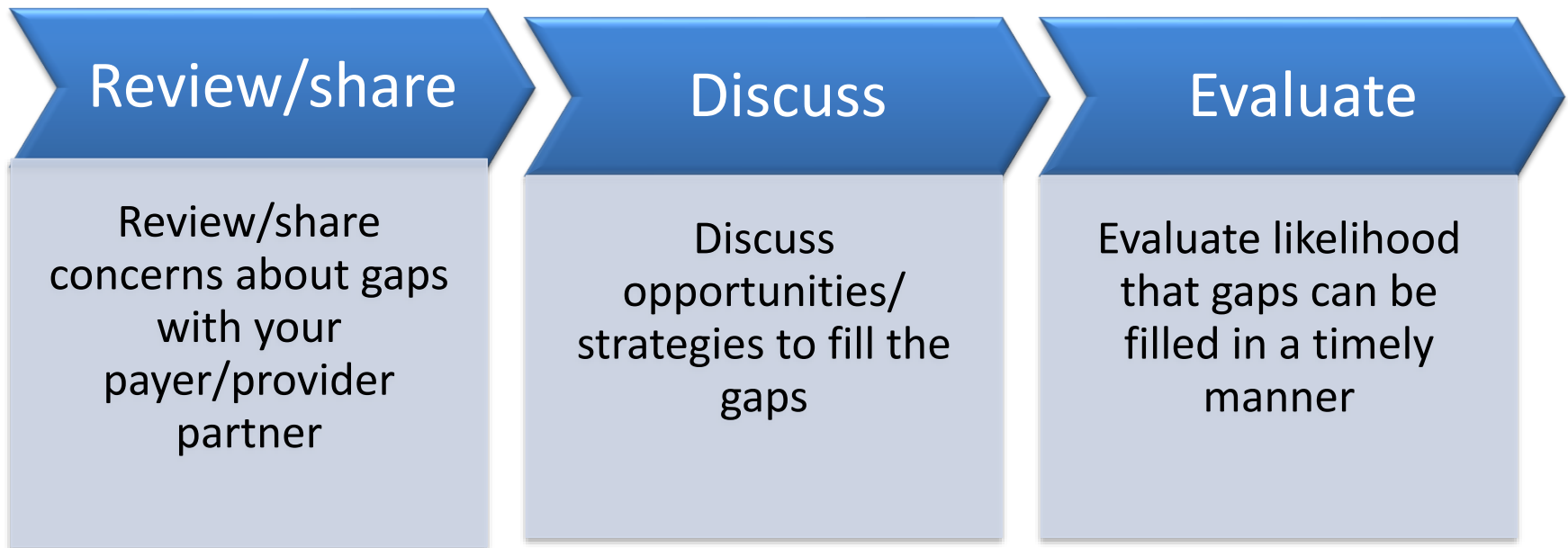
Organizational Readiness

- Ability to expand
 - Current capacity
 - Near-term capacity
 - Factors influencing ability to grow/maintain growth

Addressing Gaps in Readiness



Addressing Gaps in Readiness



Review with Partner(s): Ways to Fill the Gaps?

Organizational characteristic	Strategies to address
Core Competencies	Train existing staff Hire new staff Defer to specialty providers
Awareness and Experience	
Context of Serious Illness	Train existing staff
Awareness of Resources	Share resources, make connections

Review with Partner(s): Ways to Fill the Gaps?

Organizational characteristic	Strategies to address
Organizational Readiness	
Structures and relationships	Evaluate capacity to restructure Share resources, make connections
Team composition	Reallocate existing staff Hire new staff
Standard procedures/workflows	Leverage lessons learned from other initiatives
Time for non-clinical activity	Explore avenues to support QI, professional development
Ability to expand	Reallocate existing staff Hire new staff

Who Fills the Gaps?

Partner able to fill in gaps

Collaboration possible to fill in gaps

Partner won't be able to fill in gaps

Gap Analysis Worksheet

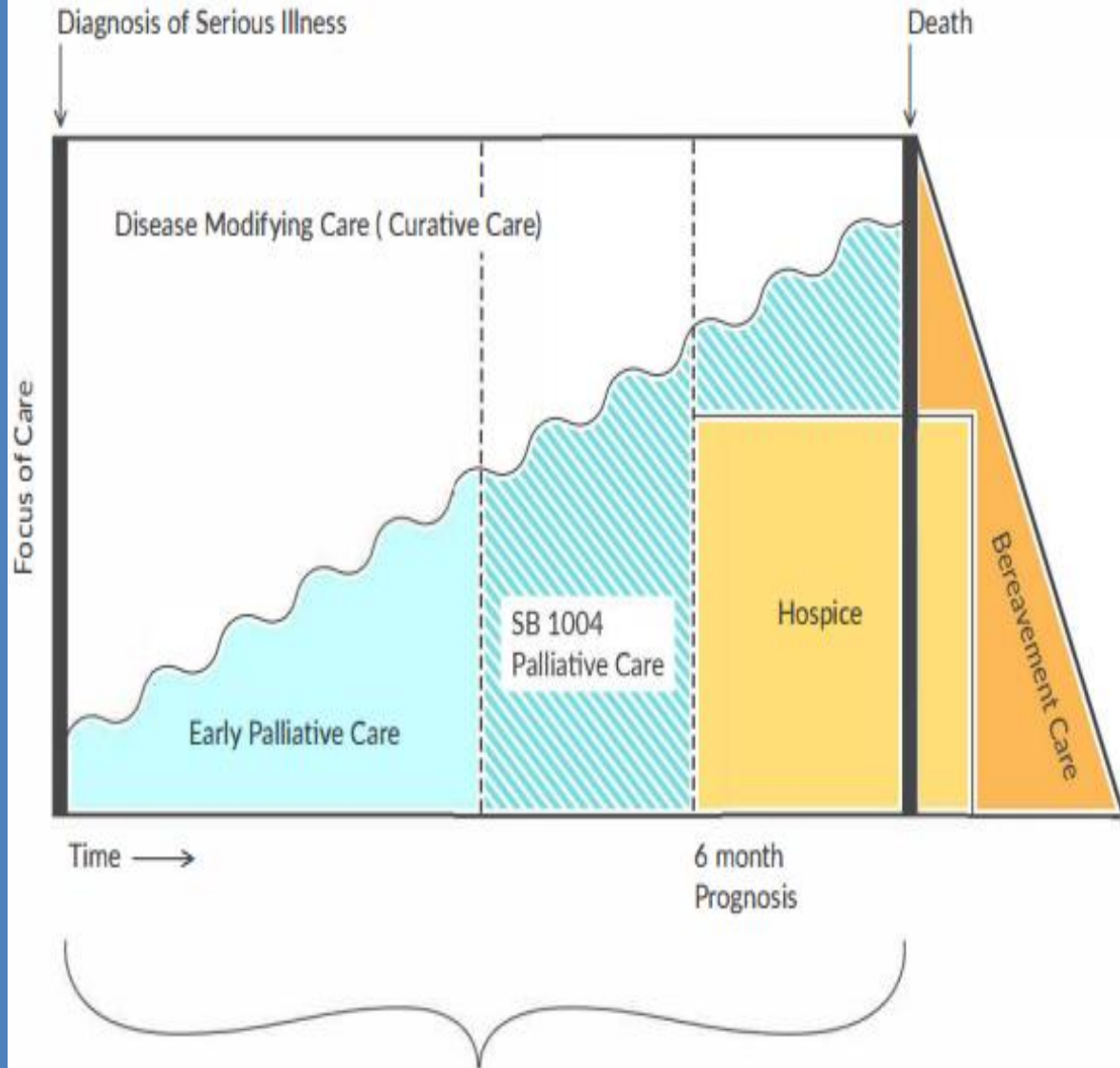
Plans and PC provider organizations can use the **Gap Analysis Worksheet**, which is available in this section of the SB 1004 Resource Center, to evaluate readiness and determine how existing gaps might be filled.

Preparation: Provider Education and Outreach

- Identify key partners
 - Access to clinical information, can help with prognosis, patient trust
 - Specialty care clinics (cardiology, pulmonology, hepatology, oncology)
 - Primary care
 - People/organizations who may recognize functional decline earlier than providers
 - Social work
 - Case management
 - IHSS workers

Care Model for SB 1004 Medi-Cal Palliative Care

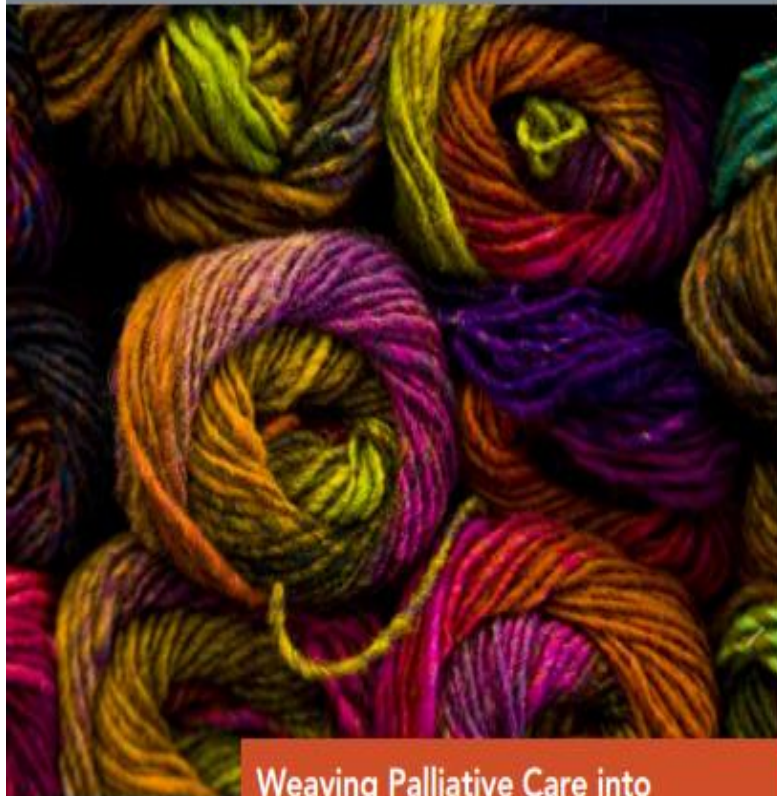
Helping
Providers to
Move
Palliative
Care
“Upstream”



Preparation:

Provider Education and Outreach

- Explore with stakeholders
 - What do you wrestle with most, when caring for seriously ill patients?
 - What additional support(s) would be most valuable to you, in caring for seriously ill patients?
 - What additional support(s) would be most valuable to your seriously ill patients?
 - Are there services (clinical or social) with smooth referral processes? What works well?
- Identify potential palliative care champions
- Education
 - SB 1004 basics
 - Suggest continuing education in palliative care (e.g. California State University Institute for Palliative Care courses)



**Weaving Palliative Care into
Primary Care: A Guide for
Community Health Centers**

AUGUST 2015

Resource to Support Providing “Early” Palliative Care

<http://www.chcf.org/publications/2015/08/weaving-palliative-care>

Promoting Sustainability: Recommendations

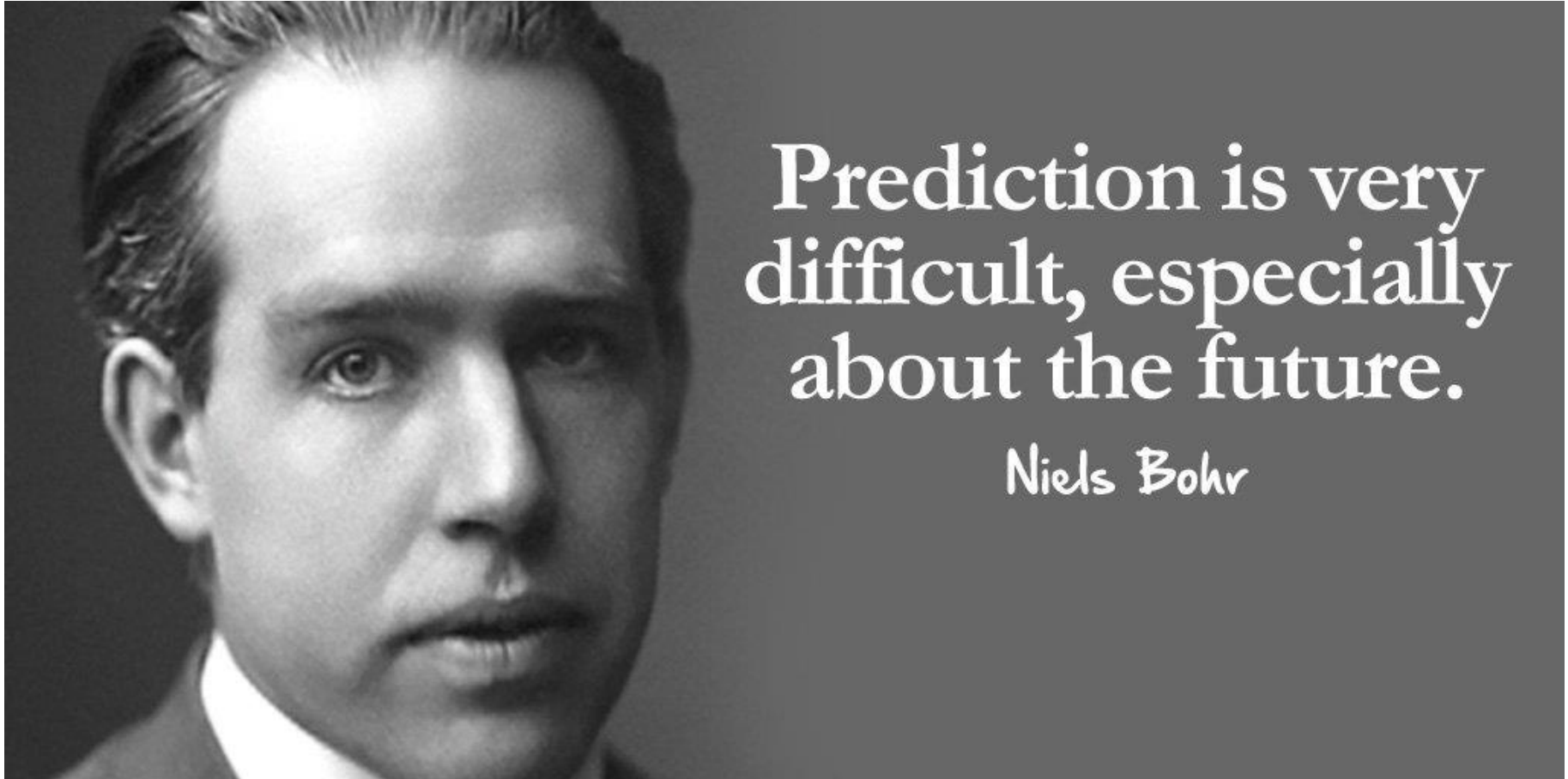
Pilot and re-evaluate

Communicate regularly

Repeat the needs assessment

Pay attention to relationship with payer/provider

A Wise Person Once Said...



Promoting Sustainability

Issue #1:

Predicting the future is impossible.

Promoting Sustainability: Pilot and Re-evaluate

Many things are hard to predict:

- Where referrals will come from, how much marketing and outreach will be required
- Which patient populations will be largest
- Roles/responsibilities of different team members
- How workflows will need to change (with changes in venue, volume, staffing, etc.)
- Projected vs. actual costs

First Choice...Best Choice?

INITIAL PLAN

(Pilot) contract
mandated 2 RN home
visits per patient per
month

CHALLENGES

- Some patients did not make themselves available for visits at predictable intervals, which reduced revenues for provider
- Some patients did not need both RN visits, but instead really needed weekly SW visits, at least in some months



Promoting Sustainability: Pilot and Re-evaluate

- Initial efforts should be framed as pilot
- Start with expectation that things will need to be adjusted
- Define parameters
 - Interval for reassessment
 - Evaluation metrics

First Choice...Best Choice?

INITIAL PLAN

(Pilot) contract mandated 2 RN home visits per patient per month

CHALLENGES

- Some patients did not make themselves available for visits at predictable intervals, which reduced revenues for provider
- Some patients did not need both RN visits, but instead really needed weekly SW visits, at least in some months

POSSIBLE SOLUTIONS

- Create process to waive or adjust requirement for certain patients / certain circumstances
- Suggest high-frequency initial phase followed by maintenance phase

Promoting Sustainability: Pilot and Re-evaluate

Issue #1:

Predicting the future is impossible.

Lesson #1:

Many successful payer-provider partnerships include routine re-evaluation of program goals, structures, workflows, and outcomes.

Promoting Sustainability

Issue #2:

Different organizations have different cultures and different ways they prefer to communicate.

Promoting Sustainability: Routine Communication

- Develop plan for communicating regularly, particularly at the beginning of the partnership, and after any major changes in the program
- Rationale
 - Changes in staffing/leadership happen
 - Your partner's goals/priorities will change
 - Can identify gaps, unmet needs on both sides
 - Can fix small issues before they grow

Promoting Sustainability: Routine Communication

Issues to consider

– Clinical

- Troubleshooting difficult cases
- Foster communication between plan-based clinical staff and palliative care providers

– Operational/Programmatic

- How many patients/members are being enrolled? How does this compare with predictions?
- Which clinics/provider groups are (or aren't) referring?
- Are there barriers or inefficiencies in the referral process?
- How long are patients/members remaining enrolled?
- What resources for patient/caregiver support are lacking?

Promoting Sustainability: Routine Communication

- What works best for communication?
 - E-mail/written
 - Remote
 - In-person
- How often are meetings needed?
- Who should be involved in different meetings?

Promoting Sustainability: Routine Communication

Issue #2:

Different organizations have different cultures and different ways they prefer to communicate.

Lesson #2:

Be explicit in developing routine communication strategies with your plan/provider partner(s) that will work for both organizations.

Promoting Sustainability

Issue #3:

Changes in personnel, leadership, and program scope can dramatically affect payer-provider partnerships.

Promoting Sustainability: Repeat the Needs Assessment

You've done a thorough needs assessment at the outset of the program; now you're set, right?

- Because things change, there may be key times when you should consider repeating a needs assessment
 - Change in partner(s) or key stakeholder(s)
 - Program expansion
 - Change in scope of work/responsibility
 - Changes in support and/or funding

Promoting Sustainability: Repeat the Needs Assessment

Change in
partner or key
stakeholder

- Leadership
- Key clinician
- Referring partner
- Community partner

Program
expansion

- New location
- New setting of care
- New patient population

Promoting Sustainability: Repeat the Needs Assessment

Change in
scope or
responsibility

- New task assigned
- Partner takes over task
- Incentive/penalty proposed

Change in
support or
funding

- Grant start/finish
- In-kind donation changes
- Community program changes

Promoting Sustainability: Repeat the Needs Assessment

Issue #3:

Changes in personnel, leadership, and program scope can dramatically affect payer-provider partnerships.

Lesson #3:

Repeat a needs assessment after significant changes occur on either side.

Promoting Sustainability

Issue #4:

Relationships are really important, but hard.

For More Information: Payer-Provider Partnerships Lessons on Relationships

<https://www.chcf.org/publication/payer-provider-partnerships-lesson-eight/>

The screenshot shows the California Health Care Foundation website. At the top, there is a navigation bar with the CHCF logo and the text 'California Health Care Foundation'. To the right of the logo are links for 'HELP | SIGN UP'. Below the logo, there is a horizontal menu with links for 'ABOUT CHCF', 'OUR WORK', 'THE CHCF BLOG', 'GRANTS', 'INVESTMENTS', 'EVENTS', 'MEDIA', and 'SEARCH'. To the right of the 'SEARCH' link are social media icons for Twitter, Facebook, and YouTube. Below the navigation bar is a dark blue banner with the word 'PUBLICATION' in white. The main content area has a white background with a light blue border. The title of the article is 'Payer-Provider Partnerships: Lesson Eight' in a large, dark blue font. Below the title is the subtitle 'Relationship Issues' in a smaller, dark blue font. The date 'OCTOBER 8, 2018' is displayed in a small, dark blue font. Below the date are the authors' names: 'Kathleen Kerr, Consultant, Kerr Healthcare Analytics' and 'Kate Meyers, Senior Program Officer, High-Value Care'. Below the authors' names is a 'SHARE' button with icons for Twitter, Facebook, LinkedIn, and a plus sign. Below the share button is a dark red button with the word 'DOWNLOADS' in white.

Creating a mutually beneficial contract can be really hard. A good payer-provider relationship makes it a lot easier.

- Empathy, transparency, and collaborative problem-solving are valued highly
- Recognize that things won't necessarily go as expected
- Organizational culture influences relationships
- It takes time to build relationships

Relationship Issues

Even a great service can't thrive if the payer-provider relationship is bad.

- Partners need to be willing to communicate openly and frequently about all aspects of program planning and implementation.
- Partners need to build trust, understand why they each want to engage in this work, and show an appreciation for the pressures and priorities that impact the other organization.

“Most Important” Characteristic that You Look for in a CBPC Partner?

Provider:

“That they be collaborative and flexible, able to appreciate the perspective of a small partner”

Payer:

“Ideal partner characteristics would be an ability to take in information from many perspectives (vision and mission plus practical information about service delivery nuts and bolts, and the environment), including an ability to appreciate the perspective of a payer partner.”

Characteristics That Might Predict a Poor Fit?

Provider:

“As we brought issues to the forefront (big and small) the plan was always willing to engage in a conversation - to hear from our perspective how a contract requirement would impact care. Even if the plan didn’t agree, it was important to us that they were willing to have that collaborative conversation. Not seeing this kind of openness would be a huge red flag; a payer that just says, ‘This is the way we do it’ would be a difficult partner.”

Payer:

“I try to get a sense during early meetings whether they are comfortable taking risks, if they have demonstrated an ability to think differently, and if they have a record of implementing innovations. An absence of such characteristics/history, or a rigid attachment to their own model of care delivery would indicate a poor fit.”

Promoting Sustainability: Pay Attention to Relationships

Issue #4:

Relationships are important, but hard.

Lesson #4:

Flexible good. Rigid bad.

Listening, transparency, empathy, and collaborative problem solving are valued highly; inflexibility is not.

Examples of Organizations that Have Built and Sustained SB 1004 PC Programs

Several plans and providers have successfully launched SB 1004 PC programs and services. Brief summaries (from January 2018) of programs built by **Health Plan of San Joaquin** and **Outreach Care Network** are available in this section of the SB 1004 Resource Center.

Lessons Learned:

Health Plan of San Joaquin

- They started education and outreach with a limited number of inpatient facilities and outpatient clinics, and focused education there. Once the program was up and running, they expanded to cover many more facilities and clinics.
 - HPSJ focuses on direct provider education and outreach to promote palliative care services and generate referrals.
 - As the program has grown, the education has become more targeted (e.g. stressing importance of prompt responses when patients need medications, equipment, etc.).
- Referral information is confirmed and consolidated before it's sent to PC providers.
- Plan-PC Providers have bi-weekly operations meetings to make adjustments to the program as it continues to grow.
- Connecting with patients can be challenging (e.g. incorrect phone numbers, mistrust), so they focus on making connections while patients are in the hospital.
- When transportation is a barrier for patients, they assist with transportation.
- It's critical to choose the right PC partners -- particularly helpful to find organizations that are willing to collaborate, innovate, adjust as needed to make it work.

Lessons Learned: Outreach Care Network

- It's very important to hire local providers who are culturally/linguistically concordant with patients (though this can definitely be a challenge in rural areas -- telemedicine can help).
- Particularly for palliative care providers with multiple contracts, need to reinforce with staff the differences in requirements and services for different patient populations.
- Staffing a patient/family advice line can be critical to avoid unnecessary admissions ("outside triage will send your patient to the hospital") and to provide consistency in care quality (aim for "2am is the same as 2pm").
- Focus on the mission/vision and doing the right thing for the patient.

Collaboration Promising Practices Resource

Effective delivery of SB 1004 palliative care requires collaboration between the plan and the PC provider. The goal of collaboration is to maximize the probability that patients who are eligible for SB 1004 are identified and enrolled in services, and that those services operate efficiently and sustainably, from the perspective of both the plan and the PC provider.

Promising Practices in Plan-Provider Collaboration, which is available in this section of the SB 1004 Resource Center, describes approaches that have been identified and endorsed by plans and PC providers that are delivering SB 1004 PC.

Recommendation #1: Consider Context and Design Programs Accordingly

- Allow flexibility in which provider disciplines see patients at which frequency, since patients' needs are dynamic and often difficult to predict.
- Reserve specialist resources for the most complex patients, and help frontline providers/organizations incorporate palliative care principles into normal workflows.
- MCPs can help their PC provider partners by connecting them with other resources to address members' complex psychosocial needs (e.g. substance use treatment programs, case management, transportation services).

Recommendation #2: Aim for Right Patients, Right Time, Right Supports

- Refer the right patients. Work collaboratively to screen members for eligibility before referral to palliative care.
- Refer patients at the right time. Identify key places in the health care system where patients can be identified by medical providers (e.g. ED, complex care management, acute care) and social service providers (e.g. case management, social workers, navigators).
- Provide the right supports for palliative care providers. PC providers often need support for education and training to care for the psychosocial complexities of Medi-Cal patients. If the MCP can help to manage some of the complex psychosocial needs, that will free the PC providers to focus on delivering the core SB 1004 services, which they are most well-trained to deliver.

Useful Resource: **Connecting Palliative Care Partners Worksheet**

Recommendation #3:

Assess Readiness to Deliver Quality PC

Consider the totality of factors that indicate readiness to deliver quality palliative care:

- Awareness and experience
 - Context of Serious Illness
 - Awareness of Resources
- Core Competencies
- Organizational Readiness
 - Structures and relationships
 - Team composition
 - Standard procedures/workflows
 - Time for non-clinical activity
 - Ability to expand

Recommendation #4: Strategize with Partners to Address Readiness Gaps

Organizational Characteristic	Strategies to Address Identified Gaps
Core competencies	Train existing staff, hire new staff, defer to specialty providers
Awareness and experience	
Context of serious illness	Train existing staff
Awareness of resources	Share resources, make connections
Organizational readiness	
Structures and relationships	Evaluate capacity to restructure Share resources, make connections
Team composition	Reallocate existing staff Hire new staff
Standard procedures and workflows	Leverage lessons learned from other initiatives (e.g. what worked in other QI or program development)
Time for non-clinical activity	Explore avenues to support QI, professional development
Ability to expand	Reallocate existing staff Hire new staff

Recommendation #5: Engage in Practices that Promote Program Sustainability

- Ongoing monitoring and modifications will be needed.
- Culture and communication differences can have a big impact on partnerships – identify issues up-front and work toward solutions that work for both organizations.
- Prioritize creating and sustaining good payer-provider relationships.

Useful Resources:

Payer-Provider Partnerships Lessons on Relationships

Promising Practices in Plan-Provider Collaboration

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