COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Driving Improvements in Palliative Care in Medi-Cal (SB 1004)

Virtual Convening Day Two
April 28, 2021

Virtual Conference Housekeeping

- Please keep yourself on mute in all sessions except the breakout sessions.
- If you are using your phone for audio, PLEASE link your phone audio to your Zoom online profile.
  - Click on “Join Audio” icon (lower left), select “Phone Call”, enter “# Participant ID #” on your phone.
- If using computer for audio be sure to have your computer microphone on so you can be heard in breakouts.
- Please change your display name to your full name and organization.
  - Hover over your own picture on Zoom; three dots will appear in the upper right; click on “Rename.”
- Slides and recordings from the main sessions (not breakouts) will be available on the CHCF website within a week or two.

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

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Driving Improvements in Palliative Care in Medi-Cal (SB 1004)

Innovation Session: MedZed

April 28, 2021

Introduction

MedZed is a technology-enabled mobile provider delivering a range of services to high-risk patients.

	Staffing	Responsibility and Frequency
Palliative Care Active panel size: 130	**+Board Certified Palliative Medical Director** **+Social Worker** **+Chaplain** **+Case Manager**	• Facilitates advance care planning, POLST, and goals of care • Provides emotional, social, and spiritual support • 1-4 in-home visits/month and weekly touchpoints • 24/7 provider hotline and same-day urgent visits • Discharged when ready for hospice
Complex Primary Care Active panel size: 2500	**+Complex Care Provider** (Remote MD, NP, PA) **+In-home nurse** **+Care Coordinator**	• Joins in-home nurse over MedZed's telehealth • Treats symptoms, makes prescriptions, and referrals • 24-72 hours post-discharge visit • 1-2 in-home visits/month • 24/7 provider hotline and same-day urgent visits • Graduated back to PCP
Health Homes (CB-CME) Active panel size: XXX	**Community Health Navigator**	• Conducts outreach & scheduling methods • Builds trust-based relationships • Collaborates with community resources • Coordinates transportation / social-need fulfillment • 24-72 hours post-discharge support

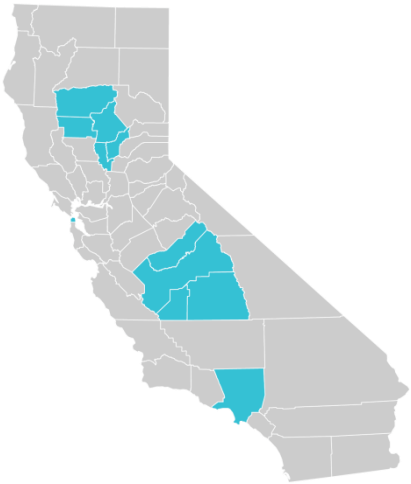
MEDZED

Introduction

Leveraging a High-Frequency, Palliative-Focused, Mobile Clinical Team

334 unique Medi-Cal members served across the state:

- Chico
- San Francisco
- Fresno
- Los Angeles



Currently 130 active patients

Attributes of our Palliative Program

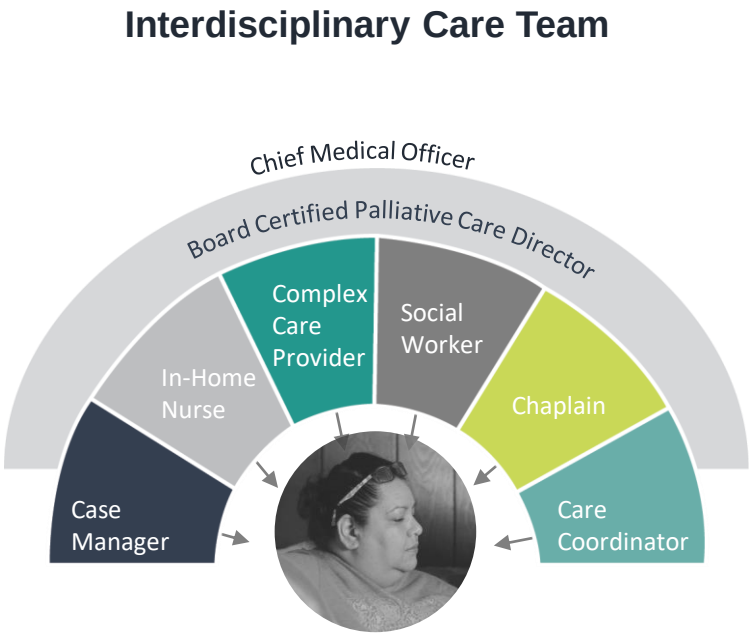
- Launched program in 2018
- Integrated model focused on social, emotional, spiritual, and palliative care
- 24/7 clinical availability
- Bereavement services offered
- Health Plan Partners: 2
- Payment model: PMPM

MEDZED

Innovation in Clinical Service Delivery Model of Care

A program designed to meet the magnitude of palliative care patient needs

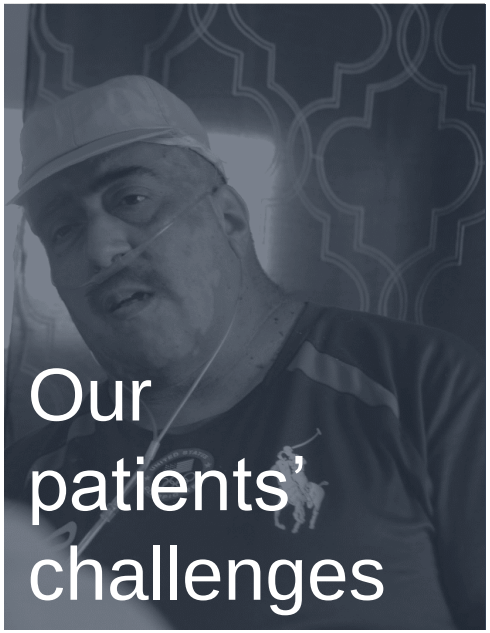
- House call program helps to funnel appropriate patients into Palliative Care
- Technology-enabled mobile delivery model bringing care to patient's homes
- Our in-home nurse uses our telemedicine platform to link in remote team members
- A core of palliative nurses are identified for ongoing specialized training
- Longitudinal telehealth model improves quality and continuity of care and patient satisfaction



MEDZED

Challenge/Need Addressed

For many of our patients, the difficult circumstances of their lives have them experience frequent gaps in care and constant care transitions.



- Poor continuity of care compromises quality and safety as a result of care gaps
- Significant social barriers limit access
- Low patient/family satisfaction due to constant changes in care settings and providers
- Limited understanding of palliative care services
- Availability of palliative care programs vary by geography

We stay with patients on their healthcare journey until they are ready for hospice.

MED ZED

Innovation Contribution

We enable continuity of care by meeting patients and families where they are in their healthcare journey.

1 Continuity of community-based team

- Identification and patient engagement through our complex primary care program
- Layering on palliative care staff and services
- Enabling connections to remote resources

2 Expanding geographic reach

- Hybrid telehealth and in-home care delivery brings:
- Social Workers
- Chaplains
- Clinical case manager

3 Using technology to coordinate care

- Effective communication across team members
- Integrated logistics management and EHR
- Track and manage patient care plans

MED ZED

Innovation Partners

The success of our palliative care program is a foundation of effective communication and collaboration with our partners and interdisciplinary team.

External Partners

Monthly IDT rounds between plan and palliative programs

Weekly call to discuss new and pending referrals

Ongoing email exchange between case managers on patient status and care needs

Monitoring ADT for timely post-discharge care

Shared EHRs throughout markets

Internal Partners

Weekly internal meeting discussing patient panel management

Daily team chat collaboration on patient social and medical needs

Monthly nurse education meetings on patient-care topics

Access to medical records in many of our markets

24/7 availability for urgent patient issues

MEDZED

Innovation Surprise

We have been heartened by the depths of the relationships developed between our team and our patients.

Results of our efforts

- Performed baptism in patient's home to fulfill his wish
- Helped multiple patients get into drug rehabilitation
- Facilitated comfortable death at home due to extenuating circumstances
- Conducted same day appointments for patients in distress to avoid unnecessary ER visits
- Found and engaged homeless patients
- Family are highly satisfied with our bereavement services

MED ZED

Innovation Takeaway

Identifying and moving patients between programs enables fewer care transitions and provides better patient and family experience.

1 Meeting patients where they are

- Reaches patients in their healthcare journey
- Provides warm handoff transiting from complex primary care program
- Community-based outreach to find and engage identified patients

2 Hybrid model of care

- Allows us to manage a dispersed interdisciplinary team
- Enables specialized palliative staff to extend expertise across the state
- Facilitates care coordination

MEDZED

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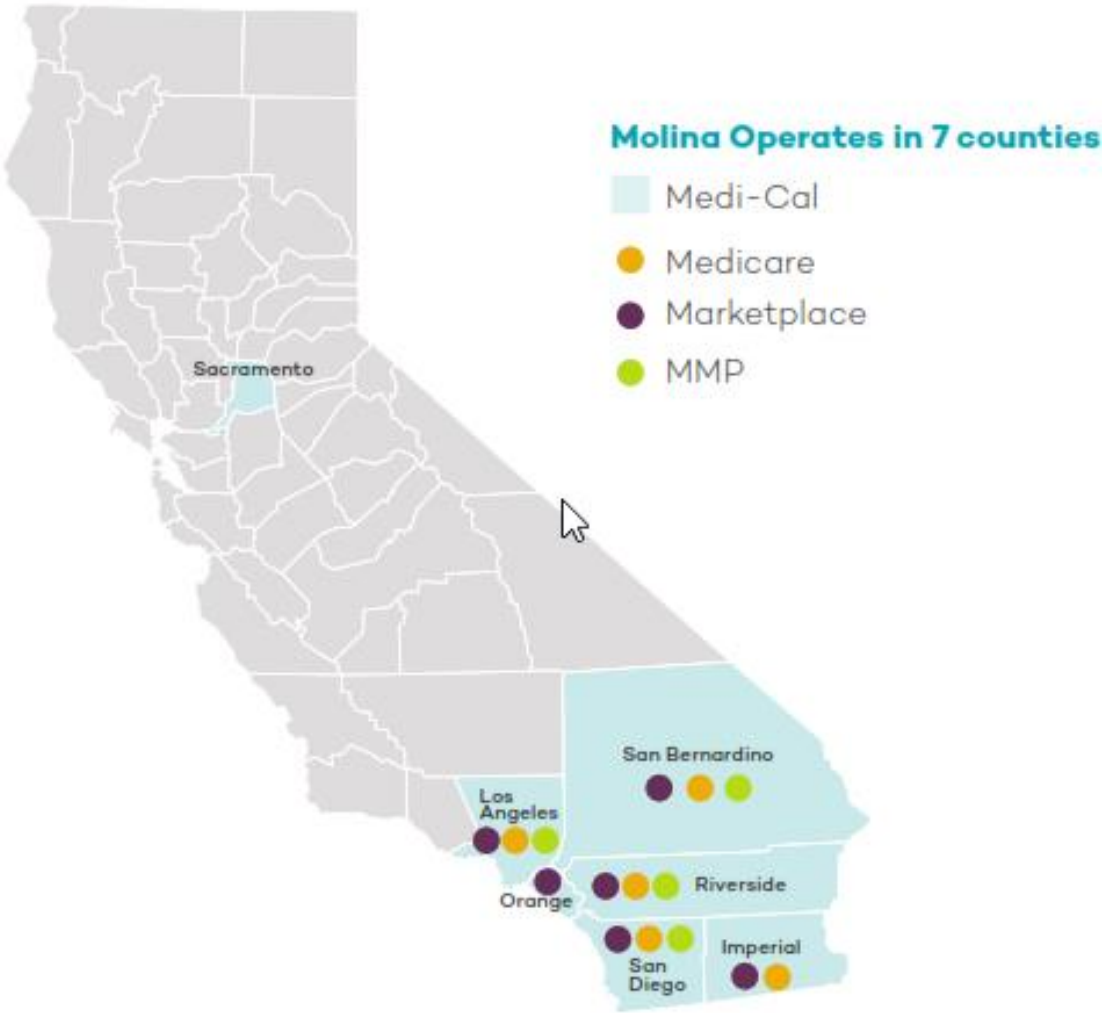
Driving Improvements in Palliative Care in Medi-Cal (SB 1004)

Innovation Session: Molina Healthcare of California

April 28, 2021

Background

Molina Healthcare of California
Established 1985



Adult Medi-Cal Membership
275,000
Contracted Palliative Care Providers
16
Key Features of Palliative Care Program
• Advanced Planning Discussions • Minimum 4 touches per month, including 1 face to face • Care Coordination • Care Support Team
Primary Payment Mechanism
Monthly Case Rate Fee For Service Add on

Innovation in Monitoring Referrals and Enrollments

Palliative Care Tracker (Excel Spreadsheet) to track referrals

Palliative Care Dashboard

A	B	C	D	E	F	G	H
My Care Referral Date	Member	Member First	Member Last	Member D	Cour	LOB	Dx
2/1/2021					SD		Liver Disease
12/17/2020					SD		Liver Disease
2/1/2021					SAC		Congestive Heart Failure (CHF)

Palliative Care Tracker

Case Manager/Palliative Care Leads responsible for updating the PC Excel Tracker.

Palliative Care Tracker (Excel Spreadsheet) Data Elements:

- Referral date
- Member demographics (name, age, gender)
- Diagnosis
- Referral source/date/outcome
- Reason for declining PC (if applicable)
- POLST/Advance Directive date
- Enrollment/disenrollment date/outcomes

Uses:

- Data summarized in Palliative Care Dashboard; claims data linked to the dashboard
- Tracks referral source for annual departmental performance metric
- Data used to provide bi-weekly updates to internal stakeholders
- Data analyzed to develop strategies and innovations

Palliative Care Dashboard

Dashboard Components:

- Summary
- Member Details
- Cost Trend
- Vendor Comparison
- Program Highlights

Palliative Care Dashboard- Summary

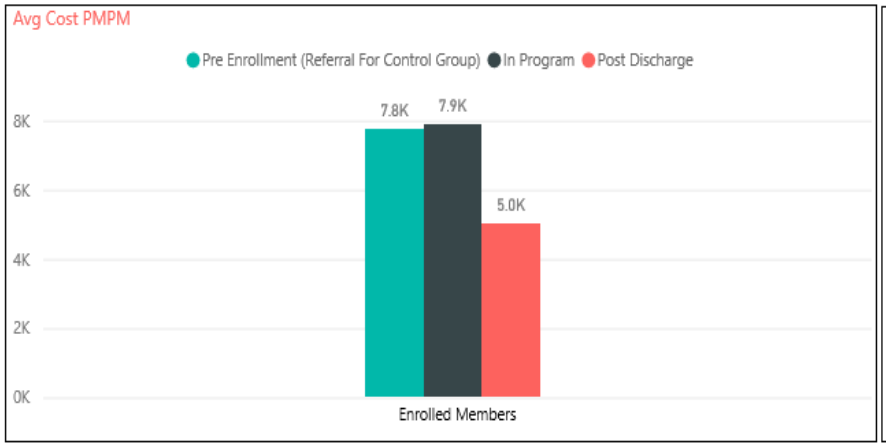
Note: There is a 90 day claim lag

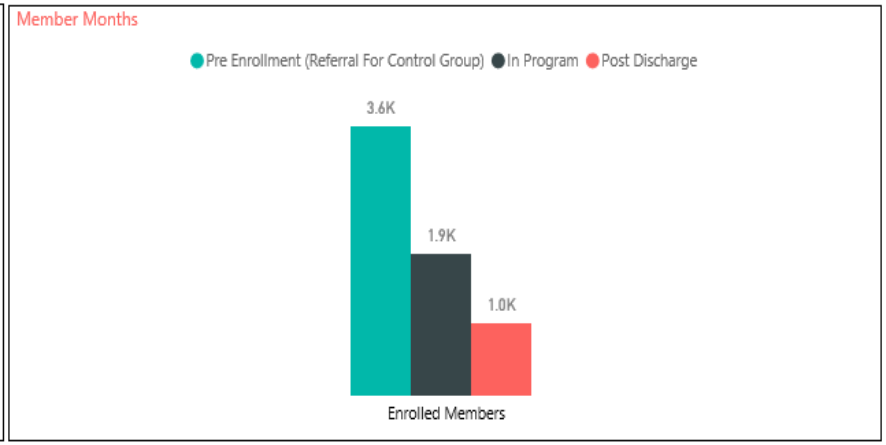
Total Members	Avg months In The Program	Avg Age	Currently Enrolled Members	Male	Female	Refresh Date
332	5.66	57	89	188	144	4/2/2021

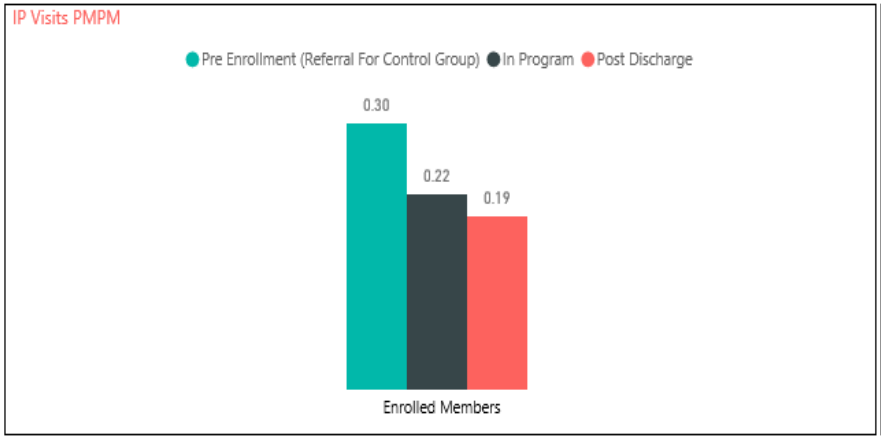
Filter

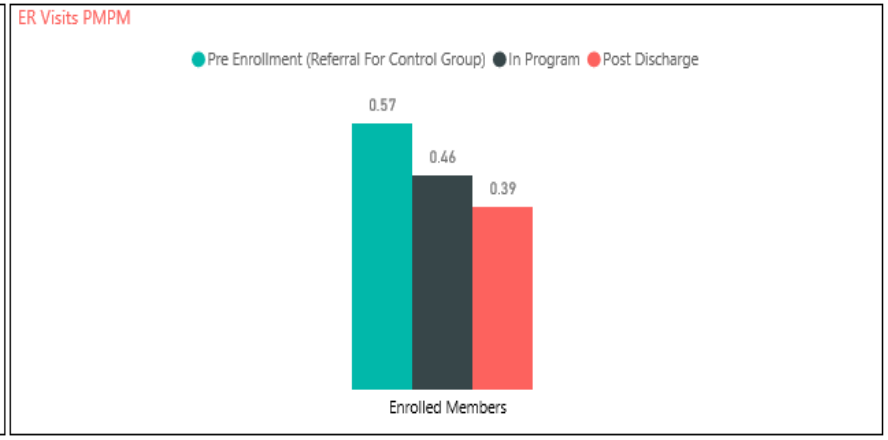
Read Me

Summary | Member Details | Cost trend | Vendor Comparison | Program Highlights

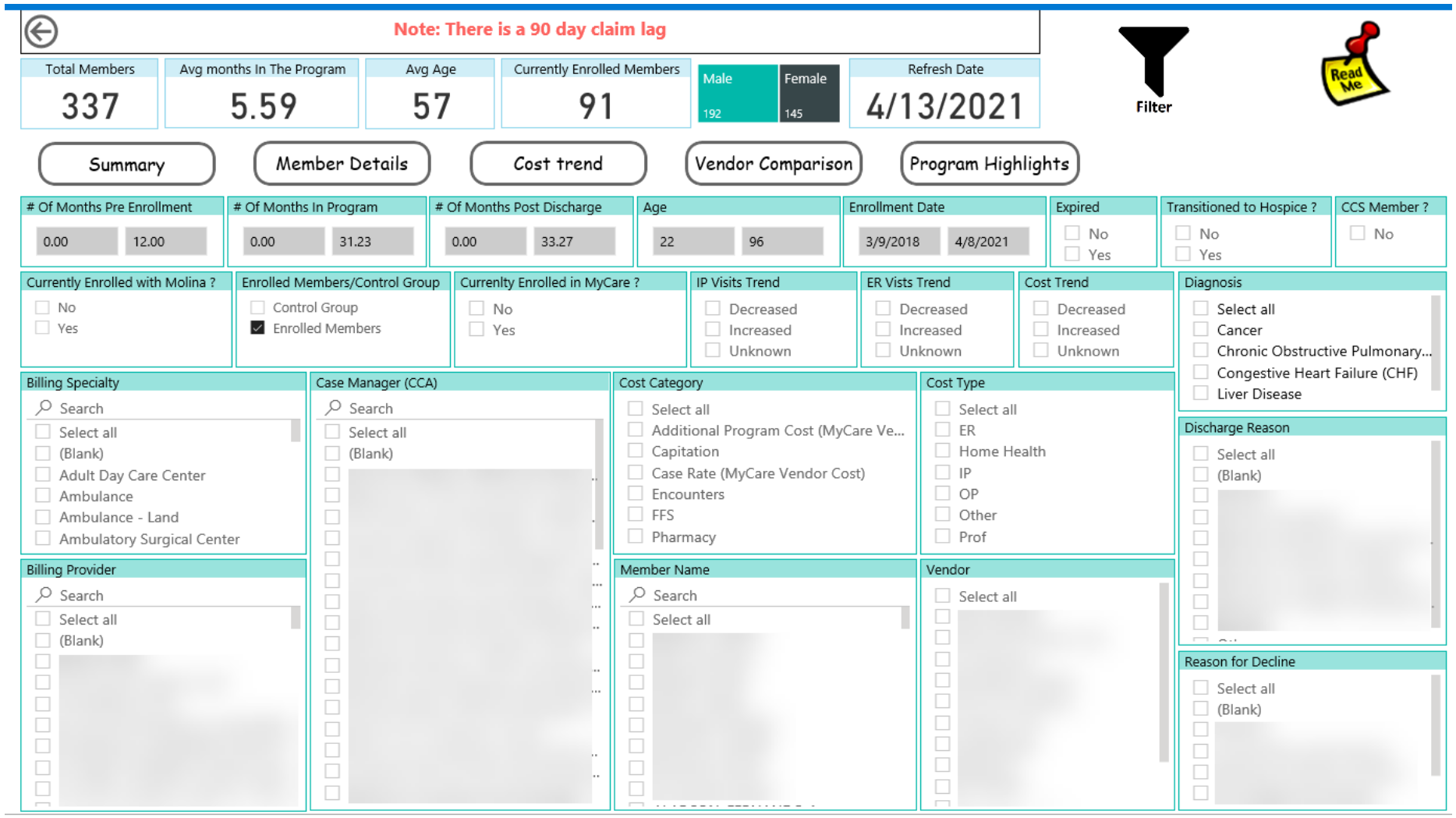




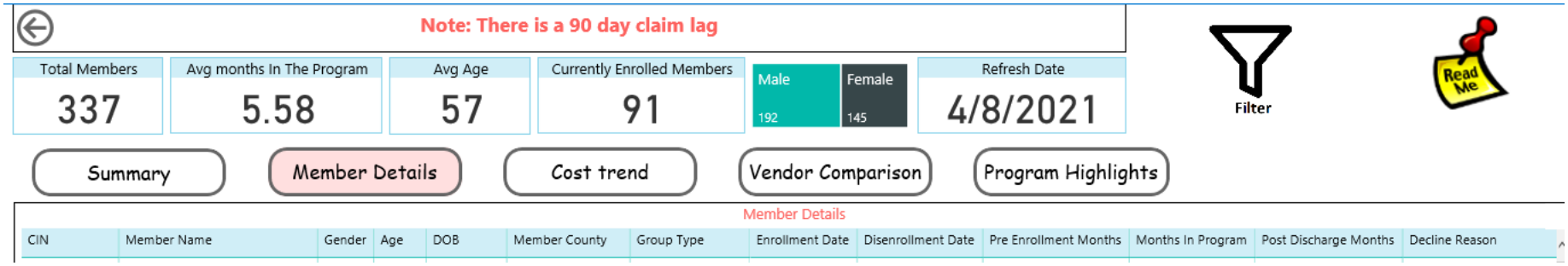




Palliative Care Dashboard- Filter option



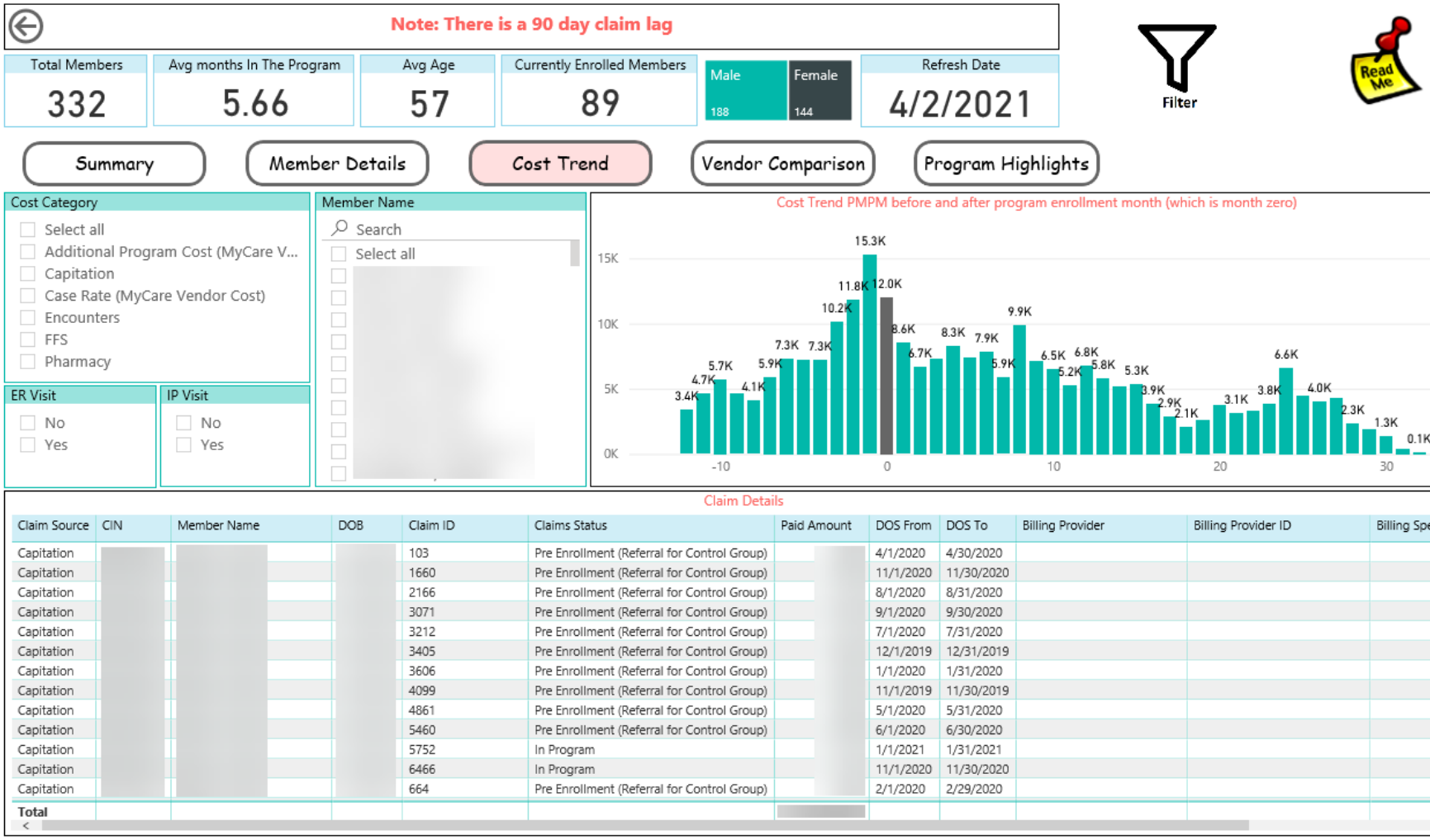
Palliative Care Dashboard- Member Details



Member Detail (Spreadsheet) Fields:

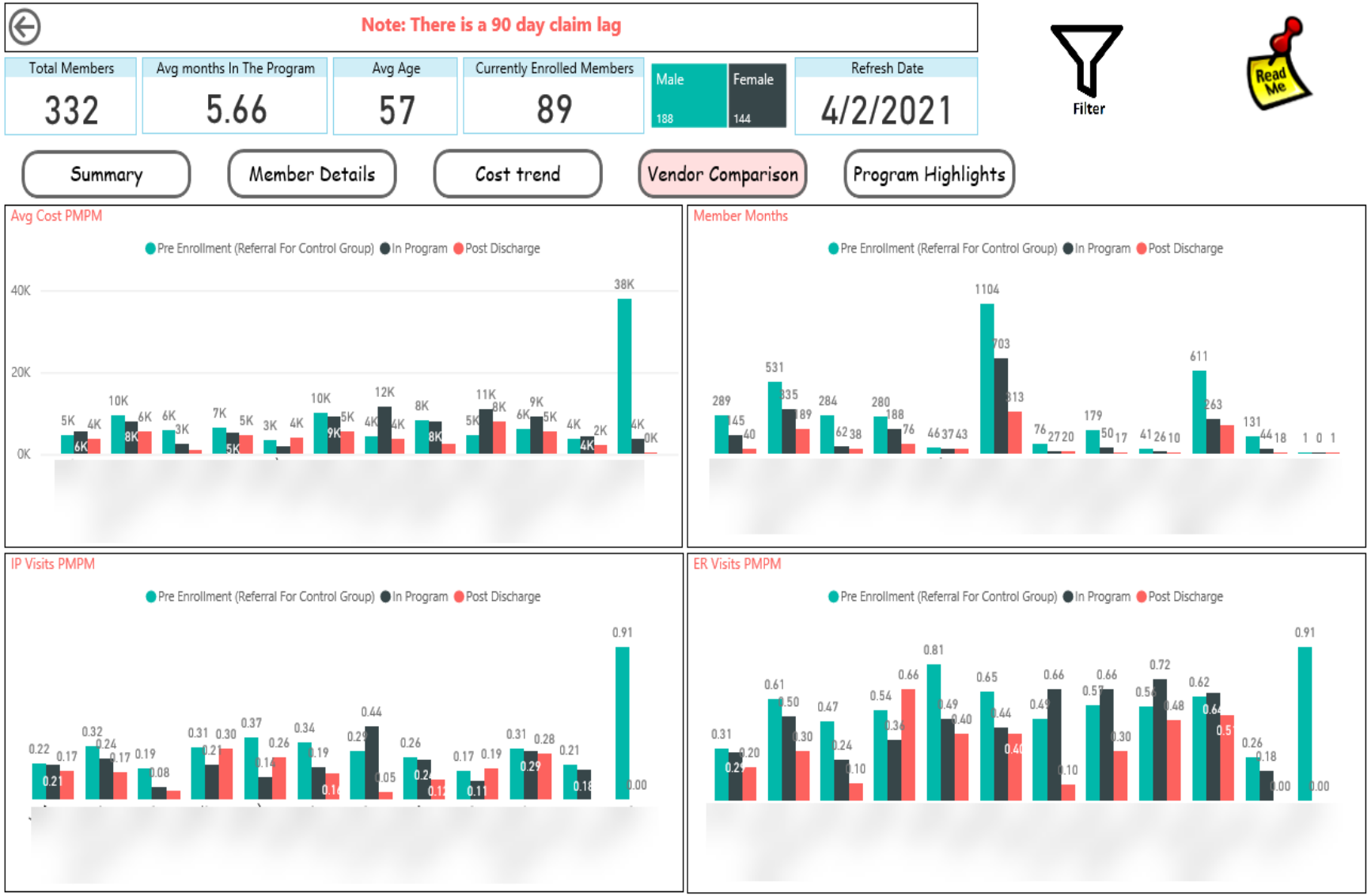
- Member demographics
- Program enrollment/disenrollment dates
- Reason not enrolled in the palliative care program (member declined, unable to contact, etc.)
- Pre-enrollment months, months enrolled in the program, post-discharge months
- Counts of emergency department visits and admissions
- Status of enrollment with Molina Health Plan
- Flag if transitioned to hospice
- Enrollment diagnosis
- Palliative care vendor that is caring for member
- Total cost

Palliative Care Dashboard- Cost Trend



Claim Source	CIN	Member Name	DOB	Claim ID	Claims Status	Paid Amount	DOS From	DOS To	Billing Provider	Billing Provider ID	Billing Specialty
Capitation				103	Pre Enrollment (Referral for Control Group)		4/1/2020	4/30/2020			
Capitation				1660	Pre Enrollment (Referral for Control Group)		11/1/2020	11/30/2020			
Capitation				2166	Pre Enrollment (Referral for Control Group)		8/1/2020	8/31/2020			
Capitation				3071	Pre Enrollment (Referral for Control Group)		9/1/2020	9/30/2020			
Capitation				3212	Pre Enrollment (Referral for Control Group)		7/1/2020	7/31/2020			
Capitation				3405	Pre Enrollment (Referral for Control Group)		12/1/2019	12/31/2019			
Capitation				3606	Pre Enrollment (Referral for Control Group)		1/1/2020	1/31/2020			
Capitation				4099	Pre Enrollment (Referral for Control Group)		11/1/2019	11/30/2019			
Capitation				4861	Pre Enrollment (Referral for Control Group)		5/1/2020	5/31/2020			
Capitation				5460	Pre Enrollment (Referral for Control Group)		6/1/2020	6/30/2020			
Capitation				5752	In Program		1/1/2021	1/31/2021			
Capitation				6466	In Program		11/1/2020	11/30/2020			
Capitation				664	Pre Enrollment (Referral for Control Group)		2/1/2020	2/29/2020			
Total											

Palliative Care Dashboard- Vendor Comparison



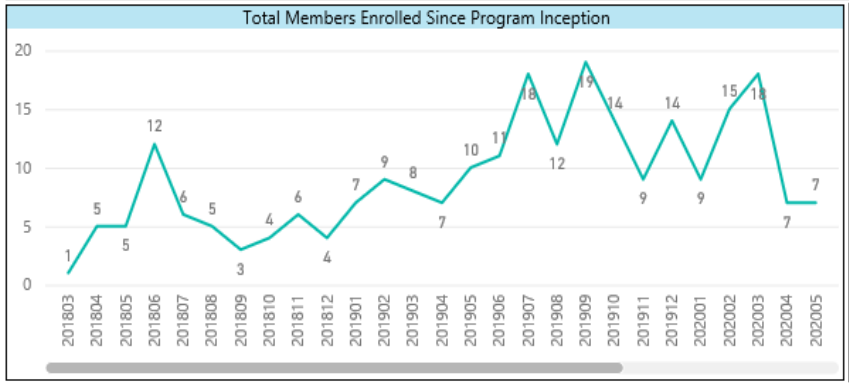
Palliative Care Dashboard
Program Highlights

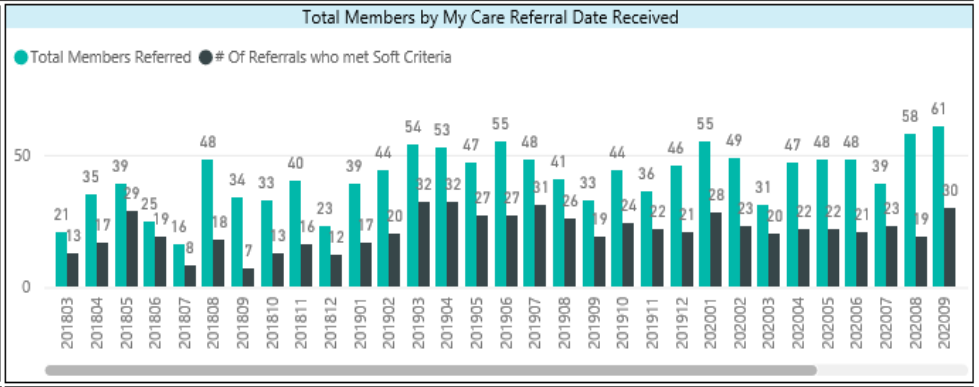
# of Referrals	# of Internal Referrals	# of External Referrals	# of Members Currently Enrolled	# of Members Enrolled Since Program Inception	# of Internal Referrals in 2021	# of External Referrals in 2021	# of Total Referrals in 2021 (Int & Ext)	# of Internal Referrals in 2021 who met soft criteria	# of External Referrals in 2021 who met soft criteria
1550	1464	86	90	346	120	4	0 124 /550	0 46 /216	3

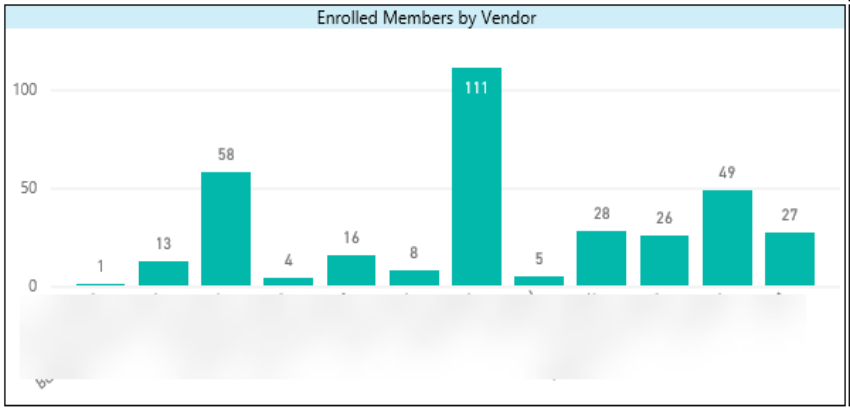
Main Dashboard

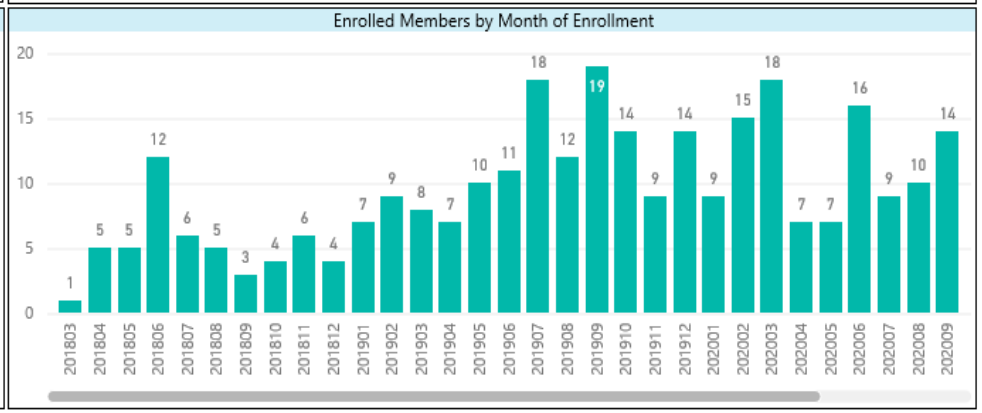
County	Currently Enrolled	My Care Referral Date Received	Refresh Date
All	No Yes	3/8/2018 3/26/2021	4/2/2021

Note : If a member is referred or enrolled twice in program then we count the members for twice.









Challenge/Need Addressed

Sustaining and Developing the Palliative Care Program

- Tracking referrals
- Monitoring impact on costs
- Vendor performance
- Access to details on individual enrollees
- Demonstrate program value to Plan leadership
- Use data to engage internal and external stakeholders to increase referrals
- Identify gaps and areas to improve program statewide and by region
- Department goal tracking for annual goal performance metric
- Identify additional diagnosis outside SB 1004 minimums to expand the eligibility criteria

Key Partners

- Dedicated Case Management staff who support the Palliative Care team and Vendors
- Program Manager
- Case Management Director
- Molina Senior Leadership
- Medical Director
- Analytics

Dashboard Uses

Dashboard Uses

- Combining and condensing large amounts of information allows us to consider program-specific data at a glance, including:
  - Comparing our data at any given time (i.e., week to week, or by region, or by vendor)
  - Filtering by year to track market trends, program growth, and costs
  - Identifying program barriers and implementing changes as needed (i.e., recognizing the need to generate more external referrals leading to pilot projects with our vendors)
- This has helped us set goals, enhance our program, and demonstrate benefits of the program to stakeholders

MOLINA HEALTHCARE

Reflection Exercise

Take 5 min to think about the innovations presented

How might you use these innovations?

Please list any questions you have for these innovation presenters in the Chat box

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Driving Improvements in Palliative Care in Medi-Cal (SB 1004)

Innovation Session: L.A. Care Health Plan

April 28, 2021

Introduction

L.A. Care Health Plan:

- Committed to promoting accessible, affordable, high-quality health care
- Provides coverage to low-income Angelenos (serving over 2 million members)
- Mission-driven health plan—programs are dedicated to elevating the safety net
- 2018 started developing the Palliative Care program—operated through Managed Long-Term Services and Supports (MLTSS) program

Innovation #1: Patient Identification/ Engagement

Member Matching Triage Tool

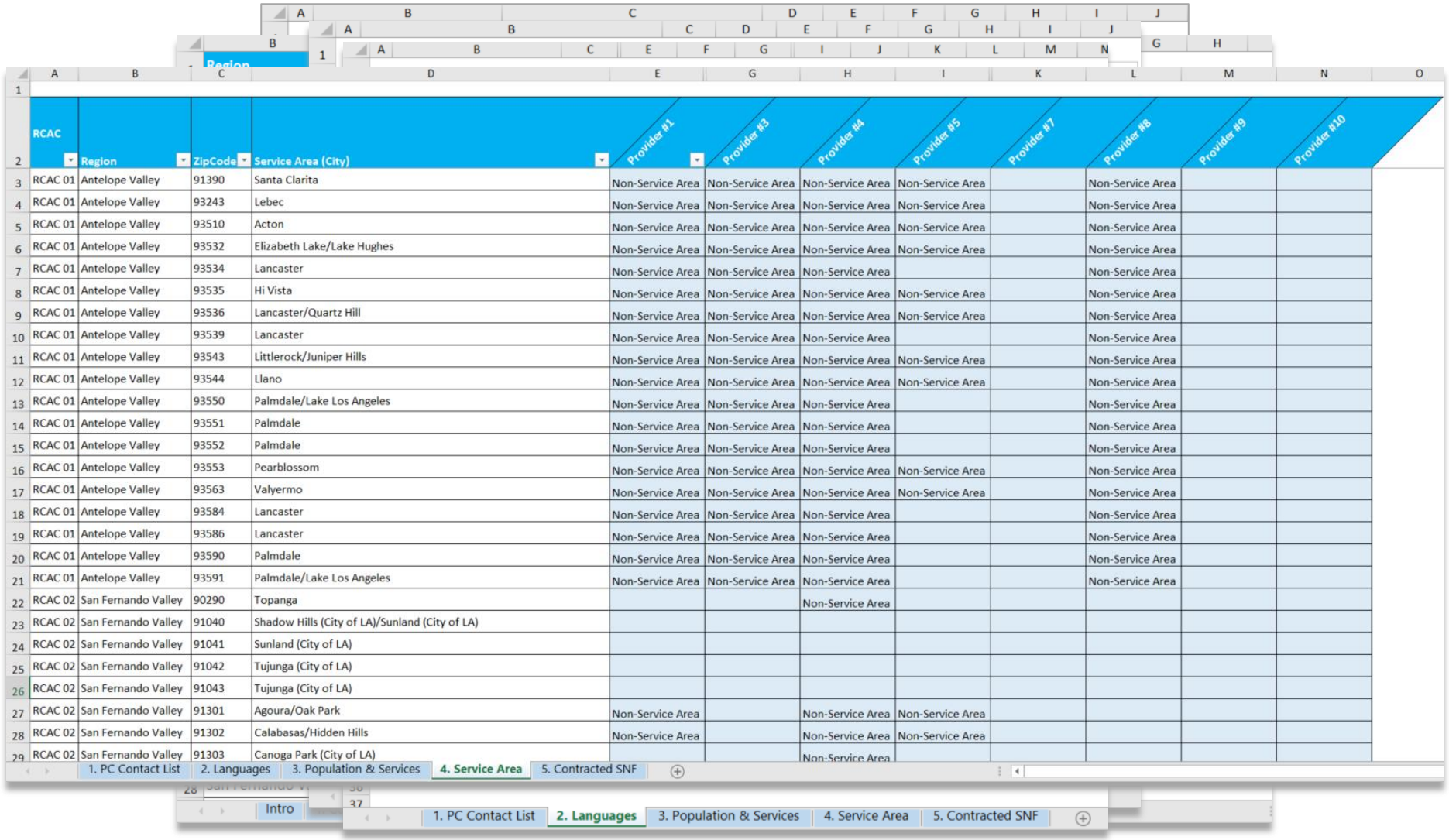
- Promotes providing culturally appropriate care to a diverse community
- Palliative care vendors/providers are matched to our members needs: language, location, social determinants, etc.
- Key success ingredient: meet members where they are and in a way they can relate to

Challenge/Need Addressed

- Providing high-quality culturally appropriate care is important to our mission as a health plan.
- For 20 years, our plan has provided care to vulnerable Angelenos through many of our programs in the community.
- Palliative care program mirrors the rich cultural diversity of our own staff, underscoring the importance of matching members to providers who meet their needs.

Innovation Contribution

Member Matching Triage Tool



RCAC	Region	ZipCode	Service Area (City)	Provider #1	Provider #3	Provider #4	Provider #5	Provider #7	Provider #8	Provider #9	Provider #10
RCAC 01	Antelope Valley	91390	Santa Clarita	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93243	Lebec	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93510	Acton	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93532	Elizabeth Lake/Lake Hughes	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93534	Lancaster	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93535	Hi Vista	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93536	Lancaster/Quartz Hill	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93539	Lancaster	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93543	Littlerock/Juniper Hills	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93544	Llano	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93550	Palmdale/Lake Los Angeles	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93551	Palmdale	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93552	Palmdale	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93553	Pearblossom	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93563	Valyermo	Non-Service Area	Non-Service Area	Non-Service Area	Non-Service Area		Non-Service Area		
RCAC 01	Antelope Valley	93584	Lancaster	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93586	Lancaster	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93590	Palmdale	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 01	Antelope Valley	93591	Palmdale/Lake Los Angeles	Non-Service Area	Non-Service Area	Non-Service Area			Non-Service Area		
RCAC 02	San Fernando Valley	90290	Topanga			Non-Service Area					
RCAC 02	San Fernando Valley	91040	Shadow Hills (City of LA)/Sunland (City of LA)								
RCAC 02	San Fernando Valley	91041	Sunland (City of LA)								
RCAC 02	San Fernando Valley	91042	Tujunga (City of LA)								
RCAC 02	San Fernando Valley	91043	Tujunga (City of LA)								
RCAC 02	San Fernando Valley	91301	Agoura/Oak Park	Non-Service Area		Non-Service Area	Non-Service Area				
RCAC 02	San Fernando Valley	91302	Calabasas/Hidden Hills	Non-Service Area		Non-Service Area	Non-Service Area				
RCAC 02	San Fernando Valley	91303	Canoga Park (City of LA)			Non-Service Area					

1. PC Contact List | 2. Languages | 3. Population & Services | 4. Service Area | 5. Contracted SNF

Intro

1. PC Contact List | 2. Languages | 3. Population & Services | 4. Service Area | 5. Contracted SNF

Innovation #2: Assessing/ Improving Quality of Care

Provider Quality Audit Tool

- Audit tool developed to level set with PC providers ensuring the care provided is meeting expected quality standards.
- Tool enabled the health plan to monitor, communicate, and make important decisions on best practices and providers.
- Results are shared with providers and followed over time to promote performance improvement as needed.

Innovation Category & Description

Provider Quality Audit Tool

- Quarterly reviews including domains of care from National Consensus Project
- Full review of charts including assessment, care plan, and follow-up (i.e., if pain or dyspnea present, what was intervention? Did intervention provide relief?)
- Were goals of care discussed and related back to advance care planning?
- Was a designated AOR identified?
- Did member receive correct number of visits and add-on services for pediatrics?

L.A. Care Palliative Care
Provider Quality Review

Point Allocation: "5" Excellent "4" Very Good "3" Average "2" Less Than Average "1" Poor "0" Requirement Not Included

Business Requirement	Comments	Score	Average Score
Proivder #1			
Documented goals of care (advanced directives/POLST)		0	0
Symptom assessment (pain, SOB, etc)		0	
POA/AOR designation		0	

Innovation Partners

- Palliative Care program success is a product of collaboration—internally and externally—with medical providers, vendors, and MLTSS staff
- Internally: case management, utilization management, population health/QI, HIM
- Externally: our capable palliative care providers, network of PPGs/IPAs
- CHCF

Innovation Surprise

- Importance of clearly defining the scope of palliative care and differentiating it (to reduce confusion) from hospice.

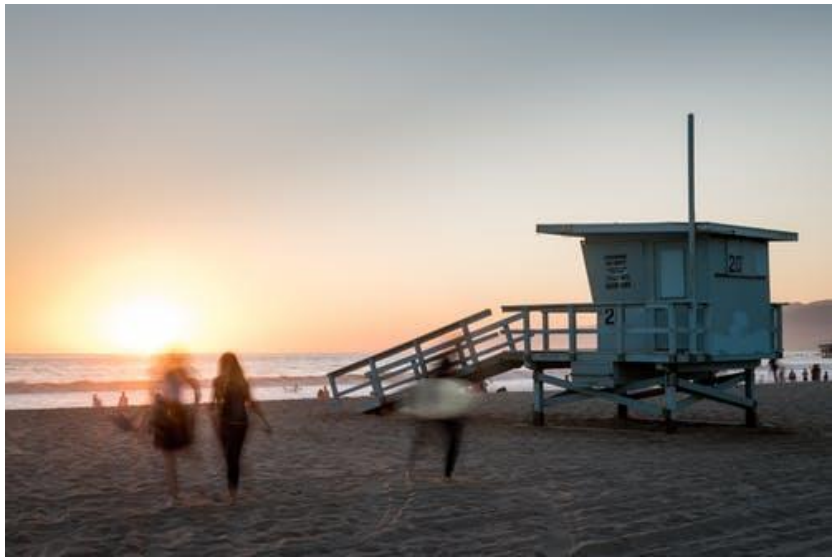
- When the benefit is visible and delivered efficiently, we are successful.

Innovation Takeaway

Health equity is central to our mission.

Our program reduces health disparities and achieves quality outcomes.

Quality is an active process requiring ongoing reassessment over time.



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Driving Improvements in Palliative Care in Medi-Cal (SB 1004)

Innovation Session: Roze Room

April 28, 2021

ROZE ROOM HOSPICE

Roze Room

- Providing Hospice Services to patients and families throughout Los Angeles and Ventura Counties for over 23 years
- Palliative Care Services for over 13 years
- Roze Room Palliative Care Program is accredited by The Joint Commission
- Office locations in Culver City, Reseda, Ventura, Pasadena, and Long Beach
- Currently contracted with over 10 Health Plans/Medical Groups paying for Palliative Care support
- Currently caring for over 275 Palliative Care patients

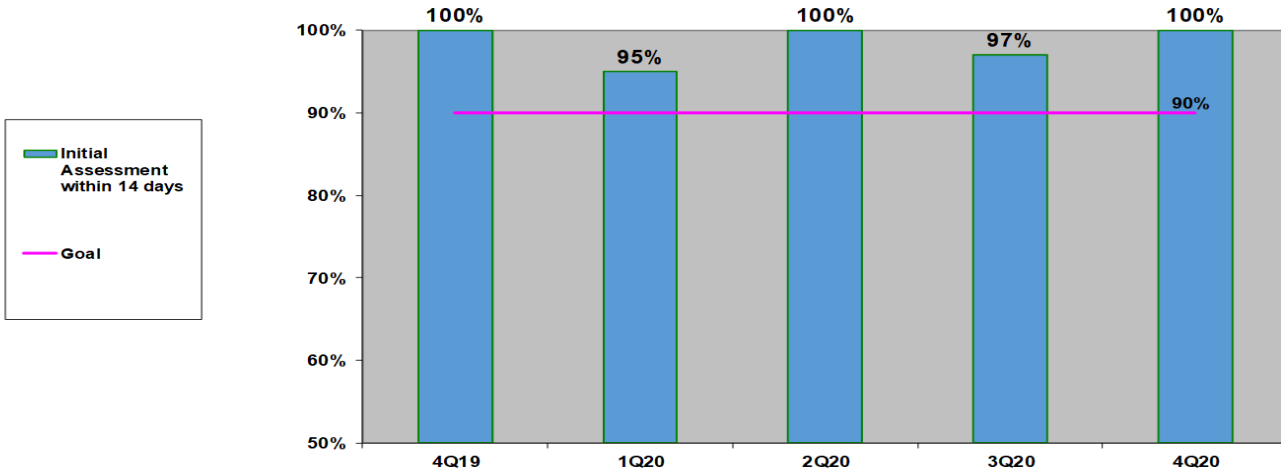
Innovation in Quality of Care

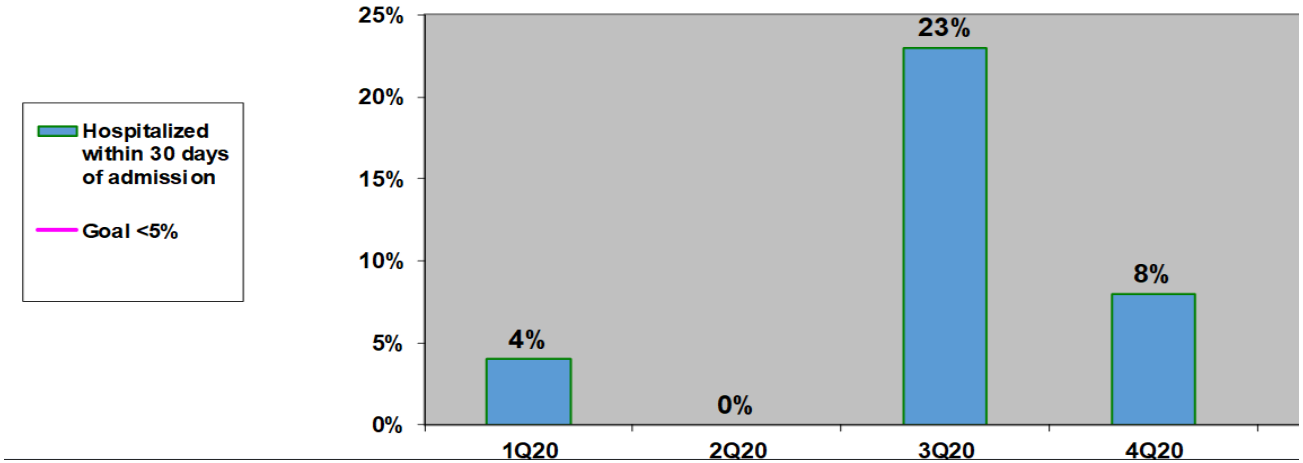
- Roze Room has a robust Palliative Care program with 360° annual Quality Assessment & Performance Improvement Plan.
- Each quarter we evaluate our performance to goal and adjust our interventions based on outcomes.

	Roze Palliative Care		LA	
	Quality Assessment and Performance Improvement			
DEPARTMENT	PERFORMANCE METRIC	2021 GOAL	FREQ. OF REVIEW	METHOD OF REVIEW
MARKETING/SALES	Admissions	per dashboard	Quarterly	Monthly management monitoring
	ADC Growth	per dashboard	Monthly	Monthly management monitoring
	Conversion Ratio	85%	Monthly	Monthly management monitoring
CLINICAL OPERATIONS-PAIN MANAGEMENT	Pain monitored each SN visit	90%	Quarterly	QA EMR Review
CLINICAL OPERATIONS-MEDICATION SAFETY	Medication management-medication evaluation of side effects, etc completed at each visit	95%	Quarterly	QA EMR Review
CLINICAL OPERATIONS-GENERAL	Patients dying in the hospital will be less than 10%	10%	Monthly	QA EMR Review
CLINICAL OPERATIONS-INITIAL ASSESSMENT	Initial assessment to be completed within 14 days of admission	90%	Monthly	QA EMR Review
CLINICAL OPERATIONS-TRANSFERS TO HOSPICE (ANY)	Transfers to hospice from Palliative care	15%	Monthly	Monthly management monitoring
MEDICAL RECORDS	POLST in place	95%	Monthly	Monthly management monitoring
PATIENT SATISFACTION	Overall satisfaction (9-10)	90%	Monthly	QA review of returned surveys
	Would you recommend RRPC? (Yes)	90%	Monthly	QA review of returned surveys
CLINICAL OPERATIONS-HOSPITALIZATIONS WITHIN 30 DAYS OF ADMISSION	Percentage of patients hospitalized with 30 days of admission	5%	Quarterly	QA EMR Review
CLINICAL OPERATIONS-PATIENTS WITH REGULARLY SCHEDULED SW VISITS	Percentage of patients with regular SW visits	30%	Quarterly	QA EMR Review

Quality of Care

Quarterly, Roze Room's Director of QAPI presents performance to goal for each of the Metrics. For example:





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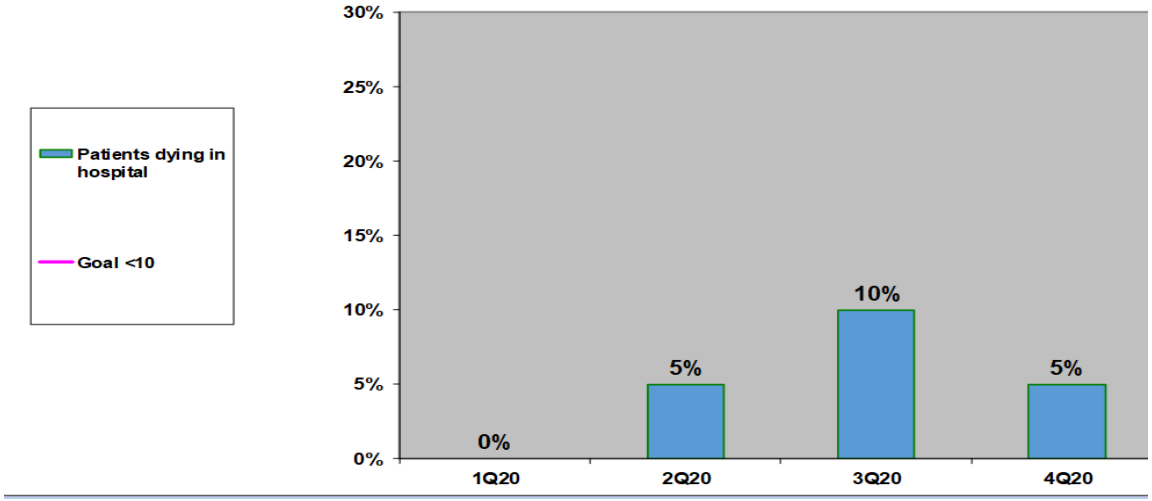
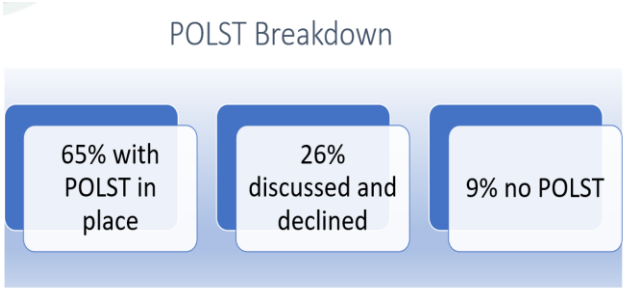




Patient Satisfaction Surveys

3 Surveys returned
67% satisfaction rating 9-10
33% not rated
100% would recommend PC services

Challenge/Need Addressed

- Our intense QAPI program performance measures set a high bar of expectations. We look at the below statistics as evidence of program efficiency:
  - Patients dying in the hospital: < 10%
  - Transfers to hospice within 30 days of admission: 15%
  - POLST in place: >95%
  - % patients hospitalized within 30 days of admission: 5%
  - Overall satisfaction: >90%

Innovation Contribution

- Utilizing a 360° Quality Assurance & Performance Improvement Plan with intense monitoring and auditing
- Further in-servicing to staff is centered around meeting/exceeding our quality goals
- Allows us to base our SB 1004 Palliative Care services to seriously-ill adult Medi-Cal enrollees on data-driven outcomes

Innovation Partners

External Partners

- Community Physicians
- Health Plan
- Medical Group C-Suite executives
- Hospital Discharge Planners/SWs

Internal Partners

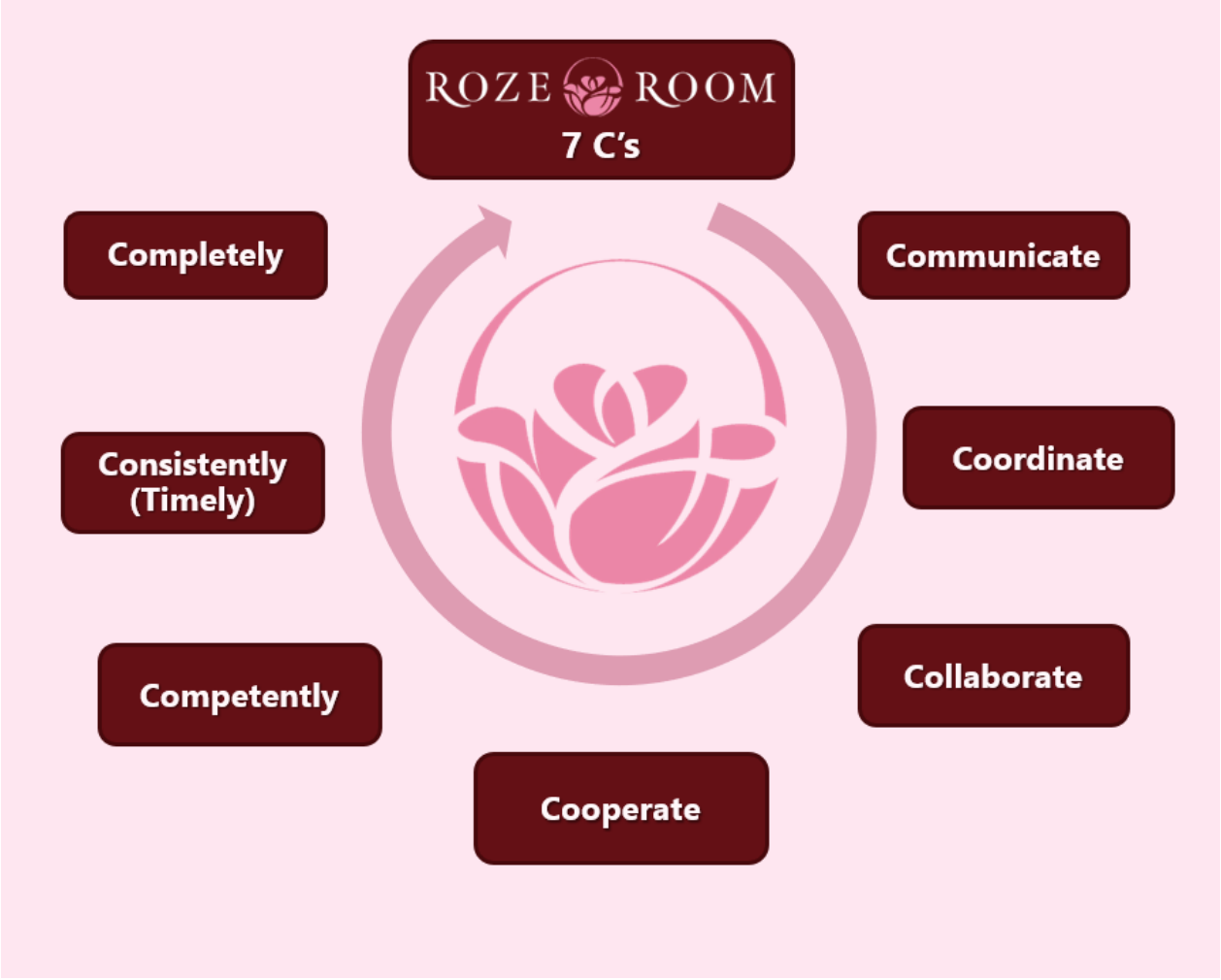
- Centralized Referral Center
- Medical Director
- Team Leader, NP, RN, LVN, SW, and SC
- Sales/Marketing Team
- After-hours/Weekend Call Center & Triage

Innovation Lesson

- As a result of implementing the QAPI program in Palliative Care, we found ourselves better equipped to promote the Palliative Care program and philosophy to other paying partners.
- It is very important to have a measuring mechanism in place to objectively demonstrate your successes.

Innovation Takeaway

We believe we are at our best when we are consistent in following our Roze Room 7 Cs.



BREAK

The convening will resume at 10:40