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

Innovation Session: MedZed

April 28, 2021
MedZed is a technology-enabled mobile provider delivering a range of services to high-risk patients.

### Staffing

<table>
<thead>
<tr>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>+Board Certified Palliative Medical Director</td>
</tr>
<tr>
<td>+Social Worker</td>
</tr>
<tr>
<td>+Chaplain</td>
</tr>
<tr>
<td>+Case Manager</td>
</tr>
</tbody>
</table>

### Responsibility and Frequency

- 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

<table>
<thead>
<tr>
<th>Complex Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>+Complex Care Provider (Remote MD, NP, PA)</td>
</tr>
<tr>
<td>+In-home nurse</td>
</tr>
<tr>
<td>+Care Coordinator</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Health Homes (CB-CME)</th>
</tr>
</thead>
<tbody>
<tr>
<td>+Community Health Navigator</td>
</tr>
</tbody>
</table>

- Conducts outreach & scheduling methods
- Builds trust-based relationships
- Collaborates with community resources
- Coordinates transportation/social-need fulfillment
- 24-72 hours post-discharge support
Introduction

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

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

334 unique Medi-Cal members served across the state:

- Chico
- San Francisco
- Fresno
- Los Angeles

Currently 130 active patients
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

Interdisciplinary Care Team

- Chief Medical Officer
- Board Certified Palliative Care Director
- Complex Care Provider
- Social Worker
- In-Home Nurse
- Case Manager
- Chaplain
- Care Coordinator
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

Our patients’ challenges

We stay with patients on their healthcare journey until they are ready for hospice.
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
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
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
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
Driving Improvements in Palliative Care in Medi-Cal (SB 1004)

Innovation Session: Molina Healthcare of California

April 28, 2021
Background

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
### Palliative Care Tracker (Excel Spreadsheet) to track referrals

#### Palliative Care Dashboard

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My Care Referral Date</td>
<td>Member</td>
<td>Member First</td>
<td>Member Last</td>
<td>Member</td>
<td>Cour.</td>
<td>LOB</td>
<td>Dz</td>
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<td>2/1/2021</td>
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<td></td>
<td></td>
<td></td>
<td>SD</td>
<td>Liver Disease</td>
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<tr>
<td>12/17/2020</td>
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<td>SD</td>
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<tr>
<td>2/11/2021</td>
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<td></td>
<td></td>
<td></td>
<td>SAC</td>
<td>Congestive Heart Failure (CHF)</td>
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</table>
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

<table>
<thead>
<tr>
<th>Total Members</th>
<th>Avg months In The Program</th>
<th>Avg Age</th>
<th>Currently Enrolled Members</th>
<th>Male</th>
<th>Female</th>
<th>Refresh Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>332</td>
<td>5.66</td>
<td>57</td>
<td>89</td>
<td>188</td>
<td>144</td>
<td>4/2/2021</td>
</tr>
</tbody>
</table>

Summary

Member Details

Cost trend

Vendor Comparison

Program Highlights

Avg Cost PMPM

Member Months

IP Visits PMPM

ER Visits PMPM
## Palliative Care Dashboard - Filter option

### Summary
- **Total Members**: 337
- **Avg months in the Program**: 5.59
- **Avg Age**: 57
- **Currently Enrolled Members**: 91
- **Refresh Date**: 4/13/2021

### Table

<table>
<thead>
<tr>
<th># Of Months Pre Enrollment</th>
<th># Of Months In Program</th>
<th># Of Months Post Discharge</th>
<th>Age</th>
<th>Enrollment Date</th>
<th>Expired</th>
<th>Transitioned to Hospice?</th>
<th>CCS Member?</th>
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<tbody>
<tr>
<td>0.00</td>
<td>12.00</td>
<td>0.00</td>
<td>22</td>
<td>3/9/2018</td>
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<td>No</td>
<td>No</td>
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</table>

### Filter Option
- **Currently Enrolled with Molina?**: No
  - □ No
  - □ Yes
- **Enrolled Members/Control Group**: Enrolled Members
  - □ Control Group
  - □ Enrolled Members
- **Currently Enrolled in MyCare?**: No
  - □ No
  - □ Yes
- **IP Visits Trend**: Decreased
  - □ Decreased
  - □ Increased
  - □ Unknown
- **ER Visits Trend**: Decreased
  - □ Decreased
  - □ Increased
  - □ Unknown
- **Billing Specialty**: 
  - □ Select all (Blank)
  - □ Control Group
  - □ Enrolled Members
- **Case Manager (CCA)**:
  - □ Select all (Blank)
- **Cost Category**: 
  - □ Select all
  - □ Additional Program Cost (MyCare Visit...)
  - □ Capitation
  - □ Case Rate (MyCare Vendor Cost)
  - □ Encounters
  - □ FFS
  - □ Pharmacy
- **Cost Type**: 
  - □ Select all
  - □ Home Health
  - □ IP
  - □ OP
  - □ Other
  - □ Prof
- **Billing Provider**: 
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- **Member Name**: 
  - □ Select all (Blank)
- **Vendor**: 
  - □ Select all (Blank)
- **Reason for Decline**: 
  - □ Select all (Blank)
- **Discharge Reason**: 
  - □ Select all (Blank)

### Note: There is a 90 day claim lag
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

Note: There is a 90 day claim lag

<table>
<thead>
<tr>
<th>Total Members</th>
<th>Avg months in The Program</th>
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</tr>
</tbody>
</table>

**Summary**

**Member Details**

**Cost Trend**

**Vendor Comparison**

**Program Highlights**

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Cost Trend PM/PM before and after program enrollment month (which is month zero)

### Claim Details

<table>
<thead>
<tr>
<th>Claim Source</th>
<th>CIN</th>
<th>Member Name</th>
<th>DOB</th>
<th>Claim ID</th>
<th>Claims Status</th>
<th>Paid Amount</th>
<th>DOS From</th>
<th>DOS To</th>
<th>Billing Provider</th>
<th>Billing Provider ID</th>
<th>Billing Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td></td>
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<td></td>
<td>108</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>4.7K</td>
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<td>4/10/2020</td>
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<tr>
<td>Capitation</td>
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<td></td>
<td></td>
<td>1660</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>5.2K</td>
<td>11/1/2020</td>
<td>11/30/2020</td>
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<td></td>
<td></td>
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<tr>
<td>Capitation</td>
<td></td>
<td></td>
<td></td>
<td>2166</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>8.6K</td>
<td>8/1/2020</td>
<td>8/31/2020</td>
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<tr>
<td>Capitation</td>
<td></td>
<td></td>
<td></td>
<td>3071</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>9.5K</td>
<td>9/1/2020</td>
<td>9/30/2020</td>
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<tr>
<td>Capitation</td>
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<td>3212</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>10.2K</td>
<td>7/1/2020</td>
<td>7/31/2020</td>
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<td>3405</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>11.9K</td>
<td>12/1/2019</td>
<td>12/31/2019</td>
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<tr>
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<td>3506</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>8.8K</td>
<td>1/1/2020</td>
<td>1/31/2020</td>
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<tr>
<td>Capitation</td>
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<td>4099</td>
<td>Pre Enrollment (Referral for Control Group)</td>
<td>5.2K</td>
<td>11/1/2019</td>
<td>11/30/2019</td>
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<td>4861</td>
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<td>5/31/2020</td>
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<td>5460</td>
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<td>6.8K</td>
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<td>6466</td>
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<td>2/1/2020</td>
<td>2/29/2020</td>
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</table>

Total
Palliative Care Dashboard - Vendor Comparison

Note: There is a 90 day claim lag

<table>
<thead>
<tr>
<th>Total Members</th>
<th>Avg months in Program</th>
<th>Avg Age</th>
<th>Currently Enrolled Members</th>
<th>Refresh Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>332</td>
<td>5.66</td>
<td>57</td>
<td>89</td>
<td>4/2/2021</td>
</tr>
</tbody>
</table>

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

**Avg Cost PMPM**
- Pre Enrollment (Referral For Control Group)
- In Program
- Post Discharge

**Member Months**
- Pre Enrollment (Referral For Control Group)
- In Program
- Post Discharge

**IP Visits PMPM**
- Pre Enrollment (Referral For Control Group)
- In Program
- Post Discharge

**ER Visits PMPM**
- Pre Enrollment (Referral For Control Group)
- In Program
- Post Discharge
Palliative Care Dashboard
Program Highlights

<table>
<thead>
<tr>
<th># of Referrals</th>
<th># of Internal Referrals</th>
<th># of External Referrals</th>
<th># of Members Currently Enrolled</th>
<th># of Members Since Program Inception</th>
<th># of Internal Referrals in 2021</th>
<th># of External Referrals in 2021</th>
<th># of Total Referrals in 2021 (Int &amp; Ext)</th>
<th># of Internal Referrals in 2021 who met soft criteria</th>
<th># of External Referrals in 2021 who met soft criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1550</td>
<td>1464</td>
<td>86</td>
<td>90</td>
<td>346</td>
<td>120</td>
<td>4</td>
<td>0</td>
<td>124</td>
<td>0</td>
</tr>
</tbody>
</table>

County: All
Currently Enrolled: Yes
My Care Referral Date Received: 3/6/2018
Refresh Date: 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

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.
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*
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

<table>
<thead>
<tr>
<th>Region</th>
<th>Zip Code</th>
<th>Service Area (City)</th>
<th>Provider #1</th>
<th>Provider #2</th>
<th>Provider #3</th>
<th>Provider #4</th>
<th>Provider #5</th>
<th>Provider #6</th>
<th>Provider #7</th>
<th>Provider #8</th>
<th>Provider #9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope Valley</td>
<td>91300</td>
<td>Santa Clarita</td>
<td>Non-Service</td>
<td>Non-Service</td>
<td>Non-Service</td>
<td>Non-Service</td>
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<tr>
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<td>Lebec</td>
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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?
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
• 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.
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.
Driving Improvements in Palliative Care in Medi-Cal (SB 1004)

Innovation Session: Roze Room

April 28, 2021
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
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.
Quarterly, Roze Room’s Director of QAPI presents performance to goal for each of the Metrics. For example:
Quality of Care

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

![Graph showing percentage of patients dying in hospital and goal comparison over quarters 1Q20 to 4Q20.]

- POLST Breakdown:
  - 65% with POLST in place
  - 26% discussed and declined
  - 9% no POLST

- Patient Satisfaction Surveys:
  3 Surveys returned
  67% satisfaction rating 9-10
  33% not rated
  100% would recommend PC services
• Our intense QAPI program performance measures set a high bar of expectations. We look at the below statistics as evidence of program efficiency:

  o Patients dying in the hospital: < 10%
  o Transfers to hospice within 30 days of admission: 15%
  o POLST in place: >95%
  o % patients hospitalized within 30 days of admission: 5%
  o 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
• 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.
We believe we are at our best when we are consistent in following our Roze Room 7 Cs.
The convening will resume at 10:40