Palliative Care for D-SNP Members

Webinar #3: Promoting Referrals, Enrollments, and Awareness

September 14, 2023

Background

The webinar series, "Palliative Care for D-SNP Members," is aimed at helping D-SNPs implement palliative care (PC) programs. The series is sponsored by the Department of Health Care Services (DHCS) and Coalition for Compassionate Care of California (CCCC), with funding from the California Health Care Foundation (CHCF) and technical support from Transforming Care Partners.

The purpose of this document is to summarize key points from the third and final webinar in the series, which focused on promoting appropriate referrals to and enrollment in PC, strategies for increasing awareness and understanding of PC, with a focus on ensuring equitable access to PC in a diverse member population.

For any questions, please contact Loren Pogir at loren@tranformingcarepartners.com.

Processes for identifying eligible members and promoting referrals

Take away #1: Multiple approaches are necessary to increase the likelihood of identifying eligible members:

1. **Lists derived from claims and administrative data** that indicate serious diagnoses along with one or more indicators of unmet symptom burden or inadequate social supports.
2. **Referrals from health plan staff** who have contact with members, such as plan care managers.
3. **Referrals from hospital-based staff**, such as hospitalists, discharge planners, and inpatient or outpatient (clinic-based) PC teams.
4. **Referrals from other treating providers**, such as oncologists, cardiologists, or other home-based service providers, such as home health agencies.

Take-away #2: Identification based on data is essential, but it alone is not sufficient.

Data-based identification is essential, but it alone is insufficient for comprehensive patient identification and acceptance. Data-based identification typically involves diagnoses/conditions *and* one or more indicator of unmet need, impaired function, or high-symptom burden. While this approach is relatively low effort, it can fall short because the data is often incomplete due to the time lag in processing claims and the absence of all eligibility criteria in the administrative data. Furthermore, additional effort is required to use lists – so a plan employee, such as a care manager or the contracted PC provider, still needs to reach out to members to introduce PC and offer assessment to verify program eligibility.

Take-away #3: Build relationships and educate providers and case managers about PC benefits and referral pathways.

Regular meetings with hospital-based staff and other treating providers help these individuals identify potentially eligible members and increase the likelihood of referrals. Education should include information about the value of PC, the specifics of the PC program offered by your plan, the referral process, and best practices for introducing PC to patients. To support this process, health plans should provide materials that providers can share with patients/members that explain PC in culturally appropriate terms and in multiple languages (as needed).

In addition to referring providers, health plans should educate plan staff such as case managers and medical directors. This education should cover the value of PC, how members can access it, and effective communication of its benefits.

Case Study: Highmark Health – Enhanced Community Care Management (ECCM)

Presenter:

- **Jo Clark, Vice President Value Based Care, Highmark Health**

Highmark began offering home-based PC, which they call Enhanced Community Care Management (ECCM), to their D-SNP population in October 2022. Currently, Highmark has approximately 41,000 D-SNP members, of which 10% have been identified by the plan as eligible for ECCM. Among these, approximately 490 members are currently engaged. Highmark promotes referrals through various strategies:

1. **Learning Listening System:** Highmark utilizes an identification and risk stratification system that incorporates both clinical and claims data. This system identifies frailty and advanced illness as markers for the program.

2. **Strategic Partner Specialists:** The ECCM Strategic Partner Specialist establishes relationships with Home Health Agencies, Outpatient and Primary and Specialty Care, Hospitals, and Nursing Facilities. They also collaborate with health systems to integrate triggers into local EHRs, fostering interoperability between ECCM and the health system.

3. **Centralization:** The central intake and outreach team manages engagements and enrollments.

Delivering palliative care to a diverse population

Panelists:

- **Cynthia Carter-Perrilliat, MPA, Executive Director, AC Care Alliance**
- **Sandy Chen Stokes, RN, MSN, Founder, and Interim Executive Director, Chinese American Coalition for Compassionate Care**

Even after being referred, people of color encounter distinctive barriers to accepting PC. People from these communities may be hesitant to accept PC services due to medical mistrust, language barriers, cultural differences, or lack of knowledge regarding what PC is and how it can benefit them and their families. These challenges can be addressed through collaboration with community-based organizations that have established trust within these communities. Such organizations have cultural and linguistic knowledge and can assist members in gaining a better understanding of PC.

For example, health plans can partner with organizations like the Chinese American Coalition for Compassionate Care (CACCC) to enhance the understanding of PC and advance care planning (ACP) among Chinese American members. This can be achieved through the utilization of CACCC materials (see resources), sponsoring community-based training initiatives, or sponsoring hospital-based patient ambassador programs in hospitals serving Chinese Americans. Additionally, organizations like CACCC can provide training to PC providers and health plans on how to adapt their practices to better align with Chinese American cultural traditions and preferences.

Health plans can also collaborate with organizations like the AC Care Alliance to improve members' understanding of PC and address disparities in existing specialty PC programs. Organizations such as the AC Care Alliance can offer community-based education on PC and ACP. Furthermore, they can offer non-medical, culturally responsive supportive care programs, including lay navigation and emotional and spiritual support, on behalf of health plans. These initiatives are designed to assist health systems and health plans in meeting the specific needs of communities of color and increasing the likelihood of referrals to PC.

Resources for identifying eligible members and promoting referrals

1. CHCF Essential Elements of Medi-Cal Palliative Care Services (*Section D. Strategies to Identify and Engage MCP Members*)
2. CAPC Screening & Assessment to Find Key Gaps in Care for Seriously Ill
3. CAPC Recommendations for Identifying the Population with Serious Illness
4. CAPC Foundational Skills for Care Managers
5. CSU Shiley Haynes Institute for PC Palliative Care for Care Managers
6. Chinese American Coalition for Compassionate Care- Educational Materials
7. AC Care Alliance – ACCA Advance Care Planning Workbook

8. AC Care Alliance- Advance Illness Care Program
9. CCCC Decision Aids for Healthcare Providers in Chinese, Spanish, Vietnamese and Korean