Palliative Care for D-SNP Members

Webinar #3: Promoting Referrals, Enrollments, and Awareness

September 14, 2023

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D-SNP Webinar Series

This series and its supporting materials were created to educate California's Dual Eligible Special Needs Plans (D-SNPs) about new requirements to provide access to palliative care services starting in 2024. Funding for the project was generously provided by the California Health Care Foundation.

Webinars

June 29, 2023

Palliative Care for D-SNP Members: Policy, Population, Services, and Providers

Recording | Slides | DHCS D-SNP Palliative Care Fact Sheet | D-SNP PC Webinar #1 Highlights

August 18, 2023

Palliative Care for D-SNP Members: Payment Model, Program Administration, and Quality Monitoring

Recording | Slides | Studies of HBPC Economic Outcomes Handout | D-SNP PC Webinar #2 Highlights

https://CoalitionCCC.org/DSNPs

Today’s Webinar

- Processes for identifying eligible members and promoting referrals
  - Case study: Highmark Health Enhanced Community Care Management
- Panel: Delivering palliative care to a diverse population

Webinar slides, brief summary of key points, and link to webinar recording will be available on the CCCC web site

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Common Identification / Referral Sources

- Lists derived from claims and other data
- Health plan staff
- Hospital-based staff
- Other treating providers/staff

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Supporting Practices

PROACTIVE IDENTIFICATION

RELATIONSHIP BUILDING

EDUCATION

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#1. Data-based Proactive Identification

Variables	Pros	Cons
• Diagnoses/conditions *and* 1+ indicator of unmet need, impaired function or high symptom burden	• (Relatively) low effort • Fairly complete capture of potentially eligible population	• All eligibility criteria may not be in admin data • No indication of patient preferences/interest • Current providers out of loop • Time lag to process claims • Someone needs to own/work the list • Can lead to cold-calls (tough on caller and answerer)

Useful resource: CAPC [Recommendations for Identifying the Population with Serious Illness]()

#2. Relationship Building

Routine meetings to:

- Screen for patients who may need palliative care
- Identify other plan programs that could help generally or for specific patients
- Assess opportunities for operational or other quality improvement

Routine communications to close the loop (what happened?)

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High-Value Relationships

Clinical services that care for seriously ill people (oncology, cardiology, geriatrics, etc.)

Inpatient and clinic-based PC providers

Hospital discharge planners

CHWs providing Enhanced Care Management or similar service

Home-based services providers (home health, hospice, PT)

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#3. Education

- Basic PC information
- Basic communication techniques
- Link to deeper dive resources

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Stakeholders to Consider

- Referring Providers
- Trusted health/social service staff
- Plan staff

Need to account for:

- Staff turnover
- Varying experience with palliative care
- Varying ways staff interface with patients/members

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Introducing Palliative Care Video Series

A collection of useful tools and resources to assist managed care plans and providers working with patients who would benefit from receiving palliative care services.

Video Series

This video series and supporting materials were developed to help case managers and clinicians become more comfortable with describing palliative care services or responding to common questions or concerns about palliative care when offering it to their members or patients.

These tools were initially developed for Medi-Cal managed care plans (MCPs) and their contracted palliative care providers to train their own staff and to educate external partners who could potentially refer patients to palliative care. *However,* these tools can support **all** health plan case managers and providers who work with seriously ill members and patients who would benefit from receiving palliative care, regardless of payer.

Introduction to Medi-Cal Palliative Care

Video | Introduction to Medi-Cal Palliative Care

Introducing Palliative Care: Case Manager and Member

Video | Introducing Palliative Care to Members: A Guide for Case Managers

Introducing Palliative Care: Case Manager and Discharge Planner

Video | Introducing Palliative Care to Medical Staff: A Guide for Case Managers

Introducing Palliative Care: Provider and Patient

Video | Introducing Palliative Care to Members: A Guide for Referring Providers and Staff

- Preferred terminology to use
- Key points to emphasize in conversations with patients/members
- Common questions / resistance from patients/members
- Common questions / resistance from potential referring staff

Useful Resources

- CHCF Essential Elements of Medi-Cal Palliative Care Services (*Section D. Strategies to Identify and Engage MCP Members*)
- CAPC Screening & Assessment to Find Key Gaps in Care for Seriously Ill
- CAPC Recommendations for Identifying the Population with Serious Illness
- CCCC Introducing Palliative Care Video Series
- CAPC Foundational Skills for Care Managers
- CSU Shiley Haynes Institute for PC Palliative Care for Care Managers

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Key Takeaways

- Common identification and referral sources = lists derived from data, health plan staff, hospital-based staff, other treating providers
- Relationship building and education will be needed initially and forever
- This work is essential and a little difficult, but there are resources to help

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Enhanced Community Care Management (ECCM)

Providing Palliative Care to the D-SNP Population

Jo Clark, Vice President Value Based Care

The ECCM Team

Palliative & Complex Care Physicians

- Medical oversight
- Symptom management support

Advanced Practice Providers (NP/PA)

- Day-to-day clinical leaders
- Comprehensive accurate assessment, diagnosis, coding, and treatment
- Symptom management
- Advanced care planning

Care Coordinators

- Establish trusting relationship
- Self-Management of Chronic Conditions
- Social care
- Facilitate solutions to reduce barriers and connect to resources

Registered Nurses

- Comprehensive assessment and education
- Optimize appropriate transitions
- Advanced care planning

Centralized Intake & Outreach Support

- Program overview with patient or caregiver
- Intake and support patient and provider callers

Licensed Social Workers

- Clinical assessment, diagnosis, coding and treatment
- Behavioral and social risk support
- Guiding goals of care conversations

Relationship Managers

- Dedicated point person to maintain partners' satisfaction and needs are promptly met
- Data and analytics delivery, review, and actionable insights on performance and new opportunities

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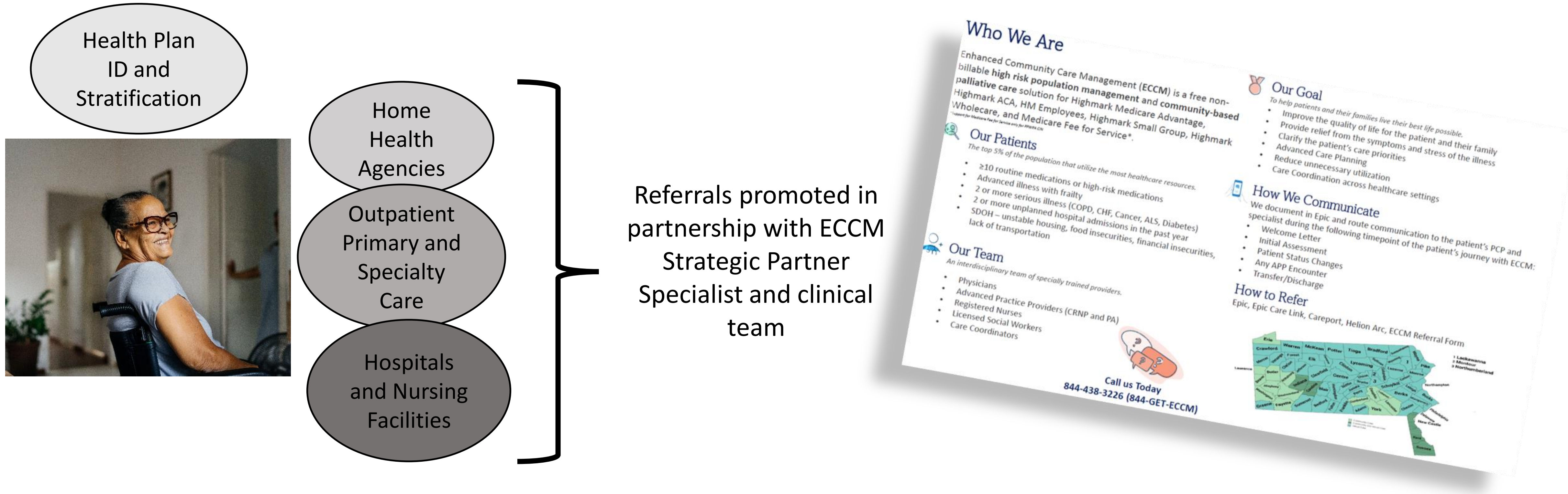
D-SNP Population – began service October 2022

~41,000 D-SNP members > ~4,100 identified by the plan as eligible > 491 members currently engaged



❖ 671 D-SNP lives touched since inception

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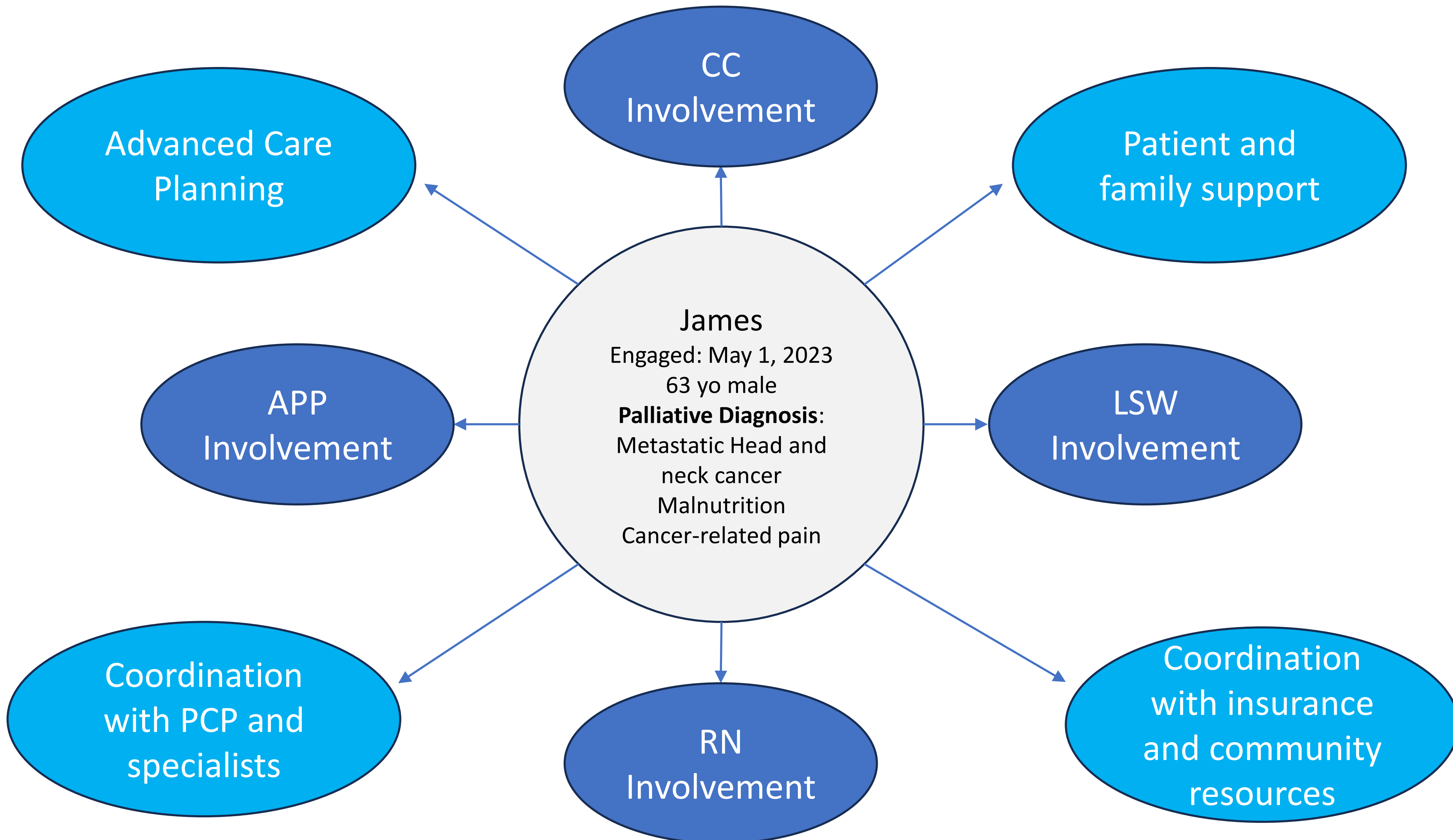
Patient Journey



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Questions?

Please use the Zoom chat feature for questions and comments

Delivering Palliative Care to a Diverse Population

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Panel

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Next in Series

- Discussion of early experiences with palliative care
- Date TBD (early 2024)

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