COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

with funding from California Health Care Foundation

Linking Population Health Strategies to Palliative Care

Medi-Cal Palliative Care
Managed Care Plan (MCP) Learning Community Webinar
February 16, 2022
12 Noon – 1:00 PM

MCP Learning Community

The Big Goal: Ensure timely access to quality palliative care for seriously ill Medi-Cal enrollees

Learning Community Goals:

- Promote peer-peer learning and connections
- Promote discovery and spread of promising practices
- Encourage integration of palliative care with new CalAIM programs

Population Health

Population Health Management (PHM) under CalAIM

To implement a whole-system, person-centered strategy that focuses on wellness and prevention, includes assessments of each enrollee's health risks and health-related social needs, and provides care management and care transitions across delivery systems and settings to improve quality and health outcomes.

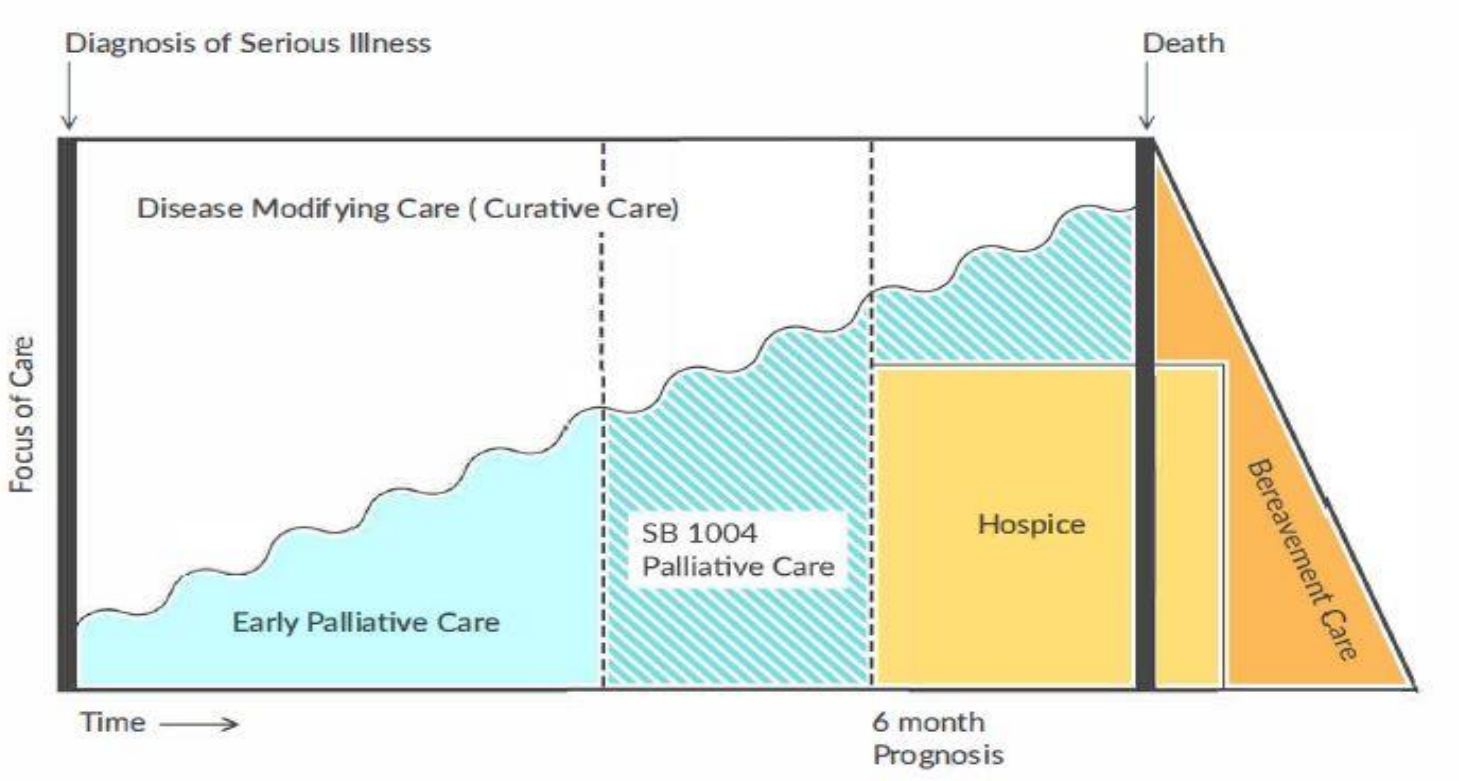
Population Health

PHM Tools:

- Focus on preventive and wellness services
- Assess member risk consistently
- Ensure effective care coordination to safeguard members during transitions across settings and system
- Provide services to address social risk factors (e.g., housing, nutrition) and to meet needs outside the managed care delivery system

Medi-Cal Palliative Care

While palliative care can be delivered at any stage of a serious illness, SB 1004 PC focuses on patients with advanced disease, where life expectancy is about 1 year.



Source: DHCS Palliative Care and SB 1004

SB 1004: Who qualifies?

Minimum criteria*

General Criteria	Qualifying Diagnosis	Evidence of Advanced Disease
• Using hospital / ED to manage illness • Death within a year would not be unexpected • Willing to participate in ACP • Etc.	• Cancer • COPD • CHF • Liver disease	• Utilization criteria • Bio-markers • Functional status • Etc.

*For details see All Plan Letter:
https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

SB 1004: What services are included?

Minimum services*

- Advance Care Planning
- PC Assessment & Consultation
- PC Plan of Care
- Interdisciplinary PC Team
- Care Coordination
- Pain and symptom management
- Provide/refer to mental health and medical social services

*For details see All Plan Letter :
https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

PHM and Palliative Care: Intersection Opportunities

Support standardized risk tiering and stratification of the Medi-Cal population

Incorporate standardized patient assessments/reassessments

Create successful data and information tracking abilities to report population health outcomes

Enhance data sharing and active coordination of care

Increase adoption of evidence-based care and clinical guidelines

Promote expanded access to specialty/needed services with referrals to palliative care for eligible members

Increase health equity through expanded palliative care access in regions with lowest community health indicators / outcomes

Linking Population Health Strategies to Palliative Care: MCP Presenters

Inland Empire Health Plan (IEHP): Takashi Wada, MD, Chief Medical Officer

Kern Health Systems: Abby Romo, MSN, RN, PHN, Director of Population Health Management

LA Care: Elaine Sadocchi–Smith, FNP, MPH, CHES, Director Population Health Management; Matt Pirritano, PhD, MPH, Director, Population Health Informatics

Linking Population Health Strategies to Palliative Care: Questions for Each Panelist

1. Tell us your perspective on how palliative care could be incorporated in your population health management strategy?

2. Please share any plans you have for operationalizing a PC-PHM linkage, and any related activities.

3. What are the biggest barriers that you have encountered or anticipate encountering in this area.

A Public Entity

Inland Empire Health Plan

- Counties covered: Riverside and San Bernardino
- Number of members: ~1.5 million
- #Members enrolled in PC annually: > 700
- Key palliative care goal for 2022: Complete 2021 evaluation of the program and make data informed decisions for future planning.
- Key population health goal for 2022: Supporting contracted palliative care groups to increase enrollment and expand geographical coverage.
- Current level of collaboration PHM + PC: Prior to CalAIM, palliative care had been part of our population health strategies. With CalAIM, it remains a key component of our population health efforts to care for our high-risk Members, but there is a need to better coordinate with Enhanced Care Management Teams and Community Supports.

Kern Family Health Care™

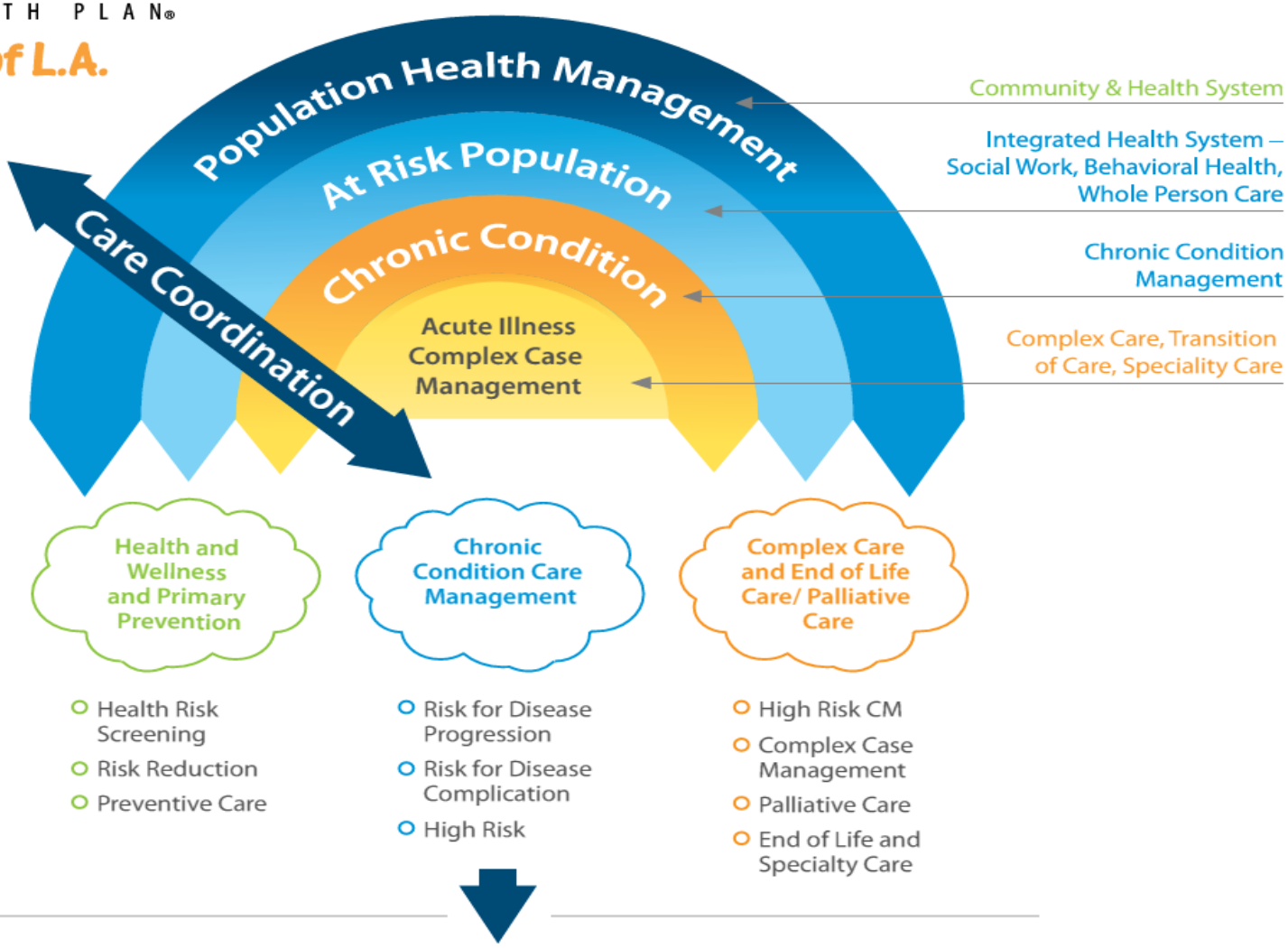
- Counties covered: Kern
- Number of members: 323,500
- #Members enrolled in PC annually: 135
- Key palliative care goal for 2022: Complete program re-design and re-launch by end of year.
- Key population health goal for 2022: Being able to provide appropriate services to members across the continuum of care.
- Current level of collaboration PHM + PC: Complete alignment/concurrent development.

L.A. Care HEALTH PLAN®

- Counties covered: Los Angeles
- Number of members: 2.4mil (all LOB)
- Number of eligible members for PC: Developing PC registry in IPro using criteria for members meeting all criteria with certainty with a score of 8 and greater is 3,159 (MCL only).
- Key palliative care goal for 2022: Expand reach across settings and enhance collaboration with all member care departments (CM, UM, TOC, MLTSS, etc.). Working together in a CF setting to further expand PC within the PHM setting.
- Key population health goal for 2022: Able to identify and refer members to the right services at the right time.
- Current level of collaboration PHM + PC: Beginning to collaborate.

L.A. Care HEALTH PLAN®

For All of L.A.



Source: http:/www.hscrc.maryland.gov/documents/md_maphs/wg_meet/-mtg-8/27-03-2014-A-Deutschendorf-HSCRC-Presentation.pdg

Save the Date!

Mark your calendar today and plan to join us May 4 – 5, 2022, at the
San Francisco Airport Hyatt Regency for the CCCC Annual Palliative Care Summit