Medi-Cal Palliative Care Medi-Cal Managed Care Plan (MCP) Learning Community
February 16, Webinar Highlights

Judy Thomas, CEO, Coalition for Compassionate Care of California (CCCC) introduced the webinar, "Linking Population Health Strategies to Palliative Care," emphasizing the importance of the linkage for MCPs. Kathleen Kerr, MCP Learning Community project team member, provided an overview of Population Health Management (PHM)—*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*—and Palliative Care's holistic person-centered approach to caring for persons with serious illness. Intersection opportunities for the two include support for standardized risk tiering and stratification of the Medi-Cal population, incorporating patient assessments and reassessments, creating successful data and information tracking abilities to report population health outcomes, and increasing health equity through expanded palliative care access in regions with lowest community health indicators/outcomes.

Representatives from three MCPs shared their perspectives, plans, and activities to promote a complementary approach to palliative care and population health management: **Inland Empire Health Plan (IEHP)**: Takashi Wada, MD, Chief Medical Officer; **Kern Health Systems (KHS)**: 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, Susan Stone, MD, MPH, Medical Director.

IEHP described their PHM approach. Using the Johns Hopkins ACG® System, they stratify members into healthy low-risk, middle-rising risk, and high risk. Each tier receives interventions and services (e.g., case management) designed to support members and promote the best health outcomes possible for them. Using analytics, IEHP coordinates care across various programs. In addition to PHM, the health plan is supporting care coordination between palliative care and CalAIM Enhanced Care Management and Community Supports. IEHP identified educating providers and members about palliative care as a core strategy and priority. The health plan focuses on advance care planning and coordinating other activities (e.g., between ECM and palliative care) to ensure members and their caregivers receive the support they need.

KHS launched a redesign of their palliative care program which dovetails with their PHM program. Elements of the updated palliative care program include 24/7 telephonic support, additional diagnoses beyond the four in the All-Plan Letter (dementia, neurodegenerative disease, AIDs), and new qualifications for palliative care providers. These changes led to a targeted focus on identifying eligible members. Currently, Kern also uses the ACG® System to identify and stratify members for various programs (diabetes, congestive heart failure, etc.). They plan to leverage this system—adding in the Charlson Comorbidity Index—to identify eligible palliative care members and develop a palliative care dashboard, modeled on dashboards in use for specific diseases and programs that are part of the larger PHM strategy. Like IEHP, Kern is focused on educating providers and members about palliative care and differentiating it from hospice care.

LA Care also follows a similar PHM approach, using a patient-centered model for care and evidence-based guidelines to meet patient needs. LA Care has developed a palliative care registry using IPRO. Current data indicate that at least 3,000 members are certainly eligible for palliative care. Palliative care and PHM have overlapping core goals: palliative care aims to continue reaching across settings and enhancing collaboration with all member care departments (CM, UM, TOC, MLTSS, etc.), including PHM. PHM remains committed to

identifying and referring members to the right services at the right time. LA Care highlighted some of the common challenges with this collaboration, including the launching of CalAIM, workforce and data management issues, and outreaching to members to educate them about the palliative care program.

During the large group Q&A, the plan representatives underscored the importance of MCPs taking time to think through and develop plans to link population health and palliative care, employing thoughtful integration, workflow, and education strategies. The link is supported by accurate data and effective human processes and touchpoints (the latter conducted by case managers, social workers, transition teams, etc.).

In closing, Judy Thomas reminded the group about CCCC's annual Palliative Care Summit May 4-5, 2022, at the San Francisco Airport Hyatt Regency Hotel, and Kathleen Kerr reminded attendees to complete the annual Medi-Cal Palliative Care survey and attend the Medi-Cal Palliative Care Annual Meeting, March 16-17, 2022. Registration links below—you must register for each day separately.

CONVENING DATES:

Wednesday, March 16, 2022
9:00 am - 12:00 noon
Click here to register for March 16

Thursday, March 17, 2022
9:00 am - 12:00 noon
Click here to register for March 17

If you have any questions, contact kscholl@coalitionccc.org or 916.779.7505.

MCPs interested in getting a free, structured assessment of their current palliative care program are encouraged to contact Keeta Scholl: kscholl@coalitionccc.org. The next MCP Learning Community activity is an Open Forum (a bi-monthly informal MCP discussions on palliative care program issues, needs, solutions to various challenges, etc.) on Monday, April 24, 2022, 12 Noon – 12:30 PM. MCPs are encouraged to e-mail any questions or topics they would like to discuss at the forum to Keeta Scholl: kscholl@coalitionccc.org.