Overcoming Challenges to Implementing SB 1004 in California

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Kathleen Kerr, BA
Kerr Healthcare Analytics

Anne Kinderman, MD
Director, Supportive & Palliative Care Service
Zuckerberg San Francisco General Hospital
Associate Clinical Professor of Medicine, UCSF
Objectives

• Describe the services required under SB 1004, and explain how different Medi-Cal plans have responded to this mandate

• Discuss common challenges to identifying and engaging with patients who are eligible for SB 1004 services, and outline strategies to overcome them

• Review barriers to engaging providers who are in a position to refer patients for SB 1004 services, and evaluate methods to collaborate effectively with this group
What is SB 1004?

- Senate Bill 1004 (2014) requires Medi-Cal managed care plans to ensure access to palliative care services for eligible members
- Implemented January 1, 2018
- SB 1004 requirements from Nov 2017 All Plan Letter (APL) include:
  - Members who are eligible
  - Services required
  - Providers who qualify

Detailed All Plan Letter available at:

http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx
Palliative Care as defined in SB 1004

[Diagram showing the progression of care from diagnosis to death, highlighting early palliative care, SB 1004 palliative care, hospice, and bereavement care.]

Source: DHCS Palliative Care and SB 1004

Advance Care Planning can occur at any time, including the POLST form for those with serious illness.
SB 1004 population: general criteria

- Likely to or has started to use the hospital or emergency department as a means to manage his/her late stage disease
- Late stage of illness, appropriate documentation of continued decline in health status, not eligible for or declines hospice enrollment
- Death within a year would not be unexpected based on clinical status
SB 1004 population: general criteria

• Has received appropriate patient-desired medical therapy, or patient-desired medical therapy is no longer effective; not in reversible acute decompensation

• Beneficiary and (if applicable) family/patient-designated support person agrees to:
  • Attempt in-home, residential-based or outpatient disease management instead of first going to the emergency department; and
  • Participate in Advance Care Planning discussions
Disease specific-criteria

Congestive Heart Failure (CHF):
• Hospitalized for CHF with no further invasive interventions planned OR meets criteria for NYHA heart failure classification III or higher, AND
• Ejection Fraction <30% for systolic failure OR significant co-morbidities

Chronic Obstructive Pulmonary Disease (COPD):
• FEV 1 <35% predicted AND 24-hour oxygen requirement <3 liters per minute OR
• 24-hour oxygen requirement ≥3L per minute
Advanced Cancer:
- Stage III or IV solid organ cancer, lymphoma, or leukemia, **AND**
- Karnofsky Performance Scale score \( \leq 70 \) OR failure of 2 lines of standard chemotherapy

Liver Disease:
- Evidence of irreversible liver damage, serum albumin \(<3.0\), and INR \(>1.3\), **AND**
- Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices **OR**
- Evidence of irreversible liver damage and MELD score \(>19\)
SB1004 Services

- Advance Care Planning
- PC Assessment & Consultation
- Plan of Care
- Interdisciplinary PC Team
- Care Coordination
- Pain and symptom management
- Provide or refer to mental health and medical social services
  - (Chaplain Services)
  - (24/7 telephonic support)
Flexibility in settings and providers

**Settings**

- Inpatient
- Outpatient
- Community-based settings

**Providers**

- “Qualified providers for palliative care based on the setting and needs of a beneficiary”
- DHCS recommends using providers with current palliative care training and/or certification

**Organizations**

- “Hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care”
Workshops, webinars, materials that can be downloaded from CHCF web site

- Estimating member/patient need
- Estimating costs for delivering services
- Assessing capacity for palliative care & launching services
- Gauging and promoting sustainability and success
- Lessons learned and adjusting programs

chcf.org/sb1004
Current status

- Policies, procedures, palliative care provider networks should be in place for all 22 MCPs

- As of March 2019, CHCF identified approximately 60 palliative care providers contracted with MCPs throughout state
  - Mostly community organizations that also provide hospice services

- Quarterly reporting to DHCS re:
  - # referred
  - # served
  - why/why not served
  - how long
  - by whom
2019 Survey: How long has your organization been providing palliative care?

- 1 year: Plans 25%, Providers 54%
- 2 years: Plans 18%, Providers 23%
- 3-5 years: Plans 21%, Providers 15%
- 6-10 years: Plans 25%, Providers 0%
- 10+ years: Plans 11%, Providers 8%
2019 Survey: Partnership information

• How many SB 1004 partners do you have?
  • Plans: Range 1-21
  • Providers: Range 1-6 (most common: 1)

• Additional services required by plans
  • No additional services required (15%) ↓↓
  • 24/7 phone support (69%) ↑↑
  • Direct spiritual care services (62%) ↑
  • Direct medication prescription (46%) ↑↑
  • Other home health services (38%) ↑↑
  • Formal caregiver assessment (38%) ↑↑
2019 Survey: Who delivers SB 1004 Palliative Care?

Disciplines directly and routinely involved in delivering services:

- **MD/DO**: 89%
- **NP**: 96%
- **PA**: 7%
- **RN**: 96%
- **MSW/LCSW**: 96%
- **LPN/LVN**: 63%
- **Other**: 30%
- **Chaplain**: 74%
- **CHW**: 26%
- **Psychologist**: 4%
- **Pharmacist**: 11%

Volunteers, care coordinator, health aide, grief counselor, dietician
2019 Survey: In what areas are plans and providers most frequently collaborating?

Areas where plans reported frequent or routine direct involvement

- Provider education: 29%
- Member education: 43%
- Identify members: 43%
- Mental health referrals: 43%
- IDT case review: 50%
- Soc Svc Referrals: 64%
- Authorizations: 71%
- Care coordination: 71%
2019 Survey: Patient/member eligibility

- Did you expand the SB 1004 eligibility criteria?
  - Yes (79%)
  - No (14%)
  - Unsure (7%)

- How did you expand eligibility?
  - Included other diseases (91%)
  - Expanded eligibility for required diagnoses (73%)

“We do not limit access.”

“It's very flexible, anyone who has a serious illness who could benefit”
Almost 2/3 of plan respondents had over 100 members referred
2019 Survey: How many members/patients actually received services in 2018?

Number of Members/Patients

- 1-25: Plans 15%, Providers 45%
- 26-50: Plans 10%, Providers 31%
- 51-100: Plans 8%, Providers 7%
- 101-150: Plans 8%, Providers 14%
- 151-300: Plans 8%, Providers 0%
- 301-400: Plans 23%, Providers 0%
- >400: Plans 8%, Providers 7%

Plans and Providers percentages are shown for different ranges of number of members/patients.
2019 Survey: Proportion of members referred actually receiving services

Proportion of Referred Members/Patients Who Receive Services

<table>
<thead>
<tr>
<th>Plans</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-15%</td>
<td>9%</td>
</tr>
<tr>
<td>16-33%</td>
<td>17%</td>
</tr>
<tr>
<td>34-50%</td>
<td>18%</td>
</tr>
<tr>
<td>51-75%</td>
<td>42%</td>
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<tr>
<td>76-100%</td>
<td>36%</td>
</tr>
</tbody>
</table>
• SB1004 mandates that MCPs ensure access to palliative care for eligible individuals

• From what we know, many plans have expanded both the eligibility criteria for SB 1004 services, as well as the requirements for what PC providers need to deliver

• Though we are in the early stages of implementation, already a few thousand individuals have utilized the benefit
DISCUSSION

• How does SB1004 as a benefit fit into the broader picture of palliative care (available to all seriously ill individuals regardless of dx or prognosis)?

• How do the required services align with what patients and families are likely to need?

• How can we interpret the variation in proportion of referred patients who actually receive services?
Common Implementation Challenges

- Identifying Patients
- Engaging Referring Providers
- Engaging Patients

Plan-Provider-Community Collaboration
Patient identification

• Just because SB 1004 services are now widely available (yay!) doesn’t mean that eligible patients will automatically get them – they need to be found

• We will review
  • Challenges to identifying patients/members
  • What plans/providers are struggling with most
  • What strategies have been most/least effective
Identifying Eligible Patients/Members: What makes it so hard?

Three types of criteria, hard to find in a single data source

<table>
<thead>
<tr>
<th></th>
<th>Claims and authorization data</th>
<th>Electronic health records</th>
<th>Screening / assessment findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifying diagnoses</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Evidence of advanced disease</td>
<td>(✓)</td>
<td>✓</td>
<td>(✓)</td>
</tr>
<tr>
<td>Patient &amp; family preferences</td>
<td>(✓)</td>
<td>(✓)</td>
<td></td>
</tr>
</tbody>
</table>
How does your organization identify potentially eligible members/patients?

| Plan identifies patients through claims data, sends list to PC providers | Plans (↑↑) | Providers | 86% |
| Primary & specialty providers asked to refer directly to PC providers | 85% (↓) | 76% (↓) |
| Non-physician staff at clinics/hospitals/physician offices asked to refer directly to PC providers | 43% (↓↓) | 55% |
| Staff in social service organizations (shelters) asked to refer directly to PC providers | 7% | 17% |
| PC provider teams participate in rounds at local clinics | 7% | 10% (↓) |
| PC provider teams participate in rounds at local hospitals | 29% | 28% (↑) |
| Members/patients self-refer | 64% | 38% |

Other common plan strategies:
Identify members in other programs (79%)
Review list of currently hospitalized members and send to PC partner (64%)
Member/Patient Identification: Most effective strategies

**Plans**
- ✓ ✓ ✓ Review lists of currently hospitalized members
- ✓ ✓ Plan Case Managers and UM nurses identify
  - Provider referrals
  - PC provider meets with referring providers

**Providers**
- ✓ ✓ Receiving list from plan
  - PC team participates in hospital rounds/warm hand offs
  - Frequent contacts with referring providers (edu, marketing)
  - Primary/specialty providers identify (best when PCP involved)
  - “This has proven to be the most difficult component.”
  - “The strategy we are using [is] not effective as the plan is not referring patients at this time.”
Identifying Members/Patients: Least effective strategies

PLANS
✓✓✓ Providing lists to PC Providers (for cold calls)
✓✓ Relying on PCP and Specialist referrals
✓✓ Relying on member self-referral

PROVIDERS
✓✓ Cold calling members from lists provided by health plans
  “outdated numbers...member's don’t respond well and engagements are lower with the list patients”

• Self-Referrals
• Referrals from PCPs, hospital dc planners
Common Implementation Challenges

- Identifying Patients
- Engaging Patients
- Referring Providers
- Plan-Provider-Community Collaboration
Patient engagement

• Once a potentially-eligible patient/member has been appropriately identified, s/he has to be approached and offered the service – *there aren’t guarantees that they will accept!*

• We will review
  • Challenges to identifying patients/members
  • What plans/providers are struggling with most
  • What strategies have been most/least effective
Engaging Patients/Members

What strategies have you used to inform members/patients about PC availability?

- Newsletters:
  - Plans: 42%
  - Providers: 7%

- Brochures:
  - Plans: 50%
  - Providers: 52%

- PC Outreach:
  - Plans: 50%
  - Providers: 48%

- Referring Provider Outreach:
  - Plans: 71%
  - Providers: 70%

- Plan Outreach:
  - Plans: 85%
  - Providers: 63%
Engaging Patients/Members: Biggest Challenges

• Plans
  ✓ ✓ Incorrect contact information
  • Cultural barriers
  • Misunderstanding PC and hospice
  • Competing priorities at the plan

• Providers
  ✓ ✓ Incorrect contact information
  ✓ ✓ Misunderstanding PC and hospice
  • (Reiterated “just getting referrals”)

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Top Reasons Members/Patients Decline Services

Areas of Agreement

• Lack of familiarity with PC org
• Doesn’t see benefit of services

• Plans think pts worry about limiting care more than PC orgs see this as a barrier
• Other barriers: Cultural norms, family resistance, mental illness, defer to referring provider; already getting other services (overwhelmed), pattern of disengagement
Patient/Member Engagement: Most effective strategies

- Referrals/encouragement from plan case managers
  - Referring provider introduces/promotes service
  - Familiarize pt with provider (e.g. warm handoff)
- Emphasize benefits: free, extra layer of support, 24/7 access to live person, manage symptoms
  - Face-to-face visits with patient/member
“inpatient pall care hand-offs to outpatient services seem to be the most effective; the other most effective strategy is having somebody the patient/family [trusts] (pcp, complex care case manager, etc.) explain and promote services - emphasizing the potential value/synergy of pall care in combination w/ attempts at curative treatments”
Identifying & Engaging Members/Patients: Reflections

• Tension between the value of claims data lists and challenges of using that information effectively
• Growing recognition of the importance of personal connections, and less with materials or marketing
• Themes around trust-building between patient and PC organization continue to be emphasized
• PC organizations aware of needing to explain benefits of service to patient, and there are consistent themes around this as well
Common Implementation Challenges

- Identifying Patients
- Engaging Patients
- Engaging Referring Providers

Plan-Provider-Community Collaboration
Strategies to engage referring providers

- Newsletters: 57% (Plans), 22% (Providers)
- Brochure/handout: 57% (Plans), 48% (Providers)
- In-person: 64% (Plans), 59% (Providers)
- Individual outreach: 100% (Plans), 89% (Providers)
- IPAs: 79% (Plans), 52% (Providers)
Which providers have you engaged?

• Attempts to engage providers:
  • Case managers/CHWs (86% plans, 81% providers)
  • PCPs (79% plans, 74% providers)
  • Specialists (71% plans, 59% providers)
  • Inpt palliative care (64% plans, 55% providers)
  • Social workers (64% plans, 59% providers)
  • FQHCs/CHCs (64% plans, 26% providers)
  • RNs (57% plans, 55% providers)
  • Chaplains (14% plans, 11% providers)
  • Other: IHSS orgs, faith-based orgs, hospital CM
Biggest barriers to provider engagement

• Plans
  • Limited/no resources for provider engagement, or feel ill-equipped to do this without clinical partner
  • Hard to get word out in large provider network
  • Referring providers see cases infrequently and forget about PC resources
  • [We don’t do this.]

Only 23% of Plan respondents reported having specific outreach strategies or referral workflows with FQHCs or community clinics to encourage referrals for palliative care
Biggest barriers to provider engagement

• Providers
  • Providers want to refer other patients (e.g. Medicare pts, other diagnoses), frustrated that they can’t
    “Some providers won't refer because [they] won't do this based on insurance.”
  • Misconceptions about what PC is → think they’re already doing it, or that it’s the same as hospice
  • Can’t access them/they don’t have enough time
Most effective strategies to engage referring providers

• Plans
  • Suggestion from plan staff
  • Peer-to-peer
  • Education; target specific teams (CCM, HH, FQHC)
  • Facilitating trust btw provider and PC org

• Providers

✓✓ Education (in-person)
  • Direct communication; provide follow-up

“If a provider has had a patient on service they often refer again.”
Engaging Referring Providers: Reflections

• More emphasis on individual outreach over materials: effective but time-consuming and very difficult in large networks (targeted outreach may help)
• Misconceptions regarding PC continues to be a big barrier that PC organizations see
• Varying engagement from plans in terms of helping to engage providers; seems to be recognition that leveraging plan CMs and clinical staff can be very effective
• Access to referring providers is likely to continue to be a barrier – building on positive experiences is key
Take-home points

• SB 1004 Palliative Care is an important benefit to be aware of for your Medi-Cal patients (primarily those only insured by Medi-Cal)

• MCPs and PC Providers are learning how to overcome common implementation challenges – newer programs can take advantage of lessons learned

• Finding ways to inform and build trust with patients and referring providers will be key in ensuring that eligible patients get the services they need
SB1004 questions and resources

• Best contact for referral issues: local Medi-Cal plan(s)
• Best contact for questions about the program: DHCS
  • [http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx)
  • [SB1004@dhcs.ca.gov](mailto:SB1004@dhcs.ca.gov)

• Technical Assistance resources: [www.chcf.org/sb1004](http://www.chcf.org/sb1004)
Study to Understand Barriers to Palliative Care: focus in LA County

**Physicians:**
- Serve Medi-Cal Managed Care patients
- Will receive $75 debit gift card for 15-20 minute interview.

**Patients:**
- Medi-Cal Managed Care patient
- Diagnosed with cancer, heart failure, liver failure, OR pulmonary disease
- Speak English, Spanish, Mandarin, or Cantonese
- Will receive $30 debit gift card for 30 minute interview

If eligible and interested, please contact:
Susan Enguidanos
+1 (213) 740-9822
enguidan@usc.edu

University of Southern California
Leonard Davis School of Gerontology
Questions?