California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Overcoming Challenges to Implementing SB 1004 in California

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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

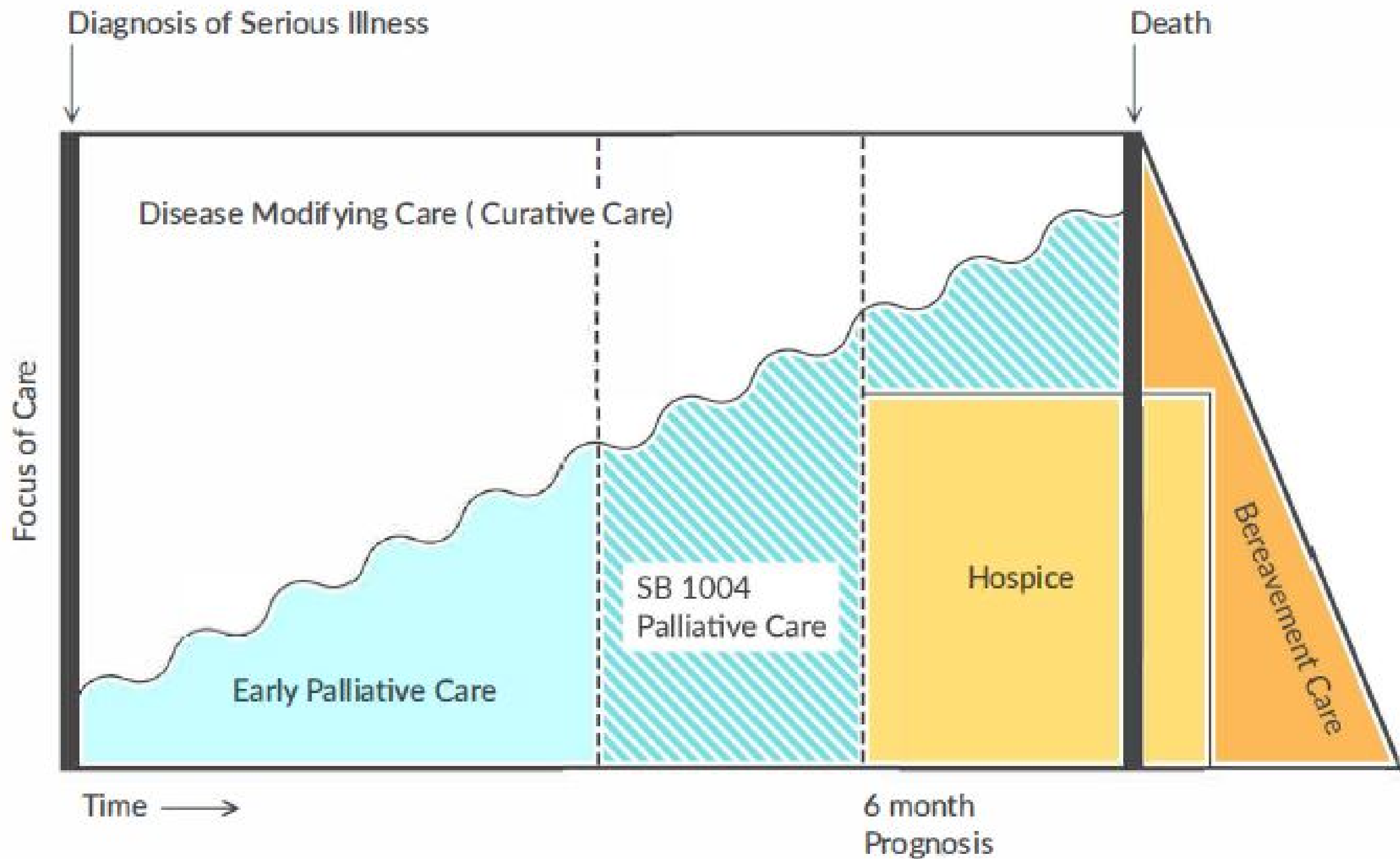
What is SB 1004?

- 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



Source:DHCS Palliative Care and SB 1004

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

Disease specific-criteria (continued)

Advanced Cancer:

- Stage III or IV solid organ cancer, lymphoma, or leukemia, AND
- Karnofsky Performance Scale score ≤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"

CHCF Technical Assistance Series

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 svcs

Gauging and promoting sustainability and success

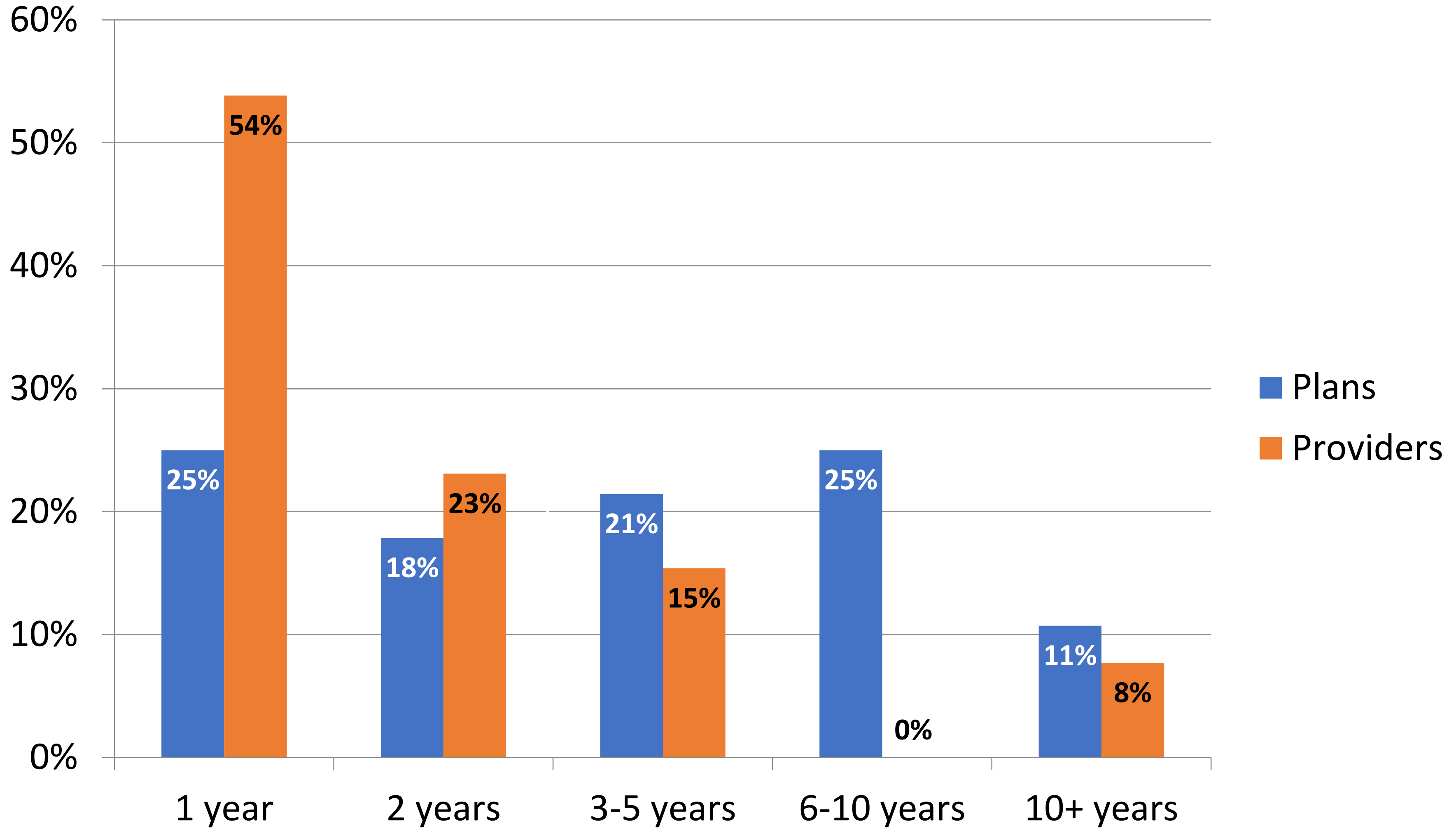
Lessons learned and adjusting programs

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

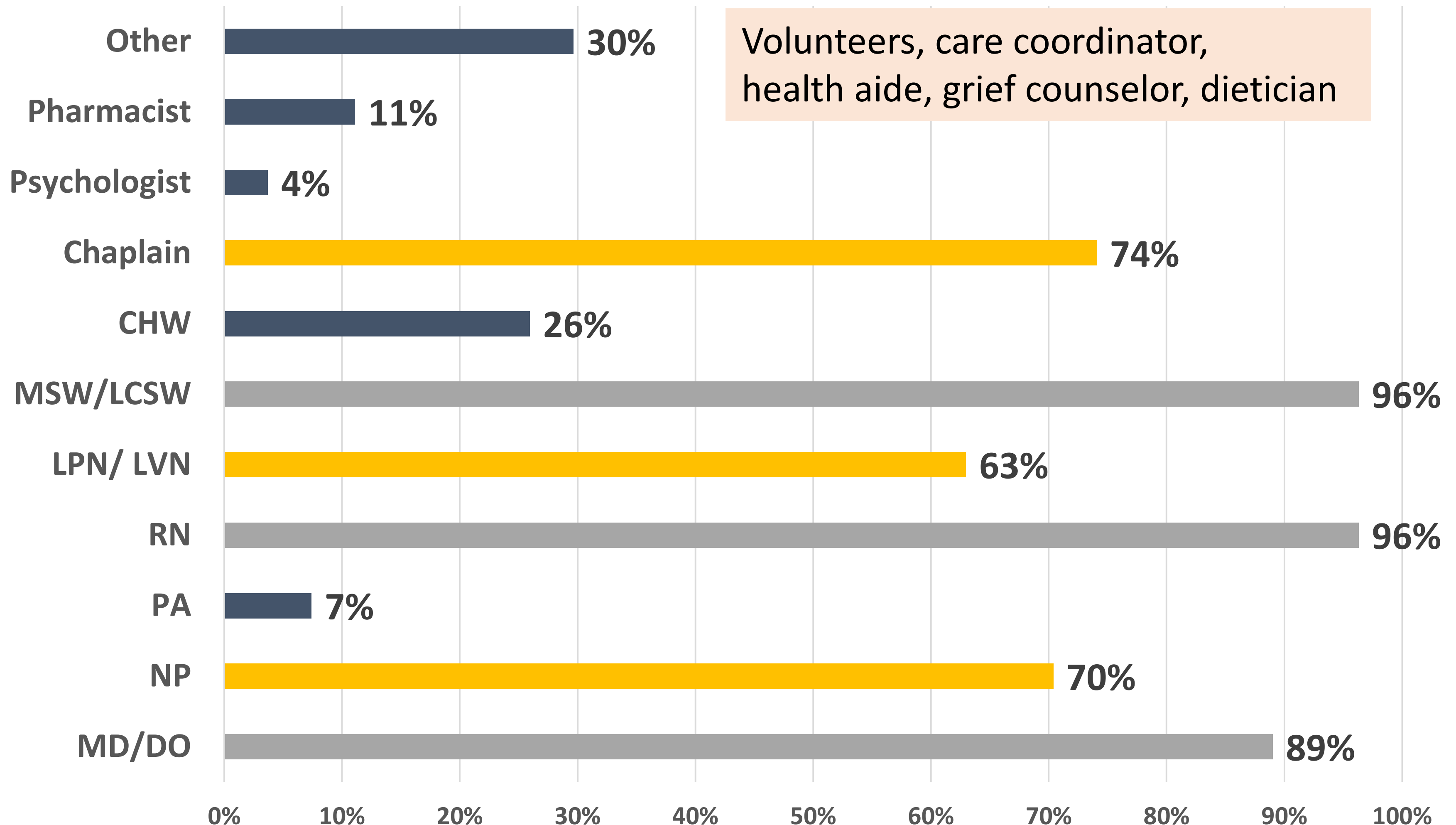
2019 Survey: How long has your organization been providing palliative care?



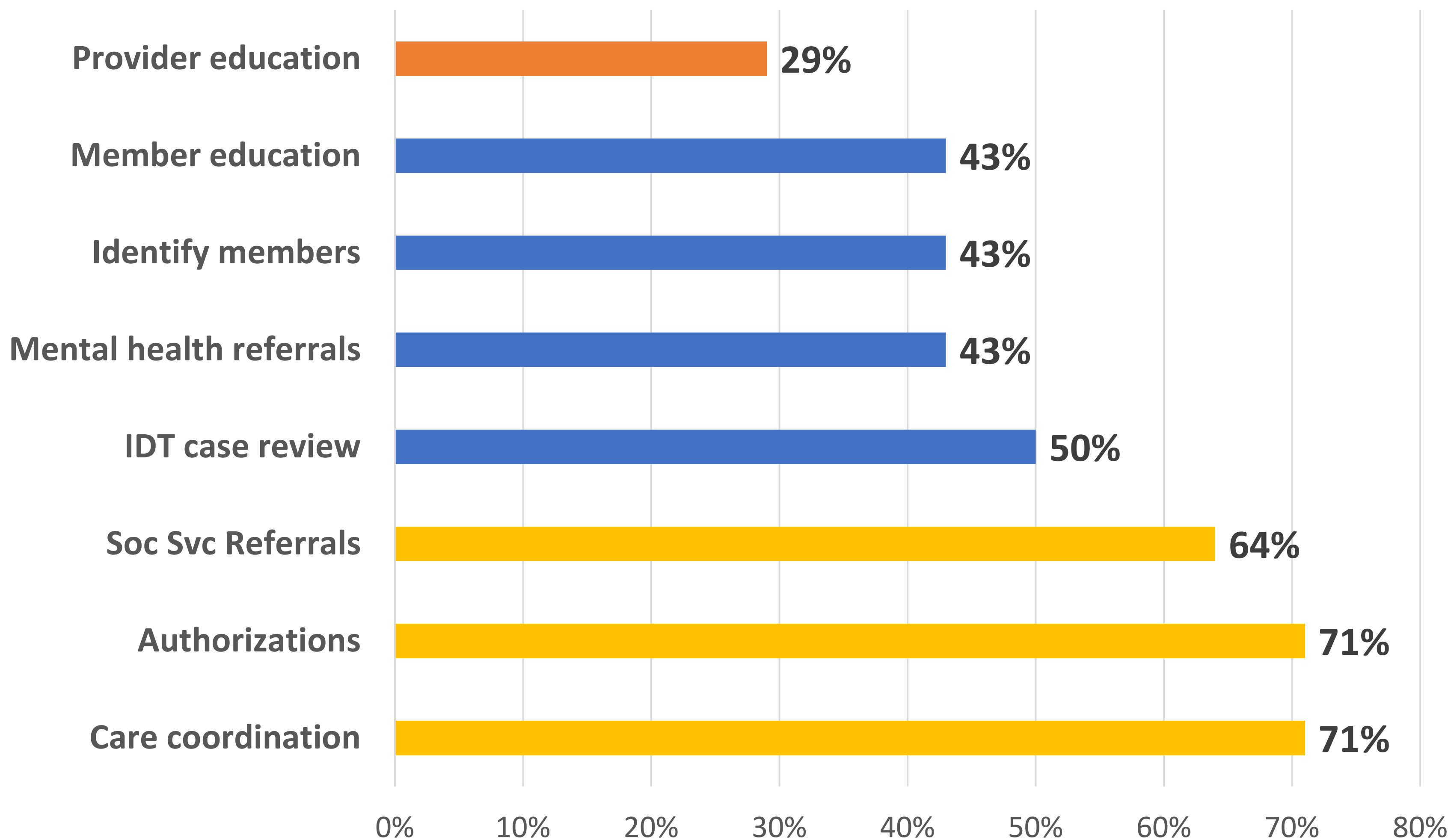
2019 Survey: Partnership information

- **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?



2019 Survey: In what areas are plans and providers most frequently collaborating?



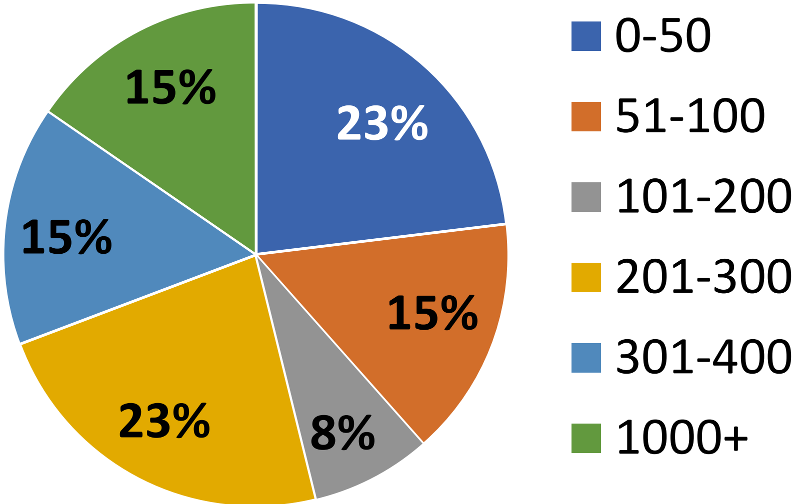
2019 Survey: Patient/member eligibility

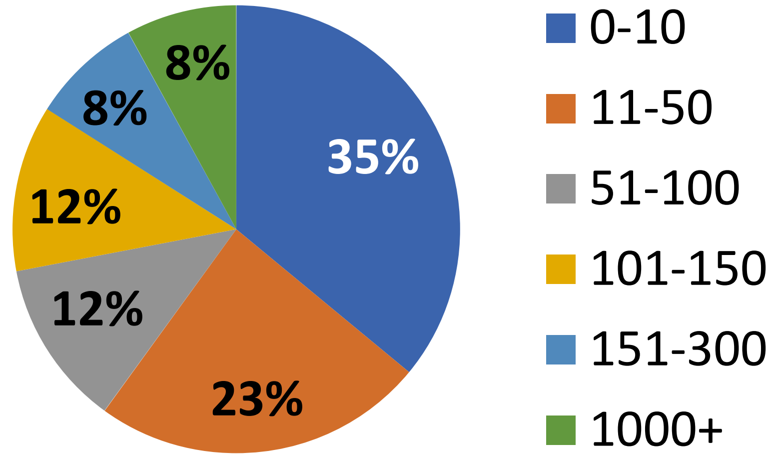
- **Did you expand the SB 1004 eligibility criteria?**
  - ✓ Yes (79%)
  - No (14%)
  - Unsure (7%)
- **How did you expand eligibility?**
  - Included other diseases (91%)
  - Expanded eligibility for required diagnoses (73%)

“We do not limit access.”

“It's very flexible, anyone who has a serious illness who could benefit”

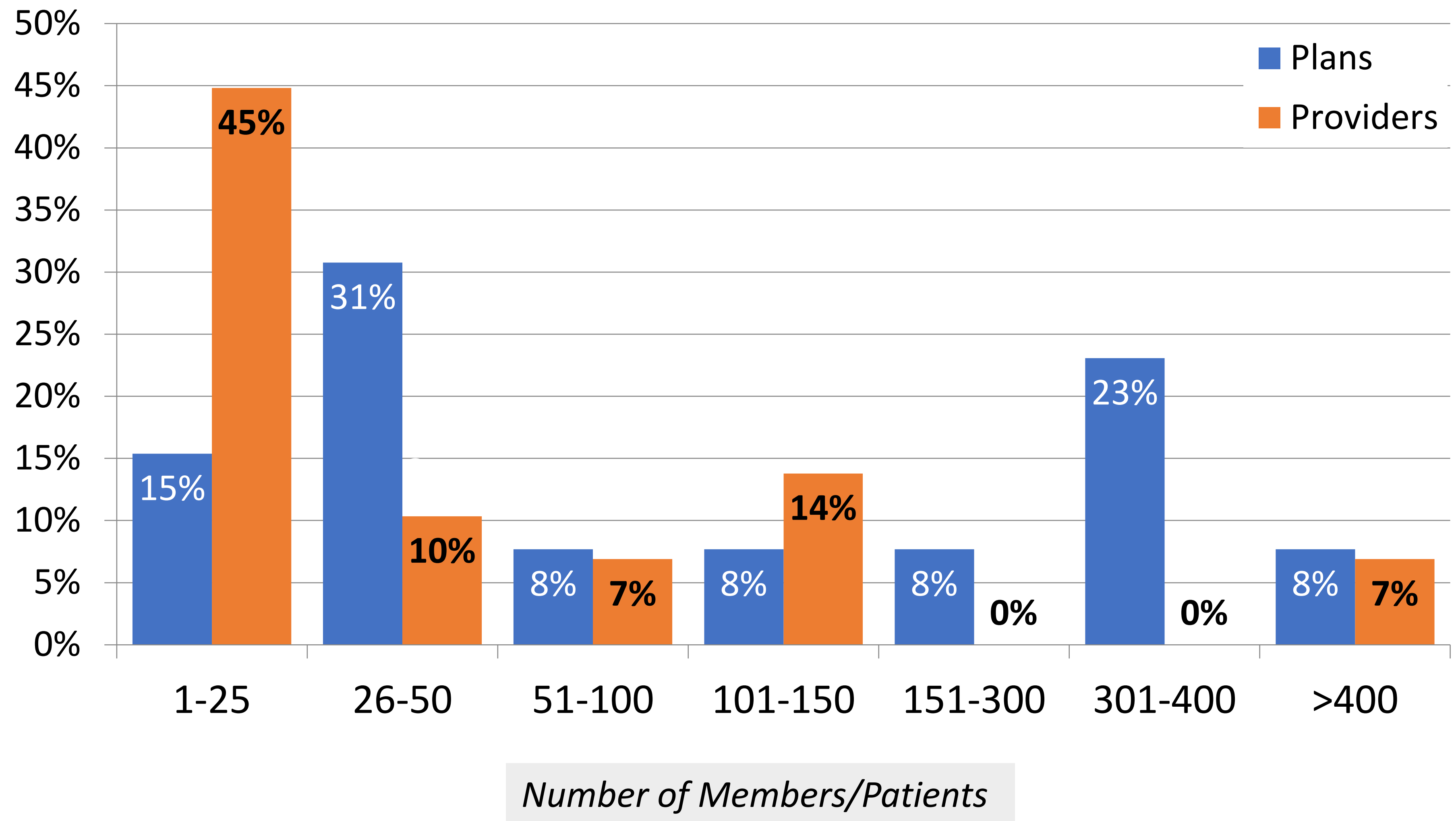
2019 Survey: Members/Patients referred in 2018



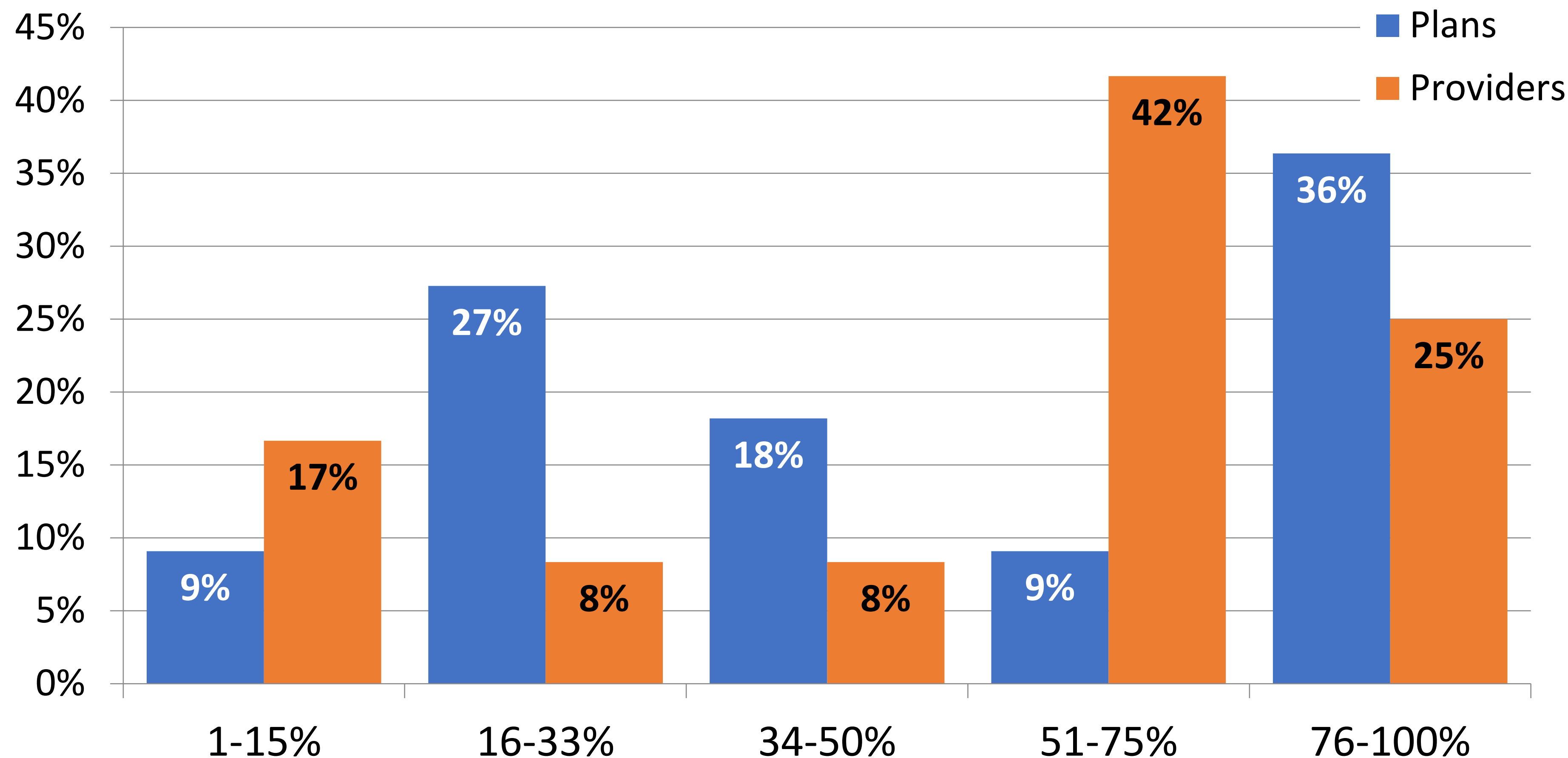


Almost 2/3 of plan respondents had over 100 members referred

2019 Survey: How many members/patients actually received services in 2018?



2019 Survey: Proportion of members referred actually receiving services



Proportion of Referred Members/Patients Who Receive Services

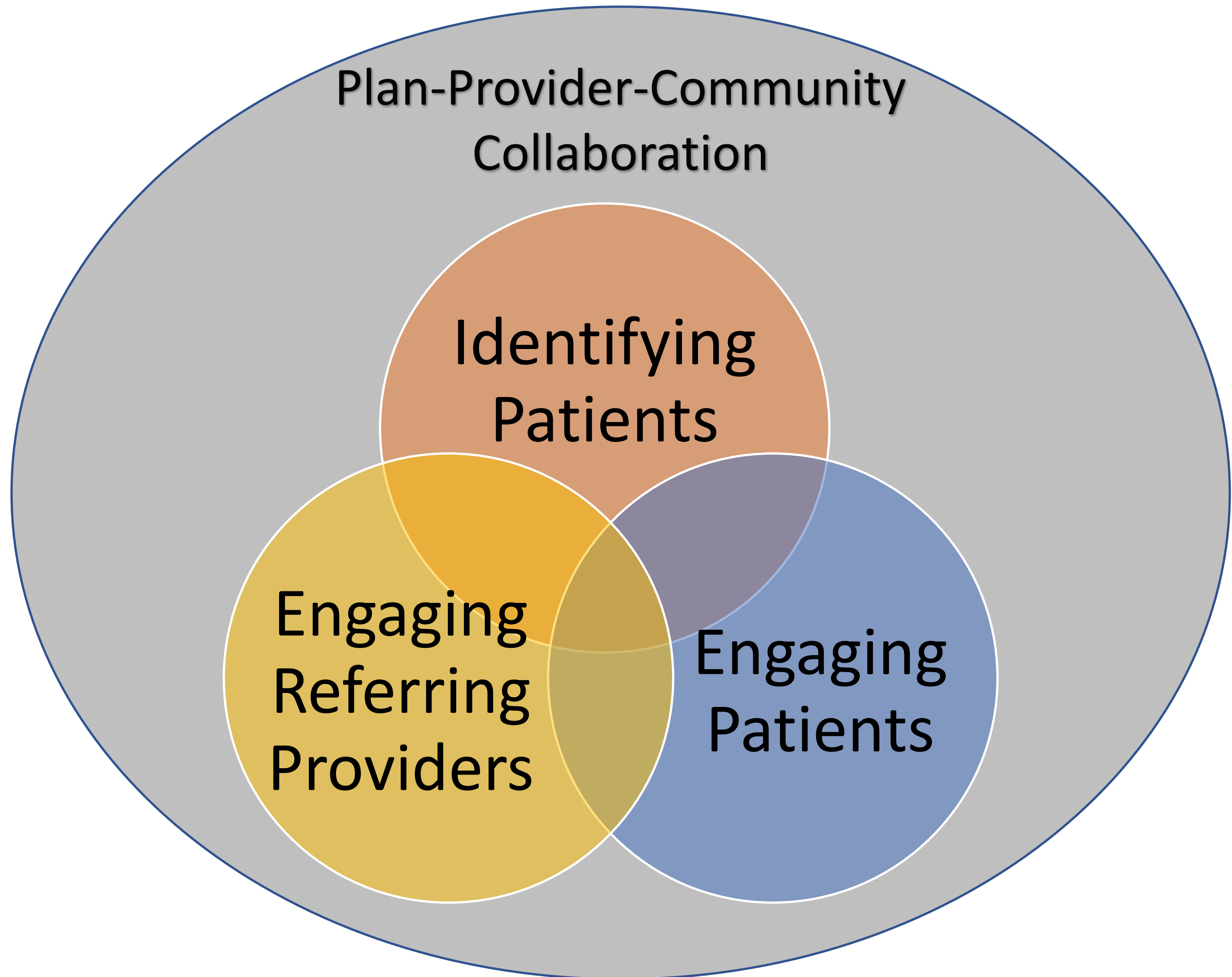
Reflections on Palliative Care and SB1004

- 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



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

	Claims and authorization data	Electronic health records	Screening / assessment findings
Qualifying diagnoses	✓	✓	✓
Evidence of advanced disease	(✓)	✓	(✓)
Patient & family preferences		(✓)	✓

www.chcf.org/sb1004 -- Topic 1: Estimating number eligible patients

How does your organization identify potentially eligible members/patients?

	Plans	Providers
Plan identifies patients through claims data, sends list to PC providers	71% (↑↑)	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

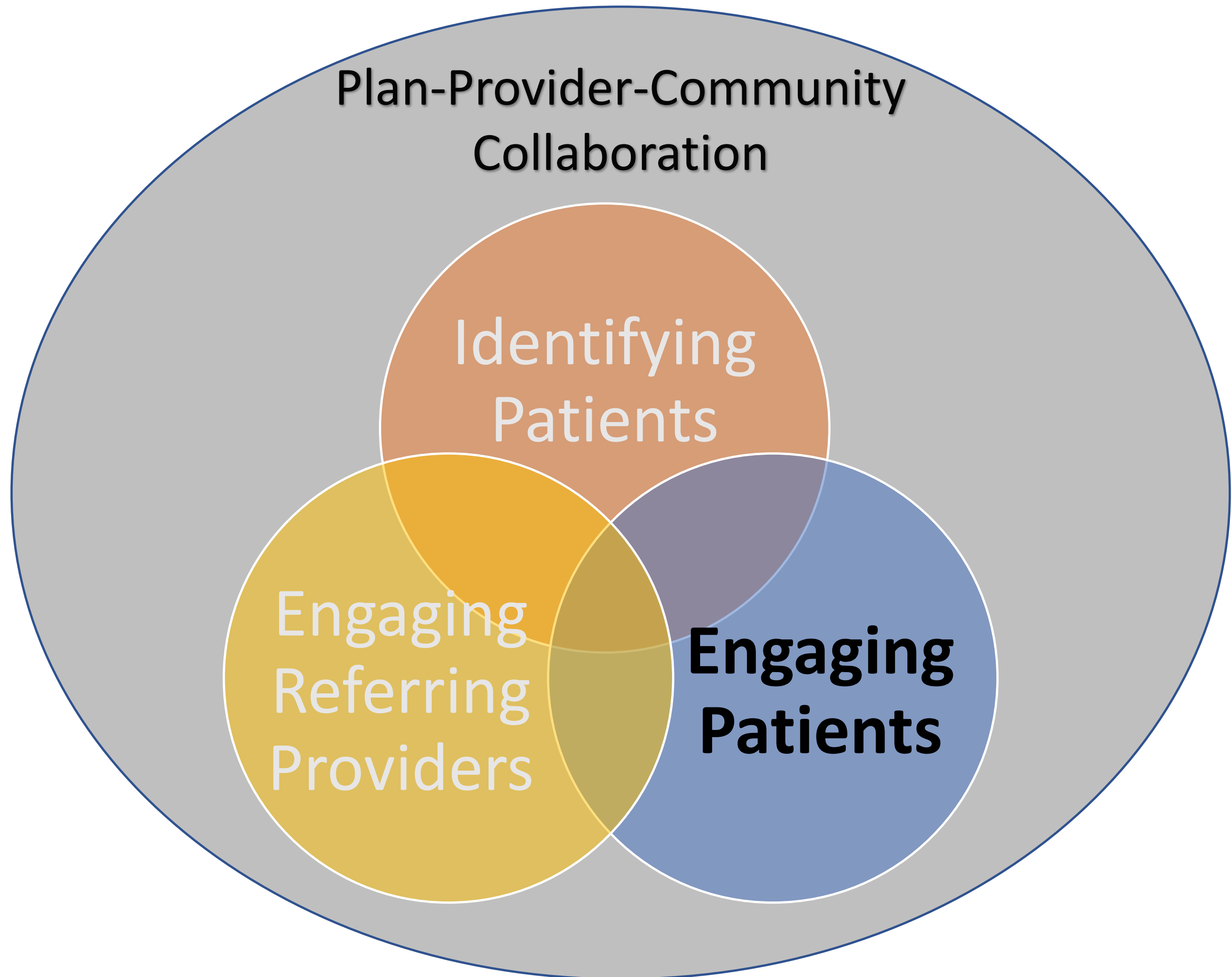
PROVIDERS

✓✓ 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

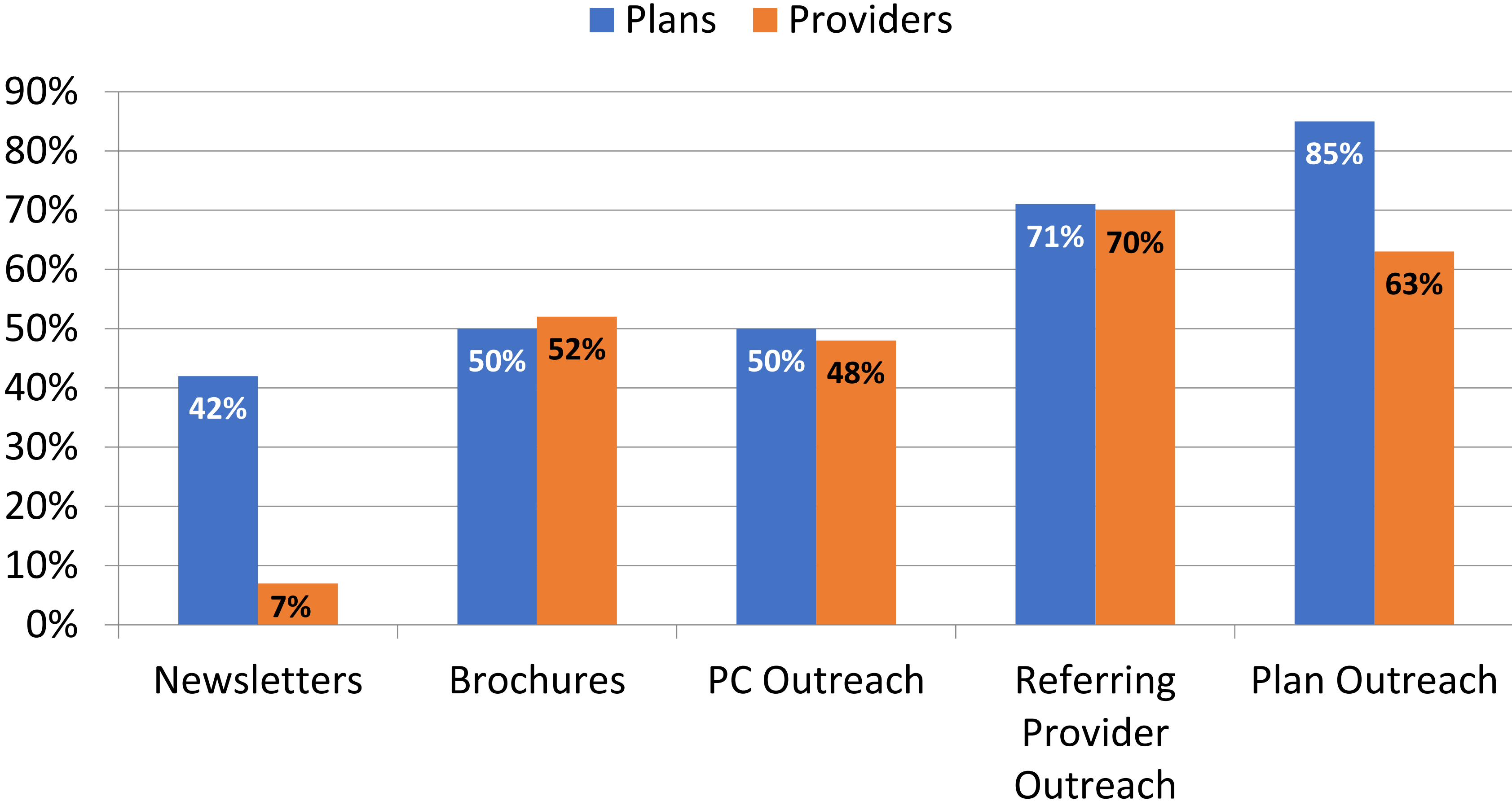
Common Implementation Challenges



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



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"

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

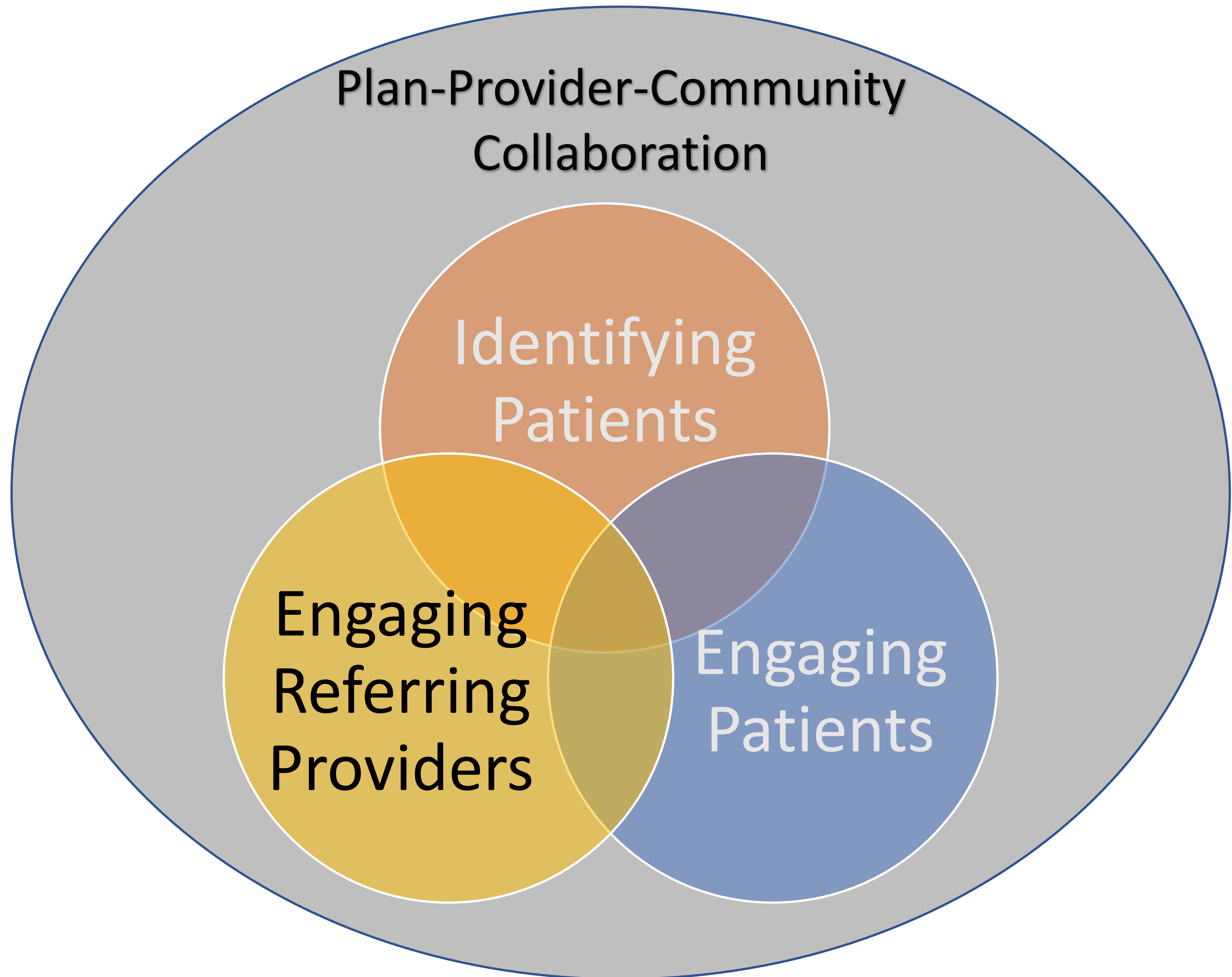
"inpatient pall care hand-offs to outpatient services seem to be the most effective; the other most effective strategy is having somebody the patient/family [trusts] (pcp, complex care case manager, etc.) explain and promote services - emphasizing the potential value/synergy of pall care in combination w/attempts at curative treatments"

Plan

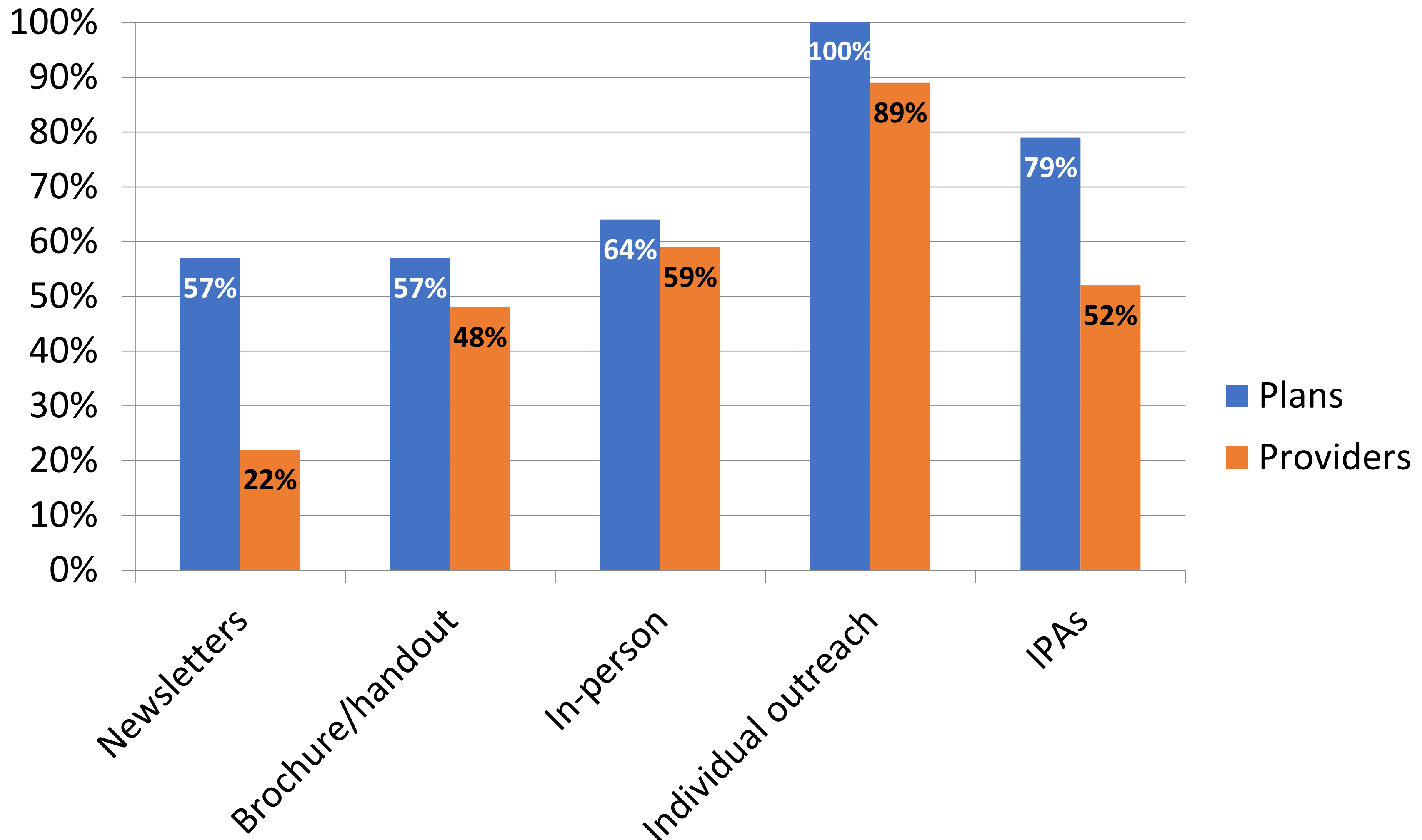
Identifying & Engaging Members/Patients: Reflections

- 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



Strategies to engage referring 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
  - SB1004@dhcs.ca.gov

- Technical Assistance resources: 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.

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

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

Questions?