

# Palliative Care – Medi-Cal Managed Care Plans

## Survey Responses

June 1, 2015

In May 2015 the Department of Health Care Services (DHCS) surveyed several Medi-Cal managed care plans regarding current palliative care efforts. This document provides a summary and range of responses.

### SURVEY QUESTIONS AND RESPONSES

#### 1. What resources does your Managed Care Plan (MCP) have in place for:

##### a. Provider education around end-of-life discussions:

**Responses included:** Education materials for physicians upon request; continuing education; referrals; CME provider education; onsite training; education for case management teams to interface with providers; none.

##### b. Member education around end-of-life discussions:

**Responses Included:** Discussions initiated during the assessment for Case Management and continue at an ongoing basis as needed; educational materials available; social workers available; complex case managers discuss with members telephonically; Member education is done on an individual basis using case managers; Continually do member education—through National Health Care Decisions Day, newsletter and on a one-to-one basis with our case managed members; Access to social worker; none.

##### c. Provider education around pain management

**Responses Included:** Comprehensive provider package delivered to all PCPs includes education and tools around pain management; New outreach and education program currently in the works; Our network have pain management specialist and members are referred by their treating physician as needed; Pain management is included in the palliative care and end of life discussions with provider groups but separate provider education on pain management has not been done; Continuing Education; none.

##### d. Provider and/or member education for community resources for spiritual support

**Responses Included:** Assess members for resource and support needs routinely; educational materials provided in mailings and on the website; education on a case-by-case basis; resources for spiritual support; access to Managed Care Plan social worker; case management referrals to local resources; identifying provider education materials and resources; plan for disseminating best practices from sister organization; none.

#### 2. Does your MCP keep track of advance directives, such as POLST forms? If so, how does your MCP accomplish that?

**Responses Included:** Building a system to store all advanced care directive information; advance directive forms received from members and providers - can be attached in software system; regular documentation of the member's wishes; regularly conduct Advanced Directive inquiries and provide forms to members who have not completed one; POLST forms are tracked for members referred to palliative care; currently note advance directive status in case management records - planning to develop a more robust method; our quality department audit for evidence of advanced directives; this is a new priority and we will identify completion targets for POLST and advanced directives; no known advanced directive tracking.

#### 3. What does care management mean for your MCP for members with complex chronic diseases?

**Responses Included:** A process of care coordination to facilitate independence towards self-care and management, integrations of covered services and, managing care transitions among providers and across care settings; a multi-disciplinary approach coordinating care between PCPs, specialists, vendors, provider groups, hospitals, vendors, and

the health plan; focus on helping members manage their chronic conditions and disease management programs; care coordination, available upon request, and a care plan is developed.

**a. How are these members identified?**

**Responses Included:** Many different sources of ID filters for events and chronic disease; referrals and use of multiple sources of data - used with a predictive modeling tool to risk stratify the members; high cost reports, transition management upon discharge from the acute setting, concurrent review, rounds with the provider group, and by case managers; risk stratification; primary care provider, specialist, self-identification, other services, or through our validated algorithm; State Claims Data, RX and Providers; specific diagnosis codes and/or utilization trends and patterns, network considerations, and clinical care initiatives; proprietary predictive modeling software based on inpatient/outpatient, medical, behavioral health, and pharmacy claims data as well as demographic variables also result in referrals.

**b. How is care coordinated?**

**Responses Included:** one to one relationship between the member and their case management nurse/coordinator; care manager works collaboratively with PCP, specialist, and other care providers, Community based services social services etc. and community resources to ensure that all available resources are available to the meet the unique needs of the member; the care managers collaborate with the affiliated Medical groups/IPAs on an ongoing basis to support the member; regular rounds with health plan medical directors, case managers, SW, behavioral health specialists, and health plan pharmacists; case management programs and communication by phone, fax or letter with our providers; regular meetings of care teams; coordinate the interventions specified in the CM Plan; Coordination of care is achieved through communication as appropriate with the member or member' representative, family, and providers.

**c. Who are the members of the care coordination team?**

**Responses Included:** team members include coordinator, LVN, MSW, Behavioral Health staff and pharmacy contact - led by the CM RN assigned to the member; PCP, member, RNs/LVNs Care managers, Care navigators, Care Coordinators, Social Workers, and others team members are included as needed - supported by a physician Medical Director; Health plan medical directors, case managers, manager/director level nurses, behavioral health specialists (psychologists/ psychiatrists), social workers, pharmacists, administrative support; Case managers communicate by fax or phone with primary care providers while the interdisciplinary team, made up of MD, RN, Pharmacist, and SW, meets weekly to discuss complex cases; Pharmacists, MDs, RNs, LCSWs, Connectors, MH, BH, Directors, Homebound NPs, Administrative Analysts, Community Partners; Utilization Management and Case Management staff, the PCP, case manager, and other professionals or agencies who have an active role in managing members' health care condition and needs.

**4. Are there particular cultural sensitivities that your MCP has identified regarding:**

**Responses Included:** Cultural issues and the member's perspective differs widely by background, language, beliefs and ethnicity -maintain a bi-lingual staff and broad translation capability; some culturally-based sensitivities when attempting to discuss end-of-life issues and advanced planning, e.g., differences in perspectives between the patient and the family, collective decision-making, discussions of death as a taboo subject, willingness to ask for pain relief, the role of religion and faith, and language barriers; core to the principals of motivational interviewing technique is understanding and identifying cultural issues which support effective communication and enhance the ability of the member to develop insight into their health care concerns or needs.

**a. Resources and educational materials for end-of-life care**

**Responses Included:** Inadequate provider and member education around need and appropriate timing of interventions; the initial care management assessment of the member includes questions on the member's care preferences including advanced directives, cultural and linguistic preferences - all staff receive cultural sensitivity training on an annual basis and topics include: Disability Language Etiquette, Gender & Sexual

diversity training, Access to Language/Communication in First Language; palliative care brochures have been developed in coordination with the palliative care vendors; materials available in multiple languages; developing language and culturally appropriate literature and staff

**b. Advanced care planning**

**Responses Included:** Brochures and educational materials on end-of-life care are available in different languages and also address cultural aspects of death and dying; members are assigned to Social Workers and Case Managers with matching language proficiency and cultural understanding as much as possible; 5 Wishes is readily available in English and Spanish- other languages can be downloaded from the website.

**c. Providing care management**

**Responses Included:** Difficult to have accurate contact information for members- reluctance of members with chronic pain and other chronic issues to accept HP interventions and outreach; member's care preferences are respected in all activities; cultural context will be vital to the implementation of any outreach, education or counselling on advanced care planning -provide access to information in different languages, seeks providers who deliver services in culturally appropriate languages, modalities and settings, and continues to seek culturally fluent providers to serve our culturally diverse membership.

**5. Has your MCP been able to address the cultural sensitivities identified in question 4? If so, how? If not, do you have any plans or ideas to address these issues?**

**Responses Included:** identified issues with cultural disparity and attempt to address these but our health system in general is not well set up to effectively change outcomes driven by diversity; member's care preferences are identified and respected in all activities; in the future, we are considering outreach to some community religious leaders to clarify religious positions on end of life care and refine approaches; yes, we follow CLAS standards, train staff annually with a mandatory training about cultural sensitivities and hire bi-lingual staff; Care Management teams refer members and providers to the Coalition for Compassionate Care of California for decision guides and POLST instructions in various languages, and local clergy has been available to our members to address issues surrounding religion and faith; we provide cultural sensitivity training to our staff; in process.

**6. Does your MCP have any pilots or projects that focus on aspects of palliative care or end of life care that you would like to tell us about? Do you utilize any resources or follow any best practices that you could list?**

**Responses Included:** outsourcing acute in home care for the fragile with a Vendor, and exploring a higher touch relationship for most of our fragile SPD members with another vendor; staff within the care management team with extra training/experience in palliative/hospice care are designated to assess/monitor all members participating in Palliative care programs in hospitals or community; home based palliative care pilot programs - referrals are encouraged through internal and external education programs- Major barriers have been coordination of standard managed care services with the palliative vendor/ palliative services, and communication between the multiple parties involved - metrics of success are being tracked in the pilots to determine the feasibility of expanding the palliative programs; developed a Program for Advanced Illness, with 3 RN case managers who are experts in working with individuals and their caregivers who are facing serious illness; Staff encourages members to document their wishes, complete a POLST or other document, address pain and help manage symptoms, work with family members and providers to help members achieve their goals; resources include the AGS Position Statement – Feeding Tubes in Advance Dementia, Clinical Practice Guidelines for Quality Palliative Care, Third Edition, and tools and resources available from the Coalition for Compassionate Care of California; developing a palliative care model that will be based on best practices established at large integrated medical; learning from our sister organization that has an integrated delivery system that implements best practices around palliative care – our new workgroups include collaboration and guidance, especially for inpatient and institutionalized members.