COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

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VIA EMAIL

Dear Anastasia:

The Coalition for Compassionate Care of California appreciates the opportunity to respond to the overview of Stakeholder Feedback/Additional Options for Consideration specific to SB 1004. As you know, the California Department of Health Care Services (DHCS) recently considered four specific areas related to the implementation of SB 1004: 1) Eligible Conditions, 2) Eligibility Screening Protocols, 3) Medi-Cal Palliative Care Services and 4) Palliative Care Provider Qualifications. Below please find a few additional thoughts on each of those areas.

1) **Eligible Conditions.** In its October 2, 2015 document, DHCS initially suggested beneficiaries with late-stage/high grade cancer with significant functional decline be eligible for palliative care. Recent discussions point toward broadening the eligible conditions to earlier diagnosis of cancer and not requiring severe functional decline. Acknowledging that when severe functional decline occurs, the patient is often almost too far along in their disease progression, likely even hospice appropriate.
    - The Coalition supports offering palliative care to patients with cancer diagnoses as early as possible, possibly as early as the time of initial diagnosis. That way, the additional layer of palliative care services can support patients as they navigate the path of treatment options. Early palliative care offers support for the emotional issues that often accompany a cancer diagnosis, as well as initiating advance care planning as early as possible.
    - The Coalition also supports allowing Medi-Cal Managed Care plans the option to include additional diagnoses for eligibility, beyond a cancer diagnosis. To determine success of these programs there will need to be a critical mass of patients participating and receiving services. There is concern that limiting eligibility to those with cancer may hamper the opportunity to enroll sufficient numbers of patients to assess program success. We support allowing enrollment to patients with diagnoses known to be serious and potentially life limiting. Current pilots suggest Cirrhosis, Congestive Heart Failure (CHF) and Congestive Obstructive Pulmonary Disease (COPD) diagnoses are amenable to early palliative care and prevalent in the

younger, non-Dual eligible Medi-Cal population. We support allowing Medi-Cal Manged Care plans to include these additional diagnoses into their early implementation of SB 1004.

2) **Eligible Screening Protocols.** Given the target patient population for SB 1004 is the Medi-Cal population (not the Medi-Medi population) they will generally be a younger population. Their presenting conditions, patterns of decline and socio-economic/family structures are often different than an older Medicare eligible population. Given that dynamic, screening protocols will need to be designed to fit this population. Both clinical screening as well as care utilization screening will be critical.
   - The Coalition supports use of the Palliative Performance Scale (PPS) to screen for palliative care eligibility. Per the Center to Advance Palliative Care (CAPC) the PPS is a reliable and valid tool and has been found useful for purposes of identifying and tracking potential needs of palliative care patients, particularly as these needs change with disease progression. The PPS is applicable to a younger population, as opposed to the Functional Assessment Staging Tool (FAST) which is specifically designed for use with dementia and related disorders. The PPS is more appropriate when the patient is highly functional, but also in need of advance care planning and assistance to navigate treatment options and emotional concerns.
   - The Coalition also supports an assessment of utilization patterns to identify potential palliative care patients, along with the appropriate eligible diagnosis. Those patients who have high emergency department utilization, numerous office/clinic visits, and /or inconsistent access to care (patients lost to care or returning to care yet obtaining services from multiple care sites such as primary care, specialist care, EDs etc.) should be further evaluated for palliative care services. Often, given the general nature of Medi-Cal enrollment and care consistency challenges (eligibility and enrollment can change month to month, patients may have difficulty with access to care, socio-economic and health literacy challenges hamper navigation of health care, etc.) these patients may present with high needs for care coordination. Assessing utilization patterns as part of eligibility for palliative care makes sense as the program is identified as a cost-neutral effort. Improved care coordination, as well as enhanced symptom management, and early advance care planning supports the work to create a cost neutral service.

3) **Medi-Cal Palliative Care Services**. Original guidance on the implementation of SB 1004 suggested including the full array of hospice services. Additional stakeholder input warned of potentially cost prohibitive hospice services such as respite care or home health/hospice aide services. A palliative care program ought to include some similar aspects of hospice, (such as symptom management), though not create a duplicative program that might further

delay appropriate hospice referrals. However, there are certain aspects of the hospice program which ought to be included in the Medi-Cal palliative care services.

- It is a tremendous challenge to expect any one discipline (eg: medicine or nursing) to adequately provide the full array of quality palliative care services. Therefore, the Coalition supports ensuring an *interdisciplinary team* is essential to the provision of palliative care. Individuals with new diagnoses of cancer (or other life altering diagnoses) often experience emotional distress. The Medi-Cal population frequently has challenging socio-economic concerns impacting access to care or consistent adherence to care. The disciplines of social work and chaplain services provide critical support to patients and families navigating complex medical care who often have limited health literacy or limited social or financial resources. The Coalition supports ensuring an interdisciplinary team specifically includes the disciplines of medicine, nursing, social work and spiritual care to provide complete palliative care under SB 1004.
- The Coalition supports the following as defined minimum palliative care services:
    i. Advance Care Planning
    ii. Symptom management (pain, dyspnea, nausea, etc.)
    iii. Care coordination
    iv. Palliative care consult (consult terms to be specified, such as: development of palliative care plan based on symptom assessment, curative care plan and treatment options reviewed, living situation and safety assessed, patient and family satisfaction assessed, etc.)
    v. Counseling [as defined in the hospice regulations]
    vi. 24/7 telephonic palliative care support (separate from a routine Advice Line)

    (Managed Care plans may elect to offer additional services.)

4) **Palliative Care Provider Qualifications.** As noted recently by DHCS, provider qualifications need to reflect the diversity of provider types available by geographic location. Contracting will depend on provider availability and capacity. Therefore, Medi-Cal Managed Care plans need authority and flexibility to identify and include appropriate providers. However, such flexibility also suggests DHCS will need to measure and assure a minimum level of quality palliative care is offered and utilized by beneficiaries. Given the paucity of formally trained palliative care providers (of all disciplines), training resources will be important. Also, in the future, national benchmarks or accreditation programs may be adopted by DHCS to ensure palliative care programs offer quality services to Medi-Cal enrollees.
    - The Coalition recognizes a developmental distinction exists between inpatient palliative care services and outpatient palliative care services. While inpatient palliative care has spread across California over the past few years, Community Based Palliative Care is still in its early development. Under Community Based Palliative Care (CBPC), provider qualifications may be defined by a mix of

experience as well as formal training. With that in mind, the Coalition supports allowing CBPC provider participation based (at least initially) on those who attest to competency in provision of the services as described above (**Medi-Cal Palliative Care Services**). Additionally, regular assessment of the successful provision of such services should be conducted to allow an agency to continue to offer CBPC.

- The Coalition further supports ensuring ongoing competency development for the provision of palliative care. As a leading educator in the field of standardized training on issues affecting people with serious illness (such as POLST and Advance Care Planning) we support development of accessible training for skill development among palliative care providers. Training and competency should be aligned to ensure providers have skills required to conduct effective advance care planning, symptom management, care coordination, etc. Non-profit organizations such as the Coalition should be preferred sources for independent training and competency assessment.
- The Coalition also supports the future requirement that palliative care programs offered under the auspices of SB 1004 will obtain full accreditation offered by nationally recognized organizations such as The Joint Commission.

Thank you for the opportunity to provide additional responses to the Department's ongoing consideration for the implementation of SB 1004. We hope these comments will be supportive and informing as you develop an All Plan Letter for 2016. If you have any questions please call, we are happy to clarify any of the thoughts provided in this summary and we would be happy to strategize with you about the educational aspects of this program.

Sincerely,

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