SB 1004 Medi-Cal Palliative Care Policy Update

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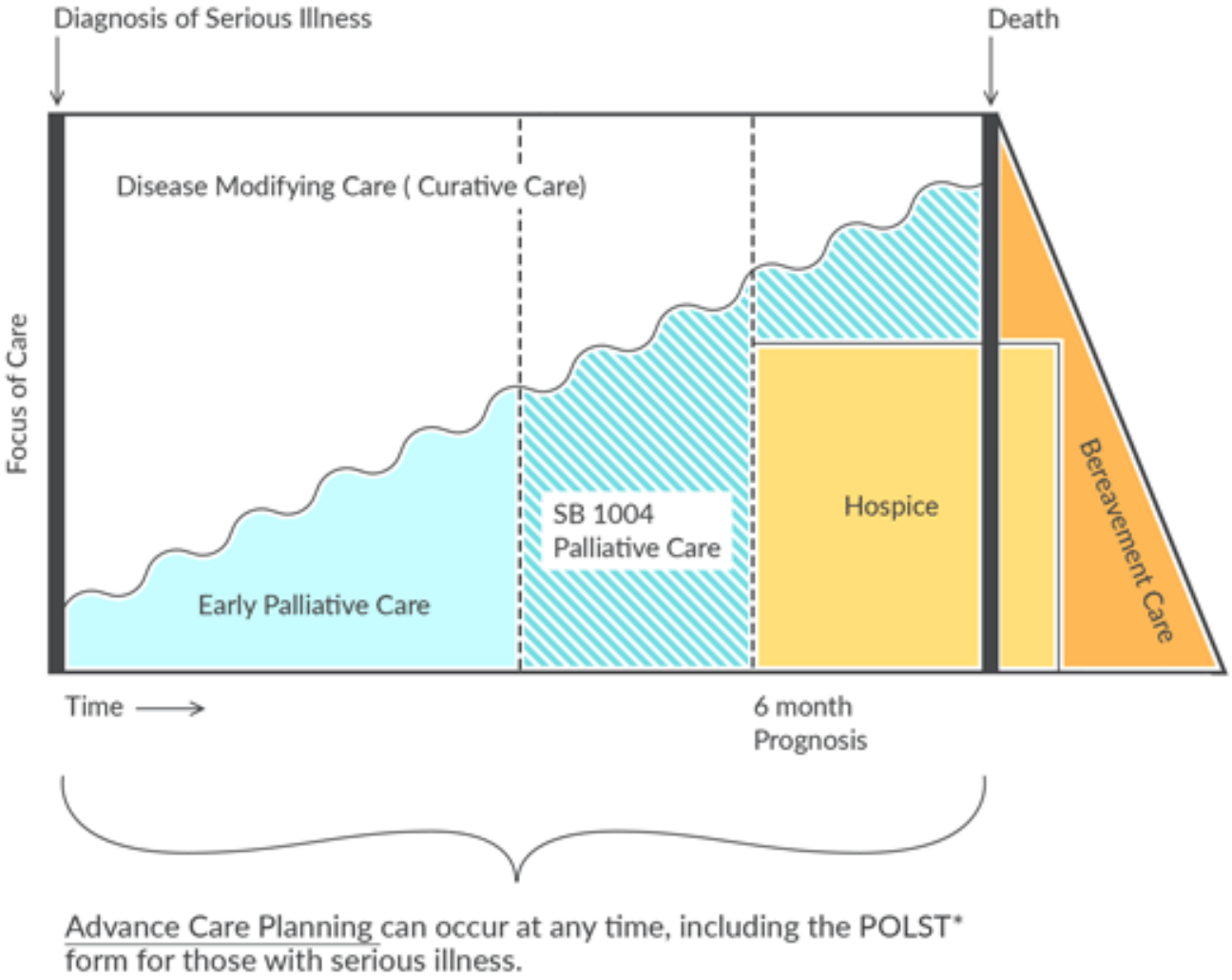
Presentation Overview

- SB 1004 Care Model
- Data Analysis
- Eligible Conditions and Criteria
- Services
- Performance Measures
- Provider Training & Technical Assistance

SB 1004 Care Model



Design adapted from the National Consensus Project for Quality Palliative Care.
*POLST: Physician's Orders for Life Sustaining Treatment

SB 1004 Care Model (cont.)

- **Early palliative care:** is often advance care planning and/or palliative care consultation, and can include pain and symptom management. Usually in combination with disease-modifying/curative care.
- Wavy line indicates proportion of palliative care and disease-modifying/curative care varies based on individual patient choices and needs.
- **SB 1004 Palliative Care:** As patient's illness progresses, those with serious illness who meet specific clinical criteria can enroll in SB 1004 palliative care programs.
- **Hospice Care:** Those who meet hospice eligibility criteria (6 month prognosis) can enroll in either hospice or SB 1004 palliative care, but cannot be enrolled in both programs at the same time.

Data Analysis: Data Sources

- Figure 1: Most Frequent Causes of Death
  - DHCS data match using Medi-Cal eligibility data and California Department of Public Health 2013 Statistical Master File. Figure shows Medi-Cal only decedent info.
  - **Bold text** includes categories that include SB 1004 conditions. (Note "Heart disease" includes several conditions).
- Figures 2A and 2B: Inpatient and Emergency Department (ED) Utilization
  - DHCS Data Warehouse claims and encounters, for 1,237 Medi-Cal-only decedents with August 2015 month of death, and 18 months prior continuous enrollment.

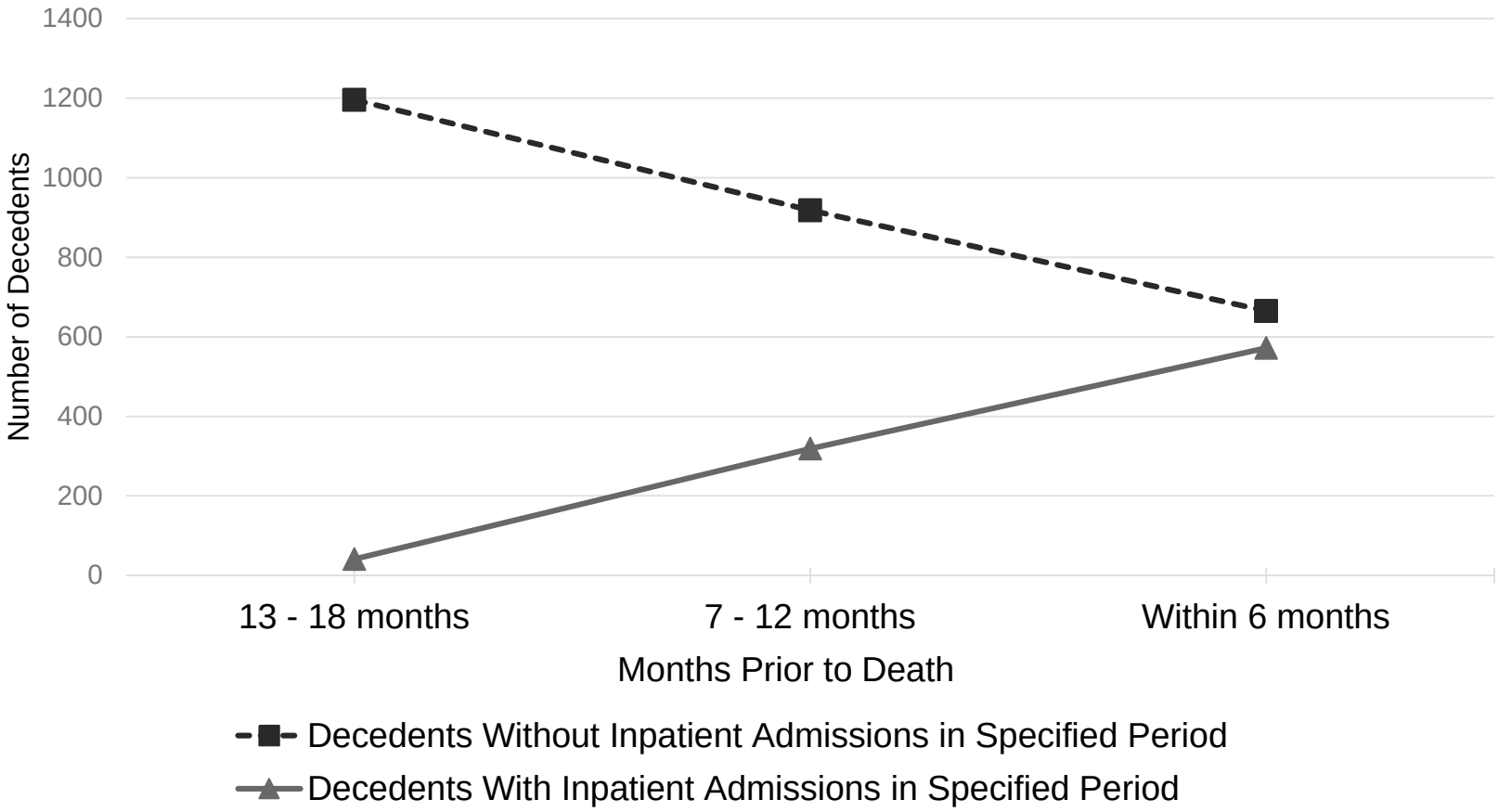
Figure 1: Most Frequent Causes of Death for Medi-Cal only* Decedents in 2013

- **Cancer (28.2%)**
- Injury/Accidents (15.6%)
- **Heart disease (14.4%)**
- **Liver disease (6.4%)**
- Stroke (3.9%)
- Diabetes Mellitus (3.4%)
- **Chronic lower respiratory disease (3.3%)**
- Influenza/pneumonia (1.6%)
- Other diseases not included above (23.2%)

*Excludes Dually Eligible Medicare-Medi-Cal Beneficiaries

Figure 2A: Inpatient Utilization

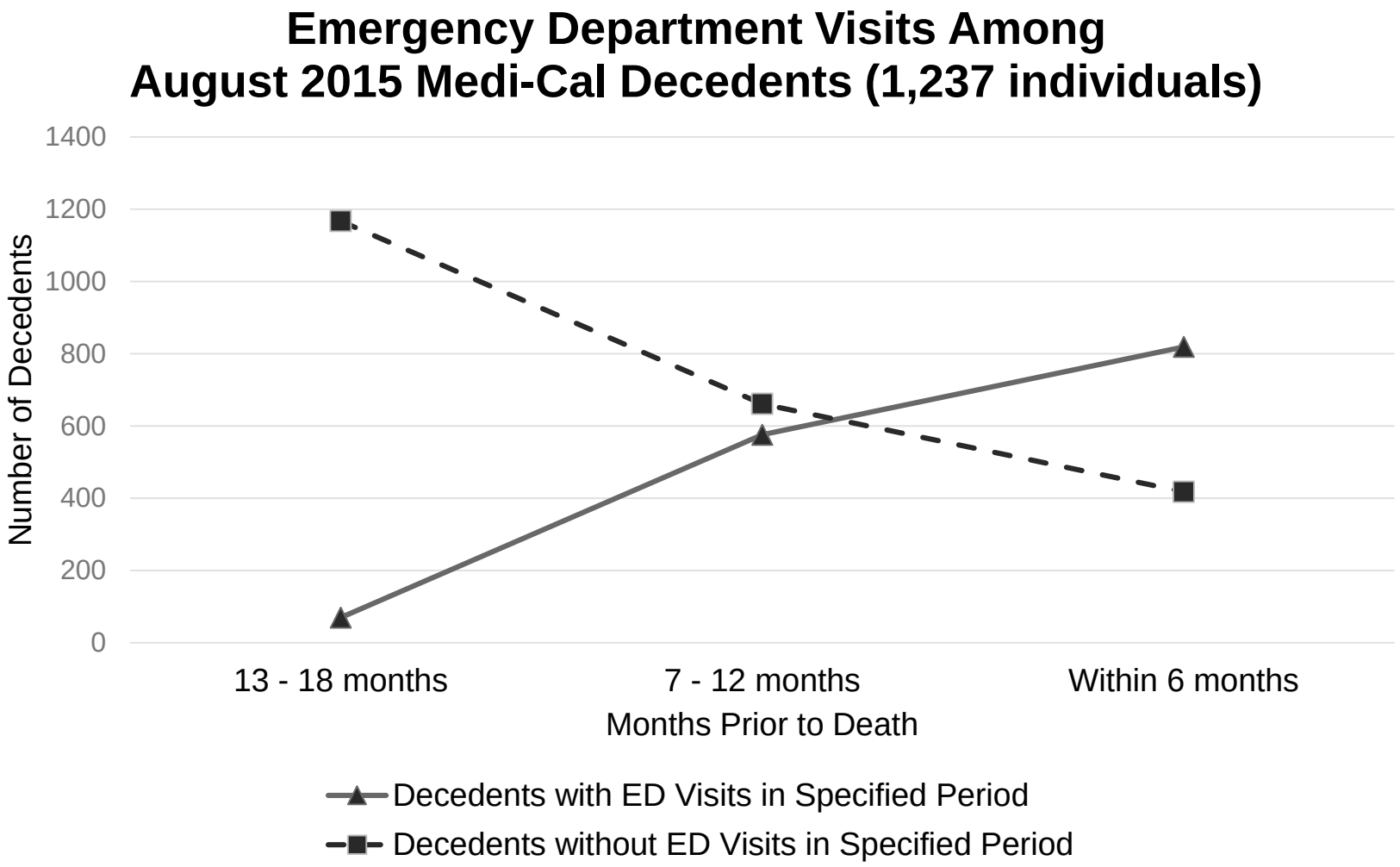
Hospital Inpatient Utilization Among August 2015 Medi-Cal only Decedents (1,237 individuals)



ED Visits Among August 2015 Medi-Cal only Decedents (1,237)

- 6% had 1 or more ED visit in the 13-18 months prior to death.
- 47% had 1 or more ED visit in the 7-12 months prior to death.
  - 26% had 2 or more ED visits in this period.
- 66% had 1 or more ED visit in the 6 months prior to death.
  - 45% had 2 or more ED visits in this period.

Figure 2B: Emergency Department Visits



Data Analysis Key Points

- In the last 7-12 months of life, hospital admissions and ED visits increase significantly for some beneficiaries.
- Some of these beneficiaries meet the criteria for SB 1004 palliative care – prior to hospice eligibility. Providing SB 1004 palliative care to these beneficiaries can reduce patient suffering and unwanted hospitalizations and ED visits.
- Notes:
  - Some beneficiaries do not have inpatient or ED visits in the last 12 or 6 months of life.
  - SB 1004 eligibility criteria includes more than just inpatient or ED utilization.

SB 1004 Eligible Conditions

- October 2015: DHCS proposed Late-Stage/High Grade Cancer with significant functional decline or limitations.
- September 2016 Update: Four eligible conditions, and patient must meet both General and Disease-Specific Criteria for any of these conditions:
  - Cancer
  - Congestive Heart Failure (CHF)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Liver Disease
- These four conditions are the minimum; Medi-Cal managed care plans (MCPs) may authorize palliative care for patients with other conditions.

General Eligibility Criteria

1. Patient is likely to or has started to use the hospital or ED as a means to manage their late stage disease. This refers to "unanticipated decompensation" and does not include elective procedures.
2. Patient in the late stage of illness (disease-specific) with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. Patient's death within a year would not be unexpected based on clinical status.
4. Patient has received appropriate patient-desired medical therapy, or for whom treatment is no longer effective. Patient is not in reversible acute decompensation.
5. Patient and, if applicable, family/patient designated support person agree to both of the following:
   a. Willing to attempt in-home, residential-based or outpatient disease management as recommended by the MCP Palliative Care team instead of first going to the ED.
   b. Willing to participate in Advance Care Planning discussions.

Disease Specific Criteria (1)

Congestive Heart Failure (CHF)

a. Any patient who is hospitalized due to CHF as the primary diagnosis. No further invasive interventions planned although access to curative care is maintained, or
b. NYHA* III (Definition of NYHA III: Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain)

AND one of the following:

a. Ejection Fraction <30 for systolic failure
b. Significant comorbidities: e.g. renal disease, diabetes, dementia, or poor biomarkers including rising BNP, pro-BNP, hsCRP, BUN/Creatinine (patient is in their best compensated state), and CAD.

* New York Heart Association (NYHA) Functional Classification

Disease Specific Criteria (2)

Chronic Obstructive Pulmonary Disease (COPD)

a. Severe air flow obstruction: FEV1 < 35% predicted AND
b. 24-hour oxygen at less than 3L/minute

OR

c. 24-hour oxygen at greater than or equal to 3L/minute

Advanced Cancer:

a. Any Stage III or IV cancer, locally advanced or metastatic cancer, leukemia or lymphoma

AND one of the following:

b. Karnofsky Performance Scale (KPS) score < or equal to 70 (KPS=70 Cares for self; unable to carry on normal activity or to do active work)

c. Being failed by two lines of standard chemotherapy.

Disease Specific Criteria (3)

Liver Disease

Irreversible Liver Damage
AND

BOTH of the following
1. Albumin <3.0
2. INR > 1.3

PLUS one of the below
a. Ascites
b. Subacute bacterial peritonitis
c. Hepatic encephalopathy
d. Hepatorenal syndrome
e. Recurrent esophageal bleeds

OR
1. Model for End Stage Liver Disease (MELD) score of greater than 19

SB 1004 Palliative Care Services

1. Advance Care Planning
2. Palliative Care Assessment and Consultation
3. Plan of Care
4. Pain and Symptom Management
5. Mental Health and Medical Social Services
6. Care Coordination
7. Palliative Care Team
8. Chaplain Services
9. 24/7 Telephonic Palliative Care Support (recommended)

- Access to Curative Care/Disease Modifying Care

Providers

- Variety of Settings:
  - Inpatient
  - Outpatient
  - Community- or Home-Based
- Providers:
  - Hospitals
  - Long-Term Care Facilities
  - Clinics
  - Hospice Agencies
  - Home Health Agencies
  - Others with licensed clinical staff

Provider Training

- Broad need for more training, in both:
  - Primary Palliative Care
  - Specialty Palliative Care

- Providers of palliative care consultations or assessments should have current palliative care training.

Recommendations for MCPs

- Outreach to specialists in targeted practice areas (Oncology and Cardiology), to promote early palliative care and advance care planning for beneficiaries diagnosed with serious illness but who are not enrolled in SB 1004 palliative care.
- Develop Consumer and Provider Outreach Plan for MCP's SB 1004 program.
- Provide 24/7 Telephonic Palliative Care Support Line.

Performance Measures

- DHCS will require MCPs to periodically provide lists of SB 1004 palliative care beneficiary participants to the Department, for monitoring and analysis.

- Further guidance will be provided on any MCP requirements for additional data reporting, such as inpatient stays, emergency department visits, or hospice enrollment, as well as quality measures.

Technical Assistance & Resources

- **DHCS SB 1004 Website and Email:** Please send questions to: SB1004@dhcs.ca.gov
- **California HealthCare Foundation (CHCF):** Wide range of online materials and resources, as well as in-person technical assistance events.
- **Coalition for Compassionate Care of California:** Consumer and provider resources on advance care planning and palliative care. Also frequent webinars and training programs.
- **California State University Institute for Palliative Care:** Instructor-led and self-paced online training for health care professionals, as well as patients and families.

Questions & Comments