

Partners in Palliative Care Pilot

Pilot Lays Foundation for Medi-Cal Palliative Care Benefit

Executive Summary

Partnership HealthPlan of California (PHC) piloted an intensive outpatient palliative care program – Partners in Palliative Care (PIPC) – with four organizations that began in September 2015. An evaluation of the pilot showed several differences from palliative care programs in other populations and other settings. These differences include a much higher burden of psycho-social issues and surprising challenges, such as a lower than expected completion of advance care planning documentation. A financial analysis of the first six months of the pilot showed approximately \$3 in hospital cost savings for every \$1 spent on the palliative care program. These results will help health plans and potential palliative care providers construct programs and contracts that meet the requirements of California Senate Bill (SB) 1004 which mandates establishment of an outpatient palliative care benefit for Medi-Cal beneficiaries.



End-of-Life Care for Medi-Cal Beneficiaries

Hospice care is a benefit for Medi-Cal members; however, it is clear from both state data and a UCSF study that hospitalization is common at the end of life. [State of California data from 2013](#) showed that 37 percent of Medi-Cal members died as hospital inpatients.

A UCSF safety-net study from 2010 to 2013 showed:

- 76% of safety-net patients were hospitalized in the last six months of life.
- 45% were hospitalized in the last month of life.
- 33% died in the hospital.
- 21% had multiple admissions in the last month of life.

Prior to the *Partners in Palliative Care* pilot, PHC contracted with hospice and palliative care physicians who could conduct visits with patients in the home and hospital setting. Palliative care provided in the inpatient setting and less intensive outpatient advance care planning activities were covered prior to the pilot, but more intensive outpatient palliative care services were only available to those enrolled in hospice.

Palliative Care Pilot

With support from the California HealthCare Foundation, PHC initiated the palliative care pilot program in September 2015 to assess the ease of implementation and outcomes of care for PHC members receiving intensive palliative supportive care at the end of life. From September 2015 through February 2016, the PIPC pilot enrolled members with two years of life expectancy or less, with selected diagnoses. The pilot sites were:

Palliative Care Team	Location	# members enrolled during 6 month pilot period
Collabria Care	Napa	19
Interim Healthcare	Redding	5
ResolutionCare	Eureka	51
Yolo Care	Davis	7

The general criteria for enrollment were:

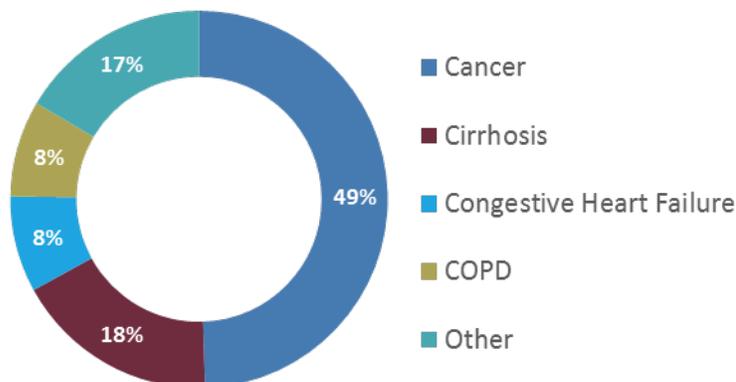
- Hospitalizations or ED visits in the late stage of illness
- Estimated life expectancy: two years or less to live
- Intolerant or declines further therapy
- Willing to do advance care planning

The following diagnoses were included:

- Cancer
- Cirrhosis
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Frailty Syndrome
- Dementia

Of the 82 PHC members enrolled during the six month pilot period, the proportion of different underlying diagnoses were:

Chart 1: Diagnoses of Participants



Primary Outcomes of the Pilot Program

The sites with the highest enrollment - Collabria Care and ResolutionCare - were able to achieve low rates of hospitalization and ED use during the study period, compared to the experience of typical Medi-Cal beneficiaries toward the end of their lives.

Patient satisfaction was also measured for PIPC patients. The program achieved high levels of patient and family satisfaction. The following response rates were recorded from the patient survey questions:

Overall, I received the best possible care from my Palliative Care team.

- Always 95%
- Usually 5%

I would recommend my Palliative Care team to others.

- Always 95%
- Usually 5%

Program Evaluation Process and Findings

The PIPC program was evaluated in two phases: 1) processes and challenges of implementation; and 2) costs of palliative care compared to usual end-of-life care.

Phase 1 Evaluation – Implementation

Evaluator: Monique Parrish, DrPH, MPH, LCSW; LifeCourse Strategies

From the first phase of the evaluation, it was clear that programs that previously provided palliative care services, such as ResolutionCare and Collabria Care, were able to attract more members quickly due to established referral patterns. The Physician Order for Life Sustaining Treatment (POLST) completion was 78 percent for those two entities and 76 percent overall. Hospital and ED utilization were also very low for these two programs and may be attributable to their 24-hour call systems and the level of services they were able to offer.

Challenges identified in the phase 1 evaluation:

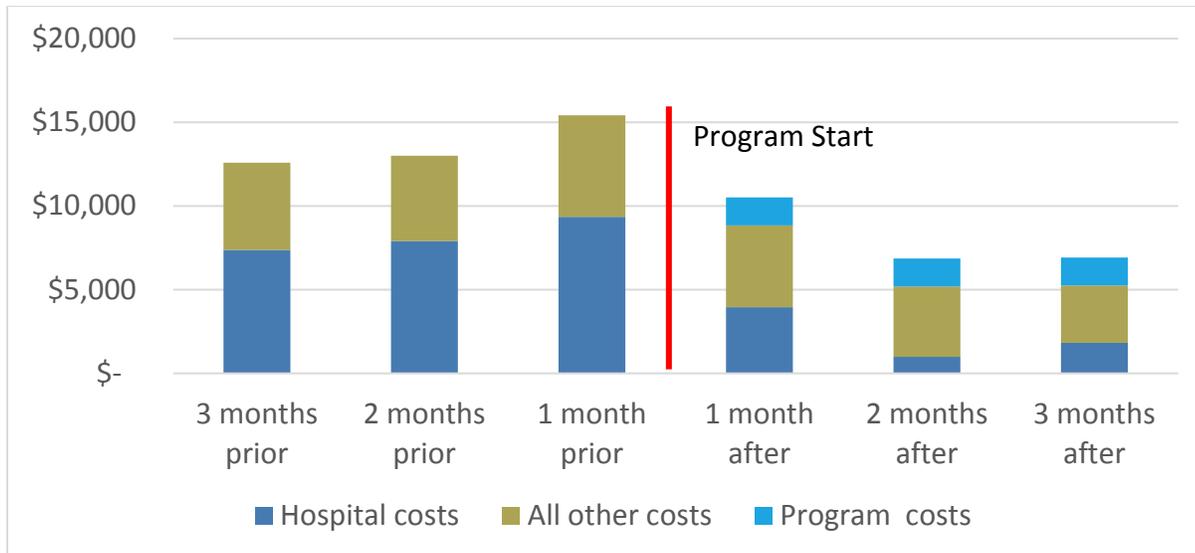
- Identifying and enrolling members was the major challenge for all sites.
- The intensity of the psychosocial needs of PHC members surprised the care teams.
- The high frequency of patients with cirrhosis was unexpected.
- POLST completion took a lot more work and time than was anticipated.

Phase 2 Evaluation – Fiscal Analysis

Evaluator: J. Brian Cassel, PhD and Donna McClish, PhD; Virginia Commonwealth University School of Medicine and Massey Cancer Center

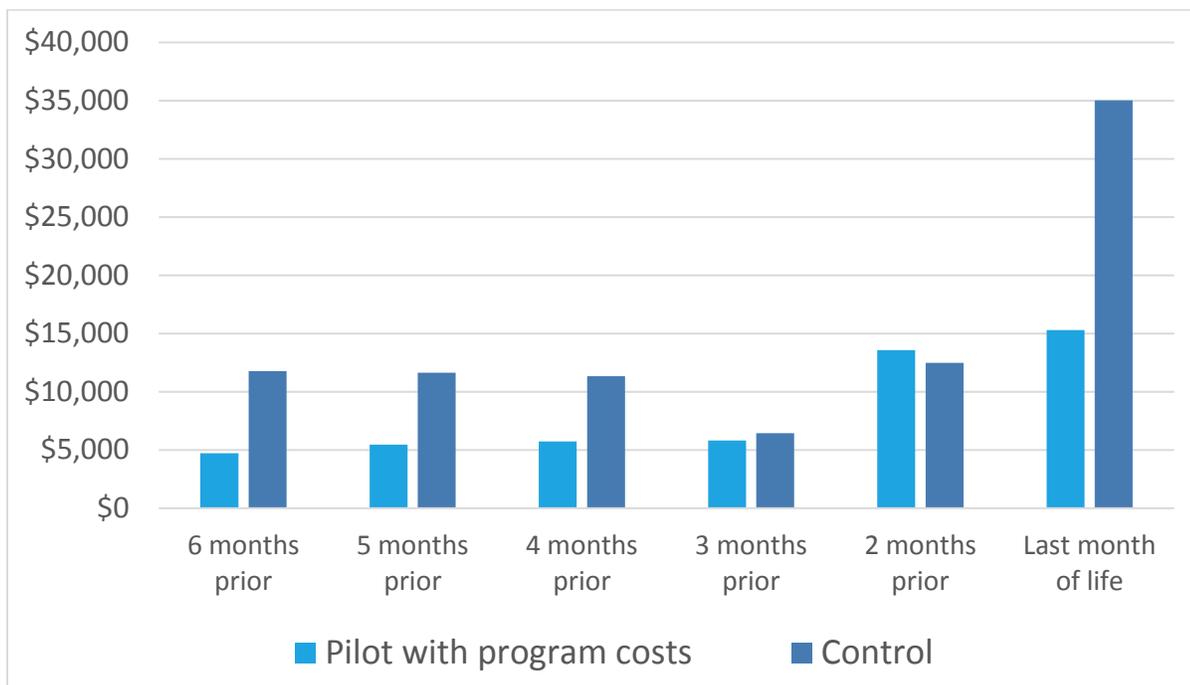
In the second phase of the evaluation, the evaluators examined the costs of providing intensive palliative care services compared to the costs of providing traditional end-of-life care. Palliative care patients in the study were 51 percent male, 60 percent white, and an average age of 55 years. The mean time from enrollment to disenrollment (death or otherwise) was 75.4 days. Disenrollments from PIPC were due to death, enrollment in hospice, or (rarely) moving out of area or a change in treatment plans. Among those known to be deceased, the mean time from enrollment to death was 90.2 days.

One analysis compared the costs of care for the three months before and after starting palliative care supportive services. There were 69 patients available for a 30-day evaluation, 63 available for 60 days, and 51 patients available who had continuous care for 90 days before and after the program. Even with the costs of the program included, the total cost of care was 33 to 50 percent less for these PHC members after beginning palliative care, primarily due to a marked decrease in hospital days while enrolled in the program.

Figure 1: Costs Per Month, Before and After Palliative Care Pilot Enrollment

The second analysis looked at PIPC patients who had died and compared their utilization with PHC members matched for age, diagnosis, and expected survival. This study was limited because there were only 29 decedents who were known to have died at the time of the phase 2 study.

Even with the small number of decedents, the analysis suggests that the pilot was cost effective due to lower hospital utilization (compared to the matched comparison patients). PIPC pilot patients were admitted 34.5 percent in the last 30 days of life compared to 72.4 percent for the matched controls.

Figure 2: Total Costs of Care in the Last Six Months of Life

Based on these two methods of financial analysis of the pilot, approximately \$3 of hospital costs were avoided for each \$1 spent on all costs associated with the PIPC pilot.

Senate Bill (SB) 1004

The state benefit for palliative care under SB 1004 was influenced by the PIPC findings. The state determined the new palliative care benefit will cover four diagnoses – cancer, end stage liver disease, congestive heart failure, and chronic obstructive lung disease, which were the four most common diagnoses in the PIPC pilot. (Dementia and frailty were the other two; a very small percentage of members in the pilot had these as their primary diagnoses.) The state will still allow plan discretion in offering to cover patients with a different diagnosis. The state lowered the life expectancy from two years (as in the PIPC pilot) to one year. Both of these changes should decrease financial risks of palliative care under SB 1004 since it will allow more predictability of costs and duration of care in the program.

Summary

Evaluation of the first six months of the Partners in Palliative Care pilot indicated the provision of comprehensive, community-based end-of-life care with very high patient satisfaction and an overall lower cost of care due to decreased inpatient utilization compared to traditional end-of life care.

For additional information:

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