

Partners in Palliative Care: A Community-Based Pilot Project 2015–2016

Implementation Evaluation Findings Executive Summary



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EXECUTIVE SUMMARY

In September 2015, following a yearlong planning period, Partnership HealthPlan of California (PHC), a County Organized Health System providing Medi-Cal coverage for over 500,000 members in 14 northern California counties, launched a six-month community-based palliative care benefit pilot, *Partners in Palliative Care (PIPC)*. The purpose of the pilot was twofold: (1) to test a palliative care program to optimize members' quality of life and (2) to share pilot findings with the California Department of Health Care Services (DHCS) to inform the department on how to structure the Medi-Cal managed care palliative care benefit under Senate Bill 1004. SB 1004 requires DHCS to establish standards and provide technical assistance to Medi-Cal managed care plans, in order to ensure access to palliative care services for Medi-Cal beneficiaries.

The pilot was implemented at four sites: Yolo Hospice (Yolo County), Collabria Care (Napa County), Resolution Care (Humboldt County), and Interim HealthCare (Shasta County). The primary target population consisted of seriously ill PHC Medi-Cal members who have begun, or are likely to begin, using the hospital to manage their late stage disease, and whose providers would generally respond "No" to the question, "Would you be surprised if this patient died within the next year or two?" Pilot sites were required to have an interdisciplinary palliative care team and to implement a service delivery model with a range of services (pain/symptom management, advance care planning, case management, round the clock telephonic support, caregiver assessment and referral, etc.). Services were primarily delivered in the patient's home, over the phone, or, in one team's case, through videoconferencing.

To evaluate the effectiveness and replicability of the PIPC pilot, a qualitative evaluation was conducted using an implementation evaluation approach that focused on collecting and analyzing pilot site and PHC phone and in-person interview, document, and observational data. The primary evaluation objectives were to assess the following: implementation of the service delivery model, identification and enrollment of patients, and sustainability and potential replicability of the pilot global payment model. Evaluation findings were grouped into four thematic areas: Service Delivery Model, Identifying and Enrolling Patients, Global Payment Model, and Pilot Successes. Key findings from each of these categories are presented below:

Service Delivery Model

- Pilot sites unanimously agreed that the service delivery model focus on home and community-based support was responsive to the needs of participants.
- Completing advance care planning (ACP)/Physician Orders for Life Sustaining Treatment (POLST) forms often took more time than expected. The pilot sites believe this was because many program participants were relatively young (30s, 40s, 50s) and were reluctant to specify what actions should be taken for their health, "if they are no longer able to make decisions for themselves because of

illness or incapacity.” Several sites reported they would benefit from staff training on communication skills and having ACP conversations with younger patients.

- All the sites stated that the restricted focus on Medi-Cal beneficiaries for the pilot prevented them from addressing the needs of a larger group of patients: dual eligibles. Dual eligibles are defined as Medicare/Medi-Cal beneficiaries and tend to be medically complex, high utilizers of health care.

Identifying and Enrolling Patients

- The most commonly cited program challenge reported by pilot site and PHC staff was confusion by referring providers about what palliative care is and who would be an appropriate candidate for the PIPC pilot.
- All the sites suggested that PHC has an opportunity to play a more dynamic and significant role in educating members and providers about palliative care and the palliative care benefit.
- The second most commonly cited program challenge was the level and intensity of psychosocial need among pilot patients (housing, substance use, etc.). Addressing these issues required greater social work involvement than anticipated.
- Pilot sites and PHC staff expressed surprise regarding the frequency of cirrhosis of the liver diagnosis (20 percent of participants).

Global Payment Model

- In general, all four pilot sites expressed satisfaction with the per member per month (PMPM) global payment model.
- Several sites recommended PHC consider offering a tiered payment system with higher payments based on psychosocial and clinical acuity.

Pilot Successes

- Significant pilot successes include the ability of teams to work through initial staffing and program operation challenges and to develop collaborative work processes and patient-centered care approaches.

Summary analysis of the evaluation findings led to two compelling conclusions. First, had PHC not devoted substantial staff, resources, and time to carefully planning the PIPC program, in collaboration with several community organizations, there would likely have been more challenges and surprises with implementing the model. PHC’s extensive planning process and understanding of the non-metropolitan and rural communities in which the benefit would be delivered (i.e., rural communities tend to have greater numbers of older, sicker, and poorer residents than their urban and suburban counterparts, as well as high rates of substance abuse and addiction), resulted in the identification and targeting of appropriate health plan members for the benefit, and support for palliative care teams with strong nursing and social work roles.

Second, notwithstanding the few marked areas for improvement and change to the current PIPC model, and the fact that the outcome evaluation will address the financial viability of

the model, the most significant evaluation finding was that pilot sites and PHC staff uniformly endorsed the PIPC model as viable, replicable, and successful.

The following are recommendations to improve future PIPC program operations and implementation:

- **Inform PHC members about palliative care and the PIPC program** through written and electronic communications.
- **Provide PIPC sites with clinical practice guidelines for psychosocial interventions** to respond to enrolled patients with serious psychosocial needs. Host a social work advisory group with pilot site social workers to develop the guidelines.
- **Explore the viability of implementing a tiered payment model**, structuring higher payments for higher levels of clinical and psychosocial care.
- **Select future sites that meet program criteria.** For example, those with a clearly defined interdisciplinary team and community education plan.
- **Continue providing infrastructure and project support** to sites providing the palliative care benefit (e.g., technical assistance, project management support) to promote project continuity and sustainability.