Partners in Palliative Care Pilot Evaluation

James Cotter, MD MPH
County Organized Health System
14 Northern California Counties
560,000 health plan members
MediCal members often die in institutional settings

Place of Death for MediCal members in 2013:

- Hospital inpatient  37%
- Nursing home  26%
- Home  25%
- Hospice  1.4%
403 Patients:

- Hospitalized in last 6 months of life: 76%
- Hospitalized in the last month of life: 45%
- Died in the hospital: 33%
- Multiple admissions in last month of life: 21%

Hospitalization is common at the end of life
General Criteria:

• Hospitalizations or ED visits in the late stage of illness
• Two years or less to live
• Intolerant or declines further therapy
• Willing to do advanced care planning
Covered Diagnoses

Cancer
Cirrhosis
Congestive Heart Failure
COPD
Dementia
Frailty
September 1, 2015 to February 29, 2016

Four practice sites:

- ResolutionCare  Eureka
- Collabria Care  Napa
- Interim Healthcare  Redding
- Yolo Hospice  Davis
## Patient Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>48%</td>
</tr>
<tr>
<td>Cirrhosis</td>
<td>17%</td>
</tr>
<tr>
<td>CHF</td>
<td>8%</td>
</tr>
<tr>
<td>COPD</td>
<td>8%</td>
</tr>
<tr>
<td>Frailty</td>
<td>6%</td>
</tr>
<tr>
<td>Dementia</td>
<td>5%</td>
</tr>
<tr>
<td>ESRD</td>
<td>5%</td>
</tr>
</tbody>
</table>

82 patients enrolled
Phase 1: Implementation
- Developing care teams
- Finding and enrolling members
- POLST

Phase 2: Outcomes
- Hospital and ED use
- Hospice referrals
- Financial analysis
# POLST Rates

<table>
<thead>
<tr>
<th>Pilot Site</th>
<th>Total Patients</th>
<th>POLST Completions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collabria Care</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>ResolutionCare</td>
<td>51</td>
<td>39</td>
</tr>
<tr>
<td>Yolo Hospice</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Interim Healthcare</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>76%</td>
</tr>
</tbody>
</table>
## Outcomes

<table>
<thead>
<tr>
<th>Site</th>
<th>Patients Enrolled</th>
<th>Hospitalizations</th>
<th>ED Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Patients</td>
<td>Encounters</td>
</tr>
<tr>
<td>Resolution</td>
<td>51</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Collabria</td>
<td>20</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Interim</td>
<td>9</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Yolo</td>
<td>7</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Data includes 5 patients enrolled in March 2016
## Utilization Rates by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Member Months</th>
<th>Inpatient</th>
<th>IP/MM</th>
<th>ED</th>
<th>ED/MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution</td>
<td>130.4</td>
<td>21</td>
<td>0.16</td>
<td>19</td>
<td>0.15</td>
</tr>
<tr>
<td>Collabria</td>
<td>56.2</td>
<td>4</td>
<td>0.07</td>
<td>6</td>
<td>0.11</td>
</tr>
<tr>
<td>Yolo</td>
<td>13.7</td>
<td>5</td>
<td>0.36</td>
<td>3</td>
<td>0.22</td>
</tr>
<tr>
<td>Interim</td>
<td>11.7</td>
<td>3</td>
<td>0.26</td>
<td>3</td>
<td>0.26</td>
</tr>
<tr>
<td></td>
<td>212</td>
<td>33</td>
<td>0.16</td>
<td>31</td>
<td>0.15</td>
</tr>
</tbody>
</table>
Yolo Hospice by Month

- **Sept**: Patients, Hospital, ED
- **Oct**: Patients, Hospital, ED
- **Nov**: Patients, Hospital, ED
- **Dec**: Patients, Hospital, ED
- **Jan**: Patients, Hospital, ED
- **Feb**: Patients, Hospital, ED

Legend:
- **Patients**: Orange bars
- **Hospital**: Gray bars
- **ED**: Yellow bars
ResolutionCare by Month

- Patients
- Hospital
- ED

- September
- October
- November
- December
- January
- February
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%
“We feel blessed to have this team working with us”
“They genuinely care for us and we for them”
“There is no other service like this”
“Outstanding individuals”
Early Findings:
• Identifying and enrolling members was the major challenge
• Intensity of psychosocial needs surprised the care teams
• High frequency of patients with cirrhosis was not expected
• POLST took a lot more work and time than anticipated
Global payment (PMPM) worked well
Home based care met our member’s needs
Very high satisfaction rates for patients and families
Challenges going forward

Identifying and enrolling members
Developing a referral system
Advanced care planning and POLST completion
Care teams with strong social services component
Meeting the Psychosocial Needs:

- Poverty
- Alcohol and drug use
- Behavioral health needs
- Limited or no family support
- Housing security and homelessness
Early Data Analysis

Pre and Post Palliative Care Management
- Decrease in Hospital Costs
- Decrease in Total Plan Costs

Comparison to Controls
- Decrease in Hospital Costs
- Decrease in ED Costs
- Decrease in Total Plan Costs
“It does not take long to recoup the start-up costs since the costs of usual care are so exorbitant”
September 1 DHCS Update:

- April 2017 start date
- One year life expectancy
- Four covered diagnoses
- No state funding
Predicting Life Expectancy

- Karnofsky Performance Status
  - Functional capacity
  - Predicts disability more than death

- Palliative Performance Scale
  - Correlates well with median survival for cancer patients
  - Score of 70 = \text{108 to 145 day} median survival

- Palliative Performance Index
  - Points based on PPS, oral intake, edema, dyspnea, delirium
  - Score over 6 indicates survival of less than \text{3 weeks}

- FAST Scale for Dementia
  - Stage 7 (very severe cognitive decline) = \text{2.5 year} average survival
Predicting survival is hard
• Scales are more accurate at the very end of life
• Very difficult to predict a “late stage of illness”

Pilot program survival
• Median survival for decedents was 61 days
• Many longer term survivors (mainly CHF, COPD patients)
Four Covered Diagnoses

- **Cancer**
  - Stage III or IV: Karnofsky <70 or failed 2 lines of chemotherapy
- **Liver Disease**
  - Albumin <3.0 and INR >1.5 plus comorbidities or MELD >19
- **CHF**
  - Hospitalization or NYHA class III, LVEF <30% or comorbidities
- **COPD**
  - FEV1 <35% and on oxygen
California MediCal Decedent Data

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>MediCal 2013</th>
<th>PPC Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>28.2%</td>
<td>48%</td>
</tr>
<tr>
<td>Accidents</td>
<td>15.6%</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>14.4%</td>
<td>8%</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>6.4%</td>
<td>17%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.4%</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>3.3%</td>
<td>8%</td>
</tr>
</tbody>
</table>
PHC: SB 1004 Going Forward

- Global Payment by PHC
  - Monthly base payment
  - Incentive payments for POLST and hospitalization avoidance

- Reviewing the covered diagnoses over time
  - Are the four diagnoses too limiting?

- Working with the One-Year Life Expectancy

- Hospital cost savings = Program sustainability