Palliative Care Across Markets

California Association of Health Plans

Palm Desert, California
October 20, 2015
AGENDA

• Introductions
• Marv Gordon - Palliative Care Overview
• Anne Kinderman – Medi-Cal
• Ken Rosenfeld – Medicare Advantage
• Marv Gordon – Piloting A Health Plan Palliative Program in San Diego
• Questions & Answers
Marvin J. Gordon, M.D. – Regional Medical Director, Health Net, lead medical director, San Diego palliative care pilot

Anne Kinderman, M.D. - Assoc. Clinical Professor of Medicine, UCSF; Director of Supportive & Palliative Care Services, San Francisco General Hospital

Ken Rosenfeld, M.D. -- Senior Investigator, Advanced Illness & Palliative Care, Sutter Health Research, Development, & Dissemination Group
Palliative Care

OVERVIEW

Marvin J. Gordon, M.D., FACP

Health Net
% population - % cost

5% population generates 60% health care cost

49% catastrophic- only 1 year of high cost
11% costs are in the last year of life
40% consistently high cost – chronic disease

11% of 5% of population = 0.55% total population
11% of 60% of health care costs = 6.6% total cost
Palliative Care

- Specialized medical care for people with serious illness. This type of care is focused on providing patients with relief from symptoms, pain, and stress from the serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment.
## Transition of Focus

<table>
<thead>
<tr>
<th>COMPLEX CASE MANAGEMENT</th>
<th>PALLIATIVE CARE</th>
<th>HOSPICE</th>
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<tbody>
<tr>
<td>Chronic and/or Complex Disease</td>
<td>End of Life 1-2 years and/or Chronic/ Complex Disease</td>
<td>End of Life 6 months</td>
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<tr>
<td>Concurrent with curative</td>
<td>Symptom Relief Concurrent with Curative</td>
<td>Symptom Relief NO Curative (for terminal illness)</td>
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<tr>
<td>PCP and Specialist</td>
<td>PCP, Specialist, and Palliative Consultant</td>
<td>Hospice Team including Physician</td>
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<tr>
<td>Complex Case Management (CCM) RN /SW</td>
<td>Integrated Team Approach MD/NP/RN/SW</td>
<td>Integrated Team plus aides, chaplain, plus respite benefit</td>
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<td>Focus: Curative treatment by usual medical team with support for psycho-social issues</td>
<td>Focus: Transition from curative only to symptom management and goals of care</td>
<td>Focus: Symptom relief by the Hospice team with NO curative treatment of the terminal illness</td>
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Marvin J. Gordon, M.D., FACG 2014
Bereavement starts long before death

Curative is mostly managed by usual health care team – case management may help to coordinate
Trajectory of Functional Decline
The Palliative Care Model

• Place of service
  – Hospital based (end of life; pain)
  – Clinic based
  – Community (home) based

• Referral source
  – Real time direct referral
  – Claims data mining
Major Referral Criteria

Utilization (using the hospital and ED to manage their condition)
• Two or more hospitalizations within the last six months
• Two or more Emergency Room visits within the last six months

Code Status / Advanced care planning / POLST
• DNR
• Artificial Nutrition
• Other treatments (vent, dialysis, hospitalization)

Diagnosis
• Prognosis of progressive disease with a < 12-24 month life expectancy

Symptoms
• Has symptoms that are out of control

Support
• Psychological, financial, social (including caregivers) or other serious care planning issues related to illnesses

Top 1% (claims data mining)
Pediatric Palliative Is Different

• High claims do not necessarily find palliative candidates
  – Sick neonates highest cost
  – Lot of catastrophic (trauma, burn, complicated append)
  – Medi Cal high cost often goes to CCS
• Illness may be more chronic
• Illness better identified by ICD-9-10 codes
• Whole family involved including siblings
• Children have limited skills for verbal expression
  – Art, music, play therapies; child life specialist
• Chronicity and expanded services affect ROI
• Prognosis determination is difficult
"There's no easy way I can tell you this, so I'm sending you to someone who can."
Palliative Care for Medi-Cal beneficiaries

Anne Kinderman, MD
Director, Supportive & Palliative Care Service, San Francisco General Hospital
Associate Clinical Professor of Medicine, UCSF
Realities of Palliative Care

Aging Population
Life with multiple chronic illnesses
Recognition of benefits of PC

Few certified providers
Prohibitive payment structures

NEED/Demand
SUPPLY
Mismatch even greater for vulnerable populations

<table>
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<th>NEED</th>
<th>SUPPLY</th>
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<td>• Present with advanced illness</td>
<td>• Fewer public hospitals (nationwide) offer palliative care</td>
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<td>• Limited margin (social support, caregiving, finances)</td>
<td>• Very limited community-based PC services in CA safety net</td>
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<td>• Risk may be underappreciated in prognostic models</td>
<td>• Even fewer culturally-concordant PC providers</td>
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Palliative Care disparities among vulnerable populations

• Blacks, Latinos less likely to enroll in hospice
• Low health literacy is associated with less advance directive completion, less certainty about choices
• Latinos, Asians less certain than Whites in choosing wishes in advance
• Low advance directive completion rates despite targeted intervention

Cohen LL, 2008 J Palliative Med
Waite, 2013 J Am Geriatrics Soc
Sudore, 2011 J Health Communication
Sudore, 2008 J Am Geriatrics Soc
New Legislation to reduce disparities: SB 1004

• Signed into law September 2014
• Builds off success of pediatric palliative care initiative
• Mandates access to palliative care for Medi-Cal beneficiaries in managed care plans
• Requires Dept of Health Care Services to provide technical assistance to plans and develop standards
Questions Raised by Plans

• What conditions will be included?
• What services will be required?
• Who can provide palliative care services?
• What is the timeline for implementation?
• What will happen to plans who are already providing palliative care services/benefits?
• Will vulnerable populations view these benefits negatively?
SB 1004: What we know so far

• Condition(s) included
  – “Late stage/high-grade cancer with significant functional decline or limitations”
  – (Other conditions can be covered, if already providing services)
  – (DHCS plans to re-evaluate after outcomes data is available, may expand to other conditions in the future)
SB 1004: What we know so far

• Services included
  – Hospice services (concurrent)
  – Palliative care consultation
  – Advance Care Planning
  – Care Coordination/interdisciplinary team assessment and care plan development

• Population: Medi-Cal managed care only
SB 1004: To be determined

• Proposed providers
  – Home health, hospice
  – CBAS

• Performance monitoring, outcome measures
  – Considering pay-for-performance components

• Timeline

• Program expansion
  – Additional eligible conditions
  – Medi-Cal FFS, Dual-eligible
SB 1004: Technical Assistance

• Planning, program development resources
  – California HealthCare Foundation CBPC Resources
    • http://www.chcf.org/projects/2015/cbpc-resource-center

• Palliative Care Workforce development
  – CSU Institute for Palliative Care
    http://csupalliativecare.org/programs/

• Patient Care tools, continuing education
  – Coalition for Compassionate Care of California
    http://coalitionccc.org/#

• Evidence base for community-based PC
SB 1004: Who pays?

• DHCS aims to develop a Medi-Cal palliative care policy that, to the extent practicable, is “cost-neutral to the General Fund on an ongoing basis.”

• Expect up-front investment, downstream cost savings

• Many plans have developed alternative payment structures (e.g. PMPM payment to palliative care/hospice provider)
The Cost of Delaying Palliative Care

Average direct cost per inpatient admission by month, final 6 months of life; 290 solid tumor cancer patients

Scibetta, Kerr, McGuire, Rabow, 2015
End of Life Utilization Patterns at SFGH

Utilization among 403 cancer patients in the last 6 months of life

- 76% Hospitalized in the 6 months preceding death
- 45% Hospitalized in the final month of life
- 1/3 Died in the hospital
- 21% Multiple admissions in the final month of life
- 4% Died within 3 days of discharge
- 47% had ED visits in the final month of life, including 11% with multiple visits
- 16% had a stay in an Intensive Care Unit in the final month of life
- **Average direct costs per final month of life admission $25,800**
- **Direct costs for inpatient admissions in the final month of life (only) > 4.7mil**

Harris H et al., Making the Case: Is Outpatient Palliative Care for Oncology Patients Feasible within the Safety Net? 2014 AAHPM/HPNA Annual Assembly
Making the Case: Early PC at SFGH

• About 1/3 of patients who die of cancer present early enough (>3 months prior to death) to be referred to an OP PC clinic

• Based on analysis, OP PC clinic could expect to make an impact on 50 patients/year

  Expect 40% reduction in inpatient utilization (38 admissions)

  Expected cost avoidance: $846,450
The Cost of Doing Business

• Would only need 0.2 FTE for team to see expected patient volume in 2 half-day clinics/week
• Salary for MD, APRN, SW + 17% Benefits = $88,290

$846,450
Direct costs avoided

$88,290
Staffing Cost

$846,450 - $88,290 = 10x ROI!!
Expanding Palliative Care for Medi-Cal Beneficiaries