NHPCO Practice Report

Palliative Care Management Services in a Medicare Social HMO

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Background

Elderplan, a Medicare Social HMO in New York City currently serves 14,000 frail community-dwelling elderly members. The Social HMO, unlike the traditional Medicare HMO, couples a broad range of community-based chronic care benefits with an extensive medical benefit package, which helps maintain the frail elderly in their homes. Elderplan is a participating agency of the Metropolitan Jewish Health System (MJHS).

In 2000, under a grant from the United Hospital Fund, MJHS created its Quality of Life program, a community-based palliative care service for older adults living with advanced illness. In 2002, MJHS expanded its Quality of Life program into Elderplan. The program utilizes a specialized, interdisciplinary care management intervention to deliver palliative care services to patients living with advanced, chronic illness who are not enrolled in hospice. The program’s goals are to improve quality of life, facilitate dignified end-of-life care and decision-making processes, and reduce inappropriate health care utilization. The Quality of Life palliative care program emphasizes patient education and self-management, referrals, patient monitoring across settings, and physician education.

A comprehensive evaluation of the first two years of the program is near completion. Findings thus far have shown significant improvements in quality-of-care components, such as pain and symptom status, hospice length of stay, and intensive care unit (ICU) utilization rates at the end of life. This report presents some of these preliminary findings.

Intervention

Elderplan’s palliative care service employs a nurse/social work team to provide care management for palliative care services. The team works with patients, their families and providers to identify medical, emotional and functional needs, then develops a care plan and facilitates access to necessary services. The palliative care team also addresses the complex effects of advanced illness on an individual’s life, and helps patients identify and address anxiety, fear, depression and isolation caused by advancing illness and age. The palliative care team contracts for a wide range of professional services, such as home health nursing, physical therapy, durable medical equipment, and transportation, as well as making referrals to community resources. The team has provided palliative care management services to over 300 patients since 2002, typically following them until death, enrollment in hospice, or until they no longer are appropriate for palliative care.

Patients are selected for palliative care through referrals from care managers, physicians, families, and hospitals, and through record review—drawing upon pharmacy, laboratory and other claims records. Patient diagnoses include advanced congestive heart failure, chronic obstructive pulmonary disease, stroke, and cancer. Upon admission, and every 90 to 180 days thereafter, the team administers a comprehensive assessment instrument adapted
from the Supportive Care of the Dying Coalition for Compassionate Care version of the City of Hope Patient Questionnaire. The results are used as the basis for planning care, as well as measurement points for outcomes evaluation. Caregivers, family members and doctors are also integrated into the planning process to help patients comply with their medication and treatment regimens, identify goals of care, communicate with their care providers, and make independent choices.

Elderplan controls where and how health care dollars are spent, which makes the provision of palliative care somewhat easier as payment barriers are virtually eliminated. Elderplan’s palliative care service draws upon plan benefits to improve quality of life for plan participants, and frequently extends Elderplan’s unique supportive in-home service benefits beyond typical coverage limits to ensure continuity of care. For example, the team will supplement home health aide/personal care services for hospice patients to ensure that 24-hour coverage is provided, purchase specialized equipment (e.g., portable oxygen and IV medication pumps), or pay for palliating radiation therapy that hospice may not cover.

Results

The palliative care program evaluation design includes service utilization, quality of care, and self-reported quality-of-life-related measures. The evaluation, which is still in progress, is using multiple comparison groups in the absence of a randomized control group. The comparison groups include Elderplan enrollees receiving other forms of care management and Elderplan enrollees not receiving care management, but with relatively high risk scores according to a leading medical risk grouping program. Analyses of subjective measures, such as pain and symptom status and communication with providers, are being done with data gathered from palliative care enrollees, using a pre-post program enrollment comparison.

During the 2-year study period, 54% (20 of 37) of palliative care enrollees died at home and/or under hospice care. Hospice length of stay during the study period ranged from 5 days to 288 days, with an average of 100 days. Palliative care enrollees who died had very low Intensive Care Unit utilization in their last month of life and in the 6-months before death: approximately one stay for every fifty member months. In contrast, deceased members of the non-care managed comparison group had significant increases in ICU utilization in the last 6-months and 1-month periods prior to death, with about one ICU stay for every seven members in the last month of life (Table 1). These differences are even more striking when two additional factors are considered: 1) palliative care patients were generally sicker at baseline than the non-care managed patients; and 2) not all of the palliative care patients were under care management for the entire study period.

Comparison of baseline results of self-reported patient questionnaire items to results following three months of palliative care showed better management of pain and symptom distress and improved communication between patient and physician. We found sizeable and significant improvements in pain ratings. On a standard 0-10 scale, mean ratings decreased from 5 to well under 2 over three months of palliative care management. This improvement was maintained in subsequent assessments. Figure 1 details the improvements found in other areas, including problematic sleep patterns, disinterest in eating, communicating care wishes, and problems getting information about care and treatment options.

Comment

The high prevalence of chronic, life-limiting illness among Medicare participants poses a

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<th>ICU Utilization in the Last Year of Life</th>
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<td>ICU Stays per Month</td>
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<td>Months 12–7 before death</td>
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<td>Palliative Care Decedents</td>
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<td>Non-Care Managed Decedents</td>
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Figures represent mean number of ICU stays per month. Repeated measures Analysis of Variance (ANOVA) was used to compare ICU utilization for the last six months of life and the last month for palliative care enrollees and non-care managed patients, using months 12 through 7 before death as a baseline. Differences between months 12 through 7 and the last six months were statistically significant at the p = 0.002 level; between months 12 through 7 and the last month at the p = 0.001 level, and between the last six months and the last month at the p = 0.001 level.
challenge for managed care plans serving this population. However, the potential for managed care to provide comprehensive, coordinated, and appropriate care for elderly individuals with advanced progressive chronic illness has been noted by a number of authorities in end-of-life care. Special programs within managed care organizations and demonstration projects have shown the feasibility of mixing preventive, restorative, and palliative care, and have achieved positive patient outcomes. In addition, managed care Medicare enrollees have higher rates of hospice use than fee-for-service Medicare beneficiaries and are less likely to die in the hospital.

**Implications for Practice**

Managed care’s organizational structure, use of provider networks, ability to configure services to individual need and ensure continuity of care, utilization controls, and systematic accountability make the provision of quality end-of-life care an achievable undertaking. Elderplan sought to bring all these tools to bear beginning in 2002 as part of a program providing palliative care management services to members with advanced illness. In the two years of providing palliative care services, we have found a profound need for comprehensive care management among people with advanced illness. Through examination of initial results of our program evaluation, we have also found that multiple significant improvements in quality of care can be achieved by taking an “upstream” and comprehensive approach to provision of palliative care services.

**References**

8. Meeting the Challenge: Twelve Recommendations for Improving End-Of-Life Care in Managed Care. National Task Force on End-Of-Life Care in Managed Care and the Education Development Center, Inc. 1999;3–10.