

ISSUE BRIEF:

SERIOUS ILLNESS STRATEGIES FOR MEDICARE SPECIAL NEEDS PLANS

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Medicare Special Needs Plans are responsible for ensuring high quality, cost-effective care for special populations, including large numbers of people with serious illness*— and palliative care is one of the few proven approaches to meeting that responsibility. As more plans develop and expand palliative care supports consistent with the strategies outlined in this issue brief, more of our nation’s citizens will be spared the repeated crises, revolving door hospitalizations, and distress that are still too common today. While palliative care applies to all three SNP types (D, C and I), as well as Medicare-Medicaid dual-demonstration plans, Institutional Special Needs Plans have a particular role in transforming care given the congregate settings; the access to staff, residents and families; and the burden of both chronic conditions and functional limitations faced by this population.

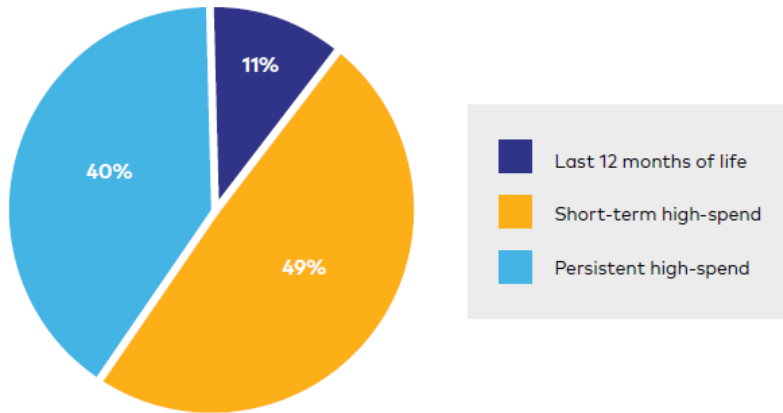
A Common Problem with an Effective Solution

Individuals with serious illness—such as cancer, advanced heart disease, and dementia—face heightened risk of preventable hospitalization. It is common knowledge that 5% of Americans account for 50 percent of all U.S. health care spending – a relationship that has been stable for over a generationⁱ. A closer look at this spending reveals that the majority of crisis emergency department visits and hospitalizations (excluding pneumonia) are due to exacerbations of pre-existing and chronic symptoms – such as shortness of breath in COPD or chest pain in cardiac illnessesⁱⁱ. Another recent study found that, among cancer patients, those with the highest physical and psychological symptom burden had significantly longer hospital lengths-of-stay and greater likelihood of readmissionⁱⁱⁱ.

Much of America’s current health care system remains ill-equipped to appropriately care for the symptoms and stresses of serious illness. Surveys of physicians found that a full two-thirds of medical practices lack systems to assess patients’ wishes^{iv} or adequately assess symptom burden^v. **These gaps leave patients and families with few viable options for relief, save calling 911 or visiting the emergency department.** Once there, the severity of their underlying illness and their distress often result in admission, where too many of these patients experience further decompensation.

It’s important to note that this high spending is not limited to those who have a terminal diagnosis. Of the top 5% of health care utilizers in the United States, only 11% are in their last year of life, with a full 40% facing year after year of high utilization^{vi}, as illustrated in the figure below:

* Serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or quality of life or excessively strains their caregivers.



Fortunately, a growing number of health plans are adopting new serious illness strategies – addressing both patient and family communication about care priorities and symptom management – which are having a significant positive impact on member quality-of-life, while improving both satisfaction with the plan and its medical expense ratio. Consider these published results from the Aetna Medicare Advantage Compassionate Care program, a program that has been in place since 2004:^{vii}

- 81% decrease in acute care days
- 86% decrease in ICU days
- \$12,600 net savings per participating member
- High member satisfaction scores
- No patient complaints in 10 years

Thanks to leading organizations like Aetna, Cambia-Regence, Blue Shield of California, and others across the country, we’ve learned that it’s both better medicine and better economics to change our approach to serious illness care. Drawing lessons from these leading organizations, the Center to Advance Palliative Care (CAPC) recommends six proven strategies:



Each of these strategies is described below.

1. Proactive Identification

Changing the approach to care for the population with serious illness requires that they be identified early in the course of the care trajectory. There is general agreement that the population at risk of unnecessary suffering can be **identified through a combination of three key types of variables: diagnosis, functional impairment, and past health services utilization**. Functional impairment – meaning limitations in activities of daily living – may be difficult to assess through claims, and therefore some plans use durable medical equipment (DME) authorizations as an identifier^{viii}. Polypharmacy, such as more than nine medications, is another good early identifier. The vast majority, if not all, ISNP members could be considered seriously ill^{ix}.

2. Member Engagement and Assessment

Once identified, seriously ill patients and their families need to interact with carefully hired and well-trained **nurses and case managers skilled in clarifying patient and family care priorities, and helping to match treatments and services to those goals**. Equally important is the ability to conduct comprehensive assessments to identify the issues that directly impact functioning and well-being, rather than focusing on organ systems and diseases. Assessment must include:

- Pain and symptom burden
- Psychological issues, including worry, stress, anxiety, and depression
- Family caregiver burden and capacity
- Social, financial and practical issues
- Spiritual concerns

3. Services and Benefit Design

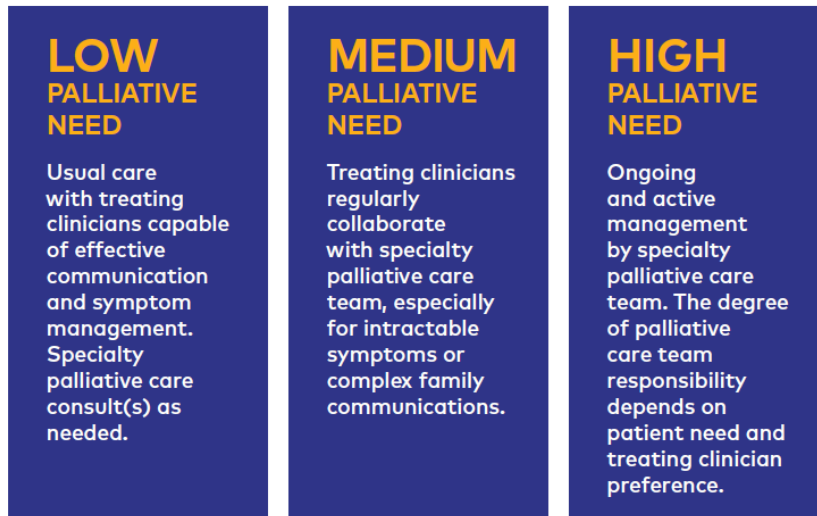
Care plans can only match seriously ill patients to needed services to the extent the health plan makes them available and accessible. At minimum, seriously ill patients and their families require:

- **24/7 and timely clinical response for pain and symptom exacerbations**, including in-home response when necessary
- **Assistance with activities of daily living**, such as personal care and sometimes housekeeping
- **Caregiver training, support, and counseling** to equip families for the responsibilities placed on them
- **Access to social and spiritual supports**, which can incorporate benefit changes and/or referral to high-quality resources in the community

Enabling concurrent hospice and curative care for selected populations may be a good way to prevent symptom crises and ED/hospital utilization.

4. Provider Network – Competencies and Access to Palliative Care Specialists

All clinicians that care for the seriously ill – including oncologists, cardiologists, neurologists, and primary care practitioners – should have core knowledge and skills in palliative care, including how to have serious conversations, clarify goals of care, and effectively manage pain and other symptoms. **Health plans can help close the skills gap by recognizing and financially rewarding providers who have successfully completed training or certification**. A recent [blog](#) highlights educational organizations that can provide such training.



At the same time, plans must ensure access to palliative care specialists and programs, for the most complex of their population. The website, getpalliativecare.org, can help plans to locate palliative care programs in all settings.

5. Payment and Incentives for your Network Providers

Health plans can encourage their provider network to acquire palliative care skills and create/expand specialty palliative care capacity through payment. Plans can pay enhanced care management fees to primary care practices to support psycho-social services, and/or they can pay case rates for a defined set of specialty palliative care services – an approach that is growing in popularity. **Quality bonuses and other financial incentives can be established for network providers that complete designated training programs and/or achieve palliative care certification**, such hospitals who secure [The Joint Commission’s Advanced Certification in Palliative Care](#).

6. Measurement and Evaluation

As above, health plan quality programs should focus on network provider competencies in serious conversations, symptom management, and palliative care programming. Other important serious illness measures include **rates of assessment for things like symptom burden or caregiver burden, rates of advance care planning conversations and documentation, and patient experience scores.**

Palliative Care and Institutional Special Needs Plans

Institutional Special Needs Plans (ISNPs) present a unique opportunity to improve the care of their members through a palliative care approach. As noted, the vast majority of the eligible population are in need of some palliative care services, and the clinical staff already have significant and trusted access to the patient and family for engagement and assessment.

When clinical staff rely on palliative care skills in their interactions with residents, families, and the nursing home staff, the results are compelling*. For example:

- A 30-facility multi-state system that introduces a skilled palliative care clinician into the care planning process by identifying the most complex patients, assessing symptoms, and holding goals-of-care conversations found a sizable reduction in Part A spending, including a significant decline in readmissions.
- The OPTIMISTIC program, a CMMI awardee, provides extensive and ongoing training to the staff of 19 facilities on symptom assessment and management as well as advance care planning, and also provides skilled palliative care clinicians as support, generated an average savings of nearly \$1,600 per resident per year.

- A study of 46 nursing homes across North Carolina and Rhode Island found that palliative care consultation addressing symptom control resulted in fewer hospitalizations, with the even less utilization the earlier the consultations took place.
- According to its leaders, a good deal of the success of the original Evercare ISNP model was due to the palliative care skills of the plan's clinical staff.

The most effective strategy for ISNPs is to equip their clinical staff with shared decision-making skills, assessment resources, and practice in modifying the care plan so that care aligns with the highest priorities of the resident and family. Resources for nurse training and support include the Center to Advance Palliative Care, Hartford Institute of Geriatric Nursing, End-of-Life Nursing Education Consortium, and many others – see [this blog](#) for more information.

ⁱ Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality. The Concentration of Healthcare Expenditures and Related Expenses for Costly Medical Conditions. Statistical Brief #455 (October 2014).

ⁱⁱ Healthcare Utilization and Cost Project, Agency for Healthcare Research and Quality, Overview of Emergency Department Visits in the United States, 2011. Statistical Brief #174 (June 2014).

ⁱⁱⁱ Nipp RD, A El-Jawahri, SM Moran, et al. The Relationship Between Physical and Psychological Symptoms and Health Care Utilization in Hospitalized Patients with Advanced Cancer. *Cancer* (2017): 123(23)

^{iv} PerryUndem Research, "Physicians' Views Towards Advance Care Planning and End-of-Life Conversations." (April 2016).

^v Agency for Healthcare Research and Quality, Assessment Tools for Care. (April 14, 2016).

^{vi} Aldridge, MA and AS Kelley. The Myth Regarding the High Cost of Health Care" *Am J Public Health* (2015): 105(12)

^{vii} Krakauer, R, C Spettell, L Reisman, et al. Opportunities to Improve the Quality of Care for Advanced Illness. *Health Aff*, (2009): 28(5).

^{viii} Faurot KR, Jonsson Funk M, et al. Using Claims Data to Predict Dependency in Activities of Daily Living as a Proxy for Frailty. *Pharmacoepidem Drug Saf* (2015): 24(1)

^{ix} Center to Advance Palliative Care. Improving Palliative Care in Nursing Homes. (2008)

^x Miller, SC, JC Lima, O Intrator, et al. "Palliative Care Consultations in Nursing Homes and Reductions in Acute Care Use and Potentially Burdensome End-of-Life Transitions." *J Am Geriatr Soc*, (2016): 64(11); RTI International, Evaluation of the Initiative to Reduce Avoidable Hospitalizations Among Nursing Home Residents: Final Report (September 2017); Carlson MDA, Lim B, Meier DE. Strategies and Innovative Models for Delivering Palliative Care in Nursing Homes. *JAMA* (2011): 12(2)