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Healthier living
Financial well-being
Intelligent solutions

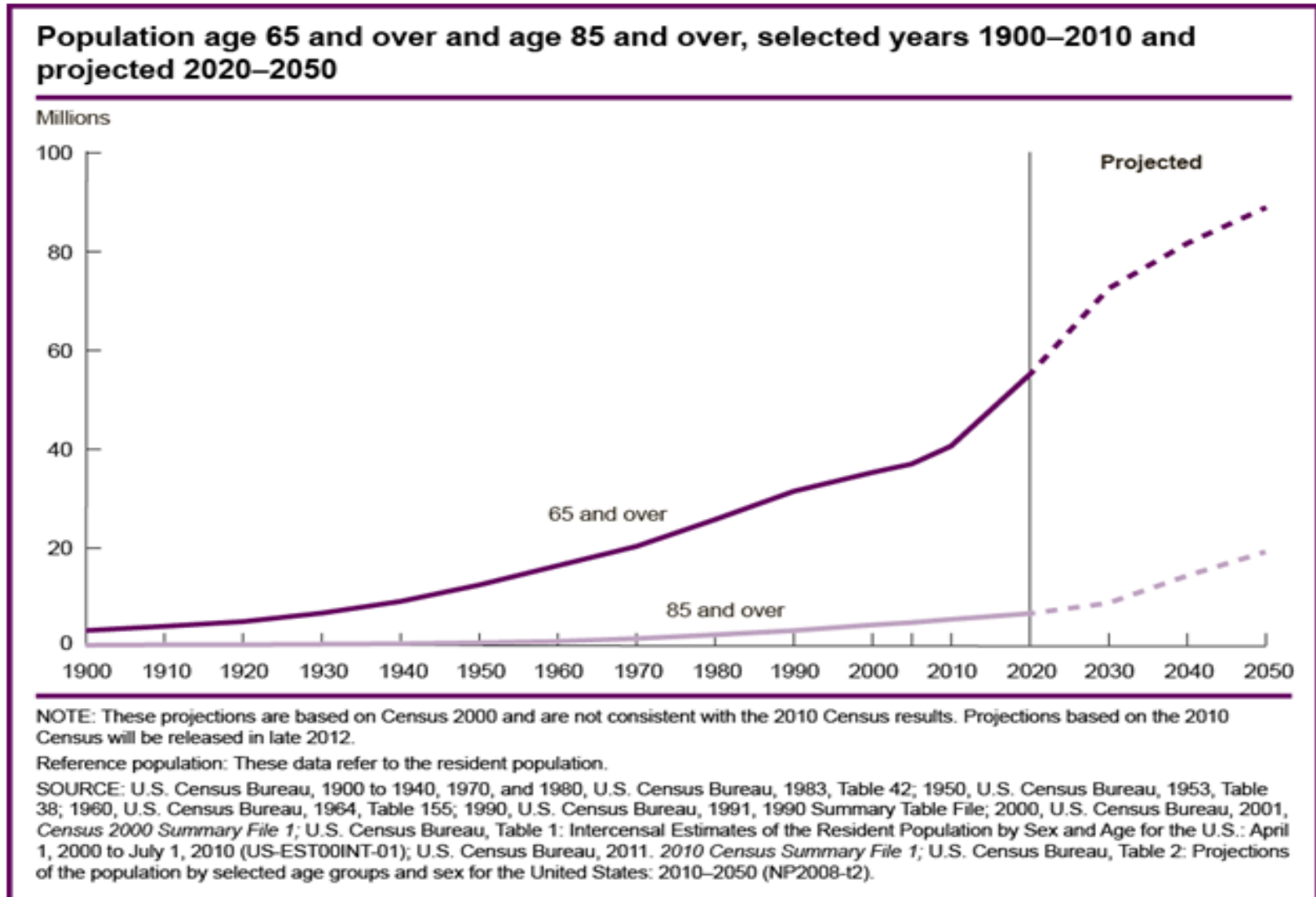


Advanced illness care coordination: A case study on Aetna Compassionate CareSM program

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Date



The aging demographic



Death in the United States

- Most deaths occur in elderly adults¹
- Seriously ill patients spend most of their final months at home¹
 - But most deaths occur in the hospital or nursing home
 - Whereas most Americans would prefer to die at home
- Location of death varies regionally ²
 - Portland, OR: 35% in hospitals
 - New York City, NY: 70% in hospitals



¹ Grunier A, Vincent M, Weitzen S. et al. Where people die: A multilevel approach to understanding influences on site of death in America. *Medical Care Research and Review*, 2007, (64): 351-378. Available at:

www.sagepub.com/frankfort-nachmiasstudy5/articles/Chapter10gruneirandmore.pdf Accessed June 6, 2013

² Tolle SW, Rosenfeld AG, Tilden VP. et al. *Annals of Internal Medicine*, 2009, 130 (8): 681-685. Available at: www.ncbi.nlm.nih.gov/pubmed/10215565. Accessed June 6, 2013.

The health continuum

- Advanced illness: persons who have one or more conditions that progress enough that general health and functioning decline, and treatments begin to lose their impact
- Healthy persons → Early-stage chronic condition(s) → Serious, progressive conditions limiting daily activities → Advanced illness and hospice-eligible

Geriatric conditions and quality scores:¹ How does advanced illness rate?

- Assessing Care of Vulnerable Elders (ACOVE) quality indicators: identified significant quality and care gaps, and opportunities that might be addressed in managing care in Medicare populations

Geriatric conditions and quality indicators	
<i>Condition</i>	<i>% QIs Passed</i>
Malnutrition	47
Pressure ulcers	41
Dementia	35
Falls, mobility disorders	34
Urinary incontinence	29
End-of-life care	9

¹Wenger NS, Solomon DH, Roth CP. et al. *Annals of Internal Medicine*. 2003; 139 (9) 740-747. Available at: [www.mms.org/workilies/mmc_services/geriatrics/Quality Medical Care Provided Vulnerable-Dwelling Older Patients.pdf](http://www.mms.org/workilies/mmc_services/geriatrics/Quality_Medical_Care_Provided_Vulnerable-Dwelling_Older_Patients.pdf). Accessed June 6, 2013.

Important factors to patients at end of life

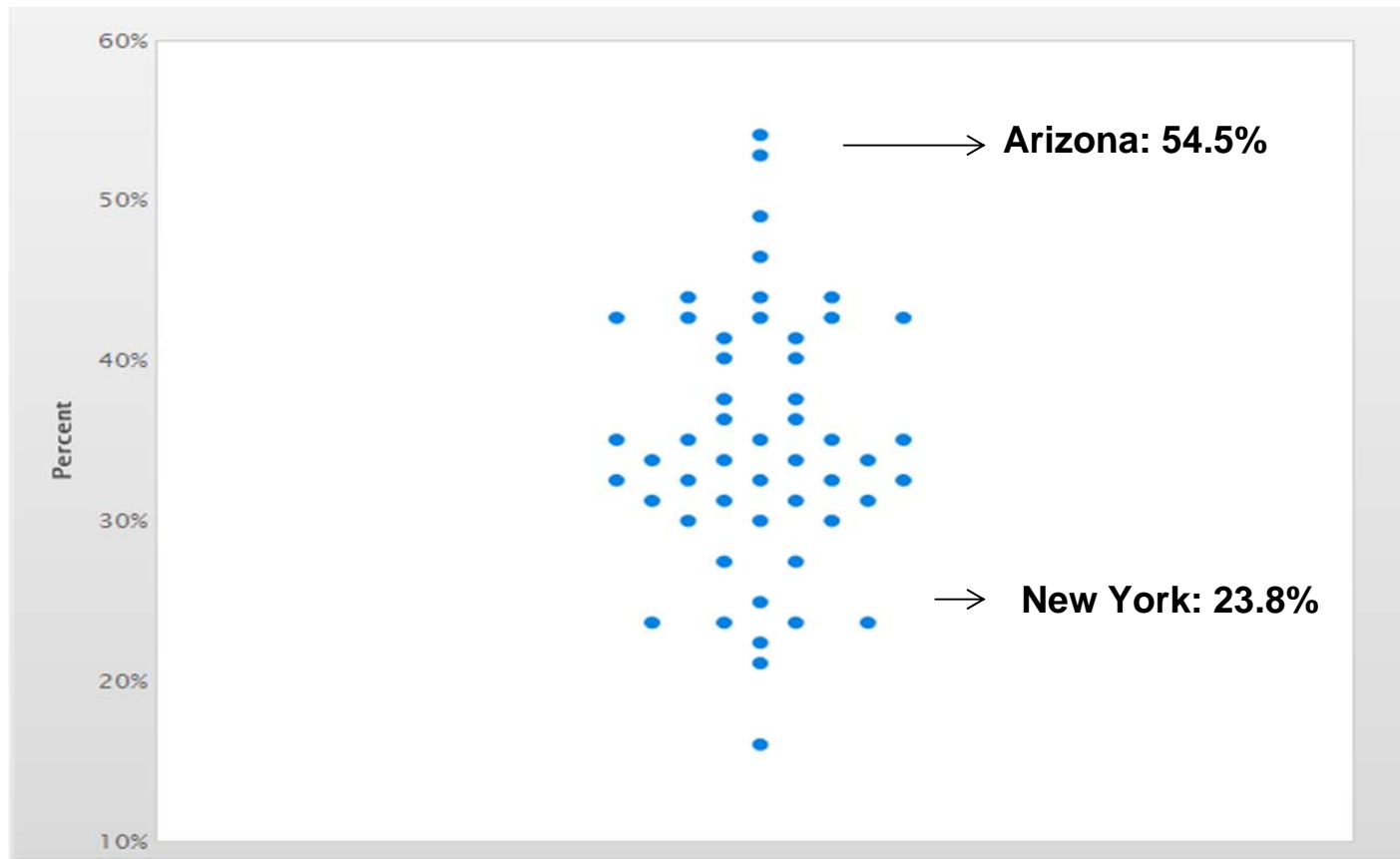
9 ranked attributes from most to least important (per patient responses):¹

1. Freedom from pain
2. At peace with God
3. Presence of family
4. Be mentally aware
5. Treatment choices followed
6. Finances in order
7. Feel life was meaningful
8. Resolve conflicts
9. Die at home

¹ Steinhauser KE, Nicholas AC, Clipp EC. et al. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000; 284:2476-2482. Available at: christakis.med.harvard.edu/pdf/publications/articles/045.pdf. Accessed June 6, 2013

Variations in end-of-life care: Dartmouth Atlas of Health Care

Percent of decedents enrolled in hospice during the last 6 months of life (2003-2007)

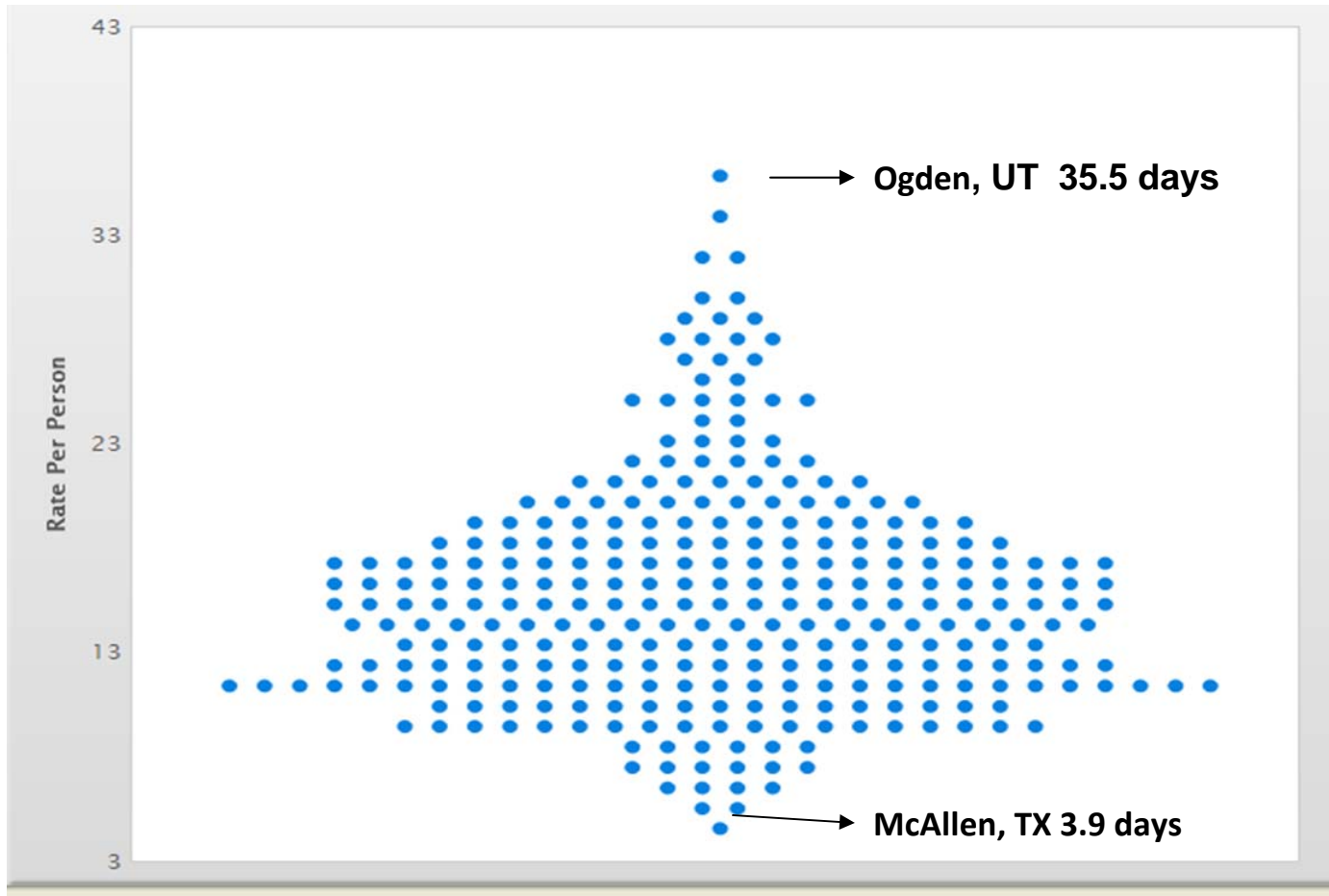


Rates are adjusted for age, sex, race, primary chronic condition, and the presence of more than one chronic condition using ordinary least squares regression.

• U.S. State

Variations in end-of-life care: Dartmouth Atlas of Health Care

Hospice days per decedent during the last 6 months of life (2003-2007)



Rates are adjusted for age, sex, race, primary chronic condition, and the presence of more than one chronic condition using ordinary least squares regression.

● Hospital Referral Region

Where are we?

- **Shortage of specialized expertise**

Compare: 1 oncologist to every 141 newly diagnosed cancer patients
vs. 1 palliative medicine doctor to every 1,200 patients with
serious or life-threatening illnesses.¹

- **Hospital-based palliative care — increasing access**

Since 2008, 19% increase in palliative care teams in hospitals.
85% of large (>300 beds) hospitals have teams.¹

- **Resources:** Approximately 25-30% of Medicare costs incurred in last year of life; in last month, 80% of expenditures are for hospitalization.²

¹ Center to Advance Palliative Care. *America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals*. NY: 2011. Available at: reportcard.capc.org/pdf/state-by-state-reportcard.pdf. Accessed May 28, 2013.

² Lubitz J, Riley GF. Trends in Medicare payments in the last year of life. *New England Journal of Medicine* 1993; 328 (15): 1092-1096. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC2838161/pdf/hesr0045-0565.pdf. Accessed May 29, 2013.

What do we need to do?

Align goals: Health system and people's wishes

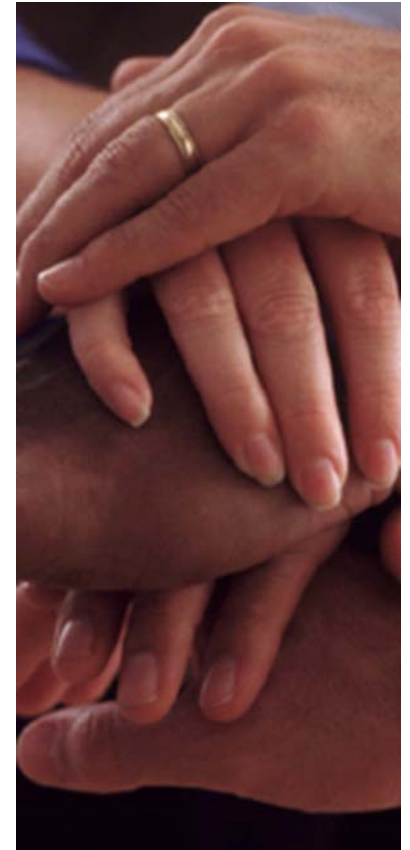
- Get the right care at the right time and place
- Honor patients' dignity
- Inform and empower patients and caregivers about their conditions and provide appropriate support
- Deliver the care in a coordinated manner across care settings
- Respect and respond to care needs of those with the most advanced stages of illness

Aetna Compassionate Care (ACCP)

Goals of the program:

- Provide additional support to members with advanced illness and their families/caregivers
- Help them access optimal care

The goal is not to create a hospice program, although hospice can be a choice when appropriate and requested by the member.



Holistic, member-centric case management

Help member understand options, with nurse case managers who are trained to:

- Assess and manage members' care in a culturally sensitive manner
- Identify resources to make members as comfortable as possible, addressing pain and other symptoms
- Help coordinate medical care, benefits and community-based services
- Inform the member about treatment options, continuity of care and advanced care planning
- Provide personal support
- Consult and coordinate with the members' treating physicians and staff (including other care coordinators where available)

Case identification

Members with advanced illness enter the program via:

1. Claims-based proprietary algorithm

2. Assessments and clinical judgment of Aetna case managers

3. Referrals from physician offices and embedded Aetna case managers within provider collaboration practices

4. Direct member/patient referral calling for information, resources, benefits questions

Aetna's Compassionate Care program is not designed around a particular diagnosis or restricted to a set of diagnoses

- Addressing patients holistically is critical; comorbidity is common.
- Opportunity to improve care for those with advanced illness covers a range of diagnoses: oncology to neurology to pulmonary to nephrology, etc.

Beginning the tasks

- Case plan development
 - Activities based on assessments
 - Goal-driven plan
 - Pain and symptom control
 - Collaboration with member, physicians and other health care professionals
 - Identification of social service or other needs
- Consultation with a medical director
- Assessment for integration with other clinical programs
- Ongoing monitoring and evaluation of the member's needs

Examples of barriers to effective care for those with advanced illness

- Inadequate treatment of pain and symptoms
- Lack of knowledge about care options
- Lack of emotional support
- Late referral
- Difficulties in determining prognosis



Case manager roles

Education, support and resources for the member and his/her family/caregivers:

1. Advanced directives and living will information

- Ensure access and understanding

2. Pain and symptom management

- Ensure member has access to effective pain management and ongoing evaluation

3. Facilitation of informed care decision making

- Allow the member and family to actively plan with the case manager and their medical team what their wishes are for continued care
- Review what they understand the prognosis to be
- Address concerns about the path ahead
- Make decisions when and if the member is unable
- Plan how to spend their time as options become limited
- Review potential trade-offs that may arise over time
- Address spiritual and cultural needs as appropriate



Case manager roles, continued

3. Facilitation of informed care decision making

- Assist with provider access
- Enable members to have their changing needs met, such as needs for durable medical equipment (DME), need for homecare, electing hospice, etc.
- Educate on benefits choices
- Explain palliative care and hospice, and what is available to the member
- Discuss ACCP website resources and assistance
 - Checklists and information on care options, advance directives and disease trajectories

Best practices

Training is integral to success

- Selecting the right staff, training, mentoring, providing opportunities for continued education
- Change management and motivational interviewing
- “Lunch and learns”
- Technical-based training
- Medical director sessions and case-based clinical rounds
- External entities, which also provide continuing education opportunities

Results: Member discussion

Example of why Compassionate Care shows impact

Wife stated member passed away with hospice. Much emotional support given to spouse. She talked about what a wonderful life they had together, their children, all of the people's lives that he touched -- they were married 49 years last Thursday, and each year he would give her a piece of jewelry. On Tuesday, when she walked into his room, he had a gift and card laying on his chest, a beautiful ring that he had their daughter purchase. She was happy he gave it to her on Tuesday -- on Thursday, he was not alert. She stated that through his business he touched many peoples lives, and they all somehow knew he was sick, and he has received many flowers, meals, fruit, cakes -- she stated her lawn had become overgrown, and the landscaper came and cleaned up the entire property, planted over 50 mums, placed cornstalks and pumpkins all around. She said she is so grateful for the outpouring of love. Also stated that hospice was wonderful, as well as everyone at the doctor's office, and everyone here at Aetna. She tells all of her friends that "when you are part of Aetna, you have a lifeline." Encouraged her to call CM with an issues or concerns. Closed to case management.

Results

▶ Favorable impact aligning patient goals with outcomes

- 82% of engaged decedents choose hospice
- 82% reduction in acute inpatient days
- 77% reduction in emergency room visits
- 86% reduction in intensive care unit days

Improved quality of life for Aetna members and their families

Data for 2010 Medicare Advantage members enrolled in Aetna's Compassionate Care program.

A Comprehensive Case Management Program To Improve Palliative Care

Claire M. Spettell, Ph.D.¹ Wayne S. Rawlins, M.D., M.B.A.² Randall Krakauer, M.D.³ Joaquim Fernandes, M.S.¹ Mary E.S. Breton, B.S., J.D.² Wayne Gowdy, B.S.² Sharon Brodeur, R.N., B.S., M.P.A.² Maureen MacCoy, B.S.N., M.B.A.² and Troyen A. Brennan, M.D., M.P.H.⁴

PERSPECTIVE: QUALITY

PERSPECTIVE

Opportunities To Improve The Quality Of Care For Advanced Illness

An Aetna pilot program shows how it can be done.

by Randall Krakauer, Claire M. Spettell, Lonny Reisman, and Marcia J. Wade

ABSTRACT: Many studies describe a sizable chasm between the care Americans consider optimal for advanced illness and what we actually experience. Aggressive or curative measures may be pursued to the exclusion of comfort, pain relief, and psychosocial support. We briefly describe a care management program that gives people culturally sensitive supportive information, to make informed choices and obtain palliative services in a timely manner. In the sample population, more members chose hospice care; acute care utilization declined. It is possible to assist Americans with advanced illness and remove barriers to selecting hospice care, if that is their choice, without adverse financial impact. [Health Aff (Millwood). 2009;28(5):1357-59; 10.1377/hlthaff.28.5.1357]

A LANDMARK STUDY by RAND Health in 2000, *Assessing Care of Vulnerable Elders (ACOVE)*, described a sizable chasm between the type of care Americans consider optimal for advanced illness and what we actually experience.¹ Too often, aggressive or curative measures are pursued to the exclusion of palliative care with its focuses on comfort, pain relief, and psychosocial support. Changing this approach will require conversations about choices and options beginning early in the course of advanced illness. Now, these conversations begin late or not at all.

Hospice election rates have been increasing for two decades.² By electing hospice, patients are opting for care that emphasizes comfort and social support, as opposed to heroic medical efforts to "cure" disease in spite of limited

potential benefit. Although the increase in patients benefiting from hospice support is encouraging, there is room for improvement. Too often, the choice of hospice does not occur until the last few days or hours of life, long after the patient would have benefited from this type of care. Opportunities for improving the quality of care for advanced illness include better coordination of care, better training for physicians and health care providers in the care of terminal illness, requirements that patients be offered hospice and palliative care consultation, and requirements that advance directives be recorded and adhered to.

Although all of these endeavors are valuable, improved care management may be one of the best ways to reach people early with culturally sensitive supportive information and access to palliative services. In a relatively

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Abstract

Objective: The objective of this study was to evaluate the impact of comprehensive case management (CM) and expanded insurance benefits on use of hospice and acute health care services among enrollees in a national health plan.

Study Design: Retrospective cohort design with three intervention groups, each matched to a historical control group.

Methods: Intervention groups were health plan enrollees who died after 2004: 3491 commercial enrollees with CM; 387 commercial enrollees with CM and expanded hospice benefits; and 447 Medicare enrollees with CM. Control groups consisted of enrollees who died in 2004 prior to the start of the palliative care CM program. The main outcomes measured were the proportion using hospice, mean number of hospice days, and number of inpatient days measured through medical claims.

Results: Hospice use increased for all groups receiving CM compared to the respective control groups: from 30.8% to 71.7% ($p < 0.0001$) for commercial members with CM and from 27.9% to 69.8% ($p < 0.0001$) for Commercial members with CM and enhanced hospice benefits. Mean hospice days increased from 15.9 to 28.6 days

Invictus: Increasing Patient Choice in Advanced Illness and End-of-Life Care

RANDALL KRAKAUER, MD, FACP, FACR

HUMANS' KNOWLEDGE of our own mortality creates a conflict with our inborn desire to live. Cultures have grappled with this conflict throughout history. In *The Epic of Gilgamesh*, one of the earliest known works of literature, the title character wrestles with the concept. The Greek philosopher Epicurus tried to define death in context: "Death does not concern us, because as long as we exist, death is not here. And when it does come, we no longer exist." Knowledge of our own demise should provide us with the means to influence some of its circumstances, and our choice might not be futile pursuit of the unattainable. Indeed, surveys have shown that when people are asked about such preferences, a majority indicate they would prefer death in hospice, with pain relief and with the support of loved ones, to death in hospital (Last Acts 2002). However, too frequently, these preferences are not honored. In many cases of critical illness, people are given the choice of where to die too late, or not at all.

Few people would aspire to end their lives in intensive care units, on various forms of life support, in pain and isolated from loved ones. We are justifiably proud of our medical technology, skills, and capabilities and of the compassion our concern bespeaks; however, do we view knowledge of our mortality as a challenge to be defeated at all costs, despite the certainty that we will lose? Is there a better path? Is the laudable Talmudic precept to preserve life absolute, or is the realization and gracious acceptance of a point of inevitability a better way? Can we transcend the emotional and physical pain by dying with the emotional and physical support of our loved ones and trusted healthcare providers? Can we reconcile the goals of preserving life and accommodating a pain-free death that is supportive to all concerned? This reconciliation will require us to identify points at which decisions and transitions are appropriate; it

Summary

- Improving the quality of care for those with advanced illness represents a tremendous **opportunity** for the country's health system, for individual patients, and for families and caregivers.
- Advanced illness care coordination requires a **holistic, patient-centric focus**.
- A program such as Aetna Compassionate Care can increase awareness of the care options available to patients and caregivers, thereby **aligning patient choice** more closely with desired types of health services and sites of care.
- This care management program **favorably impacts advanced illness**, with very high rates of satisfaction, demonstrating progress at the optimal intersection of health care quality and cost, and creates an imperative that such services become more widely available.