Disclosure of ABIM Service:  Martha Twaddle, MD

- I am a current member of the Test-Writing Committee on Hospice and Palliative Medicine.

- To protect the integrity of certification, ABIM enforces strict confidentiality and ownership of exam content.

- As a current member of the Test-Writing Committee on Hospice and Palliative Medicine, I agree to keep exam information confidential.

- As is true for any ABIM candidate who has taken an exam for certification, I have signed the Pledge of Honesty in which I have agreed to keep ABIM exam content confidential.

- No exam questions will be disclosed in my presentation.
Session Objectives

- Review the Background
  - Aetna Compassionate Care Program
  - Aspire Health
- Demonstrate the integration of care services
- Discuss the Aetna Comprehensive Supportive Care Program
- Review and Discuss Program results
- Discussion/questions and answers

Case Study:
The Aetna Compassionate Care Program
Providing support across the care continuum

- Relatively healthy
  - Approach: Wellness programs and resources to help maintain health, prevent conditions
- Risk factors and early stage chronic disease
  - Approach: Advanced programs and attention to help address most common risks/conditions
- Complex medical needs/advanced illness
  - Approach: Targeted one-on-one attention from case managers working with members and doctors

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 Program

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.

Case identification
Members with advanced illness enter the program via:

1. Claims-based Aetna algorithm
2. Assessments and clinical judgment of nurse case managers
3. Referrals from physician offices and embedded Aetna case managers within provider 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 people 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.
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 family/caregivers:

1. Advanced directives and living will information
2. Pain and symptom assessment
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 understanding of prognosis
   - Address concerns about the path ahead
   - Make decisions when and if the member is unable
   - 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, etc.
   - Educate on benefits choices
   - Discuss palliative care and hospice
   - Discuss ACCP website resources and assistance
     - Checklists and information on care options, advance directives and disease trajectories

Compassionate Care: Making a Difference

Compassionate Care
Improved quality of life for members with life-threatening conditions — and their families

3X
Length of stay increase in hospice

82%
hospice election rate

↑
Quality of life

Compassionate Care: Making a Difference

Compassionate Care
Improved quality of life for members with life-threatening conditions — and their families

77% reduction in emergency room visits
86% reduction in ICU days
82% reduction in acute inpatient days


Dissemination
Next Steps: Enhance Value by Connecting Disparate Parts of the Health System

**Goal:** To increase integration between key services:
- Aetna’s telephonic Compassionate Care Program
- In-person palliative care services and home-based services
- Hospice providers/services
- Primary care provider/treating physician(s)

**Anticipated Results:**
- Provide a more comprehensive, seamless, and coordinated set of services to Medicare members with advanced illness
- Identify more members who could benefit from palliative care/Compassionate Care earlier in the course of their advanced illness.

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Integration of Care Services & Person-centered Care in Advanced Illness
**Program/Service Descriptions**

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<thead>
<tr>
<th>Program/Service</th>
<th>Target Group</th>
<th>Description</th>
<th>Relationship to Hospice</th>
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| Compassionate Care (ACCP) | • Members 12 months or less from the End of Life | • A telephonic case management program to provide additional support to members with Advanced Illness, and their families  
• A subset of members in ACCP (estimate 40%) may benefit from receiving the enhanced set of services offered through the Comprehensive Supportive Care Program | Members may not be in hospice. Members who elect hospice will be disenrolled from the Comprehensive Supportive Care Program and remain in ACCP |
| Comprehensive Supportive Care | • Members 12 months or less from the End of Life | • A program that offers an enhanced set of services to members with Advanced Illness  
• Members in the Comprehensive Supportive Care Program are enrolled in ACCP, receive in-person palliative care visits, and have their palliative care plan developed and overseen by an Interdisciplinary Team consisting of clinicians from the participating organizations | | |
| Palliative Care Consultation | Members upstream from EOL | • A consultation delivered by a physician or nurse practitioner to discuss GOC, advanced care planning and/or address a member’s troublesome symptoms | Members may not be in hospice |

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**Why Comprehensive Palliative Care Support Services?**

- Opportunity for home care providers, transitional care programs, and other clinical programs/services to identify persons with advanced illness and connect them with resources that could improve quality of life, the care journey, and care coordination
- Aetna Medicare looks to build relationships with committed clinician partners to improve both individual quality of care and population health
When Should Supportive Care Begin?

**Shifting paradigm for palliative care**

**Key Enrollment Questions**

"Would you be surprised if your patient: ...died within the next year?"

..began to use the hospital and ED more for their condition?

**Common Disease Categories**
- Cancer
- Advanced Heart Failure
- Advanced COPD
- ESRD
- End-Stage Liver Disease
- Advanced Neurologic Disease
- Advanced Dementia

**Medicare Hospice Benefit**

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New

Old

Life Prolonging Care

Palliative Care

Hospice Care

Aspire

Life Prolonging Care

Months to Years

6-12 months

Death

Aspire Health
Aspire Health is a home-based palliative care company that establishes specialty level palliative care interdisciplinary practices to ensure that patients facing advanced illnesses receive the most appropriate care in the most appropriate settings. By doing so, Aspire provides primary care physicians, health plans and ACOs the assurance that palliative care will be delivered in a consistent, efficient and high-quality manner.

Aspire: Serving the Sickest Patients in Their Homes
"Cancer" Trajectory, Diagnosis to Death

Onset of illness → Decline usually 3 months

Basis for the Hospice Model & HMB

Organ System Failure Trajectory

Multiple hospitalizations → Death usually follows disease exacerbation

CSCP Time frame – targeting the last year of life.
Organ System Failure Trajectory

High Function

Hospital
Rehab
Home Health

(mostly heart and lung failure)

Low Function

Multiple hospitalizations

Death usually follows disease exacerbation

Time frame – targeting the last year of life.

Aspire’s Palliative Care Support Team

**Palliative Care Physician:** Aspire’s palliative care physician oversees the patient’s palliative care plan and coordinates with the patient’s other physicians; this includes talking with both PCPs and specialists about any changes. Aspire’s team may recommend to the PCP’s or specialist’s treatment plan; Aspire’s physicians are on call 24/7.

**The PCP:** Aspire Health’s team will partner with the PCP and staff to provide the best possible care for their most vulnerable patients; the Aspire team establishes and implements individualized care plans to meet the needs of each patient, family and physician.

**Palliative Care Nurse Practitioner:** Aspire Health’s palliative care nurse practitioners conduct the initial patient assessment, take the lead on developing the patient’s palliative care plan, prescribe medications, conduct follow-up home visits with the patient as needed and lead the weekly interdisciplinary team meetings; NPs are on call 24/7.

**Social Worker:** Aspire Health’s social workers provide counseling services to patients as well as help patients connect with the necessary non-clinical resources on an as needed basis; this is in part accomplished through Aspire building partnerships with leading social service organizations in each region where Aspire operates.

**Patient Care Coordinators:** Aspire Health’s patient care coordinators, many of whom are registered nurses, support the nurse practitioners and social workers in overseeing the patient’s day-to-day care, talking with the patient multiple times a week as needed.

**Chaplain:** Aspire Health’s chaplains (and broader network of spiritual leaders) provide counseling services to patients on an as needed basis.
Integrated System of Care | Population Based Health

The services and partnerships established in an integrated system of care meet the needs of the community throughout the entire health and wellness continuum.

**Manage Populations**
Well = keep them well
Chronic = manage conditions
Well → Sick → Well
Well → Sick → Sicker → Palliative Care

**Wellness Services:**
- Wellness Center
- Diet and Nutrition Coaching
- Mammography
- Colonoscopy
- Psychiatry / Psychology
- Women’s Center
- Senior Center

**Aspire Health**

**Build a clear understanding of palliative care as a separate service from hospice**
- Establish specialty palliative care physician practices dedicated to serving non-hospice patients with advanced illness.
- Educate physicians and patients on the services this specialized practice offers
- Utilize data analytics to proactively identify patients who could benefit

**Develop deep collaborative working relationships with PCPs and specialists**
- Commitment of Aspire’s lead physician to building physician-to-physician relationships.
- Develop individualized mechanisms for communicating with PCP practices based on each practice’s preferences.
- Operate outpatient clinics, some co-located within large specialist practices.

**Provide co-management, interdisciplinary palliative care clinical services 24/7 and facilitate a ‘medical home without walls’**
- Actively provide co-management with the PCP and other specialists and Case Managers
- The Aspire Practice
  - employs an interdisciplinary team that includes physicians, NPs, RNs, SWs and chaplains
  - provides 24/7 access to clinicians including home visits when necessary
- Provide a one-page visit summary to each patient’s PCP, Specialist, Case Managers after each Aspire home visit

**Utilize robust data collection, tracking and sharing processes**
- Aspire clinicians use best practice procedures and a single data system to capture quality processes and outcomes
Aspire’s Value Propositions

Patients & Families
• Provide highly personalized care focused on the needs of each patient and family
• Facilitate honest discussions with a trusted clinician throughout the course of one’s illness
• Improve symptom management
• Provide 24/7 access to Physicians and APNs, including urgent home visits when needed
• Improve clinical outcomes

PCPs & Specialist Practices
• Provide a highly effective mechanism for PCPs and specialists to care to their seriously ill patients outside of the office
• Save physician/staff time and resources by providing additional support to patients and their families
• Improve communication and information on patient’s health status when patients are out of the office
• Improve clinical outcomes

Health Plans
• Increase member satisfaction and engagement
• Reduce medical expenses
• Facilitate population-based health management: allows health plan’s care coordinators to focus on a broader group of patients
• Improve clinical outcomes

Hospital Systems
• Reduce readmissions
• Create /enhance systems of care delivery through collaboration

Case Study #1

• 82 year old female with extensive medical history, most notably COPD, CHF, CAD s/p MI with decompensated heart failure biventricular heart failure (systolic & diastolic), significant edema and pulmonary edema

• Prior to coming on service, patient had three recent hospital admissions for SOB and CHF exacerbations.

• She has received a weekly visit from Aspire NP due to pain, edema and SOB and to fine-tune her medication management.

• Facilitated order for O2 for dyspnea management and compression stockings for LE edema.

• Pain management regimen adjusted with improved outcomes and adherence.

• Patient contacted after-hours support to confirm her medication regimen adjustments.

• Patient enrolled on 8/13 and has had no hospitalizations since admission.
Case Study #2

- 90 year old female with CVAx2 and MI in 2012 who had a PEG tube placed secondary to dysphagia
- In 2014, patient developed a non-healing wound on her left leg which was found to be a stasis ulcer related to PVD; patient is now bedbound and requires total care
- Patient enrolled 3/2 and received 9 follow-up visits from Aspire NP while enrolled, including 3 urgent visits to address symptom issues
- GOC exploration, care preferences discussed and a POLST form completed reflecting patient/family wishes for DNR/DNI
- After-hours calls from patient’s daughter related to cough, abdominal pain and constipation
- Urgent visit on 7/27 to follow-up on symptom concerns (cough, SOB); Aspire NP revisited goals of care with patient’s daughter and facilitated same-day hospice transition at home.

CSCP: Primary Diagnosis

Primary Diagnosis of Comprehensive Supportive Care Patients

- Cancer: 26%
- Dementia: 24%
- CHF: 13%
- Other: 13%
- Frailty: 8%
- COPD: 8%
- Kidney Disease: 8%
Outcomes Data: Primary Diagnosis (Aspire National)

Primary Diagnosis of Patients Enrolled: typically combination of several

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Measure</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>% of program participants that receive in-person medication reconciliation on intake and at each clinical visit</td>
<td>100%</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>% of program participants assessed for pain using a standardized pain assessment tool at the first visit</td>
<td>100%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>% of program participants who report pain relief on a negotiated pain scale</td>
<td>92%</td>
</tr>
<tr>
<td>Symptom Assessment</td>
<td>% of program participants assessed for troubling symptoms using a standardized symptom assessment tool at the first visit</td>
<td>100%</td>
</tr>
<tr>
<td>Functional Assessment</td>
<td>% of program participants assessed for functional status using a standardized functional assessment tool at the first visit</td>
<td>100%</td>
</tr>
<tr>
<td>Fall Assessment</td>
<td>% of program participants that have a documented fall risk assessment</td>
<td>100%</td>
</tr>
<tr>
<td>Home Safety</td>
<td>% of program participants that receive a home safety assessment during the first home visit</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse Screen</td>
<td>% of program participants assessed for mental health status and substance abuse using a standardized assessment tool</td>
<td>100%</td>
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**CSCP: Advance Care Planning**

Advanced Care Planning: Comprehensive Supportive Care Patients vs. National Benchmark

- **Advanced Care Plan / Living Will / POLST Completed**
  - CSCP: 68%
  - National Benchmark: 50%

- **Recent Advanced Care Plan Discussion**
  - CSCP: 88%
  - AHRQ Benchmark: 12%

**CSCP & National Outcomes: Hospice Transitions**

- **Hospice Enrollment: Comprehensive Supportive Care Program Patients Who Passed Away**
  - Hospice: 82%
  - No Hospice: 18%

- **Hospice Median Length of Stay: Comprehensive Supportive Care Patients vs. National Data**
  - National Average Hospice Median Length of Stay: 10 days
  - Aspire to Hospice Median Length of Stay: 25 days
CSCP Outcomes: Hospitalizations

Admissions Per Thousand:
Comprehensive Supportive Care Program vs. Various Benchmarks

Summary:

- Improving the quality of care for older adults 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, person-centered focus.

- Comprehensive Supportive Care can offer an enhanced and integrated set of services, thereby facilitating support earlier in the course of advanced illness and facilitating seamless transitions in care.
Questions