The Advanced Care Project: A New Vision for Advanced Illness Care

by

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I. Introduction

Chairman Nelson, Ranking Member Collins, and members of the committee, I am Carmella Bocchino, Executive Vice President at America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to participate in this roundtable discussion on meeting the health care needs of patients with advanced illness. Our members have demonstrated strong leadership in this area and are committed to broadly expanding the next generation of innovative programs to improve advanced illness care management. Our testimony focuses on three topics: (1) the importance of promoting the widespread adoption of emerging clinical care models that provide higher quality, more cost-effective care for patients with advanced illness; (2) the innovative programs health plans are implementing to address this priority; and (3) the goals of the newly formed Advanced Care Project, which is bringing together a diverse group of stakeholders to accelerate progress in the development and adoption of advanced illness care models.

II. The Importance of Clinical Care Models for Advanced Illness

Meeting the health care needs of patients with advanced illness is an increasingly important challenge that has far-reaching implications for patients and their families. This patient population is highly vulnerable and typically includes individuals with declining health and functional status and limited prospects for a meaningful recovery. It is critically important for these patients to be served by clinical care models that can be customized to meet their specific preferences in a way that both improves their quality of life and ensures that they receive high quality, cost-effective care.

For many patients, there is a large gap between the care, support, and coordination they want and what they actually receive from the health care system when their illness reaches an advanced stage. Patients – along with their families and caregivers – want clear information about their options for care, support to manage their medical conditions where they live, and assistance in navigating a complex and fragmented health care system. Patients also want to know that their families and loved ones will not be financially and emotionally devastated in the process.

While some patients with advanced illness are benefiting from the innovative programs that are being pioneered by health plans and providers, greater progress is needed to ensure the widespread availability of advanced illness care models. Every family is impacted at some point by the need for advanced illness care – a reality that potentially will help build momentum for bolder steps to expand access to innovative programs addressing this priority. This is particularly true as the 78 million members of the Baby Boom generation begin to approach their older years.

Through leadership in the private sector, we are seeing the emergence of a number of advanced illness care models that provide better, higher quality, and more cost-effective care and that improve quality of life for patients and their families. Unfortunately, these innovative models and interventions often face barriers, including varied reimbursement streams and complex eligibility criteria, which prevent them from being implemented on a broader scale.

As a result, best practices are not widespread, and patients and families all too often must navigate through a maze of care settings and options with little support – resulting in financial, physical, and emotional hardships. Improvements are needed in the clinical and operational definitions of advanced illness to make this concept more easily understood by clinicians and non-clinicians alike. The lack of evidence about the effectiveness of care teams in various settings, and about strategies to promote patient and family engagement in advanced illness have also limited the scalability of this model. Action on these and other issues is needed as part of an overall strategy for fostering the adoption, replication, and broad scale implementation of advanced care programs.

III. Innovative Models Implemented by Health Plans

Many health plans have developed collaborative models with providers that improve care and are driven by the patient's goals and values. These models are characterized by:

1. Using predictive modeling to identify patients facing life-limiting chronic illness and facilitating care planning to ensure that the care provided aligns with the patient's goals and values.

    - Example: United Health Group is an early innovator in developing an Advanced Illness Care Management program. The program employs a predictive modeling program that considers the member's utilization history, functional status, and clinical and disease specific data. Once identified and engaged, a comprehensive care plan is developed to provide care coordination, advance care planning, education, and symptom management according to individual values and goals (for longevity, function, and comfort). Individuals are re-evaluated at least every 30 days and with change of condition. This program has demonstrated over 95 percent member and caregiver satisfaction and a reduction in utilization of medical interventions that the member does not want. Additionally, over 95 percent of members had identified their preferred site of death and goals of care and greater than 75 percent of members have an advance directive within 120 days of enrollment.

2. Providing case management that supports patients through interdisciplinary teams.

    - Example: SCAN Health Plan is a non-profit organization serving seniors for more than 35 years. Patients enrolled in SCAN Health Plan's case management program are supported by an interdisciplinary team of registered nurses, master's-level social workers, gerontologists, a board-certified geriatrician, a registered dietician, a behavioral health specialist, and a clinical pharmacist. Through the program, SCAN case managers coordinate care with the member's physician(s) while providing emotional support to members and their families, including discussions about advanced care planning and

cultural and spiritual needs and preferences.

3. Cultivating an environment of value for a person-centered approach to care delivery.

    - Example: Regence BlueCross and BlueShield, Cambia Health Solution's health plan, and the Cambia Health Foundation are committed to improving care for those with advanced illness. The Cambia Health Foundation has developed an initiative to cultivate emerging physician and nurse leaders in the advanced illness and palliative care fields. The Sojourns Scholar Leadership Program awards grants to six scholars each year to support research, clinical, educational, or policy projects in these areas. The foundation also funds various advanced illness management initiatives such as that of St. Charles Health System based in Bend, Oregon. The Cambia Health Foundation's ultimate goal is to optimize the quality of life for those with advanced illness and promote compassionate, person-centered and family-centered models of care. Regence is currently developing and implementing a comprehensive approach to palliative care service delivery. One component of this program includes benefit expansion for both commercial and Medicare Advantage lines of business, expanding home health service offerings and reimbursing for care coordination, care plan oversight and development, and medical team conferences. In addition, Regence is offering specialized care management for members with a serious or life-limiting illness, beginning at the point of diagnosis or decline. The health plan is also developing palliative care training and reimbursement models for network providers to develop the infrastructure to deliver quality palliative care services. The program is committed to developing a community of care that ensures each member's goals of care are documented and honored. As an employer, Cambia Health Solutions is also developing wellness activities and seminars for employees in advance care planning and communication about end-of-life goals and decisions. Regence's ultimate goal is to support the delivery of quality care for individuals and their families at any stage of life or illness.

4. Increasing patient and family satisfaction while ensuring that patients receive the care that they want.

    - Example: Highmark's Advanced Illness Services (AIS) is a specialized program to support their Medicare Advantage (MA) members and their families and caregivers in dealing with a serious or chronic life-limiting illness. Through an interdisciplinary network of physicians and other health care providers, the AIS program helps members understand their medical conditions in order to make informed health care decisions and employs uniquely qualified professionals to provide emotional support, facilitate decision-making, prepare members for effective communication with physicians, provide coordinated care services, and arrange referrals to community resources. The AIS program is available to members for whom a physician has attested he/she "would not be surprised if the patient died within the year" based on certain CPT II codes. No diagnosis is excluded. Since the official implementation in 2011, the AIS program has demonstrated for those members enrolled in the program an increased hospice enrollment and median length of stay in hospice, and reduced emergency room visits, acute hospital admission and readmission rates, particularly with respect to the intensive care unit (ICU), and chemotherapy administration in the last two weeks of life.

IV. The Advanced Care Project and Its Goals

In an effort to build upon the innovative advanced care programs that have been developed by health plans and other stakeholders, the AHIP Foundation's Institute for Health Systems Solutions and the Coalition to Transform Advanced Care have formed a new partnership – The Advanced Care Project ("ACP").

The Advanced Care Project includes many health care stakeholders: health plans, employers, a range of providers and clinicians including health systems and physician groups, as well as leaders from the faith-based community and other community-based entities. The ACP's purpose is to identify, analyze, and compare best practice clinical care models for advanced

illness care management and to promote the results of this work to health care systems and other stakeholders across the United States. The Project also aims to complement this work on clinical and care support models by outlining the key components of payment models that align financial incentives and encourage best practices.

By removing barriers to the adoption of existing models that work, the Advanced Care Project will make "the right way the easy way" for hospitals, health systems, physician groups, other clinicians, and health plans – as well as for nursing homes, hospices, and community-based organizations – to provide high quality care for patients and families living with advanced illness.

The Project is being conducted in three main phases:

- Phase I is focused on identifying, analyzing and comparing best practice clinical care models for advanced illness care management and developing an evidence-based scalable and flexible framework. This phase of the Project – which included a February 27 conference sponsored by the Commonwealth Fund – is convening experts to address issues relating to the development of a clinical models framework and complementary principles on payment focused on sustainability and aligning incentives that facilitate collaboration across multiple care settings.

  Priorities for this phase include:

  - Defining populations to be covered by advanced care programs;

  - Identifying and describing the characteristics of models that provide effective care, improve quality of life, and potentially result in cost savings for seriously ill patients;

  - Identifying and describing key program features that lead to these results, including the role of care and support teams;

- Identifying the community, population mix, and program elements that account for different features and results across geographic and demographic areas; and

- Examining the key relationships and variables among care models, institutions, incentives, and local programs and partners that achieve positive results.

- Phase II will implement and study a semi-standardized but flexible Advanced Care intervention at multiple pioneer sites across the nation. Priorities for this phase will include identifying and closing gaps in the evidence base, identifying and engaging payers and providers who are willing to participate in a network to collect and share data, and the collection and analysis of data based on common metrics.

- Phase III will focus on spreading successful models across varied geographies, medical cultures, care settings, and payment models, and promoting the results of this work to providers and payers across the United States.

The central goal of the Advanced Care Project is to ensure that more compassionate, person-centered, and effective advanced illness care is available for all individuals with advanced illness and their families. Furthermore, the Project is based on a new vision of care that emphasizes the following:

Aligning Care with the Patient's Goals, Values, and Preferences: The Project directly addresses the unique circumstances of patients with advanced illness, including their need for care options that meet their specific preferences, support where they live, and help in navigating the health care system. As we discussed above, some of our nation's most innovative health care providers and health plans are proving that a coordinated, person-centered approach yields better care, greater satisfaction and, as a consequence, more cost-effective care.

Connecting the Health System and the Community: The Project is promoting the widespread availability of new Advanced Care models that will move the focus of care out of the hospital and into the home and community, consistent with the patient's preferences. Instead of requiring

the seriously ill to visit their providers to obtain care or consult, the new models are bringing care to them, while also promoting teamwork, close communication, increased self-confidence, and better self-management. Advanced Care programs are designed to anticipate problems, avoid crises, and prevent unnecessary hospitalizations. This collaborative model of team-based care enlists the efforts of providers, health plans, and other payers to reinforce and accelerate the growth of value-based and population-based care models.

Achieving Sustainability and Replication: The Project ultimately will lead to a framework that anticipates and addresses barriers to the development and dissemination of a consensus-based model and standard of care, supported by payment models that align incentives and facilitate collaboration across multiple settings. Barriers to achieving the goal of sustainability and replication include: payment and care "silos" that vary with the site of care or benefit program; exclusionary eligibility criteria; regulatory hurdles; and the fact that many interventions for advanced illness have been developed in discrete settings (e.g., home, hospital, skilled nursing facility) or for particular stages of illness.

Looking forward, the Advanced Care Project will be sponsoring bimonthly webinars throughout the remainder of 2014 to analyze findings on clinical delivery and payment models, as well as implementation strategies from innovators across the country. The Project also is focused on publishing a comprehensive report in December 2014 that will outline finalized care delivery and payment model frameworks along with a roadmap for implementation, ongoing monitoring and evaluation, and policy recommendations.

V. Conclusion

Thank you again for the opportunity to participate in this roundtable discussion. AHIP and our members look forward to continuing a dialogue with the committee about the Advanced Care Project and the progress we are making – in collaboration with other stakeholders – toward our shared goal of providing higher quality, more cost-effective care for patients with advanced illness.