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Post-Acute Care Collaborative

Expanding the Scope of End of Life Care: Understanding Concurrent Hospice Models

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Post-Acute Care Collaborative Team

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Status Quo Far from Realizing the Full Benefit of Hospice

Research has demonstrated that hospice saves Medicare between $2,300 and $10,800 per enrolled beneficiary compared to traditional care at the end of life. Moreover, patients and families participating in hospice report better medical and social outcomes, particularly for pain and symptom management.

Yet, research indicates hospice services are currently underutilized. While more patients are enrolling in hospice, median length of stay (LOS) has remained largely unchanged since 2009 and remained at 19 days in 2012. A third of hospice stays are shorter than one week, and over 60% of hospice users only access hospice within the last month of life. Concurrently, studies indicate that the LOS to receive maximum benefit from hospice care ranges from 80 to 90 days.

60%

Proportion of hospice users that do not enroll in hospice until last month of life

Actual vs. Ideal Length of Stay

19 days

Median length of stay in U.S. hospices

80-90 days

Ideal length of stay for hospice based on research

Patient and physician attitudes to end-of-life care often delay hospice utilization. Seventy percent of consumers report that they are not at all knowledgeable about palliative care, and only a quarter of physicians caring for cancer patients express a willingness to discuss hospice with patients they have given a four-to-six month terminal prognosis.

One barrier to increased utilization is the structure of the Medicare Hospice Benefit. Medicare requires that patients forgo curative treatment related to their hospice diagnosis to be eligible and does not reimburse hospice providers for palliative treatments. As a result, physicians often wait to communicate with a patient about hospice care only after exhausting all curative options, delaying access to hospice services.

Individual Attitudes Limit Hospice Utilization

Patient-Related Factors

- Denial of severity of diagnosis, prognosis
- Desire to exhaust all treatment options
- Negative perception or misunderstanding of hospice care
- Unique cultural or spiritual beliefs, end-of-life preferences

Physician-Related Factors

- Fears of patient's emotional reaction, perception of care
- Difficulty determining prognosis
- Feeling of professional shortcoming; loss of control in patient course of treatment
- Unable to identify appropriate hospice eligibility criteria (e.g., diagnosis)

Source: Keating, N, et al., "Physician Factors Associated with Discussions About End-of-Life Care," *Cancer*, 116, no. 4 (2010): 998-1006, http://onlinelibrary.wiley.com/doi/10.1002/cncr.24761/full; National Hospice and Palliative Care Organization, "NHPCO's Facts and Figures: Hospice Care in America," October 2013, http://www.nhpco.org/hospice-statistics-research-press-room/facts-hospice-and-palliative-care, "Medicaid and Hospice Care Issue Brief," October 2011, http://www.nhpco.org/sites/default/files/public/regulatory/Medicaid_Issue_Brief.pdf; "The Debate in Hospice Care," *Journal of Oncology Practice*, 4, no. 3 (2008): 153-157, http://jop.ascopubs.org/content/4/3/153.full; Post-Acute Care Collaborative interviews and analysis.

Concurrent Care Spurs Earlier Hospice Enrollment, Benefits

The concurrent care model—also referred to as open access or simultaneous care—was developed to remove financial and psychological barriers to patients opting into hospice care. Under such models, patients do not need to choose hospice, palliative care, and curative treatments in isolation, resulting in a more gradual transition into hospice. Today, an estimated 29% of hospices have open access policies in place.

Early Evidence Suggests Improved Quality of Care a Key Benefit in Concurrent Care

Research reveals provider models using elements of curative and palliative care have successfully demonstrated improved quality and increased hospice referrals. Such models include home-based programs that ease the transition between curative and palliative care, and concurrent care offered by cancer and hospice providers.

By positioning concurrent care policies as part of a patient's advanced care planning, physicians become more comfortable with in-depth discussions of end-of-life care options earlier in the care plan for patients with a terminal diagnosis. Hospice programs that have eliminated the need for patients to choose between curative and palliative treatments have seen a wide range of quality improvements for patients with advanced illnesses, including:

- Earlier referrals, earlier access to hospice, and fewer disparities in hospice utilization
- Improved collaborative relationships between hospice providers and referring physicians
- Fewer patient days in the intensive care unit
- Clinically meaningful improvements in reported quality of life and patient mood
- Increased patient and family engagement in discussing palliative options during advanced care planning

A Clear Value Proposition Under Risk-Based Payments

Concurrent care programs are structured to advance the same goals supported by population health management, aiming to improve quality and reduce the total cost of patient care. They therefore have the opportunity to play a key role in value-based delivery systems. In addition to the care improvements outlined above, there are early indicators in both the Medicare and commercial populations that earlier enrollment in hospice (resulting from concurrent policy changes) decreases net medical costs for patients. This reduced spending is mostly attributed to fewer hospitalizations, re-hospitalizations, and emergency department visits for patients accessing these comprehensive hospice services.

Concurrent Care Model Supports Twin Goals of Population Health Management

Quality of Care

- Patient-centered model that focuses on clarifying a patient's goals for care, improving the patient's quality of life
- Expanding eligibility criteria for entry into hospice improves access to care
- Reduces racial, ethnic disparities in access to hospice

Financial Impact

- Potential to lower costs for Medicare, commercial payers, and hospitals by decreasing hospitalizations, ICU days, and avoiding aggressive, expensive treatments
- Potential to increase reimbursement to hospice providers with increased length of hospice stays

Source: Carlson MDA, et al., "Hospices' Enrollment Policies May Contribute to Underuse of Hospice Care in the United States," *Health Affairs*, 31, no. 12 (2012): 2690-2698; Wright AA, Katz IT, "Letting Go of the Rope – Aggressive Treatment, Hospice Care, and Open Access," *N Engl J Med,* 357 (2007): 324-327; Post-Acute Care Collaborative interviews and analysis.

An Overview of the Concurrent Care Continuum

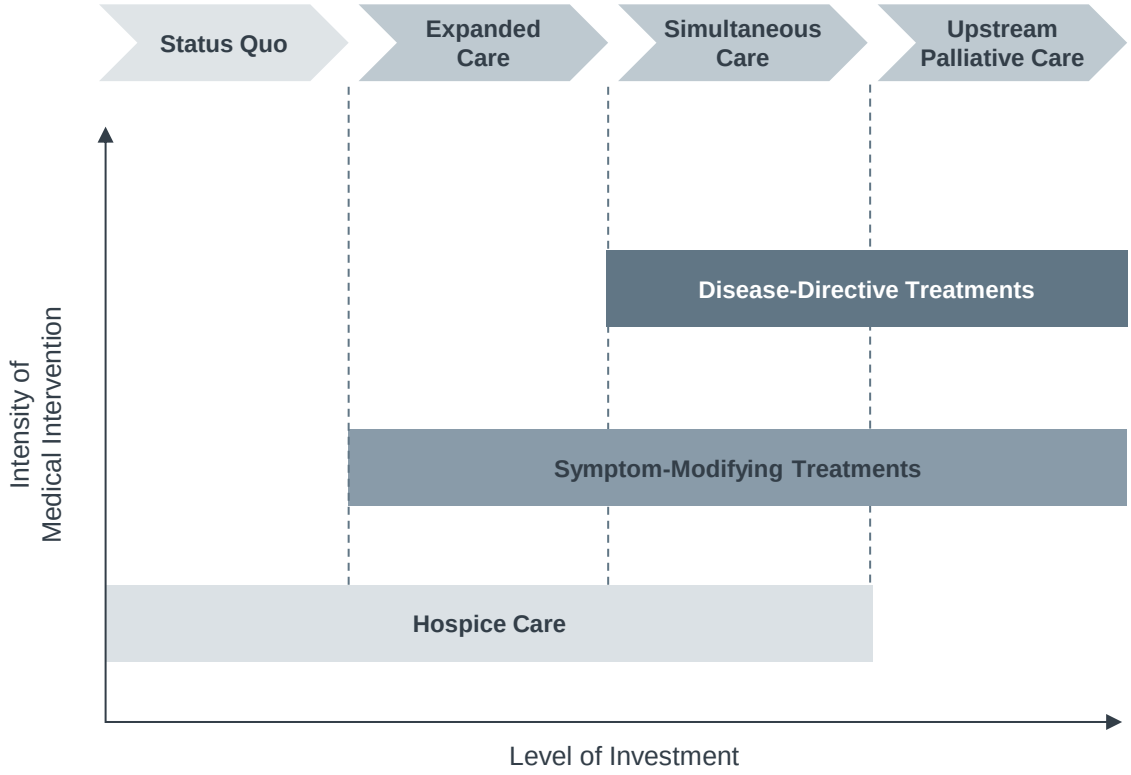
A wide range of organizations have implemented some type of concurrent care delivery for patients with advanced illnesses, including hospice providers, health systems, academic medical centers, and commercial insurers. However, the design of concurrent programs vary widely across providers and can be generally grouped into three models:

- **Expanded Care**: Layers medical treatments that provide symptom relief and increase patient's comfort on top of traditional hospice care
- **Simultaneous Care**: Allows for provision of disease-modifying and symptom-modifying treatments while simultaneously receiving hospice care; also referred to as "open access" hospice
- **Upstream Palliative Care**: Delivered prior to hospice care and receiving a "terminal" diagnosis; blends together disease-modifying and symptom-modifying treatments for patients with serious illness and prepares patients for eventual admission into hospice

The institutions profiled in this brief all share the goals of improving access, lengthening hospice stay, and improving patients' and families' experience with end-of-life care. Their models for care delivery and funding differ based on the institution's clinical capabilities, strategy, size, budget, staffing capabilities, and local market dynamics.

Although covered treatments vary by institution, at a minimum all concurrent care programs allow patients to continue receiving interventions that are considered palliative (e.g., palliative chemotherapy, BiPAP,[1] and TPN[2]). Further, select institutions allow patients to continue receiving curative treatments while simultaneously receiving hospice care.

Spectrum of Treatments Covered Through Concurrent Care



1) Biphasic positive airway pressure.
2) Total parenteral nutrition.

Source: Post-Acute Care Collaborative interviews and analysis.

Assessment of Concurrent Care Models

Multiple Paths for Developing Concurrent Care Programs

Key Elements of Profiled Institutions

	Hospice of Dayton	Roots Hospice[1]	University of California, Davis	Aetna: Compassionate Care	Sutter Health: Advanced Illness Medicine
Definition of concurrent care	Increase patient's comfort using palliative treatments	Increase patient's comfort using palliative treatments	"Hospice-like" care for patients on Phase I or II clinical trials[2]	Curative treatment alongside hospice	Palliative care, EOL planning for patients with late-stage illness
Type of program	Expanded care	Expanded care	Simultaneous care	Simultaneous care	Upstream palliative care
Eligibility for program (by prognosis)	6 months	6 months	12 months	12 months	12 months
Total annual caseload	4,484	4,462	N/A	N/A	4,500
Coverage of curative care	✖	✖	✔	✔	✔
Decision-makers for assessing patient eligibility[3]	Hospice medical director and oncologist	Hospice medical director and attending or consulting physician	N/A	N/A[4]	N/A
Care setting	Home	Home	Home, outpatient cancer clinic	Majority in home, some in nursing home	Home
Financial impact	Slight increase in costs[5]	Cost neutral[5]	N/A	Cost savings	Cost savings
Utilization impact	↓ Readmissions[5]	↓ Aggressive treatments[5]	↑ Hospice use ↑ Hospice LOS	↑ Hospice use ↑ Hospice LOS ↓ ICU days	↑ Hospice use ↓ Hospitalizations
Quality of care impact	↑ Physician satisfaction[5]	↑ Quality of life[5]	↑ Quality of life ↑ Caregiver quality of life	↑ Patient, family satisfaction	↑ Patient, family, physician satisfaction
Presence of integrated care management	✔	✖	✔	✔	✔

1) Pseudonym.
2) Clinical trials test potential curative treatments.
3) For programs that determine eligibility on a case-by-case basis.
4) Plan sponsors may decide not to cover certain treatments, although Aetna medical staff may work with plan's case managers to address exceptions to coverage.
5) Based on anecdotal evidence.

Source: Post-Acute Care Collaborative interviews and analysis.

Concurrent Care Offered to Differentiate Provider in Market

Case in Brief: Hospice of Dayton

- Serves approximately 4,500 patients annually
- Average daily census of 700 patients
- Employs 670 staff members
- Provides care in patients' homes, extended care and assisted living facilities, hospitals, and its own short-term inpatient hospice care centers

5%

Patients with cancer-related diagnoses receiving concurrent care[1]

250

Average number of patients served annually in the concurrent care program

Concurrent Care a Competitive Service Offering

As the first nonprofit hospice in its market, Hospice of Dayton began caring for patients at the end of life in 1978. Founded on principles of providing high-quality, accessible end-of-life care to all people in the communities it serves, the hospice continues to take into account its mission during key strategic decisions.

In the late 1990s, the number of for-profit hospice providers in the region grew substantially. Hospice of Dayton leaders understood that simply providing the Medicare Hospice Benefit was insufficient to remain viable in the competitive hospice arena. To differentiate itself and grow referral volumes, the hospice decided to launch a concurrent care program.

With concurrent care, the hospice now offers a greater range of services than its competitors. Initially offering only palliative radiation and palliative chemotherapy along with hospice services, the concurrent care program first focused on improving an oncology patient's level of comfort. Due to increasing numbers of patients with advanced chronic illness, the program has expanded to cover additional palliative treatments unrelated to oncology.

Today, the hospice provides concurrent care to patients with chronic heart failure, chronic obstructive pulmonary disease, and pulmonary hypertension. In addition to differentiating the organization from competitors in the market, the expanding concurrent care program is well aligned with the mission to focus on inclusionary—rather than exclusionary—practices of patient access and delivery of superior end-of-life care.

Treatments Covered Under Concurrent Care Program

- Palliative chemotherapy
- Palliative radiation
- Dialysis (that is unrelated to the hospice diagnosis)
- Dobutamine & Natrecor cardiac infusions
- Flolan infusion
- Nutrition by feeding tube
- Breathing assistance devices (such as CPAP[2]/BiPAP[3])
- Intravenous medications
- Tracheotomies
- Blood transfusions
- Total parenteral nutrition (TPN)

1) Thirty-three percent of all patients served by Hospice of Dayton have a cancer-related diagnosis.
2) Continuous positive airway pressure.
3) Biphasic positive airway pressure.

Source: Post-Acute Care Collaborative interviews and analysis.

Benefits of Concurrent Care Outweigh Cost Increases

Internal Funding Sets Concurrent Care Parameters

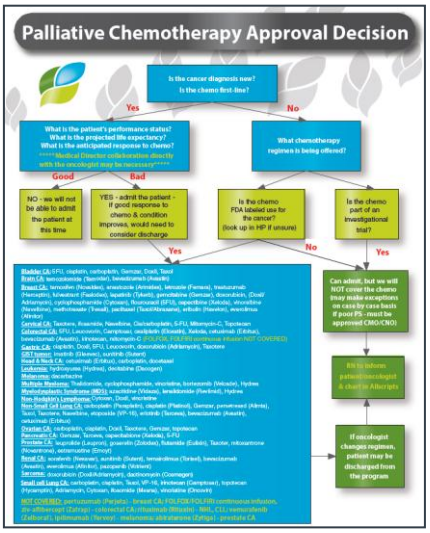
The vast majority of hospice patients are on Medicare, which does not reimburse disease- or symptom-modifying treatment for terminal conditions while in hospice. Hospice of Dayton finances concurrent treatments for Medicare patients from its own budget. Given the budgetary limitations, the hospice decided early on to limit concurrent services to those that provide palliative relief to patients with advanced diseases.

Algorithm Standardizes Approval Process, Yet Maintains Flexibility

Hospice leaders standardized the decision-making process to determine patient eligibility and which palliative treatments will be covered. Using an internally created algorithm, medical directors evaluate if a patient is appropriate for the concurrent care program. Approval is contingent on a number of factors, including a patient's performance status, projected life expectancy, anticipated response to current therapies, and whether recommended therapy is experimental.

Although these protocols give structure to decisions related to approval and denial into the program, this has not limited the type of patients participating in concurrent care. Medical directors are encouraged to collaborate when determining which patients are appropriate for the program. Medical directors work directly with the patient's physician to understand the patient's status and are encouraged to seek input from the hospice's chief medical director, senior medical director, or chief nursing officer if an exception must be considered. Even with a highly standardized decision-making process, the program accommodates a wide range of patients with expansive hospice services, which contributes to the mission of serving the community at large.

Algorithm for Concurrent Care[1]



Ongoing Collaboration with Primary, Attending Physicians Improves Hospice Referrals

Once a patient is accepted into the program, the hospice team works closely with the patient's provider (usually an oncologist) to adjust a patient's care plan if necessary. The goal is to continuously support patient comfort, which can include adjusting the duration and/or frequency of treatment. Referring physicians value the concurrent care program because they are not forced to withdraw patients from treatment to have them receive the benefits of hospice care. As a result, Hospice of Dayton has seen an increase in referrals from physicians who feel the program provides patient-centered care. Additionally, the hospice CEO meets quarterly with the largest oncology practice in the area. This relationship promotes a sense of mutual trust and shared responsibility for patients' care.

Mission the Driving Force Behind Concurrent Service Offering Despite Additional Costs

The increase in referrals has resulted in the unintended consequence of increasing costs to the hospice. This is especially challenging because as a nonprofit, Hospice of Dayton must use its own budget to cover the expenses of concurrent care not covered under the Medicare per diem reimbursement. Providing concurrent care is an upfront financial investment for the hospice, but the annual return on that investment remains unclear. Although hospice administrators have not yet calculated the program's cost-effectiveness, they will continue to offer concurrent care because of its strong alignment with the overall mission of providing high-quality care to the community.

Estimated Monthly Costs of the Concurrent Care Program

$30K-$40K	$5K-$10K
Palliative chemotherapy costs	Palliative radiation costs

1) See appendix for full algorithm.

Source: Post-Acute Care Collaborative interviews and analysis.

Expanded Care Requires New Hospice Investments

Case in Brief: Roots Hospice[1]

- Serves approximately 4,500 patients annually
- Average daily census of 550 patients
- Employs approximately 500 staff members
- Provides care in patients' homes, nursing homes, assisted-living facilities, group homes, retirement communities, hospital, and its own inpatient facilities
- Delivers concurrent care services to children

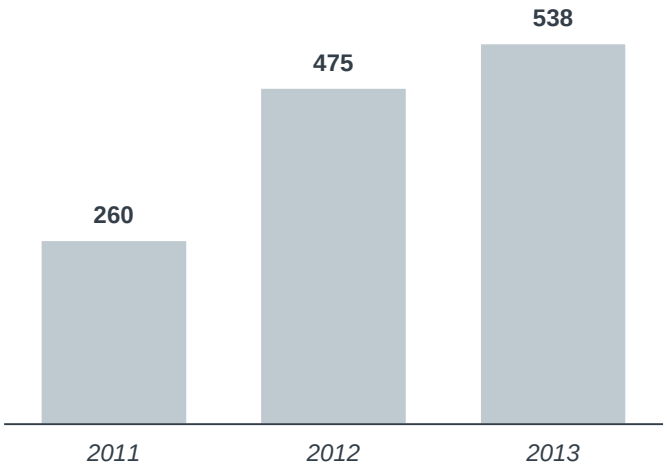
Roots Hospice has provided hospice care since 1994 and is the largest nonprofit provider in its state. In recent years, the hospice recognized that more patients were pursing aggressive treatments and delaying entrance to hospice services. Delayed entrances resulted in patients and families experiencing greater emotional distress as they transitioned between treatment, hospice, and family survivorship.

After conducting an internal review of all cases, Roots Hospice discovered medical directors had an inconsistent approach for accepting (and rejecting) cases requiring additional treatment. Hospice leaders decided to launch an expanded care program, in part to address these inconsistencies, while helping all patients and families avoid the emotional decision between hospice services and treatment. Realizing the financial limitations for expanding treatments for all patients, the hospice decided not to use an open access model and only cover treatments that have a palliative, rather than curative focus.

Technical Improvements Necessary to Deliver New Services

Services under expanded care were a significant departure from the traditional hospice model. Providing therapeutic interventions required the hospice to improve its medical treatment capabilities. Administrators had to invest in new equipment and develop clinical competencies among staff to provide more comprehensive services. As medical technology advances, Roots Hospice has continued to expand covered treatments that provide symptom relief for patients. As a result, the demand for the program has grown substantially since it was first piloted in 2009, now serving over 500 patients annually.

Number of Patients Enrolled in Expanded Care Program



86%

Percent of patients who seek enrollment in the Expanded Care program that are authorized for admission

1) Pseudonym.

Source: Post-Acute Care Collaborative interviews and analysis.

A Principled Focus on Cost Secures Program's Future

Consent Form Explicates Roles, Sets Expectations for Care Plan

Criteria for admission into expanded care is made transparent to patients and families through a consent form for the program. Acceptance to the program is based on two qualifications. First, coverage of the treatment must be substantiated on clinical grounds. The treatment should decrease patients' discomfort, yet is not primarily intended to cure. Second, the treatment must be financially reasonable. The hospice prospectively manages the budget for expanded services to ensure the program's viability for future patients.

Roots Hospice reviews the case of each patient who seeks coverage for palliative treatments while enrolled in hospice. If approved, the patient (or his representative), the primary caregiver, and the hospice all sign a consent form that outlines the specific course of treatment for the patient. By having all three parties sign the form, they agree to carry out their responsibilities and share accountability for the patient's care.

Consent Form for Concurrent Care

Patient Consent for Roots Hospice Concurrent Care

☑ Treatment	Outlines exactly which treatments are covered; allows hospice to calculate the cost of care upfront
☑ Team-Based Care	Patients must agree to receive interdisciplinary care, which includes the care team and socioemotional services provided by social workers, care managers, and chaplains
☑ Determination of Coverage	Explains patient's options if hospice decides to no longer cover concurrent treatment

Commercial, Philanthropic Funds Sustain Expanded Care Program

When the program was first launched, commercial insurers agreed to provide reimbursement for the program because of the clinical and financial benefits. However, with a large proportion of the hospice's patients on Medicare, hospice leaders must self-fund the cost of expanded services to a large number of patients. First, hospice leaders use the program's inherent philanthropic offerings to finance the program. Roots Hospice has promoted expanded care as another pillar for advancing the overall mission to serve the community, provide the highest quality of care at the end of life, and to foster hope, healing and respect. In response, the community has offered its financial support through consistent donations.

Hospice leaders also work with referring hospitals to share the cost of providing expanded care. The hospice effectively conveys the value proposition of supporting palliative interventions in a patient's home rather than delivering aggressive, expensive treatments in the hospital. Referring hospitals have partnered with the hospice to cover a portion of the cost of care, particularly when the hospice can work with low-cost DME and pharmaceutical companies and obtain affordable interventions.

As a result of sound stewardship of resources and a focus on generating a diverse funding stream, delivering expanded care is cost neutral for the hospice. Since launching the program, Roots Hospice has not seen an increase in the total cost of care for patients. Additionally, anecdotal evidence suggests that once patients are enrolled in expanded care and become comfortable with hospice, they stop aggressive treatments, thus reducing the total cost of care.

Source: Post-Acute Care Collaborative interviews and analysis.

Care Management Central to Successful Concurrent Delivery

Case in Brief: University of California, Davis

- 619-bed academic medical center
- Recognized by the National Cancer Institute as a Comprehensive Cancer Center
- Enrolled 44 patients in simultaneous care study as the experimental group
- Concurrent care program supported by grant funding

University of California, Davis Medical Center established a concurrent care program after the hospice medical director recognized an inconsistent approach to how the hospital met the needs of patients with advanced metastatic cancer. These patients had exhausted all known courses of therapies, were at the end of life, and were interested in participating in Phase I and II clinical trials to prolong their lives.

Candidates for clinical trials were the same patients that would be appropriate for hospice care. However, participating in clinical trials made patients ineligible for hospice under the Medicare Hospice Benefit. As a result, patients in clinical trials could not receive psychosocial support and symptom management services that define hospice care. This choice between a clinical trial or hospice troubled the medical director.

In an effort to avoid the "either, or decision" for patients with advanced cancer, while preserving the institution's research mission, UC Davis began to pilot a study to assess the effect of palliative care and support services on advanced cancer patients' quality of life and use of hospice care. The health system received grant funding from the Robert Wood Johnson Foundation to start a simultaneous care program and received additional funding from the National Institutes of Health and the National Cancer Institute to expand the program.

Simultaneous Care Defined by Care Management, Multidisciplinary Collaboration

The simultaneous care program was grounded in high-touch care management delivered by a nurse and social worker team skilled in palliative care. By supporting patients in their homes and focusing on the psychosocial aspects of end-of-life planning, the care team dyad addressed many of the well-known barriers to hospice enrollment, such as patient knowledge about their options and resistance to accepting end-of-life care.

The simultaneous care team also collaborated with UC Davis's cancer center staff weekly to discuss patients' physical and psychosocial status. Implementing simultaneous care was a cultural shift in cancer center operations, requiring clinical staff to understand the importance of providing behavioral health and palliative care as fundamental to clinical research trials. To facilitate this cultural shift, the simultaneous care medical director met individually with each oncologist to discuss the project, alleviate any concerns, and secure provider buy-in. Over time, cancer center staff saw the simultaneous care team as an integral part of the patient's care, trusted their contributions, and came to rely on these team members for support. Furthermore, simultaneous care significantly improved early access and referral to hospice care.

Support Provided by Simultaneous Care Team

Proactive Management

- Home visits by nurse 2-4 times/week and by social worker 1-2 times/week
- Manage patient's pain and address changes in physical condition

Socioemotional Support

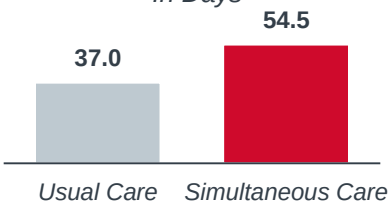
- Care team available for patients and caregivers 24/7
- Discuss emotional issues and end-of-life planning
- Coach patients before clinic visits

Care Coordination

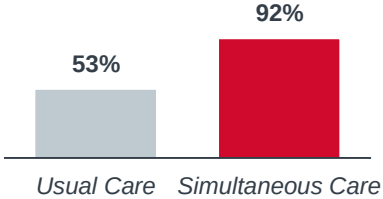
- Coordinate care plan across interdisciplinary care team
- Accompany patient to appointments with oncologists

Median Length of Stay in Hospice

In Days



Hospice Referrals



Source: Post-Acute Care Collaborative interviews and analysis.

Commercial Insurer Innovates on Hospice Benefits

Case in Brief: Aetna Compassionate Care Program

- Serves 22.2 million members in commercial plans; Medicare Advantage members account for about 3% of all members
- Piloted program with 13 self-funded plans representing more than 400,000 members

In the early 2000s, Aetna leaders recognized that the health care system was failing to meet the needs of patients who were dying. They decided to change benefits to help patients with advanced illness feel engaged in making decisions about their care when given a terminal diagnosis.

The Compassionate Care Program, created in 2004, consists of two innovations for patients at the end of life. The first focuses on expanding the traditional hospice benefit. Patients given a prognosis of 12 months or less to live are permitted to access hospice care, which is a notably longer eligibility prognosis than Medicare's 6-month time frame. Also distinctly different from the Medicare Hospice Benefit, Aetna members can continue receiving curative treatments while under hospice care. The second component of Aetna's Compassionate Care Program is a case management service the health plan provides for participating patients.

Aetna initially piloted the program with large self-funded commercial plans, representing more than 400,000 Aetna members. It secured self-funded plans' involvement by assuming full risk of the program—any increases to the total cost of care resulting from concurrent care services would be indemnified by Aetna.

Two-Part Concurrent Care Program

Enhanced Eligibility

- Prognosis of 12 months or less to live
- Patient may continue pursuing curative treatments

Case Management

- Nurse case managers engage patients and families on advanced care planning
- Coordinate with medical staff and direct patients to community-based services

Executive Leadership Key to Championing Program Support

In deciding to launch the Compassionate Care Program, program directors had to ensure that Aetna's executive leadership supported the new benefit. Although program directors had the support of Aetna's CEO and CFO, many self-funded groups remained hesitant to pilot the program for two reasons: 1) lack of evidence that concurrent care produced cost savings, and 2) feared perceptions of pushing beneficiaries toward death.

Garnering participation from self-funded groups required Aetna's CEO to engage in direct discussions with plan sponsors. He emphasized that the program was the "right thing to do" and assured cost neutrality.

Dignity and Comfort at the End of Life

"This program allows people to continue to get the medical treatment that they and their physicians believe is important while enabling patients to achieve the commonly voiced objective of dying with dignity, in a place where they are comfortable, with those whom they love most. We want people to know their options and feel empowered to make meaningful decisions in concert with their family and physicians."

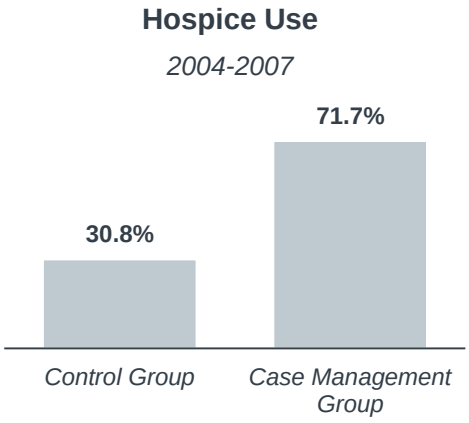
Dr. John Rowe,
Former Chairman and CEO, Aetna

Source: Wade M, "A Comprehensive Case Management Program to Improve Access to Palliative Care: Aetna's Compassionate Care," Aetna, 2011, http://www.ehcca.com/presentations/palliativesummit1/wade_ms3.pdf; Aetna News Release, "Aetna Announces Comprehensive Program to Address End-of-Life Care Issues for Members; Program Provides Expanded Benefits, Support Services and Information," April 29, 2004, http://investor.aetna.com/phoenix.zhtml?c=110617&p=irol-newsArticle&ID=520997&highlight=; Post-Acute Care Collaborative interviews and analysis.

A Clear Business Case for Commercial Patients

Specialized Case Management Essential to Increasing Hospice Utilization

Aetna built on its existing Medicare Advantage case management program and trained nurse case managers to provide specialized end-of-life care to members. To address a primary barrier to hospice—a lack of knowledge and discussion about end-of-life options—case managers discuss advance care planning with members, families, and physicians early in a patient's prognosis. Case mangers were also trained to help improve pain and other symptom management, coordinate medical care, offer personal and culturally sensitive support, and enhance members' use of community-based services and resources. Advanced care planning and comprehensive support provided by case managers substantially increased enrollment in hospice care, while decreasing medical costs.



22%

Net decrease in medical costs attributed to case management component

Expanding Patient Eligibility Facilitates Increased Overall Length of Hospice Stays

While most concurrent care programs aim to reduce delays to hospice care, Aetna's program also increases the eligibility prognosis standard to further broaden the pool of patients who can benefit from hospice care. The 12-month prognosis eligibility threshold gives patients more time to process the decision to enter hospice care. By pairing case management with the expanded hospice benefit, patients elected to enroll in hospice programs earlier than the control group, increasing overall length of stay.

Outcomes for Patients with Expanded Hospice Benefit

36.7
Average number of days patients spent in hospice vs. 21.4 days for control group

63%
Decrease in number of days spent in acute inpatient setting

66%
Decrease in number of days spent in ICU

Today, all of Aetna's commercial plan members are eligible for hospice when given a 12-month prognosis. Despite the expanded eligibility, less than 1% of members continue to receive curative treatment while receiving hospice care. To provide expanded hospice access to more beneficiaries, Aetna plans to offer the Compassionate Care Program to its Medicare Advantage population in the near future, pending approval from CMS.

Source: Wade, M, "A Comprehensive Case Management Program to Improve Access to Palliative Care: Aetna's Compassionate Care," Aetna, 2011, http://www.ehcca.com/presentations/palliativesummit1/wade_ms3.pdf; Post-Acute Care Collaborative interviews and analysis.

Beginning End-of-Life Planning Prior to 'Terminal' Diagnosis

Case in Brief: Sutter Health

- 24-hospital system located in Sacramento, California
- Serves over 4,500 hospice patients annually through Sutter Care at Home
- Average daily census of 650 patients
- Launched the Advanced Illness Medicine program in 2009 in the Sacramento, Sierra region

Sutter Health's Advanced Illness Management (AIM) program is not, strictly speaking, a concurrent care model. AIM is built on a care management model to help Medicare patients with late-stage serious illness and their families make decisions about end-of-life care.

Although patients receive AIM prior to hospice services, the goals of the program align with those of concurrent care: increase hospice utilization, increase hospice length of stay, and improve quality of care for patients at the end of life. Sutter Health implemented the AIM program because it recognized that best-in-class end-of-life planning begins before a six-month prognosis.

End-of-Life Planning Needed Beyond Hospital Walls

Patients with a prognosis of 12 months or less are eligible for the program and need not forgo curative treatment to enroll. The program's eligibility criteria were designed to serve a wider net of patients, accepting patients based on symptoms or utilization, rather than based solely on diagnosis. Focusing on symptoms helps engage patients who do not think they require end-of-life care and may not have been exposed to advanced illness planning.

AIM case managers engage patients within and outside the hospital if they are appropriate candidates for the program. These case managers work with administrative and clinical hospital staff, outpatient physicians, and home-care providers to identify patients who may benefit from AIM services. By seeking patients across multiple care sites within the health system, Sutter increases awareness of end-of-life options, including hospice care.

Appropriate Patients for AIM Admission	
✓	1 or more chronic diagnoses
✓	Questionable benefit from further aggressive treatment
✓	Decline in functional and/or nutritional status in the past 30 days
✓	Hospice-eligible but not ready for hospice
✓	Frequent ED visits or hospitalizations in the past 6 months

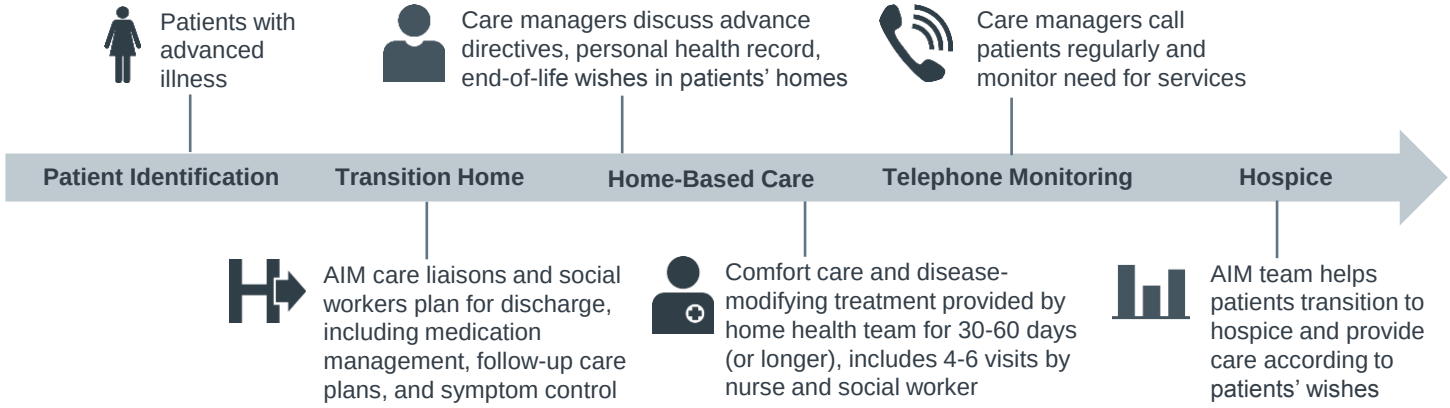
Source: AHRQ, "System-Integrated Program Coordinates Care for People with Advanced Illness, Leading to Greater Use of Hospice Services, Lower Utilization and Costs, and High Satisfaction," AHRQ Health Care Innovations Exchange, October 24, 2013, http://www.innovations.ahrq.gov/content.aspx?id=3370; Post-Acute Care Collaborative interviews and analysis.

Leveraging a Patient's Home as Key Bridge to Hospice

AIM Takes Patient-Centered Care Management Home

AIM occurs at a patient's home, where a comprehensive care team comprised of nurses, social workers, care managers, and other home health providers help patients clarify short- and long-term care goals, manage symptoms, and develop a crisis plan for safety, medication management, and red flags. When home health care is no longer necessary, case managers monitor the patient's health status through regular phone calls and notify the appropriate care team members if the care plan needs to be changed. AIM services continue until the patient is ready and eligible to move into hospice, at which point the case managers transition the patient.

Patient Pathway Under AIM Program



Positive Outcomes Position Sutter for Future Growth

Once enrolled in AIM, patients are hospitalized less frequently and spend fewer days in the ICU when compared with those that receive "usual" care. Furthermore, the AIM program is successful in increasing hospice utilization among all patients. Improvement in utilization is especially notable among the African American population who accessed hospice four times more than the control group, suggesting that AIM reduces racial/ethnic disparities related to access.

Due to demonstrated positive outcomes and the initial success of Sutter's AIM program with patients, Sutter has received a $13 million CMMI[1] grant to expand the program across the entire Sutter system. Sutter estimates it will serve approximately 5,000 patients annually when the program is fully implemented.

Cost, Outcomes from AIM Program

$900	Average program cost per month per AIM enrollee
$760	Cost savings per month per AIM enrollee for Medicare, compared to usual care
47.2%	Percent of AIM patients discharged to hospice versus 33.8% of control group
68%	Reduction in hospitalizations for patients who lived more than 30 days after enrollment in AIM
4x	More African-American patients on AIM enrolled in hospice than control group

1) Center for Medicare and Medicaid Innovation

Source: AHRQ, "System-Integrated Program Coordinates Care for People with Advanced Illness, Leading to Greater Use of Hospice Services, Lower Utilization and Costs, and High Satisfaction," AHRQ Health Care Innovations Exchange, October 24, 2013, http://www.innovations.ahrq.gov/content.aspx?id=3370; Post-Acute Care Collaborative interviews and analysis.

Challenges and Opportunities for Concurrent Care

Although notable differences exist across the concurrent care models profiled in this brief, each organization has similar challenges and opportunities for sustaining and growing concurrent services.

Challenges of Sustaining a Concurrent Care Program

Financial Sustainability

- Decreased utilization of acute services reduces hospital revenue under fee-for-service
- Select care management components are not reimbursed

Technological Advances

- New medical technologies developed to palliate symptoms may require hospice to invest in new infrastructure
- Increased incidence of medically complex patients in hospice may require new staff, additional training

Physician Involvement

- Provider perceptions, misunderstanding about hospice eligibility under concurrent care
- Lack of shared IT infrastructure between referring physicians and concurrent care staff

Opportunities for Growing a Concurrent Care Program

Identifying Patients

- Expanding concurrent care services beyond oncology patients to those with a variety of advanced illness diagnoses
- Identifying patient by symptom, in addition to diagnosis, increases population benefitting from concurrent care

Caregiver, Community Involvement

- Increasing caregiver engagement improves family quality of life, hospice experience
- Positive experiences among caregivers will promote goodwill throughout the community, improve referrals

Cross-Continuum Partnerships

- Embedding concurrent care staff in hospital, outpatient clinics to promote collaboration among providers
- Engaging providers across the continuum increases referrals, may improve partnering on cost

Source: Post-Acute Care Collaborative interviews and analysis.

Strategic Considerations

- Establish Clear Criteria for Concurrent Care
- Develop a Scorecard to Monitor, Report Success
- Demonstrate Value to Engage Commercial Insurers
- Develop Engagement Plan to Scale Financial, Care Model

Overview of Strategic Considerations

While various approaches exist for improving hospice access and providing concurrent treatments to enrolled patients, successful concurrent care programs—regardless of the model—can address select challenges to connecting patients with advanced illness with timely hospice enrollment. This section discusses key considerations for organizations to enhance hospice services by coupling with ongoing curative treatments.

Key Considerations for Expanding Concurrent Care Services

1. **Establish clear criteria of concurrent care:** Define distinct parameters for patient eligibility and services covered for any expanded set of hospice services
2. **Develop a scorecard to monitor, report success**: Create process, outcome metrics that highlight the value of concurrent services to potential partners
3. **Demonstrate value of concurrent services to engage commercial insurers:** Partner with progressive insurers to determine the appropriate parameters for reimbursement
4. **Develop principled plan to scale financial, care model:** Leverage self-insured plan populations to streamline system of care, expand model, and advance physician engagement

Source: Post-Acute Care Collaborative interviews and analysis.

Consideration #1

Establish Clear Criteria for Concurrent Care

An increasing number of treatments can be considered both life-prolonging and palliative. For example, radiation therapy for oncology patients is used for pain management, while also treating certain forms of cancer. Such overlap can be confusing to patients and referring providers alike. Key stakeholders at ab organization must agree upon a definition of concurrent care for patients entering hospice that outlines the following parameters:

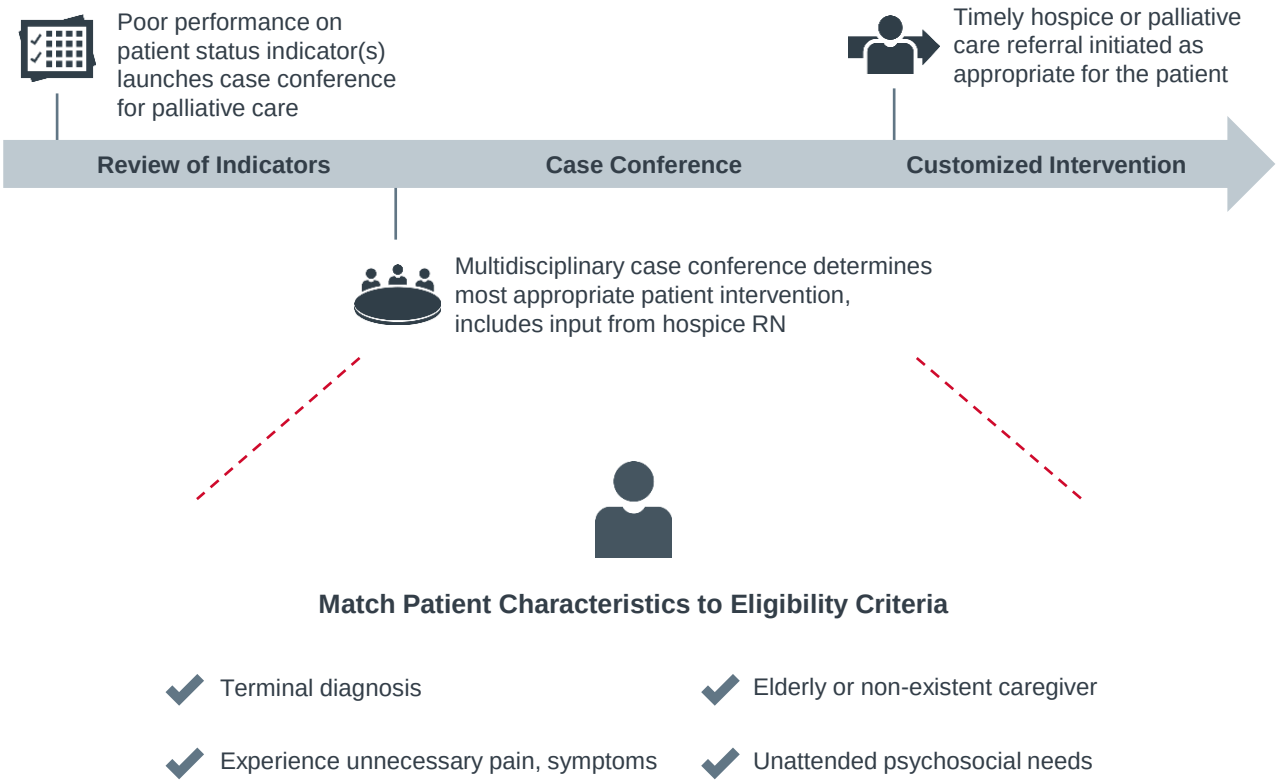
- Scope of services covered
- Duration of coverage for each service
- Expenditure cap on services (if at all)

Select hospice providers use decision trees or algorithms to evaluate patients for enhanced hospice services, while maintaining flexible policies that allow for case-by-case decisions. Your organization should establish and refine a framework for determining patient eligibility for concurrent services before expanding the benefit to a larger population. Such a framework can include criteria based on factors related to quality, patient prognosis, cost, and approval of the primary physician.

An Opportunity to Identify Admitted Patients Appropriate for Concurrent Care

An organization can leverage palliative care consults to trigger an assessment of whether or not a patient is appropriate for concurrent care services.

Hospital-Hospice Case Conference Process to Identify Patients for Referral



Source: Post-Acute Care Collaborative interviews and analysis.

Consideration #2

Develop a Scorecard to Monitor, Report Success

Hospital and payer expectations for post-acute providers—including hospice—are on the rise. As entities set up preferred provider networks, they are increasingly establishing ideal characteristics and performance targets for post-acute care organizations to help manage post-discharge referrals. While many hospices are preparing to meet higher standards, the principles of successful concurrent care models align with several key elements hospitals and payers seek in high-performing partners, resulting in better outcomes beyond those of traditional hospice services.

Sample Hospice Scorecard Information/Criteria

Hospice Characteristics	Care Transitions	Care Quality and Patient Satisfaction	Education	Strategic Alignment
• Proximity to referrer • Internet access • Ownership • Daily census • Availability of bereavement services • JC accreditation • Staff turnover and tenure	• Admissions diversity • Conversion rates • Appropriate bridge program utilization • % patients discharged alive • Length of stay • 24/7 referrals	• Medication accuracy • Appropriate help with breathing • Appropriate emotional and spiritual support from staff • Overall satisfaction scores • Falls • Readmission rates • Pain measure scores	• Community education presence • Provider education resources • Patient information access regarding care • Physician palliative care certification, training	• Willingness to use hospital-preferred vendors (e.g., DME) • EMR connectivity, including ability to upload advance directives • Assistance identifying patients for hospice and palliative care

Track Performance Data to Justify Future Investments

Since concurrent care requires an upfront financial investment that can increase with growing demand, hospice leadership must be disciplined about tracking performance. Gather data on concurrent care beneficiaries, hospice users with expanded benefits, and non-hospice users at the end of life to help make a case for expanding the program in the future. To determine (and later demonstrate) the impact of concurrent services, track outcomes related to hospice access, quality of care, quality of life, health disparities, survival, and survivorship.

Sample Indicators of a Successful Concurrent Care Program

Sample Metric	Ideal Trend
Days spent in hospital	↓
Days spent in intensive care unit	↓
Total patient hospitalizations	↓
Cost of care in last 6, 12 months of life	↓
Median hospice length of stay	↑
Hospice utilization	↑
Symptom management	↑
Referring provider satisfaction	↑

Source: Post-Acute Care Collaborative interviews and analysis.

Demonstrate Value to Engage Commercial Insurers

Select Insurers Already Paving a Reimbursement Pathway

Most patients receiving hospice services are covered by the Medicare Hospice Benefit; however, commercial insurers reimburse costs for approximately 8% of hospice users. While certain commercial insurers do not reimburse hospice care at all, other progressive insurers are attempting to change how end-of-life care is accessed by their members. The changes include expanding hospice eligibility criteria, reimbursing a variety of curative and/or palliative services, and supporting patients with enhanced care management programs. Although private insurers use different reimbursement and care delivery models, they share a common goal—to provide beneficiaries with timely, effective palliative care.

Key Elements of Select Commercial Concurrent Care Benefits

Health Plan	Eligibility Prognosis	Curative Treatment Coverage	Care Management Component
Aetna (National)	12 months	Yes	Complex case management, called "Compassionate Care Program"
University Health Alliance (Hawaii)	Prognosis not considered; any patient with diagnosis that is "active, progressive, and irreversible that will result in a reduced life expectancy" is eligible for services	Yes	Available care management nurse
Anthem Blue Cross (California) [1]	6 months	No; limited to palliative chemotherapy, radiation, and total parenteral nutrition	N/A
Health Net (California) [1]	6 months	Patient-dependent (includes, but not limited to, palliative chemotherapy, radiation, and total parenteral nutrition)	Initial care management visit to home
United HealthCare (California)[1]	12 months or terminal diagnosis	N/A	Telephone-based and in-home RN support
Kaiser Permanente (Southern California)[1]	6 months	N/A	Social worker or case manager support for physician-initiated advanced care planning

1) Health plans have regional or national scope. This chart highlights only the plans in the state of California, due to limited available research on concurrent care plans.

Source: California HealthCare Foundation, "A Better Benefit: Health Plans Try New Approaches to End-of-Life Care," April 2013: 1-11; Post-Acute Care Collaborative interviews and analysis.

Key Considerations for Engaging Commercial Health Plans

Initial conversations with commercial insurers should focus on the projected impact of revised hospice and palliative care benefits to the insurer's beneficiaries and highlight the competencies that make the hospital an optimal partner. In addition to being equipped with examples of commercial insurers already committed to concurrent care, a provider organization should consider four additional strategies.

1. **Approach the Right Payer for Proof-of-Concept Pilot**

   The right payer in your market may not be the largest payer. In fact, size may be a deterrent, as the dominant plan may not have sufficient incentive to innovate and develop a new model, or insufficient volume in your hospice program. On the other hand, plans that are too small may lack the data and resources to view hospice benefit transformation as a strategic priority. Lacking clear indicators of interest, it is important to engage a variety of payers in programmatic conversations to determine the ideal partner.

2. **Partner on Data to Demonstrate Potential Value**

   Providers must build a program that can quickly address specific population needs to attract payers to partner on expanded hospice care. The hospice can request that potential payer partners share claims data during the contract negotiation process and can offer to analyze claims data for beneficiaries in the last year of life to demonstrate the potential benefit of enhanced hospice services. Leverage historic rates of hospice utilization, median length of stay, readmission rates for patients in the last six months of life, average length of intensive care unit stays, and other quality measures to make a quality case for adjusting hospice eligibility.

3. **Provide Options for Improving Hospice Care**

   A number of options exist for achieving goals of improved hospice access and utilization, which include (but are not limited to) concurrent care. Collaborate with individual payers to determine which services best meet beneficiary needs.

Potential Options to Cover in Reimbursement Negotiation

Options for Improved Hospice Access	Include in Program
Expand eligibility for hospice beyond a six-month prognosis	✗
Cover select forms of life-prolonging treatment while patient is enrolled in hospice	✓
Reimburse all forms of curative treatment while patient is enrolled in hospice	✗
Provide a per-member-per-month fee (or "payment bump") for specialized case management of patients with advanced illness, not yet eligible for hospice care	✓
Reimburse hospice-based palliative care programs	✗

4. **Outline Demonstrated Benefits to the Payer**

   The Aetna model presents the best case study to share with other commercial insurers about the impact of concurrent care on commercial beneficiaries. At a minimum, payers will want to understand:

   - Financial impact as it relates to providing the benefits
   - Net costs to make administrative changes and any ongoing administrative costs
   - Likelihood that change might increase utilization of the benefit
   - Cost savings that are anticipated as a result of the proposed change

Source: Post-Acute Care Collaborative interviews and analysis.

Develop Engagement Plan to Scale Financial, Care Model

Scale Services Beyond At-Risk Populations

On the horizon for payment reform, select hospitals and physician groups are bringing hospice services under risk-based contracts to improve long-term patient care management and reduce costs. As organization evaluates decisions around accountable care and value-based payment models, the hospice provider can play a key role in these discussions by offering a model for improved hospice care with demonstrable data on cost and quality improvements.

Opportunities to provide concurrent care services already exist for certain patients—such as an organization's self-insured population of employees and dependents, and children covered under Medicaid or Children's Health Insurance Program (CHIP). Prior to securing additional risk-based contracts, the hospice can select a population for a small, well-defined pilot to test concurrent care services. A pilot program allows the hospice to test alternative models of care, eligibility criteria, physician engagement, and patient acceptance of disease-modifying services along with hospice care.

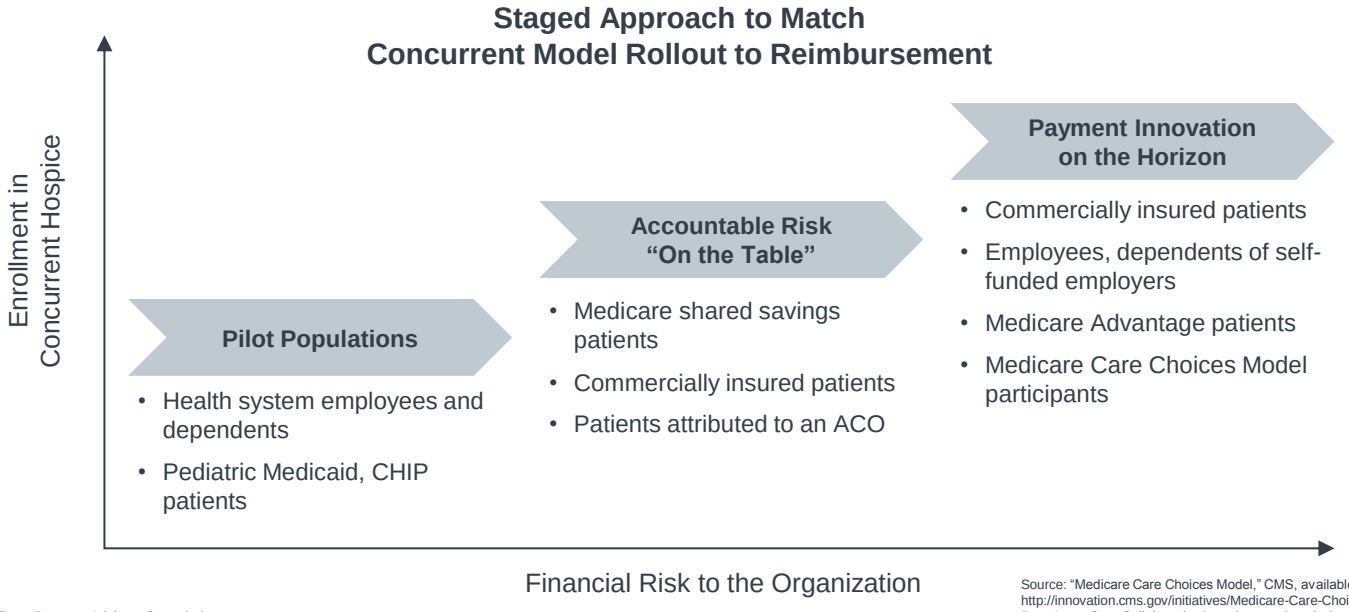
Furthermore, hospitals in the market that sign value-based contracts and form accountable care organizations (ACOs) may be amenable to partnering with hospice providers on alternative models for end-of-life care. A small-scale program creates an opportunity to identify early implementation challenges for concurrent care and reassess program parameters before extending services to these additional populations under risk.

Pilots Position Hospice to Capitalize on Future Program Opportunities, Policy Changes

Piloting concurrent care services with a select group of patients can position an organization to capitalize on future grants to expand comprehensive hospice services, or any publicly or privately funded demonstration projects. And although current Medicare policies do not support concurrent models, there is potential that this will change.

CMS has recently begun accepting applications from hospices for the Medicare Care Choices Model, under which beneficiaries can continue to receive coverage for curative treatment even after beginning hospice care. CMS expects to enroll 30,000 beneficiaries over a three-year trial period to evaluate utilization and effectiveness.

Furthermore, MedPAC[1] recently voted to recommend that Medicare Advantage (MA) plans cover hospice services in its March 2014 report to Congress. This change will eliminate the requirement that all MA beneficiaries must enroll in Medicare fee-for-service when they elect to enter hospice. Medicare Advantage has more flexibility in which services to offer its plan members when compared to traditional fee-for-service, providing individual MA plans the flexibility to offer concurrent care as a supplemental benefit. The hospice provider can begin refining its concurrent care model and documenting value so that it can quickly engage newly eligible patients whenever policy changes—whether within Medicare and/or commercially insured plans.



Source: "Medicare Care Choices Model," CMS, available at: http://innovation.cms.gov/initiatives/Medicare-Care-Choices/; Post-Acute Care Collaborative interviews and analysis.

1) Medicare Payment Advisory Commission.

Educate, Engage Key Stakeholders to Expand Access

Successfully scaling hospice services depends on creating the right program infrastructure, and also on building relationships with referring providers. When physicians trust the hospice team to work collaboratively and share responsibility for the care of patients, the likelihood of timely hospice utilization grows. The remaining aspects of developing a concurrent program, including marketing, care coordination, staffing, and funding, are each essential to a successful program but must be built upon a foundation of trust and collaboration with referring providers.

Multi-level Relationship Building Key for Hospice-Hospital Partnerships

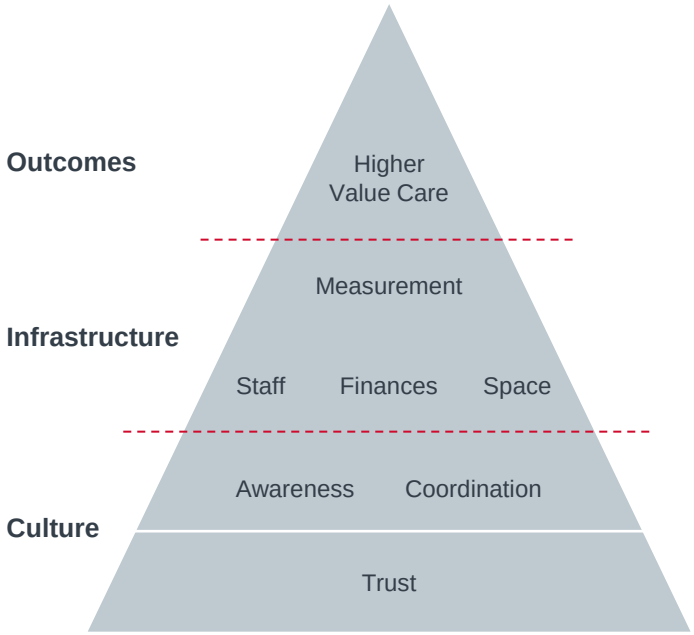
Concurrent care is not simply an expansion of hospice services, it requires that all members of a patient's care team in the health system are engaged in key decisions during advanced care planning and execution. It is important to engage physicians across all stages of expanding hospice services.

Program Design: Garner clinician support early by including key physician thought leaders on end-of-life care in the design of any program to improve hospice access. Solicit physician feedback during all pilot programs and continuously assess whether or not physician concerns and priorities for advanced care planning are being met.

Implementation: Educating health care workers on the benefits of hospice care goes a long way toward improving provider comfort with bringing up end-of-life options to patients. Repetition of the message is important when educating providers; work with well-respected palliative care advocates in the organization to present at team meetings, seminars, during continuing medical education classes, etc.

Ongoing Collaboration: Moreover, the hospice can provide a hospital nurse or social worker liaison who works with hospital clinicians to improve patients' end-of-life care. The liaison can serve as an in-the-moment source of accurate information, facilitate referrals to hospice, advocate for dying patients, and provide case management for hospice patients readmitted to the hospital. In addition to serving as a go-to information source for referring providers and patients, liaison staff can streamline care between hospital and hospice.

Conceptual Model of a Successful Concurrent Care Program



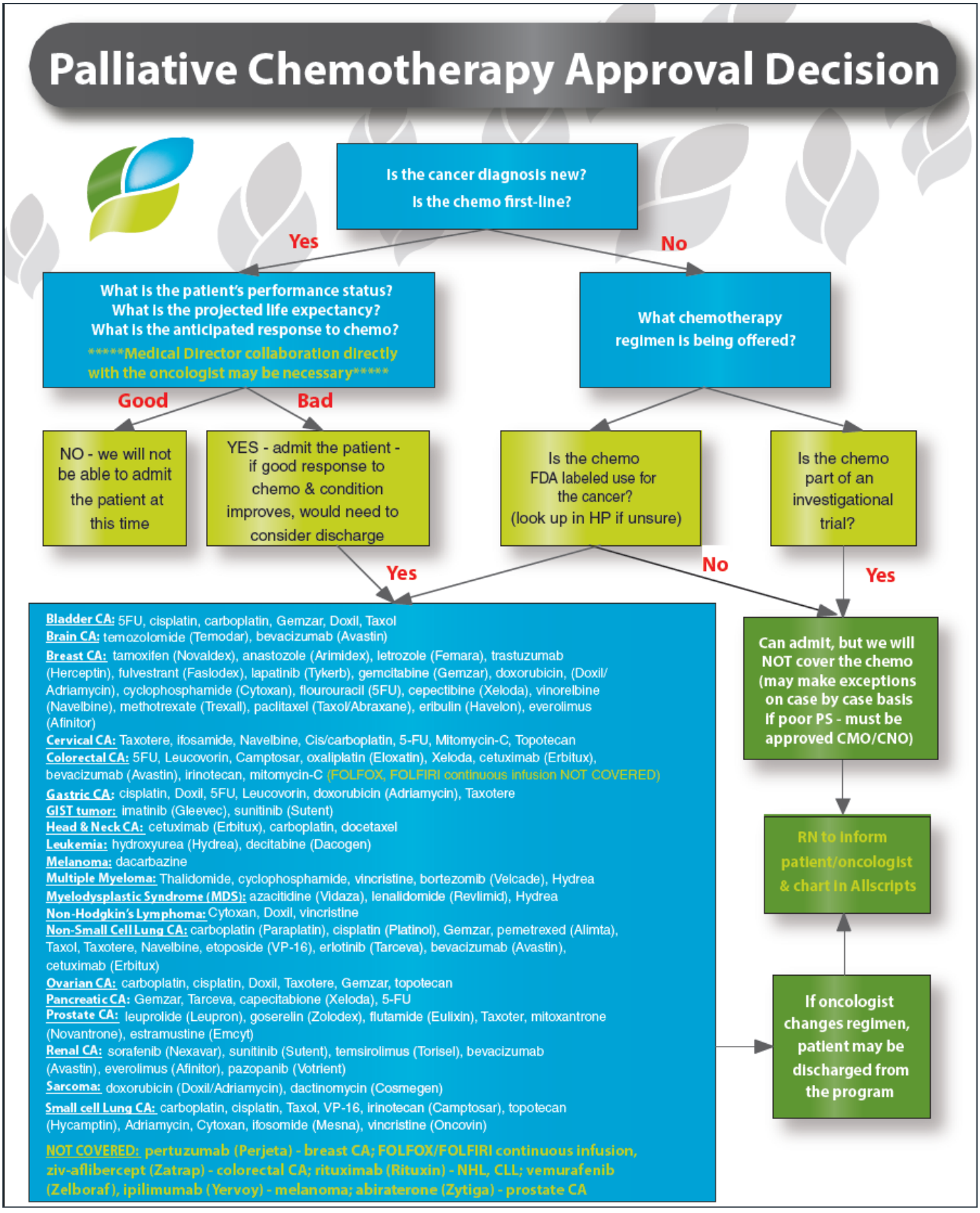
Menu of Hospice Benefits Tailored to Each Stakeholder's Interests	
Economic	• Reducing readmissions • Decreasing mortality rates • Managing length of stay • GIP[1] contract revenue • New source of care funding for the patient
Clinical (Quality, Satisfaction)	• Extending life for the patient • Comfortable end-of-life care tailored to patient preferences • Family support resources • Organization-specific quality • Satisfaction with hospice-provided transitional services
Operational	• Additional staffing support through GIP relationship • Timely, effective transitional care • Hospital/SNF staff training programs for awareness of referral appropriateness • Fundraiser support

1) General inpatient care.

Source: Post-Acute Care Collaborative interviews and analysis.

Appendix

Patient Decision Tree for Expanded Hospice Care



Source: Hospice of Dayton; Post-Acute Care Collaborative interviews and analysis.