

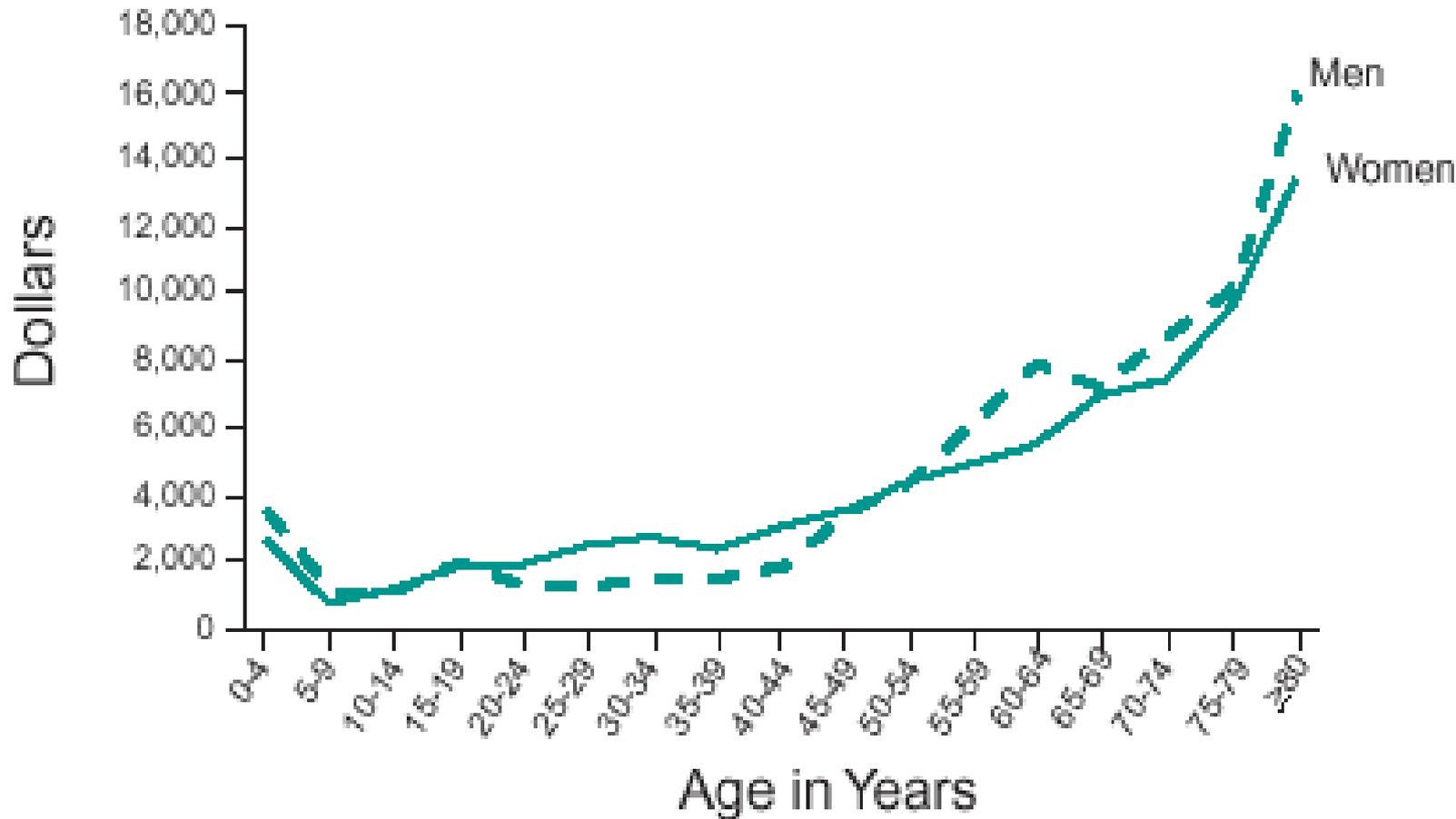
Caring for Patients with  
Advanced and Serious Illnesses:  
Changing Medical Practice and  
Patient Expectations

Aetna's Compassionate Care<sup>SM</sup>  
Program

*Our chief want in life is  
somebody who  
shall make us do what we can.  
—Ralph Waldo Emerson*

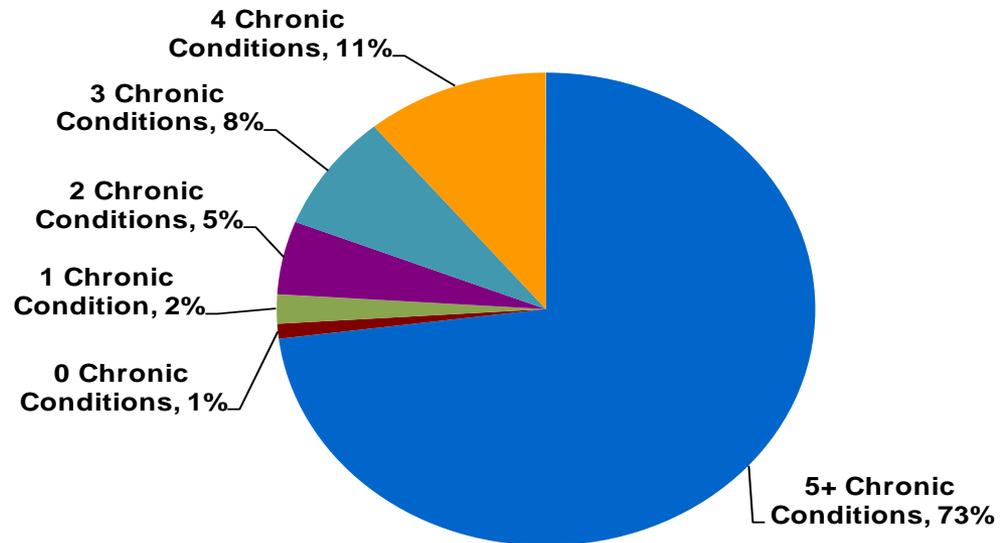
Marcia Wade, MD, FCCP, MMM  
Senior Medical Director, Aetna Medicare

# Medical Costs Increase Dramatically with Age for a Variety of Reasons



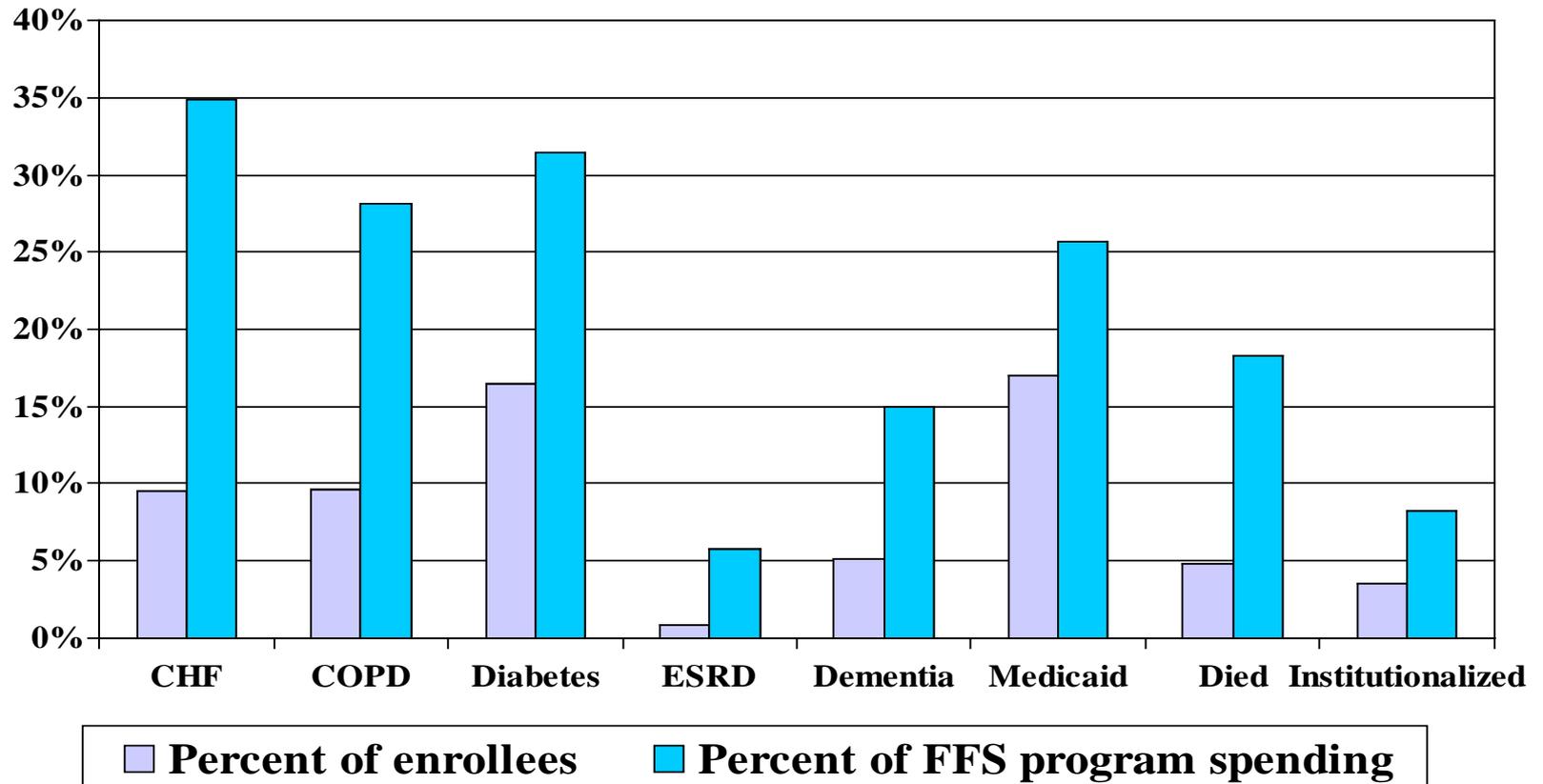
# High value Medicare medical management centers around the needs of seniors with multiple chronic conditions.

73 percent of Medicare spending is for people with five or more concurrent chronic conditions, while only 3 percent is for those with a single condition



Source: Medicare 5 Percent Sample 2004 Data

# High risk factors are often multiple, and are not all “diseases”.



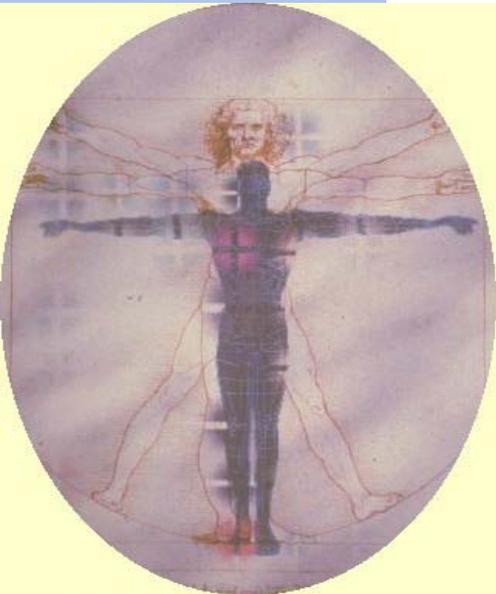
Source: C. Hogan and R. Schmidt, MedPAC Public Meeting, Washington, DC, 18 March 2004. Based on a representative sample of FFS enrollees and all their claims. Beneficiaries may be in multiple categories. Spending is for all claims costs, including treatment of beneficiaries' co-morbid conditions.

# High-Risk Member Resource Consumption

Chronic Co-Morbid Conditions	Percent of the Population	Relative Cost per Member	Percent of Total Cost	Relative Acute Admits	Average Number of Rx's per Year
>4	20%	3.2	66%	5.2	49
3-4	27%	0.9	23%	1.3	26
0-2	53%	0.1	11%	<0.1	11

# Why older patients require more medical management

Many factors make the impact of illness greater for an older patient than a younger patient with a comparable condition. All factors must be identified and managed.



## Factor



## Impact

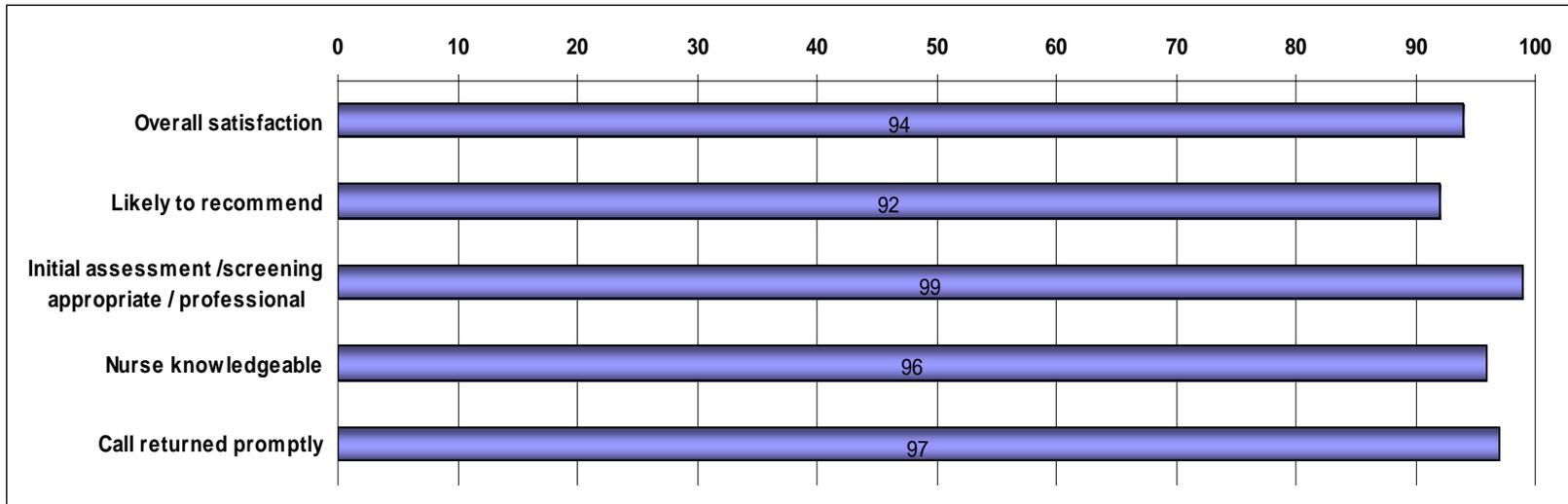
- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>▪ Prevalence of high-risk conditions</li><li>▪ Greater incidence of comorbidities</li><li>▪ Less identifiable symptoms</li><li>▪ Greater potential for damage from injury or condition</li><li>▪ Reduced ability to recover from injury or condition</li><li>▪ Less ability to follow a medical regimen</li><li>▪ Less family and social support</li></ul> | <ul style="list-style-type: none"><li>▪ Greater burden of disease</li><li>▪ Increased need for medical care</li><li>▪ Greater need for surveillance</li><li>▪ Increased need for condition management</li><li>▪ Greater need for preventive condition management</li><li>▪ Greater intensity of medical management</li><li>▪ Increased need for outside help</li></ul> |
|--|--|

# Medicare-focused Case Management: Can help improve quality of life and outcomes

- Approaches member care holistically
- Provides dedicated Medicare case management teams – nurse case managers, social workers and behavioral health case management specialists
- Helps identify members in need of care and coordination
- Specialized case management programs for high risk and vulnerable populations
- Can help reduce medical costs



# Members give Aetna high marks for Medicare Case Management services



Member satisfaction surveys are conducted on an annual basis to assess member perception of services delivered by the Aetna's Medicare Case Management program. The 2008 survey included members who had participated in the Medicare Case Management program between January 2008 and October 2008.



# Aetna Medicare Advantage Care Management Impact

31% fewer hospital acute care days\*



24% fewer ER visits



34% fewer hospital/rehabilitation sub-acute care days



**PLUS**  
39% fewer long hospital stays (greater than 15 days)<sup>1</sup>



■ Aetna Medicare Advantage

■ Medicare (unmanaged population)

\*Exclusive of denials

<sup>1</sup>2010 High performance metrics study: Aetna. Final analysis and conclusions. Aetna. March 17, 2010.

# Geriatric Conditions and Quality Scores

- The ACOVE (Rand) Study identified significant quality and care gaps and opportunities that might be addressed in managing care in Medicare populations
- Opportunities to improve care, especially for advanced illness, were clearly demonstrated

## Geriatric Conditions and Quality Scores

Condition	% QIs Passed
Malnutrition	47
Pressure Ulcers	41
Dementia	35
Falls and Mobility Disorders	34
Urinary Incontinence	29
End-of-Life Care	9

# End of Life Care – Baseline State

- **Lack of Knowledge about Care Options:**
  - Discussions with patients and families regarding plans for advanced illness and care options available are initiated too late or not at all.
- **Barriers to Care:**
  - To enter into hospice and receive palliative care, the patient must discontinue curative care, or stop treatment of the illness.
  - To enter into hospice the patient must be terminal within life expectancy of six months or less to live
  - Often there are coverage limits on hospice care that apply to both number of days in hospice and maximum dollar coverage allowance.

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## *Goal of the Program:*

*To provide additional support to members with advanced illness and to their families, and help them access optimal care.*

# Aetna Compassionate Care<sup>SM</sup>

## Two Components:

1. **Case Management Services** - All of our nurse case managers received training on issues specific to the challenges raised when facing an advanced illness, transforming this type of support into a core competency that is now an Aetna standard.
2. **Enhanced Benefits** – pilot program liberalized the hospice benefits needed by members with advanced illnesses (not for Medicare).

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## 1) Case Management Services

- *Helping members understand options, nurses were trained to:*
  - Assess and manage members' care in a culturally sensitive manner
  - Identify resources to make members as comfortable as possible, addressing pain and other symptoms
  - Help coordinate medical care, benefits and community-based services
  - Inform the member about treatment options, continuity of care, and advanced care planning
  - Provide personal support

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## 2) Enhanced Benefits Pilot Program

- Helping members access optimal care by eliminating barriers
- Not available for Medicare Advantage

Barriers to Care (current industry standard benefits)	Aetna Compassionate Care <sup>SM</sup> Program Enhanced Benefits Pilot Program
Curative treatment: not allowed	Curative treatment: allowed
Hospice: requires physician to certify patient is not likely to live longer than 6 months	Aetna: requires physician to certify patient is not likely to live longer than 12 months
Day and dollar limits placed on hospice benefit	Remove day and dollar limits from hospice benefit

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## Impact

**Results of our three year study of program participants shows:**

- **Significant increase in hospice use**

Hospice use increased dramatically with increases in the percent for members using hospice to 71% for commercial case management and 77% for Medicare.

For Medicare Advantage: 9% of deaths in acute facilities, 9% in subacute

- **Significant decreases in acute hospital utilization**

There were fewer acute hospitalization days and emergency room visits for all program participants. Decreases ranged from 30% to more than 80%.

- **Increase and earlier use of palliative and pain medications**

The increases in use of palliative and pain medications for program participants ranged from 21% to 77%.

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## Results

	Enhanced Benefits Group		Commercial CM Group		Medicare CM Group	
	Study Group	Control Group	Study Group	Control Group	Study Group	Control Group
N	387	387	3,491	3,491	447	447
Average Number of Days in CM Program	42.3	--	39.6	--	56.7	--
Percentage Using Hospice/Respite	69.80%	27.90%	71.70%	30.80%	62.90%	N/A
Mean days between first hospice claim and death	36.7	21.4	28.6	15.9	N/A	N/A
Hospice Inpatient Days / 1000 members	1,819	744	2,027	654	N/A	N/A
Hospice Outpatient Days / 1000 members	16,501	4,090	13,297	3,753	N/A	N/A
Percent of members with Acute Inpatient Stay	16.80%	40.30%	22.70%	42.90%	30.00%	88.40%
Average Length of Acute Inpatient Stay	6.19	7.06	6.54	5.97	7.28	8.26
Percent of members with Emergency Visit	9.80%	15.20%	9.70%	14.40%	8.50%	32.90%
Percent of members with ICU Stay	9.60%	23.00%	11.70%	19.90%	14.80%	50.60%
Acute Inpatient Days / 1000 members	1,504	4,106	2,438	3,882	3,389	19,148
Emergency Visits / 1000 members	96	230	137	197	107	474
ICU Days / 1000 members	863	2,576	1,455	2,000	1,996	13,906

## PERSPECTIVE

## Opportunities To Improve The Quality Of Care For Advanced Illness

An Aetna pilot program shows how it can be done.

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

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

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

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

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

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

*Randall Krakauer is head of Medicare medical management at Aetna in Princeton, New Jersey. Claire Spettell is informatics head, Aetna Health Analytics, in Blue Bell, Pennsylvania. Lonny Reisman is Aetna's chief medical officer, in Hartford, Connecticut. Marcia Wade (WadeM1@aetna.com) is senior medical director at Aetna in Princeton.*



# Aetna Compassionate Care<sup>SM</sup> Conclusion

***“Acceptance of one’s mortality is a process, not an epiphany.”***

Randall Krakauer, MD, Head of Medicare Medical Management, Aetna

This program and its pilot have successfully supported members with advanced illness as well as their families, and helped them access optimal care.

With our case managers offering care options to the seriously ill member earlier, the removal of barriers to care and the liberalization of the hospice benefit, participants were able to access the optimal care that is necessary to help them through a very difficult process.

# Aetna Compassionate Care

## Next Steps

- Continue to support and train our nurse case managers so that end-of-life case management remains a core proficiency.
- Offer expanded hospice benefits on a broader basis to plan sponsors who are looking to offer a “value-based” benefit plan design.
- Support liberalization of the Medicare Hospice Benefit
  - Allow curative therapy
  - Change definition of terminal from 6 months to 12 months
  - In discussions with CMS for large-scale implementation of Hospice benefits enhancement for Medicare Advantage

