Innovations in Community-Based, Advanced Illness Care: A Population Health Approach for Payers

by Terri L. Maxwell, Ph.D., APRN

Behind every dataset that frames a payer’s approach to population health management (PHM) and proactive identification of high-need members with serious illnesses, there are the real-life stories of people and their families: parents, grandparents, siblings or beloved friends who are often struggling with the day-to-day effects of over-treatment during the final months and weeks of life.

Members with advanced illness are broadly defined as those who have one or more conditions that become serious enough that general health and functioning decline, and treatments begin to lose their impact—usually during the final year of life. Members are often coping with new or worsening symptoms and the financial consequences of exorbitant copayments for expensive interventions.

Spending during the final year of life accounts for approximately 25% of traditional Medicare spending. Medicare paid $50 billion just for doctor and hospital bills during the last two months of patients’ lives; that’s more than the budget of the Department of Homeland Security or the Department of Education. It has been estimated that 20% to 30% of these medical expenditures might have had no meaningful impact; yet, the federal government paid most of these bills with few or no questions asked.

There is currently no meaningful, consistent, systematic way of addressing the needs of this subset of members. They frequently go back and forth between a hospital, skilled nursing facility and home, and their needs are poorly addressed with current, general strategies of PHM. In addition, most of these members are ineligible (due to admission criteria), unwilling (due to forgoing treatment) or not educated sufficiently to access the Medicare hospice benefit.

An Innovative Model of Care

To better meet the healthcare needs of members with advanced illness—among the nation’s most vulnerable populations—payers recognize the value of PHM but often fail to provide the specialized population health approach these members need. Using predictive models capable of identifying patients at risk for utilization of non-beneficial care that results in poor patient/family outcomes and high expenditures could differentiate these seriously ill members from others in the costliest top 5% of patients.

Empowered with this information, payers could optimize their PHM programs for seriously ill members by offering a model that includes advanced illness management (AIM). These models that deliver community-based, palliative interventions to seriously ill members in their home is the key to truly achieving the triple aim for this population—better health, better care and better value. Palliative care is specialized care for people with serious illness, and focuses on providing relief from symptoms and stress associated with life-limiting conditions and improving quality of life for both a patient and family. Palliative care provides an extra layer of support; it is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

AIM integrates palliative interventions to specifically address the needs of members with illnesses that are causing their health to deteriorate progressively and often rapidly. When predictive analytics identifies members suitable for AIM, payers have an opportunity to introduce palliative care services sooner rather than relying on referrals that frequently come very late in an illness—if at all. Earlier identification is a significant benefit to members who need and value this level of assistance, enabling them to receive support to remain at home rather than experiencing non-beneficial and often burdensome care in a hospital.

AIM strives to improve individual and family satisfaction, increase quality of care, reduce inefficiencies, decrease caregiver burden and increase care coordination. This model is a holistic approach that includes symptom relief; medication management; establishing goals of care that meet individual member needs and wishes; support for a family; and the maintenance of the best possible quality of life for members within the limitations of their illnesses. This level of education and support advances members’ understanding of their conditions and promotes disease self-management.

From a clinical perspective, this expanded range of services should also address social, behavioral and psychological issues that take on even more relevance for members choosing to live at home.

Optimizing a New Model of Care
While palliative care has been available on a limited basis in acute care hospitals and as part of an end-of-life program through hospice, payers are now beginning to incorporate this approach into their overall PHM strategies.

Today, there are specialty PHM companies that partner with payers to deploy community-based, palliative care models to better meet the needs of this population. A value-based, payment model allows for reimbursement of community-based, palliative care teams comprised of nurses and social workers with experience, expertise and training in offering high-touch clinical services.

This differs markedly from a community-based, palliative care program that relies on fee-for-service billing to Medicare Part B by physicians or nurse practitioners. Providing palliative nurses and social workers with the tools and training to ensure high-quality care allows for a scalable and financially feasible PHM solution while obviating the need for time and resource-intensive recruitment of medical doctors and nurse practitioners.

With a focus on care coordination, community-based, care teams promote best practices; standardize care; facilitate communication between patients and providers to improve decision making related to goals of care and advance care planning; make referrals to community resources; and manage pain, symptoms and medications. This approach not only leads to better outcomes but also captures lost opportunities for savings.

Assisted by access to advanced predictive analytics generated through PHM programs, these community-based, palliative care professionals can engage their target populations, using a consultative model that includes telephonic outreach and home visits that are guided by standardized, palliative care assessments and visit protocols.

AIM provides:

- Improved care quality, member/caregiver satisfaction and increased access to palliative care.
- Avoidance of non-beneficial, costly care at the end-of-life, reducing the overall economic burdens for a health plan, member and family caregiver.
- Care that is primarily driven by the values, goals and preferences of seriously ill individuals and their family members, resulting in more compassionate, affordable, sustainable and high-quality care.

Successful AIM population health programs are able to:

- Leverage existing, community-based, palliative care nurses and social workers who are typically attached to local hospice organizations as opposed to carving out services to a medical practice that might not be scalable or have adequate palliative care experience.
- Ensure rapid market entry in several weeks versus six-to-nine months, building local support and advancing member enrollment and retention initiatives.

This population health approach quickly improves upon the current level of care for those with advanced illness, which is often aggressive even when the prognosis is poor and costs are burdensome. It aligns with the prevailing shift away from fee-for-service to value-based care that allows payers to recalibrate their models of payment and care delivery.

Studies have shown that this care model has seen a substantial drop in healthcare expenditures, hospitalizations, readmissions, ICU days and unnecessary—often unwanted—interventions. Concurrently, there are improved symptom management, increased goals of care discussions, medication reconciliation and hospice benefit adoption.

**Advancing Goals of PHM**

By strengthening PHM strategies with AIM models that harness the capabilities of local palliative care providers, payers are able to augment capabilities to proactively scale interventions that enable better care at lower cost. PHM is better positioned to truly deliver on the promise of improved care coordination and the implementation of care plans that better reflect the goals of care as expressed by individuals and their families. This is the real path to providing patient-centered care, while reducing inefficient or costly approaches.

With the understanding that their symptoms will be better managed, members often choose treatment that is less aggressive, leading to fewer side effects and helping them to remain in their home, which is in alignment with most people’s goals at the end of life. In fact, research has found that most adults (90%) say they would prefer to receive end-of-life care in their home if they are terminally ill; yet, data show that only about one-third of Medicare beneficiaries (age 65 and older) die at home. In addition, friend and family caregivers no longer have to improvise in a role for which they might not be prepared; instead, they are able to rely upon palliative care experts for guidance, resulting in more compassionate, affordable, sustainable and high-quality care.

**Developing AIM/Palliative Care Programs**

With new AIM/palliative care programs, there are a number of important points that ACOs, population management partners, clinically integrated networks and payers should keep in mind. It’s important to implement a program that is innovative, has the ability to identify and target a specific population, engage participants and/or obtain referrals. It should be designed to measure the financial and non-financial benefits, and overcome potential challenges that could delay implementation or impact a program.

It’s also important to understand how the model fits the strategic direction of a PHM strategy. Ultimately, success relies upon engaging with partners capable of successfully streamlining healthcare by avoiding undesired or non-beneficial care, reducing inappropriate resource utilization and improving member satisfaction.


Terri Maxwell, Ph.D., APRN, serves as chief clinical officer of Turn-Key Health and as vice president, clinical education, Enclara Pharmacia, an affiliate of Turn-Key Health. She may be reached at TMaxwell@turn-keyhealth.com.