

A photograph of a man and a woman embracing outdoors. The man, with grey hair, is wearing a light blue checkered shirt and is kissing the woman on the forehead. The woman has dark hair and is wearing a white top. They are standing in front of a blurred green background, likely a garden or park.

How-to-Guide: Integrating Palliative Care into Your Purchasing Strategy

This How-to-Guide helps educate employers and other health care purchasers on the value of palliative care, how it can improve the quality of life for employees living with serious illness and their caregivers, and in so doing, reduce health care costs for them, as well as for their employers. It also introduces the Purchaser Toolkit for Serious Illness Care Strategies, jointly produced by *Catalyst for Payment Reform* and the *Center to Advance Palliative Care* that gives purchasers resources to develop a new palliative care strategy or infuse palliative care into existing health care programs.



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Executive Summary

People living with serious illness need a different approach to their care than our health care system typically provides. To meet their needs, the system must solicit their health care goals and preferences and deliver care accordingly, coordinate care across settings and over time, ensure safe and effective management of symptoms, and provide support for caregivers. Employers and other health care purchasers can play a powerful role in improving care for people living with a serious illness by demanding certain capabilities from contracted health plans, vendors, and health care providers. These capabilities are:

- Proactive identification of the population of patients living with a serious illness
- Incentives for training network providers in communication and symptom management skills
- Access to certified specialty palliative care teams across care settings
- Access to appropriately trained case managers
- Specific benefits that include home-based services and support for caregivers

This How-to-Guide for purchasers articulates the essential value of palliative care, describing how it improves the quality of life for employees living with serious illness and their caregivers, and in so doing, consistently and substantially reduces health care costs. It also introduces the **Purchaser Toolkit for Serious Illness Care Strategies** jointly developed by *Catalyst for Payment Reform* and the *Center to Advance Palliative Care* to give employers and other health care purchasers resources to develop a new palliative care strategy or infuse palliative care capacity into an existing health care program.

Introduction

[Catalyst for Payment Reform \(CPR\)](#) is an independent, nonprofit corporation on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. CPR derives momentum from its membership, a group of 30+ progressive employers and other health care purchasers who collaborate to advance health care payment and delivery reforms, innovative benefit and provider network designs and transparency on costs and quality in the health care system. CPR develop tools, conducts research, and offers education to help purchasers work collectively to push for higher-value health care.

[The Center to Advance Palliative Care \(CAPC\)](#) is a national nonprofit organization dedicated to increasing the availability of quality palliative care services for people facing serious illness and those who care for them. CAPC provides hospitals, health systems, health plans and other health care organizations with the tools, training, technical assistance and metrics needed to support the successful implementation and integration of palliative care principles and practices. With more than 1,300 organizational members, CAPC provides support for program development, clinical skill training, and national leadership on improving the care and quality of life of people living with serious illness.

Our partnership

CPR partnered with CAPC to expand awareness and support of palliative care among employers and other health care purchasers. We believe that the tremendous leverage purchasers have in the market when they collectively demand the same, or similar, things of both health plans and providers can drive needed change in access to optimal care for people living with serious illness. Thus, purchasers can make a direct and significant improvement in the quality of life of employees living with serious illness and their caregivers.

CPR and CAPC created **The Purchaser Toolkit for Serious Illness Care Strategies** to give employers and other health care purchasers resources and technical assistance for implementation of strategies to assure reliable access to quality palliative care. These efforts will improve the quality of life for employees living with serious illness and their caregivers, and by averting predictable crises, prevent unnecessary emergency hospitalizations, thus reducing health care costs at the same time. This How-to-Guide is a wrap-around resource that helps educate purchasers about palliative care, makes the case for how palliative care can improve quality of life and reduce health care costs, and introduces the Toolkit.

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and for helping to refine the Request for Information: Access to Comprehensive and High-Quality Serious Illness Care (RFI) and the Model Evaluation Guidance.

The Imperative for Better Care for Those Living with Serious Illness



Meet John.

John is a 34-year-old electronics engineer with a wife and two young daughters who was diagnosed several months ago with a tumor in his colon. He underwent a course of chemotherapy in hopes of shrinking the tumor to enable surgery. John developed painful numbness and tingling in his fingers and toes from chemotherapy and the dose had to be reduced because of this symptom.

After 9 months of chemotherapy John was scheduled for surgery, but during the operation doctors found that a surgical removal of the tumor was impossible because of innumerable cancerous lesions throughout his abdomen. With little other choice, he continued on chemotherapy, but began having debilitating fatigue and pain. John became limited in his ability to work or engage in activities with his family because of his symptoms, and he could not drive because of the neuropathy in his hands. He is no longer able to work and is panicked about how he will continue to support his family. His wife works for the same company and needs to stay on the job both for access to health insurance and to support the family as John can no longer work. She is beyond stressed between the demands of caring for her young children, John's needs, and a full-time demanding job.

John is in so much pain that he begins taking dangerously high doses of ibuprofen for pain with little relief. After another sleepless night, his exhausted and overwhelmed wife calls the oncologist in middle of the night, where she hears a taped voice telling her to hang up now and call 911 if it is a medical emergency. John's wife brings him to the emergency room and his debilitation and pain result in an admission to the hospital. During his hospitalization, the oncology team starts him on an opioid regimen to manage his pain. Although it helps his abdominal pain, it does not provide much relief of the neuropathic pain in John's hands and feet. The team discharges him and sends his opioid prescription to his local pharmacy. It is a 2-hour drive home from the hospital, and when John and his wife get to the pharmacy, they are told that the pharmacy does not have the opioid in stock. It will take 6 days to fill the prescription. It is now 7 p.m., and John's wife calls the oncology team about the medication. She leaves a message but does not get a call back. As John's pain increases, his wife sees no option but to bring him back to the emergency room. John is readmitted the next day.

Two days later, John is again discharged from the hospital. He leaves with a 4-day supply of opioids so that he has enough to last until his local pharmacy gets the medication in stock. Both John and his wife feel overwhelmed and depressed by his situation. The family continues a pattern of last-minute, emergency care that resolves crises as they arise, but they and their care team remain focused solely on tumor treatment, without any support for practical, psychological, and financial aspects of the family's quality-of-life. Both he and his wife wonder if there is a better way.

John's story is typical and illustrates the high costs of failing to meet the needs of the population living with serious illness. The system is designed well to treat individual diseases like cancer but fails to recognize and address the many consequences, stresses, and burdens of living with a serious illness, not only for the patient but for his family as well. These gaps result not only in unquantifiable human cost of suffering to the patients and their families but also in overwhelming financial costs to patients and families, to the health care system, to employers, and to society at large.

Today, John is one of 11 million adults and upwards of 400,000 children in the United States living with at least one serious illness¹ and this number is expected to increase significantly over the next two decades. While the size and health care costs of the seriously ill population is considerable and growing, this group routinely receives care that is characterized by inadequately treated symptoms, poor communication with health care providers, and enormous strain on family members or other caregivers.² John is an individual, but is typical of patients and families across the U.S. who suffer in a health care system that lacks the capabilities to care for this high-need and high-cost population.

What is a serious illness?

Serious illness refers to a health condition that carries a high risk of mortality AND either negatively affects a person's daily functioning (specifically eating, bathing, dressing, toileting, walking, and transferring from the bed) or quality of life, or excessively strains caregivers. A list of serious illnesses includes metastatic cancer, renal failure, advanced liver disease, diabetes with complications, amyotrophic lateral sclerosis (ALS), acquired immunodeficiency syndrome (AIDS), oxygen-dependent chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) with hospitalization, hip fracture, advanced heart disease, dementia, and advanced frailty.³

Concentration of risk and spending

While people with a serious illness typically represent only a small proportion of the population (roughly 2-3% of the commercial population and up to 10% of retiree populations), because they

¹ The Commonwealth Fund. High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? (August 2016).

² Kelley AS and E Bollens-Lund. Identifying the Population with Serious Illness: the Denominator Challenge. *J Palliat Med* (2018); 21(S2); Kaiser State Health Facts, www.kff.org/medicare/state-indicator/per-enrollee-spending-by-residence accessed 6/29/18.

³ Kelley AS EK Covinsky, RJ Gorges, et al. Identifying Older Adults with Serious Illness: A Critical Step Towards Improving the Value of Health Care. *Health Svcs Res* (2017); 52(1).

are so sick and complex they consume the great preponderance of health care resources. For instance, mean annual spending for Medicare beneficiaries with serious illness is more than \$34,000, compared to only \$11,000 on average per beneficiary without a serious illness.⁴

Impact on families

Moreover, serious illness doesn't just affect the individual, it also affects those who care for them. For the 11.4 million adults and children living with a serious illness, there are also millions of family caregivers who dedicate time, energy, and resources to caring for their loved one. The responsibility of taking care of a loved one, while fulfilling, can also take an enormous toll on the caregiver – more than one in five cite adverse impacts on their own health.⁵ Moreover, about 17% of full-time workers are also caregivers, and six in ten working caregivers report their caregiving role has a negative impact on their work, including cutting back on work hours, taking a leave of absence, declining job performance, having to turn down a promotion, or giving up work entirely.⁶ Overall, caregiving has been shown to reduce employee work productivity by 18.5% and the cost in terms of lost productivity to U.S. businesses is up to \$33 billion annually.⁷

The gaps in care

The gap in care for seriously ill people is no surprise given that the fee-for-service payment system is focused on volume, creating a strong financial incentive for providers to deliver more care and more costly care, as opposed to those services that are well matched to the needs of patients. As a result, there is little to no time in the encounter to discuss patient's understanding of their illness, what to expect, and what is most important to them; to assess and address social, emotional, spiritual, and practical needs; and to provide expert management of pain and other symptoms that are the universal accompaniment of living with a serious illness. Significant gaps in caring for patients living with serious illness and their families include:

- **Insufficient clinician training** to ensure that treating providers have the knowledge and skills to safely and effectively manage pain, symptoms, and other stresses, and hold difficult conversations such as those centered on advance care planning and goals-of-care for the future. Clinicians cannot be expected to address these critical issues if they have never been trained to do so.
- **Medical and utilization management inadequately incorporate palliative care.** Case managers are ubiquitous and routinely serve high need high cost patients with palliative care needs, but they lack specialized training in advance care planning, goals-of-care conversation skills, how to assess the burden posed by symptoms, how to assess psychosocial and family needs, or how to work with treating providers to modify the care plan to ensure its alignment with

⁴ Kelley AS and E Bollens-Lund. Identifying the Population with Serious Illness: the Denominator Challenge. *J Palliat Med* (2018); 21(S2); Kaiser State Health Facts, www.kff.org/medicare/state-indicator/per-enrollee-spending-by-residence accessed 6/29/18.

⁵ IBID

⁶ Caregiver Statistics: Work and Caregiving. (2016). Family Caregiver Alliance. <https://www.caregiver.org/caregiver-statistics-work-and-caregiving> accessed 9/14/18.

⁷ IBID

patient goals. As a result, they often fail to provide the supports necessary to help patients and families navigate their illness in a manner that is aligned with what is most important to them.

- **Unreliable access to specialty palliative care services** when patient needs exceed the skills and knowledge of their front-line clinicians, such as complex pain, symptoms, and other stresses of serious illness. Health plans typically do not have processes in place to screen for and identify plan participants in need of palliative care specialists, and benefit plans often do not support home-based palliative care delivery, nor ensure the quality of those services that are available.
- **Caregiver support falls short.** Many caregivers lack access to education and services designed to assist family caregivers of those experiencing serious illness, such as training in wound care or medication management, in home supports for bathing and dressing, coverage for respite stays of limited-duration in a nursing home or for visits with specialists trained in grief and bereavement.

These gaps often result in emergency department visits and hospitalizations that are otherwise avoidable. Moreover, the delivery of burdensome and costly treatments that are not likely to provide clinical benefit carry real risks of harm, steal time from patients that could be better spent at home and with family, significantly increase health care costs, and deviate from the types of care that the great majority of seriously ill people want.

Making a Difference

It doesn't have to be this way

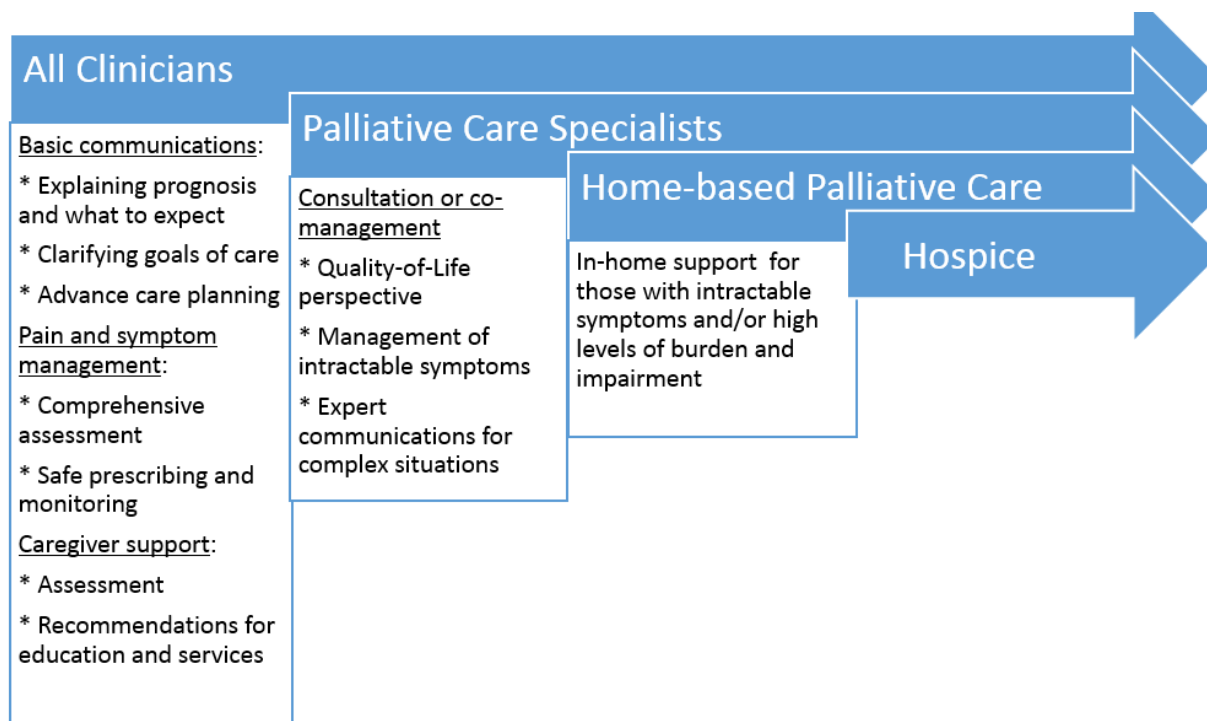
Patients do not have to experience anxiety, fragmentation, and a poor quality of life or unnecessary emergency department visits and hospital admissions. When the clinicians in the health care system routinely ask patients about their values and goals, assess and address their symptoms, concerns, and practical needs, and align treatment with their evolving goals, quality of life improves, and costs decline.⁸

Palliative care:

- Is specialized care that focuses on providing relief from the symptoms and stress of a serious illness—whatever the diagnosis.
- Is appropriate at any age, at any stage of a serious illness, and should be provided **along with curative treatment**, including for patients who are aggressively seeking a cure.
- May sometimes be called “supportive care,” “compassionate care,” and “personalized care.”

⁸ Kavalieratos D, J Corbelli, and D Zhang. Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis. *JAMA*, (2016): 316(20); Smith S, A Brick, SO'hara et al. Evidence on the cost and cost-effectiveness of palliative care: a literature review. *Palliative Medicine*, (2014); 28(2).

Basic palliative care can and should be delivered by a patient's treating clinician, provided they have completed additional training in communication skills and pain and symptom management – training that the great majority of US clinicians practicing today have never received. However, for patients with the most complex situations, significant family distress, and/or intractable symptoms, specialty clinicians who are trained and board-certified in palliative care should be added to the patient's care team.



Now, let's imagine how different John's story could be with the addition of palliative care.

John is a 34-year-old electronics engineer with a wife and two young daughters who was diagnosed several months ago with a tumor in his colon. He underwent a course of chemotherapy in hopes of shrinking the tumor to enable surgery. John developed painful numbness and tingling in his fingers and toes from chemotherapy and the dose had to be reduced because of this symptom. John and his wife express sadness over the dose reduction, as they understand that this may make the treatment less effective in controlling his cancer. His oncologist identifies both the neuropathic pain and the distress about treatment options as unmet needs and refers him to the ambulatory palliative care practice for their expertise in supporting patients with these issues.

John and his wife attend their initial palliative care office visit. They first meet the practice's Registered Nurse (RN), who introduces how palliative care can be provided concurrently with disease-directed cancer treatment. The RN completes a symptom screen and identifies moderate to severe depression, anxiety, pain, constipation, and fatigue as symptoms that interfere with the patient's ability to function and quality of life. John discusses how lost he feels since he cannot work because of the neuropathy, and John's wife shares how difficult things

have been at home since he has been more withdrawn, depressed, and less engaged over the past month. The palliative care team starts John on a medication to target the painful neuropathy. They also start an anti-depressant and medications to treat constipation. The following month, John returns for re-evaluation. He has less abdominal pain since he is no longer constipated. John's wife reports he has been more engaged with her and their children since the anti-depressant has started working. John's neuropathy is also much improved, and he isn't driving yet but he thinks he could if the neuropathy was a little more controlled. Since he is tolerating the pain medication without side effects, the physician increases the dose.

Since his last palliative care visit, John was scheduled for surgery, but during the operation the surgeon discovered that a surgical removal of the tumor was impossible because of innumerable cancerous lesions throughout his abdomen. John and his wife are tearful when discussing this. They haven't seen his oncologist since the surgery and they don't know what the next steps are in their treatment plan.

The palliative care physician offers to help John and his wife formulate some questions that might facilitate the next visit with the medical oncologist. The physician writes down John's questions, which focus on the available treatment options, his prognosis, and what the best- and worst-case scenarios might be for him with all the potential options. A copy of the questions is put into his medical record, sent to the oncologist, and printed for John and his wife. The next week, John and his wife meet with the oncologist. Using the pre-planned questions as a framework, John is told that he can continue to get the chemotherapy he's been getting, that if his cancer can be stabilized his prognosis is 2-3 years. He is presented with a clinical trial as an alternative treatment, but is not interested in this because it would require 3 visits/week and each trip to the cancer center is 4 hours round-trip. He is also told that if his cancer grows there are other treatment options available. The next month, John returns to the palliative care practice. He reports that he is now able to drive because his neuropathy is well managed. He is again able to work. His mood is much better – he feels less irritable and is spending time with his wife and children.

John is maintained on the same chemotherapy for 1.5 years. During this time, he has monthly visits with his oncologist and monthly visits with his palliative care team (on the same day). The medications he takes to address his symptoms change over time based on how he is feeling—there are times when the palliative care team starts opioids for pain, and times when he reduces or even stops taking them depending on how he is feeling. The team also helps him cope with “scanxiety” which is the overwhelming anxiety he feels in the days leading up to each restaging scan and the time between getting the scan and getting the results. Unfortunately, his next scan shows additional progression of disease and new metastatic disease in his bones and liver. He comes in and has a joint visit with both his oncologist and palliative care physician. The oncologist offers him a 2nd line IV chemotherapy or a “chemo pill” that he could take at home. John and his wife are overwhelmed with the news, but the teams work together to answer his questions in ways that are helpful to John and his wife. The oncologist shares that his prognosis without any disease-directed treatment would be less than 6 months, while additional treatments may prolong his survival to a year or maybe longer. John and his wife do not know

what to do, but the palliative care physician helps him identify that what is most important to him is being able to be at home with his children and have his symptoms controlled. Since the oral pill would allow him to make fewer trips to the hospital and the oncologist thinks it is a medically appropriate treatment, John decides to move forward with that option.

Everyone agrees that if, at any time, John decides that the treatment is more burdensome than helpful, he can stop it at any time. With a new sense of empowerment and control over their care decisions, John and his wife feel much better prepared to face the future together.

Why Palliative Care Matters for Purchasers

Value is the intersection of cost and quality

As employers and other health care purchasers pursue higher value for their health care dollar, they usually start with a focus on cost drivers impacting the workforce and health care spending. Yet purchasers can gain maximum value when quality improves at the same time their spending is reduced, when care is delivered in a manner that addresses and averts crises, reducing preventable spending.

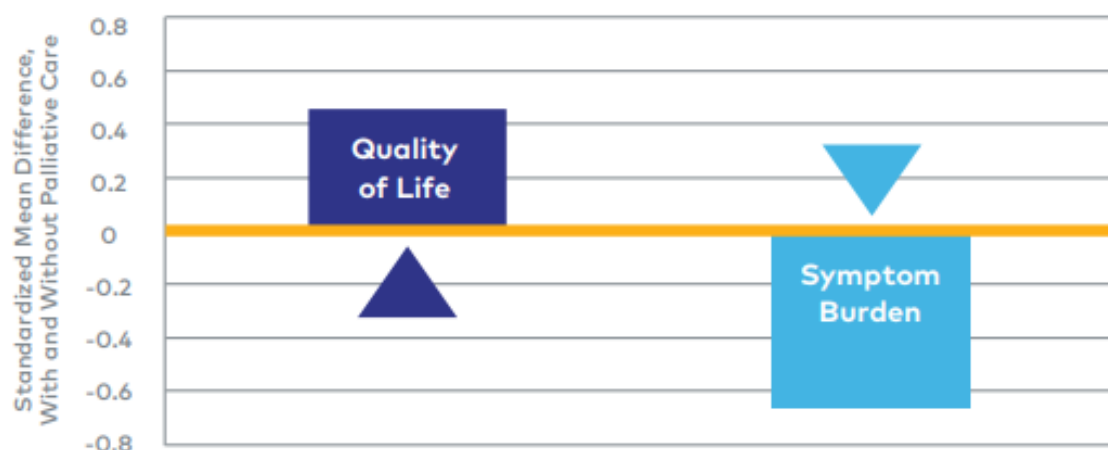
This dual-focus has been the developing trend among purchasers. Instead of solely implementing strategies designed to reduce spending, such as cost sharing through consumer-driven health plans, purchasers have also embraced strategies that lead with quality, such as contracting with and encouraging employees to seek care at centers of excellence. In so doing, they can improve quality while driving out avoidable spending. Strategies centered on palliative care are no different.

The need for palliative care

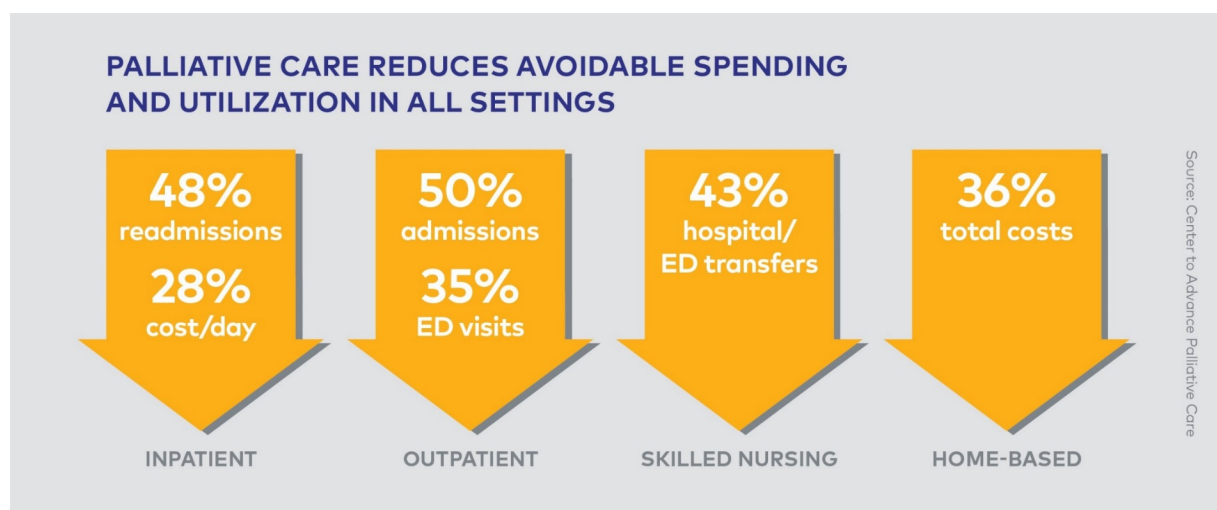
Palliative care is one of the few solutions available that has the potential to benefit all stakeholders—employees, employers and other health care purchasers, providers, and health plans—by simultaneously improving quality-of-life, ensuring satisfaction with care, and reducing spending. Furthermore, when delivered concurrently with treatment as an added layer of support, distressing symptoms such as pain or shortness of breath are significantly reduced, while families gain emotional and practical support and a sense of control.

A recent meta-analysis has confirmed these positive impacts.⁹ Other benefits include improved communication between patients and their providers, and improved ability to complete treatment regimens, precisely because symptoms are managed, and quality of life and function are preserved.

⁹ Kavalieratos D, J Corbelli, and D Zhang. Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis. *JAMA*, (2016): 316(20); Smith S, A Brick, SO'hara et al. Evidence on the cost and cost-effectiveness of palliative care: a literature review. *Palliative Medicine*, (2014); 28(2).



Palliative care reduces health spending by decreasing the occurrence of 911 calls, the need for unnecessary emergency department visits, hospitalizations, and intensive care. Cost savings also come from reducing treatments that are not aligned with patient goals and may in fact harm them.¹⁰ Research has demonstrated cost savings across care settings, including hospitals, skilled nursing facilities, and home-based settings.^{11,12,13,14}



¹⁰ Smith G, R Bernacki, SD Block. The role of palliative care in population management and accountable care organizations. *J Palliat Med.* (2015);18(6).

¹¹ Krakauer, R, C Spettell, L Reisman, et al. Opportunities to Improve the Quality of Care for Advanced Illness. *Health Aff.* (2009);28(5).

¹² May P, C Normand, JB Cassel, et al. Economics of palliative care for hospitalized adults with serious illness: A meta-analysis. *JAMA Intern Med* (2018).

¹³ Adelson, K, J Paris, JR Horton, et al. "Standardized Criteria for Palliative Care Consultation on a Solid Tumor Oncology Service Reduces Downstream Health Care Use." *J Oncol Pract.* (2017); 13(5).

¹⁴ Lustbader D, M Mudra, C Romano, et al. The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization. *J Palliat Med.* (2017): 20(1).

Palliative care also reduces caregiver burden, provides emotional and practical support (such as help with transportation or affording medications), as well as respite from the caregiving role.¹⁵ This can translate into further financial benefits for purchasers, as improved mental and physical functioning in caregivers can increase employee productivity and lead to fewer days out of work. By focusing on access to palliative care, purchasers benefit, both from the reduction in utilization, but also in the improved quality-of-life for patients and their caregivers – the very definition of high-value health care.

Applications of Palliative Care in Purchaser Strategies

There are a variety of ways employers and other health care purchasers can incorporate higher standards for care for seriously ill people into their health care strategies to get higher value health care. The Purchaser Toolkit for Serious Illness Care Strategies synthesizes the resources needed to develop a new palliative care strategy or infuse palliative care into an existing health care program.

Case studies and specific examples

Organizations in both the private and public sectors are already making strides in offering palliative care programs to their populations. The following case studies showcase the efforts of leading organizations, including purchasers, focused on improving care for people with serious illness. Purchasers can use these case studies for ideas on how to implement their own palliative care programs.

Community Care of North Carolina

North Carolina Medicaid recognized the potential of palliative care to improve quality of life for Medicaid beneficiaries and minimize program costs. The Medicaid agency partnered with Community Care of North Carolina (CCNC), a statewide medical home system, to create a comprehensive case management program leveraging a strategic risk assessment tool to identify patients most likely to benefit from case management.

Blue Shield of California

The California Public Employees' Retirement System (CalPERS) realized there were opportunities to improve care for members with serious illness and approached Blue Shield of California (Blue Shield), one of its contracted health plans, to come up with a creative solution. As a result, Blue Shield began building out a comprehensive, statewide provider network able to deliver targeted case management and palliative care services to the seriously ill population.

The Dow Chemical Company

¹⁵ El-Jawarhi A, JA Greer, WF Pirl, et al. Effects of early integrated palliative care on caregivers of patients with lung and gastrointestinal lung cancer: A randomized clinical trial. *Oncologist*. 2017; 22(12).

Dow identified a problem upon scrutiny of its data – few eligible employees were taking advantage of the hospice benefits the company provided. Dow realized the root of the issue was a dilemma its employees were facing: to access hospice services, they had to give up curative treatment. Not wanting employees to have to make this choice, Dow worked with Aetna to implement the Compassionate Care program, allowing employees to utilize hospice benefits without having to abandon curative care.

Starting a new palliative care strategy

This suite of tools can carry a purchaser through the health plan sourcing and contracting process, helping them demand and set expectations for evidence-based approaches to meeting the needs of people with serious illness, and their families.

Request for Information: Access to Comprehensive and High-Quality Serious Illness Care (RFI)

The RFI is a new Elective Section of [CPR's 2018 Health Plan Request for Information](#). CPR and CAPC developed it to help purchasers assess the offerings and capabilities of health plans related to care for seriously ill members. The RFI can be fielded as part of CPR's entire RFI or separately, according to the needs of the user. The RFI questions have seven sub-sections, each containing primary and secondary questions. The seven sub-sections include:

1. Care for Seriously Ill Plan Participants (General Questions)
2. Provider Network
3. Medical Management
4. Advance Care Planning
5. Caregiving
6. End-of-Life Care & Bereavement
7. Future Planned Serious Illness Care Strategies

Evaluation Guidance and Model Responses

Designed to help purchasers assess answers to the RFI questions, the model responses represent best practices that can apply generally and broadly to meet purchasers' needs. The document is organized by the sub-sections in the RFI and categorized by “best,” “average,” or “minimum” responses. Using this resource, purchasers can zero in on potential plan partners, ask follow-up questions to the RFI, add expectations into the purchaser-plan contract, and structure a dialogue with a plan partner to develop a long-term strategy to improve the capabilities of the plan and provider network.

Model Health Plan Contract on Access to Comprehensive and High-Quality Serious Illness Care

The Model Health Plan Contract expresses the contractual duties of the health plan to the purchaser and outlines the purchaser's expectations for how the plan shall facilitate progress in ensuring high-quality care for patients and family members facing serious illness. The Model Contract contains provisions related to three areas from the RFI: 1) care for the seriously ill patient; 2) specific benefits for plan participants; and 3) provider network. The Contract specifies benefits for plan participants—including caregivers—and expectations for the provider network.

The Model Contract is a model – it provides starting points for contracts that can be tailored and negotiated to reflect specific circumstances.

Health Plan Conversation Guide

Whether purchasers have recently fielded the RFI, executed a contract with provisions from the Model Contract, or have an existing health plan relationship, there are ongoing opportunities to talk to your health plan about how they support those with serious illness. Purchasers can use the Health Plan Conversation Guide to ensure their health plans are providing sufficient attention and resources to the seriously ill population and to track progress. If needed, the guide also provides prompts to elicit answers to specific questions.

Leveraging existing strategies

In addition to ensuring access to new palliative care capacities, purchasers may also integrate palliative care into an existing high-value health care program, such as an Accountable Care Organization (ACO) or a case management program.

The ACO Checklist

Accountable Care Organizations are groups of physicians and hospitals that share financial and medical responsibility for providing coordinated care, with financial incentives to provide high-quality care and to limit avoidable, unnecessary spending. Thus, ACOs represent a unique opportunity to address care for those living with serious illness as they likely have the appropriate structure in place to deliver high-quality, patient-centered care to all populations. The ACO Checklist was created to help a purchaser ensure that their contracted ACO has the palliative care capabilities and specialists needed to address the needs of the seriously ill population. Purchasers with direct contracting arrangements with an ACO can use this checklist during regularly scheduled meetings with the ACO. The questions in the checklist are organized into categories that illustrate a comprehensive approach to care for people with serious illness and are aligned with other tools in this toolkit.

The Case Management Vendor Checklist

Many patients working with case managers are seriously ill. If a purchaser contracts with a case management vendor to provide care coordination to employees, it's important that case managers have the appropriate skills, and training to ensure they know how to ask about and understand patients' goals, can assess and address pain and other symptoms, and provide caregivers with the practical and psychological support they need. Purchasers can use the Checklist to ensure that their case management vendor is providing sufficient attention and resources to those living with serious illness.

Conclusion

Purchasers are pulled in many directions; however, ensuring that individuals and families facing serious illness have the care they need can greatly improve the quality of life for employees while also reducing health care costs. Together, we hope this How-to-Guide and the Purchaser Toolkit will give purchasers multiple ways to integrate palliative care into their high-value health care purchasing strategies. We welcome your feedback and suggestions for how to improve these tools.