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REQUEST FOR INFORMATION: ACCESS TO COMPREHENSIVE AND HIGH-QUALITY SERIOUS ILLNESS CARE

As employers continue to focus on providing high-value care to employees, they are beginning to recognize the importance and value proposition of holistic approaches to providing medical and non-medical services. Access to serious illness care for those living with serious illness and proper support for their caregivers can significantly improve employees’ quality of life and reduce health care costs.

The **Request for Information on Access to Comprehensive and High-Quality Serious Illness Care** is a new, additional Elective Section meant to complement [Catalyst for Payment Reform’s (CPR) 2018 Health Plan Request for Information on Payment & Delivery Reform](https://www.catalyze.org/product/2018-aligned-sourcing-contracting-toolkit/).

This new RFI section can be fielded as part of a larger RFI or on its own, according to the needs of the user, and has seven sub-sections. Each subsection has Primary and Secondary Questions. CPR recommends that, especially for purchasers new to designing and implementing programs and initiatives for those living with serious illness, purchasers field the Primary Questions during the first round of the RFI and reserve the Secondary Questions for finalists. The Primary Questions cover the essential areas of a comprehensive serious illness care strategy.

Background on CPR’s 2018 RFI

The 2018 RFI has two main parts – Core Sections and Elective Sections. The **Core Sections** of the RFI are critical to assessing whether a prospective partner has progressed, or plans to progress, in the areas of payment reform, delivery reform, benefit design, network design, and price and quality transparency, which should be core to the health plan’s strategy to improve the value of health care. The **Elective Sections** of the RFI assess the health plan’s strategy related to specific delivery reforms or targeted clinical areas and how those areas can be improved by health care payment and delivery reform. Elective Sections include the Administrator’s strategies for Accountable Care Organizations (ACO), maternity care, pharmacy, behavioral health, and payment for total joint replacements.

If a Purchaser plans to use this RFI with prospective partners, please protect the document by going to the “Developer” tab and selecting “Protect Form.” By doing so, the responder will only be able to type into the grey form boxes. We also recommend deleting these instructions when issuing the RFI.

REQUEST FOR INFORMATION: ACCESS TO COMPREHENSIVE AND HIGH-QUALITY SERIOUS ILLNESS CARE

This RFI Section has seven sub-sections, each with Primary and Secondary Questions. If you are responding to this RFI for the first time, please complete only the Primary Questions. If you are participating in the finalist phase, please complete the Secondary Questions.

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**Care for Seriously Ill Plan Participants (General Questions)**

**PRIMARY QUESTIONS**

1. Please describe the general support and services Administrator provides to assist plan participants facing serious illness. Limit response to 250 words.

2. Please describe any specific benefits for identified seriously ill plan participants that provide additional support for symptom management, including specialty palliative care services. Limit response to 250 words.

3. Please describe any specific benefits for identified seriously ill plan participants that provide additional support for advance care planning and opportunities to understand patients’ values and priorities in the context of a serious illness (“goals of care conversations”), including specialty palliative care services. Limit response to 250 words.

4a. Does Administrator have defined processes (i.e. processes that are data-driven, evidence-based, and proactive) to identify plan participants living with serious illness and/or multiple chronic conditions?

      Yes

      No

5a. Does Administrator provide or cover in-home services to plan participants with serious illness?

      Yes

      No

6. Does Administrator provide access to case managers with specific training on: serious illness clinical care, symptom assessment, advance care planning and goals-of-care conversations, as well as knowledge of the specific services available?

      Yes

      No

7. Does Administrator have a process in place to expedite access to needed services for plan participants living with serious illness?

      Yes

      No

**SECONDARY QUESTIONS**

4b. Administrator previously indicated that it has defined processes to identify plan participants with serious illness and/or multiple chronic conditions. Please select each of the processes Administrator uses from the list below.

      Processes using diagnoses

      Processes using functional status information

      Processes using utilization data

      Processes using pharmacy data

Other. Please describe. Limit response to 100 words.

Are any of these processes prospective in that they are used to help Administrator proactively identify plan participants?

      Yes

      No

5b. Describe Administrator's in-home services. Respondents shall provide:

A general description of the in-home services provided to plan participants, noting anything that is specific to the identified sub-set of plan participants with serious illness. Limit response to 250 words.

Do in-home services extend to family caregivers, including parents of children living with serious illness?

      Yes

      No

Does Administrator plan to increase access to in-home services for plan participants with serious illness and multiple chronic conditions over the next 18 months?

      Yes

      No

Does Administrator plan to increase access to in-home services for family caregivers of plan participants with serious illness and multiple chronic conditions over the next 18 months?

      Yes

      No

8. Does coverage for supports and services for plan participants with serious illness extend to those plan participants in long-term care facilities?

      Yes

      No

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**Provider Network**

**PRIMARY QUESTIONS**

1a. Does Administrator use payment incentives to ensure network providers have advance care planning and goals-of-care conversation skills and/or competencies in clinical efforts to prevent, reduce and/or eliminate symptoms (“symptom management competencies”)?

      Yes

      No

2a. Does Administrator ensure that network providers, such as oncology and cardiology providers, have access to resources and training on how to have meaningful conversations and manage symptoms, in accordance with their professional guidelines?

      Yes

      No

3a. Does Administrator ensure that providers specialty-trained in palliative care are included in the network?

      Yes

      No

4a. Does Administrator evaluate specifically the quality of life of plan participants with serious illness?

      Yes

      No

5. Does Administrator offer network providers training in advance care planning and goals-of-care conversation skills?

      Yes

      No

6. Does Administrator offer network providers training in symptom assessment and management, including safe opioid prescribing?

      Yes

      No

**SECONDARY QUESTIONS**

1b. Administrator previously indicated that it uses payment incentives to ensure network providers have advance care planning and goals-of-care conversation skills and/or symptom management competencies. Please select all the incentives below that apply.

      Administrator financially incentivizes network providers, such as primary care or oncology providers, to receive training in advance care planning and goals-of-care conversation skills

      Administrator financially incentivizes network providers, such as primary care or oncology providers, to receive training in symptom assessment and management

      Administrator financially incentivizes network hospitals to acquire palliative care certifications, such as The Joint Commission Advanced Certification in Palliative Care

      Administrator financially incentivizes network clinicians, such as physicians and nurse practitioners, to acquire palliative care designations and certifications

      Administrator pays for advance care planning codes and complex case management

2b. Administrator previously indicated that it works to ensure that network providers, such as oncology and cardiology providers, have access to resources and training on how to have meaningful conversations and manage symptoms, in accordance with their professional guidelines. Please describe the resources available, and how Administrator provides them to the network. Limit response to 250 words.

3b. Administrator previously indicated that it works to ensure that providers specialty-trained in palliative care are included in the network. Please select all that apply.

      Administrator specifically identifies palliative care specialists and programs in its network

      Administrator pays for home-based palliative care services for plan participants with serious illness

      Administrator requires accountable care organizations (ACOs) to have both hospital- and community-based palliative care teams (with 24/7 response) in place or available by referral

      Administrator requires oncology practices receiving bundled payment to have community-based palliative care teams (with 24/7 response) or make them available to patients by referral

      Administrator recognizes network hospitals that hold The Joint Commission Advanced Certification in Palliative Care in its provider directory

      Administrator requires network hospitals to hold The Joint Commission Advanced Certification in Palliative Care

      Administrator pays for pediatric palliative care services, where available

4b. Administrator previously indicated that it evaluates specifically the quality of life of plan participants with serious illness. How does Administrator conduct these evaluations? Please describe the methodology, including if it differs from how Administrator evaluates the quality of services offered for plan participants with chronic disease. Limit response to 250 words.

7. What investments, including training and health information technology (HIT) to support advance care planning and symptom reporting/assessment, does Administrator make to improve these capabilities within its provider network? Limit response to 250 words.

8. Does Administrator use financial incentives, such as bonus payments, to encourage providers trained in advance care planning, goals-of-care conversation skills and/or symptom management competencies to engage in these activities or use these skills in interactions with patients?

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**Medical Management**

**PRIMARY QUESTIONS**

1a. Does Administrator provide case management services for adult and pediatric plan participants with living serious illness?

      Yes

      No

2a. Does Administrator require a documented palliative care assessment and care plan as a component of prior authorization for services involved in treating a serious illness?

      Yes

      No

3a. Does Administrator eliminate, or at least expedite, prior authorization for services or products needed to reduce pain and suffering for seriously ill plan participants?

      Yes

      No

**SECONDARY QUESTIONS**

1b. Administrator previously indicated that it offers case management services for adult and pediatric plan participants with serious illness. Please answer the following:

Are plan participants with serious illness assigned to case managers with specialized training in advance care planning and goals-of-care conversation skills?

      Yes

      No

Do case managers assess each plan participant for the burden posed by their symptoms and follow up with the providers treating them?

      Yes

      No

Do case managers assess plan participants for unmet psychosocial needs (i.e. social, mental, existential, emotional, spiritual, and/or religious needs) and follow up with the providers treating them?

      Yes

      No

Do case managers coordinate with existing medical specialty teams already involved in the care of the plan participant?

      Yes

      No

Please further describe Administrator’s case management services for seriously ill plan participants, including case manager training, and whether this differs from case management for other plan participants. Limit response to 100 words.

2b. Administrator previously indicated that it requires a documented palliative care assessment and care plan as a component of prior authorization for services involved in treating a serious illness. Please select all services that apply.

      Oral or intravenous chemotherapy for advanced stage cancer

      Transplant services

      Left ventricular assist device as destination therapy

      Other serious illness-related surgical procedures

      None

3b. Administrator previously indicated that it expedites prior authorization for services or products needed to reduce pain and suffering for seriously ill plan participants. What policies or procedures does Administrator use to expedite prior authorization for these services? Limit responses to 250 words each.

How does Administrator help ensure safe and appropriate access to pain medications, such as opioids?

How does Administrator help network providers prescribe opioids safely, including how to assess and monitor patients for issues, and how does Administrator manage issues?

4. What policies or procedures does Administrator use to expedite appeals and grievances for plan participants living with serious illness? Limit response to 250 words.

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**Advance Care Planning**

**PRIMARY QUESTIONS**

1. What services does Administrator provide to improve the quality and number of advance care planning and goals-of-care conversations among those who would benefit from them? Please select all that apply.

      Educate plan participants on advance care planning

      Provide advance care planning documents and referrals to community resources, such as advance care planning workshops hosted by community organizations

      Track and report on advance care planning conversations facilitated by case managers

      Track and report on advance care planning conversations billed by network providers, including primary care providers

      Share advance care planning documents, care plan, and chart notes with plan participant’s care team

      Disseminate guides to plan participants on how to talk to their doctor about their values and what kinds of care are most important to them

      Require advance care planning conversation and documentation as part of prior authorization process for services for plan participants with serious illness (e.g. chemotherapy, left ventricular assist device, etc.)

Other. Please describe. Limit response to 100 words.

2. What training and support does Administrator provide to staff, providers, or others to improve advance care planning and goals-of-care conversation skills? Please select all that apply.

      Share advance care planning educational materials with network providers, including primary care providers

      Train or employ case managers with expertise in advance care planning conversations

      Have space in the medical record, or at least the case management record, to document advance care planning conversations, including documentation of a medical surrogate/proxy who will serve as a patient’s health care decision maker if the patient is unable to do so for him or herself

      Incentivize providers in value-based payment arrangements by including quality measures on advance care planning conversations, completion of advance directives, or documentation of a medical surrogate/proxy

Other. Please describe. Limit response to 100 words.

3a. Does Administrator require primary care providers to engage in, or at least attempt to engage in, advance care planning with plan participants, regardless of their age?

      Yes

      No

**SECONDARY QUESTIONS**

3b. Administrator previously indicated that it requires primary care providers to engage in, or at least attempt to engage in, advance care planning with plan participants, regardless of their age. Are primary care providers required to file an advance directive for plan participants who participate in advance care planning with them?

      Yes

      No

Is the advance directive filed electronically (i.e. electronic medical record or health information exchange) to give all providers access to it should the need arise?

      Yes

      No

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**Caregiving**

**PRIMARY QUESTIONS**

1. Does Administrator assess the level of stress perceived by family caregivers due to their role (“caregiver burden”) as part of its services to plan participants facing serious illness?

      Yes

      No

2a. Does Administrator provide programs and/or services to assist family caregivers of plan participants experiencing serious illness?

      Yes

      No

**SECONDARY QUESTIONS**

2b. Administrator previously indicated that it provides programs and/or services to assist family caregivers of plan participants experiencing serious illness. Please select all programs and services that apply.

      Require caregiver support, such as resources and training, to be a part of network programs focused on care for those living with serious illness

      Case managers use a caregiver assessment tool to identify the level of caregiver burden

      Cover respite care, adult day care, or coverage for a limited-duration of care in a nursing home to support caregivers of a plan participant with serious illness, including those with cognitive decline

      Cover home health aide services for plan participants with serious illness

      Cover marriage and family therapy for families of patients with serious illness

      Include specialists in grief/bereavement in the behavioral health provider network, including child bereavement services

      Offer caregiving services to plan participants caring for a loved one who is not a plan participant

Other. Please describe. Limit response to 100 words.

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**End-of-Life Care & Bereavement**

**PRIMARY QUESTIONS**

1. Does Administrator offer various policies, programs, or supports for people at end of life, including hospice services?

      Yes

      No

2. Do case managers provide case management assistance to plan participants’ transitioning to hospice?

      Yes

      No

3a. Does Administrator offer improved hospice policies over those required under the Medicare hospice benefit?

      Yes

      No

4. What end-of-life care support and services does Administrator provide to assist a bereaved family? Limit response to 250 words.

**SECONDARY QUESTIONS**

3b. Administrator previously indicated that it offers improved hospice policies. Please select all that apply.

      Hospice coverage is extended to cover terminally-ill plan participants with more than 6-months to live (rather than a “less than 6-month” requirement)

      Policy allows for concurrent treatment while enrolled in hospice (e.g. therapeutic medications, Total Parenteral Nutrition [TPN], chemotherapy, etc.)

      Utilization and average length of stay in hospice is tracked for all individual plan participants who have died

Other. Please describe. Limit response to 100 words.

5. If hospice policy allows for concurrent treatment while enrolled in hospice, how does Administrator take action to avoid wasteful and inappropriate use of these treatments? Limit response to 250 words.

6. What quality assurance programs exist for hospice care? What family surveys does Administrator use? Are hospice agencies with continuously poor performance removed from the provider network? Limit response to 250 words.

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**Future Planned Serious Illness Care Strategies**

**PRIMARY QUESTIONS**

1. What other initiatives is Administrator implementing for plan participants managing serious illness? Where and when will they be available to our company? Limit response to 300 words.

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**GLOSSARY OF TERMS**

**ADVANCE CARE PLANNING**

A voluntary discussion about preferences for future care, held between an individual and his/her health care providers. Advance care planning helps individuals make decisions about their own care and communicate those decisions to others. Advance care planning can take into account personal preferences, values, and which types of treatments the individual wants or does not want under certain circumstances, among other considerations.

**ADVANCE CARE PLANNING AND GOALS-OF-CARE CONVERSATION SKILLS**

Health care professionals working with individuals living with serious illness need to have specific communication skills. These include: a) the ability to discuss prognosis and deliver serious news; b) the ability to hold [goals of care conversations](#goalsofcareconvo); and) c) the ability to hold [advance care planning](#advancecareplan) conversations. Professionals must be skilled in communicating with patients, family members, caregivers, and treating clinicians.

**ADVANCE DIRECTIVE**

Formal written or verbal instructions for health care delivery, if the patient is unable to make his/her own decisions.

**CAREGIVER**

An individual who provides unpaid care to a relative or friend to help that person take care of him/herself.

**CAREGIVER BURDEN** refers to the stress perceived by caregivers due to their role. Higher caregiver burden has been correlated both with higher spending for the patient with serious illness as well as poorer health outcomes for caregivers. Caregiver burden can be assessed and addressed through education, counseling, respite and assistance with a caregiver’s own personal care responsibilities.

**CASE MANAGEMENT/COMPLEX CASE MANAGEMENT**

A process where a case manager fully assesses a patient, plans and facilitates services to address the patient’s needs, and continually informs and coordinates the parties involved in the patient’s care. Most health plans and ACOs utilize case management to “quarterback” the care of those living with serious illness and/or multiple chronic conditions. Case managers can play a pivotal role in ensuring the assessment of a patient’s symptoms, the management of those symptoms, [advance care planning](#advancecareplan), and [goals of care conversations](#goalsofcareconvo).

**CONCURRENT CARE (in the context of serious illness)**

The delivery of disease-modifying treatment simultaneously with palliative care. Concurrent care is different from the prevailing Medicare hospice benefit, which, as defined below, requires patients to forgo disease-modifying treatment.

**“CORE” PALLIATIVE CARE SKILLS** refer to a combination of skills needed by any clinician when caring for a person with serious illness in [symptom assessment](#symassessment), [symptom management](#symmanagement), [advance care planning](#advancecareplan) and [goals-of-care conversations](#goalsofcareconvo). Ideally, all clinicians caring for people with serious illness can manage symptoms and hold needed conversations, requiring palliative care specialists only for intractable symptoms and/or difficult family dynamics. Effective clinical training programs exist to teach core palliative care skills.

**FUNCTIONAL ABILITY**

An individual’s ability to carry out “activities of daily living (ADLs),” specifically: eating, bathing, dressing, toileting, walking, and transferring from the bed. One’s functional abilities can be impacted by physical, emotional, and cognitive dimensions.

**FUNCTIONAL ASSESSMENT** refers to the process of identifying and describing how well an individual can perform each of the six ADLs.

**GOALS OF CARE CONVERSATION(S)**

The process of gaining an understanding of the patients’ values and hopes in the context of a serious illness, permitting a clinician to align the care provided with what is most important to the patient.

**HOME-BASED CARE**

Health care services rendered to patients in their home. Services often include nursing services, rehabilitation services (including physical and occupational therapies), nutrition services, social services, home health aide services for assistance with activities of daily living (ADLs—see [functional ability](#functionalability), above), and can also include physician services and other services.

**HOSPICE CARE**

Hospice care is a well-known and comprehensive delivery model of palliative care, often limited to terminally ill patients. The Medicare hospice benefit defines hospice eligibility as appropriate for patients when two doctors certify a prognosis of six months or less to live if the disease follows its usual course, and the patient agrees to forgo Medicare coverage for disease-modifying treatment. Other payers often follow the Medicare hospice benefit, but there is no requirement to restrict hospice access in this way.

**PALLIATIVE CARE**

Palliative care is specialized medical care for people with serious illness. It focuses on providing patients with relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. It is appropriate at any age and at any stage of a serious illness and can be provided along with curative treatment. Palliative care may be called by a different name such as “Supportive Care,” “Compassionate Care,” “Advanced Illness Management,” and “Personalized Care.”

**PALLIATIVE CARE “PROGRAM”** refers to a multi-disciplinary team with specialized training that is called in to assist the treating clinician(s) with the care of a patient living with serious illness. The program may provide [home-based care](#homebasedcare), and/or care in an office or hospital setting.

**SERIOUS ILLNESS**

Serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or quality of life or excessively strains their caregivers.

**SYMPTOM ASSESSMENT**

Formal review of a patient’s symptoms, spanning pain, fatigue, drowsiness, nausea, constipation, loss of appetite, shortness-of-breath, depression, anxiety, and overall wellbeing. Symptoms can be due to the patient’s health condition(s) and/or to the treatment(s) for those conditions. Frequent assessment enables the care team to address symptoms in a timely manner.

**SYMPTOM MANAGEMENT** refers to clinical efforts to prevent, reduce and/or eliminate symptoms. This may or may not include pain medication.

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