C-TAC
COALITION TO TRANSFORM ADVANCED CARE

C-TAC Model of Advanced Illness Care

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Coalition to Transform Advanced Care

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COALITION TO TRANSFORM ADVANCED CARE

- Over 150 healthcare system, specialty society members
- C-TAC developed the advanced care model based on Advanced Illness Management (AIM)
- CMS has now developed the Serious Illness Population (SIP) model based in part on the C-TAC advanced care model

A Large-Scale Advanced Illness Intervention Informs Medicare's New Serious Illness Payment Model

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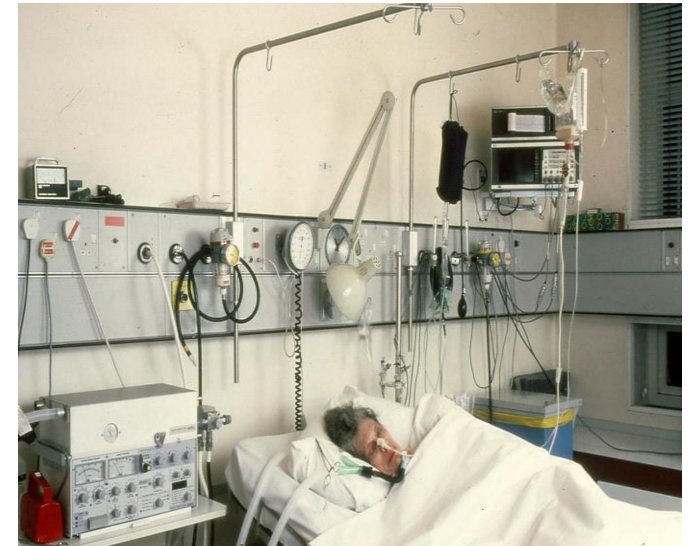
The Challenge of *Advanced Illness*

- As function declines, treatments lose impact
- Last 1-2 years of life
- Care is driven by urgency, not patient preference
- 4% of Medicare beneficiaries, 25% of costs
- Avoidable, unwanted hospital admissions
- Hospice, palliative care are underutilized



Advanced Illness Management (AIM)

- 1999: Sutter Health pilot, Northern California
  - Primary physicians delegate duties to RN-led teams
- 2013: $13M CMMI grant, controlled trial
  - ↓ hospital days by 1,361/1000 pts. ($p<.001$)
  - ↓ total cost of care in last 30 days of life by $5,657/beneficiary ($p<.001$)
- 3.0 FTE medical directors manage an average daily census of 2,214 patients in 19 counties

CMS Serious Illness Population (SIP) Payments

- Separate track within *Primary Care First* model
- Participating primary care practices can use new payments to build interdisciplinary teams
- Or hospice & palliative care organizations can partner with participating practices

The Advanced Care (and AIM) Model

Goal: Move the focus of care from hospital to home

The Recipe for Success

1. Care coordination must rise up to health system integration
2. Advance care planning must be baked into operations
3. Care management must wrap around the whole process

1. Care coordination = system integration

Systematic deployment of services:

- Initial visit while patient hospitalized
- Home visits initially and with any health decline/transition
- 24/7 access to clinical triage
- Telephonic outreach, telehealth centralized or embedded in practice
- Coordination of post-acute services, tests and procedures, primary and specialty physician visits

2. Systematic advance care planning

Person-centered approach:

- Take the handoff from the primary physician
- Continue the conversation at home
- Plan at the individual’s own pace
- Initiate and revisit goals of care routinely
- Communicate & discuss documented goals with family, caregivers and treating physicians

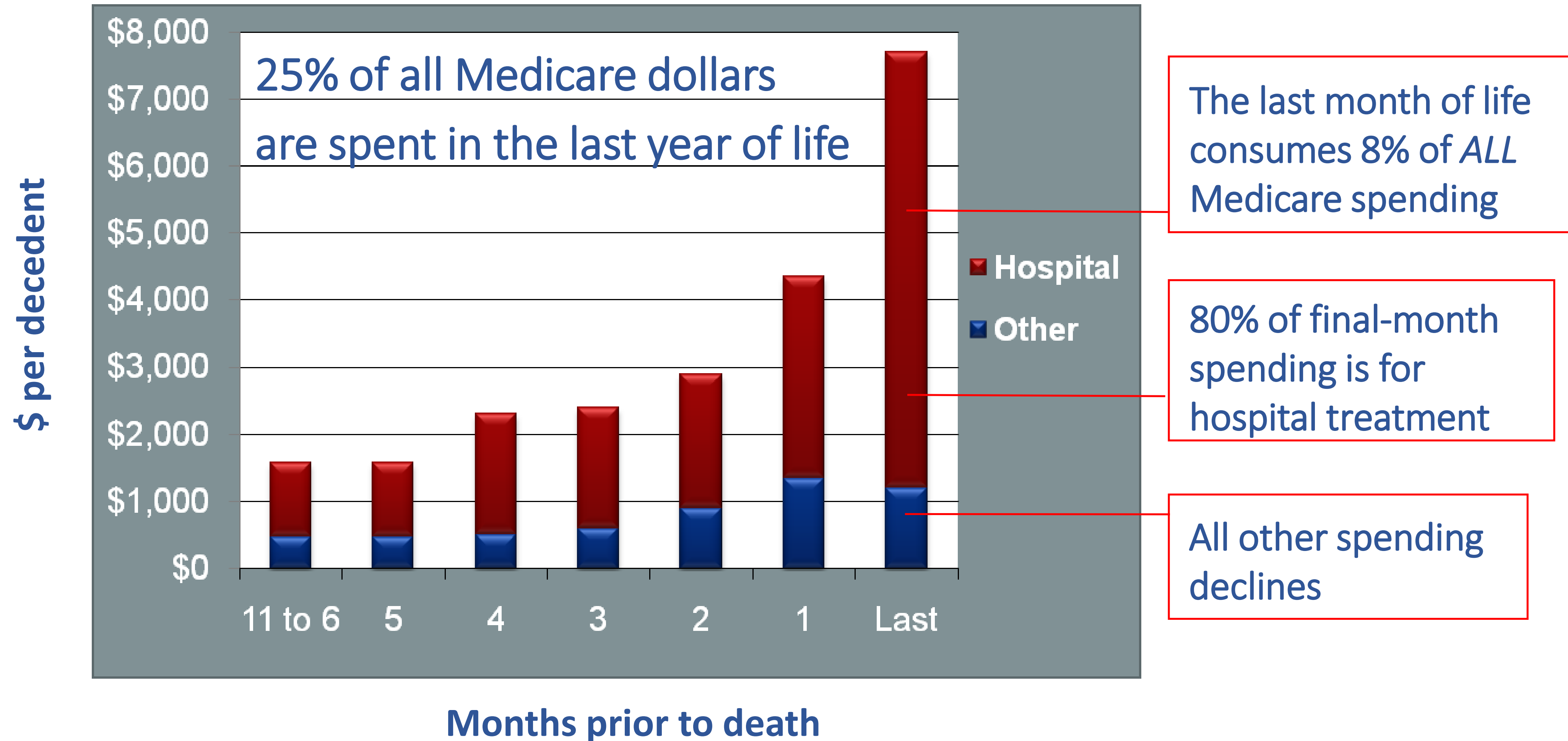
3. Wraparound care management

- Postacute care (done well) becomes preacute care
- Patient, family and caregivers gain trust & confidence in their ability to manage their own care at home
- This prevents revolving-door readmissions near the end of life
- ...And significantly reduces total cost of care

Notes on Cost Reduction

- Cutting costs cannot involve denying services
- Patient choice is key
- Hospitalization is the biggest driver of cost
- Thus the best way to cut costs is to support seriously ill **people** at home until they realize they no longer need to be **patients**
- This approach works best in advanced illness**…why?**

Medicare spending by month prior to death
(All diagnoses)



Quality Metrics We Recommended to CMS

- Utilization
- Care process
- Patient experience of care

Utilization

- Percent of patients with no ICU days in last 30 days of life
- Percent of patients who died in hospice
- Median hospice length of stay for that cohort
- Risk-adjusted ambulatory sensitive hospitalizations/1000 pt-months

Care Process Metrics

- Percent of patients with documentation of:
  - Functional assessment
  - Surrogate decision maker and preferences for life-sustaining treatment
    - CPR, other life supports and hospitalization
  - Screening for pain, dyspnea, nausea and constipation
  - Discussion of emotional needs or screening for depression and anxiety
  - Discussion of spiritual needs or screening for spiritual distress
- Percent of patients with a home visit within 7 days of discharge
- Percent of patients with med reconciliation within 7 days of discharge

Patient Experience of Care Metrics (Survey)

- Composite scores for questions in 6 domains:
  1. Overall satisfaction/willingness to recommend
  2. Timeliness of care
  3. Getting help for symptoms (pain, trouble breathing, anxiety and sadness)
  4. Effective communication
  5. Care coordination
  6. Shared decision making
- Administered at multiple times
  - 1 month after enrollment
  - Every 6 months while enrolled
  - After discharge (including death)

Now the action starts…

- CMS has announced Primary Care First and Serious Illness initiatives
- The Request for Applications (RFA) will contain important information needed by practices to help them decide whether to participate
- The RFA has not yet emerged
- CMS has committed to implement PCF/SIP on January 1, 2020

- Stay tuned!