Building a Movement
To Transform Advanced Illness Care

Tom Koutsoumpas
Brad Stuart MD

http://thectac.org
C-TAC Members: 100+ and Growing
C-TAC Board of Directors & Steering Committee

**Board of Directors**
- Tom Koutsoumpas, Caring Foundations;
- Bill Novelli, McDonough School of Business, Georgetown University;
- Myra Christopher, Center for Practical Bioethics;
- Alexandra Drane, Eliza Corporation;
- Bud Hammes, Gundersen Health System;
- Thomas Higgins, Prosetta Corporation;
- Randy Krakauer, Aetna;
- David Longnecker, Association of American Medical Colleges;
- Ann F. Monroe, Community Health Foundation of Western and Central New York;
- Reverend Tyrone S. Pitts, Progressive National Baptist Convention;
- Cynda Hylton Rushton, Johns Hopkins School of Nursing;

**Steering Committee, includes:**
- Charlie Sabatino, American Bar Association’s Commission on Law and Aging;
- Leonard Schaeffer, University of Southern California;
- Don Schumacher, National Hospice and Palliative Care Organization;
- Brad Stuart, Sutter Care at Home;
- Jeff Weiss, Center for Corporate Innovation

- Nancy Brown, American Heart Association;
- Jennie Chin Hansen, CEO, American Geriatrics Society;
- Rich Umbdenstock, American Hospital Association;
- Karen Ignagni, AHIP;
- Rev. Peg Chamberlin, National Council of Churches;
- Gail Hunt, National Alliance for Caregivers.
C-TAC Key Facts

• Founded in February, 2011
• The largest, most diverse coalition of its kind
• Over 200 individual participants directly engage with these Workgroups/Committees:
  – Public Engagement
  – Employer
  – Clinical Models
  – Interfaith and Diversity
  – Policy & Advocacy
  – Professional Education.
• Funded in part by grants from the Peter G. Peterson Foundation, The SCAN Foundation, and member support
Defining Advanced Illness on the Health Continuum

- Healthy Persons and Those with Reversible Illness
- Persons with Manageable, Early or Stable Chronic Conditions
- Persons with Serious, Progressive Conditions that Limit Daily Activities
- Persons who Are Hospice-Eligible

Advanced Illness
Person-Level Challenges

- Gap between the care people want and what they receive
- Lack of support for important healthcare decisions
- Regulatory barriers, e.g. hospice eligibility requirement
- Provider & reimbursement silos
- Payment for aggressive care, but none for care coordination
- Inadequate coverage for long-term care
System-Level Challenges

• Lack of political leadership, public dialogue and health system action on advanced illness
• Lack of quality measures and standards
• Lack of a strong coordinated research effort
C-TAC’s Role in the Movement to Transform Care

- **Convener:** bring together the most sophisticated and forward-thinking organizations
- **Catalyst:** synthesize best practices and provide technical assistance to support rapid system change
- **Voice:** get advanced illness care on the national agenda & build public demand for systems change
C-TAC: Pushing the Levers for Large-Scale Change

- Analyze and promote best-practice delivery models
- Disseminate innovative inter-professional education
- Develop and advocate for legislative and regulatory policy change
- Promote and support public education and engagement
2013 National Summit, January 29-30

Key messages:

- Harness the **power of personal stories**
- Show that **good care models already exist**
- Demonstrate **bipartisan support** for action
- Disseminate **strategies**: clinical models, public engagement, employer
- Adopt **evidence-based solutions** that impact key metrics
- Actively partner with **Faith Communities**
Key Projects

- Launch **Advanced Care Project** in collaboration with the AHIP Foundation’s Institute for Health Systems Solutions (IHSS)
- Launch consumer-focused, resource-rich website – CARE JOURNEY
- Establish a national baseline to track public opinion on advanced illness
- Develop comprehensive book outlining options for public policy
- Implement and measure outcomes from employer-sponsored initiatives to support employee caregivers and patients facing advanced illness
Advanced Care Clinical Model
Example: Advanced Illness Management (AIM)®
Sutter Health

Brad Stuart MD
Sutter Care at Home
Total Medicare Spending: 28% in Last Year of Life

8% in Last Month of Life

VARIATION = Overtreatment:
- Hospitalization
  - Readmissions
- ICU days
- LOS
- ER Visits
- Specialty consults
- Tests, procedures

US Dept. of Health & Human Services 2003

Dartmouth Atlas 2008
Why We Need Care Coordination

• System fragmentation leads to:
  • Poor handoffs
  • Lost data
  • Medication errors
• But the real problem is –

You can’t reduce readmissions from inside the hospital
Health System Fragmentation in 3 Dimensions

1. **Space**: poor coordination across settings
2. **Time**: “one-shot” advance care planning
3. **Treatment**: “treatable” vs. “terminal”
Fixing Fragmentation

1. **Space**: System integration
   Coordinate care across settings

2. **Time**: Advance care planning
   Track choices as illness worsens

3. **Treatment**: Continuum of care
   Provide a mix of cure + comfort
1. **Space: System Integration**

**Hospitals**
- Emergency Dept.
- Hospitalists
- Inpatient palliative care
- Case managers
- Discharge planners
- Care Liaisons

**Medical Offices**
- Physicians
- Office staff
- Care managers
- Telesupport

**Home-Based Services**
- Home health
- Hospice
- Transitions Team

**New AIM staff & services**

**EHR**
- Patient Registry

**911**

**Critical Events**
- Acute exacerbation
- Pain crisis
- Family anxiety

**Telesupport Center**
2. Time: Advance Care Planning

- **Start the conversation**
  - Inpatient PC
  - Hospitalist
  - PCP

- **Shared decisions over time at the person’s own pace**

- **Support in real time, any time**

- **Trained team linked across all settings**

- **EHR**

- **TELESUPPORT**

- **Hospitals**

- **Physician offices**

- **Handoff**
3. Treatment: Continuum of Care

"Curative" Treatment

Chronic Disease Management
- HF
- COPD
- DM
- etc

Advanced Illness Management (AIM)

End-of-Life Care
## Redesigning Care in Advanced Illness

<table>
<thead>
<tr>
<th>Usual Care</th>
<th>AIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care is episodic and crisis-driven</td>
<td>Care management anticipates crises</td>
</tr>
<tr>
<td>Patient must come to provider</td>
<td>Patient remains in safe &amp; familiar setting</td>
</tr>
<tr>
<td>Providers are in disconnected silos</td>
<td>Providers are linked in real time</td>
</tr>
</tbody>
</table>
Who Is an “AIM Patient?”

- Advanced chronic illness: cancer, HF, COPD, etc.
- Treatment effectiveness may be questionable
  - Multiple rehospitalizations
  - 3rd-line chemotherapy
- Clinical, functional, &/or nutritional decline
- Often eligible for hospice, but not ready
AIM Care Processes

- “Red Flag” symptom management/reporting
- Medication reconciliation
- Close MD follow-up
- Ongoing advance care planning
- Personal health record
Take-Aways

- Provide services that patients and physicians love
- Remember branding & messaging
- Connect hospital – MD – home
- Help seriously ill people choose comfort, safety and dignity over rehospitalization
- Get ready for shared risk/shared savings: “doing the right thing” pays off!