C-TAC
COALITION TO TRANSFORM
ADVANCED CARE

June 22nd, 2015

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the Coalition to Transform Advanced Care (C-TAC), we would like to applaud and commend the Senate Finance Committee on its remarkable bipartisan efforts to drive progress in advancing and addressing the needs of the millions of Americans nationwide experiencing chronic medical conditions. We appreciate the opportunity to provide comments on the critically important issue of chronic care management particularly for those with complex needs and we look forward to serving as a key technical resource to the Finance Committee chronic care working group in examining and identifying effective bipartisan solutions.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 120 national organizations including patient and consumer advocacy groups, providers, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

Today, due to a number of medical advancements and achievements over the past few decades, most Americans are living longer and healthier lives than in previous generations. However, with the aging of the Baby Boomer population, the number of Americans who will soon experience functional impairment or multiple chronic conditions will begin to increase over time. Eventually, many of these individuals will develop some form of serious or advanced illness, which occurs when one or more medical conditions become serious enough that general health and functioning begin to decline, treatment may no longer lead to patient preferred outcomes, and care-oriented toward comfort may take precedence over attempts to cure. Beneficiaries with five or more chronic conditions represent the fastest growing segment of the Medicare population and current estimates suggest that the number of Americans over the age of 85 will reach almost 9 million by 2030. These individuals have complex medical, emotional, and spiritual needs that are often insufficiently addressed by our health care system. This is the population that C-TAC— and its innovative clinical model development— is squarely focused on.

Furthermore, these people's needs are not being met and their care treatment and outcomes often times are inconsistent with their goals and preferences. Americans want to avoid burdens on their families, receive care in the home or community setting, and maintain a high quality of life. Recent data has shown that less than 25 percent of Americans want to expand life by any possible intervention. In addition, while 42 percent of individuals have had discussion on end of life issues, only 21 percent put their care directives in writing and 90 percent said that their physician never asked about this issue. The bottom line from these statistics rings clear—in order to ensure high-quality care, we must continuously examine, document, and record individual goals, values, and treatment preferences. Without this crucial piece of information, individuals with complex chronic conditions or advanced illness are unable to receive care that aligns with their wishes.

In response to the shortcomings in the standard of care for the growing population of patients with advanced illness, C-TAC and the AHIP Foundation launched a groundbreaking initiative, the Advanced Care Project (ACP), bringing together pioneering provider groups and health plans that are developing innovative programs to coordinate treatment and palliation, unify fragmented providers and settings, and move the focus of care out of the hospital and into home and community for those individuals with late-stage chronic illness. These innovators have come together to formulate a more standardized clinical model built by consensus-based best strategies and best practices now termed "advanced care". At the culmination of its clinical phase, the Project released its summary report providing a framework of best practices for this population. See the following link for more information: http://www.thectac.org/wp-content/uploads/2015/06/ACP-Report-6-18-15-FINAL.pdf

The advanced care model offers a new, transitional pathway that effectively bridges complex care management to advanced illness care by filling a void in the current continuum of care services available to Medicare beneficiaries. The model helps to connect programs such as Independence at Home, advanced illness care programs, and hospice care. It provides comprehensive services available across settings and time, and combines active treatment with palliative care, and is customized to match personal values and preferences as they evolve through the process of illness and adaptation. For more information on the details of the care model, please see the attached table in the appendix.

A number of private sector innovations, including the Sutter Health Advanced Illness Management program, the Aetna Compassionate Care model, and the Gundersen Respecting Choices model, have already begun leading the implementation of advanced illness care programs. The Sutter AIM program offers nurse-led case management, palliative care, and advance care planning services for patients with late-stage chronic illness and managed to reduce hospitalization rates by over 60 percent at 30, 60, and 90 days post program enrollment, lower ED visits, and decrease hospital days in the last six months of life. The Aetna Compassionate Care model uses telephonic case management and a team-based approach that integrates advance care planning and decision support, psychosocial support, symptom management, and care coordination and was able to reduce ED visits and ICU days among other items. The Gundersen Respecting Choices program supports an integrated system for advance care planning facilitated by trained staff and community volunteers that is constantly revised and reviewed over time as health conditions change. 82 percent of decedents in the program chose hospice, and there was over a 50 percent reduction in acute inpatient days, ED visits, and ICU days following the implementation of the program. More details on these programs are provided in the appendix.

We applaud the progress achieved in this area through the *Better Care, Lower Cost Act* (S. 1932) introduced in the 113th Congress that would ensure greater accountability and better care management and coordination for chronically ill populations. C-TAC also recognizes the historic achievements of the Committee through the introduction of the *Care Planning Act* (S. 1549) most recently that would assist individuals with serious illness in making informed decisions about their care and ensure that treatment paths honor individual goals, values, wishes, and preferences. The bill aligns closely with our policy priorities and includes provisions to authorize voluntary advance care planning through Medicare and Medicaid, test advanced illness care coordination services, increase public awareness of advance care planning, enhance advance directive portability, and support studies to help develop enhanced standards of care.

Using the evidence-based strategies and best practices provided by C-TAC membership, we have highlighted some key recommendations for your consideration that align with the three bipartisan policy goals of the Committee.

Recommendations

1. Support voluntary advance care planning and proper coordination of benefits and services as outlined in the *Care Planning Act.*

Currently, there is a lack of industry-wide standards for advanced illness management and often times, narrowly defined payment structures impede the adoption of high quality, well-coordinated, and person-centered models of care delivery. To address these issues, we recommend a series of policies that align closely with the *Care Planning Act* including the following:

- Support the development of a benefit or service that allows for an interdisciplinary, team-based discussion of patient goals and values, an explanation of disease progression, an exploration of a relevant range of treatment options, and a documented care plan that reflects the individual's goals, values, and preferences.
- Increase funding for demonstrations that examine strategies for improving coordination of care across time, care settings, and diagnoses, and provide funding to scale successful innovations nationally through CMMI. In addition, CMMI could work with State Innovation Model (SIM) grantees on building advanced care models and utilize this opportunity to change care delivery across payers.
- Increase portability of advance directives, POLST forms for those who are seriously ill, living wills, and durable powers of attorney (DPAs) across health systems and state boundaries.

2. Require or incent the creation of interoperable EHRs that facilitate advance care planning across sites of care, providers, and throughout the course of an illness. Current standards under Stage 3 Meaningful Use should be expanded to require the documentation of advance directives and POLST forms, verification that preferences are recorded, and assurance that this information is accessible in home or care settings.

- Specifically, EHRs should document the following: 1) designation of a surrogate or decision maker, 2) individual care goals and preferences, 3) advance directives, and 4) medical orders for life-sustaining treatment for targeted populations.

3. **Enhance quality measure development and use new metrics to facilitate inclusion of advanced illness care in alternative payment models.**

There should be consensus developed around comprehensive quality metrics (process, outcomes and patient/family experience) through public/private partnerships that can properly assess the quality of care delivery for individuals with advanced illness.

- Quality metrics should assess whether treatment was concordant with individual and family goals and preferences and the quality of the advance care planning discussions. CMS and private plans should build on the existing 14 evidence-based quality measures or domains endorsed by NQF for palliative and EOL care.

4. Address workforce supply issues and the lack of advanced illness-focused training.
HHS should fund studies on how to most effectively advance and structure teams and make the most effective use of providers practicing at the top of their licenses and disseminate these findings through targeted physician and other health professional societies, health systems, and payers.

Thank you again for the opportunity to provide comments. C-TAC looks forward to working with you as well as the broader stakeholder community on this and a number of other issues that relate to the aging population and individuals experiencing advanced illness.

We welcome any follow-up questions and would appreciate the opportunity to meet in-person to discuss the recommendations listed in this letter. For any questions, please contact our Senior Policy Advisor, Andrew MacPherson, at Andrew@healthsperien.com.

Sincerely,

William D Novelli

Tom Koutsoumpas and Bill Novelli
Co-Chairs, C-TAC

APPENDIX

A. The Advanced Care Framework

Participants in the Advanced Care Project (ACP) have adopted five consensus principles of care:

<table>
<tr><td colspan="3">Population Definition
Describe the population of people with chronic conditions, declining function and poor prospects for full recovery.
Design a reliable and proactive identification process that operates through referrals and/or by predictive modeling using administrative-level claims and clinical data.
Select and enroll patients that have a high probability of benefiting from intervention, i.e. those with advanced illness.
Formulate discharge criteria to ensure continuity of care and to distinguish population and services from other benefits or health care services.</td></tr>
<tr><td colspan="3">Intervention Principles
Serve “people” before “patients.” Many people with advanced illness want to avoid being patients. Define value, business model and metrics accordingly.
Personal goals drive clinical goals. Shift engagement process to ensure personal relationships lead clinical relationships. To aid personal orientation, develop staff competencies in communication (e.g. health literacy) and engagement (e.g. conflict resolution and motivational interviewing). Care planning should first focus on the goals and values of the person with advanced illness rather than on the goals and values of treatment of the person’s disease. It is only with this approach that informed consent of the person is possible.
Focus on personal preference as free informed choice among all available options for care.</td></tr>
<tr><td>Care Management
Coordinate care across all clinical settings, over time as condition progresses, via communication in real time
Move focus of care from hospital to home/community
Provide care management through interdisciplinary teams supervised by an engaged leading physician
Implement collaborative care coordination: engage individual, family, caregivers, physicians and other clinicians, other care managers, and community partners e.g. public agencies, churches, and community navigators</td><td>Advance Care Planning
Promote advance care planning through continuing conversations over time, at ill person’s pace, in safety and comfort of home
Ensure that preferences for care are communicated, documented, available and followed by clinicians at all points of care</td><td>Treatment and Palliation
Develop individualized care plan driven by personal preference and clinical/psychosocial/spiritual needs.
Provide customized blend of disease-modifying treatment + palliative care
“Tune” treatment to preferred level of symptom control
Alter care plan as preferences evolve through illness progression</td></tr>
<tr><td colspan="3">Environment:</td></tr>
</table>

Take advantage of existing or developing operational and financial innovation. Collaborate when possible with clinical integration networks (CINs), post-acute networks, ambulatory and home-based palliative care, complex case management, patient-centered medical homes, and collaborative networks that coordinate healthcare, public health and social services.

Messaging and Communication:

- **Prioritize active, positive messaging and communication, e.g. "advanced care", that implies active, value-driven engagement with clinicians and the public.**

Payment Model:

- **Align incentives and provide a bridge from fee-for-service toward risk-based, performance-based and value-based reimbursement consistent with broader payment reform efforts.**

Evaluation

- **Standardize process and outcome metrics: personal experience of care, clinical outcomes and cost**
- **Implement measures that help guide implementation to help improve effectiveness of interventions**

B. Case Studies

Sutter Health Advanced Illness Management (AIM®) Program

Care Delivery Environment	• Large health system in Northern California including hospitals, physicians, home health and hospice providers; • Program collaborates and coordinates care with Sutter and independent providers • Currently in 15 counties. Expanding into 4 additional counties. • Current daily census – 2,100 persons with advanced illness • Enrollees since CMMI grant over 5,500
Population	Individuals with advanced illness (chronic or other) in the last 12-18 months of life, with **any** of the following indicators of active decline: • Significant function decline: loss of 1 ADL in the last 3 months • Significant nutritional decline: 5 percent of baseline weight or albumin<3.0 • Recurrent and unplanned hospitalizations: 2 or more hospitalizations in the last 6 months **or** 2 or more ED visits in the last 3 months • Hospice eligible but not ready • Provider not surprised if patient died in the next 12 months
Interventions	• Home, telephonic, and direct patient encounters in the hospital, physician offices and SNFs • Accessing existing services wherever available; also filling in gaps of care where no support is available • Multidisciplinary team of nurses, social workers and palliative care physicians; team partners closely the patient's physicians and other

	providers to drive *"advanced illness care"* • Team focuses on advance care planning, symptom management, care coordination and physician follow up visits, medication reconciliation, and patient engagement and self management support • AIM services are provided until patient deceases or transitions to hospice
Outcomes	Hospital days last 6 months of life - 7.1 percent Patients have greater than 1 ED visit last 30 days of life- 3.1 percent Have ICU days in last 30 days of life – 6.1 percent Transfer to hospice – 53 percent **90 days pre/post interventions**: • Over 59 percent reduction in hospitalizations • 67 percent reduction in ICU days • Over 95 percent physician and patient satisfaction • $9,985 payer savings per enrollee • $8,289 reduction in total cost of care (hospital, physician, AIM program costs)

Aetna's Compassionate Care Program

Care Delivery Environment	• Health plan administered case management services to members in close partnership with physicians
Population	• Persons who have one or more conditions that progress enough that general health and functioning decline, and treatments begin to lose their impact • Defined by algorithm, care management process, physician referral, and or care manager clinical judgment
Interventions	• Telephonic encounter • RN case manager supported by medical director • Team focuses on advance care planning and decision support, psychosocial support, symptom management and care coordination • Compassionate services are provided until patient is deceased
Outcomes	• 82 percent of engaged decedents choose hospice • 82 percent reduction in acute inpatient days • 77 percent reduction in emergency room visits • 86 percent reduction in intensive care unit days • $12,000 cost savings per member
Further Development	• Coordinate and facilitate provider-led components such as clinic, home or hospital visits to enhance program access and provider engagement • Partner with ACP to promote adoption of similar interventions

Gundersen Health System Respecting Choices® Advance Care Planning (ACP) System

Care Delivery Environment	• Implement in the La Crosse, Wisconsin Health Region • Includes two major, integrated health systems that each operates a tertiary medical center, community hospitals, specialty and primary care clinics serving a population of 560,000 people in southwest Wisconsin, southeast Minnesota, and northeast Iowa. • Other providers including other community hospitals, nursing homes and hospice programs. These other health care provides were encourage to participate in implementing this standardized advance care planning system.
Population	• All adult patients were included, but efforts were made to involve healthy adults in late middle age in creating a well thought out power of attorney for health care (First Steps® ACP), to update this plan over time and then to create a Physician Orders for Life-Sustaining Treatment in the last year of life (Last Steps® ACP).
Interventions	• Develop an organized system for advance care planning so that patient's in the target populations were always approached, the quality of care planning was facilitated by train staff and community volunteers, systems were designed and implemented so that documented care plans could be stored and retrieved and would reliably be transitioned when patients moved from one setting to another. Care plans were update overtime as illness or health conditions changed. There was a planned community engagement to make advance care planning part of both the community and health care culture.
Outcomes	• In La Crosse County (population of 120,000), adult residents of La Crosse county at the time of death (n=400) had some type of written care plan (either a power of attorney for health care or POLST form or both) 96 percent of the time; these plans were found in the medial records of the health organization caring for the decedent at the time of death 99 percent of the time; and medical care to provide or forgo treatment was consistent with the care plan 99 percent of the time. • In the La Crosse Health Region (from the Dartmouth Atlas, 2010) • Total number of hospital days in the last two years of life is 10.0. The national average is 16.7 • Total number of ICU care in the last two years of life 2.2. The national average is 5.9 • Total cost of care in the last two years of life, $48,771. The national average is $79,337. • Average LOS in hospice is 15.5 days. The national average is 21.0.