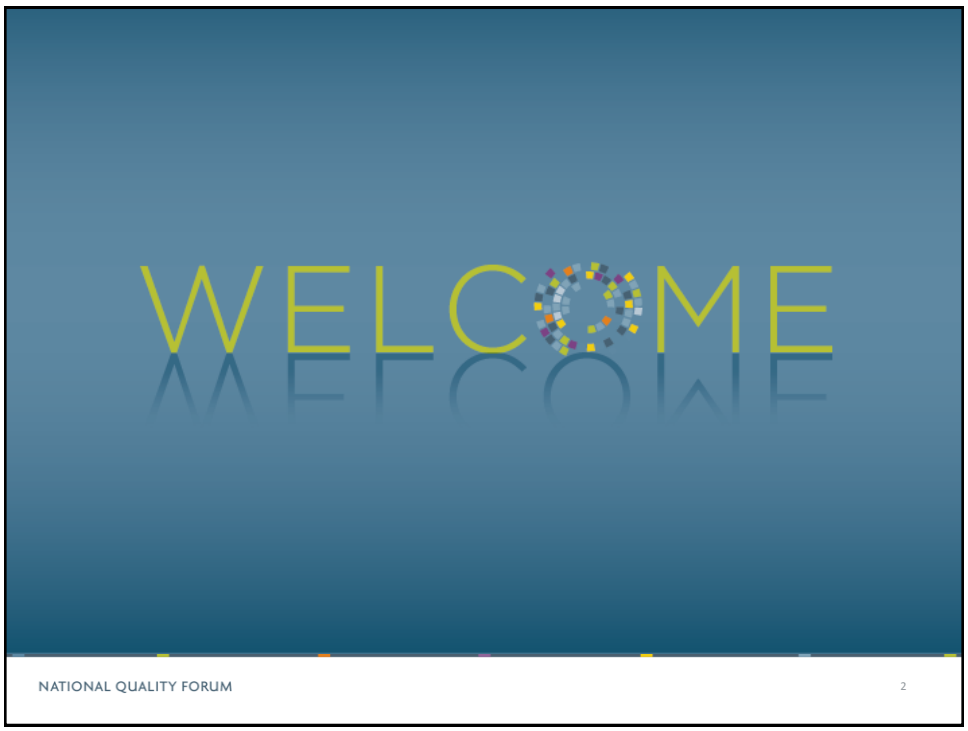
National Quality Partners

Advanced Illness Care Initiative Kickoff

NATIONAL QUALITY FORUM

September 24, 12:00 pm-1:30 pm ET



Speaker

Christine K. Cassel, MD
President and CEO

Why Advanced Illness Care?

- Opportunity to leverage national progress (IOM Report: Dying in America, CTAC: A Roadmap for Success)
- Increased demand for hospice and palliative care
- NQF's unique contribution to advanced illness care
- Need for better measures (outcomes vs. process)
- Better payment models

Speaker

Wendy Prins, MPH, MPT
Vice President, National Quality Partners

Join the Conversation Live

- Follow NQF @NatQualityForum
- Join the conversation on Twitter during the webinar using #advancedillness

NQF's Work:
Framed by the National Quality Strategy

Three aims to improve healthcare

BETTER CARE

MORE AFFORDABLE CARE

HEALTHIER PEOPLE IN HEALTHIER COMMUNITIES

NQF's National Quality Partners…

…collaborate through "Action Teams" to catalyze and accelerate improvement on the priorities and goals of the National Quality Strategy to improve quality, improve health, and reduce healthcare costs

NQF's National Quality Partners…

…maximize the impact of high-leverage drivers—payment, public reporting, consumer engagement, and accreditation and certification—that each of us brings to bear

National Quality Partners' 2015-2016 Action Teams

- Reducing antimicrobial resistance through aggressive antibiotic stewardship
- Improving advanced illness care through authentic patient and family engagement

NQP Advanced Illness Care Action Team

Supporting personalized advanced illness care based on individual values, preferences, needs, and goals

mutually reinforcing activities • communications • culture of innovation and action

NQF is the backbone organization that connects stakeholders and supports collaboration

NATIONAL QUALITY FORUM 11

C-TAC: The Coalition to Transform Advanced Care

www.thectac.org
twitter: @ctacorg

C-TAC COALITION TO TRANSFORM ADVANCED CARE

C-TAC's vision for a better future…

All Americans with advanced illness, especially the sickest and most vulnerable, will receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity.

C-TAC
COALITION TO TRANSFORM ADVANCED CARE

Advanced Illness/Advanced Illness Care

Advanced illness is that stage in the progression of one or more conditions when general health and functioning decline, curative treatments become less effective and overall quality of life increasingly becomes the focus of care. This may happen in the course of any disease and at any age but is more common in older populations.

Advanced illness care encompasses a broad range of social and clinical services, including palliative care and hospice care, but it is not synonymous with either, nor is it end-of-life care only. Specialists may be engaged in aspects of advanced illness care, but typically it is led by primary care, delivered by interprofessional teams, bolstered by community engagement and guided by the personal preference, not medical protocol only. As a result, it is often home-based.

C-TAC
COALITION TO TRANSFORM ADVANCED CARE

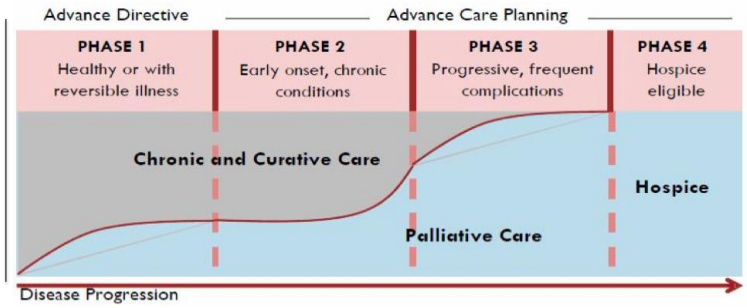
The *advanced illness* care continuum

Delivered based on an informed and shared decision-making process involving evidence, clinicians' expertise, and patients'/families' wishes and goals.

and

Delivered on a continuum* at the right time and in the right setting as determined by patients and their families with input from clinicians, families/caregivers, and spiritual advisors.

*Care Continuum:



C-TAC COALITION TO TRANSFORM ADVANCED CARE

Why advanced illness care matters…

- 11,000 Americans turn 65 every day
- 65+ group will double to 72m in two decades
- In 2030, 9 million will be 85 or older
- People want care that enhances quality of life, keeps them at home, and keeps them from being a burden to their family
- 93% of Americans identify advanced illness care as a top priority for US health care.

C-TAC COALITION TO TRANSFORM ADVANCED CARE

The Cost of Advanced Illness

- The cost of treatment is the highest concern of Americans when they think about advanced illness. And for good reason:
  - 25% of seniors lose all their assets during the last five years of life due to the costs of advanced illness care.
  - 41% lose all of their assets except housing benefits.
  - 31% of families and individuals with advanced illness lose their savings each year due to the costs of care.
  - 80% of patients and families ask about the cost implications of their care.

C-TAC COALITION TO TRANSFORM ADVANCED CARE

The Big Gap…

What People Want	*What They Get*
1. Be at home with family, friends	Recycled through the hospital
2. Have pain managed	Often inadequate, ineffective treatment
3. Have spiritual and emotional needs addressed	Often die in hospital, in pain and isolation
4. Avoid impoverishing families	Great cost to families and the nation.

C-TAC COALITION TO TRANSFORM ADVANCED CARE

CMS Medicare Goals: Fee for Service

- End of 2016
  - 85% of payments tied to Quality or Value
  - 30% via Alternative Payment Models (e.g., Bundled Payments/ACO, etc.)
- End of 2018
  - 90% of payments tied to Quality or Value
  - 50% via Alternative Payment Models (e.g., Bundled Payments/ACO, etc.)

C-TAC COALITION TO TRANSFORM ADVANCED CARE

Patient-centered Care	Person-centered Care
Centers on the management of each disease	Views diseases as interrelated phenomena
Focuses on interactions during visit	Focuses on interrelationships over time
Views comorbidity as separate diseases	Views comorbidity as constellation of disease
Views body systems as distinct	Views body systems as interrelated
Focuses primarily on evolution of disease	Adds focus on person's experience with illness
Descriptors use medical codes (ICD 10)	Descriptors include person's experience with health problems

Adapted from Starfield B. Is patient-centered care the same as person-focused care? Perm J. 2011 Spring;15(2):63-9.

C-TAC COALITION TO TRANSFORM ADVANCED CARE

CONNECTICUT CENTER FOR PATIENT SAFETY
QUALITY HEALTHCARE IS A RIGHT.

What Matters Most – Individual Voices

CONNECTICUT CENTER FOR PATIENT SAFETY
QUALITY HEALTHCARE IS A RIGHT.

Life can change in a moment

What matters most to patients

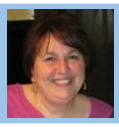
- Safe, high quality care
  - Patients don't want to become a patient harm statistic
  - Patients don't want to be 1 of 400,000 people who die each year from medical harm
- Being a respected member of their health care team
  - Communication, shared decision making and respect for personal preferences
  - Not "for" us but "with" us
- Good value
  - High quality / lower costs

Communication

- "Patients are the only ones who are there the whole time."
- "The patient is the most underutilized resource in healthcare."

Tools to empower patients and to help to initiate conversations

- Patient Preference Passport
- Choosing Wisely
- NPSF AskMe3



Email: Lisa.Freeman@ctcps.org

www.ctcps.org

Follow us on:

Facebook: Connecticut Center for Patient Safety (CTCPS)

Twitter: CTPatientSafety

Carolinas HealthCare System

Advanced Illness Management: Transitions and Beyond

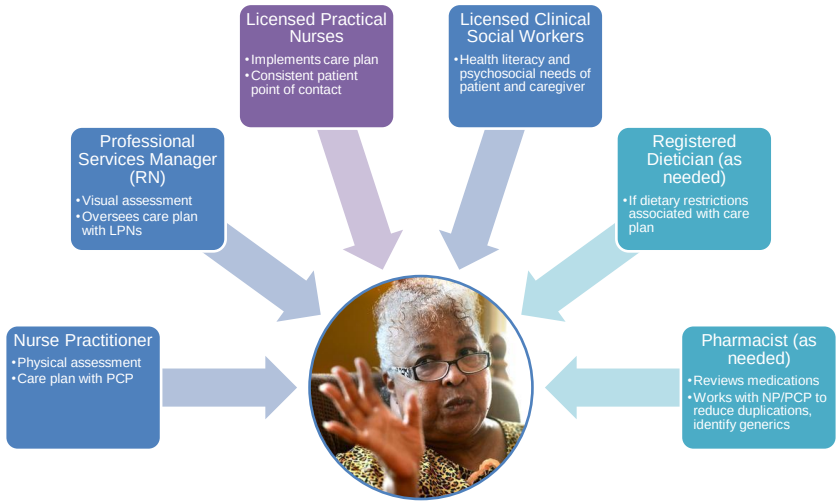
Jason Byrd, JD
Deana Williams, MBA/MHA
Carolinas HealthCare System

Goals of AIM

- Coach the patient / caregiver to a state of readiness to manage their own healthcare
  - Adherence to the medical plan of care
  - Medication / Diet / Disease / Symptom Education
  - Advance Care Planning
  - Follow-Up Care Coordination
  - Medication Reconciliation
  - Crisis Plan Development based on Red Flag Symptoms
- Help assure the patient is receiving the right care, at the right location, at the right time for the right duration
  - Appropriate utilization of PCP / Specialist, Urgent Care, ED, Hospital
  - Assist in identifying the appropriate level of care such as:
    - SNF
    - Home Health
    - Hospice

AIM Patient Criteria

- >4 ED / Hospital Visits in the last 6 months
- 3+ Chronic Conditions
- Polypharmacy
- Discharged to home
  - Does not live in a Skilled Nursing Facility / Assisted Living
- Not actively treated through an intensive health program
  - Rehabilitation Facility
  - Hospice Program
  - LCI Palliative Care Clinic
- Not involved in another care management program
  - Community Care Partners of Greater Mecklenburg (CCPGM)
  - Humana Care Management
  - BCBS Care Management



Plan of Care Development

The interdisciplinary team's patient-centered plan of care is created using the start of care assessments and the patient's goals of care.

Included in the plan of care

- Risk Stratified Frequency of Follow Up Education and Communication
- Identified Nursing and LCSW Pathways
- Advance Care Planning Needs
- Crisis Plan Development
  - Based on patient identified red flag symptoms

AIM Team Collaboration

The LPN is the patient's consistent point of contact and serves as the 'quarterback' for the AIM team to meet the patient's care management needs. This is accomplished through:

- Formal interdisciplinary team meeting to review:
  - Doctor's Appointments
  - Psycho-social Changes
  - Health Updates
- On-going communication to discuss new concerns and coordinate patient contact
  - Lowers the number of phone calls a patient receives
  - Reduces patient anxiety by providing minimal calls from other AIM team members

AIM-Patient Partnership

The AIM team and the patient work together to achieve a higher quality of life for the patient by:

- Communicating regularly regarding
  - Patient questions
  - Patient concerns / frustrations
  - Physician appointment reminders
    - LPN will attend appointments as needed
  - Medication Review
  - New or worsening symptoms
    - Discussing utilization options as appropriate
  - Change in social circumstances
  - Change in psychosocial needs

AIM-Cross Continuum Partnership

The AIM team communicates with care providers across the continuum of care to help ensure seamless patient-centered transitions:

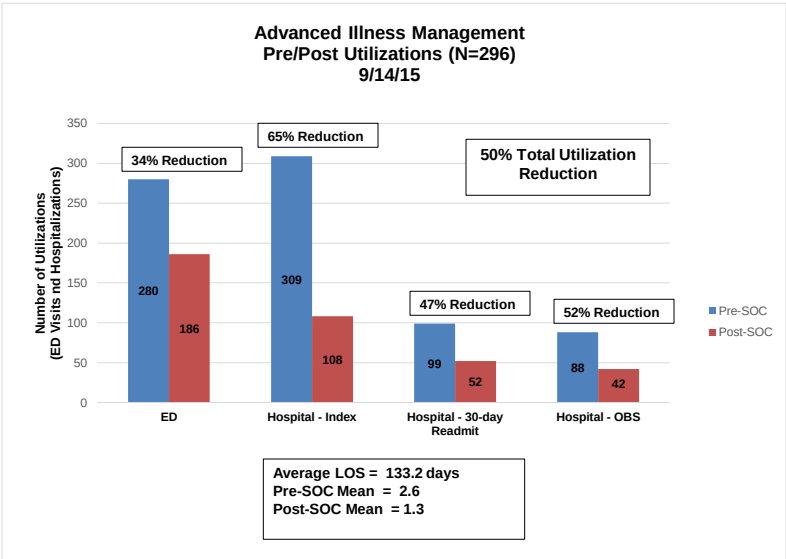
- Inpatient Case Management
- Home Health
- Primary Care Physician / Specialist(s)
  - Significant change in health status
  - Hospitalizations and ED Visits
- Skilled Nursing Facilities
- Hospice

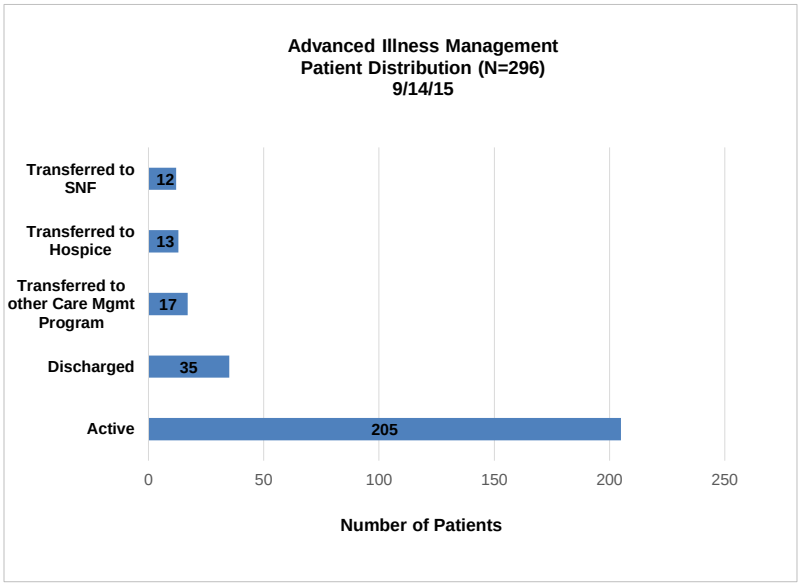
Outcomes

Avoidable Care Composite: AIM

		AIM Avoidable IP	AIM Avoidable ED	AIM Readmissions	AIM Total Avoidable Care
2014	Pre	52	43.2	22	117.2
	Post	20	33.2	4	57.2
	Ratio	**0.385**	**0.769**	**0.182**	**0.488**
2015	Pre	39	29.9	23	91.9
	Post	8	23.7	11	42.7
	Ratio	0.205	**0.793**	**0.478**	**0.465**

		AIM Avoidable IP	AIM Avoidable ED	AIM Readmissions	AIM Total Avoidable Care
2015 Q1	Pre	20	15.3	8	43.3
	Post	7	17	6	30
	Ratio	**0.350**	1.111	**0.750**	**0.693**
2015 Q2	Pre	19	14.7	15	48.7
	Post	1	6.7	5	12.7
	Ratio	**0.053**	0.456	**0.333**	**0.261**





Patient Satisfaction Survey

- Mean Satisfaction Score
  - 9.06 / 10
- Likelihood to Recommend
  - 88% Very Good and Good
- Teamwork
  - 92% Very Good and Good

"I think everyone should have a Sarah"

I really do appreciate Aprils calls and willingness to help me. She always calls at a time I need help. Thank you for this much needed service

My team was awesome and cannot be replaced. Always found the best avenues for me to get what I needed.

Anna was extremely in tune with my physical needs. I appreciate her warm approach to my family.

Sutter Health
Advanced Illness Management (AIM)®

Highlights of Advanced Illness Management (AIM®)

NQF
September 2015

Sharyl Kooyer
Regional AIM Program Director
Sutter Health

Betsy Gornet FACHE
Chief Advance Illness Management Executive
Sutter Health

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HEALTH CARE INNOVATIONS AWARDS

"This publication was made possible by Grant Number 1C1CMS331005 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services."

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ADVANCED ILLNESS MANAGEMENT (AIM®)

OUR LOCATIONS & SERVICE AREA

WHAT IS AIM?

- AIM is a care management model that employs evidence-based principles of:
  - care coordination and transitions management;
  - palliative care+ curative treatment;
  - patient engagement in self support for persons living with advanced illnesses.
- Bridges gaps between care settings
- Single model of care across all illness types and all settings help shift care towards patients home and community

- >2,800 persons served daily
- Approximately 10,000 enrolled to date
- 18 teams serving 19 counties
- RN & MSW Teams coached by Palliative Care Certified Medical Director
- Over 500 persons trained in model of care

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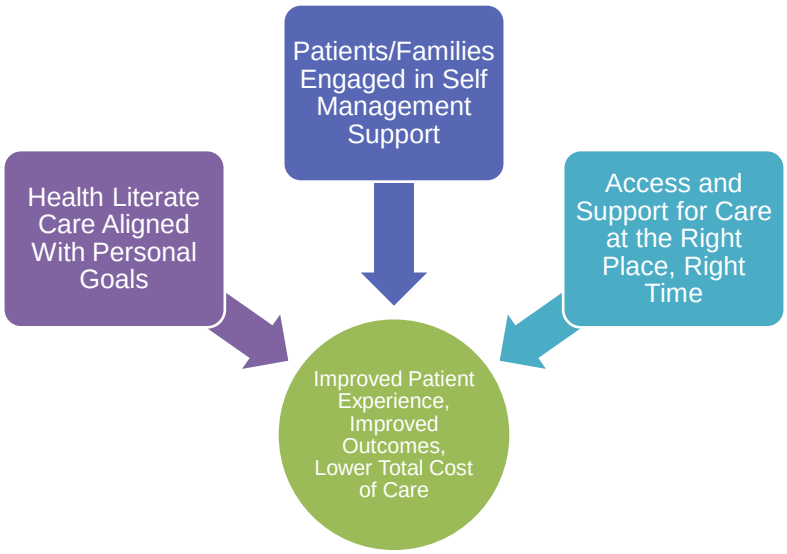
AIM



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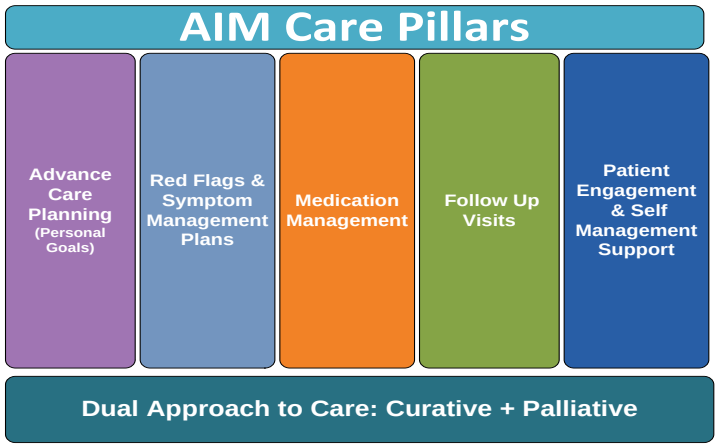
'STANDARD OF PRACTICE'



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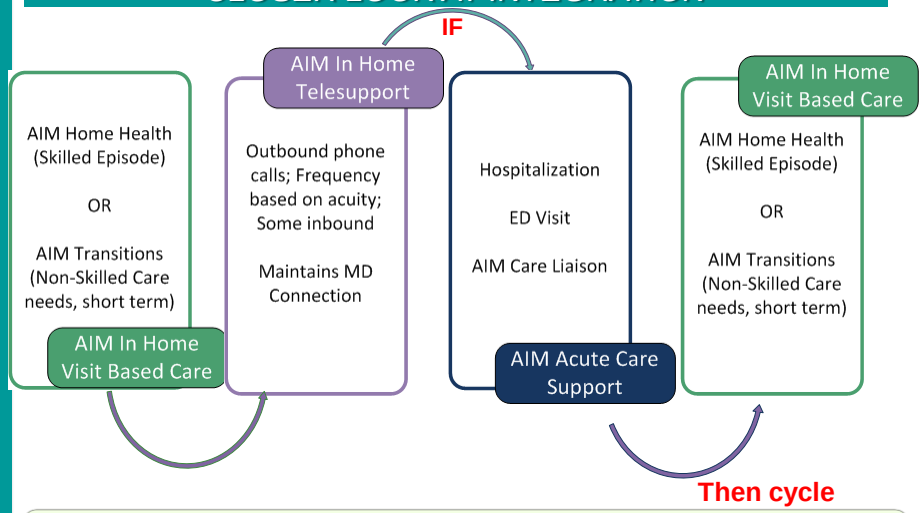
CLOSER LOOK AT INTEGRATION



Maintain Physician Communication and Connection with Patient; AIM Triage After Hours and Weekends

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CURRENT AIM MEASURES

AIM Measures 7.10.15

Descriptive Measures	Care Management & Clinical Care Measures	Outcomes, Cost & Resource Measures	Workforce Related Measures
Enrollments	Discharge Reason	Supplement - Inpatient Admission Rate per 100 Patients	Caseloads per FTE Case Manager - HH RNCC
Census	Death Location = Hospital (after receiving AIM home care intervention) as % of total AIM program discharges	Supplement - ED Visit Rate/100 Pts	Caseloads per FTE Case Manager - Transitions RNCC
% Age at AIM Start ≥75 years	Transfer Rate to Hospice	Supplement - Hospital Days in the Last 6 Months of Life	Caseloads per FTE Case Manager - Telesupport RNCC
Payer Status - % Medicare, Medicare Capitated, Medicare Capitated/Medi-Cal, Medicare/Medi-Cal, Medi-Cal	Advance Care Plan (% w ACP prior to or within 90 days of enrollment)	Proportion with more than one emergency room visit in the last 30 days of life	Staff Trained
% Hospice Appropriate at time of enrollment	PHQ2 (% within 90 days of enrollment)	Proportion ICU in last 30 Days of Life	Training Hours per staff (clinical and non-clinical)
% of Non-White (Caucasian) Patients	Average Home Visit Intensity	Proportion admitted to hospice for 3 days or less	Training Hours per staff (clinical only)
Percent who live alone	Patient/Caregiver Satisfaction	Proportion admitted to hospice for 14 days or less	Employee Retention and Turnover
AIM LOS - All Patients - Mean	Chemotherapy in last 14 days of life	Proportion admitted to hospice for 21 days or less	
AIM LOS - Pts Referred to Hospice - Mean		30,90,180 Day Pre-Post Analysis	
LOS on Hospice (SCAH overall) - Mean		Hospitalizations	
LOS on Hospice (AIM Patients) - Mean		ICU Days	
AIM LOS - Pts Deceased on AIM - Mean		ED Visits	
LOS on Hospice (SCAH overall) - Deceased Pts - Mean		ALOS	
LOS on Hospice (AIM Patients) - Deceased Pts - Mean		MD Visits and Calls	
		Total Cost of Care (Hospitals, Physicians, AIM)	

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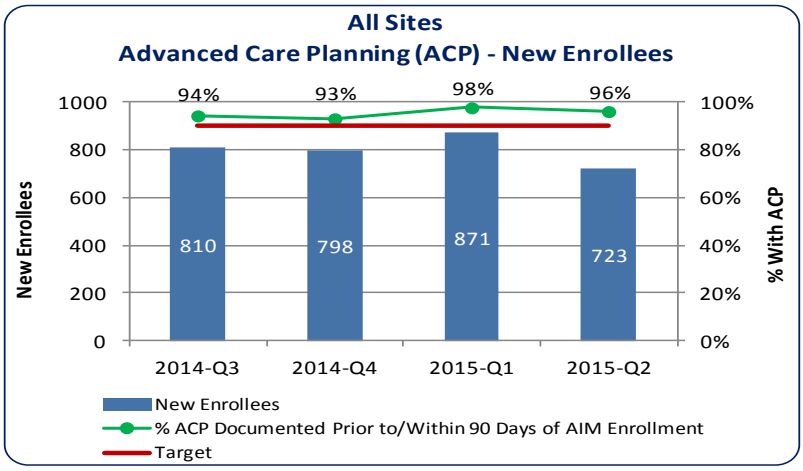
Advance Care Planning

Results not yet independently validated by CMS



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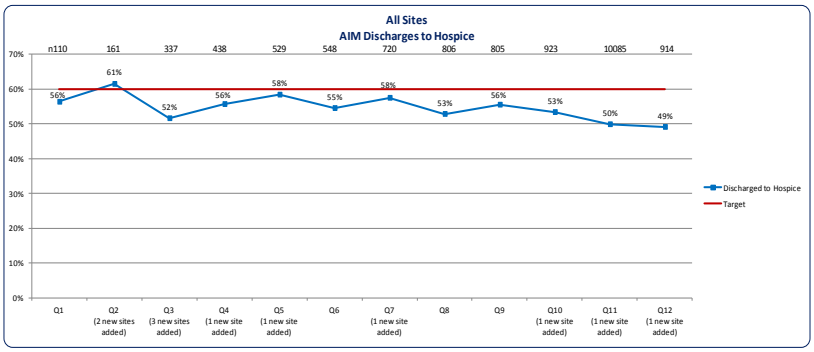
Transfer to Hospice

Results not yet independently validated by CMS



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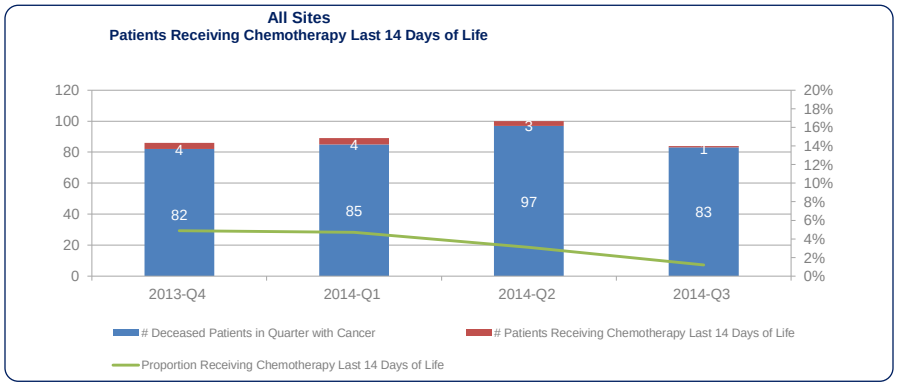
Chemotherapy Use Last 14 Days of Life

Results not yet independently validated by CMS



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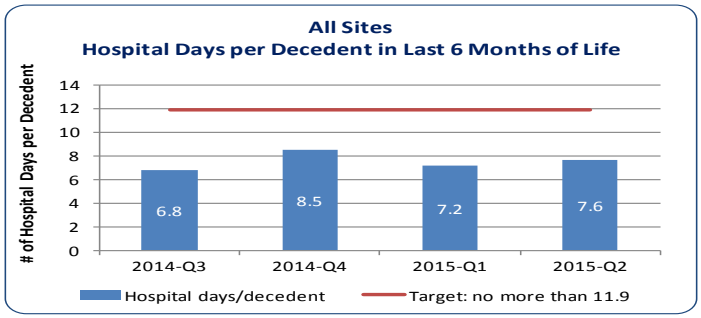
Hospital Days Last 6 Months of Life

Results not yet independently validated by CMS



Region	Location	2012-Q3 (Q1)	2012-Q4 (Q2)	2013-Q1 (Q3)	2013-Q2 (Q4)	2013-Q3 (Q5)	2013-Q4 (Q6)	2014-Q1 (Q7)	2014-Q2 (Q8)	2014-Q3 (Q9)	2014-Q4 (Q10)	2015-Q1 (Q11)	2015-Q2 (Q12)	Grand Total
All Regions	All Sites													
	Denominator	53	99	195	239	348	360	468	500	482	544	576	342	**4,206**
	Numerator	292	815	1693	2329	2617	2780	4218	3695	3284	4628	4129	2616	**33,096**
	Hospital days/decedent	5.5	8.2	8.7	9.7	7.5	7.7	9.0	7.4	6.8	8.5	7.2	7.6	**7.9**

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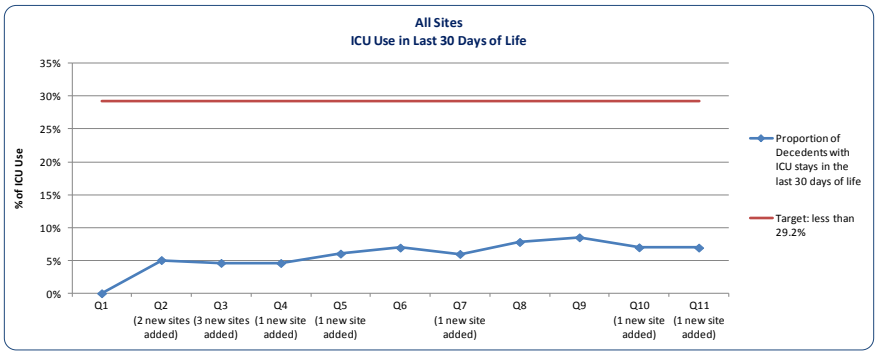
ICU Use Last 30 Days of Life

Results not yet independently validated by CMS



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All Regions	All Sites												
	Denominator	53	99	195	239	348	360	468	500	482	544	576	**3864**
	Numerator	0	5	9	11	21	25	28	39	41	38	40	**257**
	Proportion	*0.0%*	*5.1%*	*4.6%*	*4.6%*	*6.0%*	*6.9%*	*6.0%*	*7.8%*	*8.5%*	*7.0%*	*6.9%*	***6.7%***

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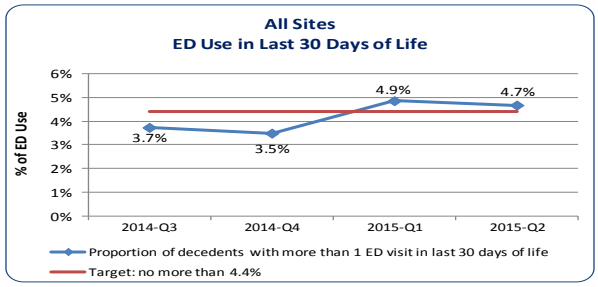
ED Use Last 30 Days of Life

Results not yet independently validated by CMS



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All Regions	All Sites													
	Denominator	53	99	195	239	348	360	468	500	482	544	576	342	**4206**
	Numerator	4	4	8	10	16	11	8	15	18	19	28	16	**157**
	Proportion	*7.5%*	*4.0%*	*4.1%*	*4.2%*	*4.6%*	*3.1%*	*1.7%*	*3.0%*	*3.7%*	*3.5%*	*4.9%*	*4.7%*	***3.7%***

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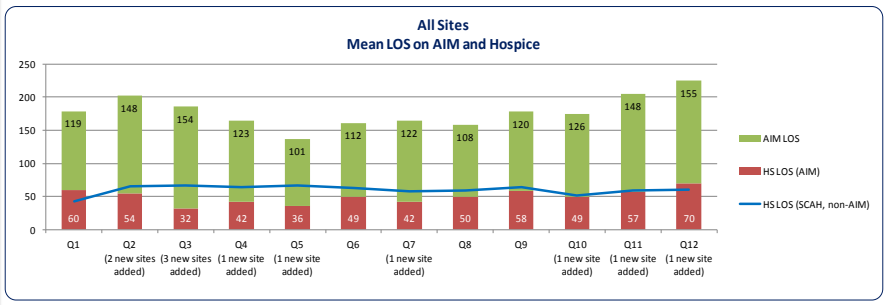
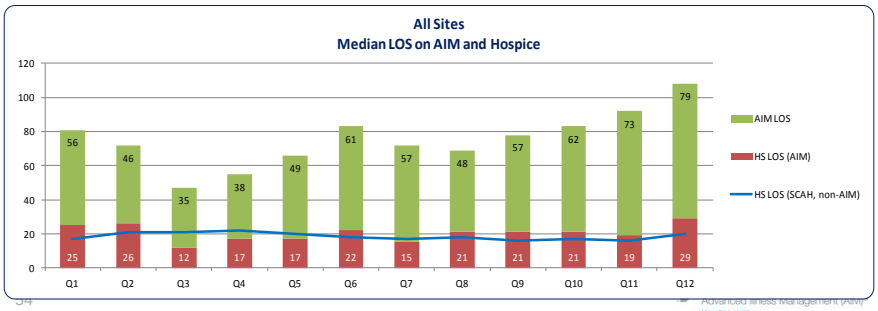
Length of Stay AIM & Hospice

Results not yet independently validated by CMS





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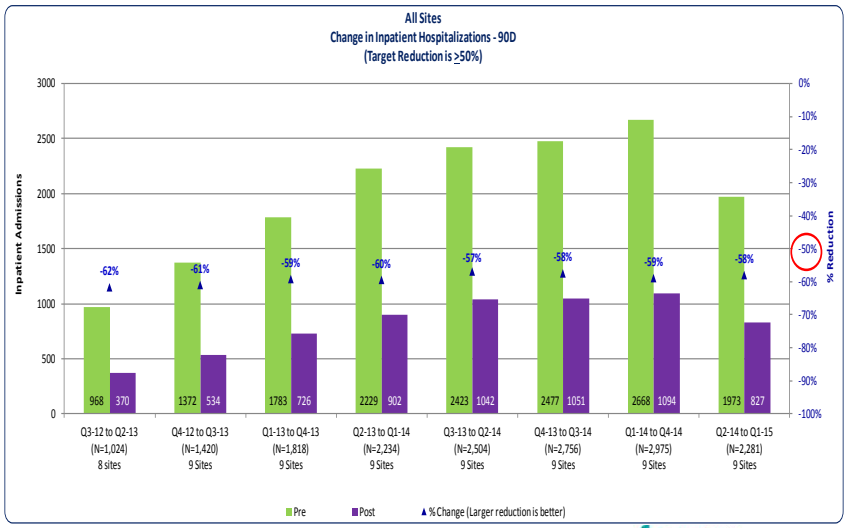
90 Day Pre/Post Hospitalization Analysis

Results not yet independently validated by CMS



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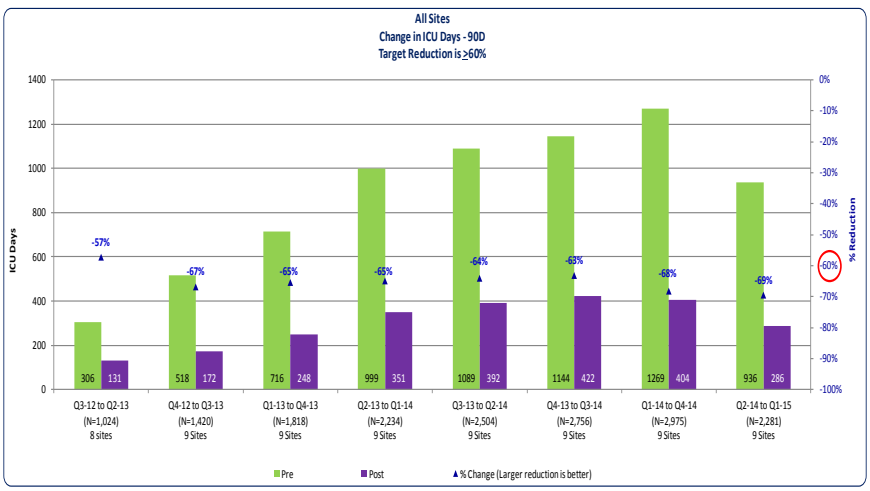
90 Day Pre/Post ICU Days Analysis

Results not yet independently validated by CMS



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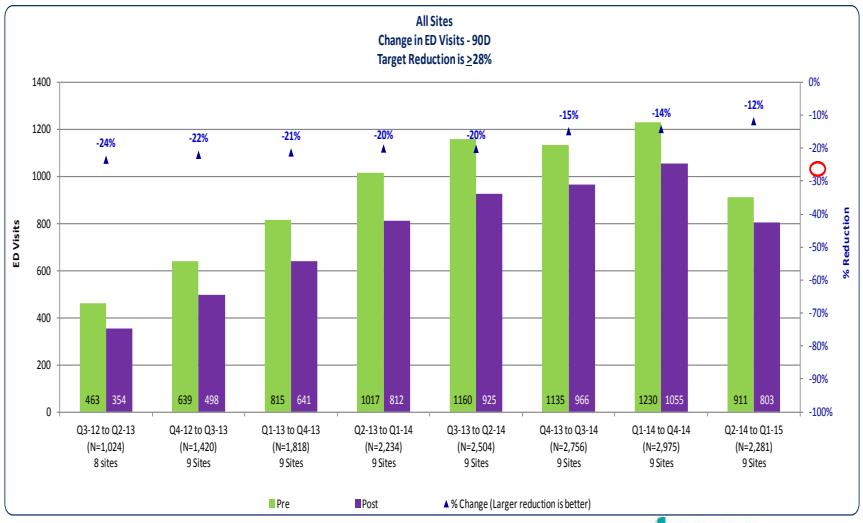
90 Day Pre/Post ED Visit Analysis

Results not yet independently validated by CMS



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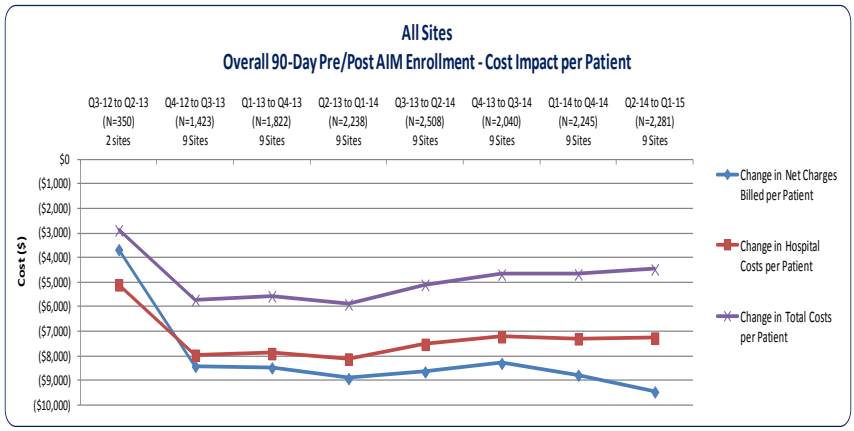
Pre/Post Payer Savings and Cost Reductions – ***Per Enrollee***

Results not yet independently validated by CMS

(Rolling 12 months periods, 1 Q lag)



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Patient Satisfaction Survey Questions

Patient/Family Satisfaction Surveys conducted at 60 and 180 Days
Q1: How often did the AIM staff listen carefully to you? (a)
Q2: Did the AIM staff treat you with respect and courtesy? (b)
Q3: How often did the AIM staff explain things in a way that was easy to understand? (a)
Q4: How often were you involved in making decisions that support your goals? (a)
Q5: How often did the care and support you received match your health care needs? (a)
Q6: How often did you feel like you had a sense of control about the coordination of your care? (a)
Q7: Did the information and tools provided by AIM staff help you manage your symptoms? (b)
Q8: How often were your symptoms for example pain, nausea , shortness of breath, etc., controlled to the level you wanted? (a)
Q9: Has the AIM Program helped you improve your confidence and ability to manage your symptoms? (b)
Q10: Overall, how satisfied are you with the care and services you have received from the AIM Program? (c)

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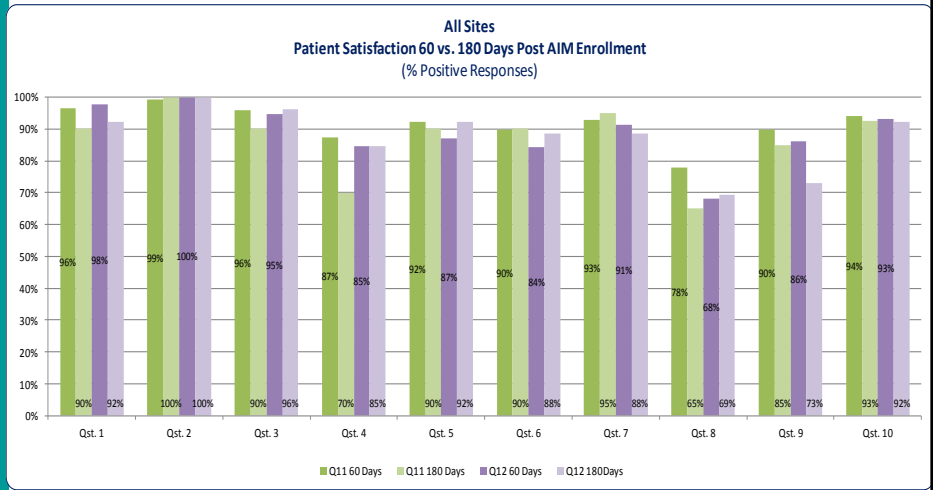
AIM Patient Satisfaction Survey

Results not yet independently validated by CMS

Q11: Jan-Mar 2015

Q12: Apr-Jun 2015



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Health Care Innovations Awards

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Open Discussion

Moderator: Ron Walters, Associate Vice President of Medical Operations and Informatics, MD Anderson Cancer Center

- What are the barriers stopping us?
- Who has baked preferences, values, and goals into advanced illness care?
- How are you monitoring progress?
- How has it been accepted by patients and families?
- Who else has accepted your approach?

Please type questions into the chat box anytime or call 877-637-9565 (no passcode)

National Quality Partners Advanced Illness Care Action Team

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