C-TAC Coalition to Transform Advanced Care

**Advanced Care: A Model for Person-Centered, Integrated Care for Late Stage Chronic Illness**

Although care delivery in the U.S. is oriented toward treatment of acute, reversible conditions, chronic illness has become increasingly prevalent. As chronic illness enters its advanced stages, quality of care may decrease due to the inherent fragmentation of the care system. Delivery redesign is needed for the growing population of patients with advanced illness in particular, a group that includes some of our most seriously ill and vulnerable citizens.

"Advanced illness" occurs when a person with one or more chronic diseases begins to decline in health status and ability to function. At this point, care needs tend to increase, as do visits to emergency room and hospital. Most importantly, responsiveness to treatment, e.g. chemotherapy for cancer, may become progressively impaired. This can lead to uncertainty about prognosis and plans for further treatment. Patients' preferences and goals may change as the burdens of treatment increase and its benefits become more questionable.

C-TAC's Advanced Care Model (ACM) – developed based on best practices by many of the leading advanced care clinicians in the U.S. – is an interdisciplinary care management intervention that focuses on each patient's personal values and goals to drive care, to anticipate and prevent crises, and to increase quality of and satisfaction with care for patients, their families, and clinicians.

**Background – The Problem for those with Advanced Illness**

With the onset of advanced illness, patient care currently tends to fragment across several dimensions:

1. *Setting:* Care between treatment settings, including hospitals, physician groups, home and community-based services, and long-term care, are often poorly coordinated and sometimes result in loss of information, medication mixups, and dropped appointments.
2. *Time:* As chronic disease progresses to advanced illness, patient goals and preferences often evolve. However, if these personal preferences are not elicited and documented, clinicians' goals stay the same. This can result in treatment that fails to contribute to patient-centered outcomes.
3. *Treatment:* Reimbursement and regulations have taught clinicians to categorize patients as "treatable" or "dying." What should be a treatment continuum centered on patient preferences is fractured in reality into two mutually exclusive segments: "curative care" and "comfort care."

**Intervention**

C-TAC has developed a foundational ACM that coordinates care across the dimensions of setting, time, and treatment. The foundational ACM incorporates processes that C-TAC believes are essential to providing quality, person-center, integrated care, while allowing for flexibility in their implementation to address local conditions and subpopulations. Through collaboration with health care stakeholders across the country, C-TAC hopes to expand, improve, and standardize the ACM.

C-TAC's ACM is based on the following principles of Advanced Care:

1. The primary goal of Advanced Care is to provide the most appropriate level of care as determined by the ill person, avoiding either over- or under-treatment.

2. The free and personal choices of the patient drive the plan of care.
3. The central setting of intervention is the ill person's place of residence, where through repeated encounters over time, education and advance care planning can proceed at the ill person's own preferred pace.
4. Advanced Care provides for the ill person's needs across the entire continuum of late-stage illness for a period of years rather than a shorter period of time.
5. Any savings compared to "usual care" result strictly from the ill person's free choice to pursue a care plan that often includes less invasive, and therefore less costly, treatment alternatives.

The foundational ACM is based on an interdisciplinary care coordination model tightly linking inpatient, ambulatory and home/community settings. The processes included in the model are derived from tested models for care coordination, pioneered by C-TAC members, including Sutter Health's Advanced Illness Management (AIM)® program, Aetna's Compassionate Care® and Gundersen Health System's Respecting Choices®.

Foundational elements of the ACM include:

- Care managers placed in the hospital, where they screen, risk-stratify, enroll and triage patients with advanced illness, and interface with hospitalists, inpatient palliative care and ED clinicians, inpatient case managers and discharge planners.
- Other care managers embedded in physician group practices, where they provide consultation to physicians and office staff, enroll appropriate patients, and provide telephonic case management either from the office or from a centralized call center.
- Mobile care management teams that provide high-touch encounters in patients' residences, whether home or facility.
- Constant real-time communication among all care managers and with the patient's attending physician.
- Other foundational ACM processes, including medication reconciliation, critical symptom self-management and reporting, advance care planning, patient safety maintenance, and close medical follow-up by both attending physician, who supervises the care team, and physicians who are part of the team.
- Regular interdisciplinary team meetings for engagement and continued learning.

**Population**

Eligibility is defined by several factors, including the presence of late-stage multimorbid chronic illness (such as cancer, heart failure, COPD, diabetes, kidney or liver failure, progressive neurologic disease, peripheral vascular disease, and others if late-stage and progressive) diminished treatment response, declining functional and/or nutritional status, and recent hospitalization. For this population, general health status is reduced and patient preferences for care may be driven by quality of life.

**The Inter-Professional Team**

In addition to the patient and family caregivers, the inter-professional teamwork is defined as an active relationship between two or more professionals and paraprofessionals who have an

intentional and shared accountability for the outcome of the ill person. Members of the inter-professional advanced care team should include: Physicians, nurses, social workers, pharmacists, patient navigators, physical and/or occupational therapists, family therapists, mental health professionals, medical or health advocates, community based clergy, long-term care helpers.

C-TAC's professional education initiative will support a broad spectrum of health care workers in order to develop basic competencies in the workers in the following areas: communication, continuity and coordination of care across settings, advance care planning, team resilience, and person-centered care.

The model seeks to expand the types of roles that will interface with patients and families around advance care planning and advanced illness care. This is innovative in that it builds on the expertise of the traditional health care team to include people in roles that can fill the gaps in the current system by facilitating meaningful relationships, systems navigation and thereby improves the health care experience and positively impact clinical outcomes.

**Outcomes**

To ensure the ACM is patient-driven, C-TAC will collect data to facilitate program improvement as the ACM evolves. Key metrics include patient and family satisfaction, family/caregiver self-efficacy, analgesic use, hospice election rates and mean/median length of stay, hospital and ICU utilization rates, decedent hospital and ICU days, readmission rates, and direct patient care costs.

**About Us**

C-TAC is a broad, active coalition of patient and consumer groups (such as AARP, American Heart Association, American Cancer Society), care providers (such as American Academy of Nursing, American Society of Clinical Oncology, American Geriatrics Society), health plans (such as Aetna, Kaiser Permanente), faith-based organizations (such as the Progressive National Baptist Convention and Jewish Healthcare Foundation), health care systems and hospitals (such as Geisinger Health System, Ascension Health, Premier Hospital Alliance) and many others. We are nonprofit and nonpartisan.