203 Panel: Translating Chronic Care Patients' Optimal Care Journeys into APMs

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA

Welcome

Rebecca Kirch

Executive Vice President
of Health Care Quality and Value,
National Patient Advocate Foundation

Panel Speakers

Craig Brammer

CEO, The Health Collaborative

Linda House

President, Cancer Support Community

Marian Grant

Senior Regulatory Advisor, The Coalition to Transform Advanced Care

Paul McGann

Chief Medical Officer, Quality Improvement and Innovation Group, CMS

Care Patients' Optimal Care Journey into APMs

Marian Grant, CTAC

My Background

- Palliative care nurse practitioner, UMMC
- Health Policy Consultant
- 2015 RWJ Health Policy Fellow

The Big Gap

What People Want

- Be at home with family, friends
- Have pain managed
- Have spiritual needs addressed
- Avoid impoverishing families

What They Get

- Recycled through hospital
- Suboptimal symptom management, unwanted, ineffective treatment
- Isolated, die alone
- Great cost to family and nation

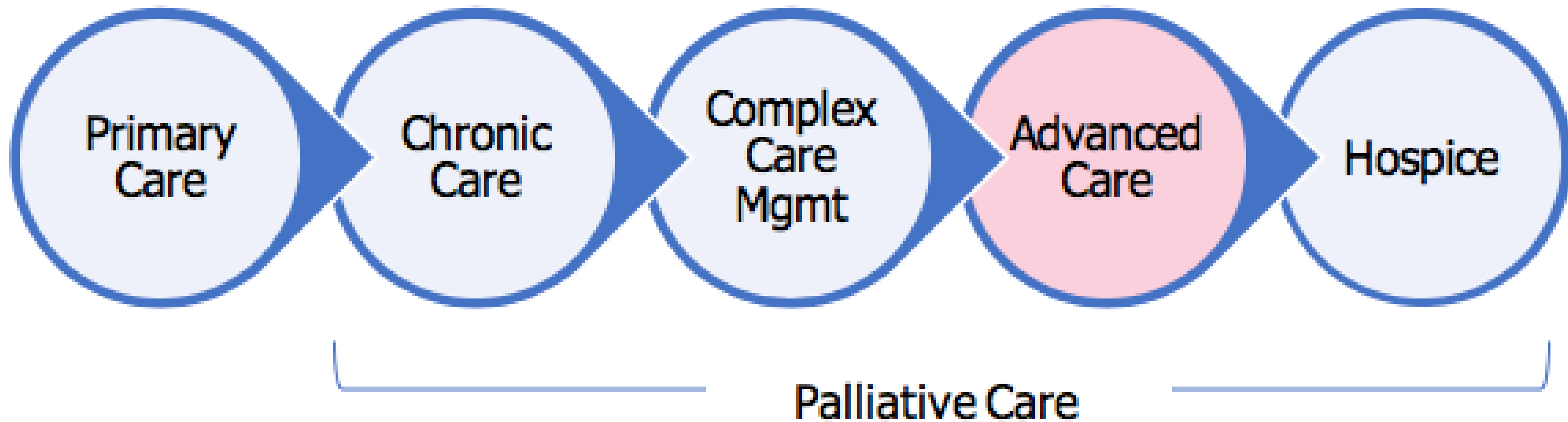
Coalition to Transform Advanced Care

- National non-partisan, not-for-profit
- 140+ national/regional organizations
  - Professional associations
  - Patient and consumer advocacy groups
  - Providers, health systems
  - Health plans
  - Faith-based and community organizations
- Washington, DC

C-TAC Mission

"All Americans 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."

Care Continuum



C-TAC Payment Model

- MACRA's PTAC for advanced APMs
- C-TAC model approved March 2018
- CMMI now refining

Model Elements

- Advanced illness
- Symptom management, care coordination, advance care planning, family support
- Interdisciplinary team, 24/7 access
- Capitated, any payment arrangement

Questions?

- Marian Grant mgrant@thectac.org

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Translating Chronic Care Patients' Optimal Care Journeys into APMs and AAPMs

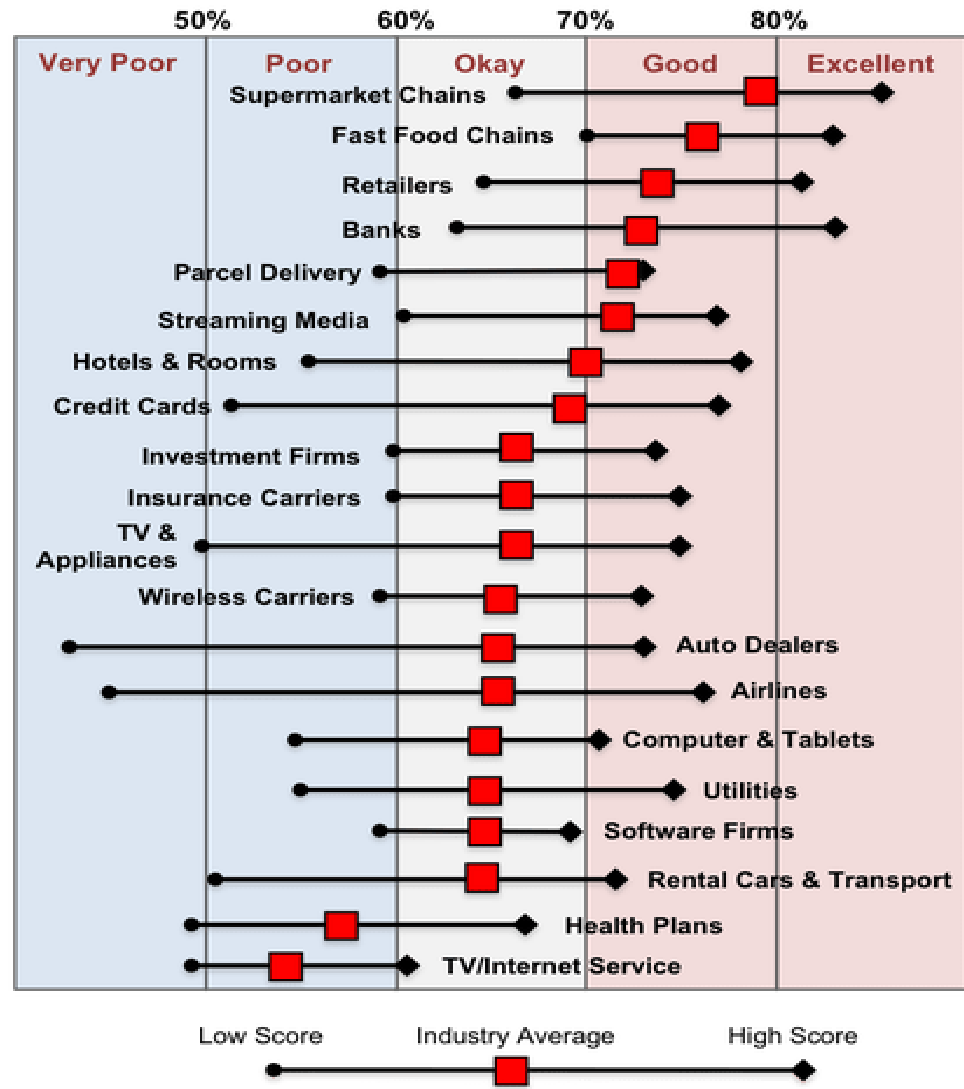
2018 LAN Summit

Sheraton Tysons Hotel

Tysons, Virginia

Paul McGann, MD
Chief Medical Officer for Quality Improvement, CMS

22 October 2018


2018 Temkin Experience Ratings (TxR),
Range of Industry Scores
50%
60%
70%
80%
Very Poor
Poor
Okay
Good
Excellent
Supermarket Chains
Fast Food Chains
Retailers
Banks
Parcel Delivery
Streaming Media
Hotels & Rooms
Credit Cards
Investment Firms
Insurance Carriers
TV & Appliances
Wireless Carriers
Auto Dealers
Airlines
Computer & Tablets
Utilities
Software Firms
Rental Cars & Transport
Health Plans
TV/Internet Service
Low Score
Industry Average
High Score
Base: 10,000 U.S. consumers
Source: Temkin Group Q1 2018 Consumer Benchmark Survey
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TEMKIN
GROUP
When experience matters

Weaknesses of Fee for Service Payment

Excessive use of low-value services

Insufficient incentives to improve quality of care

Poor coordination of care

Delivery System and Payment Transformation

Current State –

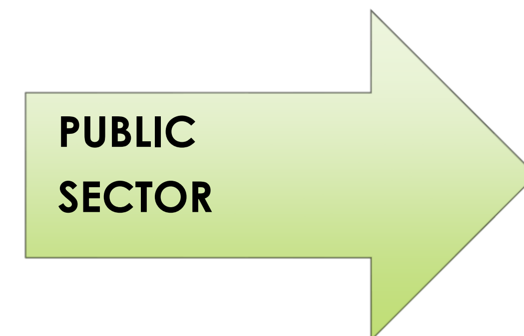
Producer-Centered

Volume Driven

Unsustainable

Fragmented Care

FFS Payment Systems



Future State –

People-Centered

Outcomes Driven

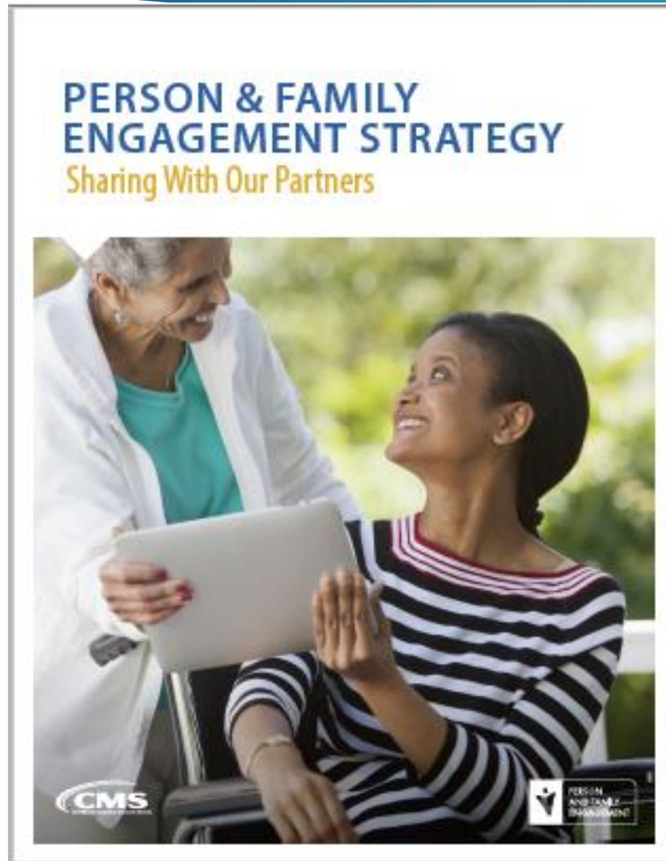
Sustainable

Coordinated Care

New Payment Systems (and more)

- Value-based purchasing
- ACOs, Shared Savings
- Data Transparency

CMS Person & Family Engagement Strategy



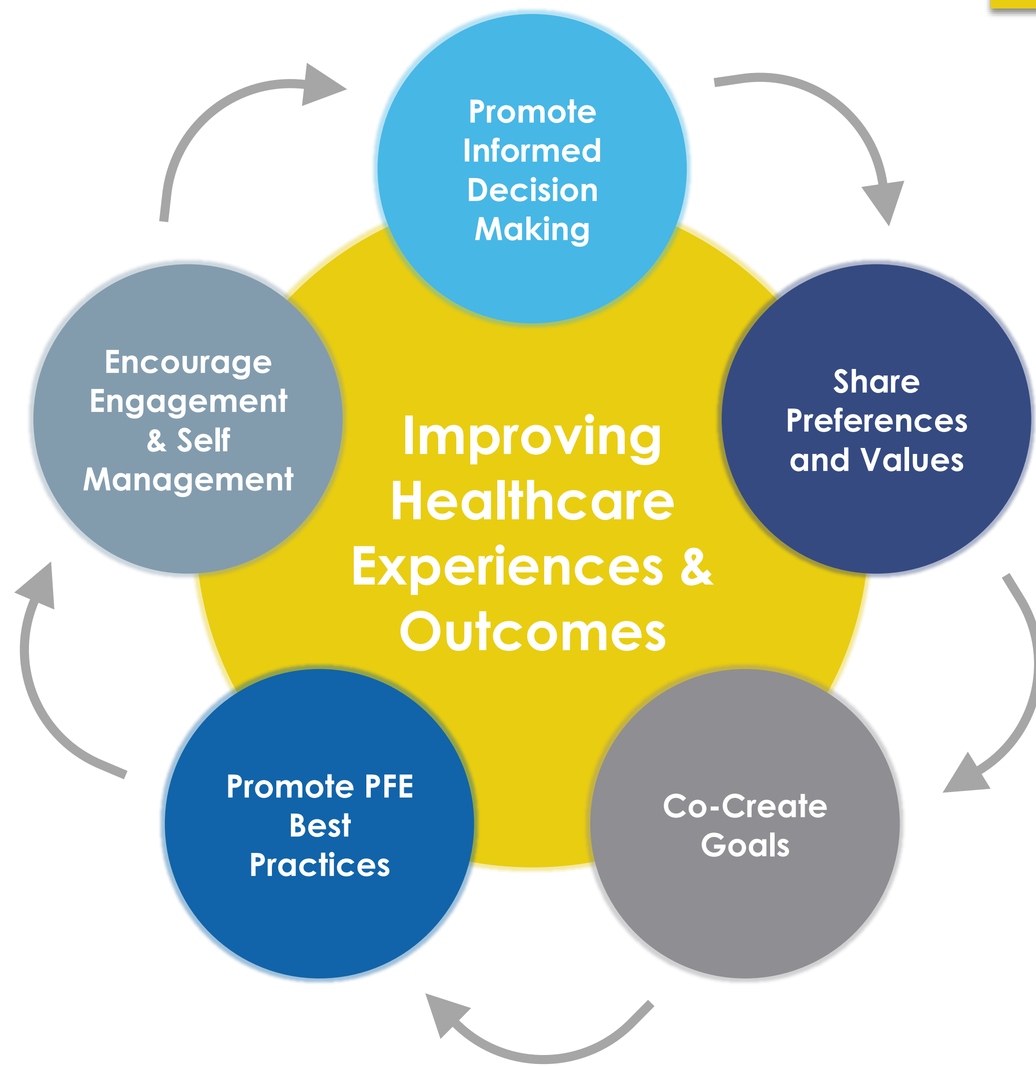
- Published in December of 2016.
- **Purpose:** creates the foundation for expanding awareness and practice of person and family engagement by providing specific, actionable goals and objectives.
- **Vision:** a transformed health care system that proactively engages persons and caregivers in the definition, design, and delivery of their care.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Person-and-Family-Engagement.html

Voice of the Beneficiary

- Coordination of care, improving systems of care
- Provider-patient communication, involvement in care
- Avoidance of harm, patient safety
- Understanding of all costs of care
- Health literacy
- Patient engagement mechanisms (councils, portals)
- Goals of Care clarifications
- Involvement in quality improvement projects/redesign
- Outreach to underserved, community resources
- Attention to care givers/care partners

Person & Family Engagement Cycle



PFE Drivers and Policy Levers

This graphic illustrates the different ways that CMS works to engage people and their families.

CMS At Work Engaging Persons and Families

Policy, Programs and Quality Improvement

- Focus groups/patients in the room for program development
- Incorporating public comments
- Learning and action networks with patients
- Measures development and patient reported outcomes
- Patient's experience of care data
- Partnership for patients
- QIOs/ESRD networks improvement activities and technical assistance

Benefit Design, Value and Incentives

- Weighting of patient experience and patient reported outcomes in VBP programs
- Innovation models aim to promote and incentivize engaging the patient and family
- Promoting patient adherence
- Develop programs and materials to assist patients in understanding their coverage and connect them to appropriate healthcare professionals to help improve their quality of life

Engagement in Decision-making, Care Coordination, Prevention and Treatment

- CMS compare sites
- Early elective delivery reduction initiative
- Every person with diabetes counts
- Transforming clinical practice Initiative
- Use of decisions support tools in HIT
- MU requirements for providing info to patients
- Advanced directives
- Promoting respect for patient values, cultures and traditions

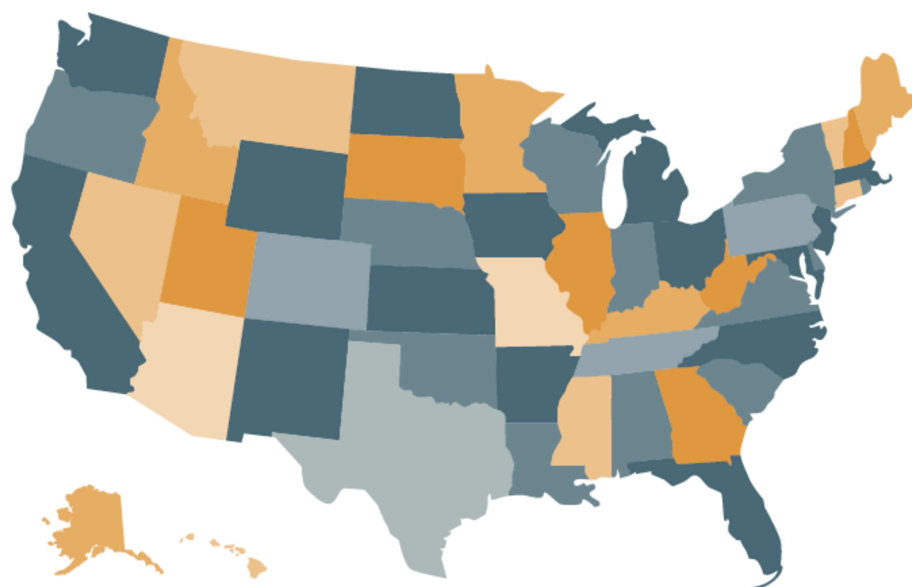
Family and Caregiver Support and Engagement

- Families in the room opportunities
- Learning and action network participation
- Respite programs
- Medicaid family counseling programs

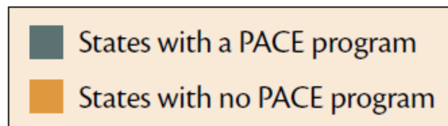
PILLAR 4: Programs of All-Inclusive Care for the Elderly (PACE®)

- Most successful models of primary care for community-based older adults who have multiple chronic conditions, including PACE,
  - 1) development of a comprehensive patient assessment that includes a complete review of all medical, psychosocial, lifestyle and values issues;
  - 2) creation and implementation of an evidence-based plan of care that addresses all of the patient's health needs;
  - 3) communication and coordination with all who provide care for the patient; and
  - 4) promotion of the patient's (and their family caregiver's) engagement in their own health care.

The National PACE Association (NPA) is a hub for collection and analysis of data related to Programs of All-Inclusive Care for the Elderly (PACE®).



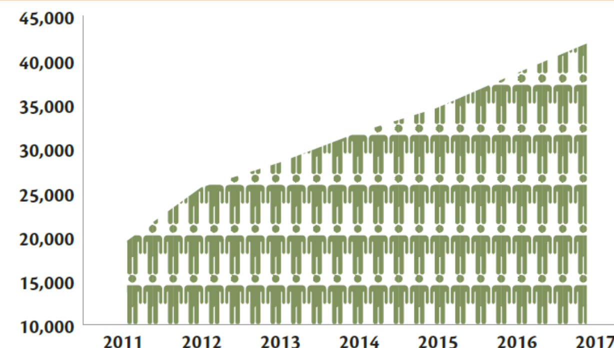
31 states have PACE programs



PACE ENROLLMENT ELIGIBILITY

- Age 55 or over
- Live in the PACE service area
- Certified to need nursing home care
- Able to live safely in the community with PACE support at time of enrollment

PACE ENROLLMENT 42,000+



NEED NURSING HOME LEVEL OF CARE 100% } 95% Live in the community 5% Live in nursing homes

End-Stage Renal Disease (ESRD) Network Activities

- ESRD Networks have a 5 Year Contract with 3 AIMS
    1. Better Care for the Individual through Patient and Family Centered Care
    2. Better Health for the ESRD Population
    3. Reduce Costs of ESRD Care by Improving Care
- Responsible for Performance-Based Outcome Driven Quality Improvement Activities
- Use of Patient Subject Matter Experts in the Development and Execution of Quality Improvement Activities
- Focus on Person, Family and Caregiver Centered Care and Rapid Cycle Improvement

ESRD Network Map

7 Key Goals of CMS Transforming Clinical Practice Initiative

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Transition 75% of practices completing the program to participate in Alternative Payment Models
7. Build the evidence base on practice transformation so that effective solutions can be scaled

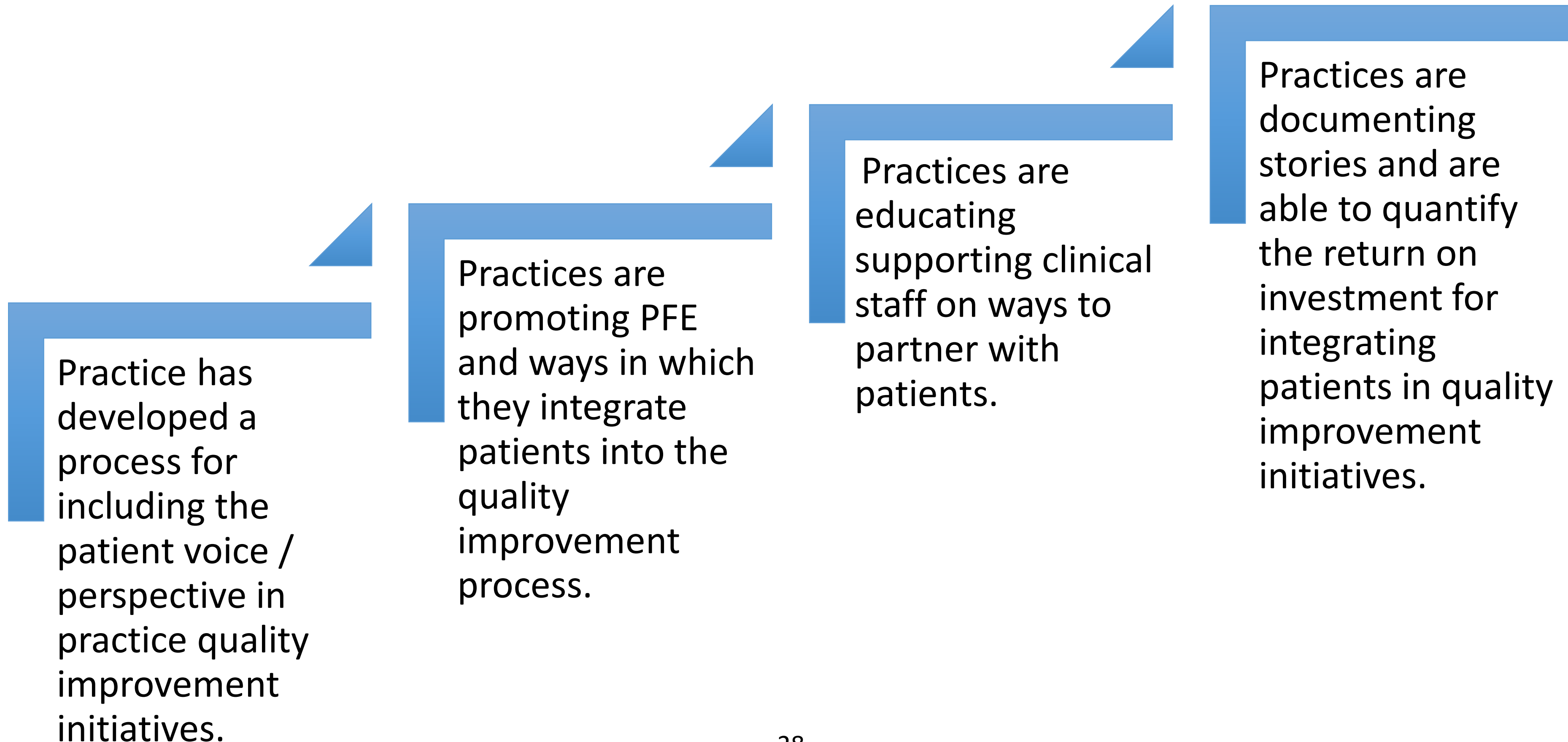
Transforming Clinical Practice Initiative (TCPi) Change Package

Primary Drivers	Secondary Drivers
Patient and Family-Centered Care Design	1.1 Patient & family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidence based care 1.7 Enhanced Access
Continuous, Data-Driven Quality Improvement	2.1 Engaged and committed leadership 2.2 Quality improvement strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of HIT
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

Transforming Clinical Practice Initiative (TCPi) PFE Program Components

- Inclusion of the patient voice in practice operations
- Use of e-technology to engage patients & family
- Measurement of patient health literacy
- Shared decision-making among clinicians & patients
- Assessment to gauge patient readiness to be "activated" as a partner in their care
- Support for patient medication use

Phases of Transformation – Supporting the Patient Voice



Person & Family Engagement (QPS)

PFE Element	Q7		Q8		Q9	
	# of Practices	% of Reported	# of Practices	% of Reported	# of Practices	% of Reported
Reported Practices	***22,593***		***21,218***		***16,500***	
Patient Voices	5,475	**24%**	6,213	**29%**	4,967	**30%**
Shared Decision Making	6,522	**29%**	7,596	**36%**	8,093	**49%**
E-Tools	7,887	**35%**	8,761	**41%**	7,774	**47%**
Patient Activation	2,522	**11%**	2,983	**14%**	3,114	**19%**
Health Literacy	2,826	**13%**	2,760	**13%**	3,324	**20%**
Med Management	5,202	**23%**	5,953	**28%**	6,800	**41%**
Other Elements	737	**3%**	853	**4%**	662	**4%**

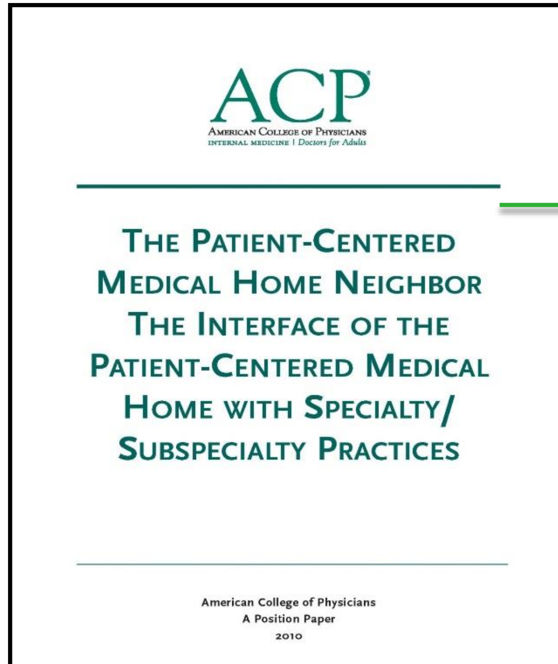
Source: Part 4 QPS Q7, Q8, Q9; Reported Practices – Part 5

HOW WAS THE PAM PILOT IMPLEMENTED?

- The pilot used the PAM tool to identify patients' baseline and follow-up activation levels.
- 113 patients completed two surveys: one at baseline and one between 3 months and 12 months after baseline.
- PAM tool was linked to the EHR.
- Care managers applied coaching techniques from the Coaching For Activation (CFA) module based on patient's level of activation.
- Success was measured by process and outcomes measures at the end of 12 months.

UW Medicine

Care Coordination Best Practices and Tools



High Value Care Coordination Tool Kit

- Sample Care Coordination Agreements
- Checklists
- Pertinent data sets for common conditions

Designed & Tested by *Practicing Clinicians*
Specialty, Sub-specialty and Primary Care
Patient & Family Advocacy Representatives

NEW HVCC CURRICULUM!

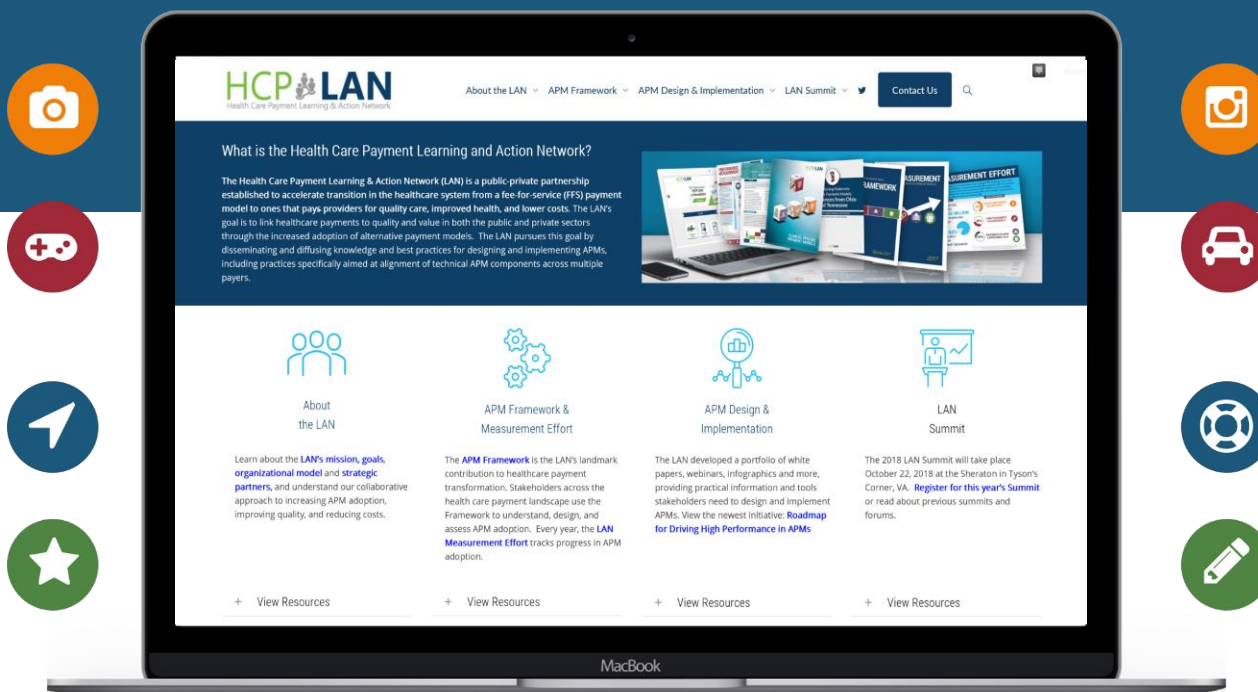
Specialty Practice Recognition
Module: Track and Coordinate Referrals

Age-friendly Health Systems-
An Initiative of the John A. Hartford Foundation

- The goal of the initiative is to develop an Age-Friendly Health Systems model and rapidly spread the model to 20 percent of US hospitals and health systems by 2020. (https://www.johnahartford.org/grants-strategy/current-strategies/age-friendly-hospitals/)
- Focus on the 4 M's
  - What Matters to the older person
  - Medication
  - Mentation
  - Mobility
- The age-friendly health system initiative partners five major U.S. health systems (Ascension, Trinity Health, Anne Arundel Medical Center, Providence St. Joseph, Kaiser Permanente)
- IHI is working with the five health systems to use improvement science to test this systems-level approach to implementation of the 4Ms consistently across hospitals, home care, post-acute rehabilitation, primary care, skilled nursing facilities, assisted living, and all the settings in today's world-class health systems

Visit the LAN Website for our Resources

https://hcp-lan.org/



Exit Survey

We want to know what you think!

Please take a moment to complete the exit survey so we can continue to improve and enrich the LAN. Use the link in ***Guidebook*** for this session to provide us your feedback.

Contact Us

We want to hear from you!

www.hcp-lan.org

@Payment_Network

PaymentNetwork@mitre.org

Search: Health Care Payment Learning and Action Network

Thank You!