Executive Summary: Driving Change through Leadership, Evidence and Action

On March 2-3, 2015 the Coalition to Transform Advanced Care (C-TAC) held its second National Summit – “Driving Change through Leadership, Evidence and Action” at the Institute of Medicine, National Academies of Science, Washington DC. The Summit convened pioneering and leading community, health system, and national leaders to share their vision for transforming advanced care in America over two days that included a half-day Community Workshop and the Summit program. Together, the speakers and audience identified the key transformative elements of initiatives in their communities, shared lessons learned and discussed how their work might be replicated in other communities. As part of its mission, C-TAC sought to capture and disseminate these key learnings and identify how to replicate successes based on the conference presentations and discussions.

Presentations and robust participation from local and national leaders, health systems, providers, payers, and others were analyzed to identify “Key Learnings” – in order to offer a high-level blueprint for communities and health systems interested in building partnerships and programs that can dramatically improve care for those with advanced illness. Over the course of the two days of presentations and engaged, interactive discussions among participants, C-TAC identified 10 Key Learnings:

1. Foster Trust and Alignment Among Major Community Leaders/Partners
2. Choose Strategic Community Partnerships
3. Develop Common Language Among Partners to Inform Shared Decision-making
4. Design Programs in a Way that Eases Adoption
5. Adhere to Common Goals that Keep Patient at Center
6. Target Individuals that Would Benefit Most from New Advanced Care Approaches
7. Identify Essential Ingredients that Cannot Necessarily Be Measured in a Traditional Paradigm
8. Push Policymakers to Catch Up to the American Public on Advanced Care
9. Use Diversity of Resources to Support Work, Sustainability
10. Close the Evidence Gaps

One of the goals of the National Summit, and this accompanying white paper, is to identify the critical elements of building successful community-based advanced care programs. The dissemination of these Key Learnings is provided as a tool to drive change in advanced illness care across the country.
Goals of the National Summit - Implementing Evidence through Leadership, Evidence and Action

Most Americans today are living longer and healthier lives than ever before. Yet, at some point, the vast majority will face advanced illness, which occurs when one or more conditions become serious enough that general health and functioning decline, treatment begins to lose its effect, and quality of life increasingly becomes the focus of care - a process that continues to the end of life. These people need and want seamless, person-centered, coordinated care that helps them live as comfortably and productively as possible, but few people are lucky enough to receive such care. Our health care system, despite its strengths, is ill-equipped to provide this kind of care when people are seriously ill. This is not a problem that can be ignored. Over the next two decades, the number of people over 65 will nearly double to more than 72 million, or one in five Americans. Most people with advanced illness will be in this age group. Without system change, they will be at greater risk for unnecessary hospitalizations and unwanted treatment, adverse drug reactions and conflicting medical advice, with resulting higher cost-of-care to families and the nation. C-TAC is dedicated to changing care for those with advanced illness. As a large and growing alliance of over 100 national organizations and leaders, C-TAC creates, supports and promotes the use of proven solutions to drive positive change in advanced illness care. C-TAC views its role as a convener and catalyst for the expanding movement across America. It achieves this as a non-profit, non-partisan coalition whose members include patient and consumer groups; health care professionals and providers; private sector stakeholders; faith-based organizations and health care payers.

The National Summit is an important part of C-TAC’s strategy for identifying and sharing proven solutions. The Summit brought together and engaged leaders at all levels and from diverse backgrounds – Federal, state, charitable foundations, communities, and patients – to drive action and change in advanced illness care. Connecting leaders across the spectrum helps drive change both from the top down and bottom up, which is critical for initial transformation and ongoing improvement and sustainability. National leaders in government, private sector, and leading institutions participated in the conference, including the Institute of Medicine, which recently released the groundbreaking “Dying in America Report”, the American Hospital Association (AHA), AARP and its Imperative for Change campaign, the Patient Centered Outcomes Research Institute (PCORI), current and former members of the United State Senate, and state and national leaders from the Centers for Medicare and Medicaid Services (CMS).
Keeping in line with the theme of leadership and implementation, C-TAC also released a book authored by experts from its member organizations – *A Roadmap for Success*. The book is a blueprint for Transforming Advanced Illness Care in America and is aimed at those who seek to drive change: clinicians, public health executives, health care companies, policy analysts, policy makers, faith leaders, academics and other thought leaders. It provides an understanding of the key issues, challenges, and solutions needed for reform; builds on the shared mission in the national movement for change; identifies action steps for achieving high-quality, advanced illness care; and, urges a call to action.

Summit conveners laid out five broad goals for the event:

1. Increase provider and consumer readiness to implement evidence-based tools and approaches to advanced illness care;
2. Connect consumers, clinicians, health systems and health plans to deliver high quality, person-centered care and commit to improved performance;
3. Disseminate information and support implementation of evidence-based advanced illness care models;
4. Identify gaps in evidence that need to be addressed to further the adoption of better advanced illness care; and,
5. Expand comparative effectiveness research to support transformational change in the field.

The National Summit demonstrated to all that there are exemplary models of community and health system partnerships that can be replicated to transform advanced care nationally, but dissemination and implementation of these models remains a challenge. For example, a pre- and post-Summit survey indicated that 70 percent of respondents felt they knew more about community based models after attending the Summit, underscoring the active and shared learning and dissemination that occurred. This White Paper aims to distill the key learnings and “ingredients” from these partnerships and programs that will drive engagement, action and change at local, regional and national levels.

**National Summit Key Learnings - Transforming advanced care is not just a management problem, but a human problem**

Over the course of the Summit, a few themes emerged from program participants and experts that help to frame the Key Learnings discussed below (see Figure 1). These themes can serve as “foundational elements” for how advanced illness care programs can be started, but just as importantly – how they can be improved and sustained over time. First, communities and health systems must be engaged in lasting partnerships, with common goals. Second, programs can be empowered to change and improve over time by thinking outside the traditional measurement
and payment paradigm. Last, sustainability of programs should be considered at the outset by building resilience in communities and health systems to drive change, to weather setbacks, and to strive for continual improvement.

Figure 1. Elements for Building Successful Community-based Programs

Building on these three elements, C-TAC analyzed and synthesized materials and discussions from throughout the Summit to identify key learnings or “ingredients” that could serve as a roadmap for communities seeking to establish effective advanced illness care programs.

1. **Foster Trust and Alignment Among Major Community Leaders/Partners**

Partnerships built on trust, transparency and honesty, with all parties working towards a common set of goals, are the foundation of any effort to improve advanced illness care in a community. The common tie across all parties is the target population – those with advanced illness and their families, which serves as a common platform to build lasting partnerships. Leaders of community-based organizations emphasized that programs and efforts should leverage existing relationships to establish rapport and early success. For instance, local foundations and leaders on social issues, especially those that affect individuals with advanced illness and their families, should be early partners - their support and validation will carry weight in the community because of their roles and reputations as trusted resources.

Partnerships between communities and health systems must also be equitable. Top down approaches are not successful. Trusting partnerships also take time to build and evolve, and must include mutual respect for cultures, spirituality and traditions, as well as an acknowledgement and appreciation of the existing resources available within communities and churches. This is
especially critical at a time when health systems are engaging in population health management strategies that involve linkage to, and integration with, non-medical social services and supporting resources that affect positive health outcomes and patient experiences.

Transparent communications among all partners is necessary to facilitate information flows and overall trust in the effort. However, as with any partnership or engagement, there will be problems. To continually evolve and improve the partnership, weakness in communication processes should be identified, historical perspectives and experiences (especially with health systems or plans) must be considered, and plans for dealing with problems or misunderstandings should be developed prospectively.

**Figure 1. C-TAC’s Goal: All patients with advanced illness receive high quality care**

Engaging the right partners, especially initially in any effort to establish advanced illness care programs, can create positive momentum among providers, community-based organizations, social service organizations, plans, and members of the community. However, figuring out where to start can be overwhelming. Summit participants advised that programs identify and pursue strategic partnerships that build on existing community resources. A logical starting place for identifying partnerships could be community services that are already connected to health
systems or patients. For instance, local hospice or palliative care organizations that also have ambulatory and home care supports and services might serve as starting points.

Multiple Summit participants also recommended that programs build on local “lynchpins” or existing community resources. Examples of such organizations include:

- Adult day services and adult night care,
- Aging Services Network, including Area Agencies on Aging (AAA),
- Community Health Centers (CHCs) and senior centers,
- Health plans that serve advanced illness or special needs populations,
- Meals on Wheels,
- Medicaid Home and Community Based Services networks,
- Program of All-inclusive Care for the Elderly (PACE),
- Spiritually affiliated social service organizations, and
- Other local levers such as affordable housing that also link health and social services.

Throughout the day, the importance of strong and strategic partnerships reemerged. For those that have already embarked on transforming advanced illness care in the communities, key learnings have included building on existing community resources, integrating initiatives wherever possible, and sharing expertise across the community.

3. **Develop Common Language Among Partners to Inform Shared Decision-making**

Progress is difficult to achieve among health systems, payers, and community partners that currently approach advanced illness differently in the absence of shared goals. However, articulating these shared goals and working towards them requires a common language for partners to use. Pioneering programs at the Summit identified the use of a common language as critical to fostering and building trust among partners and creating a patient- and family-focused environment. Creating and using a common language allows partners to work together to provide care that is oriented around patient goals – and not just their conditions - and to promote common understandings across both community and clinical settings.

Summit participants underscored that patient-centered goals should allow the focus of care to be on maintaining functionality and overall well-being. Quality of life can be improved when partners are working with patients’ and families’ goals, schedules, and other identified needs. To determine if goals are being achieved and advanced illness care efforts are working, outcomes must be measured and monitored. Like shared goals, health systems, payers, and community-based organizations must identify a set of shared outcomes in order to evaluate program success. Participants gave examples of shared outcomes that could be developed and used across clinical and community settings including:
Establishing and using appropriate metrics that measure and track progress for the range of conditions and outcomes advanced illness care affects is necessary to drive evidence-based transformation and change. This does not require reinventing the measurement wheel in all cases, however. Existing measures should be used wherever possible and measure development efforts already under way should be leveraged.

4. **Design Programs in a Way that Eases Adoption**

Successful adoption of advanced illness care programs is more likely when participation eases the burden in some way for patients and their families, as well as community-based and clinical partners. Thus, programs should be designed at the outset with the goal to make dealing with advanced illness easier for all parties. For instance, one of the Summit speakers, representing Kaiser Permanente, described a successful “one-stop shop” model in Colorado consisting of a continuum of specialty support services. The continuum is linked from inpatient to primary and specialty care clinics, post-acute care facilities, and in-home and assisted living care. Advanced illness care programs that design linkages across the continuum of care and the community and that can ease transitions for patients, providers, and community partners may be more easily adopted and maintained in the long-term.

Workforce composition and training is another design feature to consider for successful adoption. For instance, healthcare workers that are part of faith-based organizations could be recruited to support or assist with advanced illness care programs and discussions. They could be ideal candidates to help create a common language and goals – and help bridge the gap between health systems and communities. Another recommendation was to provide and conduct a needs assessment and community level training for partners. This could include surveys of community members, training pastors, church leaders, or other community-based organization leaders, and caregivers to identify what community and related patient needs might be, such as education, transportation, link to social service organizations, or caregiver training or support. Needs assessments could inform the design of advanced illness care programs, as well as training needs of those participating in the program. One program described its Pastoral training and
accompanying curriculum, as well as formal trainings for navigators and patient and caregivers.\(^1\) Some training programs focus exclusively on caregivers, such as a hospital-based program that offers caregivers instruction on all caregiver-related after-care tasks that are part of a patient’s discharge plan.\(^2\) Training programs that are adopted and embedded in their communities demonstrate their value early in the implementation process.

5. **Adhere to Common Goals that Keep Patient at Center**

One of the hallmarks of advanced illness care programs is that they focus on the patient’s goals, as well as those of their family and caregivers. “Honoring what matters most” by creating and keeping patient goals at the center of any program is a key ingredient for success. While individual and family goals will vary, standardized processes for care planning can be used and applied across community and clinical settings. One mechanism for engaging in a standardized process is through shared decision-making tools, which are supportive resources to facilitate a conversation between patients, families, providers, and others. Shared decision-making includes:

- Eliciting and understanding the patient perspective, including their psychosocial and emotional context;
- Developing a shared understanding of the clinical problem and its appropriate treatment, taking into account individual goals, preferences, and values; and,
- Empowering patients by actively involving them in decision-making about their own care.

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\(^1\) Hill, C. 2015. Alameda County Care Alliance. Presentation at the C-TAC National Summit on Advanced Illness Care, March 3, 2015.

Care planning that is grounded in a common language, takes a patient-centered approach, and employs a shared decision-making model that can bridge clinical and community partners together by providing a structure for planning and decision-making. For those with advanced illness and their families, shared decision-making requires health system and other resources to take into account the context of the individual’s surroundings and preferences. In the end, shared decision-making tools can help patients articulate their goals and wishes in a medically focused environment.

Because of the critical role shared decision-making plays in the care planning process, Summit participants also discussed barriers to their adoption. First, they add time to existing work burdens; however, small scale testing in communities can demonstrate utility and foster implementation, as well as allow for gradual scalability. A second barrier is misunderstanding the community-based needs an individual and their family may have, a cause of which is often lack of alignment between providers and community resources. To overcome this barrier, participants suggested that communities and health systems must be true partners to create a comprehensive advanced illness care program and identify ways to promote alignment on likely patient needs to ensure medical and non-medical needs are met. Participants suggested that turning to other organizations that are already doing similar work can be helpful to provide ways of promoting alignment. Adhering to patient-centered goals and needs is a hallmark of successful

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advanced care programs, and shared decision-making tools can provide a construct for those discussions.

6. **Target Individuals that Would Benefit Most from New Advanced Care Approaches**

To effect positive outcomes and change, serving those that would benefit most from advanced care approaches (especially initially) is important. However, identifying individuals that require the diversity of supports advanced illness care programs can provide is challenging. Over the course of the Summit, participants shared strategies and characteristics for targeting appropriate individuals, which requires more than an assessment of diagnostic conditions and categories. For instance, conducting assessments to identify the following characteristics could lead to targeting those individuals that could benefit from advanced illness programs:

- Functional limitations,
- Frailty,
- Dementia,
- Overwhelmed caregivers, and
- Serious illness (one or more), among others.

Using more than just diagnoses to understand the range of medical, social, and spiritual needs an individual with advanced illness and their families have is critical.

In addition, there is a growing awareness in the medical community that an array of non-medical factors affect well-being and health outcomes – and this includes those with advanced illness who are not only facing health problems, but a host of non-medical needs. As a result, social determinants of health should also be assessed as severity of illness is just one dimension of the complexity of care individuals with advanced illness need. Factors to assess include:

- Food security, or access or ability to get food;
- Housing status;
- Employment status;
- Financial status or stability; and,
- Social or family/caregiver support, among others.  

Health systems and providers can also leverage existing assessment methods to ease implementation. For instance, the Patient Centered Assessment Method (PCAM) was developed for use in primary care settings and integrates physical health, mental health, social support, and

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social needs, health literacy, and engagement with services into patient assessments.\(^5\) This allows for an integrated look at the relation between an individual and the health system.

7. **Identify Essential Ingredients that Cannot Necessarily Be Measured in a Traditional Paradigm**

Summit participants provided numerous examples of common or shared outcomes that could be measured across community and clinical settings; however, they also identified other ingredients for successful programs that are not part of the traditional measurement paradigm. For instance, one health plan-based advanced illness care program found that connection, engagement and personal assistance are keys to success, but none are “measurable” in a traditional sense.\(^6\) Partners in advanced care programs should consider articulating what these essential ingredients are, and trying to foster their adoption. Additionally, measuring how these ingredients factor into a program’s success could also be considered through the use of study designs such as interview-based or other qualitative methods.

A health plan also noted that often advanced illness care programs are asked to demonstrate return on investment (ROI); however, participants felt it was not necessary to start with ROI to assess the impact of a program. They recommended that quality of care, quality of life, and engagement with community supports and services may help to better establish value initially before ROI is tackled. Last, one presenter tried to articulate approaches that do and do not work. Leveraging these learnings from existing programs can help establish early success and adoption for those just starting down the path.

### Table 1. Examples of Program Approaches and Features that “Work” \(^7\)

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<thead>
<tr>
<th>Elements of ‘What Works’</th>
<th>Examples of Approaches that Do Not Work</th>
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<tbody>
<tr>
<td>Evidence</td>
<td>“Prove it” mentality</td>
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<tr>
<td>Layers and triage</td>
<td>Failing to assess needs</td>
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<tr>
<td>Valuing of team-based and self-care</td>
<td>Silos or thinking too narrowly</td>
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<tr>
<td>Identifying and harnessing non-physician champions</td>
<td>Leaving out community</td>
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Creating a learning system

Not standardizing processes and programs

While there is no formal measurement of these “essential ingredients” Summit participants will be engaging with C-TAC to gather a list of the factors they believe are critical to program success. Communities and health systems seeking to implement programs should use what others have learned and supplement these with their local needs when starting programs, in order to evaluate performance and share learnings.

8. **Push Policymakers to Catch Up to the American Public on Advanced Care**

Leaders in Federal and State policymaking participated in the National Summit. One of the most compelling messages that emerged from multiple members of Congress over the two days of Summit events was that public policy needed to catch up to the American public on advanced care. The pioneering efforts featured throughout the day underscored how communities and health systems are coming together to meet the public’s needs, while Federal and State policy has lagged on advanced care. However, other shifts in the healthcare landscape present an opportunity to build momentum for advanced care programs.

The U.S. healthcare system is undergoing a period of rapid transformation in the movement to value over volume. In particular, the Centers for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) have led the way on testing, spreading, and hopefully replicating effective value-based payment and delivery models. In January 2015, Medicare – for the first time in the program’s history - set clear goals for moving providers away from fee-for-service (FFS) payments to value-based or alternative payment models (APMs).

**Table 2. HHS Goals for Moving Medicare Payments from Fee-for-Service to Value.**

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Goal</th>
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<tr>
<td>Alternative Payment Models (Accountable Care Organizations, Bundled Payments)</td>
<td>• 30 percent by 2016</td>
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<td></td>
<td>• 50 percent by 2018</td>
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<tr>
<td>Quality or Value-based programs (Hospital Value-based Purchasing Program,</td>
<td>• 85 percent by 2016</td>
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<tr>
<td>Hospital Readmissions Reduction Program)</td>
<td>• 90 percent by 2018</td>
</tr>
</tbody>
</table>

These goals are not only changing the Medicare program, but act as a catalyst for continued innovation by commercial plans and providers. As payers and providers create ACOs, engage in bundled payments or global budgets, there is a greater need to use population health management approaches in which medical and non-medical needs that are necessary to support good health

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are addressed. Through CMS and CMMI alone, there are 424 ACOs across the country, serving nearly 8 million Medicare beneficiaries, and nearly 200 providers slated to participate in a nationwide bundled payment program – the Bundled Payments for Care Improvement initiative. CMMI is also working with states through the State Innovation Model (SIM) grants to test how states can employ policy and regulatory waivers to accelerate system change. Transforming advanced care in America is part of this broader movement to value in the health system. As a result, there is an unprecedented opportunity to bring public policy in line with expectations of the American public on advanced care on a bipartisan basis, as policymakers underscored.

In addition to Federal efforts, communities should also be engaging at the state level, as they are often laboratories for innovation. Governors can employ multiple policy levers to address more than just medical needs, or support a population health approach, to advanced illness. They are often conveners and consensus builders across State government and silos, bridging education, workforce, and healthcare to drive new programs. States can also leverage their own purchasing power to shape changes in the healthcare system.

9. Use Diversity of Resources to Support Work and Sustainability

Last, for advanced illness care programs to have enduring effects in their communities, they must be sustainable. While initial investments may be necessary to start the efforts, long-term financing and sustainability should be part of the conversation from the beginning to ensure that new infrastructure, training, and partnerships are lasting. First, health systems should determine how to build on, and leverage, value-based payments or APMs in the context of Medicare or commercial payers that are leading innovation on advanced illness care. The broader, more risk-based models such as ACOs can allow for more appropriate resource allocation for individuals with advanced illness than in a FFS environment where providers are only paid if they perform a procedure or have a direct encounter. In addition, state and local resources should also be surveyed to see how they can support advanced care programs. Approaches that leverage workforce and human capital investments should be explored. For instance, partners and programs can be integrated or linked by sharing human resources, such as trained volunteers, across settings.

Summit participants also discussed the importance of research and evaluation in demonstrating the initial and ongoing value of advanced illness care programs. One simple but effective approach for guiding continual program improvement is the “Plan-Do-Study-Act” cycle. The process includes:

- **Plan:** Identify a goal or purpose and craft a plan.

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- **Do**: Implement the plan.
- **Study**: Monitor outcomes to chart success or identify areas for improvement.
- **Act**: Integrate the learnings and make adjustments, then repeat the previous steps.\(^\text{10}\)

Research institutions can be early partners to support the critical “Study” step in PDSA. They can also be partners in building the evidence-based and business case for advanced illness care programs. As part of the research process for advanced illness care programs, all relevant constituents should be included. First, community members should be engaged in the design, planning, and implementation of studies related to advanced illness care. Similarly, advanced illness care programs should encourage and embrace clinical and behavioral health research to support continual learning and improvement.

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10. Close the Evidence Gaps

Throughout the Summit, participants noted that there were gaps in evidence that could, and should, be strengthened by systematic, pragmatic research built on the principle of “evidence-based clinical care”. Several of these gaps were consistent with those noted by the 2014 Institute of Medicine report, *Dying in America*, which called for "broad engagement of actors in the health care field, social and supporting services sector, as well as the organizations and institutions on which Americans rely for practical assistance, spiritual support, information, and advice....".12

The impact and effectiveness of strong community-health system relationships has been at least partially demonstrated by findings from programs such as the C-TAC/Kaiser-Permanente Alameda County Care Alliance pilot, among others.13 Such programs suggest that these relationships are synergistic- and not simply additive - when compared with similar, but unilateral efforts by providers or communities. They also suggest that there are often latent, underused resources that are not well synchronized between communities and health care providers, thus raising the potential for significant improvement when these are linked systematically. Indeed, a guiding hypothesis is that systematic linkage between community and health systems will yield better access to care, better outcomes, including quality of care, greater patient and family satisfaction, and likely lower costs of care for both individuals and commercial and public payers. However, this hypothesis has not been tested systematically or broadly enough to compel policy and regulatory changes that are based on convincing data - rather than assumptions or results from isolated programs. To make conclusions about what

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13 Other, population-based approaches to care, include: the Allina Late Life Model; Grand Junction, CO, Model; Congregational Health Network, Memphis, TN; and the Program of All-Inclusive Care for the Elderly (PACE).
constitutes effective and evidence-based programs based on these initial successes, additional research can answer questions such as:

- What are the core measures of care and service that patients, families, quality experts, payers, community and health system leaders agree are the fewest necessary to evaluate the quality and value of care provided?

- What is the impact and effectiveness of various community-based organizations (e.g., faith-based approaches, senior centers, county or state approaches) in engaging, connecting and mobilizing the public in care delivery improvement?

- What are the different strategies and tactics for engaging different faith-based groups and diverse racial and ethnic populations?

- What incentives are most effective for engaging communities in population health initiatives?

- What lessons learned from established models can be applied to caring specifically for the advanced illness population?

- What are the “integrating elements” that are essential for provision of coordinated clinical care, social services and population health for the growing 65-plus population that comprises a large portion of those with advanced illness?

State and Federal leaders, research experts, C-TAC, and other convening organizations, should work with community and health system leaders to design multi-site studies and conduct program evaluations to close research gaps the field has identified.

**Conclusion – Testing, Sharing, and Replicating Key Learnings**

The National Summit illustrated how community-based organizations, health systems, payers, and other stakeholders are building bridges to transform advanced illness care across the country. The 10 Key Learnings presented here provide a high-level roadmap for community and health system leaders who have recognized the need for advanced illness care programs for those they serve. Successful programs build on a three-fold approach focusing on person-centered goals, team-based approaches and in-home care. When these are coupled with community engagement, programs achieve synergistic results and experiences that are far more effective than those that focus on only one component of the patient-provider relationship. To move the field forward, State and Federal leaders, convening organizations, such as C-TAC, and early, successful
programs must also drive the research agenda forward to define the essential elements of evidence-based advanced illness care programs, and to demonstrate the outcomes, quality, and cost impacts of these programs on individuals, communities, and payers. The pioneering efforts presented at the National Summit are proof of concept that a diverse group of partners can be brought together to improve the lives of those with advanced illness, and their families and caregivers – and that these early programs can and should be replicated across the country to transform the care experiences of those with advanced illness.
Appendix: National Summit on Advanced Illness Care – Driving Change through Leadership, Evidence and Action

March 2-3 2015

National Academy of Sciences
2101 Constitution Avenue Northwest
Washington, DC 20418

Monday March 2

10:30am - 2:45pm
C-TAC Learning Network Workshop
(Closed Session for C-TAC Pilot Teams)

3:00-3:15pm
Welcome and Goals for Conference

Leonard D. Schaeffer, Judge
Robert Maclay Widney Chair and Professor, University of Southern California

3:15-3:40pm
Advanced Illness Care: The IOM Perspective

Victor J. Dzau, MD, President, Institute of Medicine

3:40-4:05pm
Research that Drives Change

Joe Selby, MD, Executive Director, PCORI

4:05-5:00pm
Engaging Multiple Generations

Moderator: Ellen Goodman, Co-Founder and Director, The Conversation Project

Kenyon C. Burke, Ed. D
President, Kenyon C. Burke Consulting

Rev. Rosemary Lloyd, Advisor to the Faith-Based Community, The Conversation Project

Lennon Flowers, Co-Founder and Executive Director, The Dinner Party
5:00-5:45pm The Imperative for Change

Rich Umbdenstock, President and CEO, American Hospital Association
Jeannine English, CPA, MBA
President, AARP

6:30-8:30pm Time For Caring Reception

Remarks by Nancy Brown, CEO, American Heart Association

Four Seasons Hotel
2800 Pennsylvania Avenue Northwest,
Washington, DC 20007

Cocktails, dinner buffet, and music by The Original Blue Healers. Transportation provided from the National Summit to the Four Seasons Hotel.

Tuesday March 3

7:00-8:00am Breakfast and Networking
Onsite Registration Available

8:00-8:15am Welcome and Recap of Day 1
(Auditorium)

Leonard D. Schaeffer

8:15-8:45am Opening Remarks: Driving Change

Karen Ignagni, President and CEO,
America’s Health Insurance Plans
Jeff Burnich, MD, SVP, Medical and Market Networks, Sutter Health
Amy Berman, BS, RN, Senior Program Officer, John A. Hartford Foundation

8:45- 10:15am A Comprehensive Approach to Care Transformation: Integrating Community and Clinical Models
(Auditorium)

Introduction: Rev. Diane C. Smalley, Patient and Community Engagement Council, Saint Joseph Mercy Hospital, Trinity Health
Moderator: Chris Dawe, Managing Director, Evolent Health

Bud Hammes, Director of Medical Humanities, Gundersen Health System

Daniel Johnson, MD, FAAHPM National Clinical Lead for Palliative Care, Care Management Institute, Kaiser Permanente

Rev. Cynthia Carter, Executive Director, Alameda County Care Alliance

Jeff Selberg, MHA, Executive Director, Peterson Center on Healthcare

10:15-10:30am Taking Evidence-Based Models to Scale

10:30-10:45am Break and Move to Workshop Sessions

10:45-11:45am Workshop Sessions: Closing the Gaps: What We Know vs. What We Do

A) Community and Faith-Based Partnerships

Teresa Cutts, Ph.D., Assistant Professor, Social Sciences and Health Policy, Div. of Public Health and the Maya Angelou Center for Health Equity, Wake Forest School of Medicine

Rev. Dr. Tyrone Pitts, Co-Chair, Interfaith and Diversity Workgroup, C-TAC

B) Metrics for Success

Randy Krakauer, MD, FACP, FACR, VP, National Medical Director, Medicare Strategy, Aetna
C) Engaging Patients in Dissemination and Implementation

11:45am-12:30pm
Lunch and Networking

12:30-1:30pm
Workshop Sessions:
Closing the Gaps: What We Know vs. What We Do

A) Shared Decision Making

B) Translating Evidence-Based Practice into Compelling Messages
Moderator: **Robyn Castellani**, President and CEO, Castle & Spark

**Christine K. Cassel**, MD, MACP, President and CEO, National Quality Forum

**Patricia A. Grady**, RN, PhD, FAAN, Director, National Institute of Nursing Research

**Regina Greer-Smith**, MPH LFACHE, President, Healthcare Research Associates LLC

**Ben Moulton**, JD, MPH, SVP, Advocacy and Policy, Informed Medical Decision Foundation, Healthwise

**Rae Seitz**, MD, Medical Director, Hawaii Medical Services Association

**Malene Smith Davis**, MSN, MBA, CHPN, President and CEO, Capital Caring

**Betsy Gornet**, FACHE, Chief Advanced Illness Management Executive, Sutter Health

**Diane Meier**, MD, Director, Center to Advance Palliative Care
D) Family Caregiver Support

Susan Reinhard, RN, PhD, FAAN, SVP, AARP Public Policy Institute, and Chief Strategist, Center to Champion Nursing in America
Gail Gibson Hunt, President and CEO, National Alliance for Caregiving

Move to Auditorium

1:30-2:15pm Panel: The Continuum of Care

Moderator: Brad Stuart, MD, CEO, ACI Strategies
Samira K. Beckwith, President and CEO, Hope Healthcare Services
Robert Sowislo, Board and Government Affairs, U.S. Medical Management
Jean Kutner, MD, MSPH, CMO, University of Colorado Hospital; Professor of Medicine and Associate Dean for Clinical Affairs, University of Colorado School of Medicine; Immediate Past President, American Academy of Hospice and Palliative Medicine
Cheryl Phillips, MD, SVP, Advocacy and Public Policy, Leading Age
Randy Axelrod, MD, EVP, Clinical and Patient Services, Providence Health and Services

2:15 – 3:00pm Federal Initiatives to Drive Change

Moderator: Tom Koutsoumpas, C-TAC
Coalition to Transform Advanced Care (EAIN #1259)
National Summit on Advanced Illness Care: Driving Change through Leadership, Evidence & Action
Summary Whitepaper on Key Learnings for Communities and Health Systems
Prepared by Purva Rawal, PhD and David E. Longnecker, MD
Final May 07, 2015

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<tr>
<th>Time</th>
<th>Session</th>
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<td>3:00 – 3:30pm</td>
<td>State Initiatives to Drive Change</td>
<td>Tom Daschle, Former U.S. Senator (D-SD); Founder and CEO, The Daschle Group</td>
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<td>3:30 – 4:30pm</td>
<td>Policy Forum</td>
<td>Patrick Conway, MD, Msc, Acting Principal Deputy Administrator and Chief Medical Officer, CMS</td>
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<td>4:30 – 4:45pm</td>
<td>Wrap Up and Next Steps (Auditorium)</td>
<td>Dan Crippen, Ph.D., Executive Director, National Governors Association</td>
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Bill Novelli and Tom Koutsoumpas, Co-Chairs, C-TAC