Caring for Patients with Advanced and Serious Illnesses: Changing Medical Practice and Patient Expectations

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**PEACE TRIAL**

Promoting Effective Advanced Care for Elders

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  * * * Northeastern Ohio Universities Colleges of Medicine and Pharmacy  
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The PEACE Trial is supported by  
The National Palliative Care Research Center  
& the Summa Foundation

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Summa Health System

Interdisciplinary Consortium on Aging Research and Education

Area Agency on Aging, 10B, Inc.  |  Summa Health System  |  NEOUCOM  
Kent State University  |  The University of Akron
Key Points

- A National Palliative Care Research Center-funded trial ($154,000 over 2 years)
- Collaboration between:
  - The University of Akron
  - Kent State University
  - Northeastern Ohio Universities Colleges of Medicine and Pharmacy
  - Area Agency on Aging 10B Inc.
  - Summa Health System
- A randomized controlled pilot study
- A palliative care case management intervention for Ohio Medicaid LTC Waiver- PASSPORT consumers
- Intervention involves collaborative care between a hospital-based interdisciplinary team, the Area Agency on Aging, and the consumer’s PCP
The S.A.G.E. Project

(Summa Health System/Area Agency on Aging, 10B/Geriatric Evaluation Project: A Successful Healthcare Collaborative (Est. 1995)

Improving Care through Collaboration: Integration of the Aging Network and Acute and Post Acute Medical Care Services
**SAGE Goal**

**Goal:** To integrate a comprehensive geriatric hospital-based clinical program with the community aging network to improve the health, functional status, and prevent institutionalization of older adults at risk for nursing home placement.

**S.A.G.E. Project is an example of how to partner with a community agency:**

- Acute hospital and medical care services and
- A community-based Area Agency on Aging
The SAGE Project

- A 15 year collaboration partnership
- **Multiple initiatives:**
  - A “cast of thousands”
  - Steering Committee/ Communication Protocols- Processes Task Force
  - Embedding AAoA RN assessor into hospital Acute Care for Elders and discharge planning teams
  - Integrated care planning between AAoA and health plan( AoA Grant)
  - Care Management Interdisciplinary Team- embedded geriatrician at AAoA facility
  - Linking AAoA case managers to ECIN- telehealth notification
  - Embedding AAoA RN assessor into primary care clinic
  - Embedding AAoA RN assessor into SNF network
  - AD-LIFE Trial- After Discharge Care Management of Low Income Frail Elders (AHRQ- # R01 HS014539.)
  - PEACE Trial – Promoting Effective Advanced Care for the Elderly( National Palliative Care Research Center)
The SAGE Project

- Common goal to improve the health, well being and functional status of Akron region frail older adult population
- Identified major gaps in the continuum and care processes from each partner
- Searched and defined mutual benefits
- Shared mutual threats and concerns
- Built trust
- Grew and multiplied to other regional hospitals and health systems
- Communication, communication, communication
- Vision, Vision, Vision, Vision
Who were the partners?

**Summa Health System**

**Geriatric Medicine Department**

- **6 Hospital System**
  - 2,027 licensed beds
  - 61,800 admissions

- **Level 1 Trauma**
  - 113,059 ED visits

- **Community Locations**
  - 4 outpatient health centers
  - Wellness Institute –
    - medically-based fitness

- **Health Plan**
  - 110,000 Covered Lives
  - 16,000 Medicare Risk HMO

- **Major Teaching Residency and Fellowship Program**

- **Post Acute/Senior Service Line**
  - 10 Certified Geriatricians
  - 12 Geriatric Certified APNs

- **Continuum of Care**
  - Acute Care/Acute Rehab/ LTAC/ SNF Beds
  - Home Care/ Hospice/ Home Infusion/ HME
Institute for Seniors and Post-Acute Care
Mission: To provide older adults and their caregivers long-term care choices, consumer protection and education so they can achieve the highest possible quality of life.

- Aging Resource Center
- PASSPORT Home Care Medicaid Waiver
- Assisted Living Medicaid Waiver
- Community Services Division
  - Care Coordination
  - Alzheimer’s Respite Program
  - Family Caregiver Support
- Elder Rights Division
**Integration**

**The Primary Care Physician**
- Medical model
- Limited time with patient

**The Center for Senior Health and Senior Services**
- Consult and support
- Across the continuum including outpatient, inpatient, house calls and skilled/long-term care
- Addresses medical and psychosocial
- No access to home environment or long-term case management

**The Area Agency on Aging**
- Social service model but now becoming more integrated
- Care management and services for long-term care
- Limited interaction with PCP
- Addresses functional abilities/geriatric syndromes but challenged with high risk enrollees with multiple chronic illnesses

**AD-LIFE and PEACE Model**
Health Care Utilization Experience for Patients with Chronic Conditions: Current Health Care System

Hospitalization prompting advance care decisions (often by the family)

Community-dwelling chronically ill patient with poor symptom control and coordination of care whose advance care wishes are rarely documented

Exacerbation of chronic illness
Palliative Care and Advance Care Planning

Independent Management

Advance Care Planning

Symptom Management

Disease Management

Hospice

Diagnosis

Death
Patient Centered Care

Geriatrics

Well Older Adults
Gait Disorders
Preventive care
Stable chronic dx
Geriatric syndromes
Peri-operative care
Osteoporosis

Palliative Care

Cancer
Stroke
Advanced Organ Failure
Chronic Critical Illness
Frailty
Dementia

AIDS
Cancer (<65)
Genetic/Developmental Disorders
Pediatric Oncology
Cystic Fibrosis
TBI

Morrison, Sean NPCRC
Purpose of the PEACE Pilot Study

- This randomized pilot study will determine the feasibility of a fully powered study to test the effectiveness of an in-home interdisciplinary geriatric-palliative care management intervention to improve the quality of palliative care for consumers of Ohio’s community-based long-term care Medicaid waiver program, PASSPORT.

- Key focus is using health coaching and activation for self management techniques including promotion of advance care planning discussions with PCP.
New PASSPORT enrollees >60 years old with one of the following diseases and the corresponding level of severity will be eligible for inclusion:

- CHF and being actively treated (AHA class C)
- COPD and on home O₂ or nebulizer treatments
- Diabetes with renal disease, neuropathy, visual problems, or CAD
- End-stage liver disease, cirrhosis
- Cancer (active, not history of) except skin cancer
- Renal disease on dialysis
- ALS with history of aspiration
- Pulmonary hypertension
- Parkinson’s disease (stages 3 and 4)
**Enrollment**

- RN assessors from the AAoA will screen consumers at the time of their initial PASSPORT assessment.
- RN assessor will obtain HIPAA release.
- Research nurse will obtain consent and obtain baseline measures.
- Consumers will be randomized to usual care or the intervention group.
Intervention

Each Care Manager will have approximately 10 consumers

Care Manager will make 2 home visits centered on symptom assessment & advance care planning

Care Manager will take her assessment findings to an interdisciplinary team

Team produces recommendations for consumer & PCP

Care Manager accompanies consumer to 1 PCP visit to assist consumer in discussing advance care goals with PCP

Care Manager & Palliative Care Nurse supervisor make another home visit to begin implementation of plan of care

Care Manager follows-up with consumer monthly for 1 yr to assure team recommendations are implemented
## Outcomes
**Measured at 3, 6, 9 and 12 months**

<table>
<thead>
<tr>
<th>5 Domains</th>
<th>Measurements made to determine domain score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Symptom management</td>
<td>Memorial Symptom Assessment Scale</td>
</tr>
<tr>
<td>2) Quality of life/death</td>
<td>QUAL-E</td>
</tr>
<tr>
<td>3) Relationships</td>
<td>Meaning in Life Scale</td>
</tr>
<tr>
<td>4) Decision making/care planning/continuity/communication/patient activation</td>
<td>Palliative Outcome Scale, Patient Activation Measure</td>
</tr>
<tr>
<td>5) Depression and anxiety</td>
<td>Hospital Anxiety and Depression Scale</td>
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</tbody>
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Challenges

- Getting buy in from case managers
- Education and knowledge gaps
- Changing culture of the AAA
- Needing to get more top down support for the project so AAA CM are supported for the project
- Not over “medicalizing” the care plans
Unique Features/ Successes

- Strong working relationship and commitment by the AAOA
- Addressing advance care planning and activation for self management at time of “change in support needs” e.g. independent to LTC needs
- Culture sensitivity and knowledge between aging network and acute care sector- “becoming bilingual”
- Outgrowths of other educational projects, additional funding for PC research, and bridging the community network and acute sector
Transitions of Care
AD-LIFE, PEACE, and Bridge to Home

The Primary Care Physician
- Medical model
- Limited time with patient

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AD-LIFE, PEACE, & SummaCare’s Bridge to Home

- Post-discharge care management of low income frail elderly
- Advance care planning and palliative care/geriatric syndrome management for low income seniors
- Nurse care manager activation of client
- Collaboration between a hospital-based interdisciplinary team, Area Agency on Aging, and PCP
- Integration of acute and long-term care
- Transitional care to reduce readmissions

AD-LIFE trial is supported by the Agency for Healthcare Research and Quality Grant # R01 HS014539. PEACE is funded by the National Palliative Care Research Center. Both are supported by the Summa Foundation.
- Bridge to Home is funded by SummaCare.
Additional PEACE Related Projects:

- A survey of knowledge and attitudes about ACP and PC sent to all area PCPs. Funded by the Summa Foundation.

- A statewide survey of all care managers at all AAoA that will examine knowledge and attitudes regarding ACP and PC. Funded by Northeastern Ohio Universities Colleges of Medicine and Pharmacy.

- An video on-line educational program to teach AAoA care managers how to bring PC upstream in the disease process. Funded by the First Merit Foundation.
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