

# **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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The PEACE Trial is supported by  
The National Palliative Care Research Center  
& the Summa Foundation



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

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(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

#### Summa Akron City Hospital



#### Summa St. Thomas Hospital



#### Summa Western Reserve Hospital

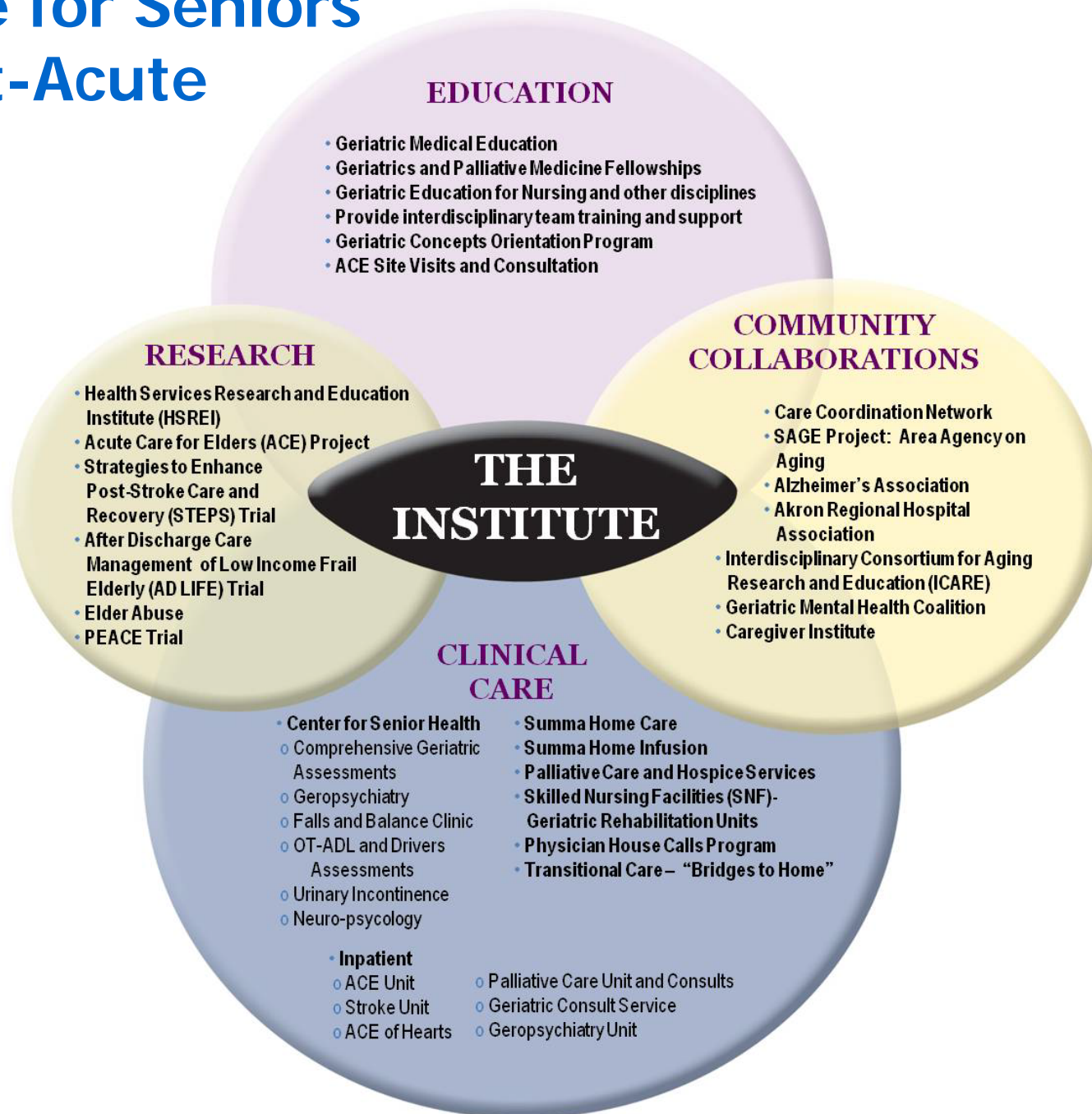


#### SummaCare, Inc.





# Institute for Seniors and Post-Acute Care



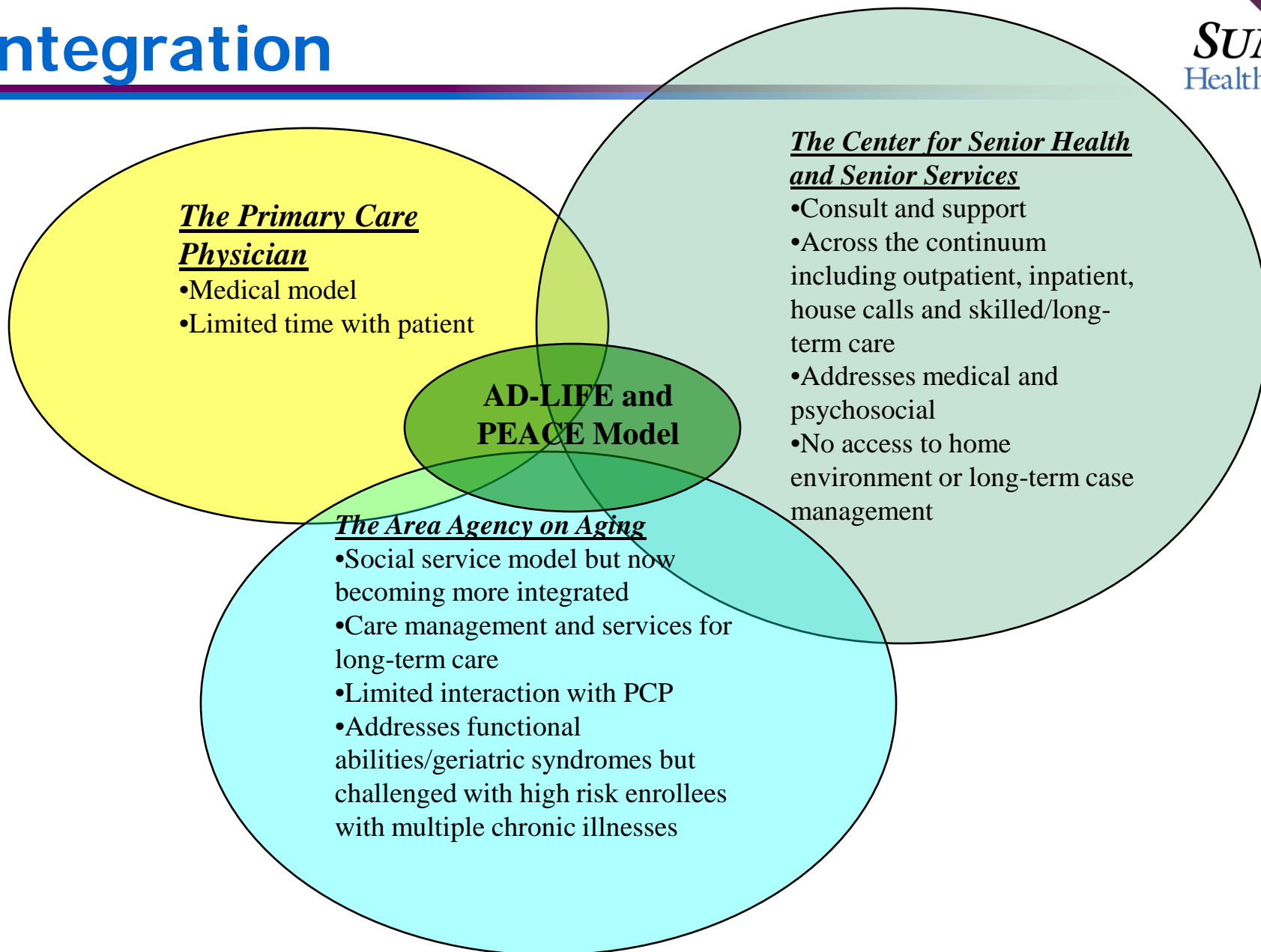
# Area Agency on Aging Programs



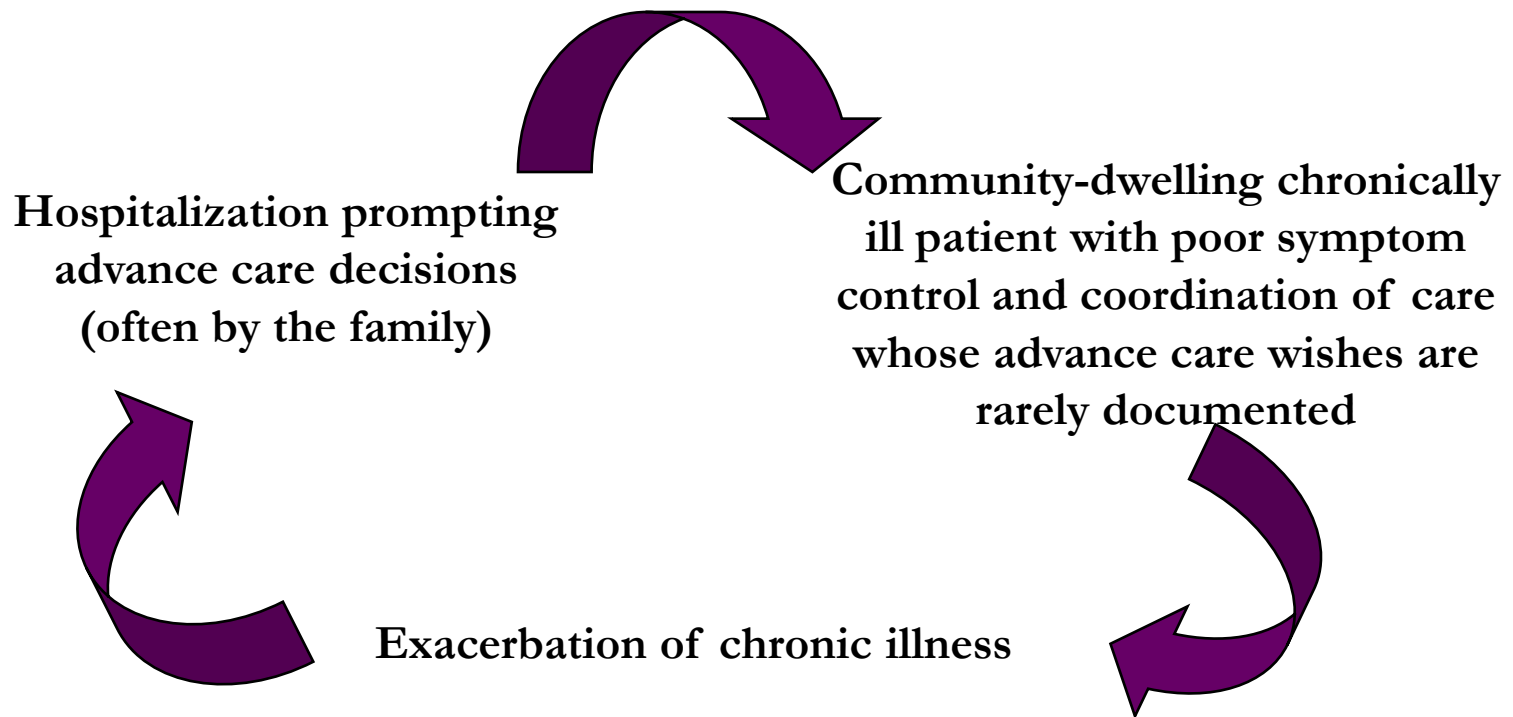
- *Mission: To provide older adults and their caregivers long-term care choices, consumer protection and education so they can achieve the highest possible quality of life.*
- Aging Resource Center
- PASSPORT Home Care Medicaid Waiver
- Assisted Living Medicaid Waiver
- Community Services Division
  - Care Coordination
  - Alzheimer's Respite Program
  - Family Caregiver Support
- Elder Rights Division



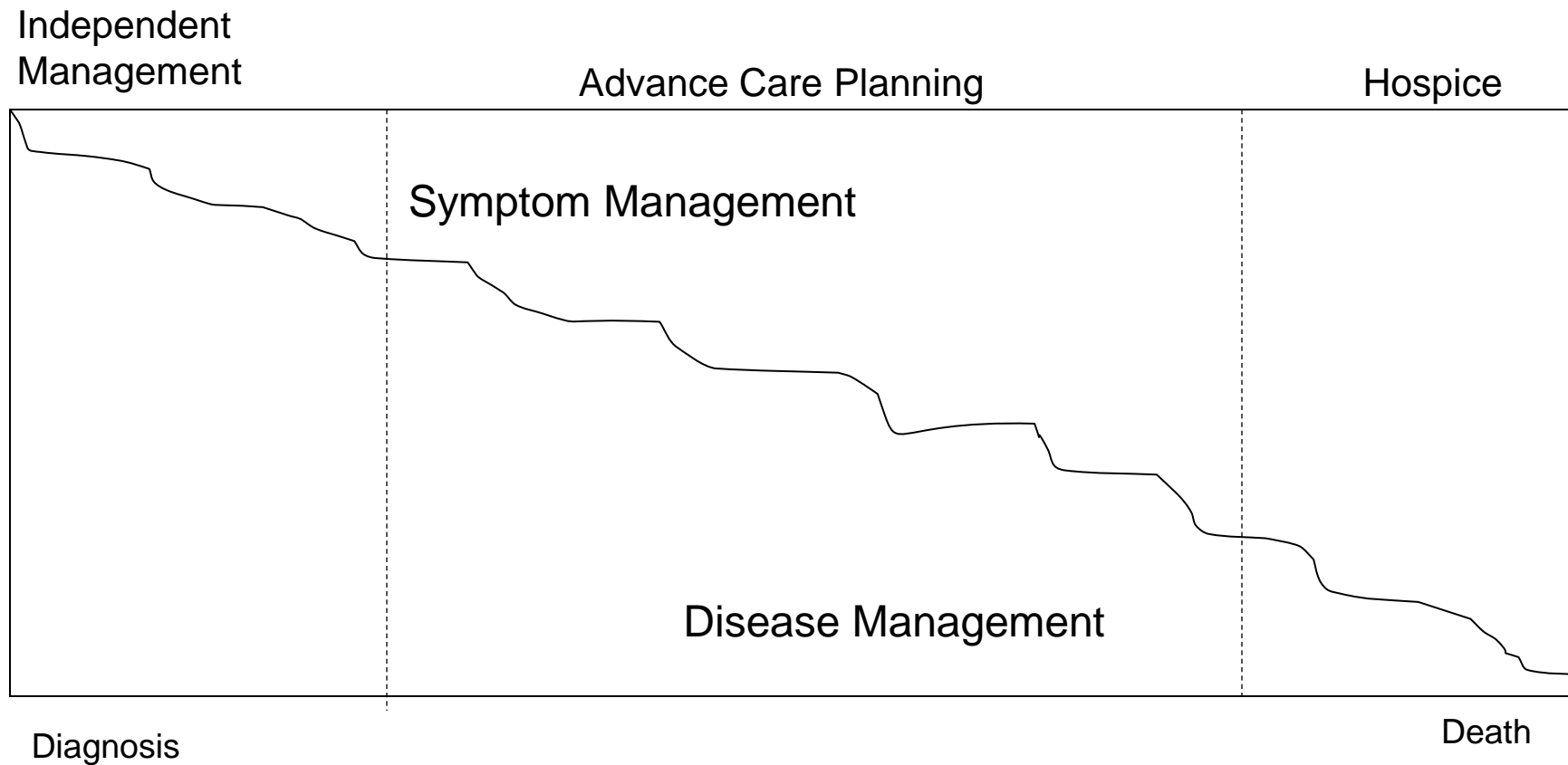
# Integration



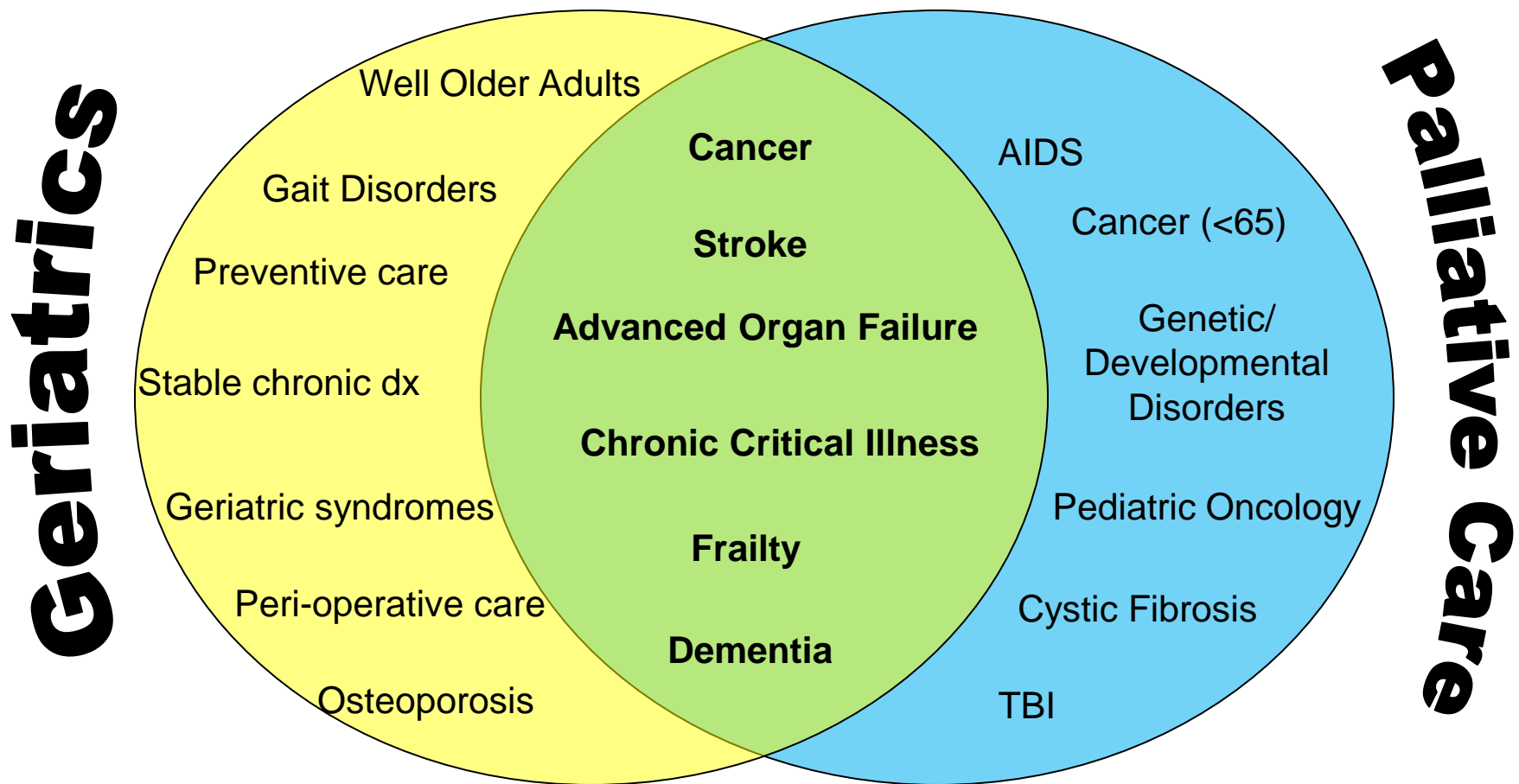
# Health Care Utilization Experience for Patients with Chronic Conditions: Current Health Care System



# Palliative Care and Advance Care Planning



# Patient Centered Care



# 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.**

# Target Population

## PEACE Pilot Study



**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 O<sub>2</sub> 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)**



- **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**

# PEACE Intervention

## 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

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

# Challenges

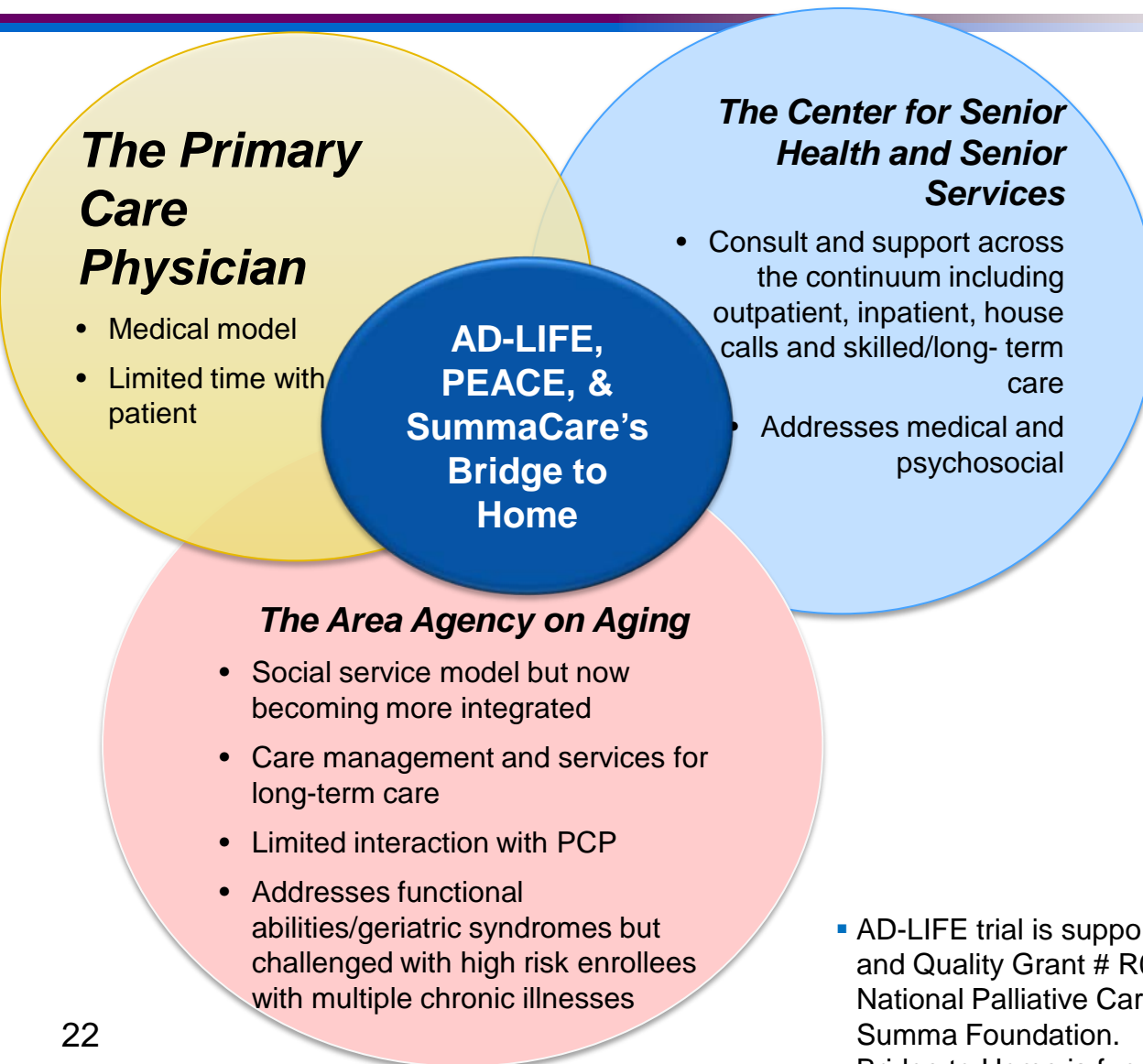
- **Getting buy in from case managers**
- **Education and knowledge gaps**
- **Changing culture of the AAA**
- **Needing to get more top down support for the project so AAA CM are supported for the project**
- **Not over “medicalizing” the care plans**

# 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



- 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
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- 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.**

# Contact Information



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