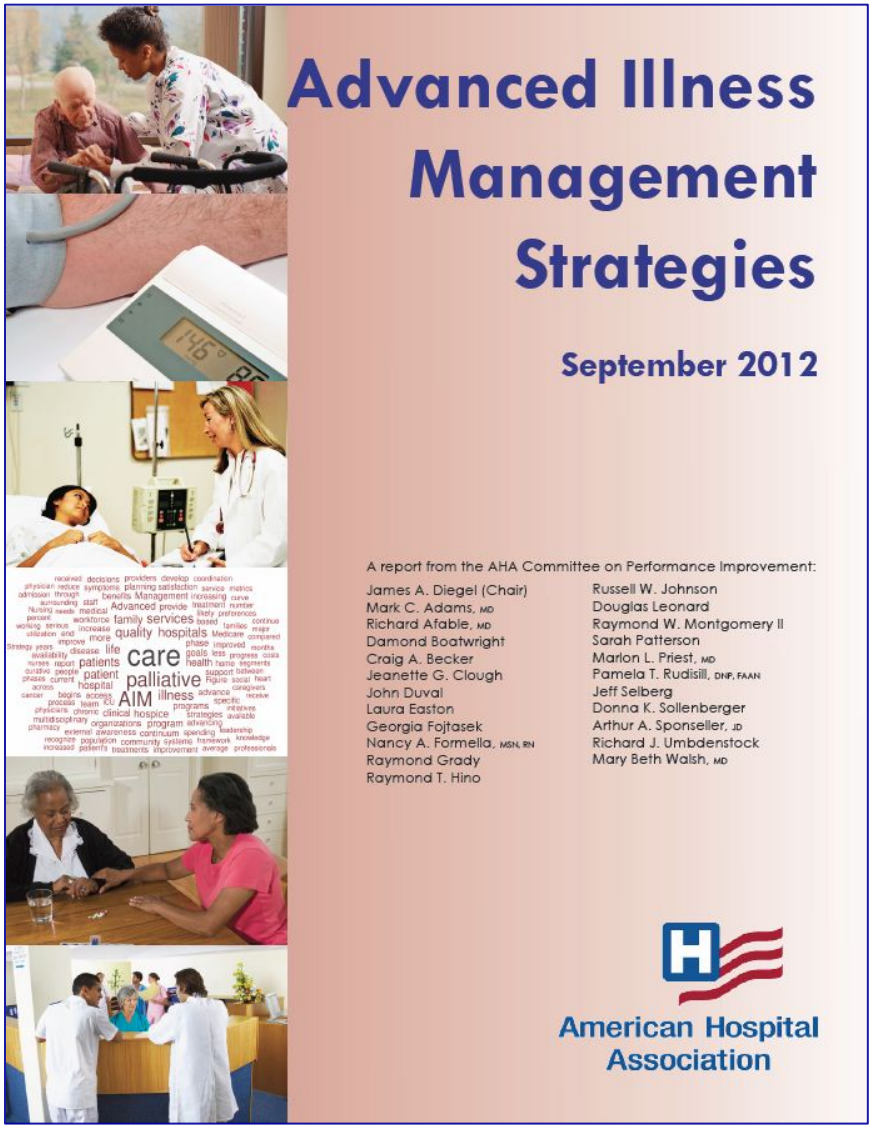
American Hospital Association

Advanced Illness Management Strategies

2012 AHA Committee on Performance Improvement Report

August 2012

Advanced Illness Management Strategies



Managing life in the gap: Moving Advanced Illness Management (AIM) from first- to second-curve

- Defining AIM
- Why AIM

Three key strategies for hospital leaders to implement to pursue AIM goals

- Access
- Workforce
- Awareness

Advanced Illness Management (AIM)

The trajectory of advancing illness leads to death. Managing its care requires proactive disease management, and balancing the changing, expanding needs with the patient's goals.

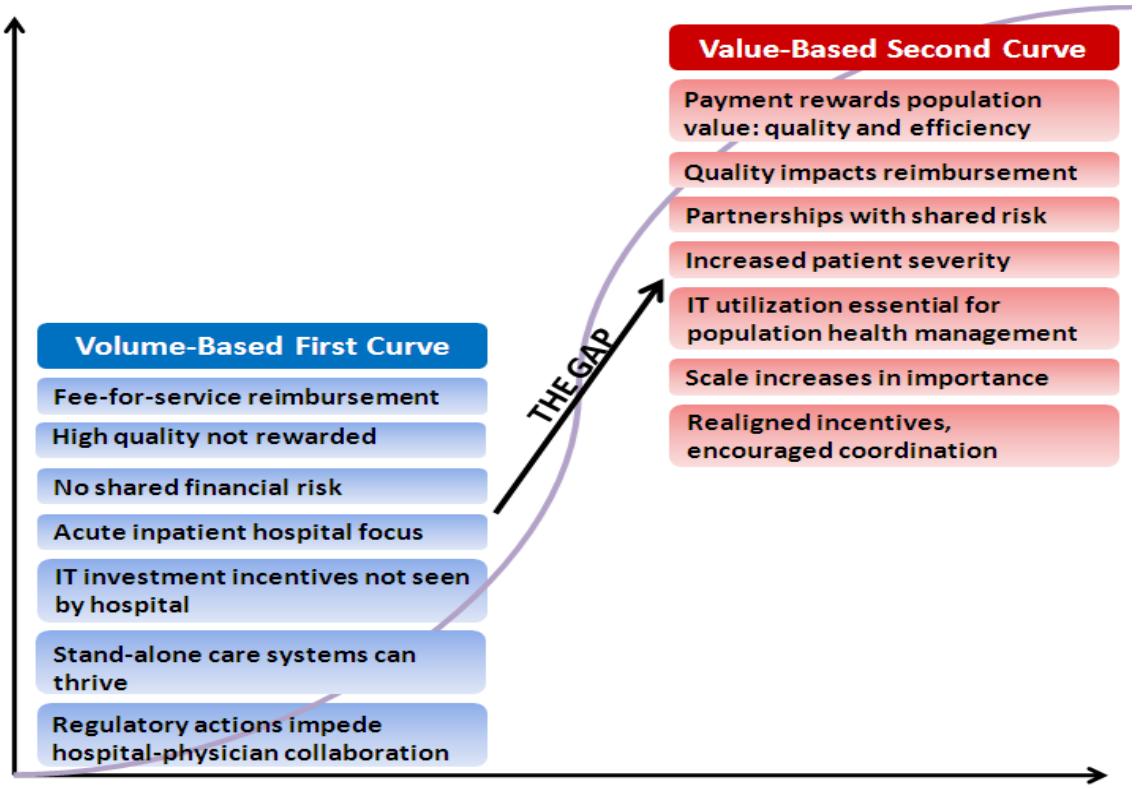
Why AIM?

Studies evaluating clinical, satisfaction and process measures show that AIM:

- reduces pain
- increases quality
- improves patient and family satisfaction
- reduces inefficiencies and increases coordination within the health care system

Managing Life in the Gap: Integrating AIM

J. Ian Morrison's first- and second- curve framework describes the shift in payment incentives and demonstrates the importance of progression from the first-to the second-curve economic markets.



AIM programs allow hospitals to navigate this transition and fill the gap.

Why Integrate AIM Programs?

In the hospital setting, AIM programs are proven to:

- provide patients with improved **quality** of life, reduced major depression and increased length of survival
- lower **utilization** of clinical treatments and hospital admissions among enrolled patients
- improve **satisfaction** scores for patients, family, caregivers and the multidisciplinary AIM-trained staff
- reduce aggregate **spending**

Proven Results of AIM

Quality

- Patients receiving palliative care have improved quality of life and fewer major depressive symptoms based on Functional Assessment of Cancer Therapy Scale
- Median survival among early palliative care patients is longer (11.6 months versus 8.9 months)

Utilization

- Medicare patients with AIM use 13.5 days of hospital care in the last 2 years of life compared to 23.5 as the national average
- Fewer ICU admissions and as much as an 85% reduction in ICU days

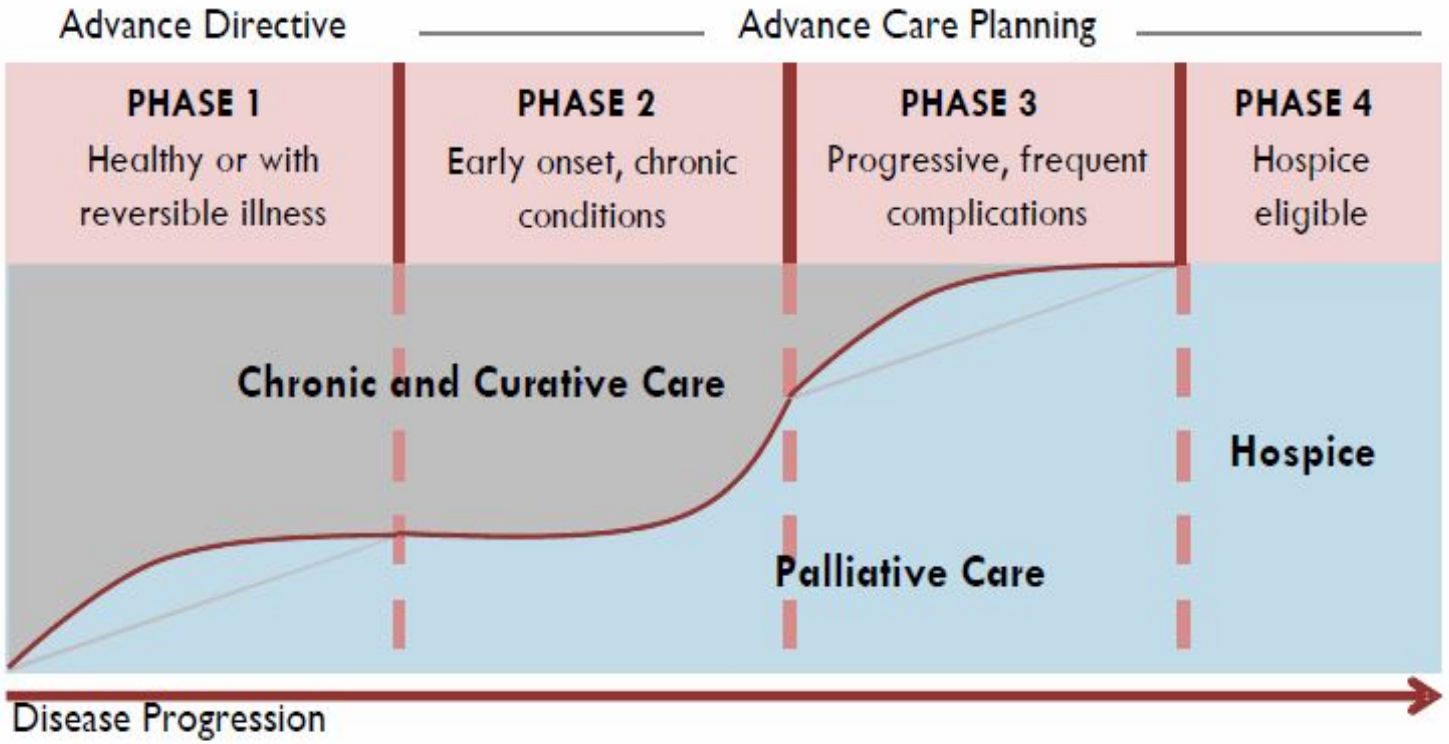
Satisfaction

- Compared to hospice care at home, care in the hospital associated with 8.8 times risk of prolonged grief disorder
- Compare to hospice care at home, care in the hospital intensive care unit is associated with 5 times the family risk of post-traumatic stress disorder

Spending

- Hospitals experienced a positive net contribution margin of $1,333 per AIM enrollment
- On average, patients who received palliative care incurred $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care

Phases of Advanced Illness Management (AIM)



Source: AHA CPI analysis, 2012, with contributions from 2012 CTAC data and 2011 Center to Advance Palliative Care data.

Four Segments of AIM

Advance Directives

These are made by a mentally capable per-son regarding goals of care or treatments for a possible or probable health event and are expressed orally or in writing.

Advanced Care Planning

This should be based on potential or likely disease scenarios and future medical decisions. An effective plan should include:

- the selection of a well-prepared health care agent or proxy
- the creation of specific instructions that reflect informed decisions geared to the person's health state
- the availability of these plans to treating physicians
- the incorporation of these plans into medical decisions

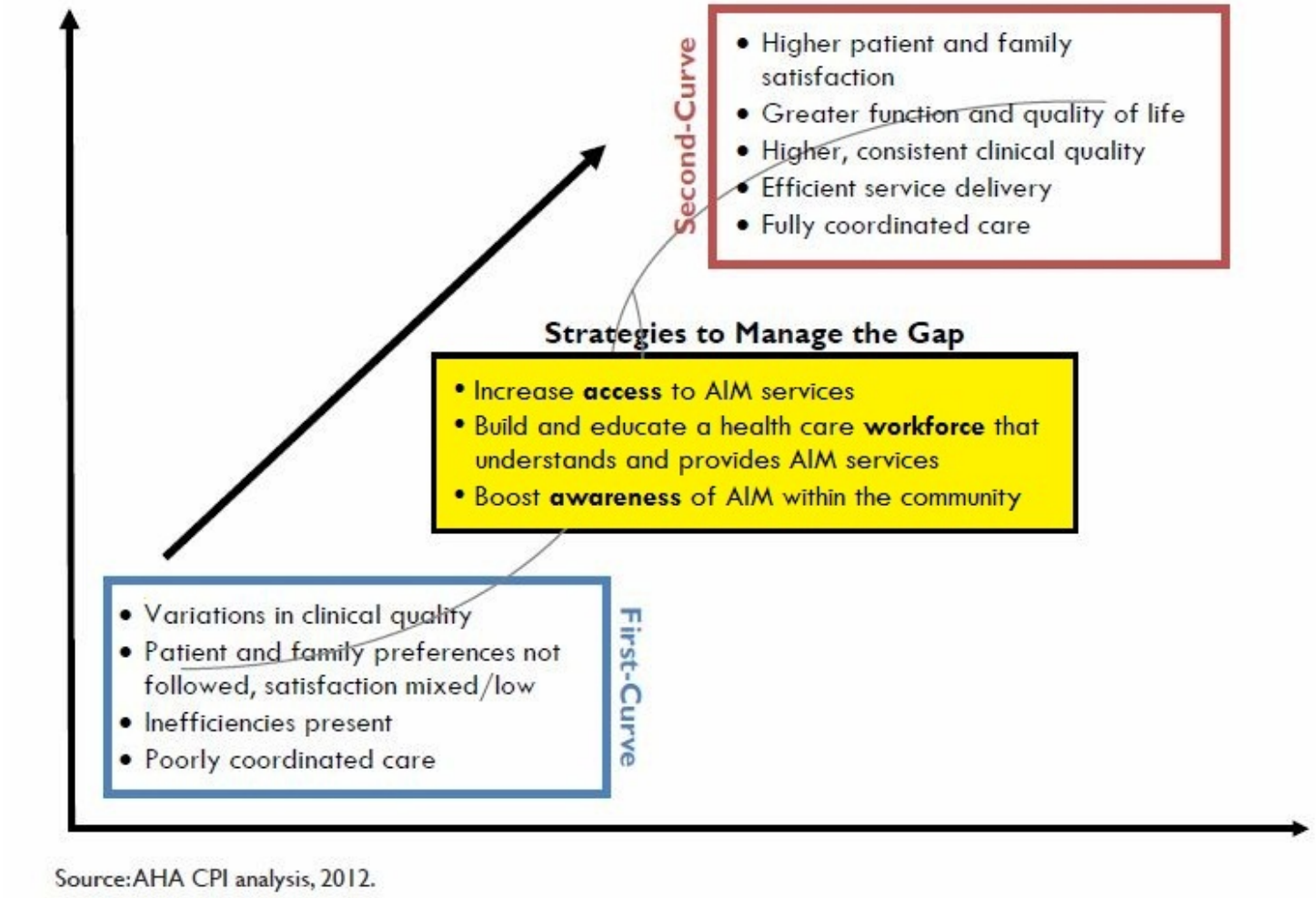
Palliative Care

It encompasses a broad spectrum of care services aimed at achieving the best quality of life possible at any phase of a disease. It can be delivered in homes, hospitals, intensive-care units, clinics, nursing homes, assisted living, or hospice.

Hospice Care

Hospice is a flexible set of services designed to meet the fluctuating, changing and expanding medical, social, emotional and spiritual needs of those approaching the last stages of life.

Managing the Gap:
Strategies to Developing a Successful AIM Program

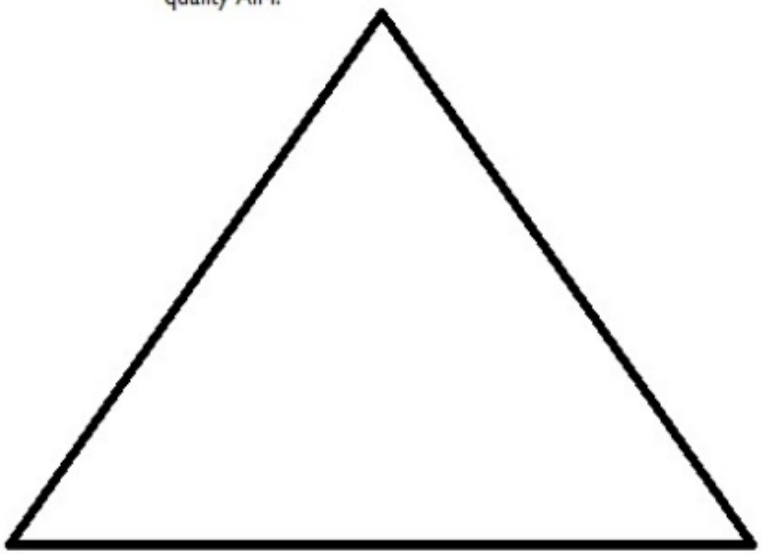


Source: AHA CPI analysis, 2012.

Managing the Gap:
3 Key Strategies

Access

Patient access to AIM services can be greatly increased when all hospitals and care systems are able to support and deliver high quality AIM.



Workforce

Excellence in AIM depends upon educating and training all health care professionals to provide care over the continuum of health and decline.

Awareness

Patient and family AIM awareness and understanding of the benefits of advanced illness planning and management can be significantly raised through community-wide strategies.

Strategy: Access

Increasing Access to AIM Programs:

- Provision of palliative care programs and hospice through own services or thru partnerships
- Integrated into organization's care continuum services (not separate)

AIM Program Framework

Guide to Coordinating AIM Services and Increasing Access

- Develop a multidisciplinary planning team
- Align with the organization’s mission and vision
- Analyze the current state of the organization
- Set goals
- Develop a customized program
- Implement an integrated program
- Collaborate and educate
- Track progress

Develop a Customized Program

AIM initiatives must be hospital and community specific. Program design will vary based on these factors:

- Clinical staff interest
- Current case management and discharge planning capabilities
- Leadership priorities
- Surrounding population demographics
- Available workforce: physicians, nurses, social workers, etc.
- Existing relationships with external AIM organizations
- Hospital chaplaincy program status
- Pain program status
- Community interest in AIM
- Multicultural environments
- Available physical location

Outcomes Metrics

How is the system performing? What are the patient-centered results?

- Meeting patient preference on longevity and quality of life
- Rate of major depression
- Pain control scores
- Symptom management control scores
- Family and caregiver depression, distress, anxiety (post-traumatic stress disorder/pro-longed grief disorder)
- Patient satisfaction
- Family and caregiver satisfaction

Process Metrics

Is the hospital performing as expected?

- Hospice referrals/consults
- Palliative care referrals/consults
- Advanced care planning discussions
- Frequency of goal documentation
- Percent of patients with advance directives
- Treatment decisions consistent with instructions
- Days with at-home hospice care
- Inpatient hospice length of stay

Balancing Metrics

What happened to the hospital after improvement in outcome and process metrics? What are the unanticipated consequences?

- Clinical staff retention and satisfaction
- Independent physician satisfaction
- Emergency department utilization
- Hospital stay cost
- 30-day readmissions rates
- Spending per admission
- Medical specialist visits
- Surgery in last month of life
- Days of hospital care in last 2 years of life
- Admissions in last 6 months of life
- ICU admissions and length of stay
- ICU days in last 2 years of life
- Laboratory utilization
- Pharmacy utilization and spending
- Treatment aggressiveness (chemotherapy 14 days or less before death, imaging studies in the last week of life, etc.)

Successful AIM Programs:
Mercy Medical Center, Cedar Rapids, Iowa

Reduced readmissions through streamlined AIM

Program Highlights

- Multidisciplinary team develops a care plan centered on the patient's preferences
- Specific medical orders travel with the patient across the care continuum and care venues and can be revocable or altered by the patient at any time
- Care plans are developed for the home and the 12-bed inpatient facil-ity

Keys to Success

- Multidisciplinary team developed a care plan centered on the patient's preferences
- Identified qualified patients upon emergency department usage, unnecessary inpatient admissions or prolonged lengths of stay
- Leadership crosses the AIM continuum
- Well-designed advance care planning discussions using a team approach and documented with IPOST forms that can be honored across settings of care
- Promoted AIM throughout the surrounding community

Successful AIM Programs:
Fletcher Allen Health Care, Burlington, Vermont

Provided palliative and hospice care education to physicians and patients throughout the region

Components to the Rural Palliative Care Network

- Telephone hotline available 24 hours a day, seven days a week
- Telemedicine consults for patients
- Mentorship program for community providers
- Visits to hospitals to observe palliative care services

Keys to success

- Knowledge of the specific communities
- Established a care team, consisting of the patient, physician and family
- Educated physicians and others in the community on available services

Successful AIM Programs:
Sharp Hospice, San Diego

Structured diseased-based AIM transitions program for better outcomes

Four Pillars of Sharp's Transition program:

- Comprehensive home-based patient and family education
- Disease specific, evidence-based prognosis
- Proactive management of the caregiver to set realistic expectations on survival
- Advance care planning with accurate descriptions of what treatments can provide

Keys to Success:

- Retained physician champions and other key stakeholders to engage support in development process
- Selected one diagnosis and worked through issues as each condition must be treated differently
- Thought outside the four walls of the hospital
- Used a performance improvement framework to measure, monitor, evaluate and adapt program between disease states and over time

Successful AIM Programs:
Sutter Health, Northern California

Provided ambulatory palliative care to patients, giving them options

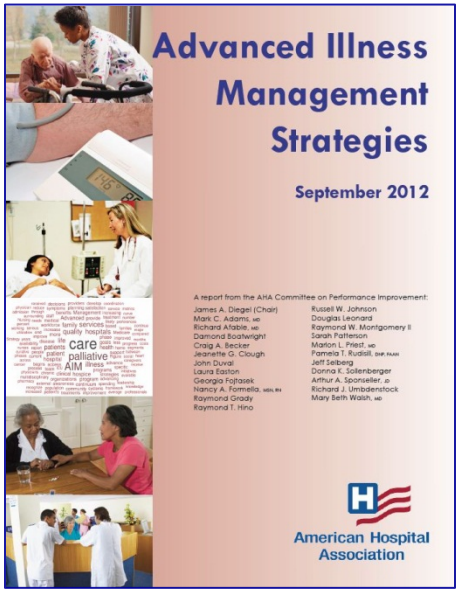
Program Highlights

- Targeted at individuals in the last 12 months of their lives and generally have at least 2 chronic conditions
- Provide patients with an alternative to receiving care at the emergency department or hospital
- AIM patients and care managers have a support network of a multidisciplinary team that consists of many health providers
- Sutter's Electronic Health Record incorporates the fluctuating goals and preferences of patients and is accessible to all providers
- Patients are typically seen in the hospital, at home for 30 to 60 days and through office-based care with telemanagement

Keys to Success

- Physician engagement
- Team-based care that is protocol driven
- A board and system that supports a patient-centered care approach
- An integrated, system approach to care delivery

Resources to Improve AIM Programs and Services



AHA Resources

Hospitals in Pursuit of Excellence
Circle of Life

Other Resources

Center to Advance Palliative Care
Coalition to Transform Advanced Care
Institute for Healthcare Improvement's Conversation Project
Joint Commission's Palliative Care Certificate Program
National Comprehensive Cancer Network
National Consensus Project for Quality Palliative Care
National Hospice and Palliative Care Organization
National Quality Forum's Palliative Care Guidelines
Respecting Choices