American Hospital Association

Advanced Illness Management Strategies: Engaging the Community and a Ready, Willing and Able Workforce

2012 AHA Committee on Performance Improvement Report

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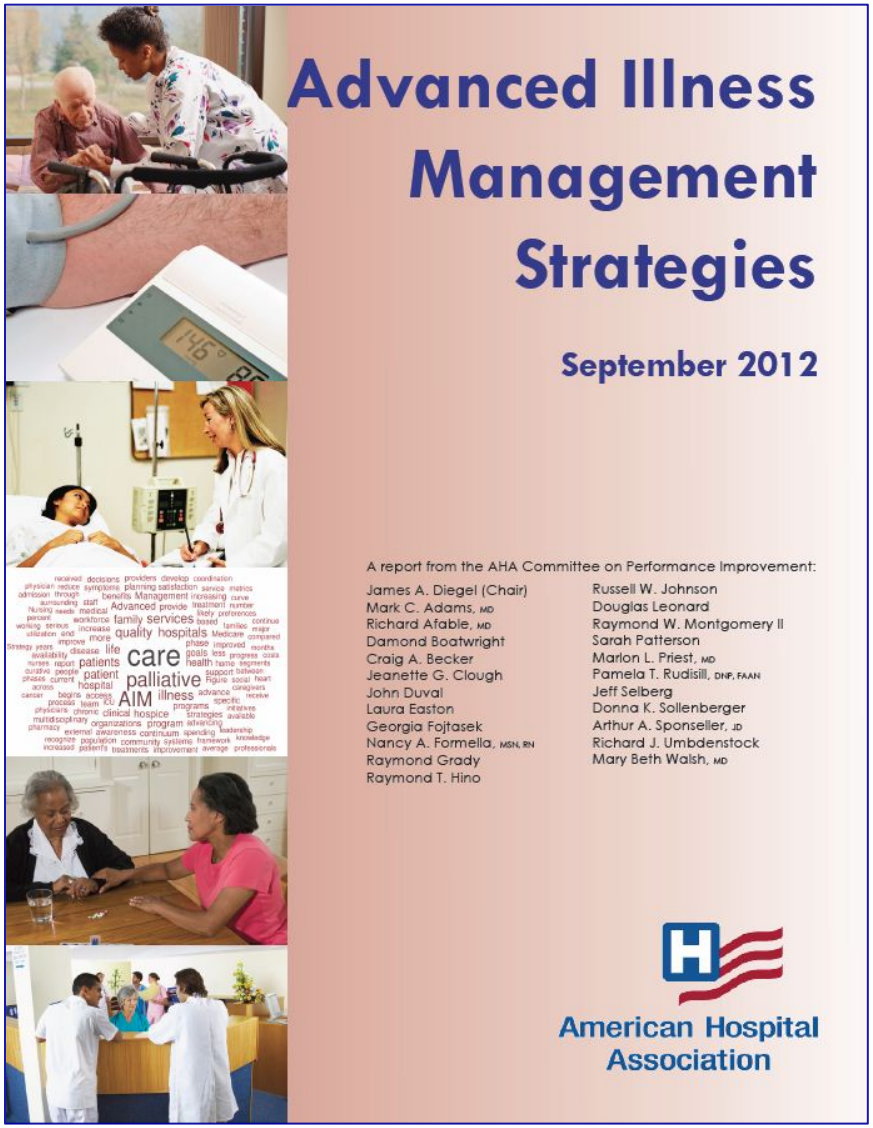
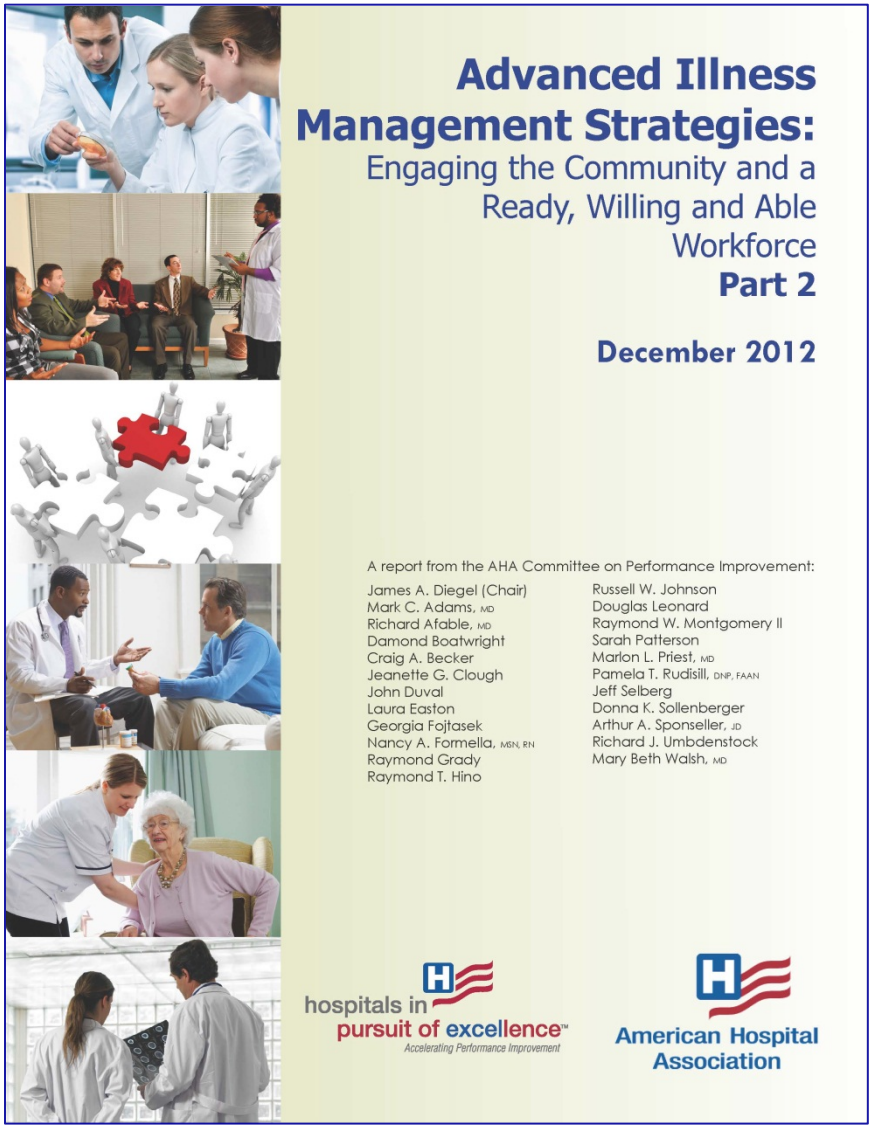
Advanced Illness Management Strategies: Part I



The first CPI report framed AIM as a four-phase process to be addressed through three strategies—***access, workforce*** and ***awareness***

The report also examined in depth how hospitals can increase ***access*** to AIM programs and change the way medi-cal services are utilized to improve outcomes and honor the wishes of patients and families.

Advanced Illness Management Strategies: Part II

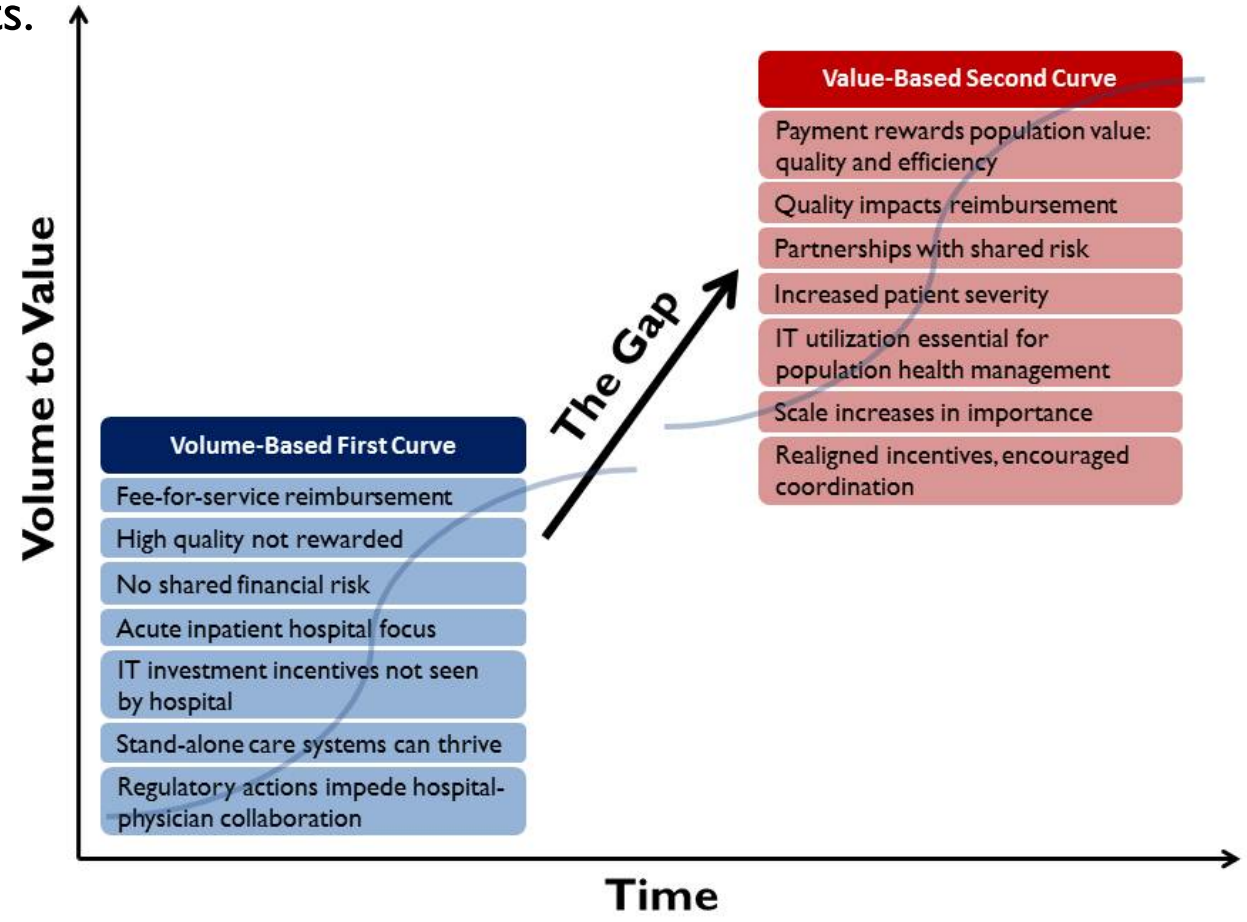


This second and follow-up report expands and explains more precisely the three key strategies of AIM.

The report also provides health care systems strategies and case examples that focus on patient and community ***awareness*** and engagement and a ready, willing and able ***workforce***.

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-curve to second-curve economic markets.



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.

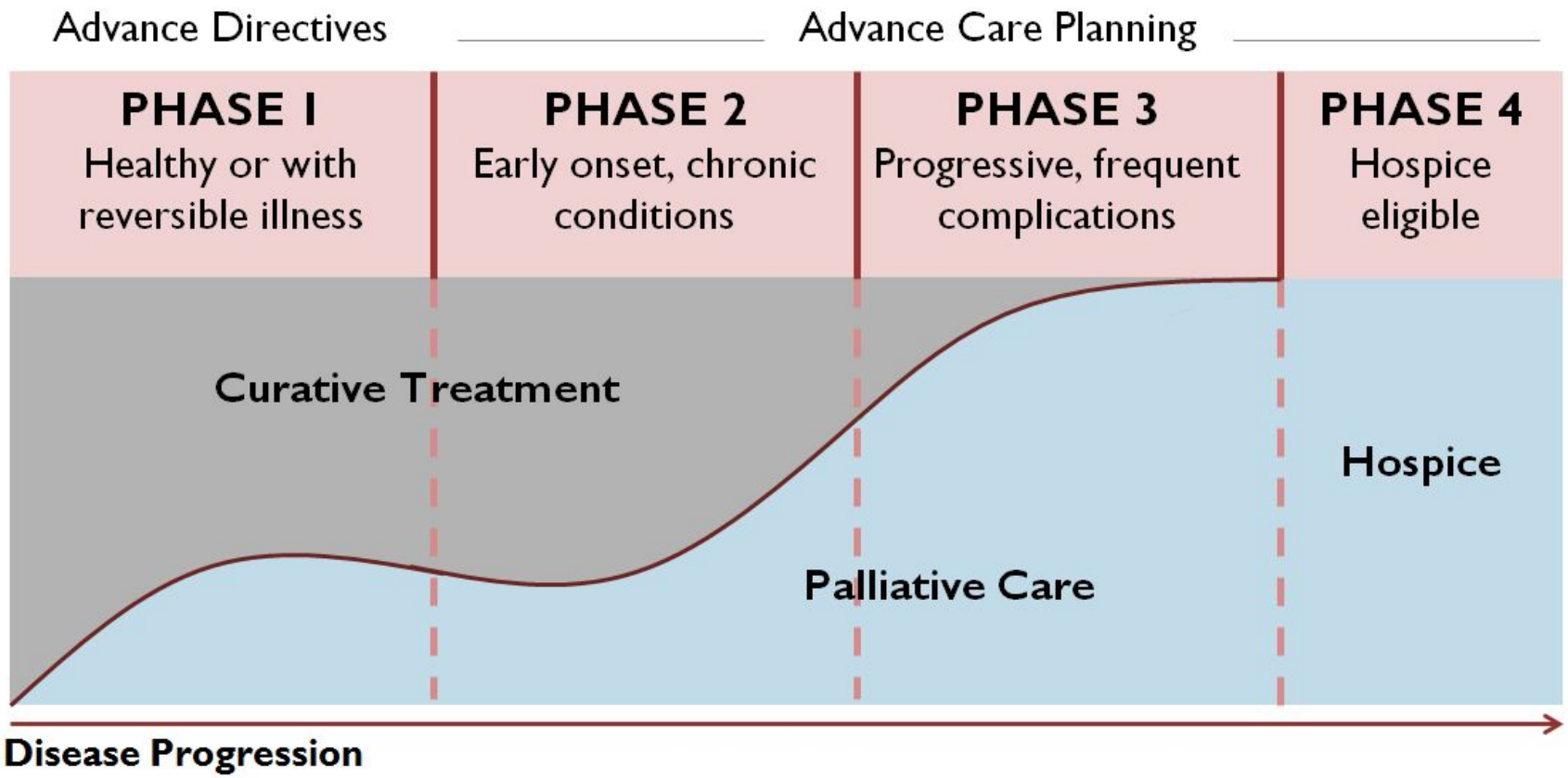
Why Integrate AIM Programs?

AIM programs allow hospitals to navigate the first-curve to second-curve transition and fill the gap.

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**

Phases of Advanced Illness Management (AIM)



Four Segments of AIM

Advance Directives

Goals of care or treatments made by a mentally capable person for a possible or probable health event and expressed orally or in writing.

Advance Care Planning

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

- Selection of a well-prepared health care agent or proxy
- Creation of specific instructions that reflect informed decisions geared to the person's health state
- Availability of these plans to treating physicians
- Incorporation of these plans into medical decisions

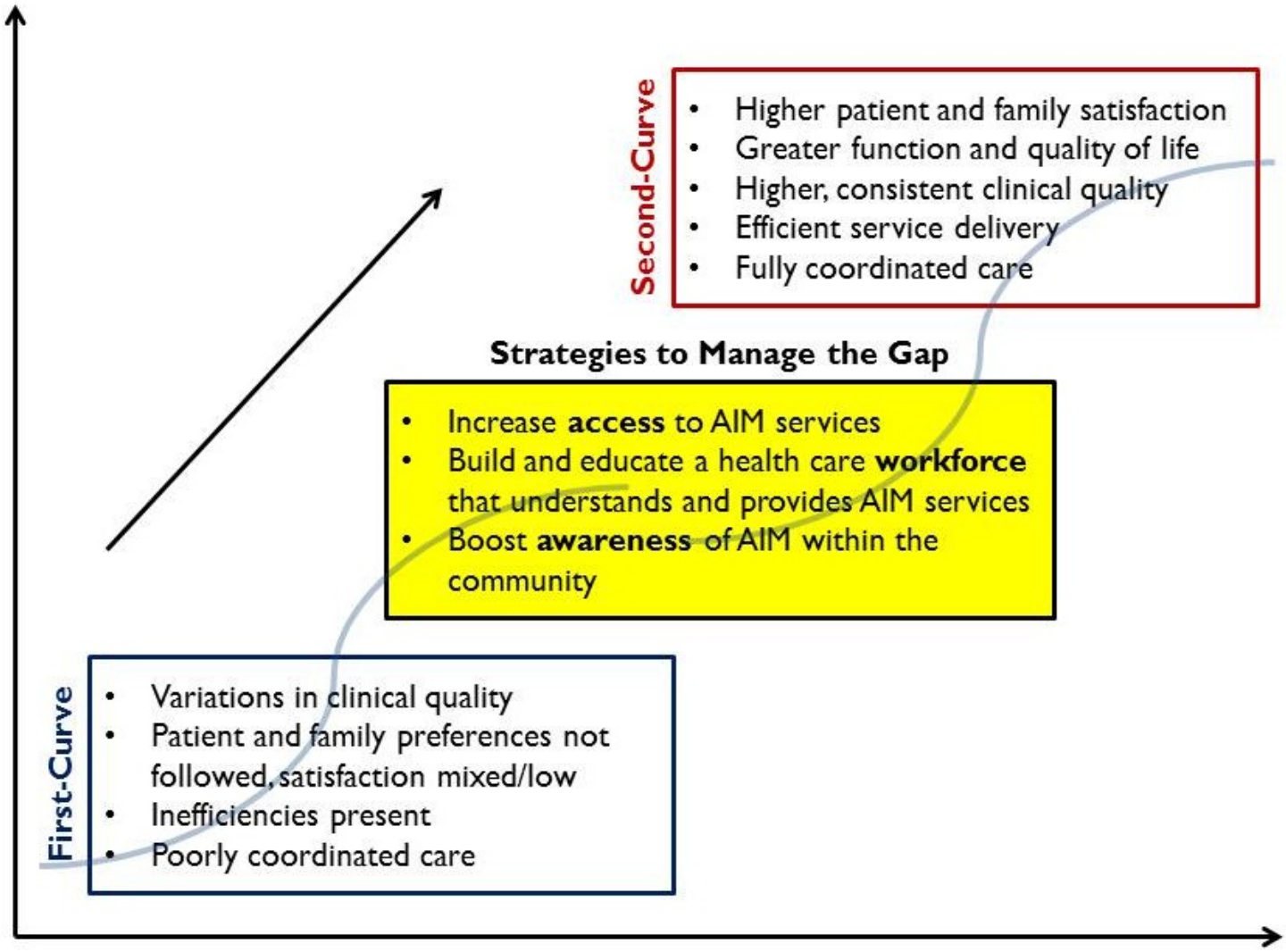
Palliative Care

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 facilities, or hospice.

Hospice Care

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.

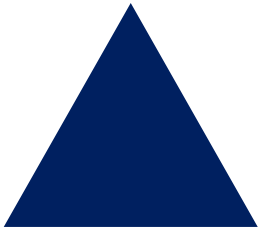
Navigating AIM



Three Key AIM Strategies

Access

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



Workforce

Excellence in AIM depends upon the education and training of health care professionals that can deliver quality hospice, palliative and end-of-life care.

Awareness

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

Three Key AIM Strategies

(1) Access to AIM Services

An infrastructure of organizational services must be in place to deliver and support high-quality, coordinated advanced illness care across set-tings. It must be supported by the structure and incentives of public and private payment systems.

(2) Patient and Community Awareness and Engagement

Patients and family members should become aware of their options and understand the benefits of all phases of advanced illness planning to attain the best quality of life and support. This will drive the demand for AIM services.

(3) Ready, Willing and Able Workforce

All health care professionals should be ready, willing and able to (1) have informed conversations with their patients about advanced illness and their evolving goals of care, (2) provide the basics of palliative care and (3) guide patients and families to more expert resources.

(1) Strategies to Increase Access to AIM Services

- Develop a multidisciplinary care team with leadership buy-in
- Identify qualifying patients through evidence-based protocols
- Think beyond the traditional four walls of the hospital to promote AIM collaboration throughout the surrounding community
- Use a performance improvement framework to measure, monitor, evaluate and adapt the program between disease states and throughout time

(2) Strategies to Expand Patient and Community Awareness and Engagement

- Increase patient accessibility to information about end-of-life care by developing awareness and "conversation-readiness" among health care professionals; work with stakeholders on the importance of conversations, advance directives and early decision making; provide effective language assistance services; and address low health literacy
- Launch community development strategies that spread awareness of cultural diversity and support partnerships with local leaders and organizations that cater to the patient population's demographics, education levels, culture and language
- Develop a workforce that embraces diversity to address the needs of patients and families from a variety of backgrounds and is equipped with the skills and knowledge necessary to support and guide those facing end of life

(3) Strategies to Build a Ready, Willing and Able Workforce

- Develop educational programs that offer ongoing training for health care professionals to learn the necessary skills and competencies for engaging in sensitive conversations and that train health care providers on the role and impact of spirituality in end-of-life care
- Use a multicultural guide/spiritual toolkit to support understanding and meeting diverse patient needs
- Create a solid program infrastructure to sustain a successful palliative and end-of-life care program

Promising Practices to Support Patient-Centered Communication Strategies

Hospitals and health system can foster and encourage patient-centered communication by finding innovative ways to address cultural differences, linguistic barriers and varying literacy levels.

- Encouraging passionate champions throughout the organization
- Collecting information to demonstrate needs
- Engaging communities
- Developing workforce diversity and communication skills
- Involving patients every step of the way
- Being aware of cultural diversity
- Providing effective language assistance services
- Being aware of low health literacy and using clear language
- Evaluating organizational performance over time

Successful AIM Programs:

Massachusetts MOLST Program

Background

MOLST is a voluntary process and standard-ized form used to translate several life-sustaining treatment preferences of seriously ill patients into valid medical orders that can be honored across all health care settings in Massachusetts.

The premise of the MOLST form is that decisions follow conversations among patients, families and providers, who help health care users understand the progno-sis, possible symptoms or complications and potential benefits and risks of various life-sustaining interven-tions.

Results

- In 2008, the Massachusetts Legislature mandated a MOLST demonstration project, and strong results led to statewide expansion of MOLST, as did the 2010 report of the Expert Panel on End-of-Life Care under the State's Executive Office of Health and Human Services.

The Conversation Project

Background

TCP is creating a movement that will make end-of-life discussions easier. TCP developed a forum for sharing stories, a marketing campaign, and resources for conversation starters and guides to help people who don't know where to begin.

Current and Future Initiatives

- TCP is working with 10 pioneer sponsors who have committed sponsorship funds, resources and expertise to develop a "Conversation Ready" change package, and with palliative care experts who will develop and communicate innovative ways to engage in difficult and sensitive conversations. After one year of implementation, the change packages will be shared with the rest of the field.
- In August 2012, TCP launched its social and national media campaign and website, which features a conversation starter kit and ways to tell stories.

Successful AIM Programs:
AETNA Compassionate Care Program (CCP)

Background

CCP is a telephone case management program developed by Aetna. Designed to improve the quality of care for members who are likely to live less than a year, CCP case managers serve as patient navigators and companions. Candidates are identified proactively through review of hospital admission records, medical history, pharmacy claims, referrals, etc.

Results

- Hospice election rate is 82 percent for Medicare Advantage members.
- Number of days in hospice has doubled but the mean is still low, 36 days.
- 86 percent reduction in ICU days.
- 82 percent reduction in acute care/hospitalizations.

Respecting Choices (RC)

Background

RC, operated by Gundersen Lutheran Medical Foundation, designed key elements to assist busy professionals to do what is right and promote the adoption of advance care planning as an ongoing process of communication, integrated in the patient-centered care routine and staged to an individual's state of health.

Results

Data study collected in 2007 and 2008 on 400 deaths at all health organizations in La Crosse County over a seven-month period showed that:

- Prevalence of care plans among adults who died in health organizations in La Crosse County was 90 percent.
- 99 percent of the time, treatments provided were consistent with the care plans.
- 67 percent of individuals had a POLST form at the time of death.
- 96 percent of individuals had either advanced directives or POLST

The Coalition to Transform Advanced Care (C-TAC)

Background

C-TAC is committed to providing resources, education and visibility that will result in the appropriate care in the right place and time. It is focused on key directives to empower consumers, change the health care delivery system, improve public and private policies, and enhance provider capacity.

Current and Future Initiatives

- Launched its website, designed to empower the public to make informed decisions about advanced illness care and provide the highest quality of resources.
- Will create public support for policy reform to improve the social and health system environment and improve norms for quality care.
- Will integrate public and clinician engagement into its clinical models to ensure that patient choice and shared decision making drive care, improve quality, promote high levels of satisfaction and reduce costs.

Successful AIM Programs:

Mercy Supportive Care (MSC)

Background

MSC at St. Joseph Mercy Oakland is a pain management and palliative care program that provides individuals suffering from an illness and/or facing the end of life with comprehensive services across the care continuum. The MSC team initiates contact with inpatients and follows a large percentage during transitions to hospice or outpatient care settings.

Results

- MSC has a high volume of referrals, more than 4200 patient visits annually.
- The cost-per-case/day was $600 less when palliative care services were involved.
- SJMO data indicated that it was able to avoid $920,000 in costs (based on volume).
- The program has been shared with more than 131 health care organizations, including competing hospitals.

Sacred Art of Living Center (SALC)

Background

SALC offers programs for spiritual formation for caregivers. The flagship workshop-retreat series of SALC, the Scared Art of Living and Dying (SALD), explores universal patterns of spiritual and emotional suffering and time-tested ways to relieve them based upon ancient wisdom traditions and contemporary clinical research.

Results

Based on more than 30,000 participant evaluations, the program exceeded the expectations of attendees, receiving 94 percent to 98 percent positive responses in:

- Overall program experience
- Practical usefulness of the series
- Meeting program goals and objectives
- Applicability for clinical practice
- Usefulness for personal/spiritual development

Successful AIM Programs:
Center for Palliative Care (CPC)

Background

Harvard Medical School (HMS) CPC fosters health care leadership and supports palliative educational programs aimed to alleviate suffering and enhance the care of patients and their families who are facing severe and life-threatening illness.

HMS CPC offers three continuing education opportunities to physicians, nurses and other health care professionals

- Palliative Care Education and Practice (PCEP)
- Practical Aspects of Palliative Care (PAPC)
- Palliative Care for Hospitalists and Intensivists (PCFHI).

Results

90 percent of program participants reported launching palliative care initiatives and attributed this success to their participation in PCEP.

Successful AIM Programs:
Education in Palliative and End-of-life Care (EPEC)

Background

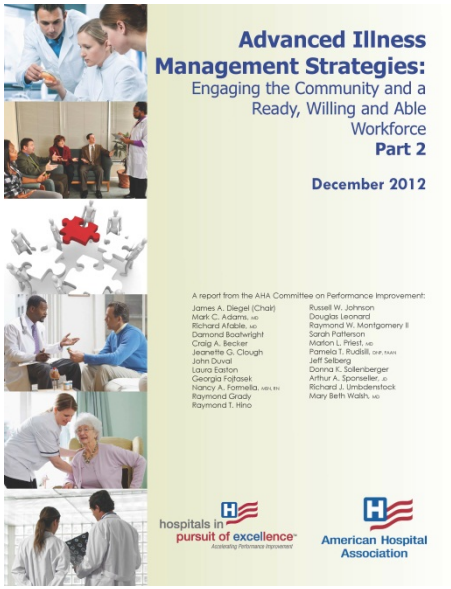
EPEC is a comprehensive training program aimed at educating physicians on the clinical competencies required to provide quality and compassionate care to patients facing the end of life

Based on adult education theory, EPEC uses interactive techniques and application of social science principles to change social expectations and behavioral norms. To disseminate its curriculum, EPEC uses the "train-the-trainer" approach to increase physician knowledge.

Results

- 90 percent of EPEC trainers were actively using its curriculum to teach others.
- It is estimated that from a sample of 184 initial trainers, they taught 120,000 other professionals.
- There are more than 2,000 trainers in the U.S. and 16 other countries, estimated to reach more than 1 million end-learners.

Resources to Improve AIM Programs and Services



AHA Resources

Hospitals in Pursuit of Excellence
Circle of Life

AHA Guides

Advanced Illness Management Strategies (Part I)
Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Challenges

Other Resources

Center to Advance Palliative Care
Coalition to Transform Advanced Care
Institute for Healthcare Improvement's Conversation Project
Joint Commission's Palliative Care Certification 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

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