

# Results of the Promoting Effective Advance Care Planning for Elders (PEACE) Randomized Pilot Study

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## Abstract

The specific aim of the PEACE pilot study was to determine the feasibility of a fully powered study to test the effectiveness of an in-home geriatrics/palliative care interdisciplinary care management intervention for improving measures of utilization, quality of care, and quality of life in enrollees of Ohio's community-based long-term care Medicaid waiver program, PASSPORT. This was a randomized pilot study ( $n=40$  intervention [IG],  $n=40$  usual care) involving new enrollees into PASSPORT who were  $>60$  years old. This was an in-home interdisciplinary chronic illness care management intervention by PASSPORT care managers collaborating with a hospital-based geriatrics/palliative care specialist team and the consumer's primary care physician. This pilot was not powered to test hypotheses; instead, it was hypothesis generating. Primary outcomes measured symptom control, mood, decision making, spirituality, and quality of life. Little difference was seen in primary outcomes; however, utilization favored the IG. At 12 months, the IG had fewer hospital visits (50% vs. 55%,  $P=0.65$ ) and fewer nursing facility admissions (22.5% vs. 32.5%,  $P=0.32$ ). Using hospital-based specialists interfacing with a community agency to provide a team-based approach to care of consumers with chronic illnesses was found to be feasible. Lack of change in symptom control or quality of life outcome measures may be related to the tools used, as these were validated in populations closer to the end of life. Data from this pilot study will be used to calculate the sample size needed for a fully powered trial. (*Population Health Management* 2014;17:106–111)

## Introduction

CHRONIC ILLNESSES CONSUME 95% of Medicare and 83% of Medicaid spending.<sup>1</sup> As the population ages, the percentage of the population with chronic illnesses is going to increase.<sup>2</sup> The US health care system, as currently structured, is not able to accommodate the needs of vast numbers of chronically ill patients, nor is it able to sustain the current level of spending.<sup>3</sup> For too long, the emphasis in chronic illness care has been on acute episodic care rather than a more balanced approach that includes prevention, symptom control, self-management support, care coordination, and collaborative community integration, with the consumer's goals driving care decisions. We now know that the lack of care coordination and poor communication of advance care wishes that characterize the current system lead to avoidable health care utilization and diminished quality of life.<sup>4,5</sup> Numerous dem-

onstration projects and research studies have attempted to improve care coordination; however, they have produced mixed results.<sup>6</sup>

This article reports the outcomes of the Promoting Effective Advance Care for Elders (PEACE) randomized pilot study.<sup>7</sup> PEACE was an in-home, interdisciplinary, evidence-based care management intervention delivered by Area Agency on Aging (AAA) care managers, who coordinate consumers' care with a health system-based geriatrics/palliative care interdisciplinary team and the consumer's primary care physician (PCP). PEACE targeted new dual eligible enrollees in Ohio's community-based, long-term care Medicaid waiver program, PASSPORT. The term dual eligible refers to those consumers who are eligible for both Medicare and Medicaid benefits. This intervention differs from the previous care management literature in that (1) the interventions are delivered in the home by community-based

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long-term care providers who are already familiar with the consumers, (2) the interventions are informed by recommendations from a combined geriatrics/palliative care interdisciplinary team from a neighboring acute care hospital that is part of an integrated health system, and (3) the interventions are carried out in collaboration with the consumer's PCP. An emphasis on symptom management, medication reconciliation, consumer activation for self-management, goal setting, and coaching for completion of advance care planning characterize the PEACE intervention.

The purpose of this report is to describe the feasibility and present the outcomes of the PEACE pilot study.

The theoretical framework for the PEACE study has been published previously.<sup>7</sup> Briefly, Wagner et al<sup>8</sup> theorize that optimal care for patients with chronic illness is not possible in a traditional health care system that focuses on acute illness care, because primary care providers have limited time to provide the necessary systematic assessments, preventive interventions, patient education, and psychosocial follow-up.<sup>9–12</sup> Furthermore, when patients transition from one care setting to another (eg, from the acute care hospital to ambulatory care), there is little or no communication between providers, creating confusion about the appropriate plan of care, as well as little emphasis on patient activation for self-care and consumer-directed goal setting. According to Wagner's model, improvement in the care of patients with chronic conditions can be brought about only when specific changes occur in the health care delivery system, including changes in organizational structure, establishing community linkages/partnerships, providing effective self-management support and activation, delivery system redesign, evidence-based decision support, and improved information systems. The PEACE study incorporates the elements of Wagner's model with a palliative care focus and application of geriatric medicine principles into a community-based, chronic illness management model.

## Methods

### *Inclusion criteria*

The study included all new PASSPORT enrollees >60 years old who passed a mental status screening (the Mental Status Questionnaire<sup>28</sup>) and had one of the following: congestive heart failure and being actively treated (American Heart Association stage C); chronic obstructive pulmonary disease and on home oxygen; diabetes with renal disease, neuropathy, visual problems, or coronary artery disease; end-stage liver disease or cirrhosis; cancer (active, not history of) except skin cancer; renal disease and actively receiving dialysis; amyotrophic lateral sclerosis with history of aspiration; Parkinson's disease stages 3 and 4; or pulmonary hypertension. These criteria were established by expert consensus and were chosen so that the intervention was targeted at those whose illness severity made it more likely that they would benefit from this geriatrics/palliative care intervention. Active alcoholics (ie, those who drink >2 drinks per day on average) and illegal substance users were excluded, as well as clients who have schizophrenia or are psychotic. These consumers were excluded because the authors' previous care management trials have shown that these other conditions tend to dominate the person's life and detract from their ability to participate in self-management

activities. Consumers who could not pass the Mental Status Questionnaire were excluded because the intervention relies heavily on chronic illness self-management and the ability of an individual to make decisions about advance care wishes. Consumers who were already enrolled in hospice also were excluded.

### *Intervention Group*

This study was approved by the Summa Health System Institutional Review Board. A more detailed description of the intervention was published previously.<sup>7</sup> Briefly, consumers were randomly assigned to specially trained PASSPORT care managers or to usual PASSPORT care. Within 3 weeks of enrollment into PASSPORT, consumers in the intervention group received the first of 2 in-home geriatric/palliative care biopsychosocial needs assessments. The PCP was informed by letter that his or her patient was in the study and asked whether the patient had few or many treatment options and whether the health care team was aware of the patient's wishes. This helped the team get a more realistic picture of the patient's medical status from the start. The second visit occurred within approximately 2 weeks of the first and concentrated on consumer goal setting.

Within approximately 2 weeks of the second home visit, there was an interdisciplinary team meeting to review the findings of the care manager's assessment. The core team included a hospice and palliative medicine specialist, a geriatrician, the PASSPORT care manager, a palliative care nurse specialist, a social worker, a spiritual advisor, and a pharmacist. Extended team members, who were consulted as needed, included physical and occupational therapists, a dietitian, a geriatric advanced practice nurse, and a psychologist. The team developed individualized, evidence-based care plans based on standardized protocols that were developed for this study and derived from an extensive literature review<sup>13</sup> that included the Assessing Care for Vulnerable Elders guidelines,<sup>14</sup> the National Consensus Project for Quality Palliative Care,<sup>15</sup> and the International Association of Hospice and Palliative Care Manual of Palliative Care.<sup>16</sup> A copy of this care plan was sent to the consumer's PCP.

The PASSPORT care manager discussed the care plan with the consumer and family, when available, to ensure it accurately reflected the consumer's goals. Once the consumer and family were in agreement, the PASSPORT care manager accompanied the consumer to a PCP visit solely intended to review the plan with the PCP, gain his or her buy-in, and provide "academic detailing."<sup>17</sup> PCPs were reimbursed as an incentive to participate with their patient in the trial.

Once the care plan was agreed upon by all, the PASSPORT care manager made another home visit to implement the plan and to teach, activate, and coach the consumer and/or caregiver. This visit included teaching disease and symptom management, identifying symptom management needs, developing an emergency response plan, addressing functional needs, teaching caregivers about disease/symptom management, assisting with access to community resources, referring to a counselor as needed for psychological support, assessing/assisting with spiritual needs, addressing unmet medical needs, reviewing medications, facilitating client/PCP/family communication and completing legal documents recognized

by the State of Ohio (ie, state Do Not Resuscitate and living will forms). The Physician Orders for Life-Sustaining Treatment (POLST) also was completed, although it is not legally binding in Ohio. The decision was made to include it, in a slightly modified form, because of its superior information content and value in guiding advance care planning discussions. It was included in the information consumers were asked to communicate to all health care providers. Consumers were provided with written self-management materials. Caregiver needs also were assessed, when appropriate, using informal, open-ended questions, and community supports were mobilized to meet identified needs. Consumers had access to either the care manager or a hospital-based team member 24 hours/day because acute exacerbations might otherwise prompt consumers to seek help in the emergency department.<sup>18</sup>

The PASSPORT care manager followed up with the consumer by phone as needed, but at least monthly, for 12 months to determine whether the goals of care had changed. If the consumer was re-hospitalized or if there was another inflection point in the trajectory of their chronic illness, the team assessment was updated and the goals of care were reevaluated.

### Usual care

Consumers randomized to usual care received usual PASSPORT care, which follows more of a psychosocial rather than a biopsychosocial model. A letter was sent to the PCP informing him or her that the consumer was enrolled in the study. Consumers also received mailed palliative care educational information every month in an attempt to mask group assignment.

### Outcomes

Outcomes recommended by the Outcomes Workgroup of the US Cancer Pain Relief Committee<sup>19</sup> were used for this pilot to promote ease of interpretation and aid in comparison of outcomes between studies. The intervention was expected to have a positive effect on these primary outcomes:

- 1) Symptom management (measured with the Memorial Symptom Assessment Scale)<sup>20</sup>
- 2) Quality of life (measured with the QUAL-E)<sup>21,22</sup>
- 3) Mood (measured with the Hospital Anxiety and Depression Scale)<sup>23</sup>
- 4) Decision making/care planning (measured with the Palliative Outcome Scale)<sup>24</sup>
- 5) Spirituality (measured with the Meaning in Life Scale)<sup>25</sup>

Health care utilization data also were collected from the AAA database. Outcomes were measured by a research nurse blinded to group assignment.

### Results

Forty consumers were randomized to the intervention group and 40 to usual care. Baseline characteristics of the PEACE population are shown in Tables 1 and 2. Chi-square was used to compare proportions and Student *t* test was used to compare means. No significant difference was found in baseline demographics (Table 1). The difference in completion of durable power of attorney approached significance in favor of the intervention group. Table 2 shows no differ-

TABLE 1. DEMOGRAPHICS

|   | Intervention Group | Control Group | P value |
|---|--------------------|---------------|---------|
| Females ( <i>n</i> )                          | 29                 | 31            | 0.60    |
| Age (mean)                                    | 69.5               | 68.8          | 0.67    |
| Mental status score (mean)                    | 0.87               | 0.82          | 0.80    |
| White ( <i>n</i> )                            | 34                 | 34            | 1.00    |
| Married ( <i>n</i> )                          | 6                  | 4             | 0.52    |
| Widowed ( <i>n</i> )                          | 15                 | 13            | 0.64    |
| Divorced ( <i>n</i> )                         | 9                  | 14            | 0.22    |
| DPOA ( <i>n</i> )                             | 31                 | 23            | 0.077   |
| Behavior classified as forgetful ( <i>n</i> ) | 15                 | 15            | 1.00    |

DPOA, durable power of attorney.

ence between groups in activities of daily living or instrumental activities of daily living at baseline.

Over the course of the year, there were 7 deaths in the intervention group and 7 deaths in the usual care group. The number of days from enrollment to death was slightly longer in the intervention group (189 days) compared to usual care (150 days) but the difference was not statistically significant. Mean differences and 95% confidence intervals for the primary outcomes at 6 and 12 months are shown in Table 3. As would be expected in a feasibility study, all confidence intervals included zero, indicating no significant difference between groups.

Table 4 shows the results of health care utilization at 12 months. There were fewer consumers with hospital visits and nursing facility placements in the intervention group.

### Discussion

The PEACE randomized pilot study has established the feasibility of a community-based interdisciplinary and

TABLE 2. BASELINE ADLs/IADLs

|                           | Intervention Group ( <i>n</i> ) | Control Group ( <i>n</i> ) | P value |
|---------------------------|---------------------------------|----------------------------|---------|
| Hands-on assistance with: |                                 |                            |         |
| Bathing                   | 36                              | 35                         | 0.72    |
| Dressing                  | 25                              | 22                         | 0.49    |
| Transfer                  | 36                              | 35                         | 0.72    |
| Transportation            | 19                              | 18                         | 0.82    |
| Shopping                  | 37                              | 38                         | 0.64    |
| Chores                    | 39                              | 39                         | 1.00    |
| Cleaning                  | 39                              | 39                         | 1.00    |
| Yard work                 | 39                              | 39                         | 1.00    |
| Laundry                   | 35                              | 39                         | 0.09    |
| Meal prep                 | 35                              | 32                         | 0.36    |
| Independent in:           |                                 |                            |         |
| Eating                    | 37                              | 36                         | 0.69    |
| Grooming                  | 32                              | 35                         | 0.36    |
| Bed mobility              | 35                              | 38                         | 0.23    |
| Toileting                 | 29                              | 32                         | 0.43    |
| Phone use                 | 37                              | 34                         | 0.28    |
| Requires supervision for: |                                 |                            |         |
| Locomotion                | 14                              | 8                          | 0.13    |

ADLs, activities of daily living; IADLs, instrumental activities of daily living.

TABLE 3. MAIN OUTCOME MEASURES

| Outcome measure                                | 6-month mean<br>difference between groups | 95% Confidence<br>interval | 12-month mean<br>difference between groups | 95% Confidence<br>interval |
|--|---|----------------------------|--|----------------------------|
| Condensed Memorial Symptom<br>Assessment Scale | -0.134                                    | (-0.439, 0.171)            | -0.328                                     | (-0.716, 0.061)            |
| Meaning in Life Scale                          | 0.369                                     | (-1.118, 1.856)            | 1.44                                       | (0.221, 3.1)               |
| Hospital Anxiety and Depression<br>Scale       | -2.919                                    | (-6.435, 0.598)            | -4.037                                     | (-8.584, 0.51)             |
| Anxiety  | -1.723                                    | (-3.769, 0.323)            | -1.926                                     | (-4.227, 0.375)            |
| Depression                                     | -1.196                                    | (-3.228, 0.836)            | -2.111                                     | (-4.697, 0.474)            |
| Palliative Care Outcome Scale                  | -2.844                                    | (-5.633, -0.055)           | -4.546                                     | (-7.853, -1.238)           |
| QUAL-E   | -4.052                                    | (-11.487, 3.382)           | -3.889                                     | (-10.722, 2.944)           |

QUAL-E, Quality at the End of Life Scale.

interagency care management intervention to improve advance illness care in low-income, community-dwelling consumers with chronic illnesses who meet the criteria for nursing home placement and are enrolled in a community-based, long-term care Medicaid waiver program. Although this pilot was not powered to detect statistically significant differences between groups, preliminary findings indicate a benefit of the intervention regarding acute hospitalizations and long-term nursing facility placement at 12 months.

This study has demonstrated the feasibility of the PEACE intervention with respect to the optimal staffing configuration, ability of care managers to implement the intervention, functionality of the team, the optimal timing and frequency of contacts with consumers, willingness of PCPs to participate and the ability to recruit, retain, and measure outcomes for these consumers. The appropriateness of the inclusion and exclusion criteria was confirmed as well as the expected mortality rate. Most important, the study established the ability of acute care and community-based providers to collaborate successfully.

Nonetheless, several issues were identified that will require revision in a larger randomized trial. For example, this pilot study used outcome measures from the domains recommended by the Outcomes Workgroup of the US Pain Relief Committee.<sup>26</sup> The authors felt that the use of reliable and valid palliative care measures was important to maximize the generalizability of the findings and to aid in comparison with other studies.<sup>27</sup> Furthermore, the authors felt that the comprehensive nature of the intervention required consideration of a broad range of outcomes (eg, quality of life, symptom control) in addition to more common measures (eg, anxiety). Thus, the Memorial Symptom Assess-

ment Scale, QUAL-E, Meaning in Life Scale, Palliative Outcome Scale, and the Hospital Anxiety and Depression Scale were measured. Feedback from care managers, patients, and families revealed that most of these tools were more appropriate for hospital-based practice and evaluation of palliative care and not for an earlier, home-based geriatric/palliative care intervention. As a result, the authors recommend that future studies focus on outcomes more reflective of the Triple Aim to achieve better care, better health, and lower cost (ie, medication appropriateness, health care utilization, patient activation, activities of daily living, and instrumental activities of daily living, hospice enrollment/place of death, consumer satisfaction, completion of the modified POLST, spirituality, anxiety, depression, and quality of life).

At the beginning of the study, when the AAA and members of the acute hospital team began meeting, there was fear that the added work of the study would overburden the care managers. Indeed, the care managers were supposed to have had their caseloads lightened during the study to accommodate the extra work. Unfortunately, this did not happen. Nonetheless, the care managers carried out their study responsibilities, though they had some difficulty in undertaking advance care planning discussions with the limited training they were provided. The authors believe that a better model would be to hire a single trained palliative care specialist care manager who could more easily assure that comprehensive assessments, consumer goal setting, and advance care planning all take place. A better model also would ensure that care managers are trained through a formal training model such as the Respecting Choices<sup>29</sup> certification course.

A formal cost-effectiveness analysis could not be undertaken because of the lack of access to the Medicare and Medicaid databases. Nonetheless, estimates of the financial costs versus benefits of the PEACE trial intervention can be derived from available data. The authors have proposed to build a better model for delivery of this intervention by hiring specially trained geriatrics/palliative care case managers. Each case manager could deliver the PEACE interventions for an estimated 100 consumers per year, or approximately \$75,000 in salary per 100 consumers (\$750/year/consumer or \$62.50/month/consumer). In addition, all interdisciplinary team members participated in semiweekly team meetings that lasted 2 hours. Calculating the approximate costs for all team members for 2 meetings per month

TABLE 4. HEALTH CARE UTILIZATION AT 12 MONTHS

|  | Utilization at 12 months |      |         |
|--|--------------------------|------|---------|
|  | UC                       | IG   | P value |
| % with ED visits                               | 25.0                     | 25.0 | 1.0     |
| % with hospital visit                          | 55                       | 50   | 0.65    |
| % with permanent nursing<br>facility placement | 32.5                     | 22.5 | 0.32    |
| % with hospice placement                       | 7.5                      | 7.5  | 1.0     |

ED, emergency department; IG, intervention group; UC, usual care group.



totals \$1600 per month (\$19,200/year) for 100 consumers (\$192/year/consumer or \$16/month/consumer). Thus, the total cost per consumer would be approximately \$942/year or \$78.50/month. Because investigators were not able to accurately record emergency department visits, days in the hospital, or days within a nursing facility (other than by reports from care managers), the estimates of health care costs must be based on these limited data. However, a 5% decrease in hospitalization and a 10% drop in nursing facility placements at 1 year were reported. An estimate of cost savings based on average cost data obtained from Summa Health System's database can be derived from these numbers. Specifically, if the average cost of a single hospital stay is \$10,300, assuming only 1 hospital stay per year per consumer, then hospital costs for each consumer would be expected to be \$10,300 per year. If the intervention reduces the number of hospitalizations by 5%, there would be a savings of \$51,500 per year in the intervention group ( $n=100$ ; \$515/consumer/year or \$42.92/consumer/month). Likewise, for costs of \$5500 per month to care for a consumer in a nursing facility (\$66,000/year), the 10% decrease seen in nursing facility placement in the intervention group would have resulted in a savings of \$55,000/month or \$660,000/year (\$550/consumer/month for 1 month in a nursing facility to \$6600/consumer/year for an entire year in a nursing facility). Thus, the overall cost of the intervention is estimated to be \$942/consumer/year or \$78.50/consumer/month and the overall savings are estimated to range from \$1065/consumer/year on average for 1 hospitalization and 1 month in a nursing facility to \$7115/consumer/year on average for 1 hospitalization and a 1-year stay in a nursing facility; there would be a difference in favor of the intervention ranging from \$123/consumer/year to \$6173/consumer/year.

A limitation of this study is the reliance on the AAA database for hospital admission and nursing facility admission data. The authors acknowledge that there may have been underreporting of hospital admissions because care managers relied on consumers' self-reports. However, the nursing facility admission data are completely accurate because nursing facility admission prompts initiation of discharge proceedings from the PASSPORT program.

Study changes suggested by this pilot will be incorporated into the authors' proposal for funding of a fully powered trial.

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### Author Disclosure Statement

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