Becoming a "Conversation Ready" Organization

Session 1: The Conversation Project

May 23, 2017

Today's presenters have nothing to disclose

Kate DeBartolo
Kelly McCutcheon Adams
Senior Project Manager

Angela G. Zambeaux, Senior Project Manager, Institute for Healthcare Improvement, has managed a wide variety of IHI projects, including a project funded by the US Department of Health and Human Services that partnered with the design and innovation consulting firm IDEO around shared decision-making and patient-centered outcomes research; the STAAR (StState Action to Reduce Avoidable Rehospitalizations) initiative; virtual programming for office practices; and in-depth quality and safety assessments for various hospitals and hospital systems. Prior to joining IHI, Ms. Zambeaux provided project management support to a small accounting firm and spent a year in France teaching English to elementary school students.
Faculty

Kate O. DeBartolo, National Field Manager, Institute for Healthcare Improvement (IHI), designs and executes the national field operations for IHI's hospital-based work and for The Conversation Project. She also manages and cultivates relationships with the statewide organizations that provide support to the hospitals across the country that are working to improve health care and patient safety. She built and manages a similar field structure to support the many different regions and communities working on The Conversation Project as part of their end-of-life care efforts. Ms. DeBartolo started at IHI in 2007 as the Eastern Region Field Coordinator for the 5 Million Lives Campaign. Prior to joining IHI, she worked as a grant analyst at the California Endowment.
Kelly McCutcheon Adams, LICSW has been a Director at the Institute for Healthcare Improvement since 2004. Her primary areas of work with IHI have been in Critical Care and End of Life Care. She is an experienced medical social worker with experience in emergency department, ICU, nursing home, sub-acute rehabilitation, and hospice settings. Ms. McCutcheon Adams served on the faculty of the U.S. Department of Health and Human Services Organ Donation and Transplantation Collaboratives and serves on the faculty of the Gift of Life Institute in Philadelphia. She has a B.A. in Political Science from Wellesley College and an MSW from Boston College.
Chat

What is your goal for participating in this webinar?
Today’s Agenda

- Ground Rules & Introductions
- *The Conversation Project: Reaching people where they live, work, and pray*
- Leaving in Action
Ground Rules

- We learn from one another – “All teach, all learn”
- Why reinvent the wheel? - Steal shamelessly
- This is a transparent learning environment
- All ideas/feedback are welcome and encouraged!
Webinar Series Objectives

At the conclusion of this webinar series, participants will be able to:

- Articulate the vision and mission of The Conversation Project and different ways to approach end-of-life care conversations.
- Describe strategies that have worked for pioneer organizations to engage patients and families in discussions to understand what matters most to them at the end-of-life.
- Explain ideas for reliably stewarding this information across the health care system, including strategies for working with electronic health records.
- Teach ways to engage communities that help to activate the public in having these conversations in advance of a potential medical crisis.
- Test methods to help staff engage in this work personally before exemplifying it for their patients.
- Describe changes to CMS reimbursement policies for advanced care planning conversations.
Schedule of Calls

Session 1 – The Conversation Project: Reaching people where they live, work, and pray
Date: Tuesday, May 23, 2017, 2:00 PM-3:00 PM Eastern Time

Session 2 – Engage: Moving from passive to proactive
Date: Tuesday, June 6, 2017, 2:00 PM-3:00 PM Eastern Time

Session 3 – Steward: Achieving the reliability of allergy information
Date: Tuesday, June 20, 2017, 2:00 PM-3:00 PM Eastern Time

Session 4 – Respect: Meeting people where they are as illness advances
Date: Tuesday, July 11, 2016, 2:00 PM-3:00 PM Eastern Time

Session 5 – The Exemplify Principle in Action/ Connecting In a Culturally Respectful Manner
Date: Tuesday, July 25, 2017, 2:00 PM-3:00 PM Eastern Time

Session 6 – CMS Reimbursement
Date: Tuesday, August 8, 2017, 2:00 PM-3:00 PM Eastern Time
A public engagement campaign dedicated to assure that everyone’s wishes for end-of-life care are expressed and respected.
TCP Founder Ellen Goodman
70% WANT TO DIE AT HOME.
70% ACTUALLY DIE IN THE HOSPITAL
80\% WANT TO TALK WITH THEIR DOCTORS.
17% have had a conversation with their doctors.
HAVE HAD A CONVERSATION WITH THEIR DOCTORS
THINK IT’S IMPORTANT TO HAVE THESE CONVERSATIONS
30%

HAVE ACTUALLY DONE SO
The Conversation Continuum

End of Life Wishes

Healthy
Living with Chronic Illness
Approaching End of Life

Expressed
Spoken
Documented

Respected
Accessed
Implemented
Awareness: Media Engagement
Accessible: Our Tools

- Conversation Starter Kit (translations + EMR summary)
- How to Talk to Your Doctor Starter Kit
- Starter Kit for Parents of Seriously Ill Children
- Starter Kit for Families and Loved Ones of People with Alzheimer’s Disease or Other Forms of Dementia
- Starter Kit for identifying and being a good proxy
The Starter Kit

Step 2 Get Set

What’s most important to you as you think about how you want to live at the end of your life? What do you value most? Thinking about this will help you get ready to have the conversation.

❓ Now finish this sentence: What matters to me at the end of life is...
(For example, being able to recognize my children; being in the hospital with excellent nursing care; being able to say goodbye to the ones I love.)
peaceful with God

quick joyful

calm quiet tranquil

natural surrounded by friends and family

comfortable a good story full of love
easy for my family

happy laughter

painless

dignified celebrated

at home

graceful

filled with music

respect celebration
The Starter Kit: Get Set

WHERE I STAND SCALES
Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

As a patient, I’d like to know...

1. Only the basics about my condition and my treatment
2.  
3.  
4. All the details about my condition and my treatment

As doctors treat me, I would like...

1. My doctors to do what they think is best
2.  
3.  
4. To have a say in every decision

If I had a terminal illness, I would prefer to...

1. Not know how quickly it is progressing
2.  
3.  
4. Know my doctors best estimation for how long I have to live
5.  
The Starter Kit: Get Set

Look at your answers.
What kind of role do you want to have in the decision-making process?
The Starter Kit: Get Set

How long do you want to receive medical care?

- **1** Indefinitely, no matter how uncomfortable treatments are
- **2**
- **3**
- **4** Quality of life is more important to me than quantity
- **5**

What are your concerns about treatment?

- **1** I’m worried that I won’t get enough care
- **2**
- **3**
- **4** I’m worried that I’ll get overly aggressive care
- **5**
The Starter Kit: Go

MARK ALL THAT APPLY:

❓ WHO do you want to talk to?
- □ Mom
- □ Dad
- □ Child/Children
- □ Partner/Spouse
- □ Sister/Brother
- □ Faith leader (Minister, Priest, Rabbi, Imam, etc.)
- □ Friend
- □ Doctor
- □ Caregiver
- □ Other: __________

❓ WHEN would be a good time to talk?
- □ The next holiday
- □ Before my child goes to college
- □ Before my next trip
- □ Before I get sick again
- □ Before the baby arrives
- □ The next time I visit my parents/adult children
- □ At the next family gathering
- □ Other: __________
When to Have “The Conversation”

- **Early**
  - Coming of Age – 18 & 21

- **Often**
  - Before a Medical Crisis – 30, 40, 50, 60, 70

- **Major Life Event**
  - College, Marriage, Children, Divorce, Medicare, Death in the Family

- **Major Trip**

- **Newly Diagnosed with a Serious Illness**
How to Start

Here are some ways you could break the ice:

“\(\text{I need your help with something.}\)”

“\(\text{Remember how someone in the family died—was it a ‘good’ death or a ‘hard’ death? How will yours be different?}\)”

“\(\text{I was thinking about what happened to } \underline{\text{person}}\text{, and it made me realize...}\)”

“\(\text{Even though I’m okay right now, I’m worried that } \underline{\text{person}}\text{, and I want to be prepared.}\)”

“I need to think about the future. Will you help me?”

“I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I’m wondering what your answers would be.”
The Starter Kit: Go

- Health Care Planning (HCP)
- Advance Directive (AD)
- Health Care Proxy
- Living Will
- MOLST/POLST
A Few Tips

- Give current answers
- Ask if this person will/can honor your wishes
- Share your wishes with more than one person
- Have two-way conversations
- Home is not always feasible. Learn more.
- This doesn’t have to be serious, but be wary of whole enchiladas and plug pulling
- Beware of family/caregiver “bullying”
- Opportunity to strengthen relationships - “It’s ok if you can’t honor this”
Community Efforts
What We’re Seeing

Live
- Local leaders promoting TCP (retirees!)
- Presentations (invited and hosted)
- Train the trainer

Work
- Health care organizations
- General employers – mailings, brown bag lunches, HR process

Pray
- Shared sermons and materials – guest preaching
- Hosted events at houses of worship
- Integration of TCP into pastoral care and seminary education
- Collaboration with regional interfaith organizations
- Conversation Sabbath
Possible Community Partners

- Assisted Living Facilities
- City Employee Retirement System
- Dept. of Public Health, Mental Health, Behavioral Health
- **Elected Officials**
- EMT providers
- Estate/Legal entities (elder law, local bar association…)
- Employers
- Faith-based organizations, clergy, chaplains ministerial associations
- **Financial community** (banks, CPA firms, financial advisors)
- Health plans/insurers
- Home care/VNA
- Retirement communities and home owners associations
- Homeless shelter/services
- **Hospice**
- Hospitals/Health systems
- Local resources: **libraries**, Chamber of Commerce, Lion/Rotary/Elks Club…
- **Media channels** (local, state, regional)
- Medical/Nursing/Hospital Association
- Nursing homes, rehab facilities, long term care
- Physician office practices/primary care
- **Prisons/jails**
- School District – employee benefits, Parent Teacher Organizations
- Senior Advocacy Organizations/Elder Services (Area Agency on Aging, senior center, transportation services, meals on wheels)
- Universities – students, faculty, alumni
- Veterans Services
The Conversation Continuum

End of Life Wishes

- Healthy
- Living with Chronic Illness
- Approaching End of Life

Expressed
- Spoken
- Documented

Respected
- Accessed
- Implemented
Conversation Ready Principles

1. **Engage** with our patients and families to understand what matters most to them at the end of life
2. **Steward** this information as reliably as we do allergy information
3. **Respect** people’s wishes for care at the end of life by partnering to develop shared goals of care
4. **Exemplify** this work in our own lives so that we understand the benefits and challenges
5. **Connect** in a manner that is culturally and individually respectful of each patient

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**the conversation project**
Identify Your Target Population: Death Chart Review

- Learn about your system and define your population
- Focus on “low hanging fruit” first
  - Patients who are DNR without a MOLST
  - Patients over 85 who had 3+ admissions in the last 90 days
  - Any patient newly diagnosed COPD
  - “Would you be surprised if this patient died in the next six months?”
- Align yourself with work already underway
Engage: proactive
Steward: The Allergy Analogy
Respect: Like Birth Plans
Exemplify: Follow Me
Connect: Culture Matters
Leaving in Action

- Download the Conversation Starter Kit and go through it.
- Share it with a loved one or a colleague
- Request for volunteers to share learning at start of next session
Session 2

Engage: Moving from passive to proactive

Kate Lally, MD, FACP
Chief of Palliative Care at Care New England Health System, Medical Director at Integra Accountable Care Organization and Hospice Medical Director of Care New England VNA Hospice

Lauge Sokol-Hessner, MD
Hospitalist and the Associate Director of Inpatient Quality at Beth Israel Deaconess Medical Center (BIDMC)

Tuesday, June 6, 2017, 2:00 PM ET