Becoming a “Conversation Ready” Organization

Session 2: Engage: Moving from passive to proactive

Kate Lally, MD, FACP
Lauge Sokol-Hessner, MD
Kelly McCutcheon Adams, LICSW
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 (STate 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.
Today’s Agenda

- Introductions
- Reflections on The Conversation Starter Kit
- Engage: moving from passive to proactive
- Leaving in Action
Kate Lally, MD, FACP, Chief of Palliative Care, Care New England Health System, also serves as Medical Director at Integra Accountable Care Organization and Hospice Medical Director of Care New England VNA Hospice. At Care New England, she developed a system-wide comprehensive, interdisciplinary palliative care program that has expanded from the hospital into the community. Dr. Lally spearheaded Care New England’s role as a Pioneer Sponsor in the Institute for Healthcare Improvement’s Conversation Ready initiative and helped integrate Conversation Ready principles into the health system’s palliative care program. She has served on the faculty of the IHI since 2013, and as a result has developed and led a number of on-line and in-person educational initiatives for both national and international audiences. As a result of her work, she has received numerous awards including “Top Doc” in RI monthly, Providence Business News “40 under 40” and was named an “Inspiring Hospice and Palliative Medicine Leader Under 40” by the American Academy of Hospice and Palliative Medicine. She is a graduate of Yale School of Medicine and did her post-graduate training in Internal Medicine at the Hospital of the University of Pennsylvania. She currently serves as an Assistant Professor of Medicine (Clinical) at the Warren Alpert Medical School of Brown University.
Laugue Sokol-Hessner, MD, is a hospitalist and the Associate Director of Inpatient Quality at Beth Israel Deaconess Medical Center (BIDMC) in Boston. He has worked in southern Africa on multiple occasions, completed medical school and residency at the University of Pennsylvania in Philadelphia, and worked as an attending physician at the University of Washington Medical Center in Seattle before joining BIDMC. On the wards, his work includes collaborating as a member of interdisciplinary teams of health care providers, coaching medical students and residents as they develop their communication skills, and caring for a broad variety of patients and their families. In his quality improvement role he leads several projects, including Conversation Ready at BIDMC.
Faculty

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 of the Gift of Life Institute in Philadelphia. She has a B.A. in Political Science from Wellesley College and an M.S.W. from Boston College.
What would you like to learn during today’s webinar?
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.
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
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, 2016, 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
Review of Session 1 Action

- What was your experience going through the Conversation Starter Kit like?
- What was sharing it with a loved one or colleague like?
The Engage Principle

Moving from passive to proactive
Agenda

- What does it mean to engage?
  - Retaining Hope vs. Reliability Health System.
- What are real world examples of what others are doing?
  - Two examples of health systems engaging with patients across the continuum
- Leaving in Action
The Tale of Two Health Systems

- Retaining Hope Health Care
- Reliability Health Care

- A look at the Engage principle
At Retaining Hope Health Care, conversations about wishes for end-of-life care are consistently pushed downstream, as no provider wants to be seen as “taking away hope”. Death is seen as the enemy and acceptance of its inevitability is not normalized in the provider and patient relationship. Discussions of end of life care wishes are separated out from discussions of smoking, weight, home safety, and blood pressure and often do not occur until Palliative Care is consulted for a patient in the intensive care unit who is receiving multiple high-level interventions and has been bouncing in and out of the hospital.
At Reliability Health Care, providers are proud of their integrated, person-centered approach to understanding what matters most to their patients. They normalize discussions of wishes for end of life care alongside many other important topics like smoking, weight, home safety, and blood pressure. They set the tone for this being an important aspect of life and follow-up on the topic throughout the life course of their patients. Patients cared for in this system see this engagement with their providers as a part of their responsibilities as adults – alongside naming guardians for their minor children and securing life insurance.
What does it mean to engage with our patients?

What does Reliability Health system get right?

- Doesn’t just link to end of life
- Asks multiple times over a period of years
- Normalize and link to routine health care
- Using an interdisciplinary team
Am I taking away hope? Does this patient trust me?

Emotions and Cognition

Do I trust this person? Does she recognize how this will affect my life?

Let’s talk about your illness

Words

What are my options?
New Palliative care program experienced explosive growth

About 70% were for goals of care

Needed a way to engage more patients with limited resources

RN very skilled in having goals of care conversation

- Re-labelled her “Conversation Nurse”
How the Conversation Nurse role took off

- Contacted directly by MDs to have goals of care conversations
- Now broad acceptance by providers and patients
- Hospital sees Palliative Care as a team based program
- Have expanded to three nurses
Our Conversation Nurse Orientation

- Shadow multiple members of the team for one month
- Think about things like body language, non-verbal communication, appropriate use of touch
- Review The Conversation Project starter kit
- Practice conversations with a team member observing
- Attend weekly team meetings where we all give feedback on how to do better (“All Teach, All Learn”)
- Undergo formal evaluation
Assessment tools

Assess the understanding of diagnosis and prognosis

_____ How are things going?
_____ What is your understanding of what has happened?
_____ What have the doctors told you about your condition?
_____ Tell me more…
_____ Can you explain what you mean?
_____ Can you tell me what you are worried about?
_____ You said you were worried about going home. Tell me more…

_____ Nurse clearly articulated the current status of the disease
    _____ Explained why the illness is advanced
    _____ Reviewed treatments that have been tried
    _____ Explained the probable course of the advanced illness
    _____ Clarified the treatment options as focus changed from cure to comfort and quality of remaining life

Goal: Therapeutic communication

_____ Nurse asked patient to articulate personal goals: What matters most?

Goal Setting/DNR Skills

_____ Nurse asked patient to articulate personal goals
_____ Nurse discussed the use of CPR within the context of the disease, and prognosis
_____ Nurse made a clear recommendation regarding CPR/no-CPR

Originally developed by the MCW Palliative Care Center; permission granted for use
Growth in Inpatient Palliative Care at Care New England
Moving “The Conversation” into the home

- Mr. F is an 85-year-old male with CHF and urinary retention related to prostate cancer requiring a monthly Foley change.
- Patient reports having a Living Will
  - Nurse never obtains a copy or asks what it says
  - No additional documentation regarding patient’s wishes
- January 2014 admitted to the hospital with respiratory distress. Found to have developed pneumonia.
- While in ICU family express concern about aggressive treatment
- 5 days later patient transferred to hospice facility where he died 2 days later
No one asked, “What matters to you?”

- 6 years of interactions with this patient
- Long term nursing relationship in the home
- Strong knowledge of patient and family
- Unique access to patient in a comfortable environment
What We Heard from Staff

- Feel it isn’t their job to ask
- Not comfortable having conversations about what matters
- Did not know where to document
- Did not know what to document
How to Change the Culture

- Document what you hear when you ask “What Matters to You”
  - Examples
    - I want to die at home
    - I want to see my sister before I die
    - I want to continue all treatment until it is clear that I cannot communicate with my family
Increased Documentation of Patient Goals

Percent of VNA Patients with Advance Directives

- April: 8%
- June: 18%
- July: 22%
- August: 25%
- September: 27.40%
- October: 26.40%
- November: 24.50%
- December: 20.57%
- January: 28.31%
- February: 28.60%
- March: 32.74%
- April: 38.10%
- May: 36.90%
Improving Transitions of Care

- Identify discharge disposition for all patients seen by inpatient Palliative Care

- Extending PC to Skilled Nursing Facilities
  - Developed partnerships with SNFs
  - Sending “Conversation Nurse” into SNF for ongoing goals of care conversations
  - APRN for symptom needs.

- Reducing readmissions
Decreased SNF Readmissions

Conversation nurse starts
Engaging with patients and the Conversation Nurse

- Now have nurses supporting our teams in the hospital, in the SNF, and in the home (through accountable care organization and VNA).
- Allows for conversations at different points in time
- Doesn’t need to be a nurse, but nursing assessment and symptom assessment have been very helpful in how we have built this model
Questions?
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- **Ambulatory**
  - Increasing the % of patients with a health care proxy

- **Inpatient**
  - Reframing the way we think about code status on admission to the hospital: pivoting to an “advance care planning assessment”
Surrogate decision makers

- It’s important that patients choose a surrogate decision maker *before* they get sick
  - Creates an opportunity for a patient-surrogate conversation
  - 50% of hospitalized adults 65 and older, require some form of surrogate decision making within 48hrs of admission*
  - Can prevent guardianship proceedings

- Massachusetts – health care agent/proxy
- Florida – durable power of attorney for health care

*Torke et al., JAMA Intern Med 2014*
The goal and the process

- BIDMC primary care clinic baseline
  - 39% of patients had chosen a Proxy
- Goal: create a sustainable process to reliably address health care proxies with every patient who comes in for a routine office visit
- Multidisciplinary team from the beginning
- Six week pilot, one doctor, Plan-Do-Study-Adjust cycles
- Trained medical assistants and clinical administrative assistants: how to discuss, complete, and manage proxies
- Weekly data review and coaching to celebrate successes and capitalize on opportunities for improvement
Process details

- MA = Medical Assistant
- CAA = Clinical Administrative Assistant (at checkout desk)

Chart showing minutes +/- standard deviation for different parts of the visit process:
- Total MA time
- MA time on proxy
- Patient time on proxy
- Patient time checking out
- CAA time on proxy with patient
- CAA time on proxy without patient

Legend:
- Blue: Proxy is not part of visit
- Green: Proxy is part of visit
% of patients needing a Health Care Proxy to be completed who leave clinic having done so

Baseline | 1-provider pilot | Suite-wide ramp-up | Maintenance phase

- North Suite
- Mean
- Upper control limit
- Lower control limit
- Other HCA Suites

Average weekly volume in HCA north suite is ~230 patients. On average ~144 need a Proxy, so a 20% rate is ~29 new Proxy forms/week
Beth Israel Deaconess Medical Center

Between Aug 2014 – May 2017 >8000 proxies were completed

% of patients leaving clinic having chosen a proxy

North
South
Central
Atrium

Between Jul 2014 and Jun 2017, >8000 proxies were completed.
Beth Israel Deaconess Medical Center

- Ambulatory
  - Increasing the % of patients with a health care proxy

- Inpatient
  - Reframing the way we think about code status on admission to the hospital: pivoting to an “advance care planning assessment”
Code status discussions on admission

- Brief
- Lack elements of informed consent
- Imply a decision must be made immediately
  - “If your heart stops, do you want us to…”
- Perceptions of what was discussed vary between patients/families and physicians
- Often lack any assessment of prior advance care planning, and are done without an understanding of the current medical situation

Jesus et al., Mayo Clin Proc 2013
Anderson et al., JGIM 2011
Chittenden et al., JHM 2006

Heyland et al., BMJ Qual Saf 2016
Deep et al., Patient Educ Counsel 2008
Breu and Herzig, JHM 2014

Binder et al., JHM 2016
Burns and Truog, NEJM 2016
Teaching inpatient doctors how to Engage

Reframing how we think about code status on admission

- Background and rationale
  - Stories and data about code status conversations
  - Data about resuscitation outcomes in our hospital
- New approach – advance care planning assessment
- Video examples with patient-family advisors
- Small group case-based role play, facilitated by hospitalist attendings
Advance care planning assessment

1. Consider the patient’s **trajectory**
2. Screen for advance care planning
   - Look in the electronic medical record for advance care planning info
   - Ask about a health care proxy
   - Ask about other prior advance care planning: “Have you ever thought about the kind of care you would want if you got very sick some day?”
   - Take care with your **words**, respond to **emotion**, promote **cognition**
3. Stop and synthesize – consider the concept of **co-production**
4. Identify next steps…
   - No further conversation
   - Conversation later
   - Conversation now
5. Document in note template and with code status order
Feedback

One thing you learned:
- “Where to find advance care planning information in the electronic medical record”
- “How to ask about prior advance care planning”
- “This is a process”

One thing you’ll teach others:
- “Always ask about a health care proxy on admission”
- “How to broach code status in a respectful, patient-centered way”
- “How to document what is learned when asking about prior advance care planning”
Summary

- There are many barriers to engaging with our patients about what matters most to them.
- Different health systems are using different processes to engage with patients at different stages of their lives.
- Use the interdisciplinary team.

- We need to…
  - Work on our words
  - Learn how to recognize and respond to emotion
  - Treat advance care planning as the process that it is
Leaving in Action: Part 1 for June 20

Review the charts of the last 20 patients* who died in your setting. As you review the charts, note evidence of the following:

- Advance directive documents are accessible and can be understood by the care team (i.e., not just a “Yes/No” notation that the patient has an advance directive);
- Documentation of provider and patient conversation(s) — or conversation(s) with a surrogate decision maker, if the patient is not able to participate — about “What matters?” to the patient regarding end-of-life care wishes;
- Location of death;
- Whether patient received life-sustaining treatment;
- A few details about the patient’s medical history and situation immediately prior to death; and
- The presence of indicators about whether the care the patient received was aligned with their documented end-of-life care wishes.

Consider including representatives from the involved clinical services in the review, to understand their perspectives on the care provided and to engage them in the work.

* We recommend 20 for a fuller picture of your system but if that is a stopper, then do 10.
Leaving in Action: Part 1 continued

For each patient chart attribute reviewed, quantify what you learned from this review. For example, for the 20 patient charts reviewed:

- 85 percent of charts reviewed had documented surrogate decision maker
- 65 percent of charts reviewed had accessible advance directive
- 50 percent of charts reviewed had documented provider and patient discussions about end-of-life care wishes

Of the patients for whom there was documentation of directive/end-of-life care wishes:

- 50 percent had indicators that the care received was consistent with the patient’s end-of-life care wishes
- 30 percent had indicators that the care received was not consistent with the patient’s end-of-life care wishes
- 20 percent did not have enough information to indicate either way
Part 2: for the July 11 session:

Briefly document two stories gleaning from the review that illustrate current end-of-life care processes (to help build will among colleagues and create a clearer picture of reasons to engage in work).

For example:

- Mr. S had a note in his patient chart that an advance directive existed, but it was not accessible in the patient chart. There was no documentation of discussions with providers about end-of-life care goals, and the care team was not able to determine alignment of care goals and Mr. S’s end-of-life care wishes.
- Ms. W had an accessible advance directive and detailed notes about end-of-life care goals in her patient record, and she was transferred to an inpatient hospice unit in apparent alignment with her wishes.

Information from the review can be used to guide team conversations about setting an aim, selecting a subpopulation, and identifying the best location for pilot testing. Additionally, this information can help build will when discussing work with colleagues.
Session 3

Steward: Achieving the reliability of allergy information

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

Please let us know if you have any questions or feedback following today’s webinar.
Eligibility for Nursing CEU requires submission of an evaluation survey for each participant requesting continuing education:

https://www.surveymonkey.com/r/TCP060617

- Share this link with all of your participants if viewing today’s webinar as a group *(Survey closes June 16)*
- Be sure to include your contact information and Florida nursing license number
- FHA will report 1.0 credit hour to CE Broker and a certificate will be sent via e-mail (Please allow at least 2 weeks after the survey closes)