Becoming a “Conversation Ready” Organization

Session 3 – Steward: Achieving the reliability of allergy information

Laure Sokol-Hessner, MD
Kelly McCutcheon Adams, MSW, LICSW
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.
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 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.
Lauge 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.
Today’s Agenda

- Introductions
- Debrief Session 3 Suggested Action
- Steward: Achieving the reliability of allergy information
- Leaving in Action
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, 2017, 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
The Steward Principle

Achieving the reliability of allergy information

Lauge Sokol-Hessner, MD
Suggested Action (spans sessions 3 and 4)

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.
For today:

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
What we learned…

• How many charts did you review?
• What percent had a…
  • Documented surrogate decision maker?
  • Accessible advance directive ?
  • Documented provider and patient discussions about end-of-life care wishes?

• Important to identify and navigate around barriers to data collection
Agenda

- What does it mean to steward?
  - Retaining Hope vs. Reliability Health System
- Explore the process of advance care planning for an individual patient
- Describe the vision of population health management
- Consider the systems needed to do this work reliably
  - Examples of what others are doing
- Leaving in Action
The Tale of Two Health Systems

- Retaining Hope Health Care
- Reliability Health Care

- A look at the Steward principle
Retaining Hope Health Care

At Retaining Hope Health Care, fragmented and unreliable processes and systems cause information about advance directives and conversations about wishes for end of life care to be scattered among patient records and inaccessible across time and boundaries. When asked about documentation of wishes, patients say that they gave a copy to their doctor or have them locked up in a safe deposit box. Although providers have high reliability in tracking patient allergies, the same cannot be said of end of life care wishes.
At Reliability Health Care, information about patients’ wishes for end of life care are inquired about, tracked, and confirmed as reliably as allergy information. An integrated information system makes information about both relevant documents and critical conversations with providers easily accessible in a timely way and across boundaries of care. Just as allergy information should not be hidden in safe deposit boxes, patients understand that their wishes are an important driver of their care plans.
Definitions

Steward: Treat information about each patient’s end-of-life care wishes as reliably as we do allergy information

Reliable: consistently good in quality or performance; able to be trusted
Advance care planning as a process

Patient establishes care

Provider A
- Usually outpatient
- Forms a relationship
- **Reach and Record:**
  - Health care proxy
  - Conversations
  - MOLST

Serious illness
- Organ failure
- Terminal illness
- Frailty

Nears the end of life

Provider B
- Often inpatient
- Often no preceding relationship
- **Retrieve** data to help ensure care is congruent with wishes → **Respect**

Active dying

Death

Allergy analogy

Towards population health management

- Consensus about “serious illness”
  - Clinician gestalt – “surprise question”
  - Specific disease criteria
  - Mortality models – eprognosis.ucsf.edu
    - Levine and Gagne scores

- Specific aspects of advance care planning
  - Legally authorized surrogate decision maker
  - Conversations about:
    - Illness, prognosis
    - Full range of options
    - “What matters most”
  - Appropriate use of POLST/MOLST

- Tracking, measuring, reflecting
Pause

Questions? Comments?
Build systems that can Steward for one patient while supporting population-level reliability

- Consider the end users
  - Go to “gemba” and ask…
    - “what is their workflow?”
    - “what data do they find helpful?”

- Collect the data into a single source of truth
  - Consider the types of data and how they are collected
    - E.g. names and phone numbers, scanned PDFs, conversations

- Manage the collected data
  - Version control

- Use the collected data
  - Measure and learn
# Rule of 5s

<table>
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<th>Change Areas</th>
<th>5</th>
<th>25</th>
<th>125</th>
<th>625</th>
<th>3125</th>
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<tbody>
<tr>
<td>Asking about a surrogate decision maker</td>
<td>Physician asks at primary care visit</td>
<td>RN asks during vital signs</td>
<td>MA asks during rooming</td>
<td>Patients enter information through portal</td>
<td>???</td>
</tr>
<tr>
<td>Conversations about “what matters most”</td>
<td>Pen and paper</td>
<td>Standardized form</td>
<td>EHR note</td>
<td>EHR template</td>
<td>???</td>
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<td>POLST/MOLST forms</td>
<td>Photocopy in paper chart</td>
<td>Practice administrator scans</td>
<td>Medical records department scans</td>
<td>Managed registry with multiple inputs</td>
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### Health Care Proxy

- **Verified on date:** 03/01/17
- **Health care proxy chosen:** Yes
- **Name of health care proxy:** Miss Piggy
- **Relationship:** significant other
- **Phone number:** 617-555-1234
- **Cell phone:** 617-555-9876
- **Proxy form in chart:** BIDMC

#### Supporting Documents

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<tr>
<td>04/02/14</td>
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<td>Health care proxy</td>
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**Comment:** no longer valid

### Other Advance Health Care Directives

- **Verified on:** 05/19/15
- **Are Other Advance Health Care Directives on file:** No
- **Have Other Advanced Health Care Directives been discussed with patient and/or proxy:** No
- **Reason not discussed:** Patient disoriented;
  **Comments:** comment goes here.

#### Scanned Data

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<tbody>
<tr>
<td>01/30/14</td>
<td>01/30/14</td>
<td>Living Will</td>
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### MOLST

- **Verified on:** 05/19/15
- **Is MOLST on file:** Yes
- **Location:** Hem-Cnc Chart;
- **Comments:** testing

No relevant scanned data on file

### OMR Notes

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<th>Author</th>
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<td>LAUGE SOKOL-HESSNER</td>
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<tr>
<td>12/12/14</td>
<td>Goals of care conversation</td>
<td>JULIE ROCKWELL</td>
</tr>
<tr>
<td>10/21/14</td>
<td>Basic advance care planning preferences</td>
<td>JOHN SMITH</td>
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Virginia Mason Medical Center’s Electronic Medical Record
Epic

Patient and I discussed Health Care Proxy and Living Will forms today.
Reports from the Conversation Ready Community

“The IHI Project was a great stimulus for us. Our main inpatient successes were... getting advance directives prominently available on our EMR, getting information about them earlier and more accurately in the admission process, improving access by having them scanned in daily (we purchased scanners for the unit clerks on every floor)”

- Erie County Medical Center, Buffalo, NY

“Chart reviews revealed wrong documents being placed in EMR advance directive file... and current AD forms were not user friendly so are being revised... also difficult to access advance directives in the EMR, so changed menu to include them and moved them to ‘prime real estate’ on a summary page for greater visibility/accessibility.”

– Winter Park Memorial Hospital, FL
Reports from the Conversation Ready Community

“Our Conversation Ready team has continued to meet monthly and is going strong… [We are getting] new scanning software with our EMR to make it easier to find the AD and POLST forms”

– St. Jude Medical Center, Fullerton, CA

“We continue to struggle with ease of documentation of these discussions in a single repository where all regional health care providers can access these. Our system is making a move to Epic as our EMR in the next 2 years so we will be aggressively planning to improve that with this change.”

– St. Charles Health System, Bend, OR
Reports from the Conversation Ready Community

“The IT working group developed EPIC AD scanning capability throughout the hospital… This initiative gave unit secretaries the ability to scan in existing AD and access previously obtained AD… We are transitioning over the next year to EPIC as the EMR for all Penn care. The CR initiatives… helped drive the EPIC chart builds that allowed us to develop a ‘goals’ tab that supports any member of the team to enter information regarding their goals conversations, ease of access to existing AD and review of these discussions and changes throughout various points of care delivery…. we are [also] testing an Advance Directive electronic platform to capture goals and push completed forms to identified emails such as the identified representative and with our goal to place directly in the Penn chart new EMR.”– University of Pennsylvania, Philadelphia, PA
What about sharing data outside your system?

- A universal problem
- How do you do it for other types of medical information?
  - Discharge summaries, medication lists, etc.
  - Leverage existing systems and consider a conversation when it’s complex
- Healthcare information exchange
  - Creating standards for data collection and sharing
  - [https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie](https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie)
- Registries
  - For example: [http://www.orpolstregistry.org/](http://www.orpolstregistry.org/)
Lessons learned

- It’s really important to get this part right – it is a critical foundation for this work
- There often isn’t a fast solution, and you’ll need to make adjustments as you scale
- Consider who you need to engage in this work
Action Period Assignment (spans sessions 3 and 4)

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To share for session July 11:

Briefly document two stories gleaned 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 4

Respect: Meeting people where they are as illness advances

Kate Lally, MD, FACP
Director of Palliative Care at Care New England Health System
and 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, July 11, 2-3 PM Eastern
Thank You!

Please let us know if you have any questions or feedback following today’s Expedition webinar.
Eligibility for Nursing CEU requires submission of an evaluation survey for each participant requesting continuing education:
https://www.surveymonkey.com/r/TCP062017

Share this link with all of your participants if viewing today’s webinar as a group (Survey closes June 30)

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)