Are you Conversation Ready?

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Patricia A. Vida, RN, MBA, Continuing Care Service Director, Kaiser Foundation Health Plan
Donna Smith, MD, Medical Director, Virginia Mason Medical Center

December 9, 2014
1:30-2:45pm

Disclosures/Information

- Kelly McCutcheon Adams is an employee of the Institute for Healthcare Improvement.
- Donna Smith serves as Conversation Ready faculty at IHI.
- Patricia Vida has nothing to disclose.
Session Objectives

- Identify the principles and key changes of being "Conversation Ready"
- Utilize testable ideas in their own environment to become more Conversation Ready

Welcome

“Unfortunately, the evidence demonstrates that even if one completes an advance directive or has a discussion on the subject with family and loved ones, it tends to be separated from the time of dying by months, years, or even decades. Most people envision their own death as a peaceful and an ideally rapid transition. But with the exception of accidents or trauma or of a few illnesses that almost invariably result in death weeks or months after diagnosis, death comes at the end of a chronic illness or the frailty accompanying old age. Few people really have the opportunity to know when their death will occur.”
Changing Culture

“The new hope is that we can change the culture to treat the patients as they wish to be treated rather than treating them because we can.”

-Billie Kester, Reid Hospital, Indiana, Conversation Ready Health Care Community Member

How did The Conversation Project lead to Conversation Ready?
The Conversation Project

A national public engagement campaign dedicated to assure that everyone’s wishes for end-of-life care are: *Expressed* and *Respected*.

TCP: Tools
Available at theconversationproject.org

- Conversation Starter Kit
- How to Talk to Your Doctor Kit
- Conversation Group Coaches Guide
TCP tools: The newest kid on the block

Conversation Ready

- In order to achieve the aim of The Conversation Project, health care systems must be prepared to receive an activated public and respect end-of-life wishes.
- IHI is working with leading health care organizations in the US and internationally to ensure the health care delivery system is prepared to receive, record, and respect patients’ wishes.
- Two years ago, a group of Pioneer Sponsor organizations collaborated with IHI to create and test the Conversation Ready principles for use in their own systems and for possible adoption elsewhere. Then, over this past year, 22 organizations joined together (including 7 Pioneer Sponsors) for the Conversation Ready Health Care Community, an innovation collaborative to further develop the change package and measurement strategy.
Conversation Ready Pioneer Sponsors

- Beth Israel Deaconess Medical Center (Massachusetts)
- Care New England Health System (Rhode Island)
- Contra Costa Regional Medical Center (California)
- Henry Ford Health System (Michigan)
- Mercy Health (Ohio)
- North Shore–Long Island Jewish Health System (New York)
- St Charles Health System (Oregon)
- UPMC (Pennsylvania)
- Virginia Mason Medical Center (Washington)

Contributing Sponsor: Gundersen Lutheran

Conversation Ready Health Care Community Members

- Beth Israel Deaconess Medical Center
- Care New England
- Elder Services of Merrimack Valley
- Erie County Medical Center
- Geisinger Health System
- Henry Ford Health System
- Kaiser Permanente San Jose Medical Center
- Knoxville Academy of Medicine
- Mercy Hospital
- Mohawk Valley Health System
- North Shore LIJ Health System
- Penn Medicine
- Reid Hospital
- Renown Health
- Scottish Government Health Department
- St Charles Health System
- St Jude Medical Center
- St Peter’s Health Partners/Ellis Medicine
- The University of Kansas Hospital
- Vidant Health
- Virginia Mason Medical Center
- Winter Park Memorial Hospital
Conversation Ready Principles and the Change Package

Current 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
Engage

Steward: The allergy analogy
Respect

Similar to Birth Plans

• Patient birth plan is important and encouraged
• Women are strongly encouraged to consider what they want their delivery to be like
• Birth plan may be altered if there are medical issues

Exemplify
Connect:
Faith Leader & Community Outreach

- Panel - “Final Goodbyes: Death & Dying Across Faith Traditions” (June 5, 2014)
- Advance Care Planning Facilitator Workshop “Respecting Choices” – “It’s about the conversation, not the form” (ongoing)
- “Advance Care Planning for Faith Leaders: Preparing to Care for Those with Chronic and Terminal Illness” (October 31, 2014)

"Death and Dying is an area of clinical practice that can benefit from more educational opportunities such as this conference... Our world presents a beautiful melting pot of faith traditions which experience the universal reality of death. Honoring and accepting differences is the ultimate form of non-judgmental caring.”
- Participant at “Final Goodbyes”

LIFE CARE planning
my values, my choices, my care

Conversation Ready
Kaiser Permanente San Jose Medical Center
San Jose, California

December 9, 2014 IHI Forum
Our Team

Ruma Kumar, MD
Denise Johnson, RN, MBA
Pat Vida, RN, MBA
Carol Moreali, RN
Jane Coppola, RN, MHA
Deborah Malone, LCSW
Annette Brennan, RN
Joanne Acorda, RN, BSN
Karin Belloumini, LCSW
Ginger Drapchaty, RN
Roxana Vanderlei, MSW
Kelly Mendall, MSW
Tanya Hebert, RHIT
Marhsanell Wright, RN, MSN

Key Milestones

1. Process mapped workflows in the Inpatient Palliative Care Department (IPPC) to invite and engage patients in sub population who need a life care planning conversation.

2. Added Life Care Planning (LCP) order to the Home Health referral for patients in subpopulation discharged from the hospital.

3. Tested sending copy of completed POLST form to Health Information Management prior to patient discharge to facilitate earlier scanning into electronic medical record.

Challenges: Scope of project across Continuum – Skilled Nursing Facility (SNF), Home Health (HH), and Hospital

Celebrating: Has become standard work. More members are engaging in “what matters” conversations.
The Story of our Data

• Goal met!
• Sustainability supported by strong workflows.
• Additional PI projects spawned within the Continuum.
Helping Peers

- Ensure support from executives and physicians and a strategy to incorporate the life care planning work into the culture of the institution.

- System wide, help providers understand the impact to patients and their families when they engage in thoughtful conversations about their values and wishes.

- Invite providers to experience the conversations with their family and loved ones to provide first-hand experience that can then be shared with patients.

- Stay focused on member stories to bring ongoing meaning and motivation to the work.

- Establish a system for easy retrieval of LCP documents which is essential to providing care concordant with the patient’s wishes.

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Life Care Planning: a population-based approach to advance care planning occurring over time

<table>
<thead>
<tr>
<th>Target Population</th>
<th>First Steps</th>
<th>Next Steps</th>
<th>Advanced Steps Planning</th>
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</table>
| All adults, initiated as a component of usual care via various pathways (e.g., new members, maternity, adult med, etc.) | Patients with chronic, progressive illnesses who have begun to experience:  
- A decline in functional status  
- Co-morbidities  
- More frequent hospitalizations & complications | Frail elderly and other individuals whose health status would make death within the next 12 months not surprising |

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| Individuals:  
- Learn more about the importance of advance care planning  
- Select a healthcare decision maker, and  
- Complete a basic written advance directive. | Patients and agents understand:  
- The progression of their illness  
- Potential complications, and  
- Specific life-sustaining treatments that may be required if their illness progresses and they are faced with a bad outcome. | Patients and agent:  
- Make specific, timely, life-sustaining treatment decisions that can be converted to medical orders |

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<tr>
<th>Document that results</th>
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<th>Advanced Steps Planning</th>
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<tbody>
<tr>
<td>Durable Power of Attorney and Advance Directive for Health Care</td>
<td>Statement of Treatment Preferences</td>
<td>POLST</td>
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A Closer Look at Life Care Planning

Ann, a 41 year-old mother in good health with little-to-no familiarity with ACP and no healthcare agent named. First Steps would introduce her to the concept of LCP and prompt her to name an agent who could speak for her in the case of an unlikely accident/trauma, etc.

Bill, a 64 year-old man with ESRD who has been on Dialysis for the last 5 years and is beginning to experience an increasing rate of complications and functional decline. Next Steps would elicit Bill's treatment preferences across a range of potential scenarios that could occur with his ESRD, and ensure his agent hears these preferences from him and can represent his wishes if he becomes unable to himself.

Baba, a 99-year-old Great-Grandmother living in skilled nursing facility. Although she is in good health, given her age, it would not be a surprise if she died within the next 12 months. Advanced Steps POLST Planning would ensure her acute life-sustaining treatment preferences are documented.

Conversation Ready

Donna Smith, MD
Virginia Mason Medical Center
Seattle, WA
CLASS: YOUR LIFE YOUR CHOICES

Electronic Medical Record: One Place=Advanced Directive Note
Advance Care Planning Packet

• What’s in it?
  – The Conversation Starter Kit
  – Conversation Project “1 pager”
  – DPOA form
  – Health Care Directive / Living Will form
  – POLST form
  – Brochure for Your Life/Your Choices class at Virginia Mason
  – SASE
Questions

Thank you

“I see three choices: to run, to spectate, to commit.”

Movie: City of Joy (1992)