Is Your Organization Conversation Ready?

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Disclosures

- Kelly McCutcheon Adams is an employee of the Institute for Healthcare Improvement.
- Lauge Sokol-Hessner is a contractor with the Institute for Healthcare Improvement.
- Becky Dobert today have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Objectives

1. Explain the five principles of being Conversation Ready
2. Develop a plan to test best practices and change ideas in their organizations or communities
3. Identify the resources available to help patients and families have “the conversation”
Ms. Jones asks her doctor how serious her abdominal cancer is, and he replies, “you’re not dying from it.” Soon after, she gets sick, is admitted, and is found to have a malignant bowel obstruction. She is told she needs emergency surgery or that she may die. Ms. Jones’ family requests to see the doctor, but he is unavailable. Instead, one of his colleagues reviews the patient’s medical record and speaks with the family. He says, “this cancer is not curable.” This is the first time Ms. Jones and her family have heard this. They are shocked and upset. Ms. Jones agrees to the surgery but suffers complications, never regains consciousness, and dies in the intensive care unit a few days later. Months pass and Ms. Jones’ family still thinks about this daily.
Taking a new perspective

- What was the problem?
  - Failure to share prognosis (a form of disrespect)

- What kind of harm(s) occurred?
  - Preventable guilt, lost opportunity to “say goodbye” → complicated grief → potential unwillingness to return
  - Non-physical harm (emotional, psychological, socio-behavioral)

- Disrespect → harm (especially non-physical)

Naming harms puts words to what we know is wrong

What is respect in the context of end-of-life care?

Components of optimal end-of-life care:
- symptom management
- psychosocial support
- help with transitions’ logistics
- bereavement support
- care that is congruent with patients’ goals, values, and preferences

Goal concordant care is respectful care, and is achieved through advance care planning (ACP)
What is advance care planning?

- “A process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care”
- Goal = the patient’s wishes are respected
- Benefits:
  - better quality of life
  - care that is more consistent with patient preferences
  - improved bereavement outcomes for family
  - a “strong preponderance of evidence shows no increased depression, anxiety, hopelessness.”
- ACP is recommended for all patients with serious illness

What are the components of advance care planning?

- Optimal process varies based on the patient & context. Often includes:
  - Identifying a surrogate medical decision-maker
  - Sharing difficult news (new diagnosis or serious prognosis)
  - Understanding “what matters most”
  - Discussing treatment options (including palliative care & hospice when appropriate)
  - Anticipating medical emergencies (including cardiac arrest, respiratory failure, etc.)
  - Communication & coordination among patient, family, and professionals
  - Shared decision-making (avoiding paternalism & unguided autonomy)

- This is complex! Where do we begin?

On Twitter in July 2017

Melissa Jo Peltier (@MelissaJPeltier) · 10h
So true. The palliative care doc who saw me & my Dad through his final days in hospice said, "Death isn't the enemy. Suffering is."

Joyce Carol Oates (@JoyceCarolOates)
Good to cheer on John McCain to "fight" cancer but please keep in mind that illness is not a sport & to be overcome is not to "lose."
Palliative Care Is Still Medical Treatment

John McCain didn’t stop treatment; he changed his goal toward dying comfortably.

By JEREMY SAMUEL FAUST  
AUG 24, 2018 • 6:13 PM
A public engagement campaign dedicated to assure that everyone’s wishes for end-of-life care are expressed and respected.
Our free tools are available: theconversationproject.org

- Conversation Starter Kit (translations)
- 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
- How to Choose a Health Care Proxy
Conversation Ready Principles

Exemplify → Connect → Engage → Steward → Respect
Conversation Ready Principles

1. **Exemplify** this work in our own lives so that we fully understand the benefits and challenges

2. **Connect** with patients and families in a culturally and individually respectful manner

3. **Engage** with our patients and families to understand what matters most to them at the end of life

4. **Steward** this information as reliably as we do allergy information

5. **Respect** people’s wishes for care at the end of life by partnering to develop a patient-centered plan of care
Exemplify: Walking the walk
Connect: Finding cultural humility
Engage:
Moving from reactive to proactive

Tar Wars®  ASK and ACT
A TOBACCO CESSATION PROGRAM
Engage: What Matters Most

Good things

Bad things

I ❤️ you so much
Today at 12:33 PM

I love ❤️ you so much that I would give you a thousand unicorns 🦄
Love Riordan
Steward: The Allergy Analogy
Respect: The real outcome
Don’t Panic – It’s OK: A Letter to my Family

If you are faced with a decision that you’re not ready for,
It’s ok
I’ll try to let you know what I would want for various circumstances,
But if you come to something we haven’t anticipated,
It’s ok
And if you come to a decision point and what you decide results in my death,
It’s ok.
You don’t need to worry that you’ve caused my death – you haven't –
I will die because of my illness or my body failing or whatever.
You don't need to feel responsible.
Forgiveness is not required,
But if you feel bad / responsible / guilty,
First of all don’t and second of all,
You are loved and forgiven.

If you're faced with a snap decision, don't panic --
Choose comfort,
Choose home,
Choose less intervention,
Choose to be together, at my side, holding my hand,
Singing, laughing, loving, celebrating, and carrying on.
I will keep loving you and watching you and being proud of you.
Conversation Starters for healthcare professionals

- 3 stages
  - No serious illness
  - Serious illness
  - Advanced serious illness

- Consider this case in your context

- Purpose/goals of “the conversation”

- Words and phrases you can use
Am I taking away hope? Does this patient trust me?

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

Let’s talk about your illness

What are my options?

Relationship and Emotions

Content and Language
No serious illness

- Ms. Lynch is 68 year-old woman with no serious illnesses, presenting for a routine primary care appointment for hypertension.
- Why start advance care planning now?
- Normalize (e.g. ask with social/family history)
- Build trust, respect, get to know the patient-as-a-person
  - “Can you tell me about the supports in your life?”
  - “Who should speak for you if you cannot speak for yourself?”
  - “Have you ever thought about your end-of-life wishes?”
  - or… “about the kind of care you’d want if you got really sick someday?”
Mrs. Lynch is unfortunately diagnosed with metastatic breast cancer and has a brief hospitalization. She’s now returning for follow-up.

What advance care planning needs to occur?

- Trust, respect, patient-as-person
  - Align around hope and respect, ask whether others should be involved

- Understanding of diagnosis, prognosis, and treatment options
  - Including a referral to specialty palliative care when appropriate

- Explore “what matters most”
  - Reflect on experiences, identify goals, hopes, fears, worries, tradeoffs

- Anticipate emergencies and make a plan when appropriate
  - *“We’re all hoping things go well. Would it be ok to talk about a plan in case things don’t go the way we’d like?”*

- Promote patient-surrogate-family conversations
Advanced serious illness

- Mrs. Lynch begins to decline, experiences multiple admissions, and is now losing weight and increasingly symptomatic. She’s no longer a candidate for cancer-directed treatment.
- Trust, respect, patient-as-person
- “Unfortunately, we don’t have any more treatments to give for your cancer.”
  - **Not** “we don’t have any more treatment”
- “We will do everything we can to help you live as well as possible.”
  - Non-abandonment, focus on living well no matter how much time there is, acknowledge there will be limitations
- Introduce the concept of hospice
- Manage difficult situations
  - family disagreements, or hoping for miracles
Conversation Ready Project: An IHI Collaborative

Becky M Dober
Project Manager, HRSA Geriatrics Workforce Enhancement Program
Practice Manager, Division of Geriatrics & Palliative Care

December 11th, 2018
Institute for Healthcare Improvement National Forum
Orlando FL
Sites Participating & Team Members

- Inpatient ACE (Acute Care for Elders) Unit D6A
- Outpatient Geriatrics Consultation Clinic/House Calls

Maura Brennan, MD
Chief Geriatrics/Palliative Care
Pat Coffelt, BSN, RN-C
Nurse Educator ACE Unit
Rebecca Laramée, RN
Healthcare Quality Specialist
Jodi Kashouh, RN
Healthcare Quality Specialist
Erin Leahy, MD
Geriatrics, ACE Medical Director
Richard Conroy, PA-C,
Geriatrics

Erin Salvador, MD
Palliative Care
Alina Sibley, NP-C
Geriatric Outpatient
Jean Peretti, RN-BC, BSN
Geriatric Outpatient
Becky Dobert
Practice Manager,
Geriatrics/Palliative
Sue Lawson
Patient and Family Advisory Council
Aim Statement

By April 30\textsuperscript{th} 2018, 95\% of Daly 6A (ACE Unit) patients will have a Health Care Proxy completed, documented, and easily attainable in the EMR
Challenges

• STAFFING
  – Impact of staffing shortages, turnover
  – Identifying champions, difficult to motivate staff
  – Necessity of staff buy-in, RNs unable/unwilling

• Leadership support
  – Interim RN Manager (competing priorities); ANM resigned
  – Shift in Med/Surg Nursing director

• Dependence on IT
  – EHR change is lengthy process, not currently system priority
  – HCP buried in chart, doesn’t carry over to new encounters
  – EHR allows RN’s to click Yes, at home for HCP (inpatient)
  – Scanning delays (outpatient)
Results Inpatient

Baystate Health
SP01_Steward: % patients with health care agent in your information system - Baystate Health Inpatient

Percent of patients

55.00 60.00 65.00 70.00 75.00 80.00 85.00 90.00 95.00 100.00


Month

Goal = 100.00
<table>
<thead>
<tr>
<th>Time Period</th>
<th>Value</th>
<th>count of patients in subpopulation who have health care agent identified in your information system</th>
<th>count of patients in subpopulation</th>
<th>Annotation Type</th>
<th>Annotation</th>
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<tbody>
<tr>
<td>3 - 2017</td>
<td>55.56</td>
<td>10</td>
<td>18</td>
<td>Event</td>
<td>Start of Project</td>
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<tr>
<td>4 - 2017</td>
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<td>83</td>
<td>118</td>
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<td>Nurse Educator did the majority of these.</td>
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<td>43</td>
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<tr>
<td>6 - 2017</td>
<td>54.55</td>
<td>6</td>
<td>11</td>
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<td>-</td>
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<tr>
<td>7 - 2017</td>
<td>66.67</td>
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<td>9</td>
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<td>Highlighting process started/QA validating HCP in EMR.</td>
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<tr>
<td>8 - 2017</td>
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<td>211</td>
<td>234</td>
<td>Change</td>
<td>OA highlighting process and nursing follow through.</td>
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<tr>
<td>9 - 2017</td>
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<td>199</td>
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<td>CM added to highlighting process increasing awareness.</td>
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<tr>
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<td>11 - 2017</td>
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<td>QI staff assisting with chart audits</td>
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<td>278</td>
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<td>December chart audits done by DHQ staff</td>
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<td>304</td>
<td>Event</td>
<td>January chart audits continue to be done by DHQ staff.</td>
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<td>3 - 2018</td>
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<td>258</td>
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<tr>
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<td>193</td>
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<tr>
<td>5 - 2018</td>
<td>82.00</td>
<td>246</td>
<td>300</td>
<td>Change</td>
<td>New ACE program assistant hired and oriented to doing chart audits. She began helping with audits second half of May.</td>
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<tr>
<td>6 - 2018</td>
<td>90.66</td>
<td>233</td>
<td>257</td>
<td>Change</td>
<td>New ACE Program Assistant doing all chart audits this month</td>
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<tr>
<td>8 - 2018</td>
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<td>254</td>
<td>Change</td>
<td>New ACE Quality Nurse is now collecting this data</td>
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<tr>
<td>9 - 2018</td>
<td>81.04</td>
<td>218</td>
<td>269</td>
<td>Change</td>
<td>New ACE Quality Nurse is now collecting this data</td>
</tr>
<tr>
<td>10 - 2018</td>
<td>83.00</td>
<td>210</td>
<td>253</td>
<td>Change</td>
<td>Quality nurse is collecting data now</td>
</tr>
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</table>
Celebrations!

- Both inpatient and outpatient initiatives have resulted in documented improvement through this collaborative approach.
- Increase in GOCC (Goals of Care Conversations) have led to decreased readmissions and decreased costs.
- HCP & MOLST now pull to Advanced Directives tab in EHR.
- Unbefriended elders identified as an at-risk population.
- BH system-wide education of healthcare providers and community members on conversations & Advanced Care Planning.
- Community Engagement.
Holding the Gains... What’s Next?

- **Staff engagement**
  - Shift in Med/Surg Nursing Director, highly enthusiastic and committed to ACE Program
  - Nurse Manager started Nov 2018
  - Better collaboration amongst project leaders

- **Advanced Care Planning Strategic Priority @ Baystate Health**

- **IHI Age Friendly Health Systems (4M’s) Collaborative**
  - What Matters, Mentation, Medications, Mobility
Questions?

- Thanks for being here with us.
- Please reach out if you would like to talk more about this work: kmccutcheonadams@ihi.org