Conversations that Count:
Improving Advance Care Planning Through Engagement of Providers and Patients

Compassion in Action Webinar Series

Eliza Shulman, DO, MPH

November 22, 2016

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Moderator

Andrea Greenberg
Communications and Partnerships Associate
The Schwartz Center for Compassionate Healthcare

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Audience Reminders

- This webinar is funded in part by a donation in memory of Julian and Eunice Cohen.
- You may submit a question by typing it into the Question and Answer pane at the right of your screen at any time.
- Respond to polling questions by selecting the response that best represents your situation or opinion.
- We value your feedback! Please complete our electronic survey following the webinar.

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Host

Beth Lown, MD
Medical Director
The Schwartz Center for Compassionate Healthcare

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Compassionate Collaborative Care Framework

Compassionate Collaborative Care Framework	
Focus attention	Demonstrate trustworthiness
Recognize verbal and nonverbal cues	Communicate with colleagues, adjust plans
Listen actively	Practice self-reflection and emotion regulation
Elicit information about the "whole person"	Build relationships, partnerships and teams
Value others with nonjudgment positive regard	Practice self-monitoring and behavioral self-regulation
Ask about and respond to emotions, concerns, distress, suffering	Practice self-care, attend to personal, professional development and wellbeing
Share information and decision-making	Practice self-compassion

http://www.theschwartzcenter.org/media/Triple-C-Conference-Framework-Tables_FINAL.pdf

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Today's Speaker

Eliza Shulman, DO, MPH
Senior Chief Innovation Engineer
Atrius Health

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Objectives

- Map of our Journey
- Leveraging local, regional, national priorities
- Identify importance of conversation as part of comprehensive advance care planning
- Explore barriers and challenges for the health care system
- Understand the need for a multifaceted approach
  - Common language
  - Education and training
  - Team based approach

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A Patient Story: Stella

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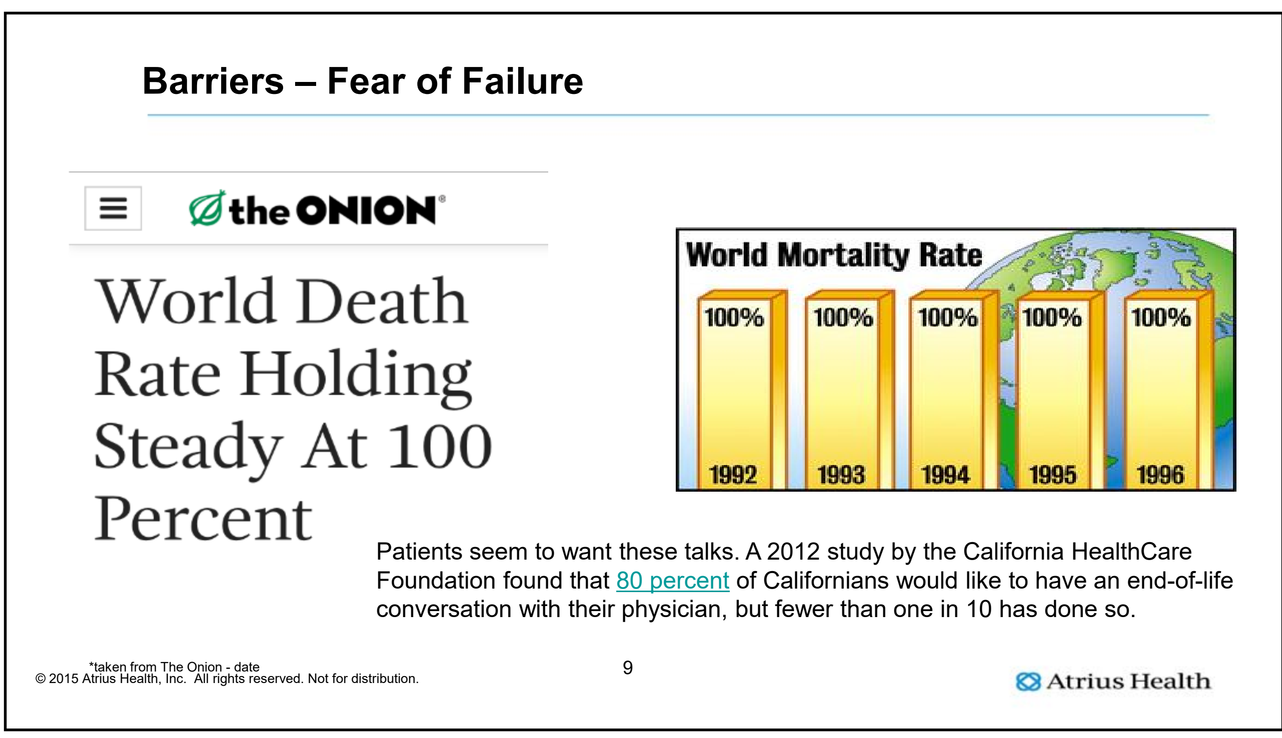
Barriers – Fear of Failure
the ONION
World Death Rate Holding Steady At 100 Percent
World Mortality Rate
100%
100%
100%
100%
100%
1992
1993
1994
1995
1996
Patients seem to want these talks. A 2012 study by the California HealthCare Foundation found that 80 percent of Californians would like to have an end-of-life conversation with their physician, but fewer than one in 10 has done so.
*taken from The Onion - date
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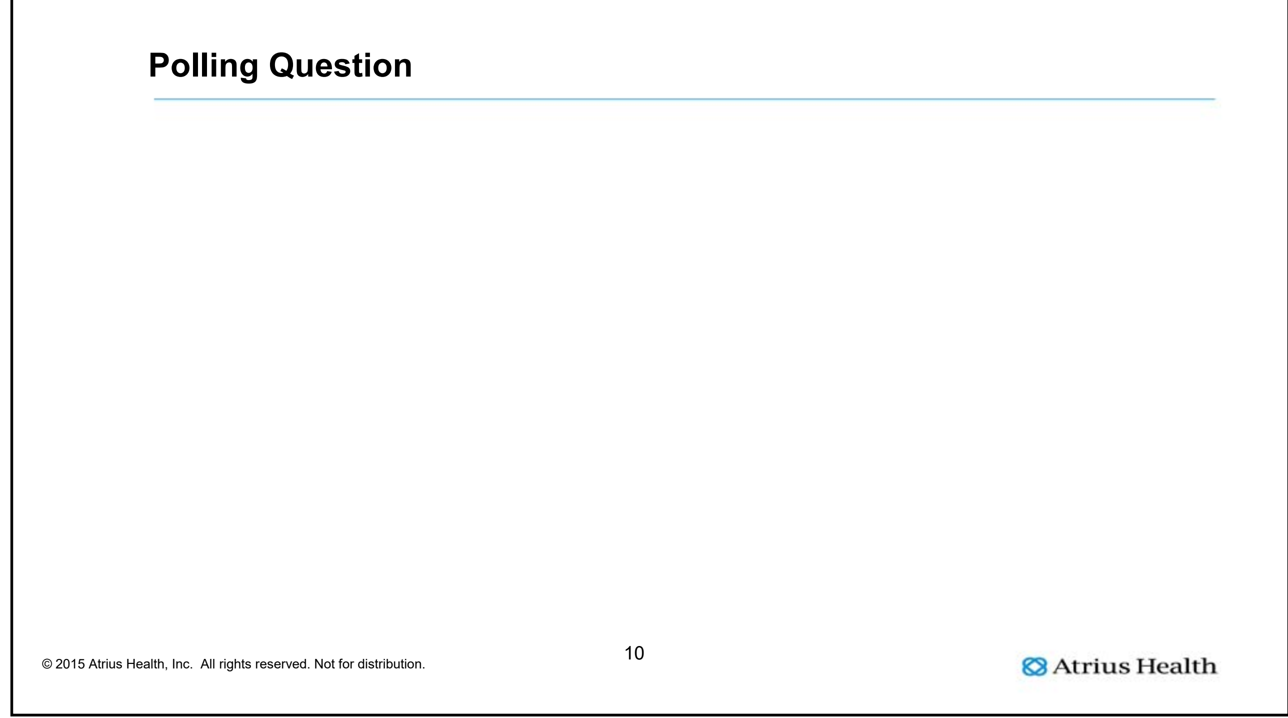
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Last Year of Life: The Disconnect

Patient Desires	Reality
To talk about Advanced Directives	Doctors reluctant to discuss
To decrease intensity of care	Majority of Medicare spending occurs within last 12 months of life
Patients want to die at home	Majority of patients die in the hospital

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What Do the Numbers Say?

- 29% US adults have living will, often not available when needed
- Surveys say most people prefer to die at home, yet more die in the hospital, 18% in ICU
- 25-40% patients use their Medicare Hospice benefit, wide geographic and ethnic variation
- 40% hospice patients in MA have length of stay 7 days or less.

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Clinician Barriers to Advance Care Planning

- Personal discomfort or fear about talking about end of life
- "I don't have enough time"
- "I can't bill for it"
- Fear of taking away a patient's hope
- Ignorance, lack of understanding – "what are the steps of ACP?"
- Topic feels "mushy" – not a "concrete" task to complete
- What do we do if a patient changes his/her mind?

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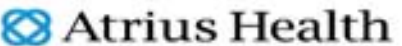

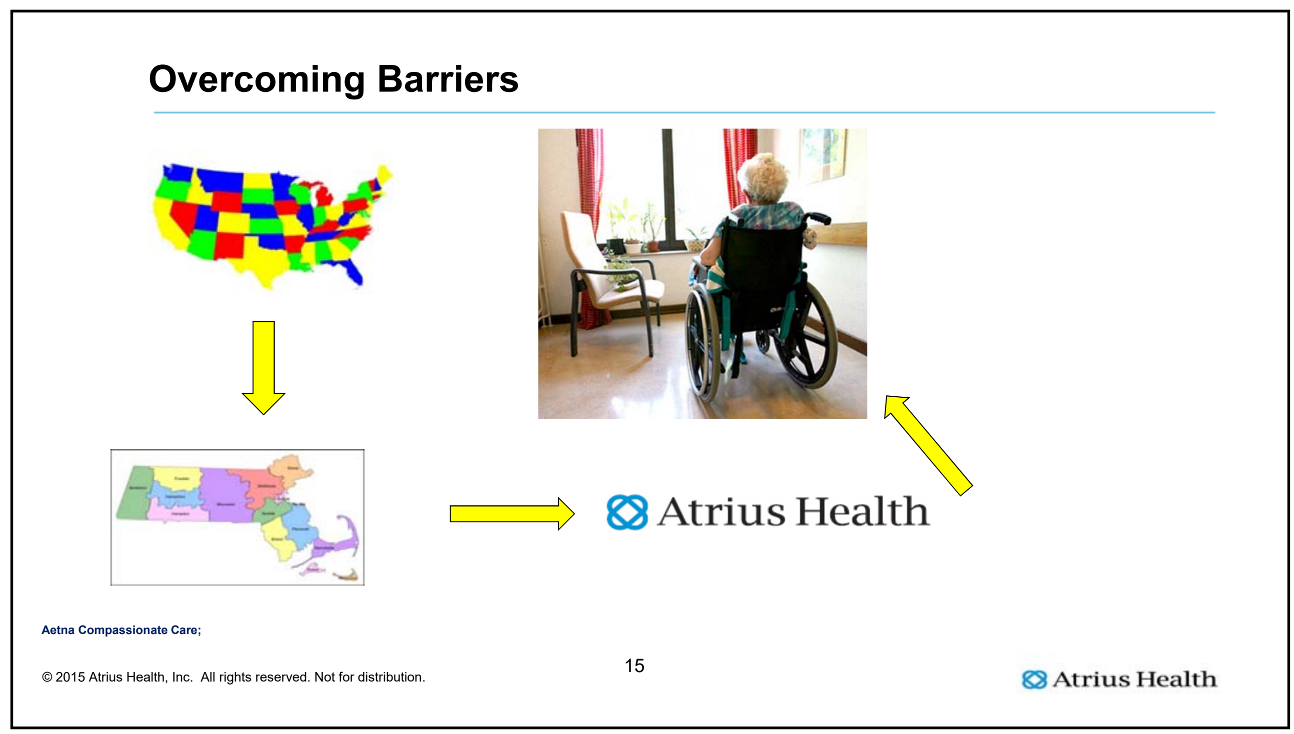
Overcoming Barriers
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Aetna Compassionate Care;
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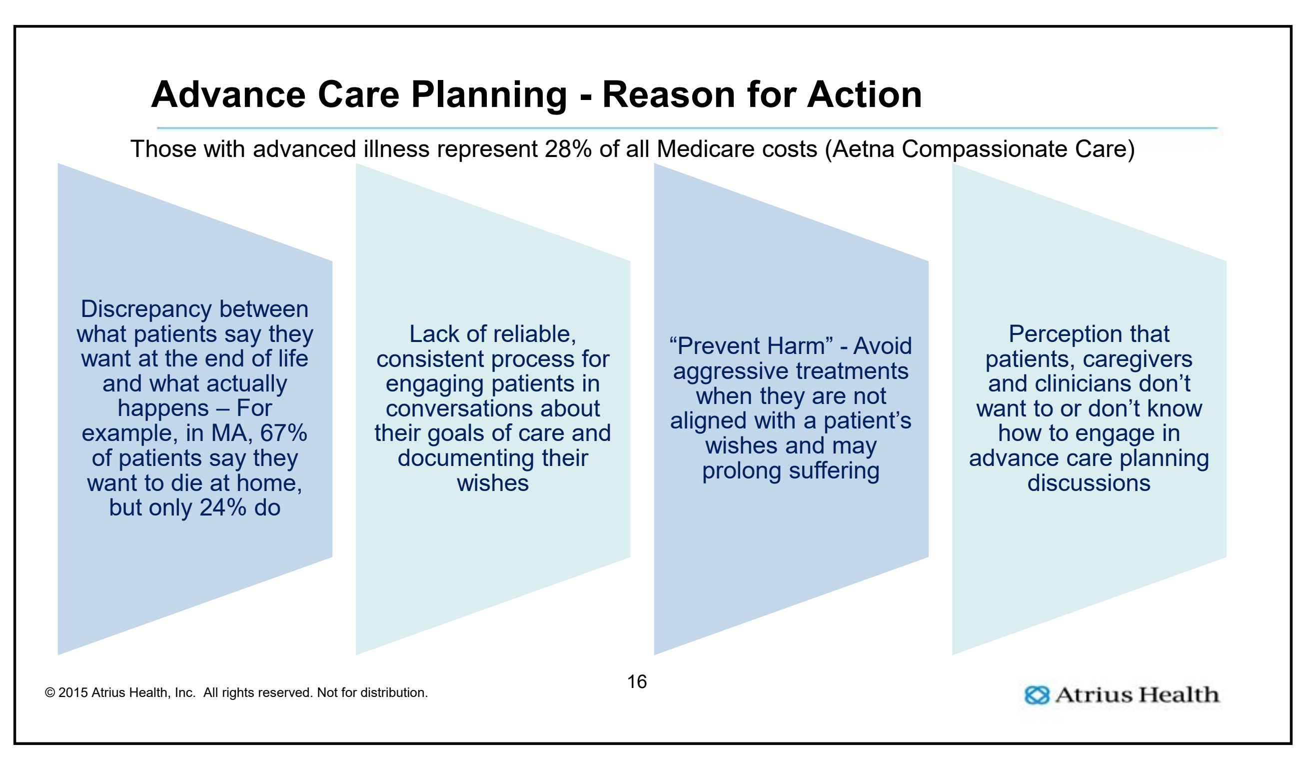
Advance Care Planning - Reason for Action
Those with advanced illness represent 28% of all Medicare costs (Aetna Compassionate Care)
Discrepancy between what patients say they want at the end of life and what actually happens – For example, in MA, 67% of patients say they want to die at home, but only 24% do
Lack of reliable, consistent process for engaging patients in conversations about their goals of care and documenting their wishes
"Prevent Harm" - Avoid aggressive treatments when they are not aligned with a patient's wishes and may prolong suffering
Perception that patients, caregivers and clinicians don't want to or don't know how to engage in advance care planning discussions
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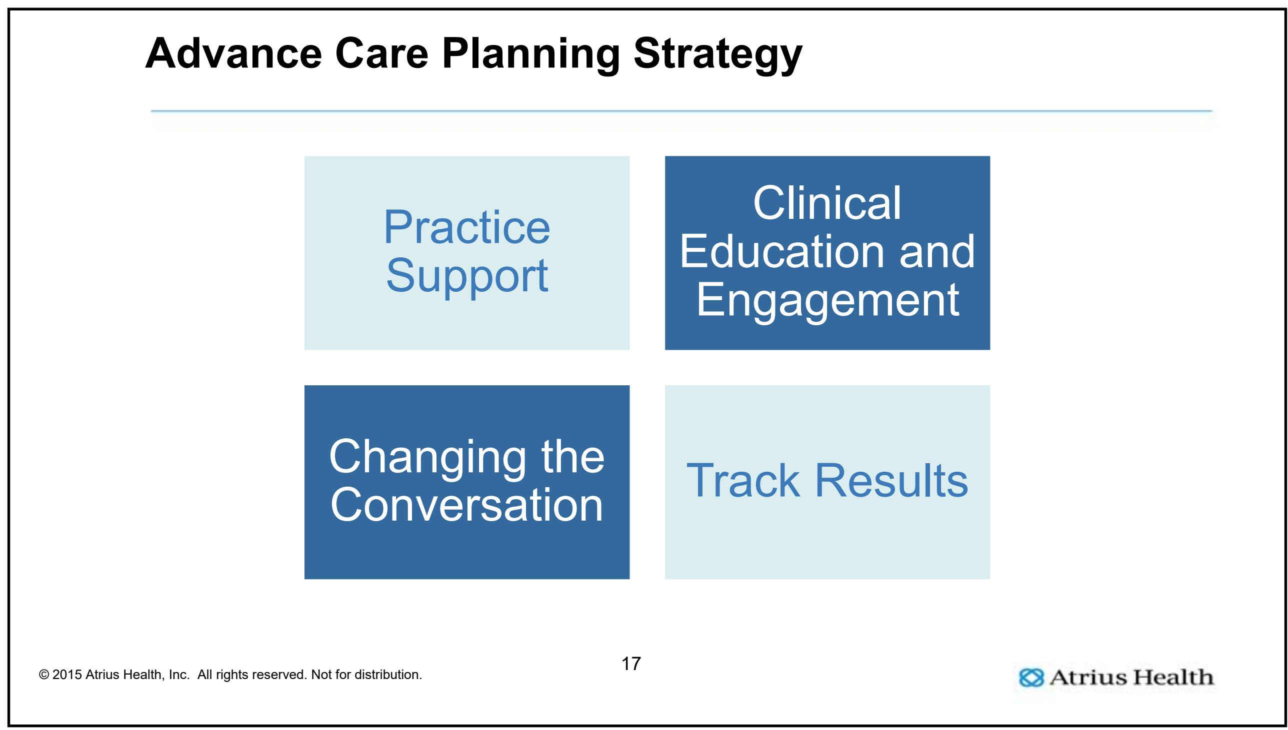
Advance Care Planning Strategy
Practice Support
Clinical Education and Engagement
Changing the Conversation
Track Results
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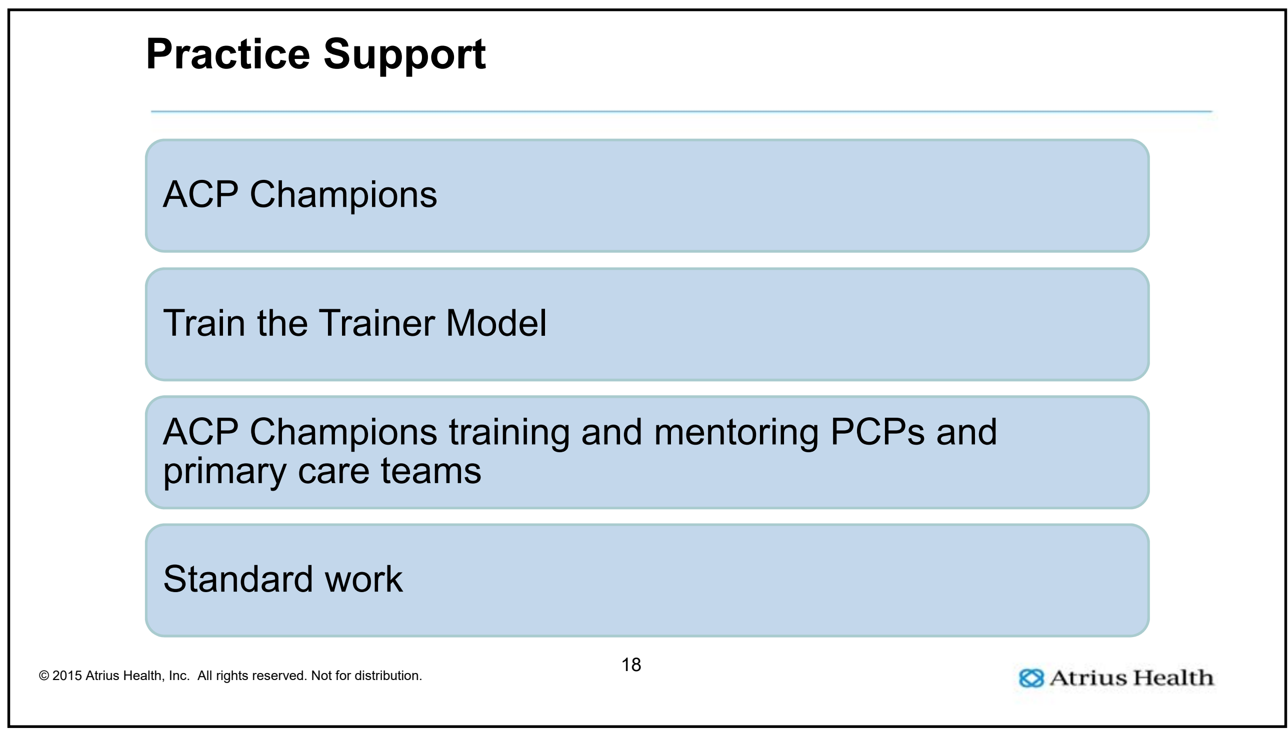
Practice Support
ACP Champions
Train the Trainer Model
ACP Champions training and mentoring PCPs and primary care teams
Standard work
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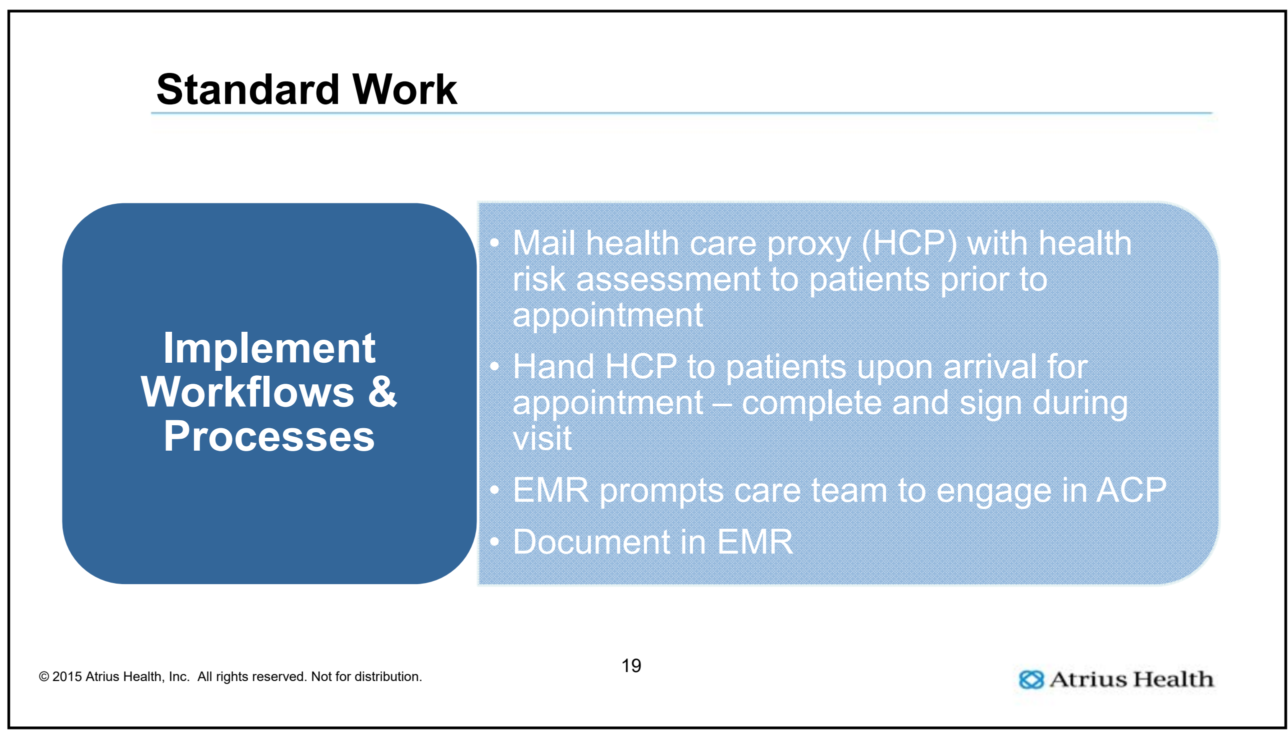
Standard Work
Implement Workflows & Processes
• Mail health care proxy (HCP) with health risk assessment to patients prior to appointment
• Hand HCP to patients upon arrival for appointment – complete and sign during visit
• EMR prompts care team to engage in ACP
• Document in EMR
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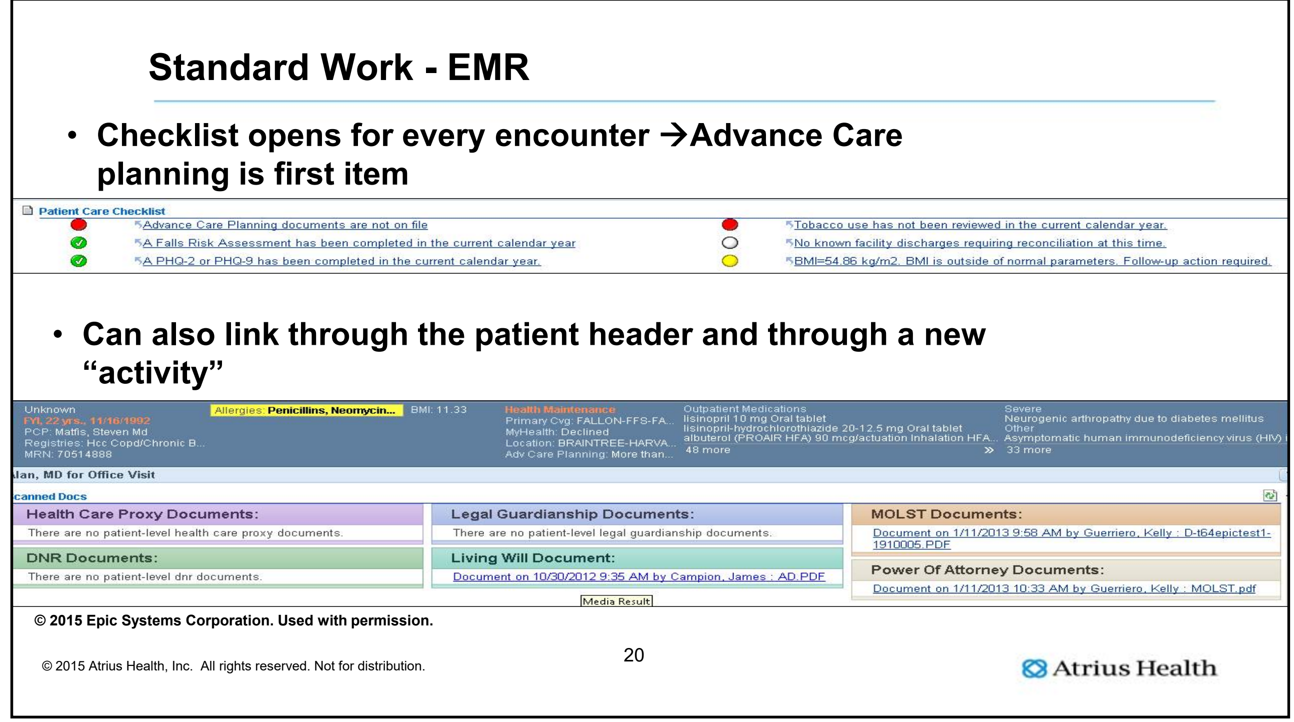
Standard Work - EMR
• Checklist opens for every encounter →Advance Care planning is first item
Patient Care Checklist
Advance Care Planning documents are not on file
A Falls Risk Assessment has been completed in the current calendar year
A PHQ-2 or PHQ-9 has been completed in the current calendar year.
Tobacco use has not been reviewed in the current calendar year.
No known facility discharges requiring reconciliation at this time.
BMI=54.86 kg/m2. BMI is outside of normal parameters. Follow-up action required.
• Can also link through the patient header and through a new "activity"
Health Care Proxy Documents:
There are no patient-level health care proxy documents.
Legal Guardianship Documents:
There are no patient-level legal guardianship documents.
MOLST Documents:
DNR Documents:
There are no patient-level dnr documents.
Living Will Document:
Power Of Attorney Documents:
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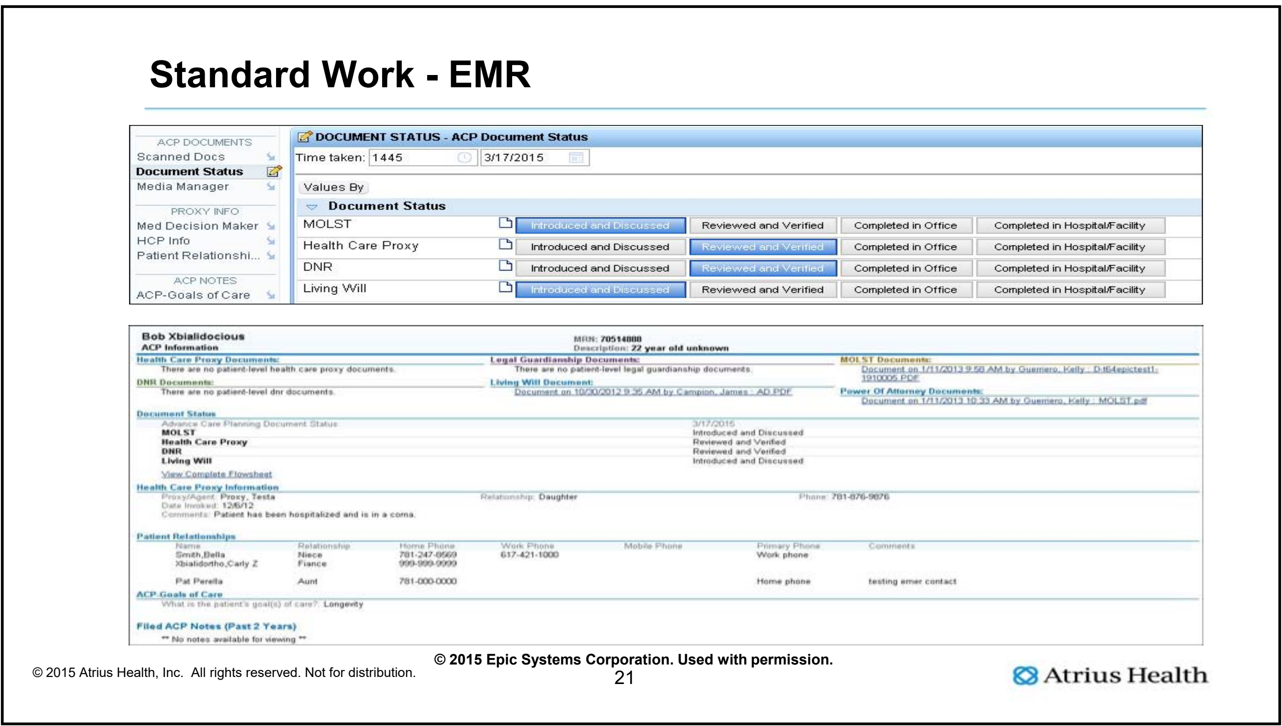
Standard Work - EMR
ACP DOCUMENTS
Scanned Docs
Document Status
Media Manager
PROXY INFO
Med Decision Maker
HCP Info
Patient Relationshi...
ACP NOTES
ACP-Goals of Care
DOCUMENT STATUS - ACP Document Status
Time taken: 1445 3/17/2015
Values By
Document Status
MOLST
Health Care Proxy
DNR
Living Will
Introduced and Discussed
Reviewed and Verified
Completed in Office
Completed in Hospital/Facility
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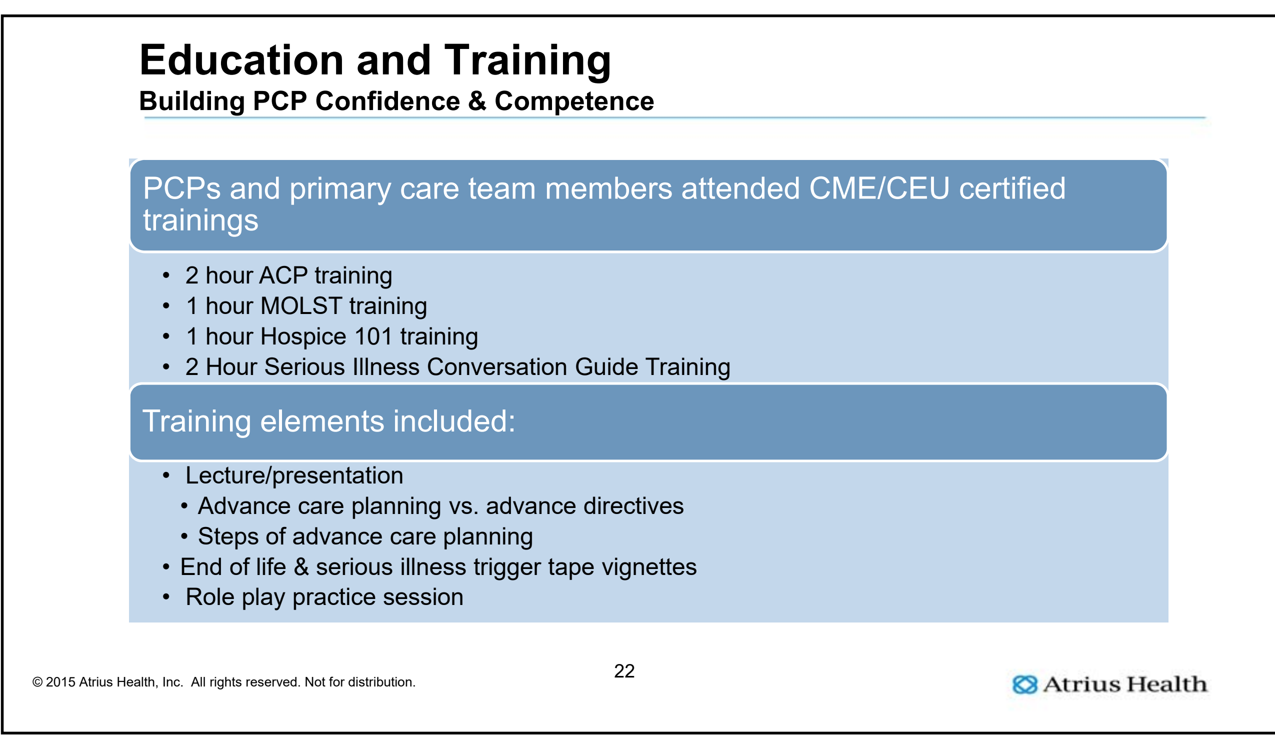
Education and Training
Building PCP Confidence & Competence
PCPs and primary care team members attended CME/CEU certified trainings
• 2 hour ACP training
• 1 hour MOLST training
• 1 hour Hospice 101 training
• 2 Hour Serious Illness Conversation Guide Training
Training elements included:
• Lecture/presentation
• Advance care planning vs. advance directives
• Steps of advance care planning
• End of life & serious illness trigger tape vignettes
• Role play practice session
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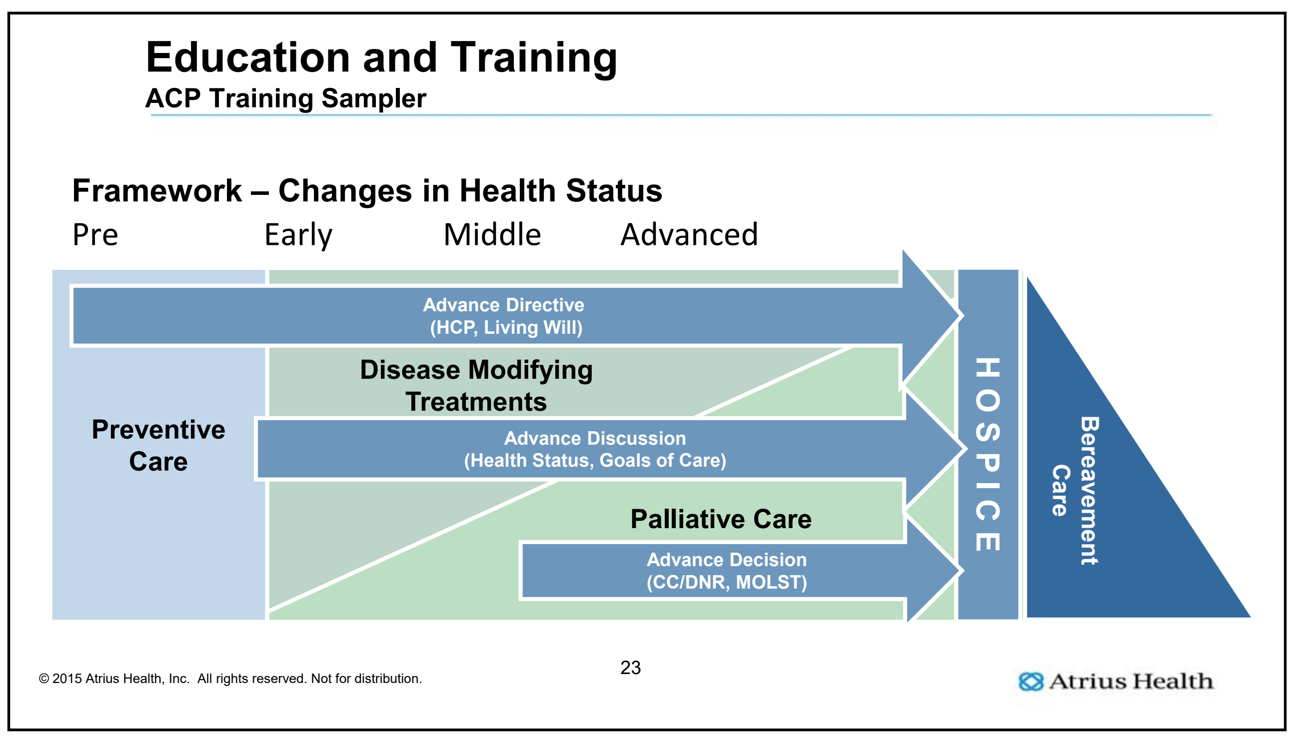
Education and Training
ACP Training Sampler
Framework – Changes in Health Status
Pre
Early
Middle
Advanced
Advance Directive
(HCP, Living Will)
Disease Modifying
Treatments
Preventive
Care
Advance Discussion
(Health Status, Goals of Care)
Palliative Care
Advance Decision
(CC/DNR, MOLST)
HOSPICE
Bereavement
Care
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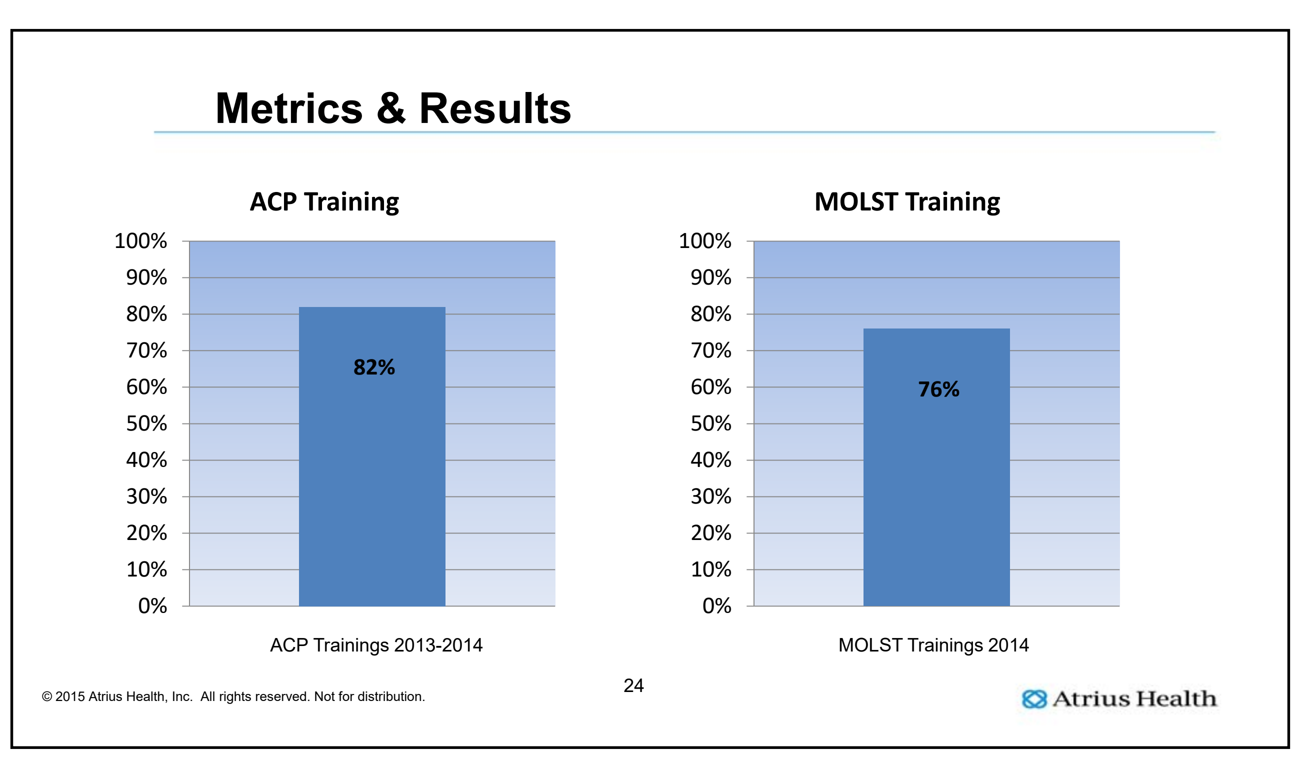
Metrics & Results
ACP Training
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
82%
ACP Trainings 2013-2014
MOLST Training
76%
MOLST Trainings 2014
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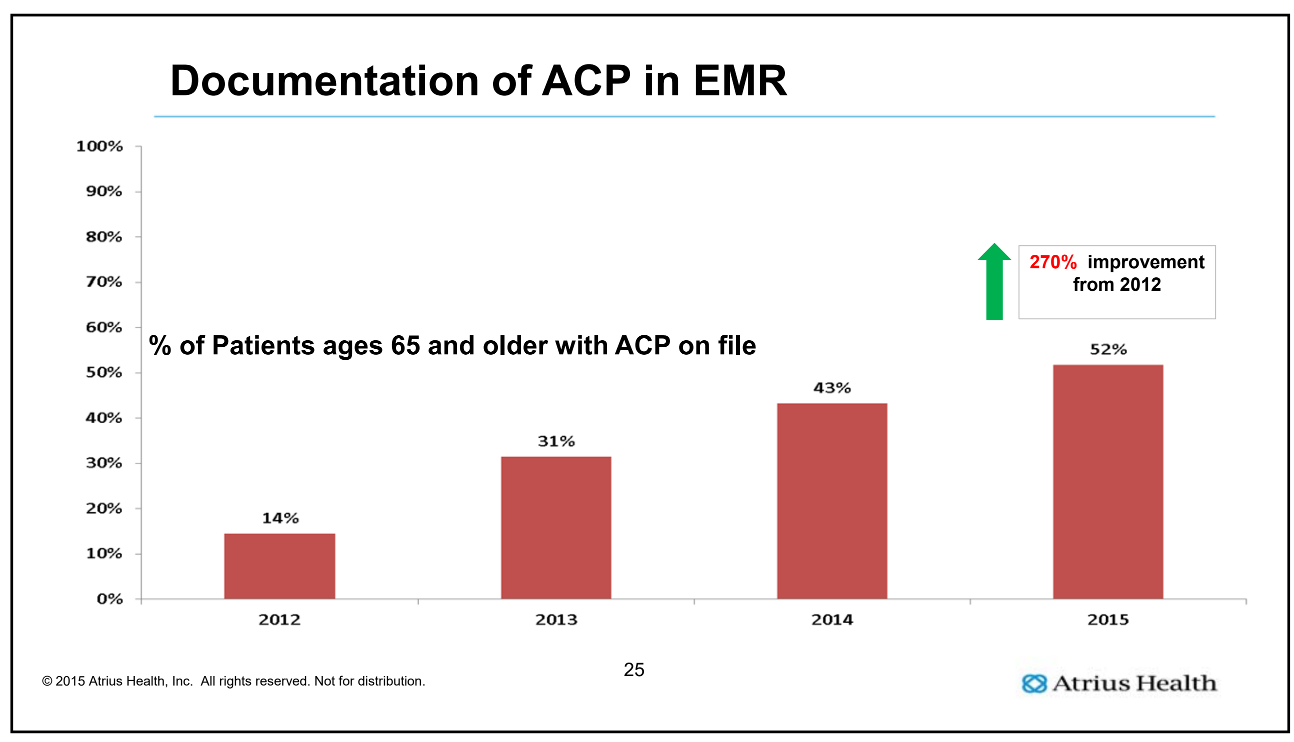
Documentation of ACP in EMR
% of Patients ages 65 and older with ACP on file
270% improvement from 2012
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
14%
31%
43%
52%
2012
2013
2014
2015
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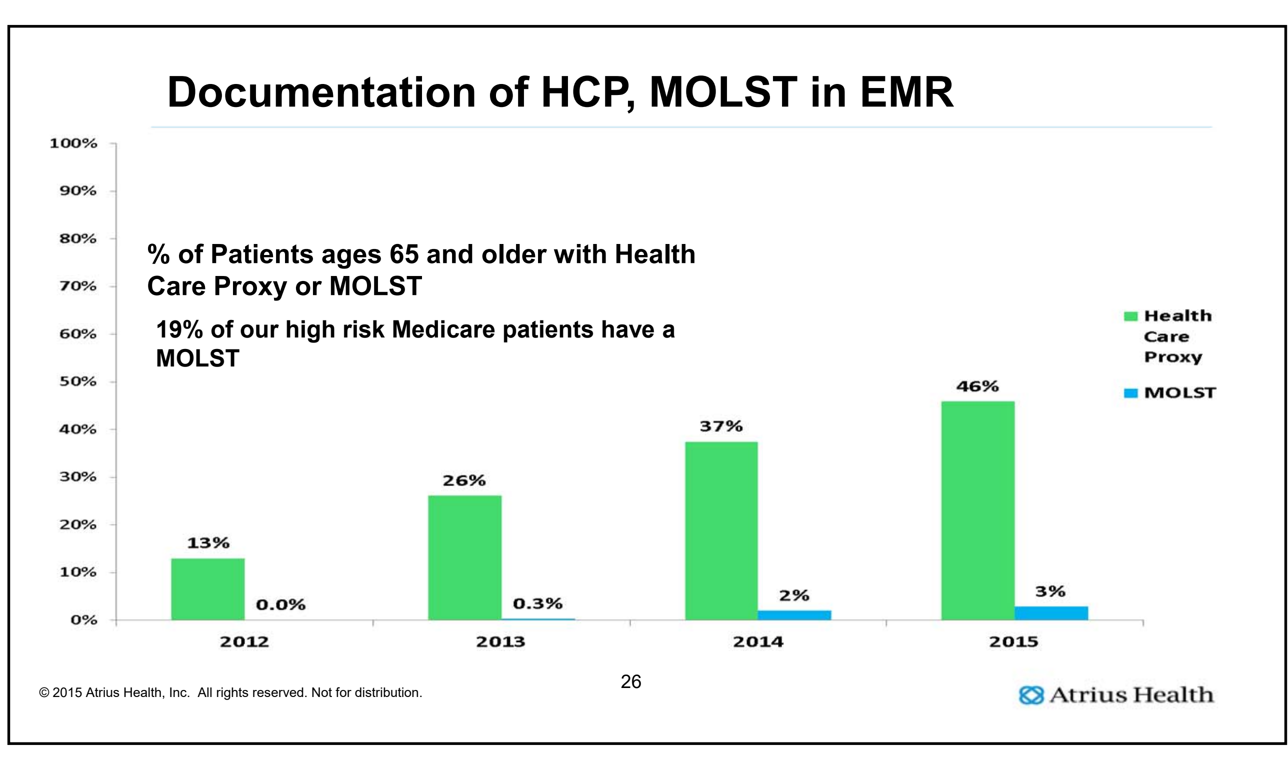
Documentation of HCP, MOLST in EMR
% of Patients ages 65 and older with Health Care Proxy or MOLST
19% of our high risk Medicare patients have a MOLST
Health Care Proxy
MOLST
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
13%
0.0%
26%
0.3%
37%
2%
46%
3%
2012
2013
2014
2015
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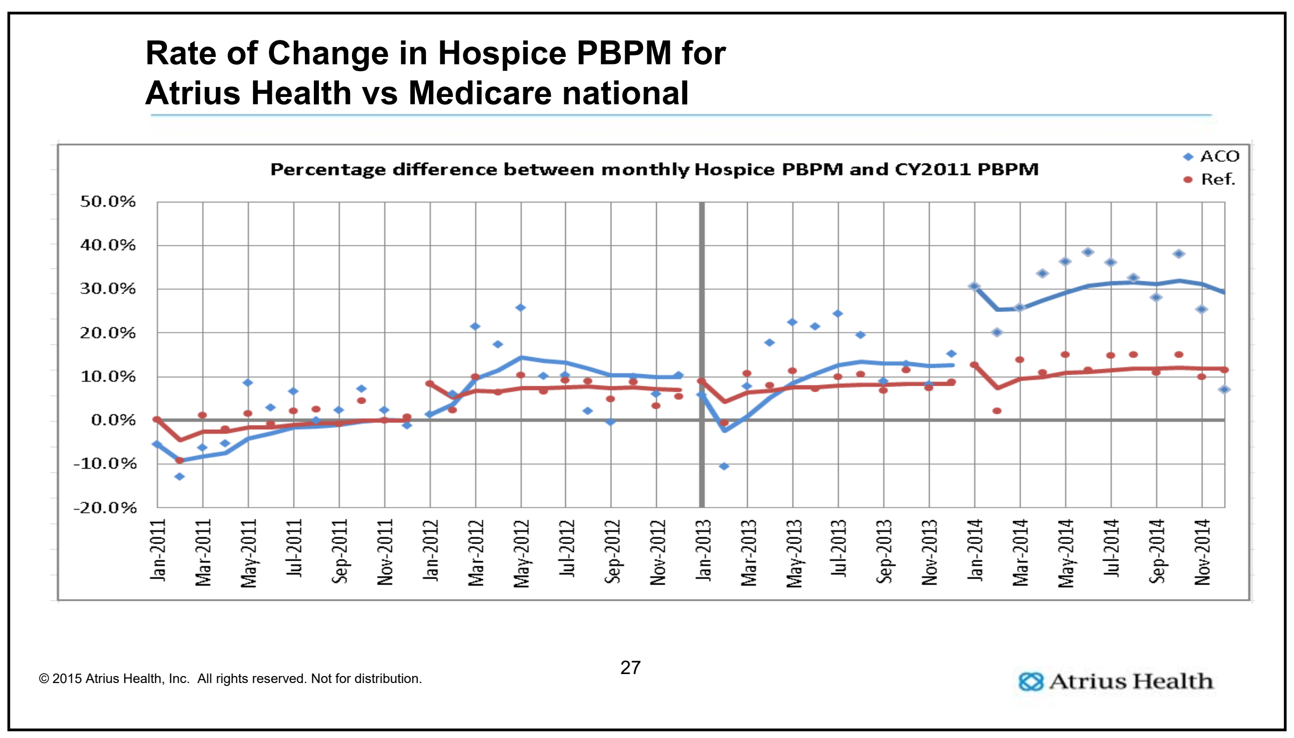
Rate of Change in Hospice PBPM for
Atrius Health vs Medicare national
Percentage difference between monthly Hospice PBPM and CY2011 PBPM
ACO
Ref.
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
-10.0%
-20.0%
Jan-2011
Mar-2011
May-2011
Jul-2011
Sep-2011
Nov-2011
Jan-2012
Mar-2012
May-2012
Jul-2012
Sep-2012
Nov-2012
Jan-2013
Mar-2013
May-2013
Jul-2013
Sep-2013
Nov-2013
Jan-2014
Mar-2014
May-2014
Jul-2014
Sep-2014
Nov-2014
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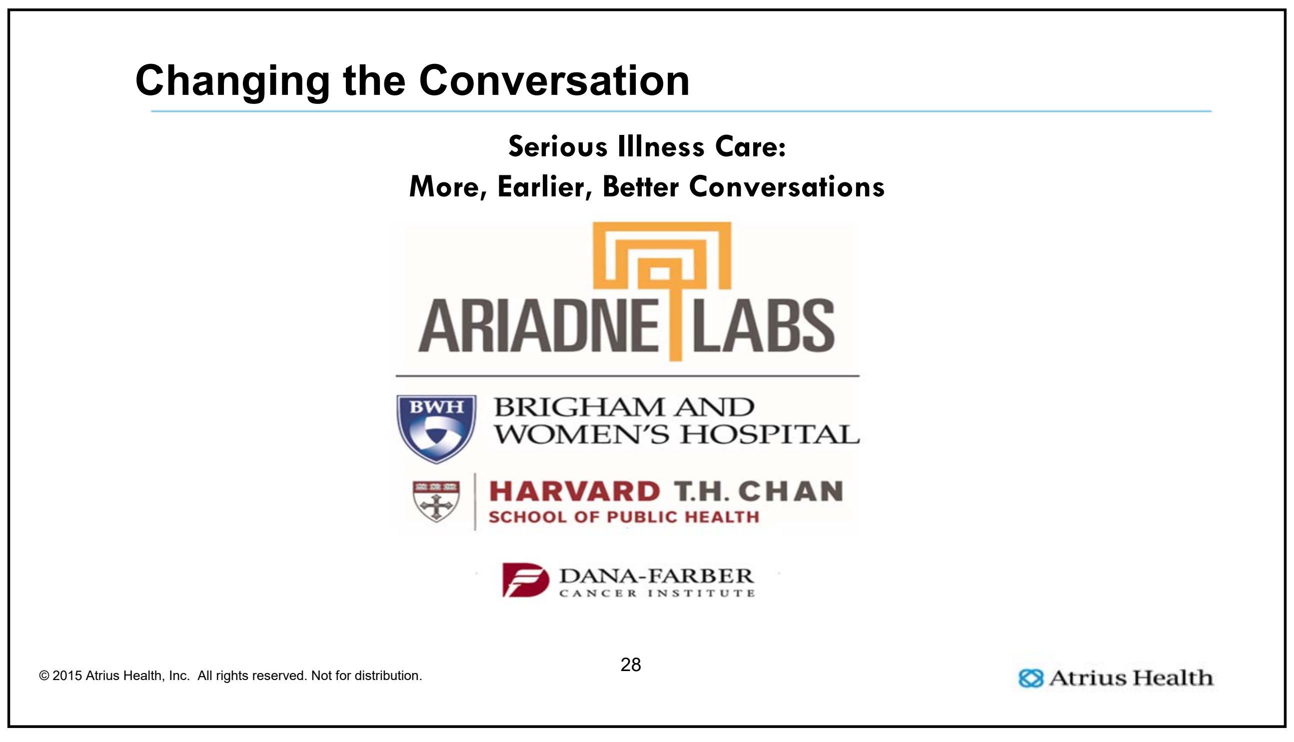
Changing the Conversation
Serious Illness Care:
More, Earlier, Better Conversations
ARIADNE LABS
BWH
BRIGHAM AND
WOMEN'S HOSPITAL
HARVARD T.H. CHAN
SCHOOL OF PUBLIC HEALTH
DANA-FARBER
CANCER INSTITUTE
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Changing the Conversation

Serious Illness Conversation Guide

8 item sequential “checklist” developed by Drs. Atul Gawande and Susan Block

Supports clinicians through a structured process for discussing and documenting patients’ main end of life issues

Tool facilitates clinician led, but patient centered discussion around:

- Patients perception of illness,
- Degree of information sharing (clinician/patient, clinician/family)
- Goals of care
- Patient concerns and functional status
- Clear and documented path for treatment

Cluster randomized controlled trial at four Atrius Health sites to run for 2 years with ~450 patients, ~450 friend/family members, ~50 clinicians

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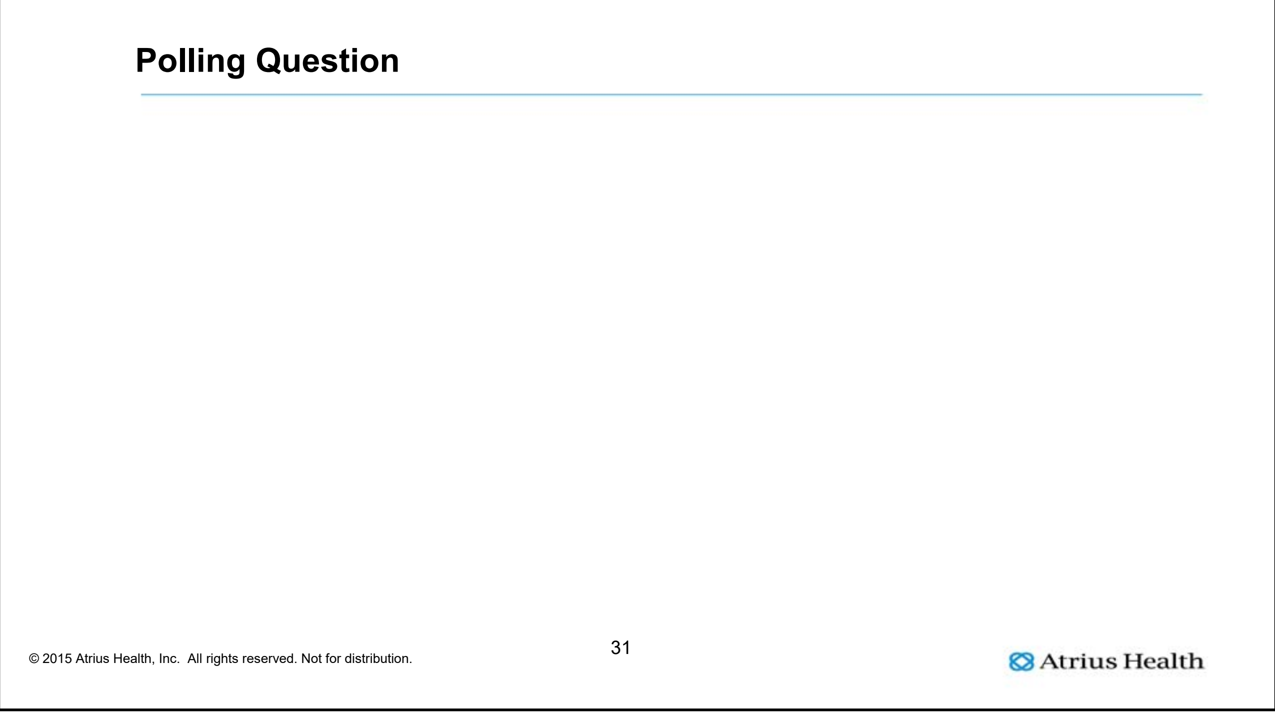

Conversation Training is Different

- Reflection
- Role Play
- Interdisciplinary
- Deliberate intermixing of the teams

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"But I already know how to do this…"

- Asking clinicians with range of experience to try something different
- Training starts out quiet
  - Can't I just sit here and get my CME?

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What will change for you after this training?

- "I know I have room to **improve** my communication"
- "I will start to speak to my patients about their **goals of care**"
- "Will start to have **more open conversations** with my patients about their long term illnesses"
- "Will try to sit with my **silence**"
- "**Change** the way I talk to my patients about end of life"
- "**Will use this** with my husband and family"

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What was training like?

- “Eye opening”
- “Real examples from practice”
- “People shared real struggles”
- “Great idea to do role playing”
- “Learned empathetic communication”
- “This will help me to bring up the topic with providers and future patients”
- “See the need to involve family”
- “I’m glad I came to this presentation”

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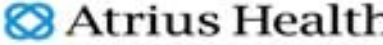

Why is this different?

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Summary

- National, State and Local Forces Aligned
- Multi-pronged approach →education isn't enough
- As metrics improve, need to take next big leap
- Moving beyond documents and into conversations
- Clinicians at every level are vulnerable, need to acknowledge as part of training

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Questions

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