Partnering with the Hospital to Reduce Readmission Rates Through Chaplaincy-Based ACP Using The Conversation Project Model

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Phyllis Coletta, JD
Rev. Rosemary Lloyd, BSN, MDiv

Goals For Today's Session

- Demonstrate the importance of having The Conversation to increase quality, patient-centered care and reduce readmissions
- Identify barriers to having The Conversation
- Develop a personal and professional plan of action
- Learn strategies for engaging communities in having The Conversation—internally and beyond the walls of your institution

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Chaplain as Business Partner

- How to help with fiscal challenges?
- In many hospital settings, Advance Care Planning (ACP) falls to the chaplains and social workers.
- How can you do this work EFFECTIVELY in a short period of time?

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ACP Can Reduce Readmissions

- Strong end-of-life planning overall – including Advanced Directives, palliative team planning, hospice, and the presence of a POSLT system (Physician Orders for Life Sustaining Treatment) are effective in reducing readmission rates.

  Sharon Silow-Carroll, Jennifer n. Edwards, and Aimee Lashbrook, reducing hospital readmissions: lessons from top-performing hospitals, Health Management Associates, April 2011

- When patients desire and are referred for hospice services, hospitalization rates in the subsequent 30 to 180 days are decreased by 40% to 50%.

  Casarett, D., Karlawish, J., Morales, K., Crowley, R., Mirsch, T., Asch, DA. Improving the Use of Hospice Services in Nursing Homes: A randomized controlled trial. Journal of the American Medical Association. 2005; 294(2):211-217

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A public engagement campaign dedicated to assure that everyone's wishes for end-of-life care are **expressed and respected.**

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TCP Founder Ellen Goodman

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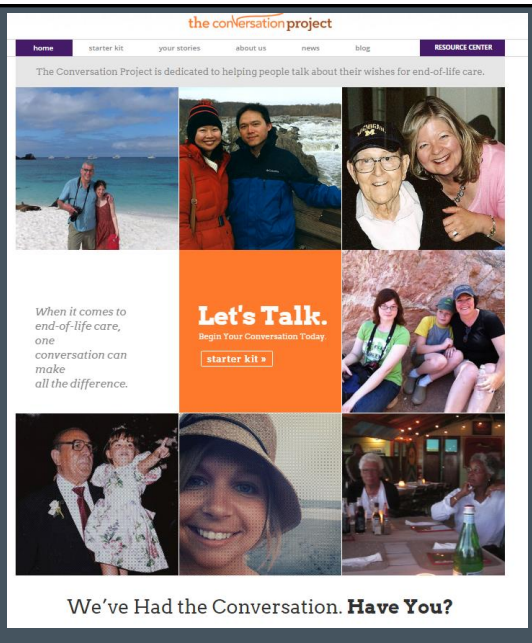

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70%

WANT TO DIE AT HOME.

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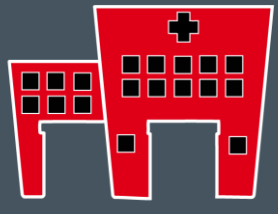
70%



ACTUALLY DIE IN THE HOSPITAL

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"I'm not afraid of death;
I just don't want to be there
when it happens."

~ Woody Allen

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**THINK IT'S IMPORTANT
TO HAVE THESE CONVERSATIONS**

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30%

HAVE ACTUALLY DONE SO

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80%

WANT TO TALK WITH THEIR DOCTORS.

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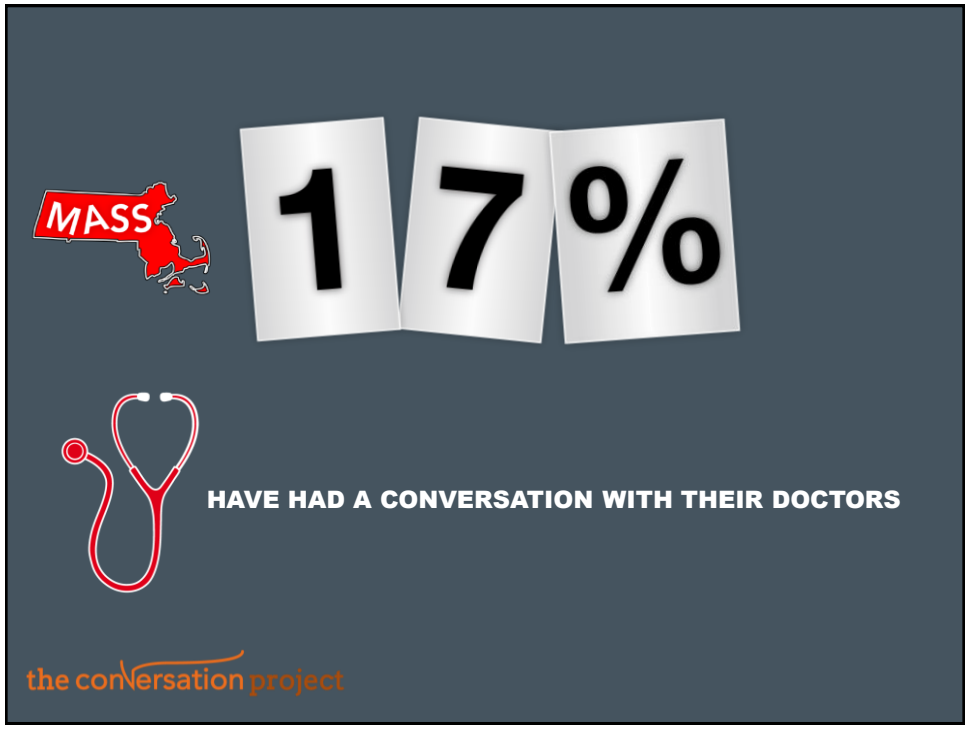
MASS
17%
HAVE HAD A CONVERSATION WITH THEIR DOCTORS
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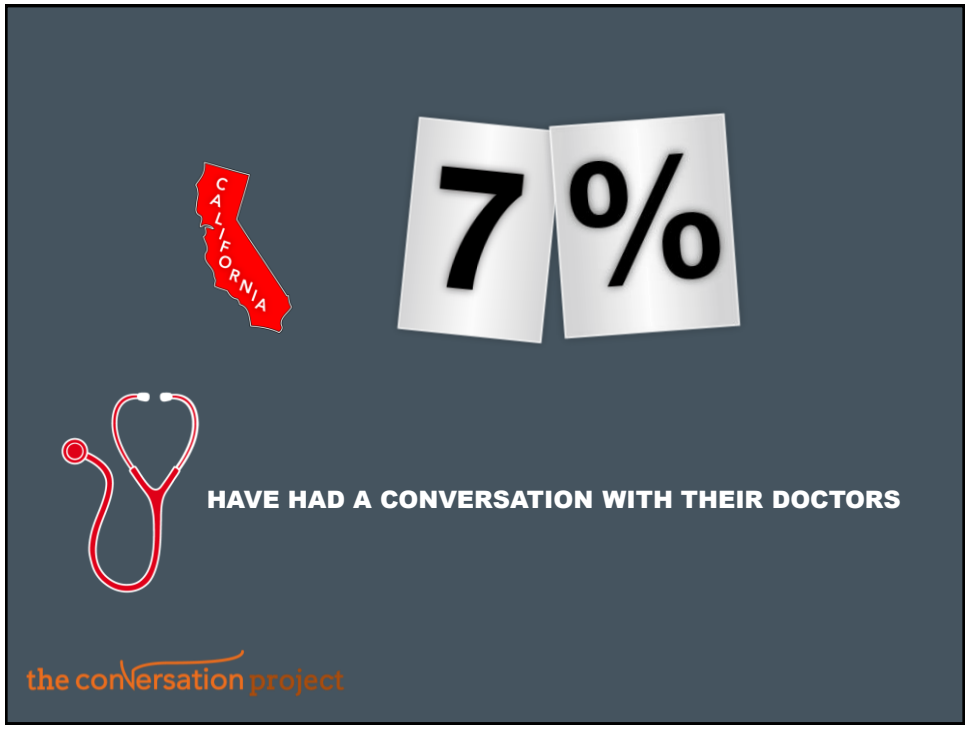
CALIFORNIA
7%
HAVE HAD A CONVERSATION WITH THEIR DOCTORS
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Signs of Cultural Change

- Mainstream
  - Atul Gawande's ***Being Mortal*** and ***When Breath Becomes Air*** hit the best seller list
  - The Writers Guilds East and West
- Medicine
  - The Institute of Medicine releases its report, ***Dying in America***
  - CMS reimburses for End-of-Life Care Conversations

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New York Times Sunday Magazine

- BJ Miller, former director of the Zen Hospice House in San Francisco, profiled in *New York Times Magazine*, January 8, 2017: "One Man's Quest to Change the Way We Die"

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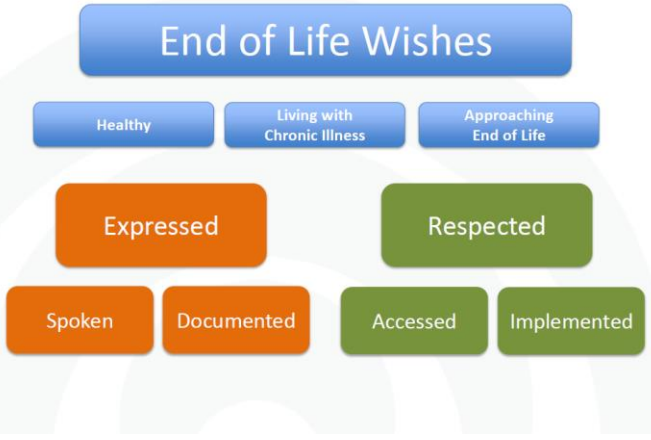
The Conversation Continuum



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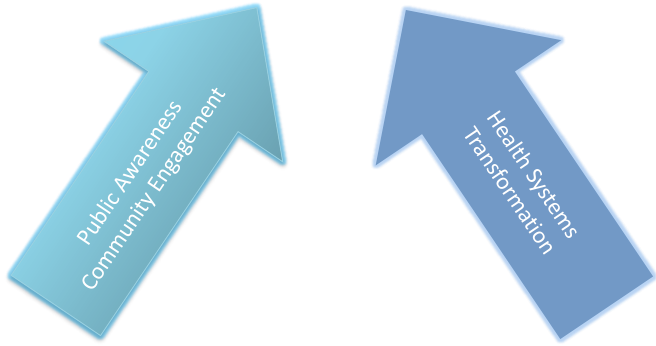
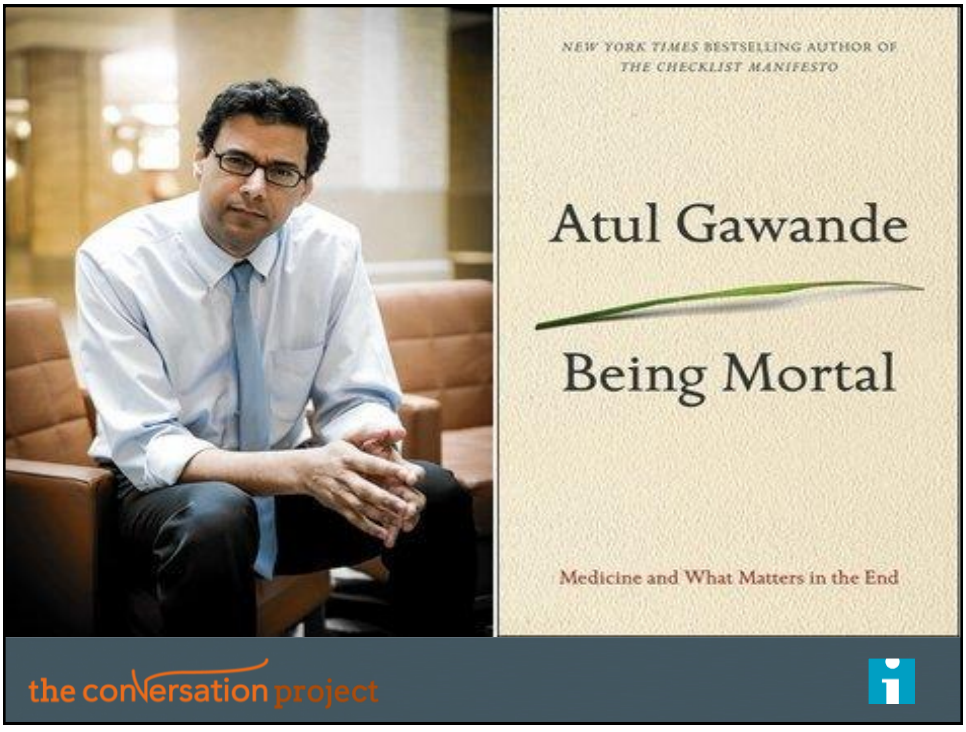
What Matters to Me

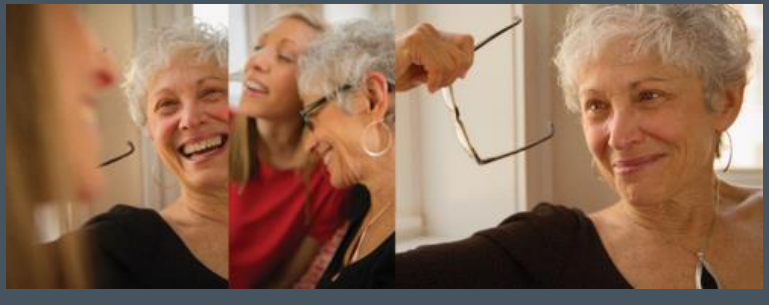
AS WELL AS

What's the Matter with Me





The Conversation Starts with You



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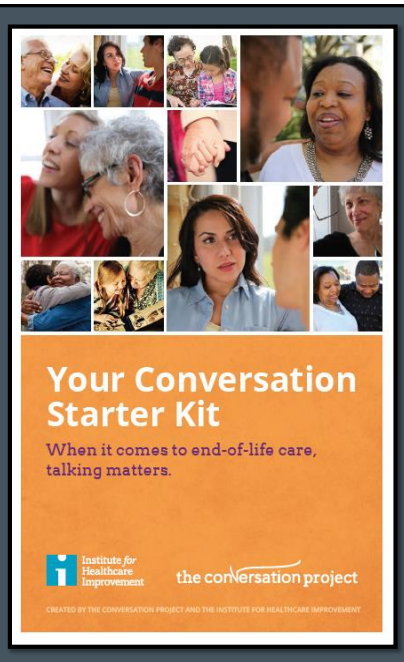

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The Starter Kit

Step 2 Get Set

What's most important to you as you think about how you want to live at the end of your life? What do you value most? **Thinking about this will help you get ready to have the conversation.**

? **Now finish this sentence: What matters to me at the end of life is...**
(For example, being able to recognize my children; being in the hospital with excellent nursing care; being able to say goodbye to the ones I love.)

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The Starter Kit: Get Set

As a patient, I'd like to know...

1	2	3	4	5
Only the basics about my condition and my treatment				All the details about my condition and my treatment

As doctors treat me, I would like...

1	2	3	4	5
My doctors to do what they think is best				To have a say in every decision

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The Starter Kit: Get Set

If I had a terminal illness, I would prefer to...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not know how quickly it is progressing

Know my doctors best estimation for how long I have to live

How long do you want to receive medical care?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Indefinitely, no matter how uncomfortable treatments are

Quality of life is more important to me than quantity

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The Starter Kit: Get Set

How involved do you want your loved ones to be?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable

I want my loved ones to do what brings them peace, even if it goes against what I've said

When it comes to your privacy...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

When the time comes, I want to be alone

I want to be surrounded by my loved ones

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The Starter Kit: Get Set

When it comes to sharing information...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I don't want my loved ones to know everything about my health

I am comfortable with those close to me knowing everything about my health

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The Starter Kit: Go

When you're ready to have the conversation, think about the basics.

MARK ALL THAT APPLY:

? WHO do you want to talk to?

- ☐ Mom
- ☐ Dad
- ☐ Child/Children
- ☐ Partner/Spouse
- ☐ Sister/Brother
- ☐ Faith leader (Minister, Priest, Rabbi, Imam, etc.)
- ☐ Friend
- ☐ Doctor
- ☐ Caregiver
- ☐ Other: _____

? WHEN would be a good time to talk?

- ☐ The next holiday
- ☐ Before my child goes to college
- ☐ Before my next trip
- ☐ Before I get sick again
- ☐ Before the baby arrives
- ☐ The next time I visit my parents/ adult children
- ☐ At the next family gathering
- ☐ Other: _____

? WHERE would you feel comfortable talking?

- ☐ At the kitchen table
- ☐ At a favorite restaurant
- ☐ In the car
- ☐ On a walk
- ☐ Sitting in a park
- ☐ At my place of worship
- ☐ Other: _____

The Starter Kit: Go

WHO do you want to talk to?

- ☐ Mom
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The Starter Kit: Go

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- ☐ On a walk
- ☐ Sitting in a park
- ☐ At my place of worship
- ☐ Other: _____

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Icebreakers

Here are some ways you could break the ice:

"I need your help with something."

"Remember how someone in the family died—was it a 'good' death or a 'hard' death? How will yours be different?"

"I was thinking about what happened to _____, and it made me realize..."

"Even though I'm okay right now, I'm worried that _____, and I want to be prepared."

"I need to think about the future. Will you help me?"

"I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I'm wondering what your answers would be."

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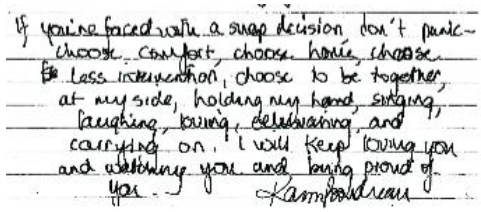
Don’t Panic – It’s OK: A Letter to my Family

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.



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Leaving in Action

- Complete the Starter Kit
- Have the Conversation with a Loved One
- Appoint a Healthcare Agent/Proxy/POA for healthcare
- Bring **What Matters Most** concept back to your institution, community, congregation, circle of care

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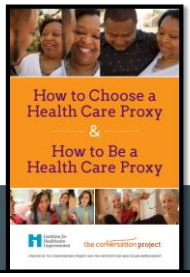
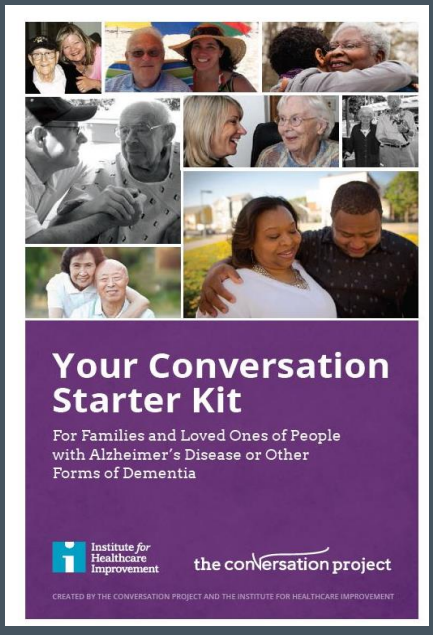
Accessible: Our Tools

- Conversation Starter Kit (translations + EMR summary)
- 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
- Starter Kit for How to Be and How to Choose a Health Care Proxy





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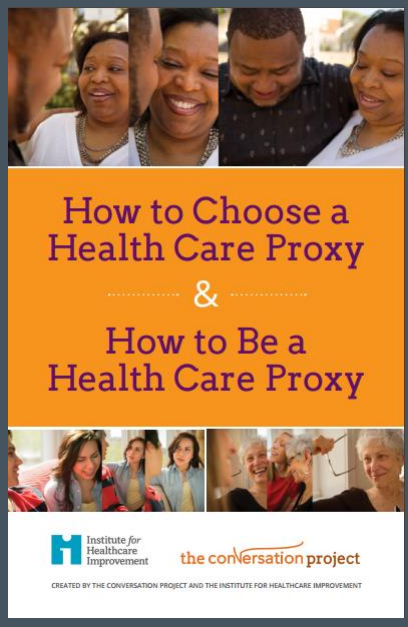

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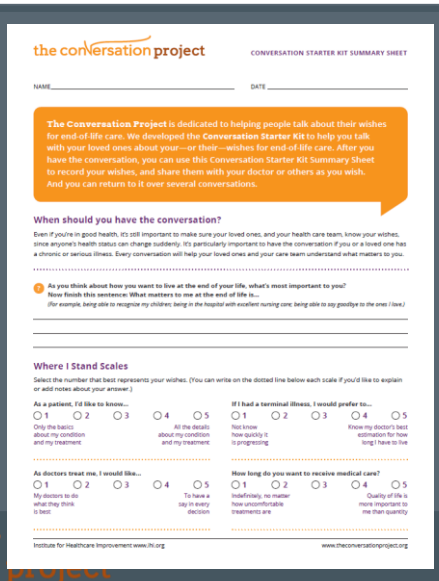
TCP Summary EHR Page



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CONVERSATION STARTER KIT SUMMARY SHEET

NAME _____ DATE _____

The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care. We developed the **Conversation Starter Kit** to help you talk with your loved ones about your—or their—wishes for end-of-life care. After you have the conversation, you can use this Conversation Starter Kit Summary Sheet to record your wishes, and share them with your doctor or others as you wish. And you can return to it over several conversations.

When should you have the conversation?

Even if you're in good health, it's still important to make sure your loved ones, and your health care team, know your wishes, since anyone's health status can change suddenly. It's particularly important to have the conversation if you or a loved one has a chronic or serious illness. Every conversation will help your loved ones and your care team understand what matters to you.

1 **As you think about how you want to live at the end of your life, what's most important to you?**
Now finish this sentence: What matters to me at the end of life is...
(For example, being able to recognize my children; being in the hospital with excellent nursing care; being able to say goodbye to the ones I love.)

Where I Stand Scales

Select the number that best represents your wishes. (You can write on the dotted line below each scale if you'd like to explain or add notes about your answer.)

As a patient, I'd like to know...
○ 1 Only the basics about my condition and my treatment ○ 2 ○ 3 ○ 4 ○ 5 All the details about my condition and my treatment

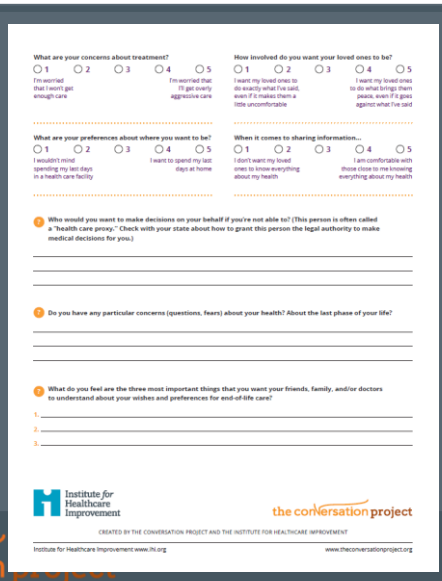
If I had a terminal illness, I would prefer to...
○ 1 Not know how quickly it is progressing ○ 2 ○ 3 ○ 4 ○ 5 Know my doctor's best estimation for how long I have to live

As doctors treat me, I would like...
○ 1 My doctors to do what they think is best ○ 2 ○ 3 ○ 4 ○ 5 To have a say in every decision

How long do you want to receive medical care?
○ 1 Indefinitely, no matter how uncomfortable treatments are ○ 2 ○ 3 ○ 4 ○ 5 Quality of life is more important to me than quantity

Institute for Healthcare Improvement www.IHI.org www.theconversationproject.org

TCP Summary EHR Page



What are your concerns about treatment?

1 2 3 4 5

I'm worried that I won't get enough care — I'm worried that I'll get overly aggressive care

How involved do you want your loved ones to be?

1 2 3 4 5

I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable — I want my loved ones to do what brings them peace, even if it goes against what I've said

What are your preferences about where you want to be?

1 2 3 4 5

I wouldn't mind spending my last days in a health care facility — I want to spend my last days at home

When it comes to sharing information...

1 2 3 4 5

I don't want my loved ones to know everything about my health — I am comfortable with those close to me knowing everything about my health

Who would you want to make decisions on your behalf if you're not able to? (This person is often called a "health care proxy." Check with your state about how to grant this person the legal authority to make medical decisions for you.)

Do you have any particular concerns (questions, fears) about your health? About the last phase of your life?

What do you feel are the three most important things that you want your friends, family, and/or doctors to understand about your wishes and preferences for end-of-life care?

1.
2.
3.

Institute for Healthcare Improvement

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CREATED BY THE CONVERSATION PROJECT AND THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

Institute for Healthcare Improvement: www.ihi.org — www.theconversationproject.org

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"Our ultimate goal, after all, is not a good death, but a good life to the very end."

– Atul Gawande

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Conversation Ready Principles

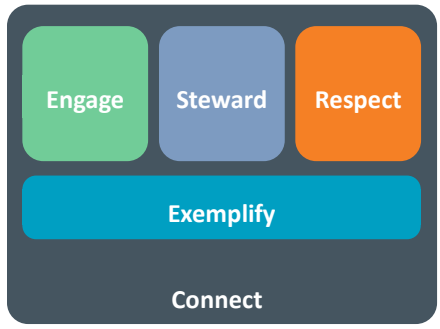
Engage with patients to understand what matters most to them at the end of life

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

Respect people's wishes for care at the end of life by partnering to develop a patient-centered plan of care

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

Connect in a manner that is culturally and individually respectful of each patient



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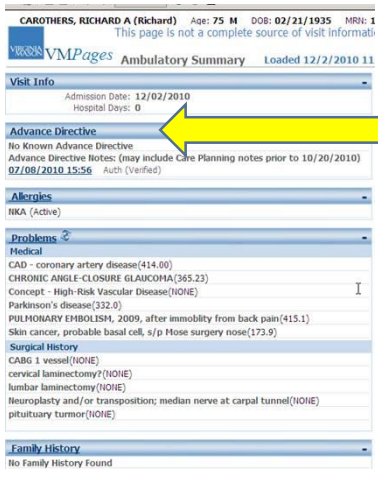
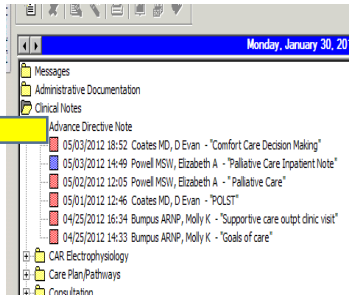
VIRGINIA MASON MEDICAL CENTER: Electronic Medical Record One Place = Advance Directive Note Type





- **All relevant documents and conversations**
  - **Ambulatory: 1' Care & specialty**
  - **Acute Care: ED, Hospital, CCU**
  - **Palliative Care**
- **Scanned POLST, Advance Directives, DPOA**

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Care New England: "Conversation Nurse"

- RN with excellent communication skills who can be deployed for goals of care conversation
- Work with medical team and/or palliative care team to help communicate goals of care
- Very patient centered
  - "What is important to you?"
  - "Where do you want to receive care?"
- Meets either with physician or independent of physician and confers with medical team

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Exemplify: "Talk Turkey"

- In 2 days, over 20 staff volunteers distributed 1,300 Health Care Proxy forms and 150 Conversation Starter Kits.
- Interviewed 17 staff members about their own personal and professional views on having a HCP.
- Produced short video for use in outreach to staff and patients.



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Starting The Conversation

Mount Auburn Hospital, Cambridge, MA

- Group educational series in out-patient setting
- Used the Starter Kit vs no Starter Kit
- 70% completed proxy vs 30% completed proxy
- Social network – factor of four people

Give the Starter Kit to patients when they turn 55yrs old

- This is important, so I know your wishes
- This is a gift you can give to your children

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Connect: Henry Ford: Faith Leader Conference

- "Advance Planning for End of Life: Tools for Faith & Health Conversations" Program goals:
  - engage the local faith community on issues surrounding end-of-life care and planning.
  - help healthcare providers and clergy understand their role in the collaborative effort to support patients and families
- Keynote: combine theology and patient care: faith often influences a patient's response to a terminal illness.
- Next steps:
  - training sessions for faith leaders on advance-care planning
  - web-based tools and resources for the faith community, including sermons, bulletin articles and frequently asked questions

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St. Charles
HEALTH SYSTEM

Advance Care Planning and The Conversation Project

Dr. Laura Mavity
Clinical Director, Advanced Illness Management
September 10, 2015

Creating America's healthiest community, together.

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Conversation Sabbath

conversation sabbath

Oct. 27 – Nov. 5 | #ConvoSabbath

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6 Reasons for Faith Community Spread

- Existing communities - shared values
- Encouraging more compassion and less fear
- Story-telling communities
- Planting seeds of cultural change
- They like to eat together!
- Positioned to support family care-providers and people with advanced and serious illness

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Two More Reasons…

- Starter Kit reaches clergy
- An avenue for reaching diverse populations where they live and pray and gather

Starter Kit Workshop at Islamic Society of Boston Cultural Center

May 2015

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Celebrating Readiness

- To talk about the reality of our mortality
- To share our wishes with loved ones and doctors
- To ground our conversations in our values and faith

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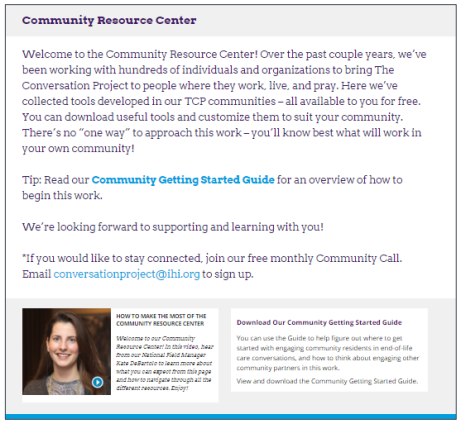
Community Engagement Resources



Community Resource Center

- Community Getting Started Guide
- Community Organizing Resources
- Hosting Events
- Materials and Tools (translations, ACP resources and videos)
- Publicity and PR Materials

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Developing Your Action Plan

Change takes place when people decide to take action. *What action do you want to take?*

- Who do you need to talk to when you get back?

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Developing Your Action Plan

Change takes place when people decide to take action. *What action do you want to take?*

- Who do you need to talk to when you get back?
- What information will you still need?

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Developing Your Action Plan

Change takes place when people decide to take action. *What action do you want to take?*

- Who do you need to talk to when you get back?
- What information will you still need?
- In one year, if you were to have wild success, what will have been the factors of this success?

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Developing Your Action Plan

Change takes place when people decide to take action. *What action do you want to take?*

- Who do you need to talk to when you get back?
- What information will you still need?
- In one year, if you were to have wild success, what will have been the factors of this success?
- In one year, if this project was a flop, what will have been the factors of this failure?

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Developing Your Action Plan

Change takes place when people decide to take action. *What action do you want to take?*

- Who do you need to talk to when you get back?
- What information will you still need?
- In one year, if you were to have wild success, what will have been the factors of this success?
- In one year, if this project was a flop, what will have been the factors of this failure?
- What will you try by next Tuesday, in six months, in one year?

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Possible Community Partners

- Assisted Living Facilities
- City Employee Retirement System
- Dept. of Public Health, Mental Health, Behavioral Health
- Elected Officials
- EMT providers
- Estate/Legal entities (elder law, local bar association…)
- Employers
- Faith-based organizations, clergy, chaplains, ministerial associations
- Financial community banks, CPA firms, financial advisors
- Health plans/insurers
- Home care/VNA
- Retirement communities and home owners associations
- Homeless shelter/services
- Hospice
- Hospitals/Health systems
- Local resources: libraries, Chamber of Commerce, Lion/Rotary/Elks Club…
- Media channels (local, state, regional)
- Medical/Nursing/Hospital Association
- Nursing homes, rehab facilities, long term care
- Physician office practices/primary care
- Prisons/jails
- School District – employee benefits, Parent Teacher Organizations
- Senior Advocacy Organizations/Elder Services (Area Agency on Aging, senior center, transportation services, meals on wheels)
- Universities – students, faculty, alumni
- Veterans Services

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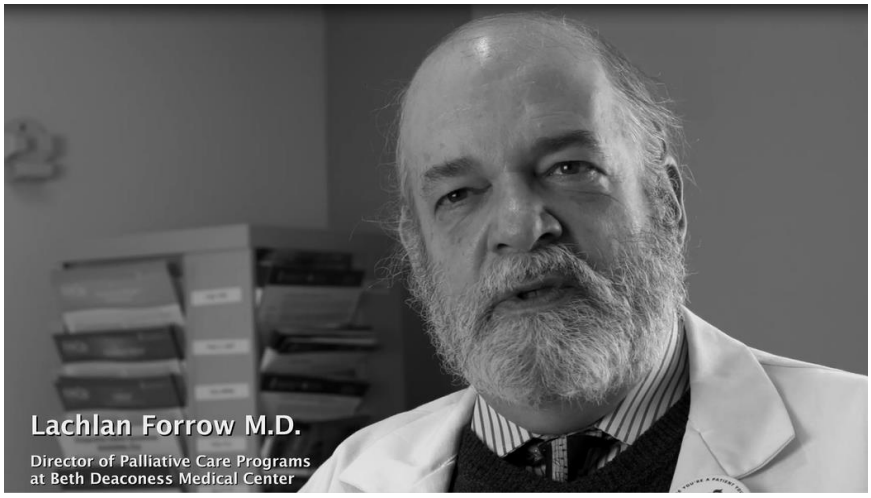
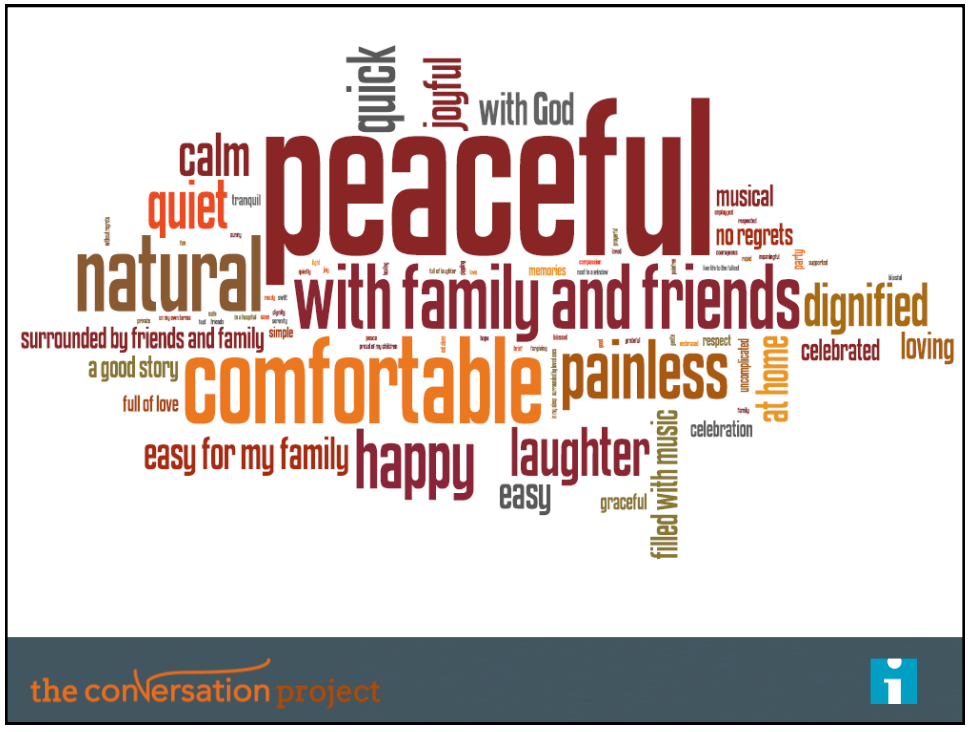
A Soul Doctor and a Jazz Singer



A Soul Doctor and a Jazz Singer


quick
joyful
with God
calm
peaceful
quiet
tranquil
musical
no regrets
natural
with family and friends
dignified
surrounded by friends and family
simple
comfortable
painless
celebrated
loving
a good story
at home
full of love
celebration
easy for my family
happy
laughter
easy
graceful
filled with music
the conversation project