Having the End of Life Conversation: Practical Concepts for Advocacy Within the Continuum of Care

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Instructions and Handouts for:

Having the End of Life Conversation:
Practical Concepts for Advocacy Within the Continuum of Care

Eastern
Standard Time
1:00 PM to 2:00 PM

Central
Standard Time
12:00 PM to 1:00 PM

Mountain
Standard Time
11:00 AM to 12:00 PM

Pacific
Standard Time
10:00 AM to 11:00 AM

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Executive Leadership Summer Series:
Clinical Model Management, Part III
Having the End of Life Conversation

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Executive Leadership Series
Part I. Organizational Structure Matters:
Learning How to Support Your
Changing Model of Care (June 28th)
Part II. From Home Health to Hospice: Care
Management Along the Continuum (July 10th)
Part III. Having the End of Life Conversation:
Practical Concepts for Advocacy Within the
Continuum of Care (July 24th)

Objectives
• Understand the context for needed change within an evolving healthcare delivery system.
• Identify executive leadership’s responsibility for creating accountability around successful transition to desired end of life care in home health. It starts with a conversation…
• Provide insight into common barriers to having the end of life conversation.
• Provide clear tools to help optimize advocacy, support smart business strategy within healthcare reform and empower clinicians in this important skillset.
Context is Critical

- Why is it important to empower clinicians with "end of life conversation" skill-set?
  - Advocacy
  - Business:
    - Reform initiatives are forcing heightened collaboration within the care continuum
    - Reimbursement incentives will reward health systems for lower avoidable rehospitalization within 30 days (e.g.: medical home models, ACO's, bundled payment, money follows the person, etc...).
    - Lower avoidable rehospitalization can be achieved through identifying and advocating for desired level of care at end of life.

Why Else is it Important?

- Effective leadership compels you to:
  - Clarify Expectations of Performance
  - Provide the tools needed to meet the expectation and measure performance
  - Hold them accountable.

Clinicians need tools to enhance their competence and comfort when discussing end of life care options with their patients.

Hospital Readmission is a Problem; Better Care Transition Can Help

- 19% of hospitalizations resulted in readmission within 30 days (2008)
- 2/3 of Medicare, medical DC's are re-hospitalized or dead within a year
- 19% Medicare Hospital DC’s followed by adverse event within 30 days
  - 2/3 drug events, most often judged “preventable”
  - MedPAC: 75% readmits avoidable (cost $12B)
- 25% of re-hospitalizations had 6 or more chronic conditions: common home health cohort
- Patients at end of life, who want comfort care instead of intervention, often go back in because no one transitioned their care effectively.

Chronic Illness Facts

- 80% of healthcare spending related to 20% of population – Chronic Disease prevails in this group.
- 49% of Americans have one or more chronic disease(s).
- Chronic diseases account for $3 of every $4 spent on healthcare. That’s nearly $7,900 (per annum) for every American with a chronic disease.
- Chronic diseases such as diabetes, cancer, and heart disease are the leading causes of disability and death in the US.
- Chronic diseases cause 7 out of every 10 deaths


Cultural Mind Shift

“The continued application of traditional treatment strategies which are valuable to the patient at an earlier time in their health experience has the opposite effect on patients at end of life resulting in inferior outcomes.”

Daniel Hoefer, MD  Associate Medical Director
Sharp HospiceCare

Optimism Can Cloud Reality

Fuzzy Prognostication Increases Cost and Reduces Advocacy

- Physicians overly optimistic by 530% - our own experience indicates that they are not alone.
  - This denial comes at a cost.
  - Too many direct admits from hospital or ER to hospice while actively dying.
  - Where is the effective transition into end of life care?

British Medical Journal; Extent and Determinants of Error in Doctors Prognoses in Terminally Ill Patients; Prospective Cohort Study; Vol. 320(7233), 19 Feb 2000 pp.469-473
27% of patients with incurable terminal disease believed they could have been cured

Unresectionable non-small-cell lung cancer 54%
AIDS 32%
CHF 22%
ALS 16%
COPD 12%


Choosing a Proactive Model for Disease Management

Å Addresses total person – emotional, physical, spiritual
Å Does not imply disease is curable
Å Prepares patient/family for inevitable outcomes of disease process

Choosing a Proactive Model for Disease/Care Management

Å Uses evidence-based prognostication to anticipate ongoing and future medical needs
Å Facilitates identification of the patient/family members ‘activation’ with respect to managing their disease-state
Å Identifies and respects patient’s goals of care
Å Guides patient through the continuum of their disease process
Å Minimizes unnecessary adverse events
Transitional Care/Advanced Disease/ Palliative Models

• Proactive In-Home Consultative Care
  • Aggressive in-home care vs. “reactive” care
  • Team approach: RN, MSW, Spiritual Care
• Evidence-Based Prognostication
  • Physician Directed
  • Qualifying Clinical Criteria
• Caregiver Support
  • Resources
  • Education
• Advance Care Planning
  • Planning for the “when” not the “if”

Facing Mortality

• No small task
• Mindfulness to process of discovery
• Requires values clarification:
  • Self
  • Patient
  • Family/Caregivers
  • Health System
  • Physician

Regulatory Guides

• Overall Prognosis
• Comorbidities/ ICD-9 and onset/exacerbation dates
• Advanced Directives, Living Will, DNR
• OASIS elements/dependence/decline
• Reform initiatives; reimbursement under new models will eventually motivate MD’s to use evidence to better prognosticate
Have the Conversation

- First with yourself; and a mirror if necessary, to find comfort in the inevitable cycle of wellness and illness and end of life. Identify and clarify values.
- Practice scripted conversations/talking points. Don’t “lean” your values on others.
- Know your resources to support further care
- Look for accuracy in prognostication
- LISTEN

Wrong Way

Tell Ask Tell

Go!

Ask Tell Ask
The Therapeutic Conversation

- Ask patient or caregiver how they see their situation
- The Response will usually cue you to deeper questions...ask more based on cues
- LISTEN
- Silence is POWERFUL and requires patience...
  - MD’s usual tolerance for silence is ~ 7 seconds

My Life Decision in 7 Seconds???

- Suggested intervals of silence for > or = to 60 seconds can help unlock dialogue of further questions:
  - Do they want to stay at home?
  - Do they want to go back into the hospital again? “What is most important to you today?”
  - Do they want comfort or intervention for the disease?
  - What are their greatest fears?
  - What do they want? What does their family know about what they want? What does family want?

Identify Goals for all Care (Clinician’s Perspective)

- How does this patient “look” at discharge?
- Is their discharge from home health a transition to end of life care?
- How can the clinician unlock the door to advocacy?
Hospice-Myths Create Barriers to Effective Transition! Bust ‘em!

• Myth: Won’t be aggressively managing disease & symptoms
• Myth: Giving up hope
• Myth: Giving up my Physician
• Myth: Family unable to care for a loved one who is dying
• Myth: Discuss care provided, payment, length of stay

Approach the End of Life Conversation

• Involve the immediate family
• Avoid the vague terms
• Ask the client and their family about their specific questions and concerns
• Acknowledge the family’s emotions
• Listen to the family and client

Continuing the Conversation

• Hope for the best yet prepare for the worst
• Avoid medical details – paint big picture.
  • “Mom has been hospitalized 3 times in the last 6 months for extreme difficulty breathing with her heart condition, she wants to stay home...this is what can be done to help her.”
Build Skill Set – Intentional Approach to Disease Management Along Continuum

- Look at agency trend to make late referrals to hospice for CHF
- Introduce concept that “we can do this better”
- Remember CHF one of top 3 hospital admitting diagnoses – health system priority
- Healthcare “reform”
- Organizational “readiness”

Palliative Care – Hospice Who Does Not Qualify

- Patients pursuing traditional hospital management: seeking interventive care rather than aggressive management of symptoms of disease
- Patients too early in the disease progression not meeting criteria
- Patients not willing to participate in developing an advanced health care plan

Follow Up with a Plan

- Transitional care initiatives
- Support for appropriate depression
- Decrease stress in caregiver population
- Advance Directive documentation is tight
- Plan of care is accurate and updated
- Learn from best practice/scripting/behaviors for supportive listening
Successful Mastery
Having the End of Life Conversation

- Allows clinicians to gain competence in comprehensive home health case management
- Allows Care Management to work toward goal directed care, provided in the most efficient and effective manner
- Allows agencies to better reduce avoidable hospitalization; helping their positioning within health system reform
- Allow us to advocate more fully, more effectively, throughout the lives of our patients.

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