

In This Issue: Practice Change Fellows Focus on Palliative Care

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Quality Improvement Related to Person-Centered Preferences



Joanne Lynn, MD, Director of the Center for Elder Care and Advanced Illness, moderated a day-long Practice Change Fellows session on eliciting and honoring older adults' preferences for the type, intensity, and location of health care services. To launch

the discussion, Dr. Lynn offered a few thoughts about how to frame quality improvement efforts. "First, know the politics," she said. "Who really owns the process, and are they willing to make change?" She also counseled change agents to get started quickly. "Nothing is more lethal to change than long delays in getting started," she said, adding that the biggest force against change is comfort in well-established processes. "Whenever possible, make a process reliable first, and then optimize it," she added. She also believes in customizing

processes for groups of individuals — "because these processes will be easier to adopt" — and avoids spending too much energy on measurement. She added that building in sustainability from the start is critical to long-term success. "During the initial design stages, think about what is needed to keep the project going into the future." Finally, she said, "Every person living with chronic health problems deserves a negotiated plan of care that reflects his or her actual medical and social situation and informed preferences. This plan of care is the central missing element in health care delivery today. It requires clinicians who have an informed and honest view of a patient's future course as well as a commitment to the patient's long-term well-being, as defined by the patient."

"Every person living with chronic health problems deserves a negotiated plan of care."

~ Joanne Lynn, MD

Cultivating Meaningful Conversations

Elizabeth Hart, MD, Associate Medical Director of HealthReach Hospice in central Maine, discussed the importance of holding meaningful conversations with individuals and families at the end of life in order to determine patient preferences. "As providers, we need to make time for a reflective process that will lead to a clear understanding of what people want at the end of life," she said, adding that clinician training rarely focuses on this important aspect of care provision. Dr. Hart noted that conversations should define realistic, attainable goals; include a clear description of the risks and benefits associated with hospitalization and various possible interventions; such as CPR, antibiotic use, and administration of artificial nutrition and fluids; avoid judgment about patient and family decisions; and acknowledge families' guilt and grief even when honoring a patient's wishes. Dr. Hart also shared a "Cultivating Meaningful Conversations" tool she developed to help providers hold difficult conversations with patients and families.

"As providers, we need to make time for a reflective process that will lead to a clear understanding of what people want at the end of life."

~ Elizabeth Hart, MD

Palliative Care for the Critically Ill

Shirley Fong Jones, MD, Assistant Professor of Medicine at Scott and White Healthcare, discussed palliative care in the ICU. "Published literature reflects a need to improve end of life care delivered in the ICU," said Dr. Jones, who discussed two potential models. In the consultative model, a palliative care team provides consultations to the ICU team. In the integrative mode, palliative care principles are embedded in ICU practice. The benefits of palliative care in the ICU include increasing family satisfaction, reducing anxiety and reducing nonbeneficial treatment. "Palliative care and critical care providers may have different specialties, but we share the same goals," said Dr. Jones. Scott and White has adopted the consultative model but has included aspects of the integrative model, including multidisciplinary rounding that involves the palliative care team and "Get to Know the ICU" brochures that aim to help families understand the ICU and its processes. Formal education about palliative care is a requirement for physicians in training. Palliative care is also integrated into the ICU via multidisciplinary psychosocial ICU rounds that include family members and "Get to Know Me" posters in each room so that families can share pictures and personal information about the patient.

"Palliative care and critical care providers may have different specialties, but we share the same goals."

~Shirley Jones, MD

Personal Testimony: A Patient's Reflections on Person-Centered Care

Amy Berman, BS, RN, a Senior Program Officer with The John A. Hartford Foundation and a much-loved member of the PCF family, discussed her views on person-centered care, which became highly personal after she was diagnosed with stage IV inflammatory breast cancer last year. "I can share an up-close view of what it's like to be on the receiving side of the health care system," she says. Ms. Berman counsels providers to understand how much each individual wants to know, and then deliver that information in an honest and straightforward manner. She notes that providers should explain when an aggressive approach might not confer much, if any, benefit in terms of quality of life, and that patients should be respected regardless of their care choices. "Providers should be brave when delivering bad news to patients and asking them about their preferences and goals," she said. "Although this conversation is difficult, it is the kindest thing you can do for someone. If you want patient-centered care, someone has to actually talk to the patient." As for Ms. Berman herself, she says, "For today, I live in the moment. And it's a great day."

Independence and Connectivity

"Caregiving is high-touch, while technology is somewhat cold – but it's possible to tie them together," said Richard Della Penna, MD. "While there is no substitute for the human touch, technology can support caregiving in meaningful ways." Della Penna is Chief Medical Officer of Independa, Inc., a company that is developing products and services to support individuals who want to age in place and their remote caregivers. Independa has developed a software interface that integrates commercially-available home/environmental sensors and health sensors with an Internet-based application caregivers use to set "rules" for phone or email alerts when sensors indicate a problem. Home sensors detect a wide variety of environmental conditions such as floods, smoke, carbon monoxide, open doors, bed/chair pressure, motion, and temperature extremes; health sensors include a blood pressure cuff, a scale, a glucometers and a pulse oximeter. "The goal is to support an individual's desire for independence while easing the stress of their loved ones, who may live far away," Della Penna explained.

Palliative Care Opportunities for Health Plans

Judith Black, MD, MHA, Medical Director of Senior Markets at Highmark, Inc., described the health plan's activities to assist members in dealing with life-limiting illness. Highmark participated in several regional, state and national collaborations, including the Governor's Task Force for Quality at the End-of-Life in Pennsylvania and the National POLST Paradigm Task Force. Highmark also incorporated palliative care indicators into a hospital pay-for-performance program. "Palliative care can address a number of factors — including poor care coordination and communication failures — that lead to avoidable readmissions and suboptimal care quality," noted Dr. Black. Finally, Highmark developed an Advanced Illness Services program that focuses on providing emotional support, facilitating decision-making, coordinating services for members with life-limiting illness and controlling pain and symptoms. "Research shows that palliative care leads to less aggressive end-of-life care and longer survival, as well as lower claims costs," she said. "Our mission is to provide high-quality palliative care that will enable our members to live longer, better, independent lives in optimal health."

Quick Study: Advance Care Planning May Be Better “In the Moment”

Traditionally, the objective of advance care planning has been to help patients and families make treatment decisions prior to actual need so that clinicians can help patients meet their care goals. However, in an article published in the August 2010 issue of the *Annals of Internal Medicine*, Rebecca L. Sudore, MD and Terri R. Fried, MD propose an alternative objective: to prepare patients and families to make good decisions in the moment, when these decisions are most relevant. The authors note, “Individuals have difficulty predicting what they would want in future circumstances because these predictions do not reflect their current medical, emotional or social context.” Alternatively, if the objective of advance care planning is decision-making preparation, the focus shifts away from premature decisions based on hypothetical information and toward a more comprehensive and complex set of considerations, such as the current clinical situation and evolving patient/family goals and needs. To meet this new objective when encouraging advance care planning, clinicians must assess and address patients’ readiness to engage in preparation, prompt them to choose an appropriate surrogate decision-maker, and establish

how much decision-making leeway is acceptable to the patient.

Sudore RL, Fried TR. Redefining the “planning” in advance care planning: preparing for end-of-life decision making. *Ann Int Med* 17 Aug 2010;153(4):256-61.



Promoting Consumer Engagement in End of Life Decisions

“Most people want a ‘good death,’ but what that means to an individual is too often left undefined until a crisis occurs or the person is no longer able to communicate,” noted Molly Mettler, MSW, Senior Vice President of Mission at Healthwise. Ms. Mettler described a three-step framework families can use to prepare for end-of-life decisions. Step 1 is “define & decide.” “It is critical to really understand what the words mean in order to make informed decisions,” she says. For example, families need to understand the difference between palliative and hospice care, the meaning of artificial nutrition and hydration, and the real implications of “do not resuscitate.” Step 2 is “discuss & delegate.” Individuals need to carefully choose a health care delegate and clearly inform that delegate of his or her wishes. Step 3, “document,” involves the completion of an advance directive and, in some states, a POST (Physician Orders for Scope of Treatment) form, which confirm the individual’s preferences. Ms. Mettler also discussed Healthwise decision support aids that promote consumer engagement and person-centered care at the end of life.

Geriatric Consultation and Palliative Care

Deirdre Doerflinger, PhD, CRNP, Geriatrics Clinical Nurse Specialist at Inova Fairfax Hospital and Anne Buckley, RN, MSW, CHPN, Palliative Care RN Coordinator at Capital Caring, a palliative care consulting firm in northern Virginia, discussed the importance of geriatric consult teams and palliative care at the end of life. Dr. Doerflinger described Inova Fairfax’s geriatrics consult team, which worked with approximately 1400 patients in 2010. “We consult with seniors who have complex care needs, addressing topics such as end of life/goals of care, nutrition, falls, confusion, functional maintenance, and community resources,” she said, adding that team consults have led to significant improvements in patients’ mental status and activities of daily living, lower rates of readmission and nursing home placement and improved medication adherence. Ms. Buckley outlined the barriers to palliative care, including a lack of understanding of the difference between palliative care and hospice, fear, loss of control, limited access, and cultural/religious barriers, but noted that awareness and education can help. “We need to integrate palliative care into the medical and nursing core curriculum,” she said.

Tri-Annual Meeting Highlights

Integrated Care for Dual Eligibles: Robert Berenson, MD, Senior Fellow at the Urban Institute and Melanie Bella, MBA, Director of the Centers for Medicare and Medicaid Services Medicare-Medicaid Coordination Office led a session on how health reform and the integrated care of individuals enrolled in both Medicare and Medicaid.

Leading Cultural Change: Robert Schreiber, MD, Physician-in-Chief at Hebrew Senior Life and Susan Gilster, PhD, RN, Executive Director of Susan Gilster and Associates led the 2009 Practice Change Fellows in an interactive skills

session on how to successfully lead organizational cultural change as part of their project development and implementation process.



The Practice Change Fellows Program

The Practice Change Fellows program is a two-year fellowship program designed to build leadership capacity among nurses, physicians, and social workers who have operations level responsibility for aging programs and geriatric service lines.

To learn more about the program please visit www.practicechangefellows.org.

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