Partnership for Community Health and Nursing Home LAN Event:

Be Conversation Ready and Centering Care Transitions Around Patient-Defined Goals

Presenters:
Kate DeBartolo
Kevin T. Fuji, PharmD, MA
Amy A. Abbott, PhD, RN

January 25, 2024

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iQUALITY IMPROVEMENT & INNOVATION GROUP

Kate DeBartolo

SENIOR DIRECTOR, THE CONVERSATION PROJECT
INSTITUTE FOR HEALTHCARE IMPROVEMENT

Kevin T. Fuji, PharmD, MA

ASSOCIATE PROFESSOR, PHARMACY CREIGHTON UNIVERSITY

Amy A. Abbott, PhD, RN

ASSOCIATE PROFESSOR CREIGHTON UNIVERSITY

Objectives:

- Discuss ideas for implementing NHDD into current practice.
- Learn messaging principles to engage patients and families in conversations about end-of-life care wishes.
- Identify areas of alignment and discordance across patients, caregivers, and health care providers during care transitions.
- Understand the importance of working within the context of patient-defined goals in the ED to encourage buy-in and engagement.

The Conversation Project

Kate DeBartolo
January 25, 2024

Helping people share their wishes for care through the end of life

National Healthcare Decisions Day
April 16, 2024

Exemplify: Taking This to Your Community

Live

- Local leaders promoting TCP (retirees!)
- Presentations (invited and hosted)
- Train the trainer

Work

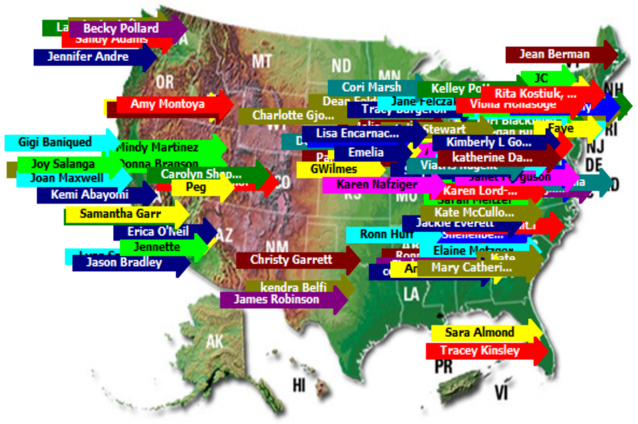
- Health care organizations
- General employers – mailings, brown bag lunches, HR process

Pray

- Shared sermons and materials – guest preaching
- Hosted events at houses of worship
- Integration of TCP into pastoral care and seminary education
- Collaboration with regional interfaith organizations

Learn

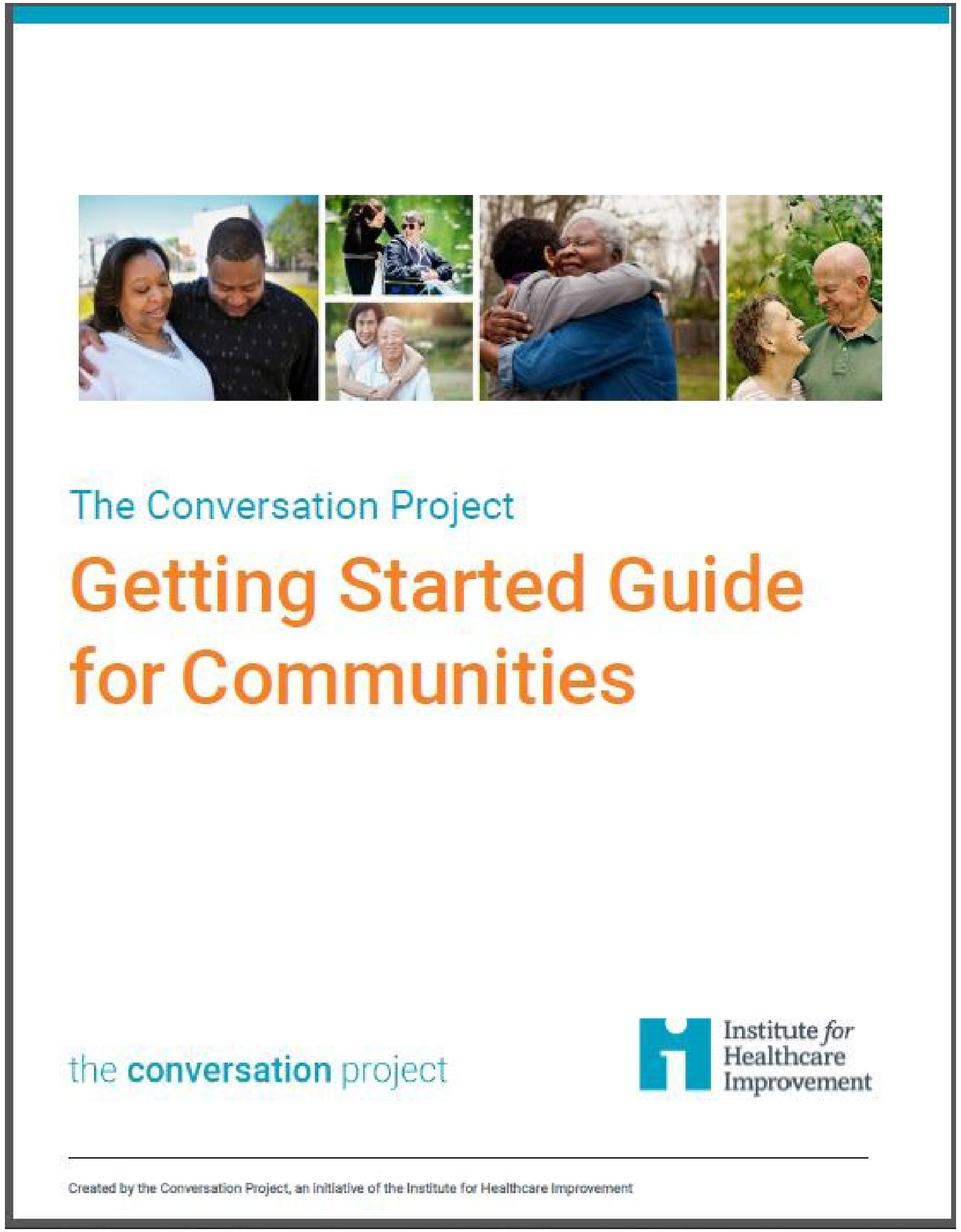
- Medical and nursing school courses
- Undergraduate courses/lectures in ethics, bioethics and humanities
- Faith-based educational institutions
- Health care systems partnering with local university/high schools
- OLLI courses



All in the Approach

Shifting From	**…To**
Death and dying	Life and living
What's the matter **with** you	What matters **to** you
Telling	Listening

Available at
theconversationproject.org/
resources/community



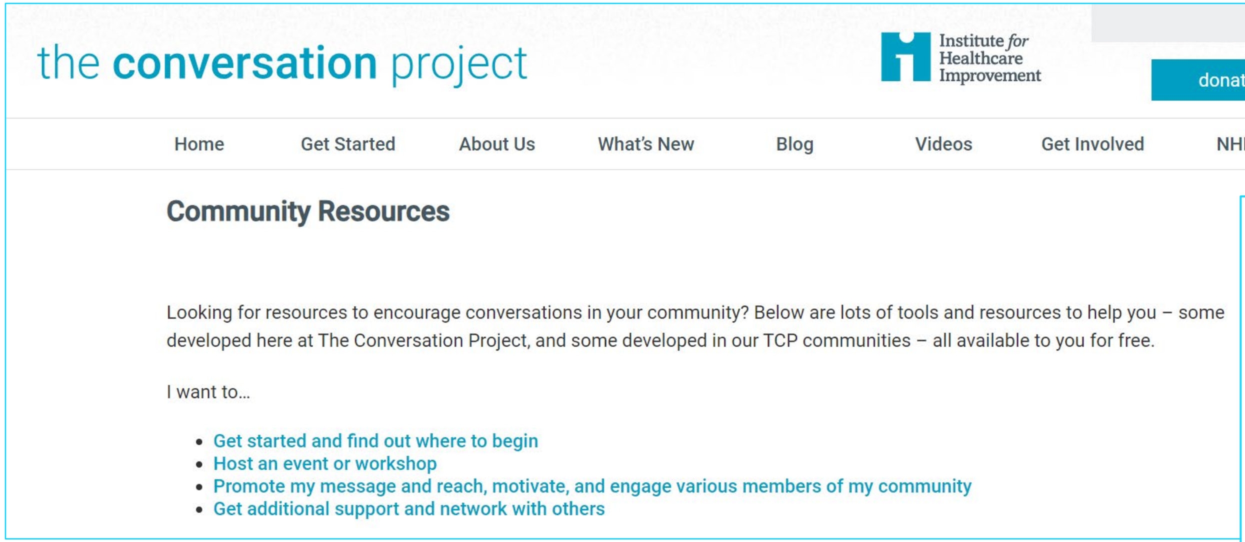
The Conversation Project

Getting Started Guide for Communities

the **conversation** project

Institute *for* Healthcare Improvement

Created by the Conversation Project, an initiative of the Institute for Healthcare Improvement



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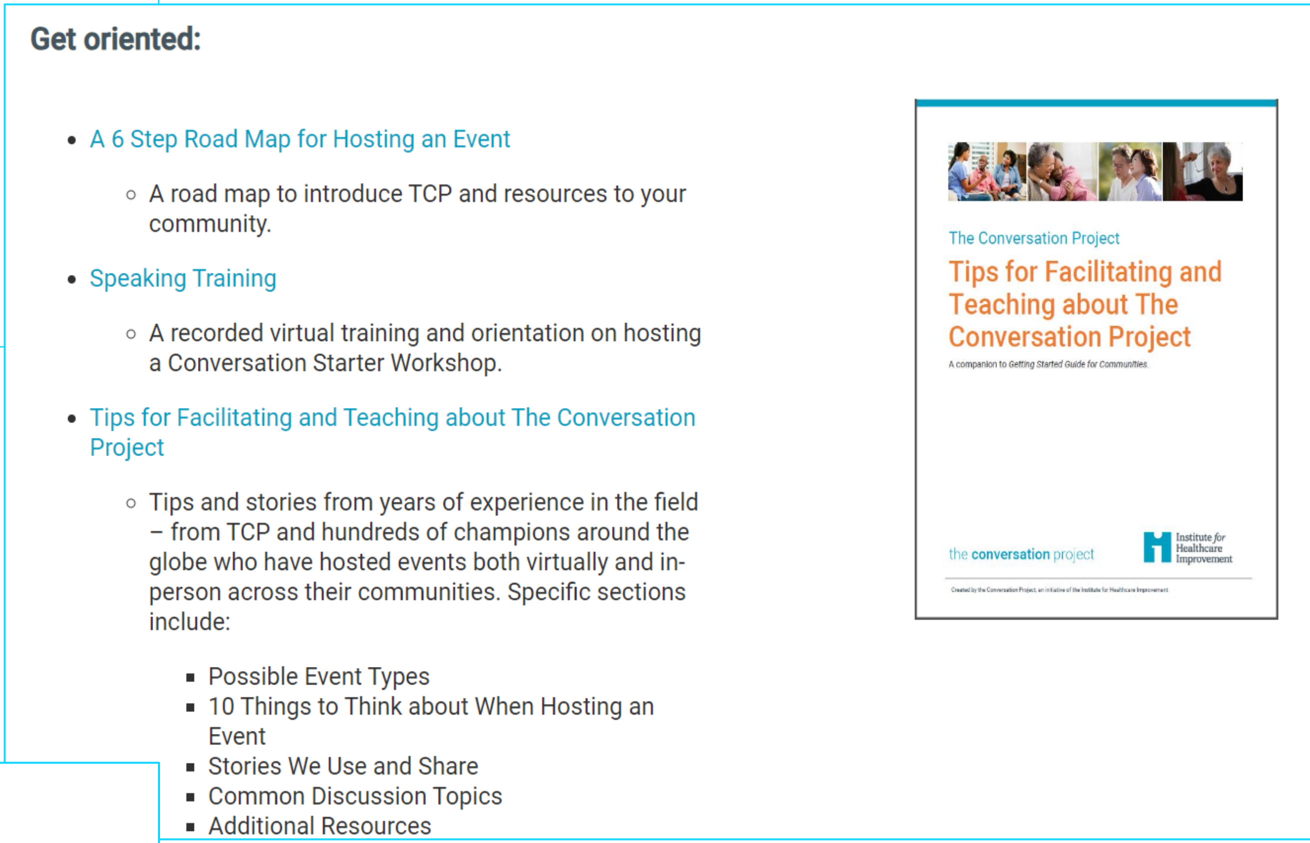
Community Resources

Looking for resources to encourage conversations in your community? Below are lots of tools and resources to help you – some developed here at The Conversation Project, and some developed in our TCP communities – all available to you for free.

I want to…

- Get started and find out where to begin
- Host an event or workshop
- Promote my message and reach, motivate, and engage various members of my community
- Get additional support and network with others



Get oriented:

- A 6 Step Road Map for Hosting an Event
  - A road map to introduce TCP and resources to your community.
- Speaking Training
  - A recorded virtual training and orientation on hosting a Conversation Starter Workshop.
- Tips for Facilitating and Teaching about The Conversation Project
  - Tips and stories from years of experience in the field – from TCP and hundreds of champions around the globe who have hosted events both virtually and in-person across their communities. Specific sections include:
    - Possible Event Types
    - 10 Things to Think about When Hosting an Event
    - Stories We Use and Share
    - Common Discussion Topics
    - Additional Resources

The Conversation Project

Tips for Facilitating and Teaching about The Conversation Project

A companion to *Getting Started Guide for Communities*

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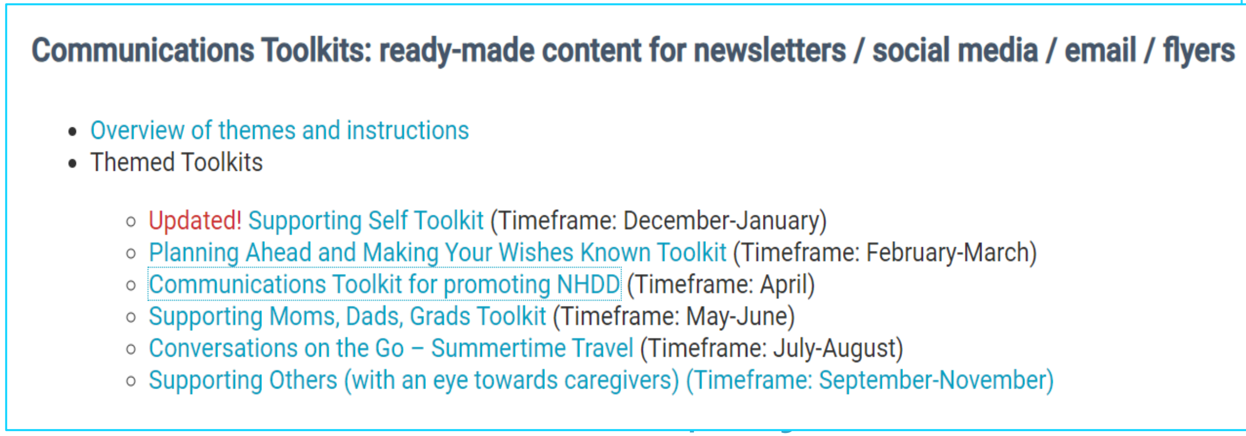


Communications Toolkits: ready-made content for newsletters / social media / email / flyers

- Overview of themes and instructions
- Themed Toolkits
  - Updated! Supporting Self Toolkit (Timeframe: December-January)
  - Planning Ahead and Making Your Wishes Known Toolkit (Timeframe: February-March)
  - Communications Toolkit for promoting NHDD (Timeframe: April)
  - Supporting Moms, Dads, Grads Toolkit (Timeframe: May-June)
  - Conversations on the Go – Summertime Travel (Timeframe: July-August)
  - Supporting Others (with an eye towards caregivers) (Timeframe: September-November)

Five Consumer Segments

Worried Action Takers 10%

Younger, diverse, most educated. Nearly half identified as having a disability.

Highest trust and regard for the health care system. ~80% have been a caregiver for an incapacitated loved one.

Self-Assured Action Takers 24%

Oldest by far; most likely to be white and least likely to be low-income.

Confident about managing their health and navigating the health care system with fewer worries about a future serious illness.

Disengaged Worriers 34%

Youngest, most diverse, lowest education and income; poorest health and health care navigation and management skills.

Seen loved ones' wishes not honored. Many worry about their health and future serious illness.

Confident Independents 18%

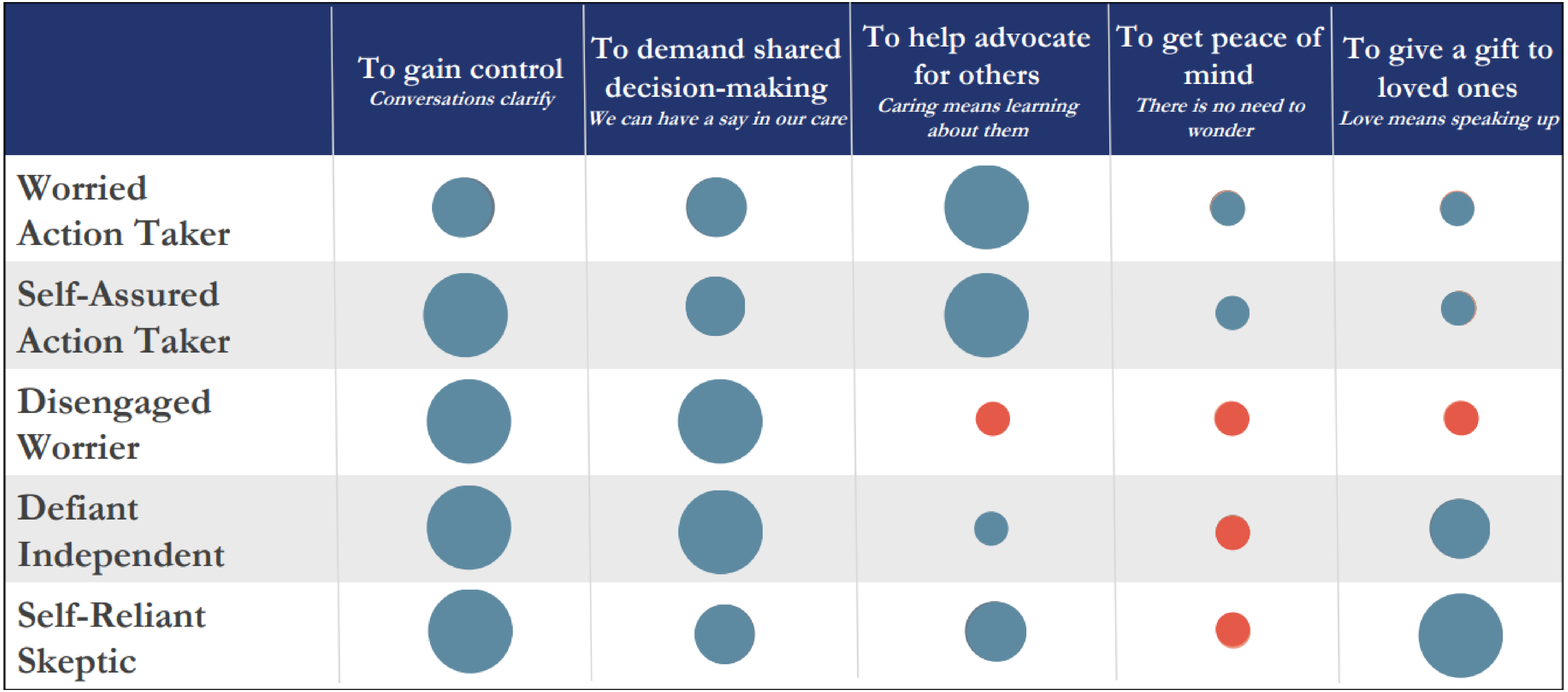
Older (mostly 45+), average education and racial composition. Fewer experiences with dying loved ones. Confident about managing their health and navigating the health care system with fewer worries about a future serious illness.

Self-Reliant Skeptics 14%

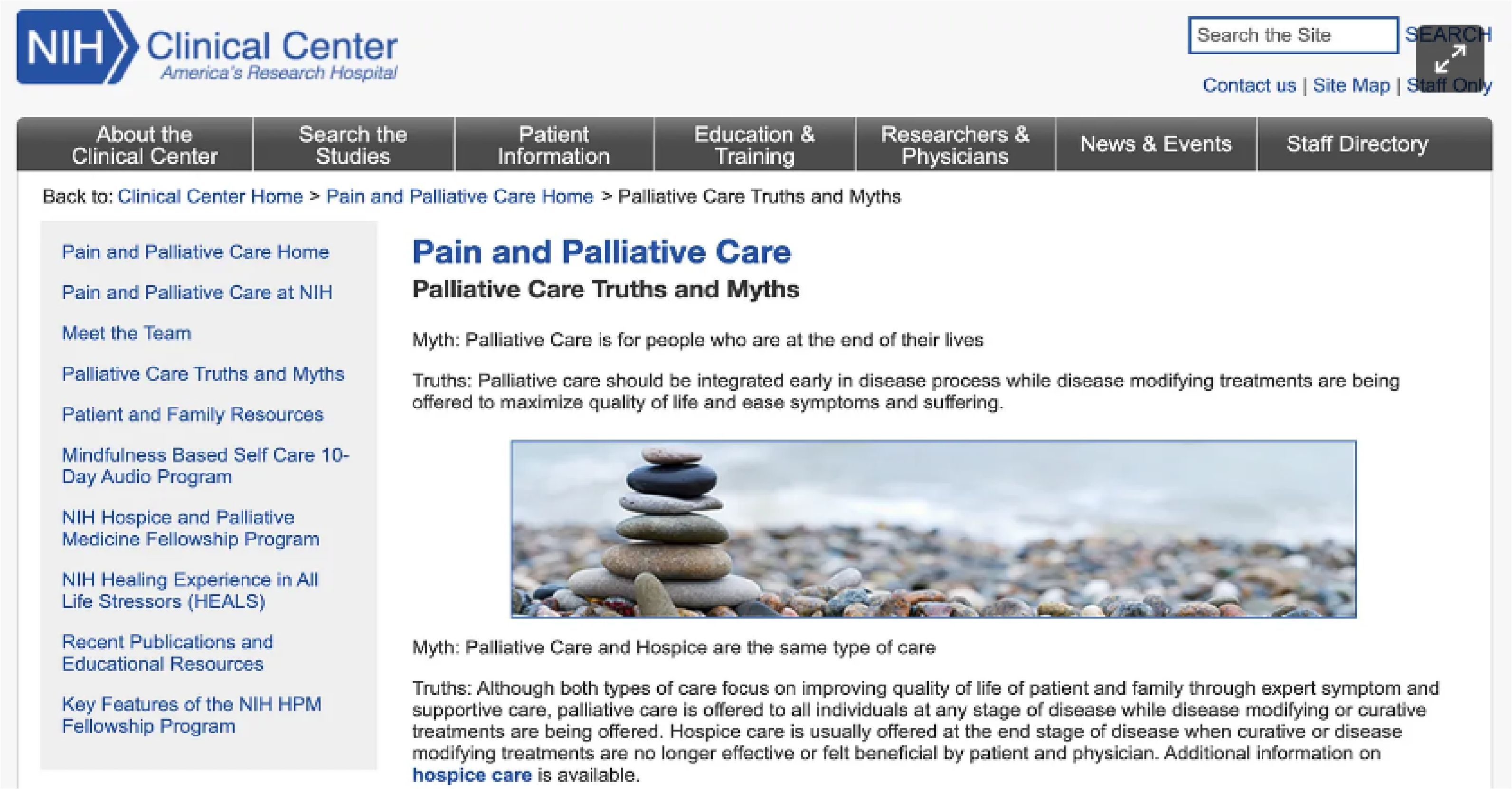
Middle-aged, lower income and education.

Lowest trust of doctors and regard for the health care system. Poorer health care self-management and navigation skills.

What Messaging Worked and Didn't by Segment



	To gain control *Conversations clarify*	To demand shared decision-making *We can have a say in our care*	To help advocate for others *Caring means learning about them*	To get peace of mind *There is no need to wonder*	To give a gift to loved ones *Love means speaking up*
Worried Action Taker	●	●	●	●	●
Self-Assured Action Taker	●	●	●	●	●
Disengaged Worrier	●	●	🔴	🔴	🔴
Defiant Independent	●	●	●	🔴	●
Self-Reliant Skeptic	●	●	●	🔴	●



Pain and Palliative Care

Palliative Care Truths and Myths

Myth: Palliative Care is for people who are at the end of their lives

Truths: Palliative care should be integrated early in disease process while disease modifying treatments are being offered to maximize quality of life and ease symptoms and suffering.

Myth: Palliative Care and Hospice are the same type of care

Truths: Although both types of care focus on improving quality of life of patient and family through expert symptom and supportive care, palliative care is offered to all individuals at any stage of disease while disease modifying or curative treatments are being offered. Hospice care is usually offered at the end stage of disease when curative or disease modifying treatments are no longer effective or felt beneficial by patient and physician. Additional information on **hospice care** is available.

At least they didn't use the hands...

We love debunking myths. This is a problem.

> Repeating myths keeps people stuck in misinformation. Then they decline services that are proven to help.

Steal These Messages: Advance Care Planning

You can have a say in your care

Treatments only work if they work for you

Talk to the people who matter most about the care you want

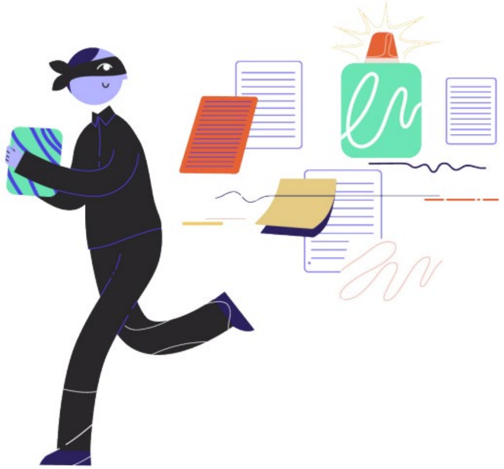
The more you speak up, the better your health care can be

Tell your doctors what matters most to you

You can get the care that's right for you

We'll figure this out together

Let's make a plan for your care



Messaging To Remember

Talk up the benefits: These services and care improve people's lives. Don't lead with dying

Present choices for every step: At every stage of an illness, we have choices

Use stories: Use positive and aspirational stories, and don't bombard them with statistics

Invite dialogue—and not just once: The call to action is to talk with someone

Invoke a new team: Patients, people who matter to them, health care providers, and the community all have a role

"We'll figure this out together"

Questions?

More examples of NHDD

February 14, 2024 | 12 – 1 p.m. ET

Kate DeBartolo - kdebartolo@ihi.org

www.theconversationproject.org

X: @convoproject

Facebook: @TheConversationProject

Instagram: @convoproject

Aligning Patient, Caregiver, and Health Care Provider's Expectations During Care Transitions

AMY A. ABBOTT, RN, PHD

KEVIN T. FUJI, PHARMD, MA

Creighton
UNIVERSITY

Learning Objectives

1. Describe the experiences of care transitions from the perspectives of patients, caregivers, and health care providers.

2. Identify areas of alignment and discordance across patients, caregivers, and health care providers during care transitions.

Care Transitions

"A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location."

Problems During Care Transitions

- Medication record discrepancies
- Patient knowledge deficiencies and misunderstanding of the care plan
- Poor communication between hospitals, community facilities and primary care providers
- Poor communication between patients and providers

Our Study

Eight focus groups

- 13 hospital providers
- 7 community providers
- 18 patients and family caregivers

Themes

1. Preplanned admissions are ideal
2. Lack of needed patient information upon admission
3. Multiple services are needed in preparing patients for discharge
4. Rushed or delayed discharges lead to patient misunderstanding
5. Difficulties in following aftercare instructions

Areas of Alignment

"We plan on them being there three days, and it is quite possible they will need more therapy before they go home. So, we tell them to check facilities out before coming to the hospital so they know what to expect and are not surprised they are going to rehab. Those probably work out the best."

Areas of Discordance

"It becomes a matter of assessing what is medically the best practice, what is the best practice the patient will accept, and where you compromise between those two…which is not always what the physician thinks is best practice and not always what the patient considers the best outcome."

Areas of Discordance

"I needed some serious education about some things…I didn't know if they were not explaining things to me because I was not going to live much longer, and it was just not worth it…how do I know?"

Areas of Discordance

"When you are in that room, all you want to do is get out. You just kind of minimize everything, you just want to get through it and get out."

Areas of Discordance

"There are times when we get information sent to us, and I'm looking at it and going, 'This doesn't sound appropriate at all.' I find that I actually need to come up and actually look and see…go through the chart, meet the family, meet the patient, and it gives us a step up to say, 'Yes, you're appropriate for our services.'"

Lessons Learned

- Involve patients in decision-making from the beginning
- Use teach-backs; don't assume your patient understands
- Interoperability of patient data has helped, but relationships between facilities are key to successful transitions

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Amy A. Abbott (aabbott@creighton.edu)
Kevin T. Fuji (kfuji@creighton.edu)

Questions?

Making Health Care Better *Together*

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