TEAM-BASED APPROACHES TO ELICITING VALUES, GOALS, AND PREFERENCES WHEN PATIENTS HAVE A SERIOUS ILLNESS

Training for Nurses, Social Workers, Psychologists, and Chaplains

Sponsored by the
National Center for Ethics in Health Care
National Social Work and Care Management Office
Geriatrics and Extended Care, Hospice and Palliative Care Program
National Office of Nursing Services
National Primary Care Office
National Chaplain Center
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Objectives

Following this learning activity, participants will be able to

• Describe three team-based models for conducting goals of care conversations with high-risk patients
• List steps for implementing proactive goals of care conversations in health care clinics
• Identify resources to help teams build skills, educate patients, and improve practices related to communicating about goals of care and serious illness
Related Webinar

Introduction to Eliciting Values, Goals, and Preferences When Patients Have a Serious Illness

- What is a goals of care conversation (GOCC)?
- What steps help ensure that high-risk patients receive care aligned with their goals and values?
- How should GOCCs be documented?

Recorded version available in TMS around Nov. 1, 2016.
Goals of Care Conversations

• To elicit the patient’s values, goals of care, and decisions about life-sustaining treatment

• Intended for patients at high risk of a life-threatening clinical event in the next 1-2 years* (or those who want to limit life-sustaining treatment)

• May take more than one visit, and involve more than one clinician

• May be conducted with the patient’s surrogate if the patient does not have decision-making capacity
Steps to ensure that care is aligned with high-risk patients’ goals

- Proactively identify high risk patients
- Prepare for a goals of care conversation
- Conduct a goals of care conversation
- Document values, goals and decisions in CPRS
- Honor the patient’s values, goals, and decisions

Quality improvement activities help identify and fix gaps in processes.
Proactive Goals of Care Conversations with High Risk Patients

- **Identify roles and responsibilities of team members:**
  - Identifying the patient’s authorized **surrogate**, and determining whether the patient would like to name a different surrogate
  - Confirming the patient’s **understanding** of diagnosis and prognosis
  - Eliciting the patient’s **values and goals** related to their health care
  - Providing **information about services and treatments** to support the patient’s goals
  - Making **shared decisions** about services and treatments (within clinician’s scope of practice)
  - Reviewing or assisting with **documents** reflecting the patient’s wishes
  - Establishing **next steps**
POLL #1

• Do you have a role (either through direct patient care or systems design) in ensuring that high-risk patients’ values, goals, and preferences are elicited, documented, and honored?
  • Yes
  • No
  • Not sure
POLL #2

• Does your clinical team have clear processes for identifying high-risk patients who may be appropriate for goals of care conversations?
  • Yes
  • No
  • Not sure
Goals of Care Conversations
Team-Based Implementation Models

- Salt Lake City VA Home Based Primary Care Team
- Madison VA Honoring Veteran Wishes Clinic
- Brooklyn VA Palliative Care-Primary Care Collaboration
Salt Lake City HBPC Team

- Multidisciplinary approach to ensure that goals of care conversations occur with high-risk patients

- Salt Lake City: LST Decisions Initiative Demonstration Site
  - Using new LST progress notes and orders since January 2015
Physicians/Nurse Practitioners

- Educate patients about life-sustaining treatments
- Conduct goals of care conversations
- Compare with previous LST notes/orders and/or state-authorized portable orders (in Utah: POLST)
- Write LST note and orders
- Re-address as indicated
- Conduct audit after death to verify that care provided was consistent with the patient’s documented decisions
Salt Lake City VA HBPC Team

Roles Related to Goals of Care Conversations

• Social Worker
  • Educates patient about life-sustaining treatments
  • Checks and updates surrogate documentation
  • Monitors consistency of documents: LST note, LST orders, POLST, advance directive; reviews at weekly team meetings (LST Audit Form)

• Psychologist
  • Evaluates to assist in determining medical decision-making capacity in complex cases
  • Assists caregiver/family re: patient’s limitations or reasoning behind decisions
  • Assesses for influence of depression on patient’s goals of care
## LST Audit Form - Reviewed at weekly team meeting

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>CAN SCORE</th>
<th>ADVANCE DIRECTIVE: DURABLE POA FOR HEALTH CARE</th>
<th>LST NOTE: SURROGATE</th>
<th>LST NOTE CODE STATUS</th>
<th>LST ORDER CODE STATUS</th>
<th>POLST CODE STATUS</th>
<th>NOTES, TO DO ITEMS (e.g., complete LST, update POLST, rescind duplicate AD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xxx, Xxx</td>
<td></td>
<td>Yes – Xxx Xxx, son</td>
<td>Yes, Xxx Xxx, son</td>
<td>DNR</td>
<td>DNR</td>
<td>Yes - DNR</td>
<td>Wife relinquished Health Care POA to son dated 9/4/2016</td>
</tr>
<tr>
<td>Xxx, Xxx</td>
<td></td>
<td>Yes - Legal Guardian (Xxx Xxx)</td>
<td>Yes – XxXx, XxXx,</td>
<td>DNR</td>
<td>DNR</td>
<td>Yes - DNR</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Legal Guardian)</td>
<td>(Legal Guardian)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xxx, Xxx</td>
<td>99</td>
<td>Yes – Xxx Xxx, sister</td>
<td>Yes – Xxx Xxx, sister</td>
<td>DNR</td>
<td>DNR</td>
<td>Yes - DNR</td>
<td></td>
</tr>
</tbody>
</table>
Salt Lake City VA HBPC Team

LST Quality Reviews

• After patient’s death, review congruence between LST Orders and treatments provided to the patient

• The Patient Safety Officer plans to complete this review for every patient for whom a code is called
Related Salt Lake City Program

Geriatrics High-Risk Evaluation & Liaison Program (GHELP)

• Home geriatric consultation team evaluating high-risk veterans
• Innovative “adapted” transitional care model
• Administratively affiliated with Home Based Primary Care program
• Team: NP, SW complete in-home evaluation
• Medical director: MD geriatrician (also HBPC medical director)
• Comprehensive geriatric assessment which can include GoCC, LST notes/orders, POLST, AD completion
Madison VA Honoring Veteran Wishes Clinic

- Goal: to elicit and document patient’s wishes before a crisis occurs
- Focus on serving “seriously ill” patients
- 1 full-time social worker and 1 full-time registered nurse
- 1280 consults in the first 2 years
  - 929 primary care
  - 109 specialty
  - 242 other
Madison VA Honoring Veteran Wishes Clinic

Clinic Process

1. “Seriously ill” patients are identified by the Primary Care provider or specialty provider

2. Telephone call to introduce service and arrange an appointment

3. 1 or 2 60 minute appointments

4. Follow up with medical provider

5. Document conversation in the medical record
Madison VA Honoring Veteran Wishes Clinic

Impact

- Retrospective Chart Review

<table>
<thead>
<tr>
<th></th>
<th>Veteran’s Received Care as Usual</th>
<th>Veteran’s Received Care Planning Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>N=35</td>
<td>N=35</td>
</tr>
<tr>
<td>Average Age</td>
<td>76.77</td>
<td>75.79</td>
</tr>
</tbody>
</table>
Madison VA Honoring Veteran Wishes Clinic

**Impact (continued)**

- Accessible documentation of wishes at time of death

<table>
<thead>
<tr>
<th>At Time of Death</th>
<th>Care As Usual (N=35)</th>
<th>Care Planning Intervention (N=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directive in CPRS</td>
<td>62.9%</td>
<td>82.9%</td>
</tr>
<tr>
<td>DNR Order in CPRS</td>
<td>48.6%</td>
<td>62.9%</td>
</tr>
</tbody>
</table>
Madison VA Honoring Veteran Wishes Clinic

**Impact (continued)**

- Use of comfort-focused services near the end of life

<table>
<thead>
<tr>
<th>Services Received by Veteran</th>
<th>Care As Usual (N=35)</th>
<th>Care Planning Intervention (N=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care</td>
<td>32.4%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>48%</td>
<td>55.9%</td>
</tr>
</tbody>
</table>
Madison VA Honoring Veteran Wishes Clinic

**Impact (continued)**

- Use of hospital services near the end of life

<table>
<thead>
<tr>
<th></th>
<th>Care As Usual (N=35)</th>
<th>Care Planning Intervention (N=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within 30 days of Death</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>54.8%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Average # of days in Hospital</td>
<td>7.50</td>
<td>7</td>
</tr>
<tr>
<td>ICU Admission</td>
<td>21.4%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Average # of days in ICU</td>
<td>5.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Location of Death: In-Hospital</td>
<td>19.4%</td>
<td>16.13%</td>
</tr>
</tbody>
</table>
Madison VA Honoring Veteran Wishes Clinic

Patient Satisfaction

- Telephone call made to each Veteran who had HVW appointment during one calendar week. Number available for interview = 12
- 100% very satisfied
- 100% found appointment helpful
- 100% would recommend this service to someone else

How was the conversation helpful?

“To figure out who pulls the plug, and when and if they should pull the plug. It changed as we talked about it.”

“For [my family], too, so they don’t have to second guess themselves afterwards, whether they made the right decisions or not. To help them not feel guilty.”
GoCC Skills Trainings at Madison

- Communication Skills Training developed to standardize the approach to GoCC for nurses, social workers, psychologists and chaplains
- 3 GoCC trainings offered at the Madison VA in first six months of 2016
- 33 clinicians trained
  - 13 RN, 16 SW, 1 Chaplain, 1 Psychologist and 1 NP
  - Actively conducting and recording goals of care conversations in CPRS
Other GoCC projects at Madison

- Palliative Care, Honoring Veteran Wishes (HVW) chart review on seriously ill Veterans with PACT teams
  - Recommend GoCCs, services for Veterans based on chart
  - 5 teams reviewed, 109 Veterans served
- New RN Care Manager in Oncology and Infusion clinic to focus on end of life care planning and GoCCs
- Increasing GoCCs for Veterans who have heart failure
  - Developing CPRS template to calculate mortality risk
  - Recommendations for GoCC, Palliative Care based on risk
  - Workgroup includes: Honoring Veterans Wishes staff, Palliative Care, Cardiology, inpatient attending, hospital executive
Brooklyn VA Palliative Care - Primary Care Collaboration

Goal

• To increase the primary care team’s ability to identify the more seriously ill patients on their panel and engage those Veterans in GoCCs

❖ We’re not looking to make sure everyone has a completed advance directive

❖ We’re not looking to have a palliative care consult on every Veteran
Brooklyn VA Palliative Care - Primary Care Collaboration

Palliative Care Team Member as Coach

• Educate PACT team on the difference between advance directives (ADs) and GoCCs

• Educate PACT team on effective communication skills to increase comfort level to engage in meaningful GoCCs

• Empower all PACT team members to begin GoCCs within their scope of practice

• Encourage PACT team members to call upon their team members for their expertise when needed (ex: MD and prognosis)
Brooklyn VA  Palliative Care - Primary Care Collaboration

Why Would Primary Care Collaborate with Palliative Care?

• Breaking the cycle for patients with multiple hospital admissions

• They’re “not getting through” to patients/families when discussing management of chronic or life-limiting conditions

• Struggling to handle a patient’s family dynamics

• Uncomfortable in broaching topics of disease progression, goals of care, end-of-life preferences
Why Would Palliative Care Want to Collaborate with Primary Care?

- Empower primary care to provide primary palliative care to Veterans- recognize their existing skill set
- Educate teams on when to involve the palliative care team
- Acknowledge and encourage providers to use their established relationship with patient and family
- Assist providers in identifying their more fragile patients, to engage in earlier GoCCs
Brooklyn VA Palliative Care - Primary Care Collaboration

Monthly Huddles

Palliative Care Coach and PACT Team review patients with CAN score 98 and 99 & other complex patients identified using clinician judgement

- Team members discuss their challenges and successes in working with these patients
- Makes a plan for PACT to engage these Veterans in goals of care discussions at upcoming appointments
- Makes a plan for PACT to refer for appropriate supportive services
- Thoughts/feelings around a patient’s death
Brooklyn VA Palliative Care - Primary Care Collaboration

Activity Between Monthly Huddles

- PACT engages in GoCCs for identified Veterans
- On-the-spot availability for warm hand-off or co-facilitation of GoCCs by Palliative Care Coach in PACT clinic
- Palliative Care Coach and PACT conduct bedside GoCC for hospitalized, high-risk patients

- Meet about 6 months after monthly huddles conclude for a check-in, with goal of sustaining ongoing identification of seriously ill Veterans and documented GoCCs
Supporting Teams in Improving Practices
National Project to Build Outpatient Palliative Care

• Intent: Strengthen primary palliative care skills among PACT and subspecialty teams, including communication skills related to goals of care and serious illness

• Supports facility-based collaboration between palliative care and PACT/subspecialty teams

• Quarterly national networking calls, educational materials, communication tools, information about QI processes and resources

• Want to get involved? Contact: Jennifer Di Biase, MSW, at jennifer.dibiase@va.gov
Supporting Teams in Improving Practices

National ICU Family Meeting Project

• Intent: Improve the implementation and documentation of earlier, comprehensive, interdisciplinary Family Meetings in ICUs

• Supports facility-based Quality Improvement Teams

• National networking calls, educational materials, communication tools, information about QI processes and resources

• Volunteer Palliative Care-ICU coaches available on request

• **Want to get involved?** Contact: Carol Luhrs, MD, at carol.luhrs@va.gov
Supporting Teams in Improving Practices

Primary Care High-Risk Roadmap

- Outlines strategies to improve care in PACT for Veterans with serious illnesses who need more care and attention

- Primary Objectives
  - To improve the care PACTs can offer their most complex patients at highest risk for adverse outcomes
  - To enhance PACT efficiency so that PACT workload is not increased despite providing better care

- https://www.vapulse.net/docs/DOC-18418
Resources for Patients and Families

Long-Term Services and Supports

• Shared Decision Making Worksheet
  • Helps facilitate decisions about long-term services and support

• Caregiver Self-Assessment Worksheet
  • Guides discussion about roles and responsibilities
  • Helps caregiver meet Veteran’s needs while also meeting their own

http://www.va.gov/GERIATRICS/Guide/LongTermCare/index.asp
Resources for Patients and Families: Setting Health Care Goals: A Guide for People with Health Problems

- What are goals of care
- What to discuss with the health care team
- Who to invite to the discussion
- How to prepare for the discussion
- Information about life-sustaining treatments – CPR, mechanical ventilation, feeding tubes, dialysis
- Information for those who make health care decisions on behalf of loved ones who cannot make decisions for themselves

vaww.ethics.va.gov/docs/GoCC/Ist_booklet_for_patients_all_sections_final.pdf
Conducting Proactive Goals of Care Conversations in Your Clinic: Steps to Success

1. Recruit team members and plan together
2. Identify roles and responsibilities
3. Promote staff training
4. Gather resources, join learning collaboratives
5. Implement changes
6. Track progress
7. Engage in quality improvement activities
Goals of Care Conversations: Need More, Better, Sooner

- Many clinicians...
  - Have never had formal training in how to conduct goals of care conversations with patients who have a serious illness
  - Don’t feel comfortable with these discussions
  - Are concerned they take too much time

These conversations require strong communication skills
Goals of Care Conversations
Skills Training Programs

• For RNs, Social Workers, Psychologists, Chaplains
  • Communication skills training
  • Interactive practice exercises
  • Train-the-trainer program beginning in 2017
  • Teams of two trainers from each facility

• For MDs/APRNs/PAs
  • Train-the-trainer program resuming in 2017
Additional Resources:

vaww.ethics.va.gov/Education/LST/ClinicalStaff.asp

Use the Q & A Box on the right side of the screen.