Engaging our Healthcare Workforce in Advance Care Planning

47th Annual Arizona Rural Health Conference

Resiliency Amid a Pandemic: Rural Arizona Challenges and Successes

June 15, 2021
Agenda

• Advance care planning and the public health emergency
• Engaging the healthcare workforce: challenges and successes
• Case Study: One organization’s approach
  — How
  — Outcomes
  — Lessons learned
The right conversation at the right time... helps ensure the right care at the right time

- Identify Health Care Proxy (HCP)
- Conversation about care preferences
- Diagnosis of Serious or Chronic Illness(es)
- Progression of Serious or Chronic Illness(es)
- Have Serious Illness Conversation
- Begin POLST Conversations
- Condition worsening
- Revisit Serious Illness Conversation (POLST)
- Goals of Care Discussion (If clinical decision)
- Poor Prognosis
- Revisit Serious Illness Conversation / Goals of Care Discussion
- Revisit POLST

18+, Healthy

Seriously Ill

Crises & Decline

End of Life

Advance Directive
- Planning for future care

POLST

Serious Illness Conversations begin - planning in the context of progression of serious illness
Goals of Care Discussion = Decision making in context of clinical progression/crisis/poor prognosis

Prognosis:
1-2 Years

Prognosis:
Weeks to Months

Serious Illness Care Program, Ariadne Labs
COVID-19: Compressed timeline for many

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Prognosis: Weeks to Months

Serious Illness Care Program, Ariadne Labs
COVID-19 and Patient Experience

Meet Ben:

- 71-year-old man
- Lives at home with 70-year-old wife
- History of heart failure and kidney disease, signs of dementia
- Has had ED visits for weakness and falls
- Has an adult son who lives nearby

Ben contracts COVID-19 during July, 2020:

- Severely short of breath, family extremely anxious
- Call to 911, taken to nearby facility, medical condition deteriorates rapidly and oxygen requirements increase
- Urgent decisions made rapidly; transferred to higher level of care
- A quick review of the medical record at receiving hospital indicates no advance directives on file
- Intubated, placed on a ventilator, and transferred to the ICU
- Is unable to communicate, Family unable to visit, very distressed
- Care team does all they can
- Ben dies alone in the ICU
- Family says “Ben never would have wanted this”
COVID-19 and the Public

Patients afraid to have in person office visits

• Their chronic health conditions and COVID-19 could have been explored and advance care planning done
• Choices were even more complex and challenging when factoring in age, overall health, and underlying medical issues
• Chronic health conditions were not followed as closely, people were much sicker when seeking care

Patients were afraid to visit the Emergency Department

• Some people suffered AMI and strokes and did not seek care
Challenges for Facilities

• Hospital staff overwhelmed
• SNF, LTC, AL very concerned about COVID-19 spread and transferred people with symptoms and (+) tests even with advance directives on file
• Rapid deterioration of patient condition
  – Decisions made very quickly
Support for the Healthcare Workforce

• Changing guidelines, lack of PPE, affected the level of trust clinicians had in the health care system.

• Healthcare workers
  – Experienced distress that families could not visit and patients dying alone
  – Concerned that patient wishes may not be honored

• Palliative care experts help ensure the patient’s treatment plan is in accordance with their wishes but there are limited providers in our state

• Free Palliative Care consults offered via telehealth—hospitals, SNFs, LTC, too busy to refer

• Some organizations used the opportunity to be creative
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
Overcoming the Historical Challenges of Advance Care Planning

• Provider and staff comfort level
  – Having the conversations
  – Understanding the documents
• Time constraints, especially during office visits
• Knowledge of coding and reimbursement
• Documentation
Examples of Pivoting to address needs

• Organizations offered incentives to employees to do their own advance directives (e.g. providing a stipend, reduction in monthly health plan premium)
  – Rationale: increase staff familiarity with the documents and process
  – ACP documents on file if they get sick

• A variety of workshops offered to meet the needs of healthcare personnel
  – Abbreviated content (need to know)
  – On-line platform
Who
Patients experiencing acute or chronic COVID-19 symptoms and related complications in any setting such as clinics, home healthcare, long term care, assisted living and hospitals.

What
A referral source for healthcare providers to help their patients navigate through the complexities of COVID-19 related serious illness.

Cost
There is no fee to participate in this program.

More information
Visit our website: palliative.vsee.me/u/clinic and complete the intake form. A medical assistant will follow up with the referring agency/patient to obtain medical records and schedule the appointment.

Questions may be directed to sseverson@azhha.org or 602-445-4303.

Palliative care is focused on helping patients live well as long as they can.

We work with the existing healthcare team to provide an extra layer of support and care focused on aligning patients' values and goals with available treatment options.

Do you have a patient in your care who is experiencing acute or chronic COVID-19 symptoms and related complications and would benefit from a telehealth consultation with a Palliative Care provider? This Arizona-based program helps healthcare providers connect patients to a licensed and credentialed palliative care provider. Palliative care provides expert communication for patients and families to achieve goal-concordant care while addressing the symptoms of their serious illness.
Case Study: Primary Care Clinic

• Prompted by a hospital initiative to increase the number of advance directives
  – Especially as people are presenting to the ED
  – Particularly important during COVID-19

• Plan
  – Educate clinic providers in 2021
  – Incentivize providers in 2022
    • E.g.: greater than 50% of people over 55 y.o. have a documented conversation

• Metrics
  – # patients seen in the prior quarter with advance directives
  – # patients with conversation documented
  – # patients who went to the hospital
Clinic Initiatives: Support for EMR integration and documentation

- Standardized scanning and alerts
- Embedded note templates to guide the conversation
  - Used AzHHA pamphlet as a guide
- Filed under Progress Notes
- Can search by Advanced Care Directives
- Tip sheets at the front desk on where to scan
- Piloted processes with a clinic: heavily involved the MAs
AzHHA Tailored Education for Providers

• Met with manager to plan content
• 1.5 hours of Advance Care Planning education with focus on
  – Introducing the topic
  – Discussing the different documents and what they are for
  – The legal requirements
  – Dialoging with your patients about their questions and concerns
  – The process of assisting with completion of documents
• Followed by 30-minute organization specific content
  – Documentation and coding
  – Expectations
• 82 providers attended
Lessons Learned

- Providing incentives was effective
- Let providers see their numbers unblinded
  - Unleashes healthy competitiveness
- Give providers flexibility with small tests of change
  - Tried adding an extra 20 minutes to the AWV
  - Called patients and offered option for additional 20 min. added to AWV or independent visit
  - Found that adding 20 min. is too long, so scheduling separate visits
- Designed a flyer for patients
- Patient satisfaction increased
Hospital example

• Hospital identified need for healthcare workers to hold Conversations in Serious Illness
• Focus on Emergency Department and Critical Care
• AzHHA conducted virtual Introduction to Conversations in Serious Illness classes (1 hour)
• **30 participants**
• Followed up with Train the Trainer (5.5 hour class so hospital can provide)
Take-aways

• Patients needed care, experienced decreased access; sometimes self imposed

• The health care workforce experienced moral distress knowing that patient’s care was not necessarily consistent with the wishes and patients were dying alone

• Although the pandemic posed challenges it also sparked creativity
  – More people encouraged to complete advance directives
  – Classes held in virtual format
  – Healthcare systems enhanced IT support
  – Telehealth Palliative Care program ongoing at this time

• Clinics and hospitals can replicate the programs developed

• Key to success: organizations champions partnered with AzHHA
THANK YOU

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