Conversations of a Lifetime®

Community Impact Report

2013—2019

Conversations of a Lifetime®.org

A program of

Hospice of Cincinnati
Experience. Compassionate. Caring.℠

Background

People believe the healthcare system will give them exactly what they need and want in the final months of their life, but often that is not the case. Physicians and other health professionals, who are trained to *cure*, often lack the skills to elicit goals and values and translate them into end-of-life care decisions and orders[i]. Through advance care planning (ACP) conversations, patients and families can ensure better alignment between end-of-life treatments and their goals and values.

Evidence suggests that early communication about goals and preferences of care can improve care. The Institute of Medicine's (IOM) report, *Dying in America*, outlines five recommendations to improve end of life care planning; one of which is better clinician-patient communication. Late or absent ACP discussions can lead to unwanted or non-beneficial care, increased suffering at the end of life, increased costs, and higher post-death family distress.

Communication about end-of-life care goals is a low risk, high value intervention for older patients and those with life-limiting illness[ii]. For advance care planning to succeed, better clinician communication skills are necessary[iii].

Conversations of a Lifetime® (COL) was designed and launched at Hospice of Cincinnati, part of the TriHealth system in 2013, funded thought a generous grant from bi3. The program combines several evidence-based strategies, creating an innovative, single offering that is one of a kind. It is designed to link education and training to practice, by teaching healthcare workers how to initiate the advance care planning process earlier in care—ahead of a crisis or end-of-life circumstance. This leads to better patient centered care for adults with life limiting chronic illness. COL also helps the community better understand the importance of starting an advance care planning conversation.

Overview

Conversation of a Lifetime's goal is to improve advance care planning conversations for all adults, healthy and those with life limiting illness. The program educates healthcare providers to initiate advance care planning conversations between providers, patients and their families by employing four key components: ***physician communication coaching, advance care planning facilitator training, community engagement campaigns and implementation support.***

The program has also built capacity in community engagement and increased awareness of advance care planning. See Conversations of a Lifetime.org/ThingsYouShouldntWaitToSay.

References

[i] Quality and Quantity of Life: Duties of Care in Life Limiting Illness. Gawande, A.2016. JAMA. 2016;315(3):267-269

[ii] Communication about Serious Illness Care Goals: A Review and Synthesis of Best Practices, Bernacki, R; Block, S. 2014. JAMA Intern Med. 2014;174(12):1994-2003)

[iii] Dying in America; Institute of Medicine Report, September 2014

Physician Communication Coaching

COL designed a communication coaching program in collaboration with VitalTalk®, a nationally recognized provider of advanced communication skills training for physicians. The 4-hour curriculum is led by VitalTalk-trained physician faculty in a small group format and includes practice of "conversation maps" with trained simulated patient actors.

Since March 2014, **382 providers** have been coached (244 MD/DO, 73 NPs, 7 PA, 58 Fellows/Residents/Students).

- 295 IM/PCPs, 11 Cardiology, 9 Oncology, 14 hospice/palliative care, 53 other
- 272 TriHealth, 30 Christ Hospital Network, 29 UC, 26 Mercy Health, 5 St. Elizabeth, 20 other

Echoing previous session feedback, survey results were excellent from a March 2019 session for a group of 20 primary care providers from The Christ Hospital Physician Network:

- 100% of attendees rated the end-of-life conversation sessions as "excellent" or "very good,"
- 95% "*strongly agree"* with the statement, "*I will use the skills demonstrated at this session as part of patient care.*"

When participants are asked about the most valuable aspect of the sessions, they often refer to the small group exercises with the simulated patient actors.

> *"The best part was the simulated patient encounters we did in small groups with frequent breaks for reflection about what was going well and what we needed to improve on. I really felt like I was able to target my weaknesses and solicit feedback on what I could do better from people who were also all learning. It was really interesting to hear all the different techniques people use to respond to emotion."*
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> ***—UC Fellow, 2016 session participant***

Advance Care Planning Facilitator Training

Respecting Choices® Advanced Steps

Registered nurse care coordinators, social workers, chaplains and others in outpatient settings and long-term care facilities benefit from advance care planning (ACP) training. COL uses the Respecting Choices® Advanced Steps curriculum, an evidenced-based best practice, designed to teach skills to have effective end-of-life discussions. Training includes five online modules and eight hours in class.

To date, **939 ACP Facilitators have been trained** (52% RN/LPN, 26% social workers, 22% other). They work in a variety of settings including 30% ambulatory, 30% inpatient, 20% long term care, and 20% other.

Evaluations (n=140) of the 2015 classes show:

- 100% of attendees "*strongly agreed*" or "*agreed*" they could identify skills to initiate Last Steps ACP conversations;
- 100% "*strongly agreed*" or "*agreed*" they could identify techniques to create a MOLST (Medical Orders for Life Sustaining Treatment) document accurately reflecting an individual's treatment decisions.

Community Engagement

Conversations of a Lifetime® has used both traditional and novel public engagement strategies to stimulate conversation around the concept of advance care planning. Traditional strategies included TV and radio advertising, speaking engagements, and the creation of a website. Since its launch in February 2014, conversationsofalifetime.org, the consumer facing website has logged 39,091 unique visitors.

The *'Things You Should Wait to Say'* and *'Things You Shouldn't Wait to Do'* campaigns ran from 2015-2017. Audiences of all ages were engaged by using positive and upbeat messages. Over 1.3 million social media impressions were made from the three years of campaigns. Video highlights of the campaign can be found at http://www.ConversationsofaLifetime.org/Thingsyoushouldntwaittosay.

In October 2018, a digital campaign called ***'The Talk'*** *was* launched. Bi-weekly articles and accompanying ads appeared on Cincinnati.com. The campaign promoted face-to-face, heart-to-heart conversations with a loved one about end-of-life care issues. This resulted in a spike in COL website traffic. When ***'The Talk'*** campaign launched, visitors increased to more than 2,000 visitors/month compared to 268 visitors/month pre-campaign.

Professional Audiences

COL program elements have been shared with physician practices, hospitals, community agencies and many other healthcare providers in the greater Cincinnati region. In 2018 and 2019, the program reached local, regional and national audiences.

Local Impact

- COL and TriHealth Corporate Health partnered to include ACP resources as part of the "menu of options" for employee wellness programs and participate in 21 events (Well-being Fairs/Lunch and Learns) for 10 local companies including the employees of: City of Cincinnati, Hamilton County, and Cincinnati Public Schools. New in 2019, the updated Advance Care Planning online workshop became available for external companies to add to their "menu" for their well-being scorecard.

- Select professional presentations in 2018 /2019 included UC College of Law, Xavier College of Nursing, Greater Cincinnati Estate Planning Professionals, and Crossroads Church *Senior Connect.*

Regional Impact

- Comprehensive Primary Care (CPC+) Statewide, regional meeting in Columbus: Breakout session presentation and panel member as the content expert for implementing advance care planning in the primary care setting.
- ACP/MOLST facilitator training January and February 2019, training 32 nurses and social workers from St. Elizabeth Physicians primary care offices in Northern Kentucky.
- A VitalTalk® physician communication coaching was provided to a group of 20 primary care providers from The Christ Hospital Network in March 2019.
- Ohio Honoring Choices Task Force SB 165 member, making suggested improvements to the new Ohio DNR form launched September 2019.
- Presentation at the Ohio Guardianship Association's annual Conference in Fairborn, Ohio September 2019.

National Reach

- May 2018- Comprehensive Primary Care + (CPC+) National meeting in Boston—a poster highlighting the implementation of advance care planning in the TriHealth Primary Care Practices using the Conversations of a Lifetime model/resources.
- The peer-reviewed Journal of Palliative Medicine published COL's manuscript describing the success of advance care planning in primary care practices. "**Initiating Advance Care Planning in Primary Care: A Model for Success**" was published online in November 2018 and in the April 2019 print edition.

- Presentation at the 'Respecting Choices National Share the Experience' Conference in October 2018, describing how COL uniquely combined the Respecting Choices 'Advance Steps' curriculum and VitalTalk® physician communication coaching to train staff in implementing ACP in TriHealth primary care practices.
- Participation in the Respecting Choices 'Advance Steps' program revision advisory group that re-launched the Last Steps as the Advanced Steps curriculum. Hospice of Cincinnati was one of two test sites for the new curriculum in the summer of 2019.

Individualized Implementation Support

A variety of tools were developed to support implementation of advance care planning into practice at TriHealth. They continue to be offered as resources and include:

- The 'Advance Care Planning in Primary Care' Toolkit
- Patient level Advance Care Plan summary report page in Epic so patients did not have to resubmit advance directives at each visit and to track ongoing conversations with members of the health care team.
- A custom Best Practice Alert (BPA) in Epic using specific defined conditions, to alert the inpatient or outpatient provider that a patient meets the criteria for initiating an advance care planning conversation.
- A CPT Code tip sheet for the two CMS approved billing codes for providers to bill and be reimbursed for voluntary advance care planning discussions with patients and families.

The COL Team

Barbara L. Rose MPH, RN , Senior Project Administrator, Advanced Illness Programs has a long career of community-based improvement projects. Since 2012, she has designed, implemented and measured the success of Conversations of a Lifetime® and PalliaCare, a home palliative care service. She has pursued numerous opportunities to share the model and success with influential national groups including: National Epic Users Group Meeting; Center to Advance Palliative Care's National Summit; and the American Geriatric Society Annual Meeting. She was the lead author in the Journal of Palliative Medicine article titled "Initiating Advance Care Planning in Primary Care: A Model for Success" published online in November 2018 and in the April 2019 print edition.

In 2017, Barbara led the effort to submit a funding proposal to bi3 to fund a new home-based palliative care service for TriHealth and the community. PalliaCare Cincinnati was designed and started in fall of 2017. To date, over 500 seriously ill patients and their families have been cared for by this niche program.

Stephanie Leung MBA, Project Specialist, started in August 2015 to help assist with the COL grant reporting, data analysis, and administrative support for the training and coaching sessions. In 2017, Stephanie stepped up and became the lead instructor for ACP/MOLST Facilitator training. Stephanie developed and was the recipient of the Gold Shovel Ideation Award for her Bright Idea: "Engaging Volunteers for the MOLST Facilitator Training". She showcased the work of COL at the Respecting Choices National 'Share the Experience' Conference in Minneapolis, MN in October 2018; and was invited to serve on the Respecting Choices Last Steps program revision advisory group. She is listed as the second author in the Journal of Palliative Medicine article titled "Initiating Advance Care Planning in Primary Care: A Model for Success" published online in November 2018 and in the April 2019 print edition. Stephanie has supported PalliaCare Cincinnati since its inception. She served on the grant writing team for the bi3 proposal; provides operational and outcome data analysis and select administrative office support.

Kelly Haley MSN, RN, CHPN Advance Care Planning Liaison joined COL in early 2019 as a newly shared role between the HOC Marketing and COL teams. Kelly is a certified ELNEC Trainer, Respecting Choices Advanced Steps Instructor; and RISHI Resiliency Instructor. She creates and develops educational presentations, including nursing and social worker CEs. She serves as nurse planner, organizer and presenter for Nursing CEs offered external to HOC; and has submitted or been approved by the Ohio Board of Nurses for the Nurse CEs on *Pain and Symptom Management at End of Life, Tips for Difficult Conversations and Total Pain for Hospice Patients* and *Introduction to Medical Orders for Life Sustaining Treatment (MOLST).*

Kelly develops advance care planning and Hospice educational tools, resources and provides individualized support in PCP, LTC, Inpatient and community settings. Some examples include:

- Health Literacy
- How to Approach the Dementia Patient at End of Life
- Conversations of a Lifetime – various ACP Presentations
- MOLST updates for regional health systems St. Elizabeth's, The Christ Hospital, and Bon Secours Mercy
- NEW 'Difficult Conversations' is geared to PCP offices (physician, care coordinators and MAs) and explores a common problem that healthcare professionals experience, having to start or continue a difficult conversation with a patient, whether a new diagnosis, a change in condition or a plan for future care. A focus is placed on prep work before the conversation and communication aids to use during the conversation (NURSE card).

For more information or questions, please contact:

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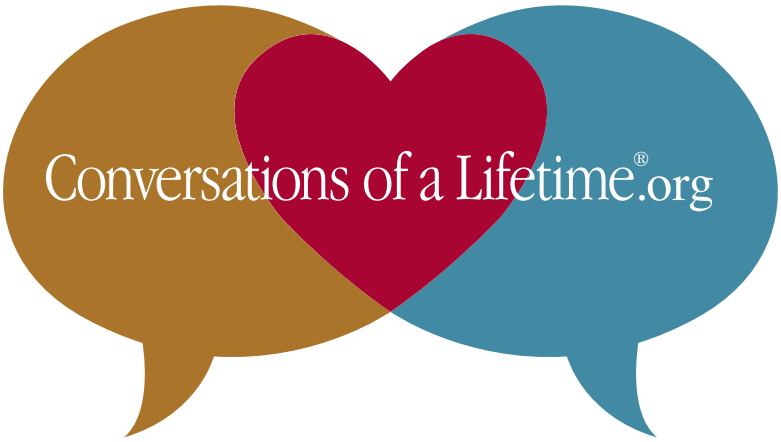

bi3 BETHESDA IDEAS INVESTMENTS INNOVATION

Initially funded by bi3, Bethesda Inc's grantmaking initiative to transform health, supported by Hospice of Cincinnati