



KPCO Life Care Planning Team



Life Care Planning

"The right care when it matters most."

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Implementation of Next Steps ACP Program, One Step at a Time Leads to the Next Step

Objectives:

- Identify two implementation strategies to successfully initiate and disseminate the Respecting Choices Next Steps ACP program
- Describe the leadership strategies required for successful implementation of the Next Steps ACP program

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Our Journey...

- Prepping for the Journey
 - Learning from NCAL
 - Leadership
 - Accountability
 - Infrastructure in place
 - Selection of the Instructor
 - Selection of the team



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Hiking the Journey, Lessons Learned...

- Schedule Appropriately
- Start sooner than later
- Thoroughly prepare Role Players
- Time out and redirect
- Stick to the conversation
- All materials distributed in a timely manner
- Need to schedule a condensed version of First Steps
- Accountability
- Provider Champions

It's only a
failure
if you don't
learn
something



Application

- Mentorship
 - Pre/post
 - Expansion for future



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Faculty Fellowship



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Reflect on the Journey...

- Continual Quality Improvement
 - Chart Reviews
 - Identifies key opportunities for improvement
 - Impacts the triple AIM
 - » High Quality
 - » Service/Satisfaction
 - » Affordability

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KPCO's Next Steps Future

- Continue to Implement in Specialty Areas
 - CMT
 - Care Coordination
 - Specialty Departments: ESRD, Cardiology, Pulmonology, etc.
- Sustain Current Programs
- Push for an effective FTE model
- Improve all Infrastructure- documentation, etc.
- To Infinity and Beyond

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In Closing with a Brief Case Study Richard's Story

- Richard is a 73 y/o Hispanic man that lives with his wife, Marcella of 40 years
 - Has multiple co-morbidities
 - Enjoys spending time with his family and grandchildren
 - Loves to work in the yard



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What about Richard?

- Hospitalist Referral to LCP at Discharge
 - Received after 2nd hospitalization
- Triage of the medical record
 - “Opportunity” List aka The Problem List
 - High: Non-compliant with medications, hx of MI, Ischemic Cardiomyopathy, and Neurogenic Bladder
 - Medium: DM2 with all associated diagnosis, LT insulin therapy, CAD
 - Not listed Memory Loss or Dementia or Advance Directives
 - Hospitalized twice March and May



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The Life Care Planning Conversation

Hopes include:

1. To be in better health
2. To not be in pain
3. To live to be 90 like his dad
4. To be like I was when I was 50 (chuckles) and states he knows that is not going to happen.

If those hopes don't come true what else does the member hope for:

1. Not to be a burden to his family; burden defined by member by having to be cared for by them, "cleaning him up, shaving, dressing, etc. to him; and costing them a lot of money".; ok going to a Nursing Home/LTC Facility to avoid being a burden to his family.
2. To be comfortable and die peacefully with his family around him.

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The Life Care Planning Conversation

Top three themes:

1. Not to be in continual pain; "pretty much a 7 out of 10 all the time", "one infection after another"
2. Right healthcare access, see the specialist in a timely manner vs. 2 months out and end up in the hospital
3. Financial burdens, medical costs and now two hospitalizations in the past six months; on a fixed income per wife, member agreed with her and states combined income, \$1200/mo.

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Richard's Choices:

Situation #1:

High survivability, cognitive disabilities (not know who they were or who they are with), and would require 24 hour nursing care-**To stop all efforts to keep me alive**
("My definition of living well is more important than length of life.")

Situation #2:

High survivability, physical disabilities, and would require 24 hour nursing care- **To stop all efforts to keep me alive**
("My definition of living well is more important than length of life.")

Situation #3:

Low survivability, prolonged hospital stay, and multiple medical interventions- **To stop all efforts to keep me alive**
("My definition of living well is more important than length of life.")

Agent agrees to honor patient's choices.

Sent SOTP and MDPOA to scanning

I want CPR attempted unless my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering

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Follow-up Plan

- **Referrals made to:**
 - **Community Resource Specialist**
 - Assistance in navigating the VA system as he is a Vietnam Veteran
 - Financial Counseling due to fixed income of \$1200/mo. combined
 - Debt to hospital > \$1000; co-pays: \$40 for PCP, \$50 for Specialist
 - Resources to apply for Medicaid to move 82 y/o brother to a facility
 - Variety of community resources
 - **Membership Services**
 - Understand their benefits and voice discontent with services
 - **PCP**
 - Cognitive Assessment in f/u to the referral to the Memory Clinic
 - Evaluation of gait (shuffle), falling, increased fatigue, and pain

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Outcomes

- SLUMS completed- 15/30
 - Problem List updated with diagnosis, Dementia
- Senior Community Resource Specialist
 - Personal outreach to wife to discuss resources
 - Extensive resources mailed, emailed, and f/u on
- Financial Counseling
 - MFA approved
- Referral to Supportive Care Services from PCP for the following:
 - medication management
 - caregiver support/respite
 - complex social situation
 - High Fall Risk

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Final Thoughts

“We are Health Care Providers not “task-masters”. Collectively, we need to get out of the “check box” mentality and back to “critical thinking”. Explore more, be open to the possibilities to what is learned, and listen to the individuals we care for...it might bring you back to our purpose of caring for others and self in a holistic manner, mind, body, spirit”.

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