Improving Veteran’s End of Life Care

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Objectives

- Identify five major components of the VA’s Comprehensive End of Life Care Initiative
- Address needs of veterans in rural areas
- Discuss the impact of the veteran’s end of life care initiatives on quality and access for veterans and their families
- Identify challenging factors caring for veterans at end of life

VA Hospice & Palliative Care Mission Statement:
To Honor Veterans’ Preferences for Care at the End of Life
VA Health Care System

- VA has experienced unprecedented growth in the medical system workload.

- VA is the largest integrated health care system in the country.
  - 163 Hospitals
  - 858 clinics
  - 137 Nursing Homes

Uniform Benefits Package

Hospice and palliative care is a covered benefit - all enrolled veterans, all settings, 38 CFR 17.36 and 17.38

VA is both a provider (eg inpatient units) and purchaser (eg home hospice) of end of life care.

Demographics of Veterans

- Over 37% of veteran population is 65 yrs or older; 13% of the general population
- 3000 World War II veterans die each day
- Numbers of veterans over age 75 will increase by 69% in 2022
Demographic Imperative

- Only 4% of Veterans die in VA (~21,000)
- 642,370 Veterans will die in 2014
- Many more with advanced serious illness

www.va.gov/vetdata/Veteran_Population.asp

Comprehensive EOL Initiative-2009

- Focus
  - Build infrastructure
  - Access
  - Quality
  - Expertise Dissemination
  - Palliative Care Program Evaluation and Support

Comprehensive End of Life Care (CELC) Initiative

- VA Field Staff and Leadership
- VISN Palliative Care Program Managers and Clinical Champions
- Implementation Center
- VACO Hospice & Palliative Care Program Office
- PROMISE Center
- Resource Center
Capacity = Reliable Access to Quality Palliative Care

Palliative Care Consultation Teams at every facility, disseminating expertise

• Outpatient Care and ICU integration
• Educational initiatives
• 24/7 access to core Palliative Care

Expand Access

Directive mandating Palliative Care Consultation Teams for ALL VA facilities

• Palliative Care Teams
• ICU integration
• Outpatient Care integration
• Improved case-finding (eg CAN)

CAN - Care Assessment Need score
Care Assessment Need (CAN)

- Probability Score of risk of hospitalization or death
- Encourages Care Coordination all participants in the delivery of health services work cooperatively
- Facilitates access to care
- Encourages Care Management Linking patients with needed services, resources, and opportunities

Key Drivers to Transformation of the Hospice and Palliative Care Program

**System transformation:**

a) Increased access within VA
b) Increased access outside VA through partnering with community hospices
c) Enhanced environment of care ("culture transformation" in nursing homes)
d) Quality measurement and intervention
e) Enhanced expertise

**Accountability for Performance:**

- Workload and process measures communicated widely
- Prioritized veteran centered quality measures with sharing of "best practices"
Implementation Center

Goal - to promote and support sustainable, high quality VISN and facility HPC programs and community partnerships

- Support and mentor VISN PMs and CCs
- PC Leadership and staff development
- Quality improvement initiatives
- Dynamic exchange of resources, discussions and educational materials on Sharepoint

Ready access to resources and materials

Palliative Care Leadership Training with CAPC

- VA Core Curriculum for PC Program Development
- 2 day trainings for 21 VISNs (148 facilities)
- 18 months of mentoring by PCLC and VA faculty
- 30 facility on-site “Good to Great” Refreshers
Implementation Center

- Regularly scheduled meetings and consultations with VISN PMs and CCs
  - Exchange information
  - Review progress, successes, challenges of programs
  - Provide support for national, VISN and facility initiatives

PC Leadership and staff development

- National workgroups to design and implement system-changing initiatives and create "experts"
  - Special Interest Groups
    - PC in ICU, HPC Units, PC in Chronic Mental Illness, PC in small VA facilities, Hospice Veteran Partnership, Outpatient PC
  - Special Project Workgroups
    - BFS-ICARE, PC-ICU, PC-PACT and PC Business Case

- New and emerging PC Leaders
  - National project leaders, content experts, coaches
  - Collaborate with Systems Redesign and Employee Education System
Implementation Center
Quality Improvement initiatives

• Selection of QI projects
  – Bereaved Family Survey results
    • Best practices and interventions
    • Bereavement and Spiritual Support QI pilots
  – Alignment with VA national goals and performance measures
    • ICARE – VA Core Values
    • Patient Aligned Care Teams

• VA as a Learning Healthcare System

Hospice and Palliative Care Units
New & Established

54 New Units
59 Established Units

VA as a Learning Healthcare System
ICARE and Serious Illness
Putting Core Values into Action

Bereaved Family Survey Results
Analysis
PROMISE Center

Networking & Support
Coach teams in implementation strategies
Implementation Center

Implementation Package
29 Interventions from VA PC Programs
QuIRC Center

Funding
45 pilots to implement interventions
HPC Program Office
Key Words at Key Times
Power of Nursing Assistant role

– BFS question
  • How often do you think the Veteran’s personal care needs—such as bathing, dressing and eating meals—were taken care of as well as they should have been? (ALWAYS, usually, sometimes, never, unsure)

– Outcome

Key Words at Key Times
Power of Nursing Assistant role

– Primary or secondary intervention in 11 BFS-ICARE & Serious Illness grant-funded pilot projects
– Focus: Communication as a comfort measure
  • After 1 quarter: 66% to 77% (N=244) (national 69%)
  • After 2 quarters: 73% (N=400) (national 68%)

Best Practice Examples-
ICARE Initiative

• Honor All Veterans
  – Bedside Ceremony with family, staff, and other resident, if appropriate
  – American Flag used to escort gurney to awaiting Funeral Vehicle
  – Memorial Display at entrance honoring deceased veteran’s life/death.

• Life Journal
  – Journaling helps define their life and leaves a legacy to share with family
Best Practice Examples

- **No Veteran Dies Alone**
  - Provides End of Life trained Volunteers to stay with veteran when family are not able.

- **Angels Among Us- Last Wishes Program**

- **Music & Massage**
  - Veterans are offered Massage by a corps of Volunteers as well as live harp music by Music Therapist to manage end of life symptoms - pain, dyspnea, anxiety, insomnia

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Final Salute

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Improving Care With Informatics
QuIRC Overview

Mission: Foster sustainable, quality practices through developing and implementing provider-facing informatics tools.

Site Sample Report 2012

All Domains

Site Sample Report 2012

Symptoms Domain

Any symptom was present for 86% of the visits (378 out of 440 unique visits).
Bereaved Family Survey (BFS) administered by the PROMISE Center

“During the Veteran’s last month of life, how often did the doctors and other staff provide the Veteran the medication and medical treatment that you and [he or she] wanted?”

- Administered by the PROMISE Center for families of all Veterans that die in VA hospitals or Community Living Centers
- Mail in survey with the Veteran's next-of-kin
- Performed 6-10 weeks after patient’s death

Veteran/Family Satisfaction is a Key Outcome

Bereaved Family Surveys = “Voice of Veterans”

- BFS needs to be shared with front line staff
- Palliative care leadership to drive QI in collaboration with facility/VISN leaders
- Peer organization endorsement
  – NQF, TJC
- Based on core pall care principles (NCP)
% of Families Rating End of Life Care as “Excellent”

Overall, how would you rate the care that the Veteran received in the last month of life?

For patients who died in VA facilities in FY10, percent of families rating care as “Excellent”

% of Families Rating End of Life Care as “Excellent” in Acute Units vs. Palliative care vs. Inpatient Hospice Unit Settings
### Impact on Overall Scores FY2010-Q3FY2012

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Impact on Overall Score (% points)</th>
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</thead>
<tbody>
<tr>
<td>DNR</td>
<td>21%</td>
</tr>
<tr>
<td>Death in a Hospice Unit</td>
<td>23%</td>
</tr>
<tr>
<td>Referral to hospice</td>
<td>14%</td>
</tr>
<tr>
<td>Palliative consult</td>
<td>12%</td>
</tr>
<tr>
<td>Chaplain/Veteran contact</td>
<td>5%</td>
</tr>
<tr>
<td>Chaplain/family contact</td>
<td>7%</td>
</tr>
<tr>
<td>Bereavement contact</td>
<td>6%</td>
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</tbody>
</table>

N=31,601

### Future Collaborations

**Clinical**
- Patient-aligned Care Teams (PACT)
- Home-base Primary Care (HBPC)
- Community-based Hospices

**Research**
- Nurse Staffing and PC Outcomes
- Concurrent Care
- PC-NCT impact on BFS scores
Comparison of % of inpatient deaths in ICU and Hospice (2014)

Number of Days in PC
Home and Community Based Care

For many, home is the best place

- Honoring Veterans’ preferences
- Need for improved access (eg age<65)
- We Honor Veterans campaign
- Hospice-Veterans Partnerships

Expand Access outside the VA

Currently with 68 participating hospices and community partners in Wisconsin

www.WeHonorVeterans.org

Wisconsin HVP

- Currently being reorganized
- Offering participation to all community hospices and partners
- Wisconsin has had a long history of HV Partnership through the HOPE of Wisconsin over the years
Reaching Out Grant:
Improve End of Life Care for Rural and Homeless Veterans

• Provide information on EOL care to community hospices and participate in Homeless veteran initiatives.


Monitors & Measures

• BFS trends
• % of inpt deaths with PC
• PCCT staffing
• PCCT and HPC unit training trends
• Venue of deaths

• # of outpt PC consults
• # of days from HPC consult to death
• VA-paid hospice for < 65 year olds
• Integration
• Capacity to grow
• HVP/WHV activity

Veteran-Centered Care

CONNECTING through STORY...

Stories are where history and truth reside and Veteran-Centered Care begins
– We honor their stories by listening, understanding and affirming

Video: Jim Cooper Story: A Veteran's Legacy

[https://www.youtube.com/watch?v=eSgRpgus4H8](https://www.youtube.com/watch?v=eSgRpgus4H8)
INFLUENCES

*Branch of Service
*Officer
*Enlisted
*Drafted
*Age

Influence: Military Culture

* Big Boys don't Cry
* No Pain. No Gain
* The more it hurts, the better.
* Fear/Pain is a sign of weakness
* Few Good Men (Marines)
* Stoicism

Male Culture in America?
Military males get a double dose of macho!

Biggest Influence? Combat!!

WWII: Heroes
Korea: Ignored
Vietnam: Shamed
PTSD:
• Exposure to a traumatic event

• Traumatic is persistently re-experienced (1 or more):
  - Recollections
  - Dreams
  - Acting as if trauma is recurring
  - Distress at cues that symbolize the trauma

• Avoidance of associated trauma (3 or more):
  - Avoidance of thoughts, feelings, conversations r/t trauma
  - Avoidance of activities, places, or people that arouse recollection
  - Inability to recall some aspects of the trauma
  - Lack of interest in significant activities
  - Feelings of detachment/estrangement from others
  - Restricted range of affect
  - Sense of a foreshortened future

PTSD Cont’d

• Persistent symptoms of increased arousal (2 more):
  - Difficult sleep patterns
  - Irritability or outbursts of anger
  - Difficulty concentrating
  - Hypervigilance
  - Exaggerated startle response

*Symptoms persist for at least 1 year
*Symptoms cause significant functional impairment

PTSD Classifications
• Acute
• Chronic
• Delayed Onset

Premature Aging

1/3 of Vietnam Vets suffer PTSD
**Combat Response Trajectories**

- **Trajectory #1:** Combat Trauma Successfully Integrated
  - "I've faced death before in the war. I'm not afraid of death any more."
  - "I faced death before and every day since has been a gift."
  - "But for the grace of God, it would have been me who died in that war. I'm aware of the gift of grace that is with me now."
  - Do these veterans have a different experience of death?
  - Do these vets have a different experience of death?
  - These are our role models for death!!

- **Trajectory #3:** Combat Trauma NOT Integrated (PTSD)
  - Suspicion and lack of Trust
  - Alcohol usage common
  - Anxiety
  - Agitation (Acting out trauma)
  - Estranged relationships
  - Unfulfilled longing for the life not lived (guilt)
  - Do these veterans have different life experiences?
  - Do they have different death experiences?
Trajectory #2:
Combat Trauma APPARENTLY Integrated:
(Subclinical PTSD)

"White Knuckle Syndrome" has kept the lid on. Mask may fool others — including themselves! Hollowness, aloofness, workaholism or other addictions may not be understood to be from the war experience. May/may not have alcohol history and estranged relationships.

Be astute to "I/He doesn't want to talk about what happened in the war."

At time of personal death:
• Anxiety
• Agitation
• Resurrected Memories

CAUGHT UNAWARE as unconscious material comes forth. Can be scary.

Interventions: All VETERANS

Intake Assessment: Veteran? If so, Combat veteran?

• Affirm the FEELING aspect of the death experience, especially the tears and tears (which the military culture taught them to disdain).

• Anticipate that they might UNDERREPORT physical and emotional pain.

Thank them for serving your country and giving you your freedom. Post a certificate of appreciation. Patriotic calendars. Pin an American flag on them with a personal message.

Interventions: Combat Vets
(Trajectories #2 and #3)

Listen and provide witness to their stories:

"Most of my brother remained in Vietnam."

"I didn’t know the person who came back."

"I’ve been fighting that war every day since I returned."

"We’ve been fighting that war every day since."

"90% of me died in that war."

"I lost my soul in Vietnam."

"If only I would have ______, he’d still be here today. If only… If only… If only……"

"Why him and not me?????" (survival guilt)
Other Interventions:

Recognize what you are dealing with.
Admission: Assess vet status and combat history
Combat vets: Encourage war stories.
"You probably saw a lot of ugly things in the war. Can you tell me a few that still trouble you?"
Develop sensitivity to the sequela of war!

Emotional Pain Scale
(0=Serenity/10=Turmoil)

Other Interventions:

Understand and accept their pain, anger, shame, fear, helplessness – especially when it presents in angry, fearful, despairing, and ugly, non-compliant ways.
Recognize that the need to remain in control may contribute to decisions that challenge therapeutic goals and treatment recommendations intended for the patient’s benefit.

Unique Needs of Veterans

• Both veterans and their families have unique end-of-life needs.
• Honor veteran culture!
• Veterans have served beyond their military years; we have a unique opportunity to ‘be present’ with veterans and their families at this life-changing event.
Other Interventions:

Recognize confusion/agitation for the PTSD that it might be (not terminal restlessness).

Be aware of possible paradoxical reactions with meds. Be cautious in using sedatives that might cause further mis-cuing and further loss of control, which only makes them fight harder to re-gain control. (Haldol, compazine, phenergan alternatives)

Enter metaphor with them. (Battle metaphors are common)

Put mattress on floor if enemy soldiers are under bed.

Assess for environmental triggers, realizing that weather/holidays/helicopters, surgery, own death or roommate's death may be triggers.

Other Interventions:

Be aware that Asian Ancestry in the healthcare provider may be a trigger for WWII (Pacific theatre), Korean, and Vietnam vets. Don’t take this personally. (This does not necessarily have anything to do with racism).

If Vietnam or Korean vet speaks about how Americans treated them, apologize. If Vietnam vet speaks about never being welcomed home, welcome him.

Delayed grief for multiple reasons, including losses on the battlefield, legal proceedings, illness, multiple losses, etc.

Using Technology

• Smartphone Apps for Stress and Mood Management
  - Breathe2Relax (link is external)
  - mTBI Pocket Guide (link is external)
  - PTSD Coach (link is external)
  - T2 Mood Tracker (link is external)
  - Tactical Breather (link is external)
HEALING

• FORGIVENESS! FORGIVENESS!
  FORGIVENESS!
  Much to be forgiven for:
  * Self (killing, etc.)
  * Self (not killing, not dying)
  * Enemy
  * Government (using/betraying them in Vietnam)
  * The World (for being like it is)
  * God (for allowing the world to be like it is)
  * Family (for treating them badly)

• Assess guilt. DON'T dismiss it with platitudes.

• What is needed is healing of the heart.

Questions???