

Successful Initiatives at the Portland VA

Bereavement Team Provides Excellent Care

In June of 2011, Jason Malcom, LCSW, Palliative Care Consult Team Social Worker at the Portland VA Medical Center, formalized a Bereavement Program targeting the next of kin of all inpatients who die in the Portland campus hospital or the Vancouver campus Community Living Center. The program began modestly, with just Jason and his MSW intern making one-time bereavement calls to next-of-kin following a Veteran's death. Through targeted outreach to a number of facility leaders, such as the Psychology Training Director and the Chaplain Supervisor, the Bereavement Program expanded to include the CLC Hospice Unit Social Worker and trainees from psychology and chaplaincy. With the increase in team members, the program expanded its services to include multiple follow-up calls and outreach to each next-of-kin throughout the first 13 months of bereavement.

Portland's Bereaved Family Survey measurements reflect an increase in several key indicators since the start and expansion of the Bereavement Program. There has been a 27% increase in bereavement contacts since FY11. In the fourth quarter of FY12, 97% of next of kin had a bereavement contact noted in CPRS. PVAMC's overall BFS score increased by 22% in FY12 compared to FY11. The facility also had a 10% increase in Emotional Support After Death scores over FY11. To learn more about Portland's Bereavement Program, the PROMISE Center interviewed Jason Malcom, who developed and coordinates the program.

❖ What is the Bereavement Team at the Portland VA Medical Center?

The Bereavement Team at the Portland VA Medical Center (PVAMC) is a team of staff and trainees that provide outreach, information, resources, and support to the next of kin (NOK) of Veterans who have died



Left to right: Jenna Wheeler, PhD, Holly Gunby, M.Div., Debbie Agee, Social Work Student, Jason Malcom, LCSW

in our hospital and community living center. At its core, the Bereavement Team consists of a multi-disciplinary team of chaplains, social workers, and psychologists. The outreach provided consists of phone calls, letters, and sympathy cards that are sent to the next of kin as listed in the Veteran's CPRS chart.

The lion's share of the bereavement services is comprised of phone calls to the Veterans' next of kin. Bereavement Team members place phone calls to the NOK five times during a 13 month period following a Veteran's death. An initial bereavement and condolence phone call is made 10-14 days after the Veteran's death. Follow-up calls are then made at one month, three months, six months, and 12 months after the initial phone call. Sympathy cards are also mailed out by the Veteran's primary care provider. Finally, staff

from Chaplain Service, the Bereavement Team, and the Palliative Care Team conducts quarterly memorial services for the family and friends of Veterans who die in our facilities.

❖ What goes into a bereavement phone call?

A script for the initial bereavement phone call is provided for Bereavement Team members who feel it is helpful to loosely follow a script. However, the script is intended to be only a guide that contains specific key points to cover during the initial bereavement call. Initial bereavement phone calls are the only semi-structured phone calls. Follow-up bereavement phone calls are less structured and are based on content and communication that occurred during the initial phone call.

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Generally speaking, the key points that are covered in an initial bereavement phone call are:

- Offer of condolences
- Inquiry into how the NOK is coping and their supports in place
- Education and information about grief responses
- Support to actively grieving NOK
- Offer bereavement and grief counseling services in local community
- Inform of PVAMC or CLC memorial service
- Offer of mailing of educational materials on the grief process
- Provide information about survivor benefits
- Offer of ongoing support from Bereavement Care Team (follow-up bereavement phone calls)

❖ How did the bereavement program get started?

We began by thinking about what the anatomy of a bereavement phone call could look like. We looked at some other models as examples. I then partnered with leaders in other disciplines to see if we could partner with members of their disciplines to build a bereavement team. Then we began a running list of the deaths that occurred in our facilities, I provided training on the process and content of bereavement calls, and we started contacting the next of kin.

❖ What are the other components of the Bereavement Program?

The core Bereavement Team consists of two staff and three trainees. I am the only dedicated staff member; however, the CLC Hospice Unit Social Worker participates and so do at least three clinical trainees – a Palliative Care Chaplain Fellow, a Palliative Care Psychology Fellow, and a Palliative Care Social Work Intern. I coordinate the bereavement services.

PVAMC Bereavement Team



Rebecca Williams, MSW, CSWA

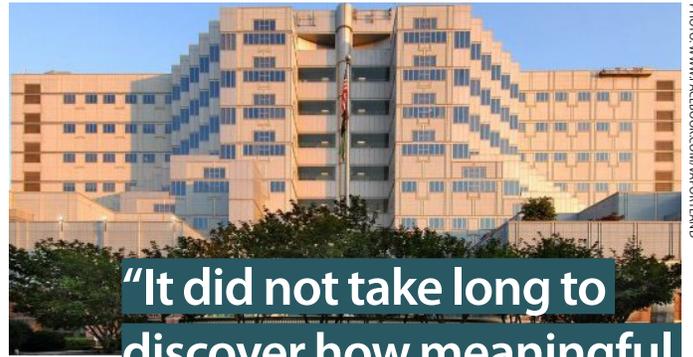


PHOTO: WWW.FACEBOOK.COM/VA/PORTLAND

“It did not take long to discover how meaningful these outreach calls can be.”

Additionally, inpatient ward and ICU staff and staff from Decedent Affairs provide condolences and valuable information to families immediately after the death of a Veteran.

❖ What was the biggest challenge to getting the Bereavement Program started?

One of the biggest challenges to getting the Bereavement Program started was identifying enough team members to handle the volume of calls. This is an ongoing and evolving challenge and we are currently looking to partner more with Chaplain Service to broaden our pool of callers.

❖ What would you advise to other VA medical centers that want to start a bereavement program?

Start with what you have and with what your clients need. We started our bereavement program with just two people making initial bereavement phone calls. We had to work out some initial kinks before we established a good process and system for making initial calls and offering supportive services. However, it did not take long to discover how meaningful these outreach phone calls can be to the NOK and the bereavement staff. Once you have a good foundation for making the initial phone calls, then you can look to expand the program to include follow up calls. ●

Evidence of Portland Successes as reflected by BFS Data

The Portland facility has shown a **10% points increase** on the Emotional Support After Death BFS item since FY2011. Portland’s FY2012 Emotional Support After Death score of 77% is higher than both the VISN and national score.



PROMISE Offers Hot Seat Calls

VISN 21's Mary Zuccaro shares her experience

The PROMISE and Implementation Centers offer regularly scheduled Hot Seat calls for VA staff in each VISN. During the call a PROMISE staff member reviews quarterly PROMISE Center report information with call participants. Based on VISN performance, the PROMISE Center and Implementation Center also offer intervention strategies aimed at improving Bereaved Family Survey scores.

VISN 21 Program Manager Mary Zuccaro, ARNP, ACHPN provided the following feedback on her experience with the calls.

How have you found the new PROMISE-led Hot Seat calls to be helpful for staff in your VISN?

The new Bereaved Family Survey (BFS) quarterly report format, and these Hot Seat calls, are the best thing since sliced bread. The sophistication of this new way of presenting BFS analysis is taking us to the next level in end of life care program development. Our teams are working hard, and they need to hear specifically what they are doing well, as we shine a light on areas that still need strengthening. And it's becoming increasingly apparent that the solutions, as well as successes, are not always within the Palliative Care camp. For example, if a station has been struggling to get their overall family satisfaction score up to the VISN benchmark, it makes a difference to everybody to hear two things loud and clear:

- the percent of families who are very satisfied with the care, by combining the very good and excellent scores--so **great for morale!**
- the top five questions associated with excellent family satisfaction score—great for focusing on what matters most to the families as hospice/PC staff work with non-hospice/PC colleagues to build a station-wide model for customer service that is meaningful for Veterans and families.

The BFS looks at family satisfaction from 17 different angles, and in all venues of care. It can be overwhelming for our teams to be doing the complex work they do every day, and at the same time trying to wrap their arms around all of this. These new calls are so empowering, because they **help us to focus on each station's critical issues**, as well as the specific venues where they occur. At the same time, it gives the PROMISE Center experts a chance to show just how powerful their data analysis can be in supporting hospice/palliative care programs, as well as advancing the overall state of the art of end of life care in all venues.

How have you found the new PROMISE-led Hot Seat calls to be helpful for you as a Program Manager?

As a VISN Palliative Care Program Manager, my job is to monitor and support six diverse programs. The Hot Seat calls empower me to serve as the BFS expert for my VISN. I study the Hot Seat call prep report, reflecting on it with the Centers experts and each team, both before and during the quarterly call. After

the call, I am fully prepared to create executive summaries that keep our VISN CMO and each program's quadrad informed of where praise would be appreciated and where their valuable support is needed. By familiarizing myself with each team's strengths, **I can match teams with a challenge to teams who have already been down that road.** Moreover, all of the VISN Palliative Care Program Managers are networked to do this on a national level, so if my VISN doesn't have an answer, another VISN usually does.

As the PROMISE team prepares the data analysis for the VISN, how do you, as a Program Manager, prepare for the call?

To prepare for the call, I send out a heads-up to all of my programs, asking them if they have any questions related to their BFS data. Ongoing, whenever a question or concern comes up, I address it as best I can, and then suggest that they bring it up on our next Hot Seat call for the benefit of all the other programs. I also track these issues, so that I'm prepared to share them with PROMISE Center experts when they are preparing our reports. Sometimes these issues lend themselves to additional data analysis that then gets included in the Hot Seat prep report. For example, if there's a staffing concern, we look at data that could be related to that particular staff role, and then track trends for any significant impact on family satisfaction. Or, if there's a concern about pain management in a specific venue of care, we can look at family satisfaction related to this issue and see if there's a noticeable difference in that venue, as compared to others in that station, or with that same venue in the other stations in our VISN. It's **all about looking for patterns and trends over time.**

We need leadership to help everybody recognize that the BFS is a station-wide measure of family satisfaction. Even if leaders are too busy to attend our calls, just inviting them helps to maintain awareness of what the PROMISE Center has to offer VA at all levels of the organization. For example, many people still don't know that PROMISE reviews every chart of every Veteran who dies in a VA facility for evidence of a palliative care consult. This is so important, because workload capture for consults is still a work in progress for many stations. The BFS can help balance the picture, when the VSSC report does not accurately reflect consults provided. And this is also very important, because it's not just a matter of statistics.

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☞ **Why is it valuable to have representatives from each facility participating on the Hot Seat call?**

We decided to devote one of our regular monthly conference calls to this quarterly call, enabling everybody to carve out time to attend. Every monthly call is a golden opportunity for each team to share their resources and to learn from the others. Along with representatives from each of our PC teams, any other BFS stakeholders (i.e., QM and leadership), may also be invited to the call. One team found it very helpful that a QM leader attended our last call; it gets everybody on the same page. Leaders tend to look at VSSC snapshot reports, while on the Hot Seat calls, we take a **deeper dive into the full quarterly comprehensive data**. Through this intelligent way of analyzing the data, we can see the impact of palliative care consults in each station, in each venue of care. And when we are enabled to fold this rich information into executive summaries of what we've learned from this deeper look, our busy leaders can benefit from the best of both worlds-- VSSC and PROMISE reports.

☞ **You have had a Hot Seat call every quarter. Why do you think it's valuable to have one regularly?**

Especially now since supplementary funding has ended, staffing is getting stretched. Our palliative care colleagues are wearing many hats. The Hot Seat call is an opportunity to have a good review of trends that may not be apparent in the daily fast-paced environment in which our teams and our leaders are functioning. Refocusing the lens on the larger picture of our work helps us keep the main thing, the main thing. Additionally, the more each VISN participates in these calls, the more we will have to share with other VISNs, and then, everybody wins: VISNs, programs, and most importantly, the Veterans.

☞ **What would you say to a VISN who hasn't had a call recently about the new format of the Hot Seat calls?**

These calls cut to the chase, providing a rigorous review of the palliative care consultation transformation measure and cutting edge customized BFS data analysis. We get a progress report for

how well each station is meeting the needs of Veterans and families, who entrust their end of life care to us. Veterans have only one chance at a good death--this is the urgency of our work and our BFS QI efforts. Our Veterans and families depend on us doing our very best every day. Honest success depends on learning from cases that don't go as well as we had hoped. By sharing what we are all learning, we all improve more quickly. I can't think of a better way to shepherd our programs through this process than to provide a regular opportunity for us to see how far we've come, and to learn from each other, as we continue on this journey toward providing the best in end of life care for all Veterans. ●

Would you like to schedule a Hot Seat Call?

Please have your VISN HPC Program Manager contact Dawn Smith at Dawn.Smith2@va.gov. Please provide at least one month's notice.

Visit our PROMISE Center Website for more information on the Bereaved Family Survey and Resources

<http://www.cherp.research.va.gov/PROMISE.asp>

Do you have questions about your data? Would you like your data presented differently? Is there additional data you would like to see? Please contact our Data Manager, Dawn Smith, at dawn.smith2@va.gov.

Please email Laura.Scott@va.gov with PROMISE Newsletter submissions



Benefits of the Comfort Care Order Set

Denver's Dr. Cari Levy provides feedback

Dr. Cari Levy and staff of the Denver VA recently worked with the Implementation Center to initiate the use of the Comfort Care Order Set in their facility. The primary goal of this planned intervention was to improve pain management for Veterans at the end of life. Dr. Levy provided feedback on the CCOS and improvement of care in Denver facility.

► How were you able to use PROMISE Center and Implementation Center data to assess your needs and implement the CCOS?

We reviewed our quarterly reports and were consistently low in two areas, pain and bereavement services. At first we didn't want to believe the data but once a sufficient number of responses were available, we couldn't ignore the data.



► In what ways were you able to tailor the Comfort Care Order Set developed by Dr. Amos Bailey to your facility's needs?

We started with Dr. Bailey's order set and then forwarded copies to all the relevant service chiefs. Everyone printed a copy of the order set and we convened a meeting of the minds to discuss what would work within our system and what would need to be modified. For example, some of the medications needed to be modified to match our hospital formulary. Our ICU nurse manager was absolutely key. She was excited about the order set and led the charge in obtaining buy-in from the ICU staff. Her support seemed to carry over to all the other services and things went swimmingly! Our Clinical Application Coordinators (CACs) were also essential. They simply asked that when the order set was ready to go, I provide one page per slide of Dr. Bailey's PowerPoint complete with hand-written edits and they would make all the changes. The service chief in charge of the CACs allotted protected time for them to create the order set thanks to the funding provided by the ICARE and Serious Illness Initiative. We originally identified one CAC to lead the effort but by the end, I believe all of them contributed to some portion of the project. A true team effort!

An interesting opportunity arose in implementing the subcutaneous infusion orders. We have wanted to make this available to our Veterans for years but ran into barriers until we could show our colleagues that others in the VA were using them and we even had the order set ready to prove it and implement. Our IV Therapy Department Head was a dream. She took the data available from our colleagues around the country and ran with it. She researched the various products available and selected the ones she felt would be most appropriate. She then trained all of her staff and the buy-in was terrific given her enthusiasm. Our hope going forward is that the IV team will alert

the palliative care team when they are finding placement of an IV or PICC difficult and wondering if it really the most humane approach for some of our Veterans with very advanced illness. We can then review the case and, where appropriate, suggest a SQ infusion instead of IV placement. We also see it as an option for Veterans and families who desire a time-limited trial of artificial hydration.

The last step was asking all of our palliative care providers to review and use a mock version of the order set. We were then able to finalize it within approximately 1 month. The quick turnaround was helpful in maintaining the momentum of all involved.

► What training opportunities were provided to staff on the Comfort Care Order Set?

The palliative care team is using "just-in-time" training with the resident physicians who are the physicians generally using the order set.

► What feedback has staff provided on their use of the order set?

It seems to be working well so far from a staff perspective. We will continue to discuss the CCOS at our monthly meetings and if additional modifications are needed, we have the ability to go back to the CAC team and make any changes. Changing order sets in CPRS always seemed so mysterious until we met the CACs and realized how talented and accessible they are. A terrific compliment to the order set was the creation of a terminal extubation checklist available to residents and ICU staff. This and a number of 1-page documents designed to be adjuncts to the order set have been well-received. We are now beginning a formal collaboration with the ICU staff which was an opportunity borne out of the CCOS project. Fortunately, collaboration seems to beget more collaboration!

In summary, the CCOS appears to be improving end-of-life outcomes for our Veterans. The project spurred creativity, exposed us to new colleagues and has woven us deeper into the fabric of our hospital. We're grateful to Dr. Bailey and the VA for providing such readily available resources to run with and encourage others considering CCOS implementation to go for it! ●

More Information on Implementation Center Resources for VA Staff

Additional information on the Comfort Care Order Set is available on the CELC Implementation SharePoint:

<https://vaww.visn3.portal.va.gov/sites/NationalImplementationCenter/default.aspx>

To gain access to the SharePoint please contact Lyndella Talamanco at Lyndella.Talamanco@va.gov.

Quality Improvement Resource Center (QuIRC)

Announces the

Palliative Care National Clinical Template

PC-NCT 3.0

Soon to be available nationwide!

The Palliative Care National Clinical Template (PC-NCT 3.0) will be available to all VA Palliative Care Consult Teams for installation in the next few months. VA clinician leaders guided the development of the PC-NCT to enable bedside providers to help promote uniform VA practices, educate learners in the essentials of consultation, and guide quality improvement through local and national data collection.



Why use PC-NCT?

- **Program development:** Provides mechanism to capture and track processes of care (health factor) data.
- **Standardization:** Provides opportunity to encourage critical aspects of care and standardize documentation of palliative care consultation.
- **Education:** Provides opportunity to teach inexperienced staff what is involved in palliative care consultation.
- **Quality Improvement:** Provides Palliative Care Consult Teams with metrics to improve quality at the bedside and compare data about their consultations with peers across the country.

For more information on the PC-NCT, please contact us!

QuIRC Hotline:

310-478-3711 ext. 48518

Monday- Friday, 8:00 am to 4:30 pm (PST)