PALLIATIVE CARE
RESEARCH COOPERATIVE

The Palliative Care Research Cooperative Group

Thinking Inside the Box:
Four Steps to Award-winning Posters

a webinar in the Investigator Development series

February 22, 2018

Host: John Beilenson
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SCP

www.palliativecareresearch.org

Thinking Inside the Box

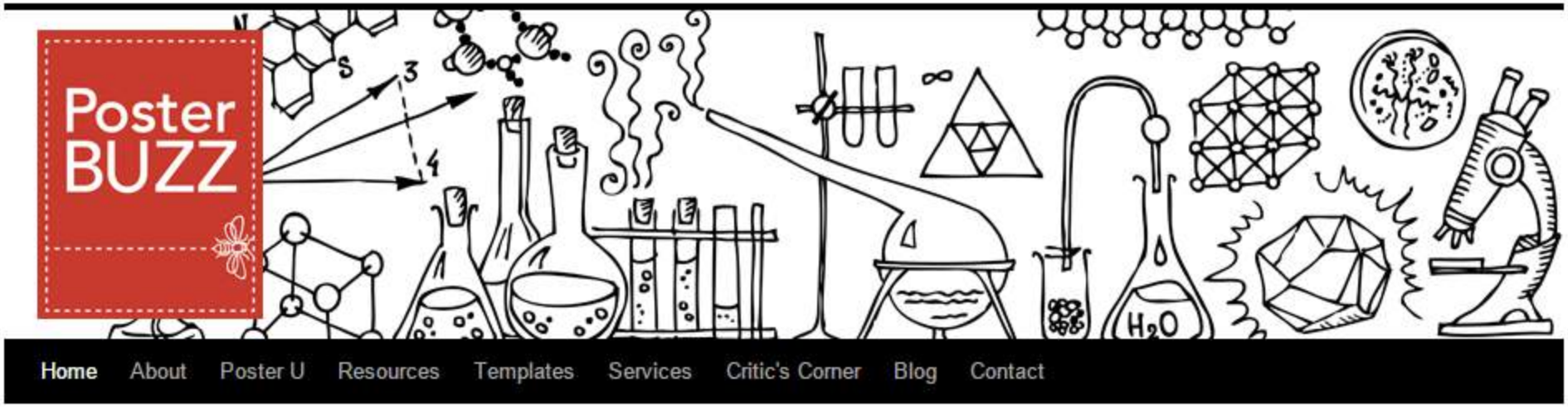
Four Steps to Award-winning Posters

Palliative Care Research Cooperative

John Beilenson @aboutscp

February 2018

PosterBuzz.com



Welcome to PosterBuzz

Scientific posters are an increasingly popular form of professional communications. Poster sessions provide a unique, face-to-face opportunity for researchers to engage their peers, get needed feedback, prompt new ideas, and meet potential collaborators.

Posters are everywhere at professional association and society meetings across the country, and yet most scientists and academics struggle to put something useful up on the wall. Then they spend poster sessions standing around hoping somebody, anybody, will come by and talk with them about their work.

So who to call? Backed by a team of communications experts who have worked with academic leaders during the last two decades, **PosterBuzz** is here to help. It is a unique


Posters!

Leadership!


Posters!

Poster Session!

Overview

- **Poster Session Challenges (All)**
- **4 Steps to Effective Poster Sessions**
- **Poster Review and Discussion**

Tell Us Your Poster Session Challenges

(Use the Q and A)

Four Steps to Better Poster Sessions

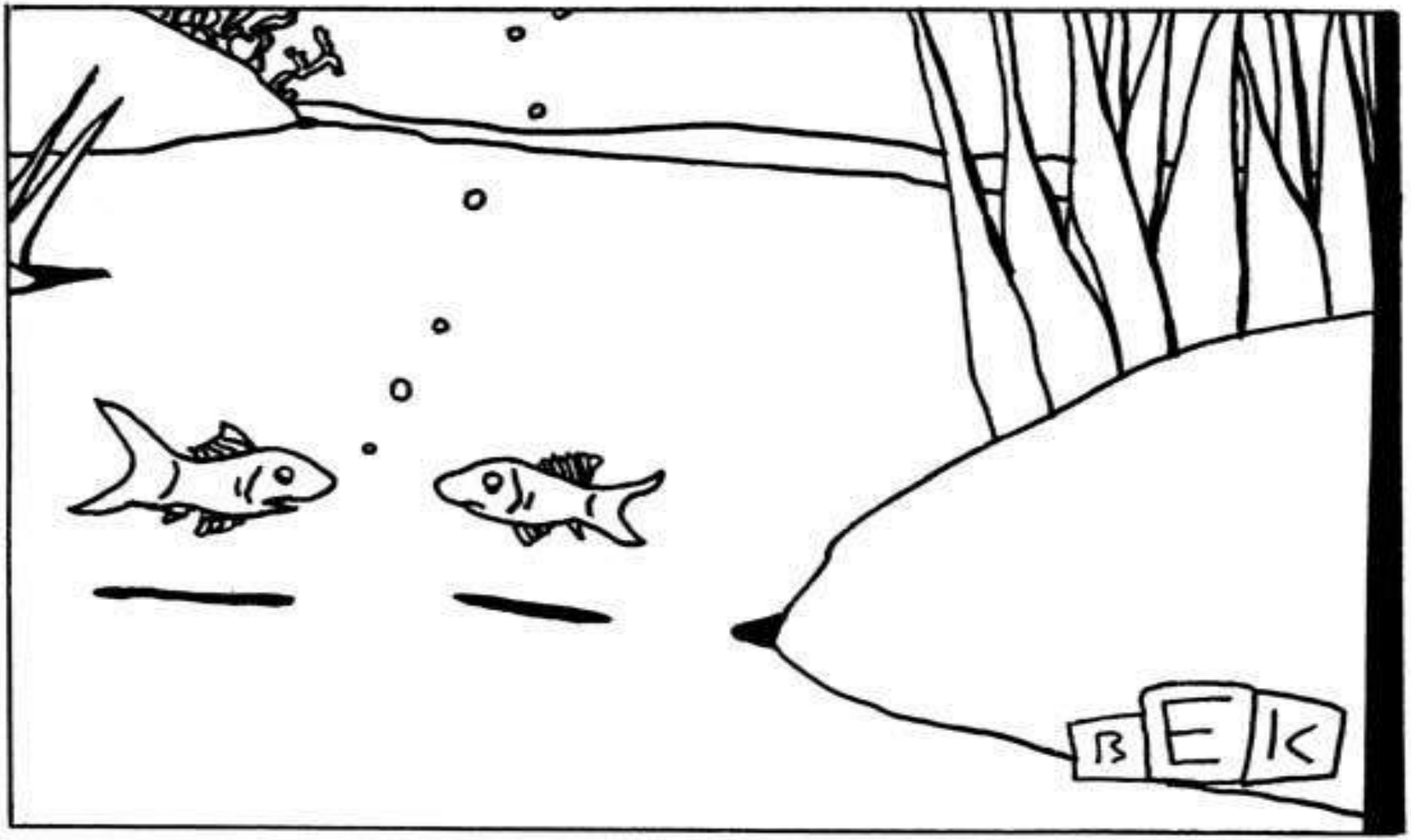
(from Anxious to Award-Winning)

Four Steps to Award-winning Poster Sessions

1. Think strategy
2. Get on message
3. Hone your design
4. Practice your “pitch”

1 Strategy

- Know where you are headed
- Know the environment
- Know your audience



"I want the whole package—the little bowl, the colored pebbles, the plastic castle."

Get SMART*

- Specific
- Measurable
- Attainable
- Realistic
- Time-bounded

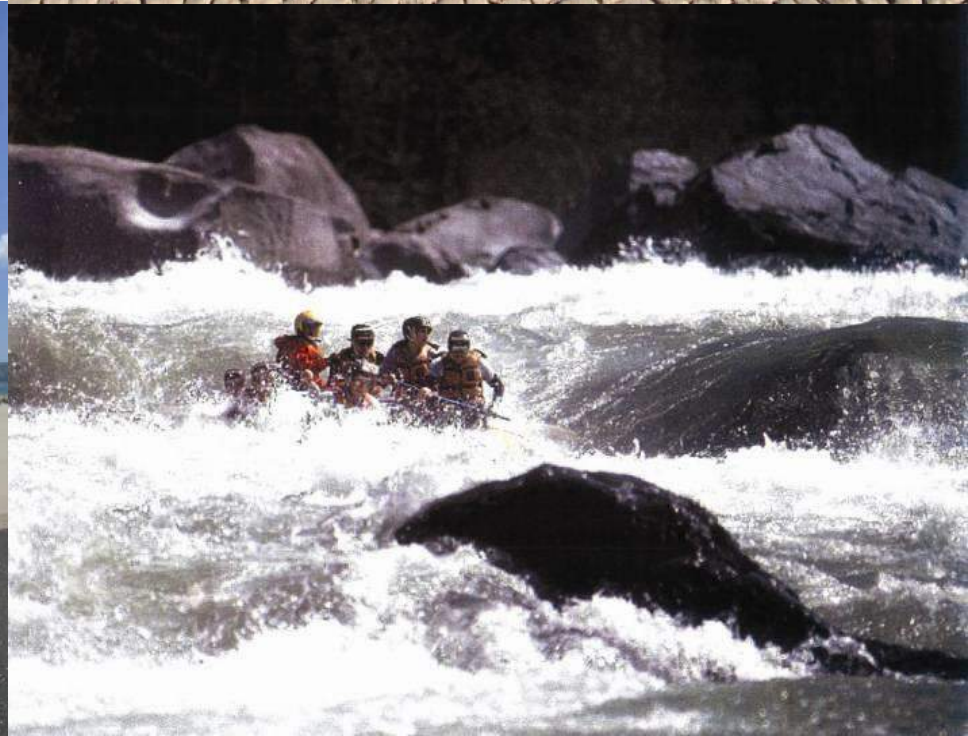
*From "The Spitfire Strategies Smart Chart 3.0," Washington, DC. www.spitfirestrategies.com

From Fuzzy to SMART

- Fuzzy Objective
  - Make a successful presentation about my research at the American Academy of Hospice and Palliative Medicine meeting in 2018.

- SMART Objective
  - In preparation for, participation in and follow up to AAHPM 2018, connect with five key academic leaders who provide constructive feedback and/or support to my research agenda.

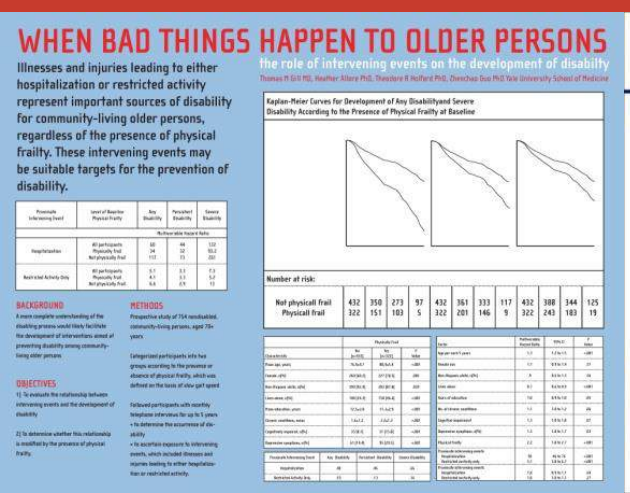
Understand the Environment



Know Your Audience

Poster Strategy Considerations

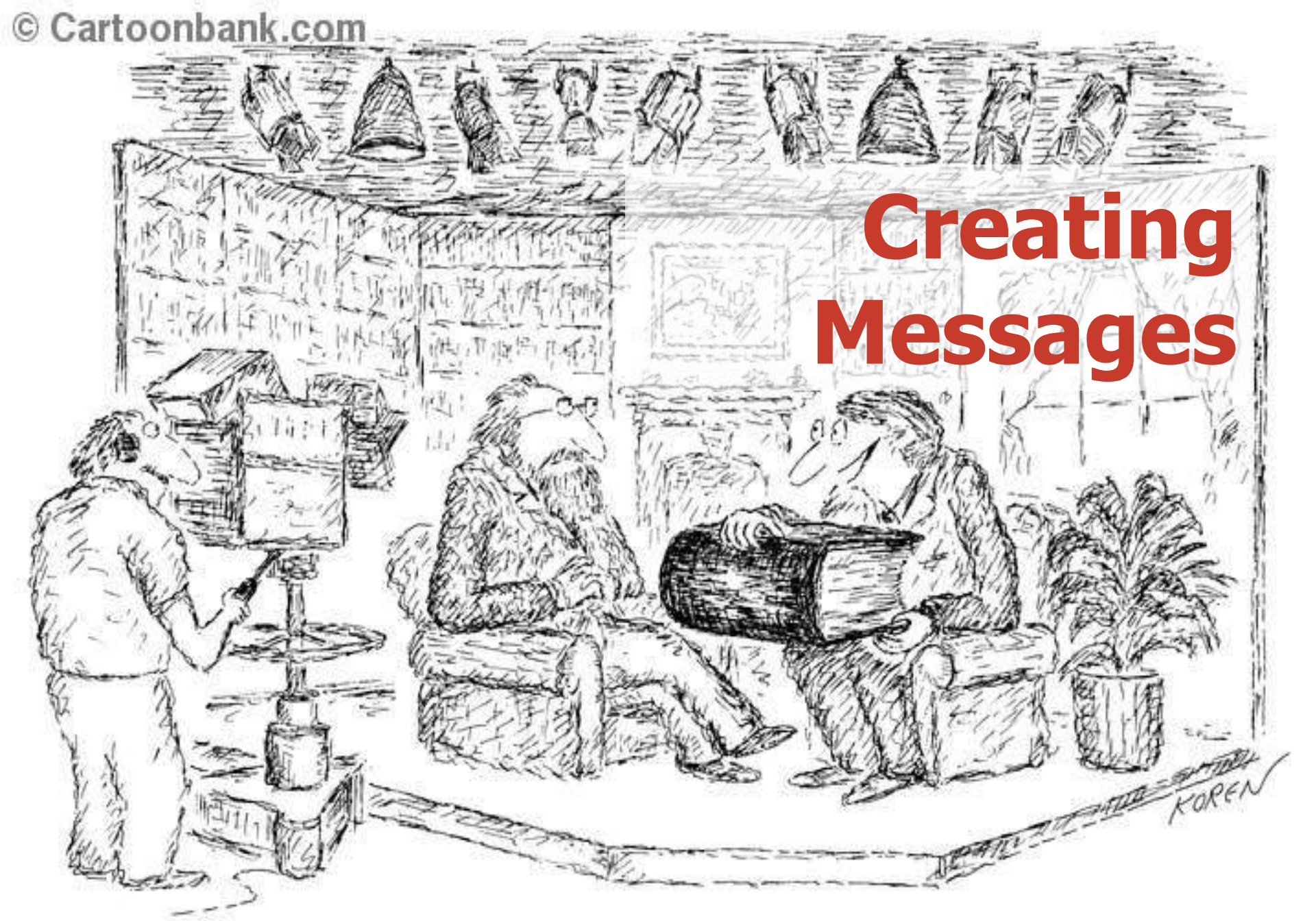
- Engagement as objective
- Poorly lit, competitive environment
- Scientific audience, on the move



2
Message

- Message = distillation
- Adapting messages
- Message challenges

Creating Messages



"If you were to boil your book down to a few words, what would be its message?"

“One Thing” Message

A good message* completes the following three statements:

- The **one** thing your audience needs to know is…
- The reason this is **important** to this audience is…
- What this audience should **do** is…

*Courtesy of Valerie Denney, Denney Communications

Adapting Messages

- Audience values
- Audience expectations
- Multiple audiences

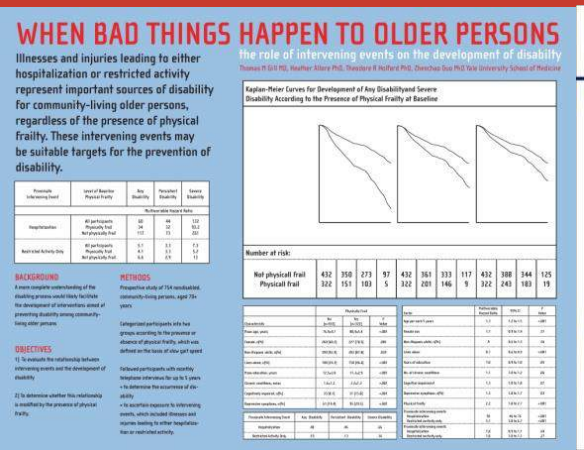
Message Challenges

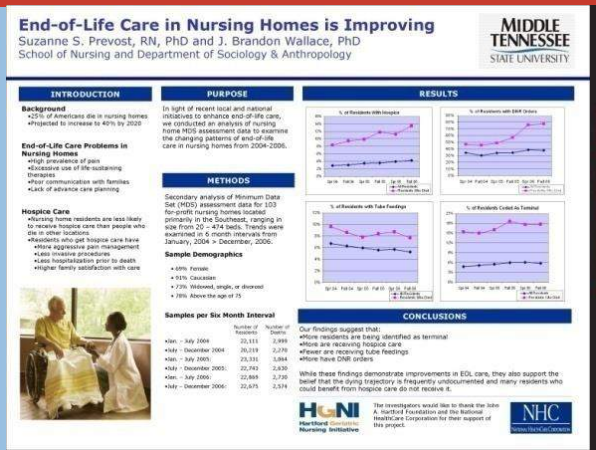
- Complexity
- Jargon
- Opacity/ abstraction
- Lack of emotion
- “Off key”

“You’re right. It does send a powerful message.”

Take a breath

- Looking to your next poster session:
  - **Explain your objective (use Q and A)**
  - Identify your target audience
  - Describe your main message





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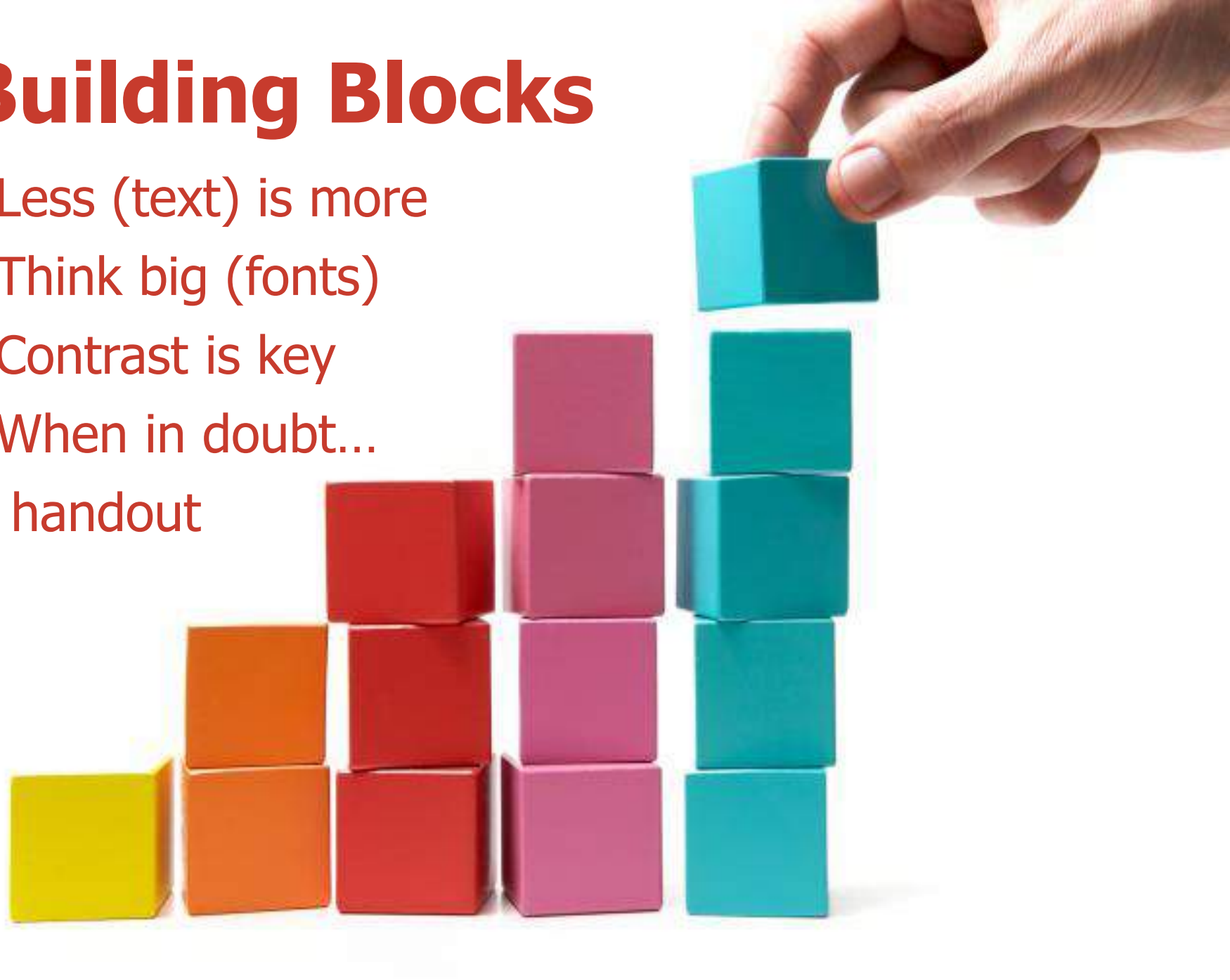
3
Design

- Know the basics
- Message drives design
- Get help

Building Blocks

- Less (text) is more
- Think big (fonts)
- Contrast is key
- When in doubt…

  handout



Think Grid (Not Just Columns)

End-of-Life Care in Nursing Homes is Improving

Suzanne S. Prevost, RN, PhD and J. Brandon Wallace, PhD
School of Nursing and Department of Sociology & Anthropology

MIDDLE TENNESSEE STATE UNIVERSITY

INTRODUCTION

Background
- 25% of Americans die in nursing homes
- Projected to increase to 40% by 2020

End-of-Life Care Problems in Nursing Homes
- High prevalence of pain
- Excessive use of life-sustaining therapies
- Poor communication with families
- Lack of advance care planning

Hospice Care
- Nursing home residents are less likely to receive hospice care than people who die in other locations
- Residents who get hospice care have
  - More aggressive pain management
  - Less invasive procedures
  - Less hospitalization prior to death
  - Higher family satisfaction with care

PURPOSE

In light of recent local and national initiatives to enhance end-of-life care, we conducted an analysis of nursing home MDS assessment data to examine the changing patterns of end-of-life care in nursing homes from 2004-2006.

METHODS

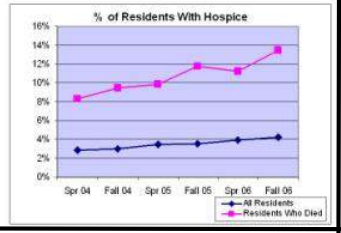
Secondary analysis of Minimum Data Set (MDS) assessment data for 103 for-profit nursing homes located primarily in the Southeast, ranging in size from 20 – 474 beds. Trends were examined in 6 month intervals from January, 2004 > December, 2006.

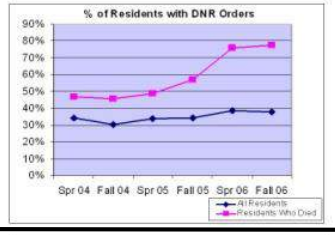
Sample Demographics
- 69% Female
- 91% Caucasian
- 73% Widowed, single, or divorced
- 78% Above the age of 75

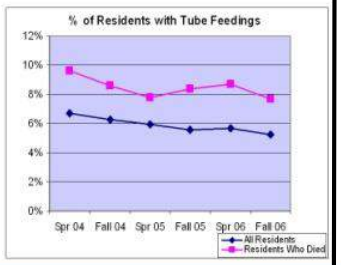
Samples per Six Month Interval

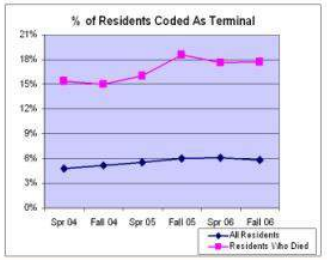
	Number of Residents	Number of Deaths
Jan. – July 2004	22,111	2,999
July – December 2004	20,219	2,270
Jan. – July 2005:	23,331	3,064
July – December 2005:	22,743	2,630
Jan. – July 2006:	22,869	2,730
July – December 2006:	22,675	2,574

RESULTS









CONCLUSIONS

Our findings suggest that:
- More residents are being identified as terminal
- More are receiving hospice care
- Fewer are receiving tube feedings
- More have DNR orders

While these findings demonstrate improvements in EOL care, they also support the belief that the dying trajectory is frequently undocumented and many residents who could benefit from hospice care do not receive it.

HGNI Hartford Geriatric Nursing Initiative

The investigators would like to thank the John A. Hartford Foundation and the National HealthCare Corporation for their support of this project.

NHC National HealthCare Corporation

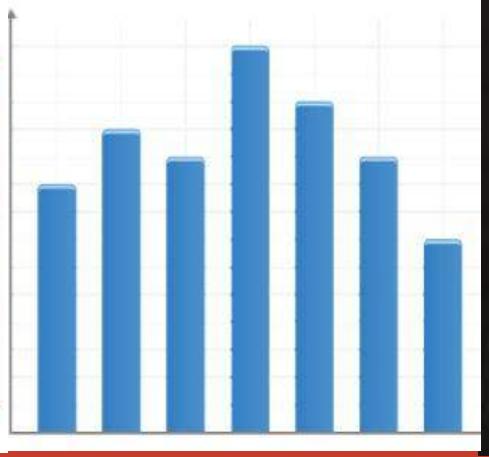
Message

=

Table 1. Health Status and Age of New Medicaid Eligibles

	Medicaid (%)	Uninsured (%)
Health Status		
% Good Health	81.6	89.5
% Poor Health	18.4	10.5
Age		
18-24	30.4	33.7
24-45	22.6	29.2
35-45	15	14.7
45-55	18.6	13.3
55-64	13.4	9.2

Source: Robert Wood Johnson Foundation and the Urban Institute, *The Health Status of New Medicaid Enrollees Under Health Reform*, August 2010



We demonstrated three key learnings

1.The characteristics of cancer survivors

2.The kinds of medical problems cancer survivors have

3.The implications of comorbid illness in cancer survivors for patients and for doctors

(i.e., table, graph, photo, colored text box, etc.)

Get Design Support!

- Templates/models
- Mentor and peer review
- Graphics departments and other pros

PHYSICAL FRAILTY, INTERVENING EVENTS AND THE DEVELOPMENT OF DISABILITY IN ACTIVITIES OF DAILY LIVING AMONG COMMUNITY-LIVING OLDER PERSONS

Thomas M Gill MD, Heather Allore PhD, Theodore R Holford PhD, Zhenchao Guo PhD, Yale University School of Medicine

BACKGROUND

Among community living older persons, the inability to perform essential activities of daily living (ADL) without the assistance of another person
is common, highly morbid, and costly

An important impediment to the development of interventions to prevent disability is an incomplete understanding of the mechanisms underlying the disabling process

Previous epidemiologic studies have focused almost exclusively on identifying vulnerable older persons at risk for disability

Relatively little is known, in contrast, about the role of intervening events that precipitate disability

While recent evidence suggests that disability may occur insidiously, particularly among older persons who are physically frail, most episodes of disability appear to be preceded by a discernable intervening event

OBJECTIVES

To evaluate the relationship between intervening events and the development of disability and to determine whether this relationship is modified by the presence of physical frailty

STUDY POPULATION

Members of the Precipitating Events Project (PEP Study)
754 community-living persons, aged 70+ years, who required no personal assistance in bathing, dressing, walking, or transferring
Persons who were physically frail, as denoted by a timed score > 10 sec on the rapid gait test (i.e. walking back and forth over a 10-foot course as quickly as possible), were oversampled to ensure a sufficient number of participants at increased risk for ADL disability
Participation rate was high: 75.2%.

DATA COLLECTION

ASSESSMENTS

Comprehensive home-based assessments were completed at baseline, 18, and 36 months by trained research nurse using standard instruments
Telephone assessments of intervening events and ADL function were completed monthly for up to 5 years with a 99.2% completion rate

INTERVENING EVENTS

Acute hospital admissions; Kappa = 0.94 for accuracy
Other illnesses or injuries leading to restricted activity
"Since we last talked on (date of last interview), have you stayed in bed at least half the day due to an illness, injury or other problem?"
"Since we last talked on (date of last interview), have you cut down on your usual activities due to an illness, injury or other problem?"
Test-retest reliability
Kappa = 0.90 for the presence or absence of restricted activity

Table 1. Baseline Characteristics of Study Participants

Characteristic*	Physically Frail: No (n=432)	Physically Frail: Yes (n=322)	P Value
Mean age, years	76.9 ± 4.7	80.4 ± 5.4	<.001
Female, n (%)	260 (60.2)	227 (70.5)	.003
Non-Hispanic white, n (%)	399 (92.4)	283 (87.9)	.039
Lives alone, n (%)	148 (34.3)	150 (46.6)	<.001
Mean education, years	12.5 ± 2.8	11.3 ± 2.9	<.001
Chronic conditions, mean	1.6 ± 1.2	2.2 ± 1.3	<.001
Cognitively impaired, n (%)	35 (8.1)	51 (15.8)	<.001
Depressive symptoms, n (%)	61 (14.1)	95 (29.5)	<.001

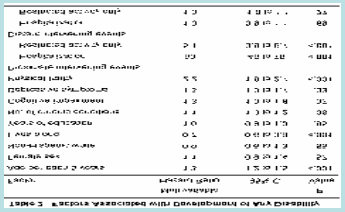


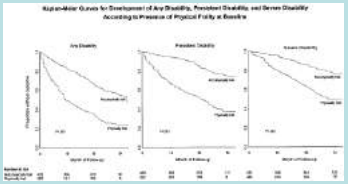
Table 3. Association Between Proximate Intervening Events and Disability Outcomes According to Physical Frailty at Baseline

Proximate Intervening Event	Level of Baseline Physical Frailty	Any Disability	Persistent Disability	Severe Disability
		Multivariable Hazard Ratio*		
Hospitalization	All participants	60	44	132
	Physically frail	34	32	93.2
	Not physically frail	117	73	261
Restricted activity only	All participants	5.1	3.3	7.3
	Physically frail	4.1	3.3	5.2
	Not physically frail	6.6	2.9	13

*All values are statistically significant at P < .001

Table 4. Population Attributable Fractions

Proximate Intervening Event	Any Disability	Persistent Disability	Severe Disability
Hospitalization	.48	.46	.66
Restricted activity only	.19	.13	.16



DISABILITY OUTCOMES

PRIMARY

Time to first occurrence of any disability over 5-year follow-up period

SECONDARY

Persistent: new disability present for at least 2 consecutive months
Severe: new disability in three or more ADLs

EXPOSURE PERIOD FOR INTERVENING EVENTS

PROXIMATE

Month prior to assessment of disability

DISTANT

Time from baseline assessment to two months prior to onset of disability or to a censoring event for participants who did not develop the relevant disability outcome

STATISTICAL ANALYSIS

Evaluated time to first occurrence of any disability, persistent disability, and severe disability, respectively, according to physical frailty at baseline using Kaplan-Meier method.

Used time-dependent Cox proportional hazards method to evaluate multivariate relationship between the independent variables, including the proximate and distant intervening events, and the development of each of the three disability outcomes; and subsequently stratified results by physical frailty at baseline

Calculated population attributable fractions of the three disability outcomes for each of the two proximate intervening events

SUMMARY

Intervening events, including illnesses and injuries leading to either hospitalization or restricted activity, were strongly associated with the development of disability in essential activities of daily living
These associations were limited to events occurring within a month of disability onset, were observed for three distinct disability outcomes, persisted despite adjustment for several potential confounders, and were present among persons who were physically frail and those who were not physically frail

IMPLICATIONS

Our results highlight the importance of intervening events as a potential target for the prevention of disability, regardless of the presence of physical frailty

WHEN BAD THINGS HAPPEN TO OLDER PEOPLE: THE ROLE OF INTERVENING EVENTS ON THE DEVELOPMENT OF DISABILTY

Thomas M Gill MD, Heather Allore PhD, Theodore R Holford PhD, Zhenchao Guo PhD Yale University School of Medicine

WHAT WE LEARNED

Illnesses and injuries leading to either hospitalization or restricted activity represent important sources of disability for community-living older persons, ***regardless*** of the presence of physical frailty.

These intervening events may be suitable targets for the prevention of disability.

BACKGROUND

A more complete understanding of the disabling process would likely facilitate the development of interventions aimed at preventing disability among community-living older persons.

OBJECTIVES

To evaluate the relationship between intervening events and the development of disability

To determine whether this relationship is modified by the presence of physical frailty

METHODS

Prospective study of 754 nondisabled, community-living persons, aged 70+ years

Categorized participants into two groups according to the presence or absence of physical frailty, which was defined on the basis of slow gait speed

Followed participants with monthly telephone interviews for up to 5 years

- to determine the occurrence of disability
- to ascertain exposure to intervening events, which included illnesses and injuries leading to either hospitalization or restricted activity

RESULTS

Kaplan-Meier Curves for Development of Any Disability, Persistent Disability, and Severe Disability According to Presence of Physical Frailty at Baseline

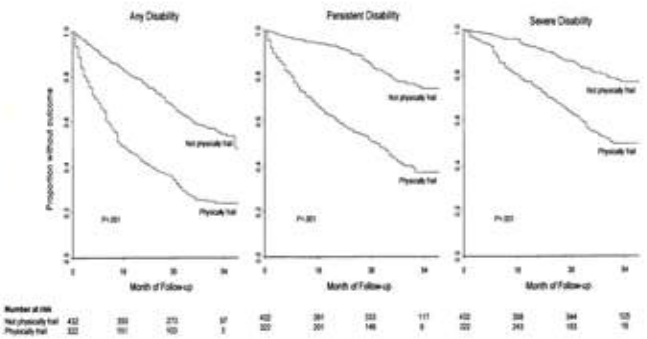


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Table 2. Factors Associated with Development of Any Disability

Factor	Multivariable Hazard Ratio	95% CI	P Value
Age per each 5 years	1.3	1.2 to 1.5	<.001
Female sex	1.1	0.9 to 1.4	.57
Non-Hispanic white	0.9	0.6 to 1.3	.56
Lives alone	0.7	0.6 to 0.9	<.001
Years of education	1.0	0.9 to 1.0	.85
No. of chronic conditions	1.1	1.0 to 1.2	.06
Cognitive impairment	1.3	1.0 to 1.8	.07
Depressive symptoms	1.3	1.0 to 1.7	.03
Physical frailty	2.2	1.8 to 2.7	<.001
Proximate intervening events			
Hospitalization	60	46 to 76	<.001
Restricted activity only	5.1	3.8 to 6.7	<.001
Distant intervening events			
Hospitalization	1.0	0.9 to 1.1	.69
Restricted activity only	1.0	1.0 to 1.1	.27

Bring the Heat!

4

Pitch

Only connect!

- Pique interest (Did you know…?)
- Connect with your audience
- Make it personal
- Tell a (brief) story
- Practice!

Poster Review

Engaging Patients in Advance Care Planning through an Electronic Health Record Patient Portal

Hillary D. Lum MD, PhD[1]; Adreanne Brungardt, MM, MT-BC[1]; Sarah Jordan, MA[1]; Lisa Schilling, MD, MSPH[2]; Jean S. Kutner, MD, MSPH[2]

[1]Division of Geriatric Medicine, [2]Division of General Internal Medicine, Department of Medicine, University of Colorado School of Medicine, and VA Eastern Colorado Geriatric Research Education and Clinical Center, Aurora, CO.

School of Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

BACKGROUND

- Only 36.7% of US adults have completed advance directives and rates of advance directives in electronic health records (EHR) are even lower
- We implemented novel Advance Care Planning (ACP) tools in the EHR patient portal, including an electronic Medical Durable Power of Attorney (MDPOA) form

OBJECTIVE

To evaluate feasibility and use of novel patient EHR-based Advance Care Planning tools

METHODS

Design Mixed methods evaluation of first 8 weeks of ACP tool use. No specific promotion about tools or outreach was performed.

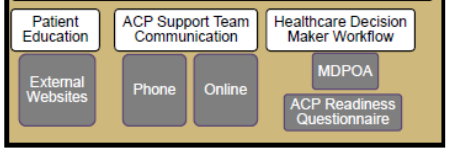
Participants and Setting Adults ≥ age 18, ~286,000 patients have a portal account.

Methods Chart abstraction and qualitative analysis of preferences on MDPOA forms

Outcomes

1) Characteristics including age, gender, geographic region, and documentation.
2) Thematic analysis of the optional section of the MDPOA form which allows patients to free-text preferences

Advance Care Planning Webpage



RESULTS

TABLE 1. Participants (n=296)

Characteristics	N (%)
Age, mean (range)	45 (18-98)
Women	213 (72)
System Region	
North	96 (32)
Metro	118 (40)
South	68 (23)
Out of State	14 (5)
Primary Care Provider	
PCP within system	163 (55)
PCP outside of system	76 (26)
Unknown	57 (19)

Fig 2. Type of ACP Interaction (n=296)

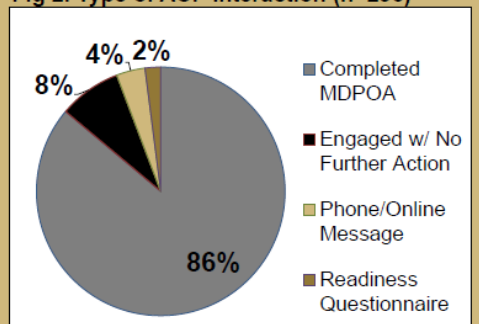


TABLE 2. Analysis of Treatment Preferences (n=107)

Main Themes	Example Quote
Procedural Requests	I want all efforts made to save my life. The only exception is a) if I am deemed brain dead for a minimum of 5 days or b) if the only way to keep me clinically alive, with no quality of life, is chronic life support
Absolute Statements	Keep me Alive!
Reference to other ACP documents	Please refer to my Living Will that is on file and my husband can provide.
Consultation Requests	I would like an early palliative care consult if I have a serious illness.
Organ Donation	Any organs or viable tissues to be used for transplant.
Address to Agent	All decisions are to be made by (agent).

Fig 1. Web-based Healthcare Decision Maker Workflow

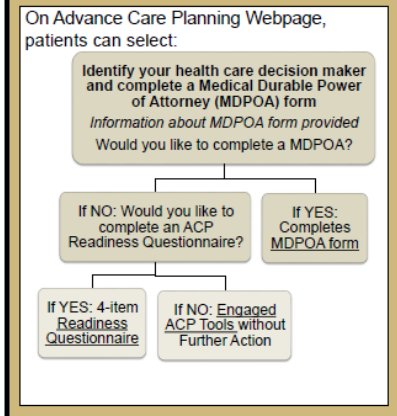
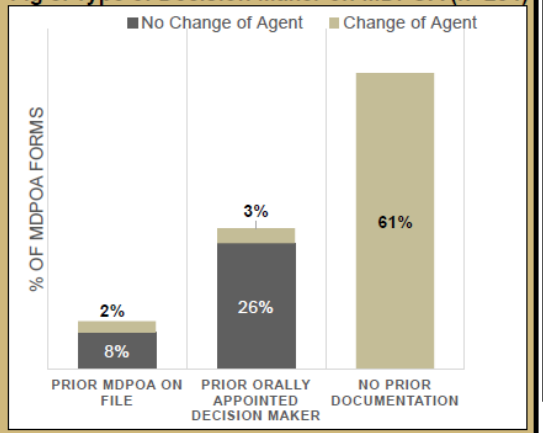


Fig 3. Type of Decision Maker on MDPOA (n=254)



CONCLUSIONS

1) Patients of all ages have engaged in ACP tools through the patient portal.
2) The web-based tools promote completion of a MDPOA form to appoint a healthcare decision maker.
3) The majority of patients who completed a MDPOA form had no prior documentation of a healthcare decision maker.

NEXT STEPS

- Develop population health-based strategies to promote use of EHR-based ACP tools
- Implement healthcare staff training and engagement to promote ACP discussion and patient outreach.

Funded by: The Colorado Health Foundation; Dr. Lum is also supported by an NIA K76 Paul B. Beeson Award.

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[1]Division of Geriatric Medicine, [2]Division of General Internal Medicine, Department of Medicine, University of Colorado School of Medicine, and VA Eastern Colorado Geriatric Research Education and Clinical Center, Aurora, CO.

School of Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

OBJECTIVE

To evaluate feasibility and use of novel patient EHR-based Advance Care Planning tools

METHODS

Design

Mixed methods evaluation of first 8 weeks of ACP tool use. No specific promotion about tools or outreach was performed.

Participants and Setting

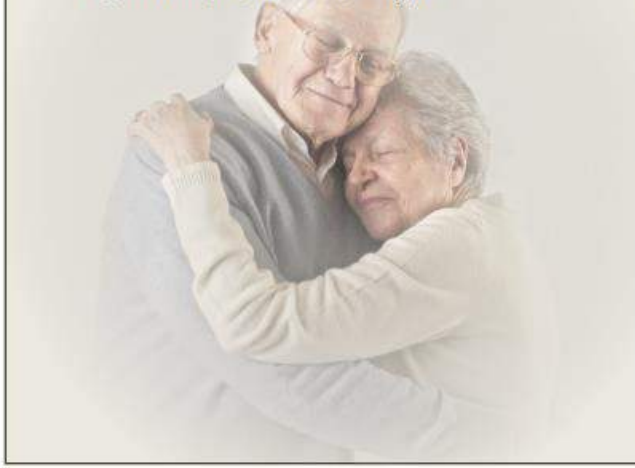
Adults ≥ age 18, ~286,000 patients have a portal account.

Methods

Chart abstraction and qualitative analysis of preferences on MDPOA forms

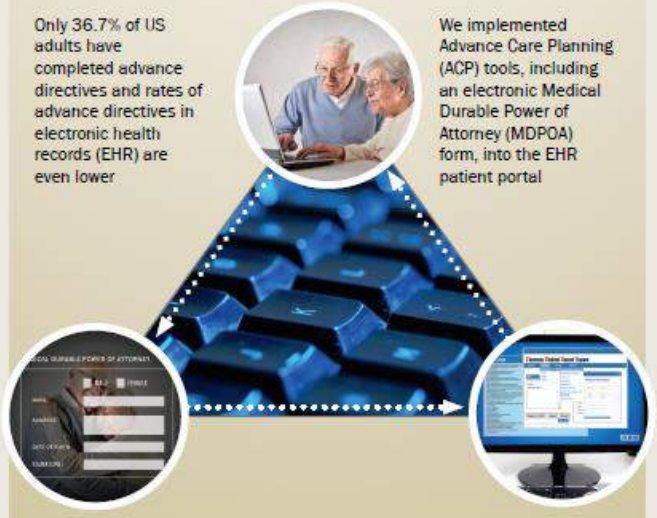
Outcomes

1. Characteristics including age, gender, geographic region, and documentation.
2. Description of how patients change documentation of a healthcare agent.



ACP to EHR

Only 36.7% of US adults have completed advance directives and rates of advance directives in electronic health records (EHR) are even lower



We implemented Advance Care Planning (ACP) tools, including an electronic Medical Durable Power of Attorney (MDPOA) form, into the EHR patient portal

FIRST-EVER ADVANCE CARE PLANNING TOOLS INTEGRATED INTO EHR

WHAT WE LEARNED

1. Patients of all ages have engaged in ACP tools through the patient portal.
2. The web-based tools promote completion of a MDPOA form to appoint a healthcare decision maker.
3. The majority of patients who completed a MDPOA form had no prior documentation of a healthcare decision maker.

NEXT STEPS

- Develop population health-based strategies to promote use of EHR-based ACP tools
- Implement healthcare staff training and engagement to promote ACP discussion and patient outreach.

Funded by: The Colorado Health Foundation; Dr. Lum is also supported by an NIA K76 Paul B. Beeson Award.

RESULTS

n = 296

Characteristics	N (%)
Age, mean (range)	45 (18-98)
Women	213 (72)
System Region	
North	96 (32)
Metro	118 (40)
South	68 (23)
Out of State	14 (5)
Primary Care Provider	
PCP within system	163 (55)
PCP outside of system	76 (26)
Unknown	57 (19)

TABLE 1. PARTICIPANTS

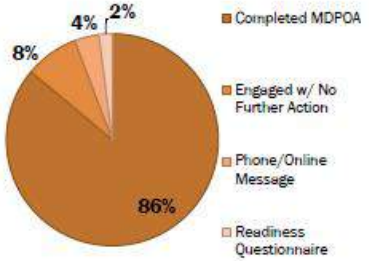


FIGURE 1. TYPE OF ACP INTERACTION

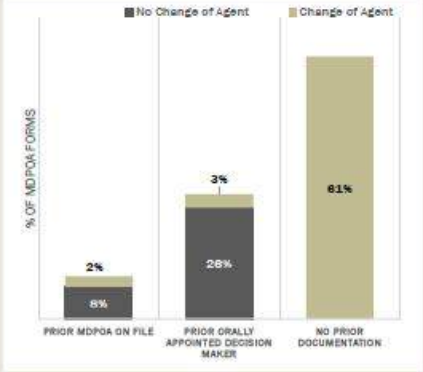


FIGURE 2. TYPE OF DECISION-MAKER ON MDPOA

TEACHING TO THE TEST: MEASURING ADVANCE CARE PLANNING QUALITY METRICS IN HOSPICE

Krista L. Harrison, PhD*[1,2]; Nicole Thompson, BA[1]; Rebecca L. Sudore, MD[1,2]; Christine S. Ritchie, MD, MSPH, FACP, FAAHPM[1]

[1]Division of Geriatrics, University of California, San Francisco; [2] San Francisco VA Medical Center

Introduction

Hospices began reporting CMS-required quality measures in 2014: the Hospice Item Set (HIS) → Public reporting begins 2017

One related to advance care planning (ACP): NQF #1641

Captures evidence of an attempted discussion with patient or proxy about:

- cardiopulmonary resuscitation,
- other life-sustaining treatments, and
- hospitalization

Objectives

To characterize multidisciplinary hospice staff perspectives on how ACP discussions are measured

Methods

- Data collected at 4 geographically-diverse non-profit hospice organizations
  - Semi-structured interviews with multidisciplinary staff:
    - Leaders (e.g. CEO, CMO, COO)
    - Clinicians
    - Quality improvement (QI) staff
  - Documents relevant to ACP or QI
- Qualitative framework analysis (inductive and deductive)

Participants

	No.	%
Participating site		
Site 1	12	24%
Site 2	13	25%
Site 3	14	27%
Site 4	12	24%
Sampling category		
Clinicians	31	61%
Leaders	13	25%
QI staff	7	14%
Clinician credentials		
Nurse	23	45%
Social Worker	12	24%
Chaplain	2	4%
Physician	7	14%
N/A	7	14%
Race/ethnicity		
White	44	86%
Black	3	6%
Asian	1	2%
Latino	1	2%
Mixed	2	4%
Gender		
Female	41	80%
Male	10	20%

Results

Current Practices of HIS ACP Measurement

HIS systems reinforce ACP at admission

"There are checkboxes in our computer documentation about whether we've had the discussion and when that first discussion that we had with them occurred. That's in the HIS section of the report and also in the body of the comprehensive assessment." RN

Ceiling effect of HIS ACP process measure

"Well, advance care planning specifically for a hospice-- I think it's an important measure. It should always have a near-perfect score. The discussion was at least attempted." QI

ACP HIS measure not an indicator of quality

"Right now it is a tool that I know is important to someone somewhere, but for me and doing my job right now it's not a measure of quality. It's a measure of did we complete something, did we get that finished. It's a check-off." QI

Assumption of ACP quality = little/no QI

"I think it [ACP] is so core to what we do that we probably would assume that it's done well. But do we really know?" Leader

ACP measurement challenges; limited resources

"It's not where we can always go and pull a report that tells us this was done, and because there are so many variables someone might complete a DNR this day, a living will that day, healthcare power of attorney… so far we don't have a best practice for how to measure that." QI

Focus on forms, checkboxes

So I think the unintended consequence is that people could get focused on the task and lose sight of, 'Why are we measuring this? What is this measure actually telling us? What can we learn from this measure?'" Leader

Teaching to the test

I think that as a result of this [HIS implementation], *we're going to see more teaching to the test. We're going to see more programs that are willing to sacrifice things that may have been more important to them to try and get their numbers up."* Leader

Participant Recommendations

Themes	*Quotes*
Use data to improve care	*"Well, I think I would probably try and ascertain why families wouldn't do it and what was the degree of the discomfort around having advanced directives, what are the barriers to doing it, and then sort of flesh out something that would help them overcome those barriers."* QI
Examine ACP longitudinally	*"So, yes, I think we need to formally start to collect what it looks at admission, what it looks like two weeks after admission…how many people are actually coming with a signed form in hand."* Leader
Examine ACP quality	*"I mean, thinking in terms of documentation, maybe it would be more helpful if there was more, you know, documentation in the record about specifically what happened during that conversation."* Nurse
Create better measures	*"I would like to see if there's some way to quantify what we're doing so that I could score it somehow. Off the top of my head, my guess is I'm probably not going to find anything, but I would like to start some way to better objectively quantify it."* QI

Summary

ACP HIS reporting and related systems remind staff to discuss ACP at start of care

However, there is limited:

- awareness of HIS across among clinicians
- focus on ongoing ACP QI
- focus on ACP quality

Recommendations include:

- Better use of data
- Examine over time
- Create a culture of learning and improving

Conclusions

Once hospices meet HIS performance metrics on ACP measurement, focus should shift to 1) QI procedures to improve ACP and 2) measuring the quality of ACP discussions

Funding

Pilot Award from the Palliative Care Research Cooperative (PCRC) Group funded by National Institute of Nursing Research U24NR014637

National Institute of Aging (T32-AG000212)

Email: krista.harrison@ucsf.edu

Beyond Checking the Box: Improving the Quality of Quality Measures in Hospice Advance Care Planning

Krista L. Harrison, PhD*[1,2]; Nicole Thompson, BA[1]; Rebecca L. Sudore, MD[1,2]; Christine S. Ritchie, MD, MSPH, FACP, FAAHPM[1]

[1]Division of Geriatrics, University of California, San Francisco; [2]San Francisco VA Medical Center

UCSF Division of Geriatrics Department of Medicine

APPLIED CLINICAL RESEARCH in Geriatrics and Palliative Care

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Objectives

To characterize multidisciplinary hospice staff perspectives on how ACP discussions are measured

Methods

- Data collected at 4 geographically-diverse non-profit hospice organizations
- Semi-structured interviews with multidisciplinary 50+ staff:
  - Leaders (e.g. CEO, CMO, COO)
  - Clinicians (e.g., nurse, social worker, physician, chaplain)
  - Quality improvement (QI) staff
- Documents relevant to ACP or QI
- Qualitative framework analysis (inductive and deductive)

Results

Participants N = 51

4 sites
61% Clinicians
25% Leaders
14% QI Staff

ACP Measurement: How Its Going Now

Hospice Item Set focuses people on checking the box, not on assessing quality

"There are checkboxes in our computer documentation about whether we've had the discussion and when that first discussion that we had with them occurred. That's in the HIS section of the report and also in the body of the comprehensive assessment."—RN

"So I think the unintended consequence is that people could get focused on the task and lose sight of, 'Why are we measuring this? What is this measure actually telling us? What can we learn from this measure?'"—Leader

"Right now it is a tool that I know is important to someone somewhere, but for me and doing my job right now it's not a measure of quality. It's a measure of did we complete something, did we get that finished. It's a check-off."—QI

Process measures have a ceiling and potential unintended consequences

"Well, advance care planning specifically for a hospice -- I think it's an important measure. It should always have a near-perfect score. The discussion was at least attempted." QI

I think that as a result of this [HIS implementation], we're going to see more teaching to the test. We're going to see more programs that are willing to sacrifice things that may have been more important to them to try and get their numbers up." Leader

Hospice assumes they do ACP well, so don't pay attention to quality assessment

"I think it [ACP] is so core to what we do that we probably would assume that it's done well. But do we really know?"—Leader

ACP Measurement: How We Can Do Better

Create better measures

"I would like to see if there's some way to quantify what we're doing so that I could score it somehow. Off the top of my head, my guess is I'm probably not going to find anything, but I would like to start some way to better objectively quantify it."—QI

Examine ACP longitudinally

"So, yes, I think we need to formally start to collect what it looks at admission, what it looks like two weeks after admission…how many people are actually coming with a signed form in hand." —Leader

Examine ACP quality (regardless of measures) and use data to improve care

"I mean, thinking in terms of documentation, maybe it would be more helpful if there was more, you know, documentation in the record about specifically what happened during that conversation."—Nurse

"Well, I think I would probably try and ascertain why families wouldn't do it and what was the degree of the discomfort around having advanced directives, what are the barriers to doing it, and then sort of flesh out something that would help them overcome those barriers."—QI

What We Learned

ACP HIS reporting and related systems remind staff to discuss ACP at start of care.

However, there is limited:

- Awareness of HIS across among clinicians
- Focus on ongoing ACP QI
- Focus on ACP quality

Recommendations include:

- Better use of data
- Examine over time
- Create a culture of learning and improving

Where We're Headed

Once hospices meet HIS performance metrics on ACP measurement, focus should shift to 1) QI procedures to improve ACP and 2) measuring the quality of ACP discussions

FUNDING

Pilot Award from the Palliative Care Research Cooperative (PCRC) Group funded by National Institute of Nursing Research U24NR014637

National Institute of Aging (T32-AG000212)

EMAIL: krista.harrison@ucsf.edu

More Posters

LONELINESS ASSOCIATED WITH BIOMARKERS OF SYSTEMIC INFLAMMATION: FINDINGS FROM MIDLIFE IN THE UNITED STATES

Paula V. Nersesian, PhD[1], MPH, Hae-Ra Han[1], PhD, Gayane Yenokyan[2], PhD, Roger S. Blumenthal, MD[3], Marie T. Nolan, PhD[1], and Sarah L. Szanton, PhD[1]

JOHNS HOPKINS SCHOOL of NURSING

WHAT WE LEARNED

Biomarker values of interleukin-6, fibrinogen, and C-reactive protein are significantly higher among lonely compared to not lonely middle-aged US residents.

Higher systemic inflammation values were found in lonely community-dwelling middle-aged adults without an acute stressor applied in a laboratory setting.

BACKGROUND

- Loneliness is prevalent among middle-aged US residents; among 35-64 year old MIDUS participants, 29% felt lonely some or most of the time.
- Middle-aged adults who are lonely have an elevated likelihood of death.

OBJECTIVE

Using population-level data, we tested if systemic inflammation is associated with loneliness in a broad age range of middle-aged adults in the United States.

METHODS

- Parent study: Midlife in the US (MIDUS) survey Biomarker Project
- n=927 participants age 35-64 years at Biomarker Project data collection
- MIDUS data collection date --1995-1996, 2004-2006, Biomarker Project 2004-2009
- Self-reported loneliness categorized as feeling lonely or not

RESULTS

Results summary of the relationship between biomarkers of inflammation and loneliness using hierarchical linear regression

Biomarker of Inflammation	β	p-value	95% Confidence interval
Interleukin-6	.07	.014	.01, .12
Fibrinogen	18.24	.011	4.26, 32.21
C-reactive protein	.08	.035	.01, .16

Potential confounders				
Demographics	Age	Sex	Race	Education
Psychosocial	Perceived stress score	Social integration	Social support	Psychological well-being
Health Behavior	History of ever smoking regularly			
Physical health	Symptoms and chronic conditions	Blood pressure	Body mass index	

INTERPRETATION

- Our results, although not causal, were consistent with gene expression studies where loneliness affects inflammation.
- Lack of exercise (consequence of loneliness) may mediate the loneliness-inflammation relationship

Support provided by:
- Pre-doctoral Clinical Research Training Program (TR001078) NCATS
- Data Management support (1UL1TR001079) National Center for Research Resources & NCATS
- Jonas Nurse Scholars Program & NEF Liesel M. Hiemenz scholarship
- MIDUS 1 MacArthur Foundation Research Network on Successful Midlife Development
- MIDUS 2 (P01-AG020166) National Institute on Aging

[1]Johns Hopkins University School of Nursing
[2]Johns Hopkins University Bloomberg School of Public Health

WHAT DO OCTOGENARIANS BELIEVE ABOUT PHYSICAL ACTIVITY?

Catherine A. Sarkisian, MD, MSPH,* Carol M. Mangione, MD, MSPH, Arleen F. Brown, MD, PhD, Sonja Rosen, MD, Thomas R. Prohaska, PhD.
[1]David Geffen School of Medicine at UCLA, Los Angeles, California; [2]University of Illinois, Chicago School of Public Health, Chicago, IL.

WHAT WE LEARNED

Octogenarians in these focus groups identified **fear of loss of function**, and the **need to keep mentally and physically active**, but not beliefs about improved life expectancy, to be important determinants of physical activity.

Implications/Next Steps: Interventions aimed at increasing walking among octogenarians might increase their impact by shifting the incentive focus away from health improvement, and towards maintenance of physical and mental functioning

.

Background

- Over 12 million Americans will be octogenarians by 2030; most will be ambulatory.
- The vast majority of ambulatory octogenarians do not participate in regular physical activity.

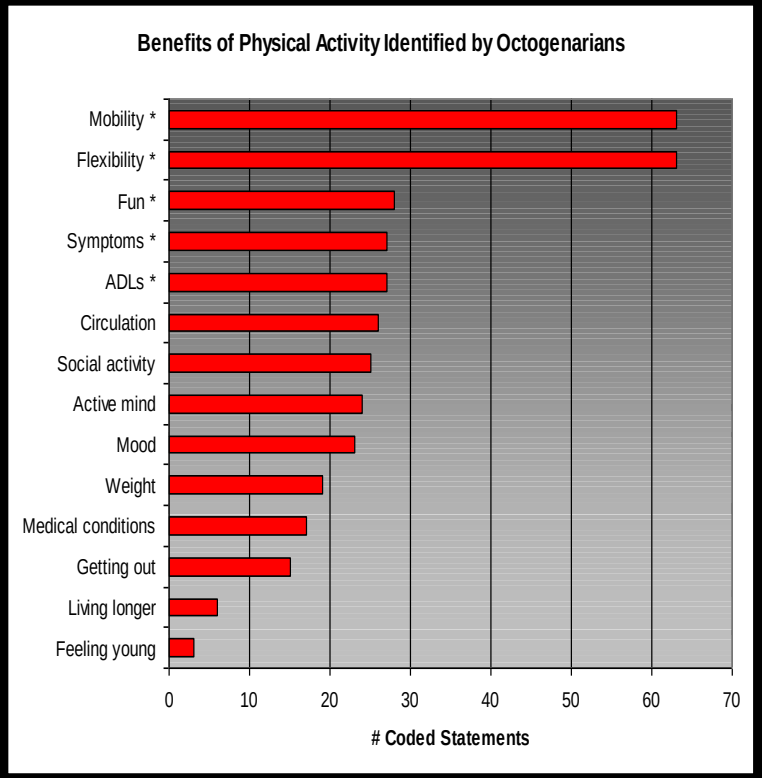
Objective

- To identify octogenarians' beliefs and attitudes about physical activity

Methods

- Recruited English-speaking octogenarians at 8 low-income senior residential housing units
- Conducted 1-hour focus groups using standardized open-ended script
- Grounded theory approach
- Transcripts read independently by 3 investigators to identify themes and develop coding template
- 4th investigator coded each line
- Reliability of coding scheme assessed on 5% of lines by 2nd coder – 83% agreement

RESULTS



* Benefit Identified in ≥ 7 of 8 focus groups

Major Themes

1. Physical activity is not regarded as an **optional** activity one might do in order to improve health outcomes, but rather as activities of daily living **necessary** to maintain mobility/ independence/ health/life.

- Sample quotes:
  "I still do my housework, we have to keep going."

2. Fear of loss is a major source of motivation for participation in physical activity.

- Sample quote:
  "a lot of people sit down and they don't think about it and the next thing you know, they can't do anything . . . "
  "you stop doing things, and you're not always able to do them again."

3. Physical and mental health are regarded as inseparable phenomena.

- Sample quotes:
  "If you just sit all day and don't do anything you're no longer thinking anymore so you get brain dead."
  "Once you get lazy at walking, you get lazy at thinking and you just sit and become like a vegetable."

End-of-Life Care in Nursing Homes is Improving

Suzanne S. Prevost, RN, PhD and J. Brandon Wallace, PhD
School of Nursing and Department of Sociology & Anthropology

MIDDLE TENNESSEE STATE UNIVERSITY

INTRODUCTION

Background

- 25% of Americans die in nursing homes
- Projected to increase to 40% by 2020

End-of-Life Care Problems in Nursing Homes

- High prevalence of pain
- Excessive use of life-sustaining therapies
- Poor communication with families
- Lack of advance care planning

Hospice Care

- Nursing home residents are less likely to receive hospice care than people who die in other locations
- Residents who get hospice care have
  - More aggressive pain management
  - Less invasive procedures
  - Less hospitalization prior to death
  - Higher family satisfaction with care

PURPOSE

In light of recent local and national initiatives to enhance end-of-life care, we conducted an analysis of nursing home MDS assessment data to examine the changing patterns of end-of-life care in nursing homes from 2004-2006.

METHODS

Secondary analysis of Minimum Data Set (MDS) assessment data for 103 for-profit nursing homes located primarily in the Southeast, ranging in size from 20 – 474 beds. Trends were examined in 6 month intervals from January, 2004 > December, 2006.

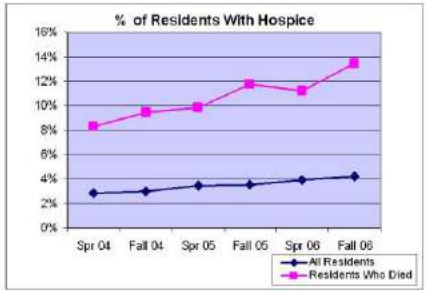
Sample Demographics

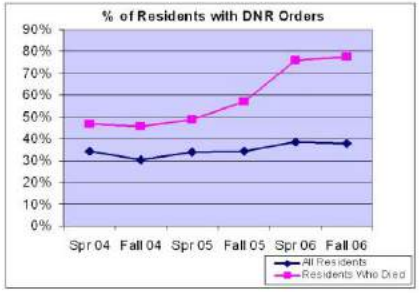
- 69% Female
- 91% Caucasian
- 73% Widowed, single, or divorced
- 78% Above the age of 75

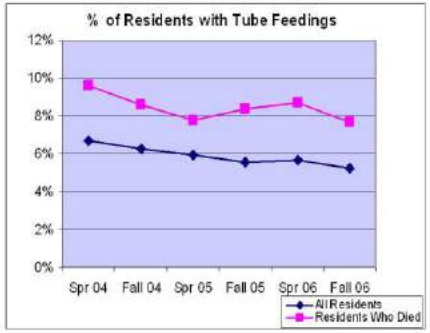
Samples per Six Month Interval

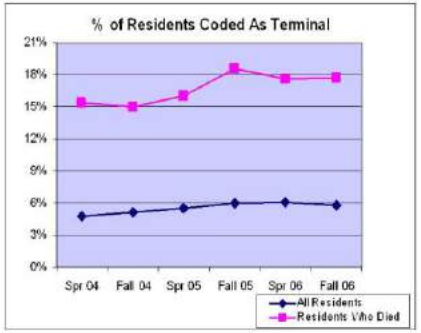
	Number of Residents	Number of Deaths
•Jan. – July 2004	22,111	2,999
•July – December 2004	20,219	2,270
•Jan. – July 2005:	23,331	3,064
•July – December 2005:	22,743	2,630
•Jan. – July 2006:	22,869	2,730
•July – December 2006:	22,675	2,574

RESULTS









CONCLUSIONS

Our findings suggest that:

- More residents are being identified as terminal
- More are receiving hospice care
- Fewer are receiving tube feedings
- More have DNR orders

While these findings demonstrate improvements in EOL care, they also support the belief that the dying trajectory is frequently undocumented and many residents who could benefit from hospice care do not receive it.

HGNI Hartford Geriatric Nursing Initiative

The investigators would like to thank the John A. Hartford Foundation and the National HealthCare Corporation for their support of this project.

NHC National HealthCare Corporation

Persistent Pain in Assisted Living Facilities

C.A. Kemp, BSN, RN, BC; L.L. Miller, PhD, RN; H.M. Young, PhD, GNP, FAAN; S.K. Sikma, PhD, RN

OREGON HEALTH & SCIENCE UNIVERSITY

HGNI Hartford Geriatric Nursing Initiative

What We Learned

Older adults with persistent pain living in assisted living facilities are more likely to have fallen in the previous year and require assistance with mobility.

Background

- Persistent pain is a common, debilitating condition among older adults regardless of residence[1]
- Assisted living facilities (ALFs) are the fastest growing segment of the senior housing market[2]

Purpose & Aims

This study describes the phenomenon of persistent pain in older adults residing in eight ALFs in Washington & Oregon

Aims

- Compare demographic characteristics, cognitive status, ADL function, & number of falls in past year in the pain group & non-pain group
- Describe analgesic orders of the pain group

Sample

- 156 residents from the Medication Management in Assisted Living Facilities study (NINR R21 NR009102-01) participated in this study
- Pain group (n=92, 59%) vs. non-pain group (n=64, 41%)
- Pain group inclusion criteria:
- Routine or PRN opioid analgesic order OR
- Routine (>once daily) non-opioid analgesic order OR
- Pain-related diagnosis (e.g., arthritis, sciatica, "knee pain")

Methods

- Secondary data analysis
- Cross-sectional, descriptive design

Results

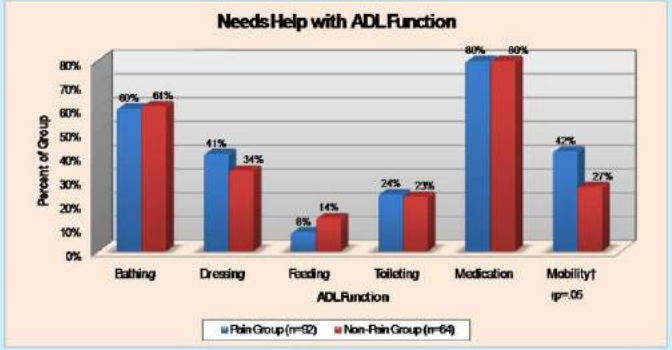


Table 1a – Sample Characteristics, Categorical Variables

Characteristics	Pain Group (n=92) n (%)	Non-Pain Group (n=64) n (%)
Gender		
Male	14 (15)	15 (23)
Female	78 (85)	49 (77)
Ethnicity		
Caucasian	89 (97)	62 (97)
Other	2 (2)	2 (3)
Not reported	1(1)	
Legal representative		
Self	53 (58)	39 (61)
Family member	36 (39)	23 (36)
Other	3 (3)	1 (1)
Not reported		1(1)
Payment source[1]		
Private	60 (66)	52 (81)
Medicaid	31 (34)	12 (19)
Cognitive status		
Alert	46 (50)	36 (56)
Confused, memory problems	40 (44)	24 (38)
Not reported	6 (6)	5 (8)
Fell in past year	**46 (50)**	**26 (41)**

†p=.04

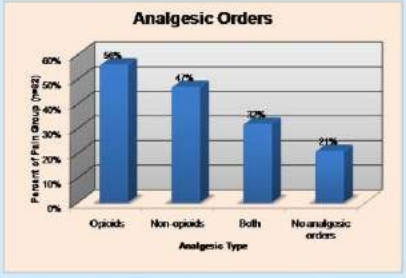


Table 1b – Sample characteristics, continuous variables

Characteristics	Pain group (n=92) mean (SD)	Non-pain group (n=64) mean (SD)	p-value
Age (years)	83 (7.8)	83 (8)	ns
ADL Function score	1.7 (1.4)	1.6 (1.6)	ns
Length of stay (months)	25.4 (22)	23.5 (18.3)	ns

Discussion

- Prevalence of persistent pain in sample (59%) matches prevalence of persistent pain in other studies with older adults
- All residents required assistance with 1 to 2 ADLs on average; however, residents in the pain group required significantly more assistance with mobility
- 50% of residents in pain group fell in past year compared with 41% in non-pain group, although difference was not significant

Next Steps

- Examine correlations among falls, mobility, and analgesic orders in assisted living residents
- Describe changes in analgesic orders over 6-month period of parent study
- Examine impact of analgesic order changes on number of falls and assistance with mobility

Limitations

- Research questions formulated based on available data
- Data collected by chart review with minimal data verification
- Cross-sectional design prohibits analysis of changes over time or causal effect

Acknowledgments

NINR R21 NR009102-01

John A. Hartford Building Academic Geriatric Nursing Capacity Pre-Doctoral Scholarship

Quality and Inequality in Home Care of Older Adults:

How do cultural background and social policy influence publicly and privately funded home care practices?

Elana Buch, University of Michigan

Background

- Home care is one of the fastest growing industries in the U.S.
- Home care workers and recipients often come from different class and ethnic backgrounds.
- Research suggests that home care participants' backgrounds may effect their ideas about of quality care.
- Current research primarily focuses on publicly funded care.

Research Questions

1. How is cultural background related to home care participants' understandings of home care quality?
2. How does public vs. private funding influence participants' ability to shape home care practices?
3. How do home care practices reproduce or transform pre-existing social relations and formal labor conditions?

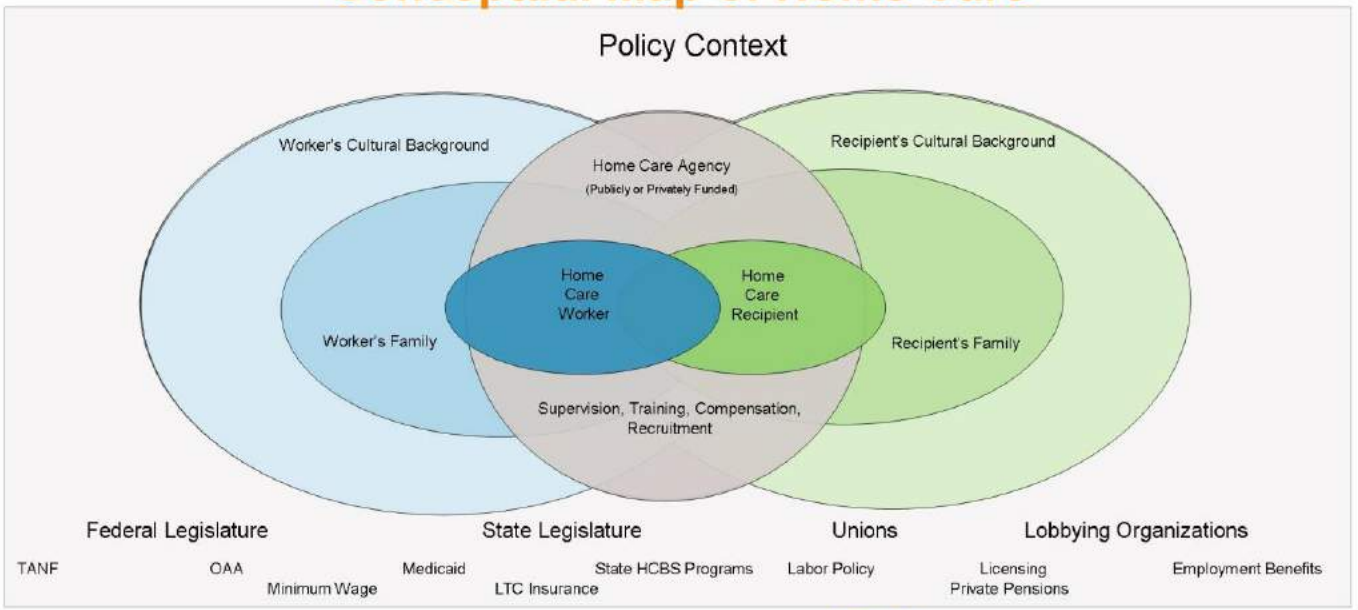
Methods

- Research sites: One publicly and one privately funded home care agency in Chicago, IL.
- Sample: Nested sample includes 15 worker-recipient pairs (criteria = cognitively-able older adults receiving avg. of 8 hrs. care/week) , available family members, agency supervisors and industry leaders.
- Data collection: Participant observation in homes and agency offices, life care history interviews, document and policy review.

Preliminary Findings

1. Workers and recipients from diverse cultural backgrounds suggest that quality care helps the recipient maintain social personhood. However, meanings of personhood are culturally informed. Workers try to learn about recipients' families, cultural backgrounds and personalities, adjusting care to reflect recipient's understanding of personhood.
2. Private pay recipients act and are treated like consumers who have the right to control their care. Clients in publicly funded programs tend to frame the care offered to them as a gift, and thus to build relationships with workers based on norms of reciprocity rather than those of market exchange.
3. Lack of acknowledgement of workers' role in maintaining recipients' social personhood exacerbates pre-existing social inequalities (greater in privately than publicly funded care). Reciprocal relationships between publicly funded workers and recipients can lead to political action addressing common causes of inequality in their lives.

Conceptual Map of Home Care



GERIATRIC SOCIAL WORK INITIATIVE

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UNIVERSITY OF MICHIGAN

A Life of Quality?

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Systematic review and meta-analysis of interventions relevant to quality of life for persons with intellectual disabilities and dementia

Background

Shifts in population, life expectancy, and associated prevalence rates have brought attention to services for persons with intellectual disabilities (ID) and dementia, which are ill-prepared to meet growing needs.

Aim

Synthesis of ID literature in order to assess: 1) the effectiveness of psychosocial interventions with QOL-related outcomes, and 2) their relevance for persons who are aging with dementia.

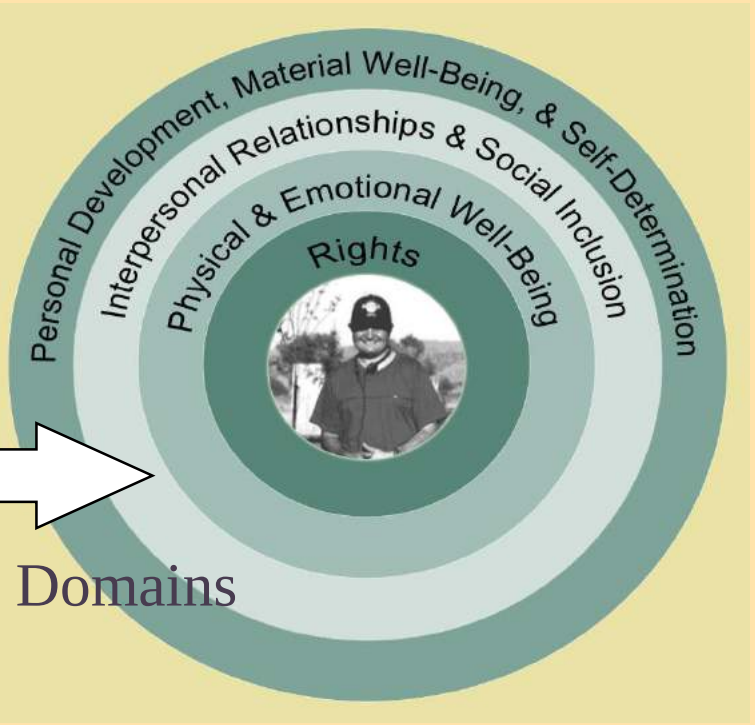
Methods

Use of a QOL conceptual framework with targeted domains/indicators (Schalock & Verdugo, 2002).

Electronic and hand searches to uncover published studies spanning 25 years from databases, journals, conference proceedings, reference lists, etc.

Study selection, quality assessment, and data abstraction undertaken by two independent reviewers.

Narrative synthesis of studies and fixed/random effects meta-analyses by classified QOL domain.



Key QOL Domains

A dissertation funded by the John A. Hartford Doctoral Fellows Program in Geriatric Social Work, Administered by the Gerontological Society of America

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1. Think strategy
2. Get on message

Take a breath…then

3. Hone your design
4. Practice your “pitch”

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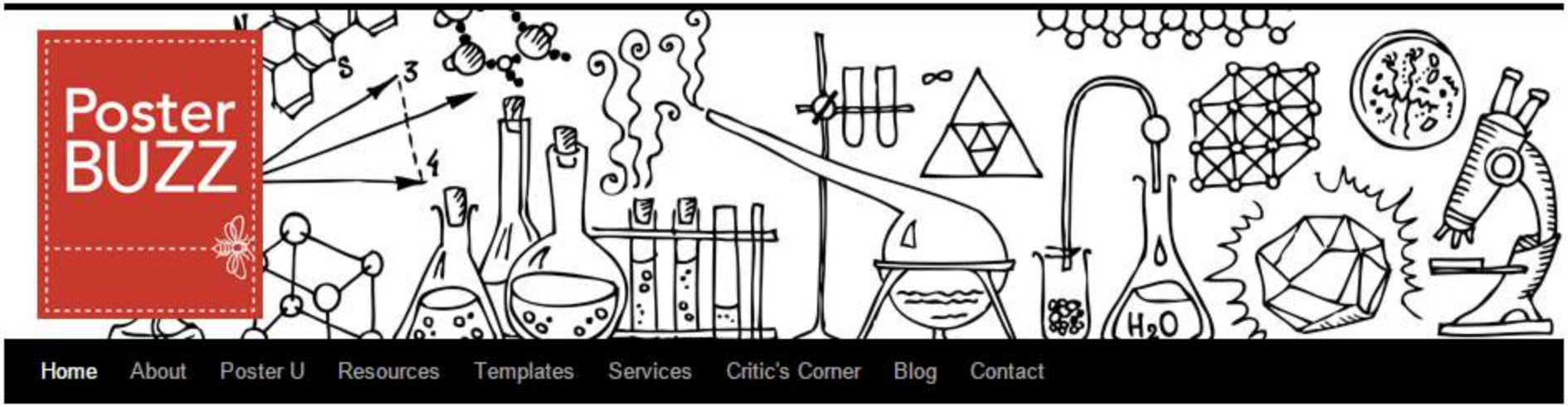

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