TRANSCRIPT: Part Two | Embracing the Four M's: A Path to Person-Centered, Reliable Hospice and Palliative Care

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Chris Comeaux 0:41
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Setting Up The Four Ms

Jeff Haffner 1:21
Welcome to TCN talks, and Anatomy of Leadership. We continue the conversation with Kelly McCutcheon Adams and Margherita Labson in Part Two, Embracing the Four M's A Path to Person-Centered, Reliable Hospice, and Palliative Care. And now, here's our host, Chris Comeaux.

Mentation And What We Can Improve

Chris Comeaux 1:44
Well, as we go to this next segment, we actually, so we talked about what matters most. Great place to start. And then we actually went to med. So let's now go to mentation. So, Kelly, I you probably want to start with this one. So, you know, mentation focuses on cognition, depression, delirium, emotional well-being. Is this area often overlooked, or

why is it overlooked in serious illness care? And how can we do better in the hospice and palliative care space?

Kelly McCutcheon Adams 2:08
That's a great way to phrase the question because what I think happens, and Margherita, I'll value your opinion here. What I think happens is that we mistake what can be solved at the big level at the at the big level with what can be aided at the small level. And so what I mean by that is if someone is on um hospice and has dementia, you know, and there's aren't there aren't cures currently, but we can't move that big needle. That's not gonna happen in any way. But what can we do that will help that person feel more grounded, more at peace, more comforted, more cared for? If we're talking about depression, are we going to fundamentally be able to see a very significant change before the end of that person's life? Probably not. But should we overlook things that might bring them peace and comfort and groundedness with delirium? I mean, and this is the one I this one's to me, Margherita, is big because if we are overlooking a reversible cause of delirium, we are missing such an important opportunity to perhaps, if what matters to someone is being able to engage with their family and they have delirium, and maybe it's hypo, you know, hypoactive delirium and we're not even recognizing it, and they're just a lotto, they're not, you know, if we miss that chance, we we might be stealing time away from that person to engage with their family. So it's not that we can rush in on our white horses and like fix, you know, every aspect, you know, dementia, depression, delirium. These are big, big things. But if there are aspects of reversibility or treatment that could bring someone some comfort um in the final stage of their life, why would we ever, ever turn away from that? So that to me, I don't want us to overlook what is possible. Um, but Margherita, you might have a different perspective there.

Margherita Labson 4:14
Well, I think what you just highlighted is the benefit of the expertise that we have in medical science to assess what's the probability that we have something that is a let's take the delirium. The delirium is a reversible situation. So I immediately what I think of is that particular individual who's having a symptom that I that the team cannot manage in the home and we require a GIP stay. Okay, general impatient for those of you that are not familiar with hospice, general impatient stay. Okay, well, we know that if we've got already got somebody that's on narcotic opioids and they are an older adult, that there is a likelihood that we could be facing a situation where that individual is going to experience some delirium. Well, it's not just a matter of, okay, we're going to medicate to the delirium. Now it's a situation of, you know, let's anticipate that. And how can we, you know, help if we if we think that this is a potentially reversible delirium because we're changing site of care and this team that's going to be caring for that individual is new. What can we do as a team? And and they will enact and come around that individual. So

maybe we have members of the IDT that typically see him in the home are also seeing him now in the GIP. And we are communicating information to the um to the ID to the IDT in the GIP unit that is picking him, picking that individual up and providing care, saying, no, no, you are going back home. This is just temporary. It it takes a lot of work. It takes a lot of work and it takes a ha a really um thoughtful level of intentional communication of what matters to that individual. And by the same token, there are times where we know that a state of altered mentation is likely to be permanent. So how do we then support what matters to that individual and keep the experience as pleasant as possible?

Chris Comeaux 6:28
So well said. You know, something occurring to me. I'm reflecting on the podcast with Dr. Berwick and in that whole podcast, the brilliance of what was the triple aim and the quintuple aim and what that, like I'm sitting here having the same reflection of the brilliance of like striping the forums across all the segments of healthcare. It's like there's these depths of knowledge and expertise that you could apply at different places and different times. You're opening my eyes, which is exactly why I want to do this podcast, that there's like there are new lands to be discovered here, which maybe this is a good segment, because this might be the one there people are like, okay, I get what matters most. I get the mentation or medication, then the mentation.

Mobility Beyond Fall Risk

Chris Comeaux 7:09
But what about the mobility? So I think a lot of people don't immediately associate mobility with hospice empowered care. Why is this still important for people that are living with a serious and advanced illness?

Margherita Labson 7:21
I can start telling them So mobility is a part of life. Imagine if you will, you can't scratch your nose. That's mobility. All too often again, we because we have this influx of we've got a patient coming in, we've got this going on, you know, we have staffing changes, we have staffing challenges, we have resource challenges. All too often we override it and we override to the default, and the default becomes a fall risk assessment. Why? Because we're measured on fall risk assessment. This is mobility. So again, looking at that North Star what matters to that older individual. Um we don't ever want to distill mobility down to simply a matter of a fall risk assessment. Instead, you look at what is the ability of that individual to independently enjoy eating an ice cream cone while he watches the Yankees play, or perhaps it is the ability of uh of somebody to wash uh their uh their preparity area

because their spiritual beliefs dictate that that modesty will prevail. I think the uh just the the simple importance of uh safely transferring to a commode is safety and fall risk built in there? Of course it is. Of course it is, because what would be mobility if it didn't have a component of safety? But the idea is it's more than just a fall risk. Always go back to this little lady who couldn't uh who just wanted to be able to always turn on her left side when she wanted to, because if she laid on her back or she laid on her right side, her the right side of her body would go numb. And all she wanted to do is be able to turn to the left side. It's that's mobility. Did we worry about you know making sure that she had side rails up and that she couldn't fall out of bed? Of course we did. Of course we did. But our our our primary driver on that team was to make sure that for as long as possible she could independently roll on her side, on her left side when she needed to. Um, it's a different piece, different piece, much broader, much more relevant based on what matters to that individual.

Chris Comeaux 9:58

Yeah, Margherita, you're reminding me. So I got to work with Dr. Janet Bull at uh Four Seasons, where I spent a lot of my career, Nashville, North Carolina area, and and we had a research department. And I remember the first time she said this, I'm like, what? But they were actually doing a research study of trying to incorporate physical therapy much more in the front part of the hospice admission, which at first face value is antithetical, but over the course of time I start to see the brilliance of what she was poking on. Interestingly, one of our TCN members recently patient wanted to stand. He had been bedridden. He wanted to stand and hug his daughter before he passed. And we actually accomplished that. And it was so, it's such a beautiful story. And that's what mattered most to him. Did it challenge the team? Would it have been easier for us to go, well, that's not what we do? But yet that's what mattered. And it was just such a beautiful story. And he actually did that. I think he passed away a couple of days afterwards. But that's what mattered most to him. Well, I've got an interesting question for you guys as I was preparing.

Should There Be A Fifth M

Chris Comeaux 10:57

I kind of ran into a curveball, may not be a curveball to you, but in some recent years, some geriatric leaders have started to maybe discuss: is there a fifth M, which is multi-complexity, which recognizes the realities of multiple chronic diseases, social determinants, caregiver burden fragmented systems. How do you guys view this? It's so fascinating, right, to see how the triple aim has now grown to the quintuple aim. And then I've heard some people are calling like the sex tuple aim that is safety. And at some point

you kind of go, okay, are we getting too far afield? Are these really sub-so I'd love to hear your wisdom?

Kelly McCutcheon Adams 11:31
Yeah, that I mean that you're you're by bringing up the you know, quintuple aim and and the evolution there, you're you're raising the fundamental question, which is where does the utility of a sticky framework take primacy over the opportunity to perhaps deepen it? And so I think that's a really important question. And uh I'm gonna quote my friend Amy, who says, we have the word simplify. Why don't we have the word complexify? So I'm gonna indulge in bad grammar and use the word complexify. There is a risk here, and we have certainly talked about and considered um the addition of M's, uh, multimorbidity, malnutrition, those are examples that come up a lot. The risk in complexifying, again, I promise I know that's not a real word, is that you lose the stickiness of the framework. You lose the ability for people to hold that and navigate it in a reliable way. And so um what we have found, and and the conversations that happen a lot, this is an important conversation. I don't want to be dismissive of it at all, is that let's use um multimorbidity as a as an example, that that actually the components of that actually are woven through the current forums, that that is not absent um from that. And so I think we have to find that tipping point of when does it become too much to remember or to navigate. Um, but what we also recommend is that we have supported organizations who have made that decision, that they've decided, you know what, we're gonna, we're gonna add a fit them. Um, and you know, what we encourage people to do um is to really have clarity about why. What is missing that make that complexification um worthwhile. And so I think as long as people are being really sound in that, um, but there are no current plans to go from a 4M to 5M.

Chris Comeaux 13:41
I love, I love that answer, Kelly. You will love this fact that we use the word uncomplexify all the time in our lexicon at TCN. And so I love, I love your answer on that.

What Success Looks Like

Chris Comeaux 13:52
So this one I think I'd love for both of you. So looking ahead to say five years, three to five years, what would success look like if the 4Ms became deeply embedded throughout hospice and powder care? How would patients, families, clinicians, and communities experience care differently?

Margherita Labson 14:08

No more lated myths. I'm gonna just speak from a clinician's heart. No more lated myth. No more individuals electing the benefits uh, you know, based on when their family decide that they need hospice rather than when they need hospice. Thinking about this very intentionally, delivering hospice care that really is of value to that older individual and fulfills uh the hospice philosophy, the hospice mission to support that individual that has invited you in during the last and most important part of their lives to optimize the quality of their life. That's what it means. For uh for uh from an administrative standpoint, in my work as an administrator and it it means it means leveling out the number of cost overruns I have. It means effective health care work, it means reliable health care practices that are not overly complicated, it means meeting regulatory demands without throw continuingly throwing out, oh, and do this, oh and do that, oh and do this, oh and do that. It focuses the work on that which produces a reliable result. Think of what that means across the care continuum in in the our current it based on what we have currently, a fragmented healthcare system where everybody's trying to do their best and get the job done to meet a patient's needs.

Kelly McCutcheon Adams 15:54

I love that answer, Margherita. Um one of the things that you when I was a hospice social worker, um, which was not a long part of my career, it was my internship and then shortly after my internship as a social worker, one of the things that broke my heart the most um was a 12-hour admission. A 24-hour admission, because that to me represented such uh failure of the whole system, that the whole system had failed. Um and I know that's a hard word, but that's how I view it. That that within our fundamentally death-denying culture, that the system had failed. And when when as my career advanced, uh, you know, went on, and I became a trauma ICU social worker, an emergency department social worker. And I just remember just some nasty, nasty, you know, fights uh with physicians about where we were, you know, in someone's life and and you know, being screamed at, I'm not giving up on this person. And I was like, oh my gosh, what how how broken are we if we can't stare at the very obvious thing that's happening in front of us and do right by that person? Again, I'm speaking very pejoratively and I will I will circle back, but that all leads to the 12-hour admission, the 24-hour admission. That that all leads to not being able to get to know people and focus on what matters to them. And so I think five years in the future, 10 years in the future, I think if we do this well, we will see fewer and fewer 12 and 24 hour and 48 hour and 72 hour admissions because there will be continuity of conversation and care about what matters. And in the hospital, in the ambulatory care setting, clinicians will be better able to say, you know, you've shared with me what matters to you. And I think the best way for that to be achieved is for you to receive hospice care so that you can be at home, so that your family can be with you, whatever aligns to that. So I think if we could build that continuity where what matters is what's driving the bus, I think we would have better and more powerful ways to talk about hospice care as being

in service of what matters, and we could get away from giving up the notion of giving up or not giving up. Um, we are looking at what's in front of us and trying to do the absolute best by that person, which could mean going home and not um, you know, not sitting in the hospital with a bunch of tubes. And I am, I'm just gonna briefly say at a personal level, I am the person. I'm I'm in my mid-50s, my friends, my own parents, my friends' parents, you know, we're in that moment. And when my friends call me and they say, you know, my 88-year-old mother is about to have an endoscopy for, you know, blah, blah, blah. And I say, what matters to your mom? What matters? Is that is that process and test going to move her towards um uh a true connection to what matters? So I think the whole system, um, when aligned and have with good continuity, could move us towards much more effective and powerful use of hospice services. I hope it's not a fairy tale, but that's where I think this could go.

Chris Comeaux 19:30
That is brilliantly stated, Kelly. We actually um we had a work group, we had we called them future councils last year that wrestled with different challenges that we're all facing as hospice and health care programs. And that was one of the conclusions that we came to is that the forums are a framework that kind of busts the linguistic challenge of talking about what we do. Um the joke is always everybody wants to go to heaven, nobody wants to die. Like, how do how do you talk about this care that we provide, right? Because they all think hospice equals death. I high five you. I think you just stated that brilliantly.

Leader Advice And Practical Resources

Chris Comeaux 20:05
Well, let me ask you both, maybe Margherita, you go first on this final question. Weave your final thoughts into this. So if you were advising a hospice leader, CEO, or just any hospice leader, and I'm almost kind of leading the witness, our listeners here, who hopefully want to compete based upon quality, um, rather than just simply survive the regulatory and reimbursement pressures, where would you tell them to start with the four M's? And of course, again, weave any other final thoughts. It's almost like you know, your halftime talk to them.

Margherita Labson 20:36
Right. So I would tell you um if you're looking for quality, nothing speaks louder than the journey, than the story of uh an older adult's journey through um through age-friendly. Okay. And um as a corollary to that, uh talk to the clinicians and hear their journey if you want to really enhance uh your uh your employee satisfaction. And having said that, uh the one thing you need to do as leaders is really understand what matters to healthcare

consumers. And if you understand what matters to healthcare consumers, then you're well on your way to understanding what age-friendly care is all about. Grab back, get your champions together and go find out more. And my final thought is I am very grateful to your network, the Teleios Network, for your interest. And I only hope that today's uh podcast has served to increase your curiosity even more. We are more than willing at the IHI to take every phone call, every email, just let us know. We're here to help you. But honestly, come join the party. It's it's a wild ride. Kelly, where would you add?

Kelly McCutcheon Adams 21:58

Sure. I'll add a very practical Level, I will add that Margherita and I are working our butts off with our team to get the uh age-friendly care description um for hospice out into the world. I think we're within a week or so of doing that, and that will allow people to seek age-friendly recognition for hospice care, which is very exciting. Um, we are putting out a supplement that helps explain the distinctions of age-friendly care and hospice as opposed to health home health. So great information coming out, hopefully, you know, soon in July. Um, there's a wealth of free resources at IHI.org, age-friendly. Um, and I'll make sure you have that link, Chris. Um, our email is AFHS at IHI.org, agefriendlyhealth system at iHI.org. Marguerite is completely right. We want to take your calls, we want to have these conversations. We are available, and we're available because of the generosity of the John A. Hartford Foundation, which I am so grateful for. So our door is open, so many resources available. And my answer to your question at a at a you know, not concrete level of bit like that is I want leaders to know leaders of hospices to know that you lead organizations that are needed and misunderstood. And they are needed as greatly as they are misunderstood. And you don't need to be ashamed of what you have. Um, you never need to apologize for what hospice is. Hospice is phenomenal. Hospice is important. Hospice is how we um care for each other. Hospice is how we acknowledge that death is real um and that it's not the enemy of medicine. Um so hospice is critically, critically important in how we are a functioning, caring society. So please don't ever, ever, ever be embarrassed about that or feel like you need to hold back in some way. And if, as Margherita has said, if what matters is your North Star, you're not gonna go wrong. So this is a way of of framing and holding the cohesiveness of the care plan together in a way that really works patient by patient. That's the individuation. Yes, you need to build reliable systems, but the what matters piece is how you individualize those reliable systems. So I'm excited by what's ahead. I'm excited.

Chris Comeaux 24:23

Well said. Well, ladies, thank you for the work that you're doing. Again, I'm I'm I'm no one's ever asked me my superpower, but maybe my superpower is I have a hunch. This is so important. And then I get in the podcast and go, oh my God, the hunch was right. And

so that's exactly what I feel about this work that you both you ladies are doing. Just thank you to both of you. You're doing very important work.

Margherita Labson 24:43
And now you go a guy. You know, two. Yeah, now I know a guy.

Kelly McCutcheon Adams 24:48
I know two gals. Thanks for sharing your superpower with us. It's really a privilege to be here. So thank you.

Chris Comeaux 24:53
Take care.

Closing Thoughts And Brain Bookmark

Chris Comeaux 24:54
Yeah, thank you. And to our listeners, we want to thank you. The end of each episode, we always share a quote, a visual. The idea is to create a Brain Bookmark, a thought prodder about our podcast subject to further your learning and growth, and thereby hopefully your leadership. And we're going for like a brain tattoo. We want it to stick. Be sure to subscribe to our channel. We don't want you to miss miss an episode. And if you're interested, you can check out the book Anatomy of Leadership on Amazon. You know it's easy for us to rail against the world. Let's be the change we wish to see in the world. So thanks for listening to TCN talks / Anatomy of Leadership. And here's our Brain Bookmark to close today's show.

Jeff Haffner 25:28
"The patient is not someone we do things to, they are the center of care." by Margherita Labson. "The Four M's, It's a framework that helps us talk about what great hospice care really is." By Chris Comeaux.