Palliative Care Chat – Episode 22 – Interview with Dr. Scott Shreve and Ms. Kat Lally

"Hospice and Palliative Care Services from the Veterans Affairs"

Dr. McPherson: Hello. This is Dr. Lynn McPherson. Welcome to Palliative Care Chat, the podcast brought to you by the online master of science and graduate certificate program at the University of Maryland. My guest today is Dr. Scott Shreve, who is the National Director of Palliative Care and Hospice for the Veteran's Affairs. Actually, Dr. Shreve did this presentation as part of the Muffins for Maniacs series of the Hospice and Palliative Care Network of Maryland, so my thanks to Dr. Shreve and my thanks to the Hospice Network of Maryland for allowing me to use this as our podcast series. I will turn it over now to Kat Lally who will introduce Dr. Shreve further.

Ms. Lally: Good morning, everyone, and welcome to our November Muffins for Maniacs webinar. My name is Katherine Lally. I'm the administrative assistant for the network. Our presenter this morning is Dr. Scott Shreve. Dr. Shreve is the National Director of Palliative and Hospice Care for the Department of Veterans Affairs. He's responsible for all policy, program development, staff education, and quality assurance for palliative and hospice care provided or purchased for enrolled and veterans.

Clinically, Dr. Shreve commits half of his time to front-line care of veterans as the medical director and teaching attendant 12 months per year at a VA in-patient hospice unit in central Pennsylvania. Dr. Shreve is a clinical associate professor of medicine in Penn State's College of Medicine. As most of us aware, the National Hospice and Palliative Care Organization and the VA established the We Honor Veterans Program, which has engaged more than 3,500 community hospices and improved care for veterans at end of life.

Dr. Shreve, if you're ready, you can take it away, and a reminder that this meeting is being recorded.

Dr. Shreve: Okay. Thank you, Katherine. Can you hear me okay with this setup?

Ms. Lally: You sound good. Thank you.

Dr. Shreve: Okay, great. Hey, thank you, Katherine. Welcome, everyone. I just want a picture in my mind. I see that there's 19 phone lines on there, and I'm hoping that people are sitting around a table with a nice cup of coffee and got into work without problems this morning, and I wish everyone safe travels this afternoon.

The picture here, a couple of pretty faces on the first slide there. I just wanted to open with sharing about Bob. Bob is a Air Force retiree. He volunteered at our VA. We had what was called an ambassador's desk. You can picture 90-plus-

year-old Bob at the ambassador's desk. He was a regular there. On a day like today, if we had gotten some snow, it wouldn't be unusual for the resident that I work with from the Hershey Med Center to perhaps call in and say they were having difficulty getting in because of the snow, but 90-year-old Bob would be sitting at the ambassador desk as walk across campus to go to our hospice unit. He was a neat guy.

I walk across by that ambassador's desk two or three times a day going to see patients on our hospice unit. One day, Bob yells out at me, "Dr. Shreve, Dr. Shreve, I heard about this program called No Veteran Dies Alone. Can I do it?" I'm like, "Oh, my gosh, Bob. You'd be wonderful for that." He goes through the training for it, and he gets the opportunity to do a shift. The No Veteran Dies Alone program at this facility, it's about a two-hour shift, if you will. It starts at 7:00 p.m. This is the time he signed up for. He comes there, and he stays way beyond 9:00 p.m. He's probably there still just shortly after 11:00 p.m. that night, and he goes home.

The next day, I'm walking across campus. I walk by the ambassador desk, and he's really calling out loudly, "Dr. Shreve, come on over." He tells me the story how, for his first night, he volunteered at the No Veteran Dies Alone program, sat at the bedside of a veteran who was dying. Later that night when he went home, he said he slept through the night for the first time since his wife had died two years earlier.

I just wanted to share this that there's so much ... it's such an honorable job that we all have in caring for veterans, but to share this veteran-to-veteran volunteering and the value that volunteers bring to the bedside and not only give but also receive, and I am so deeply honored that the family asked me going ... Fast forward another year or so, and Bob ended up dying on that same hospice unit where he was volunteering, and I got to provide his eulogy. We have such warm memories of Bob with Miss Pennsylvania here. Every year, we get visited by Miss Pennsylvania, and this is one of the joyous pictures to share with you this morning.

I am going to move forward. By the way, I'm going to try to keep an eye on the chat box. You are welcome to type in questions. If you press star six and want to verbally ask a question any time throughout the presentation, I welcome that too. A lot of familiar names on the participant list that I see here in terms of hospices. From the Maryland Hospice Network, I have heard a lot of things from Katherine Kemp at NHPCO of all the things you're doing with the We Honor Veterans program. Really, thank you for that.

I have no conflict of interest. I say this here half tongue in cheek, but it's a reality. I don't even accept cheap pens. I don't want any money coming to me in any way. We do have continuing education credits, or I should say Katherine

Lally and the network have figured out all the hard work here on getting you continuing education credits.

This is what you will rate the presentation on, on these objectives. Try to share with you one benefit of screening patients for veteran status. I don't know if I can say that all of the hospices in Maryland screen for veteran status. That would be a wonderful thing to be able to say. Two examples of how partnering with VA can help improve care, I think you may already know them, but I think it's good to always have a little bit of a refresher or a vaccination. Then two indicators that VA is actually improving in the care of seriously ill veterans well beyond hospice care upstream in the palliative care end of things.

That is just a quick overview and try to put you in the kind of the right mindset for where VA's hospice and palliative care program has come over the last eight years. In 2010, we initiated a nationwide survey, a 19-question survey sent out to all 20,000 families of veterans who die within VA facilities. We're getting about a 40% response rate, and it really is the driving force. We consider this the voices of veterans to tell us how to improve care. 2011, we opened up 54 new hospice units across the country, had designated training for all of our palliative care teams nationwide. We partnered with the Center to Advanced Palliative Care, and then we also launched the We Honor Veterans program, which I believe many of you are very integral members of.

In 2012, I wonder how many healthcare systems can say that more of their patients die in designated hospice beds than in all of ICU and acute combined. I'll elaborate on this in a little bit, but I just ... I think that's such an impressive figure. We tipped the scale in 2012, and it just keeps going. More and more veterans are choosing for hospice care. 2013, we received the American Hospital Association's Circle of Life Citation of Honor Award. 2016, over 3,000 We Honor Veteran partners. We're up above 3,500 now. In 2017, all-time high for outpatient consults. This is really interesting. Just to go back, really, five years, we had very little outpatient palliative care across VA, and it has taken off. I'll show you some of the trends on that.

In 2018, probably one of the biggest, I don't know if we can match a few other healthcare systems, but I think, pretty soon, we may even surpass them, the Department of Veterans Affairs initiated what's called the Life-Sustaining Treatment Decisions Initiative. Every physician in VA will be trained on how to have these kinds of conversations. We have a formatted template for documenting it, and the template automatically feeds into the orders, and you can access it from the medical record with one click. It is just a phenomenal system. I'll give you a reference there later on as to how you can look at how that whole initiative was implemented across VA. Just phenomenal what VA can do when it really puts its mind to it.

Coming home, you all take care of a lot of veterans. I believe you know that there's really some significant cultural differences to the different war eras. This is just an overview that you may have seen before, that World War II kind of came home with a ticker tap parade, Korea, in large part, ignored in some respects, and then Vietnam, the shaming part where a country was torn apart and very mixed emotions about that war. We'll talk about that in greater depth, but what I wanted to do was to really give you a bit of a video that the Hospice Foundation of America put together. Frank Sesno, if any of you remember Frank Sesno from Operation Iraqi Freedom/Enduring Freedom, and this video just covers a lot of topics about war eras, and I thought it was worth going back to see this clip.

Uh-oh. I pushed play, but I can't get it to play. Oh, there we go. I just wanted to kind of ... Please don't register with Hospice Foundation of America. I think they eliminated that video from their library, but the We Honor Veterans program, I believe, purchased the rights to it, and it likely will be available through We Honor Veterans if anyone wants to see it. It's a full three hours. If anybody's interested, happy to give you resources to that. There would be no charge. It was purchased through a VA contract there.

I wanted to ask people ... I think many of you may know what this is. This is an Honor Flight program down at the World War II memorial. Boy, many of us have volunteered. My wife and I have gone down a number of times, and just a wonderful experience if you ever get the opportunity to go down and be a part of this. I'll never forget there was a little guy off to the left-hand side there in kind of a plaid jacket. They bus the veterans in from Reagan National Airport, and you help them off the bus and get them to the World War II memorial here. I never forget helping him off the bus as he stuck his head out and he stated, "I thought they forgot about me," as he looked out at the memorial. Really, a wonderful opportunity, and you all are pretty close to DC to take advantage of that.

In case you haven't seen a graphic to show you how all of our jobs are going to change over the next decade or more, it's that we're going to be taking care of a lot more Vietnam-era veterans. This really, I think, highlights kind of how we need to adapt to meet the needs of Vietnam-era veterans. I just put out there that, perhaps all too often, there are strained if not estranged relationships among the cohort of Vietnam-era veterans. We've touched on PTSD, but I don't think, up to this point, we've mentioned moral injury, and there's certainly some overlap there with PTSD but yet really not a recognized diagnostic and statistical manual syndrome that has an easy treatment protocol.

Suicides, boy, that's certainly a priority with the Department of Veterans Affairs. The vast majority of veterans that are committing suicide have never been touched by the VA system, so it's really important for all of you, really, to be aware of suicide, how to work with and deal with suicide ideation. I'll just plant

a seed here that Congress has really targeted their support for care of Vietnam-era veterans getting hospice care. I'll expand on that in a little while too, but it's going to be a real steep learning curve as we all get to know how to better care for the Vietnam-era veterans.

This is just to kind of remind you all that only 3% of veterans really die in VA facilities. That video talked about 95% dying outside VA facilities. It's actually 97%. This is the 597,000 veterans that died last year, many more with advances serious illness and dementia. You hear about a decline in the number of veterans, and that's certainly true. A decade from now, there will be a estimated 485,000 veterans dying in a year. I just wanted to say that that decline is not a dramatic drop off. We'll still be close to a half million veterans dying each year.

Collaborate. I think I don't know the state statistics, but I suspect Maryland may be one of the highest participation rates in the We Honor Veterans program, but this word here, collaborate, to work with one another, to cooperate, to be on a call like this together and trying to share expertise about caring for veterans, I think, is just wonderful. That number two definition here, to cooperate, usually willingly, with an enemy nation, I think is far from the truth, that anything I can do and the Department of Veterans Affairs can do to help all of us better care for veterans at the end of life, I think I want to learn from you as much as share any expertise that I can share from VA.

"Are you a veteran?" That's really what it begins with. I don't know how many hospices across the country out of the 5,000 or so that exist, how many are routinely asking, "Are you a veteran?" Do I believe that VA can collaborate with these community hospices? I'm convinced of that. VA has historically not been a very good partner with the community, but I can assure you recent legislation ad VA leadership has really changed the culture in VA. We are reaching out beyond our walls to partner and collaborate in the care of veterans on many fronts not just hospice and palliative care.

This is just give you a bit of a graphic of the growth of the We Honor Veterans program. These are the different partner levels here. Boy, getting above 3,500 out of a total of 5,000 hospices nationwide, we're really ... I think we're beyond the tipping point of ... I believe this should just be universal, that every community hospice should be a part of the We Honor Veterans program. There's no cost involved with it in the sense of being a designee. There certainly are some costs in ramping up your program to address the needs of veterans.

I'm very thankful for all the levels, but very much want to work at that recruit level, which is a better part of a little over 1,000. I think if there's any wisdom you can share that VA and, perhaps, the National Hospice and Palliative Care Organization can use to help move people beyond that recruit phase, we

certainly welcome your guidance, and we'll continue reaching out to help people progress through the different tiers.

"Are you a veteran?" is a great starting point. I really believe that the evolution of caring for veterans needs to go beyond that to the point of asking, "Would it be okay if we talked about your military service?" You heard Paul [Shudy 00:17:43] in that video talk about how important your rank and your branch and your job is. I think that's really good to know as well, but I'm curious as to, after you ask, "Would it be okay if we talked about your military service?" Wow, the answer to that question can be overwhelming, at times, and it may unmask PTSD, or moral injury, or suicide ideation. I have concerns as to are all of our hospice teams, both in VA and outside VA, prepared and feeling expert at how to deal with those answers? We have some initiatives, moving forward, to help address that, but I'd certainly like to hear your thoughts on what is needed to make sure that we are all prepared to deal with these issues going forward.

Lessons learned, I've alluded to it already, but boy, having veterans in your organization is such a benefit in your volunteer pool. Anything you can do to have veterans interacting with other veterans that are receiving hospice services, I think, is a plus. There was a presentation on one of the national networking calls by NHPCO about ... it was called A Veteran's Café. This one hospice program just kind of brought terminally-ill veterans together with other veterans. They described it as, organically, a conversation began. It was almost, I think, like a therapy session, an unscripted therapy session for the sharing that went back and forth. I want to strongly recommend engaging any veterans in your organization in the care of other veterans. I took that Veteran's Café presentation to our local leadership here at the VA where I work, and a chaplain and myself are starting a Veteran's Café in December here at this facility and looking forward to that.

I wanted to kind of plant the seed for a little bit of the vision for where VA's palliative and hospice care program is going. Moving upstream, and I think a big part of this ... I'll try to show you or I will show you some data on VA's outpatient palliative care consults. Probably the biggest news that really opened a major hurdle for us was the VA Mission Act eliminated state borders for VA staff and the provision of telemedicine.

For example, a psychologist in Delaware at a VA facility in Delaware could provide therapeutic support via telemedicine to an enrolled veteran in the state of Maryland. Eliminating those state borders really should open up the doors for VA to use telemedicine. I want to let you know VA has immense capacity to do telemedicine. We have the technology in place and moving forward with it but, in large part, our palliative and hospice care programs have not been using it, so I think there's a great opportunity there for community hospices to tap into VA expertise virtually and bring that to the bedside. We can talk about that.

Targeting. Really, there's never going to be enough palliative care teams, in my mind, across the country, and our palliative care teams in the Department of Veterans Affairs are certainly stretched, but what we're trying to do is to see only the sickest patients and not kind of have frivolous consults. Not that we get many frivolous consults, but we want to really make sure we're targeting to those veterans that need it the most. We have a population health indicator known as a care assessment needs score. It actually predicts the risk of death or hospital admission in the next 90 days or one year. That really gives us a quick glance at who's at high risk there of potentially needing palliative care.

Quality. I talked about veterans and their families giving us input through our bereaved family survey scores. The last one is building capacity, whatever we can do to help empower community hospices as well as our VA non-palliative care providers. We want to work with you and partner with you to move forward in that.

I'm just going to go through 10 reasons why I believe partnering in the We Honor Veterans program is worthwhile just with some quick vignette stories about these top 10 reasons. Then we'll jump into some data from the Department of Veterans Affairs. Then we'll open it up to any questions you may have.

Reason number 10 to participate in We Honor Veterans, the veteran in front of you may have scars you cannot see. I'm hoping some of you know this veteran. This is Jim Cooper. If I remember correctly, it was nine marriages and 11 children, and went on to die at the Palo Alto VA, significant PTSD, and really became a spokesperson for palliative care throughout the country with his doctor, Dr. VJ Periyakoil.

Reason number nine, the veteran in front of you may have been spit on when returning from war. This is Bob and Barb. I cared for Bob on our hospice unit. Oh, by the way, his tee-shirt here says, "I'm just one big freakin' ray of sunshine, aren't I?" This is a Vietnam-era veteran, came home and went to bed and, an hour and a half later, got up and checked on his children in their bedrooms, then went out, walked the perimeter of his yard, and then went back to bed and, about an hour and a half, two hours later, got up and checked on his children, and checked the perimeter of his yard, and continued to do that. Got significant therapy from the VA here, ended up coming to our hospice unit. Anyway, just a wonderful couple here. Bob has since passed, and Barb still occasionally comes back and visits us on our unit.

Number eight, the veteran in front of you may never have been thanked for their service. Boy, I think some of the hospice programs in Maryland, you guys are really at the forefront of how to say, "Thank you for your service," and I think engaging some of the military, some of the younger people in the

ceremony, some of the ... I'm thinking of Annapolis and all the things that you do to say thank you. Those services are just so powerful.

Number seven, the veteran in front of you may not look like a combat veteran, but it can help to know it. This is when we received a Golden Vision Award, I think it was, from the National Hospice Palliative Care Organization, and just to share that the Vietnam-era veteran in this photo is Chris [Cody 00:25:21]. Many of us have fond memories of working with Chris Cody over the years.

Number six, the veteran in front of you may be from the greatest generation. In a few years, they'll all be gone. I'm really blessed. I have internal medicine residents rotating with me every month for all 12 months out of the year, and they get to meet World War II veterans and hear history firsthand. It's just such a delight to have that face-to-face sharing of what these veterans went through and what they experienced.

Number five, the veteran in front of you may need forgiveness to get closer to being at peace. This is a chaplain on our unit, and this is a Marine veteran, Bob. Bob had pretty severe symptoms from his military experience. I didn't use the phrase PTSD because he really wouldn't talk about it. He wouldn't share. All he would do when I brought it up is break down in tears and say, "I can't talk about that." Our chaplain is just a wonderful soul, and he just started having coffee and cookies with Bob in our back kitchen. Over a period of a couple weeks, you could see Bob's face relax. I asked him about if we wanted to talk any more about his difficult military experience, and he said, "Nope. Father [Dagle 00:26:48] and I have it all in line. I'm good." Just a thank you to the chaplains that do amazing care on our hospice teams.

Number four, the veteran in front of you may be a decorated hero. Homelessness has been a priority for the Department of Veterans Affairs. I'm confident in saying that, if you are a veteran, and you are homeless, and you call the VA, you will have a roof over your head and a place to stay that evening. The Department of Veterans Affairs just provides immediate response to homelessness in veterans. I've spoken to the Director of Homelessness for VA, and I think I'm paraphrasing correctly that he said, if a veteran is homeless today, it's by choice not because they haven't been offered shelter.

Number three reason to join We Honor Veterans program is the veteran in front of you may enrich your life in ways you may have never realized. This is Frank from our hospice unit. Oh, my gosh, he just warmed the hearts of our whole team. I think this is just a small evidence of how much nursing staff loved him and grew to care for him on our unit. I'm sure all of you have experienced that. Sometimes you don't even see it coming.

Number two, the veteran in front of you may be the last one of an era in our nation's history. Frank Buckles, the last World War I veteran. I suspect there are some people on this phone that may see the end of World War II era.

The last one, the veteran in front of you may have seen these beaches many years ago. This is Normandy. Just last week, I took care of a veteran on our hospice unit who paratrooped inland, I think it was about 15 miles or so inland, and paratrooped down. He described, in great detail, how he was to prevent the Germans from getting to the beach from inland side and how he booby-trapped a bridge and, if they couldn't hold back the Germans, they were instructed to blow the bridge so the Germans couldn't cross the river. He described that whole experience and shared with me how proud he was that they didn't have to blow the bridge, and they were able to hold the Germans back to protect the beach for the invasion.

They were the 10 reasons on why I think our collaboration in We Honor Veterans is so important. I want to share with you just a bit about a national initiative within the Department of Veterans Affairs. This cartoon, by the way, from a mentor of mine when I was going through medical school, he's also an artist, Dr. [Harring 00:29:36], "But how do I tell him he's going to die?" Physician at the bedside, and then the patient thinking, "When will he tell me I'm going to die?" These conversations may come more easily to those of us on this call, but for many clinicians and teams, it doesn't always come so naturally. I think that learning how to have these conversations is something that healthcare systems across the country are really taking on.

I have two kind of links here. Dr. Atul Gawande, I think all you have probably heard of. I think the most recent book is Being Mortal, a wonderful ... He's done a PBS special, a similar title, many other books. This is a three-minute YouTube that I share with the residents that come on our service. I kind of describe it as a palliative medicine fellowship in three minutes or less, and so it really capsulizes ... I'm not going to show it here, but I wanted to make mention of that.

The other reference here is really what I'll call a soup-to-nuts article on VA's comprehensive approach to eliciting, documenting, and honoring patient wishes for care near the end of life. I mentioned it briefly earlier, but I just want to give you the scope of this is that for any seriously ill veteran ... and here's how we define seriously ill. If you would not be surprised if they died in the next year or two, so this is way beyond a hospice paradigm, then you, as a VA clinician and team, need to have one of these conversations, a life-sustaining treatment discussion and goals of care conversation and then document it. We can track these conversations across the country.

We've worked with four pilots before this implementation rolled out, and now VA facilities have 18 months from the release of this directive to put this into place. I just want to let you know we're probably not up to La Crosse, Wisconsin,

that city that has just been phenomenally effective in implementing advanced directives, but this is on that par of every enrolled veteran that is seriously ill having one of these goals of care conversations and then putting it into action with the associated orders in an electronic health record that can be accessed with one click. I really think this article from the Joint Commission Journal just provides a wonderful overview of how VA is doing it and put it out there as a good reference point for anyone who wants to dig into this issue further.

My next few slides are to try to convince you that VA is actually doing some meaningful work in palliative and hospice care and what indicators or measures would convince you. There are many other indicators. If you have some on your mind and want to kind of challenge me to see if we're measuring it, I welcome that. We may or may not be measuring it, but we try to be as evidence-based as we can.

Looking at this pie, we look at the top 2%, what we consider to be the sickest 2% veterans. This is using this care assessment needs score of predicting death or admission to the hospital. We look and see how well are we attacking or approaching those sickest veterans? You can see that, of that entire pie, palliative care in the VA system has touched about 17%. I want to just put out a caveat here. These patients are at risk of hospitalization or death, so a significant number of these high-risk patients may be mental health/behavioral health patients who have recurrent admissions but are not expected to die in the next year or two. I'm not saying that all of these patients require palliative care, but this is a way to give us an initial target to look for some of the sickest of the sick.

If you flip this around, instead of all the palliative care consults that were done nationwide, what is the average care assessment needs score? That is 98. If you look at all the consults that VA palliative care teams are doing, we are seeing very sick patients nationwide and, likely, are at our capacity as to the number of patients we can see, but I'm going to share with you how we're still growing despite seemingly pushing our heads up against the ceiling of capacity.

This is a graph just to show you how VA has been able to reduce the number of deaths occurring in acute care and ICU over the last, really greater than the last decade, but also how veterans are choosing to go to hospice units in the last weeks or months of life. 60% of veterans in the VA healthcare system inpatient deaths die in a designated hospice bed. That flexion point right in the middle there at FY 2012 is when we really crossed paths there. I think this is just a phenomenal statistic for a healthcare system. There is no pressure. This is solely offering veterans the care that they need at end of life.

I just wanted to kind of qualify so people don't misunderstand it because our VA hospice units would really best be described as nursing home hospice units, meaning they're not the equivalent of your GIP. They're not acute-care units, in

large part, and so these units have a median length of stay of about 14 days. They're really the safety net for a veteran who may not have a social support system that allows staying in the home, and yet they can get specialized care in this nursing home unit within a VA facility. VA calls nursing homes community living centers. It's just I want you to know the language that we use.

This is one of my favorite slides, not only for its colorfulness, but this is what I will call the dose effect of palliative care. The green bars here show the percentage of families ... Oh, I should make note this is of all the veterans that die in VA facilities across the country, whether you die in acute care, ICU, a hospice unit, a nursing home bed without any palliative care. We look at that, and we send out these surveys to ask, "How good was your care in the last month of life, regardless of where you died in the VA system?" Then this is breaking out the percentage of family respondents who rated care as excellent. That's just what we call top-box rating.

In the green bars, you can see that's the lowest percentage of families rating care as excellent. Then, going up to the blue bars, that's if they received a palliative care consult. Statistically significant and, by the way, I should say the sample sizes in each of these years is approaching 9, 10,000 patients. We're in that 40% of the 20,000 inpatient deaths. In the red bars, that's an inpatient hospice bed, but it's not in a designated unit, so it just may be an isolated bed in a nursing home section, but they've labeled that bed hospice, and we know this patient is receiving hospice, but it's not an entire dedicated unit to hospice, which is the orange bars on the right-hand side and the highest satisfaction.

As you increase the amount of palliative or hospice care a veteran receives, the percentage of families that rate care as excellent just goes up year after year. This consistency really is convincing evidence, one, of the value of palliative care and, two, of the differences. By the way, all of these differences are statistically significant with very small p-values. Anyway, I think you should realize how good the care is in these VA hospice units. If you took the national average for the percentage of families rating care as excellent in VA hospice units, it's four percentage points higher than the national average on the hospice CAHPS survey that Medicare has mandated, so just to try to put that into perspective. I'm going to also mention that these scores are case mix adjusted as well as adjusted for non-response bias, so we try to use a very rigorous methodologic approach to reporting these scores.

Then this is just the national average, the percentage of families that rated us as excellent. In 2014, you may not remember but, boy, do I remember, in April of 2014, the media burst open with an access scandal in Phoenix, Arizona at the VA there about there being two books for keeping records on veteran's access to services. Over night, our percentage of families rating VA care as excellent dropped just three to four points over night. No care changed across the country, but the national average dropped over night. We've been really

recovering. It took us almost two to three years to recover from that access scandal, but we are well on our way and have surpassed those scores and, really, looking to increase this national average about one to two percentage points every year going forward. This is only top-box scoring, excellent. If you add in very good, it's 88% of respondent families rate the last month of care in VA as excellent or very good.

This is just to give you an idea of the growth in outpatient. We're up now really approaching that 25,000 mark, a just phenomenal amount of growth here. I'll just put this into perspective. There is no centralized targeted funding for these teams. This is local VAs deciding that palliative care, especially outpatient palliative care, has value. Our program office is supporting it, and we've learned that when we start to integrate with the specialty clinics in the outpatient arena, the referrals go up, and veterans tend to get their palliative care interventions earlier in the disease trajectory. Growing our outpatient consults as well as even community care consults through telemedicine is an area where it is really the frontier for VA and, probably, the nation.

I'm going to wrap up here with a video. This is a short segment of a video clip. Stephen Colbert is interviewing Ken Burns. I have no political agenda here, but I found this interview spoke volumes about the many perspectives of the Vietnam War. Whoop, we don't want to do Improving Care for Veterans. We want to get to the Stephen Colbert video. Anyway, it speaks volumes about the Vietnam War. I think Ken Burns also has a great closing here for us moving forward that care for Vietnam-era veterans and our country in general.

Stephen Colbert: Welcome back, everybody. My next guest tonight is an Emmy and Peabody Award-winning director whose latest documentary is The Vietnam War. Please welcome Ken Burns. It's good to see you.

Ken Burns: Thank you.

Stephen Colbert: Come on up. There you go, Ken. Good to see you again.

Ken Burns: Nice to see you.

Stephen Colbert: Now, I have seen the first two episodes of this so far, but I'm about three hours in then, and it is one of the most powerful documents I've ever seen. Of course, I grew up in the shadow of the Vietnam war because I remember the end of it, but the complexity of that war before the United States was even involved, before 1959, what we were stepping into as a country, I was completely unaware. However complicated I thought it was, I was not prepared at all for what a tangle it was. What surprised you about what you learned about this story?

Ken Burns: Everything every day. Every day working on this for 10 years surprised us. I thought I knew something about it. I lived through it. I lived on a college campus against the war. I had a high draft number. It was an amazing period, and I went in thinking, "Ah, finally, a subject I know something about," and Lynn Novick and I started working on this, and we realized how little we knew. The first episode is called Deja Vu because of the hundreds, literally hundreds of things that happened to the French that we could have taken as kind of warning symbol, like bridge out three miles, bridge out two miles, wait, barricade through, and then suddenly like a cartoon in the middle of the air going, "Hey, how did we get here?" That's Vietnam at the very beginning.

Stephen Colbert: You said, just a moment ago, that you had a high draft number.

Ken Burns: Right. Yeah, right.

Stephen Colbert: Now, for young people out here who don't know, who may not even be registered for Selective Service even though it still continues to this day ...

Dr. Shreve: Uh-oh.

Ken Burns: Mark Twain said history doesn't ...

Dr. Shreve: Boy, Katherine, little tough on the buffering here. We'll go for another minute, but-

Stephen Colbert: ... the experience, the develop ...

Dr. Shreve: I'm going to pause it for a second. Sometimes the buffering can catch up. You just want to open it up for any questions, and we'll give the buffering a chance here. I'm not going to jump to the next slide as I really want to try to show you the ending of this. We'll just see if the buffering can catch up. Oh, I think ... All right, I'll try once more here.

Stephen Colbert: ... when, by its nature, as one other documentary said, The Fog of War, it's hard to know? It's almost unknowable because it is so complex and so many of the figures end up dying in that war.

Ken Burns: That's exactly right. We tell the story of this war from all the different perspectives. When Americans talk about Vietnam, they normally just talk about themselves, but we interviewed ... Lynn Novick, my co-director, interviewed North Vietnamese soldiers and North Vietnamese civilians, Viet Cong guerrillas, South Vietnamese soldiers, South Vietnamese civilians, and diplomats, and protestors in addition to more than 50 Americans we have from every walk of life, from people who were opposed to the war to unbelievably brave Marines and Army guys charging up hills to Gold Star Mothers who didn't have to tell their incredible stories, so that we could understand that, in war, more than one

truth could happen at the same time, that we could create a space, unlike today. We are so divided. Everything is so toxic that we wanted to remind people that, even at a terrible time, we could actually describe this story by telling it from lots of different points of view and ...

Dr. Shreve: ... you and appreciate all that you do in caring for veterans. If there's anything I can do to help in the process, please don't hesitate to email or get in contact with the We Honor Veterans Group and NHPCO. I meet with them. Katherine Kemp and I talk regularly and do everything we can to support that initiative. Welcome any questions you have, assuming you're not having to run to go beat some snow. We're not getting any here yet in central Pennsylvania.

Ms. Lally: Okay. It looks like we have a question in the box. If anyone wants to ask it live, please hit star six to unmute your line so you can ask Dr. Shreve.

Dr. Wilner: Hello? It's Dr. [Wilner 00:46:54]. Can you hear me?

Dr. Shreve: Yes, I can, Dr. Wilner. Thanks.

Dr. Wilner: Yeah, hi. Thanks for the great presentation. I have two questions. One is what is the care needs assessment tool you use to screen people for palliative care needs?

Dr. Shreve: Yeah. Oh, boy, you asked a mouthful. The validation work was done by a researcher Wang. I'm sorry. It was a few years back, but it looks at 160 different variables in the VA administrative and clinical care record and has ... then goes through this predictive process with these 160 variables to predict an outcome for the veteran. It's updated weekly. I don't know the nature of your question asking about it, but my sense is it would be impossible, very difficult for another hospice or healthcare system to adopt that. It's just so involved and so laborious.

Dr. Wilner: Yeah. That tool is analogous to something called the Mortality Risk Index, which has a lot of utility in nursing homes where it calls data from the minimum data set. It's the same concept.

Dr. Shreve: Exactly, yeah.

Dr. Wilner: All right. My second question is what is the criteria for admission to your hospice units, and does every VA hospital carve out a percentage of beds to create such a unit?

Dr. Shreve: Yeah, good questions. The criteria for admission to our inpatient hospice units is different than the GIP, which I think is the world that many of you may work in. If a veteran has the life expectancy less than six months, appropriate for hospice, and requires nursing home level care, that is kind of the gist of

admission to our inpatient hospice units in the VA nursing homes or community living centers.

Now, I say that, but I also want to let you know, and I hope or believe that there are people on this call who realize that it can be very difficult to prognosticate. Often times, these units have a limited number of beds. I shared that the national median length of stay is 14 days, and that's what it is, but I just want to let you know we just ... many of us that have these units are always kind of juggling, and you get a veteran who may survive much longer than you need or longer than you kind of anticipated. I shouldn't say need, but the beds can fill up very quickly, and so we try to make the best use of them that we can.

Let me see. You asked, oh, does every VA have one? No, not every VA does. There's about 92 of these designated units across the country. Units, I said, as these facilities define a unit, but the vast majority, I mean getting up into almost every VA has the capacity to do some form of hospice care. What they'll do is have their palliative care team come and provide care in an acute-care bed. I don't think that would be the equivalent to a hospice unit, but it can oftentimes provide that bridge until we can get the veteran placed, perhaps, in a community nursing home or some other setting.

Dr. Wilner: Great. Thanks a lot.

Dr. Shreve: Thank you, Dr. Wilner.

Ms. Lally: Great. Does anyone else have a question for Dr. Shreve? Great. If anyone has a follow-up question, please feel free to email me, and I'll forward it to him. We wanted to thank you so much, Dr. Shreve, for this great presentation this morning. On behalf of the network, we appreciate it so much.

Dr. Shreve: All right. Well, thank you. I thank the network for all they do. Have a safe travel day.

Ms. Lally: You too.

Dr. Shreve: Thank you.

Ms. Lally: Thank you so much. Bye.

Dr. Shreve: Okay, and bye-bye.

Dr. McPherson: I'd like to thank our guest, Dr. Scott Shreve, who was brought to us courtesy of the Hospice and Palliative Care Network of Maryland and to thank you for listening to the Palliative Care Chat podcast. This is Dr. Lynn McPherson, and this presentation is copyright 2019, University of Maryland. For more information on our completely-online master of science and graduate certificate program in

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