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Critical Conversations: Improving Goals of Care Conversations at Southeast Family Medicine

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Quality Improve Project - Background

Introduction

Goals of care (GOC) conversations are an essential element of high-quality patient care across care contexts. At our residency clinic site, Southeast Family Medicine, there currently is not a standardized workflow that encourages and reminds providers to complete and document GOC discussions with their patients. Currently, end-of-life planning is tracked and monitored primarily through two tools: patient completion of advanced directives and POLST forms. Although these two documents are important, their use and application is at times to general or specific to truly reflect a patient's perspective on their goals of care and end of life planning. End-of-life discussions and care planning are an essential training competency for all physicians. Moreover, across our system, there is not a standard workflow of documentation of these important conversations that are readily accessible through the electronic medical record.

Resident training in this important skill set if often ad hoc and informal. We propose a quality improvement (QI) project focused on improving resident training with GOC conversations and establishing a new workflow with the aim to complete and document high-quality goals of care conversations for at least 80% of all annual wellness visits and transitional care management visits for resident patients at Southeast Family who are > 65 years old and to increase resident comfort and experience with GOC by March 31st, 2021. Over the course of multiple Plan-Do-Study-Act QI cycles, our team underwent GOC-specific trainings and developed and implemented a new workflow utilizing Epic dotphrases that successfully increased rates GOC documentation within our clinic and improved resident comfort and experience with GOC conversations.

Project Aim Statement

We aimed to complete and document high-quality goals of care conversations for at least 80% of all annual wellness visits and transitional care management visits for resident patients at Southeast Family who are > 65 years old by March 31st, 2021.

Primary Outcome: % documented GOC conversations for TCM and AWV for patients >65 for resident and faculty patients.

Secondary Outcome: Comfort and confidence levels among residents for having GOC conversations.

Balancing Measure: Advance Directive completion rates (clinic-wide).

Understanding the Problem

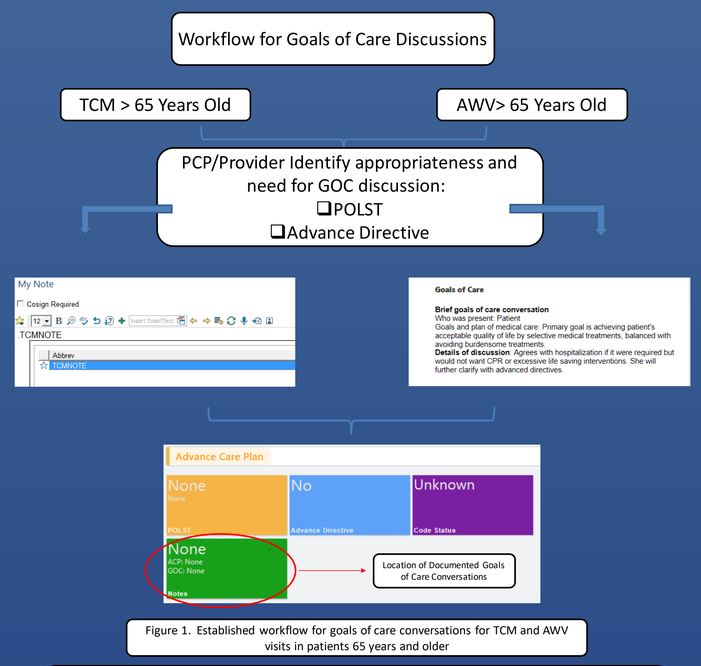


Figure 1. Established workflow for goals of care conversations for TCM and AWV visits in patients 65 years and older

For TCM visits, a new note dotphrase, .TCMNOTE, was created which incorporated the .GOALSOFCARE dotphrase

For AWV, the .GOALSOFCARE was pre-existing in the note template.

Once conversations were completed and documented, they were automatically brought into the Advance Care Planning Navigator, which is accessible in all Epic contexts (inpatient vs outpatient)

Methods

We completed three Plan, Do, Study, Act (PDSA) cycles to achieve the project aim, focusing on improving the workflow for GOC documentation within the EMR and education surrounding the implementation of ACP/GOC conversations within primary care.

PDSA 1

- **Plan:** Improve workflow of GOC documentation
- **Do:** Implement a dot-phrase within AWV and TCM progress notes to improve accessibility of GOC documentation
- **Study:** The proportion of GOC notes that were used during TCM and AWV visits for patients older than 65y/o improved after implementing the GOC dot-phrase within the template progress note
- **Act:** Inclusion of GOC dot-phrase within note template is permanent

PDSA 2

- **Plan:** Improve resident knowledge base of GOC conversations
- **Do:** Perform 2 GOC workshops during resident education time
- **Study:** Created Likert scale for residents to self-evaluate their knowledge of GOC before and after educational sessions
- **Act:** Continue to advance GOC training into resident education

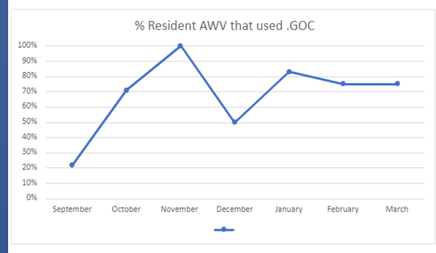
PDSA 3

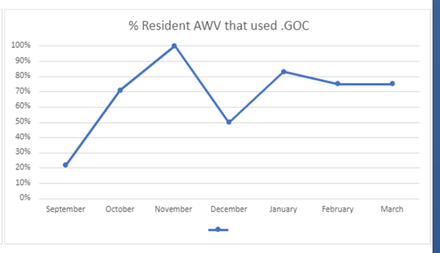
- **Plan:** Improve clinic wide awareness of GOC workflow and quality measure
- **Do:** Present GOC/ACP workflow and introduce project at clinic faculty meeting
- **Study:** Monitor primary outcome data in faculty as well as residents
- **Act:** Further advocacy for GOC training and awareness among clinic staff

Data

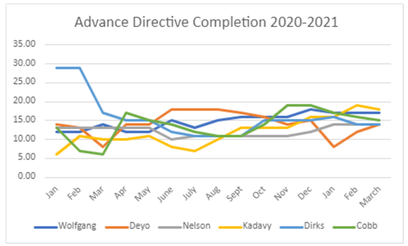
Primary outcome data

Proportion of AWV and TCM visits that incorporated the GOC dot phase in resident encounters over time



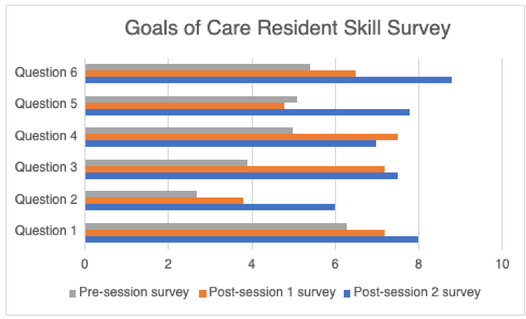


Balancing measure data:
These data show that rates of completion of advance directives during this project were relatively stable



Secondary outcome data

Residents completed 2 didactics sessions led by Palliative Care experts focus on building GOC skill competency. Skill progression was evaluated by a multi-domain skill survey. Residents demonstrated improvement across domains. Figure 2 depicts response rate changes to six representative questions (0= strongly disagree, 2 = disagree, 4 = neutral, 6 = agree, 8 = strongly agree)



Q1: I am confident in describing the different types of advance care documents
Q2: There is generally enough time during an office visit to discuss ACP
Q3: I am confident in the correct workflow documentation of GOC
Q4: I am confident in discussing end of life care with patients
Q5: I have had the opportunity to practice ACP discussions and receive feedback from my preceptors
Q6: My residency program has provided sufficient training on ACP

Conclusions / Lessons Learned

- Our PDSA cycles focused on developing a new workflow that integrated new dotphrases and resident education led to a sustained near-goal completion rate of GOC conversations for our target population.
- Availability of system-wide dotphrases within the AVW documentation improved completion rates as it created a 'hard stop' for providers to complete.
- Clinic-wide adoption of this workflow was variable
- GOC didactics sessions improved resident comfort and skill with having effective goals of care conversations with patients.
- Our target patient population and encounter type was relatively small, thus, our results may be difficult to generalize within a scaled project.
- This project did not have a significant impact on completion of Advance Directive rates among our patient population. Thus, it appears that such an intervention is additive.
- We collected our data manually through chart scrub – future QI projects would benefit from an automated data collection system.

References

Berns, S. H., Camargo, M., Meier, D. E., & Yuen, J. K. (2017). Goals of Care Ambulatory Resident Education: Training Residents in Advance Care Planning Conversations in the Outpatient Setting. Journal of palliative medicine, 20(12), 1345–1351. https://doi.org/10.1089/jpm.2016.0273
Clements JM. Patient perceptions on the use of advance directives and life prolonging technology. Am J Hosp Palliat Care. 2009 Aug-Sep;26(4):270-6. doi:
Committee on Approaching Death: Addressing Key End of Life Issues, & Institute of Medicine. (2015). Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. National Academies Press (US).
Detering Karen M, Hancock Andrew D, Reade Michael C, Silvester William. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial BMJ 2010; 340 :c1345
de Vries, K., Banister, E., Dening, K. H., & Ochieng, B. (2019). Advance care planning for older people: The influence of ethnicity, religiosity, spirituality and health literacy. Nursing Ethics, 26(7–8), 1946–1954. https://doi.org/10.1177/0969733019833120
Glaudemans, J. J., Moll van Charante, E. P., & Willems, D. L. (2015). Advance care planning in primary care, only for severely ill patients? A structured review. Family practice, 32(1), 16–26. https://doi.org/10.1093/fampra/cmu074
Nassikas, N. J., Baird, G. L., & Duffy, C. M. (2020). Improving Advance Care Planning in a Resident Primary Care Clinic. The American journal of hospice & palliative care, 37(3), 185–190. https://doi.org/10.1177/1049909119872757
Roth, A. R., Canedo, A., Balabanova, R., & Chauhan, V. (2020). My Life, My Way: A Quality Improvement Program to Increase Advance Care Planning in a Racially and Ethnically Diverse Patient Population. Journal of Pain & Symptom Management, 59(1), 147–151. https://doi.org/10.1016/j.jpainsymman.2019.10.015
The Conversation Project. 2013. New survey reveals "conversation disconnect": 90 percent of Americans know they should have a conversation about what they want at the end of life, yet only 30 percent have done so. News release. http://theconversationproject.org/ wp-content/uploads/2013/09/TCP-Survey-Release_FINAL-9-18-13.pdf (accessed September 18, 2013)