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Group Workshops for Advance Care Planning

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Abstract

The issue of Advanced Care Planning (ACP) is a pressing public health concern. The most opportune environment for effective ACP is in the primary care setting, though barriers such as time limitations and provider discomfort with the subject can be difficult to overcome. We worked with a county health clinic to create a referral process for group sessions. Over an eight-week period, data on 285 encounters was collected, which revealed breakdown in the chart review and referral process. Despite this, our innovation did increase ACP and can provide insight for others seeking to implement ACP related workflow changes.

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Practice Improvement Project: Group Workshops for Advance Care Planning

The issue of Advanced Care Planning (ACP) has been recognized as a pressing public health concern (Wilson et al., 2013). Though 60-70% of people state that they would prefer to die at home, 54% of deaths occur in the hospital setting (Broad et al., 2013). Swerrisen and Duckett (2014) identified the primary reasons people are not able to die at home are lack of planning for or discussing death and a lack of supportive services.

ACP addresses these issues by ensuring that patients, family, and providers have discussed and prepared for end of life care. Through these discussions, patients and providers create formal documents regarding the patient's wishes. The most widely used documents are the Physician Orders for Life Sustaining Treatment (POLST) and the Advanced Care Health Directives (ACHD). These documents guide care and result in increased quality of life and confidence in end of life care for the patient, as well as peace of mind and reduced stress for family members (Detering, Hancock, Reade, & Silvester, 2010; Burge et al., 2013).

Despite the benefits, many individuals have not completed ACP. An Agency for Healthcare Research and Quality (AHRQ, 2014) literature review found that less than 50% of terminally or severely ill patients had an ACP document in their medical records. Amongst the generally healthy population, only 26.3% had completed ACP (Rao, Anderson, Lin, & Laux, 2014). The urban county clinic that we worked with recognized

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low rates of ACP in its patient population. In order to ensure that their patients receive effective and quality end of life care, our practice change sought to increase the number of ACP documents on file for patients of the clinic.

Review of Literature

Spoelhof and Elliott (2012) identified key factors in effective ACP in the primary care setting: having multiple conversations with a provider concerning ACP, involving family in the planning, and focusing on the patient's and family's end of life goals, stressors, and values. Ramsaroop, Reid, and Adelman (2007) emphasized the importance of preparing the patient and the patient's family for ACP discussions prior to completing any ACP documents. Discussions help clarify patient and family roles and wishes regarding medical decisions, and also encourages support of the patient and their wishes (Detering et al., 2010; Bravo, Dubois, Wagneur, 2008).

The best time for ACP is when the individual is still healthy and living within the community (Mezey, Leitman, Mitty, Boterell, & Ramsey, 2000; Patel, Sinuff, & Cook, 2004; Spoelhof & Elliott, 2012). Key aspects to effective ACP include preparation by the patient, multiple conversations with providers, and involving family members in the process. This is easier to accomplish in the primary care setting, where providers tend to see patients over many years (NSW Department of Health, 2005).

A significant barrier to ACP in the primary care setting is time (Bravo et al., 2008; Spoelhof & Elliott, 2012). Group ACP workshops are one strategy to optimize non-billable patient time as multiple patients are able to interact with a healthcare

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provider at once. Crowe et al. (2015) found that group workshops increased patient and family member understanding of ACP, as well as increased patient satisfaction with medical care and confidence in future medical decision making.

The targeted clinic expressed strong interest in group workshops for ACP discussion as they previously had successful group workshops that were well received by patients and staff, and had available space and staff to do it. A decision aid was selected to provide patient preparation for ACP, and to encourage the involvement of family.

Practice Change Project

The clinic had a stated goal of 100% completion for ACHD or POLST forms for all patients 65 years and older. At the onset of the practice change, 42% of these patients had ACP forms on file. Though this is significantly higher than the countywide rate of 27%, the clinic historically experienced difficulties increasing rates. Previous workflows were poorly utilized and resulted in no increase in ACP. This practice change sought to improve ACP completion rates by improving workflow, utilizing time-effective ACP strategies, and involving multidisciplinary staff members in the process.

Group workshops were chosen to maximize effective use of time. Evidence supports this innovation as group workshops led by registered nurses (RN) and behavior health consultants (BHC) allow for primary care providers to devote their efforts to billable hours, maximizing reimbursement and allowing for multiple ACP conversation. RNs and BHCs were receptive to leading group workshops for ACP.

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Decision aids are useful resources for families to prompt ACP conversations and can be completed at patient's leisure with help of their family members. The project recommended the decision aid "Conversation Project Starter Kit," which focused on clarifying personal beliefs and values. The Conversation Project Starter Kit (The Conversation Project & Institute for Health Improvement, 2015) is available in multiple languages. As the clinic treats a diverse population, multiple language options were a priority in decision aid selection.

Workflow

The innovation sought to increase the clinic's ACP discussions and completion rates by creating a new workflow that addressed ACP at each visit and ultimately resulted in a referral to a group ACP visit (Appendix). The workflow utilized resources already embedded in the clinic and worked within an already established routine of chart review by the licensed practical nurse (LPN) or medical assistant (MA). The LPN or MA was responsible for documenting ACP need in the appointment details and communicating need to the provider. The new workflow designated the primary care providers discuss ACP with clients 65 and older who lack proper ACP documentation and refer interested patients for a group visit. The decision aid "Crucial Conversations" was provided to interested clients.

Implementation

To increase staff support and ability to implement the intervention, we created a charting template to facilitate faster charting. Providers were given an optional script for

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discussing ACP. This helped to ensure that ACP occurred despite the providers' potential discomfort with the topic. Before the workflow was implemented, training was provided for MA/LPN/RN's and providers on identification and documentation of patients in need of ACP, charting template, and referral process. After the workflow was approved by the clinic, it was distributed by email and posted at workstations. "The Conversation Project Toolkit" was provided in English and Spanish, in printed and electronic formats.

A three question provider survey was sent out via email midway through the project to assess for difficulties with the implementation and the workflow. Response to this survey was negligible as only one provider responded.

Results and Discussion

Over an eight week period, data was collected on 285 unique patient encounters. Data was collected for every decision point of the workflow, including review of the chart, use of the charting template, use of the diagnosis code, and referral to the group visit. This data was compiled in two week increments and are summarized in Figure 1.

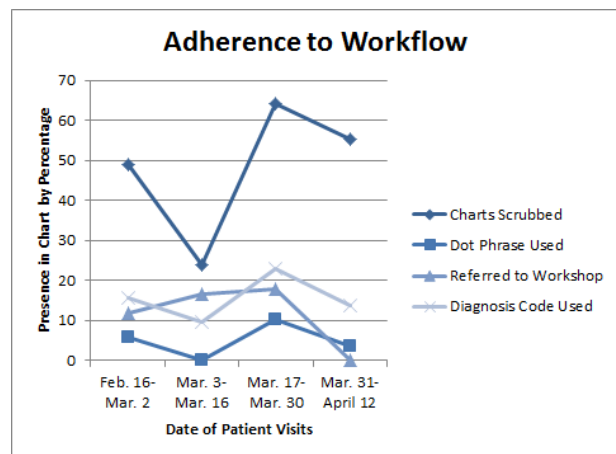


Figure 1. Adherence to new ACP workflow.

This data does not address clients who already have ACP on file but may need to re-evaluate the document to reflect health changes.

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The BHC was absent during weeks three and four and we witnessed a drop in chart review rates at that time. It was later confirmed that the MAs typically were neither reviewing the charts nor documenting ACP need. This emphasizes the importance of having a champion assist with initial implementation. The data trend suggests that reviewing the chart was associated with an increase in use of the charting template and the use of the diagnostic code. Due to limitations described below, we were unable to perform an in-depth statistical analysis.

Limitations and Lessons Learned

The process of the practice change revealed important considerations for future clinical practice. We failed to collect data on patient encounters in which the patient refused the referral or those that had previously had a referral ordered and had not yet completed ACP. Additionally, data was collected in two week sums with no patient identifiers due to the clinic's requirements. This reduced the sample size and our ability to further investigate relationships.

We did not consider roles outside of the MA for chart reviews, and later found that BHC involvement increased review rates. Also, we failed to clearly outline how to document when a chart needed ACP, and how providers should document ACP discussions in their notes. Not only did this make data collection more difficult, but the lack of consistent wording may have caused the provider to overlook those in need of ACP and potentially skewed data collection.

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Sustaining the change may be facilitated by improved measures of data collection. The data collection required extensive chart review, while a pre-built report that pulled chart template useage or diagnosis code could be a faster alternative. The clinic could benefit from utilizing the county health literacy department to assure ACP documents are at the appropriate reading level for the population served. Increased feedback from providers could aid in identifying barriers for sustaining the change. In person interactions could help to elicit this feedback given our difficulties with reaching providers electronically. The largest identified barrier was the lack of a streamlined referral process for scheduling the group visits. The clinic needs to address how to complete referrals with adequate timing to schedule patients for the group workshop.

Future Implications

Despite aforementioned difficulties with implementation, we were able to create a workflow that did result in providers discussing ACP and referring patients to a group education workshop. Group workshops may be a way to overcome common barriers such as billable hours, provider availability, and the in-depth nature of ACP. This project served to highlight the barriers that arise when implementing a non-traditional, education based intervention. Future research is needed to fully evaluate the effectiveness of such an approach in the primary care setting.

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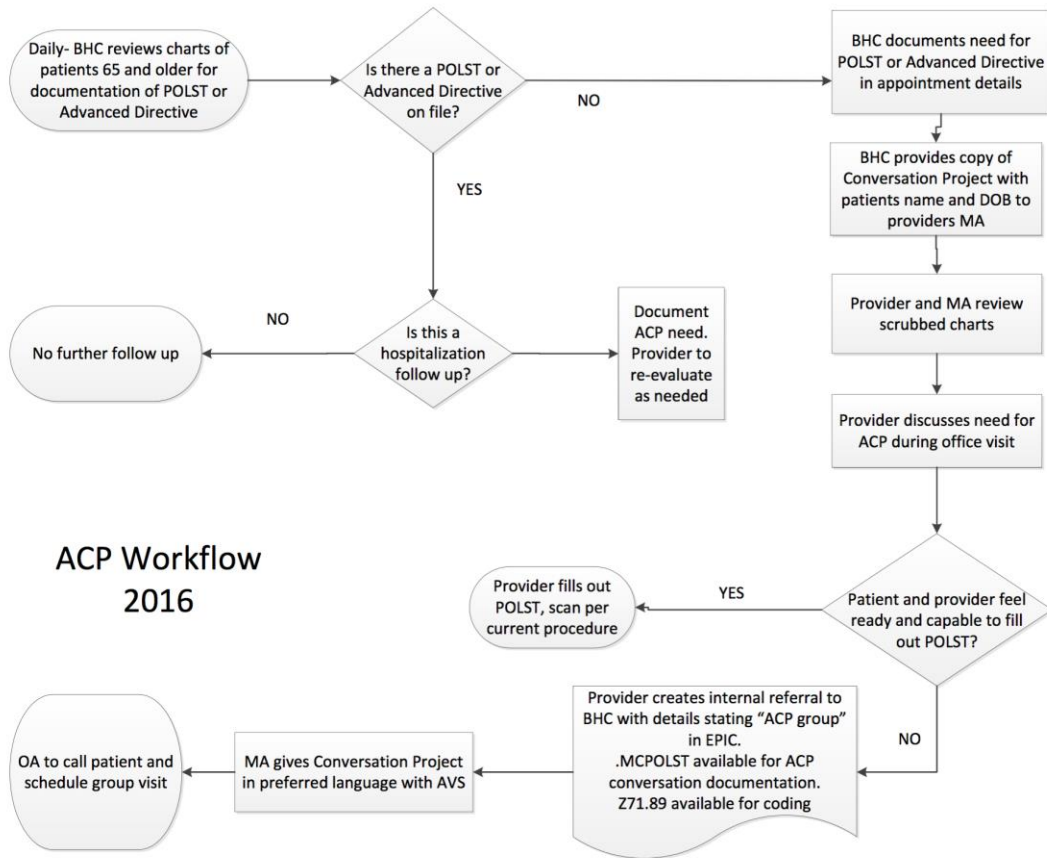
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Appendix



ACP Workflow 2016