Improving Advance Care Planning and Goals of Care Designation use through a focus on Team Process: A Primary Care Perspective

Dr. Thomas McMurray, Dr. Lauren Robinson, Dr. Sanjeev Bhatla in Collaboration with an Alberta Health Services ACP CRIO Study

Background

Advance care planning (ACP) is the process of reflecting on, discussing, and documenting wishes, fears and illness expectations for future health care[1]. Goals of Care Designations (GCD) is a "medical order used to describe and communicate the general aim or focus of care including the preferred location of that care"[1].

Previous studies have shown an association between Advance Care Planning and fewer aggressive medical interventions near the end of life, increased use of palliative resources, and reduced suffering amongst family members[2,3].

Practitioners at Bowmont Clinic identified the need for an improvement in the frequency, quality, and documentation of ACP/GCD conversations with their patients.

Methods

Patients >60 years old with one or more diagnosis of cardiovascular disease, cerebrovascular disease, chronic lung disease, and 4 common non-skin cancers were included.

On two days a week, patient encounters meeting inclusion criteria underwent chart review. Charts were electronically identified and systematically searched for the evidence of ACP discussions and GCD orders.

Participating Healthcare Providers (HCPs) and the Alberta Improvement Way (AIW) team met for a two-day QI workshop to map out current practices and identify areas for improvement. Interventions in the areas of EMR modifications, staff education, physical reminder systems, and role clarification were carried out over two PDSA cycles, which were 11 weeks each in length.

HCPs at the clinic were surveyed at baseline and again at study completion for perceived barriers to ACP/GCD discussions.

Patients identified in the chart review process were contacted to consent to a subsequent telephone survey conducted by the ACP CRIO research team. The survey looked to elicit patient understanding and experiences with ACP discussions.

Acknowledgements

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The AIW Team including Brooke Nowicki and Sandra Loevrel

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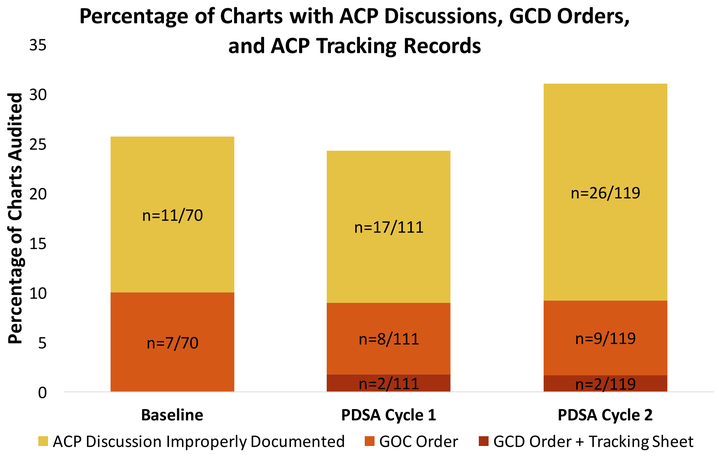
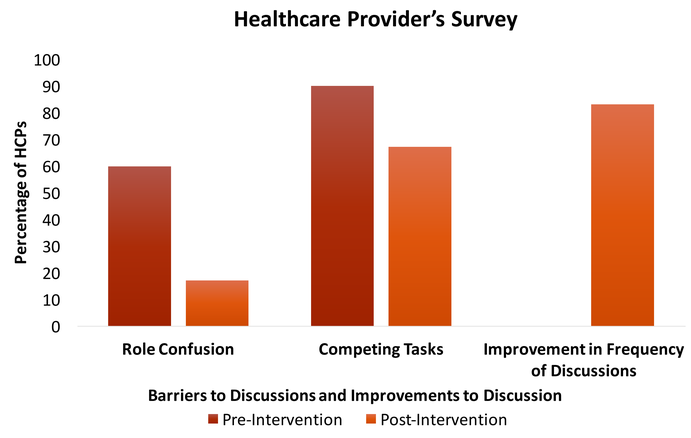
Goal: To improve the frequency and quality of goals of care conversations at the Bowmont Clinic, and decrease perceived barriers to these conversations.

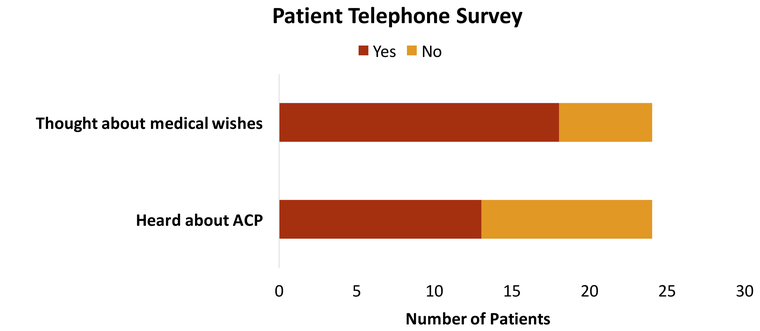
AIM Statements

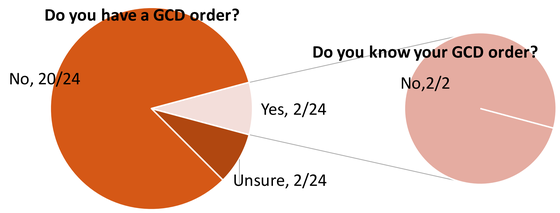
1. 15% of patient charts will contain a GCD order by February 28, 2017.
2. 5% of patient charts will contain a conversation documented on the ACP tracking record
3. There will be a 10% decreased perception of competing tasks and role confusion amongst Health Care Providers
4. By the end of the study, there will be a broadening of our understanding of patient's knowledge of ACP/GOC

Results









Discussion

1 2 The number of GCD orders did not increase over the intervention period, however the number of ACP discussions did. The lack of increase in GCD orders may be due to the relatively short time period of the study and large patient panels. Additionally, this may reflect the longitudinal nature of establishing a GCD in primary care.

3 There was a reduction in HCP's perceptions of barriers to ACP/GCD discussions, and the vast majority of providers thought there was some improvement in frequency of patient discussions. This is likely because of their commitment and collaboration throughout the QI process.

4 The patient survey demonstrated that while the majority of patients have considered their medical wishes should they become ill, just over half have heard about ACP. Significantly fewer have documented their wishes on a GCD order.

Conclusions

This project confirms the need for improvement in ACP/GCD awareness and engagement in Primary Care. While patients think ACP is important, it remains underutilized.

A combination of staff meetings focused on process improvement, electronic medical record reminders /templates, and staff education/role clarification can improve the frequency of conversations in community family practice. Additionally, these measures can reduce HCPs perceived barriers to these conversations.

Collaboration with Advance Care Planning CRIO and Alberta Health Services

This project is a branch of a larger Advance Care Planning CRIO project focusing on improvement of team processes across four clinical settings. These include an inpatient ward, homecare, outpatient specialty clinic, and family medicine clinic. The overarching goal is to "understand and enhance the processes that create high quality ACP GCD conversations and documentation among interdisciplinary team members and patients"[4].

AHS Alberta Improvement Way (AIW), the Provincial Simulation Program (E-Sim), and ACP GCD Educators have been collaborating with each team to assist with Quality Improvement.

References

[1]Alberta Health Services ACP/GCD website. 2016. http://www.albertahealthservices.ca/info/page12585.aspx
[2]Simon J., Porterfield P., Bouchal S., Heyland D., 'Not yet' and 'Just ask': barriers and facilitators to advance care planning – a qualitative descriptive study of perspectives of seriously ill, older patients and their families. BMJ Supportive & Palliative Care 2013; 0:1-9.
[3]Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*. 2008;300(14): 1665-1673.
[4]Simon, J., Berg, B., Improving Advance Care Planning and Goals of Care Designation through a focus on Team Process. Project Charter.