Supporting patients through the continuum of care

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Objectives

- Strategies to carry patient-centered goals from primary care to acute care and back again
- Identify partners committed to whole person care
- Using shared medical record to keep the patient’s story at the center of care

Silos in health care
Inpatient barriers

• “These conversations belong in primary care”
• Default Full Code – conversations with any depth are rare
• Rotating hospitalists and intensivists allow “anonymity” to perpetuate

Primary Care Barriers

• “No one in the hospital reads my notes”
• We have at least 12 different metrics we are required to address – I don’t have time for full ACP conversations
• Execution barriers included non-related witnesses or notaries for legal documents – what are your state mandated barriers?
Moving upstream

Bringing people together

• RN Care Navigators willing to identify ACP gaps to patients as part of chronic care management and DC from hosp.
• Facilitators in PCP offices willing to engage and encourage patients to talk about goals and values
Adding Home Health

- Expanding primary palliative care skills of home nursing team with focus on assessment and interventions over longer period
- Easy conversation starters suggested
- How to close the loop and create documents with patient values and goals expressed

One Epic to carry the story
Role of leadership

• Culture of concordance established
• Whole person care is a stated, stand-alone strategic goal for our system
• FT ACP Coordinator, support for facilitator training and conversation time
• Policy creation – employed notaries, volunteers as witnesses

New challenges and plans…

• Adding ACP as a routine to advance heart failure clinic (using Advance Steps conversations with RN facilitator)
• Considering ACP as an intervention to prevent 30 day readmission for HF and COPD – must find a “soft place to land” for those who don’t want to return to the hospital.
Strategic Messaging

It takes a village (of people 😊)