PROVIDENCE Medical Group

Respecting Choices®
PERSON-CENTERED CARE

National Share the Experience 2018

Improving Person-Centered Outcomes Through Collaboration

October 23–26, 2018
Bloomington, Minnesota

PROVIDENCE Medical Group

Supporting patients through the continuum of care

Kellie Durgan RN BSN
Manager, Advance Care Planning
Providence Health Care, eastern Washington
October, 2018

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

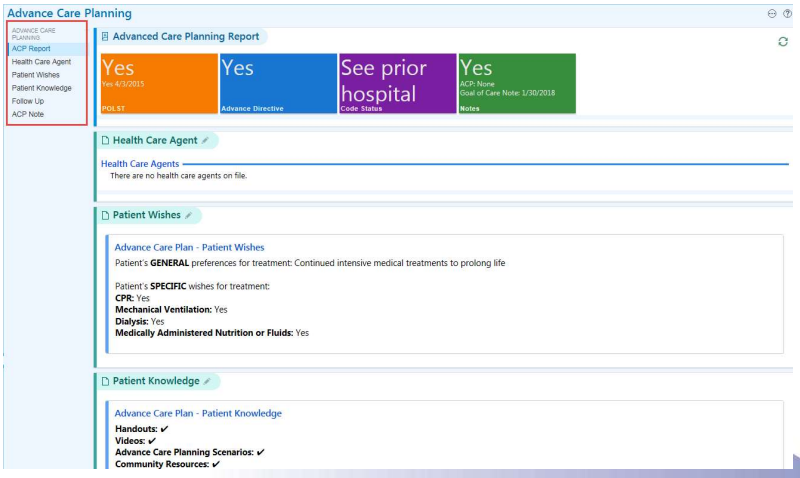
Bringing people together

- 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.

PROVIDENCE Medical Group

Strategic Messaging

PROVIDENCE Medical Group

It takes a village (of people ☺)