INITIATING ADVANCE CARE PLANNING (ACP) IN PRIMARY CARE: A MODEL FOR SUCCESS

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Learning Outcomes

• Describe how the Respecting Choices Last Steps® and VitalTalk® curriculums can be combined to train staff in the primary care setting to help implement advance care planning into the workflow.

• Identify at least two examples of electronic medical record enhancements that can be integrated into a health system to impact the long-term sustainability of person-centered advance care planning.

TriHealth

• An integrated not-for-profit health system with more than 130 sites of care

• TriHealth’s non-hospital services include:
  • Physician practice management
  • Fitness centers and fitness center management
  • Occupational health centers
  • Home health
  • Hospice care
A multifaceted improvement strategy aimed at moving the ACP process upstream of a crisis or end-of-life circumstance.

**Advance Care Planning Facilitator Training**

**Physician/Provider Coaching**

**TriHealth EMR Enhancements**

**Technical Support**

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**ADVANCE CARE PLANNING FACILITATOR TRAINING**

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Advance Care Planning Facilitator Training

• **2011** - Respecting Choices Last Steps® first introduced to the Cincinnati region

• **2013** - Integrated into the COL program
  – 1 Organizational Faculty
  – 27 Instructors trained

Advance Care Planning Facilitators

**Occupation**

- RN/LPN: 52%
- Social Worker: 26%
- Other (Chaplain, HOC staff, PA, NP): 22%
Advance Care Planning Facilitators

Setting

- **Ambulatory**
- **Inpatient**
- **Long-term Care**
- **Other**
  (Community-based, hospice, home care)

![Pie chart showing distribution of settings](chart.png)

**PHYSICIAN/PROVIDER COACHING**

![Image of healthcare provider and patient discussing a document](photo.png)
**Physician/Provider Coaching**

- 2013- custom curriculum written and facilitated by VitalTalk® trained physicians
  - Small group sessions
  - 1 hour presentation
  - 3 hour role play
  - Simulated patient actors

**Target Audience**

- Primary Care
- Oncology
- Cardiology
- Geriatrics
- Internal Medicine and Family Medicine Residents from TriHealth
- Medical Students from University of Cincinnati
• 11 trained Faculty Specializing in Hospice/Palliative Care/Oncology

“PAUSE”

Early Conversation skills

Pause, make the time.
Ask, permission and explain why.
Understand big picture values.
Suggest choosing a surrogate.
Expect emotions, respond empathically.
**VitalTalk® Talking Maps**

**“REMAP”**
Late Conversation Skills

Reframe why status quo isn’t working.
Expect emotion, respond with empathy.
Map out what’s important.
Align with patient values.
Plan to match values.

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**VitalTalk® Talking Maps**

**“NURSES”**
A Toolbox for Empathy

Name the emotion.
Understanding
Respect
Support
Explore
Silence
Synergies

- Role play with in-the-moment feedback
- Patient-centered approach
- Apply general interview/communication skills
  - Ask-tell-ask
  - Explore meaning of words/phrases
  - Anticipate emotion and respond with empathy

TriHealth Primary Care: “Learning lab”

- 36 TriHealth Primary Care Practices
- 100% Patient Centered Medical Home (PCMH) designation
- 19 Practices participated in the Comprehensive Primary Care Initiative* (CPCI, a CMS demonstration project)
  - Shared-decision making: Advance Care Planning
  - 81 primary care office staff are ACP Facilitators
  - CPC+ RN Care Coordinators, PCMH Care Coordinators
  - 123 (73%) providers completed VitalTalk® coaching

* 2017-present 38 primary care practices are participating in CPC+
Electronic Medical Record Enhancements

- Patient level ACP summary report integrated between Ambulatory and Inpatient modules
- Improved process for scanning advance directives into the medical record
- A custom ACP best practice alert (BPA)
ACP Summary Report
Patient Level ACP Summary Report integrated between Ambulatory and Inpatient modules

Improved process for scanning advance directives into the ACP summary report rather than Media tab

Checkbox field to track number of conversations initiated and documented in the record

Smartform including a new ACP note with filter for ease in locating ACP notes from any encounter

ACP Best Practice Alert

Criteria*

• 65yrs or older; AND

• + Congestive Heart Failure, End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Stage IV cancer, Cerebrovascular Accident, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Alzheimer’s, Coronary Artery Disease; AND

• Cognitively Intact; AND (nursing assessment questions on admission)

• Not enrolled in Hospice; AND

• 2+ hospital/ED/office encounters in the last 6 months; AND

• No end-of-life discussion initiated and documented (checkbox yes in ACP summary report)

*Criteria adapted from CMS demonstration/Gundersen Lutheran LaCrosse, WI
Best Practice Alert + screen message

![Best Practice Advisory - TestOSa](image)

**Clinical criteria met for advance care planning/goals of care. Document conversation in ACP Summary with checkbox 'yes' & ACP note.**

- Acknowledge reason: [ ]
- Referred to support services: [ ] No action taken

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TECHNICAL SUPPORT

![Technical Support](image)

**End of life care planning discussion initiated**

- YES
- No

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**HELP**

**SUPPORT**

**ADVICE**

**GUIDANCE**
Technical Support: Toolkit

- Setting up a system of support for ACP
- Preparing for a Patient Visit
- ACP Conversations with Patients
- Documentation and EMR tip sheets
- Improving the Process
- Supports and Resources

Process Map for ACP in Primary Care

- Operational and Staffing Considerations
- ACP information accessible to all patients
- Eligible patients identified pre-visit
- ACP Facilitator has conversation(s) with patient and family (documented in Epic)
- Patient Connected to ACP Facilitator
- Physician supports and/or introduces ACP conversation to patient and family (documented in Epic)
- Follow up with patient and family (ACP conversation and AD documentation)
- Scanning documents (HCPOA, MOLST, DNR, Living Will) and ACP goals in patient record
- Practice engages in ongoing process improvement
• Previously a primary care practice Care Coordinator
• Optimized workflows and EMR documentation through ongoing support:
  – On-site
  – E-mail
  – Phone

End of Life Care Planning Discussion Initiated and Documented in ACP Summary, 36 Primary Care Practices

- Intervention (19 CPCi practices) = 5,392
- Comparison (17 PCMH practices) = 1,808
Cumulative Total 7,200

Jan ‘16 webinar promoting the BPA
Focused ACP Liaison Support Jan – Jun ‘15
“End of Life Care Planning Discussion Initiated” Documented in Epic TriHealth Primary Care Practices

Number of Conversations initiated

2014 Total (May-Dec) 2015 Total 2016 Total 2017 Q1 2017 Q2 2017 Q3 2017 Q4 2018 Q1 2018 Q2

2014-2016 CPC= 19 PCMH = 17
2017 and beyond CPC+= 38
Cumulative total: 17,304

Success Story

- **Patient**: diagnosed with squamous cell carcinoma of the neck and throat, and after chemotherapy and radiation, the cancer returned.

- Dr. Neal initiated the ACP conversation with the patient, and introduced him to the RN Care Coordinator and Advance Care Planning Facilitator, Meg Cone to facilitate a Last Steps® conversation.

“This patient was isolated from his family and society. He needed someone to talk to about his wishes. When we found out that it was a terminal situation, it was easy to mention that we have the resources in place.” –Dr. Amy Neal (PCP)
Success Story

- Over a series of visits, Meg had a Last Steps® conversation with the patient and completed:
  - MOLST
  - DNR-CC
  - Living Will
  - Health Care Power of Attorney

“It’s been a really good experience for this patient. It has made him feel as comfortable as you possibly can and he now feels less isolated.”-Meg Cone, RN

Lessons Learned

- ACP Nurse Liaison: knew the content, EMR, the primary care practice setting
- A practice champion is essential for successful implementation and sustainability
- Timing was right for the system (CPCI)
Additional Resources

Conversations of a Lifetime™
MOBILE APP is now available!

Healthcare professionals who care for patients with serious illnesses have difficult conversations every day.
This app provides practical, actionable tips to improve communication skills and influence patient experience.

DOWNLOAD THE FREE MOBILE APP

Conversations of a Lifetime

Learn how to talk about end of life.

Things You Shouldn’t Wait To Say
Start the Conversation
Resources for Taking Action

End of Life Care
Questions? Contact Us

Sponsored by
362 VitalTalk® custom communication physicians coached
818 Respecting Choices Last Steps® ACP facilitators trained
18,437 PCP Conversations initiated and documented in EMR
2,207 TriHealth Hospital EMR documented conversations
2 EMR enhancements
• best practice alert for advance care planning
• patient level summary report (ACP Summary)
19 TriHealth Ambulatory Sites use the best practice alert
598 Downloads of the COL mobile app launched April 2016
18,835 Unique Visitors to ConversationsOfaLifetime.org
600,000 Impressions for the TYSWTS Community Engagement
  Campaign 2015 & 2016

References


Questions?

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