Critical Conversations: Improving Goals of Care Conversations at Southeast Family Medicine

Elizabeth Deyo
Michael Dirks
Tyler Nelson
Katherine Cobb
Nicholas Wolfgang

See next page for additional authors
Authors
Elizabeth Deyo, Michael Dirks, Tyler Nelson, Katherine Cobb, Nicholas Wolfgang, Hannah Kadavy, and Ben Pederson
Quality Improve Project - Background

Introduction
Goals of care (GOC) conversations are an essential element of high-quality patient care across care contexts. At our residency clinic site, Southeast Family Medicine, there currently is not a standardized workflow that encourages and reminds providers to complete and document GOC discussions with their patients. Currently, end-of-life planning is tracked and monitored primarily through two tools: patient completion of advanced directives and POLST forms. Although these two documents are important, their use and application is at times to general or specific to truly reflect a patient’s perspective on their goals of care and end of life planning. End-of-life discussions and care planning are an essential training competency for all physicians. Moreover, across our system, there is not a standard workflow of documentation of these important conversations that are readily accessible through the electronic medical record.

Resident training in this important skill set if often ad hoc and informal. We propose a quality improvement (QI) project focused on improving resident training with GOC conversations and establishing a new workflow with the aim to complete and document high-quality goals of care conversations for at least 80% of all annual wellness visits and transitional care management visits for resident patients at Southeast Family who are > 65 years old and to increase resident comfort and experience with GOC by March 31st, 2021. Over the course of multiple Plan-Do-Study-Act (PDSA) cycles, our team underwent GOC-specific trainings and developed and implemented a new workflow utilizing Epic dotphrases that successfully increased rates GOC documentation within our clinic and improved resident comfort and experience with GOC conversations.

Project Aim Statement
We aimed to complete and document high-quality goals of care conversations for at least 80% of all annual wellness visits and transitional care management visits for resident patients at Southeast Family who are > 65 years old by March 31st, 2021.

Primary Outcome: % documented GOC conversations for TCM and AWV for patients >65 for resident and faculty patients.

Secondary Outcome: Comfort and confidence levels among residents for having GOC conversations.


Understanding the Problem

We completed three Plan, Do, Study, Act (PDSA) cycles to achieve the project aim, focusing on improving the workflow for GOC documentation within the EMR and education surrounding the implementation of ACP/GOC conversations within primary care.

PDSA 1
• Plan: Improve workflow of GOC documentation
• Do: Implement a dot-phrase within AWV and TCM progress notes to improve accessibility of GOC documentation
• Study: The proportion of GOC notes that were used during TCM and AWV visits for patients older than 65/o improved after implementing the GOC dot-phrase within the template progress note
• Act: Inclusion of GOC dot-phrase within note template is permanent

PDSA 2
• Plan: Improve resident knowledge base of GOC conversations
• Do: Perform 2 GOC workshops during resident education time
• Study: Created Likert scale for residents to self-evaluate their knowledge of GOC before and after educational sessions
• Act: Continue to advance GOC training into resident education

PDSA 3
• Plan: Improve clinic wide awareness of GOC workflow and quality measure
• Do: Present GOC/ACP workflow and introduce project at clinic faculty meeting
• Study: Monitor primary outcome data in faculty as well as residents
• Act: Further advocacy for GOC training and awareness among clinic staff

Data

Primary outcome data
Proportion of AWV and TCM visits that incorporated the GOC dot phase in resident encounters over time

Balancing measure data:
These data show that rates of completion of advance directives during this project were relatively stable

Secondary outcome data
Residents completed 2 didactics sessions led by Palliative Care experts focusing on building GOC skill competency. Skill progression was evaluated by a multi-domain skill survey. Residents demonstrated improvement across domains. Figure 2 depicts response rate changes to six representative questions (0 = strongly disagree, 2 = disagree, 4 = neutral, 6 = agree, 8 = strongly agree)

Conclusions / Lessons Learned

- Our PDSA cycles focused on developing a new workflow that integrated new dotphrases and resident education led to a sustained near-goal completion rate of GOC conversations for our target population.
- Availability of system-wide dotphrases within the AWV documentation improved completion rates as it created a ‘hard stop’ for providers to complete.
- Clinic-wide adoption of this workflow was variable.
- GOC didactics sessions improved resident comfort and skill with having effective goals of care conversations with patients.
- Our target patient population and encounter type was relatively small, thus, our results may be difficult to generalize within a scaled project.
- This project did not have a significant impact on completion of Advance Directive rates among our patient population. Thus, it appears that such an intervention is additive.
- We collected our data manually through chart scrub – future QI projects would benefit from an automated data collection system.

References


- https://doi.org/10.1093/fampra/cmu074


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