Advance Care Planning: A Primary Care Innovation Model (Serious Illness Conversations in Primary Care)

56th Annual Primary Care Review

OHSU Family Medicine
Primary Care ACP Project Team

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Acknowledgement

This material for Serious Illness Conversation Training was originally developed by Ariadne Labs and has been modified by Meta-LARC ACP. The original content can be found at https://portal.ariadnelabs.org and is licensed by Ariadne Labs under the Creative Commons Attribution-Non-Commercial-Share-Alike 4.0 International License.

Acknowledgements

- Cambia Health Foundation
- Drs. Deb Cohen, Ana Quinones, Jason Webb, Hunter Poarch, Annette Tottem & Suzanne Sullivan

Team:
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Learning Objectives

At the completion of this training, learners will be able to:

- **Explain** the goals of Advance Care Planning to a patient.
- **Describe** goals of serious illness conversation why it is important in their practice.
- **Practice** a serious illness conversation using the Serious Illness Conversation Guide.
- **Examine** their own bias or behaviors that may prevent from listening patients' goals and values
- **Identify strategies** to implement serious illness conversations to elicit patients' values, goals and preferences in practice.

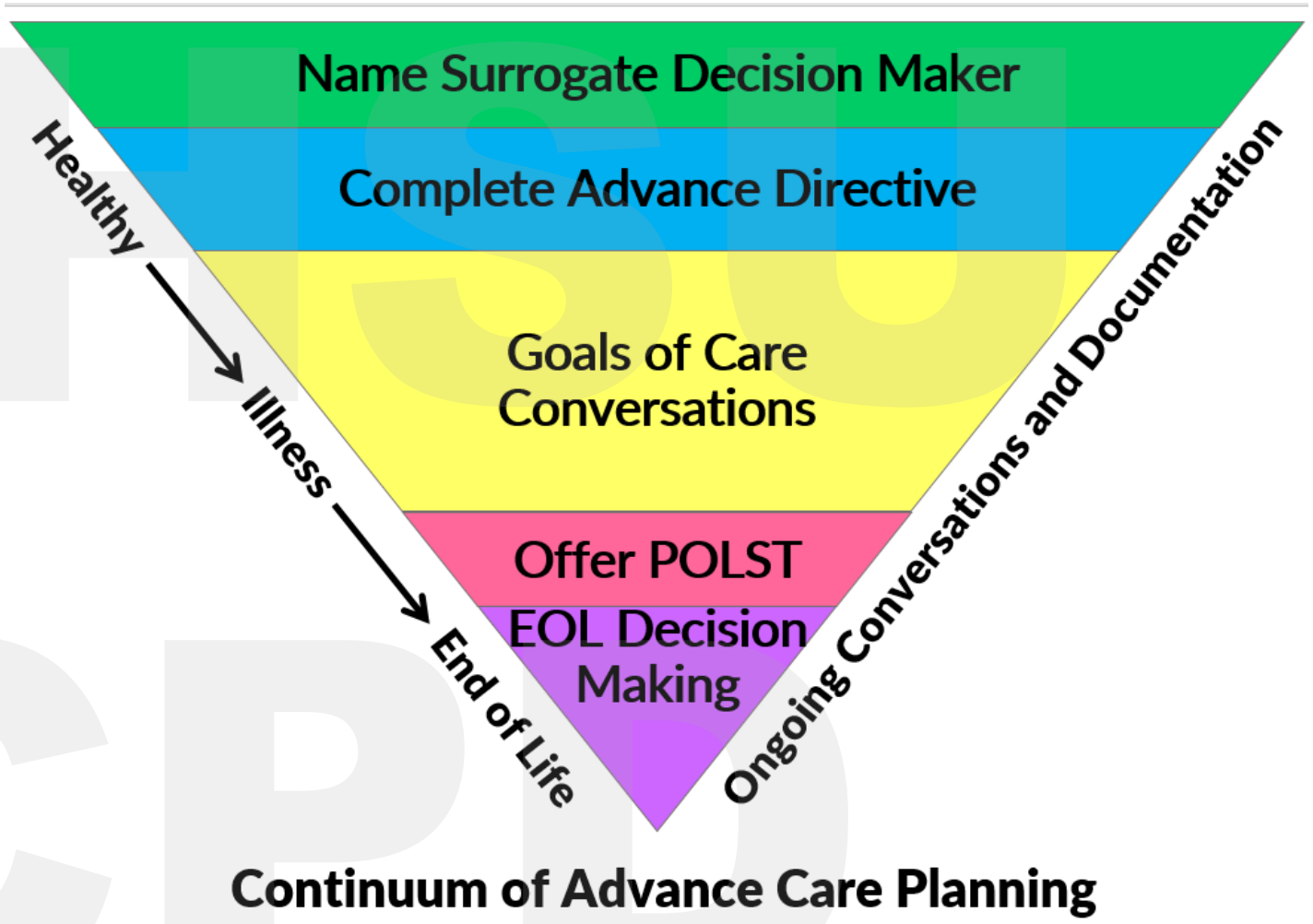
What is Advance Care Planning?

"Advance care planning is a **process** that supports adults at any age or stage of health in understanding and sharing their personal **values, life goals, and preferences** regarding future medical care.

The goal of advance care planning is to help ensure that people receive medical care that **is consistent with their values, goals and preferences** during serious and chronic illness."

(Sudore et al, 2017)

ACP can occur at anytime in a lifespan; from healthy people naming proxies in case of an unexpected injury to patients with a terminal diagnosis making end-of-life decisions.



Continuum of Advance Care Planning

Izumi & Fromme (2017) J Pall Med

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Why have ACP in Primary Care?

Primary Care Clinicians:

1. Can engage in conversation while a patient is stable and not in crisis.
2. Have a trusted, established relationship with patient.
3. Have ability to do ACP over several visits

**Advance care planning is reimbursable!*

Reflect

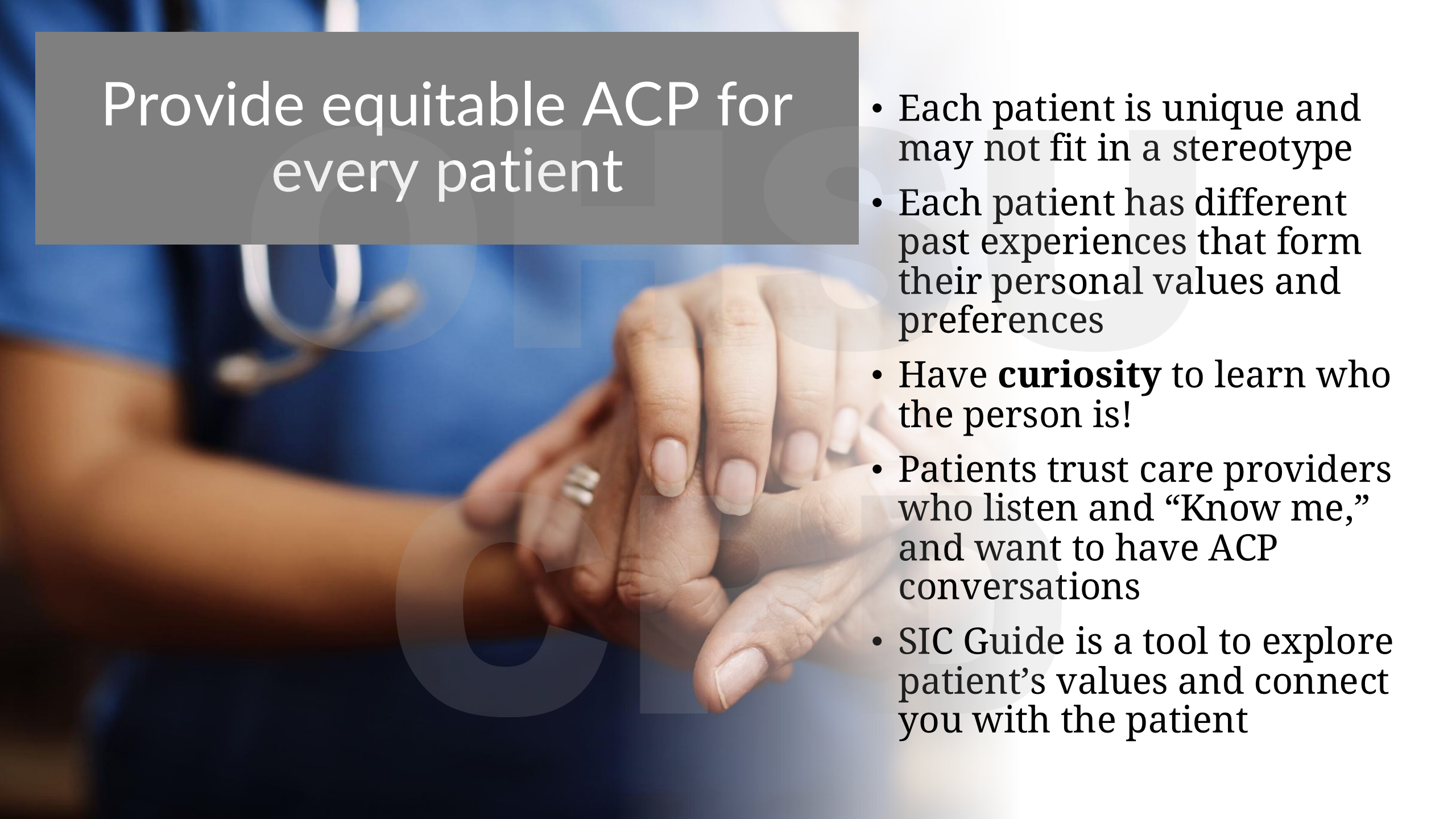
1. Which of your patients would benefit from advance care planning?

2. Think about a situation when communication about serious illness care goals (or lack of the communication)
had a positive or negative impact on one of your patients and their family.

Inclusive ACP

- 85.7% of clinicians find ACP conversations VERY challenging, *including with patients whose ethnicity is different than their own*
- People often not included in ACP: based on race and ethnicity but also socioeconomic status, language proficiency, religious belief, and sexual orientation or gender identity.
- Black, Latinos, Asians are <u>less likely to have an advance directive</u> → ***because ACP is not equally offered***

Preferences vary, person to person-- each patient is a unique individual



Provide equitable ACP for every patient

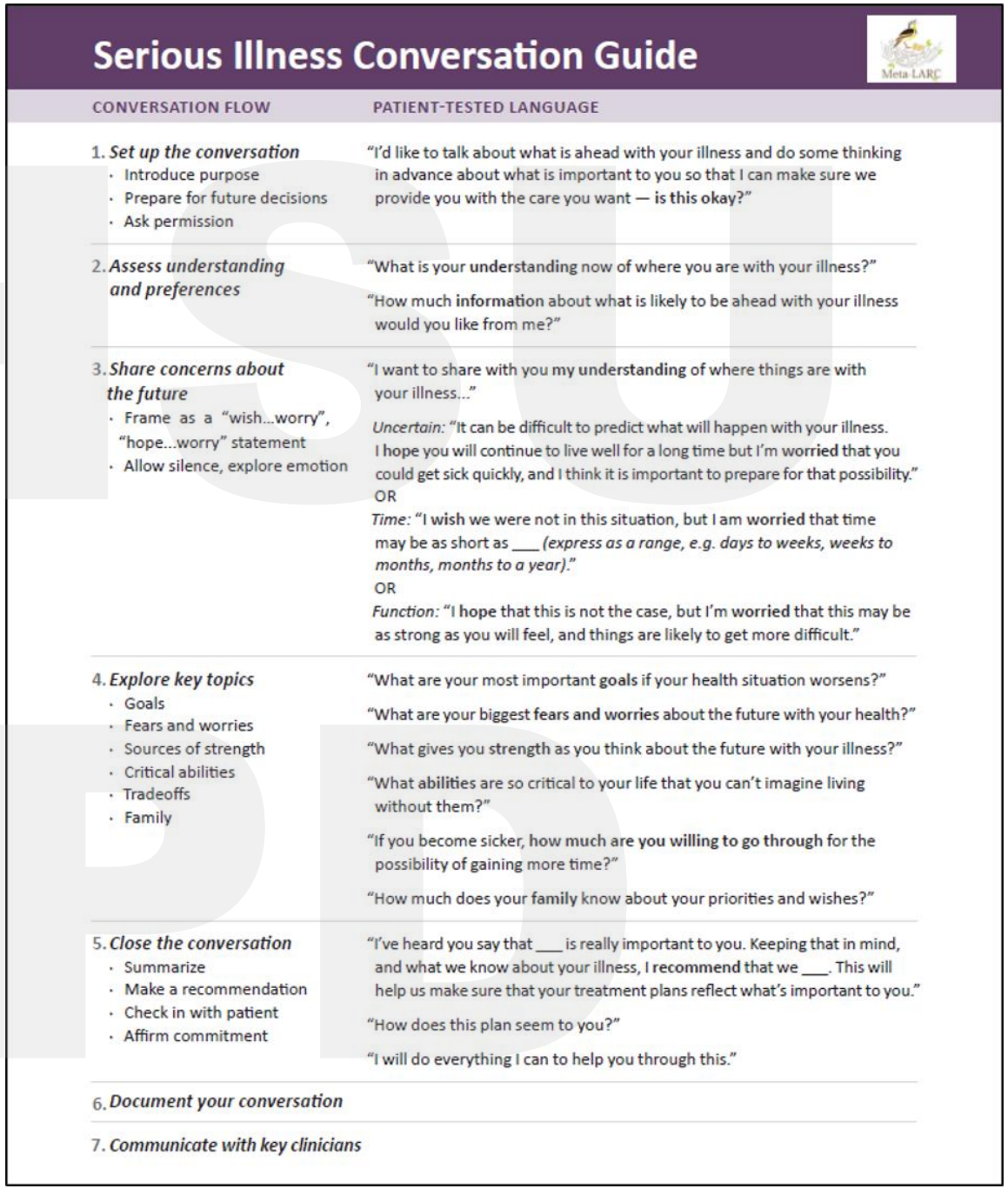
- Each patient is unique and may not fit in a stereotype
- Each patient has different past experiences that form their personal values and preferences
- Have **curiosity** to learn who the person is!
- Patients trust care providers who listen and “Know me,” and want to have ACP conversations
- SIC Guide is a tool to explore patient’s values and connect you with the patient

What is a Serious Illness Conversation?

A *dialogue* between a clinician and patient with serious illness that:

- Focuses on values, goals, and care preferences,
- Ideal to start early in the course of a serious illness,
- Provides a foundation for making specific decisions in the future,
- Should be reviewed and revised over time as a patient's condition and values may change.

Serious Illness Conversation Guide



Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. ***Set up the conversation*** · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. ***Assess understanding and preferences***	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. ***Share concerns about the future*** · Frame as a "wish...worry", "hope...worry" statement · Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness..." *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year).*" OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. ***Explore key topics*** · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. ***Close the conversation*** · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. ***Document your conversation***	
7. ***Communicate with key clinicians***	

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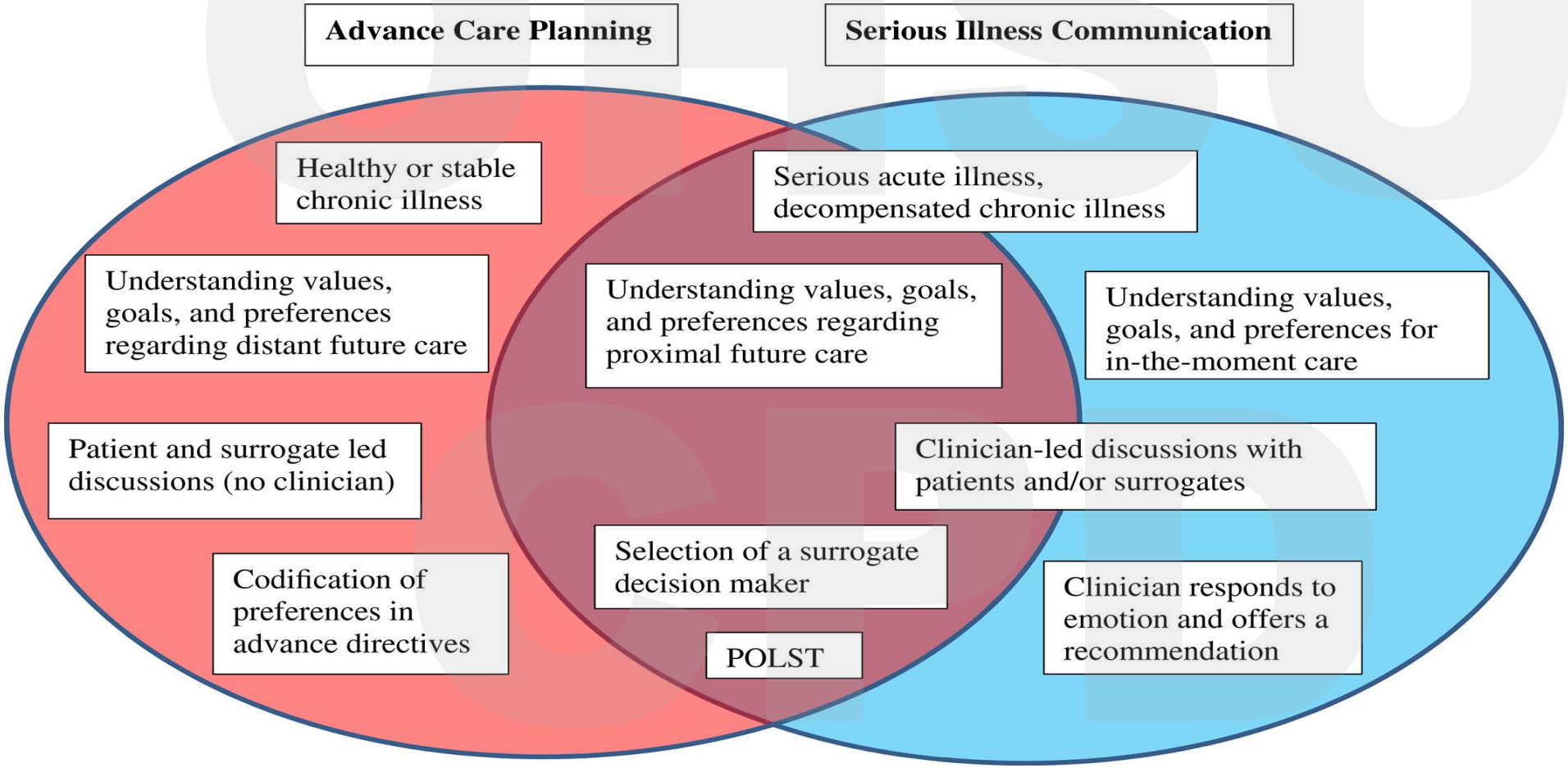
Should We Still Believe in Advance Care Planning?



J American Geriatrics Society, Volume: 70, Issue: 5, Pages: 1358-1360, First published: 07 March 2022, DOI: (10.1111/jgs.17727)

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ACP Communication Tips

- Acknowledge emotion
- Talk less, listen more
- Allow silence
- Ask permission
- Parking Lot

	Example	Notes
Tell me more	"Tell me more about…"	Use when you are not sure what someone is talking about (rather than jump to an assumption)
Ask-tell-ask	"What do you think about…" "Here's what the tests show" "Does that make sense…?"	Related to Assess-Knowledge-Respond in SPIKES. Think of this as one unit of information transfer
"I wish" statement	"I wish I could say that that the chemo always works."	Enables you to align with the patient while acknowledging the reality of the situation

Responding with empathy

The NURSE mnemonic

N - Name it

"...it sounds like you've been worried about what's going on..."

U - Understand the core message:

"...if I understand you correctly, you are worried about what to say to your family and how they will react..."

R - Respect /Reassurance at the right time:

"...I'm really impressed that you've continued to be independent ...".

S - Support:

"... would you like me to talk to your family about this..."

E - Explore:

"... I notice that you're upset, can you tell me what you're thinking?"

The NURSE mnemonic has been reproduced from Back A, Arnold R, Tulsky J. Mastering communication with seriously ill patients: balancing honesty with empathy and hope. Cambridge University Press; 2009 Mar 2.

Inclusive ACP: approaches

Patients are willing to engage in ACP and expect clinicians to initiate conversation

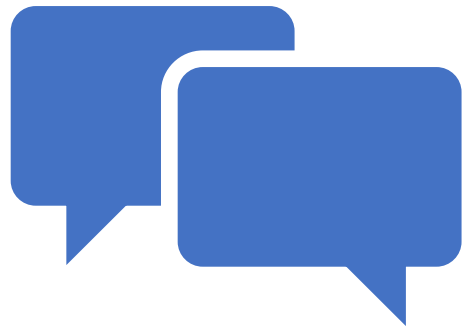
Approach each encounter with an equity lens and curiosity

Patient Dignity Question
“What do I need to know about you as a person to take the best care of you that I can?”

“Who else should be in the room as you make decisions about your future health care?”

Serious Illness Conversation: Observation

https://youtu.be/bu7V-k9tvL8



Role-Play

Non-judgmental approach. We are learning new skills; this is hard to do!

Confidentiality – what is said in the room, stays in the room

This is a safe place to practice

Everyone has something to learn

Feedback is expected and specific

Timeouts are allowed **ANYTIME** when you feel distressed or stuck

Timeouts can be allowed by ANYONE in the group

Debrief

What went well?

What was challenging?

What might you do differently?

What can you take back to your own practice today?

Recap tips for using the SICG and effective conversation

- Talk less, listen more
- NOT be afraid of silence
- Address emotions
- No need to solve problems
- **FOLLOW THE GUIDE!**
- If patient refuses or stops the conversation, that is OK

Challenging Statements

- I do not want to hear any “Negatives!”
- I don’t want to die!
- Do everything!
- Miracle will happen…
- I am a fighter.
- It is up to the god.

ACP Pilot Project findings

- Patients were overwhelmingly appreciative of the discussion, especially with a dedicated staff member, Lead RN
- Patients appreciated the depth and time spent in recording the conversation in their records at a time that was convenient to them
- Clinicians were equally appreciative of the time delegation to a trusted nurse who worked with them closely on the team
- More training with billing and around AD and POLST distinction was desired.

SWOT Analysis

- Successes
  - Interdisciplinary team creation with FM, SON, EBM leadership
  - Trained 28 faculty (MD, RN, PA, NP, SW)
  - Developed a sub grant to study residency trainees on SIC conversation- 35 trained
  - Worked with Institution collaboratively to develop a uniform documentation of ACP discussion in EMR
  - Dr. Onishi – instrumental in developing a SIC training for all medical students
- Weakness / Threats
  - ACP coordinator position was not able to be supported beyond grant cycle
- Opportunities
  - Distill the ACP coordinator role into RN care manager workflow in clinics
  - Initiate ACP billing processes in clinical encounters (RN + PCP)

Future directions

- Ongoing research by Dr. Onishi in training RN Care Managers in ACP conversations (Adventist)
- Rita and Alex-Hillman foundation grant awarded to Dr. Onishi who will be studying RN's lead in ACP conversations and billing in FQHC clinics
- ORPRN state level collaboration is being explored
- ECHO network training opportunity to be pursued
- Dr. Devarajan is training OHSU staff (all disciplines) with virtual SIC trainings

Documentation and ACP Billing Codes

ACP Billing codes - Key Points

99497 30 min (spend at least 16 minutes in ACP conversations)

99498 for each additional 30 min (spend at least 46 minutes)

Can be used by itself or with other CPT codes

Can be used as many times as needed

The patient may, or may not be present

Can be used in virtual/phone visits

- Time based; you can only include time directly engaged in goals of care discussion
- These codes are found in **Charge Capture, in the Wrap Up Activity**
- **<u>Must include some details:</u>**

"We discussed ACP, the patient shared important values and preferences for her: able to eat by herself, able to communicate with her loved ones. As long as these are possible, she is willing to try any medical treatments and procedures her care team recommends at this time.

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Congratulations!