Methods. To improve care delivery for our nation's Veterans, the Department of Veterans Affairs (VA) developed the Diffusion of Excellence Initiative to identify and spread practices developed through quality improvement methods. One such practice is Advance Care Planning via Group Visits (ACP-GV), which uses an interactive and patient-centered group session to engage Veterans in thinking about and planning for future medical decisions. In these sessions, social workers, or other health professionals, facilitate discussions for Veterans and their trusted others. Facilitators emphasize that while completing an advance directive is voluntary, it increases the chance that their care aligns with their wishes and values and relieves trusted others of having to make these difficult decisions. In addition, ACP-GV increases the effectiveness of advance care planning through allowing Veterans to discuss and process these complex topics with other Veterans in a group session.

Results. To date, 34 VA Medical Centers (VAMCs) have adopted the ACP-GV practice and more than 10,250 Veterans have attended ACP-GV sessions. Of those participants, approximately 18-20% developed a new advance care directive within one month of the session, and 86% set a smart goal to take additional steps toward advance care planning. Continued rollout of this innovative practice to VAMCs across the nation is ongoing.

Conclusions and Implications. At the conclusion of the session, attendees will have practical guidance, techniques and tools for implementation of ACP discussions using group visits in integrated (VA) or fee-for-service (Medicare) outpatient settings.

It's Everyone's Business: Capturing the Conversation (QI712)

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Objectives

1. Describe an innovative way to increase goals of care communication between providers.
2. State the required components of goals of care discussions.

Background. Results of research studies show that clinicians typically avoid discussing goals of care (GoC) and prognoses with patients. However, in order for patients facing serious illness to receive the care they want that is consistent with their values and wishes, health care providers must be skilled at challenging conversations. Currently, the GoC documentation is variable between generalist providers leaving the Palliative Care clinicians unclear as to if the discussions took place or what was understood regarding quality of life goals. Because of this, a standardized GoC form was implemented in the EHR to help facilitate communication between clinicians that would be accessible for subsequent admissions and sudden changes in the patient's condition.

Aim Statement. The purpose of this quality improvement project is to improve communication, collaboration and decision making about GoC between clinicians, patients and family members.

Methods. The current standard of care is for clinicians to review GoC with patients upon admission and to document them in the GoC section of the EHR utilizing specific criteria. After an education session to all clinicians regarding the essential information to be included, GoC discussions were reviewed for all palliative care consults and rated as good, intermediate, or poor. Monthly standardized e-mail messages are sent to providers acknowledging good documentation as well as to offer assistance to improve discussion and documentation.

Results. Good GoC discussions increased by over 25% and patients with no GoC discussion decreased by over 20% during the initial study intervention. A secondary analysis of individual provider results is in progress.

Conclusions and Implications. Providing feedback to clinicians helped to improve GoC discussions and documentation in the EHR. Additional recognition as a GoC ambassador was sent to the managers of those clinicians who consistently performed at a high level. By educating providers regarding how to have difficult discussions surrounding GoC documentation increased leading to care that aligns with the patient's wishes.

Capturing Wishes: A Novel Approach to Goals of Care Documentation for Inpatient Palliative Care Consults (QI713)

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Objectives

1. Identify the need for improved goals of care documentation in the inpatient electronic medical record among patients seen by an inpatient palliative care service.
2. Articulate a strategy for improving goals of care documentation among patients seen by an inpatient palliative care service.

Background. Patients with life-threatening illness face critical decisions regarding goals of care (GOC) and treatment preferences (TP). Palliative Care (PC) consultants play a pivotal role in clarifying and documenting patients' wishes to ensure they receive goals-aligned care. However, inconsistencies in documentation of GOC/TP in the electronic medical record (EMR) can result in patients receiving interventions incongruent with their preferences. Among a baseline sample of patients seen by the University of California San Francisco (UCSF) PC service for GOC discussions in April and May 2017, only 63.3% had any goals documented in the EMR, and only 54.5% had both overall GOC (e.g., curative) and at least one specific TP specified in addition to code status (e.g., artificial nutrition, dialysis, etc). This quality improvement study examined the impact of an easily accessible, highly reproducible EMR note template on the consistency of GOC/TP documentation for patients seen by the UCSF PC service.

Aim Statement. This study aimed to increase documentation of GOC/TP among patients seen for GOC by the UCSF PC service from 54% to 80% with the use of a note template designed to integrate into the Advance Care Planning (ACP) problem in Epic.

Methods. Study authors designed an Epic note template to facilitate consistent documentation of GOC/TP. The PC service encouraged routine use of the dot phrase by all consulting PC physicians. Analysts assessed compliance at monthly intervals.

Results. Among 640 patients seen by the UCSF PC service between September 2017 and May 2018, 466 (72.8%) were seen for GOC. Of these, 461 patients (98.9%) had documentation of both overall GOC and at least one TP in their ACP problem in Epic.

Conclusions and Implications. Implementation of an EMR note template increased consistency and clarity of GOC/TP documentation for patients seen by the PC consult service.

Reducing Medication Errors in Home Hospice to Improve Patient Safety (QI714)

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Objectives

1. Reduce medication errors in the home hospice setting by focusing on performance improvement efforts in nurse practice and patient/caregiver practice.
2. Develop patient- and family-centered educational tools for safe medication practices in a home hospice setting.

Background. Gilchrist Hospice Care's average daily census is 433 in the home care setting, representing 49% of the total served. In FY15, our medication error rate was 0.61, with 55% in home care. A Medication Safety Team uncovered root causes and focused efforts on nurse centered medication reconciliation practices and patient/caregiver education.

Aim Statement. To reduce medication errors in home hospice service by 20% by FY18.

Methods. The Medication Safety Team includes our home care Medical Director, Clinical Nurse Specialist, and nurses from home care, triage, admissions, and after-hours teams. Using the IHI model, the team developed new educational tools for medication safety: Syringe Tool, Medication Record, PRN Medication Tracker. Feedback about the ease of use during a crisis to prevent medication errors was collected from patients, family caregivers, and clinicians. The Patient and Family Advisory Council consulted on the visual representation of the tools. A double check process was initiated in the new First Dose Protocol, providing families 24/7 access to our nurse help line. Our Medical Director trained nurses in polypharmacy, to improve crucial conversations about reducing the number of medications taken.

Results. The nurses and family members surveyed reported over 90% satisfaction with use of new education tools. The FY18 medication error rate is 0.34, representing a 44% decline over a three-year period. The errors in home care decreased 9% during the same period.

Conclusions and Implications. The new tools are integrated into the hospice Caregiver Handbook and provide cues about when to administer medications, how to safely check dosing, and provide clinicians a clear picture of medication usage between visits. The double check process in triage has led to countless 'great catches'. These simple improvements to nurse practice and patient education have made a lasting impact at the frontline of care to improve patient safety and overall caregiver confidence.

Nursing Telephonic Intervention to Reduce No-Show Rates for Outpatient Oncologic Palliative Care (QI715)

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Objectives

1. Illustrate the potential value of a nursing telephonic intervention to reduce no-show rates to an outpatient palliative care practice.
2. Identify care coordination needs of patients with serious illness that may be addressed through