Decreasing Barriers and Increasing Confidence: Ambulatory Advance Care Planning Internal Medicine Resident Curriculum (QI737)

Adi Shafir, MD, University of Pittsburgh Medical Center, Pittsburgh, PA. Dio Kavalieratos, PhD, University of Pittsburgh, Pittsburgh, PA. Jane Schell, MD, University of Pittsburgh, Pittsburgh, PA. Julie Childers, MD MS FAAHPM, University of Pittsburgh, Pittsburgh, PA.

Objectives

1. Employ REMAP as a framework for teaching ambulatory ACP to learners.
2. Illustrate innovative teaching methods including use of drills and 'homework' to reinforce learning.
3. Identify barriers and opportunities to ambulatory ACP completion by residents and physicians in general.

Background. Patients are eager to participate in advance care planning (ACP) discussions, but there are numerous physician barriers to outpatient discussions. Education in overcoming these barriers are rare in residency programs.

Aim Statement. Reduce perceived barriers to ACP and increase resident willingness and confidence to have ACP conversations in the clinic.

Methods. Second and third year internal medicine residents participated in two 3-hour sessions during an ambulatory care rotation. The first session presented information about ACP; a conversation framework using the acronym REMAP (Raise the issue, respond to Emotion, Map patient values, Affirm the patient, and propose a Plan); drills practicing using REMAP, and documentation in the electronic medical record. Residents were asked to discuss ACP with a clinic patient in between sessions, and write down how the conversation went. During the second session, residents practiced ambulatory ACP skills using a simulated patient, and debriefed the homework. A pre-survey was completed by participants before the curriculum, and a post-survey was completed immediately after, ranking confidence and barriers on a 5-point Likert scale.

Results. 54 residents completed the pre-survey, and 50 completed the post-survey. Pre-post intervention medians were compared using Wilcoxon-Mann-Whitney U tests due to non-normal data. After completion of the curriculum, residents felt more confident bringing up ACP ($p<0.001$), discussing choosing a surrogate decision-maker ($p<0.001$), were more willing to bring up ACP ($p=0.007$), and felt it was more important to bring up ACP ($p=0.002$). Notably they no longer felt time was a barrier to discussing ACP ($p<0.001$), and no longer felt uncomfortable initiating the discussion ($p=0.049$).

Conclusions and Implications. An ambulatory ACP curriculum that includes a structured conversation framework and opportunities to practice with simulated patients is effective in improving resident confidence and willingness to complete ACP and help patients identify a surrogate decision maker. Future research will evaluate whether education leads to improvement in completion of AD.

Redundancy or Value-Added? Ethics Consults in Hospitalized Patients with Palliative Medicine Involvement (QI738)

JoAnna Slobodnjak, MD, Maine Medical Center, Portland, ME. Frank Chessa, PhD, Maine Medical Center, Portland, ME. Rebecca Hutchinson, MD MPH, Maine Medical Center, Portland, ME.

Objectives

1. Describe services typically provided by clinical ethics services and the ways in which these overlap with reasons for palliative medicine consults.
2. Discuss ways in which incorporation of ethical principles in palliative medicine notes and recommendations may provide additional reassurance to primary teams.

Background. Many academic medical centers have both palliative medicine (PM) and clinical ethics teams; there is overlap in the services provided by these teams.

Aim Statement. We sought to better understand what services are provided by clinical ethics consultations not currently offered by PM.

Methods. We performed a retrospective chart review on all patients seen by both PM and clinical ethics during a single admission over a two-year period. Assessment and recommendations from clinical ethics notes were abstracted verbatim. Two members of the study team used MAXQDA software to independently code themes present in the clinical ethic notes; they met to discuss and reach consensus on codes.

Results. We identified 84 patients seen by both palliative medicine and clinical ethics during a single admission over a two-year period. The three most common issues addressed by the ethics consult were goals of care, medical surrogacy, and providing support. Specific issues relating to goals of care included: patients refusing medical treatment or wanting to return home, code status discrepancies, and concerns around withdrawing or continuing life-sustaining treatment. Surrogacy issues addressed included: assistance with identifying an appropriate surrogate, concerns about the surrogate, decision making when no surrogate is available, and guardianship. There was specific language regarding legal or ethical recommendations in 32/84 patients (38%). We observed frequent explicit use of ethical principles in ethics notes, such as

autonomy and beneficence, which were not included in PM notes.

Conclusions and Implications. We noted that many of the services provided by clinical ethics are similar to those offered by PM including assistance with goals of care conversations and advice regarding surrogacy. However, use of language such as "ethically permissible" or "legally permissible," accompanied by moral reasoning, may be delivering additional reassurance to medical teams not currently provided by PM. PM clinicians may be able to further assist primary teams by using ethical reasoning in their assessments and recommendations.

Development and Implementation of a Patient-Centered Tool for the Assessment of an In-Patient Palliative Care Team (QI739)

Ana Marija Sola, BA BS, University of California, San Francisco School of Medicine, San Francisco, CA. Alejandro Perez, BS, University of California, San Francisco, San Francisco, CA. Sirisha Narayana, MD, University of California, San Francisco, San Francisco, CA. Teri Rose, BA, Braddock Family Foundation, Walnut Creek, CA. David O'Riordan, PhD MPH, University of California, San Francisco, San Francisco, CA. Giovanni Elia, MD FAAHPM, University of California, San Francisco, San Francisco, CA.

Objectives

1. Identify primary issues for patients' satisfaction with an inpatient Palliative Care team.
2. Describe areas for improvement for the palliative care team's operation and composition as identified by patients receiving care.
3. Recognize the use of Lean A3 process to improve the administration and refine the content of a survey tool.

Background. Patient feedback is an important part of evidence-based, high value care. We wanted to develop a tool for more rigorous assessment of Palliative Care Services (PCS) at our institution.

Aim Statement. Design and implement a protocol, using a standard Lean A3 problem-solving approach, for collecting inpatient feedback on Palliative Care (PC) team performance.

Methods. Eligible inpatients receiving PCS at our institution were approached in person over a 9-month period, to complete a semi-structured interview regarding their experience of care. The survey tool included Likert scale-based and open-ended questions. We examined characteristics of all patients meeting eligibility criteria and thematically reviewed responses from patient interviews. Lean A3 methods were applied to plan and improve the process.

Results. Of the 74 eligible patients, 21 completed the interview. Major themes included: Felt understood (excellent/good: 95%); communicating plans (excellent/good: 80%), effectively respond to spiritual and religious needs (excellent/good: 75%), team availability (always: 65%), controlling/alleviating symptoms (excellent/good: 80%), sharing information about illness (excellent/good: 70%), likelihood to recommend PCS (very likely: 90%). The open-ended questions identified satisfaction with time spent with and clarification of issues by the PC team. Other common themes included the desire for increased cultural sensitivity and diversity of the PC team. We observed mixed responses about patients' previous or current understanding of PC and the PCS offered.

Conclusions and Implications. Patient's perception of team effort, active listening and strength of relationship with providers has a beneficial impact on the patient's experience of care. Areas for improvement were identified as team availability and sharing of information between providers and patients. Feedback regarding team diversity and previous misunderstandings of PC highlighted the need for continuing public education and re-assessment of the composition of the PC team at our institution. Lean A3 methods were helpful in planning and improving the survey process.

Caution! Unstable Patients Will Collapse Without Warning: Improving Advance Directive Completion for Patients with Chronic Obstructive Pulmonary Disease in an Urban, Safety-Net Hospital (QI740)

Amanda Stephens, MD, National Jewish Health, Denver, CO. Kathleen Bickel, MD MPhil MS, University of Colorado School of Medicine, Aurora, CO. Daniel Handel, MD, University of Colorado School of Medicine, Aurora, CO. Stefani Madison, MD, Stephenson Cancer Center, Oklahoma City, OK.

Objectives

1. Recognize the unique challenges to advance care planning discussions in patients with severe pulmonary disease.
2. Identify markers of poor prognosis in pulmonary disease through a novel advance care planning trigger.
3. Evaluate an intervention to increase advance care planning in the outpatient setting with severe pulmonary disease.

Background. Despite recommendations, advanced care planning (ACP) occurs infrequently in patients with COPD. A few studies describe rates of 11-15%, with scant information regarding methods to increase ACP in this population.

Aim Statement. Over six months, to increase advance directive (AD) completion by 10% in patients with COPD requiring outpatient subspecialty care.