AHS Improvement Way (AIW) Project Summary
Improving team processes for Advance Care Planning and Goals of Care Designations Calgary Zone

Define Opportunity

Background

Advance Care Planning (ACP) is a policy priority within Alberta Health Services (AHS) Patient First and People Strategies. In a complex healthcare system where many medical options are available it can be hard to know how to best care for each person. ACP and Goals of Care Designations (GCD) help the healthcare team make the right decisions and provide patient-centered care even in cases where patients cannot speak for themselves.

Problem Statement

Optimal ACP and GCD processes are not being fully utilized by healthcare teams.

Too few patients are aware of their own GCD order or of how ACP and GCD can help them receive care consistent with their own health priorities. A 2015 survey of 500 Alberta clinicians found that four out of the five most frequently perceived barriers for engaging in ACP GCD activities are in team process domains. As a result, patients are at risk of receiving care that they do not value, particularly when critically unwell and lacking capacity to communicate their wishes. HCP can suffer moral distress when a patient's own goals are unknown. There are also negative health economic consequences when resources are spent on care that does not reflect the person's goals. To address these issues, a demonstration team process improvement project was undertaken with heart failure patients from four clinical settings (family practice, outpatient, acute care, homecare) in Calgary Zone.

In September 2016, baseline was measured as follows:

	Acute Care Unit (%)	Family Practice (%)	Outpatient (%)	Homecare (%)
1. Tracking Record Use	0	0	34	13
2. Patients aware of GCD	17	75	69	50
3. Competing priorities as barrier	54	45	83	83
4. Role confusion as barrier	54	27	17	17

Goal Statement:
Within 3 months,
Increase 1 & 2 by 10%
Decrease 3 & 4 by 10%

Build Understanding

Each team participated in a mapping session, focusing on how ACP and GCD conversations occur and documents are used in that setting.

Maps Scope

Outpatient Specialized Clinic: New Patient Intake to Patient Discharge
Acute Care Unit: Admission and Discharge Process
Homecare: New Patient Flow, GCD Order Reconciliation and ACP GCD Patient Education

Family Practice Clinic: Post-Hospital Admission, Periodic Health Exam, Complex Care Visit, Visit to discuss GCD

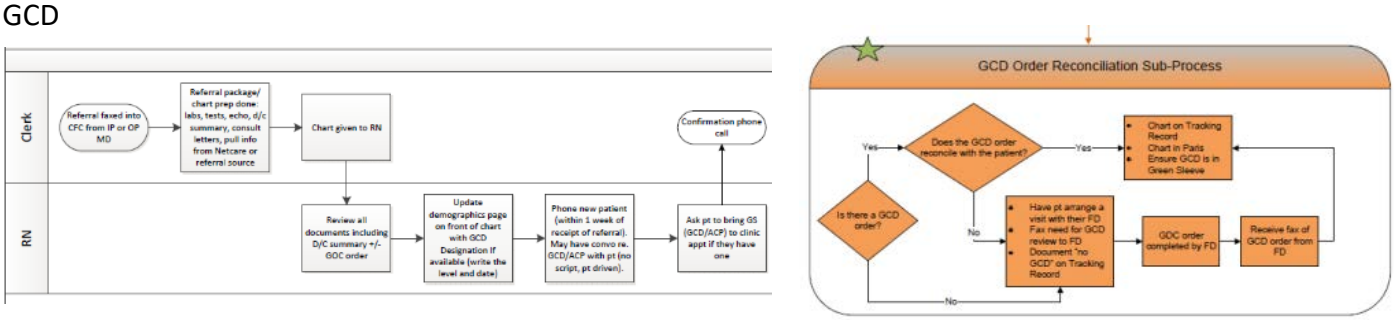


Figure 1. Sections of process maps from the specialized outpatient clinic and Family Practice Clinic

Data collection was conducted by the ACP CRIO Research Team through surveying health care providers, patients and auditing charts.

All teams identified actions for improvement around three themes:

- Process Triggers / Prompts
- Forms & IT Systems
- Role Clarity & HCP Knowledge and Ability

Manage Change

Figure 2. To manage change the four clinical teams partnered with four supporting teams: AHS AIW process improvement consultants, eSIM team function consultants, ACP GCD educators and ACP CRIO researchers.

Act to Improve

Improvement Selection & Implementation Plan:

Using Actions Tracking List and/or Gantt Chart, teams implemented:

1. Process Triggers / Prompts
    a. ACP GCD material visible and available in clinic / patient rooms
    b. All inpatients discharged with a green sleeve
    c. Systematic inquiry about prior ACP GCD during pre-visit phone calls by out-patient clinic RN
    d. Green sleeves in homecare new client package
    e. Using AHS videos about GCD for client education in homecare
2. Forms & IT System
    a. Demographic form updated with ACP GCD checkbox (out-patient clinic)
    b. Electronic Medical Records ACP GCD rule and template (family practice clinic)
    c. Screensaver instructions to help find tracking record (in-patient unit)
3. Knowledge & Ability for HCP to Engage Conversations about ACP GCD, education on:
    a. Goals of Care conversation, clarification, determination
    b. Change in Goals of Care status / designation
    c. Goals of Care conversations, making the conversation "OK", normalizing
    d. Having a GCD conversation when the client is not ready
    e. Dealing with Goals of Care discrepancies

	Acute Care Unit (%)	Family Practice (%)	Outpatient (%)	Homecare (%)
1. Tracking Record Use	6	2	64	42
2. Patients aware of GCD	34	60	79	42
3. Competing priorities as barrier	69	67	75	50
4. Role confusion as barrier	31	17	0	50

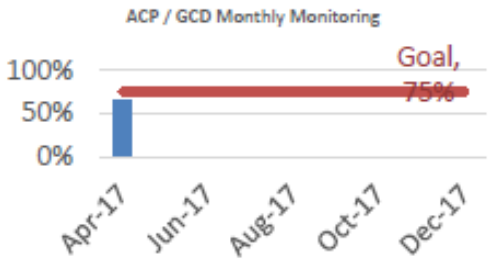
50% goals achieved

Sustain Results

Reinforce Ownership, Measurement & Continuous Improvement:

Monitoring

Acute Care: SCM tracking record utilization dashboard
Outpatient: Manual count of tracking record/month for new patient
Homecare: #GCD Dashboard of Paris Data
Family Practice: Stats per physicians on ACP GCD rule management



Education

- ACP GCD material in new staff orientation manual
- Patient education session on ACP GCD (out-patient clinic)
- Bi-annual refreshers course for Home Care

Share Learnings

Lessons Learned:

- Conversations are shorter than what we think – Measured <8 min
- Conversations are easier when patient is stable/non-crisis time
- Improvements more visible in single provider settings, takes longer to see it in multidisciplinary teams
- With increased awareness of the need to have conversations competing priorities were perceived as more a barrier.
- The same type of actions were identified by the 4 different settings
- Project duration was too short to see improvements in all outcome measures
  Recommendation: Start with process measures (These shows improvement within 3 months)

Outstanding Challenges:

- Increasing ACP and GCD conversations as clinical/organizational priorities
- Fragmented Health Care Record / EMR between sectors
- Interdisciplinary Team Expectations e.g. changing physician behavior to document on the ACP GCD tracking record.