PROJECT PROFILE

# Contra Costa Health Services

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| **Partner service line** | Department of Family and Adult Medicine |
| **Target audience** | Primary care providers |
| **Target population** | Seriously ill and older adults |
| **Palliative care process** | Advance care planning (ACP) |
| **Target behavior** | Increase ACP skills and documentation for a pilot group of 20 primary care provider champions. |

## Training (provided to primary care pilot champions)

- **Internally developed palliative care training, part A.** A 75-minute training addressed three topics: (1) Why ACP is essential to optimal patient care, (2) how to introduce ACP to a non–seriously ill patient, and (3) introduction to the new primary care workflow for ACP documentation.
- **Internally developed palliative care training, part B.** A 75-minute training addressed three topics: (1) How to approach ACP from a culturally aware perspective, (2) leading an in-depth goals of care conversation with the more seriously ill patient, and (3) review of the primary care ACP documentation workflow. This training also introduced Ariadne Labs' *Serious Illness Conversation Guide* and documentation process.
- **Center to Advance Palliative Care (CAPC) education modules.** Primary care champions were encouraged to use the CAPC self-study modules as an additional palliative care education resource.

## Identification (patient target population)

- **Older primary care patients.** The project target population was primary care patients age 60 and older assigned to a provider participating in the pilot.

## Documentation

- **Epic care gaps ACP reminder.** Primary care providers (PCPs) receive an ACP reminder on their Epic electronic health record care gaps dashboard, the tool used by PCPs to track a range of essential services. The reminder prompts the user to click on a speed button that creates an ACP note and encourages the provider to connect to the ACP navigator section in Epic, where they can document the patient's health care surrogate, or access the *Serious Illness Conversation Guide*.

## Lessons Learned

### CHALLENGES

- **Ensuring role-playing and group discussion opportunities in the online training.** Because of COVID-19, the project team revised the ACP training from in-person to virtual format, which presented challenges for role-playing and group discussions. The team addressed both by using a script of different ACP conversations modeled on online training from VitalTalk.

- **Integrating a new ACP workflow for primary care providers to support effective communication with patients while minimizing documentation burdens.** With help from the pilot primary care provider champions and information technology (IT) champion, the team addressed the ACP workflow challenge by developing a care gaps reminder on the primary care providers' dashboard in Epic.

### KEY INGREDIENTS AND TAKEAWAYS

- **Ensure the activity benefits the partner service line.** At the start of the project, the team surveyed primary care providers and learned that while some were having ACP conversations with their seriously ill patients, many more were not. They also found that many were interested in and open to having ACP conversations with patients but lacked the time, skills, training, and tools to conduct them effectively. The team responded by engaging a small group of primary care champions interested in ACP and motivated to participate in the pilot. The project team solicited pilot participants' input on Epic tools and workflows, valued their time (provided a stipend), and encouraged small wins, such as introducing ACP conversations and building from there. Pilot champions outperformed their nonpilot primary care provider counterparts in ACP activity.

- **Align with administrative goals.** The pilot project experience contributed to the selection of an optional ACP measure as a Quality Improvement Project (QIP) measure for Contra Costa Health Systems. The project team collaborated with the QIP team and IT staff to make sure that all ACP activity was effectively captured and documented in Epic to ensure appropriate tracking. Ongoing monitoring will be done under the QIP initiative.

### PROJECT LEAD TAKEAWAYS

- **Palliative care lead.** "I think the thing that has surprised me about the project overall is that a lot of our primary care doctors really care about this work, and some of them were already doing it really, really well. There were some superstars, but I think they were completely disconnected from what anyone else was doing, and there was zero guidance or standardization through the system. Our project addressed both of these issues."

- **Service line lead.** "It's always busy in a primary care clinic. Patients are coming at you with four and five big complaints, so time is always an issue. I knew that before going in to convince primary care providers to do yet another thing and embark upon a very serious conversation, we had to focus on how to have them change practice efficiently, with an integrated workflow that allows them to document in a way that isn't cumbersome."

## Measures and Key Outcomes

- **Training completion rate.** 20 of 24 pilot providers (83%) completed training. Twenty-one pilot providers were active in the project period.
- **Surrogate identification.** In the first nine months following implementation, 60% of patients seen by the 21 pilot providers designated care agents, compared to only 40% of patients seen by the 163 nonpilot primary care providers.
- **ACP activity.** Compared to all other primary care providers, pilot providers had significantly more ACP activity, including any of the following: ACP note entered, ACP education provided, surrogate designated, filed ACP documents such as an advance directive.

**Table 1. ACP Activity for Pilot and Nonpilot Providers**

| | BASELINE (January 2021) | | POSTINTERVENTION (September 2021) | |
|---|---|---|---|---|
| | Number of ACP Activities | Number per PCP | Number of ACP Activities | Number per PCP |
| Pilot PCPs (*n* = 21) | 25 | 1.2 | 160 | 7.6 |
| Other PCPs (*n* = 163) | 90 | 0.6 | 240 | 1.6 |

### PROJECT TEAM

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| **Palliative care lead** | Julie Freedman, hospitalist and palliative care physician |
| **Primary care lead** | Haley Kirkpatrick, nurse practitioner, Antioch Health Center |
| **Team members** | Kimberly Butler, primary care physician<br>Jenny German, Epic analyst<br>Amy Gordon, primary care physician<br>Joan Hoffman, primary care physician<br>Troy Kaji, associate chief medical information officer<br>Amenah Moghaddam, family nurse practitioner |
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