

Harbor-UCLA Medical Center

Partner service line	Cardiology clinic
Target audience	Heart failure nurse practitioners (NPs) and social worker (SW)
Target population	Heart failure patients seen in the cardiology clinic
Palliative care process	Advance care planning (ACP) and goals of care discussions
Target behavior	Introduce ACP and goals of care discussions to all new heart failure clinic patients and document discussions.

Training (provided to heart failure NPs and SW)

- ▶ **Internally developed palliative care training.** Developed four one-hour didactic sessions addressing the following topics: Basics of ACP — benefits and barriers, how to have a serious illness conversation, how to document ACP / goals of care, and basics of hospice.
- ▶ **Internally developed advanced heart failure presentation.** Provided an additional training on the clinical aspects of advanced heart failure.
- ▶ **VitalTalk's Mastering Tough Conversations.** NPs and the SW completed this VitalTalk course on communication skills (delivering serious news, goals of care conversations).
- ▶ **As-needed palliative care consultations.** The palliative care team provided consultations to NPs and SW as needed and conducted mini-refreshers on several training topics.

Identification (patient target population)

- ▶ **Heart failure patients seen in cardiology clinic.** All heart failure patients followed in the cardiology clinic were deemed eligible for ACP support.

Documentation

- ▶ **Cerner ACP activity documentation.** NPs and SW documented ACP activity in the Cerner electronic health record (EHR) that included scanned advance directives or POLST (Physician Orders for Life-Sustaining Treatment) forms, identification of patients' surrogate decisionmaker, and documented goals of care discussions.
- ▶ **Internal log of ACP activity.** The project team kept a clinic log on patients introduced to ACP because the clinic EHR was not suited to generating reports that tracked the target behavior.

Lessons Learned

CHALLENGES

- ▶ **COVID-19 impacted the project in myriad ways but the most significant was the lack of face-to-face patient visits.** ACP is dependent on open communication and trust. These important conversations, already challenging, had to be done over the telephone during the pandemic. This can feel impersonal to some patients, reducing the likelihood that they will engage. The project team reviewed this challenge with the NPs and SW and encouraged them to continue reaching out to patients even if they chose not to engage.
- ▶ **Many patients were not ready to discuss ACP at clinic visits.** While ACP conversations were initiated with patients during clinic visits when possible, providers found many patients were not ready to engage. Some wanted to “continue to think about [ACP]” or preferred to prioritize other health and social issues more pressing to them. Project team reminded staff that just introducing ACP to patients is important.

KEY INGREDIENTS AND TAKEAWAYS

- ▶ **Ensure activity benefits partner service line.** The project team learned the value and effectiveness of targeting nonphysician providers for an ACP intervention. The team engaged heart failure NPs and a SW, a stable workforce interested in honing their ACP skills, to participate in the training. The project empowered the group to create a new standard of practice that involves introducing ACP to all new heart failure patients in the cardiology clinic, and as needed, to refer patients completing ACP documentation to the clinic SW for ongoing support.
- ▶ **Start small and build.** A chief lesson learned from the project was the importance of initiating and having the ACP conversation itself, even if it doesn't result in completing an advance directive. The project team helped the NPs and SW understand that ACP is an evolving process, not a single event.

PROJECT LEAD TAKEAWAYS

- ▶ **Palliative care lead.** “While our initial hope was to have patients with completed advance directives, we got to the place of realizing that just the act of introducing ACP to patients was a huge victory. The heart failure clinic went from essentially never discussing ACP to introducing this concept to all new patients.”
- ▶ **Service line lead.** “When we decided to focus on the nurse practitioners and the social worker, it was an incredibly smart move. They are the constant people here, day in day out, over months, over years. If we were to focus on residents, they unfortunately rotate out after a month. And we might not be able to get them for a good chunk of the month they are with us, so any training or experience that we would provide would be at best incomplete. And they would never be able to see the fruits of their labor.”

Measures and Key Outcomes

COMPLETION OF ACP DOCUMENTATION IN THE EHR

- ▶ The monthly ACP documentation rate (e.g., scanned advance directive or POLST form, documentation of surrogate decisionmaker, documented discussion on a “Goals of Care” note type in the EHR) increased from a preintervention rate of 6.3%, to 10.5% for months one through three postintervention, and to 13.1% for months four through six postintervention (Figure 1).

Figure 1. Heart Failure Clinic ACP Documentation Rate

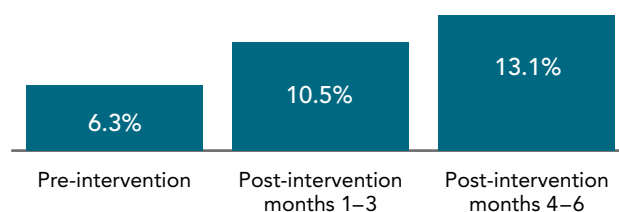


Table 1. Heart Failure Providers' Responses to the ACP Comfort Level Survey
(Score: 5-point Likert scale, 1 = "very uncomfortable" to 5 = "very comfortable")

	PRE-INTERVENTION n = 8 (mean)	POST-INTERVENTION n = 6 (mean)
Starting an advance care planning discussion with a patient	3.0	3.8
Eliciting a patient's understanding of their illness	3.8	4.2
Sharing prognostic information with a patient	3.4	3.5
Responding when a patient shows high level of emotion	3.4	3.6
Eliciting a patient's big-picture goals and values for future care	3.4	4.3
Making a recommendation about future care, based on elicited goals and values	3.4	4.3
Helping a patient to identify a surrogate decisionmaker	3.4	3.8
Completing a POLST form with a patient	3.3	3.3
Discussing an advance directive with a patient	3.0	3.0
Discussing hospice with a patient	2.9	3.5
Documenting an ACP discussion in the patient's medical record	3.1	3.8
Overall comfort having an ACP discussion with a patient	3.0	4.0

In addition, the proportion of providers that reported having "no ACP discussions" in the prior month fell from 63% preintervention to 33% postintervention.

PROJECT TEAM

Palliative care lead	Hope Cassano, director of palliative care
Cardiology lead	Robin Chand, cardiologist
Team members	Janine Acoba, heart failure nurse practitioner Orlando Balala, heart failure nurse practitioner Joan Cedeno, heart failure nurse practitioner Jill De La Cruz, heart failure nurse practitioner Claire Do, heart failure nurse practitioner Jennifer Galindo, heart failure nurse practitioner (lead) Sheryl Martinez, licensed clinical social worker Cheryl Trinh, heart failure nurse practitioner Katherine Ward, chief of general internal medicine
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