

Santa Clara Valley Medical Center

Partner service line	Renal nephrology clinic
Target audience	Nephrology physicians (MDs) and social workers (SWs)
Target population	Older patients (age 70 and older) with advanced chronic kidney disease (CKD) nearing dialysis within six months or on dialysis with declining health
Palliative care process	Advance care planning (ACP)
Target behavior	Provide tailored ACP and goals of care conversations and documentation to improve person-centered care in older patients with CKD.

Training (provided to nephrology MDs and SWs)

- ▶ **Internally developed didactic teaching session.** Chief of palliative care presented a session on advance care directives and POLST (Physician Orders for Life-Sustaining Treatment) for all nephrologists.
- ▶ **VitalTalk's Mastering Tough Conversations.** Two MDs and two SWs completed this course focused on communication skills (delivering serious news, goals of care conversations).
- ▶ **VitalTalk's Faculty Development.** One nephrologist and one palliative care team member completed VitalTalk's two-part train-the-trainer program to serve as VitalTalk communications skills trainers for other medical center staff.
- ▶ **Mentoring.** Chief of palliative care directly observed and provided feedback to renal clinicians engaged in serious illness conversations with CKD patients.

Identification (patient target population)

- ▶ **Elderly patients with advanced CKD.** Project team identified patients age 70 and older with advanced CKD nearing dialysis within six months or on dialysis with declining health as the target population. Serious illness conversations were also conducted with younger patients with advanced CKD at the discretion of the nephrologist.

Documentation

- ▶ **Electronic health record (EHR) ACP documentation.** Completed serious illness conversations were tracked by a shared list in the EHR; most were documented as "Goals of Care" notes in the EHR. Completed advance care directives and POLST forms were scanned into the EHR; patient code status and availability of these documents were highlighted on the patient's EHR face sheet.

Lessons Learned

CHALLENGES

- ▶ **COVID-19 presented significant project challenges.** Predialysis education courses (adapted from Alberta Health Services, Conservative Kidney Management) intended to be run as group classes were converted to one-on-one education sessions with the renal SW due to COVID-19. The new arrangement limited the number of patients able to receive this information and support. For patient and staff safety, in-person clinic visits were also limited, making it hard for staff to increase the number of serious illness conversations with patients. Many older patients with CKD were reluctant to come to the clinic during the pandemic and discuss ACP, given the turmoil of the pandemic. Despite these challenges, staff quickly adapted. They emailed patients ACP information in advance of their in-person meetings with the SW, and when possible, held goals of care conversations with the provider and family in a conference room, following infection prevention guidelines.
- ▶ **Bandwidth limits.** Team members were enthusiastic and dedicated to making the project successful but found it difficult to routinely make time to meet as a group, reevaluate goals, and review progress. Several team members were overwhelmed or stretched too thin to fill in patient care gaps due to COVID-19 and lack of staff. Regular meetings were set up on the calendar but due to schedule conflicts and other responsibilities were often canceled. In response, the team learned they needed to schedule regular check-ins and to delegate responsibility to accomplish project goals. They found the initiative's monthly mentor meetings helpful for keeping the team on track.

KEY INGREDIENTS AND TAKEAWAYS

- ▶ **Start small and build.** Instead of introducing ACP to patients in one session, the team opted to break the conversation into "micro conversations." By focusing on having small conversations with patients at each visit, providers were able to get to know their patients better, provide a process for them to discuss ACP at their own pace, and build on the conversations from one session to the next. In one session the provider might ask the patient if they had ever thought about identifying someone to make medical care and treatment decisions for them should they be unable to speak for themselves, and in the next they might ask if they had selected a surrogate decisionmaker.
- ▶ **Align with administrative goals.** The success of the project led to the development phase of a renal support clinic within the renal care center. The clinic would provide generalist palliative care services to patients with advanced chronic kidney disease who choose conservative care management. Ensuring these patients can participate in serious illness conversations and receive follow-up support, so they can identify realistic hopes and goals and avoid unnecessary hospitalizations, is consistent with the medical center's goals for this population.

PROJECT LEAD TAKEAWAYS

- ▶ **Palliative care lead.** "I was so impressed that the project team saw as many patients as they did and kept up the momentum. They kept going and pushing forward. It could easily have been just put aside and said, 'This is a project and is not a priority because we have so many other priorities and COVID's hit.' But they didn't. They just kept going and . . . and it was wonderful."
- ▶ **Service line lead.** "Along the way, we've all grown. We got more formal education [about ACP] and then experience. We used the tools, and when we came upon any hiccups, the chief of palliative care was there for us to bounce ideas off of. Periodically, we met as a group and discussed challenging cases. That's how we kept the momentum going. Sometimes it was emotionally draining, but as a group we're very cohesive and work very well together, so it was OK to make yourself vulnerable and to tell people where the challenges were without fear of being judged or [seen as] incompetent, you know?"

Measures and Key Outcomes

- ▶ Four out of five renal physicians and social workers completed VitalTalk’s Mastering Tough Conversations course.
- ▶ Renal providers had serious illness conversations with 57 patients with advanced CKD nearing dialysis or already on dialysis.
- ▶ Among the 57 patients who had serious illness conversations with their renal provider, only 0.5% already had an advance care directive on file.
- ▶ 58% of patients (33 of 57) were able to designate a surrogate medical decisionmaker and 26% (15 of 57) completed a POLST form.
- ▶ By the close of the project, 7 of 22 elderly patients who were deemed high priority had received individualized predialysis education that focused on prognosis, life on dialysis, and alternatives to dialysis. Two of 22 patients were offered education but declined the opportunity; 13 patients were in the process of being scheduled for education.

PROJECT TEAM

Palliative care lead	Nicky Quinlan, chief of palliative care
Nephrology lead	Rohini Arramreddy, nephrologist
Team members	Christine Bradshaw, nephrologist MaryCarmel King, medical social worker, renal care clinic Thi Ngo, program analyst Nhat Pham, nephrologist Jennifer Viesca, social worker, renal care clinic
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