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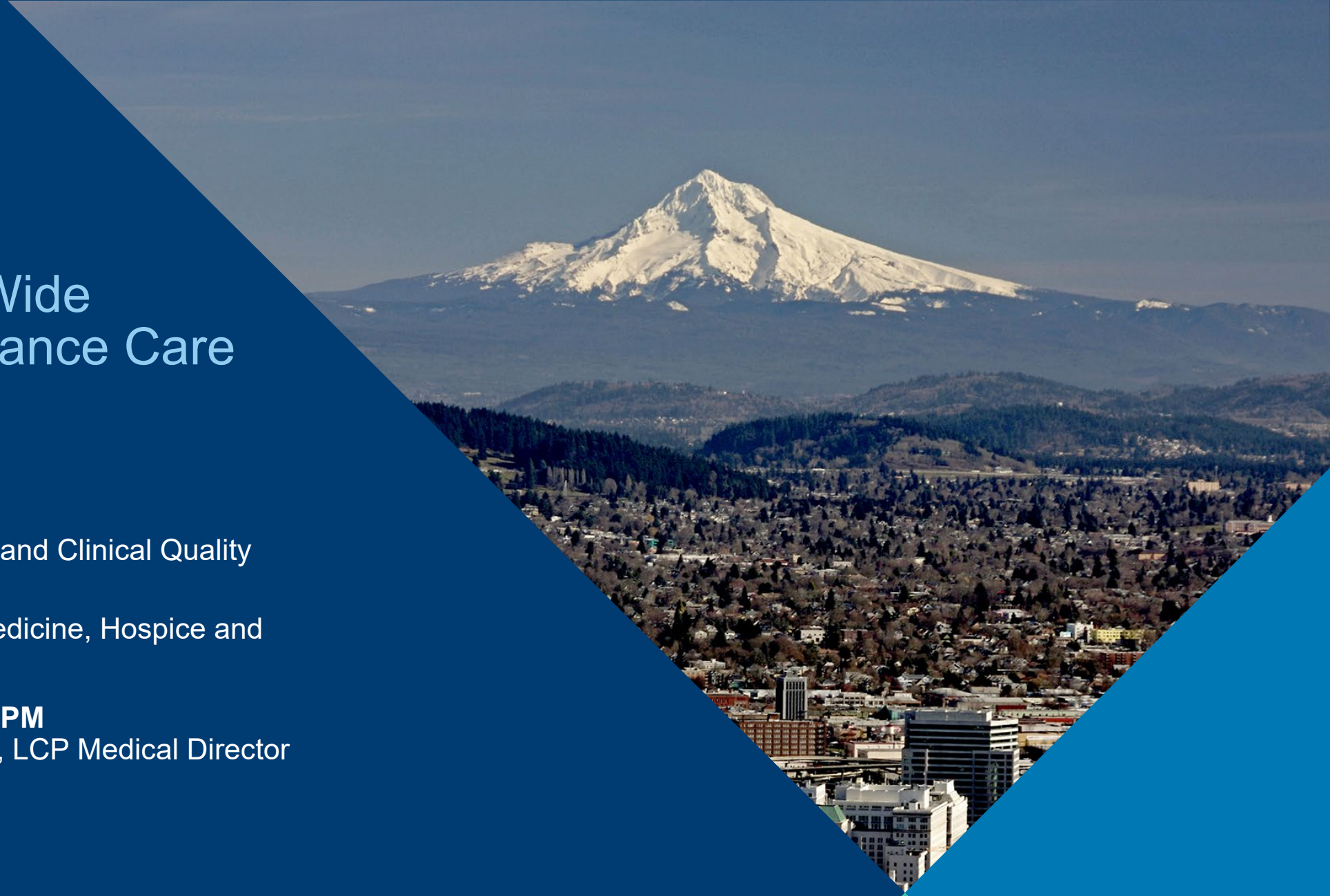

KPNW System Wide Approach to Advance Care Planning

Presenters:

Anna Scott, RN MSN CHPN
Manager, Life Care Planning and Clinical Quality

Cylia Amendolara, MBA
Practice Director, Hospital Medicine, Hospice and Palliative Care

Evgenia Krotova, MD FAAHPM
Palliative Medicine Physician, LCP Medical Director

Certified B Corporation

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Objectives:

1. Outline history of development of ACP/LCP initiative within KPNW

2. Share model of physician and staff training to enhance communication skills for conducting meaningful ACP conversations.

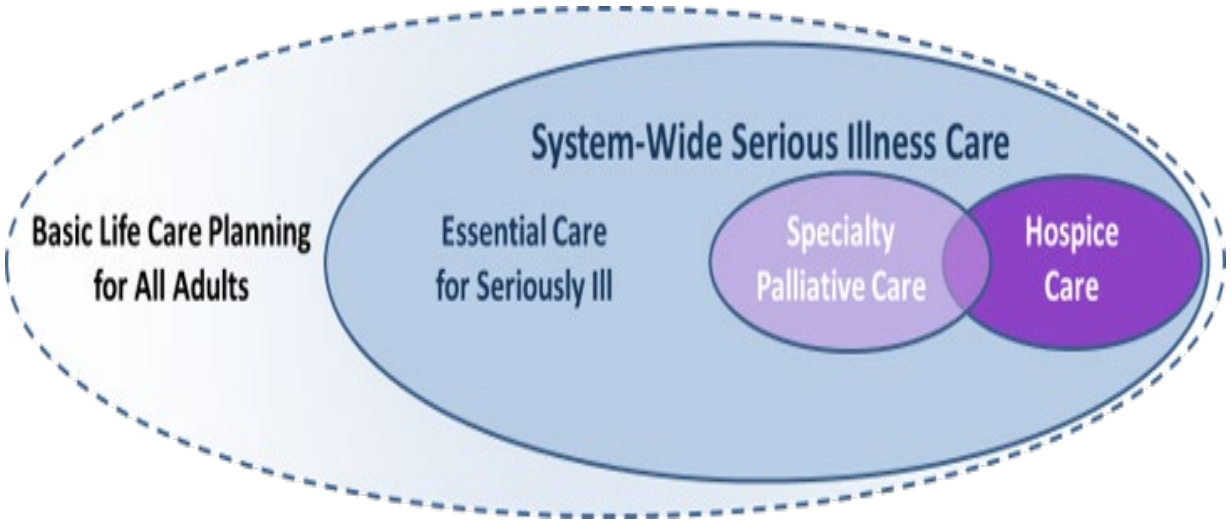
3. Describe systems design, stakeholder engagement, barriers, and tactics to advance ACP work within KPNW.

Imperative- meaningful advance care planning conversations

Point in the Journey	Healthy and living my life	Diagnosed with a serious illness	Serious illness has progressed	Advanced and end-of-life illness
Carol's Needs and Expectations	**I want to...** • Reflect upon and share **what's important** with my loved ones • **Document my wishes**, so that if something unexpected happens, my wishes are known and honored	• Receive a diagnosis in a **compassionate** manner. • **Understand my condition** and what to expect • Have my **pain, symptoms, or other needs known and addressed** • Know my **care is personalized and coordinated**	• **Access an extra layer of specialized support** for me and my family if/as my condition or needs become more complicated	• **Access hospice services** at the end of my life, if I choose, when my comfort is most important
What will enable KP to meet Carol's needs?	**Life Care Planning for Adults**	**Essential Care for Seriously Ill**	**Specialty Palliative Care**	**Hospice Care**

Paradigm – Dignified Journeys

- Systematic, enterprise approach to care for members with serious illness
- Layered approach to care delivery including: Advance Care Planning, Essential Care for Seriously Ill*, Specialty Palliative Care, and Hospice.
- Ultimate goal - enhancing patients' centered care and concordance of care delivered with patients' wishes .



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The near future - 2022 HEDIS Advance Care Planning Measure

First year measure

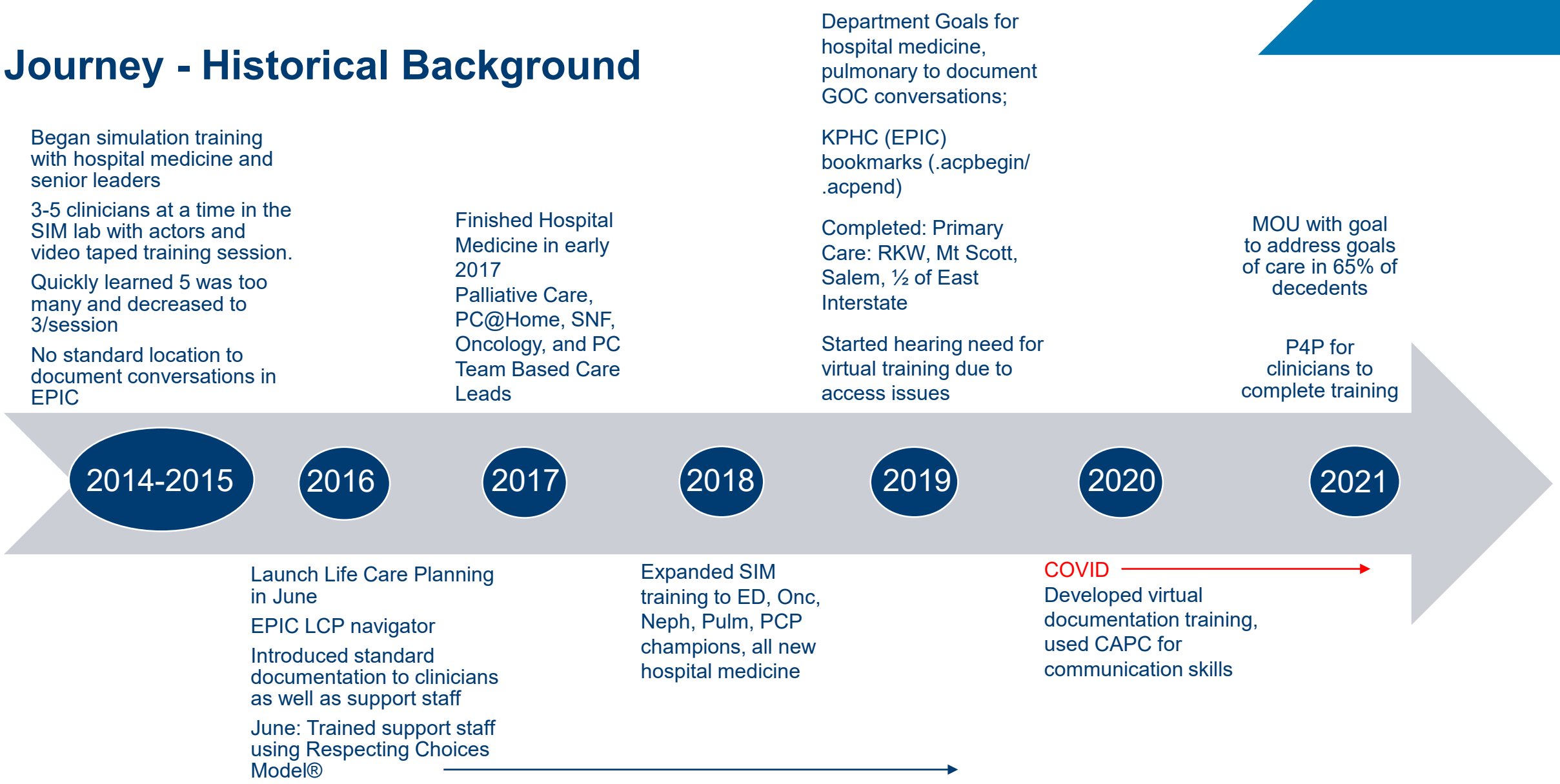
Description

- The percentage of adults 66-80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had an advance care planning conversation during the measurement year

Definition

- A discussion or documentation about preferences for resuscitation, life sustaining treatment and end of life care

Journey - Historical Background



Total clinicians trained in person simulation = 500+

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Intervention - Staff and Physician Training

There are many great resources available

- Respecting Choices®
- CAPC – Center to Advance Palliative Care
- Vital Talk
- Ariadne Labs
- Create your own

Intervention – Physician training

Training model at baseline:

- In person training SIM lab with actors and video taped training session
- 3-5 clinicians during one session
- Total yield 500 clinicians over 5 years

Scaling up during COVID:

- Go virtual, accessible to clinicians on their own time
- Use info already accessible (CAPC modules) and add homegrown materials (different patient care settings and documentation standards)
- Give resources for success (VitalTalk, Conversation guides, Symptom guides)
- Align and Incentivize via quality measures
- Total yield – 1280 clinicians in 1 year, 90% of our Medical Group

nwpuniversity.org

Apps | Conditional Format... | Find and compare i... | ZIP Code List for Or... | COVID-19 | Covid Trends | CCR - Documentati... | Work links | Imported From IE | Reading list

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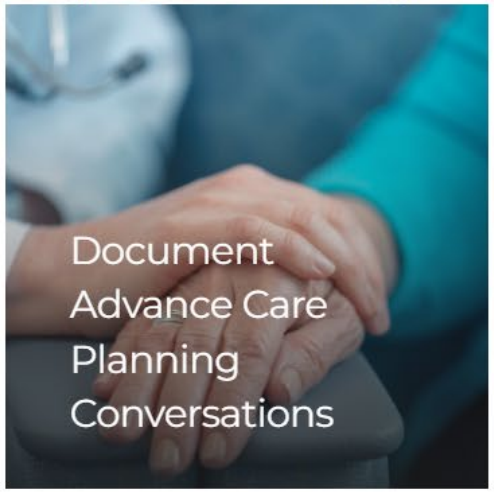
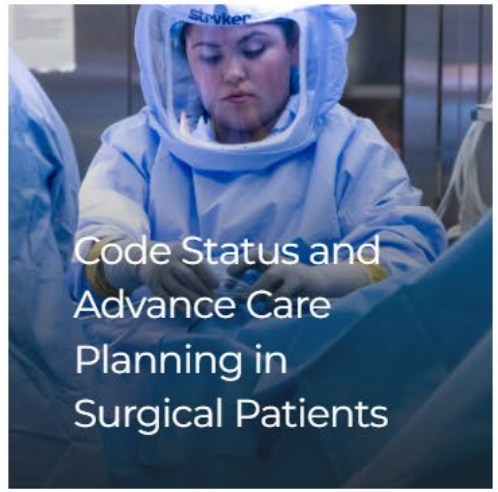
2021 Training Priorities

Belong@KP

Dignified Journeys



CAPC
Communication
Skills



Access and keep track of your training using the **2021 Training Priorities Checklist**.

nwpuniversity.org/resource-library/dignified-journeys/

Apps | Conditional Format... | Find and compare i... | ZIP Code List for Or... | COVID-19 | Covid Trends | CCR - Documentati... | Work links | Imported From IE | Reading list

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Dignified Journeys

Home · Resource Library

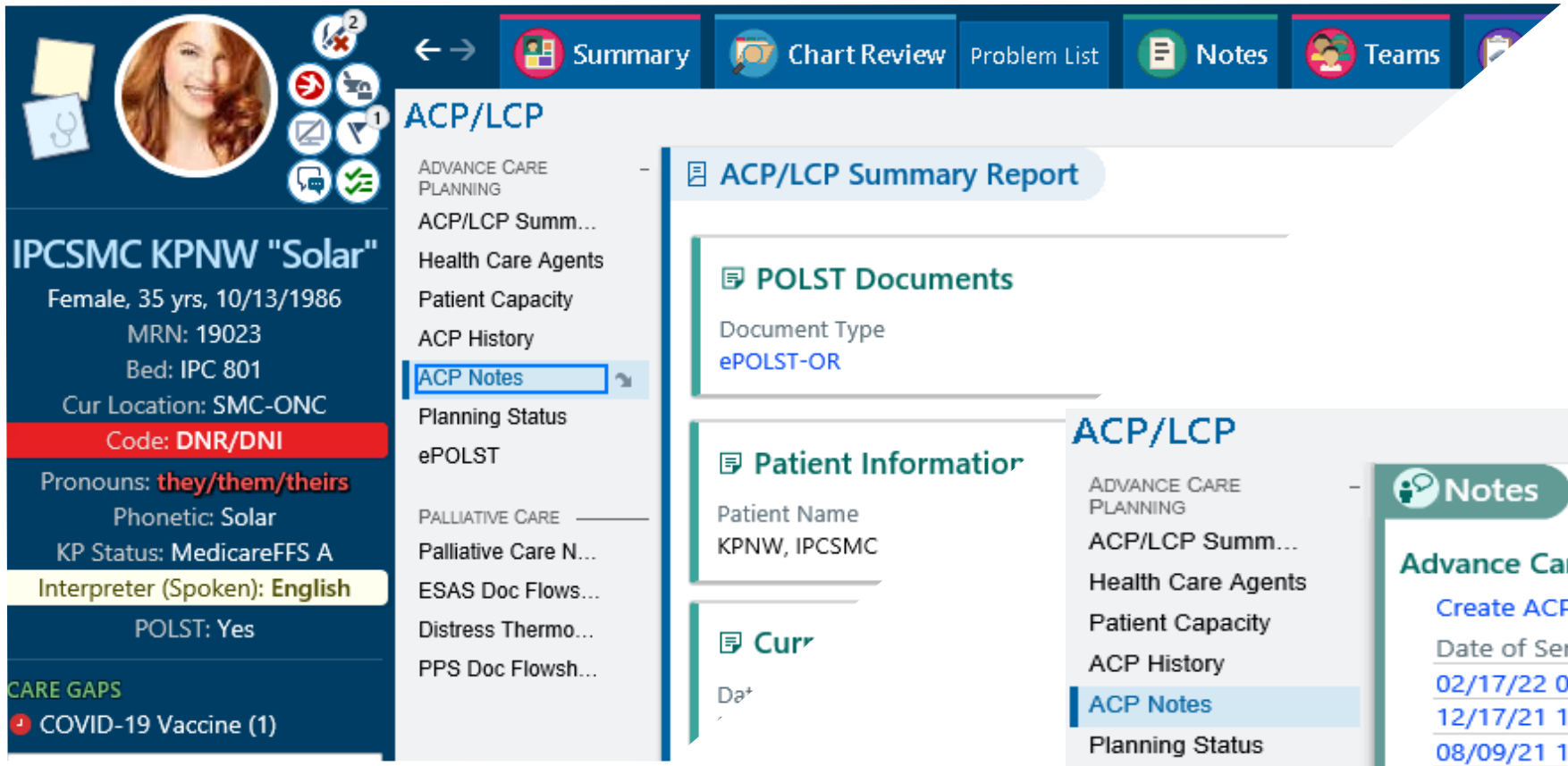
- Dignified Journeys Training Initiative
- Advance Care Planning Resources
- Surgical Code Status Resources

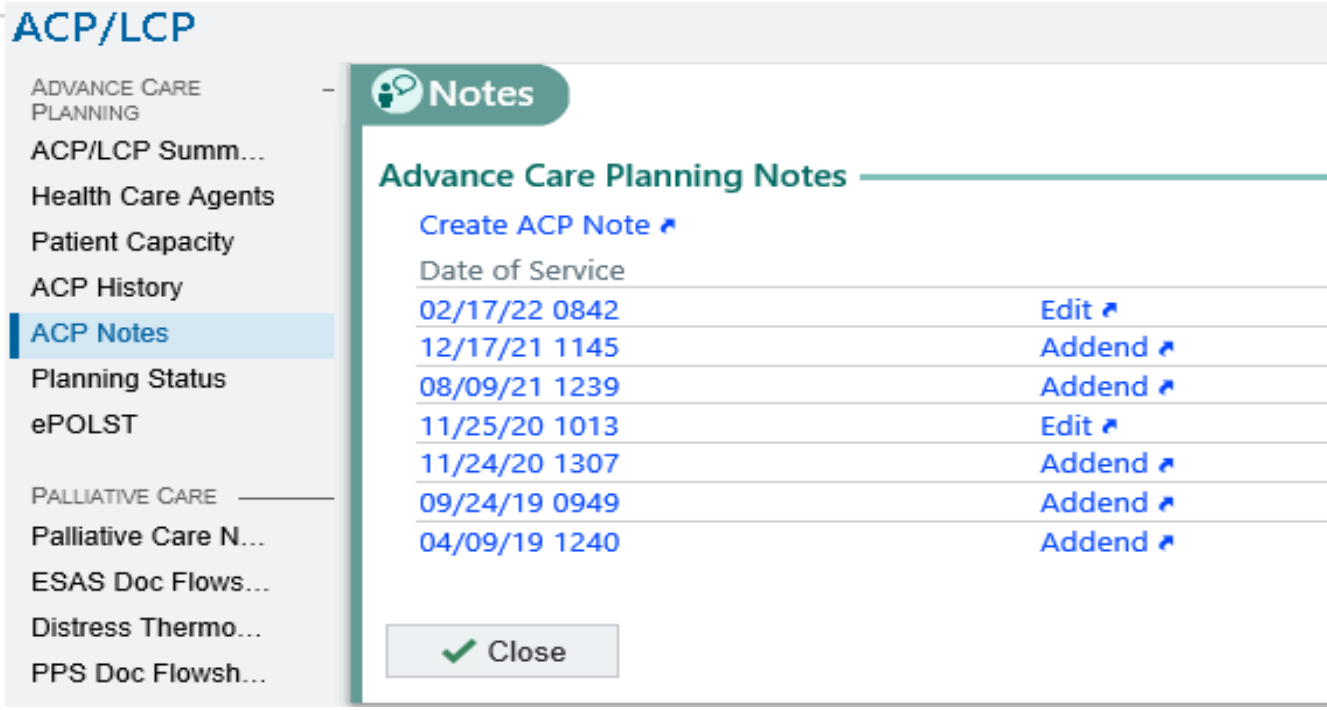
Dignified Journeys Training Initiative

> Physicians and other health professionals – even those with substantial experience caring for the seriously ill – commonly lack skills in eliciting the goals, preferences, and values of their patients in affectively tuning their care to align with those aims.
>
> **Dr. Atul Gawande, MD, MPH**

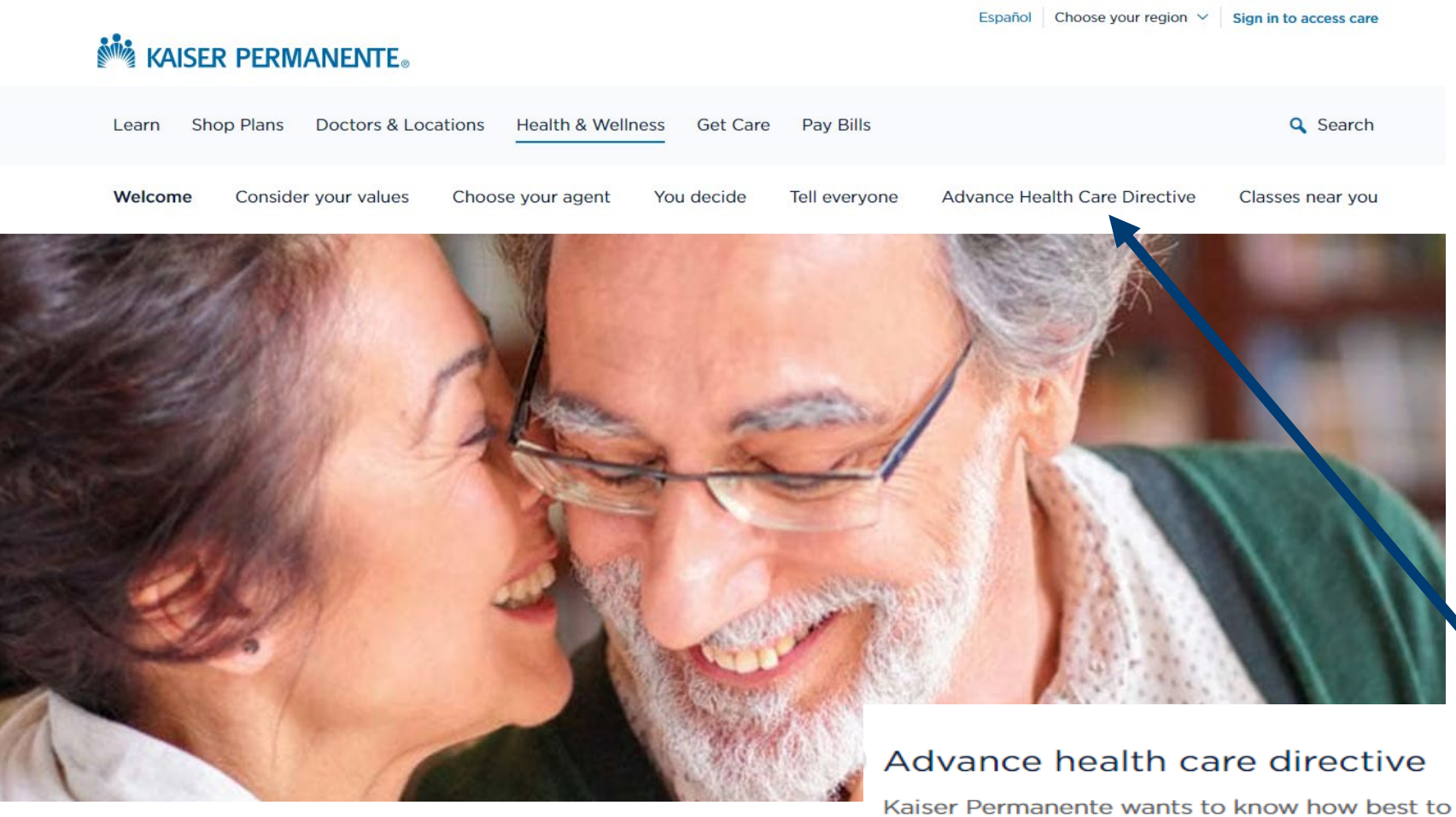
Dignified Journeys is a national KP Initiative aiming to integrate core elements of Life/Advance Care Planning

Nuts and bolts – ACP Navigator





Nuts and bolts – kp.org/lifecareplan



Advance health care directive

Kaiser Permanente wants to know how best to support you during this uncertain time. We want to know what is important to you should your health become affected. Planning in advance is helpful to you and your loved ones. One of the things you have control over is who would speak for you in the event you were not able to speak for yourself.

Download your Advance Health Care Directive form and get started.

Progress - Documentation of ACP/GOC conversations

- ACP notes placed in centralized easy to find location
- Can “plant the seed’ and monitor conversation over time.
- ACP note can be generated within any item of documentation via bookmarks.

High Quality Advanced Care Planning Note:

- Patient Attended: Yes
- Patent has capacity Yes
- Patient has intellectual or developmental disabilities? No
- Healthcare Representative/Agent in Attendance/Support Person no. Patient declined additional representative/support person.
- Who was the discussion with: Patient
- What are the patient's goals, values, fears, or concerns according to the patient, family or caregiver:
  - XXXXX says she's lived a long life and is ready to go if it's her time. Her son was murdered 37 years ago, and she looks forward to seeing him again, and is not afraid of dying. She just doesn't want to be scared or in pain.
- Discussed the following regarding their diagnosis, illness or trajectory of disease:
  - Possibility/likelihood of mass being cancer
- Patient, Family or Caregiver indicated: Understanding. She understands death is a part of life, and if this mass is cancer, she wouldn't want treatment and would want to let the disease take its course naturally.
- Recommended next steps include:
  - Consider hospice care pending further workup
- Code Status: DNR/DNI
  - This code status has changed: No
  - If the code status has changed, new status is: na
- Conversation took: 15-30 min

Admission from ED to HBI, new lung mass on CT

Impression [redacted] is a 89 yrs male with de novo castrate sensitive metastatic prostate cancer.
He has widespread bone metastases , pelvic lymphadenopathy up to 3.7 cm, and a prostate mass. PSA was 347 , no biopsy. He has a recent R arm fracture from a fall, has anemia presumed due to bone infiltration, and low performance status , ECOG 4. Other medical issues are significant including CAD, osteoporosis, diabetes, memory loss / possible mild dementia.

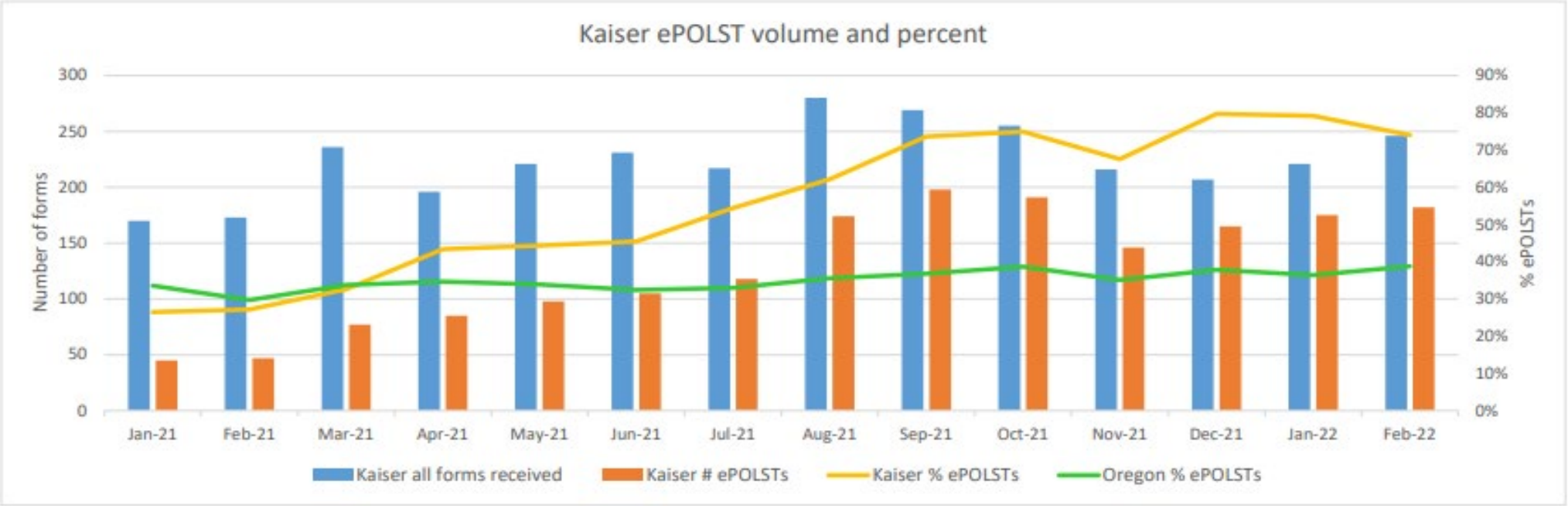
We discussed the natural history and treatment options for castrate sensitive metastatic prostate cancer. I told him without treatment his prognosis is likely < 6mos , but with basic androgen deprivation therapy perhaps a couple years depending on his other health issues. In his case considering the low performance status and age I recommend just androgen deprivation therapy. Usually that is effective and may provide significant palliation and even enable him to get stronger. He would like to have survival extending treatment , and hopes to be able walk outside again.

Plan:
- arrange leuprolide . Can stop bicalutamide 2 weeks after shot .

Progress - ePOLST

Implementation of ePOLST - Oregon introduced Dec 2020, Washington - Dec 2021

Oregon ePOSLT not registry ready rate decreased from 22% to as low as 3.9%.



Data provided from Oregon registry in monthly quality report

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Lessons learned - Challenges

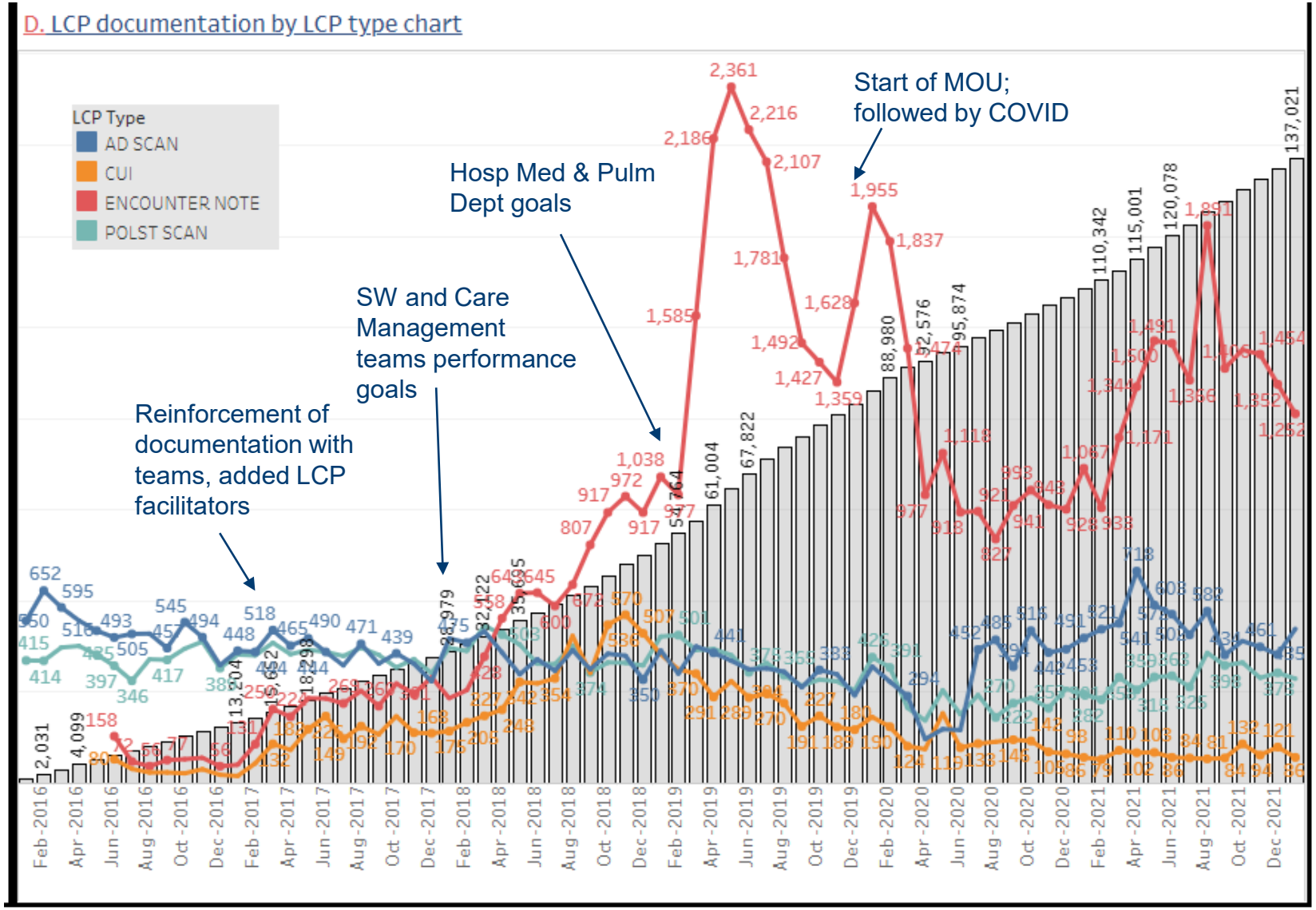
- COVID – competing priorities and urgent operational responses
- Ownership “It’s not my job to talk about this”
- Changes in leadership and reporting structures
- Making ACP training and documentation part of onboarding process/ departmental goals
- Signal to noise ratio in documented ACP/GOC conversations – need for quality control

Lessons Learned - Successes

- Getting buy in: ACP is everyone's responsibility – not just palliative care
- Communication – frank, safe, and honest feedback
- Normalizing the process – ACP/LCP is now part of onboarding/department goals
- Once engagement achieved – sustain it
- Monitoring and increasing accountability

How it started (2016)

How it is going (2022)



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Appendix

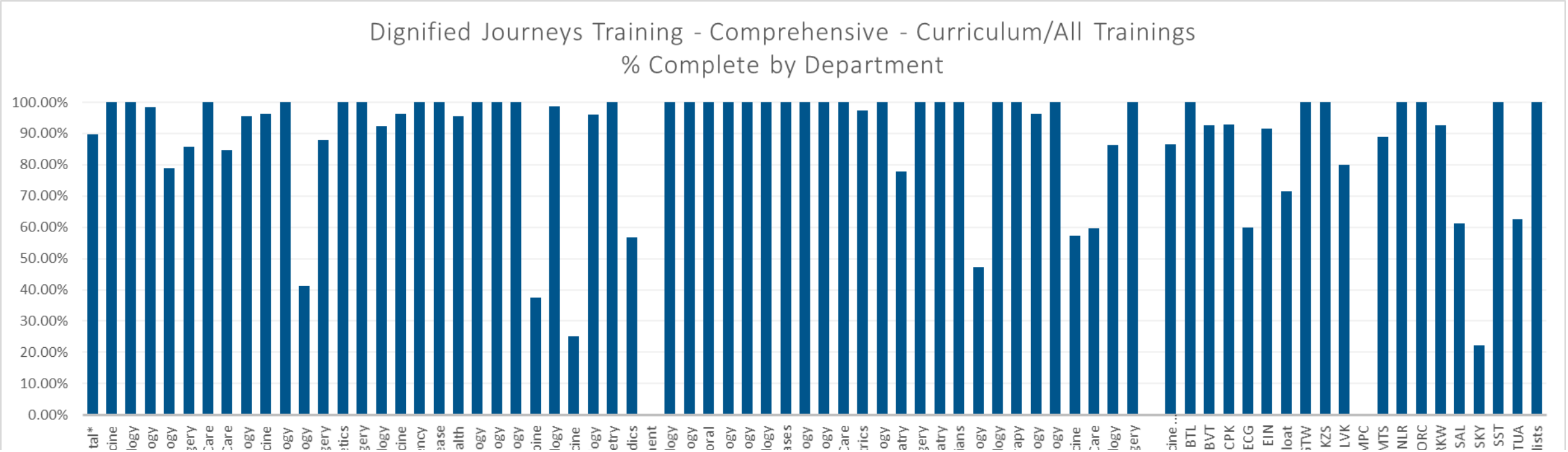
Monthly tracking to Senior and Ops Leaders: summary and detail levels

Belong@KP Part 1 Training Completion Status
Summary Report by Department
Report Date: 2.4.2022

*P4P Eligible Physicians & Clinicians - HP Affiliated Clinicians, Locums and Hires 1.1.22 or after are not included.

Department [[Filter by Department]]	Headcount as of 2.3.2022*	Belong @ KP & Dignified Journeys -- Combined --	% Complete	Belong@KP - Part 1 -- Curriculum: All Trainings --	% Complete	Dignified Journeys Training -- Curriculum: All Trainings --	% Complete
Continuing Care	37		94.59%		100.00%		94.59%

Report Information | Combined - % Complete | Combined - Detail | B@KP - % Complete | B@KP - Detail | DJ - % Complete | DJ - Detail



- 90% Training successfully completed – 1280 clinicians in medical group
- Early March report: 77% completion – many made it barely under the wire

Report Date 4/7/22

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KPNW Dignified Journeys: LCP Notes & ESII 2022 Implementation Plan

Q1

Finalize MOU Side Agreement – LCP Notes for Decedents ✓

Q2

Engage with Department Physician Stakeholders

- ESII KPHC visibility plan – know the right patient to have GOC conversations
- LCP Note rollout plans – create workflow to document those GOC conversations

P4P: Physician LCP conversation/documentation training

- Due 3/31/22

Stakeholder Meetings – Share Learnings and Review Dashboards

- Inter-dept stakeholder monthly meetings begin to review performance, barriers, opportunities, feedback
- ESII – review and confirm data to ensure high score patients are receiving LCP notes

Q3

MOU LCP Notes:

- Evaluate trajectory for remaining year based on YTD performance
- Update plans based on trajectory to hit target/stretch

Q4

Evaluate results of 2022 Op Plan and revise for 2023

- Engage teams based on trajectory in order to hit **stretch**

Key Metrics	
1.	MOU Side Agreement: Percent of Decedents with ACP conversation
2.	SPC & Hospice Index Penetration
3.	SPC touches >= 90 days prior to death