The COHO/PMG* Pilot Project (2012-2013)

An Outpatient Primary Care
Palliative and Advance Care Planning Model
(Integrating a Nurse or Social Worker as Educator/Facilitator)

Final Report

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*COHO (Choosing Options, Honoring Options), a project of
Jefferson Regional Health Alliance (501C3), Medford, Oregon

*PMG (Providence Medical Group Doctors Clinic), Medford, Oregon

*supported by a grant of The Cambia Foundation
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I. **Summary/Abstract:**

The COHO/PMG Pilot Project tested the feasibility of integrating an on-site educator/facilitator (either RN or LCSW) into a primary care internal medicine clinic (PMG Doctors Clinic):

1. to encourage meaningful conversations about end-of-life care;
2. to educate patients, families, caregivers and office staff about local options for end-of-life care;
3. to facilitate early Advance Care Planning for end of life care.

- Objectively, this one year pilot demonstrated both a significant absolute increase in number of POLST*/AD** completions (33.9%) and a very high (unanimous) acceptance/utilization of this model by patients, caregivers and providers.
- Subjectively, it generated very high levels of satisfaction by patients, families, physicians and office staff.
- External factors (conversion to a new EMR in mid-year and absence of a fully integrated system) prevented more definitive analysis of subsequent clinical events and overall financial/clinical impact.

**Conclusion:** this easily integrated, practical and effective model appears to have substantial potential for widespread adoption into other U.S. health care settings. It has subsequently been implemented at several additional outpatient clinical sites by Providence Medical Group in Oregon in 2013.

II. **Background: Challenges, Goals & Barriers:**

**Challenges:**

This innovative pilot project directly addressed one of the greatest problems facing American medicine in the 21st century: the widespread and often unwanted, inappropriate overuse of aggressive medical care near the end of life. Such care is often precipitated by default in crisis situations because patients, families and caregivers have neither conversed about, nor planned for, such possibilities prior to a final catastrophic illness. Consequently, there often exists a lack of awareness or consideration of options other than aggressive care in many final illnesses, especially palliative care. Hence, many people die in a blur of technologic/medical isolation, having missed the opportunity for serious conversations about meaning, goals of care and advance planning for end-of-life. Such unwanted care by default, frequently also results in tremendous expense, threatening the financial stability of patients and families…as well as the sustainability of our entire medical system.

*POLST: Physician Orders for Life Sustaining Treatment  
**AD: The Oregon Advance Directive
**Goals:**
The COHO/PMG pilot project attempted to address many of these challenges by integrating an on-site case management nurse or social worker into a primary care outpatient clinic. The project had three major goals:

1. **Facilitate** meaningful conversations about end-of-life care with seriously ill elderly patients and their families, beginning early in the course of potentially life-threatening illness;
2. **Educate** all concerned (patients, families and caregivers) about local options for end-of-life care;
3. **Encourage** and **facilitate** early advance care planning, accomplished while patients are capable of understanding, discussing and completing such decisions through advance directive and POLST documents.

**Barriers:**
This COHO/PMG pilot project directly addressed four of the five greatest barriers to planning appropriate end-of-life care and conversations, namely:

1. **Denial** of the reality of approaching death, a deeply embedded cultural phenomenon
2. **Lack of knowledge and comfort** with end-of-life issues/options by all concerned;
3. **Lack of time** by busy physicians to adequately address these issues (average time requirement in this project = 1 to 1.5 hours per patient);
4. **Lack of trained personnel** to carry out these basic conversations.

The fifth major barrier (which this pilot project could not address at this time) is a lack of modest reimbursement for these services in the current fee-for-service system.

**III. Methods:**

**A. Patient Population:**
The population of patients consisted of current patients of the seven internal medicine physicians providing care at PMG Doctors Clinic in Medford, Oregon. Those served were selected by the individual physicians based upon their age (>75 years), chronic serious illness, multiple co-morbidities, frailty, recent hospitalizations and/or multiple emergency room visits. Not surprisingly, this targeted population represented a variable, yet significant portion (> 60%) of the total patient population of these general internal medicine physicians.
B. Model, Planning, Implementation & Review

Model:
COHO/PMG Pilot Project tested a model designed as a result of physician interviews conducted by Susan Hearn for her master’s thesis (Hearn, 2011), which documented the need and feasibility for integrating ACP into the primary care setting. This pilot subsequently integrated advance care planning facilitation into the Providence Medical Group Doctors Clinic, a group of seven internists in Medford, Oregon. An embedded, advance care planning nurse facilitator, certified by Respecting Choices in LaCrosse, Wisconsin (Respecting Choices, An Advance Care Planning System That Works 2011), collaborated with COHO to test work flows and advance care planning tools for internal medicine patients with advanced age, frailty and chronic illness. (See Appendix 1: Work Flow Process)

The COHO/PMG Pilot was in three phases: planning, implementation and review.

Planning - Phase 1 (3 months):
1. Motivational/ information gathering interviews were conducted with all seven PMG Doctors Clinic internists - to identify current advance care planning process, greatest needs and major barriers;
2. Baseline data were established re: POLST and advance directive completion numbers and rates for each physician;
3. Materials/resources for advance care planning facilitation were identified. These included:
   - Choosing Options, Honoring Options (COHO) information brochure
   - Respecting Choices Advance Care Planning Conversation Guides (LaCrosse, Wisconsin)
   - Respecting Choices Fact Sheets
   - Harvard ACP Decisions Videos-General & disease specific
   - Go Wish Cards
   - “Consider the Conversation” (DVD)
   - Oregon Health Decisions Advance Directive Conversation Guide
   - POLST Forms
4. PMG staff were engaged to develop and implement a work flow plan, documentation (EMR), as well as patient referral/ scheduling processes;
5. PMG physicians and staff were orientated to the COHO pilot process, work flow plan, materials and results of initial physician interviews, prior to beginning actual patient visits in March, 2012;
6. An advance care planning nurse facilitator was trained and certified through Respecting Choice First Steps Advance Care Planning facilitator/instructor training courses, in LaCrosse, Wisconsin (April, 2012).
Implementation - Phase 2 (9 months):
1. A palliative care/advance care planning nurse (or LCSW) facilitator was scheduled for 12 hours per week to coordinate and meet with COHO patients and/or their healthcare representatives by appointment. Goal= 6 visits/week;
2. Actual patient visits began in the third month, (March, 2012), and were carefully monitored through the subsequent nine months of the pilot to evaluate and improve processes/materials as experience informed;
3. An initial frequent “cancellation problem ” was identified; subsequently resolved by incorporating a pre-visit phone call to confirm appointments and answer patient questions;
4. Initially the pilot experienced small referral numbers. This was quickly corrected by having the palliative care nurse review daily, the list of scheduled patients for each physician, “flagging” high risk patient charts prior to physician visits. This prompted physicians to ask about advance care planning.
5. Gathered data about visits including:
   a. Number of patients seen for advance care planning consultation
   b. Type and number of healthcare representatives present at each visit
   c. Documents and topics reviewed (AD/POLST/or both)
   d. Referrals made to other outpatient community services as needed
   e. Advance care planning materials used (see above list-planning #3)
   f. Patient Satisfaction Survey followed some counseling session
6. Evolution: During the pilot year, doctors learned to more comfortably initiate the ACP conversation themselves, subsequently often introducing the advance care planning nurse facilitator during a routine office visit. Such introductions were usually followed by scheduling a 1 hour follow-up ACP (COHO) appointment with the nurse facilitator.
7. COHO Project Coordinator (SH) met at least monthly with advance care planning nurse facilitator (JJ) and/or the PMG office manager (LH-C) to problem solve, replenish/introduce new resources, and adapt to changing practice environment (including a challenging EMR conversion halfway through the project year).

Review – Phase 3 (6 months):
1. Gather quantitative data (see “IV. Results”);
2. Final interview with palliative care/advance care planning nurse facilitator by COHO Project Coordinator;
3. Final survey interviews with internal medicine physicians by COHO Project Coordinator;
4. Plan for possibly integrating this service as a standard element of routine PMG patient care;
5. Collaboratively share and widely distribute the final report.
IV. **Pilot Partners:**

a. **COHO: Choosing Options, Honoring Options**
   COHO is one of four projects of Jefferson Regional Health Alliance, a non-profit organization in Jackson and Josephine Counties, Oregon with a mission of collaboration by regional community leaders from all sectors, acting in a leadership role to improve the health and health care resources of southern Oreganians. The COHO project’s specific mission is to encourage meaningful conversations and advance care planning, centered upon personal choices for end-of-life care.

b. **Providence Medical Group (PMG)**
   Providence Medical Group is the physician and provider service of Providence Health and Services system. The PMG Doctors Clinic, in Medford, Oregon, provides primary internal medicine services to the southern Oregon region. Providence Medical Group’s Medford and Portland based administration, Doctors Clinic’s seven active physicians and nurse case manager/facilitator, support staff and patients all assisted in the planning and implementation of this pilot project. In particular, PMG provided the personnel, facilities and the documentation (EMR) essential to the completion of this project.

c. **Cambia Health Foundation**
   Cambia Health Foundation is the corporate foundation of Cambia Health Solutions, a total health solutions company dedicated to transforming the way people experience health care. Founded in 2007, Cambia Health Foundation is committed to partnering with others to create a more person-focused and economically sustainable health care system, and champions the innovators who demonstrate what a truly transformed system can be. (www.cambiahealthfoundation.org 2013) Cambia Health Foundation provided the principal funding source for this innovative pilot project.

V. **Results**

A. **QUANTITATIVE (Objective) Results:**

**POLST/AD Completion Rates**

The table (Table #1) below summarizes the data comparing the total number of POLSTs and Advance Directives completed by patients older than 75 years. The baseline is fourth quarter, 2011; the end point is fourth quarter, 2012. (See Appendix 4: POLST/AD Completion Data).
Therefore, the COHO/PMG pilot demonstrated a substantial and significant increase in POLST/AD completions during the one year trial period, with most of the improvement occurring in the second half of the year as operational issues were resolved and clinic physicians/staff became more comfortable with the model.

**Advance Care Planning Encounter Data**

Total one hour (+) advance care planning visits during project year = \textbf{94}

April-June, 2012 = \textbf{15} social worker (LCSW) visits

July-December, 2012 = \textbf{79} nurse (RN) visits

This pilot project resulted in a substantial and significant patient acceptance and physician utilization of RN/LCSW counseling sessions, particularly in the last six months of the pilot year.

**Visit Summary Data**

During each encounter the advance care planning nurse facilitator recorded who attended the meeting (patient, family member and/or healthcare representative). She also tracked the documents and subjects covered, the referrals made and the advance care planning facilitation tools utilized during the advance care planning visit. \textit{(See Appendix 5: Summary of Nurse/LCSW Visit Notes)}
B. QUALITATIVE (Subjective) Results:

1. Physician Interviews - Pre and Post Pilot: Summaries

   a. Pre-Pilot Survey: Six of the seven participating internists were interviewed prior to the pilot regarding their opinions about advance care planning, the triggers of “the conversation” about end of life issues, as well as the experiences and challenges they commonly encountered in having conversations about end of life issues. They were asked for recommendations as to how a palliative care/advance care planning nurse facilitator might help them with such conversations and predict how many patients they expected to refer to the palliative care nurse counselor per week/month. (See Appendix 7 for detailed comments).

   b. Post Pilot Survey: The post pilot survey (4 of 7 physicians) identified a unanimous positive response to the pilot and a desire for it to be continued and expanded. An interesting theme that emerged as the pilot evolved was that the physicians felt more inclined to initiate the ACP conversation themselves, knowing that if the conversation became too complicated or time consuming, they could refer to the advance care planning nurse facilitator (See Appendix 7 for detailed comments).

2. Advance Care Planning Nurse Facilitator - Post Pilot Interview: Summary

The key observations of the advance care planning nurse facilitator were as follows:

   • Patients who received a pre-visit phone call, or better yet, an introduction to the advance care planning nurse facilitator in the office by the patients’ physician (a “warm hand-off”), better prepared the patient and family for the subsequent advance care planning visit, virtually eliminating cancellations.

   • Physicians recommended the service more often when the advance care planning nurse daily “flagged” appropriate patient charts prior to regularly scheduled physician appointments.

   • Over time, this “flagging” process (prompting the physicians to initiate), became unnecessary as the advance care planning facilitation service became a familiar routine.

   • The ACP Decisions videos were preferred by more medically sophisticated patients and families (57% found the videos “very helpful” and 61% would “definitely recommend” their use). However, 21% deemed the videos “not helpful” and “not comfortable!”

   • The Respecting Choices (LaCrosse, Wisconsin) Fact Sheet entitled “CPR or No CPR,” became the favored tool for explaining the lack of efficacy of CPR in this patient population. (Refer to Summary of Nurse/LCSW Visit Notes)
3. Patient Satisfaction Data Summary

Unfortunately, only eight of ninety-four patients seen by the nurse educator/facilitator completed the satisfaction survey. However, seven out of eight rated the service at the highest possible level. The only criticism was that one patient needed more time. (See Table #1 in Appendix 6: Patient Satisfaction Survey Data)

In addition, 28 of the 94 patients seen by the nurse educator/facilitator, completed an evaluation of the Harvard Advance Care Planning (ACP) Decisions Videos. 57% found them “very helpful,” 21% found them “somewhat helpful” and 21% found them “not helpful,” “not comfortable” and “not recommended” (see Table #2 in Appendix 6: Patient Satisfaction Survey Data). Overall then, the Harvard videos were helpful for a majority, but not acceptable to nearly a quarter of this patient population.

4. Lessons Learned from Qualitative Data:

1. Physicians, having office based ACP facilitation services immediately available, increasingly initiated the conversation themselves, substantially improving their own facilitation skills as the pilot calendar year proceeded.
2. Comfort with facilitating advance care planning evolves rapidly with increased education, experience and practice…by members of the healthcare team across the entire healthcare spectrum.
3. This project highlights the necessity for integrated information systems to record/access both advance directives and POLSTs into an EMR which is then easily accessible throughout the entire healthcare organization. In contrast to expectations, the process of conversion to EMR can be associated with significant discontinuity, effectively preventing valid data collection.
4. Harvard’s ACP Decisions videos were frequently utilized, were helpful to a majority, but often proved too difficult for some patients and families to watch.
5. Typical physician comment: “This primary palliative care model provides a practical response to the great need for embedded ACP facilitation and COHO education materials in the outpatient setting.”
6. Overall, perhaps the most significant result of this pilot project was a subsequent decision by the Providence Medical Group Doctors Clinic, to continue to implement this model as standard operating procedure at the end of the pilot year!

VI. Limitations

1. First, this was a pragmatic pilot project, not a scientific study. As such, it tested and successfully demonstrated one primary objective: the feasibility of integrating high quality advance care planning conversations into the frenetic and rapidly changing primary healthcare environment.
2. Consequently, although it more than adequately fulfilled its primary objective, this pilot suffered from a paucity of objective endpoints, with only one truly objective finding: a 33.9% growth in actual number of POLST/AD completions by chronically ill patients > age 75 during the first nine months of implementation. Further planned measurements were prevented by the unanticipated mid-year conversion to a new electronic medical record by the PMG system, rendering the collection of comparative data quite difficult. Despite this disappointment, several very positive subjective endpoints emerged (see Qualitative results).

3. This pilot was implemented by a very busy group of seven primary care internists, who had already established a baseline POLST/AD completion rate (23.2% for patients over age 75, well above the national average) in 4th quarter, 2011 (the last quarter prior to the deployment of this pilot project). In fact, one physician was already operating at a very advanced level of advance care planning and facilitation, with 57% of his patient population having completed AD/POLST at baseline! We feel this high level of achievement prior to the pilot project may explain the modest 8.5% further increase in POLST/AD completion rates during the first nine months of nurse facilitator employment, an increase in POLST/AD completion rates from baseline (23.2%) to end point (31.7%) in one year.

4. Unfortunately, no fiscal data were available to the planners of this project. Therefore, we were unable to assess the economic impact of enhanced conversations and advance care planning upon global healthcare costs. Of note is the recently published (2013) Dartmouth Atlas Project data from a similar community (La Crosse, Wisconsin), demonstrating 30% less global healthcare costs than national average in the last six months of life! LaCrosse is a community, where 97% of dying patients complete advanced directive or POLSTS (Goodman, et al. 2013).

5. This study was not designed to quantify the actual end-of-life care choices made by the patients who participated. Several lines of evidence, including data from the Oregon POLST Registry’s first 3 years (over 120,000 patients) suggest that, when high risk patients are given choice, they overwhelmingly choose not to have intensive care (87-94%) at the end of life. (Fromme, et al. 2012)

6. Finally, although Providence was a quasi-integrated system in 2012, it was not sufficiently integrated to enable this pilot to capture the impact of this outpatient intervention upon actual inpatient end-of-life care.
VII. Discussion

The ideas and needs which gave rise and substance to this clinical pilot project arose from a plethora of realities and necessities within our local community. However, they are not unique to our local experience and are, in fact, representative of an exploding national awareness of the importance of initiating early conversations about end-of-life issues and end-of-life care, well in advance of final health crises.

This pilot recognized and attempted to address a multiplicity of barriers to excellence in end-of-life care within the current U.S. healthcare system, including:

1. the current paucity of palliative care resources available in the last two years of life across the United States;
2. the huge demographic wave of the current aging baby boomer generation, now beginning to face the prospect of their own deaths, often recognizing the relative rarity of palliative care during the decline/death of their own parents;
3. the discomfort and lack of knowledge prevalent among medical professionals about palliative care and advance care planning;
4. the recognition that the principal challenge for many physicians was the time necessary to adequately discuss these issues and options with their patients; (Hearn 2011)
5. the awareness that basic education about these issues and options did not require an immediate physician presence, but could be adequately (perhaps even better) accomplished by other members of a healthcare team, (especially by nurses and social workers as counselor/educators), often with minimal additional training.

This unique clinical pilot project therefore attempted to address each of these barriers by integrating an onsite knowledgeable counselor (LCSW or nurse case manager) into a busy primary care setting to provide basic education about end-of-life care options to patients and families, as well as to facilitate conversations about end-of-life issues among all concerned (including physicians and their office staffs).

That this effort was embraced enthusiastically (in fact, near universally) by those who participated speaks to the need to integrate such efforts into the very fabric of our healthcare system at many levels. That it produced significant objective success (a 33.9% absolute rise in completed POLST/AD documents by chronically ill elderly patients at high risk for death) was therefore not surprising to those who planned this pilot project.
VIII. Conclusions:

1. The COHO/PMG Pilot Project successfully integrated an on-site nurse (or LCSW) educator/facilitator into a busy primary care internal medicine practice by:
   - encouraging meaningful conversations;
   - educating about options for end-of-life care (especially palliative care);
   - facilitating advance care planning with seriously ill elderly patients and their families.

2. Significant improvements were noted (especially over the final seven months of this one year project) both objectively (a 33.9% absolute increase in AD/POLST completions) and subjectively (very high patient and physician/staff satisfaction).

3. Future implications of the success of this practical, patient-centered, low cost project suggest that it has significant potential to be widely implemented within the current transitioning U.S. health care system, not only to improve the quality of care in the last two years of life (its primary goal), but to also significantly reduce global health care costs by acknowledging and honoring end-of-life care preferences of an informed patient population.

IX. Acknowledgements:

This pilot study was made financially possible by two major contributors:

1. The vision and generosity of a substantial Cambia Health Foundation grant to COHO: Choosing Options, Honoring Options;
2. The vision, insight and foresight of Providence Medical Group, both locally and regionally, in recognizing the importance of integrating a nurse case manager as an advance care planning educator/facilitator into a cost-effective medical team, aimed at improving the quality of medical care delivery near the end of life.

COHO recognizes the leadership, compassion, dedication and wisdom of John Jackson, MD (Medical Director of PMG Medford), Joni Johnson, RN (first PMG Nurse Case Manager and Advance Care Planning Educator/Facilitator), Carol Flinn, (Director of PMG Medford), and Father James Clifford, (Providence Hospital Chaplain and Chair of Ethic Committee for PMMC).

COHO appreciates Susan Hearn, who authored this vision and, from its beginning, graciously shepherded this concept through innumerable obstacles.

COHO acknowledges the indispensable wisdom and tenacity of its founder and leader, John Forsyth, MD, who brought clinical practicality, compassion, knowledge and perseverance, enabling COHO to bring this project to fruition.
COHO thanks Jefferson Regional Health Alliance leaders (especially Anne Alftine, MD and Kathy Bryon of Gordon Elwood Foundation), who prioritized end-of-life care and were indispensable partners in the creation and implementation of this project.

Finally, we are grateful to the patients and families who recognized the potential value of these conversations and who courageously joined us in breaking new ground.

X. References


XI. Contact Information

- John Forsyth, MD, COHO Chair Emeritus, jforsyth@charter.net
- Susan Hearn, MM, COHO Program Manager, susanbloom.hearn@gmail.com; 541-941-5960

XII. Appendices

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Appendix #1

Work Flow Process: Advance Care Planning Education/Facilitation

1) **Patient office visit with provider.** Provider initiates conversation about ACP, invites patient/family participation and recommends ACP educator/facilitator visit. If patient accepts, provider documents reason for ACP referral and makes referral.

2) Provider gives patient “COHO” take home packet (including COHO brochure/materials); prints “After Visit Summary” for patient, including .pal or .PAL quick text (see below).*

3) Receptionist schedules advance care education/planning appointment and follow-up appointment with provider.

4) Nurse case manager **calls patient** prior to appointment and documents the phone calls, reviewing the following:
   a. Explains ACP education/facilitation service
   b. Describes the importance of participation by Healthcare Representative in ACP process
   c. Answers questions
   d. Confirms appointment

5) Patient/Healthcare Representative participate in **advance care education/planning appointment** (average-1 hour) **Typical resources used:** Respecting Choices Conversation Guides, Go Wish Cards, Respecting Choices Fact Sheets, ACP Document Distribution Check List and ACP Decisions Videos are used for Advance Care Planning conversations and education).

6) Nurse case manager **documents “visit” in EMR, using Advance Care Planning Summary Note.** Nurse Case Manager then routes summary note to the patient’s provider.

7) **Process for documenting advance care planning directives:**
   a) **Advance Directive:** Nurse Case Manager copies pages 1-6 of Oregon Advanced Directive; gives to PMG medical records clerk for entering/scanning into the EMR.
   b) **POLST:** (PMG process for POLST documentation evolved during pilot) COHO recommendation is for nurse case manager to review POLST with patient. Then, if patient decides to complete the POLST, nurse case manager documents patient preferences, transmits POLST to provider for completion at subsequent follow-up patient visit.
   c) If needed, **Referral** recommendations are made to patient/provider for palliative care, home health, hospice, Connections (non-medical transitional care) or other appropriate community resources.
   d) Nurse case manager invites patient/family to complete the Patient Satisfaction Survey at end of meeting.

*.pal or .PAL quick text:

> Your doctor has referred you for help with your advance care planning. This is a free service. Our nurse case manager will provide education about healthcare options and discuss your preferences for future care if you become unable to make your own decisions. We recommend you bring along the person you’ve selected to make healthcare decisions for you, or a close loved one. If this person is unavailable to attend in person, they may participate by phone.
Appendix #2
Sample Template: Advance Care Planning Visit Note
(Completed by ACP educator/facilitator, documented in EMR)

Overall Clinical Impressions:

Reviewed:
- Patient Readiness for ACP Conversation______________________
- Counseling/Education_______________________________________
- Healthcare Representative Responsibilities____________________
- Family Understanding, Participation__________________________
- POLST _____________________________________________________
- Advance Directive __________________________________________

Tools Shared:
- Go Wish Cards (re: patient preferences)
- ACP Decisions Videos (disease specific/ general goals of care)
- Consider the Conversation DVD
- Respecting Choices Fact Sheets
- Other______________________________________________________

Recommended Referrals
- Transitional Care___________________________________________
- Home Health______________________________________________
- Palliative Care____________________________________________
- Hospice___________________________________________________
- Other____________________________________________________

Remaining Concerns, Questions, Recommendations:
__________________________________________________________
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# Appendix 3: Timeline for COHO/PMG Doctors Clinic Pilot

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<td>Respecting Choices instructor training in Wisconsin (4/28)</td>
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<td>Refer for LCSW/RN counselling/ACP/Palliative Care</td>
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<td>Evaluate and improve work flow with LCSW/RN/Lead MD</td>
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<td>Physician e-mail-educational tool reminders &amp; feedback</td>
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<td>Quarterly check-in &amp; improve with MD/MSW/RN</td>
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<td>Final interviews MDs/RN</td>
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### Appendix 4: PMG Medford Doctors Clinic- POLST/AD Completion Data
(Comparing Baseline Q4, 2011 with Endpoint Q4, 2012)

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<tbody>
<tr>
<td></td>
<td># POLSTs/ADs completed in pts. &gt; 75 years</td>
<td>Total pts. &gt;75 years</td>
<td>% POLST/AD Completion Rate</td>
</tr>
<tr>
<td>#1</td>
<td>51</td>
<td>366</td>
<td>13.9%</td>
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<tr>
<td>#2</td>
<td>65</td>
<td>451</td>
<td>14.4%</td>
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<tr>
<td>#3</td>
<td>24</td>
<td>95</td>
<td>25.3%</td>
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<tr>
<td>#4</td>
<td>31</td>
<td>204</td>
<td>15.2%</td>
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<tr>
<td>#5</td>
<td>200</td>
<td>351</td>
<td>57.0%</td>
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<tr>
<td>#6</td>
<td>67</td>
<td>360</td>
<td>18.6%</td>
</tr>
<tr>
<td>#7</td>
<td>28</td>
<td>182</td>
<td>15.4%</td>
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<tr>
<td>Totals</td>
<td>466 (1)</td>
<td>2009</td>
<td>23.2% (2)</td>
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**Notes:**
1. Total # patients > 75 yrs. with completed POLST/AD increased from 466 to 624 in one year **(net gain=158pts= 33.9 % growth)**
2. A modest 8.5% average increase (per physician) in POLST/AD completion rates in the pilot year
Appendix #5

Summary of Nurse/LCSW Educator Visit Notes
(Responses to Summary Note Template: See Appendix 2)

Data from 3/22/12 through 12/31/12~9 months actual implementation
Total Patient Visits = 94 (LCSW -15 + RN – 79 = 94 Total)
Total Family/Health Care Representative Involvement = 50/94

Reviewed:
- POLST – 75 patients
- Advance Directive – 63 patients
- Counseling – 56 patients
- Healthcare Representative Responsibility. – 43 patients
- Family – 27 patients

Referrals Made:
- Transitional Care (“Connections”) – 7 patients
- Home Health – 19 patients
- Palliative Care – 5 patients
- Hospice – 7 patients
- Other –.; Food & Friends – 3 patients; Lifeline; Caregiver Support – 3 patients;
  Attorney/Geriatric Care Mgr – 3 patients;– 1 patient each to Lovejoy Transitions,
  Long Term Care Ins, Winterspring Grief Support.

Tools Used During ACP Educator/Facilitator Visit:
- Go Wish Cards– 4
- Harvard ACP Decisions Videos – 28 (Goals of Care – 10; Advanced Disease – 4)
- Consider the Conversation DVD – 8
- Respecting Choices Fact Sheets – 15 (CPR/No CPR-14, Help w/ Breathing – 1)

As nurse case manager developed in her role, she made an increasing number of home visits, to provide/complete more extensive advance care planning and case management services (e.g. advance care planning conversations, referrals for supportive services, etc.).
Appendix # 6: Patient Survey Results

During the COHO/PMG Pilot Project, two different patient surveys were conducted:

Table # 1: Respecting Choices (LaCrosse, Wisc.) Patient Satisfaction Survey:
Completed by 8 patients immediately after the advance care planning appointment.

<table>
<thead>
<tr>
<th>Questions On Scale of 5: 1 (not at all) – 5 (very much)</th>
<th>Average Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that this discussion was helpful to me</td>
<td>4.875</td>
</tr>
<tr>
<td>I feel better prepared to make decisions about my future health care</td>
<td>4.75</td>
</tr>
<tr>
<td>I feel that the facilitator did a good job of helping me with my needs for advance care planning</td>
<td>4.875</td>
</tr>
<tr>
<td>Comments: “needed more time” and “thank you”</td>
<td></td>
</tr>
</tbody>
</table>

Table # 2: Patient Evaluations of Harvard ACP Decisions Video: “My Care Directions,” a Portland based program similar to COHO asked PMG to also use an evaluation tool specifically for the Harvard Advance Care Planning Decisions Videos used in this pilot. The evaluation includes trigger for referral, medical diagnosis, race/culture, gender and age and POLST modification data. Patients were asked whether the video was helpful, comfortable to watch, and if they would recommend it.

Harvard ACP Decisions Video Evaluations: 28 patients as of 10/31/12

- **Trigger**
  - Patient/Family Request: 11%
  - No POLST: 32%
  - Concern about full CPR status: 7%
  - Low medical literacy: 4%
  - Provider request: 46%
  - Tube feeding decision: 0%

- **Was the POLST Modified?**
  - Yes: 89%
  - No: 11%

- **Medical Diagnosis**
  - CHF (C-V disease): 61%
  - COPD: 6%
  - Dementia: 11%
  - Kidney/Liver Disease: 4%
  - Cancer (Lung, Kidney): 18%
  - Other (MS/Failure to Thrive): 7%

- **Was video helpful?**
  - Very helpful: 57%
  - Somewhat helpful: 21%
  - Not helpful: 23%

- **Race/Culture**
  - Caucasian: 89%
  - African American: 6%
  - Russian/jewish: 0%
  - Hispanic: 4%
  - Asian (Japanese/Chinese): 7%

- **Comfort in watching video?**
  - Very comfortable: 50%
  - Somewhat comfortable: 29%
  - Not comfortable: 21%

- **Gender**
  - Female: 56%
  - Male: 50%

- **Would you recommend?**
  - Definitely: 63%
  - Probably: 11%
  - Not recommended: 25%

- **Age**
  - 30-39: 4%
  - 40-49: 0%
  - 50-59: 4%
  - 60-69: 4%
  - 70-79: 29%
  - 80-89: 50%
  - 90-99: 11%
Appendix # 7

Provider Interview Comments: Pre & Post Pilot

A) PMG Provider PRE-Survey Comments: (February, 2012, interviews - 6)
Question: When is it appropriate to initiate advance care planning conversation?
- “mid 80's; or after 80”
- “With lots of medical programs, above 70 to 80 do POLST;”
- “Every opportunity...Terry Schiavo brought it up all the time. When 75 plus with many health problems, I get a POLST. I say ‘You need to make sure your family knows what you want. Complications are not rare!’”
- “Sometimes with annual wellness exam;”
- “Need to develop habit with patients in older ages”

Question: What usually triggers the conversation?
- “80’s plus, Difficult to predict the future, late stage dementia, especially when quality of life is issue. Tricky with assisted death requests”
- “Late dementia, more the family. I want to catch when patient has input to their future health”
- “Advance Directive at 60 plus”
- “When headed for a crisis, or between crises. With dementia it is difficult to have conversation up front due to so much anticipatory grief”
- “80 plus”
- “Qualifiers—multiple ER Visits with medical interventions needed.”
- “If healthy patient wants to limit intervention, I discuss scenarios where intervention would be appropriate—eg ventilator and antibiotics with pneumonia”

Question: What are the barriers to having the conversation?
- “Highly disabled patients, never make own decisions. It is difficult to get legal guardians or health care representative in the rooms.”
- “Time and timing—patient often has poor understanding of prognosis”
- “Patients reluctant to discuss”

Question: What is your experience treating dying, non-communicative patient without directives?
- “Sometimes tired and fatigued people in their 90's want others to decide. More men than women. "Whatever my family says, I'm fine with”
- “This is rare. Most patients have relationship with them or family. Most patients go to hospice- 80% on Hospice.”
- “Usually go to family to decide, then ethics committee”
- “I have encountered on rare occasions suspected elder abuse in these situations”
- “This is why conversations need to happen way before this point and have the conversation with the surrogate.”
- “Not bad-family usually can speak for patient”
- “Yes, most difficult with family conflict and out of town health care representative.”
Appendix # 7 continued:

Question: What should the advance care planning educator/facilitator focus on?
- “Doctor will normally do POLST”
- “Palliative care rather than POLST talk--get people to understand the trajectory of illness.”

Question: How many advance care planning facilitator referrals per month do you predict?
- “Until I use you more, I am not sure. This is especially needed for complex, handicapped patients who are difficult, potentially dangerous, need conversations earlier for people who can't protect themselves. It is difficult with slow progressive disease who are young with a terminal illness.”
- “Hard to say...needing coordination with family, emotional pondering”
Appendix # 7 continued:

**PMG Provider POST Pilot-Survey Comments** *(February, 2013-provider interviews=4)*

**Question 1: What worked well in the COHO/PMG Pilot?**
- “the pilot reminded me that ACP was a conversations worth having”
- “I found patients were waiting to be asked”
- “I had more ACP conversations as a result of the pilot”
- “Case support-somebody else to remind me as a clinician to have ACP discussions.”
- “COHO brochure helped”
- “Maybe saved time because ACP got done, and probably wouldn’t without pilot”
- “Collaboration helpful, but at first complex”
- “Flagging the high risk patients on day of visit for ACP was helpful”
- “Onsite was helpful-especially when I can do a warm hand off at end of patient visit”
- “the quality of ACP increase and it resolved a problem, which is important”

**Question 2: What could be improved about the process?**
- “disappointed the documentation didn’t transfer well with EPIC launch”
- “POLST transfer to EPIC so it comes up on front page of chart”
- “Improve ACP outreach to patients during regular appointments”
- “Greater awareness and plan to transfer directives to EPIC”
- “More support for nursing home patients”
- “Signage for ACP”
- “Nurse case manager would have been more successful if in her job for six months before pilot was launched.”

**Question 3: What triggered your referrals?**
- “Starting ACP conversation and can tell it’s not going to go well”
- “Flagging of high risk patients with advanced age or illness”
- “Lack of patient’s insight into their own situation”
- “A patient who is unwilling to give up driver’s license was a clue of patient’s deep denial and need for ACP facilitator referral”
- “When I initiate the conversation and get stuck.”
- “Only child or out of town family more problematic”
- “Patient’s age, change in health status, or isolated old person”

**Question 4: Did the Pilot increase your frequency of ACP discussions with your patients?**
“Yes!” x 5
Appendix # 7 continued:

Question 5: Do you have any patient feedback to share?
- “nurse case manager very positive and available.”
- “great to have the warm hand-off”
- “the home visits were enlightening and tell us a lot about the patient”
- “patients welcomed the offer of the ACP service”

Question 6: Do you want the ACP COHO/PMG Pilot to continue?
- “Yes ACP should continue”
- “We should have money to pay a clerk to dredge up POLST and put on EPIC chart”
- “Very good program, please continue”
- “Yes, definitely want it to continue. It is a good, productive idea having case managers help problem solve with ACP.”
- “Nice if this pilot program expanded to other PMG clinics.” (Ed. Note: It did!)