Combining integrated knowledge translation with quality improvement processes in the implementation of an Advance Care Planning intervention

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Disclosures

- I have no conflicts of interest
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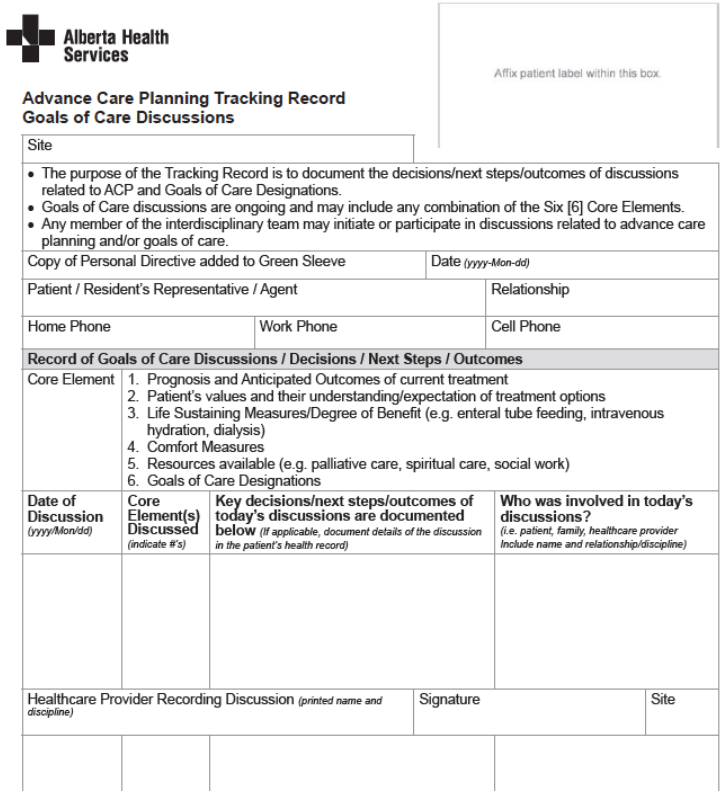
Presentation Structure

- The challenge of team process in ACP
- Addressing team process
  - Integrated Knowledge Translation
  - Quality Improvement methods
- Method/Results/Sustainability
- Lessons learned/Next Steps

Introduction/Background

- **Advance care planning (ACP)** is a process that helps adults understand and share their values, goals, and preferences regarding future medical care, with the purpose of ensuring that people receive care which is consistent with their wishes



Alberta Health Services

Affix patient label within this box.

Advance Care Planning Tracking Record
Goals of Care Discussions

Site

- The purpose of the Tracking Record is to document the decisions/next steps/outcomes of discussions related to ACP and Goals of Care Designations.
- Goals of Care discussions are ongoing and may include any combination of the Six [6] Core Elements.
- Any member of the interdisciplinary team may initiate or participate in discussions related to advance care planning and/or goals of care.

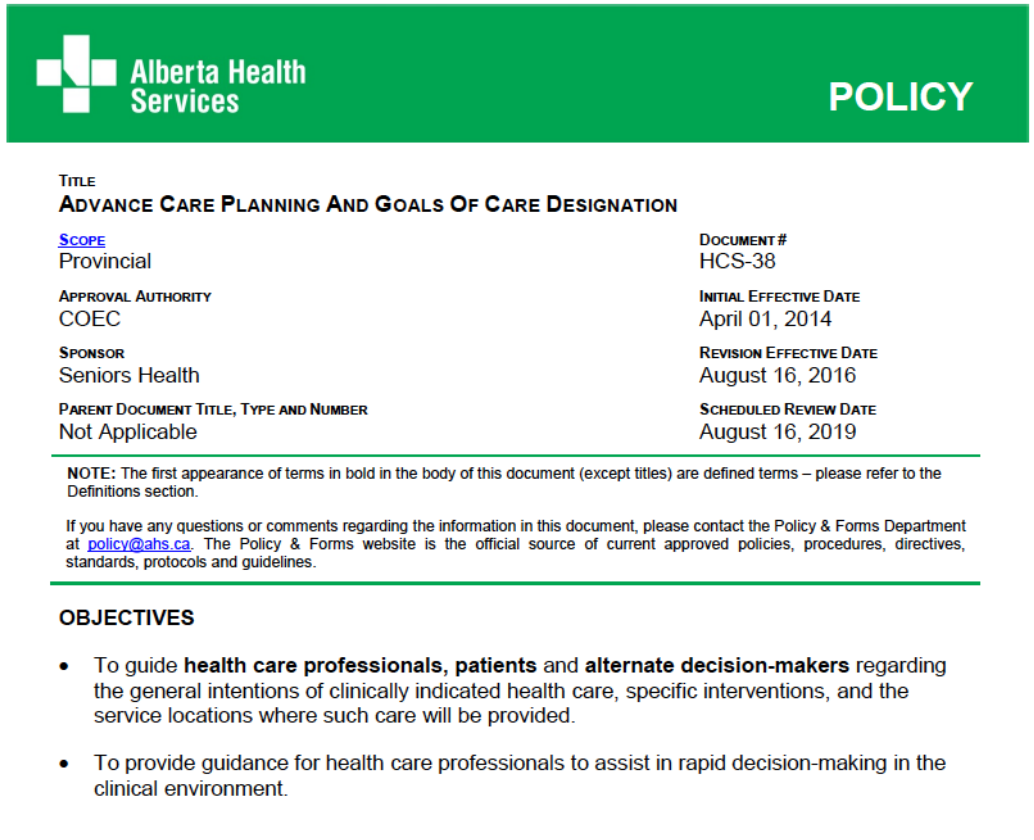
Copy of Personal Directive added to Green Sleeve	Date *(yyyy-Mon-dd)*
Patient / Resident's Representative / Agent	Relationship
Home Phone / Work Phone	Cell Phone

Record of Goals of Care Discussions / Decisions / Next Steps / Outcomes

Core Element
1. Prognosis and Anticipated Outcomes of current treatment
2. Patient's values and their understanding/expectation of treatment options
3. Life Sustaining Measures/Degree of Benefit (e.g. enteral tube feeding, intravenous hydration, dialysis)
4. Comfort Measures
5. Resources available (e.g. palliative care, spiritual care, social work)
6. Goals of Care Designations

Date of Discussion *(yyyy/Mon/dd)*	Core Element(s) Discussed *(indicate #'s)*	Key decisions/next steps/outcomes of today's discussions are documented below *(If applicable, document details of the discussion in the patient's health record)*	Who was involved in today's discussions? *(i.e. patient, family, healthcare provider Include name and relationship/discipline)*

Healthcare Provider Recording Discussion *(printed name and discipline)*	Signature	Site



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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To guide **health care professionals, patients** and **alternate decision-makers** regarding the general intentions of clinically indicated health care, specific interventions, and the service locations where such care will be provided.
- To provide guidance for health care professionals to assist in rapid decision-making in the clinical environment.

Background/Introduction

- In exploring ACP process across and within clinical contexts, we discovered significant practice variability and role confusion.

Practice Variability

'we have an advanced care planning nurse so we kind of let her do her thing," (Physician)

"we make sure that once a year like when they come in, the patient comes in to see their nephrologist that the goals of care are up to date and if they're not just letting the nephrologist know, so then that the doctor can have that conversation with the patient." (Nurse)

"we have a capable palliative care team…they can dedicate the time needed to go through these things." (Physician)

Role Confusion

"They [nurses] don't know whether - how far they should go, what they should do."
(Supportive Living Nurse)

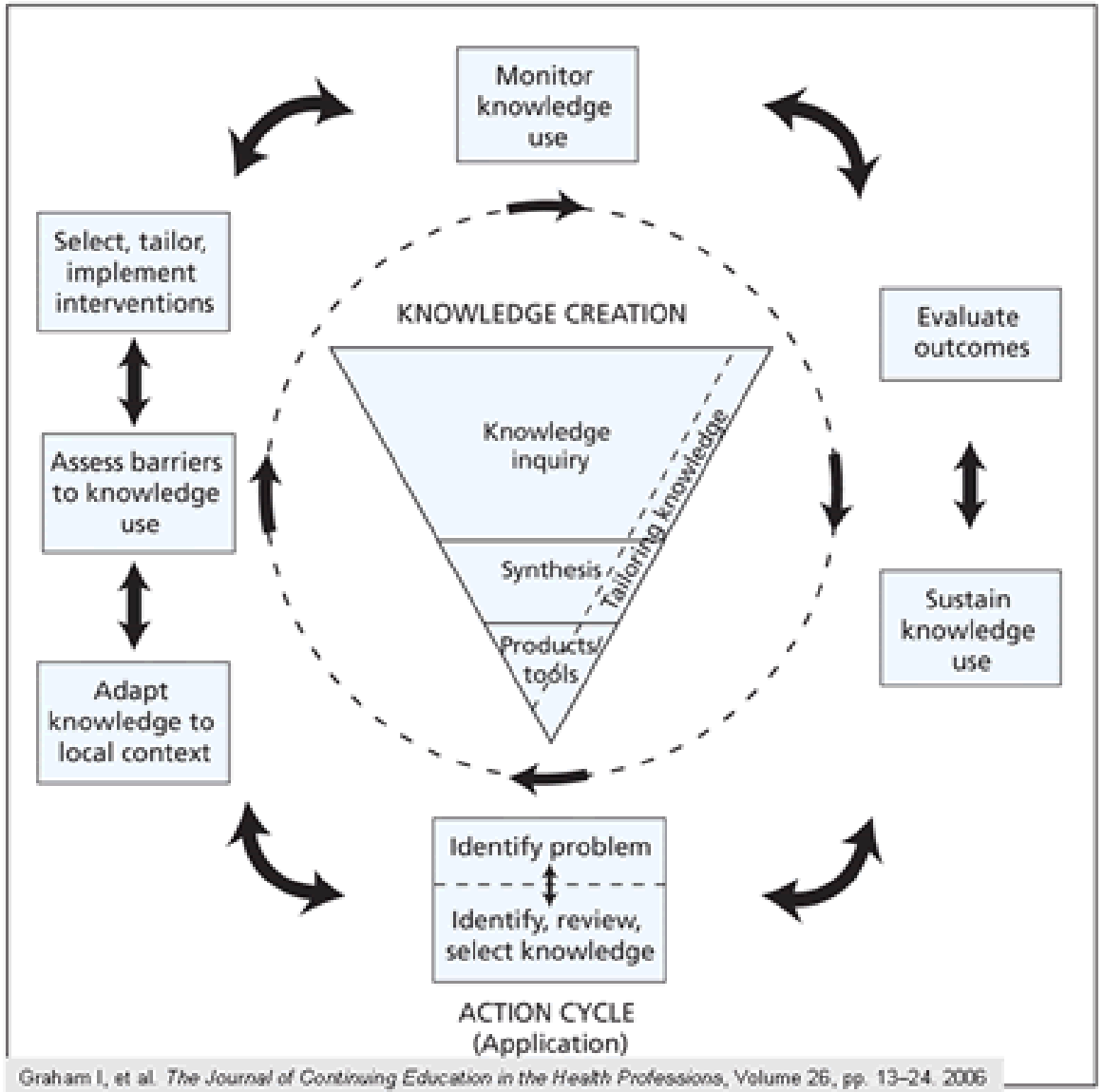
Background/Introduction

- The purpose of our study was to enhance and routinize ACP processes across four cardiac settings: acute in-patient unit, out-patient heart-function clinic, primary care clinic and heart function homecare team.

Use of Knowledge Translation (KT) Methods

- What is KT?
  - Collection of methods for translating evidence into practice (Straus, 2013).
- Why theory?
- Why use it here?
  - To close the knowledge-to-action gap

Method- The Knowledge to Action Cycle



Graham I, et al. *The Journal of Continuing Education in the Health Professions*, Volume 26, pp. 13–24. 2006

Method

- **Integrated knowledge translation (iKT)**
  - engaging knowledge users and decision makers as co-investigators in the research (Straus, Tetroe & Graham, 2011)

Method

- **Quality improvement (QI)**
  - designed to generate immediate improvements in local settings (Lynn et al., 2007).
  - In its goal of addressing behavior and changing practice, it is similar to KT science.
- Alberta Health Services Improvement Way (AIW)
  - locally developed quality improvement process that is based in LEAN and Six Sigma principles.

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Frameworks/Activities

ACTION CYCLE STEPS	Identify knowledge to action gap	Adapt knowledge to local context	Assess barriers to knowledge use	Select, tailor and implement interventions	Monitor knowledge use	Evaluate outcomes	Sustain knowledge use
	Sept 2015-March 2016	April-June 2016	August – October 2016	October-December 2016	August 2016 - April 2017		May 2017 +
ACTIVITIES	Review of literature Completion of exploratory research Developing local problem statement	Formation of clinical, research and implementation teams Role clarification Development of study goals	Process mapping Assessment of healthcare provider barriers Baseline process/outcome data collection	Enactment of implementation plan using 1. Priority matrix, 2. Actions tracking list and 3. Gantt chart	Process/outcome data collection using interrupted time series Clinic-specific:1. Monitoring strategies, 2. Education strategies	Process/outcome data collection Using interrupted time series	Sustainability of intervention Data analysis
DATA COLLECTION			Pre-Healthcare provider survey Chart audit Patient Survey	Chart audit Patient Survey			Post-intervention interviews Post-Healthcare provider survey
FRAMEWORKS/MODELS	AIW- Define opportunity	TDF AIW- Define opportunity	TDF AIW- Build understanding	COM-B + Behavior Change Wheel AIW- Act to improve e-SIMULATION education	AIW- Act to improve	AIW- Act to improve	AIW- Sustain results NHS sustainability model

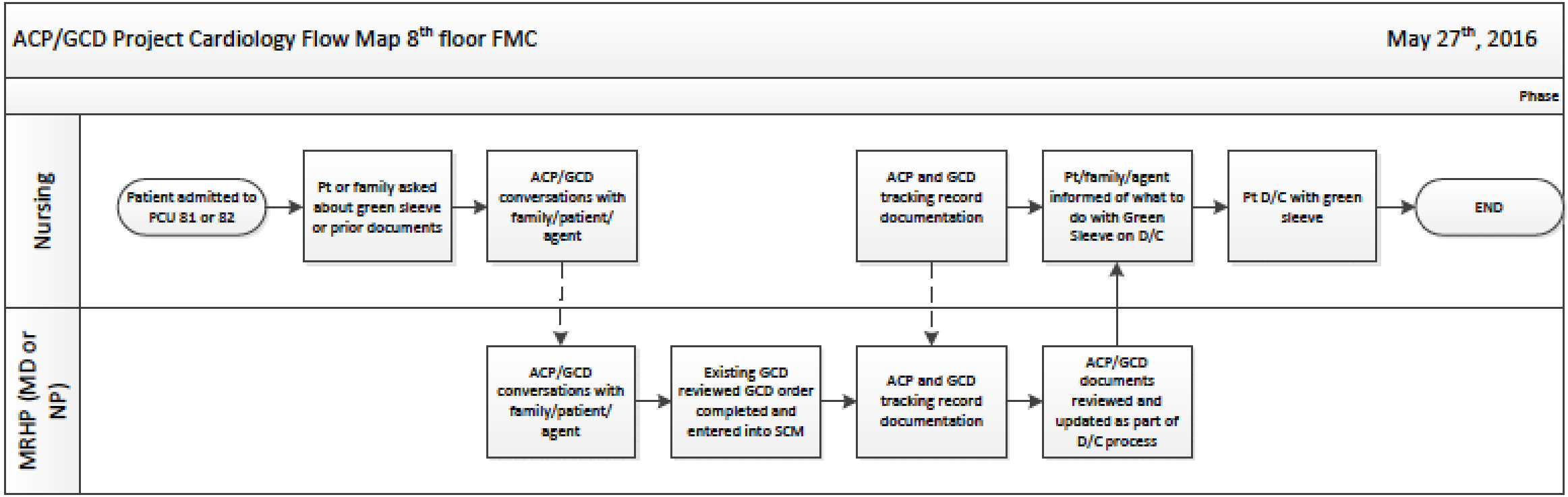
Method

- **Participants**
  - In-patient unit, out-patient HF clinic, primary care clinic, HF homecare unit

- **Data Collection**
  - Interrupted time series design (ITS)
  - Data was collected using a chart audit and patient survey.
  - Data was collected bi-weekly for 32-34 weeks depending on the clinic/unit.
  - Clinician barriers to ACP were measured using a survey administered before and after the intervention period

- **Measures/Outcomes**
  - PROCESS MEASURES that we sought to evaluate were:
    - 1. ACP conversations documented in the ACP tracking record.
    - 2. Patients with a green sleeve containing their ACP documentation.
  - Collected using chart audit
  - PATIENT OUTCOMEs:
    - Patients who indicate having been engaged in ACP by their healthcare provider.
    - Patients correctly identifying presence of a GCD.
  - Collected using a condensed version of the nationally used ACCEPT survey (Heyland, Dodek, & Lamontagne, 2012).

Method- Process Mapping



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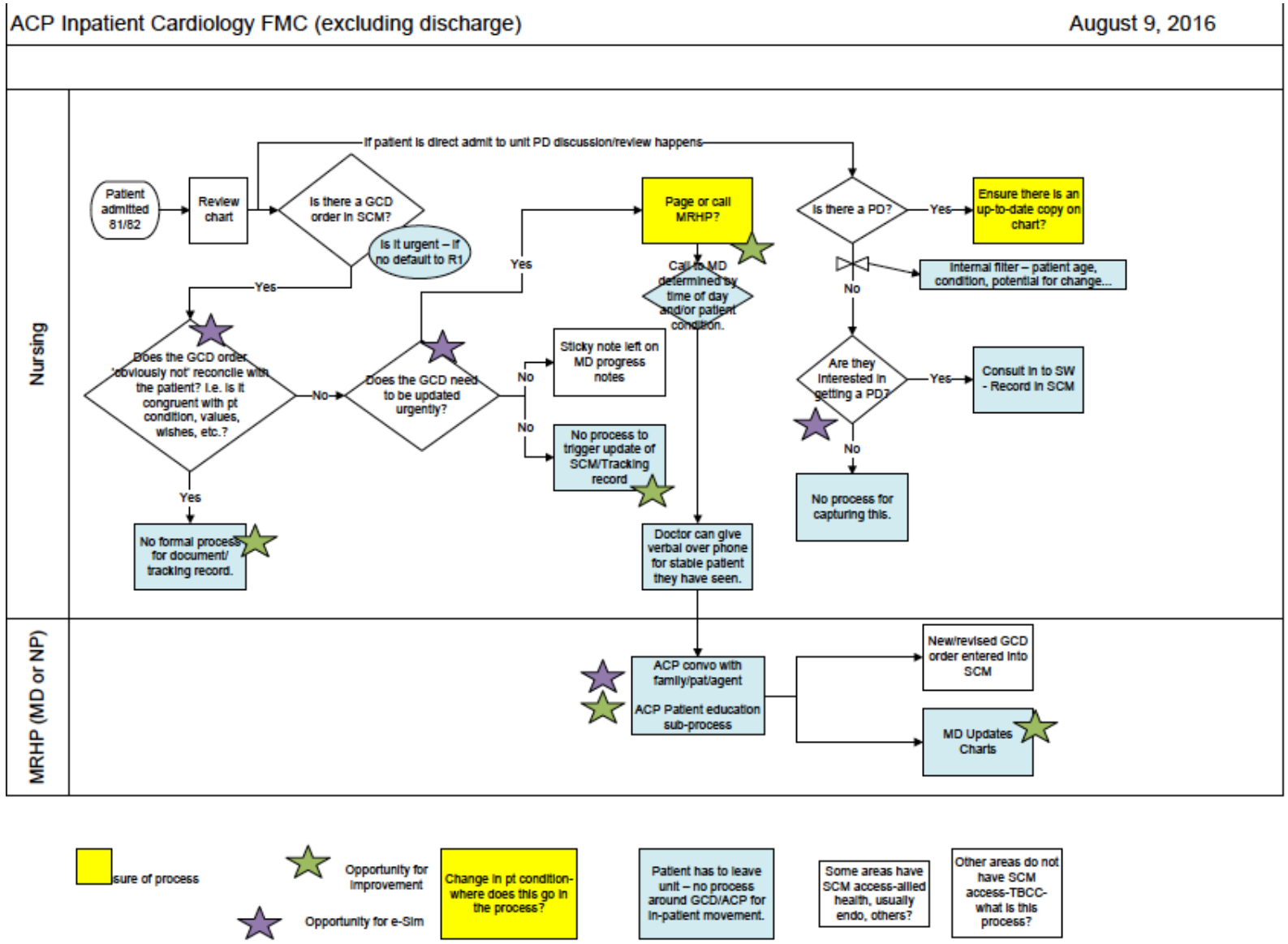
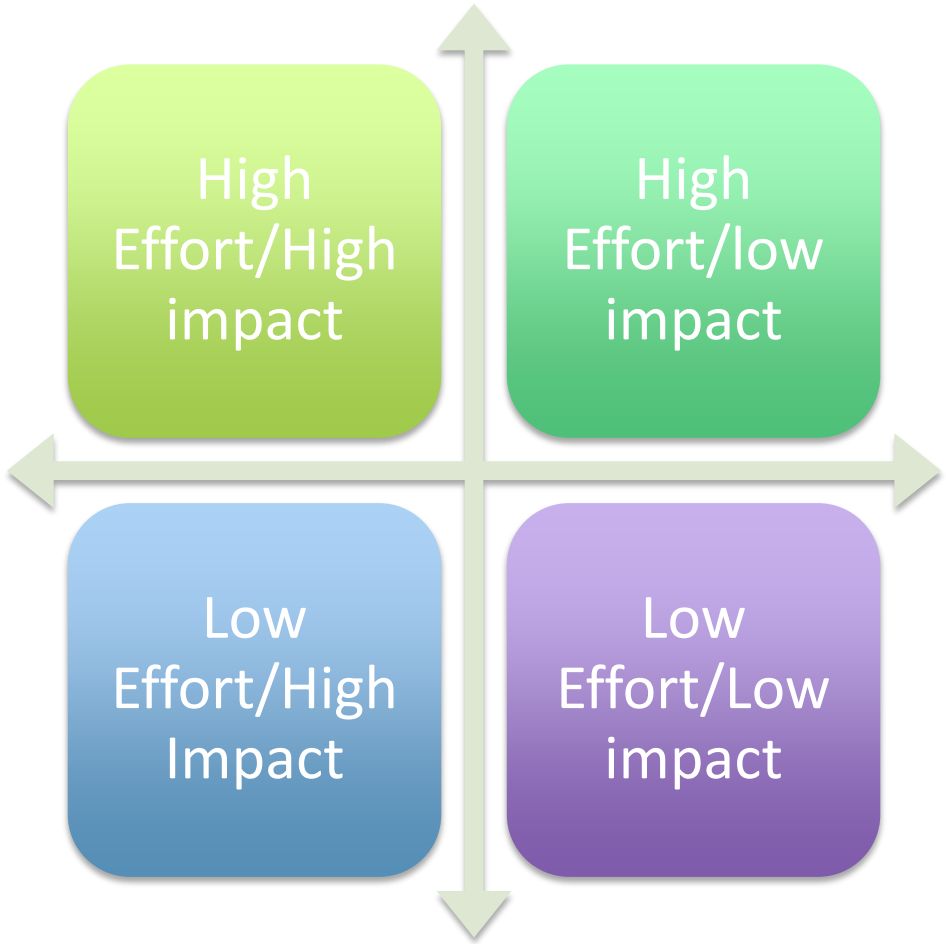


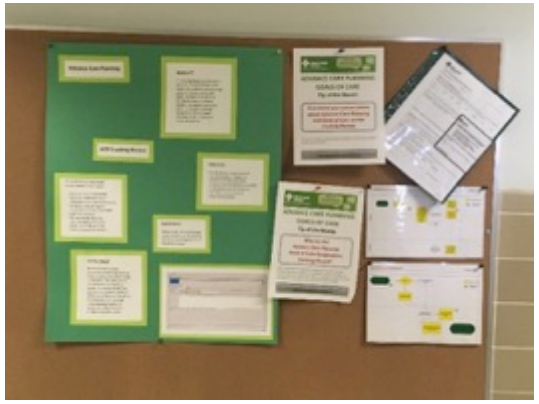
Method

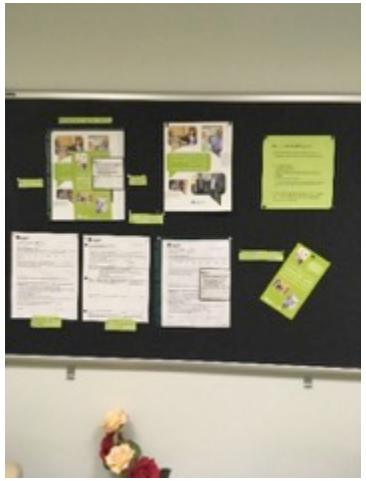

High Effort/High impact
High Effort/low impact
Low Effort/High Impact
Low Effort/Low impact

Method

High Impact/Low Effort

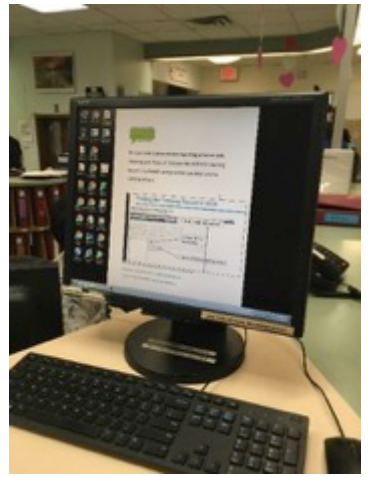
Environmental Changes





SCM now automatically printing new GCD

Enabling Tracking Record Use



Method- Intervention

TDF DOMAIN	COM-B	RECOMMENDED STRATEGIES	ACTION TAKEN FOR IMPLEMENTATION
KNOWLEDGE	Capability-psychological	Information regarding behavior/outcome	Formal education sessions led by ACP/GCD educators Debriefing sessions after e-SIMULATION exercises
SKILL	Capability-psychological	Specify goal/target Monitoring/self-monitoring Incentives Graded tasks Modeling Homework Perform behavior in different settings Rehearsal	Goals and targets set by clinical team Modeling done champion physicians, nurse educators Rehearsal done through e-SIMULATION scenarios developed by each clinical team and facilitated by e-SIM trained facilitators
MEMORY, ATTENTION, DECISION PROCESSES	Capability-psychological	Monitoring Planning/implementation Prompts/triggers cues	Monitoring ACP tracking record use through development and use of dashboards ACP tracking record prompts installed on unit computers
BELIEFS ABOUT CONSEQUENCES	Motivation- reflective	Monitoring Persuasive communication Information regarding behavior/outcome Feedback	Monitoring ACP tracking record use through development and use of dashboards Formal education sessions led by ACP/GCD educators
SOCIAL INFLUENCES	Opportunity-social	Modelling Social support, pressure, encouragement	Nursing management implemented a requirement that all patients have green sleeve included as part of their discharge package, ACP conversations be documented on the ACP tracking record and newly admitted patients are provided with an introduction to ACP and accompanying pamphlet

Method- Monitor Knowledge Use

- Instrumental monitoring
  - dashboard to monitor ACP tracking record use that is sent out to unit managers monthly
  - regular chart audits completed by unit clerks to ensure that patients have a prepared green sleeve in their discharge package.

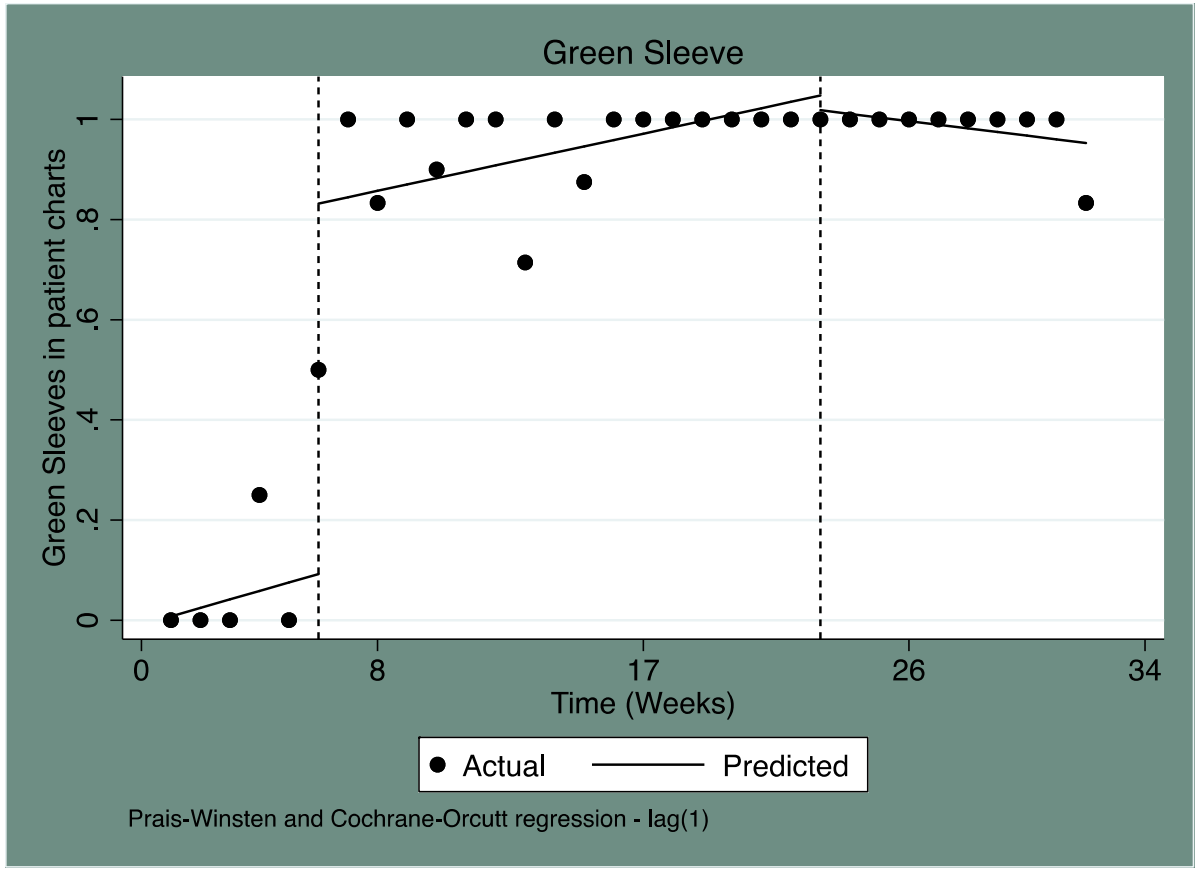
- Conceptual monitoring
  - monthly staff meetings to discuss individual progress with implementation goals (as well as address any emerging barriers)
  - tracking clinicians attending ACP education sessions.

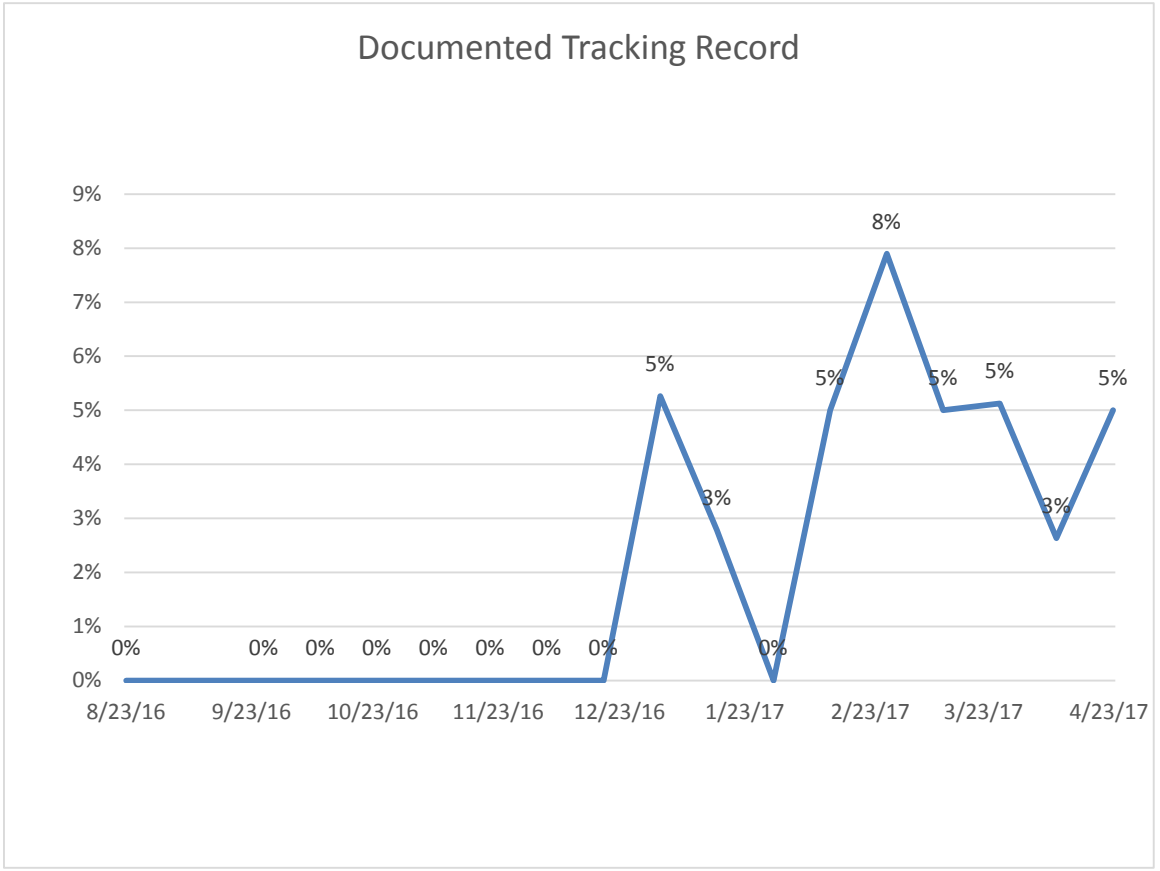
Pre-post Results

Measure	Acute Unit		Primary Care		CF Out-patient Clinic		HF home Care	
	Pre %	Post %	Pre %	Post %	Pre %	Post %	Pre %	Post %
Tracking Record Use	0	6	0	2	34	64	13	42
Patients aware of GCD	17	34	75	60	69	79	50	42
Competing priorities as barrier	54	69	45	67	83	75	83	50
Role confusion as barrier	54	31	27	17	17	0	17	50

Results (Acute Care)

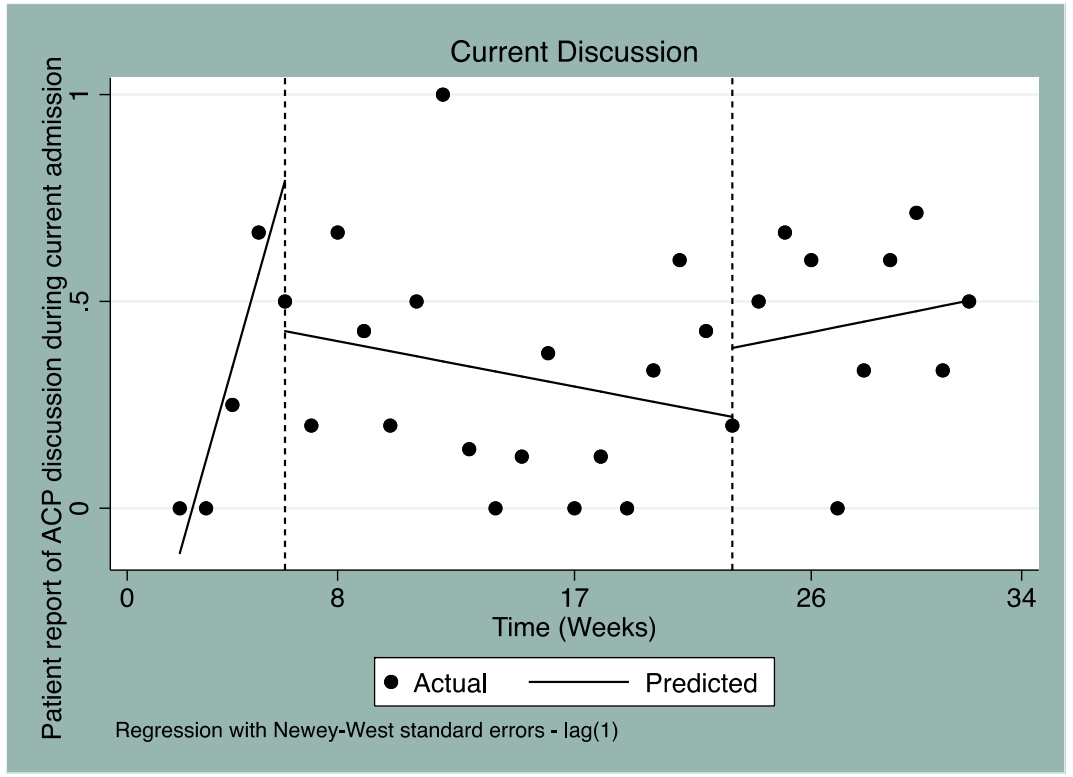
Achieved Change

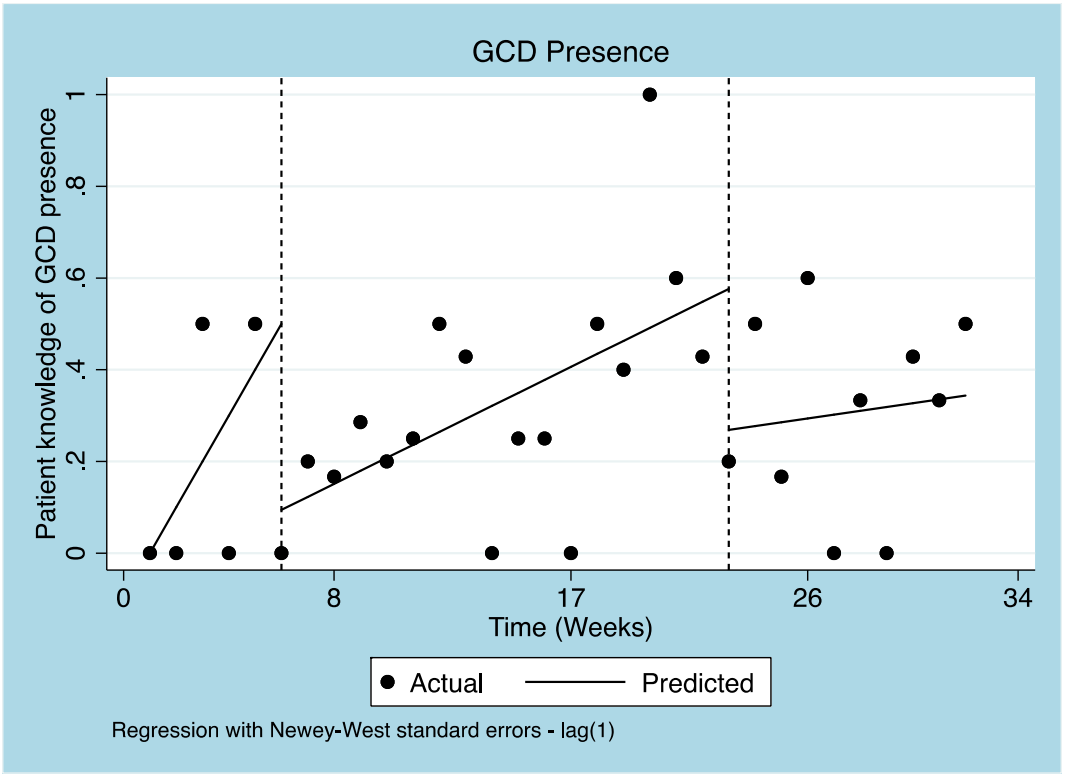




Results (Acute Care)

Change not achieved





Sustainability

NHS Sustainability Factors	Successful	Work-in progress	Actions
Process	Credible evidence Adaptable Progress monitoring in place	Benefit beyond simply helping patients	Intervention emerged from known practice gap and intervention elements are based in theory Intervention elements were selected by clinicians in each context Ongoing unit/clinic monitoring using dashboard and chart audits Effort to improve functionality of ACP tracking record
Staff	Training provided Staff involved in training development		Ongoing formal and information training available
Organization	Intervention elements fit with goals and culture of organization	Infrastructure (IT)	ACP optimization is a stated health region goal Effort to adapt electronic patient record system to more effectively be utilized for ACP and GCD documentation Availability of AIW and e-SIM for project expansion

Outpatient clinic: 84.8

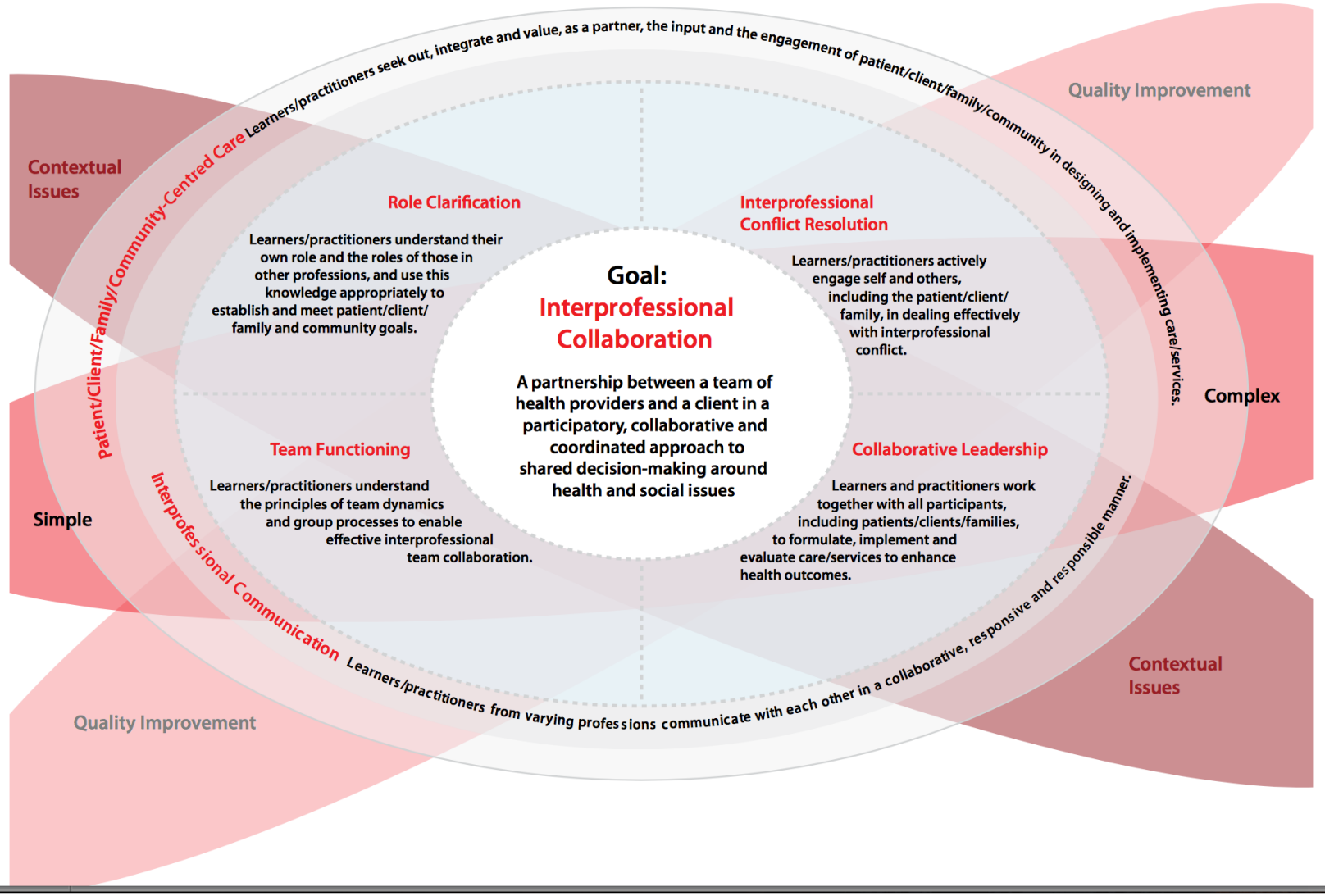
In-patient unit: 51.5

* Score over less than 55 indicates that more work should be done to address sustainibility

Lessons learned/Recommendations

- Change is hard!
- Addressing team process?
- To increase the likelihood of successful implementation:
  - Engage stakeholders (clinicians, team managers, department heads, physicians)
  - Be realistic about requirements/expectations
  - Define team member roles
  - Plan for sustainability at the beginning
  - Utilize existing resources as much as possible

Figure 1: The National Competency Framework



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Next Steps

- Process Evaluation utilizing a mixed methods approach
- iCAN ACP project (Drs. Fiona Dunne, Irene Ma, Jessica Simon)
  - Serious illness conversation guide training
- Potential for scale and spread of ACP QI (www.conversationsmatter.ca)

Advance Care Planning – Goals of Care Designation

Team Process Improvement Project: **Team Acknowledgment**

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Caroline Hatcher
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Konrad Fassbender
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