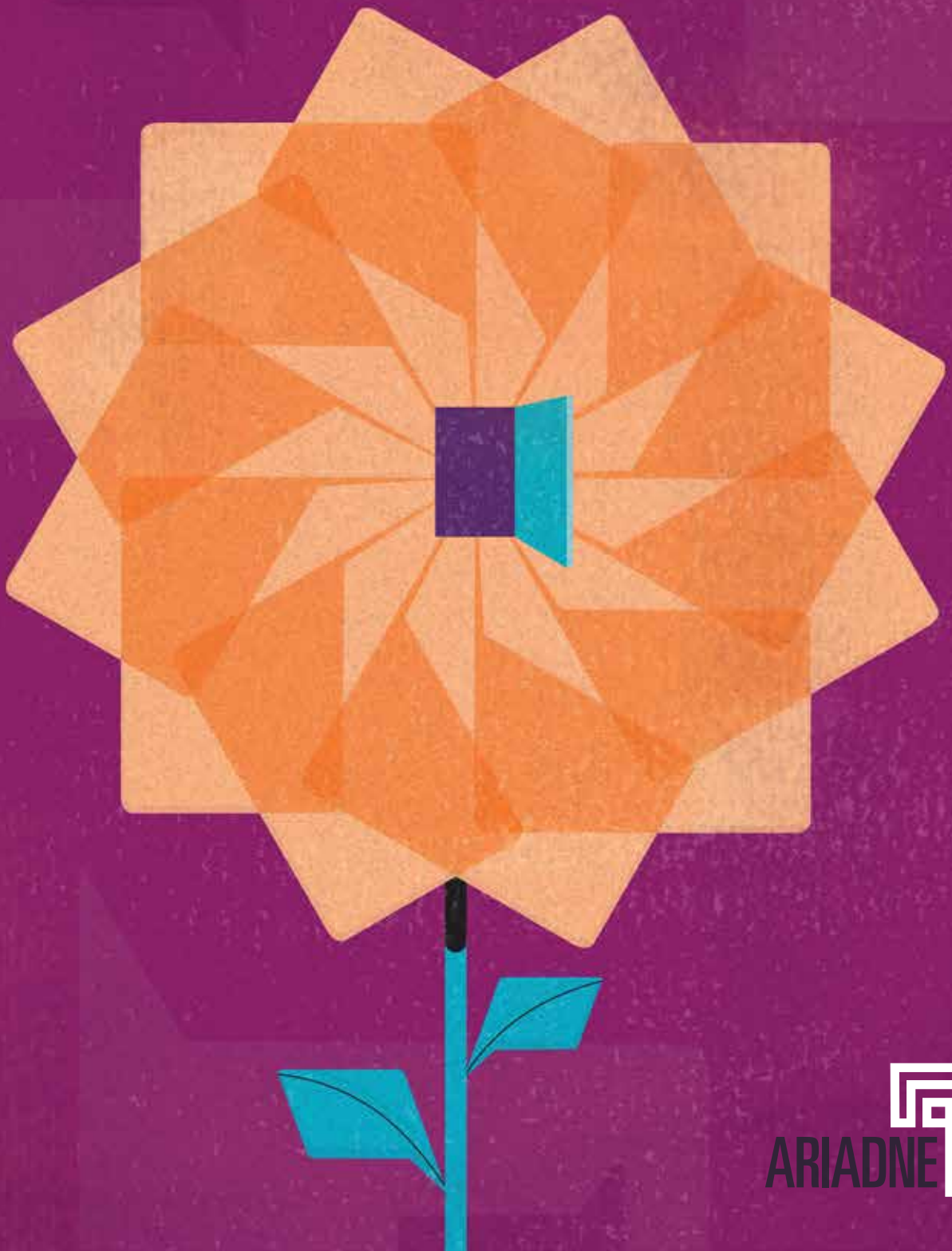
Serious Illness Care Program Implementation Toolkit



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Serious Illness Care Program Implementation Toolkit

CONTENTS

PHASE 1

Build Foundation

PHASE 2

Plan Implementation

SALLY ANSCOMBE / GETTY IMAGES

Introduction

Background and Overview

Implementation Roadmap

PHASE 3

Launch Pilot Sites

PHASE 4

Sustain and Expand

Appendix

INTRODUCTION

How to Improve Serious Illness Care: Better Conversations

In the U.S., approximately 2.5 million people die each year, mostly from chronic serious illnesses. As a result of absent, delayed, or inadequate communication about their priorities and wishes, many patients with serious illness do not receive the care they want at the end of life, experience unnecessary suffering, and die in settings not of their choice.

Currently, when conversations about end-of-life wishes do occur, they often begin late in the course of illness or in the midst of a crisis, which gives patients and their loved ones little time to prepare, to fulfill their goals, or to make informed decisions about treatment options. Often, key elements of effective conversations are not addressed, including prognostic communication and an understanding of the patient's values and priorities. These failures in serious illness communication are associated with lower quality of life for patients, increased family distress, poor alignment of medical care with patient wishes, and distress among clinical staff.

The benefits of earlier, high quality conversations about serious illness care goals are substantial, and include enhanced goal-consistent care, improved quality of life, reduced suffering and distress, higher patient satisfaction, earlier hospice care, better patient and family coping, eased burden of decision-making for families, improved bereavement outcomes, and reduced costs for non-beneficial care.

The benefits of earlier, high quality conversations about serious illness care goals are substantial, and include:

- Enhanced goal-consistent care
- Improved quality of life
- Reduced suffering and distress
- Earlier hospice care
- Better patient and family coping;
- Eased burden of decision- making for families
- Improved bereavement outcomes

The reality, however, is that these conversations are difficult for patients, families, and clinicians. In addition, patients with serious illness receive care in a complex, fragmented system that does not have adequate systems in place to support best practices.

The Serious Illness Care intervention represents a set of evidence-based practices that target the major causes of absent, delayed, or inadequate communication. Each intervention component is a critical step that addresses a gap in care. The centerpiece of the intervention is the Serious Illness Conversation Guide and training program, which gives clinicians the language they need to broach difficult conversations with their seriously ill patients. However, experiences with other communication interventions highlight that simply offering a tool and/or clinician training program does not result in widespread, consistent, and sustainable improvement in patient outcomes. As a result, this Implementation Toolkit is intended to promote systems change so that all patients with serious illness can live the best life possible and receive the kind of care they want.

The toolkit provides resources, tools, and technical advice for clinicians, non-clinical staff, and health-care leaders who aim to improve serious illness conversations and care at their own institution.

The toolkit provides resources, tools, and technical advice for clinicians, non-clinical staff, and health-care leaders who aim to improve serious illness conversations and care at their own institution. It draws on lessons learned from a wide range of health-care professionals who have tested, used, and championed the program successfully in their own health-care settings. While this program has been designed and tested in the outpatient setting, we have found it to be highly adaptable for an inpatient intervention designed to influence *post-discharge* outcomes (e.g. readmission, hospice use). It has not been tested to influence the course of care during an inpatient hospital stay.

The Toolkit covers the following key elements of planning and implementation: building a foundation for successful implementation; developing plans for the core components of clinician education and systems change; launching at your pilot sites; expanding the program; and supporting successful and sustainable implementation through measurement, coaching, and evaluation. The appendices provide a more detailed description of the tools available, as well as useful resources to complement the implementation approach.

We invite you to learn more about the Serious Illness Care Program and to contribute to the knowledge around effective ways of implementing the program in your system. Please join us and the rest of the healthcare community in continuing to improve care for patients with serious illness and their families.

BACKGROUND AND OVERVIEW

Serious Illness Care Program Development

As a result of absent, delayed, or inadequate communication about their wishes, many patients with serious illness do not receive the care they want at the end of life and experience poor outcomes. With this problem in mind, the Serious Illness Care team conducted and published a literature review of the barriers to high quality serious illness conversations. The major failures include:

+ Lack of a systematic way of identifying patients early in the course of a serious illness who are at high risk of dying
+ Little or no clinician training in communication skills and patient-centered conversations about values and goals
+ Clinician attitudes that impede communication about end-of-life issues (worries about upsetting patients; fears of being wrong about prognosis)
+ Inconsistent and poor quality documentation of patient's care goals
+ Lack of standards/best practices around serious illness communication, resulting in little or no monitoring of quality or impact

The team set out to identify the best practices that would avert each of the above key failures. These best practices were then distilled into a practical intervention, called the Serious Illness Care Program, designed to facilitate more, earlier, and better conversations. A national panel of experts, including palliative care specialists, general internists, cardiologists, oncologists, pediatricians, surgeons, patients, and caregivers provided feedback about the proposed intervention until it was refined into its current form.

Components of the Serious Illness Care Program

The Serious Illness Care Program is designed to change behavior and care delivery—the way that serious illness conversations are initiated, conducted, and communicated within a healthcare organization. It is a series of steps to ensure that effective, patient-centered conversations happen at the right time with the right patients. Using this toolkit, for each key component, you will: a) Review best practices from prior successful initiatives; b) Adapt the process to work specifically at your health-care setting; c) Establish a process of accountability and improvement through monitoring and evaluation.

PROGRAM COMPONENTS

1. **Training Clinicians:** The Serious Illness Care Program has developed a 2.5-hour interactive training program that teaches healthcare professionals—physicians, nurses, social workers—to have compassionate and effective conversations with patients using a tool called the Serious Illness Conversation Guide. The short training program is reinforced in practice by the systems-change components of the program (see 2-7 below).
2. **Screening:** In most settings, there is no screening tool to systematically identify seriously ill patients who would benefit from a conversation early in the course of an advancing illness. Although there are multiple disease-specific prognostic tools and high-risk algorithms, the simplest tool that applies to all patients and has gained acceptance is for clinicians to ask themselves The Surprise Question: Would I be surprised if this patient died in the next year?
3. **Conversation Preparation:** The program includes a process to schedule the conversation at an upcoming visit, prepare patients and families for the discussion, and remind clinicians to initiate the Serious Illness Conversation within an appropriate timeframe.
4. **The Serious Illness Conversation Encounter:** During an outpatient visit or hospitalization, a clinician initiates a discussion with the patient using the Serious Illness Conversation Guide to explore the patient's values and priorities. By ensuring point-of-care access to the Conversation Guide, clinicians are supported to have patient-centered, effective conversations using best practices in communication. At the end of the visit, the Family Communication Guide is provided to help patients and families continue these important discussions at home.
5. **Documenting Conversations:** The program includes development of a process to document conversations in the electronic medical record in a structured template that mirrors the Serious Illness Conversation Guide. This step makes it easier for clinicians to efficiently record the outcomes of their conversations and closes a major communication gap in our healthcare system: inconsistency in the quality and location of documentation of patient values and goals.

6. **Monitoring and Evaluation:** Regularly gathering information about serious illness care delivery practices offers insight about the quality of implementation and holds the organization accountable to high quality care. The program includes a process to collect and synthesize data, find trends, learn lessons, and feed back information to those who are using the elements of the program in their work.
7. **Coaching:** Coaches reinforce best practices in serious illness communication by supporting frontline clinicians who are using the Conversation Guide and offering advice for challenging patient or family situations. Coaches work closely with clinical teams to improve the efficiency of serious illness care processes, including patient screening, reminders, documentation, and measurement. By collaborating with frontline clinicians to learn what works well and what could be improved, coaches help to build a sustainable program through problem solving and the spread of successful practices.

Evidence in Support of the Intervention

This Implementation Toolkit was developed following a successful multi-year initiative that has demonstrated strong early outcomes in a randomized controlled trial at the Dana-Farber Cancer Institute for patients with cancer.

+ Preliminary results from a randomized controlled trial involving 391 patients, 350 family members, and 90 oncology clinicians (MDs, NPs, PAs) at the Dana-Farber Cancer Institute demonstrate strong positive impact of the intervention:
  - The conversations are perceived as worthwhile by 86% of patients.
  - The 2.5-hour clinician training was rated as highly effective by clinicians.
  - More than 95% of intervention clinicians have changed their behavior to adopt the Serious Illness Conversation Guide.
  - A significantly higher percentage of deceased intervention patients had at least one documented advance care planning conversation before death (93% compared to 76% p=0.009).
  - In the intervention group, the median timing of the initial documented advance care planning conversation before death was 2 months earlier than in the control group (5.2 months before death compared to 2.1 months p=0.012).
  - Documentation is significantly more patient-centered, comprehensive, and retrievable in the medical record for intervention patients compared to control.
  - The intervention significantly reduces anxiety and depression for patients with moderate/severe symptoms, and the reductions persist after the intervention.
  - Two-thirds of patients report positive behavior changes after serious illness conversations (increased attention to practical matters, more conversations involving family members, more planning for the future, and better relationships with their doctors).

Tools and Materials

THE SERIOUS ILLNESS CONVERSATION GUIDE

Building on the evidence of best practices from a literature review and expert panel, as well as extensive feedback from and testing with patients and clinicians, the project team developed a structured format to guide discussions—the Serious Illness Conversation Guide (below). The tool is designed to be used at the point of care to make it easier for clinicians, patients, and families to have these important discussions.

The Serious Illness Conversation Guide addresses illness understanding, information preferences, prognostic communication according to preferences, goals, fears, sources of strength, tradeoffs, critical abilities, and family understanding of patient priorities. It also includes steps to set up the conversation and follow-up steps to summarize the patient's goals, make a recommendation, and ensure successful documentation.

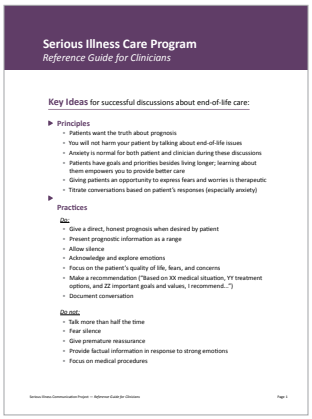
Serious Illness Conversation Guide

CONVERSATION FLOW		PATIENT-TESTED LANGUAGE
1. *Set up the conversation* Introduce the idea and benefits Ask permission	SET UP	"I'm hoping we can talk about where things are with your illness and where they might be going — **is this okay**?"
2. *Assess illness understanding and information preferences*	ASSESS	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. *Share prognosis* Tailor information to patient preference Allow silence, explore emotion	SHARE	**Prognosis:** "I'm worried that time may be short." *or* "This may be as strong as you feel."
4. *Explore key topics* Goals Fears and worries Sources of strength Critical abilities Tradeoffs Family	EXPLORE	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. *Close the conversation* Summarize what you've heard Make a recommendation Affirm your commitment to the patient	CLOSE	"**It sounds like** _____ is very important to you." "Given your goals and priorities and what we know about your illness at this stage, **I recommend**…" "**We're in this together**."
6. *Document your conversation*		

Your organization is encouraged to add your logo and name to the guide to make it your own. Clinicians may be reluctant to embrace a guide that is imposed from the outside. Even though it may sound simple, just adding your organization's name lets everyone know that the Serious Illness Conversation Guide is intended to serve your healthcare teams, your patients, and their families.

ADDITIONAL MATERIALS

Three additional resources were developed to support successful Serious Illness Conversations as part of the program.


Serious Illness Care Program
Reference Guide for Clinicians

Key Ideas for successful discussions about end-of-life care:

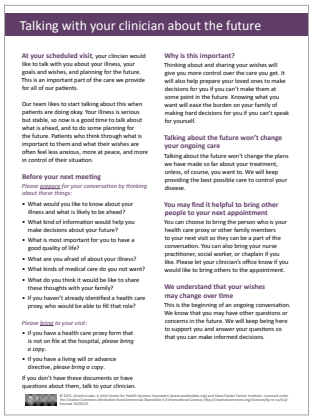
▶ **Principles**
- Patients want the truth about prognosis
- You will not harm your patient by talking about end-of-life issues
- Anxiety is normal for both patient and clinician during these discussions
- Patients have goals and priorities besides living longer; learning about them empowers you to provide better care
- Giving patients an opportunity to express fears and worries is therapeutic
- Titrate conversations based on patient's responses (especially anxiety)

▶ **Practices**

Do:
- Give a direct, honest prognosis when desired by patient
- Present prognostic information as a range
- Allow silence
- Acknowledge and explore emotions
- Focus on the patient's quality of life, fears, and concerns
- Make a recommendation ("Based on XX medical situation, YY treatment options, and ZZ important goals and values, I recommend...")
- Document conversation

Do not:
- Talk more than half the time
- Fear silence
- Give premature reassurance
- Provide factual information in response to strong emotions
- Focus on medical procedures

Serious Illness Communication Project — *Reference Guide for Clinicians* Page 1


Talking with your clinician about the future

At your scheduled visit, your clinician would like to talk with you about your illness, your goals and wishes, and planning for the future. This is an important part of the care we provide for all of our patients.

Our team likes to start talking about this when patients are doing okay. Your illness is serious but stable, so now is a good time to talk about what is ahead, and to do some planning for the future. Patients who think through what is important to them and what their wishes are often feel less anxious, more at peace, and more in control of their situation.

Before your next meeting

Please prepare for your conversation by thinking about these things:
- What would you like to know about your illness and what is likely to be ahead?
- What kind of information would help you make decisions about your future?
- What is most important for you to have a good quality of life?
- What are you afraid of about your illness?
- What kinds of medical care do you not want?
- What do you think it would be like to share these thoughts with your family?
- If you haven't already identified a health care proxy, who would be able to fill that role?

Please bring to your visit:
- If you have a health care proxy form that is not on file at the hospital, *please bring a copy.*
- If you have a living will or advance directive, *please bring a copy.*

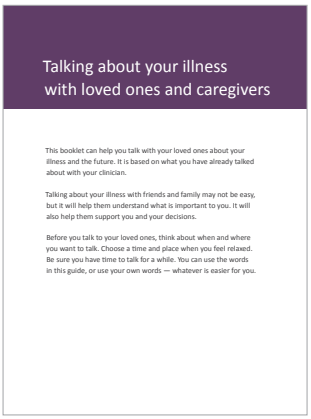
If you don't have these documents or have questions about them, talk to your clinician.

Why is this important?
Thinking about and sharing your wishes will give you more control over the care you get. It will also help prepare your loved ones to make decisions for you if you can't make them at some point in the future. Knowing what you want will ease the burden on your family of making hard decisions for you if you can't speak for yourself.

Talking about the future won't change your ongoing care
Talking about the future won't change the plans we have made so far about your treatment, unless, of course, you want to. We will keep providing the best possible care to control your disease.

You may find it helpful to bring other people to your next appointment
You can choose to bring the person who is your health care proxy or other family members to your next visit so they can be a part of the conversation. You can also bring your nurse practitioner, social worker, or chaplain if you like. Please let your clinician's office know if you would like to bring others to the appointment.

We understand that your wishes may change over time
This is the beginning of an ongoing conversation. We know that you may have other questions or concerns in the future. We will keep being here to support you and answer your questions so that you can make informed decisions.


Talking about your illness with loved ones and caregivers

This booklet can help you talk with your loved ones about your illness and the future. It is based on what you have already talked about with your clinician.

Talking about your illness with friends and family may not be easy, but it will help them understand what is important to you. It will also help them support you and your decisions.

Before you talk to your loved ones, think about when and where you want to talk. Choose a time and place when you feel relaxed. Be sure you have time to talk for a while. You can use the words in this guide, or use your own words — whatever is easier for you.

The Clinician Reference Guide is a 12-page booklet with additional information for clinicians. It provides useful language and tips to help clinicians set up the conversation, respond to challenging scenarios, and make patient-centered recommendations.

Talking with Your Clinician about the Future is a document for patients. It is designed to prepare them for the Serious Illness Conversation by explaining that a discussion about their values and goals will take place at an upcoming clinic visit.

The Family Communication Guide is for patients and families. It is a small booklet with tips to help patients and families continue these discussions at home.

IMPLEMENTATION ROADMAP

Implementation Roadmap: Introduction and Summary

Whether you are a clinician or healthcare administrator, the Implementation Roadmap will serve as a guide to help you plan a successful program. Experience with the Serious Illness Care Program has shown that simply introducing a new tool into practice, such as the Conversation Guide, will not lead to sustained improvement. It takes a dedicated team and considerable planning to improve serious illness care in a sustainable way. But do not be discouraged. This Implementation Roadmap was designed to make it easier for you and your team to plan and implement the program.

As you think about implementation of your initiative, here are principles that will help enhance the likelihood of achieving your goals:

+ **Training alone is not enough:** Training clinicians to have Serious Illness Conversations is not enough to facilitate practice change. Changing the status quo of medical practice with seriously ill patients requires a multifaceted approach that includes tools, education, and systems change.
+ **Start easy and small:** We recommend launching implementation in no more than two or three pilot sites. Pilot site implementation should be small enough and controlled enough for you to achieve success and maximize learning. An early win also helps to generate additional leadership support and excitement from other colleagues and sites.
+ **Build slowly:** Once the pilot sites are up and running, continue to implement at additional sites. Evaluate what worked well, what didn't work well, and incorporate the lessons learned as you progress.
+ **Engage and debrief frequently:** Throughout planning and implementation, talk to as many people as you can and meet regularly as a team. Reflection and critical analysis will allow you to synthesize feedback, identify strengths and challenges, and apply what you have learned.

TIP

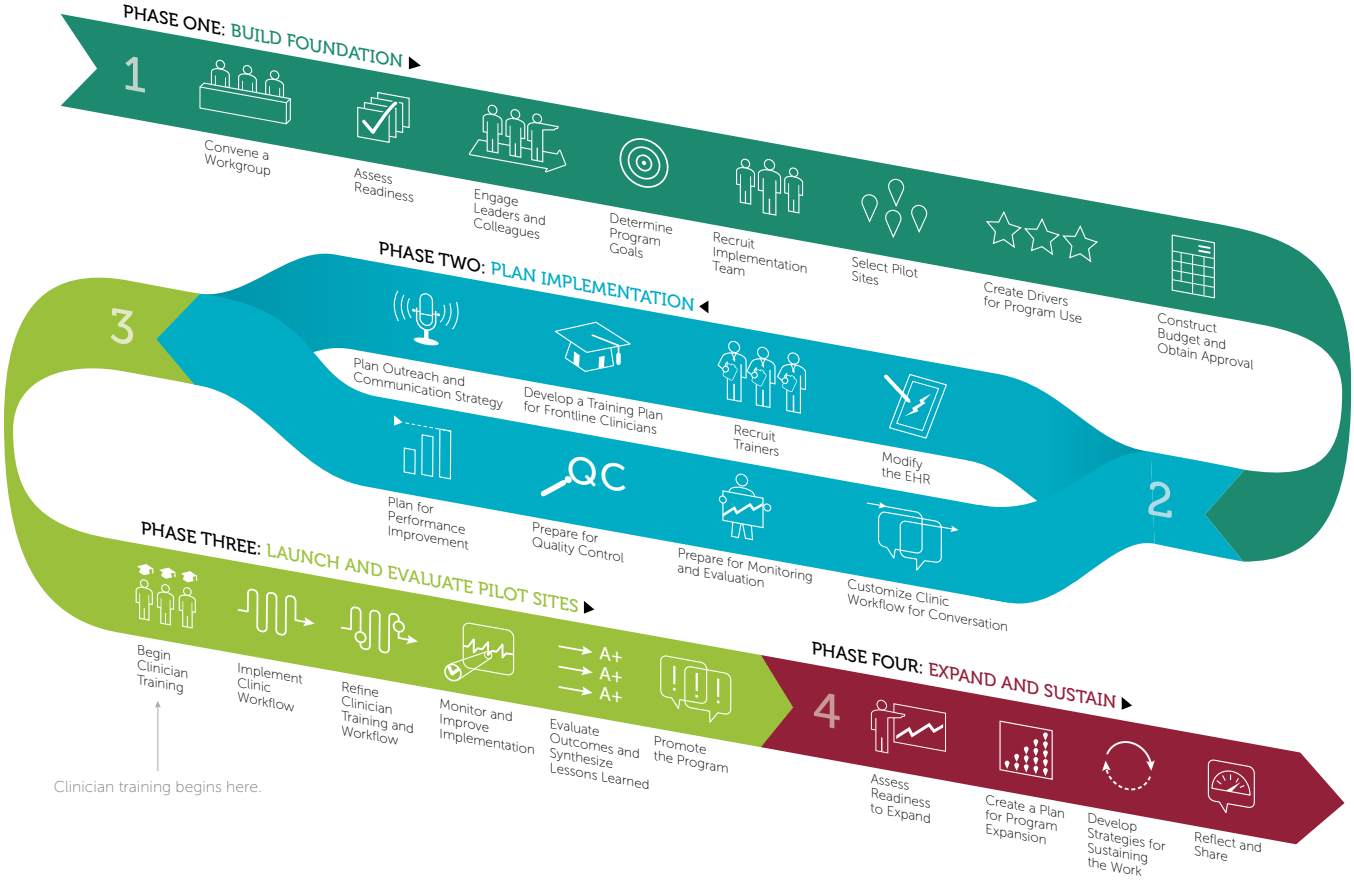
Training alone is not enough. A systems approach that includes engagement, measurement, and ongoing support can help achieve successful outcomes.

Phases 1 and 2 of this Guide are planning phases that will help you prepare for implementation launch. Implementation begins in Phase 3, localized to your pilot sites to allow adequate time for rapid cycle improvement on a workable scale. Phase 4 involves expansion to new sites, evaluation, and sustainability. In the Toolkit, each Phase has sections that include objectives, a brief description, action steps, and associated resources and tools.

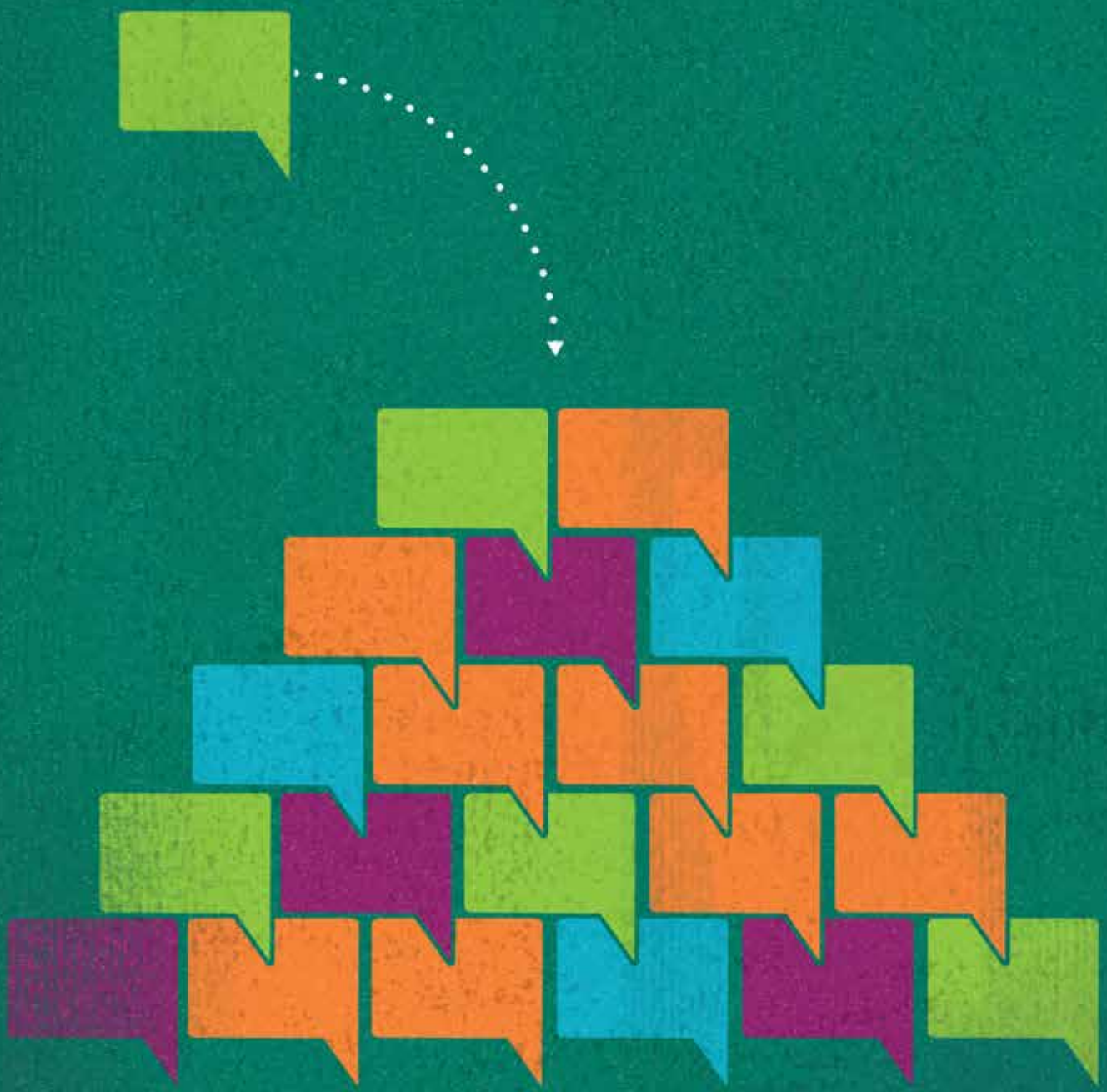
Think of the implementation roadmap as a guide, not a script. The specific objectives, resources, and action steps for each section are meant to be adapted to meet the needs of your setting. Some of the steps may be overlapping rather than linear, and others will likely need to be repeated during the implementation process. There may be additional activities that are necessary for successful implementation at your health-care system that are not included in this toolkit.

TIP

Implementation of the Serious Illness Care Program is a journey, not an event. We use the word "implementation" to refer to a span of activities, from the initial idea through the process of integrating the program into your organization and continuing with coaching and long-term improvement.

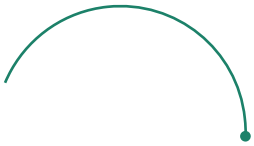


PHASE 1: BUILD FOUNDATION



Summary: Phase 1

Quality implementation begins by understanding the core components of the Serious Illness Care Program, the needs of your organization, and how they fit together. By forming an exploratory committee, you and your colleagues can learn more about the program and complete a readiness assessment to evaluate how prepared your organization is to implement the program.



Phase 1 will help you build a foundation to support high quality implementation of the program

In addition to assessing readiness, the activities in Phase 1 will also help you build a supportive environment, i.e. build readiness for implementation. The strategies highlighted during this phase include: a) Engaging leaders and colleagues to involve them in the implementation process; b) Aligning program goals with your institutional priorities; c) Recruiting clinical champions and an implementation team who will advocate for the program and support high quality implementation; d) Selecting pilot sites where implementation will begin; e) Creating drivers for program use; and f) Securing appropriate funding and resources.

By the end of Phase 1, you will have succeeded in building a foundation for success when you have institutional commitment to the following:

+ A multi-year Serious Illness Care Program initiative
+ A strategy that includes clinician education and systems change
+ Agreement on the program's goals, desired outcomes, and intended reach
+ Dedicated quality improvement resources for planning, measurement, and evaluation
+ Implementation team resources, including one or more clinical champions and project management
+ Drivers to encourage program use

If you feel that you do not have the support you need, do not be discouraged. Other organizations that were not yet ready for system-wide implementation have achieved success by starting with smaller scale projects.

Convene a Workgroup

Objective: Convene an exploratory committee

Description: If you are a clinician or administrator interested in implementing the Serious Illness Care Program, the first step is to convene an exploratory committee to learn more about the program, assess your organization, and make recommendations about how to move ahead. Your exploratory committee will complete all of the work described in Phase 1.

Steps:

1. Convene an exploratory committee
2. Review the core Serious Illness Care Program materials

Appendix Materials: Ariadne Labs faculty will provide program research materials.

1. CONVENE AN EXPLORATORY COMMITTEE

The exploratory committee will act as a planning team for this program until the implementation team is formed. The committee is responsible for completing Phase 1 activities. We recommend 3-4 members, including the following (or equivalent) persons at your organization:

+ Palliative Care leader or colleague
+ Specialist or generalist clinical leader or colleague
+ Chief Medical and/or Nursing Officer
+ Director of Quality

TIP

As with any project that implements practice change, a well-organized committee is essential to efficiently move from ideas to execution.

2. REVIEW THE SERIOUS ILLNESS CARE PROGRAM MATERIALS

The exploratory committee should be equipped with a common understanding of the Serious Illness Care Program, the evidence supporting its use, and the recommended process for implementation. We suggest the following steps:

+ Review the content in the Introduction and Background & Overview sections
+ Agree to implement the core elements of the program (clinician education, systems change components)
+ Review other sources of information and the evidence for the program
+ Review the key phases and steps of the Implementation Roadmap

Assess Readiness

Objective: Identify your organization's strengths and potential challenges related to implementation of the program

Description: The Serious Illness Care Program is a multi-year endeavor that involves commitment of clinical and operational resources. Therefore, it is important to consider cultural and organizational readiness before beginning implementation. The Readiness Assessment Worksheet in this section includes factors that indicate how easy or difficult implementation might be, but none of the factors should be considered as predictive of success or failure. It is the people on the ground who matter most — an implementation team that is dedicated and persistent and can respond to challenges as the work unfolds.

Steps:

1. Complete The Readiness Assessment Worksheet

Appendix Materials: Readiness Assessment Worksheet

1. COMPLETE THE READINESS ASSESSMENT WORKSHEET

This worksheet is designed to help you better understand your readiness to begin implementing the Serious Illness Care Program. It is a tool that prompts you with open-ended questions to assess your current environment and take stock of your resources. Keep in mind that the remaining Phase 1 activities will help you build a foundation for successful implementation (i.e. build readiness), but it is helpful to begin by working together as a committee to complete the worksheet. You may need to collaborate with leadership and additional colleagues to answer the questions and make your assessments.

TIP

Every organization has a unique set of strengths and challenges. Understanding these will help you focus your efforts as you plan for implementation of the program.

There are six key factors to consider:

1. Leadership alignment and support
2. Availability of implementation team resources and clinical champions
3. Existing population management programs
4. Commitment to quality improvement and measurement
5. Strong culture of palliative care
6. Institutional priorities that do not compete

Engage Leaders and Colleagues

Objectives:

+ Obtain agreement among key stakeholders that there is a problem in serious illness care delivery
+ Achieve consensus that the Serious Illness Care initiative is the recommended solution
+ Explore key stakeholders' concerns

Description: Engaging leaders and colleagues will help you understand how people feel about their work related to serious illness care and obtain buy-in by building the case for change. It is important for stakeholders to perceive that there is a need for the Serious Illness Care Program and that it will lead to positive measurable outcomes. The effort to improve serious illness care is more effective when you engage people deeply and emotionally in this work, specifically by having face-to-face conversations and eliciting personal perspectives about the challenges of caring for patients with serious illness. Face-to-face conversations allow you to emotionally engage with stakeholders, discuss the who/when/why and how of the initiative, and ask for feedback and help. Talking points will vary depending on your audience, but personal conversations are the optimal method to engage stakeholders.

TIP

Experience from prior initiatives indicates that a face-to-face conversation is the most effective tool you have to get leaders and colleagues interested and involved in the Serious Illness Care Program work.

Steps:

1. Determine who to engage
2. Prepare for face-to-face meetings
3. Meet with stakeholders and document the outcomes of your conversations

Appendix Materials:

+ Sample Engagement Handout
+ Tips for Talking Points

1. DETERMINE WHO TO ENGAGE

Examples of leaders and colleagues you may want to engage are listed below.

Colleagues:

+ Palliative Care Director and other Palliative Care colleagues
+ Department Chairs/Chiefs (i.e. Chief of Medicine; Oncology Director)
+ Site-specific Leaders (e.g. Director of Primary Care at Clinic A; Oncology Center Leader; Nursing Supervisor)
+ Influential clinicians who represent "end-users" (i.e. well-respected primary care or oncology clinicians; charge nurse)

Leadership:

+ Chief Medical Officer
+ Chief Nursing Officer
+ Chief Executive Officer
+ Chief Quality Officer
+ Chief Operations and Information Officers (expertise in the EHR)
+ Director of Social Work
+ Others recommended by the Chief Medical/Nursing Officers

2. PREPARE FOR FACE-TO-FACE MEETINGS

Early engagement of leaders and colleagues is often conducted by the clinical champion(s). Prepare talking points and handouts that will be useful during your meetings.

+ Review Sample Engagement Handout and Tips for Talking Points
+ Customize for your purpose

Begin by engaging colleagues to build allies before you engage leaders. We recommend starting with colleagues you know will be excited about an initiative to improve serious illness conversations and care, but don't avoid individuals you believe may have concerns--they often become your best allies. After establishing allies, move on to engage leadership. Since the leadership role of the CMO and CNO is so critical, start with these individuals before meeting with other executive leaders. Ask the CMO or CNO about leadership priorities (e.g. reducing inpatient mortality, improving patient satisfaction) and how they think the Serious Illness Care Program can be a 'win-win' for the institution

3. MEET WITH STAKEHOLDERS AND DOCUMENT THE OUTCOMES OF YOUR CONVERSATIONS

In addition to generating support and approval for the initiative, you will get a wealth of information about the strengths of your organization and potential barriers to implementation from these early conversations. It is critical to ask explicitly about reservations or concerns about the initiative because it builds trust and allows you to anticipate implementation challenges and address concerns.

FROM THE FIELD

Dr. Susan Block shares some thoughts about the importance of engagement.

"Through all of our work to improve serious illness conversations and care, we've learned the importance of creating opportunities for people to express their thoughts and feedback. As you engage your colleagues, keep in mind that it's important that they have a voice and are part of the effort."

TIP

We recommend keeping a spreadsheet to track engagement conversations, document what you have learned, and list any necessary follow-up action.

Determine Program Goals

Objective: Define what you hope to accomplish by implementing the Serious Illness Care Program

Description: Aligning your organization around common goals will help you maximize the impact of the program. Your goals can be defined by determining your specific desired outcomes and the intended reach of the Serious Illness Care Program. Goals are often aligned with the Quadruple Aim: improved patient experience of care, better outcomes for patients, more appropriate resource use, and improved provider satisfaction.

Steps:

1. List high-level goals
2. Define desired outcomes
3. Determine intended program reach

Appendix Materials: None

1. LIST HIGH-LEVEL GOALS

Your goals should be a broad view of what you consider to be success at the end of the project. For example:

1. Provide patient-centered care that is aligned with individual goals and preferences
2. Improve quality of life for seriously ill patients
3. Reduce hospital readmissions

When thinking about your goals, consider the following questions:

+ Are the goals relevant to your organization's mission and priorities?
+ Are they realistic?
+ How long do you think it will take to achieve the goals?

2. DEFINE DESIRED OUTCOMES

Desired outcomes are more specific outcomes that you hope the program will accomplish. For example:

1. Conduct and document patient-centered serious illness conversations with > 80% of high-risk patients within 3 years
2. Reduce rates of moderate/severe anxiety and depression in seriously ill patients by 50% within 3 years
3. Reduce hospital readmissions by 20% within 3 years

3. DETERMINE INTENDED PROGRAM REACH

This includes descriptions and numbers of patients and clinicians you hope the program will reach and the practice sites that will be involved.

Target patient population

+ Describe your target patient population:
  - E.g. ACO patients; Medical home patients; Oncology; Primary Care; Heart Failure; Geriatrics
+ Estimate the number of patients in the target population:

Target clinicians

+ Describe the clinicians who will need to be trained to reach the patient population:
  - E.g. Primary care clinicians; cardiologists; oncologists
  - E.g. Disciplines - MDs, NPs, PAs, RNs, SWs
+ Estimate the number of clinicians in each discipline who need to be trained to reach the target patient population(s):
+ Identify where there might be challenges to motivate clinicians to attend trainings and have conversations:
  - E.g. Different physician employment models such as an independent practice association versus staff model; fee-for-service; risk-based contract; clinician incentives that could impact willingness to have conversations e.g. volume or time based office visits

Practice sites

+ Describe the care settings in which implementation will occur:
  - E.g. outpatient clinic, medical home, clinics embedded in hospital, free-standing clinics, nursing home, hospice, inpatient implementation to affect post-discharge planning
+ Estimate the number of sites (e.g. clinic locations)serving the target patient population(s)

Recruit Implementation Team

Objective: Recruit a multidisciplinary implementation team

Description: The implementation team is responsible for planning, executing, and overseeing implementation of the Serious Illness Care Program throughout the lifetime of the project. Team members prepare and support clinicians and staff to use the intervention and improve performance over time. The structure of the implementation team will vary depending on your organization. At this point, you should begin to think about funding and potential new hires, if necessary.

TIP

Implementation of the Serious Illness Care Program is challenging work that takes time. It is the implementation team on the ground that matters most — a group of people who are dedicated, persistent, and can respond to challenges as the work unfolds.

Steps:

1. Review the provided FTE estimates for implementation team members
2. Review roles and responsibilities for team members and a sample organizational chart
3. Reach out to potential team members and confirm their commitment

Appendix Materials:
Roles and Responsibilities for Implementation Team Members
Sample Organizational Chart

1. REVIEW THE PROVIDED FTE ESTIMATES FOR IMPLEMENTATION TEAM MEMBERS

Resource needs will vary based on organizational factors and the scope of the program. In order to provide some idea of staffing needs, we have included a table that contains sample FTE (full time equivalent) estimates from prior successful initiatives. The FTE ranges in the table supported initiatives involving implementation of the full intervention in 6-12 clinical sites over a period of 2 years, which included the training and support of 50-100 clinicians to use the Serious Illness Conversation Guide. This does not include training resources, which will be discussed in a later section.

TIP

Implementation teams have different structures depending on your organization. Whichever structure you decide, assure that team members are assigned clear roles and responsibilities.

IMPLEMENTATION TEAM ROLES	FTE
Clinical Lead(s)	0.25-0.5
Project Manager	0.5-1.0
Quality Improvement (QI) specialist	0.2
Administrator	0.2
Data Analyst/Information Technology (EHR representative)	0.1
SITE-SPECIFIC CONTRIBUTORS	**FTE**
Clinician end-user representative	<0.1
Clinic manager	<0.1

2. REVIEW ROLES AND RESPONSIBILITIES FOR TEAM MEMBERS AND A SAMPLE ORGANIZATIONAL CHART

It is critical to select team members with the skills necessary to support implementation. In the Appendix, we have included detailed role descriptions and a sample organizational chart for the following positions so that you can ensure that your team is equipped for the project:

+ Clinical Lead(s), such as a Palliative Care clinician
+ Project Manager
+ Quality Improvement specialist
+ Information Technology specialist, especially with expertise in the electronic health record
+ Administrative support
+ Clinician representing proposed training cohort/implementation site (e.g. primary care clinic)
+ Internal Marketing specialist to develop and spread messages about the program

The implementation team often reports to an Executive Steering Committee for input during planning, approval for resources, and to keep them informed of progress and milestones related to the program. The roles and responsibilities of the Executive Steering Committee are also included in the Appendix section.

3. REACH OUT TO POTENTIAL TEAM MEMBERS AND CONFIRM THEIR COMMITMENT

Implementation team members must be enthusiastic, engaged, and willing to contribute time to work on this project. Some team members, including the Clinical Lead(s) and Project Manager, may require new funding or hiring. Other team roles, such as Data Analyst/IT specialist/EHR representative, Quality Improvement specialist, and Administrator, may be performed by existing people at your organization whose time can be directed to Serious Illness Care Program activities. For all team members, especially those not directly compensated, it is critical to understand how their time will be protected to serve on this project.

Select Pilot Sites

Objectives:

+ Identify two to three clinical sites that are the most suitable starting points for program implementation
+ Begin building relationships with leaders and colleagues at the identified sites

Description: The unit of implementation for the Serious Illness Care Program is the clinical site (e.g. oncology clinic). Ensuring successful implementation at two or three pilot sites before spreading to other locations can help you work out logistics and workflows before expanding more broadly. It is important to select pilot sites that have a high likelihood of success. Additionally, recruiting strong champions at the pilot sites will drive engagement and adoption at other sites where there may be less support.

Steps:

1. Choose and describe two to three potential pilot sites
2. Engage colleagues and identify local champions
3. Approve and confirm site selection

Appendix Materials: None

1. CHOOSE AND DESCRIBE TWO OR THREE POTENTIAL PILOT SITES

Identify pilot sites based on your program goals and the target population that you identified for this program. Determine which would be most likely to succeed.

+ **Sites that are most likely to succeed are sites in which there is:**
  - Strong leadership engagement: e.g., physician leader, nursing leader, clinic manager
  - Significant population of seriously ill patients
  - Engaged and motivated clinicians, including physician and nursing colleagues
  - Existing collaborative care model between physicians, nurses, social workers, and other staff
  - Middle of the road in terms of numbers of clinicians and patients (not too large or too small)
  - Demonstrated success with prior Quality Improvement initiatives
  - Easily aligned with your organization (e.g. staff model, shared risk contract)

After reviewing potential practice sites, describe the two best suited to become pilot sites below:

DESCRIBE THE FOLLOWING CHARACTERISTICS	SITE 1	SITE 2
Clinical setting • e.g. Outpatient clinic, medical home, clinics embedded in hospital, nursing home, hospice, hospital		
Target patient population • e.g. High risk primary care, oncology, cardiology		
Estimate number of patients		
Clinician population • e.g. Include all clinicians for whom the conversation is within their scope of practice (physicians, nurse practitioners, RNs, social workers)		
Estimate number of clinicians who need training		
Care delivery model* • e.g. Staff model, independent practice association, fee-for-service, risk-based contract		

*Identify where there might be challenges motivating clinicians to attend trainings and have conversations.

2. ENGAGE PILOT SITES AND IDENTIFY LOCAL CHAMPIONS

Using engagement techniques, begin having face-to-face conversations to get site leaders and colleagues interested and involved in the Serious Illness Care Program.

During the planning phase, these conversations serve several purposes:

+ Help you identify enthusiastic supporters who will help champion the work at the site
+ Identify colleagues and staff who are interested in joining your phase 2 planning efforts by contributing site-specific knowledge to adapt the elements of the program
+ Give you on-the-ground insight about the level of engagement of clinicians and staff and the potential challenges you may face in implementing the program

During implementation, local champions:

+ Promote the program and serve as a local peer clinical leader
+ Provide feedback from frontline clinical teams about implementation successes and challenges

TIP

The more involved local clinicians and staff are in the development and launch of the program for that particular clinic or hospital, the more ownership they will have over the initiative and investment in its success. In fact, pilot site leaders often become champions of the initiative for the larger institution. Other organizations that have launched the Serious Illness Care Program refer to their pilots as "Exemplar Sites," which stresses the importance and contributions of your early sites.

- Advocate for the program and speak about the rationale and benefits to colleagues
- Work with the implementation team to encourage adherence to implementation activities

3. APPROVE AND CONFIRM SELECTION

After considering the factors related to successful implementation (Step 1) and synthesizing what you have learned from Steps 2 and 3, confirm your choice for the pilot sites. If necessary, confirm with leadership that these sites are able to participate as pilots in the program.

Create Drivers for Program Use

Objective: Identify institutional policies that create levers for use of the Serious Illness Care Program

Description: When thinking about encouraging uptake of the core elements of the program, there are multiple strategies that are helpful to motivate use of the program in practice. Strategies from prior successful initiatives have been divided into four categories:

a. Engaging clinicians and staff to encourage open communication and feedback, participation, and a shared understanding of the work (see section on Engaging Leaders and Colleagues in Phase 1)

b. Building systems of accountability (i.e. measurement and coaching) to ensure high quality implementation of the program and performance improvement if goals are not being met (see sections on Customizing Clinic Workflow, Monitoring and Evaluation, Quality Control, and Performance Improvement in Phase 2)

c. Implementing high quality training that motivates clinicians to improve their practice in serious illness conversations (see sections on Recruiting Trainers and Developing a Training Plan for Frontline Clinicians in Phase 2)

d. Creating policies that involve drivers and compensation (financial and otherwise) for use of the program.

This section will focus on d) drivers and compensation. This section is included during Phase 1 because of potential financial implications that require decisions early in the process, but it would benefit from being used alongside the other Phase 2 sections mentioned in the above description.

TIP

Although incentives can be helpful, they are just one part of a multifaceted strategy to motivate behavior change. Success relies on:

- Engaging clinicians and staff
- Building systems of accountability
- Implementing high quality training and coaching
- Creating policies and drivers

Action steps:

1. Secure drivers and credit/compensation for Trainers to prepare for their roles
2. Secure drivers and credit/compensation for frontline clinicians to attend a 2.5-hour training session
3. Secure drivers and credit/compensation for clinicians to have Serious Illness Conversations

Appendix Materials: None

STEP 1. SECURE TIME AWAY FROM CLINIC AND CREDIT/ COMPENSATION FOR TRAINERS TO PREPARE FOR THEIR ROLES

We strongly recommend that the implementation planning team engage leadership early to secure time away from clinical work, and credit/compensation for Trainers. Delaying this process can jeopardize training capacity later during implementation.

+ **Organize a meeting with executive stakeholders to discuss that Trainers require the following:**

  - **ONE TIME:**
    At least 4 days of available time away from clinical practice to complete Ariadne Labs Train the Trainer courses (2 days for the courses, approximately 2 days for travel time)

  - **ANNUALLY:**
    At least 6 training days per year for the following:
    - *Lead at least 4-6 clinician training sessions per year (may vary)*
    - *Collect and compile training data and send to the central team*

    At least 4 days per year for quarterly Trainer debriefing sessions and individualized Trainer coaching sessions to improve their skills as an educator
    - *Stay familiar with the Serious Illness Care Program and receive updates*
    - *Refine training program based on evaluations and feedback*

  - **TOTAL = 14 days in the first year; 12 days per year thereafter (<0.1FTE)**

+ **Ensure that CME and/or other types of credit and compensation are available for Trainers to prepare for their roles and lead training sessions**

  Financial compensation for the above time

  Note: *It is helpful to provide direct financial compensation for each training session led by the Trainer*

  - **CME Credit** for attending Train the Trainer courses

    Note: *The section Recruit Trainers in Phase 2 will help you identify qualified Trainers who can become certified by Ariadne Labs to teach the Serious Illness Conversation Guide.*

STEP 2. SECURE TIME AWAY FROM CLINIC AND OTHER LEVERS FOR FRONTLINE CLINICIANS TO ATTEND TRAININGS

The implementation planning team should engage leadership early to ensure that time away from clinical work, CME credit, and incentives are secured for frontline generalist and specialist clinicians to attend trainings.

+ **Recommendations for frontline clinicians:**
  - **At least ½ day of available time away** from clinical practice for clinicians to attend one Serious Illness Conversation training session, plus any travel time if applicable
  - **CME and other credit for clinicians** (MDs, NPs, PAs, SWs, RNs) to attend the 2.5-hour training session
  - **Compensation:** Financial stipend to attend the training (given at the end of the training session); hourly RVU credit for training

STEP 3. SECURE LEVERS TO MOTIVATE FRONT-LINE CLINICIANS TO HAVE SERIOUS ILLNESS CONVERSATIONS

Any levers for having Serious Illness Conversations should be discussed and secured with leadership before training begins.

+ **Examples of compensation:**
  - **Billable event** (see new Medicare Advance Care Planning payment)
  - **RVUs**
  - **Bonus tied to performance** on conversation metrics/goals

+ **Examples of comparative data-driven social ranking (peer pressure):**
  - **Reports that identify "top-performing clinicians"** on goals related to serious illness conversations
  - **Reports that compare individual clinicians** to the performance of "top-performing clinicians" on goals related to serious illness conversations
  - **Reports that compare clinic-level data** on goals related to implementation of the program
  - **Social recognition** for top-performing clinicians and clinics/sites

+ **For clinicians not meeting goals:**
  - **Re-training** opportunities
  - **In-person observation** (peer-to-peer)
  - **One-on-one coaching session** with a Clinical Coach (see Quality Control and Performance Improvement sections in Phase 2)

Construct Budget and Obtain Approval

Objectives:

+ Develop a realistic budget for your project
+ Obtain approval from administration

Description: Constructing a realistic budget for your project secures your team's time to focus on this initiative. It also prevents surprises and allows you to begin planning. The budget needs to account for scope, timeline, and any constraints you are facing.

Steps:

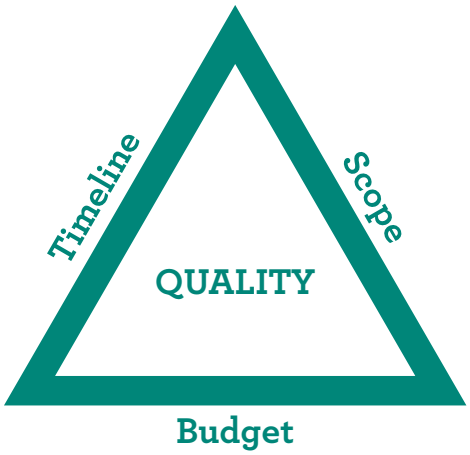
1. Understand your scope and timeline
2. Construct your budget
3. Obtain approval for the budget

Appendix Materials: None

1. UNDERSTAND YOUR SCOPE AND TIMELINE

In order to maintain a high quality project, it is critical to balance the project's timeline, cost / budget, and scope at the beginning and throughout the project (the project 'triangle.')

Prior to constructing your budget, take a step back and review your project triangle.



1. Is your timeline fixed? Has it already been decided how long this initiative will last? Maybe administration has told you that for this budgeting phase, or the pilot work, you would have a timeline of 2 years. A fixed timeline will impact the amount of work you can do in that time period.

2. Is your budget fixed? It is not uncommon for the budget to be set, which lends itself to bottom up budgeting (i.e. how much work can we accomplish with this amount of money) versus top-down budgeting (i.e. this is all of the work we wish to accomplish, and how much will it cost).

3. Is your scope fixed? If you are thinking about changing scope (i.e. from training 50% of primary care clinicians to training 80% primary clinicians), you will need to revisit your "project triangle". A change in scope will undoubtedly affect the budget and/or the timeline, which ultimately can lead to poor quality. Ask yourself, what gives? Will we cut something else out of the scope? Can we get more funding to hire others to help with this new work?

2. CONSTRUCT YOUR BUDGET

Below are three budgeting templates. Tables 1 and 2 feed into the cumulative template - Table 3. To make it easier, you may choose to copy these templates into Microsoft Excel.

TABLE 1: PERSONNEL EXPENSES

Name	Role	Position	% effort	Calendar Months	Salary ($)	Salary requested ($)	Fringe Benefits ($)	Total ($)
Sue Smith	Clinical Lead	Professional Staff		0.00	$ ---	$ ---	$ ---	$ ---
Brian Jones	Project Manager	Non-Professional Staff		0.00	$ ---	$ ---	$ ---	$ ---
				0.00	$ ---	$ ---	$ ---	$ ---
				0.00	$ ---	$ ---	$ ---	$ ---
				0.00	$ ---	$ ---	$ ---	$ ---
				0.00	$ ---	$ ---	$ ---	$ ---
				Total	**$ ---**	**$ ---**	**$ ---**	**$ ---**

KEY

Role = the role the person will play on this project (e.g. clinical lead, QI specialist, data analyst, etc)

Position = professional staff (i.e. faculty positions), non-professional staff (i.e. staff positions), fellows, and students. The position may, or may not, affect the fringe benefit at your organization

Calendar Months = The equivalent months of paid time. Calculated as % effort * 12 (e.g. 50% effort * 12 months = 6 months of time attributable to the project)

Salary requested = (Annual Salary / 12)* calendar months

Fringe benefits = Salary requested * organizational fringe rate

Total = Salary requested + fringe benefits

Note: One table will cover one year of personnel expenses. For each additional project year, another table should be completed, with any adjustments in fringe rates accounted for.

TABLE 2: NON-PERSONNEL EXPENSES			
Type	**Year 1**	**Year 2**	**Total**
Equipment (e.g. computers, software (SAS, SPSS), etc.)	$ ---	$ ---	$ ---
Travel: Domestic (e.g. attending Train the Trainer course)	$ ---	$ ---	$ ---
Travel: Foreign	$ ---	$ ---	$ ---
Participant / Trainee Support Costs (e.g. training costs)	$ ---	$ ---	$ ---
Materials & Supplies (e.g brochures, marketing costs, etc.)	$ ---	$ ---	$ ---
Consulting Services	$ ---	$ ---	$ ---
Other (e.g. conference fees)	$ ---	$ ---	$ ---
Total	**$ ---**	**$ ---**	**$ ---**

TABLE 3: CUMULATIVE BUDGET					
Type	**Year 1**		**Year 2**		**Total**
Personnel Costs					
Salary	$ ---		$ ---		$ ---
Fringe	$ ---		$ ---		$ ---
Subtotal	$ ---		$ ---		$ ---
Non-Personnel Costs					
Equipment	$ ---		$ ---		$ ---
Travel: Domestic	$ ---		$ ---		$ ---
Travel: Foreign	$ ---		$ ---		$ ---
Participant / Trainee Support Costs	$ ---		$ ---		$ ---
Materials & Supplies	$ ---		$ ---		$ ---
Consultant Services	$ ---		$ ---		$ ---
Other	$ ---		$ ---		$ ---
Subtotal	**$ ---**		**$ ---**		**$ ---**
Total Direct Costs	**$ ---**		**$ ---**		**$ ---**
Indirect Costs	**x %**	**$ ---**	**x %**	**$ ---**	
TOTAL COSTS	**$ ---**		**$ ---**		**$ ---**

KEY

Personnel Costs: Salary = Table 1 Total Salary Requested

Personnel Costs Fringe = Table 1 Total Fringe Benefits

Personnel Costs Subtotal = Salary + Fringe

Non-Personnel Costs = transferred from Table 2

Subtotal non-personnel costs = total Non-personnel Costs

Total Direct Costs = Personnel Subtotal + Non-Personnel Subtotal

Indirect Costs = Total Direct Costs * Indirect Rate

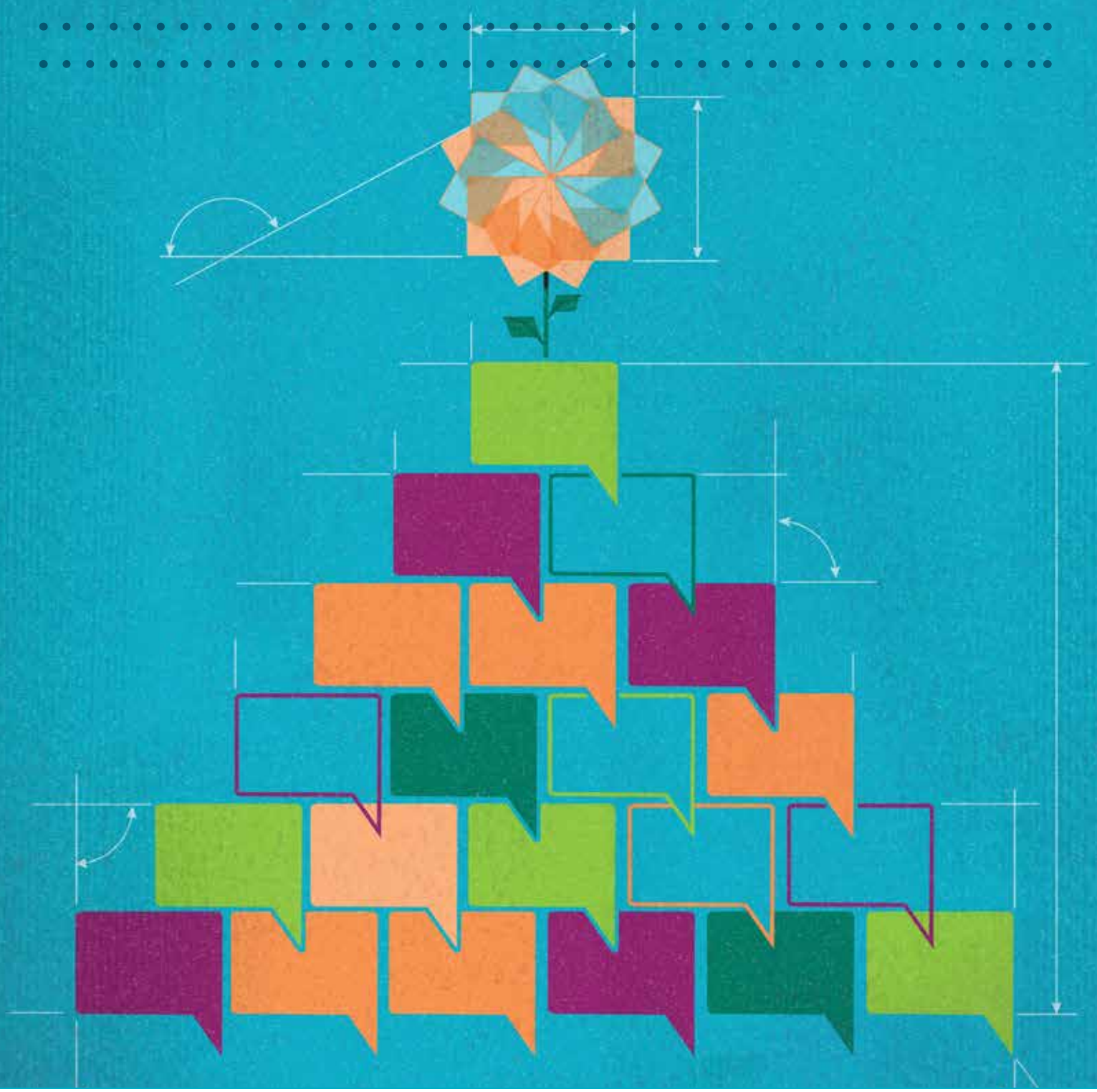
Note: Each organization's indirect rate is different. Within an organization, the indirect rate will also vary depending on the type of project. It is best to check your indirect rate with your grant or finance manager

Total Costs = Total Direct Costs + Indirect Costs

3. OBTAIN APPROVAL FOR THE BUDGET

Present your program goals, strategy, and budget to leadership to obtain approval to proceed with implementation.

PHASE 2: PLAN IMPLEMENTATION



Summary: Phase 2

Once you have institutional commitment and resources for the program, your implementation team will begin the process of developing a detailed plan to implement the components of the Serious Illness Care Program. During this phase, your team will modify the EHR to include a Serious Illness Conversation template; customize the workflow for key conversation steps; recruit trainers who will complete the Train the Trainer course; develop a clinician training plan; select process and outcome metrics and goals for each metric; establish methods to collect, report, and feedback data; develop strategies for quality control, coaching, and performance improvement; complete your baseline data analysis; and write a plan for outreach and communication.

Depending on your organization, some of the planning efforts in Phase 2 may apply to your entire healthcare system, such as instituting electronic health record modifications. Other efforts, such as customizing the clinic workflow for the steps that occur before, during, and after serious illness conversations, will likely vary from clinic to clinic.

Phase 2 activities will set in motion the people, processes, and structures necessary to make sure that frontline clinicians and staff are trained and supported to deliver high quality conversations and care.

TIP

Although there are many steps in Phase 2, they are all discreet, doable tasks that can be done in parallel.

Getting supports in place before clinician training will increase the likelihood of successful uptake and sustained use of the core elements of the program. In addition, by creating systems of accountability and measurement, you and your implementation team will quickly see the impact of your efforts.

By the end of Phase 2, you will have succeeded in planning the intervention in the following areas:

Clinician Education:

+ Approved trainers have completed Ariadne Labs Train the Trainer course
+ Training plan for frontline clinicians is developed

Systems Change:

+ A Serious Illness Conversation template is added to the electronic health record and functionality is confirmed
+ Who, what, where, when, and how for the following processes have been determined for the pilot site(s):
  - Patient screening
  - Conversation scheduling
  - Preparing for the conversation
  - Serious Illness Conversation encounter
  - Documenting conversations
+ Quality improvement decisions have been made, including agreement on process and outcome metrics and goals for key metrics
+ Data collection and reporting systems are in place
+ Plans have been developed for the following program components:
  - Monitoring and evaluation
  - Quality control for trainings and conversations
  - Coaching and performance improvement
+ Baseline data analysis is complete
+ An outreach and community strategy is defined

Modify the EHR

Objectives:

+ Design a Serious Illness Conversation module/template for your electronic health record system (EHR)
+ Implement it in your EHR and confirm functionality
+ Determine solutions to anticipated documentation challenges

Description: Documentation of patient goals and preferences in a retrievable, easy-to-use location in the medical record is a patient quality and safety issue. The purpose of this section is to offer guidance on building the Serious Illness Conversation module or template for your EHR. The module acts as a structured guide that helps clinicians document conversations about goals of care. It also reinforces the Serious Illness Conversation Guide by mirroring the structure and language of the Guide while allowing the clinician to enter free form text and make use of drop-down menus to save time.

TIP

Begin the work of electronic health record modification early, as it can take a long time.

Steps:

1. Identify approvers for EHR modification, establish committee (only if necessary), and agree on key principles
2. Review the provided Serious Illness Care Module, identify potential customizations, and obtain approval
3. Work with IT to implement the module into your EHR
4. Anticipate challenges with documentation
5. Plan training for clinicians on documentation

Appendix Materials: Serious Illness Care EHR Module Overview and Design

1. IDENTIFY APPROVERS FOR EHR MODIFICATION, ESTABLISH COMMITTEE (ONLY IF NECESSARY), AND AGREE ON KEY PRINCIPLES

The process of agreeing upon and implementing the new Serious Illness Conversation module in the EHR can take time, depending on many factors such as your EHR vendor and agreement/support from approvers. Additionally, IT often has a backlog of such requests, and joining the queue late can cause significant delays. For these reasons, we suggest starting the process early in implementation planning.

Tips and lessons learned:

+ Identify the chain of approvers who need to sign off on this modification, and obtain tentative approval as soon as possible to prevent obstacles down the line
+ If you are required to convene a committee to agree upon the changes, assemble the key stakeholders as soon as possible to get started

+ It is very helpful to build a relationship with one of your organization's EHR programmers early on - someone who is engaged and able to work with you on designing and implementing the Serious Illness Conversation module
+ If your health-care system has Open Notes (which allows patients to view their medical record), and the Serious Illness Conversation module is accessible to patients in their personal health records, discuss and plan any adaptation early, particularly related to prognostic communication

2. REVIEW THE PROVIDED SERIOUS ILLNESS CONVERSATION MODULE, IDENTIFY CUSTOMIZATIONS, AND OBTAIN APPROVAL

TIP

A best practice in documentation is to have all forms of Advance Care Planning in one retrievable place in the EHR. We call this the "single source of truth."

The module contains nine prompts related to illness understanding, information preferences, prognostic communication, goals, fears, strengths, functional abilities, tradeoffs, and family involvement. An overview and detailed review of its functionality is provided in the Appendix section Serious Illness Care EHR Module Overview and Design.

When thinking about your module, consider the following best practices:

+ **We recommend integrating the Serious Illness Conversation module with other Advance Care Planning documentation so that there is one "single source of truth" in your EHR**
  - E.g. health care proxy, code status, POLST or advance directive, living will, durable power of attorney, organ donation
+ **The module should be available and viewable by all providers in the health-care system across outpatient and inpatient settings**
  - If not, a plan should be in place about how to ensure that Serious Illness Conversations are communicated across care settings
+ **Author and date of entries should be easily viewable**
+ **Historical entries, including data, author, and date, should be viewable, since goals change over time**

When you have finalized the design of your module and its functionality, present it to your approvers and obtain the green light to begin working with IT.

3. WORK WITH IT TO IMPLEMENT THE MODULE INTO YOUR EHR

After determining any necessary customizations, it is best for an IT specialist and the Clinical Champion on the implementation team to discuss adapting the module and adding it to the EHR. IT should confirm their ability to add a module that meets your expectations for its intended functionality. At this point, design is complete and the module should enter the IT work queue. IT should give you an estimate for when the module will launch and be available for use.

4. ANTICIPATE CHALLENGES RELATED TO DOCUMENTATION IN THE EHR

Make a list of potential problems in the flow of information. Consider the following:

+ What are the foreseeable challenges related to documentation and communication of Serious Illness Conversations in the setting of multiple EHRs?
+ What are the barriers to outpatient-inpatient transmission of information?
+ What else would interfere with a Serious Illness Conversation being communicated to all relevant providers?

Brainstorm solutions to these problems.

5. MAKE A PLAN TO TRAIN CLINICIANS TO USE THE MODULE

Documenting values and goals in a structured location in the EHR is a behavior change for clinicians and therefore benefits from training and coaching. We have found the most success with uptake of the module when the 2.5-hour clinician training includes a 5 minute introduction to the Serious Illness Conversation module in the EHR.

TIP

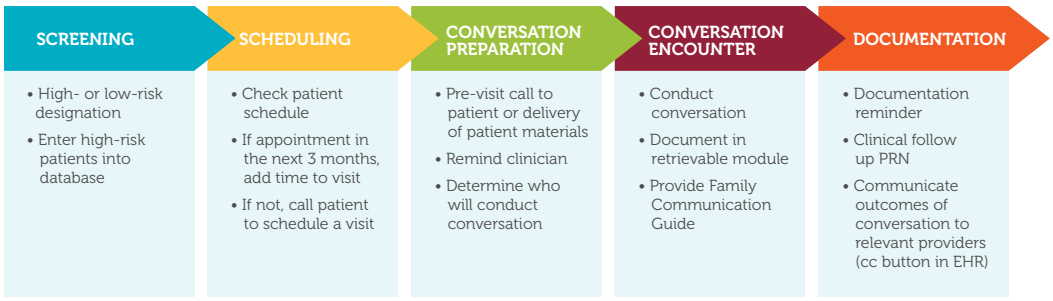
Some clinicians use the EHR module as a prompt for conversations at the point-of-care, so it is important that your module mirror the Conversation Guide.

For example:

+ **Show snapshots of your module during the clinician training session**
+ **Provide practical tips about using the module that are specific to your setting**
  - E.g. It is possible to cut and paste the content of the Serious Illness Conversation from the module into a progress note, if desired.
+ **Provide guidance about what to document in a progress note to refer to the Serious Illness Conversation module for billing purposes**
  - E.g. Consider recommending that clinicians include the following information in the progress note in reference to the Serious Illness Conversation:
    - *Names and roles of attendees of the discussion*
    - *Quick 1-2 sentence summary of the discussion*
    - *Summary of the outcomes of the discussion, including action items or care plan changes*
    - *Statement referring to the Serious Illness Conversation module for more details*
    - *Statement of the total time spent on the visit and conversation*

Customize Clinic Workflow for Conversation

Objective: Outline a clinic workflow for your pilot sites that establishes effective Serious Illness Conversation steps (before, during, and after)



This section will help you integrate key serious illness conversation steps into the workflow so they become part of the roles and responsibilities of clinicians and staff. The work of this section is most successful when done in collaboration with frontline clinical teams who will be using the program in their practice.

Description: The program works best when serious illness care delivery practices become a normal and expected way of caring for seriously ill patients. Customizing these practices to your clinic workflow ensures that serious illness conversations take place and are documented with high-risk patients within an appropriate time-frame. Every clinical setting works differently. In order to minimize extra burden on already stretched clinicians, this section describes how the implementation team can collaborate with frontline clinicians to adapt key serious illness care delivery processes to best suit the clinical workflow.

Steps:

1. Plan to integrate patient screening
2. Plan a process for scheduling the conversation
3. Plan to integrate reminders and other conversation preparation steps
4. Prepare for the Serious Illness Conversation encounter
5. Plan documentation and other post-encounter steps
6. Produce a sample workflow demonstrating the integration of all intervention steps

Appendix Materials: Clinic Workflow Planning

1. PLAN TO INTEGRATE PATIENT SCREENING

Regular patient screening ensures that those who would benefit from serious illness conversations are prospectively identified. In addition, keeping track of these patients systematically helps with monitoring implementation.

A formal flow process is necessary to use the patient screening tool and to ensure that the information is documented and acted upon. Key questions to help you develop a process include:

+ **What screening tool will you use?**

  EXAMPLES:

  Surprise Question: Clinicians review their list of patients and ask the surprise question - "Would you be surprised if this patient died within a year?" Any patient for whom the response is "No, I would not be surprised" is eligible for a Serious Illness Conversation.

  Algorithmic: An algorithm identifies patients who are at high-risk of dying or high-utilizers for the intervention

  Combination Approach: An algorithm identifies patients who are at high-risk of dying or high-utilizers. Clinicians then review those patients and ask the surprise question.

+ **Who on the clinic staff will oversee the process of patient screening (e.g. clinic manager; nurse care coordinator)?**
+ **What will be the routine time and place to screen patients?**
+ **At what frequency will screening occur? (i.e. will depend on the screened population; recommend weekly or every other week in oncology or monthly in primary care).**
+ **Where will the screening results be recorded?**
  - Date of screening
  - Result of screening (high risk; not high-risk)
+ **Where/what system will you use to keep track of the data?**
+ **Who will be responsible for entering high-risk patients into a database?**

TIP

Routinely screening patients to identify those at high risk will ensure that the program reaches patients who would benefit most from serious illness conversations. While there is no perfect approach to screening, over time your team can refine whichever method you initially adopt.

TIP

Consider automating your screening tool, such as integrating the Surprise Question into your electronic health record.

TIP

See the Clinic Workflow Planning document in the Appendix to assist you in planning these steps.

2. PLAN A PROCESS FOR SCHEDULING THE CONVERSATION

Just identifying patients who are eligible for conversations is not enough to ensure that a clinician will have a Serious Illness Conversation within an appropriate time-frame. A scheduling process is necessary for consistent practice. Ideally, all conversations are scheduled within 3 months of high-risk identification, although sooner may be necessary depending on the clinical situation.

+ Who will review the patient's upcoming visits and schedule the Serious Illness Conversation visit, ensuring that there is adequate time for the Serious Illness Conversation (average time is 20 minutes)?
+ For patients with no scheduled appointment within 3 months, who/how will a decision be made to schedule a special visit for the Serious Illness Conversation?

3. PLAN TO INTEGRATE REMINDERS AND OTHER CONVERSATION PREPARATION STEPS

Establish a routine pre-visit process that includes the following:

+ **Ensure resources are present in the clinic (see table below)**
  - Where will serious illness support documents be stored?
  - Who will ensure that support documents are available in the clinics at all times?
+ **Designate clinical staff to connect with colleagues who need to weigh in prior to the discussion:**
  - Who will contact other clinicians, if needed, before the discussion to get information about treatment options and/or prognosis?
+ **Designate clinic staff to make contact with the patient prior to the Serious Illness Conversation visit to:**
  - Provide the document Talking to Your Clinician About the Future prior to the planned Serious Illness Conversation clinic visit
  - Describe the Serious Illness Conversation process
  - Ask the patient if he/she would like to have family/friends attend the visit
+ **Ensure a reminder system is in place:**
  - At what point prior to the appointment will the clinician be reminded of the upcoming conversation?
  - Who will be responsible for providing the reminder to the clinician?
  - How will the reminder be sent? (i.e. email, in person? Automated? Conversation Guide present at the point-of-care?)

Necessary Clinician Support Documents

1. Serious Illness Conversation Guide
2. Clinician Reference Guide

Necessary Patient and Family Support Documents

1. Talking to Your Doctor About the Future—Provide ahead of planned Serious Illness Conversation
2. Family Communication Guide—Provide at conclusion of Serious Illness Conversation

4. PREPARE FOR THE SERIOUS ILLNESS CONVERSATION ENCOUNTER

At this step, the conversation occurs. Since these conversations can be emotional for patients and families, it is essential to provide tools to support them in continuing these important conversations at home.

+ **If a Serious Illness Conversation is completed:**
  - Who will provide the patient and/or family with the Family Communication Guide at the conclusion of the visit during which the Serious Illness Conversation takes place?
+ **If the conversation does not occur or is not completed:**
  - Who is responsible for establishing another Serious Illness Conversation appointment date if the planned discussion does not occur (e.g. patient cancellation, other pressing medical issues, clinician defers)?

5. PLAN DOCUMENTATION AND OTHER POST-ENCOUNTER STEPS

Having a documentation reminder system to ensure consistent and timely documentation of the outcomes of the conversation in a retrievable template and communication with all appropriate care providers, helps to guarantee that patients will receive care that is in line with their priorities. It can also facilitate team coordination and communication so that specialists are on the same page, which will prevent the transmission of mixed messages to patients and families.

+ **Designate clinic staff to monitor documentation of the conversation in the EHR structured, retrievable template:**
  - Who will monitor the EHR to ensure that the conversation is documented in the Serious Illness Conversation template following the clinical encounter within 1 week of the discussion?
  - Who will send a reminder to the clinician(s) to complete the documentation within 1 week of the conversation?
    - *Does your EHR have an automated documentation reminder?*
+ **Designate clinic staff to ensure communication of serious illness conversations to appropriate providers:**
  - Who will ensure that communication about the conversation with other providers occurs within 1 week of the discussion?

6. PRODUCE A SAMPLE WORKFLOW DEMONSTRATING THE INTEGRATION OF ALL INTERVENTION STEPS

Example of a workflow for the entire process:

+ At monthly interdisciplinary team meetings, PCPs, nurse care coordinators, and social workers review patients newly enrolled in the high-risk Medicare program who have been selected based on a high-utilization algorithm. Together, they ask: "Would I be surprised if this patient died within 2 years?". Patients for whom the answer is "No, I would not be surprised" are high-risk and therefore eligible for the conversation.
+ All high-risk patients are entered into a database by the nurse care coordinator.
+ Nurse care coordinator checks the patient's upcoming appointments and ensures that there is adequate time for the Serious Illness Conversation at an upcoming visit.
+ Social worker contacts the patient to prepare him/her for the visit using serious illness care materials.
+ Nurse care coordinator reminds the doctor about the Serious Illness Conversation 1 or 2 days before the visit.
+ Doctor reaches out to specialists to gather information prior to the visit, if necessary.
+ Doctor and nurse care coordinator have the Serious Illness Conversation and document the conversation in the EHR template. Nurse or social worker provides the Family Communication Guide.
+ Nurse ensures that all relevant providers receive notice about the outcomes of the serious illness conversation.
+ Clinical team coordinates any action plan that results from the conversation.

Recruit Trainers

Objectives:

+ Identify and recruit trainers
+ Schedule Ariadne Labs Train-the-Trainer program for trainers

Description: Selecting qualified trainers is a critically important step. Experienced trainers are key to the success of the program, since trainers are required to lead a fast-paced, intense, 2.5-hour session to teach frontline clinicians to use the Conversation Guide. This section will help you and your team select the right people to lead your trainings. Once selected and approved by Ariadne Labs Faculty, your trainers will then complete Ariadne Labs Train-the-Trainer Program to become certified in Serious Illness Conversation Guide teaching.

TIP

Experienced trainers are key to the success of the program, since trainers are required to lead a fast-paced, intense, 2.5-hour session to teach frontline clinicians to use the Conversation Guide.

Steps:

1. Organize a training committee to complete the work of the next two sections
2. Recruit trainers and submit their qualifications to Ariadne Labs for approval
3. Plan Train-the-Trainer sessions

Appendix Materials: Trainer Background Sheet
*Additional Training materials will be available by Ariadne Labs faculty separately from the Toolkit

1. ORGANIZE A TRAINING COMMITTEE TO COMPLETE THE WORK OF THE NEXT TWO SECTIONS

The training committee will work together to complete the remaining steps in "Recruit Trainers" and the following section, "Develop a Training Plan for Frontline Clinicians." The committee should consist of approximately 3 to 5 individuals and include the following roles:

+ Clinical Champion(s) on the implementation team, including at least one palliative care clinician
+ Project manager on the implementation team
+ One or more frontline clinician end-user representative(s), including physician and nursing colleagues from the pilot site(s)

Note: *We suggest that the CMO and/or CNO (if nurses will be trained) or their administrative designees be invited to participate in the planning committee, if desired or helpful in recruitment and planning.*

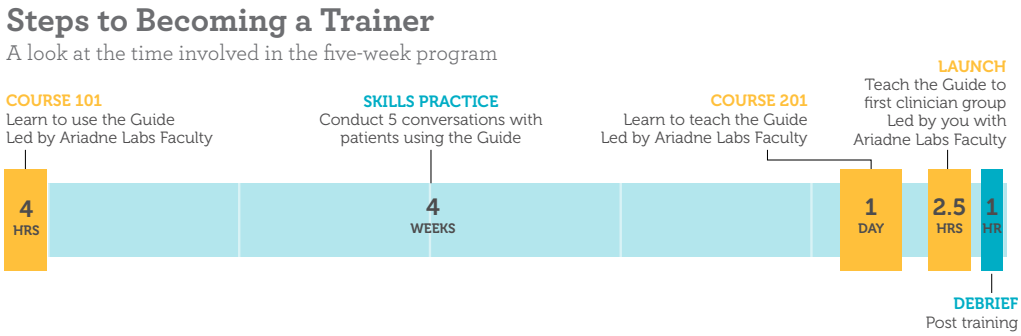
2. RECRUIT TRAINERS AND SUBMIT THEIR QUALIFICATIONS TO ARIADNE LABS FOR APPROVAL

A. Trainer Selection

A trainer is a clinician at your institution who will be trained by Ariadne Labs faculty to lead the small group 2.5-hour clinician training courses on the Conversation Guide for generalists and non-palliative care specialists. At least one of your trainers will be on the implementation team, but you will need additional trainers. Trainers must complete the Ariadne Labs Train-the-Trainer course, after which they will be certified to teach clinicians to use the Serious Illness Conversation Guide. The rate at which you will be able to teach your clinicians to use the Serious Illness Conversation Gude depends on the number of qualified trainers at your organization and the schedule of implementation. We have found that the best trainers often have previous specialized training in advanced communication skills, such as a palliative care fellowship. Consider the following criteria as you think about who to invite to become a trainer:

CRITERIA*	***REQUIRED*** FOR ALL TRAINERS	***RECOMMENDED*** FOR ALL TRAINERS
Available to complete the full Ariadne Labs TTT courses (101 & 201) to become certified	Yes	
Prior training in advanced communication skills**	Yes	
Has an active clinical practice that includes seriously ill patients	Yes	
Well-respected by their peers and colleagues	Yes	
Previous experience in teaching communication skills to clinicians		Yes

*Exceptions to these criteria will be made on a case-by-case basis by Ariadne Labs faculty.
**Each the following meet the prior training requirement:
Vital Talk Faculty Development
Program in Palliative Care Education and Practice (PCEP) Faculty Development
Palliative care fellowship (For this cohort of clinicians, the Communication in Serious Illness CME Course is strongly recommended before completing Train-the-Trainer)
3+ years of palliative care clinical experience (For this cohort of clinicians, the Communication in Serious Illness CME Course is strongly recommended before completing Train-the-Trainer)



B. Review the roles of a Trainer

Trainers must be able to:

+ Be familiar with the Serious Illness Care Program and update themselves as required
+ Teach clinicians (their colleagues) to develop and improve their skills in having serious illness conversations
  - Have the capacity to commit to at least 4-6* clinician trainings per year (numbers will vary depending on organizational needs)
  - Collect and compile training data as required and return it to the central team at the end of each training session
+ Attend quarterly Trainer meetings to debrief and receive updates about Serious Illness Care Program activities
  - Adapt the training and grow as an educator
  - Refine the training based on internal debriefing, learner feedback, and evaluations
+ Lead by example and motivate colleagues to change their behavior
  - Demonstrate use of the Serious Illness Conversation Guide in practice
  - Engage colleagues personally about the challenges and benefits of serious illness conversations

C. Identify potential trainers and complete Trainer Background Sheets

Once you have identified potential trainers, work with each of them to fill out a Trainer Background Sheet (in the Appendix).

D. Send Trainer Background Sheets to Ariadne Labs faculty for approval

Ariadne Labs will review the sheets and confirm that potential trainers are qualified for the Train-the-Trainer Program.

3. PLAN TRAIN-THE-TRAINER SESSIONS

Once trainers are confirmed, work with Ariadne Labs to schedule your Train-the-Trainer sessions. The curriculum consists of two courses, separated by a four week interval for new trainers to practice using the Guide in their own clinical setting. The diagram below outlines the Train-the-Trainer curriculum and timeline. To put their teaching skills to practice quickly, it is ideal for your trainers to start teaching clinicians within 1-2 weeks of finishing Train-the-Trainer.

Develop a Training Plan for Frontline Clinicians

Objective: Determine logistics for frontline clinician trainings

Description: Specific planning decisions for the 2.5-hour frontline clinician trainings depend on the type of clinicians, how many you plan to train, the number of trainers you have, institutional resources, and organizational culture.

TIP

Always give clinicians the opportunity to practice using the Conversation Guide with feedback from a trained facilitator before they use the Guide with a patient.

Steps:

1. Understand the scope of frontline clinician training needs
2. Plan and schedule training(s) for frontline clinicians

Appendix Materials: None

1. UNDERSTAND THE SCOPE OF FRONTLINE CLINICIAN TRAINING NEEDS

Answer the following questions based on your program goals. Examples are provided, but your answers may vary greatly depending on the scope of your initiative. The questions can help guide your team in planning the frontline clinician training program.

QUESTION	EXAMPLE ANSWERS
Who will you train? • *Scope of Practice:* Any health-care practitioner who has a role in the Serious Illness Conversation or care planning should undergo the 2.5-hour training. As part of their scope of practice, MDs, APRNs, PAs, social workers, RNs, and RN Care Coordinators often have some elements of the Serious Illness Conversation in their scope of practice, but this may vary depending on your organization.	Primary care MDs, NPs, PAs, RNs, and SWs
How many clinicians in total do you hope to train? • Think about the total number of generalist and specialist clinicians (who take care of seriously ill patients) you would like to train.	100 clinicians
How many clinicians can be trained in one session? • Ideal trainer: clinician ratio is 1:3	6 clinicians in one session if you have 2 trainers for that session 9 clinicians in one session if you have 3 trainers for that session
How many training sessions can a Trainer reasonably do in one year? • Note: Always best for Trainers to work in pairs or threes, rather than alone	4-6 per year, may vary
How much time will you have during each training session? • Best practice: 2.5-hours, no less than 2 hours	2.5 hours, recommended
Where will you train clinicians? • Simulation center • Room large enough to move chairs around (on-site to minimize time away from clinic)	On-site conference rooms
What disciplines will you train together? • Train all disciplines together • Train MDs, PAs, and NPs separately from RNs and SWs	Train MDs, PAs, and NPs separately from RNs and SWs

2. PLAN AND SCHEDULE TRAINING(S) FOR FRONTLINE CLINICIANS

Training is most effective when clinicians have the opportunity use their new clinical skills in practice immediately. Therefore, it is very important that frontline clinician trainings are scheduled to coincide closely with the launch of all other serious illness care practices (patient screening, scheduling, reminders, conversation encounter, documentation, measurement, and coaching). Review the timeout document. Once you have a sense for when the activities of Phase 2 planning will be complete, begin to plan the dates and times of your clinician training(s). Your earliest clinician trainings should be scheduled sometime after the Train-the-Trainer course, and as close to the Serious Illness Care Program launch date as possible.

TIP

Training is most effective when clinicians have the opportunity to use their new clinical skills in practice immediately. We therefore recommend scheduling clinician trainings only after the other Phase 2 systems of support are in place.

Prepare for Monitoring and Evaluation

Objective: Design and establish a measurement system to monitor implementation progress, provide feedback, and evaluate impact

Description: Integrated and ongoing monitoring of your implementation will provide you with timely and essential insights into what is actually happening, identify challenges, celebrate success, spread best practices, and improve performance. Evaluating your outcomes (what you hope to happen as a result of implementation) is similarly important to understand if you are reaching your goals and where additional attention may be needed. The goal is to select the metrics that will allow you to meaningfully monitor implementation and make improvements when needed.

Steps:

1. Partner with a data analyst or information technology representative
2. Select all of the outcomes you can and will measure to evaluate program impact
3. Gather and interpret baseline data
4. Select metrics to monitor implementation and set goals for each metric
5. Develop procedures for collecting data on all process and outcome measures

Appendix Materials:

Serious Illness Care Measures
Sample Monitoring Implementation Report
Data Collection Methods

OPERATIONS	PROCESS	OUTCOMES
Monitor to ensure processes at the clinic and/or individual levels are established.	Monitor to ensure implementation is meeting standards (practice standards and performance goals). Coaching to improve performance and positive outcomes	Capture necessary baseline data to show pre-post of ACP Evaluate specific metrics pre-post to evaluate your goals
Are patients being screened for risk of death? Are patients classified into high/low risk? Are high-risk patients fed back to clinicians? Are scheduling and preparation processes in place? Is a reminder system in place? Are clinician, patient, and family tools in place?	**HOW OFTEN** **(Numbers, Proportions)** • Training Clinicians • Tracking high-risk Patients • Having conversations with high-risk patients • Documenting conversations in a structured template • Tracking patient deaths **HOW WELL** **(Surveys, Populations)** • Quality of Training • Quality of Conversation • Patient Perspective • Clinician Perspective	**Is the program improving ACP conversations?** • More Conversations? • Earlier Conversations? • Better Conversations? **Is the program achieving your goals?** • Improved Patient Well-being • Improved goal-concordant care • Improved patient expereince • Improved Clinician satisfaction and engagement • More appropriate resource use

1. PARTNER WITH A DATA ANALYST OR INFORMATION TECHNOLOGY REPRESENTATIVE

Work closely with a QI specialist and data analyst/IT representative throughout this section. This will help you answer key questions about metrics, including what is or is not measurable based on your current data system. It will also help you determine whether creating custom reports and data extracts from the EHR is feasible and how best to build those reports so that the data is usable.

2. SELECT THE OUTCOMES YOU CAN AND WILL MEASURE TO EVALUATE PROGRAM IMPACT (OUTCOMES)

Select metrics based on your specific goals, your intended outcomes, and what information you are equipped to measure.

Review the list of outcome measures in the Serious Illness Care Measures section of the Appendix. Assess them based on importance and ease of measurement in your data system.

TIP

In prior Serious Illness Care program implementation initiatives, outcome metrics have been closely aligned with the Quadruple Aim:

1. Provide a better experience of care
2. Improve patient outcomes and well-being
3. More appropriate resource use and costs
4. Improve provider satisfaction

EXAMPLE PROGRAM GOALS (FROM PHASE 1)	EXAMPLE OUTCOME METRICS	EXAMPLE TARGETS
Improve Advance Care Planning Conversations	Proportion of high-risk patients who have had serious illness conversations	Conduct and document patient-centered serious illness conversations with > 80% of high-risk patients within 3 years
Improve well-being for seriously ill patients	Rate of moderate/severe anxiety and depression in seriously ill patients	Reduce rates of moderate/severe anxiety and depression in seriously ill patients by 50% within 3 years.

TIP

Before launching the Serious Illness Care Program, it is important to determine the current state of Advance Care Planning at your organization.

3. GATHER BASELINE DATA FOR MEASURES (OUTCOMES)

To demonstrate the effect/impact of the program, your outcomes must be compared to the current state (i.e. before the program is implemented). Collect baseline data for the measures you identified in Step 1, to the best of your ability.

4. SELECT METRICS TO MONITOR YOUR IMPLEMENTATION PROGRESS AND SET TARGETS FOR EACH METRIC (OPERATIONS AND PROCESS)

The implementation team will agree upon metrics that will measure if key serious illness care implementation steps and practices are happening. The following examples will help you make a plan to evaluate how often clinicians and sites are delivering essential serious illness care practices.

ACTIVITY CATEGORY	IMPLEMENTATION STEP	EXAMPLE METRICS	EXAMPLE TARGETS
Process	Clinician education	Are we meeting goals in clinician training? **Metric:** Proportion of target clinicians trained by target date	100% of target clinicians trained by target date
		Do clinicians find the training effective? Metric: Proportion of trained clinicians who rate the training with a score of at least 3 / 4	90% of trained clinicians rate the training with a score of at least 3 / 4
Operations	Patient screening and identification	Are patients being regularly screened for risk of death?	Yes
		Are patients being categorized into high or low risk?	Yes
		Are high-risk patients being tracked to monitor for conversation completion?	Yes
Operations	Conversation preparation, reminders, and follow-up	Are processes in place to schedule the conversation?	Yes
		Are processes in place to prepare patients for the conversation?	Yes
		Is a reminder system established?	Yes
		Are processes in place to provide the Family Communication Guide?	Yes
Process	Having and documenting conversations	Are conversations with high-risk patients occurring within an appropriate timeframe? **Metric:** Proportion of high-risk patients with a documented serious illness conversation within 3 months of identification (or 3 visits)	At least 70% of high-risk patients have a serious illness conversation documented within 3 months or 3 visits of screening as high-risk
		Are clinicians documenting serious illness conversations in a retrievable location? **Metric**: Proportion of serious illness conversations documented in the retrievable template in the EHR within 1 week of the conversation	100% of conversations documented in the Serious Illness Conversation template within 1 week of the conversation
Operations	Tracking patient deaths*	Are we tracking patient deaths in the high-risk population?	Yes

*To better understand your high-risk population and if they are receiving conversations before death, it is important to track patient deaths. In the outpatient setting, knowing if and when a patient dies can be challenging. It is helpful to think up front about how you will know if a patient in your high-risk population dies as well as additional information, such as location at the time of death. If you want to determine the effectiveness of your screening tool, you can also track patient deaths in the overall screened population as well (to determine what proportion of patients who screened "out" still die in the timeframe).

See Appendix for a Sample Monitoring Implementation Report

5. DEVELOP PROCEDURES FOR COLLECTING DATA ON ALL PROCESS AND OUTCOME MEASURES

Principles of data collection:

+ Know what data elements need to be collected for each metric
+ Know the numerators and denominators for each metric
+ Determine who is responsible for collecting the data
+ Determine how often the data must be collected
+ Establish where you will store the data once you have it
+ Decide how the data will be analyzed and by whom

Establish what you will do with the data (i.e. how you will feed it back and who is responsible for making any needed changes)

Work closely with your contact(s) in IT to determine what is feasible. The implementation team may need to collect data on process measures manually (e.g. tracking proportion of clinicians trained; tracking proportion of high-risk patients who had conversations).

See Appendix for specific details about examples of Data Collection Methods.

Prepare for Quality Control

Objectives:

+ Select tools to monitor the quality of training and serious illness conversations
+ Identify quality standards
+ Develop a plan to collect, analyze, and respond to data related to quality control

Description: Whereas the monitoring and evaluation section helps you understand how often serious illness care practices are being implemented, it is equally important to understand how well key elements of the program are implemented.

Once the program is launched, there are two components that require close monitoring for quality control:

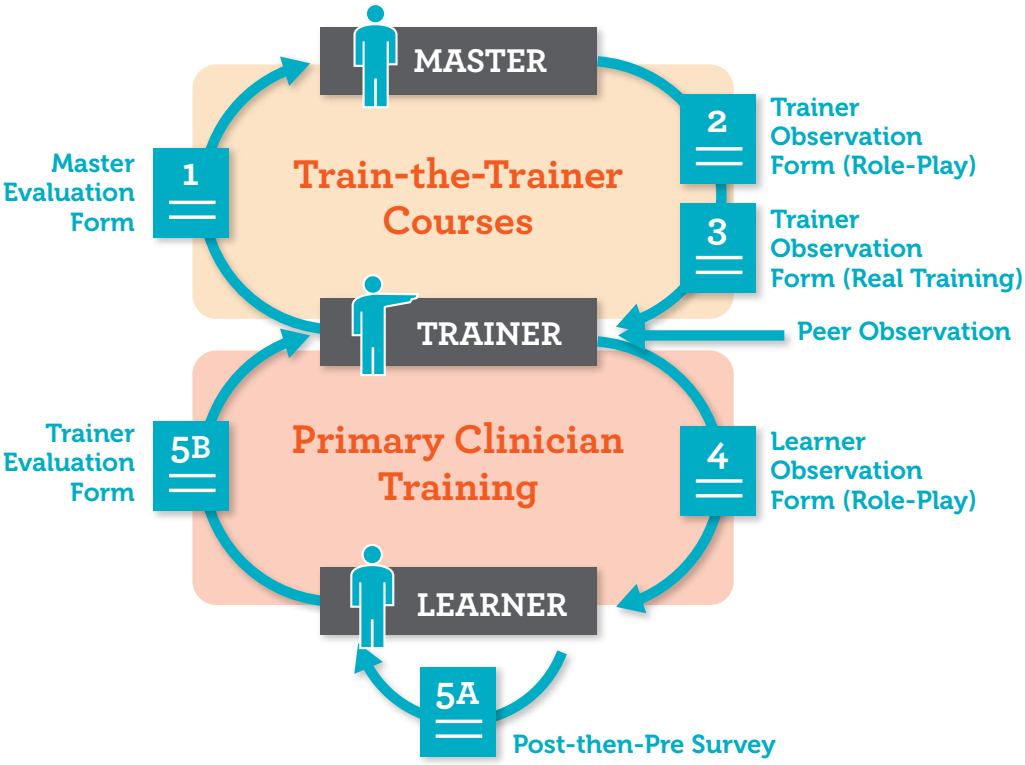
+ **Clinician training:** Effective trainers are key to the success of the program, since trainers are required to lead a fast-paced, intense, 2.5-hour focused session to teach frontline clinicians to use the Conversation Guide. Ensuring the continued delivery of high-quality training requires ongoing observation and evaluation of trainers and the curriculum.
+ **Conversations:** With a new tool being introduced into practice, it is important to have a process in place to monitor the quality of serious illness conversations. Although rare, there is the possibility of clinician and/or patient distress as a result of conversations that address prognosis and goals of care. There are several effective strategies to monitor the quality of serious illness conversations which will help you identify the need for exploration, coaching, and improvement.

Steps:

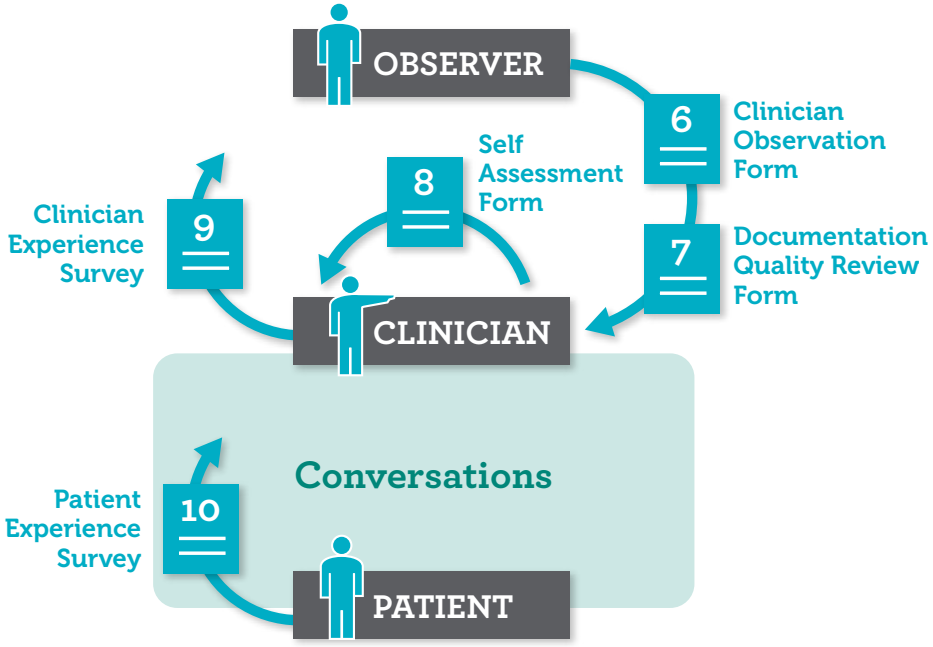
1. Review training and conversation quality control outline
2. Select tools for monitoring the quality of training and serious illness conversations
3. Set quality standards

Materials: Quality Control Surveys and Forms will be provided separately from the Toolkit by Ariadne Labs Faculty.

Overview of Training Quality Control



Overview of Conversation Quality Control



1. REVIEW TRAINING AND CONVERSATION QUALITY CONTROL OUTLINE

The following diagram and list of tools will give you an overview of the surveys and observation forms available to help you and your team ensure high quality implementation of trainings and conversations.

1. **Master Evaluation Forms (1a and 1b):** For trainers to evaluate Course 101 and Course 201 and faculty's (A.K.A. Master's) teaching skills; *Frequency:* after every Train-the-Trainer course
2. **Trainer Observation Form (Role-Play):** For faculty to observe trainers facilitating a small group role play during the Train-the-Trainer course; *Frequency*: during every Train-the-Trainer course
3. **Trainer Observation Form (Real Training):** (1) For faculty to observe new trainers lead their first full Primary Clinician Training (either video/audio or in-person); (2) For co-trainers to periodically observe their colleagues leading a Primary Clinician Training;
   Frequency: during the first training session a trainer leads, and at least quarterly thereafter (more if needed)
4. **Learner Observation Form (Role-Play):** For trainers to observe learners use the Serious Illness Conversation Guide during role play in Primary Clinician Training; *Frequency*: during every Primary Clinician Training
5. **Post-then-Pre Survey and Trainer Evaluation Form (5a and 5b):** For learners to evaluate the Primary Clinician Training quality and their trainer's teaching skills, in addition to their competence in serious illness communication skills before and after training; *Frequency*: every learner, during every Primary Clinician Training
6. **Clinician Observation Form:** Trainer or peer observation of frontline clinician using the Guide; Frequency: one observation within one month of training, with additional observations as needed
7. **Documentation Quality Review Form:** For an observer to review clinician documentation quality; *Frequency:* examine subset of documented conversations every three months
8. **Self Assessment Form:** For future trainers to self assess their ability to have serious illness conversations using the Guide after taking the Primary Clinician Training; *Frequency:* several self assessments within one month of training
9. **Clinician Experience Survey**: For clinicians to report on their experience using the Conversation Guide; *Frequency:* at three months, six months, and one year post-training
10. **Patient Experience Survey:** For patients to evaluate the serious illness conversation experience; *Frequency:* survey given after every serious illness conversation encounter, with aggregate data analyzed every 1-3 months OR survey given to a subset of patients

TIP

Any time you will be collecting information and data, you want to make sure you have the ability to use it in a meaningful way. The tools in this section will provide you with a comprehensive set of options from which you can select what is most important and feasible.

2. SELECT TOOLS FOR MONITORING THE QUALITY OF TRAINING AND SERIOUS ILLNESS CONVERSATIONS

After reviewing available tools, the next step is to select the most appropriate and feasible surveys and observation forms for your quality control strategy and customize them to meet your needs.

3. SET QUALITY STANDARDS

Commitment to a quality control plan involves setting standards so that you know when to intervene. Some of the information collected in this section lends itself to numerical standards, whereas others will involve monitoring for red flags or or any outliers that raise concerns. Examples of standards are available at the bottom of each survey and form, where appropriate.

Plan for Performance Improvement

Objectives:

+ Develop a system for reporting and responding to data
+ Develop a plan to employ coaching strategies to streamline processes and improve performance

Description: One of the challenges after implementation is translating the wealth of information being collected into useful tools for improvement. This requires analyzing the data in a way that is relevant to the needs of your team, reporting it in a way that is easily understood, and delivering it to the people who will be able to take action on what has been learned. Setting up a system of regular data collection and reporting will help build a foundation for ongoing performance improvement. However, in order to promote sustained behavior change and to assure the quality of the intervention, additional support should be provided through coaching. Coaching ensures systematic adherence to implementation goals and the spread of successful practices.

TIP

Visually displaying your data in a way that is usable for the individual or teams who will be acting on it will maximize impact, especially if the data is meant to facilitate performance improvement. Here are sample data visuals.

Implementation Team Steps:

1. Decide how data will be synthesized and reported
2. Determine the appropriate audience for the data
3. Review coaching roles and responsibilities
4. Confirm who will assume coaching responsibilities
5. Plan coaching activities
6. Develop a plan to capture information obtained via coaching

Appendix Materials: Coaching Resources

1. DECIDE HOW DATA WILL BE SYNTHESIZED AND REPORTED

The most important thing to keep in mind is that any time you will be collecting information and data, you want to make sure you have the ability to use it in a meaningful way.

a. Determine the frequency of data collection
b. Identify where the data will live so that it can be easily synthesized
c. Develop meaningful reports (visual, if possible) and establishing an appropriate reporting frequency
d. Develop a process for acting in response to the issue identified (who will act; what will they do)

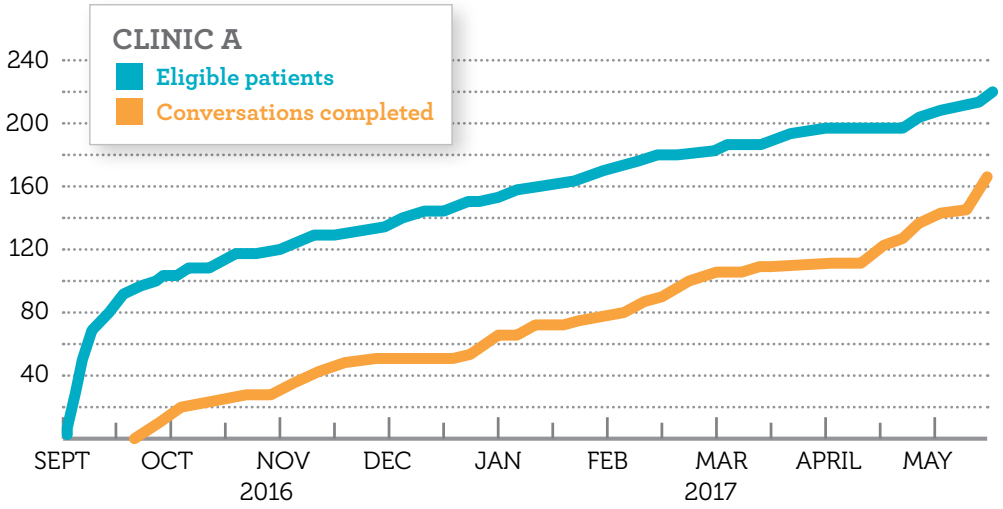
2. DETERMINE THE APPROPRIATE AUDIENCE FOR YOUR DATA

Consider how you will prepare your data for different audiences, which data is relevant to share with each audience, and how frequently you will share it.

+ **Leadership:** Keep your leadership informed of implementation progress on key measures at the practice and system level and results of the evaluation of outcomes over time.
+ **Implementation team:** Track implementation data at the practice level and at the clinician level to celebrate success and to identify performance challenges that would benefit from coaching strategies.
+ **Clinical staff and practices:** Keep frontline clinical teams informed about their own patients; keep clinicians informed about their own specific performance on key metrics related to conversations and documentation; share progress and variability across practices.
+ For the different recipients of feedback, consider:
  - What do you expect the consumers to do with your reports?
  - How should your reports be designed to help drive that change?

Conversation Tracker

Comparing the eligible patients with the number of conversations conducted



TIP

Visual displays of the data are easier to interpret and will facilitate performance improvement. Here are sample data visuals.

BAR CHART EXAMPLE

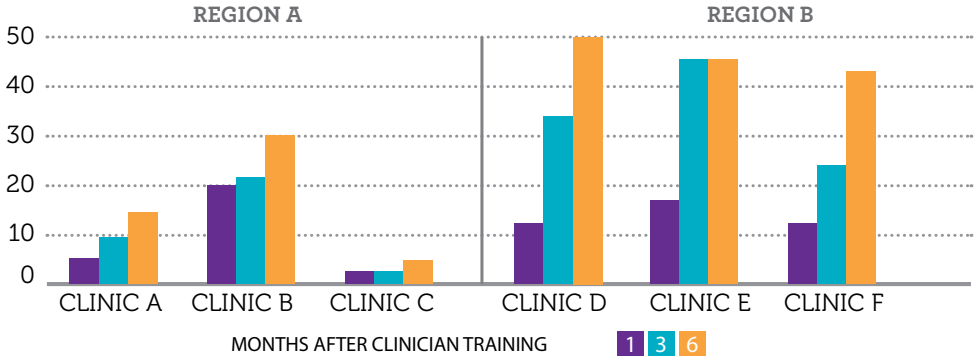
Clinician Performance

Proportion of conversations with eligible patients in the last three months

BAR CHART EXAMPLE 2

Conversations

Percentage of eligible patients with conversations



3. REVIEW COACHING ROLES AND RESPONSIBILITIES

The role of coaching is to:

+ Support frontline clinicians to improve performance and meet Serious Illness Conversation goals: Coaching will help to reinforce best practices in serious illness conversations and support clinicians who are struggling with these discussions. The Clinical Coach leads face-to-face coaching sessions with clinicians in the following situations:
  - Clinicians who are not having serious illness conversations with their patients in the appropriate timeframe
  - Top-performing clinicians to learn about the benefits and effective practices that they have experienced/implemented
  - Concerns about the quality of serious illness conversations detected by reviewing electronic medical record documentation of these conversations or patient experience surveys
  - Concerns about clinician distress related to the conversations detected by clinician experience survey or by informal feedback
+ Address challenging patient or family clinical situations: Clinical Coaches will help their colleagues respond to difficult situations that arise before, during, or after serious illness conversations, including:
  - Conflict between patient and family regarding care preferences
  - Emotional patient (someone who cries during the discussion)
  - Patients who are resistant to the conversation
  - Severe patient or family distress (anxiety, depression)
  - Suicidal ideation

4. CONFIRM WHO WILL ASSUME COACHING RESPONSIBILITIES

In prior initiatives, performance improvement roles were performed by members of the implementation team. The following are FTE estimates:

+ 0.25 FTE for clinical coaching (Clinical Lead often assumes these responsibilities)
+ 0.5-1 FTE for process improvement (QI specialist, or if needed the Project Manager, assumes these responsibilities)

5. PLAN COACHING ACTIVITIES

It is important to remember that not all clinicians will be engaged and on board with using the Serious Illness Conversation Guide or the system of care, but that should not stop you from moving forward. Monitoring serious illness care practices and simply talking to people will allow you to identify where there are challenges and successes. The below coaching tasks will help you problem-solve and improve performance.

USE DATA TO IMPROVE PERFORMANCE | **COACH INDIVIDUAL CLINICIANS AND TEAMS**

How can you use data to improve performance?

ON A REGULAR BASIS
Track data on implementation progress at the practice level
Send reports to frontline clinical teams about the status of conversations with their high-risk patients
Send reports to individual clinicians about their own performance relative to peers
Send reports on practice-level and clinician-level measures to the coach
Administer and analyze clinician and patient experience surveys

What are the actions of a coach?

TARGETED	ONGOING	AS NEEDED
Follow-up with each trained clinician after his/her 1st Serious Illness Conversation Decide on appropriate actions based on the results of the clinician and patient experience surveys	Begin regular calls to check-in with clinical teams • Get informal feedback about the benefits and challenges of using the Guide in practice and brainstorm solutions together	Coach clinicians who do not meet performance goals or need additional support • Provide telephone or in-person coaching sessions or refresher trainings for clinicians • Offer to observe peers having conversations and provide feedback

6. MAKE A PLAN TO CAPTURE INFORMATION OBTAINED VIA COACHING

While your process metrics capture whether serious illness care practices are occurring, information obtained via coaching tells you "how" and "why" practices are happening or not happening. We recommend that you establish a process to capture, document, organize, and respond to qualitative feedback from front-line clinicians and staff, and the needed adaptations and refinements that occur based on these experiences.

+ Informal feedback will come in the form of emails, semi-structured interviews, one-on-one discussions, phone conversations, and casually running into colleagues.
+ Establishing a system to collect and organize this information will make it easier to identify challenges for which you need to brainstorm solutions and record effective practices that will allow you to spread learning across sites.

Plan Outreach and Communication Strategy

Objectives:

+ Identify communication objectives to support your roll-out of the Serious Illness Care Program
+ Develop core messages and talking points for your organization
+ Craft a strategic communications plan

Description: It is best to launch the program with a clear, unified message. Additionally, the Serious Illness Care Program deals with a sensitive issue that has the potential to get people emotionally charged. It is important to develop a mission statement for the program, along with associated talking points that the implementation team agrees upon. These messages will be used in:

+ **Face-to-face conversations with colleagues, to answer the question:** "What's the Serious Illness Care Program about?"
+ **Public communications:** Your organization's website and any external communications should have consistent messaging that underscores the value of serious illness care to the community you serve.
+ **Presentations:** Having a few standardized slides or handouts that contain the mission and goals of your program will provide consistent messaging.
+ **Media:** Knowing the core messages will guide your talking points during media interviews and other events.

Steps:

1. Identify a communication lead to assist the implementation team in developing the mission statement and talking points
2. Identify your target audiences and where they are located
3. Develop your mission statement and talking points
4. Create and adopt a communication plan that is phased to your project roll-out timeline

Appendix Materials: None

1. IDENTIFY A COMMUNICATION LEAD TO ASSIST THE IMPLEMENTATION TEAM IN DEVELOPING THE MISSION STATEMENT AND TALKING POINTS

Identify an individual at your organization with expertise in media and communications who can work with your team to plan your outreach and communication strategy.

TIP

Crafting the mission statement is a great way to achieve internal buy-in for the program. We recommend holding at least one session with stakeholders to brainstorm a draft for the mission statement. There is tremendous value in allowing everyone to be heard at this stage so that when the mission is finalized, it has been accomplished with input from the individuals who will spread the mission.

2. IDENTIFY YOUR TARGET AUDIENCES AND WHERE THEY ARE LOCATED

Examples:

+ Clinical leaders and frontline clinicians of multiple disciplines and specialties:
  - Example of a key message for this audience: The Serious Illness Care Program improves your ability to provide the care patients want at the end of life. Action: Adopt the Serious Illness Care Program in your practice
+ Operational leaders and administrative staff
+ Patients and families
+ Local community groups, hospices, long-term care facilities
+ Additional local, regional, and national organizations and healthcare systems

3. DEVELOP YOUR MISSION STATEMENT AND TALKING POINTS

The following are elements of a good mission statement:

1. Big idea articulated in one sentence
2. Limited in scope and achievable
3. What you will do
4. For whom
5. Why

Our mission is to improve the lives of all people with serious illness by increasing meaningful conversations with their clinicians about their values and priorities.

The mission is more than the core purpose of your project; it is also the public message about your program.

Since your mission will be repeated and used for multiple audiences, we recommend that end-of-life language not be included in your mission statement. The program focuses on improving well-being and care for patients with serious illness, and not all patients who will be exposed to messages about your program are near the end of life or would respond to language about the end of life.

Develop a list of Talking Points; (Samples)

THE PROBLEM:

Conversations about goals of care and end-of-life planning are associated with better outcomes for patients and families. Yet for many patients with serious illness, planning for the end of life tends to occur late or not at all

When conversations do occur, they often take place during times of crisis and focus on medical treatments/procedures rather than broader values and goals

Palliative care is an important resource for high quality communication, but we do not and will not have enough palliative care providers for all patients who would benefit.

We need scalable interventions for generalists and non-palliative care specialists

THE STRATEGY:

The Serious Illness Care Program is a communication intervention and systems approach that is evidence-based, patient-centered, scalable, and addresses both clinician education and systems change.

It is designed to facilitate more, earlier, and better conversations, with the goal of improving patient outcomes and experience of care

The program strategy involves tools, education, and systems change:

- *Tested tools for clinicians, patients, and families;*
- *A short, fast-paced clinician training program for generalists and non-palliative care specialists focused on the Serious Illness Conversation Guide;*
- *Multiple systems-change components to improve serious illness care delivery, such as patient screening,conversation preparation, a reminder system, structured documentation template in the EHR, monitoring and evaluation, and coaching*

Early results from a randomized controlled trial in oncology show:

- *Implementation of the Serious Illness Care Program leads to a 20% increase in the proportion of seriously ill patients who have at least one conversation before death (93% in the intervention group compared to 76% control)*
- *Significantly earlier initiation of conversations (5 months before death compared to 2 months);*
- *A 50% reduction in anxiety and depression*
- *And patient reports of positive behavior changes and positive impact on their lives as a result of serious illness conversations.*

4. CREATE AND ADOPT A COMMUNICATION PLAN THAT IS PHASED TO YOUR PROJECT ROLL-OUT TIMELINE

We recommend building a communication strategy that:

+ Includes goals and metrics for success
+ Considers multiple communication channels to spread your message
+ Tailors the message to your target audiences while keeping the core message intact
+ Is appropriately phased with the rollout of other implementation activities

PHASE 3: LAUNCH PILOT SITES

Summary: Phase 3

Congratulations on finishing the planning stages of your implementation of the Serious Illness Care Program! This is an exciting time as you put into action the plans you developed in Phases 1 & 2. In Phase 3, you will train frontline clinicians and launch the program at your pilot sites.

A critical piece of launching the Serious Illness Care Program is assessing early and often whether your implementation strategy is working and having the flexibility to respond to challenges. Working closely with frontline clinicians will allow you to identify issues in training, workflow integration, and uptake of the Serious Illness Conversation Guide and documentation template. Regularly collecting feedback and acting quickly to improve processes will allow for the best chance of success.

TIP

Starting small with your pilot sites allows you to keep mistakes small and to refine your implementation plan before expansion.

The final part of Phase 3 involves evaluating your outcomes and promoting the program's successes. Successful pilots are important for engaging leaders and colleagues, securing additional funding, and creating demand for the work within your organization.

By the end of Phase 3, you will have succeeded in launching the Serious Illness Care Program at your pilot sites by completing the following:

+ Train first cohort(s) of frontline clinicians
+ Adapt clinical workflows at the pilot sites to integrate systems-change aspects of the program
+ Receive feedback from frontline clinicians, identify challenges, and refine the training program and workflow processes
+ Begin monitoring and evaluating implementation progress
+ Assess whether Quality Control and Performance Improvement plans are working
+ Synthesize and reflect on lessons learned
+ Promote the success of the pilot program

Begin Clinician Training

Objective: Train first cohort(s) of frontline clinicians

Description: After months of planning, implementation actually begins when you train your first cohort(s) of clinicians. During this time, members of the implementation team are encouraged to be available to collect feedback and answer questions. The goal is to solicit as many perspectives as possible, both formally and informally, by asking clinicians what is working well with the training and what needs to be improved.

Steps:

1. Conduct trainings
2. Obtain formal and informal feedback from clinicians about the training curriculum
3. Review the feedback and evaluations of the training and debrief internally
4. New Trainers debrief with Ariadne Labs Faculty

Appendix Materials: Ensuring High Quality Training

1. CONDUCT TRAININGS

Two or three Trainers will co-lead, with Ariadne Labs faculty, the first 2.5-hour primary clinician training(s)

TIP

Hold informal debrief sessions after every training to capture areas for improvement

2. OBTAIN FORMAL AND INFORMAL FEEDBACK FROM CLINICIANS ABOUT THE TRAININGS

+ Formal evaluations
  - Distribute formal evaluations to all training participants
+ Informal feedback, for example:
  - What were the highlights of the training?
  - What could be improved?

3. REVIEW THE FEEDBACK AND EVALUATIONS FOR THE TRAINING CURRICULUM AND DEBRIEF INTERNALLY

+ Review the evaluations
  - Look at the mean evaluation score and identify any trouble spots
  - Did the course meet its objectives?
+ Trainers and the implementation team debrief internally, and with Ariadne Labs faculty, about the following training components:
  - Reflection
  - Demonstration and debriefing
  - Small group role play
  - Didactics

4. NEW TRAINER(S) DEBRIEF WITH ARIADNE LABS FACULTY

Ariadne Labs faculty will complete and review the Trainer Observation Form for new Trainers and debrief about lessons learned and ways to improve.

Implement Clinic Workflow

Objective: Implement clinic workflow components

Description: Although you have planned the workflow processes in Phase 2, the richest learning often happens in the first few weeks of implementation when trained clinicians begin to use Serious Illness Care processes in their clinical practice. Similar to training, members of the implementation team are encouraged to seek feedback from frontline clinicians and staff about which parts of the workflow work well and which parts could be improved.

Steps:

1. Frontline clinicians and staff begin implementing Serious Illness Care processes
2. Obtain feedback about each process step and identify pain points

Appendix Materials:

+ Evaluate Clinic Workflow

1. FRONTLINE CLINICIANS AND STAFF BEGIN IMPLEMENTING SERIOUS ILLNESS CARE PROCESSES

+ Screening and identifying high-risk patients
+ Scheduling the conversation
+ Pre-conversation steps (e.g. reminders, patient preparation)
+ Conducting conversations using the Serious Illness Conversation Guide
+ Documenting conversations in a structured template
+ Post-conversation steps (Family Communication Guide)

2. OBTAIN FEEDBACK ABOUT EACH PROCESS STEP AND IDENTIFY PAIN POINTS

Use the worksheet included in the appendix to document feedback about effective practices and challenges

TIP

Use a written log book, digital or paper, (sometimes referred to as a "glitch book") to document pain points and areas that need improvement

Refine Clinician Training and Workflow

Objectives:

+ Identify strengths/weaknesses/barriers during initial training and implementation
+ Improve clinician training and workflow

TIP

Refining Clinician Training and Workflow is an ongoing, iterative process. It is important to continue to collect feedback as you make changes and to to be willing to adjust the processes multiple times.

Description: The implementation team will meet frequently to discuss feedback about the training and workflow. This should begin soon after training the first cohort of clinicians and continue on a regular basis especially in the first weeks and months of implementation. It is a time to synthesize what you are learning from each of the pilot sites, brainstorm solutions to problems, and iteratively improve processes to maximize uptake of the program. It is possible that different pilot sites may have different challenges and require tailored approaches to improving workflow and training.

Steps:

1. Adjust training curriculum based on trainee evaluations and feedback

2. Improve workflow components based on feedback

3. Repeat above processes for subsequent clinician trainings and implementation at each pilot site

4. Debrief frequently as an implementation team

Appendix Materials: None

1. ADJUST TRAINING CURRICULUM BASED ON TRAINEE EVALUATIONS AND FEEDBACK

Review potential solutions with early trainee cohort

2. IMPROVE THE WORKFLOW COMPONENTS BASED ON FEEDBACK

Act quickly to improve workflow integration and clinician uptake of key practices

3. REPEAT ABOVE PROCESS FOR SUBSEQUENT CLINICIAN TRAININGS AND IMPLEMENTATION AT EACH PILOT SITE

4. DEBRIEF FREQUENTLY AS AN IMPLEMENTATION TEAM

Utilize regular meetings to synthesize lessons learned

FROM THE FIELD

- **Clinical Training:** Clinician evaluations consistently showed that role plays were the most helpful part of the training. We took steps to minimize didactic time and maximize skills practice based on that feedback.
- **Data Presentation:** In one of our initial clinic trainings, we presented data about the rates of Advance Care Planning documentation in that particular clinic at baseline, which were very low. Clinicians reacted very strongly to what felt like a punitive message. Going forward, we presented only organization-level data so that we could focus on improvement without singling out any one group
- **Patient Identification:** When implementing in the high-risk primary care population, clinicians were initially identifying patients using the surprise question: "Would you be surprised if this patient died within a year?" Several primary care clinicians suggested that the question be changed to 2 years because of the challenges with prognosticating in patients with multiple co-morbidities, such as chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). For subsequent trainings and implementations, the 2-year surprise question was used and accepted by clinicians.
- **Conversation Reminders:** Once the training launched in high-risk primary care, nurse care coordinators on a few clinical teams effectively took ownership of the scheduling and reminder processes to ensure timely initiation of Serious Illness Conversations with patients. The implementation team shadowed the nurses to learn how they were doing it, and these best practices were then spread to other nurse care coordinators in different clinics. This was an effective way of increasing use of the Serious Illness Conversation Guide.

Monitor and Improve Implementation

Objectives:

+ Measure and report on implementation progress
+ Identify areas of success and address emerging challenges
+ Determine whether improvement strategies are improving performance

Description: As implementation continues with the training of additional clinicians and identification of increasing numbers of patients at each of the pilot sites, you will have data to generate reports on the implementation process metrics outlined in Phase 2. By tracking high risk patients, numbers and timing of conversations, and frequency of documentation, you will likely see variability in clinician uptake of the Serious Illness Conversation Guide and other processes, which can focus performance improvement efforts. It is inevitable that some setbacks will arise during implementation. You will begin putting your performance improvement strategies into place and seeing if they result in real change.

TIP

Dr. Susan Block often states: "If you are not meeting resistance, you are not doing change."

Steps:

1. Collect data on process metrics
2. Generate reports
3. Celebrate early successes
4. Begin coaching and performance improvement
5. Assess effectiveness of performance improvement strategies and refine
6. Collect success stories and testimonials

Appendix Materials:

+ Coaching to Ensure High Quality Conversations
+ Coaching Call Framework
+ Ongoing Process Evaluation Worksheet

1. COLLECT DATA ON PROCESS METRICS

Use methods that you outlined in Phase 2 to monitor the following Serious Illness Care practices:

+ Training clinicians
+ Identifying high-risk patients
+ Conducting conversations with high-risk patients using the Serious Illness Conversation Guide in an appropriate timeframe
+ Documenting conversations using a structured template
+ Tracking patient deaths

2. GENERATE REPORTS

Your reports will show how well different aspects of the program are being implemented at the practice level and at the clinician level. It may take several attempts to display the data in ways that are useful for monitoring and improvement.

3. CELEBRATE EARLY SUCCESSES

Celebrating success motivates frontline clinicians and staff to continue their efforts and recognizes the value of the efforts that went into implementation planning.

4. BEGIN COACHING AND PERFORMANCE IMPROVEMENT

Early coaching is about building trust with frontline clinicians by staying connected, seeking feedback, and providing support.

FROM THE FIELD

- **Post-training Coaching:** A member of our implementation team reached out to all newly trained clinicians at least once by email shortly after training to learn whether or not they had used the Serious Illness Conversation Guide. When conversations occurred, we thanked them and asked for their feedback. When they did not, we asked what challenges they were facing with using the Conversation Guide and brainstormed solutions together.
- **Targeted Coaching:** Oncology implementation data showed that most Serious Illness Conversations occurred within 2 visits of the patient being identified as high risk. If the conversation did not occur within the timeframe, the coach reached out to the clinician to set up a meeting. The coach asked the clinician how things were going, listened for barriers and challenges, provided support, and they brainstormed solutions together.

5. ASSESS EFFECTIVENESS OF PERFORMANCE IMPROVEMENT STRATEGIES AND REFINE

During this time, it is helpful to determine whether your processes are effective at identifying problems in training and implementation, whether you are efficiently collecting and using data and feedback to improve care processes, and whether your coaching strategies lead to improvement in the quality of Serious Illness Care implementation. Complete Ongoing Process Evaluation Worksheet in the appendix.

FROM THE FIELD

- **Change in Coaching Strategy:** In the early days of oncology implementation, two palliative care physicians facilitated office hours for oncologists who were using the Serious Illness Conversation Guide. The goal was to discuss successes, barriers, and challenging patient and family situations that arose with using the Conversation Guide. An MD-MD model of coaching was used due to organizational culture. Due to scheduling and concerns about discussing issues in a group, these office hours were poorly attended. The strategy was therefore changed to one-on-one coaching using email, phone, and in-person conversations. Emails were sent regularly to follow up on use of the Serious Illness Conversation Guide, but in-person coaching was reserved for clinicians who were not meeting conversation goals. There were often clinical issues, such as patient or family distress, that arose during these coaching sessions.
- **Coaching Strategy in Primary Care:** The primary care initiative spanned a large geographic region, therefore coaching was done with regularly scheduled bi-weekly calls with nurse care coordinators, which then transitioned to monthly calls. The calls were facilitated by a palliative care physician and project manager. These calls were safe spaces for nurse care coordinators to share the challenges they were facing with their seriously ill patients. The most common issues discussed were clinical issues (e.g. dealing with emotions, prognostic communication, coordination and communication with other clinicians, care planning, and process improvement.)

6. COLLECT SUCCESS STORIES AND TESTIMONIALS

Stories about the impact of the discussion on clinicians, patients, and families capture why improving Serious Illness Conversations is such an important priority. Many times clinicians and patients find it more meaningful to hear from their own colleagues and neighbors, rather than those from hospitals in other states or regions of the country.

Evaluate Outcomes and Synthesize Lessons Learned

Objectives:

+ Evaluate outcomes and impact of pilot site implementation
+ Highlight successes and areas for continued improvement
+ Assess sustainability

Description: Once the pilot sites have been up and running with the program, we recommend that the implementation team pause to reflect, debrief, and evaluate. This is a time to look across all pilot sites and determine if goals have been met. You can analyze data on available outcomes and discuss the "highlights" and "lowlights" of implementation in order to decide what to replicate and what could be done better. In addition, we recommend that the implementation team consider its own internal capacities and whether additional resources would be helpful to sustain and expand the program.

Steps:

1. Evaluate measurable outcomes

2. Reflect on implementation and launch process

3. Determine whether implementation processes are sustainable

4. Determine whether implementation team capacities are sustainable

Appendix Materials:
Post-Implementation Review

1. EVALUATE MEASURABLE OUTCOMES

At this point, you will likely have data on process metrics and potentially a few outcome metrics. Keep in mind, however, that if the outcomes selected depend on patient deaths, there will be a significant time lag before you can analyze these data. It is helpful to ask yourself two questions:

+ Are we meeting our goals?
+ Are the outcomes what we expected?

2. REFLECT ON IMPLEMENTATION AND LAUNCH PROCESS

Meet as a group to synthesize lessons learned and document intentional and unintentional deviations from the plan.

3. DETERMINE WHETHER THE IMPLEMENTATION PROCESSES ARE SUSTAINABLE

Clinical teams will integrate care delivery processes into their workflow. During this time, it is helpful to check in with them to see if the processes are burdensome or having unintended consequences. It is also helpful to begin to consider what processes can be automated, if possible, to minimize burden on frontline clinicians.

FROM THE FIELD

- **Supporting Frontline Clinicians:** In one implementation initiative, nurse care coordinators in six clinics identified a large cohort of high-risk primary care patients who would benefit from a Serious Illness Conversation. After this, nurses and physicians began having several Serious Illness Conversations each week. As a result, they were showing signs of burnout that threatened their ability to sustain this work. The implementation team acted in three ways: 1) Encouraged the frontline clinical teams to slow down their pace of conversations; 2) Instituted a bereavement program with the clinical care teams to honor the patients who died; 3) Provided colleague-colleague support and active listening.
- **Collecting Feedback:** A few months into implementation and again later on, the implementation team conducted qualitative interviews with a small subset of high adopters and low adopters, both MDs and RNs. The goal was to identify effective practices and areas of improvement in implementation processes.
- **Evaluating Workflow in Oncology:** In order to minimize burden on frontline clinicians who were identifying patients and using the Serious Illness Conversation Guide in oncology, the implementation team would manually create lists of patients for each oncologist. The oncology clinicians would review their lists to identify high risk patients using the surprise question. This manual process of list generation was burdensome on implementation team resources, and a method of automating the list was developed and implemented.
- **Evaluating Workflow:** The patient identification process for high risk primary care was burdensome. Doctors and nurses would review long lists of patients who newly entered the high risk integrated care management program, and would therefore be responsible for reviewing hundreds of patients at once. When thinking about sustainable patient identification process, there have been discussions with leadership to automate the process of identifying patients at high risk of death who would benefit from a conversation.

4. DETERMINE WHETHER INTERNAL IMPLEMENTATION TEAM CAPACITIES ARE SUSTAINABLE

After implementing at the pilot sites, the implementation team often has a better sense of what it takes to support high quality implementation. Identifying gaps in implementation team resources is a useful step before thinking about expansion. One question that is helpful to ask:

+ Have we been able to provide the necessary training, data collection, technical support, and coaching to ensure high quality implementation?

Promote the Program

Objectives:

+ Promote the program with events and activities to maintain visibility
+ Share success stories and testimonials

Description: Promotion is a key strategy, along with one-on-one conversations, for continuing to engage leaders, colleagues and staff in Serious Illness Care work. There are many ways to tell the story of your implementation experience.

Steps:

1. Re-visit Phase 1 Engagement section

2. Initiate activities that best suit stakeholders at your organization

Appendix Materials: None

1. RE-VISIT PHASE 1 ENGAGEMENT SECTION

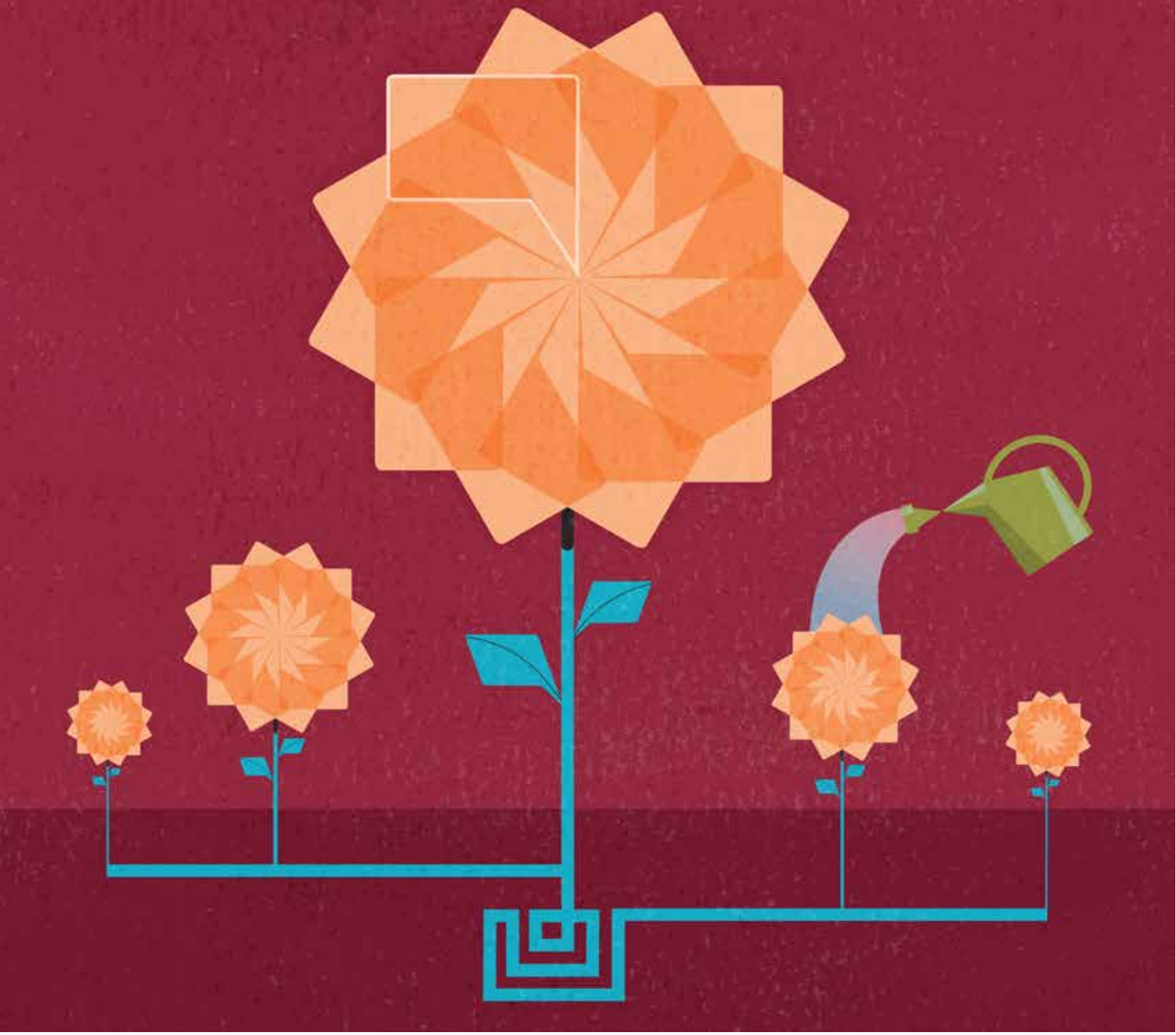
+ Although your talking points can be updated with data and experience from your pilot sites, the key principles of engagement outlined in Phase 1 Section 3, "Engage Leaders and Colleagues" still apply. Here are other practices to support your promotion strategy:
  - Continue one-on-one conversations to engage your colleagues
  - Take advantage of regularly scheduled meetings, such as staff or department meetings
  - Consider scheduling a large institutional meeting, such as Grand Rounds or others
  - Start each presentation with a story from your pilot site implementation that illustrates the importance of the work
  - Share success stories and clinician, patient, or family testimonials
  - Note: Ensure that the story cannot be traced to a specific person in the audience
  - Be consistent in describing the value this work will bring to your organization and stakeholders
  - Be consistent in asking open-ended questions to get your colleague's feedback and thoughts
  - Use photos that show people getting trained or using the Serious Illness Conversation Guide, if appropriate

2. INITIATE ACTIVITIES THAT BEST SUIT STAKEHOLDERS AT YOUR ORGANIZATION

We recommend tailoring your activities to the relevant audiences at your organization to continue to engage people in the effort and to spread excitement about the program. Different stakeholders will likely be interested in different things.

+ Frontline clinicians who have not yet been exposed to the program may be most interested in its impact on patients and how the program can support them in addressing challenges they face in their daily clinical practice.
+ Presentations for leadership about pilot site successes will likely be most effective if they address the program's impact on organizational priorities and the future of the work.

PHASE 4: SUSTAIN AND EXPAND



Summary: Phase 4

Congratulations! Planning and launching the Serious Illness Care Program is no small feat. Having demonstrated the program's success at your pilot sites, you have reached Phase 4 of the implementation roadmap: Sustaining and Expanding the Program.

To use the metaphor of a tree, this phase is about deepening your roots within your organization, strengthening your core team, and growing broad branches into new clinics and patient populations. The ultimate goal of this initiative is for the Serious Illness Conversation Guide to become so ingrained in the culture that clinicians consistently have high quality conversations with the right patients, at the right time, and promote its use to others.

While sustaining the program at the pilot sites, your next step is to determine whether your program is in a good position to spread to new sites and populations within your organization. It is critical to identify when and how to spread based on your organization's resources and capabilities. Allowing sufficient time for capacity building and expansion planning will ultimately improve your chances of continuing to deliver on the goals of your program throughout expansion.

By the end of Phase 4, you will have succeeded in promoting sustainability of the Serious Illness Care Program at your pilot sites and using the lessons learned from those sites to begin expansion to the rest of the organization by:

+ Assessing readiness to expand
+ Creating a plan for program expansion
+ Developing strategies for sustaining the work

Assess Readiness to Expand

Objective:

+ Assess your organization's ability to expand the Serious Illness Care Program beyond the pilot sites

Description:

This section asks you to assess your organization's readiness to implement and support an expansion of the Serious Illness Care Program. One method of assessment is a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis. The SWOT Worksheet in this section will guide you through this process. It will identify areas for capacity building before expansion and will help your organization determine when it is time to expand.

Steps:

1. Form expansion team

2. Review and refine program goals

3. Complete the SWOT analysis

Appendix Materials:

+ Example SWOT Analysis for Expansion

TIP

Your expansion team may be different from your original implementation team.

1. FORM EXPANSION TEAM

Some tips for forming your team:

+ Original implementation team members can provide valuable perspective as part of the expansion team or in an advisory role
+ Include a clinical representative, ideally from one of the initial expansion sites
+ Ask for a representative from system leadership (CMO, CNO, Operations Director, Department Chief, Lead Quality Officer) to:
  - Provide perspective of executives on objectives, success criteria, and risks
  - Approve expansion scope, timelines, and resources
  - Provide guidance on alignment of the project with other initiatives or activities within the system
  - Review progress and help address barriers

2. REVIEW AND REFINE PROGRAM GOALS

To determine goals for expansion, revisit Phase 1 "Determine Program Goals" and consider the lessons you have learned from pilot implementation.

3. COMPLETE THE SWOT ANALYSIS WORKSHEET

This exercise will help to provide context and direction as you determine what capabilities and resources your team needs to strengthen in order to meet your goals.

Create a Plan for Program Expansion

Objectives:

+ Work to build capacity in areas identified by your SWOT analysis
+ Conduct needs assessments at potential expansion sites
+ Develop expansion plan (Budget, Team, Timeline)
+ Expand to new clinics/practices in phases

Description: Transitioning from pilot site implementation to expansion requires dedicated planning. Expansion is when best practices in Serious Illness Conversations and care are disseminated and implemented successfully in new settings.
The SWOT analysis will have identified specific capabilities and resources your organization may need to strengthen in order to support program expansion. Taking the time to build these at an organizational level before expanding beyond the pilot sites will enable you to keep momentum once you begin expansion. When you are confident of your organization's readiness, you will identify new clinics and/or patient populations for program expansion. Since different sites have different cultures and contexts, each expansion will require you to revisit parts of Phases 1 and 2, including: engaging colleagues to get support, workflow adaptation, EHR modifications, changing the measurement strategy, and modifying the training and coaching processes. This will help to ensure you are prepared for high quality implementation at each site.

TIP

If you started with highly engaged pilot sites, then expansion may mean that you meet comparatively more resistance as you spread. Think about what you can reasonably get done in these new sites with your resources. Consider focusing your resources and time on sites in which you can have the most impact.

Steps:

1. Build organizational capacity in areas identified by SWOT analysis
2. Identify potential new clinic sites and patient populations
3. Conduct a site-specific needs assessment for each site or population
4. Establish A Phased Expansion Plan with Appropriate Scope, Goals, Budget, and Timeline
5. Obtain Approval for Finalized Expansion Plan
6. Begin Expansion in Phases

Appendix Materials: Expansion Needs Assessment Worksheet

1. BUILD CAPACITY IN AREAS IDENTIFIED BY SWOT ANALYSIS

2. IDENTIFY POTENTIAL NEW CLINIC SITES AND PATIENT POPULATIONS

Discuss what new sites or patient populations you would like the program to reach.

3. CONDUCT A NEEDS ASSESSMENT FOR EACH SITE OR POPULATION THAT INCLUDES THE FOLLOWING (SEE EXPANSION NEEDS ASSESSMENT WORKSHEET IN APPENDIX)

+ Engage site leaders and colleagues to determine if implementation is feasible in the new site or population and where there might be challenges (see Phase 1 "Engage Leaders and Colleagues")
  - Identify each expansion site's internal resources, recognizing that it may be possible to share resources across sites or repurpose those involved in the initial pilot sites
  - Plan for training, workflow, and quality improvement process adaptations: There may be different levels of adaptation required depending on whether your expansion involves new sites in the same kind of practice (i.e. additional primary care practices) or a new clinical area (e.g. oncology or cardiology).
  - Based on the above needs assessment, select your expansion sites / populations and determine the approximate order in which you will proceed (e.g remaining primary care practices, then oncology).

4. ESTABLISH A PHASED EXPANSION PLAN WITH APPROPRIATE SCOPE, GOALS, BUDGET, AND TIMELINE

5. OBTAIN APPROVAL FOR FINALIZED EXPANSION PLAN

6. BEGIN EXPANSION IN PHASES

TIP

Your organization's leadership may be eager to expand the program quickly or some leaders may be tempted to push the effort ahead prematurely. Your best defense against this is to ensure that your leadership team is informed about the planning process and how your work is progressing. Keep your leadership team informed about what you are doing and why, your deadlines and progress, and any changes or challenges. We recommend a phased expansion so that you can learn with each expansion, achieve high quality implementation at new sites, and avoid overburdening expansion team resources.

Develop Strategies for Sustaining the Work

Objectives:

+ Integrate the core elements of the program into standard organizational structures and processes
+ Demonstrate sustained use of the program

Description: Sustainability is when Serious Illness Care practices become the norm in your system. Reaching this goal takes time and dedication. The mantra we recommend for this phase is: "never stop looking." The implementation team continues to have an important role, and it will take a sustained effort to ensure that high quality Serious Illness Conversations and care are "just the way we do work around here."

Steps:

1. Review lessons on sustainability learned from the pilot sites

2. Build internal expertise

3. Incorporate program elements into reporting, accountability, and performance targets

4. Incorporate clinician training into formal training programs for new clinicians and staff

5. Maintain a high profile

6. Align program goals with external initiatives

Appendix Materials: None

1. REVIEW LESSONS ON SUSTAINABILITY LEARNED FROM THE PILOT SITES

Once the team begins expansion, there may be less attention on the pilot sites. This is an important time to assess how the program is doing at the pilot sites and understand what is needed to sustain the program.

FROM THE FIELD

- **Automate Workflow:** After primary care implementation, clinical teams gave feedback that answering the 'surprise question' on long lists of their patients was not a feasible practice. The Clinical Lead began working with leadership to find an automated way of identifying patients using the surprise question in the EHR or a new predictive analytics tool to identify high-risk patients using EHR and claims data. Any new tool will likely have benefits, challenges, and tradeoffs to consider, such as EHR alert fatigue, but it is important to consider options that may facilitate sustainable practice change.
- **Automate Measurement:** Consider automating measurement processes. Build process measures related to Serious Illness Conversations into the quality improvement dashboard.

2. BUILD INTERNAL EXPERTISE

When thinking about sustainability, begin to develop ways to transfer expertise in the core elements of the program to multi-disciplinary teams across organizational levels (e.g. quality department).

3. INCORPORATE PROGRAM ELEMENTS INTO REPORTING, ACCOUNTABILITY, AND PERFORMANCE TARGETS

+ Incorporate improvement activities into quality improvement and/or patient safety initiatives
  - Decide what data to continue collecting and measuring

TIP

Our motto about data is: if you are not using it, lose it.

4. INCORPORATE CLINICIAN TRAINING INTO FORMAL TRAINING PROGRAMS FOR NEW CLINICIANS AND STAFF

As your organization experiences turnover, develop a process to train new clinicians to conduct Serious Illness Conversations.

5. MAINTAIN A HIGH PROFILE

+ Keep the program as a priority on management agendas by
  - Aligning the continued work with institutional priorities
  - Continuing to set goals and report program successes to leadership and other stakeholders
  - Continuing to share stories to inspire staff
  - Motivating leadership to continue championing the work

6. ALIGN PROGRAM GOALS WITH EXTERNAL INITIATIVES

Integrate regional or national improvement initiatives (e.g. MACRA, Reimbursement for ACP conversations) into your program's strategy

Reflect and Share

Objective:

+ Synthesize lessons learned from your project into guiding principles for implementation

Description: You have now implemented the Serious Illness Care Program in multiple sites, addressed challenges as they arose, and determined core requirements for sustainability. The knowledge and expertise you have developed has great value to other groups as they implement the Serious Illness Care Program as well as to your own organization as it tackles other implementation efforts. Therefore, it is important to synthesize and share the lessons your team has learned. A simple approach would be to distill your experience into a few guiding principles for implementation, illustrated with examples from your sites. To begin, you could revisit changes you made to the implementation plan when transitioning from pilot sites to expansion. Additionally, it may be useful to highlight lessons that are unique to a implementing the program for a specific population or site as others may face similar challenges.

Steps:

1. Review lessons learned through all phases of implementation

2. Choose key messages to share with your organization and external audiences

3. Create materials for distribution

Appendix Materials: None

1. REVIEW LESSONS LEARNED THROUGH ALL PHASES OF IMPLEMENTATION

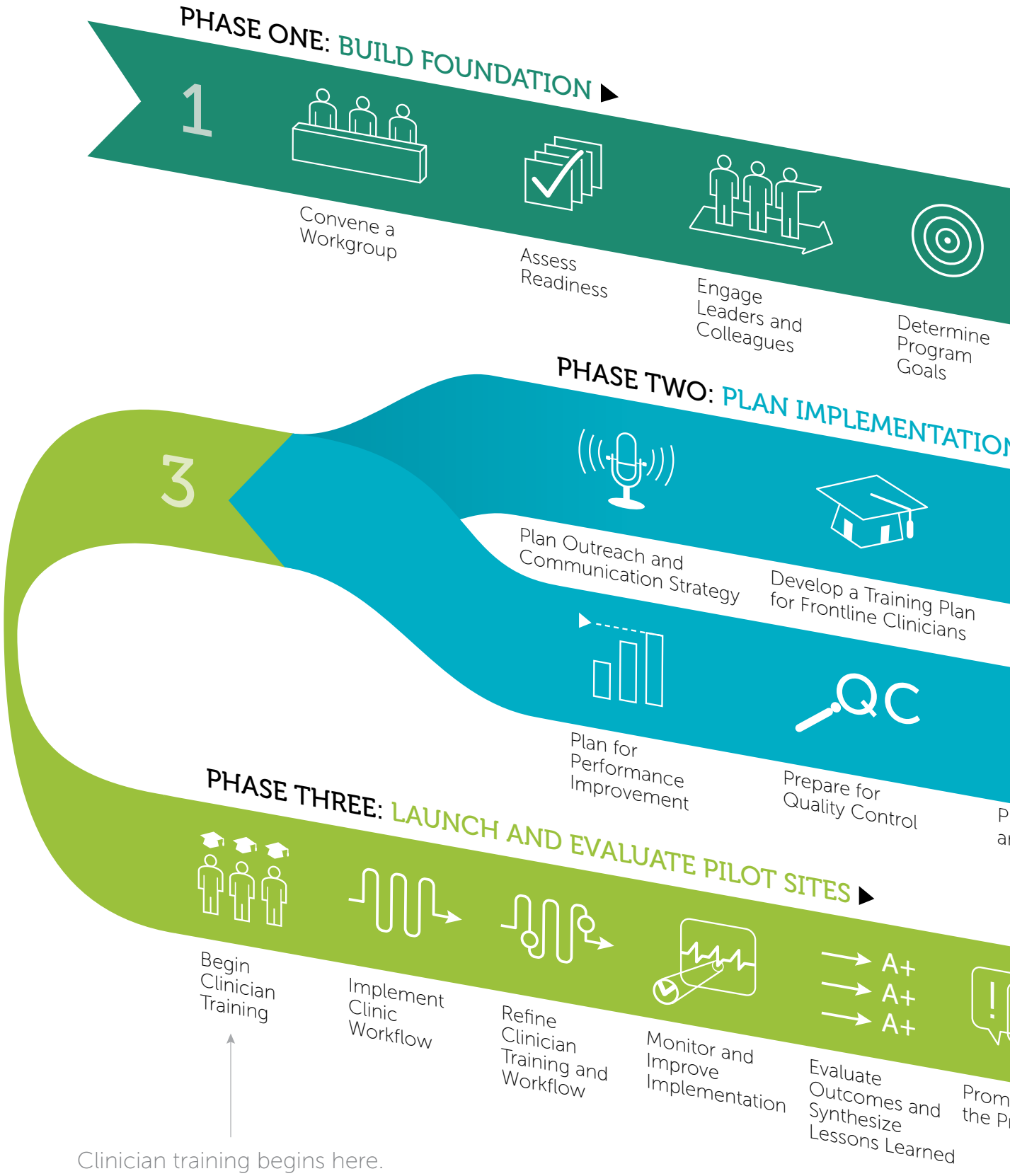
This is a great time to review any changes you made to your implementation plan along the way in response to informal feedback and more formal monitoring and evaluation.

2. CHOOSE KEY MESSAGES TO SHARE WITH YOUR ORGANIZATION AND EXTERNAL AUDIENCES

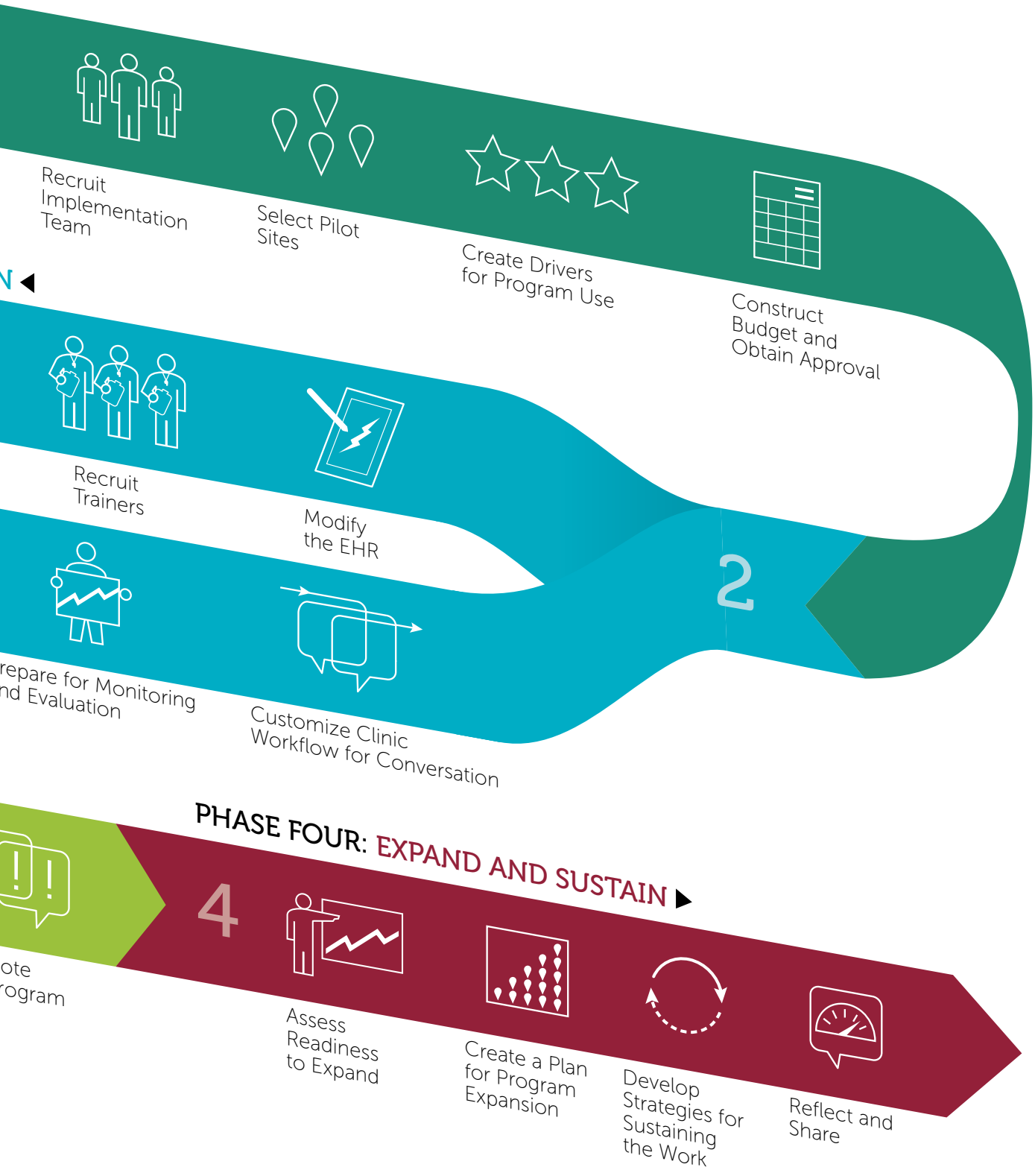
It may take some time to distill clear messages from the many decisions you've made throughout this effort. It may be helpful to consider each phase of the Implementation Roadmap independently and choose one or two lessons from each. Remember to use specific examples to highlight your experience.

3. CREATE MATERIALS FOR DISTRIBUTION

As when you created reports to share your implementation progress with your organization and team, think of presenting your lessons in a format that is easy to understand and applicable to other contexts. Remember to share the product with everyone who helped you in this effort as well as external audiences. It is a great way to both celebrate successes and show the continued reach of your work.


PHASE ONE: BUILD FOUNDATION
1
Convene a Workgroup
Assess Readiness
Engage Leaders and Colleagues
Determine Program Goals
PHASE TWO: PLAN IMPLEMENTATION
3
Plan Outreach and Communication Strategy
Develop a Training Plan for Frontline Clinicians
Plan for Performance Improvement
QC
Prepare for Quality Control
PHASE THREE: LAUNCH AND EVALUATE PILOT SITES
Begin Clinician Training
Implement Clinic Workflow
Refine Clinician Training and Workflow
Monitor and Improve Implementation
A+
A+
A+
Evaluate Outcomes and Synthesize Lessons Learned
Clinician training begins here.

Implementation Roadmap
Serious Illness Care Program



APPENDIX

Readiness Assessment Worksheet

FACTOR	QUESTION	NOTES
Leadership Alignment and Support	What is the need that is driving you to implement the Serious Illness Care Program?	
	What level of agreement do you have from leadership that the Serious Illness Care Program is the appropriate strategy to address the need?	
	What does leadership want to accomplish from the Serious Illness Care Program?	
Availability of Implementation Team Resources and Clinical Champions	Do you have staff available to assist in this project from: • Project Management • Data analytics/Information Technology (EHR) • Quality Improvement • Administration	
	Name one or more well-respected clinicians who could be the champion(s) for this project.	

FACTOR	QUESTION	NOTES
Existing Population Management Programs	What organizational initiatives currently focus on population management? • ACO • Alternative Quality Contracts • Medicare Shared Savings • Other *Population management programs may be a good fit for early implementation of the Serious Illness Care Program.	
Commitment to Quality Improvement and Measurement	What Quality Improvement projects related to advance care planning, palliative care, or end-of-life care has your organization successfully implemented in the past?	
	How would you describe your organizational culture related to practice change and quality improvement?	

FACTOR	QUESTION	NOTES
Strong Culture of Palliative Care	What services are provided by palliative care? • Inpatient consults • Inpatient unit • Outpatient clinic- stand alone • Outpatient clinic - embedded • Home-based • Hospital health system owned hospice	
	What non-consultative activities in palliative care are currently active? (i.e. advance care planning project, clinician education, patient/family engagement)	
	Name clinicians who could potentially be trainers for the program, (i.e. clinicians with experience in advanced communication or in teaching communication skills)	
Institutional Priorities	How well does the initiative match your organization's current priorities?	
	What other initiatives related to communication training are being rolled out for clinicians, if any? (i.e. AIDET, high reliability)	
	Are there any major hospital/health system priorities in progress or anticipated in the next 24 months that could impact this project; e.g. Epic implementation?	

Sample Engagement Handout

+ Please customize this handout to best suit your needs
+ Consider adding a 'call to action' specific to your initiative at the end of the document—who they can contact and what they should do next to get more information.

SERIOUS ILLNESS CONVERSATIONS: MORE. EARLIER. BETTER.

PROBLEM

For many patients with serious illness, planning for end-of-life tends to occur late or not at all, and when it does, it often inadequately addresses patient goals and needs. As a result of absent, delayed, or inadequate communication about their priorities and wishes, many patients with serious illness do not receive the care they want and experience unnecessary suffering.

PATHWAY TO IMPROVEMENT

The Serious Illness Care Program is designed to improve the lives of all people with serious illness by increasing meaningful conversations with their clinicians about their values and priorities.

GOALS

Aligned with Quadruple Aim

- Improve quality of life and experience for seriously ill patients and their families
- Train clinicians to have patient-centered, high quality serious illness conversations
- Facilitate more, earlier, and better conversations for every patient with serious illness, every time
- Align care with patient priorities and preferences by improving care delivery processes
- Lower costs by reducing the use of non-beneficial (and potentially harmful) medical resources at the end of life
- Improve clinician teamwork, satisfaction and engagement in serious illness conversations and care planning

TOOLS

- SERIOUS ILLNESS CONVERSATION GUIDE
- CLINICIAN REFERENCE GUIDE
- PATIENT PREPARATION MATERIALS
- FAMILY COMMUNITY GUIDE

EDUCATION

TRAIN-THE-TRAINER

COURSE 101 → COURSE 201 →

TRAIN CLINICIANS

2.5-HOUR CLINICIAN TRAINING SESSIONS

SYSTEMS CHANGE

PATIENT IDENTIFICATION → REMINDER SYSTEM → CONVERSATION USING THE GUIDE → DOCUMENT CONVERSATION → PATIENT & FAMILY SUPPORT

MEASUREMENT AND IMPROVEMENT (QI)

SERIOUS ILLNESS CARE PROGRAM STRATEGY

Benefits of the Program

- Patient-centered
- Evidence-based
- Scalable
- Addresses both clinician behavior and systems change

EVIDENCE

Dana-Farber Cancer Institute: A cluster-randomized controlled trial involving 391 patients, 330 family members, and 90 clinicians in outpatient oncology. Preliminary data demonstrate strong positive impact of the program:

- More than 90% of intervention clinicians have changed their behavior to adopt the process.
- Significantly higher proportion of patients have at least one conversation before death in the intervention group compared to the control group (92.5% versus 76.0%, p= 0.009).
- The conversations take place 3 months earlier in the intervention group (5.2 months before death versus 2.1 months, p=0.012).
- The conversations are more comprehensive, focused on patient goals and priorities, and retrievable in the EHR, than is the case for controls.
- The intervention significantly reduces anxiety and depression, especially for patients with moderate/severe symptoms.
- Lower levels of anxiety and depression persist after the intervention.
- The conversations are perceived as worthwhile by 86% of patients.
- Two-thirds of the conversations result in positive patient behavior change (increased attention to practical matters, more conversations involving family members, more planning for the future, and better relationships with their doctors).

Suggested Talking Points

TIPS FOR CONVERSATIONS WITH PALLIATIVE CARE COLLEAGUES

+ **Start with an open-ended question**
  - What aspects of your palliative care referrals could be improved through earlier generalist or specialist conversations with patients about goals of care?
+ **Bring the Serious Illness Conversation Guide and discuss it with them; give them a copy and ask them to discuss with their palliative care peers**
+ **Identify the 3 most important aspects of the initiative that align with their answers to the questions above**
  - Introduce the program, how it works, and why it is important
  - Bring a handout that includes high-level information about the goals and strategy of the Serious Illness Care Program
+ **Share the evidence behind the program and the benefits for patients, families, and clinicians**
+ **Ask for their feedback**
+ **Directly ask about their reservations, acknowledge their concerns, and, when appropriate, do some active problem-solving together to address them**
+ **Ask for their help**
  - Would you be willing to speak up on behalf of the program at a larger meeting?
  - Would you like to be involved in training?
  - Would you like to be involved in implementation planning?
  - Would you be willing to be consulted for questions related to implementation that would benefit from your expertise?
+ **Respond to their questions and concerns**

Suggested Talking Points

TIPS FOR CONVERSATIONS WITH GENERALIST OR NON-PALLIATIVE CARE SPECIALIST COLLEAGUES ABOUT THE PROGRAM

+ **Start with an open-ended question**
  - What are the biggest challenges you and your colleagues face in caring for patients with serious illness?
+ **Identify the 3 most important aspects of the initiative that align with their answers to the questions above**
+ **Introduce the program, how it works, and why it is important**
  - Bring a handout that includes high-level information about the goals and strategy of the Serious Illness Care Program
  - Share the evidence behind the program and the benefits for patients, families, and clinicians
+ **Ask for their feedback**
+ **Directly ask about their reservations, acknowledge their concerns, and, when appropriate, do some active problem-solving together to address them**
+ **Ask for their help**
  - Would you be willing to speak up on behalf of the program at a larger meeting?
  - Would you like to be involved in implementation planning?
  - Would you be willing to be consulted for questions related to implementation that would benefit from your expertise?
+ **Respond to their questions and concerns**

Suggested Talking Points

TIPS FOR CONVERSATIONS WITH LEADERS ABOUT THE PROGRAM

+ **Start with an open-ended question**
  - What are the institution's key priorities for this fiscal year?
    - Patient satisfaction scores? Reducing readmissions?
    - What other large institutional initiatives are occurring right now?
  - What clinical problems/patient complaints have come to your attention in serious illness or end-of-life care recently?
  - What is your perspective on the challenges clinicians face in caring for seriously ill patients?
  - What organizational cultural barriers do you think impact care for patients at the end of life?
+ **Bring a one-page handout with the goals and strategy of the Serious Illness Care Program**
+ **Share the evidence behind the program**
+ **Be ready to show and describe how the program can add value to the organization**
  - Focus on the quadruple aim
    - Provide a better experience of care: Serious illness conversations build trust and help patients with advanced illness maintain control over their medical decisions and live the best life possible, improving patient (and family) experience of care.
    - Improve outcomes: The Serious Illness Care Program uses a population management approach by delivering better care to a group of patients most at risk of poor outcomes, leading to improved well-being.
    - More appropriate resource use: By aligning care with patient priorities and optimizing well-being for the sickest patients, the program leads to more appropriate resource use by reducing non-beneficial and potentially harmful care.
    - Enhance provider satisfaction: Clinician burnout and dissatisfaction rates are at an all time high and are associated with threats to patient safety. Serious illness conversations facilitate provider engagement in care planning and can help clinicians connect with many of the reasons they went into medicine.

Suggested Talking Points (continued)

+ **Discuss the relevance to the institution's overall goals and mission**
+ **Ask for their feedback**
+ **Directly ask about their reservations about the Program, acknowledge them, and, when appropriate, do some active problem-solving together to address them**
+ **Ask for their help**

  For example: Would you be willing to send a letter to all clinical leaders sharing the importance of the program and expressing your support? What other strategies would you be willing to use to demonstrate to clinicians that the Serious Illness Care Program is an institutional priority?
+ **Respond to questions and concerns**

Roles and Responsibilities of Implementation Team Members

EXECUTIVE STEERING COMMITTEE

- Provide the implementation team with the perspective of executives on objectives, success criteria, and risks
- Approve the dimensions of the project: scope, timelines, and resources (monetary, people, etc.)
- Provide guidance to the implementation team on alignment of the project with other initiatives or activities within the system, including political aspects and messaging.
- Regularly review progress of the team and help eliminate actual or potential obstacles; approve any changes to scope, schedule, or resources

CENTRAL CORE IMPLEMENTATION TEAM

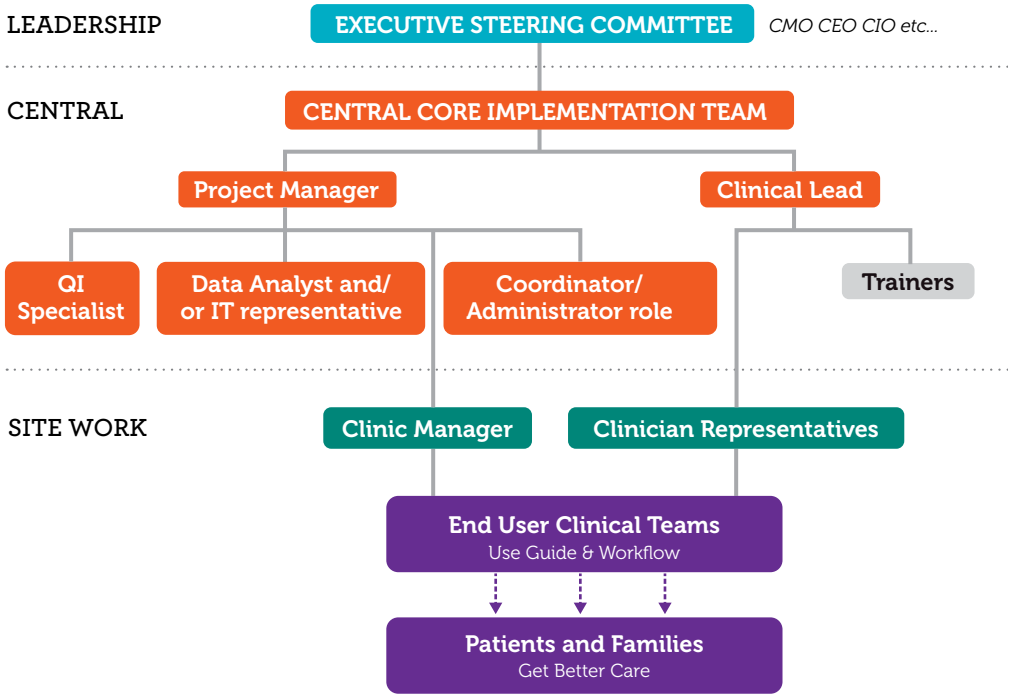
Clinical lead

- Advocate for the program across the system (face-to-face conversations, presentations, etc)
- Complete Ariadne Labs Course 101 and Course 201 Train the Trainer curriculum
- Demonstrate use of the Serious Illness Conversation Guide in his/her own practice
- Train clinicians to use the Serious Illness Conversation Guide
- Recruit additional trainers
- Collaborate with QI specialist, Project Manager, and Communications Specialist to adapt and develop a Phase 2 implementation plan on all key areas (EHR modification; clinician education; systems change; monitoring and evaluation; coaching; quality control; outreach and communication)
- Oversee clinician education outcomes
- Provide coaching to support clinicians as they use the Conversation Guide in practice

Project manager

- Develop action plans and milestones with clear measurable goals and appropriate metrics
- Coordinate the work of multidisciplinary team members to effectively implement action plans
- Identify opportunities to improve organizational structures and processes
- Streamline implementation processes and respond to challenges
- Ensure that the program remains on budget, on scope, and properly resourced

SAMPLE ORGANIZATIONAL CHART



QI specialist

- Apply QI methods to adapt and streamline intervention workflows related to systems change and serious illness care delivery practices (patient screening; scheduling the conversation; conversation preparation; documentation; etc)
- Determine a process for data collection and reporting of key process metrics
- Execute the plan to capture key process and outcome metrics
- Develop strategies to learn from the data
- Support implementers to improve performance and achieve compliance with the practice standard
- Synthesize and distribute cross-clinic learning

Data Analyst and/or IT representative

- Oversee implementation of new EHR serious illness conversation template/module
- Assess capacity of the health information system to collect, report, and share metrics
- Build any additional data systems necessary to capture, extract, and share metrics and learnings
- Oversee data quality issues
- Build any additional EHR infrastructure to effectively implement and monitor the initiative

Coordinator/administrator role

- Coordinate the printing and distribution of the Serious Illness Care Program implementation materials
- Assist with scheduling meetings for the implementation team and reserving conference rooms
- Submit requests to obtain CME credit for clinician trainings

SITE-SPECIFIC CONTRIBUTORS

Clinician representative of the "end users" (e.g. specialist or generalist)

- Advocate for the project locally
- Undergo training to use the Serious Illness Conversation Guide
- Provide recommendations and expert advice relevant to his/her specialty for implementation planning
- Demonstrate use of the Serious Illness Conversation Guide in his/her own practice

Operations/clinic manager

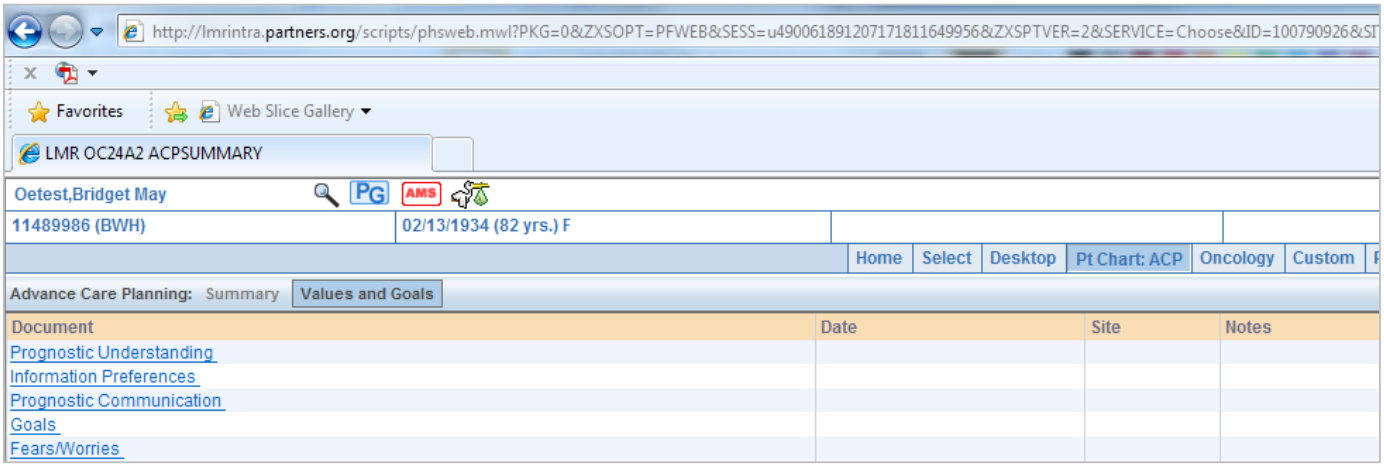
- Oversee logistics of workflow customization

Serious Illness Care EHR Module Overview and Design

The module is designed as a landing page with nine elements (the nine elements of the Serious Illness Conversation). When a provider clicks on one of the questions, a window pops up where the provider can document those aspects of the Serious Illness Conversation.

For each question, the module allows the clinician to select choices from multiple-choice options and/or enter a free-text response in the notes section to reflect the patient's answers to the questions. In the multiple-choice menus, there are examples of goals, fears, sources of strength, tradeoffs, and abilities that you can select. We recommend that the Clinical Lead become familiar with the examples. Although this was a tough decision, the examples that are available in the multiple-choice menus of the module have not been included on the Conversation Guide itself for simplicity and design.

VALUES AND GOALS LANDING PAGE

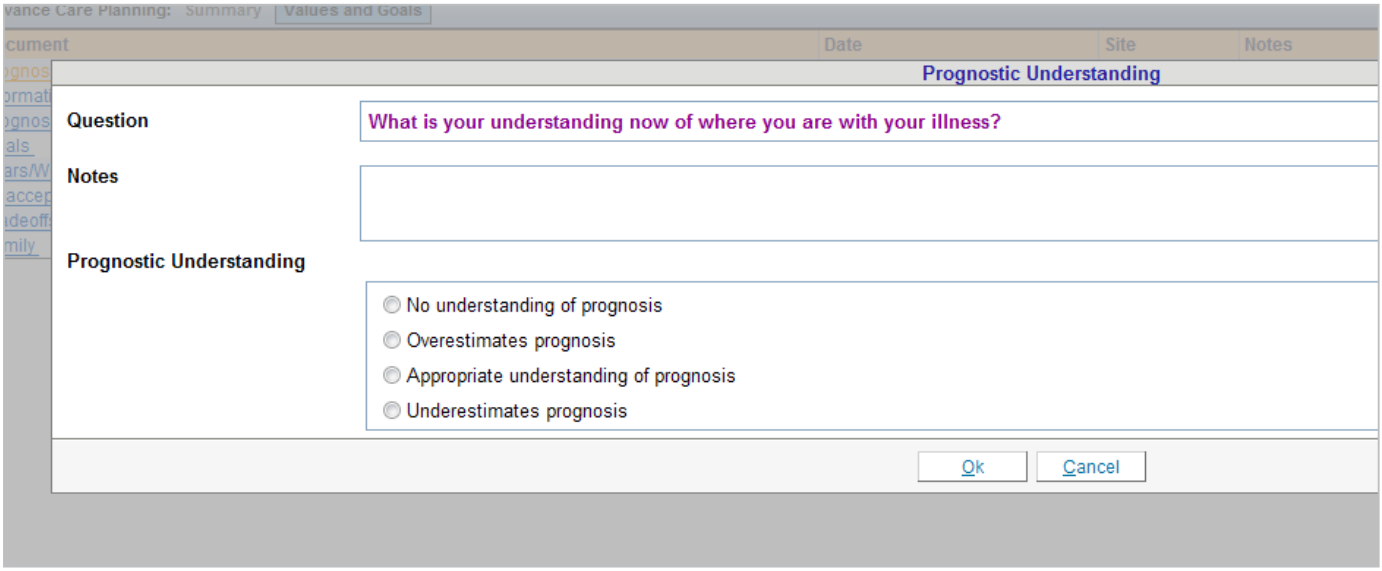


- For each element of the conversation, you can preview Date, Site, Clinician Name / Role, and Notes after they have been entered. Some of this documentation consists of both selected drop-down boxes and populated free text fields
- This EHR automatically populates the landing page with both selected drop-down boxes AND free text entered by clinicians after each respective question/element is completed
- If a patient has multiple conversations:
    - Most recent conversation is listed with the Date, Site, Clinician and role, and Notes on the landing page
    - History can be viewed and hyperlinked from the Date (can see the Date, Site, Clinician and role, and Notes from older documented conversations)

FOR ALL OF THE QUESTIONS:

- There are no character limits for any of the text fields
- There are no required fields (i.e. It is possible to select "OK" in the window and save answers with any amount of answers completed)

1. PROGNOSTIC UNDERSTANDING



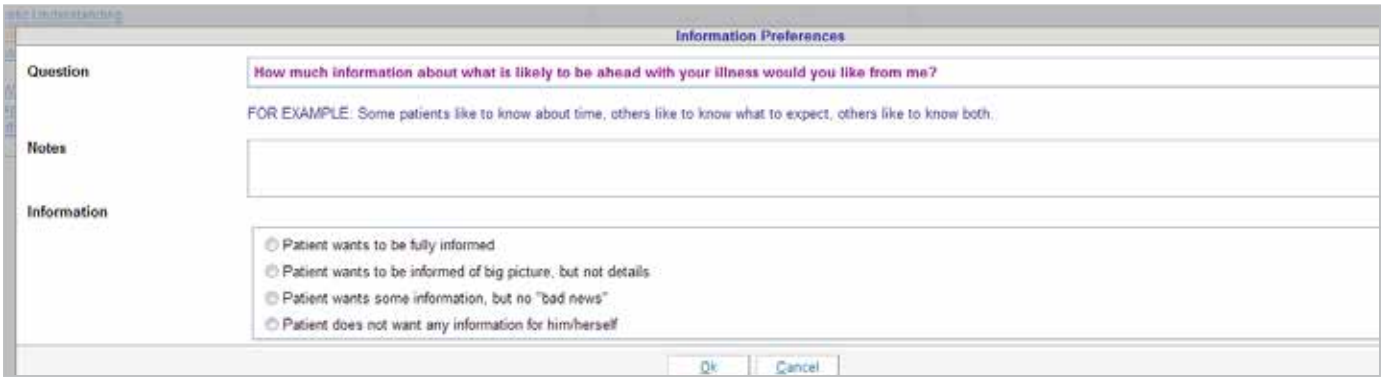
Question: What is your understanding now of where you are with your illness?

Notes type: Free text field

Radio buttons: Prognostic Understanding

- No understanding of prognosis
- Overestimates prognosis
- Appropriate understanding of prognosis
- Underestimates prognosis

2. INFORMATION PREFERENCES



Question: How much information about what is likely to be ahead with your illness would you like from me?

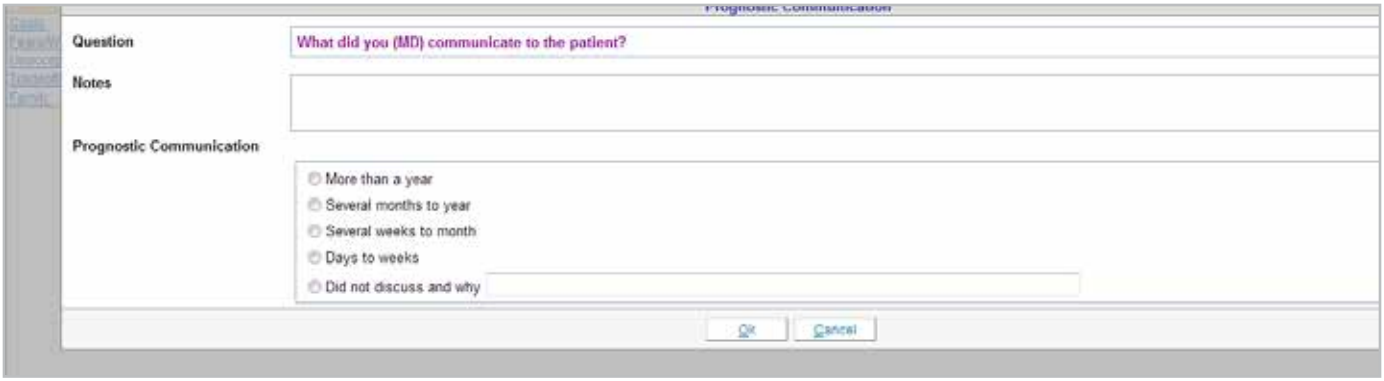
Additional text: FOR EXAMPLE: Some patients like to know about time, others like to know what to expect, others like to know both.

Notes type: Free text field

Radio buttons: Information

- Patient wants to be fully informed
- Patient wants to be informed of big picture, but not details
- Patient wants some information, but no "bad news"
- Patient does not want any information for her/himself

3. PROGNOSTIC COMMUNICATION



Question: What did you (MD, NP, PA, RN, SW, etc) communicate to the patient?

Notes type: Free text field

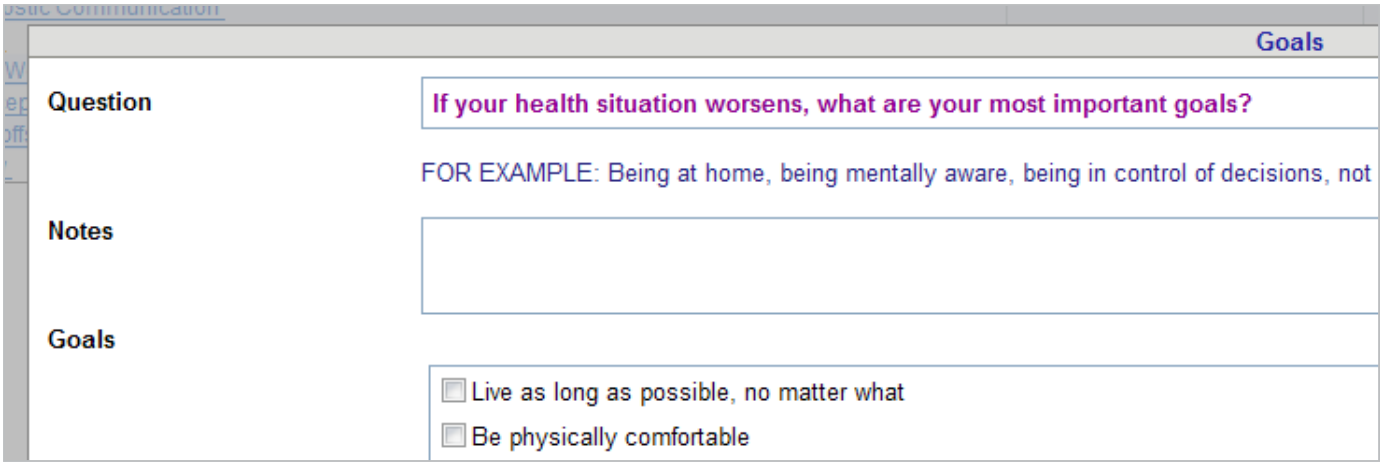
Radio buttons: Prognostic Communication

- Curable
- Incurable
- More than a year
- Several months to a year
- Several weeks to a month
- Days to weeks
- Did not discuss and why (with a free text field)

Misc Notes:

- If "Did not discuss and why" is selected, the associated text field is required.
- This text field should be disabled unless that radio button is selected.
- If "Did not discuss and why" is selected, and the user enters text, but then changes their mind and deselects that option, the text in "Did not discuss and why" should not be saved.

4. GOALS



Question: If your health situation worsens, what are your most important goals?

Additional text: FOR EXAMPLE: Being at home, being mentally aware, being in control of decisions, not being a burden, achieving life goal, supporting my children

Notes type: Free text field

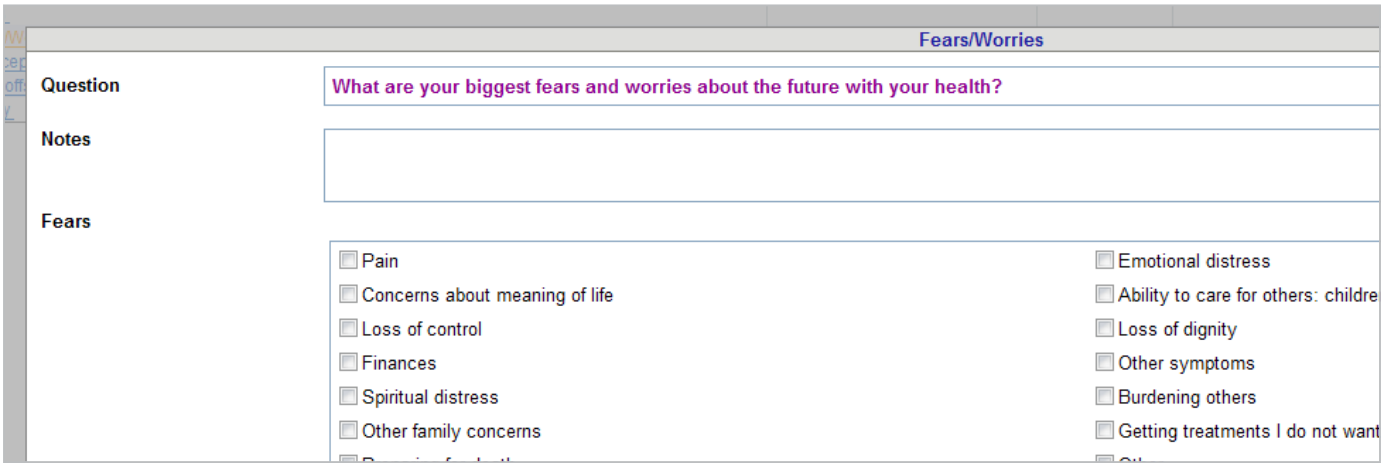
Checkboxes: Goals

- Live as long as possible, no matter what
- Be physically comfortable
- Not be a burden
- Have my medical decisions respected
- Be spiritually and emotionally at peace
- Be at home
- Be mentally aware
- Be independent
- Provide support for family
- Achieve particular life goal, please specify

Misc Notes:

- There should be a text field associated with "Achieve particular life goal, please specify."
- If "Achieve particular life goal, please specify" is selected the text field is mandatory. If that option is not selected, then the associated text field is disabled.
- If "Achieve particular life goal, please specify" is selected, and the user enters text, but then changes their mind and deselects that option, the text in "Achieve particular life goal, please specify" should not be saved.

5. FEARS/WORRIES



Question: What are your biggest fears and worries about the future with your health?

Notes type: Free text field

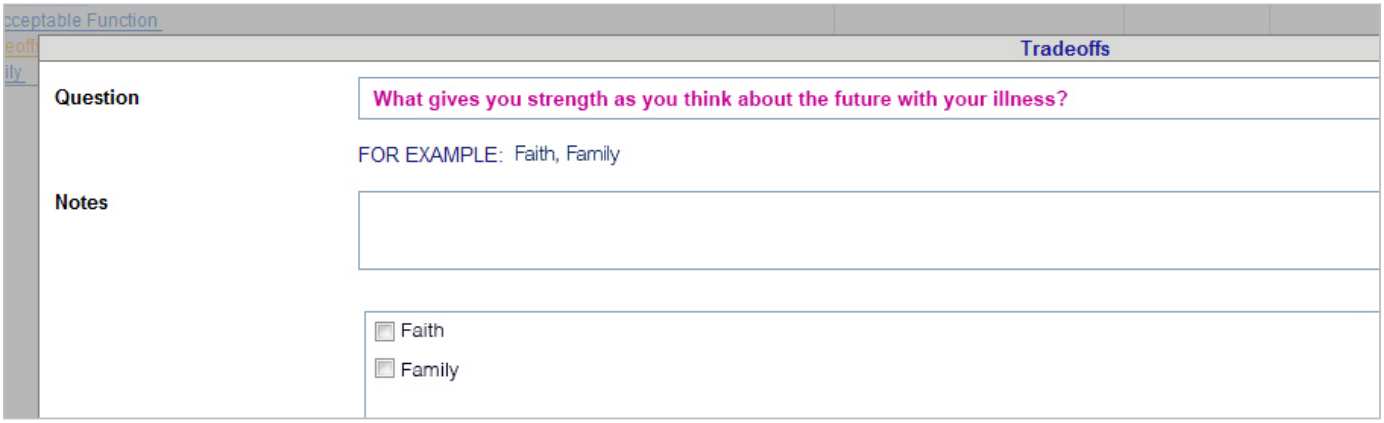
Checkboxes: Fear

- Pain
- Concerns about meaning of life
- Loss of control
- Finances
- Spiritual distress
- Other family concerns
- Preparing for death
- Emotional distress
- Ability to care for others: children, ill spouse
- Loss of dignity
- Other symptoms
- Burdening others
- Getting treatments I do not want
- Other

Misc Notes:

- There should be a text field associated with "Other"
- If "Other" is selected the text field is mandatory. If that option is not selected, then the associated text field is disabled.
- If "Other" is selected, and the user enters text, but then changes their mind and deselects that option, the text in "Other" should not be saved.

6. SOURCES OF STRENGTH



Question: What gives you strength as you think about the future with your illness?

Additional text: FOR EXAMPLE: Faith, family

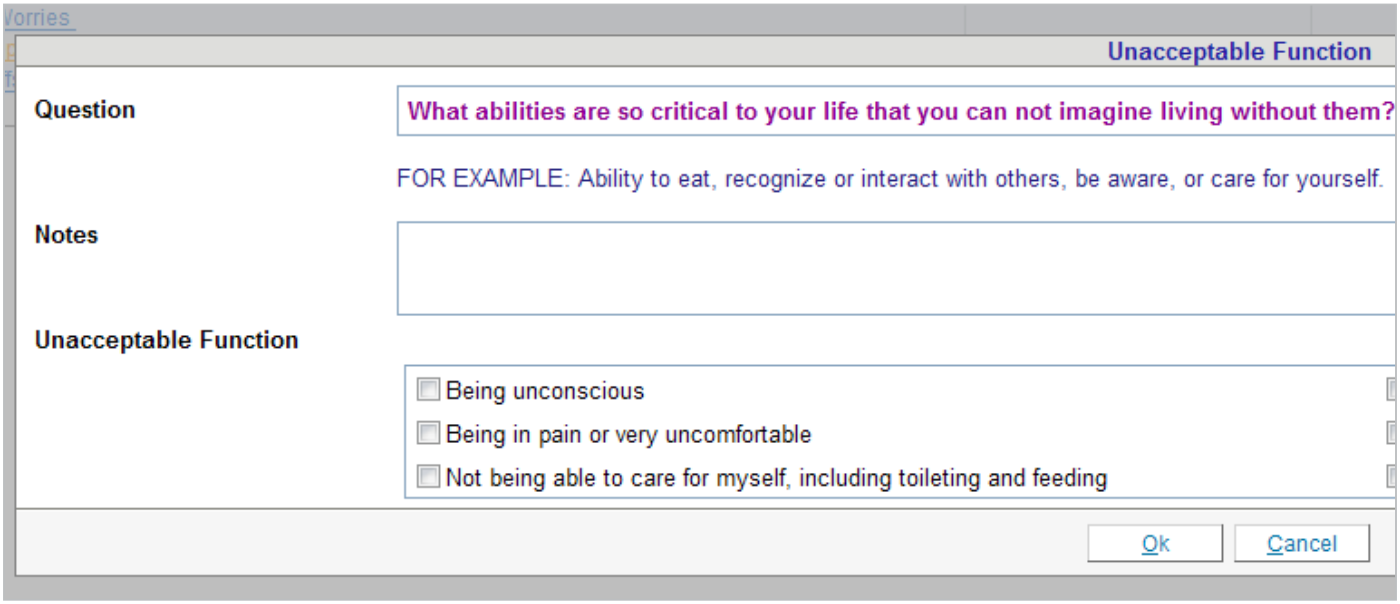
Notes type: Free text field

Checkboxes:

Faith

Family

7. UNACCEPTABLE FUNCTION



Question: What abilities are so critical to your life that you cannot imagine living without them?

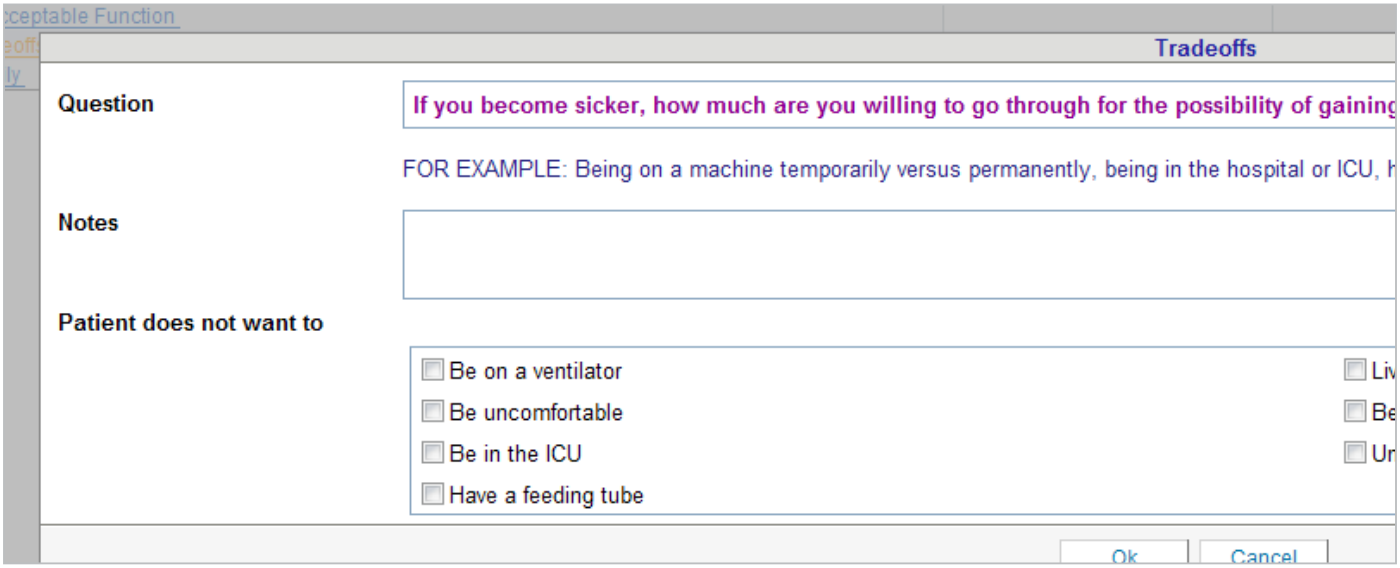
Additional text: FOR EXAMPLE: Ability to eat, recognize or interact with others, be aware, or care for yourself.

Notes type: Free text field

Checkboxes: Unacceptable Function

- Being unconscious
- Being in pain or very uncomfortable
- Not being able to care for myself, including toileting and feeding
- Being unable to interact with others
- Being unable to talk
- Not being myself

8. TRADEOFFS



Question 1: If you become sicker, how much are you willing to go through for the possibility of gaining more time?

Additional text: FOR EXAMPLE: Being on a machine, being in hospital or ICU, having a feeding tube

Notes type: Free text field

Checkboxes: Patient does not want to

- Be on a ventilator
- Be uncomfortable
- Be in the ICU
- Have a feeding tube
- Live in a nursing home
- Be in the hospital
- Undergo aggressive tests and/or procedures

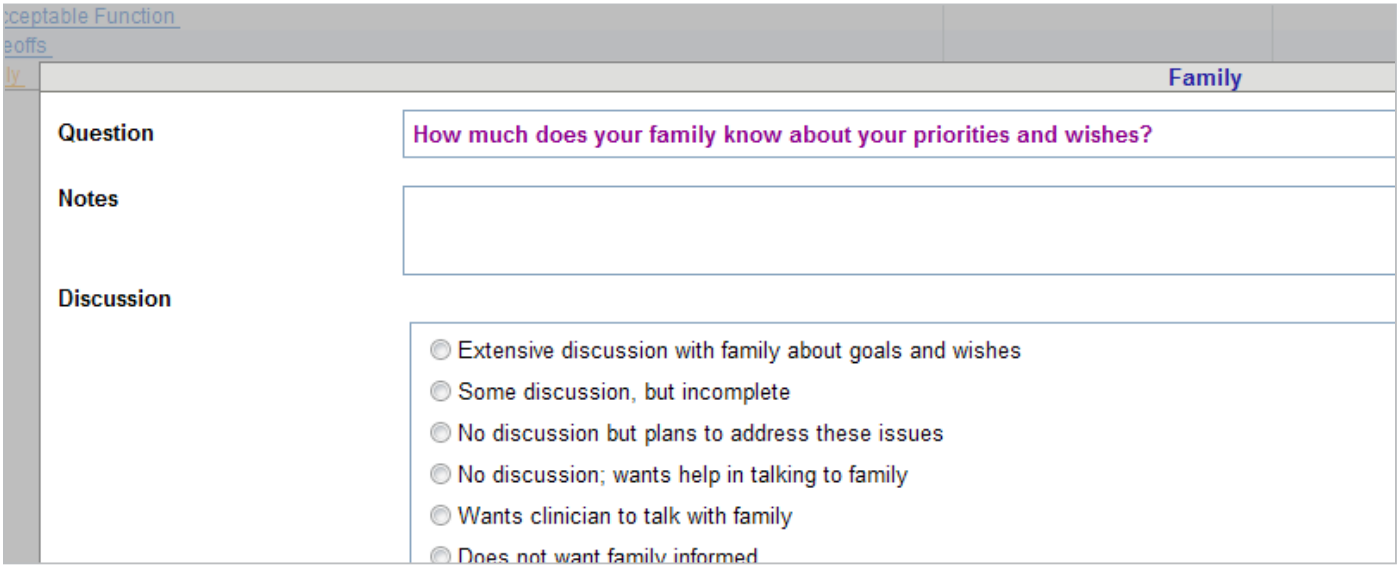
Question 2: Would this change if these were permanent states, if they did not get better?

Additional text: If so, please consider completing MOLST form with this patient

Misc Notes:

- (Opinion) The way this is structured is kind of confusing—Question 1 is asking what patient is willing to endure but checkboxes are what patient is not willing to endure—this might lead to incorrect values
- MOLST is a Massachusetts specific form, POLST (Physician Orders for Life Sustaining Treatment) is the national equivalent

9. FAMILY



Question: How much does your family know about your priorities and wishes?

Notes type: Free text field

Radio buttons: Discussion

- Extensive discussion with my family about goals and wishes
- Some discussion, but incomplete
- No discussion but plans to address these issues
- No discussion; wants help in talking to family
- Wants clinician to talk with family
- Does not want family informed

Clinic Workflow Planning

STEP: PATIENT SCREENING AND IDENTIFICATION	NOTES
Write out each step of your proposed process (Does it flow?)	
Write the best case result, worst case result, and how you expect it to go most of the time.	

STEP: SCHEDULING A SERIOUS ILLNESS CONVERSATION	NOTES
Write out each step your proposed process (Does it flow?)	
Write the best case result, worst case result, and how you expect it to go most of the time.	

STEP: REMINDERS, PATIENT PREPARATION, AND OTHER PRE-VISIT STEPS	NOTES
Write out each step of your proposed process (Does it flow?)	
Write the best case result, worst case result, and how you expect it to go most of the time.	

STEP: SERIOUS ILLNESS CONVERSATION ENCOUNTER (USING THE GUIDE)	NOTES
Write out each step of your proposed process (Does it flow?)	
Write the best case result, worst case result, and how you expect it to go most of the time.	

Clinical Workflow Planning (continued)

STEP: DOCUMENTATION AND OTHER POST-CONVERSATION STEPS	NOTES
Write out each step of your proposed process (Does it flow?)	
Write the best case result, worst case result, and how you expect it to go most of the time.	

Trainer Background Sheet

FOR EACH POTENTIAL TRAINER

NAME	
CLINICAL DISCIPLINE	
SPECIALTY	
YEARS IN PRACTICE	
TIME SPENT ON CLINICAL ACTIVITIES (FTE)	
BOARD CERTIFICATION	
PRIOR ADVANCED COMMUNICATION COURSES TAKEN (e.g. Vital Talk Faculty Development; Communication in Serious Illness CME course; PCEP Faculty Development)	
PRIOR COMMUNICATION COURSES TAUGHT	
YEARS OF CLINICAL PALLIATIVE CARE EXPERIENCE	
PALLIATIVE CARE FELLOWSHIP (IF APPLICABLE)	
OTHER	

Serious Illness Care Measures

Select measures based on your Serious Illness Care Program goals. Before launching, it is important to determine the current state of Advance Care Planning at your organization. Collect baseline data for the pre-post measures you identify to the best of your ability. It might not be possible to obtain data for some of these measures, depending on ease of measurement. You will likely need to work with your contact in IT to obtain these data.

ADVANCE CARE PLANNING (ACP) DOCUMENTATION (PRE- AND POST-IMPLEMENTATION)		
Metric	**Importance**	**How to measure**
Proportion of *deceased* patients in the target population who have at least one documented ACP conversation before death	☐ Most important ☐ Somewhat important ☐ Least important	Retrospective chart review—subset of deceased patients in target population
Median timing of initial documented ACP conversation in the *deceased population* before death	☐ Most important ☐ Somewhat important ☐ Least important	Retrospective chart review—subset of deceased patients in target population
Proportion of *decreased patients* with ACP documentation in a retrievable location in the EHR (not in a progress note)*	☐ Most important ☐ Somewhat important ☐ Least important	Retrospective chart review—subset of decreased patients in target population
Proportion of patients in the *target population (all patients)* who have any ACP documentation in the EHR*	☐ Most important ☐ Somewhat important ☐ Least important	Data extraction of structured ACP documentation from the EHR for target population, if available

*Discuss with Ariadne Labs Faculty additional ways of reporting the quality of the documentation, in terms of patient-centeredness, comprehensiveness, and the broader context of patient values and goals (versus documentation that focuses on code status or medical details only).

PATIENT EXPERIENCE AFTER A SERIOUS ILLNESS CONVERSATION (POST-IMPLEMENTATION)		
Metric	**Importance**	**How to measure**
Proportion of patients who report that their sense of peacefulness • increased • decreased • did not change after the serious illness conversation	☐ Most important ☐ Somewhat important ☐ Least important	Patient experience survey
Proportion of patients who report that their understanding of what their health may be like in the future • increased • decreased • did not change after the serious illness conversation	☐ Most important ☐ Somewhat important ☐ Least important	Patient experience survey
Proportion of patients who report that their understanding about their life expectancy • increased • decreased • did not change after the serious illness conversation	☐ Most important ☐ Somewhat important ☐ Least important	Patient experience survey
Proportion of patients who report that their sense of control over their medical decisions • increased • decreased • did not change after the serious illness conversation	☐ Most important ☐ Somewhat important ☐ Least important	Patient experience survey

PATIENT EXPERIENCE AFTER A SERIOUS ILLNESS CONVERSATION (POST-IMPLEMENTATION)		
Metric	**Importance**	**How to measure**
Proportion of patients who report that their hopefulness about their quality of life • increased • decreased • did not change after the serious illness conversation	☐ Most important ☐ Somewhat important ☐ Least important	Patient experience survey
Proportion of patients who report that the closeness they have with their clinician • increased • decreased • did not change after the serious illness conversation	☐ Most important ☐ Somewhat important ☐ Least important	Patient experience survey
Proportion of patients who report that the serious illness conversation was worthwhile	☐ Most important ☐ Somewhat important ☐ Least importantt	Patient experience survey
Qualitative question: What, if anything, have you done differently as a result of this conversation?	☐ Most important ☐ Somewhat important ☐ Least importantt	Patient experience survey

CLINICIAN EXPERIENCE WITH THE SERIOUS ILLNESS CONVERSATION GUIDE (POST-IMPLEMENTATION)		
Metric	**Importance**	**How to measure**
Proportion of clinicians who report that they are having serious illness conversations	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that they are using the Serious Illness Conversation Guide	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that the conversation allows them to gather important information efficiently	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that the Conversation Guide is easy to use	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that the serious illness conversation helps them understand their patient's values and goals of care	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that the conversation provides information that enhances their clinical care of the patient	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that the conversation helps build a trusting clinician-patient relationship	☐ Most important ☐ Somewhat important ☐ Least importantt	Clinician experience survey

CLINICIAN EXPERIENCE WITH THE SERIOUS ILLNESS CONVERSATION GUIDE (POST-IMPLEMENTATION)		
Metric	**Importance**	**How to measure**
Proportion of clinicians who report that their discussion of these issues with their patients • increased • decreased • did not change their satisfaction with their role in the patient's care	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that their anxiety about having these discussions is • increased • decreased • did not change	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey
Proportion of clinicians who report that the conversation makes their patient's emotional state • increased • decreased • did not change	☐ Most important ☐ Somewhat important ☐ Least important	Clinician experience survey

SERIOUS ILLNESS CARE OUTCOME MEASURES

Serious Illness Care Measures are aligned with the quadruple aim. In addition to the above, here are examples of additional measures from prior initiatives. An asterisk indicates that there is current data to support improvement in that outcome.

Provide a better experience of care

- Patient serious illness conversation experience survey (see above table)*
- Family bereavement survey

Improve outcomes and well-being

- Patient serious illness conversation experience survey (see above table)*
- Anxiety (GAD-7)*
- Depression (PHQ-9)*
- Goal concordant care
- Survival

More appropriate resources use (examples, there are others)

- Hospice use and length of stay
- Hospitalizations in the last 30 days of life
- Hospital days in the last 30 days of life
- ED visits in the last 30 days of life
- ICU admissions in the last 30 days of life
- Readmission rates
- Death in acute care hospital

Improve provider satisfaction

- Clinician serious illness conversation experience survey (see above table)*
- Maslach burnout inventory

Monitoring Implementation Sample Report

TRACKING PATIENT SCREENING, HIGH-RISK PATIENTS IDENTIFIED, CONVERSATIONS, AND PATIENT DEATHS BY CLINIC

CLINIC NAME	PATIENT NAME	MRN	SCREENING CLINICIAN NAME	DATE PATIENT SCREENED	ELIGIBLE? Y/N	CONVERSATION STARTED? Y/N
Jen Center	Smith, Jon	01234578	Johnson, Bob	01/27/16	Y	Y
Jen Center	Tinnon, Erin	12345689	Johnson, Bob	2/21/16	N	
Jen Center	Jones, Karen	34895049	Barwick, Pam	1/18/16	Y	Y
101 Mass Ave	Blodgett, Walter	38195938	Conwell, Alenda	2/2/16	Y	Y

TRACKING CLINICIAN TRAINING

CLINICIAN NAME	DISCIPLINE	SPECIALTY	CLINIC NAME	DATE OF TRAINING	ATTENDED Y/ N	TRAINER(S)
Johnson, Smith	Physician	Primary Care	Jen Center	12/15/16	Y	Joye, Ashlee Uchida, Richard
Barwick, Pam	Physician	Primary Care	Jen Center	12/15/15	Y	Joye, Ashlee Uchida, Richard
Lovett, Fe	Nurse Practitioner	Primary Care	Jen Center		N	
Conwell, Alenda	Physician	Family Medicine	101 Mass Ave	1/16/16	Y	Uchida, Richard Kawamoto, Grace

	CONVERSATION COMPLETE? Y/N	DATE OF CONVERSATION	CLINICIAN COMPLETED CONVERSATION	DATE OF DOCUMENTATION	PATIENT DECEASED?	DATE OF DEATH
	Y	2/14/16	Johnson, Bob	2/14/16	Y	7/1/16
	Y	1/30/16	Johnson, Bob	2/4/16	N	
	N					

Methods for Data Collection

Here are examples of data collection processes from prior successful initiatives:

IMPLEMENTATION STEP	COLLECTION PROCESS	VARIABLES
Clinician education	• Sign-in sheet for clinician trainings • Excel spreadsheet • Paper or online training evaluation survey	• Names of all clinicians at a site eligible for training • Date of each clinician training; • Names of clinicians who attended the training • Trainers who led the session • Summary score of evaluation surveys for each training session
Patient screening/ identification	• Patient registry • Manual entry into an Excel spreadsheet or database • EHR extraction	• Patient demographics • Clinician who screened the patient • Response to the screening (high-risk, low-risk) • Date of screening • Track high-risk patients
Having and documenting serious illness conversations	• Patient registries • Manual entry into Excel spreadsheet • EHR chart review or extraction to look for documentation of a serious illness conversation	• Date of conversation • Clinician(s) who had the conversation • Date of documentation in retrievable module

IMPLEMENTATION STEP	COLLECTION PROCESS	VARIABLES
Patient deaths	• Social security death index • Medical record review • Email from primary clinical providers • Patient registry that records patient deaths • Manual entry into an Excel spreadsheet	• Patient demographics • Date of death • Location of death • Name of family member of patient • Contact information for family member of patient* *Ask Ariadne Labs faculty if you are interested in a family bereavement survey to understand the patient's experience at the end of life.
Patient experience with serious illness conversations	• Survey given to patients who had a serious illness conversation	• Depends on survey questions selected (see Monitoring and Evaluation and Quality Control sections and appendices)
Clinician experience of the serious illness conversation	• Clinician experience survey sent at 3 months, 6 months, and 1 year after training • Email after first serious illness conversation • Semi-structured interviews of a subset of top performing clinicians and those who are not meeting goals	• Depends on survey questions selected (see Monitoring and Evaluation and Quality Control sections and appendices) • Qualitative data from emails and conversations

Coaching Resources

QUALITIES OF A GOOD COACH

A good coach is someone who is:

- Coachable
- Respected
- Humble
- Patient

Effective coaches are those who are coachable themselves – they are motivated to improve their own practice in serious illness conversations and will openly answer questions about their own performance, including challenges and successes. People who respond well to being coached usually have the insight, sensitivity and understanding to coach others. While a good coach does not need to hold a senior position in the clinic or health-care system, effective coaches should be trusted and well-respected by their peers.

Coaches who are humble and patient are able to build successful relationships with their colleagues. Effective coaches understand that their colleagues are already doing their best to care for seriously ill patients. With this humble attitude, coaches are much more likely to get clinicians and staff to listen to and respond to feedback. In addition, effective coaches ask clinicians to reflect on their experiences, identify the challenges they face, and brainstorm potential solutions. This increases clinician self-efficacy in improving their own practice.

NECESSARY COACHING SKILLS

In order to help clinical teams and staff improve serious illness conversations and implement other serious illness care delivery practices, coaches should use the following skills:

- Building relationships based on trust
- Demonstrating genuine curiosity
- Using effective communication skills
- Identifying root causes of performance challenges

An effective coach will take the time to build rapport and express genuine curiosity to understand the perspectives of their colleagues, which lays the foundation for a strong coaching relationship. Coaches can do this by using a nonjudgmental tone and asking open-ended questions that prompt conversation and reflection.

Additionally, coaches who ask good questions can accurately diagnose root causes of problems to better facilitate solutions that are appropriate and achievable. When coaches can help others identify for themselves the barriers that stand in the way of improvement, it is a powerful motivator for change.

A coach is likely to identify three root causes that make it difficult for others to perform serious illness care practices:

+ **OPPORTUNITY:** Environmental or contextual factors (for example: time constraints; the Guide is not available when needed)

+ **MOTIVATION:** Interest or internal attitudes and beliefs (for example: worries that the conversation will harm patients or take away hope; belief that he/she is already good at these conversations)

+ **ABILITY:** Skill, knowledge, or confidence (for example: feeling ill-prepared for the conversation; lack of understanding about the process)

HELPFUL COMMUNICATION SKILLS TO ENCOURAGE PROGRESS

+ Actively listening requires a coach to participate in the conversation, even when they are not speaking, by paying close attention to the speaker and by confirming what they hear. "It sounds like….is a challenge."
+ When giving feedback, the following approaches are recommended:
  - Ask permission
  - Make it specific: focus on behaviors and facts, not intentions or generalizations
  - Address the emotions of the person to whom you are giving feedback
+ A coach should set an appropriate time and place to share his/her feedback, making sure it is not threatening or embarrassing.

The three-part process of the Advocacy Inquiry Model allows a coach to give feedback in a safe and productive way. The description below offers an explanation and some examples of the 3-part process.

COACHING TIPS FOR FACE-TO-FACE CONVERSATIONS WITH CLINICIANS WHO ARE NOT MEETING GOALS

The 3- part process is based on a simple formula:

YOUR OBSERVATION + YOUR THOUGHTS + YOUR QUESTION

+ **Observations:** "I notice that you did not yet have a serious illness conversation with [patient name] after several reminders."
  - Other phrases: "I saw…" "I observed"
+ **Thoughts:** "I think it is really important to begin discussions with patients you identify as high risk early so they have time to prepare and to make informed decisions."
  - Other phrases: "I believe…" "It's really important to…" "I am pleased that…"
+ **Questions:** "I'm curious, what are the challenges you face to having the serious illness conversation with your patient?"
  - Other questions: "Tell me more about what is going on with your patient." "Can you help me understand why you have not yet had a conversation with…?" "What are your concerns about using the Conversation Guide?"

CHECK-IN EMAILS TO SEND TO TRAINED CLINICIANS AFTER THEIR FIRST SERIOUS ILLNESS CONVERSATION:

+ Suggest keeping check-in emails simple
+ Clinical Coach should send at least one email to every trained clinician after his/her first serious illness conversation
+ Sample Email:
  - Thank you so much for having the serious illness conversation with [patient name].
  - How did it go?
  - What feedback do you have about using the Serious Illness Conversation Guide? What worked well? What didn't work well?
  - How well did the training prepare you for the conversation?
  - I am here to support you in any way.

QUALITATIVE QUESTIONS

These questions can be used by a coach when talking to a subset of clinicians or staff who are consistently meeting goals (top performers) or not meeting goals (low performers). For each of the important serious illness care practices (patient identification, reminders, conversations, etc), the below questions will help coaches understand what is actually happening, what works well, and what can be improved.

Patient identification

+ How are you identifying patients for the intervention?
  - Is there a problem with the current process to identify patients? If yes, describe.
  - Have you encountered any patients whom you selected, but later decided not to proceed with a serious illness conversation? Why?

Scheduling and initiation of the conversation

+ Tell me about the process between choosing a patient and sitting down to start the conversation. Please walk us through your process.
  - What parts of this process work well? What parts don't work well?
+ How do you schedule the conversation?
  - Do you book your own appointment or identify existing patient visits?
  - Have you changed your scheduling practices to accommodate serious illness conversations? How?
  - What are the barriers to scheduling the conversation?
+ How do you choose what clinicians need to be involved in the conversation (who needs to be in the room)? Are you encountering any challenges with coordination of multiple specialists? If so, please describe.
+ How do you choose which clinical team member is going to do which part of the conversation? How do you plan to ensure that all appropriate team members are present for the conversation?
+ How do you obtain the Serious Illness Conversation Guide at the point of care? The Family Communication Guide?
+ How do you prepare a patient for an upcoming conversation before the visit?
  - Do you use the patient document "Talking to your clinician about the future?"
  - How do you prepare the exam room for a conversation?
  - What are we missing about the process?

Monitoring high-risk patients and conversations

+ How do you keep track of which patients need the conversation?
+ How do you keep track of which patients had the conversation?

Having and documenting conversations

+ What works well about the Conversation Guide? What are the challenges? How has your Conversation Guide use changed over time?
+ What is your process for documenting the conversation in the EHR?
  - Is documentation shared among team members?
  - Are you encountering any challenges with the functionality or usability of the module?

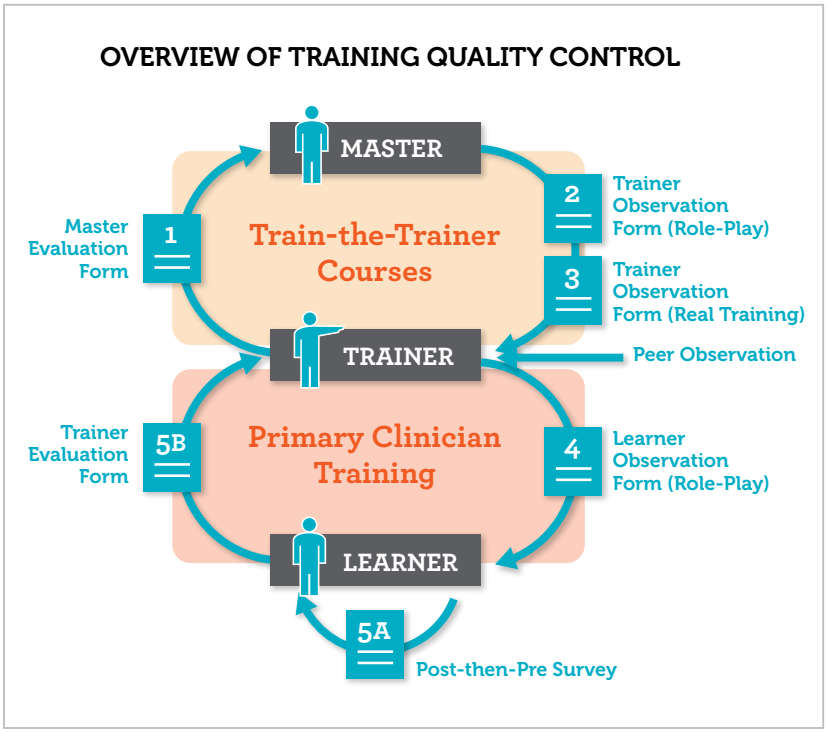
Overall feedback and lessons learned

+ Is there anything that would make the whole process more efficient or easier to do?
+ What are your overall thoughts about the program?
+ What additional support would be helpful?

Ensuring High Quality Training

After training starts, feedback on the training sessions will begin to accumulate. This section provides examples of performance targets and improvement actions

Reacting to feedback from Training Quality Control Surveys:



TRAIN-THE-TRAINER COURSES		
Form	**Benchmark/Acceptable Standard**	**Improvement Action/Remediation**
Trainer Observation Form #3	TARGET: Faculty determines that a trainer is "competent to perform independently" NEEDS IMPROVEMENT: Faculty determines that a trainer is "only competent to perform with minimal supervision" OR "needs more basic training,"	Clinical Lead schedules a coaching / debriefing session with the Trainer, and should consider re-training opportunities.

PRIMARY CLINICIAN TRAININGS		
Form	**Benchmark/Acceptable Standard**	**Improvement Action/Remediation**
Training Evaluation Form #5a	TARGET: Improvement in clinician-reported confidence in key skills after the training NEEDS IMPROVEMENT: No improvement in clinician- reported confidence in key skills after the training	Determine ways the training can be improved to support clinicians in gaining confidence in their communication skills.
Training Evaluation Form #5b	TARGET: Mean evaluation score for a training session is of 3.0 out of 4 or greater (For course objectives and faculty evaluation) NEEDS IMPROVEMENT: Mean evaluation score is <3.0 OR Any one of the questions has a "1" response or if there are more than 2 questions with a "2" response	Clinical Lead will set up a coaching / debriefing session with Trainer.

Based on feedback, evaluate the state of your training program

TRAINING PROCESS (QUALITATIVE)	
What is going well?	
What isn't going well?	
What can you do to improve it?	

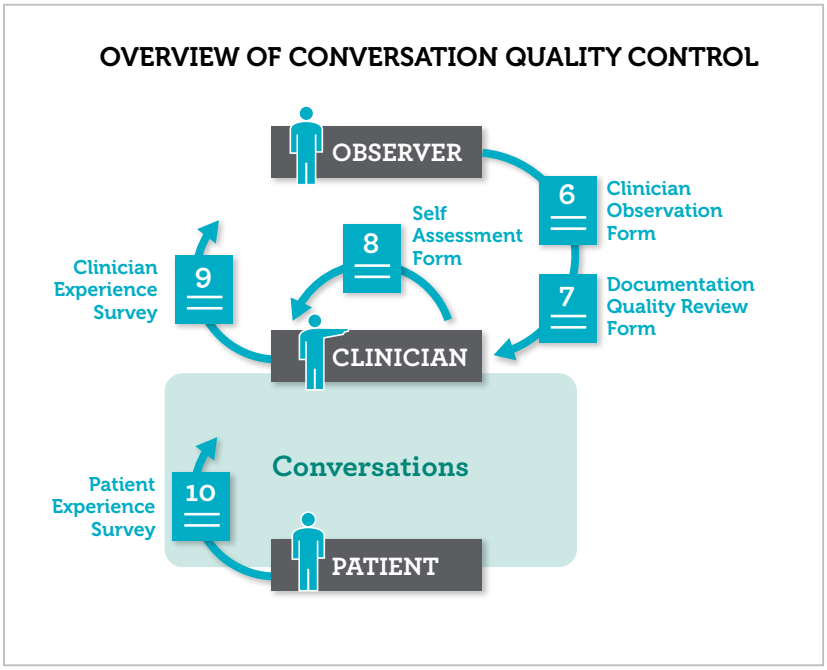
Evaluate Clinic Workflow

The goal is to integrate the Serious Illness Care Program into each pilot site's clinical workflow clinical workflows as seamlessly as possible. For each of the workflow components of the Serious Illness Care Program, describe the processes you have implemented at your pilot sites. Is everything going smoothly, or are there pain points to address? The purpose of this exercise is to identify what is going well and what might need to be improved.

WORKFLOW PROCESS	DESCRIBE PROCESS AT EACH PILOT SITE	WHAT CHANGES WOULD IMPROVE THE PROCESS?
Screening and identifying patients for Serious Illness Conversations		
Scheduling Serious Illness Conversations		
Reminders, patient preparation, and other pre-visit steps		
Serious Illness Conversation encounters		
Documentation and other post-conversation steps		

Coaching to Ensure High Quality Conversations

After training starts, feedback on Serious Illness Conversations will begin to accumulate. This section provides acceptable performance targets and improvement actions.



Reacting to feedback from Conversation Quality Control Surveys

CONVERSATIONS IN PRACTICE		
Form	**Benchmark/Acceptable Standard**	**Improvement Action/ Remediation**
Clinician Observation Form #6	TARGET: Observer determines that "Yes, this clinician can use the Guide effectively and not cause harm" NEEDS IMPROVEMENT: Observer is not confident that the clinician can use the Guide effectively and not cause harm OR Patient experience surveys indicate increased distress after Serious Illness Conversation with the clinician OR Clinician experience surveys indicate increased distress because of Serious Illness Conversations	Clinical Lead schedules a coaching / debriefing session to explore potential issues and should consider re-training opportunities depending on the issue.
Documentation Quality Check Form #7	TARGET: Documentation quality check score of 5.0 out of 7 or greater NEEDS IMPROVEMENT: Documentation quality check score of <5.0 • Fair 3-4 • Inadequate 0-2	Clinical Lead schedules a clinician coaching / debriefing session to determine if the issue is related to the conversation itself or the documentation, and support the clinician to improve
Clinician Experience Form #9	TARGET: Clinician experience is positive/acceptable NEEDS IMPROVEMENT: Discretion of the Clinical Lead - review each clinician experience survey received for red flags: • If any clinician states that their anxiety is "worse" or "much worse" as a result of the Serious Illness Conversation • If any clinician states that their patient's anxiety is "worse" or "much worse" as a result of the Serious Illness Conversation	Clinical Lead schedules a clinician coaching / debriefing session

Coaching Call Framework

1. ASK OPEN-ENDED QUESTION

+ Examples: "How are things going since we last talked?" or "Today let's discuss reminders and triggering conversations. What has been your experience in triggering conversations?" or "Tell me about a recent case in which you used or wanted to use the Conversation Guide"

2. LISTEN FOR

+ Successes/Progress in using the Guide and other Serious Illness Care processes
+ Issues of concern—clinician discusses something that you think is a current or future problem
+ Barriers to using the Guide or other processes

3. RESPOND

+ Praise the successes
+ Describe your concern and strategize alternative approaches
+ Brainstorm solutions to any barriers identified
  - Note: During group coaching calls, often users of the Guide would provide suggestions to each other about how to get something done or improve processes.

4. DISCUSS/DESCRIBE NEXT STEPS

+ Ask coachee:
  - How they plan to accomplish the task
  - Potential opportunities for task completion
  - Potential barriers
  - How you can help
  - Anticipated timeline

WRAP-UP

+ Praise successes again
+ Ask what else you can do to help them
+ Discuss time for next call

FOLLOW-UP DURING NEXT CALL

+ Ask what changes were made
+ Ask how it went

Ongoing Process Evaluation Worksheet

Think about the following when you answer these questions:

+ Monitoring implementation progress (process data) at the clinician level / practice level
  - Monitoring the quality of the training and conversations
  - Coaching and performance improvement
  - Data collection methods
  - Data feedback methods

PROCESS EVALUATION		NOTES
Are we effectively monitoring implementation successes and challenges?	☐ Yes ☐ No	
Are we monitoring the data and information we need to build reports and make improvements?	☐ Yes ☐ No	
Are we responding effectively and quickly to data and feedback?	☐ Yes ☐ No	
Is there any data that we are collecting and not using?	☐ Yes ☐ No	
Are we appropriately sharing implementation process data with frontline clinicians?	☐ Yes ☐ No	
Are our data feedback mechanisms with frontline clinicians effective and non-punitive?	☐ Yes ☐ No	
Are we building safe, trusting relationships with frontline clinicians?	☐ Yes ☐ No	

PROCESS EVALUATION		NOTES
Are we providing the necessary coaching and support of frontline clinicians?	☐ Yes ☐ No	
Are our coaching strategies working to facilitate action?	☐ Yes ☐ No	
Are we appropriately sharing implementation process data with other stakeholders besides frontline clinicians (i.e. leadership, administration, implementation team members)?	☐ Yes ☐ No	
Do we have the internal support we need to deal with the problems that are arising?	☐ Yes ☐ No	

Post-Implementation Review

After the program has been launched in the pilot clinics, it is important to conduct a retrospective analysis of your implementation experience.

The question is: What did you learn about implementation at your organization that could improve future efforts?

TIPS/TECHNIQUES

+ Reflect on successes and challenges that occurred during the planning and implementation processes.
+ Request/collect feedback from all stakeholders: the implementation planning team, leadership, stakeholders at pilot sites, trainers, clinicians using the Guide in practice, supporting staff, etc.
+ Review your plans and projected milestones and compare them to the actual progress of your implementation. Consider performing a gap analysis.
+ List unexpected events/factors that impacted the implementation

In the worksheet below, for each of the Phases and/or for Program goals, document:

- Planned or unplanned events that accelerated or facilitated the implementation process, as well as those that proved to be barriers to the program
- Lessons learned

PHASE 1		
Domain	**Facilitators & Barriers**	**Lessons Learned**
Assess Readiness		
Engage Leaders and Colleagues		
Determine Program Goals		
Recruit Implementation Team		
Select Pilot Sites		
Create Drivers for Program Use		
Construct Budget and Obtain Approval		

PHASE 2		
Domain	**Facilitators & Barriers**	**Lessons Learned**
Modify EHR		
Customize Clinic Workflow for Conversation		
Recruit Trainers		
Develop a Training Plan for Frontline Clinicians		
Prepare for Monitoring and Evaluation		
Prepare for Quality Control		
Plan for Performance Improvement		
Plan Outreach and Communication Strategy		

PHASE 3		
Domain	**Facilitators & Barriers**	**Lessons Learned**
Begin Clinician Training		
Implement Clinic Workflow		
Refine Clinician Training and Workflow		
Monitor and Improve Implementation		

PILOT PROGRAM GOALS

In the worksheet below, reflect on your original program goals as defined in Phase 1, Section 4. As a team, discuss if you have met or not met these goals, how the goals may have changed over time (and why), and what you will do to achieve these goals moving forward.

PILOT PROGRAM GOALS		
Goal	**Met / Not Met**	**Notes**

Example SWOT Analysis for Expansion / Sustainability

OVERVIEW:

SWOT Analysis is a tool designed to evaluate an initiative based on Strengths, Weaknesses, Opportunities, and Threats. In this exercise, the purpose of the SWOT analysis is to evaluate the sustainability of the Serious Illness Care Program implementation at your Pilot Sites, and to determine your capacity for expansion. The complexity and diversity of health systems means that there is no "one-size-fits-all" answer to knowing if your program is sustainable or whether you are ready to expand; ultimately, the expansion team and leadership will have to make the decision.

DEFINING STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS

+ Strengths are characteristics of your Serious Illness Care Program that give it an advantage in staying sustainable and expand.
  - Program-specific, core capabilities
  - Potential areas to look for opportunities
+ Weaknesses are characteristics of your Serious Illness Care Program that place it at a disadvantage in staying sustainable and expand.
  - Program-specific, core capabilities
  - Potential areas to look for threats
+ Opportunities are external circumstances your Serious Illness Care Program might use to its advantage in staying sustainable and expand.
  - Often result from environmental factors external to the program team, but not always
+ Threats are external circumstances that may interfere with your Serious Illness Care Program's ability to stay sustainable and expand.
  - Often result from environmental factors external to the program team, but not always

WHERE TO LOOK:

Strengths and weaknesses tend to be internal to your team/program/organization. Opportunities and threats tend to be external to your team/program and can even be external to your organization.

+ Strengths & weaknesses:
  - Leadership alignment
  - Commitment of champions and educators
  - Commitment to quality improvement
  - Culture of palliative care
  - Level of EHR/IS support
  - Resource commitment
  - Disruption to previous clinic workflow

+ Opportunities & Threats:
  - Leadership turnover
  - Competing organizational priorities
  - Other QI initiatives, new technologies being adopted, EHR implementation, etc.
  - Legislation and organizational policy changes
  - Macroeconomic trends impacting budget

OUTCOMES OF THE ANALYSIS:

Answer two major questions:

1. Are you confident that the programs at the Pilot Sites are sustainable?

☐ Yes ☐ No

2.Are you confident that the program is prepared to, and should, dedicate effort toward expansion?

☐ Yes ☐ No

If after a thorough analysis, the answer to both questions is "Yes," you can confidently proceed to planning expansion. Recognize that it is OK for the answers to be "No" or "Not yet." If there are significant weakness and threats, take the time to work through them. It is better to address them now, then to have them become serious roadblocks during premature expansion.

Example SWOT Analysis:

WHAT ARE THE STRENGTHS?	WHAT ARE THE WEAKNESSES?
Examples: • Clinicians rate the training highly • Many clinicians are using the Conversation Guide • Reimbursement for ACP conversations by CMS facilitates conversations	Examples: • Implementation processes (i.e. patient identification, reminders) worked well for a time but sustained use has become burdensome to frontline clinicians

WHAT ARE THE OPPORTUNITIES?	WHAT ARE THE THREATS?
Examples: • New predictive analytics tool available to identify patients with serious illness at high-risk • Other sites are asking for the program	Examples: • Current leadership wants to train clinicians very quickly before thinking about how to better integrate the systemic processes • There will be a new leadership transition next year (potential threat) • Competing EHR implementation at expansion sites

Expansion Needs Assessment Worksheet

A "needs assessment" is an exercise used to determine needs (or "gaps") between the current state and the desired future state. In this case, the future state is one where you have expanded the Serious Illness Care Program within your organization, to meet your expansion goals. You have already completed a successful pilot implementation of the program, you modified the program to fit your pilot sites, and you know how to implement the program in these contexts. The intent of this exercise is:

1. TO IDENTIFY HOW YOUR EXPANSION SITES DIFFER FROM YOUR PILOT SITES, AND WHAT MODIFICATIONS TO THE PROGRAM ARE NECESSARY

2. TO IDENTIFY ADDITIONAL RESOURCES REQUIRED TO MEET THESE NEW NEEDS

Depending on how you plan to expand (e.g. new departments, additional clinics, new patient populations, etc.), there might be many new needs, or relatively few.

Begin by identifying expansion site characteristics

	EXPANSION SITE CHARACTERISTICS
Clinical setting e.g. Outpatient clinic, medical home, clinics embedded in hospital, nursing home, hospice, hospital	
Target patient population e.g. High risk primary care, oncology, cardiology	
Clinician population e.g. Include all clinicians for whom the conversation is within their scope of practice (physicians, nurse practitioners, RNs, social workers)	
Estimate number of clinicians who need training	

Identify needs based on the differences. Think about differences across all areas of the implementation process:

+ Engagement / buy in
+ Implementation team
+ Drivers for training and having conversations
+ Budget
+ EHR modification
+ Clinic workflow
+ Recruiting additional trainers/coaches
+ Training curriculum and plans
+ Monitoring and evaluation
+ Quality control
+ Performance improvement

Here are several examples, provided as if your pilot implementations were in primary care and you are planning to expand within primary care and into cardiology.

IMPLEMENTATION AREA	NEEDS
Workflow	Examples: • Expanding within primary care: examine workflow of expansion sites to ensure no major differences and continue current strategy • Expanding from primary care into cardiology: plan a different process for patient identification
Training	Examples: • Expanding within primary care: possibly no needs other than continuing/expanding the current training curriculum • Expanding from primary care into cardiology: need to adapt the cases used in training to be relevant for cardiology
Engagement	Examples: • Expanding within primary care: identify expansion sites' level of engagement, perhaps they are less engaged but you've had discussions with leaders already and shared relatable pilot experiences • Expanding from primary care into cardiology: engage leaders and colleagues in cardiology to determine their level of interest and to find potential champions