ADVANCE CARE PLANNING RESIDENT EDUCATION AND PRACTICE (ACPREP)

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Background: Advance care planning (ACP) is the process of supporting adults in sharing their values, life goals, and preferences regarding future medical care[1]. While 80% of people say that if seriously ill they would want to talk to their doctor about wishes for medical treatment toward end of life, only 7% report doing this[2]. One recognized barrier to ACP is inadequate provider communication training, especially in the primary care setting[3]. At Duke Health, Graduate Medical Education (GME) trainees are often the first-line providers engaging with patients in outpatient and acute care settings. If trainee communication skills and practice strategies are deliberately developed, this could enable more ACP in outpatient settings before acute illness takes hold. Trainees will be equipped for deliberate, longitudinal patient-centered decision-making, skills also critical in a healthcare landscape that prioritizes value-based care[4].

Program Objectives: The Advance Care Planning Resident Education and Practice (ACPREP) program aims to improve the confidence and feelings of preparedness among GME trainees in the Department of Medicine and the Department of Community and Family Medicine to engage patients in ACP involving empathic discussion of sensitive medical decision-making, particularly in the primary care setting. ACPREP subsequently aims to facilitate skill application in outpatient practice.

Methods: ACPREP is a quality improvement program that utilizes the Vital Talk curriculum, an evidence-based communication training course including patient-provider simulation practice and small group-based learning, with constructive feedback from specialized clinicians. The core VT curriculum has been tailored specifically to the ACPREP objective of facilitating outpatient ACP. In the 2017-2018 academic year, approximately 100/158 eligible GME trainees will receive this curriculum during a single 4-hour session. Related real-time clinic resources will be made available to trainees afterwards. Trainee levels of confidence and preparedness will be assessed using anonymous, electronic pre and post-intervention surveys.

Findings: A total of 66 residents from the Departments of Internal Medicine and Community and Family Medicine responded to our pre-intervention survey. Of these 66 trainees, 58 trainees (92.1%) reported prior engagement in ACP conversations with hospitalized patients, while only 12 trainees (18.2%) reported 5 or more ACP discussions with primary care patients. Only 16% reported feeling very confident (top two deciles) in conducting outpatient ACP conversations. Reservations about conducting clinic ACP discussions frequently included both process-based elements [time (n=62, 94.0%); legal form completion (n=41, 62.1%); EMR documentation (n=30, 45.5%)] and skill-based elements [limited rapport (n=25, 37.9%); discomfort with outpatient ACP concepts (n=19, 28.8%)].

Significance and Implications: This data demonstrates a large difference in trainee ACP practice patterns: the ambulatory setting is relatively underutilized for ACP discussions. This difference appears to be driven by trainee unfamiliarity with the skills needed to non-emergently discuss medical values and prospective decision making, as well as a lack of clear clinic workflow for co-managing medical issues and ACP. The ACPREP program will concentrate on equipping trainees with the interpersonal strategies and conceptual framework needed to discuss serious illness before it happens. Concurrent innovation in clinic operations, as piloted by ACP@DOC, creates a platform for transforming conversations into actionable guidance that shapes healthcare utilization and outcomes.

References:

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