Integration of a Palliative Care Goals of Care Conversation in the Acute Care of the Elderly Unit

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Introduction

Palliative care (PC) interventions such as goals of care conversations (GOCC) enhance goal-concordant care, improve quality of life, increase hospice referrals, decrease readmissions and lower costs. Currently, no formal GOCC are done within Baystate Medical Center outside a palliative care consult. A preliminary analysis on BMC's ACE readmissions found that roughly 30% had unmet PC needs. In addition, 40% of patients did not have a health care proxy documented two days into admission.

Aim Statement

Aims of this quality improvement initiative:

1. Assess the feasibility of screening for unmet PC needs
2. Assess the impact of a GOCC in the ACE population.

Methods

Patients screened positive for serious illness with unmet palliative care needs if any of the following were present:

1. Provider answered "no" to the Surprise Question: *would you be surprised if your patient died in the next year?*

2. ≥ 2 hospital admissions in the prior year, or

3. Edmonton Frailty Score ≥ 12 (severe frailty)

The Serious Illness Conversation Guide, Ariadne Labs (www.ariadnelabs.org/areas-of-work/serious-illness-care/), was the GOCC format. A geriatric-trained physician assistant (GPA) performed the conversations and documented the GOCC in an EHR note template (in Advance Directives section). The note was shared with hospital-, primary care- and post-acute providers. A MOLST was completed, as needed, to document any limitations in life-sustaining treatments. This was scanned into the EHR, given to patients, and sent to primary and post-acute providers.

Tables

Figure. 1

Patient characteristics	Received GOCC
Number	30
Age (avg) years	85.5
Admission in the year prior	24 (80%)
30-day readmissions post index admission	8 (27%)

Figure. 2

As a result of GOCC:	Patients (%)
Significant change in treatment plan	15 (50%)
Enrolled in hospice	2 (7%)
Changed code status	8 (27%)
Completed MOLST forms	14 (47%)
Palliative care consults obtained	0 (0%)

Length of Goals of Care Conversations
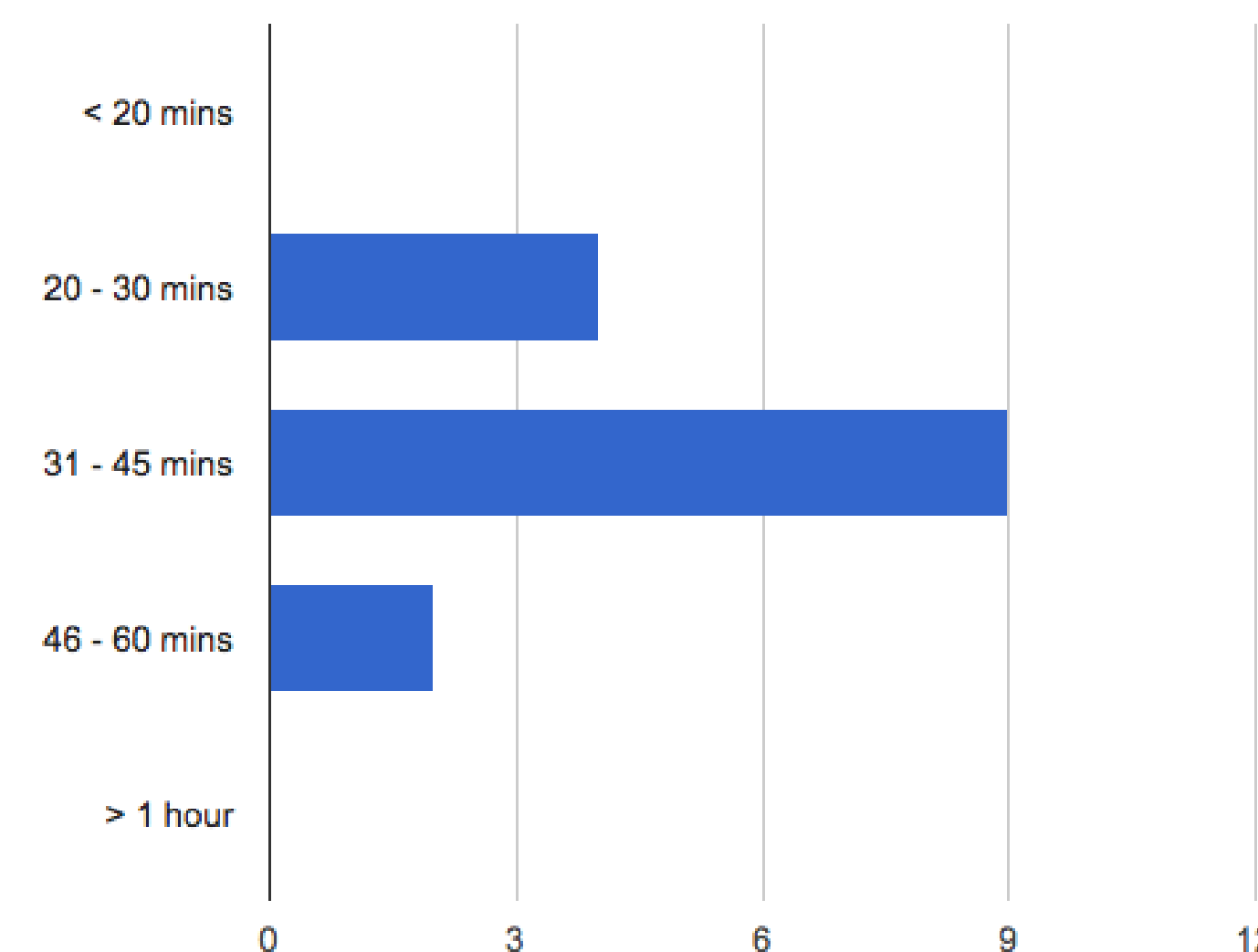
Results

❖ 125 ACE patients were screened in 3 months

❖ **82 patients (66%) screened positive for serious illness with unmet PC needs**

❖ **Among the 30 patients (37%) who received GOCC:**
- 22 patients were decisional, 8 were not decisional
- 26 (87%) had HCP forms available in the electronic health record at the time of GOCC
- 23 (77%) had GOCC attended by Health Care Proxy

See Figure1 and Figure 2

Limitations

❖ Pilot intervention not designed to prove impact on clinical outcomes

❖ Number of GOCC limited by GPA time constraints

Conclusions

❖ **Early experience suggests that screening and delivery of a standard GOCC in an elderly hospitalized population is feasible.**

❖ **This novel approach, using a GPA, is easily implemented and has a lower cost than a formal PC consult.**

❖ **Integration of PC and geriatrics is a potential new model of care for seriously ill hospitalized elderly that can extend scarce PC resources.**

❖ **Results suggest that patients who received GOCC changed treatment preferences and generally chose less aggressive care.**

❖ **The intervention was widely appreciated by patients, families, hospitalists and nurses.**

❖ Additional GOCC enrollment and analyses are needed to clarify the impact of this intervention on readmissions, cost of care, and patient experience.