Examples of Workflow Variations in Clinical Settings

Purpose

The purpose of these examples is to illustrate possibilities. They are based on examples and discussions we have had with experts and practices. They do not necessarily represent what is done now and some examples may be appropriate for some practices and not for others. Also, these are not meant to be as comprehensive and specific as the examples used in the videos and role plays.

Our goal is to apply team approach to Advance Care Planning. So we aim to portray different combinations of team members involved in the process of advance care planning. We want to encourage various team approaches that best fit to your team membership and practice structure and maximize the expertise of team members.

Team Examples

Scenario A: A practice that has RN-physician pairs who work together and a social worker (SW) working with all clinicians in the practice. The practice uses an electronic health record (EHR) with notes sections for physician, RN, and SW as well as the ability to flag items for review.

Function	Description of Process
Training	• All team members receive the IP-SIC Training
Patient Identification	• The clinic uses an algorithm to generate a list of appropriate patients and the RN, SW, and physician each review a portion of the list selecting patients they agree would be appropriate for serious illness conversations.
Patient Invitation/ Preparation	• The RN calls patients a week before their next scheduled visit and explains the purpose of SIC, prepares/invites the patient.
Patient Interaction	• At the visit, after following up on medical issues the physician covers steps 1-3 in the serious illness conversation (SIC) guide (set up, understanding, concerns about the future), and then invites the SW to join them and does a warm hand off to SW. • SW continues visit after the physician leaves the room—exploring key topics and closing the conversation.
Communication	• SW reports a summary of what patient shared during the weekly care conference with everyone in the clinic
Documentation	• SW documents that the conversation occurred in the EHR and checks the ACP flag. • After confirming the documented conversation by the SW, the physician adds the ACP code to the visit for billing to Medicare.
Follow-up	• When nurse calls patient a week later to follow up on new medications, sees the ACP flag in the EHR and asks if the patient has any questions. The patient

	does not, so the nurse adds a reminder that the patient be asked if they have any questions or concerns at the next visit. • Six months later when the patient is in for a follow up, the physician quickly reviews the plan and asks if anything has changed. The patient says what matters to him is still the same, but thinks they should change the health care proxy (his wife is sicker and it might be better if it was their daughter). The physician asks the SW to talk to the patient about this and make sure they get the proper form. • Patient returns new proxy form to office, SW enters the new form in the EHR. The SW suggests that the patient give copies to the patient's family and two specialists the patient sees regularly.

Scenario B: The practice has 3 Clinicians (2 physicians, 1 Nurse Practitioner [NP]) and a nurse care manager (RNCM) as well as a receptionist. The practice uses paper medical records and a computer-based scheduling system that allows reasons for visits and reminders

Function	**Description of Process**
Training	• Team members receive the IP-SIC Training
Patient Identification	• RNCM notices that one of the patients in her panel who is scheduled for an appointment today, is seriously ill and meets the clinical intuition criteria for serious illness conversation • The RNCM brings this up in the morning review of patients to be seen that day and the NP agrees to raise the issue with the patient, and if the patient is amenable, refer the patient to the RNCM for a serious illness conversation (SIC)
Patient Invitation/ Preparation	• The NP sees the patient, explains the importance of ACP, and asks if the patient would be willing to talk with the RNCM today after reviewing the patient's new medications. The patient agrees.
Patient Interaction	• After the NP visit, the RNCM talks with the patient about new medication management, confirms that the patient is willing to talk about her preferences should the patient get sicker and they have the SIC using the SIC Guide. • The RBCM suggests the patient talk to her family about what is important to her and naming a healthcare proxy.
Communication	• The RNCM leaves a note on the patient chart for the NP to review the summary of the SIC and for the receptionist to schedule a follow-up appointment in 6 months with reminder to follow up on medications and ACP.

Documentation	• The RNCM documents the conversation in the chart. • The NP reviews the contents of the conversation, and signs off, approving use of the ACP billing code to charge for the time.
Follow-up	• The receptionist schedules the next visit • At the next appointment, the patient brings her son. The NP, patient and son review the prior discussion and confirm they all understand. The patient asks her son to be her health care proxy. The RNCM helps them fill out the proxy form, enters it in the chart, and files it with the state registry.

Scenario C: The practice is a large primary care group with a medical assistant (MA), RN and physician/NP/PA teams, and a shared SW.

Function	**Description of Process**
Training	• Team members receive the IP-SIC Training
Patient Identification	• The clinic has decided to have serious illness conversations (SIC) with patients who are having follow up visits after a hospitalization that they think are appropriate and with any patient over 80 years old who is frail • In addition, the clinic has emphasized that any clinic staff member can suggest a SIC for any patient they think appropriate and they have discussed what to look for at their clinic staff meetings.
Patient Invitation/ Preparation	• A patient tells the MA when they are checking out that she doesn't want to disappoint the doctor but she doesn't really want to continue treatment for a progressive condition because the side effects make life not worth living. The MA says that it is very important that the patient talk to someone about this and explains that at this practice they work hard to be sure that medical care is about what the patient wants. • The MA tells the RN who puts a note in the patient record asking the SW to follow up. • The SW reviews the records, checks in with the physician about the prognosis, and calls the patient. • During the phone call, the SW invites the patient to have conversation with the physician next time. • The patients asks if they can talk some now.
Patient Interaction	• The SW goes through the entire conversation with the patient on the phone using the SIC Guide. The patient has been thinking about this for some time and was just waiting for someone to ask. • The SW asks if the patient has questions and talks about next steps. The patient has some specific medical questions about the course of the illness and would like her daughter to hear the answers.

	• The SW suggests the patient bring her daughter to the next visit so the physician can answer questions. • At the next visit, the physician answers the questions, summarizes the conversation the patient and SW had, and agrees with the patient decision to discontinue treatment. The daughter hears this, understands, and agrees to her mother's plan as well.
Communication	• The practice has an electronic health record (EHR) and team members can leave messages for other staff that are connected to a patient chart. • After the phone conversation with the patient, the SW leaves a message to the patient's physician about the SIC and patient's questions to discuss in the next visit.
Documentation	• The SW documents the phone conversation. • The physician documents the visit with the patient and the daughter, adds the codes for a complex visit, and flags the chart for a RN follow-up call in one month.
Follow-up	• In one month the RN calls the patient. Patient reports being weaker but generally feeling better on her good days without the side effects and she is still fine with the plan. The RN documents this and adds a reminder to check in again at the next visit or in 3 months, whichever is first.

Scenario D: A 2-clinician (1 physician, 1 PA) practice with a RN is part of an Accountable Care Organization that organizes some cross-practice activities, such as care partner support and chronic illness self- management groups. The practice identified the two community health workers (CHW) who run these groups as part of their ACP team.

Function	**Description of Process**
Training	• Team members receive the IP-SIC Training
Patient Identification	• A CHW who facilitates a congestive heart failure group mentions the importance of ACP to the group as part of the program. A patient asks for more information after the group meeting and the CHW gives the patient a pamphlet and suggests the patient talk to their primary care provider and their family
Patient Invitation/ Preparation	• The patient comes to an appointment and shows the clinician the brochure. • The PA explains what advance care planning is and initiates the SIC using SIC Guide.
Patient Interaction	• PA continues the SIC, following the guide. At some point the patient becomes upset and requests they stop. PA agrees and emphasizes that the practice will support whatever the patient wants, and they can talk more in the future.

	• At the next follow up visit, the RN sees the note about ACP and asks the patient if he would like to talk. The patients says not today, maybe next time. • At the next visit with the PA, the patient says a friend from the CHF group had been very sick and died. He saw how much knowing what his friend wanted helped his friend's family. The PA asks if he wants to continue the conversation they started in the past. The patient says yes and they complete the SIC.
Communication	• PA notes in the electronic health record (EHR) that the patient raised the topic of ACP, but they did not finish the conversation and adds an ACP reminder for the next visit. • The RN mentions that patient did not want to continue. • PA notes that the SIC was completed and sends a message with a summary to the RN.
Documentation	• The PA completed an ACP template in the EHR and printed out a summary.
Follow-up	• The PA adds a reminder to check with patient in 2-3 months and verify his goals and preferences as his condition may change.