Special Article

Expanding Goals of Care Conversations Across a Health System: The Mapping the Future Program

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Abstract

Context. Clinician failure to discuss goals of care (GOC) with seriously ill patients remains prevalent. Small-scale educational interventions have demonstrated improvement in physician communication skills, but it is unknown if these results translate into practice changes.

Objectives. To implement a large-scale educational intervention that would facilitate increased GOC discussions in at-risk patients, increase clinician confidence in having GOC discussions, and prove to be sustainable.

Methods. The Mapping the Future courses were four-to-eight-hour trainings, with brief lectures and demonstrations followed by practice with simulated patient cases. Participants completed precourse and postcourse surveys, including demographic information, self-confidence in a variety of communication tasks, willingness to initiate GOC discussions, barriers to GOC discussions, and self-perceived skill at having GOC conversations. We compared the rate of documentation of GOC discussions with at-risk inpatients in three hospitals for physicians who had taken the course and those who had not.

Results. Over a two-year period, we trained 512 clinicians in 42 sessions. After the course, participants felt that they had improved in all the skills that we taught and agreed that they would be more likely to initiate GOC conversations. Trained physicians were more likely than their nontrained colleagues to document a GOC discussion with at-risk patients (30.8% vs. 27.2%; $P = 0.0001$).

Conclusion. A large-scale educational intervention involving simulated patient cases increased GOC documentation across a health system. Other programs might consider collaboration with quality improvement specialists to measure the impact of education and situate it within other system changes to support increased GOC discussions. J Pain Symptom Manage 2018;56:637–644.

Key Words

Communication, teaching communication, goals of care, simulated patients, continuing medical education, postgraduate medical education, quality improvement

Background

Although most individuals indicate that they prefer only comfort-focused care in the final days of life, 30% of Medicare beneficiaries are still admitted to the intensive care unit at the end of life.[1] Clinician failure to discuss goals of care (GOC) with seriously ill patients is a major contributor to this disconnect—code status discussions typically occur within 48 hours of death, and in a study of metastatic cancer patients, only 30% reported a discussion with their physician about their future care goals.[2] Even when they do occur, GOC conversations conducted by untrained physicians are typically brief and focused on specific treatments rather than broader values and goals.[3–6]

Palliative care (PC) specialists receive training and faculty feedback in conducting conversations about GOC and advance care planning. Yet, there are not enough PC specialists to have all these conversations,[7] and it is usually more appropriate for the clinicians

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who know the patients best and are most involved in the day-to-day care of patients with serious illness, to initiate conversations about GOC. Small-scale educational interventions have demonstrated improvement in end-of-life communication skills for non-PC physicians.[8–10] However, to have the greatest impact and create system-wide change of delivery of care for seriously ill patients who may not see PC specialists, there is a need for much large-scale interventions.[11,12]

We designed an educational intervention within our health care system to address this gap. Through Mapping the Future courses, we taught non-PC-trained physicians, nurse practitioners, and physician assistants across a large multihospital academic medical center how to conduct GOC conversations using a values framework. Our primary aim was to increase the frequency with which non-PC-trained clinicians conduct and document GOC conversations in seriously ill patients. We also wished to increase these clinicians' confidence in having these discussions and ascertain whether a large-scale communication training program could be carried out on a health system level.

The Curriculum

The Mapping the Future courses were one-time four-to-eight-hour trainings based on the VITALTalk model, with brief lectures and demonstrations followed by practice with simulated patient cases. Each session included between eight and 18 learners, with at least two facilitators. We used the REMAP (Reframe, Express Empathy, Map Values, Align with Values, and Propose a Plan) communication framework, which has been previously published.[13] We developed three cases that we used for all the trainings, with modifications to the clinical details for each specialty. In the eight-hour courses, learners met the simulated patients in the morning and then revisited the same patients in the afternoon, during which patients were further into the course of their illnesses. The morning of the eight-hour courses focused on reframing (primarily giving bad news) and responding to emotion. During the afternoon, we taught skills targeted to understanding the patient's values and recommending a plan consistent with those values. The four-hour courses were condensed versions of the eight-hour course with the same cases, where the learners used all the aforementioned skills in only one visit with the patient or family. At the end of the course, all learners received a pocket card that summarized the REMAP framework with examples.

The Mapping the Future courses were specific to specialty. Our initial curriculum was tailored to hospitalists, primary care physicians, critical care physicians, and oncologists. Over time, interest in our program took hold in a variety of specialties, and we thus developed variations of Mapping the Future courses for geriatricians, physiatrists, emergency medicine physicians, surgeons, and nephrologists. We designed three simulated patient cases for hospitalists and then created variations on these cases with clinical scenarios tailored to each group being taught. We were thus able to use the same actors portraying the same emotional type and family dynamics for most of the trainings, although the clinical scenarios differed according to specialty. Each case shared common learning objectives to give a reframe or ascertain that patient/family understood prognosis, to respond to emotion, to explore and align with values, and to propose a recommendation that fit with those values. Each case also had unique challenges written into the scenario. Table 1 outlines the hospitalist cases.

In creating each specialty case and detailed character scripts, we sought input from a representative

Table 1
Case Synopses for Mapping the Future Hospitalist Courses

Case Number	Case Description	Conversation Held With
Case 1	The patient is an 80-yr-old woman with a history of moderate dementia and CAD who was admitted to the hospital 10 days ago for pneumonia. Her infection has improved, but she remains only intermittently arousable. A speech evaluation showed aspiration. Currently, she is being fed and receiving medications through an NG tube; however, she pulled the tube out two days ago, and now she is in restraints to avoid her pulling it again. The clinician needs to discuss ongoing artificial nutrition and GOC with her daughter.	Patient's daughter
Case 2	The patient is a 58-yr-old woman with a history of non-small cell lung cancer diagnosed 18 months ago. She was admitted yesterday with shortness of breath and was found to have a right lower lobe pneumonia. She is requiring 6 L of oxygen, and blood pressure is 90/60. Given that she appears septic, the clinician feels the need to clarify her code status.	Patient
Case 3	The patient is a 60-yr-old man with end-stage liver disease because of alcohol. He was admitted five days ago with altered mental status and is being treated to spontaneous bacterial peritonitis, as well as for encephalopathy, and has some renal failure, which is new, with a creatinine of 2.2 today. His MELD score is 40. He is not a candidate for liver transplantation. The patient remains encephalopathic despite maximal treatment. The clinician needs to discuss GOC with the patient's family.	Patient's sister and son

CAD = coronary artery disease; NG = nasogastric tube; GOC = goals of care; MELD = Model for End-Stage Liver Disease.