GOALS OF CARE CONVERSATIONS: A TRAINING PROGRAM EVALUATION

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PROBLEM

Conversations between clinicians and seriously ill or dying patients about treatment options and goals of care frequently do not occur.
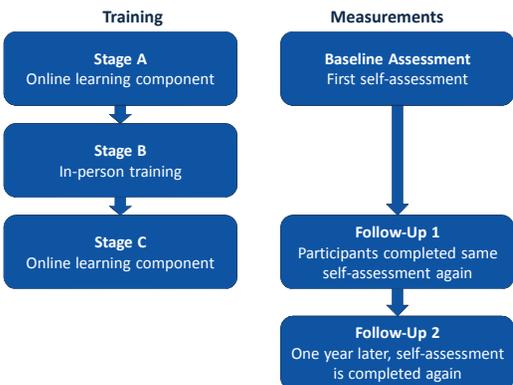
BACKGROUND

❖ Patients benefit when healthcare providers engage in conversations about treatment options and goals of care:
  - ✓ Improved quality of life
  - ✓ Improved quality of dying
  - ✓ Decreased end-of-life intensity of care
❖ These conversations, however, frequently do not take place.
❖ Researchers and practitioners have called for clinician training to increase the frequency and quality of these conversations.
❖ The Teaching Primary Palliative Care training aims to equip clinicians with the skills to engage in goals of care conversations with seriously ill and dying patients.

OBJECTIVE

To determine whether the Teaching Primary Palliative Care training increases participant comfort with engaging in goals of care conversations with seriously ill and dying patients shortly after the training, and one-year after the training.

METHODS

The Teaching Primary Palliative Care training occurs in three stages:

Training

- **Stage A** Online learning component
- **Stage B** In-person training
- **Stage C** Online learning component

Measurements

- **Baseline Assessment** First self-assessment
- **Follow-Up 1** Participants completed same self-assessment again
- **Follow-Up 2** One year later, self-assessment is completed again

METHODS, CONT.

The assessment tool:

The following questions pertain to your role in the management of seriously ill and dying patients; patients who are typically at or near the transition point where decisions need to be made about a shift in care goals from care directed towards life prolongation to goals of comfort/hospice care.

Rate your comfort level in various circumstances:

	Very uncomfortable	Somewhat uncomfortable	Somewhat comfortable	Very comfortable
Delivering bad news	☐	☐	☐	☐
Discussing CPR/DNR	☐	☐	☐	☐
Discussing hospice or palliative care referral	☐	☐	☐	☐
Discussing artificial hydration or nutrition (e.g., PEG tubes)	☐	☐	☐	☐
Discussing prognosis specifics	☐	☐	☐	☐

❖ In the fall of 2018, 78 clinicians completed the training (87% affiliated with Emergency Medicine)
❖ Assessments:
  - ✓ Baseline assessment: 77 clinicians provided usable data
  - ✓ Follow-up 1: 60 clinicians provided usable data
  - ✓ Follow-up 2: 36 clinicians provided usable data
❖ Statistical approach: We compared assessment responses using the sign test to assess for statistically significant improvement in the comfort level of clinicians to engage in goals of care conversations with seriously ill and dying patients.

RESULTS

% of Physicians Who Reported Feeling Somewhat or Very Comfortable in Goals of Care Conversations
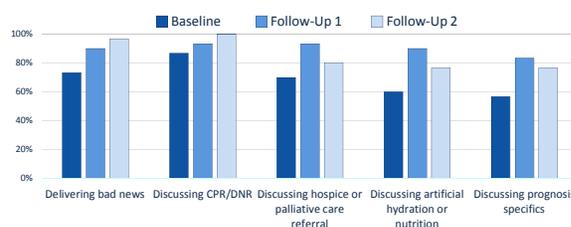
RESULTS, CONT.

Physician Comfort Level Engaging in Goals of Care Conversations: Changes from Baseline to Follow-Up 1 (n = 60)

	Became more comfortable	No change	Became less comfortable	p-value	
Delivering bad news	22 (36.7%)	31 (51.7%)	7 (11.7%)	0.0041	**
Discussing CPR/DNR	19 (31.7%)	36 (60.0%)	5 (8.3%)	0.0033	**
Discussing hospice or palliative care referral	21 (35.0%)	34 (56.7%)	5 (8.3%)	0.0012	**
Discussing artificial hydration or nutrition (e.g., PEG tubes)	33 (55.0%)	22 (36.7%)	5 (8.3%)	<0.0001	***
Discussing prognosis specifics	29 (48.3%)	27 (45.0%)	4 (6.7%)	<0.0001	***

* p < 0.05   ** p < 0.01   *** p < 0.001

Physician Comfort Level Engaging in Goals of Care Conversations: Changes from Baseline to Follow-Up 2 (n = 36)

	Became more comfortable	No change	Became less comfortable	p-value	
Delivering bad news	15 (41.7%)	17 (47.2%)	4 (11.1%)	0.0096	**
Discussing CPR/DNR	11 (31.4%)	19 (54.3%)	5 (14.3%)	0.1051	
Discussing hospice or palliative care referral	14 (38.9%)	19 (52.8%)	3 (8.3%)	0.0064	**
Discussing artificial hydration or nutrition (e.g., PEG tubes)	20 (55.6%)	11 (30.6%)	5 (13.9%)	0.0020	**
Discussing prognosis specifics	17 (47.2%)	14 (38.9%)	5 (13.9%)	0.0085	**

* p < 0.05   ** p < 0.01   *** p < 0.001

CONCLUSIONS

❖ In this sample, participation in the Teaching Primary Palliative Care training increased clinician comfort in goals of care conversations.
❖ Improvements continued after one year.
❖ Next steps: Determining whether increased comfort translates into changes in provider behavior such as conducting goals of care conversations with patients.

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