Original Article

Implementing Goals-of-Care Conversations: Lessons From High- and Low-Performing Sites From a VA National Initiative

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Abstract

Context. The Veterans Health Administration (VA) National Center for Ethics in Healthcare implemented the Life-Sustaining Treatment Decisions Initiative, including policy and practice standards, clinician communication training, a documentation template, and central implementation support to foster advance care planning via goals-of-care conversations for seriously ill veterans in 2014, spreading nationally to other Veterans Health Affairs (VA) sites in 2017.

Objectives. Our goal was to describe the range of early implementation experiences among the pilot sites, and compare them with spread sites that implemented LSTDI about two years later, identifying cross-site best practices and pitfalls.

Methods. We conducted semistructured interviews with 32 key stakeholders from 12 sites to identify cross-site best practices and pitfalls related to implementation.

Results. Three primary implementation themes emerged: organizational readiness for transformation, importance of champions, and time and resources needed to achieve implementation. Each theme's barriers and facilitators highlighted variability in success based on complexity in terms of vertical hierarchy and horizontal cross-role/cross-clinic relationships.

Conclusion. Learning health care systems need multilevel interdisciplinary implementation approaches to support communication about serious illness, from broad-based system-level training and education to build communication skills, to focusing on characteristics of successful individual champions who listen to critics and are tenacious in addressing concerns. J Pain Symptom Manage 2021;61:262–269. *Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words

Advance care planning, qualitative, veterans, goals-of-care conversations, implementation outcomes, barriers, facilitators

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Introduction

Beginning in 2014, the Veterans Health Administration (VA) conducted a national effort to implement universal advance care planning (ACP) among patients diagnosed with serious illness by proactively increasing goals-of-care conversations and documentation of life-sustaining treatment decisions. ACP is essential to high-quality care for seriously ill patients and includes processes to foster communication regarding patients' values, goals, and preferences for future care.[1–6] Ideally, ACP should occur before a crisis that requires emergent decisions regarding life-sustaining treatments.[7]

ACP and its attendant communication are associated with less burdensome end-of-life care, earlier hospice referral, and better caregiver bereavement adjustment.[8–10] Despite evidence that ACP improves outcomes, many patients do not complete advance directives or have goals-of-care conversations with their providers; or if completed, their quality is low,[11] with less specific information than necessary to make appropriate clinical decisions.[12] In addition, time pressures, immediate needs, and the medical focus of encounters may frustrate efforts to prioritize goals-of-care conversations.[4,13]

To address known gaps and promote well-being for the population of seriously ill veterans and their caregivers, the VA National Center for Ethics in Health Care implemented the Life-Sustaining Treatment Decisions Initiative (LSTDI). LSTDI uses a coordinated set of strategies to foster proactive conversations about goals, values, and preferences for life-sustaining treatments, and documentation of goals and life-sustaining treatment decisions in a standardized progress note template and order set in the electronic health record (electronic medical record [EMR]).[14]

Successfully implementing initiatives in large health care systems requires addressing organizational complexities. A single-site intervention suggested the importance of training and clinic processes in increasing the volume and quality of goals-of-care conversations,[15] but limited studies address ACP implementations at scale. The issue of *how to implement* is central to implementation science, which has primarily focused on small-scale evidence-based interventions in acute care and serious illness,[16] but is relatively underemphasized in palliative care, given the evidence for some practices.

Applying the evaluative lens of implementation science should be a high priority for translating established practices like ACP into routine practice. The urgency of improving implementation of existing value-based practices is growing with our aging population, high health care expenditures—particularly among chronically ill adults,[17] mounting fiscal pressures, and evolving payment and delivery focused on value-based care. Qualitative data is an implementation science method that allows access to the organizational context and insights into implementation facilitators and barriers.[18]

We therefore conducted postimplementation semi-structured key stakeholder interviews at 12 LSTDI sites, including four high-performing pilot demonstration sites and eight spread sites that we intentionally varied by implementation success (high or low), size (large or small), and selected for diverse geographical location. Our goal was to describe the range of early implementation experiences among the pilot sites and compare them with spread sites that implemented LSTDI about two years later, identifying cross-site best practices and pitfalls.

Materials and Methods

Setting

Sites included the four LSTDI sites, which piloted LSTDI starting in 2014 and which provide inpatient, outpatient, and home care services, and primary care clinic networks. Three pilot sites have on-site long-term care facilities and hospice beds. We selected eight additional spread sites that initiated LSTDI after January 2017 after release of the LSTDI policy to represent maximal variation. In addition to selecting pilot (early) and spread (later) implementation sites, sites represent reach/penetration (high and low uptake), size (small, medium, and large), and diverse geography.

Intervention

Intervention components reflect the best extant evidence to support goals-of-care communication and documentation[4,19] and included guidelines, a documentation template integrated into the EMR, training materials for staff, and sample reports for monitoring progress. The LSTDI demonstration project was conducted at four geographically distinct VA health care systems for more than two years. Sites agreed to implement a draft version of VA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting, and Honoring Veterans' Values, Goals, and Preferences. The policy establishes ACP practice standards to make goals-of-care conversations routine for every veteran with a serious illness and at high risk of a life-threatening event, and to improve the documentation of goals of care and life-sustaining treatment decisions within the EMR. Sites established LSTDI advisory boards, chaired or cochaired by clinical champions, to oversee implementation of new practices required in this policy. The National Center

for Ethics in Healthcare furnished assistance and resources, including multidisciplinary monthly implementation calls with each facility's LSTDI Advisory Board, provider tools (e.g., educational modules, worksheets, and pocket cards), a durable EMR progress note template and order set for documenting of goals of care and life-sustaining treatment decisions, and monitoring reports available on a cadence specific to each site to assess uptake.[14] The National Center for Ethics in Healthcare also provided technical assistance related to installation of new EMR tools, policy interpretation, and addressing implementation challenges.

LSTDI policy implementation spread nationally to all VA sites across the country was announced in VA Handbook Section 1004.03(1) on January 11, 2017. Facilities were given a deadline of initial implementation of new practices at all sites by July 11, 2018, and expectations were set for 18 months of available supporting resources, including monthly implementation support calls, policy updates, improved EMR templates, and provider tools based on demonstration site experiences, and goals-of-care conversation skills training.[20,21]

Design

We conducted semistructured interviews with 32 key stakeholders from 12 sites (including at least three from each of the four demonstration sites). We used a snowball sampling approach to identify provider and site leaders involved in LSTDI implementation. We intentionally recruited stakeholders from diverse roles to ensure multiple structural perspectives. Our interview protocol queried respondents about implementation experiences using the Consolidated Framework for Implementation Research (CFIR).[22] CFIR includes 31 implementation constructs clustered in five domains: characteristics of the intervention, outer setting (e.g., resources), inner setting, process, and characteristics of involved individuals.

Data and Analysis

A multiphase analysis approach leveraged rapid analytic qualitative procedures (RAP) to establish early themes, consensus coding of transcripts, and a matrix analysis[23] with excerpts to explore and query thematic findings. RAP has been extensively used in the VA;[24,25] we complemented RAP with the lightning report method,[26] focused on implementation barriers and facilitators. Our early themes were derived from demonstration sites, which were further along in the implementation process. Once these themes were established, we revisited our coding of the spread and demonstration sites to query these findings—sites where these findings were either further supported by spread data or even potentially undercut. The team's qualitative researchers (C. B. J., M. C. H., and K. F .G.) established coding consensus through bimonthly meetings. In a final analytic phase, we reviewed excerpts from transcripts by theme in a matrix analysis to refine our findings and allow for a primary comparison of pilot sites to spread sites and secondary comparisons between spread sites with high or low penetration of the implementation; high and low designations were based on dashboard reports and impressions derived from implementation reports and interactions with sites.

Results

We conducted 32 interviews across the four early implementation demonstration sites ($n = 14$) and the eight spread sites ($n = 18$) representing diverse perspectives: physician ($n = 10$), social work ($n = 7$), advance practice provider ($n = 6$), nursing ($n = 4$), non-clinical administration ($n = 2$), executive leadership ($n = 2$), and psychology ($n = 1$) (Table 1). We focused on interviewing site leaders in the LSTDI implementation, primarily site-level advisory board members.

We present four central implementation themes that map to CFIR constructs: organizational readiness for transformation (readiness for implementation), importance of champions (champions, leadership engagement, and opinion leaders), and time and resources needed to achieve implementation (available resources and processes of planning and executing) (Table 2).

Theme 1: Organizational Readiness for Transformation

Readiness for transformation hinged on complex layers of readiness at a variety of levels, including organization level, clinic level, team level, and individual provider level. Subthemes related to readiness included the following: 1) resistance to ACP because of prior beliefs/culture and competing priorities; 2) uneven ACP quality (i.e., goals-of-care conversations); 3) lack of fit for the intervention in departments like inpatient hospital care; 4) differences in readiness between demonstration and spread sites; and 5) the perception of untrained clinicians that high-quality goals-of-care conversations were too time consuming.

Stakeholders reported the perception that LSTDI represented "a huge culture shift" (nurse practitioner, demonstration site) that translated to strong resistance to change in some areas. Advisory board leads reported that shifting LSTDI from an individual-driven initiative over the "tipping point" to be "[just] part of the culture" (social worker, demonstration site) was necessary to sustaining efforts with LSTDI. The culture shift was

Table 1
Participant Characteristics

Participants	
Sites	Participant (*n*)
Demonstration site 1	4
Demonstration site 2	4
Demonstration site 3	3
Demonstration site 4	3
Spread site 1	5
Spread site 2	5
Spread site 3	1
Spread site 4	1
Spread site 5	2
Spread site 6	1
Spread site 7	2
Spread site 8	1
Roles	
Physician	10
Advance practice provider (NP)	6
Nurse	4
Social work	7
Psychologist	1
Executive administrator (non-clinical)	2
Non-clinical administration	2
LSTDI role	
Executive sponsorship	2
Advisory board chair/cochair	14
Advisory board member	11
Education/training subcommittee or emphasis	3
Unspecified	2

NP = nurse practitioner; IT = information technology; LSTDI = Life-Sustaining Treatment Decisions Initiative.

described by some as the need to move from disease-focused to more person-focused care.

At the individual level, prior provider beliefs about goals-of-care conversations impacted clinic and organization readiness to implement the LSTDI. Although all sites undertook training as a step to augment readiness (five to seven hours), one implementation coordinator complained, "there are some people that are just 'No, I'm not going to do it'" (nurse, demonstration site). This training subcommittee chair recognized that even policy and training were not enough to ensure readiness across all individuals.

Lack of readiness was reinforced by unwillingness of physicians to accept nonphysicians as trainers. In addition to a resistant organizational culture, clinician preparation was hindered because of the designed training, which was primarily technical (e.g., how to use the new EMR template for documentation), and was not perceived to address issues of organizational culture or include sufficiently in-depth communication practice.

In addition, academic sites host large numbers of trainees whose frequent turnover of residents with low self-efficacy for conducting goals-of-care conversations resulted in poorly executed ACP, conversations documented at the minimum level, and in some cases, inadvertently overwriting documentation from high-quality conversations. Across demonstration and spread sites, the presence and organizational role of trainees significantly impacted readiness, "… the interns particularly are really uncomfortable with these conversations and the residents are hit or miss" (physician, demonstration site).

Certain departments and clinics were more consistently prepared for LSTDI than others, indicative of variation in intervention fit for the context. Inpatient hospital care settings reported lack of readiness and resistance to initiating goals-of-care conversations. Spread sites concurred that implementing goals-of-care conversations in inpatient settings was "the biggest struggle", perhaps because of factors of fit in that environment, including the fast pace, preponderance of emergent situations, and rotating shift staff (social worker, spread site).

Readiness at demonstration sites was lower than some of the best performing spread sites because they were the first to test the intervention and pilot and refine the EMR template before national rollout in an iterative process with the National Center for Ethics in Healthcare and other demonstration sites. One provider at a demonstration site observed: "We're trying to fly a plane while we're building it" (physician, demonstration site). By contrast, in a best-case scenario, spread site implementations were facilitated by planning ahead: "We planned … far enough in advance so that it was not a hardship" (executive sponsor, spread site).

Finally, at an individual level, participants reported that clinician readiness hinged on training in how to conduct goals-of-care conversations. Untrained clinicians were perceived to avoid these discussions because they considered them too time consuming, creating a barrier to implementation. One spread site executive sponsor underscored this issue: "If it becomes the norm to have this [ACP] conversation, it will become more comfortable, but providers need to be trained."

Theme 2: Importance of Champions

Champions were critical to the initial work of implementing LSTDI; champions across diverse roles supported the initiative at the national, executive, clinic, and frontline levels, with roles in administration, clinical medical practice, nursing, and social work. Champion subthemes revolved around the following: 1) the support of national expert champions; 2) the importance of executive sponsorship to signal the value of the implementation; and 3) features of local clinical champions, including motivation from prior training in goals-of-care conversations, listening, and tenacity.

There was no one-size-fits-all champion, but instead sites pointed out the pros and cons of whatever

Table 2
LSTDI Interview Themes and Quotes

Theme 1: Organizational readiness for transformation
CFIR construct: readiness for implementation
We need to be talking about who this person is, where they're at in terms of their health before we really even start to talk about treatment planning and life-sustaining treatments.
You know what you're talking about it, you're enthusiastic about it, and you really want to see it go somewhere, but that hurdle is always … you're not a doctor, you're telling us [doctors] that we have to do something else. And I [doctors] already have enough work.
… we get new trainees every year, so it's always a new process educating them.
Theme 2: Importance of champions
CFIR constructs: champions, leadership engagement, and opinion leaders
So, one of the top things you can do is have a highly engaged and invested chief of staff because [providers are] going to follow that leadership example. If [chiefs] are visible and discussing it and understanding it and can speak to the value of it and they can see that this is somebody who is looking. … if it looks like the leadership team isn't engaged, why should the bother to put all their extra effort into something uncomfortable?
if you don't have the providers onboard or you don't have a clinical champion that really embraces this, it puts a lot of stumbling blocks in front of you to say the least.
There have been people in every setting that have been resistant to it [the LSTDI] and that still are … I just kept going to staff meetings … finally they've come around and are doing things appropriately … that was really motivating.
the more time we kind of stick with it and are sort of there walking through it with staff, that's been the biggest way we've been able to break down that barrier.
if you don't have the providers onboard or you don't have a clinical champion that really embraces this, it puts a lot of stumbling blocks in front of you to say the least.
Theme 3: Time and resources needed to achieve implementation
CFIR constructs: available resources
I mean just, [the implementation is] a lot of work, the phone calls about it, the … monitoring, having some protected [time] to work on that because it is such a big important initiative. And luckily, we haven't had anything horribly go wrong with it, but the possibility is always there. So, I think having somebody that really has some dedicated time, actually part of their role, is really important.
implementation isn't just flipping the switch … it's looking at all of the issues and providing the education for a good period of time after you go live.
if there were a way to have [dedicated time] for some of the different pilot sites to mentor some of the facilities, I think the facilities would really appreciate it.
CFIR constructs: process—planning and executing
it was just really putting the right people on that board [that] made it so easy.
Optimal advisory boards included diverse representation of roles and levels within the organization, including chief medical executives, physicians, representatives from informatics, attendings from residency programs, nurse practitioners, patient safety representatives, nurse managers, union representatives, chief residents, and representatives from education
It's just taking a long time. And I mean I guess that's the hardest part for me is trying to make sure that everybody understands the effort and the impact of these discussions and of putting these in the appropriate documentation.

LSTDI = Life-Sustaining Treatment Decisions Initiative; CFIR = Consolidated Framework for Implementation Research.

champion they could access, with a best-case scenario including top-down (executive) as well as bottom-up (clinic level) champions. These issues were similar across pilot and spread sites, with the caveat that low-performing spread sites referenced difficulties with accessing champion support.

National experts were seen as valuable for troubleshooting. For demonstration sites, access to national experts through regular teleconferences afforded rapid support for emergent issues. Executive champions provided sponsorship to signal the value or lack of value of the implementation within organizations; participants reported that clinicians accordingly prioritized or deprioritized implementation of the LSTDI. Stakeholders were aware of the importance of executive champions in motivating frontline staff to tackle the discomfort of a new initiative like LSTDI, which can include difficult conversations. On the opposite side of executive engagement, lack of support and championship from chief of staff at one demonstration site resulted in "providers really [lacking] on training": "Our chief of staff basically said nope" (social work, demonstration site).

Local champions were also critical to success. The best had undertaken training to augment their expertise, exhibited willingness to listen to critics, and demonstrated tenacity in addressing concerns. To move the LSTDI forward in day-to-day interactions, department-level or clinic-level local champions played important roles, regardless of their discipline. These local champions could be highly valuable, even if they were limited to merely supporting awareness of the intervention, for instance by keeping the topic on departmental meeting agendas. The most invested of local clinical champions often had additional interest and previous training in the area of goals-of-care conversations.

The tenacity of champions in addressing staff concerns in the face of resistance was reported to be critical in moving past barriers. Consistent connection with an advocate of the program, either through staff meetings or one-on-one meetings, was reportedly key

to moving individuals from resistance to readiness. Others concurred that regular touchpoints with staff were important: "the more time we kind of stick with it and are sort of there walking through it with staff, that's been the biggest way we've been able to break down that barrier" (social work, demonstration site). Demonstration and spread sites reported these champion attributes; low-performing spread sites validated themes in the negative. For example, a low-performing site mentioned that support requests received no response: "none of the leaders responded" (physician, spread site).

Theme 3: Time and Resources Needed to Achieve Implementation

Time and resources needed to achieve implementation was a major theme, again both at the micro (individual) and macro (team/group) levels. Stakeholders emphasized subthemes, including: 1) the importance of dedicated employee resources and time to support long-term implementation and spread; and 2) the critical allocation of an advisory board made up of a diversity of roles/specialties to represent perspectives and share information across the organization.

Regarding individual resources and time, coordinators reported the benefits of staff having dedicated time for implementing the intervention. The importance of protected time and staff full-time equivalent (FTE) was stressed by multiple sites (physician and nurse from different demonstration sites; nurse, spread site). The coordinator for one site reported that just a half-day per week was sufficient. Demonstration sites in particular noted the need to sustain dedicated staff time after initial implementation to support cross-site mentorship. Finally, the length of time needed to implement an ambitious intervention like LSTDI was greater than expected. Even at 18 months, demonstration sites did not feel the implementation was finished.

Participants reported that the structure and launch of the advisory board directly impacted LSTDI implementation, with greater resources being a key element of success. A large board with participants from diverse roles/specialties, using subcommittees to distribute work and consistent meetings to reinforce shared goals, supported spread of LSTDI across a local organization. Successful advisory boards were often large—up to 20 individuals—whereas smaller advisory boards were less successful and reported more challenges, primarily because they had fewer resources to "reach out across…service lines" and get things done (physician, spread site). Size facilitated the diverse representation of roles and levels within the organization on advisory boards including "representatives from pretty much everything" (nurse practitioner, spread site).

In addition to diverse membership, successful advisory boards used resources with frequent and consistent meetings and subcommittee structures. In contrast, low implementation spread sites struggled as a result of unstable advisory boards. Board chairs that stepped down or key personnel who were unable to continue for personal reasons or being on leave (social work, spread site) were perceived to contribute to low implementation.

Discussion

Guided by the multilevel implementation evaluation framework of CIFR, we interviewed 32 diverse stakeholders across 12 geographically diverse sites in a large integrated health system known for high-quality palliative and end-of-life care. We addressed the question of how to implement ACP and identified implementation themes of time and resources, readiness, and champions as potential factors that foster large-scale shifts in culture, practice, and workflow related to ACP.

The themes we identified as important for ACP implementation overlap with success factors outlined in a systematic review of 57 publications on implementing patient safety interventions, specifically: resources (time and available people to do the work of implementation), desirable implementation features (advisory board, interprofessional collaboration, and champions), readiness for change, receptive culture (including cultural barriers perpetrated by lack of training), and capacity in terms of people (seen here in large and diverse advisory boards).[27]

The experience reflected in LSTDI underscores the gap in training and education related to ACP. A 2018 national survey of physicians confirmed that although almost all (99%) agree that end-of-life conversations are important, less than a third have formal training.[28] Physicians often leave residency without training (37%) and mentored practice in these conversations, so this additional training translated to greater self-efficacy in ACP.[25] Clinicians do not finish their training with a sense that it is their responsibility to initiate ACP discussions.

We identified nuances in the known importance of leadership and champions in implementation.[29] Successful local champions listened to critics and were tenacious in addressing concerns. Furthermore, weaknesses in leadership at any one level were mitigated with leadership support at another level. Stakeholders reported positive implementation movement with any combination of executive, divisional, or even clinic management leadership support. Together with our insights about the importance of a diverse advisory board, this highlights the importance of interprofessional collaboration.

Previous reviews of implementation highlight the importance of nursing leadership in implementing evidence-based practices.[30] Conceptual models of interprofessional care call for clarity, attention to interprofessional and team-patient relationships, and focusing change on the system.[31] The advisory boards of LSTDI focused on interprofessional collaboration and system change; clarity of roles could be the next step for moving toward sustainability and maintenance of this initiative. Diverse stable advisory board membership was critical across sites.

We recognize several limitations to our analysis. Our insights are drawn from one health system, the VA, although the VA is a very large and diverse national health system. Our analysis used rapid qualitative methods, which may have limited the full extent of our insights; however, we bolstered the rapid approach with subsequent consensus coding, and recent explicit comparisons between rapid and traditional methods has found meaningful overlap in findings.[32]

Conclusion

Our inquiry provides insights into the gap between the high level of medical evidence supporting ACP effectiveness and documented evidence of low ACP performance in practice. We found multilevel interdisciplinary efforts and shared interprofessional responsibility contributed to ACP implementation success. Future intervention research should test these strategies proactively and their impact on implementation and effectiveness.

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