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Preventing Goal-Discordant Care: Improving Documentation of Advance Care Planning for Patients with Cancer

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Conflicts of Interest

I have no actual or potential conflict of interest in relation to this presentation.

Learning Objectives

- Use a continuous quality improvement (CQI) framework to improve safety and patient care
- Explain the impact of goals of care discussion for patients with cancer at an academic medical center
- Learn how to use a quality improvement methodology to implement change
- Engage with patients and family to guide patient-centered improvement

Methodology: Six Sigma - DMAIC

- Under the DMAIC framework (Define, Measure, Analyze, Improve, and Control), this project implemented a series of interventions using the Plan-Do-Study-Act (PDSA) Cycle.

Define the Problem

Define

Complete

Lack of advance directive (AD) negatively impacts patient care

Increased risk of providing goal-discordant interventions

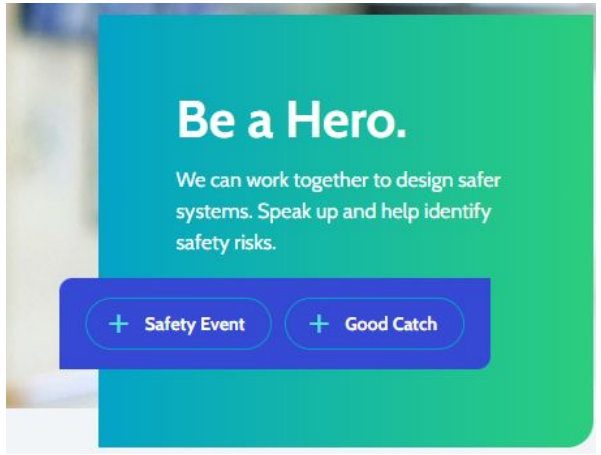
Preventable caregiver burden and decreased patient satisfaction

Established Multidisciplinary Workgroup

- Quality Improvement Leaders
- Department Clinical Leaders
- Providers and Nurses
- Palliative Care and Social Work
- Nurses and Patient Experience Staff
- Admitting & Patient Registration
- Clinical Data Analysts and Epic IT
- Patient Family Advisory Council members

Voice of the Customer (VOC)

- Survey of PFAC members
- Interview Providers – Inpatient units and Outpatient Clinics



VOC:
Lack of understanding of advance directives; patients may not understand the purpose of an advance directive
Patients are not given sufficient information and resources. Provide examples of advance directives
Being asked while hospitalized suddenly frightens you and makes you think am I going to die; advance directives are perceived as negative
For scheduled admissions provide information packets
Emphasize that an advance directive gives the patient an element of control

Define: Background and Significance

- Advance care planning (ACP) promotes the ethical principle of patient autonomy, enabling patients to actively participate in and retain control over decisions regarding their healthcare.
- Given the seriousness of a cancer diagnosis, it is important that patients engage in ACP discussions with the healthcare team.
- Patients whose wishes are not documented are at risk of receiving goal-discordant care.
- Given that treatment decisions may sometimes need to be made urgently, timely access to ACP notes and documents becomes crucial to ensure that the care delivered aligns with the patient's values.
- Success was defined as the availability of ACP documentation in the medical record.

Measure Current Performance

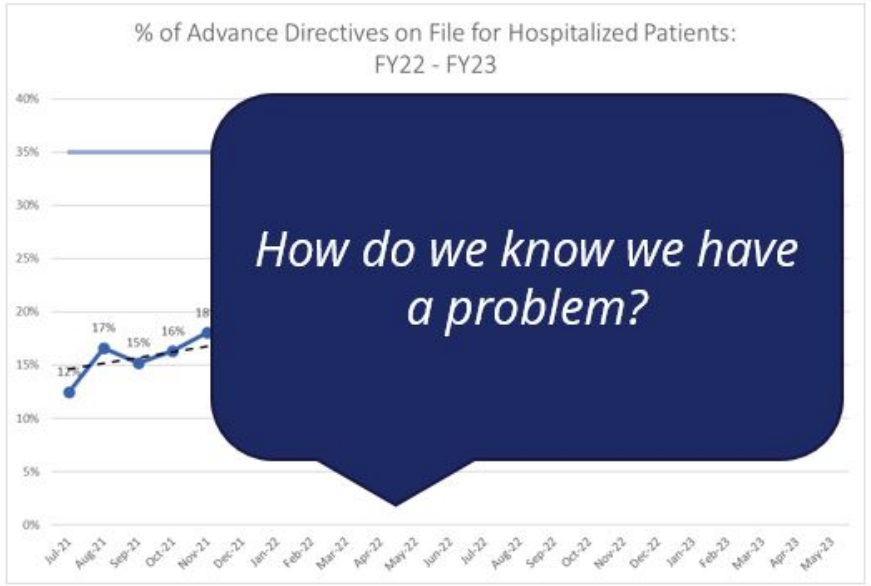
Measure

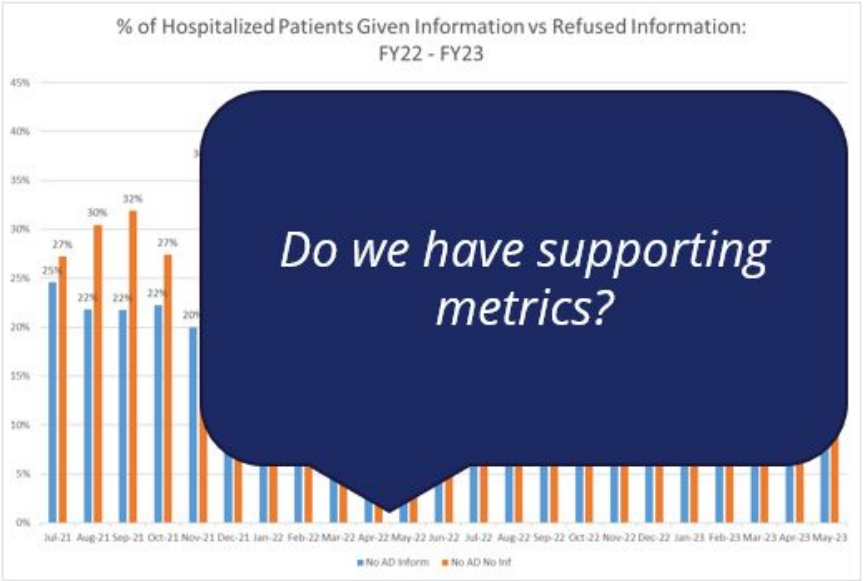
Complete

Assessed baseline data

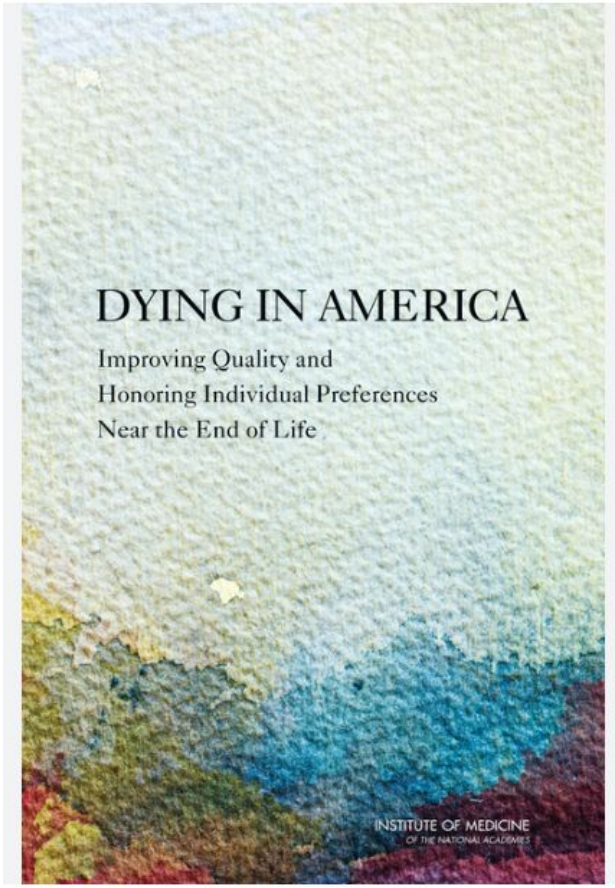
Only 12% of patients hospitalized on an oncology service have Advanced Directive available in the EMR

Gap in workflow on how and when to document Advance care planning (ACP) discussions in the EMR





Measure: The Current State of Goals of Care in the U.S



RESPECTING PATIENTS' PREFERENCES

By Kuldeep N. Yadav, Nicole B. Gabler, Elizabeth Cooney, Saida Kent, Jennifer Kim, Nicole Herbst, Adjoa Mante, Scott D. Halpern, and Katherine R. Courtright

Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care

ALLIANCE OF DEDICATED CANCER CENTERS

Improving Goal Concordant Care

Clinicians lack serious illness communication training and too few conversations occur

99% of clinicians believe that serious illness conversations are important[1]

29% of clinicians report having received serious illness communication training[1]

11% of Americans report having a serious illness conversation with their clinician[2]

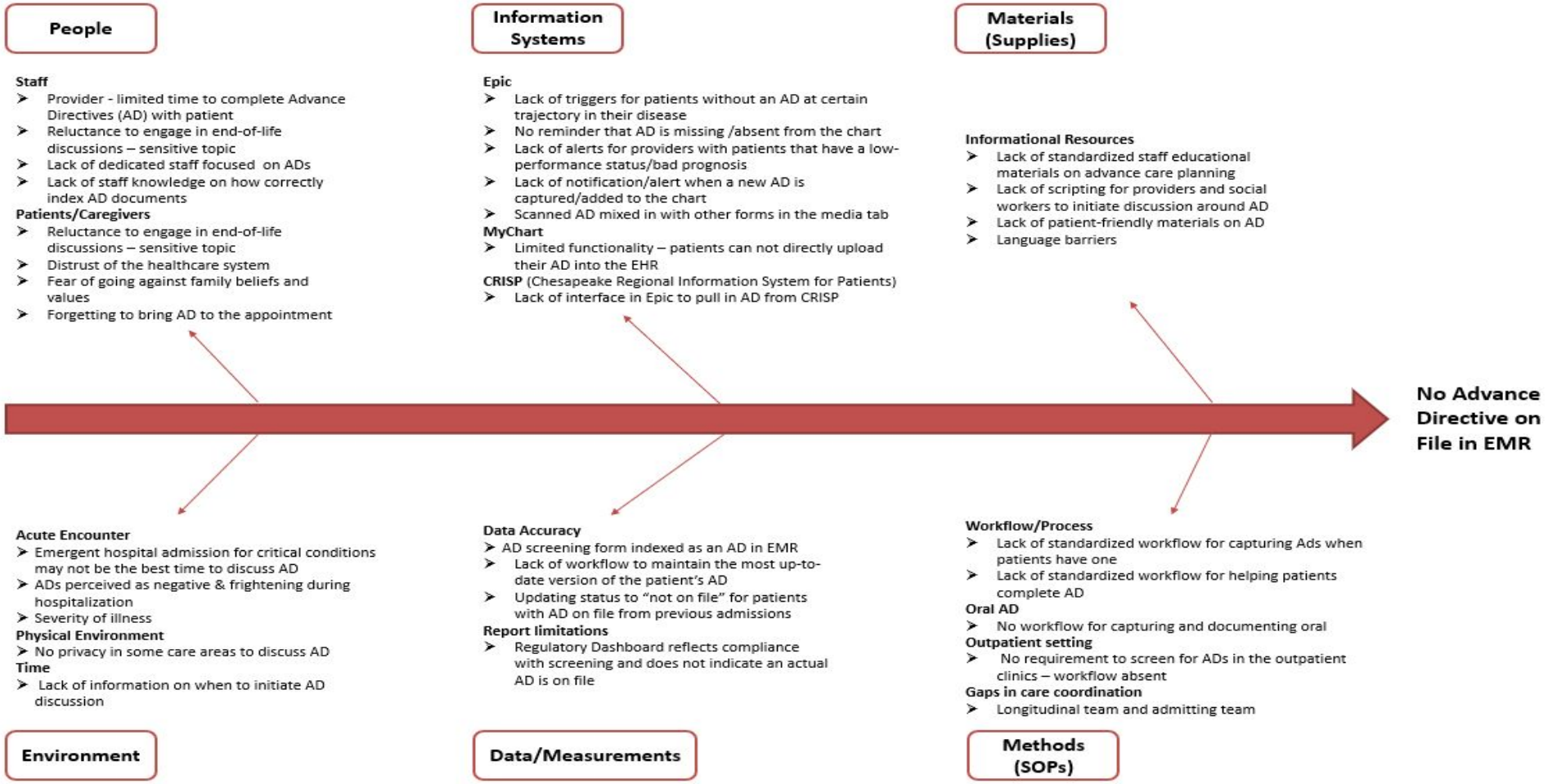
Analyze Contributing Factors

Analyze

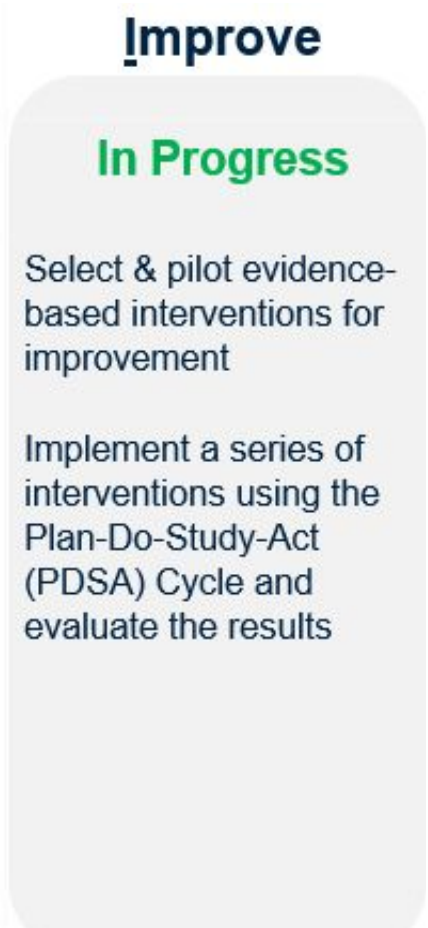
Complete

Identified contributing factors

Success is defined as the availability of ACP documentation, including AD, Durable POA, and POLST forms



Improve with Actions – National Recommendations



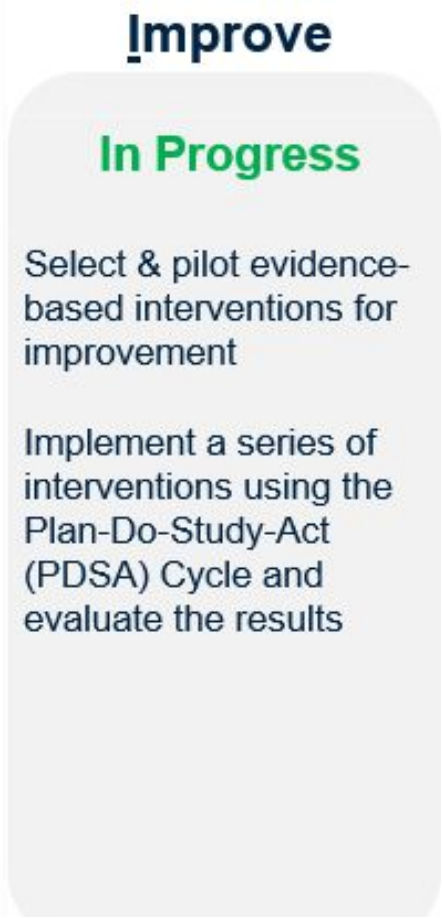
IOM – Dying in America:

- Initiate high-quality conversations about advance care planning, …, and communicate with other clinicians
- Consciously revisit advance care planning discussions

ASCO - Recommended Best Practice:

- Educate all patients about the importance of advance care planning and available services
- Establish standards for ordering and initiating advance care planning, considering initiation or change in treatment, progression of disease, change in performance status, hospitalization, acute exacerbation of disease, or initiation of palliative care
- Document time spent in the advance care planning session - bill the Medicare program for advance care planning

Improve with Actions - Plan-Do-Study-Act (PDSA)



PDSA #1

- Lack of Awareness – patients and healthcare professionals
- Incorrect Documentation of AD in the EHR

PDSA #2

- No Analytic Insight into Performance
- Lack of Staff Focus on ACP

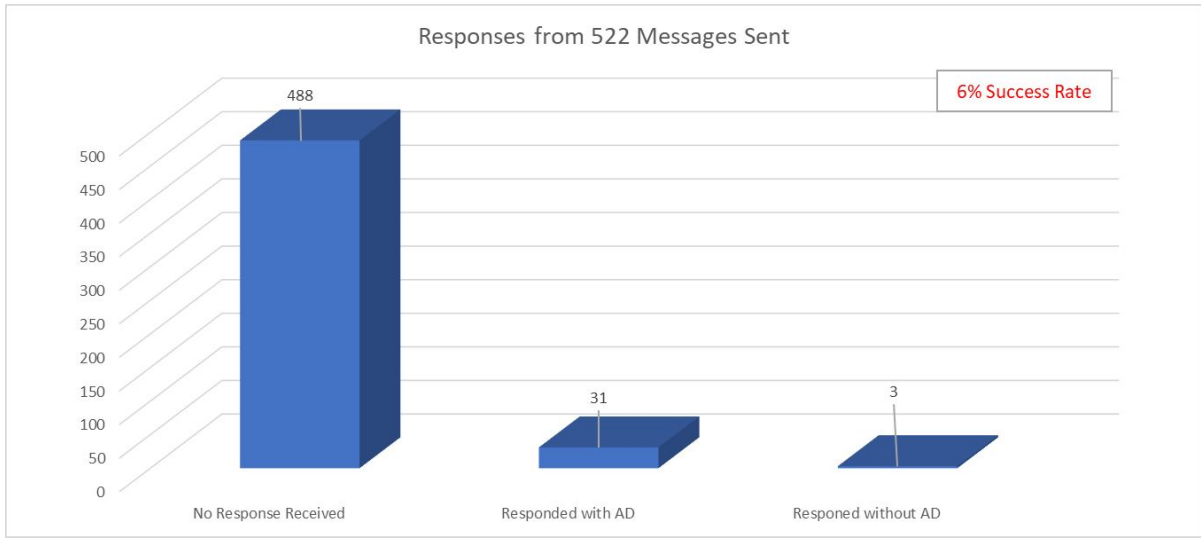
PDSA #3

- Limited Patient Capability
- Lack of Triggers for ACP

PDSA Cycle #1: Lack of Awareness

National Healthcare Decisions Day

Direct Message to Patients



Connections Made!

Over 1,000 Patients, Caregivers, and Staff!

PDSA Cycle #1: Incorrect Documentation of AD

Access | REGISTRARS & SCHEDULERS

Epic TIPS & TRICKS

Document the Patient Has an Advance Directive on File

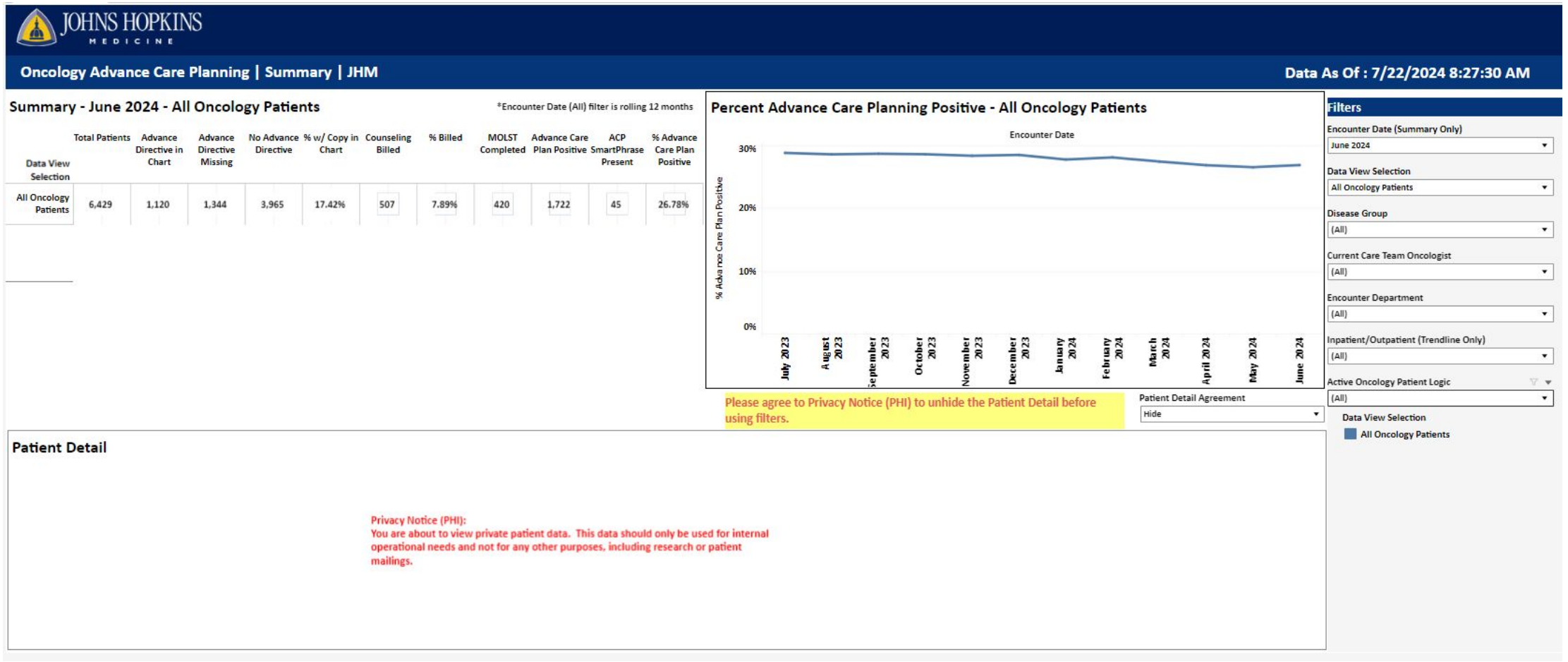
Review of the Status Choices for Documenting the Patient has an Advance Directive

The patient Document List is used to document and update patient information regarding Advance Directives. An Advance Directive is a written document of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. In order to simplify the communication we have updated the status of the Advance Directive in the Header of the patient record.

Each status that is selected in the documents table will correspond with a different status in the header. Note in this chart you will see the document status that matches the header status.

Document Status	Header/Banner Status
Blank (no Status Selected)	TBD
Not Applicable	N/A
Patient does not have advance directive, Information given	No
Patient does not have advance directive, Information refused	No
Patient has Advance Directive, Copy in Chart	Yes
Patient has Advance Directive, Copy Not In Chart	Need Copy
Patient Revoked Advance Directive	Revoked

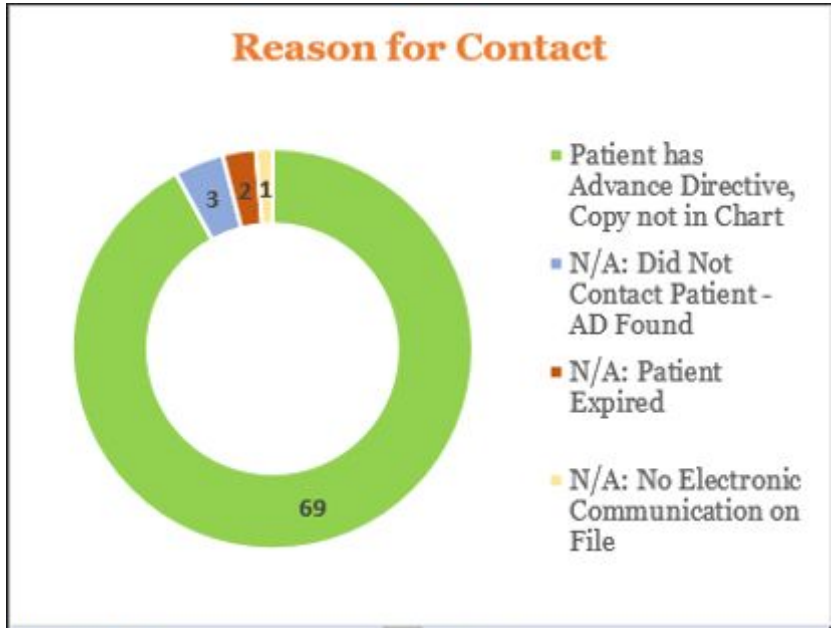
PDSA Cycle #2: No Analytic Insight into Performance



PDSA Cycle #2: Lack of Staff Focus on ACP

Dedicated Staff Pilot – Job Description

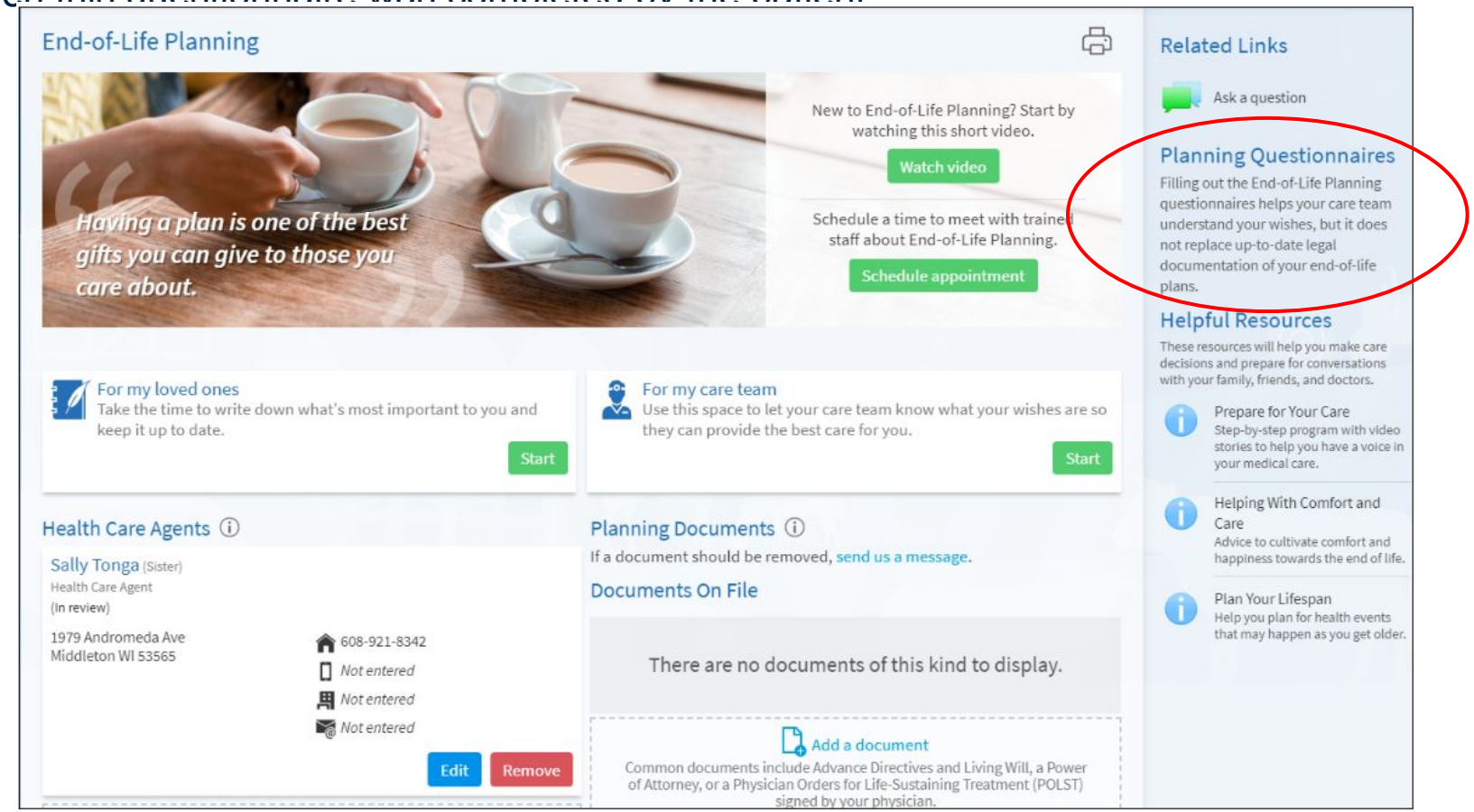
- The ACP Coordinator is expected to have knowledge of advance directives
- The ACP Coordinator will review a list of eligible patients to identify opportunity
- The ACP Coordinator will audit each chart to ensure an advance directive isn't already on file
  - If the AD is present in the chart, the ACP Coordinator verify with the patient and ensures it is correctly uploaded into the patient's medical record
- ACP Coordinator will host in-person or virtual office hours monthly for education and/or aid in the completion and upload of AD



Row Labels	Count
Patient has Advance Directive, C	69
N/A: Did Not Contact Patient - Al	3
N/A: Patient Expired	2
N/A: No Electronic Communicati	1
Grand Total	75

PDSA Cycle #3: Limited Patient Capability

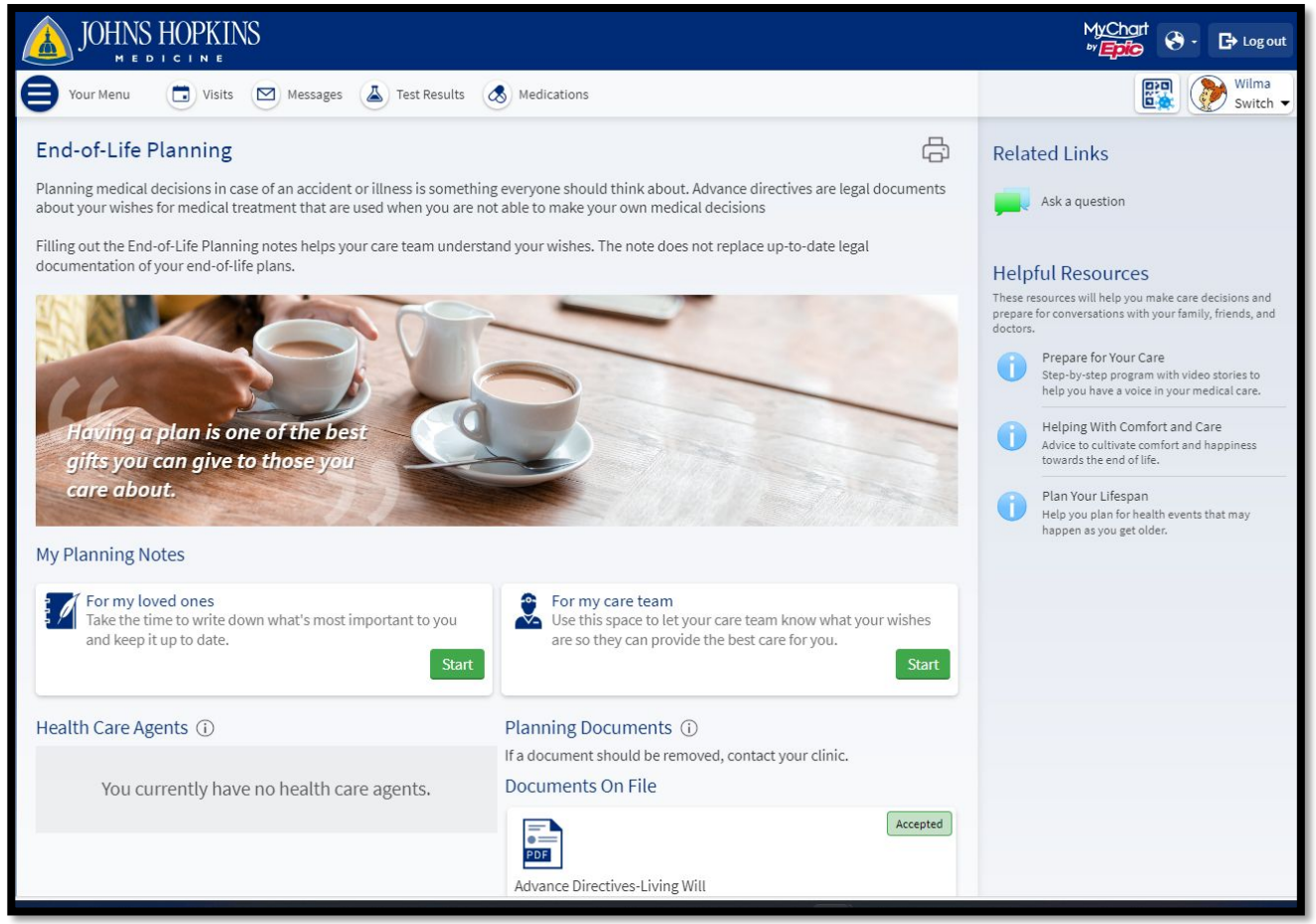
- Patients could not upload their goals of care documentation into the HER
- Goals of care questionnaires available – not a legal document
- Providers were not alerted when this questionnaire was completed by the patient



PDSA Cycle #3: Limited Patient Capability

New System Enhancement!

- Patients can now upload their Advance Directive documents into the EHR



Control for Sustainability

Control

In Progress

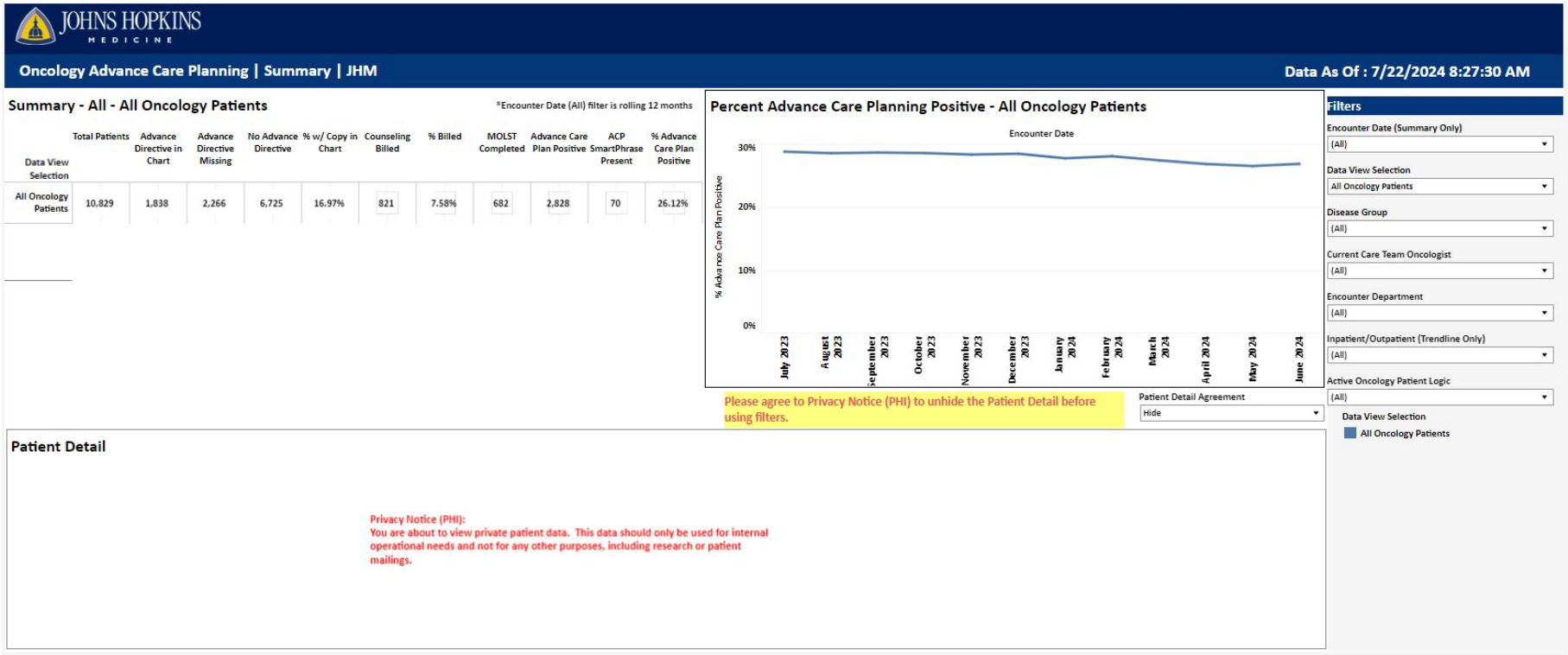
Control or sustain the results beyond the pilot phase

Monitor and communicate results

Spread the solution

Adjust as indicated

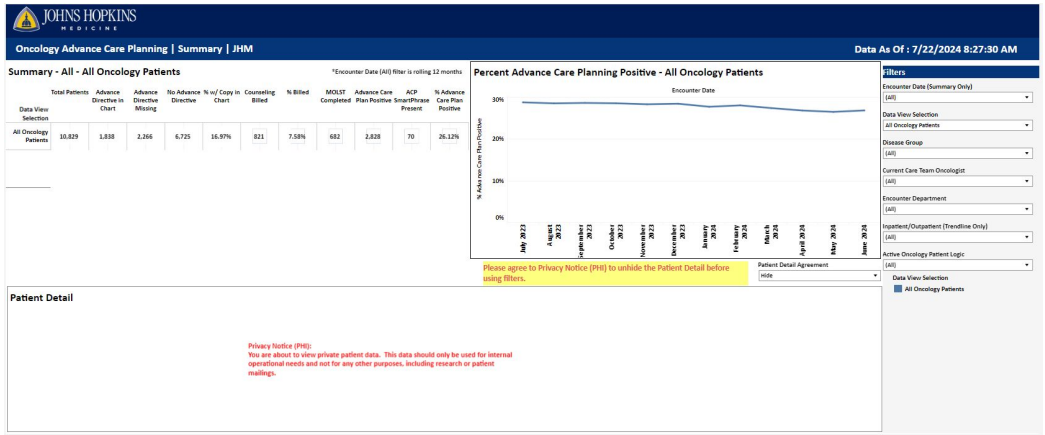
Preliminary Results



Next Steps

PDSA #3, #4, #5,…

- Develop triggers for ACP
  - Working on enhancements to the ACP dashboard to identify specific patient populations
- Provide training and resources to providers
- Continuously reassess barriers and challenges to guide future change
- Maintain patient-centered goals of care discussions as a strategic priority
  - Reduce acute care cost – prevents unnecessary hospitalization and treatment at the end of life
  - Increase inpatient bed capacity by improving outpatient palliative services



Project Team

Project Leads:

- Yanka Campbell - Quality Improvement & Patient Safety Leader, Oncology
- Jasmine Redd - Project Administrator

Sponsors:

- Dr. Allen Chen, Vice Chair for Quality, Safety & Service, Oncology
- Dr. Danielle Doberman, Medical Director, Palliative Medicine Program
- Nursing Leaders: Kathryn Yarkony, Kathy Mooney, Ella-Mae Shupe
- Admitting & Patient Registration: Damon Fisher, Daryl Minor
- Social Work: Louise Knight, Najah Williams
- Health Informatics: Monica Wilt
- SKCCC Patient Family Advisory Council (PFAC): Dr. Margaret Brennan
- Chaplain: Rhonda Cooper, Tasha Brownfield

Reference Summary

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“Failure to achieve goal-concordant care is a medical error that can harm patients and families.”

Journal of Palliative Medicine, 2018

Thank You

Questions and Feedback