



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

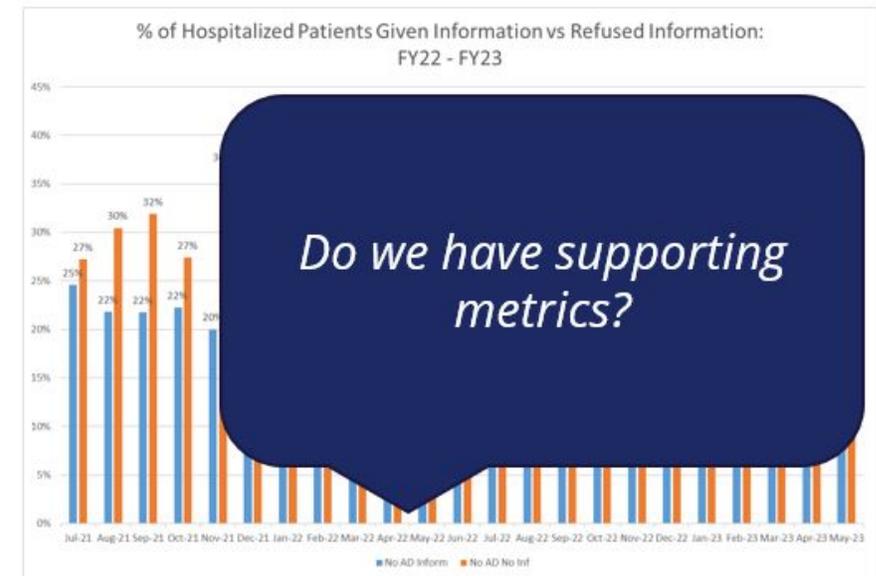


Measure Complete

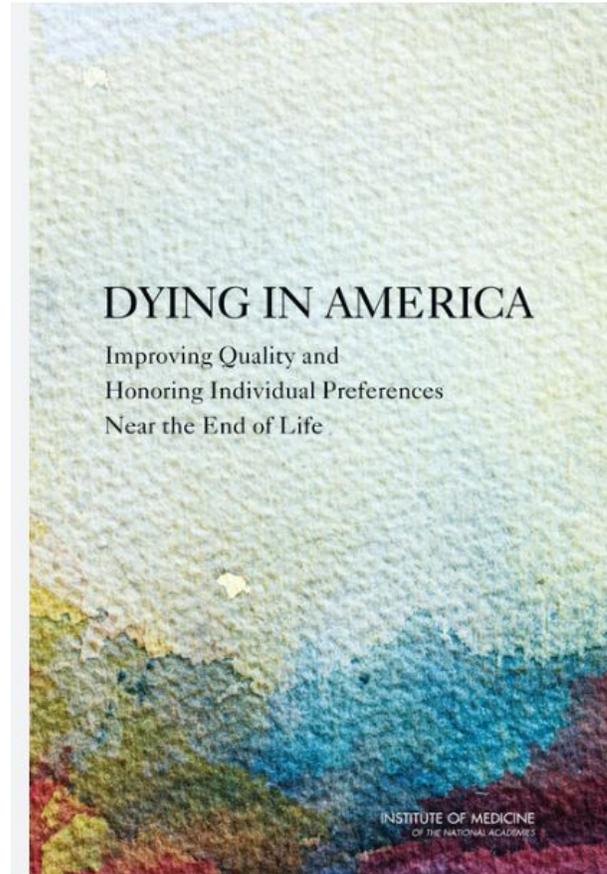
Assessed baseline data

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

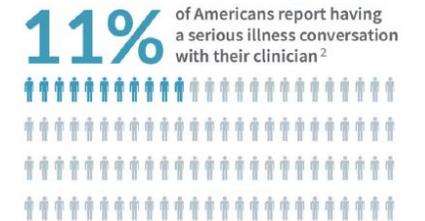
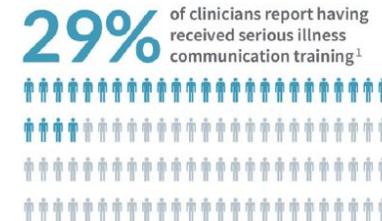
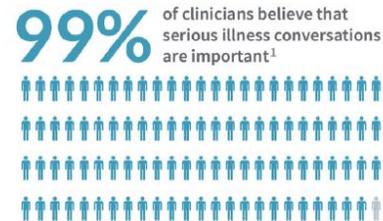
By Kuldeep N. Yadav, Nicole B. Gabler, Elizabeth Cooney, Saida Kent, Jennifer Kim, Nicole Herbst, Adjoa Mante, Scott D. Halpern, and Katherine R. Courtright

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



Improving Goal Concordant Care

Clinicians lack serious illness communication training and too few conversations occur



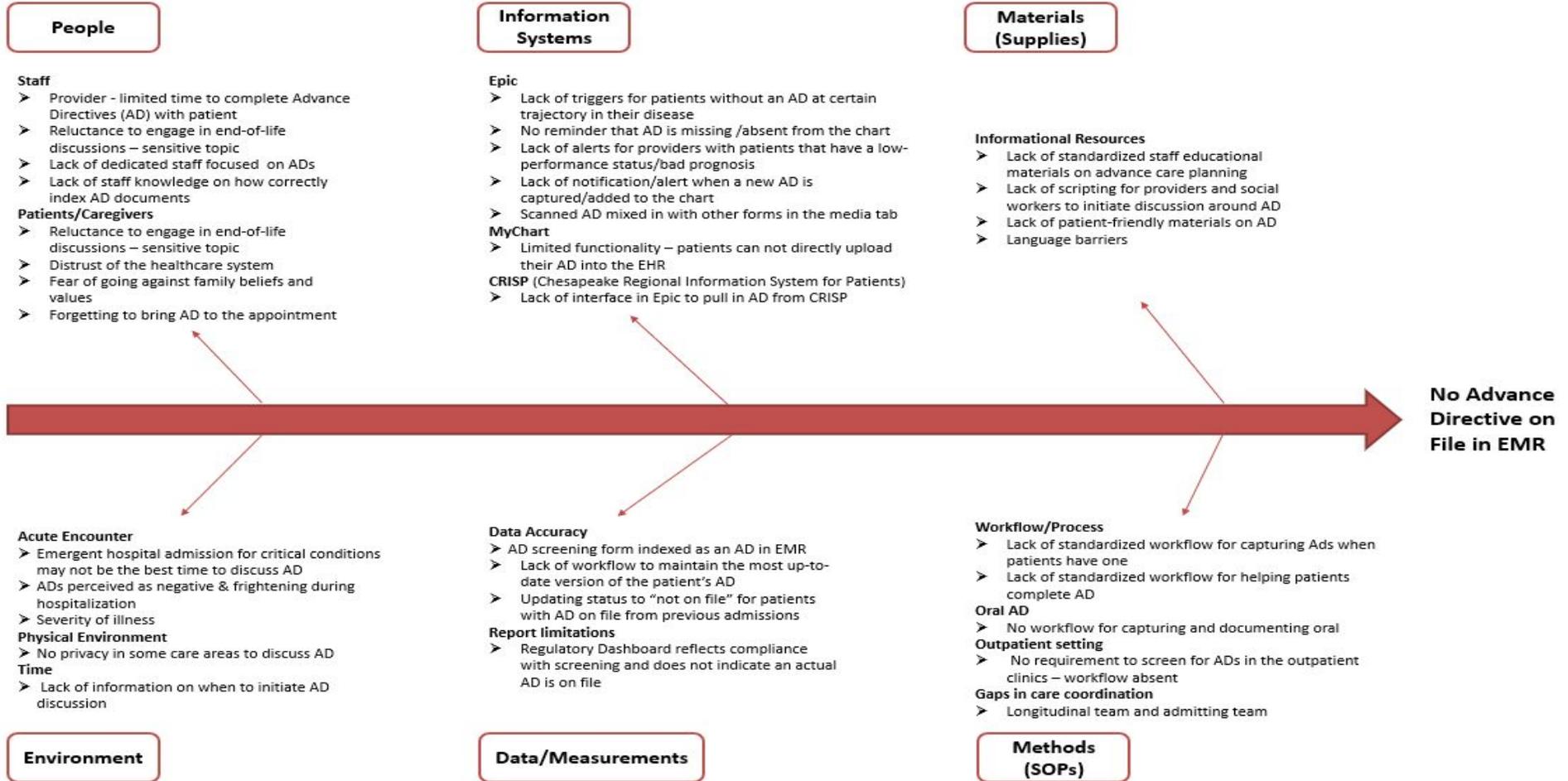
Analyze Contributing Factors



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

Improve

In Progress

Select & pilot evidence-based interventions for improvement

Implement a series of interventions using the Plan-Do-Study-Act (PDSA) Cycle and evaluate the results

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)

Improve

In Progress

Select & pilot evidence-based interventions for improvement

Implement a series of interventions using the Plan-Do-Study-Act (PDSA) Cycle and evaluate the results

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

the conversation project

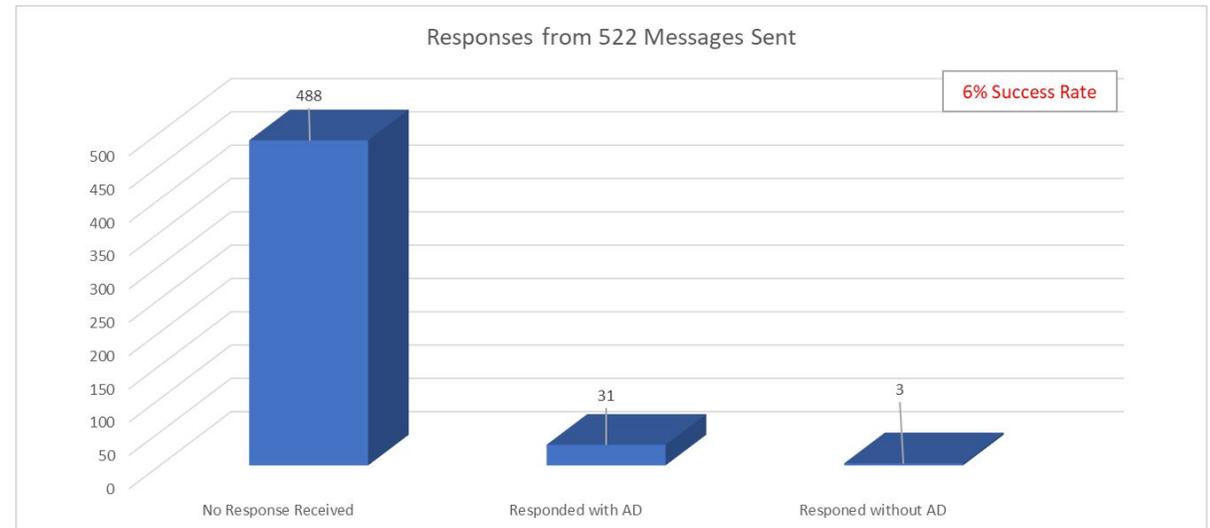


The Sidney Kimmel Comprehensive
Cancer Center at Johns Hopkins

the conversation project



Direct Message to Patients



Connections Made!

Over 1,000 Patients, Caregivers, and Staff!

PDSA Cycle #1: Incorrect Documentation of AD

Access | REGISTRARS & SCHEDULERS



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.

Bat, Hannah F, 37 yrs, 09/14/1982 MRN: 86992680	Language: English PCP: Drew Tutu, MD	Allergies: Not on File Long-Term CVAD: No	MyChart: Inactive HM Due?: None	Attending: BURKE, ANNE E Pt Location: BMC OB L&D Private: No	Adv Dir: TBD Pt Ver Status: Ver Guar Acct (PB): 2231133 Currently Admitted: Yes
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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



Oncology Advance Care Planning | Summary | JHM

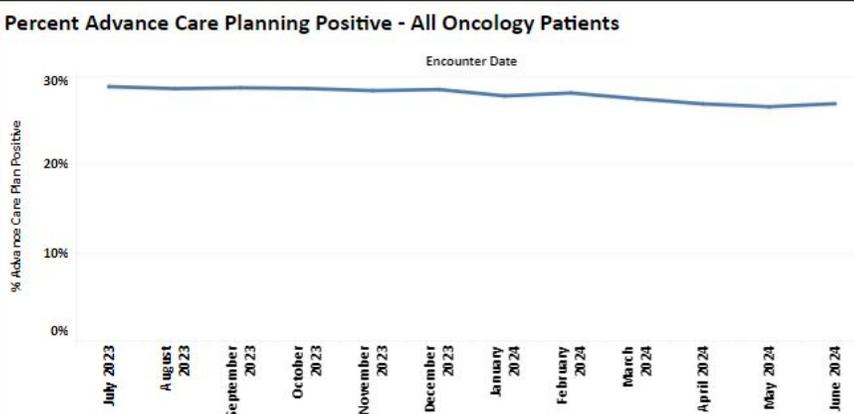
Data As Of : 7/22/2024 8:27:30 AM

Summary - June 2024 - All Oncology Patients

*Encounter Date (All) filter is rolling 12 months

Data View Selection	Total Patients	Advance Directive in Chart	Advance Directive Missing	No Advance Directive	% w/ Copy in Chart	Counseling Billed	% Billed	MOLST Completed	Advance Care Plan Positive	ACP SmartPhrase Present	% Advance Care Plan Positive
All Oncology Patients	6,429	1,120	1,344	3,965	17.42%	507	7.89%	420	1,722	45	26.78%

Percent Advance Care Planning Positive - All Oncology Patients



Month	% Advance Care Plan Positive
July 2023	26.78%
August 2023	26.78%
September 2023	26.78%
October 2023	26.78%
November 2023	26.78%
December 2023	26.78%
January 2024	26.78%
February 2024	26.78%
March 2024	26.78%
April 2024	26.78%
May 2024	26.78%
June 2024	26.78%

Filters

Encounter Date (Summary Only)
June 2024

Data View Selection
All Oncology Patients

Disease Group
(All)

Current Care Team Oncologist
(All)

Encounter Department
(All)

Inpatient/Outpatient (Trendline Only)
(All)

Active Oncology Patient Logic
(All)

Patient Detail Agreement
Hide

Data View Selection
All Oncology Patients

Patient Detail

Privacy Notice (PHI): You are about to view private patient data. This data should only be used for internal operational needs and not for any other purposes, including research or patient mailings.

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



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

The screenshot shows the 'End-of-Life Planning' patient portal interface. The main header is 'End-of-Life Planning' with a printer icon. Below the header is a large image of hands holding coffee cups with the text: 'Having a plan is one of the best gifts you can give to those you care about.' To the right of the image are two call-to-action buttons: 'Watch video' and 'Schedule appointment'. Below the image are two sections: 'For my loved ones' and 'For my care team', each with a 'Start' button. The 'Health Care Agents' section lists Sally Tonga (Sister) as the Health Care Agent, with contact information and a note '(In review)'. The 'Planning Documents' section shows 'Documents On File' and a message: 'There are no documents of this kind to display.' Below this is an 'Add a document' button and a note: 'Common documents include Advance Directives and Living Will, a Power of Attorney, or a Physician Orders for Life-Sustaining Treatment (POLST) signed by your physician.' On the right side, there is a 'Related Links' section with 'Ask a question' and 'Planning Questionnaires' (circled in red). Below that is a 'Helpful Resources' section with three links: 'Prepare for Your Care', 'Helping With Comfort and Care', and 'Plan Your Lifespan'.

PDSA Cycle #3: Limited Patient Capability

New System Enhancement!

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

The screenshot displays the Johns Hopkins MyChart patient portal interface. At the top, the Johns Hopkins Medicine logo is on the left, and the MyChart by Epic logo with a user profile icon and 'Log out' button is on the right. Below the header is a navigation bar with icons for 'Your Menu', 'Visits', 'Messages', 'Test Results', and 'Medications'. The main content area is titled 'End-of-Life Planning' and includes a printer icon. The text explains that advance directives are legal documents for medical decisions and that filling out the notes helps the care team understand the patient's wishes. Below the text is a photograph of hands holding coffee cups on a wooden table, with the quote: 'Having a plan is one of the best gifts you can give to those you care about.' Underneath the photo is the 'My Planning Notes' section, which has two cards: 'For my loved ones' and 'For my care team', each with a 'Start' button. Below these are sections for 'Health Care Agents' (showing 'You currently have no health care agents.') and 'Planning Documents' (with a note to contact the clinic if a document should be removed). A 'Documents On File' section shows a PDF icon for 'Advance Directives-Living Will' with an 'Accepted' status. On the right side of the portal, there are sections for 'Related Links' (with an 'Ask a question' button), 'Helpful Resources' (with three informational links), and a user profile section for 'Wilma Switch'.

Control for Sustainability

Control

In Progress

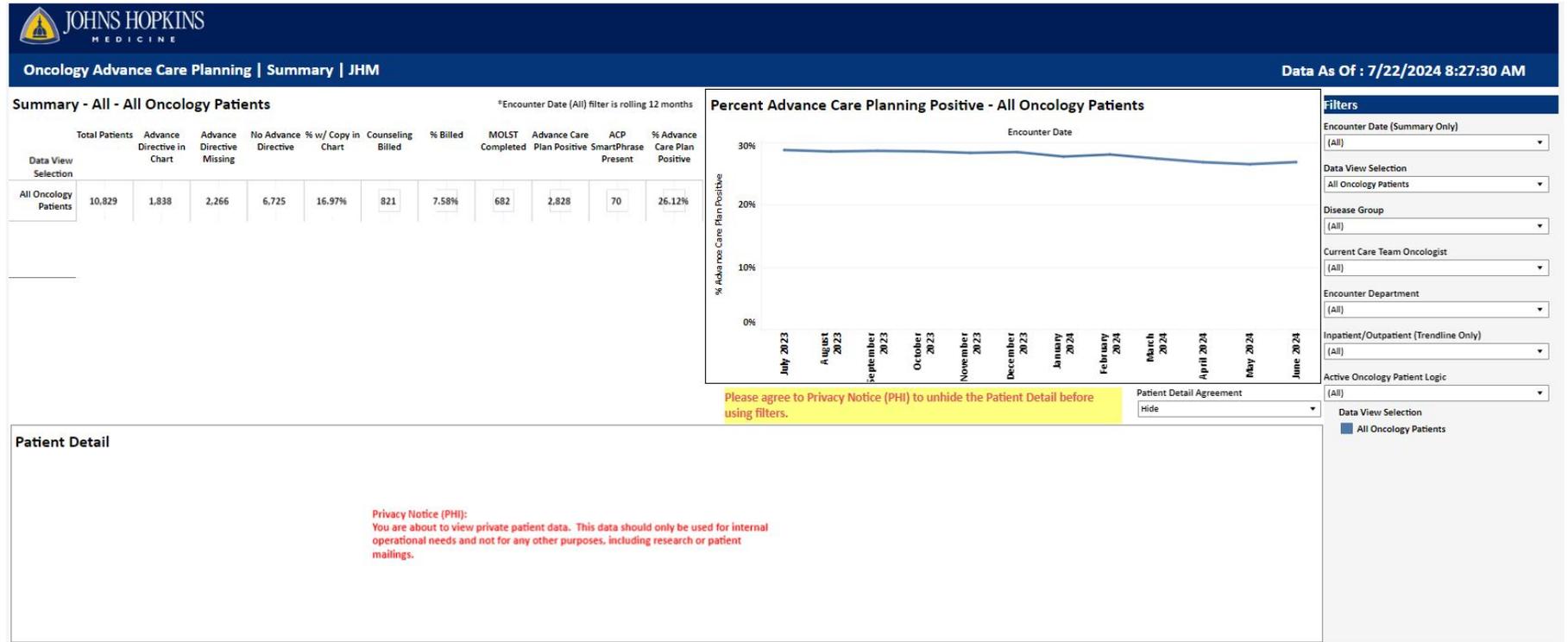
Control or sustain the results beyond the pilot phase

Monitor and communicate results

Spread the solution

Adjust as indicated

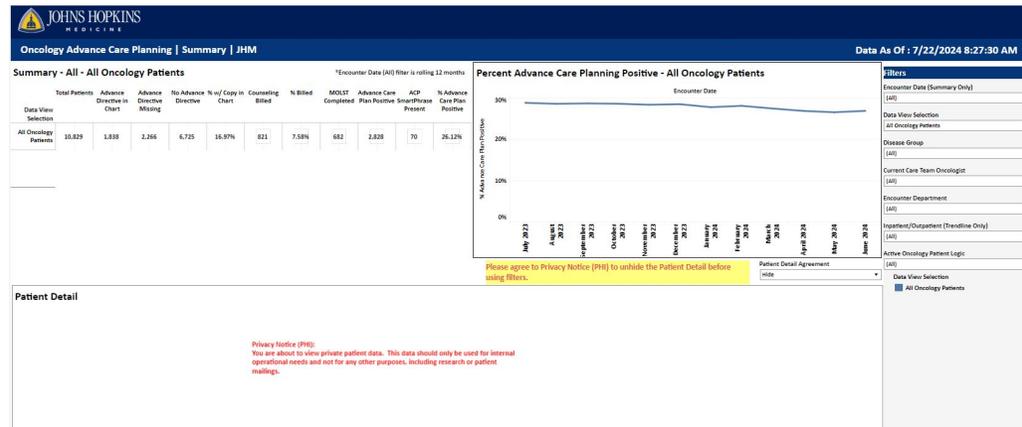
Preliminary Results



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