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Increasing Advanced Care Planning in an Ambulatory Care Setting

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Project: Increasing Advanced Care Planning in an Ambulatory Care Setting

Last Updated: 7.18.2019

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Maine Medical PARTNERS
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Team Members: MMP OPD Clinic Team: PSRs, MA's, Physicians, Nurses, Providers, Interns, Residents

Plan

Problem/Impact Statement:

Maine is the oldest state in the nation, with an increasing percentage over 65 years old. Advanced Care planning is an important part of care because patients deserve to express their goals for end of life care. When patients are in a catastrophic medical situation, we want to honor patient preferences for care. In addition, knowing patient preferences allows cost savings to the system, eliminating needless admission to the hospital or ICU. The Adult Internal Medicine Clinic at Maine Medical Center had an auditing system in place in the for targeting patients qualifying for Advanced Care Planning (ACP) discussions. Our objective data forced us to address ACP with embedded workflows.

Scope:

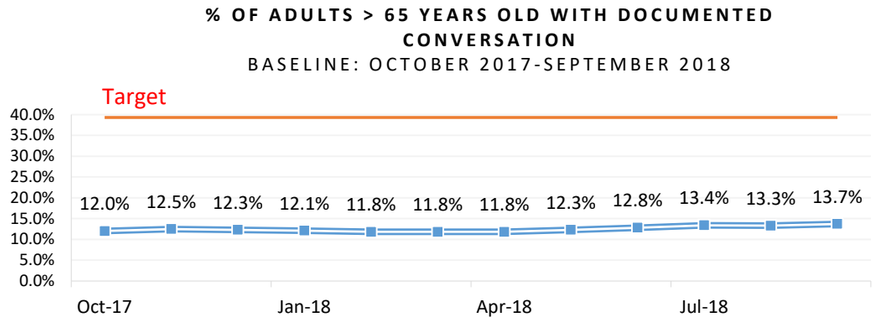
In scope: All patients greater than or equal to 65 years old, who receive care at the MMP Outpatient Department (OPD) Adult Medicine Clinic.
Out of scope: Patients under 65 years old, patients receiving care at other practices

Goal/Objective:

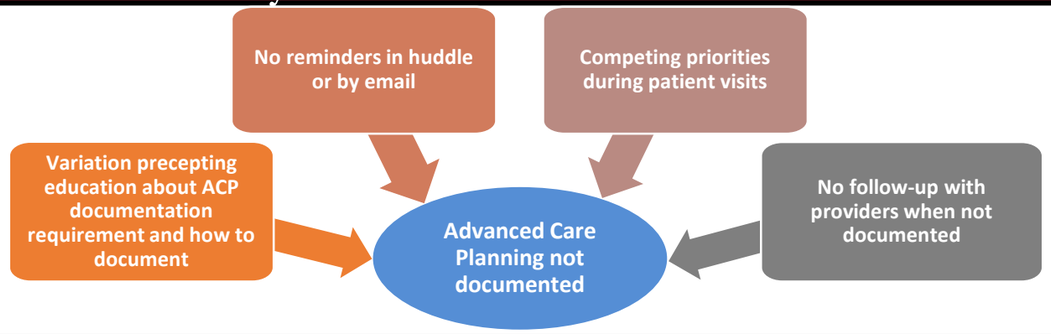
Goal: A minimum of **40% of patients 65 years** or older will have an Advanced Care Directive, POLST (Provider Orders for Life-Sustaining Treatment), or Serious Illness Conversation documented in EPIC

Baseline Metrics/Current State:

Despite increased awareness of the importance of Advanced Care Planning, documented discussion rates remained at **~12%.**



Root Cause Analysis:



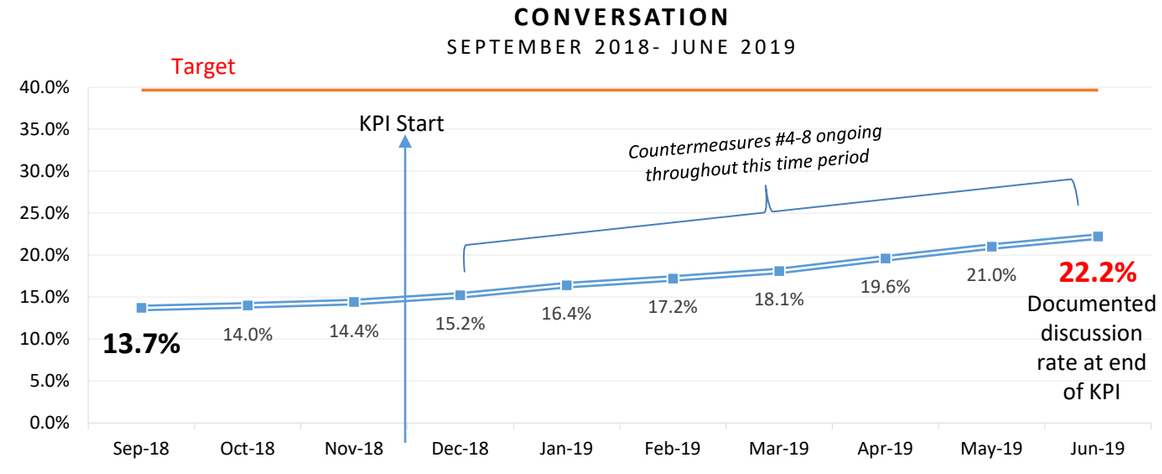
Do

Countermeasures

Intervention	Date
1. Staff Meeting presentation by MMP on tools for ACP planning	2/27/2018
2. Email reminder that Advanced Care Planning should be included in pre-visit planning	5/4/2018
3. Daily KPI Started: 100% of the time, patients 65 years of old or older will have Advanced Care Planning discussion by provider by entering the smart phrase ACP list in a note by the end of the clinical session.	11/19/2018
4. Action plan: KPI Reminder during morning huddles	Ongoing
5. Action plan: Emphasize ACP list as part of intern/resident education	Ongoing
6. Action plan: PSRS review upcoming appointments and put "ACP due" in appointment note, for patients missing Advanced Directives	Ongoing
7. Action plan: End of each day, PSRs made a list of providers who had not entered the ACP List and shared with the clinic director, for real-time feedback to providers	Ongoing
8. Action plan: KPI Progress reviewed in weekly emails	Ongoing

Study

Outcomes



Act

Next Steps

- Plan to continue the monitoring compliance for the first 6 weeks of the summer until all our new interns learn to incorporate the habit of including ACP list in there note the day of visit
- Teach providers to review ACP related reports in the BI portal
- Continue vigilance of data during monthly quality review meetings