Improving Advanced Care Planning Discussion and Documentation

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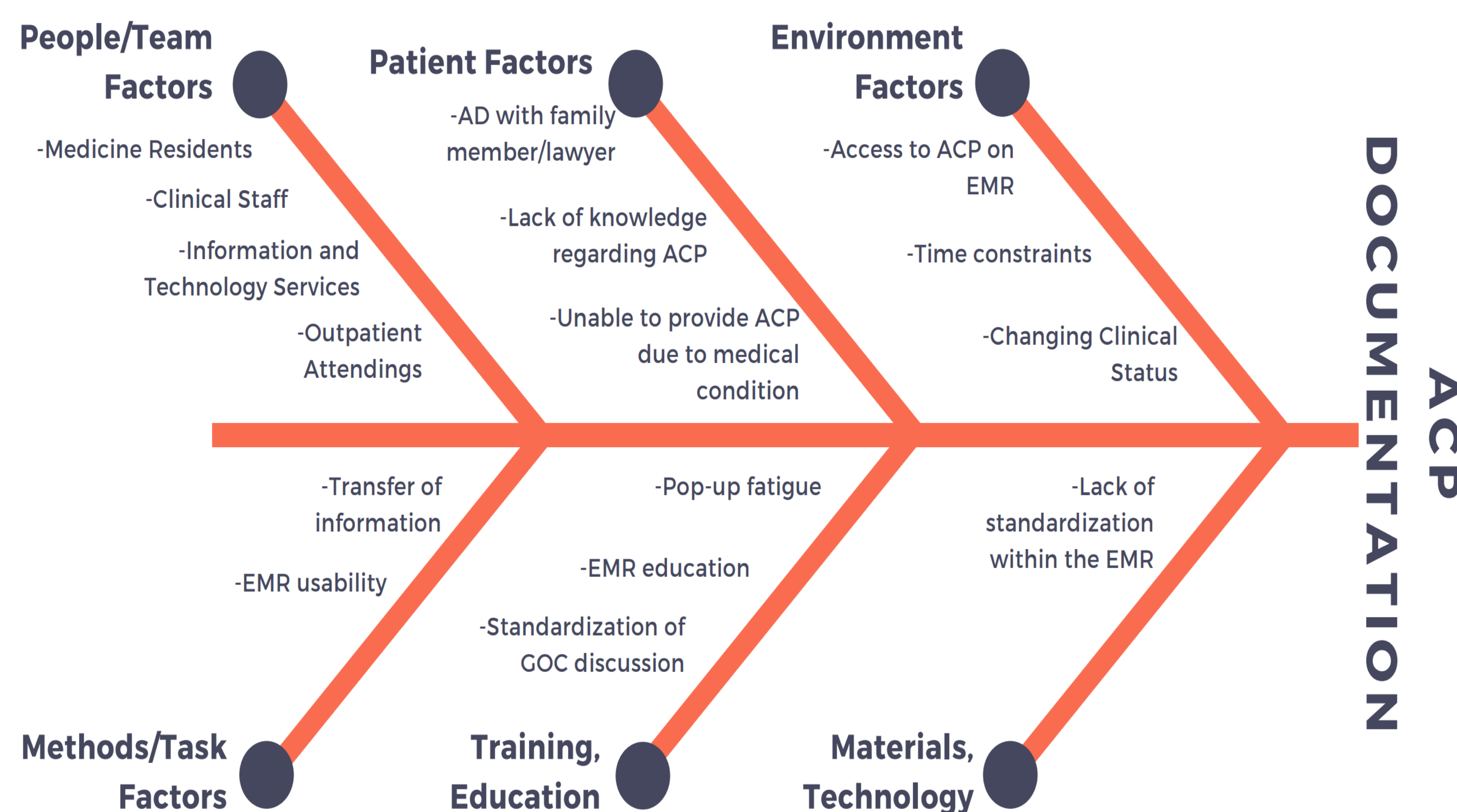
Problem Definition

Advanced care planning (ACP) is an important yet often overlooked aspect of the end of life that allows patients to dictate their own care. ACP documents should ideally be formulated in the outpatient setting with the support of loved ones and health care professionals, and they should be made easily accessible to inpatient providers.

One study suggests that physicians' role in this is oftentimes vague and poorly defined, leading to a lack of proper documentation within a patient's medical chart[1]. Another study found that outpatient physicians with computerized reminders were more likely to engage in goals of care discussions with their patients than those without, and there was a direct relationship between size of notification and likelihood to engage[2].

Thomas Jefferson University Hospital has incorporated such a reminder system within the outpatient EMR as an attempt to improve ACP documentation. Nevertheless, there are many process and education barriers that must be addressed in order to successfully execute this, especially in the resident clinic setting. Below is a fishbone diagram outlining the contributing factors.



References

1. Duke, G., Thompson, S., & Hastie, M. (2007). Factors influencing completion of advanced directives in hospitalized patients. *International journal of palliative nursing*, *13*(1), 39-43.
2. Dexter, P. R., Wolinsky, F. D., Gramelspacher, G. P., Zhou, X., Eckert, G. J., Waisburd, M., & Tierney, W. M. (1998). Effectiveness of computer-generated reminders for increasing discussion about advance directives and completion of advance directive forms. Annals of Internal Medicine, 128(2), 102-110.

Aim for Improvement

Our goal is to improve ACP discussion and documentation in patients above the age of 65 in our Jefferson Hospital Ambulatory Practice (JHAP) resident clinic. By instituting procedural changes within the EMR and the clinic, as well as improving provider education, we hope that residents can carry out a comprehensive and streamlined discussion regarding advanced care planning. We will institute these changes over the next 3 months, and we predict that there will be an increase in ACP discussion and uploading of appropriate documentation to 50% and 25%, respectively.

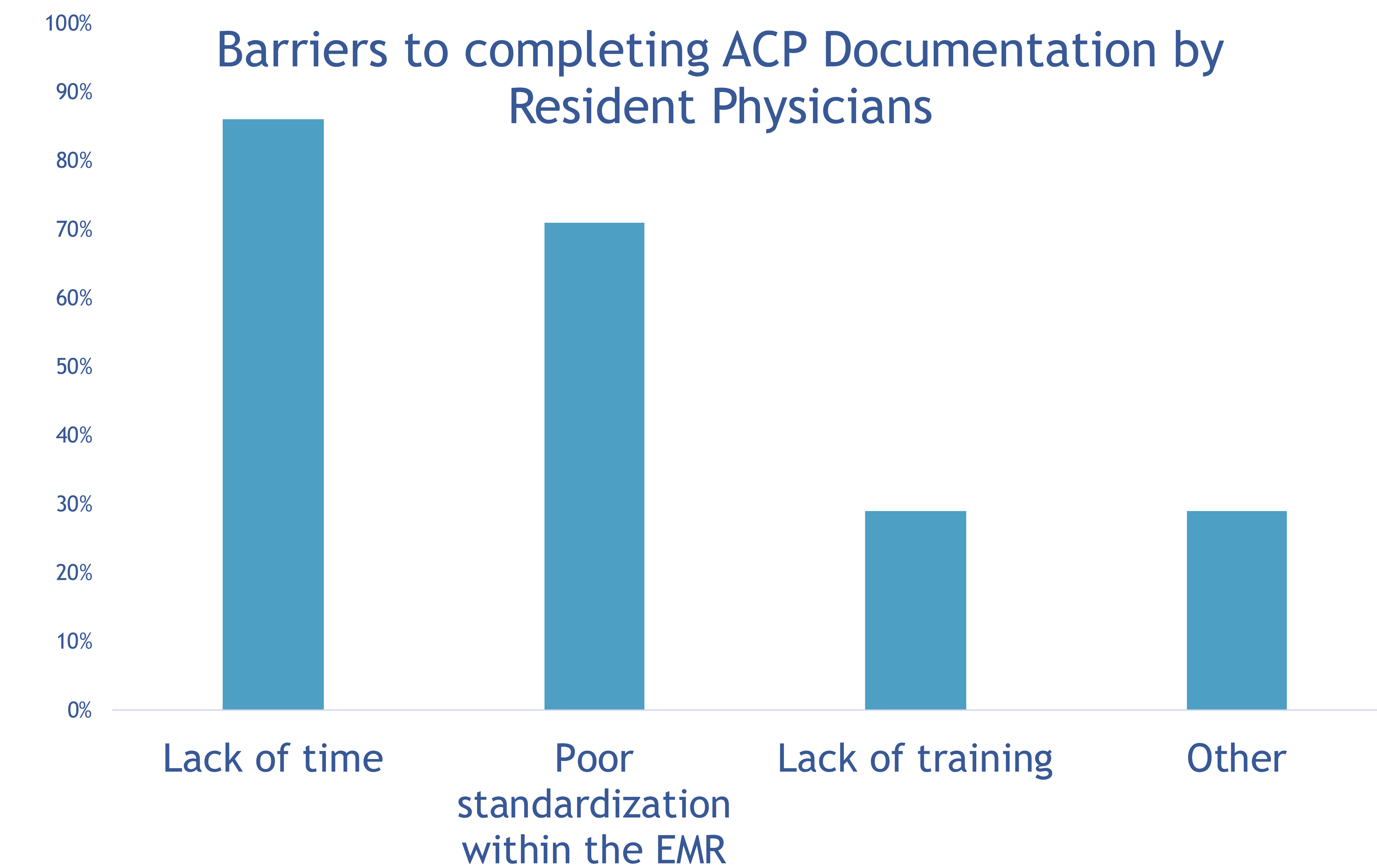
Intervention

As part of the Medicare annual wellness visit, medical assistants (MAs) will give patients a modified ACP document that is easy to read and simple to use. When the MAs notify the provider that rooming is complete, they will let the provider know of the ACP document, which can then be discussed during the visit. To ensure that these documents are uploaded to the EMR correctly, JHAP residents can consult the step-by-step guide provided in both an email and on a poster in the resident workroom.

Measurements/Results

The current process remains passive: medical assistants (MAs) give a handout to patients during their Medicare annual wellness visit to review on their own without any provider discussion. The problem of physician-driven goals of care discussion and proper documentation within the outpatient setting remains.

We reviewed charts of 39 patients over the age of 65. We found that only 5 out of 39 patients had ACP documents completed and uploaded within the EMR.



We conducted a survey of 24 internal medicine residents about the barriers to completing ACP discussion and documentation. Results (see above) showed that 83% noted "lack of time" as a main driver for limited ACP discussions in the outpatient setting, 71% noted "poor standardization within the EMR," and 29% noted "lack of training."

Following implementation of the aforementioned interventions, follow-up data will be obtained at 3 months, 6 months, and 1 year. The measures will include number of ACP documents properly uploaded into the EMR and comfort level of residents through survey.

Lessons Learned

Our intervention is currently being put into practice, and we will analyze the effects of our intervention over time. Some alterations to our methods depending on rates at 3 months may include scheduling patients for visits dedicated to ACP discussions or focusing on making the ACP-related parts of the EMR more user-friendly.

This process has taught us that there are many avenues that can be intervened upon in order to improve ACP discussion and documentation. We learned that the process of quality improvement is fluid, and it is important to adapt the problem definition and aims along the course of the project in order to identify interventions that will be most efficacious for patient care.