Improving Advanced Care Planning Documentation in the Outpatient Setting

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Background

- Advanced care planning (ACP) is a decision-making process that maintains patient autonomy when patients are unable to make decisions for themselves
- Studies demonstrate patients with advance directives received care that was more strongly associated with their preferences at the end of life[1]
- ACP discussions often occur during an acute illness. This is suboptimal compared to discussions that occur in the outpatient setting, where there are adequate time and resources available for patients to address these difficult decisions and for the discussion to be documented appropriately in the medical record[1]
- In primary care clinics of a large healthcare delivery system, a multifaceted quality improvement intervention led to an increase in ACP documentation of 2.4%[9]
- A generalized risk score exists in our electronic health record for patients at a higher risk of adverse events, which was designed from evidenced based research [2, 3, 4, 5, 6, 7, 8]
- Stakeholders of this project include: patients, residents, attending physicians, medical assistants, and palliative care physicians

Study Aims

- We aimed to increase Jefferson Hospital Ambulatory Practice (JHAP) electronic medical record documentation of advanced care planning discussion of 209 identified “high risk” patients via independently labeled ACP notes by 5% (from 1.4% to 6.4%) over a six-month period (October 1, 2017- April 1, 2018).[9] We elected to focus this pilot project on high risk patients due to time constraints of the study period and we felt that these high risk patients would likely derive the most benefit from ACP planning in the outpatient setting.

Figure 1: General Risk Score Calculation

Methods

Interventions:

- Residents
  - Pre and post intervention surveys were distributed to residents regarding knowledge and comfort with ACP discussions
  - Educational materials and scripts were provided to help facilitate advanced care planning discussions
  - Detailed instructions on how to access ACP documentation was distributed
- Patients
  - Patient were educated in the form of pre-assembled pamphlets
- Faculty and Medical assistants
  - MAs and faculty were asked to remind residents when there was a high risk patient

Figure 2: Fishbone diagram

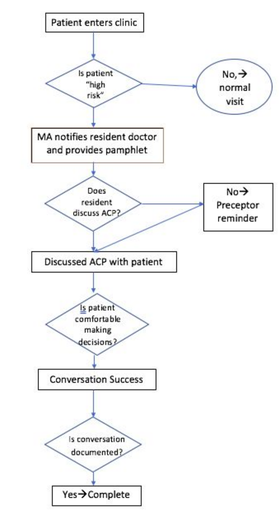

Figure 3: Process Map

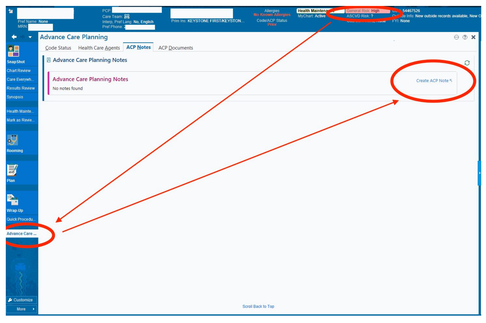

Figure 4: Example of Epic Work Flow

Results

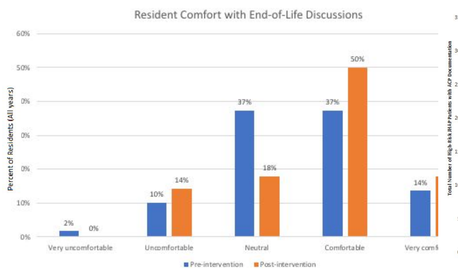

Figure 5. Resident comfort with discussion of ACP increased during the course of the intervention

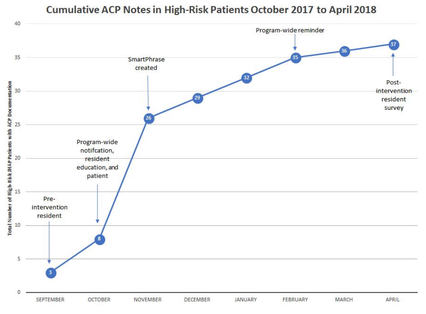

Figure 6. The cumulative number of documented ACP notes during the intervention per month is pictured above.

Conclusion

- The study aim was achieved, with an increase in ACP documentation for “high risk” JHAP patients of 16.3% (from 1.4% to 17.7%).
- ACP specfic notes have the potential to streamline medical care and decisions when patients are in complex, acute phase of illness.
- Targeted provider education and awareness has the potential to improve ACP discussion and documentation

Future Directions

- Increase provider training on utilizing EMR for documenting advanced care planning
- Formalized Advanced Care Planning curriculum in graduate medical education
- Limitations of this study included total number of high risk patients at baseline and continued reinforcement of documentation

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