Increasing Advanced Care Planning in an Ambulatory Care Setting

Jennifer Aronson
Maine Medical Center

Elizabeth Eisenhardt
Maine Medical Center

Adult Internal Medicine Clinic

Ruth Hanselman
Maine Medical Center

Suneela Nayak
Maine Medical Center

See next page for additional authors

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Authors
Jennifer Aronson, Elizabeth Eisenhardt, Adult Internal Medicine Clinic, Ruth Hanselman, Suneela Nayak, Stephen Tyzik, and Amy Sparks

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Project: Increasing Advanced Care Planning in an Ambulatory Care Setting

Last Updated: 7.18.2019

Team Members: MMP OPD Clinic Team: PSRs, MAs, Physicians, Nurses, Providers, Interns, Residents

Executive Sponsors: Dr. Rob Chamberlin, Facilitator: Dr. Jennifer Aronson, Dr. Elizabeth Eisenhardt, Ruth Hanselman

**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:**

- No reminders in huddle or by email
- Competing priorities during patient visits
- Variation precepting education about ACP documentation requirement and how to document
- Advanced Care Planning not documented
- No follow-up with providers when not documented

**Outcomes**

- % OF ADULTS > 65 YEARS OLD WITH DOCUMENTED CONVERSATION
  - BASELINE: OCTOBER 2017-SEPTEMBER 2018
  - Target: 14.0% to 14.4%
  - Study: 12.0% to 13.4%
  - Target: 15.0% to 22.0%
  - Study: 13.0% to 19.0%

**Countermeasures**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>1. Staff Meeting presentation by MMP on tools for ACP planning</td>
<td>2/27/2018</td>
</tr>
<tr>
<td>2. Email reminder that Advanced Care Planning should be included in pre-visit planning</td>
<td>5/4/2018</td>
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<tr>
<td>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.</td>
<td>11/19/2018</td>
</tr>
<tr>
<td>4. Action plan: KPI Reminder during morning huddles</td>
<td>Ongoing</td>
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<tr>
<td>5. Action plan: Emphasize ACP list as part of intern/resident education</td>
<td>Ongoing</td>
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<tr>
<td>6. Action plan: PSRS review upcoming appointments and put “ACP due” in appointment note, for patients missing Advanced Directives</td>
<td>Ongoing</td>
</tr>
<tr>
<td>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</td>
<td>Ongoing</td>
</tr>
<tr>
<td>8. Action plan: KPI Progress reviewed in weekly emails</td>
<td>Ongoing</td>
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</tbody>
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**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