ASCO's Quality Training Program

Improving Advance Care Planning and Documentation for UICC Patients

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University of Illinois Cancer Center (UICC)

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UIC Cancer Center Overview

University of Illinois
Hospital & Health Sciences System
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Quality Training Program

UNIVERSITY OF ILLINOIS
Hospital & Health Sciences System
Changing medicine. For good.

- **University cancer center**
  - 14 clinical faculty
  - 13 fellows
  - 11 chemo rooms; 19 chairs
  - 4.5 chemo RN; 3 clinic RN
  - 1 social worker → 0
  - Inpatient Palliative Care Team, new

- **June 2012 to Jan 2014**
  - 1,548 new patients
  - 13,497 established
  - 10,616 chemotherapy visits

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Diverse Patient Population

- 58.6% Medicare/Medicaid
- Significant population of minorities, lower socioeconomic and health literacy backgrounds, inmates
- Lots of advanced disease presentation at late stages, high comorbidities

Problem Statement

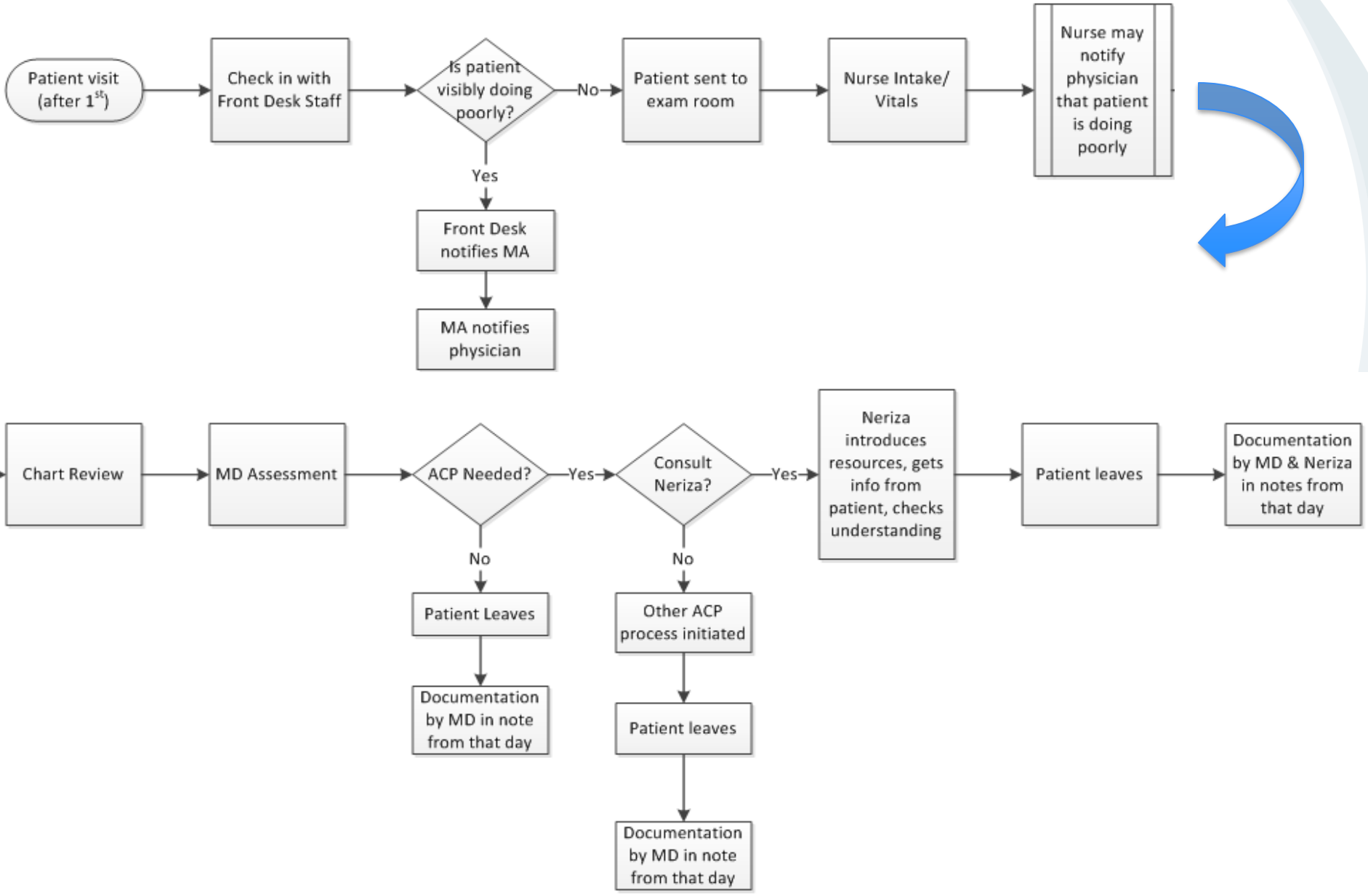
- **WHAT:** Advance care planning discussions in the ambulatory care setting are poorly documented.
  - 23% of patients currently receive advance care planning in the ambulatory care setting as documented in the last two clinic visits
  - 9% of our metastatic solid tumor patients are receiving advance care planning discussion in the ambulatory care setting documented by the 3rd visit.

- **WHO:** Metastatic solid tumor patients
- **WHERE:** Oncology clinic setting
- **WHEN:** Within 2 months or by the 3rd visit whichever is first
- **WHY:**
  - Prevent medically futile care at end of life
  - Improve communication about prognosis and goals of care early on
  - Increase hospice utilization and referrals from ambulatory setting
  - Promote aggressive symptom direct care for improved quality of life

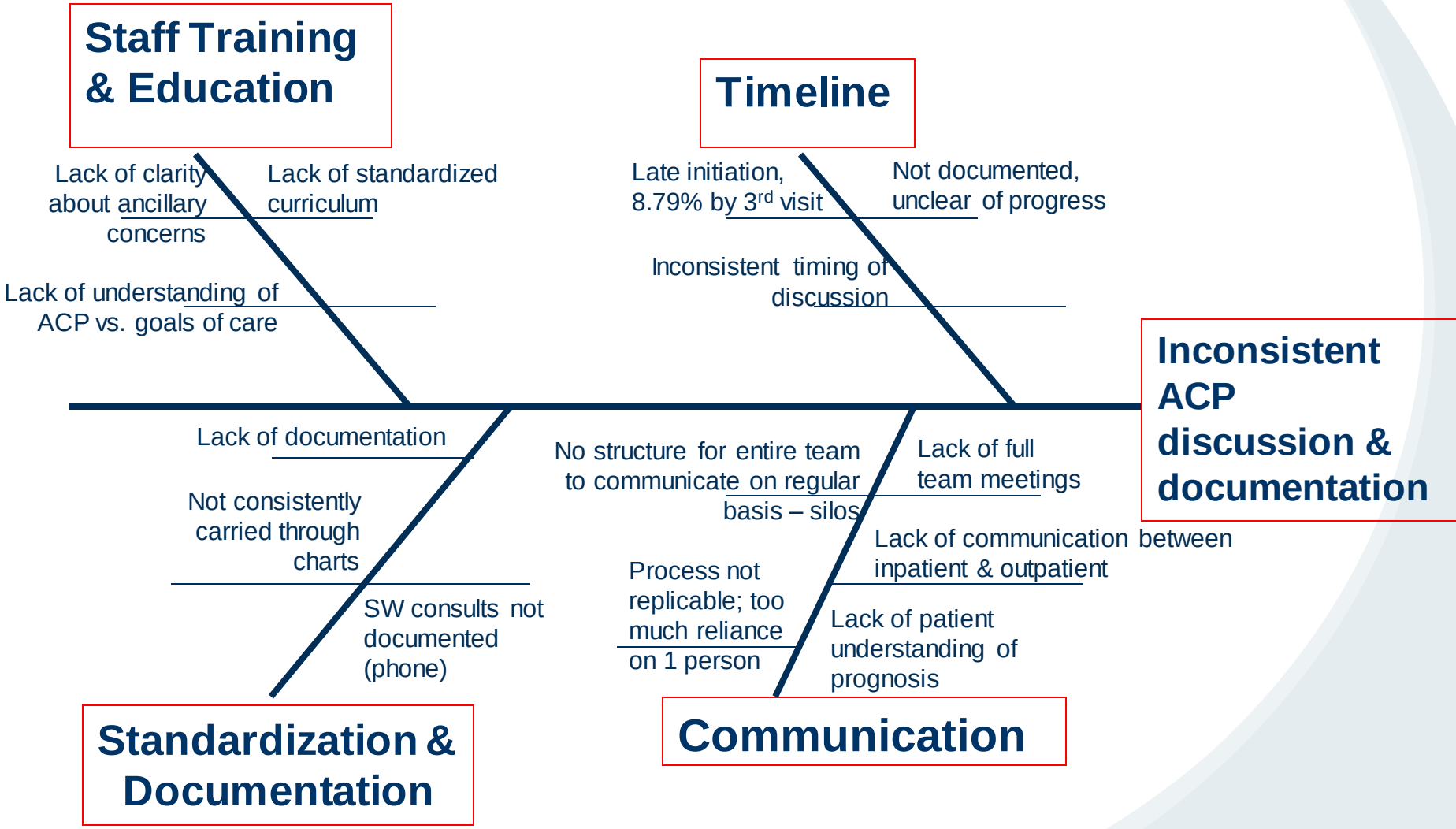
Team Members

Project Sponsor	Damiano Rondelli	Section Chief
Team Leader	Neeta Venepalli	GI Oncologist
Core Team Member	Gowri Ramadas	Oncology Fellow
Core Team Member	Polina Gorodinsky	Administrative Fellow
Facilitators	Gowri Ramadas, Polina Gorodinsky	
Team Member	Neriza Dumayas	Social Work, Outpatient
Team Member	Udai Jayakumar	Palliative Care Medical Director
Team Member	Greg Branen	Social Work, Inpatient
Team Member	Janet Golick	Nursing
Team Member, Guest	Dennis Chevalier	Director, Social Work
Team Member, Guest	Lydia Quinones	Intern, Social Work
Team Member, Guest	Hope Engeseth	Chaplain

Process Map


Patient visit (after 1st)
Check in with Front Desk Staff
Is patient visibly doing poorly?
No
Patient sent to exam room
Nurse Intake/ Vitals
Nurse may notify physician that patient is doing poorly
Yes
Front Desk notifies MA
MA notifies physician
Chart Review
MD Assessment
ACP Needed?
Yes
Consult Neriza?
Yes
Neriza introduces resources, gets info from patient, checks understanding
Patient leaves
Documentation by MD & Neriza in notes from that day
No
Patient Leaves
Documentation by MD in note from that day
No
Other ACP process initiated
Patient leaves
Documentation by MD in note from that day

Cause & Effect Diagram



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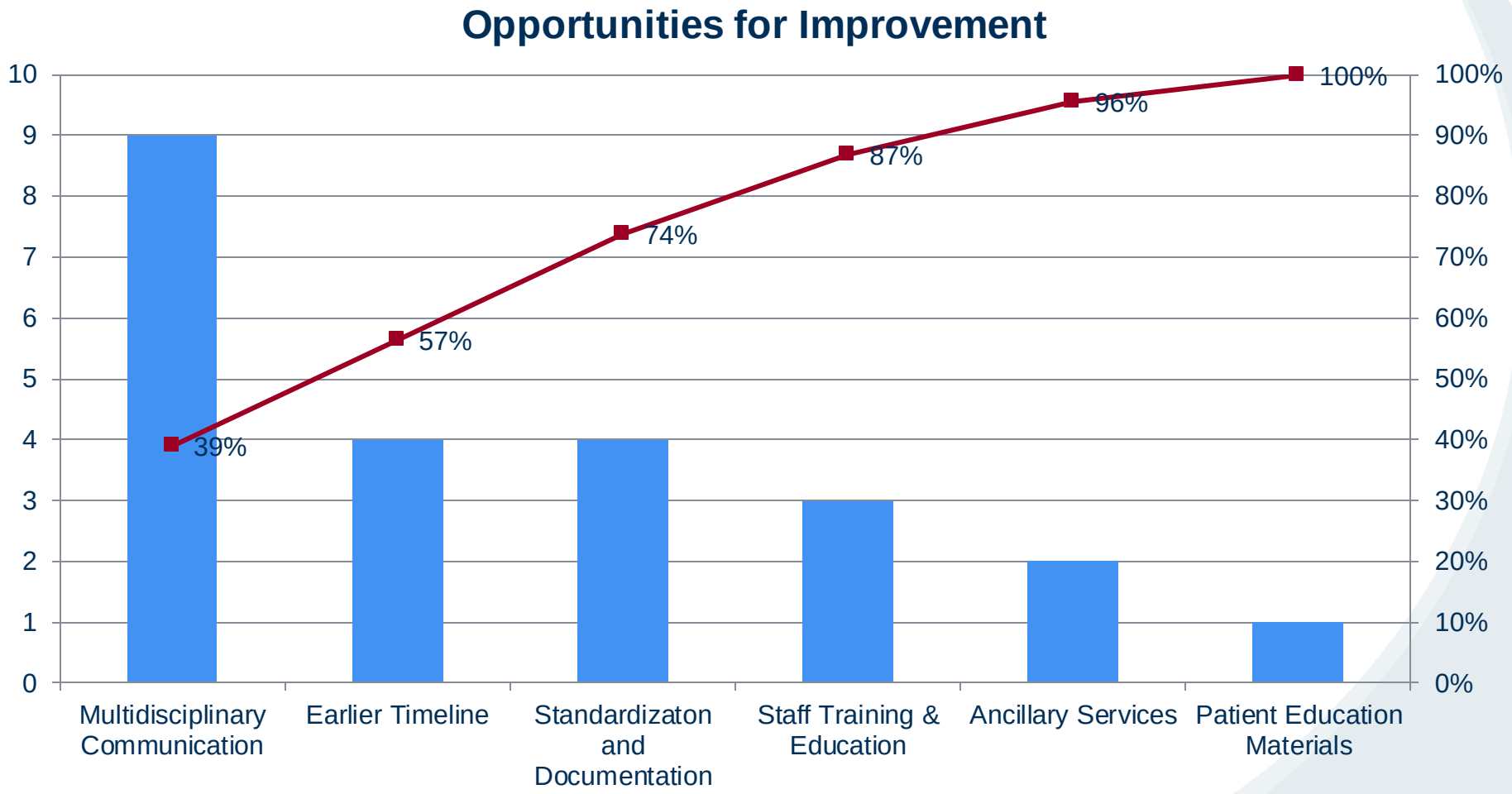
Diagnostic Data



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Aim Statement

- Process: Standardize advance care planning (ACP) discussion and documentation by 3rd visit, including patient understanding of goals.

- Outcome: By March 2014, increase ACP documentation to 75% of MD notes for patients with solid metastatic tumors.

Outcomes Measures

- What percentage of patients with metastatic solid tumors have documentation within MD notes of:
  - ACP within first two months of diagnosis?
  - ACP within last two oncology visits?
  - Advance care directive scanned to chart
  - Specifics of ACP listed in note

Process Measures

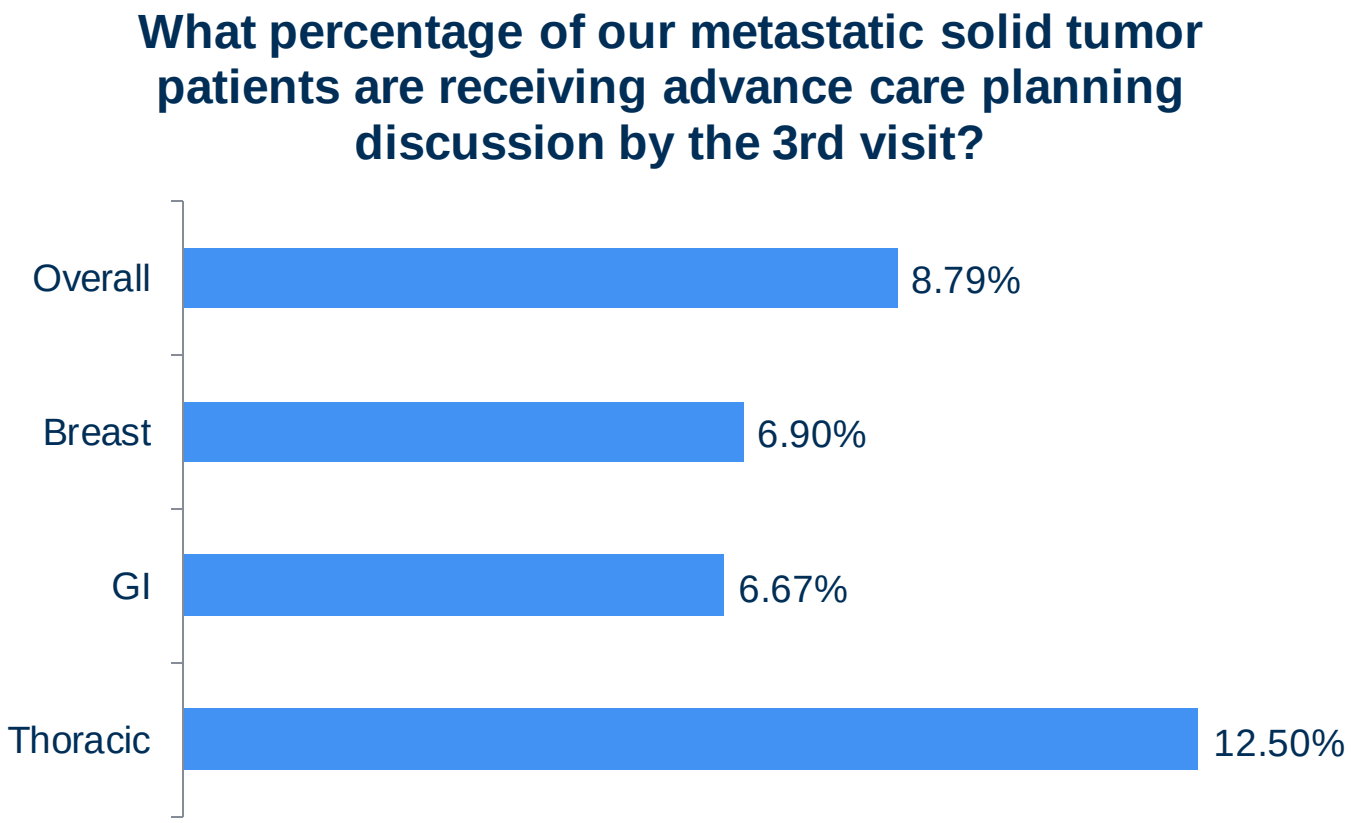
- For patients with ACP documented within the chart, who is initiating these discussions?

- What is the baseline knowledge and comfort level for initiating ACP discussions among fellows and nursing staff?

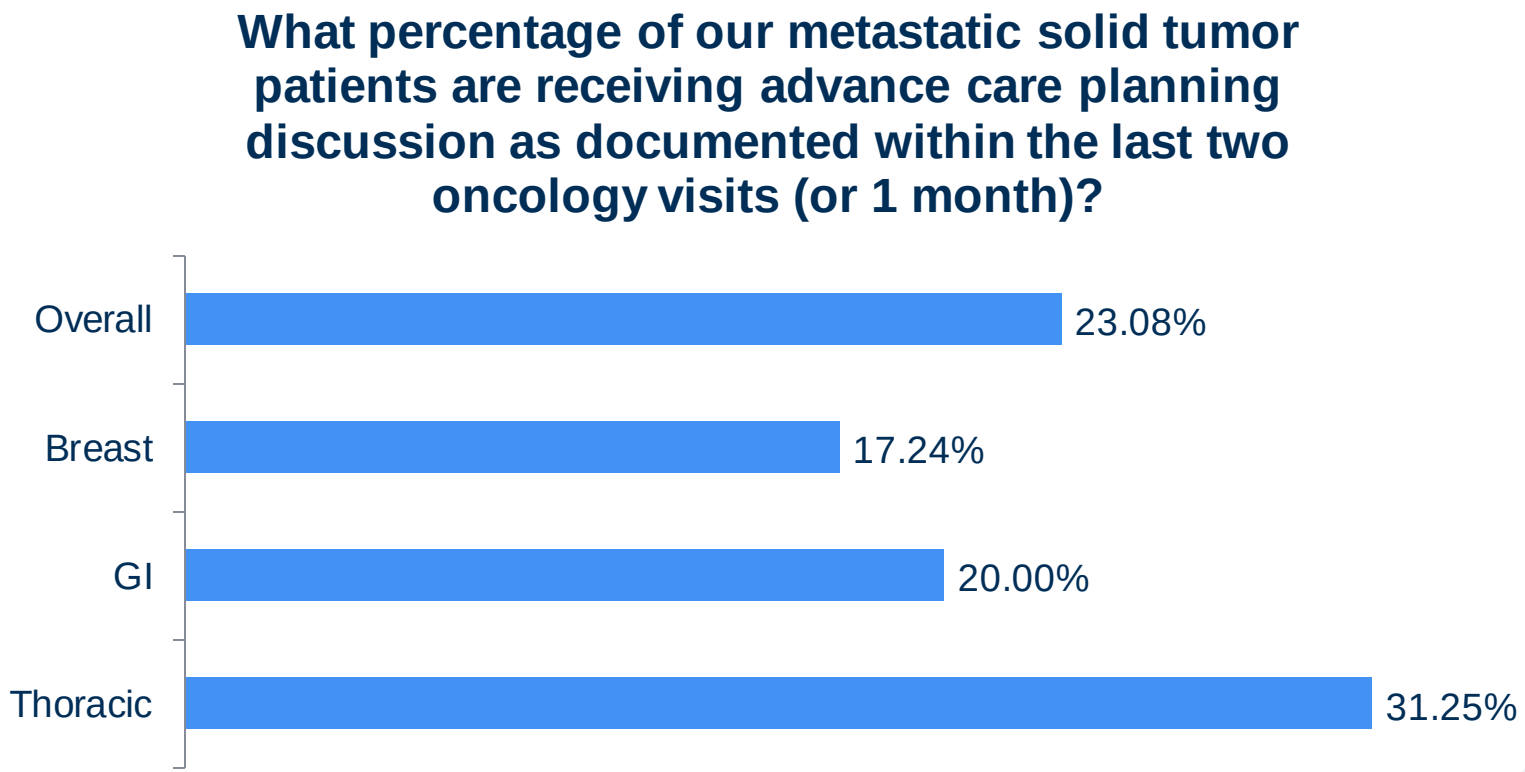
Methods

- Patient population: metastatic, solid tumor (breast, GI, thoracic), outpatient population (n=91)
  - Exclusions: other malignancies
- Retrospective chart review; N= 30 per tumor group, 4 attendings' clinics included
- Reviewed: MD notes (first 3 and last 2 visits), SW notes (any)
- Data limitations:
  - Missing information if documentation present during other visits
  - Other malignancies

Baseline Data



Baseline Data



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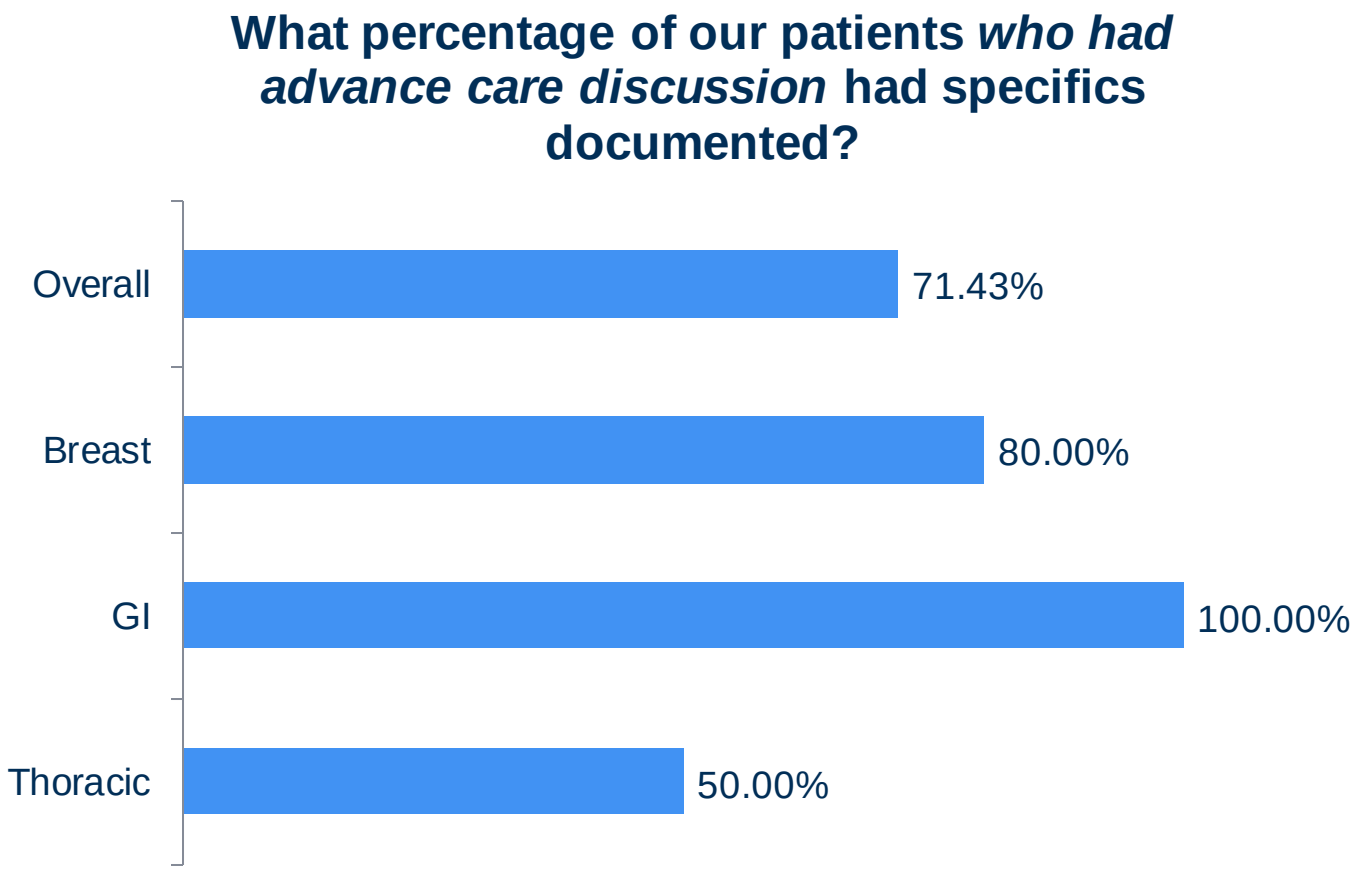

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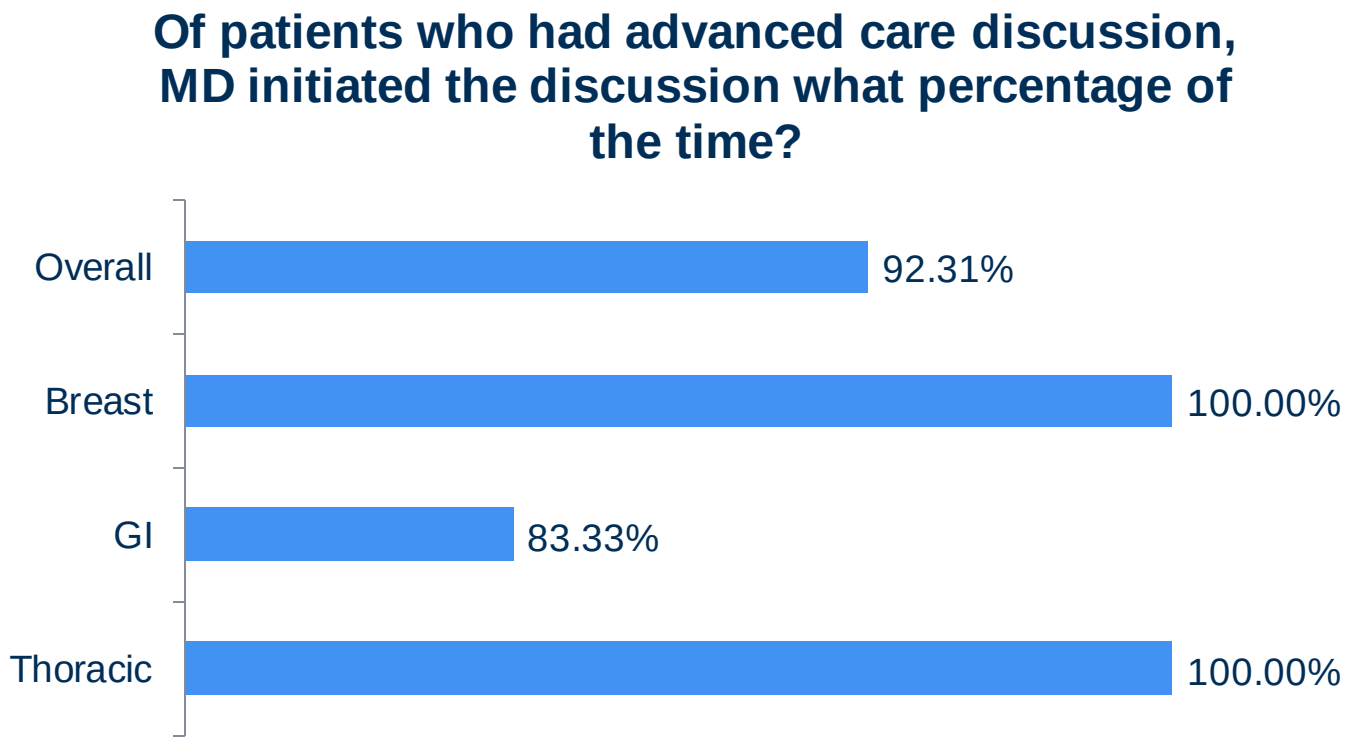
Baseline Data



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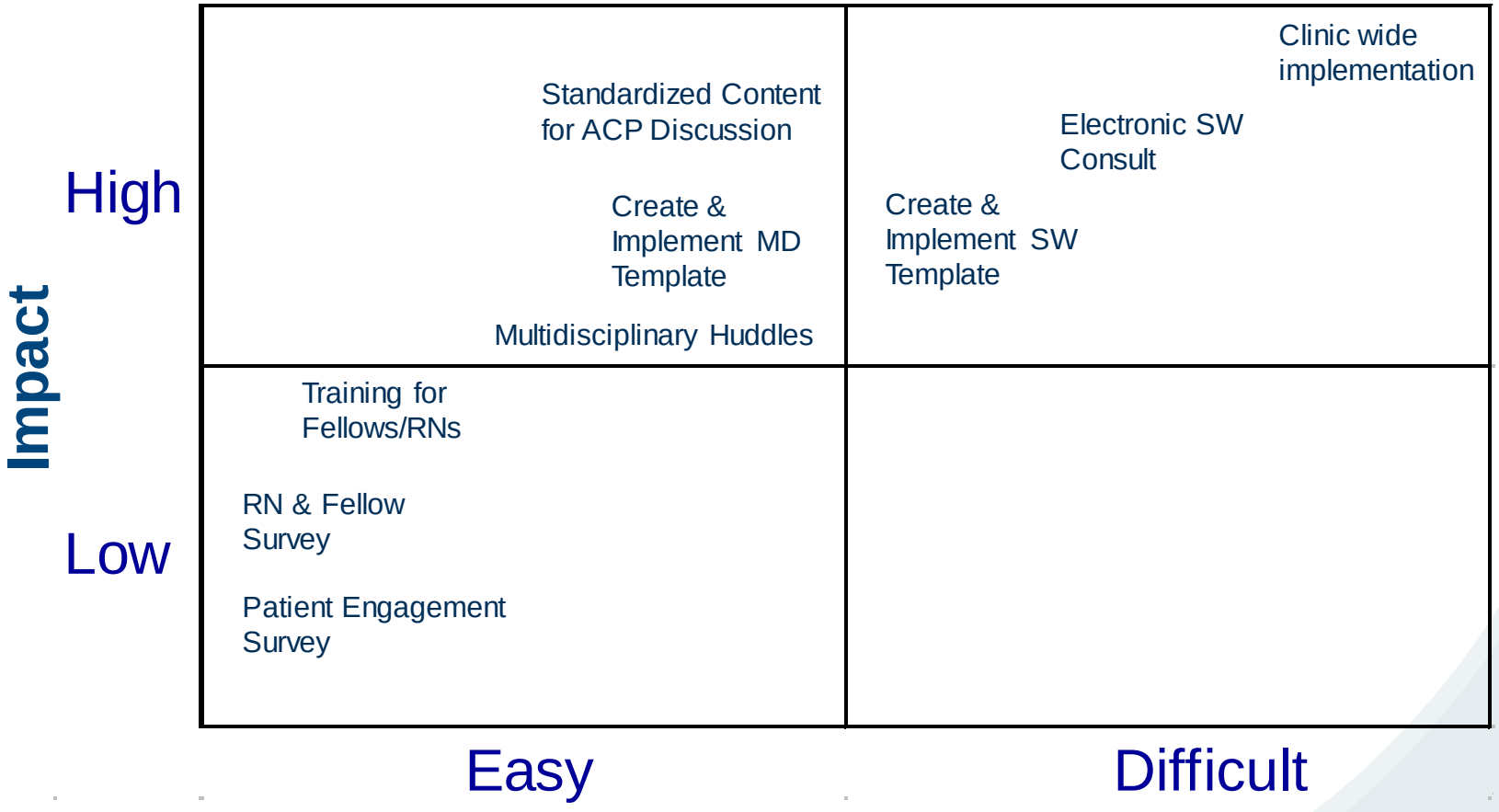
Prioritized List of Changes (Priority/Pay-Off Matrix)



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PDSA Plan (Tests of Change)

Date of PDSA cycle	Description of intervention	Results	Action steps
January 3 – March 4	Create & implement standardized MD template	Template created, validated, and piloted in 2 clinics Feb 10-March 4	Individualize to attending Expand use
January 3 – March 4	Create process for referral to SW, standardized SW template & content for discussion	Content formalized Template pilot ongoing Gaps in process identified	Continue process improvement via collaboration with SW
January 23 – February 28	Fellow training on initiating and improving ACP discussions	Training completed 3.4.14	Post fellow evaluation pending
February 3 – March 4	Multidisciplinary huddles	Piloted in 2 clinics with positive feedback	Expand use and administer RN ACP training
January 23 – March 4	Patient engagement survey	Modified 3x Piloted in 3 clinics 15 surveys	Continue

Materials (Pre Intervention)

- Baseline assessment of fellow and RN attitudes towards advance care planning discussions

- Questionnaires administered:
  - 11 fellows
  - 4 nurses
  - 1 MA

Fellow Survey ___ Year 1 ___ Year 2 ___ Year 3

1. Have you discussed code status with patients during fellowship?
   __ Yes __ No
2. Which setting has this discussion occurred most frequently?
   __ Inpatient __ Outpatient
3. Are you comfortable discussing code status in clinic with your patients?
   __ Yes __ No
4. Have you discussed Power of Attorney status with your patients in clinic?
   __ Yes __ No
5. Are you comfortable discussing Power of Attorney status with your patients?
   __ Yes __ No
6. Have you discussed goals of care with patients?
   __ Yes __ No
7. Which setting has this occurred most frequently?
   __ Inpatient __ Outpatient
8. Are you comfortable discussing goals of care in clinic with your patients?
   __ Yes __ No
9. Have you placed a social work consult to discuss the above topics in the outpatient setting?
   __ Yes __ No
10. Which topic is the hardest to discuss in clinic? Please rank with 1 being most difficult to 5 as easiest
   __ Code Status
   __ Advanced Care Planning
   __ Goals of Care
   __ Life Expectancy
   __ End of Life Symptom Management

Staff Survey RN MA Pharm SW Other

1. Have you initiated discussions of goals of care with patients in clinic?

__ Yes __ No

2. Have you discussed Advance Care Planning with patients in clinic such as Power of Attorney?

__ Yes __ No

3. Have you discussed Advance Care Planning with patients in clinic such as code status?

__ Yes __ No

4. Do your discussions happen when you are one on one with the patient, or when the physician, you and patient are all together?

One on One With MD With other team members: who___

5. Please rank your comfort level discussing goals of care, code status, and power of attorney (POA) with patients in clinic (1=not comfortable; 5=very comfortable)

Goals of care	1	2	3	4	5
Code status	1	2	3	4	5
POA	1	2	3	4	5

6. Whose responsibility is it to discuss these issues with the patient in clinic? (circle as many as applicable)

Goals of care	MD	RN	MA	Pharm	SW
Code status	MD	RN	MA	Pharm	SW
POA	MD	RN	MA	Pharm	SW

7. What is your comfort level with discussing patients' goals of care and prognosis with physicians, if you feel worried that the patient is not well? (1=not comfortable; 5=very comfortable)

1 2 3 4 5

8. Please rate communication between nurses, medical assistants, physicians about patients goals of care, and how patients are doing? (1=no communication; 5=excellent communication)

1 2 3 4 5

How should we improve communication?

9. Would you like more education on how to discuss these issues with patients?

__ Yes __ No __Indifferent

10. Do you feel physicians including fellows are comfortable discussing the above with patients in clinic?

__ Yes __ No

If no, please comment

Materials (Intervention)

- Provider:
  - Fellow and Attending Education on POLST/HPOA
  - ACP template for use in MD Notes
- Multidisciplinary communication:
  - Pre clinic meetings to discuss team concerns (RN, MA, SW, NP, fellow, MD)
- Social Work:
  - Standard curriculum/content for discussion and note
  - Infrastructure of SW ambulatory care ACP consults
- Patients: assessment of knowledge (of prognosis), and preference for ACP discussion

Advance Care Planning Template

Goals of Care, last discussed on date: _____

Intent of current treatment: _ Curative _Palliative

Intent of treatment discussed with pt: _ Yes _No

Estimated Prognosis:

__ Less than 6 months

__ More than 6 months

Patient aware of prognosis: _ Yes _No _Pt declined to know

Advance Care Planning, last discussed on date: _____

___ Power of Attorney identified

___ HPOA forms given to patient

___Code Status discussed __Full Code ___DNR/DNI

___POLST forms given to patient

___Social Work consult for Advanced Care Planning requested and placed

If Yes: _____Date requested

___Patient declined ACP discussion

Social Work Advance Care Planning

Power of Attorney Identified? ☐ Yes ☐ No

Name/Relationship:	Address	Phone Number(s)
Primary Agent:		
Secondary Agent:		

☐ Patient completed Advance Care Planning paperwork and copy sent to medical records to be scanned.

☐ Patient declined to complete Advance Care Planning paperwork.

☐ Patient has existing Advance Care Planning paperwork and will provide copy.
SW to follow up by phone in 1-2 weeks.

☐ Patient provided patient with Advance Care Planning paperwork, but requested to complete later
SW to follow up by phone in 1-2 weeks

Code Status ☐ Full ☐ DNR ☐ DNI

Three iterations, 15 patients

Patient Engagement Survey v 2.14.14

Goals of Treatment

1. What is the goal of your treatment?

__ Cure Disease __ Keep Cancer stable or shrink disease __ Do not know

2. Rate your knowledge of your treatment plan.

___ Fully Understand __ Somewhat Understand __ None

Advance Care Planning

1. What is your comfort level talking about Advance Care Planning, for example Power of Attorney status?

__ Very Comfortable __ Somewhat Comfortable __ Not at all

2. What is your knowledge of Advance Care Planning?

In terms of Power of Attorney?

___ Fully Understand __ Somewhat Understand __ None

In terms of Code Status?

___ Fully Understand __ Somewhat Understand __ None

3. Would you like more information regarding Advance Care Planning?

__ Yes __ No __ Indifferent

4. When do you want to talk about Advance Care Planning?

__ At time of diagnosis
__ At the start of treatment
__ End of Life (days to weeks)
__ Indifferent

Prognosis

1. What is your comfort level talking about an estimate of your life expectancy?

__ Very Comfortable __ Somewhat Comfortable __ Not at all

2. Rate your knowledge of your condition

___ Fully Understand __ Somewhat Understand __ None

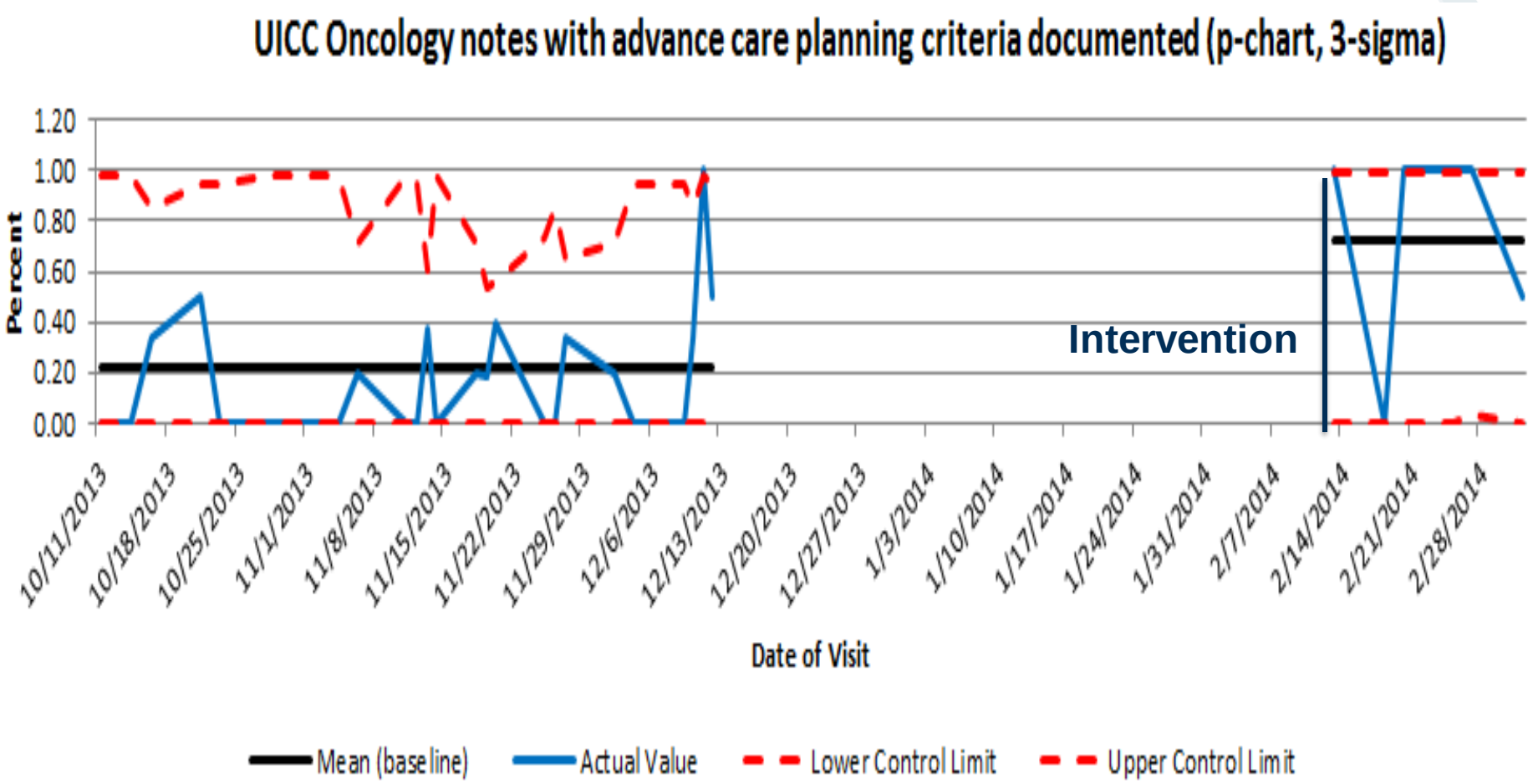
3. Do you want to know more information about your condition?

__ Yes __ No __ Indifferent

Change Data

- Chart review: Feb 10 to March 4th of all solid tumor metastatic patients in two clinics
  - ACP within first two months of diagnosis?
  - ACP within last two oncology visits?
  - Advance care directive scanned to chart
  - Specifics of ACP listed in note
  - Who initiated discussion?
- Results of patient engagement surveys
- Pending: post intervention assessment for fellows/RN

Change Data



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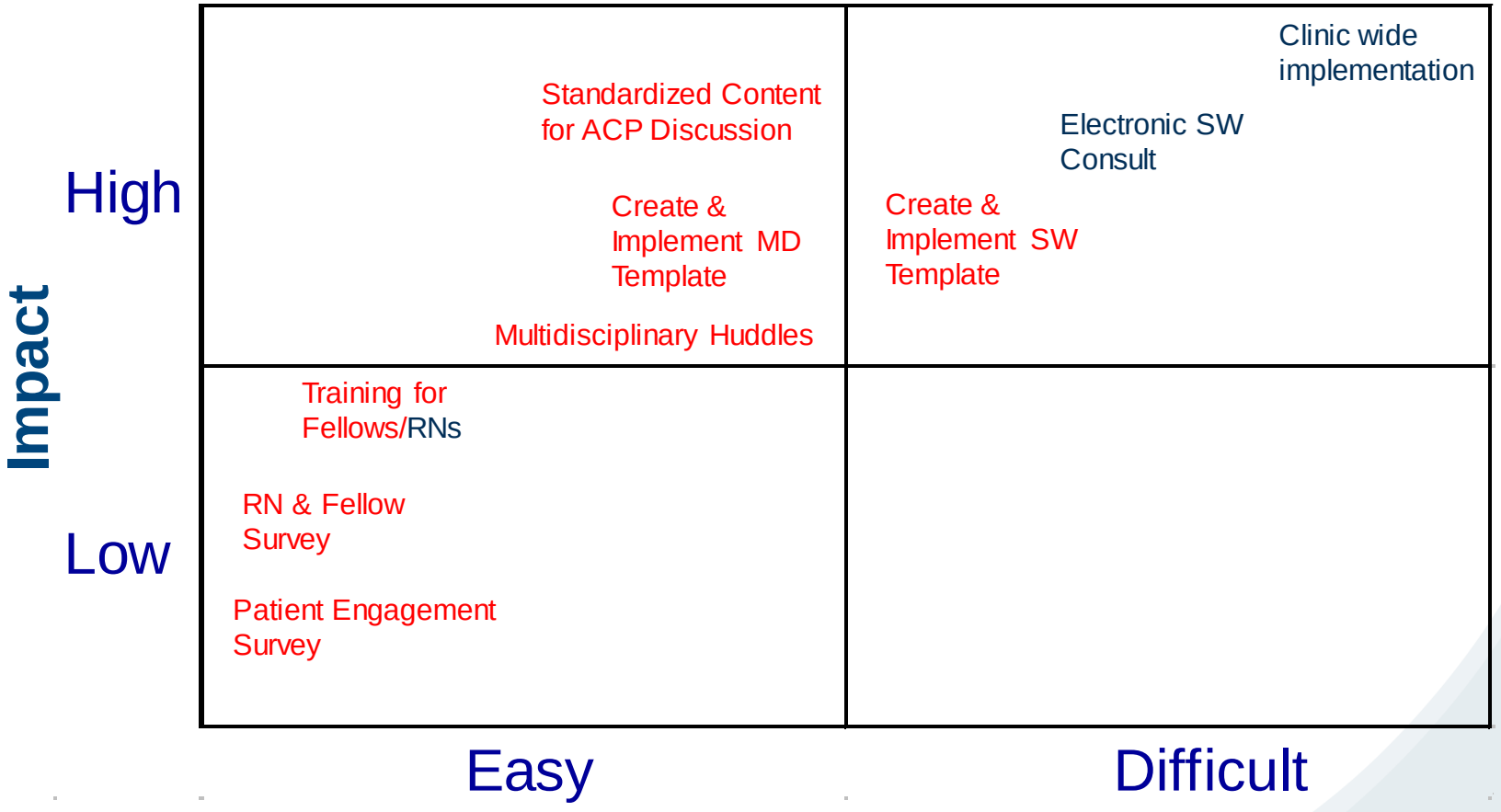
Conclusions

- Our data was not ideal for SPC analysis
- Limited data sets post intervention (7)
- Insufficient information to determine if new process is in control
- “Trend” is positive in terms of increased ACP documentation

Prioritized List of Changes (Priority/Pay-Off Matrix)



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Wins!

- Greater multidisciplinary engagement
- Effective and highly functional QI team
- Positive patient feedback
- Creation of new ACP infrastructure
- Expanded awareness of ACP

Challenges...

- Process: creating SW referral infrastructure
- Implementation: time and resource constraints
- Barriers: institutional (SW availability, EMR capability)
- Anticipated: MD engagement with pilot expansion, physical limitations of clinic and EMR

Next Steps/Plan for Sustainability

- Provider: buy in, clinic wide implementation of MD template and referral process, expand ACP process for all patients eventually
- Social work: ongoing validation of referral process, and ACP discussion process (content, template)
- IT: develop triggers for ACP discussion after second visit, improve utility of electronic SW consult
- Multidisciplinary: ongoing education for RN, MA, fellows, attendings; expand huddles
- Patients: formalize engagement survey, develop ACP information in patient portal

Neeta Venepalli, MD
Polina Gorodinsky, MHSA

University of Illinois Chicago Cancer Center

Improving Advance Care Planning for UICC Oncology Patients

AIM: Standardized advance care planning (ACP) discussion and documentation by 3rd visit, including patient understanding of goals; By March, 75% of patient charts will have completed ACP documentation template, ACP consult placed, or documentation of patient declining.

INTERVENTIONS:

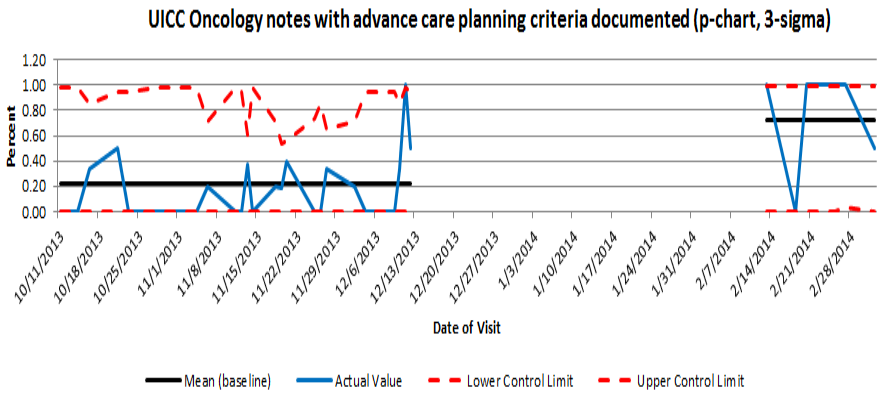
- Create and implement ACP template for MD and SW notes
- Develop standardized curriculum for ACP discussion for use by all staff
- Create process for ACP ambulatory care referrals for SW
- Increase multidisciplinary communication with pre clinic team huddle
- Involve patients early on through patient engagement questionnaire
- Expand fellows' curriculum with formal training in conducting ACP discussions

TEAM:

Dr. Neeta Venepalli
Dr. Gowri Ramadas
Polina Gorodinsky
Neriza Dumayas, SW
Dr. Udai Jayakumar
Greg Branen, SW
Janet Golick, RN
Lydia Quinones, SW
Dennis Chevalier, SW
Hope Engeseth, Chaplain

RESULTS:

1. **Insufficient data points to assess for process change**
2. **Favorable feedback from patients, social work, palliative care, nursing, fellows**
3. **Not included below: results from patient engagement questionnaire, RN and fellow surveys, feedback from fellows' didatic**



CONCLUSIONS:

- Greater multidisciplinary engagement
- Effective and highly functional team
- Positive patient feedback
- Creation of new ACP ambulatory care referral infrastructure

NEXT STEPS:

- Ongoing education: RN, fellows, attendings
- Ongoing education and involvement: patients
- Continue to validate and improve ACP ambulatory care referral process
- Obtain buy in from other attendings and nurses
- **Broaden pilot to clinic wide**

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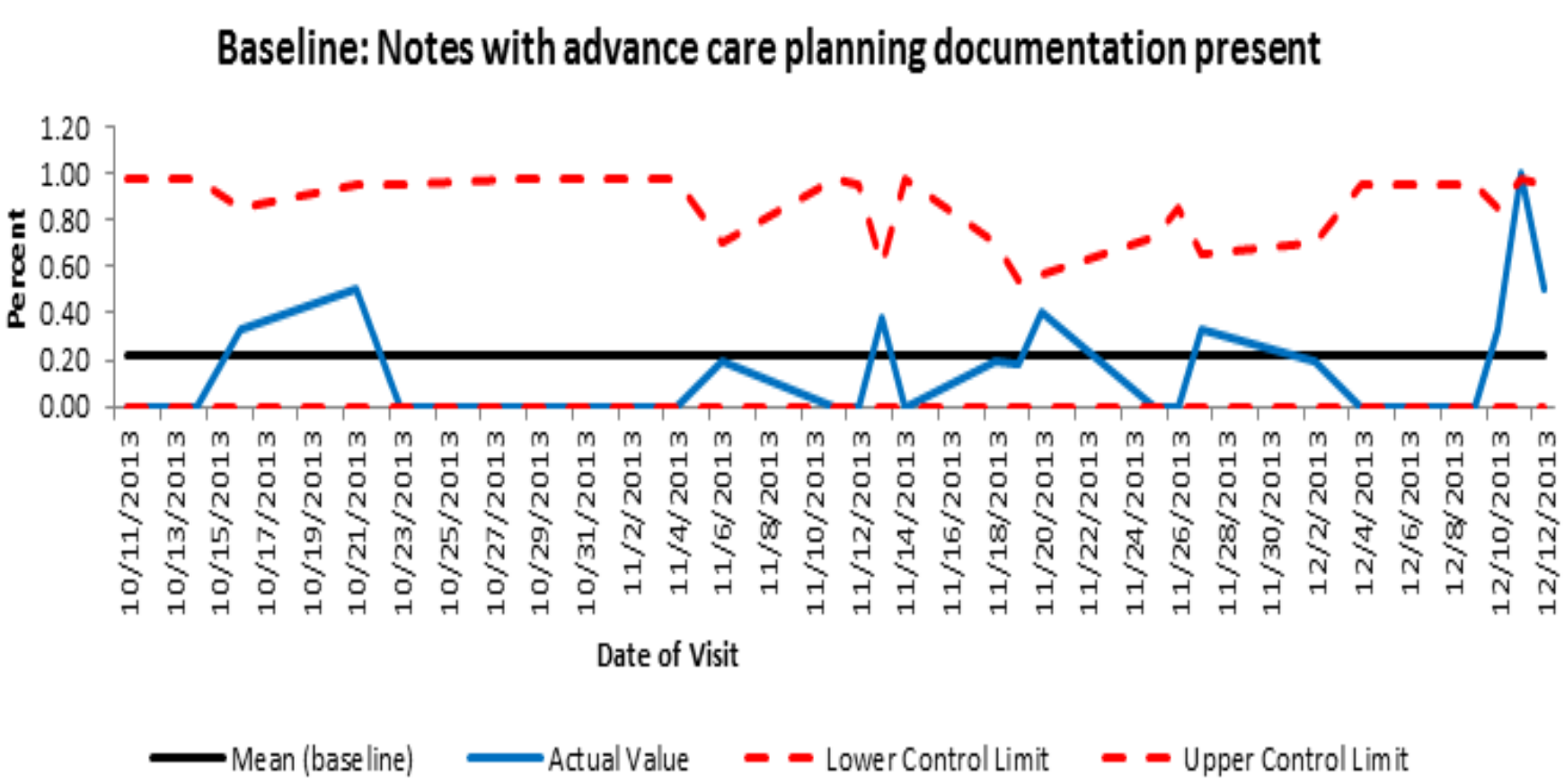
45 days of measurable snow this season…and counting

Courtesy of Google

Appendix

Change Data: Part A



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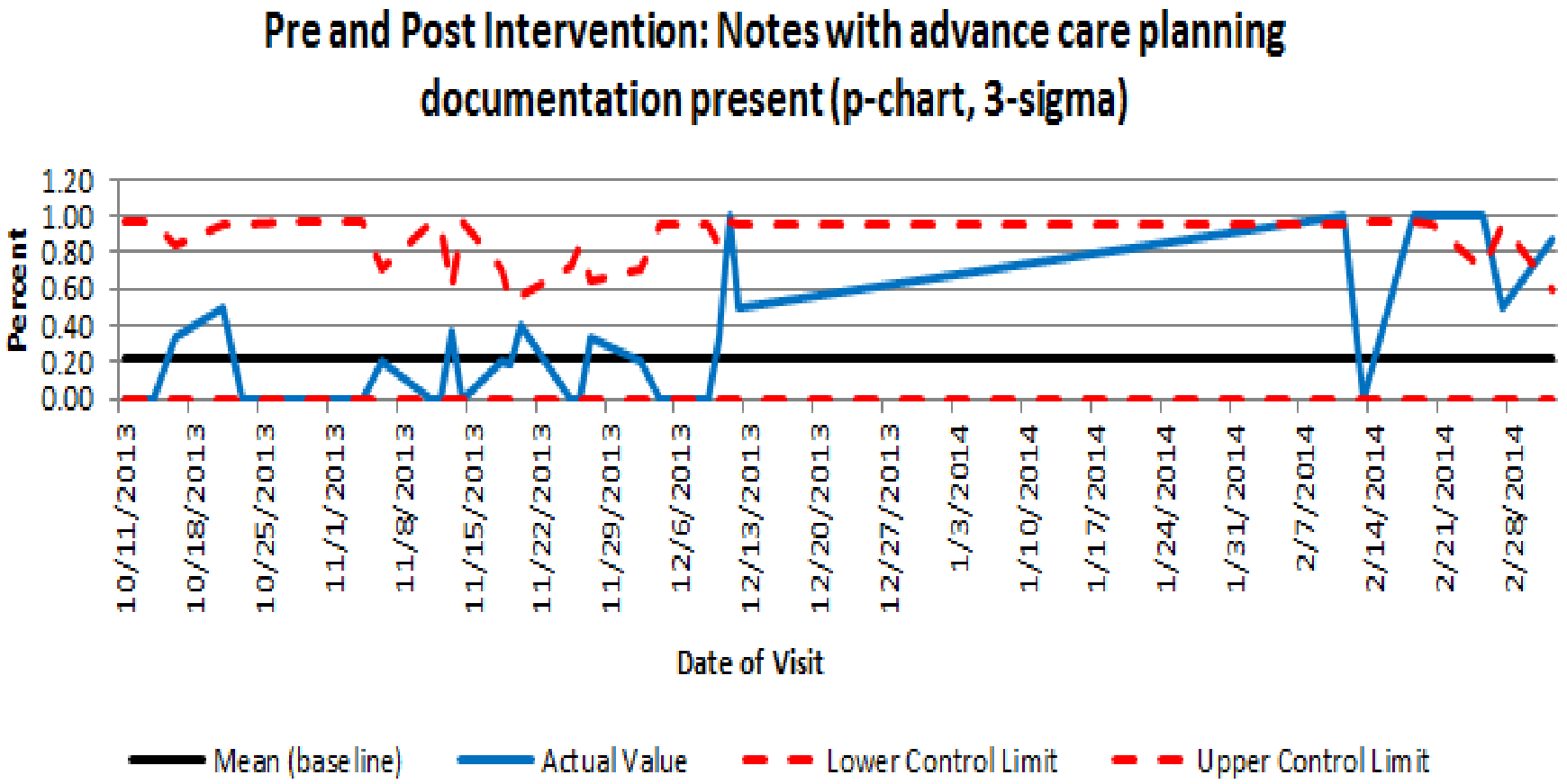
Change Data: Part B



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