Advance Care Planning (ACP) Pilot

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1 Background

Improved communication regarding advance care planning (ACP) between patients, surrogates and clinicians is associated with positive outcomes during end of life decisions. This includes, but is not limited to, less aggressive interventions, more goal oriented care delivered and an increase in palliative measures used at the end of life (Lamas et al., 2018). The Johns Hopkins Alliance for Patients (JMAP) developed and implemented a process to engage patients and their families in discussions about ACP with primary care providers at JHCP Frederick.

2 Objectives

(1) Establish a process to incorporate ACP into primary care;
(2) Empower, educate and train primary care providers to offer patient-centered ACP services to patients and their families;
(3) Engage patients and their families and/or caregivers in the process of establishing an advance directive (AD), Maryland Order for Life Sustaining Therapy (MOLST), and/or health care proxy;
(4) Improve the quality, and value of services provided to Medicare patients;
(5) Establish reporting to track success.

3 Methods

During the months of April, May and June in 2017, over 1,000 ACP letters were sent to patients who were 65 years and older, and were scheduled for an upcoming appointment. This intervention was implemented to initiate ACP discussions in the primary care setting and to encourage patients to develop an AD and/or MOLST. The documentation was then reviewed at the next primary care visit to ultimately be uploaded to the patient's electronic medical record (EMR) in Epic. If the patient did not receive the standard ACP letter, a letter was provided to them at the appointment. After the three months, each chart was reviewed to determine how many patients increased ACP documentation. For more details on this process, please see the advance care planning workflow (right).

4 Results

There were 226 prior documented MOLSTs which increased to 383 after the intervention, illustrating that 157 patients returned with new MOLST. This was a 70% increase in MOLST documentation.

There were 152 prior documented ADs which increased to 264 ADs after the intervention, illustrating that 112 patients returned with new AD. This was a 74% increase in AD documentation.

Advanced Directive and MOLST Completion Over 3 month pilot
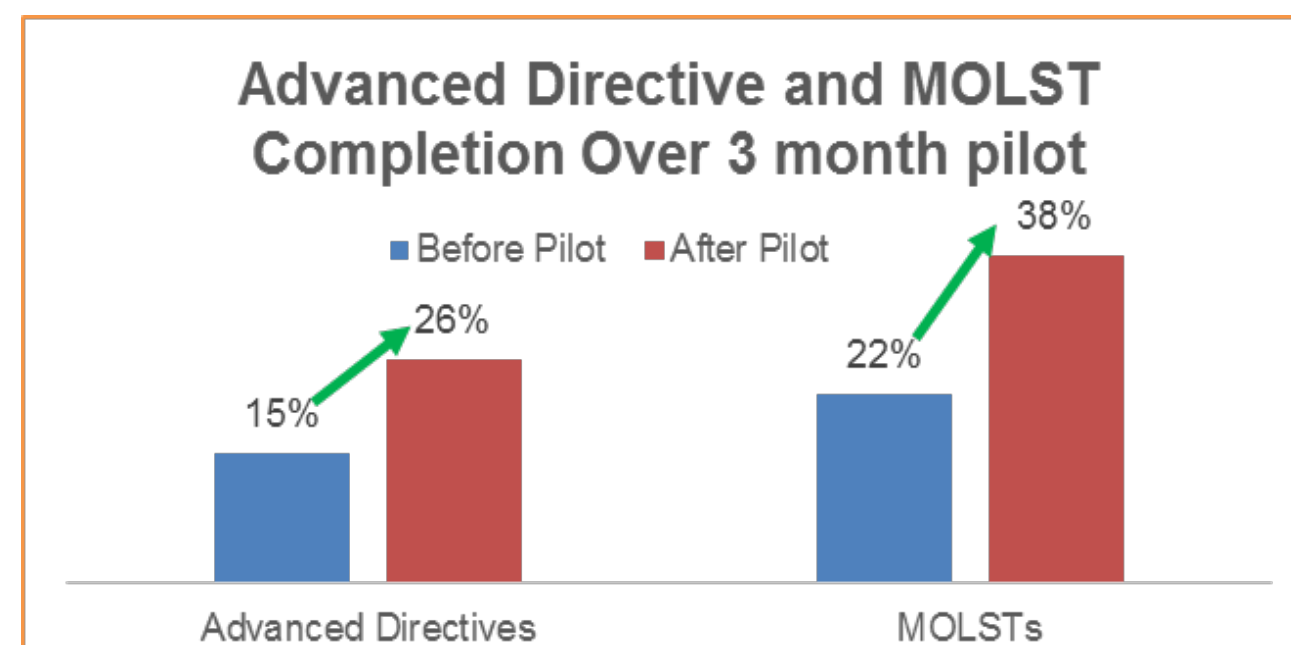
MOLST – Medical Orders for Life-Sustaining Treatment form

Overall, ACP documentation, including both AD and MOLST increased. Prior to the pilot, 311 patient records included ACP documentation. Over three months 202 more patients completed ACP documentation resulting in a total 513. This project increased the documentation rate from 30% to 50% of the patient population.

	Old Documentation	New Documentation	Total pt count
April	91	81	338
May	112	59	335
June	108	62	345
Total	**311**	**202**	**1018**

Provider documentation and ACP communication was also tracked. Out of the 1,018 patients seen over three months, 340 patients had documented discussions with their provider. Of these conversations, 33 were personalized, whereas 307 of these conversations were included in the patient instructions as a template given to patients with information on ACP.
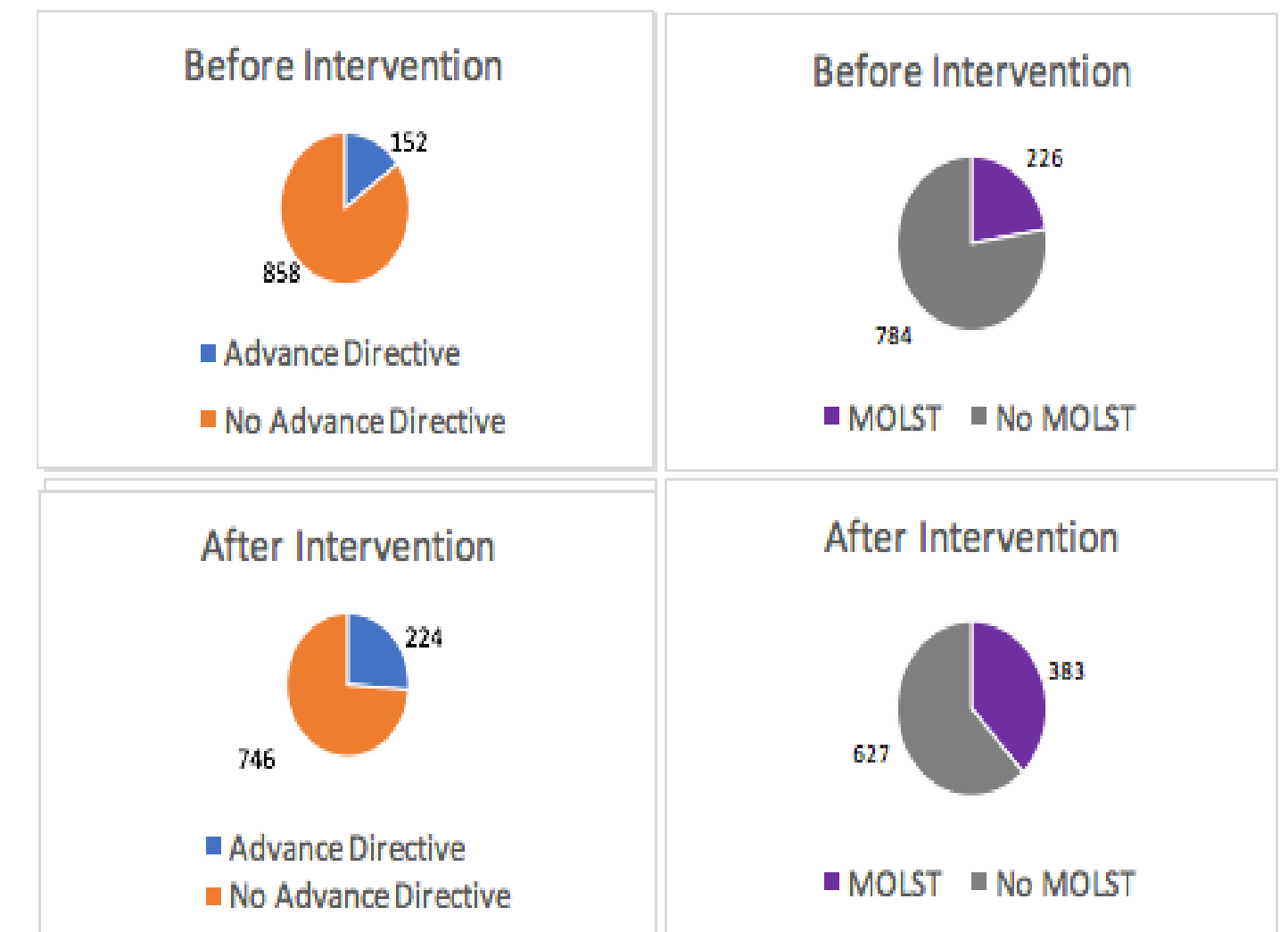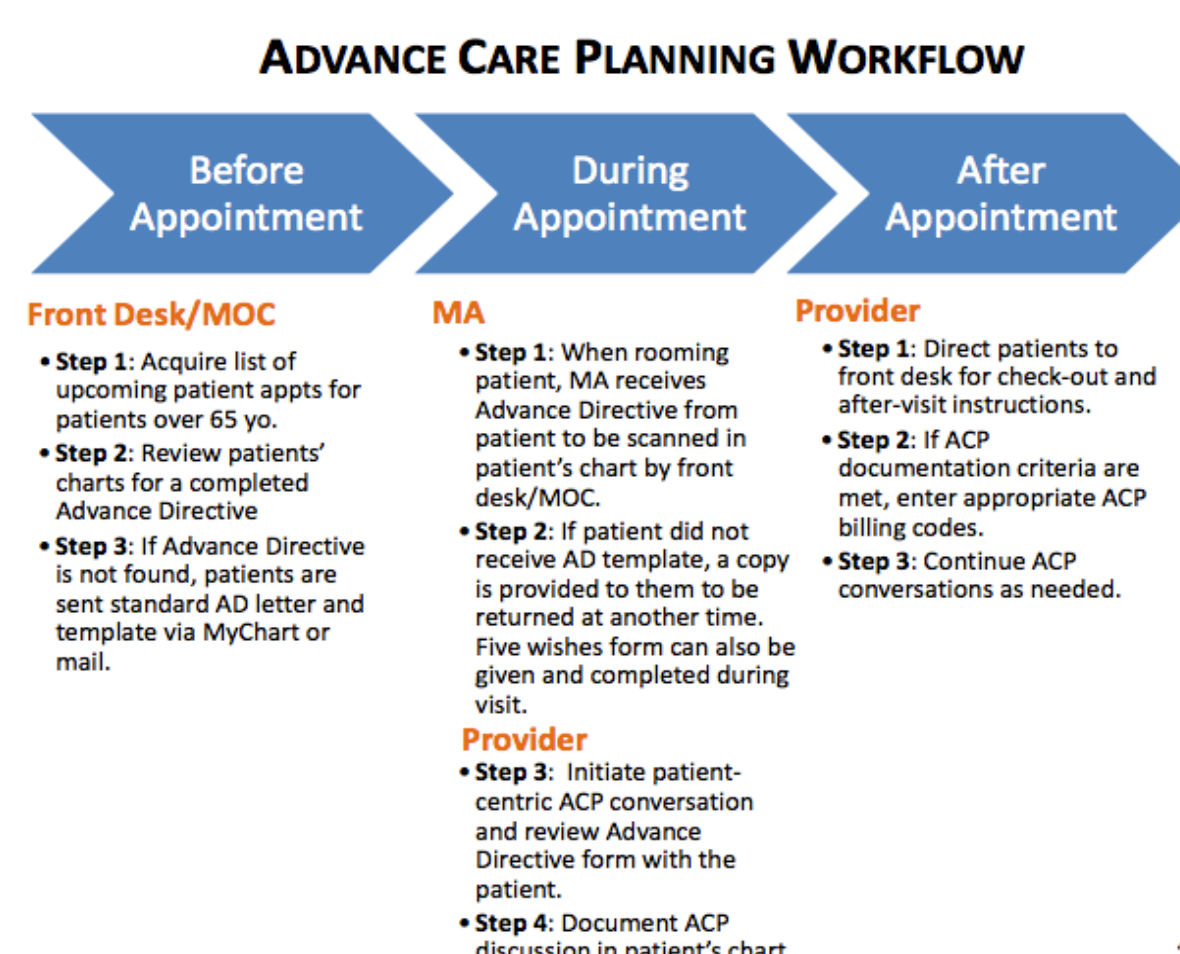
5 Conclusions

This project highlights the importance of health care professionals actively engaging in advance care planning with patients. These results suggest that having an ACP reminder and/or a discussion with a health care provider increases the incidence of documentation on patient EMRs, which can greatly improve the quality of interventions and outcomes during end of life decisions.

6 Future Directions

It is important to implement this intervention in other health care settings in order to improve rates of ACP documentation and improve the quality of end of life decisions. Although the Medicare population is a great starting point for this pilot, this intervention should be done for any patient without ACP documentation uploaded to their EMR.

7 References

Lamas, D., Panariello, N., Henrich, N., Hammes, B., Hanson, L. C., Meier, D. E., & Block, S. (2018). Advance care planning documentation in electronic health records: Current challenges and recommendations for change. *Journal of palliative medicine*.

ADVANCE CARE PLANNING WORKFLOW

Before Appointment → During Appointment → After Appointment

Front Desk/MOC
- **Step 1:** Acquire list of upcoming patient appts for patients over 65 yo.
- **Step 2:** Review patients' charts for a completed Advance Directive
- **Step 3:** If Advance Directive is not found, patients are sent standard AD letter and template via MyChart or mail.

MA
- **Step 1:** When rooming patient, MA receives Advance Directive from patient to be scanned in patient's chart by front desk/MOC.
- **Step 2:** If patient did not receive AD template, a copy is provided to them to be returned at another time. Five wishes form can also be given and completed during visit.

Provider
- **Step 3:** Initiate patient-centric ACP conversation and review Advance Directive form with the patient.
- **Step 4:** Document ACP discussion in patient's chart.

Provider
- **Step 1:** Direct patients to front desk for check-out and after-visit instructions.
- **Step 2:** If ACP documentation criteria are met, enter appropriate ACP billing codes.
- **Step 3:** Continue ACP conversations as needed.

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