ASCO’s Quality Training Program

Improving Advance Care Planning and Documentation for UICC Patients

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Ms. Polina Gorodinsky, MHSA
University of Illinois Cancer Center (UICC)

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• **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
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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Project Sponsor</td>
<td>Damiano Rondelli</td>
<td>Section Chief</td>
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<tr>
<td>Team Leader</td>
<td>Neeta Venepalli</td>
<td>GI Oncologist</td>
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<tr>
<td>Core Team Member</td>
<td>Gowri Ramadas</td>
<td>Oncology Fellow</td>
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<tr>
<td>Core Team Member</td>
<td>Polina Gorodinsky</td>
<td>Administrative Fellow</td>
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<tr>
<td>Facilitators</td>
<td>Gowri Ramadas, Polina Gorodinsky</td>
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<tr>
<td>Team Member</td>
<td>Neriza Dumayas</td>
<td>Social Work, Outpatient</td>
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<td>Team Member</td>
<td>Udai Jayakumar</td>
<td>Palliative Care Medical Director</td>
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<tr>
<td>Team Member</td>
<td>Greg Branen</td>
<td>Social Work, Inpatient</td>
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<tr>
<td>Team Member</td>
<td>Janet Golick</td>
<td>Nursing</td>
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<td>Team Member, Guest</td>
<td>Dennis Chevalier</td>
<td>Director, Social Work</td>
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<tr>
<td>Team Member, Guest</td>
<td>Lydia Quinones</td>
<td>Intern, Social Work</td>
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<tr>
<td>Team Member, Guest</td>
<td>Hope Engeseth</td>
<td>Chaplain</td>
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Cause & Effect Diagram

**Staff Training & Education**
- Lack of clarity about ancillary concerns
- Lack of understanding of ACP vs. goals of care
- Lack of standardized curriculum
- Lack of documentation
- Not consistently carried through charts
- SW consults not documented (phone)

**Timeline**
- Late initiation, 8.79% by 3rd visit
- Inconsistent timing of discussion
- Not documented, unclear of progress

**Standardization & Documentation**
- No structure for entire team to communicate on regular basis – silos
- Lack of full team meetings
- Lack of communication between inpatient & outpatient

**Communication**
- Process not replicable; too much reliance on 1 person
- Lack of patient understanding of prognosis

Inconsistent ACP discussion & documentation
Diagnostic Data

Opportunities for Improvement

- Multidisciplinary Communication: 39%
- Earlier Timeline: 57%
- Standardization and Documentation: 74%
- Staff Training & Education: 87%
- Ancillary Services: 96%
- Patient Education Materials: 100%
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
What percentage of our metastatic solid tumor patients are receiving advance care planning discussion by the 3rd visit?

- Overall: 8.79%
- Breast: 6.90%
- GI: 6.67%
- Thoracic: 12.50%
What percentage of our metastatic solid tumor patients are receiving advance care planning discussion as documented within the last two oncology visits (or 1 month)?

- Overall: 23.08%
- Breast: 17.24%
- GI: 20.00%
- Thoracic: 31.25%
What percentage of our patients who had advance care discussion had specifics documented?

- Overall: 71.43%
- Breast: 80.00%
- GI: 100.00%
- Thoracic: 50.00%
Of patients who had advanced care discussion, MD initiated the discussion what percentage of the time?

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<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Overall</td>
<td>92.31%</td>
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<tr>
<td>Breast</td>
<td>100.00%</td>
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<tr>
<td>GI</td>
<td>83.33%</td>
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<tr>
<td>Thoracic</td>
<td>100.00%</td>
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# Prioritized List of Changes (Priority/Pay-Off Matrix)

<table>
<thead>
<tr>
<th>Impact</th>
<th>Ease of Implementation</th>
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<tbody>
<tr>
<td>High</td>
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<td></td>
<td>Standardized Content</td>
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<td>for ACP Discussion</td>
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<td>Create &amp; Implement MD</td>
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<td>Template</td>
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<td>Multidisciplinary Huddles</td>
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<td>Electronic SW Consult</td>
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<td>Create &amp; Implement SW</td>
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<td>Low</td>
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<td>Training for Fellows/RNs</td>
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<td>RN &amp; Fellow Survey</td>
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<td>Patient Engagement</td>
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<td>Survey</td>
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<td>Clinic wide</td>
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<tr>
<td></td>
<td>implementation</td>
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# PDSA Plan (Tests of Change)

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

<table>
<thead>
<tr>
<th>Name/Relationship:</th>
<th>Address</th>
<th>Phone Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Agent:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Agent:</td>
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</tbody>
</table>

- 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

UICC Oncology notes with advance care planning criteria documented (p-chart, 3-sigma)

Date of Visit

- Mean (baseline)
- Actual Value
- Lower Control Limit
- Upper Control Limit

Intervention
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)

- **High Impact**
  - Standardized Content for ACP Discussion
  - Create & Implement MD Template
  - Multidisciplinary Huddles
  - Electronic SW Consult
  - Create & Implement SW Template
  - Clinic wide implementation

- **Low Impact**
  - Training for Fellows/RNs
  - RN & Fellow Survey
  - Patient Engagement Survey

- **Easy**
- **Difficult**

Ease of Implementation
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
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.

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

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

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’ didactic

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

![Graph: UICC Oncology notes with advance care planning criteria documented (p-chart, 3-sigma)]
45 days of measurable snow this season...and counting
Appendix
Change Data: Part A
Change Data: Part B

Pre and Post Intervention: Notes with advance care planning documentation present (p-chart, 3-sigma)

Date of Visit

- Mean (baseline)
- Actual Value
- Lower Control Limit
- Upper Control Limit