Project Title: Increase the percent of advance directives in patient medical records

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Institution: Tennessee Oncology, PLLC

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Institutional Overview

Tennessee Oncology is one of the nation’s leading organizations of cancer care specialists and is nationally recognized for clinical trial research and innovation in patient care.

We are one of the largest physician-owned practices in the country with nearly 80 physician partners in 30 locations throughout Middle and Southeast Tennessee.

We offer a comprehensive range of cancer care services including specialized oncology nursing care, laboratory services, outpatient chemotherapy, palliative care, specialty pharmacy, PET/CT services and patient education and support services.
Advance care planning is often initiated too late and well into a serious illness. This leads to added stress and high resource utilization at the end of life which is contrary to many patients’ wishes.\textsuperscript{1,2} Ideally, discussions about what is important to patients should start early.\textsuperscript{2}

An advance directive (AD) documents patient preferences for end-of-life care. It is estimated, that 25-50\% of new cancer diagnosis patients in our clinic have an existing AD, while less than 2\% of patients have an AD in their medical record.
Team Members

**Leader:** Christopher Waynick, M.D.

**Members:** Victor Gian, M.D.; Jan Conwill, Regional Operations Manager; Ellen Distefano, QTP Improvement Coach
Jani Sarratt, Process Improvement Specialist; Lynne Martin, RN; Kathryn Grant, NP; Carrie Toombs, Patient Navigator; Nidhi Tammareddi, Patient Navigator; Karissa Cagle, Front Office

**Project Sponsor:** Jeff Patton, M.D.; CEO
Tennessee Oncology, PLLC
Process Map

Advance Directive (AD) Screening and Scanning Process

New Patient Referral

- New patient packet sent

Ask Patient if they have an existing AD, at appointment

- Nobody asks the patient if they have an AD
- No information is offered to the patient if they do not have an AD

Ask patient to bring their AD to the next appointment

- There is no request to bring AD to appointment

Does patient have an existing AD

- Yes: Did Patient Bring AD
- No: Offer patient information on AD

Did Patient Bring AD

- Yes: Scan AD into EMR
- No: AD in EMR

Scan AD into EMR

AD in EMR

There is no standard process of what to do with an AD if a patient brings one
ACP is often initiated too late and well into a serious illness. This leads to added stress and high resource utilization at the End-of-life which is contrary to many patients’ wishes.
Pareto Chart

Categories:
- No one asks the patient for AD
- Physicians don’t discuss
- Lack of staff training
- No follow-up to ask later, after initial visit
- No knowledge of AD/misunderstanding of legality
- Referred to as DNR, not AD
- Doesn’t have one / fearful of creating one
- Forgot / lost it
- Other

Counts:
- No one asks the patient for AD: 13
- Physicians don’t discuss: 14
- Lack of staff training: 11
- No follow-up to ask later, after initial visit: 10
- No knowledge of AD/misunderstanding of legality: 9
- Referred to as DNR, not AD: 8
- Doesn’t have one / fearful of creating one: 7
- Forgot / lost it: 6
- Other: 5

Percentages:
- 13.9%
- 14.3%
- 27.5%
- 39.6%
- 50.5%
- 60.4%
- 69.2%
- 76.9%
- 83.5%
- 89.0%

Axes:
- PARETO CHART
- Categories

Values:
- 0
- 10
- 20
- 30
- 40
- 50
- 60
- 70
- 80
- 90
- 100

Values:
- 0.0%
- 10.0%
- 20.0%
- 30.0%
- 40.0%
- 50.0%
- 60.0%
- 70.0%
- 80.0%
- 90.0%
- 100.0%
Diagnostic Data

- A view of 79 new patient’s medical records, with a cancer diagnosis, ≥ 65 years old, who had a visit within 30-days of their first appointment, who were seen between January 1, 2017 and March 31, 2017 revealed:
  - 25.58% of these patients claimed to have an AD
  - 5% of these patients had an AD documented in the record within 30 days after first visit.

- Observation and staff interviews findings:
  - Process for screening for AD is unknown
  - Process for collecting and scanning into the medical record is not followed.
  - Staff are unfamiliar with AD in general.
Aim Statement

This project aims to increase the percent of AD in the medical record of new patients, with a cancer diagnosis $\geq$ 65 years old, who had a visit within 30-days of their first appointment, and noted to have an AD to at least 20% by October 1st.
Measures

- **Measure:** Percent of new patients, with a cancer diagnosis, ≥ 65 years old, who had a visit within 30-days of their first appointment, who have an AD in their medical records.

- **Patient Population:** New patients, with a cancer diagnosis, ≥ 65 years old, who have had a visit within 30-days of their first appointment.

- **Calculation methodology:**
  - **Numerator:** Number of new patients, with a cancer diagnosis, ≥ 65 years old, who had a visit within 30-days of their first appointment, who have an AD in their medical records.
  - **Denominator:** Number of new patients, with a cancer diagnosis ≥ 65 years old, who have had a visit within 30-days of their first appointment.

- **Data source:** Medical record review.

- **Data collection frequency:** 3-weeks post implementation/test of change.

- **Data quality (any limitations):** none
Baseline Data

5% of new patients, with a cancer diagnosis $\geq 65$ years old, who had a visit within 30-days of their first appointment, and noted to have an AD, actually had an AD in their medical records
<table>
<thead>
<tr>
<th>Impact</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ease of Implementation</td>
<td>Create brochure for exam room&lt;br&gt;• Request advance directive from hospital/referring MD&lt;br&gt;• Assign a department to ask about advance directive and follow up to ensure it gets to the care</td>
<td>Create checklist for NP Packet&lt;br&gt;• Create checklist for pre-visit initial call for Care Coordinator&lt;br&gt;• Have form at office to give interested patients</td>
</tr>
<tr>
<td>Difficult</td>
<td>Create a document to send in the new patient packet about advance directive</td>
<td>Designate check in person to determine if new patient has advance directive and ask for it if not already in chart</td>
</tr>
</tbody>
</table>

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

- Ease of Implementation:
  - High
  - Low

- Impact:
  - High
  - Low

- Changes:
  1. Create brochure for exam room
  2. Request advance directive from hospital/referring MD
  3. Assign a department to ask about advance directive and follow up to ensure it gets to the care
  4. Create checklist for NP Packet
  5. Create checklist for pre-visit initial call for Care Coordinator
  6. Have form at office to give interested patients
  7. Create a document to send in the new patient packet about advance directive
  8. Designate check in person to determine if new patient has advance directive and ask for it if not already in chart
## 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>
</tr>
</thead>
</table>
| 7/17/2017-8/4/2017 | Brightly colored paper in new patient packet asking patient to bring advance directive to first visit  
Care Coordinator ask patient to bring advance directive at first visit  
Request advance directive from referring institution | 3 out of 5 patients with an advance directive brought it to the clinic and it was scanned into chart | Does that patient have an advance directive they are not sharing with us? |
| 8/7/2017-8/21/2017 | Create letter from Psychologist for new patient packet | 1 out of 1 patients with an advance directive brought it to the clinic | Need education materials to help patients understand why creating an advance directive is... |
Improved Process Map

New Patient Referral

New Patient Packet sent to patient. Include letter from psychologist explaining advance directive and importance.

Care Coordinator makes phone call to patient prior to visit. Asks patient if they have an advance directive. If yes, bring the advance directive to first visit

Does patient have advance directive?

Yes

When patient arrives in clinic, Check-In staff obtain advance directive and scan into the patient's chart

End of Process

No

New Patient Intake team asks referring office if the patient has an advance directive on file

Provide education on advance directives and encourage patient to create one.
Barriers and Issues

• Patients are confused on what an advance directive is
  – Power of Attorney
  – Medical Power of Attorney
  – Patient does not want to share with physician
  – Not in patient’s possession

• Obtaining patient education materials
IMPORTANT NOTICE

If you have an Advance Directive or Advance Care Planning document,
Please bring a copy with you to your doctor’s visit.

We need to put a copy in your chart.

Thank You

Dear Patient:

We encourage you to be actively involved in your medical care plan. We know the importance of communication between you and your loved ones, and your physicians, about your diagnosis, treatment options, values and wishes. The best way to ensure that you have a voice in your care is to keep that communication open with your loved ones and your medical team.

The process of making decisions about future care is called advance care planning. Advance directives are legal papers in which you tell your doctors and loved ones what type of medical care you want, if you can’t tell them yourself due to medication, sedation or perhaps a serious medical condition. An advanced directive is not a power of attorney, health power of attorney or a will. Advanced directive forms are available in our office.

Once you’ve talked with your loved ones about your wishes, please complete the advance directive documents and make sure to give copies to your healthcare providers. This is one of the most important things you can do for your medical care and peace of mind.
Change Data

Percent of Patients With Advance Directive Tennessee Oncology Obtained on First Visit

- Before Improvements: 5%
- PDSA Cycle 1: 60%
- PDSA Cycle 2: 100%
Change Data

Percentage of Patients Who Were Asked to Bring Advance Directive to First Appointment

- Before Improvements: 0%
- PDSA Cycle 1: 96%
- PDSA Cycle 2: 100%
Conclusions

• Communicating with the patient allowed them to know what we need from them
  – Second improvement displayed that explaining why, not just how provides better results

• Creating a formal process gives structure for the staff to know what to do with the advance directives when the patient arrives
Next Steps/Plan for Sustainability

• Obtain patient education brochures
• Focus on patients who do not have an AD
• Expand to other clinics within practice
Increase the percent of advance directive in patient medical records

AIM: To increase the percent of AD in the medical record of new patients, with a cancer diagnosis \( \geq 65 \) years old, who had a visit within 30-days of their first appointment, and already have an AD to at least 20% by October 1st.

INTERVENTION: Over the PDSA cycles, the following interventions were used:

- Include request to bring advance directive to first doctor visit
- Care Coordinator remind the patient to bring the advance directive
- Change notice requesting advance directive to letter from psychologist explaining importance
- Request advance directive from referring hospital or office
- Attempted to use brochures, but were unable to order

RESULTS: We exceeded our goal of 20% of patients with an advance directive bringing the document on the first visit and it is scanned into their chart that day.

RESULTS:

| Percent of Patients With Advance Directive Tennessee Oncology Obtained on First Visit |
|---------------------------------|---------------------------------|
| Before Improvements | 5% | 60% |
| PDSA Cycle 1 | | |
| PDSA Cycle 2 | 100% | |

| Percentage of Patients Who Were Asked to Bring Advance Directive to First Appointment |
|---------------------------------|---------------------------------|
| Before Improvements | 0% | 96% |
| PDSA Cycle 1 | | |
| PDSA Cycle 2 | 100% | |

CONCLUSIONS:

- Communicating with the patient allows them to provide the information we need
- Including the “why” rather than just the “how” improves results
- Creating a formal process ensures improvement

NEXT STEPS: As we have removed barriers initially faced, we plan to complete the following in coming PDSA cycles:

- Obtain patient education brochures to give when patients want to create a advance directive
- Expand to other clinics within practice
- Focus on patients who do not already have an AD