ACP Initiative in Outpatient Geriatric & Palliative Care

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This research study did not receive any financial support. The investigators retained full independence in the conduct of this research.

Background

- The Centers for Medicare and Medicaid Services (CMS) began reimbursement for advance care planning (ACP) conversations, in January 2016
- These conversations are a means for patients, together with physicians and families, to establish goals of care (GOC) for their future.
- Although it is especially important to conduct and document ACP conversations with seriously ill and/or frail elderly patients, studies have shown patients prefer their physician to initiate these conversations.
- Outpatient offices provide an ideal setting to address ACP and hold ACP conversations to allow patients to establish GOC before a health event or crisis, rather than in the ED or ICU during a crisis.

Problem

- ACP discussions can take a few minutes or can be extensive, including a discussion of GOC, advanced directives and/or filling out Medical Orders for Life Sustaining Treatment (MOLST) forms.
- These discussions may be billable if provided face to face with patient and/or family in a 20 minute or greater time frame.
- In a usual routine visit, an ACP discussion is typically not performed, or performed but not documented in a designated area in the electronic medical record (EMR), making the discussed information inaccessible to other healthcare providers.

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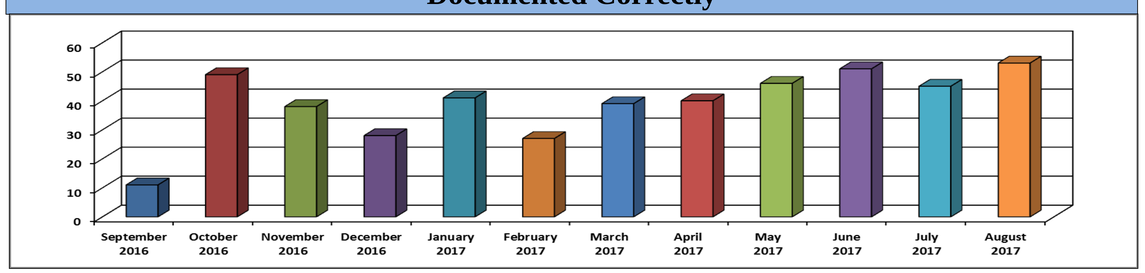
Goals

To improve outpatient ACP discussions and documentation
To educate providers and learners about the importance of these discussions
To ensure proper, consistent, documentation of ACP discussions in the chart

QI Project Methodology

- Conducted in the outpatient faculty practice of the Northwell Health Geriatric and Palliative Medicine physicians
- Multi-disciplinary team with 7 Attending Geriatric and/or Palliative physicians, 5 Geriatric Fellows, internal medicine residents, 1 social worker, 1 PharmD, pharmacy students, nurses, office manager
- Approximately 4445 patient visits annually
- Began in July 2016 with collaboration from the Institute of Healthcare Improvement
- As part of the comprehensive assessment, each patient provided information about health care proxies (HCP), MOLST forms, and/or goals of care
- Assistance with completion of HCP or MOLST, if applicable, forms in office.
- Documentation of ACP preferences in a specifically identified area of the patient's chart in the EMR, which is readily visible to outside providers
- Social work available for help for both the patients and providers
- Completed forms scanned into the patient's chart by office staff
- Office staff nurse audits two charts/provider/week (56/month) to see if ACP has been done, on a weekly basis
- Data is reviewed with the providers at the monthly faculty meetings
- Upon review with the providers at the faculty meeting, barriers are identified and solutions are discussed and shared

Figure 1. Percentage of Posted Cases (n=56/month) in which ACP Discussions were Documented Correctly



Results

Through this quality improvement project there has been an increase in ACP discussions and documentation. At the start of the project there were 31.5 of the 56 cases (56.3%) had ACP documentation. Within 6 months that rate had increased to 40.6 of the 56 cases (72.5%) (Figure 1)

Barriers

- Lack of adequate time to screen for ACP
- ACP decisions completed in different health settings, but not shared (i.e. in an inpatient setting or sub-acute rehabilitation center)
- Different EMR systems used throughout the healthcare continuum (inpatient, outpatient, skilled nursing facility)

Solutions

- Office manager to reinforce that the MOA completes the pre-visit checklist prior to a patient's arrival, including highlighting the ACP section if not completed
- Providers to educate rotating residents/fellows on the importance of ACP discussions
- The MOA gives the patient a brochure regarding ACP discussion immediately upon placement in the examining room

Discussion

Despite the push by CMS and the team support, providers struggle to accomplish 100% documentation of ACP wishes

Through comprehensive evaluation of office processes and identification of barriers and possible solutions, we were able to demonstrate significant improvement on ACP discussion and documentation in an outpatient office setting

References

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