UCLA Health System Advance Care Planning & Services Program

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Background

UCLA Health aims to provide world-class quaternary medical care and also high value, comprehensive medical care to the UCLA Health primary care population. High quality care for both patient populations requires innovative clinicians providing cutting edge care in teams functioning within an infrastructure that provides feedback for continuous improvement. A critical component is the well-informed patient who can participate in shared decision making to guide care that matches goals. To accomplish this, UCLA Health must employ a mechanism to routinely elicit patient preferences and to incorporate patients' fully informed goals into treatment. With support from the Coalition for Compassionate Care of California and a guiding stakeholder group, we aimed to develop a health system wide program for advance care planning.

Vision

UCLA Health uses cutting edge technology to treat and cure every patient for whom it is possible and appropriate, and patients are well informed and goals and preferences elicited so that patients appropriately receive timely palliative care such that the tools of medicine are employed efficiently to help the largest number of patients.

Methods

The UCLA Advance Care Planning (ACP) model includes: (1) a standardized ACP process, (2) materials to inform patients and promote ACP, (3) training mechanism yielding individuals to reproducibly implement the standardized ACP process in a clinically astute fashion, (4) CareConnect infrastructure for maintaining ACP preferences so they can be iteratively updated and applied at the point of care, and (5) metrics to evaluate ACP interventions and drive QI.

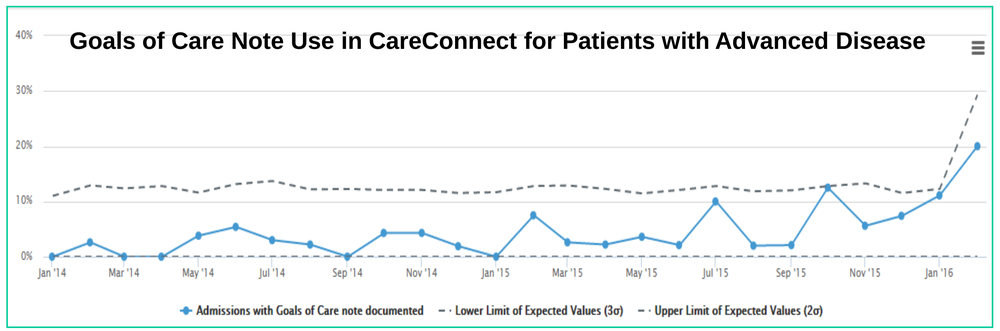
The program aims to normalize advance care planning as a regular, expected part of medical care at UCLA, with ACP implemented in a strategic fashion appropriate for each patient's level of illness and readiness to participate (see ACP levels in Table).

Results

ACP Level	Patient characteristics	Advance care planning	Mechanism
Level 1: Basic	All adults 18 years and older	Specify surrogate, ensure surrogate is aware; some complete an advance directive	Self-service specification of surrogate, easy access to ACP material
Level 2: Targeted – No proxy	Low health-risk adults without identifiable capable proxy (e.g., homeless, no family)	Completion of advance directive or a living will, if appropriate	CareConnect identifies patients and notifies appropriate clinician to ask
Level 3: Serious chronic illness	Adult patients with chronic, serious illness identified by a diagnosis and severity-based algorithm	ACP discussion with completion of advance directive. Introduce consideration of goals of care.	ACP introduced by clinician, possibly promoted by Continuity Care Coordinator. Integrated into disease management efforts
Level 4: Pre-procedure	Patients slated for high risk procedure	ACP specific risks of the procedure and rare, adverse events	Clinician obtaining procedure consent trained to discuss future health state goals or Communication Promoter within the team
Level 5: Advanced illness	Adult patients with advanced illness (e.g., incurable cancer, dementia) identified by care venue and diagnosis-based algorithms	Full advance care planning including focused discussion on valued activities, health states to be avoided with life-sustaining treatment.	Specially trained Communication Promoter embedded in strategic care venues carrying out continuity ACP discussions

Specific interventions of the ACP&S program include:

- UCLA Advance Healthcare Directive – Focused on future health states, targeted to UCLA patients
- Inpatient Hospice - Hospice care available in the inpatient setting at RR and SM hospitals.
- Embedded Palliative Nurse Practitioner in Oncology - Palliative NP in SM Oncology clinic provides symptom management and ACP for patients with incurable cancer. Pilot Anthem payment program.
- Inpatient ACP Social Worker – Social worker prospectively completes ACP including exploration of future health states with patients admitted for heart transplant and advanced cardiac care.
- Bereavement Materials – Health system-wide, functional set of bereavement support materials.
- Nursing Home POLST Transitions – Ensuring that patients who desire less than fully aggressive treatment have these preferences communicated on transfer to SNF using POLST.
- Home Palliative Care Program – NP-coordinated home palliative care visits with Palliative MD back- up to facilitate care transitions for patients with advanced disease including hospice transfer.
- Palliative Continuity Care Coordinator – Facilitating smooth connections between inpatient and outpatient providers and outpatient and community palliative care resources including hospice
- CCC Facilitated Primary Care ACP – Advance directive and POLST completion teed up by CCCs for primary care physicians to complete process



POLST among patients with DNR order discharged to Nursing Home Decedents with Advanced Disease