ADVANCE CARE PLANNING: REDESIGNING PATIENT-CENTERED CARE

Christine Wilkins, Ph.D., LCSW

March 12, 2018
Why an ACP Program?

- Despite increased awareness, many do not have advance directives.
- Even when a health care proxy has been completed, a conversation between the patient, agent, and provider has often not occurred.
- For patients with serious illness and a life expectancy of one year, Medical Orders For Life Sustaining Treatment form (MOLST) is seldom completed.
- Difficult healthcare decisions are often made in crisis, and by family/friends who do not always know patient’s wishes.
- Limited inpatient-outpatient communication about advance care planning.
ADVANCE CARE PLANNING PROGRAM AT NYULH

• Developed in 2015

• Program Leadership:
  – Champions: Kim Glassman, PhD, RN (CNO) and Fritz Francois, MD (CMO)
  – Sponsor: Thomas Sedgwick, LCSW-R, CCM
  – Program Manager: Christine Wilkins, PhD, LCSW
  – Physician Champion: Kevin Hauck, MD, MPH
  – Physician Champion NYULH-Brooklyn: Stefanie Reiff, MD
Mission and Vision

Mission
To promote enterprise-wide advance care planning in which patients’ health care preferences are discussed, documented, and honored by families, friends, and the health care community.

Vision
Advance care planning will become the standard of care for all of our patients enterprise-wide, and will ensure that every patient’s health care choices are clearly defined and honored.
Respecting Choices ACP Program Implementation

- Evidence-based
- Implemented nationally and internationally over 25 years
- Emphasizes importance of a conversation instead of form completion
- Promotes patient-centered advance care planning that is individualized to one’s stage of illness and may change over time. ACP is a process and not a one-time event.
- Explores understanding of ACP, past experiences with serious illness, previous hospitalizations and living well
- Explores personal, cultural, or religious values and beliefs
- Involves agents and loved ones to promote dialogue
- Assists in completion of a health care proxy form and/or MOLST
Five Promises of an Advance Care Planning System:

1. Promise #1: We will initiate the conversation
2. Promise #2: We will provide assistance with advance care planning
3. Promise #3: We will make sure plans are clear
4. Promise #4: We will maintain and retrieve plans
5. Promise #5: We will appropriately follow plans
Promise #1
We will Initiate the Conversation

• Institution commitment to this program at all levels
• Recognition that “Initiating the conversation” is a key component of quality patient centered care
• Adoption of the Respecting Choices Program
Promise #2
We will Provide Assistance with Advance Care Planning

• Over 300 staff trained in the First Steps Respecting Choices Program
• Over 150 staff trained in the Last Steps Respecting Choices Program
• Over 9000 staff enrolled in eMOLST
• Billing codes 99497 and 99498 can be dropped by LIP
• Last Steps Organizational Faculty Certification
**ACP Billing**

Billing Codes Used: **99497** PR ADVANCE CARE PLANNING FIRST 30 MINS  
**99498** PR ADVANCE CARE PLANNING EA ADDL 30 MINS

**Frequency of ACP Billing Codes**  
N=1717

**ACP Billing Codes by Place of Service**  
N=1717

- **Emergency Room - Hospital**: 12, 1%
- **Home**: 1, 0%
- **Inpatient Hospital**: 291, 17%
- **Off Campus - Outpatient Hospital**: 967, 56%
- **Office**: 417, 24%
- **On Campus - Outpatient Hospital**: 23, 1%
- **Skilled Nursing Facility**: 133, 7%

N=1717  
Feb-16: 4, 0%  
Mar-16: 5, 0%  
Apr-16: 29, 1%  
May-16: 2, 0%  
Jun-16: 5, 0%  
Jul-16: 14, 0%  
Aug-16: 57, 3%  
Sep-16: 51, 3%  
Oct-16: 64, 4%  
Nov-16: 69, 4%  
Dec-16: 74, 4%  
Jan-17: 103, 6%  
Feb-17: 92, 5%  
Mar-17: 82, 5%  
Apr-17: 94, 5%  
May-17: 97, 6%  
Jun-17: 133, 8%  
Jul-17: 165, 9%  
Aug-17: 183, 10%  
Sep-17: 184, 10%  
Oct-17: 210, 12%
Promise #3
We Will Make Sure Plans Are Clear

• Advance Care Planning Note developed and introduced in Epic
  • ACP note template guides conversations
  • Documentation of advance care planning efforts in the ACP note allows for a more coordinated approach
    • Makes these important conversations easily accessible to staff
    • Allows staff to build on previous conversations
  • Is available across the enterprise: inpatient and outpatient
### ADVANCE CARE PLANNING NOTE

**Today a meeting took place:**

- **Patient Participation:**
- **Health Care Agent / Surrogate Decision Maker:**
  - **Attendees:**
  - **Staff attendees:**
  - **Conversation:**

**FOR ADULT WITH SERIOUS/CHRONIC ILLNESS:**

- **Documents Reviewed:**

**Code Status Order**

- **Current Code Status with its associated discussion:**
  - **DNR (DO NOT RESUSCITATE)**
  - **Order Comments:**
  - **Goals of Care Discussion**
    - Family members present: patient.
    - Staff attendees present: Nursing and Primary Attending.
  - Patient has capacity to make goals of care decisions:
    - Yes.
  - Interventions currently not being pursued: bipap/cpap and hemodialysis.

**Follow-up Tasks:**

- **Recommendations/Plan:**

**Length of ACP conversation in minutes:**

Enter number of minutes: [22205]: "[*]" minutes
Advance Care Planning Note

ACP Note Completion (7/14/16 - 12/31/17) N=2813

Source: Epic Clarity

Hospital Encounter (Including ED, Obs)
• eMOLST adoption through Epic Single Sign On
  • Promotes shared decision-making
  • Conversations move beyond focusing solely on resuscitation and allow for more details instructions
  • Results in clear documentation of patient’s wishes
  • Produces ‘actionable medical orders’ that are valid in any care settings
• Code status order options changed:
# DNR ORDER – Limited Medical Interventions

**Process Instructions:**

- DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)
- Resuscitation Instructions when patient has no pulse and is not breathing
- This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

**MOLST on File:**

- I have reviewed the up to date MOLST and it matches the code status order
- There is no MOLST

**Family members present for Goals of Care Discussion:**

- Patient
- Spouse
- Partner
- Mother
- Father
- Guardian
- Sister
- Brother
- Daughter
- Son
- Friend
- Health Care Agent
- Surrogate
- Other (please specify)

**Staff members present during Goals of Care discussion:**

- Ordering Provider
- Care Management
- Consulting Physician
- Fellow
- Nurse Practitioner
- Nursing
- Pastoral Care
- Patient Advocate
- Physician Assistant
- Primary Attending
- Resident
- Social Worker
- Other (please specify)

**Treatment Guidelines - Orders for Other Life Sustaining Treatment when patient has a pulse and patient is breathing:**

- Comfort measures only
- Limited medical interventions
- No limitation on medical interventions

**Instructions for Intubation and Mechanical ventilation:**

- Do not intubate (DNI)
- A trial period
- Intubation and long-term mechanical ventilation, if needed

**Future Hospitalization/Transfer:**

- Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled
- Send to the hospital, if necessary, based on MOLST orders, Decision deferred

**Artificially administered nutrition:**

- No feeding tube
- A trial period of feeding tube
- Long-term feeding tube, if needed
- Decision deferred

**Artificially administered fluids:**

- No IV fluids
- A trial period of IV fluids
- Decision deferred

**Antibiotics:**

- Do not use antibiotics
- Determine use or limitation of antibiotics when infection occurs
- Use antibiotics
- Decision deferred

**Code Status Cmnts:**

- Click to add text

**Phase of Care:**

- [ ]
eMolst Completion, 8/3/16-11/30/16

**eMolst, 8/3/16 - 10/31/16**

N=21

- 8, 38% Completed
- 13, 62%Unsigned/Incomplete

- 4 Geriatrics
- 7 Palliative Care
- 2 Pending (DD)

**eMolst, 11/1/16 – 11/30/16**

N=17

- 3, 18% Completed
- 14, 82%Unsigned/Incomplete

- 2 (Tisch, HJD)
- 2 Pending (DD)
eMOLST completion 2016 - February 2018

eMOLST Completion, N = 963
Source: eMOLST Registry, Signed Forms
Promise #4
We Will Maintain and Retrieve Plans: ACP Navigator

Additional Sections
View
- Code Status Hx
- MSQ Response Hx
- ACP documents
- ACP Epic Notes

Document
- eMolst
- Code Status
- ACP Note
Promise #5
We Will Appropriately Follow Plans

• Commitment to concordance

• Code status order entered in ambulatory setting remains active

• Helping transform the healthcare culture by:
  • Educating staff that we have an obligation to honor patients’ wishes
    “Your mom has a MOLST and we need to honor her wishes” and not “Your mom has a MOLST… What would you like us to do?”
  • Promoting dialogue between patients, health care agent, and loved ones early on in the ACP process to ensure that they have opportunities to process their worries, fears and concerns

• Ensure that providers across the inpatient and outpatient settings can view the same ACP documents, have access to the ACP Report Viewer, ACP note and eMOLST

• Collaboration with community partners
Last Steps Implementation

- Heart Failure
- Cancer Center
- NYULH-Brooklyn

44 conversations completed Last Steps Conversations 11/1/2017-2/28/2018
Written Feedback from Patients

• “...was lovely, informative, and compassionate. She made a very scary situation much more bearable. She is an asset to your organization”

• “very compassionate + well informed”

• “I have a better understanding of what decisions have to be made in the future”

• “…she’s very professional and helped me with any questions I had.”

• “thank you very much….for your help”
Advance Care Planning
Advance Care Planning

At NYU Langone, we provide you with individualized care targeted to your treatment goals. This approach includes allowing you to choose who can make decisions for you in the event you are unable to do so for yourself.

This process, called advance care planning, is a key component of our patient-focused approach to care. Life is unpredictable, and our goal is to ensure that your wishes regarding the type and extent of medical treatment you receive are fulfilled. We encourage you to talk with your loved ones about your values and preferences, and to choose a trusted representative who can speak on your behalf. This process is also known as completing an advance directive.
Next Steps

- FS & LS Implementation
- Shared Decision-Making Program Implementation
- ACP Dashboard
- Continued education for staff on ACP
- Patient Education
THANK YOU