Clinical Safety & Effectiveness
Cohort # 13
Improving Documentation Within an Interdisciplinary Care Plan
CENTER FOR PATIENT SAFETY & HEALTH POLICY
UT Health Science Center
SAN ANTONIO
Educating for Quality Improvement & Patient Safety
The Team

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  - Michael Lichtenstein, M.D.
- University Health System; Executive Vice President/Chief Medical Officer
  - Bryan J. Alsip, MD, MPH, FACPM
What Are We Trying to Accomplish?

To improve the Palliative Medicine Team’s Interdisciplinary Care Plan documentation in the Process of Care section from baseline of 46% to 75% by January 9, 2014
Project Milestones

• Team Created          September, 2013
• AIM Statement Created September, 2013
• Weekly Team Meetings  10/1 - present
• Background Data, Brainstorm Sessions, 10/1 – 10/15
  Workflow and Fishbone Analyses
• Interventions Implemented (first cycle) 10/28/13
• Data Analysis          9/1 – 1/14
• CS&E Presentation      January 17, 2013
The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care identifies eight domains that are important to providing quality palliative medicine and that the interdisciplinary team should document their comprehensive care plan with the intent to improve patients care and transitions of care.
How Will We Know That a Change is an Improvement?

• Types of measures:
  – Process

• How you will measure:
  – Percent components complete

• Specific targets for change:
  – Improved documentation of elements reflecting appropriate goals of care discussion and transition of care plan documentation
Our focus
Process of Care:

Goals:
Patient is: FULL CODE\(^{(1)}\)

Family meeting today.
- Will meet at patient bedside at 3pm today 9/20/13\(^{(1)}\)

Decision Making:
Opine: Teresa (Sister)\(^{(1)}\)

Opine: Teresa: 830-223-2263 home; 210-223-2263 cell\(^{(1)}\)

Spiritual Transition Planning:
Spiritual Transition Planning: transition to home hospice chaplain care and will continue to follow in outpatient setting at LS/PC clinic\(^{(2)}\)

Spiritual Care Plan communicated to pt\(^{(2)}\)
Specific Targets for Change

• Goals of Care
  – Does it contain info other than code status?
  – Does it contain any of the standard goals:
    • Be cured
    • Live longer
    • Improve/maintain function, qol, independence
    • Be comfortable
    • Achieve life goals
    • Provide support for family/caregiver
    • Understand disease, disease course, and/or prognosis better
Specific Targets for Change

• Decision making
  – mPOA vs. surrogate
  – Does it contain all appropriate info:
    • Name
    • Contact info
    • Relationship to patient
Specific Targets for Change

- Transition of Care
  - Are all notes complete?
    - Spiritual plan
    - Social work plan
    - Physician plan
  - Are the plans consistent?
What Changes Can We Make That Will Result in an Improvement?

• Making changes to note in EMR
  – Approved by team
• Educational intervention
  – Handout to learners
• Nursing survey
Selected Process Analysis and Decision Making Tools

- Surveys
- Chart Audit
- Brainstorming
- Flowchart
- Fishbone
- Check sheet (hard stops in EMR)
Baseline Measurement

Began with current state – what is being done now?

– Chart audits
– Looking for presence of 12 specific items
– Gave partial credit for numerator
Chart Audit Tool

MRN:  
CONSULT DATE:  
DATE OF NOTE:  

CS&E Baseline Chart Audit

Does the note contain information in the Process of Care: Goals section other than code status?  YES  NO

If yes, does it contain any of the seven goals listed below?  YES  NO  DEFERRED

If yes, check those contained:
- Be cured
- Live longer
- Improve or Maintain Function, QOL, or Independence
- Be comfortable
- Achieve life goals
- Provide support for family/caregiver
- Understand disease, disease course, and/or prognosis better

If this information was found in a different section, please state where: ____________________

Does the note contain information in the Process of Care: Decision Making section?  YES  NO

If yes, which does it list:  nPOA  Surrogate

If listed, are the following present:
- Name
- Contact Information
- Relationship to patient

If this information was found in a different section, please state where: ____________________

Does the note contain information in the Process of Care: Transition section?  YES  NO

If yes, what type of transition is noted (check all present):
- Spiritual Transition Planning
- Physician Transition Planning
- Social Work Transition Planning

If multiple transition plans are present, are they consistent?  YES  NO

If this information was found in a different section, please state where: ____________________

*NOTE – Only evaluate the first IDT Care Plan note, per patient, entered more than two days after consult date
Interdisciplinary Care Plan Critical Items Documented
Pre-Intervention Data

Percent Critical Items Documented

September 6 - October 25, 2013
Intervention

• Worked with Palliative Medicine team to agree on goals and important note elements
• Surveyed 6th floor nursing staff for input on helpful elements
Implementing the Change

• Enlisted IT department to make necessary changes to team notes, including hard stops, info boxes, and drop down menus
  – Changes began Oct 28
• Created educational handouts for learners to begin utilizing new note elements
• Developed orientation procedure for learners
Process of Care:
Preferences:
Date preferences addressed/addressed: Nov-05-2013 Info reviewed and accurate.
Preference Choices for how a patient wants to receive information: wants all information known to providers (diagnosis, prognosis, test results).
Preferred Language: English
Goals:
Date GOC addressed/addressed: Nov-06-2013 Info reviewed and accurate.
Patient is: FULL CODE
Goal #1: Be comfortable (Most Important Goal).
Goal #2: Understand disease, disease course, and/or prognosis better.
Additional Discussion Details: Now that the patient’s pain is better controlled she is interested in discussing the possibility of receiving more chemotherapy and will follow up with Dr. Lu as an outpatient.
Decision Making:
Date decision-making addressed/addressed: Nov-05-2013 Info reviewed and accurate.
mPOA: Name/relationship/contact: Mother, role: Spouse
Additional Details: 210103016
Physician Transition Planning:
Transition Option Plans: home hospice
Spiritual Transition Planning:
Date Spiritual Transition Plan addressed/addressed: Info reviewed and accurate.
Physical Aspects of Care:
Assessment (Recommendations Listed By Problem):
51 y/o female with a history of early stage colon cancer, now with a cystic/soft mass of the pancreatic head/duodenum, suspicious for pancreatic adenocarcinoma, likely metastatic to cervical, supraclavicular, and superior mediastinal lymph nodes. Palliative chemotherapy was initiated but the patient states that she became depressed after 3 - 4 treatments and “gave up”. Patient will be considered for additional chemotherapy as an outpatient, and will not receive chemotherapy during her hospital stay.
Psychological/Social Aspects of Care:
Physician Psychosocial Resp:
Psychosocial Needs: The patient lives with her mother who she states “retired” to be able to take care of her.
Habits: Gigt 1ppd x 4 months
ETOH: 1 quart of beer/day
Marijuana and cocaine: until the time of this admission
Process of Care:

Preferences:
- Date preferences addressed/readdressed: Nov-05-2013
- Info reviewed and accurate.

- Preference Choices for how a patient wants to receive information: wants all information known to providers (diagnosis, prognosis, test results)

- Preferred Language: English

Goals:
- Date GOC addressed/readdressed: Nov-06-2013
- Info reviewed and accurate.

- Patient is: FULL CODE

Goal #1: Be comfortable (Most Important Goal).

- Goal #2: Understand disease, disease course, and/or prognosis better

Additional Discussion Details: Now that the patient's pain is better controlled she is interested in discussing the possibility of receiving more chemotherapy and will follow up with Dr. Lu as an outpatient.

Decision Making:
- Date decision-making addressed/readdressed: Nov-05-2013
- Info reviewed and accurate.

mPOA:
- Name/relationship/contact#: Mother, [redacted]

Additional Details: 210 [redacted]

Physician Transition Planning:
- Transition Option Plans: home hospice

Spiritual Transition Planning:
- Date Spiritual Transition Plan addressed/readdressed: Info reviewed and accurate.
Challenges Encountered

• IT support
  – Availability for changes
  – Problems with changes
    • Retroactive hard stops

• Resistance from learners and staff
  – Hard stops = Headaches (Incomplete Notes)
    • Reassurance and encouragement helped
  – Development of “Note Reminders” for where to find hard stops in note
Results/Impact

- Continued auditing IDT Care Plan notes weekly
- Calculated percentage of completed elements
Interdisciplinary Care Plan Critical Items Documented
Pre and Post Intervention Data

Percent Critical Items Documented

September 2013 - January 2014
Expansion of Our Implementation

- Will continue revising notes to increase effectiveness
- Will expand intervention to the remaining processes in the IDT note
Return on Investment

Gains:

- Time
  - Increased efficiency for finding specific data
- Improved quality improvement skills
- Development of specific GOC training for learners
  - Improved documentation by learners
Return on Investment

Costs:

- UHS and UT $ investment in training

Time:

- IT’s time investment in changing documentation
- Orientation and instruction for note completion for learners
- Team’s time investment = Time away from other projects and/or patient care.
Return on Investment

Possibilities

- Increases provider time with patient (ie. discussing GOC)
  - More time spent developing relationship with patient
  - Increased patient satisfaction
- More clearly defined sections in documentation
  - Accurate, easily found patient information for all healthcare professionals taking care of patient and their family
Conclusion/What’s Next

- Improved documentation of Palliative Medicine Team’s Interdisciplinary Care Plan in the Process of Care section – baseline 46% to 75% by January 9, 2014

- Expansion and added QI cycles needed for other sections of Interdisciplinary Care Plan note (6 other sections)
  - Physical, Psychological and Social, Spiritual Religious and Existential, Cultural, and Ethical and Legal Aspects of Care

- Roll-out to educate bedside nursing and primary teams taking care of palliative patients hospital-wide, including education on “live” clinical summary page
References


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