



Clinical Safety and Effectiveness Cohort # 14

Improved Advance Directives (AD) and Code status (CS) Documentation



Educating for Quality Improvement & Patient Safety

THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History®

The Team

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AIM STATEMENT

To facilitate clinic intake process by improving Code Status documentation from 7% to 17%, and Advance Care Planning documentation from 38% to 50% at MARC Geriatrics clinic by May 15th, 2014.

Project Milestones

- Team Created January 2014
- AIM statement created January 2014
- Weekly Team Meetings Began Jan 2014
- Background Data, Brainstorm Sessions,
Workflow and Fishbone Analyses February 2014
- Interventions Implemented April 16-May 30
- Data Analysis June 1-June 2
- CS&E Presentation June 6, 2014

Advance Care Planning?

- It is the process of planning for future medical care particularly in the event that the patient becomes unable to make his or her own decisions.
- During this process patients explore, discuss, articulate, and document their preferences.
- The process helps patients identify and clarify their personal values and goals about health and medical treatment.

The importance of ACP,AD,CS

On Myth

*My mother told me that I cried on her womb.
They said to her: he'll be lucky.*

*Someone spoke to me all the days of my life,
into my ear, slowly, taking their time.
Said to me: live, live, live!
It was death.*

Jaime Sabines

Definition

- **Advance Directive** = a written statement by a person who has decision-making capacity regarding preferences about future health care decisions in the event that the individual becomes unable to make those decisions.

Types of Advance Directives

- **Medical Power of Attorney (MPOA)** =type of advance directive in which an individual designates another person to make health care decisions on the individual's behalf.
- **Living Will** =type of advance directive in which an individual indicates personal preferences regarding future treatment options.
- **Out-of-Hospital Do-Not Resuscitate Order**

Advance Care Planning

- Form of preventive medicine because it may help to avoid future confusion and conflict.
- Promotes autonomy and dignity at end-of-life.
- Individuals with ADs are less likely to die in a hospital, fewer reported concerns with communication.

Teno JM, Gruneir A, Schwartz J et al. Association between advance directives and quality of end-of-life care: A national study. J Am Geriatr Soc 2007;55:189-194.

Outcomes improved in prospective and randomized trials

- Higher completion of AD
- Increase likelihood of compliance with pt wishes
- Reduce hospitalization at the end of life
- Less intensive treatments
- More utilization of hospice services
- Increase likelihood that a patient will die in their preferred place

However

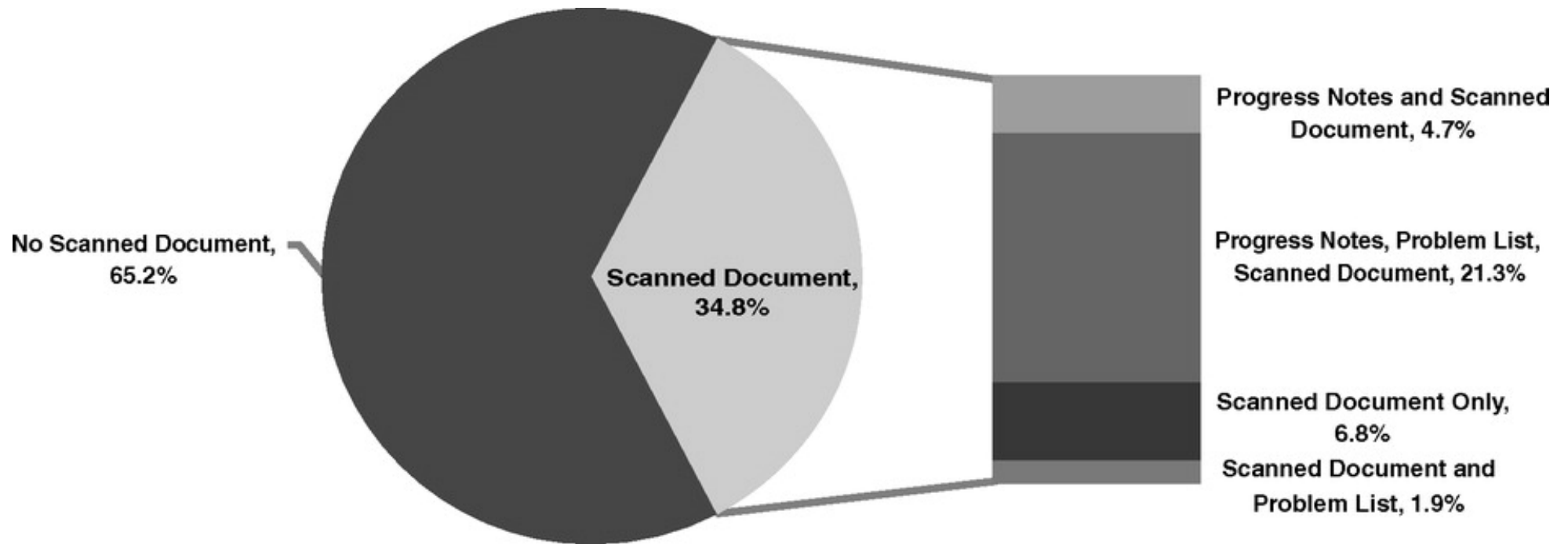
- Few patients complete advance directives.
- Physicians are often unaware of the documents even when patients have executed them-Difficult to find in an Electronic Health Record.

Teno JM, Lynn J, Phillips RS, et al. Do formal advance directives affect resuscitation decisions and the use of resources for seriously ill patients? J Clin Ethics. 1994;5:23-30.

Yung VJ, Walling AM, Min L, Wenger NS, Ganz DA. Documentation of advance care planning for community-dwelling elders. J Palliat Med. 2010;13(7):861-7.

Wilson CJ, Newman J, Tapper S, et al. Multiple locations of advance care planning documentation in an electronic health record: are they easy to find? J Palliat Med. 2013;16(9):1089-94.

Locations of Advance Directive/Living Will Documentations (n=28,400).

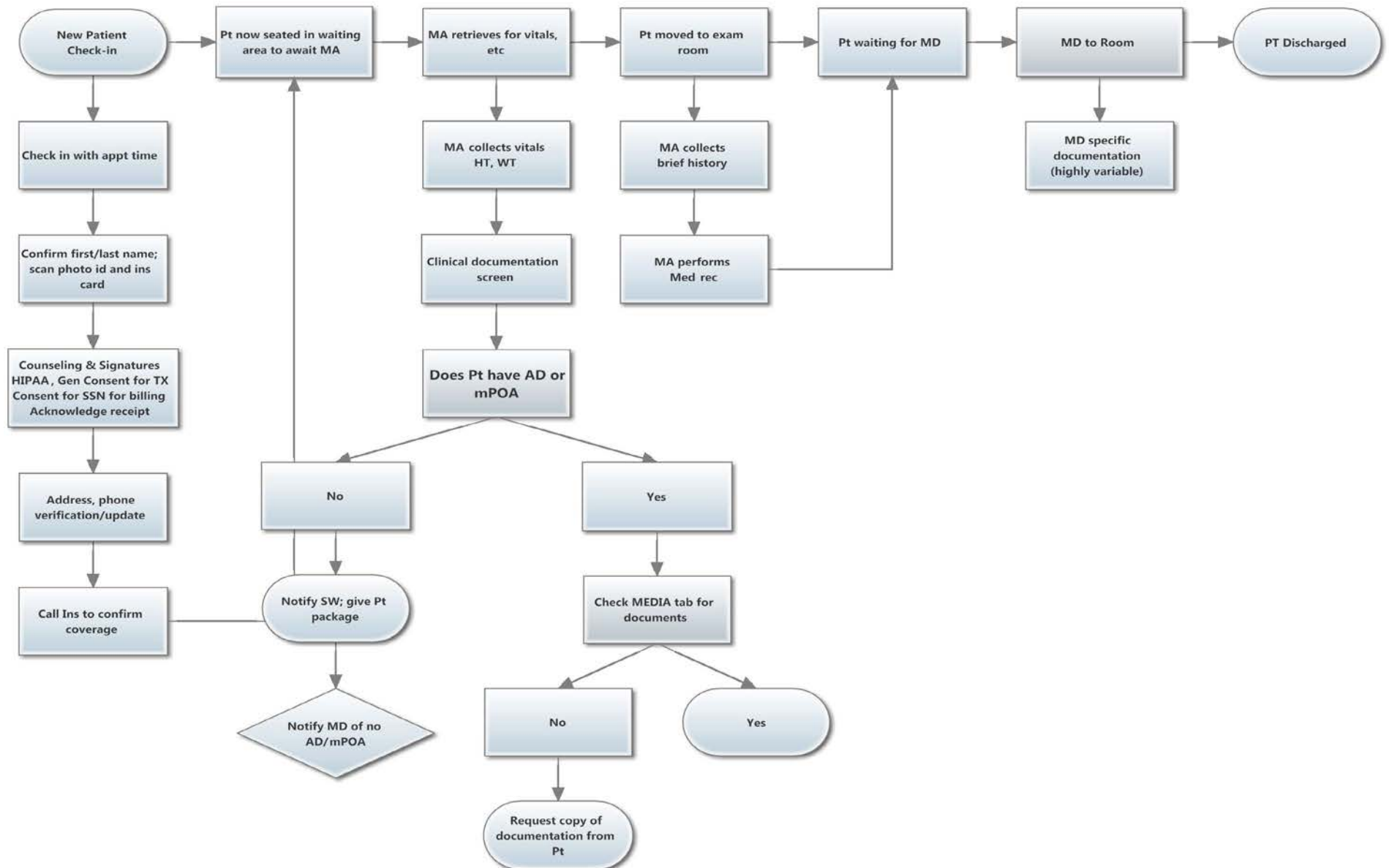


Wilson CJ, Newman J, Tapper S, et al. Multiple locations of advance care planning documentation in an electronic health record: are they easy to find? J Palliat Med. 2013;16(9):1089-94.

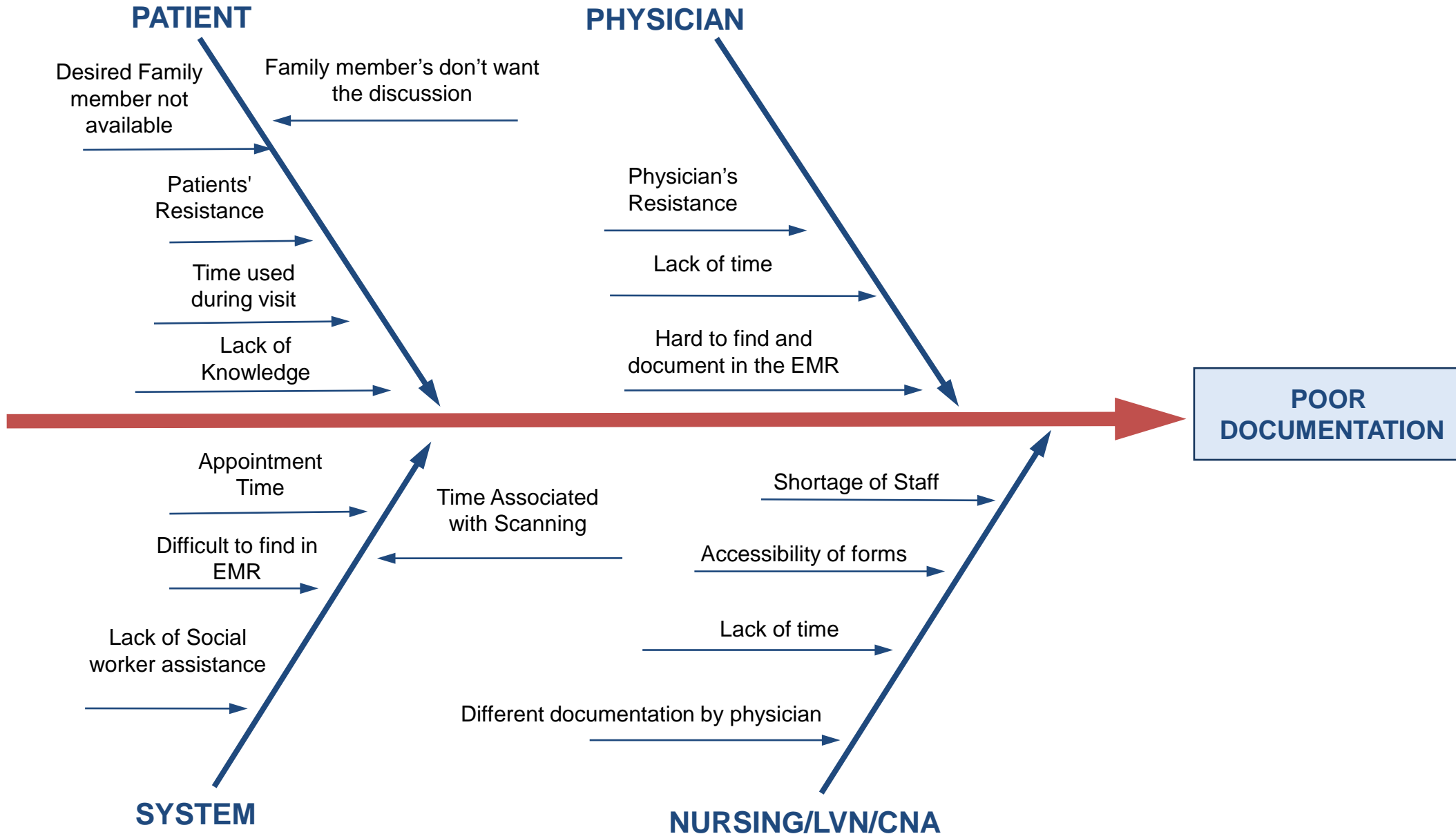
Patient characteristics associated with higher likelihood of completing AD

- Older age
- Caucasian
- Chronic disease
- High disease burden
- High socioeconomic status
- Prior knowledge about AD and EOL options
- High level of education

MARC Geriatric Clinic



CAUSES OF POOR DOCUMENTATION OF ADVANCE DIRECTIVES AND CODE STATUS



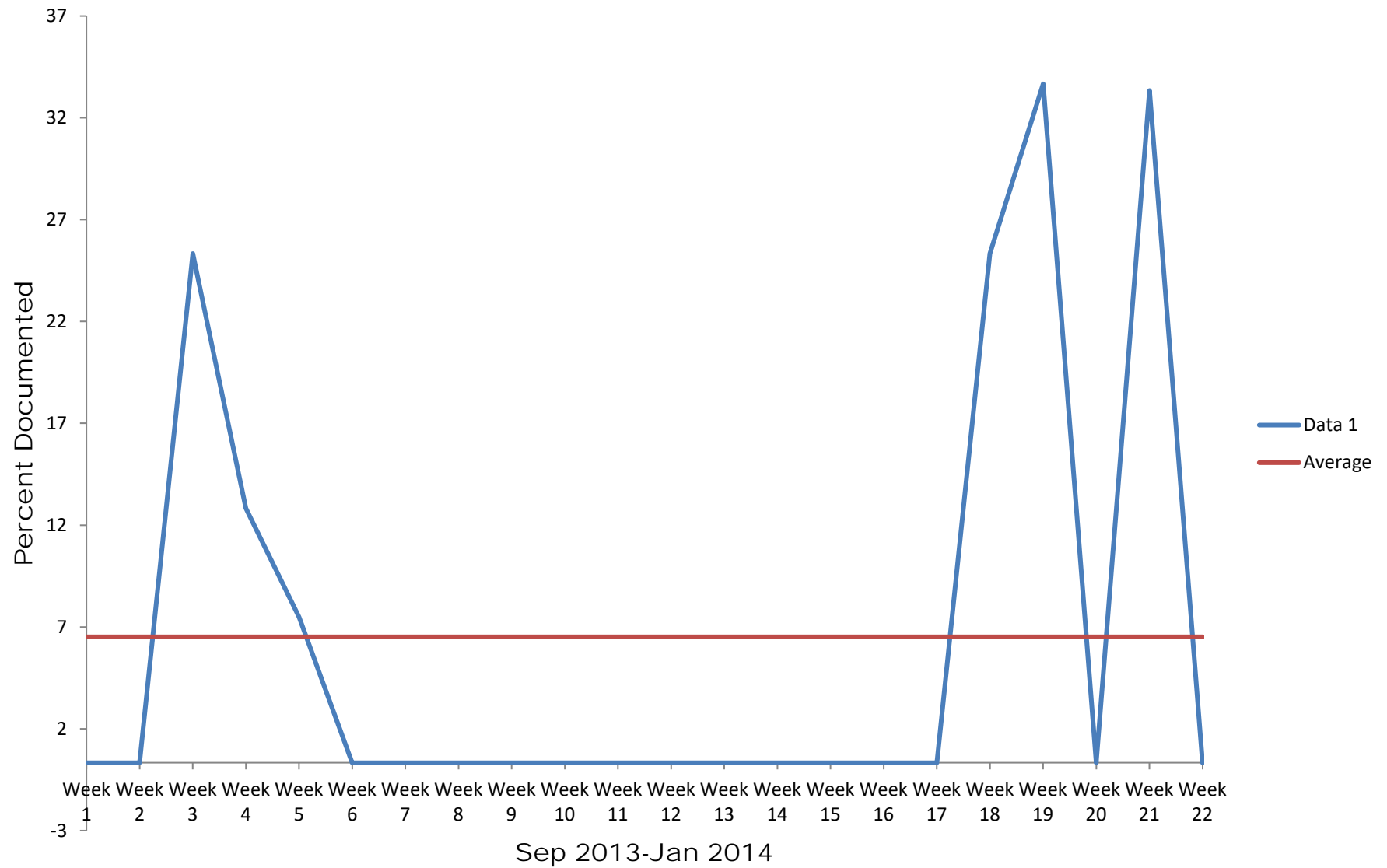




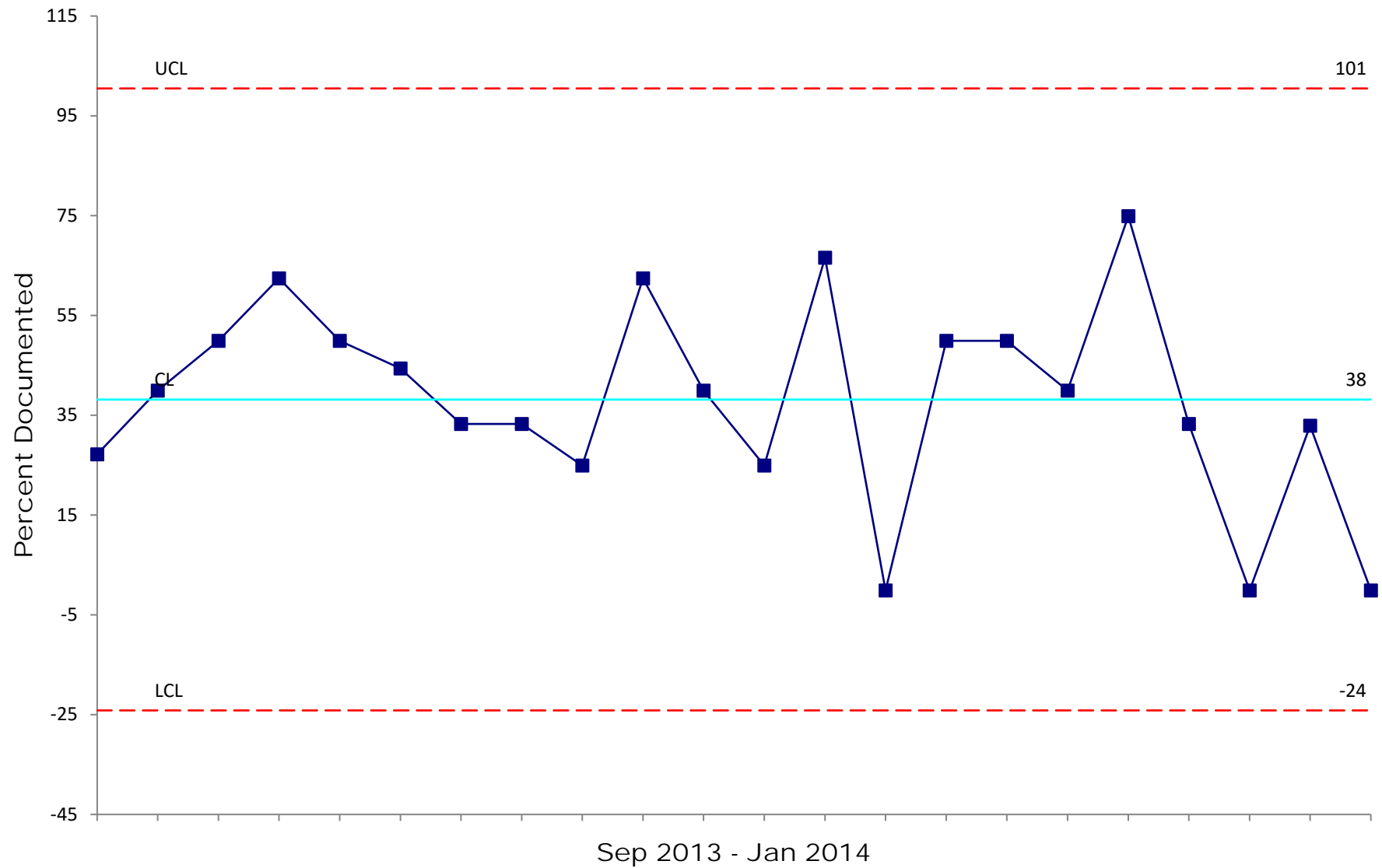
Pre-intervention Data

- Data was collected from the MARC Geriatric Clinic
- EPIC EMR
- September 2013 – January 2014
- All Providers combined

MARC Geriatrics New Pts with Code Status Documented



MARC Geriatric New Pts with Advance Directive Documented



PLAN: Intervention

- Best practice advisory(BPA) trigger in EMR: for new patients to Drs. Lichtenstein, Dahm and Garcia.
- Increase MD awareness of a new patient's Advance Directive status (Education).
- The BPA to trigger an Advance Directives consult with the case manager or to the social worker.
- Make patient handouts and forms available.

Best Practice Advisory (BPA)

[Questionnaires](#) [Admin](#) [Benefits Inquiry](#) [References](#) [Open Orders](#) [Care Teams](#) [Print AVS](#) [Preview AVS](#)

[Office Visit](#)
[Admission](#)
[BestPractice](#)
[Link Consult](#)
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Hospital Name:
Admission Type:
Admission Date: Discharge Date:
Readmission?
Attending Physicians:

[BestPractice Advisories](#) [click to open](#)

ADVANCED DIRECTIVE NOT RECEIVED This patient does not currently have an advanced directive documented as "Received" in our system. If they have an advanced directive, please instruct them to bring it to be scanned in to our record. If they do not have one, the below smart set can be added. The smart set includes a progress note section that will be added to the top of new notes or the bottom of notes that are already started (recommend you only accept smart set after note is started). It also includes information that will go into patient instructions about Advanced Directives
[Link to Directions for Completing Living Will to print](#)

[Link to Texas Living Will Document to print](#)

Acknowledge reason:

☐ Open SmartSet: ADVANCED DIRECTIVE NEEDED SMART SET [preview](#)

[Refresh](#) Last refreshed on 6/4/2014 at 4:54 PM [Accept](#)

Planning in Advance for Future Healthcare Choices Information Sheet

Without warning, you have had a life threatening event or injury. Despite the best medical treatment, your physicians believe that it is unlikely you will leave the hospital alive. You are no longer able to interact with anyone. At this point, your heart beat and respirations can be prolonged for some time through continued use of artificial life support. What would your goals be for medical treatment?

Who should decide when enough is enough? You do or at least you should.

What are advance directives?

Advance directives are legal documents that allow people to communicate their decisions about medical care to family, friends, and health care professionals in the event that they are unable to make those decisions themselves—for example, due to being unconscious or in a coma. The two main types of advance directives are a medical power of attorney and a living will.

- **Texas Medical Power of Attorney:** This document lets you name an adult, your "agent," to make decisions about your medical care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. The Medical Power of Attorney is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Your Texas Medical Power of Attorney goes into effect when your doctor determines that you are no longer able to understand and appreciate the nature and consequences of a treatment decision.
- **Texas Directive to Physicians and Family or Surrogates (Living Will):** In a living will, people indicate what kind of medical care, especially life-sustaining care, they would or would not like to receive if they become unable to speak for themselves. The most common types of care that are addressed in a living will include:
 - The use of life-sustaining equipment (such as dialysis machines, ventilators, and respirators).
 - Do Not Resuscitate orders (DNR); that is, the instruction not to use cardiopulmonary resuscitation (CPR) if your breathing or heartbeat stop.
 - Artificial hydration and nutrition (tube feeding).
 - Withholding food and fluids.
 - Organ and tissue donation.

Why Do We Hear So Much About Advance Directives? Advances in medical technology can prolong life indefinitely for patients in comatose or vegetative states with no hope of recovery. The media is filled with highly publicized legal cases involving such patients whose families and medical providers disagree on their end-of-life care. These situations are emotionally and financially draining, and can be avoided by creating advance directives.

What happens if you choose not to have an advance directive? Without an advance directive, your family, physician, hospital and in some cases a judge, would need to make decisions regarding your future care, should you become unable to make them for yourself.

When is an advance directive used? As long as you are capable of making your own decisions, you remain in control of your own medical care. If you are unable to make your decisions, your plans in the advance directive would guide decision making.

Can my advance directive be changed? Advance directives can be changed at any time, as long as you are capable of making decisions. If you do fill out an advance directive, a copy can become part of your medical file.

What if I am injured or become ill when I am away from home? The best way to ensure that you receive the type of care you want is to discuss your choices with the person who will represent you and make sure they have a copy of your advance directive. A wallet card, indicating you have an advance directive is also available.

What happens in an emergency? In the event of an emergency, life-sustaining measures may be started, possibly before your medical record is available. However, treatment can be stopped if it is discovered that it is not what you would have wanted.

Do I have to have a lawyer to complete an advance directive? No. The law does not require you to have a lawyer. The choice is yours.

If you are interested in getting more information on Advance Directives: Please contact the following:

Location of scanned AD documents in EPIC

Demographics

Contact Information

Clinical Information

Additional Information

Advance Directives

Power of attorney on file:

No

New

View

Delete Current

Go to Line

Living will on file:

No

New

View

Delete Current

Go to Line

Mark as Reviewed

Advance directives have never been reviewed

	Type of Document	Description	Status	Date Received	Location
	Power of Attorney		Not Received [11]		
	Advance Directives a		Not Received [11]		

Demographics

Contact Information

Clinical Information

Additional Information

Advance Directives

Patient Lists

Pharmacy Preferences

CVS/PHARMACY #8389 - SAN ANTONIO, TX - 8602 HUEBNER RD AT C

Lab Preferences

Primary Location:

DIAGNOSTIC PAVILION

Provider

DAHM, DENISE R [1924]

PCP type

General

☒ EpicCare Patient

☐ Restricted access

☐ Chart abstracted

Code status:



Date updated:

Comments:

[Code Status History](#)

Marital Status:

Single

Need interpreter?:

No

Race:

1

White or Caucasian

Ethnicity:

Non-Hispanic or Non-Latino

Preferred Language:

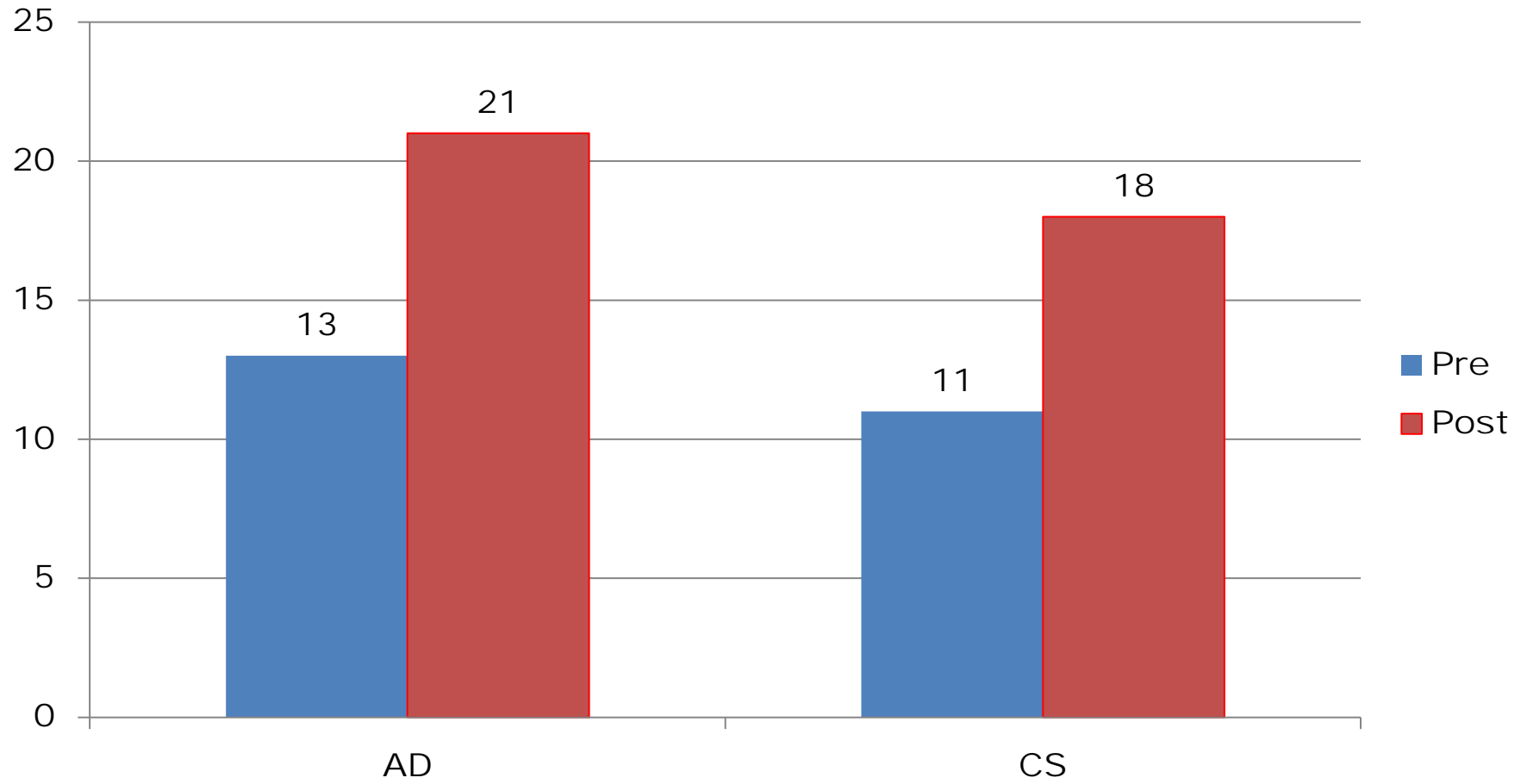
English

Permanent
comments:

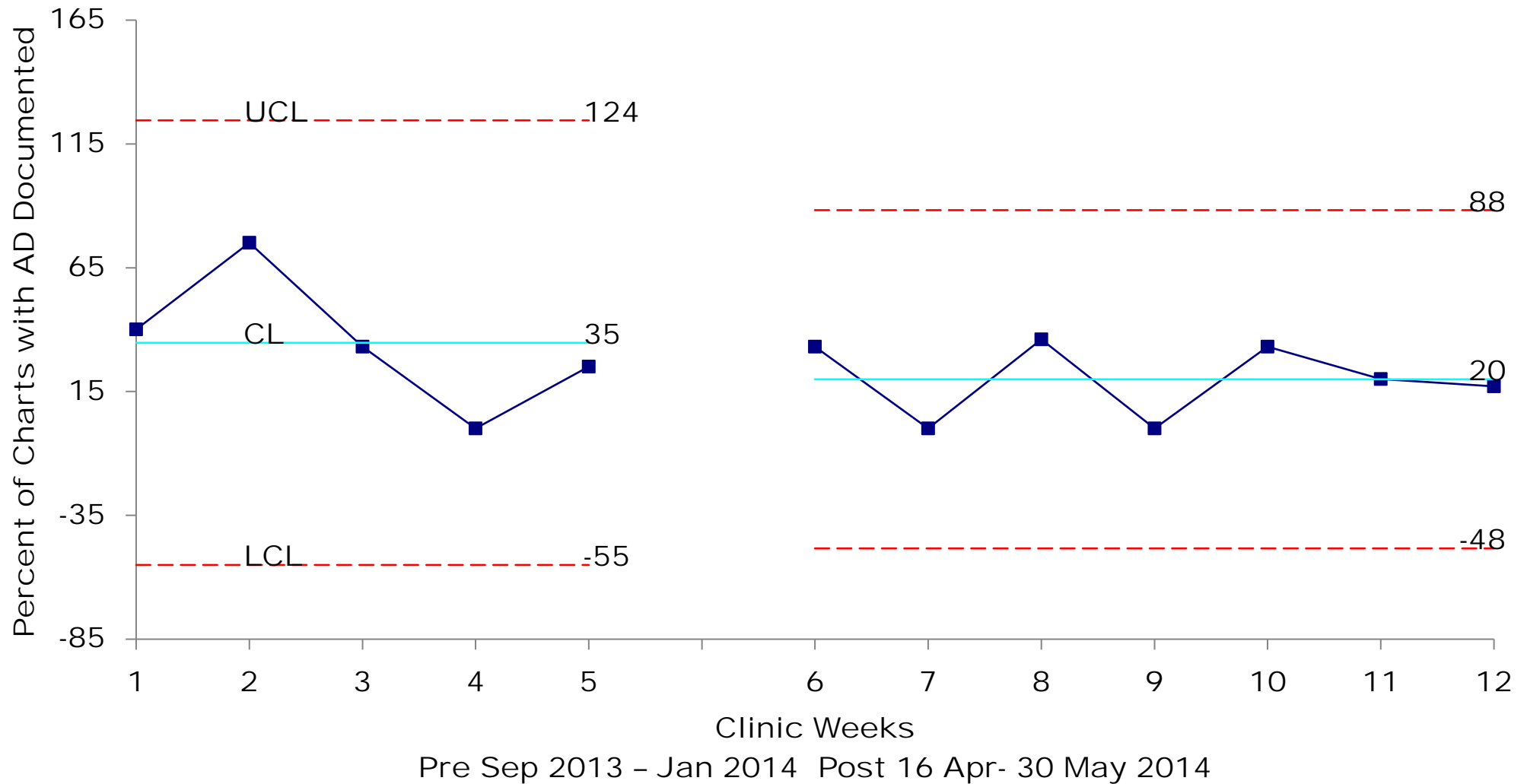


MARC Geriatric Clinic

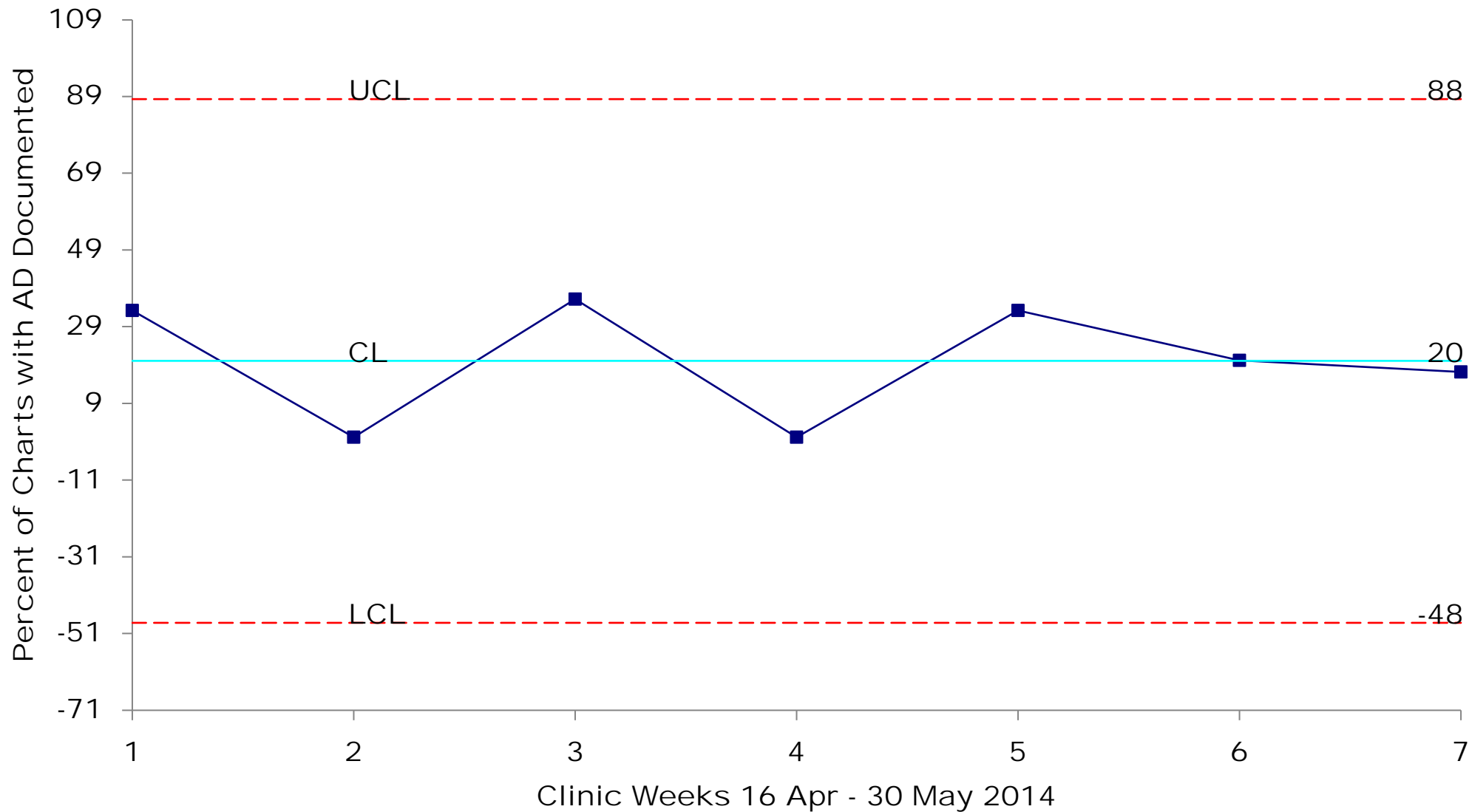
Percent of New Patient Charts with Documented Discussion of Advanced Directive or Code Status Pre and Post Intervention



Pre and Post Intervention New Patient Charts with Advance Directive Documentation

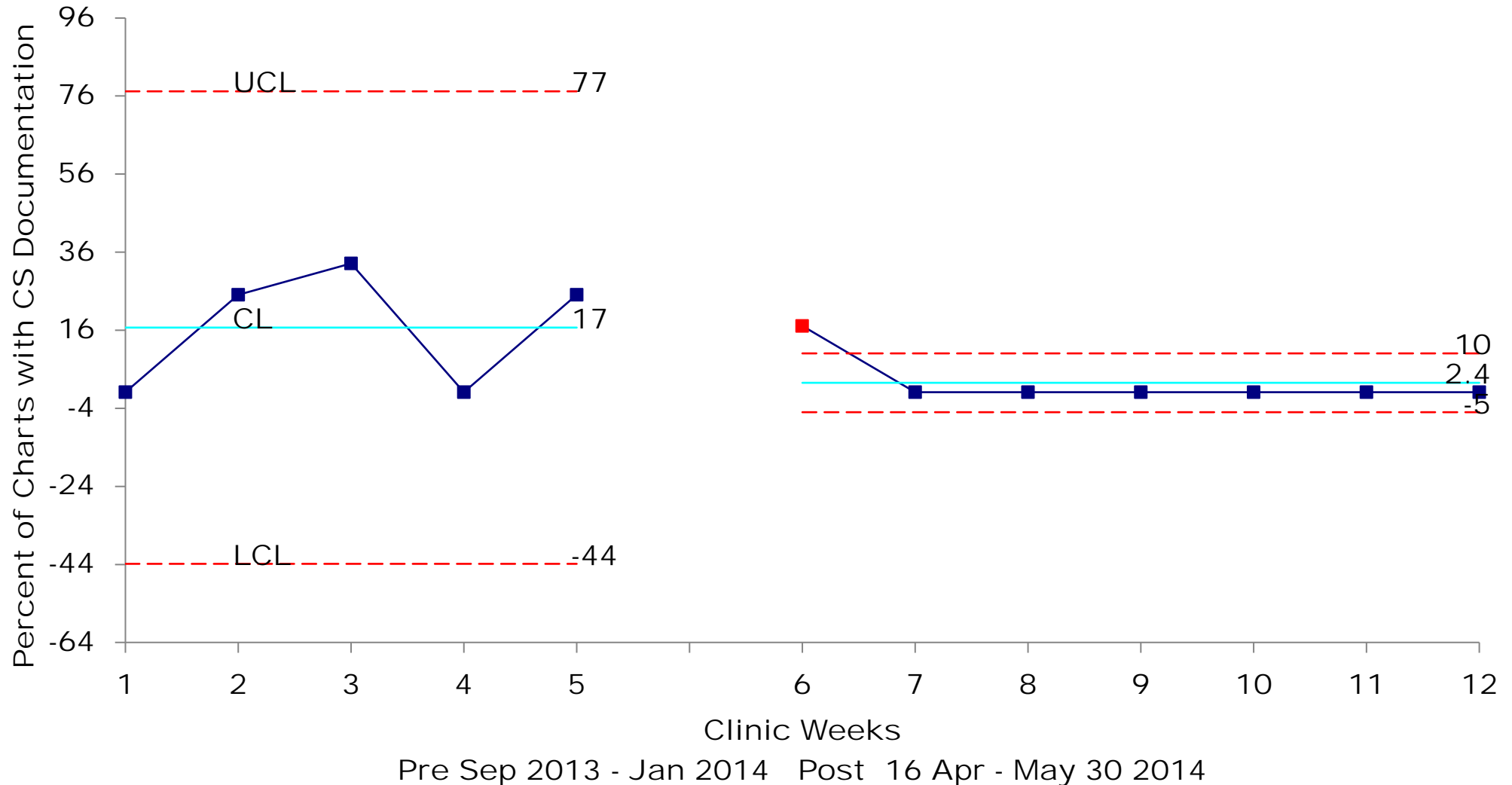


Post Intervention Percent of New Patient Charts with Advanced Directive

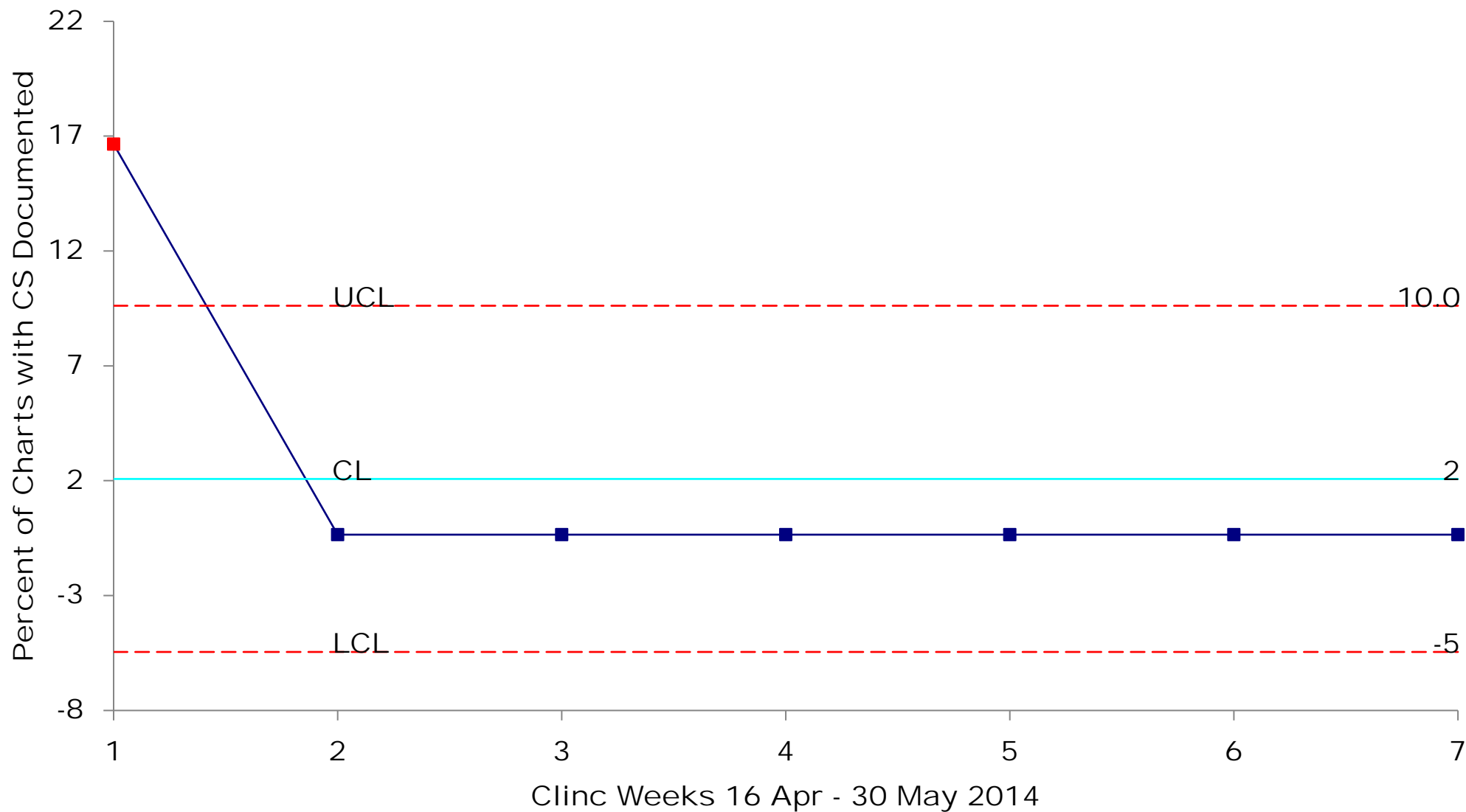


Pre and Post intervention

New Patient Charts with Code Status Documentation



Post Intervention Percent of New Patient Charts with Code Status Documented



Limitations

- Lack of time during clinic visit to discuss AD
- Less duration of the intervention data collection
- Lack of a full time social worker or other medical personnel who can take over the discussion once started by the physician
- Lack of importance given to the fact that AD and code status discussion and documentation is part of excellent patient care and is a quality indicator.

Future Directions

- Increase no. of AD discussions and code status documentations in the geriatric clinic
- Appoint a full time social worker or appropriate medical personnel to increase the ease of the process
- Create a tab on the header of each patient chart for easy visibility of Code status
- Collaborate with other clinics within MARC and at CTSC to accomplish above goals
- Educate office staff about the fact that AD and code status discussion and documentation is part of excellent patient care and is a quality indicator.

Conclusions

- Proper AD and CS documentation is not performed in most health care settings
- Interventions aimed at improving this documentation require a multidisciplinary and multisystem approach
- Lack of accountability and monitoring of this documentation as a quality measure may influence physicians poor compliance