



Clinical Safety & Effectiveness Cohort # 13

Improving Documentation Within an Interdisciplinary Care Plan



Educating for Quality Improvement & Patient Safety



The Team

- CS&E Participant: Jennifer Healy, DO
- CS&E Participant: Erin Sidle
- Facilitator: Hope Nora, PhD
- Team Member: Karen Aufdemorte
- Team Member: Irene Puente
- Team Member: Cynthia Kirk, RN
- Team Member: Michael Dodd, RN
- Administrative Champion: Bryan Alsip, MD, MPH, FACPM
- Sponsor Department: UTHSCSA Dept. of Medicine, Div. of Geriatrics, Gerontology, and Palliative Medicine
 - Michael Lichtenstein, M.D.
- University Health System; Executive Vice President/Chief Medical Officer
 - Bryan J. Alsip, MD, MPH, FACPM



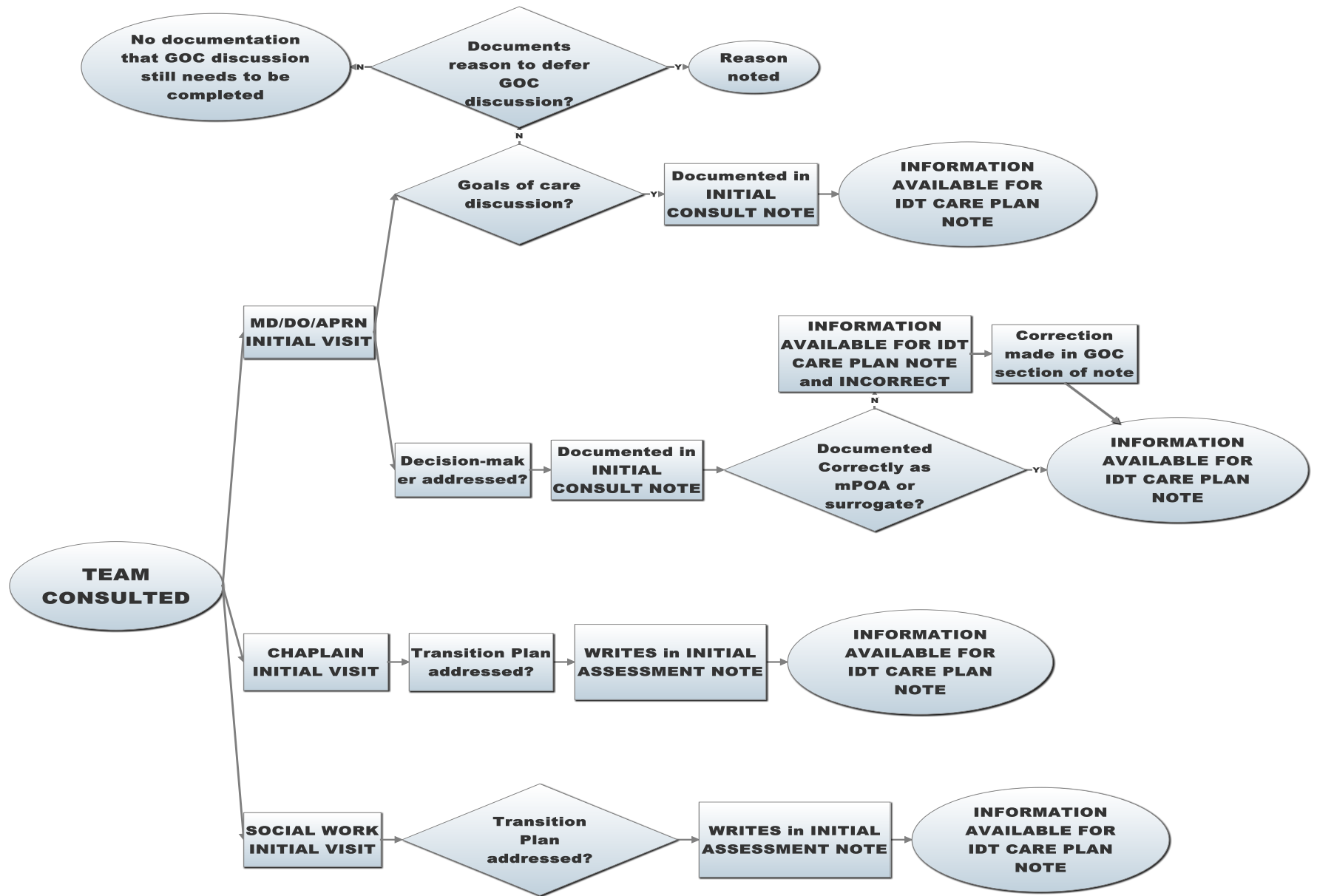
What Are We Trying to Accomplish?

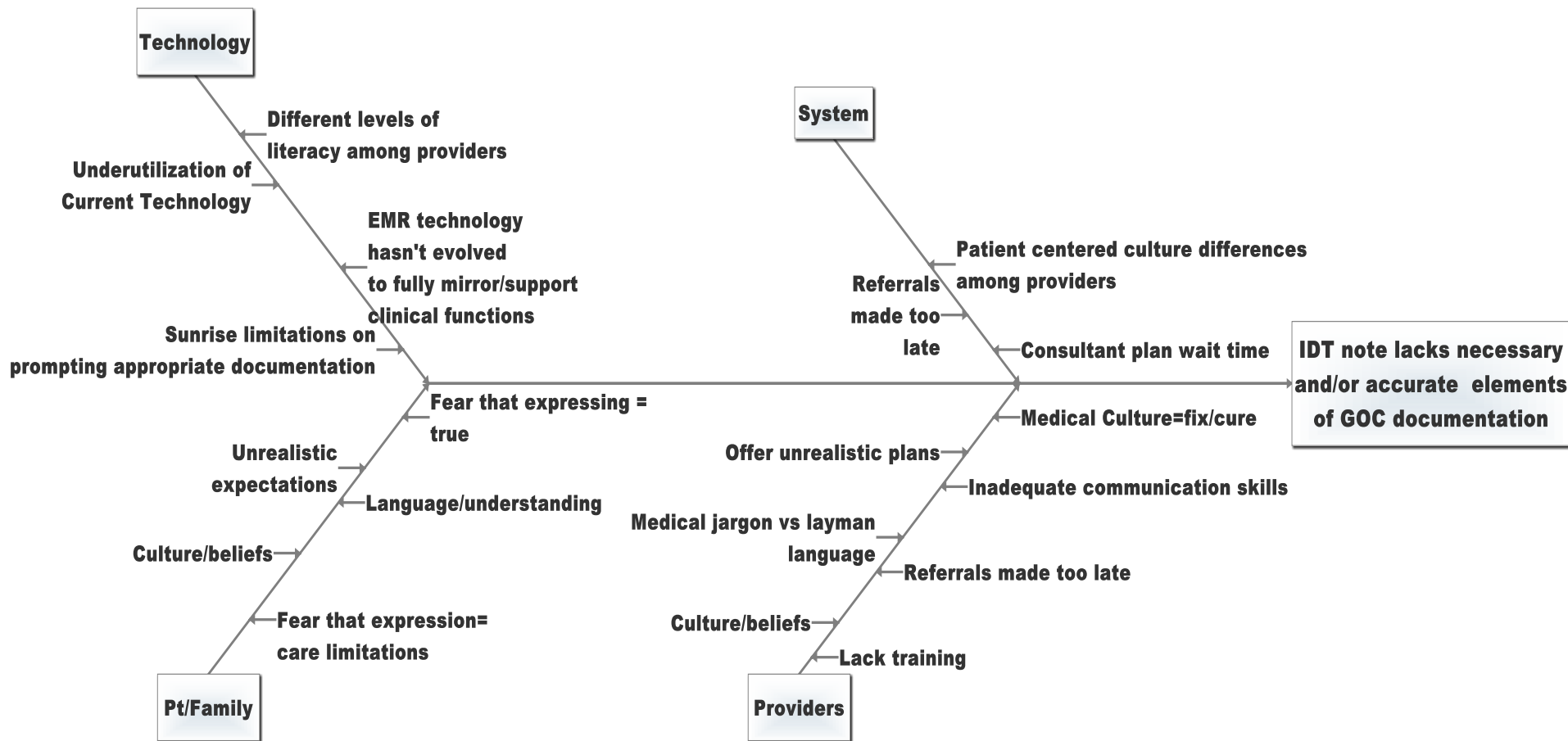


To improve the Palliative Medicine Team's Interdisciplinary Care Plan documentation in the Process of Care section from baseline of 46% to 75% by January 9, 2014

Project Milestones

- Team Created September, 2013
- AIM Statement Created September, 2013
- Weekly Team Meetings 10/1 - present
- Background Data, Brainstorm Sessions,
Workflow and Fishbone Analyses 10/1 – 10/15
- Interventions Implemented (first cycle) 10/28/13
- Data Analysis 9/1 – 1/14
- CS&E Presentation January 17, 2013





Background



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

MRN: Visit: Age: 63y	,	Gender: Female	UNIVERSITY HEALTH SYSTEM Location:
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LIFE Care/Palliative Medicine: IDT Care Plan (SD) [Sep-20-2013 13:27]-
for Visit: , Complete, Entered, Signed in Full, General

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:

~~Syndi Forrester~~ (Sister)⁽¹⁾

~~Syndi Forrester~~ 830-922-9888 home; 210-289-6600 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⁾

Physical Aspects of Care:

• **Assessment (Recommendations Listed By Problem):**

62 yo woman with pmh significant for COPD, GERD, CAD, HTN, HLP, PAD and bladder cancer s/p cystectomy with ileal conduit and mesh closure with complications including abdominal abscesses and EC fistula admitted as transfer from Methodist where she was admitted for sepsis to their ICU and currently NPO on TPN. Consulted for pain management.

Psychological/Social Aspects of Care:

Physician Psycho/Social Hx:

Psychosocial Needs: Alcohol Use: No.

Tobacco Use: No.

Drug Use: No.

Previously lived with relatives, most recently came from NH⁽³⁾

Spiritual Aspects of Care:

Religious Preference:

- **Religious Preference** Christian, Raised Catholic⁽²⁾

End of Life Issues:

End of Life Issues/Anticipatory Grief: Has difficult relationship with her 3 children. Guilt over end of marriage.⁽²⁾

Spiritual Care Summary:

Spiritual Summary: Pastoral Care visit. PT did not talk much, when she did it was hard to understand. Pt cried several times. Sometimes she did not know why and sometimes from pain. Notified nurse who said pt needed to be reminded of her button. Showed button to pt and she pushed it for pain meds. Pt did welcome prayer today which was provided. . Provided companionship and encouragement.⁽²⁾

Cultural Aspects of Care:

Cultural Aspects of Care: Caucasian, Christian/Catholic⁽²⁾

Electronic Signatures:

PERRY, BRENDA L (RN) (Signed Sep-20-2013 13:28)

Authored: Process of Care, Physical Aspects of Care, Psychological/Social Aspects of Care, Spiritual Aspects of Care, Cultural Aspects of Care

Our focus

MRN: Visit: Age: 63y	,	Gender: Female	UNIVERSITY HEALTH SYSTEM Location:
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Decision Making:

[REDACTED] (Sister)⁽¹⁾

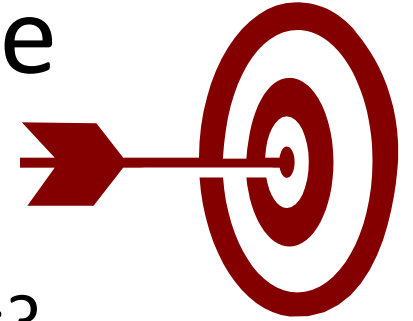
[REDACTED] 830-888-8888 home; 210-203-8888 cell⁽¹⁾

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

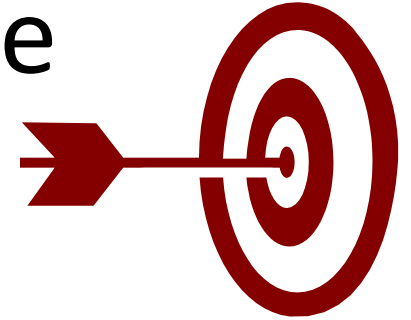
Spiritual Care Plan communicated to pt⁽²⁾

Specific Targets for Change



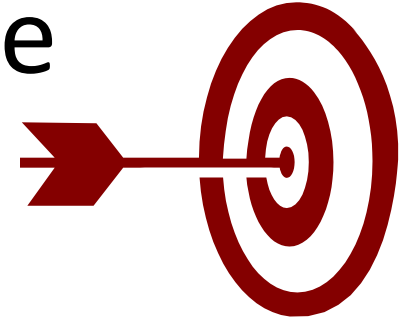
- Goals of Care
 - Does it contain info other than code status?
 - Does it contain any of the standard goals:
 - Be cured
 - Live longer
 - Improve/maintain function, qol, independence
 - Be comfortable
 - Achieve life goals
 - Provide support for family/caregiver
 - Understand disease, disease course, 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?

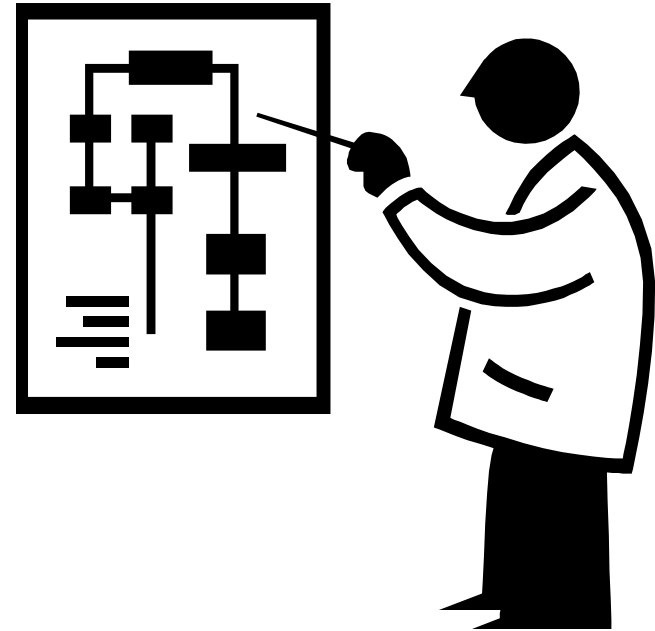
What Changes Can We Make That Will Result in an Improvement?

- 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 **1**

If yes, does it contain any of the seven goals listed below? YES NO DEFERRED **2**

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 **3**

If yes, which does it list: mPOA Surrogate **4** (any)

If listed, are the following present:

- ☒ Name **5**
- ☒ Contact information **6**
- ☒ Relationship to patient **7**

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 **8**

If yes, what type of transition is noted (check all present):

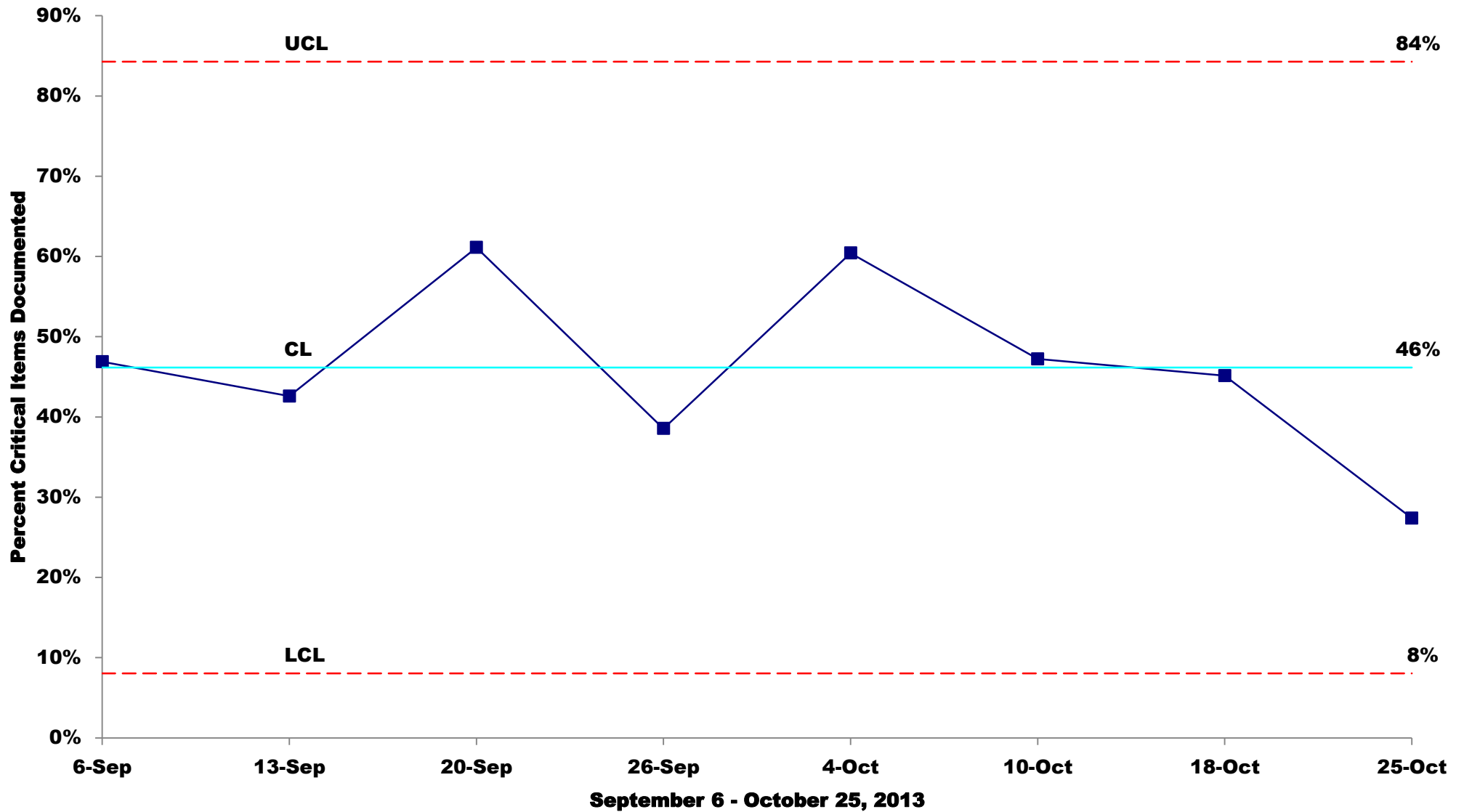
- ☒ Spiritual Transition Planning **9**
- ☒ Physician Transition Planning **10**
- ☒ Social Work Transition Planning **11**

If multiple transition plans are present, are they consistent? YES NO **12**

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

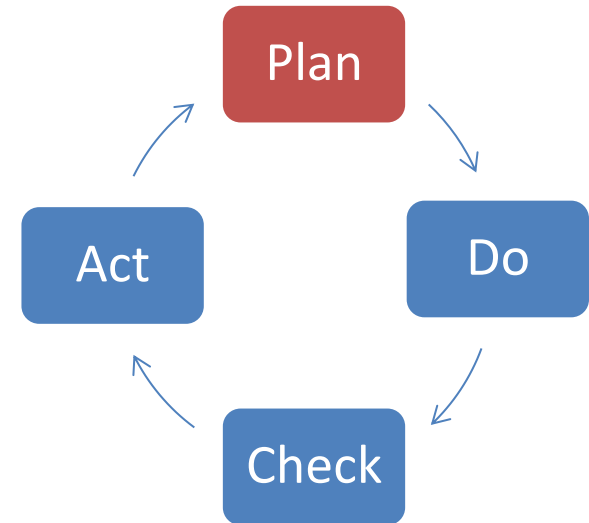
*NOTE – Only evaluate the first IDT Care Plan note, per patient, entered more than two days after consult date

Interdisciplinary Care Plan Critical Items Documented Pre-Intervention Data



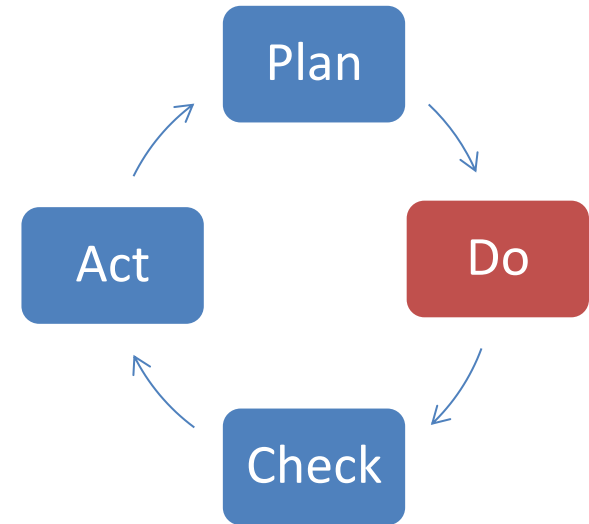
Intervention

- 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



MRN: Visit: Age: 51y	Gender: Female	UNIVERSITY HEALTH SYSTEM Location:
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 [LIFE Care/Palliative Medicine: IDT Care Plan \(SD\)](#) [Nov-08-2013
11:23]- for Visit: , Complete, Revised, Signed in Full, General

Process of Care:

Preferences:

Date preferences addressed/readdressed: Nov-05-2013⁽¹⁾ Info reviewed and accurate.

Preference Choices for how a patient wants to receive information: wants all information known to providers (diagnosis, prognosis, test results)⁽¹⁾

Preferred Language: English⁽¹⁾

Goals:

Date GOC addressed/readdressed: Nov-06-2013⁽²⁾ Info reviewed and accurate.

Patient is: FULL CODE⁽²⁾

Goal #1: Be comfortable⁽²⁾ (Most Important Goal).


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

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.⁽²⁾

Decision Making:

Date decision-making addressed/readdressed: Nov-05-2013⁽¹⁾ Info reviewed and accurate.

mPOA⁽¹⁾ Name/relationship/contact#: Mother, ⁽¹⁾

Additional Details: 210 ⁽¹⁾

Physician Transition Planning:

Transition Option Plans: home hospice⁽¹⁾

Spiritual Transition Planning:

Date Spiritual Transition Plan addressed/readdressed: 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/solid mass of the pancreatic head/duodenum, suspicious for pancreatic adenocarcinoma, likely metastatic of 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 Psycho/Social Hx:

Psychosocial Needs: The patient lives with her mother who she states "retired" to be able to take care of her.

Habits: Cig: 1ppd x 4 months

ETOH: 1 quart of beer/day

Marijuana and cocaine: until the time of this admission⁽³⁾

MRN: Visit: Age: 51y	,	Gender: Female	UNIVERSITY HEALTH SYSTEM Location:
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Transition Option Plans: home hospice⁽¹⁾

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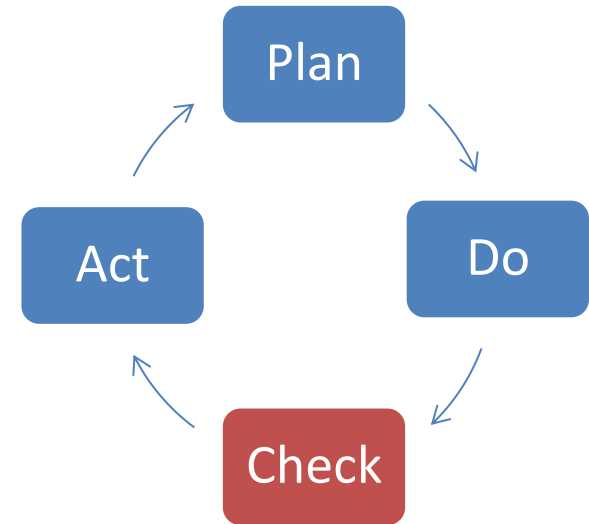
Date Spiritual Transition Plan addressed/readdressed: Info reviewed and accurate.

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

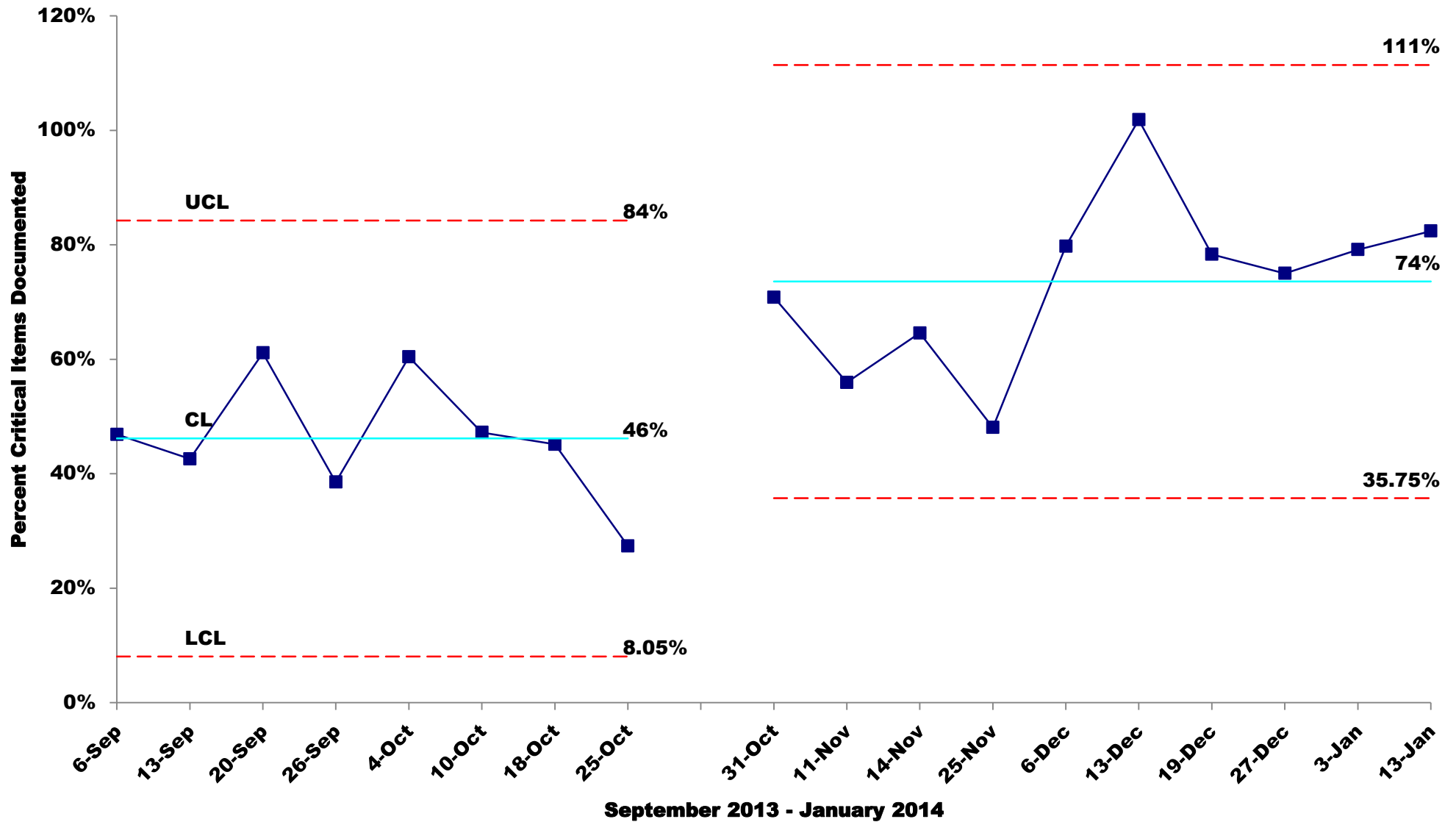
Results/Impact

- Continued auditing IDT Care Plan notes weekly
- Calculated percentage of completed elements



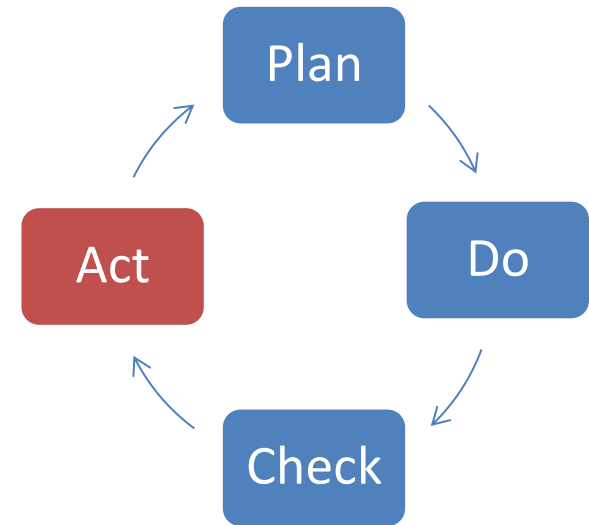
Interdisciplinary Care Plan Critical Items Documented

Pre and Post Intervention Data



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

- 1. Review Article: Goals of Care Toward the End of Life: A Structured Literature Review Lauris C. Kaldjian, Ann E. Curtis, Laura A. Shinkunas, and Katrina T. Cannon; *American Journal of Hospice and Palliative Medicine*, December/January 2009; vol. 25: pp. 501-511.
- 2. Goals of Care among Hospitalized Patients: A Validation Study. *AM J HOSP PALLIAT CARE* 2011 28: 335 originally published online 21 November 2010. Tyler H. Haberle, Laura A. Shinkunas, Zachary D. Erekson and Lauris C. Kaldjian. DOI: 10.1177/1049909110388505

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Thank you!



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