*Brief Quality Improvement Report*

# Increasing Advance Care Planning Completion at an Academic Internal Medicine Outpatient Clinic

Ngoc-Phuong Luu, MD, MHS, Candace Nigrin, Kimberly Peairs, MD, Sydney M. Dy, MD, MSc, Melinda Sawyer, MSN, RN, CNS-BC, Samantha Pitts, MD, MPH, and Brent Petty, MD

*Johns Hopkins University School of Medicine (N.-P.L., K.P., S.P., B.P.), Baltimore, Maryland; Green Spring Station Internal Medicine Clinic (C.N., K.P., S.M.D.), Lutherville, Maryland; Johns Hopkins University Bloomberg School of Public Health (S.M.D.), Baltimore, Maryland; and Johns Hopkins Armstrong Institute of Patient Safety and Quality (S.M.D., M.S., S.P.), Baltimore, Maryland, USA*

## Abstract

**Background.** We sought to increase advance care planning (ACP) completion at an academic internal medicine clinic through an electronic health record.

**Measures.** Number of eligible patients who completed a form of ACP.

**Intervention.** Multidisciplinary team approach with engagement from providers and clinic staff; implemented informational letter and appropriate forms to eligible patients before appointment; informational video and provider reminders at time of appointment.

**Outcomes.** Of 480 eligible patients, 327 (68%) completed one or more forms of ACP or had a discussion with their provider. Discussed but not completed was highest (53%). The three types of ACP completed were 1) a state-formatted advance directive form (47%), 2) Medical Orders for Life-Sustaining Treatment (45%), and 3) power of attorney designation (8%).

**Conclusions.** Implementation of a multi-disciplinary approach can facilitate ACP. However, challenges still arise because in more than half of the cases, advance care efforts led only to a discussion. J Pain Symptom Manage 2017;54:383–386. 

***Key Words***

*Advance care planning, advance directive, MOLST, power of attorney*

## Background

End-of-life care is often delivered when patients are physically or mentally unable to make medical decisions. The Health and Retirement Study estimates that more than a quarter of elderly will require surrogate decision-making at end of life.[1] Hence, advance care plans must be in place so that end-of-life care preferences reflect patients' values and goals. Having an advance care plan alleviates anxiety for patients, and surviving family members reported increased satisfaction with the quality of care received.[2,3]

Implementing electronic health records (EHRs) may improve "communication of individuals' wishes across time, settings, and providers" as recommended by the National Academy of Medicine[4]; however, implementing advance care planning (ACP) documentation in EHRs is often challenging. One study found that physician education and a one-time electronic reminder did little to improve the rate of EHR ACP documentation.[5] Another study found that even when ACP is in the EHR, it is documented in many locations and not easily retrievable by clinicians.[6]

In 2013, the Johns Hopkins Health System implemented Epic EHR.[7] At Johns Hopkins Green Spring Station Internal Medicine Clinic, an urban academic adult primary care clinic, we capitalized on this opportunity to develop, implement, and evaluate an

*Address correspondence to:* Ngoc-Phuong Luu, MD, MHS, P.O. Box 10001, PMB 419, Saipan, MP 96950, USA. E-mail: Nluu3@jhmi.edu

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interdisciplinary, team-based process to increase ACP completion. Based on Lean Sigma Value Stream Mapping,[8] we hypothesized that a multi-step approach starting with pre-visit education and materials, at-visit educational video, and reminders for clinicians when ACP was indicated were all integral to project implementation.

The Johns Hopkins University's Institutional Review Board acknowledged this project as a quality improvement initiative.

## Measures

*Development of Intervention*

The project lead mapped the process that should occur for a patient to receive appropriate ACP materials, have sufficient time to digest them and prepare for an informed discussion with their primary care providers. As part of that mapping process, we sought feedback from clinicians, front desk staff, medical assistants, clinic coordinators, and administrators.

Feedback was consistent with the three broad challenges of ACP: education for patients about ACP, clinicians' and patients' difficulty in documenting advance care plans, and discordance between patients, families, and clinicians.

To address the issue of difficulties with paperwork, before their appointment, we sent each patient a letter stating that a goal of the upcoming appointment was to also discuss ACP, and encouraging them to complete enclosed forms for an advance directive and/or Medical Orders for Life-Sustaining Treatment (MOLST). In the letter, we also encouraged patients to discuss ACP with their family and loved ones, and, if possible, to bring the person whom they would like to be their designated health care decision maker to their appointment.

At the visit, we showed a succinct informational video from the Maryland Attorney General's office[9] on ACP. Because our clinic is located in a Baltimore suburb, we thought it appropriate to choose a Maryland State government video. In addition, the video speaker is a newscaster who uses simple, easily understood terms, minimizing comprehension as a barrier.

To ensure that clinicians documented ACP consistently, we gave clinicians step-by-step training on documenting an advance directive/living will, MOLST, and power of attorney within Epic. We asked clinicians to ensure that the "task bar" for each patient under the appropriate advance directive, MOLST, or power of attorney tab turns "active" to confirm correct documentation. After each visit, the clinic administrative assistants scanned advance care plans brought in by patients and/or discussed and confirmed during the visit. The dates and location of these scanned documents were noted under the ACP tab to make them easily retrievable by clinicians.

*Determination of Measures*

Our goal was to measure the rate of completion of the three types of ACP: advance directives, MOLST, and power of attorney. Moreover, we assessed the clinician's reason(s) for not completing an advance care plan with the patient by asking clinicians to complete a short post-visit survey.

We initially planned assessment of baseline data of pre-study ACP completion; however, inconsistencies in data limited our ability to do this.

## Intervention

The initial phase was three months, from February 1 to April 30, 2015. During the initial phase, eligible patients were deemed to be those age 65 years and older, did not have an advance directive/living will, MOLST, or power of attorney already in their EHR, and were scheduled for a new patient or annual visit with their primary care provider. Two weeks before their scheduled visit, the clinic medical coordinator mailed the letter along with the ACP documents. As we could not confirm whether patients received the letters, only eligible patients who kept their clinic appointments were considered in the denominator.

At the appointment, patients could watch the short video using disposable earphones. The provider was reminded to discuss ACP by a color-coded form.

At the end of the visit, the provider was asked to complete a form answering "Was ACP discussed?" If the form was not completed, the reason why was requested.

After the initial phase, clinicians and staff at the clinic decided that the eligible age should be reduced to 60 years. Eligible visits would include not only those with new or annual appointments, but also those with post-hospitalization visits. The clinicians felt that recently hospitalized patients could benefit most from ACP. The second phase was from May 1, 2015 to March 30, 2016.

## Outcomes

During the initial phase, we sent 130 letters to eligible patients. Of those, only 96 (74%) presented to the clinic during the evaluation phase and had forms returned by the clinicians. Among the 96 patients, 69 (72%) participated in ACP; 34 (49%) of those 69 completed some form of advance care document; and 35 (51%) had a discussion about ACP during the visit. Of the 34 patients who completed an ACP document, 13 completed only an advance directive in the form of a living will (38%), 12 completed only MOLST (35%), six completed a power of attorney designation for health care decisions (18%), and three completed both an advance directive and an MOLST (9%). The remaining 35 of 69 patients