The Health Care Improvement Foundation
2018 Delaware Valley Patient Safety and Quality Award
Entry Form

1. Hospital Name

   Fox Chase Cancer Center

2. Title Of Initiative

   Your Choice, Your Voice: Collection of Advance Directive Documentation

3. Abstract (Please limit this description to 250 words.)

The subject of Advance Directives, while important for patient-centered care in all settings, is often avoided by clinical staff who may be uncomfortable with the discussion of the topic. In a setting dedicated to the care of patients with cancer, the topic can be emotional. Even when asked, patients will often promise to 'bring next time'. The unfortunate consequence of having no documentation on record, meant that the clinical staff did not have a record of the patient's wishes when they needed them and the patient was unable to participate in the decision-making. We committed to designing a plan for improving the completion of Advance Directive documents from three groups of patients: new patients, patients admitted, and patients scheduled for surgery. A workgroup was convened to identify the current practices and barriers to the collection of documents and to design a process that would address the issues identified. The baseline assessment recognized that we would need to overcome the following challenges: lack of knowledge about advance directives among staff and patients; non-standardized information and forms; difficulty finding documents on the EMR; and poor staff confidence to request the documents in routine workflow. The most significant change needed was to offer the patient an opportunity to complete the Healthcare Power of Attorney at the time of the visit The first year results were rewarded with significant initial improvement, new insight to the system and process challenges, and an initial momentum shift in the cultural behavior of the staff.

4. What were the goals of your initiative?

   The goals of the Advance Directive Documentation initiative were directed towards removing the variations that were limiting our ability to collect advanced care planning documents from our patients. The goals included:

   1. Creating one standardized set of forms and patient booklets that can be used in all settings throughout the Center. Forms are part of the book and are detachable.
   2. Staff education to provide information to promote understanding among clinical and front line registration staff about Living Wills, Power of Attorney, and Healthcare Surrogates
   3. Streamline the ability to locate Advance Directive information in the EMR.
   4. Reduce the number of lost forms by establishing a point of care scanning process to send the forms to the EMR.
   5. Provide patient / family education through information sessions, referrals to Social Service, literature availability through multi-media.

6. Create specific workflows and scripts for promoting successful patient /staff interactions at key visits and milestones. The two important aspects of this step were:

- Asking for the Healthcare Power of Attorney specifically and using that vocabulary to minimize the emotional response that is perceived to be more probable with Living Wills and even Advance Directive terminology.
- Identify milestones in the patient's visit when requests for documents should be made. Include the offer to perform real time completion of documents using the standard forms.

The first year targets were to obtain documents in the EMR for 25% of Inpatient admissions, 25% of New Patients, and 50% of patients who had surgery.

5. What were the baseline data and the results of your initiative?

The baseline for the three focused patient groups was collected from a review of 100% of patient visits during 2016.The initial results were IP admissions = 4%, Surgical Patients = 5%, and New patients registered = 0%. Clinical staff were surveyed about Advance Directives. Among the 50 physician staff who responded, 68% thought the MD had primary responsibility for discussing Advance Directive with patients and 76% responded that they did not ask. Reasons given were "too busy" , "no form", "do not know where the forms are". 45% indicated they did not know where to look in the EMR for the documents. Nursing were asked similar questions and had similar responses.

The targets for the initial implementation were set realistically. We did not have all elements in place at the initial roll-out. The elements were gradually finalized from May to August. We also knew that there were some patients who would refuse to complete forms. There were circumstances in each of the patient milestones that would not be optimal timing for introducing the discussion.

What we did not anticipate was the failure of the EMR system to consistently point the documents into the Outpatient record. Unfortunately it has greatly skewed the results in the Ambulatory new patient data and continues to be in test to correct the technical issues.

In spite of technical difficulties, we improved IP and Surgical Patient compliance by greater than 400% and New Patient will be recalculated when the system issue is resolved.

The Physicians have added prompts to their admission H & P's to include the Healthcare POA question and the documentation can now be found on inpatient admissions.

By suggestion of the Medical Oncology staff, we have added a link to the POA form and the Chemo consent form to encourage the attending MD to have both signed at the time the patient is consenting to chemo. If successful, the same link will be added for the Surgical consent.

Upon observation, the registration staff is asking each patient for their Insurance card, ID and copy of their POA with each new patient check-in. Books are given to anyone who does not have one and the patients are asked to complete. The staff in PAT has incorporated similarly.

The most encouraging element of the initiative has been the change in the staff's willingness to ask the patient about their Power of Attorney. We have overcome the

perception that it is a taboo subject. We will continue to work on the technical systems, but have successfully established the foundation for moving forward with Advanced Care planning discussions.

6. Describe the interventions that were instrumental in achieving the results for your initiative.

The successful improvement really begins with an assessment and understanding of the current state of knowledge, resources, support systems and beliefs in an organization. The most effective strategies were those that empowered the staff to be confident in their knowledge and defined their roles in the process.
The second aspect was creating opportunity to integrate the discussion into routine workflows and offer to complete the document with the patient in real time.
Create Conversation Starters: - Create standardization in resources and messaging. - Make the message and resources available and very visible in care areas - Build prompts into workflow.
Confidence grows as staff integrate the discussion into their routine and all staff share the responsibility.

7. Describe the key steps required to successfully replicate this initiative throughout the region. (Please limit this description to 100 words.)

Key to creating a change is to begin with an assessment of the barriers and beliefs that exist in the organization.
1. Education for the staff
2. Standardization of the message and the resources
3. Integration of the subject into routine workflows and include real time completion of the document.
4. Opportunities for Conversation Starters for both staff and patients.

8. Explain how the initiative demonstrates innovation (Please limit this description to 100 words.)

Innovation in this example is focused on changing an existing idea among both staff and patients through the use of process and standard messaging.

If innovation is a metamorphosis, then the process of changing perception of a potentially emotional subject to a topic that is routinely addressed as part of the care continuum is a significant transformation that can be achieved through process change.

The process is normalized and escalated 'to the next step' to an offer to complete the document with the patient rather than the traditional request to 'bring with you next time'.

9. How does this initiative demonstrate collaboration with other providers within the continuum of care? (Please limit this description to 100 words.)

The members of the workgroup were from all clinical and support domains. Patients are cared for by disease teams when they are treated at the Center. The improvement team reflected the continuum of care providers who interact with the patients during their care . Registration staff, Nurses from Inpatient, Ambulatory, and Navigation, Risk Management, Social Service, Medical Oncology, Radiation Oncology, Surgical Oncology,

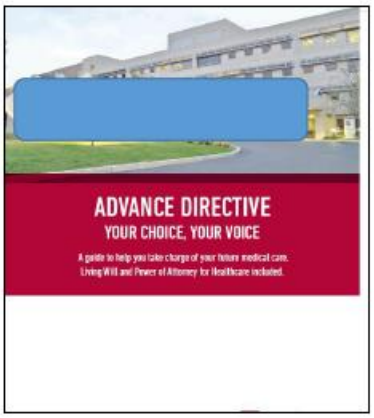
Hospitalists and the Patient/Family Advisory Committee were led by the Palliative Care Director and facilitated by Performance Improvement. Information Technology representatives provided focused guidance and support for system changes.

10. Explain ways in which senior leadership exhibited commitment to the initiative (Please limit this description to 100 words.)

    Senior leaders represented clinician and administration on both the Palliative Care Steering Committee who sponsored the initiative, and the working team. This is clearly a topic that is valued as evidenced by the participation on both committees. Members of the working group included division Chiefs and Department Directors. The administration granted funds for the development of the books that were created and supported the changes to systems and processes. We were most honored to have the Chief of the Department of Heme/Onc, Chair of Cancer Prevention and Special Advisor to the President as a member of our work group.

11. Appendices (i.e., tables and graphs)

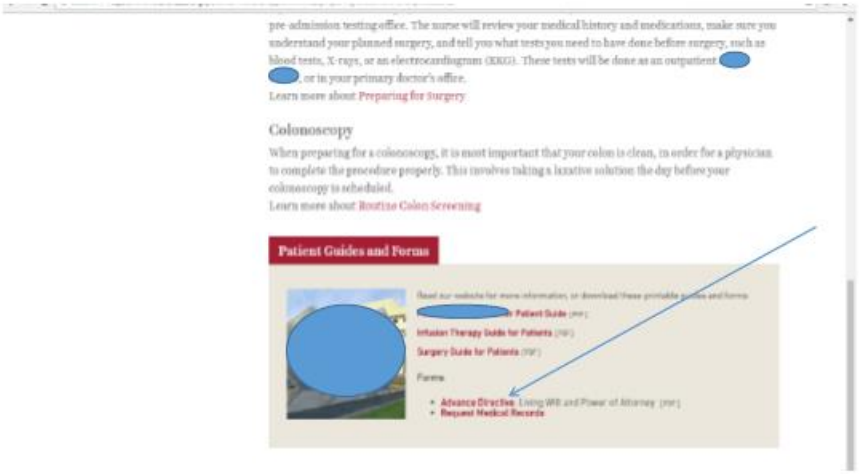
New Booklet



Available at

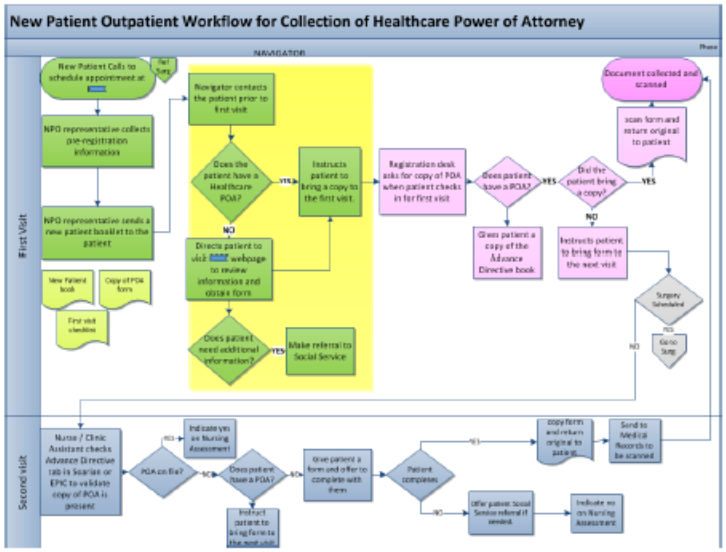
- New Patient Registration
- Clinic workrooms
- REC
- PAT
- Inpatient Nursing Units
- Social Service

On-Line Versions: My Portal



Chemo Consent Link

New Patient Process



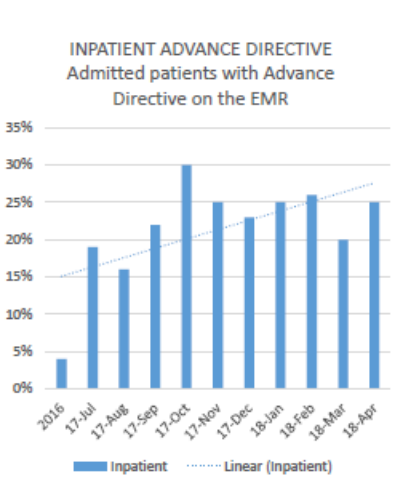
Power of Attorney form

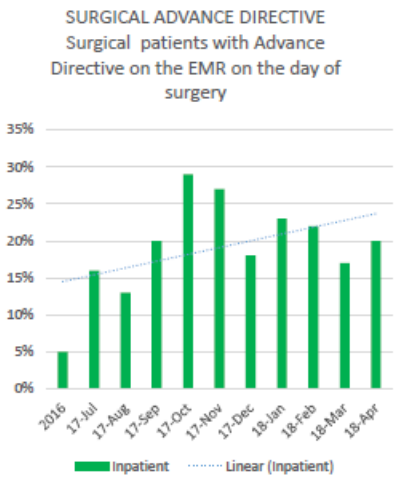
HEALTHCARE POWER OF ATTORNEY

- Two (2) witnesses must sign the form
- The form does NOT need notarization
- Hospital staff may sign as witnesses

Epic Screen

Results to Date





Outpatient	2016	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
# of Advance Directives Documents Scanned		14	35	29	13	10	3	12	9	7	9
# of New Patients		130	374	300	149	125	110	148	112	140	126
% Documented	0%	11%	9%	10%	9%	8%	3%	8%	8%	5%	7%

Surgical	2016	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
# of Advance Directives Documents Scanned		61	56	63	108	95	53	84	67	52	68
# of New Patients		392	415	310	369	358	293	361	310	300	336
% Documented	5%	16%	13%	20%	29%	27%	18%	23%	22%	17%	20%

Inpatient	2016	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
# of Advance Directives Documents Scanned		79	62	60	97	72	64	77	73	51	74
# of New Patients		424	397	272	319	290	277	312	282	256	299
% Documented	**4%**	**19%**	**16%**	**22%**	**30%**	**25%**	**23%**	**25%**	**26%**	**20%**	**25%**