Improving Advance Care Planning Documentation in Oncology

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Background:
Advance care planning (ACP) should be initiated for patients with cancer, a recommendation of both the American Society of Clinical Oncology (ASCO) and National Comprehensive Cancer Network. Additionally, this directive is prescribed by the Institute of Medicine and represents a quality metric of ASCO’s Quality Oncology Practice Initiative and the Centers for Medicare & Medicaid Services Oncology Care Model. Implementation in practice has been studied previously with moderate success of interventions and call for emphasis on use of the electronic medical record. Our intervention is novel in its expansion to all gastrointestinal and thoracic oncologists at Abramson Cancer Center Penn Medicine main campus and its emphasis on documentation in the electronic medical record which is viewable across outpatient and inpatient settings and linked to billable activity.

Project Strategy:
This project fits into an overall strategy to deliver high value, patient centered care to oncology patients. Key aims include:
• Decreasing moral distress of the patient, family and care team surrounding serious illness decision making.
• Minimizing system and societal waste, including unnecessary utilization of healthcare resources such as higher levels of care and low value tests and therapies.

Project Aim:
To increase advance care planning documentation in the electronic medical record by oncologists for patients with advanced gastrointestinal and thoracic cancers.

Changes being tested:
• Presentation of the process of documentation and billing in the electronic medical record at both gastrointestinal oncology and thoracic oncology tumor board meetings.
• Weekly e-mail to oncologists with anonymous audit and feedback with performance compared to their peers and instructions on use of the advance care planning feature of the electronic medical record.
• One on one peer teaching in how to document in the electronic medical record based on oncologist request.

Next steps:
This project has demonstrated the efficacy of tailored interventions in implementation, in this case with the interventions including the use of personalized training and anonymous audit and feedback to change behavior of oncologists. The electronic medical record offers functionality which can be leveraged in achieving effective advance care planning. As use of the advance care planning tab increases, the content of the documentation will then be standardized and the intervention scaled to include all oncology disease specialties. This project raises awareness of the electronic medical record as a complement to concurrent interventions such as clinician training on serious illness conversation strategies and optimization of palliative care services. Metrics to assess outcomes following this combined effort are planned to include hospital length of stay, time on hospice, palliative chemotherapy at the end of life.

Results:

High variability in oncologist practice exists. The above figure demonstrates the proportion of advance care planning notes out of return patient visits per oncologist since audit and feedback intervention in July 2017. Represented in red are providers performing outside of the control limits.

Measures:
Number of advanced care planning notes per oncologist per week, number of return patient visits per thoracic and gastrointestinal oncologist per week. Twelve oncologists were included, six thoracic oncologists and six gastrointestinal oncologists practicing at the Abramson Cancer Center Penn Medicine main campus, a large academic medical center.