ADVANCING ADVANCED DIRECTIVE DOCUMENTATION IN INTERNAL MEDICINE (AADD-IM)

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INTRODUCTION: BACKGROUND & CONTEXT

IMPORTANCE OF ADVANCE DIRECTIVE (AD) DISCUSSION IN PRIMARY CARE
• Planning for future health care needs has multiple benefits for elderly patients, their loved ones and the entire health care system
• 89% of patients prefer AD conversations be initiated in outpt setting
• Patients expect their primary care provider, more than any other medical provider to initiate the AD conversation

OUR CHALLENGE: INTERNAL MEDICINE RESIDENCY CLINIC (IMRC)
• 47% of IMRC patients > 65 and older have completed AD
• Existing clinic AD workflow limited utility as need process to:
  – Identify patients needing AD
  – Provide AD documentation and education to patients in busy clinic
  – Formalize workflow and tracking for patient follow up with Social Worker

MISSION/VISION STATEMENT

VISION: To demonstrate GME’s leadership role in driving a culture of continuous learning - essential in a high reliability organization
MISSION: To improve care for our patients and the well-being of our clinical team members through implementation of system aligned QI projects within and across our GME programs/clinics/service units

AIM/PURPOSE/OBJECTIVES
• AURORA AIM: Apply tested interventions to facilitate a safer environment for patients and caregivers
• OUR AIM: To Advance Advanced Directive Documentation in Internal Medicine (AADD-IM)
• OBJECTIVE: To increase our AD completion numbers for patients > 65 years old in the Internal Medicine Residency Clinic at Sinai to > 59% by project completion (best possible Advocate Aurora QI Metric)

METHODS: INTERVENTIONS/CHANGES

PHASE 1: INTERPROFESSIONAL TEAM & STANDARDIZE WORKFLOW
• Team: Work with Medical Assistants (MAs), clinic administration, residents/providers, and social work
• Review/Revise: Post Clinic Leaders input
• Produce AD Packets: Hand to patients including AD paperwork, AD workshop dates, social worker info, and AD workshop dates/times

PHASE 2: EDUCATION/TRAINING
• Residents: Two 1-Hr Noon Conf: Fill out our own ADs; Strategies to discuss topic w patients in clinic + ½ Day on goals of care conversation
• Clinic: Staff/social worker and faculty meetings

PHASE 3: MONITOR per PDSA, ENGAGE CHAMPIONS & PATIENTS

METHODS: MEASURES/METRICS

PROCESS MEASURES & OUTCOME MEASURES w 2nd residency clinic as control
• # of ADs uploaded and DotPhrase Metrics
• Audit workflow via # pts who follow-up with MSW, # of packets, direct observation of physician/patient interaction
• Clinical Learning Environment Quick Survey (CLEQS) & Well-Being Index

BALANCING MEASURES: Overall Clinic QI Scores & CLEQS clinic data

BARRIERS – STRATEGIES

CURRENT CHALLENGES AND STRATEGIES
• Convincing clinicians and patients that ADs can be impacted (time):
  – Are vital for excellent primary care
  – To complete paperwork, signatures and upload to our system
  – Ongoing refreshers from specialists on how to discuss with patients
  – Continued Education: Use examples of real life scenarios; Follow-up with each resident to complete their own AD paperwork (supports advocacy and education with patients re: how to fill out forms)
• Gaps between paperwork ↔ social worker, (co) signing and uploading
  – Explore feasibility of “clinic-based in the moment completion” approach

DISCUSSION

NEXT STEPS
• Support seamless integration into daily clinic work flow
  → 2nd clinic
• Monitoring & sustaining process > NI7 study period (all ages)

AREAS SEEKING INPUT
• How assess the “quality” of clinician communication
• Strategies for follow-up with patient to facilitate completion – from packet distribution to returning document for uploading
  – How can we get patients to “value it” and act on it?
  – Has anyone developed an approach to support patient completion in clinic?

GROUP FEEDBACK