Penn Medicine

Practical Steps to More Effective ACP: The Health System Perspective

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Advance Care Planning: Health System Perspective

WHO

- Which patients? Which clinicians?

WHAT

- Conversation versus document?

HOW

- Consistency and quality
- Systems of care

WHO? *Which patients…*

- Targeting patients with serious illness or frailty

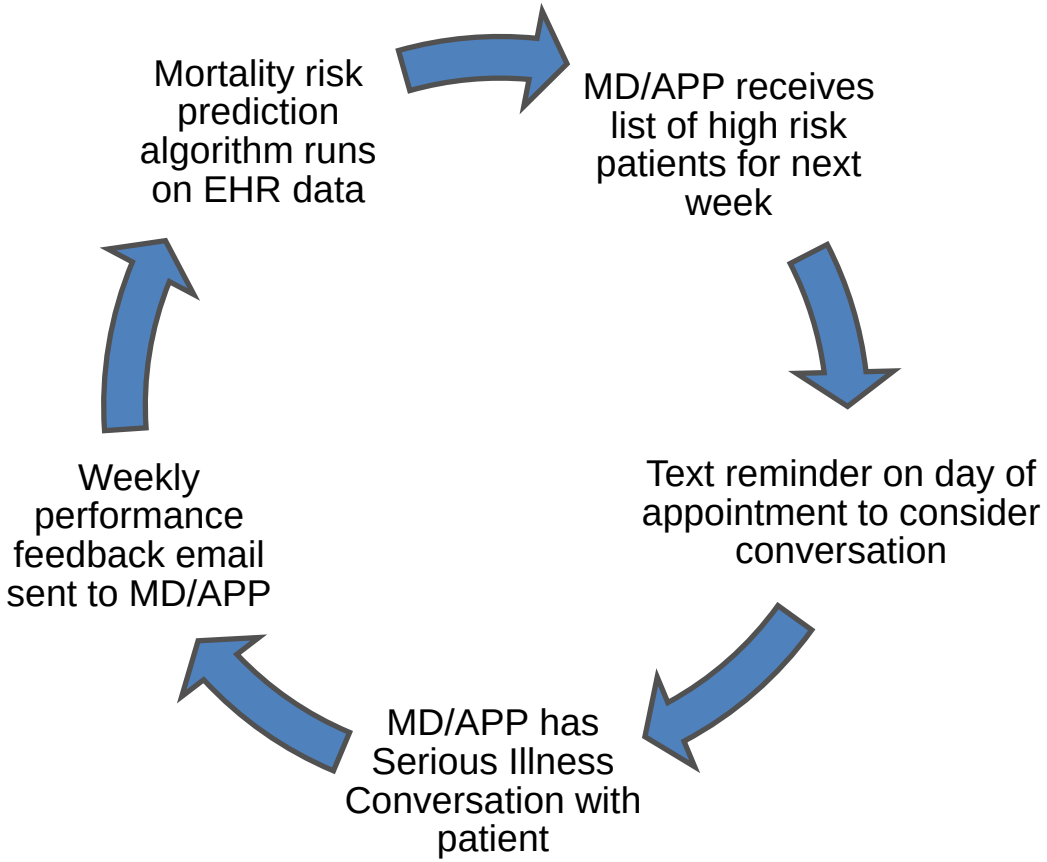
- Prioritize practices and services lines with high proportion of seriously ill
  - Cancer Service Line
  - Heart and Vascular Service Line
  - Geriatrics, including Long Term Care Clinicians
  - *Primary Care, with a focus on longitudinal care management program*

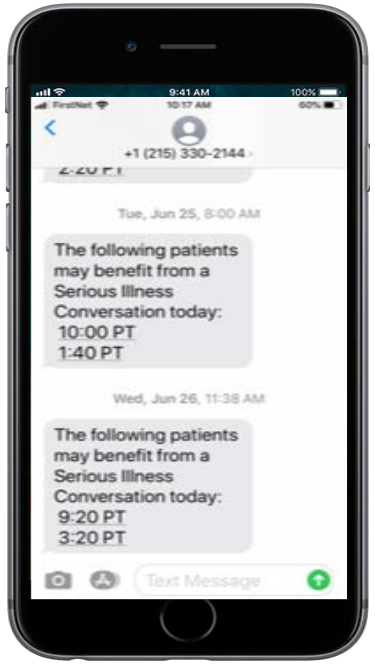
- Surprise question, with a longer horizon
  - *Would you be surprised if this patient died in the next 2 years?*
  - If PCP answers yes, patient 8.4 times more likely to die in the next 2 years[1]

[1]Lakin J et al, J Gen Intern Med 2019; 34(8):1467-1474.

WHO? *Which patients…*

- Conversation Connect = machine learning algorithm that identifies outpatients with cancer with increased risk of mortality AND no documented ACP conversation[1]





[1]Parikh RB et al, JAMA Netw Open 2019; 2(10):e1915997.

WHO? *Which Clinicians…*

- Building a scalable workforce for advance care planning

WHAT? *Which outcome to drive…*

- Focus on conversations; documents are the product of (some) conversations
- Capture conversations in consistent and easy to retrieve location in EHR
- Complete POLST form after conversation if appropriate

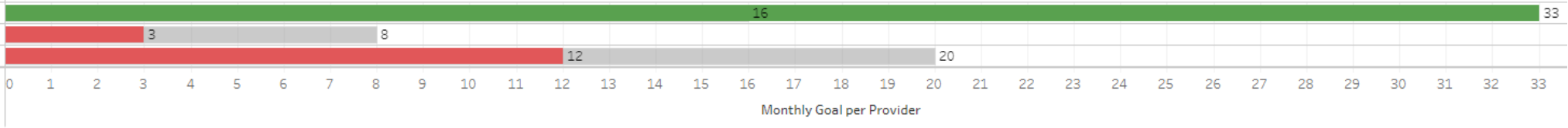
WHAT? *Which outcome to drive…*

SICP Team Goal Performance |April 2019

Green: Monthly Goal Met

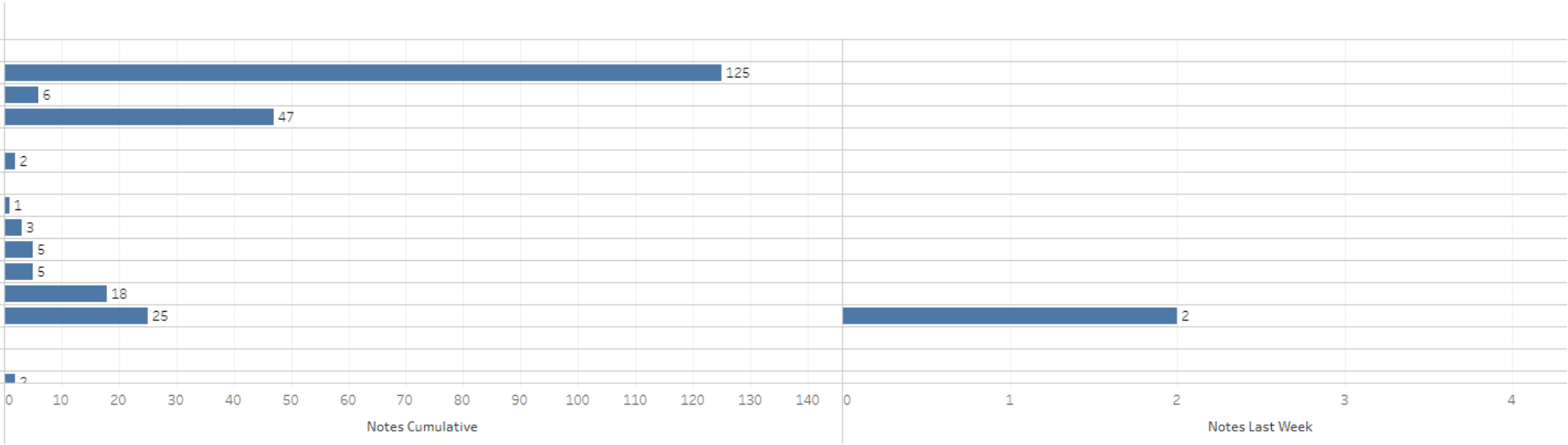
Red: Monthly Goal Not Met

Team	Number of Providers	Monthly Goal per Provider
Geriatrics	4	16
HUP HF	2	8
LTACH	5	20



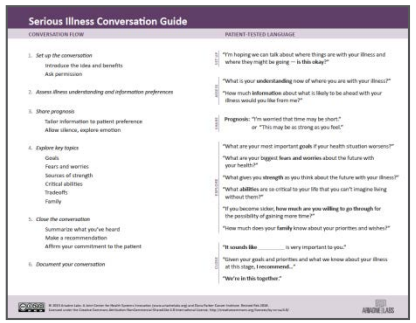
Serious Illness Conversation Notes Documented by Team, Provider

Team	Provider Name	Training Date
PPMC MICU		2018-09-25
		2018-09-25
		2018-10-05
		2018-09-27
		2018-09-25
		2018-10-05
		2018-10-05
		2019-02-15
		2020-04-06
		2019-02-15
		2019-02-15
		2020-01-22
		2019-02-15
		2020-01-22
		2020-01-22
		2020-01-22

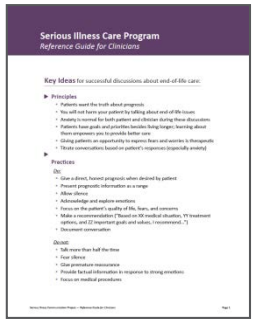


HOW: *Training + Systems of Care = Quality + Consistency*

Tools

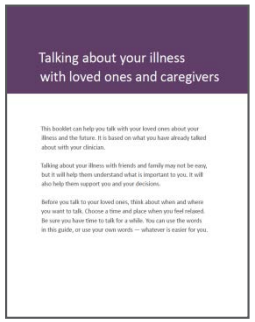


Serious Illness Conversation Guide



Clinician Reference Guide

Patient preparation materials



Family Comm. Guide

Training

Train and Coach Clinicians

3-hour clinician training
1 month post-training coaching

Systems Changes

Patient Identification → **Patient Preparation** → **Conversation Using the Guide** → **Document in PennChart** → **Retrievable Across Sites**

Measurement and Improvement

Serious Illness Care Program implemented in collaboration with Ariadne Labs

HOW: *Program Monitoring and Feedback*

- “It made me think about a lot of things - the condition I'm in, how I want things handled. Made me think about my future, what I want to do.”

- “It's a conversation everybody has to have, so didn't create any awkwardness or anything like it. I think it was a good conversation, gives her a sense of direction on where I'm leaning, gives us both a sense of direction.”

Advance Care Planning: Take Homes for Health Systems

- Define target populations; patients with serious illness and frailty should be top priority
- Data science can identify patients to prioritize for Advance Care Planning
- Conversations are the goal; some conversations (but not all) result in an Advance Directive
- Scalable training is critical to ensure consistent high quality ACP conversations
- Track and monitor conversations for ongoing program evaluation