Targeted Strategies to Improve Advance Directives in a Major Cancer Hospital

Presented by:
Finly Zachariah, MD FAAFP
Clinical Adoption Lead, Assistant Clinical Professor, City of Hope

William Dale, MD PhD
Arthur M. Coppola Family Chair in Supportive Care Medicine, Clinical Professor, City of Hope
Disclosures

We do not have anything to disclose.
Compared to patients who complete an Advance Directive “early,” patients who complete an Advance Directive near to the time of death choose…

- 56% choose More Comfort Oriented Care
- 44% choose More Aggressive Care

PLAN TODAY FOR TOMORROW
Timing Matters

Plan today for tomorrow.
“If your doctor told you that time was extremely short due to a life threatening illness, where would you WANT to die?”

A. Hospital
B. Skilled Nursing Facility
C. Home
D. My Favorite Vacation Spot (beach, mountains, etc)

**Results:**

- Hospital: 7%
- Skilled Nursing Facility: 0%
- Home: 64%
- My Favorite Vacation Spot: 29%

**Plan Today for Tomorrow**
“Where do you think you will die?”

A. Hospital
B. Skilled Nursing Facility
C. Home
D. My Favorite Vacation Spot (beach, mountains, etc)

[Bar chart showing percentages: Hospital 55%, Skilled Nursing Facility 33%, Home 9%, My Favorite Vacation Spot 3%]
Reality Check: Where Californians Die

Preferred Location of Death, California, 2011

- Hospital: 16%
- Home: 70%
- Other: 7%
- Don’t know/Not sure: 2%
- Refused: 2%
- Hospice facility: 4%

Location of Deaths, California, 1989, 2001, 2009

<table>
<thead>
<tr>
<th>Location</th>
<th>1989</th>
<th>2001</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>58%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td></td>
<td></td>
<td>13%</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>32%</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td>Inpatient Hospice</td>
<td></td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Note: Segments may not add to 100% due to rounding.

Source: Californians’ Attitudes Toward End-of-Life Issues, Lake Research Partners, 2011. Statewide survey of 1,669 adult Californians, including 365 respondents who have lost a loved one in the past 12 months.

Life Prolongation Preferences by Race/Ethnicity

- **Not sure**: 25%
- **Medical providers using everything to prolong life**: 7%
- **Dying a natural death if heartbeat or breathing stops**: 67%

**TOTAL**
- 67%

**African American**
- 58%

**Latino**
- 60%

**Asian/Pacific Islander**
- 67%

**White/Non-Latino**
- 75%

(Charts show preferences by race/ethnicity, with detailed breakdowns for medical preferences.)
## Window into City of Hope

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Patient Deaths</th>
<th>Inpatient Deaths</th>
<th>Advance Directives</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>1593</td>
<td>215</td>
<td>23%</td>
</tr>
<tr>
<td>2015</td>
<td>1625</td>
<td>224</td>
<td>27%</td>
</tr>
<tr>
<td>2016</td>
<td>1220</td>
<td>271</td>
<td>32%</td>
</tr>
</tbody>
</table>

**Plan Today for Tomorrow**
### Hospital Days in the Last Six Months of Life

<table>
<thead>
<tr>
<th>Year</th>
<th>Average Hospital Days in the Last 6 Months of Life at City of Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>25</td>
</tr>
<tr>
<td>2015</td>
<td>26</td>
</tr>
<tr>
<td>2016</td>
<td>29</td>
</tr>
</tbody>
</table>


©2012 California Healthcare Foundation
ICU Stay in Terminal Admission

Off the Chart!!!

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients admitted to ICU in Terminal Admission at City of Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>63.72%</td>
</tr>
<tr>
<td>2015</td>
<td>62.95%</td>
</tr>
<tr>
<td>2016</td>
<td>61.25%</td>
</tr>
</tbody>
</table>
Patient-Provider Communication at the End of Life

Would Like to Talk to Doctor About End-of-Life Wishes, California, 2011

If you were seriously ill, would you like to talk with your doctor about your wishes for medical treatment toward the end of your life?

- Definitely not (1%)
- Probably not (2%)
- Maybe (16%)
- Definitely (47%)
- Probably (32%)
- Refused (2%)

Most likely to say “definitely”:
- Age 65+ (61%) — especially women (70% vs. 51% men)
- White (55%)

Doctor Talking with Patient About End-of-Life Wishes, California, 2011

Have you ever had a doctor ask you about your wishes for medical treatment at the end of your life?

- Yes (7%)
- Refused (1%)
- No (92%)

Most likely to say “yes”:
- Age 65+ (13%) — especially women (66% vs. 10% of men 65+)

Most likely to say “no”:
- Age 45 to 64 (94%) vs. 90% age 65 to 79, and 84% age 80+.

Source: Californians' Attitudes Toward End-of-Life Issues, Lake Research Partners, 2011. Statewide survey of 1,069 adult Californians, including 360 respondents who have lost a loved one in the past 12 months.
Honoring Preferences and Satisfaction at the End of Life

**Overall Rating of End-of-Life Care of Loved One, by Insurance Status and Language Barrier, California, 2011**

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>No Language Barrier</th>
<th>Language Barrier</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>58%</td>
<td>36%</td>
<td>52%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>35%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Loved One’s Wishes Completely Followed, by Insurance Status and Language Barrier, California, 2011**

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>No Language Barrier</th>
<th>Language Barrier</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>51%</td>
<td>25%</td>
<td>44%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>51%</td>
<td>26%</td>
<td></td>
</tr>
</tbody>
</table>

Plan today for tomorrow.

[Image of bar charts showing percentages of overall rating and wishes followed, categorized by insurance status and language barrier.]

City of Hope
Advance Care Planning Across the Spectrum is Needed

The Challenge:

• Achieve universal capture of advance directives
• Assure care received aligns with a patient’s values, preferences, and priorities
• Provide consistent treatment and care delivery, especially as a patient’s disease progresses
“Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.”

Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel Sudore, Rebecca L. et al. Journal of Pain and Symptom Management
City of Hope’s Advance Care Planning Program

The Department of Supportive Care Medicine with Executive Team endorsement and significant institutional collaboration created a patient- and family-centered Advance Care Planning Program by:

- Changing policy to provide complimentary patient/caregiver and staff notarization for ADs
- Creating a culturally sensitive branding campaign, “Plan Today for Tomorrow”
- Revising and developing new educational materials
- Creating an Advance Directive Patient Navigator/Notary position to support patients, families, and staff
- Developing disease-specific workflows
- Created multi-lingual AD workshops/events in the Sheri & Les Biller Patient & Family Resource Center
- Leveraging the EMR to easily retrieve existing AD, know when ADs were absent, and assist in creating
- Deploying AD-specific screening questions in SupportScreen, our patient interface for needs

PLAN TODAY FOR TOMORROW
National Healthcare Decisions Week Events 2017

Monday
April 17th

Outreach at the Claremont Colleges

Tuesday
April 18th

Medical Ground Rounds
Free Advance Care Planning Services for City of Hope Staff !!!

Wednesday
April 19th

Advance Directive Conversation Café

Thursday
April 20th

Estate Planning 101: Ensure You and Your Loved Ones are Protected

PLAN TODAY FOR TOMORROW
The purpose of the new Integrated Advance Care Planning Program within the Department of Supportive Care Medicine is to:

- Educate
- Empower
- Coordinate with DSCM staff and external entities
- Create a seamless continuum of care

PLAN TODAY FOR TOMORROW
Integrated Advance Care Planning Program Outcomes

- Increase of Advance Directives
- Increase in Patient and Family Satisfaction
- Improve Treatment and End of Life Bereavement Care
- Increase Documented Goals of Care Across the Continuum
- Decrease Deaths in the Hospital
- Early Referrals to Hospice
The Team and Department Supporting Advance Care Planning

Finly Zachariah, MD
Gayle Ito-Hamerling
Nicole Boutros
Dhruti Ramchandani
Biller Resource Center Team
Sophia Yeung
Carolina De La Pena
Sarai Gonzalez
The Hunt For the Elusive Advance Directive
Billing Codes for Advance Care Planning

Billing and documentation Requirements:

- ACP may be performed on the same calendar dates as an E&M service
  - The time documented for the ACP must be separate and distinct from the E&M service time
  - Active management of the problem(s) is not undertaken during the ACP discussion

  ***Remember: don’t double dip on time***

- Both the services performed and the exact time required to complete this discussion must be documented
  - 99497 = First 30 minutes (must be minimum of 16 minutes in order to bill)
  - 99498 = each additional 30 minutes (must be minimum of 46 minutes total)
- May not report ACP on the same day as adult and pediatric critical care codes (in the same specialty)
Where Are Your Advance Directives Coming From?

Status Report on Advance Directives by Month

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Received</td>
<td>156</td>
<td>172</td>
<td>186</td>
<td>155</td>
<td>186</td>
<td>137</td>
<td>176</td>
<td>139</td>
<td>211</td>
<td>157</td>
<td>182</td>
<td>174</td>
</tr>
<tr>
<td>Census</td>
<td>26</td>
<td>33</td>
<td>29</td>
<td>35</td>
<td>21</td>
<td>16</td>
<td>14</td>
<td>20</td>
<td>16</td>
<td>7</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Correspondence</td>
<td>28</td>
<td>25</td>
<td>31</td>
<td>25</td>
<td>33</td>
<td>19</td>
<td>17</td>
<td>15</td>
<td>28</td>
<td>20</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Email</td>
<td>89</td>
<td>110</td>
<td>123</td>
<td>92</td>
<td>130</td>
<td>100</td>
<td>139</td>
<td>100</td>
<td>166</td>
<td>130</td>
<td>141</td>
<td>122</td>
</tr>
<tr>
<td>Fax</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Inpatient</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Inter-Office</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
How are they viewed and applied in the EMR?

In ConnectHope, HIMS will assist with Advance Care Planning management, ensuring that providers view accurate, up-to-date Advance Directives and Out Of Hospital DNR status. All forms will still be available to review in OnBase.

PLAN TODAY FOR TOMORROW
To make an appointment and/or request a notary, contact Jeanne Lawrence in the Sheri & Les Biller Patient and Family Resource Center.

Staff, caregivers and patients can have their advance directives notarized free of charge.

Notaries are available Monday-Friday from 8:30 am-4:30pm. They are able to notarize in PATC and both in the Inpatient and Outpatient areas of COH.

A contracted notary is available Tuesday-Friday, 11:00am-1:00 pm. The contracted notary will charge $15.00 for documents other than advance directives.

On site notaries (COH employees) speak Mandarin, Cantonese, Spanish and English.
Culturally Sensitive Branding Campaign: Language

FILL OUT AN ADVANCE DIRECTIVE TO SHARE YOUR WISHES AND EASE YOUR MIND

WHAT IS AN ADVANCE DIRECTIVE?
It’s a written instruction telling your family and health care team what you want done in case you have a serious illness or injury and cannot speak for yourself.

PROTECT YOUR WISHES
Your advance directive guarantees you’re the one making the decisions about the treatment or care you receive — not anybody else.

FOR PATIENTS OF EVERY AGE AND HEALTH STATUS
People of every age and health status fill out advance directives, even before routine procedures. Some even update them as they go through different life events and health issues.

REMOVE STRESS AND ANXIETY
Studies prove that patients and their families with an advance directive in place suffer much less stress, anxiety and depression about medical decisions.

WE’RE HERE TO HELP
For more information, visit City of Hope’s Sheri & Les Biller Patient and Family Resource Center to pick up the educational booklet Making an Advance Directive or ask to speak to a clinical social worker.
How to Complete Your Advance Directive at City of Hope

An advance directive lets you choose:
- A medical decision maker who can share your wishes and make health care decisions for you if you are unable to make them yourself
- The kind of medical treatment that you want or do not want

At the Sheri & Les Biller Patient and Family Resource Center you can:
- Pick up an advance directive form. There is also a copy in your New Patient packet.
- Meet with an advance directive navigator or clinical social worker. They can answer your questions and help you complete your advance directive. Same day appointments are often available.
- Have your advance directive notarized. City of Hope offers free notary services for patients who would like to complete an advance directive.
- Schedule a notary appointment when you are an inpatient or during your chemotherapy infusion appointment.

Already have an advance directive?
- Make sure to bring a copy during your next visit to City of Hope. Your health care team can scan it into your medical record.

For more information:
Stop by or call the Sheri & Les Biller Patient and Family Resource Center located in Main Medical behind the Guest Services desk.
Monday to Friday, 8 a.m. to 5 p.m. • 626-218-CAIRE (2273)
Culturally Sensitive Branding Campaign: Staff

PLAN TODAY FOR TOMORROW

I JOINED THE CONVERSATION
NATIONAL HEALTHCARE DECISIONS WEEK 2017

City of Hope

"The reason why I decided to complete an advance directive was to practice what I preach to my patients."
City of Hope ICU Nurse

"Now that I'm working in the field and have a better understanding of what an advance directive is, I realize the importance of having one."
Program Coordinator for the Women's Cancers Program at City of Hope and Cancer Survivor

PLAN TODAY FOR TOMORROW
Culturally Sensitive Branding Campaign: Patients

Because we want our voices heard, loud and clear.
— Michelle and Bob P., breast cancer survivor and bladder cancer survivor

Thursday, April 16, 2015
10 a.m. to 3 p.m.
Sheri & Les Biller Patient and Family Resource Center

Mi vida, mi salud, mi decisión.
— Jasmine L., cuidadora de su abuelita

Jueves, 16 de abril del 2015
Jornada de puertas abiertas de 10 a.m. a 3 p.m.

因為對於我和家人而言，在醫療護理過程中能發表我的建議是最為恰當的。
— 乳腺癌存者

二零一五年四月十六日週四
早上十時至下午三時
Sheri & Les Biller
病人及家屬資源中心
Culturally Sensitive Branding Campaign: Video

https://www.youtube.com/watch?v=B0bYZ6pyfhE
National Healthcare Decisions Week Events 2017

Monday
April 17th

Outreach at the Claremont Colleges

Tuesday
April 18th

Medical Ground Rounds
Free Advance Care Planning Services for City of Hope Staff !!!

Wednesday
April 19th

Advance Directive Conversation Café

Thursday
April 20th

Estate Planning 101: Ensure You and Your Loved Ones are Protected

PLAN TODAY FOR TOMORROW
National Healthcare Decisions Week 2017

OUTREACH AT THE CLAREMONT COLLEGES

Student Resource Advocates

PLAN TODAY FOR TOMORROW
National Healthcare Decisions Week 2017: Staff Day

109 Staff Advance Directives completed!
Feedback:
- Great talk on a difficult topic
- Thanks for fun and informational CME on a key topic
- We need more grand rounds on this topic to raise percentage of advance directives at COH and less deaths at COH, more at home

Will the information presented cause you to make any changes in your practice?
- Doing my part to work with primary teams to get involved sooner
- Kleenex box placement
- SPIKES protocol
- Easier to discuss advance directives with patients.
147 attendees
30 completed AD

“The staff are very informative”
“Thank you for thinking of patient’s decisions”
“Incredibly helpful and made my family and myself comfortable”
“Ruby did an outstanding job explaining the AD”
“I appreciate this opportunity”
“This is a great event. Thank you.”
Targeted Interventions

PLAN TODAY FOR TOMORROW
Outpatient Strategy

 estratégia de atención ambulatoria

PLAN TODAY FOR TOMORROW

- Patient is identified

  - MD/NC initiates conversation
    - MD or Nurse Coordinator

  - Staff pages Advance Directive Navigator

  - Social Worker is present in clinic for designated period of time

  - Advance Directive Navigator is present in clinic for designated period of time

  - Refer to Sheri & Les Biller Patient and Family Resource Center with referral prescription pad for Advance Directive or Notary services

  - SupportScreen triggers e-mail to Advance Directive Navigator

  - Visit takes place in clinic. Notary services arranged

  - Patient makes appointment at Sheri & Les Biller Patient and Family Resource Center for Advance Directive and Notary services

  - Advance Directive Navigator follows up with patient and offers to schedule appointment to discuss Advance Directive or Notarize
Strategies for Focus Areas

**Patient Identification**
- PATC
  - Refers to Sheri & Les Biller Patient and Family Resource Center for Advance Directive and Notary services.

**Patient Touch**
- Hospice Liaison Nurse
  - Prompts conversation and provides Advance Directive referral prescription
- Dr. Hurria Study
  - Provides Advance Directive referral prescription or pages Advance Directive Navigator
- Support Screen
  - Triggers email to Advance Directive Navigator

**Action**
- Sheri & Les Biller Patient and Family Resource Center pages Clinical Social Worker or Advance Directive Navigator for conversation and notarization.
- Patient makes appointment with Sheri & Les Biller Patient and Family Resource Center
- Advance Directive Navigator meets with patient or patient makes appointment with Sheri & Les Biller Patient and Family Resource Center
- Advance Directive Navigator follows up and offers to schedule an appointment to discuss Advance Directive or Notarize.
Initial Success: Metastatic Breast Cancer Clinic

- **Team:**
  - Engaged Oncologist and medical staff
  - Staff completed their own AD
- **Intervention:**
  - Team Huddles to identify which patients had an advance directive or needed one
  - Nurse staff empowered to discuss ADs with patients
  - Oncologist endorsed AD
  - AD Navigator was available to meet with patients in between provider visits

PLAN TODAY FOR TOMORROW
Initial Success: Metastatic Breast Cancer Clinic

Increase in Advance Directives in Outpatient Metastatic Breast Cancer Clinic

PLAN TODAY FOR TOMORROW
AD excellence, every time

• On average, after referral: 2 visits with AD Navigator before completion

• Process improvements:
  ✓ **SupportScreen**: “Yes, I have an AD, but COH does not have a copy”
  ✓ Invalid ADs submitted to Medical Records
  ✓ Identifying gaps

PLAN TODAY FOR TOMORROW
AD excellence, every time: collaboration

<table>
<thead>
<tr>
<th>Physician endorses AD</th>
<th>Patient is not expecting AD Navigator and has never heard of AD (&quot;What does AD Navigator know that I don’t?&quot;)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSW introduces form</td>
<td>Patient does not have ID</td>
</tr>
<tr>
<td>Patient is given a heads up that AD Navigator will be visiting/calling</td>
<td>AD Navigator tries new hair product that the patient says makes her smell like the forest, &quot;and not in a good way&quot; 🌲</td>
</tr>
<tr>
<td>Patient has ID</td>
<td></td>
</tr>
<tr>
<td>Patient understands that we ask everyone</td>
<td></td>
</tr>
</tbody>
</table>
Direct Engagement with Patients Matters!

• 1275 referrals in 16 months
  • 619 from staff
  • 656 from electronic screening
Moving into Transplant Hematology

PERSEVERANCE
THE COURAGE TO IGNORE THE OBVIOUS WISDOM OF TURNING BACK.
Advance Directive Opportunities in Transplant

HCT Program to Obtain Advance Directives

“Yes!” represents an Advance Directive (AD) obtained from patients and submitted to medical records for inclusion in patient record.

All aspects of the program are supported by AD notary support through the Sheri & Les Biller Patient and Family Resource Center.

PLAN TODAY FOR TOMORROW
Change in Advance Directives for Transplant Patients after HCT AD Program Implementation

<table>
<thead>
<tr>
<th>Year</th>
<th>AD Completion Rate Percentage</th>
<th>AD Percentage Change</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>28.6%</td>
<td>Baseline Year</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>31.6%</td>
<td>3.0%</td>
<td>$p=0.333$</td>
</tr>
<tr>
<td>2016</td>
<td>69.5%</td>
<td>37.9%</td>
<td>$p&lt;.001$</td>
</tr>
</tbody>
</table>

Introduction of HCT Specific AD Program
Irreducible Complexity

- Team and Champions
- What is the measure of success?
  - For Advance Directives, need an easy way to complete them
  - Choose patient-centric forms
- Accurate capture into medical records
  - How are these retrieved?
  - Clinical Decision Support
- General Interventions work for the general population
  - Where are targeted interventions needed?
- What do you need to do well?
  - What can you utilize from others?
Free Stuff

• www.cityofhope.com
  • Health Professional Education
    • Supportive Care Medicine Professional Education
      • Clinical Programs
        • Advance Care Planning Program
National Healthcare Decisions Week Events 2018

Thursday
April 14th
Staff Day

Monday
April 16th
Advance Directives 101 Class

Wednesday
April 18th
Advance Directive Conversation Café

Tuesday
April 24th
Medical Ground Rounds
To Code or Not to Code, That is the Question: Advance Care Planning, Code Status and Critical Illness Treatment Preferences in ConnectHope.

PLAN TODAY FOR TOMORROW
Questions? acp@coh.org

DO YOU KNOW THE DIFFERENCE BETWEEN A MASTER AND A BEGINNER?

THE MASTER HAS FAILED MORE TIMES THAN THE BEGINNER HAS EVEN TRIED.

JUST FILLED OUT MY ADVANCE DIRECTIVE

I'M IN CHARGE NOW.