

BACKGROUND

- The purpose of Advance Care Planning (ACP) is to clarify and document, often via an Advance Directive (AD), an individual's future wishes in the event that he/she is no longer decisional.¹
- ACP has been shown to have multiple benefits, including promoting patient-centered care, reducing decisional burden of families, decreasing use of aggressive treatment at end-of-life, and reducing number and/or length of hospitalizations.²⁻⁴
- The EPIC EHR contains SmartPhrases using the terms ".acpbegin" and ".acpend" which allow healthcare professionals to document ACP information within any note type in a patient's chart by bookending the sentences or paragraphs of interest with these "dot phrases."
- Once documentation is completed using these phrases, the relevant information can be accessed in the "Advance Care Planning" section of the patient's chart under "Advance" Care Planning Notes."
- At the Medical University of South Carolina (MUSC), the use of SmartPhrases for ACP by inpatient Palliative Care providers prior to December 2022 was estimated to be <5% due to lack of familiarity with these tools and overall infrequent use.
- Pre-existing methods of ACP documentation were variable and often provider-dependent, making it difficult to locate the pertinent information in the patient chart and to provide consistent care plans across different healthcare teams and hospitalizations.

PROJECT GOAL

To improve the utilization of EPIC SmartPhrases for ACP documentation by inpatient Palliative Care providers at MUSC from <5% to at least 50% of all patient encounters by March 2023.

METHODS

- In early December 2022, an educational session was presented to the inpatient Palliative Care provider group as part of the monthly business meeting.
- During this meeting, providers were introduced to the EPIC SmartPhrases, educated about their purpose, and encouraged to incorporate their use in everyday patient encounter documentation.
- Detailed instructions regarding SmartPhrase utilization were presented (see "Education Plan").
- These instructions were then reinforced in a printed format which was placed in a visible location at each individual provider work station (Figure 1).
- Verbal reinforcements were intermittently provided during this intervention time period.
- Data was then extracted through EPIC chart review via SPARC request in March 2023 to analyze the preintervention (9/12/22 through 12/12/22) and postintervention (12/13/22 through 3/2/23) time intervals.

Advancing the Use of Advance Care Planning Documentation Victoria Sweetnam, MD and Sophia Urban, MD Palliative Care Program, Department of Internal Medicine

EDUCATION PLAN

Step 1	Step
Sidebar Summary Edit Note 💌	The pr now v
My Note Type: Service: MED-PALLIATIV Date of Service: 11/9/2022 Cosign Required	1 Code: Unspecified (has ACP docs) Search COVID-19 Vaccine: Unknown Isolation: None No attending provider Allergies: No Known Allergies READMISSION RISK SCORE Low
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Step 2

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Advance Care Planning - .acpbegir

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ode Status: Discussed patient's goals of care to include symptom control and good quality of life, which have previously been reflected in his decisions to pursue treatment of acute problems (antibiotics, blood products, etc.) and avoid more invasive interventions (surgeries, procedures, etc.); patient reiterated those decisions today. Also readdressed code status by recommending to the patient that he continue pursuing treatments which make him feel better but avoid interventions which would likely cause nim harm and suffering, including resuscitation and life-sustaining technology. Clarified that resuscitative efforts which would include chest compressions and shocks would almost invariably require intubation and mechanical ventilation, interventions which the patient has previously identified as unacceptable and inconsistent with his goals of care. Reiterated that the peaceful death he has identified as his preference and his desire to avoid intubation and additional defibrillation would align most consistently with an AND code status to which patient was agreeable. Status in EMR changed appropriately. .acpend (not visible once note is signed) mptom Management: #Cancer-related pain: Suspected secondary to bony metastase - Continue Fentanyl patch 25 mcg/h q72h Continue Dilaudid 1 mg PO q4h PRN for breakthrough pain

#Hypercalcemia of malignancy: Noted during most recent hospitalization Treated with IV bisphosphanate. Most recent lab work reflective of normal corrected value hosocial Support Case Management Care coordination Discharge preparation Educational materials provided: none

rocess up until this point has generated a specific ACP Note that is visible to any provider able to access the patient chart.

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the patient's Code Status on the left-hand side to access the e Care Planning" section of the chart.

the date/time at which the note was generated under "Advance" Care Planning Notes" under the "Notes" section on the right-hand side.

emember to Document your ACP Information in EPIC!

your initial Consult or Daily Progress note.

tify where in the note you want to document the ACP information (code s, HCPOA, etc.).

- ".acpbegin"
- ment the appropriate ACP information.
- ".acpend" and sign your note.

ss the information you documented under the "Advance Care Planning" on of the patient chart by clicking on the patient's current Code Status and gating to "Advance Care Planning Notes."

Figure 1. Printed instructions which were laminated and placed in visible locations at each individual provider work

Three Months Post-Intervention:

- helpful

RESULTS

Pre-Intervention

• EHR data analysis confirmed that <5%, specifically 0.43% (2/468), of all patient encounter documentation by inpatient Palliative Care providers from September to December 2022 utilized the specific EPIC SmartPhrases introduced during the intervention.

• EPIC SmartPhrase use (both correct and incorrect) increased to 14.0% (55/391) in all patient encounter documentation from December 2022 to March 2023 following intervention. • Despite persistently low rates of utilization overall, this data represents a 19-fold increase in correct SmartPhrase use (i.e. using both phrases concurrently to "bookend" ACP documentation) and a 36-fold increase in incorrect SmartPhrase use (using only one phrase or neglecting to "bookend" the phrases in tandem) post-intervention.

• In a voluntary post-intervention provider survey:

1. 100% (7/7) of providers believed that the intervention was

2. 87.5% (7/8) of providers expected that the intervention would change their future practice

CONCLUSIONS

• Although the project goal was not achieved, the educational intervention targeting improved ACP documentation successfully increased the frequency of correct EPIC SmartPhrase use 19-fold.

• Barriers to this intervention included: program education limited to one introductory session, lack of subsequent followup/reminder sessions, reinforcement limited to spontaneous verbal reminders, lack of feedback provided to participating providers, possibility that printed instructions could be misplaced or lost.

• Additional follow-up training may be necessary to ensure that providers are correctly implementing the EPIC SmartPhrases in their documentation.

• Next steps of this intervention include formal follow-up reminder sessions and emails to reinforce the information reviewed during the introductory educational session as well as expansion of this intervention to other MUSC programs and departments outside of Palliative Care.

REFERENCES

1. 19 evidence-based benefits of Advance Care Planning [Internet]. Advance Care Planning (ACP) Decisions. 2021 [cited 2022Sep7]. Available from: https://acpdecisions.org/19-evidence-basedbenefits-of-advance-care-planning/

Hickman SE, Keevern E, Hammes BJ. Use of the physician orders for life-sustaining treatment program in the clinical setting: a systematic review of the literature. J Am Geriatr Soc. 2015 Feb;63(2):341-50. doi: 10.1111/jgs.13248. Epub 2015 Jan 29. PMID: 25644280

Sudore RL, Fried TR. Redefining the "planning" in advance care planning: preparing for end-of-life decision making. Ann Intern Med. 2010 Aug 17;153(4):256-61. doi: 10.7326/0003-4819-153-4-201008170-00008. PMID: 20713793; PMCID: PMC2935810.

Wright AA, Zhang B, Ray A, Mack JW, Trice E, Balboni T, Mitchell SL, Jackson VA, Block SD, Maciejewski PK, Prigerson HG. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA. 2008 Oct 8;300(14):1665-73. doi: 10.1001/jama.300.14.1665. PMID: 18840840; PMCID: PMC2853806.