HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

Advanced Care Planning (ACP) at Howard County General Hospital (HCGH)

May 30, 2018

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Agenda

- Share our ACP “journey”
- Purpose and impact of ACP coordinator
- Lessons learned and what’s next…

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Where HCGH Started

- Horizon Foundation/ IHI Learning Collaborative
- Baseline assessment - % of patients with documented Advance Directive (AD)
- Identified an Executive Champion
- Rapid Improvement Event

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Learning Collaborative

- Participated as a member of the Healthcare Track group during the Learning Collaborative
- Applied the Plan-Do-Study-Act (PDSA) cycle on a hospital and programatic level
- Consulted with medical system through IHI around use of Epic in regards to ACP

SPEAK (easy)
HOWARD

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Baseline Assessment

	All Ages			Age 80+		
FY	**Total Inpatients**	**Inpatients with AD**	**%**	**Total Inpatients**	**Inpatients with AD**	**%**
FY16	16,385	1,644	10.0%	3,404	860	25.3%
FY17	16,277	1,678	10.3%	3,216	793	24.7%

Source: Epic Clarity data pulled on September 12, 2017.
Note: Patients with an Advance Directive based on the Advanced Directive Flag in Epic, with a value of Y or N. Excludes newborns and psychiatric patients.

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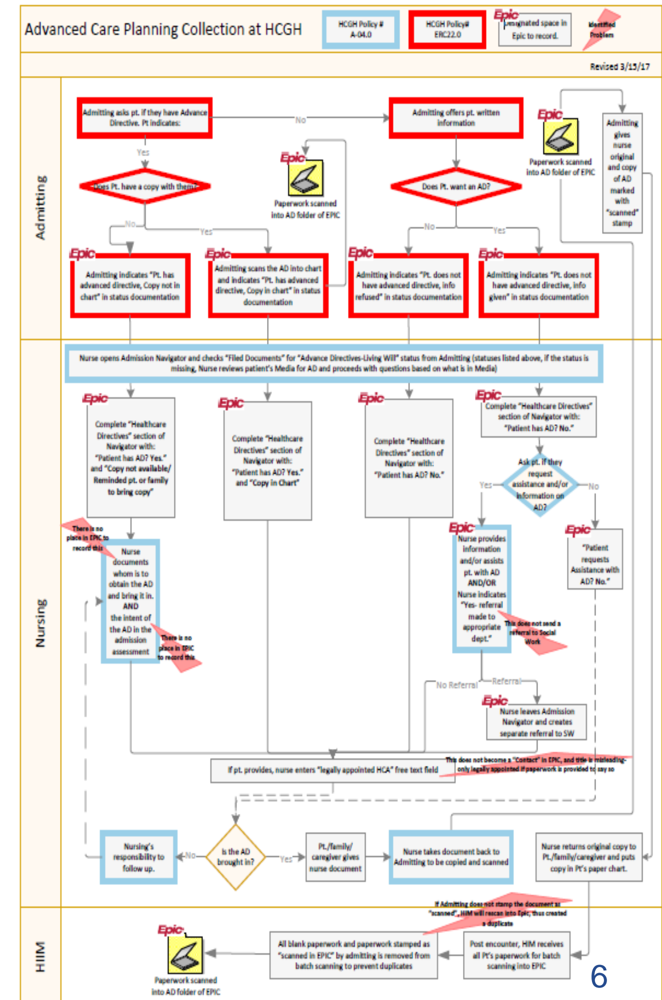
Rapid Improvement Event

- **Areas for improvement:**
  - Update current policies to match EMR functionality and processes
  - Changes in Epic funactionality to better meet needs of patients and providers
  - Fix broken referral pathways
  - Train on document identification and filing for various departments



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Rapid Improvement Event (RIE)

Participating Departments

- Hospitalists and Intensivists
- Population Health
- Nursing
- Patient Access (registration)
- Health Information Management
- Social Work
- Risk Management
- JHHS Legal
- Outpatient Surgery
- Horizon Foundation

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EMR Improvements

- ACP Navigator included as part of Hopkins EPIC upgrade
- HCGH provided guidance on Navigator build based on conversations with a hospital already using EPIC for this purpose (connection made through Learning Collaborative)
- Health Care Agent designation created
- Consolidation of ACP specific progress notes
- Physicians able to indicate patient’s capacity

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Role of ACP Coordinator

- Meet patient at bedside and post-discharge to aid in completion and collection of ADs
- Provide education on AD
- Initial target (obtained via Epic list)
  - ≥80 y.o. w/out AD
  - Patient indicates having AD but did not provide copy to Patient Access or Nursing
  - Patient indicates interested in learning more about creating AD
- Connect pts to SW when there are complex ACP needs

ACP Coordinator Workflow

- Daily worklist generated in Epic
- Communication with unit staff regarding patients on worklist
- Bedside visits with patients and families
- Uploading ACP documents into Epic
- Post-discharge follow-up with patients

ACP Coordinator Impact: Jan-April 2018

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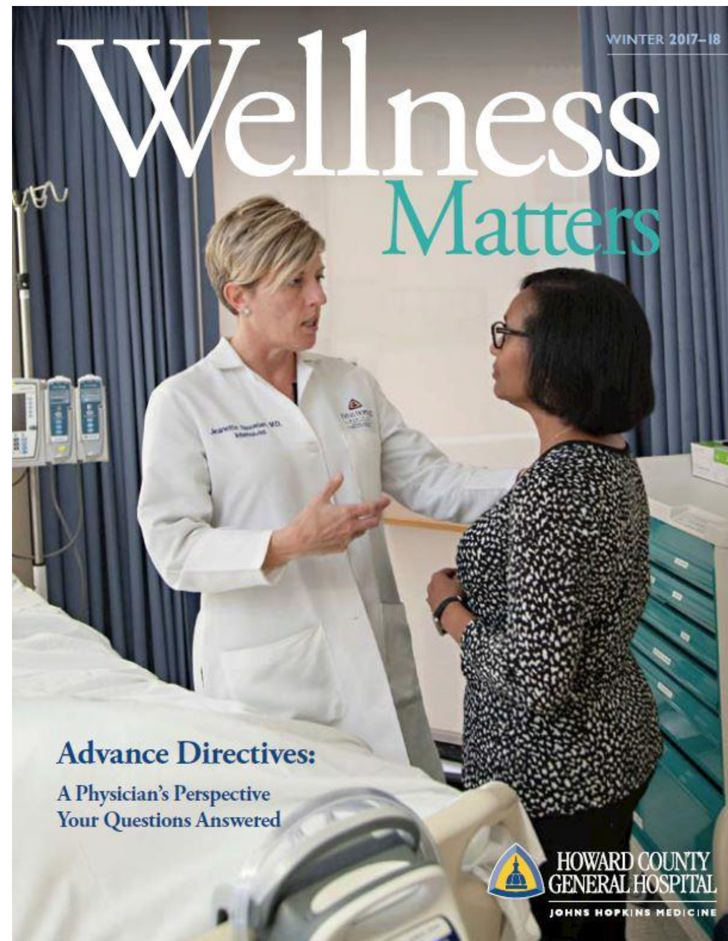
Patient Target Category	Total # of pts engaged	Total pts. who now have a HCA or LW in Epic	%
80+ years old with no Advance Directive on file	323	108	33%
Report having an Advance Directive, but not loaded in Epic	460	146	32%
Do not have Advance Directive, but want more information	128	21	16%
Total	911	275	30%

Community Promotion of ACP



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Lessons Learned

- Executive leader buy-in is key
- Collaboration between departments is critical
- Community level campaign helps to motivate change internally
- Need to ensure that processes, policies and education/training match how the work actually gets done and what happens in the EMR

What's Next

- ACP Coordinator community "office hours" to launch in July
- Electronic ADs and CRISP and EPIC
- Supporting other hospitals with improving their AD process

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