REDESIGNING PATIENT-CENTERED CARE: A NYC HEALTH SYSTEM’S COMMITMENT TO ADVANCE CARE PLANNING (ACP)

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Stefanie Reiff, MD
Tom Sedgwick, LCSW, CCM
Christine Wilkins, Ph.D., LCSW

NYU Langone Medical Center
Mission, Vision & Commitment

• Mission: To serve, teach and discover
• Vision: To become a world-class, patient-centered integrated academic medical center
• NYU Langone is committed to serving the NY Metropolitan community with a focus on Manhattan and Brooklyn through excellence in patient care, education and research
• Ranked #1 for Overall Patient Safety & Quality for three consecutive years among leading academic medical centers in University Health System Consortium Quality & Accountability Study
• Nationally ranked among the top 15 best hospitals in 2018-2019 annual survey of the best hospitals nationwide by U.S. News & World Report
• NYU School of Medicine is No. 3 in the Nation & No. 1 in New York on U.S. News & World Report's 2019 'Best Graduate Schools' Rankings for Research
Background

- Health care proxy forms or other advance directives not consistently completed
- Even when a health care agent has been identified, a conversation between the patient, agent and provider may not have occurred
- As a result, important health care decisions are often made in crisis, and by agents or loved ones who may be unaware of the patient’s wishes and goals of care
- For patients with advanced illness, frailty, and/or a life expectancy of one year, the approach until recently was similarly limited and fragmented
Advance Care Planning Program at NYULH

- Created in 2015
- Championed by Dr Kim Glassman, CNO and Dr Fritz Francois, CMO
- Physician Champions: Dr. Kevin Hauck & Dr. Stefanie Reiff (NYULH-Brooklyn)
- Respecting Choices Advance Care Planning Program
- Enterprise-wide, inpatient and ambulatory

Mission and Vision

Mission

To promote enterprise-wide advance care planning in which patients’ health care preferences are discussed, documented, and honored by families, friends, and the health care community.

Vision

Advance care planning will become the standard of care for all of our patients enterprise-wide, and will ensure that every patient’s health care choices are clearly defined and honored.
Five Promises of an Advance Care Planning System:

**PROMISE #1**
We will initiate the conversation

**PROMISE #2**
We will provide assistance with advance care planning

**PROMISE #3**
We will make sure plans are clear

**PROMISE #4**
We will maintain and retrieve plans

**PROMISE #5**
We will appropriately follow plans

ACP DOCUMENTATION AND RETRIEVAL
ACP Note

ACP Note Completion

ACP Note Completion September 2016 through August 2018 (N = 6197)
ACP Billing Frequency

Frequency of ACP Billing Codes from September 2017 through August 2018
N = 1867

ACP Billing Codes By Place of Service
N = 1867

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room - Hospital</td>
<td>153</td>
<td>8.0%</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>962</td>
<td>52%</td>
</tr>
<tr>
<td>Off Campus - Outpatient Hospital</td>
<td>305</td>
<td>16%</td>
</tr>
<tr>
<td>Office</td>
<td>588</td>
<td>32%</td>
</tr>
</tbody>
</table>

eMOLST Implementation
eMOLST Completion

**Percentage of ‘Hospice or Expired’ Patients with ACP Note and/or eMOLST at Discharge**

<table>
<thead>
<tr>
<th>2018 Month</th>
<th>Total Patient Discharges</th>
<th>Total ‘Hospice or Expired’ Patient Discharges</th>
<th># of ‘Hospice or Expired’ Patients with ACP Note Complete on Discharge</th>
<th># of ‘Hospice or Expired’ Patients with MOLST Complete on Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-18</td>
<td>2430</td>
<td>117</td>
<td>41 (35%)</td>
<td>23 (20%)</td>
</tr>
<tr>
<td>Feb-18</td>
<td>2275</td>
<td>110</td>
<td>42 (38%)</td>
<td>25 (23%)</td>
</tr>
<tr>
<td>Mar-18</td>
<td>2403</td>
<td>88</td>
<td>35 (40%)</td>
<td>21 (24%)</td>
</tr>
<tr>
<td>Apr-18</td>
<td>2363</td>
<td>100</td>
<td>47 (47%)</td>
<td>29 (29%)</td>
</tr>
<tr>
<td>May-18</td>
<td>2480</td>
<td>79</td>
<td>41 (52%)</td>
<td>15 (19%)</td>
</tr>
<tr>
<td>Jun-18</td>
<td>2639</td>
<td>63</td>
<td>30 (48%)</td>
<td>18 (29%)</td>
</tr>
<tr>
<td>Jul-18</td>
<td>2510</td>
<td>51</td>
<td>30 (49%)</td>
<td>20 (41%)</td>
</tr>
<tr>
<td>Aug-18</td>
<td>2726</td>
<td>51</td>
<td>35 (69%)</td>
<td>25 (49%)</td>
</tr>
<tr>
<td>Total</td>
<td>19826</td>
<td>669</td>
<td>301 (45%)</td>
<td>181 (27%)</td>
</tr>
</tbody>
</table>

Source: ACP Dashboard
Percentage of ‘MSQ=No’ Patients with ACP Note and/or MOLST at Discharge

<table>
<thead>
<tr>
<th>2018 Month</th>
<th>Total Patient Discharges</th>
<th>Total ‘MSQ=No’ Patient Discharges</th>
<th># of ‘MSQ=No’ Patients with ACP Note Complete on Discharge</th>
<th># of ‘MSQ=No’ Patients with MOLST Complete on Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-18</td>
<td>2430</td>
<td>241</td>
<td>68 (28%)</td>
<td>53 (22%)</td>
</tr>
<tr>
<td>Feb-18</td>
<td>2275</td>
<td>193</td>
<td>62 (32%)</td>
<td>37 (19%)</td>
</tr>
<tr>
<td>Mar-18</td>
<td>2403</td>
<td>176</td>
<td>47 (27%)</td>
<td>40 (20%)</td>
</tr>
<tr>
<td>Apr-18</td>
<td>2363</td>
<td>205</td>
<td>65 (32%)</td>
<td>48 (23%)</td>
</tr>
<tr>
<td>May-18</td>
<td>2480</td>
<td>191</td>
<td>67 (35%)</td>
<td>32 (17%)</td>
</tr>
<tr>
<td>Jun-18</td>
<td>2639</td>
<td>195</td>
<td>54 (28%)</td>
<td>33 (17%)</td>
</tr>
<tr>
<td>Jul-18</td>
<td>2510</td>
<td>208</td>
<td>65 (31%)</td>
<td>57 (27%)</td>
</tr>
<tr>
<td>Aug-18</td>
<td>2725</td>
<td>146</td>
<td>63 (43%)</td>
<td>37 (22%)</td>
</tr>
<tr>
<td>Total</td>
<td>19826</td>
<td>1555</td>
<td>491 (32%)</td>
<td>337 (22%)</td>
</tr>
</tbody>
</table>

Source: ACP Dashboard

eMOLST Rate for DNR Patients
CODE STATUS ORDER IN EPIC: CPR Order

- Code Status: CPR Orders
- Code Status Details: Attempt Cardiopulmonary Resuscitation
- CPR Information: When the patient has no pulse and/or is not breathing, CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves defibrillation (shocks) and a plastic tube down the throat to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops. Treatment will also be based on a breathing machine and heater.

DNR ORDER – Limited Medical Interventions

- DNR Order: Do Not Attempt Resuscitation (Limited Medical Interventions)
- DNR Information: When the patient has no pulse and/or is not breathing, CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves defibrillation (shocks) and a plastic tube down the throat to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops. Treatment will also be based on a breathing machine and heater.

NYU Langone Health
Advance Care Planning Navigator in Epic:

- View
  - Code Status Hx
  - MSQ Response Hx
  - ACP documents
  - ACP Epic Notes

- Document
  - eMolst
  - Code Status
  - ACP Note

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Health Care Agents > Patient Capacity > ACP Activation Note > ACP History

- Add additional contacts or update information on existing contacts
- Identify which of the contacts is the primary health care agent (HCA), as well as alternatives
- Manually mark a specific contact as the “Active” HCA – exceptions apply for NPs
Documenting Capacity Determination in Epic

Health Care Agents > Patient Capacity > ACP Activation Note > ACP History

Health Care Decision Maker Activation Note

I have personally examined the patient and have determined to a reasonable degree of medical certainty that the patient lacks capacity to make the following decisions. The causa and extent of the patient’s incapacity are . The patient’s likelihood of regaining decision making capacity is .

Attending Physician: NYU GME
November 30, 2017, 12:37 AM
Advance Directives Section in Flowsheet

**Flowsheets**
- CM/SW ASSESSMENT
- GENERAL INFORMATION
- ADVANCE DIRECTIVE

**Notes**
- Advance Directive

**Education**
- CAREGIVER
- LIVING ENVIRONMENT
- HOME SAFETY
- VALUES/BELIEFS

**Manage Orders**

<table>
<thead>
<tr>
<th>Expanded</th>
<th>View All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing HCP confirmed and in chart?</td>
<td></td>
</tr>
<tr>
<td>New HCP form completed and in</td>
<td></td>
</tr>
<tr>
<td>Reason/Intervention - No new HCP</td>
<td></td>
</tr>
<tr>
<td>Advance Directive Comment</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Capacity**
- Full capacity
- Incapacitated (HCA indicated)
- Incapacitated (No HCA indicated)
- Needs Review

**HCA Patient Header**
- Full capacity
- Active
- Not on file
- Pending

**Health Care Agents**
- Patient Capacity
- ACP Activation Note
- ACP History
Advance Directives Documentation & ACP Navigator

Changes to NYS Public Health Law Allowing NP’s to sign DNR Order and Establish Patient Capacity

- As of 5/28/18 Attending NPs can sign DNR orders and determine capacity (NYS Public Health Law). Exceptions apply.

- “Attending Nurse Practitioner”: the nurse practitioner selected by or assigned to a patient in a hospital who has primary responsibility for the treatment and care for the patient.

- NYULH policies have been revised accordingly. Please see: https://nyumc.ellucid.com/manuals/binder/2303

<table>
<thead>
<tr>
<th>Patients who lack decision-making capacity and have a health care proxy</th>
<th>Patients who lack decision-making capacity and have developmental disability</th>
<th>Patients who lack decision-making capacity due to mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP can sign DNR</td>
<td>NP cannot sign DNR</td>
<td>NP cannot sign DNR</td>
</tr>
<tr>
<td>NP cannot determine capacity</td>
<td>NP cannot determine capacity</td>
<td>NP cannot determine capacity</td>
</tr>
</tbody>
</table>
IMPLEMENTATION OF RESPECTING CHOICES PROGRAMS

Implementation of Respecting Choices Programs

- Staff training in First and Advanced (Last) Steps
- Shared Decision Making in Serious Illness Program
- Advanced (Last) Steps Organizational Faculty
- Enhanced documentation
- eMOLST implementation
**First Steps and Advanced Steps Implementation**

First Steps and Advanced (Last) Steps Implementation  
November 2017 through August 2018

<table>
<thead>
<tr>
<th>Location</th>
<th>First Steps</th>
<th>Advanced Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYU Langone Brooklyn</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>UCL East</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>UCL West</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>TH 17 East</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>TH 15 WCCC</td>
<td>4</td>
<td>42</td>
</tr>
<tr>
<td>TH 17 WCCC</td>
<td>1</td>
<td>42</td>
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<tr>
<td>Outpatient</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>16</td>
</tr>
</tbody>
</table>

**Project Aim:**

Improve advance care planning by increasing percentage of adult inpatients with a completed health care proxy (HCP) at discharge to 75%.

**Background/Problem Statement:**

Advance care planning is essential to providing value-aligned care. Ensuring that patients’ preferences are documented and easily accessible in the EHR is an important patient safety and quality improvement target to ensure patients’ wishes are honored.

**Scope:**

All NYUH adult patients need to be provided the opportunity to participate in an advance care planning session, and complete a health care proxy. HCP completion will become a discussion point where daily safety huddles are conducted. This project will initially focus on UCL with the goal of becoming standard of care across all units.

**Test of Change:**

Percentage of adult patients with a HCP scanned into Epic at discharge will reach 75%. This will be accomplished by identifying patients who do not have a HCP, facilitating an ACP conversation (using the Respecting Choices First Steps Program) with patients, and helping them complete a health care proxy form.

**Milestones/Objectives:**

1. HCP completion will be discussed as part of the medicine service daily safety huddle.
2. The NYU/VA/VA will be responsible for facilitating a First Steps conversation with patients, help with completion of a health care proxy, and ensure that it is scanned into Epic in the appropriate location.
3. Percentage of medicine patients with scanned HCP will increase from current 58% to 75% by July 2019.
4. Will monitor number of patients declining HCP completion.

**Deliverables:**

Ensure that adult patients’ preferences are documented by the presence of a HCP at discharge, thereby enhancing patient safety and high quality care.

**Project Initiation:** July 1, 2018  
**Kick-off Meeting:** June 14, 2018  
**Target Completion:** July 1, 2019

**Master Trainer:** Ashley Knighton

**HRO Project Champions:**  
Tom Sadeghian & Christine Wilkins

**Team Members:**

Kathleen Hochman, MD  
Kevin Husek, MD  
Eliassai V. Purdah, MD  
Melissa LaToma, MD  
Lynn Goodman, RN  
Renee Groves, LCSW  
Sandra Freedman, RN  
Megan Delaney, LMHC  
Heather Menten, LCSW  
John Davidson, PA-C  
Melissa Barrett-Atianou, NP  
Gabby Grigas  
Steven Werner, RN

If you have any questions please contact:  
HRCU@hmonline.org

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**Division Name or Footer**

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**Division Name or Footer**

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Advance Directive Completion – Tisch Hospital

All Tisch Inpatient

Advance Directive Completion
Cohort [All]

12,744
Completed
29,132
Discharge
14%

17E Medicine Unit

Advance Directive Completion
Cohort [17E]

1,272
Completed
2,101
Discharge
61%

NYUHC ACP Policies & Tip Sheets

• http://nyumc.ellucid.com
Advance Care Planning

At NYU Langone, we provide you with individualized care targeted to your treatment goals. This approach includes allowing you to choose who can make decisions for you in the event you are unable to do so for yourself.

This process, called advance care planning, is a key component of our patient-focused approach to care. Life is unpredictable, and our goal is to ensure that your wishes regarding the type and extent of medical treatment you receive are fulfilled. We encourage you to talk with your loved ones about your values and preferences, and to choose a trusted representative who can speak on your behalf. This process is also known as completing an advance directive.
ACP Public Outreach

ACP Materials Provided at Time of Registration

- NYS Your Rights booklet which includes Deciding About Healthcare section - inpatient
- NYS Deciding About Healthcare which is required for OPs
- NYS Health Care Proxy form & instructions – all
- NYULH’s Preparing for Life’s What Ifs - all
**WELCOME BOOKS**

*Advance Care Planning*

Advance Care Planning is about making decisions about the care you would like to receive if you become unable to speak for yourself.

**Care Coordination/Communication Inadequate/With patient and family**

<table>
<thead>
<tr>
<th>Event Basics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event Type</td>
</tr>
<tr>
<td>Event Category</td>
</tr>
<tr>
<td>Event Subcategory</td>
</tr>
<tr>
<td>Event discovery date</td>
</tr>
<tr>
<td>Event discovery time</td>
</tr>
<tr>
<td>Event occurrence date (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Event occurrence time (hh:mm)</td>
</tr>
</tbody>
</table>

Entering PSI when Patients’ Wishes are Not Honored
Strategic Plan for Program Sustainability

- Development and integration of Program Manager specifically focused on Advance Care Planning and seated in the Department of Social Work
- Ongoing meetings with key stakeholders to establish buy-in and maintain high-level steering committee
- Flood the medical center with information about advance care planning as a “normal” part of high quality health care. Provide a consistent message about ACP at every encounter point
- Initiate and continue implementation of Respecting Choices Programs
- Expand community awareness of NYULH’s Advance Care Planning Program and continue to develop strategic partnerships
  - NY State MOLST Collaborative
  - EMS
  - Manhattan Jewish Community Council
  - Home Care/Hospice and Nursing Homes

THANK YOU