In early March, a second chart review was performed of patients who had appointments since January for any new LCP documentation. A chart review in 2017 of Kaiser Permanente Supportive care found only 10% of patients had a CPR directive, and 33% had a form of LCP documentation including: Five Wishes®, Statement of Treatment Preferences, Colorado CPR Directive and Colorado Medical Orders for Scope and Treatment (MOST).

Aim Statement

By March 2019, 90% of patients will have been asked if they have a form of life care planning (LCP*), and 75% of patients will have a form of life care planning with Kaiser Supportive Care.

*LCP includes: medical durable power of attorney (MDPOA), living will including: Five Wishes®, Statement of Treatment Preferences, Colorado CPR Directive and Colorado Medical Orders for Scope and Treatment (MOST).

Methods

• A chart review was performed of the patients on the Supportive Care list on Epic in November. Each patient’s chart was evaluated for: ribbon code status, scanned documents, DNR status, and listed Health Care Agents (HCA) in their ACP/LCP tab, and additional scanned documents in the demographics tab.
• From January-March 2019, patients who had appointments with Kaiser Supportive Care were given a ½ sheet questionnaire with three questions assessing their current LCP status.
• In early March, a second chart review was performed of patients who had appointments since January for any new LCP documentation in their EHR.

Results

Figure 1. Patients who received the half-sheet questionnaire at their visit. (N=94)

Table 1.

Figure 2. Concordance self reported LCP documentation on questionnaire with EHR documentation. (N=58)

<table>
<thead>
<tr>
<th>Documentation in EHR</th>
<th>1/2 sheet</th>
<th>N 1/2 sheet</th>
<th>Blank/Declined</th>
<th>Documented on EHR</th>
<th>Not documented on EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Banner DNR</td>
<td>82%</td>
<td>15%</td>
<td>3%</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>New Doc HCA</td>
<td>16%</td>
<td>11%</td>
<td>3%</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>New Code status</td>
<td>11%</td>
<td>11%</td>
<td>3%</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>New other</td>
<td>2%</td>
<td>11%</td>
<td>3%</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>New Doc</td>
<td>11%</td>
<td>11%</td>
<td>3%</td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>

Figure 3. Percentage of patients that had new document added after receiving the ½-sheet questionnaire. (N=57)

Table 2.

<table>
<thead>
<tr>
<th>Documents Added</th>
<th>ACP/LCP</th>
<th>&quot;Other&quot; Scanned Document</th>
<th>Health Care Agent</th>
<th>Scanned MOST/AD/LW</th>
<th>Ribbon DNR</th>
<th>Total LCP + HCA</th>
<th>Total LCP in chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>% before</td>
<td>20%</td>
<td>65%</td>
<td>73%</td>
<td>73%</td>
<td>73%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>% after</td>
<td>35%</td>
<td>26%</td>
<td>28%</td>
<td>26%</td>
<td>26%</td>
<td>16%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Figure 4. Percentage of patients with LCP documents in their EHR before and after ½-sheet distribution. (N=57)

Discussion

• Approximately 82% of patients were given the questionnaire prior to their appointment with Supportive Care.
• The largest barriers to not receiving the ½ sheet were telephone encounters, occasional home visits where form was not available, or lack of time during the appointment.
• The majority of patients who indicated that they had an MDPOA or form of LCP on their ½-sheet questionnaire had some form of LCP documented in their EHR, although it may have been a different form of LCP.
• For the patients who had a new form of LCP added to their chart after using the ½-sheet questionnaire, the majority of changes were added in the "other" document section as "PD Document".
• When combining results from each individual section where documents were added in the EHR, the percentage of patients with any form of LCP increased from 46% to 65% after they saw the ½-sheet questionnaire.
• There is currently no standard protocol for documenting patient wishes causing many differences in documentation in the EHR.

Conclusions

• Providing an intake questionnaire regarding life care planning can help begin the conversation between patient and provider about end of life wishes.
• Although a LCP document may be completed and in the chart, there is no consistent location between out-patient and in-patient EHR charts.

Next Steps

• Evaluation of in-patient hospital charts to identify any consistency between out-patient and in-patient charts.
• Discussion with all stakeholders to identify best possible location in EHR for LCP information to be documented and found quickly in out-patient or in-patient settings.

References