Specific Aims

Increasingly patients with multiple chronic conditions (MCC) and serious illnesses are cared for by multiple healthcare teams spanning different specialties and locations. Prior research shows Advance Care Planning (ACP) information such as Advance Health Care Directives (AHCD) and Physician Orders for Life Sustaining Treatment (POLST) are either not documented or are inconsistently documented in the EHR therefore decreasing the likelihood they can be retrieved and honored by healthcare providers. We seek to better understand ACP documentation in the EHR at the Palo Alto Medical Foundation (PAMF) for older seriously ill MCC patients. ACP, the act of discussing patient preferences and values and planning for future medical care, is a critical and underdeveloped aspect of patient-centered care.2-4 ACP furthers patient engagement and also operationalizes patient values such as remaining independent or staying at home. Research shows ACP documentation in the EHR may be inaccessible (e.g. in progress notes), or not actionable (e.g. missing signatures).1 Poor systems for recording patient preferences are a systemic barrier to communication in the care of patients with serious and life-threatening illnesses.5

The goal of this pilot project is to characterize ACP documentation practices and then identify barriers/facilitators to ACP documentation, through meaningful collaboration between PAMF Research Institute (PAMFRI), a member of the HMO Research Network (HMORN), and Older American Independence Centers (OAIC) investigators, by answering the HMORN-OAIC call for “novel methods to use information contained in electronic health records to construct new measures relevant to chronic conditions, their treatments, and outcomes.”

PAMF, a nonprofit multispecialty group practice in California, is an ideal setting for this study. PAMF clinicians serve almost one million patients and have been using EpicCare EHR since 1999. ACP is an important component of the Welcome to Medicare and Medicare Annual Wellness Visit EHR SmartSets at PAMF. Clinicians are sent an automatic Health Maintenance Reminder for ACP for all patients 65 or older. In 2011, a palliative care initiative was launched in PAMF that included the rollout of outpatient, interdisciplinary palliative care practices in multiple locations within its four divisions. The staggered rollout was completed in 2014, thus creating a natural experiment for examining its various impacts on ACP practices among PAMF healthcare teams. PC Programs are co-located with other departments. PC providers give in-service educational seminars and engage in outreach to increase awareness among their physician colleagues in oncology, pulmonology, cardiology, and primary care. PAMFRI researchers have been collaborating with the PC Program. A joint paper was published in the Journal of Palliative Medicine,1 which has been described in detail in the recent IOM report “Dying in America.” 3 They already have IRB approval to use EHR data to examine the impact of the Palliative Care Program. Hence, they have a “shovel-ready” opportunity for this pilot. Dr. Christine Ritchie at the UCSF OAIC enthusiastically supports this pilot and will collaborate with Drs. Tai-Seale and Dillon who is an early career investigator.

The pilot will accomplish two specific aims:

1. To characterize current ACP documentation practices and evaluate the sequential impact of several components of the PC Program, MCC (number, type, severity), and other patient and care team characteristics on ACP documentation.

   Hypothesis 1a. The staged implementation of the PC Program increases the percentages of vulnerable elders with accessible and actionable ACP documentations over time.
   Hypothesis 1b. The number, type, and severity of MCC are associated with the likelihood that ACP is documented in the vulnerable elders’ EHR.

2. To identify barriers and facilitators of ACP conversations and ACP documentation, including the role of MCC, using in-depth interviews with healthcare team members in primary care, oncology, pulmonology, and cardiology who are outliers (in both directions) with respect to ACP documentation.

The collaborative relationship between PAMFRI and UCSF OAIC built in this pilot and the results will enable us to plan R01-level proposals for future collaborations aimed at building interventions to enhance ACP discussion and documentation for vulnerable elders in PAMF and beyond.