# **Setting the Stage**

**Expanding eConsent: Advance Care Planning in the 21st Century** 

## Setting the Stage: Expanding eConsent and ACP



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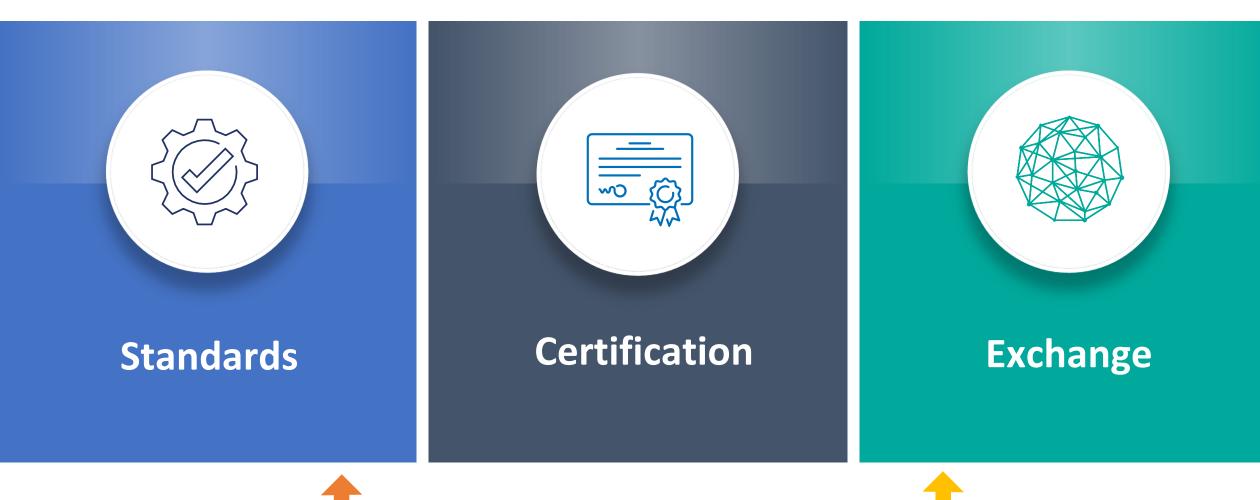


The Office of the National Coordinator for Health Information Technology

## ONC'S MISSION

Improve the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most.

## ONC Activities for Nationwide Interoperability





**COORDINATION** 



# Connected Healthcare and Health Data: Priority Target Areas in the Cures Act



#### **Patient Access:**

The facilitation of secure access by an individual and their caregiver(s) to such individual's protected health information



#### Interoperability:

Achieving a health information technology infrastructure that allows for the electronic access, exchange, and use of health information



## Privacy and Security:

The promotion and protection of privacy and security of health information in health IT



**Information Blocking:** Applicable to health care providers, health information networks or health information exchanges and developers of certified health IT.



# The Office of the National Coordinator for Health Information Technology

#### **Contact ONC**



- Health IT Feedback Form:
  <a href="https://www.healthit.gov/form/">https://www.healthit.gov/form/</a>
  healthit-feedback-form
- Twitter: @onc\_healthIT
- **LinkedIn:** Search "Office of the National Coordinator for Health Information Technology"







#### Why Focus on Advance Care Planning and eConsent?

Greater focus on Advance Care Planning activities due to....



Aging population, growing chronic disease crisis



Impact of Covid-19 is drawing greater focus on Advance Care Planning activities



Quality improvement initiatives



Focus on patients wishes

Market trends indicate a greater focus on the value of Advance Care Planning activities across the industry, but challenges exist for interoperability and access

#### Why focus on Advance Care Planning and eConsent?

Stakeholders are passionate about the topic, but more often than not, the complexity of the process hinders progress toward standardization



Variability in legislation from state to state



EHR integration can lead to multiple documents with no single source of truth



Lack of structured data for most documents



Dynamic documents with unreliable version control and contradictions

## **Advance Care Planning Journey: Creating ACP Documents**

#### 1. Engage & Educate

## Community Outreach



- ☐ Identify & engage key influencers
- ☐ Identify & engage most critical stakeholders for community collaboration
- ☐ Bring together influencers & stakeholders
- Form community collaborations
- Identify community programs & promotions
- Educate stakeholders
- Educate consumers
- ☐ Capture consumer contact information
- □ Direct contact information to ACP facilitator

## **Consumer Conversations**



- Engage consumer, advocate, family members
- Review ACP history
- □ Recap previous conversations
- □ Review existing ACP documents
- Discuss consumer wishes
- Provide ACP forms & instructions for chosen documents
- ☐ Follow-up: status, questions, additional conversations

#### 2. Create Documents

## ACP Document Development



- ☐ Facilitate ACP document(s) development with consumer, family, advocate
- Decide on eACP document(s) & eConsents to create
- Complete chosen eACP document(s)
- ☐ Complete required eConsents
- Review by facilitator for accuracy and completeness
- Execute signatures, eSignatures, or wet ink Signatures (eACP documents & eConsents)

## ACP Document Upload



- ☐ Create & authorize account
- ☐ Submit demographics for patient matching
- ☐ Select document type(s)
- ☐ Upload & submit document(s)\*
- ☐ Indicate "revised" document(s)
- Upload & submit eConsents\*
- ☐ Quality review of:
  - Demographics
  - Documents
  - eConsents
  - Signatures
- ☐ Notify submitter of status and disposition

## ACP Directory Dissemination



- □ Send ACP directory document links to EHR systems
  - Driven by patient linkages and eConsents
- ☐ Notify persons/entities where consent on file
- ☐ Indicate version of each eDocument
  - Annual reminder to patient & advocate to review, update documents

<sup>\*</sup> Upload document to a pre-determined registry and create the pointer in National ACP directory.

### Advance Care Planning Journey: Patient Arrives Needing Critical Care

#### 3. Arrival & Treatment

#### Patient Arrival at Emergency Dept



- Registration dept. alerted that ACP documents are available; Consents verified
- ☐ If no ACP documents are available, patient/family or proxy ☐ asked about availability
- □ Note placed in patient's EHR for follow-up by patient relations team
- Care team notified of patient admission

## Patient Admitted to ICU



- Care team notified of patient admission to ICU
- ☐ Hospitalist alerted via EHR of availability (or lack of) ACP documents
  - Provider direct
    access to ACP
    documents via EHR
    → ACP Directory →
    Registry

### Patient Requires Intubation



- Attending providers (eg, hospitalist) alerted if POLST, DNI, DNR on file
- Provider direct access to ACP documents
- ☐ If no DNI or other pertinent ACP documents on file, provider discusses wishes with patient/family/proxy
- Provider adheres to patient wishes
- Document discussions (EHR encounter/ clinical notes)

## Patient Transferred to Step-down Unit



- Care team notified of patient transfer
- ☐ If missing ACP documents, social work team (and/or attending physician) visits patient/family/ proxy to discuss ACP
- □ POLST (or MOLST) order placed if patient chooses & provider concurs
- Bill for ACP E&M service

#### 4. Discharge & Follow-up

## Patient Discharged



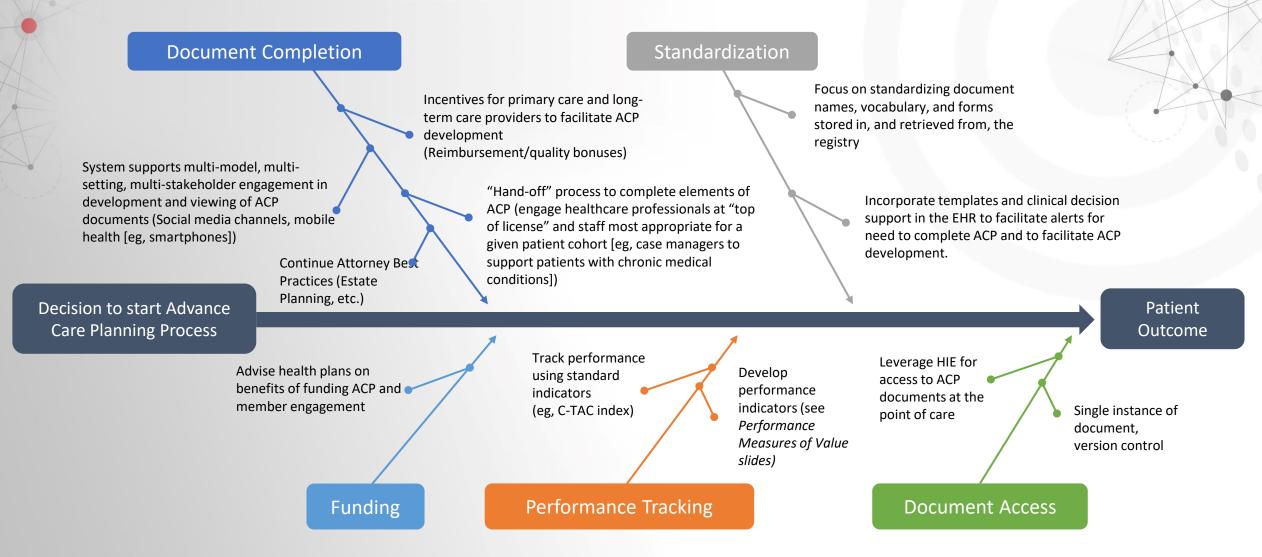
- Care team notified of patient discharge
- Discharge instructions include ACP follow-up (with/without docs on file)
- ☐ Track outcome of ACP views, acknowledgment by healthcare professionals
- ☐ Update ACP directory, patient eConsent linkages

#### Patient Follow-up Doctor Visit



- ☐ Patient contacted for review of discharge instructions, scheduling of appointment
- Patient arrives for office visit
- ☐ Provider alerted if ACP documents are available
- Provider direct access to ACP documents
- ☐ If missing ACP documents or need review for possible updates, discussion with patient and referral to ACP resources
- ☐ "Top of license" intervention by staff (best practice)
- ☐ Bill for ACP E&M service
- ☐ Update ACP views, acknowledgment by HCPs

### **Advance Care Planning: Process Improvement Model**



Sources: C-TAC (2020). Evidence-based best practices for improving state-level C-TAC ACT index results; POCP primary VOM research (2020). Model adapted from Auret, K. et al. (2019).





Source: https://www.pocp.com/white-papers-webinars-and-case-studies-2/

#### **Requires Laser Focus for Success**



#### **Driven by Real-World Problems and Accessible Standards**













Use Case

Define Roles/Actors

**Understand Workflow** 

Leverage Available Technology



**Establish the Right Governance and Oversight = Right Home** 



Fund Core Team:

#### SMEs:

- Program
- Governance
- Technical Work
- Clinical Expertise

#### Why Multi-Stakeholder Initiatives Work

**Da Vinci's Formula for Success** 















#### **KNOWLEDGE**

Right stakeholders, right leaders + right home (HL7)



Usable draft standard+ early adoptersacross stakeholders

#### **METHODOLOGY**

Rapid development of spec + supporting reference implementations

#### SUCCESS!



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