Setting the Stage

Expanding eConsent: Advance Care Planning in the 21st Century
Setting the Stage: Expanding eConsent and ACP

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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

- Standards
- Certification
- Exchange

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.
Contact ONC

Phone: 202-690-7151

Health IT Feedback Form: https://www.healthit.gov/form/healthit-feedback-form

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Advance Care Planning and eConsent
Market Need and Business Case
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

- 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

- 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

- 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)
- Follow-up: status, questions, additional conversations

- 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

* Upload document to a pre-determined registry and create the pointer in National ACP directory.

- Send ACP directory document links to EHR systems
- Notify patients of document links to EHR systems within the ACP directory
- Notify persons/entities where consent on file
- Indicate version of each eDocument
- Annual reminder to patient & advocate to review, update documents
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) ordered 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

Return to start of Journey
Advance Care Planning: Process Improvement Model

- **Document Completion**
  - Incentives for primary care and long-term care providers to facilitate ACP development (Reimbursement/quality bonuses)
  - “Hand-off” process to complete elements of ACP (engage healthcare professionals at “top of license” and staff most appropriate for a given patient cohort [eg, case managers to support patients with chronic medical conditions])

- **Standardization**
  - Focus on standardizing document names, vocabulary, and forms stored in, and retrieved from, the registry
  - Incorporate templates and clinical decision support in the EHR to facilitate alerts for need to complete ACP and to facilitate ACP development.

- **Decision to start Advance Care Planning Process**
  - Advise health plans on benefits of funding ACP and member engagement
  - Track performance using standard indicators (eg, C-TAC index)
  - Develop performance indicators (see Performance Measures of Value slides)

- **Performance Tracking**
  - Fund performance indicators
  - Leverage HIE for access to ACP documents at the point of care

- **Document Access**
  - Leverage HIE for access to ACP documents at the point of care
  - Single instance of document, version control

**Sources:**
Multi-Stakeholder Collaboratives
Core Pillars for Success
Build Structural Support

1. Establish a Project Champion
2. Create a Paid Model and Incentives
3. Build a Broad and Diverse Membership
4. Driven by Standards and Real-World Problems
5. Establish the Right Governance and Oversight
6. Professional, Neutral Program Management Team

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

- 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)

PROCESS
Usable draft standard + early adopters across stakeholders

METHODOLOGY
Rapid development of spec + supporting reference implementations

SUCCESS!
Thank You

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