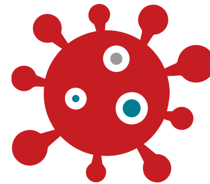
Organizing an eConsent ACP Collaborative

INTEROPERABILITY
INSTITUTE

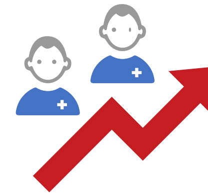
Why Focus on Advance Care Planning and eConsent?

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

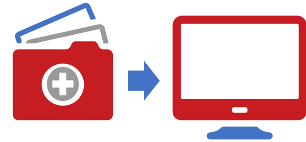
Focus on patients wishes

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

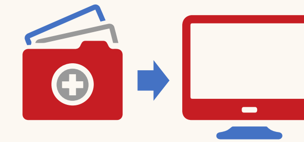
- ❑ Engage consumer, advocate, family members
- ❑ Review ACP history
- ❑ Recap previous conversations
- ❑ Review existing ACP documents
- ❑ Discuss consumer wishes
- ❑ Provide ACP forms & instructions for chosen documents
- ❑ Follow-up: status, questions, additional conversations

2. Create Documents

ACP Document Development

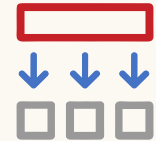
- ❑ Facilitate ACP document(s) development with consumer, family, advocate
- ❑ Decide on eACP document(s) & **eConsents** to create
- ❑ Complete chosen eACP document(s)
- ❑ Complete required **eConsents**
- ❑ Review by facilitator for accuracy and completeness
- ❑ Execute signatures, eSignatures, or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

* 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

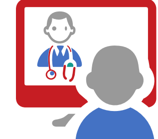
- ❑ Care team notified of patient transfer
- ❑ If missing ACP documents, social work team (and/or attending physician) visits patient/family/ proxy to discuss ACP
- ❑ POLST (or MOLST) order placed if patient chooses & provider concurs
- ❑ Bill for ACP E&M service

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

Return to start of Journey

Immediate Next Steps

1. Visit the new eConsent ACP Collaborative Website: https://interoperabilityinstitute.org/econsent-collaborative/
2. Discuss participation with your internal stakeholders. Feel free to contact Ed at ed.daniels@pocp.com
3. Attend the organizational discussion April 7th where we will:
    - Determine 2021 priorities
    - Identify core stakeholders
    - Establish a consensus draft plan
    - Finalize business case including costs and funding
4. For those making a commitment to participate, attend a follow-on meeting in late April