2018

Improving Advance Directive Use Through Provider Education at Newtown Primary Care

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Problem Identification and Description of Need

- The Conversation Project National Survey indicated that 90% of people felt it was important to talk to a loved one about their medical choices, but only 27% had actually done so[1]. Similarly, a study done in 2014 found that only 26.3% of Americans had completed an advance directive[2].
- The Ethics Committee at Danbury Hospital did a small study to see what the status of DH's patients were, and after some education to PCP's and the community, the documentation of Advance Directives went up, higher than the national average (Julia MacMillan, APRN).
- There may be an association between DNR orders and higher quality of life. This suggests that documenting preferences for end of life care in an advance directive may benefit many patients[3].
- Because many patient's first contact with health care is their primary care provider, increasing the utilization of advance directions and advance care planning in the primary care setting may be key in providing comprehensive, patient centered care. Educating health care providers may be a crucial first step in obtaining this goal.

Public Health Cost

- Riley et al. demonstrated that 25.1% of Medicare spending is used in the last year of a patient's life[4]. Much of this spending may be due to an increase in the amount of aggressive care at the end of life for elderly individuals.
- One study has shown that patients with advance directives that specified limitations on interventions have been associated with lower levels of Medicare spending[5]. It also suggests that treatment limiting advance directives increased utilization of palliative hospice care and decreased in-hospital deaths in high and medium spending regions.
- Data involving the public health cost of end-of-life care and the implications of advance care planning on spending in Connecticut has been poorly defined. One study which includes patients from New Haven and West Haven, CT has shown that those who have had end-of-life discussions had a health care cost difference that was 35.7% lower than those who had not[6].

Community Perspective - 1

Julia MacMillan, APRN, Palliative Care Coordinator, Co-Chair DHS Ethics Committee

- "In my experience, there are many misconceptions about Advance Directives. Many think that they act the same as a Code status, which is not true. Many think you need an attorney to complete, many think it needs to be notarized to make it legal. Many do not realize it is effective ONLY when the patient cannot make their own decisions. Many Health Care providers do not look to the appointed [Health Care Representative], but ask any family member who is present about decisions, when it should be the HCR making the decisions".

- "I was a former Critical Care nurse and I have seen **many** instances where we can refer to the patients Advance Directive, specifically the Living Will, and I could actually see the burden come off [the HCR's] shoulders and they make the decision based on the patient's wishes, not their own".

Community Perspective - 2

Jeanine Famiglietti, MD, Palliative Care, Western Connecticut Medical Group

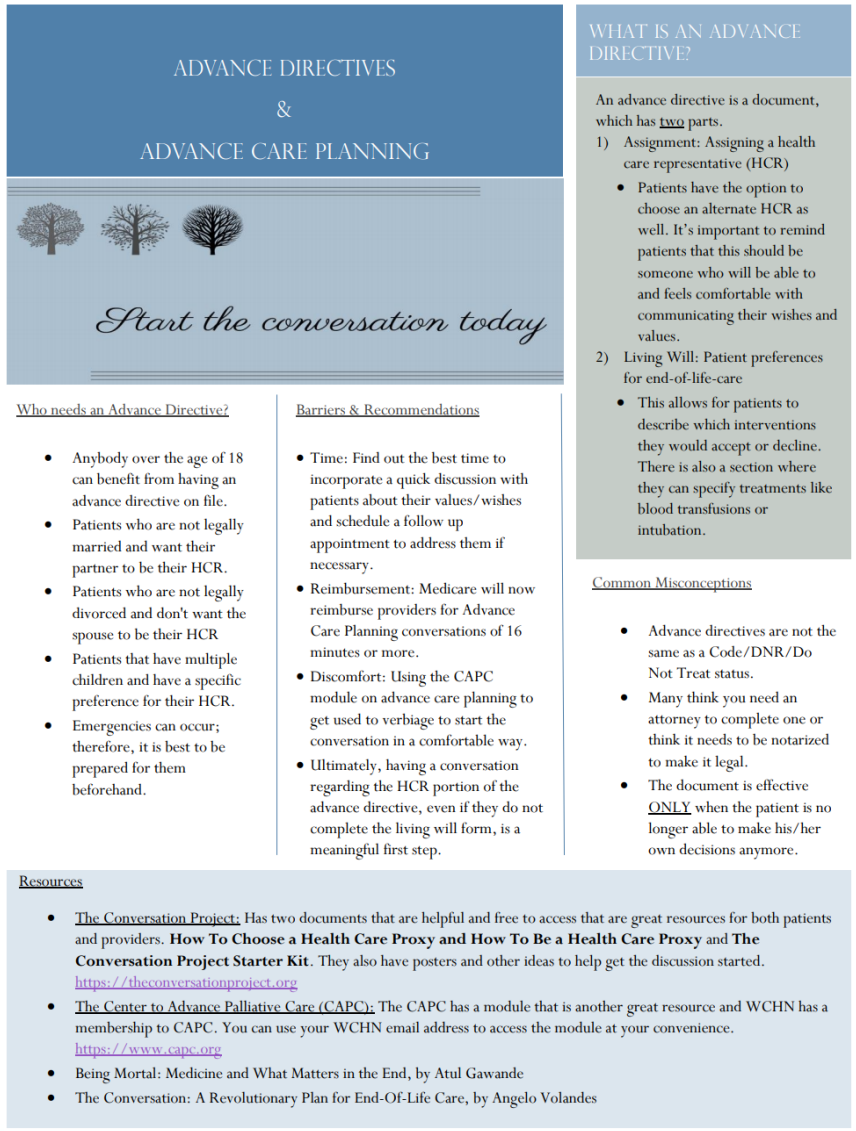
- On the biggest challenge in utilizing advance directives in primary care. “I think the biggest barrier is having the time. The other is the discomfort in bringing up the conversation if a patient is still healthy”.
- On recommendations to increase the utilization of advance directives in primary care. “Now Medicare will reimburse doctors for [Advance Care Planning] conversation for 16 minutes of more, and also for providers to practice having the conversation, perhaps using [Center to Advance Palliative Care] module on advance care planning to get used to verbiage to start the conversation in a comfortable way”.

Intervention and Methodology

- Created a one page handout for providers at Newtown Primary Care to reference when needed. Also supplemented the handout with an oral presentation discussing the importance of advance directives and recommendations for advance care planning.
- The handout includes recommended resources that providers can access at anytime for their own edification.
- Encouraged providers to utilize information learned from the presentation and handout to educate other health care professionals and their own patients.
- Recommended that providers fill out their own advance directive to familiarize themselves with the process of completing one.

Results/Response

- Supportive and positive responses to both the created handout and the oral presentation.
- The presentation generated a brief discussion afterwards, which addressed the difficulties of Advance Care Planning conversations in the practice.
- Identification of challenges offers insight into possible solutions and implementations for the future.



ADVANCE DIRECTIVES
&
ADVANCE CARE PLANNING

Start the conversation today

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a document, which has two parts.

1) Assignment: Assigning a health care representative (HCR)
   - Patients have the option to choose an alternate HCR as well. It's important to remind patients that this should be someone who will be able to and feels comfortable with communicating their wishes and values.
2) Living Will: Patient preferences for end-of-life-care
   - This allows for patients to describe which interventions they would accept or decline. There is also a section where they can specify treatments like blood transfusions or intubation.

Who needs an Advance Directive?

- Anybody over the age of 18 can benefit from having an advance directive on file.
- Patients who are not legally married and want their partner to be their HCR.
- Patients who are not legally divorced and don't want the spouse to be their HCR
- Patients that have multiple children and have a specific preference for their HCR.
- Emergencies can occur; therefore, it is best to be prepared for them beforehand.

Barriers & Recommendations

- Time: Find out the best time to incorporate a quick discussion with patients about their values/wishes and schedule a follow up appointment to address them if necessary.
- Reimbursement: Medicare will now reimburse providers for Advance Care Planning conversations of 16 minutes or more.
- Discomfort: Using the CAPC module on advance care planning to get used to verbiage to start the conversation in a comfortable way.
- Ultimately, having a conversation regarding the HCR portion of the advance directive, even if they do not complete the living will form, is a meaningful first step.

Common Misconceptions

- Advance directives are not the same as a Code/DNR/Do Not Treat status.
- Many think you need an attorney to complete one or think it needs to be notarized to make it legal.
- The document is effective ONLY when the patient is no longer able to make his/her own decisions anymore.

Resources

- The Conversation Project: Has two documents that are helpful and free to access that are great resources for both patients and providers. **How To Choose a Health Care Proxy and How To Be a Health Care Proxy** and **The Conversation Project Starter Kit**. They also have posters and other ideas to help get the discussion started. https://theconversationproject.org
- The Center to Advance Palliative Care (CAPC): The CAPC has a module that is another great resource and WCHN has a membership to CAPC. You can use your WCHN email address to access the module at your convenience. https://www.capc.org
- Being Mortal: Medicine and What Matters in the End, by Atul Gawande
- The Conversation: A Revolutionary Plan for End-Of-Life Care, by Angelo Volandes

Evaluation of Effectiveness and Limitations

- The next step in evaluating the effectiveness of the intervention is to collect baseline data that identifies the number of advance directives on file in Newtown Primary Care and monitor it moving forward.
- The handout was printed in the office for easy accessibility for any staff to access at their own convenience.
- The providers present felt more comfortable with the topic of advance care planning and appreciated the recommendations and resources given to them.
- Limitations include a small sample size (n=3) of providers in attendance for the oral presentation. The limited timeframe of one month makes it difficult to assess the effectiveness of the intervention.

Future Directions

- Collect data and monitor the completion rates of advance directives at Newtown Primary Care (NPC). Follow the completion rate trend as provider education is implemented to further assess effectiveness.
- Continue educating future healthcare providers at NPC, with eventual extension of education throughout Fairfield County practices.
- Implement workshops to discuss common misconceptions and incorporate advance care planning strategies into provider workflows.
- Incorporate advance care planning into training for all ancillary staff involved with patient care.

References

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6. Zhang B, Wright AA, Huskamp HA, Nilsson ME, Marciejewski ML, Earle CC, Block SD, Maciejewski PK, Prigerson HG. Health care costs in the last week of life. Associations with end-of-life conversations. *Arch Intern Med.* 2009 Mar; 169(5): 480-88

Interview Consent Form

Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview.

Yes __X__ / No ____

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