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Increasing Completion of Advance Directives in the Primary Care Setting

The Health Center Plainfield, VT

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Mentor: Melissa Houser, M.D.

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Identifying the Problem

- Ninety percent of people said that it was important to talk to a loved one about their end-of-life care, yet only 27% had actually done so, according to the Conversation Project National Survey.
- In 2014, a study found that only 26.3% of Americans had completed an advance directive. ¹
- Satisfaction with PCPs and overall visits were increased among elderly patients with chronic illnesses when advanced directives were discussed.²
- Patients without advance directives are enrolled in hospice for shorter amounts of time before death and are less likely to die in the setting of their choice.³
- It is expected for the population of 65+ year olds to more than double between 2012 and 2060, to 92.0 million. This means they will make up 1 in 5 U.S. residents by 2060 compared to 1 in 7 today. Those 85+ will more than triple in demographics to 18.2 million people. ⁴
- 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

- Health care cost increase and patient/family outcomes decrease without advance care planning. This can be seen through interventions made in La Crosse, WI.⁵
(<https://www.npr.org/sections/money/2014/03/05/286126451/living-wills-are-the-talk-of-the-town-in-la-crosse-wis>)
- Of Medicare spending, 25.1% is used in the last year of a patient's life. At the end of life more aggressive care is implemented, maybe causing this spike in costs. ⁶
- There is an increased level of stress, anxiety, and depression in family and friends of patients who do not have advanced care planning in place. Patient and family satisfaction was higher in those who completed ADs before an event occurred.⁷

Community Perspective

**Jonna Goulding, MD and Abbey
Rouleau, RN – Palliative Care
CVMC Berlin, VT**

- “Providers might be frightened because medical teaching has not stressed talking to patients about ADs as a skill needed to be learned. Then it becomes scary, even to talk with patients you have known for a long time. Providers often have a fear of death personally or are unaware of how to approach the topic with patients. Practitioners also might have a fear that they don’t want the patient or the family to feel like they are being abandoned, by letting them know that they are thinking outcomes are going in a different direction than the patient hoped.”

**Elisha McLam, MD
The Health Center Plainfield, VT**

- With good advance care planning, we can prioritize patient goals, quality of life and facilitate meaningful experiences at the end of life, instead of getting caught up in the chaos of “medical treatment.” Medicine operates on the premise of treatment by default, where more and more aggressive therapies are automatic, often without consideration of side effects or the realistic likelihood of benefit vs harm. However, as long as physicians continue to be unable to acknowledge the inevitability of death and unable to engage in thoughtful discussions surrounding end of life concerns, we will never be able to provide patients with the best care possible.

Intervention & Methodology

- An FAQ brochure was created using information from VT Ethics Network and the same information shared with providers so that there is a clear message to patients.
 - Terminology explained: DNR/COLST, Health Care Agent, etc.
 - Submission guidance: VT State Registry, PCP, Agents, etc.
 - Suggestions for resources used to start the difficult conversations with family and friends
- Educational presentation was given to providers and staff to encourage self-completion of ADs, as well as how to present the information to patients. A survey was given to staff before and after the presentation with the ability for staff to comment on the presentation.
- Community group session held twice for any patients interested in learning more about the completion of AD, DNR/COLST and Health Care Agent Forms for the state of Vermont.

What is an Advance Directive?

It is a legal document that allows you to give detailed instructions about your health care decisions, or to appoint another person (Health Care Agent) to make the decisions for you in the event that you cannot make decisions due to serious illness or injury. It assures that health care professionals will honor your preferences in treatment, and allows you to make your own decisions before an event may occur.

Who should fill this out?

Anyone years 18 or older should complete an advance directive while they are capable of understanding the outcomes of their health care decisions. It does not matter if you are healthy or sick at the time.

Do I need someone to help me complete the form?

The choices regarding your care should be completely your own, but speaking with your family and loved ones ahead of time can allow for your values and wishes to be shared and help them understand how to honor your choices. Also, your health care provider can walk you through the documents and explain what different types of treatments involve. You do not need a lawyer to complete the forms, and they can be held on file as part of your medical record.

Planning your care significantly decreases the stress placed on your family, friends and loved ones when a serious event occurs. Having a plan in place improves care overall and allows for family to focus on their loved one rather than worrying about medical decisions.¹



Advance Directives

FAQs and information about planning End-of-Life care



Where should I start in planning?

Step 1: Determine your Health Care Agent. This is a person who can make decisions on your behalf, so make sure you have shared your wishes with them. You can choose an alternative agent as well as choosing who you do *not* want making decisions for you.

Step 2: Complete an AD with your goal and priorities for health care treatment.

Step 3: Develop a COLST/DNR to make sure your limitation of treatments are respected across all care settings including in the community and hospital.

This seems like a difficult conversation to start. Are there resources I can use with my family and friends to open a discussion?

- www.advancecareplanning.ca/ scroll to click on "You & Your Family"
- vtethicsnetwork.org/decisions.html here you can find copies of both the short and long AD forms as well as the health care agent and DNR forms

What do I do after filling it out?

A copy should be given to your doctor, your Health Care Agent and anyone else you would like to have informed. The state of Vermont has a confidential registry that allows any health care provider in the state access to your AD when it might be necessary.

Can I ever change what I wrote?

Yes, if you complete a new form, it cancels out the older form. You can also tear up the document at any time and remove it from the medical record and/or registry. It is suggested to update an AD annually.

Does the form only refuse care?

No, the AD allows you to pick exactly what types of treatments you would like in addition to what you would not like.

Can I still make decisions?

Yes, you must make your own medical decisions as long as you are capable and can communicate your choices. Your AD only is effective when you lack capacity to make decisions.

References:

1. Detering K.M., et. al. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial BMJ 2010; 340 :c1345

Response

- Brochures will be distributed to patients over the age of 18, with increased focus on patients over the age of 65.
- The group meetings were advertised in The Health Center's email newsletter and were well attended with 12 community members at the lunch time meeting and 4 at the evening meeting.
- Immediate feedback was taken and questions were answered at the community group sessions.
- Staff and providers determined that the EMR needed to be changed to remind them to ask about ADs and set a goal of increasing the completion rate by a certain percent (still to be determined) within the year.

Evaluation

Effectiveness

- A baseline number of patients with ADs on file was collected. Going forward, the number of ADs completed can be identified to measure the effectiveness.
- Feedback directly from providers, regarding their confidence to discuss ADs with patients, will also qualitatively determine if the intervention was effective.

Limitations

- Within only one month it is difficult to fully train staff to a level of competence, and confidence to discuss advance care planning with patients.
- Patients often feel uncomfortable speaking about end-of-life care and are unaware of the benefits that ADs provide for any medical emergency.
- Carrying out effective advance care planning in elderly patients is challenging, especially when they are acutely unwell and might have limited time available to visit the office. 7

Future Interventions

- A year long study with repeated interventions at the patient and provider levels will be conducted. This includes additional community meetings that are well advertised.
- EMR requisitions of de-identified statistics of completion of ADs within different age groups will be acquired to determine progress.
- Providers agree to work to increase AD completion by a certain percentage at The Health Center and will be giving quarterly updates on the progress.

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Jonna Goulding, MD and Abbey Rouleau, RN and Elisha McLam, MD