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Advance directives: Effectiveness of a structured process for documented patient preferences at a health system

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Advance directives: Effectiveness of a structured process for documented patient preferences at a health system

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Research Study Team

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Definitions

- **Advance Directives** – documents completed by an adult capacitated person giving instructions regarding medical care should he/she become incapacitated – living will, healthcare surrogate or durable power of attorney for healthcare

- **Florida Healthcare Proxy – Legal Next of Kin Hierarchy**
  (used for incapacitated patients without a designated HC surrogate)
- Judicially appointed guardian
- Spouse
- Majority of adult children
- Parents
- Majority of adult siblings
- An adult relative
- A close personal friend
- A clinical social worker

Purpose

- This study was to compare advance directives data from a previous study (1999-2002), to post enculturation of structured advance directives process for documented patient preferences during the period of 2011 – 2015

- Secondly, to conduct a descriptive and bivariate analysis of the enculturated structured advance directives process during the period of 2011 – 2015

Significance

- The Center for Medicare and Medicaid Services (CMS) requires organizations to comply with the Patient Self-Determination Act of 1990 by having written policies and procedures to inform the admitted patient about his/her rights to execute an Advance Directive (AD) and engage in shared decision-making

History

- **At the time of 1st study (1999 – 2002)**
  - Four –hospitals within the health system
  - Each hospital had it's own AD document
  - No storage system was in place
  - AD questions were asked using a paper document

Key Points from Study of (1999 – 2002) to Consider Strategies

- 12% of patients claimed to have an AD on admission but never provided a copy
- 65% of these patients had emergency admission with longer hospital stay, and many had DNR status assigned later in hospital stay
- Staff felt uncomfortable asking patients/families each day for a copy
- Patients were dis-satisfied that we were asking for copies on each re-admission
- Of the patients who completed AD during hospital stay 34% were assigned DRG's related to child birth. This group received pre-admission packets which included AD

JONA'S Healthcare Law, Ethics, and Regulation, Vol. 7(3), 2005, 86 - 91

Strategy/Implementation

- **Bioethics Team - Post Study Initiatives:**
- 2003 standardization of AD across the health system
- AD documents created in English, Spanish, Creole including AD education brochures

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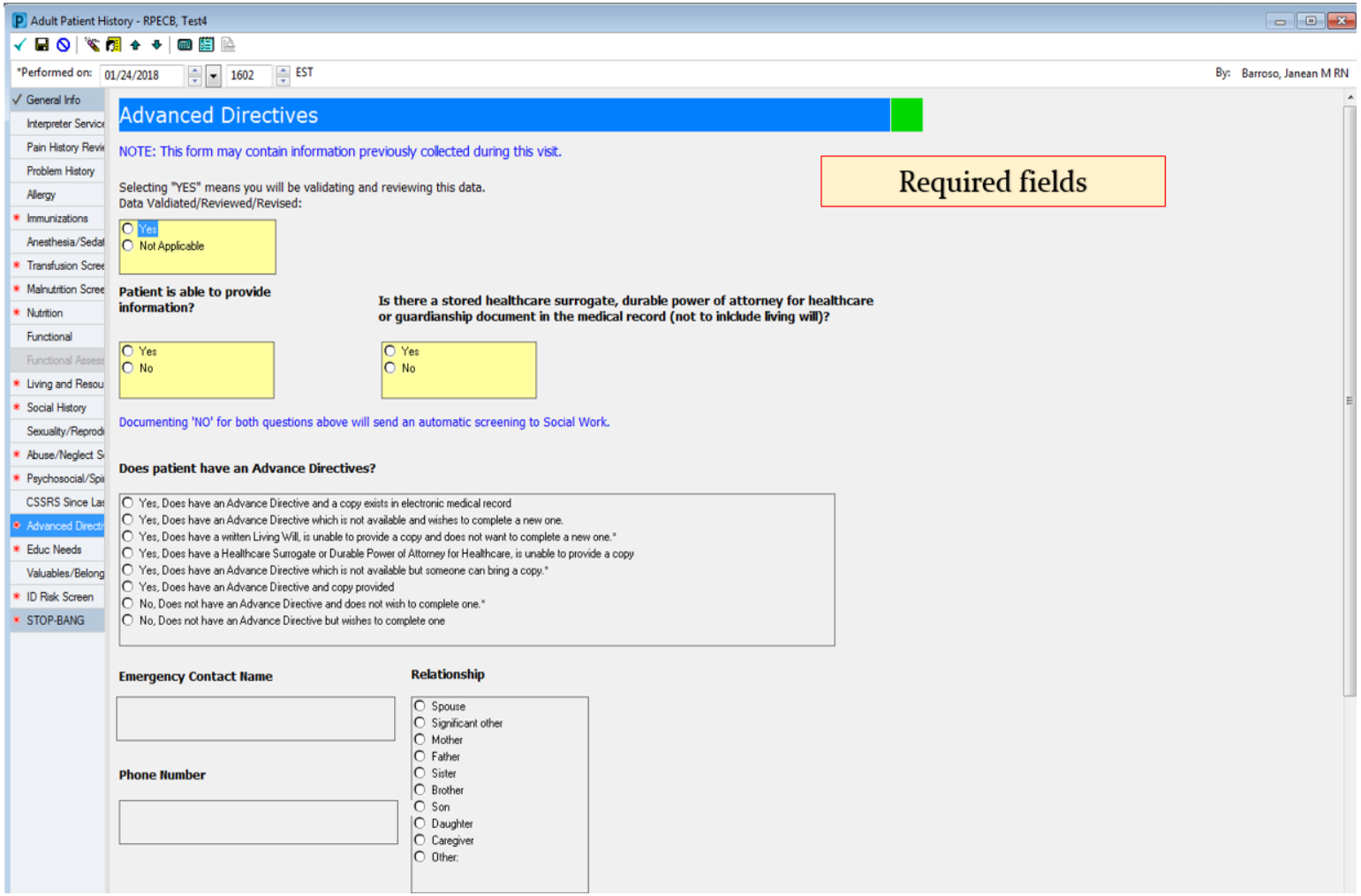
Strategy/Implementation cont'd..

- 2004 – collaboration with HIM department to create AD storage system
- Created AD EMR questions to be asked of each patient on admission. First created in Net Access and subsequently upgraded in Cerner EMR
- 2005 – Community Education following Terry Schiavo's Case
- 2013 - AD video on patient education channel & Intranet

Cerner AD Documentation



Methods

- The descriptive, comparative analysis included 500 random patients from 4 hospitals and the enculturated descriptive analysis included 302 patients from 6 hospitals

- Comparative data analysis of pre and post study was done using bivariate comparisons of proportions with *p-value* set at .05

Study Sample

- **Pre Study Group– 250 (1999 – 2002)**
  - Hospital A – 119
  - Hospital B – 96
  - Hospital C – 26
  - Hospital D – 9

- **Post Study Group – 302 (2011 – 2015)**
  - Hospital A -119
  - Hospital B – 96
  - Hospital C – 26
  - Hospital D - 9
  - Hospital E – 26
  - Hospital F -26

Evaluation

Comparative Analysis of Pre-Study versus Post-Study, Four Hospitals (n=500)

Variable	Prestudy ($n = 250$)	Poststudy ($n = 250$)	
No advance directives	208 (83%)	121 (48%)	$p < .05$
Claims to have an advanced directive	29 (12%)	3 (1%)	$p < .05$
Institutional advance directives	86 (34%)	126 (50%)	$p < .05$

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Demographic Breakdown of Post Study Group - 6-Hospitals Post Enculturation

TABLE 1

Demographic Breakdown of Post Study Group (2011 - 2015)

Demographic makeup of study group							
Variables	***Total (302)***	***Hos A (119)***	***Hos B (96)***	***Hos C (26)***	***Hos D (9)***	***Hos E (26)***	***Hos F (26)***
Average age	*59.1*	62.6	54	52.1	65.1	59.8	66.8
*Median household income**	*$57,021*	$57,385	$57,021	$42,584	$59,467	$58,322	$57,127
Female	61.60%	60.50%	67.70%	53.80%	**33.30%**	61.50%	61.50%
Racial Makeup							
White Hispanic	62.00%	61.00%	63.00%	39.00%	11.10%	88.50%	77.00%
White	22.00%	19.00%	21.00%	23.00%	77.80%	11.50%	19.00%
Black or African American	11.00%	11.00%	10.00%	31.00%	0%	0%	4.00%
Other and NA	6.00%	9.00%	6.00%	7.00%	11.10%	0%	0%
Language							
English	72.00%	70%	81%	89%	89%	58%	42%
Spanish	27.00%	29%	19%	11%	11%	42%	58%
French	1.00%	1%	0%	0%	0%	0%	0%
Married	47%	50%	54%	23%	22%	42%	42%
With religious preference	95.00%	98%	95%	89%	100%	89%	96%

** Based on Census 2015 tract data*

Admission/Discharge Breakdown of 6 Hospitals Post Enculturation

TABLE 2

Admission/Discharge Breakdown of Post Study Group (2011 - 2015)

Admission/Discharge status of study group

Variables	*Total (302)*	*Hos A (119)*	*Hos B (96)*	*Hos C (26)*	*Hos D (9)*	*Hos E (26)*	*Hos F (26)*
Admission Type							
Routine/elective	31.00%	31%	46%	11%	44%	8%	15%
Emergency/Urgent	69.00%	69%	54%	89%	56%	92%	85%
Disposition							
Home	67.00%	61.00%	85.00%	61.00%	56.00%	46.00%	54.00%
Home with Home Health	13.00%	15.00%	8.00%	4.00%	0.00%	34.00%	8.00%
SNF	9.00%	11.00%	4.00%	4.00%	11.00%	4.00%	26.00%
ALF and Intermediate Care	2.00%	3.00%	0.00%	0.00%	11.00%	8.00%	4.00%
Rehab. Facility	3.00%	4.00%	1.00%	12.00%	11.00%	0.00%	4.00%
Hospice	3.00%	3.00%	1.00%	8.00%	0.00%	4.00%	4.00%
Expired	3.00%	3.00%	1.00%	11.00%	11.00%	4.00%	0.00%

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Descriptive Analysis with Variables - Post Enculturation (6-hospitals)

Descriptive Analysis of 6 Hospitals Post Enculturation, n=302		
Variables		
Age, mean (years)	59.2	
Median household income, mean	$53,227.62	
White Hispanic, n(%)	188(62%)	
Type of Admit Highest, n(%)	Emergency/Urgent Admission, 208(69%)	
LOS, mean (days)	4.68	
Personal AD, n(%)	10(3%)	
Stored Personal AD, n(%)	**10(3%)**	
Instititional AD, n(%)	155(51%)	
Stored Institutional AD, n(%)	**58(19%)**	
Going on to complete hospital AD, n(%)	**97(32%)**	
Type of DRG (**OB) Highest for Institutional AD**, n(%)	39(25% of 155 Institutional ADs)	
Mortality, n(%)	10(3%)	
Having DNR order, n(%)	21(7%)	
Requiring Proxy designation, n(%)	25(8%)	
Having resuscitative measures, n(%)	0	

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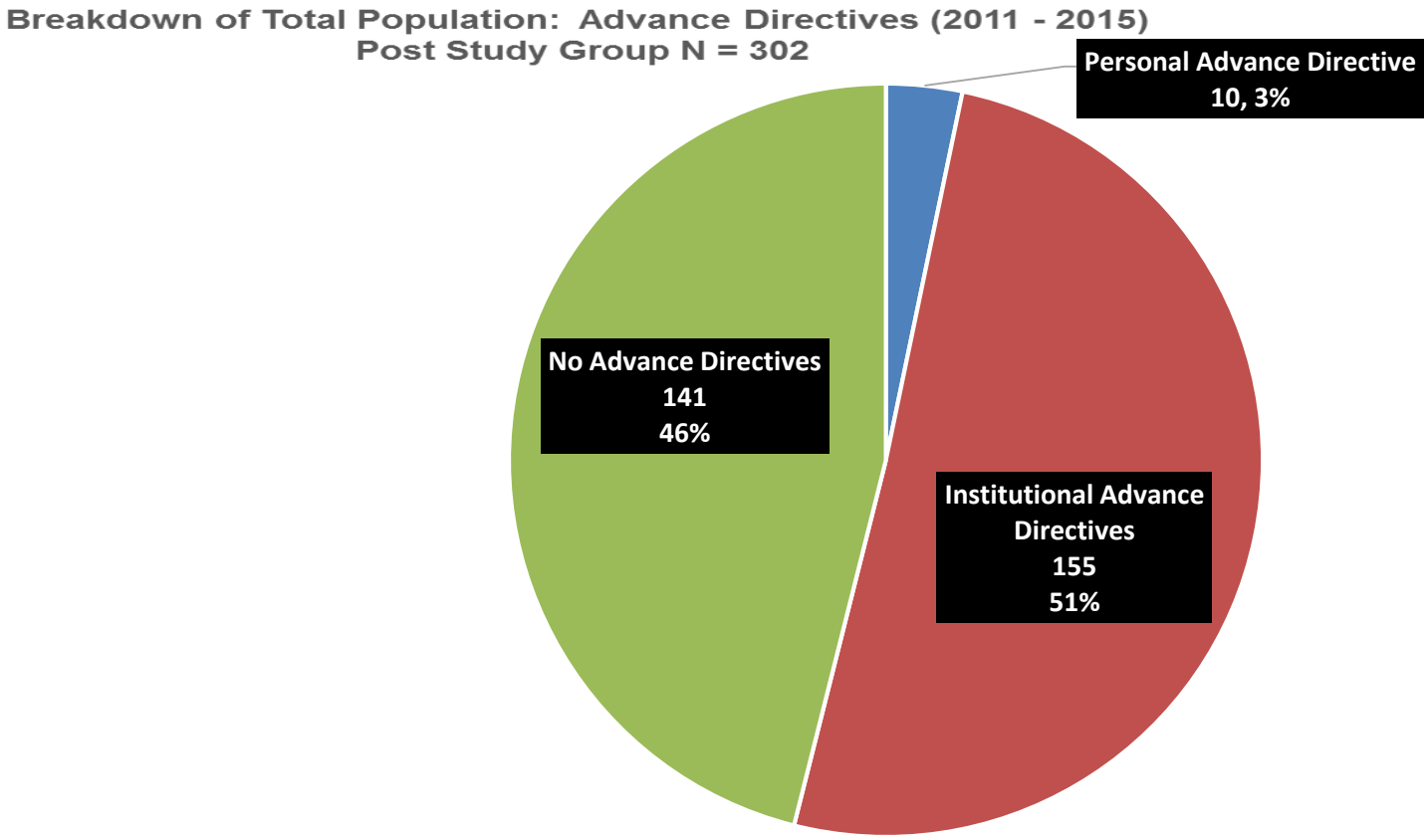
Breakdown of Total Population Advance Directives – Post Enculturation (6-hospitals)



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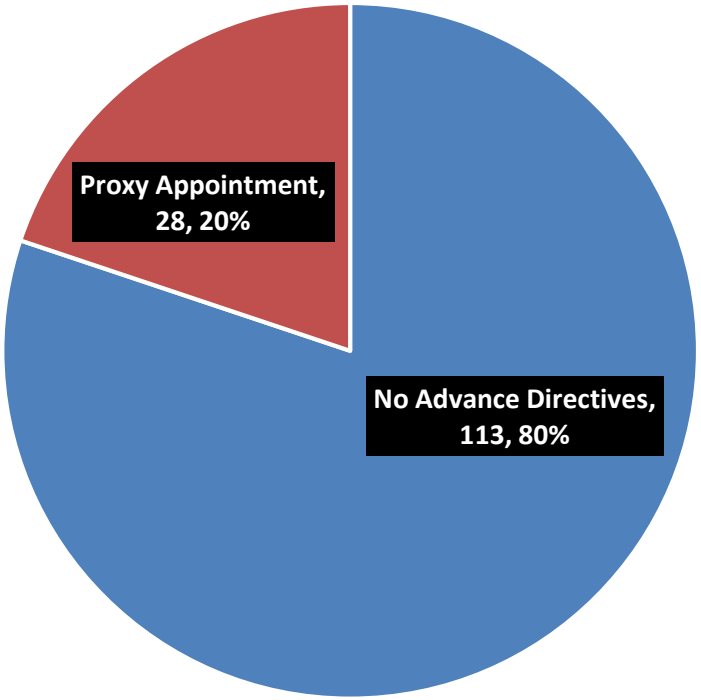
No Institutional AD with Proxy Appointment- Post Enculturation (6-hospitals)

No Advance Directives with Proxy Appointments (2011-2015) N = 141



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Percentage Breakdown of Types of AD- Post Enculturation (6-hospitals)

Variables	N = 161	Responses Percent	Percent of Cases
Healthcare Surrogate	161	91.50%	100%
Living Will	9	5.10%	5.60%
Durable Power of Attorney for Healthcare	6	3.40%	3.70%

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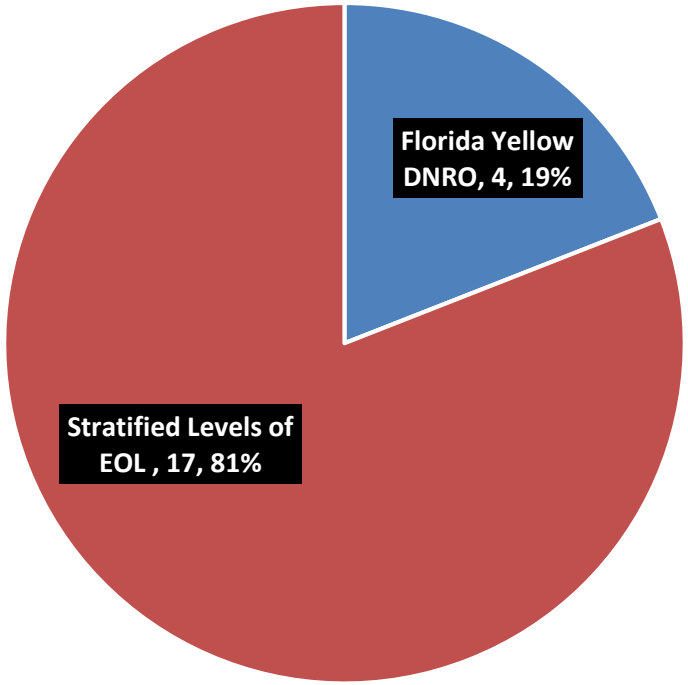
Comparative Analysis - Florida Yellow DNRO vs Stratified Patients-Post Study (6 hospitals)

DNR Types for Post Enculturated Group
(6-Hospitals)



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Discussion - Results

The sustained enculturation of a structured process for documenting patients' healthcare preferences at this organization since 2004 proved to be effective and efficient as evidenced by:

- **Statistically significant decrease** in number of post-study patients with no AD and patients claimed to have AD but could not provide a copy, when compared to pre-study group (*p-value* 0.05)
- **Statistically significant increase** in number of patients in post-study group with Institutional AD (stored and going on to complete after admission), when compared to pre-study group (*p-value* 0.05)

- Four patients had stored Living Wills and during post-study admission period, completed HCS on Institutional AD

Discussion/Results cont'd……

- Patients have the right to review/revise their AD. During every admission patients are asked to review stored AD for validity and make updates as necessary
  - One patient in post-study group had a stored Durable Power of Attorney for Healthcare naming 2 people to make healthcare decisions. During the post-study admission, the patient completed a new Institutional AD naming only one of the previous 2 people, to make healthcare decisions.
- Healthcare surrogates were the highest percentage (91.5%) of AD documents completed
- None of the subjects with personal or institutional AD in pre or post study groups had resuscitative measures when DNR status was ordered.

Discussion- Implications for Practice

- Healthcare professionals can best provide quality, patient, family-centered care when patient's preferences are known through documented advance directives

- Education for nurses, case managers and physicians is essential for goal achievement

Discussion – New Initiatives

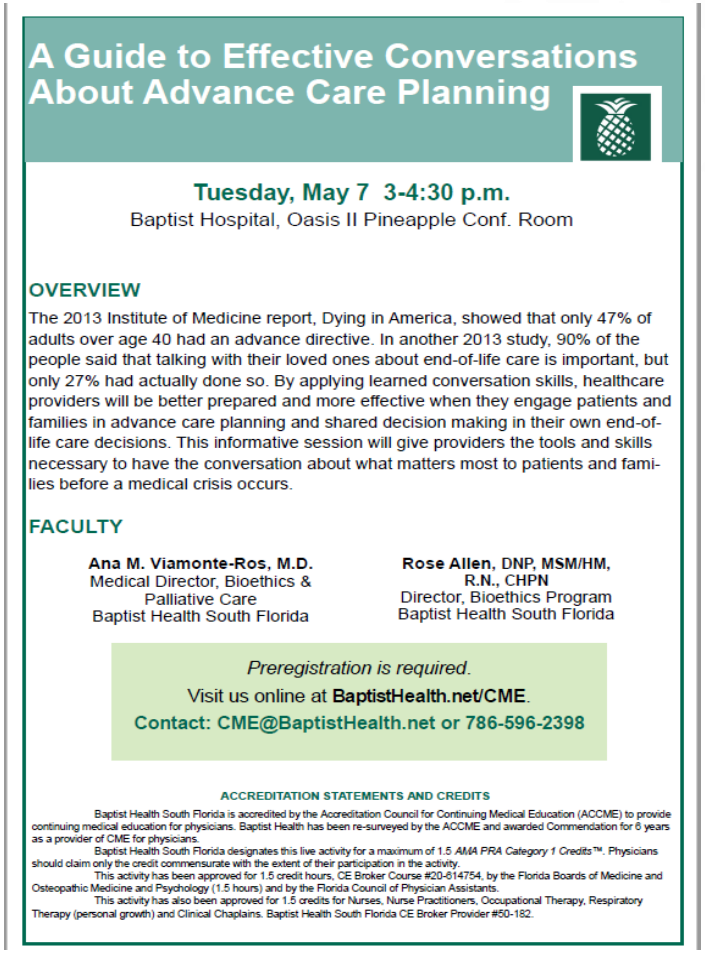
BHSF Community NHDD Education 2018 - 2020		
Year	# Events	# Attended
2018	10	284
2019	16	768
2020	5	128

https://theconversationproject.org/

Institute for Healthcare Improvement

Discussion – New Initiatives

- Education for Physicians and Healthcare Providers
- CME/CE course started in 2018
- Educated > 170 MD's & other staff



A Guide to Effective Conversations About Advance Care Planning

Tuesday, May 7 3-4:30 p.m.
Baptist Hospital, Oasis II Pineapple Conf. Room

OVERVIEW

The 2013 Institute of Medicine report, Dying in America, showed that only 47% of adults over age 40 had an advance directive. In another 2013 study, 90% of the people said that talking with their loved ones about end-of-life care is important, but only 27% had actually done so. By applying learned conversation skills, healthcare providers will be better prepared and more effective when they engage patients and families in advance care planning and shared decision making in their own end-of-life care decisions. This informative session will give providers the tools and skills necessary to have the conversation about what matters most to patients and families before a medical crisis occurs.

FACULTY

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Preregistration is required.
Visit us online at **BaptistHealth.net/CME**.
Contact: CME@BaptistHealth.net or 786-596-2398

ACCREDITATION STATEMENTS AND CREDITS

Baptist Health South Florida is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Baptist Health has been re-surveyed by the ACCME and awarded Commendation for 6 years as a provider of CME for physicians.

Baptist Health South Florida designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity has been approved for 1.5 credit hours, CE Broker Course #20-614754, by the Florida Boards of Medicine and Osteopathic Medicine and Psychology (1.5 hours) and by the Florida Council of Physician Assistants.

This activity has also been approved for 1.5 credits for Nurses, Nurse Practitioners, Occupational Therapy, Respiratory Therapy (personal growth) and Clinical Chaplains. Baptist Health South Florida CE Broker Provider #50-182.

Thank You and Appreciate Any QUESTIONS ?

References

- Allen, R. & Ventura, N. (2005). Advance directives use in acute care hospitals. *JONA'S Healthcare Law, Ethics, and Regulations,* 7(3), 86 - 91

- Allen, R., Cohn, T., Edozie, C., Howard, S., & McCrink, P. (2019). Outcomes comparison of enculturating advance directives process at a health system. *SAGE Open Nursing,* 5, 1 - 9