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Advanced Care Planning in Primary Care

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Advanced Care Planning in Primary Care Executive Summary

Introduction of the Problem

Advanced care planning (ACP) is a general term used to describe a living will, power of attorney, and do-not-resituate (DNR) orders. A DNR is particularly important when discussing end-of-life choices during an emergency. In Illinois, the DNR form is officially referred to as the Practitioner Orders for Life-Sustaining Treatment (POLST) form (POLST IL, 2021). The POLST form is a legally binding document that is used across all care continuum and facilities, unless otherwise revoked by the patient or the patient's power of attorney when and if the patient is no longer able to make these decisions. POLST forms can be used for people of any age. The POLST form is meant to legally document a patient's wishes regarding life sustaining treatment in the event of a "serious life limiting medical condition" (POLST IL, 2021).

While advanced care planning (ACP), including the POLST form, is available for all medical providers to utilize, it is grossly underutilized as fewer than 30% of Americans have utilized ACP (Hinders, 2012). In 1991, the Patient Self-Determination Act (PSDA) was passed and legally required certain facilities including hospitals and nursing homes to discuss ACP with patients; however, the PSDA does not require discussions about ACP with patients in the primary care setting (Ramsaroop et al., 2007). Therefore, there is a lack of a structured process outlined for primary care providers to speak with and identify patients who may benefit from ACP discussions.

Literature Review

A literature review of articles dated from 2003-2022 was performed using Academic Search Complete, PubMed, MedLine Complete, and CINAHL. The following terms and keywords were used: advance care directives, living will, primary care, advanced practice nurses,

nurse practitioners, POLST forms, end-of-life care, implementation age, prevalence, education, protocols, guidelines, randomized control trials, peer-reviewed, systematic reviews, and meta-analysis.

The literature review revealed several limitations regarding ACP in the primary care setting. Butterworth (2003) identified the following 10 barriers to ACP in primary care: "patient and provider reluctance, time constraints, assumptions, denial and procrastination, unrealistic expectations, delayed until a crisis, discomfort with palliative care planning, lack of documentation, cultural and health system barriers, and readiness." A systematic review by Ramsaroop et al. (2007) performed a meta-analysis on 18 studies regarding implementing ACP in primary care and concluded that direct provider interaction over multiple office visits yielded the best chance of increasing ACP completion.

A randomized controlled trial by Rando-Matos et al., (2021) used a study group to give a brief informational session and pamphlet on ACP. The authors concluded that this intervention only increased the interest in ACP, not the completion of the forms. Their suggestion was to focus on the patient population in the primary care setting that may already have an interest in ACP. One suggestion that was hard to identify through our extensive literature review was a recommendation for age implementation for ACP. A cluster randomized controlled trial performed by Fried et al., (2021) in primary care offices and select specialty offices included only participants aged 55 years and older with mean age of 68.3. This study concluded that middle aged and older adults recruited from these offices had an increased participation in ACP.

Project Methods

The purpose of this project was to initiate conversations about ACP with patient's 55 years and older in a primary care office and complete POLST forms when appropriate. This

project took place at a rural health primary care office in southern-central Illinois. The information systems (IS) department at the primary care clinic project site helped to utilize the EMR to identify the patients at the site that were 55 years and older and how many had ACP forms on file for later data comparison after completion of project implementation. With the help of the IS department, an intake form was set up in the EMR for all patients over the age of 55 that would identify a patient that did not have ACP through a series of questions that were answered by either the certified medical assistant (CMA) or licensed practical nurse (LPN) during the intake process. Once the screening tool identified a patient that was appropriate for the purpose of discussing ACP, the provider was notified by placing ACP forms outside the patient's room to signal the provider to have a discussion with the patient while in the room.

Staff education was provided though an in-person session, paper forms, and email. Data extrapolated from the project was a randomly assigned non-identifying patient number, age range, sex, and ACP status prior to and after visit. All information obtained was kept confidential and used only for the purpose of this project. Application submitted and approved from both the clinical site IRB and school IRB prior to implementation of project.

Evaluation

The project outcomes were evaluated using data derived from the EMR with the assistance of the IS department. The main outcome measured and evaluated was the number of POLST forms on file for patient's 55 years and older prior to and after the project's implementation period of two months. For the fiscal year July 1, 2021, to June 30, 2022, the clinic saw a total of 355 patients that were 55 years and older, an average of 30 patients per month. Each patient was only counted once if seen more than once for the defined fiscal year. Of those 355 patients, 73 patients had ACP directives on file in the EMR, which averages 6 per

month. This represents 20.5% for the fiscal year, or 20% per month of their patient population 55 years and old having pre-existing ACP on file prior to project implementation.

At the end of the project's implementation period, 175 patients 55 years and older were seen and 34 of them had ACP directives on file in the EMR. This averages 88 patients seen per month with 17 of those patients have ACP on file which averages to 19.4%. When comparing this to the 20% per month prior to implementation, there was a 0.6% decrease in ACP on file after project implementation was completed and analyzed with the assistance of IS.

Limitations identified within this project were being in a clinic with only one physician, implementing in a non-racially diverse rural clinic, and project implementation time period of two months. Having only one physician in a clinic can hamper the patient flow if that provider has to take a sick day, personal time off (PTO), or is seeing patients in other healthcare settings such as a local nursing home. This clinic was in a predominately white rural community which in turn did not allow for a wide range of diversity among the study's population. Therefore, it is the author's recommendation to expand this project to multiple primary care office sites in a geographical location with more diversity.

The last identified limitation was the limited time of two months for the project's implementation. A vast majority of the clinic's population was not seen in this period as many patients are seen only every three, six, or 12 months. Also, once a patient receives the information at their visit, they may not return the completed paperwork until their next visit. The recommendation is to implement this project for an entire fiscal year.

Impact on Practice

The immediate impact at the clinical site on practice was changing the way the CMA or

LPN performed their intake process for patient's 55 years and older. IS implemented a screening tool in the EMR for the clinical staff to use during the intake process to streamline this process for them. Education was provided in person to all staff prior to project implementation and a member of the project was on site during the first few days of implementation to answer questions and provide staff support. After implementation, the nursing staff were surveyed and reported 100% convenience with using the screening tool in the EMR. They were also surveyed about the rate of using the screening tool and the reaction received from patients when asking about advanced directives. Staff reported they asked patient's 100% of the time about ACP during the implementation period and that they did not observe any adverse reactions by a patient after asking about ACP. We therefore concluded that the process we implemented during this project was convenient for staff and had no adverse effects on the patient population. Staff expressed interest in continuing to use this screening tool after the end of the project.

Conclusions

While the outcome of this project showed a 0.6% decrease in the amount of ACP directives on file at the end of our implementation period, this does not equate with the process or project being directly responsible for the decrease. Also, we cannot directly measure the amount of interest in ACP this project has given rise to in this patient population. The future recommendation for this project is to implement in multiple primary care offices over a year to gain a broader, larger, and more diverse population of patients for the purpose of outcome evaluation. This project may serve as a steppingstone forward for future discussions on the necessity and process for implementing ACP in the primary care office.

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