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Improving Advance Directive Use Through Provider Education at Newtown Primary Care

Timothy Wong
Newtown Primary Care – Newtown, CT
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Anureet Gill, MD
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\textsuperscript{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\textsuperscript{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\textsuperscript{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.
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


4. Riley GF, Lubitz JD. Long-term trends in Medicare payments in the last year of life. *Health Serv Res*. 2010 Apr; 45(2):565–76


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Yes __X__ / No ____

Julia MacMillan, APRN, Palliative Care Coordinator, Co-Chair DHS Ethics Committee
Jeanine Famiglietti, MD, Palliative Care, Western Connecticut Medical Group