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Increasing Access to Advanced Care Planning Documentation

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Green Mountain Family Practice
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Problem Identification

- Yadav et al. (2017) conducted a systematic review of studies conducted between 2011 and 2016 regarding the completion of ACP documents in the United States and found only 37% of US adults had advance directives and only 33% of US adults had appointed a health care agent.
- According to the CDC, the death rate in the United States increased from 715/100,000 individuals in 2019 to 1,027/100,000 individuals in 2020, largely due to the COVID-19 pandemic which added over 350,000 deaths in 2020.
- Vermont has an aging population, noted by the 2020 US Census to have approximately 82% of our population consist of adults over the age of 18 years old which was a 5% change from the 2010 US Census.
- Here at CVMC, inpatient services transitioned to Epic from Meditech, outpatient clinics transitioned to Epic from ECW and both transitions provided opportunities for ACP documents to be buried in the EHR.

Costs to Consider

- Emotional distress of families and friends making decisions for others who have not completed ACP documents
- Conflict between health care professionals on the next course of action in treating a patient
- Requirement for additional health care professionals to be involved in the care of patients who do not have clear goals of care or a designated decision maker documented in the electronic health record
- Increased use of healthcare resources during prolonged decision making
- Emotional distress of caretakers and health care professionals trying to provide patient-centered care and engage in shared-decision making
- Innumerable others…

Community Perspective

- Practice Manager, Green Mountain Family Practice
  - GMFP had previously outlined a quality initiative to do just what this project was intending by increasing the percent of patients with advanced care planning paperwork accessible in Epic
- VT Ethics Network
  - Informed me of the Advance Directive Registry, how it could be helpful to this project, and what resources and forms were available for me to use
- I received additional helpful input from additional physicians in Palliative Care at CVMC; and through trainings in early and late goals of care conversations through TalkVT

Intervention & Methodology

- This project evolved as the year progressed:
  - Learning to have advance directive short form conversations
  - Learning to have appointment of a health care agent conversations
  - Assessing if adult patients at GMFP had existing ACP documentation, if so, where was it?
  - Documenting on the problem list if an adult patient was missing ACP documentation so that providers would know to address this in their wellness visits
  - Printing and scanning the existing ACP documents that were living in ECW or VT Advance Directive Registry but were not easily accessible in Epic
  - Conducting conversations in my wellness and chronic care visits with adult patients regarding appointing a health care agent

Results

- As of 9/2021, GMFP had a panel that included 3,478 GMFP patients over the age of 18
- 8.88% of GMFP adult patients had existing ACP documents in Epic (309/3478)
- 5.37% of GMFP adult patients had existing ACP documents in ECW or VT Advance Directive Registry (103/3478-ECW, 84/3478-ADR)
- All patients over the age of 18 at GMFP who do not have ACP documents now have a code on their problem list: “Patient does not have health care proxy”
- Missing result: # of GMFP adult patients I discussed appointing a health care agent with who did fill out paperwork during their visit.

Limitations

- Time commitment (patients and providers)
- Willingness of patients to discuss the topic of end of life decision making and fill out documents during their visits
- Many patients would inform me they had filled out documents at home, with an attorney, or had discussed who would make decisions with their family but did not have documents on file at GMFP
- My comfort level in having conversations with patients, which ultimately ended up with the project changing from advance directive short forms to appointment of a health care agent

Future Projects

- Create a workflow for advanced care planning documents to be added to the paperwork given to patients when they register at the front desk
- Create patient appointments specifically to address goals of care with a medical student who can witness and sign the appointment of a health care agent or advance directive short form and document the discussion in Epic for PCP or other providers to see
- Incorporate goals of care conversation into the template or workflow of wellness visits for all adults
- Teach medical students to have a conversation regarding appointment of a health care agent prior to their clinical exposure – this is already being done in some medical schools in the US as a response to the COVID-19 pandemic. (Huang et al., 2021)

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