INCORPORATING ADVANCE CARE PLANNING INTO THE ROUTINE PRIMARY CARE OFFICE VISIT

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OBJECTIVES

- Bring to light the problem
- Understand barriers
- Discuss overcoming those barriers
- Provide solutions
- Incorporate advance care planning into practice

CASE PRESENTATION

- 40 yo FM with stage IV colon ca
- Oncology
- PCP
- Large Cancer Center

- ADVANCE CARE PLANNING?

THE PROBLEM IS EVIDENT

- Overwhelming majority of patients in our health care system had no documentation of end-of-life care wishes.

- Studies showed that we weren't alone.[1,2]

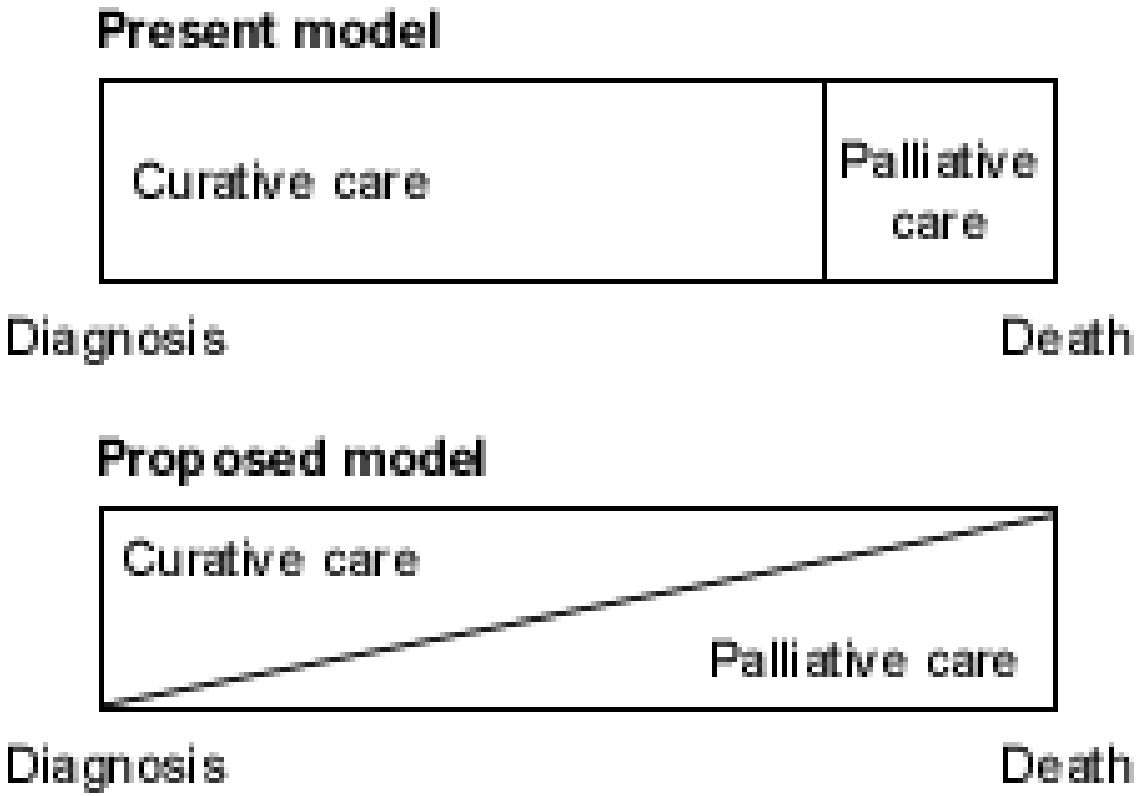
- 1. Silveira MJ, Kim SY, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N Engl J Med* 2010; 362:1211.
- 2. Rao JK, Anderson LA, Feng-Chang L, Laux JP. Completion of Advance Directives Among U.S. Consumers. *Am J Prev Med*. 2014 Jan; 46(1): 65-70. doi: 10.1016/j.amepre.2013.09.008.

SUPPORT TRIAL[3]

- 4 year study at 5 US teaching hospitals: 9,105 seriously ill patients
- 49% indicated they wanted CPR withheld but did not have DNR orders in their medical charts during hospitalization
- In patients preferring CPR be withheld, less than ½ of physicians were aware of preferences

3. The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: the study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). *JAMA*. 1995;274:1591–8 [Published erratum in *JAMA*. 1996;275:1232.]

WORLD HEALTH ORGANIZATION MODEL FOR ALLOCATION OF MEDICAL CARE RESOURCES



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  - Barriers to access
    - Access to healthcare
    - Lack of accurate information re: end-of-life care options
    - Fragmentation of care ("Who should I tell?")
    - No system in place to bring the topic up for discussion
  - Physician interactions
    - Strength of the doctor-patient/family bond
    - Who initiates the conversations[5]

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5. Sharp T, Moran E, Kuhn I, Barclay S. Do the elderly have a voice? Advance care planning discussion with frail and older individuals: a systematic literature review and narrative synthesis. *Br J Gen Pract* 2013; 63 (615) e657-e668. doi: https://doi.org/10.3399/bjgp13X673667.

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  - Time
    - Huge

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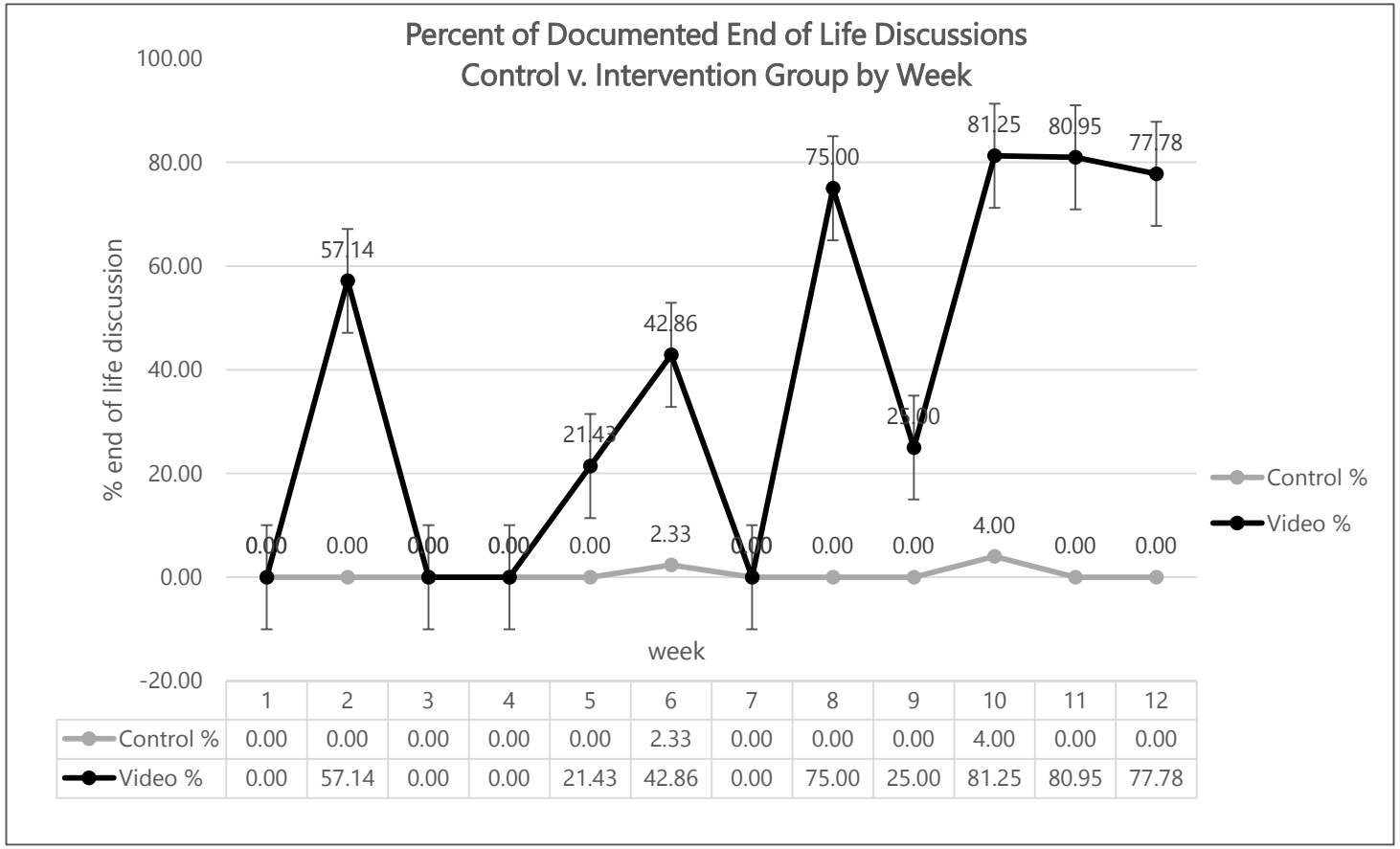
  - After each week for 10 weeks, we queried the electronic health record looking for the CPT code 99497 and compared the rates between the control group (no video watched) and the intervention group (video watched).

RESULTS



	1	2	3	4	5	6	7	8	9	10	11	12
Control %	0.00	0.00	0.00	0.00	0.00	2.33	0.00	0.00	0.00	4.00	0.00	0.00
Video %	0.00	57.14	0.00	0.00	21.43	42.86	0.00	75.00	25.00	81.25	80.95	77.78

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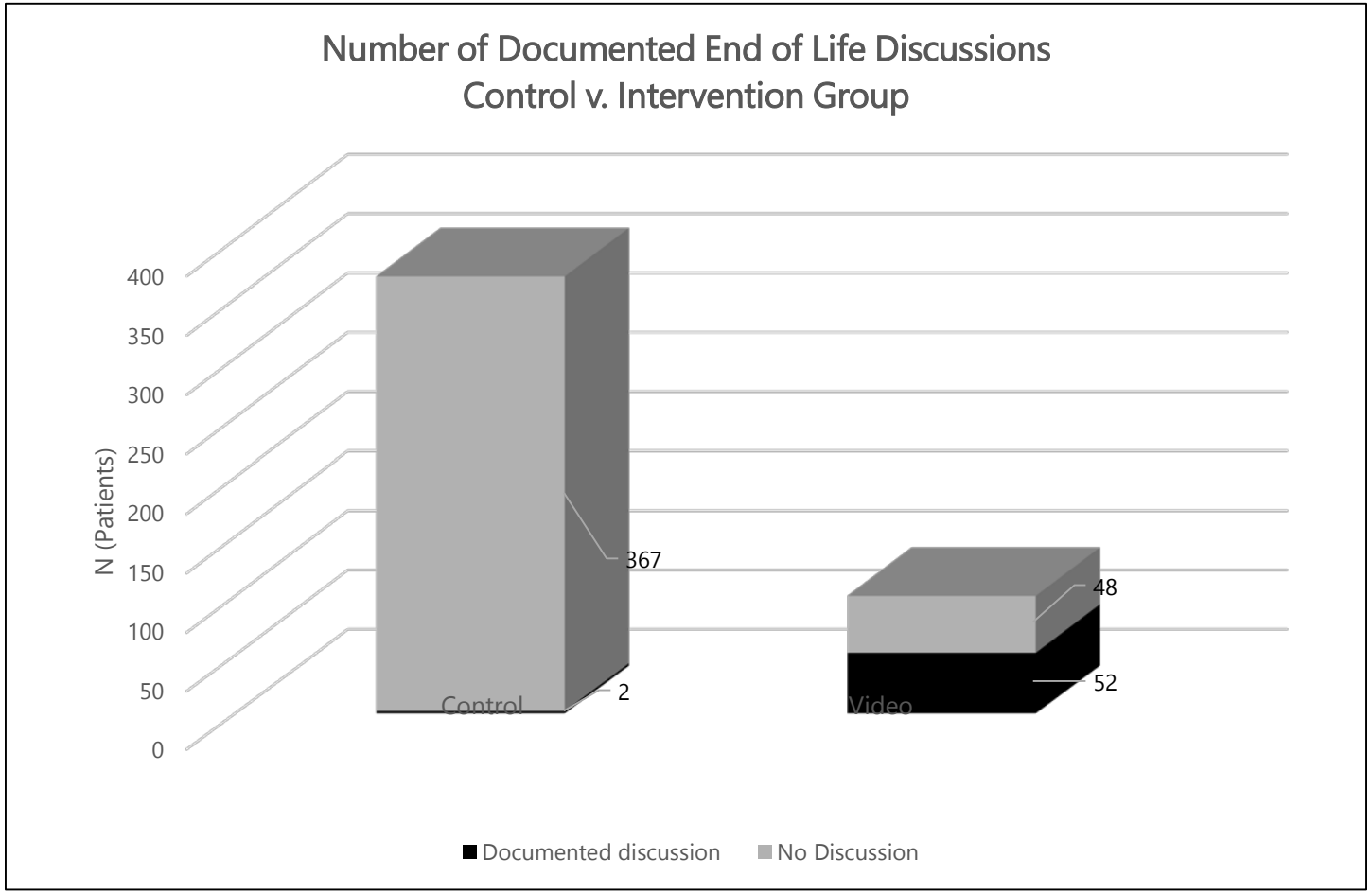
Number of Documented End of Life Discussions
Control v. Intervention Group
N (Patients)
400
350
300
250
200
150
100
50
0
367
2
48
52
Control
Video
Documented discussion
No Discussion

WHY SO EFFECTIVE?

- Elimination of barriers
  - Opt out addressed discomfort of both sides not knowing if the other was open to discussion on the topic.
  - Gave patients the impression that this is a topic that their provider deems as important and is willing to discuss with them (and now!)
  - Addressed patients' likely lack of information on the topic (both sides came to speak the same language) allowing more informed conversations.
  - Quick and easy to implement, cost effective

WHEN? JUST ASK!

- The perfect time, interaction, relationship, or degree of illness may never exist
- No time like the present
- When well, even better
- Make this part of routine care just like other preventive measures

HOW?

- Overcoming barriers:
  - Use a tool: video, handout, questionnaire that can be provided during wait time
    - This informs patient that the time is now, the topic is a priority for the physician, and there is no need to wait for the patient-physician relationship to further develop
  - Do not over-complicate it
  - Be personal but matter of fact
  - Normalize
  - Offer educational resources
  - Remind the patient that Advanced Directives can be edited or changed at any time!

STEPS FOR INCORPORATION[6]

- 1. Introduction
  - Often the most difficult step
  - Use a tool: brochure, video, website, handout
  - Have copies of advance directive drafts available for review

6. Emanuel LL, Danis M, Pearlman RA, Singer PA. Advance care planning as a process: structuring the discussions in practice. *J Am Geriatr Soc*. 1995;43:440–6.

STEPS FOR INCORPORATION[6]

- 2. Facilitation of Discussion
  - Invite the proxy (with patient's permission)
  - Develop a draft of the directive
  - Allow time for reflection and discussion with others

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STEPS FOR INCORPORATION[6]

- 3. Completion of Directive and Documentation
  - Test by applying clinical scenarios with the patient and proxy
  - Put copies of the directive and proxy form in the chart
  - Provide the patient and proxy with copies

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STEPS FOR INCORPORATION[6]

- 4. Review and Update
  - As often as needed, especially with changes in the patient's condition or life circumstances

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STEPS FOR INCORPORATION[6]

- 5. Application
  - Avoid rigid application to unpredicted circumstances
  - Interpret patient's previous statements together with document
  - Align with health care proxy to attempt to make decisions the patient would have made

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SELF REFLECTION

- Did I ask my patient about preferences for end-of-life care?
- Do I know who to contact if the patient cannot communicate their wishes?
- Did I include the family?
- Do I feel confident that I know my patient's wishes for care?
- Did I accurately document the nature of the conversation?

WHAT'S IN IT FOR US?

- Rewarding care
- Billable 99497 (>16 minutes spent in counseling and/or coordination of advance care planning)
  - This code is to bill for the first 30 minutes
  - Currently, there are no limits to the frequency of billing this code allowed

DISCUSSION

LEGAL ISSUES

- Advance directives can include a DNR request, but DNR is simply the order by the physician.
- DNR can be verbally requested directly from patient to physician and documented this way
- Family members cannot revoke a DNR requested by the patient and ordered by the physician, but they may choose to invoke DNR under certain circumstances
- Legal document for review from Oklahoma Medical Board
  - http://www.okmedicalboard.org/download/738/HEALTH+CARE+PROVIDERS+BROCHURE+NOV+2014+FINAL508.pdf
- When in doubt, seek legal counsel or ethics committee

RESOURCES FOR PHYSICIANS AND PATIENTS

- http://www.okdhs.org/OKDHS%20Publication%20Library/87-07W.pdf
- A draft version for Oklahoma advance directive
- Includes living will, proxy, and anatomical gifts
- Must be signed by 2 witnesses that are not relatives or inheritants

- https://www.oumedicine.com/familymedicine/opcrc/advance-directives
- Links to advance directives from OU Medicine in Chinese, English, Spanish, and Vietnamese

OTHER RESOURCES FOR PATIENT EDUCATION

Internet sites

- http://www.choices.org
  - Internet site for Choice in Dying. While Choice in Dying does not oppose physician-assisted dying, its principal work involves educating the public about advance directives. A booklet, " Questions and Answers: Advance Directives and End-of-Life Decisions," is available. Specific state advance directive and health care proxy forms can be downloaded free of charge from the Web site. 475 Riverside Dr., Room 1852 New York, NY 10115 Telephone: 212-870-2040 or 800-989-9455 E-mail: cid@choices.org
- http://www.soros.org:80/death.html
  - Internet site for the Project on Death in America, which seeks to transform the culture of dying by supporting initiatives in research, scholarship, the humanities and the arts, and by fostering innovation in the provision of care, in public and professional education, and in public policy.
- http://www.hcfa.gov:80/Medicare/advdir.htm
  - Internet site for obtaining information on the advance directive and health care proxy from the Health Care Financing Administration.

Journal articles and books

- Doukas DJ, Brody H. Care at the twilight: ethics and end-of-life care. Am Fam Physician 1995;52:1294–6.
- Doukas DJ, McCullough LB. The values history. The evaluation of the patient's values and advance directives. J Fam Pract 1991;32:145–53.
- Doukas DJ, Reichel W, eds. Planning for uncertainty: a guide to living wills and other advance directives for health care. Baltimore: Johns Hopkins University Press, 1993.
- Emanuel LL, Danis M, Pearlman RA, Singer PA. Advance care planning as a process: structuring the discussions in practice. J Am Geriatr Soc 1995;43:440–6.


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