

# Advance Care Planning Interventions in Primary Care

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## INTRODUCTION

- Advancements in medical technology have allowed for an increase in the average life expectancy of human beings. Patients are living longer, but their quality of life during their final days may not be optimal. To prevent individuals from suffering during their final moments, it is imperative that an advance care planning conversations (ACP) occur between patients and their providers.
- Advance care planning is, “An established process for patients to communicate their preferences for medical care during critical illness, should they ever lose their capacity to make medical decisions or articulate their wishes” (Tung et al., 2011, p. 230).
- Patients who have had an ACP discussion with their providers tend to have better congruence between their wishes and their end of life care. Families of patients at the end of life, also report higher satisfaction when their loved one has had an ACP discussion.
- ACP leads to decreased healthcare costs attributable to decreased hospitalizations and intensive care unit admissions, increased “do-not-resuscitate” orders, and decreased rates of cardiopulmonary resuscitation, mechanical ventilation, and the use of tube feeding.
- Since research findings have suggested that only 40% to 70% of medical inpatients are capable of making informed medical decisions at the end of their life, it is vital that primary care practitioners (PCPs) discuss ACP with their patients.
- Unfortunately, many barriers exist preventing ACP discussions in the primary care setting, such as, time issues, communication difficulties, personal anxiety about the topic, lack of provider training in discussing the topic, lack of provider knowledge about advance directives, and concern about patient acceptance of the discussion.
- The Patient Self-Determination Act of 1991 requires that most United States medical organizations provide adults with initial and ongoing information about their rights under state laws governing advance directives.
- The Centers for Medicare and Medicaid Services has established ACP as part of the Medicare Annual Wellness Visit, a patient’s yearly appointment with their primary care provider. Medicare also permits physicians to bill for this interaction. Unfortunately, despite these regulations, AD and ACP completion rates remain at an all-time low ranging from 5% and 39%. Thus, changes are needed for future medical practice.

## METHODS

Eight key reviews were chosen:

1. Preparing Older Patients with Serious Illness for Advance Care Planning Discussions in Primary Care (Abu Al Hamayel et al., 2019).
2. Assessing a Nurse-Led Advance Directive and Advance Care Planning Seminar (Hindered et al., 2014).
3. Nurse-Led Patient-Centered Advance Care Planning in Primary Care: A Pilot Study (Holland et al., 2017).
4. Advance Care Planning Meets Group Medical Visits: The Feasibility of Promoting Conversations (Lum et al., 2016).
5. A nurse practitioner-led community workshop: Increasing adult participation in advance care planning (Splendore et al., 2017).
6. Utilization of Patient Electronic Messaging to Promote Advance Care Planning in the Primary Care Setting (Tieu et al., 2017).
7. POLST Facilitation in Complex Care Management: A Feasibility Study (Torke et al., 2019).
8. Clinical Decision Support Technology to Increase Advance Care Planning in the Primary Care Setting (Tung et al., 2017).

Reviews provided background information on the effectiveness of primary care-based advance care planning interventions and aided in the recommendations for future practice. Findings on practice outcome and recommendations are summarized below.

## RESULTS

### Abu Al Hamayel et al., 2019

- Most patients expressed that they were open to discussing ACP with their PCP and felt comfortable with their PCP initiating the discussion.
- ACP discussions helped many patients put their wishes in writing.
- Some patients' ACP discussions involved revisiting their wishes and resulted in patients either reconceptualizing their wishes or redoing their AD.
- Discussions with family members often served as a trigger for patients to choose a HCP.

### Hindered et al., 2014

- After a nurse-led advance directive seminar, 97.7% of the participants reported that they were likely to complete an AD and to have ACP conversations.

### Holland et al., 2017

- The patients enjoyed nurse care coordinators assisting them in accessing ACP decision aids (either web-based or via booklet) and guiding them through each step in the process. The patients reported that they gained knowledge from the process, and appreciated the nurses’ assistance.

### Lum et al., 2016

- Patients attending ACP group visits evaluated the group visits as better than usual clinic visits for discussing ACP.

- Patients reported an overall increase in ACP conversations with loved ones after participating in the group, including an increase in conversations with enough details that the patient felt confident that their loved ones knew their wishes.

### Splendore et al., 2017

- After attending a nurse practitioner-led ACP community workshop, 93% percent of participants had discussed their AD with someone.

### Tieu et al., 2017

- Among the intervention group (patients receiving electronic messages regarding advance directive completion), 5.5% of patients completed and returned an advance directive during the 12-week study compared to 2% in the usual care group (no electronic message).

### Torke et al., 2019

- ACP-certified complex care clinician (advanced practice nurse or social worker) scheduled visits at the patient’s home within four weeks of their enrollment into the complex care program to facilitate POLST completion.

- 55.6% of the patients completed POLST forms during the intervention.
- 94.44% of the patients believed that discussing the POLST form benefitted them in some way.

### Tung et al., 2017

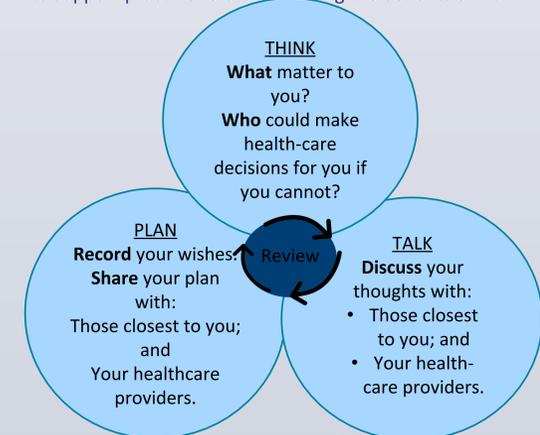
- Patients who received a packet of printed educational resources about ACP two or three weeks before their scheduled health maintenance exam were 5.26 times more likely to complete and submit an AD, compared to those patients who received usual care.
- Surveyed patients were asked which type of learning resources they preferred when learning about ACP, and most respondents said they preferred written materials to electronic ones.

## CONCLUSION

- The important conclusion to realize is that each study was successful in increasing the number of completed ACP documentations amongst their patients and thus allow their patients to have better control over their own end-of-life care. Since all interventions involved different recruitment methods and ACP completion criteria, it is not possible to compare the accomplishments of each study.
- Positive affirmations from the participants regarding the studies was a strong theme. Qualitative evidence showed that patients were appreciative of their providers for taking the time to educate them and that patients understood the importance of planning in advance. Patients also appreciated the opportunity to discuss their wishes with their family members and loved ones.

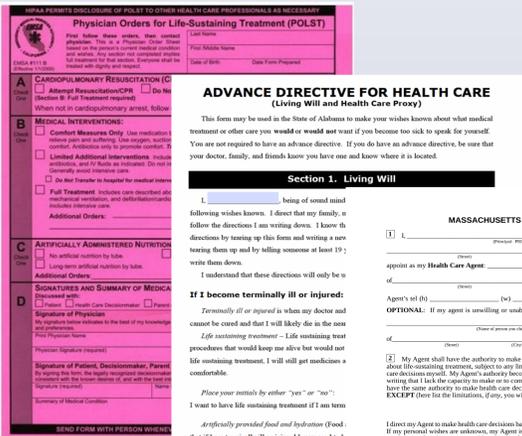
## RECOMMENDATIONS

- In patients with a limited life expectancy, ACP educational packet (including both HCP and AD forms) should be received in the mail one month prior to their yearly appointment with their PCP.
- With receipt of the ACP packets prior to their appointments, the patients will have time to assess their preferences for their end-of-life care and have time to discuss their preferences with their family.
- During the appointments, one-on-one conversations can occur between the patient and their PCP.
- If a patient does not understand ACP, or continues to have questions about the topic, the physician can then refer them to a monthly ACP seminar. The seminars will last for two hours and will be hosted by a PCP and a social worker.
- The seminars will provide participants with information regarding end-of-life decisions, rationale for the importance of ACP conversations, medical terminology, and the use of the *Five Wishes* as an AD. Time would also be allowed for patients to discuss with one another their experiences with ACP. A chaplain will also be on hand to help individuals with any religious or ethical concerns that they may have.
- Follow-up phone calls will be made two weeks after the seminars to answer any further patient questions.
- Advance care planning conversations will continue every year between these patients and their PCP to allow patients the opportunity to continue to ask questions and to make any necessary changes to their ACP forms.
- Patients’ reasons for refusal of ACP conversations should be collected to create a conversation tool or algorithm to support practitioners in explaining the benefits of ACP.



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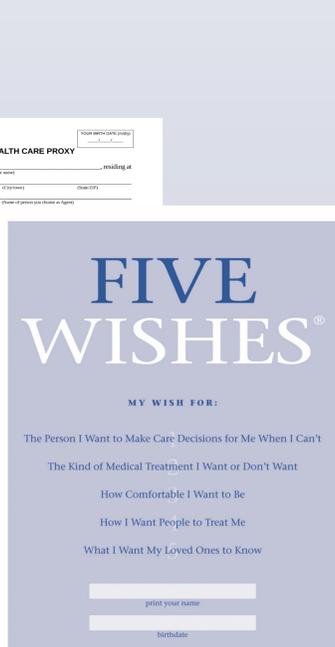


Physician Orders for Life-Sustaining Treatment (POLST)

Section 1. Living Will

Section 2. Artificially Administered Nutrition

Section 3. Signatures and Summary of Medical Decisions



FIVE WISHES

MY WISH FOR:

The Person I Want to Make Care-Decisions for Me When I Can't

The Kind of Medical Treatment I Want or Don't Want

How Comfortable I Want to Be

How I Want People to Treat Me

What I Want My Loved Ones to Know

## OBJECTIVES

To evaluate how effective advance care planning interventions by primary care providers (O) are in supporting the completion of advance directives, health care proxies, *Five Wishes* or MOLST/POLST forms (P) in patients with limited life expectancy (patients 65 years or older or who have an advanced chronic progressive illness, advanced frailty, a terminal condition, or who are unlikely to benefit from cardiopulmonary resuscitation) (C) compared to patients who do not participate in any advance care planning interventions.