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A Care Management Strategy to Improve Advance Care Planning Discussions for High Risk Patients in the Patient-Centered Medical Home

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Background

- RN Integrated Care Managers (ICM) manage the high-risk population in the physician practices. The lack of Advance care planning was identified with this population.
- RN Care Managers in the Patient Centered Medical Home are integral members of the health care team
- Advance care planning (ACP) is a communication process wherein people plan for a time when they cannot make decisions for themselves. (Howard, et al., 2015)
- ACPs include reflection, deliberation, and determination of person's values and wishes or preferences for treatment at the end of life. (Howard, et al., 2015)
- Evidence supports the effectiveness of ACP to improve the end of life experiences of patients and families. (Howard, et al., 2015)
- Despite the known benefits of ACP, often people with life-limiting illnesses facing an acute health crisis have not spoken up about their preferences. (Howard, et al., 2015)

Objectives

- To improve the number of ACP discussions in a targeted group of high risk patients.
- To complete ACP-facilitated discussions with patients and families, resulting in a completed Advance Directive document.

Methodology

This study was a quality improvement study conducted over a 6-year period with pre- and post-intervention data collection.

Sample: High risk patients managed by an ICM. Criteria to be considered high risk include; frequent utilization of emergency and inpatient services and uncontrolled chronic conditions.

Setting: Family and Internal Medicine Clinics in a large integrated medical group.

Data Collection: ICMs tracked the number of ACP discussions monthly for a six year period.

Intervention

- ICMs attended a 2-day formal training for ACP Facilitators.
- Providers referred patients to the ICM for ACP counseling using a referral in the patient's electronic medical record..
- The ICM held ACP discussions with patients and families in the office, home, and hospital.
- Standard ACP documentation was used to document ACP discussions in the patient's EMR and hard copies of the ACP were scanned in the EMR.

Advance Care Planning

Documentation:
Advance Care Planning (ACP) is an important component of quality healthcare.

Explanation of the purpose of Advance Care Planning has been discussed with {ACP EXPLAINED TO:28418}

I contacted the patient using: {CONTACT METHOD:30028730}

The following materials were given: {MATERIALS GIVEN:28328}

Documentation in EMR: Advance Care Plan: {ACP AD STATUS:28329}

Reviewed current ACP: { REVIEWED DOCUMENATION PROVIDED:300121212}
Interviewer: Susan J Watson, COORD

Standardized documentation to indicate patient's advance directive status and if ACP education material were provided to the patient.

Figure 1 Advance Care Planning Smart text

Advance Care Planning

ACP Facilitation Documentation

Who was present during the ACP Facilitation Session: {ACP PRESENCE DURING ACP FACILITATION:28420}
Was the Healthcare Agent present: {HEALTHCARE AGENT PRESENT:30025556}
Name of Healthcare Agent: ***
What was the duration of the ACP Facilitation session (in minutes): {ACP FACILITATION SESSION DURATION:28421}
Was an Advance Care Plan completed during the session: {ADV DIR COMPLETE DURING SESSION:30125556}
Was a Statement of Treatment Preferences completed during the session: {STATEMENT OF TX PREF COMPLETED:30225556}
Was there consensus: {ACP CONCENSUS:30325556}
Have the documents been scanned into Media Manager: {DOCUMENTS SCANNED TO MEDIA:30425556}

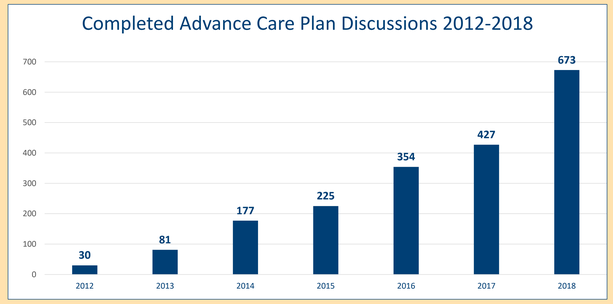
Notes related to the ACP Facilitation Session: ***

Standardized documentation to indicate facilitated ACP discussion. This discussion is detailed and requires more time for completion.

Figure 2 Advance Care Planning Facilitated Discussion Smart text

Results

- Over 6 years, ICMs increased advance care planning discussions for high risk patients.
- On average there was a 49.7% increase.
- From 2017 to 2018 there was a 57.6% increase in completed ACPs.



Conclusion

- The ICM facilitated ACP discussions with patients, families, and providers and improved the completion and documentation of ACP in the medical home.
- Over the 6 year period additional ICM resources were added to the team, positively impacting the number of ACP discussions conducted.
- ICMs are a critical team member in facilitating ACP discussions and documentation to ensure patients receive the right care at the right time through shared decision making and patient engagement.

Contact

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References available upon request.