

Original Research

Outpatient-Focused Advance Care Planning: Telehealth Consultation for Geriatric Primary Care Patients

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ABSTRACT

Introduction

Documentation of advance care planning (ACP) in the electronic health record (EHR) is a quality measure promoted by both the Centers for Medicare and Medicaid Services (CMS) and the Department of Veterans Affairs (VA). There is no best practice model for promotion of ACP in primary care. Clinic prompts reminders from staff, and provision of forms and handouts modestly increase ACP completion. Targeted advance care planning and goals of care discussions for high-risk high-need older patients may help promote ACP in primary care.

Methods

High-risk, high-need geriatric patients were identified by the clinical assessment of need (CAN) risk calculator for a telehealth intervention by an advanced practice nurse trained in palliative care and embedded in the geriatric patient-aligned care team (Geri-PACT) and provided telehealth outreach for ACP and goals of care discussions.

Outcomes

At baseline the Geri-PACT panel had a 54% prevalence of ACP in the EHR. Completion of a life-sustaining treatment note (LST) increased from 39% to 74% following the telehealth intervention producing a total of 89% ACP documents in the EHR. Additionally, 9% of patients received goals of care discussions and a need for additional home and community-based services was identified for 12% of patients contacted. Outreach to three practices in an established physician referral and patient visit network which included 10 providers indicated that primary care providers desired to approach their own patients for ACP. These providers were educated and provided tools and information about CMS and VA ACP quality improvement directives.

Conclusion

A focused telehealth intervention performed by a nurse trained in palliative care and embedded in a geriatric patient-centered medical home was able to significantly increase ACP documentation in the EHR for elderly patients in the practice. Primary care providers place core importance on the value of the patient-clinician relationship and prefer to approach their own patients rather than rely on consultation for ACP. Education for primary care providers and provision of resources to perform ACP and goals of care discussions for their patients may be a worthwhile strategy to improve ACP completion and documentation in the EHR.

Keywords

Advance directives; Primary care; Telehealth.

BACKGROUND

One third of Americans have a completed advanced directive¹ and fewer have this documented in the electronic health

record (EHR). The Centers for Medicare and Medicaid Services (CMS) and the Department of Veterans Affairs (VA) quality improvement objectives encourage completion of advance care planning (ACP) documents and inclusion in the EHR.² CMS encour-

ages documentation of the appointment of agent as well as a living will, while the VA requires a life-sustaining treatment note (LST), a formal documentation of goals of care and ACP. There is no best practice model of how to implement these recommendations. We describe a telehealth outreach to high-risk high-need patients in a VA primary care geriatric practice (Geri-PACT) utilizing a trained nurse practitioner who was an integral part of the clinic.

METHODS

Healthcare System Description

The Tennessee Valley Healthcare System (TVHS) is an integrated health care system of over 100,000 patients in middle Tennessee comprised of 2 medical centers located 40 miles apart, and 12 community-based outpatient clinics.

In 2011, TVHS developed a geriatric patient-centered medical home model for geriatric primary care—the geriatric patient-aligned care team (Geri-PACT). The Geri-PACT Team consists of the Geri-PACT provider (geriatrician or geriatric nurse practitioner with an outpatient panel size of approximately 800), a social worker, a clinical pharmacist, a registered nurse care manager, a licensed vocational nurse, and clerical staff. Geri-PACT is a special population PACT within primary care for complex geriatric and other high-risk vulnerable veterans providing integrated, interdisciplinary assessment and longitudinal management, and coordination of both VA-sponsored and non-VA sponsored (Medicare and Medicaid) services for patients and caregivers.³

The clinical assessment of need (CAN) is a clinical predictor of future hospitalization and death developed for VA populations.⁴ This methodology extracts predictors from 6 categories: social demographics, medical conditions, vital signs, prior year use of health services, medications, and laboratory tests and constructs logistic regression models to predict outcomes. CAN scores are from 1-99, with higher scores corresponding to an increased probability of future healthcare events.

We report our experience utilizing a trained advanced practice nurse who was an integral staff member of Geri-PACT to perform ACP and goals of care discussions for high-risk patients with CAN scores between 95-99.

Our overall study was designed to meet standards for quality improvement reporting excellence (SQUIRE) criteria,⁵ and this report meets the quality improvement minimum quality criteria set (QI-MQCS) domains for reporting quality improvement work.⁶

The TVHS Institutional Review Board (IRB) has determined this study as a quality improvement initiative.

OUTCOMES

The Geri-PACT practice of 793 patients included 139 patients with CAN scores between 95-99, with a mean probability of hospitalization or death of 56% within 12-months. Over a six-month follow-

up period, this high-risk population had a 10% mortality and 33.8% were hospitalized, with 59% receiving skilled and non-skilled home and community-based services. Some 12% of patients received additional home and community-based services as a result of the telehealth intervention including 5% who were referred for hospice care (Table 1). Baseline advance care documentation in the EHR showed 15% had appointment of agent or a living will and 39% had LST notes giving a prevalence of 54% documentation of ACP in the EHR at baseline. The telehealth intervention completed another 35% of LST notes providing a total of 89% of this high-risk population with ACP documentation in the EHR.

Table 1: Geri-PACT High-risk High-need Patients (CAN 95-99)

Population N=139
81 years mean age
16 mean number of medications
56% mean probability of event in 6 months
Diagnoses
10% dementia
32% congestive heart failure
23% cancer diagnosis
12% stroke
Residence
56% urban
44% rural
20% home alone
69% home with caregiver
6% assisted living residence
4% long-term care facility
Home and Community Based Services Utilization
47% None
55% Home health services
20% Homemaker home health
4% Adult day care
Outcome Measures at 6 months
90% Alive
10% Expired
33.8% Hospitalized
Advance Care Planning
15% advance directive in EHR
39% VA Life Sustaining Treatment note (LST) in place
35% LST completed with telehealth call
9% GOC discussion with telehealth call
8% referred to hospice
Additional Interventions during Telehealth Call (12%)
1% specialty clinic referral
2% referred for skilled home care
4% referred for nonskilled services (ADC, respite, H/HHC)
5% Hospice referral

ADC-adult day care; advance directives-appointment of agent, living will; CAN-clinical assessment of need risk score; H/HHA -homemaker, home health aide (non-skilled services); GOC-goals of care; LST-formal VA advance directive and goals of care discussion documentation.

Three affiliated practices comprising a total of 10 providers (6 physicians and 4 advanced practice nurses) in an established physician referral and patient visit network were approached with 30-50 high-risk patients identified for each provider. These practices had strong consultation relationships with Geri-PACT, which provided consultations for geriatric syndromes, falls, dementia, and palliative care services. Primary care providers stressed the value of the patient clinician relationship and expressed strong preferences to provide advance care and goals of care discussions for their own

patients. Individual providers were given education and tools to provide ACP discussions as well as information on CMS and VA quality improvement directives and documentation requirements. Providers indicated a desire to reserve referrals for selected palliative care services for individual patients.

DISCUSSION

Enhanced ACP discussions and completion of documents can be modestly increased by utilizing in-clinic prompts and reminders from staff, and provision of forms and handouts immediately available in the clinic.^{7,8} These processes can be further enhanced by the use of clinically derived risk scales to identify high-risk patients appropriate for ACP and goals of care discussions.^{9,10}

We found an advanced practice nurse trained in ACP discussions and who was an integrated member of the practice delivering a telehealth intervention as a focused outreach strategy greatly increased ACP documentation in the EHR. The intervention also identified a need for additional home and community-based services among 12% of patients contacted.

Barriers

Efforts to provide ACP discussions to affiliated primary care practices met resistance. Even though primary care providers referred patients for other geriatric syndromes as well as palliative care services, they appeared to wish to preserve the patient-provider relationship for advance directive discussions. We proceeded to educate primary care providers to facilitate discussions of ACP and to provide the tools for appropriate CMS and VA quality improvement documentation in the EHR.

CONCLUSION

There are not enough board-certified palliative care clinicians to provide all palliative care needs or ACP discussions. Many have advocated for a generalist model of palliative care with a coordinated palliative care model whereby the primary care physician could manage many palliative care problems, reserving palliative care consultation for more complex or refractory concerns such as symptom management. Education to enhance the skills of all clinicians to improve the ability to address basic palliative care needs and ongoing palliative care management reinforces existing patient-provider relationships and may be a more sustainable model.¹¹

Our experience validates the core importance of the patient clinician relationship and the strong preference of primary care providers to perform these advance directive discussions with their patients. These important discussions enhance the patient physician relationship and come from trusted providers. Education for primary care physicians to facilitate ACP and goals of care discussions is appropriate,¹² reserving consultation for palliative care specialty concerns for selected patients. The use of telehealth may help provide primary palliative care education to PCP's and increase access for specialty palliative care consultation.¹³

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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