Increasing Advance Care Planning Discussions and Life-Sustaining Treatment Documentation for High-Risk Patients in the VA Primary Care Setting

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BACKGROUND

- Advance care planning is essential to providing medical care that is aligned with patients' goals and values. However, these conversations are often initiated late in the course of illness.
- Proactive initiation of these discussions in the primary care setting is important to ensure patients' preferences are known and respected.
- At the VA, the Life Sustaining Treatment (LST) note documents patients' preferences regarding resuscitation and other life-sustaining interventions.
- LST documentation is especially important for high-risk patients—defined as having a Care Assessment Needs (CAN) score of ≥ 95.
- Rate of LST note completion for high-risk patients at the San Diego VA is 27%, compared to the national VA average of 49%.

OBJECTIVE

To increase advance care planning discussions and LST documentation for high-risk patients in the VA primary care setting.

METHODS

- Patients with a CAN score of ≥ 96 and no prior LST documentation were identified across eight VA primary care resident clinic panels.
- Dedicated appointments up to 30 minutes (in-person, video, or phone) were scheduled.
- Educational materials and forms were mailed to each patient for review 1-2 weeks prior to the appointment.
- During the appointment, patients' health care goals and LST preferences were discussed.
- An LST note, advance directive, and POLST form were completed. Resuscitation status orders were updated in the VA medical record system.

RESULTS

- Of the 10 patients identified as high-risk, 8 patients agreed to participate in this intervention.
- 5 patients (63%) had not previously discussed advance care planning with a medical provider.
- 2 patients (25%) had not previously completed an advance directive.
- 4 of 5 patients (80%) with a do-not-resuscitate status did not have a previously completed POLST form.
- During the 4-week intervention period, there was a 100% rate of LST note, advance directive, and POLST form completion.

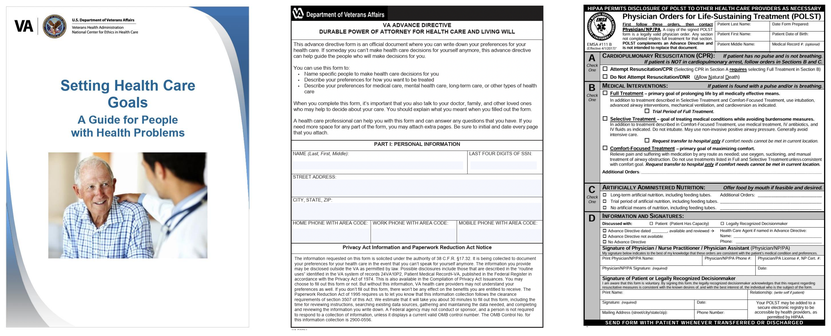

Figure 1. Documents mailed to each patient prior to appointment (from left to right): educational pamphlet with detailed information regarding advance care planning and life-sustaining interventions, advance directive, and POLST form.

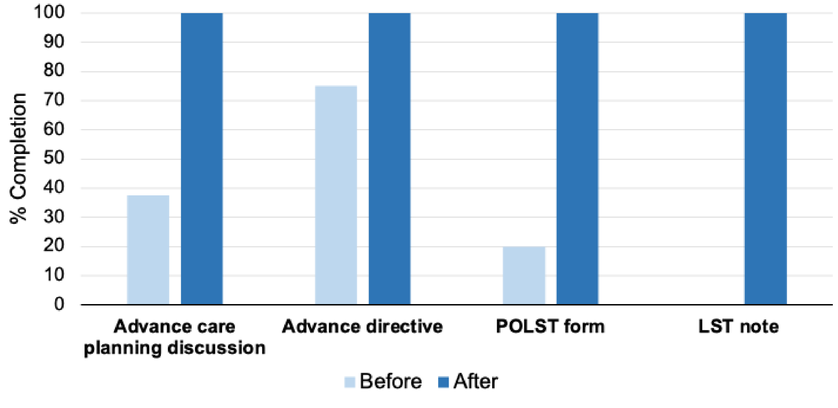

Figure 2. Bar graph series showing percentage of advance care planning discussion, advance directive, POLST form, and LST note completion before and after the intervention.

CONCLUSIONS & DISCUSSION

- We have demonstrated an effective approach to integrating advance care planning and LST documentation for high-risk patients in the primary care setting.
- Distribution of educational materials for patients to review prior to discussion with a medical provider may allow time for more thorough reflection and preparation, which may in turn facilitate the decision-making process.
- The primary care clinic represents an opportune setting for advance care planning and LST discussions given the longitudinal patient-provider relationship.

NEXT STEPS

- Developing a team-based workflow to routinely access the CAN score database, identify patients with high CAN scores, and notify providers.
- Surveying patients about their experience participating in this intervention to help assess the impact and benefit of these discussions and identify areas for improvement.
- Increasing provider education and engagement in this initiative across other VA primary care clinics.

REFERENCES

1. Setting Health Care Goals pamphlet: https://www.ethics.va.gov/ETHICS/for_veterans.asp
2. VA advance directive form: https://www.va.gov/forms/10-0137/
3. California POLST form: https://capolst.org/

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