Background

The Institute of Medicine’s *Dying in America* report calls for improvements in the advance care planning (ACP) process as current patients are often receiving burdensome and undesirable treatments in their end of life care [1]. The 1991 Patient Self-Determination Act mandates healthcare organizations to inform patients of their right to facilitate their own health care decisions through the creation of an advance directive (AD). Earlier this year, the Centers’ for Medicare and Medicaid Services (CMS) approved reimbursement for ACP conversations between qualified healthcare providers and patients. CMS has yet to offer quality metrics. By 2050, the population aged 80 and older is projected at 30.9 million [2], a 300% increase from the 11.3 million in 2010 [3]. This population is expected to be both more ethnically diverse and have more chronic conditions than the previous generation [4]. To promote medical treatment in accordance with individual patient preferences and wishes, improvements in the retrieval and use of end-of-life planning documents are a top priority. With only one-third of Americans having an advance directive [5] and 65-76% of physicians being unaware of ADs existence in the medical chart [6], process improvements and innovations are explored.

Study Objective

The purpose of this study is to establish a baseline of satisfaction and usability, among medical care providers within the University of Missouri Health System, with the current advance care planning process and documentation within the electronic health record.

Study Population

Qualified healthcare professionals (nursing staff, social workers, physicians, residents, and fellows) attached to the palliative care, critical care, intensive care unit, internal medicine, or family medicine services and/or individuals who work with patients making end-of-life care plans were invited to participate.

Methods

An 11-question online structured questionnaire was developed to identify providers’ retrieval of ACP documents, knowledge of ACP resources, barriers to wider use/recall of documents, and ranking of strategic initiatives priorities. Participation in the survey was voluntary and was open to providers from October-November 2015. Following the survey invitation, weekly reminder emails (2) were sent to invited participants. The survey had 364 respondents (15% response rate), with self-reported occupations as nurse (79%), physician (21%), social worker (4%), clinical ethicist (1%), and other (2%) [Figure 1]. This survey was reviewed and approved with an Exempt application by the University of Missouri-Columbia Institutional Research Board under Project #2003242.

Results

While 64% of survey respondents (n=364) had assisted patients with creating an AD, 77% felt somewhat comfortable or less with assisting patients in creating or modifying their AD. Almost half (45%) were unfamiliar with the “Life Choices” ACP resource book utilized within the health system with 29% being somewhat familiar. A majority (83%) of respondents do not see or access ADs in the electronic medical record (EMR) and have experienced retrieval barriers. Those who do see/access ADs in the EMR reported the documents are the appropriate length (39%), too long (19%), too short (16%), or depends on the situation (34%). Only 12% reported the EMR location of ADs is easy to locate and access. Respondents were asked to review a list of 19 barriers to proper review and utilization of ADs and report how frequently they experience the barrier. Reponses were given a value of always (4), sometimes (3), rarely (2), or never (1) with the top-ranking six barriers emerging [Table 1]. Respondents ranked 12 proposed AD improvement areas in terms of high priority, medium priority, low priority, or not a priority with the top-ranking six prioritization areas emerging [Table 2].

Discussion

Results from the provider questionnaire support the need for improvements to the ACP process. The utilization barriers can be addressed with innovative improvements within the EMR and multimodal educational initiatives with the general public and medical provider teams. The identified improvement areas support the societal trend of shifting from paper-based ACP forms towards the use of web-based technology. Future opportunities exist to both improve the current process and transform the manner in which ADs are created, stored, and retrieved by the patient and the medical team. This ongoing study aims to 1) transform the manner in which ADs and healthcare proxy documents are created by patients 2) improve document retrieval by healthcare providers within and outside of the health system and 3) embed a data infrastructure within the EMR to support future mining and analysis of population adoption, preferences, and outcomes.

References