Advance Care Planning in Outpatient Geriatric Primary Care

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Background

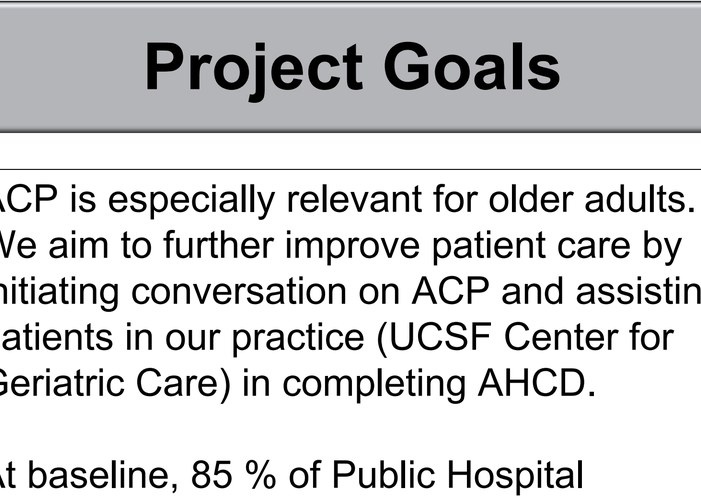
- Advance care planning (ACP) is a process that supports adults at any age or stage of health in understanding and sharing their values, goals, and preferences about future medical care.
- An advance health care directive (AHCD) is an aspect of ACP and a legal document that specifies an individual's power of attorney for health care and his/her values, goals, and preferences for care.
- Benefits of ACP:
  - Ensure care that is consistent with preferences
  - Provide clear instruction for surrogate decision maker and medical providers
  - Ease the burden on the surrogate decision maker
  - Reduce intensive treatment at end of life
  - Increase utilization of hospice
- Only about 1/3 of adults the United States have completed some ACP.

Project Goals

ACP is especially relevant for older adults. We aim to further improve patient care by initiating conversation on ACP and assisting patients in our practice (UCSF Center for Geriatric Care) in completing AHCD.

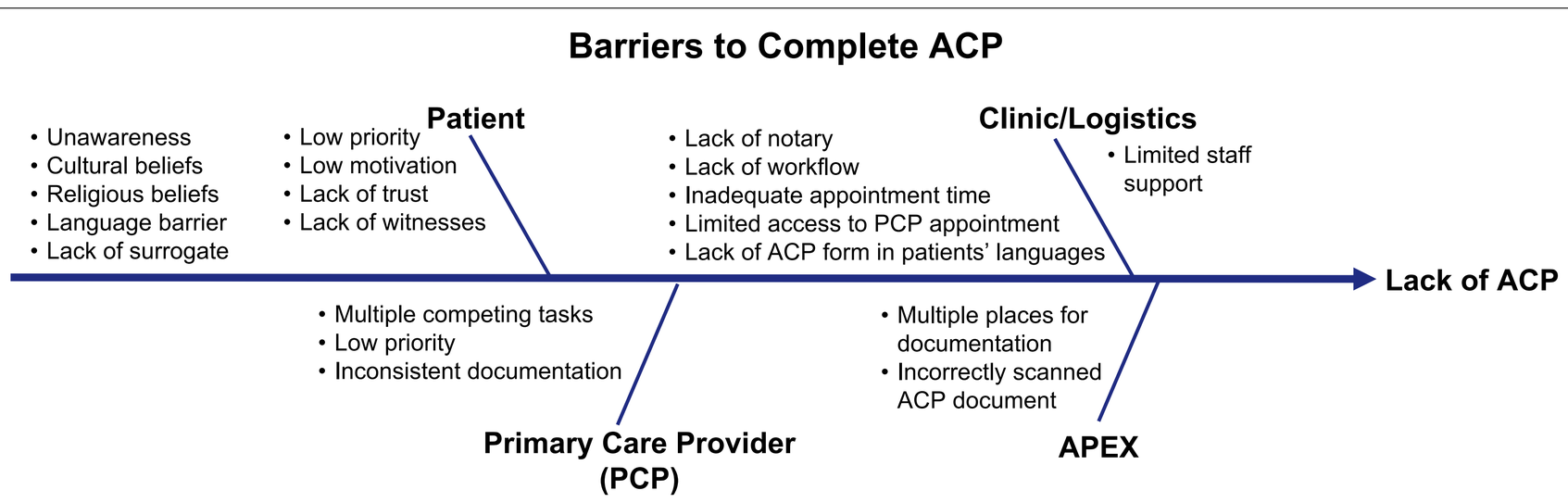
At baseline, 85 % of Public Hospital Redesign and Incentives in Medi-Cal (PRIME) patients in our practice had ACP documentation, specifically AHCD. The goal of this project is to increase the ACP documentation to 91% of our PRIME population by June 30, 2018.

ACP Completion



Project Plan and Intervention(s)

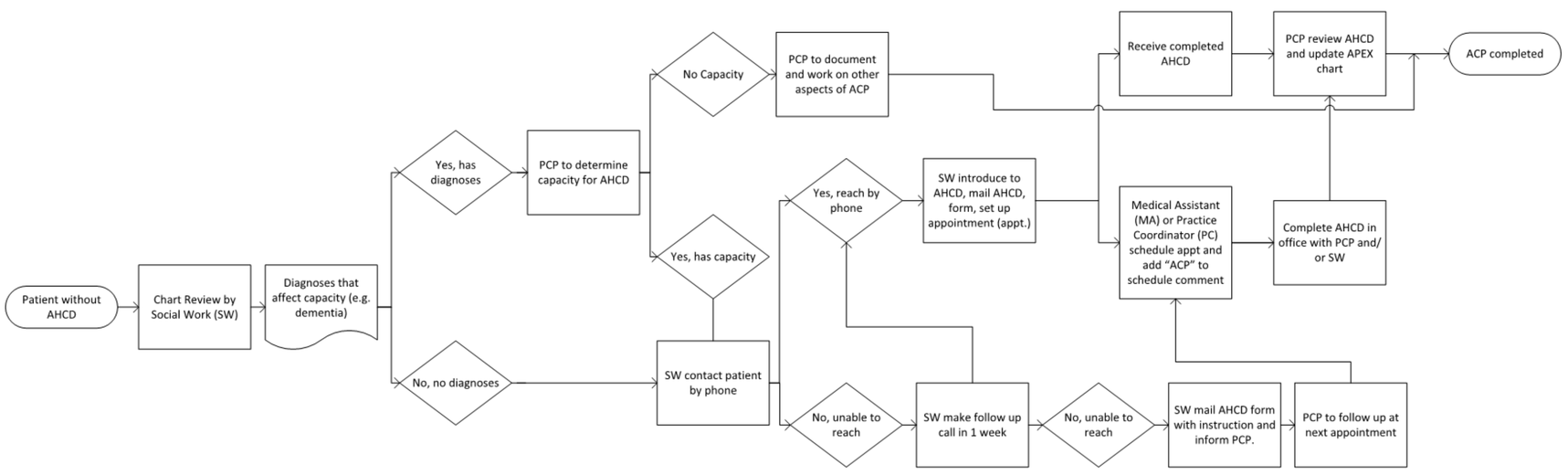
Barriers to Complete ACP



Interventions

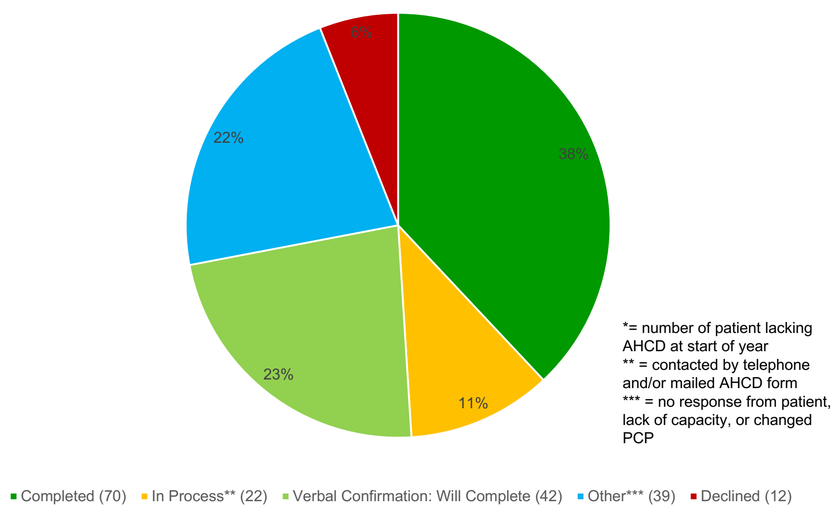
- Standardize workflow
- Hold in-service for providers to improve consistent documentation
- Delegate tasks to complete ACP: PCP, social work, medical assistants, practice coordinators
- Set up separate appointment with social work
- Set up appointment for ACP on days when the notary is on site
- Refer patients needing more assistance to Medical Legal Partnership for Seniors (MLPS) through UC-Hastings College of the Law

ACP: AHCD Flowchart

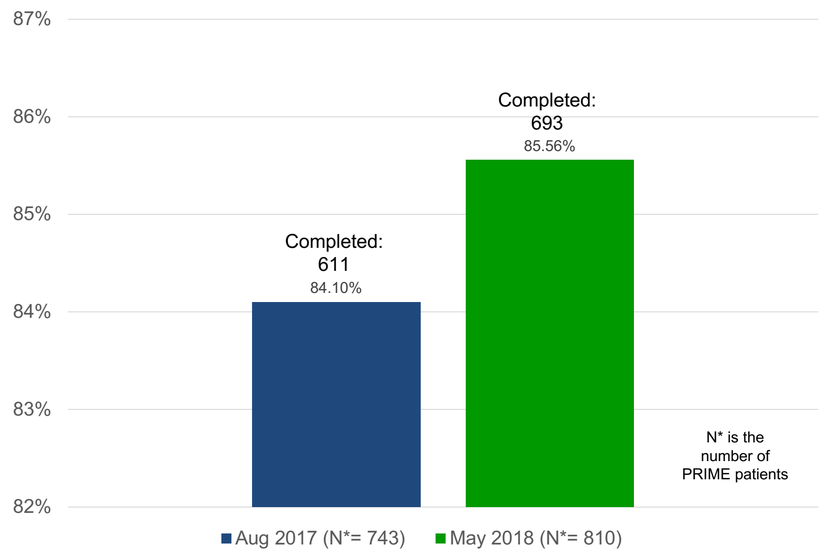


Project Evaluation & Impact

Stages of AHCD Completion (N*= 141)



PRIME AHCD Completion



Next Steps, Dissemination & Lessons Learned

Next Steps:

- Continue collaboration between PCP and SW on ACP inreach and outreach, including involvement of interprofessional learners, such as geriatrics fellows and social work interns

Dissemination:

- Adapt ACP workflow protocol to other primary care clinics in UCSF

Lessons Learned:

- ACP is a process that requires multiple approaches, including telephone and face-to-face.
- ACP outreach needs to build processes to assist patients who have cognitive impairment but still have capacity, and to engage patients who consider ACP as a lower priority in their care.

2018 UCSF Health Improvement Symposium