I-GAP
Improving Advance Care Planning in General Practice

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2015 TVN Advance Care Planning Research Session

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Canadian Association of Research at the End of Life Network

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IMPROVING ADVANCE CARE PLANNING IN GENERAL PRACTICE

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TVN Improving care for the frail elderly™

iGAP IMPROVING ADVANCE CARE PLANNING IN GENERAL PRACTICE

Working Definition of ACP

- ACP is a communication process wherein people plan for a time when they cannot make decisions for themselves. It includes reflection, deliberation and determination of a person's values and preferences for treatments at the end-of-life, communication amongst an individual, his or her loved ones, future substitute decision maker(s), and health care provider(s) about these values and preferences, identification of a substitute decision-maker, and may result in a written expression of preferences (advance care plans), although verbal or other expressions are also useful.[1]
- Should inform in-the-moment treatment decisions
- Not a medical decision or consent for treatment

[1]Sinuff T, Dodek P, You JJ, Barwich D, Tayler C, Downar J, et al. Improving End-of-Life Communication and Decision Making: The Development of Conceptual Framework and Quality Indicators. J Pain Symptom Manage. Jun;49(6):1070-80.

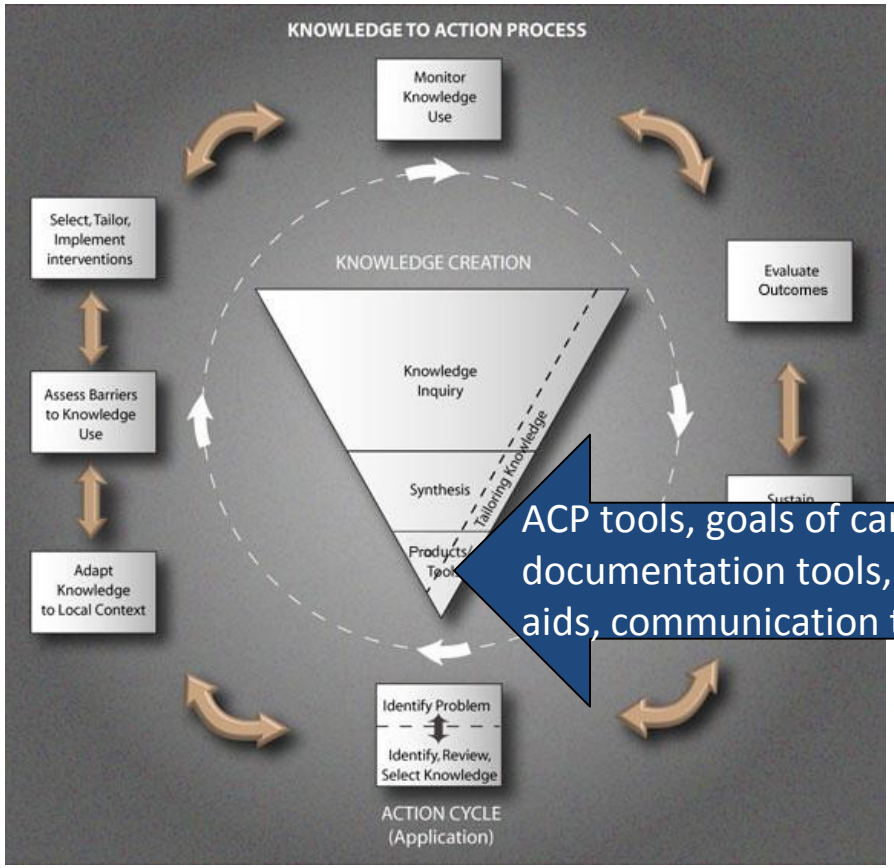
Evidence for ACP

- When patients have engaged in ACP activities, end-of-life experiences are improved for the patient and family members
- Lower rates of depression and other psychological consequences among families
- Lower rates of unwanted escalation of treatments

Why Primary Care?

- Family physician can help in shared decision-making
- Longitudinal relationship (10+ years)
- Effective strategies for ACP:
  - Multi-modal
  - Over multiple visits
  - Time for discussion
  - Incorporated into routines

Knowledge Translation Gap



ACP tools, goals of care documentation tools, decision aids, communication tools

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Research Questions

1) To what extent are patients in primary care currently completing key components of ACP?

2) What are the barriers and facilitators to implementing ACP in primary care?

3) What knowledge products/tools can be developed to narrow the evidence-practice gap and do these tools improve ACP engagement?

4) Does this ACP engagement strategy improve ACP rates at the individual primary care site level?

I-GAP Participating Practices (n=20)

- Alberta
- BC
- Ontario

- Comprehensive family practices
- Multiple provinces
- Multiple models of practice

Audit of ACP and barriers in primary care
Oct 2014 – Mar 2015

- ACCEPT audit of patient ACP from acute care adapted and piloted
  - Engagement in ACP, reasons for not
  - Comfort having discussions
- DECIDE survey for physicians, nurses, allied health adapted for primary care and piloted
  - Barriers related to: self, patient, system
  - Engagement, willingness, who should do it

ACCEPT study Methods

- Multi-center family practice audit
- Inclusion
  - ≥50 years of age
  - English speaking
  - Cognitively intact
- Opportunistic sampling, patients attending for routine office visits
- Target 30-50 patients at each participating family practice
- Self-administered questionnaire to answer study questions
- Audited chart for any documentation

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ACCEPT Results

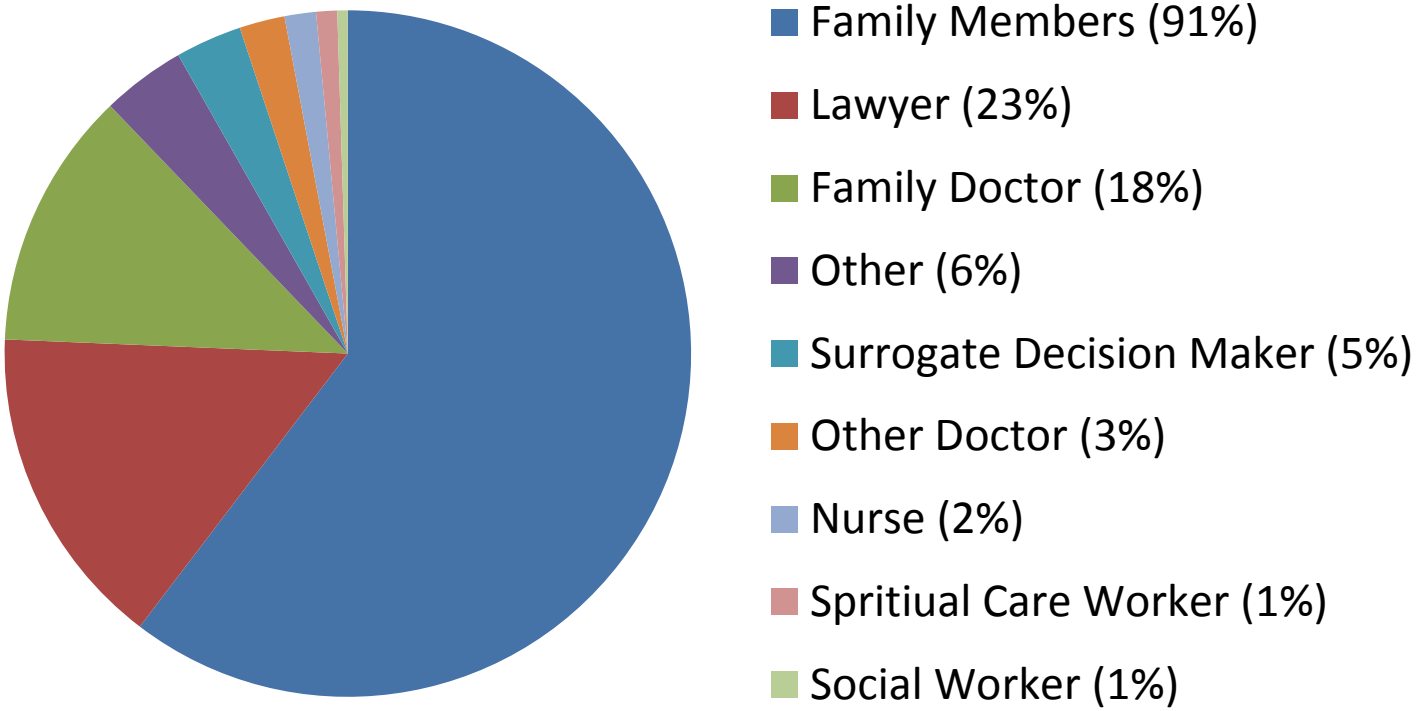
- N=810 (response rate > 70%)
- Average age 66.6, range 50-95
- 69% married or living as married
- 88% Caucasian
- 12% vulnerable for frail
- Comorbidity index mean 1.1

ACCEPT Results- Engagement

- **69%** patients thought about what kinds of medical treatments they would want, or not want, if they were to get very sick and be in a hospital.
- **53%** patients have discussed their wishes with someone.
- **32%** of patients said they have written down their wishes.
- **50%** of patients said they have named someone, in writing, to be their SDM.
- **23% had engaged in all 4 key ACP behaviours**

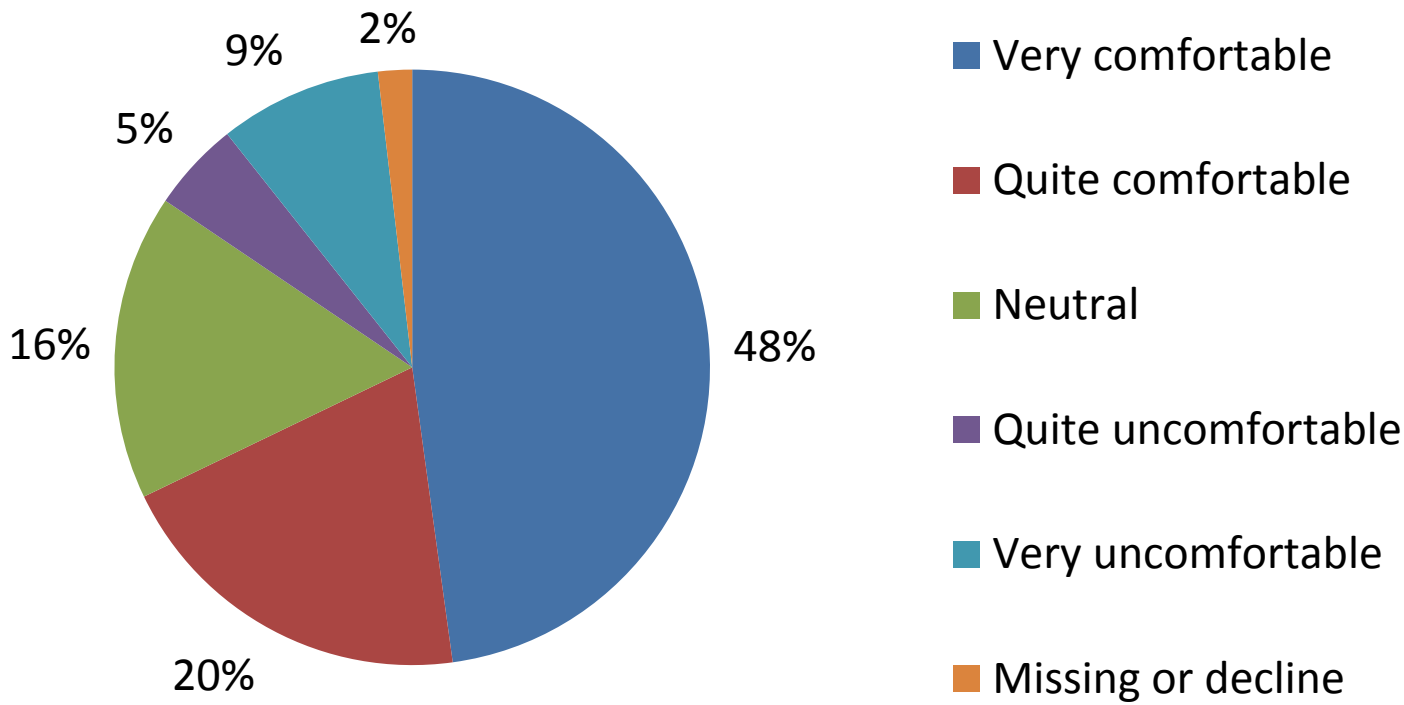
Who have they discussed their wishes with?

53% patients have discussed their wishes with someone



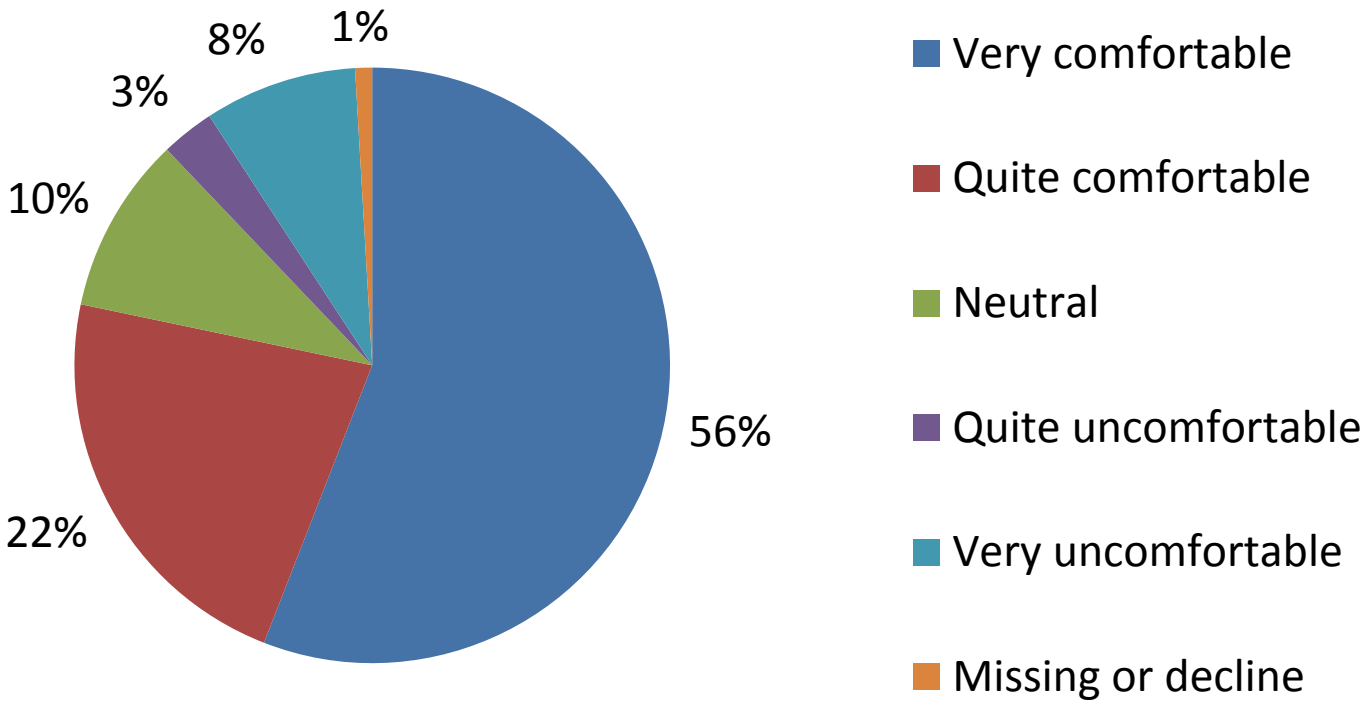
N = 404

How comfortable are you talking to your family members?



N = 760

How comfortable are you talking to your doctor?



N = 760

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ACCEPT Results

- Virtually negligible accurate documentation in chart.
  - 38 charts had documentation of treatment preferences

DECIDE Study Methods

- Multi-centre family practice survey
- Physicians, nurses and other allied health professionals
- Self-administered e-questionnaire to answer study questions (modified Dillman method)

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DECIDE study
Sampling Criteria

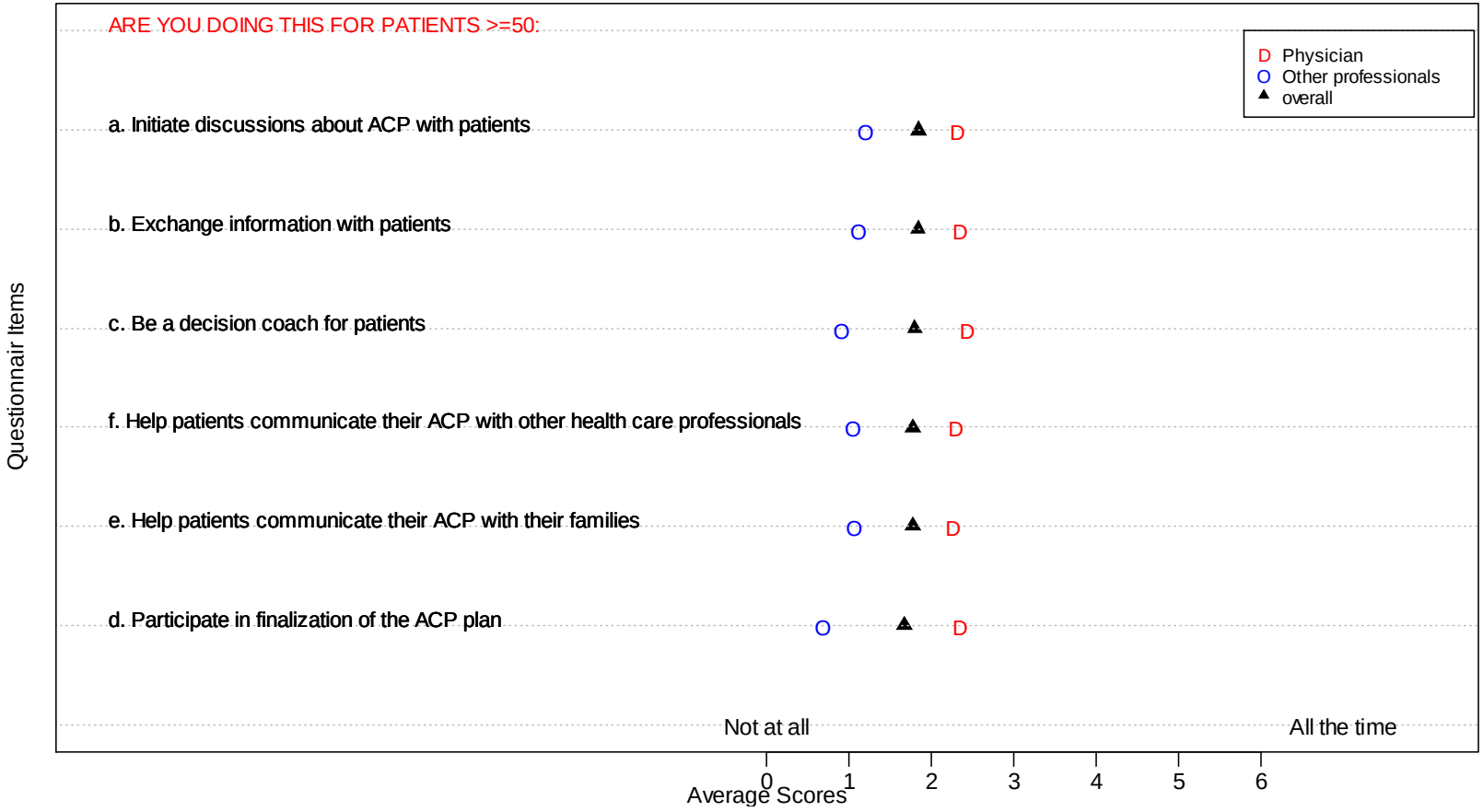
- Sent surveys to all physicians, nurses and allied health professionals at each participating family practice (20 incubator units).
- Reached out to non-participating family physicians, nurses and allied health professionals through various methods.

DECIDE study Participant Characteristics (response rate 76%)

	All (n=186)	Physicians (n=125)	Nurses and other allied health professionals (n=61)
Age	45.6±12.7	47.6±11.9	41.7±13.5
Sex			
Female	107 (64.5%)	54 (49.0%)	53 (96.3%)
Ethnicity			
White	124 (78.0)	85 (68.0)	39 (75.0)
Asian	34 (21.4)	22 (20.6)	12 (23.1)
Other	0.1 (1)	0	1 (1.9)

	All (n=186)	Physicians (n=125)	Nurses and other allied health professionals (n=61)
Years in practice	16.7±13.8	17.9±13.0	14.7±14.8
ACP skill high priority for learning (4/5 on 5 point scale)	53%	54%	52%
Extra palliative care certification or training	19%	19%	20%

Your Participation in Doing ACP with Patients



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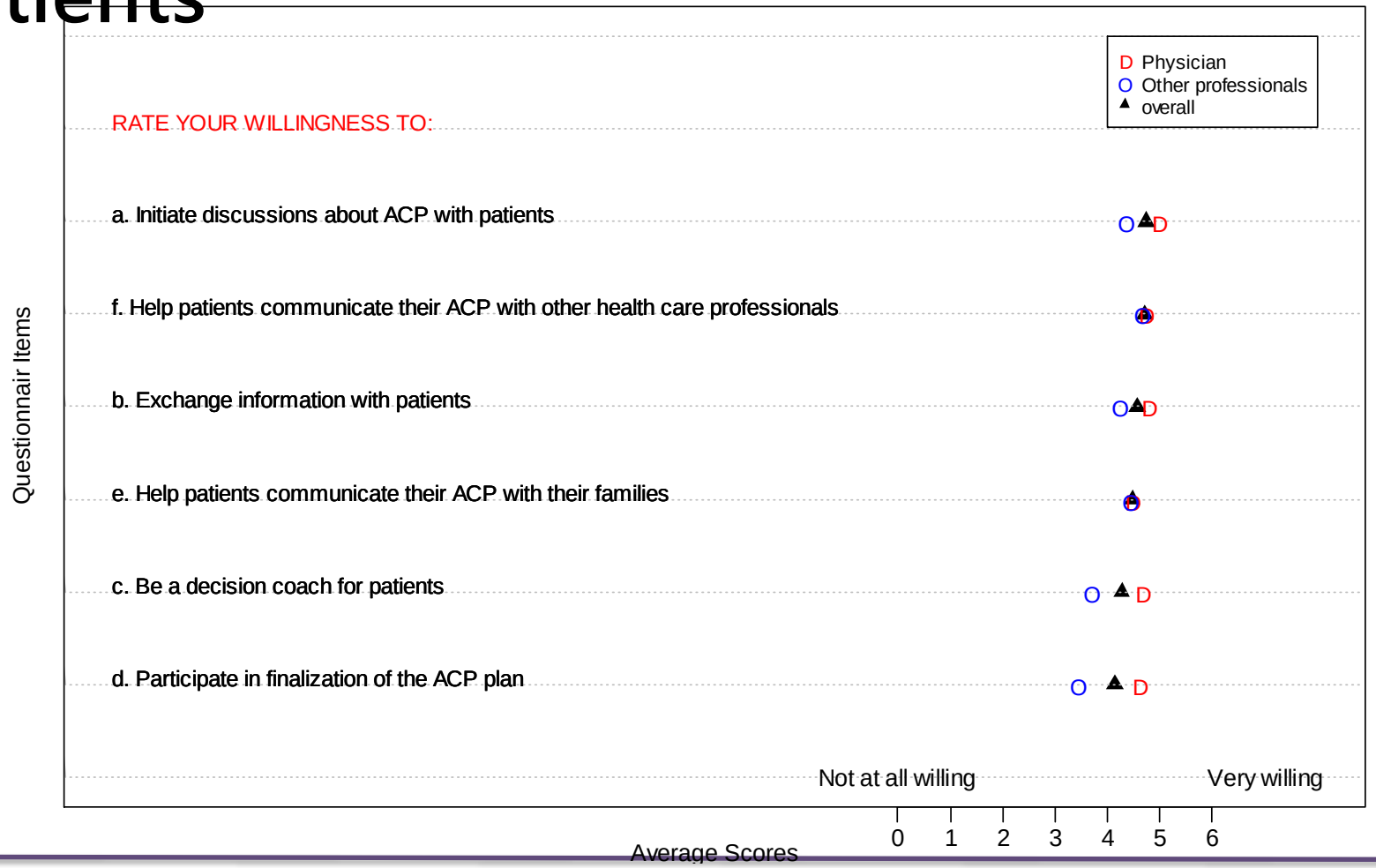
Your Willingness in Doing ACP with Patients



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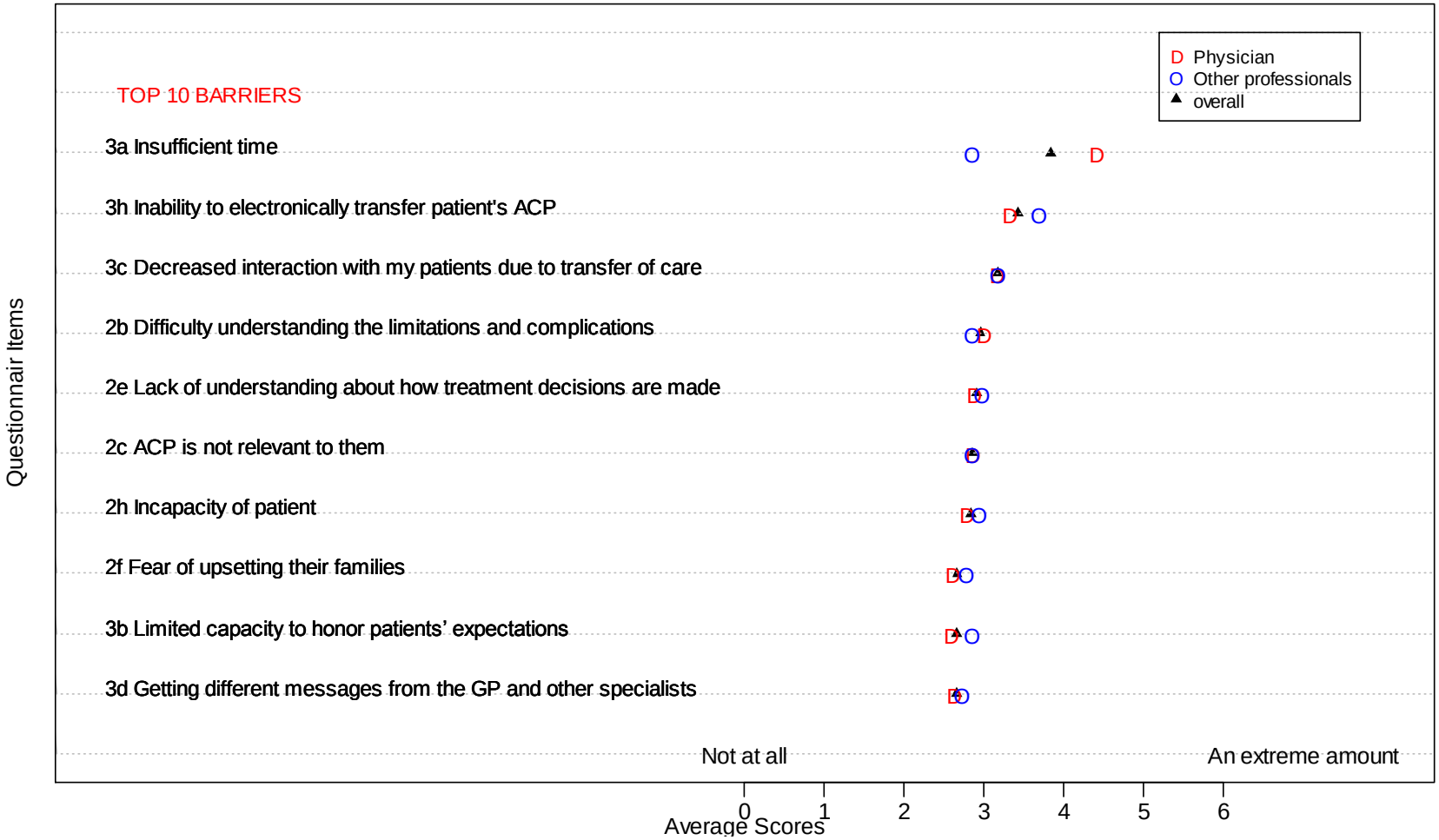
Top Ten Barriers



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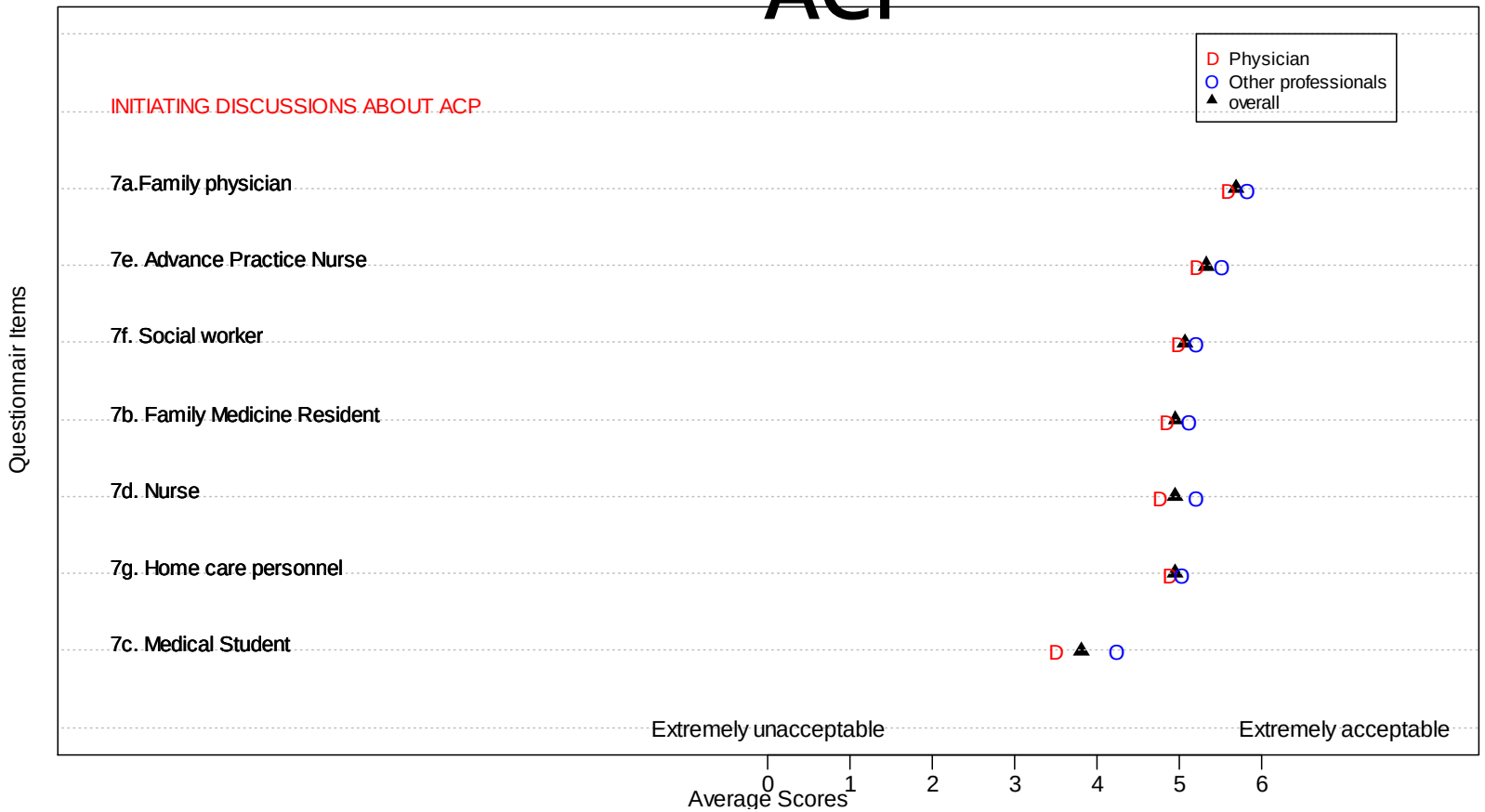
How Acceptable Is It For These Individuals To Initiate Discussions About ACP



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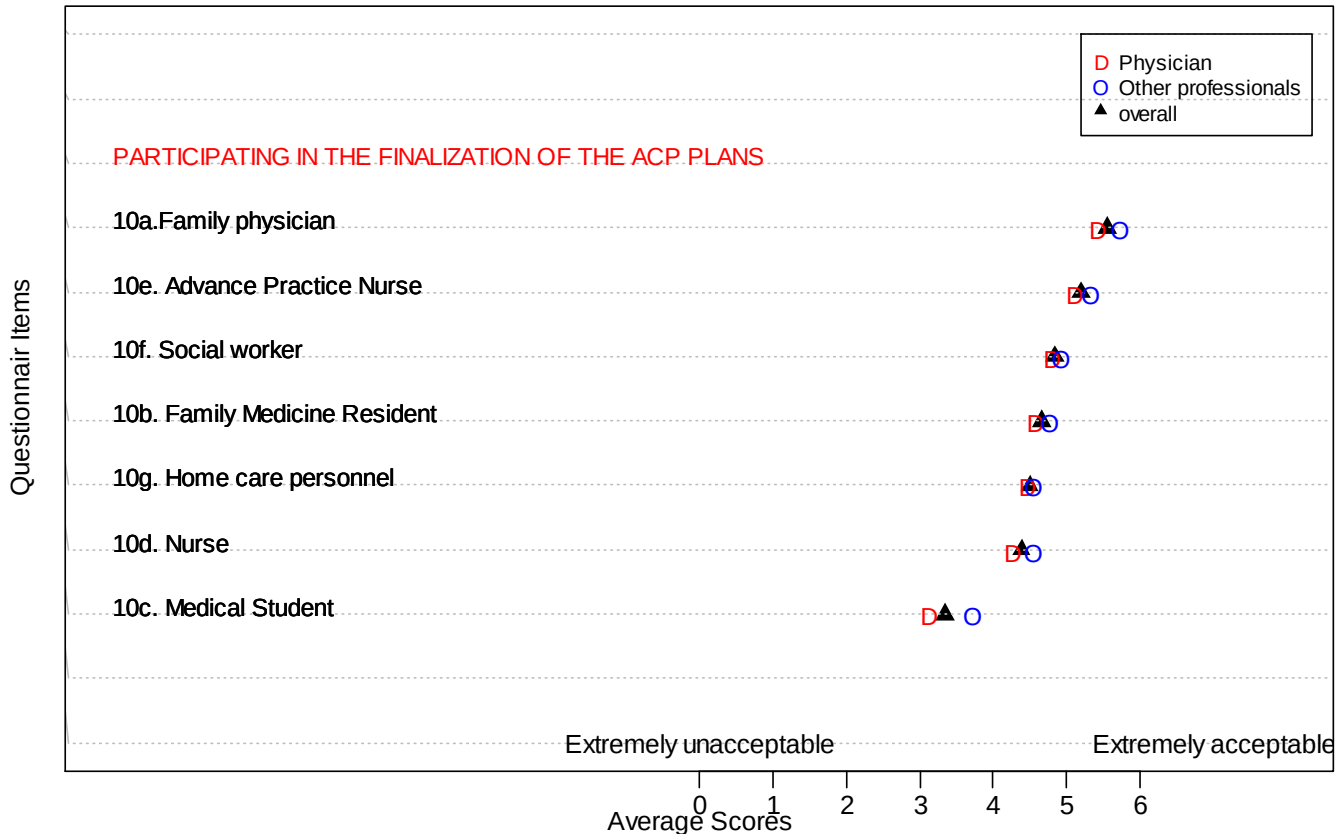
How Acceptable Is It For These Individuals To Participate in The Finalization of The ACP Plans



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DECIDE Results– Physicians

- Physicians are confident (avg 4-5 of 6)
- ½ rate as high priority for learning
- Moderately willing to do it; but not doing it
- Willing to have other providers in primary care initiate it (e.g. nurses)
- Slightly less willing to have non-MD or nurse finalize the ACP

DECIDE Results – Other HCP

- Self rated assessment –Limited skill (non-expert)
- Priority for learning – similar to MDs
- same willing to do it; but not doing it
- Less confident that MD
- Similar barriers but lack of time not so highly ranked; lack of knowledge of ACP higher

Stakeholder Meeting Recommendations

- Screening questions / tailored ACP engagement: Individual and group pathways; Cultural adaptation
- ACP prescribing: Patient engagement with take home ACP tools
- Capacitate MD and non-MD health care providers to do ACP
- ACP tool adaptation/combination to meet decision support needs
- Documentation solutions– electronic format (POLST-like form)
- Patient owns their ACP – Personal health record (PHR)

Speak Up! We'd love to hear from you

- @mhoward101 mhoward@mcmaster.ca
- @eolresearchers (Carenet) www.thecarenet.ca
- @advancecareplan (Speak Up)

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