Adapting Primary Care Workflows to Promote Advance Care Planning

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Ann Fam Med 2022;20:384. https://doi.org/10.1370/afm.2831

THE INNOVATION

The COVID-19 pandemic has sharpened attention regarding the need to proactively plan for a future medical crisis. In the last 30 years, advance care planning (ACP) has emerged as a way to potentially improve individuals' end-of-life care by ensuring that patients explore and communicate personal values, goals, and preferences regarding future medical care to surrogate decision makers and medical professionals.[1] Elevating ACP as a core function of direct patient care, the University of Southern Indiana's (USI) Geriatric Workforce Enhancement Program (GWEP) embedded a multi-modal ACP initiative in a primary care clinic, anchored by the Medicare Annual Wellness Visit (AWV).

WHO & WHERE

The ACP initiative is being implemented at the Deaconess Clinic in Evansville, Indiana by 7 provider teams comprised of 6 primary care physicians, 1 nurse practitioner, 14 clinical office assistants (COA), an Area Agency on Aging (AAA) case manager, and a dedicated ACP facilitator who is a licensed clinical social worker.

HOW

Because the AWV has no out-of-pocket costs to patients and prompts clinicians with standardized assessment questions concerning ACP, AWVs have become a cornerstone of ACP clinical interventions. At the Deaconess Clinic, patients engage in a multimodal experience through sequenced "ACP touchpoints" that precede and continue during the AWV (**Supplemental Figure**). Before the scheduled AWV, patients receive (1) a letter of invitation and electronic notification from their clinician to introduce the importance of ACP and invite engagement in a web-based platform, **PREPARE for Your Care**. (2) The AAA case manager then calls patients to discuss the ACP initiative. This is followed by (3) an electronic or telephone reminder 5 days before the AWV. During (4) the AWV, usually when vital signs are measured, the COA will remind patients about the ACP conversation to be held with their clinician and the ACP facilitator. The clinician's discussion with the patient focuses on ACP as an essential element of one's overall wellness. The final handoff is to (5) the ACP facilitator for a concluding conversation built upon the discussion with the clinician, and an advance directive is completed or updated if appropriate. (6) Follow-up conversations or appointments are scheduled as needed. This multimodal experience engages patients in ACP through different mediums—in writing, on the telephone, through the web, and in person.

LEARNING

This innovation is part of the 4Ms, a national movement aimed at the growing older adult patient population.[2] Age-friendly primary care utilizes ACP as a mechanism for the delivery of person-centered care to the older adult patient. Models incorporating ACP into primary care workflows have focused on the Medicare AWV due to its regularity, length, and connection to existing billing codes (99497, 99498) for ACP. Yet, these solutions rely on an infrequent and underutilized patient encounter and require substantial time investment by clinical teams. To reinforce ACP integration, solutions are needed that engage the patient outside of the AWV to address patient health literacy, the stigma of end-of-life conversations, and barriers to patient decision making and follow-through. The USI GWEP's multimodal and team-based approach has offered an alternative for addressing these needs, although it still has required investment by the partnering health system to realign clinical team practice patterns such that the focus is on the ACP conversation, not solely the advance directive.

References

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Key words: advance care planning; Medicare annual wellness visit; primary care, workflow

Submitted December 20, 2021; submitted, revised, February 15, 2022; accepted March 1, 2022.

Acknowledgments: We are grateful to Mary T. Scheller (University of Southern Indiana) for her contribution to the editing of this work.

Supplemental materials, including figure and funding support.

Conflicts of interest: authors report none.

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