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# What Can a Primary Care Physician Discuss With Older Patients to Improve Advance Directive Completion Rates? A Clin-IQ

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## Abstract

Advance directives (ADs) provide patients with the opportunity to indicate their preferences for medical care while they still maintain the capacity to express their wishes, thus retaining autonomy. ADs increase the likelihood that patients will receive the care they desire, as their family members and physicians will better understand the level of care desired. Despite this, the AD completion rate by elderly patients continues to be low, especially for patients not facing serious illnesses. Primary care physicians (PCPs) are uniquely positioned to engage patients in discussions about ADs before a health crisis arises yet often do not due to time constraints. Using assets associated with the PCP relationship to and longitudinal care for patients, findings reveal that PCPs who emphasize the importance of ADs and who normalize the discussion during office visits by asking questions to understand patients' health goals and holding short conversations over several visits can improve AD completion rates. (*J Patient Cent Res Rev.* 2017;4:42-45.)

## Keywords

advance directive; primary care; advance care planning; elderly patients

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## Clinical Question

What can a busy primary care physician do during a brief office visit to improve advance directive completion rates for patients 65 years of age or older?

## Answer

Evidence supports the importance of primary care physicians initiating brief, interactive conversations with their patients over several visits to increase advance directive completion rates.

**Date Answer was Determined:** July 2016

**Level of Evidence:** B. Published studies have been site-specific and have not been repeated elsewhere to determine reproducibility in the rates of advance directive completion, but common conclusions were reported.

## Search Terms

Advance directive, primary care, advance care planning, elderly patients.

## Inclusion Criteria

Related articles published since 2005 and catalogued in PubMed and Google Scholar at time of literature search were analyzed.

## Exclusion Criteria

Study results involving hospitalized patients, nursing home residents or patients with serious illnesses were excluded.

## Summary of the Problem

Planning for future health care needs yields multiple benefits for elderly patients, their loved ones, physicians, the health care system and society. When the patient is able to identify medical care goals that align with their values and document those wishes for future health care needs in an advance directive (AD), it may provide comfort to the patient, reduce the burden placed on loved ones and give the physician direction for the type of care to provide. Despite these benefits, AD completion rates for adults are low, ranging from 5% to 30%.<sup>1</sup>

The importance of primary care physicians (PCPs) initiating conversations about ADs is recognized by both PCPs and patients. Recent reports reveal that

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75% of PCPs report it is their responsibility to initiate advance care planning for Medicare patients,<sup>2</sup> and 89% of patients and families want their PCPs to have these conversations.<sup>3</sup> In a U.S. Department of Health and Human Services report to Congress, the recommended solutions to barriers in the AD process emphasized improving communication between physicians and patients.<sup>4</sup>

AD discussion barriers exist for PCPs and for patients. Physicians report the lack of time in a busy practice, discomfort with the topic and poor accessibility in the medical chart to record AD completion.<sup>5-7</sup> Patient barriers include: a belief that ADs are irrelevant (too healthy, feel future is in God's hands); emotional or time issues (don't want to think about it, too busy); relationship concerns (don't want to worry family, don't trust family or friends, family already knows patient's wishes, no family to ask); lack of information (about potential/available choices); lack of time with physician to ask about ADs (physician is busy, too many other health issues to discuss); and problems with the AD forms (lack of understanding).<sup>8</sup>

Given these barriers, thoughtfully prepared AD completion requires implementation of evidence-based strategies to document patient wishes.

### **Summary of the Evidence**

Primary care settings offer opportunities to engage patients in discussions about ADs as part of a routine visit.<sup>9</sup> Multiple short AD discussions between PCP and elderly patients can be handled similarly to discussions regarding health screening and prevention. When a PCP initiates an AD discussion as part of a general health maintenance checklist, it normalizes the discussion<sup>10</sup> and, with a patient 65 years or older, supports the establishment and sustainment of a trusting relationship with the patient<sup>11</sup> while increasing patient satisfaction with the PCP.<sup>8</sup> A pilot quality improvement program directed toward internal medicine residents and their elderly patients showed that improvement in AD completion rates was tied to adding ADs to patients' active problem lists and giving PCPs easy access to electronic health record documentation.<sup>1</sup>

Jezewski et al.<sup>12</sup> examined 25 studies, 14 of which were directed to participants who were age 50 or older. The studies were categorized by the approaches, didactic or

interactive, used to improve completion rates of ADs. Didactic approaches provided educational materials to patients that were distributed through the mail, online or in person. Interactive approaches may have included educational materials but involved an interaction with patients in which they could ask questions and receive assistance in completing the forms. Using educational materials alone had variable success, with increased AD completion rates ranging from no change to 34%. When patients were able to ask questions and discuss personal concerns, completion rates ranged from 23% to 71%. When studies involving only older adults were analyzed, the increase in completion rates ranged from 70% to 89%. The data showed that successful completion of ADs took place over time with several visits. The most effective interactive approaches were one-on-one conversations with the PCP or group discussions with a knowledgeable person able to answer questions.<sup>12</sup> In a separate study, physicians spending as little as 3 to 5 minutes with patients who were given written information improved AD completion rates by 44%.<sup>7</sup>

Interventions need to address a variety of barriers when discussing end-of-life decisions with patients. PCPs who understand their patients' health status and the barriers they face can adapt the AD conversations to demonstrate respect for each patient's beliefs.<sup>8</sup> The AD discussion can occur as brief conversations over several visits to offer information and answer questions, thus addressing clinic time limitations. This longitudinal approach provides time for the patient to reflect on his or her goals, to contemplate future health needs and to select and engage a surrogate.

Drawing from the literature, specific strategies have been provided to support the PCP's ability to efficiently initiate and advance the AD conversations (Table 1).<sup>5,9</sup> For example, initiating the conversation with open-ended questions allows the patient to express his readiness for, and understanding of, ADs and to identify possible barriers.

### **Conclusions**

Primary care physicians can improve advance directive completion rates in patients 65 years and older through brief, longitudinal discussions during screening/prevention visits. Findings are limited by variability in how authors defined AD and AD completion verification processes, inclusion of patients

**Table 1.** Evidence-Based Primary Care Physician Actions to Improve Advance Directive (AD) Completion for Patients ≥ 65 Years Old

Description and goals of visit	Statements/questions to engage the patient	Physician actions	Questions/phrases to address patient barriers
<b>ROUTINE HEALTH MAINTENANCE VISIT</b>			
<b><u>Normalize AD planning as part of health; assess readiness and goals of care</u></b>			
<ul style="list-style-type: none"> <li>• Incorporate AD in the visit.</li> <li>• Emphasize AD importance/value.</li> <li>• Determine patient's readiness to address ADs; learn about the patient's goals and fears about future medical care.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>I'd like to chat with you about having an AD as it's a very valuable health document.</i></li> <li>• <i>Are you familiar with what an AD does and its importance? If not, let me explain.</i></li> <li>• <i>Do you have an AD?</i></li> <li>• <i>What do you think about when you picture your future medical care?</i></li> </ul>	<ul style="list-style-type: none"> <li>• Make AD "normal" – incorporate AD discussion as part of prevention.</li> <li>• Explain, review AD benefits.</li> <li>• Provide, review AD forms or refer to trained AD facilitator.</li> <li>• Reinforce AD importance at follow-up visit(s).</li> </ul>	<ul style="list-style-type: none"> <li>• <i>What keeps you from thinking about advance care planning?<sup>9</sup></i></li> <li>• <i>Your AD allows others to better honor your values and wishes (family, health care team members) – takes burden off your family/friends.</i></li> <li>• <i>Having an AD reduces unnecessary or unwanted procedures/hospitalization, especially at the end of life.</i></li> </ul>
<b><u>Identify surrogate decision-makers</u></b>			
<ul style="list-style-type: none"> <li>• Identify a person the patient trusts who can communicate about his or her health care goals and wishes as well as make decisions as health conditions change.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Have you talked with anyone about your future health care goals and wishes?</i></li> <li>• <i>If you were to become very sick, is there someone you would trust to make decisions for you?<sup>5</sup></i></li> <li>• <i>Are there concerns you have about asking someone to make decisions for you if you become unable to do so?</i></li> </ul>	<ul style="list-style-type: none"> <li>• Include the surrogate in a visit and discussion.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Are there decisions about your health that you would not want your loved one to change?<sup>9</sup></i></li> <li>• <i>Your AD gives your decision-maker leeway to work with your health care team and flexibility to change your prior medical decisions if something else is better for you at that time.<sup>9</sup></i></li> </ul>
<b><u>Understand patient values</u></b>			
<ul style="list-style-type: none"> <li>• Understand what is:               <ul style="list-style-type: none"> <li>– important to the patient;</li> <li>– an acceptable quality of life.<sup>9</sup></li> </ul> </li> <li>• Identify trade-offs between quality/quantity of life.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Have you had experiences in making or helping in decisions during a serious illness in your life or a loved one's?<sup>9</sup></i></li> <li>• <i>Has that affected how you feel about planning ahead in case of emergencies?</i></li> </ul>	<ul style="list-style-type: none"> <li>• Use Centers for Medicare &amp; Medicaid Services Current Procedural Terminology (CPT®) codes 99497 and 99498 to capture services for advance care planning.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>What is important to you for your life?</i></li> <li>• <i>Are there situations where "you wouldn't want to live like that?"<sup>9</sup></i></li> </ul>
<b><u>Complete the process</u></b>			
<ul style="list-style-type: none"> <li>• Use language to describe the wishes in a clear, specific manner.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Please bring in your completed ADs so that we may keep a record of your wishes.</i></li> </ul>	<ul style="list-style-type: none"> <li>• Confirm health care team members entered AD in medical record; record AD progress/completion.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Please bring your completed AD to the office.</i></li> <li>• <i>It helps me, the clinic and the hospital know what is important to you.<sup>9</sup></i></li> </ul>
<b>MANAGEMENT OF PROGRESSIVE CHRONIC DISEASE</b>			
<ul style="list-style-type: none"> <li>• Discuss prognosis and patient's goals of care realistically.</li> <li>• Revisit prognosis and goals at subsequent visits to address changes.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>What is your understanding of your change in health?<sup>5</sup></i></li> <li>• <i>What are your goals of care now? Have you talked about these with your loved ones?<sup>5</sup></i></li> </ul>	<ul style="list-style-type: none"> <li>• Discuss how changes in health affects the AD.<sup>5</sup></li> <li>• Offer to include proxy or loved ones in the meeting.<sup>5</sup></li> <li>• Offer possible care scenarios given the patient's medical condition(s).</li> </ul>	<ul style="list-style-type: none"> <li>• <i>How do you feel about your health currently?</i></li> <li>• <i>There can be unexpected circumstances. Are you and your surrogate prepared for possible in-the-moment decision-making?</i></li> </ul>
<b>FOLLOW-UP FOR INCREASING FRAILTY AND DEPENDENCY</b>			
<ul style="list-style-type: none"> <li>• Address specific health conditions and needs.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>If time becomes short, what is most important to you?<sup>5</sup></i></li> <li>• <i>Have you spoken to your loved ones or future decision-maker about any changes in your care goals?<sup>5</sup></i></li> </ul>	<ul style="list-style-type: none"> <li>• Discuss with patient and proxy/loved ones changes in health and care goals.</li> <li>• Use empathic and reflective listening.</li> <li>• Screen for depression.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Are you feeling depressed?</i></li> <li>• <i>How are you feeling about your need for help and reliance on others?</i></li> </ul>

under age 65 in selected studies, the lack of repeated interventions to test the consistency of findings and the lack of diversity in the patient populations studied. However, commonality of findings across multiple articles highlights the importance and potential impact of brief PCP/patient conversations regarding ADs.

### Patient-Friendly Recap

- Completing an advance directive while still of sound mind and body is an important yet often overlooked aspect of personal health care for seniors.
- The authors reviewed the literature for evidence on the role primary care physicians can play in encouraging patients to complete advance directives.
- They found that incorporating brief discussions on advance care planning between primary care physicians and their patients at routine visits may increase the proportion of people who complete advance directives.

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### Conflicts of interest

Edmund Duthie is a question bank writer for the American Board of Internal Medicine Geriatric Medicine Self-Examination Program. He has also edited a text (published by Elsevier B.V., Amsterdam, The Netherlands).

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