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Alberta Innovates Health Solutions

Alberta Health Services

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O'Brien Institute for Public Health

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Covenant Health

The Alberta ACCEPT Study: Evaluating the impact of a system-wide advance care planning policy on communication, care planning and documentation

Exploring a novel surrogate for quality using patient awareness of medical orders related to goals of care

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Disclosure of speaker's interests

(Potential) conflict of interest	None/See below
Potentially relevant company relationships in connection with event[1]	None
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Background

HEALTH CARE REFORM

Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning

Daren K. Heyland, MD, MSc, FRCPC; Doris Barwich, MD, CCFP; Deb Pichora, RN, MSc; Peter Dodek, MD, MHSc; Francois Lamontagne, MD, MSc, FRCPC; John J. You, MD, MSc; Carolyn Tayler, RN, BN, MSA, CON(C); Pat Porterfield, RN, MScN; Tasnim Sinuff, MD, PhD, FRCPC; Jessica Simon, MB, ChB, FRCPC; for the ACCEPT (Advance Care Planning Evaluation in Elderly Patients) Study Team and the Canadian Researchers at the End of Life Network (CARENET)

Heyland DK, Barwich D, Pichora D, Dodek P, Lamontagne F, You JJ, Tayler C, Porterfield P, Sinuff T, Simon J
JAMA Intern Med. 2013;173(9):778-787.

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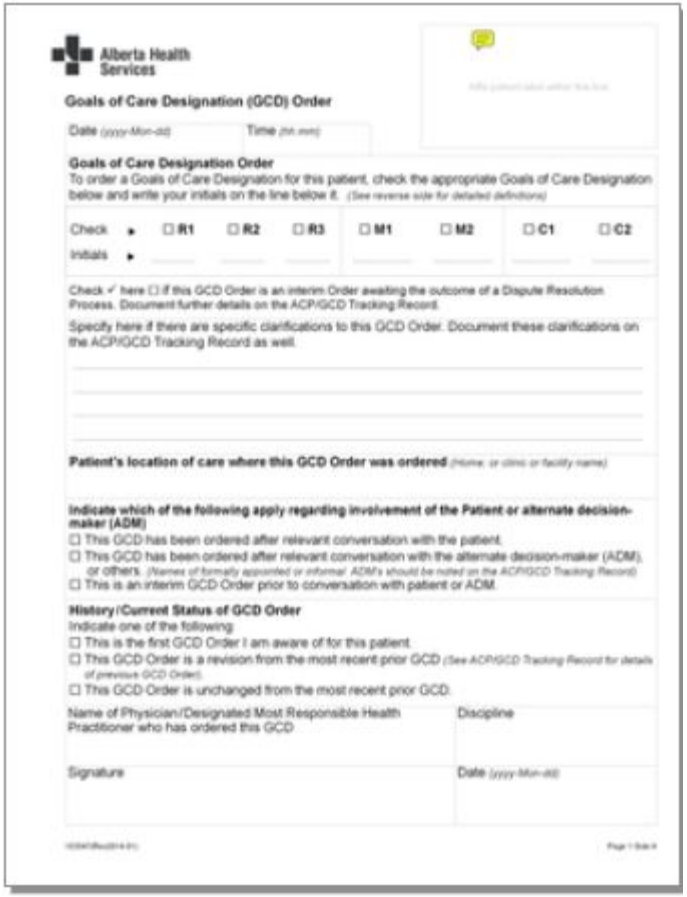
Alberta ACCEPT: Objective

3 years post provincial implementation of ACP policy: **What is the level of patient engagement, their experiences and outcomes?**

Prospective cohort patient survey and chart audit of older and chronically ill hospitalized adults



Alberta Health Services

Goals of Care Designation (GCD) Order

Date (yyyy-Mon-dd) Time (hh:mm)

Goals of Care Designation Order

To order a Goals of Care Designation for this patient, check the appropriate Goals of Care Designation below and write your initials on the line below it. *(See reverse side for detailed definitions)*

Check ▸	☐ R1	☐ R2	☐ R3	☐ M1	☐ M2	☐ C1	☐ C2
Initials ▸							

Check ✓ here ☐ if this GCD Order is an interim Order awaiting the outcome of a Dispute Resolution Process. Document further details on the ACP/GCD Tracking Record.

Specify here if there are specific clarifications to this GCD Order. Document these clarifications on the ACP/GCD Tracking Record as well.

Patient's location of care where this GCD Order was ordered *(Home, or clinic or facility name)*

Indicate which of the following apply regarding involvement of the Patient or alternate decision-maker (ADM)

☐ This GCD has been ordered after relevant conversation with the patient.
☐ This GCD has been ordered after relevant conversation with the alternate decision-maker (ADM), or others. *(Names of formally appointed or informal ADM's should be noted on the ACP/GCD Tracking Record)*
☐ This is an interim GCD Order prior to conversation with patient or ADM.

History/Current Status of GCD Order

Indicate one of the following:
☐ This is the first GCD Order I am aware of for this patient.
☐ This GCD Order is a revision from the most recent prior GCD *(See ACP/GCD Tracking Record for details of previous GCD Order)*
☐ This GCD Order is unchanged from the most recent prior GCD.

Name of Physician/Designated Most Responsible Health Practitioner who has ordered this GCD	Discipline
Signature	Date (yyyy-Mon-dd)

Medical Care

Focuses on medical tests and interventions to cure or manage a person's illness, but does not use resuscitative or life support measures.

Comfort Care

Focuses on providing comfort for people with life-limiting illness when medical treatment is no longer an option.

Resuscitative Care

Focuses on prolonging or preserving life using medical or surgical interventions, including, if needed, resuscitation and intensive care.

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Study Components

Completed 2-5 days after admission on day of consent

1. Patient Experience Survey

- Demographics
- ACP prior to hospitalization
- Goals of Care conversations in hospital
- GCD order awareness
- Current GCD order preference

2. Admission Chart Audit

Review of hospital stay until discharge, death or 3 months

3. Discharge Chart Audit

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Primary question

A Goals of Care Designation order is used by a healthcare provider to describe the general aims of your healthcare, the kind of treatments that might be used and the preferred location of that care. It is a medical order signed by a doctor or nurse practitioner after talking with you. A Goals of Care Designation can be changed at any time.

20. a) Do you have a Goals of Care Designation order?

❑ Yes ❑ No ❑ Unsure (If No/Unsure – skip to 21a)

Other <u>verbal</u> prompts given:

- "RMC Form"
- "GCD"
- Resuscitative Care, Medical Care, Comfort Care

Recruitment

Total: 502 Participants

- 55 years or older with one or more of the following diagnosis:
  - Chronic obstructive pulmonary disease
  - Congestive heart failure
  - Cirrhosis
  - Cancer
  - Renal Failure
- 80 years of age or older admitted from community with acute medical or surgical condition
- 55 to 79 years of age that meet the surprise question

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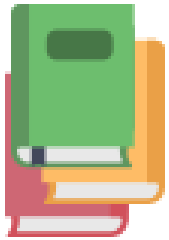
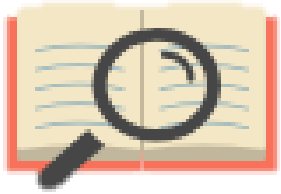
Demographics

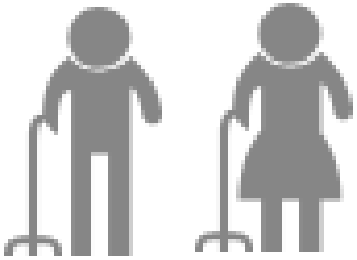


57% High School diploma or less

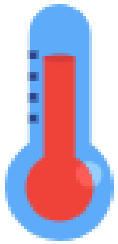


Health Literacy:
Never need help 48%

Marital status:
42% widowed, 41% married

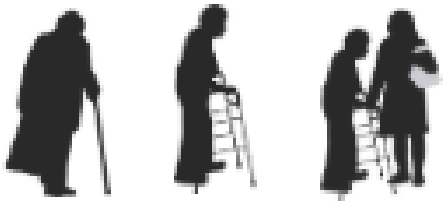


Mean age: 81 years
53% female
80% Caucasian, English speaking



Self health rating:
53/100

74% living at home,
57% have no home care



Frailty:
Vulnerable (25%), Mild (21%), Moderate (20%)

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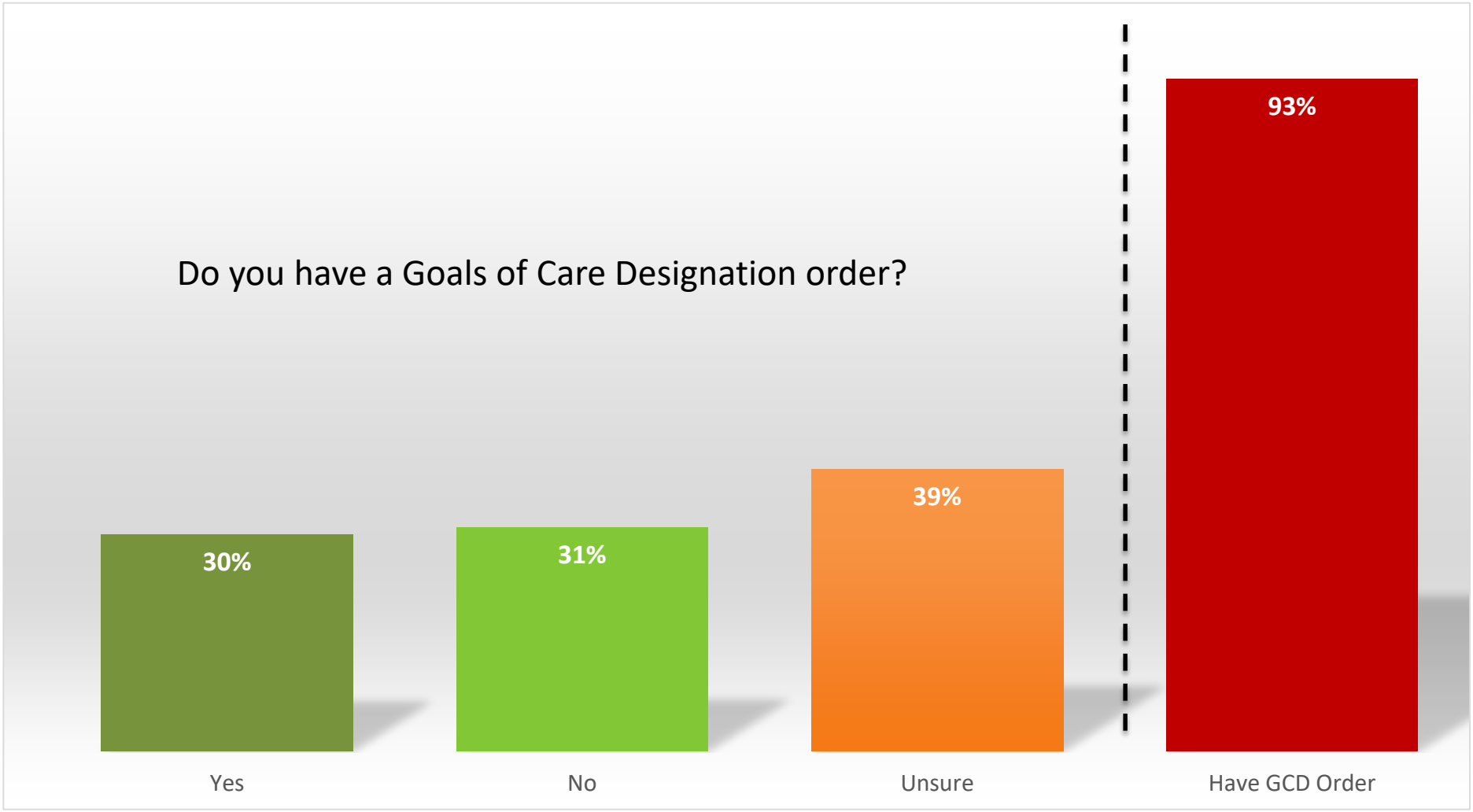
RESULTS: Primary outcome



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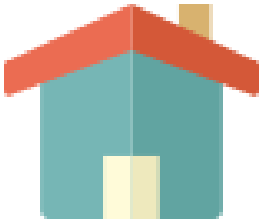
RESULTS: Secondary Outcomes

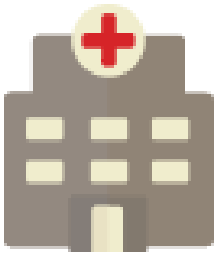
Before Hospitalization



Have you:

1. Heard about ACP (55%)
2. Thought about medical interventions you would want (77%)
3. Made EOL decisions for someone (66%)
4. Talked to family/friends (83%)
5. Talked to a HCP (73%)
6. Written down your wishes (54%)
7. Named an SDM (64%)

During Hospitalization



Has a HCP asked you:

1. What was important to you (16%)
2. Talked to you about your prognosis (19%)
3. About your fears or concerns (23%)
4. Treatment preferences (34%)
5. If you had prior discussions or written documents about ACP (19%)

None of the above (33%)

More ACP conversations happening prior to, than during early hospitalization.

67% of patients rate these conversations to be very important or important to them

82% of patients are very satisfied or satisfied with these conversations when they happen

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RESULTS: Primary Outcome (Multivariate analysis)

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B)	
							Lower	Upper
Center			21.246	**2**	**.000**			
Mild/Moderate Frailty	1.170	.597	3.843	1	**.050**	3.221	1.000	10.372
No discussion of key elements in hospital	.831	.332	6.273	1	**.012**	2.297	1.198	4.402
HCP asked if prior ACP convo/documents in hospital	-.592	.290	4.178	1	**.041**	.553	.314	.976
Patients thought discussion was important	-.739	.272	7.387	1	**.007**	.478	.280	.814
Gender	-.198	.231	.736	1	.391	.820	.521	1.290
Talked to HCP before hospital	-.092	.314	.086	1	.769	.912	.493	1.687
Frailty			6.709	3	.082			
Well/Fit	.668	.671	.991	1	.319	1.950	.524	7.260
Vulnerable/Managing well	.698	.603	1.343	1	.247	2.010	.617	6.549
Heard about ACP before hospital	-.096	.231	.172	1	.679	.909	.578	1.429
Made EOL decisions for someone else	-.119	.233	.259	1	.611	.888	.562	1.403
Thought about treatment preferences before hospital	.604	.348	3.008	1	.083	1.830	.924	3.623
Talked with family/friend before hospital	-.444	.438	1.027	1	.311	.641	.272	1.514
Written down wishes	.336	.316	1.134	1	.287	1.400	.754	2.599
Named an SDM	-.174	.338	.266	1	.606	.840	.433	1.629
Have a Personal Directive	-.396	.366	1.174	1	.279	.673	.329	1.378
HCP discussed fears and concerns	.076	.274	.078	1	.780	1.079	.631	1.847
HCP discussed treatment preferences in hospital	.333	.267	1.552	1	.213	1.395	.826	2.354
Had a Green Sleeve in chart	.097	.289	.113	1	.736	1.102	.626	1.942

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Conclusion

- There are moderate levels of prior ACP engagement in AB
- Patients experience lower levels of communication in hospital, and this seems to be associated with poor awareness of their GCD order.
- We are using this information to inform quality improvement projects related to conversations in hospital

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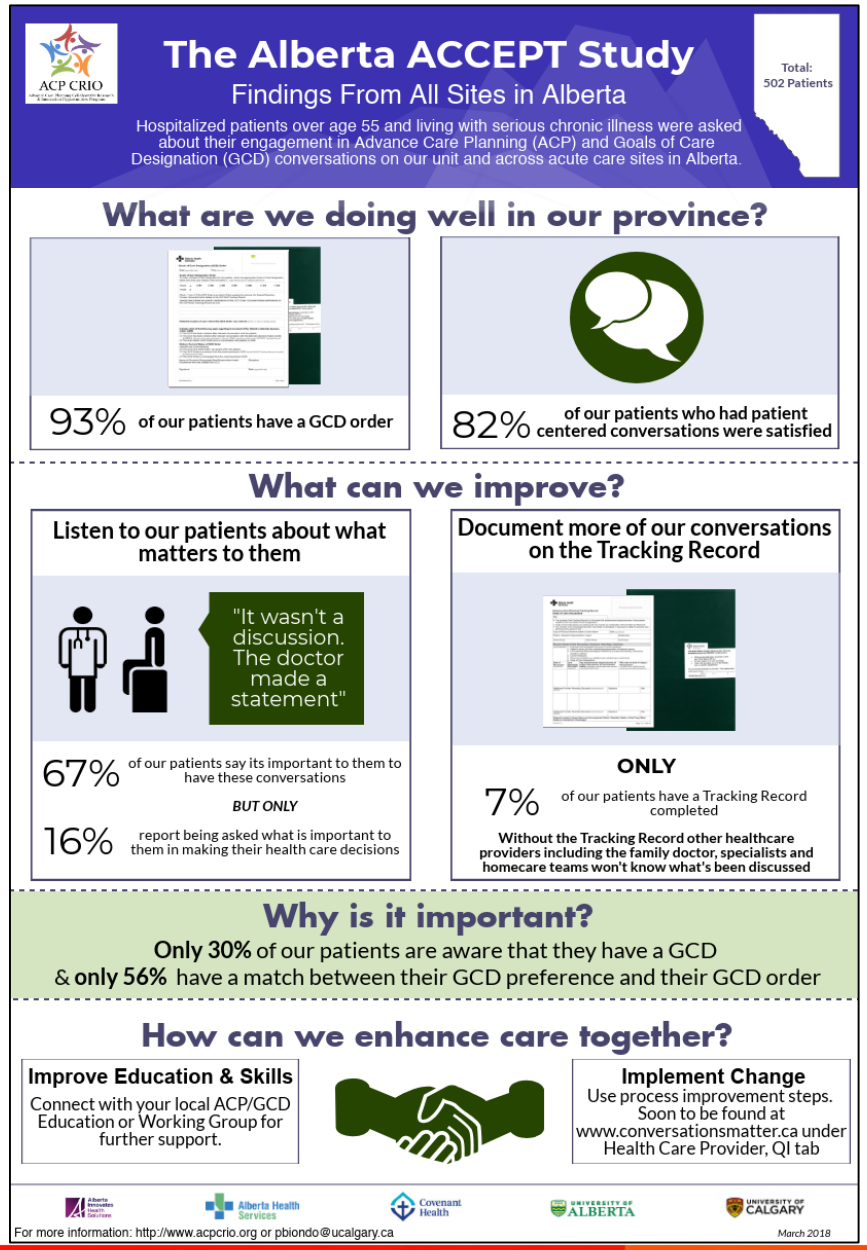
Thank you!



Questions/comments?

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