Advance Care Planning in the Chronic Kidney Disease Population
A Quality Improvement Project

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Objectives

- By the end of the presentation, the participant will be able to:
  - Recognize the need for advance care planning in a specialty and primary care population
  - Understand the value of advance care planning programs that collect medical durable power of attorney and advance directives in specialty and primary care clinics
  - Appreciate the value of quality improvement (QI) projects in the field of advance care planning and palliative care for a potential DNP project
  - The presenter has no disclosures
The Purpose and Aim of this Quality Improvement Project

- **Aim** of this Quality Improvement Project
  - To improve **end-of-life quality of care** for patients with CKD through their participation in ACP, specifically the completion of the advance directive and an MDPOA forms

- **Primary purpose**
  - To determine the **impact** of an Advanced Care Planning (ACP) intervention on pre-dialysis outpatient Chronic Kidney Disease (CKD) patients’ 65 and older participation in ACP on patients without documented Advance Directive (AD) or Medical Durable Power of Attorney (MDPOA) in the electronic medical record (EMR)
  - To determine the **completion** of AD and MDPOA forms (as defined by scanned into the EMR)

- **Secondary purpose**
  - To determine the impact of demographic variables on patient participation in ACP, specifically patient age, gender, race, and stage of CKD for the purpose of tailoring an **evidence-based ACP program**
WHAT IS ADVANCE CARE PLANNING AND WHAT TYPE OF ADVANCE DIRECTIVES ARE ADDRESSED IN CLINICAL CARE?

- **Voluntary ACP** - Voluntary discussion about the care the person would want to receive if they become unable to speak for themselves, including the goals, wishes, and preferences.

- **An Advance Directive** - is a document telling providers to stop or not start life-sustaining treatments if the person is in a terminal condition and can’t make decisions or if the person is in a persistent vegetative state (living will) - POLST, MOLST, Five Wishes.

- **Medical Durable Power of Attorney** - is a document signed naming a surrogate (s) to make healthcare decisions if and when the person is not able to. It can either be effective immediately or when the person is in a vegetative state.

- **Palliative Care** - is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness.

- **Hospice care** - services provided to Medicare Recipients for EOL care by referral primary care with certification that patient has < 6 mos. to live.
Significance of the Problem

Consider the effect of the baby boomers (1940-1964), the prediction is there will be **72.8 million** people by 2030 aged older than **65 years old**. (CDC, 2013)

According to the Institute of Medicine (IOM), many US adults have not **addressed** their personal end-of-life care (IOM, 2014)

Multiple public and private organizations **recommend** advanced care planning (ACP) as essential to quality care and yet nationally, a small percentage of patients report engaging in such discussions (AARP, 2016, IOM, 2014)

The elderly population > 75 on dialysis has **doubled** in the last two decades. Costs for caring for patients with ESRD now represent 7% of total Medicare spending, 1/3 attributable to hospitalizations during the last 6 months of life (USRDS, 2014)

Patients want to talk about end-of-life care and have made decisions about their **personal preferences** regarding life-sustaining treatment (Davison, 2012)

Patients with ESRD **die more often in ICU** and receive fewer palliative care and hospice care referrals than patients with dementia, cancer and other organ failure (Sharp et al, 2016)
IRB Approval Process and Study Timeline

1. Apply IRB Hospital where the patients would be seen
   Determined to be exempt
   Low Risk / No vulnerable population

2. Apply IRB UCCS
   Project facilitator readied herself by shadowing palliative care providers

3. Informed Consent created
   Medical Director sends out letter to Providers
   Project Commences

4. PDSA
   IRB Amendment MDPOA
   PDSA
   Staff Meeting

5. Trial Implementation + 3 months ([www.ihi.org](http://www.ihi.org)) Institute of Health Care Improvement
   60 subjects recruited
   Study completed (as much data as possible in 3 months.)
Results:
Inferential Statistics
Number of MDPOA
Post first visit
Statistically significant

- The amount of MDPOAs completed at the face-to-face visit exceeded expectations with little difference between groups.
- Statistically significant and is a simple, low resource, time-efficient collection that has been associated with a “good death”.
- McNemara = 49.02 \( p = .000 \) (\(< 0.5\) )
Future Directions/Sustainability

**Nursing Implications**

- Nurses are well posed to be in the forefront of leadership in the palliative care movement.
- Nurses unique talents make them ideal candidates to address ACP needs of the patients.
- A reminder system in the EMR could increase confidence and prompt nurses to complete AD/MDPOAs (Boot and Wilson, 2014).
- Advanced Practices Nurses are eligible for ACP CPT payments.
- Nurses have a chance to be involved in creating public policy in palliative care.
- Compatible with DNP essentials.

**Sustainability**

- Potential for ACP program.
- Provides a evidence-based cost-effective, and sustainable delivery system.
- In line with the organizational and national mission to increase completion of AD/MDPOA in EMR.
- In line with the greater primary care, nephrology, and palliative care communities to improve quality of interventions in ACP.

<table>
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<th>Coding for ACP</th>
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https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
ACP Provider Learning Resources

- NIH National Institute on Aging (English and Spanish HO and Hotline)
  https://www.nia.nih.gov/Health/Publication/Advance-Care-Planning

- ***Coalition for the Supportive Care for the Care of Kidney Patients
  http://www.kidneysupportivecare.org/For-Professionals/Advance-Care-Planning.aspx

- ***“Advance Care Planning: An Introduction for Public Health and Aging Services Professionals” (free course offering continuing education credit)
  https://www.cdc.gov/Aging/AdvanceCarePlanning/Care-Planning-Course.htm

- The Conversation Project http://theconversationproject.org/starter-kits/ Nice starter MDPOA kit just developed

- ANNA educational modules on End-of-Life and Palliative Care
  https://www.annanurse.org/resources/cne-opportunities/education-modules

- National Kidney Foundation Patient Handout
  https://www.kidney.org/atoz/content/advancedirectives

- American Bar Association Commission on Law and Aging
  http://www.americanbar.org/groups/law_aging.html
References


