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Achieving Advance Care Planning in Diverse Populations via Teleconferencing with Skilled Nursing Facility Residents

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Achieving Advance Care Planning in Diverse Populations via Teleconferencing

with Skilled Nursing Facility (SNF) Residents

by

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Abstract

Background: Advance care planning (ACP) has always been a priority in healthcare, and even more crucial during the COVID-19 pandemic. It has been extremely challenging for ACP to occur in the skilled nursing facility (SNF) population once social distancing restrictions were put in place to protect residents and staff.

Purpose: The purpose of this evidence-based project was to assess the effectiveness of ACP via teleconferencing with skilled nursing facility (SNF) residents in the hope of increasing completion of high-quality Physician's Orders for Life-Sustaining Treatment (POLST) forms.

Methods: The San Diego Coalition for Compassionate Care developed an ACP community outreach program in which an Advance Care Planner and Nurse Practitioner (NP) student conducted teleconferences with SNF residents in participating facilities to offer advance care planning conversations.

Results: At the end of a 6-month measurement period, quantitative and qualitative data was evaluated. There were a total of 10 advance care planning conversations that were conducted with two of the conversations were held in Spanish. Among the 10 conversations, seven of the 10 residents chose to complete a POLST form resulting in a 70% completion rate. Qualitative feedback responses were recorded and indicated high satisfaction with the process.

Conclusion: This project demonstrated effective discussions can take place via teleconferencing on sensitive topics such as wishes for life-sustaining treatment, even with non-English speaking residents. These findings could have broad implications for future ACP conversations, increasing the quality and volume of POLST forms that are completed for those most at risk of unwanted treatment and training clinicians to conduct ACP conversations early in their career.

Keywords: Advance care planning, advance directives, POLST, end-of-life-discussion

Achieving Advance Care Planning in Diverse Populations via Teleconferencing with

Skilled Nursing Facility (SNF) Residents

In current healthcare settings, there is substantial misalignment between the medical care people want and the medical care people actually receive (Coalition for Compassionate Care of California, 2018). Unfortunately, patients are not often empowered to speak up for the kind of care they want, and clinicians are often not adequately trained to discuss treatment options and preferences with their patients. This is why advance care planning (ACP) is highly important. According to the Institute of Medicine (IOM), there is a need for ACP services in the United States (US) healthcare system because ACP can lead to more appropriate care with better symptom relief at a lower cost (Bond, et al., 2018). According to Rietjens, et al (2016), ACP is a formalized process of communication between patients, loved ones, and professional caregivers. It is defined as a voluntary process of discussion about future care between an individual and their care providers. ACP promotes discussion of preferences and communicates these preferences to family, friends, and healthcare professionals.

In 2016, the Center for Medicare and Medicaid Services (CMS) created a provider billing option for ACP to increase provider engagement (Bond, et al., 2018). However, many clinicians have agreed that advance care planning conversations can be difficult and time consuming for both patients and the providers, which leads to decreased ACP completion. There are also some instances where the Physician Orders for Life-Sustaining Treatment (POLST) form is completed by the provider without having a meaningful conversation about preferences, values, and goals with the patient. Timely and efficient communication is an important prerequisite to address patients'

needs and preferences (Rietjens, et al., 2016). A study conducted by Gabbard, et al, (2021) showed that fewer than 3% of Medicare beneficiaries are billed for ACP on an annual basis. This is problematic given the nature of goals and preferences with changing health status in vulnerable populations.

Unfortunately, there are instances where POLST forms lack providers' signatures, which categorizes the form as invalid. An invalid form can lead to aggressive, unwanted treatment and wasteful spending. In 2009, Medicare spent about $55 million on medical bills during the last two months of patients' lives (Fay, n.d.). This significant expenditure could instead be used to provide high-quality, patient centered care during advanced stages of illness and at the end of life.

Incomplete POLST forms have been a growing issue among SNFs in California since implementation. A research study on POLST completion found 13% of POLST forms lacked provider signatures (Braun, 2016). In another study, about 15% of forms received contained some type of error (Zive et al.,2016). Because POLST forms are a medical order, they must always be signed by a provider in order to be valid. In California, SNF residents must be sent to the hospital with change in clinical condition, with the exception of hospice patients and those with completed POLST forms that directly state, "do not return to the hospital" (Jennings, et al., 2016). Preventing unwanted hospitalizations has been a priority as hospitals beds are scarce due to reduced bed capacity and new issues such as COVID-19 hospitalizations.

The topic of ACP should be addressed among all populations, especially diverse groups such as Spanish speaking residents living in SNFs in San Diego County. In emergency medical situations, the Latino population has been known choose the most

aggressive forms of medical treatment including cardio-pulmonary resuscitation, intensive care unit admission, artificial nutrition, and tube feeding (Shrank, et al., 2005). Language diversity is a major contributing factor to this problem. In Spanish speaking populations, residents may not fully comprehend what is being asked, making it difficult to successfully complete an ACP conversation or a POLST (Nedjat-Haiem, et al., 2017). This barrier deprives these residents from having their goals, wishes, and preferences honored in emergency situations.

POLST forms for SNF residents often do not reflect their wishes for life-sustaining treatment. This problem exists for several reasons. First, healthcare providers struggle to adequately complete the forms (e.g., forms filled incorrectly are considered invalid). Secondly, language diversity in minority populations has often prevented effective communication about medical decision making. Research has shown that the Hispanic population is less likely to have an AD or POLST (Shrank, et al., 2005). This is largely due to lack of information or understanding this topic and general distrust of healthcare providers. Finally, the Latino patient population greatly depends on the support of their loved ones for making these informed decisions, making it vitally important to have familial involvement in these discussions. Family participation in ACP discussions may be complicated by provider and family availability for conferencing.

According to the Coalition for Compassionate Care of California (2018), advance care planning is one of the top high-quality, low-cost interventions for healthcare. By investing time in advance care planning, clinicians can improve patient and family satisfaction, efficiently allocate resources, clarify re-hospitalization wishes, reduce

provider stress, and properly use POLST forms (Coalition for Compassionate Care of California, 2018).

Statement of Purpose

The purpose of this project was to assess the effectiveness of advance care planning via teleconferencing with skilled nursing facility (SNF) residents. The overarching objective was to leverage these discussions for increased high-quality POLST completion. The current COVID-19 pandemic has made it difficult to support ACP and POLST completion among skilled nursing facility residents. Healthcare workers have experienced an increased workload and often face difficulties initiating ACP and POLST conversations. By utilizing the teleconferencing approach, this project attempted to re-establish visual face-to-face communication and provide residents and families the opportunity to discuss and learn about ACP and POLST forms.

Methods

PICOT Question

In skilled nursing facilities, does advance care planning via teleconferencing, compared to standard practice, result in an increased completion of *high-quality* advance directives and POLSTs over a 6-month period?

Evidence Based Intervention

This proposed intervention was designed using SNFs in San Diego county and in collaboration with the San Diego Coalition of Compassionate Care (SDCCC). The advance care planner and the nurse practitioner student conducted remove conversations with SNF residents via teleconferencing. The Iowa Model was utilized to serve as a guide for this evidence-based project (Titler, 2001).

Benchmark

POLST forms are not a mandated regulatory measure in the state of California for SNF residents; therefore, no benchmark exists. The state of California determined that, "completing a POLST is the resident's choice and cannot be a condition of admission," but it does advise residents living in skilled nursing facilities to document their wishes for life sustaining treatment by using a *Preferred Intensity of Treatment* or *Preferred Intensity of Car*e form (Jennings, et al., 2016). Studies have shown an upward trend of POLST completion in SNF residents as part of an admission package. Over the last two decades, up to 46% of POLST forms were completed upon admission to the SNF (Zive et,al.,2016). While not mandated, individual SNFs may measure POLST completion as part of routine quality improvement.

Protection of Human Subjects

Confidentiality was maintained by using a coded data collection tool and de-identified data. For data analysis, each participant was given a code rather than using actual identifiers such as birthdate, medical record number or name.

Project Implementation and Process Plan

Prior to Institutional Review Board (IRB) approval, the nurse practitioner student became an active member of the SDCCC and participated in ACP training and competency validation to complete POLST forms. After IRB approval was obtained from the University of San Diego, the student's data collection began on August 22, 2020.

Process

The nurse practitioner student collaborated with members of the SDCCC, specifically the Advance Care Planner, to create a workflow for the SNFs and those

having conversations with residents. A flow diagram detailed responsibilities and facilitated transparent communication. The student provided a nurse practitioner's perspective on ACP and expanded the pool of potential participants by providing conversations in Spanish. This was a significant benefit for the Latino population who was able to interact with someone from a similar cultural group and shared language. The student brought awareness to the necessity of improving ACP in the Latino population, a minority group with historically low ACP completion.

Participants

The participants were residents of SNFs in San Diego county area who agreed to participate in a teleconference ACP discussion. These participants were recruited by an established process between the SDCCC and the SNFs.

Prior to Discussion

Because of a contractual relationship, the Advance Care Planner received a referral from the facility for the residents who agreed to participate in the ACP discussion. An introductory phone call took place prior to the teleconference where the ACP liaison and nurse practitioner student introduced themselves over the phone and provided a brief explanation on what the meeting would entail. At this time, baseline demographic data was collected including gender, age, and race. If a resident already had an existing (but invalid) POLST, this data was also evaluated and collected. The meetings were scheduled at a convenient time for the participant, family, and ACP staff. The SNF communications team set up a Zoom video conferencing platform invitation and sent it out to all participating in the discussion.

Day of Discussion

The SNF staff arranged for a computer tablet to be placed at the bedside of the resident at the appointment time. They also provided technical support and had the necessary forms (such as the POLST) readily available.

Delivering the Intervention

The ACP liaison and nurse practitioner student conducted the teleconference regarding ACP and POLST completion. If the resident and family were Spanish speaking, the nurse practitioner student provided interpretation during the teleconference. The discussion included the following questions:

- What is the resident's understanding of advance care planning? Have they heard about it before? What is the family's understanding of advance care planning?

- Does their Advance Directive /POLST state their wishes for life-sustaining treatment? Does it reflect their *current* wishes?

At the end of the discussion, three open-ended questions were asked by the nurse practitioner student to collect qualitative feedback about the teleconference process. This was done after the advance care planner had left the teleconference call to encourage information sharing. The responses to all questions were gathered and used for quality improvement to aid in further discussions.

The qualitative questions were:

1. What did the resident and family members appreciate about the process?

2. What feedback does the resident have about the process?

3. Is there something that could have been different to facilitate a smoother

    process?

After the Discussion

The designated SNF staff obtained the necessary signatures on the POLST form

from the resident. They then notified the provider of the completed discussion and of the

resident's signature. The form was then uploaded to the electronic healthcare record for

the provider to sign, at which point the SNF medical records team uploaded the POLST

registry within the San Diego Health Connect website, a health information exchange

(HIE).

Results

At the end of the 6-month measurement period, quantitative and qualitative data

were evaluated. There were a total of 10 advance care planning conversations conducted

and two of the 10 conversations were held in Spanish. The majority of the participants

were Caucasian and two residents were Latino as illustrated in Figure 1. The average

gender and age of participants were male in their 80's as illustrated in Table 1.
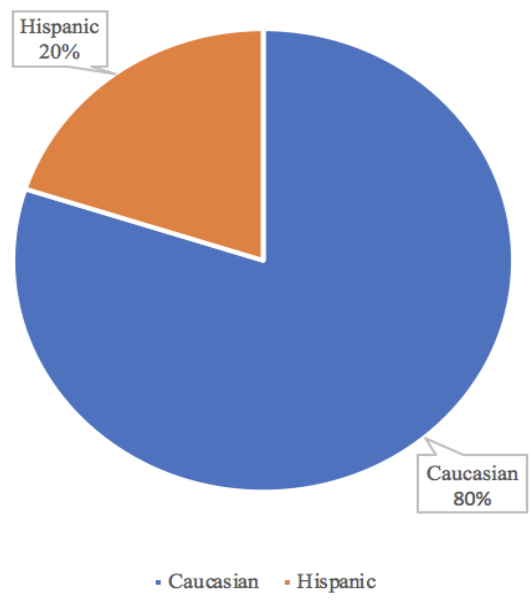
Figure 1

Race of Participants

Table 1
Age and Gender of Residents

Resident	Age	Gender
SDCCC #1	78	Male
SDCCC #2	96	Female
SDCCC #3	82	Male
SDCCC #4	83	Female
SDCCC #5	72	Male
SDCCC #6	87	Male
SDCCC #7	70	Male
SDCCC #8	95	Male
SDCCC #9	85	Female
SDCCC #10	89	Female

Five of the 10 residents chose to complete a new POLST form and there were only two residents who already had a preexisting POLST form but was inconsistent with their preferences. Their forms were updated to reflect their wishes. Three of the 10 residents did not complete a POLST form but were appreciative of the information. This

information is illustrated in Figure 2. All seven residents who completed a POLST

expressed a preference for Do Not Resuscitate (DNR). The unique part of this project

was the qualitative feedback data received from asking the three open-ended questions.

Table 2 provides a summary of the responses.

Figure 2

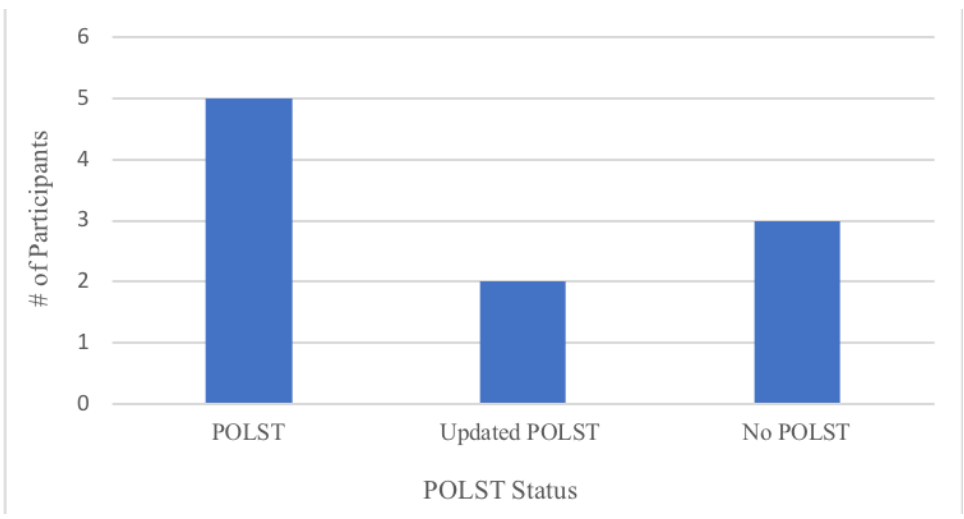*POLST Completion Among SNF Residents*

Table 2

Summary of Qualitative Feedback Responses

Qualitative Questions	Participants Responses
1. What did the resident and family members appreciate about the process?	"This provided me the opportunity to plan my end of life. I didn't even know this help existed" "I appreciate you guys taking the time to talk to me about this topic" "I appreciate what you guys are doing. This is extremely helpful. My mom will not suffer"
2. What feedback does the resident have about the process?	"This is a great idea" "I wish this was done sooner" "This was easier than I thought it was going to be. I'm not good with technology"
3. Is there something that could have been different to facilitate a smoother process?	"Nothing at all. You guys did a great job" "I wouldn't change a single thing" "Nothing different at all"

There was an interruption of referrals during the months of November 2020 through January 2021 as the number of Coronavirus cases peaked drastically, causing a decrease in referrals. The potential referrals were, unfortunately, sent back to the hospital for suspected COVID-19 infections, thus unable to complete the ACP conversation.

Discussion

Advance Care Planning (ACP) via teleconferencing is a promising new approach to have high-quality, timely conversations with SNF residents on preferences for medical treatments. In this project, teleconferencing was shown to be an acceptable and convenient method for SNF residents, families, and advance care planners to have quality discussions about preferences for care in the event of serious illness and hospitalization. The teleconferencing strategy for ACP/POLST discussions arose out of necessity from

the pandemic restrictions. Contrary to concerns from clinicians, teleconferencing for discussions of sensitive topics like resuscitation was well received and the residents' perceptions of the process were very positive. Collaboration between the SNF, residents and families, and a community non-profit resulted in an efficient workflow that produced high satisfaction among all involved.

As part of the broader community outreach plan, the SDCCC provides healthcare workers the opportunity to participate in free monthly POLST training seminars. These training sessions are completed virtually making it widely accessible to the entire county. By participating in these sessions, healthcare workers may feel more comfortable leading these ACP conversations on their own and increase the POLST completion rate among SNF residents. This no-cost, remote live training eliminates one barrier of conducting ACP conversations.

Also important is the ability to address disparities in care through outreach and replication, especially in rural areas where minority populations can be the main participants. This project also has potential for sustained progress due to the strong community-based relationships developed during execution. Additionally, the broader acceptance of teleconferencing for ACP conversations may result in this method as a practical, normal communication strategy. Despite concerns regarding discussion of sensitive topics such as life-sustaining treatment choice, residents and families were grateful to engage in these conversations, further increasing chances of sustainability.

Conclusion

Encouraging patients and providers to participate in ACP has always been a priority in healthcare, but it is even more crucial to do so during the current COVID-19

pandemic. Many providers have found it challenging to hold these conversations in person due to considerable accessibility issues. The pandemic has also made it extremely challenging for ACP to occur in the SNF population as clinicians and administrators struggled to control the spread of the virus. This evidence-based project demonstrated that effective discussions can take place via teleconferencing on sensitive topics such as ACP. This has broad implications for future ACP conversations, perhaps, increasing the quality and volume of advance directive and POLST forms that are completed for those most at risk of unwanted treatment. Through a community outreach initiative and interdisciplinary efforts, the SDCCC has created a successful telehealth program to improve POLST completion among residents and simultaneously help relieve stress of healthcare workers working in SNFs.

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