Targeting Advanced Care Planning in Primary Care with Care Assessment Need Scores

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Background

- Early goals of care (GOC) discussions are associated with improved goal-consistent care, reduced futile treatments, and better quality-of-life.
- Most adults facing end-of-life treatment lack decision-making capacity and do not have advanced care planning (ACP).
- Primary care providers (PCPs) can help bridge this gap with longer therapeutic relationships and ability to initiate GOC conversations early, but identifying appropriate patients remains a challenge.

Methods

- **Design**: Quality improvement intervention between September 2021 to March 2022.
- **Setting**: Primary Care, Rocky Mountain Regional Medical Center.
- **Methods**: A resident primary care patient panel was sorted by Care Assessment Need (CAN) scores, a proprietary Veterans Health Administration calculation that includes patient medical co-morbidities, and recent healthcare encounters to predict the probability of a hospital admission or death within 1-year (Figure 2).
- **Outcomes:** Clinic appointments were made for these patients and GOC/ACP were discussed and documented in Life-Sustaining Treatment (LST) notes.

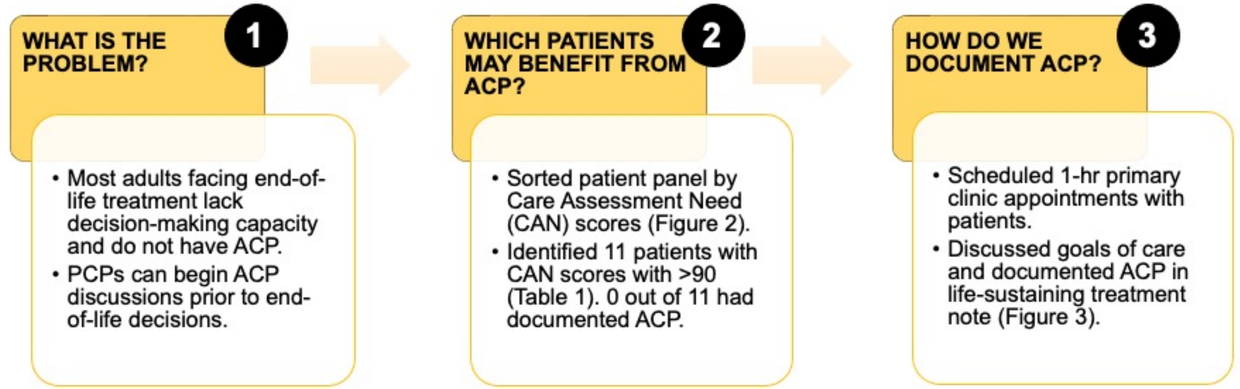

Figure 1. Overview of quality improvement intervention to target advanced care planning (ACP) in resident patient panel utilizing Care Assessment Need (CAN) scores.

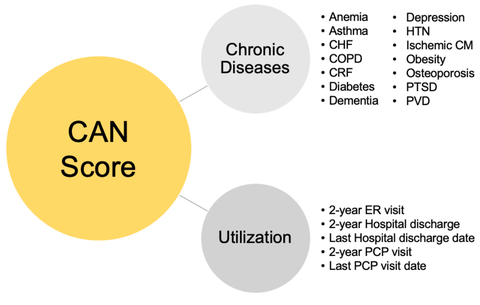

Figure 2. Components of a CAN score.

CAN SCORE	AGE	PROBABILITY OF EVENT	CHRONIC DISEASES	2 YR ER VISIT	2 YR HOSPITAL DISCHARGE	2 YR PCP VISIT
98	75	64%	4	1	2	7
98	64	64%	5	4	2	4
98	80	60%	7	2	1	13
97	60	53%	6	8	0	11
96	68	46%	6	5	0	10
90	50	28%	4	7	1	4
90	78	35%	0	3	0	6
90	69	27%	4	1	0	3
90	70	31%	7	4	2	3
90	66	31%	2	0	0	2
90	93	29%	2	1	0	6
AVG:	70.3	43%	4.3	3.3	0.7	6.3

Table1. Characteristics of patients with CAN scores >90.

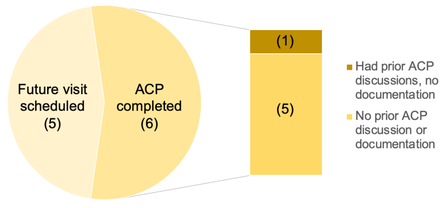

Figure 3. ACP in resident patient panel with CAN >90.

References

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Results

- Within a resident panel of 87 patients, 11 had CAN scores >90.
- Of these patients, the mean age was 70.3, qualifying medical conditions was 4.3, 2-year emergency visits was 3.3, 2-year hospitalizations was 0.7, and 2-year clinic visits was 6.3 (Table 1).
- Six of 11 patients attended their clinic appointments and six LST notes were documented within the medical record.
- Of these six patients, three requested family input before making decisions. Two waited for pending cancer diagnoses before making decisions. Notably, five of these patients had not engaged in prior GOC discussions with providers (Figure 3).

Conclusion

- The majority of patients do not have GOC discussions, despite seeing multiple providers.
- ACP requires significant effort and time to assess values, educate benefits and risks of LST, and align GOC.
- Appropriate discussion and documentation of GOC often requires several visits, input from family, and is influenced by life-threatening diagnoses.
- CAN scores can help PCPs improve quality of care by targeting ACP with patients at highest risk of hospitalization or death.