The Effects of Education and Process Development with Providers on Advance Care Planning in

the Rural Primary Care Clinic

By

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Abstract

Timely advance care planning (ACP) conversations, with a health care provider, can lead to better care and increased satisfaction for patient and family at the end of life. One rural health clinic had no formal plan in place to implement ACP conversations until presentation of a health crisis; limited ACP during the Medicare wellness visit; and no use of the ACP Current Procedural Terminology (CPT) codes. The purpose of this quality improvement project was to implement a process to improve ACP for persons age 65 and older in a rural health clinic. The Iowa Model of Evidence Based Practice to Promote Quality of Care was used to guide this project. All providers and frontline staff were surveyed about ACP to assess process barriers, comfort with initiating ACP, and learning needs. An education session on initiating ACP with patients age 65 and older during the initial or subsequent Medicare wellness exam and the use of new CPT billing codes for ACP occurred. After three months, the providers and frontline staff were surveyed about their comfort level with ACP and frequency of ACP CPT billing codes were determined. Survey results did not show an increased comfort level; however, the clinic implemented the use of the ACP packet and flow chart successfully, with 38% of the ACP packets being utilized. This resulted in two return visits for beginning ACP conversations. The implementation of the ACP packet and flow chart assisted to improve the process of ACP at one rural primary care clinic.

Keywords: advance care planning, primary care, rural elderly population

Acknowledgements

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The Effects of Education and Process Development with Providers on Advance Care Planning in

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Many older adults are living longer, healthier lives. Yet an increasing number of these

adults will be living with chronic disease which may affect decision-making capacity, function,

and quality of life (Bravo et al., 2012). With decreased decision-making capacity, health related

decisions must be made by family members and/or healthcare providers, without input from the

patient (Bravo et al., 2012). Advanced care planning (ACP) is the process to assist patients,

family members and health care providers in thinking about decisions related to future medical

care (Bischoff, Sudore, Miao, Boscardin, & Smith, 2013). Talking about decisions and health

care preferences and/or completing an advance directive enables family members and health care

providers to be advocates for the patient's health care preferences, which can result in increased

satisfaction with care received for the patient and family (Waird & Crisp, 2016).

Background

Health decisions for care at the end of life that are discussed earlier, during a serious or

chronic illness, can greatly impact a person's quality of life when the person begins to experience

the final stages of life (Eues, 2007). Only one in three adults in the United States have completed

advance directives (Yadav et al., 2017). Older adults who have not completed or discussed

advance directives and who no longer have the capacity to participate in medical decision

making, may experience increased or unwanted medical care (Jeong, Higgins, & McMillin,

2010). There is also the possibility that the care they would have chosen for themselves is not

followed by uninformed health care professionals and family members (Jeong et al., 2010).

Medicare reimburses for proactive ACP as part of the annual Medicare Wellness visit

(Centers for Medicare and Medicaid Services [CMS], n.d.). Outside of the Medicare Wellness

visit, providers can bill for time spent discussing, explaining, and assisting in the completion of advance care plan forms (CMS, 2016; Fulmer et al., 2018).

There is an increased interest in learning about health care decisions that can reflect on a person's wishes and preferences for care, therefore education on these decisions is a growing need in society and the medical community (Eues, 2007). Providers not only in urban, but also in rural primary care find it difficult to know the proper time to initiate ACP conversations and most only take this initiative when the patient is terminally ill (Glaudemans, Moll van Charante, & Willems, 2015; Keary & Moorman, 2015).

Problem Statement

Regardless of the importance of ACP conversations and the ability to receive reimbursement, ACP in the rural primary care clinic may not often occur. In one rural primary care clinic, there was no process in place that encouraged ACP. The providers took a reactive approach rather than a proactive approach to ACP resulting in crisis-focused decision making.

Purpose

The purpose of this project was to improve the process of ACP in one rural health clinic resulting in an increase in education and/or communication during Medicare Annual Wellness exams, as well as an increased use of ACP codes and self-reported confidence in facilitating ACP by the clinic team.

Objectives

1. The providers and front-line staff will demonstrate an increased confidence with accessing information to assist in discussing ACP by providing this information and having communication with their patients.

2. Within a time-frame of three months, there will be an increased confidence with beginning ACP conversations by front-line staff and providers, shown by an increase in the use of the ACP billing codes.

Definition of Terms and Concepts

- **Advance Care Planning** is the process of making decisions about the care the patient would want to receive if they became unable to speak for themselves (National Hospice and Palliative Care Organization [NHPCO], n.d.).

- **Advance Care Planning CPT Codes:**
  - Code 99497 allows providers to bill for the first 30 minutes of face-to-face advance care planning interaction with the patient (CMS, 2016).
  - Code 99498 allows providers to bill for each additional 30 minutes of face-to-face advance care planning interaction (CMS, 2016).

- The **Do Not Resuscitate (DNR) Order** is a medical order written by a physician instructing health care providers not to do cardiopulmonary resuscitation if a patient stops breathing or their heart stops beating (MedlinePlus, n.d.).

- The **Durable Power of Attorney for Healthcare (DPOA-HC)** is a written document authorizing someone whom the patient names; to make health care decisions for them in the event they are unable to speak for themselves (Living Wills & Durable Power of Attorney for Health Care, 2016). These decisions include the power to consent, refuse consent, or withdraw consent of any type of medical care, treatment, service, or procedure (Living Wills & Durable Power of Attorney for Health Care, 2016).

- **A Living Will** is a written statement of the patient's wishes with regards to medical treatment if they were to develop a terminal condition (Living Wills & Durable Power of

Attorney for Health Care, 2016). The form must be witnessed by two individuals over the age of eighteen and it is only effective if two physicians have determined the patient to be terminally ill (Living Wills & Durable Power of Attorney for Health Care, 2016).

- The **Medicare Wellness Exam** is an exam designed to develop or update a personalized prevention plan and perform a health risk assessment; covered once every 12 months (CMS, n.d.).

- The **Transportable Physician Orders for Patient Preferences (TPOPP)** is a form that aims to improve the communication of a patient's preferences regarding life-sustaining treatments (Center for Practical Bioethics, n.d.). The goal is to provide high quality care for patients.

Review of Literature

A review of the literature was completed to find information that supported this quality improvement project. This review was evidence based and discussed education and provider communication in support of ACP for their patient population. Pub Med, CINAHL, and Google Scholar databases were searched for literature published from 2010 through 2018. Search terms included "advance care plan," "advance directives," "quality of life," "provider education," "provider barriers," "primary care clinic," "rural healthcare," and "geriatric population." Literature was included in the review if it was in English and available in full text and excluded if it focused on the pediatric or young and middle adult population, did not focus on ACP, was outside of the date range, or was not in the English language.

This literature review yielded a result of over 200 studies. From the studies, approximately 40 were selected that discussed the benefits of ACP, barriers to ACP, ACP education and provider communication.

Medicare Guidelines

Patients are eligible to receive medical benefits from Medicare at 65 years of age, or earlier if disabled, or with a diagnosis of a chronic progressive disease (i.e. amyotrophic lateral sclerosis or end stage renal disease). Under the Medicare benefit, the patient is eligible for an annual wellness visit once every 12 months (CMS, n.d.). The annual wellness visit includes preventative services, but also includes time for ACP (CMS, n.d.).

ACP is complex and may require many conversations over time (Bischoff et al., 2013). CMS recognized the importance of ACP and since January 2016 allows providers to bill for time spent on ACP, explaining, and assisting in the completion of documents related to ACP with beneficiaries or family members of the beneficiary (CMS, 2016; Fulmer et al., 2018). Under this rule, providers can bill for the first 30 minutes of face-to-face ACP interaction with the patient or patient representative and then can bill for each additional 30 minutes of face-to-face interaction (CMS, 2016).

Healthcare in Rural Communities

Approximately 60 million people or 19.3% of the population in the United States lives in the rural community (US Census Bureau, 2016). The burdens faced are a combination of growing old, residing in a remote area, and managing health concerns at a distance, due to less local health services and care providers (Ashcraft & Owen, 2016). Family and community in rural areas is important. Rural adults' value and express preferences for remaining in their own home with their families for as long as possible. Rural communities may have limited community resources due to the relocation of younger generations to more urban areas. Lack of available family and health care resources within the community may affect preferences and available choices for care at the end-of-life (Ashcraft & Owen, 2016).

Advance Care Planning in Primary Care

A Primary Care Provider (PCP) is the healthcare provider that patients develop a relationship with over a period of time. Patients expect the PCP to anticipate physical or mental changes in their health and to inform them (the patient) about their illness, prognosis, and care options (Glaudemans et al., 2015). A study completed by Waldrop & Meeker (2012), found that patients depended on their primary care provider to have open communication about ACP, however topics discussed during ACP varied from provider to provider. Some providers discussed advance directives, others psychosocial topics, and still others only exchanged opinions about situations to provide insight into their patient's end-of-life preferences (Glaudemans et al., 2015). Providers in urban and rural primary care found it difficult to know the proper time to initiate an ACP conversation; and most providers reported that they only took the initiative when a patient was terminally ill or suffering from a potentially fatal illness (Glaudemans et al., 2015; Keary & Moorman, 2015). It is important to begin the ACP process prior to this time because providers and patients require time to identify improvements and obstacles in preparation for end-of-life (Keary & Moorman, 2015). Other research showed that providers understood the importance of follow-up with ACP, as they were aware that patient care preferences may change over time (Glaudemans et al., 2015; Keary & Moorman, 2015).

Patients and Early Advance Care Planning

Older adults with chronic illnesses reported they were more satisfied with and put more trust in their primary care provider who took the opportunity to discuss ACP in the context of future care (Keary & Moorman, 2015; Lum, Sudore, & Bekelman, 2015). Patients also expressed a higher comfort level with providers who were comfortable initiating ACP conversations (Snyder et al., 2012). This included talking about the specific forms such as DNR forms, Durable

Power of Attorney for Healthcare (DPOA-HC) forms, and Living Wills (Simon, Porterfield,

Bouchal, & Heyland, 2015). Patients preferred education on the benefits and burdens of life-

sustaining treatment, like cardiopulmonary resuscitation (Simon et al., 2015). Those patients that

had early ACP conversations with their providers were more likely to talk with their family

members about their wishes or preferences (Keary & Moorman, 2015).

Benefits of Early and Ongoing Advance Care Planning Communication

ACP should be initiated early during a patient's illness to allow the patient to discuss

their wishes for future medical treatment, and to designate a health care proxy to assist in making

decisions and communicating their wishes if they are no longer able (Levi et al., 2013; Waldrop

& Meeker, 2012). When the patient is given the opportunity to discuss their advance directives

with their loved one's present, there is better communication about the patient values and goals

of care (Levi et al., 2013; Waldrop & Meeker, 2012). When a patient enters the late stages of

illness, they may develop diminished cognitive capacity and their health care proxy must take

over (Waldrop & Meeker, 2012). Identifying the patient's goals and preferences for care

improves communication, alleviates anxiety, and helps to direct goal consistent care (Bernacki &

Block, 2014; Waldrop & Meeker, 2012).

ACP communication early during a patient's illness is associated with less aggressive

care when the patient is near death (Mack et al., 2012). Absent, delayed, or inadequate

communication about end-of-life care preferences is associated with inadequate quality of life,

prolongation of the dying process, undesired hospitalizations, mistrust of the health care system,

physician burnout, and excessive cost (Bernacki & Block, 2014). If the patient had conversations

about ACP prior to 30 days before death, they were less likely to receive aggressive care and

more likely to receive hospice care (Mack et al., 2012). Aggressive care at the end-of-life was

most common among patients who experienced conversations for the first time in the inpatient setting and less common when the discussions were reported in interviews that occurred outside the hospital setting with patient and family (Jeong et al., 2010; Mack et al., 2012). Less aggressive care is less costly and is also less burdensome to the family members (Bernacki & Block, 2014; Jeong et al., 2010; Mack et al., 2012). When treatment is consistent with the patient's goals and preferences, the negative effect on the family decision makers is reduced (Bernacki & Block, 2014; Cox et al, 2011). The evidence shows that ACP often leads to a better quality of life toward the end-of-life, yet many providers do not have these conversations (Bernacki & Block, 2014; Levi et al., 2013; Mack et al., 2012; Waldrop & Meeker, 2012).

Barriers to Advance Care Planning Discussion

Providers from different specialties may view ACP differently. Primary care providers viewed ACP as a comprehensive process of life planning, while those involved in the patient's care later (i.e. hospitalists, specialists, etc.), tended to focus on a patient's code status (Ahluwalia et al, 2015). Acute hospitalization offers an opportunity for inpatient providers to engage in conversations with patients and proxies about the goals of care and patient preferences during a serious illness or crisis event (You et al., 2014). Inpatient providers believed that having information about the patient's values and goals for health care, would be helpful prior to admission to guide treatment decisions (You et al., 2014).

Many providers are uncomfortable starting a conversation about ACP because of the various emotions that patients may show during these conversations (Bernacki & Block, 2014; Jacobsen, Robinson, Jackson, Meigs, & Billings, 2011; Kovacs et al., 2012; Levi et al., 2013; Snyder, Hazelett, Allen, & Radwany, 2012; You et al., 2014). Patients experienced anxiety and denial contributing to the challenge of discussing their advance care plans. Fear of emotion may

cause the provider to delay initiation of ACP conversations resulting in conversations in the last six months of life (Bernacki & Block, 2014; Jacobsen et al., 2011; Kovacs et al., 2012; Levi et al., 2013; Snyder et al., 2012; You et al., 2014). According to Snyder et al. (2012), providers who experienced personal ACP conversations (with family, themselves, or close friends) were more likely to initiate conversations with their patients. These providers felt that ACP was beneficial for their patients and were more comfortable communicating with their patients about their prognosis and their wishes.

Time is often identified as a barrier. Providers felt that there were time constraints on providing high-quality ACP as patients presented with different needs for information, options, and urgency of decisions. (Jacobsen et al., 2011). Providers spend more time on operational measures, scheduling multiple patients into their busy schedule thus leaving less time for intimate conversations with their patients (Hagen et al, 2015; You et al., 2014).

A final barrier to conversations about ACP is the structure of the electronic health record (EHR). Information about the patient's health care values and goals may not be accessible or available (Ahluwalia et al., 2015; Bernacki & Block, 2014). The EHR is designed to capture point-of-care information instead of a lengthy narrative about the patient's health. Advantages of ACP documentation in the EHR include (1) a standardized ACP documentation template, (2) electronic health information exchange between providers, (3) clinical reminders to engage patients in ACP events, and/or (4) a designated individual within the organization who discusses ACP with each patient (Ahluwalia et al., 2015; Bernacki & Block, 2014). The EHR would allow multiple providers access to ACP documents, review the patient's goals of care, and add missing information.

Facilitators to Advance Care Planning Discussion

ACP conversations should occur over multiple visits instead of just one single visit (Bernacki & Block, 2014; Kovacs et al., 2012; You et al., 2014). This provides time for the patients to discuss their wishes with family and providers while having adequate time for questions, and to deal with any emotions that may arise during the process. It also provides the opportunity for patients to plan to have family or a trusted person present for the conversation.

Literature included in this review found that not only is ACP important, but there are also many barriers to overcome for ACP conversations to be a consistent part of patient care.

Evidence Based Practice Model

The project focused on the second aim of the quadruple Agency for Healthcare Research and Quality (AHRQ) which focused on the patient experience and outcomes related to initial and subsequent ACP conversations (AHRQ, 2018). The goal of having ACP conversations earlier in the patient's course of care can support or contribute to a better overall healthcare experience and potentially increase the patient and family satisfaction with the healthcare process.

The Iowa Model of Evidence-Based Practice to Promote Quality of Care, was used to guide the project. This model was used to gather information about the needs, gaps, measurements, and interest in ACP at the rural primary care clinic. (Appendix B).

Project Design

This Quality Improvement (QI) project aimed to improve the ACP process in a rural clinic for persons 65 and older during the annual Medicare annual wellness exams, resulting in an increase in education and/or communication. In addition, the project aimed to evaluate for an increase in billing of ACP CPT codes and self-reported confidence in facilitating ACP by the providers and frontline staff.

The Institutional Review Board (IRB) at the University of Kansas Medical Center determined the project to be Quality Improvement so no further IRB review was needed prior to initiating the project. A survey consent was obtained stating that the provider and staff would remain anonymous and that no HIPAA would be involved (see Appendix D). There were no personal risks or benefits from participating in this Quality Improvement project.

Project Site and Population

A family practice clinic located in a rural community in a Midwestern state was the site for this proposed project. The clinic is part of a larger system, consisting of multiple outreach clinics and a critical access hospital. At the time of this QI project, the clinic was staffed by four full time physicians and two full time advance practice nurse practitioners. Each provider had a nurse and a patient care coordinator that assisted with scheduling and caring for the patients. There were two to three office staff that assisted with patient check in and answering phones. There was a nurse manager who oversaw the nursing staff and scheduling, as well as an office manager who handled the scheduling of the business office. The patient population in the clinic was across the lifespan. Family practice services offered included prenatal care, newborn/infant/child health care, adult care, geriatric care, women's health, men's health, as well as various procedures.

Gap Analysis of the Rural Primary Care Clinic

A gap analysis was completed for the rural primary care clinic by the Project Manager with the Quality Improvement Specialist for the clinic (see Appendix A). During this process, a gap was identified in the communication about ACP among providers and patients. The rural primary care clinic took a reactive approach to ACP. This meant that when a patient came into the office or the emergency room in crisis, it was then that ACP was initiated. This stemmed

from the providers belief that there was a lack of time to have these discussions while the patient was healthy and coming into the clinic for a well visit, or even when the provider first noticed a decline in the patient's current medical status. Another reason providers waited until there was a crisis to have these conversations, was because the providers were uncomfortable with the emotions expressed during these difficult conversations. The providers identified the need to change from taking a reactive approach to a proactive approach to begin ACP with patients before a crisis event. There also were no policies and/or procedure documentation in place related to ACP.

Quality Improvement Implementation

The project focus was on increasing the ACP education and communication with patients age 65 and older, during the Medicare wellness visit.

Data Collection

The Project Manager worked with the Director of Quality Improvement and the Chief Clinic Officer to evaluate current billing of ACP CPT codes. Since there were no ACP CPT codes documented, education was provided to the staff about the utilization of these codes.

A pre-project survey for the front-line staff and providers was created from the review of the literature and reviewed with two experts in ACP (see Appendix C). The survey was designed to identify barriers to ACP conversations, the educational needs for the providers and front-line staff, and to assess the billing of ACP conversations. The survey was stored in REDCap, a secure data base at the University of Kansas Medical Center (see Appendix C). The link to the pre-project survey was sent by e-mail to all front-line staff and providers. The front-line staff and providers were given 10 days to complete the survey.

The returned surveys were reviewed, and educational needs of providers and staff were identified. A team convened that included the Project Manager, the Director of Quality Improvement, Director of Physician Clinics, Chief Clinic Officer, frontline staff, and providers. A flow chart was developed that was used to trigger providers and frontline staff to start conversations with patients about ACP. An educational session was completed with 15 front-line staff and 8 providers at the medical clinic.

All providers and frontline staff were introduced to the flow chart (see Appendix F) during the education session. An ACP packet was created that included: Living Will, DPOA-HC, and TPOPP forms; Outside the Hospital Do Not Resuscitate form (DNR); and a copy of the Caring Conversations Workbook® (Center for Practical Bioethics, n.d.; Living Wills & Durable Power of Attorney for Health Care, 2016; MedlinePlus, n.d). The ACP packet was provided to patients who were seen for their annual Medicare Wellness Exam and accepted the packet.

Process implementation occurred over three months. The Project Manager checked in every month, or as requested, with the providers and staff. During the visits, the Project Manager informally evaluated use of the flow chart and ACP packet, asked for feedback from the frontline staff and providers, and identified changes or recommendations for process improvement.

During the final month, a final meeting was held with the providers and staff to evaluate project implementation and completion. At this time the providers and staff were informed of the post-implementation survey that would be anonymous and voluntary. The post-project survey was also developed in REDCap and was not evaluated for reliability and validity. This survey assessed for changes in knowledge about beginning ACP conversations, as well as an evaluation on the implementation of the flow chart and ACP packet (see Appendix E).

To finalize the project completion, 52 providers and staff were e-mailed a post-implementation survey. The prospective participants were given 10 days to complete the survey. At approximately day 5, a reminder e-mail was sent to the prospective participants about voluntary completion of the survey. At the end of day 10, the post-implementation survey was locked, and the results were analyzed. Finally, a report from the clinic EHR evaluated the number of times the advance care plan CPT codes, 99497 and 99498 had been used.

Data Analysis

Pre- and post-implementation survey data were organized and analyzed for similarities and differences among providers and staff. The responses by providers and staff were grouped into recurrent themes that developed through the review. The analysis of the themes evaluated for provider and staff statements of increased knowledge and confidence in implementing beginning and recurrent ACP conversations. Frequency of the use of the ACP CPT codes during the three-month timeframe was also analyzed.

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Results

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The pre-implementation survey was sent to 52 providers and front-line staff of the rural primary care clinic. A total of 17 surveys were completed but two participants did not complete the survey and did not answer any of the questions and commented that they did not feel that they were adequately able to answer the questions. Nine out of the 15 surveyed participants (60%) occasionally discussed ACP with their patients, while six (40%) never discussed ACP with their patients. Two participants (13.33%) reported feeling very comfortable initiating ACP conversations with their patients, six (40%) felt comfortable, and three (20%) felt uncomfortable with these conversations, and four (26.67%) feeling neither comfortable or uncomfortable.

To be able to adequately provide education and resources that would be beneficial to the providers and staff, the pre-intervention survey also addressed the training and resources that had been utilized in the primary care clinic. Of the 15 participants, six (40%) utilized no resources to have ACP conversations, while nine (60%) utilized paper copies of ACP paperwork (i.e. DPOA-HC form, Living Will form, and DNR forms). Evaluating the education received on ACP, seven (46.67%), received no formal training on ACP conversations with patients. Of those who had received formal education, six (40%) were educated by lecture, one (0.67%) was educated by online education, CD, or a podcast, and three (20%) were educated by CME/CE workshop. In analyzing these results, many of the participants needed education on ACP and the preferred resource would be paper copies of ACP forms. These results were utilized to develop the education and materials for the primary care clinic to use for implementation.

An education session was completed with all staff. One provider discussed how a Medicare Wellness Exam is scheduled in a one-hour time slot and the clinic is reimbursed a set rate. For every Medicare Wellness Exam completed, they could complete two to three acute sick visits and receive more revenue. The provider was not opposed to implementing the QI project, they just wanted clarification on benefits. Further discussion occurred about the revenue that can be driven from having patients return for an ACP visit to discuss their future goals and wishes.

During the education session, the Chief Clinic Officer encouraged the providers and frontline staff to utilize the ACP information provided to them. Upon completion of the education session, the project was implemented in each provider pod of the primary care clinic. Each pod received 10 ACP packets. These were kept in a file with the Medicare Wellness Exams to be utilized during these visits. The flow chart was placed into each exam room and an ACP

flyer (developed with the marketing department) was placed in each exam room (see Appendix G); brochures were placed in the waiting rooms.

One month later, another meeting was held with providers and staff to evaluate process implementation in the clinic. Little feedback was provided, as only one provider stated that "it was going well." There were no additional comments. After one-month positive results had been noted by the Chief Clinic Officer including an increase in Medicare Wellness Exams. The marketing department had ordered additional copies of the ACP forms, and the quality department distributed the additional ACP packets to their satellite clinics. Additionally, the management staff had developed and implemented an ACP policy within one week of project implementation. In evaluating the use of the ACP packets, of the 50 that were provided to the clinic, 16 (32%) had been provided to patients, with one patient scheduling a return visit for ACP conversations.

Of the potential 52 participants, six completed the post-implementation survey. In analyzing the results, three (50%) of the participants stated that they occasionally used the ACP packets and flow charts as they discussed ACP with patients 65 years of age and older, while three (50%) stated they never utilized the materials.

The comfort level, after completion of the education session and implementation of the materials, was analyzed. Two participants (33.3%) stated that they were more comfortable with ACP discussions, three (50%) stated that they were neither more comfortable or still uncomfortable, and one (16.7%) stated that they were still uncomfortable with ACP conversations. After implementation of the materials, two participants (33.3%) stated they still did not utilize any resources for ACP conversations, while four (66.7%) stated that they were utilizing the ACP packets and flow sheet provided. Overall, five participants (83.3%) felt like the

implementation of the ACP packets and flow sheets were beneficial in the initiation of ACP conversations with patients, while one (16.7%) did not feel that the materials were beneficial.

Upon final evaluation of the ACP packets, 19 total copies (38%) had been shared with patients by their providers. This was an increase of three packets since evaluating the previous month, showing providers and staff were still utilizing the provided resources.

A final evaluation of the billing of ACP CPT codes was also completed. Since implementation of this project, the rural primary care clinic had billed the 99497 CPT code twice but had not billed the 99498 CPT code. This evaluation shows that providers and staff are not only utilizing the ACP packets, but they are utilizing time for education about ACP with their patients.

Limitations

One potential limitation for this project was selection bias. Those providers that were motivated to improve their skills in ACP conversations with their patients, were more likely to participate. These providers potentially had more knowledge about the importance of having ACP conversations with their patients and the importance of allowing their patients the opportunity to develop their goals of care and to select medical decision makers. The recruitment of these select providers was chosen due to the known lack of available health care resources within the community and the negative impact on the population in the rural community (Ashcraft & Owen, 2016).

The project also had a limited time frame for implementation and data collection. This project was completed over a three-month period with data collection at monthly intervals. If the project could have been extended to six months or a year time frame, the results may have been

different. This would have allowed for a longer period of adoption, implementation, evaluation, and normalization of ACP.

Discussion

The findings from this project demonstrated that there was a need for education and educational materials to increase access to resources and improve comfort and timing of ACP conversations. Prior to the initiation of this project, the providers and staff had few resources that they utilized for ACP conversations and they took a reactive approach to these conversations, only having them at moments of crisis. As noted by the usage of the ACP packets, upon completion of this project, some providers and staff were utilizing resources to assist them in ACP conversations. In addition, the rural primary care clinic took the beginning steps to develop these ACP packets for their satellite clinics in even more remote areas of the county.

Prior to this project, the rural primary care clinic did not have a policy or procedure in place related to ACP. During the first month of this project, a policy and procedure for ACP was developed. This was a positive step forward and one that the Director of Physician Clinics wanted to take prior to the project but did not have provider support.

The rural primary care clinic had also never utilized the CPT codes for ACP conversations which became effective January 2016 (CMS, 2016). After completion of the education session, the providers used the CPT code to bill twice for the first 30 minutes of face-to-face ACP (CMS, 2016).

There were other constraints to the completion of this project. Many staff were involved in the implementation of ensuring the ACP packets were provided to the patients who agreed to the education. Another constraint, that was also considered a barrier, was the perception of time. Not only did the providers feel that they were pressed for time each day, but the front office and

nursing staff felt pressed for time with the check in of patients, collecting the forms, and then the rooming of patients, all while keeping the providers schedule for the day moving. Education about the importance of ACP was completed, but the provider and front-line staff were ultimately responsible for incorporating the training into their daily practice.

Conclusion

Communication with patients about ACP is an important piece of health care. Many providers face the barriers of time, emotions, and lack of knowledge about having these difficult conversations. With completion of this project, education shared with providers about the resources available for ACP conversations, how to share resources with their patients, and reimbursement for these conversations allowed a rural primary care clinic to make improvements in the way they provide ACP. Providers at the rural primary care clinic have started to take a proactive approach to ACP and feel more comfortable with resources and conversations about advance care planning with patients prior to a healthcare crisis.

Author Details

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Appendix A

GAP Analysis

Figure 1

STRENGTHS	WEAKNESSES
• Provider willingness to discuss their barriers to having advance care plan conversations with patients • Provider willingness to learn how to better incorporate these discussions into their practice with patients 65 years of age and older	• No documentation of practices/policies/procedures for advance care planning • Currently providers take a reactive approach to the discussion of advance care plans with patients • Social worker not involved with patients in the clinic setting
OPPORTUNITIES	**THREATS**
• Education session about the importance of advance care planning and the ability to bill for these conversations with new CPT codes • Ability to place information on patient charts to trigger these advance care plan discussions • Provide education about taking a proactive approach and having providers implement this practice	• Providers continuing to be pressed for time in clinic and not adequately taking time for advance care plan discussions • Lack of assistance given to providers to implement a new procedure

Appendix B

Iowa Model of Evidence-Based Practice to Promote Quality Care

Figure 2

Problem Focused Triggers
1. Risk Management Data
2. Process Improvement Data
3. Internal/External Benchmarking Data
4. Financial Data
5. Identification of Clinical Problem

Knowledge Focus Triggers
1. New Research or Other Literature
2. National Agencies or Organizational Standards and Guidelines
3. Philosophies of Care
4. Questions from Institutional Standards Committee

Is this Topic a Priority For the Organization — No → Consider Other Triggers

Yes → Form a Team

Assemble Relevant Research and Related Literature

Critique and Synthesize Research for Use in Practice

Is there a Sufficient Research Base?

Yes → **Pilot the Change in Practice**
1. Select Outcomes to be Achieved
2. Collect Baseline Data
3. Design Evidence-Based Practice (EBP) Guideline(s)
4. Implement EBP on Pilot Units
5. Evaluate Process and Outcomes
6. Modify the Practice Guideline

No → **Base Practice on Other Types of Evidence:**
1. Case Reports
2. Expert Opinion
3. Scientific Principles
4. Theory

Conduct Research

Is Change Appropriate for Adoption in Practice
No → Continue to Evaluate Quality of Care and New Knowledge
Yes → Institute the Change in Practice

Monitor and Analyze Structure, Process, and Outcome Data
• Environment
• Staff
• Cost
• Patient and Family

Disseminate Results

https://www.researchgate.net/figure/1998-Iowa-Model-of-Evidence-Based-Practice-to-Promote-

Quality-Care_fig1_44605641

Appendix C

Provider and Frontline Staff Pre-Intervention Questionnaire

Please answer the following questions to the best of your ability. Feel free to leave any questions blank that you are not comfortable answering or that you do not know the answer to.

1. How often do you talk with your patients 65 and older about issues related to advance care planning and goals or preferences for care at the end-of-life?
   a. Frequently
   b. Occasionally
   c. Never
2. How comfortable are you in initiating advance care planning conversations with your patients?
   a. Very Comfortable
   b. Comfortable
   c. Neither comfortable or uncomfortable
   d. Uncomfortable
   e. Very Uncomfortable
3. What resources do you currently use during your advance care planning conversations?
   a. None
   b. Online resources. Describe what resources you use: _____.
   c. Paper copies of resources (DPOA-HC, Living Will, DNR)
4. Do you know where to find resources to begin advance care planning conversations with patients?
   a. Yes
   b. No
5. What type of education have your received on advance care planning.
   a. Lecture or module during professional education
   b. Online CE, podcast on advance care planning
   c. CME/CE workshop on advance care planning
   d. None
6. What do you find challenging when thinking about or having an advance care plan conversation with your patients? May select more than one answer.
   a. Lack of time
   b. Patient emotions (denial, crying, anger, etc.)
   c. Feel it is a different provider's (specialist, hospitalist, etc.) responsibility
   d. Do not want to give unwelcome news
   e. Do not want patients to lose hope
   f. The Electronic Medical Record
7. What resources do you feel would be most beneficial to help you improve your ability to engage in advance care planning conversations with your patient? (May select more than one.)

      a. Flow chart/Check List
      b. Paper copies of documents
      c. Online resources
      d. Other: _____

Thank you for your time and the information you provided in this survey. All answers remain anonymous and will be used for data collection in this project.

Appendix D

Survey Consent Form

Dear _____,

My name is Samantha Montgomery and I am a current Doctor of Nursing Practice (DNP) Student at The University of Kansas School of Nursing. I am contacting you because you are a provider or staff member with ███████████. I am working with ███████████, Chief Clinic Officer on a quality improvement project to implement and improve the process of advance care planning for persons 65 and older in a rural health clinic. As part of this process I would like to invite you to participate in a brief survey about advance care planning. This survey should take less than 10 minutes. No identifiable information will be collected about you, and your answers and comments will be anonymous. There are no personal benefits or risks to participating in this project. Participation is voluntary, and you can stop taking the survey at any time. The results of the survey will be used to develop education for assisting in improving education and communication about advance care planning during Medicare Wellness Visits.

The link to the survey is included in your e-mail.

If you have any questions, please contact Samantha Montgomery at ███████████ or by e-mail at ███████████. The project has been reviewed by the KUMC Institutional Review Board (IRB) and has been deemed quality improvement.

Sincerely,

Samantha Montgomery
KUMC DNP Student

Appendix E

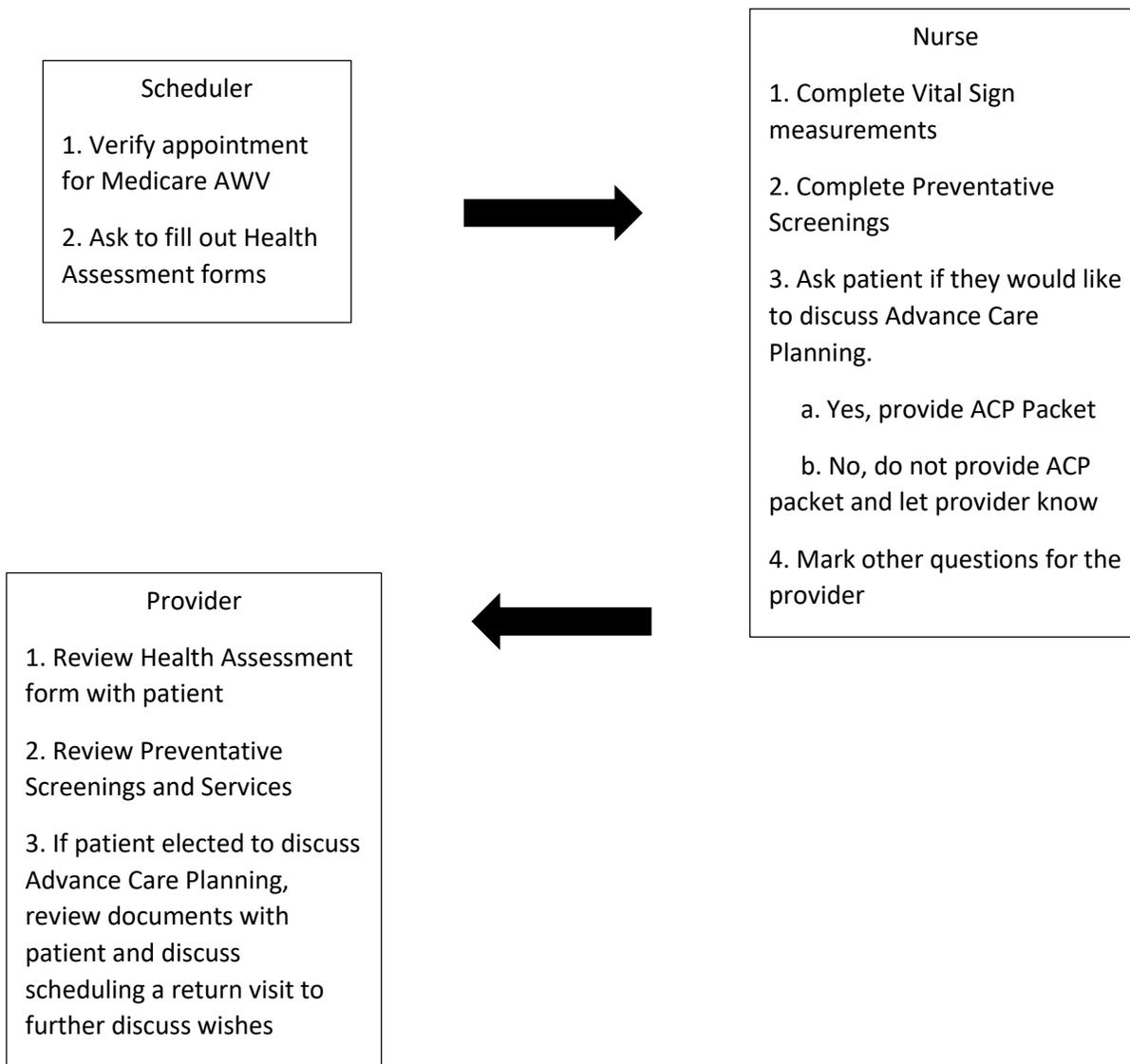Provider and Front-Line Staff Post-Intervention Questionnaire

Please answer the following questions to the best of your ability. Feel free to leave any questions blank that you are not comfortable answering or that you do not know the answer to.

1. Since implementing the advance care plan packets and flow chart in exam rooms, how often do you talk to patients 65 and older about issues related to advance care planning and end-of-life?
   a. Frequently
   b. Occasionally
   c. Never
2. Since the education session and the implementation of the advance care plan packets and flow chart, how comfortable are you initiating advance care planning conversations with patients?
   a. Very Comfortable
   b. Comfortable
   c. Neither comfortable or uncomfortable
   d. Uncomfortable
   e. Very Uncomfortable
3. What resources are you now using during your advance care planning conversations?
   a. None
   b. Online resources (Caring Conversations, Vital Talk, etc.)
   c. Paper copies of resources (DPOA-HC, Living Will, DNR)
4. Are you comfortable locating resources on advance care planning?
   a. Yes
   b. No
5. Did you find the implementation of the advance care plan packets and flow chart in exam rooms beneficial to initiating advance care planning conversations with your patients?
   a. Yes
   b. No
6. What do you feel could be done differently to improve this project?

7. What did you feel was most helpful about this project for your practice??

8. What do you feel could be added or changed about this project to make it more beneficial for your practice?

Thank you for your time and assistance with this survey and with the completion of this project. All answers will be kept anonymous and will be used for data collection and evaluation purposes.

Appendix F

Medicare Wellness Exam Flow Sheet

Scheduler		Nurse
1. Verify appointment for Medicare AWV	→	1. Complete Vital Sign measurements
2. Ask to fill out Health Assessment forms		2. Complete Preventative Screenings
		3. Ask patient if they would like to discuss Advance Care Planning.
		a. Yes, provide ACP Packet
		b. No, do not provide ACP packet and let provider know
		4. Mark other questions for the provider

Provider
1. Review Health Assessment form with patient
2. Review Preventative Screenings and Services
3. If patient elected to discuss Advance Care Planning, review documents with patient and discuss scheduling a return visit to further discuss wishes

Appendix G

Advance Directive Flyer for Patient Exam Rooms