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Advance Care Planning Evidence Based Practice Benchmark

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Advance Care Planning Evidence Based Practice Benchmark

A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

In the School of Nursing

The University of Texas at Tyler

by

Natalie K Waggoner

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Executive Summary

America is aging, with the estimated number of patients over the age of 65 to reach 72 million by 2030, approximately 20% of the population (Sade, 2012). This demographic shift characterized by an increasing elderly population has elevated the subject of death and dying to a crucial component of health care delivery. A study done by Silveira et al. (2010) demonstrated that 70% of individuals aged 60 and older were unable to participate in treatment decisions during their final days. However, most individuals in the United States have no advance directive.

The goal of this evidence-based practice intervention is to increase advance care planning by initiating discussion in primary practice. This will serve to honor the wishes of patients when acute events occur, based on their values and understanding of their diagnoses. With Medicare and Medicaid adding advance care planning to their fee schedule, discussion of advance care planning by a primary provider meets the needs of patients and is also a revenue source. A screening tool targeted to the primary care population will be created and advance care planning offered by the provider. A list of discussion prompts is provided for providers to utilize with their patients. By participating in advance care planning, patients will have more autonomy over their care towards the end of their lives, increasing their dignity and decreasing emotional distress for patients and family.

Advance care planning should be discussed in the primary setting before acute events occur. Patients should be targeted at the age of 65 or with diagnosis of moderate to severe disease. When possible, family or surrogates should be included in this process. Finally, advance care planning should be discussed on an ongoing basis to reflect the changing priorities of the patient.

Advance Care Planning Evidence Based Practice Benchmark

Approximately two thirds of Americans have no form of advanced directive (Yadav et al., 2017). This is due to several factors: a fragmented healthcare system that does not identify a responsible party for discussion of death and dying, unwillingness of patients and providers to discuss end-of-life issues, insufficient frameworks for advance care planning, and inadequate communication in acute and critical situations (Committee on Approaching Death: Addressing Key End of Life Issues, 2015). This evidence-based practice (EBP) intervention implements discussion of end-of-life wishes between primary provider and patient, with the goal of increasing advance directive utilization. The long-term goal is to have advanced directives in place before an acute event puts patients and their families in difficult situations in the ICU. The intervention addresses the question: in primary care patients over the age of 65 or with moderate to severe chronic conditions, how does implementation of a screening tool and provider initiation of advance care planning discussion, affect the number of patients who create advance directives or make appointments to further discuss advance directives, compared to patients with no screening tool or discussion, over 3 months?

Rationale for the Project

In the ICU, patients at the end-of-life are often unable to communicate their wishes; with no advance care planning, family members must guess what the patient would want. 70% of individuals aged 60 and older are unable to participate in treatment decisions during their final days (Silveira et al., 2010). This leads to invasive and expensive procedures such as CPR, central line placement, intubation and ventilation, surgery, and dialysis. Already an emotional time for the family, this is additional burden. In an IOM report (cited by Long et al., 2015, p. 177) patient care is defined as “Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values *guide* all clinical decisions.” Nurses practice beneficence and nonmaleficence, yet are required to perform uncomfortable and painful procedures on a patient who is unable to consent. Foley catheters,

gastric tubes, rectal tubes, IVs, and arterial lines are some of the invasive lines and catheters that are placed, in what is medically considered to be a futile effort to preserve life. CPR is initiated even in situations in which multiple organs have failed and the patient's heart is resuscitated repeatedly. Nurses surrounding a patient and breaking their ribs to pump the heart is a very different end-of-life scenario than one in which a patient is in their own home, given medications for comfort, and surrounded by their family. Increasing the number of patients who participate in advance care planning would create circumstances in which the patient's wishes are honored.

Literature Synthesis.

Advance care planning (ACP) should be discussed at the primary care level as a part of routine care. Many studies have found that patient discussion and implementation of advance directives increases when the topic is presented by the primary provider in an outpatient setting (Epstein et al., 2013; Hajizadeh et al., 2014; Jeong et al., 2020; Lum et al., 2016; Nassikas et al., 2020; Van Scoy et al., 2014). It is commonly thought that discussion of death and dying are undesirable by patients because it is an uncomfortable topic. However, patients are willing to participate in ACP when asked (Ko et al., 2016; Van Scoy et al., 2014). In a study of Latino patients, those without advance directives stated that they did not know they had any control over that portion of their healthcare (Maldonado et al., 2019). Primary providers are in a key position to approach the subject of a patient's wishes and update ACP as patients' priorities change. A patient's attitudes, values, and preferences can change with their circumstances; it is important for the provider who has established an ongoing relationship to have continuing conversations with the patient regarding their plans. Importance should be placed on standardization of when and whom to address regarding end-of-life issues, with age and chronic serious illness as key indicators (Hajizadeh et al., 2014). Inclusion of family members in ACP discussion increases compliance with the patient's wishes (Lyon et al., 2020; Song et al., 2015). It is often easier to discuss these types of issues with family support present. Family and

surrogates experience less anxiety, depression, and post-traumatic stress disorder when involved with ACP discussion (Clark et al., 2017). Every person is born and will die as part of the health continuum; end-of-life planning should be treated with equal importance to birth planning because it affects everyone. Most patients want to die at home while making their own decisions, although approximately two-thirds die in an institutional setting (Fischer et al, 2013). Like other healthcare decisions, many patients desire input or final decision to rest with their provider (Hajizadeh, 2014). Discussing ACP before there is an acute event creates a situation in which the patient's wishes can be upheld.

Project Stakeholders

Patients are the primary stakeholder. With ACP, patients are no longer in a position in which they are too sick to speak for themselves; this provides the opportunity to tell family and medical staff their wishes. Additional stakeholders are the family and surrogates, who experience distress when asked to make decisions for a loved one with no prior discussion. Family can be included in advance care planning discussions to assist with patient support during the decision-making process and honor patient wishes when the time arrives. Patients and their families are also burdened financially. The mean American per capita cost in healthcare dollars for the last year of life is \$80,000, of which approximately \$30,000 is hospital costs (French et al., 2017).

Stakeholders include medical staff such as physicians, nurse practitioners, and physician assistants. Primary providers develop relationships with the patients over time; they are invested in their patients care and are situated to assist with advance care planning. Although not all primary care practices are part of a larger organization with acute care hospitals, many of them are. Reimbursement rates from Medicare and Medicaid demonstrate to providers and administration that in addition to being what is best for the patient, discussion of ACP is a revenue source. The healthcare organization benefits from advance care planning in terms of reduced cost and resource utilization. Organizations also take on the financial burden

when patients and families are unable to pay their hospital bill. Indirectly, acute care providers and bedside nurses are stakeholders. They share a burden of care that is invasive, painful, and undignified in the face of unknown patient wishes. Also indirectly, taxpayers are a stakeholder; Medicare and Medicaid spending at the end-of-life decreases when advance directives are in place.

Implementation Plan

This EBP plan is to implement a screening tool for patients being seen in a primary care clinic to identify patients who meet the criteria for ACP and initiate discussion of their wishes. The screening tool would identify any patient aged 65 or above as well as any patient with moderate to severe disease. Patients who screen positive would be approached during their visit regarding ACP. If amenable, this discussion could take place during that visit; alternatively, an additional visit for ACP could be scheduled.

Change Project Champion

Identify a change project champion; depending on site, this could be a provider, EBP nurse, or research nurse. Meet with the change champion to discuss the screening tool. What type of tool would be easiest to implement at this location? This could be a short questionnaire filled out by patients as they enter the clinic, a short form filled out by staff before patients arrive or as they arrive for the day, or an electronic medical records (EMR) screening form filled out by staff. Screening tool questions should include age 65 or above and presence of moderate or severe disease. Identify what disease processes are important to be included based on the patient population seen at this site. Common diseases with definitions for moderate/severe could include but are not limited to: Alzheimer's or dementia, chronic kidney disease, cardiac disease (coronary artery disease, heart failure, cardiomyopathy), chronic lung diseases (chronic obstructive pulmonary disease, interstitial lung disease, pulmonary hypertension), cancer, HIV/AIDS, liver disease, stroke. If using hard copies, print out enough materials for the patient census at this facility for the duration of the project; if using the EMR, provide information to the

information technology specialist who will be adding it. Print out sufficient copies of the ACP script for all the participating providers (Appendix A). Plan staff meetings (occurrences and duration); have a separate meeting for staff utilizing the screening tool and an educational meeting for providers who will be discussing ACP. Plan short bi-weekly huddles throughout implementation.

Meetings

Meet with staff who will be instrumental in helping to implement screening tool and advance care planning discussion. Provide education regarding: EBP intervention background and purpose, screening tool, and reimbursement. During the provider meeting, also include the following:

- Hand out conversation prompts form to providers (Appendix A); allow questions and comments.
- Are the providers comfortable discussing ACP?
- Do they have experience with this type of discussion?
- Other than the discussion prompts, what concerns do the providers have? What barriers are there that can be addressed now?

Celebrate implementation day by decorating the breakroom, bringing dessert, or catering lunch, as well as posting a quick info board regarding the EBP project as a reminder. Have quick 10-minute huddles a couple of times each week in which project implementation can be discussed. How is it going? Are there any problems? Are there any barriers that can be identified and overcome?

Outcomes

At the end of implementation audit EMR, combine results, and compare to baseline of 3 months prior to project. Data assessed will be new advance directive creation, any visits billed as ACP discussion, and any scheduled follow-up visits for ACP discussion. Number of patients

who participated and revenue dollar amounts will be included. A meeting should be held to disseminate results to providers and staff. Dissemination of outcomes will be via round-table presentation, which presents the chance to share information with the group. This also promotes group discussion about the project and how it progressed so that the experience can be used within practice (Betz et al., 2020). Creation of a dashboard for communicating information regarding the project help stakeholders to track the improvements over time (Ward-Presson, 2020). A dashboard can be utilized after the implementation of the project; it is important to maintain momentum after the initial change period so that the EBP becomes habitual practice.

Timetable/Flowchart

Table 1
EBP Implementation Project Plan

Project component	Timeframe
Identify change project champion & create screening tool Schedule staff meetings and huddles Print screening form and discussion prompts (Appendix A)	Week 1
Staff meeting to discuss and educate on EBP project and screening tool Provider meeting to discuss EBP project, discussion prompts (Appendix A), and concerns/barriers	Week 2
Celebrate implementation day	Week 3
Implement practice change Bi-weekly huddles: How are things going? Barriers?	Weeks 3-14
Measure clinical outcomes before and after project Create dashboard and print Disseminate information via round table discussion Celebrate success!	Week 15

Note. Adapted from *Evidence-Based Practice in Nursing & Healthcare: A Guide to Best Practice* (3rd ed., p 215), by B. M. Melnyk & E. Fineout-Overholt (Eds.), 2015, Wolters Kluwer Health. Copyright 2015 by Wolters Kluwer Health.

Data Collection Methods

Evaluation of the intervention will be done by auditing the EMR, comparing pre- and post-intervention data. Data will be defined as three months prior to and three months during implementation. This will include patients who create advanced directives, have visits billed as ACP discussion, or schedule a future appointment to discuss ACP. Financial information from billing for ACP discussion will also be obtained by tracking amounts billed before and after the project to obtain revenue information.

Cost/Benefit Discussion

Required resources include wages for education and discussion of the EBP change with staff. Due to the nature of a benchmark, average wages for the providers and staff in the state of Texas are utilized. Assuming an initial two hours of education and two 15-minute huddles each week of implementation for a total of eight hours, meetings would cost \$847.68 per physician, \$437.68 per nurse practitioner, \$436.24 per physician assistant, and \$126.32 per medical assistant (U. S. Department of Labor Statistics, 2021). Medicare and Medicaid reimbursement rates for physician's offices are \$86 for the initial 30 min of ACP and \$75 for each subsequent 30 minutes spent in ACP discussion; there is no limit on discussion with beneficiaries within any time period (Coalition for Compassionate Care of California, 2020).

To cover the cost of education, each physician would have to bill for 9.86 initial ACP discussions, while each nurse practitioner and physician assistant would need to bill for 5.1 initial discussions to recoup this amount within the 12-week period. 1.47 billable ACP discussions would cover education for each medical assistant. Any costs incurred by EMR changes or purchase of education and printout materials are minimal, and should be offset by reimbursement income generation. One 10-ream case of copy paper retails for \$69.99 and is more than enough to provide screening forms and ACP discussion prompts; this would be covered by a single ACP discussion billed.

For an office consisting of one physician, two nurse practitioners, and two medical assistants, the total cost of implementation would be \$2042.67. This would be covered by

billing 24 initial discussions of ACP, an average two a week throughout implementation within the entire practice. Once implemented, there is little cost associated with maintenance of this EBP change; every ACP initial discussion or additional 30 minutes of ACP discussion would be profit. Continuing this example, if the entire office bills for a total of four ACP discussions per week, the net would be \$2062.00 for twelve weeks, not including additional 30 minutes spent in ACP discussion. Extend this throughout the first year and a net of \$15,845.33 can be realized, and this is assuming modest billing numbers of four ACP discussions per week averaged throughout the practice. If each provider billed for four ACP discussions per week this amount increases to a net of \$51,621.33 for the first year.

Discussion of Results

Unfortunately, implementation of this EBP project was unable to occur. Due to the COVID-19 pandemic and limitations of clinical sites, this project became a benchmark. Based on previous studies, there is reason to believe that this project would be successful. Finances have been discussed, but the success of the project would be measured by number of patients who choose to participate in ACP discussion and create advance directives. A modest increase of 25% of patients that screened as qualifying for ACP discussion would be considered a positive result, although more is expected.

Conclusions/Recommendations

There is a need for more high-level research regarding advance care planning (ACP) implementation effectiveness. Although a sensitive topic, there are no risks associated with this project. Advance care discussions should take place in advance of acute illness within the primary care paradigm, as a part of routine care. It should include family or surrogates when appropriate. Patients to target include patients aged 65 and older or who have been diagnosed with moderate to severe disease. A final recommendation is to customize ACP approach for each patient. Although laws focus on the patient's 'right' to decide, it is important to advise patients based on their specific situations. Advance care planning and creation of advance

directives benefits patients at the end of life, providing autonomy and dignity.

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Appendix A

ACP Discussion Prompts

Step	Purpose	Question/comment
Permission	Invites the patient to discuss their current condition and desires regarding future medical care	"Would you like to talk about what might happen in the future, and how we could make sure your wishes are followed?"
Preference	Allows patient to determine how involved in planning, and whether he or she wants others involved	"Would you like to talk about this by yourself, or are there others you would like to join us?"
Establish the baseline	To determine what the patient's understanding is regarding his or her medical situation at the present time	"What is your understanding about your medical situation?" "What have your doctors told you?"
Provide information	To provide clear information about the choices that may be faced in the future, individualized to the patient's own current medical condition	For a patient with recurrent cancer, for example: "Because your cancer came back, it is not curable. You will be living with this disease for the rest of your life, like a chronic disease."
Introduce dilemmas at hand	To determine if the patient has thought about the medical care they would like to receive in the future	"Has someone close to you had to face end of life decisions, like deciding about withdrawing a ventilator or going on hospice? What would you have wanted in that situation?"
Explore values and beliefs	To help the patient define what it means to "live well"	"What is most important to you in life?" "What are your main worries about your situation?" "When you think about your future, what do you hope for?"
Elicit ACP preferences	To guide the patient to state specific preferences about ACP, including cardiopulmonary resuscitation, life prolonging treatment, and inpatient hospitalization	"If you were to stop breathing, would you want to be on a machine that breathes for you?" <i>NOTE: if the patient is interested in a trial of life support, the clinician should ask them to specify the parameters of the trial (how long? Criteria to decide when to stop treatment).</i>
Identify a surrogate decision-maker	To specifically name someone who will carry out his or her wishes in the case he or she is unable to in the future	"If you became unable to tell your clinicians what kind of care they should provide you, who would you want to make medical decisions for you?" <i>NOTE: If the patient names multiple persons, aim to establish a primary surrogate.</i>

Educate about the role of a surrogate	To ensure understanding on how the surrogate decision maker would function in the future	"If you became unable to participate in discussions about your care, your surrogate would be called in to tell us what should be done."
Encourage dissemination among family	To ensure that the ACP decisions of the patient are known to their loved ones, and specifically, to the surrogate(s)	"It would be important to let your family know of your wishes and desires for the future. This includes letting everyone know who you have chosen as your surrogate decision maker."
Document	Encourages the patient to complete ACP forms, which will increase the chances their wishes are followed in the future	"These are important decisions that will impact your care in the future. We should make sure to get them in writing."
Review	Review of these plans on a regular basis ensures that ACP decisions accurately reflect their decisions	"Would you like to revisit your advance care plans? I just want to make sure they still reflect your wishes today, compared to when we did it the last time."
(Detering & Silveira, 2017, Table 3)		

Appendix B

Synthesis Table

PICOT Question: In primary care patients over the age of 65 or with moderate to severe chronic conditions (P), how does implementation of a screening tool and initiation of advance care planning discussion (I), affect the number of patients who participate in advance care planning discussions or create advance directives (O) over 3 months (T)?

Evidence Synthesis Table

Studies	Design	Sample	Intervention	Outcome
A	Descriptive	n=200 females with recurrent and/or metastatic breast or gynecologic cancer	Semi-structured interviews	-Completion of an AD associated with number and percentage of providers with whom the participant had a conversation about EOL decisions. -Patients who named a social worker or nurse practitioner were more likely to report having completed AD
B	Randomized controlled trial	n=56 pts with progressive pancreas or hepatobiliary cancer	Educational CPR Video	-Post-intervention knowledge increased in both video & narrative arms of study -More completion of AD in video arm vs narrative alone
C	Cohort	n=458 adult patients admitted to the general medical floor in Acute Care Hospital	Preference for site of death and actual site of death compared	-Low concordance between actual and desired site of death (37%) -Majority of patients desire to die at home (75%) -Majority of patients died in institutional setting (66%)
D	Qualitative	n=11 patients n=5 Doctors	Structured interviews	Patients -prefer shared decision making -are open to ACP discussion with providers Doctors

				<ul style="list-style-type: none"> -perceive barriers as lack as pt understanding, lack of pt empowerment -identified need for earlier ACP discussion
E	Quasi-experimental	n=1897 adult patients in 2 local health districts in Australia, both acute care inpatient and outpatient locations	ACP RNs discuss ACP with patients	<ul style="list-style-type: none"> -more AD completed after ACP intervention vs control sites (Intervention 0.85% increased to 17.6%; OR 24.9) -more AD completion in outpatient settings vs inpatient acute care settings (Outpatient District 1 2600% increase, Outpatient District 2 5100% increase; Inpatient District 1 saw a 300% increase; Inpatient District 2 saw no increase 0%)
F	Randomized controlled trial	n=449 adults with HIV	ACP planning conversation vs developmental history and nutrition planning	<ul style="list-style-type: none"> - ACP families/surrogates were more likely to accurately report patients' treatment preferences over 12 months, even as patient wishes changed over time (63.6% vs 37.7%) -ACP families/surrogates had eight times the odds of controls of understanding of patients' treatment preferences (Adjusted Odds Ratio 7.91, 95% Confidence Interval: 3.08, 20.3)
G	Descriptive	n=204 adults age 60 and over without an AD residing in two supportive housing facilities OR members of a senior center in San Diego, California	Face-to-face structured interviews	<ul style="list-style-type: none"> - the majority (72.1%) were willing to complete advance directives - Factors correlating to willingness to complete ADs included self-rated health, attitudes towards advance decision-making and social support
H	Qualitative	n=32 adult patients in a geriatric clinic	Group visit model for ACP discussion	<ul style="list-style-type: none"> - Pts reported increased ACP conversations after participating (19% to 41%, P = .02).
I	Descriptive	N=41 Latino pts aged 60 and older in the Los Angeles County and	ACP counseling with participants in their preferred language	<ul style="list-style-type: none"> - Most pts had no documented (95%) or discussed (76%) EOL wishes -61% unaware they had control over EOL treatment -83% valued learning EOL options

		University of Southern California Medical Center Geriatrics Clinic		-Comfort discussing EOL options increased from 66% to 85% -88% completed an AD post survey
J	Quasi-experimental	n=25 medical residents	30-minute educational session on ACP attended by medical residents	-Number of ACP discussions increased from 2.24 to 9.94 -Medical residents reported increased confidence in holding ACP discussions
K	Randomized controlled trial	n=210 dyads of patient and surrogate from dialysis centers	ACP discussion intervention (Sharing Patient's Illness Representations to Increase Trust)	-dyad congruence regarding EOL wishes increased (OR 1.89, 95% CI) -surrogate decision-making confidence increased -surrogates whose patient died during the study exhibited less anxiety, depression, and PTSD
L	Descriptive	n=130 inpatients urban university hospital	Prospective, structured interviews compared pts with AD and without	Pts more likely to complete AD when asked vs not asked -by medical staff 10.8 times more likely (95%confidence interval [CI] 4.59–25.3) -legal staff 46.5 times more likely (95% CI 15.1–139.4), -family and friends 68.6 times more likely (95% CI 13.0–361.3)

Legend: A = Clark et al., 2017, B = Epstein et al., 2013, C = Fischer et al., 2013, D = Hajizadeh et al., 2014, E = Jeong et al., 2021, F = Lyon et al., 2020, G = Ko et al., 2016), H = Lum et al., 2016, I = Maldonado et al., 2019, J = Nassikas et al., 2020, K = Song et al., 2015, L = Van Scoy et al., 2014, ACP = advance care planning, AD = advance directives, EOL = end-of-life, n = sample size, pt(s) = patient(s), PTSD = post-traumatic stress disorder

Outcomes Table: Effect of Advance Care Planning on Patients, Friends & Family, and Providers

	A	B♦	C	D	E♦	F♦	G	H	I	J	K♦	L
Increased AD use	↑*	↑*	NE	NE	↑*	NE	NE	↑*	↑	↑*	NE	↑*
Concordance with pt wishes	NE	NE	↓	NE	NE	↑	NE	NE	NE	NE	↑*	NE
Pts desire ACP discussion	NE	NE	NE	↑	NE	NE	↑*	↑	↑	NE	NE	NE
Provider proficiency increased	NE	NE	NE	↑	NE	NE	NE	NE	NE	↑*	NE	NE
AD use decreased anxiety, depression, and PTSD in surrogates	NE	NE	NE	NE	NE	NE	NE	NE	NE	NE	NE	↑*

Legend: A = Clark et al., 2017, B = Epstein et al., 2013, C = Fischer et al., 2013, D = Hajizadeh et al., 2014, E = Jeong et al., 2021, F = Lyon et al., 2020, G = Ko et al., 2016), H = Lum et al., 2016, I = Maldonado et al., 2019, J = Nassikas et al., 2020, K = Song et al., 2015, L = Van Scoy et al., 2014, ACP = advance care planning, AD = advance directive, NE = not evaluated, pt(s) = patient(s), PTSD = post-traumatic stress disorder

* = statistically significant findings

♦ = higher level evidence

