INTERVENTION TO INCREASE ADVANCED CARE PLANNING:

A QUALITY IMPROVEMENT PROJECT

by

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ABSTRACT

Background: Advanced Care Planning (ACP) is an ongoing process where medical provider(s) combine clinical expertise with patient values to plan for end-of-life. Successful ACP results in goal-concordant care; completion of advanced directives; and ensures satisfaction of Centers for Medicaid and Medicare Services (CMS) quality metrics.

Local Problem: The ACP workflow, patient education, and ACP documentation at the project site was not standardized. Average satisfaction for CMS ACP Registry quality metrics, targeting adults 65 years or older, was 63% average for the previous three years, which fell below the 100% benchmark.

Methods: The Plan-Do-Study-Act framework was used at a primary care office in the Western United States. A microsystem assessment and ACP quality metrics were reviewed pre-intervention. Descriptive statistical analysis of outcomes was monitored over five weeks.

Interventions: Evidence-based interventions included: staff education; standard EMR documentation and template development; new ACP workflow and role delineation; and selection of standard ACP patient education material.

Results: Seventy-five percent of staff received ACP education. Seventy-one percent of eligible patients received the ACP packet. The standard EMR template was used with 57% of eligible visits. ACP document completion and plan was prepared for 71% of eligible visits.

Conclusion: Although project staff education, workflow, and EMR template improved ACP assessment and delivery by team medical assistants (MA), provider and MA use of the EMR template increased to only 57% as limited time and discussion occurred to necessitate documentation. All interventions were only partially adopted. Full adoption would require further support including the designation of a staff leader.

Keywords: Advanced Care Planning, MIPS, Quality Improvement, Primary Care

CHAPTER ONE

REVIEW OF THE LITERATURE

Background

Advanced care planning (ACP) refers to a proactive process that supports adults in sharing personal values, life goals, and preferences regarding future medical treatment (Sudore et al., 2018; Sudore et al., 2017). ACP is defined by outcomes including designation and documentation of a surrogate decision maker, accessible ACP documents across health care settings, and receipt of care consistent with patient goals (Sudore et al., 2018; Sudore et al., 2017). The number of people in the United States aged 50 years and older will increase by 61.11% by 2050 and an estimated increase of 99.5% in people 50 years and older with at least one chronic disease (Ansah & Chiu, 2022). While older adults, aged 65 years and older, represented 16% of the population in 2019, this number is expected to increase to nearly 25% by 2060 (Centers for Disease Control and Prevention, 2022). With an aging population and high burden of chronic illness, completion of ACP is increasingly relevant and necessary to quality end-of-life care and patient empowerment in the setting of chronic illness. The literature indicates ACP discussions result in increased quality of care outcomes, namely care concordance, patient and surrogate satisfaction with communication, and decreased surrogate and clinician distress (McMahan, Tellez, & Sudore, 2020). Economically, ACP may also reduce costs related to excessive medical treatment at the end of life (Klingler, in der Schmitten, & Marckmann, 2016). Still, less than half of American's aged 50 years to 80 years have completed a medical power of attorney (MPOA) or advanced directive (Perumalswami et al., 2021).

Numerous patient and provider barriers to ACP completion are elucidated in the literature. Provider barriers cited include inability to spend non-reimbursable time with patients to complete necessary care (Sonenberg & Sepulveda-Pacsi, 2018). However, after revision in 2016, the Centers for Medicare and Medicaid Services (CMS) added inpatient and outpatient ACP codes to their fee schedule and with these changes, health care providers may now expect a modest reimbursement for services rendered. The Centers for Medicare and Medicaid Services (2023), state eligibility criteria for reimbursement for ACP as follows: involving a patient 65 years or older or their family members and/or surrogate decision-makers; face-to-face visit with a qualified provider; documentation of discussion/explanation or completion of any form of advanced care planning including advance directive, medical durable power of attorney, surrogate decision maker, or medical orders for life-sustaining treatment; 15 or more minutes with a qualified health care provider or their delegated employee spent discussing, explaining, or assisting with ACP topics or documents. The completion of ACP is a performance measure as outlined by the Merit-Based Incentive Payment System (MIPS) via CMS which aims to incentivize health care providers and measures performance across four categories: quality, cost, quality improvement, and promoting interoperability. Based on the performance score over a year-long period, a clinician or group may receive a payment bonus, penalty, or adjustment.

Despite positive changes in reimbursement for ACP, billing remains low and practitioners report lack of process, systems, and time to support providing this service (Ladin et al., 2022; Luth et al., 2022). In their report, *Dying in America,* The National Academies of Medicine (2015), call for reform of current palliative care delivery and suggest a holistic systems-based approach to palliative care and ACP that incorporates patients, healthcare staff, policy, and

appropriate financing to support excellence in health care delivery. As a trusted source of information and routine health contact, primary care providers (PCPs) are well-positioned to initiate, coordinate, and follow-up with ACP (National Academies of Medicine, 2015). However, no single guideline, best practice document, or proven tool has yet been identified or agreed to formally support practitioners in accurate, quality, and fiscally sustainable ACP delivery.

Objectives

Given the increasing age and burden of chronic disease in the United States population, the demonstrated benefits of ACP completion, and the primary care providers well-suited position to initiate and encourage ACP completion, it is important to understand the best practice interventions and associated outcomes of ACP delivery in the primary care setting. This scoping review of the literature was completed to investigate the best practice intervention or tool for completing advanced care planning in the primary care setting with older adult patients.

Methods

This scoping review was prepared using PRISMA (see Appendix A) guidelines (Moher et al., 2009). In cooperation with a Montana State University (MSU) research librarian, an initial systematic search of the literature was completed in September 2023 via the following databases: CINAHL, MEDLINE, Psych Info, and Web of Science. These databases were searched for relevant studies published in English in the last five years. Search terms included the following: “advanced care planning” AND “quality improvement” AND “primary care” OR “ambulatory care.” The initial search did not result in sufficient data and a secondary search was conducted with expanded search terms, expanded years, and additional data bases.

The secondary search, also completed in September 2023, utilized the following databases: CINAHL, Google Scholar, MEDLINE, PubMed, Psych Info, and Web of Science for relevant studies in English published in the last eight years. Search terms included: “advanced care planning” OR “end-of-life care” AND “primary care” OR “ambulatory care” OR “outpatient” AND “surrogate decision maker” OR “advanced directive” AND “quality improvement.” Reference lists of relevant literature were also examined at this time.

Eligibility

Studies were included if they met the following criteria: written in English; published in the last eight years; conducted in the United States, Canada, or European Country; primary literature that took place in a primary care, ambulatory care, or outpatient setting, or systematic review that included at large proportion of studies taking place in these settings; measuring the impacts of an intervention to increase provider skills, documentation, satisfaction, or completion of ACP; and focused on the elderly adult population with or without life-limiting or chronic illness. Both qualitative and quantitative designs were included. Studies were excluded if the population was pediatric or stated to be primarily midlife, assessed only barriers to ACP implementation, or took place solely in the hospital or inpatient setting.

Study Selection. The initial and secondary inquiries combined produced 1,558 references and a total of 833 duplicates were removed resulting in a total of 729 references advancing to the title and abstract screening stage. The author screened the title and abstracts for eligibility criteria after which 681 were excluded leaving 29 records for full-text review. The author completed a full-text review after which 15 records were excluded based on eligibility criteria and 14 remained for full literature review.

Quality Assessment. The United States Preventative Services Task Force (USPSTF) grading schema was used to assess the level of evidence in each of the included references. The USPSTF assigns a letter grade ranging from "A", indicating recommendation for service and high certainty that the net benefit is substantial, to "D", indicating recommendation against service (United States Preventative Service Task Force, 2018). "I" indicates insufficient evidence to make a recommendation (United States Preventative Service Task Force, 2018). Further, degree of certainty is calculated at high, moderate, or low based on study design, method, generalizability, and consistency across similar studies (United States Preventative Service Task Force, 2018). No study was excluded based on level of evidence/quality assessment conducted by the author.

Results

Two studies employed an exploratory prospective cross-sectional design (Brungardt et al., 2019; Dunphy et al., 2016). Six studies were of quasi-experimental design with a pre/post-test (Fang & de Peralta, 2022; Gedney-Lose, Hand, & McCarthy, 2022; Hafid et al., 2021; Hudson Lucas & Dimmer, 2021; Lakin et al., 2017; van Baal et al., 2022). One was a random control trial (Lum et al., 2018). One was a DNP quality improvement project (Marino et al., 2021). One was a mixed methods study with pre/post-test and qualitative component (Gedney-Lose, Hand, & McCarthy, 2022). Three were systematic reviews (Huber et al., 2018; Myers et al., 2018; Solis, Mancera, & Shen, 2018). Of the 14 studies included in the review, two were grade A based on USPSTF criteria, seven were grade B, five were grade C.

All primary literature studied took place in the outpatient setting to include one oncology clinic (Hudson Lucas & Dimmer, 2021), one heart failure clinic (Fang & de Peralta, 2022), one

VA health care clinic (Lum et al., 2018), and eight primary care clinics or family medicine practices (Brungardt et al., 2019; Dunphy et al., 2016; Gedney-Lose, Hand, & McCarthy, 2022; Hafid et al., 2021; Lakin et al., 2017; Lum et al., 2019; Marino et al., 2021; van Baal et al., 2022). The three systematic reviews all contained at least one third of studies within the outpatient setting (Huber et al., 2018; Myers et al., 2018; Solis, Mancera, & Shen, 2018).

Seven primary studies targeted health care providers or ancillary staff in their interventions (Fang & de Peralta, 2022; Gedney-Lose, Hand, & McCarthy, 2022; Hafid et al., 2021; Hudson Lucas & Dimmer, 2021; Lakin et al., 2017; Lum et al., 2019; Marino et al., 2021; van Baal et al., 2022). Four included patient-targeted interventions in addition to the health care provider (Brungardt et al., 2019; Dunphy et al., 2016; Lum et al., 2019; Lum et al., 2018). Of the provider targeted studies, five specifically noted inclusion of nurse practitioners, nurses, social workers, or other non-physician providers (Fang & de Peralta, 2022; Hafid et al., 2021; Hudson Lucas & Dimmer, 2021; Lakin et al., 2017; Marino et al., 2021). One noted more male patients versus female and three noted more female versus male patients (Dunphy et al., 2016; Fang & de Peralta, 2022; Lum et al., 2019; Lum et al., 2018). Seven studies specified patient populations 50 years old or greater (Dunphy et al., 2016; Fang & de Peralta, 2022; Hudson Lucas & Dimmer, 2021; Lakin et al., 2017; Lum et al., 2018; Marino et al., 2021).

Two primary studies utilized the Supportive and Palliative Care Indicators Tool (SPICT) to assist providers in identifying patients eligible for ACP (Dunphy et al., 2016; van Baal et al., 2022). One study utilized the E-Gagne tool implemented by providers to estimate the one-year mortality of patients and therefore identify them as candidates for ACP (Fang & de Peralta, 2022). One study identified patients based on clinical judgement and the “surprise question”

which asks clinicians to answer “yes” or “no” if they would be surprised if their patient died in the next year (Lakin et al., 2017). One study utilized a Provider Orders for Life-Sustaining Treatment (POLST) toolkit (Gedney-Lose, Hand, & McCarthy, 2022). Two studies introduced the Serious Illness Care Program training (SICP), an evidence-based program combining a serious illness conversation guide, clinician training and coaching, and EMR systems changes (Hafid et al., 2021; Lakin et al., 2017). Four studies incorporated a patient education component (Brungardt et al., 2019; Dunphy et al., 2016; Lum et al., 2019; Lum et al., 2018; van Baal et al., 2022). Four studies introduced a portal and/or electronic medical record (EMR) intervention (Brungardt et al., 2019; Fang & de Peralta, 2022; Hudson Lucas & Dimmer, 2021; Lum et al., 2019). Of the three systematic reviews, one noted the most often encountered interventions to increase ACP were part of the Respecting Choices program (Myers et al., 2018). The Respecting Choices Program combines onsite consultations for systems improvement with options for clinician education to enhance person-centered ACP via a systematic approach. A key feature of the Respecting Choices Program is the use of trained facilitators in the education of clinicians (Myers et al., 2018). One systematic review noted common interventions to include provision of patient educational information, electronic prompts, multi-disciplinary teams, and access to established web-based programs (Solis, Mancera, & Shen, 2018). A systematic review specifically evaluating EMR-based interventions, found standardization of provider documentation templates, followed by provider EMR prompts, to be most common (Huber et al., 2018).

ACP outcomes include completion of legal documents such as MPOA, naming a surrogate decision-maker, POLST, and advanced directives (Brungardt et al., 2019; Fang & de

Peralta, 2022; Gedney-Lose, Hand, & McCarthy, 2022; Huber et al., 2018; Hudson Lucas & Dimmer, 2021; Lakin et al., 2017; Lum et al., 2019; Myers et al., 2018; Solis, Mancera, & Shen, 2018). Three studies measured general frequency of documentation of ACP discussion initiation in the EMR and mentioned outcomes, such as the advanced directive completion, secondarily (Dunphy et al., 2016; Lakin et al., 2017; Lum et al., 2018; Marino et al., 2021). Three studies measured provider comfort and/or perceived quality of care delivered via various scales and/or provider self-rated training and confidence of ACP service delivery and acceptance in primary care practice (Gedney-Lose, Hand, & McCarthy, 2022; Hafid et al., 2021; van Baal et al., 2022). One study measured patient engagement with the *Think Ahead* tool via the SPICT program after visiting with the clinician who initiated ACP discussions in the primary care setting (Dunphy et al., 2016). Patients who received this tool via the PCP expressed comfort with ACP discussions in primary care and the study showed information delivered in this fashion enabled ACP discussions in general practice (Dunphy et al., 2016).

Themes

Provider Education and Skill-Building

Of the studies that measured provider comfort in ACP delivery after educational training, all concluded that provider competency and confidence was increased; however, demonstration that educational efforts alone resulted in increased ACP outcomes, such as documentation of care in the EMR and/or completion of legal documents, was mixed (Gedney-Lose, Hand, & McCarthy, 2022; Hafid et al., 2021; van Baal et al., 2022). Only one study, utilizing the SICP training, demonstrated a statistically significant increase in documentation of ACP in the EMR module for the intervention group (44.4%) versus comparison group (3%) (Lakin et al., 2017). In

contrast, a second high quality article, also using the SICP training, specified that provider training alone is not enough to increase ACP (Hafid et al., 2021). Dissimilarly, 86% of providers indicated that sufficient training can be provided to implement ACP into primary care, while 50% noted unspecified resources were insufficient to support implementation (Hafid et al., 2021). In addition to SPICT, resources shown to have the highest improvement in ACP outcomes include the Respecting Choices program which emphasizes values-based discussion with patients and focuses less on delineation of preferences for or against specific medical treatments (Myers et al., 2018). However, implementation of Respecting Choices for a smaller primary care practice may present feasibility barriers owing to the large commitment of time and resources required. Singular interventions aimed at education alone may increase provider comfort, knowledge, and awareness; however, will less consistently produce desired ACP outcomes (Gedney-Lose, Hand, & McCarthy, 2022; Hafid et al., 2021; Lakin et al., 2017). Instead, these studies demonstrate a broad systemic approach to change is essential; integrating both informative didactic elements and process changes to produce ACP as part of routine care (Hafid et al., 2021; Lakin et al., 2017; Marino et al., 2021; Myers et al., 2018; Solis, Mancera, & Shen, 2018).

Standardization of Documentation and Process. No single EMR intervention proved more efficacious at increasing ACP documentation in the patient medical record. However, EMR interventions overall, including a standardized documentation template and structured process, demonstrated increased documentation of ACP outcomes including surrogate decision-maker designation and completion of advanced directives (Fang & de Peralta, 2022; Huber et al., 2018; Hudson Lucas & Dimmer, 2021). For example, Fang & de Peralta (2022), demonstrated in Plan-Do-Study-Act cycle 2 that deployment of a standardized progress note template with all goals of

care to be addressed contributed to an increase in ACP delivery from 0% to 88%. Similarly, Hudson Lucas & Dimmer (2021), show that creating a standardized EMR documentation template patterned from the Supportive Care and Communication Questionnaire (SCCQ), in addition to a templated provider document within the EMR, improved documentation of advanced directives by 41%, increased POLST availability across health care setting by 29%, and resulted in 45% increase for documented surrogate decision-makers.

In contrast, patient-targeted electronic interventions present mixed results (Brungardt et al., 2019; Dunphy et al., 2016; Lum et al., 2019; Lum et al., 2018). Lum et al., (2019), demonstrated high acceptability and high usage of portal-based intervention with 89% of the 2814 participants who accessed the portal completing an electronic MPOA. Whereas Brungardt et al., (2019), demonstrate that a portal-based intervention was not preferred by the study population as more participants chose to complete their MPOA on paper than via the electronic portal and only 16% of the sixty-five participants completed at least one ACP outcome.

Interdisciplinary Approach. All five studies incorporating an interdisciplinary approach to ACP reported attainment of one or more ACP outcomes and associated this approach with success (Fang & de Peralta, 2022; Hafid et al., 2021; Hudson Lucas & Dimmer, 2021; Lakin et al., 2017; Marino et al., 2021). Marino et al. (2021), determines that integral to reaching and sustaining project goals was deployment of the intervention with multidisciplinary support from health center front desk staff, nurse managers, providers, and others whose roles were delineated and integrated into comprehensive ACP delivery. Similarly, Hudson Lucas & Dimmer (2021), highlight involvement of staff with differing roles in the planning and implementation process proved beneficial in identifying potential process-oriented roadblocks and contributed to

improvement in ACP outcomes. Physicians and other providers also agree that with proper education and training, any member of the health care team is capable to facilitate ACP provided they are equipped with the knowledge and resources (Hafid et al., 2021).

Discussion

Advanced care planning is an iterative process of discussion between a patient, whomever they designate, and their health care provider(s) that helps to align patient values, goals, and preferences related to their current and future health care (Center for Medicare and Medicaid Services, 2023; Sudore et al., 2017). As health care systems and patients are impacted by increasing burden of chronic illness and steadily advancing age, defining, streamlining, and measuring ACP grows progressively pertinent in our efforts to provide patient-centered and high-quality health care. Interventions leading to completion of ACP include measurable processes to increase ACP and goals of care conversation initiation via the primary care provider or delegated support staff, documentation of the ACP discussion via a standard template in the EMR, advanced directive and/or MPOA document completion, and accessible storage of ACP documents such as advanced directives across practice settings. These interventions are well recognized in the literature as standards and goals of ACP delivery (McMahan, Tellez, & Sudore, 2020; Sudore et al., 2018). Use of validated and evidence-based tools and programs such as SPICT and Respecting Choices materials consistently show increased patient and provider participation in ACP discussions and increased documentation of discussions (Dunphy et al., 2016; Myers et al., 2018; van Baal et al., 2022). This review illustrates parallel findings within primary care, demonstrating mutual goals of inpatient and outpatient ACP and opportunity for collaboration across health care settings to accomplish common goals.

To achieve increased ACP discussions with appropriate documentation and improved patient outcomes in primary care, this review determines four key areas for quality improvement: ACP provider education to increase communication skills and ability to facilitate value-based goals of care discussions; standardization of EMR templates; clearly defined role delineation and workflow; and a multidisciplinary team approach utilizing both licensed clinicians and support staff such as medical assistants, nurses, and front desk staff. While a component of best practice for ACP is well-informed providers with appropriate knowledge and communication skills, singular interventions of this kind do not reliably result in sustainable systems-level changes to increase ACP discussions. Efforts to increase ACP in primary care should contain a provider and staff educational element to ensure foundational knowledge and concepts are known across disciplines in addition to broad systems-level changes. As this review validates, leveraging EMR systems to standardize outcomes is a practical method to assist in comprehensive ACP. By creating customary templates, order sets, and areas for document storage, information can easily be revisited and updated, goals of care shared across health care settings, and quality metrics for reimbursement captured.

Support for integration of ACP into routine primary care is demonstrated and this review begins to echo evidence that inter-collaborative or transdisciplinary practice is aligned with and beneficial for ACP (Arnett et al., 2017). ACP hinges not only on including diverse team members in ACP delivery, but also in planning and evaluating ACP initiatives. ACP delivered via a collaborative teamwork approach leveraging the collective abilities of nurses, clinicians, medical assistants, and administrative staff could relieve barriers related to limited provider time and reported lack of systems support.

Practice and Policy Implications

Advanced care planning is multi-faceted, necessitating provider knowledge and skills, patient readiness and acceptance, systems support, and integration across settings and disciplines. This review shows promising interventions to enhance ACP; however, gaps in research are evident as are consensus guidelines, ACP definitions, and expectations of who, when, and how ACP is best delivered. As ACP is the responsibility of the health care provider, the medical community and patients would benefit from a set of best practices and guidelines for ACP. Delphi panels have been convened to define ACP and ACP outcomes. As well, consensus recommendations have been made; however, financial feasibility and integration into current reimbursement outside of Medicare has not been formally established. As such the next steps would be to formalize ACP as a reimbursable preventative health service and a quality care metric outside of Medicare.

The aging population and those that are burdened by chronic illness and life-limiting disease are surely candidates for ACP, though this service should not just be for the elderly. Any person of any age may be impacted by an accident or illness requiring prior outlining of items found in an advanced directive or necessitate naming a surrogate medical decision-maker. Systems and policy should be evaluated and adjusted to support ACP for all people as part of patient-centered, population-based, cost-efficient, equitable care as outlined by the National Academy of Medicine's quintuple aim statement (Nundy, Cooper, & Mate, 2022). This review clearly validates previous assertions that ACP should be delivered via a systematic approach involving multi-level stakeholders and will require commitment across disciplines and systems to impact ACP sustainably and reliably (McMahan, Tellez, & Sudore, 2020; Myers et al., 2018;

The National Academies of Medicine, 2015). It is not enough to proclaim an ethical obligation and educate on how to deliver ACP. Health care providers request and deserve systematic assistance from their health care systems, colleagues, and policy to effectively produce desired outcomes. Future research and practice could utilize more systems-based tools to map and enhance ACP, as well as incorporate the inter-collaborative team in program planning, evaluation, and delivery.

CHAPTER TWO

QUALITY IMPROVEMENT PROPOSAL

Introduction

Advanced care planning (ACP) is an ongoing process taking place between healthcare provider, patient, and family in which the patient's goals, preferences, and values are elicited and used in conjunction with provider expertise to plan for end-of-life or complications from chronic illness. Successful completion of ACP has been shown to: improve quality of life, promote end-of-life care that is congruent with patient wishes, decrease decisional stress on families and caregivers, and enhance provider-patient communication (Malhotra, Shafiq, & Batcagan-Abueg, 2022). However, in the United State only one in three adults have completed an advanced directive, the document that outlines the medical care desired by a patient in the event of serious illness of injury (Yadav et al., 2017). Without advanced directives and documentation of ACP discussions in the medical record prior to emergency or precipitous decline in their health, patients and their families are vulnerable to unwanted and unnecessary medical intervention, hospital admission, and death (McMahan, Tellez, & Sudore, 2020). ACP not only contributes to high-quality patient care, but it is also a CMS high-priority outcome included in the merit-based incentive payment system (MIPS) within the Medicare pay-for-performance program. When a healthcare entity is enrolled in this program, suboptimal completion of ACP results in not meeting quality metrics and decreased compensation.

Problem Statement

The problem at a small primary care clinic is inconsistent process and role responsibility, lack of staff knowledge related to impact of advanced care planning on patient satisfaction and MIPS score, and lack of process for maintaining accessible ACP documents in patient charts. Current practice is to chart and bill all ACP related documentation under the code Z71.9. In the previous quarter, this practice has not once billed for an advanced care planning discussion using the approved 99497 and 99498 CPT codes, implying lost opportunity for appropriate reimbursement. While absence of these codes may reflect difficulty in meeting provider billing requirements, namely an ACP conversation of greater than 15 minutes, it is nonetheless reflective of the brevity of these discussions. Through missed opportunities for quality patient care and lost revenue for a small non-profit clinic that could benefit from all possible avenues of reimbursement, failure to perform ACP is both detrimental to patients and the health care system.

To address these gaps in care, literature recommendations include standardized EMR documentation, templates, and staff reminders; standardized processes with designated staff roles and responsibilities; shared responsibility of ACP discussion amongst the interdisciplinary health care team; accessibility of ACP documents within the EMR; and adequate provider and staff education and training to facilitate ACP discussions.

Organizational Microsystem Assessment

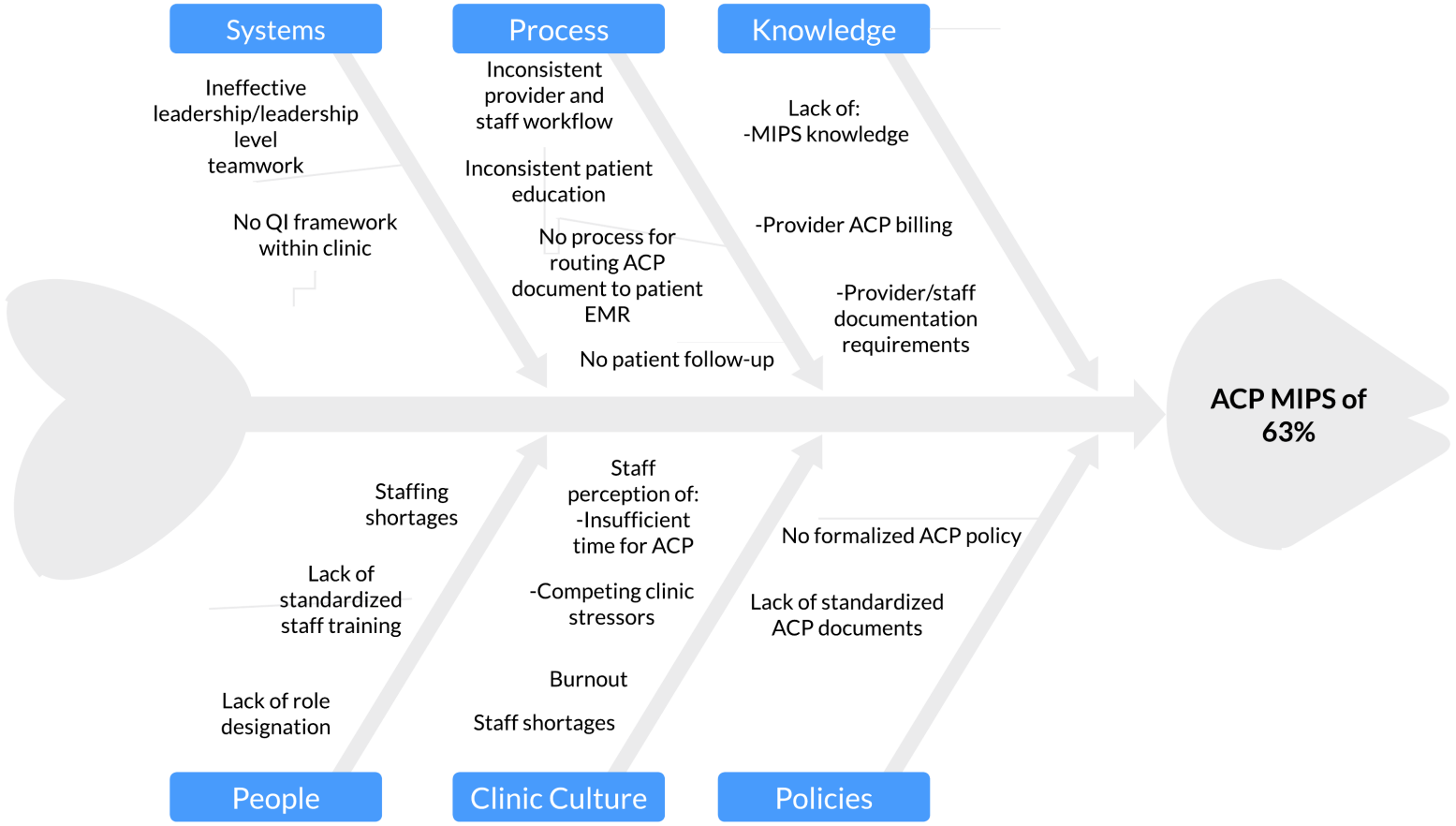
The small rural Montana family practice clinic is a 501c3 non-profit clinic providing primary care and reproductive health care. Two medical doctors (MDs), two physicians' assistants (PAs), and three medical assistants (MAs) make up the primary care medical team and provide health care services to over 3000 patients annually. In 2022, approximately 14% of

patients were over age 65, and in2022 35%, (N=133), patients over age 65, were billed for an annual Medicare wellness visit. However, as noted above, no ACP codes were utilized and the MIPS quality metric was met at 63% for 2022.

The needs assessment at this site included informal in-person interviews with stakeholders; current state process mapping; data retrieval from the EMR to determine current level of documentation and performance; and a fishbone diagram to identify causal factors related to insufficient documentation, patient identification process, ACP document storage in the EMR to maximize care continuity, and MIPS reimbursement metrics (see Figure 1). This analysis revealed the current assessment process was inconsistent, more than one version of ACP resources was provided to the patient, and no process for storing or locating ACP documents within the EMR was evident.

Data retrieval from the EMR shows that for the performance periods in 2020, 2021, and 2022, the average rate of MIPS quality metric completion for the advanced care standard as measured by clicking a specified radio button was 63% of all eligible patients aged 65 years or older. The current documentation asks: “do you have an advanced care directive?” However, no other ACP discussions are billed for or documented, and no follow-up is being performed when advance directive documentation is provided to patients. Arguably, the standard is 100% satisfaction and therefore completion of advanced care planning with every eligible patient. Not only does 63% reflect less than optimal patient care, but it also decreases the overall MIPS score for this practice in a performance year, thus impacting financial sustainability and metrics related to quality patient care.

Figure 1. Microsystem Assessment: Fishbone Diagram

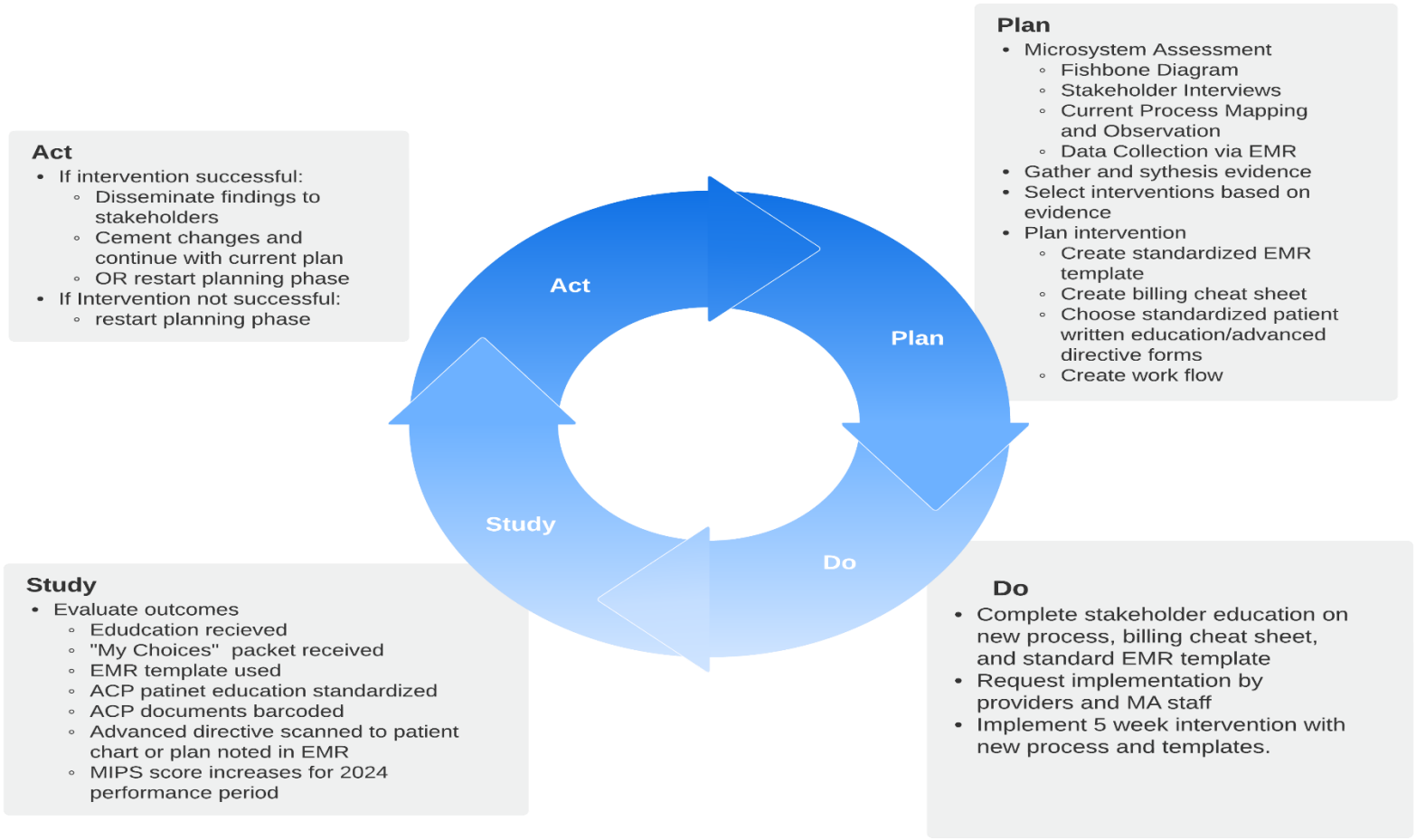


Quality Improvement Framework. The quality improvement initiative was developed using the Institute for Health Care Improvement (IHI) Quality Improvement Essentials Toolkit and included Plan-Do-Study-Act (PDSA) framework (see Figure 2). The PDSA framework, also known as the Deming Wheel, is a systematic process consisting of four iterative phases used for continuous planning and learning from changes to current processes or products (Deming Institute, 2023). During the planning phase, completed in September and October of 2023, it was found that all staff believed ACP to be a valuable service and there was collective desire to improve services offered. Microsystem assessment revealed this practice was enrolled in ACP registry completion as part of their MIPS performance standards and satisfaction of this metric was being completed via the EMR, as noted above, but completion percentages were suboptimal. Current state process mapping showed there was not an organizational protocol, clinical process, or standardized form use in place to promote ACP. No provider EMR reminders or documentation templates were in place as suggested by the literature review. Additionally, MAs were the primary staff completing the intake and documentation surrounding ACP, but without a follow-up plan being generated, the current process did not include steps to ensure that the ACP documents were located and accessible in the EMR, as recommended by the literature review.

The planning phase lead into the "do," "study," and "act" phases conducted between January 2024 and March 2024. During the "do" stage, interventions were completed over a five-week period. Actions included: stakeholder education on new ACP assessment process, staff role delineation and workflow development, dissemination of a provider billing cheat sheet and standardized EMR template, and utilization of already available barcoding system for scanning chosen ACP documents into patient charts for easy accessibility. In the "study" phase, analysis of

data to measure success of the intervention outcomes were fulfilled via weekly chart abstraction and report generation in the EMR, thus leading to the "act" phase where stakeholders determined if the intervention was completely or partially successful and decided whether to adapt the process, cement the changes, or return to the planning phase. The PDSA framework was chosen as it provided the opportunity for a brief pilot intervention and modification based on project results and stakeholder feedback. Because this family practice was new to quality improvement initiatives, small incremental changes were thought more palatable and demonstration of the PDSA framework to stakeholders would illustrate how to approach future quality improvement.

Figure 2. PDSA Cycle to Improve ACP



Specific Aims

The purpose of this quality initiative was to improve ACP delivery in a small family practice clinic to meet MIPS standards with a goal to increase to 100% ACP MIPS metric satisfaction for the 2024 performance year. Overarching goals included: standardize the current ACP process, increase the number of eligible patients receiving quality ACP services, ensure ACP documents were accessible to all healthcare providers in the EMR, and increase the MIPS score for the 2024 performance period. Five specific goals with measurable outcomes were developed to assess the success of this quality improvement initiative. These included: short term goal (1) by January 5th, 2024, 100% of stakeholders would receive training on new ACP process. Medium range goals: (2) by week three of implementation period and through project completion, 100% of eligible patients presenting for a Medicare wellness visit would receive the new "*My Choices*" advanced directive packet at check-in for their appointment; (3) By week three of implementation period through project completion staff would use the standardized EMR documentation template with 90% of eligible visits; (4) By week three of the implementation period and through the remainder of the project, 90% of Medicare wellness visits would include: (a) ACP documents scanned into patient chart OR; (b) note in the standardized documentation template, located in the assessment and plan section of the patient EMR, when and how these documents will be procured and added to the patient chart OR; (c) patient refused ACP. The long-term goal, which was outside the project timeline, was (5) By December 31st, 2024, MIPS scores will increase by 37% from an average of 63% to 100% satisfied for the entire 2024 performance period. See Figure 4 for more detail.

Methods

Implementation Summary

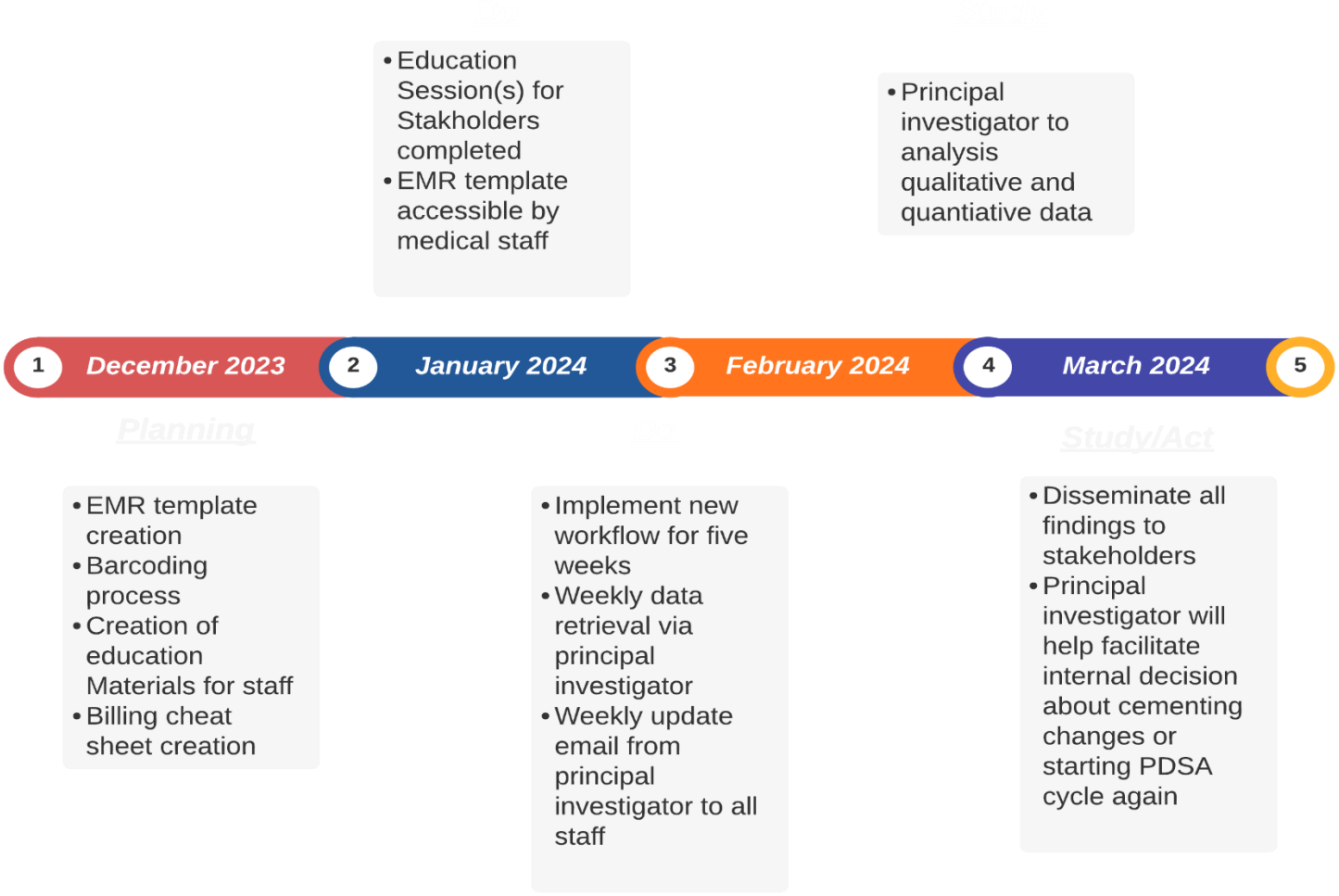
This quality improvement initiative took place at a small rural Montana family practice clinic and focused interventions on staff workflow, role delineation for clinic staff, and documentation process to improve advanced care planning delivery to patients aged 65 years or older with Medicare. Outcome measures assessed included: staff education development and completion, implementation of staff workflow and role changes, development and use of a provider documentation template, ACP document accessibility within the EMR by designating a uniform location, and improvement in CMS MIPS scores. The pilot intervention took place over a five-week period in January, February, and March of 2024 and aimed to improve the stakeholder ability to provide ACP services in a manner consistent with the previously outlined evidence-based standards (see Figure 3)

Intervention and Implementation. The intervention began with preparation of all materials and staff workflow by the project principal investigator (PI) who worked closely with the clinic manager. Materials development included preparation of the provider billing cheat sheet utilizing the Medicare Learning Network ACP fact sheet. Secondly, creation of the standardized provider ACP documentation template modeled after the Respecting Choices billing guidelines, to include all necessary components for full CMS reimbursement. Thirdly, standardized patient educational materials on advanced directives provided to patients at check-in by the front desk staff. The document utilized, as decided by the project principal investigator and supported by the clinic manager, was the free "*My Choices Advanced Directive*" provided via the State of Montana. Lastly, integration of completed advanced directive documents into the current barcoding system

for scanning patient documents into the “medical record” section of each patient’s chart. These foundation tasks were followed by an education session of all providers, medical assistants, front desk staff, clinic manager, and billing specialists. The clinic manager assisted in scheduling the staff education session to accommodate the clinic schedule and mitigate interruption to patient care. The education session included visual, oral, and written information regarding: who was eligible for the ACP discussions during the intervention period, what types of patient visits were eligible, how to bill for ACP discussions and presentation of the billing cheat sheet, overview of the new EMR template accessed via the “.dot” phrase system in the EMR, new staff role delineation and ACP workflow (see Figure 4), and routing of new barcoded completed advanced directive documents for scanning to the patient EMR. This education session also introduced MIPS scoring, the pre-project scores for the practice, future goals, and financial implications of suboptimal performance.

Second steps began in late January and at this time the new process was piloted for five weeks. During this five-week period, the project PI communicated weekly with all stakeholders via email check-ins to facilitate timely communication and maintain an open dialogue. These emails contained the weekly reports of progress via data extracted from the EMR and provided clinic staff the opportunity to communicate feedback regarding implemented interventions and ask questions in real-time. The PI was available intermittently on-site for problem-solving, concerns, and questions when they arose. The project’s PI on-site schedule was shared with the clinic staff within the weekly emails.

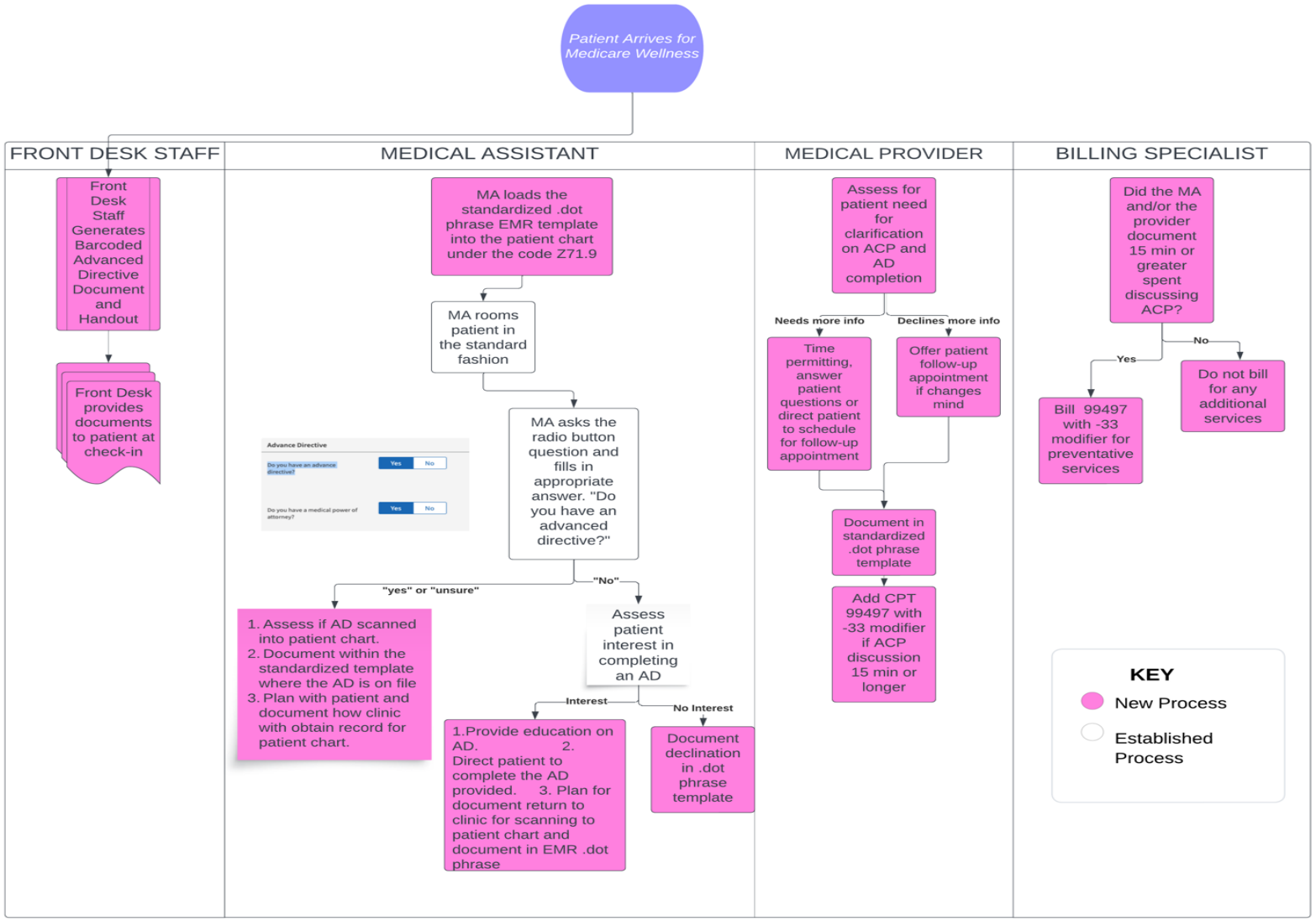
Figure 3. Implementation Timeline



The new ACP workflow (see Figure 4) added several significant steps to the pre-project process and denoted who was responsible for completing each task. Front desk staff had initial contact with the patient at appointment check-in. Front desk staff provided patients with the "*My Choices Montana Advanced Directive*" packet as part of their wellness visit pre-appointment paperwork. This packet was comprised of an introduction to ACP and the necessary documents for completing an advanced directive, naming a MPOA, and routing these documents to the Montana End-of-Life Registry. The advanced directive, MPOA, and end-of-life registry documents were generated and printed from the patient's EMR and marked with a barcode, like other patient documents in the current system. The MA loaded the new ACP documentation template (see Figure 5) into the provider's assessment and plan section in the EMR under the code Z71.9. The use of this code was not a process change. Additional new processes for the MA included documentation within the new EMR template regarding discussion and planning, along with how to receive and store the completed *"My Choices"* document within the patient chart. The medical provider utilized the new EMR template and was intended to have increased involvement in the ACP process by soliciting questions about the ACP process, explaining the significance of ACP to normalize the recommendation to complete the "*My Choices*" document, and offering the patient a follow-up appointment if more discussion was desired or deemed necessary. If a follow-up appointment was indicated, the provider would note the need to schedule on the paper bill, which was given to the patient who then presented it to front desk staff at the check-out of their appointment. This was not a new process change. Importantly, the provider would document total time for ACP discussion within the specified section of the EMR template and add the additional CPT code 99497 with the -33 modifier if the total ACP

discussion time was 15 minutes or greater. Lastly, the billing specialist would review the chart per the usual process and add or remove this code if the provider missed the step or coded incorrectly based on time.

Figure 4. Swimlane: New ACP Workflow and Role Delineation



No additional costs were incurred to implement this quality improvement project. The PI and the clinic manager collaborated to choose timing for the education session that did not impact patient appointment slots and therefore did not lessen productivity. Based on staffing availability to attend the education session, more than one session was available to be offered if needed. Necessary materials and supplies for this project included a printer, paper, ink, and the EMR system. These materials were already available at the clinic and included in annual budgeting. Furthermore, educational materials on advanced directives were already being printed and provided to patients, so switching to a new and standardized "*My Choices*" document would not incur any additional costs. The "*My Choices*" document was not copyrighted and free to demand print as needed.

Barriers to implementation comprised human factors associated with staffing instability, competing practice demands, and staff interprofessional team dynamics resulted from changing leadership. Although the clinic manager was a very new position, created during the planning stages of this project, she was a champion of this quality improvement initiative. However, in this new role, roadblocks from competing leadership objectives were present, preventing fulfillment of manager assigned job duties. Under these systems circumstances, staff may have perceived the ACP process as additional work in a time when they were already short-staffed and experiencing leadership transition. It was also reasonable to anticipate lack of time as a barrier. A wellness visit was allotted 45 minutes and already a significant amount was needing to be completed in this visit type. It is possible that staff felt there was not enough time to cover the ACP topic more thoroughly. However, the new process encouraged providers to gauge the individual time needs for each patient and schedule a follow-up if necessary. Lastly, the

implementation period was during the flu season, and it was reasonable to expect staffing absence related to illness which could have impacted project success.

Figure 5. ACP Documentation Template

ACP Documentation Template (.ACP)

1. Patient consents to discuss advance care planning.

OR
Met with (healthcare agent name) to discuss ACP for (patient name). (Patient name) was unable to participate in this conversation due to (reason).
OR
ACP discussion offered to patient. Declines to discuss today due to: (provide reason)

1. Patient's current medical state is (description). Our ACP conversation included a discussion about:

− The value and importance of ACP.
− Experiences with loved ones who have been seriously ill or have died.
− Exploration of personal, cultural, or spiritual beliefs that might influence medical decisions.
− Exploration of goals of care in the event of a sudden injury, illness, or exacerbation of current health condition (s).
− Identification of MPOA.
− Review and update, or completion of a Montana State AD

2. The patient was provided with the My Choices Advanced Directive Document today and it:

-Was completed today and will be scanned into the patient chart
OR
-Is located (where) and the patient will provide a copy via (how? Mail? Drop off? Portal?)
OR
-The patient will take the advanced directive today and return via (how? Mail? Drop off? Portal?)

Duration of discussion in minutes:

Evaluation and Analysis

Evaluation utilized EMR data, abstracted weekly by the PI, to determine the success of the five outcome measures of the project. The principal investigator accessed the EMR to assess all provider schedules from the previous week for eligible visit types and abstracted necessary data from these patient EMR charts. This quantitative data was organized on an Excel spreadsheet and divided by weekly totals (see Appendix B). Descriptive statistics were used, specifically percentages, to summarize key findings for each weekly period. Findings were displayed on a bar graph and shared weekly with project stakeholders.

Qualitative data was also solicited from the involved stakeholders after completion of the education session(s) and the five-week pilot period. Participation in staff surveys was completely voluntary. This data was collected via two separate and anonymous online surveys containing structured and open-ended questions about the education session and staff experience, along with acceptability of the new process changes. The PI analyzed each survey, summarized themes, and reported this information back to the stakeholders in the final project summary provided at the conclusion of the pilot period.

Safety and Confidentiality

The Doctor of Nursing Practice Project Proposal initiative was submitted to the Montana State University (MSU) Internal Review Board (IRB) for approval in December 2023. The project site did not have an internal review board, but the site representative consented to the full implementation of this project at their site. Confidentiality of data was strictly maintained. No protected health information was obtained or documented. All EMR data was maintained on a

password protected server and saved within the password protected EMR system. No paper copies of reports were generated or maintained. The principal investigator only accessed patient charts for abstraction of data. Data points collected were not associated with protected health information. Data was stored in a password protected Excel spreadsheet; accessed only by the PI. No personal or identifying information was removed from the site. Qualitative data collected for the post-education and post-pilot survey was stored in a password protected server and remained anonymous to protect staff identity and encourage authentic feedback without fear of reprisal.

CHAPTER THREE

QUALITY IMPROVEMENT MANUSCRIPT

Contribution of Authors and Co-Authors

Manuscript in Chapter 3

Author: Brittany Salley-Rains

Contributions: Principal Investigator, Microsystem Assessment, Literature Review, Implementation, Data Analysis, Manuscript Preparation

Co-Author: Amanda Lucas, DNP

Contributions: Editorial Review, Project Design Guidance, Result Oversight, Content Approval

Co-Author: Alice Running, PhD

Contributions: Editorial Review

Manuscript Information

Brittany Salley-Rains, Amanda Lucas, Alice Running

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Abstract

Background: Advanced Care Planning (ACP) is an ongoing process where medical provider(s) combine clinical expertise with patient values to plan for end-of-life. Successful ACP results in goal-concordant care; completion of advanced directives; and ensures satisfaction of Centers for Medicaid and Medicare Services (CMS) quality metrics.

Local Problem: The ACP workflow, patient education, and ACP documentation at the project site was not standardized. Average satisfaction for CMS ACP Registry quality metrics, targeting adults 65 years or older, was 63% average for the previous three years, which fell below the 100% CMS benchmark.

Methods: The Plan-Do-Study-Act framework was used at a primary care office in the Western United States. A microsystem assessment and ACP quality metrics were reviewed pre-intervention. Descriptive statistical analysis of outcomes was monitored over five weeks.

Interventions: Evidence-based interventions included: staff education; standard EMR documentation and template development; new ACP workflow and role delineation; and selection of standard ACP patient education material.

Results: Seventy-five percent of staff received ACP education. Seventy-one percent of eligible patients received the ACP packet. The standard EMR template was used with 57% of eligible visits. ACP document completion and plan was prepared for 71% of eligible visits.

Conclusion: Although project staff education, workflow, and EMR template improved ACP assessment and delivery by team medical assistants (MA), cumulative staff use of the EMR template increased to only 57% as limited time and discussion occurred to necessitate documentation. All interventions were only partially adopted. Full adoption would require further support including the designation of a staff leader.

Keywords: Advanced Care Planning, MIPS, Quality Improvement, Primary Care

Introduction

Due to increases in medical technology the United States population is living longer than ever before (Ansah & Chu, 2022). Advancing age, in conjunction with sedentary lifestyles and other social determinants of health, contributes to an ever-increasing burden of chronic illness and therefore increases complexity of health care management. But what happens when our bodies finally begin to fail? How does the medical community prepare patients for the inevitability of end-of-life care? One answer is advanced care planning (ACP). ACP is a process whereby a medical provider and patient determine illness prognosis and corresponding desires for medical intervention towards the end-of-life. The medical provider combines their clinical expertise with the values and preferences of the patient to plan interventions, such as desire for artificial nutrition, cardiopulmonary resuscitation (CPR), and naming a medical power of attorney (MPOA) for surrogate medical decision-making. Without advanced directives (AD) and documentation of ACP discussions in the electronic medical record (EMR), prior to emergency or precipitous decline in their health, patients and their families are vulnerable to unwanted and unnecessary medical intervention, hospital admission, and death (McMahan, Tellez, & Sudore, 2020). Primary care providers are well-suited to discuss ACP with their patients and, when considered a preventative health service, ideally ACP is broached at the annual wellness visit.

Review of the Literature

The scoping review of the literature was completed to investigate the best practice, tool, or standard for completion of ACP in the primary care setting for patients aged 65 years or older. PRISMA guidelines (2009), were used to locate literature relevant to this topic and the USPSTF

grading criteria utilized to evaluate literature quality. Fourteen studies met inclusion criteria including both meta-analysis and primary studies. Synthesis of relevant studies reveled four key components for quality improvement of ACP discussions, documentation, and improved patient outcomes in primary care. These included: provider education to increase communication skills and ability to facilitate value-based goals of care discussions, standardization of EMR templates, clearly defined staff role delineation and workflow, and a multidisciplinary team approach utilizing both licensed clinicians and support staff. Efforts to increase ACP in primary care should contain a provider and staff educational element to ensure foundational knowledge and concepts are known across disciplines. Leveraging EMR systems to standardize outcomes is a practical method to assist in comprehensive ACP throughout a health care system. By creating customary templates, order sets, and areas for document storage, information can easily be revisited and updated, goals of care shared across health care settings, and quality metrics for reimbursement captured (Fang & de Peralta, 2022; Huber et al., 2018; Hudson Lucas & Dimmer, 2021). ACP delivered via a collaborative teamwork approach, leveraging collective staff abilities could relieve barriers related to limited provider time and reported lack of systems support (Fang & de Peralta, 2022; Hafid et al., 2021; Hudson Lucas & Dimmer, 2021; Lakin et al., 2017; Marino et al., 2021).

Problem

Through a microsystem assessment of the project site, it was determined that the organization was enrolled in ACP registry completion as part of the Centers for Medicaid and Medicare Service (CMS) Merit-Based Incentive Payment System (MIPS) performance standards and satisfaction of this metric was suboptimal at 63%. Pre-project process mapping showed the

clinical site lacked any standard process or patient educational materials to promote ACP. No provider EMR reminders or documentation templates were in use. Medical assistants (MAs) were the primary staff completing ACP intake and documentation. However, without a follow-up plan being generated by provider or MA, the current process did not include steps to ensure that ACP documents, such as advanced directives (AD), were located and accessible in the EMR. Further, project site staff were unaware of the documentation criteria for MIPS reimbursement and pre-project EMR documentation was inconsistent and erroneous.

Conceptual Framework. The quality improvement (QI) initiative was developed using the Institute for Health Care Improvement (IHI) Quality Improvement Essentials Toolkit and included the Plan-Do-Study-Act (PDSA) framework. The PDSA framework was chosen as it provided the opportunity for a brief pilot intervention in weekly increments and modifications based on project results and stakeholder feedback.

Aims. The purpose of this quality initiative was to improve ACP delivery in a small family practice clinic to meet MIPS standards with a goal to increase to 100% metric satisfaction for the 2024 performance year. Measurable outcomes were developed to assess the success of this QI initiative and aimed to standardize the current ACP process, increase the number of eligible patients receiving quality ACP services, and ensure ACP documents were accessible to all healthcare providers in the EMR.

Methods

Context

This QI project took place at a small rural Montana family practice clinic with 501c3 non-profit status providing primary care and reproductive health care. Two medical doctors (MDs), two physicians' assistants (PAs), and three medical assistants make up the primary care medical team and provide health care services to over 3000 patients annually. In 2022, approximately 14% of patients were over age 65, and in 2022 35%, (N=133), patients over age 65, were billed for an annual Medicare wellness visit.

Despite opportunities for ACP during wellness visits at this practice, satisfaction of the MIPS ACP metric was suboptimal with an average of 63% receiving ACP discussion for the previous three years. Further, the site workflow did not include standard ACP documentation templates, dedicated appointments for ACP, nor did providers ever bill for specific ACP discussions using the approved CMS codes. This indicated that ACP was not adequately promoted, as specified by the literature review, both from a financial sustainability and a patient quality care standpoint.

Interventions and Implementation. Based on best practices discovered in the literature review, five individual interventions were selected for project implementation. Interventions included: completion of an all-staff education session, standardized ACP workflow with role delineation, standardized EMR documentation template, standardized AD document with patient-specific barcode and EMR routing procedure, and provider billing and coding guidelines.

Pre-implementation began with preparation of all materials and creation of staff workflow by the project principal investigator (PI). Materials development included preparation

of the provider billing cheat sheet utilizing the Medicare Learning Network ACP fact sheet (https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf) and creation of a standardized provider ACP documentation template (see Figure 3.1) modeled after the Respecting Choices billing guidelines and including all necessary components for full CMS reimbursement (Centers for Medicaid and Medicare Services 2023; Respecting Choices, 2018). In conjunction with the clinic manager, the "*My Choices Montana Advanced Directive*" packet was chosen as the standard document provided to all eligible patients (Montana Department of Justice, 2017). This packet included an introduction to ACP and the necessary documents for completing an advanced directive (AD), naming a MPOA, and routing these documents to the Montana End-of-Life Registry, along with integration into the current EMR barcoding system for patient document scanning. Prior to the five-week pilot period, the PI conducted two in-person education sessions and one separate modified education for two providers and the billing staff. These sessions included visual, oral, and written information regarding: who is eligible for the ACP discussions during the intervention period, what types of patient visits are eligible; how to bill for ACP discussions and presentation of the billing cheat sheet, overview of the new EMR template to be accessed via the ".dot phrase" system in the EMR, new staff role delineation and ACP workflow and routing of new barcoded completed AD documents for scanning to the patient EMR. After completion of the education session, all participants were asked to complete an anonymous survey disseminated via email to gauge understanding of the material.

Figure 3.1. ACP Documentation Template

ACP Documentation Template (.ACP)

1. Patient consents to discuss advance care planning.

OR

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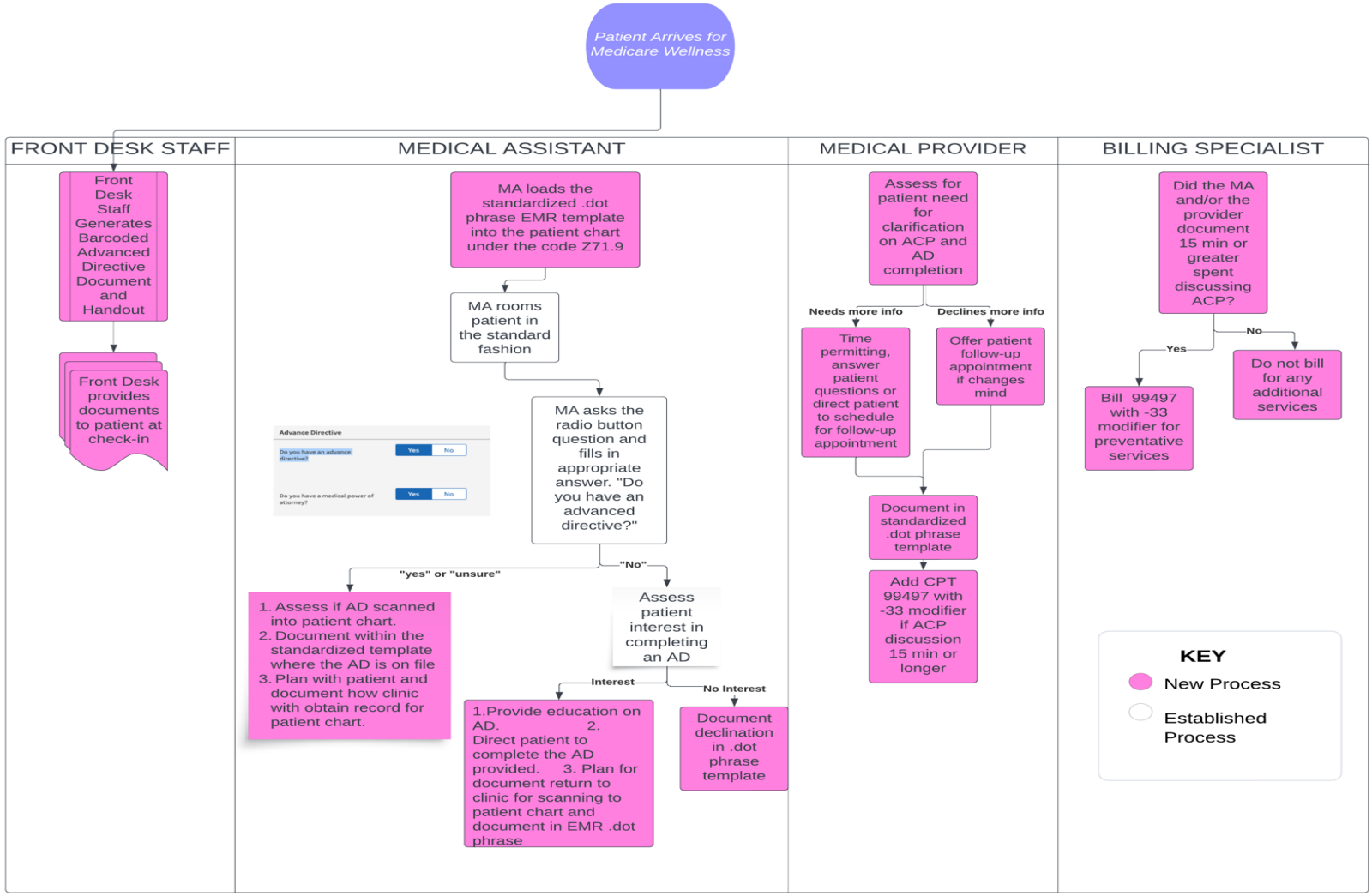
-Is located (where) and the patient will provide a copy via (how? Mail? Drop off? Portal?)

OR

-The patient will take the advanced directive today and return via (how? Mail? Drop off? Portal?)

Duration of discussion in minutes:

Figure 3.2. New ACP Workflow Swimlane



Project initiation began on January 29th, 2024 and implemented the new ACP workflow (see Figure 3.2). Front desk staff had initial contact with Medicare wellness visit patients at check-in and were instructed to provide the "*My Choices Montana Advanced Directive*" packet to all patients as part of the pre-appointment paperwork. This barcoded packet was generated via the patient's EMR which was the same process as other patient clinical documents. Prior to rooming the eligible patients, the MA loaded the new ACP documentation template into the provider's assessment and plan section in the EMR under the code Z71.9. The use of this code was not a process change. During the rooming process, the MA assessed receipt of the *"My Choices"* packet and documented it in the now standardized section of the EMR template. The MA also assessed if the patient had an ACP document on file by looking within the patient EMR. Finally, the MA planned with the patient to update the current document or complete a new AD and documented this plan within the newly developed EMR template. Additionally, the MA engaged in a "warm hand-off" with the medical provider to relay if the patient required additional assistance or discussion for completion of the AD.

The medical provider solicited questions or clarifications from the patient, normalized the ACP process, and assessed if the patient needed a follow-up appointment to complete the AD. If so, the provider was instructed to note the need to schedule on the paper bill given to the patient at the end of the appointment and handed to the front desk upon check out. This is the current process for any type of follow-up appointment but had not before been applied to ACP follow-ups. Importantly, the provider was responsible for adding the additional CPT code 99497 with -33 modifier if the total ACP discussion time was 15 minutes or greater. If present, these codes were reviewed by the billing specialist for accuracy.

During the 5-week pilot, weekly the project PI communicated on Thursdays with all stakeholders via email and spent four hours onsite allowing for project evaluation and clinic staff feedback communication.

Measures. The five project outcome measures were stratified as short-term completion during pre-implementation, mid-term reflecting goals for project completion, and long-term representing an end-of-year timeline outside the immediate project (see Appendix C). The PI used a data tracking tool to document if: ACP documents were provided and documented; the standardized EMR template was used; ACP documents were scanned into the EMR; a provider documentation template was used; if documents were to be completed and obtained later, or if the patient refused ACP services. The billing specialist tracked CMS code 99497 and 99498 in the usual manner for coding verification of all patient visits. The billing specialist reported to the PI if either code was used.

Data Collection. Weekly data extraction by the PI included manually searching provider schedules for Medicare wellness visits performed in the previous week. The PI confirmed visit eligibility by checking patient insurance and age and then reviewed the patient's full encounter summary for previously outlined project measures. In addition to the eligible Medicare wellness visits, the PI reviewed the EMR for all patients aged 65 years or older seen in the previous week to review Medicare status and asses the prior year's appointments to ascertain if a wellness visit had been completed.

Analysis. Descriptive statistics were employed, with bar graphs used to illustrate weekly and cumulative results.

Ethical Considerations and Data Management. The PI conducted all schedule monitoring and chart review within the organization. All data was de-identified and saved as percentages in a password protected Excel spreadsheet. This project received full approval from the Montana State University (MSU) Internal Review Board (IRB) in December 2023. The project site did not have an IRB, but the site representative consented to the full project implementation.

Results

Seven eligible visits occurred during the five-week implementation period. No ACP follow-up appointments were scheduled, and CPT code 99497 or 99498 was not utilized by the provider for ACP discussions of greater than fifteen minutes. Goal one noted by January 5th, 2024, 100% of staff would attend the education sessions. This goal was not achieved as only 73% of the necessary staff were present at the two separate sessions scheduled before January 5th. Goal two specified that by week three and through project completion 100% of eligible patients would receive the "My Choices" packet. Receipt of the packet was noted on the EMR template and by week three and through project completion 100% of eligible patients did receive the packet (see Figure 3.3).

Goal three specified by week three and through project completion 90% of eligible patient visits would include the standard EMR template within the assessment and plan section of the patient EMR. This goal was partially met as by week three 100% of visits did include the include the template. However, in week four the percentage dropped to 0% and then increased back to 100% during week 5 (see Figure 3.3).

Goal four noted by week three of the implementation period and through project completion, 90% of Medicare wellness visits would include: (a) ACP documents scanned into

patient chart or; (b) note in the standardized documentation template stating when and how these documents will be procured and added to the patient chart OR; (c) notation in the EMR template that patient refused ACP. This goal was partially met as by week three 100% of eligible visits included the appropriate information. However, during week four the percentage dropped to 66% and then increased back to 100% satisfaction during week five (see Figure 3.3).

Goal five specified that by December 31st, 2024, MIPS scores will increase by 37% from an average of 63% to 100% satisfied for the entire 2024 performance period. Results of this goal were unable to be collected as the end of the 2024 performance year has yet to be completed. For project sustainability, future data collection was determined to be the responsibility of the clinic manager.

The post-education session and post-pilot anonymous surveys combining both free-form commentary and Likert-type questions were not included in formal project outcome measures. However, 62% of stakeholders shared feedback after the education session and 53% completed the post-pilot survey (see Figures 3.4 and 3.5).

Figure 3.3. Smart Goal Results

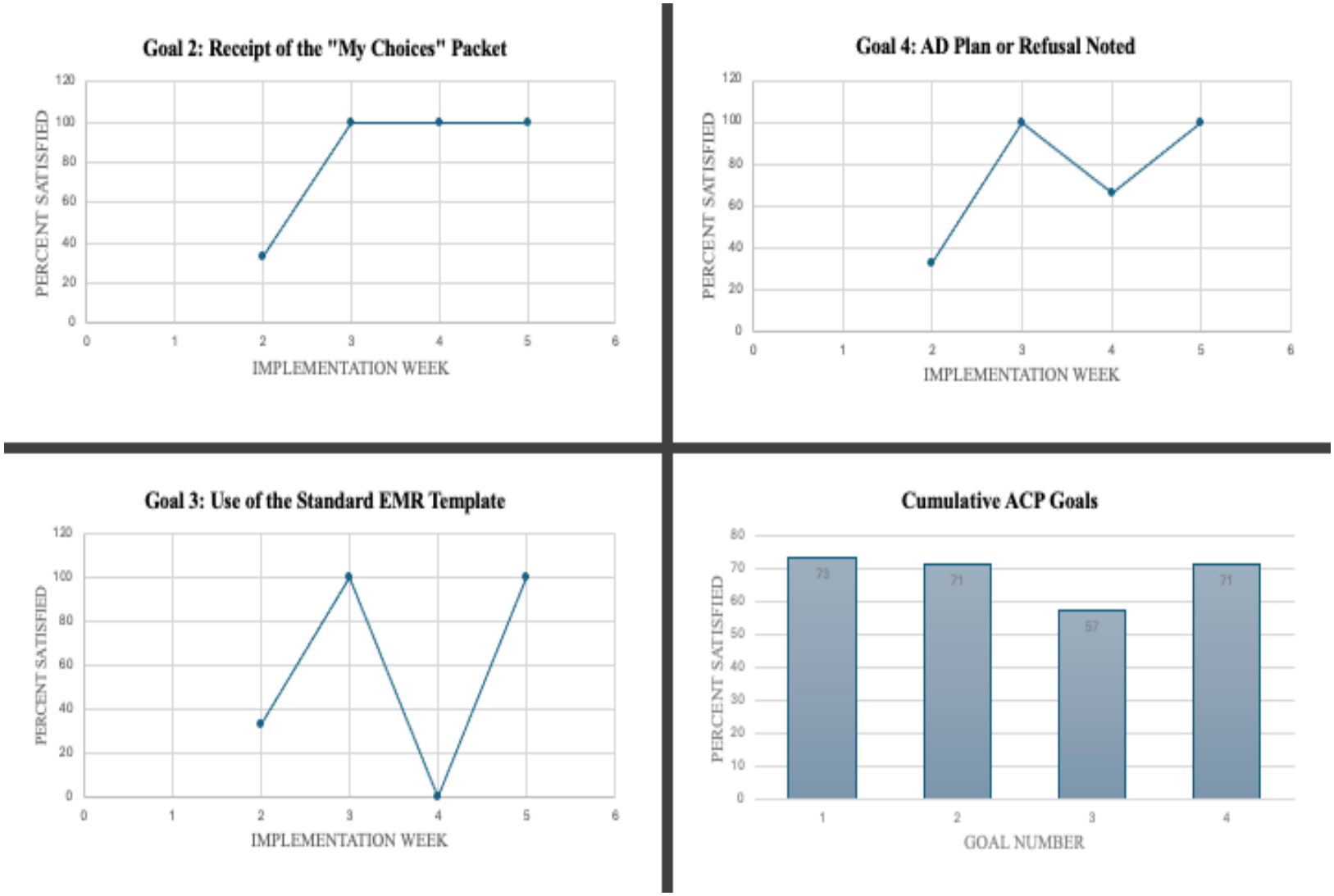


Figure 3.4. Post-Education and Post-Pilot Survey Results

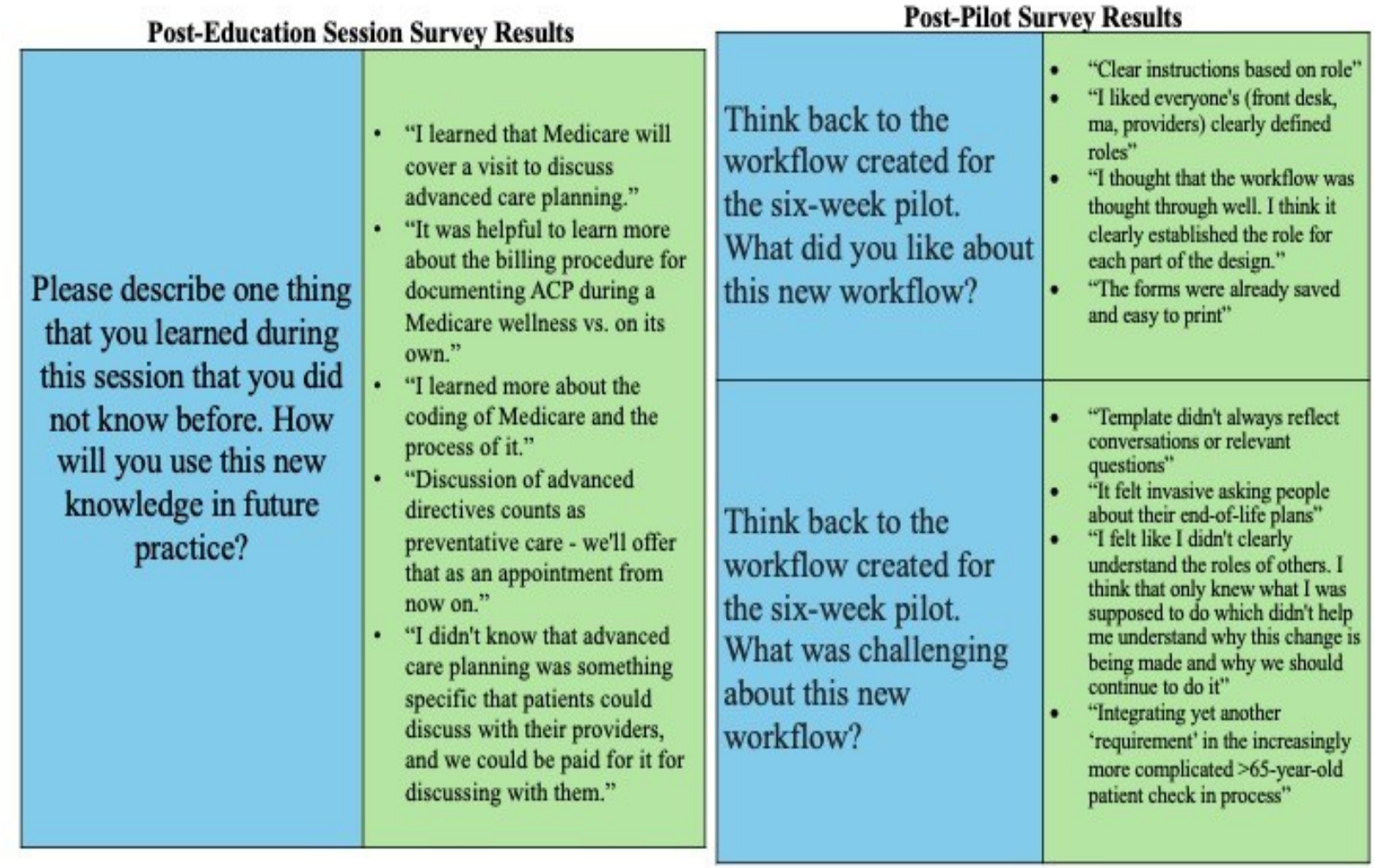
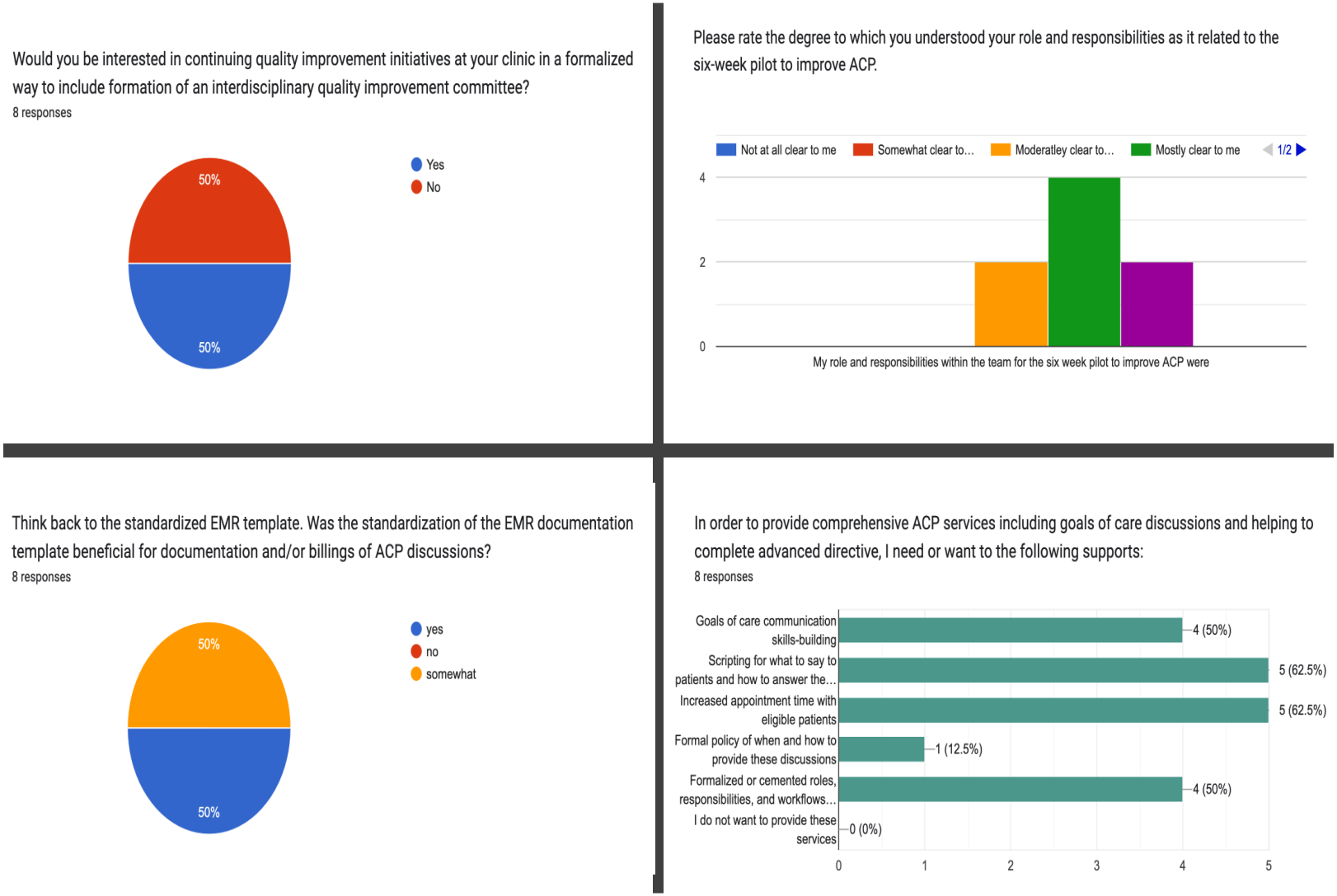


Figure 3.5. Post Pilot Survey Results



Discussion

Goal one was partially met at 73%. Though the initial two in-person education sessions were well attended by the front desk and MA staff, two medical providers and the billing department staff were not present. As such, the PI did create, for these four staff, a condensed educational PowerPoint with verbally recorded presentation and ACP pilot instructions which was disseminated after January 5th, 2024. Due to time constraints, the PI did not receive confirmation of viewing. During week one of pilot implementation, the PI sought to confirm stakeholder understanding of eligibility requirements and ACP workflow via in-person discussions with billing staff and providers who viewed the condensed PowerPoint. Via these check-ins, the PI discovered a lack of clarity as to patient eligibility requirements for the pilot period, location of the EMR template, and expectations for medical provider increased involvement as outlined in the ACP workflow. These misunderstandings were clarified verbally during the week one in-person check-ins and reiterated via the week one all-staff email. Due to lack of provider engagement with weekly emails, it is unknown if these additional conversations impacted outcome goals.

Data points represented in the bar graphs for goals two through four begin in week two as no eligible visits took place during week one. Patient receipt of the *"My Choices"* packet increased from 33% to 100% satisfied from week two through the remainder of the pilot period. Fewer packets received by patients followed by an increase was expected as staff incorporated the new workflow into the daily routine. Because data extraction by the PI relied heavily on the contents of the EMR template to assess if the patient received the packet, it should be noted that less than 100% goal satisfaction for goal two in week two could also be an error in EMR

template documentation by the MA. As such this may not represent actual failure of the front desk staff to provide the packet.

Similarly, goal three was low at 33% satisfaction for week two with an increase to 100% satisfaction for week three. During week two the PI shared feedback with one MA staff about proper EMR template use resulting in an increase to 100% satisfaction during week three. While real-time correction was provided to the individual MA, the summary and results were shared with all involved staff via week three email check-in. However, data reflects a secondary decrease during week four in appropriate use in the EMR template. This may be due to the failure of MA staff to read the regular email or failure to understand appropriate use of the document.

Goal four followed a comparable pattern of low satisfaction at 33% in week two, rising to 100% satisfied in week three, and decreasing to 66% satisfaction in week four. This fluctuation may be due to variables outlined for goals two and three. However, interpretation of all results was complicated by reliance on the EMR template to gather needed data points and therefore may be skewed.

Currently data is insufficient to measure satisfaction of goal five, as an increase in MIPS performance metrics for the 2024 performance period is yet able to be measured. Substandard completion rates of wellness visits overall, an unintentional finding during data abstraction, may be contributory to future diminished satisfaction of goal five and prohibit considerable improvement in MIPS metric satisfaction. Over the five-week pilot, the PI noted twenty-two patients aged 65 years or older with Medicare had not been seen for a yearly wellness visit in the last year. In fact, some patients had not been seen for several years. This unforeseen finding

presents implications for this QI initiative; future ACP discussions; preventative health maintenance completion; and MIPS metric satisfaction. Reasons for missed or incomplete yearly wellness visits are unclear. Considering this pilot occurred shortly post-coronavirus pandemic, it is reasonable to consider that preventative health maintenance was delayed by the project site in favor of more acute concerns, or medical staff burnout and strain associated with increasing medical uncertainty brought on by the pandemic, limited the focus on preventative care. It is also possible that changing leadership and site priorities, including reproductive health targeting a younger patient population, were contributory factors.

While not an official QI metric for success, informal anonymous post-education and post-pilot survey results did provide insight into staff project experience and elucidate possible barriers to successful QI completion. As outlined in Figure 3.4, staff did report increased knowledge and awareness of MIPS, along with new knowledge acquisition about billing for ACP. However, increased knowledge did not necessarily translate to increased confidence to provide ACP delivery and assessment, as evidenced by staff request for additional education and scripting for patient ACP interactions (see Figure 3.5). Staff who participated in the post-pilot survey expressed mixed responses to the QI initiative experience (see Figure 3.5). Notably, many respondents discussed role clarity and delineation as positive aspects of the new ACP workflow, while others stated that they were unsure of other staff's roles in the process. Further, when asked what support they would need moving forward with ACP discussions, respondents indicated clear roles, responsibilities, and workflow; scripting for patient communications; and increased appointment time with eligible patients. Respondents also acknowledged the few numbers of eligible patients with which practice the new ACP workflow. According to respondents, 50% felt

the EMR template was helpful, while 50% stated it was only somewhat helpful. Commentary provided by post -pilot survey respondents indicated that the EMR template did not always "fit" the conversation that occurred with the patient. As anticipated, some respondents called attention to overburdened staff, lack of adequate staffing, and lack of time, paralleling the literature indicated issues as barriers to successful project implementation (Scholten et al., 2018; (Sonenberg & Sepulveda-Pacsi, 2018).

Sustainability recommendations for this project include designation of an internal stakeholder to monitor schedules and flag for wellness visits and ACP assessment and discussion. The designation of a key staff member to lead this initiative in the future is crucial for long-term success and all-staff buy-in. After the initial patient visit, development of a follow-up system for AD document tracking would be necessary to ensure timely receipt and EMR storage of completed AD documents. Based on feedback from staff surveys, continued role delineation and clear division of responsibilities is also necessary to support project maintenance. Project adaption ultimately would be delegated to site staff. However, suggestions above would be highly encouraged, as would additional PDSA cycles to allow for adaptation and re-testing of modifications.

Limitations

Several limitations impact the generalizability of this QI project including a small sample size of only seven eligible patient visits and only a single site of implementation. The relatively short pilot period also impacts generalizability. Ideally, a second or third PDSA cycle could have been implemented after stakeholder feedback and appropriate adjustments. Significant practice

barriers also limit this QI initiative including changing leadership during project implementation and lack of provider participation in project feedback.

Construct and content validity are threatened by the reliance on MA documentation to abstract necessary data and data extraction performed by one individual with no secondary check to assure that data was not missed or omitted from analysis. Further, reliability of these results cannot be confirmed as test-retest reliability was unmeasurable in project design, nor was there the ability to control variables as in a random control trial.

Implications

The data from this QI initiative suggests that incorporation of standard EMR templates, workflows, ACP patient education handouts, and stakeholder education is feasible and effective to increase ACP delivery in the primary care setting. However, barriers outlined in the literature are also presented during the pilot. Specifically, adequate staffing and practice management, as well as reported concerns for sufficient time to complete necessary interventions. Continuation of interventions implemented would require a designated internal staff member to facilitate patient screening and EMR flagging for both wellness checks and ACP evaluation.

Future QI initiatives should be undertaken in primary care offices to assess sustainability of these interventions. Longer implementation periods with additional PDSA cycles would provide more robust data with less impact from outlier data points and small sample size. Designation of a secondary staff stakeholder to provide additional data review would improve validity of data, as would less reliance on data abstraction from the EMR template. Alternative methods for data capture are also warranted, as reliance on the EMR template monitoring proved challenging and potentially misrepresentative of actual events. Lastly, future studies could focus

on the best follow-up methods to ensure ACP documents are completed by the patient after the appointment, returned to the clinic, and scanned to the patient EMR.

Conclusion

Advanced care planning is a multi-faceted and individualized process requiring all-staff participation for success. When completed correctly, literature does demonstrate improved provider-patient relationships, goal-concordant care, and increased fiscal sustainability for health care practices (McMahan, Tellez, & Sudore, 2020). Best practice as outlined in the literature and supported through this initiative involves standardization of process, staff role delineation, and standardized documentation for model completion of ACP that meets both patient and provider expectations. Utilization of systems-based tools to map and enhance ACP, as well as shared responsibility of the health care team in program planning, evaluation, and delivery would strengthen ACP across the health care system. With adequate training and the above mentioned EMR tools, any member of the health care team could provide quality ACP to patients.

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CHAPTER FOUR

ADVANCED NURSING ESSENTIALS REFLECTION

The DNP Essentials

The American Association of the College of Nurses (2021) provides benchmarks for evaluation of core competencies of nursing at the undergraduate and graduate level. As demonstration of my fulfillment of these competencies I addressed several domains and sub-competencies which evidence my growth and satisfaction of these nursing education requirements through the Doctor of Nursing Practice (DNP), Family Nurse Practitioner (FNP) program at Montana State University (MSU) College of Nursing.

Domain 1: Knowledge for Nursing Practice and Domain 4: Scholarship

Domain one emphasizes the "integration, translation, and application of established and evolving disciplinary nursing knowledge and ways of knowing, as well as knowledge from other disciplines, including a foundation in liberal arts and natural and social sciences" (AACN, 2021, p. 27). The inclusion of multiple ways of knowing in clinical decision-making distinguishes nursing as an independent profession (AACN, 2021). Specifically, sub-competency 1.1e explicates the ability of advanced practice nurses (APRN) to translate evidence from nursing science as well as other sciences into practice (AACN, 2021). Sub-competency 4.2f emphasizes diverse sources of evidence to inform practice (AACN, 2021). Integration of diverse disciplines and evidence sources to inform quality patient care and clinical decision making has been demonstrated via two examples. Firstly, in the course Evidence Based Practice II, my team and I

reviewed the literature to determine the efficacy of alternative therapies, namely acupuncture, as a treatment modality for depression. We included quantitative and qualitative sources to understand the subjective experience of people impacted by depression and their experience with selective serotonin reuptake inhibitors and/or acupuncture therapy. The appraisal of the literature revealed that acupuncture is a non-harmful potentially beneficial modality for treatment of depression and side effects from SSRI medications. However, the evidence is inconsistent as far as placement of acupuncture needles, sample size, and scales used to measure outcomes.

Similarly, Advanced Pharmacology provided an opportunity to once again look at the research related to western medicine versus alternative or natural treatment. Knowledge that menopause is undertreated led me to explore management of the side-effects. Specifically, vasomotor symptoms of menopause can severely impact sleep, work performance, and overall quality of life. As part of this course, I researched safety, efficacy, mechanism of action, cost, and availability of several non-pharmacological therapies including soy isoflavones, red clover, black cohosh, and others to determine utility in menopausal therapy. By investigating different disciplines and understanding the current evidence or lack thereof, I can integrate and translate this knowledge into practice with the appropriate patient. A wide lens when approaching patient care allows for tailored treatment plans and fosters positive trusting relationships between provider and patient.

Domain 2: Person-Centered Care

According to the AACN (2021, p. 29), “Person-centered care focuses on the individual within multiple complicated contexts, including family and/or important others. Person-centered care is holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and

developmentally appropriate." When the APRN utilizes person-centered care, she distinguishes nursing practice as a disciple concerned with the whole patient and organizes care with respect for social determinants of health, encouraging empowerment, health engagement, and self-actualization of the patient.

In my nursing practice, I value this competency to build sustainable and trusting relationships with my patients. Fulfillment of this competency is evidenced by proficiency in sub-competency 2.8h, to apply counseling techniques, including motivational interviewing, to advance wellness and self-care management, and sub-competency 2.5i, to prioritize risk mitigation strategies to prevent or reduce adverse outcomes (AACN, 2021). Clinical experience throughout the MSU DNP, FNP program of study provided settings to practice patient-centered care. Risk and adverse health outcomes were mitigated through intentional individualized communication with patients. For example, one patient with comorbid diabetes type 2, hypertension, and hyperlipidemia was extremely resistant to escalate pharmacological treatment for diabetes which was uncontrolled with a hemoglobin A1c of greater than 8 mg/dL. The patient also was not amenable to statin or blood pressure medication therapies as primary prevention. Through motivational interviewing and additional health-literate appropriate education, I was able to discover what motivated these health decisions. With greater understanding of the risk of hyperglycemia over time combined with patient-specific risk factors, the patient agreed to begin a second pharmacological agent for diabetes and recommitted to consistent use of metformin. Ultimately, adverse health outcomes were reduced for the patient, team-based decision-making was achieved, and the patient experienced empowered which promotes self-engagement in care.

Domain 3: Population Health

The APRN is a leader in population health, in provision of equitable care, and health systems assessment to ensure optimized public health outcomes through prevention measures. “Population health spans the healthcare delivery continuum from public health prevention to disease management of populations” (AACN, 2021, p. 33). I have fulfilled the expectations of domain three in several capacities. Throughout my clinical rotations, a goal for each patient was to incorporate one preventative intervention to benefit individual and population health. For example, I most always review patient immunization status for gaps in care and offer these services regardless of the visit type. Proficiency of population health is also demonstrated via comprehension and action related to sub-competency 3.1j, which instructs the APRN to assess the efficacy of a system’s capability to serve a target sub-population’s healthcare need, and sub-competency 3.2e stating the APRN should challenge biases and barriers that impact population health outcomes (AACN, 2021). In Vulnerability and Health Care of Diverse Communities, I was fortunate to deeply explore and familiarize myself with the current and historical indigenous experience of health care. Via multi-dimensional media such as fiction, non-fiction, poetry, podcasts, historical writings, and more I was exposed to the historical and current injustices that shape indigenous health outcomes. Further, I participated in reflexive practice to understand my own biases and the multitude of barriers that this population faces to accessing health care. As a result of this scholarship, I have a nuanced understanding of intergenerational trauma and the systematic racism and policy that disadvantages Indigenous groups. Further, via the population health assessment, I identified key systems-level barriers to care including lack of funding for Indian Health Service facilities.

In addition to greater depth of understanding and knowledge, I practiced sub-competency 3.4h, to engage in strategies to influence policy change via Ethics, Law, Policy, and Health Care course (AACN, 2021). During the period of the course, policy detrimental to the wellbeing of the lesbian, gay, bisexual, transgender, queer (LGBTQ) community was introduced into the legislature. I engaged in a letter-writing strategy, leveraging my experience working with this population and expertise as a health care provider, to highlight the injurious consequences to population health if the policy were to be made into law. This proposed legislation did not pass and was not signed into law.

Domain 5: Quality and Safety and Domain 7: Systems-Based Practice

Quality and safety are interdependent and "as core values of nursing practice, enhance quality and minimize risk of harm to patients and providers through both system effectiveness and individual performance (AACN, 2021, p. 39). The doctorate prepared APRN is a leader in systems-level evaluation, guided by fundamental professional values such as our code of ethics, and employs evidence-based solutions as innovators in equitable and fiscally responsible health care delivery. Competency 5.1 precisely charges the APRN to apply quality improvement principles in care delivery (AACN, 2021, p. 39). Likewise, competency 7.1 denotes the APRN's ability to optimize system effectiveness through application of innovation and evidence-based practice (AACN, 2021). I have demonstrated my ability to fulfill this competency and lead in quality and safety via the planning and implementation of my quality improvement (QI) initiative to increase advanced care planning (ACP) in the primary care setting. As part of quality and safety care at the QI site, the adoption of evidence-based interventions contributed to safe care. Definitions of quality measures and outcomes were assessed via comprehensive literature

review and interventions planned to meet these benchmarks. ACP effectiveness was measured via tangible outcomes as outlined in the literature, such as completion of advanced directives. The QI initiative also utilized quality benchmarks via the Centers for Medicaid and Medicare services to evaluate both quality care and fiscal sustainability of the initiative. Interventions targeted both systems and individual level with the overall goal to improve quality and goal-concordant care for adults aged 65 years and older with Medicare.

Future Implications for Advanced Practice

As I advance my career as an APRN, I understand I represent nursing as a distinct discipline and approach. I am therefore charged with meeting the expectations of professionalism as outlined in Domain 9 and leadership via Domain 10. For example, in the future I will continue to advance equity and diversity in my practice setting by advocating for policies and procedures that are responsive to the unique needs of diverse communities and protective of individual human rights to equitable treatment and opportunities. For example, I may advocate for patient representatives to be consulted as to their needs and desires for services provided by the health care entity. As I have already done in my RN career, I will advocate for policies that allow for APRNs to work at the fullest extent of their license and scope. I will continue to reflect on my personal and professional practices and the fulfillment of nursing's core values. I will foster ethical behaviors and promote team-based care that is free of incivilities through modeling and policy development. When it is appropriate, I will participate in mentorship and contribute to the growth of the profession as well as take on formal leadership roles within my practice setting. Finally, I will maintain accountability to myself, my profession, and my patients in all aspects of my practice.

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APPENDICES

APPENDIX A

PRISMA FLOW DIAGRAM

Figure A1. PRISMA Flow Diagram



PRISMA 2009 Flow Diagram

Identification

Records identified through database searching (n =665)

Additional records identified through other sources (n =893)

Records after duplicates removed (n =729)

Screening

Records screened (n = 729)

Records excluded based on title and abstract (n = 681)

Eligibility

Full-text articles assessed for eligibility (n =29)

Full-text articles excluded
Not primary care or outpatient n= 6
Not elderly population n= 2
No outcome measured/ only barriers n=7

(n 15)

Included

Studies included in scoping review (n =14)

APPENDIX B

DATA COLLECTION TOOL

Figure B1. Data Collection Tool

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1		Goal 1			Goal 2			Goal 3			Goal 4			Goal 5		
2		Number of stakeholders who received education	Number of eligible stakeholders who received education	Percent	Number of patients eligible to receive the my choices packet	True number of patients to receive packet.	Percent	Number of eligible visit for use of the standard documentation template	Actual number of visits where documentation template was used.	Percent	Number of eligible visits where ACP documents are located or plan is completed.	Number of visits after three weeks of implementation that include ACP documents scanned into patient chart OR plan for retrieval, return, or procurement of documents noted in EMR template	Percent	MIPS score average for 2020, 2021, 2022 performance period	MIPS score for 2024 performance period	Percent Increase
3																
4	Week 1															
5																
6	Week 2															
7																
8	Week 3															
9																
10	Week 4															
11																
12	Week 5															
13																
14	Totals															

APPENDIX C

ACP SMART GOALS

Figure C1. ACP Smart Goals

<table>
<tr><td colspan="3">SMART Goal #1: By January 5th, 2024, 100% of stakeholders would receive training and education on new ACP process.
1. Who was eligible for ACP discussions?
2. What visit types were eligible for ACP discussions?
3. Discussed how to bill for ACP and presented billing cheat sheet.
4. Presented new EMR ".dot" phrase and confirmed staff access in EMR.
5. Presented "My Choices" advanced directive.
6. Clarified new role delineation and new processed for ACP workflow.
7. Presented new standardized advanced directive document with barcoding.
8. Educated on MIPS are how they impact practice.</td></tr>
<tr><td colspan="3">Description of strategies and resources used to accomplish goal.
The PI:
• Developed new process flow.
• Developed new billing cheat sheet.
• Developed new EMR template to be utilized in the assessment and plan section of the EMR.
The clinic manager:
• blocked time (s) for scheduled education and training</td></tr>
<tr><td>Data to be collected</td><td>Method of Collection and who is responsible</td><td>Planned data analysis</td></tr>
<tr><td>1. Numerator: number of stakeholders who attended education session
2. Denominator: all stakeholders eligible to attend education</td><td>PI kept track of all stakeholders who received education by signing roster upon completion</td><td>PI document the percent of stakeholders who received education in the Excel spreadsheet</td></tr>
<tr><td colspan="3">SMART Goal #2: By week three of implementation period and through project completion 100% of eligible patients who presented for Medicare wellness visits received the new "My Choices" advanced directive packet at check-in for their appointment.</td></tr>
<tr><td colspan="3">Description of strategies and resources used to accomplish goal.
The PI collaborated with the clinic manager:
- To have the "My Choices" advanced directive available to print with barcoding from the patient EMR.
The front desk staff:
- Generated and printed the "My Choices" document for every eligible patient and provided this packet in conjunction with other intake paper when the patient arrived for the Medicare wellness visit.
The medical assistant staff:
- Confirmed that the patient received the packet and documented it in the appropriate area in the new EMR template.</td></tr>
</table>

Figure C1. ACP Smart Goals continued

Data to be collected	**Method of Collection and who is responsible**	**Planned data analysis**
1. Numerator: number of eligible patients who received the packet 2. Denominator: total number of eligible patients.	PI gathered data weekly via chart abstraction and confirmed in the EMR template that the patient received the "*My Choices*" packet.	PI analyzed via bar graph - the percentage of eligible visits where patients received the *"My Choices"* packet. - Shared findings via an all-staff weekly email.
SMART Goal #3: By week three of implementation period and through project completion staff would use the standardized documentation template with 90% of eligible visits.		
Description of strategies and resources used to accomplish goal. 1. The MA loaded the EMR template via ".dot" phrase into the assessment and plan section of the patient encounter. 2. The MA filled out the template with necessary information. 3. The provider included more detail with the appropriate code when they discussed ACP in greater depth (greater than 15 min) with the patient.		
Data to be collected	**Method of Collection and who is responsible**	**Planned data analysis**
1. Numerator: number of eligible visits after three weeks of implementation that utilized the documentation template. 2. Denominator: number of eligible visits	Every week the PI: - Reviewed the provider schedules for eligible visits. - Chart reviewed the eligible visits and recorded the findings in an Excel spreadsheet.	PI analyzed via bar graph - the percentage of eligible visits where the EMR template via ".dot" phrase was utilized. - Shared findings via an all-staff weekly email.

Figure C1. ACP Smart Goals continued

<table>
<tr><td colspan="3">SMART Goal #4: By week three of the implementation period and through the remainder of the project, 90% of Medicare wellness visits included: (a) ACP documents scanned into patient chart OR; (b) noted in the standardized documentation template, located in the assessment and plan section of the patient EMR, when and how these documents were procured and added to the patient chart OR; (c) patient refused ACP.</td></tr>
<tr><td colspan="3">Description of strategies and resources used to accomplish goal.

1. The front desk staff scanned appropriate documents into the patient chart when provided to the clinic.
2. The MA or medical provider noted in the documentation template the plan for receiving the advanced directive document if the patient was not filling it out on the day of the appointment.</td></tr>
<tr><td>Data to be collected</td><td>Method of Collection and who is responsible</td><td>Planned data analysis</td></tr>
<tr><td>1. Numerator: Number of eligible visits after three weeks of implementation that included ACP documents scanned into patient chart OR planned for retrieval, return, or procurement of documents noted in EMR template OR patient refused ACP
2. Denominator: number of eligible visits</td><td>Weekly the PI:
- Reviewed provider schedules for eligible visits
- Chart reviewed the eligible visits.
- Recorded the findings in a spreadsheet and disseminated findings in a weekly email update.</td><td>PI analyzed via bar graph:
- the percentage of eligible visits where ACP documents were scanned into patient chart OR planned for retrieval, return, or procurement of documents or patient refusal noted in EMR template.
- Disseminated results to staff in weekly email update.</td></tr>
<tr><td colspan="3">SMART Goal #5: By December 31st, 2024, MIPS scores will increase by 37% from an average of 63% to 100% satisfied for the entire 2024 performance period.</td></tr>
<tr><td colspan="3">Description of strategies and resources used to accomplish goal.
To be determined through stakeholder implementation and study phases outside of the timeline of this project.
Principal investigator:
- Continued to work with stakeholders based on pilot outcomes and adapt or adopt pilot interventions.
- Shared all materials related to project with Clinic Manager for future use</td></tr>
</table>

Figure C1. ACP Smart Goals continued

Data to be collected	**Method of Collection and who is responsible**	**Planned data analysis**
1. Current MIPS score average of the 2021 to 2023 performance period 2. Future MIPS score at the end of the 2024 period determined by: a. Numerator: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advanced care plan b. Denominator: all patients aged 65 years or older with Medicare	Clinic Manager will collect MIPS quality improvement score at the end of the 2024 performance period	Percentage increase in MIPS score from combined average to 2024 performance period.