IMPLEMENTING ADVANCE DIRECTIVE SCREENING AND EDUCATION IN THE PRIMARY CARE SETTING

by

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of

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in

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DEDICATION

This dissertation work is dedicated to my family for their unwavering love and support. To my father who has always worked hard and made sacrifices to put others before himself. To my mother who finds a way to make a difference and show kindness every single day. To my husband who always loves and encourages me. Finally, to my children for inspiring me every single day. May you always dream big and reach for the stars.

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ABSTRACT

Advance care planning is a topic that has become increasing important due to medical technology advancement and the growing population of elderly Americans. Although advance care planning has been proven to positively impact patient satisfaction and quality of care, education and advance directive formulation does not occur as often as it should. The primary aim of this project was to increase the number of completed advance directives in patient medical records by 10% at a small rural Critical Access Hospital. The intervention implemented was screening patients age 65 and older for the presence of an advance directive during the clinic intake process. Patients that reported having a completed advance directive were asked to provide the site a copy and patients that reported not having an advance directive were provided an educational packet. A total of 5 patients presented to the clinic during the 6-week data collection period that were age 65 and older. Of these patients, 40% (n=2) reported having a completed advance directive, and both returned a copy. There were 40% (n=2) that reported not having a completed advance directive and did not return a completed copy. One patient did not get screened by mistake. The site is considering adjusting the screening process to be the responsibility of the clinician instead of the receptionist. A social media post was created on the site's Facebook page requesting individuals that had a completed advance directive to provide the facility a copy resulting in three additional individuals (n=3) bringing in completed directives. The goal to increase completed advance directives in patient medical records was met. A secondary aim of this project was to have facility clinicians complete an advance care planning education course from the education platform Relias, promoting their comfort to have the conversation with the patients. Facility clinicians have not yet completed the education, but the course was added to the facility's annual requirements. Currently 16 out of 36 of the non-clinician employees have completed this education course. The interventions adopted for this DNP QI project brought awareness to important topic of advance care planning and increased advance directive formulation.

CHAPTER ONE

INTRODUCTION

Introduction

The combination of advancing medical technology and an aging population that is living longer with more chronic conditions, results in an increased need to complete advance care planning. Despite reimbursement incentives, regulatory requirements and the proven benefits, advance care planning does not occur as often as necessary. Advance care planning involves discussions between patients, families and medical providers about future healthcare decisions related to end-of-life care in the event of impairment of decision-making ability. According to Sudore et al. (2016), advance care planning can be defined as:

> A process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness. (p. 431)

Advance care planning discussions usually cumulates in the formation of an advance directive document. Completion of an advance directive involves the documentation of the patient's preferences for medical care and the appointment of a surrogate decision maker (Silveria, Arnold & Givens, 2020). These documents are called the Living Will and the Durable Power of Attorney for Health Care. Living wills document the patient's preferences for life sustain treatments (ventilation, tube feedings, antibiotics, etc) and desire to receive cardiopulmonary resuscitation. Durable Power of Attorney for Health Care is a document about the patient's choice of a surrogate decision maker in the event the patient becomes incapacitated, and decisions need to be made that are beyond the content of the living will (Silveria, Arnold, &; Givens, 2020). Advance directive formulation improves healthcare at many levels. Along with a reported improved quality of life for patients, the presence of an advance directive has also been associated with a significant decrease in healthcare costs (Garrido, Balboni, Maciejewski, Bao, & Prigerson, 2015). Thus, a lack of advance care planning, in particular advance directives, results in a burden to the healthcare system.

Background and Significance

The history of advance directives over time suggests that there has been a gradual shift from a “legal transactional approach” to a “communications approach” (Sabatino, 2010). The United States (U.S.) began to develop the use of advance directives in the 1960s. Luis Kutner was a U.S. human rights activist and lawyer that is credited with the creation of the concept of the living will (Kutner, 1969). He advocated for a document that made wishes for end-of-life care known. The topic of living wills became more popular after the Karen Ann Quinlan case in 1976. Karen was placed on a ventilator at twenty-one years old after she stopped breathing and entered a persistent vegetative state (Angell, 1994). Due to the concept of advance directives not being a common practice at that time and no formal ethics committees in hospitals, Karen’s parents had to go to court to have her removed from the ventilator to allow her to die naturally. This brought attention to the need of legislation to help make these decisions about end-of-life care. After thirteen months, she was removed from the ventilator in May of 1976. Living wills became legally sanctioned in California in 1976 and by the year 1992, all fifty states had passed living will legislation.

Americans are now living longer than ever, therefore, patient-centered care for the elderly population is becoming more important. In 2014, 14.5% (46.3 million) of the U.S. population was aged 65 or older and is projected to reach 23.5% (98 million) by the year 2060 (Colby & Ortman, 2014). The threat of serious illness is an important factor to encourage documentation of care preferences of end-of-life care. In the U.S. approximately one-third of adults have completed some sort of advance directive (Yadav, 2017). The Covid-19 pandemic of 2020 has brought a new set of circumstances and motivation for the population to complete advance directives. The elderly population and individuals who have underlying medical conditions, such as diabetes or heart or lung disease, have been found to be at a higher risk for developing serious complications or death from Covid-19 (cdc.gov, 2020). When these individuals contract this respiratory virus, they can deteriorate rapidly and could require artificial life support that renders them unable to make their own healthcare decisions. Advance directives can help guide patient's family members and medical providers in the event patients that contract the virus require ventilation or other life saving measures. When healthcare providers are provided clear guidance about a patient's preferences, literature shows that this results in decreased decisional conflict (Fahner et al., 2019). Throughout the pandemic, certain areas throughout the U.S. have experienced a lack of resources available. Advance directive documents can aid resource allocation and reduce healthcare strain through instructions if certain patients do not choose to receive life saving measures (aha.org, 2020). Having an advance directive prepared could alleviate some of the stress, anxiety and depression that is heightened in individuals and healthcare providers as a result of the Covid-19 pandemic.

Another significance of this project is associated with rurality. Rural hospitals in the U.S. struggle to sustain operations for a variety of reasons, but a financial burden is the most common rationale. Since 2010, 121 U.S. rural hospitals have closed and there are currently 673 additional healthcare facilities at risk for closure representing about one-third of rural hospitals ("National Rural Health Association", 2020). These rural hospitals operate on low cash levels and may struggle with the added expenses from COVID-19, such as supplies, equipment and staff ("NC Rural Research Program, 2020). In addition to the aforementioned impact on resource allocation, decreased conflict and improved healthcare guidance, advance care planning can provide a financial incentive.

While this center is geographically important to the community, it has been threatened by financial sustainability. The site relies on tax payor funds to assist with operating expenses. Implementing and making this DNP project sustainable could help assist with alleviating some of the financial burden.

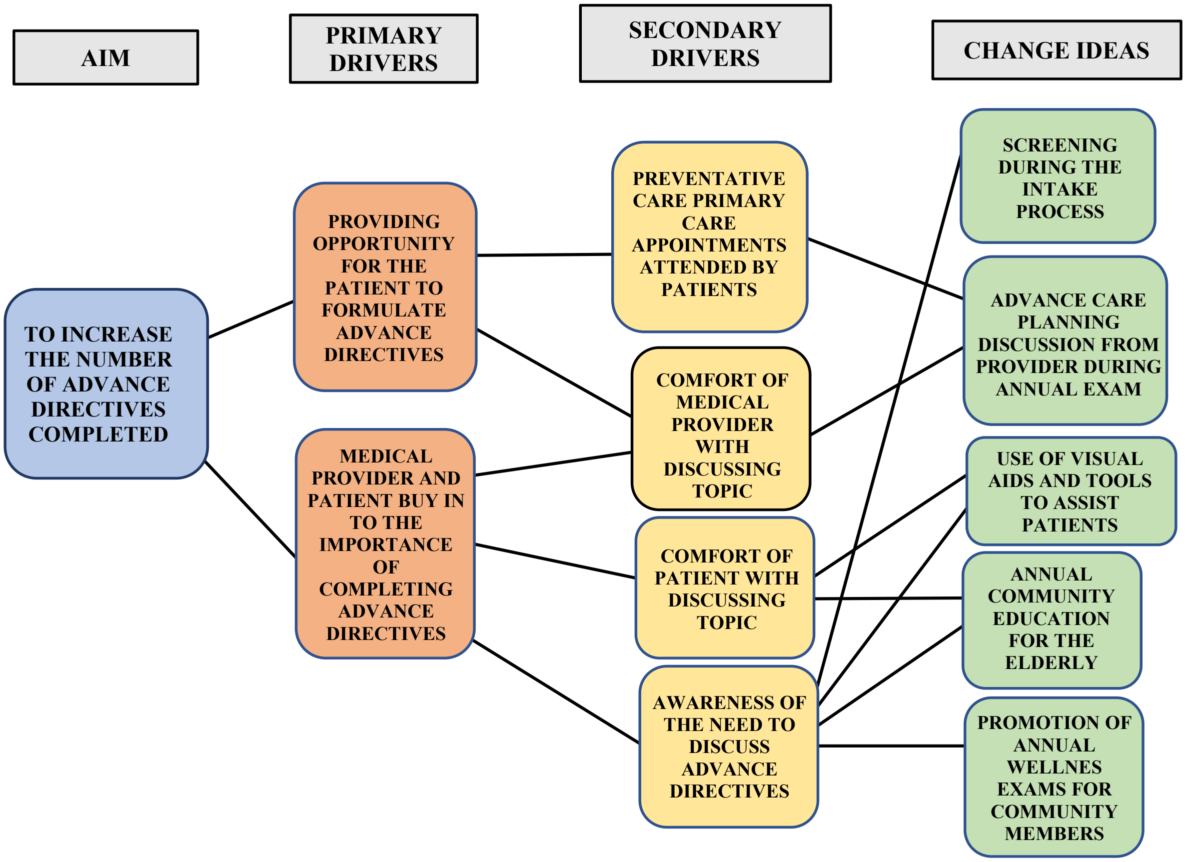
Scope of Problem at Project Site

The quality improvement committee at the organization identified a deficit of completed advance directives in the elderly population at the project site. An audit of the Medicare wellness exams in the past six months showed that none of the patients have an advance directive on file. Furthermore, in the past 5-10 years, there has been numerous nursing home residents admitted to the facility without any previous advance care planning completed. On several occasions, these residents would also have the presence of dementia upon admission and had not previously discussed their end-of-life wishes with their loved ones. This can be a challenging situation for family members of residents when they are faced with making decisions about the dying process.

Pre-project analysis determined the facility did not have steps in place for collecting advance directives from patients and storing them in the medical record. The rural health clinic was recently established facility with new staff, so many processes were yet to be streamlined. No process was in place to ensure that medical providers received education relating to exploring the topic of advance care planning with patients. Due to the low patient volume from both Covid-19 pandemic and the low established patient base, there was adequate time for clinicians to complete advance care planning discussions, but a lack of a streamlined process and guidance left uncertainty on when discussions should occur.

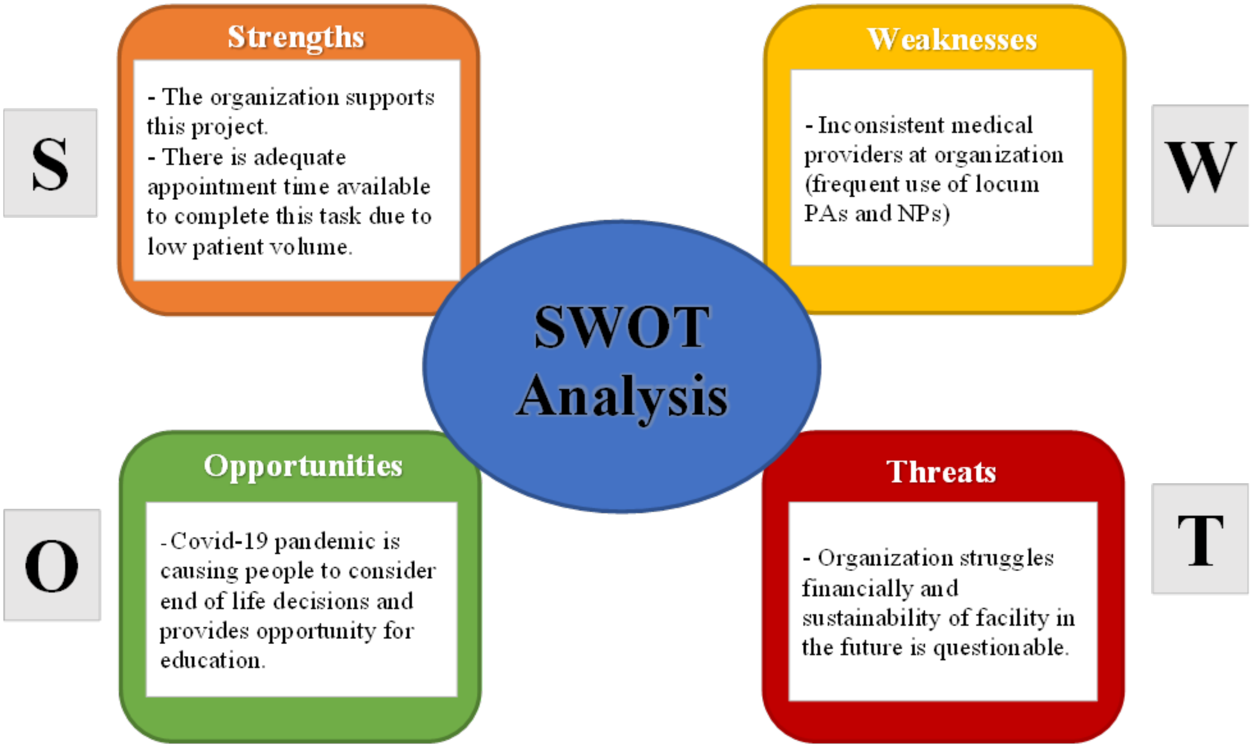
Discussion with facility leadership helped to develop a driver diagram (Figure 1) to identify potential interventions to help achieve the project goal. For this project, advance directive screening was focused on patients age 65 and older as part of the clinic intake process. Individuals that did not have a completed directive would receive advance care planning education. The project aimed to increase the number of individuals age 65 and older that have advance directives available in their medical chart by 10%.

Figure 1. Driver Diagram



A strengths, weaknesses, opportunity, and threats (SWOT) analysis is a tool that helps understand all of the factors that are involved in making a decision or change. For this project, a SWOT analysis (Figure 2) helped identify some potential problems that could arise and hinder the success of the outcome. The low amount of clinic patients was an anticipated threat for the project. Fortunately, this also means that there would be no concern about time constraints during clinic appointments, and the medical providers would have adequate time to complete advance care planning discussions if the opportunity presented. The organization is very accommodating and supportive of quality improvement projects and also has stakeholder buy in from the quality improvement director, the sole full time facility physician assistant, the clinic manager, and the administrator.

Figure 2. SWOT Analysis



Community Description

The community is a rural county located in Eastern Montana that is the 7th largest county in the state at 4,849.2 square feet (http://geoinfo.msl.mt.gov, 2020). Some patients must drive a long distance, often on dirt roads to access the facility. The population of the county as of 2017 was 1,089 and is all considered rural (city-data.com, 2020). This county has the second lowest population of all Montana counties. The median resident age for the county as of 2017 is 45.7 which is high compared to 40.0, the median resident age of Montana (city-data.com, 2020).

Persons aged 65 years and older account for 24.1% of the population of the county (census.gov, 2019).

The county ranks higher than the Montana average for number in individuals that are physically inactive at 28% compared to 22% (countyhealthrankings.org, 2020). Mammography screening and influenza vaccination completion are below average in the county at 33% compared to 43% indicating a lack of preventative care received by individuals (countyhealthrankings.org, 2020). With physical inactivity being linked to several chronic health conditions and an overall lack of preventative care in the community these statistics may indicate a profile of rural dwellers (Winters, 2021). These statistics may reflect the health beliefs, health-seeking behavior, self-reliance and independence of the patient population. Rural individuals may be unlikely to participate in estate planning measures including advance care planning and an office visit may to be the only opportunity to complete advance directives. While the people in the community have a culture that is supportive of one another (garfieldcounty.com, 2020) an additional need and importance to educate the community to plan for end of life.

The setting is a healthcare organization located in Eastern Montana and is a combination of a Rural Health Clinic (RHC) and a 24 bed Critical Access Hospital (CAH). The setting meets the qualifications to be an RHC because the facility is in a rural area and not an urbanized area (as defined by the Bureau of the Census). Also, the chief executive officer of the State and the Secretary certified as an area with a shortage of personal health services within a three-year period (cms.gov, 2020). In addition, the setting meets the qualifications set by the Centers for Medicare and Medicaid Services (CMS) to be defined as a Critical Access Hospital (CAH) because the facility is located more than 35 miles from the nearest hospital, has an annual average length of stay of 96 hours or less per acute care inpatient and there are 24-hour emergency care services provided seven days a week (cms.gov, 2020).

Purpose and Congruence

This DNP project is the implementation of advance care planning in the primary care setting. This quality improvement project will improve the overall care that individuals receive aligning with the facility's mission statement; "the center is committed to provide the highest quality health, medical and long-term care possible to the residents and visitors of the county." The primary aim is to increase the number of advance directives completed by geriatric patients of the center and to have completed advance directives available in the patient charts. This would benefit both the patients and healthcare providers to the highest quality of health by making the end-of-life decision making process more fulfilled and less stressful.

A benefit of advance care planning in this rural setting is the individualized ability to obtain and document needs from the advantage of knowing the population. Patients that must travel a long distance for care can receive optimal timing for care when presenting for various healthcare visits. Advance care planning in rural areas does pose a unique set of circumstances as establishing trust and understanding lifestyle are important components of the population's culture (Christensen et al., 2019). There is a need for more staff education and mentorship in rural areas to improve successful advance directive completion in rural areas (Christensen et al., 2019).

CHAPTER TWO

REVIEW AND SYNTHESIS OF THE EVIDENCE IN THE LITERATURE

Review and Synthesis of the Evidence in the Literature

The literature review resulted in a vast amount of content supporting the importance of advance directives for the patient, the family, medical providers, and healthcare organizations. Databases searched were Cumulative Index of Nursing and Allied Health (CINAHL), Joanna Briggs Institute and Cochrane Database. Terms used for inclusion criteria included: advance directive, advance care planning, primary care, barriers, and patient satisfaction. Search results resulted in a substantial amount of literature, therefore, studies that were completed in the last 10 years, systematic reviews and randomized controlled trials were utilized for this review of literature.

Completion of Advance Directive

One large systematic review found that 36.7% of adults in the U.S. have completed an advance directive (Yadav et al., 2017). The proportions were similar between healthy individuals and those with chronic conditions. Analysis of the advance care planning Current Procedural Terminology (CPT) codes indicates there has been an increase in the number of advance directive education visit encounters by 154% between the year 2016 to 2017 (Gazarian, 2020). The volume of claims in 2017 was 348,190 and is, unfortunately, still exceptionally low because only 3.2% per 10,000 claims contain advance care planning codes. Therefore, there may be a need for CMS to increase promotion or incentive (Gazarian, 2020).

One large study completed in the U.S. analyzed adults that did and did not have an advance directive and examined factors associated with their completion, such as access to healthcare and presence of chronic conditions. Data was collected through a HealthStyles Survey between 2009 through 2010 and analyzed in 2013. This mail panel survey examined the associations between advance directive completion and demographic and socioeconomic variables. There were 7,946 responses and 26.3% reported having an advance directive (Rao, Anderson, Lin & Laux, 2014). The rationale reported most often for not having one was an overall lack of education and awareness. Respondents that did have an advance directive were more likely to be older, have a chronic disease and received routine primary care (Rao, Anderson, Lin & Laux, 2014).

Silveria, Kim, and Langa (2010) studied data from survey proxies of people 60 years of age or older that had died between 2000 and 2006. This study revealed that 70.3% of the subjects that required decision making related to end-of-life care, lacked the ability to do so and only 67.6% of the subjects had an advance directive. The patients that did have completed advance directives received the care that was strongly associated with their preferences outlined in their living will (Silveria, Kim and Langa, 2010).

Rural Population

The rural population is unique because of the barriers faced in accessing care and due to the perceived healthcare needs of individuals. Winters (2021) found that the themes of self-reliance, independence, and hardiness parallel with the rural population culture. These characteristics can impact when a rural individual will seek healthcare. Population barriers and challenges identified in Rural Nursing Theory include social and physical isolation, distance to specialists, and a lower number of individuals with health insurance (Winters, 2021). These characteristics reflect the population of this project community described earlier in chapter one.

Chronic illness management can also be difficult for individuals that reside in a rural setting. Palliative care is a healthcare approach to improve the quality of life of patients and families by preventing and reliving the suffering related to chronic disease (Nelson et al., 2012). Despite rural populations having a higher rate of elderly individuals and an increased prevalence of chronic illnesses, programs such as palliative care are uncommon in these communities (Ceronsky et al., 2013). While potentially lacking in more formal services, rural communities can take advantage of the close relationships between patients and health care providers to establish culturally appropriate healthcare delivery models that support advance care planning (Bakitas et al., 2020). This DNP student has grown up and been employed at the site community, therefore has anecdotal experience working with a rural population and recognizes the benefits of fond relationships between healthcare providers and patients with the difficult topic of end-of-life.

Patient Satisfaction, Interest, and Readiness

The literature indicates that advance care planning is a topic that is important to patients because they appreciate the opportunity to discuss this topic with their healthcare provider. Studies show that advance care planning positively impacts the quality of care received during end-of-life care because patient’s preferences are honored (Brinkman-Stoppelenburg, Rietjens, & Heide, 2014). One prospective randomized controlled trial studied 309 elderly inpatient adults. This study concluded that end-of-life care is improved, and patient and family satisfaction is increased with an advanced care planning program in place (Detering, Hancock, Reade and

Silvester, 2010). One factor for this result is reduced stress, depression, and anxiety in the patient’s loved ones.

A cross-sectional, stratified random national survey with 1,400 participants, including patients, family members and healthcare professions involved with caring for dying patients, was completed to determine what factors are most important with end-of-life care (Steinhauser 2000). This study found that the most important overall goals included pain and symptom management. and involvement in decisions about treatment preferences. Additional meaningful factors included being prepared for death, achieving a sense of completion, being mentally aware and having funeral arrangements completed (Steinhauser 2000).

Older individuals that have had a personal major illness or previous experience with the end-of-life care of others have been shown to demonstrate greater readiness to participate in advance care planning (Amjad, 2014). Although most elderly individuals would appreciate the opportunity to discuss their end-of-life care with their medical provider, only a minority are given the opportunity according to a systematic review of seven studies (Sharp et al., 2013). Advance care planning also provides elderly individuals a sense of autonomy by giving them a choice of life supportive and sustaining treatments they would want to receive during the dying process (Lund et al, 2015).

Barriers to Advance Directive Completion

Numerous barriers exist to the completion of advance care planning in the primary care setting. The determination of who is responsible for initiating the conversation about advance directives is unclear. Patients expect the medical provider to bring up the topic and medical providers feel as though patient is responsible to express their desire to discuss end-of-life preferences (De Velminck et al., 2013). Although patients appreciate the importance and benefits of advance care planning conversations, they are often perceived as difficult and emotional (Fahner et al., 2019).

Physicians report insufficient time and other healthcare professionals report a personal lack of knowledge about the topic (Howard et al., 2018). To address the issue of discomfort with the topic, there is a need to develop intervention programs and workshops for health care professionals to improve knowledge and comfort with discussions (Kermel-Shiffman, 2017). The literature reports a need for the professionals improving public engagement and a need to integrate advance care planning into routine practice (Howard et al., 2018). Thus, clinicians need assistance with integrating the advance care planning discussion process into their workflow and overcoming hindering factors, which include limited staff and turnover and low number of trained staff available to perform interventions (Lund, Richardson, Carl, 2015). Limited resources available in primary care, fear of depriving patients of hope, and the medical provider's difficulties in determining the right moment for initiating the discussion with a patient are barriers to advance care planning discussions (De Vleminck et al., 2013).

Evidence Based Guideline

The Joanna Briggs Institute formulated an evidence summary related to advance care planning and barriers and facilitators to uptake in primary care. The evidence in this summary is a result of a review of the following literature:

- A systematic review of eight systematic reviews, eight randomized control trials, 14 analytical cross section studies, three cohort studies, nine quasi-experimental studies, 12 qualitative studies

- A systematic review of 10 qualitative studies, five cross-sectional and one mixed methods study
- A systematic review of 20 quantitative, four qualitative, and three mixed methods studies
- A systematic review of 11 cross-sectional studies (Marin, 2020)

This clinical support tool promotes the advance care planning process in the primary care setting. This practice guideline concluded that healthcare providers should be educated in advance care planning to help gain confidence and have a more positive attitude with this topic. Also, discussions about advance directive choices should be initiated as early as possible so the person and stakeholders can still be active in the conversation (Marin, 2020). Additionally, organizational and financial supports should be given to healthcare providers to have these advance care planning discussions with their patients (Marin, 2020).

Prepare for Your Care & My Choices

When advance care planning interventions, such as communication guides and informational handouts, are utilized by healthcare providers, the completion of advance directives is increased and discussions with patients about end-of-life care occurs more often (Hoube, Spruid, Groenen, Wouters and Janssen, 2014). Among these resources, the PREPARE For Your Care advance care planning program was chosen to use in this project because it is easy to read and visually appealing educational information for the target population. These educational tools are free to the public and include advance directives, brochures, and a COVID-19 tip sheet. They are easy to access and can be printed directly from the website. The PREPARE brochure was used for this project. The brochure has information about five steps to help patients make medical decisions for themselves and others. The use of PREPARE educational tools in combination with an easy-to-read advance directive has been shown to result in higher rates of patient engagement and advance care planning documentation (Sudore, Schillinger & Katen, 2018). The My Choices advance directive document is easily comprehendible and allows the individual to make detailed preferences. This document is also supported by the Montana Department of Justice and the Montana End-of-Life-Registry (End of life registry & advance health care directives, 2021). The Montana End-of-Life-Registry is accessible to healthcare providers therefore, making this the optimal choice for an advance directive form.

Summary

This review of literature substantiates the benefits of advance care planning and completion of advance directives on overall patient satisfaction and improved quality of care. Although several studies support the need for patients and medical providers to have end-of-life care discussions, several barriers still prevent these conversations from happening. Since completion rates of advance directive were 26-37% with general population, there is a need for organizational support and process flow improvement to help pave the way for advance care planning, especially in the primary care setting as an entry gate to the healthcare system.

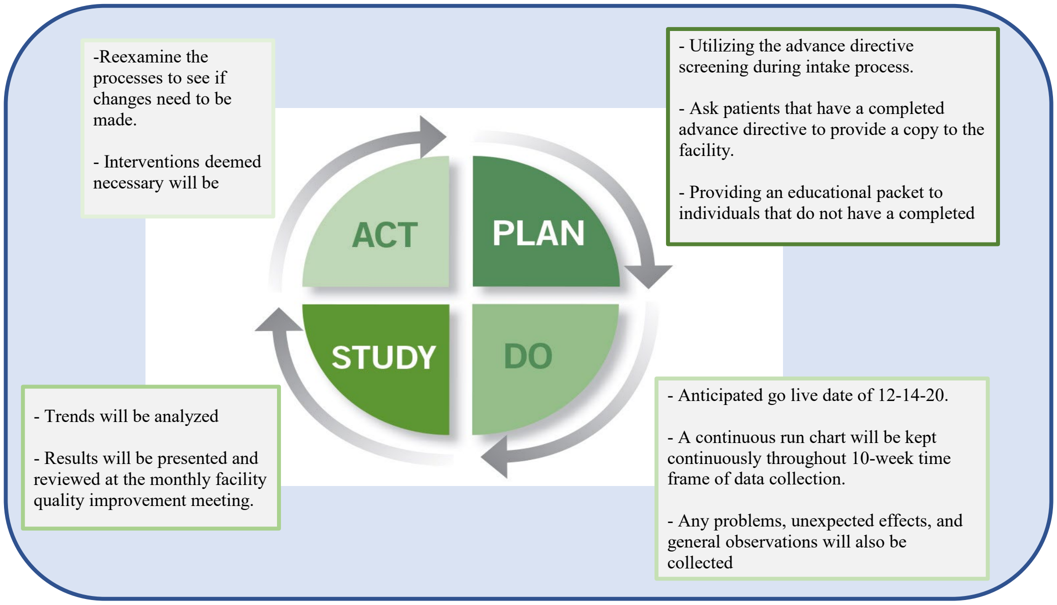
CHAPTER THREE

SETTING AND METHODS

Process Improvement Model

This DNP quality improvement (QI) project used the plan do study act (PDSA) model, which is a four-step process for change improvement (Langley et al., 2014). This model is applicable and easy to learn and use. For DNP QI projects, the PDSA works well because it allows for rapid change of new processes and adaptation and offers repetitive approach offers continuous reassessment. The PDSA framework has also been found to be an efficient trial and learning methodology to implement changes (Langley et al., 2014). These strengths of PDSA model fits best to this project (Figure 3). The project aim was to increase the number of advance directives in the records of patients aged 65 and older by 10%.

Figure 3. PDSA



-Reexamine the processes to see if changes need to be made.

- Interventions deemed necessary will be

- Utilizing the advance directive screening during intake process.

- Ask patients that have a completed advance directive to provide a copy to the facility.

- Providing an educational packet to individuals that do not have a completed

- Trends will be analyzed

- Results will be presented and reviewed at the monthly facility quality improvement meeting.

- Anticipated go live date of 12-14-20.

- A continuous run chart will be kept continuously throughout 10-week time frame of data collection.

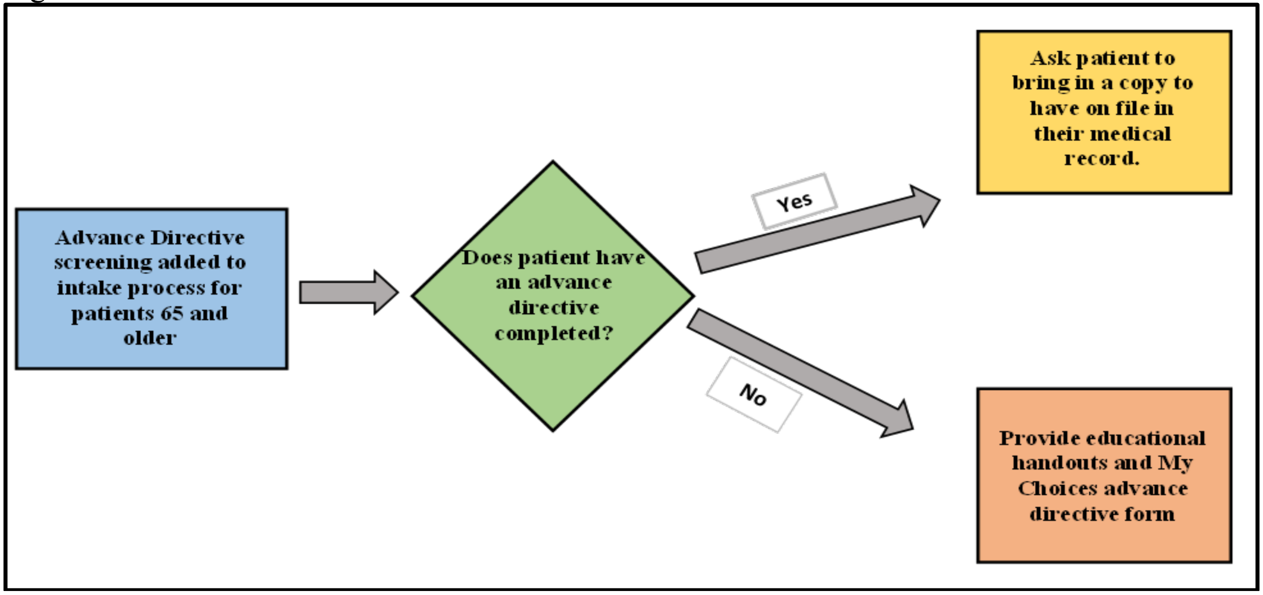
- Any problems, unexpected effects, and general observations will also be collected

Procedure/Implementation Plan

A process flow chart of the plan phase was developed (Figure 4). The “plan” phase included training of clinic receptionist to do the following steps:

- Utilizing the advance directive screening questions during the intake process
- Asking patients that do have a completed advance directive to provide a copy to the facility.
- Providing an educational packet to individuals that do not have a completed advance directive. This packet will include a “Prepare For Your Care” pamphlet (Appendix A) and a “My Choices Advance Directive” form (Appendix A).

Figure 4. Process Flow Chart



Ideally, since patients were receiving the advance care planning information prior to their appointment while waiting to see their medical provider, they will bring up any questions they have about advance directives during their appointment. Concurrently, one goal for this phase was to have all facility clinicians complete an advance care planning education course from the education platform Relias, promoting their comfort to have the conversation with the patients. The Relias platform was chosen as the organization already has a contract with the company and no additional expense was incurred for the advance care planning course.

The “do” phase had a planned go live date of 12-14-20 after project proposal completion and IRB approval. With assistance from the clinic receptionist, an excel sheet was kept continuously during the 6-week time frame of data collection. The excel sheet was updated at each individual patient encounter. All problems, unexpected effects, and general observations were gathered during this phase.

The “study” phase involved determining if the project results met the goal for improvement. The study phase of the cycle emphasized the need to build new knowledge. This helped the project to continuously build into a better process. The trends and results were presented and reviewed at the monthly facility quality improvement meeting.

The “act” phase reexamined the processes to see if changes need to be made to further improve the project. Interventions that were determined to make the approach more successful were added.

The Covid19 pandemic had caused a decline in the already low clinic volume at the facility. During planning, an additional intervention was prepared to help achieve the project goal. Four weeks after the go live date of the project, the number of patients aged 65 and older that had presented to the clinic was less than five. A social media post was then added to the project site’s Facebook page, which had 478 followers and is a social media platform from which the community is accustomed to receiving updates (Appendix A). Having this educational post on the facility Facebook page will helped raise community awareness of the organization’s interest in obtaining patient’s advance directive information.

Financial Incentive

Increasing advance care planning offers a financial incentive for the organization. The Centers for Medicare & Medicaid Services (CMS) identifies the importance of advance care planning and pays for this voluntary service annually under the Medicare Physician Fee Schedule and the Hospital Outpatient Prospective Payment System (cms.gov, 2019). Therefore, completion of advance care planning offers a financial incentive for the organization. The financial reimbursement for 30 minutes of discussion about advance care planning is $96 with an additional $76 for each additional 30 minutes (cms.gov, 2019).

Data Collection Plan

Pre-project data included:

- The number of patients that presented to the clinic age 65 and older for the previous three months.
- The demographics of these patients including: age, gender, race, community vs non community resident.
- Chronic conditions of these patients
- Presence of advance directive in electronic medical record

Data collected during the PDSA process included:

- The number of patients that presented to the clinic age 65 and older during the project.
- The number of patients that reporting having an advance directive completed.

- The number of these patients that brought in a copy of their advance directive to add to their medical record.
- The number of patients that reported not having an advance directive completed and were provided education and forms.
- The number of patients that completed an advance directive and returned to clinic to add to their medical record after education and forms were provided.
- The number of patients that asked their medical provider advance care planning questions during their clinic appointments.
- The revenue collected from provider billing of advance care planning visits.
- All data was collected on an excel spreadsheet daily. The clinic receptionist assisted with gathering this data.

Human Subject Protection

An exempt review was submitted and approved by the Montana State University Internal Review Board (IRB). The project site did not have and IRB. Authorization to proceed with project and to accept Montana State University IRB approval was received by facility Chief Operating Officer on 9-23-20 (Appendix A). There was minimal risk for the participating patients; however, emotional distress could be a potential effect due to the nature of advance directive conversations. A 3-digit patient identifier code was given to each patient to protect identity. All documents and excel spread sheets that contained data and personal information were kept onsite at the facility on a password protected computer in a locked room.

CHAPTER FOUR

RESULTS

Results

Information was collected about the patients that presented to the facility during the three months prior to the data collection period (Table 1). This data included the number of patients, demographics, and presence of advance directive in electronic medical record. The chronic conditions of these patients were unable to be collected due to several patients not having updated problem lists. During the three months prior to the data collection period twenty-one patients presented to the clinic aged sixty-five and older. These patients had a total of 27 visits out of an overall total of 106 visits, resulting in 25% of the patient volume during this period. Clinic visits for the nursing home patients in the facility were not included in the data collection. There were also no advance care planning patient encounters billed in the three months prior to the data collection period.

Table 1. Patients Age 65 and Older 3 Months Prior to Data Collection

Patients Age 65 and Older
3 Months Prior to Data Collection

Total # Of Patients	21
65-74	9 (43%)
75-84	6 (29%)
85-94	5 (24%)
95 and older	1 (5%)
Male	8 (38%)
Female	13 (62%)
Race	White, Non-Hispanic 21 (100%)
County Resident	21 (100%)
Presence of Advance Directive in EMR	None- 0
Chronic Conditions	Unable to Collect Data

During the six-week data collection period, five individuals presented to the clinic that were age 65 and older. Their detailed information is located in (Table 2). There was one individual in 60's, two individuals in 70's, and two individuals in their 80's. Four out of five were male; and all of them were community dwellers. Two of these patients reported having a completed advance directive and both individuals returned a completed copy for the facility to have on record, resulting in a 100% return rate. These two patients were the oldest individuals to present to the clinic during the data collection period with a mean age of eighty-seven. Two clinic patients reported that they did not have a completed advance directive and were provided an educational packet. None of these patients returned with a completed copy. One individual was not screened by the clinic staff.

Additionally, three individuals that were not seen as a patient in the clinic, but had heard about the request via social media, brought in copies of their advance directive to the facility for their medical record. One patient did not receive the advance directive screening during his clinic visit because clinic reception forgot to screen the individual. In total, five new advanced directives were collected and added to the patient electronic medical records. All five of these individuals requested a code status of DNR (do not resuscitate) and all had at least one chronic condition documented in their record. The most commonly documented chronic condition was hypertension and present in 4 out of the five patient medical records.

Table 2. Patients Age 65 and Older during Data Collection Period

PATIENTS AGE 65 AND OLDER THAT PRESENTED TO THE CLINIC DURING DATA COLLECTION PERIOD

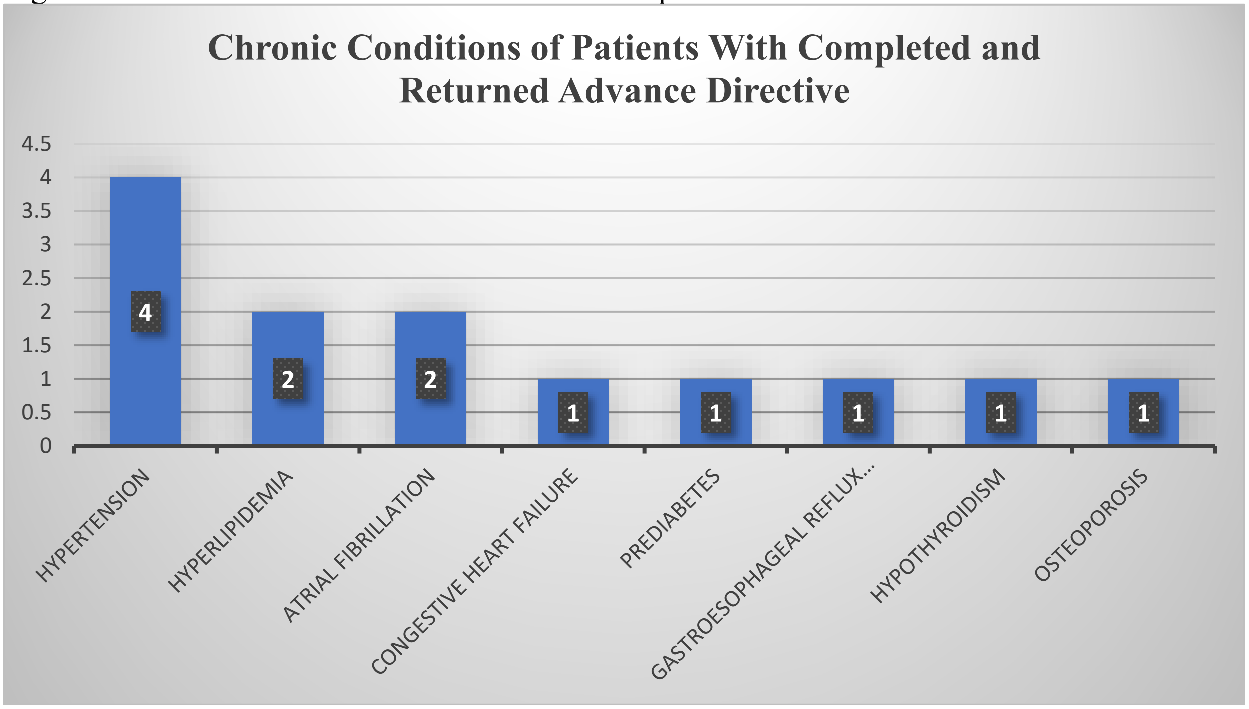
AGE	GENDER	RACE	COMMUNITY/ NONCOMMUNITY	CHRONIC CONDITIONS	PRESENCE OF ADVANCE DIRECTIVE IN EMR	DOES REPORT HAVING AN ADVANCE DIRECTIVE?	RETURNED COPY OF ADVANCE DIRECTIVE?
67	M	C	Community	hyperlipidemia	No	No	No
72	M	C	Community	not updated	No	Did not screen	No
73	M	C	Community	hypertension, hyperlipidemia, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, chronic kidney disease, prediabetes	No	No	No
84	M	C	Community	hypertension, hyperlipidemia, atrial fibrillation,	No	Yes	Yes
89	F	C	Community	hypertension, atrial fibrillation, congestive heart failure,	No	Yes	Yes

PATIENTS THAT DID NOT PRESENT DURING DATA COLLECTION PERIOD

AGE	GENDER	RACE	COMMUNITY/ NONCOMMUNITY	CHRONIC CONDITIONS	PRESENCE OF ADVANCE DIRECTIVE IN EMR	DOES REPORT HAVING AN ADVANCE DIRECTIVE?	RETURNED COPY OF ADVANCE DIRECTIVE?
68	F	C	Community	osteoporosis			Yes
74	M	C	Community	hypertension, prediabetes, gastroesophageal reflux disease			Yes
81	F	C	Community	hypertension, hypothyroidism, hyperlipidemia,			Yes

The facility did not have the opportunity to bill for any advance care planning visits during the data collection period.

Figure 5. Chronic Conditions of Patients with Completed and Returned Advance Directive



Unfortunately, clinician healthcare providers' education was not able to be completed during the data collection period. However, a Relias education course titled "Advance Care Planning Communication Skills For Success: The Five Wishes Framework" has been added to the facility's annual education requirements for healthcare employees employed at the organization. The purpose of this intervention was to promote employee comfort to have this conversation with the patients. Thus far, 16 out of 36 of the facility healthcare employees including Registered Nurses, Certified Nurse's Aides and clinic office staff, have completed this education course.

CHAPTER FIVE

DISCUSSION

Discussion

The project aimed to increase by 10% the number of individuals age 65 and older that have advance directives available in their medical chart. Over three months, the number of patients that presented to the clinic in this age range was 25% (27 visits out of 106 total visits), which is very similar to the county population which is 24.1% (census.gov, 2019). Despite this project facing some unexpected obstacles, the goal of increasing the number of completed patient advance directives in medical records by ten percent was exceeded. Prior to the project implementation date, an audit of the facility medical record room found the presence of eleven patient advance directives on file. The discovery of these advance directive records resulted in an unanticipated positive outcome and improvement for the facility's attached emergency room. Currently the emergency room uses electronic medical record documentation for the medical provider and paper charting for the nursing staff. This means that the nursing staff would not have access to patient advance directives if they were to present to the emergency department. Through the DNP QI project, all of advance directives that were collected prior to and post intervention were put into an alphabetical order file system that is readily available and accessible to healthcare staff in the facility emergency room.

The literature review found substantial evidence that patients feel much more satisfied when being active and involved in their decision and plans related to end-of-life care (Brinkman-Stoppelenburg, Rietjens, & Heide, 2014). This was validated by the willingness of individuals to provide the organization a copy of their advance directives when asked. The literature review also found that there is an overall lack of healthcare provider education related to advance care planning (Howard et al., 2018). The organization had not previously billed for any advance care planning visits prior to the intervention date. Now that there is a system in place to educate all employees and clinicians, the facility can take steps to financially benefit from these services.

Challenges and Limitations

A challenge for this project was the low patient volume. Prior to the Covid-19 pandemic, the average weekly patient census was fifteen patients. The current average weekly patient census is eight. The lack of patients made both the change process and data collection difficult and an additional barrier for the clinic staff. With the limited opportunities to complete advance directive screening, making this process part of the regular routine was difficult for the reception staff to remember.

Another factor that made this screening new process challenging was the facility had just implemented a new electronic medical record program a few days after the start of this DNP QI Project. Therefore, the staff was focused on learning this new system and made the PDSA change process more difficult. Due to the small size of the organization and limited personnel, initiating more than one change process can be overwhelming and stressful for staff. One study found that healthcare providers feel that there is a need for consistency with advance care planning documentation and the EHR has potential to improve the timing and quality of advance care planning conversations (Lamas et al., 2018). Moving forward, the plan is to assign the intervention of advance directive screening to the clinician medical provider rather than the clinic receptionist. Currently, the organization and QI committee is working on making the advance directive screening part of the medical provider’s assessment form template in the new electronic medical record program. This will pave the way for the medical provider to approach the topic of advance directives with the patient and potentially have an opportunity to provide education to their patients.

The Relias education “Advance Care Planning Communication Skills For Success: The Five Wishes Framework” has not been completed by clinician healthcare providers due to staffing challenges. The organization employs only one clinician for two weeks a month and staffs with locum clinicians the remaining two weeks. Time constraints have made it difficult for education completion. Currently, all the excess time of clinician staff between patient care is spent by reviewing education related to the new electronic medical record use.

DNP Essentials

This quality improvement project encompasses the Doctor of Nursing Practice (DNP) Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking and Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes. Essential II emphasizes the importance or collaborating within an organization for implementing and sustaining policy change (AACN-DNP Essentials, 2006). This project required brainstorming with employees at various different levels to formulate an achievable intervention. Essential VI is based on the importance of interprofessional teams working together and collaborating in a fashion that is dependent on the patient’s needs (AACN-DNP Essentials, 2006). The feedback and ideas received from the staff members providing care to patients in the clinic setting helped validate the best method for interacting with the rural elderly patients. Assisting this population with advance care planning will improve patient healthcare on several levels. The patients will feel a sense of autonomy by having a choice and plan with their healthcare wishes and decision and the organizations that are participating in their care will be able to provide the best and most cost-effective, patient-centered care.

Sustainability

No revenue was generated for the facility during the data collection period. After discussion and collaboration with the quality improvement committee, it was predicted that when Covid-19 restrictions are no longer in place and patients are presenting to their appointments as usual, the facility estimates that there is a promising potential to bill for approximately one advance care planning discussion per month. This would amount to approximately $1,200 per year. The revenue from these advance care planning encounters could benefit the organization by supporting the purchase of desired or needed equipment and supplies.

The stakeholders and healthcare team at the site demonstrate a commitment to care for individuals in their community. One theme that arises in rural nursing literature is the concept of community support (Winters, 2021). Clinicians and other healthcare providers can utilize existing personal working relationships with patients to leverage successful future projects. Rural patients are also important stakeholders and a critical part of this DNP QI project and system changes could not be achievable without this population.

Recommendations for Future Work

Considering the outcomes, strengths and limitations that were revealed with this project, there are opportunities for the organization to expand upon in the future. Based on the interest expressed from the patient population and the quality improvement committee, there are ideas and suggestions being presented about future advance care planning educational interventions. Ideas such as having a booth at the annual community health fair and educational trainings at the local senior center were discussed as prospective projects.

Although there was limited data collected to support the success of this project, the education provided about the benefits of advance care planning have assisted with integrating into the organization’s practice. This project also revealed the benefits that could be obtained and the importance this topic is for the rural community. Future studies on the interest and usefulness of advance care planning in the rural setting would be beneficial to understanding the cultural impact on personal preferences. In summary, the simple interventions adopted for this DNP QI project increased advance directive formulation and will help provide opportunities for future patients to have their end-of-life preferences achieved.

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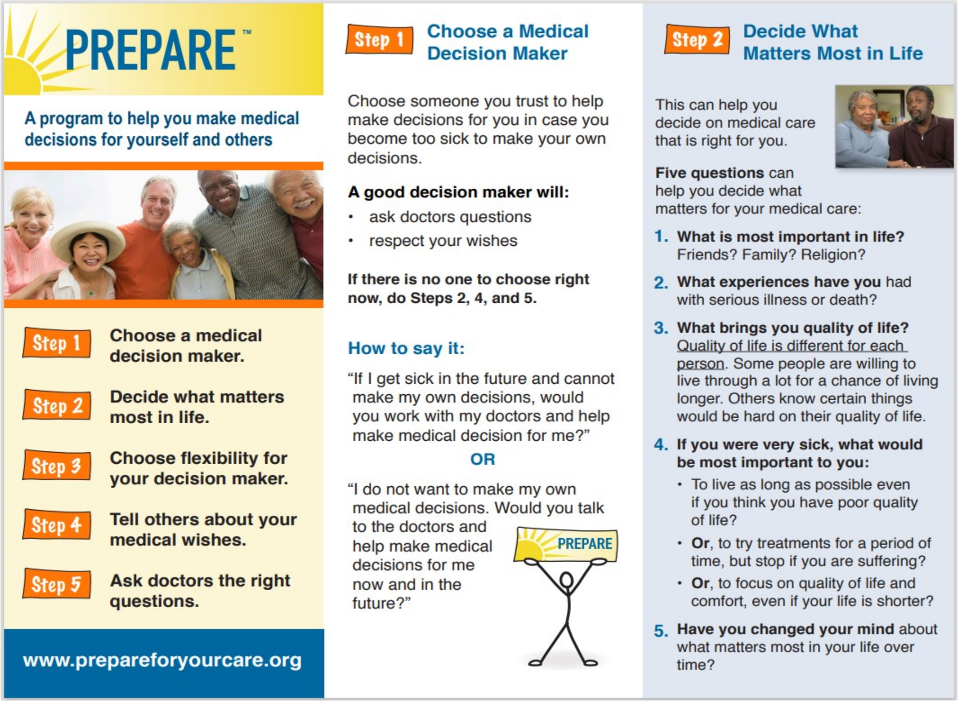
APPENDICES

APPENDIX A

PREPARE PAMPHLET



PREPARE™

A program to help you make medical decisions for yourself and others

Step 1 Choose a medical decision maker.

Step 2 Decide what matters most in life.

Step 3 Choose flexibility for your decision maker.

Step 4 Tell others about your medical wishes.

Step 5 Ask doctors the right questions.

www.prepareforyourcare.org

Step 1 Choose a Medical Decision Maker

Choose someone you trust to help make decisions for you in case you become too sick to make your own decisions.

A good decision maker will:

- ask doctors questions
- respect your wishes

If there is no one to choose right now, do Steps 2, 4, and 5.

How to say it:

"If I get sick in the future and cannot make my own decisions, would you work with my doctors and help make medical decision for me?"

OR

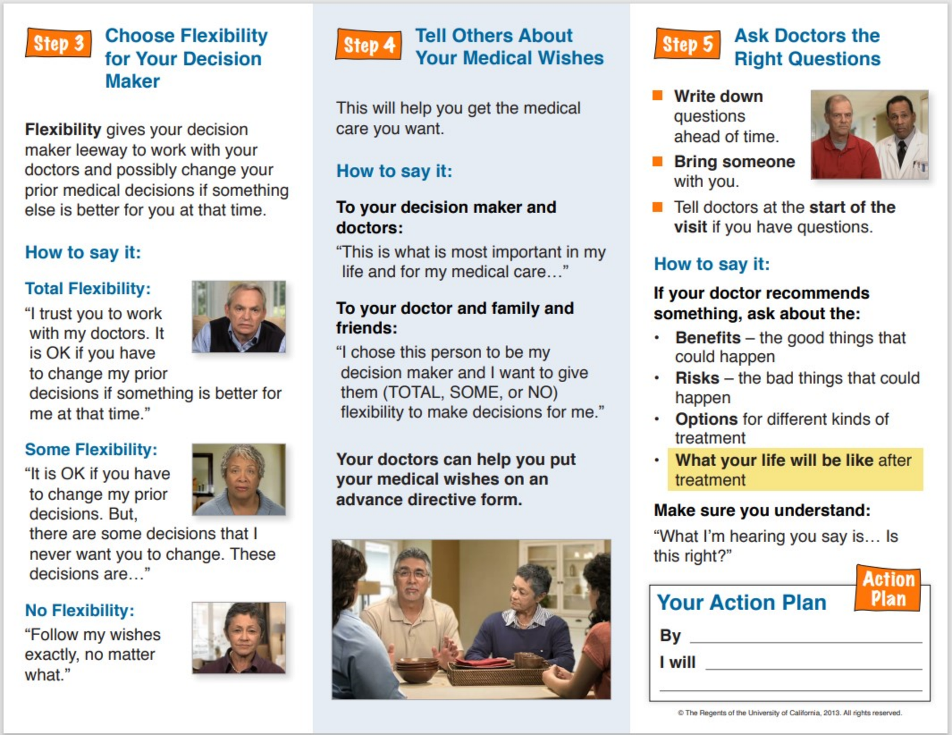
"I do not want to make my own medical decisions. Would you talk to the doctors and help make medical decisions for me now and in the future?"

Step 2 Decide What Matters Most in Life

This can help you decide on medical care that is right for you.

Five questions can help you decide what matters for your medical care:

1. **What is most important in life?** Friends? Family? Religion?
2. **What experiences have you** had with serious illness or death?
3. **What brings you quality of life?** Quality of life is different for each person. Some people are willing to live through a lot for a chance of living longer. Others know certain things would be hard on their quality of life.
4. **If you were very sick, what would be most important to you:**
   - To live as long as possible even if you think you have poor quality of life?
   - **Or**, to try treatments for a period of time, but stop if you are suffering?
   - **Or**, to focus on quality of life and comfort, even if your life is shorter?
5. **Have you changed your mind** about what matters most in your life over time?



Step 3 Choose Flexibility for Your Decision Maker

Flexibility gives your decision maker leeway to work with your doctors and possibly change your prior medical decisions if something else is better for you at that time.

How to say it:

Total Flexibility:

"I trust you to work with my doctors. It is OK if you have to change my prior decisions if something is better for me at that time."

Some Flexibility:

"It is OK if you have to change my prior decisions. But, there are some decisions that I never want you to change. These decisions are…"

No Flexibility:

"Follow my wishes exactly, no matter what."

Step 4 Tell Others About Your Medical Wishes

This will help you get the medical care you want.

How to say it:

To your decision maker and doctors:

"This is what is most important in my life and for my medical care…"

To your doctor and family and friends:

"I chose this person to be my decision maker and I want to give them (TOTAL, SOME, or NO) flexibility to make decisions for me."

Your doctors can help you put your medical wishes on an advance directive form.

Step 5 Ask Doctors the Right Questions

- **Write down** questions ahead of time.
- **Bring someone** with you.
- Tell doctors at the **start of the visit** if you have questions.

How to say it:

If your doctor recommends something, ask about the:

- **Benefits** – the good things that could happen
- **Risks** – the bad things that could happen
- **Options** for different kinds of treatment
- **What your life will be like** after treatment

Make sure you understand:

"What I'm hearing you say is… Is this right?"

Action Plan

Your Action Plan

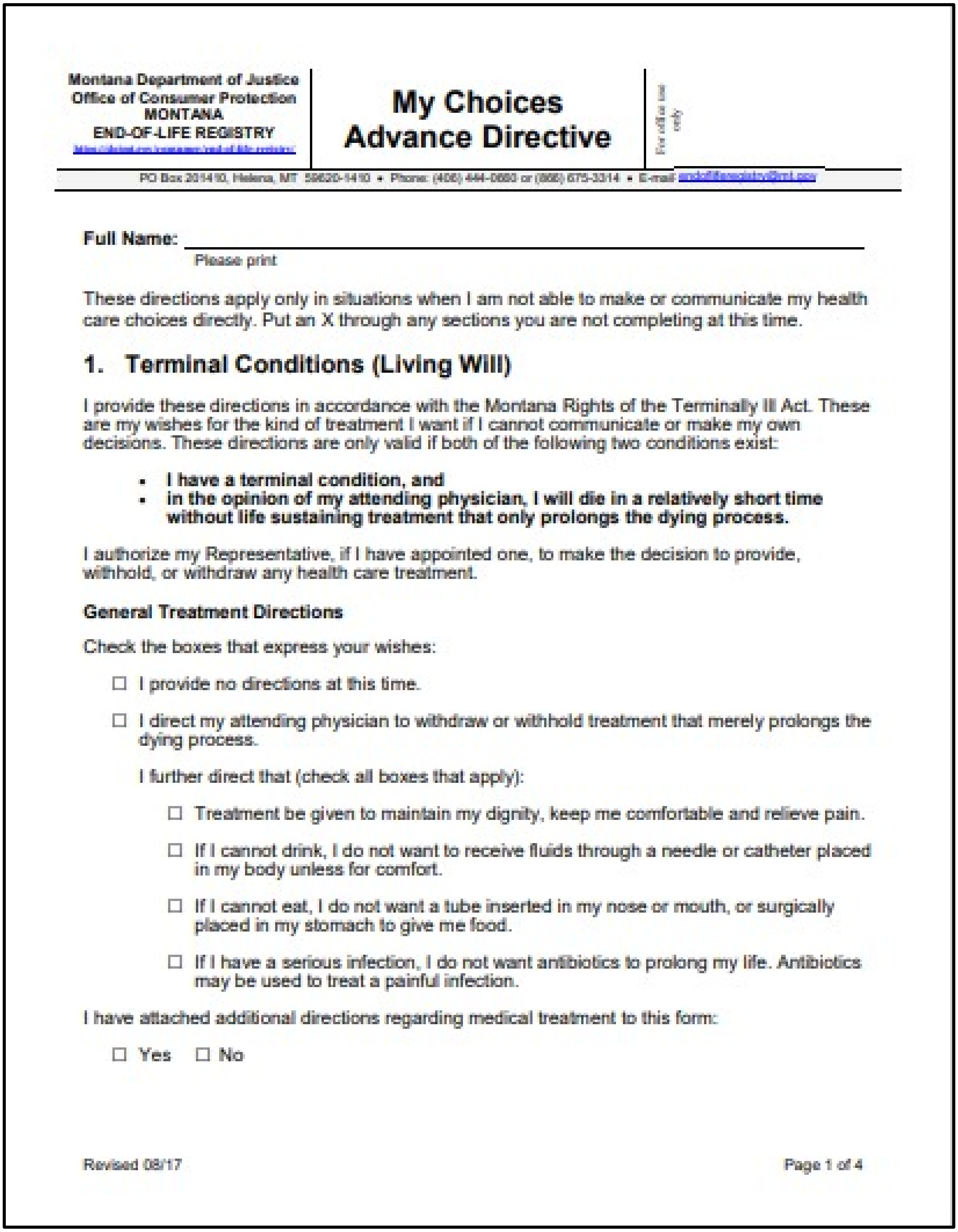
By ____________________

I will ____________________

____

APPENDIX B

MY CHOICE ADVANCE DIRECTIVE FORM



Montana Department of Justice
Office of Consumer Protection
MONTANA
END-OF-LIFE REGISTRY

My Choices Advance Directive

For office use only

PO Box 201410, Helena, MT 59620-1410 • Phone: (406) 444-0660 or (866) 675-3314 • E-mail

Full Name: ______________________________
Please print

These directions apply only in situations when I am not able to make or communicate my health care choices directly. Put an X through any sections you are not completing at this time.

1. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if both of the following two conditions exist:

- **I have a terminal condition, and**
- **in the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment that only prolongs the dying process.**

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

General Treatment Directions

Check the boxes that express your wishes:

☐ I provide no directions at this time.

☐ I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

I further direct that (check all boxes that apply):

☐ Treatment be given to maintain my dignity, keep me comfortable and relieve pain.

☐ If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.

☐ If I cannot eat, I do not want a tube inserted in my nose or mouth, or surgically placed in my stomach to give me food.

☐ If I have a serious infection, I do not want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.

I have attached additional directions regarding medical treatment to this form:

☐ Yes ☐ No

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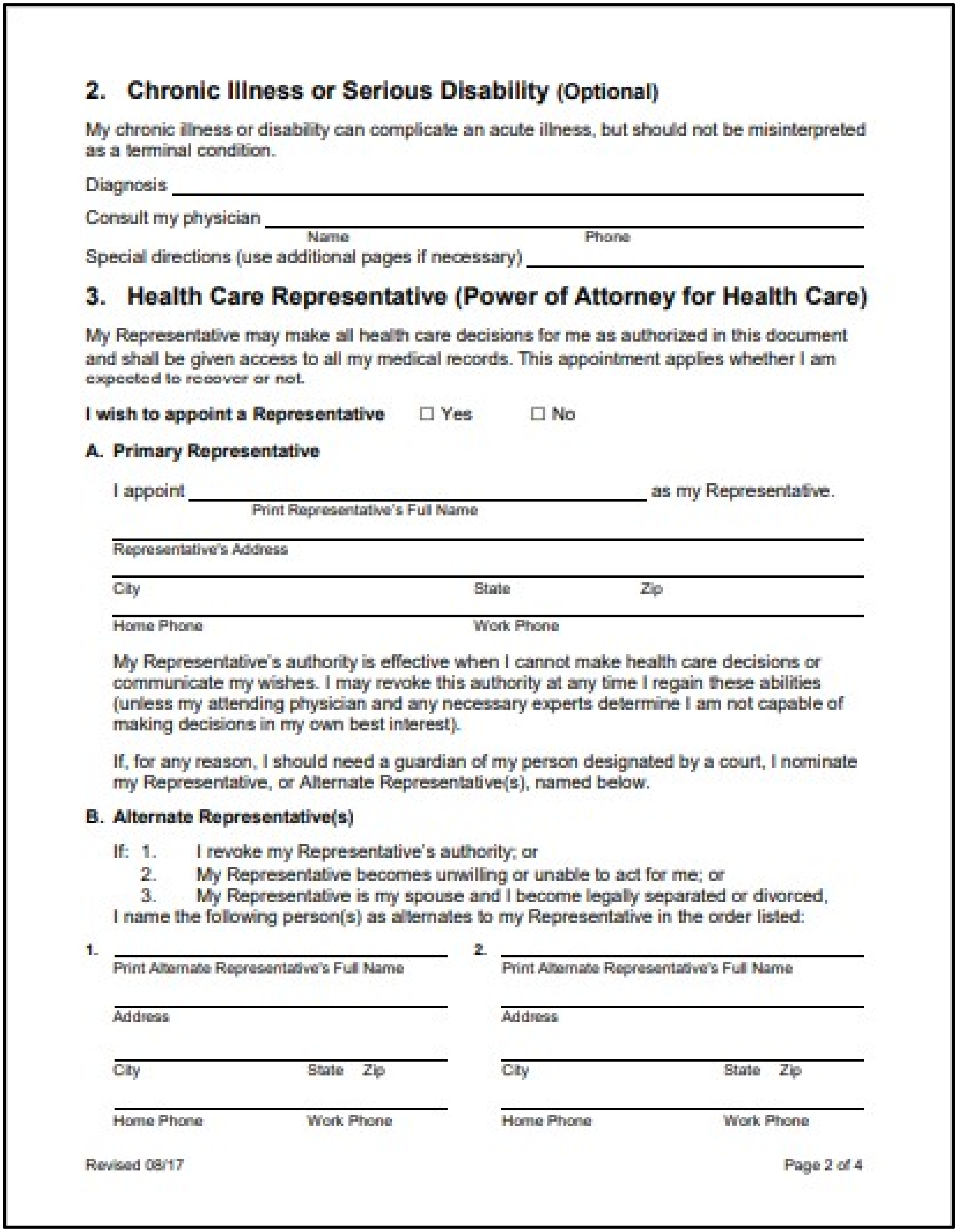

2. Chronic Illness or Serious Disability (Optional)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

Diagnosis ______________________________

Consult my physician ______________________________
Name Phone

Special directions (use additional pages if necessary) ______________________________

3. Health Care Representative (Power of Attorney for Health Care)

My Representative may make all health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

I wish to appoint a Representative ☐ Yes ☐ No

A. Primary Representative

I appoint ______________________________ as my Representative.
Print Representative's Full Name

____
Representative's Address

____
City State Zip

____
Home Phone Work Phone

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

B. Alternate Representative(s)

If: 1. I revoke my Representative's authority; or
2. My Representative becomes unwilling or unable to act for me; or
3. My Representative is my spouse and I become legally separated or divorced,
I name the following person(s) as alternates to my Representative in the order listed:

1. ______________________________ Print Alternate Representative's Full Name	2. ______________________________ Print Alternate Representative's Full Name
______________________________ Address	______________________________ Address
______________________________ City State Zip	______________________________ City State Zip
______________________________ Home Phone Work Phone	______________________________ Home Phone Work Phone

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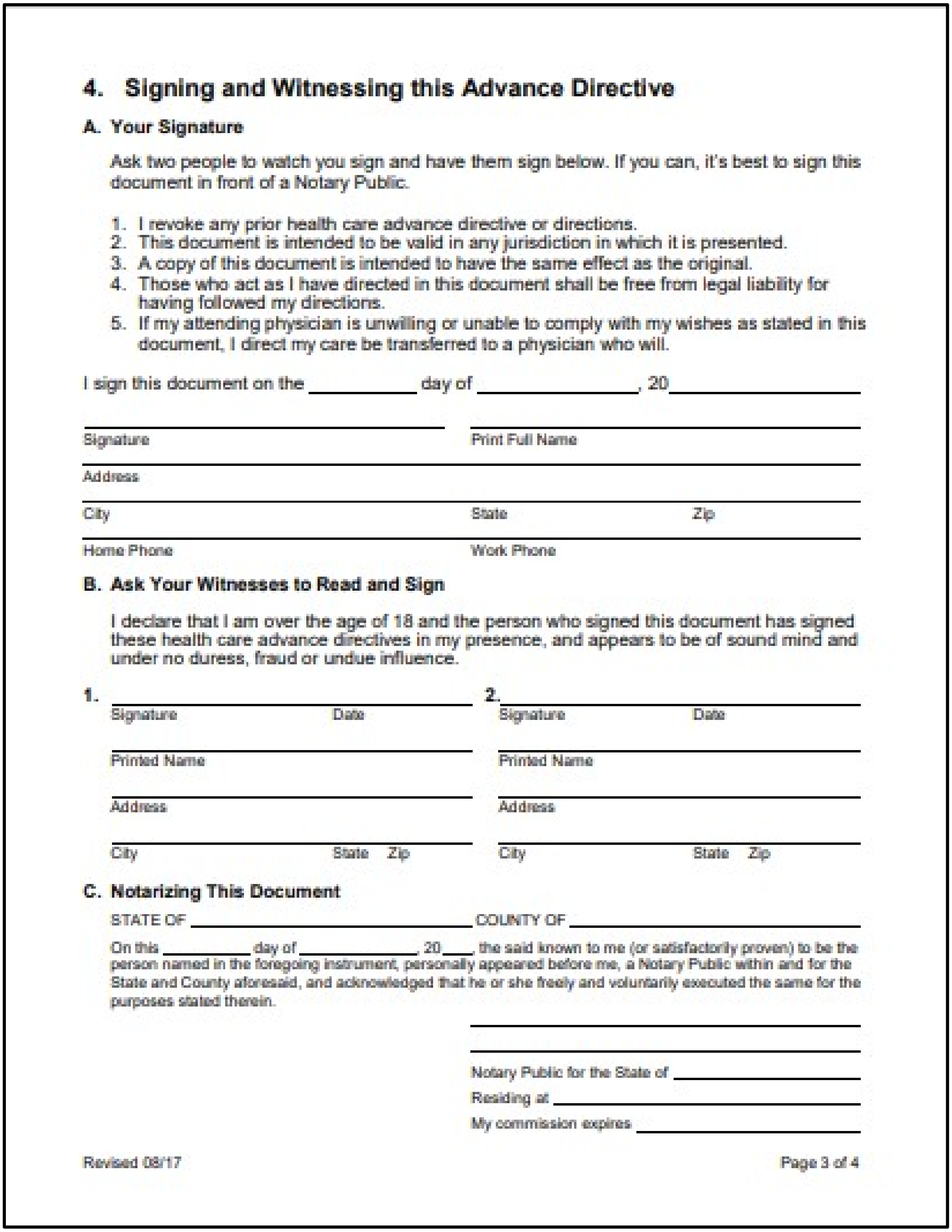

4. Signing and Witnessing this Advance Directive

A. Your Signature

Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the __________ day of ______________, 20__________

Signature	Print Full Name	
Address		
City	State	Zip
Home Phone	Work Phone	

B. Ask Your Witnesses to Read and Sign

I declare that I am over the age of 18 and the person who signed this document has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud or undue influence.

1. Signature	Date		**2.** Signature	Date	
Printed Name			Printed Name		
Address			Address		
City	State	Zip	City	State	Zip

C. Notarizing This Document

STATE OF ____________________ COUNTY OF ____________________

On this ________ day of ____________, 20____, the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

Notary Public for the State of ____________________

Residing at ____________________

My commission expires ____________________

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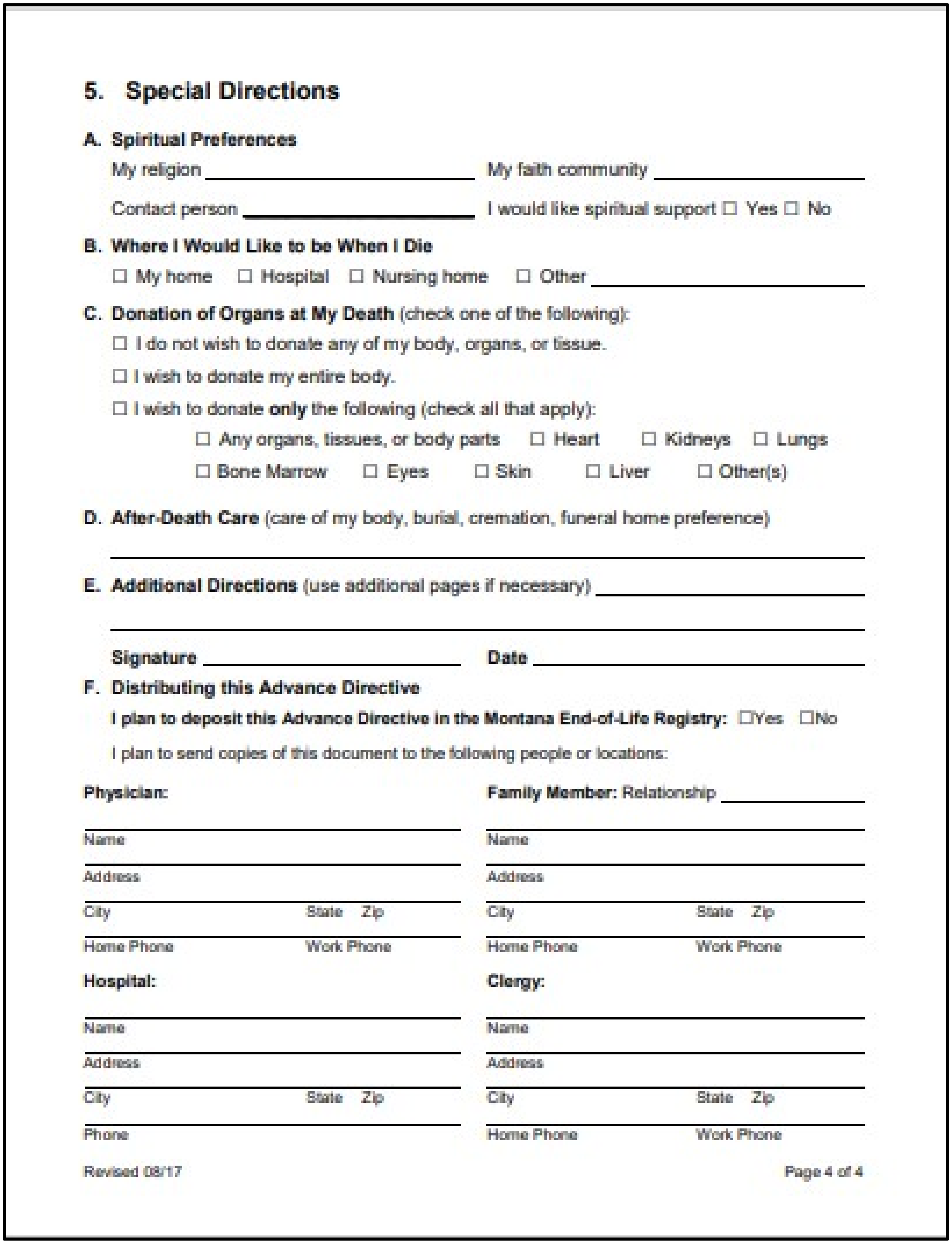

5. Special Directions

A. Spiritual Preferences

My religion

My faith community

Contact person

I would like spiritual support ☐ Yes ☐ No

B. Where I Would Like to be When I Die

☐ My home ☐ Hospital ☐ Nursing home ☐ Other

C. Donation of Organs at My Death (check one of the following):

☐ I do not wish to donate any of my body, organs, or tissue.

☐ I wish to donate my entire body.

☐ I wish to donate **only** the following (check all that apply):

☐ Any organs, tissues, or body parts ☐ Heart ☐ Kidneys ☐ Lungs

☐ Bone Marrow ☐ Eyes ☐ Skin ☐ Liver ☐ Other(s)

D. After-Death Care (care of my body, burial, cremation, funeral home preference)

E. Additional Directions (use additional pages if necessary)

Signature **Date**

F. Distributing this Advance Directive

I plan to deposit this Advance Directive in the Montana End-of-Life Registry: ☐Yes ☐No

I plan to send copies of this document to the following people or locations:

Physician:

Name

Address

City State Zip

Home Phone Work Phone

Hospital:

Name

Address

City State Zip

Phone

Family Member: Relationship

Name

Address

City State Zip

Home Phone Work Phone

Clergy:

Name

Address

City State Zip

Home Phone Work Phone

Revised 08/17

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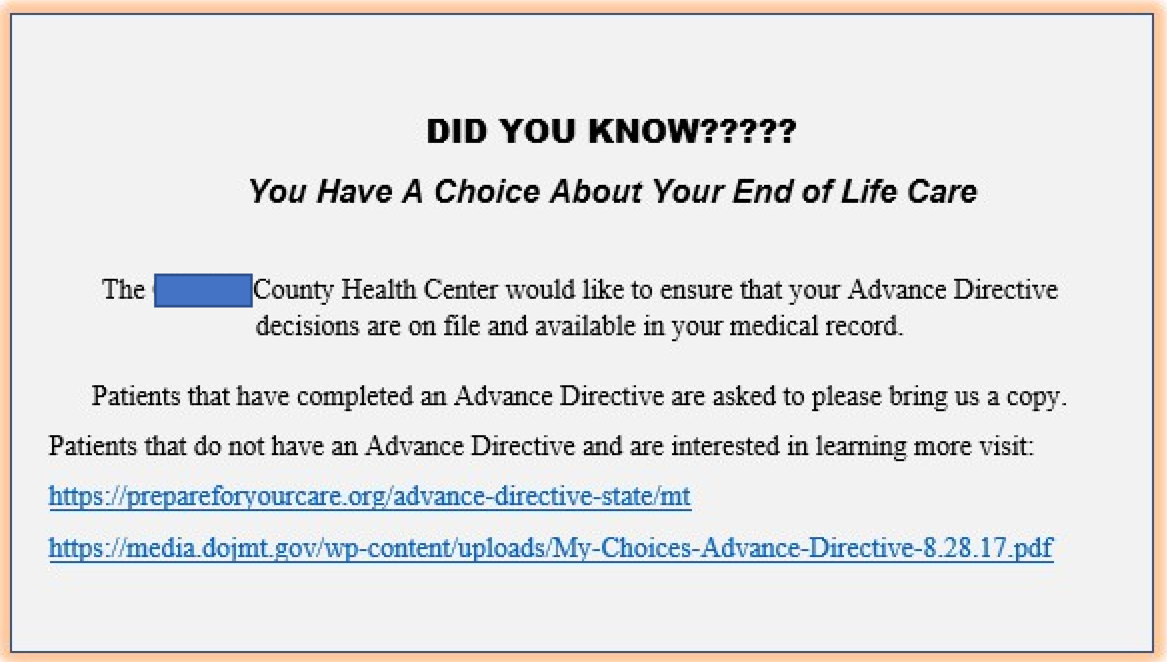
APPENDIX C

SOCIAL MEDIA POST



DID YOU KNOW?????

You Have A Choice About Your End of Life Care

The [redacted] County Health Center would like to ensure that your Advance Directive decisions are on file and available in your medical record.

Patients that have completed an Advance Directive are asked to please bring us a copy.

Patients that do not have an Advance Directive and are interested in learning more visit:

https://prepareforyourcare.org/advance-directive-state/mt

https://media.dojmt.gov/wp-content/uploads/My-Choices-Advance-Directive-8.28.17.pdf

APPENDIX D

ORGANIZATION POLICY

[redacted]

DEPARTMENT: Medical

POLICY & PROCEDURE TITLE: Advance Directive Screening & Education

INITIATION DATE: 12-14-20

REVISION DATE:

APPROVED BY: Earline Lawrence COO

Purpose:

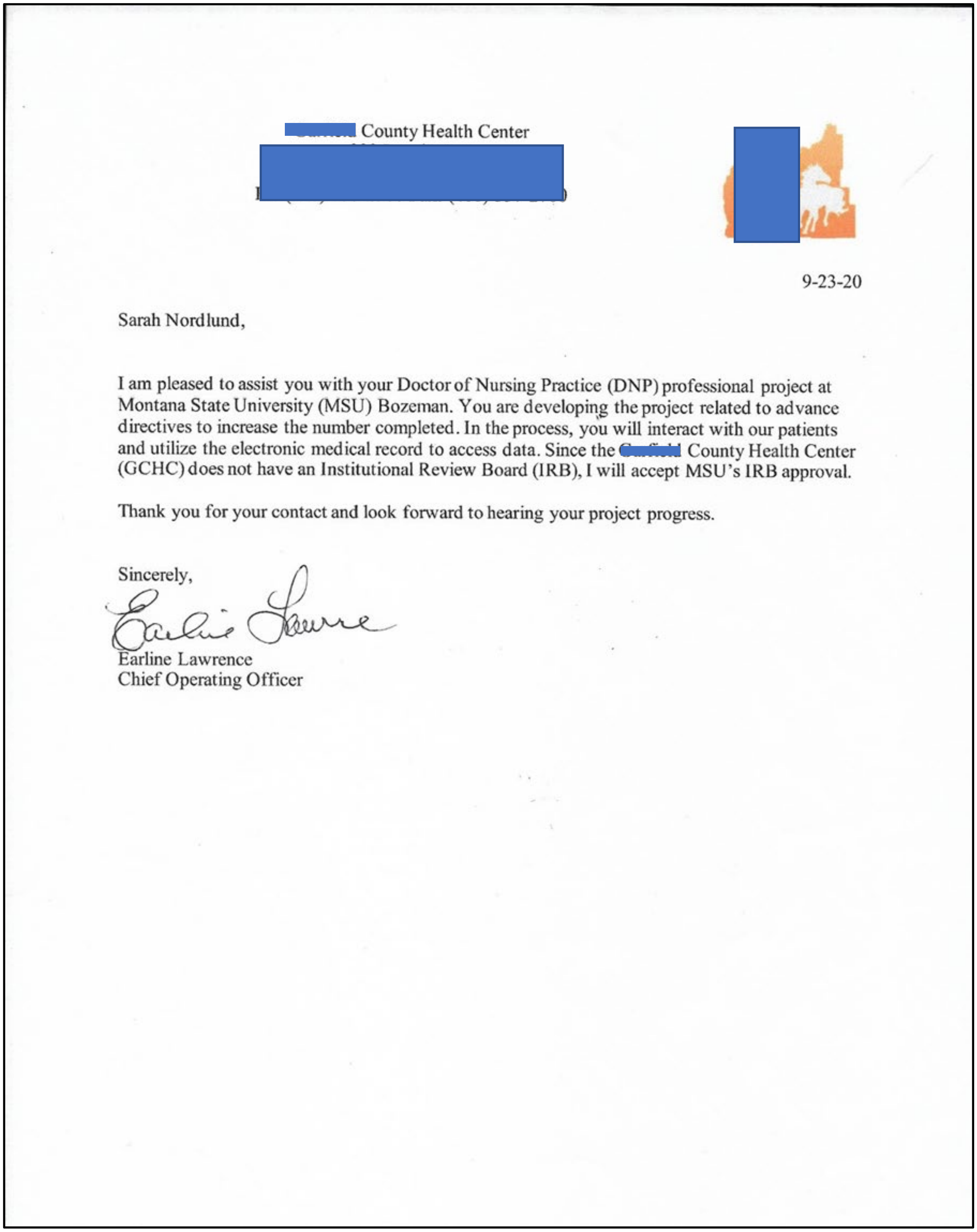
- To provide a systematic method to screen Garfield County Health Center patients for the presence of Advance Directive.
- To ensure that Garfield County Health Center clinicians are provided advance care planning education.

Policy/Procedure:

- All Garfield County Health Center clinicians will complete Relias advance care planning online education upon hire and then annually.
- All Garfield County Health Center patients aged 65 years and older will be asked by the clinic receptionist as part of the intake process if they have an advance directive.
- Patients that report that they do not have a completed advance directive will be asked to provide the facility a copy to have on file in their medical record.
- Patients that report that they do not have a completed advance directive will be provided a copy of the PREPARE informational brochure and the My Choices Advance Directive form.

APPENDIX E

SITE APPROVAL



[redacted] County Health Center
[redacted]

[redacted]

9-23-20

Sarah Nordlund,

I am pleased to assist you with your Doctor of Nursing Practice (DNP) professional project at Montana State University (MSU) Bozeman. You are developing the project related to advance directives to increase the number completed. In the process, you will interact with our patients and utilize the electronic medical record to access data. Since the [redacted] County Health Center (GCHC) does not have an Institutional Review Board (IRB), I will accept MSU's IRB approval.

Thank you for your contact and look forward to hearing your project progress.

Sincerely,

Earline Lawrence
Chief Operating Officer

APPENDIX F

EVIDENCE TABLE

EVIDENCE TABLE

Citation:	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence
Amjad, Halima, Towle, Virginia, and Fried, Terri. "Association of Experience with Illness and End-of-life Care with Advance Care Planning in Older Adults." *Journal of the American Geriatrics Society (JAGS) 62.7 (*2014): 1304-309. Web.	Transtheoretical Model	Observational cohort study	Community- 304 participants	Personal experience Stages of change Readiness for ACP	Univariate statistics were used to describe the study population and characterize the stages of change for the ACP behaviors.	Mantel-Haenszel chi-square test	84% had one or more personal experiences or experience with others. Personal experiences were not associated with increased readiness for most ACP behaviors.	Level II
Ceronsky, L., Shearer, J., Weng, K., Hopkins, M., & McKinley, D. (2013). Minnesota rural palliative CARE Initiative: Building palliative Care capacity in Rural Minnesota. *Journal of Palliative Medicine, 16*(3), 310-313. doi:10.1089/jpm. 2012.0324	None	Study of a palliative care program development	10 communities	Learning collaboratives	Presence of palliative care program Mentoring calls	Survey pre and post education	Using three prong framework confirmed the feasibility of building palliative care capacity in rural communities.	Level IV

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
Christensen, K., Winters, C., Colclough, Y., Oley, E., & Luparell, S., (2019). Advance Care Planning in Rural Montana: Exploring the Nurse's Role. *Journal of Hospice and Palliative Nursing, 21*(4), 264-271.	None	Qualitative Study Mixed Method Design and Community Based Participatory Research	2 Primary Care Settings 19 patients 16 healthcare professionals	Feedback on ICSI and Jumpstart forms	Transcription of audio recordings from focus groups Observations coded and themes aligned	Thematic Analysis Iterative Process	Both forms should be made easier to use with clearer language.	Level III
Detering, K. M., Hancock, A. D., Reade, M. C., & Silvester, W. (2010). The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ (Clinical research ed.)*, *340*, c1345. https://doi.org/10.1136/bmj.c1345	none	Randomized control trial	University hospital 309 patients age 80 and older	Usual care Usual care + ACP interventions	Wishes respected at death 5 question patient satisfaction survey Hospital anxiety and depression scale	Stata version 9.2 t tests Mann-Whitney U tests. χ2 tests or Fisher exact tests	family members of patients who died had significantly less stress (intervention 5, control 15; P<0.001), anxiety (intervention 0, control 3; P=0.02), and depression (intervention 0, control 5; P=0.002)	Level 1

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
De Vleminck, A., Houttekier, D., Pardon, K., Deschepper, R., Van Audenhove, C., Vander Stichele, R., & Deliens, L., (2013). Barriers and facilitators for general practitioners to engage in advance care planning: A systematic review. *Scandinavian Journal of Primary Health Care, 31*(4), 215-226.	None	Systematic Review	8 qualitative studies, 7 cross sectional studies	Barriers and Facilitators for ACP	Data extraction form, Critical Skills Programme	Independent assessment	Barriers identified: difficulties defining the right moment, attitude that the patient should initiate ACP fear of depriving patient of hope.	Level II
Fahner, J., Beunders, A., Heide, A., Rietjens, J., Vanderschuren, M., Delden, J., & Kars, M., (2019). Interventions Guiding Advance Care Planning Conversations: A Systematic Review. *Journal of the American Medical Directors Association, 20*(3), 227-248. doi:10.1016/j.jamda.2018.09.014	None	Systematic Review	82 articles	Patient's perspectives on illness, living well, endo of life issues, and decision making	Cochrane and COREQ	Thematic analysis- 2 authors	A framework for ACP conversations: preparation, initiation, exploration, and action. Patients appreciate and understand the benefits of ACP conversations and also feel they are difficult.	Level I

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
Garrido, M., Balboni, T., Maciejewski, P., Bao, Y., & Prigerson, H. (2015). Quality of Life and Cost of Care at the End of Life: The Role of Advance Directives. *Journal of pain and symptom management*, *49*(5), 828–835. https://doi.org/10.1016/j.jpainsymman.2014.09.015	None	Interviews 336 patients	Advance cancer patients and caregivers	Quality of life, estimated costs of care received in the week before death, heroic measures, DNP	Baseline interviews, quality of life rater, charlson comorbidity index, demographics	Stratification Mean incremental effects	Documenting preferences against resuscitation in medical orders may be beneficial to patients.	Level III
Gazarian, P. (2020). Uptake and Trends in the Use of Medicare Advance Care Planning Visits. Health Services Research, 55(S1), 16-16. doi:10.1111/1475-6773.13344	None	Examination of ACP claims by CPT codes	Data analysis	348 190 ACP claims from a 20% random sample of fee-for-service (FFS) Medicare beneficiaries continuously enrolled from 2016 to 2017	Examination of the total number of claims	N/A	The number of ACP claims increased from 137 079 in 2016 to 348,190 in 2017, an increase of 154%.	Level II

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
Heyland, D., Barwich, D., Pichora, D., Dodek, P., Lamontagne, F., You, J. J., Tayler, C., Porterfield, P., Sinuff, T., Simon, J., ACCEPT (Advance Care Planning Evaluation in Elderly Patients) Study Team, & Canadian Researchers at the End-of-Life Network (CARENET) (2013). Failure to engage hospitalized elderly patients and their families in advance care planning. *JAMA internal medicine*, *173*(9), 778–787. https://doi.org/10.1001/jamainternmed.2013.180	None	Prospective Study	12 acute care hospitals 278 patients 225 family members	Expressed preferences and orders of care documented in the medical record	Patient and family interview and questionnaire	Percentages Wald Approach	Communication with healthcare professionals and documentation of end-of-life wishes is inadequate	Level III

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
Houben, C., Spruit, M. A., Groenen, M., Wouters, E., & Janssen, D. (2014). Efficacy of advance care planning: a systematic review and meta-analysis. *Journal of the American Medical Directors Association*, *15*(7), 477–489. https://doi.org/10.1016/j.jamda.2014.01.008	None	Systematic Review and Meta-Analysis	55 studies	Completion of advance directives, occurrence of end-of-life discussions, preferences for care, delivered care, knowledge of ACP, quality of communication, satisfaction with healthcare, decisional conflict	Predefined data abstraction form	PEDro scale- 2 independent reviewers. Random effects model	ACP interventions increase the completion of advance directives	Level 1
Howard, M., Bernard, C., Klein, D., Elston, D., Tan, A., Slaven, M., Barwich, D., You, J., Heyland, D. (2018). Barriers to and enablers of advance care planning with patients in primary care: Survey of health care providers. *Canadian Family Physician, 64*(4), E190-E198.	None	Cross-sectional, self-administered study	117 family physicians 64 other health professionals	Perceived barriers relating to the clinician. Characteristics of patients System factors	7-point scale questionnaire	Percentages and continuous variables Thematic content	Physicians rated insufficient time, inability to electronically transfer the advance care plan across care settings, decreased interaction with patients, patient's difficulty understating limitations and complications of treatment. Other healthcare professionals report their own lack of knowledge.	Level III

Citation:	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence
Kermel-Schiffman, I., & Werner, P. (2017). Knowledge regarding advance care planning: A systematic review. *Archives of gerontology and geriatrics*, *73*, 133–142. https://doi.org/10.1016/j.archger.2017.07.012	None	Systematic Review	37 articles	Subjective and objective knowledge related to ACP Types of instruments	Standardized forms	Reviewed by two independent researchers. Systematically analyzed the studies in the review in term of their main conceptual and methodological characteristics.	Increased effort should be invested in increasing knowledge regarding ACP among professions and lay people.	Level I
Lund, S., Richardson, A., & May, C. (2015). Barriers to Advance Care Planning at the End of Life: An Explanatory Systematic Review of Implementation Studies. *Plos One, 10*(2). doi:10.1371/journal.pone.0116629	Analytic Framework Normalization Process Theory	Systematic Review	13 Papers	Barriers and facilitators to the implementation of ACP	Explanatory Review	Structured approach to interactions around ACPs.	Interventions most likely to meet with success are those that make elements of ACP workable within complex and time pressured clinical workflows.	Level II

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
Sharp, Tim, Moran, Emily, Kuhn, Isla, & Barclay, Stephen. (2013). Do the elderly have a voice? Advance care planning discussions with frail and older individuals: A systematic literature review and narrative synthesis. *British Journal of General Practice, 63*(615), E657-E668.	Gold Standards	Systematic Review	26 articles	Review questions- individual's attitudes, individuals preferences, professionals attitudes, professionals attitudes to diming, barriers to and facilitators, if discussions are held	Gough's Weight of Evidence Criteria	Independent Review	Individuals appreciate a chance to discuss end-of-life care. Most professionals believed it was their responsibility to initiate discussions. Barriers included reluctance of family members and passive expectation.	**Level I**
Silveira, M., Kim, S., & Langa, K., (2010). Advance Directives and Outcomes of Surrogate Decision Making before Death. *The New England Journal of Medicine, 362*(13), 1211-1218.	None	Data from the Health and Retirement Study	3746 individuals	Association between preferences documented in advance directives and outcomes of surrogate making	Multivariable logistic regression	Researcher tabulation Stata software	Patients that had prepared advance directives received care that was strongly associated with their preferences.	Level 2

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
Steinhauser, K., Christakis, A., Clipp, C., McNeilly, M., McIntyre, L., & Tulsky, A. (2000). Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA, 284*(19), 2476–2482. https://doi.org/10.1001/jama.284.19.2476	none	Cross sectional stratified random national survey	340 seriously ill patients 332 bereaved family members 361 physicians 429 other healthcare providers	Importance of 44 attributes of quality at the end of life and rankings of 9 major attributes	Survey- scale	Friedman tests Wilcoxon tests Logistic regression SAS software	Pain and symptom management, preparation for death, achieving a sense of completion, decisions about treatment preferences and being treated as a whole person were items rated as being important.	Level III
Sudore, R., Katen, M., Shi, Y., Boscardin, J., Osua, S., & Barnes, D. (2019). Engaging diverse English- AND Spanish-Speaking older adults in Advance Care planning: The prepare randomized clinical Trial (FR421D). *Journal of Pain and Symptom Management, 57*(2), 413. doi:10.1016/j.jpainsymman.2018.12.127	none	Randomized Trial	986 English and Spanish speaking patients	PREPARE plus an easy-to-read advance directive and advance directive alone	Mixed effects logistic and linear regression	Surveys at baseline, 1 week, 3 months, 6 months and 12 months	Compared with the advance directive alone, PREPARE resulted in a high rate of advance care planning documentation.	Level I

Citation:	**Conceptual Framework**	**Design/ Method**	**Sample/ Setting**	**Major Variables Studied and Their Definitions**	**Measurement of Major Variables**	**Data Analysis**	**Study Findings**	**Strength of the Evidence**
Yadav, K. N., Gabler, N. B., Cooney, E., Kent, S., Kim, J., Herbst, N., . . . Courtright, K. R. (2017). Approximately one in three US adults completes any type of advance directive for end-of-life care. Health Affairs, 36(7), 1244-1251. doi:http://dx.doi.org.proxybz.lib.montana.edu/10.1377/hlthaff.2017.0175	none	Systematic review	150 studies reviewed 795,909 U.S. adults	Advance directive completion Demographics Socioeconomic variables Presence of chronic condition Source of health care	Logistic regression analysis	Descriptive statistics Chi square	The prevalence of advance directives in the United States is low and static.	Level 1