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## Advance Care Planning in Primary Care

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## **Executive Summary**

### **Introduction of the Problem**

Advance Care Planning (ACP) is a process in which a person makes their medical wishes and preferences known about end-of-life care preemptively, while they have a decision-making capacity (Silveira, 2021). The best time to address end-of-life care is proactively, at wellness visits, in a stress-free environment, with a trusted healthcare professional. ACP is completed through a variety of forms such as a Living Will (LW), Durable Power of Attorney (DPOA), Do Not Resuscitate (DNR) and Physician Orders for Life-Sustaining Treatment (POLST) (Silveira, 2021). Completing this paperwork prior to a life-threatening injury or illness allows the patient's wishes to be honored when they are not able to make decisions. Discussions surrounding ACP can start as early as 18 years of age.

Primary care offices can routinely include ACP as a part of their exam to ensure consistency in addressing it with all patients over the age of 18. Some offices track compliance among providers and that factors into their reimbursement each quarter. However, one Midwest family practice clinic was not implementing AD compliance for providers or patients; therefore, ACP was not being addressed. This was due to lack of education on ACP, deficiency in knowledge surrounding AD, and lack of guidelines to facilitate ACP. By implementing ACP in the primary care setting, patients are allotted ample time to learn, understand, and reflect on their wishes. Education, increased awareness, and assistance with completion of these documents with both providers and the patients helps resolve this gap of care (Silveira, 2021).

### **Literature Review**

ACP supports self-determination and autonomy in patients, especially those who are critically or terminally ill. In the medical community, ACP and AD are common and well-known terms; however, many patients either do not know about ACP or have not developed an AD. According to Scholten et al. (2018), 90% of patients had heard of AD while only 17% had created and instated an AD. Another study found that only 15-30% of patients had completed an AD (Atherton, 2020). Scholten et al. (2018) found that even when critically or terminally ill, less than 50% of patients had an AD in their hospital record.

Many factors contribute to difficulties associated with ACP and AD completion. One barrier is “the lack of user-friendly features” (Wickersham et al., 2019, para 7). Medical terminology and documents can be hard to decipher for medical professionals, let alone patients who do not have a medical background. Nearly 30% of patients stated that AD material was too difficult to understand (Scholten et al., 2015). Other barriers include fear, family dynamics, and the difficulty of discussing the end of life when there is no imminent threat. Many patients do not even consider AD until death is imminent (Glennon, 2019).

According to Scholten et al. (2018), some providers do not feel competent in ACP discussion, have time constraints, and some are reluctant to discuss the end of life. Given that there are many forms of ADs, it can be time consuming to educate each patient on the different types. It is important for providers to remain organized when discussing AD and interact with the patients on a more personal level, given the complexity and sensitivity of the topic (Wickersham et al., 2019).

After discussing and instating an AD, providers can then determine billing and reimbursement. Providers can use two codes introduced by the Centers for Medicare and Medicaid Services for billing and reimbursement, if the appropriate documentation is completed.

(Barwise et al., 2020). Documentation needed for reimbursement includes: the patient's consent, total amount of time in minutes, individuals present during the discussion, information discussed, the patient's understanding of the illness, and whether an AD was completed (Barwise et al., 2020). While billing and reimbursement should not be the reason that providers discuss and implement AD for patients, knowledge of the billing and reimbursement criteria is important to ensure providers are being reimbursed for their efforts.

There is a very low percentage of individuals who have participated in ACP and have instated an AD (Scholten et al., 2018). By having an AD in place, patients can have peace of mind in knowing that their wishes are known and implemented in the event of a terminal diagnosis or fatal event.

### **Project Methods**

To increase awareness, understanding, and competence of ACP, ancillary staff and providers at a family medicine clinic were educated about ACP by both in-person discussion and with a handout. The participating provider also took a course through the Centers for Disease Control (CDC) Healthy Aging program to further their knowledge of ACP. The CDC course counted towards continuing education units (CEUs). Afterward, staff understanding of ACP and AD was evaluated by teach back of material and open discussion to confirm the education was effective. Once staff were effectively educated on the importance of ACP, the next part of the project was implemented. A questionnaire was given to patients to evaluate pre-existing understanding of ACP. The questionnaire was given to each patient 18 years or older prior to their appointment by ancillary staff. The questionnaire assessed the patients' current ACP status, knowledge, desire to learn, and desire to complete or update. This questionnaire allowed for further conversation between the healthcare team and the patient regarding ACP.

## Evaluation

Ancillary staff were evaluated through an open discussion meeting where group members presented ACP materials and questions were answered. Each staff member had to read an educational handout and sign it after the meeting to confirm their understanding of the materials discussed. The provider completed the CDC's Healthy Aging Program on ACP and presented the certificate.

There was a total of 53 patients in a 6-week period who completed the questionnaire and of those 53 patients, 77% of patients understood ADs. 21% of these patients had completed an AD prior to the survey. When asked if they wanted help updating their AD, 21% answered "Yes", 62% answered "No", and 17% answered "N/A". Of the patients who completed the questionnaire, 66% declined to receive more information on AD. Finally, when asked if they would like to receive educational materials on AD, 54% answered "Yes." A majority patients were aware of what an AD is, but 79% have not completed an AD and 62% were not interested in updating their existing AD. The results showed that about half of patients were interested in taking home educational material on AD, rather than discussing it in the office at the time of the appointment.

There were several limitations throughout the implementation phase of this project. Prior to implementation, several providers agreed to participate. However, they withdrew their participation after leaving the facility for different jobs; therefore, the data collected came from only one provider's patients. This led to a decrease in the total number of patients available. Also, many patients were given educational materials to take with them to formulate an AD and communicate with family members, with plans to bring back their AD at their next follow-up appointment. Patients who completed AD paperwork after the implementation phase were not

included in the total since it was outside of the project window. Out of the patients seen in the office throughout the implementation phase, only 16% were given the questionnaire. The group members were unable to be on site each day during the 6 weeks of implementation, which is attributed to the low percentage of patients receiving the questionnaire. The clinical staff who were tasked with distributing the questionnaires often forgot to give them to patients. Additionally, many patients declined to complete the questionnaire simply because they were uninterested.

### **Impact on Practice**

Before the survey, the facility did not have specific tools to discuss AD with patients. The immediate impact was bringing awareness to both medical staff and patients about AD through education. The predicted long-term impact surrounding AD in primary care is an increase in the number of patients who have AD. The increased number of ADs completed in primary care will then impact the care of patients with critical or terminal diagnoses.

In the future, the suggested changes include having educational material in each exam room that is visible to the patient to prompt discussion. By having educational material visible, patients may feel more inclined to read about AD on their own first, rather than immediately discussing it with a provider. Going forward, it may also be beneficial to audit patient's charts to assess completion of AD and implementing annual education via Continued Based Learning (CBLs) on ACP. Auditing charts to assess completion of AD would be a reasonable way to measure compliance of AD discussion and completion.

### **Conclusion**

ACP is a topic that is often missed at annual health visits, and many patients do not understand the importance of having an AD completed. The goal of this project was to educate healthcare professionals, so they were better equipped to assist patients in completing their AD. This project also prompted patients to consider their healthcare wishes if they become incapable of making their own decisions.

Future recommendations include requiring conversation and documentation about end-of-life care at all wellness visits for patients over the age of 18. We also encourage placement of posters or pamphlets in patient rooms to initiate ACP conversation. Finally, we encourage implementing yearly educational opportunities for staff by using CBLs on ACP.

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