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A Right to Choose: A Multi-Modal Approach to Improve Advance Directive Completion Rates

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ABSTRACT

Purpose: Advance Directives (AD) ensure that patients receive care consistent with their individual values, while also minimizing the decisional burden often placed on families when a patient's wishes are not documented at the end of their life. This quality improvement (QI) project was intended to improve patients' overall understanding of Advance directives (AD) and improve completion rates in a primary care setting for patients eighty years and above using a multimodal system.

Methods: This QI project occurred in a primary care setting from March 2016 through March 2017. The multi-modal approach used included contacting patients by telephone, mailing AD informational packets prior to scheduled visit, in office AD discussions and follow-up phone calls. Collected data included patients' age, provider, status of AD completion, multi-modal approach used and patients' availability for discussion. Patients included were eighty and above and did not have a documented AD.

Results: Pre-implementation, two participating providers had a 23.81% & 20.0% AD completion rate for patients eighty and above. Post-implementation, participating providers increased to 60.71% and 38.71% respectively.

Conclusions: A multi-modal approach with structured education on the topic of ADs and providers' recognition of patients in need of ADs, resulted in improved rates of AD completion, while also facilitating patient centered care.

Keywords: Advance Care Planning, Advance Directives, End-of-life discussion

A Right to Choose: A Multi-Modal Approach to Improve Advance Directives Completion Rates

INTRODUCTION

Advance Directives (AD) ensure patients receive care that is consistent with their unique values, while also minimizing the decisional burden often placed on families when their wishes are not documented at the end of life. Since the enactment of the Patient Self-Determination Act in 1990, advance care planning has received increasing attention.¹ Despite this, population-based estimates for adults over the age of 40 with a completed AD was 47% in 2013.² In the United States, 25% of all Medicare spending is for the 5% of patients who are in their final year of life, and most of that money goes for care in their last couple of months that is of little apparent benefit.¹⁰

Studies have shown that low AD completion rates are related to multiple factors due to physician and patient alike. Physician barriers to completing advance directives include lack of time, discomfort with the topic, and lack of reimbursement. Patient's cite lack of knowledge, fear of burdening family, and a desire to have the physician initiate the discussion. Once the advance directive is complete, barriers to implementation include vague language and accessibility of the advance directive.³ Medicare's new reimbursement guidelines that allow a charge to be made for AD discussion, may provide incentives for AD discussion and dramatically improve the rate of provider-patient discussions. Providers are pivotal in the efforts to increase AD completion rates; it has been shown that the most successful interventions include repeated conversation with the provider about completion of advance directives over time.^{3,4} Studies have also shown that

patients want their primary care doctor to initiate advance care planning while they are in good health.⁵

Family members are often burdened with difficult decisions at highly volatile and emotional times. Excessive hospital expenses accumulate as decisions are made with the hopes of keeping the patient alive, with little regard for quality of life. ADs are crucial to designating levels of healthcare intervention. Although legislative and regulatory bodies continue to promote advance directives vigorously, the overall prevalence of completed ADs in the United States remains low.⁴ The discussion of advance directives is needed, yet in most primary care settings it is not standard practice. Incorporating discussion of Advance Care Planning (ACP), including ADs, into routine practice between healthcare providers and their patients may shed light on the daunting task of end-of-life decisions. This quality improvement (QI) project was intended to increase patients' overall understanding of ADs and increase completion rates in a primary care setting for patients eighty years and above using a multimodal system.

Background

The review of literature was conducted to identify successful modalities for improving AD completion rates using health information search engines which included: Medline, CINAHL, and the Cochrane Database, from 1991-present. The Medical Subject Headings (MeSH) terms used were: Advance directive(s), study, completion, primary health and primary care. Inclusion criteria included articles written in the English language, specific to the primary care, from the year 1991-present. The year 1991 was specifically chosen, because the Federal Patient Self-Determination Act was passed in 1990, which requires hospitals, nursing homes, and other facilities to provide information about advance directives to patients and to keep a record

of any completed documents. Exclusion criteria included hospital-based interventions and articles published prior to 1991. The search yielded 47 articles, six were chosen for review. These six were specifically chosen based on the year they were published; quality of evidence and research design. Of the six articles, five were systematic reviews and one was a randomized control trial (RCT). Of these articles a variety of interventions were implemented and or looked at, regardless of success, they were chosen to show the strengths and weaknesses of certain interventions. The strength of evidence was rated from one to six using Melnyk and Fineout-Overhold rating system for the hierarchy of evidence.

Studies found that providing educational information alone did not significantly increase completion rates but providing educational information with the availability of knowledgeable people to answer questions increased completion rates dramatically, with up to 70-89% post intervention.⁷ Discussion is important, but educating patients prior to the appointment allows for a more dynamic conversation.⁸ Mailing ADs and educational literature on ADs before an appointment with a provider who asked about ADs yielded a small but significant improvement in the completion of ADs comparatively.⁹ Follow-up phone calls to answer any further questions further enhanced the patients experience as well as increase AD completion rates.⁷ Multimodal education is paramount.

Local Problem/ Context

This quality improvement (QI) project was based at a primary care office in an urban area in the Western coastal region of the United States. Providers have twenty minute blocks per patient. Despite an organization goal of 60% completion for patients eighty and above, this site had a 31% completion rate. Using the Plan-Do-Study-Act (PDSA) cycle for improvement, the

objectives for this project was to increase patients' overall understanding of advance directives (AD) and increase completion rates in a primary care setting for patients eighty years and older.

Methods

Multimodal education was selected as the intervention. The primary goal was to show that multiple educational opportunities and face-to-face discussion with a provider could enhance patient education and afford providers the added benefit of increased reimbursement through Medicare. Prior to implementation, University of San Diego Institutional Review Board (IRB) approval and the facilities IRB exemption were obtained before any data was collected.

An easy to read advance directive document along with a letter of intent from the provider was sent to the patient by the Doctor of Nursing Practice (DNP) student prior to their scheduled appointment. On the day of their appointment the medical assistant was instructed to hand the patient a laminated hard copy of the AD document for review while they waited for their provider. At the end of the routine visit the provider was instructed to ask the patient if they had any questions regarding ADs that were not addressed. Patients desiring further discussion sat down with the DNP student to review their AD. After discussion these patients were given a choice to: take the document home to complete with family or to complete document and have it notarized that day. Completed documents were scanned into the Electronic Medical Records (EMR) and the DNP student was notified by the Health Information Specialist. Patients who did not return a completed AD form within one month, were contacted by telephone from the DNP student and asked if they were able to fill out their AD form and how we could further assist them. If the patient did not complete their AD, more information was

provided, as appropriate, and they were offered an additional opportunity to complete AD forms. This was done over a four-month time span.

Measures

Squire format was used to organize the study into manuscript form.¹¹ All patients' eighty and older without an AD on file, under the care of the two providers participating in the study, were flagged. Data collected included: age, state of AD completion pre and post project implementation, if the patient was called, if they had an undocumented AD, date of scheduled appointment, if they received the mailed information on ADs, if they requested AD discussion, date of the AD and/or POLST discussion, date AD and/or POLST were scanned into the EMR, and if a follow-up phone call was made.

The measure chosen for studying processes and outcomes of the intervention was the number of completed ADs on file at the physician's office post-intervention. This was chosen to evaluate the effectiveness of a multimodal process to increase AD completion rates. Pre and post data was analyzed to assess the success of the implementation and if moving forward with the project would be appropriate for the clinic.

RESULTS

Fifty patients met the criteria for inclusion in this study. Of the 50 patients without documented ADs on file, 30 of them had a completed AD at home; most prevalent reason for not turning in their completed AD was they were unaware the provider needed it. Eleven of the 50 patients desired face-to-face conversation on ADs; conversations never went over the 30-minute window. The provider was able to bill Medicare for each of these conversations using the current

procedural terminology (CPT) code 99497, providing an estimated repayment of \$945.89. Twenty-nine successfully completed their AD and brought to the office for filing in EMR. Twenty-one made no response despite multiple interventions. Pre-implementation, the two participating providers had a 23.81% & 20.0% AD completion rate for patients eighty and older. Post-implementation, the completion rate percentage of the two providers chosen increased to 60.71% & 38.71% respectively. Delta of change for the interventional providers were 36.9% & 18.71% respectively. Mean Delta for non-interventional group was 4.6% (Figure 1).

Of the 29 patients who successfully completed their AD, 21 had a previous AD not on file and only required 1 or 2 interventions, whereas the patients who had no previous AD required up to 4 interventions for completion and documentation of AD (Table 1).

DISCUSSION

Using the multimodal approach advance directive completion rates, provider's awareness of the need for AD discussion and the availability of billing codes, as well as, revenue from Medicare reimbursement were improved as previously described in the literature. In addition, as of January 2016, the approach improves revenue. An unexpected finding of this project was that many patients already had an AD but did not understand the importance of turning them into their healthcare provider. A simple question of, "do you have an advance directive," was effective in completing more than half of the completed ADs.

Limitation of the Study

The Providers were limited to 20 minute slots for each patient, making it difficult to allow time for the extra discussion covering ADs. By the end of the project, the two participating

providers could recognize which patients were in need of an AD and were able to document, to schedule discussion appointment, as well as, bill for AD discussion. However, there was not a permanent system to identify the patients, to perform follow-up phone calls and to mail educational packets prior to visit. Next steps are to follow the PDSA model and discuss plans with the leadership team to embed this successful approach into daily operation.

Conclusions

The project resulted in improved AD completion rates and an interest by leadership to continue the multi-modal approach to improve AD completion rates. Practice implications include repeated conversations over time, and by simply asking if the patient has an AD, the provider may bridge the gap between completing an advance directive and giving the documentation to their provider.

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Conflict of Interest

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the University of San Diego. This work was prepared while the author was a student at the University of San Diego.

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Figure 1. Comparison of Advance Directives Completion Rate Between Practices with and Without Intervention: Baseline, During and Post Intervention.

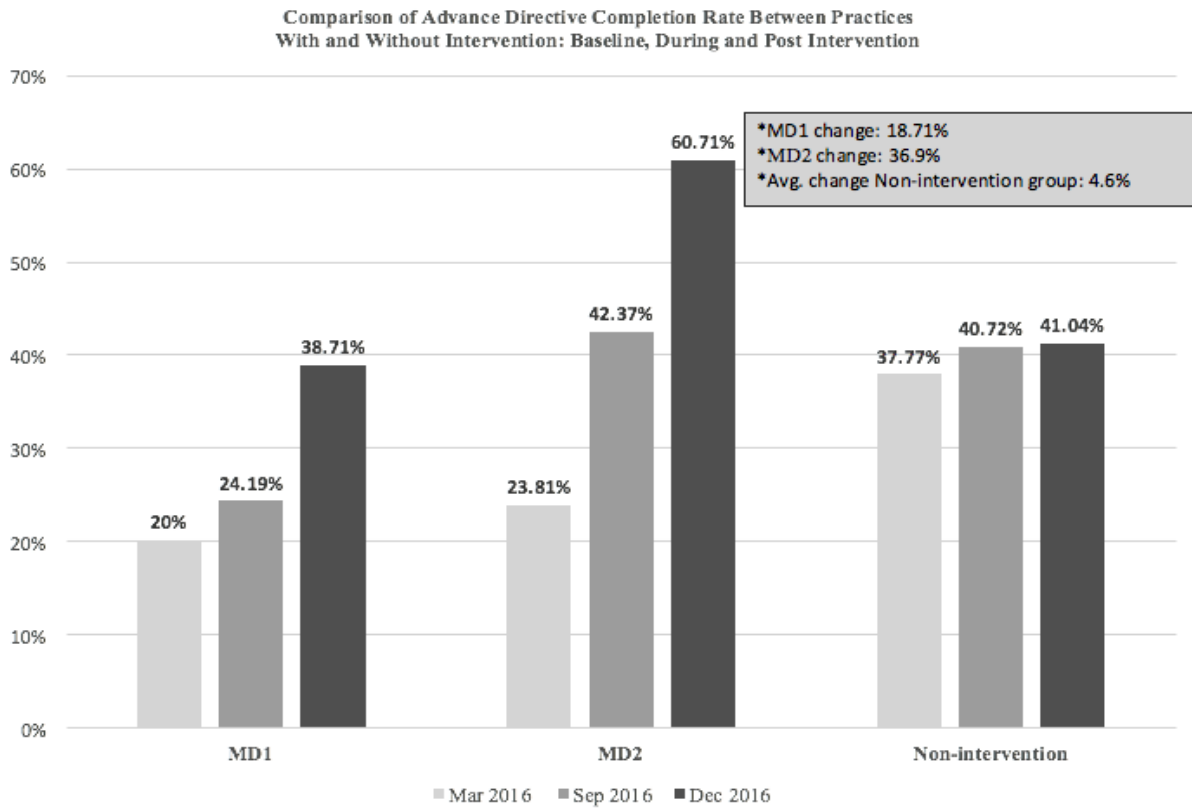


Table 1. Number of Interventions Used for Patients Who Turned in an AD.

	Previous AD, no Documentation on file	No AD
Requiring 4 Interventions		2
Requiring 3 Interventions		1
Requiring 2 Interventions	10	4
Requiring 1 Intervention	11	1

Four possible Interventions: Pre-visit phone call, Mailed packet, Face-To-Face Interaction, Follow-up Phone call