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Using Five Wishes to Improve Advance Care Planning in A Maryland Primary Care Practice

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Using Five Wishes to Improve Advance Care Planning in A Maryland Primary Care Practice

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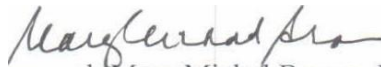
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By

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Abstract

Background

Engagement in Advance Care Planning (ACP) at this primary care practice is minimal with no consistent process to document existing advance directives (AD) or educate about ADs.

Objectives

The purpose of this QI project was to increase ACP discussions, improve documentation of existing ADs and educate about Five Wishes.

Methodology

Adults, at each office encounter, were asked three kiosk questions: Do you have an AD, know what it is and want to discuss ACP? The responses were uploaded to the EHR to become an evidence backed, visual reminder. Affirmation of existing ADs were descriptively documented. ACP engagement was analyzed by chi square comparing responses to the questions and provider engagement in ACP. Everyone was invited to a Five Wishes seminar and given the same questionnaire pre and post with mean responses assessed via a paired t-test.

Results

The 1037 participants were mostly, employed, white, married and averaged age 52. After 12 weeks, 90 ACP discussions took place compared to 6 discussions prior to implementation ($p < 0.001$). At the seminar, 21 people had mean result with mixed statistical significance. The questions regarding value of Five Wishes and discussing ACP were statistically significant ($p < 0.05$). The total number of existing ADs was 23% of 1037 encounters.

Conclusion

Engagement in ACP discussions improved by both asking about interest and creating EHR reminders. The kiosk-initiated process makes this project sustainable and normalize ACP discussions. Five Wishes does not meet legal requirements for an AD in every state and future policy should focus on full legalization.

Using Five Wishes to Improve Advance Care Planning in a Maryland Primary Care Practice

An advance directive (AD) is a legal document intended to assist loved ones and medical providers with end of life wishes when a person is unable to state their dying preferences for medical care. In the state of Maryland, there are two forms that meet the legal requirements for an AD: (a) Maryland Advance Directive: Planning for Future Health Care Decisions and (b) Five Wishes (Advance Directive, n.d). The Maryland AD outlines both the designated person to make medical decisions as well as several back up designations. Comfort and medical treatment options are also covered along with the designation of organ donation and funeral arrangements (Maryland Attorney General, n.d.).

Five Wishes is an AD that was developed by the nonprofit organization, Aging with Dignity, and supported by a grant from the Robert Wood Johnson Foundation (Aging with Dignity, 2012). This AD addresses the legal questions of health care power of attorney and medical care desires for end of life care but also includes questions to address spirituality, comfort, forgiveness and final wishes (Aging with Dignity, 2012). The five “wishes” are:

1. The person I want to make care decisions for me when I can't
2. The kind of medical treatment I want
3. How comfortable I want to be
4. How I want people to treat me
5. What I want my loved ones to know

This project focused on improving advance care planning in a primary care practice with Five Wishes.

The process of completing an AD is often done in conjunction with a medical provider. It is expected that a patient's provider can guide decisions and answer questions about ACP. ACP involves completing a chosen AD that is legally recognized by the state of residency. ADs are instrumental in communicating patients' wishes regarding end of life care and prevents loved ones from the burden of making big medical decisions on someone else's behalf. In addition, ACP can improve the quality of end of life care and substantial decrease unnecessary hospital admissions. However, the medical community, especially primary care, is vital to facilitating the completion of this important document and thus efforts are needed to proactively engage primary care providers and patients in having ACP discussions.

Background and Significance

The requirement for healthcare providers to facilitate ACP was established by the 1991 Patient Self-Determination Act (PDSA) which requires that any healthcare facility that receives federal funding should discuss, educate, and facilitate the implementation of ADs (Douglas & Brown, 2002). This established ADs as a standard of care. Recent advancements in healthcare policy to further legislate AD use has had limited success. In 2009, the Affordable Care Act (ACA) and the Advanced Planning and Compassionate Care Act both included efforts to improve AD implementation by reimbursing physicians for ACP (Whelan, 2013). Unfortunately, the factual content of the policy and myths surrounding potential "death panels" resulted in removal of this aspect from the ACA (Whelan, 2013).

By the year 2030, all the baby boomers will have reached the age of 65 or older (Van Wert, 2018), which will further increase the demand for an aging community to need ACP. This places more pressure on primary care to develop a systematic process to facilitate ACP discussions. To address this concern, Medicare ruled in November 2015 that ACP could be

billed by providers as a Current Procedure Terminology (CPT) code for up to 30 minutes of discussion starting January 1, 2016 (Verhovshek, 2016). Reimbursement for the first 30 minutes of ACP equates to approximately \$75 and an additional \$70 for each additional 30 minutes (Verhovshek, 2016). This reimbursement does not require the completion of an AD and can be billed by any qualifying provider at each encounter where ACP is discussed, regardless of the number of discussions (Verhovshek, 2016). This was intended to create an incentive for providers to improve ACP discussions, but financial incentives alone have not changed the medical culture of discussion ACP.

According to a retrospective review of Medicare ACP billing in New England, less than 1% of the 2016 Medicare claims involved ACP (Pelland, Morphis, Harris & Gardner, 2019). Providers are either not taking advantage of the reimbursement potential or have not effectively created a process to discuss ACP in their medical practice. Likely, both reasons explain the lack of implementation.

According to a 2014 “end of life” care survey, patients over the age of 18 years old were surveyed regarding perception of end of life needs, discussions with loved ones about their end of life desires, and existing advance directives (Rao, Anderson, Lin & Laux, 2014). Not surprisingly, those of advanced age and with terminal diseases were more likely to have an AD. Those who did not feel they had any end of life concern were less likely to complete an AD but most of the participants surveyed lacked AD awareness (Rao, Anderson, Lin & Laux, 2014). This lack of awareness highlights the need for primary care to proactively address AD education in all patients before they become terminally ill or of advanced aged.

Advance care planning research to support AD use varies in design and often cannot directly address the variable of cost due to ethical concerns. However, in 2018, Bond and

colleagues (2018) evaluated ACP, retrospectively, in an Accountable Care Organization (ACO) by comparing two groups of Medicare patients: those who had an AD at death versus those who did not have an AD at death (Bond et. al., 2018). The authors reported that the AD group had a nearly \$10,000 adjusted savings compared to the control group (Bond et al., 2018). The authors surmised that most of the cost savings to Medicare was in the reduction of inpatient admissions (Bond et al., 2018). Saving money is not the main goal of any end of life discussion but reducing unnecessary hospital admissions is a valuable goal. The discussion of ACP in terms of cost savings is really a discussion about unnecessary hospital admissions.

There are three common reasons why people do not complete an AD: patients either assume their loved ones know what they want, the patients do not understand ADs, or they fear an AD will withhold medical care (Splendore & Grant, 2017). In general, the people who are most likely to have an AD, are those with a terminal illness, of non-Hispanic, white race and those of a higher socioeconomic status (Rao et al., 2014). According to the 2003 report on health literacy from the US Department of Health and Human Resources, less than 13% of adults are “proficient in understanding basic health information” with an even higher percentage of Hispanic and elderly with even lower levels of literacy (n.d). The issue of health literacy highlights the need for an ACP process in primary care that is repetitive, includes everyone and has adjunctive educational options.

Shared decision making (SDM) is a core concern for this project. In order to improve provider engagement in ACP, it is necessary for providers to have strong shared decision-making skills. In a 2019 randomized control trial on the benefits of shared decision-making tools and lung cancer screening, a subset of the LSUT (Lung Screening Uptake Trail) were assigned to two methods of education on lung cancer screening. One group received the booklet alone and the

other group received both the booklet and a video with a provider giving the education. In the end, both groups had better understanding of lung cancer screening but the video group, showed an even greater understanding (Ruparel, et.al, 2019). This highlights the value of various mediums to address SDM with patients. This project addressed SDM with the provider via a SDM educational brochure and a brief SDM oral presentation.

These factors are the historical aspects of ACP that were considered for this ACP project. To successfully educate patients and reduce misconceptions, providers must be capable of successful engagement in SDM. The information on ACP must be explained to patients via various methods. Because reimbursement alone is not enough to encourage providers to have ACP discussions, a simple, systems process is needed. Lastly, repeated opportunities for patients to discuss ACP will facilitate normalization of ACP in primary care.

Needs Assessment

The previous process of addressing ACP at this project's primary care practice, was done inconsistently, by only a few providers during a Medicare annual wellness visit. Even when patients had an AD, there was no consistent process to designate that an AD existed. In a review of ACP discussions and CPT billing of ACP in Medicare patients for 2018, only 23 out of approximately 3,000 enrolled Medicare patients had CPT billing for ACP in the 2018 calendar year, for the entire practice (ECW, 2019). This primary care practice has office locations in Maryland, Virginia and the District of Columbia. The wide geographical variability required that this project start at one location in Maryland, over 12-weeks with future expectations to implement this ACP project practice wide.

A Strengths- Weakness-Opportunities-Threats (SWOT) analysis was done to evaluate the feasibility of this ACP project. Strengths and opportunities for this project are substantial. The strengths include an abundance of owner support for improving ACP. Employees are skillful and cooperative and lastly, there is a practice wide EHR, which allows for data mining and systematic processing. Additional strengths include three information technology (IT) support staff who have various levels of IT responsibilities; one IT staff is a nurse practitioner. This nurse practitioner assisted with data mining.

Weaknesses to this project include geographical distances between offices as some staff who are instrumental to this project are located at other offices and communicate mainly via email and phone. This distance did impede efficient and timely communication. Much of the success of this project required both provider and ancillary staff “buy in” to ensure practice change. The providers ability to successfully participate in SDM was not as significant a weakness as expected. Medical assistant “buy in” was the most substantial weakness to this project’s success. The ability of patients to use technology, like an electronic kiosk, was a weakness. Given the Five Wishes educational seminars was provided only in English, there were limited opportunities to educate non-English speaking patients about this specific AD. However, copies of Five Wishes were available in two other languages, Russian and Spanish, for providers and staff who speak the patient’s native language.

Opportunities for this project included continued practice growth through recent acquisition of additional practice locations in Maryland and an alignment with a larger hospital healthcare system to improve community resources. Given the expected volume of the aging baby boomers, this project could model a successful ACP process for other primary care practices to implement.

The greatest threat to this project was the stigma of discussing death. Not surprisingly, most patients did not want to discuss ACP. In general, Americans are often in denial about death and do not plan for dying (Life in the USA, n.d). This is likely hindered by poor media portrayal of dying and prior political influences on the topic of ACP.

There was a total of three providers, two physicians and one nurse practitioner, who participated in this project at the Maryland location. The nurse practitioner works at this practice location four days per week. Both physicians are the practice owners and see patients at other office locations. These two physicians work at this location, one to two days per week. The project utilized the front desk secretary and three medical assistants who disseminated information and documented data in the EHR. Apart from one medical assistant and the front desk secretary, all the other medical assistants rotate to other office locations throughout the week. Having rotating staff members exposed to this QI project facilitates the opportunity to implement this project at other offices. These staff members can become future super trainers for other offices.

The practice's strategic plan is to provide comprehensive care to all patients with a substantial focus on care coordination for the vulnerable and Medicare population. No previous attempts to implement a formal ACP program has been tried at this practice. This ACP QI project upholds the paradigm of comprehensive care and service to the aging population by improving holistic medical management.

Problem Statement

The problems addressed by this project were provider engagement in ACP, documentation of existing ADs, and educating patients about an alternative AD known as Five

Wishes. To increase ACP discussions, a process was needed to engage all patients and encourage providers to initiate an ACP discussions. In general, most patients were not interested in ACP. However, this was not assumed based on age or medical history and thus everyone was asked about interest in discussing ACP, at each office encounter. The benefit of asking everyone at every encounter was to improve patients' familiarity with the topic. Familiarity with the topic of ACP could result in the now 18-year-old understanding the importance of ACP when older and chronic disease develops. Patient responses to the question about existing AD resulted in consistent documentation in the EHR. Lastly, this project was supplemented with the additional measure of an educational seminar, open to everyone, to learn more about a unique AD called Five Wishes.

Aims and Objectives

The aims and objectives for this project were as follows. The first aim was to increase provider engagement in ACP. The first aim was assessed objectively by the total number of encounters that documented a discussion of ACP by ICD-10 code at the end of the 12-week project compared to both the number of providers who engaged in ACP discussion in the 12-weeks prior to the project and patient responses to interest in ACP. The second aim was to create a process to document existing ADs. This was assessed by percentage of existing ADs noted in the EHR over 12-weeks. The third aim was to provide a seminar that successfully educated patients about the value of ACP and an alternative AD, known as Five Wishes. Education of Five Wishes was evaluated by patient responses to a Likert scaled questionnaire given pre and post seminar at each weekly session over 12-weeks. Each patient answered the same questionnaire pre and post seminar (Appendix B) to assess their before and after perceived

value of ACP and Five Wishes, specifically. The questionnaire was adapted from previous, similar research on the educational value of a Five Wishes seminar (Hinderer, 2014).

Review of Literature

A literature review took place between February to June of 2019 (Appendix A). Using the CINAHL database, research was evaluated using the search terms “advance care planning,” and “end of life care” and the inclusion criteria of all adults, academic journals and research that was less than 5-year-old. This resulted in 54 articles for evaluation. Articles that focused on a specific subpopulation or in an inpatient setting were excluded. Ultimately, five articles of the 54 were accepted both as relevant to outpatient ACP and of acceptable quality. Another separate CINAHL search was conducted specifically using the terms “Five Wishes” including only adults, and academic journals in the past five years. This resulted in only three articles. One article was excluded based on its focus on a specific subset of seriously ill patients. The two remaining articles were similar educational seminars to this research design and thus used as examples to establish the Five Wishes educational seminar.

Lastly, CINAHL was used again to search the terms “shared decision making”, “and”, “tools or instruments”, “physicians or doctors”. This search excluded research outside of the United States and included adults, academic journals, English language with an extension to eight years (2011- 2019). This resulted in 18 articles. The extension beyond the standard five years was needed to capture a simple, evidence-based tool that addressed SDM in providers. The articles were all reviewed for both content and quality, with the most applicable to primary care and of the best quality used for this analysis.

A resource librarian was consulted for assistance with obtaining permission to use the Advance Directive Attitude Survey (ADAS). The attempt to use ADAS was unsuccessful.

Excerpts of ADAS were publicly available and noted in various articles and compiled to create the Five Wishes questionnaire.

The quality of the articles was assessed using the Johns Hopkins Nursing Evidence Based Practice Model and Guidelines (Dearholt & Dang, 2018). The articles' assessed quality is noted in Appendix A. This assessment tool qualifies research based on a scale from I-V with subdivided criteria of a, b and c signally high, good and low quality. Level I research is strongest and defined as a randomized control trials with level V representing experiential and non-evidence-based data (Dearholt & Dang, 2018).

The evidence from the following articles supported the methodology to address the aim of improving provider engagement in ACP discussions. First, providers must have the ability to engage in SDM to improve ACP. Jensen and associates (2011) supported the value of SDM by studying the effects of training physicians on the Four Habits of Communication (Appendix D) versus no training. These authors noted that, even with minimal training, patients' perceptions of SDM improved for providers who had some communication training. Although an older article, this article was included to highlight the value of, even minimal training, to improve providers' SDM ability (2011). Forcino and others (2017) provided a valid tool to assess patient's perceptions of a provider's ability to engage in SDM. The CollabRATE shared decision-making tool is a short three question tool with validity in numerous geographical primary care settings (Forcino, et. al., 2017). This tool did not fit into my methodology but highlights the value of SDM. Hayek and associates (2014) indicated that a provider's ability to successfully engage in shared decision making with patients is a vital aspect to ACP discussions.

Next, a team approach with EHR reminders lends itself to more successful ACP and satisfaction with end of life care. Reinhardt and associates described a team approach to

discussing end of life care and its positive impact on the loved ones who managed a patient's end of life wishes. Reinhardt et al. (2014) highlighted how ongoing conversations and ongoing discussions improved AD documentation and ultimately, family members felt better about their loved ones end of life care when an AD was in place (2014). Hayek and colleagues (2014) offered strong evidence that provider reminders, especially in an EHR, were more successful in improving AD implementation compared to no reminders. These authors concluded a direct association between the number of reminders and number of AD completed (2013)

The aim of improving education about Five Wishes was evaluated through research results specifically about Five Wishes Educational Workshops. The articles that evaluated Five Wishes education did not have a direct impact on the number of ADs implemented, however, all articles validated the value to patient education. Hinderer & Lee (2014) and Splendore & Grant (2017) developed educational programs to teach community adults about Five Wishes. Both programs used community workshops to deliver the education. Neither program was associated with a specific primary care practice. Both articles used a variation of a well-validated questionnaire called the Advance Directive Attitude Survey (ADAS) to evaluate their programs. As previously noted, attempts to obtain permission to use the full ADAS tool were unsuccessful. Select questions from ADAS were reported in the article and used to create the questionnaire for this project. Splendore & Grant's Five Wishes educational seminar did report an improvement in the patients' perceived importance of ACP (2017). This article was sponsored by the creators of Five Wishes. Hinderer & Lee (2014) used a community outreach project to educate adults about Five Wishes. The sampling of people in this study did not change their attitude about ACP but did statistically confirm that the educational program was perceived as valuable to the participants based on the ADAS tool. This highlights that it takes

more than just education to successfully implement an ACP program in clinical practice (Hinderer, & Lee, 2014).

Evidence-based Practice (EBP) Translation Model

The revised Johns Hopkins Model (JHM) (Figure 1) was used as the evidence-based translation model (Dearholt & Dang, 2018). This model was chosen for its inclusion of both internal and external factors to influence best practices. This is especially important in ACP where multiple internal and external factors impact implementation. An example of internal factors includes a providers' SDM ability to discuss ACP and an external factor is our societal paradigms about death and dying. The process starts with an inquiry into the problem, followed by the Practice, Evidence and Translation (PET) process to assess the question, gather the evidence and translate the information into practice, all while learning new knowledge (Dearholt & Dang, 2018).

The initial process of inquire started with identifying the need for ACP by assessing the number of patients in the practice who have a documented discussion with their provider about ACP. Next, practice owners' interest in improving ACP was determined. Together, sufficiency information supported the value of this project. This was then followed by gathering research that was evaluated for quality, as mentioned, via Johns Hopkins Evidence Based Research assessment. The research supported the value of improving shared decision making in providers. Evidence also guided the internal and external influences on ACP. This information was used to mitigate some of the research-based obstacles to implementing a ACP process. Based on this information, a process was developed that teaches providers about shared decision making and a systemic clinical process was developed to improve providers' opportunities to discuss ACP with patients and document existing ADs. In addition, the

research on other Five Wishes educational programs was modeled to address patient education about this specific AD. During implementation, the internal and external influences guided the teaching aspects that promote or inhibit implementation of ACP discussions, so practice change can be successful.

Methodology

This is a quality improvement project that improved provider participation in ACP discussions, documentation of existing ADs and education about the specific AD known as Five Wishes. The evidence from prior research was incorporated into the methodology. The process started with educating providers on shared decision making (SDM). Each provider was asked to read an educational paper on how to improve their SDM ability (Appendix D). A short power point presentation of SDM was given to all providers in the practice at our practice meeting prior to implementation. Providers' compliance with reading this educational paper on SDM was self-reported. Patient recruitment to participate in ACP was through convenience sampling of those who had an appointment at the Maryland office during the study implementation time frame. Upon arriving at the appointment, all patients were asked three screening questions about interest in discussing ACP via an electronic tablet enabled kiosk which was then uploaded to the EHR by the medical assistant (Appendix E). A paper invitation to attend the informational seminar on Five Wishes was given to every patient by the secretary (Appendix F). In addition, a large electronic poster advertising the Five Wishes Seminar was on display in every exam room. This electronic poster had the same information about the Five Wishes program date, time and content (Appendix F). In addition, providers were asked to encourage all patients and their family members to attend the Five Wishes seminar. Anyone could attend the Five Wishes Seminar. After informed consent and a pre-seminar questionnaire, a 30-minute video created by

Aging with Dignity was shown and followed by an informal question/answer session with an acute care nurse practitioner. The participants then completed the same questionnaire post seminar. The questionnaire responses were via Likert scale that corresponded with perceived value of both Five Wishes and ACP.

The following concepts noted in prior research were used in implementation. First, shared decision making (SDM) was addressed with a short educational flyer and power point presentation. Next, EHR documentation of patients who affirmed an existing AD was consistently noted. Then, the patients' responses to interest in an ACP discussion were uploaded directly to the encounter note, in the EHR, creating an evidence backed, visual reminder (Appendix E). If an ACP discussion was not possible during that office visit, patients were asked to schedule another appointment to specifically discuss ACP or attend the educational seminar on Five Wishes.

This project started on September 3, 2019 at a Maryland office location and ended November 22, 2019. All data was mined through the EHR known as E-Clinical Works (ECW) with the seminar evaluated by paper questionnaire responses (Appendix B). The Five Wishes seminar was modeled after similar educational seminars noted in the literature review and a similar questionnaire developed based on published exert of the ADAS questionnaire (Appendix B). As noted, permission to use the ADAS tool was unsuccessful, but elements of this tool were available in the literature review and used in creating the questionnaire (Appendix B). Figure 2 summarizes the project implementation process.

Setting

The setting for this QI project is a primary care practice in Maryland. The location of this practice is in one of the highest educated cities in the United States and is situated just outside

the nation's capital, Washington, DC (Raghaven, D., 2014). The building for this practice location typically accommodates only two providers and averages approximately 20 patient encounters per day. The office location provides free parking and is conveniently located near public transportation. The building is handicap accessible.

Study Population

There were two study groups evaluated. The first group consisted of a convenience sampling of patients who met inclusion criteria and were seen at this office location between September 2019 until November 2019. The second group were patients, loved ones and friends who voluntarily attended the Five Wishes seminar during the implementation period. Inclusion criteria for both groups were adults, defined as over the age of 18-year-old, of any race, gender, or socioeconomic status. Patients who were blind or diagnosed with advanced dementia without a designated power of attorney were excluded. All patients, family and friends were invited to attend a free, weekly educational seminar on the AD known as Five Wishes. It was estimated that approximately 1,200 patients would be offered ACP and invited to the Five Wishes Seminar during the study period.

Patients who were seen at this location were mostly native English speaking, non-Hispanic whites, however Russian and Spanish speaking patients are also seen at this location. The Russian and Spanish speaking patients had varying fluency in English. Most non-English speaking patients were seen by a provider who speaks their native language, or a native speaking medical assistant translated for the provider. Most patients who received care at this location, had a college education and were from a higher socioeconomic background. Patients with a disability, had the same accommodations routinely provided.

Subject Recruitment

Subject recruitment was via convenience sampling. All patients who met inclusion criteria and were scheduled to see a provider during the study implementation period were offered an opportunity to discuss ACP with their provider and given an invitational flyer on the Five Wishes seminar (Appendix F). Participants in the Five Wishes workshop comprised of a sampling from these patients, their family and friends. Electronic exam room posters advertising the Five Wishes Seminar and were visible in all four examine rooms. The free seminar took place on Thursday evenings from 5:00 to 6:30pm, each week, during the 12-week study period. One seminar was cancelled due to AV equipment malfunctioning.

Consent Procedure

Consent to participate in the Five Wishes seminar was obtained in writing from the patient by the nurse practitioner prior to each educational session (Appendix C). The patient population seen for ACP engagement at the office location, did not require consent as assessing interest in ACP is currently mandated by the 1991 PDSA and is a standard of care. In addition, all patients have HIPPA protection of their personal health information (PHI). Discussions about ACP in the office group was done privately between the provider and patient at the office encounter in a closed, exam room. No PHI from either group was published. The paper consents from the seminar were locked up in a secure cabinet inside the primary care practice and will be destroyed in May 15, 2020.

Risks/Harms

There were minimal expected risks or harms associated with participation in ACP and the Five Wishes seminars. Theoretically, a discussion about death could be emotionally upsetting

for some patients. However, interest in discussing ACP with the patient's provider was optional and consistent with the standard of care. No patients were required to complete an AD nor discuss ACP against their will.

Subject Costs/Compensation

A cost/benefit analysis is noted in Table 1. The cost of utilities, rent, and other operational cost were minimal and already part of the practice's current budget. The implementation of this project required minimal, extra work from the current medical assistants and the providers. Providers continued to be paid according to their contracts, which is based on productivity, not hourly wages. The educational seminar took place in the office, after hours when the office was traditionally vacant. No significant, extra cost was incurred from using the building after hours. Although the seminar was led, voluntarily, by a nurse practitioner during unpaid hours, for future consideration, the cost of a nurse led seminar has been included. Other additional cost from this project were the start-up cost of materials. Revenue was generated based on provider engagement and billing of the CPT code 99497 for Advance Care Planning.

No financial compensation to the subjects was provided for discussing ACP with their provider. However, patients who participated in the Five Wishes seminar were given a free copy of the AD known as Five Wishes. To purchase this AD as an individual, the patient would have paid five dollars. The practice obtained copies of Five Wishes for \$1 per copy. The cost of 120 copies of Five Wishes, along with a total 1,200 photocopies of the invitational flyer, and the cost of the Five Wishes supplemental DVD, was close to the estimated cost of \$240. Participation in the seminar did not require completion of the Five Wishes AD but only one copy of Five Wishes was given to each participant.

Intervention

Before implementation, the three providers involved were given education on shared decision-making skills. This education was presented at the practice meeting along with a one-page summary on the Four Habits of Communication (Appendix D). Providers were asked if they read the summary with all affirmative responses. At check in, every patient with an office appointment was asked three kiosk enabled questions to determine their interest in ACP (Appendix E) and given a paper flyer with information about the Five Wishes Seminar by the secretary (Appendix F). The screening questions asked at each appointment were: if they have an advance directive, if they know what an AD is and if they want to discuss an advance directive at that visit. The responses to these questions were uploaded to the office note by the medical assistant for the providers to see in the EHR. The process of an EHR notification acted as a research supported reminder to providers and efficiently communicated the patient's interest in ACP. Even if the patient was interested in ACP, it was still up to the provider to start that discussion. In addition, these questions served as a successful "ice breaker" to what is known to be a difficult topic. If time constraints existed, the provider could suggest the patient return for a separate office visit to specifically discuss ACP or attend the Five Wishes Seminar. If the patient was not interested, the provider could still decide to engage in an ACP discussion or simply remind the patient about the Five Wishes Seminar. Providers documented an ACP discussion by ICD-10 coding, and it was at their discretion to bill that the discussion qualified for a CPT billing code.

The invitational flyer for the Five Wishes seminar was given to every patient (Appendix F). The flyer provided information on location, date and time of the Five Wishes Seminar. The flyer included a statement to encourage patients to bring a loved one to the seminar. At the

seminar, consent was signed, and a pre-seminar questionnaire completed with Likert Scaled response, before watching a short 30-minute video created by the makers of Five Wishes. After the video, patients were encouraged to informally ask an acute care nurse practitioner questions about end of life care or the Five Wishes AD. After the seminar was completed, the same questionnaire was given again to the participants. This questionnaire was intended to qualitatively assess a change in the perceived value of ACP after exposure to the educational seminar (Appendix B). Completion of Five Wishes was not required, and this was stated at every seminar.

Outcomes to be Measured

The outcomes measured in this project included provider engagement in ACP, percentage of existing ADs and perceived value of the Five Wishes Seminar. The first outcome was evaluated by the number of ACP discussion, documented by ICD-10 coding compared to the number of ACP discussion at this same location, 12-weeks prior to project implementation. The second outcome regarding existing ADs, was quantitatively assessed and documented by the medical assistant in a consistent location within the EHR. This was double checked during data retrieval and then reported as a percentage of patient encounters. Demographic information about the patient population during the study period was also evaluated and included, age, gender, marital status, employment status, ethnicity and race. Given the control was the same population of patients, it was assumed to be the same cohort. A chart audit of participation in ACP, was assessed before and after the study via ICD-10 and CPT billing claims.

The third outcome measured patients' perceived value of the nurse practitioner led educational session on the specific AD known as Five Wishes. This outcome was evaluated

through the mean questionnaire responses pre and post Five Wishes seminar with the mean Likert scores analyzed for statistical reliability via a paired t-test (Appendix B).

Project Timeline

The project timeline first started with an assessment of the need for this project in the practice and the owners' interest in supporting an ACP project. A table of the timeline is noted in Figure 3. Once the evidence-based research had been reviewed, a project was developed, and SWOT concerns addressed to improve participation and success. Development continued with a review of the literature and assessment of cost versus benefit. After reviewing the evidence-based research, a plan was developed that includes the evidence that supports successful ACP. The SWOT concerns were addressed by engaging "buy in" from ancillary staff and the providers. Unfortunately, many of the threats and weaknesses could not be addressed, such as cultural perceptions about end of life care and office geography.

Next, the project was implemented using PET to guide design. The 12- week project started on September 2nd and end November 22, 2019. The Five Wishes seminars started the first Thursday after implementation. One planned seminar was cancelled due to equipment malfunction. Evaluation began after the project had been implemented with the data evaluated after completion and compared to the 12-weeks before implementation. Seminar attendance and questionnaires responses were placed into an Excel spreadsheet for easier manipulation with SPSS (Appendix G).

Resources Needed

Resources needed for this project were paper copies of the questionnaires and color copies of the invitational flyer. The AD Five Wishes cost \$1.00 per copy and a copy of the

educational Five Wishes DVD was purchased for \$24.95 plus tax. The practice purchased 100 copies of Five Wishes in English and 10 copies each of Five Wishes in Spanish and Russian. The current AV equipment owned by the practice was used to view the Five Wishes DVD. Other resources needed included the office space after hours for the educational seminars as well as SPSS software, an EHR and electronic tablet as well as resource staff such as: medical assistants, IT staff, providers, and the office secretary. Parking at the office is free.

Results

A total of 1037 office encounters were used to assess provider engagement in ACP discussions. Some patients were seen multiple times during the 12-week period. Although the repeated patients were given the same questions at each visit, their responses were not always the same. Most patients who were seen during the study period had commercial insurance, were employed full time, married, white and non-Hispanic. Table 3 gives more specific data regarding the demographics of the population studied. The median age of participants was 53. The minimum age was 18 and the oldest participant was 97. Histogram confirmed an equitable distribution among all age groups and division between men and women was 39 % and 61%, respectively. The percentage of Medicare patients who participated was 20%. Unfortunately, 220 office encounters were excluded from data analysis due to missing responses to the three pre-visit questions or lack of questions being uploaded into the EHR correctly. Patients who had at least one response to the three questions uploaded into the EHR were included in the data analysis.

Provider engagement was evaluated by Chi Square analysis and cross tabulated to the patient response to the “check in” question regarding interest in discussing ACP . The data results were statistically significant with a $X^2=205.561$ and $p<0.001$. Cronbach’s Alpha

reliability for these questions was 0.512. A total of six patients had engaged in ACP discussions at this office location, by these same providers in the 12-weeks before implementation. At the end of the 12-week implementation period, a total of 90 patients participated in an ACP discussion with their provider.

The second aim was to document patients who had an existing AD. This was assessed as a descriptive result. Prior to this intervention, there was not a consistent process in place to record that patients had an existing AD. This QI project allowed for a consistent opportunity to ask patients if they had an AD and document their response. The results over 12-weeks of patient encounters showed that of the 1037 patient encounters, 237 (22.9%) of the encounters answered the question that they had an existing AD. This number is slightly lower than other reported percentage that estimate approximately 33% of American adults have an AD (Yakov et.al, 2017). Given the denominator of this data evaluation was based on the number of encounters and not individual patients, the percentage of existing ADs may be higher than 23%.

The third aim was to create a valuable, educational seminar on a specific AD known as Five Wishes. A total of 22 people attended the seminars during the 12-week implementation phase. One person arrived after the video started and thus was not included in the statistical analysis. No demographic information for the Five Wishes participants was collected other than gender. The cohort of participants included 14 females and 7 males. On one occasions, the seminar was cancelled due to equipment malfunction. All participants were given a pre and post questionnaire regarding their opinion about Five Wishes and ADs, in general. The same questionnaire was given pre and post seminar with Likert scaled responses (0-5) that numerically correlated with positive opinions about ADs. These responses were averaged and the mean

responses analyzed via a paired t-test analysis comparing pre and post questionnaire responses. Cronbach's Alpha for this questionnaire was 0.771.

The 21 responses analyzed showed mixed statistical significance. The response to questions 3, 4 and 6 for the pre and post Five Wishes questionnaire did have statistical relevance with a $p < 0.05$ (Table 3). However, mean scores for both the pre and post questionnaire responses were positive and averaged over 4. The first question was not analyzed because it was a statement about an existing AD and thus post questionnaire responses were unchanged. Question 4 stated "I think Five Wishes is an advance directive I will use" and pre and post p value for this response was < 0.05 . The pre mean score for this question was 3.43 and post mean score was 4.62 suggesting the seminar was successful in meeting the objective of educating patients on the value of Five Wishes as an AD. The questionnaire responses, albeit positive, lacked variability as most of the participants already had a favorable opinion of AD, indicating a ceiling effect. In addition, the providers subjectively felt the ACP seminar was an added value to the practice. Given most of the patients seen during implementation, work full time, this seminar may have been more successful if held on a weekend instead of mid-week at 5pm.

In the end, there was a significant improvement in ACP discussions with the EHR reminders of patient's interest in ACP. In total, 116 patients answered that they wanted to discuss ACP at that visit, yet only 51 (44%) of those who answered yes, had a provider engage in an ACP discussion. Surprisingly, 39 (4%) patients who had answered "no" to their interest in discussing ACP, still had a provider engaged in an ACP discussion. This suggests that patients are 10 times more likely to have an ACP discussion if simply asked about interest in ACP. The elicited interest and visual reminder of the responses in the EHR did motivate provider

engagement. Most patient encounters (87.3%) answered that they did not want to discuss ACP however, 56% of these patients who did not want to discuss ACP also did not know what an AD was. This creates an opportunity for future ACP research to work on better methods to educate the general population about ADs and normalize discussions about ACP in primary care.

The other value of this study design is the benefit of eliciting interest about the topic of end of life care with a non-threatening process. Patients who wanted to discuss ACP had the ability to confirm their interest by a simple intake response which gave the provider an “ice breaker” to start the difficult conversation about dying and end of life care. It also allowed complete inclusion of everyone in this opportunity, not just aging and medically ill. Lastly, just by asking the questions, the topic and terminology was introduced to patients who may otherwise never hear these terms. Primary care is the obvious place for ACP discussions to originate given the close relationships garnered in this setting. We must continue to find creative ways to engage patients in this important but challenging topic.

Discussion

The implications to clinical practice are to change when ACP is discussed in primary care. This project demonstrated an easy and financially sustainable process utilizing technology that is already in place. Making the terminology and opportunity to discuss ACP available at every primary care encounter, changes the paradigm of who we assume needs this discussion but most importantly, normalizes ACP. Waiting to address ACP when someone is medically ill or faced with a terminal diagnosis is too late. This project successfully demonstrated how ACP can easily be incorporated as a routine part of the primary care experience. End of life care will always be a difficult topic to discuss but offering the information to everyone, can normalize the discussion and improve AD implementation.

The healthcare policy most needed to continue to support ACP, is to continue to incentivize provider engagement and patient participation in ACP. For example, many Medicare recipients do not realize that they can make an appointment with their primary care provider just to discuss ACP. Although this is already incentivized for the provider, it could also be incentivized for the patient. Annual wellness visits include numerous questions about safety, socioeconomic, existing AD and care needs. However, in clinical practice, the AD component of this questionnaire gets buried by the other areas of concern, like falls and referrals to specialist. A specific, patient incentive to see a provider just for ACP, either through a monetary or access reward, could help perpetuate this discussion.

Implications for executive leadership are to financially support clinical processes that facilitates this paradigm shift of asking every adult about ACP at every office location. In addition, with better documentation of existing AD, a process to communicate this existing document with specialist and hospitals needs to be implemented. Knowing patients have an AD is only the first step in using ADs. Because research also supports the value of a team-based approaches to ACP, leadership could facilitate ACP through advertising that patients can make appointments just to discuss ACP and continue free ACP seminars facilitated by other specialist such as spiritual leaders, social workers, attorneys, etc. The normalization of ACP is supported by making ACP a separate “product line” advertised and supported with a variety of resources.

Implications for quality and safety are in utilizing healthcare resources responsibly and improve our ability to meet the standards of care. This primary care practice is part of an Accountable Care Organization where the quality of care impacts reimbursement and ACP is a quality measure that impacts outcomes. ACP address quality in an ACO through reduction in

unnecessary healthcare spending without impacting care quality. The healthcare community has a responsibility to demonstrate quality while being good stewards of healthcare resources.

Sustainability and Future Scholarship

There was strong, financial sustainability demonstrated by this project. Approximately \$4000 in revenue was generated by this process. The process of utilizing the current electronic health resources created a seamless process to continue to normalize the terminology of ACP and engage more patients in an ACP discussion. Medicare reimbursement as well as some commercial insurance reimbursement of ACP engagement allows this project to continue to be sustainable. Future scholarship should focus on creative ways to educate and engage more patients in understanding the value of AD and ACP. This project demonstrated that most people did not want to discuss ACP, but normalization of these discussion, could change this pervasive opinion. Normalization can only be achieved by continuing research that address ACP in primary care.

Conclusion

In summary, an ACP process is a valuable addition to any primary care practice and especially for a primary care practice that values comprehensive care. This project added a missing aspect to the goal of holistic care. Evidence-based research on ACP was translated into a successful clinical process that has benefits beyond cost and most importantly, advances the conversation about end of life care. Ultimately, a successful ACP process can normalize how we discuss death with patients and open opportunities to better understand the value of an AD, especially the unique AD known as, Five Wishes.

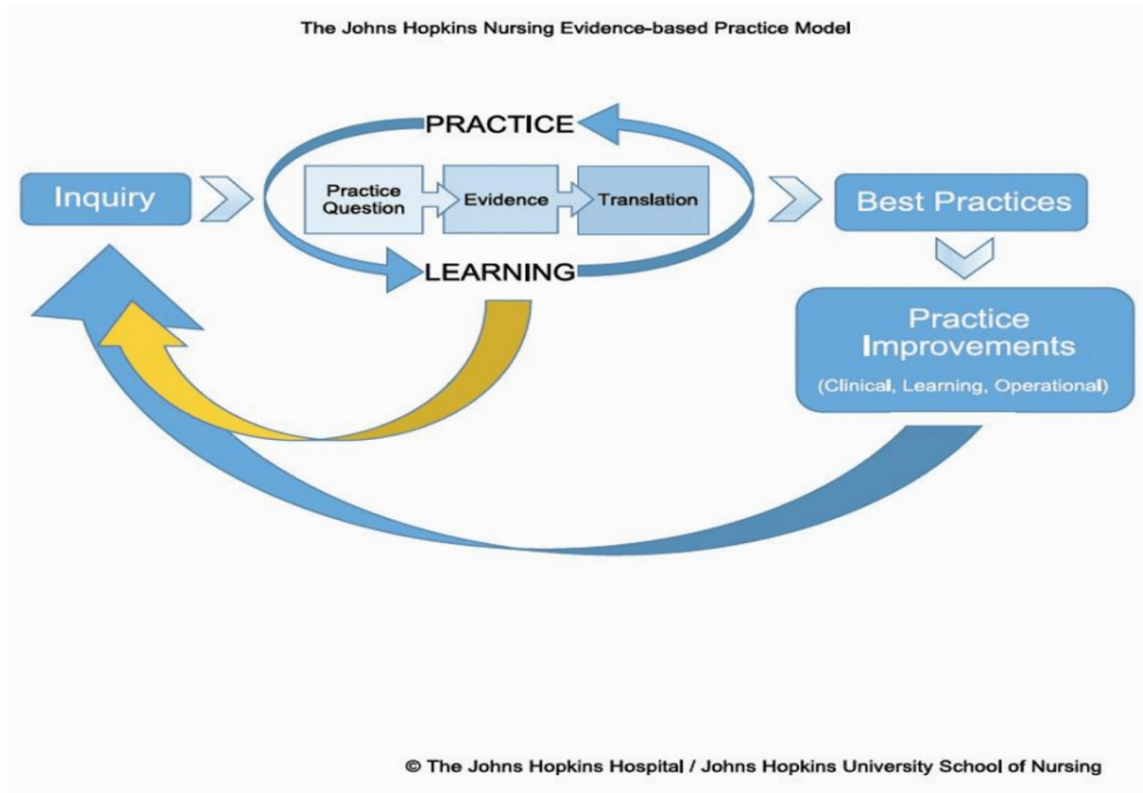


Figure 1 Revised Johns Hopkins Model (Revised Johns Hopkins Model, n.d)

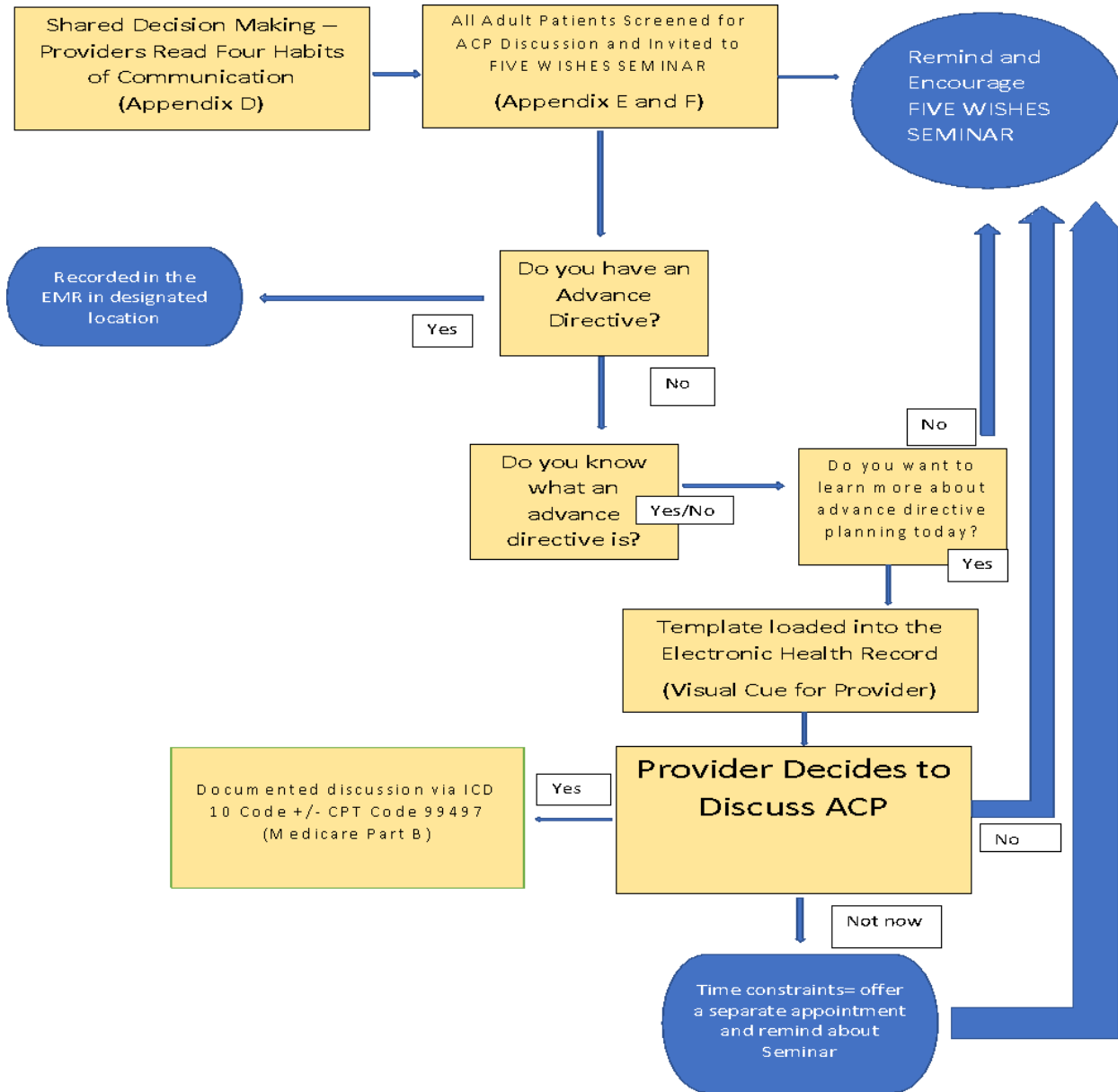


Figure 2 Methodology Map

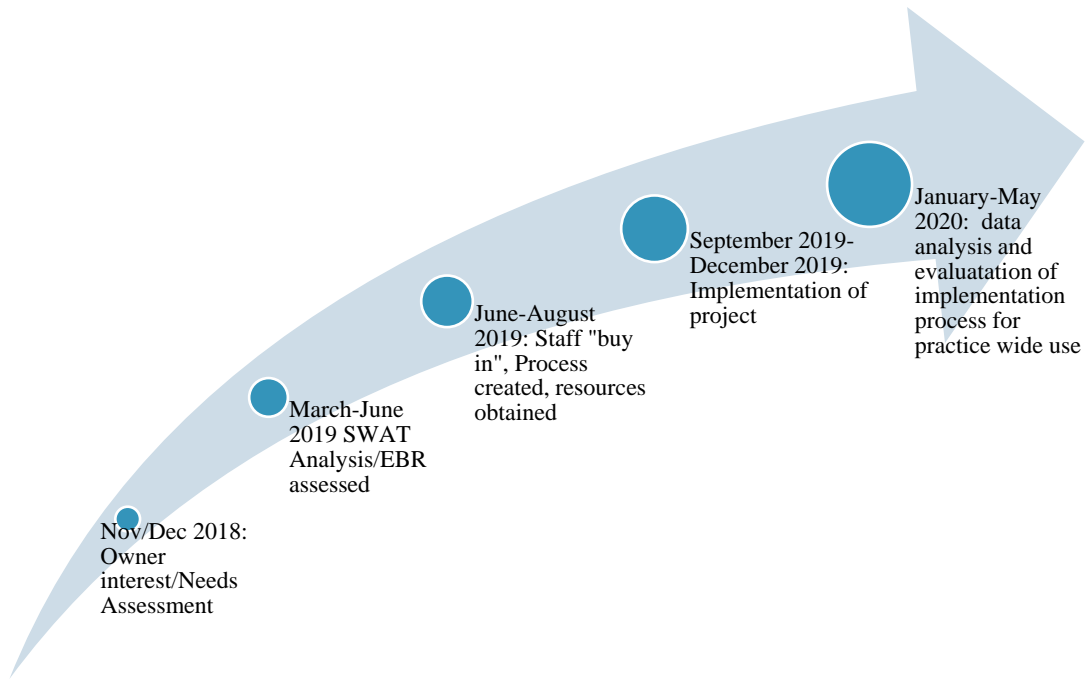


Figure 3 Project Timeline

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Appendices

Appendix A Evidence Table

Article Author Evidence Sample Findings Observable Limitations Evidence Level/Quality

Article	Author	Evidence Type	Sample, Sample Size, Setting	Findings that help answer the EBP Question	Observable Measures	Limitations	Evidence Level & Quality
Article #1	Hayek, et. al. (2013)	Prospective QI study	588 patient charts were screened with 157 meeting criteria for AD documentation	The study implemented an EHR based reminder for patients with eligible chronic medical conditions. An EHR based reminder does improve providers documentation of AD and ACP. The study used the EHR to implement a reminder process and likely, a similar reminder will be needed for my project.	An EHR based reminder for providers to address ACP/ADs did improve documentation of ADs. However, more than one reminder correlates with better implementation. The authors also suggest that a dedicated location to document AD improved documentation. These are all factors that will need to be part of my project to address provider engagement in ACP. Provider engagement is one of my SWOT concerns.	Primary care providers were given reminders to address AD/ACP for only patients who met criteria for chronic medical problems however, all patients were encouraged to complete an ACP. People with end of life and serious medical problems may be more likely to complete ADs and thus may explain the significant participation. The sample size was small. Interestingly, the ACP conversations were via medicine	IIA

						residents in training rather than by primary care providers with long standing relationships. This may be a function of excellent patient centered communication . Regardless, there is clear support to having electronic reminders for my AD/ACP project.	
Article # 2	Hinderer, K., et. al. (2014)	Quasi-Experimental	86 voluntary participants from the community age 20-89	Community participants were offered free, informational sessions about Five Wishes. This study mirrors my project by evaluating a nurse lead informational session on Five Wishes AD planning. Findings did not correlate with a change in ADAS scores (patients' attitude) about ACP post educational seminar. However, most found the seminar useful.	Advance Directive Attitude Survey (ADAS) score ranged from 16-54 with a higher score correlating with more favorable attitudes towards ACP. The study found no change in ADAS scores pre, post and 1 month after educational session. However, after the session, 97.7% reported they were likely to complete an AD. The lack of change in ADAS score may be related to 40.7% had	ADAS scores were measured prior, immediately post and 1 month after educational intervention. No data on implementation of AD one month after the session was measured. Because this took place in a community setting rather than in conjunction with a primary care practice, patients who already understood and valued ACP, may have disproportionately represented	IIB

				<p>This supports my plan to incorporate AD (Five Wishes) informational sessions after office hours and open to patients and loved ones to attend as an intervention to improve understanding and give more opportunities to answer questions about ACP.</p>	<p>been a surrogate decision makers and already had a positive attitude, 30% already had an AD and nearly 69% had already discussed ACP with a provider. Despite this, participant post intervention survey found the majority 82.6% did find the seminar useful. This supports the need for informational sessions in my project but in conjunction with SDM and provider support. The study also included a demographic instrument created specifically for the study and likely will also be needed in my project. Because the ADAS tool is valid and reliable, it will be used to measure attitudes about ACP in my own 5 Wishes informational session.</p>	<p>the sample of participants. Assessing a larger cohort of primary care patients' understanding of ACP before and after could be valuable to see if this type of informational session improves primary care patients' attitudes, and knowledge of ACP and AD implementation.</p>	
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<p>Article #3</p>	<p>Tripken, J.L, et. al. (2018).</p>	<p>Qualitative Cross-sectional survey</p>	<p>77 adults 55 years and older were surveyed from two different socioeconomic living communities</p>	<p>Adults living in High Income Eligible (HIE) were more likely to engage in ACP compared to people in an Affordable Housing Communities (AHC)</p>	<p>Because ACP is such a complex process, this article highlights that socioeconomic status does impact ACP. This encourages the need for my project to target at risk groups who may be less informed about ACP. Given we know ACP substantially impacts end of life care, this socioeconomic group needs additional focused outreach to reinforce the value of ACP.</p>	<p>Education levels differed significantly among the two groups and correlated with socioeconomic status. I suspect exposure to information about ACP is more likely to have occurred with people in a higher socioeconomic and educational level. For example, many people fill out an advance directive when they write their living will. Less educated people may be less likely to have a living will and miss the opportunity to learn about AD. Interestingly, the study evaluated self-reported health status of each group. The group least likely to complete an ACP were also the group that reported the poorest health status. This highlights that ACP may be a function of repeated</p>	<p>IIIA</p>
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						<p>exposure to the information and providers may be unintentionally avoiding ACP to this subset population. If you have poorer health, you theoretically would have more contact with a provider and thus more opportunities to discuss ACP. Therefore, I am opening my project to everyone. With repeated exposure to the information comes equal opportunity for everyone to create an AD. Lastly, despite these differences in ACP knowledge, both groups had similar attitudes and desires regarding death and dying.</p>	
<p>Article # 4</p>	<p>Splendore, E. et. al, (2016)</p>	<p>Quasi-experimental</p>	<p>Convenience sample of 40 (23 from the 1st workshop and 17 from the second)</p>	<p>Study concluded that a Five Wishes educational workshops in a community setting increased</p>	<p>Pre-workshop questionnaires with 19 self-reported and open-ended questions on understanding, perception of</p>	<p>There was not a standardized questionnaire nor was the completion of AD verified. Verification of an</p>	<p>IIB</p>

			<p>participants over the age of 18 from a rural town in Pennsylvania attended an ACP workshop held twice. No statistical difference in the two groups that attended the workshops.</p>	<p>understanding, completion and discussion of ACP/AD among participants and their family members. This AD workshop on discussing Five Wishes is part of my DNP project and thus the implementation method of this study is valuable.</p>	<p>importance and dissemination of ACP status was measured via Likert type-1 questions. Post workshop evaluations were also self-reported questionnaires and then a 1 month follow up phone call questionnaire with 8 self-reported answers regarding the ACP process, implementation and perception of importance was completed.</p>	<p>AD for my project is important as many studies show patients agree with the value of ACP, but fewer make the step to complete an AD and thus AD documented completion will be a measured value for my project. Primary care providers were not part of this ACP process in this study as it was a community project. In addition, the study was supported by Aging with Dignity who developed the Five Wishes tool creating some potential bias.</p>	
<p>Article # 5</p>	<p>Forcino, R. et. al. (2017)</p>	<p>Quasi-experimental Survey</p>	<p>3 separate primary care practice sites in the US asked patients over 18, post visit, the CollabORATE patient survey tool to measure</p>	<p>The study was intended to evaluate CollabORATE scores for 3 outpatient primary care practice in 3 different geographical locations to assess in real time, a patient's</p>	<p>Results conclude that CollabRATE can be used in a diversity of primary care settings and the short measurements tools reduce some of the administrative burden of collecting</p>	<p>Validity and reliability of the CollabORATE tool is noted in a "simulation sample". This study has value in its ability to assess shared decision making immediately after a patient</p>	<p>IIA</p>

			perceived Shared Decision Making (SDM).	experience of SDM at their primary care provider's office.	data. This could be a valuable tool to assessing patient's perception of SDM for my project. A strong sense of SDM is needed for AD planning success. Using this tool could evaluate if the providers in my practice are perceived as participating in SDM. .	encounter to give faster feedback to providers. This tool might be more beneficial if administered via an electronic platform to give immediate feedback and to have provider adjust their approach to ACP. SDM is essential for primary care to effectively create AD.	
Article # 6	Jensen, B. F. et. al (2011)	RCT, cross over	72 hospital-based doctors in various specialties were randomized to IG vs CG for a 20-hour Four Habits Communication training vs. no training	Statistically significant improvement in 4HCS score among IG and the duration of patient encounter did not change significantly. Patient satisfaction surprisingly, did not change.	4HCS is reliable and valid tool that uses a 23-item scale to assess effectiveness in communication. This study validates the benefit of the Four Habits Model in improving provider communication.	Although an older article, this was included because it is a true RCT that evaluated 4 Habits among many physician specialties and not just in mental health. The participants received a Four Habits reminder to carry with them which I may also add to my project. It was surprising that the IG did not have significantly longer patient encounters	IB

						<p>compared to CG as many providers feel patient centered communication is more time consuming. This alone supports the value of improving provider communication and will be used to encourage providers in my project to use the 4H skills. However, the authors do acknowledge that the shared decision-making aspect of the process is the most time consuming. I was surprised that patient satisfaction did not change in this study's analysis. This could be related to the environment as the providers were hospital based and not in a primary care practice where patients have a greater expectation of relationship with their</p>	
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						providers.	
Article # 7	Baik, D. et. al. (2019)	Qualitative study-literature review Systematic Review	12 Studies were reviewed for interventions that support Shared Decision Making (SDM) and subsequent patient outcomes in palliative care	Although the authors conclude inconsistent findings regarding SDM interventions and patient/caregiver outcomes, this article is valuable to my project because it lists the common SDM interventions used in other research.	MMAT tool was used to assess the quality of studies and validate rigor. SDM was categorized into 4 main areas: technology enabled delivery modes, print material, palliative care consultation and structured meetings. Technology enabled SDM tools were more frequently used. The author suggests the biggest weakness is lack of individualized SDM tools and thus a factor to consider in establishing SDM for my project.	The review highlights a need for validated and reliable instruments to assess SDM interventions. Thus, I will seek what SDM tool is most validated in preparation for my project.	VB
Article #8	Bond, W. et. al. (2018)	Quasi-experimental Case Control Matched Study	Retrospective evaluation of 325 Medicare cases with documented AD and had died were matched to similar 325 Medicare control	Cases with AD had fewer inpatient admissions, and inpatient days but slightly more CHF and COPD. Even after accounting for the cost of implementing an ACP	Unpaired t test and Chi Squared test used to evaluate the two groups. A multiple imputation method was used to fill out outcomes variables in patients who died before the	The Health Catalyst database, IDEA, is HIPPA protected, but not used routinely in all ACO practices. The addition of this database may be useful for my DNP	IIA

			cases without an AD in an ACO in Illinois.	program, the net savings over 12 months to Medicare expenditure was \$1,572,330 (104% Return on Investment).	12 months. The project used ACO data, an ACP facilitator called IDEA (database to track ACP) and EHR to analyze the data. Cost savings was statistically significant in the ACP group. Given my organization participate with an ACO, the cost savings aspect of creating an effective ACP program is strongly supported.	project but will require partner “buy in” to purchase this software that is external to the EHR. This does validate the importance of having AD documents easily accessible in a secure location will be an important teaching aspect in implementing my project. The American Bar Association also offers a free website to upload ACP and will be discussed at the informational sessions. The authors do acknowledge that cost savings is not the goal of an ACP program and many other aspects to this retrospective study, like family support, could not be measured.	
Article #9	Reinhardt, et al. (2014)	RCT	110 family Surrogates from nursing home with a family member	PCT face to face IG patient surrogates were significantly more satisfied with their	McNemar’s test was used to test the hypothesis that the IG had more advance directives in place over time.	Limitations of this study were minimal. It was a strong design but given the patient	IA

			with dementia were randomly assigned to intervention (n=58) (face-to-face meeting and follow up calls from PCT) vs comparison group (n=52)(routine nursing home care).	loved ones' care and had more advance directive planning documented compared to control. The IG was more likely to have a MOLST on record and have a DNR, DNI or DNH order included.	Surrogate satisfaction was measured at baseline, 1, 3 and 6 months. This highlights the benefits of including loved ones in ACP as well as the benefit of face to face conversations about ACP. Therefore, my project will need more than simple education. Providers will need to "buy in" to the importance of ongoing communication and face to face discussions.	population, it could not directly assess how the PCT impacted the patient. It does highlight the benefit of a team approach to advance care planning is needed.	
Article #10	Hilgeman, et. al. (2018)	RCT	50 VA patients randomized to a NSACP vs usual care (referred to a social worker)	A formal, nurse led program that taught patients the risk, benefits and alternatives of life sustaining procedures (RBA). The results show the IG were more likely to decline life sustaining treatment, had more patient satisfaction, participant retention and treatment fidelity	Demographic data, past experiences with ACP and desire for help completing an AD as well as information about RBA was collected via a questionnaire. Only 4 participants had prior discussions about ACP. The majority wanted more information about RBA than just ACP. The IG intervention was 46 minutes	The RBA information was provided by a RN via a slide show and with printed handouts. Given the CG usually does AD planning with a social worker, it validates the need for the ACP to be done by a medical provider who can answer question about RBA. Thus, the providers in my project,	IB

					<p>compared to 29 in the CG. This is valuable to my project, as the biggest limitation to providers discussing ACP at every appointment, is time. Thus, patients in my project will be offered an appointment to just discuss ACP as well as the weekly, free, informational session.</p>	<p>will be reminded to be prepared to discuss RBA when engaging in ACP.</p>	
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Appendix B FIVE WISHES SEMINAR QUESTIONNAIRE

Please answer the following questions as:

5=Strongly Agree, 4= Agree, 3= Neutral, 2= Disagree 1= Strongly Disagree 0= NA

- _____ 1. I have previously completed an advance directive
- _____ 2. I believe an advance directive is very important
- _____ 3. I feel an advance directive will help guide my family
- _____ 4. I think Five Wishes is an advance directive I will use.
- _____ 5. I plan to discuss my advance care planning desires with my family and loved ones.
- _____ 6. I plan to discuss my end of life desires with my provider.

Appendix C Consent to participate

Five Wishes Educational Seminar

Comprehensive Primary Care

5413 West Cedar Lane, Suite 203c, Bethesda MD 20814

1. PURPOSE AND BACKGROUND

Amanda Bridges, CRNP and The George Washington University are conducting research on advance directives. The purpose of your participation in this research is to help the researcher improve education about the advance directive, Five Wishes.

B. PROCEDURES If you agree to participate in this research study, the following will occur: You will be asked to answer a pre and post questionnaire. You will watch a short 30-minute video on the advance directive known as Five Wishes. Total time commitment is estimated to be 1 hour and 30 minutes.

C. RISKS There are minimal risk to participating in this study. Some patients may be emotionally upset about a discussion about end of life care and death.

D. CONFIDENTIALITY The records from this study will be kept as confidential as possible. No individual identities will be used in any reports or publications resulting from the study. All questionnaires will be destroyed after analyzed. Research information will be kept in a locked cabinet. Only research personnel will have access to the questionnaires.

E. BENEFITS OF PARTICIPATION The anticipated benefit of your participation in this study is a free, copy of Five Wishes and increased understanding of this advance directive

F. VOLUNTARY PARTICIPATION Your decision whether to participate in this study is voluntary and will not affect your relationship with Comprehensive Primary Care. If you choose to participate in this study, you can withdraw your consent and discontinue participation at any time without prejudice.

G. QUESTIONS If you have any questions about the study, please contact Amanda Bridges by calling 301-869-9776.

Signature _____ Date _____

Research Participant

_____ Date: _____

Amanda Bridges, MSN, ACNP-BC

School of Nursing THE GEORGE WASHINGTON UNIVERSITY nursing@gwu.edu 202-994-7901

Appendix D Shared Decision Making Tool

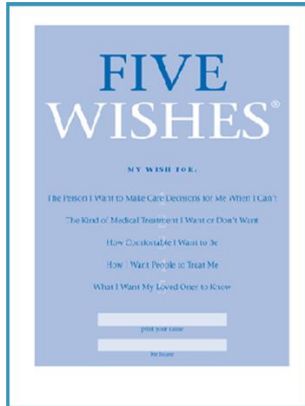
THE FOUR HABITS MODEL

HABIT	SKILLS	TECHNIQUES AND EXAMPLES	PAYOFF
INVEST IN THE BEGINNING	Create rapport quickly	<ul style="list-style-type: none"> Introduce self to everyone in the room Refer to the patient by last name and Mr. or Ms. until a relationship has been established Acknowledge wait Make a social comment or ask a non-medical question to put patient at ease Convey knowledge of patient's history by commenting on prior visit or problem Consider patient's cultural background and use appropriate gestures, eye contact, and body language 	<ul style="list-style-type: none"> Establishes a welcoming atmosphere Allows faster access to real reason for visit Increases diagnostic accuracy Requires less work Minimizes "Oh by the way..." at the end of visit Facilitates negotiating an agenda Decreases potential for conflict
	Elicit the patient's concerns	<ul style="list-style-type: none"> Start with open-ended questions: <ul style="list-style-type: none"> "What would you like help with today?" Or, "I understand that you're here for ... Could you tell me more about that?" Speak directly with patient when using an interpreter <ul style="list-style-type: none"> Make eye contact and smile at patient so you are perceived as attentive. 	
	Plan the visit with the patient	<ul style="list-style-type: none"> Repeat concerns back to check understanding Let patient know what to expect: "How about if we start with talking more about ..., then I'll do an exam, and then we'll go over possible tests/ways to treat this? Sound OK?" Prioritize when necessary: "Let's make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can't get to the other concerns, let's..." 	
ELICIT THE PATIENT'S PERSPECTIVE	Ask for the patient's ideas	<ul style="list-style-type: none"> Assess patient's point of view: <ul style="list-style-type: none"> "What do you think might be causing your problem?" "What worries or concerns you most about this problem?" "What have you done to treat your illness so far?" "Have you sought help in your community?" Ask about ideas from loved ones 	<ul style="list-style-type: none"> Respects diversity Allows patient to provide important diagnostic clues Uncovers hidden concerns Reveals use of alternative treatments or requests for tests Improves diagnosis of depression and anxiety
	Elicit specific request	<ul style="list-style-type: none"> Determine patient's goal in seeking care: "How were you hoping I could help?" 	
	Explore the impact on the patient's life	<ul style="list-style-type: none"> Check context: "How has the illness affected your daily activities/work/family?" <ul style="list-style-type: none"> "What are the main problems your illness has caused for you?" 	
DEMONSTRATE EMPATHY	Be open to the patient's emotions	<ul style="list-style-type: none"> Respond in a culturally appropriate manner to changes in body language and voice tone 	<ul style="list-style-type: none"> Adds depth and meaning to the visit Builds trust, leading to better diagnostic information, adherence, and outcomes Makes limit-setting or saying "no" easier
	Make an empathic statement	<ul style="list-style-type: none"> Look for opportunities to use brief empathic comments Name a likely emotion: "You seem really worried." Compliment patient on efforts to address problem 	
	Convey empathy nonverbally	<ul style="list-style-type: none"> Use a pause, touch, or facial expression 	
	Be aware of your own reactions	<ul style="list-style-type: none"> Use your emotional response as a clue to what patient might be feeling 	
INVEST IN THE END	Deliver diagnostic information	<ul style="list-style-type: none"> Frame diagnosis in terms of patient's original concerns 	<ul style="list-style-type: none"> Increases potential for collaboration Influences health outcomes Improves adherence Reduces return calls and visits Encourages self care
	Provide education	<ul style="list-style-type: none"> Explain rationale for tests and treatments Review possible side effects and expected course of recovery Discuss lifestyle changes that are consistent with patient's lifestyle, cultural values and beliefs Provide resources, for example, written materials, in patient's preferred language when possible 	
	Involve the patient in making decisions	<ul style="list-style-type: none"> Discuss treatment goals: express respect towards alternative healing practices Assess patient's ability and motivation to carry out plan Explore barriers: "What do you think we could do to help overcome any problems you might have with the treatment plan?" Test patient's comprehension by asking patient to repeat instructions. "Just so I am sure that I have explained things well, would you tell me your understanding of the next steps?" Set limits respectfully: "I can understand how getting that test makes sense to you. From my point of view, since the results won't help us diagnose or treat your symptoms, I suggest we consider this instead." 	
	Complete the visit	<ul style="list-style-type: none"> Summarize visit and review next steps Ask for additional questions: "What questions do you have?" Ask family members if they have other questions Assess satisfaction: "Did you get what you needed?" Close visit in a positive way <ul style="list-style-type: none"> "It's been nice meeting you." "See you in ___ months." "Thanks for coming in." 	

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Appendix E Kiosk Intake Questions

1. Do you have an Advance Directive?
2. Do you know what an Advance Directive is?
3. Do you want to discuss Advance Care Planning today?



- Have you designated a person to make medical decisions for you in the event you are unable?
- Do you know what an advanced directive is?
- Do you want unnecessary medical procedures done to you in the event you

IF YOU ANSWERED “NO” TO ANY OF THE ABOVE QUESTIONS,
GRAB A LOVED ONE AND JOIN US FOR A **FREE**
INFORMATIONAL SESSION ON ADVANCE DIRECTIVE
PLANNING.

Presented by: Amanda Bridges, ACNP-BC

Every Thursday from September 5-November 22, 2019

5pm-6:30pm

5413 West Cedar Lane, Suite 203C, Bethesda MD

What is covered:

1. Discuss common myths about advance directive planning
2. Review the types of advance directives recognized by the state of Maryland
3. Explain FIVE WISHES. Each participant will receive a FREE copy of FIVE WISHES, an easy and unique advance directive created in cooperation with the Robert Woods Johnson Foundation and Aging with Dignity. (\$5 value).
4. Presented by an acute care nurse practitioner who can answer questions regarding end of life care.
5. Participation in this informational session does not require completion of an advance directive. You are encouraged to continue discussing your wishes with your provider and loved ones.

Appendix G: Provider Engagement in ACP Data Collection Worksheet

Discussion took place?	Yes	
Insurance	Commercial	
Race	Non-Hispanic	
Ethnicity	White	
Marital Status	Married	
Employee status	Full Time	
Gender	F	
Age	51	
Q3	1	
Q2	1	
Q1 (1=yes, 2=no)	1	
Patient Initials/last 2 MR#	AB3455	

Data Collection Worksheet for Five Wishes Seminar (Pre/Post)

Initial Date	AB11/09	
Gender (M/F)	F	
PreQ1	1	
PreQ2	3	
PreQ3	3	
PreQ4	4	
PreQ5	3	
PreQ 6	5	
PostQ1	4	
Post Q2	4	
Post Q3	5	
Post Q4	5	
Post Q5	5	
Post Q 6	5	

1=Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly Disagree

Table 1 Cost Benefit Analysis

COST/BENEFIT ANALYSIS		
	ESTIMATED COST	ACTUAL COST
Start Up Materials	\$240	\$239.97
Estimated Additional Salaries	\$2,100	\$0
Additional Operational Cost (EHR, utilities, Rent, etc)	Negligible	Negligible
Revenue (CPT Billing)	\$6750	\$4,127.27
Total	(\$4,410)	(\$3,887.30)

Table 2: Evaluation

	Objectives	Evaluation Questions	Benchmarks	Methods
Overall Program				
Improve provider participation in ACP discussions	Improve provider discussions about ACP	Does a solicited opportunity for the patient to discuss ACP and an EHR reminder improve ACP discussions?	Providers will improve ACP discussions by documentation of ICD 10 code in the EHR compared to prior 3 months.	Analysis of ICD 10 ACP documentation in the chart over 3 months compared to prior 3-month control via chi-square analysis.
Increase patient education about the AD known as Five Wishes	Patients will have a better understanding of the AD known as Five Wishes.	Do patients demonstrate a change in opinion about the value of an AD by attending a Five Wishes educational seminar?	Five Wishes attendance and mean Likert Scaled responses to questionnaire	Likert scaled responses averaged pre and post seminar questionnaire. Total number of patient participants
Process				
Successfully involved owners of the practice				

Improve provider knowledge of shared decision making	Increase provider understanding of basic communication skills to improve shared decision making.	Will a brief article on the Four Habits of Communication improve providers' ability to engaged in shared decision making?	Post implementation analysis of provider use of these Four Habits of Communication	Providers will be asked after the study if they used the Four Habits of Communication during this study period.
Ancillary staff cooperation	Engage ancillary staff to implement the new process of asking about ACP and entering template into EHR	Does a preset template improve medical assistant cooperation with entering questionnaire data?	Number of patients lost	Create EHR template and simplify work flow to ensure process is easy and seamless for the ancillary staff
Structure				
Pre-created template for EHR to enter answers to question and engage providers to discuss ACP	Every patient response to the questionnaire will be entered in the EHR.	Will the screening questionnaire that collects patient response be completed by all the patients?	Attrition rates	Assess number of patients seen during the 3 months process compared to number of questionnaires completed.

Table 3 Data Analysis

Demographic Characteristics and Statistics of the Sample For Provider Engagement in ACP

Discussion

	Total Sample (N)	Frequency (%)	Before Intervention	Frequency (%)	After Intervention	Statistics
Gender	1037					
Male	404	39.0%				
Female	633	61.0%				
Age(years)						
18-40	284	27.4%				
41-64	497	47.9%				
65-79	217	20.9%				
80-100	39	3.8%				
Marital Status						
Married	598	57.7%				
Single	285	27.5%				
Divorce	76	7.3%				
Missing	42	4.1%				
Widow	36	3.5%				
Employment						
Full Time	616	59.4%				
Student	32	3.1%				
Retired	51	4.9%				
Self-Employed	47	4.5%				
Missing Data	265	25.6%				
Not employed	26	2.5%				
Race						
White	723	69.7%				
Black/AA	66	6.4%				
Asian	66	6.4%				
Other	22	2.1%				
Declined	160	15.4%				
Ethnicity						
Non-Hispanic	743	71.6%				
Hispanic	55	5.3%				
Missing/Refuse	231	22.3%				

d						
Other	8	0.8%				
Insurance						
Commercial	747	72.0%				
Medicare	207	20.0%				
Medicaid	76	7.3%				
Self-Pay/Uninsured	5	0.5%				
Tricare	2	0.2%				
Patient response to at least one question required for statistical evaluation						
Q1= People who already have an AD/ACP	237	22.9%				
Q1=People who do not have an AD	788	76.0%				
Q1=Missing response	12	1.2%				
Q2=People who know what an advance directive is	416	40.1%				
Q2=People who do not know what an advance directive is	586	56.5%				
Q2= Missing data	35	3.4%				
Q3=Patients that did want to discuss ACP	116	11.2%				
Q3=Patients that did not want to discuss ACP	905	87.3%				
Q3=Missing data	16	1.5%				
Cronbach's Alpha for intake						0.512

questions						
Total ACP discussions (all insurances) by ICD 10 EHR Documentation			6 (0.005%)		90 (8.7%)	
Provider Engagement: Discussion(see above for definition)						X ² =205.561 P<0.001 Phi=0.445
Yes and Yes	51					
Yes and No	65					
Missing/No and Yes Discussed	39					
No/Missing and No Discussion	866					
CPT Revenue Anticipated if all claims reimburse \$75					\$6750.00	
Actual CPT Revenue					\$4127.27	

Descriptive Characteristics and Statistics of the Sample for Five Wishes Seminar

FIVE WISHES*	Total (N) Frequency %	Mean response on scale (0-5)	Median	Variance	Statistics Sig of Paired t test (95% Confi) Pre/Post	T	Sig of sample correlation (pre/post)
Male	7 (33.3%)						
Female	14 (66.7%)						
Pre Question 1		2.76	3.00	4.290	NA	NA	NA
Post Question 1		2.76	3.00	4.290	NA	NA	NA
Pre Question 2		4.62	5.00	0.328	0.083	-1.826	0.000
PostQ2		4.76	5.00	0.290	0.083	-1.826	0.000
Pre Question 3		4.48	5.00	0.862	0.030	-2.335	0.146
Post Q3		4.76	5.00	0.290	0.030	-2.335	0.146
Pre Question		3.43	4.00	2.857	0.003	-3.408	0.00

4							
PostQ4		4.62	5.00	0.448	0.003	-3.408	0.00
Pre Question 5		4.57	5.00	0.457	0.083	-1.826	0.000
Post Q5		4.71	5.00	0.314	0.083	-1.826	0.00
Pre Question 6		4.48	5.00	0.462	0.042	-2.169	0.000
Post Q6		4.67	5.00	0.333	0.042	-2.169	0.000
Missing Data	0						
Five Wishes Questionnaire Cronbach's Alpha Reliability	0.771						

Table 4 Data Definitions

Data Definition Codes	
Patient ID Code	Patient Initials and last 2 numbers of MR number
Age	Age
Gender	1=Female 2= Male
Race(self-identified)	1=White 2=Black/African American 3=Asian 4=Declined 5=Other
Ethnicity(self-identified)	1=Non-Hispanic 2=Hispanic 3=Decline/refuse to answer 4=Other
Question1: Do you have an Advance Directive?	1=Yes 2=No 3=Missing
Question 2: Do you know what an advance directive is?	1=Yes 2=No 3=Missing
Question 3: Do you want to discuss Advance Care planning today?	1=Yes 2=No 3=Missing
Employment Status	1=Employed, Full Time

	<p>2=Student 3=Retired 4=Self-Employed 5=Missing Data 6=Not Employed</p>
Marital Status	<p>1=Married 2=Single 3=Divorced 4=Widow 5=Missing</p>
Insurance	<p>1=Commercial 2=Medicaid 3=Medicare 4=Self Pay/Uninsured 5=Tricare</p>
Discussion	<p>1=yes 2=no</p>
Provider Engagement	<p>1=Yes (pt wanted discussion) and yes Discussion took place 2=Yes (wanted) and No discussion took place 3=Not wanted and yes discussion took place 4=Missing response but yes discussion took place 5=Not wanted/missing data and no discussion took place</p>
FIVE WISHES SEMINAR PATIENT ID	Initials and date of attendance
Pre/Post Five Wishes Question 1	<p>0=N/A 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree</p>
Pre/Post Question 2:	<p>0=N/A 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree</p>
Pre/Post Question 3:	<p>0=N/A 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree</p>

Pre/Post Question 4:	0=N/A 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree
Pre/Post Question 5:	0=N/A 1=Strongly Disagree 2=Disagree 3=Neutral 4=Agree 5=Strongly Agree
CPT/ ICD10 claims total (all insurances)	Total number (n)
CPT Reimbursement from billing claims (Anticipated)	Anticipated Dollar value (\$)
CPT Reimbursement (Actual)	Actual Dollar Value (\$)
Total number of Discussions 3 months prior to Intervention at the same office with the same providers	Total number (n)

Table 5: Variable/Analysis Table

Independent Variable	Dependent Variable	Statistical Analysis
Five Wishes Pre-Seminar Questionnaire (pre/post, same patients)	Five Wishes Post Seminar Questionnaire (pre-post, same patient)	Paired t test
Total ICD10 EHR documentation 3 months prior to intervention at same practice location, same providers but different patients from the same practice	Total ICD10 EHR documentation after Intervention (same practice, same providers, different patients from same practice)	Chi Square analysis

Dear Amanda and Dr. Ricciardi,

Firstly, in reading your proposal, it is well written and thoughtful. One thing that stood out to me from an ethical perspective is the choice to exclude persons who are blind. This exclusion impacts the direct benefit a patient may receive from engaging in the ACP process. I strongly encourage you to reconsider this exclusion.

Additionally, patients whose first language is not English may also benefit from the ACP process. Again, I encourage you to seek ways to better include these patients. In examining the risk/ benefit of the project, these patients may be at greater risk to *not* be included in the process as ACP is such a vital component of any holistic care. Also suggested is the following article that may guide you in engaging these populations: Hines, S. C., Glover, J. J., Babrow, A. S., Holley, J. L., .Badzek, L. A., & Moss A.H. (2004). Improving advance care planning by accommodating family preferences. *Journal of Palliative Medicine*, 4(4), 481-489.

This all said, regarding the determination worksheet for the project entitled, "Using Five Wishes to Promote Advance Care Planning in A Maryland Primary Care Practice," a determination has been made that your project does not meet the definition of research. That is, a systematic investigation intended to contribute to generalizable knowledge.

This determination is being made after review of the project documents. The project nature as quality improvement intends to inform internal practice. The project does not aim to inform new theories or external standards of practice. Therefore, further review by the GW Nursing Office of Research or the GW Institutional Review Board is not required (per GW IRB Policy HRP-010, Human Research Protection Program).

Should your project change in any way that it would meet the definition of research, please contact the GW Nursing Office of Research at sonresearch@gwu.edu so we may assist you in proceeding. As a reminder, you are to conduct all projects in an ethical manner regardless of review requirements.

Please do not hesitate to contact me with any questions or concerns regarding this determination.

Kind regards,

Cortni Romaine, PhD Candidate, MS, CIP | Research Program Associate
The George Washington University School of Nursing
Member, GW Institutional Review Board

Letter of Cooperation

Dear Sir:


This letter confirms that I, as an authorized representative of Comprehensive Primary Care, allow the PI access to conduct study related activities at the listed site, as discussed with the PI and briefly outlined below, and which may commence when the PI provides evidence of IRB approval for the proposed project.

- DNP Project Study Sites: 5413 West Cedar Lane, Suite 203C, Bethesda MD 20814
- Study Purpose: To improve education about the advance directive, Five Wishes and implementation of Advance Care planning
- Study Activities: educational assessment, questionnaires, Educational videos
- Subject Enrollment: All patients over 18 with an interest in advance care planning and all voluntary patients who want to learn about Five Wishes.
- Site Support: Provide space, authorize site employee's assistance, distribute questionnaires, allow access to ECW patient records and billing information, allow use of practice equipment, and identify eligible patient subjects.
- Data Management: patient identified information will be protected, vital signs data will be collected
- Anticipated End Date: May 30, 2020

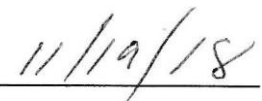
We understand that this site's participation will only take place during the study's active IRB approval period. All study related activities must cease if IRB approval expires or is suspended. I understand that any activities involving Personal Private Information or Protected Health Information may require compliance with HIPAA Laws and GWIJ Policy.

Our Organization agrees to the terms and conditions stated above. If we have any concerns related to this project, we will contact the PI. For concerns regarding IRB policy or human subject welfare, we may also contact the GW IRB.

Regards,



Mindi Cohen, DO



11/19/18