Increasing Advance Care Planning in Primary Care

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Abstract

Advance Care Planning (ACP) discusses and documents end-of-life healthcare wishes with a medical provider. Having a documented ACP has been shown to decrease Medicare spending while increasing patient quality of life and end-of-life care. There was no quality measure or standard policy for implementing ACP at the project site, a small Federally Qualified Healthcare Center (FQHC) in rural North Carolina. The purpose of this project was to increase ACP in the primary care setting by implementing a new staff process of identifying Medicare patients that did not have a documented Medical Orders for Scope of Treatment (MOST) form in their electronic medical record (EMR) and dispensing an educational handout about MOST in English or Spanish. Completed MOST forms were uploaded to the patient's EMR and returned to the patient. The population, intervention, comparison, and outcomes (PICO) framework was used to evaluate the implementation of this project. Weekly informal staff check-ins were performed to assess compliance with implementation. During the five weeks of implementation, Medicare patients with a completed MOST form in their EMR increased from less than 1% to 10%. Barriers included project site merger and highly stressed staff with poor engagement. Continued support with increasing ACP discussions in the primary care setting is necessary as it can positively influence patient quality of life and reduce healthcare costs.

Keywords: advance care planning, medicare, primary care, federally qualified healthcare center, medical orders for scope of treatment, MOST, implementation

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Section I. Introduction

Background

Advanced care planning (ACP) assists people in reflecting, deliberating, and determining their values and treatment preferences at the end of their lives (Howard et al., 2016). This occurs through end-of-life care discussions and clarifying patient values and goals through written documentation and medical orders (Zwakman et al., 2018). The primary care setting provides a longitudinal patient relationship allowing multiple discussions about initiating an ACP; however, it is infrequently discussed due to multiple barriers (Howard et al., 2016). Approximately 18% to 30% of American adults have a completed ACP (Halpert et al., 2021).

Chronic medical conditions account for two-thirds of all healthcare costs and 93% of Medicare spending (National Council on Aging, 2021). Without an ACP, patient goals and values may not be followed, leading to unnecessary hospitalizations and testing, negatively affecting patient autonomy and healthcare spending (National Committee of Quality Assurance, 2021). A case-control study of a large rural-suburban multisite organization from 2013 to 2016 of Medicare patients with ACP who died was reviewed. Bond et al. (2018) found that these patients had a lower cost of annual care by $9,500. This decrease in cost occurred by having fewer inpatient admission days. Total US Medicare spending in 2021 was $900.8 billion (Centers for Medicare and Medicaid Services [CMS], 2023). As of 2023, North Carolina has 2,102,224 enrolled Medicare beneficiaries with an expected expenditure of $10,201 per enrollee (Burns, 2023). That is an astounding $21 billion expected to be spent in North Carolina.

Organizational Needs Statement

This project was conducted at a small Federally Qualified Healthcare Center (FQHC) in rural North Carolina. The project site is a non-profit organization that aims to provide primary,

medical, behavioral, urgent care, dental health, and patient education services to medically and dentally underserved individuals. FQHCs are community-based healthcare centers that receive funds from and are overseen by Health Resources and Services Administration (HRSA) to provide primary care services in underserved areas (Health Resources and Services Administration [HRSA], 2018).

While there are stringent Performance Measurements and Quality Improvement measures that HRSA imposes to guide this FQHC's medical practice, there was no standard policy or requirement for completing ACP in the Medicare population at the project site. The project site had less than 1% of Medicare beneficiaries with a documented ACP. Compared to the national estimated adult percentage of 18 to 30% with a completed ACP, this FQHC had a significant need to address ACP (Halpert et al., 2021).

The Office of Disease Prevention and Health Promotion (ODPHP) and HRSA provide the initiative for Healthy People 2030. This initiative provides the framework that encompasses the vision for all people in the United States of America to acquire optimal health and well-being from birth to the end of life (U.S. Department of Health and Human Services [US DHHS] & Office of Disease Prevention and Health Promotion [ODPHP], n.d.). Focusing on improving the care and quality of life of all who have dementia or Alzheimer's is a foundational principle of Healthy People 2030.

As people age, their risk for dementia and Alzheimer's disease increases. According to the Alzheimer's Association (2019), Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in adults in the US. In addition to dementia, Medicare beneficiaries often have multiple medical co-morbidities, putting them at higher risk for health deterioration. Often Medicare patients present with multiple chronic medical diagnoses that must

be addressed during their routine visit with their Primary Care Provider (PCP) at the project site. Discussing ACP was not a priority during those routine chronic follow-up visits. In addition, Medicare annual wellness visits were not being conducted routinely at the subject FQHC due to a lack of staff and training. This impacted the initiation of ACPs at this FQHC because the annual wellness visits are when the topic of ACP is discussed with the patient. Both routine visits that require medical interventions and missed annual wellness visits lead to missed opportunities to address this crucial need.

End-of-life care is a part of whole lifespan care, from birth to death. Quality end-of-life care should be valued as important as any other aspect of one's healthcare. ACP discussions allow patient healthcare wishes to be known, documented, and followed. Improving the quality of life, increasing general well-being, and following the objectives set forth by Healthy People 2030. The triple healthcare aim promotes enhanced patient experience, improved population health, and reduced healthcare costs. In contrast, the healthcare *quadruple aim* expands on the triple aim, focusing on healthcare worker satisfaction (Bodenheimer & Sinsky, 2014). As part of this project, a literature review was performed on ACP in primary care settings. It was found that PCPs confront several obstacles and facilitators to implementing ACP in the primary care setting. Providers in this rural North Carolina FQHC experience the same obstacles.

Problem Statement

FQHC PCPs face multiple barriers to initiating and implementing ACP. A lack of ACP in the primary care setting can lead to unnecessary burdens on patients, families, caregivers, and healthcare systems. With increased numbers of Medicare patients who do not have documented ACP, achieving the goals of Healthy People 2030 will be negatively affected. A lack of ACP will not improve patient well-being or quality of life and will not decrease healthcare costs.

Purpose Statement

This was a process development project at a rural North Carolina FQHC to increase ACP in the primary care setting. The intervention to reduce this healthcare gap was a new process of educating staff on how to identify Medicare patients in need of ACP, and how to implement Medical Orders for Scope of Treatment (MOST) forms.

Section II. Evidence

Literature Review

A literature review was conducted to search for processes and strategies for implementing ACP in primary care. Online databases Public/Publisher MEDLINE (PubMed) and Cumulative Index to Nursing and Allied Health Literature (CINAHL) were utilized. The keywords used in the search were “advance care planning,” “advance directive,” “implementing,” “medical orders for scope of treatment,” “MOST,” “end-of-life planning,” “federally qualified healthcare center,” “primary care,” and “Medicare.”

The search was limited to published results within the last five years. PubMed provided 60 results, and CINAHL provided 38. Four articles from PubMed and three articles from CINAHL were included in the literature review. The remaining articles were read in their entirety and analyzed with a literature matrix to evaluate further content. The included scholarly articles had research hierarchy levels of evidence II-VII (see Appendix A). The inclusion criteria were: (a) articles directly relevant and applicable to ACP and primary care, (b) racial-ethnic health disparities, and (c) strategies to increase ACP. Articles that focused on acute care or were unrelated to primary care were excluded.

Current State of Knowledge

The literature review found no specific guidelines, best practices, or benchmarks to address ACP. There are recommendations that ACP benefits all adults, those age 18 or older, regardless of health status, to plan for future medical healthcare and end-of-life interventions (Rando-Matos et al., 2021; Sandoval et al., 2019; Sedini et al., 2021). Other authors recommend focusing ACP discussions on those with expected health deterioration or need for palliative care (Desai & Schneiderman, 2019; Harwood et al., 2020; Huxley et al., 2021).

Through the literature review, racial and ethnic disparities in ACP were evident. Among Medicare patients with lung cancer, it was found that within the last month of life, racial-ethnic minorities had significantly higher end-of-life medical expenditures than non-Hispanic Whites, due to greater intensity of care and interventions (Chen et al., 2020). In a study out of California comparing non-Hispanic Whites and Hispanics, the non-Hispanic White English-speaking patients had almost 50% higher rates of having a completed ACP, even when interpreters were not needed for English-speaking Hispanic patients (Gonzalez et al., 2020). It is evident that there is a need for implementing culturally diverse ACP in Primary Care.

Primary care providers encounter numerous barriers or facilitators to implementing ACP. The most frequent barriers for PCPs were lack of appointment time, lack of appropriate training or education, and uncertain timing of initiating an ACP (Hafid et al., 2021; Nagarajan et al., 2022; Tilbergs et al., 2018). The most frequent facilitators for ACP in the primary care setting were longitudinal and positive patient-provider relationships, patient desire to make end-of-life decisions, and family desire to honor those decisions (Bernard et al., 2020; Ko et al., 2021). Stakeholder engagement was a barrier and facilitator throughout the research.

Stakeholders included everyone involved in the ACP discussion. Namely the medical provider, the patient, family members, and caregivers. While several patients and family members were open to ACP discussion, many were reluctant or did not want to cause emotional distress to their families or caregivers (Ko et al., 2021). Many felt they were too young or healthy to discuss future end-of-life decisions (Bernard et al., 2020). There were gaps in the literature on the proper protocol to implement ACP and its generalizability to initiate in all healthcare settings.

Current Approaches to Solving Population Problem(s)

There were several recommendations on addressing ACP in the literature. To normalize ACP discussions, Sandoval et al. (2019) recommend that PCPs discuss ACP with all patients aged 18 or older. On-site education sessions were offered to PCPs and all staff about the value of and approach to engaging patients in ACP discussion.

Sandoval et al. (2019) standardized the workflow by recommending team pre-visit huddles to identify appropriate patients with or without a documented ACP. Those without an ACP were offered an opportunity to utilize either a Health Care Agent Advance Care Plan or Clinician Orders for Life-Sustaining Treatment (COLST) form. The rooming staff would provide that patient with the appropriate form and an educational brochure. The providers would review the information during the visit if needed.

The patients would be scheduled for a future visit with the PCP or a social worker to facilitate form completion. The completed documents would be scanned into the patient's electronic health record, generating a flag banner for easy visibility and access. This method showed a 4% increase in completed ACP (Sandoval et al., 2019).

According to Huxley et al. (2021), the United Kingdom uses the national Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form. This form was developed to integrate resuscitation decisions into more comprehensive care goals for primary care patients who are expected to experience a deterioration in health. Their focus was to develop an end-of-life document shaped by what is considered "a good death." However, it was thought that PCPs might lack specialist knowledge in identifying health deterioration and expected end-of-life, which may be a barrier to completing the ReSPECT form and transferring to acute care settings.

To increase ACP in oncology patients, Desai & Schneiderman (2019) recommend initiating early ACP with frequent readdressing in patients with advanced or poor-prognosis

cancer or a life expectancy of less than one year. To recognize appropriate patients, they recommend a mandatory four-week training program or a rotation in palliative care for hematology-oncology fellows, medical residents, advanced-practice registered nurses, or registered nurses interested in neoplastic diseases. While oncology patients are seen in primary care, this approach is not generalizable as it focuses only on oncology patients toward end-of-life.

Harwood et al. (2020) developed a palliative care screening tool for Heart Failure patients to identify patients appropriate for ACP. Once a patient was identified as appropriate, an Advance Care Plan template guided the ACP conversation and was documented in the clinic visit note. Those patients without a documented ACP received educational material regarding advanced directives. Completed advance directives were scanned into the electronic health record, which activated a red banner to identify the ACP quickly. To accomplish this, all stakeholders of the care team were educated on the documentation process of the Advance Care Plan template. After implementing this template system, patient charts with completed advance directives increased from 53% to 79%.

To increase primary care patient interest in advance directives, Rando-Matos et al. (2021) conducted a randomized control trial comparing how patients received advance directives information. The study compared the effectiveness of brief oral information by PCPs about advance directives, compared to the effectiveness of oral information and providing an educational brochure to patients. This study was done in Barcelona, Spain, on patients at least 18 years of age. Results showed that a brief oral and written intervention of the brochure delivered by the PCP resulted in significantly higher interest in advance directives. At the end of the study,

there was a 5.4% higher interest in those that received both oral and written intervention than those who received only verbal intervention (Rando-Matos et al., 2021).

Based on the literature, stakeholder engagement and education are essential for successfully increasing ACP in the primary care setting. Frequently, standardized medical decision forms were utilized to document ACP. While using a template and red banner in the electronic medical record (EMR) assists with documentation and easy visualization of ACP at some sites, altering the EMR at this rural North Carolina FQHC was not allowed. For this reason, the intervention chosen for this project was staff and PCP education about a new process to implement MOST forms for ACP.

Staff were educated about a pre-visit screening of appropriate Medicare patients to identify those patients who did not have a documented MOST form in their EMR. Medicare patients without a documented MOST form were provided an educational handout in English or Spanish, based on their preferred language. The patient could continue the conversation during the visit or opt to schedule another appointment to discuss further. The completed MOST forms were scanned into the patient's EMR under the Advance Directives Document section for easy identification.

Evidence to Support the Intervention

The intervention to educate staff about a new process of implementing MOST forms for ACP is the most appropriate and best option for this FQHC. Creating a red banner or alert had greater evidence of support in addition to the staff education; however, it was not possible with the project site EMR. The literature also revealed a racial-ethnic disparity in ACP in general and higher end-of-life healthcare costs for minorities (Chen et al., 2020; Gonzalez et al., 2020). Hispanic or Latino ethnicity was almost 50% of this rural NC FQHC patient population,

compared to the general North Carolina Hispanic or Latino population of 10.2% (United States Census Bureau, 2022). Most patients that seek care at FQHCs are uninsured or have Medicaid. In the literature on this topic, there were no available resources with the statistics of Medicare patients seen by FQHCs.

According to the Centers for Medicare and Medicaid Services (CMS) (2022), Medicare spending is expected to grow 7.2% between 2021-2030 due to the aging baby boomer generation. Minimizing excessive or unnecessary healthcare spending would help keep Medicare healthcare costs down. Addressing ACP with MOST forms for all Medicare beneficiaries at this FQHC will normalize the ACP discussion and assist patients to formalize their healthcare and end-of-life wishes. Based on the literature, a proven effective intervention to increase ACP in primary care is staff education on properly identifying patients needing ACP.

CMS (2020) describes ACP as a face-to-face service consisting of discussing a patient's health wishes. This may or may not include completing relevant documentation, such as the MOST form. In 2016, Medicare started allowing medical providers to bill for ACP discussions (National Committee of Quality Assurance, 2021). Several documents may be considered an ACP: (a) Durable Power of Attorney for Health Care, (b) Living Will, and (c) Medical Orders for the Scope of Treatment. All individuals, no matter their age or health status, can benefit from ACP to guide their future medical healthcare and end-of-life care interventions (Sedini et al., 2021).

The North Carolina MOST form is based on the national Physicians Orders for Life-Sustaining Treatment (POLST) (Caprio, 2014). The NC MOST form is a medical directive signed by the patient or legal representative and the patient's physician, nurse practitioner, or physician's assistant. While the MOST form does not replace a living will or healthcare power of

attorney, it does translate patients' preferences for treatments in different settings. This is especially important for those who are elderly, those suffering from chronic health conditions, or limited life expectancies. The MOST documentation indicates a patient's wishes regarding medical treatments in emergency and non-emergency situations. This includes whether cardiopulmonary resuscitation (CPR) will be attempted if the patient is pulseless or not breathing.

A retrospective cohort study in Japan was done from 2010 to 2016 on patients aged 65 or older that received CPR after two days of hospitalization (Hayashi et al., 2018). It was found that one in ten survived, with only half of those being discharged home. This study can be considered when discussing end-of-life and emergency care with CPR in those over 65. Older individuals are disproportionally affected by chronic diseases, with 80% of Medicare beneficiaries having at least one chronic medical condition and 70% having two or more (National Council on Aging, 2021). Medicare beneficiaries are those at least 65, those younger than 65 that are disabled, and those with End-Stage Renal Disease (CMS, 2021; US DHHS, 2021).

Evidence-Based Practice Framework

This project used the operational framework called PICO. The pneumonic PICO is Population, Intervention, Comparison, and Outcomes (Richardson et al., 1995). Richardson and his team developed this model to facilitate precise answers to clinical questions.

Using PICO, the project population was the facility staff and providers at this FQHC. The chosen intervention was to develop and implement a staff education program about a new process of implementing MOST forms. The staff was trained to offer an educational handout about MOST forms to Medicare patients who needed a MOST in their EMR. The project lead developed the handout. An effort was made to write the handout to be readable to patients with a

low literacy level. To evaluate the effectiveness of this project, the number of completed MOST forms in patient EMRs was compared before implementation and after. The outcome of this intervention was almost a nine-fold increase. The results will be discussed later.

Ethical Consideration & Protection of Human Subjects

Protecting participant rights is of the highest importance. To prepare for the formal Institutional Review Board (IRB) process and understand ethical considerations fully, the Collaborative Institutional Training Initiative (CITI) Program modules were completed. The CITI Program and IRB are methods to standardize participant protection in research, ethics, compliance, and safety in research studies (CITI Program, n.d.). The Quality Improvement and Program Evaluation Self-Certification Tool was completed to ascertain whether formal IRB would be required. It was determined that a formal University IRB review was not required for this project as it did not constitute research on human subjects. This project was designed to be a Quality Improvement initiative to improve the care provided. There was minimal risk with this project besides being encountered daily without physical or psychological examinations or tests.

The FQHC staff of certified medical assistants (CMAs) and PCPs were the focus population of the project. Participation of staff was optional. While Medicare patients were not the project population, they could accept or decline the handout. An interpreter was used for Spanish-speaking participants to ensure the ethical principle of justice was not violated. Translated educational material with a copy of the MOST form in Spanish was given to the Spanish-speaking patients for comparison and comprehension.

Section III. Project Design

Project Site and Population

A small FQHC was chosen in rural North Carolina for this project. This project's population was the site's CMAs and PCPs. Facilitators for this project included the trust and engagement with the project site champion and leadership support at the FQHC. Barriers included a merger of the small individual FQHC with a large multi-site FQHC. The merger affected PCPs and CMAs while decreasing patient visit volume during the transition.

Description of the Setting

The project site was an outpatient family primary care medical office. This primary care office serves patients of all ages, regardless of their ability to pay. They accept private insurance, Medicaid, Medicare, or a sliding scale for impoverished patients. Most patients seen at this FQHC are adults, with only a small percentage of children and Medicare recipients.

Description of the Population

The project targeted CMAs and PCPs with education about a new process of implementing MOST forms. All participating staff were female, half bilingual in English and Spanish. Medicare patients at the FQHC were the beneficiaries of the outcomes of the new process of implementing MOST forms. In a three-month review of all patients at the FQHC seen between August and October of 2022, 44% of patients identified as Hispanic or Latino, and 43% as Non-Hispanic or Non-Latino. There was no ability to review the ethnicity of only Medicare recipients.

Project Team

The project team consisted of: (a) the team lead, (b) a faculty advisor, (c) four CMAs, and (d) four PCPs, which included the project site champion. The project site employed all

CMAs and PCPs. The PCPs included one physician and three nurse practitioners. The team lead was one of the three nurse practitioners. Acting as the project site champion, the physician was involved early in the project with support. The team lead created, developed, and provided the staff and patient education handouts. The team lead had informal one-on-one staff check-ins at least once a week to track progress and address any barriers to project implementation.

Project Goals and Outcome Measures

The project aimed to increase ACP by utilizing MOST forms with Medicare recipients at the project site. According to Moran et al. (2020), performance measures must be relevant, measurable, accurate, and feasible, collected at intervals, and analyzed for opportunities for change. The project goal outcome of increased ACP was achieved using methods, interventions, and tools for implementation.

The method to achieve the project goal was to provide one-on-one staff education about ACP and MOST forms to CMAs and PCPs at the project site. The intervention was an educational handout for staff with the new process of identifying Medicare patients needing ACP. The staff was given a copy of the patient education handout about MOST forms along with the new process.

The staff would then hand out educational material to those patients without an ACP or an up to date MOST form in their EMR. The tools used were the educational handouts for staff and patient education handouts of MOST forms in either English or Spanish. The Spanish handouts were double-checked for validity with the project site champion, who is bilingual in English and Spanish. The outcome was an increased percentage of documented MOST forms. The team lead conducted one-on-one staff check-in at least once a week to analyze project implementation.

Description of the Methods and Measurement

In the project's first stage, using the EMR for data mining, a chart audit of the active Medicare patients was performed to see how many had documented MOST forms in their EMR. The number of Medicare patients a medical provider saw at the project site from October 2021 through October 2022 totaled 235. To compare the percentage of documented MOST forms before and after implementation, 235 Medicare medical records were audited for documented MOST forms.

For the project's second stage, educational material for staff was created by the project lead. The educational handouts were developed, printed, and assembled. The handouts for staff education were a new process of implementing MOST forms to increase completion of MOST forms (see Appendix B). Patient educational handouts explained MOST forms, why they are essential, how to complete them, and what to do with the completed forms in English (see Appendix C) or Spanish (see Appendix D). Copies of the North Carolina MOST forms in English (see Appendix E) and Spanish (see Appendix F) were also included for patients and staff to review.

The project's third phase was dispensing the educational handouts to staff one-on-one, including PCPs, CMAs, and Spanish interpreters. The Spanish interpreters were given handouts to be familiar with the content if the Spanish-speaking patients had any questions. Once the educational material was dispensed, reviewed, and any questions were answered, the fourth phase of the project started with the implementation phase. CMAs started using the new process of identifying Medicare patients needing MOST forms. CMAs were sharing the educational handouts with Medicare patients. Informal one-on-one staff check-ins occurred between the project lead, PCPs, and CMAs.

After implementation ended, the fifth and final phase of the project consisted of data mining the EMRs of all Medicare patients seen by a PCP during the implementation phase. The percentage of completed MOST forms of the Medicare patients seen during the fourth phase was totaled. The percentage of completed MOST forms from the active Medicare patients seen between October 2021- October 2022 was then compared to the percentage of completed MOST forms in Medicare patients seen during the implementation phase.

Discussion of the Data Collection Process

The EMR was accessed through an encrypted and password-protected computer provided by the project site to ensure data security. The project team leader informally met with staff one-on-one to follow up on the progress of the new process and how many MOSTs were completed at least once a week. The project team lead counted the number of active Medicare patients seen during the implementation phase and audited those charts for documented MOST forms. The number of completed MOST forms during the implementation phase was recorded on a spreadsheet. To ensure patient confidentiality, all personal identifiers were eliminated.

Implementation Plan

All CMAs and PCPs were given a packet that included the new staff process for implementing MOST forms. The educational handouts included the new staff process of identifying Medicare patients needing MOST forms. The explanation of how to implement the process was in English. Along with the staff process, they were given copies of the patient educational handouts and copies of the MOST form in English and Spanish. The project lead reviewed the handout with the staff, and the staff was able to ask any needed questions about the new process.

Using the new staff process while preparing for their workday, the CMA would identify scheduled Medicare patients. The CMA then reviewed their EMR under the Patient Documents, Advance Directives tab to determine if they had a documented MOST form. If the MOST form was not up to date or on file, the CMA then gave the patient the MOST form educational handout along with a copy of the MOST form in either English or Spanish. The language of information given was based on the patient's preferred language identified while in the rooming process.

The information was dispensed during the rooming of the patient in preparation for their scheduled PCP visit. The patient could either discuss the MOST form with the medical provider during the planned visit, or they could opt to make a separate appointment to discuss further. Discussion and completion of MOST forms were entirely voluntary for the patients. If a patient already had a documented MOST form, they could review it. New, reviewed, and revised MOST forms were scanned into the patient's EMR and uploaded under the Patient Documents, Advance Directives tab. The original was given back to the patient. Informal weekly in-person check-in with CMAs and PCPs was done to evaluate the process and if any barriers were present to address.

Timeline

The targeted interventions were implemented over two months, from mid-January 2023 until early March 2023. In early January, the team lead collected data on the number of active Medicare recipients at the FQHC and audited each of their EMRs for documented MOST forms. In mid-January, the team lead provided staff education packets of the new process and patient education information to be dispensed.

Mid-January through early March consisted of the implementation of the project, including weekly informal staff check-ins by the team lead. After implementation, the team lead audited the Medicare recipient's EMRs and collected documented MOST form data. The data collected was then compared before and after implementation for the project outcome. See Appendix G for the project timeline progression.

Section IV. Results and Findings

Results

Active Medicare patients were Medicare patients that had been seen by a provider at the project site between October 2021- October 2022. Two hundred thirty-five active Medicare patients were identified, and two had MOST forms in their EMR; however, they were expired. Both patients were non-Hispanic White, one male and one female.

The implementation phase began on January 23, 2023, and concluded on March 1, 2023. The project lead met informally with CMAs and PCPs once a week to determine if implementation changes were necessary. During implementation, 70 Medicare patients were seen by their PCP. Of these patients seen, 77% identified as Non-Hispanic White, 10% as Hispanic, 8% as Non-Hispanic Black, and 4% as Other ethnicities. Three of the four PCPs' Medicare patients were given the handout, and one PCP had patients complete MOST forms.

Of the 70 Medicare patients seen during the implementation phase, the MOST educational handout was given to 21. Those receiving the handouts were 80 % Non-Hispanic White and 20% Hispanic. No non-Hispanic Black or Other ethnicities were given the handouts. Seven of the 21 patients who received the educational handouts completed the MOST form and had it uploaded to their EMR. Of the seven completed MOST forms, 86% were Non-Hispanic white, and 14% were Hispanic. Before implementation, there was a less than 1% rate of MOST forms in Medicare patient EMRs. After implementation, for the 70 Medicare patients seen during the project implementation, there was a 10% completion rate. This was an over 9% increase from before implementation.

Discussion of Major Findings

Staff and patient education, along with a documented medical orders form scanned into the patient's EMR, has been proven effective in increasing ACP in primary care based on the literature. There was a gap in the literature on recommendations for increasing stakeholder engagement. There was an increase in documented MOST forms in patient EMRs utilizing the new staff process introduced with the project. However, only one PCP had patients who completed MOST forms despite weekly staff check-ins and conversations where CMAs and PCPs were supportive and encouraging about the project.

Section V. Interpretation and Implications

Costs and Resource Management

The cost of supplies for this project was minimal. The project site already had MOST forms on-site for patient use. MOST forms cost $0.04 each, purchased online through the North Carolina DHHS website (NC Division of Health Service Regulation Office of Emergency Medical Services, 2023). The greatest expenditure for supplies was copy paper and toner for printing staff and patient education handouts.

The new staff process was implemented during working hours with staff and providers during scheduled Medicare patient visits. The project lead performed staff check-ins during non-patient care time. If this project were to be conducted by a nurse practitioner (NP) in the future through their employer, a salary for the NP would be necessary to include within the itemized budget. Conducting research, planning, implementing, and evaluating a new process requires additional costs determined by the employee's qualifications and the time spent on the project. The average hourly salary for a novice NP in NC is $55 an hour (Trumble, 2023). See Appendix H for an itemized budget for the project.

The project site can bill Medicare for ACP discussion visits or during routine existing visits with PCPs using a modifier Current Procedural Terminology Code (CPT Code) used for insurance reimbursement. Potential additional revenue of $85.93 can be added to an already coded visit with the PCP using modifier CPT Code 99497 for the first 16-30 minutes discussing ACP (Garner-Huey, 2016). They can also use CPT Code 99498 for each additional 30-minute ACP conversation for $74.83. During the project implementation, the seven completed MOST forms were coded with the additional CPT Code 99497. This additional charge created a

potential revenue for the project site of $601.51. While there is a cost to implementing the project, there is also a fiscal benefit to the project that could benefit the project site long term.

Implications of the Findings

Implications for Patients

The educational handouts allow patients to familiarize themselves with MOST forms and why they are essential. This increased patient autonomy and allowed the patients to discuss and contemplate decisions for their healthcare and end-of-life wishes. The new process introduced more opportunities for ACP discussions than were previously occurring, as evident by the almost 10% increase in completion of MOST forms in Medicare patients during the project implementation.

While there was a significant increase in completed MOST forms, a disproportionate representation of ethnicities was found. Non-Hispanic White patients represented the largest percentage of Medicare patients seen, educational handouts given, and completed MOST forms. Hispanic patients were the second largest percentage of Medicare patients given educational handouts and completed MOST forms. While Hispanic patients were the second largest percentage, the number of Hispanic Medicare patients was significantly less than non-Hispanic Whites. Non-Hispanic Black and Other ethnicities were the least number of Medicare patients seen and were not given the educational handouts or completed MOST forms.

This project focused on Medicare recipients. Nearly 50% of the project site patient population consisted of Hispanic patients. However, the Medicare population comprised 10% Hispanic and 77% non-Hispanic White patients. Other ethnicities, minorities, and the uninsured need more opportunities for exposure to ACP.

Implications for nursing practice.

All PCPs and CMAs may benefit from greater exposure to end-of-life care discussions and the importance of quality end-of-life. There needs to be a normalization of these discussions to increase engagement. Normalize by repeatedly exposing patients and providers to the process and education handout. If repeatedly exposed, providers may be more willing and open to discussing these topics.

Impact for Healthcare System(s)

This project is cost-effective for both Medicare spending and the project site. The literature shows an overall cost reduction per Medicare beneficiary with an ACP, and the project site can bill for reimbursement for these conversations. This can create a positive revenue cycle for the project site if it continues long-term.

Healthcare systems have a responsibility to decrease health disparities. There is a need to increase culturally diverse initiatives to increase ACP. This project provided education handouts in Spanish to account for the project site's Hispanic population.

Sustainability

For this project to be sustainable, active stakeholder engagement is necessary. An incentive for active engagement may have improved CMA and PCP participation. Unfortunately, the project site was undergoing a merger during the project implementation, and project sustainability past the project implementation was impossible. Recommendations for future projects with other project sites or this project site post-merger will be discussed later.

Dissemination Plan

This project will be disseminated through numerous approaches. The project will first be presented at the College of Nursing project and poster presentations on July 11, 2023. The poster

will be an organized visualization of the project and its findings. The presentation will be presented to nursing leadership, interprofessional, and nursing colleagues. Following the presentation, the scholarly paper will be uploaded to the university's "ScholarShip." This will allow the paper to be digitally archived for future review by university faculty or students. The project will then be further disseminated by a presentation at the project site for stakeholder review to encourage further implementation of ACP in their patient population.

Section VI. Conclusion

Limitations and Facilitators

Numerous limitations were encountered during this project. The largest limitation was the project site merger to a new FQHC effective March 1, 2023. This merger affected the implementation time frame and the stakeholders. The stakeholders and all staff at the project site were preparing for the merger during the project's implementation phase. A new EMR was being introduced, and the staff were being trained during implementation. The office was closed for three full days for the new FQHC orientation and training. Closing the office decreased patient volume and the potential Medicare patients seen during the implementation phase.

With the merger transition, staff were under an increased amount of stress. Due to the merger, the project was not a top priority for the stakeholders or the project site. Staff reported having numerous tasks to accomplish during the rooming of a patient to see their provider, and adding another task was a barrier. The staff were stressed and reported forgetting to add the additional task of implementing the new process.

Along with staff stress, active staff engagement was a barrier to this project. One out of four PCPs had patients complete MOST forms, which was the team lead. Three out of four CMAs gave out educational info to appropriate patients. All four PCPs saw Medicare patients, some more than others based on schedules. One PCP predominantly saw the new Medicare patients. The patient-provider relationship develops over time and was not yet established. However, those new patients would still benefit from MOST education.

While CMA and PCP active engagement was low, they had positive attitudes towards the project. As facilitators, all CMAs, PCPs, and stakeholders felt the project was important and beneficial for patients. Other facilitators were patients. One patient requested to fill out a new

MOST form unprompted. In general, patients were open to discussing MOST forms. The established patient-provider relationship led to open discussions and increased completed MOST forms.

Recommendations for Others

Considering the project results, implications, limitations, and facilitators, there are recommendations for the scalability and sustainability of this project. The first recommendation would be not implementing a project during an organizational change or transition. A large organizational transition shifts staff priority and affects implementation and sustainability.

Secondly, the project would benefit from being electronically streamlined by having the EMR remove the barrier of an additional task for staff. This could occur by creating an alert for quick automatic identification of appropriate patients needing ACP. This alert can be expanded for all adults, not just Medicare patients. Incorporating all adults would increase greater diversity of ethnicities and inclusion for all. The educational handout should be given automatically to all adult patients. This would eliminate the barrier of identifying Medicare patients and allow all adults greater exposure to education about MOST forms.

Thirdly, the Medicare patients seen during the project implementation were scheduled for chronic disease follow-ups with their PCP. Limited appointment time can be a barrier to ACP, as found in the literature. The patients receiving the educational handout could discuss the MOST form during the visit or make another appointment. Having the patient make a separate follow-up appointment after their visit for another day to discuss the MOST form may increase completed MOST forms.

Another recommendation is to incentivize staff and stakeholder engagement. One way is to provide a small monetary gift card for the CMAs and PCPs to compensate for their time and

support. There is a gap in the literature about incentivizing. Standardizing the ACP discussion may eliminate incentivization. After the project site merger, the new FQHC focuses on ACP during Medicare Annual Wellness Visits, thus, standardizing MOST forms for Medicare patients.

Recommendations Further Study

To expand or scale this project, there are further recommendations. This project can be tailored to all medical offices, not just FQHCs. The MOST form can be discussed and completed at primary care, specialists, hospice, nursing homes, rehabilitation facilities, or during hospital visits. To reduce healthcare spending, health insurance companies may see that ACP reduces their expected expenditures and impose quality incentive programs. These programs may be similar to other programs that payers set forth for higher reimbursement rates for PCPs hitting quality measures. Adding a requirement of ACP and providing financial incentives by the insurance companies, including Medicare, would engage providers across all healthcare organizations.

Also, an initiative to address the gap in minorities receiving educational handouts is necessary. Expanding the project beyond Medicare beneficiaries will help address healthcare disparities. Ensuring all ethnicities are provided educational handouts could occur by all adult patients automatically being provided the handouts.

Final Thoughts

Having a documented ACP has been shown to decrease healthcare spending while improving patient quality of life and end-of-life care. Medicare patients' chronic medical conditions place them at high risk for health deterioration. ACP is not routinely discussed in the primary care setting. This rural NC FQHC project site had less than 1% of Medicare patients

with a documented ACP. This project implemented a new staff process of identifying Medicare patients without MOST forms in their EMR. Those patients were given an educational handout about MOST forms. After implementation, 10% of Medicare patients seen during the implementation phase of the project completed MOST forms.

While there was a significant increase in completed MOST forms for Medicare patients, there was a lack of staff engagement and a gap in minorities receiving the educational handout. Further recommendations have been made to address these findings, including incentivizing staff and expanding the project beyond Medicare recipients. Normalizing and having frequent ACP discussions will benefit patients, families, and healthcare systems.

References

Alzheimer's Association. (2019). 2019 Alzheimer's disease facts and figures. *Alzheimer's and Dementia, 15*(3), 321-387. https://doi.org/10.1016/j.jalz.2019.01.010

Bernard, C., Tan, A., Slaven, M., Elston, D., Heyland, D. K., & Howard, M. (2020). Exploring patient-reported barriers to advance care planning in family practice. *BMC Family Practice, 21*. https://doi.org/10.21203/rs.2.10529/v3

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *The Annals of Family Medicine, 12*(6), 573-576. https://doi.org/10.1370/afm.1713

Bond, W. F., Kim, M., Franciskovich, C. M., Weinberg, J. E., Svendsen, J. D., Fehr, L. S., Funk, A., Sawicki, R., & Asche, C. V. (2018). Advance care planning in an accountable care organization is associated with increased advanced directive documentation and decreased costs. *Journal of Palliative Medicine, 21*(4), 489-502. https://doi.org/10.1089/jpm.2017.0566

Burns, T. (2023, January 9). *Medicare plans in North Carolina*. Affordable Health Insurance. https://www.affordablehealthinsurance.com/medicare-plans/north-carolina/

Caprio, A. J. (2014). Medical orders for scope of treatment (MOST): Honoring Patient Preferences Across the Continuum of Care. *North Carolina Medical Journal, 75*(5), 349-350. https://doi.org/10.18043/ncm.75.5.349

Centers for Medicare and Medicaid Services. (2016, July 14). *Frequently asked questions about billing the physician fee schedule for advance care planning services*. Centers for Medicare & Medicaid Services | CMS. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf

Centers for Medicare and Medicaid Services. (2020, October). *Advance Care Planning*. Centers for Medicare & Medicaid Services | CMS. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf

Centers for Medicare and Medicaid Services. (2021, December 1). *Beneficiary services*. Centers for Medicare & Medicaid Services | CMS. https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Overview

Centers for Medicare and Medicaid Services. (2022, March 28). *CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures*. Centers for Medicare & Medicaid Services | CMS. https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2021-2030-projections-national-health-expenditures

Centers for Medicare & Medicaid Services. (2023, February 17). *NHE fact sheet*. Centers for Medicare & Medicaid Services | CMS. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet

Chen, Y., Criss, S. D., Watson, T. R., Eckel, A., Palazzo, L., Tramontano, A. C., Wang, Y., Mercaldo, N. D., & Kong, C. Y. (2020). Cost and utilization of lung cancer end-of-life care among racial-ethnic minority groups in the United States. *The Oncologist*, *25*(1), e120-e129. https://doi.org/10.1634/theoncologist.2019-0303

CITI Program. (n.d.). *Get to know CITI Program*. https://about.citiprogram.org/

Desai, A., & Schneiderman, H. (2019). Bolstering outpatient advanced care planning and palliative care in oncology: Why and how. *Journal of Oncology Practice, 15*(7), 360-362. https://doi.org/10.1200/jop.19.00108

Garner-Huey, K. (2016). *Advance care planning the abcs of getting paid*. Center to Advance Palliative Care. https://www.capc.org/documents/download/354/

Gonzalez, R., Lyon, L., Rabbani, J., Conell, C., Postlethwaite, D., Spaulding, M., & Mason, M. (2020). The association of Spanish language preference with advance directive completion. *Journal of the American Geriatrics Society*, *69*(1), 122-128. https://doi.org/10.1111/jgs.16809

Grove, S. K., & Gray, J. R. (2019). *Understanding nursing research: Building an evidence-based practice* (7th ed.). Elsevier.

Hafid, A., Howard, M., Guenter, D., Elston, D., Gallagher, E., Winemaker, S., & Waters, H. (2021). Advance care planning conversations in primary care: A quality improvement project using the serious illness care program. *BMC Palliative Care*, *20*. https://doi.org/10.21203/rs.3.rs-402429/v1

Halpert, K. D., Ward, K., & Sloane, P. D. (2021). Improving advance care planning documentation using reminders to patients and physicians: A longitudinal study in primary care. *American Journal of Hospice and Palliative Medicine*, *39*(1), 62-67. https://doi.org/10.1177/10499091211004890

Harwood, P., Prasun, M., Dennis, B., & Mayes, A. (2020). Advanced care planning and palliative care in the heart failure population. *Heart & Lung*, *49*(2), 222-223. https://doi.org/10.1016/j.hrtlng.2020.02.036

Hayashi, T., Matsushima, M., Bito, S., Kanazawa, N., Inoue, N., Luthe, S. K., & Wee, C. C. (2018). Predictors associated with survival among elderly in-patients who receive cardiopulmonary resuscitation in Japan: An observational cohort study. *Journal of General Internal Medicine*, *34*(2), 206-210. https://doi.org/10.1007/s11606-018-4747-5

Health Resources and Services Administration. (2018, May 8). *Federally Qualified Health Centers*. Official website of the U.S. Health Resources & Services Administration. https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html

Howard, M., Bernard, C., Klein, D., Tan, A., Slaven, M., Barwich, D., You, J. J., Asselin, G., Simon, J., & Heyland, D. K. (2016). Barriers and enablers to advance care planning with patients in primary care: A survey of clinicians. *Journal of Pain and Symptom Management, 52*(6), e47. https://doi.org/10.1016/j.jpainsymman.2016.10.053

Huxley, C. J., Eli, K., Hawkes, C. A., Perkins, G. D., George, R., Griffiths, F., & Slowther, A. (2021). General practitioners' experiences of emergency care and treatment planning in England: A focus group study. *BMC Family Practice*, *22*(1). https://doi.org/10.1186/s12875-021-01486-w

Ko, E., Keeney, A. J., Higgins, D., Gonzalez, N., & Palomino, H. (2021). Rural Hispanic/Latino cancer patients' perspectives on facilitators, barriers, and suggestions for advance care planning: A qualitative study. *Palliative and Supportive Care*, 1-7. https://doi.org/10.1017/s1478951521001498

Moran, K., Burson, R., & Conrad, D. (2020). *The Doctor of Nursing Practice Project A Framework for Success* (3rd ed.). Jones & Bartlett Publishers.

Nagarajan, S. V., Lewis, V., Halcomb, E., Rhee, J., Morton, R. L., Mitchell, G. K., Tieman, J., Phillips, J. L., Detering, K., Gavin, J., & Clayton, J. M. (2022). Barriers and facilitators to nurse-led advance care planning and palliative care practice change in primary healthcare: A qualitative study. *Australian Journal of Primary Health, 28*(2), 151-157. https://doi.org/10.1071/py21081

National Committee of Quality Assurance. (2021). *Proposed New Measure for HEDIS MY 2022: Advance Care Planning (ACP)*. Health Care Accreditation, Health Plan Accreditation Organization - NCQA - NCQA. https://www.ncqa.org/wp-content/uploads/2021/02/04.-ACP.pdf

National Council on Aging. (2021, January 1). *Get The Facts on Healthy Aging*. The National Council on Aging. https://www.ncoa.org/article/get-the-facts-on-healthy-aging

NC Division of Health Service Regulation Office of Emergency Medical Services. (2023, May 11). *Do not resuscitate (DNR) & medical orders for scope of treatment (Most) forms*. North Carolina Department of Health and Human Services. https://info.ncdhhs.gov/dhsr/ems/dnrmost.html

North Carolina Department of Health and Human Services. (2014a, June). *Medical Orders for Scope of Treatment (MOST)*. https://info.ncdhhs.gov. https://info.ncdhhs.gov/dhsr/ems/pdf/ncmostform.pdf

North Carolina Department of Health and Human Services. (2014b, June). *Órdenes médicas para el alcance del tratamiento (MOST)*. eforms.com. https://eforms.com/images/2018/03/North-Carolina-MOST-Form-Spanish-Espan%CC%83ol-Version.pdf

Rando-Matos, Y., Vives-Argilagós, T., Rodero-Pérez, E., Solsona-Díaz, L., Ballvé-Moreno, J. L., Moreno-Farrés, N., Sorando-Alastruey, R., Adroer-Martori, R., Sanfeliu-Soto, N., & Almeda-Ortega, J. (2021). Effectiveness of a brief advance directive intervention in primary care: A randomized clinical trial. *Patient Education and Counseling*, *104*(1), 207-212. https://doi.org/10.1016/j.pec.2020.06.018

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: a key to evidence-based decisions. *ACP Journal Club*, *123*(3), A12. https://doi.org/10.7326/acpjc-1995-123-3-a12

Sandoval, M. B., King, J. G., Hart, V., & Repp, A. B. (2019). Increasing advance care planning in primary care practices: A multi-site quality improvement initiative. *Journal of General Internal Medicine*, *34*(6), 809-811. https://doi.org/10.1007/s11606-018-4800-4

Sedini, C., Biotto, M., Crespi Bel'skij, L. M., Moroni Grandini, R. E., & Cesari, M. (2021). Advance care planning and advance directives: An overview of the main critical issues. *Aging Clinical and Experimental Research*, *34*(2), 325-330. https://doi.org/10.1007/s40520-021-02001-y

Tilburgs, B., Vernooij-Dassen, M., Koopmans, R., Van Gennip, H., Engels, Y., & Perry, M. (2018). Barriers and facilitators for GPs in dementia advance care planning: A systematic integrative review. *PLOS ONE*, *13*(6), e0198535. https://doi.org/10.1371/journal.pone.0198535

Trumble, P. (2023). *Nurse practitioner salary in North Carolina - 2023*. Nursingprocess.org - Your Guide to Nursing & Health Care Education. https://www.nursingprocess.org/nurse-practitioner-salary/north-carolina/

United States Census Bureau. (2022, July 1). *U.S. Census Bureau QuickFacts: North Carolina*. Census Bureau QuickFacts. https://www.census.gov/quickfacts/fact/table/NC/PST045222

U.S. Department of Health and Human Services, & Office of Disease Prevention and Health Promotion. (n.d.). *Healthy people 2030 Framework*. https://health.gov/healthypeople/about/healthy-people-2030-framework

U.S. Department of Health and Human Services. (2021, November 8). *Who is eligible for Medicare?* HHS.gov. https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html

Zwakman, M., Jabbarian, L., Van Delden, J., van der Heide, A., Korfage, I., Pollock, K., Rietjens, J., Seymour, J., & Kars, M. (2018). Advance care planning: A systematic review about patients' experiences with a life-threatening or life-limiting illness. *Palliative Medicine, 32*(8), 1305-1321. https://doi.org/10.1177/0269216318784474

Appendix A

Levels of Evidence

Levels of Research Evidence

Levels of Research Evidence	
Level I	Systematic review and meta-analysis
Level II	Randomized controlled trial or Experimental study
Level III	Quasi-experimental study
Level IV	Mixed-methods systematic review and qualitative meta-synthesis
Level V	Descriptive correlational, predictive correlational, and cohort studies
Level VI	Descriptive and qualitative studies
Level VII	Opinions of expert committees and authorities

(Grove & Gray, 2019, p. 24)

Appendix B

Staff Process for Implementation

Staff Process for Implementing Medical Orders for Scope of Treatment (MOST) Forms

1. While preparing for the day, the Certified Medical Assistant (CMA) will identify all scheduled patients who have Medicare and determine if they have a MOST form on file. Documentation for the MOST form is found under the Patients Documents, Advanced Directives tab in the patient chart.

2. If there is not a MOST form on file, the CMA will give the patient a MOST form information handout and a copy of the MOST form in either Spanish or English while rooming the patient for their scheduled visit for them to review.

3. The patient can either discuss the MOST form with the medical provider during the scheduled visit or schedule a visit just to discuss it at another time. This is completely voluntary for the patient.

4. After a MOST form is completed with the patient and medical provider, it will be scanned into the patient's chart, uploaded under the Patient Documents Advance Directives tab, and the original is to be given back to the patient.

5. If the patient has a documented MOST form, it must be reviewed at least annually or earlier if there is a change in patient health status, location, or patient preference.

6. Any reviewed or changed MOST form must be scanned into the chart and uploaded under the Patient Documents, Advance Directives tab and given back to the patient.

Coding information for providers:

- No specific ICD-10 diagnosis code is required for Advance Care Planning (ACP) codes to be billed. It is appropriate to report a condition for which you are counseling the patient or if discussing during a Medicare Annual Wellness Visit.
- ACP discussions can be a stand-alone billable visit.
- Billing is based on time with CPT Code **99497** for the first 16-30 minutes and add **99498** for each additional 30 minutes. These codes are for "Advance care planning, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed)." (Centers for Medicare and Medicaid Services [CMS], 2016).

Appendix C

English Patient Education

Patient and Family MOST Form Information

What is a MOST form?

- Medical Orders for Scope of Treatment (MOST)
- This is a documented medical order for healthcare emergency situations.

Why is a MOST important?

- Allows you to make your own healthcare decisions and wishes to be known before an emergency occurs.

Who should use a MOST?

- Anyone can, but it is especially recommended for those with chronic illnesses or who are seriously ill.

What does a MOST address?

- Your preference for emergency medical interventions including Cardiopulmonary resuscitation (CPR), breathing assistance, hospitalization, antibiotic use, hydration, and nutritional support.

How do I complete a MOST?

- Your medical provider can discuss your medical conditions and review the MOST form with you during your visit, or you can schedule a visit just to discuss it.

What do I do with the MOST?

- Place the MOST in an easily visible area for Emergency Medical Services (EMS).
    - Front of your refrigerator, on your bedroom door, or above your bed.
    - The form must go with you if you go to a hospital or nursing home.

What happens if I change my health care wishes?

- You can cancel or change the form with your medical provider at any time.

Appendix D

Spanish Patient Education

Formulario de Paciente Y Familia información de MOST

Qué es un formulario MOST?

- Ordenes Medicas para el alcance del Tratamiento (MOST)
- Esta es una orden medica documentada para situaciones de emergencia de atención médica.

Por qué es MOST importante?

- Permite tomar sus propias decisiones de salud y desea ser conocido ante una emergencia.

Quién deberías usar MOST?

- Cualquiera puede hacerlo, pero se recomienda para aquellos con enfermedades crónicas o que están gravemente enfermos.

Qué es lo que MOST se dirige?

- Su preferencia por intervenciones medicas de emergencia incluyen reanimación cardiopulmonar (RCP), asistencia respiratoria, hospitalización, uso de antibióticos, hidratación y apoyo nutricional.

Cómo completo MOST?

- Su proveedor medico puede discutir sus condiciones medicas y revisar la mayoría de formas de usted durante su visita, o puede programar una visita solo para discutirlo.

Qué hago con MOST?

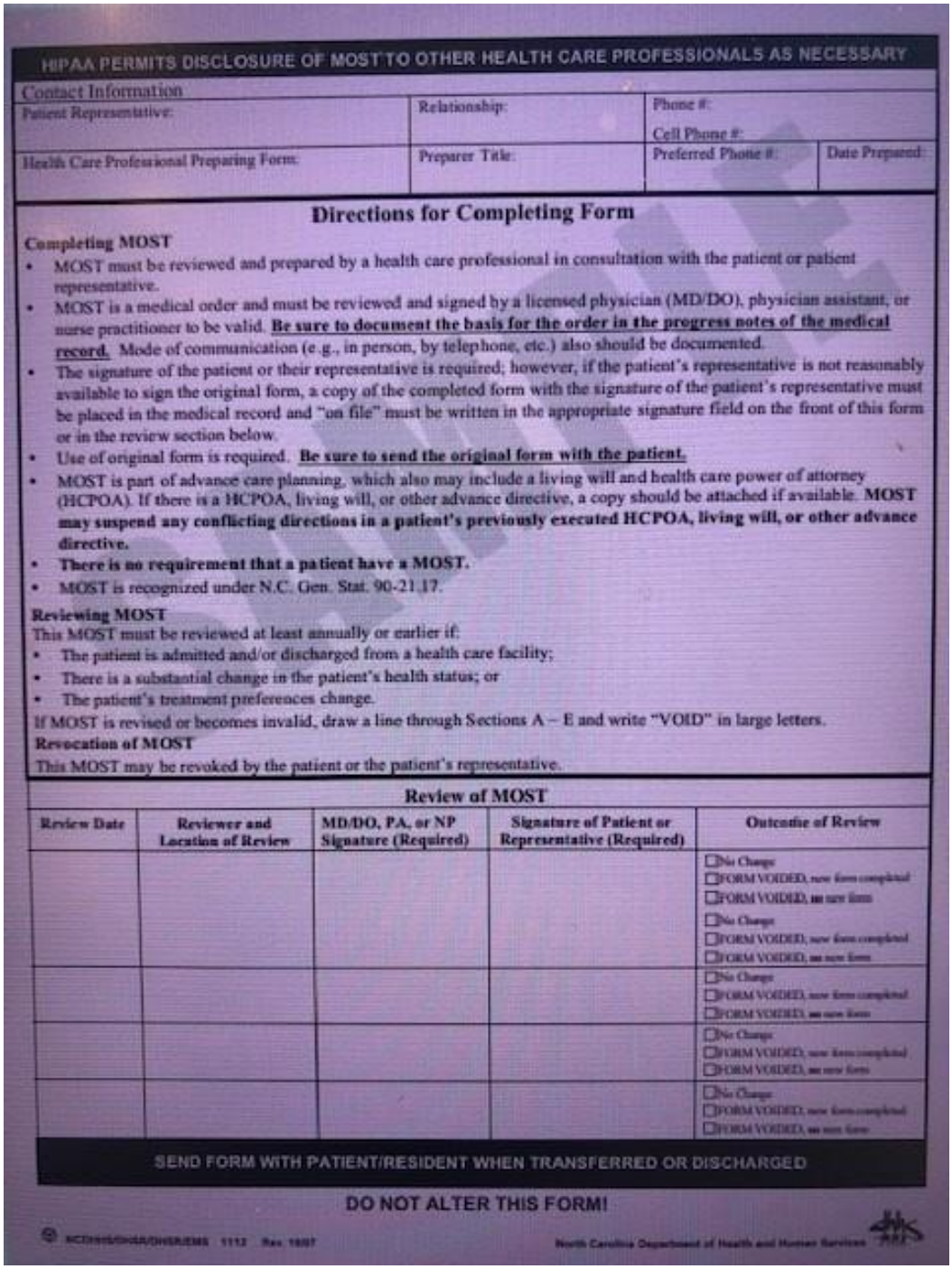
- Coloque la mayoría en una área más fácilmente visible para los servicios médicos de emergencia (EMS).
- Frente de su refrigerador, en la puerta de su evitación o sobre su cabeza.
- El formulario debe de irse con usted si va al hospital o asilo.

Qué sucede si cambio mis deseos de atención medica?

- Puede cancelar o cambiar el formulario en cualquier momento con su proveedor médico.

Appendix E

English MOST Form



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be reviewed and signed by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or their representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N.C. Gen. Stat. 90-21.17.

Reviewing MOST

This MOST must be reviewed at least annually or earlier if:

- The patient is admitted and/or discharged from a health care facility;
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

This MOST may be revoked by the patient or the patient's representative.

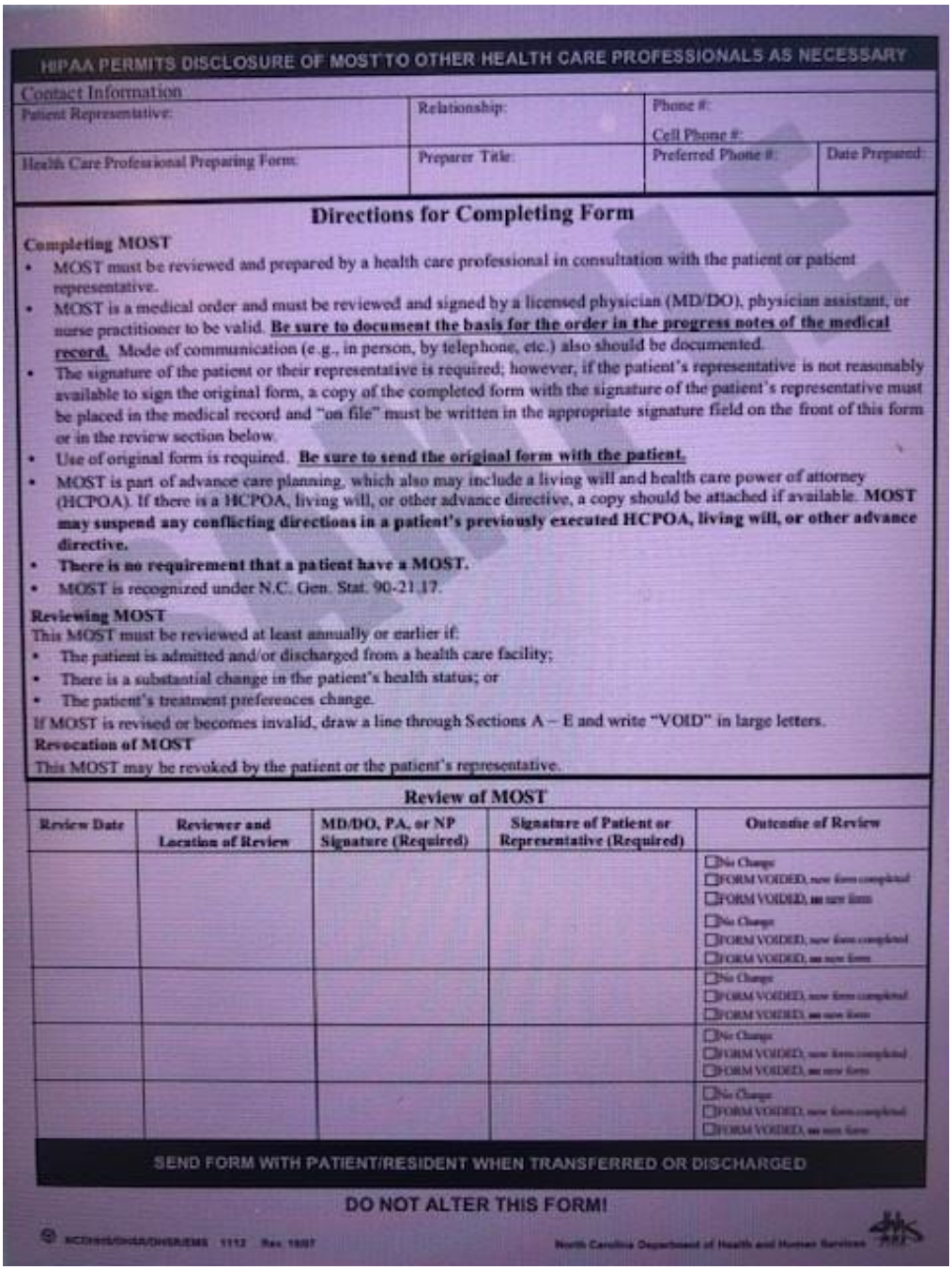
Review of MOST

Review Date	Reviewer and Location of Review	MD/DO, PA, or NP Signature (Required)	Signature of Patient or Representative (Required)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(North Carolina Department of Health and Human Services [NC DHHS], 2014a)



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

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- MOST is a medical order and must be reviewed and signed by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or their representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
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Revocation of MOST

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Review of MOST

Review Date	Reviewer and Location of Review	MD/DO, PA, or NP Signature (Required)	Signature of Patient or Representative (Required)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

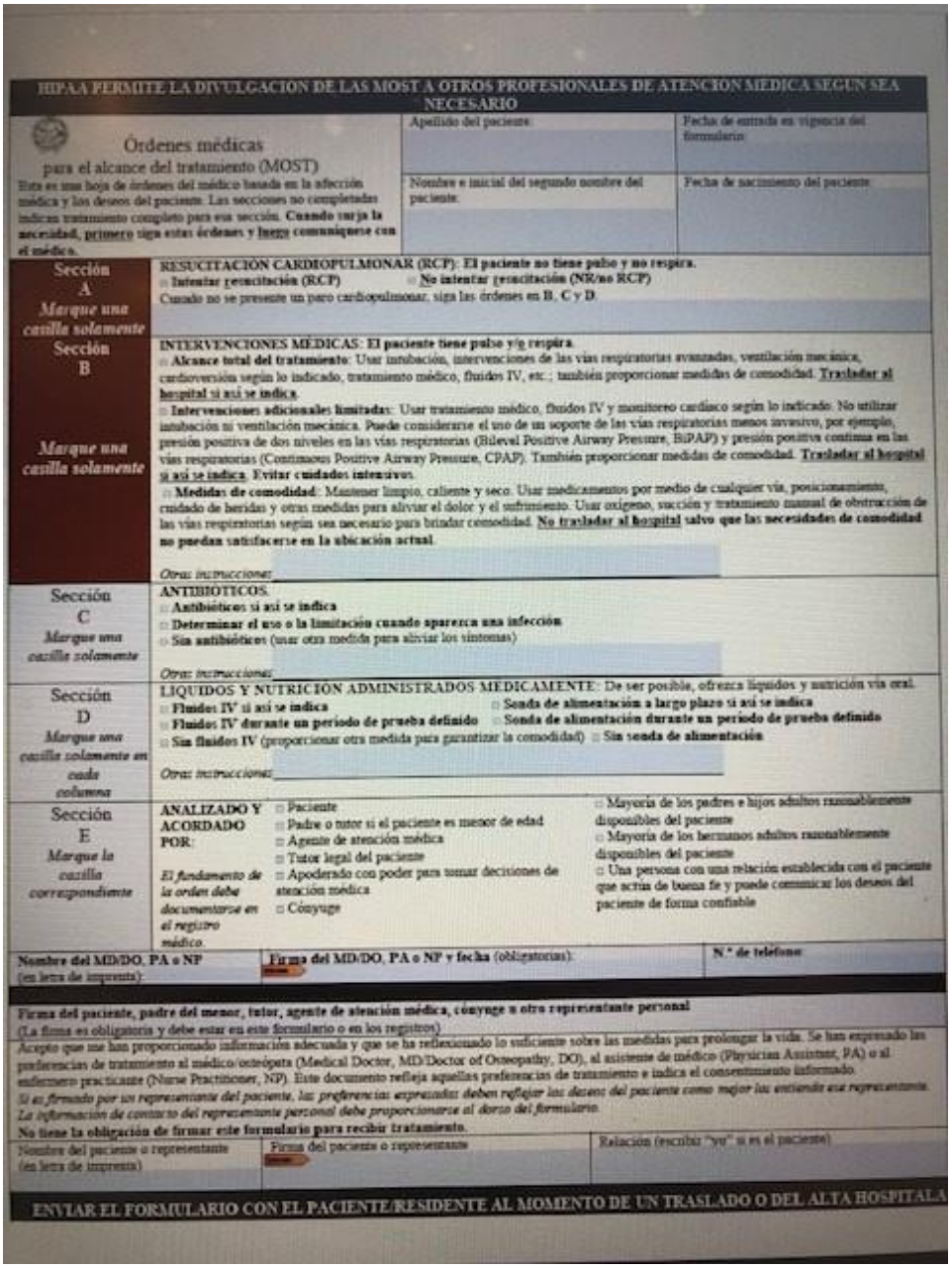
DO NOT ALTER THIS FORM!

© NCDHHS/DHSR/DHSR/EMS 1112 Rev. 10/07 North Carolina Department of Health and Human Services

(NC DHHS, 2014a)

Appendix F

Spanish MOST Form



HIPAA PERMITE LA DIVULGACION DE LAS MOST A OTROS PROFESIONALES DE ATENCION MEDICA SEGUN SEA NECESARIO

Órdenes médicas para el alcance del tratamiento (MOST)

Esta es una hoja de órdenes del médico basada en la afección médica y los deseos del paciente. Las secciones no completadas indican tratamiento completo para esa sección. **Cuando surja la necesidad, primero siga estas órdenes y luego comuníquese con el médico.**

Apellido del paciente: | Fecha de entrada en vigencia del formulario:

Nombre e inicial del segundo nombre del paciente: | Fecha de nacimiento del paciente:

Sección A *Marque una casilla solamente*

RESUCITACIÓN CARDIOPULMONAR (RCP): **El paciente no tiene pulso y no respira.**
- **Intentar reanimación (RCP)**
- **No intentar reanimación (NR/no RCP)**

Cuando no se presente un paro cardiopulmonar, siga las órdenes en B, C y D.

Sección B *Marque una casilla solamente*

INTERVENCIONES MÉDICAS: **El paciente tiene pulso y/o respira.**
- **Alcance total del tratamiento**: Usar intubación, intervenciones de las vías respiratorias avanzadas, ventilación mecánica, cardioversión según lo indicado, tratamiento médico, fluidos IV, etc.; también proporcionar medidas de comodidad. **Trasladar al hospital si así se indica.**
- **Intervenciones adicionales limitadas**: Usar tratamiento médico, fluidos IV y monitoreo cardíaco según lo indicado. No utilizar intubación ni ventilación mecánica. Puede considerarse el uso de un soporte de las vías respiratorias menos invasivo, por ejemplo, presión positiva de dos niveles en las vías respiratorias (Bilevel Positive Airway Pressure, BiPAP) y presión positiva continua en las vías respiratorias (Continuous Positive Airway Pressure, CPAP). También proporcionar medidas de comodidad. **Trasladar al hospital si así se indica. Evitar cuidados intensivos.**
- **Medidas de comodidad**: Mantener limpio, caliente y seco. Usar medicamentos por medio de cualquier vía, posicionamiento, cuidado de heridas y otras medidas para aliviar el dolor y el sufrimiento. Usar oxígeno, succión y tratamiento manual de obstrucción de las vías respiratorias según sea necesario para brindar comodidad. **No trasladar al hospital salvo que las necesidades de comodidad no puedan satisfacerse en la ubicación actual.**

Otras instrucciones:

Sección C *Marque una casilla solamente*

ANTIBIÓTICOS:
- **Antibióticos si así se indica**
- **Determinar el uso o la limitación cuando aparezca una infección**
- **Sin antibióticos** (usar otra medida para aliviar los síntomas)

Otras instrucciones:

Sección D *Marque una casilla solamente en cada columna*

LÍQUIDOS Y NUTRICIÓN ADMINISTRADOS MEDICAMENTE: De ser posible, ofrezca líquidos y nutrición vía oral.
- **Fluidos IV si así se indica**
- **Fluidos IV durante un período de prueba definido**
- **Sin fluidos IV** (proporcionar otra medida para garantizar la comodidad)
- **Sonda de alimentación a largo plazo si así se indica**
- **Sonda de alimentación durante un período de prueba definido**
- **Sin sonda de alimentación**

Otras instrucciones:

Sección E *Marque la casilla correspondiente*

ANALIZADO Y ACORDADO POR:

El fundamento de la orden debe documentarse en el registro médico.

- Paciente
- Padre o tutor si el paciente es menor de edad
- Agente de atención médica
- Tutor legal del paciente
- Apoderado con poder para tomar decisiones de atención médica
- Cónyuge
- Mayoría de los padres e hijos adultos razonablemente disponibles del paciente
- Mayoría de los hermanos adultos razonablemente disponibles del paciente
- Una persona con una relación establecida con el paciente que actúa de buena fe y puede comunicar los deseos del paciente de forma confiable

Nombre del MD/DO, PA o NP (en letra de imprenta): | **Firma del MD/DO, PA o NP y fecha** (obligatorias): | **N.° de teléfono:**

Firma del paciente, padre del menor, tutor, agente de atención médica, cónyuge u otro representante personal
(La firma es obligatoria y debe estar en este formulario o en los registros)

Acepto que me han proporcionado información adecuada y que se ha reflexionado lo suficiente sobre las medidas para prolongar la vida. Se han expresado las preferencias de tratamiento al médico/osteópata (Medical Doctor, MD/Doctor of Osteopathy, DO), al asistente de médico (Physician Assistant, PA) o al enfermero practicante (Nurse Practitioner, NP). Este documento refleja aquellas preferencias de tratamiento e indica el consentimiento informado.
Si es firmado por un representante del paciente, las preferencias expresadas deben reflejar los deseos del paciente como mejor los entienda ese representante.
La información de contacto del representante personal debe proporcionarse al dorso del formulario.
No tiene la obligación de firmar este formulario para recibir tratamiento.

Nombre del paciente o representante (en letra de imprenta) | Firma del paciente o representante | Relación (escriba "yo" si es el paciente)

ENVIAR EL FORMULARIO CON EL PACIENTE/RESIDENTE AL MOMENTO DE UN TRASLADO O DEL ALTA HOSPITALA

(NC DHHS, 2014b)

HIPAA PERMITE LA DIVULGACIÓN DE LAS MOST A OTROS PROFESIONALES DE ATENCIÓN MÉDICA SEGÚN SEA NECESARIO

Información de contacto			
Representante del paciente:	Relación:	N.° de teléfono: N.° de teléfono celular:	
Profesional de atención médica que prepara el formulario:	Cargo de la persona que prepara el formulario:	N.° de teléfono preferido:	Fecha de preparación:

Instrucciones para completar el formulario

Cómo completar las MOST

- Un profesional de atención médica debe revisar y preparar las Órdenes médicas para el alcance del tratamiento (Medical Orders for Scope of Treatment, MOST) conjuntamente con el paciente o el representante del paciente.
- Las MOST son órdenes médicas y, para que tengan validez, deben estar firmadas y fechadas por un médico matriculado (MD/DO), asistente de médico o enfermero practicante. **Asegúrese de documentar el fundamento de la orden en las notas de progreso del registro médico.** El modo de comunicación (p. ej., en persona, por teléfono, etc.) también debe documentarse.
- Se requiere la firma del paciente o de su representante; sin embargo, si el representante del paciente no está razonablemente disponible para firmar el formulario original, debe colocarse una copia del formulario completado con la firma del representante del paciente en el registro médico y debe escribirse "en los registros" en el campo de firma correspondiente en el anverso de este formulario o en la sección de revisión que aparece más abajo. Es obligatorio usar el formulario original. **Asegúrese de enviar el formulario original con el paciente.**
- Las MOST forman parte de la planificación anticipada de la atención médica, la cual también puede incluir un testamento vital y un poder notarial para la atención médica (Healthcare Power of Attorney, HCPOA). Si existe un HCPOA, un testamento vital u otra directiva anticipada, debe adjuntarse una copia si estuviera disponible. **Las MOST podrían suspender las instrucciones en conflicto en un HCPOA, testamento vital u otra directiva anticipada previamente ejecutada del paciente.**
- **No existe un requisito que obligue a un paciente a tener una MOST.**
- Las MOST son reconocidas en los Estatutos Generales de Carolina del Norte 90-21.17.

Revisión de las MOST

Se recomienda revisar el formulario de las MOST en los siguientes casos:

- El paciente es admitido en un centro médico o es dado de alta de allí.
- Hay un cambio importante en el estado de salud del paciente.

Las MOST deben revisarse si

- Las preferencias de tratamiento del paciente cambian.

Si las MOST se revisan o pierden validez, trace una línea a través de las Secciones A a E y escriba "NULO" en letras grandes.

Revocación de las MOST

Un paciente con capacidad o el representante del paciente (si el paciente carece de capacidad) pueden revocar las MOST en cualquier momento y solicitar un tratamiento alternativo según las preferencias conocidas del paciente o, si estas se desconocen, para beneficio del paciente.

Revisión de las MOST

Fecha de la revisión	Revisor y lugar de la revisión	Firma del MD/DO, PA o NP (obligatorio)	Firma del paciente o representante (preferido)	Resultado de la revisión
				□ Sin cambio □ FORMULARIO NULO, nuevo formulario completado □ FORMULARIO NULO, **no hay formulario nuevo**
				□ Sin cambio □ FORMULARIO NULO, nuevo formulario completado □ FORMULARIO NULO, **no hay formulario nuevo**
				□ Sin cambio □ FORMULARIO NULO, nuevo formulario completado □ FORMULARIO NULO, **no hay formulario nuevo**
				□ Sin cambio □ FORMULARIO NULO, nuevo formulario completado □ FORMULARIO NULO, **no hay formulario nuevo**
				□ Sin cambio □ FORMULARIO NULO, nuevo formulario completado □ FORMULARIO NULO, **no hay formulario nuevo**

ENVIAR EL FORMULARIO CON EL PACIENTE/RESIDENTE AL MOMENTO DE UN TRASLADO O DEL ALTA HOSPITALARIA

¡NO ALTERAR ESTE FORMULARIO!

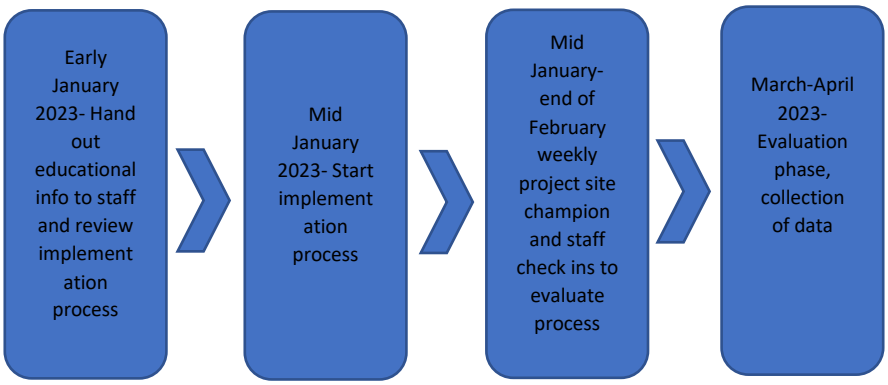
NCDHHS/DHSR/OEMS 113

(NC DHHS, 2014b)

Appendix G

Project Timeline Progression

Timeline for Project Implementation



Appendix H

Itemized Budget

Itemized Budget Table

Item	Quantity	Unit Cost	Total
Project Supplies			
Case of white copy paper	2	$50	$100
Print cartridge for copier	2	$50	$100
North Carolina MOST forms in English	250	$0.04	$10
North Carolina MOST forms in Spanish	250	$0.04	$10
TOTAL			$220

Appendix I

Literature Review Spread Sheet

DNP Project
Literature Search Log

Student: Shelby McGee | **Date of Submission: 7/14/2022**

Increasing Advance Care Planning in Primary Care through Implementation of Medical Orders for Scope of Treatment in Medicare Patients in a Federally Qualified Healthcare

Date of Search	Database	Key Word Searches	Limits	# of Citations Found / Kept	Rationale for Inclusion / Exclusion (include rationale for excluding articles as well as for inclusion)
7/5/2022	ECU Laupus library, Google	Advance care planning, barriers, and facilitators in primary care.	One article was from year 2016, over 5 years. Some had small sample sizes, unable to generalize to entire population	7 Citations found/7 kept	Included articles were relevant to clinical question.
7/6/2022	ECU Laupus library, Google	FQHC, Advance care planning, Medicare statistics, Healthy People 2030, HRSA	No data found on medicare statistics for FQHC's. Some websites did not list published date.	11 Citations found/8 kept	Inclusion- relevant to clinical topic. Exclusion- did not have needed information on statistics for FQHC's.
7/8/2022	ECU Laupus library, Google	Alzheimer's disease statistics, Triple and Quadruple aim	Older than 5 years, from eyear 2014 but still relevant information about triple and quadruple aim.	2 Citations found/2 kept	Inclusion- All information relevant to topic.
7/10/2022	ECU Laupus library, Google	North Carolina MOST forms, CMS, CMS billing for Advance care planning	One date was older, from 2014, but	3 Citations found/3 kept, however, 1 of these is a duplicate from 7/6 (so really only 2 kept since the 1 was kept 7/6)	Inclusion- All information relevant to topic.
9/12/2022	CINAHL, PubMed	Advanced Care Planning, Advanced Directives, end of life planning, federally qualified haltcare center, primary care, medicare	5 year period, relevant to topic, primary care	CINAHL- 38 found, PubMed 60 found	Plan to return back to CINAHL and PubMed to fully review again.CINAHL kept 3, others irrelevant to topic.
9/19/2022	Google	Advance care planning for all ages.	5 years period, relevant to topic.	multiple pulled up but ke	Literature to support statement in paper, citation for reference for paper.
9/19/2022	CINAHL	"Implement") AND ("Advanced care planning" OR "Medicals Order for scope of treatment")	5 year period, relevant to topic, primary care	6 found, then 3 within last 5 years. None were kept.	Did not keep any, irrelevant to topic; focus was geriatric trauma patients, or nursing students.
9/19/2022	CINAHL	("Implement") AND ("Advanced care planning" OR "Medicals Order for scope of treatment") AND ("Primary Care")	5 year period, relevant to topic, primary care	2 were found, none were kept.	serious illness conversations, but not specific to ACP.
9/19/2022	PubMed	("advanced care planning" OR "advanced directive" OR "end of life planning") AND ("federally qualified healthcare center" OR "primary care" OR Medicare)	5 year period, relevant to topic, primary care	96 found, filtered time frame to five years and 60 were found. Kept 4 articles.	Relevant to topic.
21-Sep	Google	implementation ACP primary care scholarly article to search other areas than CINAHLD and PubMed.	5 year period, relevant to topic, primary care	3 found, 1 kept	Relevant to topic implementation.

Appendix J

Driver Diagram

Appendix K

Project Implementation Worksheet

FORM 8274.11

Project Management Strategy

Student's Name: Shelby McGee

Project Site Champion: [redacted]

Project Name: Increasing Advance Care Planning in Primary Care

---

What data will you be collecting? The number of active Medicare beneficiaries that have a documented MOST form in their electronic medical record.

Where will you get the data? I will audit the active Medicare beneficiary's electronic medical records.

How often will you be at the project site? I will be at the project site at least once a week during the entire project.

How often will you meet with your site champion? I will informally meet with the project site champion once a week, along with other staff for check-ins.

What is the implementation methodology, theory, framework, etc. that you are using to guide you through the implementation phase of the project?

This project will use the operational framework PICO, which stands for Population, Intervention, Comparison, and Outcomes.

What tools will you use to track implementation and data (SBAR, PDSA, Excel tracking form, etc)?

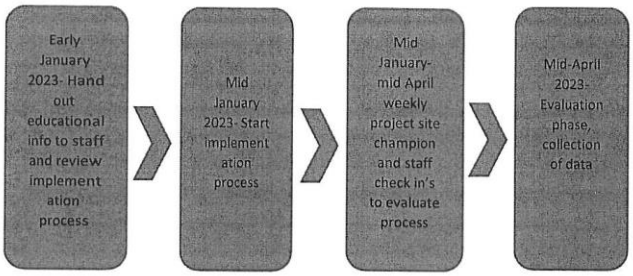
I will use an Excel project tracking form to track implantation and data. I chose this method as it allows for tracking performance metrics and data to provide reports for stakeholder review. It is important to be able to track data as the project is implemented. I will communicate project status or changes during weekly project site champion and staff check in's, and with faculty during scheduled faculty meetings and as needed.

Date Implementation began or will begin: January 16, 2023

Date for meeting with site champion to discuss your chosen tools and timeline: November 15, 2022

I will meet with the project site champion weekly face-to-face during implementation, and as needed.

Timeline for Project Implementation



I have met with and discussed my tools and implementation plan with my site champion. We are in agreement with the tools, processes, and timeline.

Student Signature: [redacted] Date 11/15/2022

Site: [redacted]

Site Champion Signature: [redacted] Date 11/15/22

Appendix L

Project Management Report 1

FORM 8274.12

Project Management Report

Name Shelby McGee

Were you able to collect the data you thought you'd collect? **Yes** No

If no, why not? I was able to collect the data, but I am concerned that the total number of active Medicare patients was inaccurate. I have been auditing charts during the implementation phase and am tracking the number of Medicare patients seen during the implementation phase.

Did you meet with your site champion on the date(s) you had planned to meet? **Yes** No

If not, why not? _____

Succinctly identify & discuss barriers to your implementation.

The project site has been closed due to the new company orientation.

Staff is stressed over the upcoming official transition to the new company at the project site.

Due to stress, staff has been forgetful about the implementation of the project.

During the implementation, the project site will be closed further for more training and decreased volume of patient visits in March, which is half of the implementation phase.

One provider sees mainly new patients, and that provider-patient relationship has not been established, and the education packets have not always been given to their Medicare patients.

Did you update/revise your tools (PDSA, data collection tools, etc.)? **Yes** No

If No, why not? I have continued my collection tool of an excel spreadsheet with the data and staff feedback, but I have spoken with staff about the barriers to implementation.

What date(s) were you at your project site during this implementation interval (face-to-face or virtually)? January 9th, 10th, 17th, 23rd, 25th, 26th, 30th, 31st; February 1st, 2nd, 3rd, 6th, 7th, 8th, 9th, 13th, 14th, 15th, 16th.

Succinctly identify 1-3 things you've learned during this implementation interval.

1. Stress and overwhelmed feelings can lead to forgetfulness, which is understandable. I know patient care is the staff's priority, and they are focusing on their already busy tasks. I have encouraged staff about the upcoming transition and reminded them of the importance of Advance Care Planning.

Statement of Collaboration

We have collaborated on the project process, needed revisions, and implementation strategies and agree that this project is on target with the timeline. As needed, provide additional comments on the following page.

Student Signature [redacted] Date 2/16/23

Site Champion Signature [redacted] Date 2/14/23

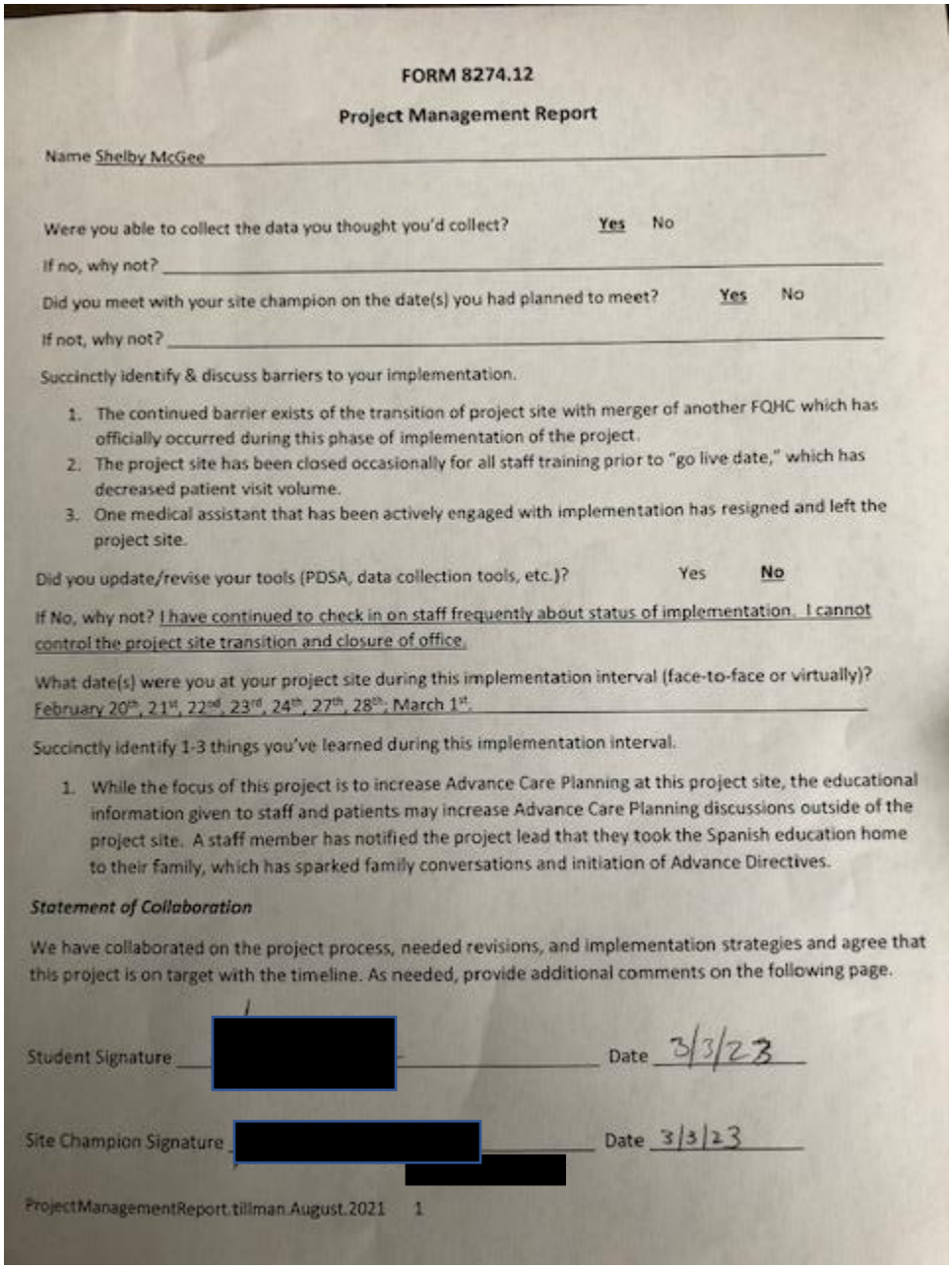
Comments

Please share addition thoughts/notes on progress, barriers, concerns, etc.

My thoughts are –

Appendix M

Project Management Report 2



FORM 8274.12

Project Management Report

Name Shelby McGee

Were you able to collect the data you thought you'd collect? **Yes** No

If no, why not? _____

Did you meet with your site champion on the date(s) you had planned to meet? **Yes** No

If not, why not? _____

Succinctly identify & discuss barriers to your implementation.

1. The continued barrier exists of the transition of project site with merger of another FQHC which has officially occurred during this phase of implementation of the project.
2. The project site has been closed occasionally for all staff training prior to "go live date," which has decreased patient visit volume.
3. One medical assistant that has been actively engaged with implementation has resigned and left the project site.

Did you update/revise your tools (PDSA, data collection tools, etc.)? Yes **No**

If No, why not? I have continued to check in on staff frequently about status of implementation. I cannot control the project site transition and closure of office.

What date(s) were you at your project site during this implementation interval (face-to-face or virtually)? February 20th, 21st, 22nd, 23rd, 24th, 27th, 28th; March 1st.

Succinctly identify 1-3 things you've learned during this implementation interval.

1. While the focus of this project is to increase Advance Care Planning at this project site, the educational information given to staff and patients may increase Advance Care Planning discussions outside of the project site. A staff member has notified the project lead that they took the Spanish education home to their family, which has sparked family conversations and initiation of Advance Directives.

Statement of Collaboration

We have collaborated on the project process, needed revisions, and implementation strategies and agree that this project is on target with the timeline. As needed, provide additional comments on the following page.

Student Signature [redacted] Date 3/3/23

Site Champion Signature [redacted] Date 3/3/23

ProjectManagementReport.tillman.August.2021 1

Appendix N

Doctor of Nursing Practice Essentials

Doctor of Nursing Practice Essentials Table

AANC DNP Essentials		
Essentials	**Description of Competency**	**Demonstration of Competency**
Essential I *Scientific Underpinning for Practice*	**Competency**-Analyzes and uses information to develop practice **Competency**-Integrates knowledge from humanities and science into context of nursing **Competency**-Translates research to improve practice **Competency**-Integrates research, theory, and practice to develop new approaches toward improved practice and outcomes	• Literature review conducted to assess the best practice intervention for increasing Advance Care Planning (ACP) in the primary care setting for use during the development of the quality improvement project • Types of ACP analyzed to determine medical documentation form to use during implementation
Essential II *Organizational & Systems Leadership for Quality Improvement & Systems Thinking*	**Competency**-Develops and evaluates practice based on science and integrates policy and humanities **Competency**-Assumes and ensures accountability for quality care and patient safety **Competency**-Demonstrates critical and reflective thinking **Competency**-Advocates for improved quality, access, and cost of healthcare; monitors costs and budgets **Competency**-Develops and implements innovations incorporating principles of change **Competency**-Effectively communicates practice knowledge in writing and orally to improve quality **Competency**-Develops and evaluates strategies to manage ethical dilemmas in patient care and within health care delivery systems	• Developed new staff process for identifying Medicare patients in need of ACP • Orally reviewed the written new process with staff • Developed written educational handout for patients that staff would give to those Medicare patients without a Medical Orders for Scope of Treatment (MOST) in their electronic medical record (EMR) • Incorporated Spanish language in educational handouts

		• Data was collected specifically without patient identifiers
Essential III *Clinical Scholarship & Analytical Methods for Evidence-Based Practice*	**Competency-**Critically analyzes literature to determine best practices **Competency-**Implements evaluation processes to measure process and patient outcomes **Competency-**Designs and implements quality improvement strategies to promote safety, efficiency, and equitable quality of care for patients **Competency**-Applies knowledge to develop practice guidelines **Competency-**Uses informatics to identify, analyze, and predict best practice and patient outcomes **Competency-**Collaborate in research and disseminate	• Critically reviewed and analyzed literature during a literature review to determine the best practice intervention for increasing ACP in the primary care setting for use during the development of the quality improvement project • Designed and developed new staff process to increase ACP in Medicare population for quality improvement • Data mined Medicare patient charts at project site to analyze status of ACP in EMR • Incorporated Spanish language into educational handouts for patients based on large Hispanic patient population of project site for equitable care • Project disseminated through presentations and online through university's "ScholarShip" database
Essential IV *Information Systems-Technology & Patient Care Technology for the Improvement & Transformation of Health Care*	**Competency-**Design/select and utilize software to analyze practice and consumer information systems that can improve the delivery & quality of care **Competency-**Analyze and operationalize patient care technologies **Competency-**Evaluate technology regarding ethics, efficiency and accuracy	• Patient EMRs utilized through computer to data mine and analyze patient ethnicity demographics and ACP data • Patient identifiers were not collected • Staff and patient educational handouts

	Competency-Evaluates systems of care using health information technologies	were designed utilizing Microsoft Office • Completed ACP data was saved through Microsoft excel to analyze
Essential V *Health Care Policy of Advocacy in Health Care*	**Competency**-Analyzes health policy from the perspective of patients, nursing and other stakeholders **Competency**-Provides leadership in developing and implementing health policy **Competency**-Influences policymakers, formally and informally, in local and global settings **Competency**-Educates stakeholders regarding policy **Competency**-Advocates for nursing within the policy arena **Competency**-Participates in policy agendas that assist with finance, regulation and health care delivery **Competency**-Advocates for equitable and ethical health care	• Recommendations made for further sustainability or scalability that includes improving equitable care by increasing ACP for minorities • Recommendations for policy change to include ACP as a quality metric for incentivization and increase in ACP while decreasing health care costs
Essential VI *Interprofessional Collaboration for Improving Patient & Population Health Outcomes*	**Competency**-Uses effective collaboration and communication to develop and implement practice, policy, standards of care, and scholarship **Competency**-Provide leadership to interprofessional care teams **Competency**-Consult intraprofessionally and interprofessionally to develop systems of care in complex settings	• Collaborated and communicated interprofessionally and intraprofessionally with project site leadership, staff, project site champion, and DNP faculty prior to, during, and after implementation of project • Project lead on site at least once a week to provide support and answer any questions if needed • Consulted with DNP faculty as needed throughout project
Essential VII *Clinical Prevention & Population Health for*	**Competency**-Integrates epidemiology, biostatistics, and data to facilitate individual and population health care delivery	• Quality improvement project developed based on gap in care of ACP in Medicare patients at project site

Improving the Nation's Health	**Competency-**Synthesizes information & cultural competency to develop & use health promotion/disease prevention strategies to address gaps in care **Competency-**Evaluates and implements change strategies of models of health care delivery to improve quality and address diversity	• Medicare patient data collected and synthesized for diverse and culturally competent educational handout in English and Spanish based on Hispanic population at project site
Essential VIII *Advanced Nursing Practice*	**Competency-**Melds diversity & cultural sensitivity to conduct systematic assessment of health parameters in varied settings **Competency-**Design, implement & evaluate nursing interventions to promote quality **Competency-**Develop & maintain patient relationships **Competency-**Demonstrate advanced clinical judgement and systematic thoughts to improve patient outcomes **Competency-**Mentor and support fellow nurses **Competency-**Provide support for individuals and systems experiencing change and transitions **Competency-**Use systems analysis to evaluate practice efficiency, care delivery, fiscal responsibility, ethical responsibility, and quality outcomes measures	• Project lead on site at least once a week to provide support to staff throughout implementation • Critical thinking and advanced clinical judgement demonstrated though literature review and development of quality improvement project to increase ACP in Medicare population

Appendix O

DNP Project Poster

ECU COLLEGE OF NURSING

Increasing Advance Care Planning in Primary Care

Shelby McGee, MSN, DNP Student, RN, AGNP-C
mcgees03@students.ecu.edu

Problem

- North Carolina 2023 expected Medicare expenditure of $21 billion
- Documented Advance Care Planning (ACP) has been shown to lower the cost of annual care
- ACP allows patient healthcare and end-of-life wishes to be known and followed
- No ACP leads to unnecessary financial and emotional burdens for patients, families, and healthcare systems

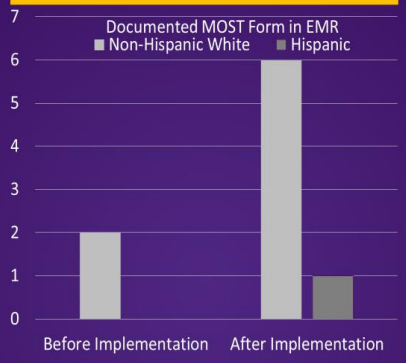
Purpose

- Increase ACP in the primary care setting by implementing a new staff process at a Federally Qualified Healthcare Center in rural NC

Methodology

- Certified Medical Assistant (CMA) identified Medicare patients without Medical Orders for Scope of Treatment (MOST) forms in their electronic medical record (EMR)
- Those without MOST in EMR were given a handout about MOST in English or Spanish language
- Occurred during rooming of the patient during a scheduled visit with their provider
- Could be discussed during the visit if the patient desired
- Completed MOST forms uploaded into EMR

Data Outcomes



Findings

- *Before implementation:*
  - <1% of Medicare patients with MOST in EMR
  - 2 Non-Hispanic White
- 70 were seen during the implementation
- 21 received educational handout
- 7 completed MOST form
- *After implementation:*
  - 10% of Medicare patients seen during implementation completed MOST
- No African American or other ethnicities were provided educational handout nor completed ACP

Barriers

- Project site merger shortened implementation time frame
- Decreased patient volume during implementation
- High staff stress
- Low staff engagement
- Inability to adjust EMR

Implications to Care

- *Patients:*
  - Patient autonomy while increasing ACP
  - Racial and ethnic minorities need further focus on increasing ACP
- *Staff:*
  - Engagement needed
  - Normalize end-of-life discussion
  - Streamline the electronic process
- *Organization:*
  - Cost-effective, positive revenue cycle
  - Potential future healthcare system reduced expenditures

Recommendations

- Avoid implementation during an organizational change or transition
- Incentivize staff
- Create EMR alert for patients in need of ACP
- Educational handout to all adult patients
- Schedule a designated ACP visit with a provider