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Increasing Advance Care Planning in the Primary Care Setting

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INCREASING ADVANCE CARE PLANNING IN THE PRIMARY CARE SETTING

A Scholarly Project

Submitted to the

Faculty of Liberty University

In partial fulfillment of

The requirements for the degree

Of Doctor of Nursing Practice

Nicole Marie Coffey

Liberty University

Lynchburg, VA

August, 2018

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Scholarly Project Chair Approval:

Sharon Kopis, Ed.D, MS, RN, FNP-C, CNE, Chair, Doctoral Studies, Professor Nursing

ABSTRACT

Evidence shows the many benefits of advance care planning (ACP) discussions, including; giving patients peace of mind, decreasing healthcare costs, increasing quality of care, and decreasing distress at the end of life. Due to the many proven benefits of ACP, the United States Department of Health and Human Services as well as many leading national health organizations are promoting ACP, even tying it to reimbursement. The best setting and time to initiate ACP is in the primary care setting as early as possible, before patients have any cognitive decline. In this context, patients have an established relationship with their provider, and the discussion can be ongoing and involve family members. However, despite the national push and abundant evidence showing the importance of ACP, the rate of ACP discussions and advance directive completion in primary care remains low. This evidence-based practice pilot project is guided by the Iowa Model of Evidence-Based Practice to Promote Quality Care-Revised (Iowa Model Collaborative, 2017). Incorporating the concepts of the Transtheoretical Model of Health Behavior Change (Prochaska & Velicer, 1997), the project sought to increase ACP discussions and the rate of completion of advance directives in a primary care office through educating clinicians. The pilot project was successful in increasing ACP documentation, with a pre-intervention prevalence of ACP conversations of 0% and a post-intervention prevalence of ACP conversations of 23.33%, which is consistent with the current evidence in the literature.

Keywords: Advance care planning, advance directive, primary care, education

INCREASING ADVANCE CARE PLANNING IN THE PRIMARY CARE SETTING

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Table of Contents

Acknowledgements	5
List of Tables.....	9
List of Figures.....	10
List of Abbreviations.....	11
SECTION ONE: INTRODUCTION	12
Background.....	13
Result of a lack of communication of patient wishes.	13
Rising healthcare costs.....	14
The role of advance care planning.	15
Current practice of advance care planning in primary care.	16
Significance of increasing advance care planning discussions.	17
Problem Statement.....	18
Purpose of the Project	18
Clinical Question.....	18
SECTION TWO: LITERATURE REVIEW.....	19
Search Strategy	19
Synthesis and Critical Appraisal of the Literature.....	19
Ideal setting and key components of advance care planning.	20
Impact of advance care planning.	22
Facilitators of advance care planning.	23
Barriers to initiating advance care planning.	24

The role of the proposed project derived from the literature.	27
Conceptual Framework/Model	28
Theoretical Framework.....	30
Summary	30
SECTION THREE: METHODOLOGY	31
Design	31
Measurable Outcomes	32
Outcome 1.	32
Outcome 2.	32
Setting.....	32
Population/Ethical Considerations.....	33
Tools	36
Intervention and Data Collection	38
Timeline.	39
Feasibility analysis.....	40
Data Analysis	41
SECTION FOUR: RESULTS.....	42
Outcome 1: Descriptive Statistics	43
Outcome 2: Descriptive Statistics	43
SECTION FIVE: DISCUSSION	43
Outcome 1: Discussion	44
Outcome 2: Discussion	44
Implications for Practice.....	45

Limitations..... 47

Sustainability48

Dissemination Plan49

References..... 51

Appendix A 57

Appendix B 66

Appendix C 71

Appendix D..... 72

Appendix E 73

Appendix F 76

List of Tables

Table 1 Number of Charts Reviewed Pre-Intervention and Post-Intervention with ACP Documentation.....	42
Table 2 Number of Charts Reviewed Pre-Intervention and Post-Intervention with an Advance Directive.....	43

List of Figures

Figure 1. Number of Patients Included in Chart Review by Type of Visit 35

Figure 2. Number of Patients Included in Chart Review by Age Range 35

Figure 3. Number of Patients Included in Chart Review by Gender 36

Figure 4. Number of Patients Included in Chart Review by Race/Ethnicity 36

List of Abbreviations

Advance Care Planning (ACP)

American Association of Colleges of Nursing (AACN)

Centers for Medicare & Medicaid Services (CMS)

Center to Advance Palliative Care (CAPC)

Doctorate of Nursing Practice (DNP)

Institute of Medicine (IOM)

Intensive Care Unit (ICU)

SECTION ONE: INTRODUCTION

Unprepared families making rapid, life-altering decisions for their loved one's end-of-life care in the hospital setting find it emotionally and mentally taxing. This situation frequently leads to unmet patient wishes, poor quality end-of life care, moral distress for families, and expensive and often traumatizing life-prolonging treatments. The literature overwhelmingly supports providers beginning advance care planning (ACP) discussions with patients in the primary care setting, especially as primary care providers usually have a more established and trusting relationship with their patients than acute care providers. Evidence shows that beginning these discussions early and having them often facilitates fulfilling patient wishes for treatment and leads to increased quality at the end of life, as well as reduced family tensions. Furthermore, in recent years with an aging population and rising healthcare costs, especially related to life-prolonging measures during patients' final days, there has been a national push for providers to initiate ACP in the primary care setting. The 2015 Institute of Medicine (IOM) report "Dying in America" provided a dismal outlook of end-of-life care in the United States, and provided strong recommendations for increasing ACP conversations in primary care. Despite the current supporting evidence and national emphasis, many primary care offices have low rates of ACP discussions with patients, and the overall rate of patients that have completed advance directives remains low (Centers for Disease Control and Prevention, 2017). This scholarly project implemented the current evidence-based recommendations for ACP by educating providers at one primary care office, seeking to increase ACP discussions with patients, with the ultimate purpose of improving patients' quality of care at the end of life and reducing overall healthcare costs for the organization.

Background

The organizational, knowledge-focused trigger for the scholarly project is: despite current evidence showing the importance of ACP discussions, the number of conversations that occur in primary care remains low. The project leader's interest in the topic of ACP began while working as a bedside nurse in an adult intensive care unit (ICU). Frequently, patients were admitted to the ICU being treated for complications and/or the progression of a chronic health condition that had been diagnosed many years prior. Many patients are admitted to and die in the ICU as a result of these chronic conditions that they suffer from for many years, with one in five deaths in America occurring in an ICU (Cook & Rocker, 2014). When the complications are severe enough, patients may be incapacitated before admission, or sometimes they lose the ability to communicate while hospitalized, leaving their family or surrogate decision maker to be their voice. The majority of healthcare providers view these deaths as the culmination of the chronic condition, and therefore anticipated. However, family members view the death of their loved one as unforeseen, and therefore, it comes as a surprise.

Result of a lack of communication of patient wishes. Many families and/or surrogates struggle making difficult care decisions for their incapacitated family members in the ICU (Cook & Rocker, 2014). Many admit they had never spoken with the patient about their desires for care, including their wishes for end-of-life interventions, before the patient's health decline (Cook & Rocker, 2014; IOM, 2015). This leads to tension and conflict among family members who disagree about decisions and can lead to unnecessarily prolonged ICU care for patients with a poor prognosis for recovery that is actually inconsistent with their wishes (Cook & Rocker, 2014). As an ICU nurse, it is morally distressing for the project leader to care for patients in these situations, leading to exploration of the current evidence related to the topic of ACP. According

to Nguyen, Chamber-Evans, Joubert, Drouin, and Ouellet (2013), avoiding the topic of death in the outpatient setting with primary care providers leads to more stress and ethical dilemmas at the end of life, and a poorer death experience.

Rising healthcare costs. Though much less significant than adhering to patient wishes, an important impetus for exploring ACP in the primary care setting stems from rising healthcare costs associated with intensive end-of-life care. One of the roles of the doctorate of nursing practice (DNP) is to help to address issues related to healthcare costs in order to provide and promote care that is efficient and sustainable (Zaccagnini & White, 2017). According to the IOM's 2015 report, the cost of healthcare is rising at a much faster rate than inflation and economic growth combined. Therefore, the IOM (2015) recommends increasing ACP to align care with patient wishes as a method of stabilizing healthcare costs. Riley and Lubitz (2010) describe how a quarter of Medicare spending goes towards treating patients near the end of their lives, with 78% spent on life-prolonging treatments in patients' final thirty days of living (Yu, 2008). The study by Zhang et al. (2009) showed that patients diagnosed with advanced cancer who had ACP discussions with their primary care physicians had a 35.7% lower cost of care in the last week of life compared with those who had not discussed end-of-life wishes. In another study, patients who had ACP discussions before hospitalization had lengthened survival and improved quality of life (Gesme & Wiseman, 2011). Patients with a higher cost of medical care during the final week of life also had a worse quality of death (Zhang et al., 2009).

Financial reimbursement for ACP discussions. Addressing the national concern of continually rising healthcare costs, seeing the value of ACP discussions in primary care, and in alignment with the recommendations of the IOM (2015) report, beginning January 1, 2016 Centers for Medicare and Medicaid Services [CMS] now reimburses providers for ACP

discussions (CMS, 2016). According to CMS (2016), voluntary ACP can be billed as many times a year as necessary by physicians and non-physician practitioners, with few exceptions.

Furthermore, if the service is provided during the same visit as the Medicare Annual Wellness Visit, the co-payment and deductible are waived (CMS, 2016). This financial reimbursement for Medicare patients is an additional incentive for primary care providers to initiate ACP discussions early.

The role of advance care planning. The majority of Americans state they wish to die at home with loved ones present, yet two-thirds die in institutions, with many treated in isolated intensive care for extended periods of time, experiencing pain, and leaving families financially and emotionally devastated (Tyler, Perry, Lofton, & Millard, 1997). The Institute of Medicine's 2014 report brief "Dying in America" states that, "Many people nearing the end of life may not be physically or mentally capable of making their own care decisions. In addition, family members and clinicians may not be able to accurately guess what a person's care preferences may be. Therefore, ACP is critically important to ensure that patients' goals and needs are met" (p. 2). CMS (2016) defines ACP as a discussion about the type of care a patient would want to receive if they are unable to speak for themselves. This may include explaining and discussing advance directives. Rather than a single conversation, ACP involves many discussions, including; identifying a surrogate decision-maker in the event patients become unable to make their own decisions, exploring patients' values and beliefs related to medical care, and completing legal documents such as advance directives (Lum, Sudore, & Bekelman, 2015). According to the IOM report (2015), ACP discussions should be patient-focused, involving family when possible, beginning at any age, and should include frequent discussions with the primary care provider over the lifespan of the patient.

Ideal setting for advance care planning. As previously noted, the emotional stress of the acute care environment is not conducive for patients and their families to make life-altering decisions related to their wishes for care. The ideal setting for ACP is within primary care, where the patient is already familiar with the setting and has an established relationship with his or her provider (De Vleminck, Houttekier, Deliens, Vander Stichele, & Pardon, 2016). In the primary care setting patients are able to more openly ask their questions and express their concerns, and the conversation can be addressed over a period of time to allow the patient to process information rather than making a rash decision (De Vleminck et al., 2016).

Current practice of advance care planning in primary care. While the literature shows the importance of ACP, overall rates in the primary care setting remain low. According to Kataoka-Yahiro, Conde, Wong, Page, and Peller (2010), over 90% of participants with stage four and five chronic kidney disease indicated that talking about death and writing a will was important to them, and 60% stated they did not want medical interventions to keep them alive if they knew they were in the dying process. While the majority expressed the importance of ACP, less than half of participants had completed an advance directive, a living will, or designated a medical power of attorney (Kataoka-Yahiro et al., 2010). According to The Conversation Project (2013), a national survey of a sample of American adults, 90% felt that it was important to talk with family about their wishes related to the end-of-life care, yet less than 30% had had any type of conversation.

The current standard of practice at many primary care offices is for nursing or medical assistants to ask patients on the initial patient visit intake assessment whether or not they have an advance directive. While all federally-funded health care facilities are legally required to ask patients about advance directives under the Patient Self Determination Act of 1990 (H.R. 5067,

1990), there is often little action taken to discuss ACP with patients after this initial information is recorded. At the site in which this scholarly project was conducted, only one patient of the 30 included in the randomized pre-intervention chart review had an advance directive within the record.

According to De Vleminck et al. (2016), some of the reasons that general practitioners are not initiating ACP with their patients include a lack of knowledge, skill, and confidence to begin the discussion. Many felt poorly prepared to conduct ACP discussions, uncertain about when to initiate these discussions, and had an overall lack of awareness of what constitutes an ACP conversation (De Vleminck et al., 2016). By contrast, positive factors leading to ACP discussions in primary care relate to providers realizing the potential positive outcomes of these conversations and having a positive attitude related to future discussions (De Vleminck et al., 2016). According to De Vleminck et al. (2016), organizational factors that limit ACP discussions include a lack of time during patient encounters and inconsistent place and method of recording and retrieving patient wishes within the health system, which made providers question the usefulness of ACP discussions if the information is not easily retrievable (De Vleminck et al., 2016).

Significance of increasing advance care planning discussions. This scholarly project meets the IOM's 2015 report recommendation that patients and providers should have improved communication, specifically related to ACP. Without ACP discussions that have been well documented, healthcare teams and families often default to aggressive treatment, even if it is painful, hopeless, and costly (IOM, 2015). Increasing ACP discussions in the primary care setting will help adhere to patient wishes, improve quality of life, reduce family burden and tension, decrease care provider burnout, and lower overall healthcare costs.

Problem Statement

Current research shows the importance of primary care providers initiating early ACP in order for patients' wishes to be honored at the end of life and to reduce family distress related to the burden of decision making. Despite the evidence, many primary care providers still do not initiate ACP with their patients, with the Centers for Disease Control and Prevention (2017) stating that 70% of Americans do not have an advance care plan.

Purpose of the Project

The purpose of this evidence-based practice project was to increase ACP in a primary care office by educating the primary care providers and raising awareness of the importance of ACP. Through increasing ACP in the primary care setting, the aim is to improve adherence to patient wishes at the end of life and secondarily, to minimize the emotional burden on families and the financial burden on the overall health care system.

Clinical Question

The purpose of this evidence-based practice project is to answer the clinical question: Among primary care providers, does providing the Center to Advance Palliative Care (n.d.) online module for advanced care planning education as well as an in-person PowerPoint presentation increase the rate of providers' discussions and completion of advanced care planning as compared to current practice? Following the PICO method, the population addressed was primary care providers. The intervention was education using the Center to Advance Palliative Care (n.d.) online training program and in-person education. Comparison was to the current pre-educational intervention practice. And, the desired outcome was to see an increase in ACP discussions as evidenced by an increase in documentation of ACP conversations and

advance directive completion in patients between 65-90 years old seen in the primary care office within one month for a chronic care or annual wellness visit.

SECTION TWO: LITERATURE REVIEW

Search Strategy

The project leader conducted a literature search utilizing the databases: CINAHL Plus with Full Text, Cochrane Library, ProQuest, and MEDLINE with Full Text. Search terms included ACP, advance directive, and primary care. Inclusion criteria for the articles were that they were available in the English language and were viewable in full-text. Exclusion criteria included any articles that were not peer-reviewed or scholarly and studies that involved hospice patients. Articles were reviewed for relevance to the proposed evidence-based practice project and the project leader included 17 within the in-depth literature review with dates ranging from 2009 to 2017. The majority of the articles were published within the last five years. Levels of evidence are assigned through this literature review according to the system from the Melnyk and Fineout-Overholt (2014) model. These levels of evidence of the articles reviewed and discussed range from level I to level VI, with one level I systematic review of randomized control trials, two level II randomized control trials, four level V systematic reviews of qualitative/descriptive studies, and ten level VI single descriptive or qualitative studies.

Synthesis and Critical Appraisal of the Literature

In analyzing the current evidence related to ACP in the primary care setting, the project leader identified several repeating concepts, as well as recurring gaps in evidence noted in many of the articles. Common themes that emerged in the literature include the key components of ACP discussions, the ideal setting for these conversations, the impact of ACP, as well as facilitators and barriers of ACP conversations in primary care. The main gap noted in the

literature is the translation of the evidence about the importance of ACP discussions into clinical practice. Appendix A contains a complete literature matrix, containing the table of evidence related to the articles within this literature review.

Ideal setting and key components of advance care planning. In reviewing the literature, a common theme that emerged was that ACP should not be a one-time activity but ideally should occur as an ongoing conversation over the lifespan of the patient (Brooke & Kirk, 2014; Glaudemans, Moll van Charante, & Willems, 2015; Houben, Spruit, Groenen, Wouters, & Janssen, 2014; Kataoka-Yahiro et al., 2010; Sudore et al., 2017). Furthermore, the literature supports beginning ACP early, while patients have the cognitive ability to understand and make decisions, and even before there is any diagnosis of a chronic condition (Brooke & Kirk, 2014; Glaudemans et al., 2015; Kataoka-Yahiro et al., 2010; Philip et al., 2012). The systematic review of randomized control trials by Houben et al. (2014) found that discussing ACP was favorable in the outpatient setting, during regularly scheduled appointments in which patients are not dealing with an acute illness. The qualitative study by Philip et al. (2012) showed agreement among patients with chronic obstructive pulmonary disease and healthcare providers that ACP and end-of-life discussions should reoccur at key points during the disease trajectory, such as the first outpatient visit after a hospitalization due to an exacerbation. However, despite this mutual sentiment between providers and patients, the majority diagnosed with chronic obstructive pulmonary disease in this study stated they had never had an ACP discussion with their provider (Philip et al., 2012). According to the post-ACP seminar survey by Scott et al. (2015), over 80% of healthcare providers agree that the ideal setting for ACP is an outpatient or subacute facility with a trusted healthcare provider. Similarly, the survey by Tung and North (2009) revealed that 86.2% of responding primary care providers agreed that it was the primary care provider's role to

discuss ACP, yet 27.7% stated they rarely discuss ACP with patients. 40.4% of providers stated they discuss ACP only when prompted by patients' family members, and 12% expressed that they never discuss ACP in the primary care setting (Tung & North, 2009).

Key components of the ACP process identified by the participants in the qualitative study by Kataoka-Yahiro et al. (2010) included understanding their treatment options and medications available to them during end-of-life care. Nguyen et al. (2013) conclude that ideally every patient should be screened at each encounter for his or her readiness to begin the ACP discussion. These results align with the Transtheoretical Model of Health Behavior Change (Prochaska & Velicer, 1997), in which patients progressed through mental attitudes before deciding to engage in ACP (Nguyen et al., 2013).

The greatest amount of disagreement in the literature was regarding provider, patient, and families' beliefs about where the ideal setting was for ACP, who should initiate, and which individuals should be included in ACP. The systematic review by Brooke and Kirk (2014) found that the families of patients with dementia preferred informal conversations with providers about ACP opposed to a formal discussion with completion of legal documents. By contrast, the systematic literature review and focused interviews by De Vleminck et al. (2016) found that ideally, clinicians should structure ACP discussions and include the opportunity to complete legal documents. The study by Kataoka-Yahiro et al. (2010) was the only one to indicate that patients preferred to initiate ACP discussions with their family and friends rather than a physician. It is not clear from the article if patients were opposed to discussing ACP with a physician, or if they just preferred discussing the issues with family before having the conversation and making decisions with their primary care provider.

Impact of advance care planning. Reviewing the literature shows the importance of ACP discussions with benefits for multiple stakeholders including; patients, providers, caregivers, and healthcare organizations as a whole. The randomized control trial, with level II evidence, by Detering, Hancock, Reade, and Silvester (2010) sought to determine the effect of coordinated ACP on end-of-life care, family levels of stress, anxiety and depression, and perceived quality of care after discharge. With statistical significance, 86% of patients from the intervention group that had received ACP had their wishes known and respected at the end of life, while only 30% that died from the control group, that did not receive ACP, had their wishes known and respected at the end of life (Detering et al., 2010). Furthermore, patients' family members in the intervention group who received ACP were more likely to be very satisfied with the care provided, and had fewer symptoms of depression, anxiety, and post-traumatic stress after their family member passed compared with the control group (Detering et al., 2010). This study empirically shows how ACP impacts quality for end-of-life care as well as reducing family distress related to the death of a loved one.

A systematic literature review of the descriptive and qualitative literature, with level V evidence, by Dixon, Matosevic, and Knapp (2015) showed that ACP is most often associated with healthcare savings, but in every case, healthcare costs never increased due to ACP. Overall, ACP reduced inpatient hospital deaths and ICU use, overall hospitalizations, length of stay, and thirty-day hospital re-admissions (Dixon et al., 2015). Decreasing hospital length of stay, ICU admissions and re-admission rates also improve hospital reimbursement rates. These findings align with the study by Nicholas, Langa, Iwashyna, and Weir (2011), with level VI evidence, which found that patients who had completed advance directives in regions with an overall high cost of end-of-life care had statistically significant lower cost of end-of-life Medicare spending.

The study also found that these patients were less likely to die in the hospital, and they were more likely to utilize hospice services (Nicholas et al., 2011).

Facilitators of advance care planning. In reviewing the literature, many studies on ACP focus on identifying and addressing the barriers and facilitators of ACP in the primary care setting (Brooke & Kirk, 2014; De Vleminck et al., 2016). Having a well-established relationship with a patient is a key facilitator of initiating ACP in the primary care setting (De Vleminck et al., 2016). In general, patients were more likely to have ACP discussions when providers initiated the conversation (Detering et al., 2010; Philip et al., 2012). Positive predictive factors for primary care providers initiating ACP discussions include having a positive previous experience with ACP and having an overall positive attitude toward the value and benefits of discussing ACP with their patients (De Vleminck et al., 2016).

Another facilitator of ACP, as described in the study by Detering et al. (2010), was the presence of family members during ACP discussions. Patients having their family members present during ACP conversations resulted in three times increased completion rate of ACP documentation, such as appointing a surrogate decision maker or completing an advance directive (Detering et al., 2010). The study by Kataoka-Yahiro et al. (2010) reinforces these findings, showing that patients preferred having ACP discussions with their families first and valued family presence during ACP discussions with healthcare providers, specifically among Asian-American and Native Hawaiian patients. In the study by Holland et al. (2017), having nursing staff assist was beneficial in facilitating ACP. When nurses walked patients through an ACP aid, with patients randomly assigned to four different tools, 85% of participants completed an advance directive, and 100% of patients identified a healthcare agent (Holland et al., 2017).

This shows that ACP tools and aiding individuals in walking through the process are important facilitators of ACP discussions.

Barriers to initiating advance care planning. In addition to the common facilitators for ACP seen through the articles analyzed, the project leader also identified many barriers in the literature that hinder ACP in the primary care setting. Overall, a general consensus emerged from the literature about the most common barriers to implementing ACP in the primary care setting. Addressing and overcoming these barriers provides an opportunity to help promote ACP discussions in primary care.

Provider barriers to initiating advance care planning. A theme that continually surfaced as a hindrance to providers initiating ACP in primary care was the sentiment that they had inadequate training to begin these discussions with their patients (Brooke & Kirk, 2014; De Vleminck et al., 2016; Scott et al., 2015; Sudore et al., 2017). The systematic review of the literature by De Vleminck et al. (2016), with level V evidence, along with their focused group interviews with providers, noted that a lack of knowledge and skill was also associated with the providers' general lack of confidence to initiate ACP discussions with patients.

Another barrier that providers acknowledged was uncertainty about the best time to initiate ACP (Brooke & Kirk, 2014; Glaudemans et al., 2015). While the literature demonstrates the importance of ACP for all adults, overall the evidence shows that the majority of providers felt that ACP was intended for, or primarily important for, patients with chronic conditions or life-threatening illnesses (De Vleminck et al., 2016; Evans et al., 2014; Glaudemans et al., 2015). Evans et al. (2014) found that ACP discussions were more prevalent among patients facing cancer than those with organ failure, old age, or dementia. However, the structured review of qualitative studies by Glaudemans et al. (2015), with level V evidence, describes how patients

felt that ACP is useful for healthy individuals, indicating that it was the providers' responsibility to initiate these discussion, especially when the individual is well.

Many providers expressed concern that discussing ACP too soon after initial diagnosis may cause unneeded additional stress, yet fear that if they wait to address the issue until disease progression it may be too late, as the patient may already have cognitive deficits (Brooke & Kirk, 2014). The literature was in agreement describing how providers feared they would cause patients to have anxiety or deprive them of hope if they initiated ACP too soon (Brooke & Kirk, 2014; De Vleminck et al., 2016; Philip et al., 2012). The qualitative study, with level VI evidence, by Kataoka-Yahiro et al. (2010), showed that patients with stage IV and V chronic kidney disease were not anxious to discuss ACP, with 94% of participants expressing that they were comfortable talking about death. This is further emphasized through the qualitative study by Philip et al. (2012), in which two patients with chronic obstructive pulmonary disease stated, "I know it will eventually knock me but no there's been virtually no talk with anyone from the hospital... I think the more a person can know about the end or possible scenarios the better you are to make an informed decision" (p. 819). It is important to note the findings from Nguyen et al. (2013), which show that in patients with chronic obstructive pulmonary disease, the severity of the illness did not correlate with a patient's readiness to discuss ACP. The perceived barrier of providers that initiating ACP too soon with patients will increase anxiety and stress is unsubstantiated by the literature.

Patient and family barriers to participating in advance care planning. In addition to provider barriers to initiating ACP, the literature shows several barriers to patients and families participating in ACP discussions. The two main sources of reluctance to participate in ACP, described by Brooke and Kirk (2014) involve those that express not wanting to for a particular

personal reason, such as a prior negative experience, and those that state they are waiting for the healthcare provider to initiate the discussion. This is similar to the findings of the structured review by Glaudemans et al. (2015), which found that patients felt that it was the providers' responsibility to initiate ACP. In the descriptive study by Nguyen et al. (2013), with level VI evidence, patients felt that before they discussed ACP with their provider they first had to accept their own mortality and then consider what they would want in the event they become incapable of speaking for themselves.

In some cases, patients stated they had not engaged in ACP simply because they were not aware of what it was, the role it played, and the overall benefits it could provide them (Brooke & Kirk, 2014). According to the study by Rao, Anderson, Lin, and Laux (2014), the most common response from a national survey regarding why individuals did not have an advance directives was that they lacked awareness of what an advance directive was and why they would have a need for one. Interestingly, Brooke and Kirk (2014) found through their systematic review of qualitative studies that a common barrier in the literature for ACP discussions regarding patients with dementia was that family members had a difficult time making decisions for patients without having spoken with the patient about their wishes before their cognitive decline. This shows the importance of initiating ACP early and in healthy patients who are able to personally express their wishes and desires.

System barriers inhibiting advance care planning. The project leader also identified system barriers in the literature that prevent ACP discussions from occurring in primary care. One of the system barriers recurrently identified was primary care offices having a lack of consistent methods to document ACP information. Several studies showed that retrieving documents, including advance directives, at the time of need was difficult and cumbersome, and

therefore many providers did not view initiating ACP as beneficial (Brooke & Kirk, 2014; De Vleminck et al., 2016; Scott et al., 2015). Wilson et al. (2013) conducted a retrospective study of charts looking for ACP documentation and found that there was not a standardized location for ACP decision documentation, with many ACP documents not properly signed or completed, and that not all patients that indicated that they had an advance directive had a scanned copy in the chart. Without a systematic method of handling ACP documentation, these documents are not viewable at the point of care when needed and therefore do not serve their purpose.

Providers in the study by Tung and North (2009) stated that a lack of a system reminders at the point of care was also a barrier to providing ACP. Another barrier noted by providers was a lack of time built into patient encounters to address ACP (De Vleminck et al., 2016; Scott et al., 2015). The study by Tung and North (2009) found that the number one perceived barrier, with 91.5% of providers acknowledging it as a barrier for ACP discussions in primary care, was a lack of time. One response to this system barrier is the addition of a billable procedural code for ACP, in which third party payers reimburse providers for the time spent discussing ACP with patients (Sudore et al., 2017). CMS (2016) reimburses as an add-on timed billing code to patient visits for ACP discussions, with no co-payment if completed with the Medicare Annual Wellness Visit.

The role of the proposed project derived from the literature. In the literature, a variety of methods helped facilitate ACP. The study by Detering et al. (2010) utilized the ‘Respecting Patient Choices’ model of ACP, which is a model that has been implemented in multiple settings around the world. According to the structured review of qualitative studies by Glaudemans et al. (2015), advance directives and the ‘Gold Standards Framework’ ACP tool were useful in facilitating ACP between providers and patients in primary care. The prospective study by Holland et al. (2017), compared four evidence-based tools for ACP including; ‘Making

Your Wishes Known,’ ‘PREPARE,’ ‘MyDirectives website,’ and an in-house institutionally created ACP booklet entitled “Advance Healthcare Planning.” The study found that there was no difference in patient satisfaction between the four tools (Holland et al., 2017). The randomized clinical trial, with level II evidence, conducted by Sudore et al. (2017) compared the efficacy of the PREPARE website, which is a patient-centered ACP website, to an easy-to-read advance directive. The results showed that the tools alone, without clinician intervention, increased ACP documentation 25% to 35% (Sudore et al., 2017). Users positively rated both the easy-to-read advance directive and PREPARE website noting them to be easy to use, helpful, with high patient satisfaction ratings, and while not a replacement for face-to-face ACP time with a provider, they can serve as useful supplements (Sudore et al., 2017).

Conceptual Framework/Model

The Iowa Model of Evidence-Based Practice to Promote Quality Care was used as the conceptual framework for this evidence-based practice project (Iowa Model Collaborative, 2017). The Iowa Model Collaborative granted the project leader permission for use of this model for the scholarly project, with documentation included in Appendix D (*Used/reprinted with permission from the University of Iowa Hospitals and Clinics, copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics at 319-384-9098*). The Iowa Model-Revised provides step-by-step guidelines for completing an evidence-based practice project from identifying an issue all the way through dissemination, with seven action steps and three evaluation questions to consider (Iowa Model Collaborative, 2017). This widely-used model designed for point-of-care clinicians is a practical tool that helps guide healthcare professionals to translate evidence into practice across a diverse range of settings, helping facilitate sustainable change (Iowa Model Collaborative, 2017). The Iowa Model-Revised has

been used to identify a knowledge trigger for this proposed project, which is the importance of ACP in the primary care setting, and a purpose which is stated above. As shown through the mission of the primary care office and their permission to complete the project, as well as the support for ACP discussions from leading national organizations including the IOM and CMS, this topic has been determined to be a priority, fulfilling the next step of the Iowa Model-Revised (Iowa Model Collaborative, 2017). Following team formation between the project leader, faculty advisor, and practice staff members, the next major decision point in the Iowa Model is to determine if there is sufficient evidence (Iowa Model Collaborative, 2017). While the literature review shows that there continue to be gaps in knowledge related to increasing ACP in primary care, there is sufficient evidence to support the proposed evidence-based practice change (Iowa Model Collaborative, 2017). According to the Iowa Model Collaborative (2017), the next step is to create and pilot the change in practice, which includes engaging patients, analyzing resources and restraints, seeking approval, collecting baseline data, developing a plan for implementation, preparing personnel and necessary materials, and promoting adoption. In this project, a plan was developed and outlined in detail in the methodology section, to educate providers and staff of the importance of ACP in the primary care setting, measuring results through collecting pre- and post-intervention data. Finally, the next decision point is to look at the data and determine if the change is appropriate for adoption, and if so, engaging key stakeholders and integrating the change into practice so that it is sustainable (Iowa Model Collaborative, 2017). Considering the importance of ACP discussions, continuing to educate providers and engaging key stakeholders within the organization will be essential in promoting lasting change. The last stage of the Iowa Model-Revised is disseminating the results, which includes sharing the results of this project

with participants and other members of the healthcare organization and publishing this scholarly project. An overview and plan for ACP discussions is detailed below.

Theoretical Framework

A theoretical model that helped guide the educational intervention of the project is the Transtheoretical Model of Health Behavior Change (Prochaska & Velicer, 1997). This model suggests that change in health behavior, in this case engaging in ACP, requires patients to progress through the six stages of change including pre-contemplation, contemplation, preparation, action, maintenance, and/or termination (Prochaska & Velicer, 1997). Just as Lum et al. (2015) describe, ACP is similar to tobacco cessation; providers must have an ongoing conversation with the patient, assessing where they are at each encounter and allowing that to guide the discussion. The Transtheoretical Model has been incorporated in several ACP studies, describing how patients move from pre-contemplation through the various stages, helping providers know when and how to approach the topic with their patients (Nguyen et al., 2013). The concepts of the Transtheoretical Model were incorporated in the in-person education for clinicians so that they understand how to assess where a patient is when discussing ACP and to show that it is an ongoing process that takes time for patients to work through. Just because a patient has never discussed ACP before does not mean he or she does not want to or will not want to in the future. Patients must move through the stages of change, and their readiness to participate in ACP discussions should be re-evaluated at each encounter.

Summary

The literature overwhelmingly supports initiating ACP early and frequently, ideally during regularly-scheduled primary care visits with a provider with whom they have a well-established relationship, before patients have any type of cognitive decline (Brooke & Kirk,

2014; De Vleminck et al., 2016; Glaudemans et al., 2015; Houben et al., 2014; Kataoka-Yahiro et al., 2010). However, in the United States the overall rate of ACP and advance directives remains low, with the study Rao et al. (2014), descriptive level VI, showing that of 7,946 respondents, only 26.3% had an advance directive. Glaudemans et al. (2015), describe in their structured review how many primary care providers do not provide ACP in a systematic way, with content varying from completing advance directives to listening to patients' rationale for choosing certain end-of-life preferences. One area that has been identified for further work is testing and establishing systematic guidelines for the best method of providing ACP (Glaudemans et al., 2015). The identified provider, patient, and system barriers can be overcome through education of providers about tools to facilitate ACP discussions, encouraging providers to initiate these conversations, teaching them how to bill for the time spent addressing ACP, and determining a consistent method of recording and retrieving ACP documentation. Therefore, with the support of the evidence, the purpose of this scholarly project was to increase the rate of ACP within a primary care office by educating the providers.

SECTION THREE: METHODOLOGY

Design

While the current evidence shows the many benefits of ACP discussions and the importance of initiating it early, rates in the primary care setting remain low with the Centers for Disease Control and Prevention (2017) reporting that seventy-percent of Americans do not have an advance care plan. The project used the Iowa Model-Revised as a guide to evaluate the effectiveness of the pilot project at increasing ACP within a primary care office (Iowa Model Collaborative, 2017). This evidence-based practice project used a quasi-experimental method to collect data to evaluate the practice change.

Measurable Outcomes

Compared with current practice, which primarily consists of staff asking patients if they have an advance directive on initial history intake, the project leader compared the prevalence of ACP discussions before and after the intervention, measured using the ACP billing codes (Current Procedural Terminology codes 99497 and 99498) (CMS, 2016) as well as the presence of an advance directive within the chart or ACP documentation. Evidence shows that increasing ACP and advance directives increases adherence to patient wishes at the end of life and minimizes the emotional burden on families (Nguyen et al., 2013). Therefore, measuring the change in prevalence of ACP discussions and advance directives effectively shows the outcome of the proposed project.

Outcome 1. To determine if there was an increase in ACP discussions after the educational intervention.

Outcome 2. To determine if there was an increase in documentation of advance directives after the educational intervention.

Setting

The project leader implemented this evidence-based practice project at a primary care office in a town of 41,130 people in central Virginia (United States Census Bureau, 2017). The office currently has four physicians. The in-person PowerPoint ‘lunch and learn’ education was conducted in the conference room of the primary care office from 12:15 to 1:15pm, so that staff did not have to stay beyond their required work hours. The project leader provided lunch for each participant from a local grocery store which did not exceed \$10 per person.

This office is a part of a larger healthcare organization network, making it a strategic location for a pilot project and to assess the practice change at a micro-level before assessing it

on a larger scale. The mission for the organization is “excellent care for life” (para. 1) with the vision, “to be the most trusted provider of innovative healthcare” (para. 2) and their values are; respect and integrity, patient-centeredness, teamwork, and drive for excellence (Centra, n.d.). The aim of this project, increasing ACP discussion in the primary care setting, fits right in to the mission, values, and vision of the organization, since ACP leads to improved quality of life, allowing patients’ and families’ wishes to be respected, especially in the final days of life (Detering et al., 2010). The regional medical director granted the project leader permission to complete the project at this office, with the letter of permission included in Appendix C.

Population/Ethical Considerations

The intervention was educating providers about the importance of ACP and providing supporting documents, including educational materials for patients and information on how to bill for ACP. The subjects were providers from one primary care office. All four of the providers were invited to participate in the project via e-mail communication eleven days before the in-person education. The email described the project, announced the time and location of the education, and provided the informed consent document for them to review (See Appendix F). The project leader asked providers to reply to the email if they agreed to participate. Three of the four providers participated, meeting the goal of recruiting at least seventy-five percent of the providers in the project. In order to protect the subjects of the scholarly project, the project leader obtained approval from Liberty University’s Institutional Review Board as well as the Healthcare organization’s Institutional Review Board and Nursing Research Council (See Appendix B). The team did not record any identifying data about the participants in the project that would link the information published back to them. The scholarly project team completed

research ethics training to ensure protection of human subjects. Refer to Appendix C to review a copy of the principle investigator's Collaborative Institutional Training Initiative Certificate.

In collecting comparison data pre-intervention and post-intervention to assess the outcomes of the education through chart reviews there were several inclusion and exclusion criteria established. Inclusion criteria established; patients had to be 65-90 years old and seen by one of the participating primary care providers in the office within 30 days for a chronic care or annual wellness visit. Exclusion criteria for the chart review included; non-English speaking patients, pregnant patients, patients with cognitive impairment, institutionalized patients, patients enrolled in hospice, and incarcerated patients. Protecting patient confidentiality was a priority, and therefore any data recorded was de-identified and stored on a secure, password-protected computer within a password-protected spreadsheet. While the retrospective chart review involved looking at patient charts, the project leader did not record any identifying protected health information related to the patients, and information was untraceable through identifiers that were connected back to the patient (Wolf, Walden, & Lo, 2005). The records will be stored on this password-protected computer for three years and will then be permanently erased. See the results section for a detailed description of the patients represented within the chart review.

Of the 60 charts included in the pre- and post-intervention chart reviews, participating providers saw 36 of the patients (60%) for an annual wellness visit, and 24 of the patients (40%) for a chronic care visit. Of the 60 charts, 14 of the patients that were included were 65-69 years old, 14 patients were 70-74 years old, 19 patients were 75-79 years old, 7 patients were 80-84 years old, and 6 patients were 85-90 years old. The gender breakdown for the patients included within the chart review was 56.67% male and 43.33% female. For the race and ethnicity of 60 patients included within the chart review, 48 were White/Not Hispanic or Latino, 4 were Black or

African American/Not Hispanic or Latino, 3 were White/Undefined, and 5 were Undefined. See *Figure 1*, *Figure 2*, *Figure 3*, and *Figure 4* for visual demographic representation.

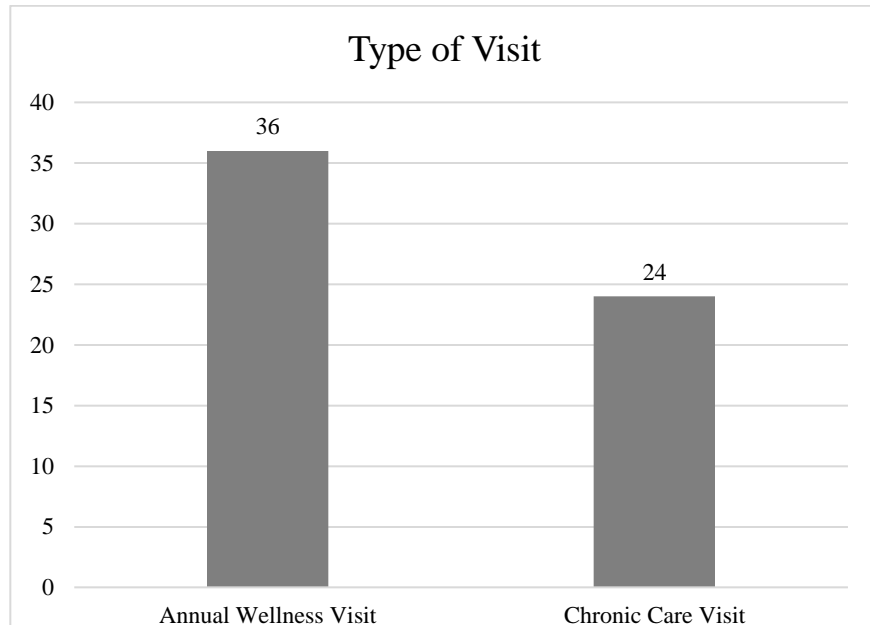


Figure 1. Number of Patients Included in Chart Review by Type of Visit

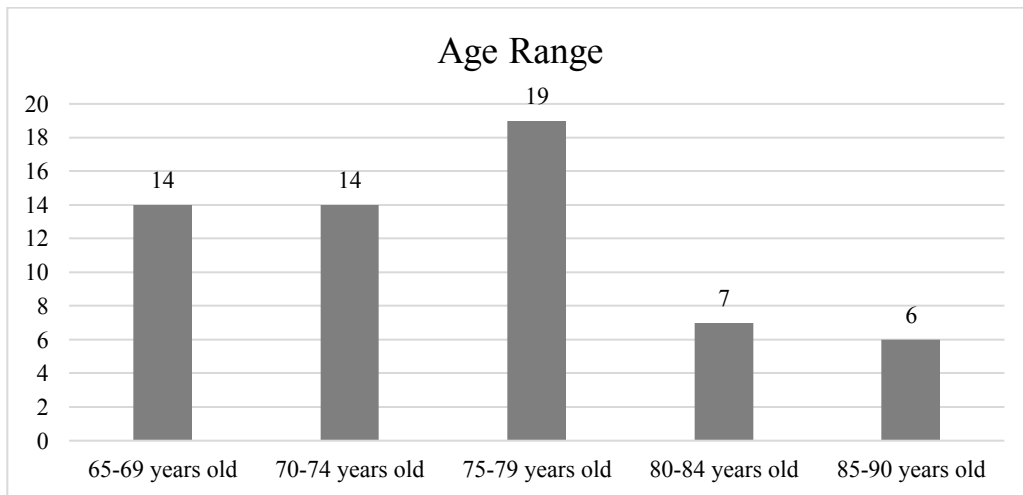


Figure 2. Number of Patients Included in Chart Review by Age Range

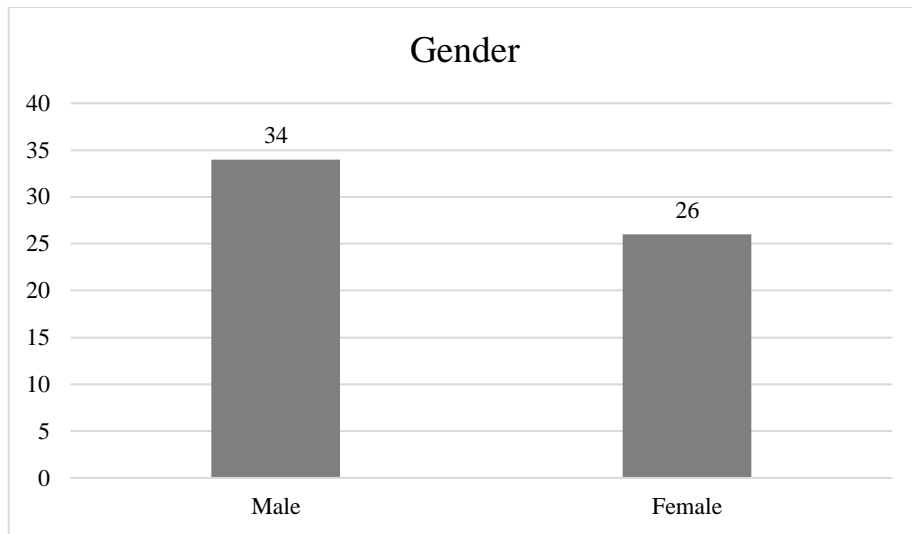


Figure 3. Number of Patients Included in Chart Review by Gender

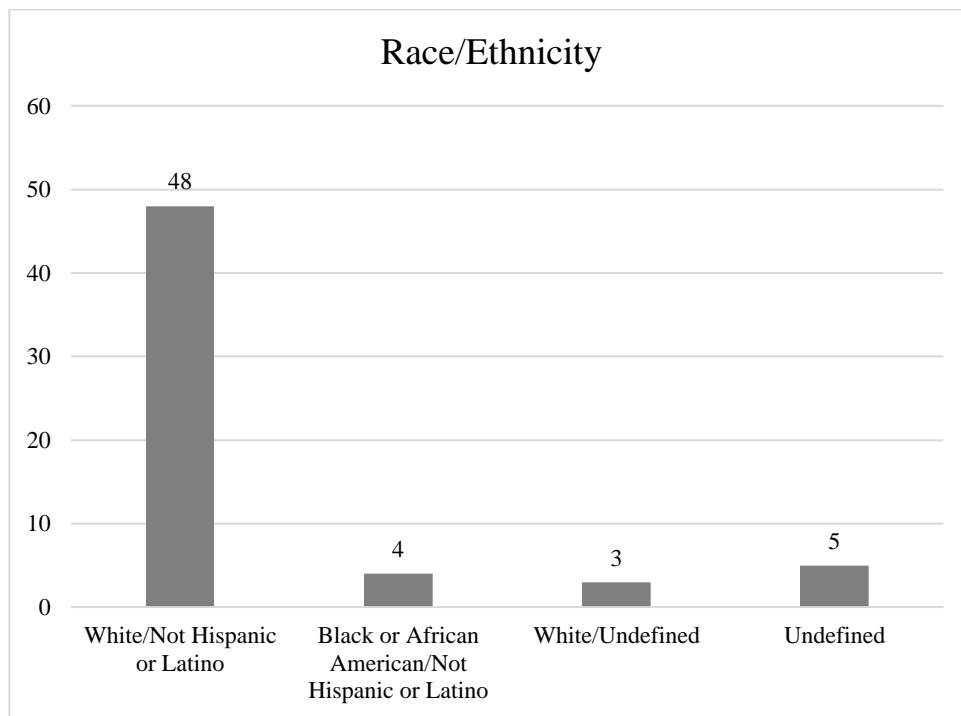


Figure 4. Number of Patients Included in Chart Review by Race/Ethnicity

Tools

A PowerPoint presentation and an online module were the educational tools used to educate and raise awareness for the provider participants of the need for ongoing ACP

discussions in the primary care setting included a PowerPoint presentation and an online module. The project leader created the PowerPoint presentation and presented it during the educational lunch for the providers. The PowerPoint presentation included a short video clip depicting the importance of ACP, an overview of the literature and current evidence related to ACP in primary care, and the two primary goals of ACP. The next part of the PowerPoint presentation described how the Transtheoretical Model of Health Behavior Change by Prochaska and Velicer (1997) applies to ACP and the need to assess a patient's readiness to make decisions. The providers were then given information on how to bill for ACP discussions according to CMS (2016). The first 30 minutes of an ACP conversation is equivalent to 1.5 relative value units and has an annual national reimbursement of \$82.90 (CAPC, n.d.). It can be billed multiple times during a year and when billed during the annual wellness visit, does not require a beneficiary co-pay or deductible (CMS, 2016). Finally, the project leader shared effective ACP communication phrases an overview of the project, and provided time for discussion and questions. One tool that was given to clinicians was the easy-to-read advance directive provided by <http://www.caringinfo.org/files/public/ad/Virginia.pdf>. This tool is in the public domain for public use, and therefore no permission was required to utilize it for this scholarly project. The project leader then presented and reviewed a booklet printed by the healthcare organization entitled "Have You Had the Talk?" as a method for providers to introduce the topic to their patients.

In addition to the in-person PowerPoint presentation, providers completed the Center to Advance Palliative Care (CAPC) online continuing education module "Advance Care Planning Conversations" (n.d.). This learning module helps health professionals know how to initiate and conduct ACP conversations (CAPC, n.d.). In addition to strengthening skills, providers received

0.5 physician CME for completing the post-test related to the training module (CAPC, n.d.). The primary care office in which the pilot project was completed had permission to access and use this module as a part of the bigger healthcare organization which has a paid subscription. See Appendix D for a copy of the letter of permission to use the content. The project leader provided a link to these online modules to the participating providers on the day of the face-to-face educational lunch, and gave the providers two weeks to complete the online module.

Intervention and Data Collection

After receiving approval from Liberty University's Institutional Review Board as well as the project site's Institutional Review Board, the project leader sent an email to the primary care office manager to coordinate a time to host the educational lunch. Three of the four primary care providers indicated interest in participating in the project. The project leader presented the PowerPoint presentation as detailed in the section above, as well as instructions for accessing the CAPC module (n.d.). Within the week after the luncheon, the project leader conducted a retrospective chart review using charts gathered from the participating providers 30 days prior to the educational intervention. In conjunction with the healthcare organization's Director of Population Health, the project leader randomized patient charts from the participating providers, identifying patients that met inclusion and exclusion criteria and selecting every other chart meeting established conditions until 30 charts had been reviewed. This initial retrospective chart review provided data about the prevalence of ACP discussions and advance directives, showing the pre-intervention data. The project leader recorded demographic data, including age range of patient, gender, and ethnicity and reported them as group descriptive statistics as seen above, as was data related to the prevalence of ACP discussions and advance directives. No information

was recorded that could be traced back to a patient's protected health information or to a specific provider.

After presenting within the office, the providers were given two weeks to complete the online educational module. Thirty days later, the project leader conducted a second retrospective chart review in which data was collected from every other chart meeting the established inclusion and exclusion criteria until 30 charts were included for the analysis. The project leader collected, recorded, and reported the same demographic data as a group statistic with the pre-intervention data, as were the presence of ACP discussions and advance directives. As described below, the project leader then analyzed the data, determining the outcome of the intervention. The team consisted of the facilitator, who was the primary individual conducting the data collection and implementing the intervention, a consulting instructor who is the chair of this scholarly project, a staff member from the primary care office who helped coordinate the intervention details with the providers, and the Director of Population Health from the organization who helped facilitate communication and preform the chart reviews.

Timeline. The timeline for the project, including pre-implementation, implementation, and then the proposed post-implementation timing is outlined below:

- August 30, 2017: Met with Faculty Chair and finalized topic for Scholarly Project
- February 8, 2018: Defended proposed Scholarly Project to Faculty Chair
- February 25, 2018: Sent email to Office Manager at primary care site with details of the proposed Scholarly Project
- March 2, 2018: Received permission in the form of a signed letter from the Regional Medical Director to complete Scholarly Project at the primary care office

- March 14, 2018: Submitted to Liberty University's Institutional Review Board
- April 6, 2018: Received approval from Liberty University's Institutional Review Board
- April 13, 2018: Presented to organization's Nursing Research Council and on April 14, 2018: Received approval to submit to organization's Institutional Review Board
- April 17, 2018: Received approval from organization's Institutional Review Board as an exempt study
- June 12, 2018: Implemented education at the primary care office through the educational lunch
- June 18-20, 2018: Conducted retrospective pre-intervention chart review and data collection (included charts 30 days prior to education: May 13, 2018 to June 11, 2018)
- July 30-31, 2018: Conducted retrospective post-intervention chart review and data collection, allowing providers two weeks after in-person educational lunch to complete online module (included charts 30 days after education: June 27, 2018 to July 26, 2018)
- By August 20, 2018: Scholarly Project will be defended to faculty chair, and pending edits and revisions will then be submitted to Liberty University's Digital Commons

Feasibility analysis. An important consideration of implementing this evidence-based practice project was determining the feasibility. This included considering required resources to complete the project; beyond the monetary cost, time, and personnel resources required for

evaluation. The project leader estimated overall financial cost of the intervention to be less than \$75, which covered the cost of providing lunch for staff during the education and the printing cost of materials. Since the project leader provided education during regular operating hours utilizing an already available space within the providers' schedule; there was no additional cost associated with these aspects of the project. Furthermore, as the meeting was during lunch, it did not take away from patient care time, and the support staff were already working their regularly scheduled hours. Another factor to consider related to personnel was the time spent participating, communicating, coordinating, and implementing the project from those involved in the project, including the principle investigator, the scholarly project chair, office manager, participating providers, and assisting staff and mentors. Equipment that was necessary to complete this project included a computer with Microsoft Word, Excel, and PowerPoint, SPSS, internet connection, and access to the electronic medical record. Overall, this scholarly project was very feasible and cost-effective and could be easily reproduced under similar circumstances.

Data Analysis

The project leader collected data from the chart reviews on a secure, password-protected computer within a password-protected Excel document. After data collection, as detailed above, the project leader entered the necessary information for statistical analysis into IBM's SPSS Statistics 24 software (<http://www-03.ibm.com/software/products/en/spss-stats-standard/>). The project leader then used the software to run descriptive statistics, determining the prevalence of ACP discussions and advance directives before and after the educational intervention. Furthermore, due to the small sample size, the project leader ran a Fisher's Exact Test to determine the significance of ACP discussions pre-intervention and post-intervention.

SECTION FOUR: RESULTS

The pilot project retrospective pre-intervention chart review used a quasi-experimental method to select every other, chart meeting criteria, until 30 charts were collected (n=30). The pilot project retrospective post-interventions chart review used the same quasi-experimental method to select every other chart, meeting criteria, until 30 charts were collected (n=30). Of the 4 primary care providers within the office, 3 of the providers (75%) agreed to participate in the pilot project.

With a total number of 60 charts included in the pre-intervention and post-intervention chart reviews (n=60), the project leader ran a Fisher's exact test to determine the significance of the change in rate of ACP documentation. The educational intervention showed statistical significance (p=0.011) in increasing ACP documentation. See Table 1 for the number of charts reviewed pre-intervention and post-intervention with ACP documentation. See Table 2 for the number of charts reviewed pre-intervention and post-intervention and the presence of an advance directive.

Table 1

Number of Charts Reviewed Pre-Intervention and Post-Intervention with ACP Documentation

	ACP Documentation		Total
	Yes	No	
Pre-Intervention	0	30	30
Post-Intervention	7	23	30
Total	7	53	60

Table 2

Number of Charts Reviewed Pre-Intervention and Post-Intervention with an Advance Directive

	Advance Directive in Chart		Total
	Yes	No	
Pre-Intervention	1	29	30
Post-Intervention	2	28	30
Total	3	57	60

Outcome 1: Descriptive Statistics

The initial chart review revealed that no providers documented ACP discussions of the 30 charts included in the pre-intervention chart review, or a prevalence of 0%. In the post-intervention chart review, of the 30 charts included, providers documented ACP discussions seven times, with a prevalence of 23.33%. Of the seven charts in the post-intervention chart review that documented ACP conversations, one chart had the Current Procedural Terminology code 99497 and no charts had the Current Procedural Terminology code 99498 .

Outcome 2: Descriptive Statistics

Of the 30 charts included in the pre-intervention chart review, one chart had a copy of an advance directive, or 3.33%. In the post-intervention chart review two charts of the 30 charts included had advance directives, or 6.67%.

SECTION FIVE: DISCUSSION

The overall goal of this proposed evidence-based practice project was to translate the research, which shows the benefits of initiating ACP discussion in the primary care setting, into practice. The project leader evaluated the success of the intervention by looking at the analyzed

data and determining if there was a change in the prevalence of ACP discussions in the primary care office that received education among participating providers. Following the guidance of the Iowa Model-Revised, the team that worked on the project spent time after the results were obtained to determine the strengths and weaknesses of the design, sampling, methods, and tools used (Iowa Model Collaborative, 2017).

Outcome 1: Discussion

The prevalence of ACP discussions before and after the intervention showed an increase of 23.33%. This percentage shows clinical improvement in the rate of ACP discussions. Therefore, the educational intervention of the in-person educational lunch as well as the online continuing educational module related to ACP were successful in significantly increasing ACP discussions within this primary care office, affirmatively answering the clinical question.

As described in the systematic review and meta-analysis of randomized control trials by Houben et al. (2014), research supports that increasing ACP communication leads to higher rates of advance directive completion. Both ACP discussion and advance directive completion leads to better alignment between patient wishes and the care they receive at the end of life, there is less caregiver burden, and patients are less likely to die in a hospital setting (Houben et al., 2014).

Outcome 2: Discussion

While the results showed a slight increase in the number of advance directives within the post-intervention chart review, from 3.33% to 6.67%, the difference is not statistically significant. Furthermore, providers had added only one of the three advance directives included within the 60 charts included in the review to the electronic medical record within the 30-day inclusion criteria after the intervention; the other two had been added to the electronic medical record before either the pre- or post-intervention period. While ideally there would be an

increase in advance directives, with the short period of time between measures, the increase of only one is not surprising. These findings align with the Transtheoretical Model of Health Behavior Change developed by Prochaska and Velicer (1997), as patients move through the continuum of readiness to engage in change. Since the education is the first time most providers are discussing ACP with their patients during routine visits, conceivably many patients would be at the precontemplation stage, in which they had not recognized a need for change (Prochaska & Velicer, 1997). According to this model, patients will continue to move through the phases to contemplation, preparation, and then to action, in which they have a meeting with family and provider and/or complete an advance directive, before moving to maintenance (Prochaska & Velicer, 1997).

Implications for Practice

Translating the current research that shows the benefits of early ACP discussions in the primary care setting into practice through educating and raising staff awareness has the potential for significant positive implications for the organization as well as the profession of nursing. With regard to the primary care office, which is the micro-level, this project helped provide a higher level of quality evidence-based care in accordance with current literature as provider awareness and knowledge of the need for ACP discussions increased. Furthermore, as providers are able to bill for ACP discussions, there will be increased revenue as ACP conversations increase. From a meso-level, as this education intervention showed effectiveness in increasing ACP discussions, the director of population health distributed the educational PowerPoint presentation to the other primary care offices within the health system network, which can experience the same benefits as the office involved with this scholarly project. Finally, from a macro level, as each of these offices feed into one hospital system in the area, increasing ACP

discussions in the primary care setting can ultimately help reduce hospital costs near the end of life, length of stay, and there will be higher patient and family satisfaction scores (Detering et al., 2010). Calculating the broader implications of expanding this pilot study, including measurements at the meso- and macro-levels was beyond the scope of this scholarly project.

This project supports and contributes to the American Association of Colleges of Nursing [AACN] (2006) Essentials of Doctoral Education for Advanced Practice Nursing. Essential III, “Organizational and Systems Leadership for Quality Improvement and Systems Thinking,” encompasses using analytical methods in order to evaluate the literature to determine the best evidence and how to implement it into practice (AACN, 2006, p. 12). The proposed evidence-based project involved a thorough literature review regarding ACP in primary care settings and developing an intervention to increase the rate of ACP. Another component of AACN’s DNP Essential III is, “disseminate findings from evidence-based practice and research to improve healthcare outcomes” (2006, p. 12). The results from the scholarly project will be shared with the primary care office in which the project was implemented, and the findings will be distributed to the healthcare organization in order to raise awareness of the need to increase ACP conversations, specifically within the primary care setting.

From an advanced nursing perspective, this evidence-based practice project has significant implications. According to the American Nurses Association (2015), nurses are ethically responsible to act as the patients’ advocates. When patients are able to express their values and desires through ACP discussions and advance directives, it enables nurses to be more effective patient advocates. This is especially true for an incapacitated patient, unable to make his or her own decisions, as their documented ACP discussions can help guide care according to the patient’s stated wishes. Regarding future scholarly work, this project helps fulfill the

recommendation of the IOM report (2015) which expresses the critical need to increase ACP, with ongoing and open communication beginning early in the continuum of care. This project has promising implications for patients, nurses, providers, and healthcare organizations as a whole, both improving quality and contributing to future healthcare that is financially sustainable.

Limitations. This scholarly project had several limitations. First, due to the convenience sample utilized, there was a small number of providers included within the intervention, and due to the time constraints of the project, the project included small sample of charts ($n = 60$) in the analysis. Furthermore, the project leader only reviewed the data 30 days after the intervention, whereas a longer timeframe or a second chart review would more accurately measure the sustainability of the project. While the findings of this practice project are promising, each of these limiting factors leads to the results not being generalizable to other settings.

Another key limitation to this project was the timing of the educational intervention. Outside of the project leader's control, the healthcare organization moved the implementation of a new electronic medical record system from March 2018 until September 2018. With the postponed implementation date, the providers within the primary care office were required to complete many online educational modules related to the new electronic medical record system at the same time as this project's educational intervention. The office manager as well as several of the providers described how busy they were trying to complete additional requirements; therefore, this may have led to less-effective education retention. Additionally, as the coding for ACP presented to providers is only effective until the new system is implemented, providers may have been less likely to bill for ACP until after the new system was in place.

An unforeseen barrier occurred when the project was first proposed at the primary care office: one of the providers attempted to bill for an ACP discussion along with the patient's annual wellness visit. The electronic medical record was configured in a way that would not allow he or she to bill for both codes during the same visit, despite the CMS (2016) guidelines for ACP discussions, which encourage this service to be offered during the annual wellness visit. One of the organization members supporting the project leader sent an email to the information technology department, and the change was made to the system that allowed for providers to bill before the beginning of the project. Despite these limitations, this project helped providers and supporting staff to provide patient-centered care that is evidence-based and holistic, embodying the essence of quality nursing care (Zaccagnini & White, 2017).

Sustainability

With the changes observed in this scholarly project being consistent with the literature in that educating providers helped increase ACP discussions in primary care, the next step will involve identifying and engaging key personnel so that the changes that were made are sustainable over time (Iowa Model Collaborative, 2017). The results of this project will be presented to the participants within the office to reinforce the benefits of the project and ACP, and thus promote sustainability. It will be important for the key personnel involved in this project to follow up with the providers to reinforce the importance of ACP discussions as well as the available resources, especially when there are new providers joining the primary care office. While the rate of ACP discussions increased significantly, it would be informative to question the providers after the pilot project to determine the barriers they encountered in order to adjust the intervention accordingly for future participants.

Reflecting on the methods used for this pilot project, one lesson learned through the implementation and evaluation is the need to involve key support staff in the educational intervention in addition to the providers. During the chart review it was evident that the providers worked very closely with office support staff, such as nurses, in order to address each aspect of patient care. While according to the CMS, ACP can only be billed for, “under the order and medical management of the beneficiary’s treating physician” (2016, p. 2), the support staff plays an important role in the team-based care approach. Including support staff in the educational intervention would be beneficial for the sustainability of ACP conversations in future projects. This would also align with the findings of the study by Holland et al. (2017), which showed that when nurses walked patients through an ACP aid, 85% completed an advance directive and 100% named a medical power of attorney.

One factor that will likely help to promote sustainability of the educational intervention is the new electronic medical record system that is being implemented by the healthcare system in the next month. This electronic medical record system will be the same between care settings, allowing for ACP documentation to be more easily accessible. Furthermore, part of the patient header information within the new electronic medical record shows whether or not the patient has an advance directive, which will help serve as a visual reminder for providers to discuss ACP.

Dissemination Plan

The findings of this project will be disseminated to the participants of the scholarly project via email, communicating key findings and reinforcing components of effective ACP conversations. One of the administrative leaders that helped throughout the process emailed the educational PowerPoint to other leaders within the organization’s primary care offices, in order

to disseminate the project findings. Methods that will be used to disseminate the findings of this project include a poster presentation for professional conferences, as well as developing a manuscript for publication.

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Appendix A

Literature Matrix

Article title, author etc. (APA format)	Study Purpose	Sample (characteristics of the sample: demographics etc.)	Methods	Study Results	Level of Evidence (use Melnyk Framework)	Study Limitations	Would use as evidence to support a change (yes or no) provide rationale
Brooke, J., & Kirk, M. (2014). Advance care planning for people living with dementia. <i>British Journal of Community Nursing</i> , 19(10), 490-495.	To study the barriers and facilitators of health care professionals engaging patients with dementia in ACP discussions	Systematic review of qualitative studies	Literature review from empirical research January 1, 2013- August 21, 2014, including to previous reviews covering previous data	1. Family members of patients with dementia were unprepared to make EOL decision if they had not had ACP before cognitive decline 2. Providers had lack of knowledge and skills to initiate early ACP, uncertainty of elements of ACP (of which documentation is needed and which is legally binding)	Level V	Focuses on ACP in patients with dementia	Yes, ACP should occur before patients experience cognitive decline, and there is an increased need for educating providers of ACP.
De Vleminck, A., Houttekier, D., Deliens, L., Vander Stichele, R., & Pardon, K. (2016). Development of a complex intervention to support the initiation of advance care planning by general practitioners in patients at risk	To develop an intervention to support the initiation of ACP in general practice	Systematic review of qualitative studies 36 GPs with varied	MRC framework. Literature review, five focus groups help with GPs	1. Reasons providers do not initiate: lack of skills, knowledge, confidence 2. Unsure of right timing 3. GPs felt patients with life-limiting illness were most eligible,	Level V	Study was conducted in Belgium	Yes, identifies key barriers and facilitators to initiating ACP

<p>of deteriorating or dying: A phase 0-1 study. <i>BMC Palliative Care</i>, 15, 17. doi:10.1186/s12904-016-0091-x</p>		<p>ages and experience</p>		<p>but also caused them to be more cautious</p> <p>4. Established PCP relationship was a facilitator</p> <p>5. Lack of time and lack of central recording system are limiters</p>			
<p>Detering, K. M., Hancock, A. D., Reade, M. C., & Silvester, W. (2010). The impact of advance care planning on end of life care in elderly patients: Randomised controlled trial. <i>BMJ</i>, 340, c1345. doi:10.1136/bmj.c1345</p>	<p>To determine if advance care planning improves end of life care</p>	<p>309 competent medical inpatients at least 80 years old (followed for 6 months or until death)</p>	<p>Prospective RCT</p> <p>Intervention group received ACP</p> <p>*Respecting Patient Choices Model for ACP</p>	<p>1. ACP median time was 60 minutes over one-three meetings with patient and family: family presence increased likelihood of complete documentation</p> <p>2. EOL wishes known and respected 86% of patients with ACP, only 30% of control group</p> <p>3. Patient or family members with intervention were more likely to respond very satisfied to survey results</p> <p>4. Post-mortem interviews with families of intervention group had less post-traumatic stress, anxiety, and depression, and had high satisfaction with the quality of death</p>	<p>Level II</p>	<p>Excluded non-English speakers and non-competent patients, single center study</p>	<p>Yes, it shows quantitatively the value of ACP on EO</p> <p>Family presence is important</p>

<p>Dixon, J., Matosevic, T., & Knapp, M. (2015). The economic evidence for advance care planning: Systematic review of evidence. <i>Palliative Medicine</i>, 29(10), 869-884. doi:10.1177/0269216315586659</p>	<p>Review and summarize economic evidence of ACP</p>	<p>18 studies were included</p>	<p>Systematic review of qualitative studies</p>	<p>No evidence suggests that ACP is costlier than not, with several studies showing</p>	<p>Level V</p>	<p>Small number of relevant studies, no cost-effectiveness studies, heterogeneity prevents firm conclusions</p>	<p>Yes, shows the economic evidence supporting ACP</p>
<p>Evans, N., Pasman, H. R., Donker, G. A., Deliens, L., Van den Block, L., & Onwuteaka-Philipsen, B. (2014). End-of-life care in general practice: A cross-sectional, retrospective survey of 'cancer', 'organ failure' and 'old-age/dementia' patients. <i>Palliative Medicine</i>, 28(7), 965-975. doi:10.1177/0269216314526271</p>	<p>Describes and compares GP EOL care</p>	<p>63 GP who cared for 1,491 patients at the end of life</p>	<p>Cross-sectional and retrospective survey</p>	<p>Found that more ACP was initiated with patients who had cancer, including palliative care discussions. Highlight need for early advance care planning in primary care for patients that have chronic diseases, so they can live as well as possible and die with dignity.</p>	<p>Level VI</p>	<p>Dutch patients</p>	<p>Shows the difference of ACP and EOL discussions initiated by general practitioners depending on patient diagnoses.</p>

<p>Glaudemans, J. J., Moll van Charante, E. P., & Willems, D. L. (2015). Advance care planning in primary care, only for severely ill patients? A structured review. <i>Family Practice, 32</i>(1), 16-26. doi:10.1093/fampra/cmu074</p>	<p>Provides an overview of ACP in primary care.</p>	<p>Ten empirical articles met criteria of 481.</p>	<p>Structured review of qualitative studies literature review</p>	<ol style="list-style-type: none"> 1. ACP occurs most with patients with Alzheimer’s, cancer, or other terminal illness 2. Only one third of patients with non-sudden deaths had ACP. 3. ACP varies from advance directive (AD) to situational conversations, and EOL preferences 4. PCPs do not have a systematic way of delivering ACP care, difficult to know when to start. 5. Important to have follow up discussions 6. Patients felt ACP was appropriate when patients were healthy 	<p>Level V</p>	<p>Limited diversity of studies and heterogeneity of results prevent firm conclusions</p>	<p>Yes, addresses specifically evidence related in ACP in primary care</p>
<p>Holland, D. E., Vanderboom, C. E., Dose, A. M., Ingram, C. J., Delgado, A., Austin, C. M., . . . Levi, B. (2017). Nurse-led patient-centered advance care planning in primary care. <i>Journal of Hospice & Palliative Nursing, 19</i>(4), 368-375.</p>	<p>Determine feasibility and acceptability of study procedures for comparing effectiveness of 4 ACP decision aids</p>	<p>40 Community-dwelling adults with multiple chronic health conditions.</p>	<p>4-arm, prospective, comparative study design was used. Structured discussions between patients and NCCs using</p>	<ol style="list-style-type: none"> 1. Patients were agreeable to participating 2. Nurses and patients were satisfied to engage in the intervention 3. 85% completed an AD and identified a healthcare agent 	<p>Level VI</p>	<p>Small pilot study</p>	<p>Yes, shows that having nurses help facilitate ACP in primary care, with use of aids, is feasible, and within their scope.</p>

<p>doi:10.1097/njh.00000000000000358</p>			<p>1 of 4 decision aids</p>				
<p>Houben, C. H. M., Spruit, M. A., Groenen, M. T. J., Wouters, E. F. M., & Janssen, D. J. A. (2014). Efficacy of advance care planning: a systematic review and meta-analysis. <i>Journal of the American Medical Directors Association, 15</i>(7), 477-489. doi:10.1016/j.jamda.2014.01.008</p>	<p>Systematically review efficacy of ACP interventions in different adult patient populations</p>	<p>Systematic review and meta-analysis of randomized control trials</p>	<p>26,628 studies were identified from 1966-2013, quality and relevance were evaluated, 64 were reviewed in detail and 56 included in the systematic review</p>	<ol style="list-style-type: none"> 1. ACP discussions led to higher completion rate of advance directives 2. ACP communication in addition to advance directive improved alignment between patient wishes and care at the end of life, and were less likely to die in a hospital 3. Completion of advance directives was associated with less caregiver burden 4. Some studies noted that advance directive preferences may change, and therefore regular re-evaluation and changes are recommended 5. Recommended that discussions occur in regularly scheduled outpatient clinical visits when patients are not acutely ill, caution that some of these decisions may not withstand real life setting 6. While discussions do not provide symptom relief, there is no 	<p>Level I</p>	<p>Half of the included studies were “low-quality trials” since there was a lack of blinding, and several studies did not use validated tools</p>	<p>Yes, it is a high-quality study that shows the benefits of ACP</p>

				evidence that ACP increases symptoms of depression or anxiety			
Kataoka-Yahiro, M. R., Conde, F. A., Wong, R. S., Page, V., & Peller, B. (2010). Advance care planning among Asian Americans and Native Hawaiians receiving haemodialysis. <i>International Journal of Palliative Nursing</i> , 16(1), 32-40.	Determine the attitudes of death, dying, and ACP completion in AA and NH patients with CKD stage 4/5, and determine who they prefer to discuss ACP with	Convenience sample 50 participants age 30-82 from outpatient dialysis center	Descriptive, cross-sectional survey.	1. There is a need for ACP, while patients identified the need few had had discussions 2. AA and NH preferred to first discuss ACP with family before provider	Level VI	Preliminary and descriptive and population was AA and NH hemodialysis patients in Honolulu	Yes, shows the need for ACP
Nguyen, M., Chamber-Evans, J., Joubert, A., Drouin, I., & Ouellet, I. (2013). Exploring the advance care planning needs of moderately to severely ill people with COPD. <i>International Journal of Palliative Nursing</i> , 19(8), 389-395.	This study aimed to explore the perceived ACP needs of people with COPD at different illness severities and how these are met by a DVD discussing ACP.	Twelve patients were interviewed	Qualitative descriptive	1. Illness severity should not be used to determine when to begin ACP 2. Sensitivity to emotional cues of patients should be considered	Level VI	Study was conducted with COPD patients, small sample size	Yes, incorporates the TTM

<p>Nicholas, L. H., Langa, K. M., Iwashyna, T. J., & Weir, D. R. (2011). Regional variation in the association between advance directives and end-of-life Medicare expenditures. <i>JAMA</i>, 306(13), 1447-1453.</p>	<p>Examine regional variation between AD and EOL expenditures, palliative and intensive care</p>	<p>Analyzed survey and Medicare claims for 3302 participants between 1998 and 2007</p>	<p>Observational retrospective</p>	<p>1. Care limiting AD were associate with lower spending, fewer in hospital deaths, and high use of hospice care</p>	<p>Level VI</p>	<p>Limited to Medicare claims, and observational</p>	<p>Yes, patients who completed AD were less likely to die in the hospital aligning with their wishes</p>
<p>Philip, J., Gold, M., Brand, C., Douglass, J., Miller, B., & Sundararajan, V. (2012). Negotiating hope with chronic obstructive pulmonary disease patients: A qualitative study of patients and healthcare professionals. <i>Internal Medicine Journal</i>, 42(7), 816-822. doi:10.1111/j.1445-5994.2011.02641.x</p>	<p>Explore the views of patients with COPD and HCP, treatment preferences and information needs</p>	<p>10 in-depth semi-structured interviews</p>	<p>Qualitative descriptive study</p>	<p>1 Both providers and patients viewed discussion goals and treatment as important 2. Patients looked to providers to initiate discussions</p>	<p>Level VI</p>	<p>Limited sample size</p>	<p>Yes, shows the gap between patients desiring to discuss and conversations occurring</p>
<p>Rao, J. K., Anderson, L. A., Lin, F. C., & Laux, J. P. (2014). Completion of advance directives among U.S. consumers. <i>American Journal of Preventative Medicine</i>, 46(1), 65-70.</p>	<p>Analyze adults who do and do not have AD</p>	<p>7946 participants through survey nationwide</p>	<p>Descriptive study</p>	<p>1. 26.3% of respondents had an AD 2. Most frequent reason for not having AD was lack of awareness 3. AD associated with higher education, older age, higher</p>	<p>Level VI</p>		<p>Yes, study examines rate of AD nationally, and reasons why individuals do not have them</p>

doi:10.1016/j.amepre.2013.09.008				income, chronic disease, and regular source of care.			
Scott, I. A., Rajakaruna, N., Shah, D., Miller, L., Reymond, E., & Daly, M. (2015). Normalising advance care planning in a general medicine service of a tertiary hospital: An exploratory study. <i>Australian Health Review, 40</i> , 391-398. doi:10.1071/AH15068	Develop, implement, and explore effects of ACP in hospital setting	Chart review, with 166 pre, and 215 post	Before-after explanatory mixed-methods analysis	1. 75% of eligible patients chose to participate in ACP, and half completed AD	Level VI	Explanatory method, no control group Inpatient setting	Yes, shows readiness of patients to engage in ACP
Sudore, R. L., Boscardin, J., Feuz, M. A., McMahan, R. D., Katen, M. T., & Barnes, D. E. (2017). Effect of the PREPARE website vs an easy-to-read advance directive on advance care planning documentation and engagement among veterans: A randomized clinical trial. <i>JAMA Internal Medicine, 177</i> (8), 1102-1109. doi:10.1001/jamainternmed.2017.1607	Compare efficacy of interactive PREPARE website with an easy to read AD to increasing planning documentation	414 participants, mean age was 71 years old, at least 2 chronic or serious conditions	Randomized control trial	1. ACP tools can increase documentation 25-35% without a clinician involved 2. PREPARE arm of study led to more documentation after 6 months than easy to read AD alone 3. Both tools were user friendly	Level II	Study occurred in California and similar tools are not available	Yes, provides tested tools for ACP

<p>Tung, E. E., & North, F. (2009). Advance care planning in the primary care setting: A comparison of attending staff and resident barriers. <i>American Journal of Hospice & Palliative Medicine</i>, 26(6). doi:10.1177/1049909109341871</p>	<p>Explore provider and resident physician experience with ACP, and identifying barriers</p>	<p>94 PCPs, with average lengths of practice 17.25 years</p>	<p>Descriptive study</p>	<p>1. Providers were more likely to discuss ACP if it was initiated by the patient’s family member or a change in health status 2. System based barriers were a major obstacle for ACP</p>	<p>Level VI</p>	<p>Limited by study design</p>	<p>Yes, helps identify and address barriers to ACP</p>
<p>Wilson, C. J., Newman, J., Tapper, S., Lai, S., Cheng, P. H., Wu, F. M., & Tai-Seale, M. (2013). Multiple locations of advance care planning documentation in an electronic health record: Are they easy to find? <i>Journal of Palliative Medicine</i>, 16(9), 1089-1094. doi:10.1089/jpm.2012.0472</p>	<p>Identify location of ACP documentation in EHR</p>	<p>30, 566 charts reviewed</p>	<p>Retrospective review</p>	<p>1. Half of patients over 65 had at least one documented ACP discussion 2. Increased likelihood of scanned documentation with age, gender, race, illness and when the provider started at the practice</p>	<p>Level VI</p>	<p>Single site study</p>	<p>Yes, shows the difficulties in locating ACP discussion documentation</p>

Appendix B

Institutional Review Board Approval Documentation

Liberty's Institutional Review Board Approval

LIBERTY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

April 6, 2018

Nicole Coffey
IRB Application 3213: Increasing Advance Care Planning in the Primary Care Setting

Dear Nicole Coffey,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your research with the data safeguarding methods mentioned in your IRB application.

Your study does not classify as human subjects research because evidence-based practice projects are considered quality improvement activities, which are not considered "research" according to 45 CFR 46.102(d).

Please note that this decision only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued non-human subjects research status. You may report these changes by submitting a new application to the IRB and referencing the above IRB Application number.

If you have any questions about this determination or need assistance in identifying whether possible changes to your protocol would change your application's status, please email us at

[REDACTED]

Sincerely,

[REDACTED]

Administrative Chair of Institutional Research
The Graduate School

LIBERTY
UNIVERSITY.

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Healthcare Organization’s Institutional Review Board Approval

IRB
Appendix H

_____ Institutional Review Board
EXEMPT RESEARCH CHECKLIST
Version 3, 21APR2015

RECEIVED
4/10/18

Central IRB #: _____ IRB of Record _____ Date: April 10, 2018

Facility: CMG Danville

Principal Investigator: Nicole M. Coffey

Email address: _____

Phone number: _____

EXEMPT
Date: 4-17-18

Title of Research Project/Study Title: Increasing Advance Care Planning in the Primary Care Setting

Attach documents related to the study.

Checklist Statements	True	Not True
Category 1 – For Educational Settings		
1. The research will only be conducted in established or commonly-accepted educational settings including but not limited to schools and colleges. (May include other sites where educational activities regularly occur.)		
2. The research will involve only normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.		
3. The research will not involve individuals as participants who are known to be prisoners.		
4. The research is not subject to FDA regulations.		
Category 2 – For Educational Tests, Surveys, Interviews, Public Behavior Observation:		
5. The research will involve only the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior.		
<i>Address statement 6 only if the research will involve children as participants. If children will NOT participate, check N/A and continue with statement 7.</i>		
6. The procedures will be limited to the use of educational tests (cognitive, diagnostic, aptitude, achievement) or observation of public behavior where the investigator will NOT participate in the activities being observed.		
7. The information obtained from educational tests, survey procedures, interview procedures or observation of public behavior will be recorded in such a manner that human subjects CANNOT be identified, directly or through identifiers linked to the subjects. <i>“True” to either statement 7 or 8 will qualify for exemption provided that statements 9 and 10 are true.</i>		
8. Any disclosure of the human subjects’ responses outside the research could NOT reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, or reputation.		
9. The research will <u>not</u> involve individuals as participants who are known to be prisoners.		
10. The research is not subject to FDA regulations.		
Category 3 – For Educational Tests, Surveys, Interviews, Public Behavior Observation of Public Officials:		

11. The research will involve only the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior AND the human subjects are elected or appointed public officials or candidates for public office. (Applies to senior officials such as mayor or school superintendent rather than a police officer or teacher.) <i>“True” to either statement 11 or 12 will qualify for exemption provided that statements 13 and 14 are true.</i>		
12. The research will involve only the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior AND federal statute(s) require without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.		
13. The research will <u>not</u> involve individuals as participants who are known to be prisoners.		
14. The research is not subject to FDA regulations.		
Category 4 – For Existing Data, Documents and Specimens:		
15. The research will involve only the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens. (“Existing” means existing before the research is proposed to the IRB to determine whether the research is exempt. All materials to be reviewed currently exist at the time of this exemption request.)		x (retrospective chart review will look at thirty days before and after intervention)
16. The sources of the existing data, documents, records or specimens are publicly available OR the information will be recorded by the investigator in such a manner that participants cannot be readily identified either directly or through identifiers (such as a code) linked to them.	x	
17. The research will <u>not</u> involve individuals as participants who are known to be prisoners.	x	
18. The research is not subject to FDA regulations.	x	
Category 5 – For Public Benefit or Service Programs (Federal):		
19. The project is a research or demonstration project conducted by or subject to the approval of a (federal) Department or Agency head and which is designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those public benefit or service programs.		
20. The research will <u>not</u> involve individuals as participants who are known to be prisoners.		
21. The research is not subject to FDA regulations.		
22. The program under study delivers a public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service (e.g., social, supportive, or nutrition services as provided under the Older Americans Act).		
23. The research or demonstration project will be conducted pursuant to specific federal statutory authority.		
24. There is no statutory requirement that the project be reviewed by an IRB.		
25. The project does not involve significant physical invasions or intrusions upon the privacy of participants.		
26. The exemption has authorization or concurrence by the funding agency.		
Category 6 – For Taste and Food Quality and Consumer Acceptance Studies:		
27. The research involved only a taste and food quality evaluations or a food consumer acceptance study in which (i) wholesome foods without additives will be consumed OR (ii) food will be consumed that contains a food ingredient, agricultural chemical or environmental contaminant that is at or below the level		

found to be safe by the Food and Drug Administration or is approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.		
28. The research will <u>not</u> involve individuals as participants who are known to be prisoners.		
Emergency Use of an Unapproved Test Article (i.e., a drug, device or biologic that is not FDA-Approved)		
The activity involves emergency use of an investigational drug, device or biologic. Such an activity is not exempt from IRB review. However, this emergency use may occur prior to IRB review and approval (see Category A and B in the Emergency Use Policy for details.) Note that such an emergency use must be reported to the IRB within five business days.		
The activity does not meet with DHHS definition of "research."		
Criteria that must be met for the research to be determined to be consistent with IRB ethical standards		
The research holds out no more than minimal risk to subjects.	x	
Selection of subjects is equitable.	x	
If there is recording of identifiable information, there are adequate provisions to maintain the confidentiality of the data.	x	
If there are interactions with subjects: There will be a consent process (and maybe some type of documentation) that will disclose such information as: <ul style="list-style-type: none"> • That the activities involve research. • The procedures to be performed. • That participation is voluntary. • Name and contact information for the investigator. 	x	
There are adequate provisions to maintain the privacy interests of subjects.	x	

Signature of Principal Investigator: Nicole Coffey
 Typing my name on the line above constitutes an electronic signature.

Printed Name Nicole Coffey

Date April 10, 2018

FOR THE IRB REVIEWER ONLY:

Is the activity exempt? YES NO

Does the research meet the standards of ethical conduct? YES NO

Which exemption category or categories apply to the activity? 4

Approved by IRB (date): 4/12/2018

Signature of IRB Reviewer: [Redacted Signature]
 Typing my name on the line above constitutes an electronic signature.

Printed Name [Redacted Name]

Date 4/12/2018

Approval from Organization's Nursing Research Council

From: [REDACTED]
Sent: Saturday, April 14, 2018 10:10 PM
To: Nicole Coffey
Cc: [REDACTED] NRCProposals
Subject: feedback on your DNP project

Hi Nicole,

Thanks for sharing your DNP project with NRC. Your project is approved and should move forward to Centra's IRB.

Recommendations:

Send NRC results of your study

Share results at [REDACTED] as a podium presenter (cc'd [REDACTED] who will be in touch)

Share results and untapped revenue with [REDACTED] (or have your physician champion do so).

You did an amazing job with this – hope the remaining time on your DNP goes well. Thanks again for coming.

[REDACTED], DNP, NEA-BC, RN-BC
VP of Nursing for Mental Health, Senior Care, and Rehab
[REDACTED] Lynchburg, VA

Office (VBH admin): [REDACTED]

Cell: [REDACTED]
[REDACTED]

Electronic Privacy Notice. This e-mail, and any attachments, contains information that is, or may be, covered by electronic communications privacy laws, and is also confidential and proprietary in nature. If you are not the intended recipient, please be advised that you are legally prohibited from retaining, using, copying, distributing, or otherwise disclosing this information in any manner. Instead, please reply to the sender that you have received this communication in error, and then immediately delete it. Thank you in advance for your cooperation.

Appendix C

CITI Certificate



Completion Date 08-Dec-2015
Expiration Date 07-Dec-2018
Record ID [REDACTED]

This is to certify that:

Nicole Coffey

Has completed the following CITI Program course:

Human subject - Basic (Curriculum Group)
Nursing (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Liberty University



Verify at www.citiprogram.org/verify/?w6835a489-9d7f-4f92-8969-5f96adba6907-17533139

Appendix D

Letter of Support from Organization



[Redacted]

[Redacted]

Phone: [Redacted]
Fax: [Redacted]

March 2, 2018

To Whom It May Concern:

Nicole Coffey will be completing her DNP Scholarly Project: Increasing Advance Care Planning in the Primary Care Setting at our office. Completion of this project will include a random chart review.

Please grant Nicole the necessary privileges to move forward.

Sincerely,

[Redacted Signature]

Regional Medical Director



Appendix E

Permission to Use Tools/Models

The Iowa Model Revised Permission

[REDACTED] - University of Iowa Hospitals and Clinics Inbox - Liberty Nicole October 31, 2017 at 12:59 PM 

Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care

To: Nicole Coffey,

Reply-To: **[REDACTED] - University of Iowa Hospitals and Clinics**

You have permission, as requested today, to review and/or reproduce *The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care*. Click the link below to open.

[The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care](#)

Copyright is retained by University of Iowa Hospitals and Clinics. **Permission is not granted for placing on the internet.**

Citation: Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. *Worldviews on Evidence-Based Nursing*, 14(3), 175-182. doi:10.1111/wvn.12223

In written material, please add the following statement:

Used/reprinted with permission from the University of Iowa Hospitals and Clinics, copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics at 319-384-9098.

Please contact UIHCNursingResearchandEBP@uiowa.edu or 319-384-9098 with questions.

Transtheoretical Model of Behavior Change Permission

[REDACTED] 8:53 AM JP

RE: Permission to use Transtheoretical Model of Change
To: Nicole Coffey

Hi Nicole:

You certainly have my permission. Additionally, our measures, scoring and related articles are available on our website: [REDACTED]

Good luck with your important study.

James

[See More from Nicole Coffey](#)

Found in Sent - Liberty Nicole Mailbox

Nicole Coffey Yesterday at 9:53 AM NC

Permission to use Transtheoretical Model of Change
To: [REDACTED]

Hello [REDACTED]

My name is Nicole Coffey, and I am currently in the last year of my Doctorate of Nursing Practice/Family Nurse Practitioner program at Liberty University. I am completing my scholarly project about increasing advance care planning in the primary care setting, and I believe your Transtheoretical Model of Behavior Change will help providers understand how patients make changes and become ready to discuss advance care planning. Can I obtain permission to use your model in educating providers during my project? In my published scholarly project I would cite the Transtheoretical Model of Behavior Change, but will not reproduce it.

Thank you so much,
Nicole Coffey
[REDACTED]

Permission to Use Education Material from Center to Advance Palliative Care

From: [REDACTED]
Sent: Friday, February 23, 2018 9:20 AM
To: Nicole Coffey
Cc: [REDACTED]
Subject: Question about permission to use training materials: [REDACTED]

[External Sender – Do not click links or download attachments unless you know the content is safe]

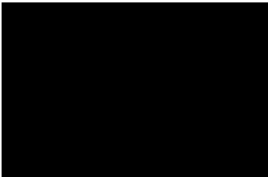
Dear Nicole,

Thank you for your question! We're pleased that you find CAPC training materials and tools helpful. You can absolutely use any documents in the website without specific permission and you can include them in your project with citations. As you indicated the courses themselves are available to anyone in your organization, since you have an active organizational membership.

Good luck and please don't hesitate to reach out with additional questions or requests.

Sincerely,

[REDACTED]
Member Relationship Manager



To whom it may concern,
I am a Doctorate of Nursing Practice student working on my scholarly project related to increasing advance care planning in the primary care setting. I would like to use the communication module on advance care planning to increase skills and awareness for providers within Centra (who already have access to your site through the organization). I am seeking permission to print the documents "Billing the Physician Fee Schedule for Advance Care Planning Services" and the "Key Takeaways" to provide to the clinicians who are completing the educational module. Also, I would like permission to include the "Communication Phrases in Palliative Care- Advance Care Planning" within my educational training PowerPoint. I will cite all of the material, and I will not publish any of the content with my scholarly project.
Can I receive permission to use these materials?
Thank you so much,
Nicole Coffey

Electronic Privacy Notice. This e-mail, and any attachments, contains information that is, or may be, covered by electronic communications privacy laws, and is also confidential and proprietary in nature. If you are not the intended recipient, please be advised that you are legally prohibited from retaining, using, copying, distributing, or otherwise disclosing this information in any manner. Instead, please reply to the sender that you have received this communication in error, and then immediately delete it. Thank you in advance for your cooperation.

Appendix F

Participant Consent Template

CONSENT FORM

Increasing Advance Care Planning in the Primary Care Setting
Nicole Coffey
Liberty University
School of Nursing

You are invited to be in an evidence base practice project evaluating if increasing primary care provider awareness and education of advance care planning increases the rate of advance care planning in primary care. You were selected as a possible participant because you are involved in providing primary care service to patients 65-90 years old. Please read this form and ask any questions you may have before agreeing to be in the project.

Nicole Coffey, a student and doctoral candidate in School of Nursing at Liberty University, is conducting this project.

Background Information: The purpose of this evidence-based practice project is to increase advance care planning in a primary care office by educating providers and raising awareness of the importance of advance care planning. Through increasing advance care planning in the primary care setting, the aim is to improve adherence to patient wishes at the end-of-life and secondarily minimize the emotional burden on families and the financial burden on the overall health care system.

Procedures: If you agree to be in this project, I would ask you to do the following things:

1. Complete a self-paced online training module related to advance care planning, approximately thirty minutes
2. Participate in a thirty-minute presentation about advance care planning.

Risks: The risks involved in this project are minimal, which means they are equal to the risks you would encounter in everyday life.

Benefits: The direct benefits participants should expect to receive from taking part in this project are possibly increased knowledge related to initiating advance care planning.

Compensation: Lunch will be provided to participants during the educational training session, with a maximum value of \$10 per participant.

Confidentiality: The records of this project will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Project records will be stored securely, and only the project leader will have access to the records.

- Data will be stored on a password locked computer only accessible by the project leader and may be used in future presentations. After three years, all electronic records will be permanently deleted.

Voluntary Nature of the Project: Participation in this project is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University or Centra Health. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

How to Withdraw from the Project: If you choose to withdraw from the project, please inform the project leader via the contact information provided below.

Contacts and Questions: The project leader conducting this project is Nicole Coffey. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [REDACTED]. You may also contact the project leader's faculty chair, Sharon Kopsis, at [REDACTED].

If you have any questions or concerns regarding this project and would like to talk to someone other than the project leader, **you are encouraged** to contact the Institutional Review Board,

[REDACTED] or email at [REDACTED]

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the project.

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT.)