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Increasing Healthcare Providers' Documentation of Advance Directives in a Primary
Care Setting

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August 4, 2016

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Table of Contents

List of Tables.....	iv
Abstract.....	1
Background.....	2
Methods	4
Results.....	7
Discussion.....	9
Implications for Practice.....	12
Limitations	12
Conclusion	13
Appendix A: Chart Review Tool	14
Appendix B: Survey Questionnaire	15
References.....	17

INCREASING AD DOCUMENTATION

List of Tables

Table 1: Patient Demographics.....	20
Table 2: Survey Responses.....	21
Table 3: Survey Open-Ended Questions Themes.....	22
Table 4: Focus Group Themes.....	23

INCREASING AD DOCUMENTATION

Abstract

Background: Advance directives (ADs) are a proactive, patient-centered tool to facilitate communication about end-of-life wishes between patients, family members, and healthcare providers. Increased importance on ADs is now emphasized in primary care settings; however, findings from recent studies indicate poor documentation of AD discussions or decisions in primary care.

Purpose: To assess current AD documentation practices in an internal medicine primary care department and to explore provider perceptions of facilitators and barriers for discussion and documentation of end-of-life preferences.

Methods: This descriptive study was conducted in three phases: 1) assessment of current state of AD documentation by retrospective chart review of 150 random charts of patients who presented for routine visits from June 1, 2014 to September 30, 2015; 2) anonymous electronic provider survey assessing provider's facilitators and barriers to discussion and documentation of ADs; and 3) provider focus group exploring facilitators and barriers of AD discussion and documentation and potential solutions to increase AD documentation in clinic.

Results: Only two out of 150 charts had AD documentation and both visits were Annual Wellness Visits. Providers' perceived barriers to AD discussion and documentation included time, lack of urgency and difficulty finding a place to document AD discussion. The key facilitator included the option of Annual Wellness Visits for patients 65 years and older.

Recommendations: Recommendations to improve AD documentation include three strategies: increase awareness of ADs among providers, utilize a standardized AD patient education tool, and encourage patient participation in Annual Wellness Visits.

INCREASING AD DOCUMENTATION

Increasing Healthcare Providers' Documentation of Advance Directives in a Primary Care Setting

An advance directive (AD) is a proactive, legal document specifying end-of-life preferences for patients in situations when they no longer have decision-making capacity (National Quality Forum, 2015; Spoelhof & Elliott, 2012). An AD, which is part of advance care planning for end-of-life care, is a valuable communication tool used by patients, their family members, and the health care team (Spoelhof & Elliott, 2012). It is comprised of two key components: a living will, in which patients specify treatments desired at the end of life, and a durable power of attorney, also known as a health care surrogate, detailing who makes decisions for the patient who does not have decision-making capacity (Hickman & Pinto, 2014; Spoelhof & Elliott, 2012).

ADs provide patient-centered care by guiding providers and patient-determined surrogates during emergent situations or when the end of life is near (Hickman & Pinto, 2014; Nelson & Nelson, 2014). ADs help to alleviate stress for patients and families and allow patients to maintain their dignity by specifying undesired end-of-life treatments (Hickman & Pinto, 2014; Nelson & Nelson, 2014). ADs have the secondary benefit of decreasing healthcare costs by avoiding unnecessary procedures in acute and ambulatory care settings (Nicholas, Langa, Iwashyna, & Weir, 2011).

The National Quality Forum (NQF), a national organization which drives patient quality and safety standards, placed increased emphasis on AD discussion and documentation in primary care by releasing standards in 2012 for providers to annually discuss ADs with patients 65 years and older (National Quality Forum, 2015). Beginning in 2016, the Centers for Medicare and Medicaid (CMS) will reimburse providers who discuss ADs with patients that have Medicare

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parts B and C during Annual Wellness Visits (AWVs) (Centers for Medicare and Medicaid, 2015). The Patient Centered Medical Home certification also includes AD documentation as an optional element (National Committee for Quality Assurance, 2014). These standards provide incentives for providers to discuss ADs in primary care and update a patient's status annually as proactive measures.

Although the NQF recommends that AD discussions occur annually with patients, AD documentation rates in primary care vary from 0% (Hayek et al., 2014) to 44% (Wheatley & Huntington, 2012). Reasons providers are not documenting AD preferences in primary care include perceived lack of comfort with and time for AD discussion (Dube, McCarron, & Nannini, 2015; Snyder, Hazelett, Allen, & Radwany, 2013; Spoelhof & Elliott, 2012), lack of urgency to initiate the discussion (Snyder et al., 2013; Spoelhof & Elliott, 2012), and lack of education about how and when to have the conversation (Snyder et al., 2013).

Because of the impact on a patient's end-of-life care, there is a need to decrease barriers and facilitate discussion and documentation of ADs for patients, particularly for patients 65 years and older who are more likely to have functional limitations and multiple co-morbidities which may limit life-expectancy (Kahana, Dan, Kahana, & Kercher, 2004). The purpose of this study is to identify and describe provider perspectives and current practices regarding AD discussion and documentation in three primary care practices at an academic medical center in the southeastern United States. The specific aims of this investigation are 1) to describe providers' current documentation practices regarding AD discussion and 2) to identify providers' perceived facilitators and barriers to AD discussion and documentation.

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Methods

This descriptive study consists of three parts: a retrospective chart review (phase 1), a provider survey (phase 2), and a provider focus group (phase 3). All phases were conducted by the principle investigator (PI) within three primary care clinics in an academic medical center. Institutional Review Board (IRB) approval was obtained from the University of Kentucky.

Phase 1: Retrospective Chart Review

All patients 65 years and older who presented to the primary care clinics and were billed for routine visits (ICD 9 code V70.0, ICD-10 code Z00.00) from June 1, 2014 to September 30, 2015 were eligible to be included in this study. A sample size of 150 charts was chosen to ensure that the maximum margin of error for the estimate of AD documentation was less than 10%, which for this study was 8%. Data analysts from the academic medical center provided 1080 unique medical record numbers from the primary care clinics to the PI, of which 150 (13.8%) charts, 50 from each clinic, were randomly chosen for review.

A chart audit tool (Appendix A) was created for this study by the PI. Data obtained from the medical records included age, gender, race, primary insurance type, previous AD documentation, AD documentation during the current routine visit, and AD education provided during the current visit. There are two possible locations of AD documentation in the current electronic medical record (EMR) template: one is the patient information/demographic section and the other is in the patient counseling section within the provider note.

If a patient had more than one wellness visit during the specified time frame, the most recent visit was used for the audit tool, although other patient visits that met the criteria were scanned for previous AD documentation. If a patient did not have a routine wellness visit

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specifically labeled during the chart review time frame, then the PI reviewed all visits that met the time-frame criteria and reviewed for AD documentation.

After data from the 150 charts was compiled, it was entered into Statistical Package for the Social Sciences (SPSS) version 22 (SPSS Inc., 2013) for analysis. The chi-squared test of association was used to determine the differences in patient demographics between the three clinics. Analysis of variance (ANOVA) was conducted to determine the differences in patients' ages between clinics. Frequencies determined the number of ADs previously documented, AD documentation during the current visit, and AD education provided during the current visit.

Phase 2: Provider Survey

All providers within the department who treat patients 65 years and older (N=28) were invited to participate in the survey and the focus group. Only internal medicine providers such as Physician Assistants (PAs), Nurse Practitioners (NPs), or non-resident physicians—Doctors of Medicine (MDs) or Doctors of Osteopathic Medicine (DOs)—were included in the survey. The PI initially contacted the providers during a routine faculty meeting to introduce the project and invite providers to participate and support the project. Providers were sent an e-mail with the consent documents and a link to the survey in REDCap, which is a secure web-based survey tool (Harris et al., 2009). Each survey contained a cover letter stating that voluntary completion of the survey indicates consent. Providers were given two weeks to complete the survey, and one reminder was sent via e-mail after the first week. All responses were anonymous.

The AD survey used in this study was adapted from a survey developed by Snyder and colleagues (Snyder et al., 2013) for a study of internal and family medicine MDs and DOs practicing within primary care practices in Ohio. The original survey had 29 questions and included items related to primary care knowledge, attitudes, experiences, utilization of advance

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care planning, palliative care, and hospice care. The knowledge and attitude section of the original survey (questions 1–12) had a Cronbach's alpha of 0.68. The adapted survey (Appendix B) was modified to omit questions specific to palliative care and hospice because the current investigation focused on discussion and documentation of AD status for healthy, non-terminally ill patients.

The abridged survey had 13 items, including seven Likert-style items related to knowledge, attitudes, and experience of ADs with responses ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). After the knowledge and attitudes section, two percentage questions to ascertain perceived need for AD discussion and four open-ended questions were asked. Open-ended questions asked for provider opinions about facilitators for AD discussion, barriers for AD documentation, and recommendations and potential opportunities to improve AD discussion and documentation.

Survey responses were analyzed in SPSS (SPSS Inc., 2013) for frequency distributions. Open-ended questions were reviewed by the PI and categorized by themes (Table 3).

Phase 3: Provider Focus Group

All providers within the department who treat patients 65 years and older (N=28) were invited to participate in the focus group. Only non-resident internal medicine providers (MDs, DOs, PAs, and NPs), were included in the focus group. The PI invited providers to participate in the focus group during a faculty meeting via an e-mail from the PI and via a flyer in the clinic. The focus group occurred during normal clinic hours during a lunch break with food provided.

At the beginning of the focus group, informed consent was obtained from all participants. Data from the previous phases was reviewed with the participants. Providers were then asked the following questions: 1) What facilitators and barriers do you find as providers which affect your

INCREASING AD DOCUMENTATION

discussion of ADs with patients and 2) What facilitators and barriers do you find within the clinics which affect your documentation of ADs with patients? The PI wrote anonymous notes on a password-protected personal computer throughout the meeting. The results from this focus group are included as qualitative data in the final results of the study, but no data was linked to individual providers.

Results

Phase 1: Chart Review

Patient demographics. The final chart review demographics are included in Table 1. The majority of the sample was female, Caucasian, and had Medicare as their primary insurance. There were no significant differences between clinic groups across demographics.

AD documentation findings. AD documentation was rare among all three clinics. No ADs were charted in the demographics section, and only two charts of the 150 charts reviewed (1.3%) had AD documentation in the provider note. Of the two visits with AD documentation, both were specifically labeled as AWVs and occurred in separate clinics. Moreover, these were the only two AWVs found among all of the charts reviewed and did not have another AWV documented within the specified time frame. AD patient education was not documented by providers on any chart.

Phase 2: Provider Survey

There are a total 28 non-resident providers (non-resident MD and DO faculty, PAs, and NP) in the department. Of these 28, 12 completed the survey for a total participation rate of 42%.

Survey data are reported in Table 2. Overall, providers felt knowing a patient's wishes for their goals of care were important and they were comfortable having AD discussions;

INCREASING AD DOCUMENTATION

however, they felt time was a major barrier to discussion and documentation. Providers also expressed a low sense of urgency with AD discussions, and indicated they discussed ADs less than 25% of the time with patients who had a progressive, life-limiting disease. While providers understood the value of ADs, they were not proactive with the AD discussions.

The findings from the open-ended questions portion of the provider survey are displayed in Table 3. Not all survey respondents answered the open-ended questions so the number of respondents to the question is displayed with the percent of providers who identified with the theme of the response. All respondents agreed time was a barrier to documentation. Providers felt using ancillary staff was a facilitator for AD discussion and documentation but time constraints limited the staff's potential opportunity to discuss ADs with patients. Interestingly, one provider expressed that a facilitator was AD patient education material that already existed in the clinic while another provider thought there was no AD education available.

Phase 3: Provider Focus Group

Six of the 28 non-resident providers in the department, or 21%, participated in the focus group. All results from the focus group were reviewed with participants at the conclusion of the focus group (Table 4).

Many solutions were discussed to address the lack of AD discussion and documentation. The focus group affirmed the survey findings that ADs are important for primary care and that the group feels comfortable having AD discussions. The group recommended identification and selection of standardized patient education tool to facilitate effective discussion about ADs. They also expressed the need for training to know where to document ADs in the EMR.

The focus group unanimously agreed AWWs are an ideal solution for patients 65 years and older since additional time is available to discuss patient wishes, standardized patient

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education can be discussed during these one-hour visits, and AD documentation is included in this clinic's AWW template. Although AWWs are already being performed by a pharmacist at these clinics, provider time is saved because they do not need to extensively review what an AD is and a patient's risk factors. Depending on the patient and if an AD has been made, providers can document a patient's preferences at the next follow-up visit or providers can annually review a patient's preferences. The focus group participants recommended training all providers about the importance of AD discussions, resources to facilitate discussions, where to document AD discussions, scanning a patient's current AD into the EMR, and using standardized patient education materials for AD discussions.

Discussion

This descriptive study builds upon prior studies concerning ADs in primary care practices (Dube et al., 2015; Hayek et al., 2014; Snyder et al., 2013; Wheatley & Huntington, 2012) and further demonstrates the need for improved AD discussion and documentation in primary care settings. The findings from this study are consistent with previous studies where time was found as the most significant barrier (Dube et al., 2015; Snyder et al., 2013), in addition to lack of provider knowledge about where to document AD discussions in the EMR (Dube et al., 2015; Wilson et al., 2013).

Increasing provider awareness of the importance of AD discussion and documentation and comfort with when and how to do it is necessary to ensure that AD discussions are occurring and then documented. AD discussions should occur annually with all patients 65 years and older and preferences should be documented and the legal AD document updated during these annual visits (National Quality Forum, 2015). Since this goal has not been met by the clinical sites that participated in this study, strategies that address these barriers of perceived lack of time and

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knowledge of documentation location need to be explored. One effective strategy is the AWW because this 60-minute visit allows more time for patients to ask questions about ADs and AD documentation is included in the template used by the clinics. The AWW is a comprehensive and proactive annual visit with a healthcare provider to discuss personalized prevention plans with patients (DiSantostefano, 2011). Any healthcare provider can perform an AWW, such as a MD, NP, or pharmacist. In the event someone other than the primary care provider completes the AWW, a strategy to ensure PCP awareness of the patient's wishes would need to be implemented.

The need for patient educational materials was also identified in this study. There was variation among providers regarding perceptions of what was or was not available and future work in this setting should identify what specific resources are currently available and identify standardized patient education materials that can be adopted by the clinics. One example is the 5 Wishes® program (Aging with Dignity, 2015), which is currently used in the acute care setting of this academic medical center. It is an effective, evidence-based strategy that could be adopted by this clinic to facilitate discussions regarding patient's wishes for end-of-life care. Since this program has already been adopted in this center's acute care setting, using the same program in the ambulatory care settings facilitates continuity of AD education between the two aspects of the academic medical center. Focus group participants also noted there is a notary present in the clinic who can sign the 5Wishes® packet after completion.

Although study participants noted the need for standardized education for patients, prior studies have shown education-only interventions yield little impact on AD discussion and documentation (Au et al., 2012; Hayek et al., 2014). One recent study sent AD education materials to providers via email as well as a brief AD education handout to patients prior to a

INCREASING AD DOCUMENTATION

provider visit and found that low rates of AD documentation persisted (Hayek et al., 2014). Similarly, Au and colleagues (Au et al., 2012) used AD questionnaires for patients to complete prior to a provider visit to stimulate AD discussions which also yielded limited impact on documentation. These studies demonstrate using patient or provider education alone is not enough to significantly influence AD documentation.

Other studies have targeted the EMR to affect AD documentation. Use of the EMR, while helpful, is a barrier for AD documentation in some facilities due to the potential number of places where ADs can be documented (Wilson et al., 2013). However, once providers are trained where to document AD preferences and have a reminder from the EMR for documentation, AD documentation in one setting increased by 76% (Hayek et al., 2014). One study used a multi-tiered intervention of education for patients and providers in addition to EMR reminders (Tung et al., 2011). The authors of this study noted a 17.5% increase of AD discussion and documentation when using education and the EMR reminder together on AD discussion and documentation (Tung et al., 2011). Similar strategies implemented in this study's clinic sites using standardized patient education and EMR AD training for providers may yield a similar increase in AD discussion and documentation.

The current study adds to our knowledge of the discussion and documentation of ADs in primary care. Future studies are needed within this study population to determine if the multi-tiered interventions using standardized patient education and provider EMR AD training increase the rate of AD discussion and documentation. Prospective studies are needed to determine the impact of AWWs on AD discussions and documentation and to determine if the standardized AD patient education chosen by the clinic providers increases AD discussion. If these two

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interventions do not yield an increase in AD discussion and documentation, they could explore the impact of adding an AD EMR reminder to the patient charts.

Limitations

There are several limitations inherent in this project which limits the strength of the findings. It is possible more AD discussions occurred than what appears in this study because AD documentation was measured by whether or not the appropriate box in the EMR was checked and would not have captured discussions documented in free text. There was a small overall response rate to the provider survey and focus group, 42% and 12%, respectively, which limits the generalizability of the study findings.

Implications for Practice

The value of AD discussion and documentation cannot be overstated. Although AD discussions are often overlooked in the healthy, non-terminally ill 65 years and older population, these discussions need to occur at least annually in order for this population to be prepared to have their wishes known in the event of for any emergent, traumatic situations. Primary care providers have the opportunity to assist their patient population with end-of-life concerns by ensuring patients know about and have a way to complete ADs in addition to the primary care office being cognizant about a patient's preferences. Practice recommendations include increasing awareness of the need for AD discussion and documentation, adopting a standardized education tool, such as the 5 Wishes®, and increasing provider knowledge of where to document AD discussion in the EMR template. Increased AD discussion and documentation is an essential patient-centered practice to help patients communicate end-of-life preferences with healthcare providers and their surrogates before those decisions are needed.

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Conclusion

The results of this study suggest there is a need to increase AD discussion and documentation in this primary care department through strategies that maximize facilitators and minimize barriers. Healthcare provider knowledge of AD wishes is the best practice for the patient, but these decisions may go unknown without documentation in provider notes and if the most recent version of the legal AD document is not scanned into the EMR. Minimizing the barrier of time will aid providers with discussion and documentation. Increasing patient participation in AWWs will provide additional opportunities for patients to be taught about ADs and their value for the patient and their chosen surrogate. Education is needed for providers regarding when, where, and how to document AD preferences in the EMR, and standardized education materials need to be incorporated. If healthcare providers knew this patient population's end-of-life preferences, unnecessary treatments could be avoided, health care costs could be decreased and patient dignity maintained.

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Appendix A: Chart Review Tool

Increasing Healthcare Providers Documentation of Advance Directives in a Primary Care Setting

Study Number: _____

Gender: _____

Age: _____

Race/ Ethnicity: _____

Insurance: _____

Clinic:

At the patient's well or routine visit was the following documented:

Information	Yes	No	Comments
Were advance directives previously documented?			
Was an advance directives discussion documented by provider at this visit?			
Was advance directives information provided to patient by provider at this visit?			

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Appendix B: Survey Questionnaire

All of your answers are confidential. Please answer how strongly you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Knowing a patient's wishes for their goals of care/ end of life wishes is more important for specialists and hospitalists	1	2	3	4	5
I am comfortable having advance care planning discussions in general with my patients	1	2	3	4	5
It takes too much of my time to discuss advance care planning with a patient	1	2	3	4	5
I feel comfortable communicating a prognosis to patients	1	2	3	4	5
Advance care planning is too upsetting for patients and their families	1	2	3	4	5
I believe it is the patient who should initiate discussion about advance care planning	1	2	3	4	5
In reality, advance care wishes are rarely honored	1	2	3	4	5

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I have been in clinical situations where having advance care wishes documented would have been greatly beneficial	1	2	3	4	5
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Now let us change perspectives.

About what percentage of patients in your practice have a progressive, chronic life-limiting disease?	0-25%	26-50%	51-75%	76-100%
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Of these patients, about what percentage have talked to you about advance directives?	0-25%	26-50%	51-75%	76-100%
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Please describe any facilitators you see in your clinic regarding advance directive discussion.

Please describe any barriers you face when documenting advance directives with patients.

Do you have any specific recommendations for how to make the documentation of advance directives easier?

Within your clinic, where are potential opportunities for providers and/or staff to discuss advance directives?

Thank you for your time in completing this survey.

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Table 1: Patient Demographics (all clinics combined) N=150	
Characteristic	Percent
Gender	Male: 23.3% Female: 76.7%
Age Range	65-95 years (Mean=71.19 years)
Primary Insurance	Medicare: 60% Medicaid: 9.3% Private Insurance: 19.3% Medicare supplement: 11.3%
Race	Caucasian: 70% African American: 26% Asian: 2.7% Hispanic 1.3%

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Table 2: Survey Responses Sample: N=12; Response Rate: 42% <i>Likert-1 (strongly disagree) to 5 (strongly agree)</i>	
Question	Median (IQR)
1. Knowing a patient's wishes for their goals of care/ end of life wishes is more important for specialists and hospitalists	2.0 (1.25-3.75)
*2. I am comfortable having advance care planning discussions in general with my patients	4.0 (3.25-4.75)
3. It takes too much of my time to discuss advance care planning with a patient	4.0 (2.0-4.0)
*4. I feel comfortable communicating a prognosis to patients	4.0 (3.25-5.0)
5. Advance care planning is too upsetting for patients and their families	2.0 (2.0)
6. I believe it is the patient who should initiate discussion about advance care planning	2.0 (1.25-2.0)
7. In reality, advance care wishes are rarely honored	2.0 (1.25-2.0)
*8. I have been in clinical situations where having advance care wishes documented would have been greatly beneficial	4.5 (4.0-5.0)
9. About what percentage of patients in your practice have a progressive, chronic life-limiting disease?	66.7% of respondents answered 0-25% of patients
10. Of these patients, about what percentage have talked to you about advance directives?	75% of respondents answered 0-25%
<i>Note.*These items are negative and were reverse scored compared to other items</i>	

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Table 3: Survey Open-Ended Questions Themes		
	Themes	Number of responses (%)
Facilitators for Discussion	Presence of Ancillary Staff	2 of 4 (50%)
	Prior Relationship with Patient	1 of 4 (25%)
	General AD Information Available in Clinic	1 of 4 (25%)
Barriers for Documentation	Time	6 of 6 (100%)
	No Education Available	1 of 6 (16.6%)
	Difficulty Finding Check-box for ADs in EMR	1 of 6 (16.6%)
Potential Opportunities to Discuss ADs	Using Ancillary Staff	2 of 5 (40%)
	During Annual Exams	2 of 5 (40%)
	Longer Appointment Times	1 of 5 (20%)
	During Check-in process	2 of 5 (40%)
Recommendations for Documentation	Training for Providers to Increase Knowledge of Where to Document ADs in EMR	3 of 6 (50%)
	Include AD Questions During Check-in	2 of 6 (33.3%)
	Use of Clinic Portal to Deliver Patient Education	1 of 6 (16.6%)

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Table 4: Focus Group Themes (N=6)		
	Theme	Number of responses (%)
Perceived facilitators of AD discussion	Annual Wellness Visit	6 of 6 (100%)
	Notary present in clinic	2 of 6 (33%)
Perceived barriers of AD discussion	Urgency	3 of 6 (50%)
	Legality of AD document	1 of 6 (16.6%)
Perceived facilitators of AD documentation	EMR	6 of 6 (100%)
Perceived barriers of AD documentation	Knowledge deficit of EMR	3 of 6 (50%)