Influence of Interventions/External Factors on ACP Rates of Hospitalist Providers for Inpatient Elderly Patients (65+)

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INTRODUCTION

- Advance Care Planning (ACP) is the process of identifying a patient's personal values and translating those values in writing to their healthcare providers, family members, and medical care plans (CMS.gov, 2020; Lum, et al., 2015)
- Advance care planning allows patients to communicate how they wish to receive care and designate a surrogate decision maker if they are unable to communicate their preferences due to a serious illness. (Lum et al., 2015)

Problem

- Lack of ACP can result in:
  - physical suffering of patients,
  - unwanted treatments or procedures,
  - monetary hardship for patients and families,
  - anxiety and stress for patients, families and providers.

  Back, et al. (2019); Brinkman-Stoppelenburg, et al. (2014); Goff, et al. (2019); Lakin, et al. (2019); Lum, et al. (2015); Rose, et al. (2019)
- Medicare started reimbursing for ACP services in the outpatient and inpatient setting on January 1, 2016 (Nassikas, et al., 2020).
- The hospitalist group for this project had ACP rates below their goal of 15% of all hospitalized elderly inpatients.

Aims

- Analyze interventions/external factors which may have increased ACP rates by hospitalist providers to a goal of 15% or greater, from January 1, 2016, through December 31,2021, for hospitalized, elderly (65+ years-old) inpatients.
- Analyze ACP rates that were increased and sustained for at least two quarters (quarter = one of four periods of three months each of a calendar year) from January 1, 2016, through 12/31/2021, for hospitalized, elderly inpatients.

METHODS

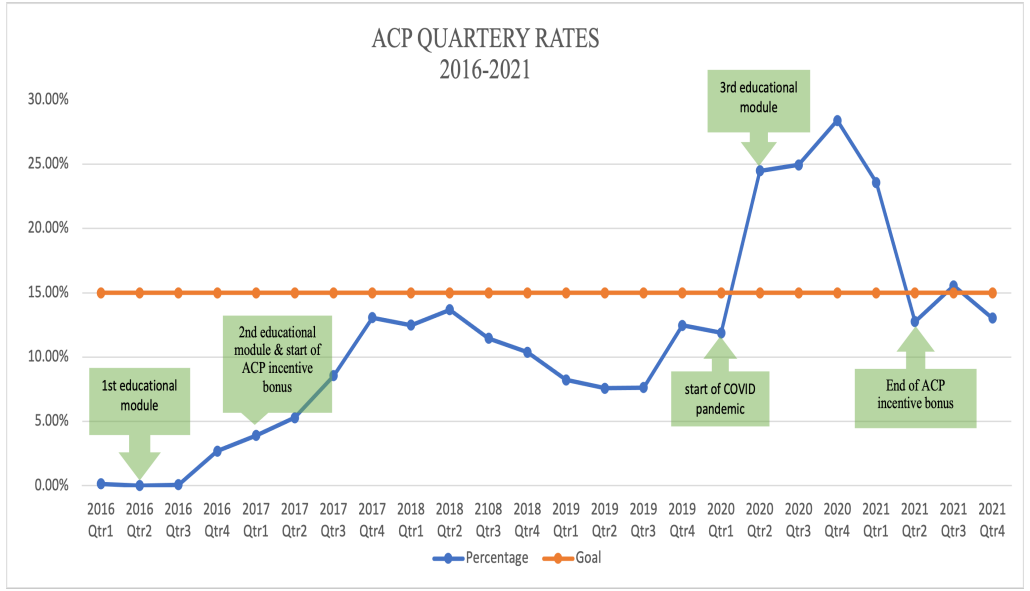
- This retrospective project analyzed ACP rates of a hospitalist group at a 400-bed community hospital in Vancouver, Washington. Quarterly ACP billing rates (only way to track ACP) for inpatients aged 65+ from January 1, 2016, through December 31, 2021, were obtained and displayed on a run chart.
- The dates of initiation of educational modules (first, second and third versions), the start of $20 bonus incentive payments, the end of the $20 bonus incentive payments for each ACP completed, and the start of the COVID-19 pandemic were marked on a run sheet to analyze the influence of these interventions/external factors.

RESULTS

- The greatest and longest sustained increase in ACP rates occurred from quarter 3 of 2016 (0.08%) to quarter 4 of 2017 (13.06%). This was an increase of 12.98% over 5 quarters. The first educational module and the second educational module were released during this time. Rates did not reach goal of 15% during this time period.
- Initiation of second educational module and start of ACP $20 bonus incentive increased ACP rates from 3.9% to 13.06% (increase of 10.82%) from first quarter of 2017 to the fourth quarter of 2017. Rates did not reach goal of 15% during this time period.
- The sharpest increase in the shortest amount of time and over the 15% ACP goal was 11.89% in quarter 1 of 2020 to 24.48% in quarter 2 of 2020. This took place at the start of the COVID-19 pandemic at this site. This was the first time that ACP rates met or exceeded goal of 15%.
- The highest ACP rate was 28.39% in quarter 4 of 2020.
- ACP rates declined from 23.57% to 12.75% from quarter 1 of 2021 to the quarter 2 of 2021 (sharpest decline of 10.82%) which is when ACP $20 bonus incentives stopped.
- The longest sustained period of increased ACP rates over the goal of 15% was from quarter 2 of 2020 (24.48%) through quarter 1 of 2021 (23.57%). Notably, the third educational module was released at this time as well as the start of the COVID-19 pandemic.

IMPLICATIONS FOR PRACTICE

- Educational modules had the greatest and longest influence to increase ACP rates at this site. Ongoing educational interventions are feasible at this site. All providers have access to an online education platform and can complete online educational modules at their convenience. Making these modules mandatory as part of onboarding for new providers and a yearly requirement for current providers may help to increase and sustain increased ACP rates (Back, et al., 2019; Goff, et al., 2019; Nassikas, et al., 2020; Palathra, et al., 2018).
- At the beginning of the COVID-19 pandemic, this site stopped elective surgeries and Hospitalist providers were furloughed due to a low patient census. This may have allowed Hospitalist providers that worked during that period to have more time with patients. This project only included ACP rates of elderly patients on Medicare. Patients hospitalized at the beginning of the pandemic at this site were elderly, which may also be the reason ACP rates for elderly patients at this site increased during this period.
- The end of the ACP incentive bonus correlates with ACP rates dropping at this facility. A small monetary incentive for each ACP completed or a stipend for completing educational modules could be implemented at this site. Studies demonstrate that financial incentives help increase and sustain ACP rates by creating long-lasting behavior changes even years after financial incentives were stopped. (Haynes, et al., 2019).



REFERENCES

SCAN ME

ADVANCE CARE PLANNING (ACP)

- Advance Care Planning is the formal process of identifying a patient's personal values and translating those values in writing to their healthcare providers, family members, and medical care plans (CMS.gov, 2020; Lum, et al., 2015)

- Advance care planning allows patients to communicate how they wish to receive care and designate a surrogate decision maker if they are unable to communicate their preferences due to a serious illness. (Lum et al., 2015)

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PROBLEM

- Lack of ACP results in:
  - physical suffering of patients,
  - unwanted treatments or procedures,
  - monetary hardship for patients and families,
  - anxiety and stress for patients, families and providers.

  —Back, et al. (2019); Brinkman-Stoppelenburg, et al. (2014); Goff, et al. (2019); Lakin, et al. (2019); Lum, et al. (2015); Rose, et al. (2019)

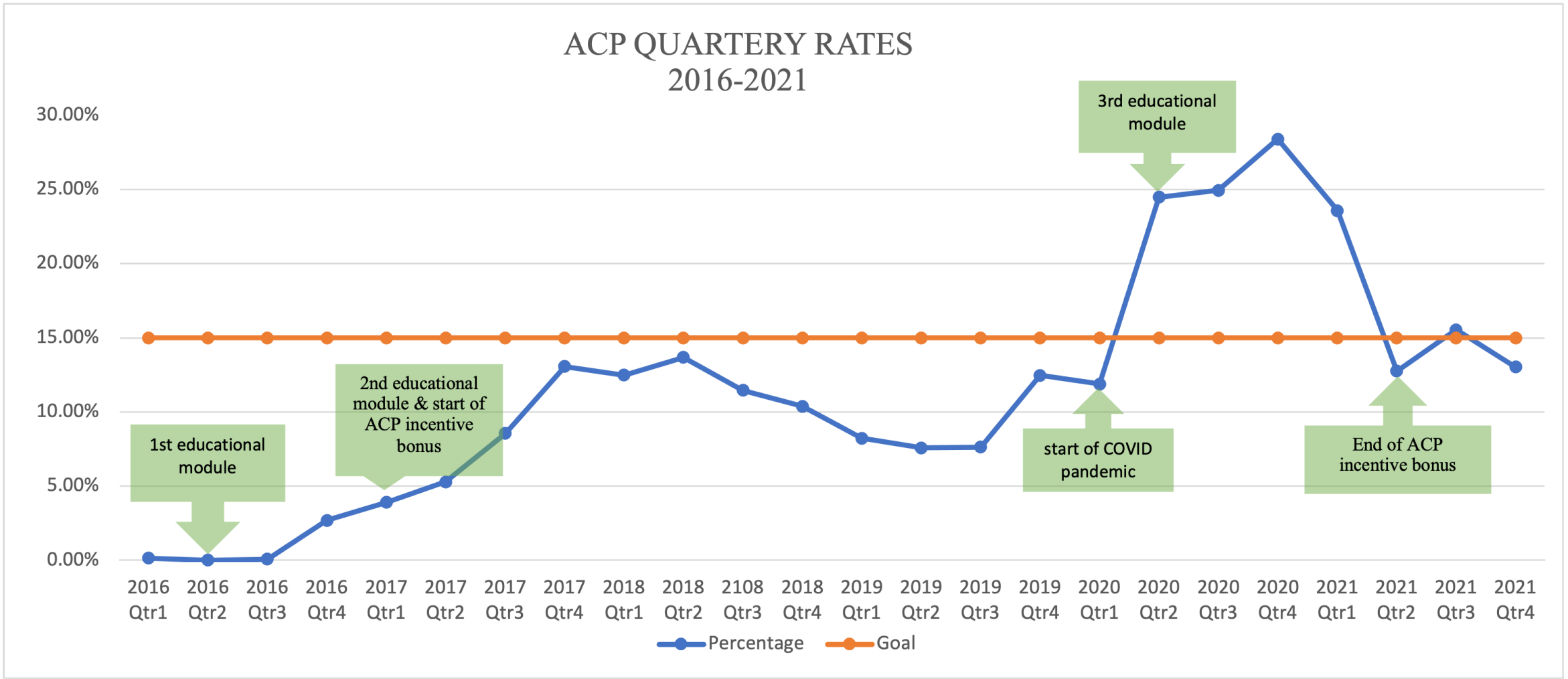
- Medicare started reimbursing for ACP services in the outpatient and inpatient setting on January 1, 2016 (Nassikas, et al., 2020).

- The hospitalist group for this project had consistently low ACP rates below goal of 15% of all hospitalized elderly inpatients.

AIMS

- Analyze interventions/external factors which may have increased ACP rates by hospitalist providers to a goal of 15% or greater, from January 1, 2016, through December 31, 2021, for hospitalized, elderly (65+ years-old) inpatients.

- Analyze ACP rates that were increased and sustained for at least two quarters (quarter = one of four periods of three months each of a calendar year) from January 1, 2016, through 12/31/2021, for hospitalized, elderly inpatients.


ACP QUARTERY RATES
2016-2021
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
1st educational module
2nd educational module & start of ACP incentive bonus
3rd educational module
start of COVID pandemic
End of ACP incentive bonus
2016 Qtr1
2016 Qtr2
2016 Qtr3
2016 Qtr4
2017 Qtr1
2017 Qtr2
2017 Qtr3
2017 Qtr4
2018 Qtr1
2018 Qtr2
2108 Qtr3
2018 Qtr4
2019 Qtr1
2019 Qtr2
2019 Qtr3
2019 Qtr4
2020 Qtr1
2020 Qtr2
2020 Qtr3
2020 Qtr4
2021 Qtr1
2021 Qtr2
2021 Qtr3
2021 Qtr4
Percentage
Goal

IMPLICATIONS FOR PRACTICE

- Educational modules had the greatest and longest influence to increase ACP rates.
  - Ongoing educational interventions are feasible at this site.
  - Online platform “Sound Institute” makes it convenient and easy for providers to complete.
  - Make modules mandatory as part of onboarding and/or yearly mandatory education for providers.
- COVID pandemic providers were furloughed in the beginning
  - Did a lower census help give providers more time with patients?
  - Were patients just sicker (higher acuity)?
  - Elderly patients were the demographic hospitalized at the start of the pandemic.

IMPLICATIONS FOR PRACTICE

- Incentive bonus of $20 may have increased ACP and stopping the incentive may have decreased ACP rates
  - Evidence demonstrates that financial incentives help increase and sustain ACP rates by creating long-lasting behavior changes even years after incentives stop (Hayes, et al., 2019).
  - Small incentives to complete educational modules on ACP or re-implementing small incentive for each ACP could be considered again to help motivate change.

PROJECT MET THE AIMS OF THE STUDY

- Analyze interventions/external factors which may have increased ACP rates by hospitalist providers to a goal of 15% or greater, from January 1, 2016, through December 31, 2021, for hospitalized, elderly (65+ years-old) inpatients.
  - The project (evidenced by the run chart) did show the influence of the educational modules, the incentive bonus and the COVID pandemic and which of these achieved goal of 15% or greater.
- Analyze ACP rates that were increased and sustained for at least two quarters from January 1, 2016, through 12/31/2021, for hospitalized, elderly inpatients.
  - The project did demonstrate several interventions/external influences that had a sustained effect on ACP rates.

STRENGTHS AND LIMITATIONS

- Strengths
  - 4 years of data for ACP rates for this site.
  - Data kept by Sound Physicians.
  - Clinical Performance Nurses (CPNs) available to help emphasize importance of ACP.
  - ACP educational modules are easily accessible and now available to everyone.
- Limitations
  - High turnover of providers at this site.
  - Small sample size (approximately 25 providers) at this site.
  - Access to data not easily accessible by everyone.
  - Limited number of providers completed educational modules.

Conclusions

- Educational modules had the greatest and longest impact to increase ACP rates.
- ACP rates were highest during the COVID-19 pandemic and the only time over goal of 15%.
- The end of the ACP $20 bonus resulted in the sharpest decline in ACP rates (10.82%).
- After ACP incentive bonus stopped, ACP rates remained below goal of 15% for 2 out of 3 quarters.

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