

IMPROVING ADVANCE CARE PLANNING: AN EDUCATIONAL
INTERVENTION FOR PRIMARY CARE PROVIDERS

by

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DEDICATION

This work is dedicated to Ross, who has always believed in my ability to change the lives of others.

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ABSTRACT

Purpose This quality improvement project aimed to provide primary care providers with the education and tools to improve their knowledge, confidence, and intention to discuss advance care planning and advance directives with their patients.

Background Advance care planning reduces unwanted medical care and patient costs, decreases the likelihood of an in-hospital death, increases end-of-life quality, and decreases hospitalizations and intensive care unit stays. Despite the positive effects of advance care planning, it is estimated that only one in three United States citizens has completed an advanced directive. Primary care providers are well suited to discuss advance care planning with patients before receiving terminal diagnoses. Primary Care Physicians, a primary care practice in Omaha, Nebraska, were not routinely completing advance care planning discussions with their patients unless prompted by the patient. A quality improvement project was planned to improve the providers' confidence, knowledge, and intent to complete advance care planning discussions with patients.

Methods An educational in-service presentation was provided to healthcare providers at Primary Care Physicians focusing on the content of advance care planning and advance directives. Additional resources for providers were provided to help start advance care planning discussions with patients. A post-survey descriptive, quantitative analysis was conducted to evaluate the effectiveness of the educational in-service.

Results A total of 5 primary care providers participated in the in-service and completed the post-survey. After participating in the in-service, 100% (n=5) participants responded either "agree" or "strongly agree" with statements that they had increased knowledge and confidence in advance

care planning and advance directives. 100% of respondents indicated they will have “more” advance care planning discussions with patients because of the educational in-service.

Conclusion The implementation of this educational in-service improved the knowledge, confidence, and intention to have advance care planning discussions for primary care providers.

Future recommendations include establishing a process to have advance care planning discussions during each annual wellness visit, providing printed-out resources for patients, updating the presentation's educational content as new evidence-based knowledge and recommendations change, and making the education a required annual review for primary care providers.

INTRODUCTION

Living out a meaningful life is a priority for most individuals. Dying a dignified death is a concept often thought about too late. Advance care planning (ACP) is a process in which a patient and healthcare provider, attorney, or other family member participates in anticipatory decision-making and plans for an individual's healthcare needs (Agarwal & Epstein, 2018; Bestvina & Polite, 2017). ACP is important to discuss with all patients, but it is essential to discuss it with patients who have life-limiting illnesses. Those patients with chronic diseases need ACP discussions because of the complexity of the healthcare decisions they will have to make as the disease progresses (Killackey et al., 2019). An advance directive (AD) is a product of the process of ACP. An AD is a clear expression of an individual's wishes for future healthcare and possibly how a patient may want to live their final portion of life (Weathers et al., 2016). Healthcare providers must address ACP soon after a life-altering diagnosis is made to facilitate planning for the future and improve the chances of a patient dying a dignified death. Primary care providers have an advantage in having ACP discussions with patients before receiving any life-limiting disease diagnoses because patients frequently seek care from them when health care concerns present. This paper described a quality improvement project that focused on conducting an educational intervention on advance care planning and advance directives in a primary care practice.

Background Knowledge and Significance

Two court cases in the 1970s and 1980s established the precedence and need for advance care planning (ACP) (Agarwal & Epstein, 2018). These cases brought about the Natural Death Act of 1976, a California state legislation allowing individuals to express their medical care

wishes if they become terminally ill or are rendered unable to make decisions (Agarwal & Epstein, 2018). The US Supreme Court approved a case in 1983 where individuals retained the right to forgo life-sustaining measures that would bring death (Agarwal & Epstein, 2018). These cases heightened awareness of ACP and completed advance directives (ADs). The main goal of ACP discussions among patients, providers, and families is ultimately documenting patients' wishes through an advanced directive so that end-of-life decision-making for the patient best aligns with what is done. These documents are known as advanced directives, which are legal documents that go into effect if you cannot speak or make decisions (National Institute of Health [NIH], 2018). Advance directives are documents that may be a living will, durable power of attorney for health care, or other ACP documents (NIH, 2018). Living wills are legal documents that communicate to your healthcare provider and family how you would want to be treated if you were dying or unable to speak for yourself in an emergency (NIH, 2018). This document may communicate if you want cardiopulmonary resuscitation (CPR), ventilator support, the long-term need for a ventilator, and artificial nutrition and hydration (NIH, 2018). A durable power of attorney for health care is another legal document that indicates someone who would make medical decisions for you if you were unable to do so (NIH, 2018). "What would I want?" is imperative when considering the end of life, but it is even more important to have patient wishes documented and known.

Life-limiting diseases are diseases that are likely unable to be cured and have great potential to limit the patient's time alive and affect their quality of life (Levoy et al., 2020). Congestive heart failure, chronic obstructive pulmonary disease, multiple sclerosis, cancer, and end-stage renal disease are all examples of life-limiting diseases. When patients are experiencing

a life-limiting disease, they are forced to consider the consequences of their illness, determine their future medical care, and identify their goals for their care (Killackey et al., 2019). The complexity of considering these things hinders them from making decisions about the quality of life they would choose or what medical measures they want. For example, 1.9 million new cancer cases will be diagnosed in 2022, approximately 5,250 new cases, and 1,670 deaths per day (American Cancer Society, 2022a). Patients with cancer need more significant participation in ACP due to the possible rapid progression of the disease and increased emphasis on cancer treatment (Buiar & Goldim, 2019). It is beneficial to introduce ACP early on in diagnosis with oncology patients and revisit the conversation throughout their cancer journey (Rodi et al., 2017). Additionally, it is estimated that in 2012 that 25.5% of US adults had two or more chronic conditions, such as chronic obstructive pulmonary disease, congestive heart failure, or diabetes, where these patients have worsened health-related quality of life, higher healthcare costs, and an increased risk of death (Boersma et al., 2020). Introducing ACP in a primary care setting would be most beneficial for these and all patients with life-limiting illnesses because ACP discussions are at a higher level of necessity once the diagnosis occurs.

ACP has many positive effects on patients and families. ACP reduces unwanted medical care and costs for oncology patients, decreases the likelihood of having an in-hospital death, increases end-of-life quality, and decreases hospitalizations and intensive care unit stays (Agarwal & Epstein, 2018; McDermott et al., 2020). Having ADs in place helps to ensure that patients' wishes are carried out and reduces family stress when surrogates are forced to make decisions (McDonald et al., 2017; McMahan et al., 2021). When an AD is in place, it also relieves stress for the patient, family members, and healthcare providers around end-of-life

discussions and allows the patient to be more engaged in end-of-life decisions (Hong et al., 2016).

Despite the positive effects of ACP, it is estimated that only one in three United States citizens has completed an advanced directive of any kind (Yadav et al., 2017). Multiple barriers exist to effectively discussing ACP in specialty and family practice settings. Advance care planning (ACP) is commonly not discussed with patients in a primary care setting. Discussions often occur when patients are chronically ill or when it is too late, leaving the family to decide for their loved ones. ACP discussions may be delayed because providers are hesitant due to their lack of knowledge, the time constraints to discuss ACP, the lack of an established time to discuss ACP freely and thoroughly with patients, and the fear that the patients may feel as if the provider is giving up on them (Bestvina & Polite, 2017; Blackwood et al., 2019; Kermel-Schiffman & Werner, 2017). Regarding the general public, there is a knowledge gap about ACP, and individuals often see it as “giving up” when a patient completes one (Cannone et al., 2019).

With the support of complementary resources, high-quality, honest discussions between providers and patients are needed for ACP to be done. (Agarwal & Epstein, 2018; McDonald et al., 2017). Evidence-based literature supports that additional education for providers increases the frequency of ACP taking place, improves the quality of ACP discussions, and improves the number of advance directives completed by patients (Berkowitz et al., 2021; Bestvina & Polite, 2017; Blackwood et al., 2019; Chan et al., 2019; Kermel-Schiffman & Werner, 2017; Miller, 2018). ACP is a dynamic and continuous conversation that should be introduced and reintroduced in a primary care setting. It should be introduced early and often revisited as patients progress through their lives. Revisiting ACP conversations may occur when a change in

health status, a new life-limiting disease is diagnosed, or when a patient or family member requests.

Methods for Advance Care Planning Improvement

Healthcare providers can improve ACP discussions and AD completion by receiving additional ACP training (Bestvina & Polite, 2017; Chan et al., 2019; Glennon et al., 2019; Kermel-Schiffman & Werner, 2017; Miller, 2018). This additional training may be an in-service, role play with a standardized patient or open discussion with peers about their ACP experiences.

The Conversations Project, an ACP toolkit for healthcare providers produced by the Institute for Healthcare Improvement (IHI), has been shown to help facilitate AD completion between patients and providers (Sorrell, 2021). There are suggestions to provide more education after providers have been practicing, but there should be a greater emphasis on ACP for all healthcare professional students (Blackwood et al., 2019).

Providing patients with electronic decision-making tools can be helpful in the completion of ADs. When patients have the Five Wishes documents embedded into their electronic health records (EHR), more ADs are completed and documented in an electronic system (Atherton, 2019). Having patients watch cardiopulmonary resuscitation (CPR) videos increases AD documentation and awareness of what CPR and advanced life support entail (Bestvina & Polite, 2017). Another avenue to increasing AD completion is providing patients with interactive decision-making tools, such as the PREPARE for Your Care program (Buiar & Goldim, 2019; Nouri et al., 2021). This program enables people to make anticipatory decisions for their care on their own time. It guides them through what it is like to prepare for the care they want for the end of their lives. The Four Conversations tool is another online decision-aide for patients to work

through and help them to discuss their wishes with their families and healthcare providers (Smith et al., 2019). This tool guides patients through opening ACP conversations with their families and healthcare providers. It gives them prompts and a way of starting the conversations.

Healthcare Provider Role

Advanced practice registered nurses (APRNs) are at the unique advantage of implementing advance directive (AD) discussions when patients are in a primary care setting (Heale et al., 2018). Introducing patients to advance care planning (ACP) discussions early and often in primary care settings benefits patients, families, and providers. Exposing patients to these discussions in primary care settings normalizes the process of ACP and having ADs readily available. Standardizing this process in a primary care setting will allow patients who receive a life-limiting or chronic diagnoses to make decisions easier when the questions come because they have had time to think about and discuss these parts of life with their families. They may be more likely to complete an AD because they do not have the pressure of navigating through a cancer diagnosis. ACP discussions with loved ones and families may open communication lines and talks about a commonly taboo topic. For providers, ACP is a low-risk, high-value intervention for patients. Introducing the topic opens communication between their patients, builds stronger rapport, and allows the provider to give holistic care.

As there is often no specification for who will discuss ACP with patients and when it will happen, APRNs are in the position to organize and establish ACP roles within practices with their leadership and holistic knowledge (Izumi, 2017). If APRNs can facilitate AD completion, more patients can live out their healthcare wishes, families can be at ease knowing their family's wishes, and we can decrease the amount of money spent on unnecessary healthcare.

Local Problem

In Omaha, Nebraska, the most populated city in Nebraska, patients have numerous choices among primary care providers. According to the United States Census Bureau (n.d.), in 2020, the estimated population of Omaha was 486,051 persons, with 66.2% of them being white and not Hispanic or Latino, 12.1% being black or African American, 14.1% Hispanic or Latino, 4% Asian, and 5% two or more races. It is estimated that 13.3% of the population of Omaha is 65 years and over (United States Census Bureau, n.d.). Primary Care Physicians is a small, independent healthcare office that serves the Omaha area. It has five primary care providers. Roughly 40% of the office's patient population are Medicare patients (G. Nelson, personal communication, June 2, 2022).

The identified stakeholders within Primary Care Physicians were the primary care providers, clinical nurse manager, medical assistants and licensed practical nurses, the patients, and the patients' families. Through my observations in this practice and discussions with a provider, it was noticed that providers were not routinely discussing advance care planning (ACP) with their patients. Often, the discussions start when a patient's life-limiting disease has begun to overcome the patient or there is a decline in the patient's overall health. This puts extensive stress on the patients, families, and providers. Providers were presented with the challenge of aiding the patient to navigate the disease while also asking what levels of care the patient would want to receive as their disease progresses.

There was a lack of consistently planned ACP discussions and AD completion, so there wasn't an established process to ensure discussions. In 2016, the Centers for Medicare and Medicaid Services (CMS) began allowing ACP discussions to be coded for reimbursement

(Garney-Huey, 2016). These discussions can occur during any face-to-face visit as an optional element of the medical wellness visit, including the Annual Wellness Visit or the Initial Preventative Physical Examination, or under Medicare Part B when not in this time frame (CMS, 2021). Some private insurers have begun following suit. Though no professional organizational guideline indicate when these conversations should be had, the American Academy of Family Physicians recognizes that there are several approaches to the conversation at different stages of life, but supports the earlier introductions of discussion, the better (Brull, 2019). Instituting ACP discussions earlier in care allows patients to contemplate what ACP truly means and what they want, and it gets patients away from thinking that ACP discussions are not end-of-life discussions (Brull, 2019).

Upon evaluation, this practice did not have a structured time or way to discuss ACP with patients. There was a flowsheet within the electronic health record where staff could ask patients about their AD status, but it was not a normal part of the intake process during a visit. The practice did not have any additional resources for the patients to evaluate on their own to begin creating an advance directive (AD). Providers also had not received any additional training about ACP from the site. In discussions with providers, there was a resounding acknowledgment that ACP was vital for patients, especially those with life-limiting illnesses. Providers identified that navigating the conversation or finding a good time to start it is challenging. This project focuses on improving ACP discussions, including confidence and knowledge of the primary care providers within Primary Care Physicians clinic.

Intended Improvement

Project Purpose

This quality improvement project aimed to provide healthcare providers with the education and tools to improve their knowledge, confidence, and intention to implement advance care planning (ACP) and advance directives (AD) discussions with patients.

Project Question

In the primary care clinic, Primary Care Physicians in Omaha, Nebraska, can the use of an educational in-service for healthcare providers about advance care planning (ACP) and advance directives (AD) improve the knowledge, confidence, and intention to have ACP discussions by primary care providers?

Project Objectives

The objective of this project was to implement an educational intervention for providers to improve their patient communication about ACP, open timely discussions about the future of their care, and enhance the knowledge, confidence, and practice intentions of ACP and AD discussion.

- Objective 1: Conduct an educational in-service for primary care providers on advance care planning discussions and advance directives.
- Objective 2: Identify strategies to introduce and conduct ACP discussions with patients and families.
- Objective 3: Provide a toolkit for primary care providers with evidence-based resources to incorporate ACP and AD discussions in their patient visits and code information for discussions.

Theoretical Framework

Theoretical frameworks guide practice and organizational changes in various ways. Adapting healthcare systems are constantly needing structured frameworks for organized change to flourish. Psychologist Kurt Lewin developed a simple theoretical framework that cultivates organized change in a system.

Lewin's Change Theory

Lewin developed a model that has shaped many theories and models of change. The three-step model, called "Lewin's Change Theory" is simplistic and a basis for various changes that have occurred in healthcare and society (Burnes, 2020; Schein, 1996). Developed in the 1930s, it was initially a framework for change geared towards making societal changes and helping resolve social conflicts, such as racism (Burnes, 2020). From it, many organizational changes have been modeled, especially in the setting of complex healthcare systems (Hussain et al., 2018). Lewin suggests that groups of individuals are influenced by restraining forces, which keep things status quo, and positive powers that allow room for change to withstand (Wojciechowski et al., 2016). This tension creates a necessary equilibrium (Burnes, 2020). So, to perpetuate change, the status quo must be broken by inhibiting restraining forces and increasing the positive forces, thus identifying a structure for planned change. Three stages characterize Lewin's change theory: unfreezing, moving, and refreezing (Schein, 1996).

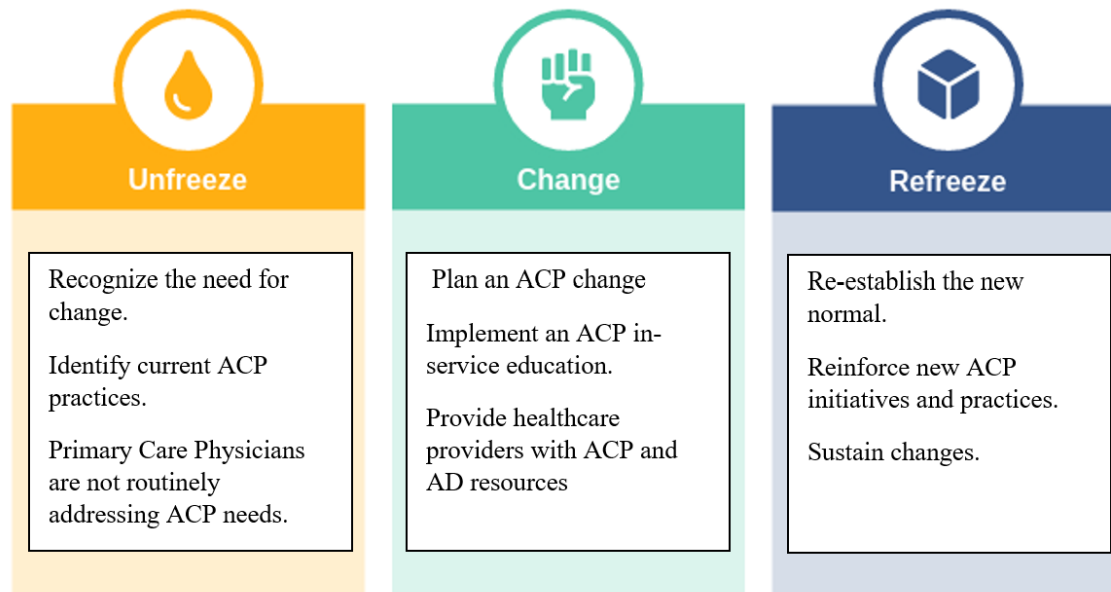
Unfreezing

The step of "unfreezing" includes allowing people to identify problems that are currently happening but, most importantly, allowing them to let go of restraining patterns that are taking place (Schein, 1996; Wojciechowski et al., 2016). Ideally, the group of individuals in a system

will conform to releasing their restraints to prepare for change. For this project, providers from Primary Care Physicians recognized that they are not routinely addressing their patients' advance care planning (ACP) needs without prompting from patients. This unfreezing was accomplished by providers discussing ACP barriers in their practice, what barriers are present when the discussion occurs, and their personal biases in ACP with their patients.

Figure 1

Lewin's Change Theory Model



(Note. This figure demonstrates Lewin's Change Theory. Adapted from *Understanding Lewin's Change Management Model*.)

Change

Lewin's "change" step includes implementing the change in the system while decreasing the restraining influences of the system at play (Wojciechowski et al., 2016). This change models a new way of doing things, re-establishing beliefs and attitudes, and moving towards a common goal of the group of individuals or systems (Burnes, 2020; Wojciechowski et al., 2016). It is also essential to identify the restraints that may inhibit the change from occurring and recognize its

benefits (Wojciechowski et al., 2016). The change included in this project is providing ACP education, resources, a structured plan to realize that patients need to have ACP discussed with them, and an opportunity to practice ACP discussions. Providers will then be able to identify the benefits of ACP discussions with patients, how the process will work within the practice, and the benefits for the patients, providers, and practice for completing ACP discussions.

Refreezing

Refreezing refers to stabilizing the new equilibrium that has been set into place (Wojciechowski et al., 2016). Its establishment becomes the new normal for the system so that the change becomes a habit and resists new restraining forces to be put upon it (Wojciechowski et al., 2016). Refreezing will occur during the ongoing integration of ACP discussions for patients, making it the standard for all patients, integrating it into the flow of an office visit in this primary care setting. Stabilizing the new equilibrium is paramount for the success of the change to withstand forces.

Literature Synthesis

Evidence Search

A literature search was conducted to promote conversations for primary care providers to have these discussions before their patients reach a life-limiting diagnosis. It aimed to explore ACP attitudes, barriers to communication, and interventions that assist providers in opening discussions with patients. PubMed and Cumulative Index of Nursing and Allied Health Literature (CINAHL) were used to conduct the literature search. The keywords “advance care planning,” “patients,” and “healthcare providers” were utilized in PubMed and CINAHL searches. The search within PubMed revealed 96 results. A search conducted within CINAHL

yielded 22 results. Inclusion criteria for articles included published within the last five years, English language, full text, original research studies, systematic reviews, or meta-analyses in peer-reviewed journals. From these searches, 20 research articles were selected for synthesis. Studies were excluded if they did not identify ACP discussion interventions for providers, ACP discussion interventions for patients, ACP barriers, research conducted in acute care settings, and any duplicates. A literature review grid can be found in Appendix H.

Comprehensive Appraisal of Evidence

Barriers to ACP Completion

Multiple barriers to completing ACP were identified. A cross-sectional survey conducted by Hobden et al. (2021) examined 104 oncology nurses' perspectives on ACP and found that nurses understood that advanced directives (ADs) aided patients and family members in making cancer care and end-of-life decisions; however there was no clear decision on who should have that conversation and at what point in their care it should start. The study found that nurses perceived that ADs made decision-making easier for families (87%) and providers (82%) and that ACP and AD discussions are the responsibility of the advanced practice provider or physician to execute (80%) (Hobden et al., 2021).

In a systematic review analyzing 37 articles, Kermel-Schiffman and Werner (2017), found that barriers to completing AD are patient-specific, time-oriented, and a lack of education among healthcare professionals. The study found that 45.9% of healthcare providers understand what "advance care planning" encompasses and what ADs entail (Kermel-Schiffman & Werner 2017). Likewise, Miller (2018) reviewed 19 studies and found that oncology, emergency, and critical care nurses had general AD knowledge (68%), but nurses that were not in these settings

had only slight to moderate confidence with ADs or felt “unprepared: to have AD conversations or answer questions. While nurses can discuss ACP, which is often part of their job, they do not feel confident in relaying AD information (Miller, 2018). And though it is part of nursing, nursing students only receive 1-1.5 hours of education about ACP in their nursing programs (Miller, 2018). Similarly, there is a lack of understanding and awareness about ACP among laypeople.

This literature synthesis revealed a lack of patient knowledge as a barrier for providers to have ACP discussions. Various barriers can be found when assessing whether patients know what ACP is and what it has to do with them. Many oncology patients perceived ACP discussions as their providers “giving up” on them; patients would instead focus on the present time or associated ADs with death (Cannone et al., 2019). These findings support primary care providers introducing these discussions early, and often, and attempting to alleviate the stigma tied to ACP.

Oncology patients and providers identified that there was a miscommunication between the two, causing a misunderstanding of patients’ disease advancement and process and that the oncology patients didn’t realize that they were at the point where they should be talking about ADs with their families and providers (Buiar & Goldim, 2019). Patients received an incorrect prediction of life expectancy after diagnosis, thus not discussing wishes with families and were more likely to receive aggressive end-of-life care (OR 2.55%, 95% CI, 1.09- 5.99, $p= 0.03$) (Buiar & Goldim, 2019). In addition, oncology patients were not talking to their families about their wishes because of their lack of comfort and understanding of ADs (Buiar & Goldim, 2019). It was found that 75% of patients preferred their provider to start ACP discussions, but only

about 5% of providers started the conversation (Buiar & Goldim, 2019). This may indicate why patients were not participating in conversations; each party was waiting for the other to bring it up first. Berkowitz et al., (2021) found that patients with cancer were less likely to have an AD than patients without cancer (53% vs. 73%; $p < .0001$). Oncology providers also find that it is challenging to support a structured time and way to discuss ACP with their patients but recognize that it is overtly necessary for them to have these discussions so they may empower their patients and encourage them to act upon their life's values and wishes (Berkowitz et al., 2021). A cross-sectional study of 705 participants the researchers found that 93% of patients with cancer discussed ACP with their family or friends and only 3.7% of the discussions occurred with their healthcare provider (Rodi et al., 2017). Often the patients, families, and providers were all waiting for the other to bring up the subject (Rodi et al., 2017). The researchers concluded that introducing ACP early and discussing it often in patients with cancer was most effective in AD completion (Rodi et al., 2017). There was also found to be a time constraint on providers. These oncology providers had office visits and, during those visits, their plans were for cancer plan of care, but they did not find that these visits provided adequate time to discuss ACP (Bestvina & Polite, 2017; Blackwood et al., 2019). Consistently through this synthesis, there was a clear need for ACP to be discussed before patients received life-altering diagnoses. Do ACP discussions lie in the hands of specialists that provide these diagnoses? Perhaps the discussion should occur well before a patient receives a cancer diagnosis or any diagnosis of a life-limiting condition.

Provider Interventions

A systematic review by Agarwal and Epstein (2018), identified that oncology nurses and nurse practitioners are crucial players in completing ACP discussions with their patients. There is a great need for high-quality, honest conversations between healthcare professionals and their patients so that ADs are completed before the progression of their disease (Agarwal & Epstein, 2018; Berkowitz et al., 2021). Also noted is that timely ACP prevents aggressive end-of-life decisions and that there needs to be a standardized time and setting for ACP discussions (Agarwal & Epstein, 2018; Berkowitz et al., 2021). In another systematic review (McMahan et al., 2021), there was a 57% improvement in ACP documentation when providers received additional training. Many providers don't feel confident in discussing ACP because of the legality involved or don't understand all of what an AD encompasses. This can be alleviated by providing education and support for oncology providers and allowing them to role-play in an educational setting (Berkowitz et al., 2021; Bestvina & Polite, 2017; Blackwood et al., 2019; Chan et al., 2019; Kermel-Schiffman & Werner, 2017; Miller, 2018).

In a randomized control trial (RCT) conducted by Goswami et al., (2021), researchers found that when providers engaged in ACP discussions in an outpatient setting, compared to providers who did not, AD completion improved (0 ADs completed before the intervention, 20 postintervention, $p < 0.0001$). Implementing additional education for healthcare students and practicing professionals are two significant interventions that increase the number and quality of ACP discussions, leading to AD completion. A systematic review by Kermel-Schiffman & Werner (2017) identified 37 articles published from 1994 to May 2016. Results supported that healthcare students benefited from professional discussions about ACP with their patients and

that more effort should be expended to educate healthcare professionals and laypeople about ACP. To support these conversations, an effective way to have ACP discussions is for providers to have a designated time to discuss them and have a structure to these conversations (Blackwood et al., 2019; Miller, 2018). The Conversation project is a kit that facilitates provider and patient discussions about ACP (Sorrell, 2018). In this literature review, providing healthcare providers with this resource improved ACP discussions and increased AD completion (Sorrell, 2018).

Patient Interventions

Introducing discussions early in outpatient settings promoting and educating patients and families is an effective way to encourage ACP discussions and increase AD completion (Glennon et al., 2019). Promoting this aspect of care and life preserves patients' wishes should be a goal of any provider. In a retrospective cohort study, McDermott et al. (2020) found that patients with ACP documents that were completed 30 or more days before death had a lower incidence of having hospitalization (OR 0.67, 95% CI 0.61-0.75), ICU admission (OR 0.71, 95% CI 0.64-0.80), or in-hospital death (OR 1.62, 95% CI 1.43-1.84). Technology mitigated ACP decision-aides have improved AD completion (Agarwal & Epstein, 2018).

Multimedia resources are constructive avenues for AD completion. Informational video aids, cardiopulmonary resuscitation videos, and online tools, such as the PREPARE for your care program, allow patients to navigate ACP independently and with their families (Agarwal & Epstein 2018; Nouri et al., 2021). In a randomized control trial by Nouri et al. (2021), cancer patients who participated in PREPARE for your care versus those who only had verbal ACP discussions had an increased incidence of AD completion ($P = .01$). Another intervention that can

aid providers in implementing ACP discussions in their practice. Providing patients with Five Wishes material improved AD completion numbers (Atherton, 2020; McMahan et al., 2021). Atherton (2021) found that conducting Project Five Wishes, which was a 30-minute presentation about ACP and AD, increased the number of ADs by 25.4% in the clinic. Multiple decision aids helped improve AD completion and promote ACP discussions. Making Your Wishes Known: Planning Your Medical Future, another decision-making tool, improved AD completion for cancer patients and was correlated with increased adherence to the patients' end-of-life wishes (Schubart et al., 2019). Four Conversations increased AD completion by 54% in patients with metastatic breast cancer than those who did not use the online decision-aide (Smith et al., 2019).

Strengths of Evidence

Many of these studies were high-quality systematic reviews. A prospective literature review by Bestvina and Polite (2017) reviewed 26 interventions for advance care planning (ACP) discussions. Of these 26, 11 articles were rated as very good. Researchers analyzed the effects of cardiopulmonary resuscitation (CPR) videos, online decision-making aids, and the pitfalls of why providers were not documenting or discussing ACP (Bestvina & Polite, 2017). Blackwood et al. (2019) is another systematic review identifying 11 articles analyzing open and closed question surveys about nurse and provider knowledge and confidence in ACP. This information is essential because it provides the perspective of healthcare professionals and provides an analysis of where healthcare professionals fall from ACP discussions. Chan et al. (2019) identified ten articles reviewing randomized controlled trials (RCTs) that analyzed instructional sessions, group discussion, role-playing, and the use of technology to educate nurses on ACP. Kermel-Schiffman and Werner (2017) reviewed articles and concluded that

healthcare professionals and laypeople need to have more education on ACP to promote advance directive (AD) completion.

As multimedia decision aids are a newer avenue for ACP awareness and promotion, there were no systematic reviews. Some robust RCTs were identified and used in literature synthesis. Nouri et al. (2021) provided a high-quality RCT that included 986 participants, with and without cancer, utilizing the PREPARE for Your Care program. Schubart et al. (2019) studied a decision-making aid: Making Your Wishes Known: Planning Your Medical Future. This RCT included 200 patients with advanced cancer (Schubart et al., 2019). Smith et al. (2019) included 252 cancer patients in their high-quality RCT evaluating the Four Conversations decision-aid.

An additional RCT directly educated nurses about AD and had them complete ADs (Glennon et al., 2019). The study found that nurses who had the education and constructed their ADs could promote ACP discussions and AD completion with patients and families compared to those who did not receive the same intervention (Glennon et al., 2019).

Weaknesses of Evidence

Many of these studies analyzed were not RCTs. Commonly they were retrospective cross-sectional analyses or qualitative studies. Many of these studies were also not specific to ACP discussion interventions in settings specific to primary care, often involving various patient populations with chronic or life-limiting diseases. Miller (2018) was an example of such. Miller examined studies involving nursing students, and nurses and their preparation for ACP discussion and education. Sorrell (2021) produced a similar review of literature that examined patient ACP conversations between families and providers and how those conversations were transmitted to patients' end-of-life care.

Gaps and Limitations

Limited studies examined providers receiving ACP training that could be found. It would be helpful to identify standardized education for healthcare professionals and different avenues for provider training that would be helpful. Specifically, no studies examined providers' ACP training and how ACP discussions occur with their patients. Identifying time and setting specific ACP discussions with patients and how those affect AD completion would be beneficial. For example, if patients received ACP discussions in a primary care setting early in their lives versus in a specialty clinic when their diseases progress to the end-of-life. There is also limited evidence of laypeople's confidence in what ACP is. Suppose people do not understand what it entails or understand that it should be a regular part of the trajectory of their lives. In that case, it is even more challenging for providers to discuss ACP and have recorded AD accomplished. There is also a lack of concrete recommendations of when or where ACP discussions should be taking place in a patient's life or disease trajectory.

It is with resounding evidence that the timing of discussing ACP with patients' needs to be standardized and, better yet, researched (Agarwal & Epstein, 2018; Berkowitz et al., 2021; Hobden et al., 2021). No portion of the literature indicated the best time to discuss ACP.

This deficit leads to ACP not being discussed. The literature has shown multiple approaches to ACP but not a standardized best practice. Some providers wait to discuss ACP until patients bring it up. Some wait until the patient receives a chronic illness diagnosis. Unfortunately, some remain until it is too late. It was never discussed with the patient. Therefore, it was never any documentation to be found, and likely, the family didn't discuss this part of life.

Healthcare providers would benefit from receiving additional ACP and AD education along with conversation-starters to aid in these ACP discussions.

METHODS

Project Design

This quality improvement (QI) project was focused on providing an educational intervention to improve the knowledge, confidence, and intent to implement advance care planning (ACP) and advance directive (AD) discussions with patients in primary care. A quantitative survey was used to evaluate effectiveness. This intervention was completed at Primary Care Physicians clinic in Omaha, Nebraska, where healthcare providers typically do not routinely engage in ACP discussions with patients unless the patient prompts them to do so.

Primary care providers are uniquely positioned to introduce and complete ACP with patients before receiving a cancer diagnosis. The primary care providers at Primary Care Physicians underwent an ACP workshop which included an in-person PowerPoint presentation and a toolkit that included conversation-starters for ACP and reimbursement information. Advanced practice nurse practitioners and physicians were the healthcare providers receiving this education.

Model for Implementation

The Institute for Healthcare Improvement (IHI) provides the Model for Improvement (MFI), which helps guide QI projects through a structured process to accelerate and continually improve changes (IHI, 2022). It is imperative to determine various components of the project to be guided clearly. The MFI has two parts to it. The first will ask, “What are we trying to

accomplish?”, “How will we know that a change is an improvement?” and “What change can we make that will result in improvement?” (IHI, 2022).

Plan-Do-Study-Act (PDSA) Cycle

Answering these questions lays the fundamental components of the project’s quality improvement, plays a crucial element for the MFI, and leads into the Plan-Do-Study-Act (PDSA) cycle (IHI, 2022). The PDSA cycle is the second part of the MFI where change is put into a real-life setting and tests how the difference is working. The PDSA cycle identifies practice improvement needs, goals, and interventions, which guides how to review the interventions to assess effectiveness (IHI, 2022). Utilizing this model guided the process of improvement for this project and continued to do so once it is done and can allow it to continue to grow in practice.

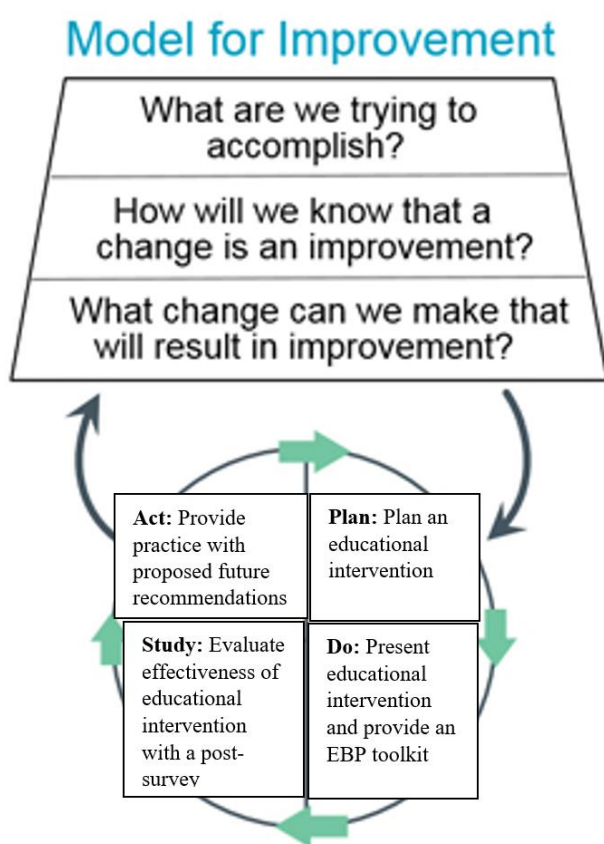
Plan

The beginning of the PDSA cycle was “plan” (IHI, 2022). This step in the PDSA cycle was where the project’s objective is established, and a plan was made to test the change (IHI, 2022). This is where team members indicate who will collect data, how it will be collected, when it will be done, and what data needs to be collected (IHI, 2022). When starting the planning process of the intervention, an observation was made at Primary Care Physicians clinic, and it was identified that there was room for improvement in the consistency in having ACP discussions with patients. Providers were not routinely completing ACP discussions with patients and families and may not be uniformly documented. An educational workshop was identified as the intervention to improve the quality of provider ACP discussions, improve the intention of having the discussions with patients, and improve provider knowledge and comfort on ACP. This education included a PowerPoint presentation and an evidence-based ACP toolkit. A post-

survey was conducted to evaluate the intervention's efficacy. The results determined the effectiveness of the educational intervention and assessed the primary care providers' knowledge, confidence, and intent to discuss ACP and ADs.

Figure 2

Institute for Healthcare Improvement Model for Improvement



Note. This figure of the Institute for Healthcare Improvement is adapted from the *Model for Improvement*. (IHI, 2022)

Do

This next step of the PDSA cycle is “do.” This step includes carrying out the tested change, which is often done on a small scale, documenting any problems or unexpected observations that occur during the execution of the intervention, and observing any consequences

of the intervention (IHI, 2022). The “doing” phase of this quality improvement project included the primary investigator (PI) presenting the educational in-service on ACP and AD discussions to the primary care providers. The PI provided participants with an ACP toolkit with evidence-based resources for starting ACP discussions and guiding patients through AD completion. Additionally, this PI provided the participants with a copy of the educational presentation for reference. Post-surveys were completed immediately after the intervention to analyze the participant’s knowledge from the intervention.

Study

The “study” phase of the PDSA cycle involves analyzing the data collected, comparing it with your predictions before the intervention, and then summarizing what was learned (IHI, 2022). During this phase, it is most important to continually reflect on what was learned to make changes for future PDSA cycles. This PI evaluated the effectiveness of the educational presentation by collecting data from the post-surveys and analyzing it. The data determined the effectiveness of the educational presentation by evaluating participant knowledge, confidence, and intent to carry out ACP discussions with patients. The PI constructed an executive summary of the findings and indicate what was learned from this process. When the summary was completed, the results were disseminated to the project's site and participants.

Act

Finally, the “act” stage allows the PI to refine the change based on what was evaluated from the intervention (IHI, 2022). This allowed the PI to modify the intervention and prepare for the subsequent intervention (IHI, 20220). Based on the findings, the PI proposed future recommendations for this practice to continually improve ACP discussions with patients.

Setting and Stakeholders

The setting of this quality improvement project was Primary Care Physicians, a primary care clinic located in Omaha, Nebraska, which serves all demographics of patients. A third (34%) of the patients receiving care from Primary Care Physicians are 65 years and older, 43% are 36-64 years old, 19% are 19-35 years old, and 4% are 0-18 years old (J. Bazar, personal communication, August 9, 2022). This family-owned clinic has been operating since 1977; many of the original patients continue to be seen. The participants of this quality QI project were healthcare providers in this clinic, including nurse practitioners and physicians of various experience levels. In total, five providers were invited to participate in the educational in-service. There was no compensation for participation in the project, and non-participation did not affect their employment.

The stakeholders included the healthcare providers and staff at Primary Care Physicians, the patients, and their families. The providers and staff can directly benefit from this project as they are receiving additional training for ACP, which can lead to improved discussions and AD completion. Patients directly benefit from this project as stakeholders because the project may allow them to express their wishes with their providers and families before they are unable to do so. The families of these patients are stakeholders because if their loved one's wishes are known, they will not have to have the pressure of making decisions for them if the family members physically cannot express their wishes.

Planning the Intervention

This QI project implementation was based on the Model for Improvement and Plan-Do-Study-Act model. An educational in-service was implemented on July 13th, 2022, which focused

on improving ACP discussions in a primary care setting. The education was presented via PowerPoint presentation conducted by this primary investigator (PI). Participants were provided a disclosure prior to the educational presentation. The presentation occurred over approximately 15-20 minutes. This meeting occurred during a regularly scheduled staff meeting in Primary Care Physicians' conferences room. The providers of Primary Care Physicians attended this educational in-service. The PowerPoint presentation guided the education and was adapted from scholarly resources from the National Institute of Health, the Institute for Healthcare Improvement (IHI), American Family Physicians, the Centers for Medicare Services, billing information, and other evidence-based research articles. The outline of the presentation included the need for ACP discussions in primary care settings, legal components of ADs specific to the state of Nebraska, and approaches to conversations in health stages that are recognized as "early", "middle" or "late, and Medicare reimbursement information. This outline can be found in Appendix E. A one-page, a paper handout was provided detailing ACP conversation starters and Medicare reimbursement and is included in Appendix E. The participants were provided a post-survey evaluation immediately after the presentation and is described below. Surveys assessed the participants' knowledge, confidence, and intent to have ACP discussions in their practice.

Participants and Recruitment

All healthcare providers from the Primary Care Physicians clinic in Omaha, Nebraska, were invited to participate in this project. There are two nurse practitioners and three physicians in the clinic. A recruitment e-mail was sent by this PI to one of the physicians so that he could distribute, inviting providers to participate in a learning experience and complete a brief survey

after the experience. A copy of the recruitment e-mail is included in Appendix C. An overview of the purpose of educational intervention and disclosure was included in the email and can be found in Appendix B. Participant inclusion criteria for this project contains that the participants must be a primary care provider at this clinic. Five providers at this clinic were eligible to participate in this QI project. The target sample was three participants, with a minimum of two.

Consent and Ethical Considerations

It is essential to consider the ethical elements when creating and executing projects that include human participants (Polit & Beck, 2017). This is done to protect the participants' rights and reduce the risk of any potential harm (Polit & Beck, 2017). According to the Office for Human Research Protections (OHRP, 2018), three main ethical research principles include human research: respect for the persons, beneficence, and justice. This QI project and PI aimed to protect those involved in the project and especially provide the principle of *beneficence* to participants. *Beneficence* is termed to persons being treated ethically in which all acts are of kindness or charity in which they go beyond obligation (OHRP, 2018). Two rules that *beneficence* follows explicitly are to “do not harm” and “maximize possible benefits and minimize possible harms” (OHRP, 2018). In following these principles, this PI fulfilled the principle of beneficence in this educational intervention for providers. Their survey responses were kept anonymous, and their choice to participate in this QI project did not impact their employment. The intervention aimed to improve provider knowledge to positively impact patient care.

The University of Arizona's Institutional Review Board (IRB) reviewed this project. Participants were supplied a disclosure form (Appendix B). Participation was voluntary, and they

could withdraw at any time. No identifiable data was collected; only aggregate data will be shared. There are no perceived psychological impacts or triggers during the presentation. All recruitment emails, data collection tools, site authorization, and participant consent are included in the appendices.

Data Collection

A quantitative post-intervention survey was distributed by the PI and data was anonymously collected following the educational session (Appendix D). This paper survey evaluated the effectiveness of the educational in-service by assessing provider knowledge, confidence, and intent to implement ACP discussions in practice. The quantitative data collected was in the form of 5-point Likert-scale questions. The Likert-scale questions were statements that allowed participants to indicate “strongly disagree,” “disagree,” “neutral,” “agree,” or “strongly agree.” A free text box permitted any additional narrative comments or feedback. The survey questions were collected and data was formed to summarize the primary care providers’ s perceived comfort, knowledge, and intent to implement ACP discussions during their patient encounters after receiving the educational in-service and ACP toolkit. Paper surveys were collected by the PI and stored in manilla envelopes.

Data Analysis

Descriptive statistics were used for data analysis for post-survey responses. Excel was the primary source of data management and analysis. Data was entered into a secure Excel spreadsheet for analysis. Paper surveys were then shredded. The themes evaluated are knowledge, confidence, and intent to use in practice. Likert-scale results were analyzed as

ordinal data. Histograms and bar graphs were created to visualize results in preparation for presentation to the clinic. Free text responses were summarized.

RESULTS

The paper post-surveys were distributed and completed immediately after the educational in-service on July 13, 2022. The principal investigator (PI) collected the surveys and the results were input into Excel for data management. Paper results were shredded.

Sample Characteristics

A total of five primary care providers participated in the educational in-service and completed the post-survey. This was a high response rate (100%) as five providers were invited to participate. Two of the providers were nurse practitioners, and three of the providers were medical doctors.

Outcomes

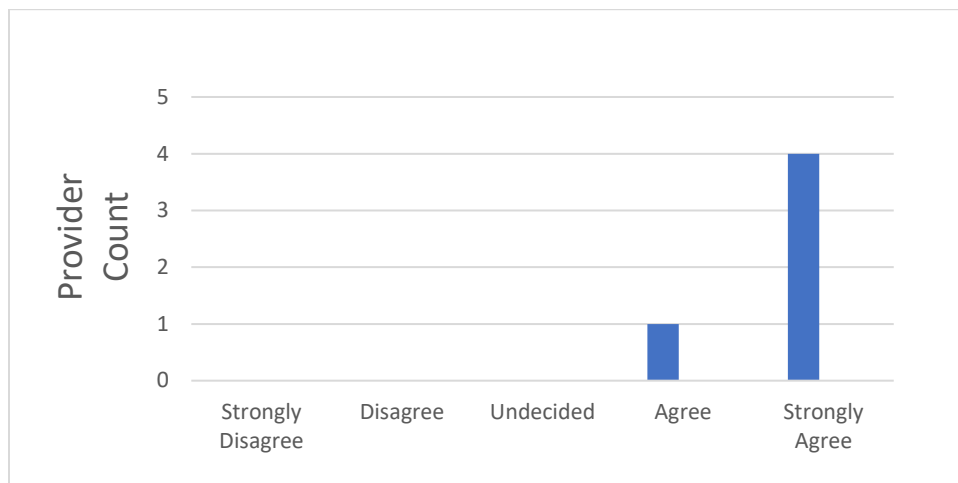
The following three outcomes were measured to evaluate the efficacy of this quality improvement (QI) project's purpose: improve primary care providers' knowledge, confidence, and intent to discuss advance care planning (ACP) with patients.

Knowledge

As a result of the educational in-service, 80% of participants (n=4) "strongly agree" with the statement "As a result of this presentation, I am more knowledgeable regarding advance care planning and advance directives," and 20% (n=1) "agree" with the statement (Figure 3).

Figure 3

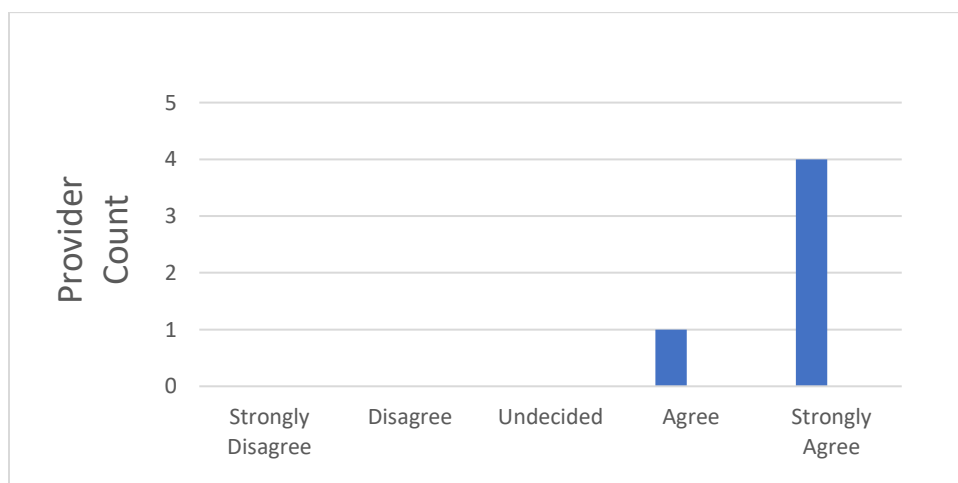
Improved Knowledge in Advance Care Planning and Advance Directives



Next, for the statement “As a result of this presentation, I feel that I will be better equipped to present advance directive information to my patients and families,” 80% (n=4) “strongly agree” and 20% (n=1) “agree” with the statement (Figure 4).

Figure 4

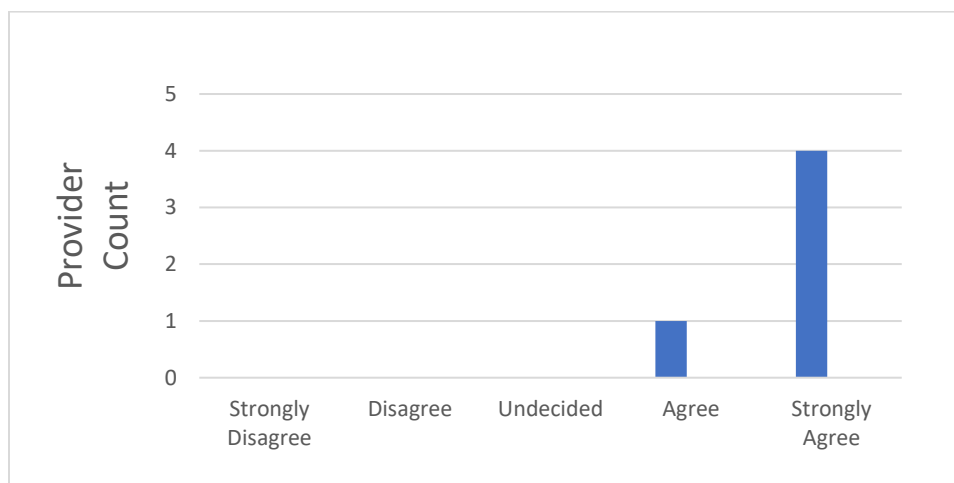
Improved Knowledge to Deliver Advance Directive Information



The third statement to assess the perceived knowledge from the education in-service was, “As a result of this presentation, I am knowledgeable regarding the evidence-based benefits of ACP for patients and families.” 80% of participants (n=4) “strongly agree” with the statement. 20% of participants (n=1) “agree” with the statement (Figure 5).

Figure 5

Evidence-based Benefits of Advance Care Planning

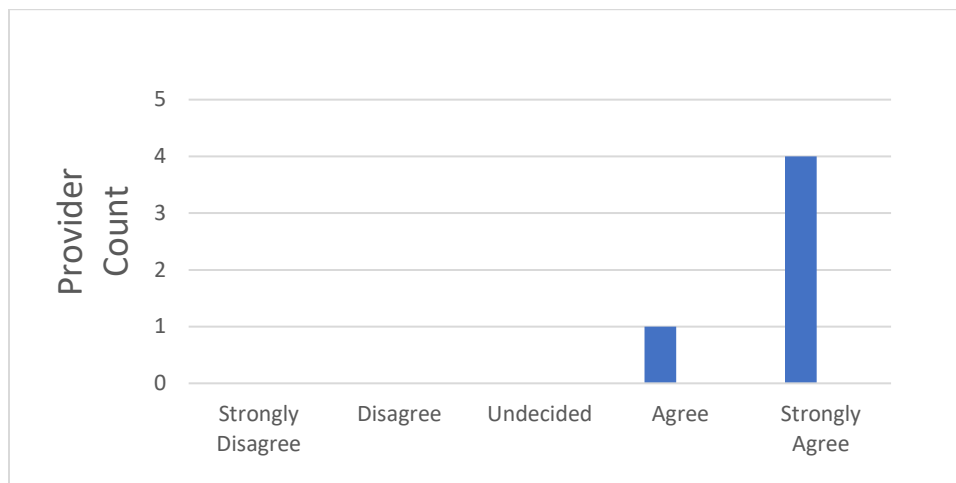


Confidence

Two statements questions were used to assess provider confidence that resulted from the educational in-service. The first statement question was, “As a result of this presentation, I feel more confident in discussing ACP with patients and their families,” and 80% of participants (n=4) “strongly agree” and 20% (n=1) “agree” with the statement (Figure 6).

Figure 6

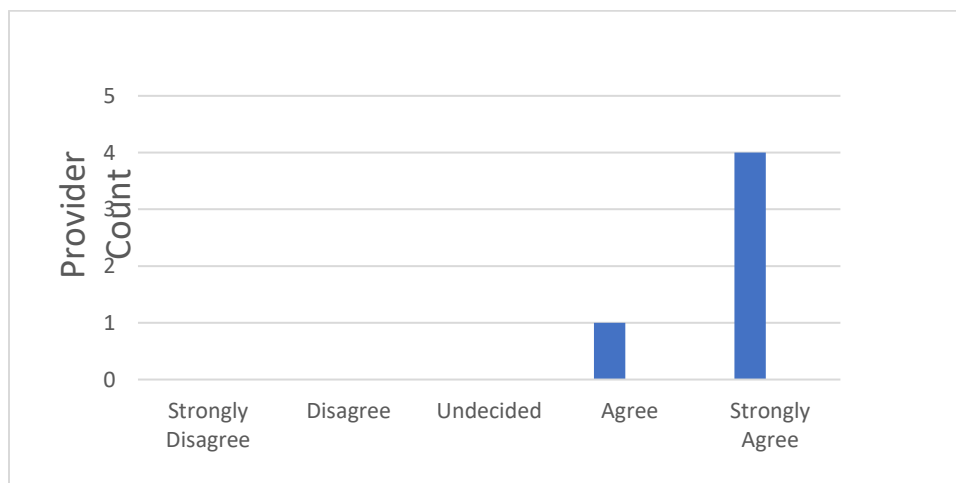
Confidence in Discussing ACP with Patients and Families



Next, as a result of the educational in-service, 80% of participants (n=4) “strongly agree” with the statement “As a result of this presentation, I feel more confident in starting ACP conversations with patients and their families,” and 20% (n=1) “agree” with the statement (Figure 7).

Figure 7

Confidence in Starting ACP Discussions with Patients and Families

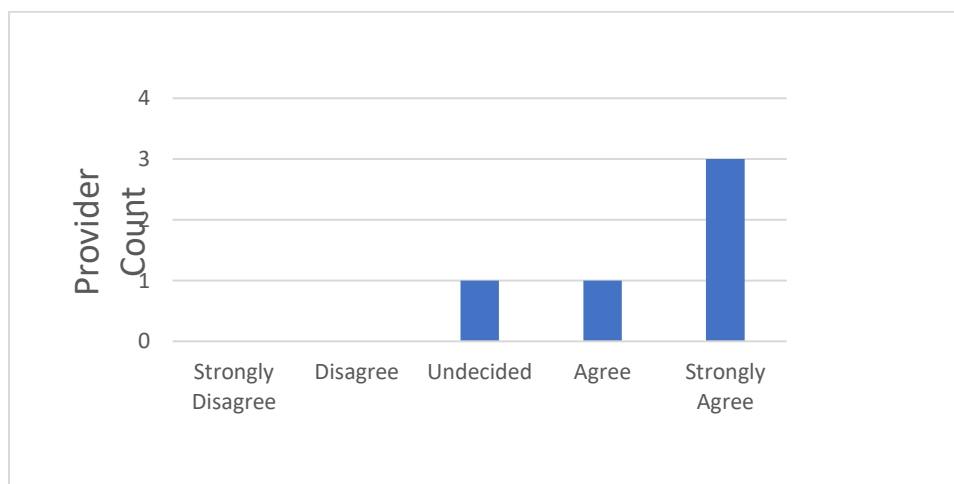


Intent

Finally, the post-survey evaluated the educational in-service's effect on providers' intent to implement the information they received and their intent to have ACP discussions with patients. For the statement, "I intend to use the information I learned during this presentation during my future patient encounters," 60% of participants (n=3) "strongly agree," 20% (n=1) "agree," and 20% (n=1) "undecided" with the statement (Figure 8).

Figure 8

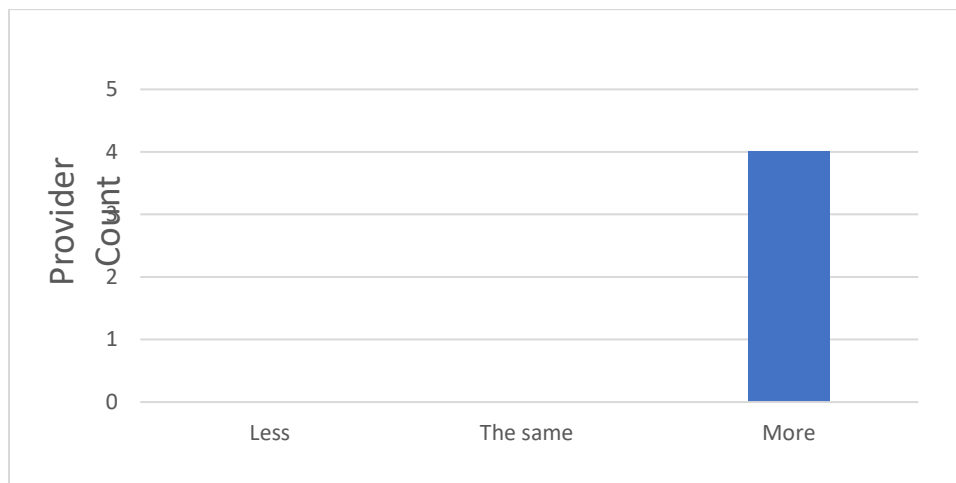
Intention to Use Information from Presentation



Ultimately, 100% of participants (n=4) responded "more" to the statement, "As a result of this presentation, I plan on introducing ACP discussions with patients" (Figure 9). One of the five participants left the question blank.

Figure 9

Provider Plans to Introduce ACP Discussions with Patients



Presentation Format

Participants were asked questions in regard to the presentation format. Participants (n=5) either “strongly agree” or “agree” with the statement, “This presentation contained the right amount of information” (Table 1).

Table 1

Presentation Information

Question #	Answer	Count	Percent
8	Strongly Disagree	0	0%
	Disagree	0	0%
	Undecided	0	0%
	Agree	2	40%
	Strongly Agree	3	60%
Total		5	100%

Next, participants (n=5) were asked to respond to the statement, “The presentation length of time was appropriate.” Some 20% of participants (n=1) “agree” with the statement and 80% (n=4) “strongly agree” (Table 2).

Table 2

Presentation Length

Question #	Answer	Count	Percent
9	Strongly Disagree	0	0%
	Disagree	0	0%
	Undecided	0	0%
	Agree	1	20%
	Strongly Agree	4	80%
Total		5	100%

Finally, 40% of participants (n=2) “agree” and 60% (n=3) “strongly agree” to the statement, “I enjoyed the presentation” (Table 3).

Table 3

Presentation Enjoyment

Question #	Answer	Count	Percent
10	Strongly Disagree	0	0%
	Disagree	0	0%
	Undecided	0	0%
	Agree	2	40%
	Strongly Agree	3	60%
Total		5	100%

In the provided free text box for comments regarding the presentation’s content, no participants included any comments.

DISCUSSION

Summary

Advance care planning (ACP) discussions are essential in primary care settings, especially before patients are diagnosed with life-limiting diagnoses. ACP reduces unwanted medical care and patient costs, decreases the likelihood of an in-hospital death, increases end-of-life quality, and decreases hospitalizations and intensive care unit stays (Agarwal & Epstein, 2018; McDermott et al., 2020). Having advance directives (ADs) in place helps to ensure that patients' wishes are carried out and reduces family stress when surrogates are forced to make decisions (McDonald et al., 2017; McMahan et al., 2021). Primary care providers have an advantage in having ACP discussions with patients before receiving any life-limiting disease diagnoses because patients frequently seek care from them when health care concerns present. At the primary care office, Primary Care Physicians, it was identified that the providers found navigating the ACP conversation challenging or finding a good time to start it. This quality improvement (QI) project was successful in providing healthcare providers at Primary Care Physicians with the education and tools to improve their knowledge, confidence, and intention to implement ACP and AD discussions with patients in the future. An educational in-service and evidence-based toolkit was provided to participants of the project to accomplish this.

All five of the healthcare providers from Primary Care Physicians participated in the educational in-service and responded to a post-evaluation survey to assess the effectiveness of the in-service. Two providers were nurse practitioners, and three were medical doctors. The results of this QI project reinforce the necessity for primary care providers to continue gaining education regarding ACP and ADs to improve their knowledge, confidence, and intent to have

ACP discussions with patients and families. The findings from this QI project strongly correlated with the synthesis of evidence in support of providing healthcare providers with additional education for them to improve the quality and frequency of ACP discussions.

Interpretation

Knowledge

This QI project affirms that the educational in-service effectively improved the knowledge of ACP discussions and ADs of the healthcare providers from Primary Care Physicians. The educational in-service provided information about AD specific to the state of Nebraska and evidence-based support to introduce ACP in regular patient visits. Questions 1-3 were designed to assess the knowledge change resulting from the educational in-service. 100% (n=5) of participants indicated that the in-service made them more knowledgeable about ACP and ADs, better equipped them to provide patients and families with AD information and improved their knowledge regarding the evidence-based benefits of ACP. Respondents answered “agree” or “strongly agree” to all three of these statement questions that represented their knowledge base of ACP and ADs. 80% (n=4) “strongly agree” with all three statement questions. In comparison, 20% (n=1) “agree” with the three statements. The synthesis of the literature supports these results. For example, documentation of ACP discussions improved when providers received additional training (McMahan et al., 2021). The results of the post-evaluation survey positively correlate with these findings.

Confidence

The next measure that was evaluated after the educational in-service was confidence. The educational in-service provided conversation starters to aid in starting ACP discussions. ACP

reimbursement and documentation information was also provided during the educational in-service. Participants were asked to respond to two statement questions regarding their perceived confidence after the educational in-service. The two statements were, “As a result of this presentation, I feel more confident in discussing ACP with patients and their families,” and “As a result of this presentation, I feel more confident in starting ACP conversations with patients and their families.” Again, 80% (n=4) of participants “strongly agree” with the two statements while 20% (n=1) “agree.” These positive results indicate that the educational in-service improved their confidence in starting and discussing ACP with patients and families. This is congruent with literature that exhibits that healthcare providers can identify that they did not feel confident discussing ACP because of not understanding the legality and what all encompasses ADs and how to approach the conversation and additional education aided in improving the confidence of healthcare providers (Berkowitz et al., 2021; Bestvina & Polite, 2017; Blackwood et al., 2019; Chan et al., 2019; Kermel-Schiffman & Werner, 2017; Miller, 2018).

Intent

Finally, the objective that is most likely to produce ACP documentation with patients and families: the intent to implement the information they received and their intent to have ACP discussions with patients. Providers were asked two statement questions to assess the efficacy of intent that resulted from the educational in-service. The first statement question was, “I intend to use the information I learned during this presentation during my future patient encounters.” Some 60% of participants (n=3) “strongly agree,” 20% (n=1) “agree,” and 20% (n=1) “undecided” with the statement. The second statement was, “As a result of this presentation, I plan on introducing ACP discussions with patients.” For this statement, participants were asked

to respond, “less,” “the same,” or “more.” 100% of participants (n=4) responded “more” to this statement. It was interesting that one participant did not answer this question, but of those who did, the results positively show that the educational in-service.

Lewin’s Change Theory was used as the theoretical framework that guided this project. The theory highlights the importance of organizational changes and utilizing the positive and negative forces in change to create change in a system so that a new equilibrium can be established (Schein, 1996). Three steps are identified in the theoretical framework for change which are “unfreezing,” “change,” and “refreezing” (Schein, 1996). The identified need for increasing ACP discussions in the primary care practice occurred during the “unfreezing” stage. Executing the educational in-service and providing the ACP toolkit comprised this QI project’s “change” stage. Changing the beliefs and practices of Primary Care Providers reflected the evidence-based findings in the literature synthesis. The “refreezing” occurred after the educational in-service. During the presentation, many discussions were started between the providers to see how they could structurally incorporate ACP into annual wellness visits. They discussed systematic processes and how they would incorporate it with all the staff. This “refreezing” will continue until the practice solidifies a new status quo.

Implications

Practice

Providing primary care providers with education about ACP and ADs increases their knowledge, confidence, and intent to implement ACP discussions with patients. This QI project can improve the outcomes for patients at this primary care clinic in Omaha, Nebraska. The favorable outcomes of this educational in-service indicate that the materials could be distributed

to other primary care offices where they could use the presentation and evidence-based toolkit to educate their providers and improve the outcomes of their patients.

Education

This QI project demonstrated that an educational in-service about ACP and ADs could improve primary care providers' knowledge, confidence, and intent to initiate ACP discussions with patients and families. The findings of this project support evidence-based research regarding the importance of providing additional ACP to primary care providers (Berkowitz et al., 2021). Providing other primary care providers with the knowledge and tools to execute ACP discussions with patients and families could result in an improved number of ADs being completed by patients.

Research and Policy

Future research may include providing the educational in-service and evidence-based toolkit to primary care providers and then tracking providers' ACP discussion documentation and coding. This research would further support the findings that healthcare providers who receive additional training about ACP produce an increase in ACP documentation (McMahon et al., 2021). As for policy advancement, ACP discussions are currently an optional component of the Medicare wellness exam. ACP discussion could become a mandatory component of Medicare wellness exams to ensure that this critical aspect of patient care is being addressed systematically. Future healthcare organizational policies could also include yearly ACP education for providers.

Strengths

The strength of this QI project is the immediate conversations that occurred during the presentation about the implications of this new knowledge. Providers began discussing when they have encountered ACP in their practice and how they can start incorporating the discussions into everyday practice. Many of them had not realized that ADs could be signed in the office and especially did not realize the positive impacts of ADs on patients and their families. The educational in-service became a discussion about what the providers could do next with this information so that they can transform their practice. The providers indicated that the evidence-based toolkit was practical in the future. Since the practice did not have ADs they could hand out to patients, the providers anticipated that the QR code on the toolkit linking them to a Nebraska state AD would be beneficial. All providers appeared engaged in the presentation. The in-person presentation utilized PowerPoint presentation, and all technical aspects of the presentation went smoothly. Another strength of the QI project is that all primary care providers invited to the educational in-service participated.

Limitations

This QI project was conducted in a small, private practice primary care office. Because of this, a limitation of this QI project is the sample size of the participants. Five providers were invited, and five participated in the project. Still, a larger number of participants, perhaps in a larger healthcare setting, could potentially impact more patients because of the number of providers that had received the educational in-service. The project sample size could result in skewed data. The intervention was tailored for Primary Care Physicians, in which the outcomes could not be replicated in all clinical settings with all patient populations. Many portions of the

education provided could be generalizable to other practices. Since the QI project was tailored for Primary Care Physicians, the sample size is adequate in showing that it positively affected ACP and AD knowledge, confidence, and intent.

DNP Essentials Addressed

The American Association of Colleges of Nursing (AACN) *DNP Essentials* is an outline of curricular competencies and foundational basis that all graduates of doctor of nursing practice (DNP) graduates should hold during their education (2006). This QI project addressed three DNP essentials.

DNP Essential I: Scientific Underpinnings for Practice

DNP Essential I highlights the importance that an individual who is a terminally academic prepared nurse understands the life process and promotion of optimal function during all states of health and wellness (AANC, 2006). The doctoral trained nurse integrates nursing science and knowledge to make positive changes in health status (AANC, 2006). The goal of this DNP project was to implement education for providers to influence positive changes in healthcare for providers and patients.

DNP Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

DNP Essential III indicates that scholarship and research are the foundation of a doctoral degree (AANC, 2006). *Essential III* supports the DNP graduate analytical methods to appraise literature and execute quality improvement methodologies (AANC, 2006). This essential was addressed in this QI project as the PI critically evaluated evidence-based literature to support the

execution of the project. Additionally, the PI designed, directed, and evaluated the improvement quality to promote patient-centered care, which aligns with a *DNP Essential III* principle.

DNP Essential VII: Clinical Prevention and Population Health

DNP Essential VII depicts that doctoral prepared nurse practitioners should promote clinical prevention for patients and implement strategies to address them (AANC, 2006). This project aimed to improve ACP discussions in primary care settings to promote early ACP discussions before to prevent the need for having ACP discussions when patients are in a position where they, or their loved ones, need to make decisions regarding their care, and preventing unwanted medical care at the end of their lives.

Conclusions

This QI project was implemented to address the gap in ACP discussions in a primary care practice in Omaha, Nebraska. The implementation of an educational in-service and providing an evidence-based toolkit regarding ACP and ADs showed that it had a positive impact on participants as it improved their knowledge, confidence, and intent regarding ACP and ADs in their practice. It can be concluded that an educational in-service can improve the knowledge, confidence, and intention to have ACP discussions for primary care providers.

Plan for Sustainability

The plan-do-study-act cycle (PDSA) will be crucial in sustaining the educational in-service and implementing the information into practice. The next step in this PDSA cycle to sustainably maintain the education is disseminating the information to clinical staff. Next, I recommend that the practice makes a plan to incorporate ACP discussion in all annual wellness exams with the consent of patients and family members. Tracking ACP discussion

documentation and billing would effectively evaluate the practice change. This may take many cycles of the PDSA to make new improvements. Tracking the potential for increased reimbursement may motivate providers to continue to have and document ACP discussions. Providing printed-out resources for patients will be beneficial when having the discussions as well. As for the educational presentation and evidence-based toolkit, I recommend that the healthcare providers update the educational content of the presentation as new evidence-based knowledge and recommendations change. Additionally, I would recommend that the education is made a required annual education for primary care providers.

Plan for Dissemination

An executive summary letter including the project implementation process, results, and key findings was provided to the project site. This included the PowerPoint presentation, a copy of the evidence-based toolkit, and future recommendations. A final defense of the project and key findings with the project's committee members was conducted.

Funding

No funding was received for this project. The PI provided a box of Nothing Bundt Cakes as a thank you to the participants.

APPENDIX A:

SITE APPROVAL/THE UNIVERSITY OF ARIZONA INSTITUTIONAL REVIEW BOARD
AUTHORIZATION LETTER

Primary Care Physicians
12782 Augusta Ave. #2
Omaha, NE 68144

May 31, 2022
University of Arizona Institutional Review Board
c/o Office of Human Subjects
1618 E. Helen St.
Tucson, AZ 85721

Please note that Autumn Rhodes, a University of Arizona Doctorate of Nursing Practice student, has the permission of Primary Care Physicians to conduct a quality improvement project at our facility for her project, "Improving advance care planning: An educational intervention for primary care providers."

Ms. Rhodes will conduct an educational presentation on advance care planning for the primary care providers of this clinic. The presentation will occur during a scheduled provider meeting. The focus will be on advance directive information, advance care planning conversation starters, and reimbursement. After the presentation, participants will have the opportunity to complete an anonymous quantitative survey to assess their knowledge, confidence, and intent to use the presented materials during future patient encounters. Ms. Rhodes's activities will be completed by December 1st, 2022.

Ms. Rhodes has agreed to provide my office with a copy of the University of Arizona IRB review document before implementation. She also agrees to share the aggregate results of the educational presentation with me.

If there are any questions, please contact my office.

Signed,



Gregston Nelson, MD



University of Arizona IRB
 845 N Park Ave., Suite 537A
 Tucson, AZ 85719
 Fax: 520-621-9810
VPR-IRB@arizona.edu

NOT HUMAN RESEARCH

June 15, 2022

Autumn Rhodes

Dear Autumn Rhodes:

On 6/15/2022, the IRB reviewed the following submission:

Type of Review:	Initial Study
Title:	Improving Advance Care Planning: An Educational Intervention for Primary Care Providers
Investigator:	Autumn Rhodes
IRB Submission ID:	STUDY00001449
Sponsor:	None
Prime Sponsor:	None
IND, IDE, or HDE:	None
Documents Reviewed:	<ul style="list-style-type: none"> • Rhodes_IRB Protocol for Determination of Human Research.docx, Category: IRB Protocol; • Rhodes_ACP EBP Toolkit.docx, Category: Participant Material; • Rhodes_Advisor Attestation.pdf, Category: Institutional Approval; • Rhodes_Disclosure Form.docx, Category: Consent Form; • Rhodes_Letter of Support Site.pdf, Category: Other; • Rhodes_Post-evaluation Survey.docx, Category: Data Collection Tool; • Rhodes_Presentation Outline.docx, Category: Participant Material; • Rhodes_Recruitment Email.docx, Category: Recruitment Materials;

The IRB determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.





University of Arizona IRB
845 N Park Ave., Suite 537A
Tucson, AZ 85719
Fax: 520-621-9810
VPR-IRB@arizona.edu

IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are research involving humans in which the organization is engaged, please submit a new request to the IRB for a determination. You can create a modification by clicking **Create Modification / CR** within the study.

All Covered Individuals must disclose all sponsored and non-sponsored Research Projects to the Office for Responsible Outside Interests (OROI) prior to Conducting Research if the individual is an Investigator. Please visit the [OROI](#) website for more information.

We value your feedback and would appreciate you taking the time to complete our survey about your experience with the IRB staff:
https://uarizona.co1.qualtrics.com/jfe/form/SV_dgQSVxqeiPhiiUd.

If questions arise at any time during your study, please email the general IRB inbox at VPR-IRB@arizona.edu.



APPENDIX B:
CONSENT DOCUMENT (DISCLOSURE FORM)

**IMPROVING ADVANCE CARE PLANNING: AN EDUCATIONAL INTERVENTION
FOR PRIMARY CARE PROVIDERS**

Principal Investigator: Autumn Rhodes, BSN, RN, DNP Candidate

Disclosure Form

My name is Autumn Rhodes from the University of Arizona College of Nursing.

I am doing a quality improvement project to improve the advance care planning and advance directive discussions between the healthcare provider and patient at Primary Care Providers. The goal of the project is to improve the knowledge, confidence, and intent to initiate advance care planning and advance directive discussions during patient interactions.

If you choose to take part in this project, you will be asked to participate in the in-service presentation and complete a short, anonymous post-survey after the in-service presentation.

It will take approximately 20 minutes to participate in the in-service educational presentation and complete the post-survey. There are no foreseeable risks associated with participating in this project. Perceived benefits of participation include increased knowledge, confidence, and intent to use the presented information on advance care planning during your future patient encounters. Your responses are anonymous. Your name will not be collected or linked to your answers.

If you choose to participate in the project, participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw at any time from the project. In addition, you may skip any question that you choose not to answer. By participating, you do not give up any personal legal rights you may have as a participant in this project.

For questions, concerns, or complaints about the project, you may call:

Autumn Rhodes, BSN, RN
DNP-FNP Candidate
autumnrhodes@email.arizona.edu

Participation in the presentation and/or survey signifies consent.

APPENDIX C:
RECRUITMENT MATERIAL (RECRUITMENT EMAIL)

Recruitment E-mail

Hi,

My name is Autumn Rhodes and I am a Doctor of Nursing Practice (DNP) student at the University of Arizona. For my doctoral project, I am conducting a quality improvement project about improving advance care planning discussions in a primary care setting. This opportunity will allow you to learn more about advance directive information, advance care planning conversation starters through all stages of health, and advance care planning coding information.

This presentation will be held at an upcoming staff meeting. If you choose to participate, you will be asked to partake in a short educational presentation during a set medical staff meeting and complete a post-survey questionnaire. The participation will take approximately 20 minutes to complete the in-service education and complete the post-survey. The survey is completely confidential. This project has been reviewed by the University of Arizona Institution Review Board.

Please see the attached disclosure form for an outline of what to expect, risks, and benefits of participation.

Thank you for your consideration to participate. For any questions or concerns please contact:

Autumn Rhodes, BSN, RN
DNP-FNP Candidate
autumnrhodes@email.arizona.edu

APPENDIX D:
EVALUATION INSTRUMENTS (POST-INTERVENTION SURVEY)

Post-intervention Survey

Perceived Knowledge

- 1) As a result of this presentation, I am more knowledgeable regarding advance care planning and advance directives:

Strongly Disagree Disagree Undecided Agree Strongly Agree

- 2) As a result of this presentation, I feel that I will be better equipped to present advance directive information to my patients and families

Strongly Disagree Disagree Undecided Agree Strongly Agree

- 3) As a result of this presentation, I am knowledgeable regarding the evidence-based benefits of ACP for patients and families

Strongly Disagree Disagree Undecided Agree Strongly Agree

Perceived Confidence

- 4) As a result of this presentation, I feel more confident in discussing ACP with patients and their families

Strongly Disagree Disagree Undecided Agree Strongly Agree

- 5) As a result of this presentation, I feel more confident in initiating ACP conversations with patients and their families

Strongly Disagree Disagree Undecided Agree Strongly Agree

Intent

- 6) I intend to use the information I learned during this presentation during my future patient encounters

Strongly Disagree Disagree Undecided Agree Strongly Agree

- 7) As a result of this presentation, I plan to introduce ACP discussions with patients:

Less The same More

Presentation Format

- 8) This presentation contained the right amount of information

Strongly Disagree Disagree Undecided Agree Strongly Agree

9) The presentation length of time was appropriate

Strongly Disagree Disagree Undecided Agree Strongly Agree

10) I enjoyed the presentation

Strongly Disagree Disagree Undecided Agree Strongly Agree

Additional comments:

APPENDIX E:
PARTICIPANT MATERIAL (PRESENTATION OUTLINE AND EBP TOOLKIT)

Presentation Outline

ACP Need

- Discussions should be initiated between PCP and patient before becoming chronically ill or receiving a life-limiting diagnosis
- For example, It is estimated that there will be 11,180 new cases of cancer diagnosed in 2022 in Nebraska (American Cancer Society, 2022b).
- Yet, it is estimated that only one out of three adults have an advance directive at the time of their death (Yadav et al., 2017).
- ACP and ADs reduce unwanted medical care and costs, decreases the likelihood of an in-hospital death, and decreases ICU stays (Agarwal & Epstein, 2018; McDermott et al., 2020).
- Having ADs in place helps ensure that patient's wishes are carried out and reduces family stress when surrogates are forced to make decisions (McDonald et al., 2017; McMahan et al., 2021).
- ADs ensure that patients' wishes are carried out and decrease family stresses when having to make end-of-life decisions (Hong et al., 2016).

Components of ACP and ADs

- ACP is a process in which a patient and healthcare provider, attorney, or other family member participates making anticipatory decision-making and plans for the future healthcare needs of an individual
- An AD is a clear expression of an individual's wishes for future healthcare and possibly how a patient may want to live their final portion of life
 - Includes a living will or durable power of attorney for healthcare
 - State of Nebraska:
 - Needs a signature witnessed by a public notary OR
 - Sign the document in the presence of two adult witnesses. One witness may be an administrator or employee of a healthcare provider who is providing treatment
 - Online template easily accessed
<https://www.caringinfo.org/planning/advance-directives/by-state/nebraska/>

Approaching the Conversation

- Do not approach the conversation as “end of life” (Brull, 2019). It is a common stigma that when we start having these conversations with patients, they feel as if we are “giving up on them.”
- AAFP supports introducing the conversation early on but recognizes stages in health trajectory when the conversation is being had (Brull, 2019):
 - Early: starting the conversation early on in a patient's life so that young and healthy patients are thinking about what their health is currently and how it may

change in the future. This allows patients to complete an AD before their health declines.

- Start conversation by talking about a TV show or recent event
 - A patient experiencing a recent funeral or illness may
- Middle: occurs when the patient's health is starting to deteriorate. PCP can ask, "Would I be surprised if this patient died within the next year?" If no, it is time to have the conversation during a routine office visit.
 - "What is your understanding of your current health?"
 - "How would you feel if your health started to change?"
 - "What do you value in your life? What are your feelings about quality of life?"
- Late: the most frequent type of ACP but least ideal. Done when you suspect that the patient only has a short period of time left but the discussion is done often in a cramped, short period of time.
 - "I am worried about your health. As it might deteriorate in the future, and may become sick again, what do you want your medical team to know about your feelings about having a breathing tube to help you breathe? Having a tube so that we can give you food? What you would want us to do if your heart stopped?"

Medicare Reimbursement

- CPT code:
 - 99497- first 16 to 30 minutes in discussion (~\$86)
 - 99498- each additional 30 minutes (~\$76)
 - Medicare waives the ACP coinsurance and the Part B deductible when ACP is:
 - Delivered on the same day as a covered MWV as an optional element of the MWV
 - Offered by the same providers as a covered MWV
 - If not done during an MWV, falls under Medicare Part B
 - Documentation must include the content and medical necessity of the ACP discussion, that the discussion is voluntary in nature, the content of any ADs, names of participants in the discussion, and the time spent in the face-to-face encounters between only the physician, nurse practitioners, physician assistant, or clinical nurse specialist
 - Independent insurers vary in coverage

Advance Care Planning (ACP) Conversation Starters

- **The elements of the conversation:** Set up the conversation, assess and understand preferences, share your current understanding of the patient's health, explore key topics (goals, fears, strengths), close the conversation, and document your conversation.
- **Early:** Start the conversation early in life so that young and healthy patients are thinking about their current health and future changes. Start the conversation by talking about a TV show or recent event. Set up the conversation if a patient has experienced a loved one's death or their own recent illness.
- **Middle:** Occurs when health becomes shaky. This may happen during a transitional period for patients: "What is your understanding of your current health?" How would you feel if your health started to change?" "What do you value in your life?"
- **Late:** The most frequent type of ACP. Often done when you suspect that the patient only has a short period of time left. The discussion is done in a cramped, short period of time: "I am worried about your health. As it may deteriorate in the future, what do you want your medical team to know about..."

(Institute for Healthcare Improvement, 2022; Fryll, 2019; Paladino & Escobar 2019)

Advance Care Planning (ACP) and Advance Directive (AD) Toolkit

ACP Needs

Estimated that only 1/3 of individuals have an advance directive.

ACP and ADs reduce unwanted medical care and costs, decrease the likelihood of in-hospital death, and decrease ICU stays.

Initiation of ACP discussions in primary care allows for more time and thought before health deteriorates.

(Yadav et al., 2017; Agarwal & Epstein, 2018; McDermott et al., 2020)

CPT Codes

99497- first 16 to 30 minutes in discussion
99498- each additional 30 minutes

Documentation must include

- The content and medical necessity of the ACP discussion
- That the discussion is voluntary in nature
- The content of any AD discussions
- Names of participants in the discussion
- The time spent in the face-to-face
- Encounters may only occur between the patient and physician, nurse practitioners, physician assistant, or clinical

(Centers for Medicare and Medicaid, 2020)



Nebraska AD Information

Needs a signature witnessed by a public notary OR the document is signed in the presence of two adult witnesses (one may be an administrator or employee of a healthcare provider who is providing treatment).

NE AD template:



<https://www.caringinfo.org/planning/advance-directives/by-state/nebraska/>

APPENDIX F:
PROJECT TIMELINE

Completion Date	Planning	Pre-implementation	Implementation	Evaluation
May 4, 2022	Submit proposal to project chair			
May 26, 2022		Obtain proposal approval from chair		
May 31, 2022		Obtain authorization letter		
May 31, 2022		Schedule proposal defense presentation with committee members		
June 13, 2022		Proposal defense presentation		
June 13, 2022	Submit to College of Nursing Research Committee			
June 16, 2022		Obtain IRB approval		
July 13, 2022			Implement and collect data	
August 1, 2022-September 3, 2022				Analyze data
September 22, 2022				Final defense presentation of project results

APPENDIX G:
LITERATURE REVIEW GRID

Project Question: In the primary care clinic, Primary Care Physicians in Omaha, Nebraska, can the use of an educational in-service for healthcare providers about advance care planning (ACP) and advance directives (AD) improve the knowledge, confidence, and intention to have ACP discussions by primary care providers?

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Agarwal & Epstein, 2018	Advance Care Planning and End-of-Life Decision Making for Patients with Cancer	Systematic review	<ul style="list-style-type: none"> • Advanced care planning (ACP) reduces unwanted medical care for oncology patients • ACP discussions between providers, patients, and families should lead to documentation of patients' wishes, beliefs, and values by completing advanced care directives • Technology may help advanced care directives being completed by providing patients videos to watch and online resources • ACP implementation conversation standardization is needed for providers <p>Oncology nurses and nurse practitioners can be an integral part of ACP in practices</p>	<ul style="list-style-type: none"> • High-quality, honest conversations between patients and healthcare professionals are necessary for cancer patients to complete ACP • Timely ACP prevents aggressive care at the end-of-life
Atherton, 2019	Project Five Wishes: promoting advance directives in primary care	Case-controlled studies	<ul style="list-style-type: none"> • 16-week Five Wishes program was implemented in a primary care practice to increase the number of advanced directives (Ads) • Five Wishes was implemented into the EHR • An increase of 25.4% of patient Ads was found <p>No statistically significant improvement was found for providers in the knowledge, comfort, confidence, perceived importance, and frequency of discussions regarding ADs</p>	Implementing Five Wishes into a primary care practice increased the number of ADs completed by patients
Berkowitz et al., 2021	Characteristics of Advance Care Planning in	Retrospective cross-sectional analysis	<ul style="list-style-type: none"> • In this retrospective cross-sectional study, researchers reviewed patients with 	<ul style="list-style-type: none"> • High-quality, honest conversations between patients and healthcare professionals are

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
	Patients With Cancer Referred to Palliative Care		<p>cancer compared to patients without cancer</p> <ul style="list-style-type: none"> • Patients with cancer were less likely to have ADs, despite having palliative care services • ACP is a challenging topic for healthcare providers to discuss • There needs to be a systematic way of completing ACP in oncology practices 	<p>necessary for cancer patients to complete ACP</p> <p>Information and acknowledgement of the necessity of AD completion is needed throughout oncology practices</p>
Bestvina & Polite, 2017	Implementation of Advance Care Planning in Oncology: A Review of the Literature	Prospective literature review	<ul style="list-style-type: none"> • Educational tools such as video decision aids can help patients complete ADs • ACP is becoming an expectation of oncology practices to be discussed within the first 3 visits • Conversations about end-of-life and ACPs are more commonly taking place within the last few months of life • ACPs can be completed by various individuals in the healthcare system • Providers are sometimes hesitant in discussing ACPs due to time constraints and the possibility of reducing patients' hope <p>ACP discussion and documentation may be most beneficial if patients watch videos about decision making and watch CPR videos</p>	<ul style="list-style-type: none"> • CPR videos and video decision-making provides more ACP completion • Electronic health record (EHR) reminders may be helpful in completing ACPs electronically <p>Additional training and support for providers should be conducted to help them feel more knowledgeable about effectively providing ACP planning education</p>
Blackwood et al., 2019	Barriers to advance care planning with patients as perceived by nurses and other healthcare professionals: A systematic review	Systematic review	<ul style="list-style-type: none"> • There is a lack of education and insufficient time for healthcare professionals to complete ACP with patients <p>Healthcare professionals feel comfortable discussing ACP with patients and families</p>	<ul style="list-style-type: none"> • There needs to be greater education and training for nurses and healthcare professionals for ACP <p>There needs to be times set to talk to patients about ACP</p>

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Buiar & Goldim, 2019	Barriers to the composition and implementation of advance directives in oncology: a literature review	Literature review	<ul style="list-style-type: none"> Educational barriers exist for patients regarding miscommunication with providers, not understanding illness advancement, and literary boundaries Many patients do not discuss ADs with their families <p>Many AD are completed by family members who are in charge of the patient's care</p>	<ul style="list-style-type: none"> Providing video decision-making tools relates to more ACP completion ACP must go through many steps to be completed No patient and treatment are different. The same goal must apply that the patient dies with a dignified death
Cannone et al., 2019	"I think it's a bit early for now": impact of psychological factors on drafting advance directives among cancer patients	Qualitative study	<ul style="list-style-type: none"> ACP can be perceived as "giving up" <p>Many patients feel that it is sometimes too early to discuss ACP</p>	ACP education is needed for patients and the general public to better understand its role for oncology patients
Chan et al., 2019	A systematic review of the effects of advance care planning facilitators training programs	Systematic review	Instructional sessions such as group discussions, role-play, and the use of advanced technology helped nurses gain understanding and comfort about ACP and end-of-life discussion	<ul style="list-style-type: none"> Additional training helps healthcare professionals in ACP by improving their knowledge, attitude, and skills <p>ACP communication education would be effective in group or advanced technology settings</p>
Glennon et al., 2019	Educating Healthcare Employees about Advance Care Planning	RCT	Study found that nurses who completed their own advanced directives and additional education for it, were best equipped to educate patients about it	<ul style="list-style-type: none"> Additional training helps healthcare professionals in ACP by improving their knowledge, attitude, and skills <p>Education should be promoted for patients and families to include discussion and electronic initiatives</p>
Goswami et al., 2020	Advance Care Planning: Advanced Practice Provider-Initiated	QI project	<ul style="list-style-type: none"> AD completion is an initiative of the ASCO, NCCN, and IOM. <p>ACP discussions increased AD completion rate and code status changes when a specific</p>	ACP discussions increase the number of AD completion

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
	Discussions and Their Effects on Patient-Centered End-of-Life Care		ACP discussion was had with cancer patients with APPs	
Hobden et al., 2021	Oncology nurses' perceptions of advance directives for patients with cancer	Cross-sectional survey	<ul style="list-style-type: none"> There is an unclear determination of who should discuss ACP with patients and their families <p>Nurses understand that ADs help patients and family members make cancer care and end-of-life decisions</p>	<ul style="list-style-type: none"> ADs have positive impacts on patients, families, and health professionals <p>Determining who would best discuss ADs in a practice is advised</p>
Kermel-Schiffman & Werner, 2017	Knowledge regarding advance care planning: A systematic review	Systematic review	<ul style="list-style-type: none"> There are multiple barriers to completing ADs which include patient specific barriers, time, and education ACP is not something the general populous understands <p>Additional education is needed for patients and healthcare professionals to complete ADs</p>	<ul style="list-style-type: none"> Additional training helps healthcare professionals discuss ACPs with their patients Healthcare students benefit from receiving additional ACP education <p>Face-to-face ACP discussions, with healthcare provider and patient, improve the rate of AD completion</p>
McDermott et al., 2020	The Association between Chronic Conditions, End-of-Life Health Care Use, and Documentation of Advance Care Planning among Patients with Cancer	Retrospective cohort study	<ul style="list-style-type: none"> Patients with cancer and heart failure have the highest odd of hospital admission vs. cancer and other conditions <p>Patients with ACPs 30+ days before death had lower odd of in-hospital death, hospitalization, or ICU admission</p>	Patients with ACPs 30+ days before death had lower odds of high-intensity EOL care
McMahon et al., 2021	Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and	Literature review	<ul style="list-style-type: none"> Face-to-face discussions, video, interactive multimedia, written, and clinician training were effective measure to increase ACP discussion and AD completion <p>Completing ADs decreased surrogate stress</p>	Videos and interactive multimedia are effective measures in increasing AD completion

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
	Where Do We Go? A Scoping Review			
Miller, 2018	Nurses Preparation for Advanced Directives: An Integrative Review	Literature review	<ul style="list-style-type: none"> Many working nurses did not feel confident in providing information about ACP Nursing programs cover AD education but commonly only spend 1.5-1 hour on the subject <p>Nurses confident in AD information were not always correct about it</p>	<ul style="list-style-type: none"> Additional training helps healthcare professionals discuss ACPs with their patients <p>Nursing students receive minimal information about ACP</p>
Myers et al., 2018	Provider tools for advance care planning and goals of care discussions: A systematic review	Systematic review	looked to determine a tool that aided advanced care planning at a provider and patient level	<ul style="list-style-type: none"> There is a lack of evidence that supports one clinical tool that is effective in advance care planning <p>There is not a distinct process or recommendation for when ACP should occur</p>
Nouri et al., 2021	The PREPARE for Your Care program increases advance care planning engagement among diverse older adults with cancer	RCT	Participants who received PREPARE for Your Care program information (interactive online program), vs those who only received verbal ACP information from providers, completed more ADs	PREPARE for Your Care interactive program increased AD completion
Rodi et al., 2017	Exploring advance care planning awareness, experiences, and preferences of people with cancer and support people: an	Cross-sectional study	<ul style="list-style-type: none"> In this study, most patients with cancer discussed their wishes with their loved ones <p>Most of those patients had not discussed their wishes with the healthcare provider</p>	ACP should be introduced early and discussed often throughout a patient with cancer's diagnosis and treatment

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
	Australian online cross-sectional study			
Schubart et al., 2019	Advance Care Planning Among Patients With Advanced Cancer	RCT	<ul style="list-style-type: none"> • Making Your Wishes Known: Planning Your Medical Future is a decision-making aid that patients can use to help with AD completion ACP type did not influence the documentation of patient wishes or end-of-life care received	Decision-aides can help facilitate AD completion
Smith et al., 2019	Four Conversations: A Randomized Controlled Trial of an Online, Personalized Coping and Decision Aid for Metastatic Breast Cancer Patients	RCT	<ul style="list-style-type: none"> • Four Conversations is an online, personalized coping a decision aid to complete ADs • It also allows for discussion between patients, their loved ones, clinicians, and spirit Four Conversations helped facilitate AD completion, compared to those who did not receive the decision aid	<ul style="list-style-type: none"> • The decision aid, Four Conversations improved AD completion amongst cancer patients Decision-aides can help facilitate AD completion
Sorrell, 2021	End-of-Life Conversations as a Legacy	Review of Literature	The Conversations Project is a kit that providers and families can use to facilitate end-of-life care discussions and complete ADs	<ul style="list-style-type: none"> • The Conversations Project helped facilitate AD completion Decision-aides can help facilitate AD completion
Zheng et al., 2016	Knowledge, attitudes, and influencing factors of cancer patients toward approving advance directives in China	Qualitative study	<ul style="list-style-type: none"> • There is a decreased knowledge about ACP and AD among cancer patients, which may be influencing their openness to discuss ACP Structured education for healthcare providers and patients is necessary for ADs to be completed	<ul style="list-style-type: none"> • Lack of knowledge of ACP is common in patients Structured ways of discussing ACP with patients improves AD completion

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