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Critical Choices Conversation Pilot Project

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Date of Submission: April 15, 2018

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Abstract

Background: Advance care planning (ACP) and advance directives (AD) inform the provision of health care that aligns with clients' goals and wishes. Less than 30% of female cancer care clients presented AD when admitted for care to a Magnet® designated hospital located in the Southwest United States (U.S.).

Methods: A quality improvement project took place on a 25 bed in-patient cancer care unit to improve these rates. The nurses received ACP training and used a clinical support tool to facilitate discussions with clients. A Palliative Care Clinical Nurse Specialist assisted as needed.

Results: Seven nurses accomplished a self-paced learning activity during a one-month timeframe. Although the nurses reported increased ACP skills after the training, the AD documentation decreased from 27% to 13% and remained below the 30% national norm. Similarly, combined ACP and AD documentation decreased from 33% to 20%. The nurses stated barriers such as time constraints, limited clinical experiences, and inability to accept the additional duties.

Conclusions: Nurses who completed the evidence-based training reported increased knowledge, but were unable to implement the tool within the health care setting. Additional trained ACP facilitators or workload adjustments may be needed as well as additional education to normalize the accomplishments of ACP and ADs.

Implications: The literature review, lessons learned, and recommendations may be used by hospital leaders to improve ACP and AD documentation, promote client-centered care, and increase compliance with federal and state laws and the Joint Commission's requirements.

Keywords: advance care planning, advance directives, inpatient, nurses, cancer care unit

Introduction

Approximately 70% of U.S. adults have not accomplished advance directives (AD) and are at risk for receiving health care that does not align with their goals and preferences if they become incapacitated due to unforeseen injury or illness (Centers for Disease Control and Prevention [CDC], 2014). Recent studies suggest this percentage is even higher among minority populations and indicates social disparities (Eggly et al., 2013; Sudore et al., 2016). Additionally, clients diagnosed with serious illnesses such as advanced cancer are at increased risk for spending down financial savings on out-of-pocket costs for treatments that may not improve quality or quantity-of-life (Institute of Medicine [IOM], 2013a). Such risks increase the potentials for emotional, spiritual, existential, physical, and financial harms to self and family.

Background

The lack of advance care planning (ACP) among persons diagnosed with serious illnesses is influenced by personal readiness, beliefs, and values (Fried, Bullock, Iannone, & O'Leary, 2009; Jenko & Pace, 2016; Mazanec & Panke, 2016; Crane & Evens, 2017); health care providers' communications (Eggly et al., 2013), training, skills (Institute for Healthcare Improvement [IHI], 2017b), and facilitation methods (Fischer, Sauaia, & Kutner, 2007); and lack of access to primary health care providers (Morrison, Zayas, Mulvihill, Baskin, & Meier, 1998) who normalize ACP by facilitating discussions during annual wellness visits (Centers for Medicare and Medicaid Services [CMS], 2016a).

Quality of health care indicators. Metrics related to the lack of or untimely accomplishment of ACP are tracked, trended, and publically reported. These include but are not limited to the “percent of deaths associated with ICU admission” for terminal care, and the “percent of Medicare decedents enrolled in Hospice within three days of death” (Dartmouth Institute for Health Policy and Clinical Practice, 2017). Less likely to be publically reported are

the “aggressive end-of-life care” indicators (Crane & Evans, 2017, p. 40) such as administration of chemotherapy during the last two weeks of life and the utilization of hospital services (i.e., emergency, inpatient, intensive care unit) within 30 days of death (Wang et al., 2016). These measures can be used by hospital leadership to identify opportunities for improvement in ACP facilitation services across the health care spectrum.

Accountabilities. Although reimbursed by fee-for-service Medicare, primary health care providers are not held legally responsible for facilitating ACP. Instead, the Medicare and Medicaid-reimbursed “hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions” are required to be the ACP safety net (U.S. Government Publishing Office, 2017). In accordance with the 1990 Omnibus Budget Reconciliation Act (OBRA), every client admitted to an inpatient unit must be screened for AD and assisted with documentation upon request. Additionally, government-reimbursed hospitals are required to educate employees and the surrounding community about AD issues (OBRA, 1990).

ACP advocates. National organizations such as the IOM (2013a) have assisted ACP education outreach efforts by sponsoring public media campaigns that inform health care consumers and providers about the unanticipated experiences of persons previously diagnosed with advanced-stage cancer. The IOM (2013b) strongly encourages cancer care clients to question their health care providers about prognosis, all available treatment options, and ACP. In order to promote these discussions, the IOM (2013b) offers a question prompt list (QPL), which is based on the consensus of cancer care experts.

Stakeholder's concerns. Consistent with national norms reported by the CDC (2014), less than 30% of inpatient clients presented AD documentation when admitted to a Magnet® designated hospital located in the Southwest United States (U.S.). Strategic and front-line stakeholders expressed concerns that the lack of ACP documentation increased the potential for clients' goals and wishes to be overlooked by the interprofessional (spiritual, medical, nursing, social-support) health care team. The hospital's Cancer Committee, Palliative Care Team, and inpatient nurses agreed that outreach ACP facilitation services should be offered by the nurses in addition to AD assistance when requested.

Increased documentation of clients' health care goals, wishes, and preferences in the medical records would promote the provision of client-centered care and improve the hospital's compliance with the Joint Commission's (2016) accreditation requirement for either AD or ACP documentation in clients' medical records. In order to facilitate ACP discussions with the clients, the nurses needed evidence-based training and a theory-based QPL. The following problem statement was collaboratively developed and stated in accordance with Muecke's (1984) and Issel's (2014) frameworks.

Problem Statement

Risks of emotional, spiritual, physical, existential, and financial harms among cancer care clients, indicated by the lack of ACP or AD documentation in the medical records, is evidenced by incidences of patient deaths during inpatient treatment and delayed hospice referrals, and caused by untimely ACP facilitations. The mediating factors included ACP facilitation opportunities and the moderating factors related to the inpatient nurses' ACP training and methods, given that the clients' conditions, readiness, cultures, beliefs, and values existed prior to the cause. Otherwise stated, cancer care clients without ACP or AD assumed increased risks

of receiving health care mal-aligned with their goals and wishes. The interprofessional health care team members' awareness of clients' goals, wishes, and preferences could be catalyzed by trained nurse facilitators. Thus, the quality improvement project was preceded by a comprehensive organizational assessment and followed by the selection, procurement, and facilitation of evidence-based training and a theory-based QPL to increase the nurses' ACP knowledge and skills competencies.

Organizational “Gap” Analysis of Project Site

An organizational assessment of strengths, weaknesses, opportunities, and threats (SWOT) and a gap analysis were conducted and guided by Issel's (2014) rapid perspective engagement strategy and the CDC's (2011) ACP Community Assessment Worksheet (Appendix A). External-contextual factors included national, regional, local, and organizational ACP information and resources. Internal factors included hospital assets, partnerships, collaborations, barriers, and gaps. Rapid perspective engagement strategies included data set queries, stakeholder interviews, and document reviews.

The data sets were provided by the Palliative Care Team and included ACP-sensitive indicators endorsed by the Center to Advance Palliative Care (CAPC) such as hospital length-of-stay outliers (Weissman, Meier, & Spragens, 2008). Additional stakeholders and informants included a client who was enrolled in inpatient hospice, her spouse and proxy decision-maker, inpatient cancer care nurses, a cancer care network physician who was a certified ACP facilitator through the Gundersen Health System's (2016) Respecting Choices® program and employed by a regional network partner, hospital leadership, and a community-based chaplain. Documents included the community assessment posted on the hospital's website, policies, and an inpatient information packet which contained ACP facilitation materials.

Assessment of capacities to meet population's ACP needs. The hospital's structure assets included updated and evidence-based ACP policies; a pre-admissions clinic that conducted ACP screening; an electronic medical record (EMR) that reminded the nurses to assess ACP during the admission process; a website that hosted cancer care information and resources; a palliative care clinical nurse specialist with extensive ACP facilitation experience; and inpatient staff (unit nurses and hospitalists) who expressed dedication to the provision of client-centered care. Structure gaps included an EMR that was not programmed to query and report metrics related to the presence of AD documentation, legal standing, and/or completion prior to discharge; a website that did not offer ACP information or links to evidence-based information; lack of periodic evidence-based refresher ACP education for inpatient staff; and insufficient Palliative Care Team staffing to support the ACP normalization and education needs of the community and the network of hospitals within the local metropolitan area.

Processes and outcomes SWOT. The hospital's process strengths included clients assessed for ACP documentation and needs by inpatient unit nurses in accordance with OBRA (1990); comprehensive 1:1 ACP services provided by the palliative care clinical nurse specialist when consulted; and ACP sensitive clinical indicators data collected by the Palliative Care Team. These included but were not limited to length-of-stay outliers. The ACP process gaps included ACP documents not consistently screened for legal-standing using a standardized protocol, and ACP not consistently facilitated using theory and/or evidence-based techniques. No ACP outcomes strengths were identified. The ACP sensitive length-of-stay outlier indicators collected by the Palliative Care Team were not integrated into the EMR and there was no ability to collect, assess or meaningfully use ACP sensitive outcomes data. The circumstances prevented potential discoveries of associations between the absence of ACP at admission and other variables of

interest or concern such as ACP completion at discharge, Medicaid beneficiary, Medicare beneficiary, beneficiary with no health insurance, gender, ethnicity, primary language other than English, age, extended length-of-stay, delayed palliative care consultation, do not resuscitate (DNR) or Allow Natural Death (AND) orders, unplanned intensive care unit (ICU) admissions, Emergency Department admissions, discharge to hospice services, and death during inpatient cancer care treatment.

Summary of gap-analysis findings. The organization/project site assessment identified several inpatient and palliative care opportunities for improvements. These included consistent application of comprehensive, theoretical, and evidence-based ACP facilitation methods and materials; increased education and involvement of inpatient nurses with ACP facilitation; the systematic collection of ACP completion, timeliness, and legal-standing data; community education outreach via the palliative care website; and community education offerings for health care consumers and primary care providers.

Review of the Literature

The following search phrases and terms were entered into the Cumulative Index for Nursing and Allied Health Literature (CINAHL), Cochrane, PubMed, and Google Scholar databases: advance care planning, advance directives, inpatient, nurses, and cancer care unit. Out of 638 articles screened, three were selected for review based on the following criteria: written in English; published between 2009 and 2017; and related to ACP facilitation by nurses in the U.S. Polit and Beck's (2008) *Quick Guide to Designs in an Evidence Hierarchy* was used to determine level-of-evidence (LOE) on a scale of I - VII. Garrard's (2014) *Matrix Method* was used to summarize the articles' results, findings, LOE, and conclusions (Appendix B). Twenty-eight additional articles were reviewed to discover information about ACP supports and issues

that could impact inpatient cancer care nurses' facilitation of ACP. These included peer reviewed papers, nursing textbooks, professional standards, government and professional organizations' publications, and evidence-based ACP clinical practice guidelines (CPGs). The *AGREE II*© instrument (Minervation, 2016) was used to appraise the four ACP CPGs mentioned in this report (quality scale 1 - 7).

Results

Advocates for client-centered health care recommend all competent adults (ages 18 and older) should accomplish ADs preceded by ACP (The Conversation Project & Institute for Healthcare Improvement, 2018). Comprehensive ACP consists of five sequential sub-processes—understanding, reflecting, discussing, documenting, and sharing health care goals and preferences (Briggs & Hammes, 2011).

First, the person develops an understanding of the importance of ACP; the different kinds of AD documents; personal health care values, goals, and preferences; current state of health; and health care treatment options including the benefits and burdens of each (Briggs & Hammes, 2011). Second, the person reflects on previous lessons learned from others who did or did not accomplish ACP and how this impacted decision making by family members and health care providers (Briggs & Hammes, 2011). Third, the person discusses their ACP ideas with family members prior to determining a proxy decision maker who should agree to honor the person's wishes under difficult circumstances when others might disagree (Briggs & Hammes, 2011). Fourth, the person documents their AD using the state-approved forms (Briggs & Hammes, 2011) which include but are not limited to the Medical Power of Attorney that identifies the proxy decision maker and the Directive to Physicians and Family or Surrogate that specifies the person's health care preferences (Advance Directives Act, 1999). Finally, the person provides copies of

their AD documentation to their health care providers and the proxy decision maker (Briggs & Hammes, 2011).

Legislative supports. Federal and U.S. state statutes regulate the facilitation and accomplishment of AD and ACP. The Medicare program requires participating hospitals to screen all clients for AD during the admission process; abide by the clients' stated wishes when providing health care; and offer ACP information, education, and facilitation services to individuals and the surrounding community (OBRA, 1990). The U.S. states legislate AD documentation and witnessing processes. Documents that comply with state requirements for consents, witnesses, date-formats, and signatures have legal standing. Documents altered by pen-ink changes are invalid and require re-accomplishment (Advance Directives Act, 1999). State-specific documentation templates are made available to U.S. citizens via the National Hospice and Palliative Care Organization's (2018) CaringInfo website.

Strategic supports. In support of the legislated requirements, the IHI, developer of the Triple AIM meta-paradigm (i.e., health, health care experience, and cost), offers free ACP information to health care providers and consumers on the IHI website and the National Healthcare Decisions Day website (The Conversation Project & Institute for Healthcare Improvement, 2017). Absent ACP metrics, baseline information, and benchmarks for evaluation, the Office of Disease Prevention and Health Promotion (ODPHP, 2016a) has stated a Healthy People 2020 goal to improve quality-of-life as well as priorities to support informed decision-making and include caregivers during person-centered care planning. For hospital accreditation purposes, the Joint Commission (2016) has established the following standard for evaluation related to AD and ACP documentation: "a one-time discussion documented anywhere in the medical record" (p.1). Additionally, the Agency for Healthcare Research and Quality (AHRQ)

(2013) offers the following measure for meaningful use by ambulatory health care providers:

“percentage of adult patients ages 18 years and older with a serious illness who have documentation in the medical record of a completed advance directive” (p. 1).

Financial supports. Fee-for-service Medicare-reimbursed ACP is defined as a 30-minute (minimum) face-to-face appointment between a Medicare-participating provider and a beneficiary (CMS, 2016a). Rules for engagement include voluntary participation by all persons and inclusion of the Medicare beneficiary’s family and/or proxy decision-maker when desired; comprehensive explanation and discussion about AD; thorough review and documentation of state-approved AD forms; beneficiary exemption from cost-shares if ACP services occurred during the annual wellness visit with the primary care provider (CMS, 2016a); provision of ACP services within health care settings (CMS, 2016b); reimbursements for ACP services when facilitated by fee-for-service Medicare providers (i.e., physicians, nurse practitioners); and no limitations on the number of ACP services provided or reimbursed if the provider produces sufficient evidence that the Medicare beneficiary experienced changes in health status (CMS, 2016b).

Professional supports. The American Nurses Association (ANA) and the IOM support proactive ACP. The ANA (2016) has established position statements related to ACP roles and responsibilities, one of which states the following: “Nurses and other health care providers have a responsibility to establish decision-making processes that reflect physiologic realities, patient preferences, and the recognition of what, clinically, may or may not be accomplished. Establishing goals of care for this patient at this time may provide a framework for discussion about what care should be provided. This process often involves collaboration with experts in decision making, such as ethics committees or palliative care teams” (p. 1). The IOM (2013a) has

declared the lack of ACP may result in the provision of cancer care that does not align with patients' goals and preferences and may delay consults to palliative care and hospice services, both of which contribute to unnecessary demands for high-cost tertiary health care services and increase the financial burdens of individuals, families, and taxpayers. For the purposes of promoting the public's awareness of ACP and normalizing ACP discussions between individuals and their health care providers, the IOM offers a comprehensive ACP education outreach campaign which includes video presentations and a consensus-based ACP QPL to facilitate ACP conversations.

Evidence-based supports. Comprehensive ACP clinical practice guidelines (CPGs) with perceived Agree II© (Minervation, 2016) quality ratings of five or higher were available via the Michigan Quality Improvement Consortium (2014), the Agency for Healthcare Research and Quality Guidelines Clearinghouse (Mitty, 2012), the National Comprehensive Cancer Network (2015), and the National Consensus Project (2013) for quality palliative care.

Common CPG themes related to the preservation of clients' autonomy and privacy; assumption of clients' capacities to make decisions; necessity of AD; determination of clients' treatment goals and care wishes; alignment of health care with clients' treatment goals and care wishes; importance of encouraging the communication of ACP information with health care providers who have the need-to-know; involvement of surrogate decision-makers in ACP; nurses' facilitation of ACP; and periodic review of ACP with updates when the clients' wishes and health changes occur (Mitty, 2012; The National Consensus Project, 2013; Michigan Quality Improvement Consortium, 2014; National Comprehensive Cancer Network, 2015). Noted CPGs differences related to the targeted populations; rating schemes for strength-of-evidence; emphasis on physicians' orders for life support (POLST); and endorsements of public, proprietary, and

evidence-based ACP facilitation products and methods (Mitty, 2012; The National Consensus Project, 2013; Michigan Quality Improvement Consortium, 2014; National Comprehensive Cancer Network, 2015).

The Gundersen Health System (2016) offered an evidence-based ACP facilitation process that can be applied throughout the lifespan and across the continuum of health care (Briggs & Hammes, 2011). Proprietary training and resources can be purchased by health care providers—including nurses. The ACP facilitation methods and materials were tailored according to the needs of well and healthy adults, clients diagnosed with chronic medical conditions, and persons likely to die within the next year. The Gundersen Respecting Choices® program demonstrated measurable increases in ACP during multiple institutional studies (Briggs & Hammes, 2011) and an inter-regional study (in der Schmitt et al., 2014).

Nursing engagement. The facilitation of ACP did not appear to be a normal inpatient nursing practice even among oncology advance practice nurses who reported moderate knowledge regarding the subject (Zhou, Stoltzfus, Houldin, Parks, & Swan, 2010). The researchers suggested nurses lacked time (Samara, Larkin, Chan, & Lopez, 2013), preparation, and/or support by leadership and the interprofessional health care team to provide ACP services (Clabots, 2012).

Nursing research. Song et al. (2010) and Song and Ward (2015) examined the effects of comprehensive nurse-facilitated ACP on client/proxy-decision maker dyads. Song et al. (2010) concluded that treatment dyads (n=10) demonstrated greater congruence regarding health care plans ($p < .05$) and perceived increased quality of communications ($p < .05$) than controls (n = 7). In a larger follow-up study, 107 client/proxy dyads were randomly selected to attend six

ACP sessions that ranged between five and 20 minutes in duration (Song & Ward, 2015). The ACP discussions focused on dyads' understanding of current illness and expectations regarding prognosis; understanding of life sustaining treatment options; determination of acceptable treatment options; statement of health care goals; acknowledgment of needs, conflicted thoughts, and the associated ambivalence; and documentation and sharing of care goals and wishes with attending health care providers such as primary care physicians and specialists (Song et al., 2010). When compared to the control group, the treatment dyads demonstrated greater congruence regarding health care goals and increased surrogates' confidence related to decision-making (Song & Ward, 2015). Additionally, the surrogates of treatment group decedents experienced decreased symptoms of depression, anxiety, and post-traumatic stress (Song & Ward, 2015).

Nursing research-translation study. Guided by the Associates in Process Improvement (2017) Model for Improvement (plan, do, study, act), nurses included a QPL in hospital admission packets to promote clients' prognostic awareness and to facilitate ACP discussions (McLawhorn, Vess, & Dumas, 2016). The QPL items were derived from the Brandes et al. (2014) question-set validated by randomized control trials. Following QPL deployment, there were noted increases in the percentages of hospice referrals and active DNR orders over a period of three months (McLawhorn et al., 2014).

Theory-based nursing clinical decision support tool. Whitehead and Carter (2017) introduced the Patient Preferences About Serious Illness (PASI) instrument to augment evidence-based ACP facilitators training. The PASI instrument was designed with consideration for Engelberg, Patrick, and Curtis' (2005) six domains of death and dying preferences and reflected Whitehead and Carter's (2017) Model of Meaningful Conversation in Serious Illness.

This ACP support tool required about 20 minutes to facilitate (Phyllis Whitehead, personal communication, February 16, 2017) and could be used by nurses across the health care spectrum (from community to inpatient) to identify clients' immediate concerns and needs related to symptom control, medical treatment, family support, caregiving services, spiritual support, and financial advisement. The information gains were intended to inform patient-centered care planning; prompt consultations to other members of the transdisciplinary team (i.e., chaplain, music therapist, social worker); document ACP discussions in the medical record; and inform other members of the health care team about the clients' health care goals and wishes.

Non-nursing ACP reviews. Tamayo-Velazquez et al. (2009) suggested repeated conversations with trained ACP facilitators were more likely to result in clients' accomplishments of AD than the use of passive methods, but meta-analyses were not plausible due to the diversity of study methods. The Agency for Healthcare Research and Quality (2014a) identified several studies that demonstrated the effectiveness of a variety of ACP methods and materials. These included QPLs, written information, computer applications, verbal interactions, vignettes, and videos all of which catered to different adult learning style preferences (i.e., visual, auditory, interactive). Butler, Ratner, McCreedy, Shippee, and Kane (2014) cited insufficient evidence to support or refute effectiveness of the computer-facilitated ACP methods.

Synthesis

The ACP processes were individualized, complicated, time-consuming, and frequently overlooked as evidenced by 70% of Americans without AD (CDC, 2014). Absent ACP, the provision of health care did not align with clients' treatment goals, values, beliefs, and wishes (National Consensus Project, 2013; Waldrop & Meeker, 2012) which increased potentials for emotional, physical, existential, and financial problems (IOM, 2013a). The IHI (2015)

considered the lack of advance directives to be as risky to clients and health care providers as the lack of information about the clients' allergies (IHI, 2015). Case in point: The health care team should not administer medications without awareness of the client's medication allergies.

Similarly, the health care team could not provide client-centered care without awareness of the client's health care goals and preferences (IHI, 2015). Preventable and undesired risks and outcomes could be avoided if inpatient safety-net nurses were equipped with education, training, and methods that normalize and facilitate ACP conversations.

Available methods and materials. The cumulative findings suggested a variety of ACP strategies that can be applied. Nurses successfully used QPLs (McLawhorn et al., 2016) and comprehensive client-centered interview strategies to build clients' trust and promote ACP normalization (Song et al., 2010; Song & Ward, 2015). Although numerous evidence-based and expert-consensus QPLs were available, additional research was needed to determine which QPLs were most efficient and effective for use by nurses in acute hospital settings, across the spectrum of health care, during discussions with ethnically and racially diverse populations, and during discussions with seriously-ill inpatient cancer care clients who lacked physical, mental, and/or emotional stamina. The theory-based PASI instrument contained QPLs and was intended to be used across the health care spectrum and in conjunction with comprehensive ACP facilitators' training (Whitehead & Carter, 2017). This clinical support tool also informed nurses about seriously ill clients' immediate needs, health care goals, and wishes, and enabled client-centered care planning.

Strategic support opportunities. There were opportunities for strategic U.S. health care agencies to assist inpatient nurses' facilitation of ACP. These included the development of Healthy People 2020 indicators and benchmarks for ACP performance evaluation; state-

sponsored ACP registries to populate Healthy People 2020 up-stream metrics and enable inpatient nurses to download clients' ACP and AD documentation; and cost-free evidence-based ACP facilitation materials specifically designed for use by inpatient nurses and seriously ill clients. Hospitals could support nurses' facilitation of ACP by providing time and effort-sensitive methods and materials to promote the efficiency and effectiveness of ACP discussions. Opportunities for research included exploring relationships between nurses' involvement with ACP and related variables such as systematic monitoring and evaluation of ACP-sensitive indicators, ACP communications among the interprofessional health care team, and incentives for facilitating ACP.

Evidence-Based Practice: Verification of Chosen Option

The literature review findings suggested evidence-based ACP facilitator's training and theory based QPLs would promote the nurses' facilitation and documentation of cancer care clients' ACP. Thus, the Cancer Committee approved the nurses to accomplish a self-learning package (SLP) which included the Gundersen Health System's (2017) on-line ACP facilitators training, and to use the PASI instrument to facilitate inpatient cancer care clients' discussions and documentation of ACP in their medical records.

Theoretical Framework

Prochaska's and Velicer's (1997) Transtheoretical Model informed the development of project components that were intended to incentivize and motivate the nurses' initiation of ACP discussions and to facilitate the nurses' and clients' ACP conversations. In accordance with the model, the stages of change include but are not limited to pre-contemplation (not ready to do ACP), contemplation (thinking about doing ACP), preparation (getting ready to do ACP), and action (doing ACP and documenting AD). Progression from pre-contemplation to contemplation,

preparation, or action indicated effectiveness of the project components which included the SLP education intervention and the PASI instrument QPLs. The SLP targeted the nurses and the PASI targeted the nurses and clients who were in ACP pre-contemplation or contemplation.

The SLP was comprised of three components: the nurses' participation incentives package; the nurses' ACP facilitation competency assessments that were conducted pre and post SLP accomplishment; and the nurses' formative and summative ACP skills evaluation surveys which were conducted pre and post PASI instrument implementation. The PASI instrument QPLs facilitated the initiation of ACP discussions that had not previously occurred between the nurses and clients. Historically, the nurses screened the clients for AD and assisted them only if requested. Paradoxically, the clients were unlikely to request ACP services due to lack of ACP normalization (Dow et al., 2010), inconsistent access to primary health care providers (Morrison, Zayas, Mulvihill, Baskin, & Meier, 1998; Fried, Bullock, Iannone, & O'Leary, 2009), and fears of giving up (Quill, 2000).

Methods

The project design was a continuous quality improvement (CQI) project guided by the Associates in Process Improvement (2017) Plan, Do, Study, Act (PDSA) method as endorsed by the IHI (2017a). The plan stage included preparations for the change; the do stage involved implementation of the change; the study stage examined the results of the change; and the act stage involved interpreting and translating the study results into recommendations for refining, normalizing, institutionalizing, and sustaining the change.

Plan

During the "plan" stage, there were two project milestones—prepare the marketing and incentives strategies to promote nurses' participation in the project orientation, and develop a

SLP to increase the nurses' readiness to facilitate and document the cancer care clients' ACPs. The quantitative measures for evaluation of the marketing and incentives strategies included the number and percent of nurses who attended the project orientation in-service. The qualitative measures for SLP evaluation included the nurse manager's and nurse champion's satisfaction with the SLP as evidenced by final approvals to distribute the SLP to the nurses.

Do

The "do" stage included marketing the project to the nurses, facilitating the nurses' accomplishments of the SLP, assessing the nurses' ACP facilitation skills pre and post SLP accomplishment, conducting the baseline medical record audit, and facilitating the cancer care clients' accomplishment and documentation of ACP. The qualitative evaluation measures related to the timeliness of the project start-date, nurses' feedback regarding the SLP, and nurses' ACP knowledge and skills indicators which included dates of ACP training and perceived abilities to comply with the hospital's policies, review AD documents for legal standing, enter AD documents into the clients' medical records, facilitate ACP discussions, and refer the client to a formally-trained ACP facilitator when needed. A subjective "low, medium, and high" scale was applied to the latter five measures. The quantitative evaluation measures included the percent of nurses who participated in the project; the percent of baseline audit medical records that contained ACP or AD documentation; the percent of nurses who completed the SLP; and the number of ACP services facilitated by the nurses.

Study

A time series analysis was conducted to compare the baseline and two follow-up medical record audits of ACP and AD documentation. Additionally, the nurses' perceptions of ACP facilitation knowledge and skills were evaluated prior to and following employment of the PASI

instrument, and the cancer care clients' ACP experiences were evaluated. The quantitative measures for evaluation included the percent change in ACP and AD documentation over a two month timeframe; the nurses' perceived abilities to facilitate ACP and identify barriers to ACP conversations; and the clients' perceived abilities to share their health care goals and preferences, make decisions about their health care plans, and have their ACP needs met. A scale of 1-5 was applied to each nurse sensitive measure and signified "low" to "high" respectively. Likewise, a scale of 1-5 was applied to each client sensitive measure and signified "not at all" to "very much" respectively. The qualitative evaluation measures included the nurses' feedback regarding opportunities to improve the SLP, the average time spent facilitating ACP with clients, and the clients' suggestions for ACP program improvement and requests for additional ACP information.

Act

The "act" stage milestones related to interpreting and translating the study results into recommendations related to refining, improving, expanding, normalizing, institutionalizing, and sustaining comprehensive ACP facilitation services. The qualitative measures were evidenced by the consideration and incorporation of clients' and nurses' comments stated on the feedback surveys. A summary of the project's PDSA stages, milestones, data sets, and measurements is documented in Appendix C.

Goals, Objectives and Measures

The following project goals and rationales were established with consideration for the IOMs (2001) six quality domains (equitable, patient-centered, timeliness, effectiveness, efficiency, safety) and the specific, measurable, attainable, relevant, timely (SMART) acronym as follows.

1. Increase the number and percentage of nurses involved in ACP facilitation using the PASI instrument during the fifth and sixth months of the project to 13 (greater than 50%) in accordance with the IOM (2001) quality standards safety and timeliness.

2. Increase the number of female cancer care clients' who accomplished the ACP processes when offered PASI facilitation during the fifth and sixth months of the project to 9 (approximately 30% of 30) in accordance with the IOM (2001) quality standards equitable and patient-centered.

3. Increase the percentage of ACP and AD documentation in female cancer care clients' medical records by 20% during the fifth and sixth months of the project in accordance with the IOM (2001) quality standard timeliness.

4. Increase the number and percentage of nurses' who effectively facilitated ACP using the PASI instrument by the seventh month of the project to 13 (greater than 50%) in accordance with the IOM (2001) quality standards effectiveness and efficiency.

5. Increase the number and percentage of nurses' who perceived empowerment to advocate for clients' health care goals and wishes by the seventh month of the project to 13 (greater than 50%) in accordance with the IOM (2001) quality standard patient-centered.

The project goals and evaluation measures are summarized in Appendix D and the corresponding objectives, measures, expected outcomes, and desired impacts are mapped to type and timeframe in Appendix E as recommended by Munet-Vilaró and Oppewal (2016).

Project Site and Population

The project was sponsored by a Magnet® designated hospital that specializes in providing state-of-the-art cancer care services for a large metropolitan area with approximately 1.8 million residents. The local health care network included nine hospitals and two emergency

centers. Recent workload volumes are displayed in Table 1.

Table 1

Magnet® Health Care System's Workload for 2012 and 2013

	2012	2013
Emergency	255,755 (average 701/day)	303,792 (average 832/day)
Inpatient	84,263	89,075
Outpatient medical	108,421	152,797
Outpatient surgery	37,421	46,538
Total	494,146	592,202

Source: Community Survey (Magnet® Designated Hospital, 2014-2016)

Description of the population. The population of concern included cancer care clients (n=198 during 2015) who resided in the local area and were admitted to the Magnet® designated hospital regardless of ability to pay. During that timeframe, approximately 20% of the residents subsisted on incomes below the federal poverty threshold (U.S. Census Bureau, 2015) and 33% of adults were medically uninsured (State Medical Association, 2010), because state legislators did not elect the Medicaid expansion provisions under the Affordable Care Act (Whitehouse.gov, 2015). According to the U.S. Bureau of Labor Statistics (2016) the unemployment rate was 4.1% and average weekly wages were \$850.00 (U.S. = \$1043.00). Ethnicities included Hispanic (58%); White (34%); Black (6%); and others (2%) (Magnet® Designated Hospital, 2014-2016). Females comprised 51% of the population and the age groups for both genders were as follows: 0-17 (27%), 18-44 (37%); 45-64 (24%); 65+ (11%) (Magnet® Designated Hospital, 2014-2016).

Within the metropolitan area, there were approximately 164 per 100,000 cancer-related deaths per year (Metropolitan Health District, 2013). This percentage exceeded the Healthy People 2020 benchmark of 161/100,000 (ODPHP, 2016b). Historical cancer disease rates are summarized in Table 2.

Table 2

2009 Gender-Specific Cancer Rates per 100,000

Cancer Type	Males	Females	U.S.
Lung	38.5	23.1	52.3
Colon	15.4	11.0	17.5
Breast	0.1	20.9	13.5
Pancreas	8.4	8.7	11.6
Prostate	11.9	--	9.4
Leukemia	5.7	3.9	7.4
Lymphoma	6.3	5.1	6.7
Liver	11.9	4.4	6.0
Ovarian	--	7.8	4.7
Stomach	4.2	5.5	3.7
Skin	1.6	1.2	2.8
Uterine	--	3.6	2.5
Cervical	--	3.1	1.3

Source: Metropolitan Health District (2009)

According to 2015 data collected by the hospital's Palliative Care Team, the majority of inpatient cancer care clients were Hispanic and White females who were eligible (or were approaching eligibility) for Social Security and Medicare benefits (Figures 1 through 3). Approximately one-third of these persons were unlikely to have experienced consistent access to primary care managers who would have expedited the detection of cancers using evidence-based primary and secondary prevention strategies, facilitated timely referrals to tertiary cancer care specialists, and normalized ACP by offering information and assistance during the annual wellness visits. These demographic and clinical profile findings suggested the lack of ACP among the clients was due to social, economic, and health care disparities.

Figure 1. Target Population by Gender

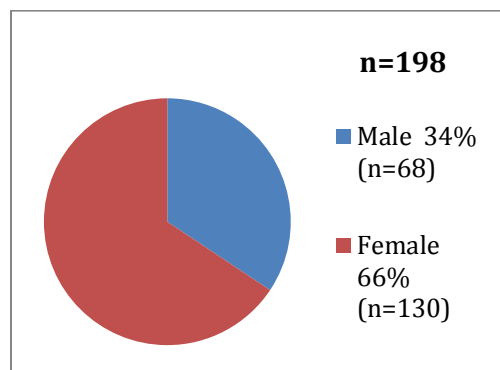


Figure 2. Target Population by Race

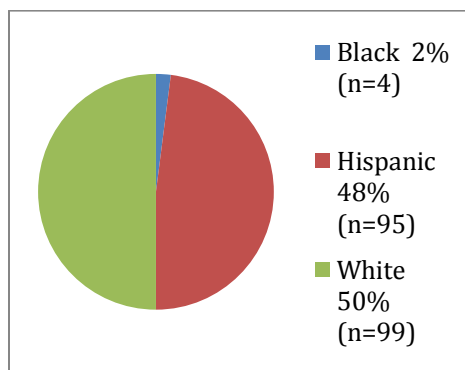
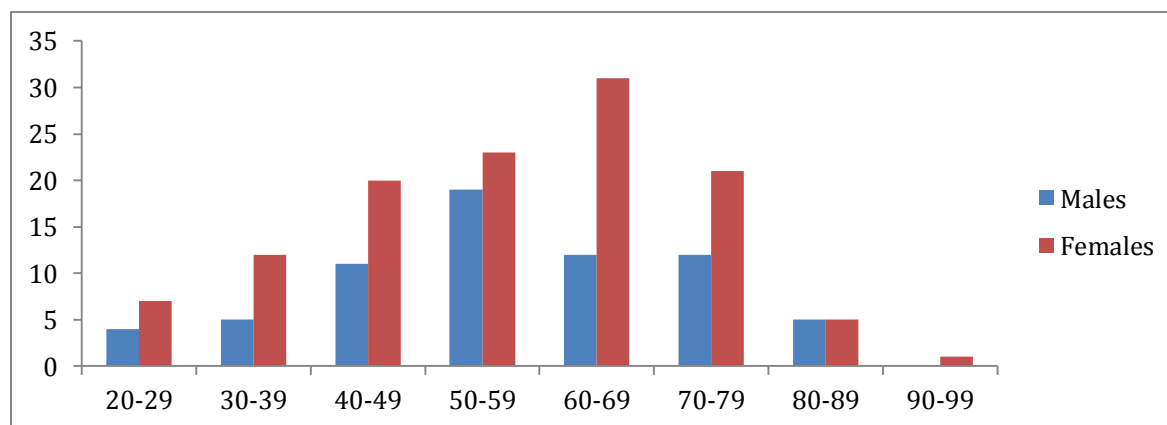


Figure 3. Target Population by Age



Project location, resources, and participants. The project took place on the inpatient cancer care unit. Resource requirements included a nurse champion, computer, Microsoft software, office space, printer, desk, Minitab statistics software, office supplies, and on-line Gundersen Health Care training modules for the nurses. The project participants included the nursing staff, the administrative assistants, inpatient clients and their families, cancer care hospitalists, the Cancer Committee, the Palliative Care Team, and a project facilitator. The Cancer Committee pre-authorized the project and monitored and evaluated progress, outcomes, and impacts.

The nurse manager, nurse champion, and the palliative care clinical nurse specialist facilitated the nurses’ ACP training and evaluation. The nurses, inpatient clients, and their

families used the PASI instrument to accomplish and document ACP discussions. The administrative assistants maintained the PASI documentation in the clients' medical records. The cancer care hospitalists endorsed the project and encouraged the nurses and palliative care team to facilitate the cancer care clients' ACP. The palliative care clinical nurse specialist and the nurse champion conducted the medical record audits in accordance with the hospital's Data Use Agreement. The project facilitator analyzed the de-identified medical record findings, monitored and evaluated the project timelines and the accomplishment of the project goals and objectives, evaluated the project impacts, and documented reports for the Palliative Care Team and the Cancer Committee. The palliative care clinical nurse specialist reported the project's progress, outcomes, impacts, and recommendations to the Cancer Committee.

Project site analysis. The 20-bed women's cancer care unit was staffed by 25 registered nurses. Specialty OB/Gyn services included but were not limited to the provision of comprehensive cancer care treatments. Based on projected community needs, there were plans to expand the nursing unit's capacity to 32-beds in the future. The nurse manager agreed to sponsor the *Critical Choices Conversation* pilot project and she designated a nurse champion. The project organizational chart is illustrated in Appendix F.

Description of the sampling method. The population of interest included inpatient clients diagnosed with cancer. The subject samples included female clients who were diagnosed with cancer for more than one week and had not accomplished AD or ACP documentation. One baseline and two follow-up collections of 30 or more medical records were audited for evidence of AD or ACP. The first sample was comprised of EMRs that closed prior to the PASI instrument facilitation project. The second and third samples included all available medical records during the first and second months of PASI instrument facilitation project respectively.

Variables such as small sample sizes, female gender, and age potentially biased the project's results and affected the interpretation and generalization of findings.

Setting facilitators and barriers. Key facilitators included the palliative care clinical nurse specialist who initiated and sustained communications with strategic hospital stakeholders; the Cancer Committee members; physician hospitalists; the nurse manager who endorsed the quality improvement project; the nurse champion who assisted the SLP development and conducted the baseline and follow-up medical record audits; and the inpatient nurses' who were motivated to learn about their clients' health care goals, wishes, and preferences and to align clinical practices with the strategic Healthy People 2020 priorities, the OBRA (1990) law, the state law, and the Joint Commission's accreditation requirements. Additional external facilitators included Dr. Whitehead's permission to use the PASI instrument free-of-charge (Appendix G) and project funding by a local university to purchase the evidence-based on-line Gundersen training for the nurses.

Project barriers included the nurses' time constraints and abilities to participate in the quality improvement project. Strategies for overcoming these barriers included palliative care team mentorship and assistance with the ACP and PASI instrument facilitation processes. Based on the literature review findings and the population demographic assessment, anticipated clients' barriers related to the lack of ACP knowledge and experience due to chronic limited access to primary health care providers who would have normalized and facilitated ACP during wellness visits; lack of motivation to discuss ACP goals and corresponding health care treatments with the inpatient health care team (Fried, Bullock, Iannone, & O'Leary, 2009); spiritual distress about life's meaning and corresponding goals and priorities (Jenko & Pace, 2016); cultural superstitions that ACP discussions could invite the occurrence of death (Mazanec & Panke, 2016); health

literacy barriers as indicated by a history of non-compliance with medication prescriptions and/or inability to safely sort medications (Mazanec & Panke, 2016); physical discomforts such as nausea, chronic or acute pain (Jenko & Pace, 2016); cognitive and sensory deficits associated with the aging process (i.e., vision, hearing); fears of frightening and stressing the proxy decision maker and/or significant others by discussing ACP goals and priorities (Mazanec & Panke, 2016); language illiteracy and inability to read and understand written ACP information (Hughes & Kinderman, 2016; Mazanec & Panke, 2016); and moment-to-moment focus on the present crises (Hughes & Kinderman, 2016).

Implementation Plan and Procedures

The project occurred over a period of seven months. Following IRB exemptions by the UMASS Capstone Committee and the Magnet® designated hospital, a request for funding was submitted and generously granted by a local university. Guided by the PDSA method, the quality improvement project was implemented in the following order: P—Developed and refined the project components which included the SLP, marketing strategies, and participation incentives; D—Marketed and facilitated the SLP, assessed nurses' ACP facilitation skills pre and post SLP, conducted a baseline medical record audit of ACP and AD documentation, and facilitated ACP with cancer care clients; S—Evaluated follow-up medical record audits of ACP and AD documentation, nurses' perceptions of ACP competencies prior to and following the employment of the PASI instrument, and clients' feedback regarding their ACP experiences; A—With consideration for the overarching project aims, translated interpretations of the study results into recommendations for improving, normalizing, institutionalizing, and sustaining ACP facilitation.

Developed marketing and incentive strategies. Consistent with the literature review findings, ACP facilitations by inpatient nurses' were not normal practices (Zhou, Stoltzfus,

Houldin, Parks, & Swan, 2010). Contributing factors included lack of time, evidence-based training, and professional incentives. In accordance with the nurse manager's preferences, the nurses were not required to participate in the project and were permitted to accomplish the SLP during duty hours. The project marketing strategies included electronic-memoranda (e-memos), a poster board, and change-of-shift in-services. The e-memos informed the nurses about the training dates and introduced the project and the SLP (Appendix H). The poster was presented during change-of-shift in-services. This visual aid informed the nurses about the PDSA cycle, project milestones, and timelines and provided a place (cloud graphic) for the nurses to document their commitments by writing their names. The in-services incorporated a review of the SLP and SLP folder contents and information about opportunities to earn free continuing education hours and clinical ladder points depending on the following levels of participation—SLP accomplishment, ACP facilitation and documentation, and medical record audit support.

The nurse champion suggested project participation should be incentivized by awarding clinical ladder points according to the hospital's I-CARE values and the policy entitled *Clinical Excellence for the Registered Nurse*. The incentives rules were established as follows: 1) four points for each nurse who implemented innovative practices by using the PASI instrument to facilitate and document cancer care clients' ACP discussions, and promoted compliance with Joint Commission accreditation requirements by documenting cancer care clients' ACP in the medical records; 2) 1.2 points for each nurse who advanced their professional development by completing the Gundersen ACP Facilitators continuing education activity; and 3) four additional points for the nurse champion who facilitated the quality improvement structures and conducted the medical record audits for evidence of compliance with the Joint Commission's requirements.

Developed self-learning package. The project facilitator, a palliative care clinical nurse

specialist, and the leadership (manager, nurse educator, and nurse champion) developed, reviewed, and refined the SLP components which included the following: table of contents; the introduction memorandum; a survey to be completed prior to and following the SLP training to assess the nurses' perceived confidence in facilitating ACP discussions; instructions for reading assignments and the on-line training activity; additional readings, resources, and references; the PASI instrument and protocol; the PASI instrument user permission letter; and formative and summative project feedback surveys. Additionally, the SLP instructed the nurses to submit their assessments and surveys to the nurse champion.

Training folder contents. Each SLP folder contained a table of contents; the SLP; an evidenced-based ACP facilitators training module; a \$25 gift card; a uniform lapel pin with the National Healthcare Decisions Day Campaign logo "Ask me about advance directives" (The Conversation Project, & Institute for Healthcare Improvement, 2017); the American Nurses Association (2016) position statement regarding the facilitation of ACP and AD; the National Academy of Sciences, National Academy of Engineering, Institute of Medicine, and National Research Council (2013) news release related to the U.S. cancer care crisis and the need for patient-centered care; the IHI (2016) ACP motivational article for health care providers to consider treating "end-of-life wishes like allergies" (p. 1); the Hospice & Palliative Nurses Association (2013) position statement regarding ACP nursing roles; the Joint Commission's (2016) accreditation evaluation standards for AD and ACP documentation in clients' medical records; and an ACP toolkit developed by the project facilitator for the Palliative Care Team's webpage.

Plan stage lessons learned. Prior to distribution to the nurses, the SLP was pilot tested by the palliative care clinical nurse specialist and the nurse champion who offered the following

feedback which was applied to refine the SLP.

Recommendation 1. Print all of the required reading materials—do not include CD-ROM disks and URL links.

Rationale. The IM/IT administrators will not permit the nurses to download private or public domain information due to concerns about cyberspace threats to the information management systems' integrity. Also, URL links can change.

Recommendation 2. Find an alternative to the on-line IHI (2017b) learning activity entitled *PFC 202: Having the conversation: Basic skills for conversations about end-of-life care*.

Rationale. This article will not be accessible to the nurses unless they purchase a subscription to the IHI website.

Recommendation 3. Instruct the nurses to document how much face-to-face time they spend with the clients during ACP facilitation with the PASI instrument.

Rationale. This level-of-effort information may be needed to justify staffing adjustments or assistance during the project and may be compared to alternative ACP facilitation strategies following the project.

Recommendation 4: Include a brief summary of information about the nurses' potentials to earn clinical ladder points after participating in the quality improvement project.

Rationale: A reminder about the clinical ladder point incentives will externally motivate the nurses to volunteer for the project.

Following incorporations of the above recommendations, the SLP was approved by the nurse manager and nurse champion for distribution during two change-of-shift in-services attended by 17/25 (68%) of the nurses. Ten nurses attended the Thursday evening in-service, and seven nurses attended the Friday evening in-service. Nurses who did not attend the two in-

services were encouraged by the nurse champion and the project facilitator to accomplish the SLP and to participate in the project.

Marketed and facilitated SLP. The project poster was placed in the nurses' breakroom and used to inform the nurses (participants and non-participants) about the PDSA cycle, project milestones, and timelines. During the in-services, two nurses' expressed concerns about facilitating ACP. One nurse mentioned that she was in orientation and did not feel knowledgeable or experienced with ACP but she was interested in learning. According to Hagen et al., (2015) and Dellava (2017) registered nurses' generally lack formal ACP education and training. The other nurse stated she did not desire the additional ACP duties. According to Gott et al., (2009) there is a persistent lack of consensus among health care providers regarding who should facilitate ACP. Both nurses' responses indicated needs for emphasis on ACP and AD by undergraduate nursing programs and increased normalization during hospital and inpatient unit orientations. With consideration for Prochaska's and Velicer's (1997) stages-of-change concepts contemplation and pre-contemplation respectively, both of these persons were encouraged to participate in the in-service and to accomplish and provide feedback about the SLP even if they did not elect to facilitate the cancer care clients' ACP discussions with the PASI instrument.

Following the in-services 12/25 (48%) of the nurses volunteered to accomplish the SLP within one month. During this timeframe, the nurse manager sent periodic e-mail reminders regarding the importance of SLP completion in a timely manner. By the due date, a total of seven (28%) nurses declared intentions to participate in the project as evidenced by their completion of the SLP and the submission of their ACP competency assessments and formative feedback surveys.

Assessed nurses' ACP facilitation skills. Prior to and following accomplishment of the SLPs, the nurses accomplished ACP facilitation readiness assessments by rating specific ACP facilitation skills as low, medium, or high. The pre and post assessment results were compared with consideration for Prochaska and Velicer's (1997) stage of change—preparation, and the findings were intended to identify nurses' needs for additional mentoring and support by the palliative care clinical nurse specialist.

Assessment tools. Pre and post SLP competency assessment tools were developed with consideration for standards contained in the state's Advance Directives Act (1999) and the OBRA law. The purposes of the assessments were to determine the nurses' baseline and subsequent needs for ACP knowledge and skills prior to and following SLP accomplishment; assist the nurse manager in updating the nurses' education records; and assist the palliative care team with tailoring ACP facilitation between the nurses and clients during PASI instrument implementation.

The assessment tools were coded to enable comparisons and to maintain the nurses' anonymity; distributed via the SLPs; and collected by the nurse champion. Both tools instructed the nurses to document dates of AD/ACP trainings and perceived skills (low, medium, high) related to complying with the hospital's AD policies; reviewing AD documentation for updated information and legal standing; placing AD documents in the medical record; facilitating ACP discussions; and referring clients/families to a formally-trained ACP facilitator when necessary (Appendix I).

Assessment findings. Seven nurses completed the SLP and submitted their pre and post competency assessments. Information of interest included recalled and recognized dates of

formal ACP training pre and post SLP accomplishment (Table 3) and perceptions of ACP knowledge and skills (Table 4).

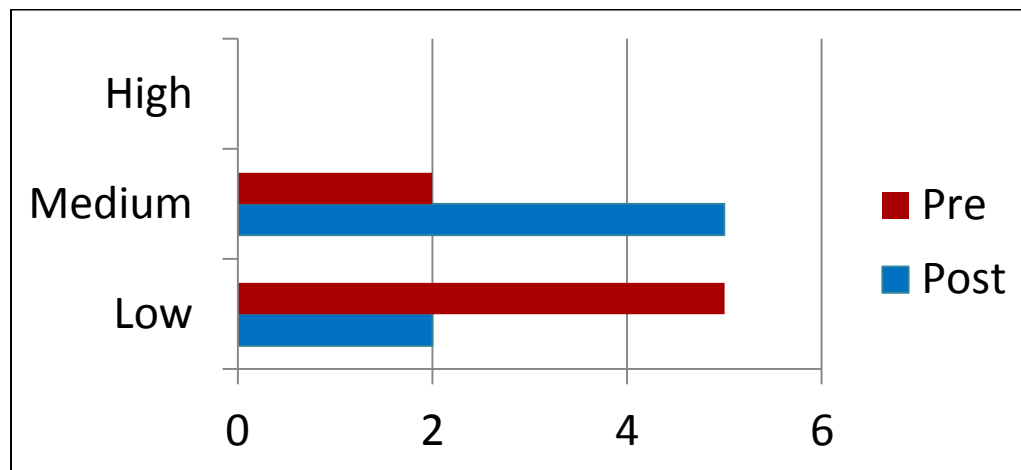
Table 3

Nurses' Recalled and Recognized Dates of Formal Training Pre and Post SLP

Measure	<i>n (pre)</i>	<i>% (pre)</i>	<i>n (post)</i>	<i>% (post)</i>	<i>trend</i>
Reviewing hospital's AD policies:					
1 year	3	43	4	57	+
5 years		0			
>5 years		0			
Other	4	57	3	43	-
Reviewing AD documents for updated information:					
1 year	2	29	3	43	+
5 years		0			
>5 years		0			
Other	5	71	4	57	-
Reviewing AD documents for correct format:					
1 year	1	14	3	43	+
5 years		0			
>5 years		0			
Other	6	86	4	57	-
Placing AD documents in medical records:					
1 year	2	29	3	43	+
5 years		0			
>5 years		0			
Other	5	71	4	57	-
Facilitating ACP discussions:					
1 year	1	14	3	43	+
5 years		0			
>5 years		0			
Other	6	86	4	57	-
Referring client/family to formally trained ACP facilitator:					
1 year	2	29	3	43	+
5 years		0			
>5 years		0			
Other	5	71	4	57	-

The pre and post SLP assessment results demonstrated upward trends in perceived ACP skills as evidenced by increased (↑) knowledge regarding the following: contents of hospital policies (43% ↑ to 57%); reviewing clients' AD documents for updated information (29% ↑ to 43%); reviewing clients' AD documents for correct format and legal standing (14% ↑ to 43%); entering AD documents in clients' medical records (29% ↑ to 43%); facilitating ACP discussions when AD documents not accomplished (14% ↑ to 43%); and referring the client to a formally trained ACP facilitator if needed or when requested (29% ↑ to 43%). Prior to accomplishing the SLP, five of seven (71%) nurses perceived low confidence in ACP facilitation skills. Following the SLP completion, five of seven (71%) nurses rated their ACP facilitation skills as medium. This upward trend is illustrated in Figure 4.

Figure 4. Nurses' Perceived ACP Skills Pre and Post SLP



Following completion of the SLP, the majority of nurses reported medium or high confidence in complying with hospital policies (71%); reviewing AD documents for updated information (71%); reviewing AD documents for correct format/legal standing (71%); placing ACP documents in the clients' record (57%); and referring the client/family to a formally trained ACP facilitator if needed or requested (71%) as summarized in Table 4.

Table 4

Nurses' Perceived ACP Knowledge and Skills Pre and Post SLP

Measure	<i>n (pre)</i>	<i>% (pre)</i>	<i>n (post)</i>	<i>% (post)</i>	<i>trend</i>
Complying with hospital's AD policies:					
Low	4	57	2	29	-
Med	3	43	2	29	-
High	0	0	3	43	+
Reviewing AD documents for updated information:					
Low	4	57	2	29	-
Med	3	43	3	43	=
High	0	0	2	29	+
Reviewing AD documents for correct format:					
Low	6	86	2	29	-
Med	1	14	5	71	+
High	0	0	0	0	=
Entering AD documents in medical records:					
Low	5	71	3	43	-
Med	2	29	3	43	+
High	0	0	1	14	+
Facilitating ACP discussions:					
Low	5	71	2	29	-
Med	2	29	5	71	+
High	0	0	0	0	=
Referring client/family to formally trained ACP facilitator:					
Low	3	43	2	29	-
Med	1	14	1	14	=
High	3	43	4	57	+

As requested, the nurses offered the following comments and feedback related to: 1) hospital policies—"should be introduced in hospital orientation and/or annual competencies"

“more open discussion on hospital policies;” 2) reviewing clients’ AD documents—“nurses need access to HPF (i.e., EMR archives) or process to ensure copies on chart on admission”

“education on knowing what to look for” “staff could use in-depth training on advance directives, medical power of attorney, etc.,” 3) entering clients’ AD documents into the medical record—“training from informatics nurses;” 4) facilitating ACP discussions—“not feasible for bedside nurses;” and 5) referring client/family to formally-trained ACP facilitator—“may require additional resources over time.”

Assessment implications. The assessment findings suggested that the nurses felt more comfortable facilitating ACP following completion of the SLP, and that their self-confidence was gaining strength. Even so, the palliative care clinical nurse specialist offered to advise and assist the nurses with ACP facilitation as needed in accordance with recommendations by Seymour, Almack, and Kennedy (2010).

Conducted baseline EMR audit. Following the IRB-exemption determinations by the UMASS and the hospital, a baseline sample of female cancer care clients’ EMRs was audited for evidence of AD or ACP documentation using the Joint Commission’s (2016) national quality measure entitled *Discussion of Advance Directives/Advance Care Planning*. The nurse champion collected daily reports of inpatient admissions, queried eligible cancer care clients’ EMRs for evidence of AD or ACP discussions, and provided the de-identified EMR audit findings to the project facilitator for analysis.

At baseline, 11/38 (29%) of pre-PASI implementation EMRs contained “A one-time advance directives/advance care planning discussion documented anywhere in the medical record” in accordance with the Joint Commission’s (2016) accreditation requirements. These baseline EMR audit findings aligned with the Centers for Disease Control and Prevention (2014)

report that approximately 70% of U.S. adults have not accomplished advance directives, and verified the need for ACP process improvement.

Facilitated and documented clients' ACP. Assisted by the palliative care clinical specialist and the nurse champion, the nurses offered nine ACP facilitations to established cancer clients who had not accomplished AD using the following script: "Often times, people who are admitted to the hospital can have questions and concerns regarding their treatment. Would you like to share your health care goals, needs and preferences at this time by answering some questions?" The nurses then offered the PASI instrument and an ACP feedback survey to the clients who were permitted to refuse or discontinue the ACP discussion at any time. The nurses then documented a receipt for each client who accepted the PASI facilitation and submitted all receipts to the nurse champion. The PASI instrument facilitation and documentation process flowchart is illustrated in Appendix J.

Determined project data to be studied. The pilot project studies focused on the documentation of ACP and AD in female cancer care clients' medical records pre and post PASI instrument facilitation; the nurses' perceived ACP facilitation knowledge and skills prior to PASI facilitation and at the conclusion of the project; and the clients' experiences and satisfactions with the ACP facilitation process.

Time series analysis. One and two month follow-up medical record audits were conducted to determine the presence of AD and ACP documentation. The findings were compared to the baseline results and percent changes were calculated in order to determine whether a 20% increase occurred. The purpose of the study was to identify opportunities for improvement in terms of ACP policies, practices, normalization, and training; and compliance with the Joint Commission's (2016) accreditation standards.

Nurses' formative and summative evaluation and feedback study. Following completion of the SLPs and during the conclusion of the project, the nurses documented formative and summative evaluations of their perceived ACP facilitation knowledge and skills, identified opportunities to improve the SLP, and estimated the amount of time spent facilitating ACP discussions with the clients. The survey results were analyzed with consideration for Prochaska and Velicer's (1997) stages of change—preparation and action, and the purpose of the study was to inform pilot project conclusions and recommendations.

Clients' feedback study. Cancer care clients who received ACP services were given the opportunity to provide feedback about their experiences and satisfaction by completing a four item survey and offering additional comments and suggestions. The survey results were analyzed with consideration for Prochaska and Velicer's (1997) stage of change—preparation and action. The purposes of the study were to identify the clients' needs for additional information, supports, and assistance from the palliative care clinical nurse specialist.

Developed measurement instruments. Project-specific instruments were developed to facilitate the study processes, determine the study outcomes and impacts, and identify opportunities for improvements and additional studies. The measurement instruments included baseline and follow-up medical record audit tools, nurses' formative and summative evaluation and feedback surveys, and the clients' feedback survey.

Audit tools. The medical record audit tools were designed with consideration for the Joint Commission's (2016) national quality measure entitled *Discussion of Advance Directives/Advance Care Planning*. The purposes of the tools were to measure whether the overarching project goal was achieved. Each tool contained the following headings: audit item, data element for inspection, data element for extraction, the findings, potential data sources,

criteria for evaluation, and rationale (Appendix K). Data of interest included the client's discharge date and presence or lack of AD or ACP documentation.

Nurses' surveys. The nurses' pre and post PASI instrument implementation evaluation and feedback surveys were developed with consideration for Briggs and Hammes' (2011) publication entitled *Building a Systems Approach to Advance Care Planning*. The purposes of the surveys were to assist the Palliative Care Team with documenting and reporting the project outcomes; identify opportunities for SLP improvement prior to offering to other inpatient nursing units; and determine the nurses' formative and summative gains in terms of facilitating ACP conversations with clients/families, identifying clients' and clinicians' barriers to ACP conversations, and applying open-ended questioning techniques using the PASI instrument when facilitating ACP conversations (Appendix L).

Clients' survey. The client/family ACP facilitation feedback surveys were also developed with consideration for Briggs and Hammes' (2011) publication entitled *Building a Systems Approach to Advance Care Planning*. The purposes of the surveys were to inform the nurses' of clients' needs for additional AD and ACP information and to use the clients' suggestions to improve the ACP processes; assist the Palliative Care Team with documenting and reporting the project outcomes; identify opportunities for ACP training and facilitation improvements; and evaluate the clients' feedback related to sharing health care goals and preferences, making decisions about their health care plan, and achieving their ACP needs (Appendix M).

Established data collection procedures. Prior to the project's approval, a hospital Data Use Agreement (DUA) was documented and signed. In accordance with the DUA, all data were required to be collected by hospital employees and de-identified of clients' and nurses'

information prior to review and analysis by the project facilitator. The follow-up medical record audits occurred one and two months after PASI instrument implementation. The inclusion/exclusion criteria were all established female clients diagnosed with cancer during the two months of the medical record audit. The nurse champion was provided access to the EMR database and she evaluated all available records that met inclusion/exclusion criteria for the presence of ACP or AD documentation.

Nurses' evaluation and feedback. Formative and summative evaluation and feedback surveys were distributed to the nurses. The formative survey process was accomplished prior to the PASI instrument facilitation and the summative survey process occurred during the conclusion of the pilot project. Both surveys were facilitated and collected by the nurse champion and coded with alphabetical letters to enable the comparison of results and to maintain the nurses' anonymity.

Clients' feedback. During the first and second months of ACP facilitation with the PASI instrument, feedback surveys were offered to the clients by the nurses and collected by the nurse champion. If the clients did not complete the feedback survey during their hospital admission, the nurse champion offered the clients a second opportunity to provide feedback during the routine post-discharge telephone follow-up encounter. The clients were informed that completion of the survey was voluntary and that their feedback would be used to identify opportunities for improvement.

Developed data analysis plan. The inpatient medical records were audited during a two month period for the presence of ACP or AD documentation. The results for each month were compared to the baseline audit findings to determine the percent changes in ACP and AD documentation. At the conclusion of the project, the clients' feedback survey item mean scores

were calculated and the comments were reviewed in order to identify opportunities for ACP facilitation improvements. The nurses' formative and summative feedback surveys were analyzed using the Wilcoxon signed-rank test in accordance with the following assumptions: matched data pairs, interval level dependent variables (scale 1 to 5), total sample greater than five pairs, and non-normal data distributions. The null hypotheses were no differences in the nurses' perceived abilities to facilitate ACP conversations; state client, family, and clinician barriers to ACP discussions; and apply open-ended questioning techniques with the PASI instrument when facilitating ACP conversations.

Ethics and Protection of Human Subjects

The following premises guided the ethical considerations and protocols to protect the human subjects: 1) the presence of ACP documentation (PASI) in the cancer care clients' medical records demonstrated compliance with the Joint Commission's (2016) accreditation standard and requirement for "a one-time discussion documented anywhere in the medical record" (p. 1); and 2) legally-competent adults reserved the right to refuse any health care services, including ACP facilitation in accordance with the OBRA (1990) and the ethical principle—autonomy. With consideration for the Joint Commission's and the OBRA standards, the project protocols did not require the nurses to obtain the cancer care clients' informed consent in order to offer and facilitate ACP discussions using the PASI instrument. The nurses engaged the clients and families with an invitation statement and then facilitated ACP with the PASI QPLs if the clients did not decline. If at any time during the ACP process the client expressed a desire to end the ACP discussion, then the nurses complied with the client's wishes.

A Human Subjects Determination Form was filed and approved by the UMASS IRB and the PASI documentation was handled in accordance with Health Insurance Portability and

Accountability Act (HIPAA) of 1996 standards that protect health care information. The PASI documents were placed in the clients' paper record and forwarded to the medical records personnel for scanning into the EMRs following the clients' dispositions. The original PASI documents were then properly disposed of in accordance with hospital policies. Risks included potentials for the clients' to physically or emotionally decompensate during the ACP facilitation. Benefits included the health care team's increased ability to understand and to honor clients' health care goals and wishes. In accordance with the hospital's DUA, all information provided to the project facilitator during the baseline and follow-up medical record audits was aggregated and de-identified. Additionally, all electronic files, analyses, and reports were password protected to prevent unauthorized access.

Results

To recap, the preparations, baseline medical record audit, and nurses' assessments and trainings occurred during the first and second months of the pilot project (Plan and Do phases). Between the third and sixth months, the follow-up medical record audits were conducted, the nurses accomplished formative and summative evaluations of their perceived ACP competencies, and the cancer care clients' feedback surveys were offered, collected, and analyzed (Study phase). During the sixth and seventh months of the project, the results of the three studies were reviewed, summarized, and reported to the Cancer Committee (Act phase). The timelines are stated in Appendix N.

Medical Record Audit

The seven participating nurses offered nine ACP facilitations and documented four ACP discussions with cancer care clients using the PASI instrument during a two month time period. The medical record audit results are summarized in Table 5.

Table 5

Medical Records Containing AD or ACP Discussions with Clients

Measure	Total # records reviewed	n	%	% change from baseline
Baseline	38	11	29	--
One-month	33	11	33	0
Two-months	30	6	20	-45

Note: The Joint Commission (2016) requires a one-time advance directives/advance care planning discussion documented anywhere in the medical record.

First-month medical record audit details. The nurses offered five ACP facilitations and 11/33 (33%) of the medical records contained either AD (n= 9) or a completed PASI instrument (n=2). Of the two clients who documented the PASI, one was subsequently admitted to hospice and the other elected to accomplish an AD prior to re-admission during the second month of the project. The percentage of cancer care clients' medical records with ACP and AD documentation was approximately equal to the baseline result and the desired benchmark of a 20% increase was not attained. Similarly, 27% (9/33) of the medical records contained AD which fell below the national norm (30%).

Second month medical record audit details. The nurses offered four ACP facilitations and 6/30 (20%) of the medical records contained either AD (n= 4) or a completed PASI (n=2). The percent change from baseline was -45% and the desired benchmark was not attained. Accordingly, 4/3 (13%) of the medical records contained AD which fell below the national norm (30%).

Nurses' Evaluation and Feedback Surveys

The seven nurses accomplished the formative and summative feedback surveys. Information of interest included perceived gains in ACP facilitation knowledge and skills, satisfaction with the SLP, and the amount of time spent with cancer care clients facilitating ACP (Table 6).

Table 6

Nurses' Perceived ACP Facilitation Skills, SLP Satisfaction, and Time Spent

Feedback Survey Item	Formative (prior to ACP facilitation with PASI instrument)		Summative (end of the project)	
	n	μ	n	μ
Facilitate ACP conversations with clients	7	3.7	7	3.6
State two client/family barriers to having ACP discussions	7	4.1	7	4.7
State two clinician barriers to facilitating ACP discussions	7	4	7	4.3
Apply open-ended questioning technique when facilitating ACP conversations	7	3.4	7	3.9
Satisfaction with SLP	-	-	7	4.4
Time spent with client				
5 minutes or less	-	-	2	-
6 to 15 minutes	-	-	3	-
16 to 30 min	-	-	1	-

Formative evaluation and feedback survey details. The mean scores for all formative survey items were 3.4 or higher on a scale of 1-5: facilitated ACP conversations ($\mu = 3.7$, range = 2-5); state client/family barriers to ACP discussions ($\mu = 4.1$, range = 3-5); state clinician barriers to ACP discussions ($\mu = 4$, range = 3-5); and apply open-ended questioning technique (PASI) when facilitating ACP conversations ($\mu = 3.4$, range = 1-5). The nurses offered the following comments and feedback: “Death is a subject that I find hard to discuss with people. I hope to get better at it.” “Perhaps providing a script on how to initiate this conversation would be helpful.”

“Would like to shadow an experienced clinician during initial ACP or AD discussion.” “Need more practice.”

Summative evaluation and feedback survey details. The mean scores for all summative survey items were 3.6 or higher: facilitate ACP conversations ($\mu = 3.6$, range = 3-5); state client/family barriers to ACP discussions ($\mu = 4.7$, range = 4-5); state clinician barriers to ACP discussions ($\mu = 4.3$, range = 2-5); apply open-ended questioning technique (PASI) when facilitating ACP conversations ($\mu = 3.9$, range = 2-5); SLP satisfaction ($\mu = 4.4$, range = 3-5). The amount of time nurses spent facilitating ACP with clients varied as follows: five minutes or less (n=2); six to 15 minutes (n=3); 16 to 30 minutes (n=1). One nurse did not report time spent information and two nurses offered the following comments and feedback: “SLP took too long.” “I was initially confused about how it all (SLP) fit together, what order to do each reading.”

Formative and summative feedback survey comparative analysis. The Wilcoxon signed-rank test was applied to test the following null hypotheses—no differences in nurses’ abilities to facilitate ACP conversations; state client, family, and clinician barriers to ACP discussions; and apply open-ended questioning techniques when facilitating ACP conversations. The following assumptions were met: two related groups (matched pairs); interval level dependent variables (scale 1-5); total sample greater than five pairs; and non-normal data distributions. The results are summarized in Table 7. According to the decision rules—failed to reject the null hypotheses. The nurses reported no statistically significant increases in ACP facilitation skills at the conclusion of the project as indicated by W values $<$ the critical value for $W_{7, 0.05} (7)$ and/or $p > .05$.

Table 7

Nurses' Formative and Summative SLP Feedback Survey Analysis

Measure	<i>W</i>	<i>n</i> <i>for W test</i>	<i>Sig (2 tailed)</i>	<i>Estimated Median</i>
Facilitate ACP conversations with client	4	4	0.855	0
State two client/family barriers to having ACP discussions	6	3	0.181	0.5
State two clinician barriers to facilitating ACP conversations	10	5	0.590	0.5
Apply open-ended questioning technique when facilitating ACP conversations	14	6	0.529	0.5

Note: Due to the small sample size, the Wilcoxon Signed-Rank test was applied.

Client Feedback Survey

One client survey was received by the conclusion of the project. Information of interest included the client's perceived ACP experiences and opportunities to impact their care plan. The client's survey item scores were as follows (scale 1-5): shared health care goals and preferences—5; made decisions about my health care plan—5; met ACP needs—5. As requested, the client offered the following comments and feedback: “want more information about hospice” and “Would like extra copies of the PASI for some of my family members.”

Discussion

The desired and actual project outcomes related to the clients' ACP participation, the documentation of ACP and AD in medical records, and the nurses' participation in ACP, perceived self-confidence with the open-ended questioning technique (PASI), and perceived self-

confidence with facilitating ACP are summarized in Table 8, interpreted, and discussed as follows.

Table 8

Project Outcomes and Measures

Desired Outcomes	Evaluation Measure	Outcomes
Increase nurses' ACP involvement	# and % nurses participated in project	7/25 = 28%
Increase clients' accomplishment of ACP	# clients who participated in ACP facilitation process	1 month n = 2/5 2 month n = 2/4
Increase ACP or AD documentation in medical records	% medical records that contained ACP or AD	Baseline = 29% 1 month = 33% 0% change 2 month = 20% -45% change
Increase nurses' ACP effectiveness	# and % nurses self-confident with open ended questioning technique (self-rated 3 or higher)	6/7 (86%) Pre μ = 3.4 6/7 (86%) Post μ = 3.9 (scale 1-5)
Increase nurses' empowerment to advocate for clients' wishes	# and % nurses confident facilitating ACP (self-rated 3 or higher)	6/7 (86%) Pre μ = 3.7 7/7 (100%) Post μ = 3.6 (scale 1-5)

Clients' ACP Participation

During the two month pilot project, four clients participated in ACP discussions facilitated by the nurses and the PASI instrument. The objective to facilitate ACP discussions with all established cancer care clients who had not accomplished their AD was not achieved. Two nurses verbalized that there was not enough time to engage with all of the eligible clients. In the future, the clients' participation in ACP may be increased by making the PASI facilitation less dependent on the nurses' availability and more dependent on the clients' motivations by placing the PASI instrument or another QPL in the hospital's admission packet as effectively demonstrated by McLawhorn et al. (2014).

Documentation of ACP and AD in Medical Records

The percentage of cancer care clients' medical records with ACP and AD documentation decreased from 29% (baseline result) to 20% during the second month of the project and the goal to increase ACP and AD documentation by 20% was not achieved. Additionally the percentages of records that contained AD (27% the first month, 13% the second month) were below the national norm (30%). In the future, increased documentation of ACP and AD may be accomplished by educating and involving more of the interdisciplinary and transdisciplinary health care team members in ACP facilitation (Briggs & Hammes, 2011) such as physicians, the pastoral care team, case managers, care coordinators, social workers, and non-medical personnel. Respecting Choices.org (2017) recommends non-physician personnel to initially “guide people through this complex conversation and call on the expertise of others, including physicians, when needed” (paragraph 2).

Nurses' Participation in ACP

Although 14/25 (56%) of the nurses completed the SLP, only 7/25 (28%) elected to facilitate ACP with the PASI. According to Prochaska and Velicer (1997) the advancement from preparation to action is catalyzed by motivators. An effective external motivator was the PASI clinical support tool which kept the ACP discussions focused. According to the nurses, the ACP facilitations took no longer than 30 minutes to accomplish—granted that Medicare fee-for-service reimbursements require AD discussions to last a minimum of 30 minutes (CMS, 2016a). Other effective external motivators included consultations by the Palliative Care Team and the SLP as evidenced by nurses' increased confidence with ACP knowledge and skills over time. Ineffective external motivators included a \$25 gift card, free continuing education hours, clinical ladder points towards promotion and awards, the ANA's (2016) position statement entitled

Nurses' Roles and Responsibilities in Providing Care and Support at the End of Life, and reassurance that the Cancer Committee and the attending hospitalists approved of the quality improvement project.

Since facilitation, education, awareness of professional standards, and professional support variables were addressed, the nurses' sub-optimal participation suggested the lack of internal motivators such as ACP normalization (Zhou, Stoltzfus, Houldin, Parks, & Swan, 2010), other personal barriers that were not verbalized, and lack of priority (Samara, Larkin, Chan, & Lopez, 2013). In the future, normalization may be improved by providing ACP facilitation training during hospital orientation, and offering periodic in-service trainings that include ACP role playing and the use of ACP facilitation scripts (Briggs & Hammes, 2011). Personal barriers may be addressed by acknowledging and sharing feelings and concerns with co-workers and the nurse supervisor (Spitrey, 2014). Lack of priority could be addressed by augmenting the nursing staff with certified ACP facilitators whose only priorities are to facilitate ACP and AD discussions with the clients (Respecting Choices.org, 2017). A similar evidence-based practice occurs on post-partum units that augment the nursing staff with certified lactation consultants because the in-patient unit nurses have many other time-consuming services to provide.

Nurses' Perceived Confidence with Open-Ended Questioning Technique (PASI)

The nurses' mean scores for open-ended-questioning techniques increased from 3.4 prior to ACP facilitation, to 3.9 (scale 1-5) by the conclusion of the project. These results suggested that the nurses' gained self-confidence which could be increased further with additional ACP facilitation experiences. With consideration for the nurses' time constraints, an abbreviated QPL that is locally developed could be implemented and incorporated within an existing process (Agency for Healthcare Research and Quality, 2014b) such as admission assessment.

Nurses' Perceived Self-Confidence with Facilitating ACP

Contrary to the previous measure, the nurses' mean scores for facilitating ACP conversations decreased from 3.7 to 3.6 by the conclusion of the project. This finding indicated the need for continued training, coaching, and assistance by subject matter experts such as the project champion and the palliative care clinical nurse specialist, both of whom served as ACP consultants during the quality improvement project. According to Clabots (2012) nurses' lack of confidence may be due to needs for additional education. In the future, nurses' could be encouraged and funded to attain ACP facilitator certification. This would enable them to support expanded ACP services that are institutionalized by hospital policy, informed by monitoring and evaluation activities that assess ACP impacts on clients' care plans and clinical outcomes, and evaluated for compliance with the Joint Commission's accreditation standards.

Recommendations

The following recommendations were offered to the Cancer Committee and related to refining the SLP and improving, normalizing, institutionalizing, sustaining, and disseminating the hospital's ACP facilitation services.

Refine the SLP. If adopted, the management of the SLP should be delegated to the hospital's education department, approved for additional continuing education contact hours, fully automated, and centrally located on the hospital's share drive (Becker's Hospital Review, 2012). Employees' should accomplish the SLP during hospital orientation and annually thereafter and these trainings should be tracked and trended in accordance with hospital policies. Additionally, ACP refresher in-services should occur when changes are made to federal, state, and or local policies (i.e., Medicare reimbursements, ACP facilitation processes, State board continuing education requirements); and a verification mechanism should be used to confirm that

the employees read the hospital's ACP and AD policies on a periodic basis. Additionally the IHI (2017b) training entitled "*PFC 202: Having the Conversation: Basic Skills for Conversations About end-of-life care*" should be purchased and incorporated into the SLP as originally intended. The IHI course includes a comprehensive cultural and faith-based education component that was not found elsewhere in the recent literature. Following the initial and annual completions of the SLP, the hospital employees should receive an ACP competency certificate that can be included in their professional continuing education portfolios.

Improve ACP facilitation. The responsibilities for ACP facilitation should be shared by the interdisciplinary and transdisciplinary members of the health care team (Briggs & Hammes, 2011). The physicians, nurses, palliative care team, pastoral care team, case managers, care coordinators, music therapist, and social workers should collaboratively establish processes for reviewing the clients' ACP documents when changes in health status or health care plans occur; and addressing the clients' needs for comprehensive ACP assistance which should be provided by a formally trained facilitator (Kirchhoff, Hammes, Kehl, Briggs, & Brown, 2012).

The following recommendations align with the IOMs patient-centered, equitable, and timeliness quality indicators, Prochaska and Velicer's Stages of Change theory, and the Joint Commission's accreditation standards: Absent medical emergencies, the clients and their families should be encouraged to gradually accomplish the ACP processes (understanding, reflecting, discussing, documenting AD, and sharing AD) at their own pace (Briggs & Hammes, 2011). Additionally, ACP should be offered to the client and family during each health care encounter if AD has not been documented (McLawhorn et al., 2014; Whitehead & Carter, 2017). Following ACP facilitation, the documentation of AD may or may not be an outcome, but all of

the client's ACP and AD documents should be placed within the medical record (Joint Commission, 2016).

Institutionalize ACP services. A comprehensive community-based ACP facilitation program should be institutionalized (Briggs & Hammes, 2011). In accordance with OBRA (1990) mandates, the hospital's strategic planners should implement and integrate comprehensive inpatient and community education outreach components. In combination, the two components would facilitate ACP in the community and the accomplishment of AD documents across the entire spectrum of health and wellness promotion venues (i.e., worksites, primary and specialty health care clinics, homes, schools, recreation facilities, community centers, adult day care centers, assisted living facilities, faith-based organizations, etc.). Hospital policies should describe the community-based ACP program components and the corresponding measures that are tracked and trended against the national norms and professional performance benchmarks.

Specific community and inpatient program components. The hospital's annual community assessment which is required by U.S. government reimbursed providers, should publically highlight that ACP facilitation and the provision of client-centered care are top strategic priorities. This document should also describe the inpatient and community ACP facilitation services and trend AD and ACP sensitive indicators reported by the Dartmouth Institute for Health Policy and Clinical Practice (2017). In addition, the palliative care webpage should contain the ACP toolkit that was developed by the project facilitator and e-versions of the hospital's *Critical Choices Handbook* for citizens and primary care providers to access and download. Most importantly, inpatient care plans should be informed by clients' ACPs as indicated by annotations in the medical record progress notes and transdisciplinary team meeting

summaries; clinical interventions that align with and address clients' emotional, spiritual, existential, physical, and financial concerns; and clients' satisfactions with experiences of care (IOM, 2013a).

Normalize ACP. All adults should be encouraged to accomplish ACP and AD (IHI, 2015). In addition to institutionalizing a community-based approach to ACP facilitation, the hospital educators should normalize ACP among hospital employees during the hospital and inpatient unit orientation processes by educating new accessions about the five ACP processes and encouraging them to accomplish or update their own AD documents (IHI, 2015) using the *Critical Choices Handbook* that is offered to the inpatient clients. New hires, particularly graduate nursing students may not have had any experiences facilitating ACP or AD.

Clinical nurse educators and affiliated academic (i.e., university, community college) partners should identify opportunities to facilitate role playing simulations that develop ACP competencies of hospital employees and nursing students from associate, baccalaureate, and graduate degree programs. In addition to collecting CAPC indicators data, the palliative care team should periodically report AD and ACP accomplishment trends and Dartmouth quality of care indicators to the Cancer Committee; study relationships between ACP and palliative care variables that can be applied to meaningful use; compare different kinds of ACP facilitation methods; and/or study relationships between palliative care variables, ACP variables, and inpatient clients' PASI instrument responses.

Sustain and disseminate ACP best practices. The project champion mentored her co-workers during PASI facilitations, obtained feedback from cancer care clients and their families during post-discharge phone conversations, and accomplished all of the medical record audits. Additionally, she stated willingness to mentor the nurses' facilitation of ACP beyond the pilot

project. Over time, her modeling behaviors could gradually promote increases in AD and ACP documentation within cancer care clients' medical records and the hospital's compliance with the Joint Commission's requirements. Even so, it is recommended that ACP services should be institutionalized by the hospital's leaders who have the authority to fund and hire formally trained inpatient and community ACP facilitators. The employment of formally trained ACP facilitators is an evidence-based practice (Briggs & Hammes, 2011) which has been successfully implemented by a regional network partner. The hospital leaders should designate an ACP team to provide oversight of the hired ACP facilitators and the palliative care clinical nurse specialist and/or the nurse champion should represent the Department of Nursing.

Similar to the regional network partner's best practices, the hospital's ACP team should be comprised of a small cadre of formally trained ACP facilitators and led by a medical director who consults the hospital ethics committee. This interprofessional team should also provide oversight of the community-based ACP facilitation program components and collaborate with the Cancer Committee to share best practices with local faith-based partners that employ Wesley health promotions nurses to assist economically disadvantaged citizens, and the network of hospitals that provides comprehensive cancer care services for diverse populations throughout the region. Additional opportunities to disseminate the pilot project results and recommendations include the state Nurses Association assembly (dates negotiable); state Public Health Association Annual Education Conference (2019 date to be determined); Sigma Theta Tau Scholarship Day (October 17-20, 2018); the Respecting Choices® National Share the Experience Conference (October 23-26, 2018); and the *Journal of Hospice & Palliative Nursing* which has previously featured articles about Whitehead and Carter's (2017) PASI instrument.

Educate the community. As previously mentioned, two ACP community education outreach products were recently developed by the pilot project facilitator. These include a one-hour ACP presentation that has been successfully piloted on five occasions with various adult age groups and an ACP toolkit for the community that could be made available to health care providers and consumers via the hospital's website.

One-hour ACP presentation. The community education outreach offering includes key terms, definitions, and information about the five processes of ACP, state laws and approved documentation templates, and additional resources. Summaries of 104 participants' feedback surveys were submitted to the hospital's Community Relations Specialist. It was noted that the mean scores for each of the following pre and post survey items consistently trended upwards: Item 1—awareness of medical treatment goals and preferences; Item 2—plan to discuss my medical treatment goals and preferences with people whom I trust; Item 3—plan to discuss my medical treatment goals and preferences with my health care provider; Item 4—plan to accomplish advance directives documentation within the next 30 days; and Item 5—Plan to seek more information about advance directives. Optimally, this presentation should be offered to Spanish and English-speaking audiences in accordance with the demographic profile.

ACP toolkit. This toolkit provides step-by-step instructions about how to document the state approved AD templates contained in the *Critical Choices Handbook* as well as additional information, resources, and a Survey Monkey feedback mechanism. It is intended to be a desk-top reference for local health care providers and a guide for community residents. This toolkit could be translated to Spanish and other languages.

Continue the pilot project. Quality improvement projects take time to accomplish. If the data collection had been extended beyond two months, the nurses' newly acquired ACP

competencies might have increased ACP documentation within the medical records. With consideration for the lessons learned and recommendations, the next PDSA cycle should begin.

Costs, Benefits and Budget

Pilot project direct costs related to the purchase of Gundersen training modules—\$1125.00 for 25 nurses (\$45 per person). Indirect costs related to the SLP training (approximately five hours per nurse). A comprehensive return on investment study was beyond the scope of the project. Potential financial benefits of ACP could relate to cost-savings associated with not providing treatments that conflict with clients' health care goals and wishes. According to Briggs and Hammes (2011) such cost-savings would occur after comprehensive ACP services have been fully institutionalized (i.e., throughout the entire hospital) for a three-year period. Under these conditions, hospital deaths should decrease 10% from baseline; hospice admissions should increase 10% from baseline; and individuals' overall health care costs should decrease during the last two years of life due to decreased ICU bed-days during the last six months of life and decreased re-admission rates within 30 days (Briggs & Hammes, 2011). The hospital's leadership may elect to review and compare their financial indicators data published by the Dartmouth Institute for Health Policy and Clinical Practice (2017) in order to determine whether there are opportunities to decrease health care costs associated with sub-optimal outcomes such as "percent of deaths associated with ICU admission" for terminal care, and the "percent of Medicare decedents enrolled in Hospice within three days of death."

Assuming ACP facilitation could be institutionalized in the future, a cost quote was formulated based on the following sustainment resources: project manager's salary--\$70,000.00; laptop computer--\$850.00; printer--\$250.00; telephone desk set--\$500.00; telephone line--\$50.00

per month; office desk and chair--\$1200.00; and office supplies--\$50.00 per month. The out-year estimates assumed a 1.5% annual inflation rate (Appendix O).

Conclusions

Although the overarching outcome of increasing ACP or AD documentation in clients' medical records by 20% was not achieved within a two month timeframe, nine cancer care clients were offered opportunities to inform the interprofessional health care team about their needs, goals, wishes, and preferences during hospitalizations for serious illnesses. Additionally, seven nurses gained knowledge about the Joint Commission's accreditation requirements and the hospital's AD policies following completion of the SLP. The nurses also gained self-confidence in ACP facilitation skills and experiences by applying the PASI instrument to initiate ACP discussions.

Key project facilitators included dedicated inpatient nurses, the palliative care clinical nurse specialist, the Cancer Committee, and a funding donation which enabled the purchase of the evidence-based ACP facilitators' training modules. Barriers to project participation related to the lack of ACP normalization and the nurses' time constraints, both of which offset the theory-informed incentives package in terms of motivating project participation. Several opportunities for improvement were identified for ACP facilitation, institutionalization, normalization, sustainment, and sharing of best practices with network and regional partners.

Recommendations included but were not limited to chartering a team of formally trained inpatient and community ACP facilitators led by a staff physician as exemplified by a regional network partner. Additional opportunities included ACP studies and formal program management strategies such as monitoring, evaluating, and benchmarking ACP measures and consulting network and regional partners who also desire to improve compliance with the OBRA

requirements related to inpatient and community education outreach, and the Joint Commission's accreditation requirements to document AD or ACP in all inpatient clients' medical records.

In conclusion, quality improvement projects take time to establish, accomplish, evaluate, and refine. Had the data collection been extended beyond two months, the nurses' newly acquired ACP competencies might have increased ACP documentation within the medical records. With consideration for the lessons learned and recommendations, the next PDSA cycle should begin.

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Appendix A

Advance Care Planning Community Assessment

Name: Lorena Paul

Date Completed: 31 October 2016

This worksheet is designed to be used in conjunction with Advance Care Planning e-learning. Access this course at <http://www.cdc.gov/aging/advancecareplanning>.

Agency Information	
Magnet Designated Hospital	Location: U.S. Southwest

Internet Resources	
National Association of Chronic Disease Directors http://www.chronicdisease.org	National Healthcare Decisions Day Website http://www.nhdd.org/public-resources/#where-can-i-get-an-advance-directive
National Association of Area Agencies on Aging http://www.n5a.org/	American Hospital Association: "Put it in Writing" brochure, wallet card, public service announcement. http://www.aha.org/advocacy-issues/initiatives/piiw/index.shtml
National Association of States United for Aging and Disabilities http://www.nasuad.org/	Compassion and Choices: National Non-Profit Organization advocates end-of-life decision making
Cancer Control P.L.A.N.E.T. http://cancercontrolplanet.cancer.gov/state_plans.jsp	State Hospital Association: "Put Your Wishes in Writing"
American Cancer Society https://www.cancer.org/about-us.html	State Medical Association: "Advance Directives"

After completing Module 1, fill in the information for Section I.

SECTION I – Making the Case for Advance Care Planning (Module 1)
Current Agency Involvement in Advance Care Planning
What is your agency's mission? "Serving Humanity to Honor God by providing exceptional and cost-effective health care accessible to all."
What organizational units of your agency are involved in chronic disease and aging? Cardiology, cancer care, bone marrow transplants, emergency medicine, neurosciences, gynecology, and orthopedics.
What is your agency's current involvement in advance care planning (ACP)? Include names, positions, and responsibilities. In accordance with OBRA, "all patients are provided written information upon admission regarding their right to formulate and implement advance directives. During pre-admission process, the patient is asked about advance directives and to bring existing documents to the hospital on day of admission. A copy of the directive is made for patient's record at time of admission. During inpatient admission, each patient is asked about advance directives and if he/she brought a copy of an existing directive to the hospital. The patient's response to the question about directives is entered into the medical record. If the patient states he/she does not have a directive and is requesting information, the <i>Critical Choices Handbook</i> is provided. This handbook is available in English and Spanish. After the patient reviews the <i>Critical Choices Handbook</i> the nurse may initiate a request for patient consultation with Bioethics or direct the patient to other assistance with completing the directives. When the patient arrives with an advance directive, a copy of the patient's document is made and placed in the patient's medical record. If the validity of an advance directive is questioned, staff will contact Bioethics or Risk Management for review and guidance." The <i>Critical Choices Handbook</i> includes State approved templates for advance directive and medical power of attorney in English and Spanish.

Agency Contacts Related to Advance Care Planning

Agency Contacts Related to Advance Care Planning			
Agency	Name	Phone	E-mail
State Health Department: Hosts webpage that emphasizes the importance of advance directives and provides information about legal support services for adults over age 60	None	None	None
Local Health Department: Offers no information regarding advance care planning.	None	None	None
State Health Department: Hosts Advance Care Planning webpage that emphasizes importance and offers the following information and resources (STATED VERBATIM): “Thinking Ahead: My Way. My Choice. My Life at the End. (PDF) can be used to help plan what someone wants to happen at the end of their life. Form 2189, Palliative Care, is for use by a physician to document palliative care choices and services for residents in nursing facilities at the end of life.”	None	None	None
“Directive to Physicians and Family or Surrogates is designed to help people communicate their wishes about medical treatment at some time in the future when they are unable to make their wishes known because of illness or injury.”			
“Medical Power of Attorney — Except to the extent you state otherwise, this document gives someone named as agent the authority to make any and all health care decisions in accordance with someone’s specified wishes, including religious and moral beliefs, when they are no longer capable of making them themselves.”			
“Out of Hospital DNR Information & Form (PDF) instructs emergency medical personnel and other health care professionals to forgo resuscitation attempts and to permit the patient to have a natural death with peace and dignity. This order does NOT affect the provision of other emergency care including comfort care.”			
“Advance Directives presentation defines life-sustaining treatment, terminal condition and irreversible condition and identifies three types of advance directives recognized by...law and resources for making advance directive decisions. “			
“Tube Feeding and Advance Care Planning presentation, developed by the DADS Quality Monitoring Program dietitians, includes the steps for advance care planning process; comprehensive care plan examples; and the risks, benefits, and alternatives to tube feeding.”			
“Advance Care Planning Facility Checklist (PDF) consists of items to be included in nursing home policies and procedures for advance care planning.”			
“Advance Care Planning Protocol (PDF) includes information on how to implement advance care planning activities for nursing facility residents.”			
“Advance Care Planning Frequently Asked Questions (PDF) can be used to train staff, residents and families to implement the advance care planning process. In Spanish (PDF).”			
“Advance Care Planning References (PDF) literature review conducted in 2013.”			
Area Agency on Aging: The State Department of Aging and Disability Services provides templates in English and Spanish for ACP documentation: <u>Directive to Physicians and Family or Surrogates Form</u> ;	None	None	None


Agency Contacts Related to Advance Care Planning			
<u>Medical Power of Attorney Form; and Out of Hospital Do Not Resuscitate Information and Form</u>			

Advance Care Planning Groups
Does your state or county have an advance care planning advisory committee or coalition? No
If yes, who sponsors it and who are the members? N/a

Comprehensive Cancer Center Plan
Access a copy of the Comprehensive Cancer Center Plan for your state or county. The Cancer Alliance published the first State Cancer Plan Evaluation Report in September 2015
How does the Plan address advance care planning (ACP) issues? The Plan does not address ACP.
How does your agency’s mission fit in with the Plan? The agency provides state-of-the-art inpatient (tertiary) cancer care for all persons regardless of abilities to pay.

After completing Module 2, fill in the information for Section II.

SECTION II – The Essential Elements (Module 2)
State Policies: HEALTH AND SAFETY CODE TITLE 2. HEALTH SUBTITLE H. PUBLIC HEALTH PROVISIONS CHAPTER 166. ADVANCE DIRECTIVES SUBCHAPTER A. GENERAL PROVISIONS
What are your state’s policies related to the following:
Health care advance directives. Include medical or durable power of attorney; living will; out-of-hospital DNR; and directive to physician. The principal must give consent. Once accomplished, advance directives cannot be altered; new documents must be accomplished. Advance directives should be reviewed regularly or when health condition changes. Advance directives may state organ, tissue, cornea, living, and whole body donations.
Medical or Durable Power of Attorney. Is an advance directive that takes effect when attending physician documents in principal’s medical record that principal is unable to make decisions for (him/her) self. The medical power of attorney document states the principal’s surrogate decision-maker/health care agent.
Guardianship or conservatorship. Probate court judge-appointed guardian for adult deemed incapacitated. Faith based organization contract with Probate Court conducts annual visits to document and report guardian’s provisions for adult wards. The principal is not legally capable of consenting to advance directives.
Living Will (HSC 166.033). Is an advance directive that takes effect when attending physician documents in principal’s medical record a terminal or irreversible illness and life expectancy less than or equal to 6 months. The living will document states the principal’s written instructions to the surrogate-decision maker and health care providers regarding his/her health care wishes should a terminal or irreversible condition occur. A “Directive to Physician” is a type of living will that can be individualized according to the following circumstances/conditions: Healthy person; Advance-aged person; Person with life-limiting chronic illness; Person incompetent/incapable of making health-care decisions (Adult Ward of the State); Religion-specific doctrines.
Witnesses. Medical Power of Attorney must be authenticated by a notary or two witnesses. Living Will must be authenticated by two witnesses. The witnesses must not be relatives of the principal or anyone providing direct health care to the principal.
Proxies and surrogacy (HSC 166.039). Absent a guardian or Medical or Durable Power of Attorney, the legal next-of-kin will be authorized to make medical decisions with attending physician in the following order of priority: Spouse; available adult children; parents; nearest living relative.

Client Support and Education
Does your agency offer clients or patients access to your state’s advance directive policy (not sure) and form? Yes If yes, how is access offered? Hospital information/orientation package.
Does your agency have a protocol for advance care decision making for a client? Yes If yes, what is the protocol? Protocol states key ACP definitions and general information. Facility procedures include addressing patient complaints; withholding/withdrawing life-sustaining treatment; directive to physicians; medical power of attorney; out-of-hospital DNR order; declaration for mental health treatment; references; documentation (forms).
Does your city or county offer consumer community education around advance care planning? No the city government does not offer advance care planning information. Yes, the county health care system (University Health System) offers advance directives information and legal document links to the public. If so, who offers it and what topics does it cover? Defines advance directives; provides state-approved forms; encourages communications with primary care provider; Offers the following product which doesn’t work.


After completing Module 3, fill in the information for Section III.

SECTION III – Making a Difference (Module 3)
Collaboration for Advance Care Planning
What could you do to foster collaboration between public health agencies, aging services, health services, and spiritual entities to further advance care planning in your state or community? Invite diverse stakeholders (primary care providers; nursing home providers; home health care providers; senior center; public health; faith based organizations) to form a coalition and to develop, plan, and evaluate a culturally competent ACP education outreach to community.

Possible Roles
What could your agency, state health department, or state unit on aging do to —
Offer expanded educational opportunities related to advance care planning for professionals? Offer ACP continuing education offering for social workers, physicians, nurses.
Encourage advance directives and inclusion of palliative care within benefit packages? ACP information in currently provided in English and Spanish.
Collect data on advance care planning and track success stories to share with consumer and professional communities? # and % of patients who have ACP when admitted; # and % of patients who have ACP when discharged.

Leadership
What activities can initiate, expand or strengthen your agency’s role in advance care planning? Quality improvement project endorsed by leadership that expands dedicated staff resources to meet ACP needs of clients

and community.

ADDITIONAL NOTES: State, County, Region, City, and Agency advance care planning (ACP) strengths, weaknesses, opportunities, and threats (SWOT) are perceived and summarized as follows:

Level	Strength	Weakness	Opportunity	Threat
State:	The Cancer Prevention and Research Institute has legal authority and responsibility for the State's Cancer Plan which includes goals, objectives, strategies, and evaluation metrics related to controlling cancer. Current focus is to align cancer care delivered throughout the State with national Healthy People 2020 priorities, evidence-based guidelines, U.S. Preventive Services Task Force Recommendations for cancer screening; and identifying and addressing cancer health disparities. The Cancer Alliance published the first Cancer Plan Evaluation report in September of 2015.	Neither the state Cancer Plan nor the Cancer Plan Evaluation report mentions advance care planning (ACP). Absent ACP advisory committee or coalition	Promote ACP facilitation by health care providers and faith-based organizations. Promote ACP completion by the public.	ACP is not specifically recognized as "a multi-disciplinary team approach to coordinate patient care" (p. 10) Absent ACP proponents
	ACP information and state-approved documentation templates are available to all state residents who have access to the internet in English and Spanish languages.	Absent Government sponsored ACP registry where people can create, document, and share their documents with family and health care providers	Collect public ACP data and metrics to inform the CPRIT regarding public education outreach needs	ACP registry is not perceived need
Regional	A regional network partner has implemented evidence-based (Respecting Choices) ACP services and provides ACP facilitator training for interested volunteers.	Program is in final stages of program development, therefore there is no program evaluation information available yet.	Network partner has offered to share non-proprietary strategies, tools and templates.	Maintaining sufficient volunteers to facilitate ACP.
County	The county health care system offers advance care planning information and legal document links to the public.	Absent advance care planning advisory committee or coalition One of the links no longer exists.	Agency Cancer Care webpage could offer links to this county information and resources.	Absent strategic ACP proponents Altered public trust that Information and forms are up to date.

City	Local 2020 website, offshoot from Healthy People 2020. Priority areas include but are not limited to family-wellbeing.	Health Department website is silent regarding the subject of advance care planning.	A faith-based community service organization offers ACP services for sliding-scale fee	ACP not perceived by City government as a "family wellbeing" indicator.
Agency	Competent and confident inpatient ACP facilitators are available to persons admitted for tertiary health care.	Inpatient nurses do not apply consistent ACP facilitation methods and materials	Palliative care nurses are interested in applying evidence-based ACP strategies such as "Respecting Choices."	Human resource limitations.
	Staff Development: Inpatient nurses attend end-of-life care training activity during hospital orientation.	No evidence of comprehensive advance care planning facilitation training.	A nurse educator mentioned structures in place for developing education presentations.	Agency does not perceive comprehensive advance care planning facilitation training to be a staff development need.
	Inpatient ACP policies are in place.	No evidence of requirement to assess ACP at discharge. AD completion rates by inpatient clients upon admission are similar to CDC reports (~30%)	Electronic medical record can be modified to assess ACP at discharge. Electronic medical record queries can be built to assess the # and % of patients	Commercial product's copyright may preclude electronic medical record modification or queries

Appendix B

Review of Nursing Studies

Citation & Classification	Participants & Setting	Purpose	Level & Grade of Evidence	Design	Results/ Findings	Conclusions
Song, M. K., Donovan, H. S., Piraino, B. M., Choi, J., Bernardini, J., Verosky, D., & Ward, S. E. (2010). PRIMARY	19 African American client/surrogate dyads Dialysis, kidney transplant	Examine effects of client-centered ACP	Level II, Single RCT	Experimental	Treatment dyads demonstrated increased congruence regarding treatment preferences and perceived higher quality communications.	Client-centered ACP improved dyads' communications.
Song, M. K., & Ward, S. E. (2015). PRIMARY	210 principal/surrogate dyads Dialysis unit	Validate theory-based ACP method	Level II, Single RCT	Experimental	Six session, nurse facilitated ACP increased surrogates' confidence with decision making, and dyad goals of care congruence.	Patient Education theory translated to practice via ACP facilitation methods and tools.
McLawhorn, V.C., Vess, J., & Dumas, B.P. (2016). PRIMARY	Patients with diagnosis of solid malignancy admitted to tertiary medical center Baseline cohort n= 128 patients. Post-process improvement cohort n= 166.	Practice quality improvement	Level IV, Single Correlational Study	Cohort Concurrent review of living persons' electronic medical record over a period of three months	Positive correlations between clients' review of question prompt list and conferences with health care providers. Positive correlations between clients' review of question prompt list and election of DNR. Positive correlations between clients' review of question prompt list and hospice.	Admission packet communication aid promoted clients' awareness of prognosis and informed end-of-life discussions between patient, family and health care provider.

Appendix C

Project Stages, Milestones, Data-Sets, and Measurements

Stage	Milestones	Data-Set	Qualitative Measurement	Quantitative Measurement
Plan	Developed project marketing plan	In-service attendance roster	None	# and % of nurses who attended the SLP orientation in-service
	Developed SLP	Nurse manager feedback mechanism (SLP approval)	nurse manager's satisfaction with SLP contents	None
Do	Marketed project to nurses	Project milestones timelines	Timeliness of project milestones accomplishment	# and % of nurses who elected to participate in the project
	Facilitated nurses' accomplishment of SLP	Competency and feedback survey data sets	None	# and % of nurses who completed SLP
	Facilitated and documented clients' ACP	Project log maintained by nurse champion		# and % of ACP services offered by nurses
	Conducted baseline record audit	MRs		# and % of baseline audit MRs that contained evidence of AD or ACP
	Evaluated nurses' perceptions of ACP facilitation skills	Nurses' pre and post SLP self-assessment (scale low, medium, high)		Most recent date of ACP training
Suggestions for ACP program improvement				
Perceived AD facilitation skills				
Perceived AD documentation skills				
		SLP feedback		
Study	Evaluated nurses' perceptions of ACP facilitation skills	Nurses' formative and summative evaluation and feedback survey	SLP feedback	# and % perceived increased ACP facilitation skills

Stage	Milestones	Data-Set	Qualitative Measurement	Quantitative Measurement			
		(scale 1-5)		# and % perceived increased ability to state two client ACP barriers			
				# and % perceived increased ability to state two provider ACP barriers			
				# and % perceived increased ability to apply open-ended ACP questioning technique			
				Conducted time series analysis	MR documentation	None	# and % of MRs that contained ACP (PASI) documentation
				Evaluated cancer care clients ACP experiences	Clients' ACP experience survey (scale 1-5)	Suggestions for ACP program improvement	# and % able to share goals and preferences
						Requests for additional ACP information	# and % able to make decisions about their health care plans
	# and % able to have their ACP needs met						
Act	Recommended SLP improvements	Nurses' competency assessments Nurses formative and summative feedback surveys	Nurses' comments and recommendations applied to refine the SLP	None			
	Recommended ACP process improvements	Nurses formative and summative feedback surveys Cancer care clients' feedback survey	Nurses' and clients' comments and recommendations applied to refine ACP process	None			
	Recommended	Nurse manager,	Nurses'	None			

Stage	Milestones	Data-Set	Qualitative Measurement	Quantitative Measurement
	system improvements for normalizing, institutionalizing, and sustaining ACP facilitation services	Palliative care clinical nurse specialist, and nurse champion reflections	recommendations applied to normalize ACP facilitation services	
			Nurses' recommendations applied to institutionalize ACP facilitation services	
			Nurses' recommendations applied to sustain ACP facilitation services	

Appendix D

Project Goals and Measures

PDSA Stage	Goals	Evaluation Measure
Do	Increased nurses' involvement with ACP facilitation in support of IOM (2001) quality standards: safety, timeliness	# and % of nurses who participated in the project
Study	Increased cancer care clients' accomplishment of the five ACP processes (i.e., understanding, reflection, discussion, documentation, and sharing) in support of IOM (2001) quality standards: equitable, patient centered	# cancer care clients who participated in ACP (PASI) facilitation process
Study	Increased ACP or AD documentation in medical records (AD national norm = 30%) in support of IOM (2001) quality standard: timeliness	% medical records that contained ACP or AD documentation
Study	Increased nurses' effectiveness in facilitating ACP in support of IOM (2001) quality standards: effectiveness, efficiency	# and % of nurses who perceived confidence with open-ended questioning technique
Study	Increased nurses' empowerment to advocate for clients' goals, wishes, preferences in support of IOM (2001) quality standard: patient-centered	# and % of nurses who perceived confidence with facilitating ACP

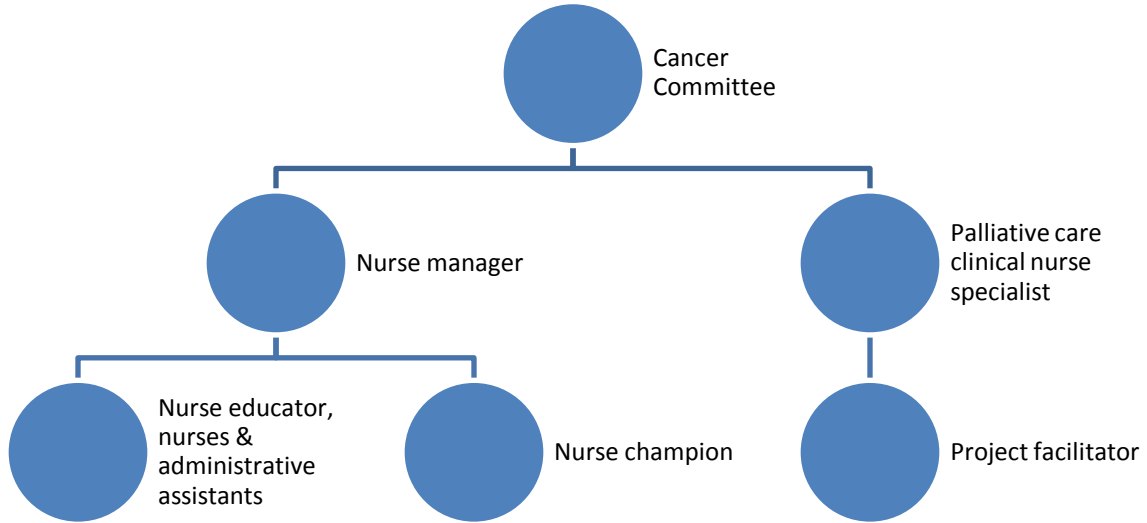
Appendix E

Objectives Matrix

Goal(G)/Objectives	Target; Type; & Timeframe	Measures	Desired Project Outcomes	Desired Impacts
G1.1. Provided with SLP, nurses (RNs) complete the ACP facilitation training during the first month of the project.	Individual and aggregate RNs; RN compliance; Short-term	# RNs completed training /Total # RNs # of RNs who participated in the project/Total # of RNs	Increased # and % of RNs who participated in the project	Provision of health care services aligned with IOM (2001) quality standards <i>safety, timeliness</i> Pilot project started on time
G1.2. Prior to SLP completion, RNs assess their baseline ACP facilitation skills on a scale of low, medium, high.	Individual and aggregate RNs; RN performance; Short-term	# RNs who perceived “low” ACP facilitation skills / Total # RNs	Increased # and % of RNs who self-assessed their ACP facilitation skills at baseline	RNs identified opportunities for ACP facilitation growth and improvement
G1.3. Following SLP completion, RNs assess ACP facilitation skills as “medium” on a scale of low, medium, high.	Individual and aggregate RNs; RN performance; Intermediate	# RNs perceived “medium” ACP facilitation skills / Total # RNs	Increased # of RNs who perceived increased confidence in their abilities to facilitate ACP from baseline	RNs sustained their involvement with ACP facilitation during and following the project
G2.1. Following ACP facilitation by RNs: a. The client/family rate “shared my goals and preferences” with 3 or higher on a scale of 1-5. b. The client/family rate “made decisions about my health care plan” with 3 or higher on a scale of 1-5. c. The client/family rate “my advance care planning needs were met” with 3 or higher	Individual and aggregate clients/ families; Staff performance; Short-term	# cancer care clients who participated in ACP (PASI) facilitation process/# cancer care clients who were offered PASI facilitation by the nurses # survey items rated 3 or higher / total number of surveys	Increased # of clients who participated in ACP processes Client/family satisfaction with ACP facilitation	Patient/family shared ACP, AD, MPOA goals, preferences and wishes with the health care team Receipt of health care services aligned with IOM (2001) quality standards <i>equitable, patient-centered</i>

Goal(G)/Objectives	Target; Type; & Timeframe	Measures	Desired Project Outcomes	Desired Impacts
on a scale of 1-5.		reviewed		
G3.1 With assistance from administrative assistant, RNs correctly place PASIs in clients' medical records.	Individual and aggregate RNs; Staff performance; Short-term	# of clients' MRs that contained PASI documentation/ Total # of clients' MRs reviewed	Increased # of medical records that contained ACP or AD documentation	Increased provision of health care services aligned with IOM (2001) quality standard <i>timeliness</i>
G3.2 Using the PASI instrument, RNs facilitate 20% increase in clients' ACP or AD documentation in the medical records (MRs).	Individual and aggregate RNs; RN performance; Short-term	# of clients' MRs that contained completed PASI or AD / total # of clients' MRs reviewed		
G4.1 Following ACP facilitations, RNs perceive increased confidence in facilitating open-ended questioning technique with PASI.	Individual and aggregate RNs; RN performance; Intermediate	# nurses who perceived confidence with open – ended questioning technique (PASI)/total # of nurses who participated in the project	Increased nurses who perceived confidence with open-ended questioning technique	Increased provision of RN services aligned with IOM (2001) quality standard <i>effectiveness, efficiency</i>
G5.1 Following ACP facilitations, RNs perceive increased confidence in facilitating ACP.	Individual and aggregate RNs; RN performance; Intermediate	# nurses who perceived confidence with facilitating ACP/total # of nurses who participated in the project	Increased nurses who perceived increased confidence with facilitating ACP	Increased compliance with the Joint Commission's accreditation standards and IOM (2001) quality standard <i>patient-centered</i>

Appendix F
Project Organizational Chart



Appendix G

PASI Instrument User Permission



2/17/17

Dear Ms. Paul,

Thank you for your interest in my questionnaire, "Patient Preferences About Serious Illness" (PASI), that is designed to facilitate dialogues between seriously ill patients and their healthcare team. I am excited you will be integrating this instrument into your study. You have my permission to use the PASI. I only ask that you keep me posted on your progress and your study findings.

Sincerely,

Phyllis Whitehead

Phyllis Whitehead, PhD, APRN, ACHPN, RN-BC
Palliative Care/Pain Management Clinical Nurse Specialist
Assistant Professor VTC School of Medicine

Appendix H

Project Introduction Electronic Memorandum

To: RNs

Subject: Advance Care Planning Continuous Pilot Quality Improvement (CQI) Project

Greetings!

My name is Lorena Paul and I am a DNP student working with the Palliative Care Team and the Cancer Committee to facilitate an advance care planning (ACP) quality improvement project using the *plan, do, study, act* framework. The aim of the project is *to increase medical record documentation of ACP conversations* with inpatient clients.

Currently, only 30% of U.S. citizens document their advance directives (Centers for Disease Control and Prevention, 2014) and the percentage is even lower among minority populations (Sudore et al., 2016). These persons are at risk of receiving health care that does not align with their values and preferences if they become unable to make decisions due to an unforeseen injury (i.e., from a car accident) or illness. The lack of advance directives may be due in-part, to inconsistent access to primary health care providers who normalize the ACP process and assist clients with completing their advance directives during wellness visits.

Following enactment of the Omnibus Budget Reconciliation Act (1990), Medicare and Medicaid-reimbursed hospitals became the advance directives *safety-net!* This is why RNs must screen every client for advance directives during the admission process. Fortunately, two on-line training programs and Whitehead and Carter's (2017) ***Patient Preferences About Serious Illness (PASI)*** instrument are available to increase: 1) RNs confidence in facilitating ACP discussions; 2) Clients' and families' comfort discussing ACP; and 3) RNs documentation of clients' ACP discussions in the medical record. This self-learning package (SLP) is intended to share evidence-based education and innovative QPL resources with you, and to refresh your memory about the related hospital policies and Joint Commission requirements.

Each page of this SLP provides the instructions that you need. Periodically and upon completion of the SLP, you will be requested to provide feedback about the SLP. Your feedback will be used to fine-tune the SLP prior to dissemination to other nursing units. I very much look forward to working with you on this Critical Choices Conversation Project. Please note that additional information is available at the National Healthcare Decisions website: <http://www.nhdd.org/> If at any time, you have any questions/concerns about the SLP, my contact information is as follows: _____. Thank you in advance for your support!

Lorena Paul, MSN, MEd, RN-BC

Appendix I

Nurses' Competency Assessment Matrix

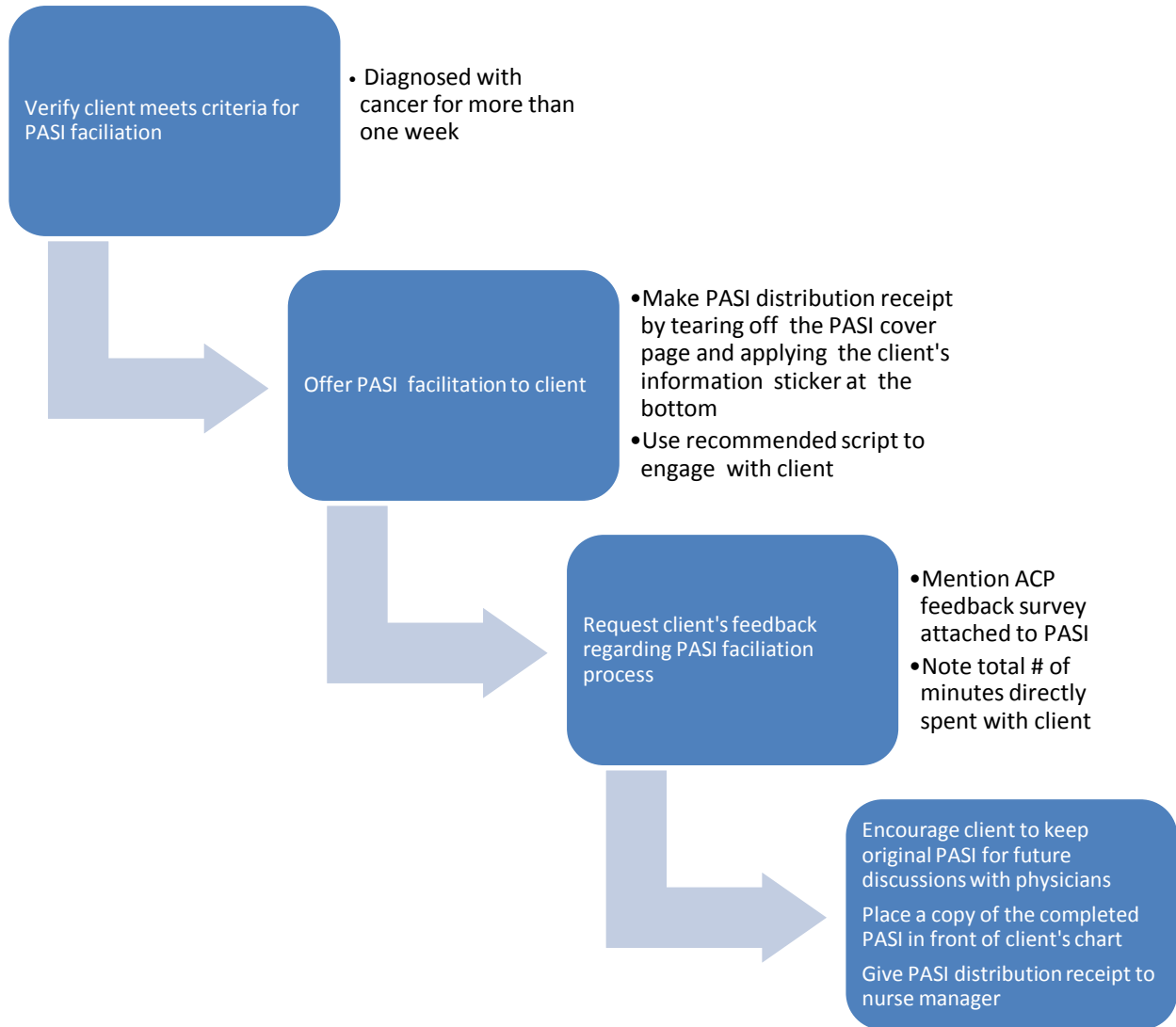
For each of the below ACP program components, please state the date of your most recent ACP training, perceived skill level, and suggestions for ACP program improvement. Following completion, please submit this form to your nurse educator.

ACP Program Component	Date of Most Recent Formal Training or Review	Perceived ACP Skill Level H = High M = Medium L = Low	Suggestions for ACP Program Improvement?
Hospital policies regarding Omnibus Reconciliation Act and AD			
Reviewing clients' AD and MPOA documents for updated information			
Reviewing clients' AD and MPOA documents for correct format (legal standing)			
Entering clients' AD and MPOA documents into the medical record			
Facilitating ACP discussions with client/family when AD and MPOA have not been completed			
Referring client/family to a formally-trained ACP facilitator if needed/requested			

Abbreviations Key: AD Advance Directives; ACP Advance Care Planning; MPOA Medical Power of Attorney

Appendix J

Advance Care Planning Facilitation Process Flow Chart



Appendix K

Medical Record Audit Tool (Baseline)

Name of Auditor: _____

Date of Audit: _____

Audit Item #	Data Element for Inspection	Data Element for Extraction	Finding	Potential Data Sources	Criteria for Evaluation	Rationale
1	Not applicable	Client's date of discharge from the hospital	Date:	Stamp plate	Date occurred prior to Jan 1, 2018	Reflects standard of care prior to quality improvement project intervention
2	Medical record documentation of one or more of the following: 1) Directive to physicians and family or surrogate 2) Medical Power of Attorney 3) Do Not Resuscitate Order 4) Allow Natural Death Order 5) Advance care plan	Not applicable	Yes or No	History and physical Progress Notes Discharge Summary Care transition record Consultation form Discharge planning form Hospice referral	"A one-time advance directives/advance care planning discussion documented anywhere in the medical record" The Joint Commission (2016)	In accordance with Joint Commission National Quality Measures Manual

Appendix L

Nurses' Formative and Summative Evaluation and Feedback Survey

Instructions: Please rate your achievement of the project objectives and your satisfaction with the self-learning package, then submit this survey to your nurse educator:

Objective 1: Facilitate advance care planning conversations with clients/families.

1	2	3	4	5
(low)				(high)

Objective 2: State a minimum of two client/family barriers to having advance care planning conversations.

1	2	3	4	5
(low)				(high)

Objective 3: State a minimum of two clinician barriers to facilitating advance care planning conversations.

1	2	3	4	5
(low)				(high)

Objective 4: Apply open-ended questioning technique when facilitating advance care planning conversations.

1	2	3	4	5
(low)				(high)

COMMENTS:

Appendix M

Client/Family Survey

Please provide feedback about advance care planning with your health care team:

1. I shared my health care goals and preferences.

1	2	3	4	5
(not at all)				(very much)

2. I made decisions about my health care plan.

1	2	3	4	5
(not at all)				(very much)

3. My advance care planning needs were met.

1	2	3	4	5
(not at all)				(very much)

4. I would like more information (please specify):

5. Other comments and suggestions:

Appendix O

Optional Costs Quote (1.5% Interest Rate)

Year 1 Costs		
On-line Gundersen Health System® Facilitators Training	\$45.00 per nurse	\$1125.00
Nurse Consultant (NC) Salary	Annual per 1 nurse	\$70,000.00
NC Office Equipment and Supplies	Laptop Computer	\$850.00
	Printer	\$250.00
	Telephone desk-set	\$500.00
	Telephone line \$50.00 per month	\$600.00
	Office supplies	\$100.00
		Total \$73,425.00
Year 2 Costs		
On-line Gundersen Health System® Facilitators Training	\$1,141.88 per nursing unit X 5	\$5709.40
NC Salary	Annual per 1 nurse	\$71,050.00
NC Office Equipment and Supplies	Telephone line \$50.75 per month	\$609.00
	Office supplies	\$101.50
		Total \$77,469.00
Year 3 Costs		
On-line Gundersen Health System® Facilitators Training	\$1,159.00 per nursing unit X5	\$5795.00
NC Salary	Annual per 1 nurse	\$71,902.00
NC Office Equipment and Supplies	Telephone line \$51.50 per month	\$618.00
	Office supplies	\$103.00
		Total \$78,418.00