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Implementing Point-of-Care Tools to Increase Advance Care Planning Discussions Among Older Adults

Megan Harbert

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Implementing Point-of-Care Tools to Increase Advance Care Planning Discussions Among Older Adults

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By
Megan Harbert
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DNP Project Chair: Dr. Amy Lask

DNP Project Team Members: Staff of Messiah Lifeways

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Table of Contents

Abstract

Background: The adult population 65 years of age and older is increasing, but a lack of advance care planning discussions has led to poor completion of advance directives. Advance directives express one's medical wishes once they are not able to make their own decisions and are approaching the end of their life. Advance directives prevent futile care that patients do not want. **Problem**: Lack of knowledge, lack of time, and unwillingness to discuss advance directives prevent providers from including advance care planning in their current workflow. Advance directives are important to provide in the long-term care setting, as these patients often have multiple comorbidities and are at higher risk for hospital readmission. **Methods**: Participants included patients aged 65 and older who are residents of a skilled nursing and rehab facility. They must be admitted for at least one week and be able to make their own medical decisions. **Intervention**: The DNP project leader initiated advance care discussions using the PREPARE conversation guide. Patients received an advance care discussion guide published by PREPARE and reviewed it with the DNP project leader and family members. Completion of the advance directive was measured at the time of and one week after the intervention. **Results**: There was a statistically significant increase in post-implementation advanced directive completion scores compared to baseline completion scores **(**p = .006) **Conclusion**: The PREPARE point-of-care tools improved completion of advance directives and aided in advance care planning discussions in older adults.

Keywords: advance directives, point-of-care tool, geriatric, conversation guide

Implementing Point-of-care Tools to Increase Advance Care Planning Discussions Among Older Adults

In 2019, the U.S. Census Bureau noted a steady rise in the older adult population in the United States (Administration for Community Living, 2021). The number of U.S. citizens aged 65 and older had increased 4% from the 2009 census to a total of 54.1 million older adults in 2019. A rise in older Americans often leads to increased demand for advance healthcare. As more older adults are approaching the end of their life expectancy, providers should be proactive in discussing patients' wishes for end-of-life care.

Problem Statement

Advance care planning is an important part of the care of the older adult but often gets overlooked due to time constraints or hesitancy from both patient and provider. Only approximately one in three Americans have completed an advance directive. Lack of provider education, inappropriate screening for patients who should have an advance directive, and hesitancy from both the patient and provider to have advance care planning discussions are all factors that contribute to this problem. As a result, patients and their families feel stressed about making treatment choices at the end of life, overuse medical resources that are not necessary, and are not provided with services that may be beneficial to them. Patients who do not plan for the end of life may lack autonomy in their care and experience a more traumatic or painful death.

Often, advance care wishes are not discussed prior to hospitalization. A lack of knowledge regarding what care a person may or may not want during their hospital stay greatly increases the risks of futile care, increasing health care spending (Carter et al., 2017). Futile care can also cause great physical and psychological harm to patients and families and deprive them of quality end-of-life care.

Overview of Key Terms

Advance directives are a communication tool that allows patients to inform their providers and loved ones of their preferences for medical interventions should they become incapacitated or unable to make their own medical decisions (National Institute on Aging, 2022). Three types of advance directives commonly used in the health care of older adults in Pennsylvania are living wills, durable power of attorney, and Portable Orders for Life-Sustaining Treatment (POLST) forms (Louisiana Health Care Quality Forum, 2022; National Institute on Aging, 2022). A living will is a document that identifies a patient's wishes for medical treatment should they no longer be able to make their own decisions (National Institute on Aging, 2022). Although helpful for the decision-making process, a living will is not a legally binding document. Durable power of attorney for health care is a legal document that allows a proxy to make health care decisions for the patient. Ideally, the proxy is a sibling, child, or friend. In this project, the power of attorney may also be referred to as a medical decision maker (MDM) as not all medical decision makers were designated in legal terms. A POLST is a medical directive that expresses a person's wishes when critically ill and used both in and outside the hospital and supersedes wishes expressed in a living will (Louisiana Health Care Quality Forum, 2022).

Many older Americans wait to address their end of life wishes. Early discussions of advance care planning that occur outside of the hospital better prepare patients and their families to make in-the-moment decisions regarding healthcare (Howard et al., 2018). Older adults in skilled nursing facilities often have multiple comorbidities that need to be addressed with advance care planning. In long-term care, it is especially important to understand the patient's thoughts about their illness and how providers should provide high-quality medical care. Medically futile care consists of life-prolonging treatment that does not result in the intended outcomes, either worsening quality of life or resulting in death (University of Washington Department of Bioethics & Humanities, 2018). Advance care planning is when providers and their patients or family members discuss their wishes and complete the documents previously discussed (Howard et al., 2018).

Needs Assessment

Messiah Lifeways is a community of combined older adult resources including, but not limited to, inpatient and outpatient rehabilitation, skilled nursing, assisted living, and independent living services. It serves the greater Cumberland County area, which has approximately 262,919 people as of the 2020 census (U.S. Census Bureau, 2021). Messiah Lifeways was chosen for this Doctoral of Nursing (DNP) project because of the large population of older adults in the area as well as its proximity to several major medical organizations.

A strengths, weaknesses, opportunities, and threats (SWOT) analysis was completed to evaluate internal and external attributes of this site and can be viewed in Appendix A. A fishbone diagram, as seen in Appendix B, was completed to analyze the causes that led to a lack or absence of advance care planning discussions between providers and their geriatric residents. One of the strengths of Messiah Lifeways is that providers establish advance care planning upon admission to their facility. However, this only involves completion of a POLST form on file, which notes resuscitation status and whether they would want artificial nutrition or hydration or if they would like antibiotics to be given should they become ill. Anything beyond those advance care decisions is not assessed unless provided by the resident or the resident’s family.

Aim, Objectives, Purpose Statement

The aim of this project is to increase advance care planning discussions with older adults to decrease futile medical care towards the end of life. The objectives of the implementation of this project are to:

- Over a 3-month intervention phase, the DNP project leader meets with at least 80% of eligible residents of specified units at Messiah Lifeways.
- Over a 3-month intervention phase, 75% or more of participating residents will complete at least 50% (POLST/MDM/Living Will) of the advance directive one week after intervention.
- Over a 3-month intervention phase, at least 50% of participating residents will fully complete the provided advance directive.

The overall purpose of this quality improvement project is to implement a point-of-care tool that increases advance care planning discussions and completion of advance directives among older adults in the outpatient setting.

Review of Literature

The question this literature review seeks to answer is: in the outpatient setting, does nurse-led use of point-of-care tools increase advance care planning discussions with patients aged 65 and older when compared to no intervention?

The literature search and appraisal were implanted during July 2022 through February 2023; the search was limited to articles written in English, focused on the geriatric population (ages 65 and up), and published during 2017 to 2022. The databases searched include CINAHL, Medline, PubMed, Cochrane Database for Systematic Reviews, and Google Scholar. Search terms included “advance care discussions,” “advance care planning,” “tools,” “conversation guide,” and “e-tool.” The associated Preferred Reporting Items for Systematic Reviews and

Meta-Analyses Articles (PRISMA) diagram can be referenced for a more detailed report of article results, inclusions, and exclusions in Appendix C. Articles of poor quality were excluded, but most were excluded because they did not answer the PICO question or were not generalizable to the population and setting of this DNP project. One article from Google Scholar met inclusion criteria for appraisal. Articles were excluded from Google Scholar if they were poor quality, not from peer-reviewed journals, or if they were duplicates found in other research databases. Ultimately, 12 articles of A or B quality were chosen for appraisal and inclusion in the review of literature. Of these 12 reports, six were Level I evidence, one was Level II evidence, three were Level III evidence, and two were Level V evidence.

The articles were appraised using the Johns Hopkins Nursing Evidence-Based Practice Models and Guidelines (Dang et al., 2022). More specific information about the articles used in this literature review and their appraisal can be found in the individual evidence summary tool in Appendix D. There were several point-of-care tools investigated in all the articles. Four systematic reviews were included in the literature review, some of which measured evidence of increased advance care planning (ACP) discussions (Huber et al., 2018; Ryan et al., 2022). Other researchers reviewed common themes among point-of-care tools (Fahner et al., 2019; Myers et al., 2018).

Conversation guides were shown to significantly improve and increase ACP discussions for providers without differences in outcomes between types of conversation guides (Fahner et al., 2019; Myers et al., 2018; Ryan et al., 2022). Respecting Choices is a not-for-profit organization that provides training and conversation guide materials to aid healthcare professionals in ACP discussions (Respecting Choices, 2022). In Gabbard et al.'s (2021) randomized control trial, statistically significant improvement was seen in all measured outcomes ($p < .001$) when a Respecting Choices trained nurse navigator led ACP discussions. The outcomes shown to improve in the EHR included “documented ACP, named surrogate decision maker, advance directive/living will/power of attorney, medical scope of practice treatment form, and use of advance care planning billing codes” (Gabbard et al., 2021, p. 4). Six studies evaluated in the systematic review by Myers et al. (2018) showed a positive correlation between Respecting Choices and increased ACP completion, as well as increased consistency between patient wishes and medical interventions. The Serious Illness Care Guide is a subset of the Respecting Choices organization and was shown to significantly ($p < .001$) improve providers’ perceived ability to have ACP discussions, which ultimately led to increased frequency of ACP discussions (Hafid et al., 2021; Ryan et al., 2022).

Electronic tools (e-tools) were used as a patient-centered approach to ACP communication. E-tools used by patients and providers allowed almost immediate documentation and translation into the electronic health record, and changes in orders were seen if applicable (Huber et al., 2018; Monchis et al., 2020; Ryan et al., 2022). The e-tools provided healthcare professionals with materials to guide the ACP conversations as well as help with documentation of the ACP conversations. The e-tool also triggered order sets based on the provider’s documentation that would update the patient’s chart to reflect their wishes. Patients whose advance care planning was evaluated with e-tools were more likely to agree to less aggressive treatment than those who were not (Monchis et al., 2020). An example of an e-tool is PREPARE, a website that navigates patients through the steps of advance care planning (Myers et al., 2018; Sudore et al., 2017). The use of the easy-to-use website in addition to an ACP guide significantly increased ACP engagement and ACP documentation rates ($p < 0.001$; Sudore et al., 2017). The PREPARE website also provides other tools, such as an easy-to-read advance directive and conversation guide that are free for all to print and use. When compared to other easy-to-read advance directives, the use of PREPARE's resources has been shown to significantly improve engagement in ACP discussions (Freytag et al., 2020), increase advance directive completion (Hickman et al., 2016; Overbeek et al., 2018), and increase documentation of advance care planning discussions (Sudore et al., 2018).

Though there was evidence of ACP communication tools increasing and improving ACP for patients and proxies, there was less evidence of how these tools affected providers involved in ACP discussions. Many researchers focused on ACP in older adults with specific life-limiting illnesses. Few studies featured a generalized population of older adults without terminal illnesses. One limitation of this review is some of the selected articles chosen were not specifically focused on participants over the age of 65, but the age demographics of the study had a mean participant age of 65 and older (Fahner et al., 2019; Myers et al., 2018; Ryan et al., 2022; Sudore et al., 2017). Not all research took place in the United States; however, research did occur in other developed countries where healthcare closely resembles that of the United States, where interventions could be replicated.

Overall, point-of-care tools have been shown to significantly improve ACP discussions between older adult patients and providers in the outpatient setting. In the available literature, e-tools and conversation guides showed promise in initiating ACP conversations. Healthcare providers are most likely to use an e-tool or conversation guide. These themes provided substantial evidence of increased ACP discussions and documentation and created a foundation for constructing the project intervention. In combination with provider training on how to use the point-of-care tool of choice, these tools can have increased frequency of ACP discussions (Huber et al., 2018; Myers et al., 2018; Sudore et al., 2017).

Theoretical Model

Ajzen's (1991) theory of planned behavior (see Appendix E) is a psychological theory that stems from the theory of reasoned action. This theory features the individual's intention to perform a given behavior. Factors such as attitude toward the behavior, social pressure to perform the behavior, and perceived behavioral control represent the individual's actual control over the behavior. Ajzen's theory predicts that should the individual have the required opportunities, resources, and intention to perform the behavior, they will be successful in doing so. The theory of planned behavior easily translates to the theoretical model of this DNP project. A person's attitude toward advance care discussions, knowledge of advance directives, and previous experiences may affect their intention to initiate advance care planning. Having resources available, such as point-of-care tools, will increase patient's intention to complete advance directives by improving knowledge and possible perception of the behavior intended (Ajzen, 1991). Changing a person's perception and knowledge of advance care planning with the addition of a point-of-care tool will, according to Ajzen's theory, increase patient's intention to complete an advance directive.

Translation Model

The translation model that will be used in this DNP project is the Knowledge to Action Framework (see Appendix F; Graham et al., 2006). This model focuses on the translation of knowledge by "capturing the benefits of research . . . through improved health, more effective services and products, and a strengthened health care system" (Graham et al., 2006, p. 15). The action phase of this process functions as a cycle to apply the knowledge into action. The Knowledge to Action Framework derives its concepts from over 60 translational theories. This model combines common themes into one action cycle. The action cycle starts with identifying problems that need to be addressed. Next, the action cycle includes evaluating the outcomes of application and identifying new problems that arise from the application. This translation model is best for this DNP project because it began with a clear gap in advance care planning discussions in the outpatient setting and adapted the knowledge available for research to the context of a long-term care facility. Barriers to the DNP project have been considered and addressed leading to the tailoring of specific interventions that will be most successful in the context of this DNP project.

Methodology

This project was implemented for two months from February 2023 to April 2023 at a skilled nursing facility in south central Pennsylvania. A point-of-care tool was obtained and used to aid in advanced care planning discussions among the residents. The methodology of implementation and data collection have been broken down into their individual elements and discussed below.

Participants

Participants included patients admitted to two Messiah Lifeways units during implementation of the intervention. Residents of Messiah Lifeways were recruited through convenience sampling and had the choice to not participate in the project should they not want to discuss advance directives. Inclusion criteria for patients included patients aged 65 and older who are able to make their own medical decisions and residents of Messiah Lifeways in the Wagner and Hampden neighborhoods (units). Exclusion criteria included dementia or other cognitive disabilities, residents already on comfort measures or receiving hospice care, residents younger than 65 years old, and residents who were transferred or discharged within one week of admission.

Setting

The project took place at Messiah Lifeways, a not-for-profit organization that serves the south central Pennsylvania community (Messiah Lifeways, 2020). Messiah Lifeway's facility includes 208 independent living apartments, 152 independent living cottages, 183 personal care apartments (maximum capacity of 238 residents), and 184 licensed skilled nursing beds. Of the 184 skilled nursing beds, 31 are designed for short term rehabilitation. Messiah Lifeways residents, using skilled nursing and rehab services, on average are 65 years and older and suffer from multiple comorbidities that diminish their ability to complete activities of daily living. Messiah Lifeways staff includes nurse aides, licensed practical nurses (LPNs), registered nurses (RNs), and physical and occupational therapists. One physician sees and treats residents in the Wagner and Hampden neighborhoods. Prior to implementation of the intervention, the DNP project leader met with staff of Messiah Lifeways to explain the role of the provider in the quality improvement project and the materials given to patients to review with their providers. The DNP project leader also attended Messiah Lifeways new hire orientation to understand the standards of behavior for staff and residents. Additionally, the project leader attended training sessions to navigate the electronic health record that is used for documentation.

Barriers to Project Implementation

There were multiple barriers to implementing this quality improvement project at Messiah Lifeways. Like many skilled nursing facilities across the country, there were outbreaks of COVID-19 among residents that hindered recruitment for participation. Residents who were positive for COVID-19 were only to be seen for essential care. Another barrier to implementation included a decrease in admission rates at Messiah Lifeways. Therefore, recruiting residents to participate in this quality improvement project became more difficult as the implementation period progressed. A high number of residents had a diagnosis of dementia; this diagnosis excluded them from participating in the project.

Tools

No instruments were used in this quality improvement project. PREPARE is an organization that provides advance care planning resources for patients and providers online as well as handouts and pamphlets for healthcare organizations (PREPARE, 2022). The conversation guide (see Appendix G) and advance care directive (see Appendix H) have been used in studies to lead advance care planning discussions (Myers et al., 2018; Sudore et al., 2017). The use of PREPARE resources has been shown to significantly increase documentation of ACP with older adults ($p = 0.04$; Sudore et al., 2017). The PREPARE conversation guide and easy-to-read advance directive were used to assist in the advance care planning process for this project.

Intervention

The DNP project leader met with each eligible and available resident in the Wagner and Hampden neighborhoods at Messiah Lifeways from the end of February through the beginning of May 2023 to start the advance care planning discussion processes using the resources from PREPARE as demonstrated in the process map (see Appendix I). An easy-to-read advance care guide was given to the residents and reviewed at the bedside with residents and family if present. Residents had time to review the materials alone, with loved ones, or with staff members. Completion of the advance directive was measured as either complete or incomplete for all three sections of the advance directive. These sections included the POLST, designation of medical decision maker, and living will. The DNP project leader then followed up with each resident after one week to assess for further completion of the advance directive. Any components of the advance directive that were completed were placed in the resident's chart.

Data Collection

Data collection was obtained through retrospective chart review throughout the implementation period. Resident information was available via physical chart and electronic health records. Data was collected prior to the project leader meeting with residents and one week post implementation. The DNP project leader also collaborated with nursing staff to identify residents qualifying for participation.

Preimplementation

Data collected during the preintervention phase contained the resident's demographic data, such as age, gender, race, and ethnicity. Notes were also taken if life-limiting comorbidities were present for the resident upon the time of implementation, such as diabetes, congestive heart failure (CHF), chronic kidney disease (CKD), history of stroke, coronary artery disease (CAD), history of or current cancer, and chronic obstructive pulmonary disorder (COPD). Both physical and electronic charts were reviewed, and the DNP project leader documented the presence of POLST, health care power of attorney, or living will. Information collected was de-identified and connected to a sample number. All data were filed on a password-protected computer on site.

Postimplementation

Immediately after implementation, the DNP project leader assessed for completion of the advance directive components as mentioned above. Each component was documented as either complete or incomplete. Completion of the entire directive was documented if all three components were present. After one week, the DNP project met with the resident and documented any further completion of the advance directive, providing additional support at that time if needed. All data was collected by the DNP project leader and input into SPSS (IBM, 2021) using sample numbers to remain compliant with the Health Insurance Portability and Accountability Act (HIPPA).

Cost Analysis

The cost of this project mainly related to the cost of having the guides printed as booklets. Because the advance care directive guides will continue with the patient wherever they might go, they needed to be printed on heavier paper to last longer. Due to the amount of needed print material, it was more financially responsible to print the guides and other resources professionally. Therefore, ink and paper were not included in the budget as the printing budget was all inclusive (see Appendix J). The cost of the guides was provided by the project leader. The time needed for this project was donated by the project leader and no additional time was needed by staff. There were no operational costs that needed to be included in the budget as the facility operates all hours of the day.

Currently, the financial burden associated with a lack of advance directives is severe. It is estimated that approximately $151.1 million dollars are spent on futile care every year at the national level (Carter et al., 2017). Not only are there millions of dollars spent on end-of-life care, but without advance care planning, patients are more likely to be readmitted to the hospital for futile care and services, decreasing reimbursement rates for Messiah Lifeways. At Messiah Lifeways, there is no budget devoted to advance care planning discussions, and it is left to the providers to have these conversations on their own time or refer to social work.

This project has the potential to decrease costs of medical care at the end of life for the residents of Messiah Lifeways. Millions of dollars are spent providing futile care to older adults

(Duncan et al., 2019). The highest costs of medical care occur during a person's last 6 months of their life. Although it is not possible to eliminate expenditures for futile care, this DNP project can reduce it in the context of its setting.

This project will impact provider productivity in the long term. With advance care planning being completed while the patient is medically stable, it reduces the time needed for care planning when the patient begins to decline and can no longer make decisions for themselves. Not needing to have ACP discussions about end-of-life care when it is too late may provide relief for providers and nursing staff. Reducing futile care may also provide relief for care staff.

Timeline

After the DNP proposal was presented and defended, the next steps included finalizing the proposal paper and receiving Institutional Review Board (IRB) approval, which was completed in December 2022 (see Appendix K). Because this project only needed to be reviewed by Messiah University's IRB, the expected date for completion of the IRB form was flexible. No additional time was needed to recruit participants, as they were recruited by convenience at the time of implementation. Implementation of the intervention and collection of data began in February of 2023 and will continue until the beginning of May 2023. Analysis of the data and dissemination of evidence is expected to be completed in the summer of 2023. The final presentation and DNP project defense are expected in August of 2023.

Ethics and Human Subject Protection

The Messiah University IRB exemption was obtained prior to initiating the DNP Project. All patients were protected by HIPAA, which protects the privacy of the patients' health information (Office for Civil Rights, 2015). The DNP student followed the *Standards of Care* for practice in a skilled nursing facility (American Nurses Association, 2021).

The risk to patients participating in this project was no different from the risks of patients receiving standard care. The DNP project leader obtained all personal information from residents' medical charts. The DNP project leader completed Protection of Human Research Subjects online training prior to project implementation. Participant confidentiality was assured by coding the participants using individual identification numbers. The list of participants and their identifying numbers were kept in locked filing cabinets in a locked office, only accessible to the DNP project leader. All electronic files containing identifiable information were kept on a password-protected computer to prevent access by unauthorized users and only the DNP project leader had access to the password. After 3 years, the electronic data will be deleted.

Results

Data was obtained via convenience sampling and stored in an Excel workbook in a password protected computer. Upon completion of implementation, the data was cleaned, de-identified and input into SPSS (IBM Corp, 2021) for analysis. There was no missing data prior to statistical analysis. Implementation

Demographic Data

Demographic data was analyzed using frequency tables and tested for normal distribution by calculating skewness and kurtosis. This convenience sample of 16 white, non-Hispanic older adults ranged in age from 71 to 105 years (M = 86.2, SD = 8.3), with the majority having a primary diagnosis of ambulatory dysfunction (50%, n = 8) and an average of 5 medical comorbidities. Half were female (n = 5). See Table 1.

Table 1

Demographic Data

Cluster	Sub-category	n	%
Age (mean)		86.2	
Gender			
	Male	8	50
	Female	8	50
Race			
	White	16	100
Ethnicity			
	Non-Hispanic	16	100
Primary Diagnosis			
	Ambulatory Dysfunction	8	50
	Joint Replacement	3	18.8
	Stroke	2	12.5
	Syncope	3	18.8

Implementation Data

The amount of time it took to implement the point-of-care tool with each resident was recorded and analyzed. The total time to implement the point-of-care tool ranged from 5 to 60 minutes (M = 17.5, SD = 15.2). However, the data for three residents were outliers at 36, 43, and 60 minutes, skewing the data. With the outlying data omitted from the analysis, the time to implement the POC tool ranged from 5 – 15 minutes, with an average time of 11 minutes (SD = 3.5). Extra time was needed with these residents due to visual or hearing impairments.

Completion of advance directive components (ADC) was noted as being either complete or incomplete. This includes completion of a POLST, medical decision maker, and Living Will. The total number of components completed (out of 3) was collected as numeric data. Finally, completion of all three components was noted if obtained. Complete data for the baseline and post-implementation point-of-care tool variables is found in Table 2. Data for the total advance directive components met the assumptions for a dependent samples t-test. There was a statistically significant increase in post-implementation advanced directive scores (M = 2.5, SD = .73) compared to baseline scores (M = 2.0, SD = .63), *t*(15) = 3.16, *p* = .006, *d* = .79, 95% CI .16, .84).

Table 2

Advanced Directive Components (ADC) Descriptives

		POLST %(n)	**Medical Decision Maker** %(n)	**Living Will** %(n)	**Total ADC** ***M*(*SD*)**
Baseline	incomplete	0	18.8%(3)	81.3%(13)	2(.63)
	complete	100%(16)	81.3%(13)	18.8%(3)	
Post-Implementation	incomplete	0	12.5%(2)	37.5%(6)	2.5(.73)
	complete	100%(16)	87.5%(14)	62.5%(100	

Discussion

All of the original objectives for this DNP project were met and the results exceeded expectations. Over the three-month intervention phase the DNP project leader met with 89%(n=25) of the 28 eligible residents. Of those 25, only 16 chose to participate and met all requirements throughout the intervention. Over the three-month intervention phase, 87.5% (n=14) of participating residents completed at least 50% of the advance directive one week after intervention. Over the three-month intervention phase 62.5% (n=10) of participating residents fully completed the provided advance directive.

There was a statistically significant incrase in post-implementation advance directive scores (M = 2.5, SD = .73) compared to baseline scores (M = 2.0, SD = 6.3; *t*(15) = 3.16, p = .006, *d* = .79, 95% CI .16, .84). The large effect size indicates clinical significance in supporting the use of nurse-led point-of-care tools to increase advance directive completion in the setting of this QI project. This strongly suggests future use of this point-of-care tool in order to aid advance care planning discussions to continue to improve advance directive completion with older adults

Significance to Advanced Practice Nursing

This project increased the number of older adults at Messiah Lifeways with advance directives. The dissemination of statistically significant data should provide guidance for other long-term care health facilities in improving advance care discussions with their patients. The results of this project will be significant to advance practice nurses, as the results show that point-of-care tools can improve advance care planning discussions between providers and their older adult patients.

Increasing advance care planning discussions can decrease futile medical care in the future and provide older adults with the chance to state their wishes to their providers and loved ones. Advance practice nurses have a responsibility to honor patient wishes. When an advance care directive is in place, honoring patients' wishes is straightforward. Having an advance care directive can relieve the pressure on families having to make decisions for their dying loved ones.

Lastly, the impact on the patients' families should be recognized and discussed. Discussions about end-of-life care are difficult for families. How does an adult child talk about end-of-life wishes with their mother or father? The purpose of the conversation guide and advance care planning booklet is to make advance care planning as simple as possible. Once a patient can no longer make medical decisions on their own, having advance care planning in place provides a significant amount of relief for caregivers and family members. Caregivers and family will know they will be following their loved one's wishes.

Conclusion

Many older adults do not have an advance directive in place. Providers are unsure of how to discuss end-of-life wishes with their patients, especially in the skilled nursing setting. Long-term care patients, in particular, need to have advance directives in place, as they have multiple comorbidities. Research shows that point-of-care tools provide guidance for providers, increases advance care planning discussions, and increases completion of advance directives. With the implementation of a point-of-care tool, there was a statistically significant increase in completion of advance directives. The PREPARE conversation guide and advance directive were easy to use and can be accessed by anyone for implementation. The improvement in advance care planning discussion seen in this DNP project shows that the use of point-of-care tools can change the workflow of providers in the outpatient setting to include advance care planning in their daily workflow.

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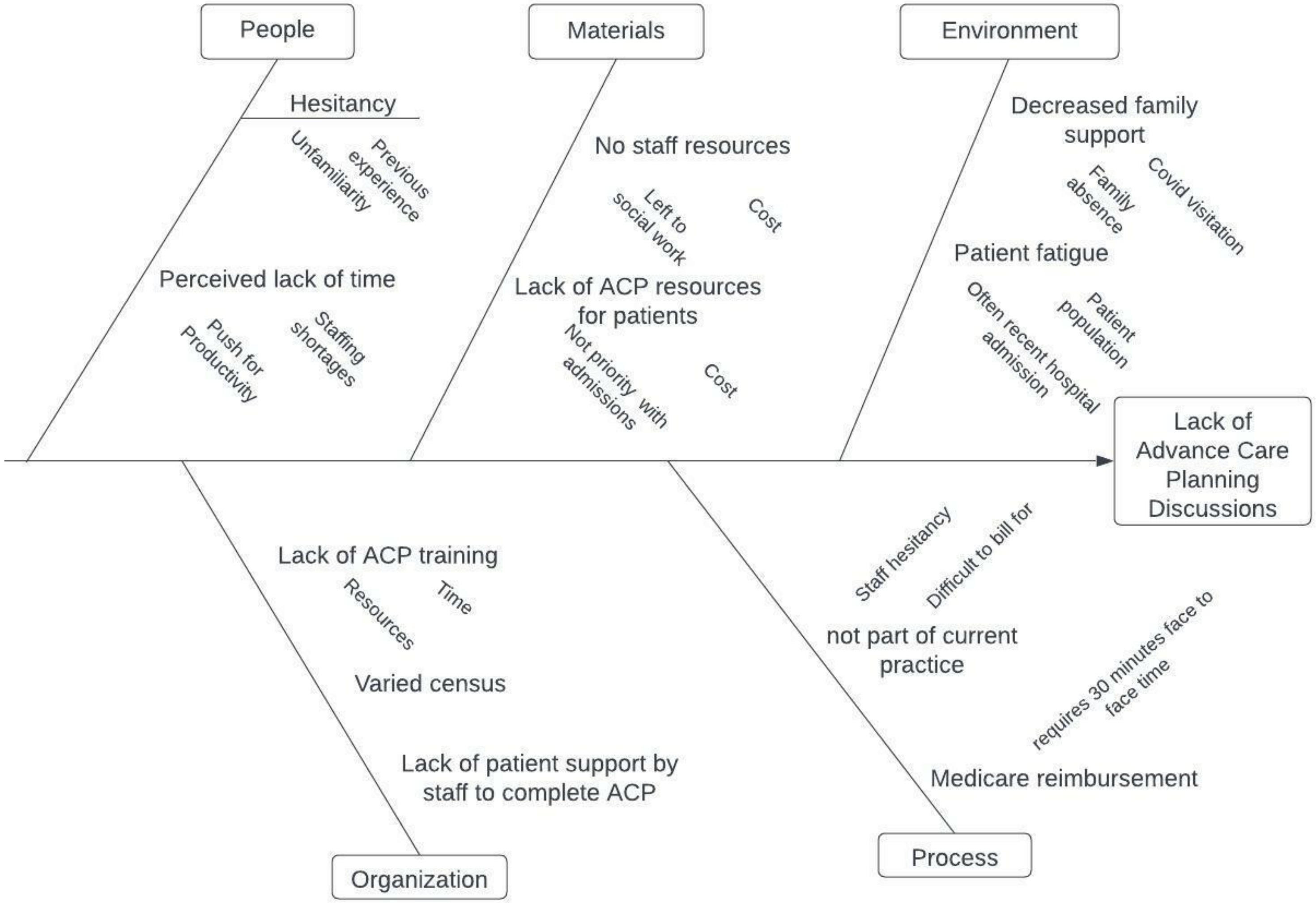
Appendix A

SWOT Analysis

Strengths	Weaknesses
• Requires completion of POLST form upon admission • Long-term and short-term patients averaging age 65 and up • Social workers and case managers available to residents during regular business hours • Admissions to facility allow for more face-to-face time with patients • Support from department of nursing	• Poor staffing ratios: only one provider per section of the facility leaving little to know time for ACP discussions • Providers don’t view ACP as priority during visits • Nursing staff not trained in ACP discussions • Mostly paper charting
Opportunities	**Threats**
• Opportunity for more residents to complete advance directives • Education for nursing staff and providers about advance directives beyond POLST form • Potential for conversation guide to be used beyond time frame of the DNP project	• Ongoing material and training fees • COVID-19 outbreaks among residents • Lack support from on-call provider • Higher intake of residents with dementia

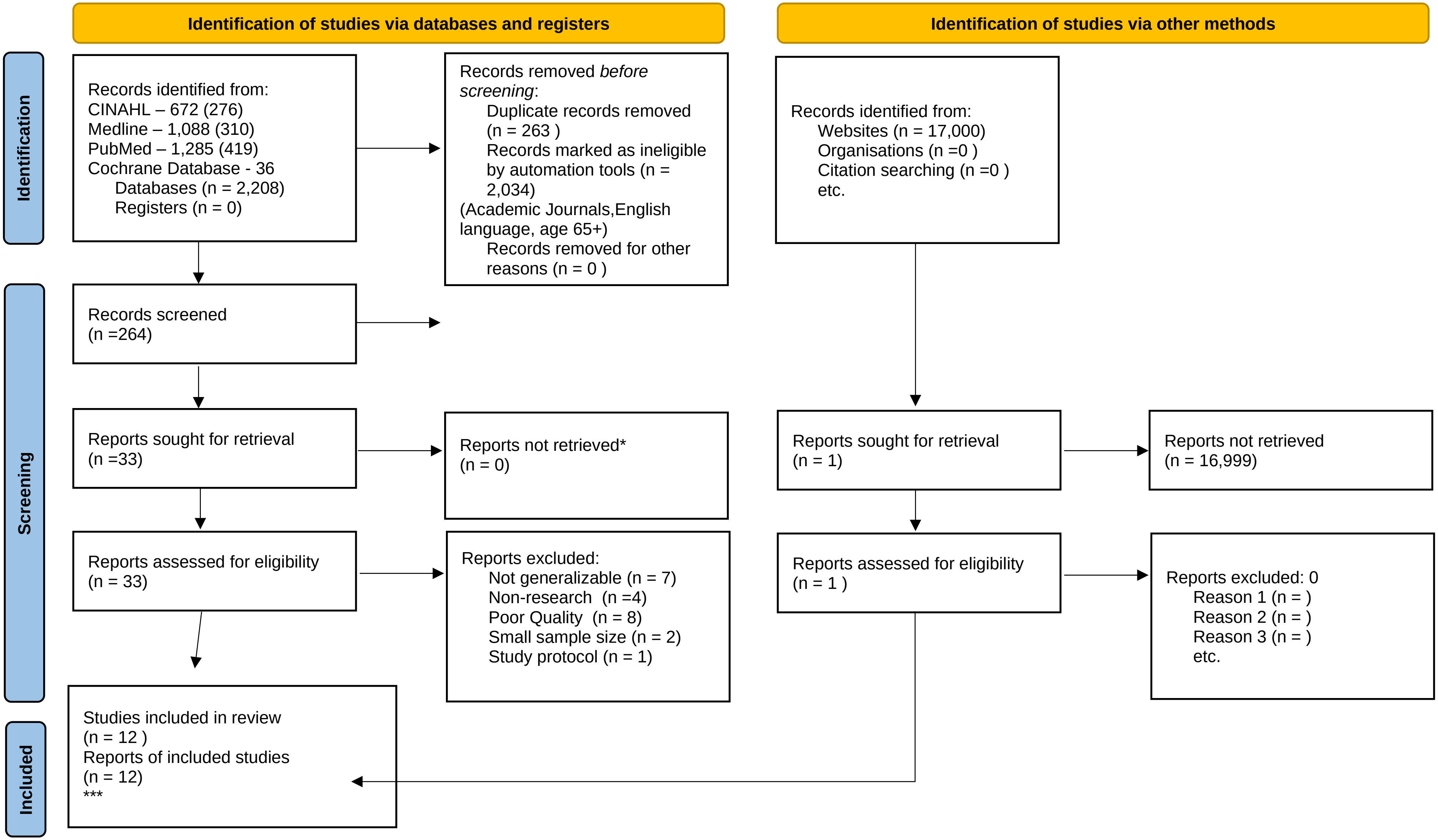
Appendix B

Fishbone Diagram



Appendix C

PRISMA Diagram



Appendix D

Individual Evidence Summary Tool

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
1	**Fahner et al. (2019)** Journal of the American Medical Directors Association	Systematic Review	To evaluate the content, rationale, and empirical evidence on the effect of ACP interventions based on conversation guides; Searched MEDLINE, Embase, PsycINFO, and CINAHL	21 RCT's, 3 non-randomized controlled trials, 13 observational studies, 22 mixed-methods studies, 13 qualitative studies; Majority of studies focused on ages 65+ or with terminal illness	Exact scripted conversation guides with or without scripted questions; information booklets for patients; face to face conversations outpatient over the phone	No instruments used in this systematic review	Significant evidence of increased quality of communication, discussions with surrogates, discussions with clinicians Phases of the guides: preparation, initiation, exploration, and action	Strengths: compares one intervention type; reports common themes and examples form conversation guides; exhaustive literature search Limitations: review did not include any interventions from gray literature, websites, or handbooks	Level III Quality A
2	**Freytag et al. (2020)** Journal of the American Geriatrics Society	RCT	The purpose was to compare the PREPARE website an easy to ready advance directive (AD) when compared to another AD in order to increase discussion of ACP with older	393 participants (216 in control group) were randomly selected from 7 different primary care clinics in San	The PREPARE guide and AD provide videos and instructions for participants and their families to easily	Participation was measured by number of times participants spoke (in turn) during their follow-up ACP discussion visit with their PCP; the visits were	Participants in the intervention group (mean [SD] = 10.5 [16.84]) showed significantly (p = .03) more measurable signs of active engagement in ACP discussions (i.e. asking questions, utterances, etc.) than those in the control group (mean [SD] = 6.61	Strengths: Previous studies that measured participation in ACP discussions did so by self-reported impression of involvement and participation of the process. This	Level I Quality A

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
			adults and their primary care providers; Participants were randomly selected and put into to two participants blocks based on health literacy	Francisco, CA; Inclusion criteria: must have 2 or more chronic illnesses, and have been seen twice by PCP in the past year in addition to a visit to the ER/hospitalization Exclusion: cognitive or hearing impairment, lack of access to phone	identify wishes for end of life care; participants in control and intervention group followed up with their PCP to have ACP discussions	analyzed using audio recordings	[13.44]. Participants who were more actively involved in discussion were also 15 % more likely to have their wishes documented in the EHR (p<.001)	randomized control trial is different as participation in discussions were identified by measurable outcomes using audio recordings. Limitations: Reanalyzes data and shares participants from other research studies using the same intervention	
3	**Gabbard et al. (2021)** JAMA Internal Medicine	RCT	To determine effectiveness of a nurse navigator-led ACP pathway with EHR interface improves the occurrence of the ACP discussions and documentation in the EHR	249 patients (146 in the intervention group) who are 65 years and older with multiple comorbidities or frailty from 8 primary care practices in North Carolina	Nurse navigators were trained using respecting choices to review protocol and telephone version of EHR documentat	Instrument Quality of care survey was going to be used initially to score quality of ACP discussions, but they were unable to due to auto population of documentation into the	All results are statistically significant (p <.001) With nurse navigator – increased documentation of ACP, named surrogate decision maker, advance directive/living will/power of attorney, medical scope of treatment form, use of advanced care planning billing codes	Strengths: Large sample size and pragmatic design, attached supplement of ACP pathway, EHR integration Limitations: participants recruited from a single health system, system already had nurse	Level I Quality B

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
					ion and engage them in a nurse navigator-led ACP documentation process	providers notes; no validity or reliability were discussed		navigators in place	
4	**Hafid et al. (2021)** BMC Palliative Care	Quality Improvement Project	Explore the perceptions of providers in an interprofessional academic family practice regarding implementing ACP into routine care using an adapted SICP; quality improvement project collecting both qualitative and quantitative data	Two primary care clinics with 36 primary care providers included in the study; Ontario, Canada	Training session consisting of group-based discussions and simulated conversations using Serious Illness Care Guide (SICG)	Likert scale survey of participant's self-assessment of skill pre- and Post- training. NoMAD survey – Cronbach's alpha = 0.89 with good validity exhibited	The use of SIGC significantly improved ($p < 0.001$) provider's perceived ability to have ACP discussions with patients Barriers identified were physician perspective and discomfort of ACP discussions, physician schedules, and difficulty identifying appropriate patients for ACP discussions. Suggestions included having ACP discussions over multiple visits, increasing collaboration between providers and allied health professionals, more training, and resources to normalize ACP discussions.	Strengths: Clearly identified point-of care tool used (SICG) Identified gaps in research and areas for future research Limitations: not in the United States Reflective of only one health organization Does not measure frequency of ACP discussions	Level V Quality B
5	**Hickman et al. (2016)**	Quality Improv	To implement nurse-lead ACP intervention that	Convenience sampling of nursing home	OPTIMISTIC RN's were	No instruments used	69% of residents made changes to their care preferences based on ACP	Data only represents initial phase of	Level V Quality B

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
	Journal of the American Geriatrics Society	ement Project	allows all nursing home residents access to OPTIMISTIC advance care planning discussions	residents in 19 nursing homes in urban and suburban Indiana; Residents must have been in nursing home for >100 days; reached a total of 2,709 nursing home residents	trained to have advance care planning discussions using Respecting Choices. Nursing home residents were approached by nurses for ACP discussions		discussions with nurse (no p-value noted) 84% of residents filled out an advance directive because of the intervention. (no p-value noted) This project shows effectiveness of nurse-led advance care planning discussions and its effect on advance care decisions	implementation, and the project is continuously evolving to better improve intervention and evolve as needed; No measurable goal set for ACP in this setting	
6	**Huber et al. (2018)** American Journal of Hospice & Palliative Medicine	Systematic Review	Describe the EHR components of ACP interventions, identify populations in which the interventions were implemented, and assess the efficacy of the interventions in these populations. 7 databases were searched using	Inclusion criteria: include an EHR component of ACP and implemented intervention Excluded: those that reported only concepts and planning were excluded 16 articles met the criteria: 1 RCT trial, 3	Electronic navigators; Automated prompts; ACP documentation templates linked to orders	No instruments were used in this systematic review	With EHR tools, there was improvement of one or more ACP outcomes in all studies used in the systematic review. The ACP outcomes most often seen with use of EHR tool were changing of code status and completion of advance directives.	Strengths: exhaustive literatures search; well documented search strategies Limitations: unable to quantitatively synthesize the study effects due to the wide heterogeneity in the included types of interventions, study designs, and reported results; not all in outpatient setting;	Level III Quality A

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
			MeSH headings and key words related to the documentation of ACP (words not listed)	nonrandomized control trials, 3 pre-post analysis, 2 historical control studies, 5 descriptive analyses				breakdown of different populations not reported	
7	**Monchis et al. (2020)** Canadian Medical Association Journal	Nonrandomized pilot study	Participants selected from Royal Victoria Regional Health Centre Inclusion criteria: Age 79+, been in hospital for at least 24 hours but less than 48 hours, Code status not documented or documented as wanting full medical interventions. Excluded those who received diagnosis of life-limiting illness during stay; aim was to evaluate an e-tool used by	37 acute care geriatric (aged 79 or older); 339-bed acute care community hospital located in Barrie, Ontario; 86.5% of participants live in the community	The PA would contact patients eligible for pilot study daily to obtain consent for ACP discussion; an e-tool was used to aid PA in discussions; the PA then reviewed patient orders after ACP discussion	E-tool – contents were derived from validated instruments or prognostic scoring tools; no psychometrics included	Patients that were exposed to e-tool intervention were more likely to consent to less aggressive treatments; 38.2% less participants agreed to aggressive treatment when compared to control group (no p-value noted)	Strengths: Developed e-tool based on other statically valid and reliable tools Limitations: pilot study; acute care setting not primary care; e-tool only available in English; e-tool needs tested for its own reliability and validity; not in the United States	Level II Quality B

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
			PA's to facilitate ACP discussions						
8	**Myers et al. (2018)** American Journal of Hospice & Palliative Medicine	Systematic review	To provide evidence regarding tools and/or practices available for use by health-care providers to effectively facilitate advance care planning conversations and/or goals of care discussions. Sources: MEDLINE, EMBASE, and the proceedings of the International Advance Care Planning Conference and the American Society of Clinical Oncology Palliative Care Symposium.	49 studies were reviewed and retained; combination of systematic reviews, RCTs, qualitative and quantitative studies Inclusion criteria: English language, patients with chronic illnesses, health care provider tools, minimum study size of 30 and could not include case studies or editorials (Myers et al., 2018)	Many different interventions were measured for initiating, facilitating, and documenting ACP discussions	No instruments were used in the systematic review	The ACP tool most often encountered was the Respecting Choices tool which "showed increased advance directive completion, increased appointment of a surrogate, more involvement in EOL decisions, increased consistency between patient wishes and medical interventions undertaken at increased patient and surrogate satisfaction with care received, increased ACP knowledge, fewer symptoms of anxiety and depression in family members of decedents, decreased decisional conflict, and increased consistency between wishes of patients and their surrogates" (Myers et al., 2018).	Strengths: wide variety of studies included among different health populations; majority of populations studied were ages 65+ Limitations: Did not share statistical evidence from studies included in review; did not specify limitations	Level III Quality B
9	**(Overbeek et al., 2018)**	RCT	Purpose is to identify if an	201 Assisted living	Intervention was	13- Item Patient Activation	PAM score did not differ between intervention and	Strengths: intervention	Level I

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
	Journal of the American Geriatric Society		older adult's ability to manage medical care decisions improves with ACP discussions or not Secondary outcome: documentation of care preferences, appointing of surrogate decision maker, and use of medical care	residents and surrounding older adults receiving at home care in Europe (100 in intervention group) Inclusion Criteria: aged 75 and older, frail (Tillburg Frailty Index score of 5 and above), and capable of making medical decisions Exclusion	offering participants ACP guides and conversations using the Respecting Choices materials and tools	Measurement (PAM) (Cronbach α = 0.81) with 5-point Likert scale measures "individuals' knowledge, skills, and confidence to manage their health and healthcare" (Overbeek et al., 2018, p. 1091) Used this instrument to calculate a theoretical scoring range of 0-100	control group at baseline or after 12 months. However significantly more older adults completed an advance directive in the intervention group (n=78) versus the control group (n=34) (p<.001) after the 12-month follow-up. And 71 of participants in the intervention group had an appointed decision maker in writing after 12 months compared to only 23 in the control group (p<.001)	showed to ineffective for primary outcome, but significantly effective for secondary outcomes which ultimately has the greater impact for those who participated; RCT with adequate sample size Limitations: Takes place in Europe, but does not say where specifically	Quality A
10	**Ryan et al. (2022)** Cochrane Database of systematic reviews	Systematic Review	"To assess the effects of interventions designed to improve verbal interpersonal communication about end-of-life care between health practitioners and people affected	8 RCT's mostly from the United States; all but 1 study had mean age of 60+ Patients of any age were included and all interventions	Communication interventions examples: prompts and guides for patients, web-based collaborative tool,	No instruments used in this systematic review	There was no statistically significant evidence that one intervention was more effective than the others. However all, studies assessed the interventions to improve effectiveness of ACP discussions when compared to usual care.	Strengths: All studies included were Level I evidence Limitations: Studies included has low evidence ratings; not all studies included in the systematic review took place	Level I Quality B

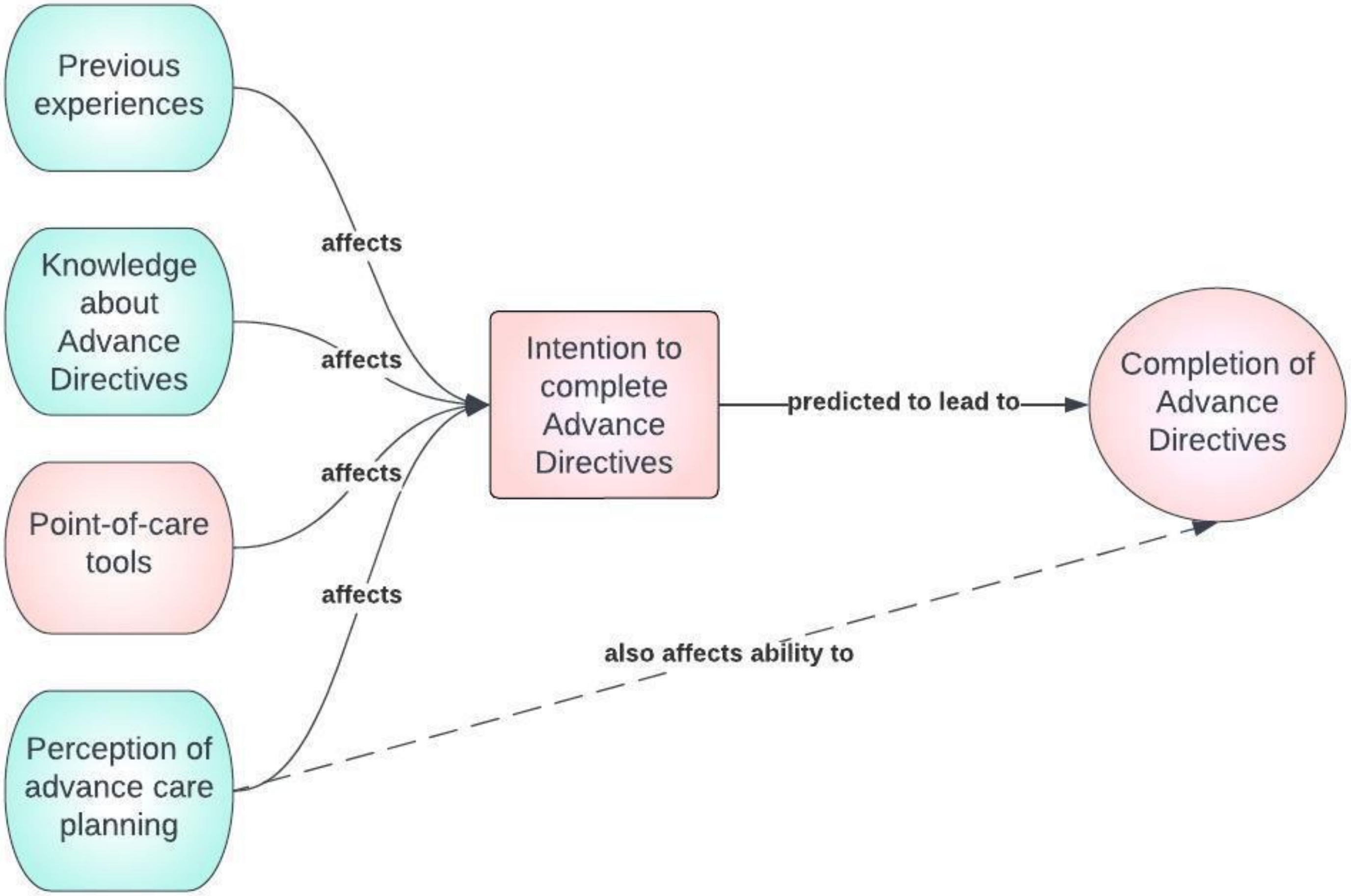
Article #	**Author, Publication Source, & Date (alphabetical order)**	**Evidence Type & Specific Research Design**	**Purpose & Methods**	**Sample Type, Size, Setting**	**Intervention**	**Instruments (include psychometrics)**	**Results/Findings & Recommendations for practice**	**Strengths/ Limitations**	**Evidence Level & Quality Rating**
			by end-of-life care" (Ryan et al. 2022, p. 1); searched CENTRAL, MEDLINE, Embase, PsycINFO, and CINAHL databases	requiring communication were included; focus was also maintained on care in the last 12 months of life	nurse led EOL discussions; family meetings			in the United States	
11	**Sudore et al. (2017)**	RCT	To compare ACP discussion outcomes from easy-to-read ACP guide alone as compared with ACP guide combined with PREPARE website	414 veterans (92% power); mean age 71.1; 9% women; 43% non-white; collected from women's geriatrics, and internal medicine VA offices in San Francisco, CA; of the 414, 205 were randomized into intervention group	Control group: easy-to-read ACP guide Intervention: easy to read ACP guide and use of PREPARE website	Patient-reported ACP engagement survey (no psychometrics included)	ACP documentation rates: 6 months prior to intervention: 0.8% After 9 months: (p = 0.04) ACP + PREPARE – 37% ACP only – 27% Self-reported ACP engagement was significantly higher (p < .001) in the ACP + PREPARE arm	Strengths: Randomized, with adequate sample size; ethnically diverse participants Limitations: majority of participants are male, and measurements relied on self-reports by participants	Level I Quality B
12	**Sudore et al. (2018)**	RCT	To compare the PREPARE easy-to-read advance	Convenience sampling of older adult	Patients reviewed PREPARE'	ACP engagement Survey -	Overall, new documentation of advance care planning was higher	Strengths: large sample in randomized	Level 1 Quality B

Article #	Author, Publication Source, & Date (alphabetical order)	Evidence Type & Specific Research Design	Purpose & Methods	Sample Type, Size, Setting	Intervention	Instruments (include psychometrics)	Results/Findings & Recommendations for practice	Strengths/ Limitations	Evidence Level & Quality Rating
			care planning tool (in English and Spanish) with standard advance care directives in regard to increasing advance care planning discussion and improving patient engagement	patients within 4 primary care clinics in San Francisco, CA (n=986)	s advance care planning discussion guide and online tool. Control: (given a generic advance care planning guide)	Cronbach Alpha - 0.94 (0.91–0.96) (Sudore et al., 2013)	in the intervention than the control group [43%/33.1% (p<.001)] after 15 months. Behavior change scores were significantly higher (p<.001) in the intervention group (97.5 %) compared to the control (87.3%). Action scores were significantly higher (p<.001) in the intervention group (94.8%) vs the control group (78.4%)	controlled trial; Low attrition rate; in-depth statistical analysis of data Limitations: participants were all recruited from same health system, possibly limiting generalizability; Cronbach alpha was not noted in report (had to find elsewhere)	

*Modified from JHEBP (2022), Appendix G. Refer to page 316-318 for detail

Appendix E

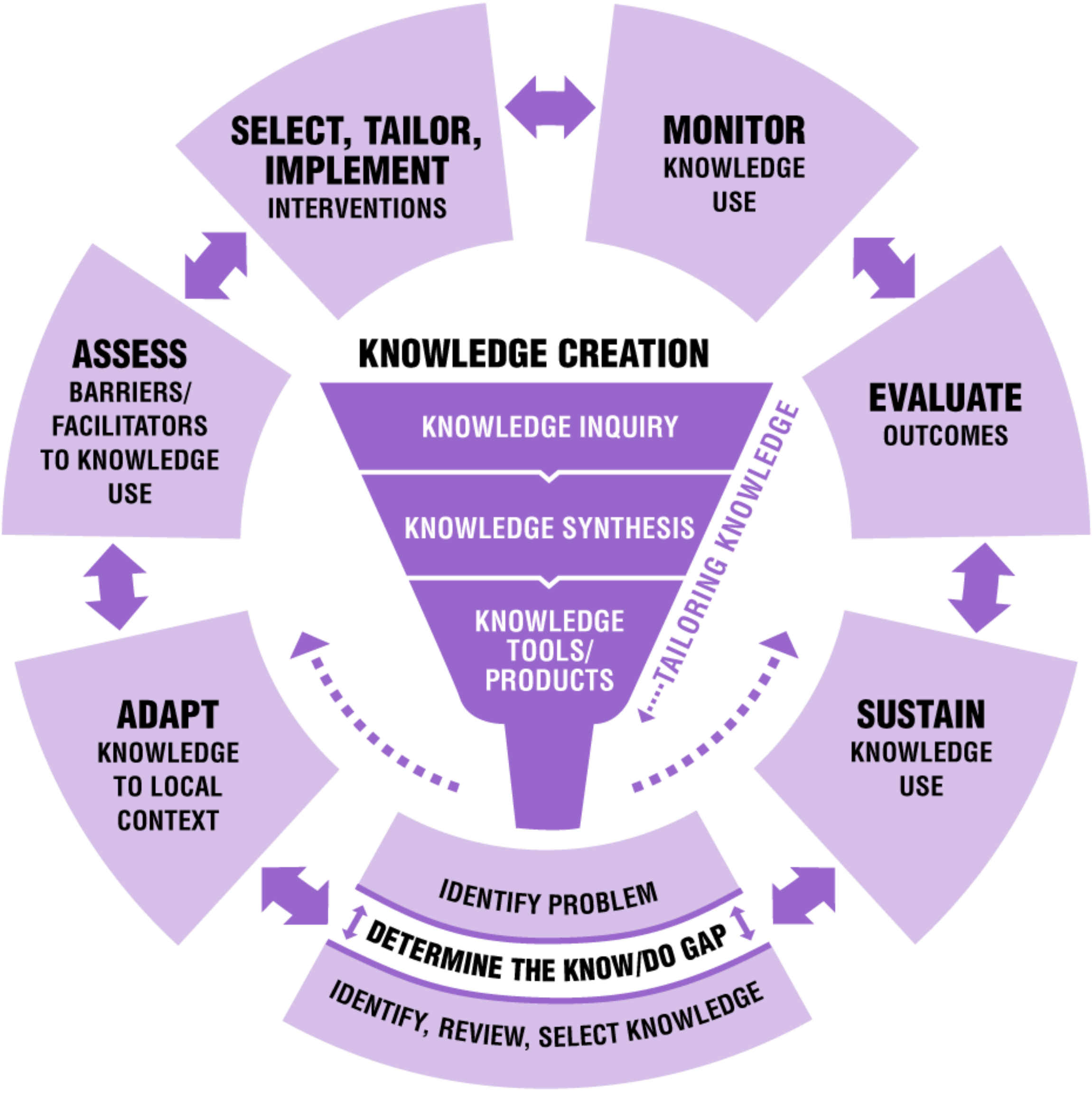
Theoretical Model



(Ajzen, 1991)

Appendix F

Translation Model

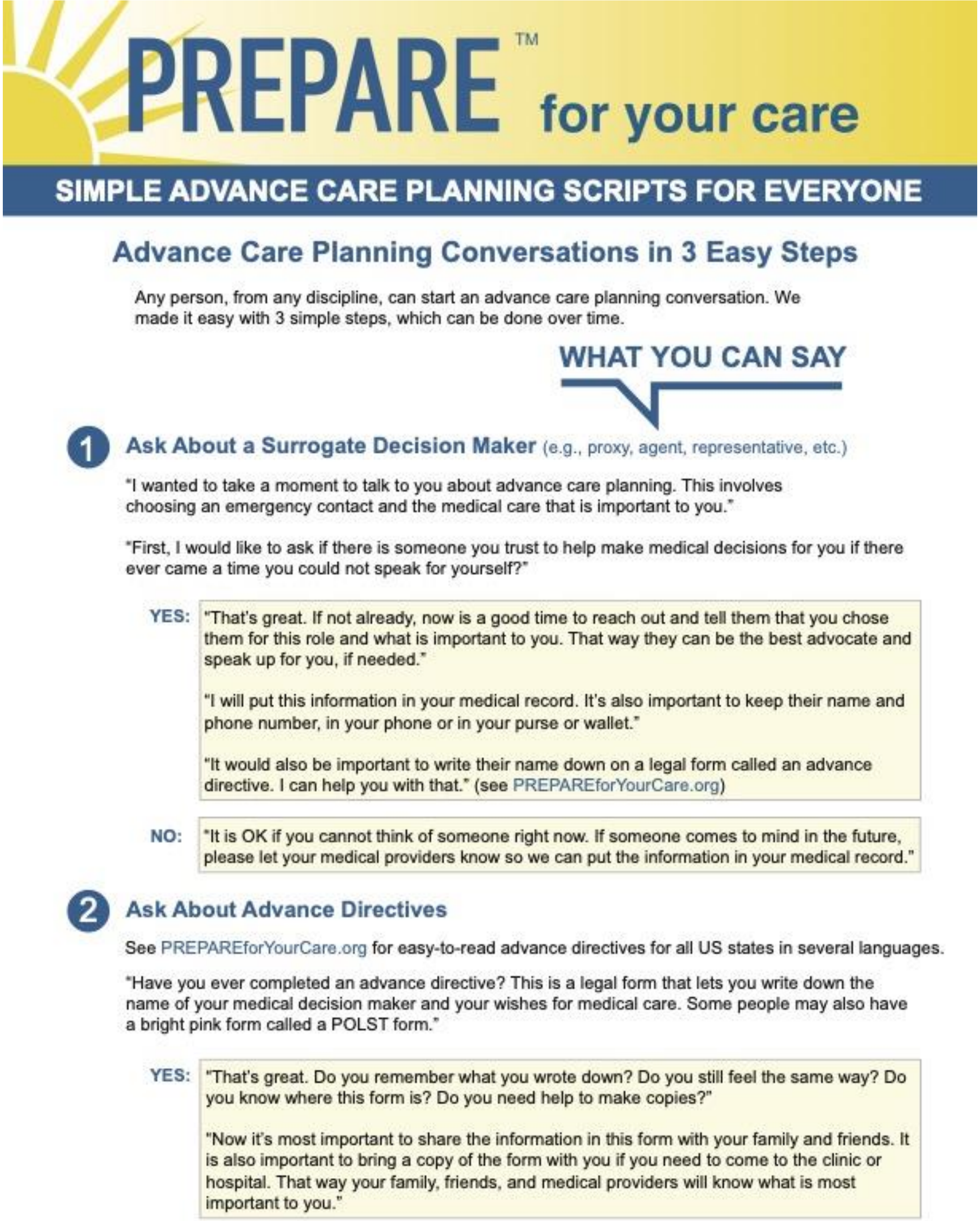


Knowledge-to-Action Framework (Graham et al., 2006). Used with permission.

(Graham et al., 2006)

Appendix G

Conversation Guide



PREPARE™ for your care

SIMPLE ADVANCE CARE PLANNING SCRIPTS FOR EVERYONE

Advance Care Planning Conversations in 3 Easy Steps

Any person, from any discipline, can start an advance care planning conversation. We made it easy with 3 simple steps, which can be done over time.

WHAT YOU CAN SAY

1 Ask About a Surrogate Decision Maker (e.g., proxy, agent, representative, etc.)

"I wanted to take a moment to talk to you about advance care planning. This involves choosing an emergency contact and the medical care that is important to you."

"First, I would like to ask if there is someone you trust to help make medical decisions for you if there ever came a time you could not speak for yourself?"

YES: "That's great. If not already, now is a good time to reach out and tell them that you chose them for this role and what is important to you. That way they can be the best advocate and speak up for you, if needed."

"I will put this information in your medical record. It's also important to keep their name and phone number, in your phone or in your purse or wallet."

"It would also be important to write their name down on a legal form called an advance directive. I can help you with that." (see PREPAREforYourCare.org)

NO: "It is OK if you cannot think of someone right now. If someone comes to mind in the future, please let your medical providers know so we can put the information in your medical record."

2 Ask About Advance Directives

See PREPAREforYourCare.org for easy-to-read advance directives for all US states in several languages.

"Have you ever completed an advance directive? This is a legal form that lets you write down the name of your medical decision maker and your wishes for medical care. Some people may also have a bright pink form called a POLST form."

YES: "That's great. Do you remember what you wrote down? Do you still feel the same way? Do you know where this form is? Do you need help to make copies?"

"Now it's most important to share the information in this form with your family and friends. It is also important to bring a copy of the form with you if you need to come to the clinic or hospital. That way your family, friends, and medical providers will know what is most important to you."

NO: "This is OK. A good place to start is a website called PREPAREforYourCare.org. It has simple information and advance directive forms for free. You can get the website on a smartphone, a tablet, or a computer. You can even do this with your family and friends. You can download the form to fill out on your computer or print it out. Do you need help getting a copy of the form?"

3 Document Patients' Wishes in the Medical Record

Learn and use your hospital's standard documentation practices that allow the information to be in *a central location* so that other medical providers can find it when needed.

IF YOU HAVE MORE TIME

Additional ACP Communication:

Focus on values, not a menu/checkbox approach.
"What is most important in your life and what brings you joy? Is it family, friends, pets, or hobbies?"

Ask about their own experiences to help shape their values.
"Have you ever had your own experience with a serious illness or a friend or family member who was very sick or dying?" *[Optional]:* "Do you remember seeing someone on TV who was very sick or dying?"

When you think back, what do you think went well and what did not go well?
"If you were in these situations [again], what would you want for yourself?"

Normalize the spectrum of peoples' preferences.
"It can sometimes be helpful to think in general about what kind of medical care would be important to you. How people feel about their quality of life falls along a wide spectrum (can use hands to show the spectrum). On one end of the spectrum, some people may say that life would always be worth living no matter what type of serious illness, disability, or pain they may be experiencing. And, on the other end of the spectrum other people may say that there may be some health situations or experiences that would be really hard on their quality of life. And, those things may make them want to focus their medical care more on comfort rather than trying to live as long as possible. To get the care that is right for you, it can help to think about where you are on this spectrum? What type of person are you? Are there any health situations or experiences that would be hard on your quality of life?"

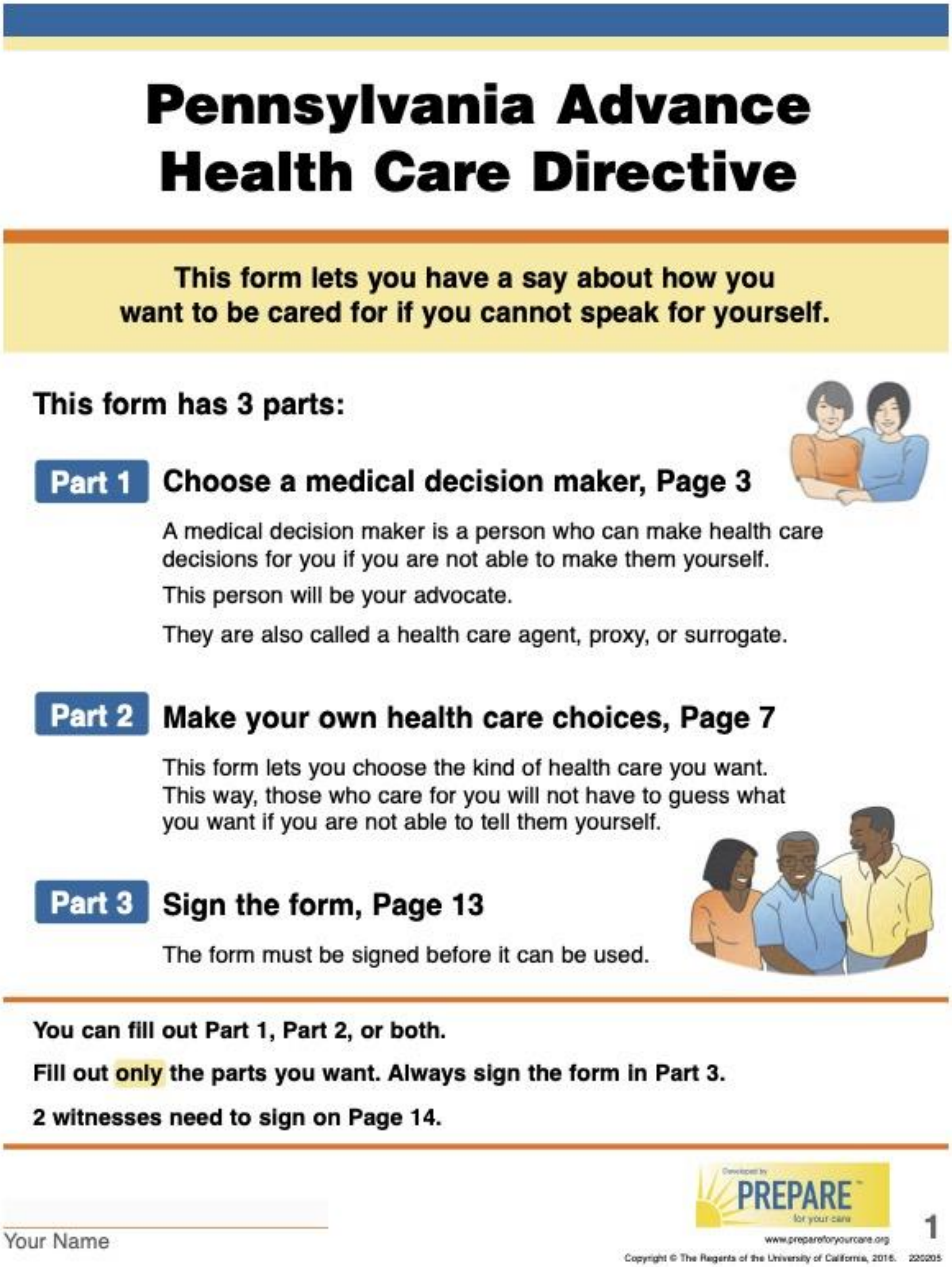
[Optional]: "People may feel very differently about their care, now in their current health, and in the future if they were to get very sick. Have you thought about this?"

"It is very important that you share this with your family, friends, and medical providers. If you have to come to the clinic or hospital, you may be asked these questions again."

For more information visit: **www.prepareforyourcare.org**

Appendix H

PREPARE Advance Directive



Pennsylvania Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 **Choose a medical decision maker, Page 3**

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

This person will be your advocate.

They are also called a health care agent, proxy, or surrogate.

Part 2 **Make your own health care choices, Page 7**

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 **Sign the form, Page 13**

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14.

Your Name

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1

220205

This is a legal form that lets you have a voice in your health care.

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

What should I do with this form?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.

What if I want to make health care choices that are not on this form?

- On Page 12, you can write down anything else that is important to you.

When should I fill out this form again?

- If you change your mind about your health care choices
- If your health changes
- If your medical decision maker changes

If your spouse is your decision maker, and you divorce, that person will no longer be your decision maker.

Give the new form to your medical decision maker and medical providers.

Destroy old forms.

Share this form and your choices with your family, friends, and medical providers.

Part 1 Choose your medical decision maker

Your medical decision maker can make health care decisions for you if you are not able to make them yourself.

A good medical decision maker is a family member or friend who:

- is 18 years of age or older
- can talk to you about your wishes
- can be there for you when you need them
- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- is not afraid to ask doctors questions and speak up about your wishes

Legally, your decision maker cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I do not choose a medical decision maker?

If you are not able to make your own decisions, a person will be chosen for you according to Pennsylvania law. This person may not know what you want.

If you are not able, your medical decision maker can choose these things for you:

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- who can look at your medical information
- what happens to your body and organs after you die

Here are more decisions your medical decision maker can make:

Start or stop life support or medical treatments, such as:

- **CPR or cardiopulmonary resuscitation**
  cardio = heart • pulmonary = lungs • resuscitation = try to bring back
  This may involve:
    - pressing hard on your chest to try to keep your blood pumping
    - electrical shocks to try to jump start your heart
    - medicines in your veins

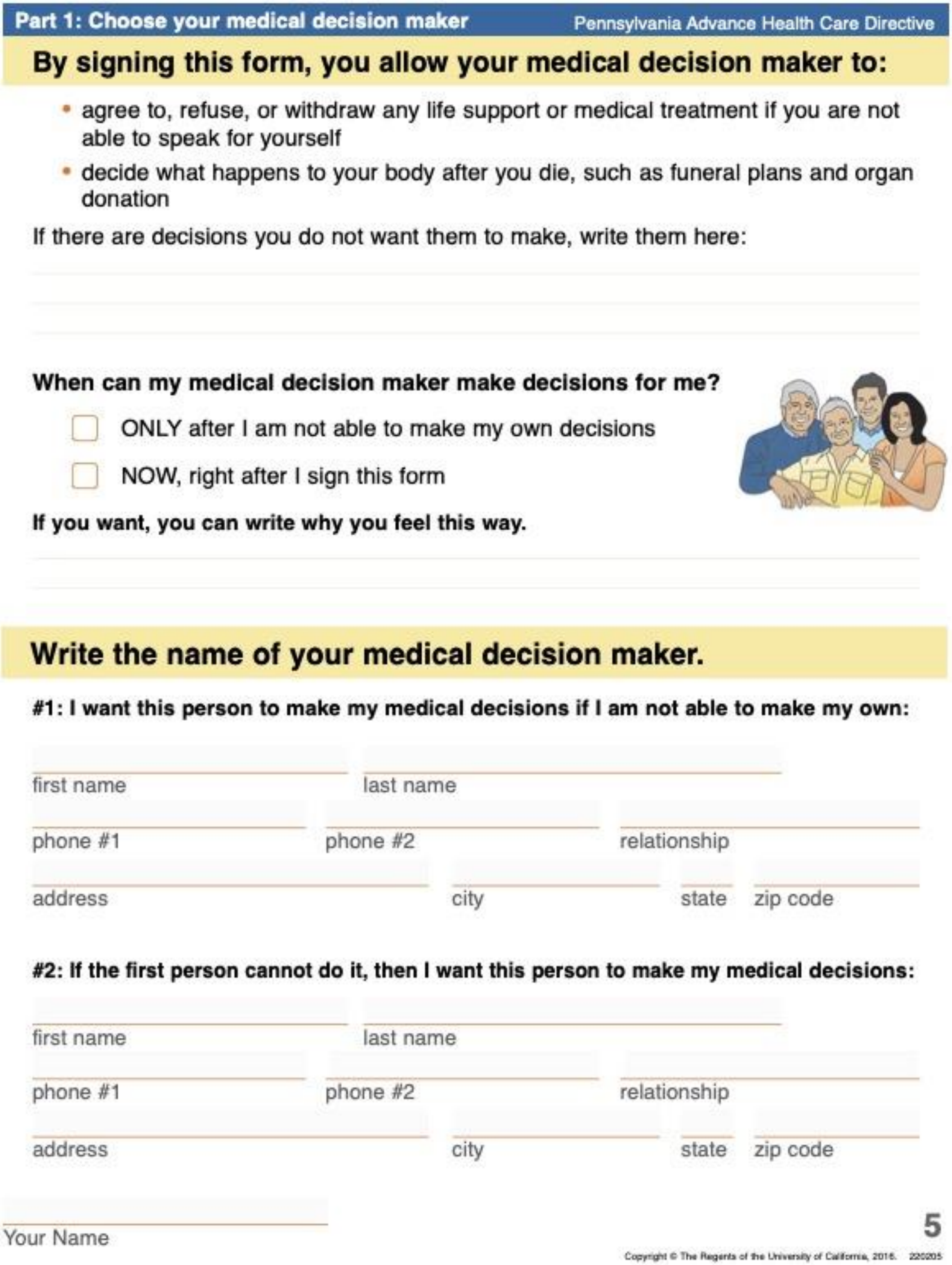
- **Breathing machine or ventilator**
  The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.
- **Dialysis**
  A machine that tries to clean your blood if your kidneys stop working.

- **Feeding Tube**
  A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.
- **Blood and water transfusions (IV)**
  To put blood and water into your body.
- **Surgery**
- **Medicines**

End of life decisions your medical decision maker can make:

- call in a religious or spiritual leader
- decide if you die at home or in the hospital
- decide about autopsy or organ donation
- decide about burial or cremation

Your Name



Part 1: Choose your medical decision maker Pennsylvania Advance Health Care Directive

By signing this form, you allow your medical decision maker to:

- agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself
- decide what happens to your body after you die, such as funeral plans and organ donation

If there are decisions you do not want them to make, write them here:

When can my medical decision maker make decisions for me?

☐ ONLY after I am not able to make my own decisions

☐ NOW, right after I sign this form

If you want, you can write why you feel this way.

Write the name of your medical decision maker.

#1: I want this person to make my medical decisions if I am not able to make my own:

first name last name

phone #1 phone #2 relationship

address city state zip code

#2: If the first person cannot do it, then I want this person to make my medical decisions:

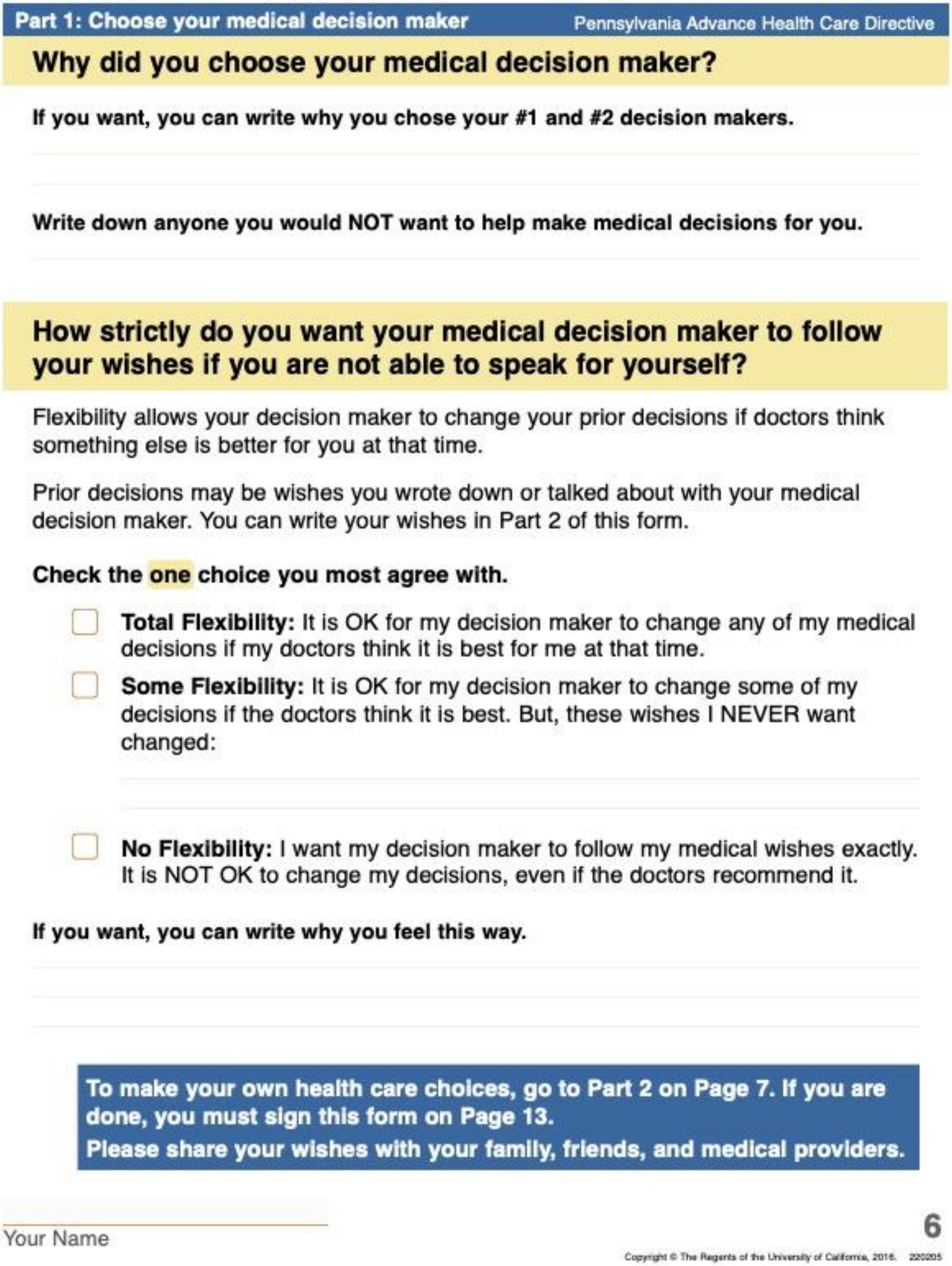
first name last name

phone #1 phone #2 relationship

address city state zip code

Your Name

5



Part 1: Choose your medical decision maker Pennsylvania Advance Health Care Directive

Why did you choose your medical decision maker?

If you want, you can write why you chose your #1 and #2 decision makers.

Write down anyone you would NOT want to help make medical decisions for you.

How strictly do you want your medical decision maker to follow your wishes if you are not able to speak for yourself?

Flexibility allows your decision maker to change your prior decisions if doctors think something else is better for you at that time.

Prior decisions may be wishes you wrote down or talked about with your medical decision maker. You can write your wishes in Part 2 of this form.

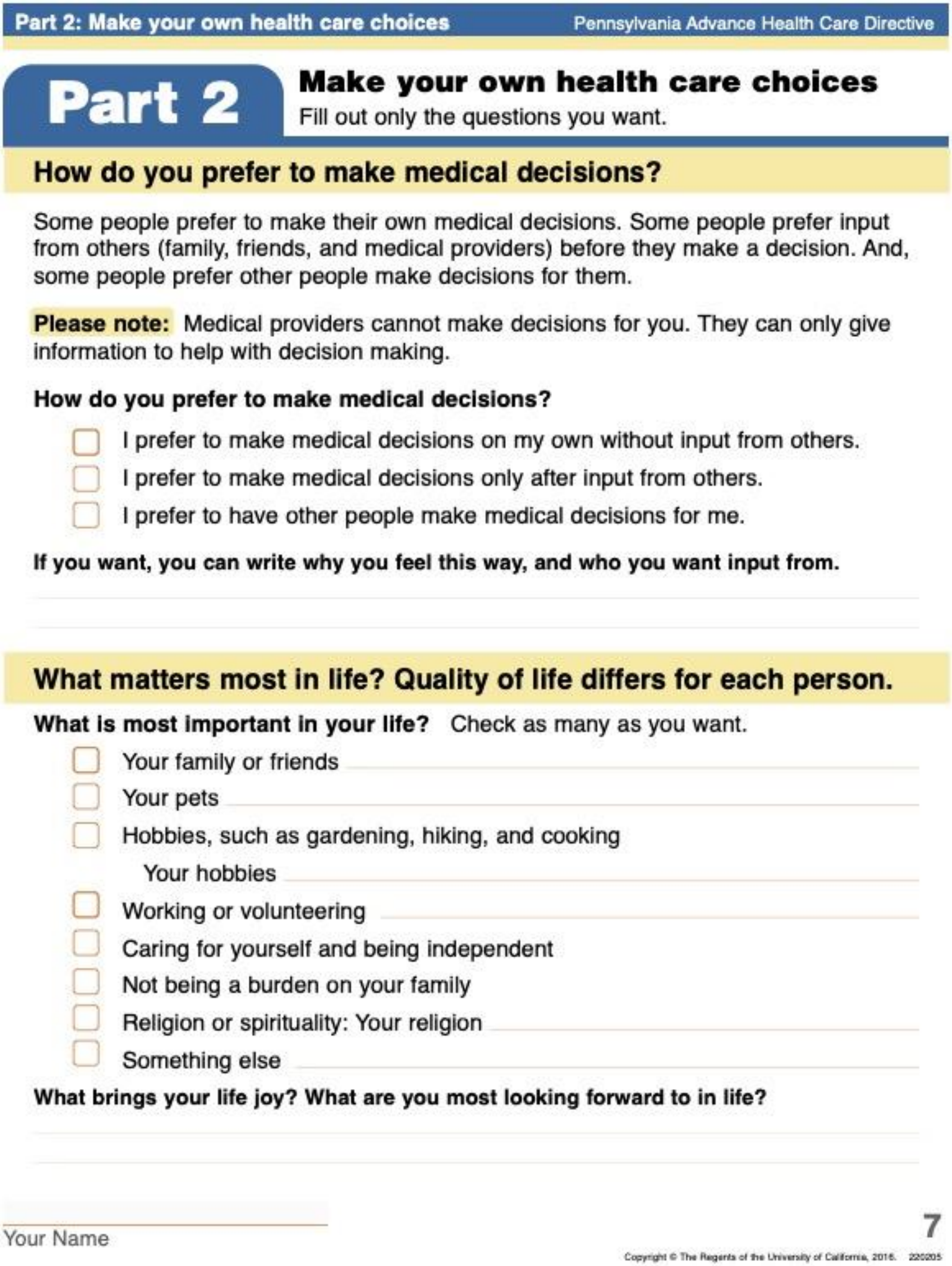
Check the one choice you most agree with.

- ☐ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ☐ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:
- ☐ **No Flexibility:** I want my decision maker to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

If you want, you can write why you feel this way.

To make your own health care choices, go to Part 2 on Page 7. If you are done, you must sign this form on Page 13.
Please share your wishes with your family, friends, and medical providers.

Your Name



Part 2: Make your own health care choices Pennsylvania Advance Health Care Directive

Part 2

Make your own health care choices

Fill out only the questions you want.

How do you prefer to make medical decisions?

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

Please note: Medical providers cannot make decisions for you. They can only give information to help with decision making.

How do you prefer to make medical decisions?

- ☐ I prefer to make medical decisions on my own without input from others.
- ☐ I prefer to make medical decisions only after input from others.
- ☐ I prefer to have other people make medical decisions for me.

If you want, you can write why you feel this way, and who you want input from.

What matters most in life? Quality of life differs for each person.

What is most important in your life? Check as many as you want.

- ☐ Your family or friends
- ☐ Your pets
- ☐ Hobbies, such as gardening, hiking, and cooking
  Your hobbies
- ☐ Working or volunteering
- ☐ Caring for yourself and being independent
- ☐ Not being a burden on your family
- ☐ Religion or spirituality: Your religion
- ☐ Something else

What brings your life joy? What are you most looking forward to in life?

Your Name

7

What matters most for your medical care? This differs for each person.

For some people, the main goal is to be kept alive as long as possible even if:

- They have to be kept alive on machines and are suffering
- They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. **What is important to you?**

Your goals may differ today in your current health than at the end of life.

TODAY, IN YOUR CURRENT HEALTH

Check one choice along this line to show how you feel today, in your current health.

○ ——— ○ ——— ○ ——— ○ ——— ○

My main goal is to live as long as possible, no matter what.	Equally important	My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

AT THE END OF LIFE

Check one choice along this line to show how you would feel if you were so sick that you may die soon.

○ ——— ○ ——— ○ ——— ○ ——— ○

My main goal is to live as long as possible, no matter what.	Equally important	My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

Your Name

Quality of life differs for each person at the end of life. What would be most important to you?

AT THE END OF LIFE

Some people are willing to live through a lot for a chance of living longer.

Other people know that certain things would be very hard on their quality of life.

- Those things may make them want to focus on comfort rather than trying to live as long as possible.

At the end of life, which of these things would be very hard on your quality of life?
Check as many as you want.

☐ Being in a coma and not able to wake up or talk to my family and friends
☐ Not being able to live without being hooked up to machines
☐ Not being able to think for myself, such as severe dementia
☐ Not being able to feed, bathe, or take care of myself
☐ Not being able to live on my own, such as in a nursing home
☐ Having constant, severe pain or discomfort
☐ Something else ______________________
____

☐ **OR**, I am willing to live through all of these things for a chance of living longer.

If you want, you can write why you feel this way.

____

____

What experiences have you had with serious illness or with someone close to you who was very sick or dying?

- If you want, you can write down what went well or did not go well, and why.

____

____

If you were dying, where would you want to be?

☐ at home ☐ in the hospital ☐ either ☐ I am not sure

What else would be important, such as food, music, pets, or people you want around you?

____

____

____
Your Name

How do you balance quality of life with medical care?

Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please read this whole page before making a choice.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.

Check the one choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

☐ **Try all life support treatments** that my doctors think might help. I want to **stay on life support** treatments even if there is little hope of getting better or living a life I value.

☐ Do a **trial of life support treatments** that my doctors think might help. But, I **DO NOT want to stay on life support** treatments if the treatments do not work and there is little hope of getting better or living a life I value.

☐ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a **natural death**.

*If you are pregnant and become unable to make decisions: Pennsylvania law may require your doctor to give you life support treatments even if you have an advance directive.

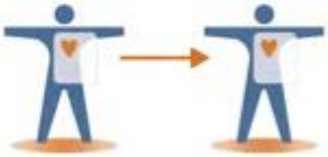
What else should your medical providers and decision maker know about this choice? Or, why did you choose this option?

Your Name

Your decision maker may be asked about organ donation and autopsy after you die. Please tell us your wishes.

ORGAN DONATION

**Some people decide to donate their organs or body parts.
What do you prefer?**



☐ I **want** to donate my organs or body parts.

Which organ or body part do you want to donate?

- ☐ Any organ or body part
- ☐ Only ____________________

☐ I **do not** want to donate my organs or body parts.

What else should your medical providers and medical decision maker know about donating your organs or body parts?

____

____

AUTOPSY

**An autopsy can be done after death to find out why someone died.
It is done by surgery. It can take a few days.**

☐ I **want** an autopsy.

☐ I **do not** want an autopsy.

☐ I **only** want an autopsy if there are questions about my death.

FUNERAL OR BURIAL WISHES

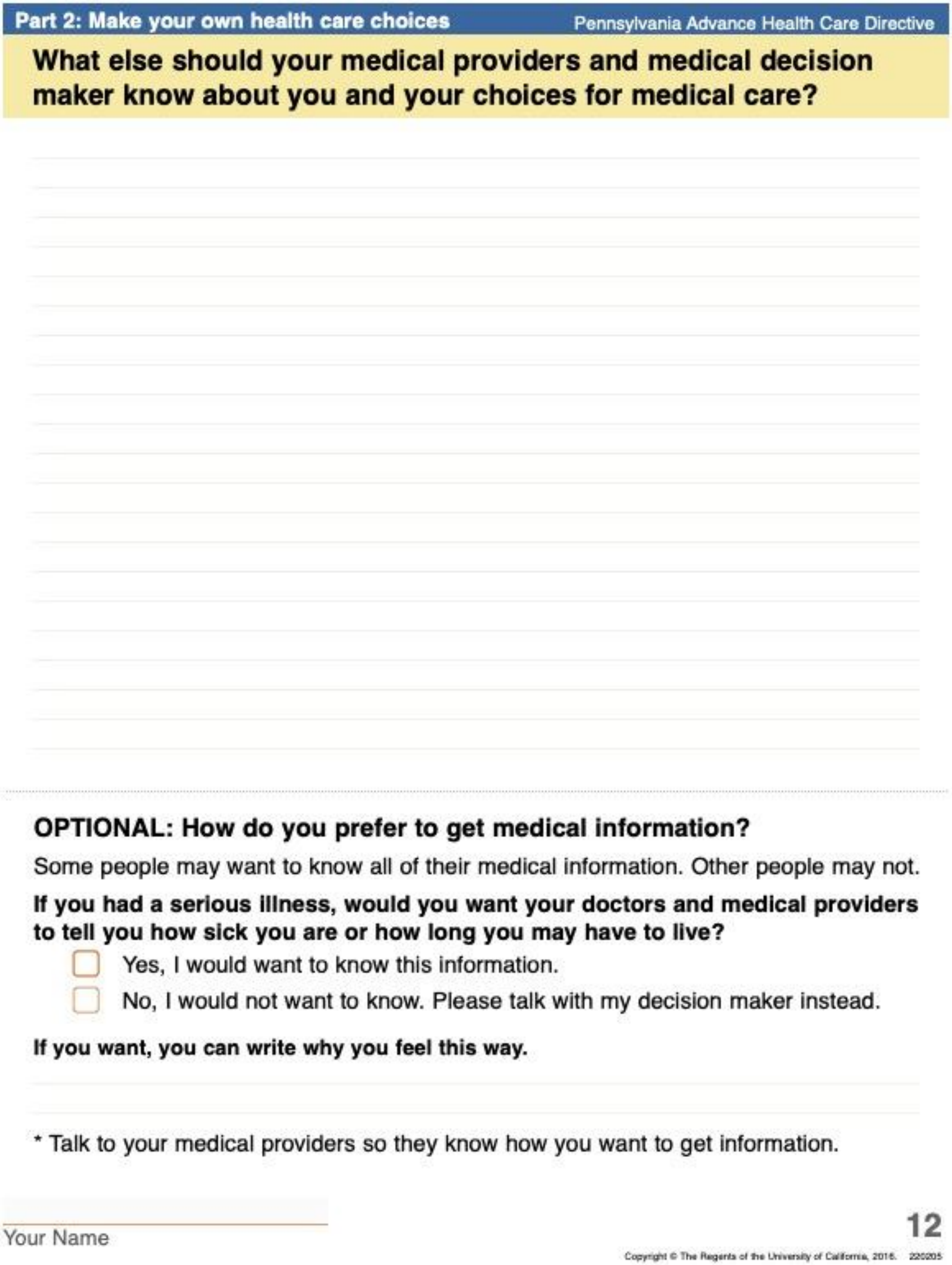
What should your medical providers and decision maker know about how you want your body to be treated after you die, and your funeral or burial wishes?

- Do you have religious or spiritual wishes?
- Do you have funeral or burial wishes?

____

____

____
Your Name



What else should your medical providers and medical decision maker know about you and your choices for medical care?

OPTIONAL: How do you prefer to get medical information?

Some people may want to know all of their medical information. Other people may not.

If you had a serious illness, would you want your doctors and medical providers to tell you how sick you are or how long you may have to live?

☐ Yes, I would want to know this information.

☐ No, I would not want to know. Please talk with my decision maker instead.

If you want, you can write why you feel this way.

* Talk to your medical providers so they know how you want to get information.

Your Name

Part 3 Sign the form

Before this form can be used, you must:

- sign this form if you are 18 years of age or older
- have two witnesses who can watch you sign this form

Sign your name and write the date.

sign your name today's date

print your first name print your last name date of birth

address city state zip code

Witnesses

Before this form can be used, you must have 2 witnesses sign the form.

Your witnesses must:

- be 18 years of age or older
- see you sign the form

Your witnesses cannot:

- be the person that signed this form for you

Witnesses need to sign their names on Page 14.

Have your witnesses sign their names and write the date.

By signing, I promise that ______________________ signed this form while I watched.
(the person named on Page 13)

They were thinking clearly and were not forced to sign it.

I also promise that:

- I am 18 years of age or older
- I am not the person who signed this form on Page 13

Witness #1

sign your name ______________________ date ____________

print your first name ______________________ print your last name ______________________

address ______________ city ______________ state ________ zip code ________

Witness #2

sign your name ______________________ date ____________

print your first name ______________________ print your last name ______________________

address ______________ city ______________ state ________ zip code ________

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to www.prepareforyourcare.org

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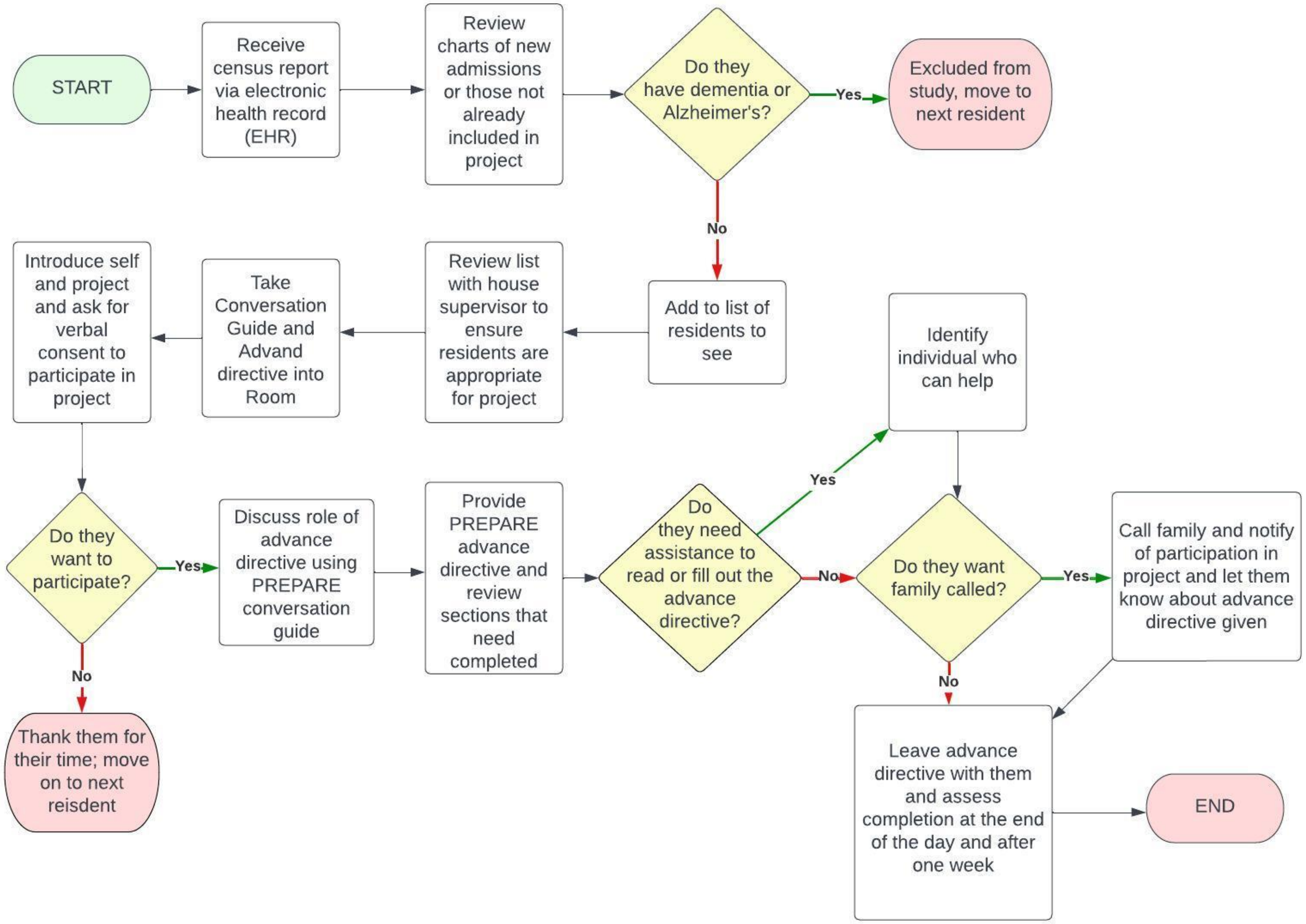
Appendix I

Process Map



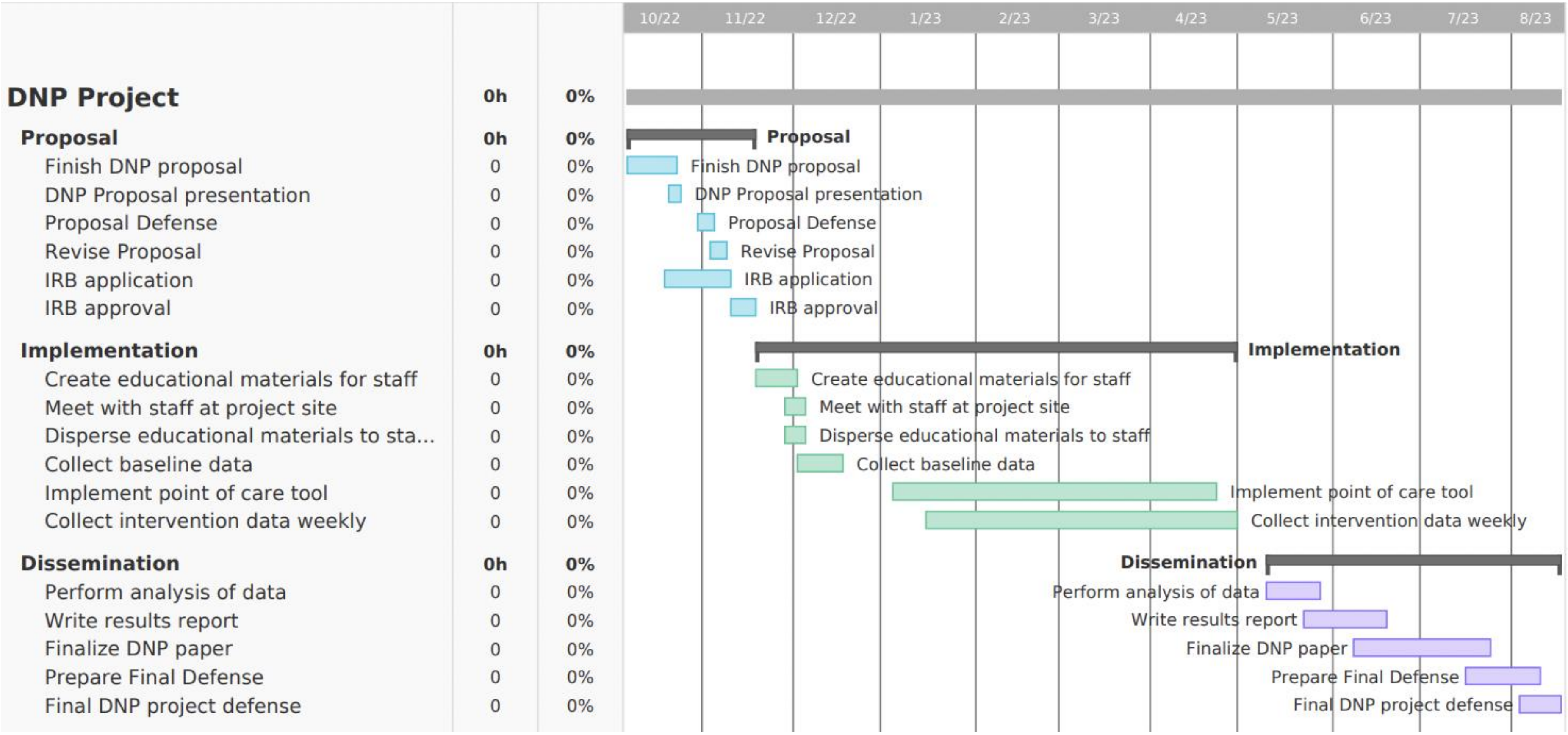
Appendix J

Project Budget

Project Expenses		
Salaries/Wages*		
	Monthly	Total
• Registered Nurse	Hours donated by Project Leader	$ 0
Total Salary Costs	$ 0	$ 0
Startup Costs		
	Monthly	Total
• Copies of script	$ 1.36 per page	$ 6.80 for 5
• Copies of guide	$ 7.59 per booklet	$ 569.10 for 75
• Shipping costs	$ 0 – available for pick up	$ 0
Total Startup Costs	$ 8.95	$ 575.90
Capital Costs		
	Monthly	Total
Hardware	$ 0	$ 0
Equipment	$ 0	$ 0
Other	$ 0	$ 0
Total Capital Costs	$ 0	$ 0
Operational Costs		
	Monthly	Total
• Electricity	$ 24/7 facility	$ 0
• Heat	$ 24/7 facility	$ 0
• Water	$ 24/7 facility	$ 0
• Patient insurance bill	$ Medicare waves coinsurance for ACP	$ 0
Total Project Expenses	$ 0	$ 575.90
Program Revenue		
	Monthly	Total
• Predicted Medicare reimbursement	$ 50 per patient	$ 2,500
Total Project Revenue	$ 50	$ 2,500
Less Expenses	$	$ 575.90
Total Project Benefit/Loss	$	$ 1924.1

Appendix K

GANNT Chart



DNP Project	**0h**	**0%**
Proposal	**0h**	**0%**
Finish DNP proposal	0	0%
DNP Proposal presentation	0	0%
Proposal Defense	0	0%
Revise Proposal	0	0%
IRB application	0	0%
IRB approval	0	0%
Implementation	**0h**	**0%**
Create educational materials for staff	0	0%
Meet with staff at project site	0	0%
Disperse educational materials to sta...	0	0%
Collect baseline data	0	0%
Implement point of care tool	0	0%
Collect intervention data weekly	0	0%
Dissemination	**0h**	**0%**
Perform analysis of data	0	0%
Write results report	0	0%
Finalize DNP paper	0	0%
Prepare Final Defense	0	0%
Final DNP project defense	0	0%