RUTGERS
School of Nursing

DOCTOR OF NURSING PRACTICE (DNP) PROGRAM

A DNP PROJECT:

AN EDUCATIONAL MODULE FOR HEALTHCARE PROVIDERS TO FOSTER POSITIVE ATTITUDES TOWARDS ADVANCE CARE DISCUSSIONS

Abstract:

Purpose of Project: Advance care planning (ACP) entails use of living wills, designation of healthcare proxies, conversations of hopes and fears, and specific medical interventions the patient desires or wishes to forgo. Benefits of early ACP include increase in patient dignity, autonomy, satisfaction, greater utilization of palliative care services, less aggressive medical treatments during end-of-life care, and decreases in healthcare costs (Dube et al., 2015). Despite these benefits only 18 to 36% of Americans have a completed advance directive (AD) on file, which is linked to an average of $750 billion, or 30% of all healthcare costs being spent on unwanted medical interventions (Splendore & Grant, 2017). Evidence points to the lack of initiation of early ACP discussions by healthcare providers (HCPs) as a contributor to the low rates of completed ADs. For HCPs, the most cited reasons for not initiating these discussions are lack of time and most importantly, lack of knowledge and training on ADs and how to engage patients in these sensitive discussions with proper, culturally-sensitive communication skills (Howard et al., 2018). **Methodology:** This quality improvement project utilized a pre- and post-quasi-experimental study design to measure healthcare providers attitudes towards initiating ACP discussions. A pre- and post-survey with identical statements using a Likert-scale was administered prior to and upon completion of the educational module. **Results:** The findings of this study demonstrate an increase in healthcare provider comfort to initiate ACP conversations with patients in response to the educational module. **Implications for Practice:** Therefore, an online educational module geared towards HCPs on how to engage patients in early ACP discussions using the Five Wishes AD tool and proper billing for these services will foster positive attitudes that will lead to an increase in patient-healthcare provider conversations. This article supports the need for HCP educational interventions to foster early ACP conversations that will increase AD completion rates in the United States, a national goal of the Institute of Medicine report.

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An Educational Module for Healthcare Providers to Foster Positive Attitudes Towards Advance Care Discussions

Introduction

Medical and technological advances in the United States have prolonged life expectancy for patients living with multiple chronic illnesses. These advances have blurred the concept of end-of-life care (EOL) and when or how individuals should prepare for it. There is considerable evidence that patients in healthcare crises and during EOL care often receive treatments that are incongruent to their desired wishes (*Advance Directives and Advance Care Planning: Report to Congress*, 2016). Advance care planning (ACP) provides a method for ensuring patients maintain their autonomy during these difficult times resulting in improved patient and family satisfaction with the healthcare system. According to Reidy et al. (2017) ACP and advanced directives (ADs) reduce unwanted aggressive medical treatment associated with increased medical costs.

Despite widespread state and federal efforts to promote ACP and ADs, only 18 to 36 % of Americans currently have completed ADs on file (*Advance Directives and Advance Care Planning: Report to Congress*, 2016). These numbers are of major concern as lack of patient ADs has been directly linked to vast unnecessary healthcare spending, estimating about $750 billion. These unnecessary costs take away from funding to other areas of healthcare, such as research and programs offered to children and the elderly. In addition, increased patient and family anxiety have been associated with lack of planning for a medical crisis. Patient and healthcare provider (HCP) barriers have further contributed to the lack of ACP discussions and AD completion. This project aims to address the barriers related to healthcare providers initiating

early ACP discussions with their patients. The research hypothesis is that an online educational module for healthcare providers detailing benefits of ACP, addressing HCPs and patients' attitudes towards ACP, fostering communication skills to increase comfort with ACP, and use of *The Five Wishes* tool by HCPs to facilitate AD completion by patients, would foster positive attitudes towards initiating and having ongoing discussions about advance care planning.

Background and Significance

Advance care planning entails use of living wills, designation of healthcare proxies, conversations of hopes and fears, and specific medical interventions the patient desires or wishes to forgo (Splendore & Grant, 2017). Several benefits of ACP include but are not limited to increased patient comfort, increased patient autonomy, increased patient and family satisfaction, improved healthcare provider-patient communication, greater utilization of palliative care services, decreased anxiety and stress during EOL for patient and families, and shortened length of hospital stay (Woollen & Bakken, 2016). Despite the proven benefits of having ADs, only 18 to 36% of Americans have one completed.

Low rates of ADs affect all populations including healthy individuals and individuals with chronic or terminal illnesses. This has become an alarming issue as failure to discuss ACP and implement an AD has resulted in distress, guilt, and suffering for both patients and caregivers due to unwanted aggressive medical procedures (Splendore & Grant, 2017). More importantly, these unwanted medical interventions have led to a significant increase in healthcare costs. According to the *Institute of Medicine* (2012), an estimated $750 billion, accounting for 30% of all healthcare costs, were linked to unwanted medical procedures.

Patient barriers

Various studies have been conducted to assess reasons for the low completion of ADs amongst patients despite the overwhelming benefits. The main reasons for not completing an AD were related to both patient and HCP barriers. Patient barriers include but are not limited to lack of knowledge about ADs, lack of available healthcare proxies, fear of burdening loved ones, and cultural traditions (Dube, McCarron, & Nannini, 2015). For example, African Americans were less likely to complete an AD and more prone to want aggressive medical treatment during EOL care. Hispanics and Asians were also less likely to complete an AD due to the traditional custom of relying on family members to make medical decisions when loved ones are not capable (Spoelhof & Elliott, 2012).

One of the greatest reasons for lack of interest in completing ADs can be traced to a reluctance of patients and families to initiate conversations about death and EOL issues (Myers et al., 2018). This may be due to denial of medical conditions, prognosis, or the patient being too young and feeling they are too healthy to focus on advance care planning. In addition, patients often feel that HCPs should be the ones to initiate discussions regarding ADs; while providers feel that the patients themselves would bring up the sensitive topic when they are ready (Woollen & Bakken, 2016). Furthermore, healthcare providers are often found asking themselves how do they even start this conversation.

Healthcare provider barriers

Healthcare provider barriers have been noted as major contributors to the alarmingly low rates of advance directives. Barriers include but are not limited to communication difficulties, anxiety about decreasing hope for patients, personal discomfort with the topic of death, not

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feeling the need was urgent for their particular patient population, family disagreements, perceived lack of reimbursement, and time constraints (Chander et al., 2017). For instance, in a review by Spoelhof and Elliott (2012), ACP discussions with patients and families averaged 30 minutes or more of the total appointment time. Physicians perceived this as lengthy and many stated that billing for this service was problematic or at times impossible. This led to negative provider attitudes towards initiating discussions about ACP.

A crucial barrier amongst healthcare providers was lack of experience with ADs and lack of proper training in conducting ACP discussions (Dube et al., 2015). This lack of formal training left providers feeling ill equipped to discuss ADs and appropriately handle the emotional response it can elicit from patients. Fulmer et al. (2018) found that less than two thirds or 68% of providers reported not having formal training on communication with patients and families about ADs and EOL care. The lack of formal training has led to less knowledge about AD tools and the available resources. Minimal to no experience with proper communication skills for discussing ACP has left HCPs feeling inadequately prepared to have these active discussions with their patients. As a result, discussions about ACP are delayed until health crises occur or are even avoided all together.

Reviews of literatures have found consistent evidence on the lack of formal training for HCPs in discussing advance care planning. The next important step is to find methods to overcome this significant barrier in order to foster positive attitudes in providers towards initiating ACP discussions with patients and families. This will hopefully lead to an increase in rates of ADs on file in the United States. In 2012, the *Center for Disease Control and Prevention* (CDC) identified the need to educate HCPs and the public about ACP and palliative care services. In a study by Hutchison, Raffin-Bouchal, Syme, Biondo, and Simon (2017), the ability

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of clinicians to engage and communicate the importance of ACP in a way that is meaningful and relevant to the patients and families fostered a willingness from them to participate in ACP discussions and complete advance directives. Therefore, the focus must be on further education to all current HCPs about ACP with proper communication skills and a strong knowledge base about advanced directives.

Needs Assessment

The Institute of Medicine report *Dying in America* solidified ACP as "critically important" in synchronizing a patient's wishes with the medical treatment received and reducing unnecessary treatments at the EOL (Reidy et al., 2017). According to the *Agency for Healthcare Research and Quality*, 25% of all Medicare spending, about $139 billion, is spent towards care for 5% of beneficiaries in their final year of life (*Advance Directives and Advance Care Planning: Report to Congress*, 2016). Of the most important benefits of ACP is the potential to reduce overall healthcare costs. Research indicates that about $1.7 billion can be saved annually in health-care expenses if all adults had a completed advance directive.

The associated financial impact in addition to other unfavorable healthcare outcomes of not completing an AD have made this an alarming issue for the entire nation. Several federal and state initiatives have been developed in order to address the problem. In 1990, Congress passed the Patient Self-Determination Act to incite competent adults to complete ADs that would foster their patient autonomy (*Advance Directives and Advance Care Planning: Report to Congress*, 2016). The act requires healthcare facilities obtaining Medicaid or Medicare reimbursement to ask patients whether they have ADs, provide information on ADs if patients do not have one, and incorporate ADs into the medical record. Unfortunately, this act did not result in the intended reduction in unwanted aggressive treatment at the EOL or its associated costs. This was largely

due to ADs being underused with only 18 to 36% of Americans having a completed AD on file despite the federal initiative.

The Uniform Health Care Decisions Act of 1993, a state effort, focused on the concern of unwanted resuscitation of terminally ill patients in hospice settings (*Advance Directives and Advance Care Planning: Report to Congress*, 2016). The national model centered on AD portability and resulted in use of out-of-hospital do-not-resuscitate (DNR) orders. In addition, the act established simple rules for accepting almost any kind of oral or signed written statement as an AD, even if not witnessed. The state of New Jersey added to this act by being the first state to combine the living will with the healthcare proxy into a single advance directive. By 2008, the number of states offering this dual type of AD increased to 26 federal states.

The Oregon state initiative, called the Physician Order for Life-Sustaining Treatment (POLST) program, was made in an attempt to elicit patient care preferences and translate these wishes into a set of medical orders (*Advance Directives and Advance Care Planning: Report to Congress*, 2016). These medical orders are documented in highly visible form ensuring portability across different healthcare settings. Studies have demonstrated positive effectiveness of this initiative in translating patient care preferences across the continuum of care. Populations using POLST received increased comfort care and were seldom transferred to a hospital for life-sustaining efforts.

In addressing the specific barrier related to lack of HCPs starting the discussions with patients about early ACP, two major initiatives have been established that have been considered promising. In January 2016, in a federal effort to increase provider conversations with patients about ACP, Medicare began reimbursing providers for time spent with patients or families

engaging in ACP discussions (Wright, 2018). In order to bill, these dialogues must be face-to-face and involve discussions about patients' EOL wishes and designation of healthcare proxies. This change to Medicare regulations was in response to the *American Medical Association's* (AMA) support for the need to reimburse providers for ACP discussions, in an effort to increase the number of discussions providers are having with their patients about advanced directives. Under the new regulation, HCPs will be reimbursed for ACP discussions of thirty minutes in length or longer. CPT code 99497 will bill for discussions lasting 15 to 45 minutes and CPT code 99498 will reflect each additional 30-minute increment after the first 45 minutes (Dingfield & Kayser, 2017). The reimbursement value is $86 for inpatient discussions, $80 for outpatient discussions, and $75 for additional time spent (CPT 99498). In addition, there are no limits to the frequency of reimbursement for ACP discussions. Beneficiaries are not responsible for any costs of ACP discussions if completed as part of the annual wellness visit, but billing during other visits are coverage-dependent therefore providers must be aware if the patient's insurance will cover this service at future appointments to avoid patient copays (Wright, 2018). As to the effectiveness of this initiative, results are mixed. According to *Center for Medicare and Medicaid Services* (CMS) (2016), the number of patients for which providers billed for ACP services is only a small fraction of the more than 55,000,000 Medicare recipients. This may be due to lack of provider knowledge about the Medicare rule change that allows ACP service reimbursements. Another reason for the low billing can be traced to low institutional support evidenced by lack of sections in the electronic health records to document ACP discussions, which are a requirement for Medicare reimbursement. In addition, studies are revealing that provider participation in ACP discussions remains low due to discomfort with EOL topics traced back to a lack of formal training on how to conduct these conversations.

The second initiative showing promise to foster positive attitudes in HCPs and therefore increase patient-provider ACP discussions is through educational interventions. According to the *Advance Directives and Advance Care Planning: Report to Congress* (2016), studies performed to improve provider communication skills to foster comfort in ACP discussions have mixed results. Some studies have shown education alone has no effect on provider comfort in conducting ACP discussions, while vast studies have shown positive effects of educational interventions on improving attitudes of providers to initiate ACP discussions with patient and families. The review of literature will present articles of different levels of evidence demonstrating the effectiveness of educational modules in fostering positive attitudes in HCPs towards ACP discussions.

Problem Statement

Several benefits have been associated with early ACP in the literature, such as increased patient dignity, autonomy, patient and family satisfaction, greater utilization of palliative care services, less aggressive medical treatments during EOL care, and decreased healthcare costs (Dube et al., 2015). Despite these benefits only 18 to 36% of Americans have a completed AD, which has been directly linked to an average of $750 billion, or 30% of all healthcare costs, being spent on unwanted medical treatments during EOL care (Splendore & Grant, 2017).

Evidence has pointed to the lack of initiation of early ACP discussions by HCPs as a major contributor to the low rates of completed ADs amongst Americans. For HCPs the most cited reasons for not initiating these discussions were lack of time and most importantly, lack of knowledge and training on how to prepare an AD and on how to engage patients in these sensitive discussions with proper, culturally-sensitive communication skills (Howard et al., 2018). Therefore, it is imperative to educate healthcare providers on early ACP discussions in

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order to foster positive attitudes that will lead to an increase in patient-HCP conversations about EOL care.

Clinical Question

Will an online educational module, using the Five Wishes tool, affect healthcare providers' attitudes towards initiating advance care planning discussions with patients?

Aims and Objectives

The principal aim of this project was to foster positive attitudes among HCPs in initiating early ACP discussions with patients and families through education. The project attempted to foster positive attitudes and comfort in HCPs to discuss ACP through the following objectives:

1. To evaluate the knowledge deficits of healthcare providers towards advance directives.
2. To evaluate current attitudes and comfort with engaging in early ACP discussions.
3. To increase provider knowledge about advance directives including benefits, Medicare reimbursement updates, and proper communication skills.
4. To introduce providers to an easy-to-use advance directive tool called *The Five Wishes*.
5. To compare attitudes in initiating early ACP discussions with patients and families pre and post educational module.
6. To assess healthcare provider perceived effectiveness of using *The Five Wishes* AD tool with patients and families post educational module.

By completing the stated objectives, it was hoped that the project would lead to positive HCP attitudes towards initiating early ACP discussions with patients and families leading to an increase in discussions and in the future to an increase in rates of completed ADs by the American public.

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Review of Literature

An in-depth review of literature was performed to identify current healthcare providers' comfort with ACP discussions, knowledge of ACP and available tools, and the correlation between education and provider attitudes in initiating ACP discussions with patients and families. The key terms 'module'; 'healthcare providers'; 'the Five Wishes'; 'attitudes'; 'advance care plan*' and 'end-of-life' were searched in CINAHL, PubMed, and The Cochrane Library. The keywords were combined using 'OR' and 'AND'. These searches yielded 67, 695 results. The search was further narrowed by including key terms 'online', 'education', 'nurse practitioners', 'residents', 'medical students', 'perspectives', 'comfort', 'advance directives', 'end-of-life discussions' and after a thorough analysis of the available literature, fifteen articles were selected for critical appraisal. Thirty articles were excluded due to being performed outside the U.S and written in non-English language.

Fifteen articles were critically appraised (see Appendix A), of which two sources were non-research references and the remaining thirteen were research articles. Of the thirteen research articles, two articles were systematic reviews, seven were quasi-experimental studies, two were non-experimental descriptive studies, and the remaining two were randomized control trials. All studies took place in the United States and were written in the English language. The studies included were assessed for strength and quality of research evidence using the John Hopkins Nursing Evidence-Based Practice (JHNEBP) appraisal tool. Based on the literature appraisal, all fifteen articles were assigned a level of evidence and quality rating. Three studies were appraised level I, eight were level II, two were level III, and two were level IV. The majority of studies were assessed to be of good quality of evidence (B), four were high quality of evidence (A), and one study was low quality of evidence (C).

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In 2015, the Institute of Medicine (IOM) conducted a consensus study on the current medical care given to patients of all ages suffering from a life-threatening medical condition, which was entitled *Dying in America: Improving quality and honoring individual preferences near the end of life*. This consensus report had four objectives: 1) to review progress made from the 1997 and 2003 IOM reports on palliative care, 2) evaluate approaches to providing family and team-based care to patients with life-threatening conditions, 3) develop recommendations to change policies, payment practices, research, and supportive care, and 4) promote public participation and action. Through research, the report found individuals who engaged in ACP often chose maximizing quality of life and independence over quantity of life. These patient preferences demonstrated that early ACP could reduce healthcare costs associated with unwanted medical treatments. With this evidence, the report established several recommendations in an attempt to increase ACP discussions and AD completion. Several of the recommendations were tailored towards healthcare providers. Recommendation two urges professional societies to adopt policies that facilitate ACP reimbursements for healthcare providers. Recommendation three states that educational institutions, healthcare organizations, credentialing bodies, and state agencies need to establish appropriate training for all clinicians to strengthen palliative care skills and knowledge. These initiatives support the need for the principle investigator to establish an educational module for healthcare providers to foster early ACP discussions.

The release in 2018 of the *New Jersey Governor's Advisory Council on End-of-Life Care Report and Recommendations* further recognized the emerging importance of healthcare providers establishing goals of care with patients that are congruent with their wishes and increasing utilization of palliative care services. This was based on the Dartmouth Atlas Project that demonstrated that patients residing in New Jersey experienced more aggressive medical care

at EOL without benefit. In fact, N.J. was ranked first on resource consumption compared to any other state. As a result, the report laid out several recommendations based on the latest evidence. Recommendation four states that all licensed physicians, medical residents, nursing professionals, social workers, and hospital administrators should be required to take education courses on EOL options and advance care planning. Recommendation six states that ACP education should be required on an annual basis for all clinicians incorporating the topics of EOL and POLST. Recommendation eight further emphasizes developing a standardized educational module for training advance practice nurses and physicians on AD in all healthcare settings. Therefore, the consensus report supports the need for the proposed DNP project.

A common theme surfaced throughout the researched literature; healthcare provider barriers of time and discomfort with EOL topic due to a lack of formal training impeded early ACP discussions (Dube et al., 2015; Howard et al., 2018; Houben, Spruit, Groenen, Wouters, & Janssen, 2014; Flowers & Howe, 2015; Chan et al., 2016; Splendore & Grant, 2017). For example, Dube et al. (2015) conducted a study with 160 nurse practitioners (NPs) in which participants were surveyed about barriers and facilitators for ACP discussions. Results indicated that 79% of NPs believed that additional training would enhance ACP discussions. In addition, NPs having formal education on EOL or who had taken continuing education courses reported having more ACP discussions with their patients than those without education (86.8 % compared to 72.8%, respectively). In conclusion, an educational program tailored for NPs is critical to enhance ACP discussions with patients and families.

To overcome healthcare provider discomfort with ACP discussions, several interventions have been tested. In a systemic review by Houben et al. (2014), eleven studies demonstrated increase occurrences of EOL discussions between HCPs and patients following an educational

intervention compared to control groups. In addition, five studies supported an increase in knowledge of HCPs following an educational intervention. Another systemic review by Chung, Oczkowski, Hanvey, Mbuagbaw and You (2016), found that in eight studies, including 522 participants, end-of-life communication training was positively correlated to improved provider self-efficacy with discussion. In addition, four studies, including 290 participants, found that communication training led to increased knowledge scores.

Research studies have further introduced specific educational programs for clinicians to foster comfort in ACP discussions (Flowers et al., 2015; Chan et al., 2016; Murray, Stacey, Wilson & Oconnor, 2010; Bergman et al., 2016; Green & Levi, 2011; Trietsch, 2017). In a study by Flowers et al. (2015), a training program was established for healthcare staff members where they used an AD tool called *the Five Wishes* to fill out their own care preferences. The educational program resulted in an increased understanding of benefits of EOL documents, staff conversations with their own family members, and staff willingness to discuss EOL issues with patients. In studies by Chan et al. (2016), Green and Levi (2011), Murray et al. (2010), and Trietsch (2017), medical students and residents participated in educational interventions involving online modules, lectures led by facilitators, small group discussions, and simulations. All studies resulted in an increase in participant comfort and confidence in initiating ACP discussions. Limitations of these studies included small sample sizes, single settings affecting generalizability, and lack of instrument validity.

The remaining literatures focused on effectiveness of an AD tool called *The Five Wishes,* which can be utilized by healthcare providers to increase AD completion by patients and families post-ACP discussions. The Five Wishes is an advance directive, developed by the organization Aging with Dignity, that is considered a legal document in 42 states. The document was

originally introduced in 1996 in Florida and was the first AD to combine a living will, health care proxy, and matters of spirituality and comfort care. It was disseminated nationally with the help of a grant from the Robert Wood Johnson Foundation. It has been described by the developers as a "living will a heart and soul." It is also made available in 28 languages and in Braille ("The Five Wishes," 2019).

In a study by Martin (2015), more knowledge and comfort with AD tools and living wills by healthcare providers led to increased rates of AD completion by patients. The *Five Wishes* document is a feasible, easy to understand AD tool that breaks down preferences for patient care into five categories in layman terms: Wish 1: The Person I Want to Make Healthcare Decisions for Me When I Cannot, Wish 2: The Kind of Medical Treatment I Want or Do Not Want, Wish 3: How Comfortable I Want to Be, Wish 4: How I Want People to Treat Me, Wish 5: What I want My Loved Ones to Know. Most of the literature (Splendore & Grant, 2017; Marshall, Avery, & Weed, 2014; Hinderer & Lee, 2014) demonstrated the use of *the Five Wishes* tool was feasible, generated positive patient responses, and was effective in increasing AD completion rates.

In a study by Wenger, Asakura, Fink, and Oman (2012), *the Five Wishes* AD tool was administered to registered nurses in an attempt to increase RN AD completion rates and determine if improved RN documentation of patient AD discussions in different hospital units (ICU, oncology, and acute care units) occurred after the intervention. The results demonstrated that 58% of RN participants fully completed and 28% partially completed *the Five Wishes* AD. Overall, 99% of participants would recommend *the Five Wishes* to others, including their patients. In addition, RN documentation of patient AD discussions improved after the intervention, which may have indicated more confidence to address EOL issues with patients.

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The literature review illustrates *the Five Wishes* document as an effective AD tool for healthcare providers, therefore supporting its use in the proposed educational module.

Theoretical Framework

The Knowledge to Action Model (see Appendix B) is a framework developed by Graham and colleagues that integrates knowledge creation, knowledge translation, and knowledge application (White & Dudley-Brown, 2012). The process begins with knowledge inquiry and research on the topic, which funnels down to knowledge being synthesized and finally tools created to present the new knowledge. The new tools and products are key features to the acceptance and adoption of the new knowledge. Planned actions using these tools are intended to facilitate change, which encompasses evidence translation.

The Knowledge to Action model provided an appropriate framework for the integration of the DNP project. The model provided step-by-step direction to implement the project by synthesis of knowledge regarding the existing HCP barriers to ACP discussions and interventions to overcome these barriers. Initially, there was a creation of a tailored educational module for healthcare providers to assist with implementation of existing evidence. Finally, the knowledge was monitored using pre-and post-Likert scale surveys. The outcomes were then evaluated and ultimately sustained knowledge regarding initiating ACP discussions by HCPs was accomplished that could potentially translate into clinical practice changes.

Methodology

Study design

As discussed in the literature review, lack of knowledge and formal training were cited as major barriers to initiation of early ACP discussions with patients and families. In all studies,

these barriers were overcome by providing education to healthcare providers about advance care planning and tools that could be utilized to increase patient AD completion rates. Therefore, the goal of this project was to foster positive attitudes in healthcare providers to initiate ACP discussions through an educational module which introduced the Five Wishes AD tool. This quality improvement project utilized a pre- and post-quasi-experimental study design to measure healthcare providers attitudes towards initiating ACP discussions. A pre- and post-survey with identical statements using a Likert-scale (see Appendix C) was administered prior to and upon completion of the educational module.

Setting

The educational module was disseminated to graduate-level nurse practitioner students and licensed independent practitioners in the [redacted] community. All [redacted] affiliated nurse practitioner students and licensed independent practitioners had access to "Canvas", an online interactive platform. The advance care planning module was optional and made available through this online platform to facilitate access.

Study population

The [redacted] community includes three regional campuses: [redacted]. Inclusion criteria for this study included graduate-level nurse practitioner students and licensed independent practitioners with access to the "Canvas" system. An exclusion criterion included individuals less than 18 years of age and undergraduate health science students. The study used a convenience sampling. The online educational module was made available to the study population for three months (August to November 2019).

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Subject recruitment

Subject recruitment commenced August 18, 2019 with emails being sent to all graduate-level NP students and independent practitioners via [redacted] Outlook email. The introductory email sent encouraged the study population to complete the educational module on fostering positive healthcare provider attitudes towards initiating ACP discussions with patients that was be made available through their "Canvas" course shell. Following this introductory email (see Appendix D), the researcher sent email reminders every 3 weeks to the participants to complete and submit the module during the three-month period. A total of 135 subjects were recruited via a Canvas course invitation using a convenience sampling method. Of these 135 invitations sent, 17 participants consented to partake in the study, which represented about a 13% response rate. A total of 16 out of the 17 participants completed the entire online module and received 1 hour CEU for participation.

Consent procedure

The consent for participation in this study appeared as the first section of the educational module on Canvas (See Appendix E). Participants consented in order to start the educational module. Consents were voluntary and subjects were permitted to stop participation in study at any given time.

Risks and Benefits

The risks to participants in this study were minimal but included discomfort with pre- and post-survey questions and known participation in the study. All data collected for analysis was de-identified. The benefits to the participants included increased knowledge on advance care planning tools, communication skills, and CMS billing for these services. In addition, the educational module could serve as a future tool for healthcare providers in different setting, such

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as institutional organizations or universities. The anticipated benefit of participation in this study would be an increase in patient AD completion in the United States by motivating healthcare providers to have the conversation with patients and families.

Subject cost and economic consideration

There were no subject cost in this study and participation was voluntary. Subjects were not paid or compensated for participating in this study. Participants received continuing education credits (CECs) through [redacted] for completion of the entire educational module. The associated cost for providing the CECs was $500, which was free of charge for the investigator through [redacted] University. There were no associated costs for participants in this study other than their dedicated time spent to complete the module.

Study intervention

The study intervention was an educational module intended for healthcare providers of the Rutgers community that was made available through an online platform called Canvas. The following educational points regarding advance care planning were covered in the module (see Appendix F) :

- ACP introduction
- Background and significance
- Needs assessment
- Patient and healthcare provider barriers
- Literature review on HCP education on ACP
- Why, when, where, and how to initiate ACP discussions
- Use of advance directive tools

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- The Five Wishes overview
- Literature review on the Five Wishes
- The Five Wishes resources
- Billing for ACP discussions

Outcomes measure

In the literature review presented, healthcare provider education led to increased comfort to initiate discussions with patient about advance care planning. In these studies, the researchers used a variety of educational methods including online modules, simulations, open discussions, and lectures. However, the appraised articles did not delineate the educational material covered in their studies. Therefore, the education module was developed de novo using various references on advance care planning. In addition, there was no single valid tool used to assess healthcare provider attitudes. Consequently, questions were developed using subsets of questions from different research studies appraised. The pre-Likert survey and post- Likert survey constructed were identical and administered prior to and upon completion of the module respectively. The Likert scores on both the pre and post surveys were measured and used to assess the outcome of the educational module on healthcare provider attitudes.

Project Timeline

The project timeline was outlined using the Gantt's chart (see Appendix G).

Evaluation Plan

The educational module addressed one of the major barriers cited in the literature review, which was lack of knowledge, education, and formal training on advance care planning. The educational module on Canvas was disseminated with the assistance of Dr. Jeanette Manchester,

a director at the Center for Professional Development at Rutgers University. An anticipated barrier to completion of the educational module was participant constraints due to work-life responsibilities. This was addressed by development of a time efficient module that took an estimated forty-five minutes to complete. Continuing education credits were provided to study participants, in order to incentivize module completion.

Data analysis

The sample size for this study was 17 participants. Of the 17 participants who provided responses pre-intervention, only one did not complete the post-intervention survey, and this participant was therefore excluded from analysis. The statistical analysis was performed using Microsoft Excel software. Data was tracked and datasets were cleaned on Excel. Responses were evaluated for each of the 11 survey items, both pre- and post-intervention. In addition, two questions were only posed post-intervention, and the responses to these items are described below. In order to test for changes in the rate of agreement post-intervention, responses were converted from a five-point Likert scale (Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree) to a binary grouping of *agree* (agree, strongly agree) or *did not agree* (neither agree nor disagree, disagree, strongly disagree).

Changes in the proportion of agreement to each question were evaluated using McNemar's test, a repeated-measures Chi-square ($\chi 2$) design. Rather than evaluating the proportion of agreement to an item for the group as a whole, this approach addresses the changes in attitudes of each individual. For example, while half of a group may agree with an item and the other half may disagree pre-intervention, if every individual changed their opinion, then the group results would appear identical (50% agreement both pre- and post-intervention), and a

group evaluation would overlook the significance of this finding. The results of this analysis are outlined below in the study results section.

Data Maintenance and Security

The data was securely stored in a password-protected computer in the Rutgers Biomedical Health Sciences building located at 65 Bergen Street, Newark NJ 07103. All data was locked, following the RU encryption process. A secure Qualtrics server collected and stored the data in the password protected electronic format. This server ensures that all responses remain anonymous, as it does not collect information such as name, link to e-mail, or IP address. The data collected was then tracked using Microsoft Excel. Microsoft Excel was then used for data analysis of de-identified data. No names or identifying information will be included in any publications or presentations, and all responses to the questionnaires will remain confidential. Subject confidentiality will be maintained and only the principle investigator will have access to the information from the pre and post-Likert surveys.

Study Results

The findings of this study demonstrate an increase in healthcare provider comfort to initiate ACP conversations with patients in response to the educational module. The ultimate goal of this study is to foster positive attitudes in healthcare providers to begin ACP discussions with patients by providing knowledge on the Five Wishes ACP tool, billing procedures, and communication skills using an online platform. The agreement of each individual's response to an item (*agree, did not agree)* were evaluated both pre- and post-intervention, placing each individual into one of four categories for each question: 1) agree pre, agree post, 2) agree pre, disagree post, 3) disagree pre, agree post, or 4) disagree pre, disagree post. Table 1 (see

Appendix H) outlines the number of individuals in each category for each question, with the $\chi 2$ test statistic indicating the significant rejection of the null hypothesis that no change in opinion occurred. Significant findings ($p < .05$) indicate that a significant change in attitudes occurred following the intervention. Critically, all 16 participants who were included in this analysis agreed with question 1 (Q1) both before and after the intervention. Similarly, the majority of participants disagreed with Q2, Q3, Q4 and Q5 both before and after the intervention. While a small handful of individuals indicated a change following the intervention, the proportion was not high enough to be considered significant or replicable.

For all remaining pre- and post-intervention items (Q6, Q7, Q8, Q9, Q10, and Q11), the majority of individuals did not agree prior to the intervention, but did agree following the intervention. In all cases these changes in attitudes were found to be significant, even at a strict threshold of $p < .01$. Despite the small sample size (n=16), these findings are considered reliable. Comparisons of the proportion of agree responses pre- and post-intervention are shown in Figure 1 (see Appendix I). Lastly, two items were only posed post-intervention (Q12 and Q13). Agreement was found in 15 of 16 individuals for each of these two items, suggesting that an overwhelming majority of participants feel more strongly equipped as a result of the intervention. In addition, according to the course evaluation results, 92% of participants stated they would be able to explain the *Five Wishes* AD tool to a patient and family and integrate proper communication skills when engaging patients in ACP discussion. All participants (100%) stated they would be able to state the requirements to bill for ACP discussions. These results highlight the aim and objectives of this study were met.

Discussion

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The results of the study positively correlated to the findings of previous literatures. In two important systemic reviews by Houben et al. (2014) and Chung et al. (2016), studies demonstrated increases in EOL conversations between healthcare providers and patients following an educational intervention compared to control groups. In other studies by Chan et al. (2016), Green and Levi (2011), Murray et al. (2010), and Trietsch (2017), medical students and residents participated in educational interventions involving online modules, lectures led by facilitators, small group discussions, and simulations. All studies resulted in an increase in participant comfort and confidence in initiating ACP discussions.

Importantly, all listed study objectives of the project were met. This was made possible by the facilitating factors of an exclusively online educational module that targeted healthcare providers of all practice settings (ICU, oncology, cardiology, etc.). This comprehensive module combined all study objectives into one 45-minute online session. The statistical significance of the project was affected by the small sample size of participants. Low participation rates can be largely due to barriers involving lack of time to complete the module or lack of interest in the subject material. Other limitations of this study include a single institutional setting affecting generalizability and lack of instrument validity of the Likert survey.

An unintended negative consequence of this project was potential participant emotional distress due to the sensitive subject matter. This could explain the reason one participant consented and started the module but never completed it. A possible unintended positive consequence could be further development of educational modules on ACP by inspired participants of the study. The plan for process evaluation is geared towards addressing suggestions for improvement from the course evaluations. Participants felt the healthcare provider communication section of the educational module did not assist with their confidence

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level in having these actual sensitive conversations with patients and families. This could be addressed in future modules by implementing videos of real case scenarios where providers are seen using effective communication skills to address ACP issues with patient and families. Nonetheless, the majority of participants demonstrated increases in confidence level with use of the *Five Wishes* AD tool and in knowledge regarding how to bill for ACP discussions.

Study Implications

Clinical practice

The educational module introduced to healthcare providers in this study will hopefully lead to clinical practice change. This practice change involves healthcare providers engaging in early ACP discussions with patients and families using proper communication skills. Healthcare providers engaging in these discussions and normalizing them as part of clinic visits will elicit better acceptance from patients to discuss their end-of-life wishes. These open discussions will generate increases in patient AD completion rates, which has been outlined as a major goal in the *Institute of Medicine report: Dying in America* (2015). Ultimately, growth in AD completion rates will translate to better patient quality of life and autonomy as patient preferences will be acknowledged and fulfilled.

Healthcare policy

Based on the study findings, changes in policy need to occur. These changes could include mandating healthcare providers to complete at least two hours of continuing education credits annually on advance care planning and advance directives. In this way, healthcare providers will have annual refreshers on how to conduct ACP conversations and how to bill for

these time-sensitive discussions. This would hopefully translate to more conversations being held with patients and families regarding goals of care across an illness continuum.

Quality and safety

According to the U.S. Department of Health and Human Services, approximately 80% of deaths occur in the acute care setting, whereas most individuals would have rather spent their last moments in the community setting (e.g. their home) (Splendore & Grant, 2017). These preferences are often not known to patients' families or healthcare providers due to lack of prior ACP discussions and proper AD completion. Low AD completion rates have therefore been linked to anxiety, stress, and turmoil among families and healthcare providers as well as adverse family bereavement outcomes. Therefore, educating healthcare providers on how to have ACP discussions will increase awareness for patients and families about the benefits of having these conversations early in a disease trajectory. This would significantly improve healthcare quality and safety for patients and families, as well as healthcare providers.

Education

The results of the study demonstrated that healthcare providers did not feel adequately trained to engage in end-of-life discussions prior to the educational intervention. Post-intervention, participants had significant changes in attitudes regarding their comfort level with engaging patient and families in early ACP discussions. These results correlate with changes that need to be made in healthcare provider education requirements, specifically for advance practice nurses. Advance practice nurse curriculums should be updated to include courses that focus on the topics of end-of-life, palliative and hospice care, advance care planning, and advance directives. With more educational focus on these topics in healthcare curriculums, healthcare

providers will feel more comfortable and well equipped to discuss ACP with patients and families.

Economic

The ultimate goal of this project was to foster positive attitudes in healthcare providers to have early ACP discussions with patients and families. In this way, patients and their significant others would be motivated to complete ADs consequently reducing the economic burden on healthcare funding spent on unnecessary medical interventions towards the end-of-life. This means cost savings of up to approximately $139 billion per year. In addition, by understanding the billing process for ACP discussions healthcare providers could request proper reimbursements for these services therefore increasing their net profit as well.

Plan for Sustainability and Translation

The educational module has the potential to be disseminated to larger groups of healthcare providers due to its online accessibility, ease of use, and generalizability to most healthcare settings. This is due to the relevancy of advance care planning for almost all healthcare settings in New Jersey including private medical practices, long-term care facilities, hospitals etc. that have daily contact with patients in need of advance directives. Sustainability efforts can initially focus on [redacted] University incorporating the educational module into one of their DNP theory courses. The instructor of the course can focus one of their class lectures on ACP and include the online module for student participation for a pass/fail grade with a dedicated deadline for completion. Making this module mandatory to aspiring doctorate of nursing practice students would address the barrier encountered in the study of low participation rates.

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Plan for Dissemination and Professional Reporting

The study was disseminated through various methods. Submission of the study manuscript and conclusions are in the process of being sent to *The Journal for Nurse Practitioners*. This project aligns with the purpose of the journal, which strives to help nurse practitioners excel as providers of primary and acute care across the lifespan. The study findings and subsequent poster will also be presented at the 2020 New Jersey League for Nursing (NLN) conference. In addition, it is the hope of the investigator that [redacted] University will offer the educational module to students and faculty members that are in need of continuing education credits for professional licensure maintenance.

Plan for Future Scholarship

The completion of this study has motivated my future scholarship endeavors. With the experienced gained from conducting a study, I would like to engage in research efforts at my current institution that is one of the leaders in cancer research. This institution focuses heavily on cancer research, including various active clinical trials of innovative therapies. I would like to continue my future scholarship by being an active member of one of the teams who are coordinating new protocols and clinical trials for the sarcoma oncologic service. Hopefully one of these clinical trials that I could be a team member of will lead to a publication in an oncology journal, which would be a great career accomplishment.

Conclusion

Advance care planning has been outlined as a major goal by the IOM report as ACP has been shown to have various benefits on a patient and family's health and wellness. In addition,

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early ACP discussions between HCPs and patients often gets the ball rolling for patients to consider advance directive completion. With more ADs being completed by patients, less financial expenses would be wasted on providing aggressive care to patients towards EOL that otherwise would have elected more conservative treatments. This study was geared towards delivering education on ACP to primary healthcare providers to foster positive attitudes towards initiating early discussions with patients and families. The study results positively correlated to previous literatures that demonstrate that education led to increases in provider comfort on having these discussions. In addition, this study enhanced providers' knowledge on an AD form called *the Five Wishes* and on how to properly bill for ACP discussions. In the future, this study can be conducted in multiple settings with a larger sample size and a validated confidence tool in order to evaluate how education can affect primary care providers' attitudes towards initiating early ACP discussions with patients and families.

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Appendix A
Table of Evidence

Article #	**Author, year of publication, & title**	**Evidence Type**	**Sample, Sample Size, & Setting**	**Study findings that help answer the EBP question**	**Limitations**	**Evidence Level & Quality**
1	Houben et al., 2014, Efficacy of Advance Care Planning: A Systematic Review and Meta-Analysis	Research (Systemic review)	-55 studies identified -15 studies (26.8%) recruited patients from inpatient setting; 37 studies (66.1%) from outpatient setting; and 4 studies (7.1%) from both settings -Most studies described original data, were RCTs, and were written in English	-Meta-analyses demonstrated increase occurrence of patient-provider discussions about EOL preferences following educational interventions compared with control groups -5 studies supported increase in knowledge following educational intervention -Conclusion: ACP interventions increase completion of ADs, occurrence of discussions about EOL preferences, and congruence between patient preferences and EOL care	-55.4% of the trial were low-quality trials as per the PEDro scale -Lack of intention to treat and concealed allocation -Various trials used instruments that were not formally validated -Several trials included small sample sizes and were conducted in single settings making generalizability difficult	Level I, Quality A

2	Chung et al., 2016, Educational interventions to train healthcare professionals in end-of-life communication: a systemic review and meta-analysis	Research (Systematic review)	-20 studies (6 RCTs, 14 Observational) -Most studies were completed in the USA, and 17 were aimed toward medical trainees, one to postgraduate medical trainees and nurse practitioners in acute care programs, and two studies were open to all acute care HCP	-8 studies (2 RCTs, 6 Observational), including 522 participants found EOL communication training was associated with increased self-efficacy compared to no training. -4 studies (2 RCTs, 2 Observational) including 290 participants, reported increased knowledge outcomes compared to no training -Conclusion: supports the use of structured education on communication training to improve HCP's ability to discuss and facilitate EOL	-Low quality of evidence, according to GRADE, due to limited studies in this area -Search restricted to studies in English language only -Terminology used in the area of EOL communication is not well established and therefore literature search was difficult	Level II, Quality A
3	Bergman et al., 2016, Engaging Physician Learners Through a Web-based Platform: Individualized End-of-Life Education	Research (Quasi-experimental)	114 participants composed of medical students, interns, residents, fellows, and attending physicians at the [redacted] and	-Online education has shown sustained improvement in knowledge and increased learner satisfaction and efficacy -Participants who clicked on both online module hyperlinks	-Small sample size -Assumption that hyperlink clicks represent participants desire to learn -Measures used not formally validated	Level II, Quality B

			the [redacted]	experienced improvement in knowledge and attitudes compared to those who clicked on one or no links -Auxiliary resources accessible by hyperlinks are an effective adjunct to Web-based learning in EOL care as connecting students to effective resources reinforces learning.	-Changes in knowledge and attitudes may not correlate with changes in actual practice	
4	Chan et al., 2016, Outpatient Advance Care Planning Internal Medicine Resident Curriculum: Valuing Our Patients' Wishes	Research (Quasi-experimental)	-16 post-graduate year 2 internal medicine residents at [redacted]	-Responses regarding residents' comfort level in ACP increased from 2.56 to 3.88 pre-intervention and 4.00 to 4.44 post-intervention -Quality of formal training showed a significant increase in the post-intervention questionnaire -Conclusion: supports structured educational interventions/curriculums to educate internal medicine residents in EOL care and led to	-Subjective nature of self-assessment and self-reflection survey tools -Small sample size -Single institutional setting -Lack of long-term follow-up on communication skills	Level II, Quality B

				increase in resident comfort level and confidence in initiating EOL discussions		
5	Flowers, 2015, Educating Aging Service Agency Staff About Discussing End-of-Life Wishes	Research (Quasi-experimental)	-57 staff members from a single home care agency	-Conclusion: a training program educating staff members resulted in an increase understanding of benefits of EOL documents, staff conversations with their own family members, and staff willingness to discuss EOL issues with consumers	-Small sample size -Single agency setting -Culturally diverse staff which pilot training did not account for	Level II, Quality B
6	Dube et al., 2015 Advance Care Planning Complexities for Nurse Practitioners	Research (Non-experimental, descriptive)	-160 responses from a nonprobability convenience sample of NPs from a statewide organization's database	-79% of NPs felt that additional training would enhance their ability to conduct ACP discussions -NPs with formal education on EOL or had taken CEUs on this topic were having more discussions (72.8% versus 86.8%) -39% of NP respondents did not have knowledge of the CMS mandate that Medicare patients need to	-Low survey response -Convenience sample -Study was conducted in a medically dense geographic population thus survey may be skewed	Level III, Quality B

				be provided AD information -Conclusion: offering education in EOL care can increase the incidence of ACP discussions therefore developing an educational program for providers is essential		
7	Trietsch, 2017, Educational Module on Tools for Advance Care Planning at UMass	Research (Quasi-experimental)	-9 residents from [redacted]	-After the module, 100% of the residents felt moderately or fairly comfortable having ACP discussions -14% of residents were minimally likely to introduce the Luminat ACP tool to their patients	-Small sample size -Lack of discussion of CMS reimbursement -Lack of workflow suggestions on how to incorporate ACP discussions in a busy practice	Level II, Quality C
8	Splendore et al., 2016, A nurse practitioner-led community workshop: Increasing adult participation in advance care planning	Research (Quasi-experimental)	-40 community-dwelling adults ages 18 and older from Pittsburg, Pennsylvania	-13 of 15 participants who completed an AD utilized the Five Wishes document -The workshop demonstrated the ease of implementation of the Five Wishes in nontraditional setting	-Convenience, homogenous sample -Instruments have not been validated	Level II, Quality B

				-The Five Wishes document was feasible, acceptable, and effective in this population		
9	Marshall et al., 2014, Increasing African American Advance Directives: Implementing the Five Wishes Educational Protocol	Research (Non-experimental)	-22 participants in three senior citizen centers -All participants were African American	-Post-intervention 77.3% of participants completed the Five Wishes AD and 54.5% provided copies of the completed document to their PCP -Conclusion; the Five Wishes Education Protocol was effective in increasing AD completion rates	-Small sample size -Homogenous sample -Time frame of recruitment -Use of a single education intervention -Completion rates were self-reported which could be inaccurate	Level III, Quality B
10	Hinderer et al., 2014, Assessing a Nurse-Led Advance Directive and Advance Care Planning Seminar	Research (Quasi-experimental)	-103 community dwelling, English-speaking adults >/= 18 years recruited using flyers, newspaper advertisements, community calendar, emails, etc. -Setting: Wicomico County, Maryland and Sussex County, Delaware	-Participants had overall positive response to use of the Five Wishes document as a guide for AD completion -Development of an educational intervention was an easy way to increase AD completion -Education also improved attitudes about AD and willingness to	-Homogenous sample -Varying laws on ACP and AD from state to state	Level II, Quality B

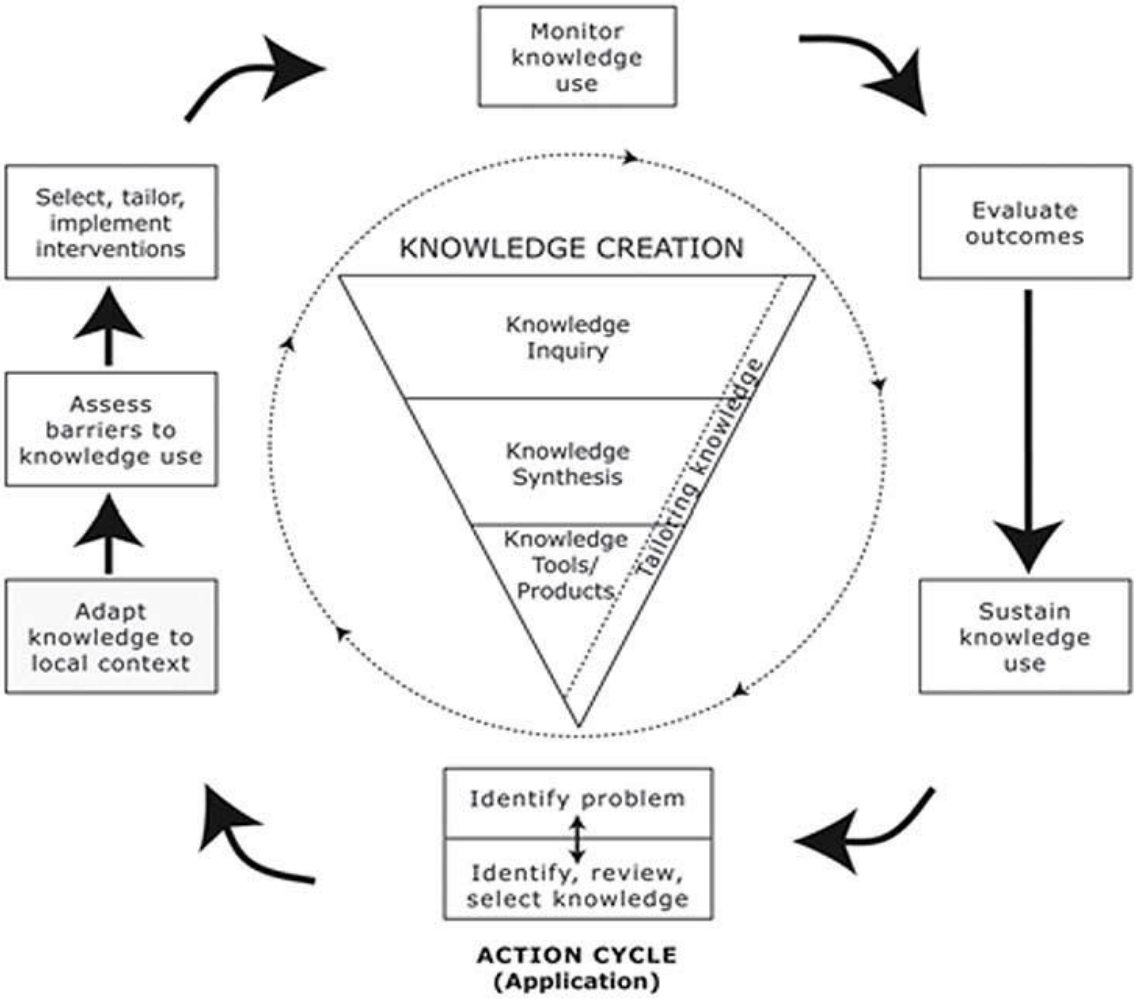
				have ACP conversations		
11	Green, M., & Levi, B., 2011, Teaching Advance Care Planning to Medical Students with a Computer-Based Decision Aid	Research (RCT)	121 second year medical students (60 in Decision Aid group and 61 in standard group) at a single midsized medical school [redacted]	-Decision Aid group demonstrated increased knowledge about ACP compared to control group -Students confidence increased significantly in both groups post-intervention, but increase was more significant in the Decision Aid group across all areas -Students' satisfaction with ACP was greater in the Decision Aid group compared to control group -In conclusion, the study demonstrated that a computer-based program/module significantly outperformed standard ACP materials across all parameters measured	-One cohort of medical students at a single academic medical center -Study was not blinded, which could have affected how participants responded to intervention -Measures used in the study have not been formally validated	Level I, Quality B

12	Wenger et al., 2012, Dissemination of the Five Wishes Advance Directive at Work	Research (Quasi-experimental)	-160 RNs from various inpatient units from a single academic hospital	-Of all RN participants, 58% fully and 28% partially completed the Five Wishes AD -Mean scores of difficulty in completing the Five Wishes AD were low among participants -99% would recommend the use of the Five Wishes to others -Conclusion: focused educational sessions lead to improved RN AD completion rates	-Educational sessions occurred during RN work hours affecting recruitment -One academic hospital setting affecting generalizability	Level II, Quality B
13	Murray et al., 2010, Skills Training to Support Patients Considering Place of EOL Care: A Randomized Control Trial	Research (RCT)	Participants were recruited from 7 community-based organizations and 3 hospital-based institutions in three Ontario health networks. -Of 112 practitioners, 88 (79%) consented to participate	-Intervention group who received education scored significantly higher on the knowledge test than the control group -50% of the intervention group strongly agreed to provide decisional support to patients compared to 28% of the control group -Conclusion: following the education	-Participants were not blinded -No physicians expressed interest in participating in study	Level I, Quality A

				program, the intervention group provided a higher quality decision support to patients than the control group.		
14	Institute of Medicine report: *Dying in America*, 2015	Non-research (Consensus)	N/A	Recommendation #3: Educational institutions, credentialing bodies, accrediting boards, state regulatory agencies, and health care organizations should establish the appropriate training, licensure requirements to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness or during EOL.	N/A	Level IV, Quality A
15	New Jersey Governor's Advisory Council on End-of-Life Care Report & Recommendations, 2018	Non-research (Consensus)	N/A	Recommendation 4: Develop and require education on EOL care for all nursing professionals, physicians, and medical residents. Recommendation 8: Develop	N/A	Level IV, Quality B

				standardized educational module for training healthcare professionals including physicians, advance practice nurses, and emergency personnel that incorporates advance directives in all healthcare settings.		

Appendix B



Adapted from Graham et al., 2006

Appendix C

Pre- and Post- Survey

For each of the following statements below, circle the response that best characterizes your attitudes about the statement where: 1= Strongly Disagree, 2= Disagree, 3= Neither Agree nor Disagree, 4= Agree, and 5= Strongly Agree.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. It is important as healthcare providers to talk with patients about the care they would like to receive near end-of-life.	1	2	3	4	5
2. It is important to talk about EOL care with patients **only** when there is a significant illness or disease progression.	1	2	3	4	5
3. The majority of patients want everything possible done to extend their lives.	1	2	3	4	5
4. I believe patients or families will initiate the conversation about ACP when they are ready, therefore I am less likely to initiate the conversation.	1	2	3	4	5

5. I believe that initiating discussions about ACP with chronically ill or terminal patients will make them lose hope.	1	2	3	4	5
6. I feel comfortable, as the healthcare provider, being the one to initiate advance care planning discussions with patients, based on their values, in my current practice.	1	2	3	4	5
7. I feel I have had adequate educational training that enables me to communicate effectively when it comes to discussing advance care planning and end-of-life care decisions with patients.	1	2	3	4	5
8. I feel comfortable advising patients on how to go about completing formal advance directives and designating a healthcare proxy.	1	2	3	4	5

9. I feel comfortable finding reliable resources related to AD and ACP to offer my patients.	1	2	3	4	5
10. I feel comfortable using ACP tools, such as the Five Wishes, with my patients.	1	2	3	4	5
11. I understand CMS requirements for billing and how to appropriately bill for ACP discussions.	1	2	3	4	5
12. Because of this module, I feel better equipped to offer advance care planning tools to assist my patients in completing advance directives.	1	2	3	4	5
13. Because of this module, I feel confident that I can initiate early advance care planning discussions with my patients in an effective manner.	1	2	3	4	5

Appendix D

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[redacted]

Let's Have the Conversation:

Advance Care Planning

This research will assess healthcare provider attitudes towards initiating early advance care planning discussions (ACP) with patients. The intervention will be an educational module delivered through an audio PowerPoint on Canvas geared towards healthcare providers. Information discussed will include barriers to ACP discussions, when, where, and how to have ACP discussions, use of an ACP tool to facilitate discussions, and billing for ACP services. A pre survey will be given to healthcare providers prior to the start of the module to assess attitudes towards initiating ACP discussions. A post-survey will be given after completion of the module to assess changes in healthcare provider attitudes after receiving education on the topic of ACP.

Eligibility: Graduate level nurse practitioner students and/or licensed independent practitioners

Location: Online Canvas platform [redacted]

Time Commitment: Approximately 45 minutes time commitment required.

Benefits:

- Increased knowledge on advance care planning tools
- Enhanced communication skills
- Knowledge of CMS billing for ACP discussions
- Participants will receive one hour continuing education unit for completion of module.

Contact Information:

Principle investigator:

Cara Padovano

[redacted]

Study coordinator:

Romina Tara

[redacted]

In support of improving patient care, Rutgers Biomedical and Health Sciences is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

JOINTLY ACCREDITED PROVIDER

V.2
7.23.19

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Appendix E

CONSENT TO TAKE PART IN A RESEARCH STUDY

TITLE OF STUDY: An Educational Module for Healthcare Providers to Foster Positive Attitudes Towards Advance Care Discussions

Principal Investigator: Cara Padovano, DNP, APN

This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. It is your choice to take part or not. After all of your questions have been answered and you wish to take part in the research study, you will be asked to sign this consent form. You will be given a copy of the signed form to keep. Your alternative to taking part in the research is not to take part in it.

Who is conducting this research study and what is it about?

You are being asked to take part in a research study conducted by Cara Padovano, DNP, APN who is a Rutgers faculty member in the School of Nursing. The purpose of this study is to foster positive attitudes in healthcare provider to initiate conversations about advance care planning with patients.

What will I be asked to do if I take part?

If you agree to take part in this research, you will be asked to take part in a pre- and post- survey and review a Canvas educational module. Your participation in this study will take about 45 minutes. We anticipate 50 to 60 subjects will take part in the study.

What are the risks and/or discomforts I might experience if I take part in the study?

Breach of confidentiality is a risk of harm but a data security plan is in place to minimize such a risk. Also, some questions may make you feel uncomfortable. If that happens, you can skip those questions or withdraw from the study altogether. If you decide to quit at any time before you have finished the study your answers will NOT be recorded.

Are there any benefits to me if I choose to take part in this study?

There no direct benefits to you for taking part in this research. You will be contributing to knowledge about whether delivering education to healthcare providers about advance care planning will foster positive attitudes towards them initiating discussions with patients and families. The modules are available at no cost and are not required as part of the program

Will I be paid to take part in this study?

You will not be paid to take part in this study. Participants will receive one hour of continuing education units for entire module completion.

How will information about me be kept private or confidential?

All efforts will be made to keep your responses confidential, but total confidentiality cannot be guaranteed. We will use the electronic Canvas platform to collect information regarding the study that include demographic information, pre-survey, and post-survey results and forward your anonymous responses to us. Data collected will be sent to the Center for Professional Development and returned to the primary investigator in a spreadsheet format. We will not receive any information that can identify you or other subjects. Data from this study will be analyzed using Microsoft Excel. The study findings will be professionally presented or published after analysis is complete. No information that can identify you will appear in any professional presentation or publication. If applicable, decision to participate in this study or not participate will not be shared with any of your course faculty.

What will happen to information I provide in the research after the study is over?
The information collected about you for this research will not be used by or distributed to investigators for other research.

What will happen if I do not want to take part or decide later not to stay in the study?

Your participation is voluntary. If you choose to take part now, you may change your mind and withdraw later. If you do not click on the 'submit' button after completing the form, your responses will not be recorded. You may also choose to skip any questions that you do not wish to answer. However, once you click the 'submit' button at the end of the form, your responses cannot be withdrawn, as we will not know which ones are yours.

Who can I call if I have questions?

If you have questions about taking part in this study, you can contact the Principal Investigator: Dr. Cara Padovano at [redacted]. You can also contact the study coordinator: Romina Tara, Rutgers DNP-FNP candidate by email:[redacted]

If you have questions about your rights as a research subject, you can call the IRB Director at:

Newark HealthSci (973)-972-3608

Please print out this consent form if you would like a copy of it for your files.

If you do not wish to take part in the research, close this website address. If you wish take part in the research, follow the directions below:

By beginning this research, I acknowledge that I am 18 years of age or older and have read and understand the information. I agree to take part in the research, with the knowledge that I am free

to withdraw my participation in the research without penalty. Click on the link that will take you to the educational module.

Click on the "I Agree" button to confirm your agreement to take part in the research.

I Agree | I Do Not Agree

Appendix F

Introduction

- Advance care planning (ACP) is a process that supports adults of any age or health status in understanding and sharing their personal values, life goals, and preferences regarding medical care.
- The goal of ACP is to provide medical care that is consistent with a person's values, goals, and preferences.
- ACP should be proactive, appropriately timed, and integrated into a patient's routine care.
- ACP commonly includes completion of advance directives.
- Advance directives (AD) is a legal written document in which the patient states their medical preferences in the event the person is no longer able to make decisions for themselves.

Background and Significance

- Benefits of ACP include:
  - Increased patient comfort
  - Increased patient autonomy
  - Increased patient and family satisfaction
  - Improved healthcare provider-patient communication
  - Greater utilization of palliative care services
  - Decreased anxiety, stress, and guilt during EOL for patients and families
  - Shortened length of hospital stay
  - $750 billion, accounting for 30% of all healthcare costs, could be reduced

Despite these benefits, only 18 to 36% of Americans have an AD completed !

Needs Assessment

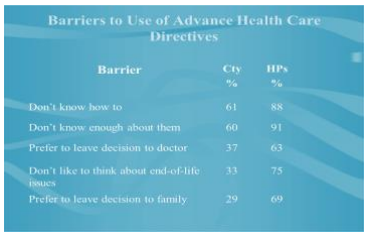
- Federal and state initiatives to address ACP include but are not limited to:
  - Patient-Self Determination Act of 1990
  - Uniform Healthcare Decision Act of 1993
  - Oregon State Initiative (Physician Order for Life-Sustaining Treatment)
- Despite these initiatives, patient AD completion rates remains below the targeted national benchmark
- Two major documented factors contributing to low patient AD completion rates can be linked to patient and healthcare provider barriers.

Patient Barriers

- Lack of knowledge about ACP and Ads
- Lack of available healthcare proxies
- Fear of burdening loved ones
- Cultural traditions
- Reluctance to initiate the conversation about ACP and ADs

Healthcare Provider Barriers

- Communication difficulties
- Anxiety about decreasing hope for patients
- Personal discomfort with the topic of death
- Not feeling the need was urgent for their particular patient
- Perceived lack of reimbursement
- Time constraints
- Lack of knowledge on ADs
- Lack of training in conducting ACP discussions



Barriers to Use of Advance Health Care Directives

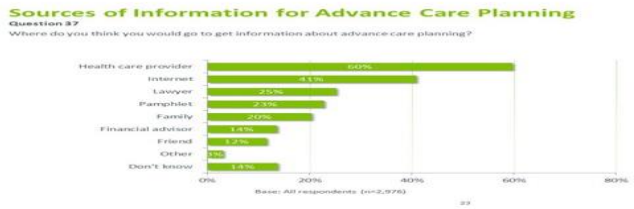
Barrier	Cty %	HPs %
Don't know how to	61	88
Don't know enough about them	60	91
Prefer to leave decision to doctor	37	63
Don't like to think about end-of-life issues	33	75
Prefer to leave decision to family	29	69

Review of Literature

- Dube et al. (2015) found that nurse practitioners having formal education on EOL or who had taken continuing education courses reported having more ACP discussions with their patients than those without education (86.8 % compared to 72.8%, respectively).
- In a systemic review by Houben et al. (2014), eleven studies demonstrated increase occurrences of EOL discussions between HCPs and patients following an educational intervention compared to control groups.
- Chung, Oczkowski, Hanvey, Mbuagbaw and You (2016), found that in eight studies end-of-life communication training was positively correlated to improved provider self-efficacy with discussion. In addition, four studies, found that communication training led to increased knowledge scores.

Why Initiate the Conversation

To increase patient completion of advance directives



When to Initiate the Conversation

- Diagnosis of chronic medical conditions
- Disease progression or deterioration
- Prognosis of 6 months to 12 months
- Annual wellness exams for all individuals over 18 years of age
- Routine follow-up visits for patients with established chronic conditions
- As part of primary prevention questions

START ACP CONVERSATIONS AS SOON AS POSSIBLE !

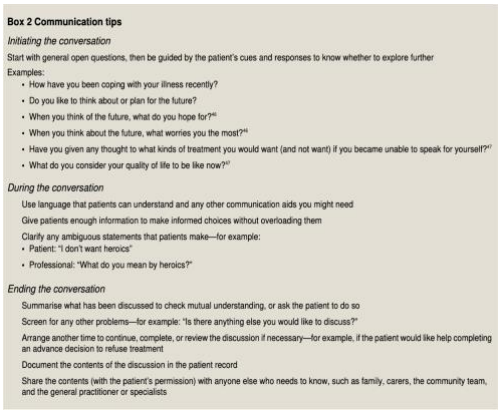
Where to Initiate the Conversation

Ideally, the discussions should initially take place in:

- primary care office
- an outpatient setting
- family-centered environment (ex. home)

These discussions should occur well in advance of any health care crisis!

How to Initiate the Conversation



Box 2 Communication tips

Initiating the conversation

Start with general open questions, then be guided by the patient's cues and responses to know whether to explore further

Examples:

- How have you been coping with your illness recently?
- Do you like to think about or plan for the future?
- When you think of the future, what do you hope for?[40]
- When you think about the future, what worries you the most?[41]
- Have you given any thought to what kinds of treatment you would want (and not want) if you became unable to speak for yourself?[37]
- What do you consider your quality of life to be like now?[37]

During the conversation

Use language that patients can understand and any other communication aids you might need

Give patients enough information to make informed choices without overloading them

Clarify any ambiguous statements that patients make—for example:

- Patient: "I don't want heroics"
- Professional: "What do you mean by heroics?"

Ending the conversation

Summarise what has been discussed to check mutual understanding, or ask the patient to do so

Screen for any other problems—for example: "Is there anything else you would like to discuss?"

Arrange another time to continue, complete, or review the discussion if necessary—for example, if the patient would like help completing an advance decision to refuse treatment

Document the contents of the discussion in the patient record

Share the contents (with the patient's permission) with anyone else who needs to know, such as family, carers, the community team, and the general practitioner or specialists

How to have end-of-life conversations

- Make eye contact
- Sit close to patient
- Allow time and silence for patient and family to express their thoughts
- Listen carefully and reflect what the patient and family say
- Show compassion and respect
- Initiate discussion of the patient's and family's concerns about the future and dying
- Allow patient and family to defer conversation to another time
- Avoid medical jargon
- Provide emotional support

What to discuss during advance care planning discussions

- Definition of and rationale for a health care proxy
- Definition of cardiopulmonary resuscitation and code status
- State-specific mechanism for enacting a health care proxy
- Specific hypothetical situations to identify the patient's health care goals
- Completion of an advance directive, assignment of a surrogate decision-maker, completion of a Physician Orders for Life-Sustaining Treatment form
- Importance of updating and referring to these documents in different care settings

— ADAPTED FROM CLAYTON JM, HANCOCK KM, BUTOW PN, ET AL. CLINICAL PRACTICE GUIDELINES FOR COMMUNICATING PROGNOSIS AND END-OF-LIFE ISSUES WITH ADULTS IN THE ADVANCED STAGES OF A LIFE-LIMITING ILLNESS, AND THEIR CAREGIVERS. MED J AUST. 2007;185(10 SUPPL):S77-S79. S83-S108.

Link to ACP Video

Use of Advance Directive Tools

- Provides a guide to HCPs and patients for having the conversation
- Promotes communication between HCP, patients, and families
- Some tools can be considered legal AD documents

- Resources:

https://www.americanbar.org/content/dam/aba/administrative/law_aging/Health_Decisions_Resources.authcheckdam.pdf

https://www.cdc.gov/aging/pdf/acp-resources-public.pdf

Everything Five Wishes

- Introduced in 1996 by Aging with Dignity
- Considered a legal AD
- Affordable
- Easy to understand
- Available in 29 languages and Braille
- Addresses all a person's needs:
  - Medical
  - Personal
  - Emotional
  - Spiritual

WISH 1

The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- *My attending or treating doctor finds I am no longer able to make health care choices, AND*
- *Another health care professional agrees that this is true.*

If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

The Person I Choose As My Health Care Agent Is:

First Choice Name | Phone

Address | City/State/Zip

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

Second Choice Name | Third Choice Name

Address | Address

City/State/Zip | City/State/Zip

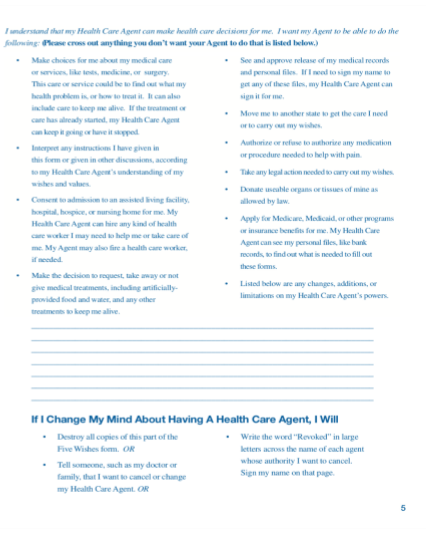
Phone | Phone

Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they **are** the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be **at least 18 years or older** (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

4



I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following: **(Please cross out anything you don't want your Agent to do that is listed below.)**

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values.
- Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent's powers.

If I Change My Mind About Having A Health Care Agent, I Will

- Destroy all copies of this part of the Five Wishes form. *OR*
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. *OR*
- Write the word "Revoked" in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.

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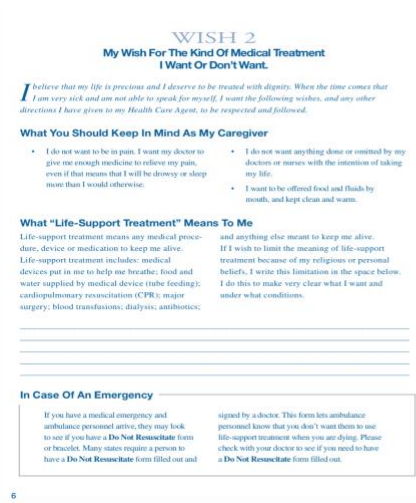

WISH 2

My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What "Life-Support Treatment" Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a **Do Not Resuscitate** form or bracelet. Many states require a person to have a **Do Not Resuscitate** form filled out and signed by a doctor. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a **Do Not Resuscitate** form filled out.

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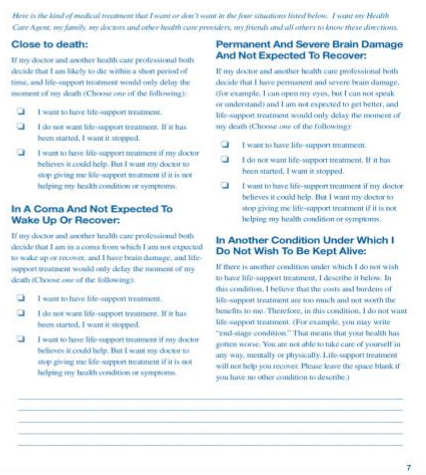

Here is the kind of medical treatment that I want or don't want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and all others to know these directions.

Close to death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ☐ I want to have life-support treatment.
- ☐ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In A Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ☐ I want to have life-support treatment.
- ☐ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ☐ I want to have life-support treatment.
- ☐ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write "end-stage condition." That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)

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Rutgers, The State University of New Jersey

The next three wishes deal with my personal, spiritual and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

WISH 3

My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- I wish to have my favorite music played when possible until my time of death.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

WISH 4

My Wish For How I Want People To Treat Me.

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.

WISH 5

My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried or cremated.
- My body or remains should be put in the following location_____.
- The following person knows my funeral wishes: _____.

If anyone asks how I want to be remembered, please say the following about me:

_____

_____

_____

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):

_____

_____

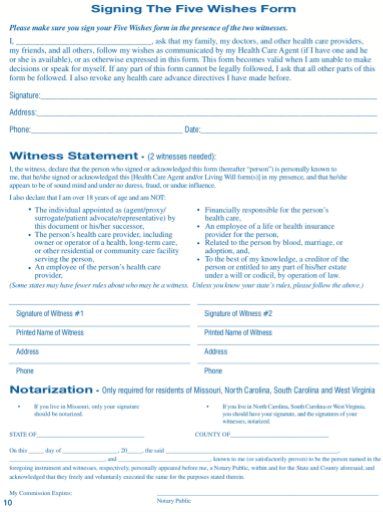
_____

(Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Please attach a separate sheet of paper if you need more space.)

_____

_____

_____



Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses.

I, _____, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature:_____

Address:_____

Phone:_____ Date:_____

Witness Statement - (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

- The individual appointed as (agent/proxy/ surrogate/patient advocate/representative) by this document or his/her successor,
- The person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state's rules, please follow the above.)

Signature of Witness #1	Signature of Witness #2
Printed Name of Witness	Printed Name of Witness
Address	Address
Phone	Phone

Notarization - Only required for residents of Missouri, North Carolina, South Carolina and West Virginia

- If you live in Missouri, only your signature should be notarized.
- If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

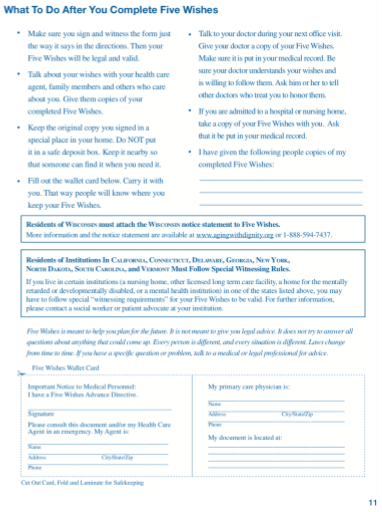
STATE OF_____ COUNTY OF_____

On this ____ day of _____, 20____, the said _____, and _____ known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: _____

Notary Public

10



What To Do After You Complete Five Wishes

- Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid.
- Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Five Wishes.
- Keep the original copy you signed in a special place in your home. Do NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Fill out the wallet card below. Carry it with you. That way people will know where you keep your Five Wishes.
- Talk to your doctor during your next office visit. Give your doctor a copy of your Five Wishes. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.
- If you are admitted to a hospital or nursing home, take a copy of your Five Wishes with you. Ask that it be put in your medical record.
- I have given the following people copies of my completed Five Wishes:

Residents of Wisconsin must attach the Wisconsin notice statement to Five Wishes.
More information and the notice statement are available at www.agingwithdignity.org or 1-888-594-7437.

Residents of Institutions In California, Connecticut, Delaware, Georgia, New York, North Dakota, South Carolina, and Vermont Must Follow Special Witnessing Rules.
If you live in certain institutions (a nursing home, other licensed long term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in one of the states listed above, you may have to follow special "witnessing requirements" for your Five Wishes to be valid. For further information, please contact a social worker or patient advocate at your institution.

Five Wishes is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.

Five Wishes Wallet Card

Important Notice to Medical Personnel:
I have a Five Wishes Advance Directive.

Signature

Please consult this document and/or my Health Care Agent in an emergency. My Agent is:

Name
Address City/State/Zip
Phone

My primary care physician is:

Name
Address City/State/Zip
Phone

My document is located at:

Cut Out Card, Fold and Laminate for Safekeeping

11

Review of Literature

- In a study by Flowers et al. (2015), a training program was established for healthcare staff members where they used *the Five Wishes* to fill out their own care preferences.
- The educational program resulted in an increased understanding of benefits of EOL documents, staff conversations with their own family members, and staff willingness to discuss EOL issues with patients.
- In a study by Wenger, Asakura, Fink, and Oman (2012), *the Five Wishes* AD tool was administered to registered nurses in an attempt to increase RN AD completion rates and determine if improved RN documentation of patient AD discussions occurred after the intervention.
- The results demonstrated that 58% of RN participants fully completed and 28% partially completed *the Five Wishes* AD. Overall, 99% of participants would recommend *the Five Wishes* to others, including their patients.

The Five Wishes Resources

- https://agingwithdignity.org/about-us/
- https://fivewishes.org/shop/order
- https://fivewishes.org/shop/order/product/the-conversation-guide-for-clinicians
- https://www.youtube.com/watch?time_continue=3&v=oEOevM-wass

Billing for ACP Discussions

- Discussions should be face-to-face
- Discussions must be >/= 15 minutes
- CPT code 99497: ACP discussion of 15 to 45 minutes
- CPT code 99498: for each additional 30-minute increment
- CPT 99497 reimbursement value: $86 for inpatient discussions; $80 for outpatient discussions
- CPT 99498 reimbursement value: $75 for additional time spent
- No limits to the frequency of reimbursement for ACP discussions

References

- Advance directives and advance care planning: Report to congress. (2016). Retrieved from https://aspe.hhs.gov/pdf-report/advance-directives-and-advance-care-planning-report-congress
- Chung, H. O., Oczkowski, S. J., Hanvey, L., Mbuagbaw, L., & You, J. J. (2016). Educational interventions to train healthcare professionals in end-of-life communication: A systematic review and meta-analysis. *BMC Med Educ, 16*, 131. doi:10.1186/s12909-016-0653-x
- Detering, K., & Silveira, M. J. (2018). *Advance care planning and advance directives*. Retrieved from https://www-uptodate-com.proxy.libraries.rutgers.edu/contents/advance-care-planning-and-advance-directives?search=advance care planning&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1
- Dingfield, L. E., & Kayser, J. B. (2017). Integrating advance care planning into practice. *Chest, 151*(6), 1387-1393. doi:10.1016/j.chest.2017.02.024
- Dube, M., McCarron, A., & Nannini, A. (2015). Advance care planning complexities for nurse practitioners. *The Journal for Nurse Practitioners, 11*(8), 766-773. doi:10.1016/j.nurpra.2015.05.011
- Flowers, K., & Howe, J. L. (2015). Educating aging service agency staff about discussing end-of-Life wishes. *Journal of Social Work in End-of-Life & Palliative Care, 11*(2), 147-166. doi:10.1080/15524256.2015.1074144
- Houben, C. H. M., Spruit, M. A., Groenen, M. T. J., Wouters, E. F. M., & Janssen, D. J. A. (2014). Efficacy of advance care planning: a systematic review and meta-analysis. *J Am Med Dir Assoc, 15*(7), 477-489. doi:10.1016/j.jamda.2014.01.008
- Myers, J., Cosby, R., Gzik, D., Harle, I., Harrold, D., Incardona, N., & Walton, T. (2018). Provider tools for advance care planning and goals of care discussions: A systematic review. *American Journal of Hospice and Palliative Medicine®, 35*(8), 1123-1132. doi:10.1177/1049909118760303
- Splendore, E., & Grant, C. (2017). A nurse practitioner-led community workshop: Increasing adult participation in advance care planning. *J Am Assoc Nurse Pract, 29*(9), 535-542. doi:10.1002/2327-6924.12467
- Spoelhof, G. D., & Elliott, B. (2012). Implementing advance directives in office practice. Retrieved from https://www.aafp.org/afp/2012/0301/p461.htm
- Wenger, B., Asakura, Y., Fink, R. M., & Oman, K. S. (2012). Dissemination of the Five Wishes advance directive at work. *Journal of Hospice & Palliative Nursing, 14*(8), 551-558.
- Woollen, J., & Bakken, S. (2016). Engaging patients with advance directives using an information visualization approach. *J Gerontol Nurs, 42*(1), 16-20. doi:10.3928/00989134-20150804-63
- Wright, M. S. (2018). Change without change? Assessing Medicare reimbursement for advance care planning. *Hastings Center Report, 48*(3), 8-9. doi:10.1002/hast.848

Appendix G

Gantt chart of project's timeline

Milestones	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020
Module available through Canvas						
Weekly email reminders sent to complete module						
Data collection: **Pre- and post-Likert survey**						
Data analysis: **Pre- and post-Likert survey**						
Data evaluation						

Appendix H

Table 1.

Changes in Attitudes Pre and Post-Educational Intervention

	AGREE PRE, AGREE POST	AGREE PRE, DISAGREE POST	DISAGREE PRE, AGREE POST	DISAGREE PRE, DISAGREE POST	SIGNIFICANCE
Q1	16	0	0	0	χ2=0, DF=1, p=1.00
Q2	0	1	0	15	χ2=0, DF=1, p=1.00
Q3	5	1	1	9	χ2=0.5, DF=1, p=0.479
Q4	0	3	0	13	χ2=1.33, DF=1, p=0.248
Q5	0	2	0	14	χ2=0.5, DF=1, p=0.479
Q6	4	0	10	2	χ2=8.1, DF=1, p=0.004
Q7	2	0	12	2	χ2=10.083, DF=1, p=0.002
Q8	4	0	12	0	χ2=10.083, DF=1, p=0.002
Q9	5	0	11	0	χ2=9.091, DF=1, p=0.003
Q10	5	0	11	0	χ2=9.091, DF=1, p=0.003
Q11	3	0	13	0	χ2=11.077, DF=1, p<0.001

Note: *The number of individuals in each of four categories pre- and post-intervention. The χ2 test statistic, and its significance, is shown for each question addressing the null hypothesis that no change in attitude occurred. Significant changed in attitudes are shown in green.*

Appendix I

Figure 1. Participant Agreement to Survey Items

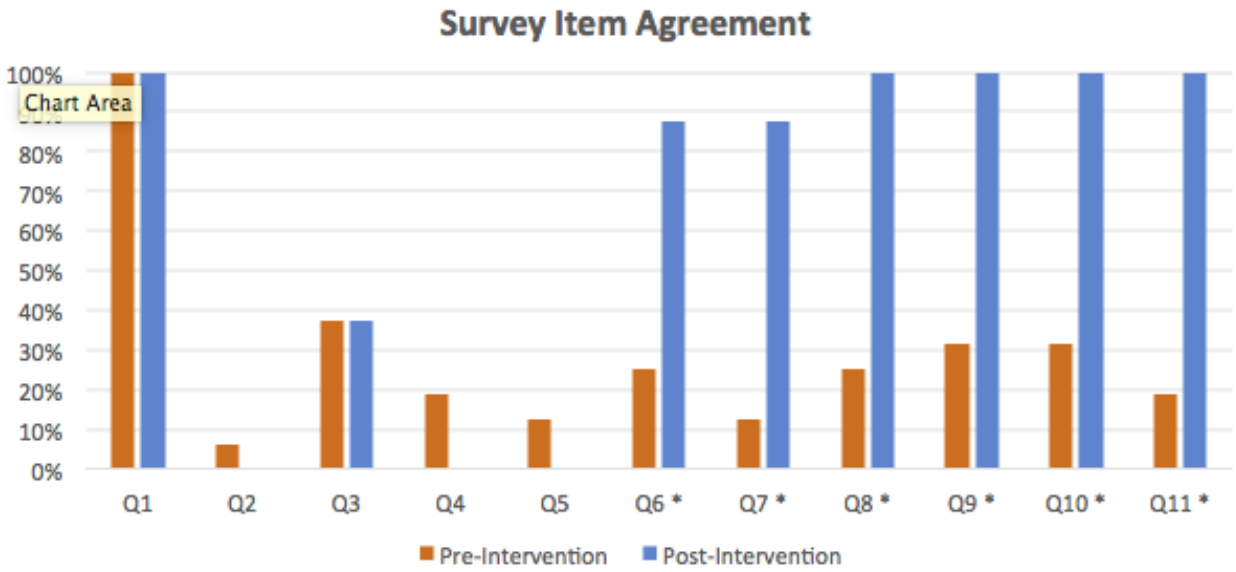


Figure 1. The proportion of respondents agreeing to each of the first 11 survey items pre- and post-intervention, where an asterisk (*) indicates a significant shift.

References

Advance directives and advance care planning: Report to congress. (2016). Retrieved from https://aspe.hhs.gov/pdf-report/advance-directives-and-advance-care-planning-report-congress

Bergman, J., Ballon-Landa, E., Lerman, S. E., Kwan, L., Bennett, C. J., & Litwin, M. S. (2016). Engaging physician learners through a web-based platform: Individualized end-of-life education. *Am J Hosp Palliat Care, 33*(8), 748-754. doi:10.1177/1049909115598741

Chan, D., Ward, E., Lapin, B., Marschke, M., Thomas, M., Lund, A., . . . Obel, J. (2016). Outpatient advance care planning internal medicine resident curriculum: Valuing our patients' wishes. *J Palliat Med, 19*(7), 734-745. doi:10.1089/jpm.2015.0313

Chandar, M., Brockstein, B., Zunamon, A., Silverman, I., Dlouhy, S., Ashlevitz, K., . . . Obel, J. (2017). Perspectives of health-care providers toward advance care planning in patients with advanced cancer and congestive heart failure. *Am J Hosp Palliat Care, 34*(5), 423-429. doi:10.1177/1049909116636614

Chung, H. O., Oczkowski, S. J., Hanvey, L., Mbuagbaw, L., & You, J. J. (2016). Educational interventions to train healthcare professionals in end-of-life communication: A systematic review and meta-analysis. *BMC Med Educ, 16*, 131. doi:10.1186/s12909-016-0653-x

Dingfield, L. E., & Kayser, J. B. (2017). Integrating advance care planning into practice. *Chest, 151*(6), 1387-1393. doi:10.1016/j.chest.2017.02.024

Dube, M., McCarron, A., & Nannini, A. (2015). Advance care planning complexities for nurse practitioners. *The Journal for Nurse Practitioners, 11*(8), 766-773. doi:10.1016/j.nurpra.2015.05.011

Dying in America: Improving quality and honoring individual preferences near the end of life. (2015). The Institute of Medicine. Washington, D.C.: The National Academies Press.

Flowers, K., & Howe, J. L. (2015). Educating aging service agency staff about discussing end-of-Life wishes. *Journal of Social Work in End-of-Life & Palliative Care, 11*(2), 147-166. doi:10.1080/15524256.2015.1074144

Fulmer, T., Escobedo, M., Berman, A., Koren, M. J., Hernández, S., & Hult, A. (2018). Physicians views on advance care planning and end-of-life care conversations. *Journal of the American Geriatrics Society, 66*(6), 1201-1205. doi:10.1111/jgs.15374

Green, M. J., & Levi, B. H. (2011). Teaching advance care planning to medical students with a computer-based decision aid. *J Cancer Educ, 26*(1), 82-91. doi:10.1007/s13187-010-0146-2

Hinderer, K. A., & Lee, M. C. (2014). Assessing a nurse-led advance directive and advance care planning seminar. *Appl Nurs Res, 27*(1), 84-86. doi:10.1016/j.apnr.2013.10.004

Houben, C. H. M., Spruit, M. A., Groenen, M. T. J., Wouters, E. F. M., & Janssen, D. J. A. (2014). Efficacy of advance care planning: a systematic review and meta-analysis. *J Am Med Dir Assoc, 15*(7), 477-489. doi:10.1016/j.jamda.2014.01.008

Howard, M., Bernard, C., Klein, D., Elston, D., Tan, A., Slaven, M., . . . Heyland, D. K. (2018). Barriers to and enablers of advance care planning with patients in primary care. Retrieved from http://www.cfp.ca/content/64/4/e190

Hutchison, L. A., Raffin-Bouchal, D. S., Syme, C. A., Biondo, P. D., & Simon, J. E. (2017). Readiness to participate in advance care planning: A qualitative study of renal failure patients, families and healthcare providers. *Chronic Illness, 13*(3), 171-187. doi:10.1177/1742395316675023

Marshall, P., Avery, G., & Diane Weed, L. (2014). Increasing African American advance directives: Implementing the Five Wishes education protocol. *GSTF Journal of Nursing and Health Care, 1*(2). doi:10.5176/2345-718x_1.2.49

Martin, C. A. (2015). Promoting advance directives and ethical wills with the HIV-aging cohort by first assessing clinician knowledge and comfort level. *Journal of the Association of Nurses in AIDS Care, 26*(2), 208-214. doi:10.1016/j.jana.2014.09.001

Murray, M. A., Stacey, D., Wilson, K. G., & Oconnor, A. M. (2010). Skills training to support patients considering place of end-of-life care: A randomized control trial. *Journal of Palliative Care, 26*(2), 112-121. doi:10.1177/082585971002600207

Myers, J., Cosby, R., Gzik, D., Harle, I., Harrold, D., Incardona, N., & Walton, T. (2018). Provider tools for advance care planning and goals of care discussions: A systematic review. *American Journal of Hospice and Palliative Medicine®, 35*(8), 1123-1132. doi:10.1177/1049909118760303

New Jersey governor's advisory council on end-of-life care report and recommendations (pp. 1-47, Rep.). (2018). Retrieved from https://www.state.nj.us/health/advancedirective/documents/NJAdvisoryCouncil_EOL_FinalReport.pdf

Reidy, J., Halvorson, J., Makowski, S., Katz, D., Weinstein, B., McCluskey, C., . . . Tjia, J. (2017). Health system advance care planning culture change for high-risk patients: The promise and challenges of engaging providers, patients, and families in systematic advance care planning. *J Palliat Med, 20*(4), 388-394. doi:10.1089/jpm.2016.0272

Splendore, E., & Grant, C. (2017). A nurse practitioner-led community workshop: Increasing adult participation in advance care planning. *J Am Assoc Nurse Pract, 29*(9), 535-542. doi:10.1002/2327-6924.12467

Spoelhof, G. D., & Elliott, B. (2012). Implementing advance directives in office practice. Retrieved from https://www.aafp.org/afp/2012/0301/p461.htm

The Five Wishes. (2019). *Aging with Dignity*. https://fivewishes.org/five-wishes/who-we-are/about-us/our-history-and-mission

Trietsch, R. (2017). Educational module on tools for advance care planning at UMass. *University of Massachusetts Medical School.* Retrieved from https://works.bepress.com/rayna-trietsch/1/

Wenger, B., Asakura, Y., Fink, R. M., & Oman, K. S. (2012). Dissemination of the Five Wishes advance directive at work. *Journal of Hospice & Palliative Nursing, 14*(8), 551-558.

White, K. M. & Dudley-Brown, S. (2012). *Translation of evidence into nursing and health care practice*. Springer Publishing Company.

Woollen, J., & Bakken, S. (2016). Engaging patients with advance directives using an information visualization approach. *J Gerontol Nurs, 42*(1), 16-20. doi:10.3928/00989134-20150804-63

Wright, M. S. (2018). Change without change? Assessing Medicare reimbursement for advance care planning. *Hastings Center Report, 48*(3), 8-9. doi:10.1002/hast.848

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