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Use of the PREPARE Tool to Increase Completion Rates of Advance Care Planning Documentation

Janella Thompson
University of St. Augustine for Health Sciences

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**Use of the PREPARE Tool to Increase Completion Rates of Advance Care Planning
Documentation**

Janella Thompson MSN, RN

School of Nursing, University of St. Augustine for Health Sciences

This Manuscript Partially Fulfills the Requirements for the
Doctor of Nursing Practice Program and is Approved by:

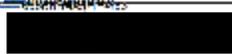
David Liguori, DNP, NP-C, ACHPN

Robert W. Kentner, DNP, RN, CPHQ, CEN, TCRN

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**University of St. Augustine for Health Sciences
DNP Scholarly Project
Signature Form**

Student Last Name: Thompson	First Name: Janella	Middle Initial: J
E-mail: j.thompson1@usa.edu		
Title of DNP Project: Use of the PREPARE Tool to Increase Completion Rates of Advance Care Planning Documentation		
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DNP Project Primary Faculty: David Liguori, DNP, NP-C, ACHPN		8/8/2022
DNP Project Preceptor: Robert W. Kentner, DNP, RN, CPHQ, CEN, TCRN		8/9/2022
DNP Project Preceptor:		

Abstract

Practice Problem: One in three adults aged 55 and older admitted to the hospital lack advance care planning. Patients without advance care planning may not receive treatment that reflects their personal values, wishes, and preferences

PICOT: The PICOT question that guided this project was in adults 65 years or older (P), how does the implementation of a patient-centered web-based advance planning tool kit (I) compared to the usual practice of addressing advance care planning (C), affect the completion rate of advance care planning documentation (O) within 10 weeks (T).

Evidence: The current evidence has demonstrated that advanced care planning promotes patient-centered care by ensuring patients' personal preferences regarding medical care are understood. Patients that receive care that is consistent with their personal preferences decrease the burden of family members having to make difficult healthcare decisions when patients are unable to make decisions for themselves. The benefits of advance care planning also extended to the healthcare team by reducing the costs associated with expensive treatments and hospitalizations.

Intervention: The intervention utilized the PREPARE Tool to educate participants on advanced care planning. The tool was easily accessible on the internet which provide the steps required for completing an advance directive.

Outcome: The project results demonstrated that the implemented web based PREPARE tool increased the completion of advance care planning.

Conclusion: The goal of this change project was to increase awareness and the completion of advanced care directives. To ensure patients remained at the center of care, the PREPARE tool was utilized to provide education on advance care planning to participants in the community resulting in a significant increase in completed advanced directives.

Use of the PREPARE Tool to Increase Completion Rates of Advance Care Planning Documentation

Advance care planning reflects a patient's medical care wishes based on values, traditions, beliefs, and personalized preferences. These wishes can be altered as the patient's circumstances change. The goal of having advance care planning is to ensure that the patient remains at the center of care and increases the quality of care by providing care that is consistent with the patient's preferences (Fleuren et al., 2020). Additional benefits include reducing families and caregivers' burden, anxiety, and depression, and empowering medical providers to prevent unwanted burdensome care (Boerner et al., 2018).

Professionals in the fields of public health and aging services are in positions to help older adults and their families address important issues related to advance care planning. By completing legal or other written documents such as a living will, do not resuscitate order, and physician order for life-sustaining treatment order (POLST), ensures that individuals and their families will discuss what care they would like to receive if they become unable to make their own decisions. Thus, the most important task to increase advance care planning documentation (ACP) are to appoint a surrogate decision maker, ensuring the person's family and caregivers understand the individual's attitude about life, death, and dying; by engaging in a conversation about the person's wishes for care under various scenarios that might occur (Boerner et al., 2018; CDC, 2017; Carr & Luth, 2017).

Significance of Practice Problem

Despite the ethical, personal, and health service benefits of advance care planning (ACP), there is a lack of advance care planning documentation in place for the aging population (Carr & Luth, 2017). The lack of ACP may prevent patients from receiving the personalized treatments they desire in the event they are unable to articulate their wishes. One in three adults aged 55 and

older are being admitted to the community hospitals and do not have any form of advance directive (Yadav et al., 2017). Many older adults that have the capacity to make decisions and are willing to discuss advance care planning are not offered the opportunity until they are either admitted to a nursing home or imminently ill (Waller et al., 2019).

In a national study of 7946 participants by Yadav et al. (2017), 67% had concerns regarding end-of-life care, including pain they might experience, their comfort measures being rendered, and the cost of care. Forty-eight percent that had concerns did not discuss end-of-life preferences; however, of the 7946 respondents, 26.3% completed some form of advance directives, 18% had no concerns regarding end-of-life care, and 14% did not know about advance directives.

Family

According to Oechsle (2019), advance care planning is associated with better outcomes for family members. This included reducing symptoms of anxiety, stress, depression, and the burden of decision-making. Without advance care planning, family members were subjected to making decisions regarding accepting or rejecting medical treatments without knowing the patient's preferences (Boerner, 2018). Additionally, family members may disagree with each other or disagree with the health care provider regarding the treatment of care. A family that engages in ACP with detailed discussions of goals will mitigate the patient receiving unwanted care by ensuring the patient remains at the center of their care (Mignani, 2017).

Healthcare System

The Center for Disease Control (2016) reported an increase in chronic diseases in Americans. The increase of older Americans with chronic diseases accounts for a rise in Medicare spending and an increase in Medicare expenditures (CDC, 2016). The CDC also reported the leading cause of death in the US is due to chronic diseases including diabetes,

stroke, heart disease, cancer, and chronic obstructive pulmonary disease. Therefore, dying in America, according to Klingler (2016), requires more palliative and advance care planning (ACP) services in the U.S. healthcare system. Often patients are gravely debilitated to make medical decisions leading to unwanted care that becomes burdensome both for the patient and family. Therefore, when the relevant documentation regarding advance care is present, the issues are eliminated.

ACP is intended to improve the quality of life for all Americans; yet in practice, it is underutilized by older adults. Tripken and Elrod (2017) examined young adults' perspectives regarding ACP. Most young adults lacked an understanding of the basic principles of advanced care planning. To help ensure that all Americans get the medical care they desire, it is important to engage the younger population in ACP conversations as they are the future caregivers of their older loved ones (Tripken et al., 2018).

Tripken et al. (2018) addresses the risk factors of Social Determinants of Health and how they affect ACP documentation. The instability of the economy and lack of access to healthcare often deter patients' compliance with medical behaviors. Those patients that are of lower socioeconomic status are less likely to complete ACP documentation versus those that are of higher SES. Rates of ACP are especially low among older Blacks and Latinos, relative to Whites. Estimates vary across samples; however, most research finds that Whites are two to three times as likely as Blacks and Latinos to have an advance directive (Portanova et al., 2017). ACP rates also vary by age, marital and parental status, and other psychosocial factors (Tripken et al., 2018). Often physicians are dissuaded from following the directives of a surrogate for fear of possible civil litigation and/or criminal liability. This fear, in part, is manifested by inconsistencies in the law, misunderstanding, and misapplication of the law (Kapp, 2016).

Cost

End-of-life (EOL) expenses are responsible for a high percentage of healthcare costs (Duncan et al., 2019). During the final six months of life, the average cost of care for blacks is \$26704 (32% more), and for Hispanics, \$31702 (57% more) (Bond et al., 2018). Similar differences exist within sexes, age groups, all causes of death, all sites of death, and within similar geographic areas (Duncan et al., 2019, Bond et al., 2018). According to CMS (2021) expenses incurred by hospitalized patients account for 92 percent of decedents compared to 58 percent of survivors. Hospitals see savings that occur through Medicare reimbursements. The average Medicare reimbursements per enrollee is \$4,527 for decedents and \$729 for survivors (CMS, 2021). According to Duncan et al. (2019), care rendered in a hospital setting during the end-of-life is considered futile because of its aggressive nature and often will not meet the needs of the patient's preferences. Studies done by French et al. (2017) and Einav et al. (2018) showed that community-based care will help identify patient's requiring early EOL services, encourage more patients to complete advance directives, and reduce the adult inpatient death rate from 2.4% to 2.1%. The Healthcare system will also see a savings of \$100,00.00 yearly on life-saving procedures such as CPR, prolonged use of ventilators, artificial nutrition and hydration, or comfort care (Einav et al., 2018). Cost reduction strategies must prioritize the health of the patients while examining opportunities to cut costs. By having ACP, which is patient-centered, more patients will be given the care that is congruent with their preferences.

PICOT Question

In adults 65 years or older (P), how does the implementation of a patient-centered web-based advance planning tool kit (I) compared to the usual practice of addressing advance care planning (C), affect the completion rate of advance care planning documentation (O) within 10 weeks (T)? The population involved is all adults aged 65 and older living in the community that

does not have any form of advance directive or advance care documentation. The intervention included the introduction of a web-based tool that provided step-by-step directions on advance care planning. The comparison intervention was patients' usual practice of addressing ACP within ten weeks.

The Johns Hopkins Nursing Evidence-Based Practice & Change Theory

The John Hopkins Nursing Evidence-Based Practice model (JHNEBP) serves as a problem-solving model that utilizes the best evidence-based approach to clinical decision-making within an organization (Dang et al., 2022). By integrating scientific evidence, current research, and best practices, nurses can use the model as an organizing tool to create an optimal environment to enhance patient care. The model was used to help ensure the implementation of the EBP project using the PET Process Guide by optimizing time and healthcare resources (Dang et al., 2022). The PET Process Guide is a step-by-step plan used to guide the EBP project by identifying a practice question, through clinical research and evaluation, identifying the best evidence to answer the question and translate the evidence into the practice setting. The Question Development Tool was used to clarify and develop the practice question that leads to the process of finding and evaluating clinical evidence. The Stakeholders Analysis and Communication Tool was used to identify and communicate with key stakeholders early in the process and kept them updated on progress to ensure their buy-in for implementation. The Research Evidence Appraisal Tool was used to determine the usefulness of each article to the practice change. The Individual Evidence Summary Tool was used to record and gather the results of the appraisal of each piece of evidence. The Synthesis and Recommendation Tool was used to guide the team through the process of synthesizing each individual piece of evidence. The Translation and Action Planning Tool guided the examination of the best evidence that will fit to translate the EBP project for the

change setting. The publication Guide is a structured template that was used as a guide in writing the EBP project for publication (Dang & Dearholt, 2017; Dang et al., 2022).

Changes were made using Kotter's eight-step model. These changes were used to guide the project, and are embedded in the organizations culture and practices.

Kotter's eight-step change model:

Creating a sense of urgency: By identifying the increase in the cost of hospitalized patient care, this indicates a new sense of urgency for the organization to see the importance of having ACP.

Form a powerful Coalition: To create change and keep the members interested in change, the church board members were the driving force in recruiting other congregants that helped to convince people that the change was necessary. Younger members were willing to take risks to have change created. Appealing to the older women and mothers helped to draw attention because these are people that are often listened to.

Create a vision of change: A clear vision and strategy helped everyone see that the change was necessary. The pastor and the project leader created a clear memorable vision of how the future would be. Sharing the vision and strategy with the board of directors and staff allowed them to ask questions and give their input.

Communicate the vision: Special meetings were called to talk about the change, board members were interested in creating the change, and they told their friends and families about the importance of ACP. the vision was applied to all aspects of the daily operations, and training and support were offered to staff. Ensured that the organization and all events reflected and supported the change.

Remove obstacles: All grievances filed were directed to the pastor, and there were incentives for designated change agents. The project leader met with the pastor to assess for any barriers, staff were rewarded for making changes happen.

Create short-term wins: The short-term goal was to train the entire staff in ACP in one week. The training was done in small groups, and staff and members that participated were awarded. Board members assisted in the training.

Build the change: Weekly meetings were held, where team members identified their successes, then set weekly goals. The younger population was invited to be a part of the team to keep the team abreast of new technology.

Anchor the change in corporate culture: The pastor along with the board members ensured that the changes were reflected amongst the other chapters of the organization. The organization created a plan that included the change process when new staff was hired.

Evidence Search Strategy

Databases used for the search included CINAHL, Ovid Medline, and Search USA. When the limiter AND & OR included all the keywords using the intervention, outcome, and comparison, the search returned 19, 126 articles. There was a difference between using the expander OR with the search results, namely, the articles are more specific to the keywords used which are advanced care planning AND (toolkit or tool kit or web-based tool or education or curriculum or program) AND (palliative care or end of life care or * standard care) web-based interventions or e-health or internet-based interventions AND (quantitative research or quantitative study or quantitative).

To maximize the search with the best possible articles that answered the picot question, the limiters used were full-text and abstracts academic journals, published in English in the

United States from 2016. The search strategy was revised using the specific research design of systematic and meta-analysis research which included the above keywords, which yield 411 from CINAHL, 13 from Ovid/Medline, and 118 from Search USA. After review of the literature 3 from CINAHL, 3 from Ovid, and 7 from Search USA met the inclusion criteria of studies done in the United States. Exclusion criteria included ages 0-65 years, adults with any form of advance directive, and children.

Evidence Search Results

This literature review located community-based interventions that attempted to increase the amount of advance care planning documentation in adults 65 years and older. A total of 553 abstracts were initially reviewed. Four were excluded for duplicity, four were level IV research studies and of poor quality. Thirteen research studies met the inclusion criteria, following 536 being excluded for having mixed interventions. Study designs included seven RCTs, three systematic reviews, plus additional prospective studies (cohort studies and surveys). No meta-analyses were located. The Johns Hopkins Research Evidence Appraisal Tool was applied to the studies 5 were Level I and 6 were Level II (McKenzie et al., 2021).

Overall, the quality of the thirteen studies that emerged from the search strategy for this literature review was all Level I and II with quality scores of A and B using the Johns Hopkins Evidence Level and Quality Guide. There were Level I and Grade A quality research studies.

Themes with Practice Recommendations

There were four themes that emerged from the literature review.

1. Addressing ACP in the context of patients' prognosis and patients' religious beliefs.
2. Discussing the concern of burdening surrogate decision makers.
3. The value of a tool to support conversation and initiation regarding ACP and collaborative support.

4. Patient's knowledge about ACP and finding solutions for the lack of time to discuss ACP with clinicians.

Addressing ACP in the context of patients' prognosis and patients' religious beliefs.

Many religious people showed an understanding of how religion affects their decision-making skills regarding healthcare affairs. For people of faith, advance care planning can be a theological, medical, and legal process (Coates, 2017). Catholic ethics distinguishes that the dying patient must receive ordinary care but have the choice to refuse extraordinary care.

Medical treatment such as the use of a ventilator can be ordinary or extraordinary, depending on the circumstances. Orthodox Jews will present all end-of-life issues and questions to an authority on Jewish law, preferable before the issues become urgent. Attempts to engage religious people in advance care planning should consider relevant theological teachings and should include faith leaders and chaplains as complementary resources for decision-making (Coates, 2017).

Discussing the concern of burdening surrogate decision makers.

Undertaking Advance Care Planning (ACP) can help reduce burden and stress. Having experienced making medical decisions for someone else may influence the way people make decisions for themselves. Kermel and Warner (2021) suggests that interventions should be developed to encourage family members to undertake ACP for themselves, which emphasizes the advantages of the process and involve significant others in the formal and informal aspects of ACP.

The value of a tool to support conversation and initiation regarding ACP and collaborative support.

Many faith communities are open to a variety of tools for advance care planning including training, workshops, sermons, book discussion groups, film screenings, and forums. Because non-medical facilitators may have limited ability to discuss health care scenarios or the

success rates and consequences of life-sustaining interventions, high-quality decision aids would be valuable in aiding these decisions. A tool that has sound evidence and clinical value can be universally applicable.

Patient's knowledge about ACP and finding creative solutions for the lack of clinicians participation in discussions.

Advance care planning can help alleviate unnecessary suffering, improve quality of life, and provide a better understanding of the decision-making challenges facing the individual and his caregivers (Akdeniz, 2021). Advance care planning (ACP) is an ongoing process in which patients, their families or other decision-makers, and their health care providers reflect on the patient's goals, values, and beliefs, discuss how they should inform current and future medical care, and use this information to accurately document future care needed.

Practice Recommendations

The Synthesis and Recommendation Tool was used to review the literature, which included studies of elderly patients 65 and older. Recommendations includes an online program and educational intervention will lead to an informed decision regarding end-of-life care and advance care planning.

Six studies found support in using the PREPARE tool will assist in ACP engagement and completion, of the six studies, two studies report that healthcare providers are also instrumental in recommending EOL measures and ACP documentation. Two studies included the initiation of ACP conversation in the clinical setting and one study include the use of the PREPARE toolkit by case managers in the hospital setting. Six studies reported information on goals and patients' preferences towards care. Two of those studies also compared beliefs of the younger population towards EOL care and having ACP. Among older adults, goals of care were associated with levels of health literacy, whereas those with the highest health literacy levels were more likely to

complete ACP documentation. The five Level I and Grade A quality research studies consistently reported statistically significant results favoring the comprehensive approach described above and a clinically meaningful difference between the use of the PREPARE tool and standard care.

Setting, Stakeholders, and Systems Change

The setting for this project was a community-based Church in Fort Lauderdale. The church is a not-for-profit organization that supports disease prevention and promotion for the community. To understand the Strengths, Weaknesses, Opportunities, and Threats involved in a project, a SWOT analysis was used. The strengths of the organization focused on strategies used by the educated team and experts in advance care planning. In an effort to advance the community, educational opportunities in ACP were available. This increases the likelihood of participants completing advance directives without reservation. Participants being versed in ACP also negates any weaknesses the project may face such as stakeholder participation, management, and staff shortage. However, it is important to identify opportunities that will strengthen the project objectives. This includes encouraging the young people to be part of the team and utilizing them to educate the older team members on new technology and trends. By forming alliances with other organizations within the community allows for a shared vision for the project thus making their mission a catalyst for community change. Because there is an urge for technology engagement through education within the systems, the project provides the community with access to exceptional patient-and family-centered care, including medical education and innovation. To support the project's intervention by ensuring patients were equipped with the body of information that translated evidence into practice. To mitigate threats such as a change in technology, the project leader assigned members that are IT experts to monitor use and access to technology equipment. To reduce cost, by having fundraising

community events or have team leaders participate in grant writing workshops. Have planned events to visit other community programs (Bravo et al., 2018; Hendricks et al., 2016).

The pastors within the organization have recognized an increase in the number of its congregants with concerns regarding end-of-life wishes. Thus, prompting initiating the need for an intervention that involves advance care planning and patients' preferences (Bravo et al., 2016). Recommendations from the Stakeholder Analysis communication Tool supports the integration of patient-centered care and evidence-based intervention will increase the patient receiving care that is congruent with their wishes (McDonnell & Idler, 2020). In addition to ensuring patients are well informed and engaged in their care, the implementation of a standard web-based tool was used to encourage congregants and their families how to initiate advance care planning (Nouri et al., 2021).

The stakeholders were present at every stage. Their visibility was evident through their involvement in the project, by providing suggestions, support, and participation in quality improvements initiatives (AHRQ, 2020). The clerical administrator was the driving force in getting the staff and community members engaged by being an effective communicator. The healthcare educator assisted in establishing a teaching environment, with clear expectations. The pastor also continuously observed and supervised the progress of the project. According to Dixon and Knapp (2018), a key benefit to organizational support is collaboration within a team. When healthcare providers refer patients within their organization, it delivers a positive experience for the patient. This meets the patients' needs and preferences through team-based care by engaging the patients as participants, in their care while encouraging providers to function to the full extent of their education, experience, and certification (Heath, 2019). Providing care that is consistent and patient-centered, allows for easier ACP conversations.

According to research by Lennox et al. (2018a, 2020b), continuous reporting of how processes are utilized will ensure the longevity of any evidence-based intervention. Within a community-based organization, continuous evaluation and processes must be done to identify any hindering factors to the success of the intervention. Strategies may include the use of the advance care planning evaluation tool that was used to evaluate the level of achievement of employees. Creating effective strategies through quality improvement initiatives starting at the planning phase and continued until closing was beneficial to the organization, the community, and patients (Lennox et al., 2018). To attain the goal of increasing ACP documentation, care was provided by community-based providers that are successful in implementing evidence-based interventions best practice guidelines (Sharpin et al., 2019). A staff with a positive culture towards advance care planning ensured sustainability and long-term integration of the change. Thus, increasing the chances for positive outcomes at the macro level (Ho et al., 2021).

Leadership at the macro level maintains focus on strategies that are long-term and transformational (Eckardt et al., 2019). While keeping the organization and community as a priority, the project leader also focused on external factors such as technological advancement that enhanced the organization's sustainability (Ferguson et al., 2018). From a strategic standpoint, a SWOT tool aided in identifying the Strengths, Weaknesses, Opportunities, and Threats of the organization (Gurel, 2017). It is essential for organizations to make decisions on how to utilize their resources through strategic planning. Gurel (2017) stated macro-level leadership will achieve their organizational goals by reflecting the organization's mission, visions, and objectives by monitoring the organization's external and internal environment.

Implementation

According to Arnett et al. (2017), members of the interprofessional team are crucial in facilitating ACP discussions. Team members are primary care provider, nurse, church secretary,

case manager, pastor, community liaison, and nurse educator. Each member can improve clinical flow by being ACP competent through education and by being aware of the objectives:

- Clear effective communication
- Fostering a team culture
- Provide feedback and positive reinforcement
- Provide quality educational materials.

To facilitate communication, there were weekly team meetings. Any changes in plan were immediately notified by text and email. Daily reminders of upcoming tasks were sent at the end of each day. There were set expectations of the interprofessional team. Each member was expected to be proficient in their expected role while keeping the organizations goals and patient values in mind. The nurse educator ensured that the team members are knowledgeable in ACP discussion and planning. To empower the team, the project manager ensured there were adequate resources available, such as educational materials that were easily accessible by the elderly population. There was access to handouts that are printed in bold easy to read letters. A budget (Table 1) was available that demonstrates the required cost for the project.

As evidence by the project schedule in Appendix (C) during week one, there was a meeting that included the preceptor and pastor to orient and review the organizations policy and procedures. The team met at 8 am daily during week one. All team members were present. Role responsibilities was assigned by the project leader. Once roles have been assigned, the team used the PET Guide Process to define the organizations problem. The nurse educator introduced the PREPARE tool to the team members which can be accessed electronically with any mobile device. The team collaboratively reviewed the use of the tool with the intended population.

During week two, the nurse educator, assisted by the team leader conducted five days of education and training on how to assess a patient's decision-making ability and ACP planning. By the end of week two, The Use of the PREPARE tool to increase completion rates of advance care planning documentation proposal was submitted to EPRC and approval was granted. Prior to the submission of the proposal, permission was granted to use the JHEBM tools. The PREPARE tool was available for public use, no permission was needed for this project.

Week three was the first dinner presentation, the project leader, nurse educator, church secretary, the primary care provider and the pastor were present at each presentation. The church secretary as the project manager ensured that internet-accessible devices were available and working for those that did not have a mobile phone. Two large posters were on display, placed on either side of a podium making them visible from any location in the room. The first poster was the PREPARE advance directive and the second poster was the PREPARE pamphlet.

Data collected included demographic data (age, sex, race, ethnicity, gender), economic data (income, occupation) social data (education and housing). Additional data collected included a choice of advance directive whether electronic or paper form. The amount of time it took to complete the advance directive was also collected. The team leader conducted a live poll of the participants' knowledge on ACP before and after each presentation. The team leader also documented the number of participants with knowledge before and after the presentation. Participants that did not wish to participate were asked to leave.

The nurse educator introduced the PREPARE tool and ACP. The web page was highlighted on an overhead projector. After each presentation, the pastor assessed and counted the amount of demographic, data sheet completed. All data collected was stored in a locked cabinet. Protecting participants' anonymity was important during the project. There were no identifiable data available to connect the data sheets to the participants. To further assure

anonymity, participants were given clear instructions of the intended use of the data sheet and to omit writing names on each. There was a question-and-answer session after each presentation.

According to HHS.gov the HIPAA Privacy Rule requires appropriate safeguards to protect the privacy of protected health information and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization. For this project it required that all participants personal information and identifiers be removed. The locked cabinet was accessible only by the pastor and the project leader using a smart app.

During weeks four and five each participant present completed a data sheet and participated in a live poll. The primary care physician was available for participants to consult with, before completing the advance directive at the end of each presentation.

Results

The evidence-based project was performed at a local church community center. Members of the church were able to view monthly and upcoming events in the Sunday church bulletin. There were posters throughout the community, and the monthly topic was posted on the church's community bulletin outside the church. Each adult sixty-five and older, able to read English, had a cellphone, and could make decisions without limitations, was invited to the dinner presentations. Participants younger than 65 were not invited to the presentation. Participants that were deaf or hard of hearing were assisted by the project leader who has experience working with this population.

The validity of the PREPARE tool is documented in a pilot study where case managers that introduce the web-based tool to patients that do not have ACP saw an increase in these patients completing ACP or some form of advance directive (Nouri et al., 2021). Data was analyzed by the project leader using the University analysis software Intellectus Statistics. The software was used to complete a two-tailed independent samples *t*-test which ran both parametric

and nonparametric tests. The test was conducted to examine whether the mean of patient's age was significantly different between the female and male categories, in completing advance care planning.

The assumptions to answer the PICOT question were based on normality and homogeneity of variance. Shapiro-Wilk tests were conducted to determine whether Age could have been produced by a normal distribution for each category of Gender (Razali & Wah, 2011). The result of the Shapiro-Wilk test for Age in the Female category was significant based on an alpha value of .05, $W = 0.84$, $p < .001$. This result suggests that Age in the Female category is unlikely to have been produced by a normal distribution. The result of the Shapiro-Wilk test Age in the Male category was not significant based on an alpha value of .05, $W = 0.93$, $p = .091$. This result suggests that a normal distribution cannot be ruled out as the underlying distribution for Age in the Male category. The Shapiro-Wilk test was significant for the Female category of Gender, indicating the normality assumption is violated.

Levene's test was conducted to assess whether the variance of Age was equal between the categories of Gender. The result of Levene's test for Age was not significant based on an alpha value of .05, $F(1, 57) = 0.01$, $p = .919$. This result suggests it is possible that the variance of Age is equal for each category of Gender, indicating the assumption of homogeneity of variance was met.

The result of the two-tailed independent samples t -test was not significant based on an alpha value of .05, $t(57) = 0.41$, $p = .684$, indicating the null hypothesis cannot be rejected. This finding suggests the mean of Age was not significantly different between the Female and Male categories of Gender. Analysis of the studies consistently reported statistically significant results favoring the comprehensive approach described above and a clinically meaningful difference between the use of the PREPARE tool and standard care. The results are presented in Table 2. A bar plot of the means is presented in Figure 2.

This Advance Care Planning Project provided education on the use of the PREPARE toolkit via internet access to individuals in the community. This allowed easy access, and a step-by-step process that guide individuals to make decisions and inform their families of their care and preferences in the event they lost the capacity to make their wishes known.

Impact

The project showed a significant and positive effect on the community by creating an increase in advance care planning in the organization. There was a change in behavior in both the organization and the community participants. For example, participants were sharing their personal values, life goals and preferences regarding future medical care. The organization benefitted by having trained employees in advance care planning. This allowed employees to perform their work effectively. Being knowledgeable about ACP, ensures employee compliance with training and ensures the organization shares a common culture regarding advance care planning. The stakeholder's involvement helped the project identified strategies that promoted and attracted individuals in completing an advance care plan. The community participants had access to educational information, valuable practitioners that are competent in ACP, and easy access to the PREPARE tool that was needed to complete advance care planning. The PREPARE tool was employed to assist in easy communication between the patient and their family. The tool provided ongoing advance care planning communication between the patient and their healthcare provider before a crisis occurs. The tool is available electronically or in paper format. To assist in the achievement for better health outcomes for the aged populations, the PREPARE tool was required.

There was no immediate alteration in practice however, the two most important barriers to advance care planning are lack of education and insufficient time (Blackwood et al., 2019). There was a need for employee training and access to available ACP resources. The nurses that

were available within the organization, need adequate time to have ACP conversations with patients due to busy schedules.

This project was a pilot project within the community which was funded through a community-based fundraiser and a five-hundred-dollar budget from the organization. There was no need for further monitoring of the project due to the PREPARE tool availability for public use. The project was evaluated after two weeks by the project leader via phone interviews. Checking for participants' use, and any changes in personal information.

Future implications suggested that educational programs about advance care planning may be more effective if family members were included in the sessions. Further, community education concerning advance care planning can help empower individuals in the community to take an active role in their end-of-life treatment decisions. Additionally, state policies that bestow decision-making in a particular order may mean that older adults who rely on someone other than a legal spouse or biological child may require more deliberate conversations about their end-of-life preferences (Carr & Luth, 2017).

Dissemination

The result of the change project was reported to all stakeholders by the pastor. According to AHRQ (2020), the effectiveness of communicating the evidence in various contents and formats will increase the likelihood that most adults 65 and older that have a phone will understand and use the PREPARE information. Therefore, by submitting the findings of this project to a professional society such as the American Medical Association, as well as the relevant stakeholders integral to the process of advance care planning, patient care will improve by promoting and implementing these procedures. Such procedures are widely recognized to support patient self-determination, facilitate decision making, and promote better patient outcomes.

Conclusion

Advance care planning reflects a patient's medical care based on values, traditions, beliefs, and personalized preferences. Because advance care planning has beneficial effects on the aging population, is important for everyone sixty-five years and older ensure they have some form of advance directive in place. Having ACP increases the probability that patients with life-limiting illnesses will have their wishes and preferences understood and respected by everyone during end-of-life care. Advance care planning helps relieve family and caregiver decision burden, it helps the healthcare team to make decisions in stressful situations and improves patient and family satisfaction with care by reducing stress, anxiety, and depression within family. To ensure that the patient remains at the center of care, the intervention PREPARE tool was used to increase the completion of advance care planning. This enhanced the quality of care according to patients wishes documented in their advance directives.

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Table 1

Budget

Expenses		Revenue	
Supplies		Grants	
Notepad, pens,	10		
ACP survey			
2 posters size 16x20	5.99		
		Institutional Budget	500.00
Services			
Statistician/Data Analyst			
IT Specialist	150.00	Donations	
Printing ACP survey	30.00		
Misc.			
Refreshments for meetings	50.00		

Table 2*Two-Tailed Independent Samples t-Test for Age by Gender*

Variable	Female		Male		<i>t</i>	<i>p</i>	<i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Age	59.89	3.20	59.56	2.91	0.41	.684	0.11

Note. N = 59. Degrees of Freedom for the *t*-statistic = 57. *d* represents Cohen's *d*.

Figure 1

Prisma Diagram

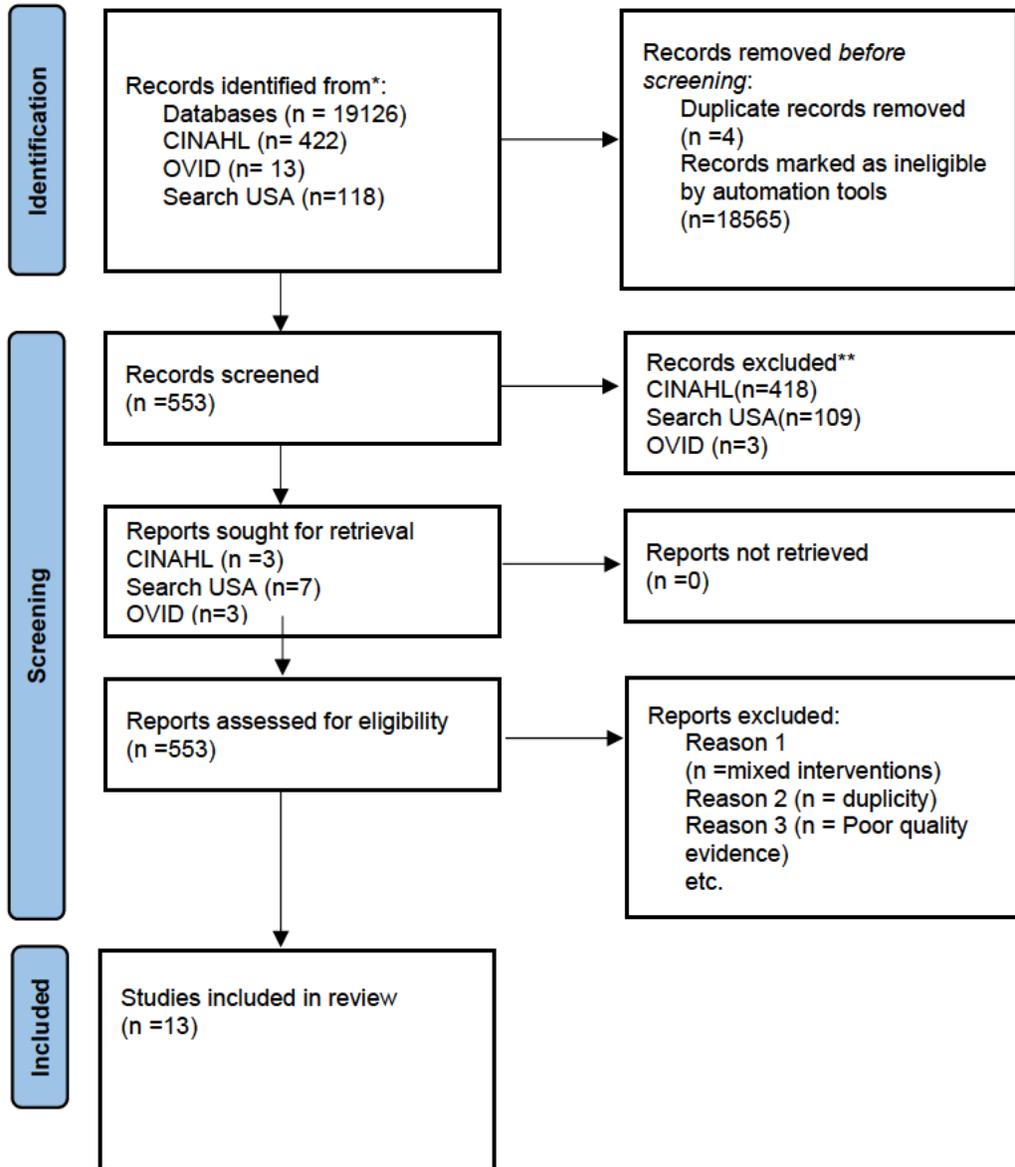
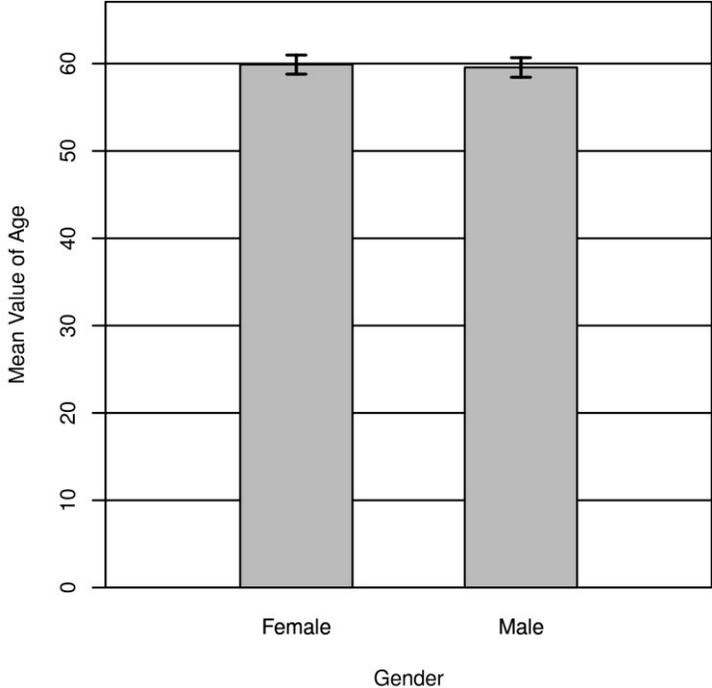


Figure 2

The mean of Age by levels of Gender with 95.00% CI Error Bars



Appendix A

Summary of primary evidence results.

Source	Design	JH Level And Quality	Key features of interventions	How outcomes were measured	Findings	Conclusion
McDermot et al., (2018)	Systematic review	Level I Quality A	Clinician education in cultural competence	unvalidated tools and convenience samples and lack of reflexivity.	A communication-focused approach to ACP may better meet the needs of culturally diverse populations. Many interconnected cultural factors influence the acceptability of ACP in progressive, incurable disease	Advance care planning (ACP) can improve end-of-life outcomes
Berkowitz, et al., (2021)	A retrospective cross-sectional analysis	Level II Quality B	Patient's performance scale was for palliative care was measured via computer tracking	The Quality Data Collection Tool for PC database	Despite having serious illness many patients with serious illness lack ACP	Oncologist plays a key role is recommending patients to completing ACP
Elliot, et al.,(2021)	A systematic review	Level I Quality A	Healthcare workers acknowledge the importance of informing patients and family caregivers		The literature provided an understanding and overview of the experiences, needs, and shortfalls of dementia-related palliative and end-of- life care services and supports in rural areas.	Having early conversations about advanced care and treatment options to allow for informed decision-making and providing a person-centered approach to allow for individuals to remain cared for in their preferred care settings.

			about end-of-life care to facilitate discussion.			
Nouri, et al., (2021)	A pilot study	Level I Quality B	92% of clients would recommend the toolkit for ACP	Five point-Likert scale	<p>The ACP-Toolkit resulted in higher case manager confidence in facilitating ACP and client readiness to engage in ACP, Case managers would recommend tool kit to others. All clients found the Toolkit easy to understand and were comfortable with case managers using it.</p> <p>Case managers agreed that the tool kit was easy to use</p> <p>Suggest offering toolkit in other language</p> <p>Suggest disseminating in clinical area</p>	ACP tool-kit may be a feasible solution to increase ACP engagement among frail, older adults receiving in-home care.
Jones, et al., (2021)	A systematic review	Level I Quality A	Examine studies of interventions used to target ethnic groups regarding end-of-life care	The modified Downs and Black tool	More high-quality intervention studies are needed to study ACP, educational interventions indicate that interventions targeting underrepresented groups can have significant and positive effects on advance directives and/or advance care planning-related outcomes.	Educational interventions indicate that interventions targeting underrepresented groups can have significant and positive effects on advance directives and/or advance care planning-related outcomes
Taber, et al., (2019)	Mailed survey	Level IV Quality	82% of whites has knowledge of palliative care	Chi-square test	There were no differences in awareness as a function of age	Increasing knowledge and positive beliefs about palliative care should lead to more informed decision making about whether and when to obtain palliative care.

			<p>10% of Blacks has knowledge</p> <p>8.7% Hispanics has knowledge</p>		<p>Those who expressed greater awareness had more years of education</p> <p>Interventions will need to do more than just improve knowledge and attitudes,</p>	
Resick, et al., (2020)	Survey	Level IV Quality B	<p>16% of practitioners participated</p> <p>55% non-physicians had > 15 yrs experience</p> <p>84% of physicians had >15yrs</p> <p>45% had minimal experience</p> <p>10% had certificate of educational training</p>	The CF foundation web-based tool (Listserv)	<p>Most health care providers understand their role to CF patients, in-end-of life care.</p> <p>Data suggest a gap in educational intervention to improve care at EOL.</p>	Most healthcare providers are involved in the education/discussion with EOL care for their patients.
Freytag, et al., (2020)	RCT	Level I Quality A	(30.5%) had limited health literacy,	<p>Incidence rate ratio</p> <p>Confidence interval</p>	<p>PREPARE may mitigate barriers to ACP among English- and Spanish-speaking older adults.</p> <p>The PREPARE program and easy-to-read AD empowered patients to</p>	PREPARE increase ACP documentation

			(25.2%) were Spanish speaking. 41% more active patient participation in ACP discussions		actively participate in ACP discussions during clinical visits	
Fleuren, et al., (2020)	Randomized control trial	Level I Quality A	(30.5%) had limited health literacy, (25.2%) were Spanish speaking.	validated Active Patient Participation Coding Scheme.	41% more active patient participation in ACP using PREPARE during clinic visits	The prepareforyourcare.org online program increase ACP documentation
Shi, et al., (2019)	Survey	Level IV Quality A	Changes at twelve month is narrow 0.76 to 1.07 Using the PREPARE tool changes 0.44 to 0.64 When compared between the two groups ranged narrowly	correlation	Short ACP surveys are useful in assessing ACP engagement Short survey detects changes at all points	ACP engagement is effective in clinical settings

			from 0.24 to 0.30			
Sudore, et al., (2018)	Randomized control trial	Level II Quality A	(39.7%) had limited health literacy (45.1%) were Spanish speaking.	Intent to treat analysis using mixed-effects logistic and linear regression,	Results remained significant among English speakers and Spanish speakers. No participant characteristic differed between the 2 groups,	Prepare program and an easy-to-read advance directive, without clinician-level or system-level interventions, increased documentation of advance care planning
Tripken, et al., (2018).	Cross-sectional sample	Level II Quality A	1/3 of people that had knowledge about ACP discuss wishes with their family Majority had good attitudes and beliefs about ACP	Descriptive statistics & correlation tests	Young adults lacked familiarity and knowledge regarding ACP Those who were most familiar with ACP terminology were more likely to be older, female, enrolled in a graduate program, and employed full time.	Young people are instrumental in assisting older family completing ACP
Weaver, et al., (2021).	Randomized cross-sectional	Level II Quality B	Most young adults were interesting in knowing about ACP		Participants who received the intervention were less likely to worry about not getting enough care. Participants are more likely to complete verbal and written ACP within three months	Interventions can raise awareness and enhance completion of ACP among young people

Appendix B

Summary of Systematic Reviews (SR)

Citation	Quality Grade	Question	Search Strategy	Inclusion/Exclusion Criteria	Data Extraction and Analysis	Key Findings	Usefulness/Recommendation/Implications
Elliot et al., (2021)	B	What were the main themes identified across the literature pertaining to dementia-related palliative care	Joanna Briggs institute, Medline EMBASE, PSYCINFO and CINAHL	English language only/ no exclusion mentioned		Healthcare works acknowledge the importance of informing patients and family about end-of-life care to facilitate discussion	Having early conversations about ACP will allow for informed decision-making and provide person-centered approach.
Jones et al., (2021).	B		CINAHL, MEDLINE, EMBASE, Peer-reviewed studies	English language	The modified Downs and Black tool	More high-quality intervention studies are needed to study ACP, educational interventions indicate that interventions targeting underrepresented groups can have significant and positive effects on advance directives and/or advance care planning-related outcomes.	Educational interventions indicate that interventions targeting underrepresented groups can have significant and positive effects on advance directives and/or advance care planning-related outcomes

<p>McDermott & Selman (2018).</p>	<p>B</p>	<p>Can the presence of a pre-existing immune response, as identified by expression of the T_{eff} gene signature, may be associated with clinical benefit to immunotherapy-containing regimens.</p>	<p>MEDGEN PUBMED Kaplan–Meier methodology was used to estimate the median PFS for each treatment arm, and Kaplan–Meier curves were produced.</p>		<p>(95% confidence interval (CI),</p>		<p>Safety dose is the recommended dose, efficacy, and immune correlates for nintedanib use in combination with pembrolizumab in patients with advanced cancers.</p>
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Appendix C

Project Schedule NUR7801

Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor and Pastor	Identify weekly goals and objectives Review meet schedule	Review weekly objectives and goals with project leader	Review objectives with Preceptor, set weeks schedule.					
Prepare project proposal	Present project charter Continue practicum activities	Review project proposal	Continue working on Proposal, revision review content with faculty and preceptor					
List the steps for your project. Specifically, and operationally define what you plan to do and when.		Project Leader, pastor and primary Care provider, nurse and secretary conduct presentation, secretary will assess number of surveys completed	Complete project required hours					

NUR7802

Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor	Review organization policies and procedures, requirements for practicum, meet the team	Review objectives, set weekly schedule and activities						
Prepare project proposal	Review project with faculty for submission to EPRC	Review ERPC checklist, JHNEBP tools permission obtained						
List the steps for your project. Specifically, and operationally define what you plan to do and when.								

NUR7803

Activity	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor	Review assignment, set weekly schedule	Conduct project evaluation	Implement project	Implement project	Prepare for Dissemination and reassessed			
Prepare project proposal								
List the steps for your project. Specifically, and operationally define what you plan to do and when.								

Appendix D

Florida Advance Health Care Directive

This form has 3 parts:

Choose a medical decision maker, PSage 3

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

This person will be your advocate.

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

Make your own health care choices, Page 7

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

Sign the form, Page 13

The form must be signed before it can be used.

Part 1

Part 2

Part 3

You can fill out Part 1, Part 2, or both. Fill out only the parts you want. Always sign the form in Part 3. 2 witnesses need to sign on Page 14.

What should I do with this form?

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

What if I have questions about the form?

It is OK to skip any part of this form if you have questions or do not want to answer.

Ask your doctors, nurses, social workers, family, or friends to help.

Lawyers can help too. This form does not give legal advice.

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

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

When should I fill out this form again?

If you change your mind about your health care choices

If your health changes

If your medical decision maker changes

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

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

Destroy old forms.

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

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

is 18 years of age or older can talk to you about your wishes

can be there for you when you need them

you trust to follow your wishes and do what is best for you

you trust to know your medical information

is not afraid to ask doctors questions and speak up about your wishes