Background/Significance

Advance care planning (ACP) is necessary for aligning patients’ treatment preferences with healthcare they receive when they are unable to speak for themselves. Undesired, burdensome treatment, the most distressing outcome when ACP has not occurred, will persist as long as patients are not proactively engaged in ACP before it is needed. There is a critical need to identify an approach to the ACP process that promotes acceptance of, and participation in, high-quality ACP.

Purpose

We propose an ongoing process of identifying and communicating preferences is invaluable for ACP.

Ongoing ACP discussion sessions can improve patients’ role in decision-making and enhance the goals of ACP. The purpose of this study is to identify strategies to overcome barriers to ACP engagement.

Methods

Design: A 4-arm, prospective, comparative design guided by the Individual and Family Self Management Theory.

Setting & Sample: 40 patients from a large primary care clinic in Midwest USA who will not have an advance directive (AD) or have an old one on file recruited from 5 NCCs. If a Surrogate Decision Maker/Health Care Agent (SDM/HCA) is identified, the patient, the SDM/HCA is also recruited.

Procedures: NCCs are trained in the ACP process and use of the decision tools. After providing consent, patients are randomized to 1 of the 4 decision tools. Outcomes are measured after ACP intervention sessions are completed.

ACP Intervention:

1. Initiate and facilitate conversations about ACP with patients.
2. Complete/review one of the 4 decision aids with a family member.
3. Identify strategies to overcome barriers to ACP engagement.
4. Complete Knowledge of Patient Preferences questionnaire.
5. Measure the effectiveness of the training after it is deployed.

Outcomes and Measures:

1. ACP Engagement Survey: Acceptability and feasibility.
2. ACP Decision Aids: Formal identification of a SDM/HCA.
3. ACP Completion: ACP process.
4. ACP Engagement: ACP process.

Analysis:

Content analysis of interview data and ACP Engagement Survey data.

Preliminary Results

5 Primary Care NCCs trained in intervention

11/14 Patients completed and AD (79%)
8 New ADs
2 Updated ADs
8 New ADs
Number of ADs: 9 on average
Gender: Female 10 (71%)
Male 5 (29%)
8 New ADs
Not completed: 1 (7%)
9 SDM/HCAs interviewed. All agreed that they:

1. Have a good understanding of what medical treatments this person would want (or not want) if he/she were unable to make medical decisions.
2. Have enough information about this person’s preferences to make medical decisions.
3. Make appropriate medical decisions on his/her behalf.
4. Make medical decisions.
5. Have a good understanding of what medical treatments this person would want (or not want) if he/she were unable to make medical decisions.
6. Make appropriate medical decisions on his/her behalf.
7. Have enough information about this person’s preferences to make medical decisions.
8. Make appropriate medical decisions on his/her behalf.
9. Have enough information about this person’s preferences to make medical decisions.

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Implications

Utilizing nurses to facilitate ACP discussions is an opportunity to engage patients in identifying their goals and preferences and discuss them with their families.

Study supports full-scale nursing practice in the transformation of healthcare, patient-centeredness in primary care settings.

Study is innovative in leveraging the nurse role in primary care to reteach ACP from isolated content to complete a meaningful process.

References

5. Reference 2014;06/30/14.
9. SDM/HCA interview. AS agreed that they:

- Have a good understanding of what medical treatments this person would want (or not want) if he/she were unable to make medical decisions.
- Have enough information about this person’s preferences to make medical decisions.
- Know what matters most to this person regarding his/her end-of-life preferences.
- Have enough information about this person’s preferences to make appropriate medical decisions on his/her behalf.

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