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Improving Advance Care Planning Among Native Americans

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MS, Walden University, 2018

BS, California State University, 1996

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November, 2022

Abstract

A staff education project was created in a tribal health system of primary care clinics to improve advance care planning (ACP) conversations between care providers and Native American tribal patients. ACP conversations and advance directive documentation occurrences were found to be low or negligible in the project site despite primary care clinics being an ideal place to start these conversations. The purpose of the staff education project was to improve the knowledge and attitudes of providers toward initiating ACP conversations in a rural underserved community of Native Americans. The knowledge-to-action model was used to frame the project. Pretests and posttests were used to gather data, and nonparametric tests were used to check the difference between scores, before and after education, related to attitudes and comfort, knowledge, and cultural competency of providers. Pretest and posttest survey data were analyzed using SPSS software. The staff education led to improved attitudes among healthcare providers ($z = -3.918$, $p < 0.001$) and knowledge ($z = –4.406$, $p < 0.001$) about ACP that were consistent with previous research evidence. Although statistical significance was not achieved on the cultural competence questions, this was likely due to preexisting knowledge and small sample size. The study’s findings confirm previous findings that staff education leads to improvement in knowledge and attitudes to start ACP conversations and documentation. The project can lead to positive social change in the lives of Native American patients by improving their end-of-life care and ensuring care aligns with their cultural beliefs, values, and preferences. Further study can be conducted to see if actual change occurs in ACP conversations between providers and patients.

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Dedication

This project is dedicated to God that helps me to get through all the tough times including my mother's passing away during the Doctorate Program. Almighty gives me light and direction every day to keep me moving forward. Next, I am thankful to my late parents and brother that always encouraged and inspired me to pursue education. I want my children to know that they always have been a constant purpose and joy in my life that always reminded me that life is beautiful and worth exploring.

Acknowledgments

First, I would like to thank my mentors Dr Barbara Niedz and Amy Lou Wilson for spending so much time to give me direction and help succeed. Heartly thanks to all the advance practice nurses and staff at my collaborating institution for giving me opportunity to plan and implement my project and willingness to participate in it. Additionally, I would like to thank tribal patients and their families for showing trust, strength, regard, and hope on daily basis. Finally, I want to thank my family and friends for understanding my commitment during the doctoral journey and providing support.

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Section 1: Nature of the Project

Introduction

This doctor of nursing practice (DNP) project was created to improve healthcare providers' advance directive (AD) conversations and related documentation for one Native American (NA) tribe served in a primary care setting. Tribal patients' advance care planning (ACP) conversations with primary care providers have very low to negligible occurrences per clinic staff and primary care clinic administrator. This educational intervention was planned to help improve the population's end-of-life (EOL) experiences to align with their values and preferences. By improving NA patients' experiences and increasing primary care staff's knowledge about ACP, I sought to bring positive social change in the population.

Problem Statement

The project was planned for the tribal health centers or primary care medical clinics, which are part of the Indian Health Service (IHS). The clinic or health center is part of the Tribal Health and Human Services designed to provide healthcare to NAs. The Tribal Health and Human Services has multiple primary care clinics or health centers in underserved rural areas related with the tribe. This is the only tribal health system for the tribe in the area and almost all tribal members are enrolled in the system. Incidences of inability to locate AD documentation have occurred, leaving family members and care providers unaware of patients' EOL wishes for health care. A failure to engage in ACP can result in inappropriate rapid response review in the context of clinical deterioration that may not be in line with a patient's or a family's priorities or preferences (Pearse et al., 2019). According to clinic's medical providers, patients' ACP conversations were found to be very low to almost negligible; this is due, at least in part, to cultural differences and to discomfort with the subject. Providers are aware that ACP is an important part of quality healthcare, so this lack of ACP conversations represents a gap in practice. The healthcare providers voiced a need for more information and training on the subject and wanted to know how they can include that practice in the system's process of routine healthcare.

According to the Accreditation Association for Ambulatory Health Care (AAAHC, 2018), an AD is a formal document or documents that represent a person's EOL wishes in case the person becomes temporary or permanently incapacitated. Examples include a living will, a durable power of attorney of healthcare, or healthcare proxies. These documents are legal in all 50 states and the District of Columbia. According to the Chapter 1 of the AAAHC handbook, patient rights and responsibilities require compliance that providers should provide ADs as required by prevailing laws and regulations (AAAHC, 2018). In addition to state and federal laws, the American Nurses Association Code of Ethics indicates that nurses are ethically obligated to educate patients about EOL decisions and advocate for patients' rights to self-determination that should align with their cultural beliefs and values (Miller, 2017). Nurses' role at all levels of practice requires promoting patients' autonomy by educating them about their decisions and consequences (Miller, 2017).

Purpose Statement

A problem statement is a declaration of disparity or difference (a gap) in practice that is usually addressed by a defined process (Houser, 2018). ACP for end-of-life (EOL) care requires a conversation between patients (including family members or others if a patient so wishes) and health care providers in primary care to close the gap in practice (Lillie et al., 2020). Completion of AD paperwork and documentation is an important part of ACP (Wickersham et al., 2019). The primary care setting is an ideal place to start these conversations when a patient is still healthy (Risk et al., 2019). An AD is an important part of the AAAHC's accreditation requirement and/or part of a tribal member's rights to health care (AAAHC, 2018). An aim of this project was to help make healthcare practice change in tribal primary care to include EOL conversations for ACP, documentation completion, and to make ACP for patients a sustainable part of routine healthcare processes through an educational program provided to primary care staff.

The problem statement led to a guiding practice-focused question to address the identified gap in practice, i.e., low instances of ACP conversations and AD documentation. The practice-focused question was: Would an ACP tool kit provided to primary care providers and other staff members in an educational program enable greater instances of ACP conversations with NA patients? The project was planned to address the gap in practice. The staff education project with the help of a tool kit based on research evidence was planned to help improve ACP conversations and documentation.

Nature of the Doctoral Project

The purpose of this education project was focused on improving ACP conversations between healthcare providers and NA tribe and increasing documentation. The education project was created to help improve the knowledge, skills, and comfort level of healthcare providers in the clinic to help initiate conversations with patients and help them make decisions about EOL. In turn, the education project could potentially improve documentation in patients' electronic health records. The anticipated improved knowledge, skills, and comfort level of staff will help close the gap in practice and address the low to negligible ACP conversations occurring between providers and NA patients.

Sources of evidence were collected to meet the purpose of doctoral project. A self-evaluation was used before and after the education session to assess staff's increase in knowledge, understanding, and comfort with educational material. A quantitative approach was used to assess the effects of the staff education project. A self-evaluation scale was used to assess providers and staff nurses' improvement in knowledge and comfort in discussing ACP. Results of the pretest and posttest assessment were compared after the education project. Wilcoxon signed ranks and Pearson's chi-square tests, the nonparametric equivalents were used to test the hypothesis as the data did not meet assumption of normality. The Wilcoxon signed ranks test was used to compare a paired data of sample population to test group differences in ordinal-level measures within-subjects design per Polit (2010).

Significance

This doctoral project has potential contributions to nursing practice. Creation of an education program can help advance an advanced practice nurse (APN) to a doctor of nursing practice. In this project, I learned how to plan, implement, and evaluate a staff education project using evidence-based practice to bring about a change in practice. This project prepared me to support and bring about social change to the underserved NA patient community. This outcome aligns with the Institute of Medicine's (2010) recommendation for nurses to be at the forefront of healthcare change under Patient Protection and the Affordable Care Act and support healthcare reform. Next, the project helped fulfill the nursing code of ethics in supporting patients in EOL care decisions.

This educational project has the potential for positive impact on patients and their families or loved ones. Improved staff knowledge and training can improve patient and family satisfaction with ACP interventions and support the use of ACP in high-quality EOL care. This education program would also support the clinic in terms of provider reimbursement laws (Wert & Wallace, 2018). Staff education was found to be a crucial component to improve EOL care (Colville & Kennedy, 2013). The training of providers was conducted to increase their awareness of ACP, validate their knowledge and skills, improve their attitudes toward ACP, and lead to positive impact on their clinical practice. The staff educational project was planned to improve healthcare providers' knowledge, confidence, and experiences (Mauleon, 2019).

The project can be replicable in a similar setting with a similar population depending on the practice problem and gap in practice. The findings of the project can be transferable to other tribal health clinics with a similar patient population and setting in the area. If the project remains successful in achieving its goals and purpose, similar educational sessions can be planned and implemented in other tribal health clinics.

According to Walden University (2021), positive social change pertains to creating and applying strategies, ideas, and actions deliberately to promote worth, preserve dignity, and contribute to development of individuals, communities, institutions, cultures, and/or societies. Such changes result in the improvement of human and social conditions (Walden University, 2021). The project was intended to bring social change in the lives of NAs. According to Walden University (n.d.b), through social change, the goal is not only to improve other people's lives but also to make the world better in terms of lasting happiness and personal growth. One person may not be able to change the entire world, but one can put effort into making small improvements or bringing small social changes like improving lives of local communities (Walden University, n.d.b).

This educational project was created to empower the local NA tribal community and concerned tribal members to make better choices about their EOL care that would align with their values and beliefs. Furthermore, the practice change in the healthcare process of tribal healthcare system would lead to improved quality health care. Walden University's mission is to provide an opportunity to career professionals from various backgrounds to transform themselves into scholar–practitioners so they can bring positive social change (Walden University, 2021). As a doctoral student at Walden University, I had to fulfill its mission by using my knowledge and skills learned during the program to promote positive social change in the underserved rural community of NAs.

Summary

There had been low to negligible end-of life conversations and documentation between tribal patients and health care providers in one of the tribal clinics at the project site. A staff education project was planned to improve practice to start EOL conversations and increase documentation in the tribal health clinic. The project implications included improving nursing practice and knowledge, bringing positive social change, closing a gap in healthcare practice, fulfilling accreditation requirement of the AAAHC, complying with nursing code of ethics, and supporting healthcare reform.

Section 2: Background and Context

Introduction

The practice problem pertained to low to negligible EOL conversations and documentation as part of ACP among tribal primary care providers and NA patients. The purpose of the project was to improve providers’ knowledge and confidence in starting such conversations and completing paperwork in the electronic health record system. The staff education project was created to improve providers’ knowledge and comfort with starting such conversations, which, in turn, would improve the quality of EOL care among the underserved rural population of one of the NA tribes. EOL care should align with patients’ beliefs and values. The practice-focused question in this project was: Will education offered to tribal primary care providers regarding using an ACP tool kit increase ACP conversations among healthcare providers and NA patients?

Concepts, Models, and Theories

Advance Care Planning

ACP is an ongoing process of discussing and planning between patients, family members, and/or care givers and healthcare providers to establish values, goals, and preferences for EOL care (Goswami et al., 2020). The product is an exchange of information rather than an act of documentation (Nicholson, 2021). Nurses should engage patients in such conversations formally and informally (Nicholson, 2021). ACP is an essential part of medical care, which is billable and an iterative process that results in completion of an AD and/or medical orders and offers healthcare providers an opportunity to assure patients’ goal-concordant care at EOL (DiBello, 2021). These decisions might be related to use of emergency treatments or several artificial and mechanical ways of keeping a person alive, e.g., cardiopulmonary resuscitation, ventilator use, artificial nutrition, or comfort care (National Institute of Aging, n.d.). There is a large variation in definitions and content in ACP, study designs, implementation strategies, and outcomes (Flu et al., 2016). Usually, healthcare professionals are hesitant to engage in ACP and multiple interventions can help to engage them into the process (Schichel et al., 2019).

Nicholson (2021) compiled a concept analysis and searched various PubMed databases, historical documents, position statements, and dictionary definitions and found 187 articles for review regarding the concept of ACP. Additional documents were reviewed for relevance of the concept (Nicholson, 2021). Three descriptions of the ACP concept were explored (Nicholson, 2021). The proposed concept of ACP was defined, including antecedents (two or more people, willingness to engage in value discussion), defining attributes (communication process and EOL information exchange), consequences (autonomy at EOL, concordance of patient goals, decreased caregiver distress, and cost savings), and empirical references (ADs, physician’s orders for life-sustaining treatment, do not resuscitate orders, living wills, and power of attorney). ACP decreases costs of EOL care and has potential to align EOL with patient values (Nicholson, 2021). ACP is a process of involving patients and/or their loved ones in the conversation when a patient is still able to engage with providers (Nicholson, 2021). There are ways to improve the communication by increasing facilitation and reducing barriers (Nicholson, 2021). Providers can be empowered by developing tools to facilitate and measure communication within ACP. Tools must be validated and reliable among diverse populations to ensure appropriate and culturally sensitive communication (Nicholson, 2021). Barriers include concerns about initiating conversations, discussion too late in the trajectory of illness, and confusion about documentation (Nicholson, 2021). The core process of ACP is the act of communication measured by completion of AD but such completion cannot measure the concept adequately (Nicholson, 2021).

Goswami et al. (2020) conducted a study to determine if ACP initiated by a provider would enhance patient-centered EOL care. Retrospective data were collected using 20 inpatients and 20 outpatients without scanned ADs in their electronic health records at the time of admission or clinic visit and ACP intervention by an advanced practice provider (Goswami et al., 2020). Goswami et al.'s pilot project focused on enhancing patient-centered EOL care as evidenced by an increase in AD completion. The intervention involved face-to-face ACP discussions and reviews of AD documents with patients by providers (Goswami et al., 2020). Providers completed ACP certification prior to intervention (Goswami et al., 2020). The project outcomes included an increase in AD completion rate and a change in code status via ACP discussions (Goswami et al., 2020). Next, a significant difference in AD completion was found between inpatients and outpatients; 11 inpatients and seven outpatients expressed readiness to complete AD (Goswami et al., 2020). Thus Goswami et al. found that ACP allowed for personalized decision making by patients regarding AD and may increase the number of patients cared for outside the hospital or intensive care unit. Limitations included small sample size, possible patient previous knowledge and perception of ACP and AD that could threaten internal validity, convenience in following inpatients more so than outpatients, occurrence of loss of follow-up with outpatients, and limited generalizability as participants had metastatic cancer (Goswami et al., 2020).

Schichtel et al. (2019) used systematic review and meta-analysis to identify interventions that had the greatest potential to engage clinicians with ACP in heart failure patients. Eligible criteria included randomized controlled trials and cluster randomized controlled trials with clinician-targeted interventions, rather than standard professional development, and patients with heart failure (Schichtel et al., 2019). Included studies were required to demonstrate sufficient detail of intervention description, clinicians working in primary and secondary care, and patients in community and hospice settings (Schichtel et al., 2019). The focus was to promote implementation of ACP regarding AD, health proxies, living wills, and durable power of attorney for healthcare by changing clinician behavior (Schichtel et al., 2019). The expected outcome was completion of ACP document or whether the ACP engagement between healthcare providers and patients increased because of intervention. Schichtel et al. performed a quantitative meta-analysis using a random effects model and assessed publication bias using statistical methods. There were 14,175 articles screened, and 131 full-text papers reviewed (Schichtel et al., 2019). Ultimately, 13 randomized controlled trials and one cluster randomized controlled trial were selected. Schichtel et al. concluded that using the right time was the most successful intervention to involve patients and deliver ACP; examples included waiting time before a patient’s scheduled appointment, the point of admission to a hospital ward, and after a recent hospitalization. A lack of support for the patients led to decreased outcomes in terms of AD completion (Schichtel et al., 2019). The types of interventions included patient-mediated interventions, clinician education and training, and reminder system or prompts (Schichtel et al., 2019). Such findings can be useful in considering services or how these ACP services can be introduced by health care professionals.

End-of-Life Care

EOL care is care people receive when they are near the end of their lives and have stopped treatment to cure or control disease (National Institutes of Health National Cancer Institute, n.d.). EOL care involves physical, emotional, spiritual, and social support to patients and their families. The goal of EOL care is to control pain and other unpleasant symptoms of disease so a patient can be as comfortable as possible and die with dignity. EOL care includes palliative care, hospice care, and supportive care (National Institutes of Health, National Cancer Institute, n.d.). EOL care varies according to the healthcare setting (e.g., home-based care, long-term care facilities, or hospital-based care), available resources to provide care, and patients' goals of care or level of care required (Bernazzani, 2016).

Similarities and distinctions exist between EOL care and palliative care. Ufema (2003) mentioned that hospice care fell under palliative care. Hospice care is for those patients who have been diagnosed with terminal illness and have life expectancy of fewer than 6 months, whereas palliative care is provided to individuals with severe illness who need pain and symptom management. Palliative care is not just EOL care and can be received early in illness (National Health Service, n.d.). Palliative care is built on the concept of medical care, and some provide an option of continuing focus on curative care

(Bernazzani, 2016). A patient under palliative care is overseen by interdisciplinary team of healthcare professionals that are also expert in palliative care. Such patients are less likely to require care in intensive care units as the palliative process aligns with patient preferences and can lead to lower hospital costs (Bernazzani, 2016).

Home-based care depends on resources available at home to provide care and long-term care facilities (including skilled nursing facilities and assisted living) provide care to individuals who need higher specialty care than what can be provided in a home setting. Hospital-based care is for patients who desire a more intense level of care that includes specialty units, in-patient general units, and intensive care units (Bernazzani, 2016). Hospital-based care leads to higher health care costs, and hospitals have been found to be the preferred place to die because there is lower caregiver strain (Schwarz & Benson, 2018). The undesirable effects of hospital-based care include dying in the company of strangers, a lack of empathy from physicians, and the existential dilemma of treatment withdrawal per Bernazzani (2016).

Da Silva et al. (2022) conducted an integrative literature review according to PRISMA-P and searched multiple databases. The researchers selected 22 original articles and 14 were classified as evidence Level VI (da Silva et al., 2022). According to the research-based quality of evidence pyramid, Level VI includes case-controlled studies, case series, and reports (Dang & Dearholt, 2017). Da Silva et al. focused on understanding the roles and experiences of professionals, patients, and families on palliative care in primary care, thematic management and organization of health services, and importance of educational services. The studies indicated an insufficiency in professionals’ management and training for palliative care (da Silva et al., 2022). The studies demonstrated barriers like lack of knowledge and skills in primary healthcare, financial systems not allowing palliative care refunds, problems with drug availability policies, lack of structure and professional/specialist support, lack of early identification of patients needing palliative care, and limited understanding of management and population about the care (da Silva et al., 2022). Communication strategies, such as sensitive listening and understandable speech, should be implemented by all health professionals (da Silva et al., 2022). Da Silva et al. suggested training health care professionals through meetings to discuss the theme with specific information about palliative care for different specialties (multidisciplinary in nature) and to sensitize the community about the role and importance of palliative care. The study’s limitations included small sample sizes and use of free online studies that may have excluded studies with theme and in turn use of low-level studies (da Silva et al., 2022).

Schwill et al. (2020) indicated that general practitioners have low confidence in their ability to provide EOL care and little is known about volume and kind of training about EOL among general practice trainees. The researchers compared pre and post comparisons after a 2-day education seminar on palliative care (Schwill et al., 2020). There were 294 general practice trainees who participated (n = 75 in control group and n = 219 in intervention group). There was no difference in sociodemographic characteristics, preexisting experience, or overall expertise between both groups (Schwill et al., 2020). Three quarters (75%) of general practice trainees declared having extended competencies in EOL care after intervention, and 70% indicated the intervention was helpful or very helpful (Schwill et al., 2020). Among participants, 66% expressed a positive attitude toward death, dying, or grief after the intervention and 18% indicated they experienced a change in attitude (Schwill et al., 2020). Schwill et al. concluded that intervention fostered personal competencies, understanding, and self-confidence in EOL care among general practice trainees.

Barra (2021) investigated the association between nursing staff and EOL discussions as conversations deficiency arose from the limited knowledge on advance care documents using a qualitative approach. A staff training was planned to identify staff's own deficiencies that prevented their involvement with AD completion and to develop AD competency. The providers expressed the need for education to prepare them to initiate the EOL conversation and meet the needs of patients and families per study. Major provider concerns included ability to answer questions effectively, responding to patient reactions appropriately, and providing guidance. A convenience sample was selected of nursing staff (n-35). The mandatory in-service class was scheduled in 3-week span to accumulate all required participants to attend 60-minute classes. The nurse educator led the group discussions and semi-structured individual interviews that comprised of transcripts for the data collection. The objective was to acquire thorough information to identify categories and themes. A Colaizzi phenomenological method was applied to create four categories and 11 subthemes from nursing responses and experiences with EOL matters. The four categories included *not qualified to introduce EOL documents, reluctance to get involved, right place, right time, and right words, and who wants to think about death*?

Carey et al. (2019) explored prevalence of barriers and enablers to palliative care provision reported by primary care practitioners. The study was a systematic review of quantitative data-based studies. Inclusion criteria was used for study selection and abstracts were used. There were 21 studies that met inclusion criteria. The barriers were found to be related to bureaucratic procedures, communication between healthcare professionals, primary care practitioners' personal commitments, and skills and confidence. The enablers were providers' education, nurses and trained respite staff to assist with care delivery, better communication between professionals, and templates to facilitate referral to out-of-hours services. A lack of confidence was reported across many areas like treatments, symptoms management, and psychological and communication issues, reflecting the holistic nature of palliative care (Carey et al., 2019). The study suggested better training of providers and addressing barriers. Limitations included use of studies only in English and exclusion of qualitative studies that could have led to identification of broader range of barriers and enablers. Other limitations included limited generalizability, coverage bias among some studies, and unclear report of results in some studies indicated possible risk bias. Strengths included systematic review and methods used for the review (Caret et al., 2019).

Barriers: Lack of Professional Confidence in Staff

Self-confidence refers to a self-assessed belief or confidence in one's own judgments or powers (Holland et al., 2012). Professional confidence can be defined as a dynamic, maturing personal belief held by a professional (Holland et al. 2012). This includes an understanding of and a belief in the role, scope of practice, and significance of profession based on their capacity to competently fulfil those expectations and is fostered through process of affirmation experiences. It should be nurtured and valued to the same extent as professional competence. The confidence underpins the competence, and both are linked to professional identity (Holland et al. (2012).

Lonnbro et al. (2019) investigated whether educational intervention based on collegial discussions on patients' cases could increase interns' professional confidence in prescribing. The participants were recruited at Sahlgrenska University Hospital between years 2014-2016. Inclusion criteria included providers who were in a hospital-based internship program, equal or more than 6 months remaining of year, and signed written consent. Participants were allocated to intervention and control groups. They were stratified by sex, place of degree completion, and whether internship included time for research. The intervention was a short educational program designed to increase interns' knowledge of management of drug treatment in clinical practice. Two 3-hour seminars with time to review and practice between sessions were planned. The effects of intervention were assessed using questionnaire. A total of 57 out of 69 interns completed the study and were included in analysis. The study concluded that structured discussions on pharmacotherapy even for a short duration led to increased self-confidence in prescribing medications among junior physicians. The study's limitation included that control group scored better in pretest so, there was some inherent difference between both groups. Another limitation included that the intervention could not be blinded. Strength includes high participation rate.

Selman et al. (2016) demonstrated the effects of a 2-day EOL care course that increased hospital and community health staff's self-rated confidence, competence, and knowledge It was conducted to evaluate participants' self-rated confidence, competence, and knowledge of EOL care topics. The study used before and after intervention, a self-completion questionnaire with 14-self assessment questions that examined self-confidence and understanding of knowledge pertained to EOL care topics. Means scores were calculated and t test was used. There were 236 staff members who participated in the study including 42% who worked in hospitals and 55% who were employed in a community setting. Most of them were nurses (49%), senior nurses (16%), and general practitioners (15%). The authors suggested that the study's findings had utility for the international policy recommendations to improve palliative skills of generalist healthcare providers (Selman et al. (2016). The study concluded that educational course improved participants' self-rated confidence, competence, and knowledge of EOL care (Selman et al. (2016). Limitations included low sample size, self-assessment after course could lead to bias due to willingness to favorable answers, and self-selection of course by participants could lead to motivated sample.

Similarly, a survey study (cross-sectional) by Ogawa and Nakatani (2020) explored factors related with professional confidence of public health nurses and professional competency. A sample of 1512 public health nurses working in local government agency was selected. A survey questionnaire with demographics characteristics and 34 items on professional confidence was administered. A total of 883 responses were received and 467 were valid. The results indicated that professional confidence was related with technical practice, effortful learning, exploring the evidence, and educators in workplace. The professional confidence underpinned the professional competency (Ogawa & Nakatani, 2020). The limitations of the study were related to the survey design, low return rate that could cause selection bias, biased wording, impersonal, and missing answers etc. (Houser, 2018)

Advance Directives

ADs provide documentation of patients' wishes for future care and promote their autonomy (Goswami et al., 2020). They are statements written in advance by patients about their wishes and treatment preferences if, they lose capacity to make such treatment decisions in the future (Hartog et al., 2014). ACP allows patients to consider future health care decisions (You et al., 2014). Once, one makes a final decision about the future care or whom he/she wants as a proxy, the next step is to fill out the legal papers or AD detailing those wishes per National Institute of Aging (n.d.). There are two elements in AD i.e., a living will and durable power of attorney (National Institute of Aging, n.d.). There are other ACP documents like Do not resuscitate orders/ Do not Intubate orders, Organ and tissue donation, Brain donation, Physician Orders for Life-Sustaining Treatment and Medical Orders for Life-Sustaining Treatment (MOLST), regarding blood transfusion, and dialysis (National Institute of Aging, n.d.). Power of attorney for healthcare pertains to a document naming healthcare proxy or someone to make medical decisions for a person when he/she is unable to do so. The proxy can be named as an agent or surrogate, that is familiar with person's values and wishes (National Institute of Aging (2021). AD is a living document that can be changed as new issues come up while one is still capable of making such decisions per article. Even after preparation of AD, one should revise the document every 10 years or when situation or health status changes per article (National Institute of Aging, n.d.)

Julia-Sanchis et al. (2019) explored viewpoint of mental health professionals toward implementation of Advanced Healthcare Directives (AHDs) in mental health. The study's sample (n-11) comprised of healthcare workers from a province in Spain. The qualitative study used semi-structured interviews that were thematically analyzed. Three main themes were identified i.e. *care planning culture, barriers to practically manage AHDs,* and *reasons to not honor patient's AHDs*. The study suggested that to implement AHDs, improvement of knowledge and awareness of AHDs and management of non-technical skills through training are needed. Such training also should include users and families. Acquiring up-to date perspective on attitudes of professionals toward AHDs allows organizations to address the aspect that need reinforcement. The study further suggested wider awareness, staff training, and new ways of relating to users are necessary to implement AHDs in Spanish context. In order to improve providers' poor levels of knowledge and communication skills, educational AHD projects offering training via simulation in communication, non-technical skills, and latest developments in bio-ethics should be implemented (Julia-Sanchis et al., 2019) The limitations included small sample size, need to address geographical restrictions in future studies, and inclusion of providers that had implemented AHD among mental health users already per study.

Inoue et al. (2018) indicated that agencies funded by Medicaid/Medicare are required to ask patients if, they have AD, and inform patients about their right to have

AD along with information. There is no standard procedure or approach to deliver the information like by who and what information has to be provided. The study's aim was to understand the procedures and challenges faced by, in delivering the information about ADs. So, case study method using semi-structured interview with personnel from nine agencies was planned. The method could enable investigators to explore process and person from each agency, and gain understanding of why there might be variations and discrepancies among nine selected Medicare/Medicaid agencies (Inoue et al., 2018). The data analysis was compatible with Stake's categorical aggregation used in case-study methods. Constant comparative analysis and substantive coding were used during transcript coding. A purposive sampling method was used to recruit participant agencies and 10 agencies agreed to be interviewed and one agency was removed from the list. 30-60 minutes interviews were conducted with every agency participant. After analyzing the data, three overarching themes were identified i.e. organizational procedures, staff interactions, and staff perceptions. Participants indicated that they need to understand that many clients and families lack clear understanding of ADs and nurses and social workers are usually responsible for delivering the information, but it is a collaborative effort. Lack of formal training was addressed by all respondents. Challenges included competing priorities, challenging conversation, and misconceptions. The study results indicated need for AD-specific training for the staff responsible for delivering ADs. So, implementation of formal procedure/guidelines can help to maintain a quality standard across the agencies per study. Limitations included small sample size from geographically defined small area (Inoue et al., 2018), A quality improvement study within a federally qualified health center (FQHC) that was also a patient-centered medical home (PCMH) was conducted to increase AD conversation documentation in primary care by Marino et al. (2021). It was a part of Doctor of Nursing Practice (DNP)-led quality improvement initiative and part of federally funded large project that aimed to improve organization's ability to care for older adults and families. The patient population had 64% Hispanic, 9% African American, and 10% adults over 60 years that had multiple comorbidities. A process map was used to identify strengths and weaknesses of initial process and small-scale changes were made to increase the rate of AD conversation documentation. The Plan-Do-Study-Act (PDSA) cycle guided planning, implementation, testing, and refinement of those changes per study. CPT codes were used to document AD conversation in electronic medical record (EMR) system.

Analysis of the process revealed that providers had sole responsibility for facilitating ACP. Barriers included time allocation for annual wellness visit and time for patient education per Marino et al. (2021). Based on the findings like need for AD, desire to learn more about AD during the encounter with provider, willingness to complete AD during the visit, changes were implemented. To standardize the AD conversation initiation and documentation, a geriatric workforce enhancement program (GWEP) annual wellness exam template was created and added to EMR. The template in EMR prompted questions like if, patient had AD and documentation like completed or not-completed by using CPT codes. Barriers included not having enough time to discuss and complete AD during 15 minutes visits so, ADs were introduced during first check in.

Patient could make a follow-up appointment at the front desk if, wanted. The initiative increased AD documentation to 52% and sustained at 30% afterwards per article.

Semi-structured interviews revealed that GWEP physicians were champions of the project. Race/ethnicity, level of acculturation, and ability to speak English were factors that affected completion of AD. A passive education method like distributing education material was found to be less effective than one to one counseling intervention per article. The limitation of the project was evaluation of the AD documentation completion in EMR or checking actual forms for completeness but, study showed increased AD education and conversation. The project can serve as a model for quality improvement efforts to boost ACP in underserved communities. The findings suggested that multiple disciplines at different times of the visit can effectively compensate for limited time during patient encounters and increasing AD conversation and documentation depends on patient's preferences and goals and provider's attitudes towards importance of ACP, and ease in documentation and/tracking conversations in EMR (Marino et al., 2021).

Atherton (2020) indicated that primary care is the best place for ACP but, many barriers exist. Providers of the Northern Arizona private practice clinic expressed frustration with their current ability and standard of care regarding ADs. The study was a 16-week trial designed to increase the number of ADs and increase primary care knowledge, comfort, confidence, perceived importance, and frequency of discussions about ADs with patients per study. It was a study project in dual-site family practice with team of seven providers i.e. four Doctors of Medicine (MDs), one Doctor of Osteopathy

(DO), two Family Nurse Practitioners (FNPs). Eligibility criteria included employment as PCP at the project site providing care for patients 18 years and older, willing to pretest and posttest, and could use site's electronic health record (EHR). Intervention includes user-friendly AD form that is cost-effective, legally recognized, and easily accessible. Five Wishes form was chosen written in everyday language that guides an individual through process of completing an AD by asking questions regarding personal, spiritual, medical, and legal wishes. It is available in 27 different languages and meets the legal requirement. It is also available online. Interventions were focused on eliminating barriers to ACP through 30-minute presentation for providers and by integrating a user-friendly AD form into the office workflow. The number of ADs increased by 25.4% and there were no significant changes in providers' knowledge, comfort, perceived importance, and frequency of discussions regarding ADs. Limitation of the project was lack of a standard assessment tool for the secondary outcome. It was a pre- and posttest that relied on self-report, which can be affected by many external and internal influences (Atherton, 2020).

Knowledge to Action

Knowledge to Action (KTA) is a conceptual framework for describing the process of moving research evidence into frontline use or closing an implementation gap (White et al., 2020). It has two components: knowledge creation and an action cycle. Knowledge creation pertains to creation of knowledge tools that is a descriptive process by which knowledge about intervention passes through several stages like accumulative evidence, aggregation of evidence, and practical synthesis of evidence per article by White et al.

(2020). The framework provided a frame of reference to organize thinking, guide action, and guide interpretation (Field et al., 2014). The available research evidence was used to prepare tool kit for the staff education or contextualize prior implementation (WHO, n.d.). The action cycle is a dynamic process of knowledge application that is deliberately designed to change current ways and adopt innovative and evidence-based interventions. The action cycle involves identifying problem, adapt knowledge to local context, assess barriers to knowledge use, tailer interventions, monitor knowledge use, evaluate outcomes, and sustain knowledge use (Hamilton Health Sciences, 2021).

According to an article by Simon et al. (2016), Alberta state in Canada had a policy for ACP and goals of care designations (GCD). The state used Graham et al.'s Knowledge to action cycle to evaluate impact and understand how best to implement ACP across the complex system. It included assessing barriers to knowledge for tailoring the implementation of ACP. The study was conducted in various contexts like cancer, senior care, and chronic disease as well as various settings like community, out-patients, and in-patients. The study's results indicated that process capability was mixed around healthcare providers' knowledge and skills. Patient's capability domain to participate depended on previous experiences, perceived personal relevance of ACP, and facilitated by providers' conversation initiations. In opportunity domain, the study identified great need for public engagement and patient preparedness. Healthcare providers and administrators found time and competing priorities as barriers and leadership support as a facilitator. Process barriers included lack of integrated EHR, role confusion, and absence of ACP in routine care by peers. Facilitators included perceived benefits to ACP and

GCD to patients. The authors indicated, study findings helped to target interventions to enhance ACP and GCD uptake. The team process improvement intervention and strategies to enhance public participation were planned. So, combination use of KTA and theoretical behavior change model proved powerful in addressing policy implementation.

Relevance to Nursing Practice

Nursing role in ACP, EOL care, and AD is well documented in literature from various perspectives. Nursing advocacy in improving the EOL care by supporting ACP with culturally appropriate information to help patients make EOL care decisions that align with their values and preferences is a critical component of quality health care (Lillie et al., 2020; Hunsucker, 2012; Zagner, 2011). Nurses, as front-line workers, and APNs in multiple settings are well positioned in this role to address issues with ACP, EOL care, and AD. Historically, an evolving concept of self-determination, the Patient Self-determination Act (Federal Law) with varied state laws, and American Nurses Association's Code of Ethics defined nurses' obligation to educate patients and advocate for their legal right to self-determination (Miller, 2017). According to Miller, the American Nurses Association (ANA) Code of Ethics (2017) requires nurses to provide patient education about ACP and be knowledgeable to discuss different types of AD. Health care providers do not feel comfortable or confident talking about the EOL care and start ACP that leads to AD completion (Nassikas et al., 2020; Selman et al., 2016). Multiple studies consistently provided evidence that provider education can lead to increased ACP documentation and AD completion.

As compared with white peers, NAs are less likely to have AD, living will, or durable power of attorney of healthcare (Kwak et al., 2019). Colclough and Brown (2018) found that 76% of Blackfeet Indians were comfortable in talking about dying if that did not violate their cultural beliefs. Studies by Carresse and Rhodes (2000), Hansucker (2012), and Lillie et al. (2019) provided guidance how to include cultural preferences and values while discussing ACP among NAs. A study by Zager and Yancy (2011) indicated that education of healthcare providers on cultural differences and how to lead discussions promoted ACP.

The Five Wishes form was found to be the most preferred AD form due to its' easy-to-follow nature and other document qualities as compared to other AD forms (Wickersham et al. (2019). Lillie et al. (2019) mentioned that it is important to include cultural values and priorities into ACP, determine who the patient wants to involve during the conversation, and consider local and culturally relevant barriers and facilitators. AD completion rate documenting patient preferences regarding EOL care can be increased by patient directed interventions (Atherton, 2020; Patel et al., 2021). Marino et al. (2021) found importance of one-to-one counseling in AD completion. A study by Ogawa and Nakatani (2020) indicated that professional confidence was related with technical practice, effortful learning, exploring the evidence, and educators in workplace. The professional confidence underpins the professional competency. So, the DNP project focused on provider education using education tool kit to cover the gap in practice related to low incidence ACP discussions in tribal primary care clinic.

Local Background and Context

The tribal population is one the rural and underserved community. The incidence of ACP conversations between healthcare providers and NAs in primary care clinics (one of the tribal health care systems) was almost negligible per conversations with providers and data from EHR documentation gotten by the clinics' administration. The providers did not feel confident enough to start such conversations and felt uncomfortable with the topic. According to the AAAHC, ACP discussions' documentation and AD completion as appropriate are important part of primary care system's accreditation (AAAHC, 2018). Supporting EOL care by providing culturally sensitive patient-centered information during ACP to help patient self-determine about EOL care is one of the important nursing roles per nursing code of ethics written by ANA (Miller, 2019).

Again, tribal health care is part of IHS and federally financed system that requires quality health care for this underserved population and compliance with federal and state requirements and professional code of ethics. The IHS's mission is to raise physical, mental, social, and spiritual health of American Indians to highest level per IHS website (n.d.). Its' vision is to have healthy communities and quality health care system through partnerships and culturally responsive practices. The IHS's one of the strategic goals is to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to NAs (IHS, n.d.). So, it was important to investigate if, the education provided to healthcare providers via education tool kit would increase providers' participation in ACP with tribal members.

Tribal system comprised of multiple health clinics/centers providing various levels of medical services in the rural area out of which, some of them are satellite and some are full primary care clinics per tribal website. There are approximately 25-30 healthcare providers including physicians, mid-level providers, and nurses that work there. These tribal centers provide primary or general care to this underserved community of NAs.

Role of the DNP Student

I planned DNP project in one of the tribal health care systems and I am also enrolled in the DNP program. I noticed that the system's provider participation in ACP among this rural underserved population was almost negligible. Such gap-in-practice leads to EOL care that does not align with patients' cultural preferences and wishes (Pearce et al., 2019). So, it was important for these patients to get patient-centered culturally sensitive information/ options during ACP discussion that would support these patients in self-determination about their EOL care. It is nurses' professional duty to advocate for quality healthcare for these patients that is also part of IHS system's strategic goal and AAAHC accreditation requirement. The literature review done to address the issue consistently indicated important role of healthcare providers' education in filling the practice gap in health care delivery among NA population (Lillie et al., 2020; Zagner & Yancy, 2011; Simon et al., 2016). The DNP project was directed toward filling the practice gap in healthcare system through education of the concerned providers.

My educational institution's mission is to prepare diverse community of career professionals with an opportunity to transform themselves into scholar-practitioners so, they can bring positive social change (Walden University, n.d.). By being a DNP student at the institution, the planned DNP project gave me an opportunity to bring social change in the lives of NA community. I hypothesized that the tribal members would be able to make better choices about their EOL care that would align with their cultural preferences and wishes.

Being a provider at one of the tribal systems, I was motivated to bring practice change in the collaborating tribal institution and was curious if, the planned interventions based on the research evidence would be effective in this practice environment. The project held significance to me as it would benefit this underserved community and I realized that ACP conversations were difficult for all the involved parties so, the literature search provided tools to facilitate such practice. Being in a role of principle investigator, I explored literature for background information for deeper understanding of the issue among NA population and staff education tools to address the issue. Some of the foundational work was completed under the supervision and guidance of my mentor. Further foundational work was completed during practicum hours to support the project development, implementation, and evaluation. I did not notice any personal, financial, or commercial biases that might have impacted the nature of this DNP project.

Summary

In Section 2, I explored the concepts and theories to guide the project e.g. ACP, EOL care, AD, and Knowledge to Action framework. Literature was reviewed for deeper understanding of concepts i.e., definitions, background, and application in the practice context and population. The section highlights how staff education increases the likelihood of promoting comfort and confidence of the institution's staff in starting ACP conversations, supporting EOL care decisions, and AD completion. Additionally, this section gave me an opportunity to put light on and connect the project's relevance to nursing practice, local background and context, and my role as a DNP student.

Section 3: Collection and Analysis of Evidence

Introduction

Health care providers play an important role in encouraging and supporting ACP for EOL care and completion of ADs. Primary care is an ideal place to start ACP as patients are still healthy and can self-determine the EOL care options that align with their values and preferences (Wickersham et al., 2019). I work in one of the tribal systems for one NA tribe and was interested in improving healthcare among NA tribal communities. At one of the tribal primary care sites of my collaborating institution, it was noted that incidence of ACP conversations and documentation between the primary care providers and patients were very low to negligible. During conversations, the primary care providers expressed a lack of confidence in their skills and knowledge about how to start conversations of ACP and EOL care. The providers expressed a need for more education on the topic. Multiple barriers exist that limit health care providers starting such conversations, including discomfort with the topic, lack of confidence in knowledge and skills regarding the topic and options, and patients' values and preferences (Goswami et al., 2020; Nicholson, 2021; Risk et al., 2019).

I conducted a literature search and review to explore various relevant strategies to overcome the barriers to ACP among NA populations (Risk et al. 2019). Multiple strategies have been proposed based on the research evidence that could be effective in improving healthcare providers' confidence in starting and facilitating these conversations or discussions. Although tribal members may vary in how much they follow their culture and traditions, the cultural concept of death and dying is an important part of most NAs' beliefs (Colclough & Brown, 2019; Isaacson, 2017). Therefore, primary healthcare providers should have tools on how to proceed with such conversations with NA patients. The implementation of staff education promotes staff knowledge and skills, which can lead to increased provider confidence and comfort in starting ACP conversations (Selman et al., 2016). In previous sections, I have explored the rationale for the project, provided the theoretical framework to guide the project, and discussed local background and context. This section includes the practice-focused question, sources of evidence, details of the literature review, analysis, synthesis, and a summary conclusion.

Practice-Focused Question

Low to negligible incidences of ACP conversations between providers and NA patients in the tribal clinics reduce NA patients' opportunities to learn about EOL options and to make decisions about EOL care based on their preferences and values. For the project, I wanted to investigate if, the staff education could lead to an increase in primary care providers' comfort and confidence in starting ACP conversations and fill a gap in practice. Based on the literature review to address the practice issue, I developed the following practice-focused question: Will staff education based on the education tool kit lead to an increase in primary care providers' confidence and comfort in starting ACP conversations with NAs patients? An answer to the question was demonstrated by comparing the pretest and posttest scoring before and after a staff education intervention in one of the tribal health systems.

The staff education project was planned using education and a tool kit prepared from the evidence gathered during the literature review. During the education program, I presented various effective strategies based on the latest research evidence to support ACP conversations about EOL care. Pretests and posttests were used before and after the staff education to assess any changes in primary care providers' comfort and confidence level regarding starting ACP conversations.

Sources of Evidence

The research evidence used to answer the practice-focused question, develop the education intervention, and create a tool kit was gathered using various search engines in the Walden University library. An extensive literature review was performed to gather evidence regarding best interventions to address the practice-focused question or to facilitate practice change or improve ACP discussions in the primary care setting of a tribal health system and to gather information in relation to various concepts related to ACP and cultural sensitivity. The research articles including individual studies, systematic reviews, and integrative reviews to define and explain the topic, including its concepts, understanding of ACP, EOL care, and completion of AD, factors impacting ACP and completion of AD, and impact of staff education on improving the ACP process/communication, were selected and reviewed for evidence.

The evidence from various sources was analyzed for consistency or any conflicting research evidence to increase knowledge about the evidence-based interventions for the practice change or to answer the practice-focused question. The research evidence consistently pointed toward intervention, i.e., staff education, including culturally sensitive information. This leads to an increase in ACP initiation and discussions among patients and providers. The information can include EOL care options, AD forms, and information on how to include culturally sensitive information when initiating ACP among NA patients and families. The literature evidence consistently suggested that such interventions lead to an increase in knowledge and confidence among health care providers and in turn results in increased ACP discussions among health care providers, patients, and their families. The staff education project's goal was to assess if the education tool kit (based on research evidence and culturally sensitive information) regarding ACP and EOL care would increase knowledge and confidence of staff to initiate ACP discussions with NA patients and their families or loved ones in the tribal health system.

Published Outcomes and Research

Research evidence related to practice issue, concepts, and theory or framework was explored using various electronic databases like CINAHL and Medline combined, Ovid, EBSCO, ProQuest, and Google. Peer-reviewed primary and secondary research sources were reviewed. Literature regarding ACP, EOL care, cultural sensitivity in ACP, and AD in various settings, including primary care, related with NA populations was also explored. Effort was made by using Boolean search strings on the subject related to NAs, American Indians, Alaska Indians, Indigenous people, health care providers, nurses, general practitioners, knowledge, attitudes, confidence, hospice care, palliative care, ACP, AD, EOL care, and staff education. The search was limited to literature available in English and published between 2016 and 2021. Some seminal articles were selected published between 2000 and 2015 to look at historical perspectives on practices and concept evolution. All literature was reviewed and summarized for the project. The literature was focused on adult and elderly patients in various settings related to ACP, EOL care, and AD. About 46 research articles were used to create a literature review for the project. Overall, the literature review demonstrated consistently that staff education in various healthcare settings can lead to increased knowledge and confidence of healthcare providers to initiate ACP discussions among healthcare providers and their patients.

Evidence Generated for the Doctoral Project

A lot of research evidence was generated for the project starting from topic concepts and their importance in relation to staff education interventions including their impact or outcomes as assessed by the respective researchers. An evidence-based education tool kit including decision aids like the Five Wishes AD form and other culturally sensitive education material were prepared for translation of research evidence into practice. The health care provider or staff education training was focused on ACP principles, AD forms, patient education materials, and how to help patients with AD forms completion (Marino et al., 2021). The knowledge-to-action framework was used in varying degrees of completeness to close the gap in practice (Field et al., 2014). The knowledge-to-action framework was used to guide the plan of action; identify the gap in practice (low to negligible incidences of ACP conversations) and reason for the gap; review literature for planning interventions or gathering knowledge to promote ACP conversations or to close the gap; adapt knowledge to the local context of the NA population; assess barriers/facilitators to knowledge use; and select, tailor, and provide culturally sensitive interventions for staff education in the form of tool kit (Crockett, 2017). The pretest and posttest were used to assess outcomes of the staff education (Atherton, 2020; Selman et al., 2016).

Participants

Participants in the DNP project were staff members of the tribal organization, and Walden University policy encouraged me to use the word *learner* for participants. The learners in the project were healthcare providers including physicians, certified nurse practitioners, physician assistants, registered nurses, licensed practical nurses, certified nursing assistants, and medical assistants. The total learners who participated in the education project were 27 staff members from three tribal primary care clinics. Although there were five clinics that were originally interested in the education, only three sites participated in the workshop. The written material and online resources were made available to the learners for education. Due to the high staff turnover rate in the rural area, the number of learners varied somewhat during the intervention and data collection phases. The selection of the learners was dictated by the practice-focused question. Certified nursing assistants and medical assistants were included in the education interventions because, due to extreme staff shortages in the area, they were trained to cover certain nursing tasks and could be considered as a part of the nursing team. Sometimes, certified nursing assistants and medical assistants were cross trained to perform dual activity of being at the front desk as a clinic receptionist and help nursing staff by performing certain nursing activities, like taking vital signs, providing handouts or forms for signature, and asking certain basic questions regarding health for data collection.

The project's objective was to increase staff knowledge and confidence in initiating ACP discussions with tribal patients. The research evidence suggested that evidence-based education interventions could improve knowledge and skills of staff that, in turn, could lead to increased confidence and comfort of staff in discussing ACP with patients. The interventions were created to improve practice and close the practice gap or address the project question. The tribal health system staff were the focus of this project's educational interventions. The primary care clinics of the system are mainly run by health care providers like doctor of medicine (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), physician assistant (PA), certified nursing assistant (CNA), and medical assistant (MA). These care providers were selected as learners in the project. Staff members' role differentiation regarding ACP discussions was provided during education session. The certified nursing assistants and medical assistants could ask patients if they already had an AD and could provide handouts if asked by patients. These staff members were educated to direct patients' further questions regarding ACP to doctors, nurse practitioners, and physician assistants. They were taught where to document information in a patient's electronic medical record in the system.

Procedures

A combination of educational strategies is more effective in improving knowledge and skills of the learners than a single strategy. The education tool kit covered the various aspects of curriculum. As part of the staff education project, the aggregated tool kit covered multiple topics ACP, EOL care, and AD, the concepts, including cultural sensitivity in initiating discussions with NA patients and their families or loved ones, and addressing barriers to practice. I e-mailed the agenda and overview of the topic and contents prior planned education activity to all staff members selected for the intervention. I sent two personal reminders about the education project's objectives, agenda, and presentation dates to get the attention and prepare for the upcoming activity. A pretest was administered before starting the instruction. Tool kit and educational agenda are included in Appendix A. At the end of the instruction, posttest was administered.

The intervention period lasted for 8 weeks due to multiple sites of the tribal health system. The visual aids and written material were kept in their break rooms for review and to reinforce the learning. Staff education (face to face due to the sensitivity of the topic) was provided in one 45 to 60 minutes session (total of 60 minutes education intervention) depending on the time availability of providers on site due to their busy schedules. The period of 2 weeks at every site helped to include the staff members that missed first time. There were five primary care clinics so, I visited three small clinics for two weeks and two large clinics for two weeks. Due to the providers' busy schedules, I selected lunch time or end of the patient schedule day so, the staff can give full attention. A lunch and learn or evening coffee (after patient schedule time) for ACP education meeting were scheduled depending on what time would work best for the staff and clinic at the time. To keep the instruction standardized for every clinic, same criteria and style was used to meet staff's learning objectives. Case studies and role play were included as part of the curriculum for providers to promote learning through personal engagement and help them experience different scenarios based on the barriers to ACP.

A full description of the education and tool kit can be found in Appendix A. References from the review of the literature are included, as well as a thorough description of the roles of multidisciplinary team. The tool kit provided resources to answer providers' questions regarding ACP. Role differentiation included, what the CNA/MA expected to do differently in their job role after the educational program? What role the RN and LPN played in ACP? What tools and documentation responsibilities would the providers use (MDs, NPs, PAs)? The ACP topic could be sensitive and attention to role play, case study review and discussion were important to engage the learners and assure a change in practice occurred after the education was provided. Information regarding various facilitators and barriers to ACP including how to start the ACP conversations were provided in the tool kit. See Appendix A for the curriculum and tool kit.

The data analysis led to the assessment of the educational outcomes (See Appendix A for the components of the tool kit). The questionnaires were formulated after reviewing multiple previous studies that used Likert scale to assess confidence, knowledge, and comfort levels of the learners in the education projects. Selman et al. (2016) used a before and after design using self-completion questionnaire with 14 questions examining confidence, understanding, and knowledge of EOL care topics. Lonnbro et al (2019) used questionnaire before and after education intervention to assess change in self-rated confidence and knowledge. Ogawa and Nakatani (2020) used professional confidence questionnaire developed from literature review to examine confidence before and after self-improvement intervention.

The reliability of the scale was checked by calculating Cronbach's alpha (0.852) using SPSS software. Cronbach's alpha measured internal consistency between the items of the scale. Cronbach's alpha coefficient was calculated using SPSS software v.28 to check the internal consistency reliability of the questionnaires. Validity had already been established (Lonnbro et al., 2019). The questionnaire was mainly developed to measure the self-reported comfort and confidence in applying the knowledge about ACP in clinical setting with patients. Content or face validity was assessed using three healthcare providers panel at the clinic. Increased knowledge and skills of the staff via education project leads to increased confidence and comfort with the content and its use per Ogawa and Nikatani (2020). Still, the questions about the change in knowledge related to the content/concepts (AD, ACP, EOL care) were added to assess the difference in knowledge before and after education intervention as compared with change in comfort and confidence. The sample was small (*n*=27) and data did not meet the assumption of normal distribution. The Wilcoxon signed-rank test was used to analyze change in confidence, attitudes, comfort, and knowledge of nursing and other primary care staff's pretest and posttest scores during analysis. Additionally, Pearson's Chi-Square test was used to analyze change in cultural competency scores (pretest and posttest) of primary care team.

The DNP project data was generated by administering pretest and posttest questionnaires to the same group of staff learners in primary care clinics of the tribal health system (Appendix B: Confidence, Attitude and Knowledge About ACP Pretest/Posttest). The tests were administered before and after education interventions. The education presentation was provided to the nursing and medical staff through face-to-face instruction/ discussion using power point (See Appendix A; Curriculum and tool kit). Hard copies of the education material in the tool kit were provided to each individual learner during education session. Role-play and case studies were included in the curriculum to engage learners (See Appendix B). According to research, engaging students in a learning process increases their attention and focus, motivates them to practice higher-level critical thinking skills, and promotes meaningful learning experiences (University of Washington, 2021). Two education sessions were held at four sites with one session every week and one session held at fifth site. Three sites were scheduled within the same weeks. The visual aids like posters or additional resources for the staff were made available either in the break room or with clinic's staff resources so, the staff had access to educational material during break time and visual aids for the memory. The DNP student remained available during intervention period (for two weeks) via phone, personally, or via e-mail to answer staff members' questions.

Both, pretest and posttest questionnaires had similar sixteen questions to assess learners' knowledge about the educational content, attitudes as well as comfort levels regarding various aspects of the topic i.e. theory and practice, and cultural competency before and after interventions (Appendix B: Confidence, Attitude and Knowledge About ACP Pretest/Posttest). The tests were formulated by DNP student based on the scope of educational content, staff's learning objectives, and questionnaires used in the previous similar studies (Lonnbro et al., 2019; Ogawa & Nakatani, 2020; Selman et al., 2016). The pretest included additional six questions regarding learners' demographic data like age, number of years in the medical field, gender, previous training in ACP, and education level to explain reason for any skewed data results or check for the effects of extraneous variables later or at the end of project during discussion. Five-point (odd) Likert scale was used in the pretest and posttest questionnaires to measure learner's attitudes/comfort level toward certain statements pertaining to educational content and practice (Survicate, 2021). The Likert scale assessed staff's agreement, importance, and likelihood of action. Odd Likert scale helped to rate the neutral responses also (Survicate, 2021).

The Likert scale quantified the responses with 1 being strongly agree and 5 being strongly disagree. Open ended question was added to the posttest to explore staff's opinion about the education content or give suggestions for future staff education projects. The yes and no questions (seven) and true/false questions (three) with neutral response tested concrete knowledge about the topic, cultural competency, and previous experience/training pertaining to ACP. Such questionnaires assessed staff members' understanding of concepts, confidence in using knowledge to initiate the discussions, and finding/documenting information on the topic in patients' charts. Open ended question was added to the posttest for the learners to suggest if, they would like to include any more information about the topic into the education tool kit or had any suggestions to improve their future learning.

The pretest and posttest questions regarding attitude and comfort were formulated after reviewing previous questionnaires used in previous studies (Lonnbro et al., 2019;

Ogawa and Nakatani, 2020; Selman et al., 2016). Questions regarding cultural competency and knowledge about the topic were formulated while taking multiple factors into account like relevance to the educational content and learning objectives, length, staff's educational level, cultural or language adaptation, avoidance of leading or biased questions, avoiding asking two questions in one, mixing positive and negative questions, and sampling (Empower, n.d.). See Appendix B for the questionnaires used before and after the education offered in this project.

Protections

The educational program and data collection for the project started after approval from Walden University's Institutional Review Board (approval # 03-18-22-0370395) and site approval from the collaborating institution IRB/Medical Director. The questionnaires were kept anonymous and names of the participants and/or institution were not used during data collection or data saving processes. As the educational program was part of the professional staff's ongoing and continuing education, communication/ message that the education project would improve patient care and professionals' confidence, knowledge, and comfort regarding ACP served as an intrinsic motivation for them (Recognition Professionals International, n.d.). And, providing a certificate of participation in ACP training (a token of achievement) served as extrinsic motivator for the staff (DeakinCo., 2017).

Analysis and Synthesis

The education project was a primary analysis of the survey questionnaire data. The primary data is generated by the researcher herself/himself through surveys, interviews, experiments that were designed for understanding and solving research problem at hand (Benedictine University, 2021). The benefits of such data included that data was more accurate and reliable, was a real time data, and was specific to the PICO question (Benedictine University, 2021). The advantages to use such method of data collection included that it could be anonymous, non-threatening in collecting data, easy to compare and analyze regarding pretest and posttest, and could be developed easily as similar questionnaires were used in previous studies. The challenges included that wording could bias client responses, impersonal, and might not get careful feedback (Benedictine University, 2021). The validity and reliability of the instrument and/or questions were checked in the previous studies and by the researcher to address such concerns. The collected data was analyzed using SPSS software to examine the difference in confidence, knowledge, and comfort scores before and after education intervention.

After obtaining the data, total number of participants were assessed including their demographics like age, highest education level, gender, religion, and number of years in medical field. The nature of the data was qualitative and quantitative however, the project focused on quantitative data. Regarding the change in knowledge, I assessed the change in scoring related to practical knowledge about ACP, AD, and EOL care (concepts). In case of assessing attitudes, confidence, and comfort, I analyzed the learners' self-reported scoring of agreement with the statements. The goal of the project was to improve healthcare providers' confidence and comfort in starting ACP conversations with patients. Few questions to examine the knowledge were added to assess if, there was an actual improvement in knowledge also along with confidence and comfort to be analyzed later. Demographic data could explain the skewness of the data later in the analysis.

Summary

The staff education project included literature search and evaluation of the gathered evidence to address practice gap, implemented effective staff education interventions to improve ACP in primary care setting, instrument to assess outcome of the education project, assessment of validity and reliability of the instrument, identified participants, procedures, protections, and data analysis.

Section 4: Findings and Recommendations

Introduction

This DNP project was focused on improving ACP conversations and AD documentation among health care providers and tribal patients and their family members and loved ones. Primary care has been considered an ideal place to start ACP conversations, when patients are still healthy enough to make decisions about their EOL care that align with their values and preferences (Wickersham et al., 2019). Such ACP conversations and AD documentation were found to be very low to negligible in one of the tribal health systems that was the project site.

During problem assessment, providers verbalized a need for more education about ACP, EOL care, and ADs. Providers expressed a lack of confidence and knowledge regarding such conversations despite knowing that ACP is an important part of patient healthcare. This lack of ACP conversations represented a gap in practice for the project site. The gap may have been related to cultural differences and discomfort with the subject.

Multiple barriers and facilitators for ACP conversations were identified during the literature review. Barriers included discomfort with the topic of ACP, lack of health care provider knowledge and skills regarding the topic and AD options, and patients' values and preferences (Goswami et al., 2020; Nicholson et al., 2021; Risk et al., 2019). The problem statement led to the guiding practice question to address the identified gap in practice. The practice-focused question was: Will staff education based on an education tool kit provided to primary healthcare providers and their staff members lead to an increase in confidence and comfort in starting ACP conversation with NA patients in the tribal health system project site?

The staff education project was planned to improve learners' knowledge regarding the topic and how to include cultural sensitivity in ACP conversations. Content for the education session was selected based on the practice question. Primary data to assess outcomes were collected by using pretest and posttest questionnaires. The pretest and posttest questionnaires were developed based on the educational content and sample instruments from similar studies. The Cronbach alpha was 0.852. Psychometric properties of such instrument in nursing have been established already (Cadorin et al., 2017; Osmancevic et al., 2021). The content validity of the instrument was checked by a panel of three healthcare providers at the tribal clinic. The pretest and posttest were conducted before and after the education lesson to determine improvements in self-rated attitude and comfort in initiating ACP conversations with patients, change in knowledge, and improvement in cultural competency of learners. SPSS software was used to analyze the data to find any changes in scores by comparing pretest and posttest scores.

Findings and Implications

Face-to-face education was provided to 27 primary care clinic staff members. Participation by learners in the education project was voluntary. Survey data were collected from three sites (clinics) before (pretest) and after (posttest) and analyzed using SPSS software. The demographic data were analyzed to calculate learners' frequency related to age, highest level of education, gender, previous training in ACP, and number of years in medical field. Table 1 presents the ages of participating learners; frequency of learners with more than 50 years age group dominated all other age groups. Table 2 shows the education level of learners. Table 3 presents that the female-to-male gender ratio was 8:1; there are more female healthcare providers than male healthcare providers in these rural clinics. Almost half of the learners mentioned previous training in ACP per analysis (Table 4). Finally, Table 5 presents learners' number of years in the healthcare field.

Table 1

Ages of Participating Learners

Age	Frequency
18–24 years	1
25–30 years	1
31–39 years	7
40–50 years	7
>50 years	11
Total	27

Table 2

Participating Learners' Highest Level of Education

Highest level of education	Frequency
High school	4
Some college	5
Associate degree	5
Bachelor degree	5
Master's degree	5
Doctorate in nursing	1
Doctor in osteopathic medicine	2
Total	27

Table 3

Participating Learners' Genders

Gender	Frequency
Male	3
Female	24
Total	27

Table 4

Participating Learners' Previous Training in Advance Care Planning

Previous training in ACP	Frequency
Yes	14
No	13
Total	27

Table 5

Participating Learners' Years in Medical Field

Time in medical field	Frequency
Fewer than 2 years	9
2–5 years	2
5–10 years	3
10–20 years	5
20–30 years	8
Total	27

The pretest and posttest questions (Questions 7 to 12) to check change in learners' attitudes were explored for any missing values; there were no missing values. The data were explored by comparing added preintervention attitude scores with postintervention scores as the answers varied between 1 = *strongly agree* and 5 = *strongly disagree*. When summed across all six attitude items, a high score of 35 indicated negative attitudes toward ACP and a low score of 6 indicated more positive attitudes. The differences between preintervention attitude scores' mean (17.2963, with standard error 1.00825) and postintervention attitude scores' mean (11.6296 with standard error .78473) were compared using non-parametric Wilcoxon-signed ranks test because the data were not normally distributed and because the observations were paired. The difference between the means led to the conclusion that learners indicated more positive attitudes after the staff education intervention. The test findings (Table 6) showed a statistically significant difference between the preintervention and postintervention attitude scores, or the attitudes toward ACP were more positive after staff education intervention ($z = –3.918$, $p < .001$).

Table 6

Wilcoxon Signed Ranks Test on Preintervention and Postintervention Attitude

Ranks		N	Mean rank	Sum of ranks
Post attitudes	Negative ranks	20[a]	14.35	287.00
Pre attitudes	Positive ranks	4[b]	3.25	13.00
	Ties	3[c]		
	Total	27		

a = Post attitudes > Pre attitudes
b = Post attitudes = Pre attitudes
c = Post attitudes < Pre attitudes

Test statistics Post attitudes – Pre attitudes	
Z	–3.918
Asymp. sig. (2-tailed)	<.001

a = Wilcoxon signed ranks test
b = Based on positive ranks

The change in knowledge of learners was compared using the same questionnaire instrument before and after the education session. The pretest and posttest scores were added separately for comparison. Five questions pertaining to knowledge had yes and no responses and three questions had responses of *true*, *false*, and *don't know*. The total knowledge scores ranged from as low as 8 to as high as 19.8. A low score of 8 indicated a participant answered all 8 questions correctly. There were no missing values. The preintervention knowledge total scores mean was 12.6296 and the postintervention knowledge total scores mean was 8.4815. There were more correct answers after training than there were before the training. The tests of normality indicated the data were not normally distributed. Wilcoxon signed ranks test, a nonparametric was used to test the significance of change in knowledge (Table 7). The findings indicated statistically significant improvement ($z = -4.406$[b] and $p < .001$) in knowledge after the education program.

Table 7

Wilcoxon Signed Ranks Test on Preintervention and Postintervention Knowledge

Ranks

		N	Mean rank	Sum of ranks
Post knowledge Pre knowledge	Negative Ranks	25[a]	13.94	348.50
	Positive ranks	1[b]	2.50	2.50
	Ties	1[c]		
	Total	27		

a = Post knowledge < Pre knowledge
b = Post knowledge > Pre knowledge
c = Post knowledge = Pre knowledge

Test Statistics[a]

	Post knowledge Pre knowledge
Z	–4.406[b]
Asymp. sig. (2-tailed)	<.001

a = Wilcoxon signed ranks test
b = Based on positive ranks

The change in cultural competency was analyzed using pretest and posttest scores on Questions 13 and 14 related to cultural sensitivity. Two cultural sensitivity questions tested the cultural competency of learners using yes and no responses. Question 13 and Question 14 scores were analyzed separately using Pearson's chi-square tests. A chi-square test of independence is used to assess whether a relationship exists between two categorical variables, and Pearson's chi-square test determine whether the data are significantly different from expected (Pilot, 2010). No statistically significant differences were found between pretest and posttest scores for Questions 13 (see Table 8) and 14 (Table 9). No measures of association were computed for crosstabulation of pretest and posttest scores regarding Question 14. In such case, at least one variable in each 2-way table upon which measures of association were computed was a constant per SPSS analysis. No statistically significant differences pre to post intervention were found as everyone answered correctly in the posttest. The reason for such unexpected finding was likely due to the small sample size and preexisting knowledge.

Table 8

Chi-Square Tests on Cultural Competency-Pre/Post Question 13

Chi-square tests question 13: All Native Americans carry the same value and preferences regarding life and death

	Value	df	Asymptotic significance (2-sided)	Exact sig. (2-sided)	Exact sig. (1-sided)
Pearson Chi-square	.297[a]	1	.586		
Continuity correction[b]	.000	1	1.000		
Likelihood ratio	.514	1	.474		
Fisher's exact test				1.000	.778
Linear-by-linear association	.286	1	.593		
N of valid cases	27				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is .22.
b. Computed only for a 2x2 table

Symmetric measures			
		Value	Approximate significance
Nominal by nominal	Phi	-.105	.586
	Cramer's V	.105	.586
N of valid cases		27	

Table 9

Chi-Square Tests on Cultural Competency-Pre/Post Question 14

Chi-square tests on Question 14: All Native Americans do not like to discuss EOL care and having and AD.

	Value
Pearson chi-square	.a
N of valid cases	27

a. No statistics are computed because POST: All Native Americans do not like to discuss EOL care and having an AD is a constant.

Symmetric measures		
		Value
Nominal by nominal	Phi	.a
N of valid cases		27

Notes. No statistics are computed because POST: All Native Americans do not like to discuss EOL care and having an AD is a constant.

Implications

The staff education project was conducted to improve ACP conversations between healthcare providers and patients as well as their loved ones. ACP is an important part of quality healthcare. The research evidence consistently pointed that the staff education could lead to increase in comfort and confidence or attitudes of health care providers in starting such conversations and documentation (Ogawa & Nakatani, 2020; Selman et al., 2016). The project findings confirmed the previous research that staff education of healthcare providers leads to learners' improved knowledge, self-rated comfort, confidence and attitudes in starting ACP conversations and documentation. The initiation of ACP conversations by the providers will support patients and their loved ones to make better decisions about their EOL care that would align with their cultural values and preferences. By addressing the gap in practice, the healthcare organization will satisfy the AAACH's requirement of making ACP a part of routine quality primary healthcare. It will also help nurses meet their ethical obligation of supporting patients' and/or tribal community's self-determination (while they are still healthy) about their EOL care in case they become incapacitated later in life. Such EOL care will align with their cultural values and preferences and will help them die with respect and dignity. Additionally, such practice will lead to social change in this tribal community as it will improve their EOL care. It will also align with Walden University's mission of transforming DNP student into scholar-practitioners that will bring positive change in the community where he/she works or lives (Walden University, 2021).

Ethical Implications

According to Schroder-Back et al. (2014), public health ethics are evaluated based seven principles i.e. non-maleficence, beneficence, health maximization, efficiency, respect for autonomy, justice, and proportionality. The staff education project meets the ethical principle of beneficence as it will benefit tribal patients' (target population) decisions about their EOL care that will align with their cultural values and preferences. The project will improve healthcare providers' attitudes or comfort and confidence toward initiating ACP conversations with tribal patients. So, the healthcare providers will be able to support tribal patients to self-determine about their EOL care and die with dignity and respect. The project meets the principle of efficiency as it is moral duty of program planner to use of scarce resources efficiently to cover more people. The program's performance measurement and monitoring data was used to compute costs per output (intermediate, quality, and final) (Kettner et al., 2017). Long-term impact on the organization will be calculated in-terms of quality improvement and lowering potential healthcare costs. Usually, under the conditions, when a patient becomes incapacitated and their EOL care wishes is not known, the healthcare team or loved ones make such decisions for the patient that add to healthcare costs and don't align with patients' values and preferences (Lewis et al., 2016). Based on the ethical principle of justice, all humans should have autonomy and equal moral worth. The ethical principle of justice requires that the rural underserved community of tribal patients should have equal opportunity as other communities to self-determine about their EOL care.

Recommendations

Based on the findings and previous literature evidence, it is recommended that the staff education can be used to improve healthcare providers comfort and confidence in initiating ACP conversations and address the gap in practice i.e. low incidence of ACP conversations initiation and documentation. Due to the limitations of staff education project, the findings should be used with caution. As the project was conducted in primary care organization serving NA community of one of the tribes in rural underserved area, the findings may be applicable in the similar settings. The replication of such staff education project after addressing the limitations will improve the strength of evidence.

The limitations of the findings also limit further recommendations as only immediate outcome of the staff education was assessed by using pretest and posttest questionnaires. The actual change in practice was not assessed. In future, the additional staff education project can be conducted to assess the actual improvement in practice of health care providers and documentation. It would be interesting to see the actual impact or long-term effects of education/training like 3 months, and 6 months post education intervention. Future research is needed to evaluate the staff education's impact on patient, family members/loved ones, and cost-effectiveness. In-depth qualitative exploration of participant experiences and views, and patients, staff, and family outcome measurement using tools can provide valuable evidence to inform future research. The project findings have utility for organization policy recommendations to improve healthcare providers' knowledge and skills in ACP and other related topics. So, the findings can be used while taking limitations into consideration.

Contribution of the Doctoral Project Team

The DNP student planned and implemented the staff education project. Face-to-face education and same education technique were used to keep the consistency in methodology. There was no doctoral project team involved in the planning and implementation of staff education project. The program chair provided guidance and support throughout the project. So, no role differentiation or division of responsibilities among project team members was needed. Additionally, there is no plan to extend the project beyond DNP doctoral project.

Strengths and Limitations of the Project

The staff education project led to improvement of staff knowledge, attitudes, or comfort, and/or confidence regarding initiation of ACP conversations postintervention that was in accordance with the results of previous research studies. The improvement in attitudes and knowledge were the primary outcomes. Some of the greatest strengths of the study were that there were no missing values in the data collected by using instrument and pretest and posttest questionnaires were paired to assess actual effects. Most importantly, I received a full support and cooperation from all the stakeholders and all clinics' management in carrying out the project without any issues and in timely manner. Another study's strength pertains to its findings that they added to and/or confirmed the previous research evidence i.e. staff education leads to improvement in comfort and confidence or attitudes of healthcare providers to initiate ACP conversations with patients and their loved ones and documentation.

A small sample size (*n* = 27) limits the generalization of findings to other settings. The participation in the education project was voluntary so, the selection bias could not be fully excluded. Again, the small sample size could reduce power effect and in turn reliability of the t test. As the project was implemented in one of the rural underserved community of NAs so, the findings can be applicable in similar context or setting. Next, more data was collected from more rural sites of the organization whereas, less participation (data) was noted in the parent site (less rural and larger) that could have biased the study results. Based on research evidence, it was assumed that the staff education would lead to increase in knowledge and skills of learners regarding ACP, ADs, and EOL care that would lead to learners' positive attitudes or comfort and confidence in initiating ACP conversations with NA patients and documentation. The study's findings indicated statistical difference in knowledge and skills but, not in case of cultural competency of learners when compared pretest and posttest scores although, learners answered more correctly in posttests. Additionally, a certain level of knowledge and experience, and one's own responsibility for the practice are required to recognize skills are lacking and if, there are issues with practicing in real world (Lonnbro et al., 2018). Overall, study's findings were consistent with previous research evidence that the staff education increases knowledge and skills of healthcare providers and in turn increase in comfort and confidence of health care providers (Alvarez & Agra, 2006; Dryden & Addicott, 2009; Runkle et al., 2008; Selman et al., 2015).

Participative and interactive learning strategies were used for staff education that might be particularly important in EOL care training per Pulsford et al. (2013). The pre-post study design provided useful guidance for course development and an indicator for further evaluation. Since, it was methodologically weak in terms of assessing effectiveness, for which randomized controlled trial is a gold standard (Selman et al., 2015). So, additional research is required to link knowledge and skills with change in attitudes as well as staff's actual behavior change. Professional confidence underpinned the healthcare providers' competency in study by Ogawa and Nakatani (2020). The questionnaires were developed by the DNP project manager, validated with other providers, and were used first time in the study. Using the questionnaires that had been tested in previous studies already could have increased reliability of the instrument. In the study, learners self-rated their knowledge, skills, comfort, and confidence about the topic and content but, testing of competencies was not implemented. Similar study can be replicated in the future after addressing such limitations. Furthermore, a future study can be planned to assess the actual effects of the staff education project on tribal patients and their loved ones.

Section 5: Dissemination Plan

The purpose of this project was to improve EOL care among tribal patients at clinics in a tribal healthcare system. The staff education project was created to improve healthcare providers' comfort and confidence and attitudes to initiate ACP conversations with NA patients. The full implementation of the recommendations of this project is beyond the scope of this paper. The project's findings added to the previous body of research evidence that the staff education led to improved knowledge and attitudes of healthcare providers about initiating ACP conversations with patients. To assess long-term impact in terms of improved EOL care among tribal patients and decreased healthcare costs, further study should be planned. The staff education led to improved attitudes of healthcare providers ($z = -3.918$, $p < 0.001$) and knowledge ($z = -4.406^b$, $p < 0.001$) about ACP that were consistent with previous research evidence (Ogawa & Nakatani, 2020; Selman et al., 2015). Such educational initiative will improve practice and improve healthcare providers' confidence and comfort about initiating ACP conversations and documentation. The project will be presented in a face-to-face meeting at the collaborating institution with healthcare providers, the collaborating team includes administrators and learners during monthly clinic-based meeting and/or providers' meetings conducted every 3 months to disseminate findings and to elicit suggestions regarding possible education initiatives. I hope to discuss integrating the recommendations from this project into new healthcare providers' orientation process and yearly performance evaluations at the institution.

Disseminating the results of program design and evaluation is an ethical responsibility of a DNP-prepared nurse (White et al., 2021). Dissemination is a process of spreading new knowledge or research through journals or at conferences that involves identifying appropriate audience and tailoring the medium and message according to the audience (White et al., 2021). It is a primary goal or expectation of research, and for clinicians who work with translation of research findings, it is a secondary gain. Depending on the audiences, I will modify the language and mode of message. During my professional education, I have used multiple nursing and medical journals. For publishing results of the project design and evaluations for healthcare professionals, I will choose a venue such as the *BMC Public Health Journal*. Peer-reviewed articles generally carry more weight on decisions about disseminating research through journals (Charlesworth Author Services, 2021).

Analysis of Self

As an APN and a DNP student, it is my professional obligation to improve patient care and support practice change in the healthcare organization where I work or live. In practice, there were low to negligible incidences of ACP conversations between tribal healthcare providers and tribal patients. After the project data analysis, I concluded that the staff education led to a change in attitudes of the healthcare team to change practice, but the project findings have limitations for future research. The ACP discussions should be individualized for each patient depending on cultural values, preferences, and disease state. The implementation of the recommendations of this paper are beyond the scope here. The DNP project experience helped me grow as a scholar–practitioner, and I could see beyond my previous professional obligation and practice. I was able to look beyond my role as a family nurse practitioner and use my developed knowledge and skills to critically analyze present practices and to plan evidence-based change in the organization to refine practice or improve patient health and better manage chronic and acute health conditions.

Conducting this project refined and widened my vision as a provider by improving my knowledge and skills and made me realize my position in the healthcare system as a source of evidence-based change to transform healthcare. This project empowered me with leadership skills and knowledge from various nursing and other sciences to meet the triple aim set by the Institute of Health Improvement (White et al., 2021). The project opened my eyes to the racial and geographical disparities faced by the NA tribal community. Making quality improvement a priority is challenging in such institutions, where staff shortages and staff turnover are common. Such rural healthcare organizations that serve underserved communities of NAs need to find other ways to finance the system or increase government grants to eliminate racial and geographical disparities (Health & Human Services Agency, 2019).

Furthermore, my collaborating institution is Magnet designated, which means the organization has been deemed a center of excellence in primary medical care and nursing. I consider myself extremely fortunate to practice in a nonprofit institution that serves a rural underserved community of NAs and that has a strong vision and patient-centered values. This project emphasized the importance of developing an institution-wide care model that integrates principles, processes, and practices of continuous quality improvement as part of the organizational priorities.

Completion of the Project

The staff education project was completed with success, objectives were met, and the collaborating team including clinic administrators and management were delighted and enthusiastic about the continuing education. Although the project is completed, my movement in starting this conversation is not finished, and education and outcomes evaluation will continue throughout the facility. I want to plan further study to evaluate the actual impact of education in practice and long-term impact on tribal community members in terms of improved quality of EOL care and healthcare cost savings.

Summary

ACP conversations and AD completion are part of ethical healthcare provided to patients and one of the requirements of AAAHC. The communities that live in rural and underserved areas like tribal communities should be given particular attention to address racial and geographical disparities. Staff education as part of healthcare providers' continuing education is one of the most effective evidence-based interventions to improve healthcare providers' attitudes or comfort and confidence to start such conversations and documentation. ACP should be integrated in routine work processes to make it a sustainable practice (White et al., 2021). This will empower healthcare teams to use ACP techniques with patients. Finally, ACP is not a death sentence but an opportunity to exchange information between healthcare teams and patients and assist patients in receiving care that is consistent with their wishes.

References

Aging with Dignity. (n.d.). *Five wishes*. https://www.fivewishes.org/five-wishes-sample.pdf

Alvarez, M. P., & Agra, Y. (2006). Systematic review of educational interventions in palliative care for primary care physicians. *Palliative Medicine, 20*(7), 673–683. https://doi.org/10.1177/0269216306071794

American Nurses Association Center for Ethics and Human Rights (2019). ANA position statement: The nurse's role when a patient requests medical aid in dying. *Online Journal of Issues in Nursing, 24*(3). https://doi.org/10.3912/OJIN.Vol24No03PoSCol02

Atherton, K. N. (2020). Project Five Wishes: Promoting advance directives in primary care. *Journal of the American Association of Nurse Practitioners, 32*(10), 689–695. https://doi.org/10.1097/JXX.0000000000000289

Benedictine University. (2021). Public health research guide: Primary & secondary data definitions. https://researchguides.ben.edu/c.php?g=282050&p=4036581

Barra, M. (2021). Nobody wants to talk about dying: Facilitating end-of-life discussions. *Journal of Continuing Education in Nursing, 52*(6), 287–293. https://doi.org/10.3928/00220124-20210514-08

Bernazzani, S. (2016). Guide to end-of-life care options. *American Journal of Managed Care.* https://www.ajmc.com/view/guide-to-end-of-life-care-options

Booth, A. T., & Lehna, C. (2016). Advanced directives and advanced care planning for healthcare professionals. *Kentucky Nurse, 64*(2), 7–10.

BrunelASK. (2015, September 17). *Reliability test: Compare Cronbach's alpha using SPSS* [Video]. YouTube. https://www.youtube.com/watch?v=OdIhhtg-3LE

Cadorin, L., Bressan, V., & Palese, A. (2017). Instruments evaluating the self-directed learning abilities among nursing students and nurses: A systematic review of psychometric properties. *BMC Medical Education, 17*(229). https://doi.org/10.1186/s12909-017-1072-3

Carey, M. L., Zucca, A. C., & Freund, M. A. G. (2019). Systematic review of barriers and enablers to the delivery of palliative care by primary care practitioners. *Palliative Medicine, 33*(9), 1131–1145. https://doi.org/10.1177/0269216319865414

Carresse, J. A., & Rhodes, L. A. (2000). Bridging cultural differences in medical practice. *Journal of General Internal Medicine, 15*, 92–96. https://doi.org/10.1046/j.1525-1497.2000.03399.x

Charlesworth Author Services. (2021). *Choosing the right venue for sharing your research*. https://www.cwauthors.com/article/Choosing-the-right-venue-for-sharing-your-research

Colclough, Y. Y., & Brown, G. M. (2018). Moving toward openness: Blackfeet Indians' perception changes regarding talking about end of life. *American Journal of Hospice and Palliative Medicine, 36*(4), 282–289. https://doi.org/10.1177/1049909118818255

Colclough, Y. Y. (2014). Complete manuscript title: American Indians' experiences of life-threatening illness and end of life. *Journal of Hospital & Palliative Nursing,* *16*(7), 404–413. https://doi.org/10.1097/NJH.0000000000000086

Colville, E., & Kennedy, C. (2013). ACP conversations in clinical practice: Impact of an education initiative. *British Journal of Community Nursing, 17*(5), 230–234. https://doi.org/10.12968/bjcn.2012.17.5.230

Crocket, L. (2017). The knowledge-to-action framework. *Knowledge Nudge*. https://medium.com/knowledgenudge/kt-101-the-knowledge-to-action-framework-7fbe399723e8

Da Silva, T. C., Nietsche, E. A., & Bastos Cogo, S. (2022). Palliative care in primary health care: An integrative literature review. *Revista Brasileira de Enfermagem, 75*(1), 1–9. https://doi.org/10.1590/0034-7167-2020-1335

Dang, D., & Dearholt, S. L. (2017). *John Hopkins nursing evidence-based practice: Model and guidelines* (3rd ed). Sigma Theta Tau International.

Deakin University. (2017). 14 practical strategies for motivating your staff to learn and grow in workplace. *Deakin Co.* https://www.deakinco.com/resource/14-practical-strategies-for-motivating-your-staff-to-learn-and-grow-in-the-workplace/

DiBello, K. (2021). Underscoring the importance of advance care planning. *Nurse Practitioner, 46*(9), 24–29. https://doi.org/10.1097/01.npr.0000769740.05465.f1

Dryden, H., & Addicott, R. (2009). Evaluation of a pilot study day for healthcare assistants and social care officers. *International Journal of Palliative Nursing, 15*(1), 6–11. https://doi.org/10.12968/ijpn.2009.15.1.37946

Empower. (n.d.). *Guidance for pre- and posttest design.* https://empowerweb.org/assets/uploads/tools-resources/461/5._guidance_for_pre-

_and_posttest_design.pdf

Field, B., Booth, A., & Gerrish, K. (2014). Using the knowledge to action framework in practice: A citation analysis and systematic review. *Implementation Science, 172*. https://doi.org/10.1186/s13012-014-0172-2

Flo, E., Husebo, B.S., Bruusgaard, P., Gjerberg, E., Thoresen, L., Lillemoen, L., & Pedersen, R. (2016). A review of the implementation and research strategies of advance care planning in nursing homes. *BMC geriatrics, 16*, 24. https://doi.org/10.1186/s12877-016-0179-4

Goswami, P., Mistric, M., & Barber, F.D. (2020). Advanced practice provider-initiated discussions and their effects on patient-centered end -of-life care. Clinical Journal of Oncology Nursing, 24(1), 81-87. https://doi.org/10.1188/20.cjon.81-87

Guide Gray, J. R., Grove, S. K., & Sutherland, S. (2017). *Burns and Grove's the practice of nursing research: Appraisal, synthesis, and generation of evidence* (8th ed.). St. Louis, MO: Saunders Elsevier.

Hamilton Health Sciences. (n.d.). *Knowledge-to-action framework*. https://www.hhscebi.ca/resources/knowledgetranslationframework/

Harog, C.S., Peschel, I., Schwarzkopf, D., Curtis, J.R., Westermann, I., Kabisch, B.,…Reinhart, K. (2014). Are written advance directives helpful to guide end-of-life therapy in the intensive care unit? A retrospective matched-cohort study. *Journal of critical care, 29*(1), 128-133. https://doi.org/10.1016/j.jcrc.2013.08.024

Harwood, P., Prasun, M., Dennis, B., Mayes, A. (2020). Advanced Care Planning and

Palliative Care in the Heart Failure Population. *Heart & Lung, 49*(2), 222-223. https://doi.org/10.1016/j.hrtlng.2018.10.020

Health & Human Services Agency. (2019). *Reducing and eliminating health disparities with information (REHDI) initiative.* https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/reduce_eliminate_health_disparities_initiative.html

Hodges, B.C., & Videto, D.M. (2011). *Assessment and planning in health programs* (2nd ed.). Sudbury, MA: Jones & Bartlett Learning.

Holland, K., Middleton, L., & Uys, L. (2012). Professional confidence: A concept analysis. *Scandinavian journal of occupational therapy, 19*, 214-224. https://doi.org/10.3109/11038128.2011.583939

Houser, J. (2018). *Nursing research: reading, using, and creating evidence* (4th ed). Jones & Bartlett Learning

Hunsucker, H.L. (2012). Cultural considerations at the end-of-life: Communication of healthcare providers with native American patients. *Montana State University*, 1-42. https://scholarworks.montana.edu/xmlui/bitstream/handle/1/1526/HunsuckerH0512.pdf?sequence=1

Indian.org. (2018). *Chippewa Indians.* Retrieved from http://indians.org/articles/chippewa-indians.html

Inoue, M., Tompkins, C., Scruggs, K., & Robles, J. (2018). Advance directives information delivery in Medicare/Medicaid-funded agencies: An exploratory study. *Journal of social work in end-of-life & palliative care, 14*(2-3), 177-193. https://doi.org/10.1093/geront/gnw162.881

Isaacson, M.J. (2017). Wakanki Ewastepikte: An advanced directive education project with American Indian elders. *Journal of Hospital & Palliative Nursing, 19*(6), 580-587. https://doi.org/10.1097/njh.0000000000000392

Jackson, B.N., Purdy, S.C., Cooper-Thomas, H.D. (2019). Role of professional confidence in the development of expert allied health professional: A narrative review. *Journal of Allied Health, 48*(30), 226-232.

Julia-Sanchis, R., Garcia-Sanjuan, S., Zaragoza-Marti, M.F., Cabanero-Martinez, M.J. (2019). Advance healthcare directives in mental health: A qualitative analysis from a Spanish healthcare profession's viewpoint. *Journal of Psychiatric & Mental Health Nursing, 26*(7/8), 223-232. https://doi.org/10.1111/jpm.12539

Kataoka-Yahiro, M.R., Conde, F.A., Wong, R.S., Page, V., Peller, B. (2010). Advanced care planning among Asian Americans and native Hawaiians receiving hemodialysis. *International Journal of Palliative Nursing, 16*(1), 32-40. https://doi.org/10.12968/ijpn.2010.16.1.46181

Kettner, P.M., Moroney, R.M., & Martin, L.L. (2017). *Designing and managing programs: An effectiveness-based approach* (5th ed.). Thousand Oaks, CA: Sage.

Kwak, J, Ik, C.Y., Lee, Y., Hyunjin, N., Soonhee, R. (2019). Differences in advance care planning between American Indian and white older adults. *Research in Gerontological Nursing, 12*(1), 34-43. https://doi.org/10.3928/19404921-20181212-02

Lang, E.S., Wyer, P.C., & Haynes, R.B. (2007). Knowledge translation: closing evidence to practice gap. *Annals of Emergency Medicine, 49*(3), 355-363. https://doi.org/10.1016/j.annemergmed.2006.08.022

Lewis, Ebony, Cardona-Morrell, M., Ong, K.Y., Trankle, S.A., & Hillman, K. (2016). Evidence still insufficient that advance care documentation leads to engagement of healthcare professionals in end-of-life discussions: A systematic review. *Palliative Medicine, 30*(9), 807-824. https://doi.org/10.1177/0269216316637239

Lillie, K.M., Dirks, L.G., Curtis, J.R., Candrian, C., Kutner, J.S., & Shaw, J.L. (2019). Culturally adapting an advanced care planning communication intervention with American Indian and Alaska Native people in primary care. *Journal of Transcultural. Nursing, 31*(2), 178-187. https://doi.org/10.1177/1043659619859055

Lonnbro, J., Nylen, K., & Wallerstedt, S.M. (2019). Developing professional confidence in the art of prescribing-a randomized controlled study on structured collegial discussions during internship. *European Journal of Clinical Pharmacology, 75*(5), 687-696. https://doi.org/10.1007/s00228-018-02619-4

Marino, V.R., Hyer, K., Hamilton, L., Wenders, A. M., Andel, R. (2021). Evaluation of a quality improvement initiative to increase rates of advance directive conversation documentation in primary care. *Geriatric Nursing, 42*(1), 303-308. https://doi.org/10.1016/j.gerinurse.2020.09.004

Mauleon, J. & Staffileno, B. (2019). Integration of an advance care planning model in home health: Favorable outcomes in end-of-life discussions, POLST rates, and

60-day hospital readmissions. *Home healthcare now, 37*(6), 337-344. https://doi.org/10.1097/nhh.0000000000000797

Michigan State University Geo Project. (n.d.). Ojibwe. *Michigan State University.* https://project.geo.msu.edu/geogmich/ojibwe.html

Miller, B. (2017). Nurses in the know: The history and future of advance directives. *The Online Journal of Issues in Nursing, 22*(3). https://doi.org/10.3912/ojin.vol22no03ppt57

Mishra, P., Pandey, C.M., Singh, U., Gupta, A., Sahu, C., & Keshri, A. (2019). Descriptive statistics and normality tests for statistical data. *Annals of Cardiac Anesthesia, 22*(1), 67-72. https://doi.org/10.4103/aca.aca_157_18

Moran, K., Burson, R., & Conrad, D. (2017). *The doctor of nursing practice scholarly project: A framework for success* (2nd ed). Jones & Bartlett Learning

Nash, D. B., Joshi, M. S., Ransom, E. R., Ransom, S. B., (Eds). (2019). *The healthcare quality book: Vision, strategy, and tools* (4th ed.). Chicago, IL: Health Administration Press.

Nassikas, N.J, Baird, G.L., & Duffy, C.M. (2020). Improving advance care planning in a resident primary care clinic. *American Journal of Hospice & Palliative Medicine, 37*(3), 185-190. https://doi.org/10.1177/1049909119872757

National Health Service (NHS). (n.d.). *What end of life care involves?* https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/

NIH-National Cancer Institute. (n.d.). *End-of-life care.*

https://www.cancer.gov/publications/dictionaries/cancer-terms/def/end-of-life-care

NIH-National Institute on Aging. (n.d.). *Advance care planning.* https://www.nia.nih.gov/health/advance-care-planning-health-care-directives

Nicholson, B. (2021). Advanced care planning: The concept over time. *Nursing Forum.* https://doi.org/10.1111/nuf.12631

Ogawa, T., & Nakatani, H. (2020). Factors associated with professional confidence in Japanese public health nurse: A cross-sectional Survey. *Public Health Nursing, 37*(2), 272-280. https://doi.org/10.1111/phn.12705

Osmancevic, S., Schoberer, D., Lohrmann, C., & Grobschadl, F. (2021). Psychometric properties of instruments used to measure the cultural competence of nurses: A systematic review. *International Journal of Nursing Studies, 113*. https://doi.org/10.1016/j.ijnurstu.2020.103789

Patel, R., Sinuff, T., & Cook, D.J. (2021). Influencing advance directive completion rates in non-terminally ill patients: A systematic review. *Journal of Critical Care, 19*(1), 1-9. https://doi.org/10.1016/j.jcrc.2004.02.002

Pearse, W., Oprescu, F., Endacott, J., Goodman, S., Hyde, M., & O'Neill, M. (2019). Advanced care planning in the context of clinical deterioration: a systematic review of the literature. *Palliative Care: Research and Treatment,* 1-14. https://doi.org/10.1177/1178224218823509

Pirschel, C. (2016). Ethical dilemmas at the end-of-life. *Voice*. https://voice.ons.org/news-and-views/ethical-dilemmas-at-the-end-of-life

Polit, D.F. (2010). *Statistics and data analysis for nursing research* (2nd ed). Upper Saddle River, NJ: Pearson Education Inc.

Pulsford, D., Jackson, G., & O'Brien, T. (2013). Classroom-based and distance learning education and training courses in end-of-life care for health and social care staff: a systematic review. *Palliative Medicine, 27,* 2221-2235. https://doi.org/10.1177/0269216311429496

Recognition Professionals International. (n.d.). *Employee incentive program ideas to maximize employee motivation.* https://www.recognition.org/RPI/RPI/About/Employee_Incentive_Program.aspx

Risk, J., Mohammadi, L., Rhee, J., Walters, L., & Ward, P.R. (2019). Barriers, enablers and initiatives for uptake of advanced care planning in general practice: a systematic review and critical interpretive synthesis. *BMJ Open, 9*(9), 1-17. https://doi.org/10.1136/bmjopen-2019-030275

Runkle, C., Wu, E., Wang, E.C., Gordon, G.H., & Frankel, R. (2008). Clinician confidence about conversations at the end of life is strengthened using four habits approach. *Journal of Psychosocial Oncology, 26*(3), 81-95. https://doi.org/10.1080/07347330802118040

Schichtel, M., Wee, B., Perera, R., Onakpoya, I., Albury, C., & Barber, S. (2019). Clinician-targeted interventions to improve advance care planning in heart failure: a systematic and review meta-analysis. *Heart, 105*(17), 1316-1324. https://doi.org/10.1136/heartjnl-2019-314758

Schroder-Back, P., Duncan, P., Sherlaw, W., Brall, C., & Czabanowska, K. (2014).

Teaching seven principles for public health ethics: towards a curriculum for a short course on ethics in public health programs. *BMC Med Ethics, 15*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4196023/

Schwarz, B., & Benson, J.J. (2018). The medicalized death": Dying in the hospital. *Journal of Housing for the Elderly, 32,* 379-430. https://doi.org/10.1080/02763893.2018.1505462

Schwill, S., Reith, D., Walter, T., Engeser, P., Wensing, M., Flum, E., Szecsenyi, J., & Krug, K. (2020). How to ensure basic competencies in end-of-life care- a mixed methods study with post-graduate trainees in primary care in Germany. *BMC Palliative Care, 19*(9), 1-12. https://doi.org/10.1186/s12904-020-00540-1

Selman, L., Robinson, V., Klass, L., Khan. S., George, R., Shepherd, K., Burman, R., Koffman, J. (2016). Improving confidence and competence of Care, 6(2). healthcare professionals in end-of-life care: an evaluation of the 'Transforming end of life care' course at an acute hospital trust. *BMJ Supportive & Palliative, 6*(2). https://spcare.bmj.com/content/6/2/231

Simon, J., Shaw, M., Biondo, P., Holroyd-Leduc, J., Davison, S., Wasylenko, E., Gjosh, S., Howlett, J., Hutchinson, L., Booker, R., Marlett, N., Raffin, S., Fassbender, K., Hagen, N. (2016). A11-B form knowledge -to-action: A synthesis of barriers and facilitators to advance care planning policy implementation across a healthcare system. *Journal of Pain and Symptom Management, 52*(6), e13. https://doi.org/10.1016/j.jpainsymman.2016.10.019

Survicate. (2021). *Likert scale survey template.* https://survicate.com/survey-templates/likert-scale-survey/?utm_source=google&utm_medium=cpc&utm_campaign=survey-templates-top&utm_adgroup=likert&utm_term=likert%20scale%20templatepc&camp_id=14997454552&adgroup_id=131504442391&ad_id=554348460197&hsa_tgt=kwd-335457220446&hsa_grp=131504442391&hsa_src=g&hsa_net=adwords&hsa_mt=p&hsa_ver=3&hsa_ad=554348460197&hsa_acc=6519365081&hsa_kw=likert%20scale%20template&hsa_cam=14997454552&gclid=EAIaIQobChMI3J_k8obD9AIVxCdMCh01Kw_BEAAYAyAAEgKMaPD_BwE&gclid=EAIaIQobChMI3J_k8obD9AIVxCdMCh01Kw_BEAAYAyAAEgKMaPD_BwE

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). (2018 updated). *Accreditation handbook for ambulatory care.*

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). (n.d.). What does accreditation mean for my care? https://www.aaahc.org/my-care/#:~:text=The%20Accreditation%20Association%20for%20Ambulatory,of%20care%20provided%20to%20patients.

Ufema, J. (2003). Insights on death & dying: Safety, comfort, peace. *Nursing, 33*(9). https://doi.org/10.1097/01.nurse.0000360250.33693.4d

Walden University. (2018). *Doctor in nursing practice: Doctoral project prospectus guide*.

Walden University. (2017). *Doctor in nursing practice scholarly project: Manual for staff education project.*

https://drive.google.com/file/d/0B1_8mknkC0j1dU0xR19EbUtoanc/view

Walden University. (2021). *Social change.* https://catalog.waldenu.edu/content.php?catoid=72&navoid=13346

Walden University. (n.d.a). *Doctoral prospectus resources*.

Walden University. (n.d.b). *Evidence-based research: Levels of evidence pyramid.*

Walden University. (n.d.c). *5 Things that everyone should know about social change.*

Wert, R.V., & Wallace, E. (2018). Impact of advance care planning interventions on patient and family satisfaction: A systematic review and description analysis. *Journal of Pain and Symptom Management, 55*(2), 698-699. https://www.jpsmjournal.com/article/S0885-3924(17)31182-X/fulltext#relatedArticles

White, G. (2019). Do not postpone discussing advanced directives. *CMAJ. https://doi.org/10.1503/cmaj.72212*

White, K.M., Dudley-Brown, S., & Tehaar, M.F. (2021). *Translation of evidence into nursing and health care practice* (3rd ed.) Springer.

White, M.C., Daya, L., Karel, F.K., White, G., Abid, S., Fitzgerald, A., Mballa, G.A.E., Sevdalis, N., Leather, A. (2020). Using knowledge to action framework to describe a nationwide implementation of the WHO surgical safety checklist in Cameroon. *Anesthesia & Analgesia, 130*(5), 1425-1434. https://doi.org/10.1213/ane.0000000000004586

Wickersham, E., Gowin, M., Deen, M.H., Nagykaldi, Z. (2019). Improving the adoption of advanced directives in primary care practices. *Journal of the American Board* *of Family Medicine, 32*(2), 168-179. https://www.jabfm.org/content/jabfp/32/2/168.full.pdf

World Health Organization (WHO). (2021). *Sexual and reproductive health: Knowledge-to-action framework.* https://www.who.int/reproductivehealth/topics/best_practices/greatproject_KTAframework/en/

Yale Poovu Center for Teaching and Learning. (2021a). *Building upon students' prior knowledge and skills*. https://poorvucenter.yale.edu/StudentsPriorKnowledge

Yale Poovu Center for Teaching and Learning. (2021b). *Strategies for teaching.* https://poorvucenter.yale.edu/FacultyResources/Teaching-Strategies

You, J.J., Fowler, R.A., Heyland, D.K. (2014). Just ask: discussing goals of care with patients in hospital with serious illness. *Canadian Medical Association Journal, 186*(1), 425-432. https://web-b-ebscohost-com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=4&sid=b57e7444-bf6f-4731-8cc1-95af76d9a6b0%40pdc-v-sessmgr01

Zager, B.S., & Yancy, M. (2011). A call to improve practice concerning cultural sensitivity in advanced directives: A review of the literature. *Worldviews on Evidence-Based Nursing, 8*(4), 202-211. https://web-a-ebscohost-com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=9&sid=5efadc64-6d12-48d5-ae97-9ffd2b41ce05%40sessionmgr4008

Zia, A. (2020). *Statistically testing validity of a questionnaire using Pearson's correlation coefficient.* (Part 1) [Video].

https://www.youtube.com/watch?v=gVUR7sR2iDM

Appendix A: Curriculum for ACP Provider Training and Tool Kit

Curriculum

Learning Outcome (s): Improving knowledge about ACP. Improving healthcare providers' confidence and comfort in discussing ACP with NA patients.			
Topical Content Outline	Time frame	References	Teaching method/learner engagement and Evaluation method
Pretest Introduction of the topic: ACP, why important, why in primary care	5" 5"	See Appendix B Da Silva, T.C., Nietsche, E.A., & Bastos Cogo, S. (2022). Palliative care in Primary Health Care: an integrative literature review. Revista Brasileira de Enfermagem, 75(1), p. 1-9. Retrieved from https://www.scielo.br/j/reben/a/JbmfPk9FQjBpj9pv5HW3LrL/?lang=en Goswami, P., Mistric, M., & Barber, F.D. (2020). Advanced practice provider-initiated discussions and their effects on patient-centered end -of-life care. Clinical Journal of Oncology Nursing, 24(1). p 81-87. Retrieved from https://web-a-ebscohost-com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=4&sid=e4015e4d-1da8-4bc8-aa37-38d11088cf7f%40sdc-v-sessmgr03 Marino, V.R., Hyer, K., Hamilton, L., Wenders, A. M., Andel, R. (2021). Evaluation of a quality improvement initiative to increase rates of advance directive conversation documentation in primary care. Geriatric Nursing, 42(1), p. 303-308. Retrieved from https://www-sciencedirect-com.ezp.waldenulibrary.org/science/article/pii/S0197457220302652?via%3Dihub Nicholson, B. (2021). Advanced care planning: The concept over time. Nursing Forum. Retrieved from https://onlinelibrary-wiley-	Power point/lecture Power point/lecture/ Q&A

		com.ezp.waldenulibrary.org/doi/full/10.1111/nuf.12631 Pearse, W., Oprescu, F., Endacott, J., Goodman, S., Hyde, M., & O'Neill, M. (2019). Advanced care planning in the context of clinical deterioration: a systematic review of the literature. Palliative Care: Research and Treatment. P. 1-14. Retrieved from https://journals-sagepub-com.ezp.waldenulibrary.org/doi/pdf/10.1177/1178224218823509 Wickersham, E., Gowin, M., Deen, M.H., Nagykaldi, Z. (2019). Improving the Adoption of Advanced Directives in Primary Care Practices. Journal of the American Board of Family Medicine, 32(2). P. 168-179. Retrieved from https://www.jabfm.org/content/jabfp/32/2/168.full.pdf	
Misconceptions regarding ACP	5"	Carey, M.L., Zucca, A.C., & Freund, M.A.G. (2019). Systematic review of barriers and enablers to the delivery of palliative care by primary care practitioners. Palliative Medicine, 33(9), p. 1131-1145. Retrieved from https://journals-sagepub-com.ezp.waldenulibrary.org/doi/full/10.1177/0269216319865414 Izumi, S. (2017). Advance Care Planning: The Nurse's Role-A consistent system-wide approach can normalize the process, dispelling fears and misconceptions. AJN, 117(6), pp. 56-61. Retrieved from https://ovidsp.dc1.ovid.com/ovid-a/ovidweb.cgi?WebLinkFrameset=1&S=DKFLFPKODCACCDBIKPOJFFFOLKMPAA00&returnUrl=ovidweb.cgi%3f%26Full%2bText%3dL%257cS.sh.22.23%257c0%257c00000446-201706000-00028%26S%3dDKFLFPKODCACCDBIKPOJFFFOLKMPAA00&fromjumpstart=0&directlink=https%3a%2f%2fovidsp.dc1.ovid.com%2fovftpdfs%2fFPACKPFOFFBIDC00%2ffs046%	Power point/lecture/ Q&A

		2fovft%2flive%2fgv023%2f00000446%2f00000446-201706000-00028.pdf&filename=Advance+Care+Planning%3a++The+Nurse%27s+Role.&pdf_key=FPACKPFOFFBIDC00&pdf_index=/fs046/ovft/live/gv023/00000446/00000446-201706000-00028 Risk, J., Mohammadi, L., Rhee, J., Walters, L., & Ward, P.R. (2019). Barriers, enablers and initiatives for uptake of advanced care planning in general practice: a systematic review and critical interpretive synthesis. BMJ Open, 9(9). P. 1-17. Retrieved from https://www-proquest-com.ezp.waldenulibrary.org/docview/2293678140?accountid=14872 UCLA Health. (2021). Myths VS Facts. Retrieved from https://www.uclahealth.org/advance-care-planning/myths-vs-facts	
Topic concepts-ACP, AD, and EOL care: definitions, types		Bernazzani, S. (2016). Guide to End-of-Life Care Options. The American Journal of Managed Care (AJMC). Retrieved from https://www.ajmc.com/view/contributor-institutional-engagement-with-physicians-is-key-to-managing-cost-and-quality CaringInfo. (2021). Advanced Directives. National Hospice and Palliative Care. Retrieved from https://www.caringinfo.org/planning/advance-directives/ Centers of Disease Control and Prevention. (n.d.). Advance Care Planning: Ensuring Your Wishes Are Known and Honored If You Are Unable to Speak for Yourself. Retrieved from https://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf National Health Service (NHS). (n.d.). What end of life care involves? Retrieved from https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/ NIH-National Cancer Institute. (n.d.). end-of-life care. Retrieved from https://www.cancer.gov/publications/dictionaries/cancer-terms/def/end-of-life-care	Power point/lecture/Q&A

		NIH-National Institute on Aging. (n.d.). Advance Care Planning. Retrieved from https://www.nia.nih.gov/health/advance-care-planning-health-care-directives	
Cultural sensitivity: varies, NA culture, how to introduce the topic? Tips, including family members/loved ones, good time to introduce, Time constraints: barriers	15”	Hunsucker, H.L. (2012). Cultural Considerations at the End of Life: Communication of Healthcare Providers with Native Americans Patients. Montana State University. P. 1-42. Retrieved from https://scholarworks.montana.edu/xmlui/bitstream/handle/1/1526/HunsuckerH0512.pdf?sequence=1 Isaacson, M.J. (2017). Wakanki Ewastepikte: And Advanced Directive Education Project with American Indian Elders. Journal of Hospital & Palliative Nursing, 19(6). P. 580-587. Retrieved from https://oce-ovid-com.ezp.waldenulibrary.org/article/00129191-201712000-00014/HTML Lillie, K.M., Dirks, L.G., Curtis, J.R., Candrian, C., Kutner, J.S., & Shaw, J.L. (2019). Culturally Adapting an Advanced Care Planning Communication Intervention With American Indian and Alaska Native People in Primary Care. Journal of Transcultural. Nursing, 31(2). Pp 178-187. Retrieved from https://journals-sagepub-com.ezp.waldenulibrary.org/doi/pdf/10.1177/1043659619859055 Zager, B.S., & Yancy, M. (2011). A Call to Improve Practice Concerning Cultural Sensitivity in Advanced Directives: A Review of the Literature. Worldviews on Evidence-Based Nursing, 8(4). P. 202-211. Retrieved from https://web-a-ebscohost-com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=9&sid=5efadc64-6d12-48d5-ae97-9ffd2b41ce05%40sessionmgr4008	Role play: case studies
Most commonly used AD form: Five wishes, easy	5”	Atherton, K.N. (2020). Project Five Wishes: promoting advance directives in primary care. Journal of the American Association of Nurse Practitioners, 32(10), p. 689-695. Retrieved from https://oce-ovid-	Lecture, handouts, demonstration

to navigate, self-explanatory		com.ezp.waldenulibrary.org/article/01741002-202010000-00010/HTML Five Wishes (2021). See how Five Wishes can help. Retrieved from https://fivewishes.org/https://fivewishes.org/ Samaritan Life-Enhancing Care. (2021). Five Wishes- A Living Will Document. Retrieved from https://samaritannj.org/resources/5-wishes-living-will-documents/	
Clarification of role: what does the provider do and document, what does the MA/CNA do and document?	5”	Barra, M. (2021). Nobody Wants to Talk About Dying: Facilitating End-of-Life Discussions. The Journal of Continuing Education in Nursing, 52(6), p. 287-293. Retrieved from https://www.proquest.com/docview/2542412103?accountid=14872 Hemsley, B., Meredith, J., Bryant, L., Wilson, N.J., Higgins, I., Geogiou, A., Hill, S., Balandin, S., & McCarthy, S. (2019). An integrative review of stakeholder views on Advance Care Directives (ACDs): Barriers and facilitators to initiation, documentation, storage, and implementation. Patient education and counselling, 102(6), p. 1067-1079. Retrieved from https://reader.elsevier.com/reader/sd/pii/S0738399118308103?token=B30E572BBF6527E929C0C0172411EB70F0A90A89F97EC0E5664EDE9C74FD75791157D86D43A19EE24901CFED95AECF26&originRegion=us-east-1&originCreation=20211230224116 Role Differentiation of Multidisciplinary Team Members: ../Desktop/Role differentiation, DNP project 12:30:21.pdf	Lecture/ power point, demonstration
Documenting in chart	5”	Documentation demonstration using EMR system, different access for documentation in system.	Exercise: documentation in EHR system
Clarifying misconceptions about AD	10”	Commission on Law & Aging. (n.d.). Myths and Facts About Health Care Advance Directives. Retrieved from https://bcan.org/wp-content/uploads/2017/12/ABA-Myths-and-facts-about-Advance-Directives.pdf	Role play; case studies

		Julia-Sanchis, R., Garcia-Sanjuan, S., Zaragoza-Marti, M.F., Cabanero-Martinez, M.J. (2019). Advance healthcare directives in mental health: A qualitative analysis from a Spanish healthcare profession's Viewpoint. Journal of Psychiatric & Mental Health Nursing, 26(7/8), p. 223-232. Retrieved from https://onlinelibrary-wiley-com.ezp.waldenulibrary.org/doi/full/10.1111/jpm.12539 Patel, R., Sinuff, T., & Cook, D.J. (2021). Influencing advance directive completion rates in non-terminally ill patients: A systematic review. Journal of Critical Care, 19(1). P. 1-9. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/nahs/docview/1033833348/E60628A0CA4B14PQ/13?accountid=14872 Sabatino, C. (2015). Myths and Facts About Health Care Advance Directives. American Bar Association, 37(1). Retrieved from https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_37/issue_1_october2015/myths_and_facts_advance_directives/	
Posttest	5"	See Appendix B	

Tool kit Accompanying Educational Program

Best ways to start ACP conversation:

- Tips and techniques of Ongoing process of ACP: ../Desktop/Tips and techniques for Ongoing Process of ACP.pdf
- References:
    1. Barra, M. (2021). Nobody Wants to Talk About Dying: Facilitating End-of-Life Discussions. *The Journal of Continuing Education in Nursing, 52*(6), p. 287-293. Retrieved from https://www.proquest.com/docview/2542412103?accountid=14872
    2. Schichtel, M., Wee, B., Perera, R., Onakpoya, I., Albury, C., & Barber, S. (2019). Clinician-targeted interventions to improve advance care planning in heart failure: a systematic and review meta-analysis. *Heart, 105*(17), p. 1316-1324. Retrieved from https://www.proquest.com/docview/2269866335?accountid=14872

Cultural Sensitivity:

- References used as actual "handouts" in the training:

1. Zager, B.S., & Yancy, M. (2011). A Call to Improve Practice Concerning Cultural Sensitivity in Advanced Directives: A Review of the Literature. Worldviews on Evidence-Based Nursing, 8(4). P. 202-211. Retrieved from https://web-a-ebscohost-com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=9&sid=5efadc64-6d12-48d5-ae97-9ffd2b41ce05%40sessionmgr4008
2. Isaacson, M.J. (2017). Wakanki Ewastepikte: And Advanced Directive Education Project with American Indian Elders. Journal of Hospital & Palliative Nursing, 19(6). P. 580-587. Retrieved from https://oce-ovid-com.ezp.waldenulibrary.org/article/00129191-201712000-00014/HTML

Team play:
Algorithm- ../Desktop/Team Algorithm, ACP.pdf

Barriers and Facilitators

1. References.

Risk, J., Mohammadi, L., Rhee, J., Walters, L., & Ward, P.R. (2019). Barriers, enablers and initiatives for uptake of advanced care planning in general practice: a systematic review and critical interpretive synthesis. BMJ Open, 9(9). P. 1-17. Retrieved from https://www-proquest-com.ezp.waldenulibrary.org/docview/2293678140?accountid=14872

Carey, M.L., Zucca, A.C., & Freund, M.A.G. (2019). Systematic review of barriers and enablers to the delivery of palliative care by primary care practitioners. *Palliative Medicine, 33*(9), p. 1131-1145. Retrieved from https://journals-sagepub-com.ezp.waldenulibrary.org/doi/full/10.1177/0269216319865414

Vleminck, A.D., Houttekier, D., Pardon, K., Deschepper, R., Audenhove, C.V., Stichele, R.V., & Deliens, L. (2013). Barriers and facilitators for general practitioners to engage in advance care planning: A systematic Review. *Scandinavian Journal of Primary Health care, 31*(4), p. 215-226. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3860298/

2. Document hyperlink: How Nurses Facilitate the Advance Care Planning Process: https://acpdecisions.org/how-nurses-facilitate-the-advance-care-planning-process/

Five Wishes
Form: ../Desktop/five-wishes-sample.pdf
Planning Guide: ../Desktop/5-Wishes-Advanced-Planning-Guide1.pdf

Reference list

Kataoka-Yahiro, M.R., Conde, F.A., Wong, R.S., Page, V., Peller, B. (2010). Advanced care planning among Asian Americans and Native Hawaiians receiving hemodialysis. International Journal of Palliative Nursing, 16(1). P. 32-40. Retrieved from https://web-a-ebscohost-com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=11&sid=5efadc64-6d12-48d5-ae97-9ffd2b41ce05%40sessionmgr4008

Lillie, K.M., Dirks, L.G., Curtis, J.R., Candrian, C., Kutner, J.S., & Shaw, J.L. (2019). Culturally Adapting an Advanced Care Planning Communication Intervention With American Indian and Alaska Native People in Primary Care. *Journal of Transcultural. Nursing, 31(*2). Pp 178-187. Retrieved from https://journals-sagepub-com.ezp.waldenulibrary.org/doi/pdf/10.1177/1043659619859055

Schwill, S., Reith, D., Walter, T., Engeser, P., Wensing, M., Flum, E., Szecsenyi, J., & Krug, K. (2020). How to ensure basic competencies in end-of-life care- a mixed methods study with post-graduate trainees in primary care in Germany. *BMC Palliative Care, 19*(9), p. 1-12. Retrieved from https://web-p-ebscohost-com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=6&sid=7c5dfcca-eef4-4870-b925-4a2ad0ce2f65%40redis

ICD coding information for ACP: ../Desktop/2017.11-Advance-Care-Planning-Under-Medicare-CMS-ACP-Codes-FAQs-CCCC.pdf

List of websites

- PrepareForYourCare.org
- CaringInfo.org
- UpToDate
- Polst.org

Brochures for Patient Education

- ACP brochures: ../Desktop/InstituteHCD-Brochure.pdf, ../Desktop/ACP brochure.PDF
- ACP introduction: ../Desktop/ACP info sheet.pdf
- ACP information: ../Desktop/ACP INFO CARD.pdf
- ACP Booklet: ../Desktop/ACP Booklet.pdf
- Durable power of attorney for health care versus living will: ../Desktop/DPOA for HC vs Living will.pdf
- CPR versus No CPR: ../Desktop/CPR vs No CPR.pdf
- Breathing machine: ../Desktop/BREATHING MACHINE.pdf

Role Play/ Case Studies

Document:

Case Studies.docx

Appendix B: Confidence, Attitude and Knowledge About ACP Pretest/Posttest

I. Demographic Information:

1. Age:
[ ] 18-24 years
[ ] 25-30 years
[ ] 31-39 years
[ ] 40-50 years
[ ] >50 years
2. Highest Level of Education:
[ ] High School
[ ] Some college
[ ] AD
[ ] BS/BA
[ ] Master Degree
[ ] Doctorate in Nursing
[ ] Doctor in Medicine
[ ] Doctor in Osteopathic Medicine
3. Gender:
[ ] Male
[ ] Female
4. Previous training in Advanced Care Planning:
[ ] Yes
[ ] No
5. Religion:
    [ ] Christian
    [ ] Jewish
    [ ] Hindu
    [ ] Buddhists
    [ ] Muslims
    [ ] None
6. Number of years in medical field:
    [ ] 0-5
    [ ] 6-10
    [ ] 11-15
    [ ] 16-20
    [ ] 21 years or more

II. Questions regarding learners' Attitude and comfort level toward the topic and content:

7. I feel comfortable initiating advanced care planning (ACP) topic with my patients.
[ ] Strongly agree-1

[ ] Agree-2
[ ] Neutral-3
[ ] Disagree-4
[ ] Strongly Disagree-5

8. I feel knowledgeable enough to talk about types of end-of-life care.
[ ] Strongly agree- 1
[ ] Agree-2
[ ] Neutral-3
[ ] Disagree-4
[ ] Strongly Disagree-5

9. I feel knowledgeable enough about types of Advanced Directives.
[ ] Strongly agree-1
[ ] Agree-2
[ ] Neutral-3
[ ] Disagree-4
[ ] Strongly Disagree-5

10. I feel comfortable in using Five Wishes form.
[ ] Strongly agree-1
[ ] Agree-2
[ ] Neutral-3
[ ] Disagree-4
[ ] Strongly Disagree-5

11. I feel comfortable enough to answer patients’ questions about Advance Care Planning.
[ ] Strongly agree-1
[ ] Agree-2
[ ] Neutral-3
[ ] Disagree-4
[ ] Strongly Disagree-5

12. I incorporate cultural sensitivity while discussing Advanced Care Planning with patients.
[ ] Strongly agree-1
[ ] Agree-2
[ ] Neutral-3
[ ] Disagree-4
[ ] Strongly Disagree-5

III. Questions regarding cultural competency

13. All Native Americans carry same cultural values and preferences regarding life and death.
[ ] Yes
[ ] No

14. All Native Americans do not like to discuss EOL care and having an AD.
[ ] Yes

[ ] No

IV. Questions regarding knowledge about the topic:

15. First step in starting Advanced Care Planning is discussion to clarify the concept of ACP and any misconceptions about the topic.

[ ] Yes
[ ] No

16. Best times to start discussing ACP are recent hospitalizations, yearly physical, new life threatening-diagnosis, and establishment of care.

[ ] Yes
[ ] No

17. I know where to chart the ongoing discussions about ACP and/or AD documentation

[ ] Yes
[ ] No

18. I know the facilitators and barriers to ACP discussions.

[ ] Yes
[ ] No

19. I know various types of ADs.

[ ] Yes
[ ] No

20. The Patient Self Determination Act requires that every competent individual should sign an Advanced Directive.

    [ ] True
    [ ] False
    [ ] I don’t know

21. A person can revoke AD at any time.

    [ ] True
    [ ] False
    [ ] I don’t know

22. AD is written document to specify person’s wishes/preferences regarding EOL care.

    [ ] True
    [ ] False
    [ ] I don’t know

Additional Questions for the Posttest Only

Suggestions to improve learning or education projects in future:
Any suggestions about the educational content that you would like to include in the tool kit or improve learning in the future education projects? Write below:
Answer: