Education for Primary Care Providers on Advance Care Planning: A Systematic Literature Review

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Education for Primary Care Providers on Advance Care Planning:

A Systematic Literature Review

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N749: NP Qualifying Project Manuscript Development

Dr. Ricky Norwood

December 3, 2023
Abstract

**Background:** Healthcare providers in primary care treat patients at various stages of life. As patients age, it becomes necessary for providers to support their older patients throughout the aging process and address patient care even into life’s end stages. Primary care providers (PCPs) are well-positioned to provide this support and can do so through incorporating end-of-life (EOL) conversations in practice. Such discussions are called advance care planning (ACP). Though PCPs can play a crucial role in their patients’ EOL care decisions, providers report their limited knowledge of ACP as a barrier to its application. Consequently, further education for providers on utilizing ACP in practice can increase provider knowledge and confidence in implementing this aspect of patient care. **Objective:** This literature review will illustrate how PCPs are uniquely prepared to support their patients in EOL care discussions but could benefit from further education on ACP to address the knowledge gap. **Methods:** A comprehensive literature search was conducted regarding barriers to ACP use in the clinical setting and further education for providers on ACP to increase its implementation. The search used several databases, including CINAHL Complete, PubMed, and Scopus. **Results:** Ten studies met the inclusion criteria for analysis. Three major themes arose during the literature review: PCPs are well-suited to implement ACP; limited provider knowledge of ACP is a barrier to the occurrence of EOL conversations in practice; further education for providers on ACP could increase their knowledge of and confidence in implementing ACP with patients. **Conclusions:** The literature review indicates that provider education on ACP is necessary and can contribute to positive patient outcomes.

**Keywords:** advance care planning, end of life, palliative, nurse practitioner, provider, primary care, continuing education, training, older adult, patient, toolkit
Education for Primary Care Providers on Advance Care Planning: A Systematic Literature Review

The United States Census Bureau (2020) states that, by 2034, one in five Americans will be at or beyond the age of 65. Considering this upcoming age demographic shift, healthcare providers must strengthen their knowledge of end-of-life (EOL) conversations, as such dialogue produces multiple benefits for patients and their families. This type of conversation between provider and patient is called advance care planning (ACP). ACP is a discussion of a patient’s EOL healthcare wishes. Its purpose is to indicate these wishes clearly should the patient be unable to make their decisions known to providers and family members due to a sudden health decline or medical emergency. Anyone of any age can participate in ACP. However, it is applicable, especially to older adults, and should be prioritized as the aging population expands.

ACP offers numerous benefits. ACP discussions promote patient autonomy and dignity because patients can take ownership of their healthcare decisions and specify the medical care they do or do not want. ACP benefits extend beyond the care of patients as individuals. EOL care conversations can decrease stress and anxiety for families and loved ones, given that the patient’s care wishes will have been previously established (Kendell et al., 2020).

Moreover, ACP can decrease out-of-pocket hospital costs for patients and their families by eliminating unwanted medical interventions and lengthy hospital stays. Zhu and Enguidanos (2022) explored the relationship between advance directive (AD) completion and hospital out-of-pocket costs at the EOL. An AD is legal documentation of a patient’s healthcare decisions that arise from ACP. Zhu and Enguidanos analyzed the EOL healthcare costs of patients who died between 2000 and 2014 (N = 9228). Approximately 44% of decedents had completed an AD,
and the study determined that AD completion was associated with $673.00 lower hospital out-of-pocket costs.

Despite the positive attributes of ACP, the general population’s participation in this aspect of healthcare is minimal. Only one in three American adults have completed any form of ACP (Yadav et al., 2017). However, this is not due to the population’s lack of interest. In 2018, the Institute for Healthcare Improvement conducted a national survey that reported 92% of Americans say it is important to discuss EOL care wishes, 95% of Americans state they would be willing to talk about their wishes, and 53% say they would be relieved to have this conversation (The Conversation Project, 2017).

Healthcare providers can play a significant role in addressing the population’s needs and improving ACP participation. Such providers include physicians, nurse practitioners, and physician assistants in the primary care setting, as they interact with patients at various stages of life, even life’s end stages. PCPs are well-positioned to provide EOL care planning support and can do so by facilitating ACP in practice. Though PCPs can be crucial in patients’ EOL care discussions, providers report that their limited knowledge of ACP and how to facilitate such conversations deters them from being proactive in discussing EOL care with patients (Batchelor et al., 2019; Glaudemans et al., 2019; Ke et al., 2015). The purpose of this manuscript is to discuss the aptness of ACP in primary care, explore how limited provider knowledge of ACP is a barrier to its occurrence in practice, and highlight the importance of further education for providers on ACP to increase their knowledge of and confidence in implementing EOL discussions with patients.

Methods
A comprehensive search was conducted on literature regarding barriers to ACP use in the clinical setting and further education for providers on ACP to increase its implementation. The search used several databases, including CINAHL Complete, PubMed, and Scopus. Using CINAHL, the keywords and Boolean operators were searched: advance care plan* OR end of life; nurse practitioner OR provider; educat* OR train*, primary care; the search yielded 181 results. The Scopus search used the terms advance care planning AND nurse practitioner AND training; 28 articles were returned. The following terms were searched when utilizing the PubMed database: advance care planning OR palliative AND nurse practitioner AND training AND primary care, with five articles returned.

Various limits were applied to narrow the search. The information included in the search was limited to articles written within the past ten years (2011-2021), information involving the adult population, research articles, peer-reviewed articles, academic journals, clinical trials, meta-analyses, practice guidelines, randomized controlled trials, and systematic reviews. Also accepted for review were international research studies, information relating to a specific type of clinical setting or diagnosis, and articles referring to providers as physicians or doctors instead of strictly nurse practitioners. Studies excluded from the review contained information primarily about patient education on ACP or focused on the pediatric population. Following applying the limits and the criteria for either inclusion or exclusion, the search yielded 27 results.

After the abstracts of the 27 articles were examined, ten studies were selected for a more thorough analysis (see Appendix A). A critical appraisal of the evidence was conducted using The Johns Hopkins Research and Non-Research Nursing Evidence-Based Practice (JHNEP) appraisal tools. The tools helped determine the strength and quality of the evidence in the ten studies that were ultimately selected for the literature review (Dang & Dearholt, 2022).
Results

Three specific themes arose during the literature review. The findings of three studies suggested that primary care providers are well-suited to implement ACP. Several other studies’ evidence illustrated that limited provider knowledge of ACP hinders EOL conversations in practice. The remaining studies supported the idea that further education on ACP for providers could increase their knowledge and confidence in incorporating ACP into practice. The literature review indicates that provider education on ACP is necessary and can contribute to positive patient outcomes.

ACP in the Primary Care Setting

Three articles explored the appropriateness of ACP implementation in the primary care setting. Initial findings suggested that patients value having thorough, focused EOL discussions with a familiar primary care provider or nurse in the outpatient clinic setting. For example, Kendell et al. (2020) interviewed older patients with declining physical health to determine their feelings about early ACP implementation in a Canadian primary care setting ($n = 11$). Patients supported the idea of initiating ACP in this setting, as it gave them time to consider plans for the remainder of their lives. Patients also wanted face-to-face outpatient provider appointments dedicated to EOL care planning.

Similarly, Miller et al. (2019) examined patients’ perspectives on engaging in a structured ACP conversation with general practice nurses (GPNs) in several primary care clinics in Sydney, Australia ($n = 13$). Researchers felt that the GPNs were uniquely positioned to implement EOL discussions given their knowledge of various disease processes, caring, compassionate natures, and enthusiasm to participate in ACP with patients. Considering these assets, researchers focused part of the study on training the nurses to initiate structured EOL discussions in practice.
After the nurse training, patients reported that the ACP conversations led by the GPNs were a positive experience, especially if there was an existing therapeutic relationship between patient and nurse.

Aoki et al. (2017) also explored primary care and ACP by conducting a cross-sectional study in 28 Japanese primary care clinics \( (n = 535) \). Researchers assessed the relationship between patient experience of primary care and the occurrence of ACP conversations or official documentation. Initially, the study evaluated patient satisfaction with various aspects of their primary care clinics using a Likert-scale questionnaire called the Japanese version of the Primary Care Assessment Tool (JPCAT). Following this, Aoki et al. asked patients to report whether their provider had initiated an ACP conversation or documentation. Study results found that positive patient experiences of primary care were strongly associated with the occurrence of ACP conversations between patient and provider \( \text{[odds ratio (OR) per 1 SD increase} = 4.33; 95\% \text{ confidence interval (CI),} 2.53–7.47\]. \) On the other hand, there was no significant relationship between patient experience of primary care and official ACP documentation \( \text{(OR per 1 SD increase} = 1.42; 95\% \text{ CI,} 0.94–2.12\]. \) Overall, the study’s findings support that primary care providers can positively integrate ACP into outpatient visits.

**Facilitators and Barriers to ACP**

Several reviewed articles sought to identify common facilitators and barriers to ACP in the clinical setting. For example, Batchelor et al. (2019) conducted a systematic review that revealed significant themes that could help or hinder ACP discussions, as reported by nurses, doctors, patients, and families in Australian aged care settings. Knowledge and education, as well as skills and training, comprised two of the categories. Clinicians and patients alike reported that the level of provider knowledge and skills around ACP could either encourage or
impede EOL conversations. As a result, researchers concluded that providing further ACP education and training for providers could support the implementation of EOL discussions with older adult patients.

Glaudemans et al. (2019) uncovered similar themes when they explored how Dutch primary care professionals experienced in EOL care overcame the identified barriers associated with the ACP aspect of practice ($n = 14$). Fourteen providers participated in the study, and all reported having experienced barriers to implementing ACP with their older patients. Researchers discovered that providers noted their limited ACP knowledge and skills as barriers to incorporating EOL discussions into practice. Participants shared that to address their knowledge gap, they pursued continuing education on ACP and even taught their peers to solidify their knowledge and skills.

Howard et al. (2018) also explored various barriers to and enablers of ACP according to primary care healthcare providers in Canada; the study produced varied results. In this cross-sectional study, researchers invited 255 healthcare providers in the primary care setting to complete an electronic survey about perceived self-knowledge of and barriers to ACP implementation in practice. Of the 181 providers that responded, 117 were family physicians, and 64 were described as other health professionals. The latter group of providers consisted of nurses with varying levels of education, social workers, physician assistants, and psychologists. The literature review focused on reports from family physicians.

Contrary to the findings of other studies, the survey results did not cite limited physician knowledge as a significant hindrance to ACP. Physicians expressed in this study’s survey that insufficient time during scheduled appointments was the primary barrier to ACP implementation in practice. Additionally, most physicians reported having an average amount of knowledge
regarding ACP. Nevertheless, in the open-ended survey questions addressing ACP enablers, physicians indicated that learning ACP skills is a high priority.

**Education to Increase Provider Knowledge of ACP**

The remaining studies suggest that educating providers on ACP will help increase their knowledge and confidence in conducting EOL discussions in practice. For instance, Izumi et al. (2019) studied how an educational intervention on ACP would impact nurses’ knowledge of and confidence in initiating ACP conversations in a bone marrow transplantation unit in Oregon ($n = 60$). This quality improvement project also assessed for any nurse practice changes over three months following the educational session. Pre- and post-intervention survey scores noted a significant increase in nurse knowledge and confidence regarding ACP implementation after the educational session ($p < 0.001$). Nurse practice changes surrounding ACP also occurred after the session. Study participants reported initiating EOL conversations more often with their patients, though this finding was not statistically significant.

Burgunder-Zdravkovski et al. (2020) also studied the effects of an educational intervention for providers. Researchers sought to improve EOL care conversations between patients and healthcare providers by providing several inpatient and home health nurses with an educational session about communication skills and techniques and practical and actionable EOL information in the form of an “ACP Toolkit” ($n = 18$). Study results using pre- and post-intervention surveys showed that the educational session significantly increased the nurses’ confidence levels in initiating ACP conversations with patients and families ($Z = −2.101, P = .036$).

Colville et al. (2012) took a qualitative approach to determine the outcomes of an ACP study day intervention on the practices of six nurses in the community ($n = 3$) and hospital
settings \((n = 3)\). Post-intervention interviews with participants reflected nurses’ reports of increased knowledge and confidence around ACP. Nurses expressed that the communication techniques discussed in the study day positively impacted their own clinical ACP practices.

Finally, Evans et al. (2021) sought to evaluate the effectiveness of a three-year pilot project involving palliative care education for providers at four Ontario primary care clinics. Researchers described palliative care as a treatment approach to alleviate suffering and increase the quality of life for patients experiencing significant, life-limiting illnesses. ACP conversations and documentation are often an aspect of palliative care. Participating providers attended a two-day educational workshop on the best current palliative care practices. Providers also completed a 20-question pre- and post-workshop questionnaire to measure their knowledge of and confidence in delivering palliative care. Questionnaire results showed a significant increase in provider confidence in implementing palliative care, specifically initiating ACP discussions with patients \((30\% \text{ mean increase, } P < .05)\).

**Discussion**

The literature review revealed three main themes. First, Kendell et al. (2020), Miller et al. (2019), and Aoki et al. (2017) spoke to the appropriateness of ACP in the primary care setting. Kendell et al. (2020) found that patients appreciate ACP discussion in primary care because it allows time for thoughtful consideration of their life goals and EOL care wishes. The findings of Miller et al. (2019) also point to the benefits of having ACP conversations in primary care. Patients in this study reported that having EOL care discussions with primary care nurses was a favorable experience. Patients said that previously established rapport between patient and nurse enhanced the ACP experience. Lastly, Aoki et al. (2017) found a positive association
between patient satisfaction levels and the occurrence of EOL care conversations with a PCP, suggesting that patients value ACP in the primary care setting.

The literature also discussed facilitators and barriers to ACP. Batchelor et al. (2019) showed that patients and medical clinicians (e.g., nurses and doctors) support providers having strong knowledge and skills around ACP, as this competence can be an asset in EOL care conversations. Moreover, patients and clinicians hold that a provider’s limited ACP skill set could threaten EOL care discussions. Consequently, the researchers recommended continued ACP training for providers to strengthen this aspect of primary care practice. In Glaudemans et al. (2019), providers well-versed in EOL care shared how their initial lack of experience with ACP posed a barrier to such discussions in practice. Providers overcame this barrier by seeking further ACP education and instructing their peers to hone their skills.

On the other hand, Howard et al. (2018) shared differing results. The physicians who responded to this study’s survey on the facilitators and barriers to EOL discussions did not indicate limited physician knowledge as an impediment to ACP. Instead, the participating physicians reported a lack of time during patient appointments as the most significant barrier to implementing ACP. However, in the open-ended question portion of the survey, the physicians still mentioned the importance of having adequate ACP skills.

Lastly, the literature review showed the connection between ACP education for providers and its potential to increase provider knowledge and confidence in having EOL care conversations with patients. For example, Izumi et al. (2019) found a significant increase in nurse-reported knowledge and confidence around ACP in a post-intervention survey following an educational session about having EOL care discussions with patients. Researchers also noted that some nurses incorporated EOL conversations into patient care more often within the three
months following the educational intervention, though this was a small finding. This study illustrates that ACP education can expand provider knowledge and elicit practice change. Burgunder-Zdravkovski et al. (2020) uncovered similar findings when they provided home health nurses with EOL care education through a practical, actionable “ACP Toolkit.” As in Izumi et al. (2019), this study’s pre- and post-intervention questionnaires indicated a significant increase in nurse confidence levels around facilitating ACP discussions with patients. Colville et al. (2012) used qualitative research with pre- and post-intervention interviews to show how an ACP study day increased the participating nurses’ self-reported knowledge and confidence. Furthermore, the nurses shared that the study day section on communication techniques was especially helpful in enhancing EOL care conversations with their patients. Finally, Evans et al. (2021) used an educational session format for providers in primary care accompanied by pre-and post-intervention surveys to determine that PCPs felt more confident following the session in initiating ACP discussions with patients.

Limitations

Reduced generalizability was the primary limitation of the articles included in this review. For instance, much of the research examined small sample sizes of patients and providers, making applying the findings to larger populations challenging. Similarly, two of the studies that involved educational interventions took place in specialty units; the same interventions may produce varying outcomes in different settings. Additionally, the fact that most of the articles were international limits generalizability due to possible cultural differences. The general American population may hold viewpoints on ACP, EOL care, and death that differ from those of global populations.
Furthermore, several studies included healthcare professionals other than primary care providers, such as registered nurses, social workers, and psychologists. This decreases generalizability further, as the participants’ differing professional and educational backgrounds could affect their reports of self-perceived knowledge of and confidence in ACP. Finally, several studies exploring provider views on their ACP knowledge before and after an educational intervention relied on self-reported data. This could decrease the validity of post-intervention survey results.

**Implications and Recommendations for Provider Practice**

In light of the multiple benefits of EOL care planning and expanding America’s aging population, primary care providers must prepare to incorporate ACP into practice. Continuing education for providers on ACP can strengthen provider knowledge and confidence in having EOL discussions with older patients. Information on ACP can be disseminated to practicing providers through employer-run informational sessions. For instance, healthcare employers could organize sessions to share information on ACP with providers and how to implement it with patients best. These presentations could feature another clinician as a keynote speaker specializing in ACP and EOL care. It is also important that healthcare providers and researchers conduct additional studies to explore patients' quality of life and health outcomes after incorporating ACP into care instead of focusing solely on provider knowledge of ACP. Shedding light on ACP and best practices can bring EOL care conversations to the forefront of providers’ minds and has the potential to decrease unwanted emergency room visits, hospital visits, and invasive treatments for patients. Research and continuing education on ACP can empower providers in primary care to recognize and honor their patients’ EOL care wishes.

**Conclusion**
ACP discussions and documentation are known to preserve patient dignity, foster autonomy, and help prevent undesired medical treatments at the EOL. As the age demographic of the American population shifts, it becomes crucial that healthcare providers in the primary care setting acknowledge the role they can play in supporting their patients during the aging process. Providers can effectively facilitate EOL care conversations with their older patients with the correct knowledge and skills. By initiating such discussions in practice, providers allow patients to establish their EOL healthcare wishes, thus promoting patient dignity and autonomy. Addressing the knowledge gap providers have around ACP through further education can result in positive patient outcomes at any stage of a patient’s life.
References


Appendix A: Evaluation Table

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<thead>
<tr>
<th>Purpose of Article or Review</th>
<th>Design / Method / Conceptual Framework</th>
<th>Sample / Setting</th>
<th>Major Variables Studied (and their Definitions)</th>
<th>Measurement of Major Variables</th>
<th>Data Analysis</th>
<th>Study Findings</th>
<th>Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s)</th>
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<tbody>
<tr>
<td>Purpose: to identify facilitators and barriers to the implementation of ACP in aged care settings</td>
<td>Design: systematic review and thematic analysis</td>
<td>Sample/setting: older adults/resident s, family members, nurses, doctors at various Australian community or residential aged facilities</td>
<td>Independent variable for the 2 interventional studies: ACP practices in the facilities</td>
<td>It was noted that the included studies did not have clear outcome measurements to determine the implementation of ACP in the aged care settings</td>
<td>Deductive thematic analysis to gather major themes related to ACP facilitators and barriers. Each article read by two authors who determined themes and verified themes with a third author</td>
<td>Six themes were identified regarding facilitators and barriers to ACP in aged care settings: Knowledg e and education; skills and training; procedures and resources; perception and</td>
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<tr>
<td>strategies utilized on electronic databases Data extracted and common themes summarized</td>
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<td>culture; legislation ;systems may have limited the returned information; included studies were generally of low quality <strong>Feasibility:</strong> not noted <strong>Conclusions:</strong> multi-disciplinary, person-centered approach is needed to increase implementation of ACP, taking into account varying legislation across Australia <strong>Recommendations:</strong> more research is needed to determine if interventions for increasing ACP are effective; more research is needed especially on needs of minority groups that are culturally and linguistically different; more research needed in community aged care settings</td>
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Definition of abbreviations: ACP – advance care planning
### Purpose of Article or Review
Purpose: to assess the impact of a PC educational session and mentorship on the confidence levels of nurses in starting PC conversations with patients

### Design / Method / Conceptual Framework
**Design:** quasi-experimental
**Method:** Part 1 - interactive educational session on communication skills/techniques & ACP Toolkit
Part 2 – real-time mentorship conversations by certified ACP nurse facilitators

### Sample / Setting
**Sample:** 18 Nurses (6 acute care and 12 home care)
**Setting:** large Midwestern academic hospital’s med-surg and pulmonary units and home health agency

### Major Variables Studied (and their Definitions)
**Independent variable:** Nurse demographics (length of time as a nurse, highest education, presence of hospice experience)

### Measurement of Major Variables
**Outcome variable** measured by pre-/post-intervention survey scores using a 4-item survey with answer options “strongly agree,” “agree,” “neither agree or disagree,” “disagree,”

### Data Analysis
Wilcoxon matched pairs signed rank test & Cramér’s V

### Study Findings
Statistically significant improvement in pre-/post-intervention survey scores, suggesting an increase in nurse comfort levels when having PC discussion with patients and families

### Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s)
**Level of evidence:** II B

**Worth to practice:** Educating providers on PC can increase patient awareness of and access to PC services. PC services can improve patient quality of life and reduce costs for the patient by eliminating any unwanted aggressive treatment interventions.

**Strengths:** results indicate that focused education on PC can improve nurse practice attitudes and behaviors on the topic

**Weaknesses:** small sample size and highly motivated participants decreased generalizability; unable to have mentored conversations with all home health nurses due to various logistics and

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<tr>
<td>framework: Pamela Reed's Theory of Self-transcendence</td>
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<td>“strongly disagree” relating to nurse comfort levels with discussing ACP and code status; importance of multidisciplinary collaboration; initiation of ACP conversations; use of ACP to develop patient goals of care</td>
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<td>unforeseen care circumstances; participant misunderstanding of mentored conversation intervention Feasibility: not mentioned Conclusions: educating providers on PC can increase provider confidence in implementing PC conversations with patients Recommendations: not mentioned</td>
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Definition of abbreviations: PC - Palliative care; ACP - Advance care planning; Med-surg - medical-surgical
### Purpose of Article or Review

Explore the effect of ACP education on nurse confidence in and knowledge of ACP implementation and any changes in practice; to identify barriers to ACP implementation on the unit.

### Design / Method / Conceptual Framework

**Design/Method:** Quality improvement project to increase ACP conversations led by nurses; sing-group pre-/post-test design relating to 30-minute educational session on ACP; group interviews done to discuss barriers to ACP implementation.

**Sample:** 60 nurses on a bone marrow transplantation unit (BMTU) in Oregon Health and Science University, an academic medical center.

**Setting:** Educational intervention conducted in one out of the three educational days that occur in the week.

### Major Variables Studied (and their Definitions)

**Independent:** 60 nurses on the BMTU attending the education day where the ACP educational session was held.

**Dependent:** Pre-/post-test scores and identified barriers.

### Measurement of Major Variables

**Independent:** (nurse demographics): gender, race, employment type, presence of own advance directive.

**Outcome variables:** Pre-/post-test scores with a Likert scale test asking about nurse confidence in knowledge about ACP and its implementation; also asking about current personal nursing practices around ACP implementation.

**IBM SPSS Statistics, version 24 used descriptive statistics to summarize survey results and perceived barriers to ACP Wilcoxon signed rank test to compare levels of confidence and ACP practices during the time of the project.

### Data Analysis

**Findings:** Interventions increased nurse confidence in and knowledge of ACP. Nurses noted to have discussed ACP with more patients, though not in a statistically significant manner; Barriers

### Study Findings

**Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s) /**

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| session, 1<sup>st</sup> post-test directly after session, 2<sup>nd</sup> post-test three months after session | year | later measured by an 18-month patient chart review identifying presence of ADs (ADs served an indicator of nurse practice change); Barriers to ACP identified in group discussion during educational intervention | Group interviews were recorded and later listened to; common themes were extracted | include lack of time, inefficient workflow, concerns about questioning providers’ understanding of patient preferences | nurses. **Weaknesses:** the QI approach in a single unit limits generalizability; the sample size was small and there was neither a control group nor randomization; results may have been skewed by the fact that the unit’s nurse manager participated in the project – some staff may have not participated due to discomfort around voicing opinions about ACP with management present. **Feasibility:** not mentioned **Conclusion:** practical and actionable education is needed to address the barriers, knowledge gap, and limited confidence nurses have regarding ACP **Recommendation:** It would be beneficial to look at how EHR systems can support nurses in documenting their
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<td>ACP practice as a way of promoting practice change</td>
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Definition of abbreviations: ACP – advance care planning; BMTU – bone marrow transplantation unit; AD – advance directives; EHR – electronic health record
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<td><strong>Purpose:</strong> explore patient perspectives of engaging in an ACP intervention in general practice setting after the GPNs had received training on initiating and leading the intervention in practice</td>
<td><strong>Design:</strong> qualitative <strong>Method:</strong> GPNs were trained on initiating and leading an ACP intervention with patients; semi-structured interviews were conducted with patients after ACP intervention; 6 major themes were identified from</td>
<td><strong>Setting:</strong> Four general practice clinics in eastern Sydney, Australia, from which 5 GPNs voluntarily took the ACP intervention training <strong>Sample:</strong> 20 patients received the ACP intervention; 13 patients participated in the interview after the</td>
<td><strong>General practice clinics:</strong> in eastern Sydney, computerized, 3-8 clinic providers, serves high number of older adults, GPN present willing to lead ACP, no previous history of having used a systematic approach to ACP <strong>ACP Intervention on which GPNs were trained:</strong> 3-page referral document with patient</td>
<td><strong>Patients:</strong> age, gender, primary language spoken, relationship status, common principal diagnosis length of time as patient of GP, frequency of visitation to GP in 12-month span <strong>Primary outcome variable of patient interview responses:</strong> measured by: recorded and transcribed Transcripts imported into Nvivo (QSR International, Version 10) <strong>Inductive thematic analysis</strong></td>
<td><strong>Patient demographic s stated in initial GP referral analyzed with descriptive statistics</strong> Interviews were recorded and transcribed Transcripts imported into Nvivo (QSR International, Version 10) <strong>Inductive thematic analysis</strong></td>
<td>6 major themes emerged: working through ideas, therapeuti c relationshi p with nurses, significanc e of making wishes known, protecting family from burden, autonomy in</td>
<td><strong>Level of Evidence:</strong> III A/B <strong>Worth to practice:</strong> Thoughtful ACP done in primary care can be beneficial on multiple levels to patients and their families, though uptake of ACP is low. Several identified barriers to ACP, such as limited provider knowledge; special provider training on ACP to increase its implementation in practice can enhance patient care <strong>Strengths:</strong> results of the study aligned with findings of other current research studies <strong>Weaknesses:</strong> findings may have been influenced by sample, as participants were long-term clinic patients with chronic health conditions, though overall stable health;</td>
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<td>interview transcripts</td>
<td>intervention</td>
<td>background information from GP to GPN who then initiated ACP conversation with patients (and any present family/substitute decision makers/caregivers) using ACP workbook and ACD template to guide discussion; GPNs referred patients back to GP for any review or signing of ACD forms</td>
<td>imported into data analysis software to extract 6 common themes</td>
<td>done by coders to extract common themes and concepts until thematic saturation occurred</td>
<td>decision-making, and challenges of family communication. Overall, patients felt the ACP discussion with GPNs were helpful</td>
<td>not all patients who received intervention participated in interview Feasibility: not mentioned Conclusions: GPNs can initiate structured ACP conversations with proper training; this can greatly benefit patient care. Recommendations: More research on a larger scale is recommended</td>
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<td>Experiences with ACP, perspectives on intervention and on GPNs performance, thoughts on how the intervention impacted their families in any way</td>
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Definition of abbreviations: GPN – general practice nurse; ACP – advance care planning; GP – general practitioner; ACD – advance care directive
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<td>To explore how Dutch primary care professionals experienced in ACP with older patients overcome the identified barriers associated with the ACP aspect of practice</td>
<td>Semi-structured interviews with 14 Dutch primary care professionals who were experienced in practicing ACP with older adults. Providers noted initial barriers to ACP in practice and how they had overcome the identified barriers.</td>
<td>Researchers utilized various medical associations and network groups to contact (in person, phone, email) 422 primary care professionals experienced in ACP with older adults. The group was paired down to 14 voluntary participants</td>
<td><strong>Participant demographics:</strong> profession, age, sex, patient population characteristics as estimated by respondents. <strong>Patient interview responses</strong> during interviews that lasted 57-82 mins</td>
<td>Voiced recorder was used to record interviews, which were then later transcribed verbatim.</td>
<td>MAXQDA software used to thematically analyze the transcripts. Open coding and inductive analysis used to determine various ACP approaches, the barriers, and how to overcome the barriers</td>
<td>The study identified several barriers to healthcare providers discussing advance care planning (ACP) with their older patients, one being the providers’ lack of adequate knowledge on the</td>
<td><strong>Level of evidence:</strong> Level III, B  <strong>Worth to practice:</strong> few older adults benefit from ACP due to provider barriers to implementing ACP in practice; it is important to address and overcome these barriers to offer the best ACP care to patients  <strong>Strengths:</strong> first study to give an overview of how various healthcare professionals experience and overcome barriers to implementing ACP; respondents had much experience with the matter  <strong>Weaknesses:</strong> small sample size; experienced providers may not share same identified barriers to ACP as less</td>
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<td>who were known to regularly practice ACP with older adults. Other participants were eliminated due to lack of response/interest in the project or if researchers did not feel that were experienced enough.</td>
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<td>topic. The study suggested that providers could overcome this specific barrier by increasing their knowledge through continuing education on ACP.</td>
<td>experienced providers; possible risk of preconceptions and bias since interviewers were also providers. <strong>Feasibility:</strong> nothing explicitly noted <strong>Conclusions:</strong> ACP should be promoted in a safe way; care providers should gain ACP knowledge and skills and improve beliefs and attitudes around ACP; a more efficient way to deliver ACP should be developed. <strong>Recommendations:</strong> future research on patient/family views on overcome barriers to ACP; development and testing of interventions that support patients/families in ACP</td>
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Definition of abbreviations: ACP – advance care planning
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| To identify barriers to NPs implementation of ACP and define the role of NPs in the ACP process through the development of Nurse Practitioner Advance Care Planning Competencies | Modified Delphi approach – several (3) rounds of anonymous participant feedback to reach an expert consensus on what should be NP competencies: ACP; participation guided by questionnaires | Purposive sample of 29 NPs across Ontario; taken from an original sample of 102 NPs across Ontario that had responded to a survey from another study; 15 NPs participated in the final round of the Delphi approach | Round 1: 4 competencies identified from a survey from a previous study Round 2: 29 NPs rated relevance of these competencies to NP practice Round 3: 15 NPs edited and finalized the list of 4 competencies | In round 2, 29 NPs rated relevance of each component of the 4 previously identified competencies on a scale of 1-7. 1= low, 7 = high | Researchers gave each component a total score based on how each of the NPs score the components. Lowest possible score was 29 if every nurse rated the competency a “1” (1 x 29) and highest score possible was if every nurse rated the | Final draft of competencies: possessing knowledge of the logistics of ACP, including how and when to implement it with patients, having ability to consult and collaborate with the patient and other | Level of evidence: Level IV consensus panel, B
**Worth to practice:** NPs are well-positioned to implement ACP with patients given their advanced education, authority, and advocacy for patients; still, NP involvement in ACP is limited
**Strengths:** none explicitly noted
**Weaknesses:** loss of 51.7% of respondents between rounds 2 and 3 may limit generalizability of the recommendations to other NPs
**Feasibility:** nothing explicitly noted
**Conclusions:** the competencies can be used by NPs as a clear guide to identify their role in ACP |

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<td>competency a “7” (7 x 29) Score, 5,6,7 = high relevance 4 or less = low to intermediate relevance; Actual scores ranged from 108-132 which translated to percentages of 53% - 65%</td>
<td>profession als, including emphasis on advocating for the general use of ACP in all patients, and using of compassionate, therapeutic communication</td>
<td>implementation with patients; make ACP a more widespread practice across various healthcare settings <strong>Recommendations:</strong> to look at the extent to which these competencies are discussed in NP school and if competencies should shift based on clinical setting; also look at overlap between NP roles and roles of other disciplines to encourage a multidisciplinary approach to ACP care</td>
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Definition of abbreviations: NP – nurse practitioner
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| To improve the capacity for ACP in primary healthcare settings | Development of a computerized algorithm to help PCPs identify patients with declining health or at risk for death; Qualitative interviews with stakeholders (patients and families) re: views of this development and challenges/preferences around ACP | 14 Patients of PCPs in Nova Scotia and Ontario 65+ years of age with declining health and the 11 self-identified caregivers of these types of patients Participants recruited from clinics, senior housing complexes, senior living centers, and the community | Participant interviews | Audio recorded interviews that were later transcribed verbatim | Coding of transcripts and identification of themes Identified specific quotes that illustrated key concepts and ideas | Participant s liked the identification of a declining health condition as an indication for a need for ACP. Felt it provided an opportunity to make independent health decisions related to future care. They liked early | Level of evidence: Level III B  
Worth to practice: The care patients receive at EOL do not always align with their actual wishes and ACP can ensure that EOL care and wishes are aligned; limited use of ACP by patients due to providers being unable to identify need for ACP and patients’ hesitation to initiate ACP convos with providers  
Strengths: no strengths explicitly noted in study  
Weaknesses: Small sample size limits generalizability; not all participants were familiar with ACP so researchers’ definition of ACP could have influenced findings  
Feasibility: nothing explicitly | APA Reference:  
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<td>ACP in the primary care setting so they could consider plans for the remainder of their lives</td>
<td>Varying participant preference around ACP with most saying they would prefer face-to-face convos</td>
<td>noted</td>
<td><strong>Conclusions</strong>: patients and families value a personalized, patient-centered approach to ACP and feel providers should have adequate time for these convos</td>
<td><strong>Recommendations</strong>: providers should be allowed and compensated for longer appointments for ACP convos with patients; referrals to relevant community resources as part of the ACP process are important</td>
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Definition of abbreviations: ACP – advance care planning PCP – primary care physicians EOL – end of life

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<td>PCPs; Participants noted perceived barrier of clinicians lacking sufficient time for these convos</td>
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<td>To explore participants’ experiences of implementing ACP discussions in practice after an ACP study day.</td>
<td>Qualitative, semi-structured individual interviews with participants</td>
<td>6 nurses of various types and from various workplaces (generalist/specialists; hospitals/community) who had attended an ACP study day</td>
<td>Participant interviews</td>
<td>Interviews that lasted 20-60 minutes; recorded digitally; interviewers kept a diary for reflections on the interview process → this information was transcribed verbatim.</td>
<td>Interviews analyzed themes Interviewers also described, explained, and transformed the data to form new ideas around ACP</td>
<td>3 major ideas/themes emerged. First, “Bringing it all together” – ACP study day increased nurse confidence around ACP and increased nurse awareness/validated knowledge around ACP, especially around</td>
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**Level of Evidence:** Level III, B

**Worth to practice:**

**Strengths:** nothing explicitly noted

**Weaknesses:** small sample size; also, participants volunteered and may have had previous exposure to ACP information aside from study day that could influence interviews.

**Feasibility:** nothing explicitly noted

**Conclusions:** education on ACP validated and expanded participants’ clinical practices

**Recommendations:** acute care nurses and other team members need to communicate to ensure that patient care wishes are known; providers must acknowledge that ACP can be
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<td>communication techniques → positive impact on clinical practice</td>
<td>emotional → EOL discussions must be well-timed and appropriately communicated</td>
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### Purpose of Article or Review
To investigate the relationship between patient experience of primary care and ACP

### Design / Method / Conceptual Framework
Cross-sectional; Assessed experience of primary care with JPCAT and its relation to ACP discussion and AD

### Sample / Setting
Japan October 2015 to February 2016; 28 primary care clinics in Japan; 535 primary care patients who visited one of the clinics within a week of survey administration; 20+ years of age; regularly attended the clinic for usual care (USC)

### Major Variables Studied (and their Definitions)
Patient experience of primary care – JPCAT

ACP – “process of discussion with health care providers on future health care, particularly in the event that the patient is unable to make his or her own decisions”

AD – states treatment decisions should patient be unable to express them

### Measurement of Major Variables
Descriptive statistics: participant characteristics & patient experience of primary care – JPCAT (self-administered Likert scale questionnaire)

ACP measured on a binary, ‘yes’ or ‘no’ scale of have you had ACP conversations with your provider

AD measured by written documents and on

“Generalized linear mixed model (GLMM) with a logit link function that includes a random effect for clinic and individual covariates as fixed effects” to assess relationship between JPCAT and ACP/AD.

### Data Analysis
Better patient experience in primary care was associated with ACP discussion but not significantly associated with completion of AD

### Study Findings

### Level of Evidence (Critical Appraisal Score) / Worth to Practice / Strengths and Weaknesses / Feasibility / Conclusion(s) / Recommendation(s)

**Level of Evidence**: Level III, B

**Worth to practice**: ACP has positive impact on EOL care for patients

**Strengths**: first study to connect patient experience of primary care and ACP

**Weaknesses**: low response rate; unable to determine depth of ACP conversations between patient and provider; cross-sectional nature of study so relationship between ACP and patient experience cannot be definitely determined; did not adjust for clustering within physicians; these primary clinics had interest in research and education so this may have limited generalizability.

**Feasibility**: not specifically

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|                            |                                        |                 | a binary, ‘yes’ or ‘no’ scale of have you written AD |                               |               |               | mentioned

**Conclusions:** positive patient experiences in primary care can play a role in quality end of life care.

**Recommendations:** primary care providers need to support their patients in ACP documentation.

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Definition of abbreviations: ACP – advance care planning, JPCAT – Japanese version of Primary Care Assessment Tool; AD – advance directives; USC – usual source of care; EOL – end of life
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| What are barriers and enablers to ACP according to providers in primary care | Cross-sectional study with self-administered survey received via email | Survey based on another larger study researchers were doing on ACP; providers asked to rate importance of 31 barriers to conducting ACP with general population of patients 50+ years of age | Health care professionals in primary care in Canada November 2014 to June 2015 Physicians and other health care professionals (RN, NP, RPN, SW, other such as PA or psychologist) | Survey done on a 0-6 Likert scale regarding importance of 31 barriers to ACP Qualitative responses of enablers of ACP via open-ended survey question | Survey: Categorical variables described as counts. Percentages and continuous variables described as means and standard deviations Qualitative responses: thematic analysis | Survey results shared top 3 barriers to ACP as indicated by physicians and other health care professionals. Lack of knowledge was not in top three and most participant rated their ACP skills as average. However, most | Level of Evidence: III, A Worth to Practice: ACP produces positive patient outcomes and primary care providers might be well-positioned to integrate ACP into practice Strengths: variety of family practice primary care provider types included from 3 provinces and were team-based and non-team-based; survey instrument used from previous study proved to have validity and sensibility Weaknesses: participants volunteered and may have different views that those who did not elect to participate Feasibility: not specifically noted Conclusion: need to develop strategies at multiple levels to integrate ACP into practice to

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<td>in past 9 months.</td>
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<td>participant s felt learning ACP skills was a high priority and in the thematic analysis of qualitative responses, the importance of training and education emerged as themes per the participants</td>
<td>achieve best patient outcomes. <strong>Recommendation:</strong> not specifically noted</td>
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Definition of abbreviations: ACP – advance care plan(ning)
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<td>To look at the effectiveness of an intervention made to prepare providers for palliative care delivery</td>
<td>INTEGRATE project – provider education about palliative care and care model to promote early identification of palliative care needs</td>
<td>4 primary care clinics in Ontario with every provider being invited to participate in project</td>
<td>Intervention - INTEGRATE project of palliative care education (2-day LEAP course) and then a program to facilitate early identification of patients with palliative care needs and linkages to services</td>
<td>LEAP course – course about current practices of caring for patients with life-limiting illnesses</td>
<td>Chi squared test for comparing pre and post intervention surveys</td>
<td>Increased provider confidence in delivering palliative care, increase in self-provided use of palliative care tools and services</td>
<td>Level of Evidence: II, A Worth to Practice: Many Canadians only receive palliative care in the last month of life and providing this care in primary care can let patients experience its benefits. But PCPs need more education on palliative care and associated services/resources Strengths: not specifically noted Weaknesses: inclusion of self-reported data; unable to create matched-pairs for pre and post intervention survey responses for each individual; focus was only on provider outcomes and not on patient quality of life or health outcomes Feasibility: not specifically</td>
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<td>semi-structured interviews</td>
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<td><strong>Conclusion:</strong> a standardized program for early identification of patients who need palliative care support is feasible in primary care settings if training and education is provided <strong>Recommendation:</strong> more research is needed around practice factors that affect palliative care interventions; also explore patient outcomes</td>
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