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Utilization of REMAP Conversation Tool to Improve Advance Care Completion in the Home-based Palliative Care Community Setting

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Utilization of REMAP Conversation Tool to Improve Advance Care Completion in the Home-based Palliative Care Community Setting

A DNP Project Submitted to the
Graduate Faculty
of Jacksonville State University
in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Nursing Practice

By
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Jacksonville, Alabama

August 5, 2022

Gwendolyn S. Starkey August 5, 2022

Abstract

Background: The World Health Organization and the American Society of Clinical Oncology guidelines endorses mandatory communication skills training in care goals for seriously ill patients (Back et al., 2019). In one survey of primary care providers (PCP), 68% reported no formal training to discuss advance care planning (Comer et al., 2020). Advance care planning is essential to manage chronic conditions in our growing aging population to provide the best patient care. This manuscript aimed to discuss best practices and techniques in advance care planning and optimize skills to provide patient-centered care conversations that honor patient wishes, reduce unwanted hospitalizations, and focus on the patient's quality of life.

Purpose: The Doctor of Nursing Practice (DNP) project was a process improvement initiative in the home-based community setting. The nurse practitioner/DNP candidate educated nurse practitioners who participate in advance care planning. This project utilized REMAP: Reframe, Expect emotion, Map out values, and Plan (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.). Outcome measurements were completed advance care planning documentation. These were measured pre-and post-project implementation.

Methods: The DNP project was a 9-week study examining ACP upload rates. Ten nurse practitioners participated in this project with a 100% participation rate. Each week, the number of patients with and without ACP uploads was recorded.

Results: According to a simple linear regression analysis, the trend noted was an increase in ACP document completion and uploads (See Table 3). The investigation noted that the B-coefficient weekly was positive (0.17), indicating that ACP upload rates increased as the study progressed. This project had a value of $p=0.46$. Therefore, the study did not reflect a statistically significant change in the ACP upload rates.

Conclusion: Using REMAP within provider training could increase ACP documentation over time. Although this 9-week intervention was not statistically significant, a lengthier timeframe could show significance.

Keywords*:* Palliative care, end of life care, goals of care conversation, goals of care, tools, advance care planning, living will, living will completion, geriatrics, quality of life, nurse practitioner

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This project is dedicated to my three children, Christina, Joshua, and Samuel. They are a beautiful gift from the Lord. And of whom Samuel most recently said, "I don't give up because my mom won't give up."

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Utilization of REMAP Conversation Tool to Improve Advance Care Completion in the Home-Based Palliative Community Setting

Advance care planning (ACP) has a wide range of definitions. The working definition to be used in this manuscript is “the overarching aims of medical care for a patient that are informed by patients’ underlying values and priorities, established within the existing clinical context and used to guide decisions about the use of or limitation(s) on specific medical interventions” (Secunda et al., 2019, p. 1560). An international multi-disciplinary panel defines advance care planning as an ongoing conversation or process in which adults of any age or health status share their goals and values. Therefore, the subsequent care is aligned with the patient's goals (Sudore et al., 2017). The panel defined the goals of ACP as bringing the person and individuals they trust together within the decision-making process to discuss health prognosis with a healthcare provider(s). It should prepare the person to make the best medical decisions by being a fully informed participant in their care, and these conversations should be revisited over time (Sudore et al., 2017).

True ACP consists of goals of care conversations (GOC). It addresses medical conditions, prognosis, values, goals, treatment plans, and emotional support. In addition, GOC explores values before deciding on treatment recommendations (O’Connor et al., 2020). One qualitative study, including a questionnaire of aging patients and families on GOC conversations, included preferences for care, prognosis, values, fears, and questions (O’Connor et al., 2020). ACP discussions typically prepare for future health decisions. However, evidence also suggests that not all patients or families are comfortable talking about ACP.

At times, surrogate decision-makers are needed to make decisions on behalf of the patient. This term is referred to as the health care proxy or durable power of attorney (DPOA).

However, surrogate decision-makers are frequently unprepared and do not feel confident in making these decisions, often viewing them as an emotional burden.

The primary source of ACP discussions is the primary care provider (PCP). In one survey of PCPs, 68% reported no formal training to discuss advance care planning (Comer et al., 2020). However, the World Health Organization and the National Academy of Medicine endorse mandatory goals of care communication skills training for all providers with seriously ill patients (Back et al., 2019). Also, the 2017 American Society of Clinical Oncology guidelines promotes training for all oncologists (Back et al., 2019).

Advance care planning is essential to manage chronic conditions in our growing older adult population to provide the best patient care. This manuscript discusses best practices and techniques in advance care planning and strategies for optimizing skills to provide patient-centered care conversations that honor patient wishes, reduce unwanted hospitalizations, and focus on the patient's quality of life.

Background

Advance Care Planning and Palliative Care

According to the Centers for Disease Control and Prevention (CDC), 45% of Americans suffer from at least one chronic condition: cancer, diabetes, hypertension, coronary artery disease, and chronic obstructive pulmonary disease. In addition, nine out of 10 geriatrics patients have a severe illness that is chronic and can be life-limiting (Back et al., 2019). Therefore, with an increase in chronically ill and older adults, ACP and ongoing discussions regarding GOC conversations are essential for medical practice.

Advance care planning (ACP) knowledge and actual discussion of patient wishes and values are two different challenges. In one cross-sectional study to assess academic knowledge of living wills, less than 12% of participants answered questions correctly. It was noted that understanding what defines ACP is not enough to enhance actual discussions (van Dyck et al., 2021). Other issues indicated a disconnect between what the patient understands as a goal of care conversation versus what the provider states is a conversation (Modes et al., 2019). In one cross-sectional study, out of 236 visits where the provider entered goals of care conversations, 35% of patients did not believe such a conversation occurred (Modes et al., 2019).

Furthermore, even when a goal of care was said to occur, 38% of those conversations were not documented in the electronic medical record (EMR) (Modes et al., 2019). In one study of metastatic colon cancer patients, 80% of those who participated in the study after a prognosis discussion believed they still had a possibility of a cure (Back et al., 2019). The finding revealed a significant disconnect from what the provider was trying to relay. Nevertheless, this study also acknowledged that patients could be relaying their hopes for a cure (Back et al., 2019).

With this disconnect, a guided conversation tool is essential. Other studies suggest that 20% to 80% of primary care providers report these conversations in the clinic. (Back et al., 2019; Fleshner et al., 2019; Modes et al., 2019; van Dyck et al., 2021). Yet, the patients report these discussions at a significantly lower rate of 15% to 35% (Fleshner et al., 2019). Decision aids, videos, and guides improve patient understanding of goals and may lead to more documented goals of care conversations, including care focused more on comfort than on interventions (Comer et al., 2020).

Financial Costs Associated with End-of-Life Care

Palliative care patients utilize the emergency room at increased rates of an average of $8.3 billion yearly (Fink-Samnick, 2020). Literature shows that 75% of all healthcare spending is toward the care of those with chronic illnesses (Raghupathi & Raghupathi, 2018). Specifically for adults 65 years and older, healthcare expenditures in the last year of life can be up to 30% of the total. Another viewpoint is that the per capita cost of the last 12 months can escalate to $80,000 (Fink- Samnick, 2020).

Furthermore, the last month of life spent in the hospital can cost an average of $32,379 (Fink-Samnick, 2020, p.112). According to the Centers for Medicare and Medicaid Service's (CMS) statistical analysis for 2019, Medicare spending grew to $799.4 billion, or 21% of the national health expenditure (*NHE Fact Sheet,* 2021). Furthermore, Medicare forecasts the highest expense partly due to considerable enrollment growth and our aging population.

The location of where one dies is also associated with varying costs. According to the literature, only 7% of chronically ill patients die while receiving hospice care and 40% die in the hospital (Fink-Samnick, 2020). The cost of dying in a hospital is seven times more and is estimated at $32,00 versus a home death of $5,000 (Fink-Samnick, 2020). Therefore, having conversations centered around where one would like to die is imperative.

Benefits of Advance Care Planning

Advance Care Planning (ACP) is linked to improved patient care and lessens caregiver burden, such as reducing decision conflict (van Dyck et al., 2021). A lower risk of caregiver depression and grief was reported with ACP completion (Modes et al., 2019). Understanding patients' preferences for life-sustaining measures like CPR and the location of death should be a part of this discussion. Less delayed Do Not Resuscitate (DNR) orders benefit ACP. For the families involved with ACP, better support in decision-making skills is reported along with a reduced prolonged grieving process (Fleshner et al., 2019). In one study using caregivers of advanced cancer patients, those caregivers of a Do Not Resuscitate (DNR) status patient reported a decrease (Falzarano et al., 2021). Completing an ACP can reduce unpreparedness for death and eliminate poor end-of-life decisions (Falzarano et al., 2021). The prolonged grieving disorder may be reduced for caregivers when ACP completion is done (Falzarano et al., 2021). Finally, for providers, ACP and the communications skills required to promote trust between patient and provider will lead to less burnout and frustration for the provider (Back et al., 2019).

Usual Care of Advance Care Planning

The primary purpose of the living will is to prepare a health care proxy to make decisions that align with the person's goals should they become incapacitated. Furthermore, it is a legal document and an opportunity for end-of-life preferences to be known (Myers et al., 2018). The Patient Self-Determination Act (PSDA) was passed in 1990 and is legislation that requires hospitals, nursing homes, home health, hospice, and health maintenance organizations to provide information on advance care planning on admission (Clark et al., 2015). A copy of the Alabama Living Will is online on multiple platforms for free download. One such location of the Alabama Living Will is at Free Alabama Living Will Forms | Advance Health Care Directive : Living Will Forms (*Free Alabama Living Will Forms/ Advance Health Care Directive*, 2022).

However, little is often done to explore values beyond giving literature. In addition, the living will and health care proxy forms can vary from state to state and can make completing these forms more difficult depending on state requirements. Most patients rely on their providers to bring up goals and are hesitant to discuss them independently. According to the Institute of Medicare's *Dying in America* (2015), the primary care provider does most of the advance care planning. In a recent discussion, 99% of providers agreed that ACP planning is necessary, but only 29% have training in addressing end-of-life care.

Most advance care conversations occur from the primary care provider and involve healthy adults and only introductory information. However, merely introducing information is inadequate for patient planning regarding care goals. For example, in a survey, 14 out of 31 participants stated their provider did not assist in advance care planning decisions or put wishes into writing (*Conversation Starters: Research Insights from Clinicians and Researchers on Conversations About End-of-Life Care and Wishes*, 2016). Also, the EMR often does not have adequate documentation reflecting these conversations as they should or adequately relay the values and hopes of the patient (Sanders et al., 2018).

Advance Care Planning and the Nurse Practitioner or Provider

Changes in advance care planning should start with healthcare organizations and provider improvements as ACP is underutilized (van Dyck et al., 2021). In addition, health care systems are moving to a more value-based approach to address length of stay, readmissions, and cost (Fink-Samnick, 2020). The Institute for Healthcare Improvement outlines guidelines to improve population health, reduce cost and improve quality. These are referred to as Triple Aim or Quadruple Aim Initiatives. Quadruple Aim initiative also focuses differently on the healthcare provider (Fink-Samnick, 2020). Triple and Quadruple Aim programs discussed that providers should focus energy on educating best practices and decisions that give the best care for the population at a suitable time and discuss specifically care that may not be helpful to the patient's goals (Fink-Samnick, 2020). To promote the importance of these conversations, CMS now allows billing for advance care planning.

With advancements in improving communication, such as EMRs and patient portals, documenting advance care planning is more accurate and allows providers to align plans of care with patient goals (Halinski, 2020). One understands that not all ACP discussions lead to a completed living will document. Therefore, documentation of these discussions is essential for all providers to access. ACP should start with those with advanced disease beginning at diagnosis (Clark et al., 2015).

Barriers to Advance Care Planning

Barriers are noted in ACP. Such barriers can include low educational levels and culture. GOC discussions can be impacted by the environment, communication skills, and expectations (O'Connor et al., 2020). In addition, evidence suggests that race and religion can affect care conversations and decision goals. For example, research indicates that African Americans and some religious organizations may choose more life-prolonging care plans. Still, people may choose hospice care as the disease progresses (Comer et al., 2020).

Barriers to conversations include inexperience, patients feeling they were not heard or respected, and not having a quiet environment (O'Connor et al., 2020). In addition, decisional incapacities such as dementia can be a significant barrier. Finally, according to a systematic review by Marin (2020), uncertainty about the timing of ACP and the future are common. This study of barriers concluded that healthcare professionals should undergo training on ACP, and these discussions should be initiated as early into the disease process as possible. This is considered Grade A evidence (Marin, 2020).

There are tools to assist in discussing advance care planning instead of current standard practice. Structured communication tools were shown according to the evidence to improve conversations. (*Five Wishes- a Living Will Document*, 2021; Freytag et al., 2020; Jeong et al., 2019; Myers et al., 2018). In addition, the skillset for ACP notes that these conversations are ongoing, can occur over time, and should be documented to reflect the patient's values (Myers et al., 2018).

Needs Analysis

Community Home-Based Environment

The community home-based environment was the location of the Doctor of Nursing Practice (DNP) project. This palliative-based program predominantly served Medicare-aged patients throughout the state. This service has been provided for over seven years. Based on acuity, the framework was designed to assess the patient's home environment every two to four weeks. In addition, 24-hour day access was available via telephone. This palliative home service was free to its recipients. These visits provided in-home assessments, promoted health, reviewed medications, prevent hospitalizations, and coordinated care.

Furthermore, the palliative home visit included goals of care conversations and assistance in completing ACP documents. This required involving family providers and aligning with the patient's wishes. The metric for the practice site included completing ACP documentation and uploading it to the EMR at a rate of 78%. Unfortunately, completed ACP documentation rates in 2020 and previous years have been as low as 3%. As of December 2021, the upload rate averaged 15%, which is a significant improvement but inadequate for the standard of care framework.

SWOT Analysis

A strengths, weaknesses, opportunities, and threats (SWOT) analysis assessed internal strengths, weaknesses, external opportunities, and threats (see Appendix B). The internal strengths of this project included a collaborative initiative to increase the ACP rate. This collaboration included nurse practitioners, nurses, social workers, physicians, clinical director, and chief medical officer. Also, having the goals of care conversations and the ACP document uploaded into EMR allowed all providers and colleagues to understand the patient's wishes.

Another strength is seen in the practice environment setting. Being in the home environment allows the practitioner to assess the barriers to ACP. Furthermore, time in the home setting every four weeks provides a foundation to establish trust for GOC conversations.

Internal weaknesses include the patient's lack of interest in the discussion or family members. Sometimes the weakness was a lack of understanding of the prognosis. Not having a built-in tool to guide the conversations was a weakness this DNP project sought to address. Furthermore, the lack of witnesses to sign the consent form was challenging in rural areas, especially when social distancing due to COVID-19. Another weakness within this project location was the lack of a central office for providers traveling. Therefore, no immediate oversight in this clinical setting was available, making continuity in conversation guidance and mentorship a challenge.

External opportunities were noted within the organization. For example, placing a provider in the home with support from social workers can improve goals of care conversation, especially after receiving ongoing training and using a guided tool (Chan et al., 2018). Improving advance care planning for the palliative patient population can reduce unnecessary hospitalizations or medical procedures. It can guide the patient and provider to align with the most beneficial plan of care and increase patient and family satisfaction (Marin, 2021a). Insurance companies benefit from aligning care as evidenced by cost reduction, identified goals, and reduced hospitalizations by having trained providers (Fink-Samnick, 2020).

Palliative care can be challenging in the home. EMRs were not always functioning, and internet access was at best unreliable. Not promptly obtaining medical records was a considerable challenge in discussing prognosis and care goals. Furthermore, the team of providers was unable to meet in person for the last two years secondary to COVID-19 restrictions. This restriction set forth by the organization reduced in-person simulation to role play. As a result, role-playing in care conversations in-person versus virtual platforms was challenging. A table of SWOT and GAP/ needs analysis is in Appendix A and B for review.

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Problem Statement

Advance care planning is an integral part of holistic health care. Presently, only one in three Americans have completed an advance directive (van Dyck et al., 2021). See Appendix C for a copy of the advance care directive. Evidence reveals that advance care planning can improve the quality of life for patients and caregivers. GOC conversations should address the patient's current medical condition and values before discussing a treatment plan (Comer et al., 2020). Evidence states that goals of care conversations can improve quality of life and prevent unwanted life-prolonging measures (Marin, 2021a). Knowledge of ACP and discussion or engagement in ACP are different and should be evaluated differently (van Dyck et al., 2021). Presently, the practice gap in advance care completion rates in the principal investigator's (PI) home-based palliative care practice is low. The PI practice target was 78%, and each nurse practitioner was assessed individually for complete advance care planning documents. Some of the advance care completion metrics were as low as 3%. Therefore, increasing the completion rate was needed and identified as a practice gap. Vital Talks is a communication education program that teaches skill sets for simulation and training on ACP and GOC conversations. Vital Talks include a tool for late GOC conversations called REMAP, a mnemonic for Reframe, Expect emotion, Map out values, and Plan (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.). A stepwise framework for this guided conversation is listed below

1. R: Raise the issue, normalize ACP, and ask permission: "I talk to all of my patients would it be okay if we talked about this today?"

2. E: Empathize: “I know these things can be hard to talk about.”
3. M: Map out what’s important to the patient:
    3.a. Obtain a surrogate decision-maker: “Is there someone in your life you would trust to make medical decisions for you if you were unable to do so?” It is important to emphasize that this person can be family, a friend, or even a neighbor.
    3.b. Map out patient values using questions such as “If you were seriously ill, what would be most important to you?”, and “What would you be worried about?”
4. A: Affirm the patient: “Thank you for having this discussion.”
5. P: Propose a plan. This involves encouraging the patient to complete a written advance directive and have a discussion with their surrogate. (Fleshner et al., 2019 pg. 2632).

Using the REMAP conversation guide as an implementation strategy was the purpose of the DNP project. Evidence-based literature supports using REMAP as a conversation-guided tool to have open-ended care conversations (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.; Comer et al., 2020; Crossman et al., 2021; Childers et al., 2017; Fleshner et al., 2019; Siropaides et al., 2020). The PI noted the pre-implementation data as the uploaded ACP documents from January through March 2021. After training the advance care providers using education via a virtual platform, role-play, and mentorship via weekly group phone conversations, the weekly completed ACP uploads were measured for nine- weeks. In addition, the PI evaluated the effectiveness of advance care planning by assessing the completion of living will documents in the EMR after using the tool REMAP.

The question that was answered through this project was the following: for advanced care providers of palliative care patients (P) will utilizing the REMAP conversation guide (I) as an educational tool to discuss advance care planning with patients and caregivers compared to no guided conversation (C) impact completion of advance care planning (O) over three months? (T)

Aims and Objectives

As a process improvement initiative, the PI educated nurse practitioners on advance care planning by employing the REMAP tool to support nurse practitioners' discussions regarding advance care planning with patients within the home-based setting. Outcome measurements for this project included the number of complete advanced care planning documents uploaded to the EMR pre-and post-implementation. The overarching aims of this project were to (a) promote open-ended conversations of advance care planning with the utilization of the tool REMAP and (b) increase advance care planning completion rates among home-based palliative care patients. The DNP project was a process improvement initiative in the home-based setting.

The overarching aims of this project were to:

1. Promote open-ended conversations of advance care planning with the utilization of the tool REMAP and
2. Increase advance care planning completion rates among home-based palliative care patients.

Review of Literature

A literature review was performed with primary considerations: (a) best practice in advance care conversations in the home-based community setting; and (b) advance care completion in the older adult population. The findings are presented here.

The databases utilized were the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, Joanna Briggs Institute, and Grey Literature, using master headings and mesh headings. The key terms palliative care, end-of-life care, goals of care conversation, goals of care, tools, advance care planning, living will, living will completion, geriatrics, quality of life, and nurse practitioner were used in CINAHL In addition, the following

Mesh key terms were applied in PubMed: palliative care, end of life care, goals of care conversation, goals of care, tools, advance care planning, living will, living will completion, geriatrics, quality of life, and nurse practitioner.

The first evidence search included those articles published within the last five years. For example, the PubMed search using palliative care, living will completion, and goals of care yielded 18 articles. A secondary search of PubMed for articles published within the last five years utilizing the search terms palliative care, goals of care, tools, and systemic review yielded more articles.

The Cochrane database utilized multiple headings and included AND for each header yielding approximately 25-62 evidence-based articles. Unfortunately, many of these were not applicable. One beneficial aspect of the Cochrane database was the option to look at the reviews, protocols, and trials. This system also had a PICO tab to assist in reviewing the literature. Out of 62 articles, the PI identified six that were meaningful to the DNP project and evidence-based.

The Joanna Briggs Institute (JBI) was utilized for the best evidence-based practices for advance care planning. The goal was to find evidence for home-based or community-dwelling practices. This database assessed levels of evidence and was reviewed using the terms: advance care planning, community, tools, advance care completions, living wills, elderly, and end-of-life care. One of the most impressive parts of searching JBI was the synopsis of evidence available when clicking on the article. JBI was narrower in its scope in finding evidence; however, this source of information contained helpful features. Approximately eight articles were located.

Grey literature was also assessed, including websites such as Vital Talks, Healthy People 2020, and CDC information. For example, vital Talks was used through the literature review as a guided educational, clinical tool for GOC conversations and developed the guided conversation tool REMAP (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.).

Discuss the Findings

The JBI review of best practices, including a systematic review, identified 82 articles, including randomized control trials (RCT), non-RCTs, observations, mixed methods, and qualitative studies reporting on 34 ACP interventions (Marin, 2020). Evidence suggests that ACP should explore decision tools (Marin, 2020). No substantial evidence is clear that one ACP facilitator program is more effective than another, as patient outcomes were not consistent. Level 1 evidence suggests a system-wide approach to ACP and a multi-disciplinary team would be more effective. The systematic review states that conversation guides help providers align with patient goals. This is considered Grade A evidence. Furthermore, Grade B evidence notes that ACP includes discussion on prognosis, health, death, and dying, including caregivers, treatment preferences, and emotional support (Marin, 2021a).

Three research questions guided the review in a systematic process of providing tools for ACP. First, which tools assist providers in introducing ACP discussions? Secondly, which tools facilitate ACP discussions? And thirdly, which tools are best for documenting conversations (Myers et al., 2018)? This review covered 14 randomized control trials (RCT) and 33 non-RCT trials.

Physician Orders for Life-Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST) was the most common tool used for medical orders in this review (Myers et al., 2018). However, this form is not legally binding in Alabama, where this project was performed. In addition, living will documents are often not universally accepted (Sanders et al., 2018). A POLST form is a medical order that a physician must sign, and the completion of the form is guided by a conversation framework (Comer et al., 2020).

Respecting Choices

Respecting Choices is an ACP-intensive program that assists providers and skilled laypeople in having conversations and is referred to as the most common program in this review (Myers et al., 2018). Respecting Choices uses trained facilitators to provide intensive training. The result of paid formal training assisted in promoting motivation and confidence in having ACP conversations (Myers et al., 2018). In addition, there is evidence to support that the integration of this model can result in reduced hospitalizations or readmissions and increases caregivers' understanding of their loved one's goals (Sanders et al., 2018). The most considerable evidence attributed to the success of this model is tied to its patient value-centered approach. Due to this being a paid facilitator training, this was not an option for this DNP project. However, the evidence of patient-centered discussions was integral in choosing the right tool for the DNP project.

Evidence Supporting the Use of a Guided Tool

Myers et al., 2019 as noted above, did a systematic review that included 14 randomized control trials (RCT) and concluded that there was a lack of consistent evidence to support one clinical tool over another for ACP discussions. The 14 RCTs were reviewed and guided using the AMSTAR tool (Myers et al., 2018). AMSTAR is a mnemonic for A MeaSurement Tool to Assess systematic Reviews (Shea et al., 2017). The AMSTAR is a critical appraisal instrument for RCT and non-RCT clinical trials. It provides the investigator with a process to assess evidence-based RCT trials while reducing bias (Shea et al., 2017). In reviewing the Myers et al.

evidence who utilized the AMSTAR appraisal instrument, there was no evidence that one structured tool was more effective than another (2019).

Best practice suggests using a guided ACP tool that meets the patient population's local needs and context (Marin, 2021b). Significantly, a systematic review is level 1 evidence and is the highest tier of evidence available to the researcher. It is robust, quality evidence that is reproducible. The systematic review is level 1 evidence and does not promote one tool over another but supports the most effective tool in the clinical setting.

Clinical Trials

A longitudinal randomized control trial was performed in Washington, DC, with adults living with human immunodeficiency virus (HIV) and surrogate decision-makers. The objective was to use an ACP intervention to increase ACP documentation (Lyon et al., 2019). This study's sample size was 223 members; 86% were African Americans, and all were HIV positive. This study was an RCT consisting of the control group focused on self-care and the intervention group of two-session ACP discussions. The intervention group utilized Respecting Choices or 5 Wishes (Lyon et al., 2019). After three months, the intervention group increased from 13% ACP completion to 58% ACP document completion. The control group increased to 20% (Lyon et al., 2019). This study revealed a p-value of statistical significance ($p < 0.0001$). An RCT trial is evidence of level II and is strong evidence that a guided discussion of ACP effectively increases ACP documents. This study concludes that using trained facilitators for GOC conversations increases the completion rate of ACP documents (Lyon et al., 2019). This study is significant in how it relates to the PI’s DNP project in that evidence suggests a facilitated guided approach increases the completion of said documents. In addition, the evidence supports an extended time frame to promote more conversation and opportunities for completion.

In a randomized controlled trial in Hong Kong, a nurse-led guided conversation tool was found to introduce early-onset goals of care conversations in the community effectively. In addition, Chan et al. (2018) also showed the importance of the clinician in providing time to lessen rushed decisions and reduce conflict. This RCT's sample size was 230 community patients and their families. The participants were provided a trained nurse in ACP discussions in the home for three visits. The follow-up occurred at one month and again at six months to see how the ACP process progressed. The results were less decisional conflict than the control group and increased conversations about ACP with family at six months (Chan et al., 2018). It was concluded that nurse-led guided conversation programs could increase the discussion of GOC, reduce decisional conflict, and improve documentation (Chan et al., 2018). In addition, the six-month follow-up showed statistical improvement in documentation of ACP discussions, whereas the first-month follow-up did not show statistical significance (Chan et al., 2018). The study's methodology also applied to the DNP project’s goal that nurse practitioners using a guided conversational tool in the home can effectively complete ACP documents. This study was an RCT and level two reproducible and robust evidence.

Freytag et al. published the results of their PREPARE (Prepare for your Care) RCT after a long study period dating back to 2011 (2020). This RCT is significant as using a document to assist in ACP can increase active participation. The study included 393 participants and was randomized to the usual care or intervention group of PREPARE with an easy-to-understand living will document (Freytag et al., 2020). In addition, PREPARE utilized videos and interactive modules. The material and support call reminders were given to each participant one to three weeks before their primary care appointment. The primary care visit hosted the ACP discussion was audio-recorded with permission (Freytag et al., 2020). The transcripts were reviewed, and the results were statistically analyzed. Results include a 41% increase in GOC conversation in the intervention group and 14% in documented conversations in the EMR (Freytag et al., 2020). Thus, using an easy-to-read living will document and a tool to host discussions improved ACP completion and documentation. This supports the DNP project in that not only the conversation of GOC is essential, but the completion of the living will and documentation into the EMR. However, PREPARE videos are not feasible for this DNP study as a rural environment's internet connectivity may not support interactive modules and videos.

There was no gold standard for having these conversations in Epstein's randomized control trial of ACP and oncology patients (Epstein et al., 2018). The interesting note in this study was that out of 200 eligible participants, 51 declined participation. Interestingly, 31 patients declined participation because they did not want to discuss ACP (Epstein et al., 2018). This RCT is pertinent to the DNP project for assessing and exploring possible barriers to completing an ACP document.

One cohort study reviewed discussed when ACP should occur. This study group was 200 female metastatic breast or gynecological cancer patients through a multidisciplinary program and identified that discussions should begin at diagnosis, before expected death, and any hospital or intensive care unit admission (Clark et al., 2015). This study revealed that patients want to discuss end-of-life care, yet their oncologists were hesitant because they found it difficult to discuss (Clark et al., 2015). In this study, 48% of women with stage III or IV breast or gynecological cancer had self-reported that they had named a health care proxy. However, only 14% of these were uploaded to the EMR (Clark et al., 2015). These discussions and where ACP was introduced most often occurred during the first advanced disease discussion. Patients with a social worker or nurse practitioner actively participating in their care were more likely to complete a living will (Clark et al., 2015). This study's significance to the DNP project is that an interdisciplinary team approach can increase GOC conversations. The DNP project practice site uses a collaborative approach model with nurse practitioners, social workers, and nurses, making this an ideal for these discussions. The limitations of Clark et al. (2015) study were that the ACP document uploads were self-reported and may not be accurate. This level of evidence is a cohort study utilizing subjective data.

A retrospective analysis study utilized a multidisciplinary team approach to increase care planning in those older adult patients undergoing surgery. This study used a surgical optimization program for older adults that included 131 participants (Kata et al., 2018). The intervention assessed how geriatrician-trained nurses, student nurse practitioners, and health coaches who used structured ACP discussions would increase a patient's willingness to name a surrogate decision-maker or complete an ACP document (Kata et al., 2018). The method was four coaching calls over one month. The result in naming a surrogate increased from 67% to 78% and completed advance directives from 51% to 72%. In addition, the completed documents scanned into the EMR rose from 14% to 60% (Kata et al., 2018). The strength of this study includes the development of a working interdisciplinary team model to promote ACP discussions. Similarly, the DNP project site promotes a multidisciplinary model with similar goals and is designed to include family members. This cohort study is level IV evidence.

Mentorship

Roger’s theory of change notes that nursing is both a science and an art (Moran et al., 2019). Change requires onboarding all participants, which needs clinical solid leadership and mentorship. Late adopters of a project initiative change are estimated as high as 34%, and those that lag average 16% (Moran et al.,2019). Therefore, having mentorship is essential in a successful DNP project. One recent evidence-based nursing mentorship program, Evidence Based Practice Mentorship Program (EBPMP), was an intensive program that utilized staff nurses to engage in evidence-based support with heavy mentorship (Schuler et al., 2020). EBPMP was a volunteer program spanning over three years with 56 participants. Each participant spent, on average, 33 hours immersed in the educational program (Schuler et al., 2020). After completing the program, 16 participants furthered their educational experience by either becoming a mentor, being accepted into a fellowship, or climbing professionally into leadership positions (Schuler et al., 2020). Thus, this article speaks to mentorship programs such as EBPMP that can improve the dissemination of evidence-based research and propel into clinical practice more effectively than without such mentoring opportunities.

A qualitative study in the United Kingdom (U.K.) assessed the importance of mentorship in utilizing evidence-based practice in the community setting (Brooke & Mallion, 2016). The results of the qualitative study in which 33 nurses participated in a focus group included challenges in the community setting of time barriers and the need for more clinical autonomy. In addition, it was reported nurses in community settings may have more isolation; therefore, mentorship is warranted to promote evidence-based practice guidelines and overcome barriers (Brooke & Mallion, 2016).

One integrative review of the literature article notes the importance of integrating evidence-based practice into the clinical setting (Alves, 2021). By 2020, the Institute of Medicine's recommendation includes that 90% of all healthcare decisions should be evidence-based. The integrative review signifies the importance of EBP mentors in the clinical setting to achieve this goal (Alves, 2021). Providing ongoing mentorship in the clinical environment can include patient and provider satisfaction, fewer medical errors, financial cost-effectiveness, and improved clinical staff education (Alves, 2021).

Literature Review of REMAP

Vital Talk is a clinical tool-guided educational program that utilizes the mnemonic REMAP and is an evidence-based tool to guide communication regarding GOC and ACP (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.). Several studies and articles were located and reviewed in reviewing the literature and assessing the use of REMAP. However, many REMAP studies are qualitative due to ACP conversations' subjective nature, including patient values.

One significant and robust literature article discusses using REMAP with oncologists to discuss GOC with stage IV cancer patients. This evidence reveals that oncologists chart only 27% of goals conversation (Childers et al., 2017). Oncologists report that GOC conversations are needed but often lack the skillset. REMAP helps discuss prognosis values and align with the patient’s goals (Childers et al., 2017). This study also examined patients' and caregivers' lack of trust in the oncologist's ability to prognosticate. The decreased ability to prognosticate and host GOC discussions could contribute to an emotional response from the patient (Childers et al., 2017). REMAP is designed with flexibility, role-playing, and patient care to increase their comfort in having GOC conversations. Aligning their values with patients, making appropriate recommendations, and allowing oncologists to document these conversations are beneficial in the care plan. Childers's article relayed the importance of educating oncologists with REMAP to overcome obstacles in ACP and improve their skillset (Childers et al., 2017).

REMAP recently was used as a conversation framework for COVID-19 illness and goals of care conversations as it is an “evidence-based skillset shown to improve patient satisfaction and outcomes" (Siropaides et al., 2020, p. 191). REMAP provides the framework for the discussion on prognosis, quality of life, goals, and discussion of the patient's worries and values, thus providing a patient-specific recommendation. Furthermore, this literature also supports VitalTalk as a guide to communicating with patients using REMAP (Siropaides et al., 2020). REMAP is noted as effective for simulation practice (Comer et al., 2020). VitalTalk, the founder of the tool REMAP, offers online resources and support for advance care planning conversations and more guided tools (Comer et al., 2020).

In a qualitative study, a survey of emergency room physicians was done to determine their skill sets in having advance care planning conversations. Ninety-four percent of emergency room physicians claimed they needed formal training on goals of care conversations, especially in the COVID-19 pandemic (Crossman et al., 2021). The educational platform was a virtual event and consisted of emergency medicine residents using REMAP as a guided conversation tool to formulate a plan of care that aligned with patient wishes (Crossman et al., 2021). The goal was to improve the skillset and the quality of care. Education was performed using virtual online platform conferences and break-out sessions. The virtual platform was noted to have its challenges, and 61% of the surveyed emergency room providers believed it was suitable for education (Crossman et al., 2021). Notably, 100% of those surveyed agreed or strongly agreed they would plan to utilize their learning in practice (Crossman et al., 2021). This study was qualitative and held a level 6 on the hierarchy of evidence studies. Most qualitative studies collect subjective data via Likert scales and surveys. These findings relate to the PI study population as the evidence shows that formal training in palliative care is warranted and evidenced-based.

REMAP was utilized specifically regarding pulmonary hypertension (PHTN) to align with values and goals and is a template to decipher how much information the patients want to receive (Ismail et al., 2021). Patients can expect frequent and often urgent admissions with right-sided heart failure. The mean survival rate from diagnosis of PHTN is 2.8 years (Ismail et al., 2021). Therefore, early addressing goals and spiritual beliefs is imperative in this chronic palliative disease. Due to time limitations, the article notes that most clinical visits focus on clinical issues and symptom burden, not goals or prognosis.

Furthermore, ethics dictate that proper discussion of prognosis should occur with the clinical team leading this conversation to allow the patient to choose how to spend their remaining time. One barrier reported is the clinician's fear of lessening hope for patient improvement if hosting a GOC conversation (Ismail et al., 2021). Early on, the provider should educate on the disease process and prognosis. Thus, the provider builds provider-patient relationships and starts end-of-life care planning (Ismail et al., 2021). This article used REMAP tool to introduce goals of care conversation into a palliative population with PHTN patients and document ACP (Ismail et al., 2021).

Fleshner et al. (2019) utilize REMAP in what some clinicians now deem a palliative diagnosis is substance abuse disorders. Fleshner (2019) discusses that the definition of a palliative diagnosis includes a prognosis of whether the provider would be surprised if the patient died next year. This article identifies substance abusers as appropriate for palliative care (Fleshner et al., 2019). Uncontrolled substance abusers are at high risk of needing life-sustaining treatment, and discussions are essential. Substance abusers are often vulnerable in that they may not seek routine care and could be homeless in addition to having chronic medical conditions (Fleshner et al., 2019). In this intervention, the VitalTalk tool REMAP was utilized in ACP conversations with substance abusers to identify values and goals and find the appropriate surrogate decision-maker (Fleshner et al., 2019). There were barriers noted in attempting to host GOC in substance abusers. Such obstacles were that this population was often not seeking regular medical care, lacked resources to care, and had less decision-making capacity (Fleshner et al., 2019).

Further evidence that REMAP was used to explore GOC was in the palliative treatment of aggressive lymphomas (Odejide, 2020). This literature notes that 26,000 people are diagnosed with aggressive lymphomas yearly, with half becoming retracted. Unfortunately, many of these lack understanding of their prognosis. Up to 56% of hematologists acknowledge that GOC conversations happen too late to discuss preferences and may occur when death is pending. Also, in this literature, only 11% of patients felt they had the opportunity to express their end-of-life care wishes (Odejide, 2020). This literature promoted the use of the question, “would you be surprised if the patient died within the next year to prompt using REMAP” (Odejide, 2020, p. 150). Training hematologists in REMAP to start earlier GOC conversations can increase patient preferences and satisfaction. And significantly, if hematologists do have earlier goals of care conversations, hospice is initiated earlier than days before death (Odejide, 2020).

One qualitative analysis study introduced GOC conversations using REMAP for nephrology residents. The intervention included a didactic session with a palliative care specialist using REMAP with the Kidney Failure Risk Equation (Nair et al., 2020). Sixteen residents spent approximately six weeks working with the palliative care team and led a minimum of six ACP conversations (Nair et al., 2020). At the end of the intervention, the 16 participants reported increased ease in having these conversations. Twelve said they could identify appropriate patients using the Kidney Failure Risk Equation to have GOC conversations

(Nair et al., 2020). Therefore, the outcome suggests a correlation between prognostication, GOC conversations, and guided tools to improve nephrology residents' skillsets. In addition, the nephrology residents had increased comfort in hosting these conversations with education over time and could effectively chart the GOC conversation in the EMR (Nair et al., 2020). This study was significant to the PI because it discusses three things that must occur to increase ACP. One is knowledge, the second is a positive attitude, and the third is a willingness to champion change in the practice. All three lead to positive and sustainable change in ACP planning. One noted benefit of this study was that the REMAP educational tool could be ongoing and did not require travel or expense to host in the clinical setting. Thus, training nephrology residents in REMAP enhances communication skills, can be cost-effective, and aligns with the DNP project goals.

Summary of Literature Review

In the synopsis of the literature review, 68% of providers note that advance care planning is often a missing component of their training (Comer et al., 2020; Crossman et al., 2021). The evidence reflects the need to develop a skillset to host ACP and GOC conversations. Programs and mentorships such as Respecting Choices are intensives and provide resourceful forums to gain valuable knowledge (Myers et al., 2018). However, these can be cost-prohibitive and inappropriate for the PI DNP project. Mentorship is essential in onboarding clinical staff towards evidence-based practice and would be necessary for ACP training. Mentorship programs such as EBPMP can improve the dissemination of evidence-based research and propel into clinical practice more effectively than without such mentoring opportunities (Schuler et al., 2020). A qualitative study in the United Kingdom (U.K.) assessed the importance of mentorship in utilizing evidence-based practice in the community setting (Brooke & Mallion, 2016).

The literature review supports that a guided conversational tool is level 1 evidence. A systematic review that included 14 RCTs concluded that consistent evidence was lacking to support one clinical tool over another for ACP discussions. (Meyers et al., 2019). Noting that the review states that not one tool is shown to be more effective than another, REMAP was assessed in the literature review. REMAP is a guided conversational tool in which multiple qualitative studies reflect improved skillsets in hosting ACP conversations. REMAP is a conversational guide for late goals of care conversations and is free, interactive, and provides video support (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.). REMAP's use in emergency settings shows improved clinical skillsets to host ACP conversations, and 94% surveyed continue to use the tool in practice (Crossman et al., 2021). Furthermore, using REMAP and palliative mentorship, nephrologist residents improved their comfort in GOC conversations and their prognostication skillsets (Nair et al., 2020). Thus, a design methodology was developed for this DNP project after complying with the literature review.

Theoretical Model

Roger's 5-step change theory was the theoretical model used in this DNP project. An overview of Roger's 5-step change theory and its application to this project will follow (Moran et al., 2019). Step 1 identified who and what needed to change. In this study, this would be how the advanced care nurse practitioners educate palliative care patients on prognosis and obtain advance care planning in this situation. Step 2 involved onboarding those engaged in understanding the need for change and educating advanced care nurse practitioners on why a uniform education tool would be effective. Step 3 was the implementation of the DNP project. The advanced care nurse practitioner used the REMAP conversation guide in the home to initiate end-of-life conversations and educate on advance care documents. Step 4 implements the change based on the project's success and evidence. Implementing the project requires ongoing mentorship from the PI to sustain lasting change in practice (Moran et al., 2019). As the team utilized the tool for educational purposes and to promote advance care conversations, discussion of barriers was essential. Step 5 is to confirm the adoption of change. The change involves finalizing the onboarding of all employees (Moran et al., 2019). In this case, the project gained valuable knowledge and tools to engage patients and caregivers on options regarding advance care planning and increased advance care planning documentation. As Rogers's theory acknowledges, nursing is a science and an art (Moran et al., 2019). As expected, ongoing mentorship would be needed to support and continue the process improvement project, noting barriers and allowing open-ended conversations between the participants and PI.

Methodology

This project was a quality initiative for home-based practitioners to improve their advance care planning skillset. Additionally, this project was intended to increase the number of completed advance care planning documents uploaded into the EMR. The primary intervention was to educate the home-based palliative care nurse practitioners through hour-long educational sessions. For mentorship, brief 10-minute weekly interdisciplinary sessions on REMAP's evidence-based tool were held for the duration of the study. The communication tool's goal was to assist the flow of advance care planning conversations. After using REMAP in the home setting with each visit during the study period, the patient was offered assistance and the opportunity to complete advance care planning.

Setting

The DNP project setting was implemented primarily in a rural southern community. The patient's home served as the site for the advanced care nurse practitioners to meet with the patient and caregivers. This project included a home-based community that encompassed most of Alabama. The average census of the advanced care nurse practitioner was between 70 to 100 palliative patients. Each patient was seen at least monthly.

Population

The population was advanced care nurse practitioners who served home-based palliative care patients. Ten advanced care nurse practitioners were eligible and consented to participate. The qualified nurse practitioners worked part-time or full-time day shifts, weekday hours typically from 8–4 PM. In addition, each of the 10 advanced care nurse practitioners took their usual rotation of the on-call schedule.

Inclusion/Exclusion Criteria for Nurses and Patients

Inclusion criteria:

- Those patients who were on service as of 12/31/21 and received palliative care were included.
- All advanced care nurse practitioners who agreed to participate in the project were included.

Exclusion criteria:

- Those patients who were on the census of the principal investigator were excluded.
- Those with a dementia diagnosis were excluded from this study.

Recruitment

A flyer was developed and sent by email to all advanced care nurse practitioners in the practice setting for Alabama. This provided information on the DNP project and educational session that would take place on January 25, 2022 (see Appendix C). Recruitment was also done online via the virtual platform during regular bi-weekly meetings. It was used to discuss the upcoming DNP project. Finally, project recruitment came from weekly interdisciplinary team phone meetings every Monday morning. In addition, two educational sessions occurred. Each academic session was one hour, offered online, and provided an option for participation.

Consent

Before project intervention, consent was obtained from all study participants (see Appendix D). It was emphasized that this student-run DNP project aimed to improve advance care planning completion using the open-ended conversation guide tool REMAP (Appendix E). Permission to use the conversation-guided tool was obtained through VitalTalks (see Appendix F). The PI of this project ensured that participation was voluntary, and there was no penalty for withdrawal at any time. Risk and benefits were explained, including that the home-based palliative care company supported this project and design but had no influence or participation in this project. Furthermore, as detailed in the consent form, management was unaware of who chose to participate in the project. Therefore, no impact on evaluation or promotion would occur.

Citi training was completed according to institutional policy. The certificate is found in Appendix G. Consent to use the practice site for the DNP project was obtained. A supporting letter with approval was received. Furthermore, Institutional Review Board (IRB) approval was necessary and completed with permission for this DNP project. The IRB approval letter is in Appendix H.

Design

The DNP project was a quality improvement initiative designed within the home-based palliative care setting using new skills obtained by the nurse practitioners. The identified practice gap was low advance care planning completion rates. For example, the practice framework expects an upload rate of 78% of patients with a completed ACP document in the EMR. The DNP project was designed to improve this gap since the advanced care nurse practitioners were measured on this metric.

After reviewing the literature, a conversation-guided tool was best noted to guide the advanced care nurse practitioners in hosting these conversations in the home setting. However, consistent evidence was lacking to support one clinical tool over another for ACP discussions. (Meyers et al., 2019). The practice framework provided an in-home nurse practitioner visit monthly or telephonically. The design was to educate the advanced care nurse practitioners in a formal meeting via an online meeting platform on the literature findings and promote the tool REMAP as the focus of this intervention.

Further discussions regarding barriers, review of REMAP, role simulation, and progress were scheduled during the online meetings and through weekly Monday morning phone meetings among the interdisciplinary team. As stated previously, the PI uses Roger’s theory of change model, of which Roger notes that nursing is both a science and an art (Moran et al., 2019). Therefore, mentorship for advanced care providers to buy into the project initiative is needed to enact ACP process improvement. Rogers's theory of change encouraged mentorship to guide nurses toward evidence-based practice and to foster successful project implementation (Brooke & Mallion, 2016).

After nine weeks of implementation, the project ended, and data were analyzed for statistical significance. The goal was to see if the REMAP evidence-based conversational tool guide would improve the number of completed advance care planning documents uploaded into the EMR.

Chart Review

After IRB approval, a pre-intervention data review took place to assess the number of advance care documents completed in the EMR. The data review included retrieving metrics from January 2021, February 2021, March 2021, and December 2021 as pre-implementation data. The data from all nurse practitioners who volunteered to participate in the DNP project was utilized as a whole unit. The electronic medical record was used for data extraction, which held the ACP and GOC discussions, and any uploaded ACP documents. All data were de-identified and located securely on the PI laptop. A data analyst within the home-based palliative care institution site who volunteered to work on the DNP project was utilized to retrieve the pre-implementation DNP project data. In addition, the data analyst was instrumental in retrieving data during the DNP project implementation every week. The formatting was a simple excel worksheet in which the PI removed identifying data. Therefore, de-identifiable data was the only data included in the analysis.

Risks and Benefits

The DNP project posed minimal risk to the advanced care nurse practitioner participating. Risk included the potential issue of breach of confidentiality, but they were assured that their participation status would not be known to those who could evaluate their performance. Also, the time required to volunteer in this study would be inconvenient. The time inconvenience was noted by the necessity to attend the hour-long sessions and participation in any interdisciplinary discussions on an optional basis.

Participating in the DNP project included an improved skill set to host ACP conversations. Also, the increased open-ended conversations regarding ACP and GOC would potentially improve their metric of ACP documents uploaded into the EMR. This DNP project who participated. The DNP project's goal to uphold the principle of autonomy was imperative. The core value of this DNP project was to benefit those advanced care nurse practitioners who volunteered in this study to improve their ACP document upload rates and improve their skills to host these conversations.

Compensation

All advanced care nurse practitioners were offered two coffee vouchers, REMAP tool cards, and other supporting handouts during the educational sessions

Timeline

The timeline was developed to frame the steps of the DNP project. In addition, the timeline delineates the key factors and dates of the DNP project. The timeframe for this DNP project started in June of 2021 with project planning and proposal development. PERC and IRB approval was obtained in October 2021, allowing project implementation to begin in January 2022. The project duration was nine weeks, with completion in March of 2022, with the dissemination and final manuscript in July of 20222. See Appendix I for details.

Budget and Resources

The Budget and Resources needed for the DNP project were assessed and listed in preparation for the project. The list of specific budget items can be found in Appendix J. This project required more paper resources (copies), the use of the existing medical record, and the current PDF scanner to upload documents. In addition, nurse practitioners need this project time but not out of existing scheduled meetings. The proposed budget, including the manuscript's poster and binding, was $1500.00, but the actual budget was nearly half at $802.00.

Evaluation Plan

Statistic Considerations

The DNP project was a 9-week study looking at ACP upload rates. Each week, the number of patients with and without ACP uploads was recorded, and the percentage of patients with uploads was calculated. A line graph and scatterplot to visually display weekly ACP upload rates were created using SigmaPlot version 10.0. Descriptive statistics of weekly ACP uploads and upload rates, including means, standard deviations, minimums, and maximums. A simple linear regression model was utilized to examine whether there was a trend in ACP uploads during the study. These analyses were performed using SAS version 9.4.

Data Maintenance and Security

The PI kept the volunteer nurse practitioners confidential and patient data on those who completed advance care planning documents. Data were de-identified, and information was held in a secure password-protected computer in a locked office. Information gathered for this DNP project included pre-and post-metric data of ACP uploads into the EMR throughout the intervention period. The data collected included the number of patients seen with ACP documents uploaded into the EMR versus those with no documented ACP. The data was assessed weekly and had a primary palliative diagnosis. The patient and nurse practitioner's names and locations were removed. Therefore, no identifiable data was included in the manuscript.

Pre-Implementation Data

The pre-implementation data was obtained from a chart review. This data reviewed the number of ACP uploads into the EMR compared to the same months of this project implementation. This raw data was from the entire month of January to March of 2021 and again in December 2021, which is immediately before the DNP project implementation. See table below.

Table 1
Pre-implementation Data For 2021

Month	**Number of ACP uploads**
January 2021	*3*
February 2021	*7*
March 2021	*9*
December 2021	*8*

Interpretation: This is pre-implementation data documenting number of ACP uploads in 2021.

Results

The results of the data analysis are reviewed below. The data analyzed included quantitative results regarding the DNP intervention assessing the number of ACP document uploads in the EMR. Key findings are discussed further using descriptive statistics, tables and graphs. See appendix for figures and tables.

Results of Intervention

Ten advanced care practitioners participated in this DNP project. Each advanced care provider was asked to identify their age bracket, years of experience in nursing, gender, and if they had any prior knowledge of REMAP. Nine out of 10 practitioners were female. The average age bracket was the mid to late 40s. The years of nursing experience varied from 12 to 38 years, with an average of 23.4 years. Six out of 10 had heard the term REMAP before, but only one had utilized REMAP in prior practice.

Descriptive statistics were utilized over the nine-week study period. The PI used a paid statistician Jackie Szymonifka for assistance in interpreting and analyzing the raw data. The statistician analyzed the upload rates, standard deviation, median, and mean. Also evaluated was the Beta-coefficient (β-coefficient). A simple linear regression analysis was utilized. The number of uploads and percentage of uploads were assessed. The statistician developed graphs and tables to display the results visually.

Table 2

Weekly Data Collection And Related Calculations

Week	Patients with ACP upload	Patients without ACP upload	Total number of patients	Percent of patients with ACP upload
1	2	85	87	2.35%
2	2	105	107	1.90%
3	2	62	64	3.23%
4	3	112	115	2.68%
5	1	120	121	0.83%
6	3	75	78	4.00%
7	0	120	120	0.00%
8	3	112	115	2.68%
9	6	107	113	5.61%

Interpretation: This is an overview of the study and the week-by-week data used in the analysis.

Table 3

Descriptive Statistics Of Weekly ACP Upload Totals and Percentages

Factor	Minimum	Maximum	Mean ± standard deviation (SD)
Number of ACP uploads	0	6	2.4 ± 1.7
Percent of ACP uploads	0.00%	5.61%	2.59% ± 1.65%

Interpretation: The number of ACP uploads ranged between 0 and 6; on average, there were 2.4 uploads per week. And similarly, the weekly percentages of ACP uploads ranged between 0% and 5.6%, while the weekly average was 2.6%.

Table 4

Simple Linear Regression Results for ACP Upload Rates (Percentages) By Week

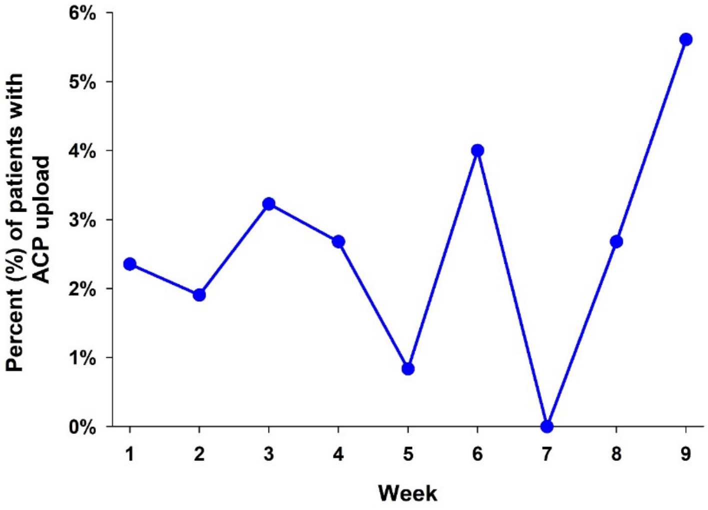
Factor	β-coefficient ± standard error	p-value
Intercept	1.74 ± 1.23	0.20
Week number	0.17 ± 0.22	0.46

Interpretation: Regression analysis assesses a general "trend" in the upload percentages over the project.

The p-value for this study was set for a significance of less than 0.05. A power analysis was not conducted to determine if the sample size was large enough to evaluate statistical significance and generalizability. Not performing a power analysis was partly due to all participants who volunteered in this study equaling 100% participation of available participants who were seeing their regular caseload. Therefore, the study participants were 10 with a monthly caseload of 70 patients.

According to simple linear regression analysis, the trend was an increase in ACP document completion and uploads (see Figure 1 below). The Beta Coefficient was utilized to assess the trend and evaluate the number of ACP uploads. The analysis found that the β-coefficient weekly was positive (0.17), indicating that ACP upload rates increased as the study continued. Considering p-values less than 0.05 were statistically significant, results showed that this project had a value of p=0.46. Therefore, the study did not reflect a statistically significant change in the ACP upload rates.

GRAPH 1
Percentage of weekly ACP uploads



Intrepretation: Documents the number of ACP uploads in percentage form weekly, showing general increase.

Discussion

The PI acknowledges that the p-value did not show statistical significance in this project, but the trend of increasing ACP uploads during the duration was positive. Furthermore, this positive trend was determined by a simple linear regression analysis found in Table 3. Therefore, it can be an ongoing sustainable project that may reflect more future ACP uploads over a lengthier timeframe. Over the nine weeks of the study, the number of ACP uploads ranged between 0 - 6, and on average, there were 2.4 uploads per week. And similarly, the weekly percentages of ACP uploads ranged between 0% and 5.6%, while the weekly average was 2.6%. Therefore, the standard deviation was assessed, and the statistician formatted a table (see Table 2) that reflects the number of ACP uploads and the percentages of ACP uploads during the study.

The pre-implementation data from January, February, March, and December 2021 was reviewed in table form and reflected data from one year ago. January 2021's raw data reflects three uploads. February of 2021 reflected seven ACP uploads, and March 2021 was eight uploads. December of 2021's data report revealed nine uploads.

The number of patient visits was comparable across 2021 and 2022. The PI notes that January and March 2022 for this DNP project were only partial months, and the data comparison between 2021 and 2022 does not reflect accordingly. The number of uploads for the partial month of January 2022 was six. February's data reflects seven uploads. Again, March's timeframe was a partial month and reflected nine uploads. The trend increases each month despite January and March being partial months in this nine-week study. Favorable consideration in that one could imply the guided tool REMAP may not be statistically significant in this DNP project given the timeframe. Still, it is assisting the advanced care providers. For example, the percentage of uploads before project implementation has been as low as 3%. This data reflects an upward trend to a positive range of 5.6%. Therefore, despite the raw data of 2021, the evidence demonstrates that the conversation-guided ACP tool improves advanced care providers' skills in hosting these conversations and documentation.

Implications for Clinical Practice

With the rising concerns over COVID-19 and limited access for the family at the bedside, having goals of care conversations before an emergency or declining health is imperative and best practice (Block et al., 2020). The goals of care conversation benefits include increased quality of care, patient satisfaction, and less decisional conflict. Consistent evidence was lacking to support one clinical tool over another for ACP discussions. (Meyers et al., 2019). However, it is difficult to host conversations regarding advance care planning if not trained. Like other nursing skills, hosting advance care conversations takes practice, education, and mentorship (Marin, 2020). The clinical implications of this DNP project are to foster affordable palliative training for all clinical providers. REMAP is an interactive and cost-effective tool showing a positive trend in the ACP completion rate though not statistically significant. Over time, this PI believes the tool REMAP would show a statistically significant increase in ACP documentation. Clinical implications should include home-based practices, clinical sites, and institutions training. Training intensive options are available nationwide; however, they can be costly and require travel. VitalTalks allows clinical providers to use their resources, including interactive programs and mnemonics, for educational purposes (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.). Literature suggests that, as previously reviewed, a guided conversation tool empowers providers, oncologists, and other specialists to develop skill sets in hosting conversations while improving confidence (Childers et al., 2017).

Further implications would include providing mentorship and role-playing educational sessions for all providers on an ongoing basis. Mentorship is needed to onboard clinical staff and disseminate evidence into the clinical field. As implied in this study, the changing behavior of the advanced care provider is required to onboard and adopt new clinical standards and policies (Schuler et al., 2020). It can be challenging to onboard all providers and adopt new habits using this tool. Also, as implied, a lengthier study could change behavior in adapting the REMAP tool and increasing advance care planning documentation.

The Patient Self-Determination Act (PSDA) was passed in 1990 and is legislation that requires hospitals, nursing homes, home health, hospice, and health maintenance organizations to provide information on advance care planning on admission (Clark et al., 2015). It is noted that the law requires emergency room and hospital admission to ask for a copy of a living will. Yet, most patients do not have one nor understand how to complete one. This DNP project suggests that trained providers can address this gap and would be an excellent future study.

Implications for Healthcare Policy

The World Health Organization acknowledges the importance of access to palliative care. Palliative care encompasses ACP and discussion of goals of care. Reducing symptom burden and preventing unnecessary hospitalizations by being proactive is the goal of palliative care (*Palliative Care*, 2020). Therefore, initiating palliative care early and having earlier goals of care conversations reduces decisional conflict. In addition, Healthcare policy changes should empower and train clinical providers to become experts in communication to host these conversations through guided tools (Sudore et al., 2017).

In addition, for Alabama, more dialogue between palliative providers and lawmakers to promote the use of other forms of acceptable living will documents; specifically, the Five Wishes should be initiated and supported. The Five Wishes is a patient-centered approach to understanding values and wishes and relaying such to providers and family members (*Five Wishes- a Living Will Document*, 2021). On a state level, one way to initiate this process is through the Alabama Nurses Association (ANA). In addition, utilizing resources and data through the American Nurses Association may also help promote the proper channels in empowering palliative care education and using Five Wishes in Alabama (*Five Wishes- a Living Will Document*, 2021)

The DNP project data shows a positive trend for completing ACP documents over time. Thus, allowing additional living will form choices to be added in Alabama could increase the completion of ACP documents using REMAP. Therefore, the implications of the DNP project regarding healthcare policy include the need to recognize additional living will documents. This should be at the forefront of initiatives in Alabama and could consist of the 5 Wishes document (*Five Wishes- a Living Will Document*, 2021).

Implications for Education

Implications for this DNP project stem from the review of the literature. Best practice suggests using a conversation-guided tool, yet one tool is not promoted over another (Meyers et al., 2019). Dissemination of information can take a prolonged timeframe if considering policy change. The skillset in hosting these conversations requires education, ongoing practice, mentorship, and role-play using case studies. Changing the behavior of the advanced care provider should also be considered in the educational process. This DNP project's educational sessions were done through virtual online platforms. Online education has its limitations, which are explored further in this manuscript. However, the implications of this DNP project suggest that more education and mentorship are needed to increase the comfort level of the advanced care provider to host these ACP conversations and discuss goals of care. As Roger's theory of change discussed, buy-in from project participants is needed for successful intervention (Moran et al., 2019). In adopting change, only 2.5% of participants are innovators of change, and 34% are late adopters (Moran et al., 2019). Therefore, mentorship is ongoing to provide education and support to onboard late adopters. It could be implied that a longer length of study could impact higher ACP uploads once late adopters are onboarded to the PI project. Each patient situation can pose challenges; therefore, more role-play and mentorship are needed. VitalTalks has an online interactive application program to engage and promote daily activities to hone skill sets (*Addressing Goals of Care: Smoothing Discussions About Prognosis and Treatment*, n.d.). This DNP project used the interactive application to assist in mentorship. The interactive tool from which REMAP was derived is a helpful ongoing educational program that the study implies can be helpful and should be used readily and frequently.

Limitations

The main limitations of this study were based on the narrow timeframe of nine weeks. However, the tool demonstrated promising results. If a more extended timeframe was available for the study, more ACP discussions could result in ACP document completion. During this study period, the patient was assessed in person by an advanced care provider, on average, for two visits. In some cases, the patient may have had a third or telephonic visit by the advanced care provider. Furthermore, most patients had one telephonic social worker visit. Therefore, it may be possible that a third visit using the tool REMAP could increase goals of care discussions and ACP completion and documentation upload rates.

Another limitation is the training of the intervention tool. The virtual education of the intervention was due to company COVID-19 restrictions and was a limitation. The PI notes that post-COVID-19 practice changes will likely continue with virtual training platforms. One quality improvement study reviewed virtual platforms from an oncology setting in community settings. Both advantages of virtual educational platforms and barriers were discussed with three hundred thirty-three oncology providers (Perlmutter et al., 2022). One recommendation included using both a virtual and an in-person component for educational purposes (Perlmutter et al., 2022). Successful virtual platform educational meetings require active participation. “Zoom fatigue” refers to the mental fatigue from extended virtual sessions (Perlmutter et al., 2022). Mental fatigue and multi-tasking are also common during virtual meetings and may cause less active participation in the conference versus in-person meetings.

Furthermore, providers have fewer opportunities to network without in-person meetings. Another issue reported in this study was the quality of the discussion in the form of hearing the conference, talking over others, and learning the technology (Perlmutter et al., 2022). These could also have impacted the PI's project through decreased role-playing and mentoring through the virtual platform educational sessions. The advanced care providers would benefit from in-person educational forums and virtual meetings to engage in roleplay of REMAP, return demonstration of talking points, improve skillset, and increase the comfort level in hosting these conversations.

Teaching through an interactive platform can have issues like internet connectivity, technology mishaps, and distractions. Therefore, one limitation in this DNP project was a lack of mentorship within the home setting to observe and assist in standardizing the intervention. Each advanced care provider had their patient census, and the tool's variations could occur without direct observation or regular in-person mentorship. In turn, this could impact this study's completion rate. As noted in Roger's theory, behavior change of the advanced care provider and onboarding of the adopted change takes time (Moran et al., 2019). Late adopters of a project initiative are common and could have occurred in this DNP project implying that ACP documentation numbers would have continued to increase over time. However, the nine-week time was a limitation with the onboarding and adoption of the REMAP tool to show statistical significance.

Patient visits were limited to thirty-minute visits per standard practice. Time limits can pose a challenge in providing care and discussing goals of care. Additionally, some patient visits were telephonic during this project timeframe, which impairs the ability to have these conversations. The telephonic visits were part of a particular health plan pilot that affected a portion of patients, and some telephonic visits were due to remaining COVID-19 restrictions. In weekly mentorship conversations with the participant team, time limits were discussed as the visit timeframe was often insufficient to address acute issues and goals of care conversation.

Moreover, a lack of family support in participating in goals of care conversation was noted. As per the design of the DNP project, the PI initiated weekly support calls for the participants to reinforce teaching, provide mentorship and discuss barriers to project implementation. These barriers were discussed as a whole team during these weekly fifteen-minute support calls for the nine weeks of the project duration. Barriers were noted on paper as discussed. Throughout the project implementation, family members were often distracted or showed unease in discussing goals of care. One project participant noted it appeared easier to discuss and collaborate on a hospice transition than to complete a living will document in the home with family members. The PI would consider this an excellent future study.

Furthermore, technical issues such as the complexity of the living will in Alabama were noted. The prominent barrier in this situation is the lack of qualified witnesses to sign the living will. The clinical team and family members were not allowed to sign the document as witnesses. The strict witness qualifications burdened completing the document, especially considering COVID-19 restrictions. In other states, the document 5 Wishes is a legal living will and is more favorable for completion (*Five Wishes- a Living Will Document*, 2021). This is partly due to ease of use and is less burdensome to obtain witnesses. However, this is not a legally accepted document in Alabama. Again, future studies would be helpful to initiate policy change for acceptance and would be excellent for legislature discussion.

Other limitations can include the timing of day to host these conversations, which were noted to be less effective at the end of the day secondary to mental and emotional fatigue. Furthermore, the acute needs of patients can overshadow ACP conversations as time is spent assessing needs and preventing hospitalizations. Lastly, routine education and medication reconciliation tasks can be time-consuming and prevent needed conversations.

Dissemination

The findings of the DNP project were disseminated through this manuscript, a poster, and a presentation at Jacksonville State University. In addition, the final DNP manuscript was entered into Jacksonville State Digital Commons repository. The PI will seek opportunities for dissemination through poster presentations at clinical continuing education conferences. Also, the PI will disseminate findings within the larger umbrella practice institution for educational support and quality improvement. Finally, the PI would like the opportunity to seek discussions regarding state policies to ease the burden of living will documentation completion.

Sustainability

This DNP project aimed to improve the advanced practice nurses' skillset using a conversation-guided tool REMAP to be continued within the organization after study completion. After the DNP project, the tool was still readily available, and utilization was encouraged in goals of care conversation. In addition, barriers continued to be discussed during bi-weekly meetings. The practice acknowledged that advance care conversations should be part of the provider's skillset daily. Therefore, the collaborating physicians discussed specific patients with the advanced care providers in their bi-weekly meetings to further encourage sustainability.

The sustainability of the DNP project is recognized as a positive outcome. The tool was generally accepted within the practice by the advanced care providers, the clinical director, social workers, and physicians to host advance care conversations. In addition, the practice recognized the need to improve the documentation of advance care planning and acknowledged the cost-effectiveness of the instrument. Furthermore, it did not increase the workload or burden on the advanced care providers.

Plans for Future Scholarship

This study adds to the supporting data that using a conversation-guided tool like REMAP can assist providers in advance care planning conversations. The PI suggests a similar investigation is warranted using a more extended timeframe as it could likely show statistical significance. Other considerations are that this positive trend in increasing uploads can be applied to different settings and may be beneficial to engage in a future study. One suggestion is to evaluate the effectiveness of placing an educated palliative provider for ACP discussions in the geriatric clinic and preoperative setting. This provider could provide training onsite in clinical offices using the REMAP tool. Although this intervention was performed in a home-based setting, the implications imply the benefits apply to other clinical settings. Therefore, it may be a beneficial study to place a trained provider in goals of care conversations in these settings, especially after new diagnoses and hospitalizations.

Also, future scholarship is needed to assess and improve the quality of advance care planning conversations and documentation within the EMR. For example, a study using the tool REMAP embedded within the EMR evaluates the patient values and allows medical staff to continue the goals conversation in future visits. Thus, the tool's documentation would be helpful in integrated EMRs that include specialist providers and hospitals.

In addition, A future study could evaluate whether using REMAP in a face-to-face setting as role-playing versus virtual meetings could increase the provider’s comfort level. In-person educational sessions on REMAP could optimize and standardize advance care planning conversations in the home setting where deviations can occur. Thus, reducing variations in care.

Also, as suggested previously, the family barriers regarding completing advance care planning should be explored. For example, one specific family barrier could include why it appears a patient and family’s willingness to align with hospice care more frequently than completing a living will be an excellent future study. And finally, exploring opportunities with the Alabama Nurses Association (ANA) and Alabama’s legislature to engage in conversations on using other living will documents should be a political and quality improvement initiative.

Conclusion

This manuscript aims to discuss best practices and techniques in advance care planning and optimize skills to provide patient-centered care conversations that honor patient wishes, reduce unwanted hospitalizations, and focus on the patient’s quality of life. The overarching aims of this project were two-fold. The first was to promote open-ended conversations about advance care planning with the tool REMAP. Secondly, to increase advance care planning rates among home-based palliative care patients.

ACP is linked to improved patient care and lessens caregiver burden, such as reducing decision conflict (van Dyck et al., 2021). The framework REMAP provides for discussion on prognosis, quality of life, goals, and values. Thus, REMAP can assist in delivering a patient-specific recommendation on future medical care. VitalTalk is an interactive online guide and tutor to increase communication skills using REMAP (Siropaides et al., 2020). REMAP is a valuable framework to assist in a guided approach to patients and families when situations change and is effective for simulation practice (Comer et al., 2020).

The study results concluded that using the guided conversation tool REMAP could increase the number of completed ACP documents and goals of care conversations if utilized over a longer timeframe in the home setting. Furthermore, despite the p-value not being statistically significant, the β-coefficient was positive and suggested a continued upward trend in ACP completion rates should the project have had a lengthier timeframe. Therefore, the PI concluded that the evidence reflects the best practice to use a conversation-guided tool for goals of care conversation. Thus, the practice site will continue to implement such a practice.

In conclusion, the PI notes that ACP conversations are essential to practice and are wanted by patients and families despite their discomfort in discussing them. Having ACP conversations is crucial in expressing patient values and wishes, allowing families, caregivers, and providers to align with these goals. The evidence reflects that the best way to initiate these conversations is through guided conversation tools like REMAP. In addition, the best way to document these conversations is through family-inclusive discussions led by a trained clinical provider. The results are recorded, and a completed ACP is uploaded into the EMR.

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Appendix A

GAP Analysis

Project topic	**Impact of the subject on patient outcome**	**The current state of practice**	**Desired state of practice**
Advance care planning in the geriatric population with those that have chronic illnesses. The project's goals are to increase the completion rate of advance care directives by using a tool to help open discussion of end-of-life care, such as five wishes (*Five Wishes- a Living Will Document*, 2021). To increase the multidisciplinary team's competency in discussing end-of-life care in the community before critical decisions must be made urgently.	The goal of the project outcome would be to increase advance care planning conversations and completion rates. Thus, increasing documentation uploads into the facility or national register will occur. If more patients choose their end-of-life preferences and a discussion occurs, unnecessarily prolonged measures will result. Increase in positive outcomes, as families will be alleviated from difficult decisions if the patient has already completed a living will.	Presently, only one in three Americans has a Living Will completed (Yadav et al., 2017). The current legal document used in the state is the Alabama Living Will. Presently, most facilities must ask if a living will exist and offer admission information. Medicare will reimburse for advance care planning in the clinical setting (Yadav et al., 2017). However, there is a gap in what a patient may wish for and their care. Conversations may occur only after a patient is critical and decisions are rushed.	The desired state of practice would be more trained interdisciplinary team members achieving competency in discussion advance care planning and the increased rate of advance care to be completed. If patients have completed advance care planning documents, families would have more support in end-of-life care. All team members know how to care for patients in life-sustaining measures and unnecessary or unwanted measures avoided.

Actions needed to address Gap	**The technology required to address the gap**	**Implications to patient outcomes, organization, community**
The first action to address the gap would include reviewing the literature on current best practices in advance care planning. The Alabama Living Will document is what is currently accepted as a living will. In review, this is often intimidating and hard to understand. Some say, "I don't want to be hooked to machines, "but are not knowledgeable about other end-of-life decisions. Increasing the competency of the interdisciplinary team in guiding advance care conversations is the gap.	Electronic medical records (EMRs) can adjust and create a living will or advance care planning section. The National Living Will registry is available for patients, families, and any facility and provider (*U.S. Advance Care Plan Registry*, 2018). Unfortunately, the registry is not well known, and some are charged a fee for using the database—approximately $60.00 for five years of access (*U.S. Advance Care Plan Registry*, 2018). . Some of these telehealth visits can be done by social workers or nurses and discuss end-of-life planning. Another technology used in an RCT was a PREPARE trial video system to introduce living wills in the clinic setting (Freytag et al., 2020). Forward to 2021, telehealth visits are more common and acceptable practices with billable codes.	If the stigma of advance care planning is overcome and reduced, open conversations overvalue goals and preferences can occur. Hopefully, these conversations occur with family who can honor the patients' decisions. Furthermore, if advance care planning documentation is completed and goals are aligned with care preferences, Completing advance care directives would help ensure the patient's wishes are honored and what is important to them is valued and heard. For the facility, having advance care directives completed assists in legal needs works to plan appropriate goal-aligned care for the patient and gives cost-effective care. Most Medicare expenditures occur in the last six to 12 months of life and are about 25% of the total budget (Freytag et al., 2020). Reducing unnecessary tests and

		providing comfort would be valuable to the facility while aligning with goals. Increased awareness of advance care planning.

Appendix B

SWOT Analysis: Community home-based palliative care practice

Internal		External	
Strengths	Weaknesses	Opportunities	Threats
Support from the company, MD, Social Workers, RNs, and APP. Support from the clinical director and chief medical officer. The overall team wants to improve the rate of ACP uploads Available EMR to upload discussions, documents, and progression of ACP	Time contrast Lack of medical records from providers to discuss prognosis. Lack of patients willing to complete the form or lack of available witnesses COVID precautions	More Face time with the provider Able to establish a relationship with patient, family Able to review form and discussion in nonemergent situation	Time barrier Lack of witnesses to sign ACP Lack of available family support or caregiver open to discussions of ACP COVID precautions

Appendix C

Participant Recruitment Flyer
Next page

PROJECT TITLE:

UTILIZATION OF REMAP CONVERSATION TOOL TO IMPROVE ADVANCE CARE COMPLETION IN THE HOME-BASED COMMUNITY SETTING

WHEN:
January 26, 2022
8am-9am

LOCATION:

ZOOM MEETING DURING REGULAR ASSIGNED IDT MEETING

MORE INFORMATION:

GSTARKEY@STU.JSU.EDU

205-743-8314

COST:
FREE

RSVP:

NOT REQUIRED

SPONSERED:

GWENDOLYN STARKEY DNP CANDIDATE, JACKSONVILLE STATE UNIVERSITY

BENEFITING
All advanced care providers to engage in more clinical skills for advance care planning using REMAP guided tool

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BENEFITING
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Appendix D

Participant Consent Form

Participant Information Form and Consent Form

Study Title: Utilization of REMAP conversation tool to improve advance care completion in the home-based palliative community setting.

Principal Investigator: Gwendolyn Starkey, MSN NP-C

Why is this project being done?
This project aims to increase clinical providers' advance care completion documents using REMAP's guided conversation tool in the home setting. Empowering clinical providers in educating palliative patients and their caregivers on advance care planning using REMAP could help optimize end-of-life care.

What will you be asked to do if you participate in this research project?
As a participant, you will be asked to take a survey to participate in a one-hour educational session via Zoom. The participant will then be asked to implement this tool during regular visits with palliative patients. At the end of the project, 12 weeks or 3/31/22, the post metric of advance care planning documents will be collected.

What risks or discomforts might you experience if you participate in this project? No expected harm should occur in this project. Time invested in participation in the study and implementation of the new tool is asked.

Where will this project occur?
The nurse practitioner will attend a training session via Zoom for one hour during customarily scheduled meeting times for practice. The use of the REMAP tool will occur in the home-based practice setting during regular patient visits. No extra time will be required.

How will information about you be kept private or confidential?
All efforts will be made to keep your information confidential. All data on the survey will be held in a locked office and personal identifying information removed with an ID number placed.

Is there any cost or compensation for this project? No, this project has no cost or compensation.
What will happen if you do not wish to participate in the project or if you later decide not to stay in the project? Withdrawal can occur at any time. Participation

is voluntary, and no loss of benefit can occur or penalty if you choose not to participate or withdraw. Management will not be aware if you chose to or chose not to participate in this DNP project and will have no forbearing on any evaluation.

Who can you call if you have any questions?
Gwendolyn Starkey, principal investigator
205-743-8314
gstarkey@stu.jsu.edu
gwendystarkey1@gmail.com

Agreement to Participate

Subject Consent: I have read this form, or it has been read to me, and I agree to participate in this project voluntarily. I have had the opportunity to ask questions and understand that I can withdraw anytime. If I choose to withdraw, I can contact the above number or information without penalty and at any time or date.

Participant Signature **Participant Last Name** **Date**

Signature of Investigator/Individual Obtaining Consent: To the best of my ability, I have explained the project goals, contents, and consent form. Questions about the research subject have been accurately answered.

_

Investigator Signature **Printed Name** **Date**
Date

Appendix E

REMAP Tool

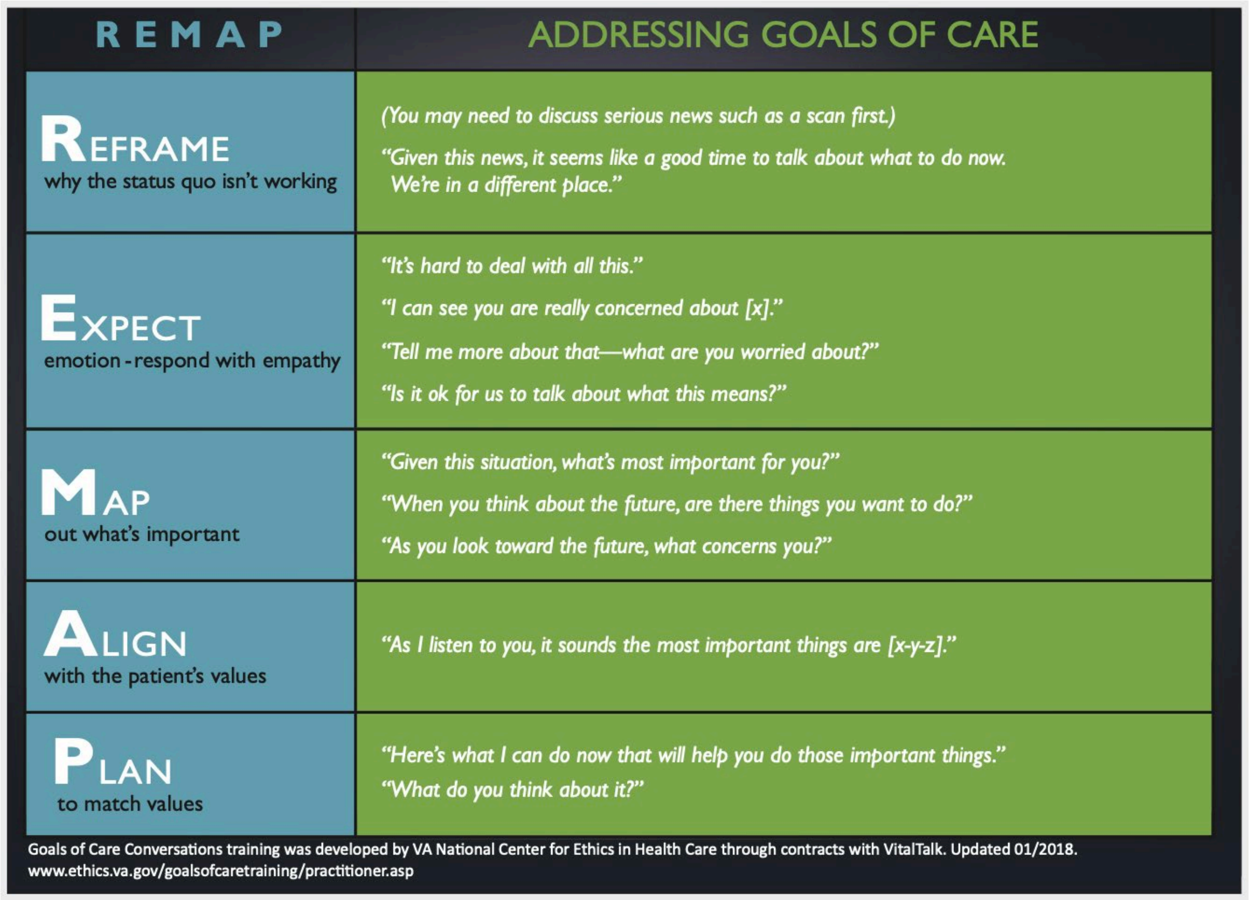
Transitions/Goals of Care

Addressing Goals of Care: Using the REMAP tool

We designed this talking map to give you a just-in-time route through a complex conversation. Think of it as a series of signposts—you might find that not all apply to a particular patient.

Step	What you say or do
1. Reframe why the status quo isn't working.	**You may need to discuss serious news (e.g., a scan result) first. "Given this news, it seems like a good time to talk about what to do now." "We're in a different place."**
2. Expect emotion & empathize.	**"It's hard to deal with all this." "I can see you are really concerned about [x]." "Tell me more about that—what are you worried about?" "Is it ok for us to talk about what this means?"**
3. Map the future.	**"Given this situation, what's most important for you?" "When you think about the future, are there things you want to do?" "As you think towards the future, what concerns you?"**
4. Align with the patient's values.	**As I listen to you, it sounds the most important things are [x,y,z].**
5. Plan medical treatments that match patient values.	**Here's what I can do now that will help you do those important things. What do you think about it?**
EXTRA: Expect questions about more anticancer treatment.	**Here are the pros and cons of what you are asking about. Overall, my experience tells me that more chemo would do more harm than good at this point. It's hard to say that though.**

EXTRA: Talk about services that would help before introducing hospice	**We've talked about wanting to conserve your energy for important things. One thing that can help us is having a nurse come to your house to can help us adjust your medicines so you don't have to come in to clinic so often. The best way I have to do that is to call hospice, because they can provide this service for us and more.**
	Copyright © 2020 Vital Talk. All rights reserved.



REMAP	ADDRESSING GOALS OF CARE
REFRAME why the status quo isn't working	*(You may need to discuss serious news such as a scan first.)* *"Given this news, it seems like a good time to talk about what to do now. We're in a different place."*
EXPECT emotion - respond with empathy	*"It's hard to deal with all this."* *"I can see you are really concerned about [x]."* *"Tell me more about that—what are you worried about?"* *"Is it ok for us to talk about what this means?"*
MAP out what's important	*"Given this situation, what's most important for you?"* *"When you think about the future, are there things you want to do?"* *"As you look toward the future, what concerns you?"*
ALIGN with the patient's values	*"As I listen to you, it sounds the most important things are [x-y-z]."*
PLAN to match values	*"Here's what I can do now that will help you do those important things."* *"What do you think about it?"*

Goals of Care Conversations training was developed by VA National Center for Ethics in Health Care through contracts with VitalTalk. Updated 01/2018.
www.ethics.va.gov/goalsofcaretraining/practitioner.asp

Appendix F

Permission to use REMAP tool

Hello Gwendolyn,

Thank you for contacting us. We are so happy that the REMAP has been helpful to you and your teaching. We appreciate your sensitivity and compliance with copyright and ask you to agree to the following:

1. Acknowledge that your use of VitalTalk content is for informational, non-commercial or educational use only
2. Do not alter our content without our express written permission
3. Include our website vitaltalk.org in your citation
4. Include copyright notice at the end of the material, specifically, "Copyright © 2020 Vital Talk. All rights reserved".

You are welcome to cite VitalTalk as well as adapt our guides. Please see our attribution policies here and let me know if you have any questions.

Thank you,
Team VitalTalk

On Wed, November 17, 2021, at 5:05 PM, gwendy starkey <gwendystarkey1@gmail.com> wrote:

Good evening,

I am a DNP candidate at Jacksonville State University School of Health and have been a nurse practitioner for 12 years and work in palliative care.

My DNP project is on goals of care conversation in the home setting and working on completing advance care directives.

I request to use REMAP in the DNP project as a conversation guide/ tool to assist our nurse practitioners.

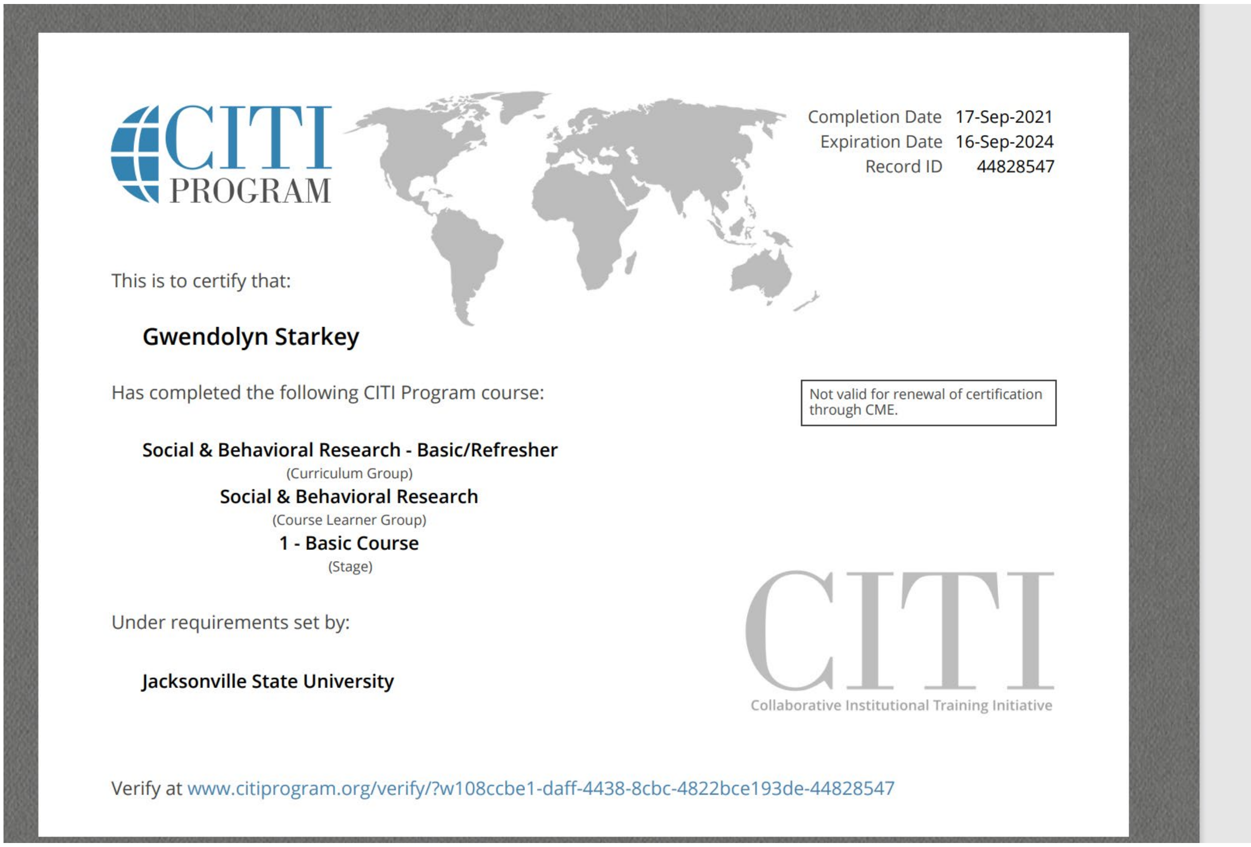
I am under the impression REMAP was developed with VitalTalk and hope to acquire permission to use it in my DNP project.

Thank you for your time,

Gwendolyn Starkey NP-C, DNP Student

Appendix G

CITI Training Certificate



CITI PROGRAM

Completion Date 17-Sep-2021
Expiration Date 16-Sep-2024
Record ID 44828547

This is to certify that:

Gwendolyn Starkey

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Social & Behavioral Research - Basic/Refresher
(Curriculum Group)
Social & Behavioral Research
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Jacksonville State University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w108ccbe1-daff-4438-8cbc-4822bce193de-44828547

Appendix H

University IRB Approval

See next page

INSTITUTIONAL REVIEW BOARD
JACKSONVILLE STATE UNIVERSITY

Institutional Review Board for the Protection of Human Subjects in Research
203 Angle Hall
700 Pelham Road North
Jacksonville, AL 36265-1602

December 2, 2021

Gwendolyn Starkey
Jacksonville State University
Jacksonville, AL 36265

Dear Gwendolyn:

Your protocol for the project titled "Utilization of REMAP conversation tool to improve advance care completion in the home-based palliative community setting" 12022021 has been granted exemption by the JSU Institutional Review Board for the Protection of Human Subjects in Research (IRB).

If your research deviates from that listed in the protocol, please notify me immediately. One year from the date of this approval letter, please send me a progress report of your research project.

Best wishes for a successful research project.

Sincerely,

Lynn Garner

Lynn Garner
Associate Human Protections Administrator, Institutional Review Board

Appendix I
DNP Project Timeline

TASK	START	DURATION
Project planning/proposal development	6/2021	Six months
Proposal Approval by PERC	9/21	One month
Obtain the Agency Letter of Support	8/21	Two months
JSU IRB Submission/Approval	9/21	Three months
Implementation	1/22	Five months
Data Collection	1/22	Five months
Data Analysis	8/20	23 months
Writing DNP Manuscript Results, Discussion, and Implications	7/21	11 months
Final Presentation and Dissemination	7/15/2022	

Completion:	**Pre-Design**	**Design**	**Implementation**	**Evaluation**
First Summer 2021	Define the clinical problem. Develop the initial PICOt. Complete an initial review of the literature.			

Fall 2021	Finalized the PICOt Question. Communicated with University faculty about project ideas. Met with Preceptor and chief medical officer at the practice facility Review of Literature: Completed Table of Evidence on advance care planning and living will completion, Select Theoretical Model Complete CITI training PERC, PERC redo x 2 IRB process and approval Draft beginning of the manuscript	Obtain approval for site use for the DNP project Obtain a letter of support Verify authorization to use the design tool Start E-portfolio		

		Began draft of Project Proposal Obtain PERC Approval Submit and obtain IRB Approval. IRB approved Preceptor Paperwork due Prepare to start the project		
Spring 2022			Implement DNP Project. Teaching class Send materials Part one Manuscript Part two Manuscript Part three Project ends Work with statistician	Data collection and statistical analysis Final project manuscript preparation.

			Final data collected Finished manuscript due Preceptor evaluation E-portfolio completed	
Final Summer 2022				Final project manuscript submission, Project Dissemination, Poster Presentation and submit E-portfolio.

Appendix J

Budget

Item	**Budget**	**Actual Cost**
Printed Materials Toner cartridges x 3	$100.00	$250.00
Mailing Costs	$200.00	$212.00
Pocket Cards	$100.00	$0.00
Poster Printing	$100.00	$0.00
Refreshments for Educational sessions (2)	$100.00	$100.00
Final Bound Copy of Project Manuscript	$200.00	$0.00
Statistician Cost	$600.00	$240.00
Editor Cost	$300.00	$0.00
Total Cost:	$1500.00	$802.00