
Advance Care Planning

Advanced practice provider–initiated discussions and their effects on patient-centered end-of-life care

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BACKGROUND: Advance care planning (ACP) is an ongoing process of communication involving patients, family members, and caregivers on one side and healthcare providers on the other to establish values, goals, and preferences for future care, along with discussions concerning end-of-life care options. Advance directives promote patient autonomy and provide written documentation of a patient's wishes for future care.

OBJECTIVES: This quality improvement project aimed to determine if ACP discussions initiated by an advanced practice provider (APP) would enhance patient-centered end-of-life care.

METHODS: This study involved retrospective data collection of 20 inpatients and 20 outpatients without a scanned advance directive in the electronic health record at the time of admission or clinic visit, as well as an ACP intervention by an APP.

FINDINGS: APPs can initiate ACP discussions with patients with cancer, which may assist in their understanding of ACP, resulting in completion of the advance directive documents and a change in their code (resuscitation) status.

KEYWORDS

advance care planning; advance directives; end of life; code status; advanced cancer

DIGITAL OBJECT IDENTIFIER

10.1188/20.CJON.81-87

ADVANCE CARE PLANNING (ACP) IS A VOLUNTARY AND ONGOING PROCESS of communication among patients, family members and caregivers, and healthcare professionals to understand, review, and plan for future healthcare decisions; ACP promotes shared decision making in accordance with patients' preferences. ACP discussions also provide better outcomes for family members, including reduced decision-making burden, anxiety, and depressive symptoms (Stein et al., 2013; Sumalinog, Harrington, Dosani, & Hwang, 2017). An advance directive comprises the selection of a medical power of attorney for healthcare designation, as well as the creation of a living will that articulates a person's wishes regarding treatment, resuscitation with CPR including mechanical ventilation, and tube feeding at the end of life (Carr & Luth, 2016).

Guidelines from the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN) recommend that ACP discussions take place within three months of a diagnosis of incurable cancer (Bestvina & Polite, 2017). The Institute of Medicine ([IOM], 2014), in its report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, identified an urgent need for improvement in health care at the end of life, as well as called for patient-centered end-of-life care that honors individual preferences and promotes quality of life. A systematic review of 113 observational studies by Brinkman-Stoppelenburg, Rietjens, and van der Heide (2014) revealed the impact of ACP on end-of-life care, as demonstrated by increased compliance with patients' preferences and improved quality of life for patients and their families; the presence of the do-not-resuscitate (DNR) order was associated with a decreased use of CPR and increased use of hospice and palliative care services.

The University of Texas MD Anderson Cancer Center adheres to the Quality Oncology Practice Initiative standards of the American Society of Clinical Oncology, with an ACP policy requiring providers to initiate ACP discussions by the third office visit, a template for documenting ACP discussions, and online education for patients. Social workers assist patients with completing the advance directive documents. In the Department of Investigational Cancer Therapeutics (ICT), patients with solid tumors with advanced metastatic disease who have exhausted all standard-of-care