

Advance Care Planning Complexities for Nurse Practitioners

Monica Dube, DNP, FNP-BC, Amy McCarron, DNP, FNP-BC, and Angela Nannini, PhD, NP-C

ABSTRACT

Patients and families are often asked to make critical decisions about end-of-life (EOL) care without any warning or knowledge of the patient's wishes. EOL decisions may cause significant anxiety for all involved. A study was conducted to assess the prevalence of advance care planning (ACP) discussions and to identify barriers and facilitators to these discussions by nurse practitioners. Educational, time, and systems factors were found to impact these discussions. Developing educational programs and influencing policies surrounding ACP may increase the number of discussions and promote advocacy for the patient and improve health care.

Keywords: advance care planning, advance directives, barriers, end of life, nurse practitioners

© 2015 Elsevier, Inc. All rights reserved.

Although patients may live longer because of advances in medical technology, the quality of life near end of life (EOL) may not be optimal. The complexity of multiple chronic conditions along with an aging population may lead to more frequent and prolonged hospitalizations. These circumstances may create a situation in which patients or families are asked to make critical decisions about EOL care without any warning or knowledge of the patient's wishes in a time-restricted manner. Decisions made during a time of health care-related crisis for the patient can be overwhelming. Conversations about EOL issues at this time can cause added stress and may not accurately reflect the patient's wishes.¹ These discussions need sufficient time allotted for explanations,² require an empathetic approach, and demand honesty from the care provider to give the patient and family sufficient information to make appropriate decisions. Ideally, these conversations occur in advance of a crisis through an ongoing dialogue with one's health care provider.

The process of advance care planning (ACP) is a method by which patients contemplate future health care decisions and document their wishes.³ Discussions with patients and their families to engage them as active participants in their care are essential to ACP. Through patient engagement, explanations of

illnesses, and anticipatory planning, patients can make informed health care decisions. These proactive ACP conversations may help reduce both personal stress and financial burdens.

Health care costs and their burden on society have recently been the focus of much public attention. This burden encompasses issues of patient advocacy, personal financial expenses, concerns about controlling health care costs, and the future viability of both Medicare and private insurance systems. Improvements in medical treatments and prognoses have contributed to instances in which health conditions previously considered terminal are now extended chronic illnesses. At a time of acute hospitalization, a lack of previous ACP discussions may add to the personal anxiety of the patient/family and lead to medical interventions that may not be desired. ACP is crucial to help reduce the cost associated with EOL concerns for both the patient/family and the health care system.

Several benefits of ACP have been cited in the literature and include patient comfort and dignity; increased patient satisfaction with care; decreased patient, family, or provider anxiety with respect to making a life decision in an urgent situation; increased knowledge of the provider in understanding patients' wishes; and decreased cost to the health care system.⁴⁻⁶ Despite the widely known benefits of

ACP discussions, many barriers may exist to having these discussions. These may include time issues, communication difficulties, personal anxiety about the topic, lack of provider training in discussing this topic, lack of provider knowledge about advance directives (ADs), and concern about patient acceptance of the discussion.^{1,7,8}

Knowledge of nurse practitioner (NP) practice in the area of ACP is limited. Previous research has primarily focused on increasing the numbers of ADs rather than the process of ACP and almost exclusively concentrated on physicians.^{7,9-13} Few studies exist involving NPs and ACP.^{14,15} Provider beliefs may also impact the decision to initiate ACP discussions. Stoeckle et al¹⁶ investigated provider beliefs in 1998. Revisiting the changes in beliefs in the current health care environment may also lead to additional insight regarding NP practice and ACP discussions. Current health care policy experts are investigating increasing patient satisfaction, containing costs, and encouraging NPs to be primary care providers.^{17,18} Research investigating whether NPs are having ACP discussions or not should be included.

NPs are advocates for their patients in all aspects of health care, and this should include ACP. Having and appropriately documenting these discussions may also increase the quality of care and decrease long-term costs. Exploring the barriers and facilitators NPs encounter with respect to ACP discussions is critical to improving patient advocacy and lowering health care expenses at EOL. Aligning with Kolcaba's Comfort Theory¹⁹ of providing support as patients progress through life and death, the purpose of this study was to assess the prevalence of ACP by NPs and to identify perceived personal, professional, and systems barriers and facilitators to NPs having ACP discussions.

METHODS

Study Design and Participants

This study used a quantitative nonexperimental descriptive design. A nonprobability convenience sample of NPs from a statewide organization's database self-selected to participate in the survey. The survey was delivered via the Internet using SurveyMonkey (SurveyMonkey, Inc. Palo Alto, CA). It was conducted using an established and validated

questionnaire¹⁶ to investigate provider beliefs and perceptions along with a professional and demographic component developed by the principal researcher.

The questionnaire included 5 demographic and 6 professional characteristic questions, 4 questions about previous EOL education, and 2 questions about barriers and facilitators to ACP for NP practice identified by a review of the literature followed by Stoeckle's End of Life Care Decision Questionnaire II (EOLCDQ II).¹⁶ The participants were asked to respond to the barrier and facilitator questions in a 5-point Likert scale format rating various time issues and systems factors. One open-ended question was included to identify any other EOL issue not addressed by the formal questions.

Procedure

Both the institutional review board of the university and the research committee of a statewide organization of NPs approved this study. After obtaining approval, a cover letter explaining the purpose of the study and containing the SurveyMonkey link was sent to the web editor of the state organization who in turn distributed the survey to the organization's database for members to complete. Each participant was required to electronically check a box in order to proceed, indicating consent to participate. Upon completion, survey responses were automatically sent to SurveyMonkey for storage.

Data Collection

Data were collected over a 75-day time period in 2014. A reminder notice was not sent because of technical issues with the Internet format. All responses were anonymous and kept confidential in an electronic password-protected location. A total of 160 responses were returned for a response rate of 13%.

Data Analysis

Data were analyzed using descriptive statistics using the SPSS statistical program (version 22; SPSS Inc, Chicago, IL). The demographic questions and the EOLCDQ II were evaluated with measures of central tendencies. Cross tabulations were used to evaluate relationships between NP education, EOL

educational opportunities, demographic responses, and personal experiences to conducting ACP discussions. The dependent variables of how often NPs were having ACP discussions with patients and families were grouped according to reported frequency of discussions. The three categories were never/rarely, sometimes, and often/always. The barrier questions to ACP discussions were evaluated and recoded according to the categories of time-related barriers and insufficient organizational (systems) factors. The facilitator questions were also analyzed according to time-related and organizational (systems) facilitators. The 3 categories of reported ACP discussions were used to assess the associations

between the various possible barriers and facilitators and the frequency of ACP discussions using 1-way analysis of variance (Kruskall-Wallis). A post hoc power analysis was conducted. Sample size was sufficient to achieve 80% power.

RESULTS

The majority of the NP participants were female (94.4%), white (92.5%), and married (77%) with a master's degree (87.2%) and working 30 hours or more (76%). The ages of the respondents ranged from 20 (5%) to over 65 (3%) with the majority falling between 30 and 65 (92%). Areas of practice were dispersed throughout the state with the majority

Table 1. Nurse Practitioner Sample Characteristics

Characteristic	Value	n (%)	% of Discussions	
			Patient	Family
Age (N = 160)	20-39	52 (32.5)	65.4	61.5
	40-60	83 (51.9)	69.9	67.4
	>60	25 (15.6)	72.0	68.0
Sex (N = 160)	Female	151 (94.3)	68.2	64.9
	Male	9 (5.6)	77.7	75.0
Practice Setting (n = 159) missing 1	Physician/outpatient	61 (38.0)	64.5	61.3
	Hospital/outpatient	26 (16.3)	57.7	50.0
	Community	6 (3.7)	66.7	83.3
	Hospital/inpatient	13 (8.1)	100.0	92.3
	Long-term care	11 (6.9)	100.0	100.0
	Other	42 (26.4)	64.3	61.9
	Specialty (N = 160)	Family	68 (42.5)	63.3
	Adult/gerontology	47 (29.3)	89.4	80.8
	Pediatric	6 (3.7)	0.0	0.0
	Women's health	4 (2.5)	0.0	0.0
	Primary care	5 (3.1)	60.0	60.0
	Other	30 (18.7)	73.3	76.7
Years in practice (n = 158) missing 2	0-5	46 (29.1)	68.1	61.7
	6-15	56 (35.4)	66.0	69.7
	16-25	30 (18.9)	70.0	60.0
	>25	26 (16.4)	73.9	69.2
Primary care (n = 158) missing 2	Yes	86 (54.0)	70.9	65.1
	No	72 (46.0)	65.3	65.2

in either the capitol city (27%) or the north shore region (22%). Of the respondents, 55% practiced in physician offices or outpatient settings. The majority of respondents held specialty certification for family/adult gerontology (71%). The number of reported years in practice ranged from 0 to greater than 25 with the majority between 6 and 25 years (54%). Practicing primary care; age greater than 30; having certification in adult/gerontology; working more than 20 hours; and working in long-term care, inpatient, or a community setting were associated with a higher frequency of ACP discussions. Overall, 65% of NPs report having discussions at least some of the time. [Table 1](#) summarizes the sample characteristics and the frequency of ACP discussions.

Seventy-nine percent of NPs felt that additional training would enhance their ability to conduct ACP discussions. Evaluating the association of education and ACP discussions revealed that those who reported having formal NP education on EOL or had taken continuing education courses were having more discussions (72.8% and 86.8%, respectively). Thirty-nine percent of the respondents did not have knowledge of the federal mandate for health care institutions that accept Medicare to provide AD information to patients.

Barriers and facilitators were categorized into time- and systems-related factors. [Table 2](#) lists these factors. The median scores of time-related variables did not differ across the NP groups having ACP discussions with patients and families because time was reported as both a barrier and a facilitator across all groups although it was not statistically significant in the NP groups having discussions with families ($P > .05$). All 3 groups of NPs felt extra time was a facilitator to ACP discussions with both patients and families. Lack of time was reported as a barrier to

discussions except for the NP group always having discussions with families.

The median scores of systems factors did differ among all the NP groups ($P < .05$). The NPs who were never having discussions with patients or families reported systems factors to be a barrier, whereas those always having discussions did not feel that systems factors were a barrier. System factors were reported to be facilitators in the NP groups sometimes and always having discussions. The group never having discussions reported no systems facilitators with patients or families.

Three major themes were identified in the open-ended question concerning ACP discussions. These included a lack of knowledge, issues related to specific practice settings, and cultural or language concerns.

The EOLCDQ II ¹⁶ questionnaire results focused on participants' beliefs about EOL concerns. The results of the 9 questions are found in [Table 3](#). For comparison, the table lists the initial survey results in 1998 as well as the current results from this study. Key findings identified pertained to education and changes in opinions about patient-centered care. The most dramatic change was noted in the last question concerning the patient having the right to make his or her own EOL care decisions.

DISCUSSION

The overall results of this study indicate that although there is a substantial group of NPs regularly having ACP discussions, personal, professional, and systems factors all influence whether or not the NP will conduct these discussions. These findings show results similar to those previously reported in the literature with physicians. The pivotal role of education is confirmed by the finding that NPs who had taken continuing education courses were more than twice

Table 2. Barriers/Facilitators

Time-related Barriers	Time-related Facilitators	Systems Barriers	Systems Facilitators
Lack of time	Adequate staff	Lack of education	Having an EMR
Staff shortage	Length of appointment	Lack of forms	Availability of forms
Length of appointment	Type of appointment	Lack of EMR	Support of leadership
Type of appointment		Lack of leadership	Previous training

EMR = electronic medical record.

Table 3. Comparison EOLCDQ II¹⁶ 1998 and 2014

Question	Survey Year	Strongly Agree, n (%)	Agree, n (%)	Neutral, n (%)	Disagree, n (%)	Strongly Disagree, n (%)	Missing, n (%)
My work experience enables me to discuss end-of-life care decisions with patients and their families	1998	0 (0.0)	1 (0.5)	6 (2.8)	86 (40.4)	119 (55.9)	1 (0.5)
	2014	48 (29.8)	67 (41.6)	18 (11.2)	17 (10.6)	5 (3.1)	6 (3.7)
My educational preparation enables me to discuss end-of-life care decisions with patients and their families	1998	1 (0.5)	13 (6.1)	16 (7.5)	106 (49.8)	76 (35.7)	1 (0.5)
	2014	19 (11.8)	73 (45.3)	30 (18.6)	34 (21.2)	1 (0.6)	4 (2.5)
I feel comfortable using the words "die" and "death" when discussing end-of-life care with my patients or families	1998	1 (0.4)	14 (6.6)	27 (12.7)	90 (42.3)	78 (36.6)	3 (1.4)
	2014	38 (23.6)	87 (54.0)	14 (8.7)	12 (7.5)	4 (2.5)	6 (3.7)
Patients and their families are given consistent information in end-of-life care discussions	1998	12 (5.6)	84 (39.4)	44 (20.7)	59 (27.7)	13 (6.1)	1 (0.5)
	2014	7 (4.3)	39 (24.2)	47 (29.2)	49 (30.4)	13 (8.1)	6 (3.7)
Patients and their families understand the information they are given about end-of-life care decisions	1998	5 (2.3)	54 (25.3)	73 (34.3)	64 (30.0)	14 (6.6)	3 (1.4)
	2014	5 (3.1)	36 (22.4)	60 (37.3)	46 (28.6)	8 (5.0)	6 (3.7)
I believe patients and families are approached about end-of-life care decisions in an atmosphere that is nonthreatening and conducive to processing difficult decisions	1998	7 (3.3)	66 (31.0)	48 (22.5)	70 (32.9)	19 (8.9)	3 (1.4)
	2014	15 (9.3)	66 (41.0)	42 (26.1)	28 (17.4)	3 (1.9)	7 (4.3)
Patients and families are regularly included in update discussions regarding their end-of-life care decisions	1998	9 (4.2)	53 (24.9)	39 (18.3)	88 (41.3)	21 (9.9)	3 (1.4)
	2014	13 (8.1)	54 (33.5)	51 (31.7)	32 (19.9)	5 (3.1)	6 (3.7)
End-of-life care discussions facilitate physician and family agreement on treatment	1998	1 (0.5)	7 (3.3)	14 (6.6)	107 (50.2)	82 (38.5)	2 (0.9)
	2014	40 (24.8)	91 (56.5)	19 (11.8)	4 (2.5)	2 (1.2)	5 (3.1)
All patients have a right to make end-of-life care decisions	1998	1 (0.5)	4 (1.9)	8 (3.8)	55 (25.8)	143 (67.1)	2 (0.9)
	2014	111 (68.9)	41 (23.3)	2 (1.2)	3 (1.9)	0 (0.0)	4 (2.5)

as likely to have had ACP discussions with patients compared with NPs who had not taken classes. The majority of respondents felt that additional education would enhance their ability to conduct ACP discussions. Lack of knowledge regarding the Patient Self-Determination Act also influenced whether NPs were having ACP discussions because those who were aware of the federal mandate indicated they were having more frequent ACP discussions. Despite

the importance of education in conducting ACP discussions, only a single study had previously addressed the educational preparation of NPs regarding EOL care.²⁰ Offering education in EOL issues may help increase the incidence of ACP discussions.

One of the key findings in this study was that all the NPs indicated time factors to be critical in facilitating ACP discussions. ACP is a process that

requires sensitivity and extended time to answer questions, investigate spiritual values, and educate the patient. This cannot be accomplished during a single or an urgent visit.²¹ This indicates that the primary care setting, where a patient has repeated contact with a provider, is the best location to conduct ACP discussions. The current study also found a positive association between length of time having known the patient and more ACP discussions. This result also supports the primary care setting as quintessential for ongoing conversations at regularly scheduled appointments. Scarce literature exists investigating the initiation of the ACP process upon first entry into adult primary care and with healthy patients. This is an ideal time to start the ACP process; having repeated discussions rather than a 1-time conversation and older age of the patient were facilitators to ACP.^{7,13,22} Scheduling appropriate-length appointments to allow sufficient time for these focused conversations is critical to encouraging this process.

Systems issues including ACP/AD form availability, lack of leadership support, and reimbursement concerns were all reported to be significant barriers to ACP discussions. This study aligned with previous research that had also identified many of these same concerns.^{12,22,23} Improving these organizational issues may be accomplished through changes such as incorporating an electronic medical record (EMR) to assist with documentation and form retrieval. In an extensive literature review, Jezewski et al⁹ found that combining patient and provider interventions was more successful than either patient or provider interventions alone. Although this study identified provider barriers and facilitators, ideally a combined approach of addressing provider and patient concerns can be used to encourage ACP discussions. Limitations noted in this review of the literature consisted of time constraints and reimbursement issues similar to the current study's findings of time barriers. The current model for reimbursement is based on diagnosis rather than time. Without a specific diagnosis code associated with ACP and with complex patient issues that must be managed during routine visits, ACP discussions may not be a priority. Encouraging leadership to support ACP as part of routine care and help resolve systems barriers is essential.^{13,22} A promising result of this study is that

despite the perceived limitations NPs identified surrounding ACP, at least 60% of NPs are sometimes or always having discussions.

This study also noted a dramatic change in provider beliefs about EOL as previously documented with the EOLCDQ II.¹⁶ Increases were noted in the respondents' belief that patients and families were more directly involved in EOL discussions and decisions. This patient and family involvement included being given consistent EOL information and being involved in treatment plans. Promoting the participation of the patients in their own care by sharing information and helping the patients/families in understanding the complexities of EOL is within the sphere of NP influence. The most significant finding was the change in the belief that the patients had a right to make EOL decisions for themselves. Almost all of the NPs currently believe that patients are at the center of their care. This represents an important step toward empowering patients to be active participants in their care, which is a cornerstone of ACP. The evolution of the NP role in promoting patient autonomy throughout the life span may be an explanation.

LIMITATIONS

Some limitations of this study include the low survey response, using a convenience sample, and obtaining little information regarding the type of practice and practice setting. The results may not represent the true NP population. This study was conducted in a medically dense geographic area. The responses on the survey may be skewed because of the availability of expert medical care, particularly at EOL, as well as proximity to academic medical centers.

The EOLCDQ II¹⁶ scale is more than 15 years old. The health care industry has undergone significant changes during that time period. NP practice has expanded into specialty areas, and the NP role has increased in the primary care setting. In addition, patients have become much more educated and involved in their health care over the past 20 years, especially with the availability of information on the Internet. These issues may have influenced the dramatic difference in responses to the EOLCDQ II.¹⁶

Lack of understanding by the respondents regarding the difference between the concept of ACP

and an AD may have affected their responses. There also may have been some confusion regarding being a primary care provider as opposed to providing some form of primary care.

IMPLICATIONS FOR PRACTICE

ACP is a complex process. Incorporating interventions to address both provider and patient considerations may increase the likelihood of having these conversations. This study's results support the idea that education focused on ACP is essential to enabling providers to engage in ACP. Developing an educational program that will both enhance the formal preparation of NPs as well as provide continuing education regarding ACP is needed.

More research is needed to address some of the many other factors that may influence ACP and NP practice. This study could be replicated across all NP specialties and geographic areas to increase knowledge about this topic. Additional research regarding health literacy may also be beneficial. Health literacy was addressed in only 1 study¹⁰ and was found to be a limiting factor. Patients' lack of comprehension may be a barrier to participating in ACP. Towers²⁴ presented a protocol for having ACP discussions that included evaluation of the patient's values, wishes, and understanding of ADs. Further research is needed to understand whether discussion is more successful than giving educational materials or forms to the patients for review on their own.

Additional research may help determine the appropriate content for successful discussions as well as the communication style of the provider. A certain technique may increase patient comfort with these difficult discussions and facilitate continued dialogue, but weak evidence exists for an ideal communication style. Charlton et al²⁵ reported that a patient-centered communication style positively affects patient outcomes. Involving the patient directly in his or her care not only fulfills the directive of the Patient Self-Determination Act but may also improve patient satisfaction. Quality patient-centered care that incorporates regular ACP discussions may also improve clinical outcomes. Research is also needed to include the younger, healthier population because traumatic events often occur in the younger population who may

not have been encouraged to investigate their wishes for EOL.¹¹

The results of this study also revealed that practice concerns around time and systems factors influence the frequency of ACP. Addressing the types and length of appointments as well as issues surrounding the availability of forms and leadership support may help to make ACP an integral part of routine care. Consideration for revising reimbursement schedules based on quality of care, rather than length or type of appointment, may also increase the likelihood of ACP. Although some codes exist for the discussion of palliative care or resuscitation status, these codes do not apply to the healthy population and are not reimbursable as a stand-alone code. They may, however, help to identify if and when ACP discussions are occurring. NPs are in a position to affect some of these policy and procedural changes because they are assuming larger roles in the primary care domain and need to be advocates for both the patient and the health care system. Becoming comfortable conducting ACP conversations, making the conversations part of the preventive care model, and receiving compensation for these complicated discussions may encourage NPs to continue these conversations.

CONCLUSION

The results of this study suggest that developing specific programs to enhance the formal and continuing educational options of NPs as well as addressing the organizational barriers that currently exist may increase ACP discussions. Evidence that exposure to information about ACP increases the frequency of conversations indicates that additional education is critical.

Addressing both provider and patient factors to encourage ACP discussions includes evaluating the delivery of current health care. Reconsidering the method of scheduling appointments; providing forms to be immediately available, retrievable, and more easily understandable; having leadership support; and establishing a diagnosis code for ACP discussions may also increase the likelihood of ACP.

This study's findings are consistent with the recommendations included in the Institute of Medicine's report *Dying in America*, which encourages

additional training, using electronic technology, and increasing reimbursement and provider engagement to incorporate ACP into practice.² NPs are in a position to be leaders in this important aspect of health promotion. As they continue to expand their roles in all aspects of patient care, incorporating these discussions into regular preventive care fosters the ideal of patient-centered health delivery. **JNP**

References

- Nelson JM, Nelson TC. Advance directives: empowering patients at the end of life. *Nurse Pract.* 2014;39:34-40.
- Institute of Medicine Committee on Approaching Death. *Dying in America: Improving quality and honoring individual preferences near the end of life. Key findings and recommendations.* Washington, DC: National Academy of Sciences; 2014. <https://www.iom.edu/~media/Files/Report%20Files/2014/EOL/Key%20Findings%20and%20Recommendations.pdf>. Accessed May 12, 2015.
- You JJ, Fowler RA, Heyland DK. Just ask: discussing goals of care with patients in hospital with serious illness. *CMAJ.* 2014;186:425-432.
- Chrash M, Mulich B, Patton CM. The APN role in holistic assessment and integration of spiritual assessment for advance care planning. *J Am Acad Nurse Pract.* 2011;23:530-536.
- Detering KM, Hancock AD, Read MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomized controlled trial. *BMJ.* 2010;340:c1345.
- Goodman D, Esty A, Fisher E, Chang CH. Trends and variation in end-of-life care for Medicare beneficiaries with severe chronic illness. A report of the Dartmouth Atlas Project. 2011. http://www.dartmouthatlas.org/downloads/reports/EOL_Trend_Report_0411.pdf. Accessed March 14, 2015.
- Ramsaroop SD, Reid MC, Adelman RD. Completing an advance directive in the primary care setting: what do we need for success? *J Am Geriatr Soc.* 2007;55:277-283.
- Tierney WM, Dexter PR, Gramelspache GP, Perkins AJ, Zhou XH, Wolinsky FD. The effect of discussions about advance directives on patients' satisfaction with primary care. *J Gen Intern Med.* 2001;16:32-40.
- Jezewski MA, Meeker MA, Sessanna L, Finnell DS. The effectiveness of interventions to increase advance directive completion rate. *J Aging Health.* 2007;19:519-536.
- Schickedanz AD, Schillinger D, Landefeld CS, Knight SJ, Williams BA, Sudore RL. A clinical framework for improving the advance care planning process: start with patients' self-identified barriers. *J Am Geriatr Soc.* 2009;57:31-39.
- Spoelhof GD, Elliot B. Implementing advance directives in office practice. *Am Fam Physician.* 2012;85:461-466.
- Tung EE, Vickers KS, Lackore K, Cabanela R, Hathaway J, Chaudhry R. Clinical decision support technology to increase advance care planning in the primary care setting. *Am J Hosp Palliat Care.* 2011;28:230-235.
- Wisow LS, Belote A, Kramer W, Compton-Phillips A, Kritzer R, Weiner JP. Promoting advance directives among elderly primary care patients. *J Gen Intern Med.* 2004;19:944-951.
- Duffield P, Podzamsky JE. The completion of advance directives in primary care. *J Fam Pract.* 1996;42:378-384.
- Resnick B, Anderson C. End-of-life treatment preferences among older adults: a nurse practitioner initiated intervention. *J Am Acad Nurse Pract.* 2002;14:517-522.
- Stoeckle ML, Doorley JE, McArdle RM. Identifying compliance with end-of-life care decision protocols. *Dimens Crit Care Nurs.* 1998;17:314-321.
- Future of Nursing-Institute of Medicine. <http://iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>. Accessed March 14, 2015.
- Goodell S, Dower C, O'Neil E. Primary care workforce in the United States. Robert Wood Johnson Foundation Policy Brief No. 22, 2011. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70613. Accessed March 14, 2015.
- Novak B, Kolcaba K, Steiner R, Dowd T. Measuring comfort in caregivers and patients during late end-of-life care. *Am J Hosp Palliat Care.* 2001;18:170-180.
- Paice JA, Ferrell BR, Virani R, Grant M, Malloy P, Rhome A. Graduate nursing education regarding end-of-life care. *Nurs Outlook.* 2006;54:46-52.
- Malcomson H, Bisbee S. Perspectives of healthy elders on advance care planning. *J Am Acad Nurse Pract.* 2009;21:18-23.
- Hammes BJ, Rooney BL, Gundrum JD. A comparative, retrospective, observational study of the prevalence, availability, and specificity of advance care plans in a county that implemented an advance care planning microsystem. *J Am Geriatr Soc.* 2010;58:1245-1255.
- Fried TR, Bullock K, Iannone L, O'Leary JR. Understanding advance care planning as a process of health behavior change. *J Am Geriatr Soc.* 2009;57:1548-1557.
- Towers J. Advance care directives: counseling the patient and family in the primary care setting. *Nurse Pract Forum.* 1992;3:25-27.
- Charlton CR, Dearing KS, Berry JA, Johnson MJ. Nurse practitioners' communication styles and their impact on patient outcomes: an integrated literature review. *J Am Acad Nurse Pract.* 2008;20:382-388.

Monica Dube, DNP, FNP-BC, is a family nurse practitioner at Lahey Health System in Lexington, MA, and can be reached at Monica.Dube@Lahey.org. Amy McCarron, DNP, FNP-BC, is an adjunct professor at the School of Nursing, University of Massachusetts Lowell. Angela Nannini, PhD, NP-C, is an associate professor emeritus at the School of Nursing, University of Massachusetts Lowell. In compliance with national ethical guidelines, the authors report no relationships with business or industry that would pose a conflict of interest.

1555-4155/15/\$ see front matter
 © 2015 Elsevier, Inc. All rights reserved.
<http://dx.doi.org/10.1016/j.nurpra.2015.05.011>