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# Advance Care Planning in Faith Communities: A Quality Improvement Project

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## Advance Care Planning in Faith Communities: A Quality Improvement Project

### Cover Page Footnote

Advance Care Planning in Faith Communities: A Quality Improvement Project Lorie Hacker, Marian University Jessica Grimm, Touro University Nevada Catherine Chung, Touro University Nevada Jan Gaddis, Franciscan Health Touro University Nevada, School of Nursing Disclaimers: None Corresponding Author: Lorie Hacker 2235 Game Bird Drive Franklin, Indiana 46131 317-828-1540 ~ loriehacker@gmail.com

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## Introduction

Advance care planning (ACP) is an important aspect of care for adults. Effective screening and prevention are key to determine individual treatment preferences to improve quality of life (National Committee for Quality Assurance [NCQA], 2018). ACP improves patient outcomes by increasing clinician understanding of patient wishes, reducing hospitalizations and aggressive care at the end-of-life, increasing use of hospice programs, and increasing patient satisfaction with care provided (Detering & Silveira, 2018, p. 3). Ninety-two percent of people indicate that having a conversation regarding end-of-life care is important, however only 32% have had this conversation (The Conversation Project, 2020). Faith communities play an important role in shaping social issues and values surrounding end-of-life care and can help to overcome barriers to health promotion in many cultures. This quality improvement project targeted faith communities through the development of an ACP Training Tool (ACPTT) with implementation in the faith community nursing program of an Indiana hospital. This ACPTT provided structure for the faith community nurse (FCN) to conduct ACP interventions in their individual community-based faith groups (Sun et al., 2017).

## Background

ACP has been promoted since the first living will was proposed in 1967 with a focus on common and constitutional law requirements regarding patient treatment without consent. Since the 1970's advance directives have been used as legal tools to formally communicate one's wishes regarding end-of-life care (Sabatino, 2010, p. 212). Through the technological evolution of medical care in the 1970's questions arose regarding difficulty distinguishing life-saving interventions from interventions that prolong suffering and death. Many began to question why medical providers would need immunity when the law already presumed immunity and that providers would respect their patient's wishes (Sabatino, 2010, p. 213).

Today, ACP is defined as discussion between the patient and others about future care with the goal being to ensure patients receive medical care that is "consistent with their values, goals and preferences" (Detering & Silveira, 2018, p. 1). ACP conversations may lead to the completion of advance directives (AD) such as Health Care Surrogate (HCS) documents, Living Wills (LW) and other actionable documents such as a Do-Not-Resuscitate (DNR) order (Detering & Silveira, 2018, p. 2). Broadly defined, goal concordant care is treatment that matches patient-stated or documented goals (Halpern, 2019). The FCN functioning in the community setting can be compared to the role of a community health worker engaging in ACP. Litzelman et al., (2016) describes the effectiveness of the community health worker in the dissemination of education regarding ACP. This was demonstrated to be an effective way to increase knowledge and awareness of ACP, leading to increased completion of AD (Litzelman, Cottingham, Griffin, Inui, & Ivy, 2016, p. 641).

There is ample evidence in the literature of the support and need for ACP in the community setting. The positive impact on patient outcomes and the cost avoidance by health systems empowering patient autonomy, preventing futile care undesired by the patient and family has been noted (Detering & Silveira, 2018). Although community settings, specifically faith community settings, are often underserved, the FCN is uniquely positioned to provide

effective, culturally relevant ACP education and outreach to increase ACP engagement and AD completion (Lind & Chase, 2014).

Gaps in transitional care in the community exacerbate hospital readmissions. FCNs increase the use of preventive medical and social services, adherence to treatment regimens and provide support for community members to thrive in their own homes (Schroepfer, 2016). The American Nurses Association (ANA) scope and standards of practice for the FCN include the assistance of faith community members with life transitions for adults with chronic illness and specific direction to assess social determinants of health to develop targeted health promotion activities (Health Ministries Association, 2017). Additionally, the FCN can access populations that may be difficult to reach due to socioeconomic disparities and decreased access to primary care (Schroepfer, 2016). Health care systems have routinely partnered with FCNs to reach the vulnerable. FCNs integrate mental, physical, and spiritual health connecting with fellow church members. This intimacy leads to a more thorough congregational needs' assessment and health promotion. Members perceive the FCN as a positive, beneficial, and trusted healthcare resource (Lind & Chase, 2014). The integration of faith and health creates an ideal setting for the FCN to be an educator and motivator of health in the community (Gotwals, 2018). The FCN role is naturally adaptable in a variety of settings to include home or church which is based on the needs of the members. These characteristics provide an ideal platform for the faith community nurse to engage in ACP activities.

## Opportunities to Move to Goal Concordant Care

Exposure to ACP information and outreach is known to significantly increase completion of AD (Splendore & Grant, 2017). Health care professionals are often uncomfortable speaking with patients and families about ACP and 87% report hesitation to implement until illness become severe (Booth & Lehna, 2016). Patients who often wait for their medical provider to prompt them in these discussions are left vulnerable.

Faith communities, defined as a group of people who share a set of religious beliefs (Longman, 2020) in collaboration with FCN programs can meet this need by partnering with health care organizations to reach the community and support ACP conversations (Kotecki, 2002, p. 61). Although this FCN program had offered education regarding ACP, no formal training existed.

## Purpose Statement

The development of an Advance Care Planning Training Tool (ACPTT) to engage faith communities in ACP will equip FCNs with education, tools, and resources that will be sustainable for future implementation at this project site. The aim of this project was to increase FCN ACP knowledge and self-efficacy, and to increase ACP outreach and completion of AD in targeted faith communities by 25% in the fall of 2020.

## Theoretical Framework

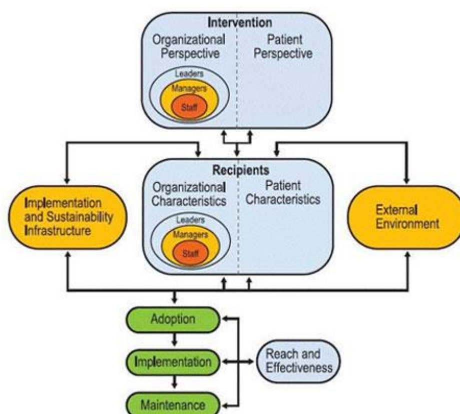
The project utilized the practical, robust implementation and sustainability model (PRISM) to guide the project implementation process (National Institutes of Health [NIH], n.d.)

and reference to the theoretical model of faith community nursing (Ziebarth, 2014) as a basis for the ACPTT development.

The PRISM theory (Figure 1) was a useful framework for the development of the project as the application of each of the domains provides a method for implementing and sustaining the ACPTT at the project site (Feldstein & Glasgow, 2008). Assessment of the FCN program included evaluation of readiness of the project site, appraisal of the strength of evidence for ACP in this environment, and consideration of barriers such as minimal resources for the primarily volunteer FCN group. Special attention was given to the cost, adaptability, and usability of the ACPTT. The ACPTT was developed with the patient perspective in mind so that it provides adaptability among faith community needs and yet remains client centered. An evaluation of community resources such as ACP educational modalities, and regulatory bodies such as the legislation related to ACP in the state of Indiana identified applicable state, national and international groups that shaped the tool. The process included the development of a dedicated project team, inclusion of training for the ACPTT, the development of metrics to evaluate performance data, and a robust communication system to assist with training and support (Feldstein & Glasgow, 2008). Evaluation of organizational health and culture and consideration of the front-line FCN as primarily volunteer was crucial in the development of the ACPTT. This eliminated or reduced the time burden for implementation. The patient characteristics considered for the project were perceptions of end-of-life, cultural and religious beliefs, and health literacy. Inclusion of these elements was important during the development of the ACPTT (Feldstein & Glasgow, 2008).

**Figure 1**

*PRISM Model*




## Theoretical Model of Faith Community Nursing in ACPTT Development

The theoretical model of faith community nursing supported the tool development as "a method of healthcare delivery that is centered in a relationship between the nurse and client… that occurs in an iterative motion over time when the client seeks or is targeted for wholistic health care" (Ziebarth, 2014, p. 1831). The essential attributes included faith integrating which is continuous and "health promoting, disease managing, coordinating, empowering and accessing

health care" that occurs with intentionality in a variety of settings including the "faith community, home, health institution and other community settings with fluidity as part of a community, national, or global health initiative" (Ziebarth, 2014, p. 1831). The ACPTT provided the FCN with a structure that empowered clients, assisted with the coordination of health care by promoting the discussion of ACP, and the completion of AD.

## Methods

### Setting

The setting for the project was a central Indiana FCN program at a local hospital system. The site employed one half time program facilitator and one program manager. The staff included 18 active and 5 inactive professional non-paid FCNs. This represented approximately 23 faith community groups in the region. The documentation system at the site was an informal process and included intermittent paper charting determined by individual FCN practice. Monthly reporting on the community benefits inventory for social accountability (CBISA) form was submitted to the facilitator to document FCN activity.

### Population of Interest

The direct population of interest included FCNs at the practice site. The indirect population of interest included members of the faith community which are also known as healthcare consumers. Healthcare consumers are defined as "the person, client, family, group, community or population who is the focus of attention and to whom the registered nurse is providing services as sanctioned by state regulatory bodies" (Health Ministries Association, 2017, p. 87). Inclusion criteria was voluntary participation for each FCN at the site. FCNs that are not affiliated with the practice site were excluded from data collection.

### Interventions

Interventions for this quality improvement project included the development of a robust, adaptable, and portable ACPTT (Figure 2) for use among the FCNs at the site, modification of the CBISA report that included ACP outreach and AD completion tracking, ACPTT delivery and education to the FCNs at the practice site, and pre- and post-intervention data collection and analysis.

The ACPTT provided foundational information regarding the importance of ACP and AD completion, implications for whole person care, and provided a variety of methods and resources for planning outreach activities within faith communities.

**Figure 2**

*Advance Care Planning Training Tool*

# Advance Care Planning Training Tool

## for the *Faith Community Nurse*

*Lorie Hacker MSN, NP-C, RN, CNE*

*The purpose of this tool is increase advance care planning outreach and advance directive completion in faith communities by equipping the faith community nurse with resources.*

### Prayer for the Faith Community Nurse

*Dear God,*
*Send your Holy Spirit into my heart today and hear my prayer for health and healing.*
*Use my hands as if they were yours to touch and help heal others.*
*Use my ears as if they were yours to listen to those in pain, loss, or, indecision.*
*Use my heart as if it was yours to love and accept those that are different from us, lonely, and afraid.*
*Use my arms as if they were yours to embrace those who need reassurance and security.*
*Use my soft voice as if it was yours to pray and provide comfort.*
*Use my gentle spirit as if it was yours to bring your Holy presence into those who need you close.*
*Give me your strength and ability to work through you and give of myself for others in need.*
*Amen.*

Table of Contents

Why is Advance Care Planning important? .......... 3
Evidence Based Practice .......... 5
FCN Model .......... 7
Basic Quick Start Guide .......... 8
Steady Start Guide .......... 9
Advanced Start Guide .......... 11
Resources .......... 13
Clergy and Leadership .......... 20
Cultural Considerations .......... 21
Palliative Care & Hospice .......... 22
Barriers to ACP .......... 23
COVID-19 Resources .......... 24
References .......... 27

The ACP outreach and AD completion data were not previously collected at the site, so a modification to the current CBISA template was completed. Pre-intervention survey data was collected from the voluntary FCN participants, prior to introduction and education of the ACPTT during the fall 2020 FCN meeting. Post-intervention survey data of AD knowledge and self-efficacy was collected immediately after the intervention and CBISA data and again 5 weeks after the intervention for analysis.

## Tools

The tools selected for data collection included the CBISA monthly report and the Advance Care Planning Engagement 34 Item Survey. The ACPTT was disseminated in the fall

2020 using demonstration and Socratic technique for educating the FCNs regarding the use of the tool.

### *CBISA Monthly Report*

The number of ACP outreach activities and AD completion was compared pre- and post-intervention based on the frequency of events from the CBISA report.

### *Advance Care Planning Engagement 34 Item Survey*

The FCN knowledge and self-efficacy of ACP and AD was measured using the ACP Engagement 34 Item Survey. This survey is culturally vetted and validated and measures the complex process of ACP including knowledge and self-efficacy of ACP and AD. This survey was developed and validated by *Prepare for Your Care* (The Regents of the University of California, 2013). "The survey is based on social, cognitive, and behavior change theories and focuses on four behavior change constructs (i.e., knowledge, contemplation, self-efficacy, and readiness within four ACP domains" (The Regents of the University of California, 2013, p. 3).

### *ACPTT Education*

The ACPTT was delivered to the FCN group with a high-level overview of the tool's purpose and use. This educational intervention provided a means for guided discovery of the ACPTT and gave the FCNs an opportunity to begin to develop a practical use and implementation plan.

## Study of Interventions and Data Collection

### *Data Collection*

The CBISA report data was aggregated pre- and post-intervention and the ACP engagement survey was distributed in person and via email to the participants immediately prior to the delivery of the ACPTT education.

### *Ethics and Human Subjects Protection*

Ethical treatment and protection of human subjects in research is an integral component of high-quality translational quality improvement (Robinson Bailey, n.d.). The quality improvement project design was reviewed by the Touro University Nevada project team and did not require review by the Institutional Review Board from the university or practice site.

The privacy of the voluntary participants in this quality improvement project was protected with the assignment of participant identification numbers that removed identifiable information from the data. Each participant was assigned an identification number that was stored electronically with a secure password separate from the data file.

# Results

The data collected included pre- and post-intervention responses from eight FCNs. Survey data included the 34 question ACP Engagement Survey that measured ACP knowledge and self-efficacy. The CBISA data, collected pre- and post-intervention, measured the frequency of ACP outreach and AD completion. The data was entered into a Microsoft Excel data file with variables named for each of the 34 survey questions delineated by pre- and post- intervention (ex: Q1pre and Q1post), and CBISA data (ex: ACPpre and ACPpost). The data set was uploaded to the IBM SPSS software (Pallant, 2013) and evaluated for errors. Procedures were followed for checking for categorical and continuous variables. No out-of-range variables were identified.

The paired t-test was conducted via SPSS software to compare the mean scores for the FCN group at two different time intervals (pre- and post-intervention) for the ACP engagement survey of knowledge and self-efficacy. A frequencies measure was used to calculate a percentage change for the ACP outreach and AD completion using Microsoft Excel.

## Results

### *ACP Engagement Survey: Knowledge and Self-Efficacy Results*

A paired-samples t-test was conducted to evaluate the impact of the ACPTT intervention on the FCN scores for knowledge (Q1-Q2) and self-efficacy (Q3-Q34). Improvements to ACP knowledge (Q1 and Q2) and self-efficacy (Q3, Q8, Q10-Q17, Q19, Q22- Q34) were demonstrated. There was no statistically significant difference in the Sig. (2-tailed) scores from Q1-Q34 pre- to- post- intervention overall (range of $p = .080$ to $p = 1$) (see Figure 3). The positive mean change for knowledge (Q1 and Q2) was -.063 and -0.38 respectively (see Figure 4). The average mean for the positive changes for the self-efficacy scores (Q3, Q8, Q10-Q17, Q19, Q22- Q34) ranged from -0.13 (Q8) to -1 (Q27).

**Figure 3**

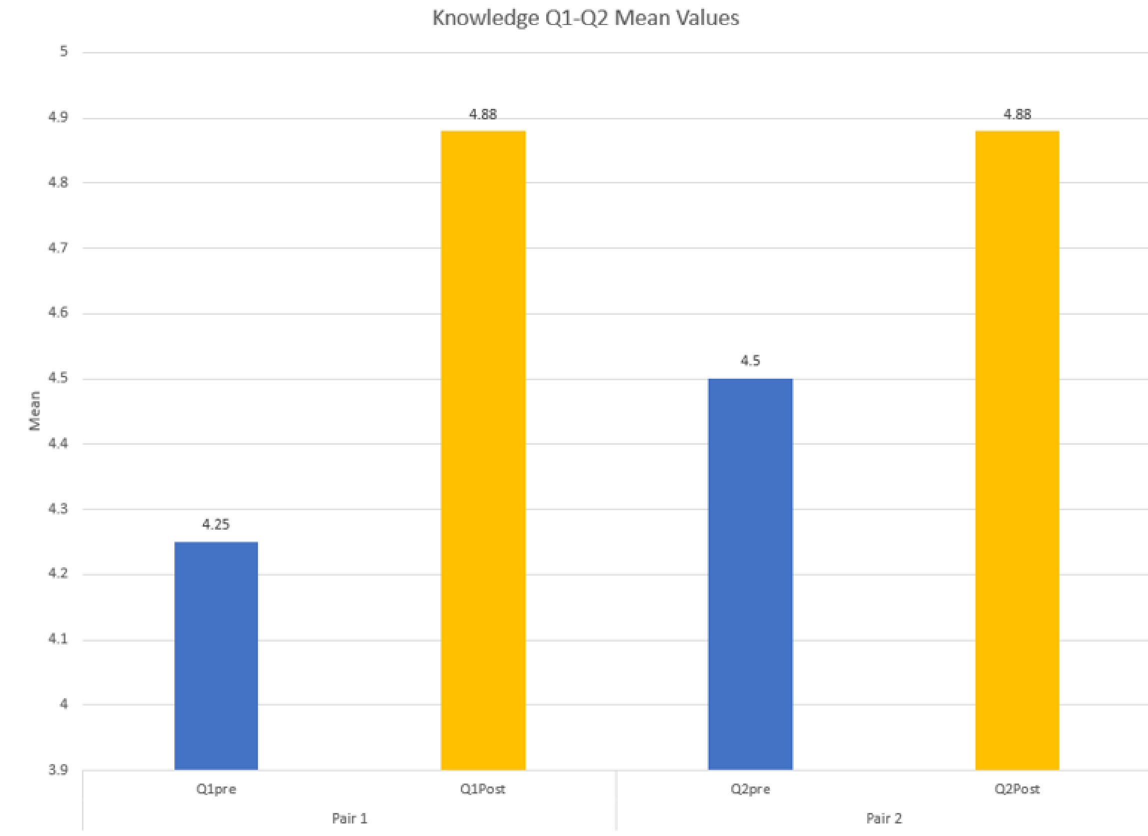
*Paired Samples Test: Knowledge and Self-Efficacy*

**Paired Samples Test**

| | | Paired Differences | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 95% Confidence Interval of the Difference | | | | |
| | | Mean | Std. Deviation | Std. Error Mean | Lower | Upper | t | df | Sig. (2-tailed) |
| Pair 1 | Q1pre - Q1Post | -.625 | .916 | .324 | -1.391 | .141 | -1.930 | 7 | .095 |
| Pair 2 | Q2pre - Q2Post | -.375 | .744 | .263 | -.997 | .247 | -1.426 | 7 | .197 |
| Pair 3 | Q3pre - Q3post | -.375 | .518 | .183 | -.808 | .058 | -2.049 | 7 | .080 |
| Pair 4 | Q4pre - Q4post | .000 | .535 | .189 | -.447 | .447 | .000 | 7 | 1.000 |
| Pair 5 | Q5pre - Q5post | .000 | .926 | .327 | -.774 | .774 | .000 | 7 | 1.000 |
| Pair 6 | Q6pre - Q6post | .125 | .641 | .227 | -.411 | .661 | .552 | 7 | .598 |
| Pair 7 | Q7pre - Q7post | .000 | 1.069 | .378 | -.894 | .894 | .000 | 7 | 1.000 |
| Pair 8 | Q8pre - Q8post | -.125 | 1.356 | .479 | -1.259 | 1.009 | -.261 | 7 | .802 |
| Pair 9 | Q9pre - Q9post | .125 | .641 | .227 | -.411 | .661 | .552 | 7 | .598 |
| Pair 10 | Q10pre - Q10post | -.375 | 1.506 | .532 | -1.634 | .884 | -.704 | 7 | .504 |
| Pair 11 | Q11pre - Q11post | -.250 | .707 | .250 | -.841 | .341 | -1.000 | 7 | .351 |
| Pair 12 | Q12pre - Q12post | -.500 | 1.309 | .463 | -1.595 | .595 | -1.080 | 7 | .316 |
| Pair 13 | Q13pre - Q13post | -.500 | 1.195 | .423 | -1.499 | .499 | -1.183 | 7 | .275 |
| Pair 14 | Q14pre - Q14post | -.500 | 1.690 | .598 | -1.913 | .913 | -.837 | 7 | .430 |
| Pair 15 | Q15pre - Q15post | -.667 | 1.366 | .558 | -2.100 | .767 | -1.195 | 5 | .286 |
| Pair 16 | Q16pre - Q16post | -.500 | 1.604 | .567 | -1.841 | .841 | -.882 | 7 | .407 |
| Pair 17 | Q17pre - Q17post | -.750 | 1.753 | .620 | -2.215 | .715 | -1.210 | 7 | .265 |
| Pair 18 | Q18pre - Q18post | .000 | 1.690 | .598 | -1.413 | 1.413 | .000 | 7 | 1.000 |
| Pair 19 | Q19pre - Q19post | -.125 | .991 | .350 | -.954 | .704 | -.357 | 7 | .732 |
| Pair 20 | Q20pre - Q20post | .000 | 1.069 | .378 | -.894 | .894 | .000 | 7 | 1.000 |
| Pair 21 | Q21pre - Q21post | .125 | 1.126 | .398 | -.816 | 1.066 | .314 | 7 | .763 |
| Pair 22 | Q22pre - Q22post | -.250 | 1.753 | .620 | -1.715 | 1.215 | -.403 | 7 | .699 |
| Pair 23 | Q23pre - Q23post | -.375 | 1.598 | .565 | -1.711 | .961 | -.664 | 7 | .528 |
| Pair 24 | Q24pre - Q24post | -.500 | 1.927 | .681 | -2.111 | 1.111 | -.734 | 7 | .487 |
| Pair 25 | Q25pre - Q25post | -.500 | 1.927 | .681 | -2.111 | 1.111 | -.734 | 7 | .487 |
| Pair 26 | Q26pre - Q26post | -.500 | 1.690 | .598 | -1.913 | .913 | -.837 | 7 | .430 |
| Pair 27 | Q27pre - Q27post | -1.000 | 1.633 | .617 | -2.510 | .510 | -1.620 | 6 | .156 |
| Pair 28 | Q28pre - Q28post | -.857 | 1.773 | .670 | -2.497 | .782 | -1.279 | 6 | .248 |
| Pair 29 | Q29pre - Q29post | -.714 | 1.496 | .565 | -2.098 | .669 | -1.263 | 6 | .253 |
| Pair 30 | Q30pre - Q30post | -.571 | 1.902 | .719 | -2.331 | 1.188 | -.795 | 6 | .457 |
| Pair 31 | Q31pre - Q31post | -.857 | 2.193 | .829 | -2.885 | 1.171 | -1.034 | 6 | .341 |
| Pair 32 | Q32pre - Q32post | -.429 | 1.902 | .719 | -2.188 | 1.331 | -.596 | 6 | .573 |
| Pair 33 | Q33pre - Q33post | -.125 | .835 | .295 | -.823 | .573 | -.424 | 7 | .685 |
| Pair 34 | Q34pre - Q34post | -.625 | 2.326 | .822 | -2.570 | 1.320 | -.760 | 7 | .472 |

**Figure 4**

*Knowledge Q1-Q2 Mean Values*



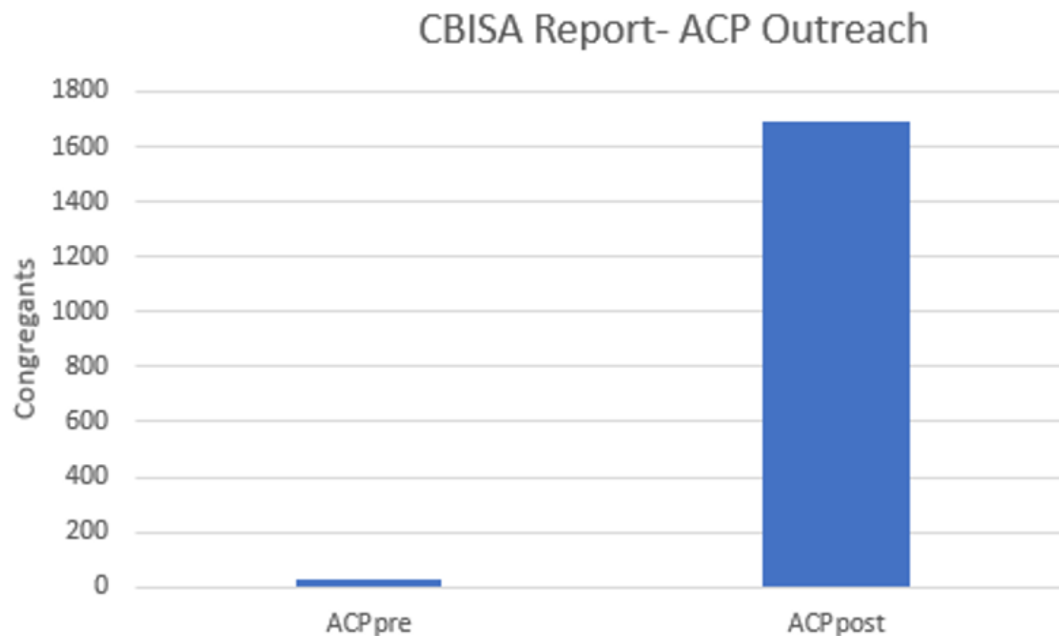

### *CBISA Data: ACP Outreach and AD Completion Results*

The CBISA reports prior to the ACPTT intervention revealed that only one out of the eighteen churches affiliated with the FCN program conducted ACP outreach activities. This resulted in the completion of one AD. The total number of congregants that received ACP outreach prior to the intervention was 30.

After the ACPTT intervention was completed three churches engaged in ACP activities and reached 1,690 individuals, resulting in the completion of one AD (see figure 5). There were no measurable differences in the completion of AD pre (1) and post intervention (1).

**Figure 5**

*CBISA ACP Outreach Number of Congregants reached: Pre- and Post- Intervention*




***Analysis***

The results revealed improvements to knowledge, self-efficacy, and ACP outreach after the ACPTT was distributed to the FCN group. Although, due to the small sample size (N=8) statistical significance was not demonstrated, the results demonstrate clinical significance (Sylvia & Terhaar, 2018).

The survey questions that measure knowledge (Q1 and Q2) revealed an average of 11% increase post intervention. The self-efficacy questions had an average of a 14% increase. Notably, a 41% increase was found for Q27, which described "how much they have thought about talking with their medical decision maker about how much flexibility they would give them". A 27% increase was demonstrated for Q28 which described "how confident they were that today they could talk with their doctor about how much flexibility they would give to the medical decision maker". There was a 26% increase for Q31 which referenced "how ready they were to talk to their doctor about how much flexibility they would want to give their decision maker".

Advance directive (AD) completion revealed no change from pre- to post-intervention. An explanation of this could be due to the continuous nature of ACP. This is a process that evolves over time that involves education, thoughtful reflection, and conversations with family and health care providers. The post intervention data was collected just 4 weeks after the intervention and may not have provided adequate time to demonstrate this continuous process resulting in the completion of AD forms. Additional ramifications include the timing of the intervention over the Thanksgiving holiday and during the COVID-19 pandemic. New

restrictions and barriers to typical FCN practice such as health outreach efforts in the group settings has been ongoing.

The impact of improvement of knowledge (11%) and self-efficacy (14%) were below the stated objectives of 25% for this project. The pre-intervention scoring on average ranged moderate (3) to high (5) which illustrates that the baseline knowledge and self-efficacy of this group was high leaving a small margin for measurable improvements in these areas.

Although these changes are not statistically significant (Sig. 2-tailed Q1pre-Q1post = 0.095, and Q2pre-Q2post = 0.197), the clinical significance is important to consider. Clinical significance is revealed and has implications for FCN practice. Measurable increases in ACP outreach activities among faith communities support the continuous efforts of ACP and helping communities achieve goal concordant care. Clinical significance reflects the impact on clinical practice (Ranganathan, Pramesh, & Buyse, 2015). Clear and measurable improvements to ACP outreach efforts were demonstrated among the group. The clinical significance of the impact of education and receipt of the ACPTT to the FCNs resulted in an increase in the number of churches conducting outreach activities. The increase in outreach efforts resulted in an increase in the number of congregants that received ACP education. The literature supports that engaging communities in the dissemination of education regarding ACP has proven to be an effective way to increase knowledge and awareness of ACP which leads to increase completion of AD and the move to goal concordant care (Litzelman, Cottingham, Griffin, Inui, & Ivy, 2016).

## Discussion

The purpose of this project was to evaluate the impact of providing an ACPTT to FCNs on outreach and education of ACP in faith communities compared to those with FCNs with no training guide. Evaluation of the project objectives included the development and dissemination of an ACPTT, demonstration of an 11% increase in knowledge and 14% increase in self-efficacy of ACP and AD, a 5.553% increase in ACP outreach activities, and no change in AD completion post-intervention compared to pre-intervention from October to December 2020. Demonstrative increases in knowledge and self-efficacy resulted in a significant increase in ACP outreach activities among faith communities.

The ACP process is reflective of ongoing conversations and communication regarding future medical care therefore results from this project may yet unfold in the future (McMahan, Tellez, & Sudore, 2020). The FCNs engagement within the community underscores the potential access to vulnerable and often underserved members of society. Through the practice of whole person care FCNs fostered continued conversations for members with ACP outreach activities to aide communities to move closer to goal concordant care. These professional unpaid nurses planted seeds to over 1,690 congregants over an approximately six-week period regarding the value of ACP as part of health promotion programs. This was accomplished despite the barriers of a pandemic and social distancing policies that prohibited many in-person gatherings common to FCN practice. The integration of faith and health created an ideal setting for the FCN to be an educator and trusted motivator of health in the community (Gotwals, 2018) during a time of an unprecedented viral pandemic. Equipping FCNs with tools to increase knowledge and self-efficacy provided a foundation for ACP outreach and eased facilitation of what otherwise might have been a difficult and complex endeavor.

Equipping the FCN with an evidence-based tool increased engagement in ACP outreach activities among faith communities. Outcomes that are important for communities and especially those suffering from chronic or serious illnesses include ACP and goal concordant care (Murali et al., 2020). Goal concordant care is a key priority by the National Academy of Medicine and a key quality measure by health care systems. Some have described goal concordant care as a type of high-quality communication and evaluate whether specific medical interventions were goal concordant (Halpern, 2019). Providing community-based nurses with tools to promote ACP outreach and education provides a foundation for clients to have conversations with others about future medical care. This project has demonstrated a clinically significant impact on faith communities as an integral part of achieving goal concordant care.

## Limitations

Limitations included the small sample size, implementation during a pandemic with face-to-face restrictions, a largely non-paid professional nursing workforce, and a relatively short time for the FCN to implement the project over the winter holiday season.

## Implications for Nursing and Health Care Systems

The implication of this quality improvement project on nursing reiterates the importance of faith integration and whole person care. The value of nursing in the facilitation of ACP has been highlighted during the COVID-19 pandemic of 2020. Overbaugh (2020) emphasized that improving nurse knowledge of ACP and subsequent reflection on their own values and preferences are important first steps. Education and training tools serve as vehicles to improve knowledge and self-efficacy. Additionally, nurses should consider the implications of ACP and AD at strategic moments during a patient healthcare experience such as during admission or when knowledge deficits regarding health care surrogacy or future medical care are identified. Equipping nurses at large to advocate for goal concordant care by asking questions such as what matters most can be facilitated from the trusted and therapeutic relationships inherent in the act of caregiving (Overbaugh, 2020). Nursing as a profession can be informed by this project to prioritize whole person care regarding the topic of mortality, death and dying and the anticipation of future medical care through ACP conversations.

Faith communities are intimately involved in life events such as birth, illness, and death. The FCN facilitate advancements in the ACP conversation by identifying congregants who have a new medical diagnosis or are experiencing life transitions and events. The FCN can gently walk beside these members and provide support, education, and guidance that is palliative in nature. This fosters a trusting relationship between a congregant and the FCN that occurs in part due to this intimacy and provides a safe space to support conversations about what matters most and future medical care. FCNs bridge the gap between intention and desire to have these discussions. These efforts culminate in movement toward goal concordant care. This trusting relationship is beyond the reach of traditional healthcare systems that may be devoid of the personal connection integral to these intimate conversations. Healthcare often operates in silos which further disconnects traditional healthcare providers from the concepts of whole person care. This profoundly influences the nature of support provided when discussing future medical care. Empowering nurses with accurate information to facilitate conversations, integral to high-quality care, can and should be revisited over time. These relationships further permit gradual

adjustments for congregants and their families to take control and process the notion of goal concordant care while reflecting on what matters most for them and their families (Walshe, 2020).

## References

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

Detering, K., & Silveira, M. J. (2018). Advance care planning and advance directives. Retrieved from https://www.uptodate.com/contents/advance-care-planning-and-advance-directives?search=advance%20care%20planning&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

Feldstein, A. C., & Glasgow, R. E. (2008, April). A practical, robust implementation and sustainability model (PRISM) for integrating research findings into practice. *The Joint Commission Journal on Quality and Patient Safety*, *34*(4), 228-243.

Gotwals, B. (2018). Self-efficacy and nutrition education: A study of the effect of an intervention with faith community nurses. *Journal of Religious Health*, *57*, 333-348. http://dx.doi.org/https://doi.org/10.1007/s10943-017-0465-2

Halpern, S. D. (2019, October 24). Goal-concordant care: Searching for the Holy Grail. *The New England Journal of Medicine*, *381*(17), 1603-1606. http://dx.doi.org/DOI:10.1056/NEJMp1908153

Health Ministries Association (2017). *Faith community nursing: Scope and standards of practice* (3rd ed.). Silver Spring, MD: American Nurses Association.

Kotecki, C. N. (2002). Developing a health promotion program for faith-based communities. *Holistic Nursing Practice*, *16*(3), 61-69.

Lind, S., & Chase, S. (2014). *How to turn a healthcare crisis into a health care opportunity* [A Special Report on Faith Community Nursing]. Retrieved from Advent Health: https://www.adventhealth.com/adventhealth-press/how-turn-a-healthcare-crisis-a-health-care-opportunity

Litzelman, D. K., Cottingham, A. H., Griffin, W., Inui, T. S., & Ivy, S. S. (2016, December). Enhancing the prospects for palliative care at the end of life: A statewide educational demonstration project to improve advance care planning. *Palliative & Supportive Care*, *14*(6), 641-651. http://dx.doi.org/DOI:10.1017/S1478951516000353

Longman. (2020). faith community. In *Faith Community*. Retrieved from https://www.ldoceonline.com/dictionary/faith-community

McMahan, R., Tellez, I., & Sudore, R. L. (2020). Deconstructing the complexities of advance care planning outcomes: What do we know and where do we go? A scoping review. *The American Geriatrics Society*, 1-11. http://dx.doi.org/https://doi.org/10.1111/jgs.16801

Murali, K. P., Merriman, J. D., Yu, G., Vorderstrasse, A., Kelley, A., & Brody, A. A. (2020, June 8). An adapted conceptual model integrating palliative care in serious illness and multiple chronic conditions. *American Journal of Hospice and Palliative Medicine*, *37*(12). http://dx.doi.org/https://doi.org/10.1177/1049909120928353

National Committee for Quality Assurance. (2018). Care for older adults. Retrieved 03/22/2020, from https://www.ncqa.org/hedis/measures/care-for-older-adults/

National Institutes of Health. (n.d.). Toolkit part 1: Implementation science methodologies and frameworks. Retrieved 05/07/2020, from https://www.fic.nih.gov/About/center-global-health-studies/neuroscience-implementation-toolkit/Pages/methodologies-frameworks.aspx

Overbaugh, K. J. (2020). Advance care planning: An update for the medical-surgical nurse in the age of COVID-19. *MEDSURG Nursing*, *29*(5), 299-307. Retrieved from

https://web.b.ebscohost.com/ehost/detail/detail?vid=7&sid=46e18dbe-8d62-4d72-b807-6eacc3fef7df%40pdc-v-sessmgr01&bdata=JkF1dGhUeXBlPWlwLHNzbyZzaXRlPWVob3N0LWxpdmU%3d#db=rzh&AN=146412754

Pallant, J. (2013). *SPSS survival manual* (5th ed.). Berkshire, England: Open University Press.

Ranganathan, P., Pramesh, C.S., & Buyse, M. (2015, July-Sep). Common pitfalls in statistical analysis: Clinical versus statistical significance. Perspectives in Clinical Research, 6(3), 169-170. http://dx.doi.org/10.4103/2229-3485.159943

Robinson Bailey, L. (n.d.). History and ethical principles-SBE. Retrieved September 17, 2020, from https://www.citiprogram.org/members/index.cfm?pageID=665&ce=1#view

Sabatino, C. P. (2010). The evolution of health care advance planning law and policy. *Milkbank Quarterly*, *88*(2), 211-239. http://dx.doi.org/doi:10.1111/j.1468-0009.2010.00596.x.

Schroepfer, E. (2016, January-February). A renewed look at faith community nursing. *MedSurg Nursing*, *25*(1), 62-66. Retrieved from http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=24&sid=a9a02331-e511-463f-9e75-d614a64f928c%40sessionmgr4007

Splendore, E., & Grant, C. (2017, September). A nurse practitioner-led community workshop: Increasing adult participation in advance care planning. *Journal of the American Association of Nurse Practitioners*, *29*(9), 535-542. http://dx.doi.org/https://doi.org/10.1002/2327-6924.12467

Sun, A., Cheng, J., Bui, Q., Tsoh, J., Gildengoren, G., Lai, K., ... Chan, J. (2017, April). Efficacy of a church-based, culturally tailored program to promote completion of advance directives among Asian Americans. *Journal of Immigrant & Minority Health*, *19*(2), 381-391. http://dx.doi.org/ https://doi.org/10.1007/s10903-016-0365-7

Sylvia, M. L., & Terhaar, M. F. (2018). *Clinical analytics and data management for the DNP* (2nd ed.). New York, New York: Springer Publishing Company.

The Conversation Project. (2020). Consider the facts. Retrieved from https://theconversationproject.org/

The Regents of the University of California (2013). Advance Care Planning Engagement Survey [measurement instrument]. Unpublished instrument. Retrieved from https://prepareforyourcare.org/content/default/common/documents/Advance-Care-Planning-Engagement-Survey.pdf

Walshe, C. (2020). Aims, actions and advance care planning by district nurses providing palliative care: An ethnographic observational study. *British Journal of Community Nursing*, *25*(6), 276-286. http://dx.doi.org/https://doi.org/10.12968/bjcn.2020.25.6.276

Ziebarth, D. (2014). Evolutionary conceptual analysis: Faith community nursing. *Journal of Religion & Health*, *53*(6), 1817-1835. http://dx.doi.org/https://doi.org/10.1007/s10943-014-9918-z