CONVERSATIONS ABOUT DYING: UTILIZING THE CONVERSATION PROJECT TOOLKIT IN AFRICAN-AMERICAN CHURCHES TO FACILITATE END OF LIFE PLANNING

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ABSTRACT

Nancy Kebaso: Conversations About Dying: Utilizing the Conversation Project Toolkit in African American Churches to Facilitate End of Life Care Planning. (Under the direction of Beth Perry Black)

Background: Advance directives (AD) allow patients to make cooperative health-care decisions with their health-care providers and family members and give patients a sense of control over critical health-care and life-sustaining choices. The primary intent of the AD is to improve end-of-life (EOL) by rendering care consistent with patient’s wishes, thus reducing anxiety and stress associated with EOL care. Although the completion of AD remains limited in the general population, African Americans (AAs) have the lowest rates of AD completion.

Purpose: The purpose of this project was to apply The Conversation Project (TCP) Toolkit in discussing with AAs about AD and encouraging EOL conversations among AAs in community faith-based settings.

Methods: Using a descriptive, cross-sectional design using a convenience sample of African Americans in three different African-American churches in North Carolina, I tested the effectiveness of TCP toolkit in changing attitudes about advance directives and the TCP influence on initiation of EOL discussions. I conducted three intervention groups between December 18th 2017 and January 19th 2018, and used the Advance Directive Attitude Survey (ADAS) in pre-and post-intervention group discussions to assess changes in attitude towards AD. I also administered a 2–question survey pre-and post-intervention group discussion to assess the likelihood that participants will hold an end of life discussion with their loved ones or institute ADs.
**Results:** Mean ADAS score increased from 2.678 pre-intervention to 3.044 post intervention.

**Conclusion:** The TCP toolkit led to a positive change in attitude towards AD when used as an education tool for EOL discussion choices among AAs. The TCP toolkit can be used to inform African Americans about EOL choices and encourage AAs to initiate EOL discussions with other family members.
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<td>AD</td>
<td>Advance Directives</td>
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<td>CMS</td>
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<td>Cardiopulmonary Resuscitation</td>
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<td>Doctorate in Nurse Practice</td>
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<td>IOM</td>
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<td>MVC</td>
<td>Motor Vehicle Collision</td>
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<td>NAM</td>
<td>National Academy of Medicine</td>
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<td>PSDA</td>
<td>Patient Self-Determination Act</td>
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<td>QOL</td>
<td>Quality of Life</td>
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CHAPTER 1: INTRODUCTION

Background and Significance

An advance directive (AD) is a product of a process by which a person’s preference and goals for future medical care are discussed with family members or healthcare providers and recorded. These recorded choices serve as guidance in the event a person becomes seriously ill and/or incapable of making health-related decisions. The process may result in the completion of an AD document, identification of a healthcare proxy/health care power of attorney (HCPOA) or both (American Geriatric Society, 2015). The primary intent of the AD is to improve end-of-life (EOL) by rendering care consistent with patient’s wishes, thus reducing anxiety and stress associated with EOL care (West & Hollis, 2012; Winter & Parks, 2011).

AD allow patients to make cooperative health-care decisions with their health-care providers and family members and gives patients a sense of control over critical health-care and life-sustaining choices. Cardiopulmonary resuscitation (CPR), mechanical ventilation and the use of artificial hydration and nutrition are examples of life-sustaining interventions. The presence of AD may reduce futile medical treatment and excess burden on patients and family members by preventing unnecessary prolongation of the dying process (Ackermann, 2016). In a situation where patients have not specified in advance their preferences for treatment, they are likely to be over-treated rather than being under-treated. Disputes and confusion within the family may arise. Such a case may cause unnecessary discomfort, stress, and financial strain (Carr, 2011; McAfee, Jordan, Sheu, Dake, & Miller, 2017).

In 1983, in the state of Missouri, a twenty-five-year-old woman, Nancy Cruzan survived a motor vehicle collision (MVC) that rendered her in a persistent vegetative state. Oblivious to her environment except for involuntary spastic movements, she was unable to function
independently. Ms. Cruzan’s life was sustained through a gastrostomy feeding tube because she was unable to swallow. Ms. Cruzan had no written advance directives; however, before the MVC, she had verbalized casually to her friends her desire not to continue to live if she couldn’t function at least “halfway normally” (Olick, 2012, p.233). Her parents waged a legal battle against the medical team in Missouri spanning eight years in an effort to have the medical team remove the feeding tube and stop nourishment. The parents were determined to fulfill Ms. Cruzan’s wishes and allow her to die naturally. Finally, in 1990, the United States Supreme Court ruled in favor of the parents allowing the removal of the feeding tube. Nancy Cruzan died 11 days after her feeding tube was removed (Olick, 2012).

This Cruzan landmark case of “right to die” led to the enactment of the Patient Self-Determination Act (PSDA) of 1991. The act was developed to protect patient’s fundamental rights to treatment options. It gives patients legal rights to determine how vigorously they would want to be treated in life or death situations (Black, 2016). Although providers are not required to implement ADs, the PSDA requires health care institutions and providers receiving federal funding to inquire if patients have an AD in place. If not, the PSDA requires the facilities or providers to provide patients with information regarding AD (American Geriatrics Society, 2015). As of January 2016, the Centers for Medicare and Medicaid Services (CMS) made the AD discussion between patients and providers a billable service. Providers spending face-to-face time counseling and discussing AD with their patients can claim and get reimbursement (CMS, 2017). Despite the passage of the PSDA, the completion of ADs remains limited in general.
Problem Statement

In a 2010 and 2011 nationally representative survey, approximately 31% of Whites had AD compared to 17% of African Americans (Rao, Anderson, Lin & Laux, 2014). In contrast to Whites, AAs have lower rates of AD completion (Belisomo, 2017; Portanova et al., 2017; Rao, Anderson, Lin & Laux, 2014). Portanova and colleagues (2017) completed a nationally representative study of Health and Retirement Study (HRS) data collected from records of 7,117 Whites, Blacks and Hispanics who died between 2000 to 2012. The study was to investigate how AD completion and preferences for aggressive care changed over time within ethnic groups. In this study, nearly 51.7 percent of Whites compared to 15 percent of Blacks had completed AD. This study advocated for further investigation on the effect of cultural differences on AD completion among ethnic groups (Portanova et al., 2017).

In the absence of AD, AAs choose more aggressive, life-sustaining treatment even if that treatment seems likely to be burdensome with little chances of success (Belisomo, 2017; Melhado & Bushy, 2011). There is need to undertake more research to scrutinize variations within racial clusters and point out factors connected to the disparities in EOL care between AAs and whites; specifically, more attention is needed to identify what determinants function as facilitators or barriers to AD completion, particularly among diverse race and marginalized populations (Koss & Baker, 2016).

Improving the quality of life (QOL) is a primary public concern (National Academy of Medicine, 2015). Clinical interactions at the end of life focus almost exclusively on the possibility of prolonging life, thus failing to account for other patient and family goals such as human interaction, autonomy, dignity, and spirituality (Gawande, 2014). According to a 2014 consensus report from the NAM, in a growing culturally diverse population, the nation should
implement a person-centered, family-oriented approach in discussing EOL preferences (NAM, 2014). The NAM committee also pointed out the need for community education and discussions about EOL care plans at family, public and organizational levels.

Attitudes, knowledge, and use of AD are far from a universal consensus. A one-size–fits-all approach misses the cultural relevance unique to AAs. When the general population efforts for institution of AD have failed, the only other considerable means is an approach specifically targeting the population and their specific needs (Belisomo, 2017). AA’s shared experiences, beliefs and values elicit specific barriers influencing their motivation to complete AD; therefore, a dire need exists for the development of culturally competent models of community engagement that will empower AAs on issues such as AD and EOL planning (Belisomo, 2017; Carr, 2011; Portanova et al., 2017).

**Purpose Statement**

AD’s are often completed in the acute settings while the patient is ill or has just learned about a serious illness. The patient may be experiencing a barrage of emotions and most likely lacking adequate knowledge about the new diagnosis. This environment does not provide an excellent opportunity to discuss AD (Tschirhart, Du & Kelley, 2014). In 2014, NAM recommended for healthcare systems to actively engage the public in high-quality and culturally relevant discussions on EOL care (NAM, 2014). AD discussions should shift from a health system’s hospital rooms and physician offices to neighborhoods, churches, and other locales central to AAs’ family life (Belisomo, 2017). In the health realm, community, faith-based collaborations have proven to be effective, culturally appropriate and spiritually sensitive methods of reaching out to AAs (Robinson, 2016).
Interventions for the end of life should reflect the culture and spirituality of the intended population (Fang, Sixsmith & Sinclair, 2016). Many AAs value their beliefs and support the fact that their AD decisions should be respected and be consistent with their teachings and faith (Hendricks et al., 2016). Introducing AD decisions through faith-based organizations provides an opportunity to nurture trust and relationship while introducing or teaching appropriate topic or knowledge to a marginal population (West & Hollis, 2012). Churches operate as a trusted source of offering information, an institution of education, and source of spiritual guidance. Church and community programs provide the opportunity to provide more comfortable environments for participants to discuss and explore cultural beliefs about illness and death, while misinformation is reframed (Belisomo, 2017).

A practical approach to end of life discussions should happen in a non-pressed deliberative environment. Therefore, the purpose of this project is to introduce The Conversation Project (TCP) Toolkit to African Americans in a community faith-based setting. Primary objective is to assess TCP effectiveness in changing AD attitudes and influence on initiation of EOL discussions among AAs in this church setting. The goal is to enhance the end of life discussion as a precursor to AD institution among AA population.
CHAPTER 2: LITERATURE REVIEW

In this literature review I examine the complexity of barriers to AD among AAs. This review involved a comprehensive search of peer-reviewed studies from 2011 to 2017 from CINAHL, PUBMED, MEDLINE, Psych Info and Google Scholar databases. I identified research articles and systematic reviews of advanced directives barriers and facilitators in AAs using various combinations of the keywords: end of life care, care of the older adults, advanced directive, EOL decision-making, advanced care planning, power of attorney, health care proxy and African Americans/Blacks. The inclusion criteria were publications from January 2011 through 2017 to obtain a current perception on the topic. Articles were also limited to those that only focused on adult population (above 18 years of age), were published in English and addressed end of life issues in AAs.

Overall, for all ethnic groups, the rate of AD completion or participation has increased over the past decade, but noteworthy race discrepancies persist (Huang et al., 2016; Koss & Baker, 2016). The completion of AD among racial and ethnic minorities in the United States has been consistently noted to be low (Portanova et al., 2017). Despite dedicated efforts to adopt AD documentation and communication, AAs were less likely to designate a healthcare proxy, complete a living will, or deliberate on healthcare preferences before EOL than whites (Huang et al., 2016; Koss & Baker, 2016; Tschirhart, Du & Kelley, 2014). The fundamental concepts identified in this review as barriers or facilitators to AD completion in AAs include health care mistrust and racism; religion, and spirituality; family and community; lack of exposure and understanding about AD.
Health Care Mistrust and Racism

In a random digit dialing survey study, Armstrong and colleagues (2013) compared racial differences in healthcare system distrust (HCSD) among AAs and whites. The study found that AAs, compared to Whites, had a higher overall suspicion of the medical system compared to Whites. Additionally, healthcare access discrepancies between Whites and AAs still persist and these discrepancies have long been documented as one of the barriers to completion of AD in AA (Burgio et al., 2016).

The NAM has described EOL experience as a public health crisis (NAM, 2004). NAM’s 2004 initial report on “Unequal Treatment” concluded that people from minority races and ethnicity tend to get lower healthcare quality than the whites. Minorities experience a range of barriers to accessing care. In a subsequent follow-up report, Dying in America, in 2014, NAM stipulated that the disparity still exists years later. According to NAM, to eliminate these complex inequalities, a comprehensive, multi-level strategy involving participation across the healthcare system is required (NAM, 2014). After living without adequate access to health care services for a long time and with limited treatment options, AAs have strikingly higher levels of aggressiveness when it comes to the issue of life-prolonging care at the EOL (Noah, 2012).

Scholars in the health care industry have discussed the lack of trust of AAs in the predominately White medical system. AAs do not trust healthcare providers in general because of perceived favoritism, the legacy of racial discrimination in medicine and social distance between physicians and their AA patients (Noah, 2012). Lack of trust in the medical field can be traced back to the antebellum South, a time during which enslaved AAs were subjected to
dissection and medical experiments (Kenny, 2013). Given their positions as voiceless slaves and
easy targets for abuse and exploitation, southern White medical researchers and educators used
bodies of deceased African Americans for dissection demonstrations in classrooms, experimental
facilities and even at bedside. Living AAs were also subjected to numerous surgical and medical
procedures against their will and without anesthesia (Kenny, 2013). Years later, these
experiences discourage some AAs from seeking medical attention in advance, even at times
when care is accessible and inexpensive (Lew, Arbauh, Banach, & Melkus, 2015; Noah, 2012)

The mistrust in the medical community was further amplified by AAs medical
experiences with the U.S. government and healthcare system. Perhaps the most widely known
biomedical research injustice on AAs is the Tuskegee study of syphilis. The Public Health
Service in Macon County, Alabama conducted the study on over 400 exclusively AA males
(Noah, 2012). Researchers withheld the standard effective treatment for syphilis with penicillin
to study the disease progression (Noah, 2012). The Tuskegee study has been strongly linked to
the damaged trust of AAs toward public health efforts in the United States. The study led most
AAs to equate completion of an AD document to a death warrant instead of the right to choose
the care they need and desire when they can longer make such decisions themselves (Noah,
2012). Because of distrust, some AAs perceive the healthcare system to be controlling and thus
worry that their wishes (in the form of AD) might be disregarded (Melhado & Bushy, 2011).

Race and ethnicity are significant determinants of the health status of the American
cultural values, beliefs, and experiences in society, eventually increasing their comfort with each
other (Periyakoil, Vyjeyanthi, Neri & Kraemer, 2015). Scholars have suggested that the concept
of cultural competency should be emphasized and expanded to the community, organizational level and clinical levels (Carr, 2011; Huang et al., 2016).

Questions of trust between the provider and the patient may result in discord and consequently lead to non-compliance with treatment suggestions and reluctance to complete an AD. Some providers lack the cultural sensitivity and capability, two critical fundamental elements when discussing AD with AA (Periyakoil, Vyjeyanthi, Neri & Kraemer, 2015). Most non-African American providers lack awareness of cultural, spiritual and family-based decision-making process on EOL issues among AAs (Fang, Sixsmith, Sinclair & Horst, 2016). Based on these cultural differences and knowledge inadequacies among numerous health care providers, barriers to participation in AD completion are anticipated to continue being a challenge (Koss & Baker, 2016). Providers should acknowledge their cultural challenges by acquiring new knowledge on successful, research-proven, culturally sensitive approaches to deliver effective EOL care for ethnocultural groups (Fang, Sixsmith, Sinclair & Horst, 2016). Iannacone, (2017) recommended that health care providers learn how to communicate with AAs with the aim of lessening the cultural differences.

Religion and Spirituality

A 2009 Pew Research Foundation survey observed that AAs are more religious on a variety of measures than the U.S. population as a whole. In this survey, AAs stood out as the most religiously committed racial or ethnic group in United States (Sahgal & Smith, 2009). The role of religion and spirituality dates back to slavery. The growth of a society of African slaves led to an amalgamation of African beliefs (Gamble, 1997). Eventually, slaves were recruited to Christianity by force or through conversion, which led to exposure and adaptation to Christian
practices such as the fight for freedom from slavery and salvation (Gamble, 1997). Slaves were allowed to practice Christianity but prohibited from White American churches. Left with no choice, slaves established their churches and places of worship. Though enslaved, AAs refashioned and transcended their negative experiences through spirituality, which instilled hope and emotional fortitude in their relationships (Robinson, 2016).

In their suffering, AAs developed faith and belief in God’s ability to heal. Religion and spirituality serve as a source of expression, meaning and refuge in the advent of racial and economic disadvantage faced by AAs (Sanders, Robinson & Block, 2016). This increased emphasis on religion and spirituality led to the acceptance of aggressive medical care being pursued to have time for God to show healing. To AAs, long life is a gift from God and preserved at all costs (Schmidt, 2015). A robust religious support and believe in the miracle of healing develops during sickness and is associated with more aggressive EOL treatment (Sanders, Robinson & Block, 2016; Schmidt, 2015).

Buck and Meghani (2011) conducted a study to describe and contrast expressions and values about the use of spirituality for pain in AAs and White oncology patients. They concluded that AAs were prone to verbalize the necessity for prayer and embrace the idea of faith in God when experiencing cancer pain than whites. This idea defined God as a healer, and in complete control of their lives, while white participants equated prayer with equal consideration as other therapies (Buck & Meghani, 2011). For many AAs, illness is considered a test of faith, thus requiring that no interventions or barriers exist against aggressive treatment or discontinuation of life support (Brinkman-Stoppelenburg, Rietjens & Van der Heide, 2014). The time leading to death may involve a significant struggle, pain, and suffering that some AAs endure as a necessary component that cannot be avoided but as part of the spiritual commitment (Robinson
& Block, 2016). These beliefs have often proved to be a barrier to engagement in AD completion because they discourage deliberations or discussions on decisions regarding sickness and dying.

**Family and Community**

Historically, communities and families have had a fundamental role in AAs lives likely attributable to slavery and consequent structural injustices, which contributed to the establishment of extended relatives’ networks. Families and communities act to protect AAs from untrustworthy healthcare providers (Parks et al., 2011). A near-universal trust in the family may exist over a range of responsibilities (Burgio et al., 2016). Moral caregiving obligations are based on established networks among family members. When the family is responsible for decision making on health care issues, including decisions regarding AD, these family networks may serve as a barrier to AD institution.

Older family members pass down social and cultural norms such as religion and mannerisms to younger family members. For instance, older AAs believe that their children will decide on matters concerning their EOL care, therefore, they have no reason to complete AD (Robinson & Block, 2016). In a focus group study done among AA from Baptist churches in NC, participants expected their immediate family members to anticipate their medical decisions and EOL preferences despite lack of a prior discussion or a written advance directive (West & Hollis, 2012). This kind of relationship exists at all economic levels among the AA community, providing the strength and support for both family and community level (Burgio et al., 2016). Therefore, families and communities have critical influence on participation by AA in AD completion, acting both as a source of motivation and as a significant barrier to AD completion.
Lack of Exposure to AD

In a systematic review examining factors affecting perceptions of advanced care planning among AAs with varying degrees of exposure to end of life issues, most participants without AD stated they lacked understanding of what advance directive(s) entailed (Sanders, Robinson & Block, 2016). Lack of awareness or knowledge and low accessibility to AD documents are the most common barriers to ACP engagement among ethnic minorities (Robinson, 2016). In another study examining multidisciplinary perspectives of AAs on end-of-life care in the community, most AAs felt that completion of an AD would mean that health-care providers would no longer care for them or that AD would hasten their death (Rhodes et al., 2017). In a similar study done by Huang et al., 2016 to assess unique barriers to AD engagement among AAs in the U.S. Deep South states, participants cited lack of patient education resources in the local community as one of the main reasons for low AD engagement.
CHAPTER 3: THEORETICAL FRAMEWORK

Background of Purnell Model

The Purnell model for cultural competence is a framework providing an approach to cultural competence among diverse cultures related to sickness, health and wellness promotion. The framework reflects on the significance of recognizing and understanding the patient’s culture in order to improve quality of care provided (Purnell, 2012). The model is an accumulation of both primary and secondary characteristics of culture. Fundamental features consist of attributes that shape an individual’s worldview and cannot be changed (Rich, 2013). Examples of primary traits include nationality, age, and race. Secondary characteristics influence the extent to which people identify with their cultural group of origin. Secondary features include educational status, socioeconomic status, occupation, military experience and political beliefs. Others include urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation and gender issues (Purnell, 2012).

I obtained permission to use the model and figure from Dr. Purnell (appendix 1). The model (Figure 1) is depicted in a series of circles. The outer rim represents the global society, and the second rim represents the community. The third rim represents family and the fourth rim represents the individual. The center of the circle is dark representing the unknown phenomenon. Emanating from the dark center are twelve pie shaped wedges depicting cultural domains and their concepts (Purnell, 2012). The 12 domains are: Overview and Heritage, Communication, Work Force Issues, Family Roles and Organizations, Bicultural Ecology, High-Risk Behaviors, Nutrition, Pregnancy & Childbearing Practices, Death Rituals, Spirituality, Healthcare Practices and Healthcare Practitioners.
Unconsciously Incompetent - Consciously incompetent - Consciously competent - Unconsciously competent

Variant cultural characteristics: age, generation, nationality, race, color, gender, religion, educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status)

Unconsciously incompetent: not being aware that one is lacking knowledge about another culture
Consciously incompetent: being aware that one is lacking knowledge about another culture
Consciously competent: learning about the client’s culture, verifying generalizations about the client’s culture, and providing culturally specific interventions
Unconsciously competent: automatically providing culturally congruent care to clients of diverse cultures
Application of Purnell Model to the Project

Culture has a significant impact on people’s lives. Culture influences a person's interaction with the healthcare system as they seek for treatment and at end-of-life. An individual's beliefs, rituals, and external expressions can affect care (Ackermann, 2016). Therefore, to cater for needs of a diverse society in healthcare, culturally sensitive care is paramount for the improvement of patient outcomes (Long, 2011). The Purnell model for cultural competence is a framework that provides an approach that fosters cultural competence among diverse cultures during times of sickness, health and wellness promotion. The framework reflects on the significance of recognizing and understanding the patient’s culture in order to improve quality of care provided (Purnell, 2012).

The Purnell model has been praised for clarity, practicability and general precision but in its entirety, it is complex. Performing a cultural assessment using all the 12 domains in any given setting is almost impossible (Rich, 2013). The organizing framework for this project is based on five most applicable domains of the Purnell model: 1) Overview/Heritage; 2) Communication; 3) Family Roles and Organization; 4) Spirituality; and 5) Healthcare Practices.

Overview/Heritage

This domain is comprised of concepts relating to a person’s country of origin, the current residence of an individual, economic health and politics. It also includes the reason for relocation, academic status of a person, and profession. Learning about a culture entails being familiar with persons’ heritage as well as understanding prejudice, discrimination and oppression issues that influence systems and beliefs used by people in their everyday life (Purnell, 2012). For this DNP project, understanding the influence of geographic location, education and racial discrimination on healthcare decisions and AD institution in AAs is imperative. Overview/
heritage is essential in delivering a culturally congruent care by considering the differences in age, gender, religion and socio-economic status. Knowing an individual or group's baseline heritage is an excellent starting point in providing appropriate care.

**Communication**

Communication is the sharing of feelings and thoughts with others and is the means by which culture is conveyed and shared. The concept of communication in Purnell’s model includes the dominant language, tone, dialect, volume and intonations, and also deals with the readiness to share opinion and feelings (Rich, 2013). Health care practitioners should be aware of the patients' practices regarding verbal and non-verbal communication (Stepanikova et al., 2012). Most AAs are known to have a dynamic and expressive speech and therefore healthcare providers should not interpret this as anger (Purnell, 2012). Purnell further states that AAs place a strong value on oral tradition as a way of conveying important stories and morals on how to live life. It is paramount to identify and utilize the preferred method of communication in healthcare. This will lead to better rapport, patient–physician trust, satisfaction, health compliance, symptom management, long-term improvements in health, and AD discussions.

**Family Roles and Organization**

This domain focuses mainly on family structure, priorities and the behavioral norms of its members. AA families share a wide range of values, goals and priorities (Purnell, 2012). Respect is bestowed upon elders in AA community and awareness about family decision making and whom to approach when making healthcare decisions is important (Purnell, 2012). It is also important to recognize the role of extended family members. For example, most AAs have a collectivist culture, extended family may include biological and non-biological relatives.
including church family (Stepanikova et al., 2012). Healthcare decisions may be deferred or delayed until the entire family has been consulted (Purnell, 2012).

**Spirituality**

This consists of religious practices, use of prayer, formal religious beliefs related to faith and affiliation (Rich, 2013). Spirituality helps to provide equilibrium between the mind body, and spirit. Spiritual wellness is important in helping individuals embrace free choices, have a high self-esteem and feel satisfied with life (Purnell, 2012). By assessing a person’s spiritual life, the health providers can fulfill cultural competence that is unique to every individual (Purnell, 2012). Of all major racial and ethnic groups, AAs are most likely to report a formal religious affiliation: 80% consider religion to be very important, nearly 60% are affiliated with historically Black churches (Wingood et al., 2013). As an institution, the AA church is among the most visible and credible agency in the AA community.

**Healthcare Practices**

This domain focuses on promotion of wellness, health maintenance, health restoration, and prevention of injuries, illness and disease prevention (Purnell, 2012). Among AAs, there is a belief that the individual, family and community at large have great influence on health while others believe in having no control over their health and illness (Stepanikova at al., 2012). A history of racial bias has made older AAs suspicious and cautious of health care providers with whom they are not familiar (Stepanikova at al., 2012). AAs will perceive these unfamiliar providers as outsiders and may therefore resent sharing their problems or return for follow up care (Purnell, 2012). In order to implement effective healthcare interventions or practices among AAs, building a trusting relationship is key, which is particularly important in AD discussions.
CHAPTER 4: METHODOLOGY

Design

I completed a descriptive, cross-sectional study using a convenience sample from AAs from three different predominantly AA churches in North Carolina. The intervention consisted of educating participants on importance of AD and EOL discussions with loved ones or family members using TCP toolkit. I administered a pre- and post-intervention Advance Directives Attitude Survey (ADAS) and 2 questionnaire surveys to assess for changes in attitudes towards AD and EOL discussion.

Subjects

The study’s sample consisted of: 1) twenty AA’s, 18 years and older; 2) attendees of any of the three AA churches; and 3) able to read and write. I conducted an intervention group in each of the three churches and had 6-8 participants in each group ($N=20$). Participation was voluntary. I did not collect any individual identifiers.

Setting

The project took place in three predominantly AA churches in three cities in North Carolina; Clinton, Raleigh and Franklinton.

Ethical considerations

The study was a quality improvement project to evaluate a toolkit in a specific setting. There was no data collection of personal identifying information. The University of North Carolina at Chapel Hill Institutional Review Board (IRB) deemed this project not human subjects research. I posted flyers at the main entrance of each church informing potential participants about the study (appendix 2). Proposed dates, time and venue of the study for each church were dictated on the flyer.
Implementation Toolkit

The Conversation Project (TCP) (appendix 3), founded by Ellen Goodman, was launched in 2012 as a toolkit in collaboration with Institute for Healthcare Improvement (IHI). The TCP toolkit can be utilized in community partnerships with civic organizations, faith communities, employers and others in facilitating the engagement of people in end-of-life care conversations before a health crisis occurs. The aim of TCP is to encourage the public to engage in early ‘kitchen table’ conversations with their loved ones about their end of life preferences away from hospitals and intensive care units (McCutcheon, Kabcenell, Little, & Sokol-Hessner, 2015). TCP’s goal is to have every individual’s end-of-life wishes expressed and respected, rather than persons dying in circumstances they would not have chosen (McCutcheon, Kabcenell, Little, & Sokol-Hessner, 2015).

Instruments

The ADAS tool was developed by Nolan and Bruder in 1996 to assess patients’ attitudes towards ADs on medical surgical units in a tertiary level teaching hospital in the Mid-Atlantic region. The ADAS (appendix 4) is a 16-item, 4-point Likert scale measuring the extent to which ADs are viewed positively or negatively by respondents. Participants can choose answers from a scale of 1 (strongly disagree) to 4 (strongly agree). Higher scores would imply more favorable AD attitudes while lower scores would imply unfavorable attitude (Douglas & Brown, 2002). I obtained permission to use the survey tool and scoring from Dr. Nolan (Appendix 4). The ADAS was used to assess attitudes of the participants regarding AD before and after TCP toolkit intervention group discussions. In addition, I developed a 2-question survey to assess the likelihood that participants will hold an end of life discussion with their loved ones or institute
AD; this survey was administered pre-intervention (Appendix 5) and post-intervention (Appendix 6).

**Procedure**

Between December 18\textsuperscript{th} 2017 and January 19\textsuperscript{th} 2018, I implemented an educational intervention on importance of having an EOL conversation using the TCP toolkit. None of the participating churches or study participants had been exposed to the TCP toolkit prior to the study. Prior to implementing the intervention, I completed a 2-hour course offered by Institute for Health Improvement (IHI) on basic skills on how to hold an EOL conversation (Appendix 7). I initiated TCP discussion by introducing my role as a Doctor of Nursing Practice (DNP) student and moderator of the intervention group. I then introduced TCP and its purpose. Discussion followed, and I used TCP toolkit format on how to initiate EOL conversation:

Step 1: Get Ready—You will have many questions as you get ready for conversation. Here are two to help you get started:

- What do you need to think about or do before you feel ready to have the conversation?

- Do you have any particular concerns you want to be sure to talk about?

Step 2: Get set—What’s most important to you as you think about how you want to live at the end of your life? What do you value most?

- Now finish this sentence: What matters to me at the end of life is...

- What do you feel are the three most important things that you want your friends, family and/or doctor to understand about your wishes and preferences for end of life?

Step 3: Go—When you’re ready to have the conversation, think about the basics.
• Who do you want to talk to?
• When would be a good time to talk?
• Where are you comfortable talking?
• What do you want to be sure to say?

The discussions included some medical terms, which I explained (e.g., advance directives; artificial hydration and nutrition; cardiopulmonary resuscitation (CPR) do not resuscitate (DNR); HCPOA; among others.

Data Collection

Each intervention group lasted approximately 50-90 minutes with a 15-minute break. At the beginning of each intervention group discussion, participants completed three forms: demographic information (gender, race, age, income, education, knowledge about AD and whether or not they have AD in place; Appendix 8). No names or personal identifiers were required or collected. Next, participants completed the 2-question pre-implementation survey and a pre-implementation ADAS. At the end of the intervention group discussion, participants completed a post –implementation ADAS and a post –discussion 2-question survey. I gave each participant a copy of the TCP starter kit to help complete AD or initiate end of life conversations with their loved ones at home if they wished. Additionally, upon completion of the post-implementation ADAS survey, each participant was compensated with $20 for their participation.

Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) software, version 24.0 (IBM SPSS), generating descriptive and inferential statistics using matched-paired t tests and grouped data.
CHAPTER 5: RESULTS

All 20 participants completed pre- and post-intervention ADAS surveys and questionnaires. All were African American. Mean age was 51 years. 35% (n=7) were male, 65% (n=13) were female. Most had high school/GED and associate degree level of education.

Table 1

Demographic Characteristics of Study Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>65</td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>High school/ GED</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>Some college/ Associate</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18- 34</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>35- 51</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>52- 68</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>69- 84</td>
<td>6</td>
<td>30</td>
</tr>
</tbody>
</table>

Note: N= 20
One of the participants (5%) had instituted AD (Figure 1); however, (70%; n=14) had prior knowledge regarding AD while (30%; n=6) had no prior AD knowledge (Figure 2).

*Figure 3: Percentage of Participants with AD*

![Pie chart showing 5% with AD and 95% without AD.]

*Figure 4: Percentage of Participants with Knowledge of AD*

![Pie chart showing 70% with knowledge of AD and 30% without knowledge.]

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Table 2

*Paired Statistics of Survey Data Results*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre-Intervention group</th>
<th>Post-Intervention group</th>
<th>Significance (p≤.05) (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean(SD)</td>
<td>Mean(SD)</td>
<td>t (p)</td>
</tr>
<tr>
<td>1. I have choices about treatment I will receive at the end of life.</td>
<td>2.75(.72)</td>
<td>3.20(.70)</td>
<td>-3.33(.004) *</td>
</tr>
<tr>
<td>2. I will be given choices about the treatment I will receive at the end of my life.</td>
<td>2.65(.75)</td>
<td>3.00(.80)</td>
<td>-3.20(.005) *</td>
</tr>
<tr>
<td>3. My doctor will include my concerns in decisions about my treatment at the end of my life.</td>
<td>2.75(.72)</td>
<td>2.90(.72)</td>
<td>-.90(.380)</td>
</tr>
<tr>
<td>4. If I cannot make decisions, my family will be given choices about the treatment I will receive.</td>
<td>3.25(.45)</td>
<td>3.40(.50)</td>
<td>-1.83(.080)</td>
</tr>
<tr>
<td>5. I think my family would want me to have an advance directive.</td>
<td>2.40(.68)</td>
<td>3.15(.67)</td>
<td>-5.25(.000) *</td>
</tr>
<tr>
<td>6. Making my end of life treatment wishes clear with an advance directive would keep my family from disagreeing over what to do if I were very sick and unable to decide for myself.</td>
<td>2.75(.64)</td>
<td>3.20(.41)</td>
<td>-3.94(.001) *</td>
</tr>
<tr>
<td>7. Having an advance directive would make my family feel left out of caring for me</td>
<td>2.50(.69)</td>
<td>2.90(.72)</td>
<td>-2.18(.420)</td>
</tr>
<tr>
<td>8. Making my end of life treatment wishes clear with an advance directive would help to prevent guilt in my family.</td>
<td>2.55(.76)</td>
<td>2.80(.70)</td>
<td>-2.03(.056)</td>
</tr>
<tr>
<td>9. Making my end of life treatment wishes clear with an advance directive would have no impact on my family</td>
<td>2.65(.75)</td>
<td>2.95(.61)</td>
<td>-2.04(.055)</td>
</tr>
<tr>
<td>10. Having an advance directive would prevent costly medical expenses for my family</td>
<td>2.35(.67)</td>
<td>2.75(.72)</td>
<td>-2.99(.008) *</td>
</tr>
</tbody>
</table>
Mean scores and paired samples t test were used to compare pre-TCP scores to post-TCP item scores. In general, survey items had higher mean scores post-intervention compared to pre-intervention items. Cumulative ADAS scores increased from pre-intervention ($M=2.68$, $SD=.41$) to post intervention scores ($M=3.04$, $SD=.32$) and demonstrated a significant positive change in advance directive attitude ($t (19) = -6.58$, $p<.00$). The increase was statistically significant ($p \leq .05$) for items 1, 2, 5, 6, 10, 11, 12, 14 and 16, indicating that more participants were likely to consider holding EOL discussions with their loved ones and/or executing AD. No significant changes were noted pre- and post-intervention ($p>.05$) with items 3 and 4, which specifically address healthcare provider involvement and their ability to include family members in EOL decisions.

Similarly, participation in the TCP intervention group significantly improved the likelihood of completing an AD (Figure 4). Post-intervention scores ($M=3.40$, $SD=1.05$) were significantly higher $t (19) = -5.21$, $p<.00$, than pre-intervention scores ($M=2.25$, $SD=1.61$). The percentage of those who were ‘definitely sure’ that they would not institute an AD declined from
(20%; n=4) pre-intervention to (0 %; n=0) post-intervention. Similarly, the percentage of those who had indicated they probably would not (35%; n=7) or were not sure (15%; n=3) pre-intervention declined to (0%; n=0) and (5%; n=1) respectively post-intervention. The frequency of those indicating they would probably institute AD increased from (20%; n=4) to (30%; n=6), while that of the participants who definitely sure that they would institute AD rose from (10%; n=2) pre-intervention to (65%; n=13) post intervention.

Figure 4: Likelihood of completing an AD

Results from 2-survey questions indicated that participation in TCP education intervention groups significantly increased participant’s likelihood of having EOL conversations with loved ones (Figure 5). Post-intervention scores ($M=4.60$, $SD= .60$) were significantly higher $t (19) =-7.07, p< 0.00$, than pre-intervention scores ($M=2.65$, $SD=1.31$). Percentage of those who indicated
they would definitely not hold EOL discussions pre-intervention decreased from (35%; n=7) to (5%; n=1) post intervention. There was an increase in the percentage of those would probably hold EOL discussion pre intervention (5%; n=1) to post intervention (30%; n=6). Those that were definite willing to hold EOL discussion increased from (5%; n=1) pre-intervention to 15%; n=3) post intervention.

*Figure 5*: Likelihood of having EOL conversations with loved ones
CHAPTER 6: DISCUSSION

Summary of Findings

Rendering culturally-appropriate care improves compliance and reduces healthcare costs (NAM, 2014). Conflicting perceptions, communication barriers, and insensitivity to cultural differences often mar the quality of healthcare and effectiveness of education delivered to AAs. Purnell (2012) noted that cultural competence is not necessarily linear, but a conscious process. In order for culturally competent care to be minimally effective, it must “have the assurance of continuation after the original impetus is withdrawn; it must be integrated into and valued by the culture that is to benefit from the interventions” (Purnell, 2012, p.7). In this project, I incorporated five domains of the Purnell Model. With consideration of AAs past experiences, current location, family beliefs and spirituality, I focused on AAs as a unique group in delivering TCP education successfully in a culturally congruent way. The TCP toolkit intervention led to a positive change in attitude towards AD when used as an education tool for EOL choices among AAs. The TCP toolkit can be used to enlighten AAs about EOL choices and encourage them to initiate EOL discussions with other family members.

Effects of TCP on AD institution

An important historical perspective to consider is the AA culture of oral history, which dates back to the slavery period in the early nineteenth century (1800-1820). Slave owners institutionalized illiteracy to prevent AAs from challenging their authority through legal discourse (Hamlet, 2011). Based on this history, oral communication became a viable method to freedom. The oral tradition culture has been kept alive as a fundamental vehicle for cultural expression and survival, rather than written documents. As an observation from this study, I
suggest that AAs may not see the need for written AD but may benefit from EOL education and discussions. All the participants agreed to hold an EOL conversation but not all agreed to institute an AD. The goal of TCP is to encourage kitchen table discussions with family on goals of care at end of life; completion of a written AD should not be the main focus but may be an added advantage if they wish to do so.

**Effects of TCP on EOL discussion**

Religious or spiritual beliefs remain pivotal in the lives of most AAs; these beliefs provide a sense of continuity of hope and a sense of belonging, especially in the face of tumultuous life events or serious illness (Puchalski, Blatt, Kogan, & Butler, 2014). According to the 2014 consensus report by NAM, *Dying in America*, Civic leaders, public health and other governmental agencies, community-based organizations, faith-based organizations, consumer groups, and professional societies, should engage their constituents and provide fact-based information to encourage ACP and informed choice based on the needs and values of individuals. Public education and engagement efforts should aim to normalize these difficult conversations and to assist people in achieving the necessary information to have meaningful discussions about the values and goals of care (pg.370).

TCP was successful in promoting EOL discussion in this study. At the completion of the study, all participants agreed to hold a conversation with their loved ones.

**Implications for practice**

The CMS concurs that EOL conversations can reduce futile, expensive and sometimes unnecessary treatment (CMS, 2017). TCP as a means of public health education meets the public demand to change the way care is delivered among AAs at the EOL. Community and spiritual
leaders act as trusted members of the AA community and may be helpful in engaging their constituents and congregants in EOL conversation prior to an illness or catastrophic injury. Public engagement on death education using TCP toolkit should be extended beyond churches to schools, workplaces, recreational centers and other venues. These difficult death discussions may seem easier or more comfortable when done with loved ones in the comfort of a natural surrounding—not the intensive care unit.

Limitations

Results of the study could have been affected negatively by several factors: the sample size was small therefore inferences from statistical analyses must be made with caution. The study was done in only three AA churches of two denominations. The ADAS and 2-question surveys may have inclined participants to respond in a generally acceptable way instead of their actual beliefs on AD. Both pre- and post-intervention measures were done in one session. Results may have been different if TCP education and follow-up measures were completed in two separate sessions and on different time frames.
APPENDICES

APPENDIX 1: PERMISSION TO USE PURNELL MODEL AND FIGURE

From: Larry Purnell <lpurnell@udel.edu>
Sent: Sunday, November 5, 2017 11:47:32 AM
To: Kebaso, Nancy
Subject: Purnell Model

You have permission to use the Purnell Model and figure for your dissertation. Here is a copy that might be better for you.

Larry Purnell, PhD, RN, FAAN
Professor Emeritus, University of Delaware
Adjunct Professor, Florida International University
Adjunct Professor, Excelsior College
410-438-3826
APPENDIX 2: PARTICIPANT INVITATION FLYER

PARTICIPANTS NEEDED FOR
AN INTERVENTION GROUP STUDY
We are looking for volunteers to take part in a research study called “Conversations About Dying; Can African American Churches use the TCP toolkit to Facilitate End of Life Care Planning?”

What is this study about?
This study is being done to determine if African Americans might gain better attitudes and awareness of the benefits of advance directive using a discussion toolkit. You will participate in a discussion session where the Conversation Project toolkit will be used as a guide. The intervention group will be moderated by Nancy Kebaso, RN, BSN graduate student at The University of North Carolina (UNC)-Chapel Hill. Ms. Kebaso is being supervised by Dr. Beth Black, a professor at the UNC-Chapel Hill and Dr. Apollo Townsend, an adjunct professor at UNC-Chapel Hill, who is also the director of Transitions Life Care Hospice, Raleigh. Two surveys will be done before and after the discussion session to assess any changes in attitude towards advance directive. The discussion will be kept confidential and will not be recorded.

Why is this study/knowledge important?
This study seeks to enhance discussions on end of life with African Americans. The study may add practical knowledge to research literature on how providers can work with churches to inform African Americans of their ability to choose their end of life preferences through discussions.

How much time will it take for the study?
You will participate in one group session that will last a maximum of 90 minutes.

Will it cost me anything to participate?
Other than time, it will not cost you anything to participate in this study.

Will, I receive any compensation for participating in this study?
Yes. You will receive $20 (twenty dollars) for completion of one entire discussion session.

What are the benefits and risks to my participation?
Although benefits cannot be promised with participation in this study, you may learn more about
advance directive and end of life decisions during the discussion.
While the researcher will maintain confidentiality, we cannot promise this on behalf of other participants, although it will be requested.

**Privacy**
Your privacy will be protected. All documentation (demographics) will not contain any identifying information. The discussion will be kept *strictly confidential*. Tape recording will not be used. Anonymous demographic information and survey forms will be destroyed once the data analysis is completed.

**What are my rights in regards to participation to this study?**
The study is voluntary. You can refuse to be in this study or chose to leave at any point of the study. There will be no effects on your relationship with the UNC-CH school of nursing, Transitions Life Care Hospice or your church.

**Questions**
If you have any additional questions, concerns, or complaints about the study, please ask. If you have questions or concerns about the study later, please call the investigator Nancy Kebaso, RN, BSN at 201-912-0994 or Dr Black at 919-731-8000 or Dr.Apollo Townsend at 614-562-9700. You may also ask questions, make suggestions, file complaints or concerns through the IRB and the office of human research ethics at [http://research.unc.edu/human-research-ethics/](http://research.unc.edu/human-research-ethics/) Telephone number 919-966-3113
APPENDIX 3: TCP TOOLKIT

The Conversation Project (TCP) Toolkit

APPENDIX 4: ADAS SURVEY TOOL

Advance Directive Attitude Survey (ADAS)

Please mark an “X” in the box that best describes your attitude

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have choices about treatment I will receive at the end of life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I will be given choices about the treatment I will receive at the end of my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. My doctor will include my concerns in decisions about my treatment at the end of my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. If I cannot make decisions, my family will be given choices about the treatment I will receive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I think my family would want me to have an advance directive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Making my end of life treatment wishes clear with an advance directive would keep my family from disagreeing over what to do if I were very sick and unable to decide for myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Having an advance directive would make my family feel left out of caring for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Making my end of life treatment wishes clear with an advance directive would help to prevent guilt in my family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Making my end of life treatment wishes clear with an advance directive would have no impact on my family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Having an advance directive would prevent costly medical expenses for my family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Having an advance directive would make sure family knows my treatment wishes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>---</td>
<td>------------------</td>
<td>---------</td>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>12. Having an advance directive would make sure that I get the treatment at the end of my life that I DO want.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I trust one of family or friends to make treatment decisions for me if I cannot make them for myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. It is better to make an advance directive when you healthy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Having an advance directive would restrict the treatment I would be able to get at the end of my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I am not sick enough to have an advance directive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Ms. Kebaso:

I am attaching a Microsoft Word document that contains both the subscales and the actual survey of patient attitudes towards advance Directives. You have my permission to use this instrument. There is no charge but I would appreciate it if you would cite the *Nursing Outlook* article where the survey was first described when you present or publish work in which the instrument was used. In the subscale list, the words “reverse score” next to some of the items indicates that the score for the item should be reversed (a response of 4 is scored as 1, a response of 3 is scored as 2, etc) when scored on a 4-point scale from strongly disagree to strongly agree.

Best of wishes for a successful study.

Sincerely yours,

Marie T. Nolan, PhD, RN
Professor and Executive Vice Dean

APPENDIX 5: PRE-TCP 2-QUESTION SURVEY

PRE-DISCUSSION 2-QUESTION SURVEY

Before we start this discussion, circle the option that best reflects your position.

1. What is the likelihood that you will hold an end of life conversation with your loved ones/family?
   - Definitely not
   - Probably not
   - I might. Not sure
   - I probably will
   - I definitely will

2. What is the likelihood that you will complete an advance directive?
   - Definitely not
   - Probably not
   - I might. Not sure
   - I probably will
   - I definitely will
APPENDIX 6: POST-TCP 2-QUESTION SURVEY

POST DISCUSSION 2-QUESTION SURVEY

After this discussion, circle the option that best reflects your position.

1. What is the likelihood that you will hold an end of life conversation with your loved ones/family?
   - Definitely not
   - Probably not
   - I might. Not sure
   - I probably will
   - I definitely will

2. What is the likelihood that you will complete an advance directive?
   - Definitely not
   - Probably not
   - I might. Not sure
   - I probably will
   - I definitely will
This certificate is awarded to Nancy Kebaso

For participating in the educational activity entitled

PFC 202: Having the Conversation: Basic Skills for Conversations about End-of-Life Care

On 11/16/2017

The activity was designated for 2.00 hours of AMA PRA category 1 credit.

support of improving patient care, the Institute for Healthcare Improvement is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
APPENDIX 8: DEMOGRAPHICS QUESTIONNAIRE

Demographics (please do not include your name or date of birth)

Please indicate your age (in years): __________.

Please indicate your gender: __________Female________Male

Please indicate your race: __________White ________Black

Level of Education Completed

Less than high school graduate __________

High school graduate or GED __________

Some college or Associates degree __________

Bachelor’s degree __________

Graduate degree __________

Do you know what is an advance directive?

Yes __________

No __________

Do you have an advance directive?

Yes __________

No __________
REFERENCES


perspectives of end-of-life care planning and decision making. *Qualitative Health Research, 11*(3), 385-398.


