COMMENTARY

Implementing Advance Care Planning: Barriers and Facilitators

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An article by Izumi et al. (2019) in the current issue describes the effect of a brief educational intervention for nurses to increase confidence in their knowledge of advance care planning (ACP). The description of this project offers a useful exemplar for those wishing to implement ACP interventions. This commentary raises questions about the role of nurses in ACP and the design of effective, sustainable ACP programs within complex health systems.

The aim of the quality improvement (QI) project by Izumi, Burt, Smith, McCord, and Fromme (2019) in the current issue of the *Oncology Nursing Forum* is to determine the effect of a brief educational intervention to improve bone marrow transplantation (BMT) nurses' confidence in their knowledge and practice about advance care planning (ACP). Interview data also were collected at preintervention and at six months to identify ACP barriers. Although the findings from this small-scale QI project alone are insufficient to change practice, the project provides a detailed roadmap and lessons learned that could benefit others wishing to implement ACP interventions. It also provides a blueprint for the design and testing of future interventions to address barriers to ACP.

ACP is an ongoing process that encompasses more than completing an advance directive (AD); it is a multistep process to help individuals make decisions regarding value-based choices about life-saving treatments at the end of life (Schickedanz et al., 2009). ACP offers a means through which patient and family preferences are identified, negotiated, and recorded. Although ACP provides valuable direction to families and healthcare professionals, conversations about and documentation of patients' wishes are often suboptimal—too little and too late. Evidence suggests that expanding ACP in populations undergoing aggressive but potentially curative oncology treatments, such as

hematopoietic stem cell transplantation, can have a positive effect on survival rather than adverse outcomes, as some believe (Ganti et al., 2007). Despite evidence-based guidelines and policies, barriers at the individual, clinician, organization, and health-system level can hamper implementation of ACP. Strategies to increase the adoption of ACP have included communication skills training for clinicians, community-based education for patients and family members, and improving efficiencies of documentation and workflow at the system level (Lin et al., 2019).

Prior to the intervention, nurse participants reported that their lack of training and knowledge were obstacles to ACP activities. As expected, training and knowledge barriers decreased after the intervention (Izumi et al., 2019). Another encouraging finding is that the nurses reported increased confidence in conducting ACP activities immediately after the intervention. Confidence, however, was only partially maintained three months later. Compared to preintervention, the proportion of nurses assisting patients in ACP sometimes or all the time increased at three months, but did not reach statistical significance. These mixed findings may be due, in part, to the small sample, psychometrically untested measures, or the short testing period. Also, a brief educational intervention may not necessarily influence individual factors, such as a nurse's belief that ACP takes away a patient's hope or a nurse's readiness for ACP activities, such as initiating conversations about end-of-life choices. Lasting behavior change often requires a change in attitude, readiness to change, and internal motivation. It is possible that desired ACP behaviors would be sustained if the intervention addressed attitudes, readiness, and motivation, as well as included ongoing organizational support.