2023

Are You Ready to Engage? The Impact of Decisional Conflict on Advance Directives Education

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NSUWorks Citation
Marcia Brown. 2023. *Are You Ready to Engage? The Impact of Decisional Conflict on Advance Directives Education.* Doctoral dissertation. Nova Southeastern University. Retrieved from NSUWorks, Halmos College of Arts and Sciences - Department of Conflict Resolution Studies. (234)
https://nsuworks.nova.edu/shss_dcar_etd/234.

Are You Ready to Engage? The Impact of Decisional Conflict on Advance Directives Education

by

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A Dissertation Presented to the
Halmos College of Arts and Sciences at Nova Southeastern University
in Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University
2023

Nova Southeastern University
Halmos College of Arts and Sciences

This dissertation was submitted by Marcia E. Brown under the direction of the chair of the dissertation committee listed below. It was submitted to the Halmos College of Arts and Sciences and approved in partial fulfillment for the degree of Doctor of Philosophy in Conflict Analysis and Resolution at Nova Southeastern University.

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Dedication

To my sister, the Late Maxine Carlin Roberts MacGregor Brown, whose life was an inspiration for this work and the rest of my family who persevered with me on this journey. Thank you!

Acknowledgments

My first recognition goes to the Divine whose love, mercy, and grace allowed me to complete this project. My heartfelt thanks go to the following individuals: Dr. Mary Hope Schwoebel, whose willingness and mentorship was much appreciated during the evolution of this important work. Dr. Elena Bastidas, Dr. Neil Katz, and Dr. Ray Moseley, my committee members who were instrumental in seeing this research to its conclusion. The expertise of Dr Ken Goodman and William Allen, J.D., who helped foster my knowledge of Bioethics. Chaplain Debra Hepburn, DMIN-NH, MDIV, who provided faith leadership connections, and Dr. LaToya O'Neal for her lessons in community programming. To my colleagues and friends who reviewed my dissertation content and statistics, the late Michael Robinson, Darrice Montgomery, Ben Rooks, Helen Yates, James Cooley, and Richard Toumey, your input may have saved me more than you know. Lastly, I would like to extend my gratitude to Dr. Joy Benjamin, Stacy Allsop, MLS, my research participants, and faith leaders, I know that without all of you, this project would not have been possible. Thank you!

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Abstract

End-of-Life (EOL) refers to medical support given to those facing death and advance directives (AD) is a document that helps to distinguish the nature of that support. The literature suggests conflict is a barrier in the advance care planning (ACP) process and if it remains unresolved in the absence of an AD, there is prolongation of unwanted treatment, increased costs, and lower quality of care. The purpose of this research was to uncover decisional conflict and determine the usefulness of ACP engagement factors in faith communities through a unique intervention – CADE (Conflict and Advance Directives Education). Three theories – general systems theory, value theory, and Lederach's model of conflict transformation were relevant in explaining the context of conflict around EOL and behavioral change. A posttest quantitative approach was used to check for decisional conflict and the level of two engagement factors, Readiness and Self-Efficacy. Upon statistical analysis, decisional conflict was detected with a higher score in the control group. For the ACP factors, participants were confident (had self-efficacy) in their decisions around EOL but lacked readiness to demonstrate flexibility and ask questions of their providers. Unmarried participants were most vulnerable and less ready to engage in the process. Among the participants who were ready to engage, they were certain about choosing their decision maker and asking provider questions. The high frequency of decisional conflict and the lack of readiness for ACP engagement during CADE solidified its potential as an educational resource to capture and minimize disparity in advance directives.

Chapter 1: Introduction

The Patient Self-Determination Act (PSDA) of 1990 was the first U.S. federal mandate that dealt with end-of-life (EOL) care. The PSDA allows you to request the kind of medical support you want to receive and the right to refuse care. This enactment had two goals, as per Wolf et al. (1991); one was to inspire adults to discuss and/or assign their treatment wishes. The second was to have their decisions honored by health providers. The hope was that preconceived EOL care would translate as a norm in society. This has yet to materialize nationally, but some progress has been made in many states.

The change in end-of-life care historically started with the recognition that patients' decisions were either neglected or not conducted as they intended (Wolf et al., 1991). After PSDA, this changed and the distribution of advance directives (AD) propelled nationwide, but its efforts were not inclusive. The National Academy of Medicine (formerly known as Institute of Medicine) acknowledged that more was needed to influence sociocultural norms (2015). One perceived barrier to this norm was its confinement to a complex, conflict-enriched health network. This hurdle is not insurmountable with a collaborative effort and easily achievable with biopsychosocial, public health, and conflict resolution practices. Kripalani et al. (2022) believed that the biopsychosocial approach can enhance end-of-life discussions. Rao et al. (2002) and Sallnow et al. (2015) concurred that with public health assistance, end-of-life talks may be gaining social acceptability. Sadly, the field of conflict resolution lags in this contribution and if it remains uninvolved, families fractured over EOL conflict will continue. This project delivered a broad picture of end-of-life conflict through conflict resolution lens in conjunction with the bioethical guidance of its gold standard, the advance directive. The exposition also digested a review of applicable systems and theories, the incidence of conflict, its root causes, and a synopsis of previous strategies.

Bioethics and Advance Directives

The bioethical principles seek to rationalize the advance directive laws and provide credence for the power of decisional capacity. The four ethical tenets are autonomy, justice, beneficence, and non-maleficence. Jonsen et al. (2015) described autonomy as the moral right to make one's own health decisions. Justice speaks to the fairness of the health care distribution and beneficence on the utmost benefit of treatment. Non-maleficence, as from the tenets of Hippocrates, "do no harm," avoid such harms. Autonomy is a crucial principle within advance directives and when it is connected to shared decision-making, it exhibits the ideal picture of ethical compliance.

For such a partnership to exist, there must be mental or decisional capacity. As per Jonsen et al. (2015), decisional capacity is the ability to comprehend and appreciate the risks and benefits of the treatment, then rationally deliberating on those choices based on one's values or preferences. Mental capacity is not synonymous with competence as the latter requires intervention by a court of law. Jonsen et al. (2015) also implied that this distinction is consequential when executing advance directives. The authors posed that even though one may be legally competent, it is still possible that one lacks the decisional capacity to make a sound medical decision. Therefore, when decisional incapacity is evident, the importance of autonomy in the informed consent process must be maintained.

Kates (2017) recounted that the earliest report of end-of-life discussions occurred in the 1960s and was limited to those with morbid outcomes. Nowadays, it is a reimbursable office visit for clinicians under the name, Advance Care Planning (ACP). Advocates for advance care planning attested that the process not only includes documentation, but it should be acted upon regardless of one's health status (National Institute on Aging [NIA], 2021). State laws and national health organizations have made it easy for clinicians to encourage and protect patients from stressful, unavoidable medical catastrophe through advance directives. The intent is admirable since ADs are a practical and cheaper option for individuals, but not foolproof. Advance directives vary by state and are only executable when a patient loses the ability to make his or her own health decisions (NIA, 2021). In Florida, a person must have decisional incapacity and a terminal illness before a health care provider can activate end-of-life care. These specific care instructions can be found in one of the state's acceptable forms: Living Wills, health proxies, health care surrogates, or anatomical gifts (Health Care Advance Directives Act, 2015).

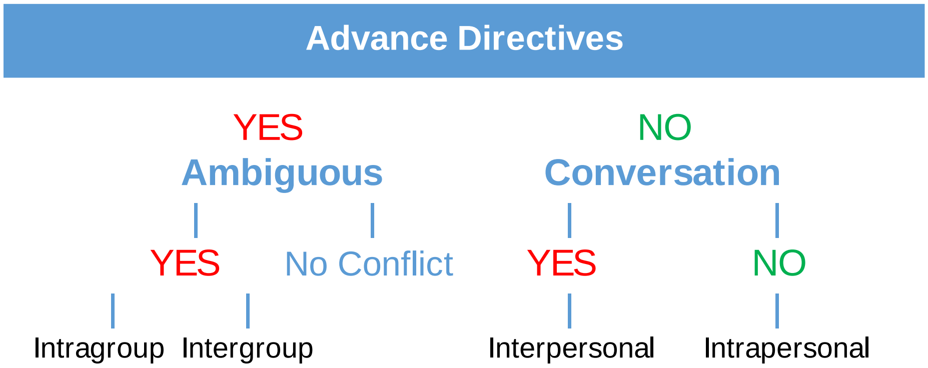
End-of-Life Conflict

One of the main bioethical principles, autonomy, has been cited as a source of conflict (Karnik & Kanekar, 2016). Benson et al. (2019) recounted that it is prevalent when a patient fights to sustain it or tries to regain their treatment decision-making. Similarly, Chin et al. (2019) reflected that it was the center of the dispute of a multidisciplinary team trying to maintain a patient's end-of-life goals. Both authors found autonomy counterproductive to medical professional obligations. They believed that if it is strengthened, then there is an argument that conflict must be addressed as well. It may become a barrier within these systems and have detrimental impacts if not thwarted.

Conflict with advance directives has arisen in traditional categories like intrapersonal, interpersonal, intragroup, and intergroup (Figure 1). Decisional dilemmas are high in intrapersonal conflict among the patient's surrogates (Jeon et al., 2018; Famakinwa, 2010) and providers (Caulley, 2018). When it occurs between patient's relatives, interpersonal is more prevalent. Kramer and Boelk (2015) claimed that family conflict counteracts the quality of care during the end-of-life process and hinted that if the familial relationship is poor, it hampers care and incites more conflict. Figure 2A emphasizes how family context contributes to EOL conflict. Intergroup and intragroup equate to Yerramilli et al. (2019) summarization. They concluded disputes between the patient's caregivers and providers were consistent with intergroup conflict. Pope (2019) acknowledged that most of the intergroup conflict that arises comes from the physician's objections to the family's request to maintain life-sustaining treatment in the patient's futile illness. The final type, intragroup, tends to dominate when clinicians disagree among themselves. Nonetheless, drawing on these struggles and the confusion seen near the end-of-life, unhandled conflict adds to the tumultuous process.

Figure 1.

Conflict with Advance Directives



Problem Statement

Hickman and Pinto (2014) indicated that decisional conflict increases in the absence of an advance directive. Their work had two profound effects. First, it sheds light on its value near end-of-life and two, how conflict ensues in the aftermath. Kramer and Boelk (2015) studied the latter and established a high frequency of family conflict. They attributed their results to ambiguous advance directive preferences that produced uncertainty and devalued the quality of care. These shortcomings have negative impacts such as delays in the withdrawal of unwanted treatment (Walling et al., 2010; Carter et al., 2019). Boerner et al. (2016) cautioned that AD ambiguity leads to inadequacies and overtreatment results in an increase in medical expenditures. Other articles divulged conflict escalation with AD absence (Kramer & Boelk, 2015; Hickman & Pinto, 2014), and diminished when AD is present and well-executed (Malhotra et al., 2020; Chiarchiaro et al., 2015).

Additionally, Jonsen et al. (2015) confessed that it was customary for clinicians to act slow in giving less aggressive life-sustaining treatment over the patient's EOL preference. This was especially true if they were in the Intensive Care Unit, in a critical condition, or were terminally ill. Such choices violated the patient's autonomy. Cultural insensitivity was also an issue if it was exacerbated by familial conflicts which were more common in underrepresented groups (Su et al., 2014). The 2015 *Death and Dying Report* cited that health professionals lack the awareness of cultural beliefs around end-of-life which caused further aggravation. The existence of conflict contemporaneously without removal of obstacles renders advance directives ineffective, which defeats the intended purpose.

A bulk of studies dealt with advance directives completion rates, but only a few highlighted the lower rates in racial-ethnic groups in comparison to the national average (Collins et al., 2018; Ejem et al., 2019). The small number of articles about ethnic or racial completion rates, coupled with a shortage of research that target advance directive education in faith-based organizations (FBOs), produced even more concerns. FBOs have been underutilized although they share a rich history of success in promoting community health initiatives in underserved populations with academic partners (Aponte et al., 2013). Community-academic partnerships (CAP) show promise as a community tool to reduce systemic barriers (Noel et al., 2019). An article by Taneja et al. (2019) advised that in their Canadian community, less decisional conflict with advance directives education was probable. These efforts and a systematized review unleashed the potential of CAP as a legitimate access point to tackle decisional conflict through advance directives education.

Research Purpose

Advance directives can function as great conduits when an individual makes the inevitable decision about his or her medical care near the end-of-life. To use this conduit, one must learn about their end-of-life options. The scarcity of literature identifying advance care planning programs in the faith communities and the inequality of advance directives in marginalized populations sparked the idea behind this in-depth look. Hence, the primary intention of this dissertation was to quantitatively investigate if the Decisional Conflict Scale (DCS) and Advance Care Planning Engagement (ACPE) surveys were beneficial in an educational intervention and to discover the participants' decisional conflict and readiness to engage in end-of-life planning within faith-based communities in Florida. Community-academic partnerships served as entry points and were referred to as "…community members and an academy who have an equitable role in achieving a specific aim that is applicable to the community of interest" (Drahota et al., 2016, p. 192). The main goal was to raise awareness for advance directives and assess decisional conflict in members of faith-based organizations. This venture would offer a new opportunity to gain access to advance care planning, which was notably lagging in the state.

Research Questions

The most constructive endeavor to evaluate decisional conflict, improve advance directives awareness, and reach racial-ethnic faith communities was to plan an educational intervention that evaluates the effectiveness of the DCS and ACPE components. The intervention, conflict and advance directives education or CADE, provided an overview of advance directives, end-of-life conflict, and basic conflict management skills with the aim to assess decisional conflict and advance care planning engagement behaviors through validated surveys. The central research question exposed whether the intervention could detect decisional conflict and the level of readiness to engage in advance care planning. Three sub-questions were employed to examine the five factors of decisional conflict and the fifteen ACPE behavioral change agents through three distinct inquiries:

1. Was there an effect on the participant's decisional conflict and the factors of advance care planning engagement with and without the CADE intervention?
2. Is there an association between marital status and the level of Readiness in those who engaged in the workshop versus those who did not?
3. What is the difference in the Readiness score and the level of Uncertainty between the participants who were ready to engage in ACP and those who were not?

The first question pursued advance care planning engagement and decisional conflict influence among faith community participants. The second question differentiated associations between marital status and the participant's level of Readiness. The last one drew a picture of the participant's level of uncertainty and his or her readiness to engage in the advance care planning process.

Theoretical Framework

As with any academic research, there is a place to integrate theory with practice. Three rudimentary theories fit contextually with conflict near the end-of-life. They were general systems theory, value theory, and Lederach's model of conflict transformation. General system theory takes an interdisciplinary approach at behaviors within a system that generate reactions in other constituents within the same system (Mele et al., 2010). A bioethical premise that defines the value theory comes from Hirose and Olson, (2015). They believe the theory ranks the value of things as good or bad, then explains what makes the thing good or bad, and the extent of good or bad. The last theory is Lederach's model of conflict transformation. It strives to empower the parties to change their perception, behavior, and relationships (Lederach, 2003). This project expounded each theory in the next chapter.

Definitions and Key Concepts

There were several concepts worth defining to grasp the context for this research. They were:

Advance Care Planning (ACP). An ongoing communication process between an individual, his or her family and friends, and a health care provider on the type of medical care the individual desires if or when he or she cannot make that decision in the future (Shanley & Wall, 2004).

Advance Care Planning Engagement (ACPE). Discrete advance care planning behaviors indicate an individual's value and goals around their health, illness, and end-of-life, leading to either documenting and/or communicating their decisions to loved ones and medical providers (Sudore et al., 2013).

Advance Directive (AD). A witnessed oral statement or written document that provides instructions on the health care choices the person prefers. (Florida Bioethics Network, 2011).

Cooperative Extension. A nationwide land-grant university system dedicated to addressing public needs through non-formal education and community activities relevant to county residents, the youth, and to families of farmers and ranchers (National Institute of Food and Agriculture, n.d.).

Decisional Incapacity. A physical or mental state where a person is unable to communicate his or her health care decision willfully or knowingly (Florida Bioethics Network, 2011).

Decisional Conflict. A term that is characterized as a state of uncertainty about a course of action over treatment choices that involve risk, decisional regret, loss, or challenges to personal values (O'Connor, 2010, p 2).

End-of-Life (EOL). A medical definition that explains the kind of medical support or health care one receives near death (National Institute of Aging, 2021).

Faith-Based Organization (FBO). A non-profit religious entity that provides spiritual, health, and social programming activities to local and national communities (Bielefeld & Cleveland, 2013).

Flexibility. An expression that refers to the extent of leeway a health care surrogate has in making health care decisions (Sudore et al., 2013).

Healthcare Ethics Consultant. A bioethicist working in health care to guide the medical team in the ethical conduct of complex patient cases or issues (Tarzian et al., 2015).

Health Care Surrogate (HCS). A competent adult expressly designated by a person to make health care decisions on his or her behalf in the event of incapacity (Florida Bioethics Network, 2011, p. 54).

Informed Consent. A process that provides an exchange of information between patients and their health care providers on medical treatment options and where there is allowance for patient's questions or affirming procedure risks and benefits. This process ends with agreement to, or refusal of care (Florida Bioethics Network, 2011).

Level of Uncertainty. An emotional state perceived from unclear personal values or by feeling uninformed, unsupported, or pressured to make a choice or move on a course of action (O'Connor, 2010).

Life-Sustaining Treatment. Any treatment that serves to prolong life without reversing the underlying medical condition. It may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. Life-sustaining treatment is sometimes referred to as life-prolonging procedure (American Medical Association Journal of Ethics, 2013, paragraph 1).

Living Will. An advance directive in which a person states their medical treatment preferences in writing or verbally, in advance of becoming incapacitated or unable to express those treatment choices. Its execution is governed by state law. (Florida Bioethics Network, 2011, p. 101).

Quality of Life (QoL). A personal value that identifies goals about health states in which a person's life reaches a point that he or she feels is worth living or not living over the length of life (Sudore et al., 2013).

Shared Decision-Making. Represents a model of patient-centered care where the patient is encouraged to play a role in the decisions affecting their health when communicating with their health care professionals or medical providers (Agency for Healthcare Research and Quality, 2020).

Values. Are a set of ideals, interests, principles, or standards that a person endorses and commits to as good (Harold, 2005).

Dissertation Outline

End-of-life conflict is a grave issue and to deal boldly with it, innovative strategies are necessary. This research gauged decisional conflict to improve advance directives readiness of faith participants by piloting an educational intervention, CADE (Conflict and Advance Directive Education). The project unmasked the current problem and provided supplemental questions to highlight its effects. Three theoretical frames fortified the project's design, purpose, and goals followed by a quantitative methodology to investigate its feasibility, as depicted in Chapters Two and Three, respectively. Chapter Four captured the results of the analysis with an overview of implications and conclusions detailed in the closing chapter. A social inquiry like this was poised to be a resource that has the adeptness to transform conflict around end-of-life.

Chapter 2: Literature Review

An extensive review of the literature on conflict near the end-of-life brought with it a plethora of evidence that affirmed its magnitude. While the topic has affected all societal hubs, it was imperative to appreciate the legal domain around advance directives because of its power in the communities. Florida has the Health Care Advance Directives Act that regulates how an AD can be executed. The Act encompasses a set of guidelines for its execution, but end-of-life care is not a black or white matter. There may be intricacies that arise during care and state laws do not have the capability to deal with each circumstance. The Institute of Medicine recognized these inadequacies within the federal and state laws, so it gave a special committee the mission to solve some of these complexities through collaboration of the brightest minds.

The 2015 *Death and Dying Report* drafted by the institute sought to highlight the deficiencies found throughout the nation. The report spoke of five apparent weaknesses in EOL and the most relevant was the gap in public education and engagement. The committee informed the reader that the "younger, poorer, minority, and less-educated individuals, do not have [end-of-life] conversations" (p. 1). Furthermore, the members of the committee mentioned that even the community of health professionals "have not fully utilized strategies to make that knowledge available, meaningful, and relevant across diverse population groups" (p. 2). The statement confirmed a critical void between the public and those charged with educating them. Their report proved that a wider range of innovations to attack the lack of public education and engagement among the various stakeholders were needed. A comprehensive solution at the local or national level would require a literature search that incorporated an ambitious strategy.

In this chapter, the topics covered were theoretical underpinnings for EOL conflict, decisional conflict, advance care planning engagement, the effect of culture, AD implementation and completion rates, community academic partnerships, faith-based organization influences, main community interventions, AD websites, and it ended with a summarization of what was found.

Literature Search

The initial search began with reviewing the topic, advance directives, and faith communities in PubMed. This quest returned only four articles. To broaden the search, the librarian recommended the University of Florida multidisciplinary databases, namely the Academic Search Premier, EBSCO (CINAHL and PsyInfo), ProQuest, and the Web of Science over Google Scholar to generate new key words. See Table 1B for the list of key words and abbreviations that were used during the investigation. The search within these databases spanned twenty years with preference given to 2010 articles and beyond and comprised of materials from peer-reviewed journals, reports, books, and dissertations. Some materials older than 2010 were kept for relevance. Most articles were retrieved with at least two key words and only the English versions were reviewed. From the inventory of articles, it was clear that there were several interventions on advance directives education, but none were combined with a conflict management exercise. In fact, conflict management training had not been studied with end-of-life education prior to this project. A few of the articles crafted a picture of the ideal components for a novel intervention, but first, it was essential to perform a robust examination of the various categories around advance directives. The next subsections contextually summarized the classifications and key positions.

Conflict and Advance Directives

Advance directives contain interactions between the patient's proxy or health care surrogate, medical care providers, the institution, and state health law. Conflict is expected when there are shifting relationships in a complicated health system, so a prominent view of such interactions is the presence or absence of ADs. Hickman & Pinto (2014) spotted conflict as more frequent in those without an advance directive and Malhotra et al. (2020) saw that it was less in those that completed one. When conflict was seen, experts categorized the root cause as intrapersonal and normal among health proxies or surrogates who were refusing to consent to the patient's wishes (Kramer & Boelk, 2015). Interpersonal conflict was popular between the patient, his or her family member, or the treating provider (Boelk & Kramer, 2012). Su et al. (2014) explained one phenomenon behind this kind of conflict was the appearance of a controlling, out of touch relative desiring to disregard their relative's EOL preferences out of guilt. In the absence of AD, conflict surfaced from withdrawing life-sustaining medical care and characteristically embodied the intergroup or intragroup type (Boelk & Kramer, 2012; Caulley, 2018). Kramer and Boelk's (2015) research acknowledged that either type happened when the medical team had difficulty accepting the patient's impending death (intragroup) or they had a disagreement over how to distribute care (intergroup). Thus, conflict from the lack of an advance directive or from the possession of one required further consideration.

Cultural Conflict with End-of-Life Issues

Certain articles mirrored how culture has impacted conflict during the execution of advance directives. Johnstone and Kanitsaki, (2009) perceived culture as a priority when observing forced assimilation of white Anglo-Saxon Protestant end-of-life beliefs on patients from other identity groups. The team asserted that the intrusiveness of Western cultural beliefs spawned intrapersonal conflict of values within these racial factions. Sudore et al. (2010) reinforced this notion. Her group magnified that end-of-life decisional uncertainty seen in the racial-ethnic groups. She claimed that it was due to poor health literacy ascribed by inadequate culturally sensitive materials.

The work by Su et al. (2014) exposed sibling rivalry as a prime source of cultural conflict in EOL matters among African Americans, Asians, and Hispanics. His work noted that conflict erupted when the exertion of EOL power was given to the eldest child rather than the sibling who had been more involved in their relative's care. Other culprits of cultural conflict observed among African Americans were from the inspiration of family members, spirituality, and religion (Sanders et al., 2019, LoPresti et al., 2019). Sander's study detected conflict when the planned EOL treatment contested the family's religious beliefs or their wishes. Another cultural interest among African Americans that was unearthed was trust, but Laury et al. (2019) refuted that it was not a real concern in their study. The thorough inspection on culture proved that it was a substantial factor in EOL conflict and activities around advance directives must integrate culturally sensitive materials.

Strategies in End-of-Life Conflict

The occurrence of conflict adds to the usual chaos of health care. Kroning (2014) commented that the KAESAD (Knowledge - Attitudinal - Experimental Survey on Advance Directives), a continuing educational credit course meant for nurses, irrefutably was insufficient to curb the massive need. Song et al. (2015) also tried with the SPIRIT (Sharing Patient's Illness Representations to Increase Trust) program to illustrate some improvement in patient's confidence in their EOL decisions. Besides that, facilitation was listed as a routine technique by hospital's ethics consultants (Core Competencies Task Force, 2011). Luce, J. (2010) projected that some EOL conflicts were well-suited for mediation. The renowned author, C. W. Moore, and his 2014 expansive work on mediation provided several strategies in mediation, but the pioneering efforts of Nancy Dubler and Carol Liebman (2011) on bioethics mediation would be most beneficial for end-of-life issues. They detailed cases where mediation would be an effective solution. Chiarchiaro et al. (2016) testified that palliative physicians may also resolve conflict if trained in effective communication and Hopeck and Harrison (2017) reported on the original model - the Five R's. They recounted end-of-life resolution through reframing, refocusing, referring, reconciling, and reflecting was doable. Whilst the above practices suggest viable work, these efforts further unmasked the role of conflict resolution. The paucity of conflict resolution skills training directed at patients, or the faith community merits a reasonable exploration.

Advance Directives Completion Rates

The 2015 *Death and Dying Report* denoted several factors why the underserved communities have been overlooked during end-of-life care. The report announced that a major contributor to the problem was a lack of resources to provide the general population with advance directives education. As a result, racial-ethnic groups were inadvertently affected. Some studies corroborated the 2015 institute's testimony whereas others demonstrated the underserved groups were less likely to have an AD in comparison to their white counterparts. The findings typically disclosed a small percentage for racial and ethnic groups (Morhaim & Pollack, 2013, Rao et al., 2014, C. Huang et al., 2016, Lopresti et al., 2016, Platts-Mills et al., 2017, and Rhodes et al., 2019). Regardless, advance directives used in the population at-large remain unknown, though it is suspected to be low. The Morhaim's team had assessed the rate to be at least one-third, nationally. Pfirstinger et al. (2017) mirrored a similar rate of 33 percent, but Yadav et al. (2017) and Rao et al. (2014) displayed an incidence of 24 to 26 percent, respectively. In the elderly, a higher rate of AD completion was seen among those who faced end-of-life care sooner or held a terminal diagnosis (Morhaim & Pollack, 2013). The estimated rate for elderly Caucasians lies between 70 to 72 percent with only sparse data on those in the underrepresented community (Silveira et al., 2014; Narang et al., 2015). The lower completion rate by racial ethnic groups accentuated the decision to focus on a population that had disparity with advance directives.

Advance Directives Implementation

Two broad groupings emerged from the systematic appraisal of EOL conflict due to AD implementation. They were human dynamics and external factors. Bergman et al. (2008) illustrated that conflict from the human dynamics were associated with either denial of the patient's expressed wishes by family members or physicians disagreeing among themselves on hospital care or prognosis. Other irregular conflicts were disputes between the relatives, the clinicians, or the patient's care team on the safest course of action (Boelk & Kramer, 2012; Caulley et al., 2018; Chin et al, 2019). The external factors were linked to communication patterns, logistics, suppressed emotions, the health system, physicians' compliance, and end-of-life literacy (Fried et al., 2017; Shields et al., 2014; Visser et al., 2014; Rhodes et al., 2019). Also, van der Smissen et al. (2020) learned that there is discordance between the patient's preferences and their received care due to understudied implementation barriers. Still, among these factors, logistics, physician's compliance, and end-of-life literacy held tangible issues that could be immediately solved. For instance, education was feasible with either logistics like an unclear advance directive, absent AD, or EOL literacy. The Volandes' group recommended education as a great resource in disenfranchised socioeconomic groups in their 2008 article, but only small strides were made since then. The creation of an advance directives education aimed at a specific population was a plausible solution to minimize the hurdles captured by researchers.

Community-Academic Partnerships as an Avenue for Change

Drahota et al. (2016) conceptualized that community-academic partnerships, CAP, incorporate community stakeholders and their academy affiliates in a collaborative function to accomplish an objective. The intent was that through collaborations, CAP would become indispensable at fostering change in community settings on matters of health and mental wellness (Noel et al., 2016). Drahota's team cited that this type of collaboration has been successful in some preventive health programs when CAP was the focal point of access to the targeted audience. As an entity, it contains influential gatekeepers, problem-solvers, and socially respected individuals who would be fundamental for any kind of anticipated change. However, change may require more than just strong partnerships. Fawley (2018) re-emphasized that lasting social change would require both leadership and community involvement since these issues span multiple societal levels. Change from Shapiro's perspective advised that one should add problem-framing, its method, knowledge on how the behavior is expected to change, and an evaluation of the intended outcome to build a framework for the desired transformation (2005). This framework may be linear, as in Kurt Lewin's three-stage model of change (Marcus, 2016) or as interactions flowing through open systems to make change inevitable (Kriesberg, 2015). Despite which premise of change is undertaken, CAP would be a path to fill the void in faith communities around end-of-life planning. This project attempted to do this by combining advance directives education with conflict management skills training to address the inequity seen in the underserved populations.

Faith-Based Organizations and Health Promotion

Health promotion done in concert with faith-based establishments is not new. According to Levin (2014), FBO's partnership in health promotions began decades ago, but its full potential has barely been utilized. Some researchers have placed a spotlight on its reliability for specialized populations like rural, low-income, racial, and ethnic populations (Newlin et al., 2012; Kwon et al., (2017). Wells et al. (2022) and Schoenberg and Swanson (2017) pointed out that faith leaders were often intertwined in the social lives of its members and advocated for FBOs as excellent health promotion partners. Hardison-Moody et al. (2011) announced that they have been instrumental as allies in improving health outcomes in the community. Meade et al. (2011) capitalized on FBO's significant role to promote their community-based participatory research to offset cancer disparities. Flood et al. (2015) inspired the development of a nutrition and physical activity program in faith communities. The program sustained positive outcomes for individual empowerment through education and behavioral change which were inclusive of family norms, change to policies in their FBOs, and in their local community. Public Health officials noticed an upward trend of academic partnerships with FBOs on other health issues and suspected that they would be great partners for SARS-COV-2 pandemic vaccine campaign. Their suspicion was correct as the uptake of the vaccine among skeptics was noticeable (Extension Foundation, 2023). Advance care planning education could follow this plan with a nuance to enrich underrepresented populations with conflict management skills, which are lagging with disproportionate ill-effects. This project prioritized the CADE intervention as an essential tool for end-of-life planning to curtail conflict.

Advance Directives Websites and Interventions

The national campaign for advance directives, National Healthcare Decisions Day (NHDD) began in 2008 and occurs annually on April 16. During NHDD, facilitators urge individuals to either document or have end-of-life conversations about the medical care they may want to receive when they can no longer speak for themselves. Even though the uptake of advance directives around the National Healthcare Decisions Day is fantastic, a systematized review of literature revealed a need for more community interventions. When the federal government mandated expansion of advance directives education, academe offered modern initiatives like dynamic websites and novel community programs. Websites that cater to advance directives education are not scarce and most provide forms for a Living Will, designated health care surrogate, health care proxy, or durable power of attorney for health care for free or at low cost. On the other hand, there are only a handful of community interventions which are discussed in the subsequent paragraphs.

Websites

There are four well-established websites that increase advance directives uptake or begin conversations about end-of-life. They are Death Over Dinner, Five Wishes, Prepare Your Care, and the Conversation Project. The Death Over Dinner evolved out a course at the University of Washington by Michael Hebb and Scott Macklin. They were intrigued and concerned that many Americans were not achieving their dying wish of natural death at home due to squandered opportunities to talk about it. They felt that speaking about such wishes over dinner could change those numbers. Consequently, since its inception in 2013, their program has tracked over 500 dinners globally and continues to climb (Death Over Dinner, n.d.).

Five Wishes is another popular website maintained by a private, non-profit organization, Aging with Dignity. The organization markets itself as the only advance care planning program in the United States (Five Wishes, n.d.). The founder, Jim Towey, was Mother Theresa's former legal counsel and worked alongside the sick and dying for several years. This work inspired his foundation where he led a 25-year effort to inform the public about the importance of protecting their last wishes. His non-profit entity boasts its widely available easy-to-read Five Wishes booklet. The booklet can be downloaded or provided digitally as a low-cost advance care planning document accepted by most U.S. health institutions (Five Wishes, n.d.).

Another ACP advocate, the Prepare Your Care program was developed in 2013 by Dr. Rebecca Sudore. Dr. Sudore is a licensed physician in Geriatrics and Palliative Medicine and a clinical researcher at the University of California at San Francisco. The Prepare Your Care program has a vetted survey as well as an online hub for patients and their families. Visitors to the website learn how to have better end-of-life conversations (PrepareForYourCare.org, n.d.). The website is one of few that houses culturally sensitive materials and can be personalized for free. It was originally devised as a public space, but recently, the program's validated tools were extended to health care organizations.

Finally, the Conversation Project was born out of a collaboration between the Institute for Healthcare Improvement (IHI) and a Pulitzer Prize writer, Ellen Goodman. The IHI is a non-profit organization that pledges to improve individual health and the healthcare system worldwide. Its main program, the Conversation Project, encourages everyone to talk about the care they want near the end of life before it is too late (Theconversationproject.org, 2023). Their studies found that early conversations make it easy for a person's wish to be respected by both family and medical providers. The IHI proudly brags about 1.8 million people accessing their website with over 600,000 conversation toolkits downloaded. The kits have three versions: Chinese, English, and Spanish, and it has been assessed from every U.S. state and in more than 160 countries (Theconversationproject.org, 2023).

Federal law directed health care organizations to provide education on advance care planning. Most institutions amassed copies of pamphlets from verifiable sources to meet this mandate, but a few of them went a step further. They sketched their own information or had links to their health department where a Living Will document or health care surrogate/proxy forms could be found. Even with that, a smaller number placed documents on specialized websites like the ones described earlier. All these online initiatives were contemplated during the design of the CADE intervention and the Prepare Your Care program was chosen. The website was straightforward and hosted culturally appropriate, multilingual materials, and a validated Advance Care Planning Engagement survey.

Interventions

In 2014, Houben et al. summarized 56 randomized control trials between 1966 and 2013 and Weathers et al. (2016) located nine trials that gave attention to advance directives completion, communication during end-of-life, and the interventions that accompanied them. Their work confirmed that these interventions increased ADs uptake and EOL discussions. There were about a dozen more interventions since Houben's and Weathers' efforts and several of them had a bonus component. They supplemented the interventions with a facilitator who was either a lay person or a medical professional. Some of this evidence warranted a more in-depth look, so a synopsis of the interventions has been provided. Outcomes that displayed nurses, physicians, health care proxies or surrogates, lay persons, and case managers were highlighted.

There was a mixed report when medical professionals, proxies, surrogates, or case managers were used as facilitators during an intervention. Chan et al. (2018) reported that nurse facilitators decreased decisional conflict, had more congruence with the patient's EOL preferences, and boosted an above average AD completion rate. Another team of researchers utilized Emergency Room providers to conduct a brief negotiated interview to increase ACP engagement among chronically ill older adults (Pajka et al., 2021). Their technique increased engagement with the immediate uploading of the electronic health care proxy form, an act that was uncommon. In contrast, Sinclair et al. (2020) agreed that their nurse-led interventions can enhance EOL conversations, but patients' satisfaction and their quality of life was unaffected. Then, the use of case managers as an alternative was thought to be an innovative approach. Despite this, Detering et al. (2017) established that Australian case managers did not recover a high percentage of advance directives completion. In fact, for patients who did finish one, their AD was of mediocre quality.

For proxies and surrogates, Bravo et al. (2016) applied proxies to figure out if they could predict their loved one's wishes. The team motivated older adults to finalize their advance directives and compared them to their proxies. There was a higher rate of completed ADs, but the intervention failed to show that their proxies' predictions were correct. The team emphasized that conversations with proxies were compulsory for adequate assurance that their wishes were heard. Another study explained that surrogates in the intervention acted as a barrier to ACP. Fried et al. (2017) noted this hurdle when they instigated advance care planning for veterans and their surrogates. Their qualitative endeavor recognized that the value differences between the two triggered conflict and their surrogates' exhibited signs that they were not ready to assume the responsibilities that were placed on them. One article was surprising. When Aasmul et al. (2018) conducted a Train-the-Trainer program at a nursing home, their AD documentation went up by 62%, but the nursing staff complained about time constraints and their lack of competence to continue. These articles determined that the involvement of health professionals can have superb rates of AD completion, but time limitations are a drawback if the program is to be sustained. This opened the door for interventions to use alternatives like non-providers as educators.

A review of articles substantiated decent outcomes when integrating lay persons as navigators (Fink et al., 2020), volunteer health workers (Patel et al., 2020), and hospice volunteers (Candrian et al., 2020) within interventions. For example, Fink's team paired patients with bilingual navigators when the ACP education was co-facilitated with a nurse or a physician. Patel's intervention used LEAPS (Lay health worker Educates Engages and Activates Patients to Share). The team allowed lay health workers to engage and inspire patients to share their advance care planning experience upon diagnosis with cancer. It was a trial that proved feasibility for the low-income groups. Similarly, Candrian et al. created an impressive intervention with the RELATE model of communication (Rapport, Explore, Listen, Adapt, Tailor, and Empower) with hospice volunteers. The model exemplified an "ideal interaction to encourage connection, understanding, and space to be heard and understood before decision-making" (Candrian et al., 2020, p. 4). The volunteers gained ACP certification after their communication skills were evaluated. These types of interventions determined that with ingenuity, the possibility for community engagement in ACP was attainable.

Two kinds of ACP interventions were depicted in the review of substitute approaches. First, Kang et al. (2020) wrote about a non-provider intervention. They recruited from the general population and taught advance care planning and palliative care via video. Their efforts were terrific as the intent to document rose to 68% when matched with the institution's simple

ACP handouts. The second article described a scan of ACP web-based programs. Their group saw ACP programs with one or more of these components: responsive AD documentation, improved conversations between family and health professionals, and/or expanded knowledge of ACP (van der Smissen et al., 2020). The literature was filled with other outstanding ACP trials. The purpose of drawing attention to these was to emphasize what was lacking and to integrate desirable elements that would serve as the cornerstone for CADE.

Bazargan & Bazargan-Hejazi's, (2021) scoping review yielded another collection of themed interventions that were multidisciplinary, multilevel, multi-faceted, community-based, and culturally sensitive in nature. Their results were few and hinted at the need for both national and community programs. Roth et al. (2020) talked about the achievement of their quality improvement program. Their urban community hospital had a racially and ethnically diverse patient load and the highpoint of their intervention was 60% AD completion, 9% health care proxy selection, and a 3% rise in their Do-Not-Resuscitate orders. Their strides verified Schichtel's et al. (2020) testimony. The team designated that the ACP process can be perfected if it involved: (a) patient satisfaction; (b) maintained quality of life; (c) endorsed end-of-life communication; (d) held regular follow-up with family; (e) considered ethnic diversity; and (f) embraced knowledge of disease. The literature announced that an intervention with all six parts has been elusive, but there was one notable attempt in Florida – the Art of Goodbye series.

This short-lived community, educational series held four of six pieces and was compiled by a University of Florida Extension agent. The series covered five lessons on end-of-life talks, self-reflection, Medicare, health concerns, and communication (Smith & Spence, 2016). The impact of the series was not well-documented, so its outlook in the community never materialized. The CADE intervention adapted five of the key areas and mixed in three conflict resolution management skills. The education portion covered an overview of advance directives and the importance of end-of-life conversations. The second half dealt with conflict management basics like listening and self-reflection. These skillsets, plus a lesson on the effects of conflict at the end-of-life, forged a creative and succinct product that was specifically constructed for underserved faith audiences.

Decisional Conflict

Health care decision-making was revamped over the decades to what is now known as shared decision-making, a model where there is more patient involvement in informed consent and shared decisions. Previously, physicians unilaterally made decisions on treatment, provided their recommendations, then expected the patients to assent. Now, with the requirement of informed consent and shared decision-making, patients participate in the choices about their treatment options, the risks, and benefits, that tolerably adhere to their personal preferences (Garvelink et al., 2019a). Informed consent and shared decision-making are fundamental units because health care decisions can be complex and may produce decisional conflict. Decisional conflict can be inherent and results when there is a state of uncertainty over treatment choices, its risks, regrets, losses, or incompatibility with personal values (O'Connor, 2010). Other manifestations include distress or concern over undesired outcomes, indecisiveness, physical stress, and decision delays (O'Conner et al., 2003). The main reason for this matter is that unresolved decisional uncertainty impedes timely, informed conversations and implementation of care (Garvelink et al., 2019a), leading to a cyclic phenomenon of unmet decisional needs. When symptoms manifest repeatedly from such decisional snags, patient decision support aids, clinical counseling, and physicians' treatment dyads can be used to communicate with providers. There was no specific tool to measure the extent of decisional conflict, so the decisional conflict scale was created to fulfill this function.

Janis and Mann began the decisional conflict construct in 1977, which was later refined by the North American Nursing Diagnosis Association in 1992. The authors and the nursing group denoted that individuals typically face uncertainty when the treatment options have unknown risks or outcomes. According to O'Conner (2010), patients were vulnerable to uncertainty when: (1) there were high-stakes choices like life or death; (2) personal value tradeoffs over a course of action; and (3) regret is anticipated from rejection of a positive treatment regimen. Likewise, uncertainty leads to clinically significant decisional conflict. Thompson et al. (2016) deciphered that clinically significant decisional conflict has a positive association with decisional delay. It produces regret and increases the chances of a legal suit for treatment harms. His research concluded that decisional conflict was modifiable with decision support tools. These tools provide clear treatment options, knowledge of potential risks and benefits, and resources to support decisions based on personal values.

Annette M. O'Connor, designer of the decisional conflict scale, measured decisional conflict in a clinical setting and published her findings in 1995. The report illustrated how uncertainty impacts health care decision-making, the factors contributing to it, and the perceived effects of such decisions. Sun (2006) verified O'Connor's work and implied that high decisional conflict not only causes decision delay, but it also forces discontinuation of a selected option which leads to decisional regret. Garvelink et al.'s (2019a and 2019b) scoping review underscored other ways in which the decisional conflict scale was useful. The team demarcated two decades of utilization in Primary and Cancer Care, Obstetrics and Gynecology, and Gerontology as a decision support intervention. Yet, despite many types of decision tools, it was not paired with the advance care planning engagement. The CADE research sought to capitalize on this deficit and retained DCS as a reliable instrument for this project and a sample is listed in the supplementary resources.

Advance Care Planning Engagement

The advance care planning process shapes the conversations that a patient may have with family, friends, and health providers about their future care near the end-of-life. If ACP is completed, it can soften the dying process. Van Dyck et al. (2021) echoed that some researchers noted that ACP can reduce decisional conflict and improve bereavement outcomes of caregivers. The Center for Medicare and Medicaid Services recognized this value and made it a reimbursable medical visit. ACP is voluntary and if patients decide to speak about their wishes during their health visit, physicians could engage in EOL discussions and be reimbursed for their time. Moreover, the concern is that most patients require inspiration to begin such conversations or seek out an advance care plan. If they do, they can forge a path where they can be guardians of their own mortality.

Shanley and Wall (2004) stressed that the ACP process is an engagement in communication whilst Sudore et al. (2013) extended it as a set of ongoing discrete behaviors.

The advance care planning behavior held two core components – knowing one’s personal value during health or illness and sharing it with relatives and/or providers. Sudore and her team sought to illuminate this behavioral change process with a standardized survey. The survey answered engagement questions on who, what, and where, and divided it into two subdivisions – behavioral domains and action measures. The behavioral portion characterized the Behavior Change Theory with four factors: Knowledge, Contemplation, Self-efficacy, and Readiness. Knowledge highlighted familiarity on how to choose care. The Contemplation variable divulged thoughts on how to ask for EOL care and Self-efficacy publicized one’s confidence in asking for that care. Readiness marked how eager a person might be to make a change to document such a request.

The other section dealt with four ACP action measures: (1) Decision Maker; (2) Quality of Life; (3) Flexibility, and (4) Ask Provider. A Decision Maker is an individual responsible for making health care decisions. Quality of Life refers to personal values on how one wishes to spend his or her end-of-life. Flexibility, as the name dictates, gives permission to the decision maker to alter original health decisions and the last action measure, Ask Provider, lends the participant the ability to freely inquire from clinicians any concern over an EOL decision. Within each action measure, there are one to three subfactors: (1) Talk to Decision Maker; (2) Talk to Doctor; and (3) Sign Official Paper. The subfactors function as an assessment to pinpoint a precise issue to focus on during the engagement process. The Self-Efficacy behavior domain has three subfactors, one in the Quality of Life and two in the Flexibility. The Readiness domain holds seven subfactors, where there are at least two in three action measures and one in the fourth. The survey organized the sub-variables in a way that each ACP behavior domain, Self-Efficacy and Readiness, is paired with one of four of the action measures.

Stevens et al. (2023) described how the domains and action measures assessed patient's ACPE Self-Efficacy and Readiness levels in a primary care practice in Belgium. They noticed that providing information alone (Self-Efficacy) was not associated with change. When the measurement of the Readiness variable was included, the outcome was better. They illuminated that together, the ACPE variables can boost a distinct behavior. Sudore's team pursued the idea to encourage change. They would seek questions that made the participants think about a behavior, then inspire them to document their decision.

Theoretical Foundation

Three contexts were deemed useful for examining end-of-life conflict and the planned research. Their combination made them an exceptional platform to display the various elements, their intersections, and their role in EOL conflict. The theories were general systems theory (GST), value theory, and Lederach's model of conflict transformation. The first two theories covered conflict perspectives surrounding concerns with end-of-life. The latter endorsed the essence of the intended methodology. The given theories were not exhaustive and portrayed a splinter of this complex topic, but they were relevant and prudent.

General Systems Theory

Holism was coined by Jan Smuts and permeates throughout the practice of medicine. Holism is a notion that a system does not depend on the constituents themselves, but on the whole entity and their interconnectedness (Mele et al., 2010). The general system theory operates under a holistic phenomenon and uses the elements of space, time, setting, purpose, and structure to clarify its function. Two prominent theorists, Ludwig von Bertalanffy and Ross Ashby, perpetrated this phenomenon further. Bertalanffy (1968) purported that wholeness, and the distinct parts can be seen in a bounded system to which it is either open, closed, or isolated. Open systems have interconnections within and outside its boundaries, closed systems exchange from within, and the isolated system lacks the ability to interchange at all (Mele et al., (2010). Heylighen and Joslyn (1992) believed that these system interactions strengthen the elements' interdependence and make the holistic view more potent.

Ross Ashby expounded general system theory by introducing Cybernetics. Cybernetics rationalizes the flow of communication within a system. Conant (1981) proposed that communication is more than a set of terminology. Cybernetics takes this communication and unites interdisciplinary approaches through fostering of a shared language. Through this shared response, communication of complex issues can be simplified and controlled. Then, it can be strategized to a reasonable, generalizable, reputable, and transferable message (Ashby, 1956). Together, general system theory and Cybernetics breakdown communication within our socioeconomic and biopsychosocial systems of which, end-of-life is intricately entangled.

The conflict system of end-of-life can be unwrapped by general system theory where its units' interdependence resembles Newton's third law of motion – for every action, there is an equal and opposite reaction. This means that the elements in the end-of-life system adapt to minimize the damage when one of its units fails. For instance, when a patient meets with the physician to discuss end-of-life care but does not document his or her preferred wishes on an advance directive, this will produce a break in the communication when the patient is admitted to hospital. To restore balance in the system, the physician documents the visit in the hospital's electronic health record to acquire some of the information previously lost. Other components in the end-of-life system, like health surrogate or proxy, hospice, health care team, hospital policy, state law, and public education can be dysfunctional. General system theory and Cybernetics can exemplify how these system disruptions can maintain their homeostasis between the relationships and communication interactions.

Value Theory

The definition of value is not universal. In fact, there are differing characteristics of value. Hirose and Olson (2015) likened value axiology as a "look at which things are good or bad, how good or bad they are, and what is it for a thing to be good or bad" (p. 1). Matar et al. (2019) believed that value is built on intrinsic and extrinsic motivations. Intrinsic motivations govern inherent beliefs like freedom, health, or love whereas extrinsic, cover motivations that are linked to something external or is dependent on the intrinsic value (Harold, 2005). Value itself, can be unpacked from the intersection of two branches of ethics: metaethics and normative ethics (Schroeder, 2021). Metaethics sees value with an economic narrative and as an evaluative piece. The economic side puts value on a scale of good or bad and the evaluative unit depicts what makes value good or bad (Hirose & Olson, 2015). In contrast, Moseley (2016) equates normative ethics as theoretical questioning of actions of what should be considered good or bad.

Both types of ethics adequately recognize the implications of value, but there is also a conflict resolution assertion. Blomberg et al. (2019) implied that some conflict of values may arise from either extrinsic or intrinsic motivation produced by the perception that a professional task may contradict another colleague's mission. These conflicts in values can be irreconcilable and can bring about noticeably negative human behaviors. Shonk (2020) encouraged dispute resolution specialists to steer the parties towards mutual respect of other's values. Without this respect, defensiveness, alienation, and distrust will be disastrous for a professional relationship. Hence, the overlapping features of value by both disciplines proved the discourse from the field of conflict resolution brings a complementary advantage to the problem.

Moral philosophers coalesce on the viewpoint that value theory sets aside one's own character to address what is good, not good, and why it is good (Harold 2005). Immanuel Kant, a German philosopher, and the father of the deontology stated that the intent of our moral acts should have more weight than the consequences themselves (Barrow & Khandhar, 2020). Misselbrook (2013) agreed with Kant's view and submitted that our morality should also permeate our duties. Nevertheless, in the US health care system, professional duties have often superseded feelings or morality (Ingraham & Parker, 2010). This unspoken act signified the prevalence of utilitarianism that Jeremy Bentham embraced. Crimmins (2021) conveyed that this philosophical assumption judges on consequences alone and perpetuates that an action is morally right if it is done for the greater good or leads to a positive outcome.

Value theory then becomes evident when provider duties collide with patients' values. This can be seen when a patient has an ethical right to decline, withhold or withdraw life-sustaining treatment at will (Moseley, 2016). Conversely, deontology calls physicians to make every effort to save a life over their own emotions. Their utilitarian counterpart spurs on such actions for the greater good even if it is against the patient's wishes. These principles wreak havoc on physicians internally and may delay treatment decisions without bioethics consultation. Therefore, a simple request to withhold or withdraw treatment can initiate end-of-life conflict over a clash of personal values. The tenets of Kant and Bentham reflect this type of conflict and value theory explains how it can arise.

Lederach's Model of Conflict Transformation

The term, conflict transformation, Lederach (2003) described as a lens and an approach. He insinuated that when social conflict exists, having conflict transformation as a lens may assist in grasping, framing, and sharpening the focus of the issue. As a model for approaching conflict, it encourages mutual respect to help parties to resolve their own conflict. Both have a sense of empowerment and the potential for short and long-term constructive change (Lederach, 2003). Furthermore, in Lederach's view, transformational change is linear and circular. He perceived a linear transformation can occur in a straight line like cause-and-effect reactions. The circular pattern is typical when an individual tries to navigate through each segment of social conflict to bring about their desired change.

The Bush and Folger partnership and Mark Chupp have unique positions on conflict transformation. Bush and Folger were convinced that at the core of our identity lies the capacity to understand and the freedom to be self-determined (2010). They listed four grounds for the transformation process: (1) the need to be connected and motivated by their morality; (2) desire to maintain autonomy and personal connections; (3) self-fulfillment and compassion; and (4) frame and reframe conversations between parties for equitable considerations (Paranica et al., 2013). Chupp (1993) saw conflict transformation as a circular and spiritual process with constructive exchanges to bring about relational and/or structural changes. He insisted it has seven stimuli that follow the path of: (a) coming together; (b) commitment and trust; (c) listening; (d) vulnerability; (e) empathy; (f) dialogue; and (g) restoration. Coming together entailed the disputants overcoming fear and personal distrust to retain their relationship. Commitment keeps the trust going to allow listening, vulnerability, and empathy, producing feelings of validation. When these attributes are reciprocated, restoration begins, and a true dialogue yields a win-win resolution.

The Bush and Folger team and Chupp's revelations were applicable to end-of-life conflict and the faith community. Bush and Folger's transformation route is a practice of autonomy that is governed by morality and the ability to reframe during a conflict. Lederach's cyclic model of change, Figure 3C, is a good case to illustrate that point. As things move forward, a wall (conflict) stops the process. There is self-regulation (autonomy and morality) before movement begins again. If transformation is missing, the process goes backward, but if the problem is reframed, the cycle continues. Conflict during end-of-life can stall care. If transformational change (often delivered by Ethics Consultants) is present, medical decision-making moves forward, but, if not, the repercussions can be costly.

Chupp's description of a cyclical spiritual process resembles the foundation of some churches. Faith communities often come together for spiritual transformation. The transformation may be voluntary like in a congregational revival or from trauma. Trauma transformation may be apparent when unresolved internal disputes fracture the faith in leadership. The transformation process then offers commitment, trust, vulnerability, listening, empathy, dialogue, and restoration which are necessary to preserve their ongoing relationships. If there is a disruption within their enclosed church system, subsequently each cyclic transformative feature would work to restore equilibrium in their community.

Chapter Summary

The quest to unearth themes of end-of-life conflict did not unleash many articles. Instead, the scarcity of literature forced an in-depth look at advance directives. A plethora of evidence on ADs narrowed themes to documentation rates, strategies to evoke completion, implementation, cultural competency, AD websites, and interventions. A deeper dive supported a role for community academic partnerships and faith-based organizations. Community academic partnerships and FBOs were elemental for carving access to the underserved population on health topics. Although there were two websites with vetted resources, the Prepare Your Care website was picked for the community intervention, and the activities of a few of the community program's elements would foster an inventive project. This review also discovered that the field of conflict resolution could contribute to what was missing by developing a community workshop that battles conflict and disparity in EOL education. CAP and the FBOs leaders provided active access to their network and the two valid surveys, DCS and ACPE, explored the participant's decisional conflict and behavioral change. The intervention brought a hearty collaboration between disciplines and a snapshot appraisal of its effectiveness.

Chapter 3: Research Method

The literature captured the frequency of conflict at the end-of-life and a deficiency of advance directives education among the underserved. This research aimed to combine conflict resolution training with advance directives education to measure change in behavior. The community academic partnerships would reach the at-risk populations and provide the connections for this plan. The intense probing demanded that the project's journey force change rather than be one simply describing a need for change. Creswell (2013) recommended that the subject matter propels the technique. This implied that the right approach should be based on the topic's conceptual framing.

Shapiro's 2005 work added that the plan should include reasonable, testable, and attainable mechanisms. She depicted a reasonable intervention as one that produced the preferred effects and a testable methodology that would certify the wanted outcomes. The attainable aspects of the intervention embraced the technical attributes like gatekeepers, time constraints, and finances. Shapiro's mechanisms were deemed necessary for this research and were explained throughout the five major sections. The first segment defended the research's design and the second, justified the reason for the type of quantitative inquiry. Section three uncovered the procedures related to the study's population, sampling procedures such as recruitment, data collection, and hypothesis testing. The heading, Instrumentation and Operationalization Constructs exploited the variables' origination and how they were used in the computation. The last part of this chapter deliberated on the statistical analysis and argued for the perceived assumptions, threats to validity, and ethical considerations.

Research Design and Rationale

The research's objective was to enact individual behavior changes around conflict and advance directives. The spirit behind this goal led to hypothesis development from a postpositivist epistemology. Positivism or scientific method has a rational, realistic philosophy that enables the researcher to assess theories or observations that may generate an effect or outcome (Mackenzie & Knipe, 2006). They suggest that the positivist aligns well with the quantitative world. Nonetheless, this world is as intuitive, holistic, exploratory, and inductive as the qualitative method. Hypothesis testing marks the quantitative approach, and the Experimental technique is a better choice over other quantitative subtypes – Survey, Descriptive, Correlational and Causal-Comparative (Pedamkar 2020).

Survey research describes group characteristics and Descriptive secures and interprets the variables status. Both miss when change would occur. Correlational and Causal-Comparative evaluate relationships between groups of variables where Correlational tries to establish a pattern and Causal-Comparative applies the laws of cause and effect (Pedamkar, 2020). Comparative and Correlational can produce pertinent information, yet they cannot accomplish the desired outcome from the projected hypothesis. Frey (2016) suggested that the Experiment method is a popular strategy for group comparisons and does not sacrifice scientific theory. The hypotheses for this research illuminated resources essential for participants in an intervention. The resources were minimal but human capacity and time were constricted, which led to the development of two safeguards, a simplified recruitment process and a workshop intervention. The recruitment plan and the chosen intervention were appraised in the subsequent sections.

Workshop as a Community Health Intervention

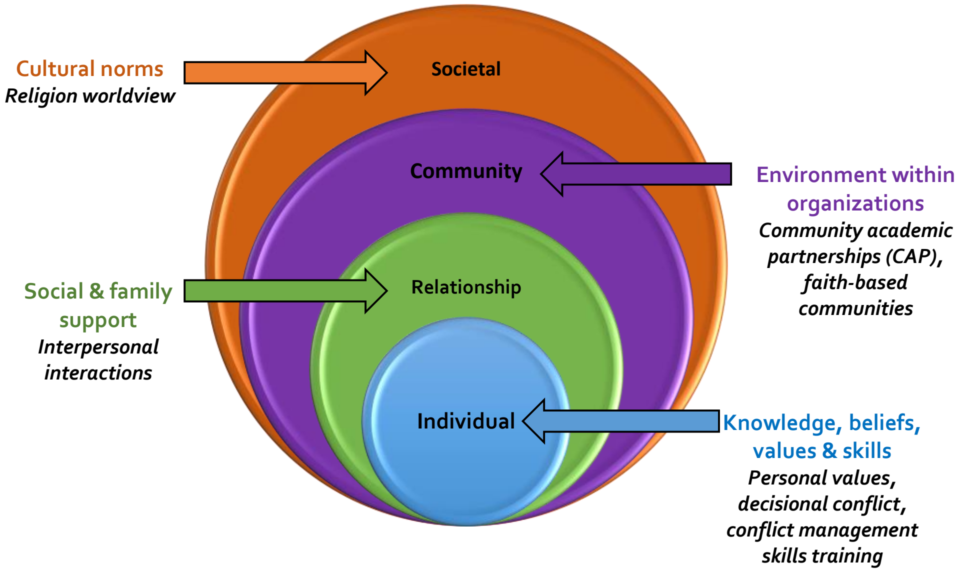
According to McLeroy et al. (2003), community interventions began decades ago, and their review of such interventions concluded that they were effective at health promotion. One nationally recognized community health intervention, Diabetes Prevention Program (DPP), reduced the risks of complications from Type 2 diabetes nationwide through its curriculum (Centers for Disease Control and Prevention [CDC], 2021). Fawcett and Nady (2021) admitted that programs like DPP studied individual behaviors and made the required environmental changes to encourage the person's behavioral decisions long-term. They believed that when a handy intervention was precise and systematic, it was easy to stimulate learning about an issue especially if it improved the general health of the residents. Additionally, workshops were part of the DPP's success. Organizers of DPP held training workshops for health promotion specialists to take to their communities. Warner et al. (2021) documented that such workshops were efficient at achieving their maximum potential in each population, including interdisciplinary work like conflict resolution. Workshops provide firsthand skills, introduce new material, and require only a smaller number of participants at a time ("Conducting a Workshop," 2021). This solidified that a workshop was a compatible educational intervention and the name, CADE (conflict and advance directives education), made its purpose distinguishable. A workshop with a quantitative design may function within a given model. McLeroy et al. (2003)

recalled that the social ecological model (SEM) has a framework that allows for interactions at diverse levels of an environment. A workshop like CADE fell within one or more of them.

Social ecological model. Center for Disease Control and Prevention (2022) accounted for the four phases of the social ecological model (SEM): individual, relationship, community, and societal. The CADE intervention applied SEM and is represented by the diagram in Figure 4. The first level has interconnected factors like age, education, values, and income, which categorize the individual stage. The intervention used factors at this level to scan for decisional conflict and readiness for advanced care planning engagement. The ability to foster conflict management skills is another activity at this phase. The second stage engulfs the individual to form the family and social unit. Planning for end-of-life care requires interpersonal interactions located in this relationship level. The third phase embraces the community where the environment and organizations intermix. Community academic partnerships, faith leaders, hospitals and/or academic centers are found in this phase of the model. The invention relies on referrals from this stage which have an intersection with the societal level. This top level holds the religious worldview from the cultural norms of a society and the community. Thus, the conflict and advance directives education workshop works mostly at the individual, relationship, and community phases. McLeroy et al. (2003) resolved that with the multifaceted nature of change, the ecological levels in the social context of individual behavior must be considered. They judged behavior to be an accrual of knowledge, attitudes, values, and as a product of our societal powers. As such, it was extremely sensible to measure behavior collectively with its factors.

Figure 4.

Social Ecological Model adapted for the CADE Research



Note: Adapted from *The Social Ecological Model: A Framework for Prevention (CDC.gov)*

CADE workshop intervention. The Conflict and Advance Directive Education workshop had three parts: Overview of conflict and end-of-life, overview of advance directives, and a session on conflict management skills as depicted in the workshop agenda outlined in Appendix E. The first session introduced conflict's terms, the participant's conflict style assessment, and conflict relevant to end-of-life issues such as miscommunication, health literacy, and treatment values. Knowing the reasons for EOL conflict helps to deter miscommunications between families, providers, and with hospital policies. If the medical team does not invest in shared-decision making, then low health literacy can sometimes be a problem. Last of all, conflict over treatment values can be tough. A family's religious beliefs or physicians themselves may find it hard to deal with a specific treatment request, especially when the treatment requested is not justified. All these reflect some of the content that came from either the Fall 2019 faith community conflict management workshop or from the literature.

The second part of the workshop covered advance directives terminology and end-of-life decision-making. The overall purpose was to explain each term, the associated advance directive form, and examples of vetted websites that featured them. The eight terms discussed were: (1) Do-Not-Resuscitate (DNR) orders; (2) life support; (3) ventilator; (4) cardiopulmonary resuscitation; (5) health care proxy; (6) health care surrogate; (7) Living Will; and (8) video directives. Once the terms were completed, the participants were given a value worksheet to figure out what matters most near the end-of-life. The worksheet would substantiate their beliefs and prepare them for imminent decisions. Due to time-limits and the complexity of end-of-life, only introductory information was presented to foster their health literacy.

The last section focused on conflict management skills. The three main skill builders taught were self-reflection, active listening, and the AEIOU (Acknowledge, Express, Identify, Outcome, Understanding) technique by Jerry Wisinski. The designated skill builders were preferred for their simplicity and their intersection with the discussed frequent causes of EOL conflict. The self-reflection and listening practices were adapted from Dr. Neil Katz, a training expert in conflict management. The self-reflection exercise granted introspection and demanded that individuals own their feelings for personal growth (Katz et al., 2011). Success in this part allowed them to consider what values were important for their end-of-life wishes. Listening, although unusual for this type of workshop, would be an important skill for the participants. Katz et al. 2011 framed it as an act that can occur concurrently with a person's expressed thoughts while comprehending their viewpoint. Stevens et al. (2023) cited it as a factor that changed ACP preparedness. Together, they solidified that any improvement to the attendees' listening skills would be handy for future miscommunications. Whilst CADE was designed for a virtual audience, the third activity needed to be brief, memorable, and interactive and the AEIOU technique fulfilled those functions. Wisinski 1993 stated this technique was effective at managing differences through the positive intentionality concept integrated with a collaborative, win-win outcome. He surmised that positive intentionality meant the other party had good intentions and did not want to cause a conflict. With that assumption, the party's issue becomes manageable, and conflict thwarted. The three conflict management exercises guaranteed that the participants would walk away from the workshop with at least one impressive skill.

The intervention's plan held that one facilitator led the activities if the cohort contained less than eight participants. If there were eight or more in attendance, the contingency plan included a co-facilitator. Facilitators were either specialists in conflict resolution or bioethics and were provided with a workshop guide to minimize variability. The virtual intervention lasted three hours with two breaks of five to ten minutes each on Zoom software. Workshop participants and non-attendees received their assigned surveys according to their communication preference and administered online. The control group's survey was delivered within three days post-randomization. For those in the intervention, Sudore et al. (2017) mentioned that the ACPE survey had proven efficiency at one or more weeks post-intervention.

Parayre et al. (2014), Chiarchiaro et al. (2015), and Jeon et al. (2018) established that true translation of behavioral change was best seen after 6 months after an intervention, but time was a restriction. Hence, the intervention group was sent the survey within one-week post-intervention for this experimental methodology.

Quantitative Methodology

Quantitative or experimental methodology has a scientific connotation and refers to the manipulation of variables and their measured effect on each other (Bevans, 2019). There are three main facets of experimental research: pre-, quasi-, and true-experimental. All calculate observed changes caused by either a dependent or independent variable, but the main distinction is the presence or absence of a control group ("Experimental Research Design," 2021). The pre-experimental records the observed outcome and does not have a control (Pedamkar, 2020). The quasi and the true experimental types are differentiated by sample randomization. Both have control groups although for the latter, there is random assignment to the treatment group. In addition, true-experimental research has three subgroups: posttest, pretest-posttest, and the four-group design. The posttest typically has its statistical evaluation done following the intervention and looks for change between the treatment and the control. The pretest-posttest scheme inspects for change in each group before and after an intervention. One group receives the actual intervention, and the other is given a placebo. The last subgroup utilizes four groups where two of them use the posttest method and two operate under the pretest-posttest design ("Experimental Research Design," 2021). This research chose the true-experimental strategy because a group comparison study was highly influential. CADE would occur in small groups because literature supported its efficiency among ethnic classes (Lum, 2016). Small groups are known to stimulate vulnerability if done in a warm atmosphere to encourage connections (Shapiro, 2005). The four subtypes have a place, but the posttest modality as shown in Figure 5E was a better fit for the intervention since it shortened the time for the workshop attendees and lightened the analysis burden for the researcher. The rest of the quantitative approach steered the rationale for a suitable population, recruitment and sampling procedures, and statistical analysis in the next segments.

Study Population

In this prolific investigation, it became evident that a disparity in advance directives education exists among racial-ethnic minorities. Song et al. (2016) corroborated that there have been only a few end-of-life interventions dedicated to people of color. This research would join this exclusive group and present a novel choice of community-academic partnership to address the problem. Leaders within faith-based organizations who have lived or worked in Florida and held an existing relationship as an academic partner with the University of Florida represented the community in CAP (Figure 6F). The key players for the academic side were those who were either trained in bioethics, conflict resolution, or dealt with end-of-life issues. Some were physicians, healthcare ethics consultants, clinical social workers, or hospital chaplains. The network between these two communities held the door for the study's population. The research would permit residents of Florida who self-identify as members of one of the racial-ethnic groups defined by the Office of Management and Budget which were: American Indian or Alaska Native, Asian, Black, or African American, Native Hawaiian or Pacific Islander, or members of

Latino or Hispanic ethnicity (National Institute on Minority Health and Health Disparities, 2022). Correspondingly, the age of the population made a difference since the literature demonstrated that ADs were more prevalent in adults older than six decades (Rao et al., 2014; Silveira et al., 2014) and less in the younger adults (Kim et al., 2019). Therefore, the recruitment process prioritized anyone under the age of 65.

Recruitment and Participation Procedures

The research embarked on summarizing personal change within faith communities and relied heavily on CAP members within its network for recruitment. Faith leaders who had at least 25 percent racial-ethnic congregants or had programs that served that population were invited first. Academic partners and faculty were then tapped to meet the rest of the recruitment quota. Most advertised the research through the distribution of flyers, word-of-mouth, phone calls, text, and social media. When those efforts did not produce enough participants, the next step stipulated face-to-face recruitment at church functions in the Gainesville and Orlando area. Anyone interested in participating was expected to meet the eligibility criteria before the research details were provided. The three criteria were:

a. Age 18 years and older.
b. Did not have a Living Will or an advance directive document.
c. Identified with a faith or church community.

When individuals met the above criteria, they were moved to the informed consent procedure. If they agreed to participate, they took a brief online or paper version questionnaire and had their contact information (name, phone, and email) placed in a secure database. The participants in the database were assigned to workshop or control and those selected for the workshop, were given predetermined workshop dates to create a cohort. Each cohort contained participants with the same date availability.

There were additional research participatory instructions. For the workshop attendees, they had the freedom to leave or refuse any question that made them feel uncomfortable during CADE, but their attendance was mandatory if they wanted the $20 e-gift card. They were also given an optional, feedback anonymous 18-question survey of their experience with the intervention. The last procedure expected from all research participants was the completion of the DCS and ACPE surveys that were combined in an online platform. Those in the workshop got their links post-intervention and the control group received theirs through email or text within three days after randomization. No other research activities were expected of them following the completion of this main survey.

Sampling Procedures

The project's aim was to recruit from faith communities within the state of Florida. The 2019 U.S. Census Bureau estimated the population of Florida to be 21,477,737 million with 47 percent (approximately ten million) holding ethnic or racial ties. BestPlaces.net projected that 39.7 percent of Floridians have a religious affiliation, which generated an educated guess of eight million. However, the actual number of individuals in a faith community who self-identify in a racial-ethnic group was unknown, so the sample size was drawn from known parameters derived from the literature. The parameters were population size, prevalence, sampling error, and significance level (Martinez-Mesa et al., 2014). The units were: (1) population unknown (∞);

(2) estimated prevalence of 50 percent; (3) five percent sampling error; and (4) 95 percent confidence interval with an alpha level of .05. All were consistent with Martinez et al. (2014) and Martinez-Mesa et al. (2016) as examples of how to apply the standard parameters.

A comparison of similar methodologies recommended a sample size with 80 percent power and a medium range .5 to .79 effect size. This range was decent because of the target population, the type of intervention, and the validated surveys used. The 2020 Benchmark Six Sigma sample size calculator performed the power analysis at 80 percent which yielded a minimum of 48 participants from estimate proportions of 35 and 65. Those estimates represented the general population of those with and without an AD, respectively (Rao et al., 2014). A sample size manual formula was instituted to account for data loss from unanticipated and expected events like withdrawals and follow-up mishaps. Faber & Fonseca (2014) insisted on a higher sample size since inadequate samples may be disastrous for both the researcher and participants. Utilizing the formula, an extra 12 samples brought the total to 64. This range, 48 to 64, resembled other thresholds for community interventions and would suffice to detect the effectiveness of CADE (Martinez et al., 2014; Lum et al., 2016; Fink et al., 2020).

The fact that people of color were less likely to possess an AD made it crucial to reach this population via a prudent strategy. Faith leaders who had a relationship with the University of Florida increased the exposure to this at-risk group through their statewide networks which held sufficient individuals to draw an adequate sample for randomization. Martinez et al. (2016) and Thomas (2020) reported that simple random sampling was a strong probabilistic method to safeguard uniform selections and it can secure lofty internal and external validity to minimize the effects of confounding variables. The other randomization styles – stratified, cluster, and block – were too elaborate to achieve the study's objective. Stratified designated variables that should be taken after the surveys and cluster entailed grouping that were not important for the outcome. The block technique can predicate the next allocation which made it discordant (Kim & Shin, 2014).

Simple randomization using the random numbers technique was well-suited for the study's needs. The List Randomizer at Random.org was used to obtain a list of 64 random numbers at the beginning of the study (See Appendix G). All generated odd numbers were selected as controls and those with even numbers were invited to attend the CADE workshop. This predetermination assured equal dispersion between the intervention dates and selection bias was minimized by blinding the consenter. Following the consenting process, participants were assigned a random number in the order found on the list and a distinctive study identification. The activities related to their group assignment were then dispensed accordingly. These few proceedings were a robust argument for the Posttest – Control blueprint that Morgan and Renbarger (2018) stated as convenient and efficient with a minimal resource requirement.

Instrumentation and Constructs Operationalization

The ambition of this project was to gauge ACP engagement behaviors through an educational intervention. To see the impact of the workshop, the best scientific design was Posttest-Control where the variables were previously fixed from the literature. The posttest surveys were inclusive of variables that examined advance care planning engagement (ACPE) and decisional conflict scale (DCS). The operationalized variables highlighted four sets of elements: (1) demographics; (2) CADE intervention; (3) DCS; and (4) ACPE. For the demographics' operationalization, it included age, gender, ethnicity, race, marital status, education, and income. The age was provided as an interval range and measured in years. The binary variables were gender and ethnicity. The Hispanic variable had Latin or Spanish in the question description to guarantee ancestry. The race and marital status were nominal variables and carried the standard answers. The ethnicity included the option, Other for those that did not identify with suggested options. The marital status category chose Never Married to further delineate singlehood along with the usual societal status. The final demographic variables, education and income, were ordinal and organized in an ascending order. The second operationalization was the CADE intervention which carried only one variable and operated under a binary code for workshop attendance. Table 2 displays these operationalizations.

Table 2

Operationalization of Variables for Demographics and CADE Intervention

Variables	Operationalized
Age (years) ^{o}	18-24 (1) 25-34(2) 35-44 (3) 45-54 (4) 55-64 (5)
Gender ^{b}	Male (1) Female (2)
Race ^{n}	Black/AA^ (1) White (2) Asian (3) Indian/Islander+ (4) Other (5)
Ethnicity ^{b}	Hispanic (1) Non-Hispanic (2)
Marital Status ^{n}	Married (1) Widowed (2) Divorced (3) Never Married (4) Partner* (5)
Education ^{o}	HS# (1) Technical (2) Associate (3) Bachelor (4) Graduate (5)
Income ($1000) ^{o}	<15 (1) 15 - 30 (2) 30 - 45 (3) 45 - 60 (4) >60 (5) PNA~ (6)
	CADE Intervention
Workshop ^{b}	Yes (1) No (2)

Note: ^{b} binary; ^{n} nominal; ^{o} ordinal; ^African American; $^{+}$American Indian or Pacific Islander; *Living with partner; $^{\#}$High School; ~Prefer not to answer.

The third operationalization was applied to the Decisional Conflict Scale's 45 questions. All the responses were on the 5-point Likert scale. The responses were the same among its five main variables: (1) Informed; (2) Values Clarity; (3) Support; (4) Uncertainty; (5) Effective Decision-Making and held three statements per variable. The variables were grouped into three major ACP options. Each option had a total of 15 statements. Table 3 exhibits the summary of the DCS variables operationalizations of one statement per variable across one ACP option.

Table 3

Operationalization of Variables of Decisional Conflict Scale

Variable Types	Operationalized
Informed**	Yes (0) Probably Yes (1) Unsure (2) Probably No (3) No (4)
Values Clarity**	Yes (0) Probably Yes (1) Unsure (2) Probably No (3) No (4)
Support**	Yes (0) Probably Yes (1) Unsure (2) Probably No (3) No (4)
Uncertainty**	Yes (0) Probably Yes (1) Unsure (2) Probably No (3) No (4)
Effective Decision-Making**	Yes (0) Probably Yes (1) Unsure (2) Probably No (3) No (4)

Note: **5-point Likert scale;

The final operationalization was done for the advance care planning engagement questionnaire. The ACPE questionnaire measured two behavioral action domains, Self-Efficacy and Readiness which had six statements. Self-Efficacy held the same responses across its six action measures variables (four main and two sub-measures) and listed as (1) Not at all; (2) A

Little; (3) Fairly; (4) Somewhat; (5) Extremely; and (6) Not sure. The Readiness domain had nine action measures (four core and five extra sub-measures) with the following statements:

(1) I have never thought about it.

(2) I have thought about it, but I am not ready to do it.

(3) I am thinking about doing it in the next 6 months.

(4) I am definitely planning to do it in the next 30 days.

(5) I have already done it.

(6) Not sure.

The ACPE operationalizations required translation to the 5-point Likert scale for its six statements. Statistical analysis were performed on its dependent variables with these translated values according to the hypotheses.

Independent and Dependent Variables

The CADE research incorporated two validated surveys totaling 60 questions (DCS 45; ACPE 15) and eight other questions to acquire the participant's demographics. These are chronicled in Table 4H under independent and dependent variables. The independent variables encompassed eight demographics, three DCS options, two APCE action domains, and one CADE intervention variable. Out of the demographics' variables, marital status was of interest based on articles by Gerst and Burr (2008) and Cooney et al. (2019) that suggested marital status may be linked to advance directives conversations. Marital status was paired with at least one DCS and ACPE dependent variable. For the DCS independent variables, there were three advance care planning options to delineate the area of decisional conflict. The three options chosen were

Health Care Surrogate, Living Will, and Do-Not-Resuscitate. These crucial clinical units tend to be the foci of conflict near the end-of-life when absent. Each of them was paired with the five main DCS variables to address any influence with and without the intervention. The two ACPE action domains, Self-Efficacy and Readiness, were the independent variables to denote behavior in the care planning process. The Readiness variable was the most tested between the two, which made it the best factor to analyze for the research. The CADE intervention had only one variable, the workshop, which was at the center of this project.

The dependent variables encircled five decisional conflict clinical areas, four ACPE action measures, and three sub-measures. The DCS dependent variables – Informed; Values Clarity; Support; Uncertainty; and Effective Decision-Making – were all relevant in deciphering decisional conflict leading to decision delay (Sun, 2006). Still, the level of Uncertainty was heavily analyzed because it held equivalence between the groups and among the DCS options. On the other hand, there were 15 dependent variables in ACPE. The two action domains each contained four action measures: (1) Decision Maker; (2) Quality of Life; (3) Flexibility; and (4) Ask Provider. Some had one to three subfactors: (1) Talk to Decision Maker; (2) Talk to Doctor; and (3) Sign Official Paper. Table 5 detailed these summative factors below. The Self-Efficacy behavior domain was built around the participant's confidence in the four measures, whereas the Readiness observed their engagement in the action measures. The sub-measures highlighted the behavior where the participant may or may not be either confident or ready to engage. The level of Readiness for the Decision Maker and its sub-measures were manipulated more since the workshop intervention was geared at determining if the participants were ready to engage in talking with their provider about a decision maker or ready to sign official paperwork listing their decision maker. These were critical factors for ACP engagement and were attributed in two of three research questions.

Table 5

ACPE Action Domains Variables

Self-Efficacy Domain	Readiness Domain
Decision Maker	**Decision Maker**
	(1) Talk to Doctor#
	(2) Sign Official Paper#
Quality of Life	**Quality of Life**
(1) Talk to Doctor#	(1) Talk to Decision Maker#
	(2) Talk to Doctor#
	(3) Sign Official Paper#
Flexibility	**Flexibility**
(1) Talk to Decision Maker#	(1) Talk to Decision Maker#
(2) Talk to Doctor#	(2) Talk to Doctor#
Ask Provider	**Ask Provider**

Note: (#) Sub-measure

Decisional Conflict Scale

The Decisional Conflict Scale is a publicly available clinical tool that has a test-retest reliability coefficient of .81. It has a high internal consistency and an alpha coefficient range between .78 and .92. The scale's validity was confirmed with a statistically significant *p* of <.002. A difference was seen between those who had either a strong inclination to accept or reject immunization for breast cancer screening compared to those who were uncertain about the treatment (O'Connor, 1995). DCS also picked up a correlation between decisional conflict and knowledge. The results noted that those who had less knowledge were more uncertain of the risks.

The scale has several versions. The common Traditional version has 16-statements with five types of responses and has been tested vigorously. The Question format (same statements but posed as questions) has two subversions. Version A has 16 questions with five responses (like the traditional version) and version B has ten questions with three answers format. The last version, SURE (Sure of myself, Understanding information, Risk-benefit ratio, and Encouragement) has four questions with two responses. Parayre et al. (2014) validated the efficacy of this 4-item version which had the statistical strength to predict the clinically significant decisional conflict. Boland et al. (2017) also confirmed the SURE test capacity to predict decisional conflict in parents.

While the SURE survey occurred later, the initial testing for DCS occurred in Ottawa, Ontario, Canada. There were three groups of subjects: health science students, staff at a teaching hospital, and either cardiac or respiratory patients. The creators wanted to assess the subjects' health decisions on the influenza vaccination and breast cancer screening. To standardize each version, analysis calculated a score to be interpreted. The score's interpretation was binary in nature and transpired at a certain threshold. A score higher or lower than the threshold signaled the presence or absence of decisional conflict. If the numerical score exceeded another high threshold, it implied high decisional conflict. This was done initially on a specific population, then generalized for other patient types.

As a validated survey with multiple versions, the variables' operationalization held a 5-point Likert Scale for statements with five responses on a zero to four range. The three-answer format had a scale of [0] for Yes, [2] for Unsure, and [4] for No, and the two responses in the SURE version, applied binary scores [0] for Yes and [1] for No. These raw scales were transformed into the decisional conflict score which was made up of five themed variables: Informed, Values Clarity, Support, Uncertainty, and Effective Decision-Making. Statements one to three calculated the score for the Informed theme. Statements four to six represented the Value Clarity factor, seven to nine included statements for the Support theme, ten to 12 for Uncertainty, and the Effective Decision-Making held statements for 13 to 16. Three manipulations per theme were needed to score each variable: (1) the sum of the scores in each category; (2) divided by the number of statements; and (3) multiplied by 25. The answer should fall in the range between 0 and 100. The effect size range of the DCS was reported to be 0.4 to 0.8, so scores that were less than 25 were associated with certainty of implementing decisions. Scores that were greater than 25 were deemed clinically significant decisional conflict and applied as the standard definition throughout the analysis. Any score that was higher than 37.5 indicated high uncertainty or delay in decision-making with a specific factor (Knops et al., 2013; Thompson et al., 2016). Table 6 houses the interpretation of the decisional conflict scale scores.

Table 6

Decisional Conflict Scale Interpretation

DCS Variable Types	Percent [0]	Percent [100]
Inform	Extremely informed	Extremely uninformed
Values Clarity	Clear about values	Unclear about values
Support	Supported in decisions	Unsupported in decisions
Uncertainty	Certain about best choice	Uncertain about best choice
Effective Decision Making	Good decision	Bad decision

Note: DCS, Decisional Conflict Scale

Scoring Advance Care Planning Engagement

The initial validation of the advance care planning engagement survey by Sudore et al. (2013) began with an 82-item questionnaire that was administered to seniors from diverse cultures at two San Francisco hospitals. Their results were compared to a healthy cohort of university students for a test-retest reliability of .70 for the process factors and .87 for the action domains. The internal consistency was excellent with a Cronbach's alpha of 0.94 and a validity report of $p <.001$. The ACPE survey past validation led to further testing and authentication of a 55-item, 34-item, 15-item, 9-item, and 4-item modified versions. Each version can be obtained publicly by researchers interested in capitalizing on its versatility and usefulness in advance care planning engagement. One major criticism of ACPE is that most of its sub-variables in the shorter format, except for Readiness, have not been sufficiently tested to warrant absolute conjecture from its findings. This was kept in mind during the creation and was the rationale for analyzing some sub-variables for the subsequent hypotheses.

The ACPE survey assessed the intent or behavioral change with: (1) Knowledge; (2) Contemplation; (3) Self-Efficacy; and (4) Readiness as specific action domains. To outline an area within a domain, four measures were developed, which were: (1) Decision Maker; (2) Quality of Life; (3) Flexibility; and (4) Ask Provider. A participant would respond to an action measure within a certain action domain to represent their engagement. All responses had six statements which were transcribed into the 5-point Likert scale for analysis. The CADE research worked with the 15-item version that integrated only two of the four behavioral changes (Self-Efficacy and Readiness) and their action measures. The ACPE Readiness variable was extensively analyzed to produce a reliable Readiness score and had three reporting preferences. The authors recommended either recording the average Likert score for each action measure as a whole or separately with its sub-measures.

The third route required the average Likert score for each measure or sub-variable to be dichotomized to Yes or No. For the variables that were dichotomized, the first two responses on the Likert scale were the pre-contemplation stage and given a response, No, for Not Ready. The third, fourth, and fifth responses on the Readiness scale represented the action phase and given, Yes for Ready. The dichotomized variables received Yes, if their raw or mean score contained a three or higher and No, if they did not. The outcome would then be calculated either as the number of cases with Yes or No or as a percentage of the total number of cases with responses with three or higher in that action measure. The CADE research reported all three types of outcomes in its statistical analysis.

Statistical Analysis

A rapid assessment of the literature illustrated that a workshop as an intervention was an indispensable tool for changing behavior. As such, this quantitative inquiry concentrated on two surveys that incorporated some of the factors of change to harness data for the research. The central question measured behavioral change per group due to the intervention, with its sub-questions emphasizing the type of expected change. The main question explored the effect of the CADE intervention on decisional conflict and readiness for the advance directives process among church members. Three sub-questions narrowed this outcome by looking at factors that: (1) impacted decisional conflict and ACPE participant's scores; (2) identified the existence of an association within the level of Readiness subscale on marital status; and (3) the Readiness between those with and without the intervention and their level of Uncertainty. The hypothesis used in the statistical analysis had three sub-questions in mind.

Hypotheses

Every quantitative approach is guided by its hypotheses and for this project, there were three research questions that were summarized into 10 themed hypotheses. Each hypothesis is accompanied by labeled statements of either the variable or its sub-variable. For organizational purposes, each hypothesis statement has the letter, H, and a number. Some of the statements have a capital letter that corresponds to the testing of the variables within the theme. The null hypothesis was represented by the subscript, *n,* and the alternative, with the subscript, *a*. If a theme had more than three variables, they were placed in a table for easy viewing. An explanation is given alongside some themes to defend their use in this setting.

The decisional conflict scale (DCS) checks for decisional conflict among five variables: Inform, Values Clarity, Support, Uncertainty, and Decision-Making. Each of these variables is paired against three common advance care planning options – Health Care Surrogate, Living Will, and Do-Not-Resuscitate orders. Chiarchiaro et al. (2015) used the DCS to demonstrate decreased decisional conflict among health care surrogates of patients in the Critical Care Unit. The work by Jeon et al. (2018) also channeled DCS. Their study exposed high decisional conflict in families of cancer patients near the end-of-life. DCS helped distinguish that families who knew the patient's end-of-life wishes had low decisional conflict in contrast to those who did not.

All five of the DCS variables are routinely analyzed together to determine which of them is the culprit for decisional conflict in clinical settings. There is a rarity in the literature that examines DCS factors against the three regular ACP options in a community setting. The CADE research recognized that an exploration on the impact of the intervention, along with testing for decisional conflict in the ACP options, would be unique and instrumental. The hope of the DCS hypotheses was to detect decisional conflict. The next step would examine them around the EOL options in a different environment. The hypotheses for these were as follows:

H1: Health Care Surrogate

A_n There is no effect on the DCS INFORM factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

A_a There is an effect on the DCS INFORM factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

B_n There is no effect on the DCS VALUES CLARITY factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

B_a There is an effect on the DCS VALUES CLARITY factor between those who had the CADE intervention and those who did not in the Health Care surrogate Option.

C_n There is no effect on the DCS SUPPORT factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

C_a There is an effect on the DCS SUPPORT factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

D_n There is no effect on the DCS UNCERTAINTY factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

D_a There is an effect on the DCS UNCERTAINTY factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

E_n There is no effect on the DCS DECISION-MAKING factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

E_a There is an effect on the DCS DECISION-MAKING factor between those who had the CADE intervention and those who did not in the Health Care Surrogate option.

H2: Living Will

A_n There is no effect on the DCS INFORM factor between those who had the CADE intervention and those who did not in the Living Will option.

A_a There is an effect on the DCS INFORM factor between those who had the CADE intervention and those who did not in the Living Will option.

B_n There is no effect on the DCS VALUES CLARITY factor between those who had the CADE intervention and those who did not in the Living Will option.

B_a There is an effect on the DCS VALUES CLARITY factor between those who had the CADE intervention and those who did not in the Living Will option.

C_n There is no effect on the DCS SUPPORT factor between those who had the CADE intervention and those who did not in the Living Will option.

C_a There is an effect on the DCS SUPPORT factor between those who had the CADE intervention and those who did not in the Living Will option.

D_n There is no effect on the DCS UNCERTAINTY factor between those who had the CADE intervention and those who did not in the Living Will option.

D_a There is an effect on the DCS UNCERTAINTY factor between those who had the CADE intervention and those who did not in the Living Will option.

E_n There is no effect on the DCS DECISION-MAKING factor between those who had the CADE intervention and those who did not in the Living Will option.

E_a There is an effect on the DCS DECISION-MAKING factor between those who had the CADE intervention and those who did not in the Living Will option.

H3: Do-Not-Resuscitate

A_n There is no effect on the DCS INFORM factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

A_a There is an effect on the DCS INFORM factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

B_n There is no effect on the DCS VALUES CLARITY factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

B_a There is an effect on the DCS VALUES CLARITY factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

C_n There is no effect on the DCS SUPPORT factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

C_a There is an effect on the DCS SUPPORT factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

D_n There is no effect on the DCS UNCERTAINTY factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

D_a There is an effect on the DCS UNCERTAINTY factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

E_n There is no effect on the DCS DECISION-MAKING factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

E_a There is an effect on the DCS ECISION-MAKING factor between those who had the CADE intervention and those who did not in the Do-Not-Resuscitate option.

The advance care planning engagement (ACPE) survey has several versions geared at assessing change in behavior during advance care planning. The popular behaviors, Self-Efficacy and Readiness, plus some of their subdomains were fundamental in gauging the patient's readiness to participate in ACP. The majority of ACPE survey evaluations were completed by hospital patients on several kinds of intervention. The articles indicated its lack of use in the community and there was no workshop intervention in faith-based institutions. The CADE study would apply the two ACPE domains and their accompanying process measures to influence change in the priority population. The subdomains would be vital to narrowing the behavior mostly affected by the intervention, so they were judged attentively. Tables 7I1 and 8J described the hypotheses details for the variables associated with ACPE Self-Efficacy domains and subdomains. The broad hypothesis was:

$H4_n$ There is no change in the participants scores for the advance care planning engagement Self-Efficacy domains with the CADE intervention compared to those without.

$H4_a$ There is a change in the participants scores for the advance care planning engagement Self-Efficacy domains with the CADE intervention compared to those without.

The ACPE Readiness domain examined behavior in four areas: Decision Maker, Quality of Life, Flexibility, and Ask Provider. The details for these factors were split into three tables for better visualization and can be found in Appendix K – M. Tables 9K, 10L, and 11M underline the hypotheses for the Decision Maker and its subdomains. Table 9K focused on the Decision Maker, 10L on the Quality of Life, and Table 11M featured the hypotheses for Flexibility and the Ask Provider domains. The ACPE Readiness domain fell under hypothesis five (H5) with the sub-variables between A through I. The general hypothesis was listed as:

$H5_n$ There is no change in the participants scores for the advance care planning engagement Readiness domains with the CADE intervention compared to those without.

$H5_a$ There is a change in the participants scores for the advance care planning engagement Readiness domains with the CADE intervention compared to those without.

Fried et al. (2010) established the statistical strength for each of these domains and process measures. They found that the Readiness variables have a closer relationship to anticipated change compared to the other apparent behaviors. This was inevitably a good agent for measuring statistical outcomes. Intrinsically, its components can pinpoint the type of Readiness which functions as a precursor to change. This variable and its sub-variables have been reported as a percentage in several studies, which made it essential to maintain the same kind of representation. The CADE research sought to explore the readiness of the participants to select a Decision Maker, Sign Official Paper, and the Ask Provider questions. The factors were chosen because of their practicability within the intervention period. The hypotheses would determine the percent Readiness between in the related domains and the two groups. They were written as:

H6: Readiness – DECISION MAKER

A_n The DECISION MAKER domain Readiness percent will be significant between those who participated in the CADE intervention and those who did not.

A_a The DECISION MAKER domain Readiness percent will not be significant between those who participated in the CADE intervention and those who did not.

H6: Readiness – SIGN OFFICIAL PAPER

B_n The DECISION MAKER subdomain SIGN OFFICIAL PAPER Readiness percent will be significant between those who participated in the CADE intervention and those who did not.

B_a The DECISION MAKER subdomain SIGN OFFICIAL PAPER Readiness percent will not be significant between those who participated in the CADE intervention and those who did not.

H6: Readiness – ASK PROVIDER

C_n The ASK PROVIDER domain Readiness percent will be significant between those who participated in the CADE intervention and those who did not.

C_a The ASK PROVIDER domain Readiness percent will not be significant between those who participated in the CADE intervention and those who did not.

The CADE demographics variables covered ethnicity, race, age, education, income, marital status, and gender. Out of these, an association was linked with age, education, and income to advance directive completion as per Rao et al. (2014). Cooney et al. (2019) attested that married women and divorced men were at-risk for not having ACP discussions. The CADE research attempted to reaffirm the marital status type. In addition, there was a need to grasp the level of Readiness for a Decision Maker, their behavior in the presence of the Doctor, and their readiness to Sign Official Paper. Prior to CADE, the level of Readiness had not been investigated in faith communities. Below is the conventional hypothesis for Readiness and marital status followed by the complementary variables' statements (Table 12).

$H7_n$ The level of Readiness and marital status are not different for those who engaged in the workshop versus those who did not.

$H7_a$ The level of Readiness and marital status are different for those who engaged in the workshop versus those who did not.

Table 12

Hypotheses for Decision Maker Level of Readiness and Marital Status

	Hypotheses Statements
A_n	The DECISION MAKER Readiness and marital status are not different for those who engaged in the workshop versus those who did not.
A_a	The DECISION MAKER Readiness and marital status are different for those who engaged in the workshop versus those who did not.
B_n	The DECISION MAKER – subdomain DOCTOR Readiness and marital status are not different for those who engaged in the workshop versus those who did not.
B_a	The DECISION MAKER – subdomain DOCTOR Readiness and marital status are different for those who engaged in the workshop versus those who did not.
C_n	The DECISION MAKER – subdomain SIGN OFFICIAL PAPER Readiness and marital status are not different for those who engaged in the workshop versus those who did not.
C_a	The DECISION MAKER – subdomain SIGN OFFICIAL PAPER Readiness and marital status are different for those who engaged in the workshop versus those who did not.

Inoue et al. (2019) purported that personal demographics were important variables for completion of advance directives. They predicted age, race, income, and education were more likely to have an association with it. Sadly, the association between marital status and end-of-life planning was inconclusive based on these few studies. The work by Hart et al. (2018) remarked that they did not find any relationship, but Cooney et al. (2019) demonstrated that divorced men and married women were less likely to prepare an advance directive compared to the other social status. Similarly, another research effort highlighted disparity in marital status along with other demographic attributes between ethnic and racial groups (I. Huang et al., 2016). They found that African Americans and Hispanic older adults were less likely to possess an advance directive and the probability did not change with religious faith or health values. The conflict and advance directives education research would take on the challenge to compare the married and the never married within these ethnically diverse groups in faith communities rather than all the previously studied factors. The advance care planning engagement survey functioned as a precursor for advance care planning, so the research captured data missed by prior studies by including an assessment of the participants' readiness to engage in advance care planning. Keeping the above view in consideration, hypothesis 8 expressed marital status and the level of Readiness for those with and without the CADE intervention. Table 13 itemized the hypothesis statements for each of the Decision Maker process measures and its subdomains.

$H8_n$ Marital status does not have an association with the level of Readiness for those who engaged in the workshop versus those who did not.

$H8_a$ Marital status does have an association with the level of Readiness for those who engaged in the workshop versus those who did not.

Table 13

Hypotheses for Association of Level of Readiness and Marital Status

	Hypotheses Statements
A_n	Marital status does not have an association with the DECISION MAKER Readiness for those who engaged in the workshop versus those who did not.
A_a	Marital status does have an association with the DECISION MAKER Readiness for those who engaged in the workshop versus those who did not.
B_n	Marital status does not have an association with the DECISION MAKER – subdomain DOCTOR Readiness for those who engaged in the workshop versus those who did not.
B_a	Marital status does have an association with the DECISION MAKER – subdomain DOCTOR Readiness for those who engaged in the workshop versus those who did not.
C_n	Marital status does not have an association with the DECISION MAKER – subdomain SIGN OFFICIAL PAPER Readiness for those who engaged in the workshop versus those who did not.
C_a	Marital status does have an association with the DECISION MAKER – subdomain SIGN OFFICIAL PAPER Readiness for those who engaged in the workshop versus those who did not.

Another outcome worth pondering was the level of uncertainty from the decisional conflict scale. The project warranted a glance at this because it was essential to clarify if the level of Uncertainty was responsible for decision delays when choosing a Health Care Surrogate or requesting a Do-Not-Resuscitate order. This knowledge may explain the patient's lack of readiness, which may help to prepare providers for the ACP visit. Earlier assertions did not address this, which implied that asking such questions could garner the data wanted to verify or disapprove its usefulness. The hypotheses would discover if there was an effect of decisional conflict between the advance care planning options. It would also reveal if the level of uncertainty played a role in how the decision was made. McMahan et al. (2013) insisted that extra steps may be required for the ACP process. These hypotheses provided answers to which step should be taken. H9 measures the level of Uncertainty among Health Care Surrogate and the Do-Not-Resuscitate options.

H9: Uncertainty – HEALTH CARE SURROGATE

A_n A change is not seen when comparing the workshop and control to the level of UNCERTAINTY in the Health Care Surrogate option.

A_a A change is seen when comparing the workshop and control to the level of UNCERTAINTY in the Health Care Surrogate option.

H9: Uncertainty – DO-NOT-RESUSCITATE

B_n A change is not seen when comparing the workshop and control to the level of UNCERTAINTY in the Do-Not-Resuscitate option.

B_a A change is seen when comparing the workshop and control to the level of UNCERTAINTY in the Do-Not-Resuscitate option.

In the advance care planning process, two of six components of behavioral change were choosing a health care surrogate and documenting a living will (Fried et al., 2010). Stevens et al. (2022) exclaimed that education is not enough for the ACP process. The physician's role is pertinent in terms of whether the patient feels connected to ask questions about their future care. These behavioral measurements were puzzle pieces for advance directives education and fit well with the motive for the intervention. The conflict and advance directives education research would express how to manage and what to ask of his or her health provider during an advance care planning visit. This manifested a need to scrutinize if there is a barrier to designating a decision maker and asking provider questions. These were lacking in the literature, so it seemed applicable to rule out any involvement of decisional conflict caused by uncertainty.

Hypothesis ten had four hypotheses. They would calculate the Decision Maker and Ask Provider Readiness factors for two of the ACP options. The Health Care Surrogate and Do-Not-Resuscitate were selected as the most appropriate because they were key influencers in the process. If Clinically Significant Decisional conflict was detected, its presence is distinct. The knowledge that a patient was attempting to elect a health care surrogate or ask questions of their providers would be preparatory. Therefore, the underlying hypotheses had to be:

H10: Decision Maker – HEALTH CARE SURROGATE

A_n There is no difference between the DECISION MAKER level of Readiness score and the level of Uncertainty in the Health Care Surrogate option.

A_a There is a difference between the DECISION MAKER level of Readiness score and the level of Uncertainty in the Health Care Surrogate option.

H10: Decision Maker – DO-NOT-RESUSCITATE

B_n There is no difference between the DECISION MAKER level of Readiness score and the level of Uncertainty in the Do-Not-Resuscitate option.

B_a There is a difference between the DECISION MAKER level of Readiness score and the level of Uncertainty in the Do-Not-Resuscitate option.

H10: Ask Provider – HEALTH CARE SURROGATE

C_n Comparing the Readiness scores for ASK PROVIDER and the level of Uncertainty, a difference is not detected in the Health Care Surrogate option.

C_a Comparing the Readiness scores for ASK PROVIDER and the level of Uncertainty, a difference is detected in the Health Care Surrogate option.

H10: Ask Provider – DO-NOT-RESUSCITATE

D_n Comparing the Readiness scores for ASK PROVIDER and the level of Uncertainty, a difference is not detected in the Do-Not-Resuscitate option.

D_a Comparing the Readiness scores for ASK PROVIDER and the level of Uncertainty, a difference is detected in the Do-Not-Resuscitate option.

The ten hypotheses intended to retrieve results pertinent to the research questions. They were manipulated in several contexts to first acknowledge the previous evidence. The next purpose was to highlight their importance in the research’s inquiry. The final aspect was to draw inferences from the analysis. To prove the legitimacy of the hypotheses’ analysis, statistical assumptions were established. If met, this would ensure that the results were both authentic and irrefutable.

Statistical Assumptions

Qualitative inquiry has an adept ability to probe complex matters with indispensable details (Creswell 2013). Quantitative exploration does so equally but with numerical appraisals. This project annexed the quantitative process of the CADE intervention to verify its effect in the racial-ethnic minorities faith community with assistance of existing community academic partnerships. The primary work began with a sketch that understood the coverage for both parametric and non-parametric assumptions. The four basic parametric assumptions were: (1) interval or ratio data; (2) independence; (3) normality; and (4) the homogeneity of variance. The two common non-parametric equivalences were randomness and independence. An explanation of these is detailed in the subsequent subsections.

Parametric Assumptions. These statistical tests assume that the population has a normal distribution, that is, data will predictability fall under the familiar bell-shaped curve. For that to be true, four rules are required.

(a) The dependent variables should be an interval or a ratio level since parametric testing cannot be achieved with nominal data.

(b) Each data point is independent and not interdependent or influenced by others.

(c) Meet the definition of normality where the distribution of the sample means is normally distributed.

(d) The homogeneity of variance for group comparisons are equal.

Freedman (2010), along with his editors, Collier, Sekhon, and Stark agreed that statistical assumptions are only valid if it is true for a given population from which they are derived. If any of them are untrue, then their assumptions are false and the interpretations invalid. This research has ordinal and interval levels of measurement to fulfill the first assumption. To satisfy the latter three assumptions, the other variables were checked using exploratory data analysis. Komogorov-Smirnov test for normality, the Levene test for homogeneity of variance, and histograms were executed to draw meaningful conclusions of the assumptions. Variables that violated the assumptions were deferred to non-parametric testing.

Non-Parametric Assumptions. Variables that were nominal and had either skewness or kurtosis were manipulated for independence and randomness. The Chi-square test was preferred as a phenomenal non-parametric evaluator for independence, goodness of fit, and homogeneity. The Mann-Whitney U. test was a natural choice since it was a better assessor for randomness and distinguishing two groups with one variable. These tests were perfect for the variables of the decisional conflict scale and the advance care planning engagement, but their application was limited to the data analysis procedure. The analysis procedure held several manipulations to prepare the primary data. Then, it would undergo the usual statistical calculations to determine the outcome for the hypothesis testing. The succeeding paragraphs explained how this was done.

Data Analysis Procedure

The exploratory data analysis was implemented from the variables stemmed from the hypotheses. The goal of the procedure was to learn about each variable descriptive statistic and to visualize its distribution. This knowledge was the signal to proceed with either the parametric or non-parametric testing. Microsoft 365 Excel was appointed to garner raw data and to prepare the data for manual transformation. The IBM SPSS Statistics Version 29 (2022) was the principal instrument for the statistical analysis requiring the mean, median, standard deviation, variance, *p*, and the confidence interval (CI). The preparation was conducted as follows:

- All missing data points were reassigned with 999 so that SPSS can read them as missing and compute accordingly. Microsoft Excel was the program of choice for this preparation since it was easily maneuverable. Some variables were renamed, rearranged, and color-coded to limit transferrable errors on SPSS. The DCS and ACPE factors had raw scores on the 5-point Likert Scale in Qualtrics as 1, 2, 3, 4, and 5. Reading from the user manual, the DCS variables were changed to 0, 1, 2, 3, and 4 that corresponded to Yes, Probably Yes, Unsure, Probably No, and No, respectively. These raw scores required more computation where 16 statements were broken down into five overall scores. Every three statements matched the score of one variable until statement 12 (i.e., four of five DCS variables). For statements 13 to 16, four statements were needed to score the fifth variable. The three statements per variable were summed up, divided by three, then multiplied by 25 to produce the final score. The fifth variable (the one with 4 statements), performed the same steps as above, except that its sum was divisible by four instead of three. The scores were then reported as a percentage and utilized in the analysis. The ACPE scores called for transformation of the Readiness variable. The author of the ACPE user manual insisted on dichotomizing five variables relating to Readiness. From the raw score, scores greater than or equal to three were summed per group (control or workshop), then averaged. This average was used for analysis.

- The test for normality was accomplished through Excel and SPSS. Excel displayed histograms for ordinal and nominal variables particularly age, education, income, gender, marital status, and race. For ACPE and DCS, SPSS was more useful for normality testing. The Komogorov-Smirnov test and the Levene test for homogeneity of variance were checked on both sets of variables. Variables not meeting the normality tests were shifted to non-parametric testing. [See the notes under inferential statistics].
- Descriptive statistics was the most efficient test. IBM SPSS provided descriptive frequencies of all variables, but only the frequencies as count and percent for the demographics were reported.
- The inferential statistics closed out the data analysis procedure. The independent T-test, Mann Whitney U., and bootstrapping were done where applicable. Results obtained were listed as the mean, median, standard deviation, 95% confidence interval (CI), and the *p* value. For the Chi-square test of Independence (Crosstabs on SPSS), outcomes were matched to the X^2 results, the corresponding *p* value under the Fisher-Exact test, as required.

The data skewness required bootstrapping for at least one instance. Bootstrapping functioned as an alternative method for hypothesis testing where it treated the sample as one drawn randomly out of many samples to estimate a sample distribution. Kulesa et al. (2015) cited that a bootstrap can approximate the sample's distribution normal shape from the replicas observed if the sampling independently came from one data source. The sample was independent, so the bootstrap sampling was set to 1000 samples on SPSS. Jim Frost (2018) argued that bootstrapping applies sampling distributions as the essence for constructing confidence intervals and testing of the hypothesis. Also, according to Frost, bootstrapping comes with three steps:

(1) In each dataset, data used for inclusion has an equal and random probability of being drawn from the original data.
(2) A data point may be selected more than once and reused or replaced in the calculations.
(3) The data that gets resampled intuitively matches the size of the original set.

When the process stops, it signals that there is enough simulated data to complement the original values. Sample statistics are then drawn from this amalgamated sampling distribution. Though the sampling is random and reapplied, the original dataset is best representative of the population being evaluated, bootstrapping just acts as its proxy (Frost, 2018).

Threats to Validity

Fraenkel and Wallen (2009) announced that the participants' attitudes can be extrapolated from asking a series of statements about preferences. This discovery was foundational for data retrieval and comes with threats to its validity. Two notable threats to construct validity were pre-randomization of the sample and treatment artifacts of the independent variable. Pre-randomization held the temptation to violate random allocation during recruitment. This was minimized by blinding the consenter. The treatment was an educational workshop where the participants chose their convenient location. The probability that their choice may have produced unexpected distractions could hamper their ability to fully grasp the material and reduce the impact of the intervention.

An attempt was made to control such distractions by giving the participants guidelines for success at the beginning of the workshop. The guidelines encouraged them to be mentally present and engaged and they were allowed to reschedule if they felt that their attention was divided. The threat of internal and external validity was related to group composition or attrition and non-representative sampling, respectively. The CADE research had six cohorts composed of individuals from diverse backgrounds and in different life stages, so it is possible that pre-existing influences could impact the outcome. For external validity, it was known that the sample compiled did not represent all faith communities in the state of Florida, which was highlighted in the study's limitations. Lastly, other threats may be caused by unknown or unanticipated covariates and confounders. The idea of recognizing what may obscure the research's outcome makes it an effective tactic to oversee issues and offers a justifiable defense of the outcomes.

Ethical Procedures

The University of Florida (UF) Institutional Review Board reviewed the study's protocol and the review board at Nova Southeastern University yielded its revision to UF. As part of the university's approval process, five steps were addressed to ensure protection of human subjects. The steps featured: (a) protection of personal information and privacy; (b) confidentiality; (c) risk and benefits; (d) recruitment ethics; and (e) data collection and storage. When these were satisfied, an approval letter granting permission to begin recruitment was sent through the research compliance system. The research was given protocol number 202201165 under Expedited Review and set to expire on July 29, 2025. The following was submitted to satisfy the IRB requirements:

(a) The Protection of Personal Information (PPI) and privacy are covered under HIPAA Privacy Rule. This federal provision insists that participants understand their rights of how their information will be used (U.S. Department of Health & Human Services, 2013). The subject's contact information was required to deliver the study-related material so mustering their name, email, and phone number was a necessary action. The discussion on how privacy was maintained can be found under the data collection and storage section.

(b) Confidentiality is one of the core ethical concerns in human subjects' research. In fact, federal law governs organizations performing research and they in part monitor researchers for compliance. Confidentiality was preserved with this study as all participants' personal information was kept on a UF-protected network server that was password-protected. There were no paper records except for the respondents who tendered a paper copy of the anonymous survey that was placed in a large envelope and kept private. As an extra precaution to workshop attendees, they were instructed to avoid sharing sensitive material outside the workshop as part of the guidelines.

(c) The research had an essence where the benefits outweighed two potential risks. The first risk was the possibility of a security breach. This risk was minimal since the data was stored on the university's server and protected by a secure password. For risk two, if a workshop participant recalled an uncomfortable memory at the end-of-life, this may have produced some discomfort. This was kept at a minimum because they were given a preamble at the beginning of the workshop to engage only in what was most comfortable for them. The study's benefits were elaborated in the implications section of Chapter 5.

(d) All participants volunteering for the research took part in the informed consent process that was either online or in-person. Most of the recruitment was in-person, so many of them had their questions answered on the spot. The few individuals who chose to do it online were given information on how to contact the researchers, if needed. The consent was written at the eighth-grade level and within it was information on the safety of personal data, the risk and benefits of participation, research activities, and the right to refuse or withdraw at any time without consequence. Material in the consent also had who would receive the $20 compensation, which was not deemed coercive by the review board. As a research institution, a small compensation for participating in a research study is commonplace. Another ethical concern was the hypothetical inequitable distribution of AD education for those in the control group. To deal with this, non-attendees were instructed to view at their convenience the Prepare Your Care website, found at https://prepareforyourcare.org. The website had been culturally vetted and held numerous sources, including research-based video demonstrations of advance directives with easy-to-read lessons.

(e) For data collection and storage, the relevant variables were garnered from the literature and surveys. The data was stored and compiled within the University of Florida approved program software company, Qualtrics XM. This technology company incorporates their software into the university system and permits the creation of surveys using survey templates. Qualtrics XM also prepares data for integration with other statistical software like SPSS. One important concern that the university considered with Qualtrics XM was its ability to keep the data private and secure. The CADE project amalgamated personal data with research data, so keeping both information safe was paramount. A good example of this at work was during the informed consent process. All participants offered their personal information, which was kept in the university's computer database and each researcher had his or her own private password protected. When the participant's information was entered, a unique identifier was created which eliminated the need to use names.

Chapter Summary

The CADE research is a quantitative analysis of its effectiveness within faith communities. With assistance from community academic partners who shared the research within its network, interested persons at local congregations throughout the state were invited to participate. The study had a posttest strategy where consenting persons were randomized to workshop or control. Each was given an anonymous survey to collect data to answer three postulations which included computation of descriptive frequencies, independent T-test, and Chi-square. These tests were used for differences in the participants' scores for ACPE and DCS variables, association between marital status and the level of uncertainty, and the extent of change in the participant's readiness to document an advance directive. Chapter 4 describes the results of this data compilation.

Chapter 4: Results

The CADE project sought to discover conflict around advance directives in a logical manner and surmised that end-of-life conflict functioned as a barrier to medical care. With bioethical guidance and reviewing the EOL system with theoretical eyes, the incidence of conflict, its root causes, and current strategies helped to inform the purpose of this research. The project used quantitative methodology to examine if the decisional conflict scale and advance care planning engagement survey was a resourceful tool in CADE and deciphered if participants were ready to engage in the ACP process within Florida's faith communities. Based on this rationale, three core questions were studied: (1) Which of the participant's DCS and ACPE factors were affected with and without the CADE intervention? (2) Was there an association between the level of Readiness and marital status for those who attended the workshop over those who did not? (3) Was there a difference in the Readiness scores and the level of Uncertainty with those who were ready to engage and those who were not?

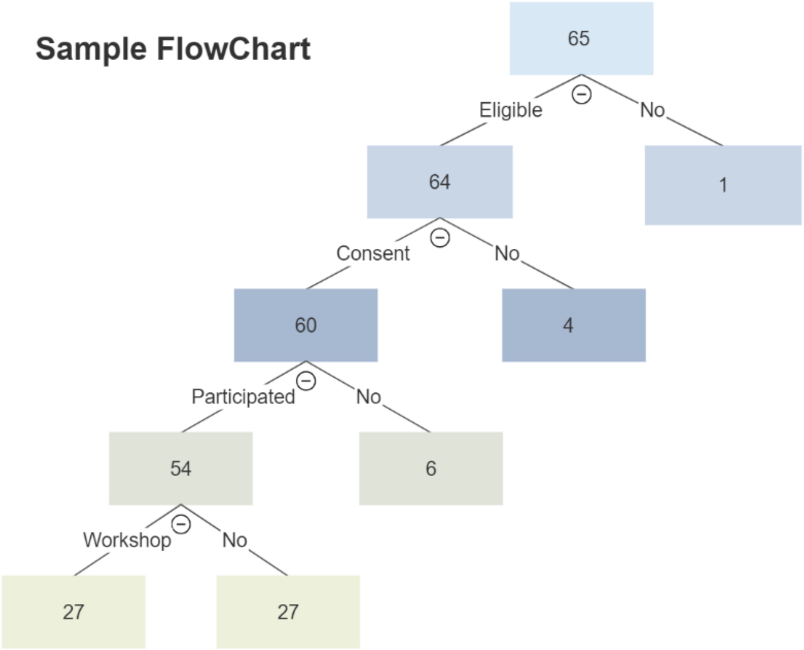
These three questions generated twelve hypotheses. The hypotheses scrutinized the factors of decisional conflict and advance care planning engagement. Some inspected the decisional conflict scale with three advance care options and ascertained the level of Readiness (ACPE) and the level of Uncertainty (DCS) between the intervention and control and marital status within the groups. Finally, this chapter was organized to speak primarily on how the data was collected, the planned and unplanned challenges, and its results. For this chapter, the results were structured in four sections. The first two unveiled the descriptive and inferential statistics, the third unwrapped what was observed, and the fourth provided a summary of the findings.

Data Collection

The research was approved by the University of Florida in late Summer of 2022 and 64 participants were recruited in early Fall. Figure 7 displayed that 65 individuals were approached and 64 were deemed eligible. For those who met eligibility, 60 consented to prompt a response rate of 93%. Out of 60 who agreed to partake, three withdrew, three were lost to follow-up, and 54 were randomized to workshop or control with 27 per group.

Figure 7

Randomization Sample Flowchart



Data collection began in October 2022 and ended in March 2023 with six CADE interventions, two per month between December and February. All participants were from faith communities who felt connected to Christianity and resided in seven different counties represented by four territorial regions of the state. Fifty-eight percent were from Alachua County and 57% self-reported as having end-of-life conflict in the family as shown in Figure 8. The sample population was restricted to those who identified with a faith community with priority given to underrepresented groups.

Figure 8

End-of-Life Conflict Reported by Participants

The race and ethnicity were as follows: 55% identified as Black or African American, 21% Caucasian, 17% Other, 7% Asian, and 25% had Hispanic ancestry. All the ages fell between 18 and 65 years where 35% were in the range 25 to 34, 21% from 35 to 44, 19% from 45 to 54, and

15% held ages 55 to 64. Other characteristics include female as the largest gender at 67%, 66% had a bachelor's degree or higher, and 64% made more than $45,000 annual household income. See Table 14N.

Intervention Fidelity

Several challenges happened during the research which were unanticipated and classified as either environmental, participant preference, or researcher capacity. In Fall 2022, three hurricanes hit Florida which demanded resident's preparation which caused three distinct delays. Some counties incurred huge damage to properties and livelihood, so CAP avoided recruitment in those areas. Another source of interruption was the participants' request to change their randomization assignment. Some exclaimed their inability to participate in the workshop due to scheduling and requested to be moved to the control group. Then, there were a few in the control group that desired to attend the workshop. The shifting between groups was tricky, but they were only accommodated if there were enough requests to make the switch work. The third difficulty that merited commenting on was the limitation on the researcher capacity to recruit. CAP members referred potential individuals or provided an audience for recruitment. Most times, these referrals were drastically slow. To improve recruitment in the allotted time limit, in-person recruitment was compulsory for several cities and arduous encounters were expedited to keep the project moving forward.

Research Findings

End-of-life discussions can be daunting and irrelevant if you are in good health, but it can be invaluable to minimize conflict. The CADE intervention and the anonymous surveys were established to reduce conflict and aid familiarity with end-of-life options. The workshop tried to encourage members of faith-based organizations to be more absorbed in the inevitable by attesting to the viewpoints of providers and health care policymakers. This would allow them to understand their perspectives, respect their duties, and explain why it was important for them to fill out a Living Will. The anonymous survey extracted the participant's knowledge related to decisional conflict and the advance care planning engagement process. The results provided an indication of clinically significant decisional conflict and their readiness to engage in ACP. The outcomes also signified an avenue for intervention improvement, feedback on the workshop participants' skillset, and the facilitator's presentation evaluation. The following was an accumulation of what was found.

Descriptive Statistics

There were 10 themed hypotheses and a total of 45 individual statements that would produce the groundwork for the findings. The hypotheses commanded a test for the parameter assumptions, mainly normality and homogeneity of variance. The normality exploration for the demographics, DCS and the ACPE variables unmasked that the data was skewed or had kurtosis for most variables with the Komogorov-Smirnov test. On the other hand, the test for homogeneity of variance, that is, the Levene statistic in SPSS, revealed that most of the variables had equal variances. There were four factors that were the exception:

Under the DCS options:

(1) Do-Not-Resuscitate, the Inform variable.

(2) Living Will, the Support variable.

The ACPE factors were:

(1) Self-Efficacy sub-variable Flexibility.

(2) Readiness sub-variable Sign Official Paper.

Surprisingly, the sample demographics between the intervention and control were comparable in their median distribution (Table 15). Their *p* values were insignificant between groups, although their histograms were skewed.

Table 15

Demographics Comparison between Workshop and Control

Demographics	Control median (n=26)	Workshop median (n=26)	*p**
Gender	2.0	2.0	.413
Age	3.0	2.5	.354
Ethnicity	2.0	2.0	1.000
Marital Status	2.0	2.0	.301
Education	4.0	4.0	.430
Income	4.0	3.5	.917

Note: Comparison of median with SPSS Descriptives; *p** calculated with Pearson's Chi-Square; n number of cases.

The descriptives divulged that the decisional conflict scale survey held three advance care planning options for the participants to answer: (1) Health Care Surrogate (HCS); (2) Living Will (LW); and (3) Do-Not-Resuscitate (DNR). Each option was tested against the five DCS variables: (1) Inform; (2) Values Clarity; (3) Support; (4) Uncertainty; and (5) Decision-Making. Under the Health Care Surrogate option, the Inform factor diagnosed that 51% of the participants had clinically significant decisional conflict. For Values Clarity and Uncertainty, the participants had 46% and 44%, respectively. The Living Will option had two variables with an equivalent number of cases - Inform and Uncertainty at 45%. The level of Uncertainty under the Do-Not-Resuscitate option also had 45% of participants with decisional conflict. These results are depicted in Table 16.

Table 16

Decisonal Conflict Scale Descriptives

DCS Factors	n	HCS Cases (%)	n	LW Cases (%)	n	DNR Cases (%)
Inform	41	21 (51)	40	18 (45)	40	14 (35)
Values Clarity	41	19 (46)	38	14 (37)	39	10 (27)
Support	41	11 (27)	38	8 (21)	39	9 (23)
Uncertainty	41	18 (44)	38	17 (45)	38	17 (45)
Decision-Making	41	12 (29)	38	13 (34)	37	12 (32)

Note: Cases calculated as a percentage with decisional conflict score > 25; n, number of cases; HCS, Health Care Surrogate; LW, Living Will; DNR, Do-Not-Resuscitate.

For ACP engagement descriptives, the four action measures analyzed were: (1) Decision Maker (DM); (2) Quality of Life (QoL); (3) Flexibility (FLX); and (4) Ask Provider (ASK), and two ACPE behaviors, Self-Efficacy and Readiness. The Self-Efficacy descriptives showed 81% of the participants were confident in choosing a Decision Maker and 77% were noted to have the boldness to Ask Provider questions. The level of Readiness was at least three times lower than those in the Self-Efficacy domain. Most of the participants' scores fell between 25% and 32%, two of which had the same number of cases (Decision Maker and Flexibility). The highest score was in the Ask Provider column. Table 17 parades ACPE descriptive inquiry of the number of cases with scores ≥ 3 in each domain.

Table 17

Advance Care Planning Engagement (ACPE) Descriptives

	ACPE Behavioral Domains			
Action Measures	Cases	Percent	Cases	Percent
	Self-Efficacy (n=53)		Readiness (n=53)	
Decision Maker	43	81	13	25
Quality of Life	38	72	16	30
Flexibility	31	58	13	25
Ask Provider	41	77	17	32

Note: n, total number of participants; cases, number of participants within a certain action measure; percent, calculated as a percentage from the number of cases; Under the Readiness domain, number of cases with scores ≥ 3.

Inferential Statistics

There were some findings where either parametric or non-parametric testing were computed. The parametric used the Student’s T-Test with bootstrapping and the Mann Whitney

U. and Chi-squared for non-parametric data. With 45 single statements categorized into 10 themed hypotheses, it was vital that the results had an identical structure for comparison. The first five hypotheses (30 statements) captured the analysis for decisional conflict and ACP engagement. The last five of the hypotheses (15 statements) were explicit for either the level of Readiness or Uncertainty and their sub-variables amid the intervention and control. The outcomes were along these lines:

Hypotheses 1 to 3 investigated clinical decisional conflict between the intervention and control. Table 18 showed that decisional conflict was present in the Inform, Values Clarity, and Uncertainty scores among all ACP options, that is, Health Care Surrogate, Living Will, and Do-Not-Resuscitate. The null was retained for these since the *p* value was not statistically significant between the groups. The score, 39.9, was greater than 37.5 and was the highest among all the scores. It represented that under the Do-Not-Resuscitate option, the participants in the control group felt unsure about their decisions. The variables Support and Decision-Making, had most of its mean scores < 25 for all the DCS options in both groups which was associated with implementing decisions they made. Of note, the Informed category had higher decisional conflict scores in the control group compared to the those in the workshop and the level of Uncertainty was consistent across both groups under all the advance care planning options.

Table 18

Group Comparison of Decisional Conflict Scale Scores

DCS Options	Health Care Surrogate			Living Will			Do-Not-Resuscitate		
Variable	C n=20	W n=21	*p*	C n=19	W n=19	*p*	C n=19	W n=21	*p*
Informed	33.7[a]	29.3[a]	**.400**	35.0[a]	24.2	**.183**	39.9[b]	22.2	**.205**
Values Clarity	35.4[a]	26.2[a]	**.257**	29.4[a]	21.9	**.452**	29.5[a]	26.0[a]	**.813**
Support	16.2	20.6	**.904**	9.6	19.7	**.223**	11.8	26.7[a]	**.204**
Uncertainty	27.9[a]	27.4[a]	**.968**	27.6[a]	28.9[a]	**.795**	23.2	35.1[a]	**.284**
Decision Making	20.3	18.4	**.749**	15.9	19.9	**.795**	13.5	23.3	**.461**

Note: Statistics drawn from Mann Whitney U; reflects mean percent score from descriptives; DCS, Decisional Conflict Scale; C, control; W, workshop; n, number of cases; Scores < 25 associated with implementing decisions; [a]Scores > 25 associated with clinically significant decisional conflict; [b]Scores > 37.5 is associated with decision delay about an option.

The next set of comparisons was hypothesis 4. The advance care planning engagement Self-Efficacy domain and its subdomains were computed against the intervention and control. Table 19 indicated no statistical difference in their Self-Efficacy behaviors between groups. Thus, the null was retained because *p* was greater than .05. Another noticeable finding was that the control group had higher scores than those who participated in the intervention. The Ask Provider variable was the exception where it had a slightly higher score in the workshop group over the control.

Table 19

Group Comparison of Advance Care Planning Engagement Self-Efficacy Behavior

Action Measures	Control n=27	Self-Efficacy Workshop n=26	*p*
Decision Maker	27.9	26.4	.644
Quality of Life	29.9	24.0	.148
Quality of Life-DOC	29.6	24.3	.193
Flexibility-TDM	28.6	25.4	.443
Flexibility-DOC	28.3	25.6	.515
Ask Provider	26.3	27.8	.720

Note: Group comparison with Mann Whitney U Test; values reflect mean rank score per action measure; n, number of cases; Sub-variables [DOC (doctor); TDM (talk to decision maker)]; Flexibility in the Advance Care Planning Engagement 15-question survey does not include Flexibility as a single variable.

Table 20 housed the outcomes for the Readiness behavior for hypothesis 5. Those in the workshop had slightly higher Readiness scores than the control. The highest mean scores were seen in the workshop under the action measures Flexibility sub-variable Doctor and Ask Provider and under Decision Maker in the control. The null was still retained for most except for Flexibility - DOC and Ask Provider. The null was rejected since there was a statistical difference between the control and the CADE intervention. The *p* value for both were less than .05 denoting that a change was present.

Table 20

Group Comparison of Advance Care Planning Engagement Readiness Behavior

Action Measures	Control n=27	Readiness Workshop n=26	*p*
Decision Maker	26.3	27.8	.712
Decision Maker-DOC	25.8	28.2	.516
Decision Maker-SOP	25.2	28.9	.361
Quality of Life-TDM	24.9	29.1	.299
Quality of Life-DOC	23.9	30.2	.112
Quality of Life-SOP	26.1	28.0	.633
Flexibility-TDM	24.2	29.9	.153
Flexibility-DOC	22.8	31.3	.026*
Ask Provider	22.9	31.2	.036*

Note: Mann Whitney U. test reflects mean rank score; *Statistically significant; Sub-variables [DOC (doctor), SOP (sign official papers); TDM (talk to decision maker)]; n, number of cases.

Hypothesis 6 examined the change in the level of Readiness between the control and workshop which was estimated by arithmetic. The values were obtained from the descriptives from SPSS software and the difference manually calculated as a percentage. The null implied that the change would be significant. The analysis illustrated that there was not a statistical change in the Readiness action measures between the groups. The Decision Maker action measure had a higher percentage in the control and the sub-variable, SOP (Sign Official Paper), that is, the groups were equally comparable. For those in the workshop, they were more ready to Ask Provider questions than the non-attendees. Even though there was a percent difference among the groups, the null hypothesis was retained after the results of the Pearson Chi-square test. The outcomes are shown in Table 21.

Table 21

Group Comparison of the Level of Readiness

Readiness	n	Control %	Workshop %	X^2(df)	*p**
Decision Maker	20	55	45	.21(1)	.646
DM-SOP	16	50	50	.01(1)	.928
Ask Provider	17	35	65	1.71(1)	.192

Note: Readiness descriptives between Decision Maker and its subdomain Sign Official Paper (DM-SOP) and Ask Provider; n, number of cases represent the participants who scored three or more on the readiness variables. %, cases calculated as percentage; X^2(df), Chi-square statistic with degrees of freedom*;* *p* value* calculated on Excel.

Table 22 represents hypothesis 7 which entails the mean comparison of marital status and the ACPE level of Readiness for the Decision Maker and its sub-variables. Utilizing the mean scores from the SPSS descriptives, the mean scores were calculated manually to gauge the extent change. The table showed that the mean Readiness scores were higher in the Married group attending the workshop in the Decision Maker action measure than those who did not. The same was true for those who did not participate in the intervention among the Never

Married. There was a statistical difference between the control and workshop for the Never Married under the Decision Maker, but no difference was appreciated for the Married. The Readiness scores for this action measure were higher in the control with a score of 5.0 compared to those who attended the intervention. The action sub-measures, Doctor and Sign Official Paper, had comparable Readiness mean score in both marital status groups. Thus, a difference does not exist between the intervention and control under the Decision Maker sub-variables. A statistical difference with first action measure (Decision Maker) forced a rejection of the null and retained in the others for hypothesis 7.

Table 22

Group Comparison of Decision Maker Level of Readiness and Marital Status

Action Measures	Married (n=10)			Never Married (n=7)		
	C (mean)	W (mean)	*p*	C (mean)	W (mean)	*p*
Decision Maker (DM)	3.7	4.3	0.357	5.0	3.3	0.038*
DM-Doctor	4.5	3.5	0.293	4.0	4.0	1.000
DM-Sign Official Paper	3.8	3.3	0.401	4.3	3.0	0.184

Note: Mean Readiness Score in Advance Care Planning Engagement; Ready ≥ 3; W, workshop; C, control; Decision Maker Subvariables [DM-Doctor; DM-Sign Official Paper]; n, number of cases; *p* value calculated on Excel using independent Student T-Test; * statistical significant p value.

For Hypothesis 8, the Chi-square of independence determined the association between the level of Readiness and marital status. The two subdomains, Doctor and Sign Official Paper, were incorporated to delineate which part of the decision-making process had issues. The highest Chi-square statistic was observed in the Never Married class and lowest in the Sign Offical Paper under the Married column. The Never Married group also had higher X^2 scores in all domains than the Married. The inquiry did uncover that there was an association between the level of Readiness and marital status. A strong statistical difference was seen in the Never Married for the Decision Maker and a borderline association for its subvariable, Sign Official Paper. As a result, the null was rejected for these two and retained under the Doctor subvariable. For the Married group, no association was found among any of the actions measures, so the null was retained. The above outcomes were depicted in Table 23.

Table 23

Association between Decision Maker Readiness and Marital Status

Action Measures	Married (n=18)		Never Married (n=29)	
	X^2(df=4)	*p*	X^2(df=3)	*p*
Decision Maker (DM)	3.06	.737	14.9	<.001*
DM-Doctor	2.85	.752	5.16	.202
DM-Sign Official Paper	2.43	.937	7.36	.049*

Note: X^2, Chi-square test of independence; **p* value statistically significant; Decision Maker and its sub-variables (doctor and sign official papers) and the Advance Care Planning Engagement level of Readiness between workshop and control and marital status; n, number of cases; df, degrees of freedom.

The ninth hypothesis, H9, disclosed the comparison of marital status against the level of Uncertainty for choosing a Health Care Surrogate and seeking a Do-Not-Resuscitate order. The analysis was organized with or without CADE intervention. The null hypothesis suggested that there was no change in the stated variables. Descriptive statistics and arithmetic were employed to satisfy the background for the hypothesis and Table 24 described these outcomes. There was an obvious difference between the Married participants who attended the workshop and those who did not for the Health Care Surrogate option. The *p* value was less than .05, so the null was rejected. No statistically significant change was found in the Do-Not-Resuscitate option for the same Married participants between control and the intervention. The level of Uncertainty for the Never Married in both options was also statistically insignificant.

From the observations, the mean comparison of the Marrieds in the control group showed that they had extremely elevated levels of Uncertainty with choosing a Health Care Surrogate. The same was noted with the Do-Not-Resuscitate order compared to their counterparts who attended the workshop. There was a borderline statistical difference between the marrieds who went to the workshop versus those that did not under HCS, so the null was rejected. For all others, the null was retained. In addition, the Never Married who joined in the intervention also had an equally elevated level of Uncertainty than the those in the control. The highest clinically significant decisional conflict was observed in the Do-Not-Resuscitate variable under the Never Married intervention crowd. These results determined that an effect existed with the level of Uncertainty and a person’s relationship status.

Table 24

Group Comparison of Marital Status and Level of Uncertainty

	Married				Never Married			
Uncertainty	C (mean) n=7	W (mean) n=6	X^2 df=1	*p*	C (mean) n=12	W (mean) n=17	X^2 df=1	*p*
HCS	38	15	3.90	.048*	27	35	.90	.342
DNR	43	21	.74	.359	13	45	2.87	.085

Note: SPSS Descriptives; Comparison of mean percent for Married and Never Married and level of Uncertainty between control and workshop for the decisional conflict options: Health Care Surrogate (HCS) and Do-Not-Resuscitate (DNR); n, number of cases; <25 more certain about an option, >25 uncertain about an option >37.5 extremely uncertain about an option; X^2(df), Chi-square statistic with degrees of freedom calculated on Excel*; **p* statistically significant.

The last hypothesis, (H10), designated a group comparison of the level of Readiness with Decision Maker and Ask Provider factors based on their decisional Uncertainty. The descriptives pinpointed that 26% (10/38) of the participants were ready to engage in an activity for a Decision Maker and 29% (11/38) were ready to Ask Provider questions. 72% on average were not ready for either activity. Table 25 illustrated low mean percent scores for the Ready group with a range of 8.3 to 17.4 and the Not Ready clan with a range 33.0 to 36.3 across the variables. The statistical significance tackled the null hypothesis, which explained that there was no difference among the ACP options between those who were ready versus those who were not. Within the Decision Maker's level of Readiness, the null hypothesis was rejected for the Health Care Surrogate and Do-Not-Resuscitate with *p* values of <.001and .001, respectively. The Ask Provider level of Readiness was also rejected with p <.05. for the Health Care Surrogate option. There was no difference in the level of Uncertainty among those who were ready and not ready in the Do-Not-Resuscitate option, so the null was retained under the Ask Provider as the *p* value was .158. Other outcomes taken from Table 25 were explained and rationalized in the ensuing paragraph.

Table 25

Comparison of the Level of Readiness and Uncertainty within ACP Options

Level of Uncertainty	Ready Mean^a ± SD^b (CI)^c	Not Ready Mean^a ± SD^b (CI)^c	*p*
Decision Maker	n=10	n=28	
Health Care Surrogate	8.3 ± 15.7 (0.9, 20.8)	34.2 ± 25.3 (24.9, 43.9)	<.001*
Do-Not-Resuscitate	9.1 ± 13.8 (1.5, 19.1)	36.3 ± 34.4 (23.8, 49.6)	.001*
Ask Provider	n=11	n=27	
Health Care Surrogate	13.6 ± 23.0 (2.2, 30.5)	33.0 ± 24.9 (23.7, 41.9)	.033*
Do-Not-Resuscitate	17.4 ± 28.9 (3.3, 39.2)	33.9 ± 33.1 (21.7, 46.3)	.158

Note: Independent T-Test with bootstrapping; Advance Care Planning Engagement level of readiness in a Decision Maker and Ask Provider. Ready ≥ 3 or higher; Level of uncertainty on the decisional conflict scale (DCS) calculated in percent under Health Care Surrogate and Do-Not-Resuscitate advance care planning (ACP) options; *statistically significant *p* value from equal variance not assumed; **statistically significant *p* value from equal variance assumed; Mean^a DCS percent; ^{b}SD standard deviation; ^{c}*CI* confidence interval; N number of cases; <25 more certain; >25 uncertain.

Observed Findings

The intervention fidelity section spoke to the unexpected events during the research's implementation, but there were some projected encounters from the recruitment circumstances and statistical analysis. In recruitment, there were two clear observations. First, the end-of-life topic is difficult. It was not unusual that during recruitment, some were not prepared to listen to a dialogue even at their faith leader's request. Those who were attentive, were candid about their personal experience with EOL conflict and were supportive of the initiative. The second feature observed was in the community academic partners. Some of the faith leaders had intergenerational members and knew that the younger population, that is, less than 35 years, were more apt to respond by social media than by word-of-mouth, so the recruitment was carried out by that avenue. Other faith leaders felt that one-on-one recruitment would be productive among their older congregants, which was where they spent most of their efforts. The familiarity with their congregants confirmed CAP's status as social leaders and accounted for the 93% recruitment response rate.

Some of the data findings had mixed observations. For instance, the level of Readiness did not seem to matter with education or income. Two-thirds of the participants had either a college degree or an annual income ≥ $45,000. Yet, a sparse number of participants were ready to engage. Another surprising observation was in the Do-Not-Resuscitate order educational component in CADE. The data discovered that those who were married and in the control were more likely to be uncertain about choosing a Do-Not-Resuscitate order compared to those who participated in the workshop. The opposite was true for the Never Married clan. Those who were placed in the workshop had increased level of Uncertainty for this option. A third important finding was the level of confidence (Self-Efficacy) the participants had about what they wanted at the end-of-life. Still, they were not ready to engage in the conversation. A fourth observation was between the level of Uncertainty and Readiness. The two factors were inversely proportional to each other. With low decisional uncertainty in those who were ready, there was high decisional conflict in those who were not. Some researchers might expect this since decisional conflict can accompany a degree of uncertainty. On a final note, a wide confidence interval was not anticipated upon statistical inspection of hypothesis 10. The sample size estimate was adequate, but in the real world, variability in the sample might be naturally occurring and was visible there.

Chapter Summary

The research's purpose was to delve into a strategy that minimizes decisional conflict by improving the participant's knowledge base of advance directives and providing conflict management skills. Three questions were posed to pragmatically answer the effect of this plan. Hypotheses one through five unwrapped the impact of the DCS and ACPE factors and analysis would thoroughly assess any changes in the participant's scores. Examination unveiled that the scores did not change for DCS. For ACPE Self-Efficacy and seven out of nine Readiness variables, there was also no change. Nevertheless, change was detected between the intervention and control in two ACPE level of Readiness factors: the Ask Provider and the Flexibility – Doctor subdomain.

The sixth through eight hypotheses addressed the level of Readiness between the intervention and control, the comparison of marital status, and its association of the two, respectively. Analysis proved that there was a statistical difference and an association with the level of Readiness and marital status where the Never Married crew was mostly affected. The significant *p* values were related to the Never Married level of Readiness and their level of Uncertainty if they attended the workshop. The Marrieds that did not attend the workshop had higher decisional conflict scores and a higher level of Readiness when assessed against the Never Married. Another part of the quest unpacked the level of Uncertainty and Readiness between the participants and the ACP options. In the analysis between those who were ready and not ready, there were three significant *p* values. Two *p* values were under the ACP options, Health Care Surrogate and Do-Not-Resuscitate for the Decision Maker. The other *p* value was found in the Ask Provider domain under the Health Care Surrogate. The next chapter further elaborated on these findings, the project's limitations, tentative recommendations, the study's implications, and concluding remarks.

Chapter 5: Discussions, Recommendations, and Conclusion

The request by the Institute of Medicine to equalize the advance care planning in people of color was expeditious. This research tried to answer the call by introducing an EOL program to faith-based organizations hosting racial-ethnic groups. CAP was utilized to expand recruitment and demonstrated that it was the right tool for that activity. Besides that, the project's quantitative investigation inspected if the factors of decisional conflict and ACP engagement were a valuable assessor for behavioral change. The analysis also scrutinized the participants' willingness to participate in end-of-life planning.

The findings pronounced that the clinical threshold for decisional conflict between the intervention and the control was detectable for Health Care Surrogate, Living Will, and Do-Not-Resuscitate options. In the exploration of ACP engagement factors, all participants showed confidence in their ability to decide on a Decision Maker, Quality of Life, Flexibility, and Asking Provider questions. However, they were not ready to engage in discussions on Flexibility and Asking Providers questions. The comparison between marital status and the level of Readiness revealed that the Never Married group was at-risk for not participating in the ACP process. The final appraisal considered the level of Readiness and the decisional conflict level of Uncertainty for those who were ready to engage in ACP and those who were not. The study found that among the participants who were Ready to engage, they were very certain about their decision on a decision maker for a Health Care Surrogate and Do-Not-Resuscitate orders compared to those who were Not Ready. For decisional conflict in the Ask Provider option, the level of Readiness was equitable for the Do-Not-Resuscitate order and statistically different for the

Health Care Surrogate. This chapter covers these findings in detail, the project's limitations, some recommendations grounded from the results, implications of the research, and concluding remarks.

Interpretation of Findings

There are likely to be extraneous reasons for the outcomes attained by this quantitative inquiry, but the research was not designed to figure out causality. It served to give a big picture of CADE's usefulness in conducting education in end-of-life planning for faith residents in underrepresented communities. The intervention provided measurements of the attendees' knowledge of advance directives and gathered the extent of their readiness to engage in ACP. The decisional conflict scale gave a glimpse of where clinical decisional conflict was located and positively identified the educational areas where the participants felt strongest and where their weaknesses lie. The ACPE survey had two purposes. The primary goal was to check the participant's readiness to engage and the secondary one was to determine where the engagement was needed. The interpretations from the analysis were rearranged according to the research questions specified in Chapter 1.

Research Question 1

Hypotheses one through five answered the effect of the intervention on the participants' decisional conflict and advance care planning engagement scores. The five DCS variables were computed for H1 to H3. Results revealed that clinically significant decisional conflict was present in both groups under each of the three DCS options. Out of the five DCS variables, three variables, Informed, Values Clarity, and Uncertainty had higher decisional conflict scores in the control group under the Health Care Surrogate option. For the Uncertainty variable, the workshop group held higher scores in the Living Will and Do-Not-Resuscitate options. Jointly, these signaled that both groups were equivalent since there was no difference. So, statistically speaking, CADE did not have a strong impact in alleviating decisional conflict.

Another finding from the analysis was that it picked up decision delay (DCS score >37.5) under the Informed variable in the control group for the Do-Not-Resuscitate option. This meant that these participants did not feel well-informed about this treatment order, which might be a future educational opportunity. For scores under 25, data showed that in general, the participants had less decisional conflict under the Support and Decision-Making variables. They felt supported and certain about their decision-making skills, signifying they were most comfortable with these parts. Hence, it was unmistakable that DCS could track decisional conflict on the three main ACP options. The CADE intervention then, has a feasible attribute that makes it a good resource to detect decisional conflict.

The ACPE factors were investigated under H4 and H5. Hypothesis 4 tested the Self-Efficacy variables and hypothesis 5 checked the level of Readiness. In the Self-Efficacy domain, both groups felt equally confident that they can engage in advance care planning based on the lack of statistical significance. The control group had higher scores than their matching partner. Lower scores in the workshop group were reasonable as those in the intervention group were introduced to topics that made them rethink their positions. Hypothesis 5 cleared the way for the nine action measures in the Readiness domain. It unmasked a difference in two measures, Flexibility - DOC (flexibility to speak with a doctor) and Ask Provider (asking the provider questions). These measures projected that the workshop participants were more ready to ask their provider questions and speak about the amount of flexibility they would allow during their end-of-life care than those in the control. As such, the ACPE factors were effective at determining the participants' readiness for some aspects of the ACP process and the CADE intervention was useful in capturing data to explain their behavior.

Research Question 2

The second question responded to hypotheses 6 to 8 with the overall theme recognizing the difference in the behavior between the intervention and control for: (1) readiness; (2) marital status and readiness, and (3) association of marital status and readiness. Hypothesis 6 scrutinized the level of Readiness between groups. The percentage in the number of cases was not equivalent in two variables: Decision Maker and Ask Provider. For the Decision Maker – SOP (Sign Official Paper) variable, the percentage in cases was the same. In the Decision Maker, more participants in the control group were ready and in Ask Provider, those in the workshop were more ready. Nevertheless, the null hypothesis was true. The *p* value was greater than .05 in all factors, so both groups were deemed comparable in their readiness to engage.

A major difference that the analysis highlighted was the readiness by those in the control to choose a Decision Maker over those in the workshop. In contrast, those in the CADE workshop were more ready to Ask Provider questions. This report was unsurprising as the choice of Decision Maker was reviewed in the workshop to which those in control groups were not privy too. During the intervention, it was stressed that having the right surrogate is a matter of life and death and should be weighed carefully. This speculation suggested that those in the control group may not have realized the seriousness of their probable decision maker and made their choice haphazardly. The same would be accurate for the Ask Provider action measure where those in the workshop were given the knowledge on what to ask of their providers. Thus, they were more ready to ask questions of their provider than those in the control clan.

Hypotheses 7 inspected the mean comparison of the participants' level of Readiness and marital status. Prior studies unearthed that marital status was a vulnerable factor for end-of-life discussions. Cooney et al. (2019), Gerst & Burr (2008), and Carr & Khodyakov (2007) attained that married women, divorced men, and the never married were unlikely to have informal end-of-life conversations. Analysis asserted that those who Never Married were at risk for not deciding on a Decision Maker than the other two options. Even so, it was unexpected that the participants in both control groups had higher readiness scores. Higher scores insinuated that they were more ready to decide on the measures than those in the intervention. CADE was created to increase readiness in specific ACP processes, which appeared to be helpful under the Decision Maker factor in the Marrieds attending the workshop. For H7 then, the intervention complemented previous findings and confirmed that an educational endeavor on choosing a Decision Maker may be valuable for those who are married and the unmarried.

A reminder about ACPE was that it was not an instrument of choice for previous studies with people of color. CADE was unique in that sense. Simple statistics isolated a difference in this ethnic group among their Never Marrieds, which was consistent with the literature. Also, an important outcome worth mentioning is the flipped results seen in the control. Participants in this grouping had higher readiness scores in all measures, except for one variable. This unusual finding can be explained by recognizing that those in control were not well-informed about the ACP process. All the CADE participants were selected because they had limited knowledge of the topic. If that was true, it was logical that they were less familiar with choosing a Decision Maker, talking to their providers (DM-Doctor), and signing the official paper (SOP). They choose their responses based on self-knowledge to produce what the analysis found.

For Hypothesis 8 (H8), it revealed plausible associations between marital status and the participants' Readiness. There was a connection between the level of Readiness and those who Never Married as the *p* value for that comparison was statistically significant. Although there was significance, the type of relationship was not examined, but there was a strong association with Decision Maker ($p < .001$) and a weak one with Sign Official Paper, (p 0.49). The *p* value close to .05 was interpreted with caution since the variance for this factor was unequal. No association was prevalent between marital status and the level of Readiness when talking to doctor (DM-Doctor). The insignificant *p* value meant that both groups were equally ready to speak with their provider. Finally, there was one vital impression from the association statistics. The Never Married group were unlikely to participate in the ACP process, which placed them at-risk for high decisional conflict.

Research Question 3

The last two hypotheses (H9 and H10) explored if the level of Uncertainty can act as a barrier in a participant's readiness to engage in ACP. Hypothesis 9 probed if marital status played a role in the level of Uncertainty. The analysis illustrated that the Married in the control group were more uncertain about choosing a health care surrogate and seeking a Do-Not-Resuscitate order than those who attended the workshop. The report was the opposite of the Never Married group in the intervention. Their level of Uncertainty was higher than those who did not attend in both ACP options. Both outcomes had intelligent explanations. The Marrieds in the control did not have access to the details that may have shaped their decisions on those activities. In the workshop, the facilitator went over particular topics, which required the attendees to rethink their position in those areas. Therefore, the common denominator was CADE. With it, the participants were given clues on what to assume from the ACP process.

There were two findings that were alarming and interesting. Under the Do-Not-Resuscitate option, the intervention Never Married group had extremely high decisional conflict mean percent scores. This suggested that they were vulnerable to decision delay, a state that should be minimized if not avoided. The appealing part of CADE was that it disproved the assumption that if you are married, choosing a health care surrogate would be easy. The byproduct of this research confirmed that marital status is a risk factor for advance care planning. Irrevocably, H9 deduced that CADE may be a good preparatory tool for those who are married or unmarried, as well as a satisfactory resource to detect levels of Uncertainty during the advance care planning process.

Hypothesis 10 applied the robust ACPE survey to compare the level of Readiness and Uncertainty. The outcomes were legitimate as the p value was $<.05$ in three of four instances in two ACP options, the Decision Maker, and the Ask Provider variables. The statistical significance endorsed that there was a difference between the level of Readiness and Uncertainty. The initial set of measurements detected the participant's level of Readiness or the lack thereof. The results established that most participants were not ready to choose either a Health Care Surrogate or seek a Do-Not-Resuscitate order. There was another finding under the Ask Provider Readiness factor. A difference was undetected in the Do-Not-Resuscitate order between the Ready and the Not Ready group. This implied that both groups were statistically equivalent in their readiness level.

A second facet seen in the findings was that decisional uncertainty was present in all categories among those who were not ready. The decisional conflict scores under the level of Uncertainty were greater than 25 in those who were not ready and less than 25 in those who were. Most were proximal to decisional delay. The inverse results were a clear sign that the level of Readiness was divergent with the level of Uncertainty. This provides evidence that decisional conflict might be prevalent in the ACP process. With prominent levels of Uncertainty, it will affect an individual's readiness to engage in end-of-life preparations.

Study Limitations

The intervention's global intention was to learn if DCS and ACPE were appropriate instruments for CADE and included some practical conflict management skills to reduce EOL conflict during the ACP education. This effort did come with limitations from underlying human and statistical influences. The drawbacks under the human influence pertain to theological view, sample population bias, participants' knowledge of advance directives, and CADE's design. For the theological perspective, most of the participants self-identified as a member of a Judeo-Christian faith, so the interpretation only reflects one religious sect and not all faith types. Next, Alachua County had the highest number of residents who may not be a true representation of Florida's racial-ethnic cultures, increasing the probability of convenience sampling. Third, end-of-life is a complex topic and a snapshot of it may be inadequate to decide on preferred wishes in the workshop's brief time span. One ultimate detail was that CADE incorporated conflict management subsections that were not authenticated for use within a controversial health topic. Without further testing, it would be difficult to interpret CADE as a sound community intervention.

The statistical estimation had flaws as well. First, the ACPE sub-variables TDM (Talk to Decision Maker), DOC (Talk to Doctor), and SOP (Sign Official Paper) were insufficiently verified as a standalone component under the Self-Efficacy action domain for the 15-question survey. The creator of the survey insisted that the 80-question survey was best when analyzing those variables. Inappropriate verification can lead to Type 1 or 2 error which would hamper the results. Secondly, Faber and Fonseca (2014) agreed that too small or too large samples may compromise a study's conclusion. With 12/53 (23%) missed responses in the DCS portion, some sample cells had less than the expected counts which again can incur Type 1 or 2 error. One final assertion on the research's setback was allocation bias. Suresh (2011) stated that sampling and allocation biases can interfere with the data's interpretation. Consequently, the movement of some participants from their original random allocation might have had that effect.

Recommendations

Innovative programming with positive outcomes can have a benefit to society if it can reach the intended target through the program type and the correct implementation scheme.

The CADE research was an inventive attempt to contribute to society by accentuating the inequity of advance directives in racial and ethnic communities to decrease barriers in that group. With that in mind, the study's findings and weaknesses may direct where future research may be needed. There were a few parts worth mentioning.

(1) The Informed variable within the decisional conflict scale was most consistent in discriminating against treatment options. Yet, it was underutilized in this research due to the perception that those with higher education were more likely to be more informed about advance directives. This research demonstrated that awareness of advance directives is not equivalent to being truly informed. One direction for further study would be to isolate the real impact of the CADE intervention on this Informed variable since the workshop group had lower decisional conflict scores across three DCS options.

(2) Another route to investigate would be to demarcate individual behavioral change. The Pretest-Posttest approach would be a sensible method for a within-group design to discover personal knowledge assessments and actionable measures like behavioral change over time. If funding is not an obstacle, this potential hypothesis will provide an answer to this inquiry.

(3) The CADE intervention had no reliable assessment of its components as a combination, so a version that tests this amalgamation in the community would be ideal. A program aimed at a specific group must consider interactions at all societal levels which is a good indicator for community-based participatory

research (CBPR). This scientific investigation has the capacity to use proven techniques of community engagement and environmental policies to properly vet educational materials, engross diverse faith or religious types, and gather a representative sample of the perceived population.

(4) Fifty-seven percent of the participants experienced EOL conflict, but the type of conflict was not elicited in this research. A probable next step would be to perform qualitative research to collect these stories. This would provide their narrative voices, guide the educational focus, and determine which conflict management skills would be best.

(5) CADE was intended for a virtual audience and offered only generalized approach to conflict. A pilot study with either a face-to-face standalone or as a hybrid would make it more desirable. In addition, the research would entail finding out if the current activities were appropriate or determining if different exercises were necessary. This trial investigation would also involve teaching them how to resolve conflict of values using the conflictual and/or the problem-solving model. With this knowledge and practice, the participants would gain specific skills related to end-of-life conflict.

All the recommendations tackled some of the latest end-of-life constructs in literature. The hope is that it potentially opens the door for other innovations and solidifies CADE as a dependable resource.

Implications

The apparent arching contribution of the study's objectives was decreasing decisional conflict through ACP engagement in faith communities in Florida. To make that happen, a network of community academic partners was tapped to provide access to leadership in underserved faith-based organizations. This arrangement opened doors to reach the specific population and provided the field of conflict resolution (CR) an opportunity to shine in this setting. Conflict near the end-of-life can wreak havoc in family relationships. If it remains unresolved, it can prolong the grieving process and lead to poor care. Conflict resolution specialists are in a prime spot to expand into the end-of-life arena and there are three ways in which to make this a possibility:

(1) Conflict resolution practitioners could draw attention to end-of-life conflict, its consequences, and provide skills training for patients, families, and health care providers. Conflict management education may empower them to have less interpersonal conflict and elevate the communication skills of providers and hospital staff around end-of-life conflict.

(2) CR specialists can foster a bridge between pracademics and clinical ethics consultants. Pracademics are experienced in the community and clinical ethicists are advisors in hospital settings. Both have expertise that would be mutually beneficial for the right audience and topic.

(3) Hospital Chaplains are integrated in the health care system, and many do not have conflict management training. As spiritual gatekeepers for patients and

their faith community, their impact could be doubled with proper training. CR specialists can provide four paths for them:

(a) Offer training in skills specific to end-of-life conflict.

(b) Prepare an introductory course as a continuation education elective for certification purposes.

(c) Create a Train-the-Trainer program to deliver a similar workshop with the aid of conflict resolution specialists.

(d) Train the Chaplains in conflict resolution so that they would be prepared to help their congregants.

The project's endeavor also included a social ecological model to display which levels have interactions around the topic. Through this model, CADE's impact can unrefutably supplement the society at-large. The model has a societal phase that contains the religious worldview. The educational workshop can be adapted to a cultural norm to reach those of the same faith, interfaith, or the irreligious. Organizations within the community represent the second level of the model and it is where academia resides. Land-grant universities are accustomed to community partnerships like faith-based organizations built from years of trust. It is this trust that produced a shared network that is mutually beneficial, and the CADE intervention relied heavily on such relationships for its instillation.

The next level in the model is social support which is appropriate for families and individuals. Faith leaders are good examples of individuals capable of supporting spiritual sustenance. If taught, they can also encourage health education among their congregants. The lowest level of the model is the individual phase. This is where new knowledge, skills, and a reflection time for personal values reside. At this level, the participants could change their end-of-life story. The social ecological model employed within CADE is poised to be an advantage in the society in the following ways:

(a) Ascertained areas where education may be indispensable when working with faith communities who have younger congregants.

(b) Elucidated how partnerships with academia can assist in working with the underserved communities.

(c) Permit conflict resolution specialists to be active in events at senior centers and community hospices who host annual advance care planning. At these centers, CR specialists can educate residents in conflict skills training to reduce end-of-life conflict.

(d) A Train-the-Trainer program for Hospital Chaplains could transfer their knowledge to other community leaders who may have networks regionally and nationally.

(e) Encourage conflict resolution specialists' involvement in other initiatives to diminish health inequalities in marginalized communities such as managing conflict arising from the lack of health care access.

There were shortcomings in this research project. Nonetheless, the global message was that with the aid of community partners, advance care planning education is possible within faith communities and can be used to handle conflict issues around the end-of-life.

Conclusion

A well-known example of an end-of-life conflict that gripped Florida in the early 1990's and the nation was Terri Schiavo's case. The conflict between Schiavo's family over the right to refuse treatment and nutritional sustenance ended in a legal battle that lasted more than a decade and resulted in a fractured family. The message was clear. The lack of documentation of one's last wishes can fuel conflict. The literature provided evidence of conflict erupting from end-of-life matters. It is a common tale that those without advance directives will be most vulnerable. Sadly, underserved groups remain predisposed, which made it essential to decrease this risk by improving education to document their EOL preferences.

This study had 79% of its participants from racial-ethnic ancestry and CADE laid the groundwork for a community program to increase completion rates of advance directives among this group. Through community academic partnerships, the research extended the working relationship with faith leaders to access their network for recruitment. Success in recruitment led to data collection of surprising and anticipated outcomes. For example, most individuals were unprepared for end-of-life talks, but they were confident in what they wanted. Some felt equipped to document their care, while others were ready to ask their provider questions. Another finding was that unmarried individuals were susceptible to neither discussing nor completing an AD. The CADE intervention proved that decisional conflict may be frequent during the ACP process and the readiness to engage is related to a person's level of Uncertainty. Ultimately, the conflict resolution field can rectify mayhem caused by conflict through practical projects like CADE, that emphasized EOL preparation with skills training.

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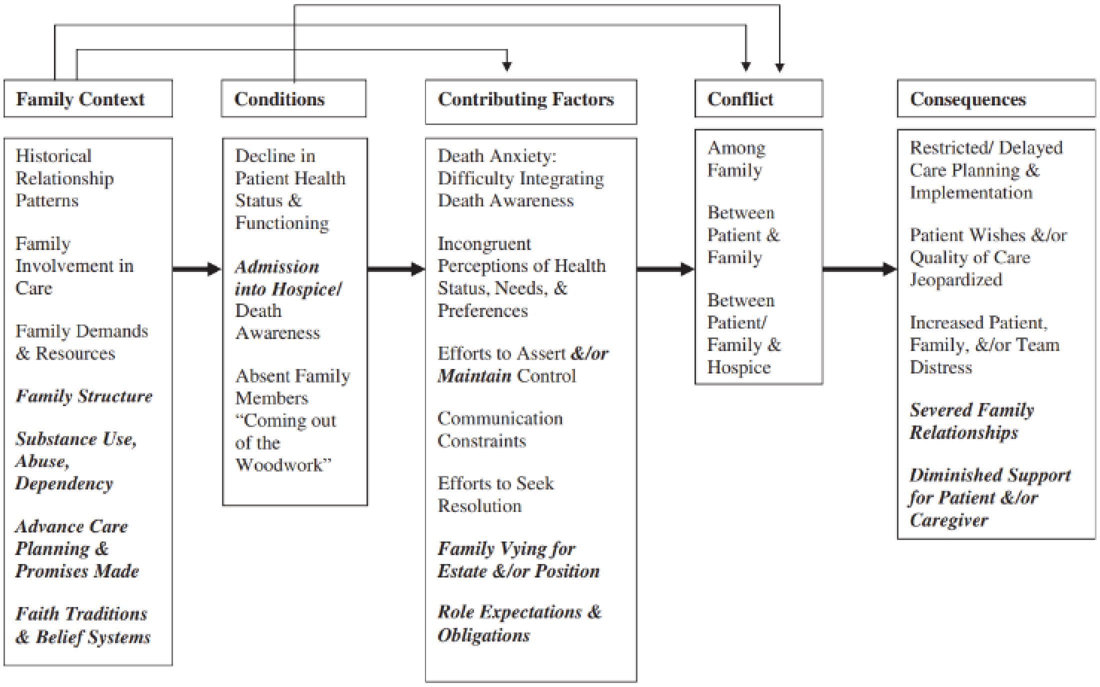
Appendix A

Figure 2. *Family Conflict at the End-of-Life*



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Appendix B

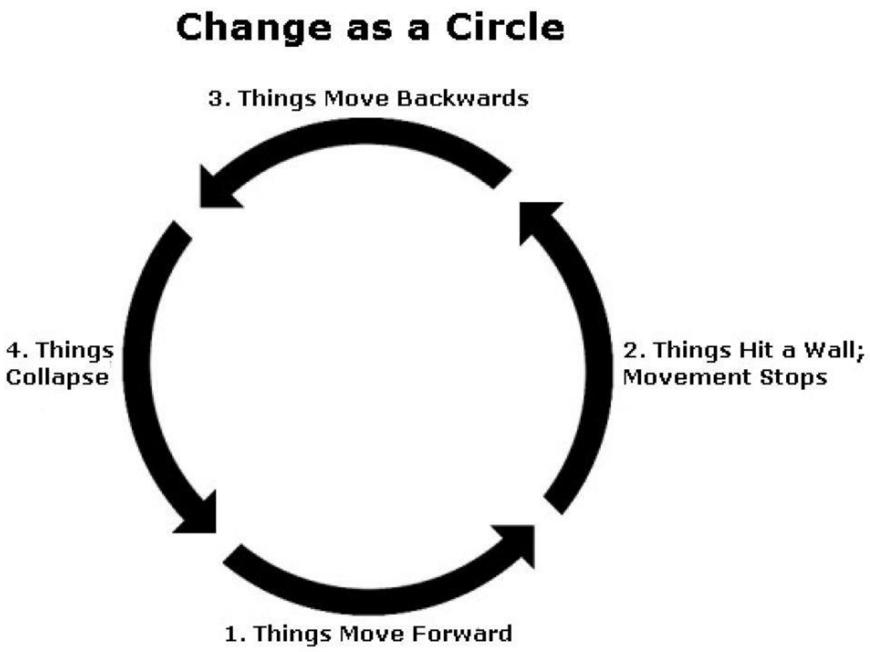
Table 1. Keyword Searches and Abbreviations

advance care plan*
advance directive*
Autonomy
community academic partner*
community partner*
community program*
completion rates
Conflict
conflict management
conflict resolution
conflict skills training
conflict strategies
disagreement*
dispute*
education
end-of-life; end of life
end-of-life conflict; end of life conflict
ethical dilemma*
Facilitat*
faith communit*
faith-based organization*
family conflict; famil* conflict
honor*
implementation

Note: * abbreviated

Appendix C

Figure 3. Lederach's Change as a Circle



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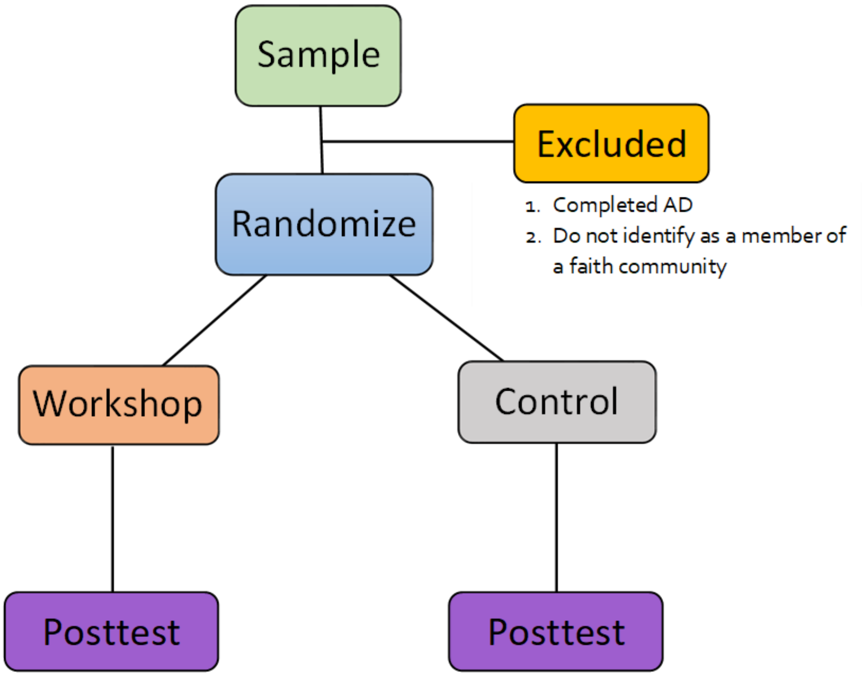
Appendix D

CADE Workshop Outline

I.	Introduction	Facilitator
II.	Icebreaker	Facilitator
III.	Conflict Overview	Facilitator
IV.	Break	All
V.	Advance Directives Overview	Facilitator
VI.	Break	All
VII.	Conflict Management Practice	Facilitator
VIII.	Break	All
IX.	Closing	Facilitator

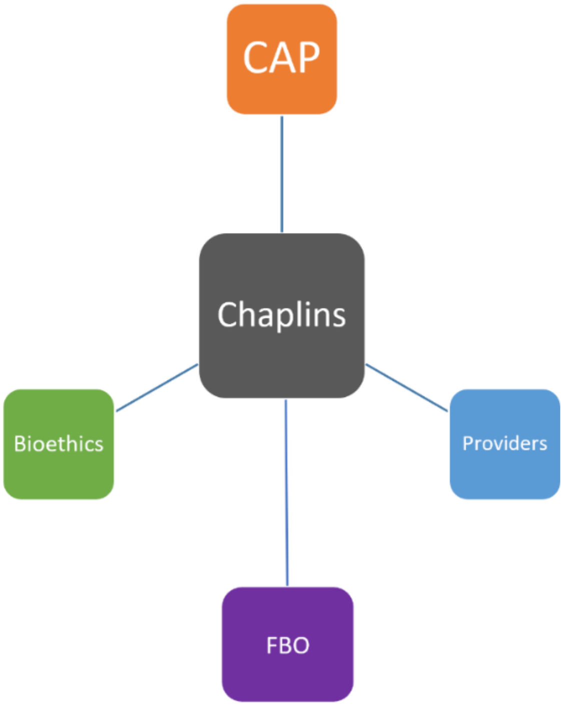
Appendix E

Figure 5. Posttest Sample Pathway



Appendix F

Figure 6. Sample Recruitment by CAP



FBO (Faith-Based Organization)

Appendix G

List of Random Number with Designation

59 – Control
26 – Workshop
45 – Control
30 – Workshop
37 – Control
12 – Workshop
36 – Workshop
55 – Control
24 – Workshop
63 – Control
6 – Workshop
31 – Control
10 – Workshop
7 – Control
29 – Control
57 – Control
13 – Control
18 – Workshop
25 – Control
52 – Workshop
48 – Workshop
38 – Worksop
20 – Workshop
40 – Workshop
34 – Workshop
11 – Control
1 – Control
23 – Control
21 – Control
17 – Control
56 – Workshop
49 – Control
14 – Workshop
16 – Workshop
42 – Workshop
39 – Control
51 – Control
60 – Workshop
64 – Workshop
54 – Workshop
33 – Control
15 – Control
41 – Control
8 – Workshop
58 – Workshop
46 – Worksop
50 – Workshop
22 – Workshop
53 – Control
27 – Control
62 – Workshop
9 – Control
28 – Workshop
35 – Control
4 – Workshop
2 – Workshop
43 – Control
44 – Workshop
32 – Workshop
5 – Control
3 – Control
47 – Control
61 – Control
19 – Control

Appendix H

Table 4. Independent and Dependent Variables

Independent	Dependent
Demographics	**Decisional Conflict**
Age	Informed
Gender	Values Clarity
Ethnicity	Support
Race	Uncertainty
Marital Status	Effective Decision-Making
Income	
Education	__ACPE Action Measures**__
County	Decision Maker
	Quality of Life
Decisional Conflict Options^	Flexibility
Health Care Surrogate	Ask Provider
Living Will	
Do-Not-Resuscitate	**ACPE Action Sub-measures**
	Talk to Decision Maker
__ACPE Action Domains*__	Talk to Doctor
Self-Efficacy	Sign Official Paper
Readiness	
CADE Intervention	
Workshop	

Note: *Advance Care Planning Engagement (ACPE) Action Domains act as independent variables describing the category of behavior; **Describes the types of behavior being measured & subjected to manipulation; ^Act as independent variable since it lists the type of advance care planning area being evaluated.

Appendix I

Table 7. Hypotheses for Self-Efficacy Decision Maker & Quality of Life

Hypotheses Statements	
A_n	There is no change in the participants scores for the self-efficacy DECISION MAKER domain with the CADE intervention compared to those without.
A_a	There is change in the participants scores for the self-efficacy DECISION MAKER domain with the CADE intervention compared to those without.
B_n	There is no change in the participants scores for the self-efficacy QUALITY of LIFE domain with the CADE intervention compared to those without.
B_a	There is change in the participants scores for the self-efficacy QUALITY of LIFE domain with the CADE intervention compared to those without.
C_n	There is no change in the participants scores for the self-efficacy QUALITY of LIFE subdomain DOCTOR with the CADE intervention compared to those without.
C_a	There is change in the participants scores for the self-efficacy QUALITY of LIFE subdomain DOCTOR with the CADE intervention compared to those without.

Appendix J

Table 8. Hypotheses for Self-Efficacy Flexibility & Ask Provider

Hypotheses Statements	
D_n	There is no change in the participants scores for the self-efficacy FLEXIBILITY subdomain TALK to DECISION MAKER with the CADE intervention compared to those without.
D_a	There is change in the participants scores for the self-efficacy FLEXIBILITY subdomain TALK to DECISION MAKER with the CADE intervention compared to those without.
E_n	There is no change in the participants scores for the self-efficacy FLEXIBILITY subdomain DOCTOR with the CADE intervention compared to those without.
E_a	There is change in the participants scores for the self-efficacy FLEXIBILITY subdomain DOCTOR with the CADE intervention compared to those without.
F_n	There is no change in the participants scores for the self-efficacy ASK PROVIDER domain with the CADE intervention compared to those without.
F_a	There is change in the participants scores for the self-efficacy ASK PROVIDER domain with the CADE intervention compared to those without.

Appendix K

Table 9. Hypotheses for Readiness-Decision Maker and Subdomains

	Hypotheses Statements
A_n	There is no change in the participants scores for the readiness DECISION MAKER domain with the CADE intervention compared to those without.
A_a	There is change in the participants scores for the readiness DECISION MAKER domain with the CADE intervention compared to those without.
B_n	There is no change in the participants scores for the readiness DECISION MAKER subdomain DOCTOR with the CADE intervention compared to those without.
B_a	There is change in the participants scores for the readiness DECISION MAKER subdomain DOCTOR with the CADE intervention compared to those without.
C_n	There is no change in the participants scores for the readiness DECISION MAKER subdomain SIGN OFFICIAL PAPER with the CADE intervention compared to those without.
C_a	There is change in the participants scores for the readiness DECISION MAKER subdomain SIGN OFFICIAL PAPER with the CADE intervention compared to those without.

Appendix L

Table 10. Hypotheses for Readiness-Quality of Life and Subdomains

	Hypotheses Statements
D_n	There is no change in the participants scores for the readiness QUALITY OF LIFE subdomain TALK to DECISION MAKER with the CADE intervention compared to those without.
D_a	There is change in the participants scores for the readiness QUALITY OF LIFE subdomain TALK to DECISION MAKER with the CADE intervention compared to those without.
E_n	There is no change in the participants scores for the readiness QUALITY OF LIFE subdomain DOCTOR with the CADE intervention compared to those without.
E_a	There is change in the participants scores for the readiness QUALITY OF LIFE subdomain DOCTOR with the CADE intervention compared to those without.
F_n	There is no change in the participants scores for the readiness QUALITY OF LIFE subdomain SIGN OFFICIAL PAPER with the CADE intervention compared to those without.
F_a	There is change in the participants scores for the readiness QUALITY OF LIFE subdomain SIGN OFFICIAL PAPER with the CADE intervention compared to those without.

Appendix M

Table 11. Hypotheses for Readiness-Flexibility & Subdomains & Ask Provider Domain

	Hypotheses Statements
G_n	There is no change in the participants scores for the readiness FLEXIBILITY subdomain TALK to DECISION MAKER with the CADE intervention compared to those without.
G_a	There is change in the participants scores for the readiness FLEXIBILITY subdomain TALK to DECISION MAKER with the CADE intervention compared to those without.
H_n	There is no change in the participants scores for the readiness FLEXIBILITY subdomain DOCTOR with the CADE intervention compared to those without.
H_a	There is change in the participants scores for the readiness FLEXIBILITY subdomain DOCTOR with the CADE intervention compared to those without.
I_n	There is no change in the participants scores for the readiness ASK PROVIDER with the CADE intervention compared to those without.
I_a	There is change in the participants scores for the readiness ASK PROVIDER with the CADE intervention compared to those without.

Appendix N

Table 14. Sample Demographics

Demographics	Cases (%)	Demographics	Cases (%)
Gender		**Marital Status**	
Male	17 (33)	Married	18 (34)
Female	35 (67)	Divorced	6 (11)
		Never Married	29 (55)
Age (years)			
18 – 24	2 (4)	**Education**	
25 – 34	19 (36)	GED/High School	4 (8)
35 – 44	12 (22)	Technical	9 (17)
45 – 54	10 (19)	Associate	5 (9)
55 – 64	8 (15)	Bachelor	20 (38)
65 – 74	2 (4)	Graduate/Professional	15 (28)
Race		**Income (annual)**	
African American	29 (55)	<15,000	4 (8)
Asian	4 (7)	15,000 – 30,000	6 (11)
Caucasian	11 (17)	30,000 – 45,000	6 (11)
Other	9 (11)	45,000 – 60,000	11 (21)
		>60,000	18 (34)
Ethnicity	13 (25)	Declined	8 (15)
Hispanic	40 (75)		
Non-Hispanic			

Note: %, percent