Interventions in the Primary Care Setting Aimed at Improving the Rate of Completion of Advance Directives

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In fulfillment of the requirements for the degree of

Doctor of Nursing Practice

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Abstract

The majority of people never discuss their choice of treatment in end-of-life issues and do not have an advance directive (AD). The cause may be due to the lack of organized efforts to achieve completion of ADs. This project used a quasi-experimental one-group pretest-posttest design to determine if an educational intervention increased the completion of an AD. Project results showed that the combination of repeated written and verbal educational information about ADs provided via a primary care setting is an effective intervention to increase completion of ADs. A convenience sample revealed 14% of 90 primary care clinic patients had a completed AD. Following the educational intervention for those patients without an AD, the completion rate was 56% (p=0.01, 95% Confidence). The overall completion percentage in the clinic sample increased to 62%. These results were both clinically and statistically significant, (p <0.05, 95% Confidence).

Keywords: advance directive, end-of-life, educational intervention, primary care
Interventions in the Primary Care Setting Aimed at Improving the Rate of Completion of Advance Directives

An advance directive (AD) is a legal written statement regarding the extent of medical treatment desired in the event that the person is unable to communicate and is no longer able to make decisions. The AD prevents misunderstanding among the patient, family, and healthcare providers. Unfortunately, the majority of people, regardless of educational level, age, or gender, never discuss their choice of treatment in end-of-life issues, and do not have an AD (Maller, 2013).

**Problem Area**

Less than a third of Americans have documented their end-of-life choices or appointed a health care agent to do so (Wilkinson, Wenger, & Shugarman, 2007). This is troubling because end-of-life care can be unnecessarily prolonged, painful, expensive, and emotionally burdensome (Connors et al., 1995). In one study, 25% of lay respondents reported lack of awareness as the reason for not having an AD (Rao et al., 2007). A study by Duke, Thompson, and Hastie (2007) found the cause of a continuing low completion rate of ADs may be due to the lack of organized efforts to achieve completion of ADs. Primary care providers should educate their patients on the importance of an AD, but few consistently do, and even fewer document the existence of an AD (GAO, 1995). Health care providers often fail to initiate the difficult and time-consuming discussions of end-of-life care and ADs (Stiller et al., 2001).

**Literature Review**

Using a search of multiple databases for studies conducted after the year 2000 in primary care settings in the United States, it was found that many educational interventions have been studied regarding their efficacy in completion of ADs. Current evidence can be categorized into
interventions that are patient-centric, provider-focused, or modality specific. A summary is found in Table 1.

**Interventions**

**Patient Centered.** A patient-focused intervention may be more appropriate than a provider-only intervention (Heiman et al., 2004). Giving the patient the chance to ask questions and to personalize the information improved AD completion rates (Jezewski et al., 2007). The provision of oral information about ADs delivered over multiple visits is the most successful intervention (Bravo, Dubois, & Wagner, 2008). Interventions that were most effective included repeated contacts with the patient by the provider (Jezewski et al., 2007).

**Provider Focused.** Direct counseling appears to positively influence the completion rate of ADs (Patel, Sinuff, & Cook, 2004). Providing information on ADs, whether orally or in writing, forms, and assistance with their completion lead to higher rates of ADs (Bravo, Dubois, & Wagner, 2008). Provider-reminder only was an ineffective method to increase completion of ADs (Heiman et al., 2004).

**Specific Modality.** Multimodal interventions were shown to increase AD completion rates with the most effective intervention being the combination of educational material and repeated conversations (Ramsaroop, Reid, & Adelman, 2007; Tamayo et al., 2010). Combined written and verbal educational interventions were more effective than single written interventions in increasing the completion rate (Durbin, Fish, Bachman, & Smith, 2010). Written materials without face-to-face interaction were ineffective in improving the completion rate (Ramsaroop, Reid, & Adelman, 2007).
Summary of Literature Review Findings regarding Effectiveness

The combination of written and verbal educational information about ADs was found to be the most effective intervention to increase completion of ADs. Face to face education, take home educational materials, and a follow-up intervention will allow the patient to discern his specific choices for end-of-life care and to increase the rates of completed ADs. One-on-one counseling with a trusted provider positively influences the completion rate. Current research supports the use of multimodal interventions that include oral and written information in the primary care setting.

Theoretical Framework

Prochaska’s stages of change model (transtheoretical model) was selected as the framework for this project because it has been widely used in health behavior interventions (see Figure 1). The transtheoretical model (TTM) assumes that behavior change occurs gradually in stages. The TTM can be utilized to assess a patient’s readiness to make a behavior change, and supporting the use of an appropriate intervention to assist in completion of an AD. Providers can assist in the completion of an AD through understanding the stages of change. The TTM can be used to increase AD completion by assisting the patient to progress from Precontemplation to Contemplation to Preparation for action and Maintenance (Prochaska & Norcross, 2001).

Medvene et al. (2003) describes the stages of change model in the process of AD completion as Precontemplation and Contemplation (e.g., “I’ve been thinking I might want to sign an AD”), Preparation (e.g., “I’ve read the information and talked with my family”), Action (e.g., “I’ve signed an AD”), and Maintenance (e.g., “I’m interested in revising my directive”). Being uninformed about the importance of an AD is indicative of the Precontemplation stage and education is the focus during this stage. Contemplation is the stage of awareness to consider the
benefits of advance planning. Individuals in the Contemplation stage are not ready to act immediately (Prochaska & Norcross, 2001). Allowing time for the patient to study the educational materials and to discuss with family is the key during the Contemplation stage. Preparation is the stage in which people intend to take action in the near future. Ensuring the patient has access to the appropriate documents and repeated discussions are the key to the Preparation stage. Action is the stage in which AD is completed. Maintenance is the stage in which the completed AD will be reviewed and documented in the patient records during this stage.

**Project Purpose and Objectives**

The purpose of this project was to determine whether a verbal educational intervention with take-home information packet, followed by a phone call at two weeks that reinforced the education, would lead to increased completion of ADs in a sample of adult patients in a Family Practice clinic. The objectives of this project were (1) train the clinic staff via an educational inservice to educate patients regarding the importance of advance directives to improve end-of-life care; (2) establish a standardized approach in this clinic for patient education on advance directives; and, (3) increase the number of patients with a completed advance directive to improve end-of-life care.

**Methods**

**Project Design and Participants**

The project design was a quasi-experimental one-group pretest-posttest design. The pretest was the percentage of patients in the intervention Family Practice clinic that had an Advance Directive (AD) prior to the intervention. The intervention was the repeated verbal and
written education per protocol. The posttest was the percentage of patients who received the educational intervention and completed an AD.

The project setting was a private Family Practice clinic in Denton, TX. The clinic was staffed by one full-time MD, one part-time Nurse Practitioner, two medical assistants, a receptionist, and a clinic manager. The study period ranged from May 15, 2015 to July 30, 2016. A letter of support from the clinic was obtained endorsing the project (Appendix A). The University of Texas Arlington Institutional Review Board approved the project as quality improvement (Appendix B). Inclusion criteria included patients less than 18 years of age, English speaking, and did not already have an AD. A convenience sample of 90 participants was obtained. The sample population included 43.3% males and 56.7% females. The sample age ranged from 20 years to 92 years, with a mean age of 50.5 years (see Figure 2). Caucasians comprised the majority of the sample. (see Figure 3).

Measures

A script to emphasize the importance of the AD and answer concerns was used for data collection during the follow-up phone calls (see Appendix C). The following data were collected: age, gender, race, residual questions/educational needs at two weeks, if the AD had been completed at one month, location of AD, reason for non-completion, and chronic diseases. The nominal level of measurement was used to classify the data. Yes/No responses were used as well as comparing ages and genders. The patient responses to reasons for non-completion were open-ended and analyzed. The study variables were measured through an interview process. The data were recorded systematically into a computerized file.
Procedure

Baseline data were derived from the convenience sample of 90 patients from a review of the patient’s medical record for documentation of advanced directive status and verbal confirmation that the patient did not have a completed advance directive. The baseline data served as the pretest. The project process was clearly outlined for the successful completion of this project (see Figure 4). The medical assistant verified that the patient did not have an advance directive through verbal inquiry and the lack of documentation in the electronic medical record. The provider gave verbal education via script about the importance of ADs to include the rationale of AD completion and the definition of AD. The clinic conversation was estimated to take 15 minutes. Additionally, the patient was given an education packet to take home that included an infographic (see Appendix D), available resources for AD forms and storage (see Appendix E), My End-of-life Wishes (see Appendix F), and a blank AD form approved as legal in Texas (see Appendix G). A follow-up phone call by the provider at two weeks, reinforced the educational intervention through verbally answering any questions and discussing concerns. The two-week follow-up educational intervention was estimated to take 15 minutes. Notation was made if unable to contact the patient after 3 attempts to repeat the educational intervention at two weeks. Outcome data were obtained through a one-month follow-up phone call to determine if the patient had completed an advance directive. According to the United States Preventive Services Task Force (2015), follow-up is best scheduled within a relatively short time period (e.g., one month). Additionally, the studies discussed in the literature review utilized a time period of one to six weeks for follow-up. The one-month call was estimated to take 10 minutes. Documentation was completed in the EMR confirming completion and location of the patient’s AD.
Statistical Analysis

The approach to analysis involved descriptive statistics and a comparison of pretest and posttest scores using nonparametric analysis with chi-square and Fisher’s exact tests. The tests were conducted at the alpha level \( p < 0.05 \).

Results/Findings

Completion of Advanced Directive

Fourteen percent (14%) of the sample group (n=90) in this Family Practice had an Advance Directive prior to the educational intervention. Following the repeated educational interventions by a trusted healthcare provider, the sample population (n=90) had a 62% completion rate (see Figure 5), with \( p = 0.01, 95\% \) (see Table 2). For the 77 patients without an Advance Directive prior to the start of this project, the completion rate went from a baseline of 0% to a post intervention completion rate of 56% (see Figure 6), \( p > 0.05, 95\% \).

Twenty-six patients, (34% of sample) did not receive the second educational intervention due to inability to make contact with them after three attempts. There was no significant difference (\( p > 0.05 \)) of AD status at one-month from baseline for those participants who did not have the two-week follow-up intervention (See Figure 7). Although there was a measurable increase in the completion rate from baseline for those who did not have a 2-week educational follow up, the difference was not significant at the 95% confidence level.

In the group that did receive the two-week intervention, there was a significant difference (\( p < 0.05 \)) in the completion of an AD compared to baseline (See Figure 7). The final one-month
completion rate of ADs is statistically significant ($p < 0.05$, 95% Confidence) for those patients who received both the initial face-to-face intervention and the two-week educational follow-up (See Table 3).

**Gender**

Females had a higher completion rate than males (see Figure 8).

**Race/Ethnic**

Caucasians had a higher overall completion rate than the other races (see Figure 9). Of note, completion rates of ADs within a specific group showed the following order: African-American (100%), Other (100%), Hispanic (63%), and Caucasian (52%).

**Age**

The mean age of African-Americans (AA) in the sample population was 45 years. The mean age of the Other race in the sample population was 62 years. The average age for Hispanics that completed an AD was 40 years, and 38 years for Caucasians. Patients over the age of 50 years accounted for 62.5% of the completed ADs. Of the distinct age categories by decade, the fifth through the ninth decades in the sample population had the highest percentage of completion within their decade (see Figure 10).

**Reasons for Non-Completion of AD**

The reasons given for non-completion included not interested (86%), lack of time (11%), and language barrier for participant with English as his second language (3%). A probe into the "not interested" response primarily indicated that the patient did not feel as if they needed an AD. Such responses as "my family knows what I want" were noted. The post study process for
this Family Practice will be to ask every patient about AD status and to provide educational material.

Co-Morbidities

The past medical history was collected on the sample population (see Figure 11). Patients in a morbidity category that had a >50% completion rate included cardiac, respiratory, endocrine, and renal failure. The sample population with chronic pain states, involving the musculoskeletal and gastrointestinal systems, had completion rates of >50% as well. The sample population with no prior medical history (mean age of 45 years) had a completion rate of 67%. One patient with breast cancer declined to complete an AD.

Discussion

The results show a statistically significant difference between the AD completion rate prior to the intervention and the completion rate after the intervention. The experimental hypothesis that there would be a significant difference in completion of an AD after intervention and education was validated due to the baseline completion rate of 14% that improved to 62% after the intervention. The results of this study were consistent with prior research stating multimodal interventions increased AD completion rates with the most effective intervention being the combination of educational material and repeated conversations (Ramsaroop, Reid, & Adelman, 2007; Tamayo et al., 2010).

The findings were also consistent with prior research that combined written and verbal educational interventions were more effective than single written interventions in increasing the completion rate of ADs (Durbin, Fish, Bachman, & Smith, 2010). The difference in completion rate for those patients who did not receive the two-week intervention, versus those who did,
validates prior research that the most effective interventions included repeated contacts
(Jezewski et al., 2007).

The AA and Other populations had a higher completion rate within their own race than
that of Hispanics and Caucasians. Prior research has found that AD completion was less frequent
among non-white respondents (Rao et al, 2014). Literacy level, mistrust of the health care
system, and the belief that legally generated directives are unnecessary may be the root cause of
lower rates of AAs with an AD (Melhado & Bushy, 2011; West & Hollis, 2012; Dupree, 2000).
This project makes an important contribution to prior research showing that the AAs in this
sample successfully completed ADs with the Project intervention.

The sample population over age 50 had the highest completion rate of ADs, likely due to
increasing awareness of mortality or presence of disease states. The median age in the sample
population that cited a lack of interest as the reason for non-completion was 45 years. Those in
the later decades may also have more time to complete paperwork than those in the younger
generation. Lack of time was a common barrier to completion. The sample demographic was
predominantly still of working age, many with children still at home. Gender did not play a
significant role in the completion of an AD.

The statistical analysis showed a clear and significant impact that multimodal, repeated
interventions have on the completion of an AD. The project revealed that serial interventions
over time, both written and verbal, in which the patient was given the opportunity to discuss with
family, have questions answered, and repeated discussions with their provider result in a higher
rate of completed ADs. Educational intervention works, and works even better when repeated as
a follow-up. The Fishers exact for the non-follow up two-week group was very close to
significance (p = 0.055) and may merit future investigation. It is still clinically significant that
there were a measurable number of patients who filled out an AD one month later with no two-week follow-up at all.

The patient care in this Family Practice setting was transformed through practice, education, and leadership exhibited by the investigator putting into action the skills obtained through Doctor of Nursing Practice (DNP) education. The DNP degree allowed the investigator to translate the evidence into practice and to implement changes to improve outcomes. Sustainability of the project was accomplished through staff education and process changes to query patients about AD status and to provide educational material as well as documentation of AD status in the medical record.

Project Limitations

Study limitations included the short time period, single facility site, and small sample size. Uncontrolled threats to validity included history, instrumentation, and maturation. These threats were not believed to have affected the intervention or outcomes.

Implications For Practice

Advance care planning discussions can be uncomfortable for providers to initiate. However, advance care planning is the ethical thing to do for our patients. Beneficence requires the healthcare provider to act for the benefit of the patient and to place the patient’s best interests above all other considerations. A conversation between patient and provider that defines goals for care, treatment options, and informed medical decision-making could result in completion of an AD. Advance care planning gives patients control of their medical care.
AHRQ (2015) recommends providers establish a protocol for end-of-life care decision-making, education for the patient and family, provide forms, and have the signed document readily available, either online or on the patient's chart.

Further research needs to be done to evaluate the appropriate time frame for follow-up after an educational intervention to determine understanding and compliance. Also, the impact of spirituality and religious beliefs on completion of an AD merits investigation. Further research should be conducted regarding the impact of comorbidities on the completion of an AD.

New reimbursement opportunities enable providers to spend the additional time necessary to educate and discuss end-of-life care. The CPT codes, 99497 ($90) and 99498 ($75), cover "Advance care planning including the explanation and discussion of ADs such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; face-to-face with the patient, family member(s), and/or surrogate," for the first 30 minutes and then for each additional 30 minutes. These codes can be added to an office visit charge.

Conclusions

Conversations about end-of-life care are never easy for the provider, the patient, or the family. However, advance care planning can improve the quality of life and give control to the patient. Providers should translate research into evidence-based practice by implementing processes to facilitate end-of-life care discussions and utilization of resources to increase completion of ADs in Primary Care settings. The intervention is realistic and feasible in a Family Practice setting as the clinic conversation, two-week follow-up, and one-month follow-up took
15 minutes or less per patient to complete.

Finally, the project validated the findings from the literature that multimodal interventions were shown to increase AD completion rates through repeated contacts, direct counseling with a trusted provider, verbal interactions, and written education.
<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Intervention</th>
<th>Finding</th>
</tr>
</thead>
</table>
| Ramsaroop, Reid, & Adelman (2007) | • Face to face interaction  
• Written materials | • Multimodal interventions increase AD completion rates.  
• Face to face interactions over multiple visits were most successful.  
• Written materials without face-to-face interaction were ineffective. |
• Repeated conversations | • Passive information alone was not effective in increasing AD completion rates.  
• Educational material and repeated conversations were most beneficial. |
• Mailouts | • Provider reminder plus mailouts were more likely to result in a completed AD. |
| Jezewski, Meeker, Sessanna, & Finnell, (2007) | • Group education  
• Video instruction  
• Mailed brochures | • Group education was twice as effective as individual sessions.  
• Video instruction did not improve AD completion.  
• Mailed brochures alone made no difference. |
| Durbin, Fish, Bachman, & Smith, (2010). | • Written education materials  
• Verbal education | • Combined written and verbal interventions were more effective. |
Figure 1. Transtheoretical Model for Behavior Change

Figure 2. Age Distribution in Sample
Figure 3. Race Distribution in Sample

Figure 4. Project Design

Figure 5. Percentage of Overall AD Completion after Project Intervention
Table 2. Chi squared test for total sample population, n=90

<table>
<thead>
<tr>
<th>Chi-Square</th>
<th>df</th>
<th>Asymp. Sig.</th>
</tr>
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<tbody>
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<td>5.378a</td>
<td>1</td>
<td>.020</td>
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a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 45.0.

Figure 6. Percentage of Completed Advance Directives after Project Intervention

Before intervention (n=77 with no AD) 0

After intervention (n=43 with AD) 56%, p<0.05
**Figure 7.** Impact of Repeated Intervention on Completion Rate at 1 month

**Table 3.** Chi squared test highlighting Fisher's exact test

<table>
<thead>
<tr>
<th>TWO WEEK INTERVENTION</th>
<th>Value</th>
<th>df</th>
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<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
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<td>0.118</td>
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<td>Fisher's Exact Test</td>
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<td>0.01</td>
<td>0.95</td>
</tr>
<tr>
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<td>Linear-by-Linear Association</td>
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<td>0.039</td>
<td>0.95</td>
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<tr>
<td></td>
<td>N of Valid Cases</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>N of Valid Cases</td>
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\(^a\) 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.00.

\(^b\) Computed only for a 2x2 table.

\(^c\) 0 cells (0.0%) have expected count less than 5. The minimum expected count is 31.50.
Gender Distribution in Completed ADs

- Male (n=25): 45.00%
- Female (n=31): 55.00%

*Figure 8. Gender Distribution with Completed AD*

Race Distribution in Completed ADs

- Caucasian: 68.00%
- Hispanic: 17.80%
- African American: 12.50%
- Other: 1.70%

*Figure 9. Race Distribution with Completed AD*
### Figure 10. Completion of AD by Decade

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Sample Population</th>
<th>Number of Completed ADs</th>
<th>Percentage Completed in Age Group</th>
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</thead>
<tbody>
<tr>
<td>20s</td>
<td>14</td>
<td>8</td>
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</tr>
<tr>
<td>30s</td>
<td>13</td>
<td>7</td>
<td>54%</td>
</tr>
<tr>
<td>40s</td>
<td>18</td>
<td>6</td>
<td>33%</td>
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<tr>
<td>50s</td>
<td>15</td>
<td>10</td>
<td>67%</td>
</tr>
<tr>
<td>60s</td>
<td>17</td>
<td>14</td>
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<td>70s</td>
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<td>83%</td>
</tr>
<tr>
<td>90s</td>
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<td>1</td>
<td>100%</td>
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### Figure 11. Completion of AD by Disease System

<table>
<thead>
<tr>
<th>Disease System</th>
<th>Completed AD</th>
<th>Declined AD</th>
<th>Percentage that Completed by Disease System</th>
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</thead>
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<td>Respiratory</td>
<td>4</td>
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</tr>
<tr>
<td>GU</td>
<td>1</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Renal</td>
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<td>100%</td>
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</tr>
<tr>
<td>Endocrine</td>
<td>10</td>
<td>5</td>
<td>67%</td>
</tr>
<tr>
<td>No PMH</td>
<td>18</td>
<td>9</td>
<td>67%</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>5</td>
<td>3</td>
<td>63%</td>
</tr>
<tr>
<td>Cardiac</td>
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<td>Hematology</td>
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<td>50%</td>
</tr>
<tr>
<td>Psych</td>
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<td>2</td>
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</tr>
<tr>
<td>Neuro</td>
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<td>2</td>
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</tr>
<tr>
<td>Derm</td>
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<td>2</td>
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References


Appendix A
Facility Consent

March 24, 2016

To Whom it May Concern:

I have been informed that Denise Goddard, our Nurse Practitioner, has opted to do a QI project on Advance Directives and would like to invite our patients to participate. I am enthusiastic about the project and she has full approval to include our patients in her research. I am happy to provide any additional support necessary in order to ensure that Denise has the tools she needs to complete her project, and I welcome the positive impact it will have on our patient population.

Please do not hesitate to contact me if there is anything else I can do.

Regards,

Sara Colorado
Practice Administrator
940-387-3837
Based on your summary, this seems like a QI project and not human subject research. Your intent is to improve a process in the clinic — the completion of an Advance Directive form. This project is not designed to contribute to generalizable knowledge — the design is to improve clinical practice only. Since the data will only be used in this class project and in the clinic, this is a QI project.

Thanks,

Mary-Colette
Introductory Statement:

2-week follow-up: This is Denise Goddard NP calling from Texas Optimum Healthcare Clinic. How are you doing today?

- I am calling to see if you had any questions or concerns about the Advance Directive educational packet that you received at your appt 2 weeks ago? Y N
- Have you had a chance to discuss your wishes with your family? Y N
- Have you completed your AD yet? Y N
  - If so, where is it stored?
  - If no, can you describe why you have not completed an AD?

1-month follow-up: This is Denise Goddard NP calling from Texas Optimum Healthcare Clinic. How are you doing today?

- I am calling to see if you had any questions about the Advance Directive educational packet that you received at your appointment 1 month ago? Y N
- Have you had a chance to discuss your wishes with your family? Y N
- Have you completed your AD yet? Y N
  - If so, where is it stored?
  - If no, can you describe why you have not completed an AD?

Conclusion: Thank you for participating in this Quality Improvement project. Please contact the clinic for your healthcare needs or any further questions about ADs

Contact Information:
Initials
Age
Sex
PMH
Phone or Email
Appendix D
Patient Infographic Handout

ADVANCED DIRECTIVES

Give you control over your health care
To consent for treatment or To refuse treatment

Composed of four documents.
You can complete 1, 2, 3, or 4 of the documents.
Most people should complete the
Living Will & Medical power of attorney.

The Directive to the Physician (LIVING WILL) states what life sustaining health care treatment you would desire if you had a terminal condition and were unable to physically or mentally make a medical decision.

The Medical Power of Attorney names one or more persons who will be legally able to make your health care decisions in the event that you are physically or mentally unable to communicate.

An Out-of-Hospital "Do Not Resuscitate" (DNR) Order appropriate for any person who does not wish to undergo life sustaining treatment. If you have been diagnosed with a terminal condition, then you may wish to complete this form.

A Directive for Mental Health Treatment which allows you to determine in advance the mental health treatments you would not want in the event that you were mentally and physically unable to make or communicate your own choices.

While Texas law provides a suggested form, the state does not require the use of any specific form for an advance directive. The law also states that no health care institution can require you to use a specific form. Texas requires that your advance directive either be signed by two witnesses or by a notary public.
Resources for Advance Directives

TexasLivingWill.org
Forms are available to complete online or print out and complete.

CaringInfo.org
Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end-of-life.

MyDirectives.com
MyDirectives.com helps you create your own emergency medical care plan for your family and doctors so they can make decisions on your behalf.

My Health Care Wishes App
You can carry your health care wishes on your smartphone. Your wishes and those belonging to your loved ones stored in one place, just a click away. If you have documented your health care wishes in any way, you don’t want them tucked away in a safety deposit box or in a file cabinet somewhere. Import and store them on your smartphone so they are there for medical decision-making anytime, anywhere. You can also include key family and medical contacts, insurance information, and any other health related information you want. Your information is protected because the data resides only on your smartphone, not on any server or cloud service. It is designed to revolutionize information sharing during a medical crisis so that your advance care documents and key medical information can be conveyed as a PDF and delivered to a hospital or physician in minutes. The information is easily accessible to view, text, email, or fax no matter where you are. You will have a digital library in your hand, containing your advance care plan and those of your spouse, parents, children, and anyone you care for.
Appendix F
Conversation starter from www.BeginTheDiscussion.Org

My End of Life Wishes

Name: ______________________ Date: __________________

Instructions and Suggestions On Using "My End of Life Wishes"

This worksheet will present 8 different questions and topics for discussion. A number of possible answers and comments have been provided under each question of topic. Please select as many answers as you want.

Space has also been provided at the end of each question or topic for your individual answers. You are encouraged to write down any response you want. You can also use this space for writing comments and concerns you have about your answers.

This worksheet is meant to help guide a conversation with others. Close friends and family are good choices of people to include. You are encouraged to discuss your responses and concerns with others in order to help them understand your needs and preferences towards the end-of-life. Be sure to write down the names of the people involved in this discussion on the front page. You may also want to write down their relationship to you.

Lastly, you should revisit your responses and keep them up to date. If your values, preferences, or needs change after completing this worksheet, make sure your new values, preferences, or needs are known. The worksheet is green to make it easy to find in a file cabinet, folder or drawer. Keeping it in a place where it will be safe but is easily accessible is suggested. Be sure your family or friends know where to find it in case of emergency.

Names of people involved in the discussion:

__________________________________________ Relationship ____________________________________

__________________________________________ Relationship ____________________________________

__________________________________________ Relationship ____________________________________

__________________________________________ Relationship ____________________________________

__________________________________________ Relationship ____________________________________

__________________________________________ Relationship ____________________________________
Do you have an advance directive? Yes ___ No ___

If you answered yes please indicate what type of advance directive you have:

___ Do Not Resuscitate Order (DNR)
___ Out of Hospital Do Not Resuscitate Order (DNR)
___ Advance Directive
   ___ Directive to Physician (Living Will)
   ___ Durable Power of Attorney for Health Care (Health Care Proxy/Surrogate)

Who is _______________________

Other _______________________

Where would you like to die?

___ My Home ___ Hospital
___ A Relatives Home ___ Hospice
___ In A Church ___ Nursing Home

Other/Comments _______________________

______________________________

______________________________

______________________________

______________________________
Who would you like to have with you when you die?

- Nobody, I Want To Be Alone
- Spouse/Partner
- Parents
- Children
- Other Relatives
- Close Friends
- Spiritual Advisor
- Nurses
- Doctors
- Close Friends
- Other/Comments

Who do you want to make decision about your health care and death?

- Myself
- Spouse/Partner
- Parents
- Children
- Other Relatives
- Close Friends
- Spiritual Advisor
- Nurses
- Doctors
- Other/Comments
What do you fear most about death?

- [ ] Pain
- [ ] Fear Of The Unknown
- [ ] Watching Family Grieve
- [ ] Being Cold
- [ ] Losing My Independence
- [ ] Losing My Dignity
- [ ] Not Going To Heaven
- [ ] Leaving Before Mending Relationships With Family
- [ ] Leaving Before Mending Relationships With Friends
- [ ] Leaving Before Mending My Relationship With God
- [ ] I Have No Fears

Other/Comments

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Describe tasks you would like to accomplish before you die:

- Tell My Family And Friends I Love Them
- Prepare My Friends And Family
- Prepare Myself
- Say Goodbye To Family And Friends
- Mend Relationships
- Become Religious
- Gain A Sense Of Closure
- Gain Peace Of Mind
- Spend Time In My Favorite Place
- Get My Finances In Order
- Help Plan My Funeral
- Tell My Story
- Try A New Hobby
- Try New Food
- Travel

Other/Comments

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Describe the setting in which you would like to die:

- __ Alone
- __ Surrounded By Family
- __ Surrounded By Friends
- __ With Music Playing
- __ Surrounded By Friends
- __ In A Well Lit Room
- __ Surrounded By Flowers
- __ Surrounded By Pleasant Smells
- __ Surrounded By Photographs
- __ Surrounded By My Favorite Art
- __ In A Warm Place
- __ In My Bed
- __ In A Quiet Place
- __ Outdoors

Other/Comments ________________________________

Describe the state of mind you would like to be in at the time of your death:

- __ Calm
- __ Accepting Of Death
- __ Free Of Stress
- __ Happy
- __ Satisfied
- __ Independent

Other/Comments ________________________________
DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

I, ____________________, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible;  

OR

I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible;  

OR

I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician and/or family members, you may wish to consider checking specific requests in this space that you do or do not want if you have a terminal or irreversible condition and can no longer communicate your wishes). Initial the statements that match what you would desire. If you do not initial a statement, then you are leaving your medical power of attorney to decide. There is room to make additional requests at the end of this document.) Only initialed statements are endorsed and indicate my desires. Statements made in this section override those made in the prior section.

I request that if my heart should stop beating and my lungs should stop breathing that no efforts at resuscitation should be made  

OR

I request that if my heart should stop beating and my lungs should stop breathing that all resuscitation efforts should be made.  

I request that if clinically appropriate and offered by my physician, artificial nutrition and hydration be withheld or removed  

OR

I request that if clinically appropriate and offered by my physician, artificial nutrition and hydration always be given.
I request that if clinically appropriate and offered by my physician, intravenous antibiotics be withheld or removed

OR

I request that if clinically appropriate and offered by my physician, intravenous antibiotics be given.

I request that if clinically appropriate and offered by my physician, dialysis be withheld or removed

OR

I request that if clinically appropriate and offered by my physician, dialysis be given.

I request that if clinically appropriate and offered by my physician, blood and blood products be withheld or removed

OR

I request that if clinically appropriate and offered by my physician, blood and blood products be given.

I request that if clinically appropriate and offered by my physician, respiratory support should be withheld or withdrawn

OR

I request that if clinically appropriate and offered by my physician, respiratory support should be given.

If there is a clinical experiment which has a chance of benefiting me, then I give my decision maker permission to consent for my participation

OR

If there is a clinical experiment, which has no chance of benefiting me, then I give my decision maker permission to consent for my participation.

I request that if clinically appropriate and offered by my physician, surgery intended to prolong my life (as opposed to be palliative or provide comfort) should not be done

OR

I request that if clinically appropriate and offered by my physician, surgery intended to prolong my life (as opposed to be palliative or provide comfort) should be done.

Quality of life is more important to me than quantity

OR

Quantity of life is more important to me than quality.

I wish to be free from pain even if it shortens my life.
After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I have not designated a medical power of attorney, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort (applies only if initialed)

OR

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I still wish that all efforts be made to sustain my life (applies only if initialed).

I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed _____________________________ Date ________________

City, County, State of Residence ____________________________

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

WITNESS 1: __________________________

Print Name __________________________

Signature __________________________

WITNESS 2: __________________________

Print Name __________________________

Signature __________________________
MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.

I, ____________________________ (insert your name) appoint:

Name: ____________________________________________
Address: __________________________________________
City: _____________________________________________
State: _____________________________________________
Zip Code: __________________________________________
Phone: ____________________________________________
Email: _____________________________________________

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

DESIGNATION OF ALTERNATE AGENT:
(Note: You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent
   Name: __________________________________________
   Address: _________________________________________
   City: ____________________________________________
   State: __________________________________________
   Zip Code: _______________________________________
   Phone: __________________________________________

B. Second Alternate Agent
   Name: __________________________________________
   Address: _________________________________________
I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: ____________

PRIOR DESIGNATIONS REVOKED.
I revoke any prior medical power of attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)