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Utilizing an Educational Intervention to Increase Advance Directive Completion Rates for African Americans in a Family Practice Clinic in Louisiana

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Abstract

Advance care planning (ACP) is a process that allows for an individual to document ahead of time the medical treatment they want if they are unable to communicate after an unexpected life-threatening situation. The legal forms used to document these wishes are called advance directives (ADs). Since African Americans (AAs) develop chronic disease at younger ages and often experience shorter lifespans than other racial groups, it is imperative that they have a clear understanding of the pros and cons of ACP. Regrettably, because AAs seldom complete ADs, more aggressive, and often, ineffective medical care is provided at the end of life. The purpose of this Doctor of Nursing Practice (DNP) quality improvement project was to promote patient autonomy by equipping and empowering these individuals with the knowledge needed to make informed decisions regarding end-of-life care (EOLC). The intervention utilized educational resources to engage patients in meaningful discussion and dialogue on the advantages and disadvantages of ACP during regularly scheduled clinic visits over a one-week time frame. The average number of patients aged 50 years and older who were seen in the clinic during a one-week timeframe was calculated and multiplied by 0.80 two weeks prior to the project being initiated. These calculations determined the number of chart audits that were required for pre- and post-study implementation. Sixty-five patients met the study criteria and received AD education. Fifty-six of the 65 patients agreed to be counted for the study. Fifteen ADs were executed during the intervention. This represents 27% of those who agreed to be counted.

Keywords: advance directive, advance care planning, end-of-life care, African Americans

Executive Summary

Project Title: Utilizing an Intervention to Improve Advance Directive Completion Rates for African Americans (AAs) in a Family Practice Setting.

Problem: Many AAs are afflicted by chronic disease and likely to succumb to complications at younger ages than other racial groups. Advance directives (ADs) are legal documents that establish what medical treatment an individual desires in case of a life-threatening event where they are unable to communicate. Regrettably, research shows that AAs are less likely to execute ADs. This project was implemented because, in a Family practice clinic in North Louisiana, there is an absence of ADs in patient medical records along with acknowledgment by the MD clinic owner that there were no advance care planning (ACP) procedures or activities in place.

PICO: Does offering ACP education with an opportunity to complete ADs to African Americans aged 50 years and older, as compared to no current ACP initiative, improve advance directive completion rates in a Family Practice setting?

Purpose: The purpose of this DNP quality improvement project was to determine whether an educational intervention aimed at increasing the patient's knowledge of ADs improves African American advance directive completion rates.

Goals: To increase advance directive completion rates in the clinic by at least 25% during a one-week period.

Objective: To educate patients on ACP so that they would have the knowledge needed to make informed decisions regarding EOL care and provide an opportunity for advance directive documents to be executed.

Plan: This was a Quality Improvement (QI) project that provided education on ACP with an opportunity to complete ADs if desired. Random chart audits were performed pre- and post-intervention to compare the number of records with ADs in place. The expectation was that there would be an increase in the number of ADs completed after the intervention. When patients who met the study criteria presented for their routine visit, they were given an introductory letter and educational brochure about ACP and instructed to review while they waited. After being triaged and placed in a room, the DNP student entered, provided AD education, and engaged the patient in conversation.

Outcomes and Results: There were no executed ADs found during the pre-intervention assessment. Sixty-five patients met the study criteria and received AD education. Fifty-six of the 65 patients agreed to be counted for the study. Fifteen ADs were executed during the intervention. This represents 27% of those who agreed to be counted. The post-intervention audit revealed one chart with a completed AD.

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Utilizing an Educational Intervention to Increase Advance Directive Completion Rates for African Americans in a Family Practice Clinic in Louisiana

Advance care planning (ACP) is the activity of pre-selecting the medical care wanted at the end-of-life (EOL) with the assistance of a healthcare provider or legal representative (Atherton, 2020). These preferences are placed in legal documents entitled advance directives (ADs). A Living Will and Durable Power of Attorney for Healthcare are examples of ADs. A Living Will is a means for an individual to express the medical treatment they desire or disapprove of under specific circumstances. A Durable Power of Attorney for Healthcare appoints a healthcare representative to make decisions on behalf of an individual in situations that prevent that individual from being able to communicate. The purpose of this DNP project was to assess the effect of an educational intervention aimed at expanding the patient's knowledge and understanding of advance care planning to increase the execution of ADs in the African American (AA) community.

Problem Recognition

Problem Statement

According to Sandman et al. (2019), patients benefit from healthcare goals, including preserved health and sovereignty, extended life, and dignity. Although today's healthcare environment consists of new technologies and treatment modalities, patients still grapple with independence from the healthcare team regarding their opinions and desires regarding their medical care (Bu & Jezewski, 2006). ACP and EOL care are obligatory components of health literacy whose complexity has increased over the years (Halinski, 2020). Healthcare providers and patients often elude ACP conversations despite being an important matter to examine (Halinksi, 2020). Patients and healthcare professionals often fail to comprehend that an executed

AD is the epitome of autonomy. Terry (2018) asserts that the DNP graduate is enthralled in preventative and population health matters that aim to improve the country's overall health. The ACP process requires education about EOL care choices and the completion of the legal documents that provide written documentation regarding the patient’s desires for future medical care (Catlett & Campbell, 2021). Advance practice nurses that have completed a DNP degree utilize a holistic approach to assist patients in making positive decisions that improve health and increase the quality of life (Terry, 2018).

PICO Question

Does offering advance care planning education to African Americans aged 50 and older as compared to no current advance care planning education initiative, increase advance directive execution in the African American community?

For this quality improvement project, the population, intervention, comparison, and outcomes were as follows:

Population (P): For American Americans aged 50 and older who are clients of a family practice clinic in North Louisiana

Intervention (I): Providing advance care planning education during routine office visits

Comparison (C): Compared to no current advanced care planning education initiative

Outcome (O): Increase advance directive execution

Timeframe (T): Over one week

Project Significance

There is an amalgamation of influences that contribute to the poor health outcomes of AAs living in the U.S., particularly in Louisiana. Caddo Parish ranks 50, (bottom is 64) for health outcomes (University of Wisconsin Population Health Institute, n.d.). When the poverty rate multiplies between populations, lifespan decreases (Canicosa, 2020). Even though many studies have been carried out, the cause for race disparities in ACP is not thoroughly comprehended (Koss, 2018).

Xu et al. (2021) emphasize that the primary care setting is the best environment for AD execution. This project was considered because of the DNP student's assessment of absent AD documents in patient charts. The observation was confirmed by the physician who is also the owner of the clinic.

Growing evidence has revealed several factors that contribute to low AD completion rates. According to Spoelhof and Elliott (2012), a clinical method fitting to the patient's age group could nurture successful and collaborative advance directive conversations (i.e., asking whom the patient would trust to make medical decisions during discussions about preventative care such as colorectal screening). Ramsaroop et al. (2007) maintain that the most effective initiative utilized direct patient-provider communication. The probability of AD completion was threefold for those who were engaged in ACP conversations than those who were not (Gordon & Shade,1999). Therefore, it was vital that effective methods to improve the completion rate of ADs in the primary care setting were established (Xu et al., 2021).

Foundational Theories

The two theoretical frameworks that guided this QI project are Johnson's Behavioral Systems Model and the Health Belief Model (HBM). Dorothy Johnson was a nursing theorist who developed the Behavior System Model in 1968 (Zaccagnini & White, 2017). Her work utilized components of systems thinking along with Nightingale's philosophies to further elaborate on the relationship between the sick individual and the effects of the environment (Ghanbari & Pouy, 2020). The model alleges that encouraging positive behavioral functioning will avert illness (Ghanbari & Pouy, 2020). The individual is defined as a behavioral system with seven behavioral subsystems (Ghanbari & Pouy, 2020). Each subsystem is comprised of four essential traits (Ghanbari & Pouy, 2020). A discrepancy in a system causes instability and the nurse's responsibility is to help the patient maintain equanimity (Ghanbari & Pouy, 2020). When this model is used as a prototype in the clinical setting, the problem causing unbalance is ascertained, then nursing interventions to generate change are implemented (Zaccagnini & White, 2017). Regarding this project, the absence of ADs was the unbalance, therefore the DNP student addressed the unbalance with ACP education and assisted with the completion of ADs, which restored equilibrium.

The HBM is a health promotion theory that explores how an individual's opinions influence his or her healthcare choices (Carpenter, 2010). The theory has been changed in many ways over the years, but the earliest prototype encompasses four theoretical elements (Rawlett, 2011). The elements encompass perceived susceptibility, perceived severity, perceived benefit, and perceived barriers (Rosenstock, 1966). Lastly, cues to action are what the model describes as being necessary to ignite a behavior change (Rosenstock, 1966).

Element 1: Perceived susceptibility

The first element asserts that if an individual thinks they are more inclined to be negatively affected by a malady, the response will include more health-promoting behaviors (Rosenstock, 1966). In the context of advance care planning, if an individual believes they will develop a terminal illness or succumb unexpectedly (i.e., demise from complications of COVID-19 or injury resulting from a car accident), the likelihood for AD execution increases. However, if it is believed that vulnerability to demise is low, risky behaviors may be engaged, and EOL planning is not considered.

Element 2: Perceived severity

The second element refers to an individual’s evaluation of the seriousness of a health condition and may be different for each person (Rosenstock, 1966). The more life-threatening an individual may believe the health condition is, the more likely they are to partake in behaviors that prevent it (Rosenstock, 1966).

Element 3: Perceived benefits

The third element concerns an individual’s opinion of what will be gained by changing their behavior to lower disease risk (Rosenstock, 1966). The individual must sense that the pursued conduct will result in compelling positive advantages (Carpenter, 2010). Regarding ACP, when an individual completes an AD, they understand that the legal documentation of their end-of-life care wishes will be adhered to (perceived benefit), and autonomy will be promoted (lowering the risk of receiving medical treatment that does not align with their beliefs).

Element 4: Perceived barriers

The fourth element argues that if an individual believes that obstacles hinder them from participating in health-promoting behavior, they will not (Rosenstock, 1966). For example, if individuals fear completing an AD (preventive behavior) because they do not fully understand what it is (obstacle), the document will not be established.

Cues to Action

According to the HBM, a determinant that acts as a prompt to set off a fitting response is needed (Rosenstock, 1966). The strength of the required prompt will differ for each individual as it depends on their willingness to act (Rosenstock, 1966). Pertaining to ACP, an example of a prompt could be an individual’s close family member or friend passing away from an unexpected cardiac event without ADs in place and the individual reaching out to their physician to initiate the ACP process.

Background

African Americans (AAs) are diagnosed with chronic illness earlier, cutting their lives short, unlike their European counterparts (Williams, 2012). Studies reveal that there are many influences that contribute to the hardships AAs and other racial minority groups face that lead to unfavorable health outcomes (Xanthos et al., 2010). Many diseases that bring about death in America primarily affect AA and Latino nationalities (Maness & McCauley, 2020). The human immunodeficiency virus is more likely to be detected in African Americans (AAs) than in any other ethnic category in the United States (Lyon et al., 2019). Around 13.2 percent of AAs age 20 and older have diabetes; when compared to Whites, the amount doubles (Chode et al., 2016). Forty-four percent of AA males and 48 percent of AA females are affected by cardiovascular disease resulting from various avoidable conditions (Maness & McCauley, 2020).

ADs and ACP are completed much less in the AA population than in other races (Collins, 2018). There is an increasing movement toward influencing AAs to participate in ACP because it is associated with improved clinical results near-death (Kwak & Ellis, 2020). Despite there being a substantial amount of research concerning obstacles to ACP completion in the AA community, very few studies have appraised the benefits of methods that promote ACP (Sanders et al., 2016, Song et al., 2015; LoPrest et al., 2016 as cited in Ejem et al., 2019). When the barriers AAs contend with during a medical crisis are identified, help can be extended to eradicate those obstacles (Mayeda & Ward, 2019).

The absence of EOL care planning by an individual before a catastrophic event may result in mental distress for family members having to make those complicated decisions

(Collins et al., 2021). ACP, palliative care, and hospice are also seldom utilized by AAs (Rhodes et al., 2019). Because AAs seldom establish ADs, forceful and often ineffective care is provided near death (Catlett & Campbell, 2021). ACP can mitigate scenarios like these (Catlett & Campbell, 2021).

As per Hunsaker and Mann (2013), the United States government has employed efforts to advocate and regulate ADs with unreliable findings. The Patient Self-Determination Act (PDSA) was the federal legislation passed in 1990 that promotes AD use in North America (Hunsaker & Mann, 2013). This act obligates every medical establishment that receives Medicare or Medicaid monetary support to inform patients of ADs during the check-in process (Koss, 2018).

Systematic Review of Literature

Forty-seven articles were collected from various research databases including Medline, CINAHL, Academic Search Premier, and Cochrane. Search terms encompassed the following: advance directives, advance care planning, initiatives, social determinants of life, end-of-life care, African Americans, minorities, and palliative care. Manuscripts unavailable in English were not retrieved. Eighteen items were eliminated, leaving 29 sources to critique. The review focused on methods to increase AD execution.

Level of Evidence

The DNP student utilized Melnyk and Fineout-Overholt’s (2015) levels of evidence hierarchy to rate the remaining twenty-nine articles. No articles provided Level I evidence (systemic review or meta-analysis). There were four randomized controlled trials (Level II), one controlled trial without randomization (Level III), four case-control or cohort studies (Level IV), five systemic reviews of qualitative or descriptive studies (Level V), nine qualitative or descriptive studies (Level VI), and six opinions or consensus (Level VII) (Appendix A).

Emergent Themes

Of the 29 documents that were examined, nine themes were uncovered. Four of the themes are provider-specific barriers to AD completion. The remaining five are patient-related.

Provider Specific Barriers

Theme 1: Knowledge deficit related to ACP.

Halinski (2020) contends that medical providers are not well-versed in what the ACP process entails and how to go about assisting patients with the task of executing ADs.

Theme 2: Time constraints.

Key informants maintain that there is not enough time to perform daily job requirements in addition to providing ACP education (Marino et al., 2021).

Theme 3: Absence of well-defined patient education procedures.

Atherton (2020) conducted research to augment the number of ADs executed in an Arizona primary care clinic with two sites. Neither location had AD documents available for review and/or discussion with patients (Atherton, 2020). Similarly, Marino et al. (2021) describe a quality improvement (QI) project initiated by him and his team that provided supplementary ACP learning tools and AD forms via an education packet. Unfortunately, the information was disregarded by the patients. A reliable source maintains that after care had been completed for the day, the documents were found scattered about the waiting room (Marino et al., 2021).

Theme 4: Lack of buy-in.

Atherton (2020) implemented research that involved two primary care offices. She asserts that prior to her project, there had not been any ACP initiatives. Additionally, Wissow et al.(2004), found that despite providing medical practitioners with ACP materials, cues, and more time for patient visits, the providers maintained that they did not have sufficient time. Later, they admitted reluctance to initiate AD discussions (Wissow et al., 2004).

Patient-Specific Barriers

Theme 5: Skepticism of the healthcare system.

Bazargan and Bazargan-Hejazi (2021) discovered that medical mistrust was a hindrance to ACP between AAs. Comparatively, Johnson et al. (2008) discovered that AAs felt uncomfortable thinking about death, wanted ventilator support, feeding tubes, and intensive care stays, have spiritual beliefs that contradict palliative care goals, and distrust the healthcare system.

Theme 6: Fear.

Rhodes et al. (2017) conducted a study that investigated AA views of ACP, palliative care, and hospice. Ignorance of ACP created fear that prohibited AD completion (Rhodes et al., 2017). In comparison, Bazargan and Bazargan-Hejazi (2021) unearthed that fear of the ACP process and previous encounters with America's medical management system were the culprits of AAs averseness to completing ADs.

Theme 7: Lower Health Literacy.

Limited reading, writing, or mathematical comprehension are characteristics of patients with low health literacy which inhibits them from effectively steering through the healthcare ecosystem (Wittink & Oosterhaven, 2018). Understanding of disease, its' progression, available treatment modalities, and EOL care programs may be underutilized due to low health literacy. (Melhado & Bushy, 2011). Studies suggest that AAs are provided with insufficient information about ADs and are likely to have less dialogue regarding ACP with the healthcare team (Mack et al., 2010). A scholarly review was executed by Melhado and Bushy (2011) that included a modest sample of patients dealing with a terminal illness in the hospital. The subjects divulged that they believed questions regarding end-of-life care were insinuating euthanasia or assisted suicide (Torke et al., 2005 as cited in Melhado & Bushy, 2011). Subject responses establish the misinterpretation of the objectives of ADs (Melhado & Bushy, 2011). There were three collective hindrances to AD implementation covering young to late adulthood uncovered by West and Hollis (2012). They included surrogate decision-making, ACP illiteracy, and fear and denial (West & Hollis, 2012). Dignity, family relations, and religiosity were the three primary themes concerning AA perceptions of ADs that were uncovered by Dupree (2000). Although the subjects seemed to comprehend that the purpose behind the discussion was to survey their thoughts about ADs, additional concerns were conferred (Dupree, 2000). Matters included buying burial plots, amputation, cremation, and donation of the body to science (Dupree, 2000). The discussion validates the absence of ACP comprehension (Dupree, 2000).

Theme 8: Faith in God & the Afterlife.

Religiosity offers comfort and support to many AAs that God will decide when death occurs (Catlett and Campbell, 2021).

Theme 9: Strong Matriarical Structure of AA families affects EOL decision making.

Collins et al. (2021) used nursing cultural competency to improve interaction and comprehension of EOL care decisions made by AAs. The research revealed patterns that showed trustful connections between grandmothers, mothers, and daughters that nurture family decision-making and surrogate EOL decision-making (Collins et al., 2021). It also revealed that communication between family members is instigated and conveyed mainly between female family members (Collins, 2021). Additionally, if a legal testament is in effect and/or funeral service wishes have been communicated by the patient, it will be shared with them as well (Collins, 2021).

Market and Risk Analyses

SWOT Analysis

The SWOT analysis is an organized, comprehensive method of ascertaining and investigating areas for business expansion, allocation of resources, and operational weaknesses requiring enhancement or change (Blayney, 2008). The SWOT analysis offers a means to present the current condition of an organization and precise evaluation for possible expansion in the future, two significant advantages. (Demirkol et al., 2020). A SWOT analysis was completed for this project (Appendix B).

Strengths

Employee buy-in was especially vital to the success of this project. The clinic physician and staff were supportive of the advance directive initiative. Thus, the ACP education provided to the team and patients was unequivocal. Additionally, the AD forms were readily available at no cost and easily downloaded and printed for convenience.

Weaknesses

The clinic physician had not made advocating for advance care planning a priority; hence staff had limited education about advance directives. The clinic was short-staffed, so protocols regarding project implementation may not be followed appropriately.

Opportunities

This quality improvement initiative provided an opportunity for the patients and staff to have increased knowledge and understanding of the purpose and importance of completing an advance directive. Since the patient’s future medical care wishes are articulated via these legal documents, an improved patient care experience may result. Unwanted hospitalizations and unnecessary or aggressive medical treatment can be avoided in the future. There was also an improvement in the documentation of ACP conversations facilitating billing for reimbursement from the Centers for Medicare and Medicaid Services.

Threats

Medical mistrust/distrust was identified as a barrier to the completion of ADs. Past and current events have contributed to the negative feelings of AAs and other minority groups toward the healthcare system (Kennedy et al., 2007). AAs distrust of the health care system is deep-rooted from feeling like guinea pigs after being used in unethical clinical studies (Kennedy et al., 2007). Threats to this project’s success included knowledge gaps and/or misconceptions of the purpose of advance directives and negative patient attitudes/behaviors toward end-of-life planning/care.

Driving, Restraining, and Sustaining Forces

Before implementing this DNP project, it was essential to consider the driving, restraining, and sustaining forces. Since research demonstrates that African Americans generally experience shorter lifespans than other racial groups, they must have a clear understanding of the pros and cons of ACP. For those reasons, there was a pressing need to provide ACP education to the African American community.

Driving Forces

Statistics regarding AD completion rates are inaccurate (Yadav et al., 2017). The researchers completed a systemic review that appraised studies from 2011 to 2016 for answers and concluded that AD completion in the U. S. is low and unchanging (Yadav et al., 2017).

Since there has been an upsurge in therapeutic and medical technology innovations, there is a greater need for individuals to convey their wishes for EOL care (Atherton, 2020). As previously ascertained and before plans for this QI project, there were no ACP activities in this family practice clinic.

Restraining Forces

Restraining forces to ACP included provider time constraints, no structured education process for patients, providers not fully engaged in ACP activities, patient mistrust of the healthcare system, fear, and lower health literacy. Various interventions were implemented to mitigate these dynamics by providing educational brochures to patients explaining ADs and allotting enough time during patient visits to answer questions and address fears thoroughly.

For any quality improvement initiative to be effective, stakeholder buy-in is critical. Although the physician and his staff were supportive of the ACP project, the current staffing shortage issue may affect its' ongoing viability. All employees in the organization were informed of the DNP project plan and their specific roles for successful program implementation. The maintenance of this project will rely heavily on the clinic physician/owner and staff and their ability to adequately carry out everyday clinic functions in addition to continuing this initiative.

Sustaining Forces

Patients who did not want to complete ADs during the project implementation were encouraged to resume the ACP discussion with the physician during their next visit. When these patients are contacted via telephone to verify that they will be present at their next scheduled visit, they will be reminded about ADs. Additionally, extra patient brochures were ordered and extra AD forms were printed and left with the physician so that the momentum of AD completion can continue.

Stakeholders and Project Team

According to Moran et al. (2020), stakeholders are persons or parties that affect the project in some manner or have relevance to the result of the project. Patients and their families, employees of the clinic, the MD clinic owner, the DNP student, the Centers for Medicare and Medicaid Services, and other insurance providers being billed for patient care services were all stakeholders. The project team included Nicole Richards, the DNP student responsible for the overall implementation of the QI initiative; Dr. Lora Claywell, Capstone Chair; Dr. Cheryl Kruschke, Research Methods Advisor; Dr. Mairus McFarland, Clinic MD/owner; and Dr. Nora Martinez, DNP mentor.

Cost-Benefit Analysis

As stated by Zaccagnini and White (2017), creating a cost-benefit analysis combines the actual expenses for the project and deducts them from its advantages. The DNP student provided most of the time required to implement the study. A small amount of effort was needed from the office staff to provide selective patients with copies of ACP brochures and project introductory letters. This project had reasonably low costs associated with the interventions. The total estimated cost of the project was $580.14. The DNP student covered the entire cost.

Table 1

Itemized List of Costs Associated with Implementing DNP Project

ITEM	**COST**
110 ACP patient brochures (Channing Bete Company)	$194.08
3 Realms of 500-count copy paper	$20.22
60 Blue Ink Pens	$5.93

3 Black printer ink (63 XL)	$135.72
1 Color printer ink (63 XL)	$45.24
5 Acrylic sign holders (exam room flyers)	$28.95
Training Lunch on ACP with office staff	$150.00
Office staff assistance with providing patients with AD paperwork	Negligible
TOTAL	**$580.14**

Benefits of the initiative include a potential reimbursement to the MD/clinic owner of approximately $85.93 for every patient who receives ACP education (Garner-Huey, 2016). For instance, if the Centers for Medicare and Medicaid Services is billed for 70 patients over a three-month timeframe, he would profit $6430.14. After subtracting the project cost of $580.14, the total gain would be $5850.00. Additionally, if ACP discussion is provided on subsequent visits, the physician would be able to bill an additional $74.83 per patient (Garner-Huey, 2016). Currently, there are no limits on the number of encounters that can be provided if the coding and documentation are correct (Garner-Huey, 2016). Furthermore, in addition to the potential revenue that can be gained by implementing an ACP education policy, over the long term, ACP could: 1) divert direct medical costs related to unnecessary and unwanted medical treatment, 2) lead to improved patient care experience, and 3) provide the patient with an enhanced quality of life. These benefits are invaluable.

Project Objectives

Mission and Vision

The mission of this project was to deliver educational resources, meaningful discussion, and dialogue on the advantages and disadvantages of ACP to African Americans aged 50 years and older being seen for care in a family practice clinic in North Louisiana. The vision was to equip and empower these individuals with the knowledge needed to make informed decisions regarding EOL care, then document it by way of ADs.

Goals

This project aimed to improve advance directive execution in the clinic by 25% during the one-week project period.

Outcomes

Bonnel and Smith (2022) state that positive outcomes are usually associated with better patient care and act as indicators of attainment in the clinical environment. The anticipated results for this initiative were that AAs would have the intellectual capacity to make more informed decisions about EOL care. Additionally, AD documents would be at hand and accessible, patients would have an enhanced care experience, and there would be improved documentation of provider and patient communication regarding ADs, increased execution of ADs, a reduction in unwanted hospitalizations and unnecessary or aggressive treatments, and improved quality of life. The seven objectives for the project were to:

1) Create an exam room flyer by June 15, 2022 (Appendix E).
2) Order ACP booklet by July 2022 (Appendix K).
3) Perform patient chart reviews for the presence of ADs pre-intervention by October 2022.
4) Provide ACP education to clinic staff (before the project begins) and explain individual responsibilities to each clinic employee for program implementation by September 2022.

5) Provide ACP education to all patients who agree to participate in the project by October 2022.
6) Perform patient chart reviews for the presence of ADs post-intervention by November 2022.
7) Share the final study results with MD/clinic owner and staff by April 2023.

Project Plan and Evaluation

Research Design and Evaluation

When the DNP project objective is to instigate a modification through intervention, practice enhancement, or enact a modern representation of care approach, the design selection incorporates a research or quality improvement methodology (Moran et al., 2020). Quality improvement projects in healthcare incorporate endeavors that enhance services for the future (Moran et al., 2020). These projects are efficient, usually concentrate on a distinct, community-wide issue, and are concerned with a fixed, intended target (Portela et al., 2015). This was a quality improvement project that aimed to improve advance directive completion rates by approximately twenty-five percent by utilizing interventions that involved patient education and conversation.

Population and Sampling

The target population was African Americans aged 50 years and older who did not have an executed AD and were decisional. The average number of patients aged 50 years and older who were seen in the clinic during a one-week timeframe was calculated and multiplied by 0.80 two weeks prior to the project being initiated. These calculations determined that 56 random chart audits would be required pre-and post-study implementation. The subjects were a convenience sample who were scheduled over a one-week period and presented to the clinic for treatment.

Setting

This quality improvement initiative took place at a family practice clinic in North Louisiana. It has been in operation since 1986, and is physician-owned and managed. Care is available five days a week and there are a total of four employees (excluding the physician). The practice was established in 1986 and is open Monday through Friday.

Educational flyers promoting ACP were placed in each exam room. When patients who met project criteria presented for their routine visit, they were given an introductory letter and educational brochure about ACP and instructed to review them while they waited to be placed in an exam room. After the patient had been triaged and assigned a room, the DNP student entered and explained the QI initiative. Everyone who met inclusion criteria received AD education and the opportunity to execute directives at once.

The PDSA (plan, do, study, act) cycle was the approach that was used to guide the project. The “plan” phase required research by the DNP student of available advance care planning educational materials, Louisiana Durable Power of Attorney, and advance directive forms. It also designated inclusion criteria for participants and described the process by which data would be collected. The “do” phase entailed placing the order to Channing Bete for ACP booklets, printing the State of Louisiana AD forms, creating the exam room flyer, and educating the physician and office staff about the purpose of advance care planning and advance directives. Additionally, this segment was where education and discussion about ACP and AD with subjects were provided. The “study” phase involved the evaluation of AD completion rates pre- and post-intervention. The “act” phase garnered feedback from the physician and staff regarding the project's success. Since the improvements were successful, these procedures can now be standardized as the physician has expressed that he plans to continue to offer ACP and AD education to those who present to his clinic for care.

Figure 1

PDSA Model of Improvement

Associates in Process Improvement. (2022). PDSA Cycle. https://www.apiweb.org/#:~:text=Associates%20in%20Process%20Improvement%20(API,capability%20for%20on%2Dgoing%20improvement.

Logic Model

The W. K. Kellogg Foundation Logic Model Development Guide was used to create the conceptual model for project intervention of providing education and in-person discussion on ACP. Earp and Ennett (1991) imply that a conceptual model utilizes viewpoints represented by squares and routes defined by arrows to illustrate the research question under exploration or the current emphasis of a particular interventional act. Resources, activities, outputs, short-term & long-term outcomes, and impact were all summarized (Appendix D).

Protection of Human Subjects

Prior to project implementation, the project was designated by Regis University's Institutional Review Board (IRB) as non-human subject research, thus exempting it from approval. Furthermore, the owner of the family practice clinic consented to the project. All patient information was kept confidential. Every patient that met inclusion criteria was provided an introductory letter, ACP booklet and education, and the opportunity to complete ADs right away.

Data Collection and Treatment

Terry (2018) maintains that data collection usually occurs via exploration when the researcher goes to where the subjects are located to examine and document their actions. A pre- and post-intervention chart audit was performed during normal clinic hours. The information that was recorded included the patient age, gender, and whether an AD was present or completed during the project intervention. Patients were kept track of numerically and there was no collection of identifiable personal health information. The data collected was categorical and dichotomous and noted on the chart audit tool.

Data Analysis

The statistical methods that will be used to analyze findings should be suitable for the research design (Zaccagnini & White, 2017). Qualitative research is vital because it permits the nurse to view each patient independently, taking into account each individual's state of affairs (Zaccagnini & White, 2017). An inferential statistical test was not able to be run due to the pre-chart audit having a constant value of one for all charts. This is based on coding the chart audits with 1=no AD present and 2= yes AD present. Thus, descriptive statistics were used to analyze the data where appropriate, and tables were developed to present the results.

Project Findings and Results

The discussion of ADs and ACP was more difficult than anticipated. When the topic was presented, some patients became teary-eyed, exhibited poor eye contact, withdrew, and/or offered limited responses. Several, who had been recently discharged from the hospital, and were being seen for a follow-up visit found the topic of end-of-life care planning especially uncomfortable. They were hesitant to take part in the ACP discussion and declined AD execution. One subject who had experienced cardiac arrest one week prior to the office visit (requiring CPR and defibrillation), appeared extremely agitated when an attempt to engage him in dialogue occurred. Others willingly participated in ACP and AD conversations after education but stated they were "not ready" to complete AD forms. Conversely, some were easy to connect with, pleasant, and promptly executed the directives.

Sixty-five patients met study criteria and received AD education (Table 2). Fifty-six of the 65 patients agreed to be counted for the study. Fifteen ADs were executed during the intervention. This represents 27% of those who agreed to be counted (Table 3).

Table 2

Advance Directive Conversations

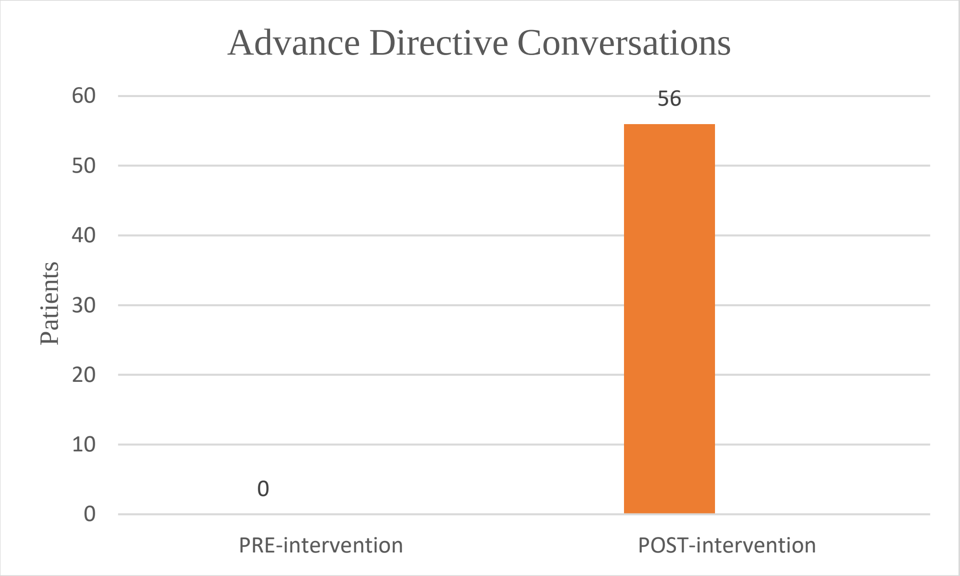

Table 3

Data Results for Advance Directives Completed

	# of ADs completed n=56
Pre-intervention	0
Post-intervention	15 (27%)

Limitations

This project had certain limitations that must be considered. First, only African Americans aged 50 years and older could participate, therefore findings may not be generalizable to other populations. Next, the sample size was small which could have skewed results. Lastly, the project was short in duration and it is possible that those who required more time to consider their EOL care preferences may have completed directives if the project timeframe was extended.

Recommendations

End-of-life care discussions need to be normalized but until AAs fully understand the purpose and intent behind ADs, completion rates will continue to be disproportionate to other races. Since most of the patient-specific barriers to AD completion identified in the systemic review of literature were also experienced during this project implementation, AA attitudes toward ACP and AD conversations should be explored further. The message that ADs are not just for those of age and chronically ill should be emphasized. The dialog should focus on: 1) how executed ADs foster patient autonomy and 2) the need for ACP and AD completion before an unexpected event occurs to mitigate mental distress and trauma on the family.

Limited time was a provider-specific barrier noted in the systemic review of literature and a potential obstacle to AD completion noted by the researcher as well. Although time consumed with each patient varied, the minimum amount of time spent educating each patient was 15 minutes. Depending on other variables such as a patient's visual acuity and/or manual dexterity, another 10 to 15 minutes was easily spent waiting as they read and signed the documents. While medical providers should be primarily responsible for guiding end-of-life care planning conversations, in order to increase efficiency while maintaining quality care, once a full discussion has taken place and all questions addressed, the provider should be able to hand off task completion to the clinic staff. The staff should know what documents are necessary for ACP and AD execution and have them readily available when needed. This includes the staff being familiar with where the patient's name and signature should be placed on the document as well as witnessing it.

There were several patients who took the documents home to review with family and planned to return them on their next visit. Moreover, after the project was completed, the physician expressed interest in wanting to continue the initiative. Since he has been treating many of these patients for more than 20 years, he may experience even greater success. Considering the aforementioned, performing random chart audits for the presence of ADs at three, six, and 12 months after project implementation would likely demonstrate a significant increase in AD execution as it may have been somewhat premature to perform a chart audit immediately after the intervention.

Implication for Change

AAs have endured oppression in many forms including systemic racism, poverty, and unethical treatment, (i.e.Tuskegee Syphilis Study), which has resulted in their mistrust of the healthcare system. For instance, although the researcher had been present at the clinic for several days every month since the Fall of 2021, this did not appear to influence AD completion rates during the implementation period.

While the primary setting is the ideal place for ACP, this responsibility can not lie with the primary care provider alone. An enhanced healthcare substructure can initiate social change and bring about improved health for all (Maness & McCauley, 2020). In order for a transition to occur, more effort to expose these realities must be shared on Capitol Hill so that Congress can act. “The community has to be educated about promotion and prevention related to health and health care issues” (Kennedy et al., 2007, p. 4). Funding for increased community outreach directed toward AD awareness extended to minority populations would be beneficial. To further increase ACP and AD completion rates, EOLC conversations should be spearheaded by the patient’s trusted medical provider and reinforced by treating specialty physicians and patient advocate and/or surrogate decision maker. Once in place, directives should then be revisited yearly to update and make changes if necessary.

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Appendix A

Level of Evidence Table

Level of Evidence	Number of Articles	Authors and Dates
I Systematic Review or Metanalysis	0	
II Randomized, Controlled Trial	4	1) Xu et al. (2021) 2) Lyon et al. (2019) 3) Ejem et al. (2019) 4) Bonnel and Smith (2022)
III Controlled Trial without Randomization	1	1) Wissow et al. (2004)
IV Case-control or Cohort Study	4	1) Van Scoy et al. (2020) 2) Chode et al. (2016) 3) Gordon and Shade (1999) 4) Mack et al. (2010)
V Systematic Review of Qualitative or Descriptive Studies	5	1) Bazargan and Bazargan-Hejazi (2021) 2) Mayeda and Ward (2019) 3) Catlett and Campbell (2021) 4) Collins et al. (2018) 5) Ramsaroop et al. (2007)
VI Qualitative or Descriptive Study	9	1) Atherton (2020) 2) Marino et al. (2021) 3) Koss (2018) 4) West and Hollis (2012) 5) Dupree (2000) 6) Johnson et al. (2008) 7) Kwak and Ellis (2020) 8) Collins et al. (2021). 9) Rhodes et al. (2017)
VII Opinion or Consensus	6	1) Halinski (2020) 2) Melhado and Bushy (2011) 3) Maness and McCauley (2020) 4) Williams (2012) 5) Xanthos et al. (2010) 6) Kennedy et al. (2007)

(Melnyk & Fineout-Overholt, 2015)

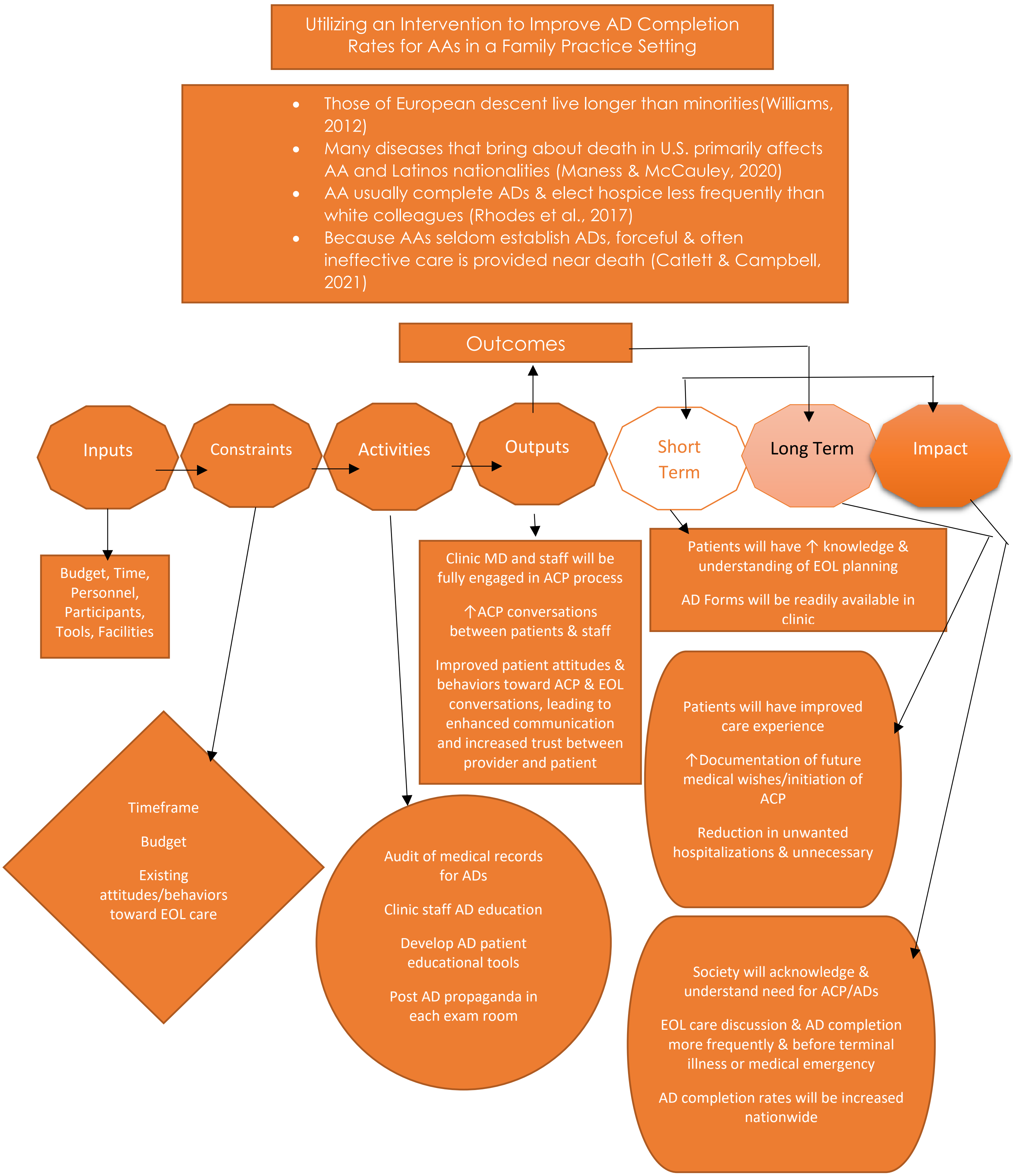
Appendix B

Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis

STRENGTHS	**WEAKNESSES**
• Clinic MD and staff are supportive of advance directive initiative • DNP student will provide education to staff • Advance directive forms are available at no cost and can be easily downloaded and printed for convenience	• Clinic MD has not made advocating for advance care planning a priority thus staff has limited education about advance directives • Clinic is short-staffed so protocols regarding project implementation may not be followed appropriately
OPPORTUNITIES	**THREATS**
• Patients and staff will have increased knowledge and understanding of the purpose of advance directives • Future medical care wishes will be articulated via completed advance directives resulting in an improved patient care experience • Unwanted hospitalizations and/or unnecessary or aggressive medical treatment will be avoided • Improvement in documentation of advance directives • Advance care planning can be billed by providers for reimbursement from Medicare	• Knowledge gaps/misconceptions of purpose of advance directives • Negative patient attitudes/behaviors toward end-of-life planning/care

Appendix C

Conceptual Model



Utilizing an Intervention to Improve AD Completion Rates for AAs in a Family Practice Setting

- Those of European descent live longer than minorities(Williams, 2012)
- Many diseases that bring about death in U.S. primarily affects AA and Latinos nationalities (Maness & McCauley, 2020)
- AA usually complete ADs & elect hospice less frequently than white colleagues (Rhodes et al., 2017)
- Because AAs seldom establish ADs, forceful & often ineffective care is provided near death (Catlett & Campbell, 2021)

Budget, Time, Personnel, Participants, Tools, Facilities

Timeframe

Budget

Existing attitudes/behaviors toward EOL care

Audit of medical records for ADs

Clinic staff AD education

Develop AD patient educational tools

Post AD propaganda in each exam room

Clinic MD and staff will be fully engaged in ACP process

↑ACP conversations between patients & staff

Improved patient attitudes & behaviors toward ACP & EOL conversations, leading to enhanced communication and increased trust between provider and patient

Patients will have ↑ knowledge & understanding of EOL planning

AD Forms will be readily available in clinic

Patients will have improved care experience

↑Documentation of future medical wishes/initiation of ACP

Reduction in unwanted hospitalizations & unnecessary

Society will acknowledge & understand need for ACP/ADs

EOL care discussion & AD completion more frequently & before terminal illness or medical emergency

AD completion rates will be increased nationwide

Appendix D

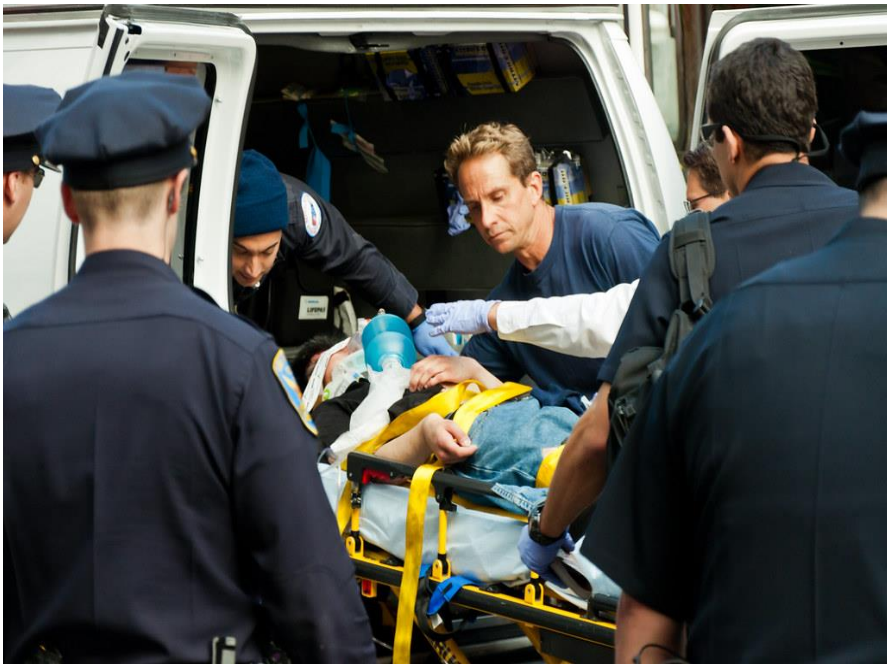
Logic Model

RESOURCES	ACTIVITIES	OUTPUTS	SHORT & LONG-TERM OUTCOMES	IMPACT
In order to accomplish our set of activities we will need the following:	*In order to address our problem or asset we will accomplish the following activities:*	*We expect that once accomplished these activities will produce the following evidence of service delivery:*	*We expect that if accomplished these activities will lead to the following changes in 1-3 then 4-6 years:*	*We expect that if accomplished these activities will lead to the following changes in 7-10 years:*
Budget **Time** **Personnel** Volunteers **Participants** Clinic patients aged 60 years and older **Tools** ACP educational materials & forms Telephone **Facilities** Clinic	Audit of applicable medical records (60 years and older) for ADs Clinic staff AD education Develop AD patient educational tools Post AD propaganda in each exam room Print AD forms Order ACP educational brochures Provide patient education in office	Clinic physician and staff will be fully engaged in the ACP process Increased ACP conversations between patients and staff Improved patient attitudes & behaviors toward ACP & EOL conversations (increased self-efficacy), leading to enhanced communication and increased trust between provider and patient	**Short-term Outcomes** • Patients will have increased knowledge & understanding of end of life planning • AD Directive Forms will be readily available in the clinic **Long-term Outcomes** • Improved care experience • Increased documentation of future medical care wishes/initiation of ACP • Reduction in unwanted hospitalizations and unnecessary/aggressive treatments • Improved quality of life	Society will acknowledge and understand the necessity for ACP/ADs End-of-life care discussion and AD completion will occur more frequently and long before terminal illness or medical emergency Advance directive completion rates will not only be increased in the clinic but also nationwide

Appendix E

Exam Room Flyer

Does Your Family Know What Medical Treatment You Would Want in the Event of a Life-Threatening Situation?



Advance Care Planning is a way for an individual to document ahead of time the medical treatment they want if they are unable to communicate. The legal forms used to document these wishes are called Advance Directives.

Having an advance directive in place could lower the mental stress on loved ones having to make difficult decisions about your future medical treatment.

For more information about Advance Directives, please ask any member of the office staff.

Appendix F

Patient Letter

Date

Dear Sir/Madam:

I am a nurse practitioner and Doctor of Nursing Practice student at Regis University located in Denver, Colorado. As part of my degree requirements, I will be completing a quality improvement project at McFarland Family Clinic. This initiative will focus on increasing advance directive completion rates for African Americans 50 years and older. Advance Care Planning is a way for an individual to document ahead of time the medical treatment they want if they are unable to communicate after an unexpected life-threatening event. The legal forms used to document your wishes are called Advance Directives (ADs).

Please know that participation in this project is voluntary, and completion of ADs is not required. This project is being implemented to make patients aware of their end-of-life care choices. In addition to this letter, you will also find an advance directive brochure. Please review it as you wait to be seen by the doctor.

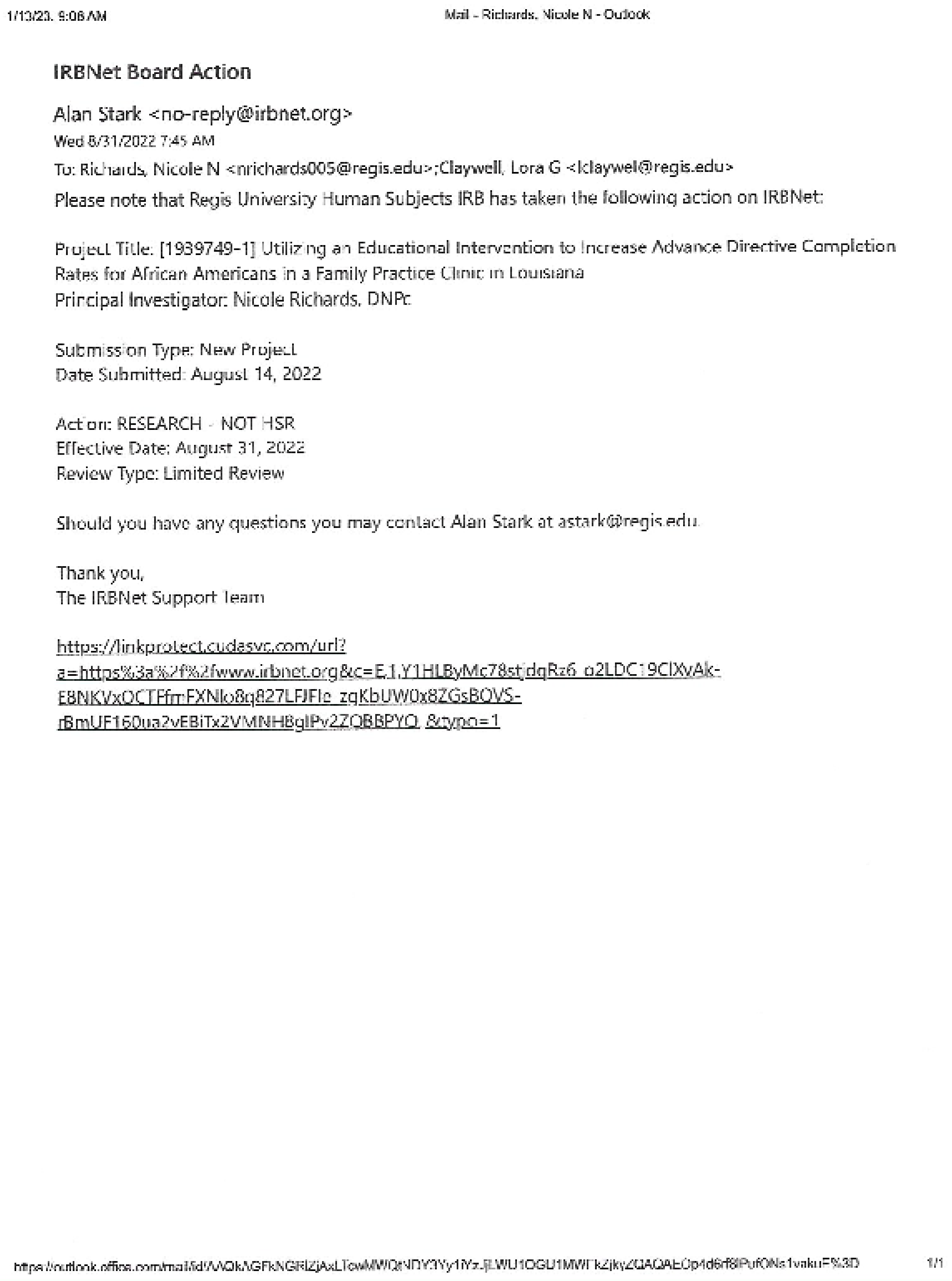
Thank you so much for assisting me with this endeavor. I look forward to speaking with you!

Respectfully,

Nicole N. Richards, MSN, APRN, FNP-C, DNP student

Appendix G

IRB Approval Letter



1/13/23, 9:06 AM Mail - Richards, Nicole N - Outlook

IRBNet Board Action

Alan Stark <no-reply@irbnet.org>
Wed 8/31/2022 7:45 AM
To: Richards, Nicole N <nrichards005@regis.edu>;Claywell, Lora G <lclaywel@regis.edu>

Please note that Regis University Human Subjects IRB has taken the following action on IRBNet:

Project Title: [1939749-1] Utilizing an Educational Intervention to Increase Advance Directive Completion Rates for African Americans in a Family Practice Clinic in Louisiana
Principal Investigator: Nicole Richards, DNPc

Submission Type: New Project
Date Submitted: August 14, 2022

Action: RESEARCH - NOT HSR
Effective Date: August 31, 2022
Review Type: Limited Review

Should you have any questions you may contact Alan Stark at astark@regis.edu.

Thank you,
The IRBNet Support Team

https://linkprotect.cudasvc.com/url?
a=https%3a%2f%2fwww.irbnet.org&c=E,1,Y1HLByMc78stjdqRz6_o2LDC19ClXvAk-E8NKVxOCTFfmFXNlo8q827LFJFle_zqKbUW0x8ZGsBOVS-rBmUF160ua2vEBiTx2VMNHBglPv2ZQBBPYQ,&typo=1

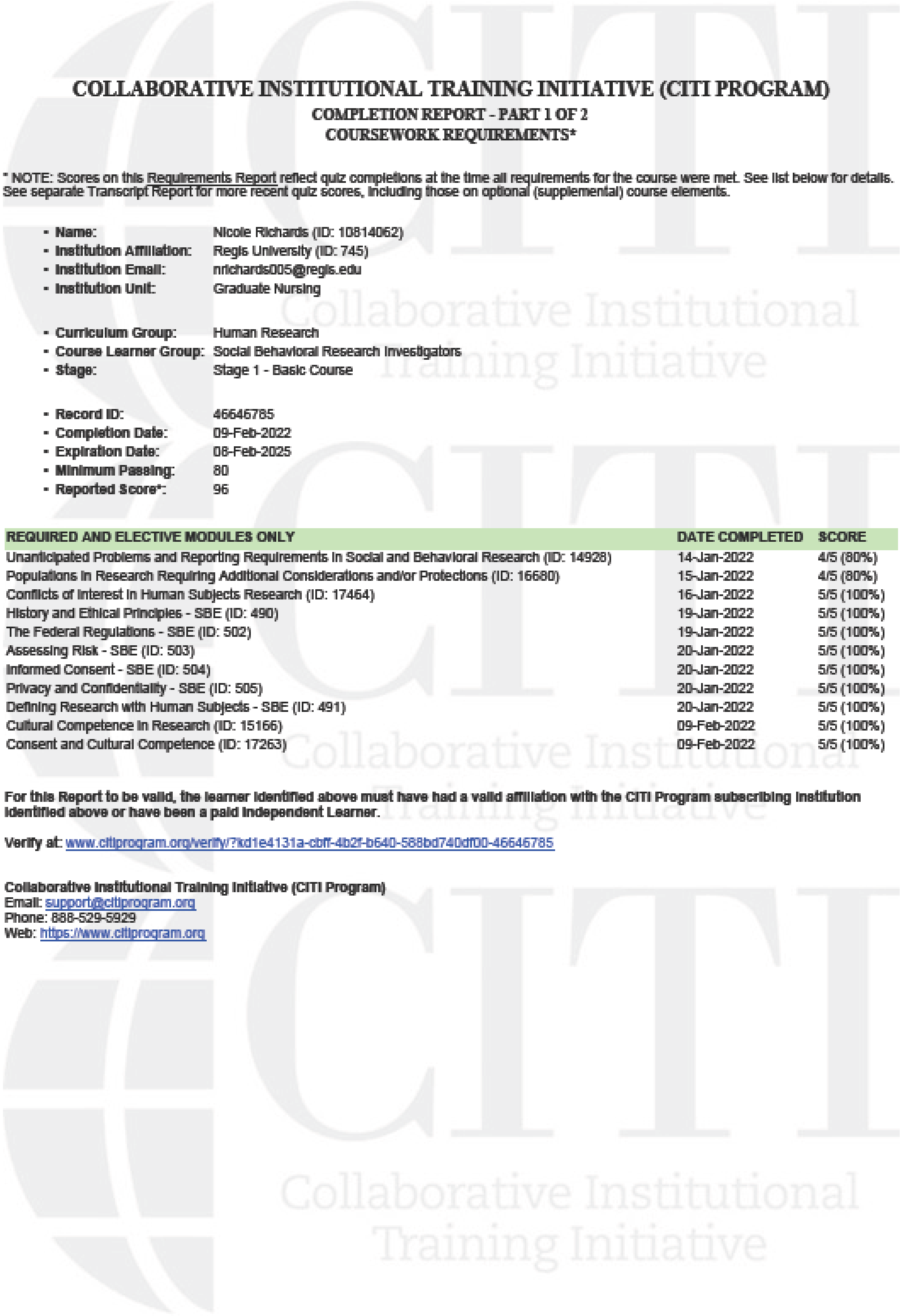
https://outlook.office.com/mail/id/AAQkAGFkNGRlZjAxLTowMWQtNDY3Yy1iYzJjLWU1OGU1MWFkZjkyZQAQAEOp4d6rf8lPufONs1vakuE%3D 1/1

Appendix H

Budget

ITEM	**COST**
110 ACP patient brochures (Channing Bete Company)	$194.08
3 Realms of 500-count copy paper	$20.22
60 Blue Ink Pens	$5.93
3 Black printer ink (63 XL)	$135.72
1 Color printer ink (63 XL)	$45.24
5 Acrylic sign holders (exam room flyers)	$28.95
Training Lunch on ACP with office staff	$150.00
Office staff assistance with providing patients with AD paperwork	Negligible
TOTAL	**$580.14**

APPENDIX I CITI Completion Report Page 1



COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

Name:	Nicole Richards (ID: 10814062)
Institution Affiliation:	Regis University (ID: 745)
Institution Email:	nrichards005@regis.edu
Institution Unit:	Graduate Nursing
Curriculum Group:	Human Research
Course Learner Group:	Social Behavioral Research Investigators
Stage:	Stage 1 - Basic Course
Record ID:	46646785
Completion Date:	09-Feb-2022
Expiration Date:	08-Feb-2025
Minimum Passing:	80
Reported Score*:	96

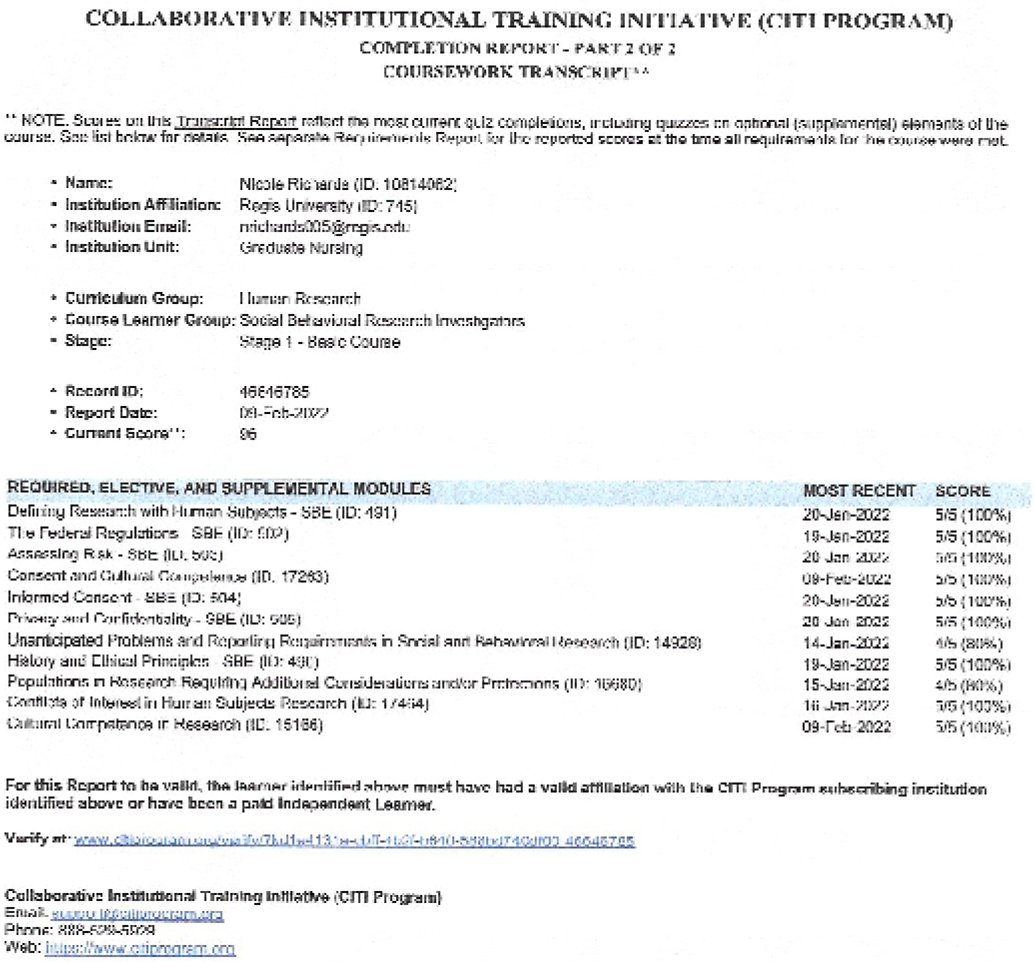
REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID: 14928)	14-Jan-2022	4/5 (80%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	15-Jan-2022	4/5 (80%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	16-Jan-2022	5/5 (100%)
History and Ethical Principles - SBE (ID: 490)	19-Jan-2022	5/5 (100%)
The Federal Regulations - SBE (ID: 502)	19-Jan-2022	5/5 (100%)
Assessing Risk - SBE (ID: 503)	20-Jan-2022	5/5 (100%)
Informed Consent - SBE (ID: 504)	20-Jan-2022	5/5 (100%)
Privacy and Confidentiality - SBE (ID: 505)	20-Jan-2022	5/5 (100%)
Defining Research with Human Subjects - SBE (ID: 491)	20-Jan-2022	5/5 (100%)
Cultural Competence in Research (ID: 15166)	09-Feb-2022	5/5 (100%)
Consent and Cultural Competence (ID: 17263)	09-Feb-2022	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?kd1e4131a-cbff-4b2f-b640-588bd740df00-46646785

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

CITI Completion Report Page 2



COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2

COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Nicole Richards (ID: 10814062)
- **Institution Affiliation:** Regis University (ID: 745)
- **Institution Email:** nrichards005@regis.edu
- **Institution Unit:** Graduate Nursing

- **Curriculum Group:** Human Research
- **Course Learner Group:** Social Behavioral Research Investigators
- **Stage:** Stage 1 - Basic Course

- **Record ID:** 46646785
- **Report Date:** 09-Feb-2022
- **Current Score**:** 96

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Defining Research with Human Subjects - SBE (ID: 491)	20-Jan-2022	5/5 (100%)
The Federal Regulations - SBE (ID: 502)	19-Jan-2022	5/5 (100%)
Assessing Risk - SBE (ID: 503)	20-Jan-2022	5/5 (100%)
Consent and Cultural Competence (ID: 17263)	09-Feb-2022	5/5 (100%)
Informed Consent - SBE (ID: 504)	20-Jan-2022	5/5 (100%)
Privacy and Confidentiality - SBE (ID: 505)	20-Jan-2022	5/5 (100%)
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID: 14928)	14-Jan-2022	4/5 (80%)
History and Ethical Principles - SBE (ID: 490)	19-Jan-2022	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	15-Jan-2022	4/5 (80%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	16-Jan-2022	5/5 (100%)
Cultural Competence in Research (ID: 15166)	09-Feb-2022	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: [illegible]

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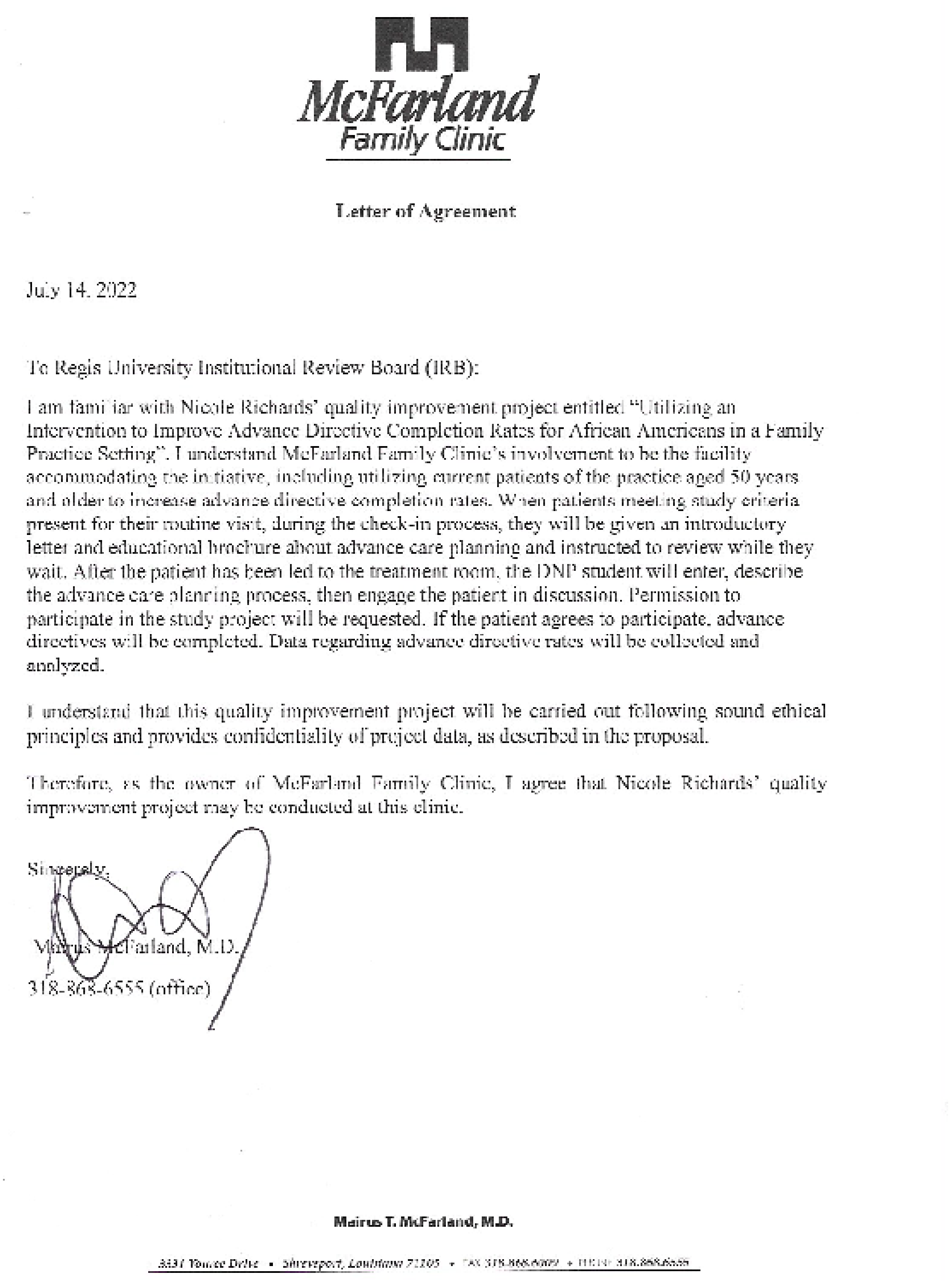
APPENDIX J

Letter of Agreement



McFarland
Family Clinic

Letter of Agreement

July 14. 2022

To Regis University Institutional Review Board (IRB):

I am familiar with Nicole Richards' quality improvement project entitled "Utilizing an Intervention to Improve Advance Directive Completion Rates for African Americans in a Family Practice Setting". I understand McFarland Family Clinic's involvement to be the facility accommodating the initiative, including utilizing current patients of the practice aged 50 years and older to increase advance directive completion rates. When patients meeting study criteria present for their routine visit, during the check-in process, they will be given an introductory letter and educational brochure about advance care planning and instructed to review while they wait. After the patient has been led to the treatment room, the DNP student will enter, describe the advance care planning process, then engage the patient in discussion. Permission to participate in the study project will be requested. If the patient agrees to participate, advance directives will be completed. Data regarding advance directive rates will be collected and analyzed.

I understand that this quality improvement project will be carried out following sound ethical principles and provides confidentiality of project data, as described in the proposal.

Therefore, as the owner of McFarland Family Clinic, I agree that Nicole Richards' quality improvement project may be conducted at this clinic.

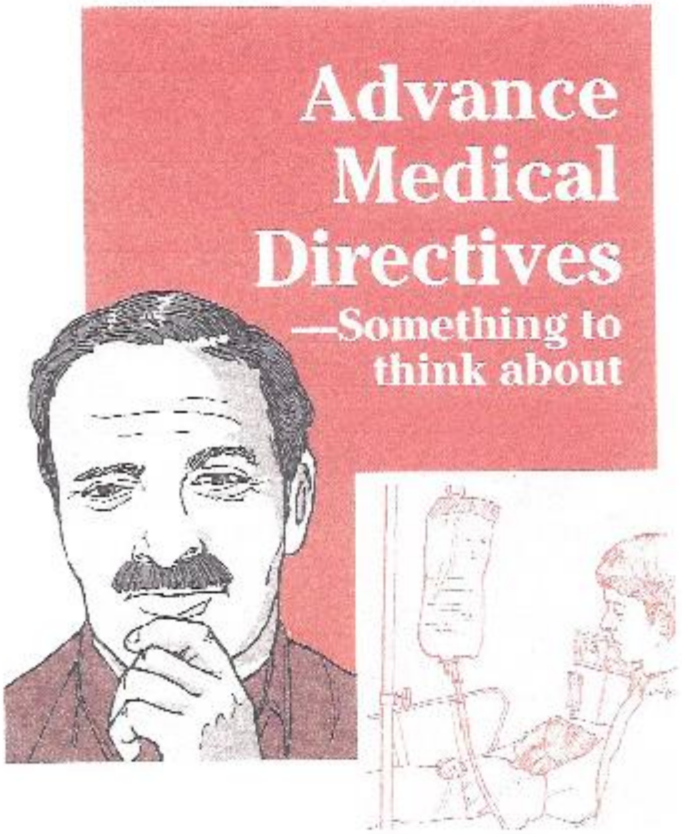
Sincerely,

Mairus McFarland, M.D.
318-868-6555 (office)

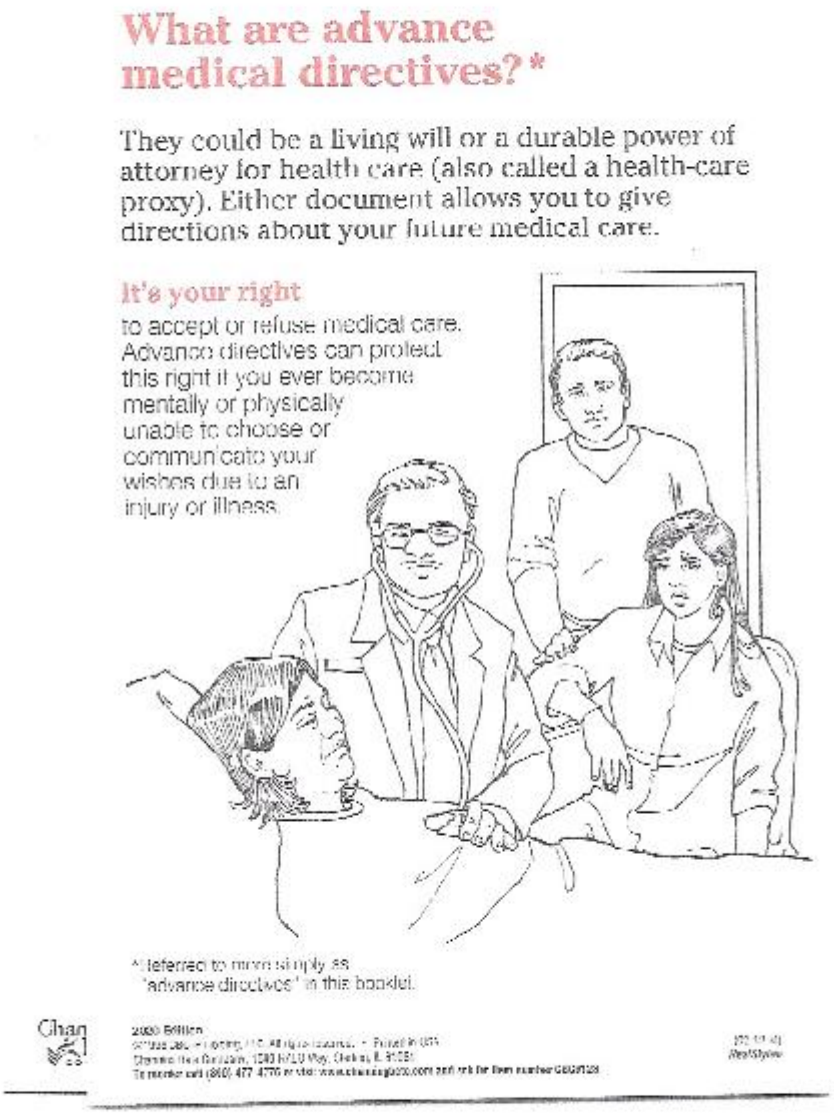
Mairus T. McFarland, M.D.

APPENDIX K

Advance Care Planning Booklet



Advance
Medical
Directives
—Something to
think about



What are advance medical directives?*

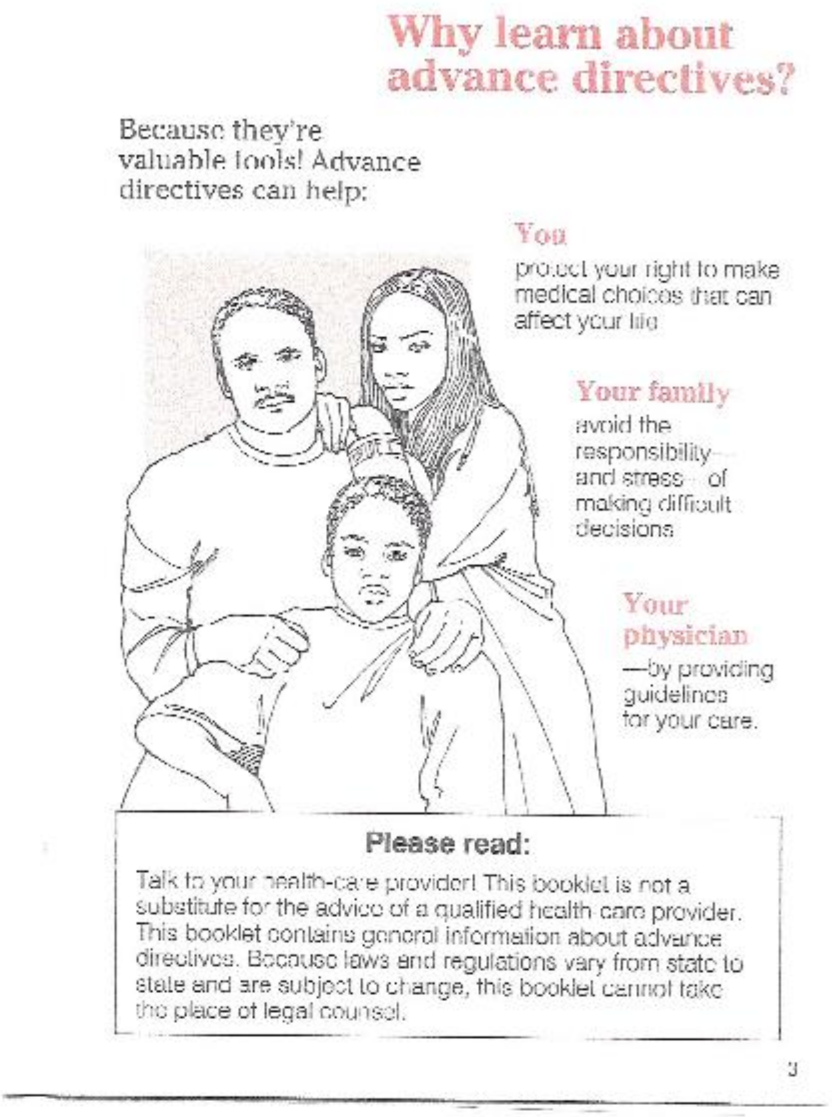
They could be a living will or a durable power of attorney for health care (also called a health-care proxy). Either document allows you to give directions about your future medical care.

It's your right

to accept or refuse medical care. Advance directives can protect this right if you ever become mentally or physically unable to choose or communicate your wishes due to an injury or illness.

* Referred to more simply as "advance directives" in this booklet.

2020 Edition



Why learn about advance directives?

Because they're valuable tools! Advance directives can help:

You

protect your right to make medical choices that can affect your life

Your family

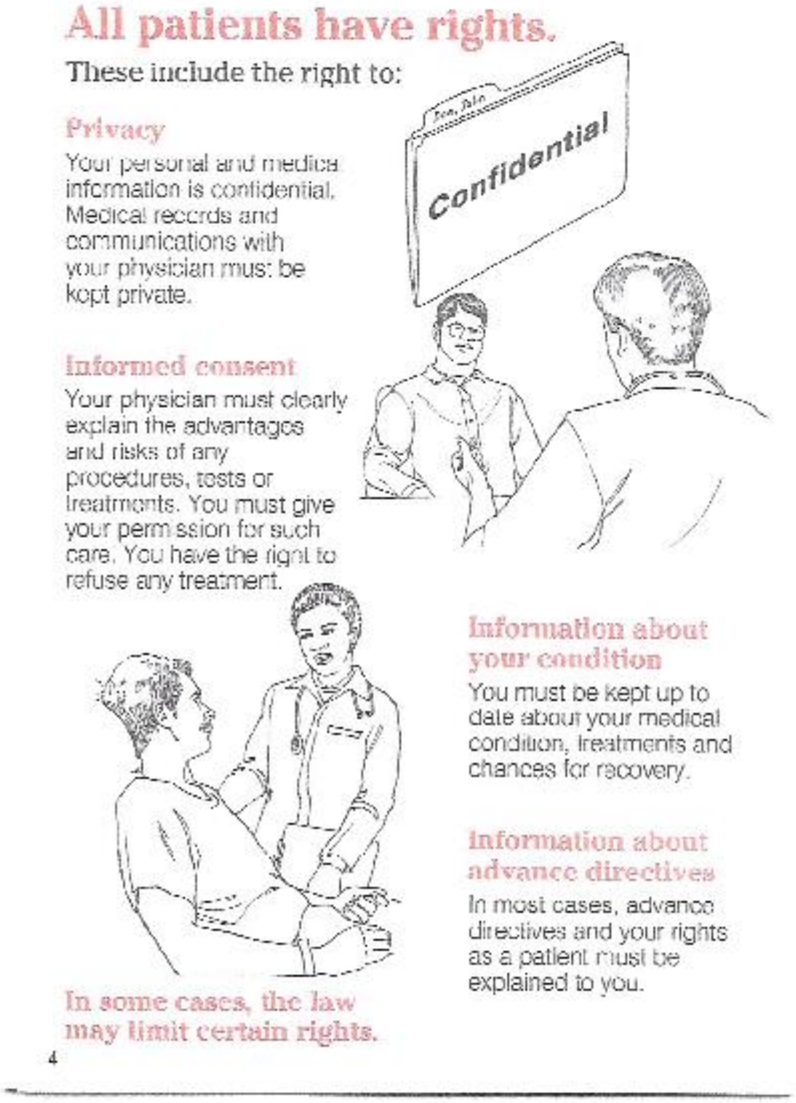
avoid the responsibility—and stress—of making difficult decisions

Your physician

—by providing guidelines for your care.

Please read:

Talk to your health-care provider! This booklet is not a substitute for the advice of a qualified health care provider. This booklet contains general information about advance directives. Because laws and regulations vary from state to state and are subject to change, this booklet cannot take the place of legal counsel.



All patients have rights.

These include the right to:

Privacy

Your personal and medical information is confidential. Medical records and communications with your physician must be kept private.

Informed consent

Your physician must clearly explain the advantages and risks of any procedures, tests or treatments. You must give your permission for such care. You have the right to refuse any treatment.

Information about your condition

You must be kept up to date about your medical condition, treatments and chances for recovery.

Information about advance directives

In most cases, advance directives and your rights as a patient must be explained to you.

In some cases, the law may limit certain rights.

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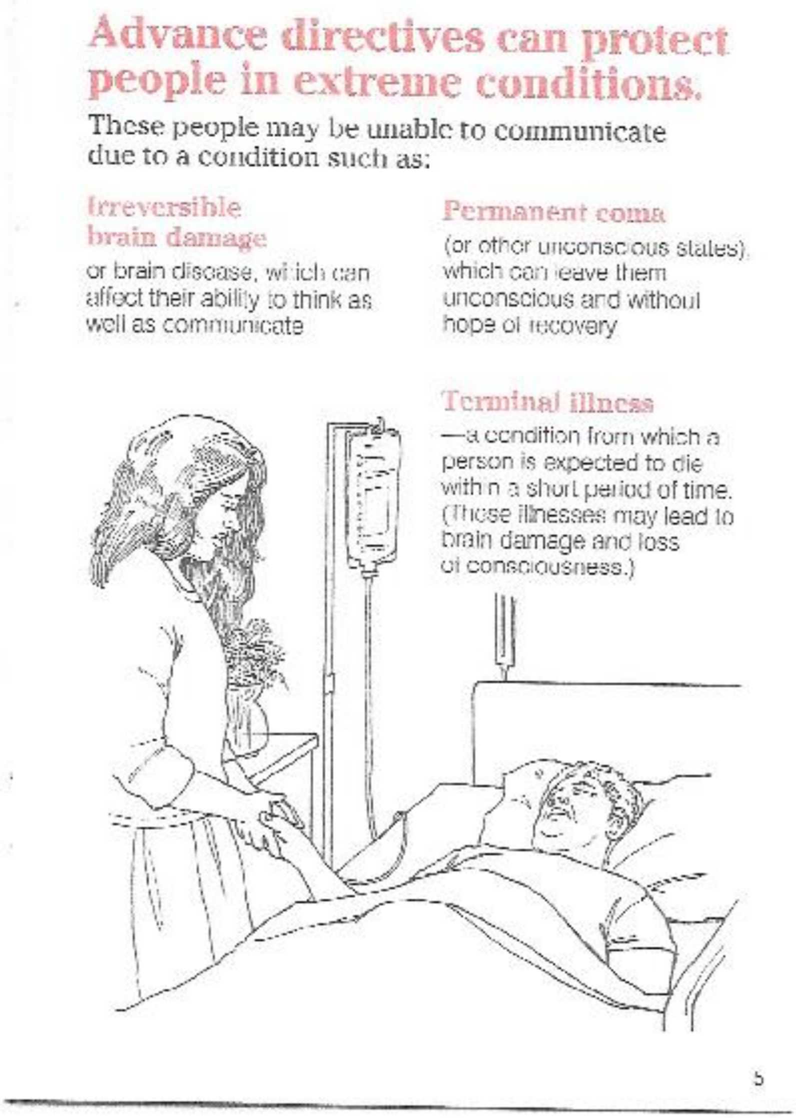


Advance directives can protect people in extreme conditions.

These people may be unable to communicate due to a condition such as:

Irreversible brain damage

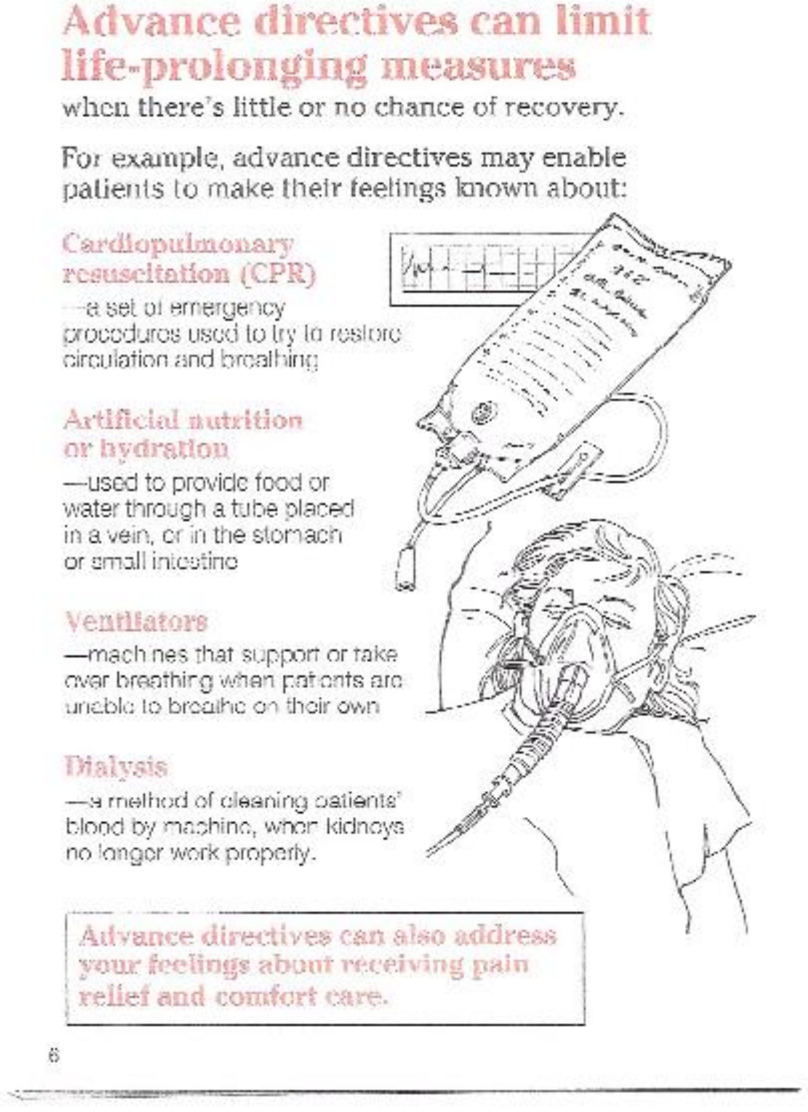
or brain disease, which can affect their ability to think as well as communicate

Permanent coma

(or other unconscious states), which can leave them unconscious and without hope of recovery

Terminal illness

—a condition from which a person is expected to die within a short period of time. (These illnesses may lead to brain damage and loss of consciousness.)



Advance directives can limit life-prolonging measures

when there's little or no chance of recovery.

For example, advance directives may enable patients to make their feelings known about:

Cardiopulmonary resuscitation (CPR)

—a set of emergency procedures used to try to restore circulation and breathing

Artificial nutrition or hydration

—used to provide food or water through a tube placed in a vein, or in the stomach or small intestine

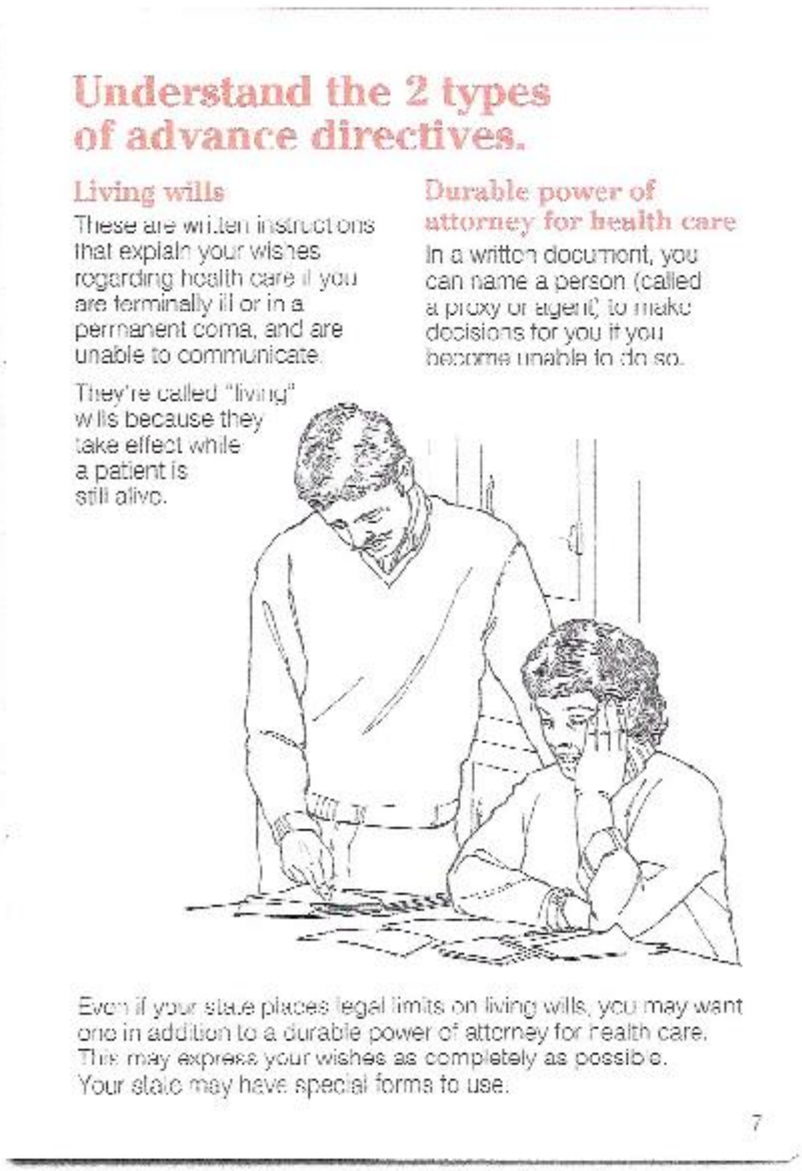
Ventilators

—machines that support or take over breathing when patients are unable to breathe on their own

Dialysis

—a method of cleaning patients' blood by machine, when kidneys no longer work properly.

Advance directives can also address your feelings about receiving pain relief and comfort care.



Understand the 2 types of advance directives.

Living wills

These are written instructions that explain your wishes regarding health care if you are terminally ill or in a permanent coma, and are unable to communicate.

They're called "living" wills because they take effect while a patient is still alive.

Durable power of attorney for health care

In a written document, you can name a person (called a proxy or agent) to make decisions for you if you become unable to do so.

Even if your state places legal limits on living wills, you may want one in addition to a durable power of attorney for health care. This may express your wishes as completely as possible. Your state may have special forms to use.

Let your values be your guide

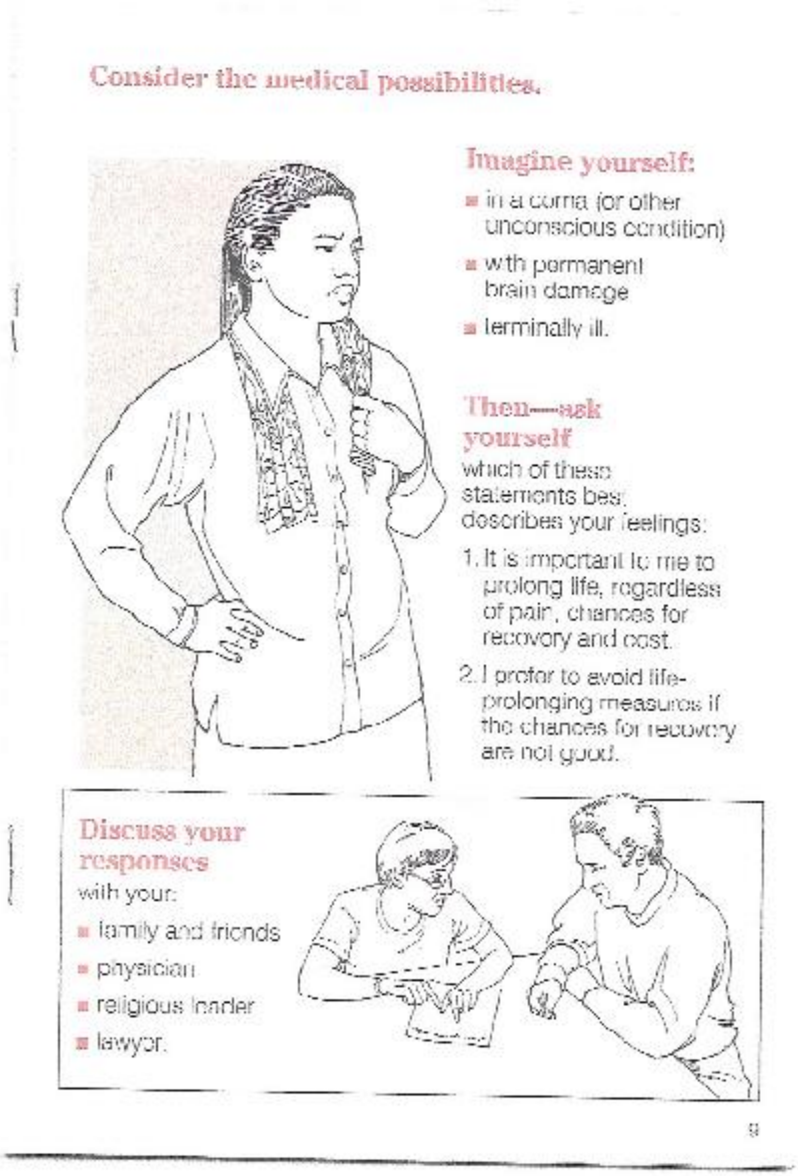
when creating advance directives.

Consider what's important to you.

Which of these statements express how you think you'd feel if you were near death?

It's important for me to:

- die without pain and suffering
- be able to make my own decisions
- leave my family with good memories
- not burden my family with difficult decisions
- act according to my religious beliefs
- be with my loved ones at death.



Consider the medical possibilities.

Imagine yourself:

- in a coma (or other unconscious condition)
- with permanent brain damage
- terminally ill.

Then—ask yourself

which of these statements best describes your feelings:

1. It is important to me to prolong life, regardless of pain, chances for recovery and cost.
2. I prefer to avoid life-prolonging measures if the chances for recovery are not good.

Discuss your responses

with your:

- family and friends
- physician
- religious leader
- lawyer.

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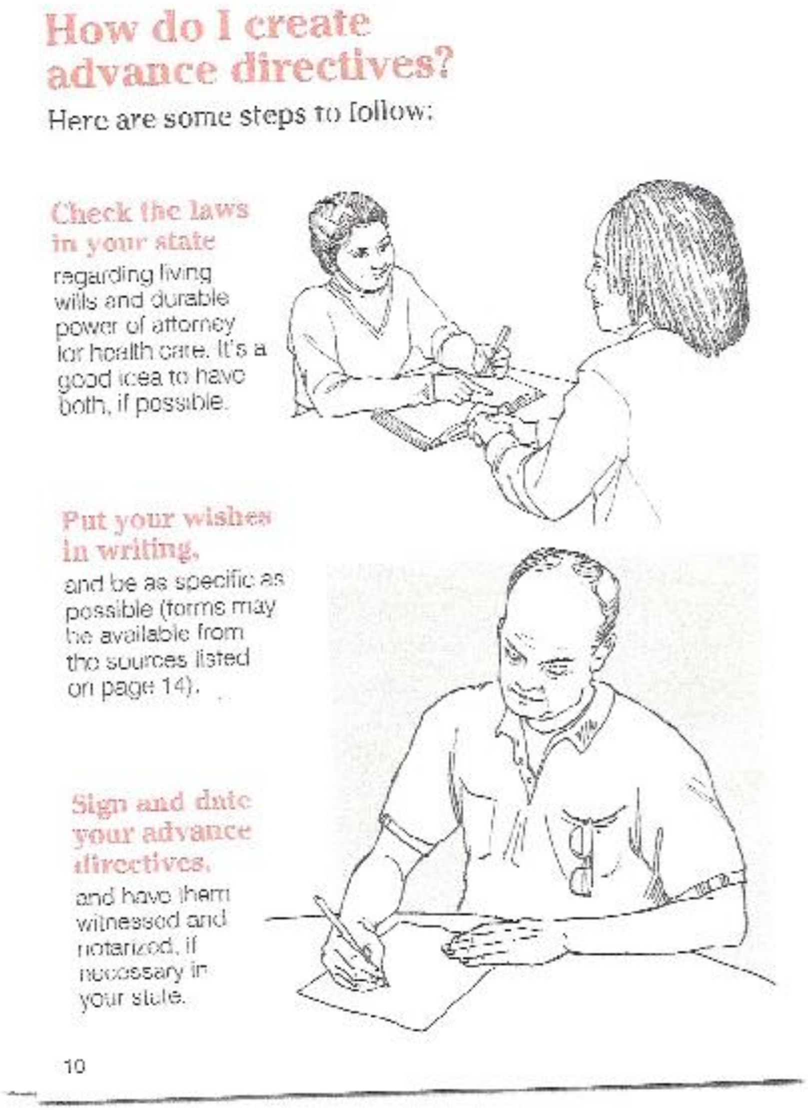


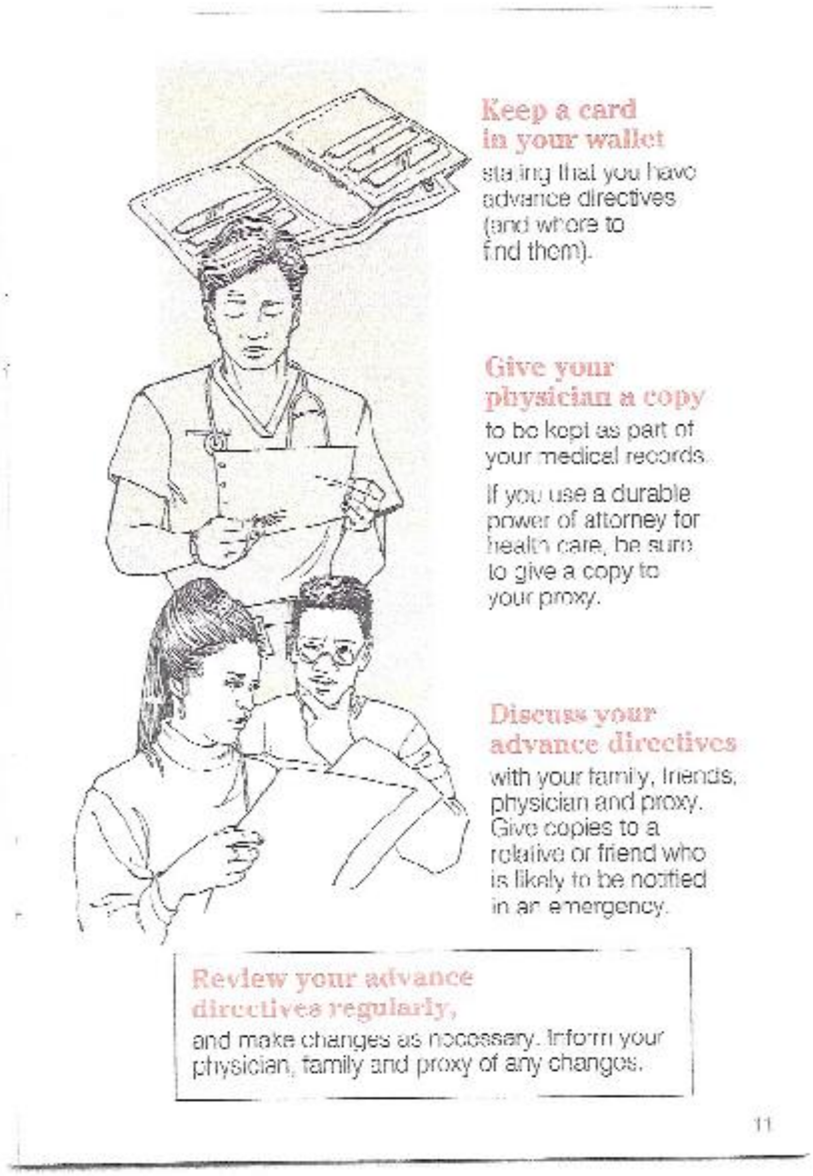
How do I create advance directives?

Here are some steps to follow:

Check the laws in your state regarding living wills and durable power of attorney for health care. It's a good idea to have both, if possible.

Put your wishes in writing, and be as specific as possible (forms may be available from the sources listed on page 14).

Sign and date your advance directives, and have them witnessed and notarized, if necessary in your state.



Keep a card in your wallet

stating that you have advance directives (and where to find them).

Give your physician a copy

to be kept as part of your medical records.

If you use a durable power of attorney for health care, be sure to give a copy to your proxy.

Discuss your advance directives

with your family, friends, physician and proxy. Give copies to a relative or friend who is likely to be notified in an emergency.

Review your advance directives regularly,

and make changes as necessary. Inform your physician, family and proxy of any changes.

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Some special issues

Do-not-resuscitate (DNR) orders

A DNR order instructs health-care providers not to attempt CPR or related procedures if your breathing or heartbeat stops. You or your proxy can request a DNR order. A physician must write and sign it. Discuss this option with your physician.

Organ donation

Advance directives can state your wishes to donate specific organs (or your entire body).

Other specific treatments and procedures

You may want to request or refuse procedures such as the ones listed on page 6.

Some questions and answers

Can I refuse treatment for my child?

You may in some cases, depending on a medical evaluation of the:

- child's condition
- chances of recovery
- expected effects of treatment.

What if I change my mind after I fill out my advance directives?

If you are a competent adult, you can always change or cancel your advance directives. In some cases, you may even cancel them orally.

My relative has valid advance directives—can I prevent them from taking effect?

Generally no, unless you can prove that the relative was not thinking clearly when he or she created them.

Help and information are available.

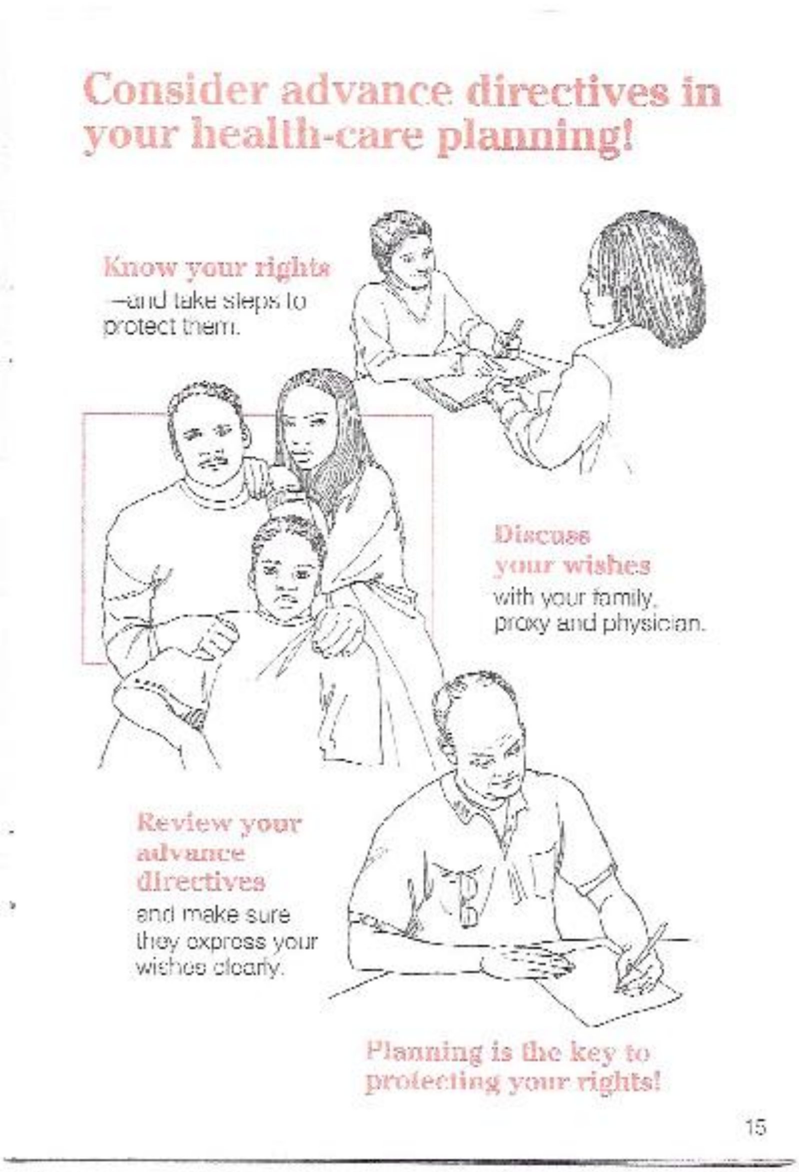
If you need help in preparing advance directives, or if you'd like more information, contact:

Local resources

These include:

- a lawyer
- hospitals, hospices, home health agencies and long-term care facilities
- your state attorney general's office.

National Hospice and Palliative Care Organization
www.nhpco.org
1-800-658-8898



Consider advance directives in your health-care planning!

Know your rights —and take steps to protect them.

Discuss your wishes with your family, proxy and physician.

Review your advance directives and make sure they express your wishes clearly.

Planning is the key to protecting your rights!

Appendix L

Project Timeline

	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023
Began writing project proposal	🟧											
Completed project proposal		🟧										
Created budget		🟧										
Created Exam room flyer		🟧										
Oral Presentation for proposal		🟧										
Educational brochures/supplies purchased			🟧									
Site approval letter submitted			🟧									
Proposal to Regis IRB				🟧								
Project deemed Not HSR by Regis IRB				🟧								
Pre-intervention charts audited						🟧						
Educated clinic staff on ACP						🟧						
Project intervention began						🟧						
Project intervention ended						🟧						
Post-intervention charts audited							🟧					
Data collected						🟧	🟧					
Data analyzed								🟧				
Met with chairperson for feedback/revisions									🟧			
Redraft based on feedback										🟧		
Project Oral Defense											🟧	
Written, oral, and/or electronic dissemination											🟧	🟧