2017

Intervention for Increasing Advance Directive Documentation in the Primary Care Setting by Placing a Flag in the Electronic Medical Record (EMR)

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Intervention for Increasing Advance Directive Documentation in the Primary Care Setting by Placing a Flag in the Electronic Medical Record (EMR)

Linda J. Wilson

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Abstract

Regardless of the Patient Self-Determination Act in 1992, only 15% of Americans have an advance directive (AD). This will be an even more significant factor by 2030 when the expected elderly population will be 72.1 million people. **Purpose:** If an individual does not have an AD, they may be subjected to futile, costly and unnecessary suffering at end-of-life. Loved ones may also suffer the emotional burden of not knowing what type of care is wanted if the person is unable to communicate. Primary care providers are first line in caring for patients and are in an ideal position to ensure that their patients have an AD completed. This should not be confined to the elderly, but anyone over the age of 18 as an unexpected illness or tragic event may occur. The literature is consistent concerning the emphasis on this important document but points out that it is not being done due to many constraints such as lack of education on ADs, discomfort with subject, time restraints and difficulty with accessing ADs in electronic medical records (EMR). **Method:** This quality improvement project seeks to have the AD flagged in the EMR to prompt the provider to have the conversation and easily document the results. One hundred and ten providers and thirty allied staff were involved in the project. Education concentrating on knowledge, comfort and legal aspects of ADs was provided to all staff. A community forum was offered to the public to provide information regarding ADs and its importance. At the start of the project, patients were asked to complete a card with a simple yes or no if their provider discussed completing ADs during their visit. **Outcome:** This project provided evidence of an increase in documentation due to the “flag “reminder. Education for the community and providers reinforced the importance of ADs. **Conclusion:** This project will easily be sustainable since the providers were educated on the benefit to their patients, their families and the facility. The flag
will have prompted the conversation and documentation with the additional benefit of fulfilling Medicare and Meaningful use requirements.

*Keywords*: advance directives, end-of-life, primary care, staff education, EMR reminders
**Introduction and Background**

The Patient Self Determination Act (PSDA) enacted under the Omnibus Budget Reconciliation Act of 1990, established requirements regarding advance directives (ADs) (Federal patient self-determination act final regulations, 1991). This act encourages individuals to decide the extent and type of medical care they would want if they are unable to make decisions due to illness or injury. Healthcare facilities that receive payments from Medicare and Medicaid are required to ask if a person has an AD and to provide information if one is not completed (American Cancer Society [ACS], 2015). Facilities are also required to provide information concerning patient’s rights under state law. These rights include the ability to make decisions regarding care and the right to refuse unwanted care (ACS, 2015).

Despite the good intentions set forth by these acts, Rao, Anderson, Feng-Chang, and Laux (2014) surveyed 7,946 American citizens 18 and older and determined that only 15% had ADs. House and Lach (2014) disclosed that only 12% had discussed end-of-life care with their providers. A report by the Agency for Healthcare Research and Quality (AHRQ, 2012) revealed a 72% unavailability of ADs in medical records. The Centers for Disease Control and Prevention (CDC, 2012) reported that only 28% of home healthcare patients, 65% of nursing home residents, 88% of hospice patients, and 50% of critically ill patients had completed ADs. Bischoff, Sudora, Miao, Boscardin, and Smith (2013) conducted a health and retirement survey. The 6,942 responses indicated ADs were associated with a lower rate of in-hospital deaths, and an increased use of hospice (Bischoff et al., 2013). A study by O’Hara at the Veterans Administration (VA) in 2014 determined 36% of participants stated they had discussed end-of-life care with their providers and wanted to be advised of the downside of treatment options. They did not want treatment if it meant they would be unable to care for themselves (O’Hara,
Patients were asked if their providers were aware of their decisions; 88% stated yes, and 70% felt their providers knew how they felt, but only 18% actually had the conversation and completed ADs (O’Hara, 2014).

Continued growth in the proportion of older adults in the United States (US) is unprecedented in this nation’s history (National Institute of Aging [NIA], 2014). The NIA (2014) concluded that by 2030, Americans aged 65 and older will number approximately 72.1 million people. This exceeds twice the number in the 2010 census. More than one in four elderly will face questions about medical treatments near the end-of-life, and many will not be mentally or physically capable of making these decisions (Advance Directives, 2014).

Medical advancements have been a significant factor in contributing to increasing the life expectancy for Americans. However, it is likely that an older person will live one or two years with a chronic illness (NIA, 2014). The Institute of Medicine (IOM, 2014) estimates that 70% or more of Americans will die of a chronic illness. Alzheimer’s disease will be more prevalent with people living to an older age. Alzheimer’s disease may affect as many as 20%, with another 42% developing functional limitations over age 65 (IOM, 2014). The CDC (2012) proposes 24% of noninstitutionalized persons aged 65+ report fair to poor health, and 7% indicate that they need help with personal care.

According to the Regence Poll (2011), 71% of Americans believe that quality of life is more important than extending life with all available medical interventions if it serves only to prolong suffering. Pollack, Morhaim, and Williams (2013) conducted a study of 1,195 Maryland residents 18 and older. The intent was to acquire information to validate concerns that futile and expensive end-of-life care was a public health problem. It was determined that approximately
25% of a person’s lifetime medical cost was spent in the last few months of life (Pollack et al., 2013).

Volandes (2015) expressed that unnecessary medical care at the end-of-life was a toxic result of medicine’s ability to prolong life even under futile circumstances and concluded that 80% of people want to die comfortably at home, 24% actually have this happen and 63% die in the hospital or nursing home.

A positive step, in a forward direction, is a mandate by The Center for Medicare and Medicaid Services (CMS). This mandate states that as of January 1st, 2017 providers will be reimbursed for two conversations regarding ADs. The third installment of Meaningful Use requires providers to document an AD discussion. Changes in medicine appear to be no different than other segments of society. A mandate or financial incentive must be instituted for a change to take place.

Advance care planning (ACP) does not just concern older age. At any age, an accident or illness can occur that can render someone too ill to make medical decisions (NIA, 2014). A completed AD has the potential to provide patients with autonomy, and a family with clear direction for following the loved one’s wishes. In addition, conserving healthcare dollars ethically and correctly serves to respect the values and wishes of the individual’s end-of-life decisions (Pollack et al., 2013).

**Problem Statement**

Noncompletion of ADs among adults 18 years and older potentially leads to unnecessary and inappropriate medical interventions at the end-of-life. The uncertainty of loved ones wishes creates emotional turmoil for family members when decisions need to be made and patients are unable to articulate how they want their care to proceed. This is an all too common scenario
when the discussion and subsequent completion of ADs is not initiated by providers during primary care visits due to difficulty of the conversation, lack of education concerning the topic, and time constraints.

A quality improvement plan was developed to improve the completion rate of AD discussions and documentation in the primary care setting. Meetings were held to educate the staff on Vermont and New Hampshire ADs. Education was provided on New Hampshire forms as the facility borders New Hampshire and has patients from that area. Information technology was approached to have an AD reminder placed in a conspicuous position within the EMR. The intention was to develop a “flag” that would initiate a conversation about ADs. This provided a prompt for providers to discuss and document if forms were completed or if the conversation needed to be addressed.

**Literature Review**

A comprehensive search of the literature for information regarding ADs was conducted that included the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed of the National Library of Medicine, CDC, and National Institute of Health (NIH). The Medical Subject Headings (MeSH) were ADs, primary care, staff education, EMR reminders and end-of-life planning. The search yielded 160 articles published between 2007 and 2016. All articles not in English or older than 5 years were not included unless they were considered hallmark articles or well done randomized control studies or systematic reviews. Duplicate studies, small numbers of participants and studies with mainly subjective results were eliminated. Ten studies with subjective results were included due to the data creating a foundation for further research. None of the articles or studies reviewed suggested development of evidence based medicine (EBM) on advance directives.
The inclusion criteria included articles in English that were published within the last five years in peer reviewed journals. Forty-three articles were selected from the search. The articles selected addressed the subjects of provider education, patient/provider discussions of ADs, EMR reminders and barriers to completion in primary care. Of the 43 articles selected; 20 were systematic reviews of the literature: five were randomized control trials; ten were surveys; five were semi-structured interactive interview processes; and three were cross-sectional descriptive studies (see Appendix C). The John Hopkins scale was used to evaluate the credibility of the articles and studies.

Brinkman-Stoppelenburg, Rietjens and Van der Heide (2014) and Frost, Cook, Heyland, and Fowler (2011) focused their analysis of systematic reviews on critically ill and nursing home patients and found a decrease in futile life-sustaining care when advanced care planning (ACP) was in place. Brinkman et al. (2014) discerned that ADs increased the use of hospice and palliative care and Frost et al. (2011) focused on how culture and ethnicity effected end-of-life decisions.

Hinderer and Lee (2013), Pollack et al. (2013) and Rao et al. (2014) committed to a community-based population with questionnaires and telephone follow up. The researchers concluded that only one third of the respondents had ADs completed and one quarter did not realize the importance but specified they would discuss with their provider. The studies utilized subjective measures to obtain results, the common thread is that most respondents were unaware of the importance of the documents.

**Patient Education**

There is evidence that prior education concerning ADs improves completion during a provider visit. Durbin, Fish, Bachman and Smith (2010), Rao et al. (2014) and Tung et al. (2011)
found combined written and verbal instructions increased AD completion. Durbin et al. (2010) did not take into consideration gender or diversity, Rao et al. (2014) implemented a survey which can be subjective and Tung et al. (2011) had a poor survey follow-up and did not allow for low literacy skills. Tung et al. (2011) was the only study that included a control group.

Provider Education

A planned educational program for providers increased their knowledge of providing information about ADs to their patients. Durbin et al. (2014) and Tung et al. (2014) identified lack of education concerning state policies and general information on ADs as a universal learning gap among providers. Both studies were at one institution and depended on subjective answers from providers who may respond in a way they felt was most appropriate to their superiors. In general, education for providers in the primary care setting was supported by the literature reviewed (Bergman-Evans et al., 2008; DeVieiminick et al., 2013; Fried et al., 2010; Spoelhof & Elliot, 2012; Sudore et al., 2008; Tamayo-Velazquez et al., 2010; and Westley & Briggs, 2004).

Summary of Literature

Provider Interaction

Satisfaction and trust is increased when the provider discusses ADs with their patients. Written materials before the visit strengthen the likelihood that ADs will be completed (Durbin et al., 2010; Keary & Moorman, 2015; Jezewski, Meeker, Sessanna & Finnell, 2007). AD information mailed prior to office visits prepared patients for a verbal exchange that conceivably could be shorter, but beneficial in increasing AD conversations with a trusted provider (Adler & Sered, 2001; Heiman et al., 2004; Tierney et al., 2001; Tung et al., 2014). Findings are
consistent that both written and verbal conversation is a positive factor in AD completion (Malcomson & Bisbee, 2009; O’Sullivan, Mailo, Angeles, & Agarwal, 2015). Older hallmark studies also concluded that ADs were more likely completed following conversations with trusted providers (Adler & Sered, 2001; Heiman, Bates, Fairchild, Shaykevich, & Lehmann, 2004; Tierney et al., 2001).

**Electronic Medical Records**

ADs in a conspicuous place in the EMR increases the likelihood that it will be discussed and documented by the provider (Hayek et al., 2014; Linder et al., 2007; Rogodki, 2014; Yung et al., 2010). Weekly reminders to providers on AD placement improved completion and documentation of ADs (Hayek et al., 2014). Linder and colleagues (2007) documented that a targeted position in the EMR increased ADs completion. Rogoski (2014) implemented an “advance directive navigator” to allow caregivers to quickly access the AD in the EMR. Yung et al. (2010) elaborated on issues concerning the inaccuracy of end-of-life information with review of medical records and structured interviews. Standardizing the information in a single place in the EMR improved the problem (Yung et al., 2010). The commonality was that the reminder had to be in a user-friendly place and not require multiple steps that decrease the motivation to discuss and document. Placing EMR AD reminders in an obvious, convenient location could have the potential to facilitate a discussion and documentation (Hayek et al., 2014; Tierney et al. 2001; Tung et al., 2011). However, no figures were given as to the success of this intervention.

**Provider Education**

Providers in primary care expressed increased confidence in discussing ADs after attending educational sessions (Detering, 2010; Tung et al., 2014). However, the precise
percentages of improvement were not determined. Data regarding continuation of the interventions were absent in each study.

**Community**

Brinkman et al. (2014) evaluated systematic reviews, but did not differentiate between gender, culture, or ethnicity. Frost and fellow researchers (2011) did consider culture and ethnicity, but both research groups did not include individuals from the community and focused on patients who were already ill and in hospitals or nursing homes. Hinderer and Lee (2014) did include community members, but most of the participants were female and the study lacked heterogeneity.

An attempt was made to create a diversity of literature to develop an overall projection of how best to achieve the goal of AD completion and to identify the gaps that hinder the development of solid evidence-based medicine (EBM). Each study recognizes the problems, but no answers were derived to initiate changes that would continue interventions for a complete resolution or provide a basis for EBM. This was evident even in the older studies that contained systematic reviews and random controlled trials and focused more on the patient/provider interaction in the primary care setting. Unfortunately, diversity of populations, types of faculties, and variance in practice styles does not create the continuity needed for the implementation of EBM development. ADs appear to still be an option, although it is becoming more evident that the benefit is humane and cost effective. Adding a conveniently located flag to the EMR to initiate AD discussion and documentation is a logical solution to the low rate of AD completion in primary care settings.
Theoretical Framework

Lewin’s change theory has three phases that clearly define the concepts appropriate to develop the changes necessary for AD discussions and documentation to take place in a primary care setting. Lewin (1951) viewed his theory as the equilibrium between driving and restraining impact within a discipline. The driving forces move towards change and the restraining suppresses the change. The restraining forces represent the barriers that are identified as preventing the changes taking place, and the driving forces are the project goal changes to balance the restraining forces. Lewin (1951) discovered that as individuals become involved in discussing the change and its value, they were more likely to accept the change. A diagram of this theory is noted at the end of this paper (see Appendix A).

The driving forces are increased during the initial unfreezing and the restraining forces are decreased. Potentially this represents the education of staff to envision the value of ACP to patients and their families. This involved moving from the status quo to a higher level of functioning. Driving forces must outweigh the restraining forces to create the desired change.

The change phase was implemented by working with IT to create a user-friendly reminder and documentation system. This represents a balancing of driving and restraining forces. Refreezing is the last phase that embodies the changes into the structure of the organization. Assessment is an ongoing process to keep individuals invested in the benefits of the changes. This should be seen in the acute and primary care areas of the facilities. Individuals with completed ADs will have their end-of-life decisions established, thus providing guidance for care should they become seriously ill or injured.

Moving forward this change will require continuous encouragement, and reinforcement by the DNP student who will be cognizant in identifying ambiguous staff. Tactful interaction
with the development of a team effort for change will be the goal of establishing a unified approach to change.

Refreezing to integrate a permanent change was the goal. It was measured by an increase of completed ADs in the EMR and providers understanding the advantages to having the documents in place. This was evident when decisions are needed regarding patient care at the end-of-life. Appreciating that their patient’s wishes have been fulfilled, and their families less stressed should be an encouragement toward adopting these changes in practice.

**Project Design and Methods**

The DNP project was conducted using a quality improvement design to enhance the rate of AD completion in outpatient primary care clinics. This was accomplished by having a reminder “flag” placed in a conspicuous location in the EMR to prompt the provider to discuss and document ADs.

The project design consisted of education with a pretest and posttest to determine improvement of the knowledge and comfort level in the discussion of ADs by the staff and providers. The site selected for the DNP project consisted of one main clinic and nine outlying rural clinics. All the clinics are under the same medical system. This made it impossible to have all 110 providers attend an educational session. Packets were prepared for all the providers that included concise information relating to addressing ADs with their patients. A pre-and post-test was included to determine if the information was helpful. A comment section was added for providers to share his or her thoughts on AD discussions (see Appendix F). The results were somewhat disappointing as only 15 providers filled out the forms. One provider even wrote “ADs were discussed if the patient brought it up”. A personal visit to each clinic by the DNP
student did not increase the interest in the project. The most common comment was “there was not enough time to discuss ADs”.

A community educational session, with a power point presentation, was held at a community center (see Appendix I). Posters were displayed at the center, the main clinic, and the library. Articles were placed in the local paper and senior citizen newsletter (see Appendix H). Booklets were prepared that briefly described ADs and its advantages. The booklets were also made available to the clinics and placed in the waiting area and clinic rooms (see Appendix G).

The long and short Vermont AD forms were discussed (see Appendix J). The New Hampshire forms were not discussed as there were no New Hampshire residents present. Five Wishes was also discussed as an alternative form. It is accepted in Vermont as well as 42 other states. It is available online and is written on a fifth-grade level: therefore, it is easier to understand and complete. Five Wishes includes a card that the patient can keep with their identification. This provides information on how to access the patient’s ADs if a tragic event occurs (see Appendix L).

Information was also provided on registration of the forms in a national database so it can be accessed from anywhere in the country. The process is free, and the form can be downloaded from the internet or requested by calling Vermont Ethics Network.

Questionnaires were distributed at the end of the session to ascertain if the information was helpful and would lead to completion of ADs. The offer was extended to return and assist anyone who would like help filling out the forms. Twenty people attended the session and there were many questions after the educational session was completed.

The nurses and medical assistants were invited to a lunch and educational session to discern their comfort level in approaching the subject of ADs when they roomed a patient.
Unfortunately, this was not well attended due to their schedules being busy. The staff that did attend was very open with their thoughts and filled out questionnaires asking if they found the information helpful. It was interesting that one nurse stated “she did not like to talk about anything to do with death”. The intent was to educate on the importance of ADs, and assess their comfort level with introducing the subject of ADs. If the staff approached the patient and provided written information, the patient might be open to a discussion with the provider.

At the start of the project 100 cards were prepared and left at two clinic patient check in reception areas for patients to fill out at their discretion. The cards asked if their provider discussed ADs during their visit. The cards stated no names were to be included, only a simple yes or no and their gender. All the cards (n=100) were filled out resulting in a 100% completion rate over a time period of three weeks, 15% indicated that their provider discussed ADs. The gender distribution was 55% female and 45% male.

Information Technology (IT) was the most difficult hurdle as they were understaffed and did not have commitment to the project. After much discussion and the assistance of my mentor, IT did include a flag to the EMR. It was placed at the top of the face sheet that appears when the patient’s chart is opened. They were unable to provide information regarding how many patients already had ADs on file. IT stated that the EMR was “hard wired” and could not retrieve this information. This information would have been helpful for determining the success of the project if it could be revisited in a year. Documentation currently being imprecise would make comparison difficult. However, an improvement in the documentation would have provided information on the validity of the intervention.

The Plan, Do, Study, Act [PDSA] was used for the project implementation (Plan-Do-Study-Act Worksheet, 2011). The plan portion was setting the objective for the project,
researching the AD forms and the collection of data to be able answer any questions on ADs. Preparing the educational sessions, booklets, posters and articles for the papers was an important part of the planning. Having faith in the prediction that a “flag” in the EMR would improve AD completion in the primary care setting was the incentive for the plan. The realistic goal was to increase the documentation of AD’s 25% for the three-month time period of the project.

The do portion was providing educational sessions to the community, providers, and staff. Articles were sent to the local paper and the newsletter at the community center. Booklets were placed in the waiting areas and clinic rooms. Posters announcing the educational session at the community center were placed in prominent places in the town and primary care clinics. The patient cards were distributed in the check in area. Extensive time was spent working with IT to have a “flag” placed in the EMR. This was intensive as they were resistant to making any changes in the EMR. The outlying clinics were visited in an attempt to gather more feedback when only a few of the questionnaires from the packets were returned.

The Study portion took place after the data was compared to predictions and what had been learned and summarized. An important part of what was learned was how difficult it is to make changes within the medical system. The providers are busy, time is limited, and ADs are not a priority.

Assessment was ongoing for anyone with questions or problems that may hinder the project so that a team effort could be established. Providers were assessed as to their input on the convenience of the AD reminder and ease of documentation. Staff discussions were initiated to eliminate discrepancies and identify barriers that would need to be addressed. A team effort was the goal to increase AD completion by 25% over the period of the project. This constituted the Act portion of PDSA to ensure the future of the implementation of the project and to determine if
changes can be sustained. Included in the final stage was the evaluation of what changes were needed to improve the project. This was based on feedback from the project educational sessions and questionnaire answers (see Appendix B).

**Goals, Objectives, and Data Analysis**

The overall goal of this quality improvement project was to increase the knowledge and comfort level of the providers and allied staff in discussing ADs with patients and develop a “flag” system in the EMR to remind providers to discuss and document ADs. The expected increase in knowledge and comfort level was 50%. Following the community forum the number of patients having the conversation or intending to have the conversation was expected to increase by 25%. The overall documentation of AD conversation and completion was projected to increase by 25%.

The actual data did not meet the intended goals of the project due to poor attendance at the nurses and allied staff educational meeting and the poor response from the 110 providers who received the packets. The 15 providers who completed the questionnaires regarding information on the AD conversation, knowledge of the AD forms, and comfort level in initiating the conversation were very similar in their responses. The responses to knowledge of ADs were 75% felt they had a good knowledge of the forms, 25% responded they did not. All the responses on the New Hampshire forms were 100% negative even though most of the clinics border New Hampshire and one clinic is in New Hampshire. Five Wishes was known by only 25% of providers even though it is an accepted alternative to the state form in Vermont.

The comfort level of initiating the conversation was 75% high and 25% medium. Only 25% found the information on starting the conversation to be helpful. Time was the most frequent comment on why the conversation was not happening. However, 100% felt that the
conversation was best addressed during a physical or wellness exam. Only one provider commented that an effort was made to ensure all patients had an AD documented in the EMR and it was reviewed yearly.

The allied staff members (nurses and medical assistants) educational session was not well attended even though it was advertised with posters in their break room, lunch room and flyers in their mailboxes. Ten licensed practice nurses (LPN), two certified medical assistants (CMA) and the clinic care coordinator attended. The attendees were open to suggestions on how to approach the subject with patients and the importance of the documents.

Time was a problem since each LPN or CMA worked with two providers and had very little time with each patient. Part of their job description was to open each patient’s chart the day before their visit and check to see if they needed labs, or follow ups of any kind. They unanimously agreed that if a flag for ADs was on the demographic page, it would prompt them to list it as needing to be addressed.

The care coordinator also added that she asks the patient if they have ADs, but does not have a supply to give to patients who do not. After the session she felt she needed to request the forms so she could distribute to those who did not have them completed.

Everyone filled out a questionnaire at the end of the session and 100% felt the information was helpful and enlightening to the importance of all patients having ADs. The comfort level of approaching the subject with patients was also 100% even though one nurse, on a personal level, had a hard time thinking about death in general.

The following table is a summary of the goals and objectives of this DNP project. It explains the expectation of what the project intends to accomplish as a quality improvement measure.
Table 1

*Goals and Objectives for DNP Project*

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine the comfort level of allied staff and providers before and after the education sessions by administering pre and post questionnaires</td>
<td>The stakeholders will be more comfortable with the patient conversation regarding ADs</td>
</tr>
<tr>
<td>Work with IT to have the information concerning ADs in the template that opens when the patient’s chart is entered</td>
<td>This will remind the provider to ask about ADs and document the results of the discussion. Anyone who cares for the patient will have the information regarding what the patient wishes for care should illness or an accident occur</td>
</tr>
<tr>
<td>Educate the public on ADs and their importance to their overall healthcare by conducting a community forum</td>
<td>To enable individuals to appreciate the and understand the necessity of documents that will enable their wishes for care to be followed and ease the burden for their families and loved ones</td>
</tr>
<tr>
<td>Patients 18 and older will be the target population to accomplish the goal of AD completion.</td>
<td>No one will be subjected to treatment that may only prolong suffering in a situation where recovery is futile.</td>
</tr>
</tbody>
</table>

**Setting and Resources**

The primary care health clinics in central, rural Vermont was an appropriate setting for the quality improvement project. The ADs that are completed are scanned into the system in an inconsistent manner and it can take a considerable amount of time to locate the documents. This can create difficulties if the documents are needed urgently.

The clinics are part of a medical system under the umbrella of Federally Qualified Health Centers (FQHC) and practices the Medical Home system of care. The vision is to provide high quality, comprehensive primary care and preventative services regardless of the ability to pay. This care system includes ten community primary care sites, a rural hospital with 25 acute beds,
an oncology department, a rehabilitation unit, a pediatric clinic, a radiology department, general surgery, obstetrics, orthopedics and palliative care. Specialist in neurology, plastic surgery, and cardiology are available from other practices on certain days. It also has an emergency room and is a critical-assess hospital with a helipad for transport to Dartmouth Medical Center or Boston depending on the patient’s needs. Behavioral health is available through affiliation with a mental health facility in Bellow Falls, Vermont. Three separate walk in acute care centers are a recent addition.

**Description of the group, population or community.** The main clinic site has five full-time physicians, five physician assistants, and three nurse practitioners. Two pediatric physicians are available for patients younger than 18 years of age. There are two diabetes educators and three nutritionist available for referrals. A rehabilitation center and lab is available at the main clinic. The patients in the clinic are diverse with elderly housing and subsidized housing in the town. The outlying clinics, in the more rural areas, have a varied provider population depending on the community needs.

The main clinic is in the largest town of 9,232 residents, most of whom are Caucasian, with 3% non-Caucasian. It is a working-class community with a mean yearly income of $34,169. Since it is within 50 minutes of Lebanon, New Hampshire, Dartmouth Medical Center and adjacent to interstate 91, most of the residents work outside the town. There are two elderly housing facilities and a nursing home located in town. Since the clinic is a border town to New Hampshire it will be important to provide information on New Hampshire AD forms.

**Ethics and Human Subjects Protection**

Human subjects were safeguarded by password protected information in the EMR. Each password was automatically recorded when a patient’s chart was entered to prevent unauthorized
entry. The Health Insurance Portability and Accountability Act 1996 (Public law 104-191 (HIPPA)) violations were avoided as no data collection of personal information occurred outside of the EMR. The information collected from patients was a simple yes or no regarding if the patient’s provider discussed ADs during their visit. Names were not connected to any responses. The only information needed was the percentage of patient/provider AD conversations and percentages of responses to the education provided. IRB approval was not needed since this was a quality improvement project to evaluate an intervention at a specific location. The project did not require any identifiable, individual protected health patient information.

**Results**

**Outcomes**

The outcome of the project cannot be fully realized due to the short time frame of the project. The community forum did initiate many questions regarding ADs. The type of questions determined that 75% of the 20 participants found the state forms intimidating and hard to understand. This prompted the opportunity to explain components of the forms and suggest the new short form which only requires an authorized health agent. None of the participants were aware of Five Wishes as an alternative to the state forms.

The booklets were well received and extras were taken to give to friends. All participants filled out the questionnaires and universally indicated the forum was helpful, but only 13 of the 20 indicated they would discuss completing ADs with their provider. No one made an appointment for help filling out the forms.

The return rate on the physician questionnaires was unsatisfactory. This was a disappointment, but coincided with the literature on the topic of ADs that time was a major factor. Providers did not feel that ADs were as important as more pressing medical problems. A
more robust response may have indicated that ADs were an important component of their patient care.

The nurse and allied staff education session was not well attended. However, a lively exchange and discussion took place that had a positive result with the participants responding that the session was helpful and they could see themselves as having a positive role in improving AD completion.

**Facilitators and barriers.** Management of the medical system was concerned that Meaningful Use requirements are not being met in regards to ADs. There are also concerns that end-of-life planning is an important part of quality patient care. Medicare now provides reimbursement for two conversations for end-of-life planning. Financially this is an important motivator. Providers having the time and comfort level to initiate the conversation was a barrier. Educating providers that this is an important part of ongoing patient care was an essential goal to overcome this barrier.

Placing an AD flag in a conspicuous location in the EMR to remind providers to have this conversation and conveniently document the results should ease concerns about adding work to their day. Educating staff and providers that they are fulfilling a patient’s wishes if an illness or tragedy takes place, should elucidate the need for this quality improvement project.

The exact same barriers were found in implementing this project that were identified in the research of the literature on ADs. Providers do not feel they have the time to initiate a conversation when appointment time is short and the medical problem that brought the patient to the clinic must be addressed. Discussion of ADs is not the immediate problem when time is of the essence.
The mentor for the project was the Professional Development Director for the entire medical system. Her support was ongoing and encouraging. It was through her suggestion that the packets were made and distributed to the providers. The clinics extend over a 30-mile radius therefore it was unrealistic to get everyone together for an educational session. The Professional Development Director felt that a better than 10% return was acceptable because when she sends out a survey, she feels fortunate if she receives a 10% response rate.

Unfortunately, the individual managers in the outlying clinics were too busy to consider involvement in the project. While this is understandable, it was disappointing not to have their input when the effort was made to visit each clinic individually.

Cost-Benefit Analysis/Budget

The DNP student was responsible for the full cost of the project. The pamphlets, posters and questionnaires were provided by the student. The hospital expressed they would undertake the cost of the changes to the EMR. The clinic stakeholders felt this was an important and sustainable improvement that would benefit patients and providers. It has the potential to decrease the overall cost of medical care and provide quality care to the patient.

Table 2

Cost Itemization For DNP Project

<table>
<thead>
<tr>
<th>Cost</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 packages of colored printer paper</td>
<td>$17.00</td>
</tr>
<tr>
<td>1 toner cartridge</td>
<td>$30.00</td>
</tr>
<tr>
<td>12 36x12 poster sheets</td>
<td>$36.00</td>
</tr>
<tr>
<td>Laptop computer and printer</td>
<td>$600.00 for computer and $200.00 for printer Not part of cost owned by DNP student</td>
</tr>
</tbody>
</table>
Lunch for nurse’s educational session | $79.00
---|---
Transportation to project settings | $60.00 for gasoline, parking free
Personnel for project | DNP student project manager (3 credits for course at $700.00 credit = $2100.00)
Total actual cost of QI project | $222.00

**Timeline.** The DNP project extended from mid-September to mid-December. The initial objective was working with IT. The educational sessions were scheduled to avoid the holiday.

The provider packets were distributed early in the project to allow time for completion. A return date was indicated.

Table 3

*Timeline For DNP Project*

<table>
<thead>
<tr>
<th>Task</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>work with IT to create flag for AD reminder, provide cards for patients to document if providers discussed ADs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education of allied staff and providers, community forum to educate public on ADs</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect questionnaires from providers</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Analyze data</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Discussion/Interpretations

It was anticipated that increasing the completion of ADs in the primary care setting would be difficult. The barriers that were identified in the literature review were validated as the same barriers found during the project. The main objective was to find a solution to overcome the barriers. It was anticipated that the stakeholders would envision the project as helping to meet the new requirements by Medicare and Meaningful Use in a way that would be simple and straightforward.

When providers go down the list of what they ask at each visit the “flag” would be there as part of the routine information. This would ease the way to asking about ADs and answering questions. The opportunity would be presented to identify reluctance, cultural differences and to encourage patients to talk with their loved ones regarding their wishes should they suffer an accident or serious illness. Importantly, it would start the thinking process of who the patient would consider appropriate for a health care agent.

The general lack of interest in the subject of ADs throughout the duration of this project provides an understanding of why the extensive literature on the subject does not come to any resolution. This is most likely why Medicare has decided to pay for two conversations regarding ADs and Meaningful Use is requiring documentation of the conversation. Fifteen years has transpired since the intentions of the PSDA and the problem has not been solved. This leads to the realization that the completion of ADs must be mandated and reimbursed.

The motivation is not entirely to benefit the patient and families. Part of the issue is the enormous health care cost of terminally ill patients entering the intensive care unit or being subjected to futile care because nothing is written concerning what the patient wants for care when they have little chance of getting better. How a person ends their life is as important as
how they start their life. The primary care provider must realize that educating about ADs is as
important as educating about high blood pressure.

It is the opinion of the DNP student that inclusion of ADs as part of a patient’s care will
not be routine until private insurance pays for the conversation to take place. It needs to take
place before a patient qualifies for Medicare. State regulatory statutes also need to require all
facilities that provide medical care to mandate ADs are addressed and documented. A patient has
the right to refuse, but that must be documented as well.

Conclusion

The primary care clinic has a very poor rate of ADs recorded. This is compounded by the
AD information being “buried” within the computer. It also is not scanned in a universal
location. Working with IT to correct this problem was accomplished by creating a flag that is
displayed when the patient’s chart is opened. A place for documentation will be within the
template for that visit. This intervention has the potential to be sustainable because of its ease of
availability. It can be extended for use throughout the other areas within the hospital
organization. Hopefully this QI initiative can make a contribution by increasing awareness of the
importance of ADs being a part of the patient’s record and potentially be replicated in similar
healthcare facilities.

This project would have more credibility if it could be revisited in a year to determine if
there is an increase in AD completions. Patients do not visit their provider enough in three
months to be able to conclude if placing a reminder flag, in a conspicuous place, within the EMR
improved AD completion rates. In reality, it will take more than one visit to have the
conversation with the patient. Patients will need to decide on an appropriate healthcare agent and
consider all the options for care they do or do not want. If this project could be revisited in a year, the benefit of the intervention would have a better resolution.

In retrospect, it would have been better to confine the project to the one main clinic. The mentor, however, wanted information from all the clinics. The reason being the new Medicare and Meaningful Use requirements.

It will be important to work with the state on forms that are written in layman’s terms and a fifth-grade reading level. Currently the forms are difficult to understand and potentially would be discouraging for someone who did not have the knowledge to understand how to answer the questions regarding the types of medical procedures they may or may not want.

Continuing to provide information within communities and offering assistance with filling out forms, is part of a plan to continue the project to another level. The questions asked at the community forum made it very evident that education is needed for the general public.

This DNP student has already offered to talk to nursing programs to empower nurses with the knowledge of the importance of ADs. Some states have required end-of-life planning to be part of nursing education and since Vermont does not have this requirement, a letter has already been written to the governor suggesting its inclusion.

A sequence of articles explaining the importance of ADs, clinician orders for life saving treatment (COLST) and explanation of what different types of treatment involve will be offered for publication to the local paper. An ongoing offer will be extended at the community center to provide assistance with filling out AD forms.

It is felt this project would have been more successful if it could have been implemented at the original site where the DNP student had an excellent relationship with the staff and providers. This would have increased participation and willingness to provide information that would have
improved results. It was a challenge to work with individuals that consider your project just one more thing to do in a busy day. However, overcoming challenges is how we develop the courage to persist in our goals for improving the quality of patients.
References


Appendix A

Kurt Lewin Theory
Appendix B

Plan-Do-Study-Act Worksheet

What changes are we going to make based on our findings?

What exactly are we going to do?

What were the results?

When and how did we do it?
Appendix C

Criteria for Literature Review

PubMed accessed studies from electronic database inquiry (n = 97)

CINAHL accessed studies from electronic database inquiry (n = 63)

Criteria for inclusion: English speaking human subjects, studies from last five years in peer reviewed journals, full text only

Criteria for exclusion: inadequate methodology, small numbers of participants, studies not in English, studies older than 5 years unless hallmark studies

Studies in final literature review (n=43)
Appendix D

Community Education

What is an advance directive?
A Lifeline for life on your terms.

When you do not write down your wishes for the medical care that you would want should you have an accident or a serious illness, these decisions would be left up to family or loved ones, your doctor or even a judge. They may not know your wishes if you were unable to speak for yourself. Completing an advance directive continues your values and goals for life on your terms even when you are unable to speak for yourself. It is only used if you cannot speak for yourself.

Who should have one? In a word everyone.
A person who is young and healthy because they may have an accident
Someone with some health issues, but has a good prognosis because they too may have an accident or an illness develop that is life threatening
Someone who is sick enough to be facing end of life decisions

There are two basic types of health care documents that everyone should have. One is naming a trusted person to direct your health care if you cannot do this yourself. This is called a durable power of attorney for health care. The person is called your agent and you want to be sure that this person can assert your health care wishes and be able to act in an emotional situation and follow your wishes even if they differ with your decisions. They also should be reasonably available. This can be a loved one, family member or trusted friend.

The second document states the type of medical care you would want or not want in certain situations. You do not need an attorney to prepare these forms. You can do it yourself by filling in the blanks. Some of the questions on these forms concern the following:
Would you want a trial of life-sustaining treatments if it might help to restore normal functioning and discontinue if it does not.

If faced with a life-limiting condition you may not want to prolong life with life-sustaining treatment.

All this can be stated in your advance directive along with anything else that expresses your values and beliefs. You can even include what you want for services, organ donation and anything else that is important to you. It is your document.

Vermont combines these two documents in what is called an advance directive. There is a long and short state form. The long form consists of questions you personally answer and can make comments. The short form requires that you appoint just an agent who knows and will follow your wishes. It does provide a short description of basic treatment choices and a place to add anything not listed.

These forms are available online or from your provider for health care.

There is another form available online called “Five Wishes” it is legal in Vermont with two witnesses. It is easier to understand and you can also make comments or cross anything out that you do not want to answer. This form is accepted in 42 states as a legal document.

All forms have to be witnessed. In Vermont you need two adult witnesses. The witnesses cannot be your spouse or any other family member or beneficiary.

There is another form available that your health care provider would have to make out and sign. It is called a COLST form (clinician orders for life-sustaining treatment). It directs if you want a DNR order. It also includes if you do or do not want intubation, antibiotics or feeding tubes prolong your life.
If you spend time in another state you will need to find out if they will respect your advance directives or if you will need one for that state.

You will want to make sure your provider, agent, hospital has a copy of your advance directive. A good way to make sure it is available for any agency to view is to register it with the Vermont Advance Directive Registry. You can mail or fax it to them. Your bank may fax it for you free. You also can call them and ask them to mail you the form. You will have to sign a form giving permission for a medical facility or physician to have a copy. You will receive a wallet card directing that you have an advance directive on file and a number where it can be assessed quickly.

Vermont Advance Directive Registry
PO Box 2789
Westfield, N.J. 07091-2789
Fax: 1-908-654-1919
1-888-548-9455

Registration is free but you must send a registration agreement to give permission for a hospital etc to access your Advance Directives you can also call 1-802-828-2909 (Vermont Ethics Network) and ask for this form, you also can get answers to questions regarding Advance Directives at this number.

Remember you can change your advance directive or COLST form at any time. It should be reviewed periodically to make sure it remains what you want for care.

You should do these forms while you are well and able to make decisions. It is recommended everyone 18 and older have these forms completed. Advance
directives are a process, they can be changed as situations change, but should be done while you are healthy enough to make your decisions known.

It is important to everyone that their wishes and values be honored. You should discuss these wishes to those close to you so they understand how you feel. This will give them great peace to know that what you want will happen if you are not able to speak for yourself. Advance directives ideally are a family affair and planning ahead is a loving gesture to those who will want to feel that they fulfilled your wishes. ADs reflect your values and beliefs and your right to participate in health care decisions. It is especially important since modern medicine can sustain life in a state from which a person will never recover.

Our medical system has advanced so that life can be prolonged even when a person is terminally ill, sometimes this care only provides increased suffering. It is your right to decide if you want this care if you are seriously ill or if you prefer to have a more peaceful end of life outside of the hospital setting. Your values should guide all clinical decisions. An Advance Directive keeps you in control of your life no matter what the circumstances.

Things to think about:

- Discussing with loved ones so they understand how you feel and can be at peace with your decisions

- Do you want to be in a position where you are totally dependent on others?

Family Finances

- Conditions that would make life intolerable to you
Would you want artificial life-support?

What brings quality to your life and what would take it away?

How would you want your last week of life to be, where would you want to be and who would you want to be with

Advance directives can provide what you want to happen and respect your autonomy, it is life on your terms

1. Do you have a completed Advance Directive?

2. If you have not completed the forms, do you intend to discuss completing them with your provider

3. If you are a Vermont resident are you aware of the “Five Wishes” form that is legal in Vermont
Appendix E

To the providers and staff at Springfield Health Systems:

My name is Linda Wilson and I am a nurse practitioner with 26 years’ experience in treating patients with chronic illness. Currently I am finishing a doctorate of nursing practice degree at the University of Massachusetts. The quality improvement project I have chosen is increasing the conversation regarding advance directives in primary care. The targeted age group is eighteen and older. The intention is to start the conversation before illness or an accident renders an individual unable to verbalize how they want the end of their life to take place. This is not an easy conversation. According to research on the subject, patients prefer to have the discussion with a trusted provider.

Your current comfort level may be excellent regarding this important conversation. However, I have a few suggestions that I would like to share and would appreciate your filling out the short questionnaire on rather or not you found them helpful. My goal is to present this project as a proposal for developing an evidence based protocol on this important topic. I fully realize that every patient is different. Culture and religious beliefs are an important consideration. That is one of the most difficult stumbling blocks to having patients actually make decisions that lead to filling out an advance directive. Especially having the discussion with their loved ones who may or may not be in agreement. Your participation is greatly appreciated; no names need to be included. Only your kind input is needed.

The following are just suggestions gleaned from extensive research. Each conversation will be different as every individual is different. The conversation will probably take place over several visits, but the important part is getting the patient to think about something that is difficult, but important. I am certainly not suggesting something that is not already known. Federal and state regulations are encouraging the completion of advance directives and the nationwide figures are sadly quite low. As you well know it can be very hard on patients and families if documentation of what a person wants for care is not available when needed.

1. Do you have any thoughts about completing an advance directive should an illness or accident occur that would make it difficult for you to express what you would want for care? This question is asked of all my patients and has nothing to do with your present health, it is part of your routine care.

2. Are there any questions about what this involves and the options for care that I can answer? If not today, then please bring questions on your next visit so we can discuss them together.

3. Is there a friend or loved one that you would want to share your wishes with so they could understand what is important to you and follow your wishes if you were unable to express them yourself? This person would be called your agent and their selection is very important.

4. What fears do you have about getting sick or needing medical care? What would make life intolerable to you?
Appendix F

Provider Questionnaire

Do you think that you have a good understanding of the Vermont AD and COLST forms? Yes  No

Do you think that you have a good understanding of the New Hampshire AD and POLST Forms? Yes  No

Are you aware of the availability of the Five Wishes form as an alternative to the Vermont AD? Yes  No

Is there any information that you think would be helpful to discuss completing ADs with your patients?

How would you rate your understanding of ADs? Low  Medium  High

How comfortable do you feel having a conversation regarding ADs and end-of-life planning with your patients on a scale of 1-10?

If the conversation would be difficult what do you believe would be helpful to improve your comfort level?

When do you think is the best time to have this conversation?

Do you routinely review ADs with your patients? Yes  No

Has your knowledge increased after the suggestions about the conversation? Yes  No

Has your comfort level increased after the suggestions? Yes  No

ADs (Advance Directives)

Thank you so much for taking the time to answer these questions, the answers will be very helpful in the
process of developing evidence based medicine concerning ADs. Please give the form to the receptionist in your office when completed.
Appendix G

Advance directive booklet

Advance Directives:
Life On Your Terms
Advance Directives are a legal document that asks questions about your wishes for care if you have an accident or an illness that makes you unable to speak for yourself. Every state has a different form. Vermont has two forms, a long form that allows you to write exactly what you want for care and a short form that allows you to appoint an agent who knows and agrees with your wishes. Vermont accepts another form called “Five Wishes”. Five Wishes is easier to understand than the state form. They can all be accessed online. Your healthcare provider can provide you with the state forms. The long form also requires a health care agent, but asks individual questions on what you do and do not want.
You do not need an attorney to help with the forms, but you will need two witnesses to verify your signature. The witnesses cannot be a spouse, relative, a healthcare provider or someone who works for a provider. It also cannot be a beneficiary of your estate.
The advantages of completing an advance directive are as follows:

- Your wishes for care will be honored
- Your family will be spared the heartache of trying to decide what you would want for care
- Family strife will be avoided when individuals may disagree about your care
- You will be providing your loved ones with a sense of peace because they will know they are following your wishes
- If you have an illness that cannot be cured or a tragic debilitating accident you will not be subjected to aggressive care that is not helpful and may prolong suffering
- Peace of mind that you are where you want to be, and who you want to be with should your condition become serious
Appendix H
Advance Directives 101
What You Need To Know

Advance Directives: Purpose
- Enable an individual to make decisions concerning care before a serious illness or accident occur
- Opportunity to prepare for the future while mentally and physically able
- Time to discuss with family members and loved ones so they can process and understand how the person feels about end of life care

Advance Directives: Purpose
- Ensures autonomy and relieves loved ones stress
- Comfort in knowing that their loved ones wishes were honored
- Health care dollars saved when futile treatment is avoided

Advance Directives: Essentials
- Care providers should be sensitive to culture and religious views on end of life care
- Legal documents can be beyond literacy level offer assistance or Five Wishes
- “Five Wishes” is an alternative, available online, fifth grade reading level and easier to understand

Advance Directives: Basics
- Majority of patients prefer trusted provider to initiate conversation
- Most comfortable in outpatient setting while still healthy
- May take several visits, preferably with health care agent present
- when individual ready to complete documents they need to know

Advance Directive: Essentials
- New Hampshire requires government document and written personal wishes in addition to “Five Wishes”
- All forms can be downloaded on the internet
- Vermont and New Hampshire have a video explaining advance directives on their website
Advance Directive: Barriers

- Difficulty bringing topic to discussion
- Time restraints

Solutions to Barriers

- Comfort with starting conversation
- Provide written information that is culturally sensitive and easy to understand
- State forms available and information regarding “Five Wishes”

Advance Directives: Advantages

- Compliance with JACHO, Meaningful Use requirements
- Most importantly patient’s autonomy preserved
- Family members and loved ones spared decision making at emotional time, an enduring “gift”

Advance Directive: Advantages

- Avoidance of unwanted and futile care at the end of life
- Saving of unnecessary health care expenditures
- Suffering avoided when additional treatment will not be curative
VERMONT ADVANCE DIRECTIVE FOR HEALTH CARE

YOUR NAME ___________________________ DATE OF BIRTH ___________________________ DATE ___________________________

ADDRESS ___________________________

CITY ______________________ STATE _________ ZIP ______________

PART ONE: YOUR HEALTH CARE AGENT

Your health care agent can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and agrees to act as your agent.

I appoint this person to be my health care AGENT:

NAME __________________________________________

ADDRESS _______________________________________

HOME PHONE __________________ WORK PHONE __________

CELL PHONE __________________ EMAIL _______________

(If you appoint co-agents, list them above or on a separate sheet of paper)

If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my alternate agent:

NAME __________________________________________

ADDRESS _______________________________________

HOME PHONE __________________ WORK PHONE __________

CELL PHONE __________________ EMAIL _______________

Others who can be consulted about medical decisions on my behalf include:

_____________________________________________________________________

Primary care provider(s):

NAME __________________________ PHONE __________

ADDRESS _______________________________________

NAME __________________________ PHONE __________

ADDRESS _______________________________________

PART ONE CONTINUED NEXT PAGE
Those who should NOT be consulted include:


I want my Advance Directive to start:
- [ ] When I cannot make my own decisions
- [ ] Now
- [ ] When this happens:

### PART TWO: HEALTH CARE GOALS AND SPIRITUAL WISHES

**My overall health care goals include:**
- [ ] I want to have my life sustained as long as possible by any medical means.
- [ ] I want treatment to sustain my life only if I will:
  - [ ] be able to communicate with friends and family.
  - [ ] be able to care for myself.
  - [ ] live without incapacitating pain.
  - [ ] be conscious and aware of my surroundings.
- [ ] I only want treatment directed toward my comfort.

Additional Goals, Wishes, or Beliefs I wish to express include:


**People to notify if I have a life-threatening illness:**


If I am dying it is important for me to be (check choice):
- [ ] At home
- [ ] In the hospital
- [ ] Other:
- [ ] No preference

### My Spiritual Care Wishes include:

**My Religion/Faith:**


**PLACE OF WORSHIP**


**ADDRESS**


The following items or music or readings would be a comfort to me:
PART THREE: LIMITATIONS OF TREATMENT

You can decide what kind of treatment you want or do not want at the end of your life. These wishes can apply to all situations or to situations that you specify. Regardless of the treatment limitations stated you have the right to adequate management for pain and other symptoms (nausea, fatigue, shortness of breath) related to your illness. Unless treatment limitations are stated, the medical teams are required and expected to do everything possible to save your life.

1. If my heart stops: (choose one)
   - ○ I DO want CPR done to try to restart my heart.
   - ○ I DON’T want CPR done to try to restart my heart.

   *CPR means cardio (heart)-pulmonary (lung) resuscitation, including vigorous compressions of the chest, use of electrical stimulation, medications to support or restore heart function, and rescue breaths (forcing air into your lungs).*

2. If I am unable to breathe on my own: (choose one)
   - ○ I DO want a breathing machine without any time limit.
   - ○ I want to have a breathing machine for a short time to see if I will survive or get better.
   - ○ I DO NOT want a breathing machine for ANY length of time.

   *“Breathing machine” refers to a device that mechanically moves air into and out of your lungs such as a ventilator.*

3. If I am unable to swallow enough food or water to stay alive: (choose one)
   - ○ I DO want a feeding tube without any time limits
   - ○ I want to have a feeding tube for a short time to see if I will survive or get better.
   - ○ I DO NOT want a feeding tube for any length of time.

   NOTE: If you are being treated in another state your agent may not automatically have the authority to withhold or withdraw a feeding tube. If you wish to have your agent decide about feeding tubes please check the box below.

   - □ I authorize my agent to make decisions about feeding tubes.

4. If I am terminally ill or so ill that I am unlikely to get better: (choose one)
   - ○ I DO want antibiotics or other medication to fight infection.
   - ○ I DON’T want antibiotics or other medication to fight infection.

If you have stated you DO NOT want CPR, a breathing machine, a feeding tube, or antibiotics under any circumstances, please discuss this with your doctor who can complete a DNR/COLST form to ensure you don’t receive treatments you don’t want, particularly in an emergency situation. A DNR/COLST order will be honored outside of the hospital setting.
Additional Limitations of Treatment I wish to include:


PART FOUR: ORGAN/TISSUE DONATION & BURIAL/DISPOSITION OF REMAINS

My wishes for organ & tissue donation (check your choice(s)):
- I consent to donate the following organs & tissues:
  - Any needed organs
  - Any needed tissue (skin, bone, cornea)
  - I do not wish to donate the following organs and tissues: ____________________________
  - I do not want to donate any organs or tissues
  - I want my health care agent to decide
- I wish to donate my body to research or educational program(s). (Note: you will have to make your own arrangements with a medical school or other program in advance.)

My Directions for Burial/Disposition of My Remains after I Die (please check & complete):
- I have a Pre-Need Contract for Funeral Arrangements:
  NAME ______________________________________ PHONE ____________________________
  ADDRESS ______________________________________
  I want the following individuals to decide about my burial or disposition of my remains (check choices):
  - Agent
  - Alternate Agent
  - Family:
    NAME ______________________________ PHONE ______________________________
    ADDRESS ______________________________________
  - Other:
    NAME ______________________________ PHONE ______________________________
    ADDRESS ______________________________________

Specific Wishes: Check your choice(s).
- I want a Wake/Viewing
- I prefer a Burial — If possible at the following location: (cemetery, address, phone number)
- I prefer Cremation — With my ashes kept or scattered as follows:

(PART FOUR CONTINUED NEXT PAGE)
ADVANCE DIRECTIVES

ADVANCE DIRECTIVE, PAGE 5

NAME ___________________________ DOB ___________________________ DATE ________________

☐ I want a Funeral Ceremony with a burial or cremation to follow
☐ I prefer only a Graveside Ceremony
☐ I prefer only a Memorial Ceremony with burial or cremation preceding
☐ Other Details: (such as music, readings, Officiant)


PART FIVE: SIGNED DECLARATION OF WISHES

You must sign this before TWO adult witnesses. The following people may not sign as witnesses:
your agent(s), spouse, reciprocal beneficiary, parents, siblings, children or grandchildren.

I declare that this document reflects my health care wishes and that I am signing this Advance
Directive of my own free will.

SIGNED ___________________________ DATE ________________

I affirm that the signer appeared to understand the nature of this advance directive and to be free from
duress or undue influence at the time this was signed. (Please sign and print)

FIRST WITNESS (PRINT NAME) ___________________________
SIGNATURE ___________________________ DATE ________________
ADDRESS ___________________________

SECOND WITNESS (PRINT NAME) ___________________________
SIGNATURE ___________________________ DATE ________________
ADDRESS ___________________________

If the person signing this document is a current patient or resident in a hospital, nursing home or
residential care home, an additional person (designated hospital explainer, long-term care ombudsman,
member of the clergy, Vermont attorney, or person designated by the probate court) needs to confirm
below that he or she has explained the nature and effect of the Advance Directive and that the patient or
resident appears to understand this.

NAME ___________________________ DATE ________________
TITLE / POSITION ___________________________ PHONE ___________________________
ADDRESS ___________________________
The following have a copy of my Advance Directive (please check):

- Vermont Advance Directive Registry: Date registered: ____________________________
- Health care agent
- Alternate health care agent
- Doctor/Provider(s): ____________________________
- Hospital(s): ____________________________
- Family Member(s): Please list:
  - Name: ____________________________
    Address: ____________________________
  - Name: ____________________________
    Address: ____________________________
  - Name: ____________________________
    Address: ____________________________
  - Name: ____________________________
    Address: ____________________________
  - Name: ____________________________
    Address: ____________________________

- Other:
  - Name: ____________________________
    Address: ____________________________
  - Name: ____________________________
    Address: ____________________________
  - Name: ____________________________
    Address: ____________________________
Appendix K

Advance Directive Screen Flag
Appendix L

Web Sites for the Vermont long form and Five Wishes

Vermont long form: http://www.vtethicsnetwork.org

Five Wishes: www.agingwithdignity.org
Appendix M

Table 4

Comfort level of Providers with AD Discussion

N=15

<table>
<thead>
<tr>
<th>Not comfortable before education</th>
<th>Comfortable before education</th>
<th>Comfortable after education</th>
<th>Change in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>75%</td>
<td>80%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Provider Pre-Questionnaire Results on Comfort Level of Discussing ADs:

- 25% were not comfortable with conversation about ADs
- 75% were comfortable with conversation about ADs