Improving Advance Directive Completion Rates in the Primary Care Setting

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By

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Background and Significance

Patients often do not discuss their wishes regarding end-of-life care with their family members prior to the time of a critical illness or traumatic event. This time is difficult for all involved in the care of the patient. The healthcare providers want to honor the wishes of the patient; the family members want their loved one to live on; none involved want to cause pain and/or harm to the patient. Patients may receive expensive life saving measures that they never wanted; their quality of life may be sacrificed (Salmond & David, 2005).

As technology has improved and the ability to artificially prolong life has increased dramatically, so has the need to draw attention to end-of-life care issues (Duke, Thompson, & Hastie, 2007). The Federal Patient Self-Determination Act (PSDA) of 1991 first brought attention to the importance of advance directives (ADs), (Government, 1995). Since that time, little has been done to educate, encourage and enforce this initiative highlighting the need for directed efforts focused on improving techniques and interventions to increase AD completion rates (Duke, Thompson, & Hastie, 2007). Regulatory agencies, such as the Joint Commission (JC) and Centers for Medicare and Medicaid Services (CMS), have begun to require that some organizations educate staff and inform patients about ADs, but these requirements do not require an increase in completion rates. Increasing the focus on advance directives for adult patients in the primary care setting could assist in increasing completion rates, prior to hospitalization.

An appropriate setting to complete advance directives is in the primary care setting due to the importance of having ADs prior to hospitalization. Many studies have been done regarding completion of ADs, reiterating the importance of completing ADs in the primary care setting.
(Dexter, et al., 1998; Heiman, Bates, Fairchild, Shaykevich & Lehmann, 2004; Ramsaroop & Adelman, 2007). There are multiple reasons to support this setting for a focus on advance directives completion. These include the ability to develop a strong patient-provider rapport, the length of professional relationship and the ability to have multiple patient-provider interactions over time to discuss patient wishes and to potentially complete the AD during the interaction. Completing ADs in the primary care setting can assist in communicating the patient’s wishes prior to a critical incident or traumatic event. This should allow the patient to receive the type of care they would want at end-of-life; no more, no less.

Providing patient and family centered care is important for patient’s wellbeing and healing, but it is also very important in instances of end-of-life care. Six key components of patient and family centered care, as described by Halm, Sabo & Rudiger, 2006, are:

1. Recognizing that patients’ families are the constant in the patients’ lives, whereas the service systems and personnel within those systems fluctuate;

2. Being aware of the strengths and individuality of patients’ families and having respect for different methods of coping;

3. Encouraging and facilitating family-to-family support and networking;

4. Sharing complete and unbiased information about a patient’s care with the patient’s family members on a continuing basis and in a supportive manner;

5. Incorporating the developmental needs of children and adolescents into healthcare systems;
Designing accessible healthcare delivery systems that are flexible, culturally competent, and responsive to the needs of patients’ families.

These elements can be as applicable to the primary care setting as they are to the acute care, hospital setting. Developing more of a patient and family centered care delivery system will allow for a more fluid exchange of information and decision making process (Halm, Sabo, & Rudiger, 2006).

In this country, it is the patient who is responsible to make the decisions regarding what they would want for their end-of-life care. Do not resuscitate (DNR) orders were initially created to allow competent patients to have a say in the treatment they want to receive, or not, in their final days. The discussions regarding end-of-life care often comes too late and the patient is not able to make their own decisions (Lachman, 2010). Increasing completion rates of ADs prior to the hospital setting may assist in alleviating some of these dilemmas by having written documentation of the patient’s wishes.

**Problem Statement**

The purpose of this project was to test a model to increase AD completion rates, to provide more complete patient centered care. Many programs and interventions have been implemented since the PSDA was enacted in 1992, some have been able to increase rates; other interventions have had little impact. It has been estimated that only 5%-15% of all patients have completed ADs (Ramsaroop & Adelman, 2007). This indicates a need for programs to educate and empower patients and providers to ensure ADs are completed.
Review of Literature

Relevant literature was reviewed to evaluate the interventions that have been used in the past and what can be done to move the completion rates higher. History of the PSDA was highlighted to show the need for focused improvements in the area of ADs. The optimal setting to discuss ADs was also discussed, with a review of the literature to support this location. This review demonstrated the need for improvement in practice and discussed the chosen interventions that may assist in improving AD completion rates in the primary care setting.

Providing education and support in the primary care setting may lead to an increase in advance directive completion rates. This increase in completion rates will assist patients in receiving the end-of-life care they desire and will assist providers in providing the care outlined by the patient.

A review of current literature, focused on interventions to improve AD completion rates was completed. Patient and provider influences, as well as educational needs were discussed in the review. Focus was put on potential barriers to completing ADs. Multimodal interventions were highlighted as having the biggest impact in improving AD completion rates.

Review of Literature Method

The review was conducted using a health information systems database which included Medline, CINAHL, and the Cochrane Database. The Medical Subject Headings (MeSH) terms used were: ADs, advance care planning, intervention(s), completion, community, and primary care. Inclusion criteria included articles written in the English language, the year 1998-present, specific to the primary care or community setting. Exclusion criteria included hospital based interventions and articles published prior to 1998. The search yielded 41 articles for review, ten were chosen for review. These ten were specifically chosen based on the year they were published; the most recent studies that were high level research studies were chosen. The setting
the study was implemented in was also taken into account, specifically looking at the primary care setting. A variety of interventions that were implemented, regardless of success, were also chosen to show the strengths and weaknesses of certain interventions. Of these ten articles; one was a 17-item survey; four were randomized controlled trials; two were systematic reviews of literature; one was a randomized trial; one was a semi-structured interactive interview process; and one was a cross-sectional descriptive study.

Review of Literature Results

The following research studies were rated based on the levels of evidence outlined by Melnyck and Fineout-Overholt (2005). This allowed for consistency in rating throughout all of the research studies that were reviewed and chosen for inclusion. These studies on ADs described patient and provider influences; education for patients; and interventions to increase AD, including mailings, computer alerts to prompt providers, group educational sessions and individual counseling with face-to-face education.

Patient and Provider Influences

Tung and North (2009) sent a 17-item, level III survey to 144 staff primary care providers and internal medicine residents, of which 94 responded answered questions such as, “When do you discuss advance care planning with your patients?”, “Who should counsel patients about advance care planning?”, and “What are the largest barriers to discussing advance care planning during the clinical encounter?”. Primary care professionals cited “lack of time” as the main reason for not discussing ADs. They also pointed out that there was no formal education for providers and no formal process to educate patients regarding ADs. Many providers did not
know how to broach the subject with patients and often took informal cues from the patients or family members to initiate the discussion. Providers frequently answered that they wait for the patient or family member to prompt the discussion of ADs. The providers also responded that their perceived patient’s barriers were the patient’s lack of knowledge and reluctance to discuss end-of-life issues. Eighty-six percent of providers agreed that the primary care setting was the most appropriate setting to discuss ADs but many disagreed regarding who should initiate the discussion. The survey was only distributed to providers at one institution; this reflected a concrete weakness of the study (Tung & North, 2009).

Spoelhof and Elliot (2012), a level V review, focused on barriers to improving completion rates in the primary care setting. Specific provider barriers were identified as lack of institutional support, lack of time and discomfort with the topic. A major barrier that was identified was the lack of reimbursement for the discussion that can take 30 minutes or more depending on the patient, the family and complex health issues. Patient barriers were identified as fear of burdening family, health literacy, as well as spiritual, cultural and racial traditions. Another barrier that patients may have to deal with is social isolation and lack of a reliable proxy. Many elders did not have options for a reliable proxy. They may not have had children, they may be estranged from family or their loved ones may no longer be living. This may pose difficult circumstances for the patient and provider and was identified as barrier to completing ADs. In these instances the Medical Orders for Life-Sustaining Treatment (MOLST) form proved to be most important. This allowed patients to direct their end-of-life care, even if they do not have a reliable proxy. They were able to express their wishes on the MOLST form and leave it in a conspicuous location for first responders to locate when and if the time comes. Once
these barriers are overcome and ADs are completed it is important to provide documentation of
the ADs to the local medical facility to assist in successful implementation of the patient’s
wishes when the time comes. It was determined that it was also important to verify patient’s
wishes, especially when health status declines (Spoelhof & Elliot, 2012).

Duke, Thompson and Hastie (2007) completed a level III, cross-sectional, descriptive
study to determine what characteristics and factors influenced hospitalized patients to complete
ADs. The barriers to initiating the discussion regarding ADs during hospitalization were very
similar to the barriers in the outpatient setting. Barriers identified included lack of knowledge,
confusing paperwork and vagueness regarding who should initiate the discussion and who is
educated to have the discussion. A convenience sample was obtained from two acute care
facilities in East Texas using the following criteria: English-speaking, completed ADs, willing to
be interviewed or to use the written tool, alert and oriented to person, place and time. The
Advance Directive Assessment Tool (ADAT) was used, which was a 39 item questionnaire
developed to gather information from the patients. Sixty-four percent of the patients who
completed the questionnaire indicated that they had ADs. The most influential reason’s for
having ADs were influences from spouses or loved ones and not wanting to be a burden to their
family, as well as strong spiritual beliefs. Thirty-six percent of individual who had ADs
indicated that they had significant health issues, but seventy percent stated their health status did
not influence their decision. Understanding barrier to completing ADs, as well as understanding
why some patients choose to complete ADs is an important step in increasing overall completion
rates (Duke, Thompson, & Hastie, 2007).
What influences individuals to begin the advance care planning process? Levi, Dellasega, Whitehead and Green (2010) completed a level II study with three focus groups, using a semi-structured interactive interview process. Each focus group lasted between 60 and 90 minutes and was led by an experienced nurse researcher. Twenty-three individuals participated in the focus groups and four distinct reasons for engaging in advance care planning emerged: 1) concern for self – wanting to maintain autonomous, and having a meaningful existence/quality of life; 2) concern for others – not wanting to be a burden on others, input from family as an important influence, as well as completing advance care planning to counter pressure from family; 3) expectations about the impact of advance care planning – trust and/or mistrust in the system and providers can undermine efforts towards advance care planning; and 4) anecdotes, stories and experiences – current stories in the media had a great impact on how and when people decided to engage in advance care planning, as well as personal experiences with loved ones. The sample size and restricted participation of the study may lead to limited generalizability (Levi, Dellasega, Whitehead, & Green, 2010).

**Educational Influences**

Education for the patients regarding AD completion have been identified as an area of concern (Sudore, et al., 2007). Providing educational pamphlets or packets are only effective if the patients can read, comprehend and retain the information. Adult literacy levels are determined to be at a fifth grade reading level with graphics. The standard AD forms are at a 12+ grade level and many patients report not being able to understand the forms. A randomized trial, level II, was conducted using the standard California AD form which was an 8 page, 12-point font, no color or pictures document versus a redesigned 12-page, 14-point font document
with color pictures and arrows indicating the next steps. Two hundred five patients over 50 years of age were assigned to the redesigned group and had overall higher completion scores (69.1% vs. 48.7%) that were attributed to ease of use and understanding of the redesigned form. Generalizability was limited due to the fact that the new AD forms were only distributed to general medicine patients at one institution (Sudore, et al., 2007).

Interventions

Simple and cost effective interventions in the primary care setting are important to improve AD completion rates. Dexter et al. (1998) and Heiman et al. (2004) both used computerized physician reminders as an intervention to increase completion rates. The computerized physician reminder prompted the provider to discuss ADs during the visit. The Heiman study also included patient mailings. The mailings included educational information as well as AD forms, mailed to the patient one to six weeks prior to the patient’s next appointment.

Patients in the level II Dexter study were more likely to have AD discussions with their provider than the patients that did not have computerized physician reminders. A total of 1,009 patients who were at least 75 years old, or 50 years and older with a serious disease, as well as 147 primary care physicians were used for this study. The level II Heiman study, which involved 1,079 patients from five general medicine clinics affiliated with the academic medical center, only showed a statistically significant difference in the group that had both the physician reminders, as well as the mailings, odds ratio 4.2, p=<.001. The difference between the two study findings were attributed to the type, size and location of the computerized reminder. The Dexter study had more success with the computerized reminder alone, which was a larger reminder, more prominently displayed; it also had an area for the provider to write comments
regarding the AD discussion. The Heiman study’s reminder was smaller and could easily be overlooked. Tierney et al. (2007) used computerized physician reminders to prompt AD discussion. This level II randomized control trial focused on the use of computers to remind physicians to discuss ADs with their elderly and chronically ill patients. Six hundred eighty-six patients who were at least 75 years old or 50 years and older with a diagnosis of a serious disease were enrolled in this study with a total of 87 primary care physicians. The increase in the number of physician initiated conversations was directly linked to patient satisfaction with their primary care provider, specifically in patients with chronic illnesses. The fact that exact details of the discussion could not be recorded was identified as a limitation of the study recognizing that different providers may provide differing levels of attention and compassion during the discussion.

A systematic review of studies designed to increase AD completion in the primary care setting was completed using a meta-analytic technique (Ramsaroop & Adelman, 2007). Some interventions proposed were: delivering educational material by mail; video education at the time of visit; 30-minute education sessions; group education to physicians, including talking points; and physician reminders. Fifteen of the eighteen studies included described multimodal interventions. Common barriers to completing ADs were identified as lack of time, education for the provider, health literacy level of the patient, lack of privacy for the discussion, and the perception that the patient was “not sick enough”.

The biggest increase in completion rates included multiple interactions with a healthcare provider over time. This was identified as a limitation due to the expense and time intensiveness. Written information provided prior to the visit, as well as a shorter discussion with the provider
did show an increase that would be more realistic and cost effective (Ramsaroop & Adelman, 2007).

Patel, Sinuff and Cook (2004) completed a systematic review of educational interventions that influenced non-terminally ill patients in completing ADs. It was determined that advance directives were completed in three stages; 1) Discussion of options between patient and provider, 2) Formulation of preferences by patients after a discussion with family/surrogate decision-makers, 3) documentation of preferences for the health care team. This complex process usually requires many interventions to successfully complete. Five studies used direct counseling with a clinician and demonstrated an increase in AD completion rates, pooled odds ratio 5.95, p=.005 for heterogeneity. The other 4 studies that did not use direct patient counseling showed an much smaller increase, pooled odds ratio 2.28, p=<.001 for heterogeneity (Patel, Sinuff, & Cook, 2004).

**Synthesis of Review of Interventions**

Providers reported that comfort level and time were significant barriers to initiating AD discussions (Tung & North, 2009). Primary care providers that were educated on advance care planning were more comfortable initiating conversations regarding ADs. Patient’s educational level needed to be considered (Sudore, et al., 2007). Using educational materials and forms with a more appropriate literacy level assisted in increasing completion rates. Multimodal interventions have been shown to increase completion rates with a specific focus on face-to-face conversations with trained healthcare professionals (Ramsaroop & Adelman, 2007). Having the opportunity to ask questions and receive educated, compassionate answers led to patients completing AD forms.
There are many reasons why AD completion rates have not increased since the PSDA was implemented, all of which are valid to the individual and providers. Reluctance from patients and providers to initiate the conversation; time constraints; assumptions by the patient and providers; denial and discomfort are all real issues that prevent patients from completing ADs (Duke, Thompson, & Hastie, 2007; Spoelhof & Elliot, 2012; Tung & North, 2009). It is the role of the health care provider to educate themselves, as well as the patients about the importance of ADs and to assist patients through the process. Time constraints and lack of reimbursement were real issues the provider faced, these constraints should not have prevented the initiation of the conversation (Spoelhof & Elliot, 2012).

Providers have a great responsibility to know their patients, know the current state of their health status, as well as their learning and literacy levels. This knowledge assisted providers in determining appropriate education and in implementing appropriate interventions that will assist their patient population in completing ADs. The task of having to assist patients in making and documenting end-of-life decisions may seem overwhelming and time consuming, but once there is a defined plan in place the discussions will become fluid. Implementing multi-modal interventions wisely will not eliminate the need for face to face discussions but may enhance those discussions with education provided prior to the scheduled visit and by allowing the patient to be prepared for the discussion at their next appointment (Ramsaroop & Adelman, 2007).

The current evidence supports an intervention that is multimodal, realizing that one form of communication and interaction with the patient is not enough. Patients need education that is verbal, as well as visual; patients also need time to process the information prior to the
interaction, as well as during the interaction. These multimodal interventions have been shown to make the biggest impact in increasing AD completion rates. This project implemented and evaluated a plan based on these recommendations.

Theoretical Framework

The decision to complete an AD can be a difficult one due to the need to face one’s own mortality. The transtheoretical model (TTM) is a behavioral model for change, assessing a patient’s willingness and readiness to change. This model focused on the patients’ intentions for change and assessed interventions that can be implemented at each stage. The purpose of utilizing this model in conjunction with increasing AD compliance is to move the patients along the continuum from precontemplation to action and maintenance (Prochaska, Norcross, & DiClemente, 1994). Understanding the stages of change assisted providers in understanding the barriers that may be associated with completion of ADs and assisted them in moving patients through the stages with proper interventions (Finnell, Wu, Jezewski, & Meeker, 2011).

There are five stages within the transtheoretical model: precontemplation, contemplation, preparation, action, maintenance (Figure 1). The precontemplation stage, the individual has no intention of action within the next six months. At this stage, increased awareness of the need for change, as well as personalizing the benefits of change, are important. Education will be key at the precontemplation stage; discussion with and educating patients about the importance of completing ADs. In the contemplation stage, the individual intends to take action within six months. Support is an important intervention at this stage, as well as motivation to make plans for change. After education is completed, patients will have the opportunity to review information and discuss their AD plans with their family members prior to completing their ADs.
The preparation stage, there have been some steps towards action and the individual plans on taking action within the next thirty days. Assistance is needed in this stage to develop and implement the action plan and set goals as needed. Preparation stage was supported with appropriate materials, documents and education in order to move the patient closer to the goal. The action stage was when the behavior has changed for less than six months; maintenance is sustained action for greater than six months. During the action stage reinforcement, feedback and assistance as needed was imperative. The maintenance stage requires encouragement and reminders of the importance of the change (White, 2012). The ADs were completed during the action stage and will be reviewed at follow up visits during the maintenance stage (Jezemski, et al., 2009).

Figure 1: Transtheoretical Model for Behavioral Change
Method

Setting

This program was implemented at Main Street Medical (MSM), in Melrose Massachusetts. MSM is a successful family practice that was established in 1991. The practice has two physicians; one family physician and one physician specializing in Endocrinology, as well as one Nurse Practitioner who see patients at varying hours, Monday through Saturday. There is a large office staff including nurses and medical assistants who perform triage and various laboratory testing. Melrose is a small city located north of Boston, with an approximate population of 28,150 people. The majority of Melrose citizens are Caucasian, with approximately 7% African American, 6% Asian, and 10% Hispanic population (About Melrose, 2012).

Program Design

The program was approved by the University DNP Committee in December 2012. Computer access was obtained through MSM for the purpose of data collection for the project. Data collection began once approval was obtained. No constraints were perceived at the start of the project. For the purpose of this project, key stakeholders were the providers at MSM, as well as the patients and family who benefitted from the completion of ADs. The local medical center was also a key stakeholder, as they may benefit from the increase in completion of ADs.

Hundreds of health care organizations have used the Plan-Do-Study-Act (PDSA) cycle method to test and implement changes for their organization. The PDSA worksheet (Appendix A) is an important document that can be used in many different circumstances and was the tool
that was used to increase ADs completion rates at Main Street Medical (MSM) (Plan-do-Study-Act Worksheet, 2011). The aim for this project was that completion rates will be improved by approximately twenty five percent over the three month implementation period.

The National Guideline Clearinghouse had a guideline for improving ADs compliance for geriatric patients. This was the most applicable quality measure; it focused on the geriatric population but was easily utilized in a general population. The major outcome to be monitored was increasing the number of ADs completed in the primary care setting (Ramsey & Mitty, 2003). In order to improve completion rates in the primary care setting records were reviewed of all patients age 18 and older that had a physical or follow up appointment scheduled during the three month implementation period. If the patient had an AD, it was noted within their chart and the Excel tracking tool, used and developed by the Doctor of Nursing Practice Candidate (DNPC), was noted as such. If the patient did not have an AD, their chart was flagged for education when the patient presented for an annual physical or follow up exam. It was important for these discussions to be initiated at a well visit because when patients are ill, they often do not want to discuss end of life care, they do not want to complete forms or documents at that time and they are not receptive to education. Once the well exam was completed the patient/family was provided with education, support and assistance in formulation of their AD; Precontemplation and Contemplation Stage. If the patient declined completing their ADs at that time, a follow up phone call was made within two weeks of the initial visit to answer any questions that may have arisen and to give an additional opportunity to complete an AD form.

Studies have shown that multi-modal interventions work best (Ramsaroop & Adelman, 2007). The patients were given educational information prior to their scheduled appointment
through the mail, as well as in the presence of the DNPC. A discussion, approximately 15 minutes in length, was had between the patient/family and the DNPC regarding the educational information; Preparation Stage. If the patient was prepared at that time, they were assisted in completing an initial AD form; Action Stage. Questions were answered and an appointment for a follow up discussion was made, if needed.

The planning took place prior to implementation. Educational materials were developed for the patients and family members. The “do” portion was preparing and sending out educational mailings to patients who were scheduled to be seen in the office for an annual physical or a follow up visit for medication review (Appendix B, C, D). Education and support was provided to patients and families to assist in obtaining completed ADs. Educational flyers were developed and put in each exam room to prompt patients to initiate AD discussions with their providers (Appendix E). The “study” portion of the project was the calculation of the compliance rates before and after implementation of the project, as well as the follow up with the patients and families within two weeks after being seen in the office via phone call or follow up visit, if applicable, to determine the effectiveness of the education provided. “Act” was evaluating the educational materials and making changes to them as needed, based on nurse/provider/staff and patient feedback (Figure 2).
The objective was to gather data and record whether the patient had an AD. If the answer was “yes”, the response was immediately documented in the electronic medical record, and the patient was reminded to bring a copy to the office for their permanent medical record. If the answer was “no”, educational information, as well as a Massachusetts Healthcare Proxy form was mailed to the patient prior to their scheduled visit (Advance Care Planning, 2012). When the patient presented for the scheduled appointment, the DNPc discussed the AD with the patient and family members who were present. If the patient was 18 years or older the importance of a health care proxy was discussed. If the patient or family declined to complete the ADs at that time, the discussion and education that took place was documented in the electronic record.

The optimal aim of this project was that all patients, 18 years or older, would have an AD decision documented or they would have the discussion and education documented. A realistic goal for the limited timeframe of the project was to have an increase in completion rates by twenty five percent. The GE Centricity electronic medical record computer program had a specific area to document advance directives; every patient had this area documented as either
completed or declined, with the copies of the patient’s Healthcare Proxy scanned into the EMR as well as a notation under the “directives” link in the EMR (Figure 3). The patient or family member was given the original copy for their records.

Figure 3: GE Centricity “Screenshot” showing Directives area for documentation

The denominator was based on the number of patients scheduled for an annual physical and/or follow up appointment for medication review and who provided accurate mailing information to obtain the educational materials prior to visit. The numerator was the number of patients with a completed AD either at the initial visit, at home with their family members or at subsequent visits during the project timeline. The percentage of patients with completed ADs was calculated based on the total number of patients who received educational mailings and education and those patients who ultimately completed ADs.

Sample

The sample was a convenience sample, with 71 subjects who were scheduled for an annual physical, or a follow up appointment for medication review, during the three month
period. These patients received information regarding ADs and education at least one week prior to arriving in the office for their scheduled appointment. They also received education at the time of the visit, as well as an opportunity to complete their AD with the assistance of the DNPC.

**Protection of Human Subjects**

This was a quality improvement project to evaluate a program in a specific setting. Quality improvement projects are not subject to IRB approval in the organization involved unless there is tracking of identified personal health information. There was no data collection of identified personal health information in this project. The only information that was recorded for purposes of this project was age, gender and state of AD completion pre and post project implementation. All patient information was kept confidential. Patients were given the opportunity to decline being part of this project; they were still offered educational information regarding the importance of ADs and communication of their end-of-life wishes. Based on these factors, this project was exempt from IRB approval.

**Method of Evaluation**

The measurable outcome was to increase AD completion rates in the primary care setting. The goal was to increase completion rates by at least twenty-five percent for the patients that were scheduled for an annual physical or follow-up appointment for medication review during the three-month implementation period. After the three-month implementation period, data was calculated to determine the increase in percentage of AD completion. Data was collected from the electronic medical record system, the documentation of AD completion rates
was reviewed and entered into an excel spreadsheet to track and compile for ease calculation of the completion rates.

**Timeframe and Budget**

Records for patients, who were scheduled for annual physicals or follow up appointments in the months of January 2013, February 2013, and March 2013, were initially reviewed in December 2012. Data collection began for all patients who were scheduled for annual physicals or follow up appointment during those three months in the weeks prior to their actual scheduled appointment. Educational information, including AD forms and a letter explaining the intent were sent out to all patients meeting the appropriate criteria a week prior to their scheduled appointment. The implementation dates were from January – March, 2013 (Appendix G); it was extended to mid-April to allow for open houses, which allowed patients to walk-in to discuss their ADs without the time constraints of a scheduled visit. The patients were be contacted by phone within two after their appointment to discuss their satisfaction with the educational material. If the patient declined to complete an AD form, this follow up discussion offered more information, as appropriate, and offered an additional opportunity to complete AD forms.

The time required by the other providers and office staff within the practice was very limited, they were asked to collect paperwork from patients, if needed and remind the patients to bring the AD paperwork to their appointment when they normally called with their appointment reminder. The majority of the time that was required was donated by the DNPC. The resources needed, were replication of forms, posters and copies made of the letters of intent and educational material, as well as mailing resources totaling approximately $376.00, which was paid for by the DNPC, though some copies were made at the hospital print shop (Appendix H).
Evaluation

Results

Addressing ADs in the primary care setting was a difficult task, as anticipated. Many of the known barriers identified in the review of literature were also barriers during the implementation of this project. The goal and task was to overcome these barriers with the multimodal interventions that were identified, as well as other creative interventions that may have made an impact.

The first task was to identify what type of AD was appropriate for patients. Many different forms including “Personal Wishes” & “Five Wishes” were reviewed to determine the best fit. Ultimately it was determined that it was most important for all patients 18 years and older to have a Massachusetts Healthcare Proxy (HCP) form completed (Appendix D). Increasing the number of patients with this form completed will decrease the number of incidences of confusion and uncertainty when patients are in a situation where decisions have to be made regarding their healthcare wishes.

At MSM, the Physician and Nurse Practitioner began addressing patients’ healthcare wishes, specific to end-of-life care at age 60, or sooner if the patient had a terminal condition. With this knowledge and the knowledge that the Massachusetts Medical Order for Life-Sustaining Treatment (MOLST) form was going to be a statewide initiative, it was determined that the MOLST form would be used for all patients greater than age 60 who were prepared to make these decisions (Appendix F). The MOLST form was adapted from the Physician Orders
for Life-Sustaining Treatment (POLST) form, with the first successful pilot implemented in Worcester, Massachusetts in February 2010 (MOLST information for Legal Professionals, 2013). Since that time Massachusetts convened a panel to discuss end-of-life recommendations, in October 2010; they recommended the MOLST form be instituted statewide (Care, 2010); the Massachusetts Department of Public Health supported this initiative in March 2012. The MOLST form was not included in the patient mailings as it was a form specific to certain patient population and required discussion regarding the options available to select or decline such as hemodialysis or artificial nutrition. The MOLST form is also a valid physician, nurse practitioner, physician assistant order and should be completed in the presence of a provider.

**Data Analysis**

Seventy-one patients received education mailings within one week prior to their scheduled visit. The number of female patients versus male patients was fairly evenly distributed with female patients accounting for 40.8% of the total mailings, and the male patients accounting for 59.1% (Figure 4). The mailings were sent out to all patients 18 years or older who were scheduled for an annual physical or follow up appointment, their age did not play a factor in the mailings because it was determined that all patients 18 years or older should have a healthcare proxy form completed. The letter of intent discussed possibly needing more documentation completed based on age and condition. Approximately 69% of the patients that received the mailings were between the ages 41-70; 14% were 40 years old or younger; 16.9% were greater than 70 years old (Figure 5).
Figure 4: Patient Mailings, Gender Distribution

Figure 5: Patient Mailings, Age Distribution
The educational mailings included a letter of intent, frequently asked questions to begin the educational process and a HCP form with instructions on how to complete the form. All 71 patients received education with the DNPC after their scheduled visit. Educational session lasted approximately 15 minutes but was shortened at times due to patient and provider schedule.

Eighteen patients opted to complete their HCP form, which was a total increase of 25.4%. The gender distribution of patient who completed their HCP forms was 55.5% female, 44.4% male; male gender was higher for the overall gender distribution, illustrating that females were more likely to complete their HCP than male patients (Figure 6).

The MOLST form was targeted towards patients who were greater than 60 years old, based on the current practice of this practicum site. If the patients were healthy, without any chronic or terminal conditions the MOLST form was deemed inappropriate and the education
regarding the importance of completing a healthcare proxy was highlighted. After reviewing the patients with the Nurse Practitioner, it was determined that 28 patient were appropriate to have MOLST form reviewed. This was based on the patients past medical history, current diagnoses, and comorbidities, as well as patients rated as “High Risk” based on criteria from case managers through the local healthcare facility in coordination with the physician and nurse practitioner. After discussion and education five patients were prepared to complete their MOLST form in the office, for a completion rate of 17.85% (Figure 7).

**Completion Data**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Patients</th>
<th>HCP Completed</th>
<th>MOLST Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;80</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>71-80</td>
<td>7</td>
<td>3</td>
<td>2</td>
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<tr>
<td>61-70</td>
<td>15</td>
<td>5</td>
<td>2</td>
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<td>51-60</td>
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<tr>
<td>41-50</td>
<td>14</td>
<td>4</td>
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<tr>
<td>31-40</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>&lt;30</td>
<td>2</td>
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<td>0</td>
</tr>
</tbody>
</table>

Figure 7: HCP & MOLST Completed by Age

**Discussion**

Many of the patients that declined to complete their AD in office stated they had a HCP or living will at home; these patients were encouraged to bring a copy to their next appointment so it could be scanned into their medical record. Follow up phone calls were made to the
patients who declined completing their ADs in office. This opportunity was also used to discuss the educational forms and their readability, as well as to ask patients for feedback on how to better deliver this important information. Only six out of the fifty-three patients were able to be contacted. Messages were left for all additional patients with no response. The six patients that were able to give feedback felt that the forms were appropriate and felt that the education was thorough. The six stated that they had plans to complete their AD after having conversations with their family members. The patients were encouraged to bring a copy to the office when complete so it could be scanned into their medical record, highlighting the importance of their primary care provider having this information. Future programs should specifically ask patients which mode is best to reach them, telephone, email, mail, etc., to possibly increase availability to follow up.

End-of-life issues are not always an easy topic to discuss for many reasons. It is also very difficult to discuss in any setting, specifically a primary care setting due to time constraints for the provider, as well as the patients. Many patients only allot so much time for their appointments and cannot or will not stay longer for education. The patients want to get in and get out; they may have another appointment, or have to get to their ride or just get home. Time was often an issue. Finding a way to streamline education and tailor it to the individual patient was an important step in eliminating this barrier.

Education was also needed for patients to explain to them that their “Next of Kin” was not an official HCP. This distinction was not always clear; explaining to patients the difficulties that may arise in hospital was often eye-opening to them. Patients were also quick to say that their family members knew what they would want. A lot of education was focused on these misconceptions and encouraging the patient to have these conversations with their family
members prior to the time that the HCP may need to be invoked. The biggest impact completing a HCP can make is starting the conversations within the family.

A barrier that was expected was the concern from patients regarding their religious beliefs (Spoelhof & Elliot, 2012). Many patients felt if they were not a Full Code or didn’t say they wanted everything done, then it would be going against what God would want for them. Some perceived it similar to committing suicide. Education focused on the patients naturally passing away, and CPR was intervening with that natural passing. Patients were also reminded that the decision to become a Do Not Resuscitate did not translate to Do Not Treat. Patients were reminded that they would still be treated for conditions such as infection, dehydration, etc., but if death took place naturally they may decide not to have healthcare providers intervene. Many patients were reassured with this explanation and discussion.

A potential barrier that was not realized prior to implementation was the fact that the DNPc did not have an established rapport with many of the patients. Research that highlighted the primary care setting as the most ideal location for discussing ADs cited provider-patient rapport as once reason discussions may be better in this location (Patel, Sinuff, & Cook, 2004). The DNPc has been at this practicum location since September 2012, so many patients were familiar with the DNPc but a well-established rapport was not developed with many of the patients. This is often a process that can take years with a primary care provider. This may have been a deterrent for some patients to complete these very personal forms. Other patients saw the DNPc as a welcomed change, knowing the DNPc had more time to sit with the patient and family, discuss the options and how they would relate to the patient.

For the purposes of this time-limited project the number of patients that participated was sufficient, but more patients may have been able to be reached with mailings prior to their
scheduled visit if the scheduling for the nurse practitioner was altered. The nurse practitioner had approximately 6-10 patients scheduled for the following week when the schedule was reviewed and the mailings were sent. The schedule did fill up as the week carried on and the nurse practitioner saw many more patients. If the patient was appropriate for a HCP or MOLST the discussion was attempted and the forms completed if the patient was prepared, but this did not allow for the multimodal interventions that were being tested and was often not successful.

Based on the barrier of time, for the provider and patients, open houses were set up. Flyers were mailed to over 150 patients including the patients identified as “High Risk” allowing patients to make appointments to meet with the DNPc without the pressure of the appointment schedule (Appendix I). This also allowed the patients to be prepared for the discussion when they arrived. This mode did not produce many patients but the seven patients that did take advantage of this option completed a HCP and MOLST form and were very thankful for the time and attention given to discuss their options and provide support as needed. This intervention increased the HCP completion rate to 35.2% and the MOLST completion rate to 42.8%. This would not be the most cost effective option for providers, but for purposes of this project it made an impact to the patients who took advantage of this option.

Conclusions

This project completed the objectives that were set forth. The goal of a 25% increase in AD completion rates was met and patients and family members were satisfied with the education that was provided. This process needs to be continued to truly have an impact on this practice. Diligence needs to be maintained moving forward to be sure all patients have an AD completed. Patient preferred having the information mailed to them prior to their visit so they can be
prepared when they come in for their appointment. Patients were willing to complete their ADs, but they needed the time to process the information and discuss options.

Having a process in place for the primary care provider’s office was an important step in continuing to keep this important issue at the forefront of patients and providers minds. Whether it is monthly, quarterly, or annually, focus needs to be paid to a specific educational session or intervention with the patient population that can benefit most from ADs. It is the provider’s responsibility to initiate these discussions with patients and family members and to update the plan as needed. Follow up with the Physician and Nurse Practitioner discussed the potential of continuation of this initiative after cessation of the project. The weekly mailings and follow up may not be feasible, but the educational materials will be used in the future for patients. There was also a discussion regarding utilizing students, both nursing and medical students to complete projects, such as ADs, in the practicum site. Students are eager for the clinical portion of primary care, but there is also a great need to learn how to provide support and education to patients. Utilizing the students to continue the AD discussions will benefit the patients, the practice, as well as the student because it will help them develop much needed skills in discussing end-of-life issues.

**Post Project Plan**

Getting patients and families involved in developing additional plans and interventions to tackle this AD initiative is an important area to focus on. Developing a patient and family advisory council has been started in many hospitals, but primary care practices may benefit from this same idea on a smaller scale to promote patient-centered care within the practice. ADs can be the first initiative that is addressed and patients can discuss ways to keep the momentum moving forward with this initiative. Incorporating some of the six components of patient and
family centered care into a primary care advisory patient and family council will assist in
overcoming some of the barriers identified in this project (Halm, Sabo, & Rudiger, 2006). The
patients know best when it comes to these types of conversation, they should be used as a
resource to reach more patients.

This project was successful, and may patient’s verbalized appreciation for the time and
attention to such an important topic. Mailings, open houses and multiple face-to-face discussion
will continue to be utilized by the DNPe, once able to practice independently ensure all patients
have ADs. The impact that can be made is life altering for the patients and family members, as
well as the providers.
References


Appendices


Aim: Increase Advance Directive Completion Rates at MSM by 25% from January 2013 – March 2013

*Every goal will require multiple smaller tests of change*

<table>
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<th>Describe your first (or next) test of change:</th>
<th>Person responsible</th>
<th>When to be done</th>
<th>Where to be done</th>
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**Plan**

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<th>When to be done</th>
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<tbody>
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</table>

<table>
<thead>
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<th>Predict what will happen when the test is carried out</th>
<th>Measures to determine if prediction succeeds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Do**

Describe what actually happened when you ran the test

**Study**

Describe the measured results and how they compared to the predictions

**Act**

Describe what modifications to the plan will be made for the next cycle from what you learned
Appendix B - Patient Mailings

Letter of Intent

Spring, 2013
Dear Patient,

You are receiving this letter because you are scheduled for an annual physical or follow up appointment at Main Street medical in January – April 2013.

I am a Family Nurse Practitioner and Doctor of Nursing Practice student through UMass Amherst who will be implementing a project this semester. My goal of the project is to increase Advance Directive completion rates through education, support and guidance in completing the appropriate paperwork.

Attached you will find Frequently Asked Questions regarding advance directives as well as a Massachusetts Healthcare Proxy form for your review and completion. Please take time to review these forms, discuss with your family members and complete them, if possible, prior to your next appointment. Please bring the Healthcare Proxy with you to your next appointment so we can scan it into your medical record.

If you already have a completed Healthcare Proxy, please bring it to your next appointment so we can have a copy for your records.

If you are uncertain or uncomfortable completing this forms at this time, please bring them with you to your next appointment and we can discuss the benefits, any concerns you may have and what the next steps may be.

If appropriate we will discuss completing further advance directives during your appointment.

I appreciate your time in assisting me with completing my Capstone Project and I look forward to working with you over this next semester.

Sincerely,

Esperanza Donahue
Epi Donahue RN, MSN, FNP/DNPc
Family Nurse Practitioner/Doctor of Nursing Practice Candidate
Appendix C

Frequently Asked Questions Regarding Advance Directives

Q: **What are advance health care directives?**

A: Advance health care directives are written instructions to your loved ones and others about the type of medical treatment and health care you would like to receive if you're unable to communicate directly with your health care providers.

Q: **What is a living will?**

A: A living will is a legal document that states your preferences for medical treatment if you are terminally ill or permanently unconscious and unable to actively take part in making decisions for your own life. In that case, the living will may state that you do not want to be kept alive through life support systems.

Under a living will, you can state whether you want - or don’t want - certain life-sustaining procedures, including artificial respiration, cardiopulmonary resuscitation, and artificial means of providing nutrition and hydration.

Q: **What is artificial nutrition and hydration?**

A: Artificial nutrition and hydration refers to the use of artificial means to feed and hydrate a person who is not able to eat and drink on his own. It generally includes giving food and water through an intravenous catheter (commonly called an "IV") or through a nasogastric tube.

Q: **What is a healthcare proxy?**

A: A "healthcare proxy" is a legal document in which you name another person as your agent to make health care decisions for you. You can include instructions about the types of medical treatments you want - or don’t want.

Q: **Who should be my healthcare proxy?**

A: This is a very important question. Whomever you decide to name as your proxy should be someone you know very well. It should also be someone you respect and someone whose judgment you value. This person should also have a good understanding of who you are and what your values and feelings are.
Q: At what age should I complete a healthcare proxy and a living will?

A: Any age. Any person 18 years or older should have a completed healthcare proxy and living will, outlining their healthcare wishes. This is not only for older adults whose health may be declining. Accidents happen at any age and these forms communicate your wishes to health professionals.

Q: Can I name more than one agent to act for me?

A: Yes. However, if you appoint more than one agent, then you should specify whether each agent can act separately or whether they all must act collectively. There are advantages and disadvantages to both forms of appointment. Another option is to appoint only one agent, with another named as an alternate in case the first named agent is unable to act for you.

Q: Where should I store these documents?

A: You should inform your family members, your attorney, your personal physician, and each person you have designated as either your health care agent or your guardian or conservator for future incapacity. In fact, it’s advisable that you discuss these important decisions with these people before you even sign the documents.

You should keep the originals in a safe place, particularly one that is free of any potential water or fire damage. It is also a good idea to give copies of these documents to the people who are most likely to need this information when the time comes, particularly your attorney and your personal physician.

Q: How long will my advance directives last?

A: There is no time limit for these documents. Generally, they will last until you change them or terminate them. You may change them at any time and from time to time by simply signing new documents. It is always a good idea to destroy your old documents so that they aren’t confused with your new ones.

Q: Must a lawyer create my advance directives?

A: No. Your health care proxy can be completed by yourself and signed by two witnesses. This form is valid and binding.
Appended D

NOTICE: The following form is protected by federal copyright law and may be photocopied or reproduced only by the end user for his or her personal use. Health care organizations, institutions, professionals, and others can purchase the form in quantity, or license a digital copy, from Massachusetts Health Decisions, the nonprofit publisher of the form and educational materials related to the Massachusetts Health Care Proxy. The form is available in English and 14 other languages. A complete information packet including two copies of the form, a basic brochure, and a 16-page "User's Guide" in question-and-answer format is available for $6 postpaid. Please contact Massachusetts Health Decisions, Publications, PO Box 1407, Apex, NC 27502, or by email: proxy@masshealthdecisions.org

Massachusetts Health Care Proxy
Information, Instructions, and Form

What does the Health Care Proxy Law allow?

The Health Care Proxy is a simple legal document that allows you to name someone you know and trust to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions. It is an important document, however, because it concerns not only the choices you make about your health care, but also the relationships you have with your physician, family, and others who may be involved with your care. Read this and follow the instructions to ensure that your wishes are honored.

Under the Health Care Proxy Law (Massachusetts General Laws, Chapter 201D), any competent adult 18 years of age or over may use this form to appoint a Health Care Agent. You (known as the “Principal”) can appoint any adult EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage, or adoption. Whether or not you live in Massachusetts, you can use this form if you receive your health care in Massachusetts.

What can my Agent do?

Your Agent will make decisions about your health care only when you are, for some reason, unable to do that yourself. This means that your Agent can act for you if you are temporarily unconscious, in a coma, or have some other condition in which you cannot make or communicate health care decisions. Your Agent cannot act for you until your doctor determines, in writing, that you lack the ability to make health care decisions. Your doctor will tell you of this if there is any sign that you would understand it.

Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including treatment that could keep you alive.

Your Agent will make decisions for you only after talking with your doctor or health care provider, and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your doctor, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interests. After your doctor has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decisions will be honored unless a Court determines that you lack capacity to make health care decisions.

© Massachusetts Health Decisions 1991-2014
Your Agent’s decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

How do I fill out the form?

1. At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (Optional: If you think your Agent might not be available at any future time, you may name a second person as an Alternate Agent. Your Alternate Agent will be called if your Agent is unwilling or unable to serve.)

2. Setting limits on your Agent’s authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. However, if you want to limit the kinds of decisions you would want your Agent or Alternate Agent to make for you, include them in the blank.

3. BEFORE you sign, be sure you have two adults present who will be witnesses and watch you sign the document. The only people who cannot serve as witnesses are your Agent and Alternate Agent. Then sign the document yourself. (Or, if you are physically unable, have someone other than either witness sign your name at your direction. The person who signs your name for you should put his/her own name and address in the spaces provided.)

4. Have your witnesses fill in the date, sign their names and print their names and addresses.

5. OPTIONAL: On the back of the form are statements to be signed by your Agent and any Alternate Agent. This is not required by law, but is recommended to ensure that you have talked with the person or persons who may have to make important decisions about your care and that each of them realizes the importance of the task they may have to do.

Who should have the original and copies?

After you have filled in the form, remove this information page and make at least four photocopies of the form. Keep the original yourself where it can be found easily (not in your safe deposit box). Give copies to your doctor and/or health plan to put into your medical record. Give copies to your Agent and any Alternate Agent. You can give additional copies to family members, your clergy and/or lawyer, and other people who may be involved in your health care decisionmaking.

How can I revoke or cancel the document?

Your Health Care Proxy is revoked when any of the following four things happens:

1. You sign another Health Care Proxy later on.
2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.
3. You notify your Agent, your doctor, or other health care provider, orally or in writing, that you want to revoke your Health Care Proxy.
4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.
MASSACHUSETTS HEALTH CARE PROXY

I, ____________________________, residing at ________________________________

(Principal: PRINT your name)

(Street) ____________________ (City/town) ____________________ (State/ZIP) ____________________

appoint as my Health Care Agent: ____________________________

(Name of person you choose as Agent)

of ________________________________

(Street) ____________________ (City/town) ____________________ (State/ZIP) ____________________

Agent’s tel (h) ____________________ (w) ____________________ E-mail ____________________

OPTIONAL: If my agent is unwilling or unable to serve, then I appoint as my Alternate Agent:

(Name of person you choose as Alternate Agent)

of ________________________________

(Street) ____________________ (City/town) ____________________ (State/ZIP) ____________________

My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent’s authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them EXCEPT (here list the limitations, if any, you wish to place on your Agent’s authority):

I direct my Agent to make health care decisions based on my Agent’s assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent’s assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

Signed: ____________________________ Date: __/__/__ (mo/day/yr)

Complete only if Principal is physically unable to sign: I have signed the Principal’s name above at his/her direction in the presence of the Principal and two witnesses.

______________________________ ______________________________

(Name) ____________________ (Street) ____________________

(City/town) ____________________ (State/ZIP) ____________________

WITNESS STATEMENT: We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.

In our presence, on this day __/__/__ (mo/day/yr).

Witness #1 ____________________________ Witness #2 ____________________________

(Signature) ____________________________ (Signature) ____________________________

Name (print) ____________________________ Name (print) ____________________________

Address ____________________________ Address ____________________________
Statements of Health Care Agent and Alternate Agent (OPTIONAL)

Health Care Agent: I have been named by the Principal as the Principal’s Health Care Agent by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal’s wishes.

(Signature of Health Care Agent)

Alternate Agent: I have been named by the Principal as the Principal’s Alternate Agent by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal’s wishes.

(Signature of Alternate Agent)

* * * * *
Health Care Proxy developed by Massachusetts Health Decisions in association with the following member organizations of the Massachusetts Health Care Proxy Task Force:

Boston University Schools of Medicine and Public Health: Massachusetts Hospital Association
Law, Medicine, and Ethics Program Massachusetts Medical Society
Deaconess ElderCare Program Massachusetts Nurses Association
Hospice Federation of Massachusetts Medical Center of Central Massachusetts
Massachusetts Bar Association Suffolk University Law School:
Massachusetts Department of Public Health Elder Law Clinic
Massachusetts Executive Office of Elder Affairs University of Massachusetts at Boston:
Massachusetts Federation of Nursing Homes The Gerontology Institute
Massachusetts Health Decisions Visiting Nurse Associations of Massachusetts

For prices and information on quantity orders, or for non-English language licensing, please contact non-profit

Massachusetts Health Decisions
Email: proxy@masshealthdecisions.org

rev. 1/13
Appendix E

Exam Room Flyer

Five Times to Re-Examine Your Healthcare Wishes

- **DECADE** When you start each new decade of your life.
- **DEATH** Whenever you experience the death of a loved one.
- **DIVORCE** When you experience a divorce or other major family change.
- **DIAGNOSIS** When you are diagnosed with a serious health condition.
- **DECLINE** When you experience a significant decline of an existing health condition.

Please discuss updating your healthcare wishes with your provider.
Appendix F
Medical Orders for Life-Sustaining Treatment

MASSACHUSETTS MEDICAL ORDERS
for LIFE-SUSTAINING TREATMENT
(MOLST) www.molst-ma.org

Patient’s Name ____________________________
Date of Birth ____________________________
Medical Record Number if applicable: __________

INSTRUCTIONS: Every patient should receive full attention to comfort.

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the patient's clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
→ If a section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A
Select one circle ➔
CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

O Do Not Resuscitate
O Attempt Resuscitation

B
Select one circle ➔
VENTILATION: for a patient in respiratory distress

O Do Not Intubate and Ventilate
O Intubate and Ventilate

Select one circle ➔
O Do Not Use Non-invasive Ventilation (e.g. CPAP)
O Use Non-invasive Ventilation (e.g. CPAP)

C
Select one circle ➔
TRANSFER TO HOSPITAL

O Do Not Transfer to Hospital (unless needed for comfort)
O Transfer to Hospital

D
Select one circle below to indicate who is signing Section D:

Patient ☐ , Health Care Agent ☐ , Guardian ☐ , Parent/Guardian of minor ☐

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section D signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. *A guardian can sign to the extent permitted by MA law. Consult legal counsel with questions about guardian's authority.

Signature of Patient (or Person Representing the Patient) ____________________________
Date of Signature ____________________________

Legible Printed Name of Signer ____________________________
Telephone Number of Signer ____________________________

E
Clinician Signature ☐

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

Signature of Physician, Nurse Practitioner, or Physician Assistant ____________________________
Date of Signature ____________________________

Legible Printed Name of Signer ____________________________
Telephone Number of Signer ____________________________

Optional
Expiration date and other patient care contacts

This form does not expire unless expressly stated. Expiration date (if any) of this form: ____________________________

Health Care Agent Printed Name ____________________________ Telephone Number ____________________________
Primary Care Provider Printed Name ____________________________ Telephone Number ____________________________

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

Approved by DPH 1/1/2012  MOLST Page 1 of 2
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<th>Statement of Patient Preferences for Other Medically-Indicated Treatments</th>
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<td><strong>INTUBATION AND VENTILATION</strong></td>
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<td>Select one circle →</td>
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<tr>
<td></td>
<td>○ Use intubation and ventilation as checked in Section B, but short term only</td>
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<td><strong>NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)</strong></td>
</tr>
<tr>
<td></td>
<td>Select one circle →</td>
</tr>
<tr>
<td></td>
<td>○ Use non-invasive ventilation as checked in Section B, but short term only</td>
</tr>
<tr>
<td></td>
<td>○ Undecided</td>
</tr>
<tr>
<td></td>
<td>○ Did not discuss</td>
</tr>
<tr>
<td></td>
<td><strong>DIALYSIS</strong></td>
</tr>
<tr>
<td></td>
<td>Select one circle →</td>
</tr>
<tr>
<td></td>
<td>○ No dialysis</td>
</tr>
<tr>
<td></td>
<td>○ Use dialysis</td>
</tr>
<tr>
<td></td>
<td>○ Use dialysis, but short term only</td>
</tr>
<tr>
<td></td>
<td>○ Undecided</td>
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<tr>
<td></td>
<td>○ Did not discuss</td>
</tr>
<tr>
<td></td>
<td><strong>ARTIFICIAL NUTRITION</strong></td>
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<td>Select one circle →</td>
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<tr>
<td></td>
<td>○ No artificial nutrition</td>
</tr>
<tr>
<td></td>
<td>○ Use artificial nutrition</td>
</tr>
<tr>
<td></td>
<td>○ Use artificial nutrition, but short term only</td>
</tr>
<tr>
<td></td>
<td>○ Undecided</td>
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<tr>
<td></td>
<td>○ Did not discuss</td>
</tr>
<tr>
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<td><strong>ARTIFICIAL HYDRATION</strong></td>
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<td>Select one circle →</td>
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<td>○ No artificial hydration</td>
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<td>○ Use artificial hydration</td>
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<td></td>
<td>○ Use artificial hydration, but short term only</td>
</tr>
<tr>
<td></td>
<td>○ Undecided</td>
</tr>
<tr>
<td></td>
<td>○ Did not discuss</td>
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<tr>
<td></td>
<td>Other treatment preferences specific to the patient’s medical condition and care</td>
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</table>

<table>
<thead>
<tr>
<th><strong>G</strong></th>
<th>Select one circle below to indicate who is signing Section G:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○ Patient ○ Health Care Agent ○ Guardian* ○ Parent/Guardian of minor</td>
</tr>
</tbody>
</table>

Signature of patient confirms this form was signed of patient’s own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient’s representative (indicated above) confirms that this form reflects his/her assessment of the patient’s wishes and goals of care, or if these wishes are unknown, his/her assessment of the patient’s best interests. A guardian can sign to the extent permitted by MA law. Consult legal counsel with questions about guardian’s authority.

<table>
<thead>
<tr>
<th>Signature of Patient (or Person Representing the Patient)</th>
<th>Date of Signature</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
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<table>
<thead>
<tr>
<th>Legible Printed Name of Signer</th>
<th>Telephone Number of Signer</th>
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</table>

<table>
<thead>
<tr>
<th><strong>H</strong></th>
<th>Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Signature of Physician, Nurse Practitioner, or Physician Assistant</td>
</tr>
<tr>
<td></td>
<td>Date of Signature</td>
</tr>
<tr>
<td></td>
<td>Legible Printed Name of Signer</td>
</tr>
<tr>
<td></td>
<td>Telephone Number of Signer</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
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</table>

**Additional Instructions For Health Care Professionals**

- Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.
- Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. If no new form is completed, no limitations on treatment are documented and full treatment may be provided.
- Re-discuss the patient’s goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.
- The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment.
## Appendix G

### Project Timeline

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Proposal Approval/ initiation</td>
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<td>Chart audits/Mailings sent</td>
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<tr>
<td>Capstone writing &amp; revising</td>
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<td></td>
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<td></td>
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<tr>
<td>Finding presentation to institution</td>
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<td></td>
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<td></td>
<td></td>
<td>X</td>
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Appendix H

Project Budget

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
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<tbody>
<tr>
<td>10 - 11X14 inch Posters for each exam room</td>
<td>$140.00</td>
</tr>
<tr>
<td>Postage for approximately 255 patients</td>
<td>$120.00</td>
</tr>
<tr>
<td>Envelopes</td>
<td>$16.00</td>
</tr>
<tr>
<td>Approximately 600 copies of educational materials and Advance directive forms through online service</td>
<td>$100.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$376.00</strong></td>
</tr>
</tbody>
</table>
Appendix I
Open House Mailings

Spring is in the air!

With new beginnings happening all around us, let us pause and take time to plan for the future.

All patients and family members are welcome!

April 2\textsuperscript{nd}, 1PM-6PM
April 8\textsuperscript{th}, 9\textsuperscript{th}, & 10\textsuperscript{th} 8AM-4PM
Main Street Medical
675 Main Street, Melrose, MA 02176
781-662-4934

Please contact the office to schedule time to meet with a Doctoral Nurse Practitioner student from UMass Amherst to discuss completing a Health Care Proxy, as well as other important forms needed to communicate your healthcare wishes. Within a short amount of time you will have the proper paperwork completed & documented in your medical record; the originals will be sent home for your personal files.