

IMPROVING OLDER ADULT PATIENT EDUCATION REGARDING ADVANCE
DIRECTIVES

by
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As members of the DNP Project Committee, we certify that we have read the DNP project prepared by Yvett Valencia, titled Improving Older Adult Patient Education Regarding Advance Directives, and recommend that it be accepted as fulfilling the DNP project requirement for the Degree of Doctor of Nursing Practice.

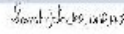

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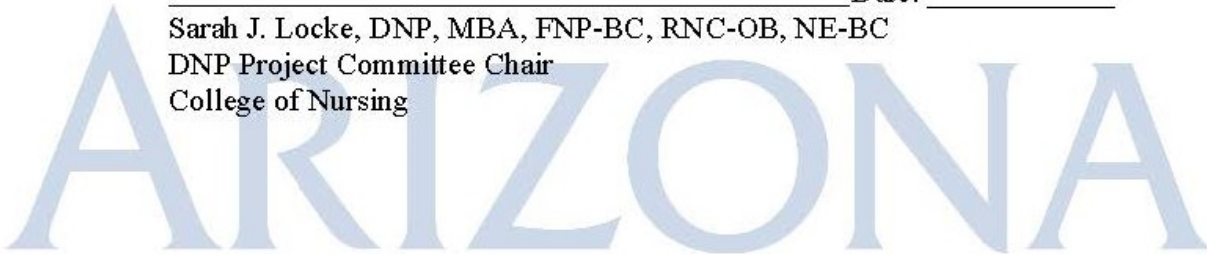

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LAND ACKNOWLEDGEMENT

We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. Committed to diversity and inclusion, the University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service.

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ABSTRACT

Purpose: This was a quality improvement project to educate patients on Advance Directives (AD) through a brief electronic teaching session. The purpose of this project was to provide patients with education on AD so they are well-informed, and can ask their provider for further guidance.

Background: Normalizing AD education in a primary care setting has been shown to reduce instances of family members having to make difficult decisions regarding EOL care. Economic impact and ethological considerations are also issues regarding delaying EOL decisions, as it can result in costly life-sustaining treatments that can lead to an ethical dilemma for the patient.

Methods: Using the Health Belief Model as a theoretical foundation, an educational electronic teaching session on AD was provided to patient-participants aged 65 or older at Vail Valley Clinic in Vail, AZ. The education was completed in the clinic while the patients waited to be seen by their providers. The Model for Improvement was utilized to develop the methodology. A four-question post-survey, using the Likert scale, assessed if the educational intervention improved the participants' knowledge about AD and their intent to discuss AD with their primary care provider.

Results: 14 patient participants met the inclusion criteria and completed the intervention. 93% of participants reported an improved understanding of AD, intent to discuss AD with family, and comfort level in discussing end-of-life planning with their provider. 43% indicated intent to complete their own AD.

Conclusions: Post-survey data analysis demonstrates that an educational video on AD to primary care patients aged 65 and older, is a successful intervention to improve AD knowledge, intent to complete AD, and comfort level in discussing AD with a provider.

INTRODUCTION

An advance healthcare directive, also known as a living will, is a personal, advanced, medical directive that is a legal written document containing an individual's end-of-life (EOL) medical wishes and preferences if they are unable to make their own healthcare decisions (Mayo Clinic, 2020; House et al., 2022). Advance directives (AD) are not just for patients with terminal illnesses or transitioning to hospice care, they are something all adults should be thinking about and setting up to protect their healthcare decisions in case they become unable to make those important decisions on their own (Mayo Clinic, 2020; House et al., 2022). This ensures that their family members know exactly what their EOL wishes are and can honor their decisions respectfully as the individual has outlined. It is estimated that only half of adults aged 65 and over have an AD in place, and 65-75% of providers are not aware if their patient has an AD in place (CDC, 2018; House et al., 2022). This DNP project intends to provide patients (adults aged 65 and over) with an electronic education presentation on AD while waiting to be seen in their provider's office, so they are well-informed and can ask their provider for further guidance if they wish.

Advance care planning decisions include cardiopulmonary resuscitation (CPR), artificial airway support, such as a ventilator in an emergency, the use of artificial nutrition such as a feeding tube, along with pain management, organ tissue donation, and/or donating remains to science (U.S. Department of Health and Human Services, 2018; House et al., 2022). It is often the medical assistant (MA) or new patient paperwork that asks the question: "Do you have an advanced directive or living will?" This question is often not followed up with any open-ended discussion and is simply answered with a 'yes' or 'no' by the patient (Mayo Clinic, 2020; House

et al., 2022). The provider has time constraints to have AD or EOL discussions with each of their patients or if the patients even know what these terms mean; which makes this topic closed-ended to the patient (Mayo Clinic, 2020; House et al., 2022).

The clinical question for this quality improvement (QI) project is to determine if in the primary care setting, electronically implemented patient education in the waiting room improves elderly patients' understanding of advanced directives in end-of-life care and their intention to discuss these topics with their provider.

Background Knowledge and Significance

Types of Advanced Directives

It is reported that two-thirds of all Americans have a living will outlining healthcare preferences and/or EOL wishes (Mayo Clinic, 2020; House et al., 2022). There are choices the patient has when it comes to setting up advance directives and EOL wishes. A patient can choose to sign over a medical power of attorney (POA) to a specific person so that they can make medical decisions if the patient is unable to. The POA can be referred to as a health care proxy, surrogate, agent, representative, or patient advocate. This person must also meet the state's requirements for becoming a POA (U.S. Department of Health and Human Services, 2018; Prince-Paul et al., 2017). A living will is a legal document that is set up by the patient and spells out what the patient wants and does not want to be done if they become unresponsive or/unable to make their own healthcare decisions. These wishes include those involving the use of life-sustaining treatments (CDC, 2016; Prince-Paul et al., 2017). The living will include whether the patient wants intubation/mechanical ventilation, and if they prefer other measures, such as do-

not-intubate (DNI), CPR or do-not-resuscitate (DNR), feeding tube for nutritional support, organ tissue donation, dialysis, or comfort/palliative care (CDC, 2016; House et al., 2022).

Quality of Life

It is reported that 56% of the older adult population (people aged sixty-five and over) do not want to burden their loved ones with tough decisions about EOL care when unable to make those decisions for themselves (Prince-Paul et al., 2017). Studies have shown that patients who have designated their healthcare preferences and end-of-life decisions have improved quality of care and satisfaction with their medical care overall (CDC, 2016; House et al., 2022; Glass et al., 2021). Patients who do not have AD care planning in place risk having their loved ones make tough health-related decisions for them, which places a lot of stress on families, especially if they do not know what the patients' EOL wishes are (Weathers et al., 2016).

Economic Impact and Ethological Considerations

Life-sustaining treatments and measures come with financial consequences along with an ethical dilemma regarding EOL care decisions (Klingler et al., 2016). Studies have shown that rising healthcare costs near EOL do not mean improved quality of care for the patient, and just because more aggressive care is given to the patient, it doesn't always align with what an individual considers ethical (Klingler et al., 2016). The goal of end-of-life care for dying patients is to prevent or relieve suffering as much as possible while respecting the patients' desires (Akdeniz et al., 2021). Since decisions to be made concern patients and their family members, it is important to protect the rights, dignity, and vigor of all parties involved in the clinical ethical decision-making process (Akdeniz et al., 2021). Studies have shown that fewer deaths occurred in inpatient settings when AD was in place, which was conducive to the patient's wishes

regarding quality of life at EOL (Orlovic et al., 2020). Having the older adult patient population better educated on AD will also lead to reduced healthcare costs by eliminating unwanted and prolonging life-sustaining measures and treatment (Klingler et al., 2016; Khandelwal et al., 2017). According to a study by Duncan et al. (2019) the highest amount of Medicare spending is in an acute care hospital setting ranging from 90-180 days preceding the death of an individual. The study also demonstrated that 25% of Medicare beneficiaries end up dying in a hospital inpatient setting and that the cost would have been substantially lower if the patient was on a hospice program (Duncan et al., 2019).

Communication

Studies have shown that even though death and dying discussions should be a standardized approach to treating a patient as a whole person, it is often a conversation that providers and patients prefer not to have to avoid an uncomfortable response such as patients not wanting to think about the end of their life, providers not being trained in having these crucial conversations, and/or the conversation makes providers think of their end of life which can cause bias opinions (Brown, 2019; Atherton, 2020). Providers think that questions about death and dying will offend a patient, especially if they do not have a terminal condition at the time the questions are being asked (Brown, 2019). Patients are often too scared to ask questions, so they avoid the conversation and answer questions about AD on paperwork even though they might not fully understand what the questions refer to (Brown, 2019).

The opportunity to educate older adults on these important topics in outpatient family care clinics removes the negative stigma of AD and EOL decisions and allows the topic to

become routine by having an open-ended discussion to further the patient's understanding (House et al., 2022).

Local Problem

As Arizona continues to grow so does the aging population, which makes it especially important for providers to start discussing advanced directives early on so patients can plan EOL decisions accordingly (Arizona Department of Health Services, 2016; House et al., 2022). In Arizona, it's estimated that 48.4% of the population are persons aged 65 years and older, which is greater than the national average of 34.2% (Arizona Department of Health Services, 2016). The life expectancy in Arizona is 76.3 years as reported on life expectancy at birth by state (CDC, 2022). The Vail community located in Vail, Arizona, consists of a population of 13,604 in 2020 according to the U.S. Census Bureau (2023). The Vail community located in Pima County has a small primary care clinic that branches off from other rural clinics located in Benson, Arizona in Cochise County. This clinic, known as Vail Valley Family Healthcare Clinic, has a large patient population of 65 and over individuals. The U.S. Census Bureau (2023) currently reports that 13.8% of the Vail, Arizona population is persons aged 65 and over. The U.S. Census Bureau (2023) also reports that 64.9% of individuals living in Vail, Arizona reported their race as white alone, not Hispanic or Latino. There is currently no information available on the amount of AD and EOL care planning in place about community members aged 65 and over residing in Vail, Arizona. There is currently no electronic health record (EHR) prompt on the Athena software system, used within the Vail Valley clinic, to alert the providers to discuss AD with their patients. There is a section in the EHR where the MAs can enter whether the patient has an AD or not, which could be looked up by the provider. Other than the questions on the new

patient paperwork, no other follow-up is in place regarding AD, so patients are left to ask for further information on their own.

Older adult patients, family members, providers, and clinic staff are key stakeholders involved in making sure this population is informed about AD and EOL care decisions. Providers educating their patients about what AD are, and why they are important will give this population the tools necessary to make informed EOL care decisions. These decisions, which would otherwise go unknown, could lead to costly EOL treatment measures that go against a patient's wishes and are associated with poor quality-of-life outcomes (House et al., 2022). Having buy-in from these key stakeholders allows the quality improvement project to be fully supported and ensures everyone is on board with its success during implementation at the Vail Valley Family Healthcare Clinic. Advanced Practice Registered Nurses, as well as physicians providing care, must be well-versed in providing education to patients and removing barriers when it comes to AD and EOL decisions. Other key stakeholders are clinic administrators, such as the office manager.

Intended Improvement

Project Purpose

The purpose of this project is to provide patients with education on AD so they are well-informed and can ask their provider for further guidance, if they choose, during a routine health visit. This is a quality improvement project to educate patients on AD through a brief electronic teaching session they can watch on a provided tablet while awaiting their visit with the provider. Through education and planning of the quality improvement project, the patient and provider

takeaway will enhance the knowledge of AD and allow the patient to verbalize EOL wishes, thus removing any negative stigma surrounding the topic of AD and EOL care decisions.

Project Question

Does a brief electronic educational presentation on AD presented to older adult patients at Vail Valley Outpatient Clinic increase the patients' understanding of AD and EOL care decisions and/or increase the patients' intent to discuss AD and EOL care decisions with their provider?

Project Objectives

The aim of this project is to provide patients with education on AD so they are well-informed and can ask their provider for further guidance, if they wish, during a routine health visit. The following project objectives were established to achieve this aim.

Objective 1: Create and present a brief electronic educational presentation on AD to the older adult patient population at Vail Valley Outpatient Clinic in Vail, AZ.

Objective 2: Create and present a post-survey to the same patient population determining if the educational presentation increased their understanding of AD and EOL care decisions and/or increased the patients' intent to discuss these decisions with their provider.

Objective 3: Analyze the data collected from the post-survey to determine if the educational presentation was successful utilizing a Likert scale and present findings to providers.

Theoretical Framework

Health Belief Model (HBM)

The Health Belief Model (HBM) was developed in the 1950s by social psychologists Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen Kegeles, and Howard Leventhal at the U.S. Public Health Service to better understand the widespread failure of screening programs for tuberculosis (Jones et al., 2015). The Health Belief Model has been used as a tool to define various health behavior-related characteristics: (a) to prevent disease, (b) to facilitate patient safety, and (c) to increase the degree of patient involvement in treatment (Jones et al., 2015). HBM concepts are one of the most widely applied theories of health behavior and have been used to predict if, and why, an individual will engage in health-related behaviors that will avoid, manage, and identify disease conditions (Jones et al., 2015).

The HBM is one of the first theories of health behavior and is based on six major concepts: perceived susceptibility, perceived severity, perceived threats, perceived benefits, perceived barriers, and cues to action (Jones et al., 2015). The HBM was chosen as the best fit for the proposed project. As previously mentioned, perceptions are significant drivers of one's behavior to act in a particular manner. How patients perceive illness or disease is directly proportionate to their level of understanding. Research shows that the lack of knowledge regarding AD inhibits one's ability to make informed care decisions (Waller et al., 2018). Another contributing factor related to health perceptions is how the individual rates their current health status. For example, an individual who perceives their current health status as good is more reluctant to seek out information on AD and EOL care decisions than someone who perceives their health status as poor (Waller et al., 2018). Demographic variables, such as age,

and psychological characteristics, such as personality, are also factors in an individual's willingness to seek out information on AD (Waller et al., 2018). Increased awareness of the benefits of AD and EOL care decisions will provide the older adult population with the tools they need to make the best decisions about their care (Waller et al., 2018).

Perceived Susceptibility and Perceived Severity

First, perceived susceptibility relates to the individual's subjective perception of the likelihood of having a specific disease or condition. The HBM predicts that individuals who perceive that they are susceptible to a particular health problem or condition will engage in behaviors to reduce their risk of developing that problem. Individuals with low perceived susceptibility may deny that they are at risk of contracting a particular illness or being in a particular condition (Jones et al., 2015).

Secondly, perceived severity relates to the individual's subjective assessment of how severe the disease or condition will be if developed. The HBM also proposes that the more severe an individual perceives a disease or condition, the more likely they are to engage in behaviors to reduce the severity of the condition (Jones et al., 2015). In addition, perceived benefits refer to behaviors that are influenced by the perceived benefits of acting. For example, if an individual believes that a particular action will reduce their susceptibility to a health problem, or decrease its seriousness, then the individual is more likely to engage in that behavior regardless of objective facts regarding the effectiveness of the action (Jones et al., 2015). These theories align with the QI project in that the patient may be reluctant to seek out information on their own regarding AD due to perceiving their health status as good and perceiving having an AD in place as something people only need to think about at EOL.

Perceived Barriers and Threats

Furthermore, perceived barriers and threats are an individual's perceived beliefs of things preventing them from getting something accomplished, which may hinder their success in achieving the health-promoting behavior change (Jones et al., 2015). Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behavior (Jones et al., 2015). One of the perceived barriers and threats patients may have about AD is the fear of dying, patients may also be uncomfortable discussing the topic of death and dying with family members so as to not upset them. Patients may also perceive setting up an AD as expensive, or something that can only be done by hiring a lawyer.

Perceived Benefits

Perceived benefits refer to a person's perception of the effectiveness of various actions available to reduce the threat of illness or disease (or to cure illness or disease). The course of action a person takes in preventing (or curing) illness or disease relies on consideration and evaluation of both perceived susceptibility and perceived benefit, such that the person would accept the recommended health action if it was perceived as beneficial (Jones et al., 2015). This aligns with the QI project that by having AD and EOL care decisions in place prior to the onset of illness or disease will benefit not only the patient but also the family, as it will allow them to carry out the wishes that were outlined by the patient without burdening the family to make though healthcare decisions regarding EOL.

Cues to Action

Another component of the HBM is cues to action. Cues to action focus on cues to the individual for prompting engagement in health-promoting behavior. This can be done by having internal and external cues of action to prompt the individual (Jones et al., 2015). Offering an educational presentation regarding AD during routine visits with the patient's PCP can help promote a better understanding of AD. This allows the patient to be in control of their health regarding EOL wishes while they are able to voice what they do and do not want done to them if they ever become unable to make those decisions for themselves.

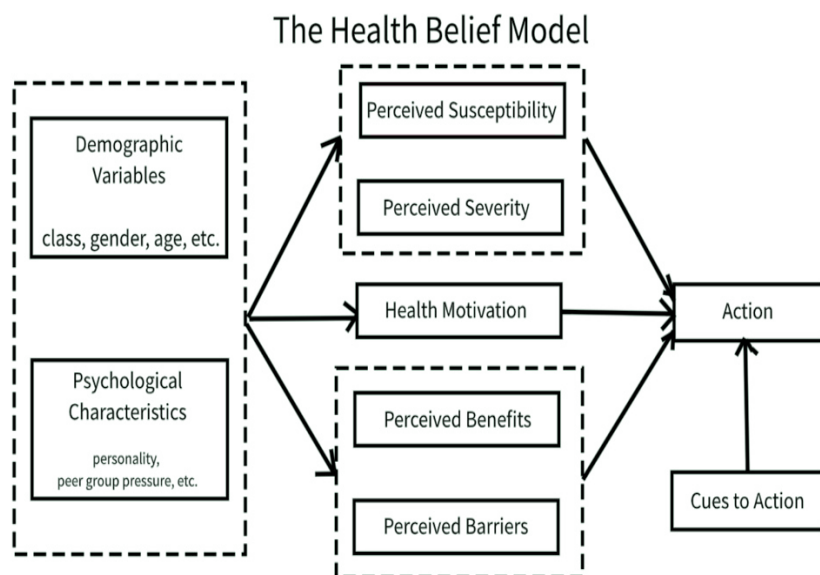
Self-Efficacy

Lastly, self-efficacy is defined as an individual's perception of his or her competence to successfully perform a behavior (Jones et al., 2015). This theory correlates to the QI project by allowing the patient to be in the driver's seat regarding their EOL care decisions. Through AD education, the patient can feel confident in knowing how to set up an AD if they choose at any time in their life.

Literature Synthesis

Evidence Search

A literature review was conducted by the project director (PD) using an extensive search on PubMed and the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database. These searches were conducted through the Arizona Health Sciences Library. The Medical Subject Headings (MESH) consisted of: "Advanced Directives AND over 65," "End-of-Life Decisions in the Elderly Population," "Medicare Cost AND Prolonging Life," and "Advanced Care Planning AND the Elderly Population."

Figure 1*Health Belief Model*

(Jones et al., 2015)

Comprehensive Appraisal of Evidence

A general search was entered on PubMed and CINAHL pertaining to just AD, which produced 3,551 articles. An updated search pertaining to AD and EOL care decisions in the 65 and over population produced 141 articles on PubMed, and 168 articles on CINAHL. An updated literature search was conducted using the same updated search criteria as listed above. From the updated search, 124 articles were produced on PubMed, and 172 on CINAHL. Articles were excluded if they contained information on patients with terminal illnesses such as cancer, patients residing in long-term care facilities and/or patients that were already on hospice or palliative care. No restriction on the date of publication was used due to limited research on Ads with these exclusion criteria. Articles were also excluded if there were duplicate studies in the search. Out of the 10 articles chosen, six of them were quantitative, two were systematic reviews

and one was a cohort study. Four major themes emerged from the articles: the importance of advance directives, normalizing advance directives, honoring end-of-life wishes, and the cost of end-of-life care.

Importance of Advance Directives

The literature review suggested that AD is important for several reasons. Research conducted by Bischoff et al. (2013) and Glass et al. (2021) indicated that advanced care planning is beneficial to patients and their families in that this population had increased quality regarding EOL care when AD was established early on in the disease process. In Bischoff et al. (2013) observational cohort mixed-methods study consisting of 4,394 elderly subjects at the end of their life who are now deceased and had a mean age of 82.6 years, 76% of the subjects engaged in advanced care planning, and decedents next of kin showed higher satisfaction rates due to feeling like their loved ones received the care they desired. 92% of patients with advance directives in this study prioritized comfort care over other types of care, likely resulting in improved QOL. The study also demonstrated that advanced care planning was associated with lower rates of hospital deaths, and an increase in the usage of hospice and palliative care, which allowed individuals to pass peacefully at home with loved ones (Bischoff et al., 2013).

Similarly, Glass et al. (2021) conducted a study consisting of 715 decedents' next of kin whose family member died at 65 years of age or older. These respondents reported that 80-90% of the decedents had discussed or had an AD in place with thought to EOL care desired. Family members also reported that the decedents with AD and EOL care decisions established prior to their passing gave positive feedback, with 95% of them stating it was the care they wanted and believed they received the right amount of care desired (Glass et al., 2021). Both Bischoff et al.

(2013) and Glass et al. (2021) concluded from their studies that higher patient and family satisfaction were reported when AD was set up before the onset of disease or illness. As discussed, the literature shows greater decedent satisfaction, lower rates of hospital deaths, increased utilization of hospice and palliative care, family members' peace of mind, and peaceful passing of the decedent when AD is established early on in the death and dying process.

Normalizing Advance Directives

Normalizing or making routine of AD was another theme that was identified in the existing body of knowledge. Atherton (2020); studied providers in a Northern Arizona private primary care clinic. The providers in the clinic expressed frustration with their current ability and standard of care regarding AD. The providers reported that only 0.8% of their established older adult patients had an AD currently in place and that evidence suggested that the best place for an AD to be established is through a patient's primary care provider (Atherton, 2020). In the multi-site cross-sectional study by Bernard et al. (2020), results of the questionnaire noted that participants did not know enough about ACP regarding EOL decisions, and that they were waiting for their provider to initiate the conversation.

Atherton (2020) Bernard et al. (2020) and Ohr (2021) similarly noted within their studies that as a society, death and dying are often not discussed until the individual is terminally ill. The studies also discussed how individuals, including family members, are often faced with having to make difficult decisions regarding their loved ones' care while laden with uncertainty and intense emotions (Atherton, 2020; Bernard., 2020; Ohr 2021). According to a study by Bernard et al. (2020), despite numerous attempts to promote advance care planning (ACP) regarding EOL decisions worldwide over the last two decades, the uptake of ACP still remains low. Study

findings also concluded that extensive literature regarding reasons for low ACP uptake consists of patients' and families' perspectives including inadequate awareness and education of ACP, societal reluctance to discuss end-of-life issues, the time-consuming process of initiating ACP EOL, and complexity/confusion about the paperwork that needs to be filled out by patients and/or family members (Bernard et al., 2020). Additionally, Bernard et al. (2020) concluded that instead of waiting for disease or illness to make important EOL care decisions, individuals need to think about EOL care when they are of sound mind to let their family know what those decisions entail.

Discussions on AD and EOL care should be done on initial and/or subsequent visits to a patient's primary provider's office, rather than being deferred only if the patient asks questions regarding AD or EOL care decisions or in the event of disease or illness (Atherton, 2020; Bernard et al. (2020). Research conducted by both Bernard et al. (2020) and Atherton (2020) discussed the importance of primary care providers discussing AD and EOL care decisions early on with patients, especially prior to any onset of disease or illness. The studies also discussed how the secondary purpose was to increase primary care provider knowledge, comfort, confidence, perceived importance, and frequency of discussions about Ads with patients. Atherton (2020) and Bernard et al. (2020) both discuss that normalizing AD in a primary care setting is needed since the majority of older adults see their primary healthcare provider on a regular basis and have developed a rapport of trust and a level of comfortability with them.

In Bernard et al. (2020) the study discussed 878 participants who met with the researchers and completed a study questionnaire, one of the ongoing findings collected from the questionnaire was that patients did not know enough about AD to ask their provider the

appropriate questions. The study also found that the majority of participants believed it should be the healthcare provider's responsibility to bring up and discuss ACP decisions regarding EOL care and not the patients. The literature shows the importance of normalizing AD discussions early on with patients in the primary care setting and not delaying them until the onset of disease or illness. The literature also suggests that the conversation is best implemented in the primary care setting as the patient has developed a sense of comfort with the provider. The study goes on to further discuss how it should be the primary responsibility of the provider to initiate the conversation rather than waiting for the patient to ask questions.

Honoring End-Of-Life Wishes

Honoring a patient's EOL wishes is something that can weigh heavily on loved ones, especially in an emergency situation where time is of the essence. What the patient envisions for EOL care does not always mirror the outcomes (Khandelwal et al., 2017; Weathers et al. 2016). From a total of 1,212 family members interviewed in the study by Khandelwal et al. (2017), 13% stated that the care of their loved one was inconsistent with the decedent's final wishes. It was reported in the study that death at home was more likely to represent consistent care and that death at a long-term care facility or hospital was more likely to represent inconsistent care (Khandelwal et al., 2017).

Findings from Khandelwal et al. (2017) and Cook et al. (2017) studies show that that the goal of end-of-life care for dying patients is to prevent or relieve suffering as much as possible while respecting the patients' desires. Both Khandelwal et al. (2017) and Weathers et al. (2016) demonstrated that study participants who had AD and EOL care decisions in place at the time of their death had higher satisfaction of the care they received and that family members reported

better peace of mind regarding honoring the decedent's final wishes. They additionally noted the most severely and terminally ill individuals did not have an AD documented in their medical record stating their healthcare preferences (Weathers et al., 2016; Khandelwal et al., 2017). These individuals reported the main reason for not having an AD in place was due to lack of awareness and education regarding EOL care decisions (Weathers et al., 2016; Khandelwal et al., 2017). Evidence in the studies also showed that if these individuals had prior knowledge about AD, they would have established them rather than having waited until hospitalization or terminal illness (Weathers et al., 2016; Khandelwal et al., 2017).

Cost of End-of-Life Care

EOL care costs can result in financial burdens to the decedent's family and loved ones, as well as driving up costs for insurers. Families may have to pay out-of-pocket expenses to afford medical equipment, medications, and private caregivers in the absence of not knowing what the decedent's final wishes were (Duncan et al., 2019; Luta et al., 2021). This also drives up the cost for Medicare in the event that the patient is hospitalized and needs expensive diagnostic testing performed, or if the patient is placed on a ventilator for life support (Duncan et al., 2019; Luta et al., 2021). It is reported that 25% of all Medicare's Annual costs are accounted for by decedents without AD in place (Duncan et al., 2019; Luta et al., 2021).

In their quantitative study, Duncan et al. (2019) used a review of the Medicare Limited Data Set (LDS). The study also found that Medicare's annual costs would be substantially lower if more older adults had AD established, which would allow them hospice and palliative programs reducing overall spending by eliminating expensive treatments in hospitals that don't alter the patient's outcome. It was also noted that the average Medicare expenditures per

decedent were greater in the last 90 days preceding death versus the last 180 days preceding death, which shows the importance of establishing AD and EOL care decisions early rather than later to avoid unnecessary and costly EOL care treatments (Duncan et al., 2019). Luta et al. (2021) also mirrored this finding in their systematic review. In this review it was noted that better patient care can be provided at lower costs for people in the last phase of life with intentional hospice and/or palliative care interventions. Having an advanced directive set in place can reduce cost and as the research indicates, it opens the door for hospice and palliative programs to be better utilized which can support patients' wishes while conserving healthcare dollars.

Strengths, Limitations, Weaknesses, and Gaps of Evidence

The literature review revealed several different strengths to support this QI project. One of the strengths noted was the number of quantitative studies as these types of studies use objective research allowing for the variables and data to be reliable and accurate (Noyes et al., 2019). Quantitative studies also look at and test hypothesis, which looks at the attitudes and opinions of a large population, this allows the reader to have a more reliable and objective insight from the data to understand the trends and patterns used within the study (Noyes et al., 2019). Bischoff et al. (2013) had the largest study size with a total of 4,394 participants, followed by Khandelwal et al. (2017) with 1, 212 participants.

One limitation in the literature synthesis was the lack of articles pertaining to the topic of AD in the older adult population not already on hospice or palliative care. The lack of updated research on the topic was also a weakness in this literature synthesis resulting in some articles reviewed that were older than five years, with the oldest being from 2013. However, these older

studies provided important information on older adults and AD. One of the articles from 2013 gave great insight as to the importance of discussing AD early in the older adult population, and how it was associated with improved quality of care at the end of life, including less in-hospital deaths and an increased use of hospice care (Bischoff et al., 2013). Another article from 2016 was a systematic review of randomized control trials, which concluded that if these (older adult patients) had prior knowledge about AD, they would have established them early on rather than having waited until hospitalization or terminal illness (Weathers et al., 2016). A third article from 2017 added to the synthesis on the topic that normalizing AD care planning discussions is a public health concern that requires an upstream approach; for example, starting the conversation early about AD with older adults in a primary care setting during routine visits (Prince-Paul et al., 2017). Lastly, an article from 2017 highlighted how common inconsistencies in EOL care were compared with the patient's wishes (Khandelwal et al., 2017). Despite the paucity of recent research on the topic, these older articles contributed significantly to the synthesis through insightful information on the topic.

Literature pertaining to AD and EOL care in the older adult population not already on hospice or palliative care is limited, which proposes challenges for providers to find research suggestive for practice implementation. Most of the research available on AD is for terminally ill patients. There is a need for further research on educating older adults on AD in a primary care setting prior to onset of severe, acute, and/or life-threatening illness.

METHODS

The Health Belief Model was utilized as a guide for this project with a focus on quality improvement. A post-survey utilizing the Likert scale was utilized to measure the outcomes of

this QI project to determine whether the patient had an increased understanding of AD and EOL care decisions and/or an increased intent to discuss AD and EOL care decisions with their provider after watching a brief electronic educational presentation. Participants without AD were recruited from the Vail Valley clinic located in Vail, Arizona. Medical assistants (MAs) provided a tablet to the participants while waiting to be seen by their provider. The tablet contained a link to an educational video on AD. After the participant watched the presentation, they completed a short post-survey to assess whether the information increased their knowledge about AD if the education increased their intent to discuss AD further with their provider during their visit, and if they had any additional questions they would like answered about AD.

Project Design

This QI project aimed to educate the elderly population on AD and EOL care planning through a presentation on an electronic device while awaiting to be seen by their primary care provider in an outpatient clinic setting. The post-questionnaire portion of the educational session was designed to gather data on the learning material presented to improve needed education on the topic. This QI project was guided by the theoretical framework of the Health Belief Model.

Model for Improvement

Plan-Do-Study-Act (PDSA) Cycle

The Plan-Do-Study-Act (PDSA) model was used to help guide this QI project and demonstrated a correlation of the steps involved in the process (IHI, 2021). The PDSA cycle is a way to plan out a change needed for a QI project and monitor the results to see if further modifications or changes are needed (IHI, 2021). The Model for Improvement (MFI) provides a framework for developing, testing, and implementing changes leading to improvement (IHI,

2021). The MFI framework consists of three questions which include: 1. What are we trying to accomplish? 2. How will we know if the change is an improvement? 3. What changes can we make that will result in improvement? (IHI, 2021). The PDSA cycle includes 4 steps, plan, do, study, and act, and is initiated once the three questions are answered. The above questions were answered as follows:

- 1) The goal of this QI project was to improve education about AD in the older adult population and to increase the patients' intent to discuss AD and EOL care decisions with their providers.
- 2) More patients discussing AD further with their provider and completing AD paperwork. This data was measured based on the feedback computed from the Likert scale used in the post-question survey.
- 3) Providing the older adult population with educational material on AD while they await to be seen by their primary care provider in an outpatient clinic.

Plan

The first component of the PDSA cycle was the 'plan' (P) for the QI project (IHI, 2021). This step included the QI project question and determining what data needed to be collected to answer the question. The next steps in the plan were to create the educational material and project proposal and submit them to the university's Institutional Review Board (IRB). Once approved, the electronic presentation session on AD was created along with the post-questionnaire. The plan involved the stakeholders and any potential threats to the success of the project were mitigated.

Do

The second component of the PDSA cycle was the ‘do’ (D), which consisted of running the test (IHI, 2021). The QI project was implemented by first recruiting participants. The MAs provided the patients with an electronic device with a short PowerPoint presentation on AD, followed by a post-questionnaire to gather the outcome data regarding increasing the patient's understanding of AD and EOL care decisions and/or increase the patient’s intent to discuss AD and EOL care decisions with their provider.

Study

The third component of the PDSA cycle was to ‘study’ (S) the results (IHI, 2021). This portion included analyzing the data collected to determine if it aligned with the anticipated outcomes, and if the post-questionnaire results determined if the patients found the session educational regarding increasing their understanding of AD and EOL care decisions and/or increasing their intent to discuss AD and EOL care decisions with their provider.

Act

The final component of the PDSA cycle is ‘act’ (A), which allows the shared outcomes to be modified and/or changed and improvements within the clinic based on the data collected (IHI, 2021). This step included how the project might be altered to enhance measured outcomes. This portion also included disseminating the findings with the clinic staff such as the providers and MAs. The PDSA cycle can be continued until the desired outcomes are achieved

Setting and Stakeholders

This QI project was implemented at the Vail Valley Family Healthcare Clinic located in Vail, Arizona. This clinic is under the umbrella of Benson Hospital, which is a rural 22-bed

hospital in the San Pedro Valley of Arizona in Cochise County. Benson Hospital joined partnership in 2018 with Tucson Medical Center (TMC), which is a 641-bed community hospital located in Tucson, Arizona. The stakeholders for this QI project were Benson Hospital and TMC administration, along with the clinic staff at Vail Valley Clinic such as the office manager, MAs, primary care providers, and patients. The Vail Valley Clinic consists of one front office assistant, one office manager, two Family Nurse Practitioners (FNP), and two MAs. The clinic providers see on average approximately 16-20 patients per day. Clinical staff were the significant stakeholders regarding this QI project. MAs were directly involved with administering disclaimer forms to the patients, along with administering the tablet that contains the presentation and post-questionnaire survey, and lastly, collecting all materials once the patient has completed them. The providers also played a significant role by providing further education on AD and EOL care if the patient desired so, and/or helping the patient to fill out forms such as a DNR. Current processes in place for AD, at the Vail Valley Clinic, include the intake form, which is a 'yes' or 'no' question asking if the patient has an AD or living will. The other only other time the topic of AD comes up is during the Medicare annual wellness visit, which is where providers refer patients, who do not have AD in place. The Five Wishes, which is a standardized packet that talks about the patients' personal, emotional, and spiritual needs, as well as their medical wishes. This packet can be filled out by the patient, then notarized by a certified notary public to make the form valid. Patients played a pivotal role as stakeholders by agreeing to participate in the educational presentation on AD and EOL care, and by giving their honest feedback through the post-survey.

Planning the Intervention

This project was implemented in a primary outpatient clinic setting over the course of one week. MAs were educated about the project, which included the MAs handing the project disclaimer (Appendix B) to the older adult population while the patient waited to be seen by their provider. The MAs were instructed to follow inclusion criteria by looking in the EHR before seeing the patient to determine if the patient is at least 65 years or older and asking whether the patient has an AD already in place. If the patient did not already have an AD documented in the EHR system, and they met the minimum age requirement, the MAs proceeded by handing the patient a project disclaimer form (Appendix B), providing the patients the tablets pre-loaded with the educational presentation and the post-survey, if the individual chose to participate, and collecting the materials after the participant completed them. The electronic device did not ask for any personal patient information to stay within compliance with the Health Insurance Portability and Accountability Act (HIPAA) and ensured no data could be altered by having a protected passcode on the settings that only the PI could access. The electronic educational session consisted of a short voice-over PowerPoint presentation with information on AD and EOL care decisions. Participants were directed to click on the link for the PowerPoint presentation to start. At the end of the presentation, there was a link to the post-survey through Qualtrics, which the participant clicked on to be directed to take the post-survey questionnaire. The post-questionnaire consisted of questions pertaining to whether the presentation increased the participants understanding of AD and EOL care decisions and/or increased their intent to discuss AD and EOL care decisions with their provider utilizing a Likert scale five question format of the following answers to choose from: strongly disagree, somewhat disagree, neither

agree nor disagree, somewhat agree, and strongly agree. Once the patient completed the educational session and post-questionnaire, they returned the electronic device to the MA for disinfecting and preparation for the next patient. Tablets consisted of two iPads that the Project Director (PD) checked out through the University of Arizona's student resources department. The PD loaded the electronic presentation from Panopto onto the iPads and embedded a link through Qualtrics into the last slide of the presentation for the patient to click on and be directed to the post-questionnaire survey.

Participants and Recruitment

The inclusion process consisted of the clinic patients aged 65 and over coming into the Vail Valley Family Healthcare Clinic to see their primary care provider, who also did not currently have an AD in place according to demographics entered in their EHR and/or the patients that stated "no" when asked if they had an AD during intake by the MA. Patients were excluded if they were currently on hospice or palliative care, not cognitively intact, and/or were terminally ill.

Consent and Ethical Considerations

Patients were able to choose to participate in the educational session at the time of administration by the MA. The patient had the option to either accept to watch the session or decline to watch. If the patient chose to watch the educational session, they were given a brief overview and disclaimer (Appendix B) of the session on the electronic device before it started. The patients were also informed they could stop the session at any time if they choose.

To ensure compliance with human subject testing appropriate ethical considerations were made, and the PD received the University of Arizona's IRB approval before starting the QI

project. Ethical medical considerations were taken into account to ensure the well-being of the participants, which included non-maleficence (to ‘do no harm’ to the patient) by not depriving the patient of their right to AD education, justice (all patients are to be treated fairly) by treating the patient fairly no matter what their EOL decisions may be, beneficence (prevention of harm to the patient) by advocating for the patient regarding their EOL care decisions, and lastly, autonomy (giving the patient the freedom to choose freely, where they are able) by allowing the patient to choose whether they would like to participate in the QI project (Young & Wagner, 2022).

Data Collection

The data collection goal was to take place over the course of one week at the Vail Valley Family Healthcare Clinic, with a goal of 10-20 participants to allow for data analysis. After the participants watched the electronic presentation on the tablet, they clicked a link embedded within the last slide of the presentation where they completed an electronic post-survey through Qualtrics consisting of four questions:

- 1) I have a better understanding of what AD are after watching the presentation
- 2) This educational presentation has increased my intent to complete my own Advanced Directive forms.
- 3) I intend to discuss End-of-Life care wishes with my family.
- 4) I have an increased comfort level to discuss End-of-Life planning with my provider.

The post-survey can be found in Appendix D. The post-survey questions were assessed using a Likert scale by asking if something was learned from the presentation, which the participant could choose “1” being ‘strongly disagree’ through “5” being ‘strongly agree.’

The data collected from the participants utilized a survey through Qualtrics, which the collected data automatically uploaded to for this QI project. This data is safely secured in Qualtrics through the University of Arizona College of Nursing. The participant data, which does not contain any personal patient information, will be kept on file through Qualtrics in a secured computer for approximately 6 years from the date of collection.

Data Analysis

The PD collected the data from the post-survey questions and analyzed the mean of the Likert scale. This was done by calculating the total number of responses for each sentiment level (i.e. 'strongly disagree,' 'disagree,' 'neither agree nor disagree,' 'agree,' 'strongly agree'), adding the totals, then dividing the totals by the total number of respondents to equal the mean of the Likert scale. Utilizing the Likert scale allowed the PI to analyze the data collected to determine if the AD presentation increased the patients' understanding of AD and intent to discuss AD with their provider.

RESULTS

The implementation period lasted for one week at the Vail Valley Family Healthcare Clinic in Vail, Arizona from March 26, 2024, to April 2, 2024. The electronic presentation on AD, via a tablet, was given to 14 participants who all met the inclusion criteria out of 21 potential participants. All 14 participants who watched the presentation also participated in the post-question survey via an embedded link at the end of the electronic presentation through Qualtrics. No demographics of participants were taken to ensure participant privacy. The post-survey questionnaire contained four questions utilizing a Likert scale with the answers consisting of: 'strongly disagree,' 'neither agree nor disagree,' 'somewhat disagree,' and 'strongly agree.'

The post-survey questionnaire consisted of the following questions: “I have a better understanding of what Advance Directives are after watching the presentation,” “this educational presentation has increased my intent to complete my own Advance Directive forms,” “I intend to discuss End-of-Life care wishes with my family,” and “I have an increased comfort level to discuss End-of-Life planning with my provider.” (Tables 1 - 4).

Table 1

Post-Survey Results – Understanding of AD

Q1 - I have a better understanding of what Advanced Directives are after watching the presentation. Page Options

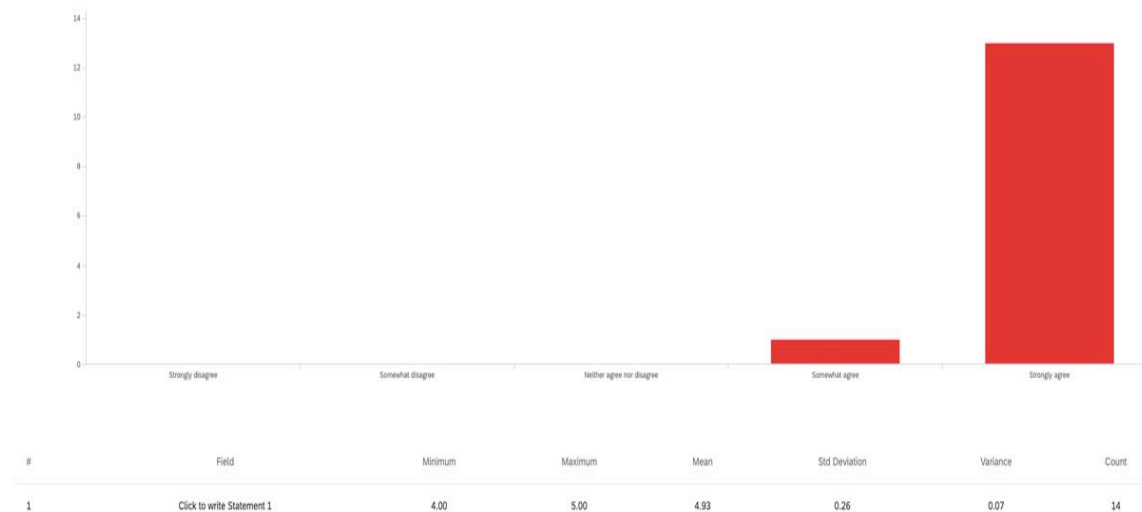
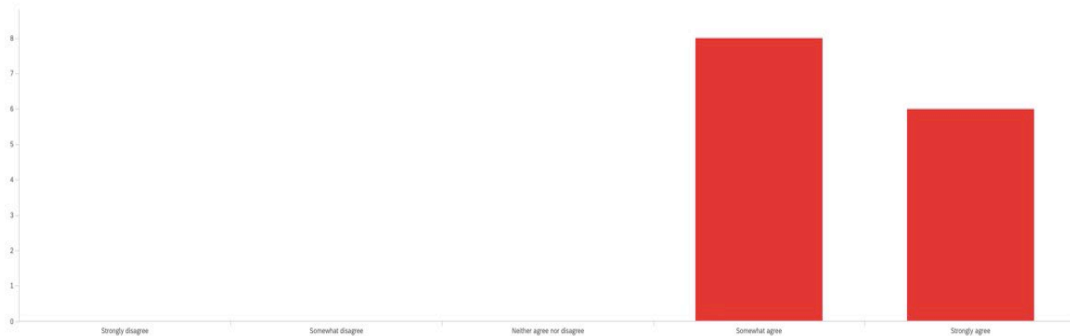


Table 2

Post-Survey Results – Intent to Complete AD

Q2 - This educational presentation has increased my intent to complete my own Advanced Directive forms.

Page Options ▾



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Click to write Statement 1	4.00	5.00	4.43	0.49	0.24	14

Table 3

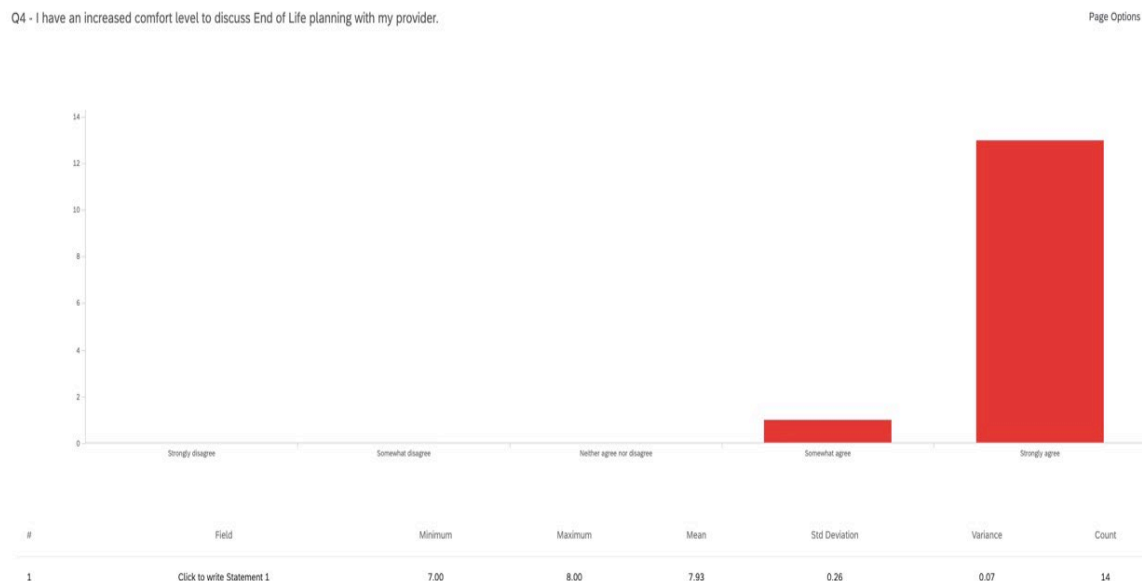
Post-Survey Results – Intent to Discuss EOL

Q3 - I intend to discuss End of Life care wishes with my family.

Page Options ▾



#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Click to write Statement 1	7.00	8.00	7.93	0.26	0.07	14

Table 4*Post-Survey Results – Increased Comfort Level to Discuss EOL***Outcomes**

The target goal set by the PD of 10-20 participants for this QI project was met. Out of the 21 potential participants, a total of 14 met the inclusion criteria for the QI project. Of those 14 participants, 13 reported that they had a better understanding of what AD is after watching the electronic presentation by choosing “strongly agree” and one participant choosing “somewhat disagree.” Six (43%) out of 14 participants reported that the presentation has increased their intent to complete their AD, with six participants choosing “strongly agree” and eight participants choosing “somewhat disagree.” 13 (93%) out of 14 participants reported that after watching the presentation they intend to discuss EOL care wishes with their family, with 13 participants choosing “strongly agree” and 1 participant choosing “somewhat disagree.” Lastly, 13 (93%) out of 14 participants reported that their comfort level with discussing EOL care

planning with their provider had increased post-presentation, with 13 participants choosing “strongly agree” and one participant choosing “somewhat disagree.”

DISCUSSION

Summary

The importance of having an AD in place has become a growing concern for the older adult population, and since only half of adults aged 65 and over have an AD in place, and up to 75% of providers are unaware if their patient has an AD in place (CDC, 2018; House et al., 2022) makes this a needed topic of discussion in the primary care setting. This QI project was developed based on the need for AD education in the primary care setting. The project focused on adult patients, aged 65 and over, without an AD in place being seen by their primary care provider in the Vail Valley Family Healthcare Clinic located in Vail, Arizona. The project was focused on educating this population utilizing an electronic presentation the patients could watch on a tablet while waiting to be seen by their provider. A post-question survey at the end of the presentation that the patients clicked on through Qualtrics showed a mean score of 4.9 on a five-point Likert scale for these patients having a better understanding of AD after watching the presentation.

Interpretation

The QI project overall was shown to have increased the older adult patients understanding of AD as measured through the post-questionnaire. Question 1 of the Qualtrics survey showed an overall successful outcome related to participants having a better understanding of AD after watching the electronic presentation. Question 2, which was the least successful of all the questions regarding outcomes, with eight out of 14 participants answering

that they *somewhat agree*, when asked if the presentation had increased their intent to complete their own AD forms. This could have been due to the participant not feeling ready and/or having a perceived barrier about AD, such as the fear of dying as discussed earlier in the HBM (Jones et al., 2015). Due to limited time, the PD had to condense a lot of information into a very short presentation, which could have hindered learning outcomes for the participant, such as feeling rushed through the presentation. With more time and education, this question may have had a more successful outcome. Question 3 showed to be successful, with 13 out of 14 participants answering *strongly agree*, that they intend to discuss EOL wishes with their family. Lastly, question 4 was shown to be successful, with outcomes showing 13 out of 14 participants *strongly agree* that they have an increased level of comfort in discussing EOL planning with their provider. Workflow within the clinic was not disturbed by the project, as the intervention was short enough that it was able to be completed while the patient waited to be seen by their provider.

Implications

Practice

The purpose and the outcomes of this QI project aligned with the supporting evidence indicating that studies show improved patient quality of care and satisfaction with overall medical care when designated healthcare preferences and EOL decisions are in place (CDC, 2016; House et al., 2022; Glass et al., 2021; Prince-Paul et al., 2017). This QI project demonstrated an increase in understanding of AD and intent to communicate with the provider. This QI project demonstrated that clinical outcomes can be improved for patients by allowing them to voice their wishes for EOL care, which ensures they do not receive any unwanted life

sustaining treatments and/or family having to make decisions on their behalf in an emergency. This intervention is easy to implement in the outpatient setting, which allows it to be implemented seamlessly without distraction.

Education

The educational presentation on AD through an electronic device, even though brief, is successful in providing older adult patients with important information regarding their EOL decisions. This QI project has proven to be effective not only by providing general information on AD, but also by assessing the patients' comfortability and intent to discuss the topic further with their provider and loved ones. This aligns with the research conducted by the PD that as a society, death and dying are often not discussed until the individual is terminally ill, which increases the importance for more patient education regarding EOL decisions (Atherton, 2020; Bernard, 2020; Ohr, 2021). Since the presentation was concise, it was effective for patient education with positive outcomes. The project topic and research did highlight a need for more Nurse Practitioner (NP) education regarding difficult conversations with patients related to AD and EOL care decisions. This educational intervention is easy for primary care providers to adapt into their current clinic workflow to prevent missed opportunities in addressing AD and EOL with their patients.

Research

There is a lack of updated research on AD in the older-adult population, especially for those individuals not already receiving hospice or palliative care (Bischoff et al., 2013). This could be one of the underlying reasons why this patient population does not know when it is appropriate to ask for information regarding AD, or when to start discussing EOL care decisions.

Further research on this topic is needed to determine the underlying reasons why so many older adults do not have an AD in place. Some of the limited research on the topic suggests that the conversation between providers and patients is not happening until the client is hospitalized or terminally ill (Weathers et al., 2016). Other research indicated that due to time constraints of the provider, makes it difficult to have time for discussions regarding AD and EOL care decisions (House et al., 2022). There is also little to no follow-up in primary care clinics regarding AD, such as provider prompts on the EHR system alerting providers to ask and/or discuss AD, other than the question on an intake form asking if the person has an AD or living will, which is a closed-ended question (House et al., 2022). This project adds to current evidence on the importance of patient education regarding AD by educating patients early regarding EOL decisions. This project aligns with the research regarding the effectiveness of educating patients in their provider's office while waiting to be seen by their provider.

Policy

Federal funding is needed to strengthen EOL initiatives, such as having standardized methods implemented into practice to alert healthcare providers to discuss the topic. Mandating AD education for all Medicare enrollees, along with increasing reimbursement for providers completing AD information in patient's records are also needed to strengthen this gap in care. More funding is also needed for research on this topic from a primary care perspective.

Limitations

Due to the limited time for intervention, one of the limitations of this project was that the sample size may not have been truly representative of the clinic population regarding older adults without an AD in place. Another limitation could have been the length of the educational

presentation, such as being too short for the patient to fully understand in such a minimal amount of time.

DNP Essentials Addressed

The Doctor of Nursing Practice (DNP) Essentials are the foundational outcome competencies deemed necessary for all graduates of a DNP program (American Association of Colleges of Nursing [AACN], 2006). Eight DNP essentials guide and inform all components of the doctoral nursing education experience (AACN, 2006). These essentials align with this DNP project as outlined below.

DNP Essential I: Scientific Underpinnings for Practice

This DNP Essential was addressed with this QI project as it focuses on the life process, human behavior, and the optimal function of human beings, sick or well. This DNP Essential is demonstrated by the PD by focusing on future and current practice issues related to educating the older adult patient on AD and EOL care planning guided by ethics. The DNP Essential has prepared the PD to educate this population utilizing new practice approaches using nursing-based theories.

DNP Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

This DNP Essential was addressed by creating a QI project that was implemented in a local family healthcare clinic. The PD first discussed the emerging practice problem with clinic staff, then the PD looked at the health needs related to a target group of patients based on the clinical needs within the organization, the PD assessed that there was a systems issue within the organization for AD follow-up, as the only time AD was addressed was during new patient

intake. The PD then chose the older adult population as the focus to educate on AD based on the needs of the clinic. The PD assessed the improvement strategies utilizing a QI project in creating an electronic presentation the patient population could watch on an electronic device while they waited to be seen by their provider. The PD also addressed this DNP essential by maintaining leadership of the project throughout the process by incorporating stakeholders throughout the project implementation, providing feedback regarding data collection from post-survey results submitted by the participants, along with utilizing the PDSA cycle to guide implementation of this project.

DNP Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

This DNP Essential was addressed by selecting scholarly peer reviewed journals and articles that the PD analyzed to critically appraise the chosen literature. The PD was also guided by evidence to determine best possible outcomes from meaningful data that would address gaps in the findings.

DNP Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

This DNP Essential was addressed by the utilization of information technology which was utilized throughout the DNP project by creating an electronic presentation on AD that the patient population watched on a tablet. Improvement and transformation were evaluated through Qualtrics, which is an online survey the patient clicked on electronically at the end of the presentation in order to collect their results for the PD to analyze for best outcomes.

DNP Essential V: Health Care Policy for Advocacy in Health Care

This DNP Essential was addressed through plans for healthcare policy that were demonstrated by the PD by creating a QI project related to AD change within an organization for better outcomes of care through education. The PD acted as an advocate for policy change by educating stakeholders on a recognized gap in care and the need for process improvement.

DNP Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

This DNP Essential was addressed by the PD through functioning as a collaborative team member with clinic staff at the Vail Valley Family Healthcare Clinic where the QI project was implemented. The PD demonstrated highly effective communication amongst all stakeholders along with demonstrating interprofessional leadership through patient education and data results to clinic staff.

DNP Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

This DNP Essential was addressed by the PD through analyzing data and outcomes of gaps in population health related to AD in the older adult population.

DNP Essential VIII: Advanced Nursing Practice

This DNP Essential was addressed by the PD utilizing advanced levels of clinical judgment by designing, delivering, and evaluating evidence-based care to improve patient outcomes in a clinical setting. This project will affect this PD as a future NP in practice through identifying a need for change through QI.

Conclusions

Overall, providing the older adult patient with an electronic presentation on AD, while they wait to be seen by their provider in an outpatient clinic setting demonstrated to have effective outcomes without disrupting workflow in the clinic. Outcomes measured by the PD through the Qualtrics survey gave much insight into the overall success of the project, along with areas of potential improvement. The MFI provided a framework and guide for developing, testing, and implementing changes leading to improvement throughout this QI project (IHI, 2021). The Health Belief Model was a theoretical guide for this project with a focus on quality improvement. The post-survey, which utilized the Likert scale, showed that the outcomes of this QI project was effective and beneficial to the patient population. Organizational support acted as a key factor in the implementation process of this QI project. Having buy-in from the organizational stakeholders was an essential part of planning, implementing, and outcomes to ensure the success of this project. The PD can take learned experiences from this QI project into future practice by identifying gaps within an organization and working with stakeholders to implement change through the leadership of a QI project.

Plan for Sustainability

The PD presented the positive outcome findings of the project results to the organization. The PD recommended that the Vail Valley Family Clinic implement the project as is or have someone take over from the organization in order to implement and repeat the PDSA cycles until the desired outcomes have been achieved by the organization lead. One suggestion to the clinic by the PD was to put the information on AD in a pamphlet instead of having the patient watch an electronic presentation for its success to continue. Another recommendation by the PD is

strengthening the processes in the EHR system, such as enabling notifications for patients 65 and older with each new patient encounter. There is also a need for process improvement to fill the gaps of this population not having the education to make an informed decision on AD and EOL care decisions. By providing opportunities for AD and EOL discussions this can have a profound effect on increasing patients' knowledge on the subject and allow their wishes to be carried out.

Plan for Dissemination

The PD provided the clinic manager with a copy of the electronic presentation in paper form, along with information and local resources to help guide patients in establishing their AD if they desired. The project was also disseminated by the final project defense through the university. The PD intends to disseminate the project externally in the form of an educational poster.

Funding

No funding was required for this QI project.

APPENDIX A

SITE APPROVAL / THE UNIVERSITY OF ARIZONA INSTITUTIONAL REVIEW BOARD

APPROVAL LETTER

Vail Valley Clinic

13370 East Mary Ann Cleveland Way #102

Vail, Arizona 85641

February 5, 2024

University of Arizona Institutional Review Board
c/o Office of Human Subjects
1618 E Helen St
Tucson, AZ 85721

Please note that Ms. Yvett Valencia (Eve), UA Doctor of Nursing Practice student, has permission of the Vail Valley Family Healthcare Clinic to conduct a quality improvement project at our facility for her project, "Improving Older Adult Patient Education Regarding Advance Directives."

Ms. Valencia will conduct a voluntary survey after showing a presentation on advance directives to the older adult patients (65 years or older) at the clinic. Ms. Valencia's activities will be completed by December 2024.

If there are any questions, please contact my office.

Signed,

A handwritten signature in black ink that reads "Karen Martin". The signature is written in a cursive style with a large, sweeping flourish at the end.

Karen Martin

Office Manager



University of Arizona IRB
845 N Park Ave., Suite 537A
Tucson, AZ 85719
Fax: 520-621-9810
VPR-IRB@arizona.edu

NOT HUMAN RESEARCH

March 22, 2024

Yvett Valencia

Dear Yvett Valencia:

On 3/22/2024, the IRB reviewed the following submission:

Type of Review:	Initial Study
Title:	IMPROVING OLDER ADULT PATIENT EDUCATION REGARDING ADVANCE DIRECTIVES
Investigator:	Yvett Valencia
IRB Submission ID:	STUDY00004380
Sponsor:	None
Prime Sponsor:	None
IND, IDE, or HDE:	None
Documents Reviewed:	<ul style="list-style-type: none"> • Advisor Attestation for Yvett Valencia.pdf, Category: Institutional Approval; • IRB Protocol for Determination of Human Research -2.docx, Category: IRB Protocol; • Participant Presentation.docx, Category: Participant Material; • Post Survey Questionnaire.docx, Category: Participant Material; • Site Authorization Letter 2024 Vail Valley.docx, Category: External Site Authorization; • Vail Valley Disclaimer Form.docx, Category: Consent Form; • Vail Valley Recruitment.docx, Category: Recruitment Materials;

The IRB determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.





University of Arizona IRB
845 N Park Ave., Suite 537A
Tucson, AZ 85719
Fax: 520-621-9810
VPR-IRB@arizona.edu

IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are research involving humans in which the organization is engaged, please submit a new request to the IRB for a determination.

All Covered Individuals must disclose all sponsored and non-sponsored Research Projects to the Office for Responsible Outside Interests (OROI) prior to Conducting Research if the individual is an Investigator. Please visit the [OROI](#) website for more information.

We value your feedback and would appreciate you taking the time to complete our survey about your experience with the IRB staff:
https://uarizona.co1.qualtrics.com/jfe/form/SV_chQ04WxNA06b42i.

If questions arise at any time during your study, please email the general IRB inbox at VPR-IRB@arizona.edu.



APPENDIX B

CONSENT DOCUMENT (DISCLAIMER FORM / PROJECT DIRECTIONS)

Disclaimer Form

The purpose of this project is to introduce advance directives and bring awareness of what they are to the older adult population.

If you choose to take part in this project, you will be asked:

1. View a short presentation on Advanced Directives provided by the staff
2. Complete a four-question survey at the end of the presentation.

It will take approximately 5-10 minutes to listen to the presentation and answer the two survey questions.

There are no foreseeable risks associated with participating in this project. You will receive no immediate benefit from your participation. Your responses are anonymous and no personal or identifying information will be obtained or recorded. Nothing that identifies you will be linked to your answers.

If you choose to participate in the project, participation is voluntary. Starting the presentation implies that you agree to participate in this project. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and the care you receive at this clinic will not be negatively affected in any way. You may withdraw at any time from the project. In addition, you may skip any question that you choose not to answer. By participating, you do not give up any personal legal rights you may have.

Project Directions

1. Please make sure you read the sections above.
2. Click on the link to the presentation on the tablet screen and view the presentation
3. Answer the four post-survey questions after the presentation.
4. When you are done, please return the tablet to the Medical Assistant.

For questions, concerns, or complaints about the project, you may call the Principal Investigator Yvett Valencia, BSN-RN, DNP-FNP student at (520) 425-9899.

APPENDIX C
RECRUITMENT MATERIAL (RECRUITMENT SCRIPT)

Hello,

My name is Yvett Valencia and I'm a student at the University of Arizona in the Doctor of Nursing Program. I'm studying to become a Family Nurse Practitioner. I'm doing a quality improvement project, focusing on advance directives in the older adult population (65 years and over). Advance Directives are individualized forms specifying your wishes in the event you are not able to. This project aims to increase awareness of these forms so that individuals, such as yourself, are well-informed about the important role Advanced Directives play in End-of-Life care planning. Thank you so much for taking the time to listen to this presentation and participating in this project. Please read the **disclaimer form** about what this project entails before beginning.

APPENDIX D
EVALUATION INSTRUMENTS (QUALTRICS POST-SURVEY)

Qualtrics Post-Survey



I have a better understanding of what Advanced Directives are after watching the presentation.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Click to write Statement 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

This educational presentation has increased my intent to complete my own Advanced Directive forms.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Click to write Statement 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I intend to discuss End of Life care wishes with my family.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Click to write Statement 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I have an increased comfort level to discuss End of Life planning with my provider.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Click to write Statement 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



APPENDIX E

PARTICIPANT MATERIAL (PRESENTATION OUTLINE / VOICE OVER SCRIPT /
POWERPOINT PROPOSAL DEFENSE SLIDES)

Presentation Outline

What are Advance Directives?

- Advance directives are legal documents that allow you to voice your wishes regarding future medical care/treatment in the event that you become unable to do so for yourself.



Why Do We Need Them?

- Advance directives are legal documents that provide instructions for medical care and only go into effect if you cannot communicate your own wishes.
- Advance directives specify where you want to stay during your end-of-life care, such as hospice or at home.



Durable Power of Attorney for Health Care

- Appoint a family member, close friend or lawyer to be your “agent” to speak on your behalf. An agent is a person you designate to make your decisions if you were not able to do so.



Durable Power of Attorney for Health Care (CONTINUED)

- The agent:
 - Will speak for you only if you become incapacitated due to illness or injury.
 - Can make treatment decisions (how/who), medical facilities, organ donation, and what to do with your body after death.
 - Cannot revoke wishes from a living will.



What's the difference?

- Durable Power of Attorney for Health Care
 - Appoint an agent to make medical decisions for you if you were to become incapacitated.
- Durable/Non-Durable Financial Powers of Attorney
 - Someone you appoint to make financial decisions if you were not able to do so.



Living Will

- An instruction list to your physician, family, and friends that outlines what type of life-sustaining procedures you want in the case of a life-threatening event.
- Outlines wishes to allow for a natural death using comfort measures only if wanted.



What's the difference?

- Living Will
 - Medical and health care wishes not requiring a lawyer.
- Wills & Living Trusts
 - Complex legal documents requiring a lawyer that addresses how your property and assets will be transferred after your death.



Frequently Asked Questions About Advance Directives:

- **Do I need a lawyer to complete an Advance Directive?**

No, you do not need a lawyer to complete advance directives in Arizona.

- **When should I begin to think about completing advance directives?**

Now, anyone over 18 years of age can have an advance directive. It is never too early to be prepared



Resources:

Making an advance directive is free and straightforward

For more information and forms go to:

End of Life Care Planning, call (520) 790-7262 or visit azendoflifecare.org.

Free advance care planning legal forms available at TMC for Seniors, 2695 N. Craycroft Road on the Palo Verde Campus. To make an appointment with an ACP volunteer call (520) 324-1960.

Free Notary Advocate Program – (520) 383-3905 Hours of operation 8:00 a.m. to 3:00 p.m. Two notaries available but work specific hours, please call ahead. Please call to make an appointment.

Life Care Planning packet and individual forms on the Attorney General's website or by calling the Community Outreach and Education Section at (602) 542-2123.



Voice Over Script

Hello and thank you for participating in this electronic presentation on advance directives.

What are advance directives? Advance directives are legal documents that allow you to voice your wishes regarding future medical care, in the event that you become unable to do so for yourself.

Why do we need them?

Advanced directives are legal documents that provide instructions for medical care, and only go into effect if you cannot communicate your wishes.

Advance directives specify where you want to stay during your end-of-life care, such as hospice or at home.

What is the durable power of attorney?

It's when you appoint a family member, close friend or lawyer to be your agent, to speak on your behalf. An agent is a person you designate to make your decisions. If you are not able to do so yourself, the agent will speak for you only if you become incapacitated due to illness or injury.

The agent can make treatment decisions, such as which medical facility you will go to, organ donation and what to do with your body after death. An agent cannot revoke wishes from a living will.

So, what's the difference?

A durable power of attorney for health care is someone you appoint as an agent to make medical decisions for you if you were to become incapacitated.

A durable, non-durable financial power of attorney is someone you appoint to make financial decisions if you were not able to do so yourself.

What is a living will? It's an instruction list to your physician, family and friends that outlines what type of life sustaining procedures you want in the case of a life threatening event. It also outlines wishes to allow for a natural death using comfort measures only if you wanted. It also lifts the burden off of family members having to make those tough medical care decisions on your behalf.

So, what is the difference between a living will and a will and living trust?

A living will is a document outlining medical and health care wishes, not requiring a lawyer.

A will and living trust are complex legal documents requiring a lawyer that addresses how your property and assets will be transferred after your death.

Frequently asked questions about advanced directives. Do I need a lawyer to complete an advanced directive?

No. You do not need a lawyer to complete an advanced directive in the state of Arizona.

When should I begin to think about completing an advanced directive?

Now. Anyone over 18 years of age can have an advanced directive. It is never too early to be prepared. Please proceed to take the post-survey in paper format.

When you are through, please notify the Medical Assistant for gathering of the post-survey.

Thank you for participating in this electronic presentation on advanced directives.

PowerPoint Proposal Defense Slides

6/3/24

▲▲▲
**IMPROVING OLDER ADULT
 PATIENT EDUCATION
 REGARDING ADVANCE
 DIRECTIVES**

Yvett Valencia, BSN, RN, DNP-FNP Student



1

BACKGROUND

- Systematic review found strong evidence that patients with designated end-of-life care decisions have improved satisfaction regarding their healthcare and quality of life (CDC, 2016; House et al., 2022; Glass et al., 2021).
- 56% of the older adult population (people aged sixty-five and over) do not want to burden their loved ones with EOL care decisions (Prince et al., 2017).

2

**BACKGROUND
 (CONTINUED)**

- Studies show that rising healthcare costs near EOL do not mean improved quality of care for the patient (Klingler et al., 2016).
- Studies also show that less deaths occurred in inpatient settings when AD were in place, which mirrored patient's wishes regarding EOL care (Orlovic et al., 2020).

3

DID YOU KNOW?

Only two-thirds of all Americans have a living will outlining healthcare preferences and/or EOL wishes.



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6/3/24

LOCAL PROBLEM

48.4% of the population in Arizona are persons aged sixty-five years and older, the national average is 34.2% (Arizona Department of Health Services, 2016).

13.8% of the population in Vail, Arizona are persons aged 65 and over (The U.S. Census Bureau, 2023).



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LOCAL PROBLEM (CONTINUED)

- No electronic health record (EHR) prompt on software system used within the Vail Valley clinic to alert providers.
- No other follow-up in place regarding AD, so patients are left to ask for further information on their own.



6

INTENDED IMPROVEMENT

To provide patients with education on AD so they are well-informed and can ask their provider for further guidance.

IMAGE CAPTION



7

INTENDED IMPROVEMENT (CONTINUED)

- Quality improvement project educating patients on AD through a brief electronic teaching session.
- Enhance the knowledge of AD and EOL care decisions.



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6/3/24

PROJECT QUESTION

- Does a brief electronic educational presentation on AD presented to older adult patients at Vail Valley Outpatient Clinic increase the patients' understanding of AD and EOL care decisions and/or increase the patients' intent to discuss AD and EOL care decisions with their provider?

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PROJECT OBJECTIVES

- 1: Create and present a brief electronic educational presentation
- 2: Create and present a post-survey
- 3: Analyze the data collected from the post-survey

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THEORETICAL FRAMEWORK (THE HEALTH BELIEF MODEL)

- Perceptions are significant drivers of one's behavior to act in a particular manner
- How patients perceive illness or disease is directly proportionate to their level of understanding
- Research shows that the lack of knowledge regarding AD inhibits one's ability to make informed care decisions

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LITERATURE SYNTHESIS

- Literature review conducted by project director using PubMed and the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database.
- Searches were conducted through the Arizona Health Sciences Library.
- Four major themes from articles: importance of advance directives, normalizing advance directives, honoring end-of-life wishes, and cost of end-of-life care.

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6/3/24

METHODS

- A guide for this project was the Health Belief Model with a focus on quality improvement
- A post-survey utilizing the Likert scale will be utilized to measure the outcomes of this project
- Participants without AD will be recruited
- Medical assistants will provide a tablet to the participants
- The tablet will contain a link to an educational video on AD
- After the participant watches the presentation, they will complete a short post-survey

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PROJECT DESIGN

- QI project aims to educate the 65 and over population on AD and EOL care planning through a presentation on an electronic device
- Post questionnaire portion is designed to gather data on the learning material presented to improve needed education on the topic
- This QI project was guided by the theoretical framework of the Health Belief Model.

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MODEL FOR IMPLEMENTATION

- The Plan-Do-Study-Act (PDSA) model was used to help guide this QI project
- The PDSA cycle is a way to plan out a change needed for a QI project and monitor the results

This PDSA by Unknown Author is licensed under [CC BY-SA](#)

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SETTING AND STAKEHOLDERS

- This QI project is set to be implemented at the Vail Valley Family Healthcare Clinic located in Vail, Arizona.
- This clinic is under the umbrella of Benson Hospital
- Benson Hospital joined partnership in 2018 with Tucson Medical Center (TMC)
- Stakeholders for this QI project are Benson Hospital and TMC administration, along with the clinic staff such as the office manager, MAs, primary care providers and patients

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PLANNING THE INTERVENTION

- Project to be implemented in a primary outpatient clinic setting over a course of one week
- Project director will educate MAs and clinic staff on project
- MAs will give qualified patients a disclaimer form regarding the project, tablet with presentation, and instructions on post survey

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PARTICIPANTS AND RECRUITMENT

- Inclusion process will consist of clinic patients aged 65 and over coming into the Vail Valley Family Healthcare Clinic to see their primary care provider
- No current AD in place
- Excluded if on hospice or palliative care, not cognitively intact, or are terminally ill

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CONSENT AND ETHICAL CONSIDERATIONS

Patients can choose to participate in the educational session at the time of administration by the MA. The patient has the option to either accept to watch the session or decline to watch

THE PD will comply with the University of Arizona's IRB prior to starting the QI project.



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CONSENT AND ETHICAL CONSIDERATIONS (CONTINUED)

- Ethical medical considerations were taken into account to ensure the well-being of the participants, which include:
- Non-maleficence (to do no harm to the patient)
- Justice (all patients are to be treated fairly)
- Beneficence (prevention of harm to the patient)
- Autonomy (giving the patient the freedom to choose freely) (Young & Wagner, 2022).

20

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6/3/24

DATA COLLECTION

- Data collection to take place over one week at the Vail Valley Family Healthcare Clinic
- Goal of 10-20 participants

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PRESENTATION

22

22

What are Advance Directives?

- Advance directives are legal documents that allow you to voice your wishes regarding future medical care/treatment in the event that you become unable to do so for yourself.

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Why Do We Need Them?

- Advance directives are legal documents that provide instructions for medical care and only go into effect if you cannot communicate your own wishes.
- Advance directives specify where you want to stay during your end-of-life care, such as hospice or at home.

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24

6/3/24

Durable Power of Attorney for Health Care

- Appoint a family member, close friend or lawyer to be your "agent" to speak on your behalf. An agent is a person you designate to make your decisions if you were not able to do so.

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Durable Power of Attorney for Health Care (CONTINUED)

- The agent:
 - Will speak for you only if you become incapacitated due to illness or injury.
 - Can make treatment decisions (how/who), medical facilities, organ donation, and what to do with your body after death.
 - Cannot revoke wishes from a living will.

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What's the difference?

- Durable Power of Attorney for Health Care
 - Appoint an agent to make medical decisions for you if you were to become incapacitated.
- Durable/Non-Durable Financial Powers of Attorney
 - Someone you appoint to make financial decisions if you were not able to do so.

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Living Will

- An instruction list to your physician, family, and friends that outlines what type of life-sustaining procedures you want in the case of a life-threatening event.
- Outlines wishes to allow for a natural death using comfort measures only if wanted.

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What's the difference?

- Living Will
 - Medical and health care wishes not requiring a lawyer.
- Wills & Living Trusts
 - Complex legal documents requiring a lawyer that addresses how your property and assets will be transferred after your death.

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Frequently Asked Questions About Advance Directives:

- **Do I need a lawyer to complete an Advance Directive?**
No, you do not need a lawyer to complete advance directives in Arizona.
- **When should I begin to think about completing advance directives?**
Now, anyone over 18 years of age can have an advance directive. It is never too early to be prepared

30

Frequently Asked Questions About Advance Directives: (CONTINUED)

- **Where can I find free Arizona advance directive forms?**
You can get copies of the [Life Care Planning packet](#) and the individual forms on the [Attorney General's website](#) or by calling the Community Outreach and Education Section at 602-542-2123.

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Resources

- Making an advance directive is free and straightforward
- For more information and forms go to:
<https://www.fivewishes.org/>



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Resources:

Making an advance directive is free and straightforward

For more information and forms go to:

End of Life Care Planning, call (520) 790-7262 or visit azendoflifecare.org.

Free advance care planning legal forms available at TMC for Seniors, 2695 N. Craycroft Road on the Palo Verde Campus. To make an appointment with an ACP volunteer call (520) 324-1960.

Free Notary Advocate Program – (520) 383-3905 Hours of operation 8:00 a.m. to 3:00 p.m. Two notaries available but work specific hours, please call ahead. Please call to make an appointment.

Life Care Planning packet and individual forms on the Attorney General’s website or by calling the Community Outreach and Education Section at (602) 542-2123.

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THE UNIVERSITY OF ARIZONA

Have a better understanding of what Advance Directives are after watching the presentation.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
0	0	0	0	0

Click to view answer!

This educational presentation has increased my intent to complete my own Advance Directive forms.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
0	0	0	0	0

Click to view answer!

I intend to discuss End of Life care wishes with my family.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
0	0	0	0	0

Click to view answer!

I have an increased comfort level to discuss End of Life planning with my provider.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
0	0	0	0	0

Click to view answer!

34

DATA ANALYSIS

- The PD will collect the data from the post survey questions and analyze the mean of the Likert scale

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REFERENCES

Arizona Department of Health Services. Health equity (2016, February). Retrieved November 19, 2021, from <https://www.azdhs.gov/newsroom/news-releases/health-equity/>

Centers for Disease Control and Prevention. (2016, August 4). Advance Care Planning Course. Retrieved November 19, 2021, from <https://www.cdc.gov/advancecareplanning/courses/advancecareplanningcourse.htm>

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Prince-Paul, M., & DiFrancesco, E. (2017). Uptitrating and normalizing advance care planning conversations—a public health approach. *Behavioral Sciences*, 7(2), 18. <https://doi.org/10.3390/bs702018>

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APPENDIX F
PROJECT TIMELINE

Completion Date	Planning	Pre-implementation	Implementation	Evaluation
August 2024	December 2023 – January 2024	February 2024	March 26, 2024 – April 2, 2024	June 2024 – July 2024

APPENDIX G
LITERATURE REVIEW GRID

Project Question: *Does a brief electronic educational presentation on AD presented to older adult patients at Vail Valley Outpatient Clinic increase the patients' understanding of AD and EOL care decisions and/or increase the patients' intent to discuss AD and EOL care decisions with their provider?*

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Atherton, 2020	Promoting advance directives in primary care	Quantitative	The number of ADs recorded increased by 25.4% in primary care.	Evidence suggests that the best place for advance care planning (ACP) is in primary care.
Bischoff, Sudore, Miao, Boscardin, & Smith, 2013	Advance care planning and the quality of end-of-life care in older adults	Cohort Study	<p>Seventy-six percent of subjects engaged in advance care planning.</p> <p>Ninety-two percent of advance directives stated a preference to prioritize comfort.</p> <p>Subjects who engaged in advance care planning were less likely to die in a hospital.</p> <p>Advance care planning was associated with improved quality of care at the end of life, including less in-hospital death and increased use of hospice.</p>	Evidence suggests that having an advance directive, assigning a durable power of attorney and conducting advance care planning discussions in primary care are all important elements of advance care planning.
Brown, 2019	Why many doctors still find it difficult to talk about dying with patients	Quantitative	Need for open-ended discussions with patients on AD and death and dying process.	Normalizing how providers can have an open-ended conversation with their patients in an outpatient setting.
Duncan, Ahmed, Dove, & Maxwell, 2019	Medicare Cost at End of Life	Quantitative	<p>Advance care planning reduces Medicare expenditures.</p> <p>Average Medicare expenditures per decedent per month are greater in the last 90 days preceding death versus the last 180 days preceding death, confirming the exponential increase in costs as death approaches.</p>	<p>Beneficiaries at EOL account for a significant portion of Medicare spending.</p> <p>Greater use of hospice and palliative care, with their lower cost per patient, offers the possibility of expense reduction to the Medicare program while also improving quality of life outcomes.</p>

Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
			The highest spending occurs in acute care hospitals.	
Glass, Wang, Minardi, & Kanter, 2021	Concordance of end-of-life care with end-of-life wishes in an integrated health care system	Quantitative	Meeting end-of-life wishes through discussions with next of kin and primary care providers prior to onset of disease or illness showed higher satisfaction from patients regarding EOL care.	A large proportion of decedents 65 years and older had end-of-life discussions and documentation, had their wishes met, and received the amount of care they thought appropriate.
Khandelwal, Curtis, Freedman, Kasper, Gozalo, Engelberg, & Teno, 2017	How often is end-of-life care in the United States inconsistent with patients' goals of care?	Quantitative	Among family members, 87.4% reported care consistent with decedents' wishes whom had an AD in place prior to illness. Death at home was more prevalent among decedents receiving goal-concordant care, whereas death in the hospital was more prevalent among decedents receiving inconsistent care.	The finding that decedents whose care was inconsistent with their preferences (according to informants) were more likely to die in the hospital setting (including intensive care unit [ICU]) supports this approach to measuring goal-concordant care of having an AD in place prior to onset of disease or illness.
Luta, Ottino, Hall, Bowden, Wee, Droney, Riley, & Marti, 2021	Evidence on the economic value of end-of-life and palliative care interventions	Quantitative	Evidence on cost-effectiveness relates to home-based interventions and suggests that they offer substantial savings to the health system, including a decrease in total healthcare costs, resource use and improvement in patient and caregivers' outcomes.	Decrease in healthcare costs with the use of hospice, palliative, and home-health programs as opposed to keeping patients' in the hospital to receive care inconsistent with their wishes.
Prince-Paul, & DiFranco, 2017	Upstreaming and normalizing advance care planning conversations-a public health approach	Quantitative	For most people in the United States, until a loved one is facing a serious, life-threatening illness, interest in engaging in AD discussions is often low.	Need for normalizing AD conversations early on with the older adult population in a primary care setting.
Waller, Sanson-Fisher, Ries, & Bryant, 2018	Increasing advance personal planning: The need for action at the community level	Systematic review	Adoption of advance personal planning at a community level may be achieved by using primary care settings to initiate the conversation of AD and EOL care planning.	Initiating the conversation of AD and EOL care decisions in a primary care setting to bring awareness to the older adult patient who may otherwise wait for the onset of disease or illness to have the conversation with a healthcare provider.

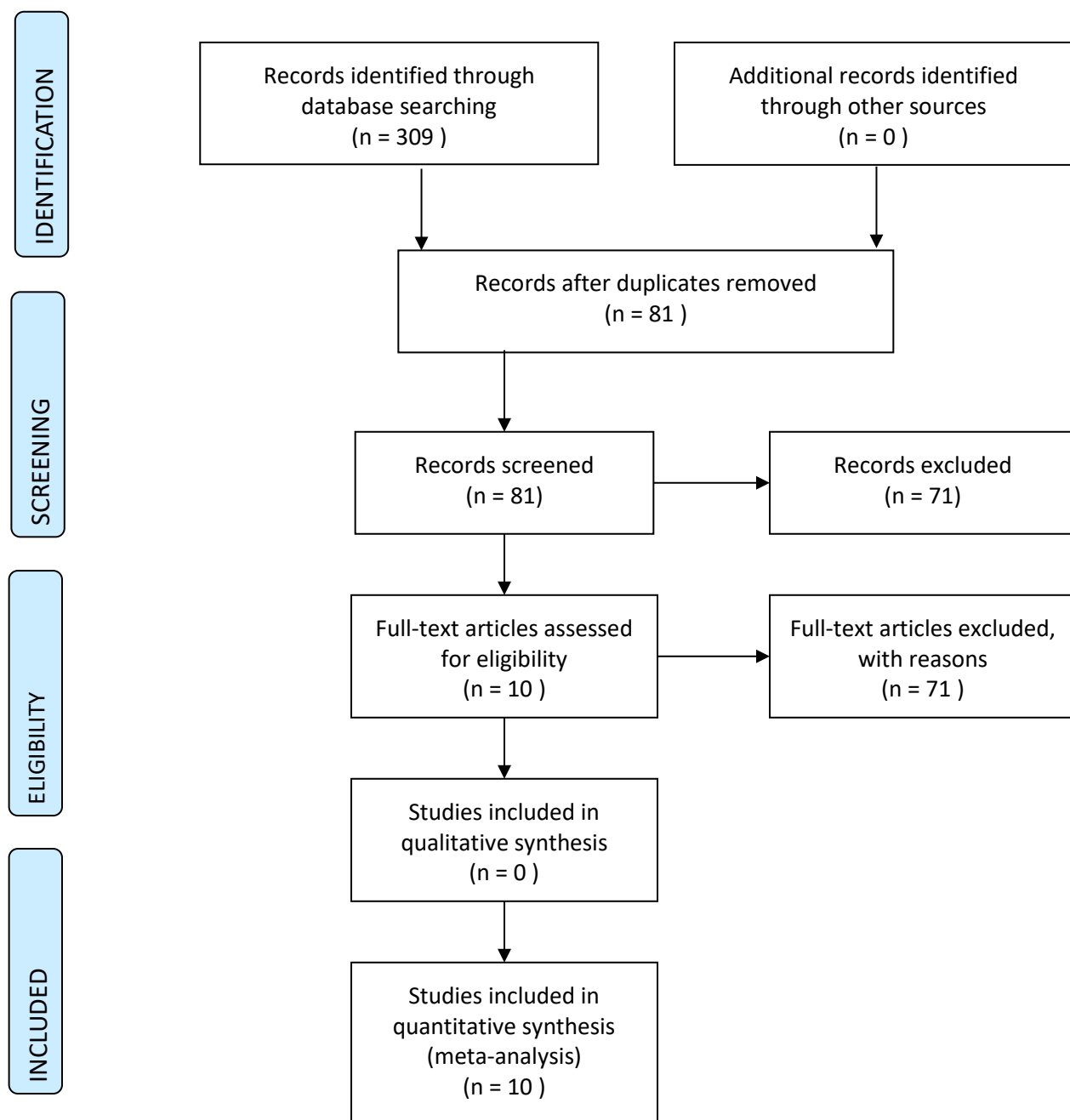
Pub. Year; Author's Last Name	Title of Publication	Type of Study	Main Outcomes of Findings	Support for and or Link to Project
Weathers, O'Caomh, Cornally, Fitzgerald, Kearns, Coffey, Daly, O'Sullivan, McGlade, & Molloy, 2016	Advance care planning	Systematic review	Advance care planning (ACP), involving discussions between patients, families and healthcare professionals on future healthcare decisions, in advance of anticipated impairment in decision-making capacity, improves satisfaction and end-of-life care while respecting patient autonomy. It usually results in the creation of a written advanced care directive.	Increase in AD and EOL care planning when discussions were brought up by providers during healthcare visits.

APPENDIX H

OTHER DOCUMENTS AS APPLICABLE TO THE PROJECT (PRISMA 2009 SEARCH
HISTORY FLOW DIAGRAM / FINAL PROJECT POSTER)



PRISMA 2009 Flow Diagram



Final Project Poster

Improving Older Adult Patient Education Regarding Advance Directives

Yvett Valencia, BSN, RN, DNP-FNP Student

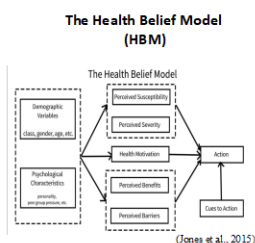
Purpose

- Quality improvement project to educate older adult patients on advance directives (AD) through a brief electronic teaching session they could watch on a provided tablet while awaiting their visit with the provider.

Background

- Reducing obesity is a priority for employers seeking to lower the incidence and severity of chronic illness and the associated demand for health care costs (HCC) and impact on productivity. (Yarborough III et al., 2018)
- ME anti-obesity programs have been shown to lower BMI and in contrast to western medicine anti-obesity interventions of pharmaceuticals and bariatric surgery. ME increases overall health while empowering the individual. (Daly, Pace, Berg, Meron, & Szalacha, 2016)
- Information and motivation alone are often not adequate to change health behavior. (Fisher, Fisher, W. A., Williams, & Malloy, 1994)
- Practicing a desired health behavior skill greatly enhances the adoption of a health behavior change. (Fisher, Fisher, W. A., Williams, & Malloy, 1994)
- This study evaluates a ME pilot program designed and implemented for city employees in Southern Arizona in 2015.

Theoretical Framework



Methods

- Fifteen Participants without an AD were recruited from the Vail Valley clinic located in Vail, Arizona.
- Medical assistants (MAs) provided a tablet to participants while waiting to be seen by their provider. The tablet contained a link to an educational video on AD.
- After the participant watched the presentation, they completed a post-survey to assess whether the information increased their knowledge about AD, and if the education had increased their intent to discuss AD further with their provider during their visit.

Results

- All 14 participants that watched the presentation participated in the post question survey via an embedded link at the end of the electronic presentation through Qualtrics.
- The post survey questionnaire contained a total of 4 questions utilizing a Likert scale with the answers consisting of: strongly disagree, neither agree nor disagree, somewhat disagree, and strongly agree.
- The post-survey questions: "I have a better understanding of what Advanced Directives are after watching the presentation", "This educational presentation has increased my intent to complete my own Advanced Directive forms", "I intend to discuss End of Life care wishes with my family" and "I have an increased comfort level to discuss End of Life planning with my provider."

Implications

- Outcomes of this QI project aligned with the supporting evidence indicating that improved patient quality of care and satisfaction with overall medical care when designated healthcare preferences and EOL decisions are in place (CDC, 2016; House et al., 2022; Glass et al., 2021; Prince-Paul et al., 2017).
- This QI project demonstrated an increase in understanding of AD and intent to communicate with the provider.

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