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Improving the Completion Rate of Advance Directives in Home Health Agencies

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has been found to be complete and satisfactory in all respects,
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Walden University
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MS, Western Governors University, 2014

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Project Submitted in Partial Fulfillment
Of the Requirements for the Degree of
Doctor of Nursing Practice

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Abstract

The number of individuals aged more than 65 years in the United States and their life expectancy has been increasing in the past decades. In spite of the presence of federal and accreditation policies recommending completion of advance directive documents by patients admitted to health care settings, advance directive completion rates are low in most health care organizations. The purpose of this study was to determine the level of advance directive completion among home health patients. The health belief model provided the theoretical framework that guided this study. A retrospective chart review was carried out in a home health agency with about 51 patients. Demographic details, including age, gender, ethnicity, nature of illness and type of health insurance were collected. Descriptive statistics were used to determine the percentage of home health patients with existing advance directives and those who do not have an advance directive. The study revealed that only 25% of the patients in the home health care agency had a completed advance directive. The finding indicate a disconnect between the recommended and the actual practice with regards to end of life issues. There is a pressing need for more complete documentation of the patient's desires and wishes regarding end of life care at home health care facilities. Documenting the patient's end of life preferences and wishes may potentially ease the decision-making process, making the end of life days less stressful for the patients and their families at the same time promoting the provision of personalized health care at the end of life.

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Table of Contents

List of Tables

List of Figures

Section 1: Overview of the Evidence-Based Project

Introduction

The older adult population is living longer. It is estimated that 72 million people in the United States will be 65 years and older by the year 2030 (Smith, 2013, p. 325). In the year 2010, the population of adults 65 years of age and older accounted for 13% of the overall population of the United States (Smith, 2013). Goldberg and Atkins (2013) posited that "only a small percentage of the population that will need nursing or home care has coverage ahead of time" (p. 1). The current social insurance system may not adequately meet the needs of this growing population. According to Healthy People 2020 (2010), older adults, especially those with disabilities, may not have the resources they need to help them stay at home; suggesting that the number of people whose personal and health care needs exceed what can be provided at their homes is likely to increase.

As people approach the end of their life, most of them prefer to remain in their homes and community surrounded by family and friends. Hall and the World Health Organization (2011) found that home is a "preferred place of care and death for most people," even though it may not always be a feasible choice (p.9). Based on the severity of the disease or condition, it may be impractical to have the needed resources to care for people at end of life at their homes. Smith (2013) estimated that the number of Baby Boomers aged sixty-five and over was about forty million in 2010 (p. 325). Some of these individuals, especially the older adults, do not have advance directives (ADs) that stipulate their end-of-life wishes. Jones, Moss, and Harris-Kojetin (2011) found that only 28% of home health patients had advance directives. ADs are decisions made by the patient that outlines their instructions about their end-of-life wishes, ensuring that their wishes are carried out (Wiesel & Alici, 2014). The document may contain two main components: a living will that stipulates health care treatment options and a durable power of attorney that appoints a surrogate to make decisions on their behalf.

Problem Statement

The Patients Self-Determination Act (1994) stipulated that all health care organizations that receive money from Medicare and Medicaid must notify patients of their right to be involved in their care. As the length of hospital stays reduces, home is becoming an extension of hospital care. Home health agencies provide care to ease the transition of patients from the hospital to the home care settings. Home health agencies deal with patients with chronic diseases and disabilities. The elderly patients are now living well into their 90s, resulting in increased homecare nursing (Miller, 2009, p. 10).

In this project, I examined the completion rate of ADs in the home health care setting. Home health care has gained recognition and popularity as more patients choose to live out their days at home instead of at long-term care facilities (Wiesel & Alici, 2014). As patients move back and forth between the hospital and home, AD documents become a vital part of their health care needs. It is imperative that the wishes of these patients be carried out. A completed AD is essential to implement patients' wishes at the end of their lives.

Project Question

What is the level of advance directive completion in the home health setting?

Purpose Statement

The purpose of the project was to enhance the quality of life of people as they approach the end of their life by assisting them to document how they would like for the end of their life to be managed if they are unable to express their wishes. The end of life decisions helps guide health care professionals in the provision of effective treatment and management of diseases according to the patient's desires. In order to serve and advocate for all home health patients, it is imperative to have a duly executed AD that specifies their end of life choices and treatment options.

Developing a program that improves the quality of life of older adults as they approach the end of life requires input from different professionals. The patient and health care professionals interact to facilitate the development and implementation of the wishes of an individual, with the goal of increasing the participation of the older adult in stipulating their end-of-life wishes using ADs for such a time that the patient may be unable to make his or her wishes known. Silveira, Kim, and Langa (2010) found that patients who had prior ADs received care that was consistent with their wishes. Primary care physicians and nurses can facilitate the program for home health patients by educating patients on the importance of having ADs. Salmond and David (2005) found that out of the 82% participants who received the paperwork, only 18% completed advance directive upon implementation of an educational intervention. These findings suggest that there are factors beyond awareness of AD completion which impact on the decision to or not to complete AD documents. The findings support development of AD documents congruent with the needs of the target groups.

Goals

To ensure the effectiveness of any program, it is imperative to include and involve representatives in the process of goal setting and objectives formation. In this project, the representatives included home health agencies, the patients, and their families. Hodges and Videto (2011) posited that involving the target population in the program development ensures support, improves implementation, acceptance, and sustainability. Representatives play the role of advocates for programs they would have otherwise resisted if they were not carried along (Hodges & Videto, 2011). In addition, representatives can become so well vested in the program that they become knowledgeable and skillful in updating the assessment data and or the program itself (Hodges & Videto, 2011). Finally, as representatives from the target population, being involved in developing goals and objectives will provide a "framework for action" (Kettner, Moroney & Martin, 2008, p. 122) and provide the basis for program planning, implementation, and evaluation.

Objectives

- To determine the level of advance directive completion in home health setting

Theoretical Foundation

Nursing theories orientate the role of nurses as they provide individualized and holistic care to the sick based on a set of concepts relating to patients beliefs and abilities (Maier-Lorentz, 2008). The health belief model is the most appropriate theory for the problem that deals with the quality of life of the older adult approaching the end of life.

Grove, Burns, and Gray (2013) posited that “as members of a practice discipline, nurses may develop research frameworks from their clinical experiences” (p. 131). The health belief model was developed to explain the widespread failure of people to participate in a program to prevent or to detect disease (Rosenstock & Strecher, 1988). Further details about this model have been provided in Section 2.

Significance of the Project

ADs had their origin from the U.S. Supreme Court in response to the landmark case of Nancy Cruzan, who was left in a vegetative state after an auto accident. Her family took the battle through the legal system in order to have the right to withdraw nourishment or medical treatment (Lewin, 1990). Consequently, the Patient Self-Determination Act was enacted in 1990 so that patients could participate in their care by stipulating their wishes. The act required health care providers who took part in Medicare/Medicaid to provide written information to patients upon admission about their rights to accept or refuse treatment.

Under the law, providers were also required to inform patients on how they will comply with their treatment choices (Morrell et al., 2008). Furthermore, patients were not to be discriminated against based on whether or not they completed Ads (Morrell et al., 2008). The DNP project contributes to the existing body of knowledge on AD completion rates in home health agencies. Completion of AD documents is ensured because it may lead to reduced stress at the end of life for the patient, health care practitioners, and for family members, consequently improving the quality of life.

Implications for Social Change

Nurses with advanced educational preparation who apply evidence-based knowledge are the hallmark of expertise and excellence. A DNP nurse uses both research and critical thinking skills and applies them to practice through evidence-based research. Having an advanced degree means holding oneself to the highest possible standard.

According to Hickman, Hammes, Moss, and Tolle (2005), about 70% to 80% of adults in in the United States have not completed ADs. Developing a simple and standardized form to be used by home health agencies can increase the rate of AD completion, improve the quality of life, reduce health care costs, facilitate the communication of a dying patient's end of life wishes, and decrease anxiety among patients and their families.

Definitions of Terms

Advance directives (ADs): ADs are decisions made by the patient that outlines his or her instruction about his or her end-of-life wishes that ensures that his or her wishes are carried out (Wiesel & Alici, 2014).

Doctor of nursing practice (DNP): The DNP is defined as the highest level of preparation for the actual practice of nursing. DNP-prepared nurses apply evidence-based knowledge in the provision of direct patient care (Zaccagnini & White, 2012).

Durable power of attorney: A legal document that gives another person authority to make health care decisions on behalf of the patient when he or she is unable to do so (Boykin, 2014).

End of life decision-making: Is a concept that is based on individual autonomy to better ensure that patients receive care consistent with their choices (Winzelberg, Hanson, & Tulsky, 2005).

Home health agency: Is an organization primarily engaged in providing skilled nursing services and other therapeutic services. Home health agency policies are established by a group of professionals that includes one or more physicians and one or more registered professional nurses to govern the services which it provides (Center for Medicare & Medicare Services, 2013).

Home health care: Is a special form of health and rehabilitation care that is offered by a qualified medic at home (Penhaker, Černý, Martinak, Spišák, & Valkova, 2007).

Home health patients: Refers to patients receiving care in a home environment.

Living will: Informs doctors and other health care professionals about the person's wishes regarding life-sustaining treatment (Boykin, 2014).

Patient Self-Determination Act (PSDA): The PSDA (1990) requires organizations that are funded by Medicare and Medicaid to empower patients to refuse or accept medical care and execute ADs (Moss, 2014).

Self-efficacy: Refers to the people's belief in their capabilities to produce given attainments (Bandura 2006).

Assumptions

1. Increasing the completion rate of ADs among home health patients can effectively reduce health care costs.

2. The AD document should be simple, easy to understand for completion by people of varying educational levels.
3. ADs should form part of the intake application form completed by patients as they are admitted to the home health agency.
4. ADs should give patients the confidence that their end-of-life decisions will be carried out

Summary

In Section 1, I presented a synopsis of the low completion rate of ADs in health care organizations, especially in home health agencies. In spite of legal requirements for completion of AD documents, a large percentage of patients in long-term care facilities have not completed AD documents. Patients can be empowered to participate actively in their care and make their wishes known. Effective implementation could contribute to the wealth of nursing knowledge and improve patient satisfaction, enhance the quality of care, decrease health care costs, and also reduce anxiety as patients and their families face uncertainties as they approach the end of life. The next section presents a review of existing literature on completion of ADs.

Section 2: Review of the Scholarly Literature

Introduction

In this project, I combine theory, knowledge, and research in order to execute a project that is evidence-based to ensure patient safety, outcome, and culturally sensitive care. The interrelation of these concepts provides a guide for the DNP project. The purpose of this project was to determine AD completion rates among home health clients. An extensive literature review was done to reflect what scholars have said on ADs, the rate of completion of ADs in the home care population, barriers to the completion of ADs, and the interventions that demonstrate an increase in the completion rate of ADs in the home care patients. In Section 2, I present a review of the scholarly literature regarding the history of ADs. The PSDA (1990), Medicare/Medicaid involvement in ADs, and impact of health care reform guide the implementation of ADs.

Literature Search Strategy

The information gathered from the literature was done electronically. A search of the following databases within ten years was conducted: CINAHL, Medline, ProQuest, PubMed, Google Scholar, and Cochrane Library. Only landmark research articles outside the 10 years were used. Terms used for the search were the following: *advance directive*, *Patient Self-Determination Act*, *completion rate of advance directives*, *theoretical framework*, *health care reform*, and *Medicaid and Medicare*. To limit the volume of articles, the publication period was limited to ten years, and full text and scholarly (peer-reviewed) journals.

History of Advance Directives

ADs emanated from two landmark cases that brought the right to refuse treatment and the concept of informed consent to the public attention in the US (Brown, 2003). The two historic cases provoked the discussion on the value of having a person's end of life preference and choices documented in the event of a catastrophic illness or injury, hence the birth of ADs. In 1975, Karen Quinlan, a patient with a history of substance abuse, was resuscitated after she went into cardiac arrest, after which she remained in a complete vegetative state. In 1976, her family fought and won the right to withdraw life support in the New Jersey Supreme Court. The court upheld the patient's right to privacy over the state's interest to preserve life. After the ventilator was removed, the patient was able to breathe on her own and was sustained for 10 years by tube feeding (Brown, 2003).

The physicians in Karen Quinlan's case were worried about a potential lawsuit that may result from withdrawing life support. The court held that medical professionals in the care of a patient whose life support has been withdrawn cannot be held legally liable after a determination has been made by the hospital's ethics committee that there was no possibility of that patient returning to a cognitive state (Annas, 2005). Similarly, in 1983, Nancy Cruzan was left in a vegetative state after an auto accident. It was during the seven-year battle that went all the way to the Supreme Court where the court upheld the decision to withdraw tube feedings and authorized the removal of tube feeding. Nancy Cruzan's case was decided in 1990. In that same year, she suffered a cardiac arrest and died (Fine, 2005).

As these cases were unfolding, states were taking notice. Arkansas became one of the first states to pass laws that allowed patients to refuse treatment that would extend their life. In 1983, Pennsylvania became the first state to enact Durable Power of Attorney Legislation for Healthcare (Brown, 2003). Some scholars have reflected on whether the intent of ADs has been achieved. This reflection will be considered under the following subheadings: completion rates of advance directives, compliance with completed advance directives, education planning for advance directives, and costs and quality of end of life care.

Completion Rates of Advance Directives

Family members of patients who had ADs reported fewer communication problems and had better use of hospice care for their loved ones (Teno, Gruneir, Schwartz, Nanda, & Wetle, 2007). According to Fried, Bradley, O'Leary, and Byers (2005), many caregivers and patients stated that their need for more communication regarding ADs was unmet. Kossman (2014) found that completion rate of ADs is correlated with how well the information is communicated to patients and their families. The finding suggest that completion of ADs can be improved by educating patients about end of life issues and ensuring sufficient details are provided to enable patients make informed decisions.

Rates of AD completion vary significantly between various ethnic groups. Among races, European Americans have the highest completion rate of 70%, follow by 35% for African Americans, 23% for Latinos, and 5% for Korean Americans among community dwelling older adults (Kossman, 2014). Johnson, Kuchibhatla, and Tulsky (2008) noted that cultural values accounted for the difference in the completion between European Americans and African Americans. Smith et al. (2008) found that European Americans had a completion rate of 80% and African Americans and Hispanic Americans had 47% respectively, with African Americans and Hispanic Americans subscribing to more life-prolonging care than European American patients. The disparities in completion of AD among different ethnic groups in the US raises question of whether AD documents are tailored to the needs of various ethnic groups.

Compliance with Completed Advance Directives

The PSDA (1990) made it mandatory for health care providers to provide patients with written information about ADs to enable them to communicate their preferences during hospital admission (Later & King, 2007). The law also required providers to give written information on how the policy would be implemented (Clarke, 2009). Hickman et al. (2005) showed that only about 20% to 30% of U.S. adults had completed ADs. ADs had limited influence on patients' end of life. It is one thing for patients to complete ADs that inform health care providers about their wishes and treatment preferences, and another for these wishes to be carried out. Perkins (2007) noted that "medical crisis cannot be predicted in detail, making most prior instructions difficult to adapt, irrelevant, or even misleading" (p. 51). Although unforeseen circumstances exist that may interrupt and possibly alter the wishes of ADs as stipulated by the patient, health care organizations have shown consistency in following the tenets of this document.

Solutions on Improving Compliance with Advance Directives

One of the ways to increase the compliance with completion of ADs is through patient education. Nurses routinely provide education to patients on a variety of topics, such as disease process, health promotion and disease prevention, medication and treatment, and other health care issues. The professional nurse is in a unique position to educate patients about ADs (Later & King, 2007). This education can be provided routinely as health care professionals encounter patients in varying degree of acuity. Educating patients about the importance of ADs should be a part of a multidisciplinary care planning. Black (2005) suggested that the distinct skills possessed by social workers place them in a good position to communicate with patients about ADs more than doctors and nurses.

With technological advances in health care, people are selecting to live out their days in the comfort of their homes. An AD is a useful instrument that spurs discussion on end-of-life issues (Tulsky, 2005). Ninety percent of patients identified as having a life-limiting illness were willing to complete ADs (Ratner, Norlander, & McSteen, 2001). Ratner et al. also noted the importance of facilitating a discussion involving end-of-life care at home.

Cost and Quality of End-of-Life Care

The short-term implication for not addressing low completion of ADs in home health care lies in the cost and quality of care. Silveira, Kim, and Langa (2010) found that patients who had prior ADs received care that was consistent with their wishes. Home health patients may not have the opportunity to express what they want to be done for them when they are unable to make their own decisions, thereby causing health care professionals to provide inadequate or inappropriate care. Over the long term, families may be in a protracted legal battle with medical professionals to resolve end-of-life issues that were not explicitly stated (Brown, 2003). For example, the battle in the landmark case of Nancy Cruzan, who was left in a vegetative state after an auto accident, raged on for many years. Her family took the battle through the legal system in order to have the right to withdraw nourishment or medical treatment (Lewin, 1990).

Patients approaching end of life or patients with incurable diseases are often faced with questions about the quality of care they will receive as they approach the end of life. Some elderly patients with chronic diseases, and patients who are physically, developmentally, and mentally challenged, are receiving care in the comfort of their home from health care professionals.

The costs and quality of care received by patients at the end of life has been the subject of many discussions. It is important to understand the role of finances and how money informs the quality of care. Patients may be subjected to unnecessary and costly treatment as they approach the end of their life (Landers, 2010). Curtis, Engelberg, Bensink, and Ramsey (2012) estimated that 25% of health care costs are spent in the final year of life. This capital outlay can be used to cater for needs that compliment patient’s wishes at the end of life if an AD document is completed. According to Giovanni (2012), large numbers of ill patients do not want life-prolonging care, suggesting a need for evidence-based interventions to promote completion of AD documents so that care can be provided based on the patients’ needs.

Patient Self-Determination Act

The PSDA (1990) was passed following the Supreme Court decision in the pivotal case of *Cruzan v. Director, 1990* (Duke, Yarbrough, & Pang, 2009). After the Supreme Court upheld the decision to withdraw tube feeding from the patient, the PSDA was enacted so that patients are able to participate in their care. Patients are given written information by their health care organizations about their right to participate in their care (Duke, Yarbrough, & Pang, 2009). The goal of the PSDA was to nurture and foster communication between health care providers and their patients by having an environment that encourages patients to become actively involved in making their decisions about their healthcare needs. The PSDA was passed as part of the Omnibus Budget Reconciliation Act (OBRA) and was implemented in 1991 (Clarke, 2009). The major stipulations of the Act were the following:

- To provide patients with written information upon admission about their right to make healthcare decisions and information on how the organization will implement those rights
- Record whether or not patients completed ADs (Clarke, 2009)
- Ensure that patients are not discriminated against based on whether they completed an AD or not
- Ensure that the provider is in compliance with state laws
- Educate staff and the community about ADs

Medicare/Medicaid Involvement in Advance Directives

In order to ensure compliance with the PSDA (1990), organizations that receive funding from Medicare and Medicaid are mandated to empower patients to accept or refuse care (Moss, 2014). The Center for Medicare and Medicaid Services (CMS) requires that facilities that receive funding from CMS establish, maintain, and implement written policies and procedure on ADs. The health care organizations are required to inform and educate patients about their rights. Moreover, the facilities have to establish a plan to help patients exercise their rights and make treatment choices and options, including the patients' right to accept or refuse treatment or care (CMS, 2012).

Impact of Health Care Reform

Health care disparity in the United States necessitated the enactment of the Affordable Care Act (ACA) of 2010. As a result of the ACA, there was an influx of patients with medical insurance coverage necessitating increased medical care. Under this new health care law, millions of people in the United States gained access to health care and preventative care. The passage and implementation of the ACA brought many positive changes in the U.S. health care system. The underinsured and uninsured are now receiving coverage. According to Buettgens and Hall (2011), the ACA will expand coverage to about 30 million uninsured people. This would reduce the number of uninsured by 70% (Buettgens & Hall, 2011). The gap between the rich and poor in the area of access to health care is closing slowly.

Before the passage of the ACA, the provisions that included advance care planning were removed. However, the Obama administration required health care professionals to provide written information to patients and authorize Medicare to cover costs related to voluntary advance planning during annual visits (Pear, 2010).

Preventative care is covered under ACA. Preventative care will ensure that covered health care screening is performed periodically and as needed. As more people participate in preventative care, many more diseases can be avoided and/or managed. According to Bodenheimer and Grumbach (2012), out of the $2.5 trillion spent on health care in 2009, preventative care accounted for 3% of the expenses. Before the passage of PPACA, little was spent on prevention. As a result, various people were not getting to their full potential for end of life care (Koh & Sebelius, 2010). The intent of the ACA was to provide health insurance that is affordable. The ACA could reduce the number of uninsured people in the United States by 70% (Schoen, Doty, Robertson, & Collins, 2011).

Theoretical Framework

Nursing theory is an invaluable aspect of nursing research. It informs nursing practice and helps nurses to develop evidence-based practices and nursing research to improve and enhance nursing practice. The practice of nursing must be based on knowledge or evidence generated through research (Grove, Burns, & Gray, 2013). The field of nursing is gaining more recognition as more nurses engage in empirical studies, resulting in the use of evidence-based practice.

Health Belief Model

The health belief model (HBM) was developed in the field of public health by a group of investigators who were confronted with finding solutions to practical problems, especially in the area of preventative care (Rosenstock, 1974). It essentially targets the belief system of people so that education can be tailored to effect positive health change

(Carpenter, 2010). The HBM has been applied in both applied and behavioral sciences, such as medicine, public health, sociology, and psychology.

HBM is a suitable framework for encouraging people to make positive health decisions to avoid undesirable outcomes. Rawlett (2011) posited that the essence of the HBM is that individual beliefs affect the actions a person takes relating to his or her health. Therefore, the HBM is more concerned about the individual perception about health behavior. According to Hodges and Videto, (2011) the core concepts applied by HBM are the following

1. Perceived susceptibility, which refers to how an individual perceives a particular threat or risk. Where someone finds themselves on the health continuum can influence the action taken to implement change. A sense of fear can be created in patients who are elderly with life-threatening disease that causes a perception of defenselessness. This perception may affect their feelings and attitude toward completing an AD to assure them that their wishes are carried. When this perception is affected, an individual may be motivated to make positive health care decisions.
2. Perceived severity works in conjunction with perceived susceptibility to create a sense of terror toward a particular disease. Perceived severity causes people who believe that a disease to be potentially deadly to take action to protect themselves (Jornet, Garcia, Berdugo, Perez, & Lopez, 2015).

3. Perceived benefit occurs when a person considers the recommended actions as the perceived benefit of taking positive steps. An AD document stipulates the wishes of a patient. As the benefits of this document are weighed through the provision of information, people's beliefs and feelings begin to change and give in to preventive actions or actions that will assure self-efficacy.
4. Perceived barriers are those obstacles that are preventative in nature. Individuals may perceive a barrier such as lack of social support, low educational attainment, or low socioeconomic status as barriers. It is important as a part of the educational program for these patients to reduce barriers when possible so that health education and health promotion programs can be effective.

Summary

Research has shown how two landmark cases contributed to the advent of ADs. The review of literature has demonstrated that even after twenty-five years of the Patient Self-Determination Act of 1990 that was enacted to engage patients and their health care providers, the aim of the Act has not been fully and completed achieved among patients in all healthcare arenas, especially in the home healthcare.

Furthermore, the literature reviewed has established that, even though the minimum requirement from Medicaid and Medicare was to provide written information to patients, this requirement has not translated to more completed advance directives by patients. As many patients are still without ADs, and significant disparity exists in the completion rate among the different ethnic groups (Smith, et al., 2008).

It is still early to fully assess the full impact of ACA on advance directives. That notwithstanding, it is expected that some progress will be made as costs related to advance care planning to discuss end-of-life wishes are picked up Medicare during annual visits with health care professionals (Pear, 2010).

The factors that influence a person's ability to make health-related changes will be explored using the Health Belief Model. The HBM suggests that the ability to engage in recommendations related to their health is solely dependent on a person's perception of their perceived susceptibility, perceived threat, perceived barrier, and perceived benefits (Hodges & Videto, 2011). These factors work to affect the decision to engage in health promotion and health educational programs to foster self-efficacy and reminders that spurs one into action. Life abhors vacuum. When an individual creates a vacuum by not being proactive about their health affairs, this vacuum must necessarily be filled when life changing health event warrants action to the taken on behalf of that individual.

Patients and multidisciplinary team of health care providers all make up the patients' care team. Empowering patients to participate in their healthcare decision-making have helped patients address their healthcare needs in a better way. An advance directive is of particular importance because it supports patient's autonomy in self-determination. Research conducted by Silveira, Kim, and Langa, (2010) between 2000 and 2006 found that patients who had ADs received care that was consistent with their wishes and preferences.

As a result of the Patient Self-Determination Act that mandated healthcare organizations to notify patients of their health care rights, steps have been taken to increase the use of ADs in those settings (La Puma, Orentlicher, & Moss, 1991). However, the law only requires them to be notified; they can decide not to complete ADs. In the home care arena, there has been increased recognition and popularity of the importance of home health care as more patients elect to live out their days at home versus the long-term care facilities. By moving back and forth between the hospital and home, it becomes imperative that not only are these home care patients aware of this document, but to understand the importance of having a duly executed one as a vital part of their healthcare needs.

Section 3: Approaches/Methods

Introduction

In Section 2, I provided a review of extant literature on AD completion, and I demonstrated the need for further research on home health agencies to determine ADs completion rates. In this section, I outline the research approach employed to explore the research problem. In particular, I discuss the evaluation methods and tools used, research design, participants, data collection and analysis, and the steps taken to uphold ethical principles in research.

Evaluation Methods and Tools

In this project, I used a retrospective chart review to data management and analysis (Figure 1). Retrospective data were collected to determine the percentage of home health patients with existing ADs and those who did not have an AD using retrospective chart review.

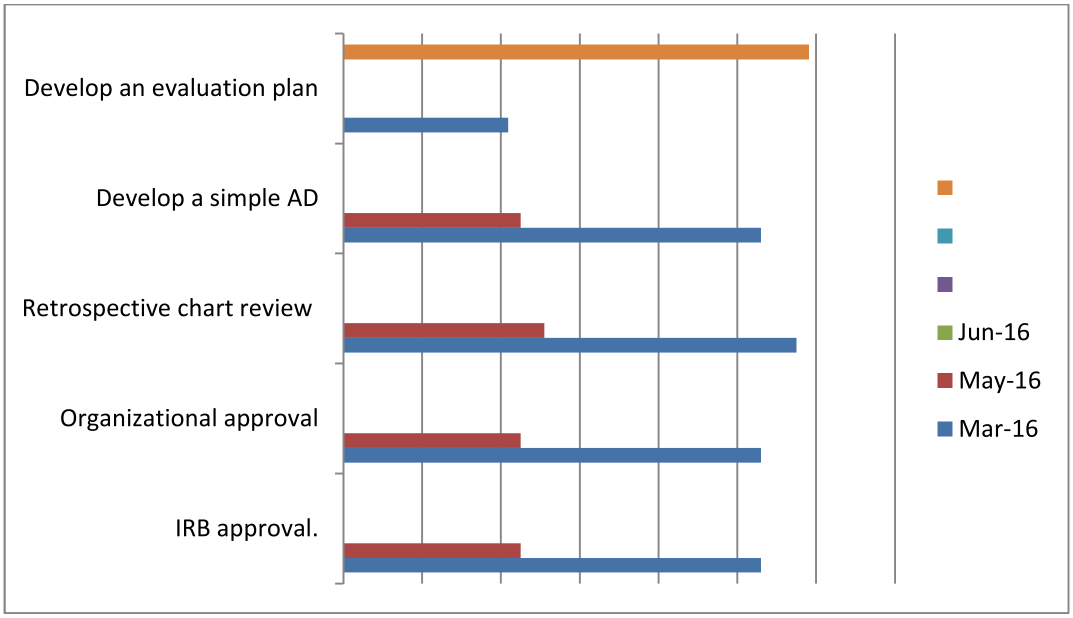

Figure 1. Gantt chart with project timeline.

Using the Iowa Model

According to Grove, Burns, and Gray (2013), the Iowa model provides guidelines for implementing patient care based on the best research evidence and monitoring changes in practice to ensure quality care (p. 505). Therefore, I selected the Iowa model to ensure that the best evidence-based research used can be adequately monitored to ensure excellent patient care and outcomes.

A potential challenge for this research was how or where to recruit a large number of home health patients who are 65 years and older. In addition, the level of literacy of participants also posed a problem. According to White and Dudley-Brown (2012), open communication builds trust and engages a person in knowledge sharing (p. 176). Factors such as socioeconomic status, age, education, race, and others affect health literacy among individuals. Older patients are slower in processing information, and nurses should make allowances for additional time for data processing and feedback during patient education.

Research Design

In this study, medical charts for patients receiving care from the home health agency were reviewed to determine the AD completion rates. Thus, the research design for this project was a retrospective descriptive study.

Participants

The participants for this project were home health patients, both temporary and permanent. Generally, patients needing care can vary in age. However, for the purpose of this study, the age group of participants ranged from 20- to 95-years-old, including male and female participants. All ethnicities were included.

Data Collection and Analysis

Retrospective data were collected and analyzed. Demographic details such as age and gender were collected to describe the characteristics of the population of interest. I collected data about the number of patients with existing ADs. Descriptive statistics including percentages, frequencies, and means were calculated for both clinical and demographic data. The collected data were entered into a table using subheadings. A spreadsheet was used to input the data from limited data sets. Each category was given a descriptive label. A tabular representation was generated, and the data were analyzed using MS Excel.

Ethical Considerations

Data collection commenced after I received institutional review board (IRB) approval to conduct research. The organization granted me institutional approval before data collection began. Identification numbers were unique to each participant and no personal identifiers such as names were used. IRB approval was obtained from Walden University, and organizational permissions was obtained from the vice president of HQC (Appendix C). The agency is primarily involved in providing private duty nurses and aides to all the participants.

Human Subject Protection

There was minimal or no risk involved in this research project. No names or direct identifiers were used; limited data sets were used. The research posed no risk to participants or their family, but had the benefit of increasing the completion rate of ADs among home health patients.

Data collected from the research were maintained in strict confidentiality and anonymity. I also obtained an Organizational Study Approval Letter from my nursing agency to enable me to have access patient files for retrospective chart review. I also received IRB approval from Walden University before any data collection commenced. In accordance with Walden University policy, before the start of any research, every researcher has to complete the National Institutes of Health (NIH) online course on protection of human research participant (see Appendix B).

Summary

The current project involved a retrospective descriptive research aimed at evaluating the completion rate of ADs among home health patients. Demographic details including age, gender, ethnicity, nature of illness, and type of health insurance were collected. No patient charts were excluded, apart from those of individuals aged less than 20 years. The data were analyzed using MS Excel to determine the means, frequencies, and the percentages. Descriptive statistics were also used to compute the ADs completion rates in the agency. Section 4 presents the results, discussions, and implications for research and practice.

Section 4: Results and Discussion

Introduction

In spite of the presence of federal and accreditation policies recommending completion of an AD documents by patients admitted to health care settings, AD completion rates are low in most health care organizations. The purpose of this research project was to determine the level of AD completion among home health patients. Retrospective chart review was used to ascertain the percentage of home health patients with ADs. A total of 51 patients' files were accessed from limited datasets at the HQC agency. The demographic information extracted included age, gender, nature of illness, years with the agency, type of medical insurance, and ethnicity. The data were analyzed using MS Excel.

Characteristics of the Participants

The data were collected from 51 patient charts at the HQC facility. Demographic data including age, occupation, race, gender, length of stay, and nature of illness were collected, and no patient charts were disqualified apart from those of minors. The data gathered were analyzed using MS Excel and I found that most of the patients were aged between 20 and 29 years (27%), and 80 years or older (22%) (Table 1). The average age of the sampled participants was 57.6 years.

Table 1

Age of the Participants

Age	Frequency	Percentage
20-29 years old	14	27
30-39 years old	4	8
40-49 years old	1	2
50-59 years old	2	4
60-69 years old	7	14
70-79 years old	11	22
80 -89	11	22
90-99	1	2
Totals (n=51)	51	100

Nature of Illness

There was a high prevalence of chronic diseases including endocrine diseases (28%), respiratory diseases (18%), neurologic diseases (90%), and cardiovascular disease (67%) (Table 2). Ten percent of the patients were wheelchair, ambulatory or bed bound, while others suffered from depression, arthritis, and blindness.

Table 2

Breakdown of Type of Illness by Body System

Neuro	Respiratory	Cardio disease	GI/GU	Psych	Endocrine	Musculoskeletal
46 (90%)	9 (18%)	34 (67%)	16 (31%)	8 (16%)	14 (28%)	10 (20%)

Type of Medical Insurance

The Medicaid insurance program was the most common form of insurance held by the sampled patient population (90%). The other type of insurance program held was the private insurance (10%). Under the Medicaid program, there were different subprograms such as REM, Medicaid waiver program, Living at Home Waiver, and Older Adults Waiver (Table 3).

Table 3

Types of Medical Insurance

Type of insurance	Number of patients (%)
Medicaid	46 (90%)
Private	5 (10%)

Place of Care Before Joining the Agency

About 48% of the sampled patient home health population had been admitted to the HQC facility following an acute admission to a hospital facility, 30% of the patients had been admitted from nursing homes, while 20% from home health care. The remaining 2% (one patient) did not have the prior locality listed on her chart at her admission to HQC agency (Table 4).

Table 4

Place Prior to Admission

Place prior to admission	Number (%)
Hospital	24 (48%)
Nursing home	15 (30%)
Home health care	10 (20%)
Not listed	1 (2%)

Length of Stay With the Agency

From the data collected, 18 patients (35%) had been with the agency for a period of 2 years or less, 14 patients (27%) had a length of stay of 3 to 5 years, 13 (25%) patients had been with the agency for a period of 6 to 8 years, and six patients (12%) had been with the agency for a period of less than 2 years (Table 5). The average length of stay with the agency was 4.25 hours years.

Table 5

Years With the Agency

Duration with the agency	Number (%)
0-2	18 (35%)
3-5	14 (27%)
6-8	13 (25%)
9-11	6 (12%)

Ethnicity and Gender

According to the data, most of the home health patients were African American (88%) and European American (10%). One patient chart did not indicate the ethnicity of the patient. Thirty one home health patients were females (61%), while the male population represented 39% of the total population (Table 6).

Table 6

Ethnicity

Ethnicity	Number (%)
African-American	44 (88%)
Caucasian	5 (10%)
Not listed	1 (2%)

Home Health Patients with Advance Directives

The advance care planning data collected involved documentation of the patient's code status, the presence and type of AD, and prior advance care planning documentation as required by federal and accreditation bodies (Table 7; Table 8). Descriptive data analysis was carried out using MS Excel to determine the frequencies, percentages, and the means.

Table 7

Patient Code Status

Characteristic	Number (%)
Yes	45 (88%)
No	6 (12%)

Table 8

Advance Directive Present

Characteristic	Number (%)
Yes	13 (25%)
No	38 (75%)

The data summarized in Table 7 showed that 88% of the patients had an AD code status listed on their charts. Most of the patients sampled had never completed an advance directive documented in their chart. Only 25% (Table 8) of the patients who had the charts sampled had completed an AD following their admission to the HQC facility. However, it was not possible to determine the types of ADs completed by the patients (living will, DNR, or HCPOA) because the data were not captured in patient charts. The agency only documents the code status in patient charts.

Potential Correlations

Another achievement that I made through the current study was examining a potential relationship between the demographic details (age, natural of illness and AD completion rates). About 76% (10 out of 13 individuals with completed AD) of all individuals aged more than 60 years had completed AD documents suggesting that there might be a positive relationship between age and AD completion rates. Moreover, 61% (8 out of 13) of all individuals who had completed an AD had cardiovascular disease suggesting a potential relationship between heart diseases and AD completion rates. The findings suggest that age and heart disease can have an effect on AD completion rates.

Discussions and Implications

The initial objectives of this study were to develop a document that is easy to read and understand by the various group and culturally diverse home health patients, and to increase the number of home health patients with ADs to 80%. Owing to time limitations, it was not possible for me to address the second and the third objectives, and as a result, I had to rely on retrospective data to determine the rate of completion of ADs at the HQC agency. An additional objective was to determine a possible relationship between the demographic details and the rate of AD completion by the home health patients. Another objective was to develop a comprehensive and easy to read document for the various ethnic groups of home health patients.

As the American population increases, more aged and ill individuals will use the HQC agency for home health care. The importance of having discussions on ADs with all stakeholders cannot be overemphasized. The discussions can make the last moments of a patient less stressful and emotional, having the understanding that his or her preferences and cultural/religious beliefs will be taken into consideration accordingly while undergoing medical procedures and treatments. Moreover, documenting end of life wishes can lighten the decision-making burden on family members or physicians. The Patient Self-Determination Act (PSDA) encourages completion of a written AD immediately after a patient is admitted to a care facility if they had not completed an AD document before.

A huge percentage (88%) of the sampled population was African American citizens with females accounting for 70% of this population. The total African American population constitutes about 13% of the U.S population (Colby, & Ortman, 2015). This is an indication that the findings reported in this study may not be representative of the entire America's population. The discrepancy can be attributed to the fact that the current study was carried out in a rural setting with a large number of African American population.

The sampled home health patient population in the current study had both acute and chronic health problems. The most common chronic conditions identified in this study were diabetes, arthritis, obesity, cardiovascular disease, and respiratory diseases.

The findings were consistent with those reported by Center for Disease Control and Prevention (CDC) in February 2016. The most common chronic condition identified among U.S residents were diabetes, arthritis, cardiovascular diseases, diabetes and cancers (CDC, 2016).

The advance directive completion rate in the current study was 25%. The findings are consistent with those reported by Salmond and David (2005) who found that 82% of the sample patient population in their study did not have a completed AD document, in spite of the fact that the hospital had distributed AD documents to all the patients involved. The findings reported in the current study are worrying considering that most of the patients came from other medical facilities prior to their enrollment at the HQC agency. The prevailing federal and accreditation policies state that all care users preferences and beliefs should be respected, even when they are not able to verbally express their decision.

The policies require the wishes and preferences to be articulated through an advance directive and this should take place at their admission to a health care center. Admission to the HQC agency served as second health care point of entry, thus AD completion rates ought to have been higher than those reported in this study, though this was not the case. The data collected could not be used to explore the relationship between the first point of contact with a health care facility and the AD completion rates.

Existing literature indicates that advance care meetings should take place while a patient is of sound mind to guide the decision-making process in case of an emergency (Blackford, Strickland, & Morris, 2007). According to Silvester et al. (2012), there should be an active involvement of the patient and the discussion should address the patient's end of life goals, their wishes, cultural and religious beliefs and values to ensure a personalized end of life for the patient. However, the study site had no documented data on advance care planning meetings, indicating that such meetings may not be taking place at all.

There should be advance care meetings in the organization and they should involve a discussion of the patients' end of life goals and preferences. In addition, there should be consistent documentation of the involvement of the patients and identification of values and concerns with regard to end of life issues. The advance care planning meetings should involve health care providers with a wide range of expertise (Silvester et al., 2012). Overall, participation of the patients, social workers, nursing staff and family members in the advance care meetings should be high and well documented during advance care planning meetings.

The current study found a weak but a noteworthy relationship between older age and completion of an AD document. Sixty one percent (8 out of 13) of the patients with completed an AD document were over the age of 65 years in comparison to 39% of the patients aged less than 64 years. The findings are consistent with those reported by Rao, Anderson, Lin, and Laux (2014). The researchers found that age had an impact on AD completion rates. In their study, individuals aged less than 54 years were less likely to have a completed advance directive (32% had an AD document) in comparison to those aged more than 54 years (68%) (Rao et al., 2014).

Almost 50% of the patients had been admitted to the HQC facility for more than five years. Nevertheless, 75% of the participants did not have a completed AD document at the time of the study. These low completion rates are consistent with the findings presented by Chrash, Mulich, and Patton (2011) who found that chronically ill patients had low completion rates of ADs. Nevertheless, 73% of the patients involved in Yung et al. (2010) reported completing a written AD document. The difference in the findings can be attributed to the fact that Yung et al. (2010) used an older patient sample population (mean age 81 years) with most of the participants being at higher risk of death due to the presence of various chronic conditions.

Theoretical Framework

The health belief model informed and provided theoretical guidance for the current study. The theory states that the likelihood of a person performing health related behavior can be projected by the presence of certain cues to the action as well as four perceived constructs. The four core concepts in HBM include perceived susceptibility, severity, barriers, and benefits (Rosenstock, 1974). Applying the theoretical framework to this study, the condition or the circumstance to be avoided is a death where the individual end-of-life wishes are not taken into consideration. This might include death after unwanted life support, or prolonged survival in a vegetative state against the patient wishes. If such a death is not a desirable incident by an individual; then, he or she may complete an AD to avoid it. Health beliefs influence the decision to complete ADs (Ko & Lee, 2010). In this case, the health beliefs refer to the perceived effects of a death where an individual wishes were not respected and the perceived advantages such as personalized end-of-life care and reduced costs as a result of completing an AD. The low completion rate of ADs at the home health agency suggests that the perceived barriers to completion of the documents may be stronger than the perceived benefits.

There are various factors that impact on the individual's willingness to complete AD documents which are demographic as well as psychological elements. There are also barriers to completion of AD, which may include individual or health system related factors. A cue to encourage appropriate health behavior is necessary in the completion of ADs (Ko & Berkman, 2012). With regards to the above arguments, I recommend development of an educational intervention to promote completion of ADs at HQC home health agency. The educational intervention would address patient and health provider related barriers such as viewing completion of AD as time-consuming, upsetting and inadequate awareness. It is my hope that the proposed educational intervention will overcome the barriers and increase the completion rate of ADs at the home health agency. This is in line with the HBM assertion that appropriate health behavior can be reached if the cues and barriers hindering it are overcame (Rosenstock, 1974).

Strengths and Limitations of the Study

Strengths

There are various strengths and limitations present in the current study. One of the main strengths is identifying a problem in the health care sector that has been inconsistently addressed in the prevailing literature. Moreover, the study investigates the correlation between AD completion rates with the various types of health insurance coverage and chronic illness. Another strength of this study is its contribution to the health care sector and promotion of social change; it emerged that AD completion rates in home health facilities are low (25%) and this means that there is a need for creating awareness about advance directives and the importance of assisting patients/families in making ADs.

Limitations

Just like any other research, this study is not without limitations. One of the main limitations of this study is the limited external validity, making it impossible to generalize the findings obtained to the entire home care facilities in the U.S. Secondly, this study only relied on data obtained from patient charts, and there is likelihood that some advance care documents given by patients to the agency may have been misplaced or not filed accordingly. Lastly, the health care providers may have discussed patient's concerns, values and wishes during the meetings with the patients, but failed to document the meetings or the issues verbally discussed during the home visits.

Implication for Practice, Policy, and Social Change

The current study describes the advance directive completion rates (25%) in a home health care facility located in the state of Maryland, U.S. The finding indicates that there is an evident disconnect between the recommended and the actual practice with regards to end of life issues. Most of the patients came from acute care settings where advance directive documents should have been completed, and the findings reported in this study suggests that the facilities are not addressing the end of life issues as recommended.

There is a pressing need for more complete documentation of the patient's desires and wishes regarding end of life care at home health care facilities. In addition, there is a need for consistent meetings with patients and documentation of their wishes in home health care facilities. Documenting the patient's end of life preferences and wishes and increasing the number of advance care meetings may potentially ease the decision-making process, making the end of life days less stressful for the patients and their families at the same time promoting the provision of personalized health care at the end of life (Chrash, Mulich, & Patton, 2011; Rao, Anderson, Lin, & Laux, 2014).

Implication for Future Research

The recommendation for moving forward is a quality improvement program to be carried out at the home health agency and across various home health facilities with an objective of increasing the advance directive completion rates. Moreover, the studies can be carried out in a variety of settings (urban, suburban and rural) to be able to obtain generalizable results. Last of all, a prospective study could be carried out to evaluate the potential relationship between cardiovascular disease, education levels, socioeconomic status as well as profession.

Analysis of Self

Being an Advanced Nurse Practitioner (ANP) comes with great roles and challenges in the nursing profession. It is important that ANPs become aware of the benefits of and rates of AD completion in home health agencies. The process of trying to accomplish the above goals came with scholarly, personal, and professional growth that cannot be enumerated. In this section, I describe my analysis as a scholar, practitioner, and project developer upon conducting the current research. The contents have been classified into three themes focusing on my improvement of academic and professional skills.

As a Scholar

Undertaking this research gave me a valuable opportunity to improve on my skills as an independent learner. One of the greatest contributions of this research was the development of a critical mindset while evaluating information and arguments presented in secondary sources of data. I have to admit that before conducting this research, I was likely to take viewpoints and arguments formulated in articles and books as the absolute truth, arguing that if an individual has managed to publish a book or a journal article, he or she must have deep expertise in that particular area.

However, the process of completing this DNP project made me change my point of view- I learned how to identify strengths and weaknesses of research at the same time taking into account different viewpoints from different authors before reaching a conclusion. Developing a critical mindset in terms of evidence presented in secondary sources of data will be of value to my future scholarly life, now that I have been equipped with essential skills that can be used to identify weaknesses associated with various research studies, and provide valuable insights on how the evidence presented can be improved or made reliable.

Moreover, I gained competency in prioritizing secondary data. There are numerous sources of evidence in the contemporary world, ranging from journal articles, newspapers, websites, and published books (Schneider, & Whitehead, 2013).

Conducting this research, particularly writing the literature review has made me acknowledge that it is impractical to collect data from all sources, and a scholar has to include and exclude some literature resources. Accordingly, while conducting the literature review, I had to prioritize data in terms of the type of publication, their relevance, publication date and the credibility of the author. The skills of prioritizing secondary data that were developed offered a wide range of extensive benefits, including raising the reliability of the findings presented in this research and reducing time wastage in the literature review by excluding inappropriate studies.

Undertaking this research made me realize my strength and my weak points. I found referencing using APA as one of my main strengths as a scholar, having an enhanced understanding of the APA referencing style from journal articles, and also appreciating the importance of correct referencing. According to Angélil-Carter (2014), proper referencing is an indispensable part of academic writing and it not only assist the authors in avoiding plagiarism but also adds authenticity to their studies by supporting the arguments made. Carrying out this research also brought my attention to my weak areas. In previous assignments in the university, I had significant challenges with note taking and paraphrasing techniques and carrying out this research gave me an invaluable moment to improve on my weak areas.

My level of self-confidence as an author significantly improved upon conducting this research. Acknowledging feedback from my supervisor and rectifying the identified issues has been a noteworthy element for the development of my scholarly skills. It not only assisted me in recognizing my strengths and weaknesses but also improved my self-confidence and enthusiasm - two critical factors for personal development (Ross, 2014).

As a Project Manager

Apart from developing my scholarly skills, undertaking this research gave me an opportunity to improve my time management skills. Though effective time management was one of my main strengths in the previous assignments that I had accomplished in my academic career, I learned that there was still a room for improvement. To be precise, conducting this study demanded extensive groundwork and preparation for each single stage of the dissertation journey.

In the beginning, I experienced significant time challenges trying to balance school and work issues. I always found myself constantly behind the time plan regarding the number of sections completed. I had to revise the timetable for my research project, as well as improving on the level of self-discipline in following a set timetable. Specifically, I developed a SMART plan that specified the amount of work to be completed on a weekly basis, and it was extremely useful because I was able to avoid all unnecessary activities in the process of conducting research.

As a Practitioner

Having worked in the home health industry for about a decade, I felt that my scholarly project should have at least a possibility of serving a wider purpose other than that of attaining my DNP degree. As a nurse practitioner, I was bothered by the fact that most of the patients I was dealing with in my place of work did not have completed advance directive documents. This was of concern to me because I had a deep understanding of the importance of advance directive. I felt that it was essential for me to determine the magnitude of the problem in my place of work.

Accordingly, I decided to use retrospective chart review to collect patient data and determine the proportion of patients with advance directives in my place of work. Upon conducting data analysis, I was worried by the fact that the advance directive completion rate in my place of work was about 25%. The data analysis also suggested a positive relationship between various chronic diseases and completion of an advance directive document.

Upon reviewing the patient charts and interacting with some patients, it emerged that there were some unique reasons in my organization for the low rates of completion of advance directive documents. Some patients could not understand the advance directive documents while others lacked the necessary guideline to complete them on their own. As a result, I decided to develop an advance care document that contained simplified language in an attempt aimed at increasing the completion rates by 80%. However, due to time limitation, I was not able to carry out the quality improvement in my place of work.

While carrying out the background reading, I realized that low completion rates of advance directive are a problem in a wide range of health care centers providing care to the aged and chronically ill patients. Since then, I have become an advocate of advance care meetings and completion of AD documents at my place of work. I believe that there should be a more active involvement of patients in advance care meetings, and their goals, wishes and beliefs should be taken into account to provide personalized end of life care to the patient.

In conclusion, carrying out this research served as a platform for development and progress of my skills as a nurse practitioner, as a scholar and as a potential project developer. Overall, I was able to identify my weak points and strengths, having received feedback from my supervisor. Moreover, I learned that there was still a room for improving my time management skills, and this has made me develop an action plan for future improvements and identifying techniques for recognizing and turning weaknesses into strengths.

Dissemination Plan

Proper dissemination of research findings is essential in the health care sector because it facilitates sharing of crucial data on how the quality of care provided to patients can be improved (Glasgow et al., 2012). To ensure that the findings obtained in the current research informs the current home health care practices regarding advance directive issues, this dissemination plan will be used to distribute the findings to various audiences of interest. The target audience includes nurses working with home health agencies, patients, social care workers, home health agency stakeholders, and the members of the public in general. Completion of ADs remains a daunting challenge in the current health care system. The findings from this research will intensify awareness regarding completion of AD documents, and may lead to a positive social change by promoting provision of personalized end of life care to the patients.

The findings will be shared during workshops and seminars on end of life issues, and a presentation of the summary of the findings and recommendations will be made to the facility's stakeholders during an internal meeting. In addition, the findings will be presented on a larger scale, through the internet (twitter and emails) and submission a summary of the findings in a peer-reviewed journal for potential publication. According to Glasgow et al. (2012), advanced nurses have the responsibility of impacting positive changes in practice by disseminating evidence-based knowledge.

Section 5: Summary and Conclusions

The numbers of people aged more than 65 years in the U.S have been increasing in the past decades due to increased life expectancy. It is estimated that 72 million or 20% of the U.S population will be 65 years and older by the year 2030 (Smith, 2013). A huge proportion of this population will require long-term health care, and there is a high likelihood that the number of individuals receiving care from home health agencies will increase in the future. There are reports indicating that an increasing number of the aged individuals cite home as their preferred place of care and death.

The existing federal policies recommend that ADs should be completed by all patients approaching end of life. In spite of the presence of federal and accreditation policies advocating completion of AD documents by patients admitted to healthcare settings, AD completion rates are generally low in most health care organizations. As a result, the set forth objectives of this project were developing an advance directive document that was easy to read and understand, and adopting it to increase the rate of advance directive completion by 80% in the home agency. However, the initial objectives of the research could not be met due to time limitations, and retrospective chart review data were used to compute the rates of advance directive completion in the home health agency.

The retrospective descriptive study involving patient charts was carried out in a home health agency with about 51 patients. Demographic details, including age, gender, ethnicity, nature of illness, and type of health insurance were collected. No patient charts were excluded, apart from those of individuals aged less than 20 years. The data were analyzed using MS Excel to determine the means, frequencies, and the percentages. Descriptive statistics were also used to compute the advance directive completion rates in the agency.

Upon data analysis, only 25% of the patients were found to have a completed AD document. 88% of the patients had an advance directive listed on their patient charts, though only a small proportion of the patients had completed their AD documents. The average age of the participants was 58 years, and 90% of the patients had Medicaid insurance cover. Prior to their admission to the facility, most patients came from other health centers, a clear indication that AD completion rates are low in other health care settings. A positive correlation, though not statistically significant emerged between cardiovascular disease, advanced age, and AD completion rates.

There is a need for a prospective study to increase the current AD completion rate in the home health agency. Educational interventional should be provided to patients and there should be discussions about end of life issues, and the patients should be provided with adequate time to process the AD information. Patients, family members and health care providers including nurses, clinicians, and social workers should be involved in advance care planning meetings to facilitate improvements in AD completion rates.

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Appendix A: Protecting Human Research Participants

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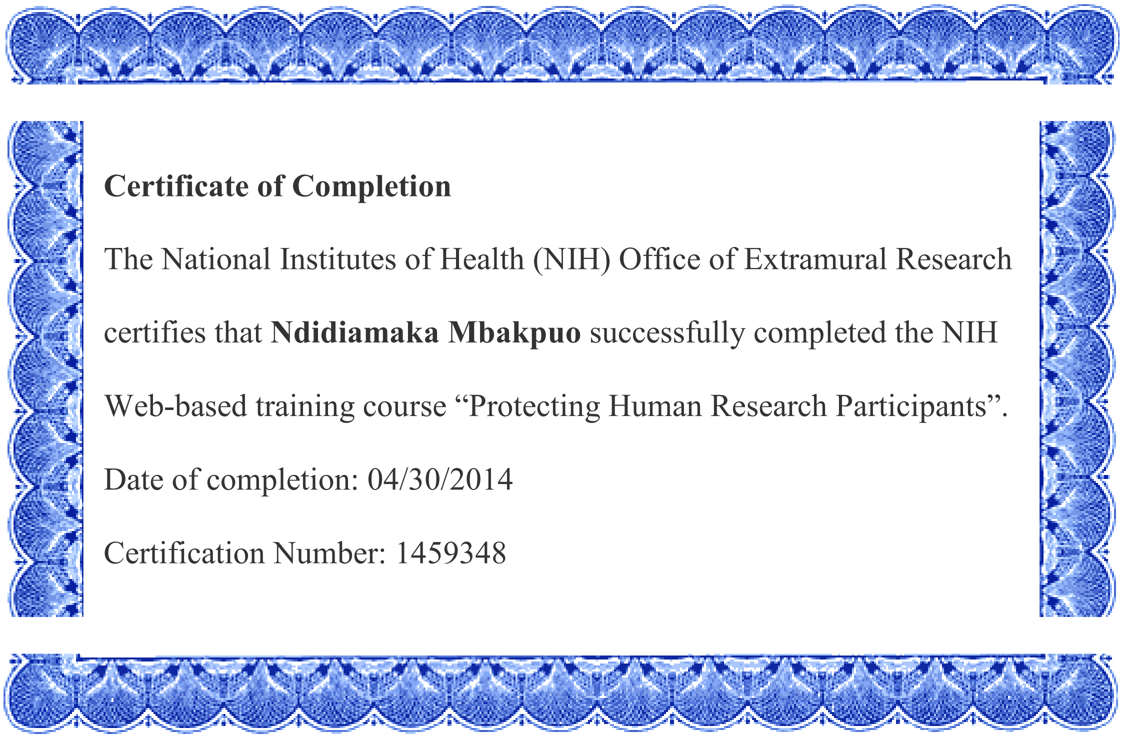

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Ndidiamaka Mbakpuo** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 04/30/2014

Certification Number: 1459348

Appendix B*:* Organizational Study Approval Letter

<Letterhead>

<Date>

Walden University

Institutional Review Board

The purpose of this letter is to grant Ndidiamaka Mbapuo, a student at the Walden University, permission to conduct research at High Quality Care Nursing Inc. The Research project, "*Increasing the completion rate of Advance Directives among home health clients*" entails a qualitative descriptive research model will used to investigate the percentage of home health clients patients who have completed Advance Directive and do who did not.

This study will gather information from questionnaires, personal interviews and surveys from about thirty home health patients. The purpose of this project is to determine the level of advance directive completion in home health setting. High Quality Care Nursing was selected because Ndidiamaka is employed by the company as a home health nurse supervisor.

I understand that the research project research will take place from May 1, 2015 to August 1 2015.

I understand that Ndidiamaka will receive informed consent from all research participants, that any data collected by Ndidiamaka will be kept confidential, and that

Ndidiamaka will receive Walden IRB-approval before she recruits research participants or collects data.

Information gathered from the research will be shared with the organization at the end of the research project.

As the Vice President at High Quality Care Nursing, authorized to act on behalf of High Quality Care Nursing on research matters, I do hereby grant permission for Ndidiamaka to conduct a research project titled "*Increasing the completion rate of Advance Directives among home health clients"* at High Quality Care Nursing Inc.

<Original ink signature>

<Title>

<**Direct** contact information of signer to include: address, phone number, email address>