Improving Health Care Proxy Procurement Rates for Hospitalized Adults - A Nurse Led Intervention

Improving Health Care Proxy Procurement Rates for Hospitalized Adults - A Nurse Led Intervention

Johanna Baldassari

University of Massachusetts, Amherst

Elaine Marieb College of Nursing

DNP Project Chair: Hyeyoung Park

Site Mentor: Annie Lewis-O'Connor

April 30, 2026

Table of Contents

Abstract

Background It is estimated that 1 in 3 Americans have completed advance directives. A health care proxy (HCP) is a type of advance directive that identifies a health care agent to make medical decisions on their behalf when the patient is unable to communicate their wishes. At the intervention site, there is no clearly identified pathway for obtaining HCP forms for admitted patients. The purpose of this DNP project was to implement a nurse led intervention to increase the HCP completion rate for adults aged 18 and older discharged from an inpatient medical unit.

Methods All patients aged 18 and older discharged from an inpatient medical unit of a community teaching hospital were reviewed for having a completed HCP form scanned into the electronic medical record (EMR). A brief educational intervention consisting of what a HCP is, how to assess for and counsel patients on HCP completion, and how to complete the forms was presented by the DNP student and a senior social worker to unit nurses using a PowerPoint slide deck. Pre and post intervention data was collected via existing dashboards within the EMR.

Results HCP completion rates increased from 69% pre-intervention to 76% post-intervention. Significant differences ($p < 0.05$) were noted in post-intervention HCP completion rates by age (68% for ≤64 years vs. 80% for ≥65 years), and language (78% for English speaking vs. 61% for non-English speaking) using Chi-square analysis.

Conclusion An educational intervention educating bedside nurses on their role in assessing and counseling patients on completing HCP at time of admission increased HCP completion rates on a single inpatient medical unit in an urban community teaching hospital.

Keywords: health care proxy, power of attorney, advance care planning, documentation, nurse led intervention, nursing, acute care hospital

Improving Health Care Proxy Procurement Rates for Hospitalized Adults - A Nurse Led Intervention

Introduction

Background

Advance directives are a central component of providing care that is in line with patients' wishes leaning on the ethical principle of informed consent. While there are variations of advance directives, they are typically considered to include three components: physician order for life sustaining treatment (POLST), a healthcare power of attorney, and a living will (House et al., 2023). The Commonwealth of Massachusetts recognizes the healthcare proxy as the healthcare power of attorney. For consistency, the term healthcare proxy (HCP) is used throughout this project.

With the 1990 passing of the Social Security Act amendment, known as Patient Self-Determination Act (PSDA), hospitals, skilled nursing facilities, home health and hospice organizations, and Health Maintenance Organizations (HMOs) became required to notify patients of their right to be involved in the decision making of their medical care. One key aspect of the PSDA is that the above organizations are required to ask patients about advance directives and for those organizations to document and implement said directives (Teoli & Ghassemzadeh, 2023).

Completion rates for advance directives for hospitalized patients are low. Prior to the COVID-19 pandemic, a benchmark systematic review of 150 studies incorporating 795,909 patients, revealed an advance directive completion rate of 36.7%, and a completion rate specific to health care power of attorney documentation of only 35.3%. Completion rates were significantly higher for patients aged 65 years and older (45.6%) and for those patients in hospice

or palliative care (59.6%) (Yadav et al., 2017). High quality research has demonstrated that interventions involving nurses in the advance care planning process have shown promise.

Problem Statement

There is risk of potential harm to hospitalized adults such as prolonged length of stay, increased risk of hospital acquired conditions, loss of autonomy, and not providing care that is aligned with patient wishes. This risk is indicated by the low advance directive completion rate, specifically the health care power of attorney, in adults ages 18 and older in an urban community hospital, and results from lack of clinician awareness, time, and interdisciplinary coordination. The purpose of this DNP project was to implement a nurse led intervention to increase the completion rate of advance directives, specifically that of the healthcare proxy, for patients ages 18 and older admitted to an urban community hospital in Massachusetts.

Review of the Literature

Methods

The initial search terms of advance care planning, health care power of attorney proxy, inpatient, hospitalization, documentation or electronic medical record (EMR), nurse or advance practice nurse, improvement, completion rates, and intervention were used in the following data bases: PsycINFO, Cumulative Index of Nursing and Allied Health (CINAHL), PubMed, and Web of Science. The search yielded 450 results. It was then limited to English-language articles published between 2018 and 2024 which yielded 89 results. Exclusion criteria included quality improvement projects, editorials, and studies targeted pediatric patients. Inclusion criteria included any intervention that involved a nurse. This yielded 15 articles. Using the Johns Hopkins Nursing Evidence Based Practice (JHNEBP) rating scale, the strength of the evidence

evaluated and determined to be strong with 9 of the studies meeting level 1 criteria (Chan et al., 2018; Gabbard et al., 2019; Hilgeman et al., 2018; Houben et al., 2019; Krones et al., 2022; Nair & Kohen, 2019; Overbeek et al., 2018b; Rodriguez et al., 2024; Sinclair et al., 2020). The quality of the evidence was good. However, two recurrent themes presented themselves while assessing the quality of the evidence: selection bias and possibility of significant attrition of the sample population due to death.

Findings

Content Issues

The studies in this review varied in focus, but most examined the role and effectiveness of nurse led interventions in advance care planning. One study was a Delphi study to gain expert consensus to develop an advanced care planning (ACP) pathway for hospitalized cancer patients (Pedrosa Carrasco et al., 2022). Another systemic review sought to determine the impact of integration of palliative care into ambulatory care and completion of ACP documentation (Sloan et al., 2021). Several articles explored the effectiveness of an intervention that included trained nurses to facilitate the initial introduction and discussion of ACP with patients (Gabbard et al., 2021; Hilgeman et al., 2018; Overbeek et al., 2018b; Rodriguez et al., 2024). Some studies evaluated the nurse's experience leading the intervention by either studying the experience of the nurse (Ohr et al., 2021; Rogers et al., 2020) or that of the patient (Miller et al., 2019; Sinclair et al., 2020). One study evaluated the impact of a nurse led intervention on providing "congruent care" or care that was aligned with patient's documented wishes (Chan et al., 2018).

Methodology Issues

Five studies were randomized controlled studies (Chan, et al., 2018; Gabbard et al., 2019; Hilgeman et al., 2018; Houben et al., 2019; Rodriguez et al., 2024; Sinclair et al., 2020). One

study was quasi-experimental (Ohr et al., 2021) and one was a prospective pre/post (Nair & Kohen, 2019). The remaining three studies used qualitative design (Miller et al., 2019; Ohr et al., 2021; Rogers et al., 2020). With the exception of one large study involving more than 16,000 patient encounters (Kantor et al., 2021), sample size varied from 50 to 500 participants. (Chan et al., 2018; Gabbard et al., 2021; Houben et al., 2019; Krones et al., 2022; Nair & Kohen, 2019; Overbeek et al., 2018a; Rodriguez et al., 2024; Sinclair et al., 2020).

The most common setting was ambulatory care, with eight studies conducted in outpatient practice settings (Gabbard et al., 2021; Hilgeman et al., 2018; Houben et al., 2019; Miller et al., 2019; Ohr et al., 2021; Rodriguez et al., 2024; Rogers et al., 2020; Sloan et al., 2021). The other six studies occurred in either a residential care home or hospital setting (Chan et al., 2018; Kantor et al., 2021; Krones et al., 2022; Nair & Kohen, 2019; Overbeek et al., 2018; Sinclair et al., 2020). Patients were adult and of older age. Geographically, six studies occurred in North America (Gabbard et al., 2021; Hilgeman et al., 2018; Kantor et al., 2021; Nair & Kohen, 2019; Rodriguez et al., 2024; Sloan et al., 2021).

The clinicians delivering the interventions were predominantly nurses (Chan et al., 2018; Gabbard et al., 2021; Hilgeman et al., 2018; Houben et al., 2019; Miller et al., 2019; Ohr et al., 2021; Overbeek et al., 2018; Sinclair et al., 2020). Two studies included nurses in their interdisciplinary intervention (Krones et al., 2022; Rodriguez et al., 2024).

Research Findings

Incorporating nurses, either as leaders or members of an interdisciplinary team, into the ACP discussion proved to be successful. Increased advance care planning completion rates were the primary outcomes in six studies (Gabbard et al., 2021; Hilgeman et al., 2018; Kantor et al., 2021; Krones et al., 2022; Overbeek et al., 2018; Rodriguez et al., 2024) and secondary

outcomes in three studies (Houben et al., 2019; Nair & Kohen, 2019; Overbeek et al., 2018). Additionally, incorporating nurses did not negatively impact patient satisfaction (Miller et al., 2019). It improved patient's quality of communication and reduced anxiety (Houben et al., 2019) and increased congruency of care (Chan et al., 2018)

Discussion/Synthesis

The successful completion of advance directives remains low. Studies that educated nurses to lead the ACP discussion as well as serve as a facilitator to liaise with the patient, family, and primary physician were successful at increasing completion rates (Chan et al., 2018; Gabbard et al., 2021; Hilgeman et al., 2018; Krones et al., 2022; Overbeek et al., 2018). The impact of having nurses lead and facilitate ACP discussions had positive impacts on patients and clinician care teams by decreasing anxiety and increasing the quality of communication (Houben et al., 2019), and did not change patient satisfaction (Hilgeman et al., 2018; Miller et al., 2019; Sinclair et al., 2020). One theme that emerged from the qualitative studies is the relationship with the nurse and the patient, and the patient's trust in the nurse was noted to be an important contributor to meaningful discussions (Miller et al., 2019; Rogers et al., 2020).

Conclusion

Current ACP completion rates remain low. Incorporating the nurse into the solution to build upon the relationship founded on trust between the patient and the nurse to begin these conversations is supported by the current evidence. Interventions that educated nurses and incorporated the nurse and the ACP discussion into a lager clinician team were successful in increasing ACP completion rates.

Theoretical Framework

The Chronic Care Model (Wagner, 1998) is a theoretical framework that guided the project. It identifies four levels of change concepts that are built on the foundation of healthy community resources and health system organizations that are centered on system leaders who are committed to providing safe high-quality care. The four levels of change concepts: (a) self-management support: providing patients the tools to care for themselves; (b) delivery system design: assuring efficient care; (c) decision support: facilitating clinician access to evidence based guidelines and support; and (d) clinical information systems: use of technology to organize data and information to clinicians to promote effective care (Wagner, 1998).

This framework aligns with the work to obtain advance directives. Health care proxies can span across the healthcare continuum from ambulatory to acute hospitalization to long-term care facilities. Health care proxies facilitate self-management as they allow for the patient's voice, via the health care agent, to be heard when the patient is no longer able to communicate. Completing health care proxy forms supports self-management –patients are empowered to determine who will make decisions for them if they become incapacitated. The HCP form is available to confirm immediately, anywhere in the EMR across numerous hospitals. Clinical information systems are used to store health care proxy forms and allow the forms to be retrieved by all care team members across various practice settings and locations (see Appendix A). Healthcare proxy forms facilitate efficient care as they transfer over time and over healthcare settings. They can also help to avoid prolonged hospital stays. The framework supports productive care teams and informed patients. The education sessions the unit nurses attended in this project provided them with tools to support evidence-based practice. Finally, by having the outcome measure be the number of HCP forms scanned into the EMR, this project leverages the clinical system efficiencies that technology can foster.

Objectives and Expected Outcomes

The question the project aimed to answer was "for hospitalized adult patients, how does nursing facilitating the completion of the HCP impact HCP completion rates as compared with usual process during patients' hospitalization?". See Table 1.

Table 1

Project Objectives and Expected Outcomes

Purpose	Objectives	Outcome
To streamline the HCP procurement process to acquire health care proxy documentation for admitted patients ages 18 and older on medical unit.	To conduct a nurse led educational intervention for clinical nurses on their role to facilitate completion of health care power of attorney forms. To assess completion rates for differences in age, gender, and language	85% of full-time nurses on intervention unit will attend the education presentations. Increase health care proxy procurement rate to 90% for admitted patients ages 18 and older. Patients aged 65 and older will have procurement rates of 95%, non-English speaking patients will have procurement rates of 40%, and no difference will exist between genders.

Methods

Project Site and Population

This project occurred on a 37-bed inpatient adult medical unit of an urban community teaching hospital located in Massachusetts. The DNP student collaborated with the inpatient unit nurse director, unit social worker, and unit professional nurse educator to implement the education intervention.

To determine which medical unit should be the site of the project, the hospital chief medical officer, chief nursing officer, and nurse director of case management were engaged for support. They were provided with preliminary data and early project proposal for review. The unit was chosen at their discretion based on hospital goals and strategic planning. The chosen unit employed 57 nurses at the time of the intervention. On this unit, medical care is provided by two medical resident teaching teams, consisting of two interns, one resident, and one medical attending. The medical interns and residents rotate through the unit in two-week blocks. Common conditions treated on this unit include congestive heart failure exacerbations, respiratory disease, sepsis, and substance use disorders. On rare occasions, patients ages 16 and 17 may be admitted to this unit, they were excluded from this project as their parent or legal guardian would serve as their health care agent.

In 2025, this unit discharged nearly 2,500 patients. Demographics are notable for being roughly 65% white, 21% black, 1% Asian, and remainder not identified. Approximately 14% of patients identified as Hispanic and 85% as non-Hispanic. The most common preferred language is English (88%) followed by Spanish (7%) and Haitian Creole (1.6%). It is a heavily geriatric population with 60% of its patients aged 65 and older and 18% aged 85 and older. Sixty-four percent of patients were female and 43% were male. Top diagnoses for this unit include sepsis,

congestive heart failure, respiratory disease, gastrointestinal disorders, diabetes, and alcohol and substance use disorders. The average length of stay for patients admitted to this unit is about 5 days. Nearly 75% of patients are discharged to home independently or with services.

As screening for and obtaining healthcare proxy forms is a standard part of the nurse and advance practice nurse admission assessment, no additional nurse recruitment was necessary. Unit nurses were required to attend the educational session. The unit nursing director and unit nurse educator received approval from hospital leadership to provide additional nurse staffing to cover nurses while they attended the 30-minute session.

Measurement

The primary measurement for this project was the rate of completed healthcare proxy documentation attached in the chart for patients aged 18 and older:

$$\text{Rate} = \frac{\#\ of\ completed\ and\ attached\ HCP\ forms\ for\ patients\ aged\ 18\ and\ older\ discharged\ from\ the\ unit}{total\ \#\ of\ patients\ aged\ 18\ and\ older\ discharge\quad with\ valid\ HCP\ assessment} \times 100\%$$

A pre-existing report that existed in the hospital EMR was modified to capture the following data:

- date of admission
- date of discharge
- hospital unit
- patient age
- preferred language
- if patient was screened for having a HCP
- if HCP form is available (i.e. scanned into the EMR)

The report was validated by reviewing 10 unique patients and verifying by manual chart review that the findings are accurate. Baseline HCP completion rates for the nine weeks immediately prior to the education intervention were established using the above-described report.

Data Collection Procedures

Pre-intervention

Baseline completion rates were established using the aforementioned report. The DNP student collected the rates of completion for nine weeks immediately preceding the first education intervention. This data included the overall HCP completion rate for all discharged patients aged 18 and older and included demographic data of age, gender, and language.

Intervention

The intervention consisted of a PowerPoint presentation (Appendix B) led by the DNP student with assistance from a senior hospital social worker. The content of the educational intervention was created by review of best practices for advance care planning education. Hospital policy was taken into consideration as well as hospital resources (access to social work, interdisciplinary collaboration, and hospital EMR). The Institute for Healthcare Improvement "Conversation Ready": A Framework for Improving End-of Life Care provides guidance on a systems approach to implementing change. This includes observing four core principles to provide respectful care: exemplify, connect, engage, and stewards of information (Sokol-Hessner et al., 2019). Additionally, education content specific to Massachusetts was developed from guidance from the official website of the Commonwealth of Massachusetts (Mass.gov, 2026). The DNP project focused on being stewards of information. The three main objectives of this

educational intervention were to understand what an HCP is, to identify patient cognitive limitations and when to refer further capacity assessment to the provider, and to understand the preferred process for obtaining a HCP and attaching it in the chart.

The DNP student and unit leadership team planned coverage for four, 4-hour sessions, for a potential total of thirty-two 30-minute sessions over the course of two weeks. Session dates were strategically identified to accommodate the largest number of unique nurse staff at any time. Nursing leadership approved having an extra nurse compensated at regular time to help cover the unit during the four 4-hour sessions. Unit leadership was also present to encourage attendance and help cover the unit during the educational session. Two additional 30-minute sessions were held to capture nurses that could not attend the previous sessions and did not require additional nurse staffing. The sessions and supporting coverage occurred between 5AM-9AM and captured both night and day shifts. Each session was allotted nearly 30 minutes as unit staffing levels could support. Five minutes at the end of each session were reserved for collecting feedback. The sessions were held in the nursing breakroom where there was AV equipment to support the presentation and light refreshments were provided.

Post-intervention

Data collection began immediately after the first education session and was obtained by running the established EMR report that was used to collect the baseline data. Data was collected and results reported on a weekly basis through the end of the project period. Unit leaders had the ability to spot check if patients had an HCP and intervene with their staff. Education to assess HCP completion was reinforced at shift huddles and at daily interdisciplinary rounds. Weekly completion rates were displayed on the unit quality board and at bi-weekly unit high reliability organization rounds. The post-intervention period was seven weeks.

Data Analysis

Descriptive statistics (frequencies and percentage) were used to characterize pre- and post-intervention data. Chi-Square test was performed to assess if statistically significant differences existed in the total completion rates between the pre and post intervention groups. Additionally, Chi-Square test was performed to examine if statistically significant differences existed in the completion of HCP forms for gender, preferred language (English speaking v. non-English speaking), and age (≤64 years old v. ≥65 years old). Chi-square was chosen because the proxy data is nominal. Statistical significance was set at $p < 0.05$. Data analysis was performed using Statistical Package for the Social Sciences (SPSS) version 31 software.

Protection of Human Subjects and Ethical Considerations

The University of Massachusetts Amherst Internal Review Board (IRB) approval was obtained prior to initiating the DNP project (Appendix C). Site approval was granted by site associate chief medical officer and by the site chief nursing officer. This project was also reviewed by the hospital system IRB and received a not human subject study designation and did not require IRB process. Participants were protected by the Health Information Portability and Accountability Act of 1996. All information collected was deidentified and did not include any potential patient identifiers. Data was stored on a secure file sharing platform. Access to the unit specific EMR report was limited to the DNP student.

Ethical considerations include the possibility of moral distress to both patients and their caregivers while discussing their mortality, prompting realizations that they may have no one to identify as their HCP, or potentially identifying capacity limitations that may have otherwise been unnoticed.

Results

A total of 58 nurses were trained. This included 52 of the 57 actively employed unit nurses or 91 % of the unit nurses. Six nurses from other areas in the hospital including the float pool also completed the training.

Patient Demographics

Pre-intervention data was collected between Aug 1, 2025, and Sept 29, 2025. There were 440 patient records in the pre-intervention group of whom 232 (53%) were female and 208 (47%) were male. Three hundred and ninety-three (89%) spoke English and 47 (11%) were non-English speakers. Two hundred and forty-six (55%) were aged 65 and older while 194 (44%) were aged 18 to 64. Post pilot data was collected from Sept 30, 2025 through Nov 13, 2025 and included 312 patient records. One hundred twenty-four (40%) patients were aged 18 to 64 and 188 (60%) were aged 65 to 103; 275 (88%) spoke English and 37 (12%) were non-English speaking; 141 (45%) were male and 171 (55%) were female. See Table 2 for detailed demographics.

Table 2

Patient Demographics

	Age ≤64	Age ≥65	Male	Female	English	Non-English
Pre (n = 440)	194 (44%)	246 (55%)	208 (47%)	232 (53%)	393 (89%)	47 (11%)
Post (n = 312)	124 (40%)	188 (60%)	141 (45%)	171 (55%)	275 (88%)	37 (12%)
Total (n = 752)	318 (42%)	434 (58%)	349 (46%)	404 (54%)	668 (89%)	84 (11%)

Overall HCP Completion Rates

The rates of HCP completion increased overall from the pre-intervention to the post-intervention group. Among 403 pre-intervention patients, 278 (69%) had a completed HCP scanned into the EMR. Post-intervention, 216 patients (76%) had a completed HCP scanned into the EMR. This rate does not meet the expected outcome of 90%. Pre and post-intervention HCP completion rates can be found in Table 3.

Table 3

Pre and Post-Intervention HCP Completion Rates

	Pre-Intervention		Post-Intervention	
	N	Valid %	N	Valid %
HCP Yes	278	69	216	76
HCP No	125	31	68	24
HCP N/A (missing)	41		29	
Valid Total	403	100	284	100
System Total	444		313	

**Valid%=HCP documentation is complete, either Yes or No*

To determine if the increase in HCP rates in the post-intervention group was significant, Chi-square analysis was used to compare expected frequencies. The observed post-intervention HCP completion rate was significantly greater than expected, $\chi^2(1, N = 687) = 4.127$, $p = 0.042$. See Table 4.

Table 4

Chi-square Test Comparing HCP Completion Rates of the Pre-intervention Group to the Post-intervention Group

	Pre-Intervention		Post-Intervention		Total		χ^2
	N	%	N	%	N	%	4.127
HCP Present	278	69.0%	216	76.1%	494	71.9%	
HCP Absent	125	31.0%	68	23.9%	193	28.1%	
Total	403	100.0%	284	100.0%	687	100.0%	

Chi-square (1, *N*=687) = 4.127, *p*=.042

Relationship between HCP and Language, Gender, and Age

HCP Completion Rates by Language

Chi square analysis of post-intervention results indicates a significant difference between the HCP completion rates between English and Non-English-speaking patients χ^2 (1, N= 284) = 4.166, p = 0.041) with English speakers having higher rates of completion as compared to non-English Speakers. See Table 5.

Table 5

Post-intervention HCP Completion Rates for English and Non-English Speaking Participants

	Health Care Proxy Yes		Health Care Proxy No		χ^2
	N	%	N	%	4.166
English	197	78%	56	22%	
Non-English	19	61%	12	39%	
Total	216		68		

Chi-square (1, *N*=284) = 4.166, p = 0.041 (<0.05)

HCP Completion Rates by Gender

Chi square analysis for HCP completion rates for gender do not show a significant difference ($\chi^2(1, N=284)=1.039$, $p = 0.308$). See Table 6.

Table 6

Post-intervention HCP Completion Rates by Gender

	Health Care Proxy Yes		Health Care Proxy No		χ^2
	N	%	N	%	1.039
Male	101	79%	27	21%	
Female	115	74%	41	26%	
Total	216	76%	68	24%	

Chi square (1, *N=284*) =1.039, *p*=0.308 (<0.05)

HCP Completion Rates by Age

Chi Square results for HCP completion rates by age show a significantly greater HCP completion rate for adults aged and older as compared to those aged 64 and younger $\chi^2(1, N=284)=5.816$, p=0.016 as displayed in Table 7.

Table 7

Post-intervention HCP Completion Rates by Age

	Health Care Proxy Yes		Health Care Proxy No		χ^2
	N	%	N	%	5.816
64 and younger	70	68%	33	32%	
65 and older	146	80%	35	19%	
Total	216		68		

Chi-square (1, *N*=284) =5.816, *p*=0.016 (*p*<0.05)

Discussion

This DNP project was successful at increasing the rate of healthcare proxies obtained on a single inpatient medical unit in an urban community teaching hospital. The findings are most notable for having significant differences in HCP procurement rates based on language and age. The differences in age are most likely explained by targeted interventions during the project to capture older adults. Aside from including the need to procure HCP in patients regardless of language, the education intervention, and the process for obtaining non-English HCP forms, no focused intervention was implemented to address non-English speakers. This discrepancy is consistent with prior research that has identified non-English speaking or limited English as a barrier to HCP completion (Sudore et al., 2018; Thom et al., 2021).

Identifying a health care agent, and completion and storage of the health care proxy document, are important components of advance care planning. The chronic care model builds on the system delivery of the hospitals and community resources along with the empowered patient to achieve positive outcomes. This project leaned heavily on existing policies, the clinical information system, and system delivery to develop a process that supported high quality care management for chronic disease.

Benefit of a Nurse-led intervention

A key intervention for this project was establishing that nursing would lead the assessment and completion of health care proxies at time of a patient's admission. This was a significant change in practice, as previously, "everyone" (physicians, advance practice providers, social workers and nurses) was responsible for documenting and obtaining this information. Research has demonstrated that involving nurses in advance care planning and discussion improves completion outcomes and this project reinforces the evidence (Gabbard et al., 2021;

Hilgeman et al., 2018; Overbeek et al., 2018b; Rodriguez et al., 2024). Unit level and executive leaders were extremely engaged and critical to the realization of this change management, contributing to the project's success.

Nurses Positive Perception of Educational Intervention

The education sessions were well received by nurses. Completion of a brief post- survey allowed for real-time adjustment of the education to better meet the educational needs of the nurses. For example, early on, one nurse suggested bringing forms to the session so that the nurses could practice completing the form in real-time. This suggestion was rapidly implemented following the plan-do-study-act (PDSA) framework (IHI, 2026). Nurses shared that they are "More confident education *sic* patients on HCP as well as knowing how to document and place within the patient's chart, and "easily understandable and felt good asking questions video was eye-opening."

Implications for Nursing Practice

The research supported that nurses are key leaders in advance care planning discussion (Chan et al., 2018; Houben et al., 2019; Miller et al., 2019). Nurses are well versed to address barriers such as language or ethical considerations that may impact completion of the HCP form. They are well positioned to communicate with both patients and members of the interdisciplinary team. They are educated in using interpreters (either virtual or in-person) to facilitate communication. The nurse-patient relationship is ideally built on trust and places the nurse in a position to advocate for the patient as needed (Allande-Cussó et al., 2022) . It is possible that initiating discussion around advance directives may cause distress for patients and their caregivers by addressing their mortality, realizations that they may have no one to identify as

their HCP, or identifying cognitive limitations that may have otherwise remained unnoticed. Nurses, with their education in ethical principles, are able to support patients through these potentially difficult scenarios.

Limitations/Barriers

This project does have some limitations. It only addressed one aspect of advance care planning, HCP completion. Comprehensive advance directives also incorporate serious illness conversations and completion of physician orders for life sustaining treatment to support a fully informed patient and health care agent. While the HCP identifies an agent, it does not ensure that conversations regarding patients' values, goals, and preferences occur. The HCP does not identify specific life-sustaining measures a patient may or may not want pursued, so questions or confusion about a patient's true wishes can still exist in the absence of the health care agent or patient care team having had a serious illness conversation. Future iterations of this work should incorporate all aspects of advance directives in a systems-based approach. Additionally, this DNP project was conducted on a single unit in a community teaching hospital in Massachusetts This hospital has its unique ethnic, cultural, and socioeconomic demographics. These factors may influence a patient's understanding of the need to complete an HCP or willingness to participate in advance care discussion (Clark et al., 2018). This project did not evaluate differences in HCP completion rates amongst different ethnic and racial groups. Project design and outcomes may not be reproducible in other geographic areas. It may not be readily applicable to other healthcare delivery sites such as ambulatory care settings or pediatrics.

Conclusion

Hospitals are required, by the PDSA Act of 1990, to ask patients about their advance directives, as well as document and implement those directives. Despite this mandate, rates of completion remain low (Yadav et al., 2017). This DNP project aimed to increase the rates of completion and procurement of HCPs with storage within the EMR as its primary outcome and supported the evidence-based practice of having nurses leading this discussion with patients. While it was successful in increasing the rate, it did not achieve its goal rate of 90%. Future work should include trying to reduce any barriers in the completion and scanning of the HCP. This could include the ability to complete the HCP electronically with electronic signature pads, or even creating a state registry similar to the MOLST to ePOLST transition that is currently underway in Massachusetts, so that it is immediately available to the patient and institutions electronically increases completion rates as well.

References

Allande-Cussó, R., Fernández-García, E., & Porcel-Gálvez, A. M. (2022). Defining and characterising the nurse–patient relationship: A concept analysis. *Nursing Ethics*, *29*(2), 462–484. https://doi.org/10.1177/09697330211046651

Babb, E., Matrick, A., Pollack, T., & Rosenthal, L. J. (2021). Hospital guardianship: A quality needs assessment of "unbefriended" patients who lack decisional capacity. *Journal of the Academy of Consultation-Liaison Psychiatry*, *62*(5), 538–545. https://doi.org/10.1016/J.JACLP.2021.04.002

Bogue, R. J., & Joseph, M. L. (2019). C-Suite strategies for nurse empowerment and executive accountability. *The Journal of Nursing Administration*, *49*(5), 266–272. https://doi.org/10.1097/NNA.0000000000000749

Chan, H. Y. L., Ng, J. S. C., Chan, K. S., Ko, P. S., Leung, D. Y. P., Chan, C. W. H., Chan, L. N., Lee, I. F. K., & Lee, D. T. F. (2018). Effects of a nurse-led post-discharge advance care planning programme for community-dwelling patients nearing the end of life and their family members: A randomised controlled trial. *International Journal of Nursing Studies*, *87*, 26–33.

CITI Program (2024) Retrieved from: https://www.citiprogram.org/members/index.cfm?pageID=900&cr=65582408&cr_verify=086DCCBD4A6872189C2AB1DA51C035FE402E1EADF1B5E1E1F3A564EDBFB1435AAC5CABD24DCBB49D0611A3E02DAAB1CCEC994622F85F586CB8C6BF225624C1F1&p=50#view

Clark, M. A., Person, S. D., Gosline, A., Gawande, A. A., & Block, S. D. (2018). Racial and Ethnic Differences in Advance Care Planning: Results of a Statewide Population-Based Survey. *Journal of Palliative Medicine*, *21*(8), 1078–1085. https://doi.org/10.1089/jpm.2017.0374

CMS (2024) Retrieved from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_047_MIPSCQM.pdf

Gabbard, J., Pajewski, N. M., Callahan, K. E., Dharod, A., Foley, K. L., Ferris, K., Moses, A., Willard, J., & Williamson, J. D. (2021). Effectiveness of a nurse-led multidisciplinary intervention vs usual care on advance care planning for vulnerable older adults in an accountable care organization: A randomized clinical trial. *JAMA Internal Medicine*, *181*(3), 1. https://doi.org/10.1001/JAMAINTERNMED.2020.5950

Grudniewicz, A., Gray, C. S., Boeckxstaens, P., De Maeseneer, J., & Mold, J. (2023). Operationalizing the Chronic Care Model with Goal-Oriented Care. *The patient*, *16*(6), 569–578. https://doi.org/10.1007/s40271-023-00645-8

Grudzen, C. R., Buonocore, P., Steinberg, J., Ortiz, J. M., Richardson, L. D., Aslakson, R. A., Ast, K., Elk, R., Garner, K. K., Gramling, R., Grudzen, C., Kamal, A. H., Lamba, S., LeBlanc, T. W., Rhodes, R. L., Roeland, E., Schulman-Green, D., & Unroe, K. T. (2016). Concordance of advance care plans with inpatient directives in the electronic medical record for older patients admitted from the emergency department. *Journal of Pain and Symptom Management*, *51*(4), 647–651. https://doi.org/10.1016/J.JPAINSYMMAN.2015.12.318

Henage, C. B., McBride, J. M., Pino, J., Williams, J., Vedovi, J., Cannady, N., Buno, L. R., Chatman, T., Busby-Whitehead, J., & Roberts, E. (2021). Educational interventions to improve advance care planning discussions, documentation and billing. *American Journal of Hospice and Palliative Medicine*, *38*(4), 355–360. https://doi.org/10.1177/1049909120951088

Hilgeman, M. M., Uphold, C. R., Collins, A. N., Davis, L. L., Olsen, D. P., Burgio, K. L., Gordon, C. A., Coleman, T. N., DeCoster, J., Gay, W., & Allen, R. S. (2018). Enabling advance directive completion: Feasibility of a New Nurse-supported advance care planning intervention. *Journal of Gerontological Nursing*, *44*(7), 31–42. https://doi.org/10.3928/00989134-20180614 -06

Houben, C. H. M., Spruit, M. A., Luyten, H., Pennings, H. J., Van Den Boogaart, V. E. M., Creemers, J. P. H. M., Wesseling, G., Wouters, E. F. M., & Janssen, D. J. A. (2019). Cluster-randomised trial of a nurse-led advance care planning session in patients with COPD and their loved ones. *Thorax*, *74*(4), 328–336. https://doi.org/10.1136/THORAXJNL-2018-211943

House, S. A., Schoo, C., & Ogilvie, W. A. (2023). Advance Directives. *Lessons on Aging from Three Nations: Volume II: The Art of Caring for Older Adults*, 161–177. https://doi.org/10.4324/9781315224237-14

Institute of Healthcare Improvement (IHI) (2026). Retrieved from: https://www.ihi.org/library/model-for-improvement/testing-changes

Institute of Medicine (2001). Crossing the quality chasm: A new health system for the 21st century

Joshi, M., Ransom, S. Ransom, E. (2022). The Healthcare Quality Book: Vision, Strategy, and Tools (5th ed.). Health Administration Press.

Kantor, M. A., Scott, B. S., Abe-Jones, Y., Raffel, K. E., Thombley, R., & Mourad, M. (2021). Ask About What Matters: An Intervention to Improve Accessible Advance Care Planning Documentation. *Journal of Pain and Symptom Management*, *62*(5), 893–901. https://doi.org/10.1016/j.jpainsymman.2021.05.007

KFF (2024). Retrieved from: https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day-by ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Krones, T., Budilivschi, A., Karzig, I., Otto, T., Valeri, F., Biller-Andorno, N., Mitchell, C., & Loupatatzis, B. (2022). Advance care planning for the severely ill in the hospital: a randomized trial. *BMJ Supportive & Palliative Care*, *12*(e3), e411–e423. https://doi.org/10.1136/BMJSPCARE-2017-001489

Mass.gov (2026) Retrieved from https://www.mass.gov/info-details/massachusetts-law-about-health-care-proxies-and-living-wills

MGL (2024) Retrieved from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_047_MIPSCQM.pdf

Miller, H., Tan, J., Clayton, J. M., Meller, A., Hermiz, O., Zwar, N., & Rhee, J. (2019). Patient experiences of nurse-facilitated advance care planning in a general practice setting: a qualitative study. *BMC Palliative Care*, *18*(1). https://doi.org/10.1186/S12904-019-0411-Z

Overbeek, A., Korfage, I. J., Jabbarian, L. J., Billekens, P., Hammes, B. J., Polinder, S., Severijnen, J., Swart, S. J., Witkamp, F. E., van der Heide, A., & Rietjens, J. A. C. (2018). Advance care planning in frail older adults: A cluster randomized controlled trial. *Journal of the American Geriatrics Society*, *66*(6), 1089–1095. https://doi.org/10.1111/jgs.15333

Nair, R., & Kohen, S. A. (2019). Can a patient-directed video improve inpatient advance care planning? A prospective pre-post cohort study. *BMJ Qual Saf*, *28*(11), 887–893. https://doi.org/10.1136/bmjqs-2018-009066

Ohr, S. O., Cleasby, P., Jeong, S. Y. S., & Barrett, T. (2021). Nurse-led normalised advance care planning service in hospital and community health settings: a qualitative study. *BMC Palliative Care*, *20*(1). https://doi.org/10.1186/S12904-021-00835-X

Overbeek, A., Korfage, I. J., Jabbarian, L. J., Billekens, P., Hammes, B. J., Polinder, S., Severijnen, J., Swart, S. J., Witkamp, F. E., van der Heide, A., & Rietjens, J. A. C. (2018a). Advance Care Planning in Frail Older Adults: A Cluster Randomized Controlled Trial. *Journal of the American Geriatrics Society*, *66*(6), 1089–1095. https://doi.org/10.1111/JGS.15333

Pedrosa Carrasco, A. J., Berlin, P., Betker, L., Riera-Knorrenschild, J., von Blanckenburg, P., & Seifart, C. (2022). Developing a care pathway for hospital-based advance care planning for cancer patients: A modified Delphi study. *European Journal of Cancer Care*, *31*(6). https://doi.org/10.1111/ECC.13756

Reed, M.,; Stewart, S., Meyer, S., Seferian, E., Sax, H. (2020). Enhancing POLST completion in a hospital setting: An interdisciplinary approach. *Journal of Healthcare Management 65(6)*. https://doi.org/10.1097/JHM-D-19-00003

Ricotta, D. N., Parris, J. J., Parris, R. S., Sontag, D. N., Bioethics, M., & Mukamal, K. J. (2018). The burden of guardianship: A matched cohort study. *Journal of Hospital Medicine*, *13*(9), 595–601. https://doi.org/10.12788/JHM.2946

Rodriguez, G. M., Parikh, D. A., Kapphahn, K., Gupta, D. M., Fan, A. C., Shah, S., Srinivas, S., Teuteberg, W., Seevaratnam, B., Asuncion, K., Chien, J., Moore, K., Ruiz, S. M., & Patel, M. I. (2024). Coaches Activating, Reaching, and Engaging Patients to Engage in Advance Care Planning: A Randomized Clinical Trial. *JAMA Oncology*. https://doi.org/10.1001/jamaoncol.2024.1242

Rogers, J., Goldsmith, C., Sinclair, C., & Auret, K. (2020). The advance care planning nurse facilitator: describing the role and identifying factors associated with successful implementation. *Australian Journal of Primary Health*, *25*(6), 564–569. https://doi.org/10.1071/PY19010

Sinclair, C., Auret, K. A., Evans, S. F., Jane, F., Dormer, S., Wilkinson, A., Greeve, K., Koay, M. A., & Brims, F. (2020). Impact of a Nurse-Led Advance Care Planning Intervention on Satisfaction, Health-Related Quality of Life, and Health Care Utilization Among Patients With Severe Respiratory Disease: A Randomized Patient-Preference Trial. *Journal of Pain and Symptom Management*, *59*(4), 848–855. https://doi.org/10.1016/J.JPAINSYMMAN.2019.11.018

Sloan, D. H., Hannum, S. M., DeGroot, L., Dy, S. M., Waldfogel, J., Chyr, L. C., Heughan, J. A., Zhang, A., Wilson, R. F., Yuan, C. T., Wu, D. S., Robinson, K. A., & Cotter, V. T. (2021). Advance Care Planning Shared Decision-Making Tools for Non-Cancer Chronic Serious Illness: A Mixed Method Systematic Review. *The American Journal of Hospice & Palliative Care*, *38*(12), 1526–1535. https://doi.org/10.1177/1049909121995416

Sokol-Hessner L, Zambeaux A, Little K, Macy L, Lally K, McCutcheon Adams K. *"Conversation Ready": A Framework for Improving End-of-Life Care (Second Edition)*. IHI White Paper. Boston: Institute for Healthcare Improvement; 2019

Sudore, R. L., Schillinger, D., Katen, M. T., Shi, Y., Boscardin, W. J., Osua, S., & Barnes, D. E. (2018). Engaging Diverse English- and Spanish-Speaking Older Adults in Advance Care Planning: The PREPARE Randomized Clinical Trial. *JAMA Internal Medicine*, *178*(12), 1616–1625. https://doi.org/10.1001/jamainternmed.2018.4657

Teoli, D., & Ghassemzadeh, S. (2023). Patient Self-Determination Act. *StatPearls*. https://www.ncbi.nlm.nih.gov/books/NBK538297/

Thom, N., McKeen, W., & Bird, K. (2021). Racial and Language Disparities in Appointing Health Care Proxies (2300). *Neurology*, *96*(15_supplement), 2300. https://doi.org/10.1212/wnl.96.15_supplement.2300

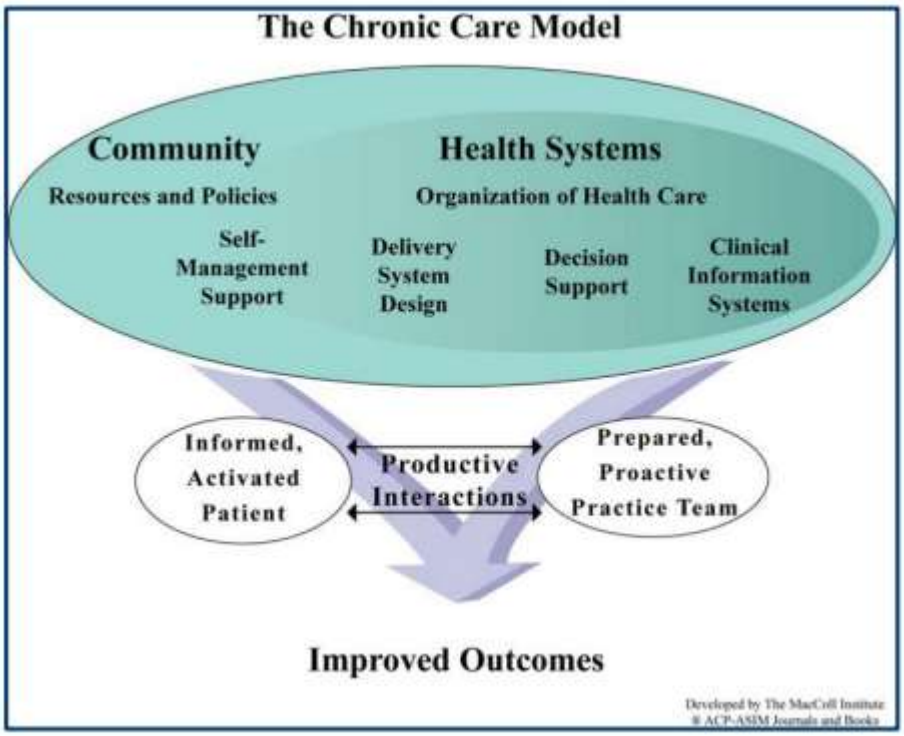
Walker, E., McMahan, R., Barnes, D., Katen, M., Lamas, D., & Sudore, R. (2018). Advance care planning documentation practices and accessibility in the electronic health record: implications for patient safety. *Journal of Pain and Symptom Management*, *55*(2), 256–264. https://doi.org/10.1016/J.JPAINSYMMAN.2017.09.018Wagner E. H. (1998).

Chronic disease management: what will it take to improve care for chronic illness?. *Effective clinical practice : ECP*, *1*(1), 2–4.

Yadav, K. N., Gabler, N. B., Cooney, E., Kent, S., Kim, J., Herbst, N., Mante, A., Halpern, S. D., & Courtright, K. R. (2017). Approximately one in three us adults completes any type of advance directive for end-of-life care. *Health Affairs*, *36*(7), 1244–1251. https://doi.org/10.1377/HLTHAFF.2017.0175/ASSET/IMAGES/LARGE/2017.0175FIGEX3.EPS.GZ.JPEG

Appendix A

Project Theoretical Framework



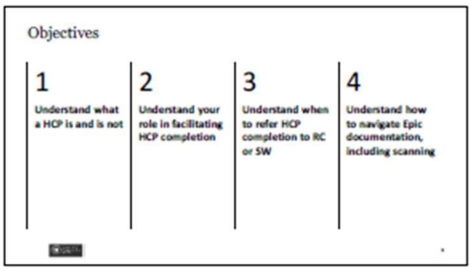
Used with permission of American College of Physicians from Effective Clinical Practice, Chronic disease management: what will it take to improve care for chronic illness? Edward H. Wagner, 1, 1998; permission conveyed through Copyright Clearance Center, Inc.

Appendix B

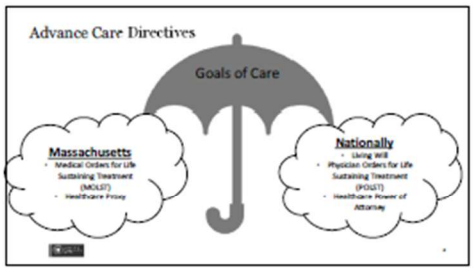
Educational Materials

1

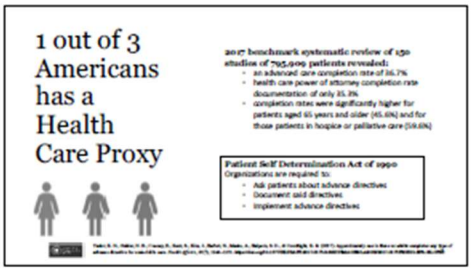
2



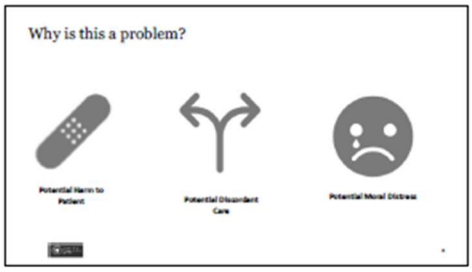
3



4



5



6

Case Example

7

Health Care Proxy- What is it?

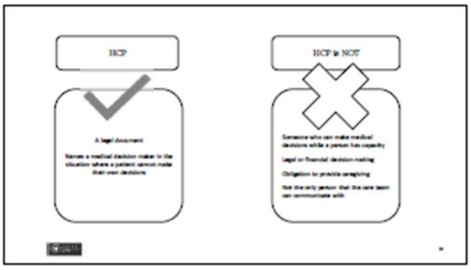
- A legal document that names an individual who can make medical decisions on a person's behalf if they are incapable of making such decisions themselves
- When activated or affirmed, a named health care agent can make any medical decision that a person could make for themselves
- In Massachusetts, only a designated Health Care Agent or a court-appointed legal guardian has the legal authority to make medical decisions for another person.

8

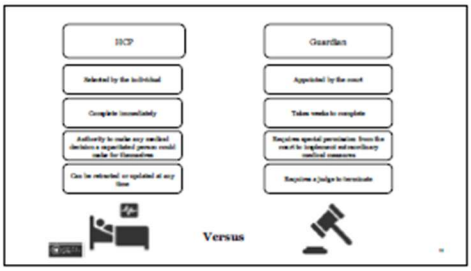
Definitions

Health Care Proxy (HCP)	Health Care Agent (HCA)	Witness	Activation/Invocation	Affirmation
• A legal document naming person(s) who an individual trusts to make medical decisions for them in a situation where they are incapacitated	• The named decision maker in a HCP. There can be a primary and secondary agent named • Cannot be a member of the patient's healthcare team	• 2 witnesses are required for a HCP to be valid • Witnesses attest that they believe the person signing the HCP understands what they are signing and are not signing under duress • The witnesses cannot be the person(s) named as the Health Care Agent and must be 18 years old	• When a physician determines that an individual lacks capacity, they activate or invoke a HCP • HCA expected to make decisions on individual's behalf • An order is placed in Epic to activate/invoke the HCP	• If there is disagreement between an individual and their active HCA, the hospital may choose to go to court to have the HCP affirmed, a legal process to enforce the HCA's decision

9



10



11

Case Examples

Case #1

76 F with Type II DM, CAD, HTN, Parkinson's Disease presents after being found down. Found to have had a large cerebellar infarct with aphasia and significant L side neglect.

- No HCP prior to admission
- Guardianship pursued
- Course complicated by recurrent aspiration, hypoxemic respiratory failure.
- Transition to CMO significantly delayed while awaiting expanded guardianship

Case #2

84 M with OA, spinal stenosis, BPH, dementia, AFib on anticoagulation admitted with fall resulting in thoracic compression fractures and significant pain. Noise is HCP. HCP was activated prior to admission. Course complicated by delirium. PT recommending skilled nursing facility at discharge. Patient adamantly refusing to go to rehab.

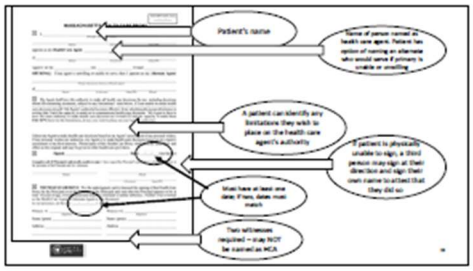
- HCP proxy affirmed by court prior to transfer to SNF

Case #3

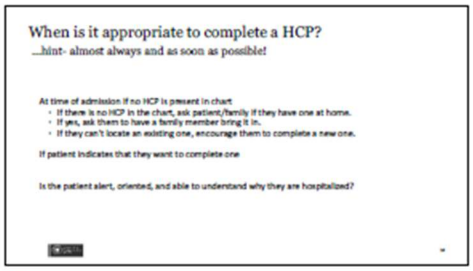
75 F has a past medical history of cognitive decline NOS, depression, HTN, hypothyroid disease presented with altered mental status. Determined to lack decision making capacity by hospitalist attending. Legal guardianship pursued and prolonged due to complex financial situation.

- Course complicated by DVT
- Anticoagulation started resulting in GI Bleed
- Found to have new ductoral malignant mass

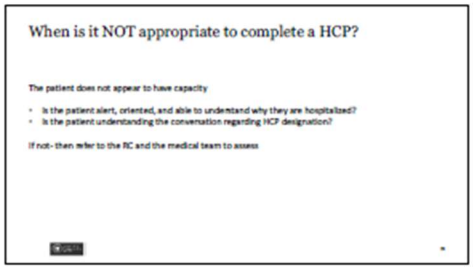
12



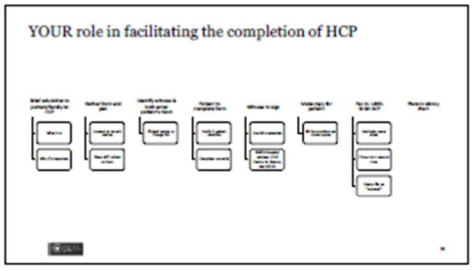
13



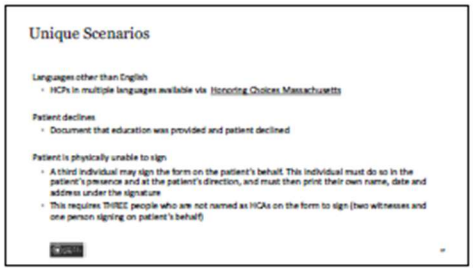
14



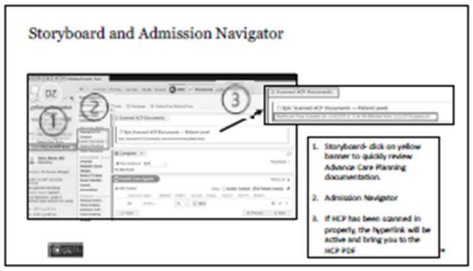
15



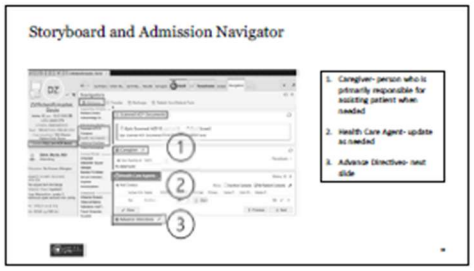
16



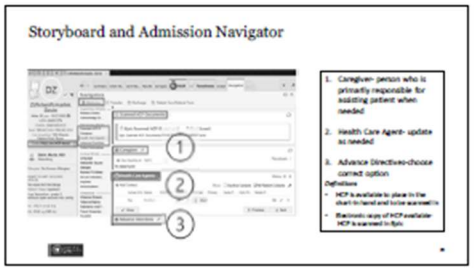
17



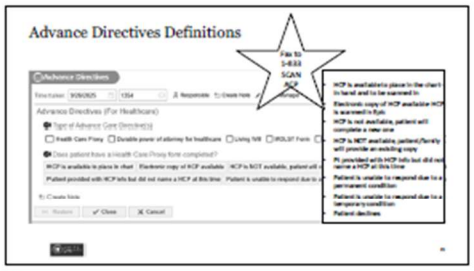
18



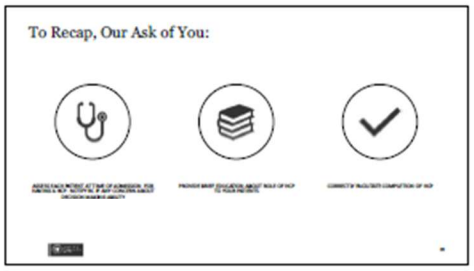
19



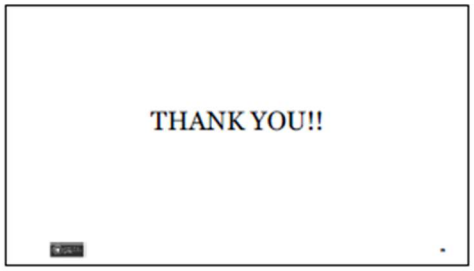
20



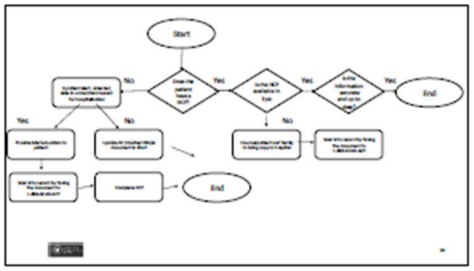
21



22



23



24

Appendix C

University of Massachusetts IRB Approval

UMassAmherst

Human Research Protection Office

Mass Venture Center
100 Venture Way, Suite 116
Hadley, MA 01035
Telephone: 413-545-3428

Memorandum – Not Human Subjects Research Determination

Date: May 19, 2025

To: Professor Kristine Ruggiero and Johanna Baldassari, College of Nursing

Project Title: *Improving Health Care Proxy Procurement Rates for Hospitalized Older Adults- A Nurse Led Intervention*

HRPO Determination Number: 6716

The Human Research Protection Office (HRPO) has e6aluated the above named project and has made the following determination based on the information provided to our office:

☐ The proposed project does not involve research that obtains information about living individuals [45 CFR 46.102(f)].

☐ The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information [45 CFR 46.102(f)(1), (2)].

☒ The proposed project does not meet the definition of human subject research under federal regulations [45 CFR 46.102(d)].

Submission of an Application to UMass Amherst IRB is not required.

Note: This determination applies only to the activities described in the submission. If there are changes to the activities described in this submission, please submit a new determination form to the HRPO prior to initiating any changes. ***Researchers should NOT include contact information for the UMass Amherst IRB on any project materials.***

A project determined as "Not Human Subjects Research," must still be conducted ethically. The UMass Amherst HRPO strongly expects project personnel to:

- treat participants with respect at all times
- ensure project participation is voluntary and confidentiality is maintained (when applicable)
- minimize any risks associated with participation in the project
- conduct the project in compliance with all applicable federal, state, and local regulations as well as UMass Amherst Policies and procedures which may include obtaining approval of your activities from other institutions or entities.

Please do not hesitate to call us at 413-545-3428 or email humansubjects@ora.umass.edu if you have any questions.

Jorge A. Guzman, Associate Director
Human Research Protection Office