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# Development and Evaluation of an Educational Intervention Regarding Advance Directives in a Native American Population

Donna Alford

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DEVELOPMENT AND EVALUATION OF AN EDUCATIONAL INTERVENTION  
REGARDING ADVANCE DIRECTIVES IN A NATIVE  
AMERICAN POPULATION

by

Donna Alford

A Doctoral Project  
Submitted to the Graduate School,  
the College of Nursing and Health Professions  
and the School of Leadership and Advanced Nursing Practice  
at The University of Southern Mississippi  
in Partial Fulfillment of the Requirements  
for the Degree of Doctor of Nursing Practice

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## ABSTRACT

The Patient Self-Determination Act of December 1991 directs healthcare facilities to inform patients regarding their right to make decisions about their healthcare, their right to refuse care, and their right to designate a healthcare surrogate. Culturally diverse populations often do not complete advance directives as often as other populations. The purpose of this project was to determine if an educational intervention, using a culturally appropriate video and written materials, improves understanding about advance directives among a Choctaw Native American population. The project used feedback from tribal members to evaluate the effectiveness of this educational intervention and modify it so that it can be used in Tribal healthcare and community settings to improve understanding of advance directives. The theory for this project, Leininger's Culture Care Diversity, and Universality Theory allows providers to use culturally focused clinical educational interventions to promote respect and decision-making in cultural populations (Leininger & McFarland, 2006).

The advance directive educational video and written materials were prepared with the Tribal healthcare employees and video department. Eight Choctaw tribal members evaluated the video and educational materials. None of the participants had advance directives, and 75% of them said they had never been told about advance directives. Choctaw tribal members expressed favorable responses to using a video to discuss advance directives. The Choctaw tribal members did emphasize the importance of making the materials and video in their Choctaw language. The healthcare outcomes and education should be further examined when this information is presented using Choctaw Tribal language by partnering with Choctaw Tribal language experts.

## ACKNOWLEDGMENTS

This student appreciates the contributions of the nursing faculty who have helped me throughout this DNP education. Special thanks to the ever-patient leadership of Dr. Bonnie Harbaugh and Sonia Adams. Although initially resistant to the suggestion that the DNP or nursing profession could have a “terminal degree,” I have learned a great deal.

I would also like to acknowledge the Mississippi Band of Choctaw Indians and Choctaw Health Center staff for their contribution and support of this project.

I would also like to acknowledge the support and prayers of many great friends at Home-Based Primary Care at the G.V. “Sonny” Montgomery VA Medical Center.

## DEDICATION

I would like to dedicate this project to my family, who encourage and support all my endeavors. I would like to especially dedicate this to my dad, who was paralyzed with metastatic cancer and he looked up at me and said, “I may be dying, but they are killing me up here.” Dad and I had a lot of difficulty getting his wishes followed at the end of life.

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## CHAPTER I - INTRODUCTION

The Patient Self-Determination Act of December 1991 directs healthcare facilities to inform patients regarding their right to make decisions about their own health care, their right to refuse or accept care, and their right to designate and record advance directives (Thomas, 2005). Advance directives are designed to allow patients to make decisions regarding their end-of-life care, whether by choosing specifics about their care or by choosing a healthcare surrogate. Healthcare providers are obligated to make sure patients are aware of their options and that they can make decisions about their care. Advance directives, delivered in an efficacious manner, prevent undue suffering and allow patient autonomy regarding their end-of-life care (Duke, Yarbrough, & Pang, 2009).

### Purpose of the Project

Culturally diverse populations often have difficulty participating with healthcare providers in the completion of advance directives due to diverse cultural meanings associated with sickness and death. An educational intervention, which improves the Native American patient's knowledge, participation, and the ability for decision making regarding advanced directives, is the desired outcome of this project. Increasing understanding of the purpose and use of advance directives within this population is necessary, as is informing patients of their rights when completing advance directives.

The project involves formulating an intervention to enhance understanding and increase the completion of advance directives among Native American patients through the development of culturally appropriate educational video with supplementary printed educational materials. This educational intervention and written materials can be utilized

by tribal and nontribal providers in multiple hospital and clinic settings to educate Mississippi Choctaw tribal members about advance directives. The intervention provides a culturally specific instructional video and educational material about completion of advance directives. This intervention is specific for this population and (a) helps overcome barriers preventing tribal members from completing advance directives, and (b) assists providers in providing education to Native American patients.

The purpose of this doctoral project was to develop a culturally appropriate educational intervention that increases the use of advance directives within the Mississippi Choctaw population. This plan utilized input from tribal community representatives in three hospital settings to formulate a culturally appropriate video featuring Choctaw healthcare educators along with culturally appropriate printed educational materials and presented this information to tribal members. Choctaw tribal members meeting in small groups or community settings provided oral and/or written feedback about the advance directive education. The revised version of the video will be available for use by tribal and nontribal providers in multiple hospital and clinic settings where Choctaw tribal members receive patient education about completing advance directives.

The project provided a mechanism to deliver cost-effective patient education with the use of educational video and printed materials that are culturally appropriate for use in several different patient care settings. The deliverables of this project included an educational video and printed educational materials, which are culturally focused on Native American patients and could be used in both hospital and clinic settings. The

strengths, weaknesses, opportunities, and threats for this project are summarized in Appendix A. A project Logic Model may be examined in Appendix B.

### Doctor of Nursing Practice Essentials

The Doctor of Nursing Practice (DNP) Essentials provide a basis or foundation for DNP practice. They were formulated in response to the changing healthcare climate, which responded to the patient care needs for increased information systems, coordination of care in an efficient manner, and increased need for patient safety (American Association of Colleges of Nursing [AACN], 2006). The delivery of culturally competent care within these essentials can also provide a basis for advanced practice (McFarland & Eipperle, 2008). Advanced nursing practice can provide culturally competent care using scientific underpinnings of nursing and culturally competent theory, such as Leininger's to provide care to different populations (Leininger & McFarland, 2006). Patient care technology, which can be used to promote culturally specific care, applies to another DNP essential to provide care which improves the delivery of care to specific populations. This technology can be cost-effective for the advanced practice nurse. Another DNP essential utilized in this project was a healthcare policy, which takes the legal rights of advance directives and introduces them through the use of a culturally competent video for this patient population. This project also utilized the important DNP essential of promoting population health care by utilizing a video to educate this population about advance directives. The complete list of DNP essentials and how they are related to this project can be found in Appendix C.

## Project Question

Does an educational intervention, which includes the use of culturally appropriate video and written materials, improve understanding about advance directives among a Native American population?

## Background and Significance

The rights of patients to direct their own medical care are based on both common and legislative law. The Patient Self-Determination Act of December 1991 directs healthcare facilities about informing patients regarding their rights to make decisions about their own healthcare, their right to refuse or accept care, and their right to designate and record advance directives (Thomas, 2005). Healthcare facilities are also mandated to provide education to the community about their rights to make decisions that direct their healthcare (American Bar Association, Division of Public Education, n.d.).

Mississippi addresses provider and patient responsibilities in end-of-life care in the Uniform Healthcare Decisions Act (1998). This legislation allows Mississippi patients to designate preferences for end-of-life care and/or healthcare proxy or to take no actions. Patients can give oral or written designation. They have the right to be specific or not to specify anything. Current legislation does not require patients to complete advance directives; however, healthcare professionals are required to instruct patients about their right to complete advance directives. Each patient has the right to make an advance directive or designate a power of attorney for healthcare at any time with their healthcare provider.

## Needs Assessment

The Native American population targeted by this educational intervention is a Choctaw tribal population in rural Mississippi. Healthcare is provided by one tribally based hospital that serves all of the Choctaw tribal communities. This tribal hospital contracts service with several similar facilities in nearby communities. The Choctaw hospital social worker has the responsibility of assisting with completion of advance directives for patients in the tribal facility. This social worker estimated that < 10 patients within the tribe have completed advance directives. The project author attended an in-service with 10 Native American providers present. One provider, who had over 5 years of experience with the local Native American population, expressed difficulty when discussing end-of-life decisions with Native American patients.

No current educational programs exist within the tribal healthcare system for advance directive education other than a discussion about advance directives that is usually discussed with the patient by the social worker or provider. No routine advance directives are being discussed in the clinic settings. Although most tribal members speak English, they often request a family member or a trusted tribal member to help interpret the meaning when discussing healthcare decisions with providers who are unfamiliar to them. Choctaw is a language that is not spoken by all tribal members. Often younger tribal members may not know some of the words that older tribal members use. Therefore, discussions about advance directives may be ineffective if the right family member or tribal interpreter is not present with the patient.

Educational interventions that target the healthcare needs of different cultural populations are needed within health

care environments. The cultural population to be impacted by this evidence-based project includes rural Native American Mississippi Band of Choctaw Indian communities in Mississippi with a total population of approximately 10,000 residents. These tribal communities are spread over 35,000 acres in 10 counties within Mississippi (Mississippi Band of Choctaw Indians, 2016). The dissemination of culturally appropriate education regarding advance directives is important because Native American patients are at higher risk for complications of chronic medical conditions and often have comorbid complications that put them at higher risk for complications (Liao et al., 2011). Limitations that affect access to healthcare are well documented with Native Americans. Native Americans rate their healthcare as poor and suffer higher rates of chronic medical conditions in the community settings. These illnesses lead to a cycle of economic, educational, and social inadequacy for Native Americans in the community setting which need to be addressed during interactions with their healthcare providers (Liao et al., 2011).

Native Americans are a minority population who continue to have poor access to healthcare, multiple risk factors for accidental and chronic disease, and multiple chronic medical conditions. Poor access to healthcare often compounds these chronic medical conditions because many Native Americans do not seek healthcare in settings that are not tribally located. Partnering with Native American providers in tribal settings to increase patient education is one strategy to improve Native American culturally focused healthcare knowledge. Findings of the Racial and Ethnic Approaches to Community Health Across the U. S. Risk Factor Survey (2009, as cited in Liao et al., 2011) reiterates

the importance of community-based strategies that can impact the health of minority populations.

The foundation of patient care should include an agreement between the provider and the patient related to medical care needed and the patient's preferences for care, which requires that the knowledge and discussion of patient preferences for care be mutually discussed and agreed upon. Many people have specific cultural or religious beliefs that they want to be carried out when they are or may be dying. Failure to observe patient rights related to advance directives may result in litigation regarding medical battery, breach of contract, negligence, lack of informed consent, and wrongful life (Watson, 2010). Legal issues can arise when there is a poor understanding of the rights and responsibilities of the patient, provider, and institution. Legal problems can undermine patient satisfaction, outcomes, and provider practice. Failure to observe patient rights can also increase healthcare costs (Klingler, in der Schmitten & Marckmann, 2016).

### Theoretical Framework

This DNP project is based on Leininger's Culture Care Diversity and Universality Theory (Leininger & McFarland, 2006). This theory explores the relationship between caring and the wellness/illness continuum of diverse cultural populations. The goal of this DNP project was to develop an educational intervention for use with a Native American population to make their wishes relating to advance directives known to their providers in the healthcare setting. The participation of culturally expert staff and Native American professionals will enhance the use of this educational project within this culturally unique population. This educational intervention will provide a resource to

increase knowledge of the use of advance directives for this Native American population as well as a decision-making tool that will enhance decision-making abilities and encourage questions about advance directives.

Clinical expertise, advocacy, collaboration, and systems thinking were used during this project to formulate an educational intervention for this culturally distinctive population. A culturally focused clinical educational intervention will provide an intervention that is both caring and responsive to the cultural diversity unique to this population. Leininger's Culture Care Diversity and Universality Theory is utilized in a variety of cultural settings to promote respect for cultural methods individualized for patient populations that ensure the important outcome of informed decision making (Leininger & McFarland, 2006).

The Culture Care Diversity and Universality Theory (Leininger & McFarland, 2006) is used to discover cultural beliefs within a population. The method used to discover these cultural meanings and practices is also known as the ethnonursing research method, which was developed by Leininger to qualitatively assess cultural populations in order to plan culturally congruent care for these populations. The Culture Care Diversity and Universality Theory (Leininger & McFarland, 2006) allows planning and confirmation of caring practices that provide outcomes described as both protection as well as respect for vulnerable, culturally diverse patient populations. Caring practices mandate anticipation of the patient's unique cultural beliefs and enhance understanding and competence sensitive to their culture and care. Input from the patient, family, and the multidisciplinary team is needed to promote the cultural input in planning this intervention. Culturally-specific input allows meanings and expression of care within

this population to allow for culturally appropriate healthcare decisions. Cultural educational interventions will enhance the process to provide enhanced provider and patient participation within a climate which is culturally caring to the unique population served.

Limitations with the use of Culture Care Diversity and Universality Theory (Leininger & McFarland, 2006) lie with the difficulty among the variable beliefs and meanings within the population utilizing this culturally-specific education. The culturally-based educational intervention should not limit the cultural expression of each participant's use of advance directives. The Native American population may be unpredictable among different ages, families, and among different communities with respect to their beliefs about end-of-life issues. Interventions that limit cultural expression of these beliefs might reduce the participant's use of an educational intervention. Nursing caring in this cultural population should not enforce beliefs that impose limitations within this educational intervention.

Leininger's Culture Care Diversity and Universality Theory (Leininger & McFarland, 2006) were used to discover cultural caring by healthcare professionals. This process allows the provider to interact with the culturally specific "lifeways" of this population (Leininger & McFarland, 2006, p. 74). Culturally specific education allows for the influence of cultural structure, values, and beliefs in the provider/patient interaction. Utilizing the video format allows key cultural elements and key cultural informants to be visible in the structure of this educational intervention.

## Review of the Evidence

Several researchers related that the completion of advance directives among the general population is about 20% and that completion among certain Native Americans can be as low as 1% (Baldrige, 2011). Several factors are implicated in these rates, such as (a) written information not culturally or linguistically individualized for the population, (b) a distrust of hospital or governmental regulations, and (c) lack of understanding the medical terminology involved in the advance directive process (Kwak & Haley, 2005; Searight & Gafford, 2005; Zager & Yancy, 2011).

In a 2005 survey of Native American healthcare directors, 58% rated advance care planning as one of their most current needs related to end-of-life care in their communities (Michalek, Mahoney, Gilbert, & Kaur, 2005). Although recent case studies with Native Americans have had success with the community-based one-on-one completion of advance directives, a recent Cherokee tribal program has noted that completion of legal forms, such as advance directives, is a substantial barrier and may even delay hospice care or referral (Baldrige, 2011).

The Institute of Medicine's (IOM) report in 2014 stressed the importance of evaluating strategies to foster healthcare decision making among culturally diverse populations. Collaborations among racial minorities and healthcare providers can empower the patient's cultural decision-making among patients and families (IOM, 2014). Qualitative research in this report suggests that Native Americans perceive discrimination in care more from nontribal providers; therefore, education at the tribal level is much less likely to be perceived as negative in nature. Many nontribal providers may demonstrate bias because some Native American patients may have difficulty

translating some parts of language from their native language to English language. They may fail to openly discuss issues because of these language barriers. Some Native American patients may not openly discuss issues based on varying cultural factors, such as needing to discuss issues with family before making end-of-life decisions. Other cultural issues that could create bias in nontribal providers are the fact that some Native Americans avoid direct eye contact as a way of respecting the other person. They may even prefer another tribal person to speak for them. These issues may affect nontribal providers who interpret these actions as disinterest or lack of knowledge about healthcare decisions, thereby creating a bias in caring for these patients. These biases can negatively impact the care of Native American patients (Canales et al., 2011; IOM, 2003).

Review of current research involving different racial groups and decisions regarding end-of-life demonstrates a poor understanding of advance directives that impact the ability of these minority racial groups to complete advance directives (Kwak & Haley, 2005). Barriers to completion of end-of-life decisions have included problems related to the sensitivity of these discussions with Native American patients. Many of the Native American facilities may focus on acute episodic care rather than chronic care; however, the increasing incidence of Native American patients dealing with chronic medical illnesses makes end-of-life discussions a necessity. Kitzes and Berger (2004) examined the medical records of 114 Native American patients; about 95% of the charts reviewed demonstrated no end-of-life planning discussions in the medical records. The conclusion of the study emphasized the need for family discussions and individual variety of preferences regarding end-of-life care decisions. Native American patients may want to withhold making healthcare decisions until they speak with family or native healers.

Qualitative research conducted among several Native American tribal members suggests that there is considerable variability in beliefs and considerations with completing advance directives (Canales et al., 2011). Quantitative research conducted by Johnson, Kuchibhatla, and Tulskey (2008) consisted of 205 Caucasian and African-American clinic patients. Johnson et al. found that ethnicity, more than culture, might explain differences in advance care planning. Native Americans also have variability in their beliefs among tribes. Current programs have demonstrated that assumptions about their cultural beliefs might not be accurate. Many programs have success when they provide individual care which assesses patient beliefs and needs (Baldrige, 2011).

Legal issues may also hinder Native Americans from completion of advance directives. Castillo et al. (2011) discussed several legal concerns related to advance directives which impact different cultural groups. Readability is a major concern with completion of advance directives with varying cultural groups since laws related to advance directives are written above the 12th-grade level. Lengthy legal forms and requirements for notary witness of signatures can also hinder completion of patient wishes. Although Mississippi permits oral advance directives, some hospitals have requirements for notarized advance directives in their facilities. Legal requirements can be interpreted by some Native Americans as “intrusive and insensitive” (Kitzes & Berger, 2004, p. 836).

Different ways to present advance directive discussions have been compared. Fixed procedures of just signing and witnessing forms in the hospital setting may create barriers with obtaining Native American patients’ true wishes for end-of-life care. Payne, Prentice-Dunn, and Allen (2010) compared advance directive information when given in

a threatening/coping manner as compared to a preventive/positive intervention and found that elderly adults were more likely to complete advance directives when they were part of the preventive/positive intervention group. However, this research did not differentiate between different cultural groups.

Educational interventions have been shown to be effective when discussing advance directives. Education about advance directives and advance care planning should be culturally sensitive since cultural beliefs influence illness and death. For example, the Navajo believe that talking about death could cause it to occur; therefore, discussions of advance directives might have some variability in different tribal settings (Baldrige, 2011). Educational interventions can include family members since some cultural groups value input from the family unit with discussion and decision-making. Research demonstrates that healthcare planning education enhances culturally-based understanding of end-of-life issues (Johnson et al., 2008; Zager & Yancy, 2011).

Educational interventions within Native American populations involve communication, which not only should have easily understood wording, but research has also shown improved results when this education is delivered in a culturally-appropriate manner. Since listening is important to Native Americans, the tone of communication should be calm and steady. Assertiveness and being direct are not valued among Native American conversation. Non-verbal communication, such as avoidance of direct eye contact and emotional expressions, are important factors in Native American communication. Education, which is part of their community, is more appealing than education delivered by an outside person they may not trust (Baldrige, 2011).

Group interventions have proven successful in Native American settings. Canales et al. (2011) also utilized group meetings with tribal leaders and cancer survivors to collect qualitative data about cancer experiences and educational needs. Canales et al. discussed the implications of intergenerational distrust among Native Americans which impact their cancer care. They advocate the importance of building provider relationships in Native American healthcare. Lack of education worsens the distrust that many Native Americans experience. Canales et al. (2011) stressed the powerful influence of word-of-mouth information in Native American communities and families (see Literature Matrix in Appendix D).

## CHAPTER II – PROBLEM AND MISSION STATEMENT

Many factors can influence the completion of advance directives among Native American people. Evidence does support the use of culturally appropriate educational interventions to improve the completion of advanced directives. The purpose of this DNP project was to develop a culturally appropriate educational intervention designed to increase the use of advance directives within the Choctaw population.

The intervention was based on the current review of research evidence. Sources document that some Native American tribes have no problems discussing end-of-life issues, whereas some tribes have beliefs that if they discuss end-of-life issues this might bring less than favorable outcomes (Baldrige, 2011). Many factors impact the understanding of patient information in culturally-diverse populations. Feedback from multiple small groups within the Choctaw community members will enable revision and improvement of the video and printed educational materials to enhance culturally appropriate understanding. The mission of this educational intervention involves the formulation of an educational intervention and revision of this educational intervention utilizing culturally-based small group feedback to revise the intervention so that it can be utilized in a variety of tribal healthcare settings.

### Project Objectives

The objectives of this DNP project were as follows:

1. Evaluate the scientific basis for an advanced directive educational intervention within a Native American population.
2. Utilize organizational and clinical leadership in the implementation of a culturally-based advance directive educational intervention.

3. Implement a community-based educational intervention utilizing input through collaboration with other healthcare providers, members of the Native American population, and review of research related to advance directives.
4. Revise this educational intervention based on the feedback from members of the Native American community who participate in the educational intervention.

### Project Activities

#### *Setting*

This project was conducted in a Native American community setting in rural Mississippi. Permission was requested for implementation of this project from the Tribal Chief, and a letter of approval from the Mississippi Band of Choctaw Indians for this project was received from the Choctaw Tribal Chief (see Appendix E). Tribal and hospital staff provided cultural input related to the educational intervention. The main tribal hospital and two outlying community hospitals have Native American staff, which currently provide care for Native American patients and will be asked for their input in the formulation of this educational intervention. Meetings with the staff from all three of these medical centers provided input for this educational intervention that will be available for use in a variety of practice settings.

#### *Population*

The population for this educational intervention is a southern tribe of Native Americans with a population > 10,000 members. Participants were older than 18 years of age.

## Design

This project was an educational intervention co-created with tribal healthcare providers and was evaluated by eight people from the local tribal population who viewed the educational video and written materials. After completion of consent and demographic information, the tribal participants evaluated and gave critique in interviews, meetings, and a culturally focused questionnaire.

## Procedures

The sample of eight tribal members evaluated this educational intervention. An explanation of the project and consent for participation was obtained prior to each person's participation. The participants included Native Americans in this community setting who ranged in age from 28 to 69 years. Five men and three women participated. The education consisted of a video presentation and review of a printed pamphlet (see Appendix F). Participants were encouraged to ask any questions related to the presentation. After the presentation, the participants completed a brief demographic questionnaire and a culturally focused questionnaire (see Appendices G and H). The questionnaires were created for this educational intervention. None of the participants included their name on the questionnaire. Based on the evaluative information received, the printed materials and video will be revised in the future and then provided to healthcare providers for use with Native American populations. The video utilized a Native American presenter to discuss the advance directives and was produced in the tribal video department at no cost to the Choctaw tribe. The video script and printed pamphlets were co-developed with the Native American presenter and the Native American social worker. The project resulted in cost savings to the tribal facility for both

the production expense and the time that healthcare providers would spend formulating a similar video. The readability level of the written handout was 5th-grade—the Flesch-Kincaid grade level.

#### Ethical Protection of Human Subjects

Approval for this project was obtained from The University of Southern Mississippi's Institutional Review Board (IRB, Protocol #18071907) (see Appendix I). There were no known risks for participation in this project, and the only benefit to participation was the information that the participants and the tribe gained. Discussion of the content of the presentation on advance directives was recognized as being uncomfortable for some participants. However, none of the participants who were approached declined to be in the project. Participant instructions included that participation was voluntary and that they could withdraw from participation at any time (see Appendix J), which no one did. Adequate time at the end of the presentation was allowed for questions, and none of the participants needed to stay and talk with the student and tribal member who was assisting with the presentation to dispel discomfort. No one was referred to a tribal mental healthcare provider for counseling. The presenter read the questions aloud to groups and individual participants so that they could answer the questions. An interpreter was available for patients to speak in Choctaw; however, no one requested translation. All participants were 18 years old and Native American. Participants were asked not to share their questionnaire responses with anyone. Questionnaire responses were confidential, and participants did include their name on the questionnaires. The participants' questionnaires were kept in a locked box.

Questionnaires will be stored in a locked file cabinet for 5 years at the student's home, then will be shredded.

An informational letter was included with the questionnaire for participants. The informational letter included the general purpose of the project and a description of procedures. This letter included the amount of time needed for the educational intervention and an expression of appreciation for participation in the presentation. The letter informed participants that participation in the educational intervention was voluntary and that they could terminate participation at any time without any penalty or recourse to the participants. The letter also stated that completion and submission of the signed letter was consent to participate in this DNP project. The participants were also given instructions about any follow-up questions by providing the name and contact numbers for the project presenter. There were no costs to the participants. After project participation, participants were given a \$10 Subway© gift card.

#### Timeline

The educational video and educational pamphlets were completed in early fall of 2018 with the participation of a Choctaw tribal member who taped the video. Evaluation was viewing of educational materials completed in mid-fall of 2018.

#### Resource Requirements and Source

Completion of the video was completed at the local tribal audiovisual department of the tribe with participation of a tribal volunteer who presented the video information.

## Budget

The estimated budget for the video and written information was \$500 which included the video and written information. Payment was made to the tribal audiovisual department at the student's expense. Incentives cost \$80 in the form of Subway® gift cards.

## CHAPTER III RESULTS

The advance directive educational video of 7 minutes in length was created by the tribal video department after the content was discussed with tribal social worker and other tribal healthcare workers. One individual recommended by the tribal video department who had worked with numerous tribal videos. The pictures and sound for the video presentation were taken from the usual tribal filming resources. The video was completed in about 4-6 weeks, with continual input and interaction between the student, tribal video department, social worker, and presenter.

Selection of the participants for review of the video was completed in three different tribal communities. The recruiting of the participants was via the tribal facility building personnel who suggested tribal people who would be good representatives to review the video. They were encouraged to select both some old and young and some men and women. Tribal facility personnel agreed to the time anticipated for completion of the video and questionnaires by the tribal members. Some additional tribal patients came and volunteered to review the video when they heard the presenter was at the community building. In the end, eight participants reviewed the video and written materials. Description of the information letter and each of the questionnaires were read by the project leader to each of the participants. None of the participants requested a tribal language translator. Each of the participants were given a Subway© gift card in the amount of \$10 for a sandwich in appreciation for completing this project.

The demographic questionnaire was completed by all participants in this project. All of the eight participants who participated were Native Americans. Five of the participants were male, and three of the participants were female. The ages ranged from

28 to 69 years. None of the participants had an advance directive, and 75% of them said they had never been told about advance directives. Half of the participants said they had family members with advance directives (see Appendix K).

The questionnaire used to evaluate this project was a 14-question survey with a range from 1 to 5 Likert type scale, which rated the questions as mainly traditional (5) to nontraditional (1) (see Appendix L). Traditional responses were responses that were more Choctaw or tribally oriented and nontraditional were responses that were more non-Choctaw or non-tribally oriented. The greatest number of responses fell into the “3” or middle range on the questionnaire when all eight respondents’ questionnaires were compared. The responses, which were rated as a “4” or “5” (more to mainly traditional) had a frequency of one response except for the following questions:

1. How do you view this video being used in the CHC and community? (25%)
2. How this relates to your daily beliefs? (25%)
3. How this reflects your religious and spiritual beliefs? (37.5%)

The written comments of each of the participants are summarized in Appendix M. Most all the respondents stated it would be good to have a video done in the Choctaw language for the “older” patients; respondents included written comments related to this request. There were several favorable responses about video presentation being a good idea for use in the tribal communities. Several of the participants expressed their appreciation of the information and being informed about their rights.

During the discussion with participants as they viewed the video and completed the questionnaires, this project author discussed the importance of tribal language with several of the respondents and they recommended consulting with the tribal language

department for assistance with translation of the materials into the Choctaw language. Although one of the respondents recommended that the video should be done by a female presenter who would present a more nurturing presentation, most of the respondents did not necessarily want a certain gender or a more native appearing dress. Several participants reflected that more casual dress closely resembled the usual Native American community. One participant related that he had family members with advance directives; however, he did not think that the medical providers followed the written requests of the family member who had an advance directive. Providers should discuss the advance directives with patients and families and with the broader healthcare provider community to make sure the advance directives were honored.

The video will have the following inserted at the end. This video was created by Donna Alford, Nurse Practitioner, in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice (DNP) at The University of Southern Mississippi College of Nursing and Health Professions. The Mississippi Band of Choctaw Indian and Choctaw Health Center employees assisted in the preparation of this video.

## CHAPTER IV – DISCUSSION

This advance directive educational project will be modified in the future to include a version in the tribal Choctaw language; however, healthcare providers' care to Choctaw tribal patients should continue to offer Choctaw translation services to tribal patients. When discussing advance directives, most of these Choctaw tribal members emphasized the importance of their Choctaw tribal language. Until a Choctaw language version can be produced, providers should include a family member or employee who can translate discussions into the Choctaw tribal language to avoid any misunderstanding and to make the patient's wishes known. These discussions will also assure that family members know that their family's wishes and goals for their care are carried out by their healthcare providers.

Choctaw tribal members expressed favorable responses to the use of a video to discuss advance directives. None of this sample of tribal members had advance directives, and most of them related that they had never been told about advance directives. They did discuss that they thought the use of a video and printed educational materials could be used in the community setting to explain advance directives to other tribal members. The eight tribal members who viewed the video expressed that this was useful information and that tribal members should be informed about this information.

One of the tribal members related that he would have preferred that the video had been presented by a female presenter. When the video is done in Choctaw tribal language, then the presenter could be completed with a female presenter. All the tribal members that reviewed the video and educational materials thought that the information on the video and pamphlet should be presented in Choctaw tribal language.

## Summary

In summary, the Culture Care Diversity and Universality Theory (Leininger & McFarland, (2006) can be utilized to discover cultural beliefs that impact the care of a population. The culturally focused questionnaire utilized in this project did help demonstrate the importance that the Choctaw tribal language has to this population. Even providers with numerous years of experience might not realize the importance of the Choctaw tribal language to patients that they care for every day. This knowledge has implications for both patient education and direct patient care. The use of tribal language translators should be examined more carefully in the care and patient education of this population.

The use of a video and accompanying pamphlet to provide patient education seemed to be received quite favorably by these Choctaw tribal participants. Increased use of patient education that can be used in the community, clinic settings, or even Choctaw tribal websites should be examined. The use of healthcare educational videos in the Choctaw tribal language and with some women who are presenting the information should be further examined. The healthcare outcomes as a result of this educational intervention should be further examined when this information is presented to this population in a culturally congruent manner to the input of their specific Choctaw tribal language. The use of tribal language translators should also be increased with this population to include partnering with the Choctaw tribal language experts for the healthcare organizations serving this population.

Further examination of patient education, which can be self-serviced using a tribal wellness website or clinic viewing, should be expanded culturally modified for use in the

Choctaw tribal population in the future. Written and video information about preventative priorities, such as diabetes care, influenza vaccines, etc., should be available in both English and Choctaw tribal language. Choctaw video information could be presented so that English wording can be captioned so that the viewer has Choctaw language being spoken, yet they can read the English version at the same time. Future culturally specific education can be evaluated further by examining the frequency of viewing and patient evaluation done utilizing web pages. Choctaw Tribal members also reported that they were visual and they enjoyed pictures; therefore, further education should be evaluated using culturally appropriate colors and pictures reflecting their tribal life.

There is an indication for further education for healthcare providers outside the tribal health system (contract providers) who might not recognize the significance of the Choctaw tribal language to this population. The availability of a Choctaw speaking video to discuss this advance directive information could be utilized in contract healthcare settings. Choctaw language and cultural education would be of benefit to healthcare providers in a variety of settings to improve the care of the Choctaw tribal population.

Leininger's Culture Care Diversity and Universality Theory should be further examined considering the uniqueness of this Choctaw tribal population (Leininger & McFarland, 2006). Cultural traditions have significance that are not always able to be detected by healthcare providers without deeper examination using a cultural perspective. Exploration of cultural uniqueness of healthcare populations cannot be underestimated in current medical care.

## APPENDIX A – SWOT Analysis

### **Strengths**

- Within one cultural population
- Can be used in a variety of healthcare settings

### **Weaknesses**

- Overcoming complexity of language and paperwork
- Education might not address the variety of beliefs

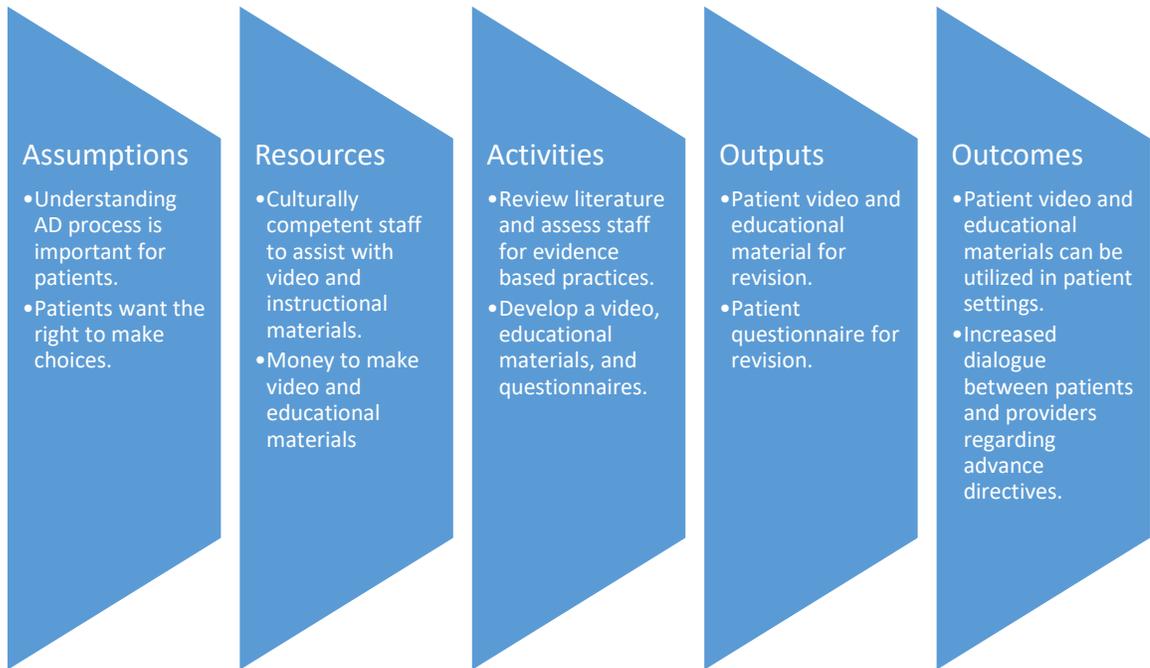
### **Opportunities**

- Consistent initial education
- Time efficient

### **Threats**

- Cultural beliefs
- Staff may resist using

## APPENDIX B – Logic Model



APPENDIX C – DNP Essentials and Clinical Implications for This Project

DNP ESSENTIALS	CLINICAL IMPLICATIONS
DNP Essential I: Scientific underpinnings for practice	The Integration of Leininger’s Culture Care Diversity and Universality Theory (1991) allows advanced practice nurses to utilize and respond to cultural influences within the populations that are cared for within these educational interventions.
DNP Essential II: Organizational and systems leadership for quality improvement and systems thinking	Organizational and systems leadership for quality improvement will be impacted by utilizing culturally-based input for revision of the educational intervention which is described in this project.
DNP Essential III: Clinical scholarship and analytical methods for evidence-based practice	This project is used to translate research into evidence-based practice utilizing an educational intervention... This project will utilize current research and culturally-based community input to formulate and revise an educational intervention which can be utilized in a variety of clinical settings for this Native American population.
DNP Essential IV: Information systems/technology and patient care technology for the improvement and transformation of health care	Utilizes information systems and technology to review literature through web-based data searches and use the findings to develop a video. Utilizes video technology to provide information in multiple clinical settings for this Native American population.
DNP Essential V: Health care policy for advocacy in healthcare	Involves patient advocacy and leadership in developing and implementing an educational intervention/video to improve health care outcomes for Native Americans.
DNP Essential VI: Interprofessional collaboration for improving patient and population health outcomes.	Includes interdisciplinary and intercultural collaboration to assess and formulate an educational intervention. This same collaboration will be utilized to evaluate this intervention for revision and improvement of the intervention to improve population outcomes.
DNP Essential VII: Clinical prevention and population health for improving the nation’s health	Education of this population of Native Americans will improve patient knowledge of their rights for completion of Advance Directives and prevent unnecessary services which might even be harmful.
DNP Essential VIII: Advanced nursing practice	Utilize advanced nursing practice with a cultural population to formulate and revise this educational strategy for this population.

APPENDIX D –Literature Matrix

<b>Author(s) Date</b>	<b>Purpose or Research Question(s)</b>	<b>Research Design/ Methods</b>	<b>Sample Method, Size, and Setting</b>	<b>Results</b>	<b>Weaknesses</b>	<b>Implication (s) for Practice</b>
Payne, Prentice-Dunn, & Allen (2010)	Evaluated whether older adults who received a protection motivation theory versus a general healthy aging theory were more likely to complete advance directives.	Pre and Post-intervention assessment. 46-item Likert-type questionnaire.	Non-random sampling in community-based setting. Participants had to be greater than 50 years of age, did not have an AD, and had to have intact cognition. 42 individuals were the sample size (majority of women and Caucasian) with only 34 completed 3-month follow up.	Post-intervention showed PMT participants expressed higher intents to complete AD, however, this was not a significant finding when physical functioning, age, and education were taken into account. At 3 month follow up more participants in the healthy aging group had both greater intentions to complete AD and did complete AD.	Prior Knowledge may have had an influence on results.  High female and Caucasian population.  Post-intervention assessments had missing items on questionnaires.	More studies with diverse populations and ages.  Need randomly assigned population for study.

<b>Author(s) Date</b>	<b>Purpose or Research Question(s)</b>	<b>Research Design/ Methods</b>	<b>Sample Method, Size, and Setting</b>	<b>Results</b>	<b>Weaknesses</b>	<b>Implication (s) for Practice</b>
Baldrige (2011)	Discussion of four case studies of programs which provide end of life care for Native Americans.	Case Study Discussions	4 Case Studies	Survey of four end of life programs for Native Americans showed success with advance care planning is possible.	These programs used different approaches, therefore you could not compare success between programs.	End of life discussions are individual and provider should make no assumptions.  Providers must realize that Native American Culture is not static and it reflects changes.  Empathy and inherent respect are important.
Canales, Weiner, Samos, Wampler, Cuna, & Geer (2011)	What are the Native American's cancer coping strategies and health care education needs?	Qualitative Investigation with both group and individual interviews	91 Northeastern Native Americans	Mistrust and miscommunication affect cancer care for Native Americans.	Only 17 individual interviews	Approaches to increase education and trust.

<b>Author(s) Date</b>	<b>Purpose or Research Question(s)</b>	<b>Research Design/ Methods</b>	<b>Sample Method, Size, and Setting</b>	<b>Results</b>	<b>Weaknesses</b>	<b>Implica- tion(s) for Practice</b>
Johnson, Kuchibhat la, & Tulsky (2008)	Survey of 5 scales (Hospice Beliefs & Attitudes, Preferences for Care, Spirituality, Healthcare System Distrust, and Beliefs about Dying and Advance Care Planning) to determine use of AD and beliefs about Hospice to determine what explains racial differences.	Cross- sectional survey	Random sample of primary care patients who were >65 with a total sample of 205.	Whites were more likely to have AD  African Americans were more likely to want life- sustaining measures.	A combination of beliefs and values influence end-of-life decisions	
Kwak & Haley, (2005)	Review of research literature to compare racial/ethnic diversity and end of life decisions to discuss findings and research recommen- dations.	Research literature review	33 Research articles	1. Non-white patients showed lack of knowledge and less support for AD. 2..African Americans favored life support. 3. Asian and Hispanics prefer family- centered decision- making. 4. Some multi- factorial variance was between groups.	Convenience Sampling  Some Self- developed measurement scales.	Need more culturally sensitive end-of-life planning for diverse racial or ethnic groups.

<b>Author(s) Date</b>	<b>Purpose or Research Question(s)</b>	<b>Research Design/ Methods</b>	<b>Sample Method, Size, and Setting</b>	<b>Results</b>	<b>Weaknesses</b>	<b>Implica- tion(s) for Practice</b>
Zager & Yancy, (2011)  Castillo, et al, (2011)	Examined cultural sensitivity areas with AD planning  Examined advance directive laws and legal actions related to their usefulness in clinical settings	Research literature review  Legal review of advance directives	10 research articles reviewed.  Review of laws related to AD in 50 states Review of 20 articles related to AD law Review of 105 federal and state legal proceedings	Increased need for education about cultural differences to assist with end-of-life planning Identification of 5 legal and content barriers: poor readability, health care agent restrictions, execution requirements, inadequate reciprocity, and religious, cultural, and social inadequacies.	End of life planning which respects values and beliefs of varying cultures Change from legal to a relationship, communication-based approach to AD planning. Change readability to a 5th-grade reading level. Remove health care agent limitations	
Searight & Gafford (2005)	What are the cultural factors that influence the patient reaction to serious illness and decisions.	Research literature review and U.S. Census data.	2000 U.S. Census data  Qualitative summaries	Discussion of different cultural preferences for end-of-life care.	Discusses preferences of many different cultures	Providers need improved cultural end-of-life care.

<b>Author(s) Date</b>	<b>Purpose or Research Question(s)</b>	<b>Research Design/ Methods</b>	<b>Sample Method, Size, and Setting</b>	<b>Results</b>	<b>Weaknesses</b>	<b>Implica- tion(s) for Practice</b>
Michalek, Mahoney, Gilbert, & Kaur (2005)	What are the available and desired resources for palliative care in Indian country?	Survey of tribal health directors	An online survey of tribal health directors with only 37% response rate	50-60% reported an urgent need for advance care planning	37% response rate	
Kitzes & Berger, 2004	Examine end of life issues at Indian Health Service Facility	Retrospective chart review	114 records from Native American deaths over a 4 year period due to chronic conditions	"minimal" documentation of palliative care services (including AD planning)	Retrospective study	--20% of charts reviewed had AD discussion --Need for more initiatives for Indian Health

APPENDIX E – Letter Requesting Permission to Conduct Study and Approval from  
Agency

October 16, 2014

To: Honorable Chief Phyllis Anderson

I would like to request your written permission to conduct and evaluate an educational project that could be used to improve practice for tribal patients. I am currently completing requirements for a Doctor of Nursing Practice, which is a practice-focused doctoral degree at the University of Southern Mississippi. To complete the degree I am required to complete a Capstone Project designed to improve nursing practice and patient outcomes.

As a nurse practitioner with Choctaw Health Center for the past fourteen years, I have observed that many tribal patients do not take advantage of their right to designate their choice related to advance directives. My proposed project would include developing an educational video to discuss advance directives along with printed materials that could be utilized with tribal patients to improve understanding of advance directives. I will utilize current research and education about advance directives, but would also like input from other tribal employees to develop this video. Providers are required in hospital settings to discuss advance directives with all patients so that their wishes are included in their medical record if they so choose. When patients are in a variety of settings, it is unlikely that this education is delivered in a clear, consistent manner to the patients. Development of a culturally appropriate video for use in a variety of settings might improve this process for the tribal patients.

The video and printed materials will be developed at my expense and time, therefore there will be no tribal expense associated with the capstone project. However, I would like to utilize some small tribal groups, first at Choctaw Health Center and then in the community setting to have community members view the video. I would like to get input through discussion and a questionnaire to evaluate the video. Participation in the discussion and questionnaire will be voluntary since some people might not want to write comments on paper. Questionnaire responses will be anonymous since no names or identifying information will be included. Confidentiality of patients giving verbal feedback will be maintained and no names or identifying data will be recorded from the discussion. This feedback will allow revision and improvement of this educational intervention. The finished product will be available to the Choctaw Tribe at no expense.

Sincerely,

Donna Alford, MSN, ANP/PNP/GNP-BC  
Nurse Practitioner



OFFICE OF THE TRIBAL CHIEF PHYLLIS J. ANDERSON  
101 Industrial Road • Post Office Box 6010 • Choctaw, Mississippi 39330  
Phone: (601) 656-5251 • Fax: (601) 656-7333

Ms. Donna Alford  
Philadelphia, MS 39350

28 JAN 15

**RE: Capstone Educational Project Request at Choctaw Health Center**

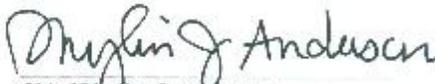
Dear Ms. Alford:

I am writing to notify you that your proposed educational research project to be conducted at the Choctaw Health Center has been approved. My understanding is that you will not be using actual patient data in this project, but you will be producing an educational video that could be beneficial to Tribal patients. Your request has been reviewed and recommended as favorable by the Mississippi Band of Choctaw Indians' Tribal Attorney General's Office, as well as by the leadership of the Choctaw Health Center. The Tribe engaged in a formal agreement through Tribal Council resolution in 2005, to continue working-relationship agreements with the University of Southern Mississippi, and your project aligns with ongoing affiliations between MBCI and USM.

I understand that you are pursuing your PhD in Nursing at USM, and that you are currently employed as an Emergency Room Family Nurse Practitioner at Choctaw Health Center. You also worked earlier as an RN at our Conchatta Healthcare Clinic.

I would like to request copies of the educational materials and video that you produce as a result of your research project at Choctaw Health Center. Thank you for your continued service to the Tribe, and I extend my best wishes to you as you seek to complete your PhD in Nursing.

Many Blessings.

  
Chief Phyllis J. Anderson

C: Tina Scott, Director, CHC  
File

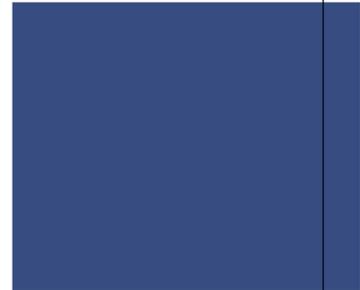
"CHOCTAW SELF-DETERMINATION"

The Patient Self Determination Act is a federal law that makes health care providers talk to adult patients about their right to accept or refuse medical treatment, and their right to decide about their health care. What you decide about health care is written in an advance directive.

Before making healthcare decisions you should consider:

- Your life
- How you feel about death with no pain.
- What do you want to prolong your life?
- Your culture and religion.
- Talk to family and friends.

## Advance Directives: Living Will and Power of Attorney



**Advance Directives protect:**

**YOU** and your right to make medical choices.

**YOUR FAMILY** because they know what you decide about healthcare.

**YOUR PROVIDER** because you tell them what care you want or don't want.



**What are Advance Directives, Living Wills and Power of Attorney for Healthcare?**

**Power of Attorney for Healthcare**

You choose a person to decide for you if you are not able to make decisions.

**Living Wills** will say whether you want or do not want such things as:

- Chest Compressions or CPR
- Electrical shock to re-start your heartbeat
- Breathing Machine to breath for you
- Tube to feed you
- Medication for pain
- Dialysis to work for your kidneys
- Organ Donation

**Who helps you decide?**

- Your Family
- Doctor
- Nurse Practitioner
- Nurse
- Social Worker
- Chaplain or Priest
- Mental Health Worker
- Lawyer

**Give a Copy to:**

- Clinic
- Hospital
- Family
- Provider
- Keep a copy

APPENDIX G Demographic Questionnaire

INSTRUCTIONS: Please provide the following information.

1. Gender:             Female     Male
  
2. Current Age:         Years
  
3. Ethnicity:            Native American  
                          Other (please specify)
  
4. Highest education earned:  Years in School  
    GED/High School Degree  
    College
  
5. Do you have an Advance Directive, Living Will, or Power of Attorney for Healthcare?  
    Yes  
    No
  
6. Have you been told about Advance Directive, Living Will, or Power of Attorney for healthcare?  
    Yes  
    No
  
7. Do you have a family member who has an Advance Directive, Living Will, or Power of Attorney for Healthcare?  
    No  
    Yes

APPENDIX H – Survey

Question	Mainly traditional 1	2	Average	4	Non-traditional 5
1..Rate the language, talking and gestures. Notes:					
2. Use in your community Notes:					
3. Clothes and physical look of the video. Notes:					
4. Rate the education being done by video. Notes:					
5. Rate this video being used in the Choctaw Health Center and health community. Notes:					
6. Rate this education being used with your family. Notes:					
7. Rate this education being used in your community. . Notes:					
8. How this reflects your daily beliefs. Notes:					
9. How this reflects your religious or spiritual beliefs. Notes:					
10. How this relates to your education beliefs. Notes:					
11. How this relates to your legal beliefs. Notes:					
12.Rate this video by your native health beliefs and practices. Notes:					
13. Rate this video by your views of care for you. Notes:					
14. Rate this video by your views of preventing illness and preserving wellness. Notes:					

## APPENDIX I – IRB Approval Letter



THE UNIVERSITY OF  
**SOUTHERN MISSISSIPPI.**

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### INSTITUTIONAL REVIEW BOARD

118 College Drive #51471 Hattiesburg, MS 39406-0001

Phone: 601.266.5997 | Fax: 601.266.4377 | [www.usm.edu/research/institutional.review.board](http://www.usm.edu/research/institutional.review.board)

### NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.  
Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 18071907

PROJECT TITLE: Development and Evaluation of an Educational Intervention Regarding Advance Directives in a Native American Population

PROJECT TYPE: Doctoral Dissertation

RESEARCHER(S): Donna Alford

COLLEGE/DIVISION: College of Nursing

DEPARTMENT: School of Leadership and Advanced Nursing Practice

FUNDING AGENCY/SPONSOR: N/A

IRB COMMITTEE ACTION: Exempt Review Approval

PERIOD OF APPROVAL: 07/23/2018 to 07/22/2019

**Edward L. Goshorn, Ph.D.**

**Institutional Review Board**

## APPENDIX J- Information Letter for Participants Information Letter for Participants

My name is Donna Alford and I am a Nurse Practitioner in the Doctor of Nursing Practice program at The University of Southern Mississippi. I am using an educational video to discuss advance directives along with printed materials that could be used with patients to help understand Advance Directives.

1. **Purpose:** I have seen that many tribal patients do not use their right to choose related to advance directives. My proposed project would include developing an educational video to discuss Advance Directives along with printed materials that could be used by tribal patients to improve understanding of advance directives. I would like tribal members to view this video to see if it helps understand Advance Directives.
2. **Description of Project:** I am requesting your help in this project to view this educational video and read the handout about Advance Directives. You may decline participation in this project at any time. You will be provided an informed written consent for your participation in this project. Participants will be asked to view the educational video and read the handout about Advance Directives. You will be asked to complete a questionnaire to help this student tell if this educational project is useful. The questionnaires to be completed include a sheet with questions which will gain information about the viewer such as age, gender, education and previous experience with Advance Directives. A sheet with questions to help tell about your thoughts about the video/educational materials will also be given. No more than two hours (90 minutes) will be required to complete this task.
3. **Benefits:** Potential benefits from program participation are to help understand the use of Advance Directives and your right to complete Advance Directives. This could also improve your participation with your medical provider.
4. **Risks:** Minimum risk is involved in the participation in this project. The project provider has received education on the protection of human research participants. Participation is voluntary and informed consent will be obtained from all participants before their voluntary participation. All participants have the right to withdraw during any part of the program without penalty. If any emotional distress is experienced, referral to mental health provider is available. Participants will be reassured that this program is only intended to improve their knowledge and understanding of Advance Directives.
5. **Confidentiality:** All information obtained during participation in this program will be kept confidential. In order to protect the identity of all participants, confidentiality of all documents no names will be on the questionnaires. A number code will be provided to each participant's questionnaires and no

names will be on the forms with questions. The signed informed consent forms will be stored in another locked box and will be separate from the completed questionnaire forms.

6. **Alternative Procedures:** The alternative is not to participate in the project.
7. **Participant's Assurance:** This project has been reviewed by the Human Subjects Protection Review Committee at the University of Southern Mississippi, which makes sure that research projects with human participants follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board at (601) 266-6820. Participation in this project is completely voluntary, and participants may withdraw from this project at any time without penalty, prejudice, or loss of benefits. Any questions or concerns about this project should be directed to **Donna Alford at (601) 201-0088.**

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Signature of Person Participating

Date

APPENDIX K – Demographic Questionnaire Results

**INSTRUCTIONS: Please provide the following information.**

No.	Question	<i>n</i>	%
1	Gender Female Male	3 5	37.5 62.5
2	Current age (years)	1 = 28 1 = 29 1 = 52 1 = 54 1 = ] 60 1 = 69 2 = 30	1 = 12.5 1 = 12.5 1 = 12.5 1 = 12.5 1 = 12.5 1 = 12.5 2 = 25.0
3	Ethnicity Native American Other (please specify)	8 0	100.0 0.0
4	Highest education earned Years in school GED/HS degree College	1 = 11 2 5	12.5 25.0 62.5
5	Do you have an Advanced Directive, Living Will, or Power of Attorney for Healthcare? Yes No	0 8	0.0 100.0
6	Have you been told about Advanced Directive, Living Will, or Power of Attorney for Healthcare? Yes No	2 6	25.0 75.0
7	Do you have a family member who has an Advanced Directive, Living Will, or Power of Attorney for Healthcare? Yes No	4 4	50.0 50.0

APPENDIX L- Survey Results

<b>Question</b>	<b>Mainly traditional 1</b>	<b>2</b>	<b>Average 3</b>	<b>4</b>	<b>Non-traditional 5</b>
1. Language, Communication, and Gestures Notes:	<i>n</i> = 1, 12.5%	<i>n</i> = 1, 12.5%	<i>n</i> = 2, 25%	<i>n</i> = 1, 12.5%	<i>n</i> = 3, 37.5%
2. General use in your community Notes:	<i>n</i> = 1, 12.5%		<i>n</i> = 5, 62.5%		<i>n</i> = 2, 25%
3. Wearing Apparel and Physical Appearance Notes:			<i>n</i> = 5, 62.5%		<i>n</i> = 3, 37.5%
4. Technology being used: Notes:	<i>n</i> = 1, 12.5%		<i>n</i> = 4, 50%	<i>n</i> = 1, 12.5%	<i>n</i> = 2, 25%
5. How do you view this video being used in the Choctaw Health Center and community? Notes:	<i>n</i> = 2, 25%	<i>n</i> = 1, 12.5%	<i>n</i> = 3, 37.5%		<i>n</i> = 2, 25%
6. Rate this education being used with your family. Notes:	<i>n</i> = 1, 12.5%		<i>n</i> = 5, 62.5%		<i>n</i> = 2, 25%
7. Rate this education being used in a community setting Notes:	<i>n</i> = 1, 12.5%	<i>n</i> = 1, 12.5%	<i>n</i> = 5, 62.5%		<i>n</i> = 1, 12.5%
8. How this reflects to your daily beliefs Notes:	<i>n</i> = 2, 25%		<i>n</i> = 3, 37.5%	<i>n</i> = 2, 25%	<i>n</i> = 1, 12.5%
9. How this reflects your religious or spiritual beliefs Notes:	<i>n</i> = 3, 37.5%		<i>n</i> = 4, 50%		<i>n</i> = 1, 12.5%
10. How this relates to your educational beliefs Notes;	<i>n</i> = 1, 12.5%	<i>n</i> = 1, 12.5%	<i>n</i> = 4, 50%	<i>n</i> = 1, 12.5%	<i>n</i> = 1, 12.5%
11. How this relates to your legal beliefs Notes:	<i>n</i> = 1, 12.5%		<i>n</i> = 5, 62.5%	<i>n</i> = 1, 12.5%	<i>n</i> = 1, 12.5%
12. Rate this video according to your native healthcare values, beliefs, and practices. Notes:	<i>n</i> = 1, 12.5%	<i>n</i> = 1, 12.5%	<i>n</i> = 3, 37.5%		<i>n</i> = 3, 37.5%
13. Rate this video according to views of caring for yourself Notes:	<i>n</i> = 1, 12.5%		<i>n</i> = 2, 25%	<i>n</i> = 2, 25%	<i>n</i> = 3
14. Rate this video according to your views on preventing illness and preserving wellness Notes	<i>n</i> = 1, 12.5%	<i>n</i> = 1, 12.5%	<i>n</i> = 3, 37.5%	<i>n</i> = 1, 12.5%	<i>n</i> = 2, 25%

Source: Mississippi Band of Choctaw Indians, 2016.

APPENDIX M – Questionnaire Results

Question	Comments
1. Language, Communications, and Gestures	S2—Would consider a little more Choctaw translation. S3---Was hoping for an optional language preference for the movie (Choctaw version). S5—Tribal language, add pictures. S6—It is non-traditional. S7---English version is better; man as presenter is OK. S8---I enjoyed the video.
2. General Use in your community	S3---Movie needs to play at clinics. S8---Something that we need to know.
3. Wearing Apparel and Physical Appearance	
4. Technology being used	S3—Visual is better. S8---Video was nice.
5. How do you view this video being used in the Choctaw Health Center and community?	S2—Yes S8---I would very much like it for CHC and communities.
6. Rate this education being used with your family.	S6—It's good education. S8---Being educated about our rights
7. Rate this education being used in a community setting.	S6—Good S8---Very much needed
8. How this reflects your daily beliefs.	S2—It's something I never thought about it. S6---I have my doubts. S8---Some elders prefer no prolonging procedures.
9. How this reflects your religious or spiritual beliefs.	S6---Doesn't affect it. S8---Everyone should have a right to make a choice.
10. How this relates to your educational beliefs.	S6—My education goes along with this. S8---I believe it's something we need to be educated about.
11. How this relates to your legal beliefs.	S6---It is legal. S8---I personally have not thought about Advance Directives until now.
12. Rate this video according to your native healthcare values, beliefs, and practices.	S3---Lot of tribal members relate more to visual, very beneficial! loved it! S6---I think it's too non-traditional. S7--Think older people would like more choices. S8--It is very informative.
13. Rate this video according to views of caring for yourself.	S6---Good information S8---It's something I have not thought of.
14. Rate this video according to your views on preventing illness and preserving wellness.	S6---Not applicable

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