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Physician Orders for Life-Sustaining Treatment (POLST) Forms in a Primary Care Setting

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Physician Orders for Life-Sustaining Treatment (POLST) Forms in a Primary Care Setting

UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
Beyster Institute of Nursing

DOCTOR OF NURSING PRACTICE PORTFOLIO

by

Elena Johns, BSN, RN

A portfolio presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree

DOCTOR OF NURSING PRACTICE

May 22,2022

Caroline Etland, PhD, RN, CNS, ACHPN, Faculty Advisor

Noli Cava, MD, Clinical Mentor

Acknowledgements

I would like to express my gratitude to Dr. Caroline Etland, my faculty advisor and clinical mentor throughout this program. I knew from the very first semester I needed to connect with Dr. Etland, absorb and learn from her extensive expertise in Palliative Care. Being new to the world of Hospice, End-of-life Care, and Palliative Medicine, I could feel my passion soar.

I would also like to thank Dr. Noli Cava for allowing me to precept with him in his private clinics and complete my DNP project under his guidance. This project would not be possible without his support.

Of course I would like to thank my family, friends, and fiancé who have supported me throughout these last three years in furthering my education and pursuing my Doctorate Degree in Nursing.

Opening Statement

Purpose in Pursuing the DNP

Nearly every person who knows that I am a nurse has asked me in one form or another, why I became a nurse. For me, that answer is constantly evolving. I cannot point to a specific day, event, or even a specific moment in my life that made me want to become a nurse. But, each and every day, my personal goal is to point out at least one moment that makes me say with pride, "This is why I became a nurse!"

As a newly graduated RN, I knew that I wanted to begin my career in Critical Care. I thrive in challenging situations that require critical thinking skills, and situations that require calm leadership in the midst of chaos. While I am a highly motivated individual who can take the lead in situations, I understand the importance of a strong healthcare team and continuity of care in treating patients. Throughout these past couple of years in the Critical Care Unit, I have constantly been challenged and motivated to provide optimal and safe care to my patients.

I recently decided to further my career by working alongside Cardiologists, as well as Nurse Practitioners, in Specialized Cardiology. This opportunity has allowed me to sharpen my communication skills, as well as to experience the broader view of various patient cases. I have a better understanding of case management, preventative health, and the importance of encouraging the patient to be proactive with regards to their health.

As a Registered Nurse, I have learned invaluable skills, not only from my supervisors and fellow healthcare team, but also from my patients and their families. One of the most important skills I have learned is advocating for my patients. I have learned to be proactive, detail oriented, and to speak up when the patient's safety is on the line.

Another important skill that I have learned is effective communication. I understand the importance of communication between nurses and the entire healthcare team, and it is this that motivates and drives me to continue my education to become an Advanced Practice RN as a Nurse Practitioner. I have learned that a simple miscommunication, or lack of communication, can determine the outcome of a patient's hospitalization. As such, I believe that there is room for improvement among healthcare professionals with regards to effective communication. This is especially true among the geriatric patient population, as well as the chronically ill patient population. I truly believe that by improving communication skills among ourselves, and with patients, we can and will improve the care that we provide. I am passionate about this belief and I know that as a Dual Adult-Gerontology/Family Nurse Practitioner, I would be better equipped to provide optimal care to patients.

I understand the important role of an Advanced Practice Nurse in the healthcare profession, and how they utilize their communication skills and are tuned into the entire picture regarding the patient's health. I desire to become a part of that team. I believe that I would be working towards my full potential and that I would be an asset to the healthcare team as a Nurse Practitioner.

Documentation of Mastery of DNP Program Outcomes

Manuscript Physician Orders for Life-Sustaining Treatment (POLST) Forms in a Primary Care Setting

Elena Johns, BSN, RN
DNP Student

Caroline Etland, PhD, RN, CNS, ACHPN

University of San Diego

Abstract

Purpose: To increase completed POLST forms among elderly patients aged seventy-seven and older with chronic/debilitating illnesses, by at least 50% in a Primary Care clinic setting, from September 2021 to January 2022.

Background: The government pays for over two-thirds of healthcare costs for the elderly aged sixty-five and older. Furthermore, by ages seventy to ninety, medical spending more than doubles. Many elderly and chronically ill patients report that they would prefer less aggressive treatment and more comfort care measures. However, patients also report a lack of knowledge about their end-of-life (EOL) wishes particularly when it comes to completing the Physicians Orders for Life Sustaining Treatment (POLST) form. Completing the POLST form within the Primary Care setting, rather than in the Hospital setting, allows for a calm discussion in the clinic rather than in the hectic environment of the hospital.

EBP Model/Framework: This project utilized the Ottawa Model of Research Use (OMRU).

Practice change and Implementation Strategies: Pre-implementation data was collected, which included the percentage of completed and up-to-date POLST forms. After screening for age and diagnosis on each patient's chart, a discussion occurred with the patient about the various end-of-life medical preferences listed on the POLST form. Next, each section of the POLST form was explained to the patient and they assisted in completing the form within the primary care setting. Once completed, the POLST form was given to the Medical Assistant who arranged for the Provider to sign by the end of the day. Once signed, the secretary uploaded the POLST form into the patient's

chart. This processes ensured every healthcare provider has access to and is aware of the patient's end-of-life wishes. Data analysis was completed at the end of the measurement period by comparing the percentage of pre and post-implementation POLST forms.

Results: According to pre-implementation data, thirty-five percent of patients had a completed POLST form and that percentage increased to seventy-two percent post-implementation. Thus, the project demonstrated a fifty-two-percent increase from baseline, demonstrating that the goal was met.

Conclusions and implications for practice: Having a target age group and identified workflow supports sustainability and cost-effectiveness and should become standard practice within the clinic setting.

Keywords: *Physician Orders for Life-Sustaining Treatment, Primary Care, Geriatrics, Chronic Illnesses, Terminal Illness, Advanced Directives, End-of-Life Planning, End-of-Life Discussions, Medical Spending on Elderly*

Background and Significance

Due to Western Medicine and the incredible advances in technology, many patients are not aware of the more comfort-focused measures of care that are available to them when the burden of illness becomes too great. Thus, it is more imperative than ever to provide information and education to patients about the alternative options available to them. One of the most important resources available to patients, especially those who are elderly and/or have a chronic illness, is the Physicians Orders for Life Sustaining Treatments (POLST) form. Discussions between providers and patients weigh the benefits and burdens of each type of treatment and elicit patients' values regarding quality of life. Completing this form allows the patient to choose her/his medical wishes with regard to what they specifically desire when it comes to end of life measures (Hickman et al., 2021). The POLST form was implemented into California law in 2009, although it was first introduced in Oregon in 1991. The POLST form is divided into four sections, labeled A-D, and each of those sections lists several EOL medical treatment options. Section A lists the two most important options i.e. whether or not the patient wishes to receive Cardiac Pulmonary Resuscitation (CPR). The remaining sections lists invasive options such IVs, feeding tubes, and hospitalizations, versus a more comfort-centered approach with no invasive treatments or hospitalizations (National POLST, 2020). The POLST form differs from Advanced Directives in that the latter is a legal, binding document appointing a person(s) to make health care decisions in the event the patient cannot. The POLST form on the other hand, is strictly a medical document, which specifies medical treatments and can be updated/changed without a witness or notary (National POLST, 2020). Although the POLST form is a fairly simple document,

research had identified several barriers to completing this form in an appropriate and timely manner (Mack & Dosa, 2019). Such barriers include lack of patient knowledge of the form, lack of provider education on POLST conversations and completing the form, cultural discrepancies and lack of uniform method among states. Additionally, according to research, the form is often incomplete, making it unclear to the healthcare team as to what exactly the patient's wishes are (Hickman et al., 2020). Another issue regarding these important forms is that most POLST forms are completed in Hospitals, including the Emergency Room or Intensive Care Unit, where it is very chaotic and stressful. Alternatively, completing the form in the Primary Care setting allows for a calm and composed discussion regarding the sensitive topic of end of life care and treatments. Consequently, surveys show that patients and their family members are more open to discussions in a clinic setting rather than in a hospital setting (Combes et al., 2019). Allowing patients the time and a calm environment to contemplate and discuss these difficult decisions can provide clear direction to loved ones and providers regarding medical decision making in a crisis.

Purpose/Aims

The purpose of this Evidence-Based Practice (EBP) project was to implement a protocol in order to increase the number of completed POLST forms for patients aged seventy-seven and older, by at least fifty percent, within the Primary Care setting. The Doctor of Nursing Practice (DNP) student collaborated with a private practice clinic affiliated with Sharp HealthCare to implement a method that supported the existing goal set by Sharp. The original Sharp goal was to increase the number of completed POLST forms in patients aged seventy-seven and older. The goal however, was very broad and

did not stipulate a method or a specific process to follow, in order to reach that goal at the target clinic site. Thus, the student posed a Population, Intervention, Comparison, Outcome, and Time (PICOT) question, in order to assist and guide the clinic in reaching the proposed goal: in patients aged seventy-seven and older (P), does providing education about the POLST form and aiding patients in completing the form during their scheduled visit (I), versus no education or assistance (C), result in increased number of completed POLST forms within a five month period (T)? The goal of the project was to increase the number of completed POLST forms by fifty percent within a five-month timeframe. The aim of the project was to increase patient knowledge and awareness about life-saving methods and document their wishes, as well as to increase provider knowledge about patient medical wishes.

Evidence-Based Practice Model

The EBP project utilized the Ottawa Model of Research Use (OMRU). This model was developed by Graham and Logan in 1998 containing a six-step method that unifies decisions and actions in order to implement change and continuity-of-care across diverse organizations and clinical settings (Melnyk & Fineout-Overholt, 2019). The OMRU model is focused on an interdisciplinary framework and allows input from those utilizing the model. It is also designed as a feedback loop, which allows regular consideration on the changes that have been implemented. Educating and aiding patients in completing their POLST form within the clinical setting supports an interdisciplinary framework as well as allow patients to actively participate in their medical care. Additionally, the Ottawa model is especially beneficial in guiding the implementation of

continuity of care, which is directly related to the POLST form as it allows all providers to visualize the patients' wishes (Graham & Logan, 2004).

Literature Review/Evidence for the Problem

Advanced Care Planning (ACP) and end-of-life (EOL) discussions are an integral part of every patient's medical plan of care. Currently, the Physicians Orders for Life-Sustaining Treatment (POLST) form is a document that indicates the patient's medical wishes. For example, one of the options on the form clearly indicates whether the patient wishes to receive Cardiac Pulmonary Resuscitation (CPR) or does not wish to receive Cardiac Pulmonary Resuscitation (DNR). While each form varies slightly per state, once the form is signed by the patient's provider, the order must be honored by medical providers including Emergency Medical Staff (EMS) and any licensed medical personnel (National POLST, 2020). Research shows however, that many patients, families, and their medical providers do not engage in ACP or EOL discussions in a timely manner (Combes et al., 2019). Studies also highlight several barriers remain in place with regards to end-of-life discussions, advanced care planning, and advanced directives (AD), and most importantly the POLST form (Mack & Dosa, 2019). Barriers include lack of education among patients, stigmas regarding end-of-life and hospice equated to "giving up", family avoidance of these discussions, patients fearing they will let their loved ones down, and overall lack of education about end-of-life planning and resources (Combes et al., 2019). A recent article published in the National Library of Medicine discusses a randomized clinical trial conducted at Vanderbilt University Medical Center, which reveals that most medical residents are not comfortable initiating EOL discussions with

patients or families. The article goes on to discuss that there is an overall lack of EOL training and education among students, with less than 18% of students and residents reporting it is part of their curriculum (Schultz et al., 2018)

Another barrier to the completion of the POLST form is lack of cultural consideration and competency among providers, as well as proper utilization of an official translator system. Pertinent to the particular project discussed in this paper, cultural discrepancies were highlighted among the Hispanic population due to the particular geographical area of the clinic. A recent study revealed a significant need for a tailored approach among Spanish speaking patients, most especially when discussing end-of-life treatments and advanced care planning. Without an official translator, important details and cultural considerations are missed (Gonzalez et al., 2020).

A recent systematic review highlighted the need for ACP, EOL, and POLST discussions to take place early in a disease process and discuss the benefits of integrating these discussions into the routine scheduled visits (Combes et al., 2019). According to the review, patients, especially those who are elderly and frail, are more likely to engage in these discussions when they are incorporated in their care, such as a routine clinic visit or follow-up. The review goes on to discuss the benefits such as a decrease in hospitalizations and re-hospitalizations, as well as an overall increase in patient satisfaction and quality of life (Combes et al., 2019). Perhaps most important to the discussion, Primary Care Provider (PCP) involvement supports improved patient outcomes. A retrospective cohort study completed last year and recently published in the Journal of Palliative Medicine demonstrated that PCP involvement correlated with earlier ACP completion (Sherry et al., 2022). Early ACP, which includes the completion of the

POLST form, allows for greater continuity of care because it allows every provider to visualize and honor the patient's medical wishes.

Methods

The need for a defined method of completing POLST forms within the clinic was assessed and the project took place in a private practice clinic in San Diego from September 2021 to January 2022. Pre-implementation data was collected, which included obtaining the percentage of completed POLST forms among the age group of seventy-seven and older. At the start of the project, thirty-five percent of patients aged seventy-seven and older had a completed and up-to-date POLST form already scanned into their chart. During the patient's routine visits, the DNP student provided an education brochure to each patient aged seventy-seven and older, and these patients were then given the opportunity to complete a POLST form at the conclusion of the scheduled visit. The forms were available in several different languages. Specific to the EBP project, the form was printed in Spanish and several of the medical assistants were fluent in Spanish and available to assist the student and physician in translation. If a patient was unsure or needed additional time, the POLST form was sent home with them to be considered and brought in to be signed during the next scheduled visit. The DNP student, who completed POLST training prior to this project, explained each section of the POLST form and answered any questions the patient had, and then assisted each patient in completing the POLST form. The POLST form was given to the physician to sign, and was then scanned into the patients Electronic Health Record (EHR) at the conclusion of the day.

Ethical Considerations

This project was approved by the Institutional Review Board of the University of San Diego, Hahn School of Nursing (IRB-2021-47). Patient participation in the EBP project was voluntary and all personal health information was kept secure through the use of identifying codes and password-protected computers.

Results

One hundred and ten patients were approached and asked to complete a POLST form with the DNP student at the conclusion of their routine visit. One hundred patients completed their POLST form with the DNP student. In September 2021, at the start of the project, pre-implementation data revealed thirty-five percent of patients aged seventy-seven and older had an up-to-date and completed POLST form scanned into their chart. In January 2022 at the conclusion of the project, post-implementation data was collected. The analysis revealed a fifty-two percent increase in completed forms since September 2021. Thus, the project goal was met and seventy-two percent of patients aged seventy-seven and older had a completed and up-to-date POLST form scanned into their chart.

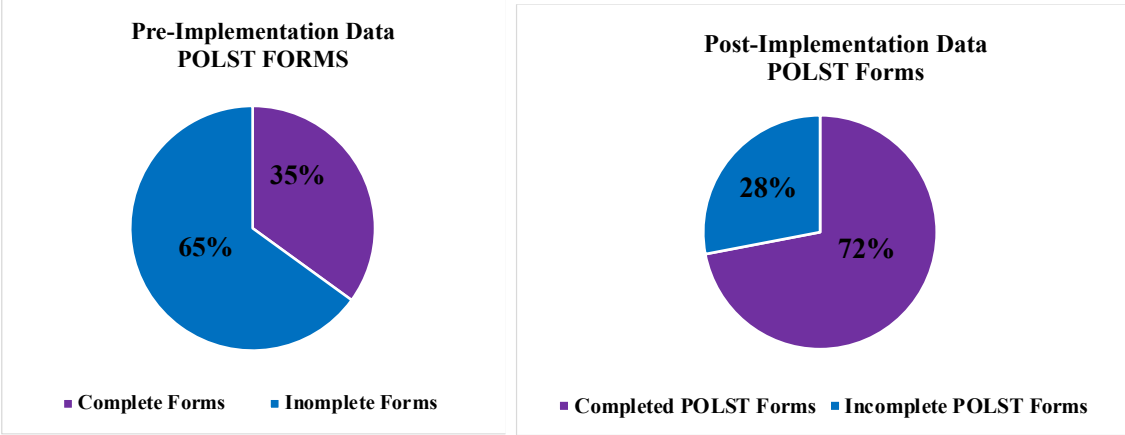

Figure-1: Pre-implementation data; 35% completed POLST forms, 65% incomplete POLST forms

Figure-2: Post-implementation data; 72% completed POLST forms, 28% incomplete POLST forms

Study Limitations

Overall, limitations to the EBP project were minor. Due to the Covid-19 pandemic, several routine visits were conducted via Telehealth, making it difficult to explain the POLST form and have a serious conversation with the patient via a computer screen rather than in person. Thus, several patients opted to wait until they could come to the clinic in person to complete the form, which unfortunately was out of the project timeline. Additionally, several patients did not keep their scheduled appointments during the project months of September 2021 to January 2022, most likely due to fears of contracting Covid, being in isolation due to exposure and/or recovering from the virus. Therefore, the target population was slightly reduced; nonetheless, the goal of the project was met.

Discussion

The EBP project was successful overall and demonstrated that completing POLST forms within the Primary Care setting is not only possible, but simple as well. Although the project focused on patients aged seventy-seven and older, the method can be applied to any patient population. Ideally, broadening the population can yield greater results. Although the primary provider at the clinic was knowledgeable about the POLST form and had completed training, not every provider is proficient in the POLST form. If the intervention were to be implemented in other clinics, perhaps including an incentive for providers to complete POLST training would be beneficial. Additionally, encouraging

providers to become educated in EOL discussions and POLST forms is extremely beneficial to patients and their family.

Implications for Future Clinical Practice

This evidence-based project demonstrated that incorporating a defined process or protocol for assisting patients in completing a POLST form within the clinic setting resulted in a significant increase in the number of completed forms. An increased number of current, complete POLST forms not only benefits patients and their families, but it also benefits each provider as it allows everyone to visualize and be aware of the patient's medical wishes. This promotes continuity of care and allows the patient to be treated with optimal and compassionate care. While the project only included patients aged seventy-seven and above, the patient population could be broadened to include seniors aged sixty-five and above. Moreover, including patients with chronic, debilitating diseases, regardless of age, could prove beneficial as well. Broadening the patient population would not only be beneficial to patients and their families, but again, would be beneficial to the entire team of providers as they would be aware of the patient's medical wishes. Additionally, due to the significant medical expenditures and insurance coverage by the government for the elderly population, having patients' preferences for life-sustaining treatment documented in the EHR is crucial to the optimal and efficient care of the patient. There is a need however, for providers to educate themselves and become trained in completing POLST forms with patients. The training is a simple, one-time process, but in order to be successful in discussing the form with patients, every provider should have a basic understanding of each component (National POLST, 2020). Once trained, providers can determine a specific policy tailored to their

clinic. The need has been identified through research and the EBP further confirmed that incorporating the POLST discussion during routine visits results in an increased number of completed forms.

Conclusion

Providing education on EOL measures and aiding patients in completing their POLST form in a timely manner ultimately improves patient outcomes and quality of life. Current research shows the importance of the POLST form completed in a calm setting, preferably incorporating the discussion into the patient's routine clinic visit, is associated with increased patient satisfaction and decreased hospitalizations (Combes et al., 2019). Having a target age group and identified workflow supports sustainability and cost-effectiveness and should become standard practice within the clinic setting. Furthermore, broadening the target population, for example, all patients with chronic and debilitating diseases, regardless of age, could reveal similar or perhaps even more positive patient outcomes.

Reference:

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Sherry, D., Dodge, L. E., & Buss, M. (2022). Is primary care physician involvement associated with earlier advance care planning?: A study of patients in an academic primary care setting. *Journal of Palliative Medicine*, *25*(1), 75–80. https://doi.org/10.1089/jpm.2021.0069

Concluding Essay:
Reflections on Growth in Advanced Practice Nursing Role

These past three years pursuing my Doctorate Degree have proved challenging, yet rewarding. During this time I have cultivated an intense passion for palliative medicine and have gained invaluable experience along the way.

I believe in silver linings and if there is one associated with the Covid-19 pandemic, I believe it brought to light a great need for palliative care. My hope is that knowledge of this specialty will continue to grow. I had the opportunity to assist fellow healthcare providers in Brooklyn New York during the early days of the pandemic. During that time, I witnessed first hand how palliative medicine plays such an integral part in patient's lives when they are dealing with serious and debilitating illnesses. I also recognized the need to educate my fellow healthcare providers on palliative care, what it has to offer, and why it is incredibly important in today's modern medicine world.

As I begin my journey as an Advanced Practice Nurse working in palliative medicine as a Nurse Practitioner, I will strive each and every day to advocate for my patients and engage in EOL discussions early on, so as to provide them optimal care. I will also strive to aid my fellow healthcare providers in understanding the importance of palliative medicine, early EOL discussion, and timely completion of POLST forms. While current nursing and physician curriculum often lack education on having EOL discussions with patients and their families, death and dying, quality of life, and hospice care, we as healthcare providers can work together to improve this very important area of our healthcare.

Appendix A
IRB Approval

Aug 20, 2021 8:26:53 AM PDT

Elena Johns
Hahn School of Nursing & Health Science

Re: Initial - IRB-2021-436 Physician Orders for Life-Sustaining Treatment (POLST) Completion in a Primary Care Setting

Dear Dr. Elena Johns:

University of San Diego Human Subjects Review Board has rendered the decision below for Physician Orders for Life-Sustaining Treatment (POLST) Completion in a Primary Care Setting.

Decision: No Human Subjects Research

Findings: The USD IRB has determined this project is not subject to regulation under 45 CFR part 46. Therefore, IRB oversight is not required and this project is not subject to periodic review requirements. Other Federal, State or local laws and / or regulations may apply (e.g., HIPAA).

Research Notes:

Internal Notes:

The USD IRB requires annual renewal of all active studies reviewed and approved by the IRB. Please submit an application for renewal prior to the annual anniversary date of initial study approval.
If an application for renewal is not received, the study will be administratively closed.

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,

Eileen K. Fry-Bowers, PhD, JD
Administrator, Institutional Review Board

Appendix B

Poster Abstract

Purpose: To increase completed POLST forms among elderly patients aged 77 and older with chronic/debilitating illnesses, by at least 50% in a Primary Care clinic setting, from September 2021 to January 2022.

Background: The government pays for over two-thirds of healthcare costs for the elderly aged sixty-five and older. Furthermore, by ages seventy to ninety, medical spending more than doubles. Many elderly and chronically ill patients report that they would prefer less aggressive treatment and more comfort care measures. However, patients also report a lack of knowledge about their end-of-life (EOL) wishes particularly when it comes to completing the Physicians Orders for Life Sustaining Treatment (POLST) form. Completing the POLST form within the Primary Care setting, rather than in the Hospital setting, allows for a calm discussion in the clinic rather than in the hectic environment of the hospital.

EBP Model/Framework: This project utilized the Ottawa Model of Research Use (OMRU). This model and framework allowed for a smooth and concise detailing of the evidence based intervention.

Practice change and Implementation Strategies: Pre-implementation data was collected, which included the percentage of completed and up-to-date POLST forms. After screening for age and diagnosis on each patient's chart, a discussion occurred with the patient about the various end-of-life medical preferences listed on the POLST form. Next, each section of the POLST form was explained to the patient, and each patient was assisted in completing the form within the primary care setting. Any questions the

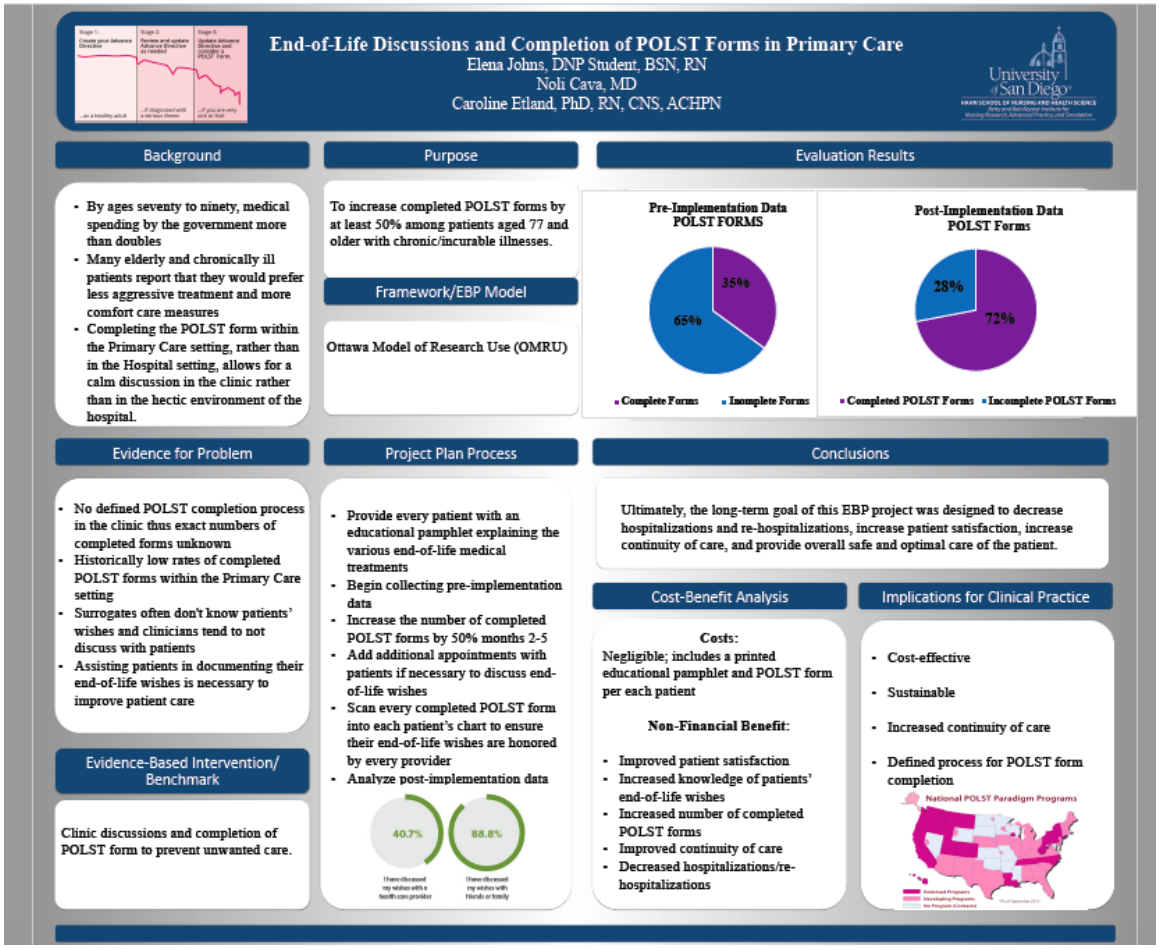
patient might have had were also addressed during this time. Once completed, the POLST form was given to the Medical Assistant who arranged for the physician to sign by the end of the day. Once signed, the secretary uploaded the POLST form into the patient's chart. This process ensured every healthcare provider has access to and is aware of the patient's end-of-life wishes. Data analysis was completed at the end of the measurement period by comparing the percentage of pre and post-implementation POLST forms.

Results: 35% of patients had a completed POLST form pre-implementation which increased to 72% post-implementation. This was a 52% increase from baseline, demonstrating the goal was met.

Conclusions and implications for practice: Having a target age group and identified workflow supports sustainability and cost-effectiveness and should become standard practice within the clinic setting.

Appendix C

Poster



Appendix D

Conference Approval

Dear Elena,

Congratulations! We're pleased to announce your abstract Physician Orders for Life-Sustaining Treatment (POLST) Completion in a Primary Care Setting., has been accepted for Poster presentation

We ask that you respond to mbrown@csusm.edu by Thursday, November 4 at midnight indicating that you are still interested in presenting and will be present for the Symposium.

Upon receipt of your response, we will provide you with further information about your presentation and information on how to officially register for the conference at the discounted presenter rate o

See our Symposium website for travel information and other information that may be of interest to you.

Thank you for being willing to share your work with your colleagues and peers at the 2022 Symposium. We look forward to seeing you in October!

Kind regards,

Jennifer Moore Ballentine, M.A., Executive Director
Pamela Kohlbry, Ph.D., RN, PhD, CNL Director, University Relations and Research
Maria Brown, M.Ed., MBA, Planning Consultant for Symposium 2022

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CSU The California State University
SHILEY HAYNES INSTITUTE
FOR PALLIATIVE CARE

Appendix E

Certification

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Elena Johns (ID: 8522497)
- **Institution Affiliation:** University of San Diego (ID: 1652)
- **Institution Email:** ejohns@sandiego.edu
- **Institution Unit:** ICU

- **Curriculum Group:** Social & Behavioral Research - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

- **Record ID:** 33722125
- **Completion Date:** 17-Oct-2019
- **Expiration Date:** 16-Oct-2022
- **Minimum Passing:** 80
- **Reported Score*:** 85

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and Its Principles (ID: 1127)	26-Sep-2019	3/3 (100%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	10-Oct-2019	4/5 (80%)
Students in Research (ID: 1321)	17-Oct-2019	4/5 (80%)
History and Ethics of Human Subjects Research (ID: 498)	26-Sep-2019	5/5 (100%)
Defining Research with Human Subjects - SBE (ID: 491)	17-Oct-2019	4/5 (80%)
Informed Consent - SBE (ID: 504)	17-Oct-2019	5/5 (100%)
Privacy and Confidentiality - SBE (ID: 505)	10-Oct-2019	3/5 (60%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?k15b3b82f-bbdb-4787-a798-2a624d684870-33722125

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

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- **Institution Unit:** ICU

- **Curriculum Group:** Responsible Conduct of Research
- **Course Learner Group:** Humanities Responsible Conduct of Research Course
- **Stage:** Stage 1 - Basic Course
- **Description:** This course is for investigators, staff and students with an interest or focus in the humanities research. This course contains text, embedded case studies AND quizzes.

- **Record ID:** 33512735
- **Completion Date:** 10-Oct-2019
- **Expiration Date:** 09-Oct-2023
- **Minimum Passing:** 80
- **Reported Score*:** 86

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Authorship (RCR-Basic) (ID: 16597)	10-Oct-2019	4/5 (80%)
Collaborative Research (RCR-Basic) (ID: 16598)	10-Oct-2019	4/5 (80%)
Conflicts of Interest (RCR-Basic) (ID: 16599)	10-Oct-2019	4/5 (80%)
Data Management (RCR-Basic) (ID: 16600)	10-Oct-2019	5/5 (100%)
Mentoring (RCR-Basic) (ID: 16602)	10-Oct-2019	5/5 (100%)
Peer Review (RCR-Basic) (ID: 16603)	10-Oct-2019	4/5 (80%)
Research Misconduct (RCR-Basic) (ID: 16604)	10-Oct-2019	4/5 (80%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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Appendix F
POLST Form

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

EMSA #111 B
(Effective 4/1/2017)*

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ *Trial Period of Full Treatment.*

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ *Request transfer to hospital **only** if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available Name: _____
☐ No Advance Directive Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

Appendix G

AACN DNP Essentials/NONPF Competencies/USD DNP Program Outcomes Exemplars

AACN DNP Essentials & NONPF Competencies	USD DNP Program Objectives	Exemplars Provide bulleted exemplars that demonstrates achievement of each objective
DNP Essential I: Scientific Underpinnings for Practice **NONPF: Scientific Foundation Competencies** *The scientific foundation of nursing practice has expanded and includes a focus on both the natural and social sciences including human biology, genomics, science of therapeutics, psychosocial sciences, as well as the science of complex organizational structures. In addition, philosophical, ethical, and historical issues inherent in the development of science create a context for the application of the natural and social sciences.*	**2.** Synthesize nursing and other scientific and ethical theories and concepts to create a foundation for advanced nursing practice.	**Fall 2019** • Established a PICOT question utilizing the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Model. Incorporated Evidence-Based research and practice in establishing the PICOT to improve education and practice regarding end-of-life care. (DNPC611) **Summer 2020** • Exhibited an understanding of reflective practice as well as the role it plays in professional nursing. Participated in discussions, written work, and self-awareness projects (DNPC610). • Implemented Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Model in manuscript

		"Cystic Fibrosis Comprehensive Review of Pathogenesis and Emerging Treatments (DNPC622). **Spring 2021** • Applied principles of program planning to develop a screening for postpartum depression EBP project (DNPC 686) **Summer 2021** • Explored the ethics related to the non-beneficial medical treatments and the importance of having Advanced Directives in place (DNPC 630). **Fall 2021** • Under supervision of a provider, demonstrated an understanding of an ethical framework and the legal requirements for clinical practice as a nurse practitioner (NPTC 608).
DNP Essential II: Organizational & System Leadership for Quality Improvement & Systems Thinking **NONPF: Leadership Competencies/Health Delivery System Competencies**	**5.** Design, implement, and evaluate ethical health care delivery systems and information systems that meet societal needs and ensure accountability for quality outcomes.	**Spring 2020** • SWOT Analysis Presentation for chosen healthcare organization—analyzed and disseminated pertinent information (DNPC 626).

Advanced nursing practice includes an organizational and systems leadership component that emphasizes practice, ongoing improvement of health outcomes, and ensuring patient safety. Nurses should be prepared with sophisticated expertise in assessing organizations, identifying system's issues, and facilitating organization-wide changes in practice delivery. This also requires political skills, systems thinking, and the business and financial acumen needed for the analysis of practice quality and costs.		• Root-Cause Analysis case study—participated in group discussion and presentation (DNPC 626). **Summer 2020** • Exhibited and applied knowledge of labor costs, planning, and budgeting. Provided a written financial plan, which included productivity to healthcare scenarios (DNPC653). **Spring 2021** • Evaluated vulnerable populations and societal needs and established a plan of care to address those needs (DNPC 630). **Summer 2021** • Developed strong clinical skills in assessing the clinical culture when planning a project involving POLST discussions. Assessed and evaluated an elderly and vulnerable patient population with regards to planning the project, utilizing delegation skills and an efficient workflow (NPTC 605).

		Fall 2021 • Began evaluating the pre-implementation data results for the EBP project "Physician Orders for Life-Sustaining Treatment (POLST) Completion in a Primary Care Setting" and provided education to each participant (DNPC 630). • Discussed and assessed various ethical issues related to the EBP and delivery systems to facilitate POLST completion within the primary care setting (NPTC 608). **Spring 2022** • Implemented an evidenced based capstone project to best serve vulnerable populations such as the elderly and those with chronic health issues. Presented a stakeholder presentation in the clinic setting, as well as presented a Poster of the EBP at the National Symposium for Academic Palliative Care Education and Research (DNPC 630).

DNP Essential III: Clinical Scholarship & Analytical Methods for Evidence-Based Practice **NONPF: Quality Competencies/Practice Inquiry Competencies** *Scholarship and research are the hallmarks of doctoral education. Although basic research is viewed as the first and most essential form of scholarly activity, an enlarged perspective of scholarship has emerged through alternative paradigms that involve more than discovery of new knowledge. These paradigms recognize: (1) the scholarship of discovery and integration "reflects the investigative and synthesizing traditions of academic life"; (2) scholars give meaning to isolated facts and make connections across disciplines through the scholarship of integration; and (3) the scholar applies knowledge to solve a problem via the scholarship of application that involves the translation of research into practice and dissemination and integration of new knowledge.*	**4.** Incorporate research into practice through critical appraisal of existing evidence, evaluating practice outcomes, and developing evidence-based practice guidelines.	**Fall 2019** • Acquired previously researched data, as well as synthesized, and critiqued evidence to write an evidenced-based paper titled "Providing Palliative Care Education" (DNPC611) **Spring 2020** • Synthesized and disseminated evidence-based research in Complementary and Alternative Medicine Modalities Presentation: Rosemary (APNC523). • Researched, discussed, and incorporated evidence-based practice regarding the pathophysiology and treatment of Sickle Cell Anemia, in Grand Rounds Assignment (APNC 520). • Partner project—developed a secondary prevention screening program on "Identifying Marfan Syndrome in Children" (DNPC 625).

		Spring 2020 • Obtained evidence-based research on Rosemary for the Complementary and Alternative Medicine Presentation Project. Created a tri-fold brochure and presented the information in class (APNC 523). **Summer 2020** • Exhibited an ability to process and navigate through moral and ethical dilemmas in healthcare through case scenario evaluations [DNPC610]. **Fall 2020** • Collaborated with group go develop manuscript "Cystic Fibrosis Comprehensive Review of Pathogenesis and Emerging Treatments (DNPC622) **Spring 2021** • Developed and implement plans of care to include end-of-life care (POLST forms) for older adults with chronic conditions in collaboration with preceptor, patients and their families that integrate end-of-life wishes. (NPTC 604).

		Summer 2021 • Developed a clinical guideline, based on patient age and prognosis, to aid patients in completing their POLST form in clinic. Edited and primed the process for a smooth implementation (DNPC 630). **Fall 2021** • Incorporated research and knowledge into clinical practice when caring for the geriatric population when discussing chronic diseases, goals of care, POLST forms, and safety measures. Evaluated and discussed practice outcomes with providers (NPTC 608). **Spring 2022** • Implemented a clinical guideline, based on patient age and prognosis, to aid patients in completing their POLST form in clinic (DNPC 630). • Collaborated with the Palliative Care Team in discussing guidelines to establish goals of care and EOL discussions with patient and their families (NPTC 609).

DNP Essential IV: Information Systems/Technology & Patient Care Technology for Improvement & Transformation of Health Care **NONPF: Technology & Information Literacy Competencies** *DNP graduates are distinguished by their abilities to use information systems/technology to support and improve patient care and health care systems, and provide leadership within healthcare systems and/or academic settings. Knowledge and skills related to information systems/technology and patient care technology prepare the DNP graduates apply new knowledge, manage individual and aggregate level information, and assess the efficacy of patient care technology appropriate to a specialized area of practice along with the design, selection, and use of information systems/technology to evaluate programs of care, outcomes of care, and care systems. Information systems/technology provide a mechanism to apply budget and productivity tools, practice information systems and decision supports, and web-based learning or intervention tools to support and improve patient care.*	**7.** Incorporate ethical, regulatory, and legal guidelines in the delivery of health care and the selection, use, and evaluation of information systems and patient care technology.	**Fall 2019** • Obtained Biomedical Research Human Certification – Basic/Refresher Course through CITI (DNPC 625). • Obtained Social & Behavioral Research Certification— Basic/Refresher course through CITI (DNPC 625). **Spring 2020** • Term paper titled "Electronic Health Records and Their Use"—discussed the history of the Electronic Health Record (EHR), as well as the utilization of and advancements of the EHR. Also discussed the pros and cons of the EHR (HCIN540). **Summer 2020** • Exhibited an understanding of healthcare finance and business management by creating a business plan for improving patient outcomes, decreasing re-hospitalizations, and increasing time in hospice care, through providing a palliative care bridge program to home health patients [DNPC653].

		Fall 2020 • Incorporated health screening and developmental screening methods in care of individuals across the lifespan in a primary care setting (NPTC 602). **Spring 2021** • Developed a proposal for implementation of POLST for completion in the Primary Care setting. (DNPC 686). **Summer 2021** • Evaluated the Electronic Health Record (EMR) in the clinic in order to track and make more accessible the POLST forms in the patients charts (DNPC630). **Fall 2021** • Aided staff in evaluation of information systems and patient care technology and collaborated ways to enhance the electronic health record with regards to updated information, as it pertained to the EBP (DNPC 630).

		• Incorporated ethical guidelines such as appropriate use of an official translator when implementing the intervention in order to best treat all patient populations (NPTC 608).
DNP Essential V: Health Care Policy for Advocacy in Health Care **NONPF: Policy Competencies** *Health care policy, whether created though*	**3.** Demonstrate leadership in collaborative efforts to develop and implement policies to improve health care delivery and outcomes at all levels of professional practice (institutional, local, state, regional,	**Spring 2020** • Developed and discussed a policy brief on Prescription Drug Pricing Reduction Act of 2019 (DNPC 648). • Utilized Ruth Malone's

governmental actions, institutional decision-making, or organizational standards, creates a framework that can facilitate or impede the delivery of health care services or the ability of the provider to engage in practice to address health care needs. Engagement in the process of policy development is central to creating a health care system that meets the needs of its constituents. Political activism and a commitment to policy development are central elements of DNP practice.	national, and/or international).	questions/framework for assessing the policy titled "How the ACA Reframed the Prescription Drug Market and Set the Stage for Current Reform" as well as developed a health policy scholarly paper (DNPC 648). • Partner Presentation—discussed and developed a presentation on "Title X: New Regulations" regarding Planned Parenthood specifically and proving support or opposition from healthcare agencies/organizations (DNPC 648). **Fall 2020** • Exhibited socio-cultural understanding and competence in promoting improved healthcare delivery in a clinical setting (NPTC 602). **Summer 2021** • Become a member of the National Hospice and Palliative Care Organization (NHPCO), which allows advanced practice nurses to contribute to the development of policy and recognize the need for policy changes. The above allows

		the advanced practice nurse to practice to the full extent of their scope (DNPC630). **Fall 2021** • Applied and was accepted for poster presentation at the 2022 National Symposium for Academic Palliative Care Education and Research: Palliative Care: Disparities, Distress, and Directions for the Future (DNPC 630) • Utilized pathophysiological concepts to develop differential and evaluation of individuals with abdominal pain. (NPTC 608). **Spring 2022** • Presented the EBP Poster at the National Symposium for Academic Palliative Care Education and Research (DNPC 630).

DNP Essential VI: Interprofessional Collaboration for Improving Patient & Population Health Outcomes **NONPF: Leadership Competencies** *Today's complex, multi-tiered health care environment depends on the contributions of highly skilled and knowledgeable individuals from multiple professions. In order to accomplish the IOM mandate for safe, timely, effective, efficient, equitable, and patient-centered care in this environment, health care professionals must function as highly collaborative teams. DNPs have advanced preparation in the interprofessional dimension of health care that enable them to facilitate collaborative team functioning and overcome impediments to interprofessional practice. DNP graduates have preparation in methods of effective team leadership and are prepared to play a central role in establishing interprofessional teams, participating in the work of the team, and assuming leadership of the team when appropriate.*	**1.** Demonstrate advanced levels of clinical practice within defined ethical, legal, and regulatory parameters in designing, implementing, and evaluating evidenced-based, culturally competent therapeutic interventions for individuals or aggregates. **3.** Demonstrate leadership in collaborative efforts to develop and implement policies to improve health care delivery and outcomes at all levels of professional practice (institutional, local, state, regional, national, and/or international).	**Fall 2020** Collaborated and shared evidence-based research and literature with clinicians in primary care setting. The goal and purpose was highlighting a need for EBP project within the primary care setting (NPTC 602). **Spring 2021** • Shared evidence-based literature with clinicians in a Primary Care setting, specifically related to the beneficial outcomes of AD/EOL/POLST discussions. Highlighted the evidence points to more beneficial outcomes for patient and clinicians (DNPC 686). **Summer 2021** • Utilized technology and systematic reviews of clinical research as a basis for evidence-based practice. Evaluated relevant developmental, behavioral and sociocultural concepts in assessing the health care needs of older adults and their families. This involved interacting with an interdisciplinary team consisting of MDs, NPs, RNs, and MAs (NPTC 535). • Collaborated with clinicians in discussing policies appropriate to implement in the primary care setting, in order to improve health outcomes (NPTC 605).

		Fall 2021 • Demonstrated an understanding of and practice within an ethical framework and the legal requirements for clinical practice as a nurse practitioner, by working alongside nurse practitioners caring for geriatric patients. Discussed goals of care and end-of-life planning with geriatric patients and those with debilitating diseases (NPTC 608). • Demonstrated leadership in collaborating with clinicians and team in implementing an evidenced-based intervention. Discussed potential of the intervention being incorporated into the policy in the primary care setting (DNPC 630). **Spring 2022** • Demonstrated advanced level of clinical practice and leadership by developing a protocol to discuss and aid patients in completing their POLST form in the primary care setting (DNPC 630). • Recognized emergency situations

		and initiated appropriate interventions within the hospital and clinic setting. Emergent situations included altered mental status, code blue and stroke situations (NPTC 609).

DNP Essential VII: Clinical Prevention & Population Health for Improving Nation's Health **NONPF: Leadership Competencies** *Consistent with national calls for action and with the longstanding focus on health promotion and disease prevention in nursing, the DNP graduate has a foundation in clinical prevention and population health. This foundation enables DNP graduates to analyze epidemiological, biostatistical, occupational, and environmental data in the development, implementation, and evaluation of clinical prevention and population.*	**6.** Employ a population health focus in the design, implementation, and evaluation of health care delivery systems that address primary, secondary, and tertiary levels of prevention.	**Fall 2019** • Developed a secondary screening program for Hypertension (DNPC 625) **Spring 2020** • Evaluated and discussed current health care gaps in diagnosis and treatment of Alzheimer's disease (DNPC 626). **Summer 2021** • Evaluated and discussed health screenings for the older adult population, such as lung, cancer, prostate cancer, aortic aneurysm and colon cancer (NPTC 605). • Evaluated and discussed appropriate secondary and tertiary levels of care and prevention for the elderly population in the geriatric clinical setting (NPTC 535). **Fall 2021** • Evaluated the need for an intervention, which would address the disparity between patient wishes and actual care they receive. Implemented an intervention to aid patients in completing the Physicians Order for Life Sustaining Treatments (POLST) form in the primary clinical setting (DNPC 630). • Evaluated and discussed tertiary levels of prevention and care within the primary care setting, including the management of

		COPD, hypertension, diabetes, and heart failure (NPTC 608). **Spring 2022** • Discussed primary prevention level of care with the geriatric population including immunizations, fall prevention, and EOL/AD/POLST discussions (NPTC 609).

DNP Essential VIII: Advanced Nursing Practice **NONPF: Independent Practice/Ethics Competencies** *The increased knowledge and sophistication of healthcare has resulted in the growth of specialization in nursing in order to ensure competence in these highly complex areas of practice. The reality of the growth of specialization in nursing practice is that no individual can master all advanced roles and the requisite knowledge for enacting these roles. DNP programs provide preparation within distinct specialties that require expertise, advanced knowledge, and mastery in one area of nursing practice. A DNP graduate is prepared to practice in an area of specialization within the larger domain of nursing.*	**1**. Demonstrate advanced levels of clinical practice within defined ethical, legal, and regulatory parameters in designing, implementing, and evaluating evidence-based, culturally competent therapeutic interventions for individuals or aggregates.	**Spring 2021** • Plan to implement DNP project in the Primary Care setting (DNPC 630). **Summer 2021** • Demonstrated competence in caring for the vulnerable/elderly patient populations. Demonstrated culturally competent and therapeutic interventions within the adult and geriatric clinical setting (NPTC 535). **Fall 2021** • Began implementing an evidenced-based intervention, which allows clinicians to provide culturally competent, ethical, and optimal care to patients in the primary care setting using a low-health literacy tool (DNPC 630). • Demonstrated advanced clinical skills within the primary care setting, in providing care to diverse and variable patient populations, including the management of diabetes, chronic pain, and COPD (NPTC 608). **Spring 2022** • Demonstrated advanced level of clinical practice by discussing goals of care, quality of life, EOL planning, and comfort-centered treatments with patients enrolled in Palliative Care (NPTC 609).