IMPLEMENTATION OF POST FORMS UPON HOSPICE ADMISSION: AN EVIDENCE-BASED PRACTICE INTERVENTION TO REDUCE HOSPICE REVOCATIONS

A Scholarly Project
Submitted to the
Faculty of Liberty University
In Partial Fulfillment
of the Requirements for the Degree
of Doctor of Nursing Practice
by
Joanna Grace Asselin, RN, BSN
Liberty University School of Nursing
Lynchburg, Virginia
June, 2020
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ABSTRACT

Background and Purpose: Reduction of live hospice discharges in the form of revocations is necessitated in order to maintain regulatory compliance and meet quality measures. Upon admission to hospice services, many have not considered personal desire regarding further intervention beyond Do Not Resuscitate (DNR) status. Evidence-based practice has revealed Physician Order for Scope of Treatment (POST) forms as effective in enhancing translation of patient desires related to care and interventions at end-of-life. The clinical question of this scholarly project asked if implementation of POST forms upon admission to hospice services would result in decreased revocations with related emergency department (ED) visits and hospital readmission reduction when compared to those not utilizing POST forms. Conduction of an in-depth literature review was performed to support the proposed question. Implementation of POST forms upon admission to hospice services to facilitate end-of-life wishes, decrease revocations, emergency department visits and hospital readmissions was supported.

Proposed Project Methods: Based upon the nature of the Doctor of Nursing Practice (DNP) scholarly project, an evidence-based practice project has been conducted. This involved a quantitative, non-experimental pilot project utilizing the Iowa Model as the foundational framework. Outcome measures were guided by a cross-sectional correlational design due to time restraints. A convenience sample of 8-15 patients had POST form reviewed upon hospice admission by a POST facilitator from January 27th – February 29th. Completion of the form was voluntary. Outcomes in the form of revocations, emergency department visits and hospital readmissions were reviewed and compared with those having not received POST intervention.

Keywords: Revocations, hospice, POST, compliance, quality, readmissions, outcomes
Copyright Page
Dedication

This project is dedicated to Lois Carter (Lolo), my adopted grandmother who believed in, encouraged, supported, cheered, and prayed for me. I will always love you Lolo, thank you for believing in me and being one of my biggest fans. I promise to always strive for excellence in the work God calls me to do and to always make you proud.
Acknowledgements

Throughout the past four years many curve balls have been thrown, some exciting and others challenging. The words of Dr. Sharon Kopis were remembered numerous times throughout this program, “Life is not going to stop just because you are in DNP school.” Upon reflection of the past few years, above all else, I give total glory to my Lord and Savior, Jesus Christ, for without Him, I can do nothing. When I had no strength, He strengthened me, when I was afraid, He comforted me, when I struggled with concepts, He provided avenues in which I could understand, when I could not find a pediatric preceptor, He provided. There is not enough ink or paper to describe how good God has been to me.

I would also like to thank the amazing Liberty University DNP professors who have poured their hearts and souls into my education. Each prayer, word of encouragement, minute of time and energy have meant more than words can say. I would also like to thank my chair Dr. Lynne Sanders who has supported, guided, encouraged, and answered countless questions related to my scholarly project and LU research week.

I could not imagine attempting this journey without my squad who gave of their time, talents, and treasures to promote personal successful completion of the DNP program (names are alphabetized): Debbie, Don, Greg, Josh (my amazing husband), Kim, Leana, Penny, Terri and Tonya. I love you guys and cannot thank you enough for all you have done and continue to do for me. Thanks to each friend and family member who have provided words of encouragement and support along the way. To my DNP class of 2020 family, thanks for all you have taught me and the memories that will last a lifetime. To my Lord and Savior, thank you again for your blessings on me.
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List of Abbreviations

- CMS: Centers for Medicare and Medicaid Services
- CNA: Certified Nursing Assistant
- DNP: Doctor of Nursing Practice
- ED: Emergency Department
- EMR: Electronic Medical Record
- HRRP: Hospice Readmission Reduction Program
- IRB: Institutional Review Board
- MOST: Medical Order for Scope of Treatment
- NCBI: National Center for Biotechnology Information
- POLST: Physician Order for Life Sustaining Treatment
- POST: Physician Order for Scope of Treatment
Section One: Introduction

Qualification for hospice benefit coverage through Medicare is indicated for those with terminal illness and life expectancy of six months or less with natural disease progression (Center for Medicare and Medicaid Services [CMS], 2019). This provision includes nursing, certified nursing assistant (CNA), chaplain, social work, and volunteer services (CMS, 2019). Additional benefits involve coverage of disease related medications, durable medical equipment, and related incontinent supplies (CMS, 2019). Desire to discontinue medical intervention and pursue comfort measures should be verbalized by the patient or power of attorney (CMS, 2019). Education and support from healthcare providers is vital to empower this population in making informed decisions (Nedjat-Haiem et al., 2019). Absence of knowledge and understanding has potential to enhance risk of hospice revocation. Evidence has revealed effective tools such as physician order for scope of treatment (POST) forms in aiding the terminally ill with communicating desires regarding end-of-life care (Nedjat-Haiem et al., 2019).

Background

High rates of live discharges from hospice in the form of revocation was identified as a quality improvement project trigger. Centers for Medicare and Medicaid Services have developed a project with intent to further measure hospice quality through identification of inappropriate discharges (CMS, 2018). This is defined by CMS as death occurring within 30 days, or acute care necessity within seven days of discharge (CMS, 2018). Initiation of the Hospice Readmission Reduction Program (HRRP) in 2012 resulted in quality measures based upon 30-day readmission rates for specified chronic disease process (CMS, 2018). Failure to meet related quality measures results in punitive action in the form of fiscal reimbursement withholdings (CMS, 2018). Referral to hospice services from acute care organizations is
occurring absent of adequate education (Nedjat-Haiem et al., 2017). A recent study reviewed discharge medication reconciliations in those being discharged from the hospital setting to hospice (Kadoyama et al., 2019). Results revealed documentation of family involvement rarely occurred (Kadoyama et al., 2019). Such findings present the necessity of evidence-based intervention. POST form utilization among the terminally ill population has been shown to improve translation of end-of-life care desires (Treece et al., 2018).

**Problem Statement**

High percentages of hospice revocations with concomitant emergency department visits and hospital admission/re-admissions was identified within a private organization. Hospice revocations and hospital re-admissions are currently monitored and related to quality measures by Centers for Medicare and Medicaid services (CMS, 2018). Healthcare organizations are subsequently penalized for 30-day readmission rates related to specified terminal and chronic disease process (CMS, 2018). Need to ensure and enhance compliance with government regulatory and quality measures is present.

**Purpose of the Project**

Purpose of the evidence-based practice project was to decrease live hospice discharges in the form of revocations. Concomitant reduction of emergency department visits and hospital admissions/readmissions was anticipated. This is vital to remain complaint with CMS regulations and meet government quality measures. Desire was present to implement an evidence-based intervention decreasing hospice revocations resulting in decreased hospital re-admissions and enhanced regulatory compliance through utilization of POST forms.
Clinical Question

A clinical question was developed utilizing the patient/problem, intervention, comparison, outcome (PICO) mnemonic (White, Dudley-Brown, Terhaar, 2016). Would implementation of Physician Orders for Scope of Treatment (POST) forms upon hospice admission decrease the percentage of hospice revocations, resultant emergency department visits and hospital readmissions when compared to not utilizing POST forms?

Section Two: Literature Review

A thorough literature review was conducted to support significance of the proposed trigger and intervention through published research. Search strategy with concomitant critical appraisal and synthesis was employed. Throughout this process the conceptual framework provided foundational support for articles chosen. Each step is presented and discussed in detail.

Search Strategy

Literature review strategy involved a systematic method for identification of related, supportive, informing, and high-level evidence articles. Implemented process involved employment of search engines, keywords, and phrases. Utilization of the following search engines: PubMed, CINAHL, National Center for Biotechnology Information (NCBI), and Ebsco were executed. Keywords and phrases included: hospice, revocations, POST forms, physician order for scope of treatment, end of life care, hospital readmissions, and palliative care. Search parameters were utilized to ensure relativity, evidence level, and current application. Such parameters were articles published within the past five years in the English language, peer reviewed, research, systematic reviews, and randomized control trials.

Approximately 200 articles were identified in the initial search. Upon application of stated parameters 30 articles were chosen for utilization and presented within the synthesis table.
Articles not meeting parameters were primarily related to date exceeding five-year range, and periodicals rather than peer reviewed research. Retained articles ranged from evidence levels 2-6, are peer reviewed, no more than five years old, and support the stated trigger and intervention.

Critical Appraisal

Critical appraisal of extrapolated articles was performed to articulate levels of evidence, designs, methods, purpose, strengths, weakness, and results. Utilization of an evidence table via article matrix promoted analyzation of obtained articles as a unit and individually. Presented articles inform the presented PICOT question promoting implementation of the identified intervention.

Sixteen level four articles were identified to support the presented project regarding POST form implementation. Study topics included but were not limited to POST form utilization with correlational hospital readmissions and hospice admissions (Cassel et al., 2018; Hopping-Winn et al., 2018; Nugent et al., 2019). Comparison studies relating POST form utilization to patient demographics and advanced directives promote the need for enhanced utilization of this intervention (Fromme et al., 2014; Pedraza et al., 2017). Cohort studies revealed hospice revocations as being problematic with need for intervention (Riolfi et al., 2014; Wang et al., 2016). Additional level four articles identified POST form utilization gaps among physicians and need for accurate implementation among the long-term care population (Jennings et al., 2016; Zive et al., 2015). A level five study discussed hospice fiscal benefits, supporting the vitality of revocation reduction (Treece et al., 2018).

Three level two articles revealed POST form enhancement of compliance with patient end-of-life wishes, correlation to hospice services, and programs to aid understanding of the intervention (Lum et al., 2017; Patrick et al., 2019; Walczak et al., 2017). A level three article
revealed signing of POST forms while in intensive care units (ICU) was observed to decrease length of stay (Constantine et al., 2018). Nine level six articles were extrapolated. Four of these explored utilization of POST forms within long-term care facilities, needs upon admission to hospice, and how collaboration relates to hospice revocation and hospital readmission (Hickman et al., 2018; Hyunjin et al., 2017; Joseph et al., 2016; Rahman et al., 2017). Additional articles discuss nurse/provider comfort and knowledge regarding POST forms, and areas for improvement (McGough et al., 2015; Mirarchi et al., 2015; Pirinea et al., 2016; Tarzian et al., 2017; Mo-Ying Liao, 2019). A final level six article discussed quality of life enhancement through POST form utilization (Lamahewa et al., 2018). Appendix A provides a detailed synthesis matrix of each extrapolated article.

**Synthesis**

The clinical question sought to answer if implementation of POST forms upon admission to hospice services will reduce hospice revocations. Based upon article search, review, and critique, this was reinforced. Evidence pointed to accurate POST form utilization enhancing patient knowledge, understanding, and communication regarding end-of-life care (Patrick et al., 2019; Treece et al., 2018). Evidence was also present supporting enhanced compliance with end-of-life wishes with proper POST form intervention. Based upon article analysis results, evidence supported implementation of POST forms upon admission to hospice services (Torke et al., 2019).

**Conceptual Framework**

The Iowa Model was the conceptual framework which supported the scholarly project (White, Dudley-Brown, & Terhaar, 2016). Utilization of this framework bestowed a step-by-step progression method for implementation (White, Dudley-Brown, & Terhaar, 2016). Iowa Model
intent for use among practitioners desiring to translate evidence-based research at the point of care has been recognized among researchers (Buckwalter et al., 2017). Probability of positive outcome achievement has been enhanced through accurate implementation of this model (White, Dudley-Brown, & Terhaar, 2016).

Step one of the Iowa Model involves trigger identification which was presented as high hospice live discharge rates in the form of revocation (Iowa Model Collaborative, 2017). Team formulation is the second step (Iowa Model Collaborative, 2017). Comprised team members included scholarly project chair, company vice president, director of administration, chief executive officer, and director of quality assurance and performance improvement (QAPI).

A literature search and review were conducted as part of step three (Iowa Model Collaborative, 2017). Thirty articles were obtained providing evidence to support implementation of POST forms upon admission to hospice services. Extrapolated articles were synthesized in accordance with step four (Iowa Model Collaborative, 2017). Evaluation through use of a synthesis matrix revealed appropriateness and support of the proposed topic (Iowa Model Collaborative, 2017).

Step five involved translation of evidence into practice (Iowa Model Collaborative, 2017). This began January 27th, 2020 through implementation of POST forms upon admission within a private hospice organization (Iowa Model Collaborative, 2017). Dissemination of initiative results followed pilot project completion in accordance with step six (Iowa Model Collaborative, 2017). Throughout this process, the project leader continuously analyzed, asked questions, and re-evaluated data to ensure result accuracy (White, Dudley-Brown, & Terhaar, 2016). Permission to utilize the Iowa Model framework is attached in Appendix D.
Summary

Literature review findings supported implementation of POST forms into end of life planning at various evidence levels. Limitations included small sample size, incomplete POST forms, single organizational studies, and some level six evidence articles. Utilization of this tool revealed benefits related to deeper understanding regarding disease process, personal desire for further intervention, and end-of-life measures among patients and caregivers. Limitations included small sample size, incomplete POST forms, single organizational studies, and some level six evidence articles.

All identified articles supported implementation of POST forms with end-of-life care planning. Obtained evidence positively supported the clinical question of POST form implementation upon hospice admission to reduce revocations and project initiative (Patrick et al., 2019; Torke et al., 2019; Treece et al., 2018). Purpose of the evidence-based practice project was to decrease live hospice discharges in the form of revocations. Concomitant reduction of emergency department visits and hospital readmissions was desired. This is vital to remain compliant with CMS regulations and meet government quality measures. Desire was present to implement an evidence-based intervention decreasing hospice revocations resulting in decreased hospital re-admissions and enhanced regulatory compliance through utilization of POST forms.

Section Three: Methodology

Design

Secondary to the nature of the Doctor of Nursing Practice (DNP) scholarly project, initiative design was that of an evidence-based practice project (VanderKooi, 2018). Purpose involved quality improvement at the point of care through implementation of evidence-based practice interventions (VanderKooi, 2018). The Iowa Model served as the foundational
framework (Iowa Model Collaborative, 2016). In attempt to answer the clinical question, evaluation of the presented practice change occurred through implementation of a quantitative, non-experimental pilot study (Lau, 2017; Roush, 2019). Outcome measures were guided by a cross-sectional correlational design due to time restraints (Lau, 2017; Roush, 2019).

Physician order for scope of treatment (POST) forms were implemented upon admission to hospice services among a convenience sample of patients from January 27, 2020 to February 29th, 2020. Completion of the form was voluntary. Rates of revocation, emergency department visits, and hospital admission/readmission among the remaining admissions not receiving POST form intervention between the dates of January 27, 2020 and February 29th, 2020 were tracked. Monitoring of hospice revocation, emergency department visits, and hospital admission/readmission between the two groups continued until May 9, 2020.

**Measurable Outcomes**

1. A 5% reduction in live hospice discharges in the form of revocations among the group receiving POST form intervention within the stated time frame.

2. A 2% reduction in post admission emergency department visits among the group receiving POST form intervention within the stated time frame.

3. A 2% decrease in hospital admissions/readmissions among the group receiving POST form intervention within the stated time frame.

**Setting**

Project setting involved a private hospice organization within the southeastern United States (World Population Review, 2019). Organizational mission and values involve provision of quality care to the terminally ill and their families. In order to perform at this level, government regulatory statues must be met. Key stakeholders included organization president, vice president,
executive director of administration, and the chief operating officer. Project site support was strongly present. A letter confirming support of the proposed project is presented in appendix C.

**Population**

The population chosen was that of the terminally ill having received hospice referral from a physician. Many patients receiving terminal prognosis lack understanding of hospice care and have not considered in-depth desire for further intervention (Nadjet-Haiem et al., 2019). Upon hearing devastating news and being overwhelmed, such considerations often fail to take place until an event sparks a state of panic (Russell, 2017). Panic frequently results in ED visits and hospital readmissions (Russell, 2017). Utilization of POST forms aid in consideration and communication of personal desire regarding end-of-life interventions (Hopping-Winn et al., 2018). Evidence has revealed enhanced fulfillment of desired end-of-life care measures in those utilizing POST forms (Hopping-Winn et al., 2018).

Sample size included 15 patients receiving POST form intervention compared to 15 individuals admitted without receiving this intervention. A convenience sample was utilized as hospice referral type varies in diagnosis, age, race, and socioeconomic status. Inclusion criteria involved patients being admitted to hospice services under the hospice Medicare benefit greater than 18 years of age. Exclusion criteria included pediatric patients younger than 18 years of age, core patients, and those with private insurance as primary payor source. This is secondary to absence of Medicare billing and differing regulatory statues among the excluded population.

**Ethical Considerations**

Protection of human subjects remained at the highest priority and forefront throughout project implementation. Completion of research ethics training was completed by the DNP project team comprised of student and project chair in the form of CITI training. A copy of the
CITI training certificate is available for review in appendix C. The project was also be submitted to and approved by the Institutional Review Board (IRB). A copy of the IRB approval letter is presented in appendix D. Utilization of consents was not necessary as neither a study nor new research was performed, rather implementation of evidence-based interventions. Protection of patient information in the form of data was conducted through following of HIPPA regulatory statues, utilization of password locked computers, locked filing cabinets, and desk drawer.

Data Collection

The project coordinator reviewed and discussed POST forms upon admission to hospice services from a random convenience sample. Project coordinator involvement in this area was to ensure continuity in POST form completion. Quantitative data collection occurred through utilization of the WellSky/Consolo electronic medical record (EMR) system (Roush, 2019). Data input from intake coordinators, administration, and nursing staff regarding admissions, live discharges in the form of revocations, and those receiving POLST form intervention were reviewed and extrapolated. Obtained data included resultant emergency department (ED) visits and hospitalizations/readmissions. This was conducted by the project coordinator over the stated time period. Comparison of revocation rates between the intervention and non-intervention group occurred via collected data.

Tools

The primary tool that was utilized for this project was the POST form. It is important to note that names of this tool vary among different states and may be referred to as the Medical Orders for Scope of Treatment (MOST) form or Physician Order for Life Sustaining Treatment (POLST) form (Scotti, 2016). Utilization of the POST form tool was chosen as this is recognized and utilized within the state of Virginia. Physician orders for life sustaining treatment (POLST)
forms were derived in 1991 by medical ethicists and key stakeholders in attempt to align patient desires regarding end-of-life care with provision of interventions (Scotti, 2016). Tool intent is to aid patients and caregivers in communicating personal end-of-life care desires resulting in a signed physician order (Scotti, 2016). This results in an order that can be carried out through various healthcare settings (Scotti, 2016).

Virginia administrative code 12VAC5-66-10 regarding durable DNR definition was expanded to include POST forms in November of 2016 (Virginia Law, 2019; Virginia POST Collaborative, 2016). Completion of POST forms should occur after an advanced care planning discussion has occurred with a physician, advanced practitioner, or trained post form facilitator (Virginia POST Collaborative, 2016). Trained post form facilitators may include registered nurses, social workers, and chaplains (Virginia POST Collaborative, 2016). A copy of the POST form tool is attached in Appendix F.

Topics of discussion include mechanical ventilation, intravenous fluids, antibiotics, parenteral feedings, and cardiopulmonary resuscitation (Scotti, 2016). Numerous research studies have been conducted regarding efficacy of this tool. Evidence-based research promotes implementation of POST forms in the terminally ill population (Hopping-Will et al., 2018). High tool reliability has been noted in the support of advanced care planning (Lovadini et al., 2019). Permission to use this tool was obtained. A copy of the letter attesting to permitted utilization of the POST form is presented in appendix E. Additional tools include utilization of the Wellsky/Consolo EMR for data collection. This is the EMR system in place within the identified organization. Statistical Package for the Social Sciences (SPSS) software was a tool utilized in tracking data, creating graphs and charts depicting outcomes, and drawing statistical conclusions (University of California, Los Angeles [UCLA], 2019).
**Intervention**

Initiative intervention involved project development from August 12th, 2019 through October 11th, 2019. Institutional Review Board approval was obtained the week of January 1st, 2020. Implementation of POST forms upon admission to hospice service began January 27, 2020 and continued through February 29th, 2020. During this time frame, revocations were monitored among all patients being admitted to hospice services. This included monitoring of resultant ED visits and hospital admissions. Revocation rates, ED visits, and hospitalizations among the intervention group were compared with the non-intervention patients. Hospice revocation monitoring continued among the two groups until May 9, 2020.

**Timeline**

<table>
<thead>
<tr>
<th>Project Development</th>
<th>August 27th, 2019-October 11th 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liberty University Institutional Review Board Submission</td>
<td>Week of November 18th 2019</td>
</tr>
<tr>
<td>Presentation of Proposal to Organization Key stakeholders</td>
<td>Week of December 1st 2019</td>
</tr>
<tr>
<td>Implementation of POST forms at time of admission</td>
<td>January 27th, 2020 – February 29th 2020</td>
</tr>
<tr>
<td>Collection of data regarding post form utilization, revocations, ED visits, and hospital admissions/readmissions</td>
<td>January 27th – May 9th 2020</td>
</tr>
<tr>
<td>Data analysis and writing of results and discussion</td>
<td>May 10th – June 9th 2020</td>
</tr>
<tr>
<td>Final editing</td>
<td>June 15th – July 15th 2020</td>
</tr>
</tbody>
</table>
Data Analysis

Measurable Outcome #1: A 5% Reduction in Live Hospice Discharges in the Form of Revocations Among the Group Receiving POST Form Intervention Within the Stated Time Frame.

Evaluation of this outcome measure was conducted through a cross-sectional, correlational review between the intervention group and non-intervention group (Lau, 2017). Data was extrapolated via the WellSky/Consolo EMR system to identify live discharges in the form of revocations. Descriptive statistics were implemented for statistical variable measurement (UCLA, 2019). This was chosen to answer the stated clinical question and evaluate outcome measures accurately and statistically. Identification of relationships regarding live hospice discharges in the form of revocations between the intervention and non-intervention group was imperative for outcome measurement evaluation. Statistical software utilization included SPSS (UCLA, 2019).

Measurable Outcome #2: A 2% Reduction in Post Admission Emergency Department Visits Among the Group Receiving POST Form Intervention Within the Stated Time Frame.

Evaluation of this outcome measure was conducted through a cross-sectional, correlational review between the intervention group and non-intervention group (Lau, 2017). Data was extrapolated via the WellSky/Consolo EMR system to identify ED visits occurring within patients admitted to hospice services within the stated timeframe. Descriptive statistics were implemented for statistical variable measurement (UCLA, 2019). This was chosen to answer the stated clinical question and evaluate outcome measures accurately and statistically. Identification of relationships regarding ED visits between the intervention and non-intervention
Measurable Outcome #3: A 2% Reduction in Hospital Admissions/Readmissions Among the Group Receiving POST Form Intervention Within the Stated Time Frame.

Evaluation of this outcome measure was conducted through a cross-sectional, correlational review between the intervention group and non-intervention group (Lau, 2017). Data was extrapolated via the WellSky/Consolo EMR system to identify hospitalizations/readmissions occurring among patients admitted to hospice during the stated timeframe. Descriptive statistics were utilized for statistical variable measurement (UCLA, 2019). This was been chosen to answer the stated clinical question and evaluate outcome measures accurately and statistically. Identification of relationships regarding hospitalizations/readmissions between the intervention and non-intervention group was imperative for outcome measurement evaluation. Statistical software will involve utilization of SPSS (UCLA, 2019).

Section Four: Results

Results were obtained after successful project implementation, data collection and analyzation. Each of the stated measurable outcomes were evaluated through a cross-sectional correlation review between the intervention and non-intervention groups. Data collection occurred from January 27\textsuperscript{th} – May 9\textsuperscript{th} with subsequent thorough analyzation utilizing SPSS software to obtain descriptive statistics (UCLA, 2019).

Descriptive Statistics

Utilization of SPSS provided descriptive statistics revealing the percentage of hospice revocations, emergency department visits and hospital admissions between the intervention and
non-intervention groups (UCLA, 2019). This includes frequencies and percentages depicted through tables and graphs (UCLA, 2019). Each of the proposed measurable outcomes were statistically analyzed utilizing SPSS (UCLA, 2019).

**Measurable Outcome #1: A 5% Reduction in Live Hospice Discharges in the Form of Revocations Among the Group Receiving POST Form Intervention Within the Stated Time Frame.**

The above stated measurable outcome regarding live hospice discharge in the form of revocations among the intervention group was evaluated through a cross sectional correlational review using SPSS software (UCLA, 2019). A total of 15 patients received POST form intervention upon admission to hospice services from January 27th, 2020 – February 29th, 2020. A second group of 15 patients admitted to hospice services from January 27th, 2020 - February 29th, 2020 did not receive POST form implementation. Data was collected from January 27th, 2020-May 9th, 2020 comparing hospice revocations among the group receiving POST form intervention and the non-intervention group.

Descriptive statistics revealed a 6.7% reduction in hospice revocations among the POST form intervention group when compared to the non-intervention group. Desire was to obtain a 5% reduction through POST form implementation. Data analysis reveals measurable outcome #1 was met and exceeded. The presented tables and charts depict descriptive statistics and findings.
Table #1.

<table>
<thead>
<tr>
<th>Intervention Group</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
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<tbody>
<tr>
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Table #2.

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<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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</thead>
<tbody>
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<td>14</td>
<td>93.3</td>
<td>93.3</td>
<td>93.3</td>
</tr>
<tr>
<td>Hospice Revocation</td>
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<td>6.7</td>
<td>6.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Measurable Outcome #2: A 2% Reduction in Post Admission Emergency Department Visits Among the Group Receiving POST Form Intervention Within the Stated Time Frame.

The above stated measurable outcome regarding post admission emergency department visits among the intervention group was evaluated through a cross sectional correlational review using SPSS software (UCLA, 2019). A total of 15 patients received POST form intervention upon admission to hospice services from January 27th, 2020 – February 29th, 2020. A second group of 15 patients admitted to hospice services from January 27th, 2020 - February 29th, 2020 did not receive POST form implementation. Data was collected from January 27th, 2020- May
9th, 2020 comparing hospice revocations among the group receiving POST form intervention and the non-intervention group.

Descriptive statistics revealed an absence of reductions in emergency department visits among the POST form intervention group when compared to the non-intervention group. This was due to unexpected and uncontrollable events. Desire was to obtain a 2% reduction through POST form implementation. Data analysis reveals measurable outcome #2 was not met. The presented tables depict statistics and findings.

Table #3

<table>
<thead>
<tr>
<th>Intervention Group</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tbody>
<tr>
<td>Valid</td>
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<tr>
<td>No Emergency Department Visits</td>
<td>14</td>
<td>93.3</td>
<td>93.3</td>
<td>93.3</td>
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<tr>
<td>Emergency Department Visit</td>
<td>1</td>
<td>6.7</td>
<td>6.7</td>
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<tr>
<td>Total</td>
<td>15</td>
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Table #4

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<tr>
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<tbody>
<tr>
<td>Valid</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Hospice Revocation</td>
<td>14</td>
<td>93.3</td>
<td>93.3</td>
<td>93.3</td>
</tr>
<tr>
<td>Hospice Revocation</td>
<td>1</td>
<td>6.7</td>
<td>6.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
<td>100.0</td>
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</table>
Measurable Outcome #3: A 2% Reduction in Hospital Admissions/Readmissions Among the Group Receiving POST Form Intervention Within the Stated Time Frame.

The above stated measurable outcome regarding hospital admission/readmissions among the intervention group was evaluated through a cross sectional correlational review using SPSS software (UCLA, 2019). A total of 15 patients received POST form intervention upon admission to hospice services from January 27th, 2020 – February 29th, 2020. A second group of 15 patients admitted to hospice services from January 27th, 2020 - February 29th, 2020 did not receive POST form implementation. Data was collected from January 27th, 2020- May 9th, 2020 comparing hospice revocations among the group receiving POST form intervention and the non-intervention group.

Descriptive statistics revealed a 6.7% reduction in hospital admissions after admission to hospice services among the POST form intervention group when compared to the non-intervention group. Desire was to obtain a 2% reduction through POST form implementation. Data analyzation reveals measurable outcome #3 was met and exceeded. The presented tables depict descriptive statistics and findings.

Table #5

<table>
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<tr>
<th>Intervention Group</th>
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<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tr>
<td>No Hospital Admissions</td>
<td>15</td>
<td>100.0</td>
<td>100.0</td>
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Table #6

<table>
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<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tbody>
<tr>
<td>Valid</td>
<td>No Hospital Admissions</td>
<td>14</td>
<td>93.3</td>
<td>93.3</td>
</tr>
<tr>
<td></td>
<td>Hospital Admissions</td>
<td>1</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Within the non-intervention group it is important to note and unexpected finding in which a patient was discharged for cause secondary to significant safety concerns. This does not happen frequently however was unavoidable. Revocation percentages are non-reflective of this as it is an unrelated incidental finding. The presented bar charts present data analysis findings including the discharge for cause.

Figure #1

POST Form Implemented Upon Hospice Admission (Intervention Group)
Section Five: Discussion

The presented pilot project supported the utilization of POST forms upon admission to hospice services to aid in reduction of live hospice discharges in the form of revocations. This was evidenced by a 6.7% reduction of hospice revocations within the intervention group when compared to a control group. Clinical significance in this finding is related to potential for meeting patient end of life care wishes with concomitant regulatory fulfilment.

Reduction of emergency department visits were not evident within this pilot project. It is important to note that the emergency department visit occurring within the intervention group was secondary to violent behaviors in which the patient was a danger to self and others within an assisted living facility. The family did not desire an ED visit however this was unavoidable for
safety reasons. Based upon this knowledge, probability of ED visit reduction through utilization of POST forms is present and may be evident within a larger project or study.

Hospital admission/readmission reduction was evident through a 6.7% decline noted among the POST form intervention group when compared to the control group. This is significant as potential is present for meeting patient end of life care goal while concomitantly complying with regulatory statues. Implication for practice, sustainability and dissemination plan were evaluated and discussed below.

**Implication for Practice**

This project revealed significant implications for practice including reduction of hospice revocations and hospital admissions/readmissions. Probability exists regarding reduction of ED visits. Future implications include utilization of POST forms to identify patients and families who are not hospice minded. In such cases referral to appropriate services such as home health could be provided. This would promote continued meeting of individual patient wishes while concomitantly reducing expected revocations for those desiring further intervention.

Throughout the implementation process acceptance of POST form utilization was widely received among the intervention group. Review of the stated form resulted in answers such as, “I had never thought of that before,” when discussing IV hydration at end of life. Discussion regarding POST form topics facilitated conversations centered around individual patient and family goals. This further enhanced individualized, patient centered care plan development and additional regulatory compliance.

**Sustainability**

Pilot project results support a change in the hospice admission process involving implementation of POST forms. Sustainability issues considered included admission efficiency
related to time spent and proper training to ensure accurate completion. Throughout the implementation process time added to admission length was approximately 3-5 minutes on average. This was found to vary based upon individual questions, considerations, knowledge base and current hospice mindset.

Foreseeable barriers involve staff buy in as the consideration of additional admission forms and paperwork can be overwhelming. Face- to- face training in the middle of a global pandemic presents additional challenges. Electronic signing of hospice consents due to facility lockdowns results in POST form discussion via telephone. Despite the stated obstacles, avenues in which to proceed are open and available due to advanced technological platforms. Properly educating and informing staff regarding how and why POST forms are being implemented may alleviate anxiety and fears arising related to perceived extra work.

**Dissemination Plan**

Pilot project results have been disseminated among company key stakeholders. Short term goals include a plan for education to take place with nurses and social workers to accurately implement POST form utilization upon hospice admission company wide. Additional dissemination goals include publication and sharing with the Virginia Post Collaborative. Long term goals are multifactorial. Reshaping of the end of life care landscape for the promotion of improved patient outcomes with concomitant organizational regulatory compliance is desired. The primary goal is wide dissemination of project results in an effort to make a difference on earth and for eternity.
References


the American Association of Nurse Practitioners, 30(1), 10–16. https://doi-org.ezproxy.liberty.edu/10.1097/JXX.0000000000000012


https://doi.org/ezproxy.liberty.edu/10.1200/JOP.2017.022566


### Appendix A

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<td>Article 1 Jennings, L. A., Zingmond, D., Louie, R., Chi-Hong, T., Thomas, J., Kate O’Malley, &amp; Wenger, N. S. (2016). Use of the physician orders for life-sustaining treatment among California nursing home residents. <em>Journal of General Internal Medicine, 31</em>(10), 1119-1126. doi:<a href="http://dx.doi.org.ezproxy.liberty.edu/10.1007/s11606-016-3728-9">http://dx.doi.org.ezproxy.liberty.edu/10.1007/s11606-016-3728-9</a></td>
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<td>1–8. Retrieved from <a href="http://search.ebscohost.com.ezproxy.liberty.edu/login.aspx?direct=true&amp;db=rzh&amp;AN=101664026&amp;site=ehost-live&amp;scope=site">http://search.ebscohost.com.ezproxy.liberty.edu/login.aspx?direct=true&amp;db=rzh&amp;AN=101664026&amp;site=ehost-live&amp;scope=site</a> (Mirarchi et al., 2015).</td>
</tr>
<tr>
<td>Article 5 Turnbull, A. E., Ning, X., Rao, A., Tao, J. J., &amp; Needham,</td>
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<table>
<thead>
<tr>
<th>Article Title, Author, etc. (Current APA Format)</th>
<th>Study Purpose</th>
<th>Sample (Characteristics of the Sample: Demographics, etc.)</th>
<th>Methods</th>
<th>Study Results</th>
<th>Level of Evidence (Use Melnyk Framework)</th>
<th>Study Limitations</th>
<th>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</th>
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<tr>
<td>D. M. (2019). Demonstrating the impact of POLST forms on hospital care requires information not contained in state registries. <em>PLoS One, 14</em>(6) doi:<a href="http://dx.doi.org.ezproxy.library.edu/10.1371/journal.pone.0217113">http://dx.doi.org.ezproxy.library.edu/10.1371/journal.pone.0217113</a></td>
<td>how research design can reveal the impact of POLST form utilization (Turnbull et al., 2019).</td>
<td>individuals found linked to a DNR within the identified system (Turnbull et al., 2019).</td>
<td>study (Turnbull et al., 2019).</td>
<td>DNR’s were readmitted to the hospital within a 30-day timeframe (Turnbull et al., 2019).</td>
<td>study (University of Michigan Library, 2019).</td>
<td>involving only one facility (Turnbull et al., 2019).</td>
<td>Yes, provided evidence support intervention regarding end of life desires and hospital readmissions (Turnbull et al., 2019).</td>
</tr>
<tr>
<td>Article 6 Nugent, S. M., Slatore, C. G., Ganzini, L., Golden, S. E., Zive, D., Vranas, K. C., &amp; Sullivan, D. R. (2019). POLST Registration and Associated Outcomes Among Veterans With Advanced-Stage Lung Cancer. <em>American Journal of Hospice &amp; Palliative Medicine, 36</em>(7), 564–570. <a href="https://doi-">https://doi-</a></td>
<td>Study purpose involved characteristics of end of life care provided to Veterans having completed and lacking completion of POLST forms (Nugent et al., 2019).</td>
<td>Three hundred and forty-six residents of Oregon with end stage lung cancer were examined from the years 2008-2013 (Nugent et al., 2019).</td>
<td>A retrospective cohort method was utilized analyzing sociodemographic and clinical (Nugent et al., 2019).</td>
<td>Study results revealed veterans having completed POLST forms having a higher chance of going home with hospice and not being readmitted to a VA acute care facility</td>
<td>Level 4: Correlational retrospective cohort study method was utilized (University of Michigan Library, 2019).</td>
<td>Limitations include small sample size (Nugent et al., 2019).</td>
<td>Yes, provided evidence support implementation of POST forms upon hospice admission to decrease hospital readmission (Nugent et al., 2019).</td>
</tr>
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<td>Sample (Characteristics of the Sample: Demographics, etc.)</td>
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<td>Study Results</td>
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<tr>
<td>org.ezproxy.liberty.edu/10.1177/104990911882453</td>
<td>Study purpose was to obtain data within the state of Maryland regarding POLST form in order to inform future practice and research (Tarzian &amp; Cheevers, 2017).</td>
<td>Chart reviews included 1,959 from 137 facilities (Tarzian et al., 2019).</td>
<td>Study method involved chart review and data analysis involving Maryland hospitals, long term care facilities, home health agencies, hospice companies and dialysis clinics (Tarzian &amp; Cheevers, 2017).</td>
<td>Areas for improvement in POLST form obtainment involved abstaining from contradiction and selection of only one order (Tarzian &amp; Cheevers, 2017).</td>
<td>Level 6: Descriptive Design (University of Michigan Library, 2019).</td>
<td>Study limitations include level six design (Tarzian &amp; Cheevers, 2017).</td>
<td>Despite being a level six research design, beneficial information was gleaned regarding POLST form implementation (Tarzian &amp; Cheevers, 2017).</td>
</tr>
<tr>
<td>Article Title, Author, etc. (Current APA Format)</td>
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<td>Sample (Characteristics of the Sample: Demographics, etc.)</td>
<td>Methods</td>
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<td>Article 8 Lamahewa, K., Mathew, R., Iliffe, S., Wilcock, J., Manthorpe, J., Sampson, E. L., &amp; Davies, N. (2018). A qualitative study exploring the difficulties influencing decision making at the end of life for people with dementia. <em>Health Expectations, 21</em>(1), 118–127. <a href="https://doi-org.ezproxy.liberty.edu/10.1111/hex.12593">https://doi-org.ezproxy.liberty.edu/10.1111/hex.12593</a></td>
<td>Purpose of this study served to identify end of life care quality for the dementia population (Lamahewa et al., 2018).</td>
<td>Sample involved a combination of 22 former and current dementia patient caregivers and healthcare professionals (Lamahewa et al., 2018).</td>
<td>Methods included four focus groups and interviewing of current and former family caregivers of dementia patients, and healthcare providers (Lamahewa et al., 2018).</td>
<td>Study results revealed lack of preparedness, uncertainty, caregiver and family dynamics, and care delivery challenges as the primary issues impeding end of life care (Lamahewa et al., 2018).</td>
<td>Level 6: Descriptive Design</td>
<td>Limitations include small sample size and level six design (Lamahewa et al., 2019).</td>
<td>Despite being a level six design, evidence support implementation of intervention such as the POLST form to aid in preparing for end of life care and decision making in the dementia population (Lamahewa et al., 2018).</td>
</tr>
<tr>
<td>Article 9 Pirinea, H., Simunich, T., Wehner, D., &amp; Ashurst, J. (2016). Patient and health-care provider interpretation of do not resuscitate and do not intubate. <em>Indian Journal</em></td>
<td>Study purpose involved identification of patient and provider understanding of advanced directives</td>
<td>A total of 687 individuals participated in the survey and included patients, family members, and</td>
<td>A descriptive survey was implemented, non-experimental in nature (Pirinea et al., 2016).</td>
<td>Results revealed 50% of healthcare providers and 86% of patients were unfamiliar with POLST forms</td>
<td>Level 6: Descriptive Design (University of Michigan Library, 2019).</td>
<td>Limitations include single institution study involving a survey (Pirinea et al., 2016).</td>
<td>Yes, despite being a level six design, this study revealed need for provider and patient education regarding advanced</td>
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<tr>
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<td>including POLST forms (Pirinea et al., 2016).</td>
<td>health care providers (Pirinea et al., 2016).</td>
<td>(Pirinea et al., 2016). Sixty-nine percent of patients and family members provided feedback revealing advanced directives had never been discussed with them by their provider (Pirinea et al., 2016).</td>
<td></td>
<td>Level six: Descriptive design (University of Michigan Library, 2019).</td>
<td>Limitations of the study include small sample size and level six design (Mo-Ying Liao et al., 2019).</td>
<td>Despite being a level six study, results provide evidence reinforcing the intense need for proper, competent...</td>
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<tr>
<td>Article 10</td>
<td>Purpose of the study involved identification of knowledge and attitudes regarding advanced</td>
<td>Study sample included 75 end stage heart failure participants (Mo-Ying)</td>
<td>Study methods involved a survey cross sectional in method in an outpatient</td>
<td>Results of the study revealed four out of seventy-five participants had signed advanced directives and POLST forms (Pirinea et al., 2016).</td>
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<td>Article Title, Author, etc. (Current APA Format)</td>
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<td>directives among the heart failure population (Mo-Ying Liao et al., 2019).</td>
<td>Liao et al., 2019). cardiovascul ar clinic and an in-patient unit using a validated measuring tool (Mo-Ying Liao et al., 2019).</td>
<td>directives (Mo-Ying Liao et al., 2019). Those identified as not religious and have poor ejection fraction were identified as having positive attitudes toward this subject (Mo-Ying Liao et al., 2019).</td>
<td>utilization of advance directives such as post forms in the population nearing end of life (Mo-Ying Liao et al., 2019).</td>
<td>Level 4: Correlational Design, retrospective cohort study (University of Michigan)</td>
<td>Identified limitations include small sample size and missing chart information (Hopping-Winn et al., 2018).</td>
<td>Yes, this study promotes the utilization of POLST forms at end of life to promote individual wishes are upheld</td>
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<tr>
<td>Article Title, Author, etc. (Current APA Format)</td>
<td>Study Purpose</td>
<td>Sample (Characteristics of the Sample: Demographics, etc.)</td>
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<td>Palliative Medicine, 21(4), 541–545. <a href="https://doi-.org.ezproxy.liberty.edu/10.1089/jpm.2017.0317">https://doi-.org.ezproxy.liberty.edu/10.1089/jpm.2017.0317</a></td>
<td>carried out (Hopping-Winn et al., 2018). specified end of life care planning programs and with year of death 2015 (Hopping-Winn et al., 2018). identify documented end of life care wishes and interventions provided (Hopping-Winn et al., 2018). utilizing the POLST forms (Hopping-Winn et al., 2018).</td>
<td>Library, 2019).</td>
<td>Level 4: Correlational design, retrospective cohort study (University of Michigan Library, 2019).</td>
<td>Yes, this study promotes the need for utilization of POLST forms and the need for further education among the elderly (Zive et al., 2019).</td>
<td></td>
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<td>Article 12 Zive, D. M., Jimenez, V. M., Fromme, E. K., &amp; Tolle, S. W. (2019). Changes Over Time in the Oregon Physician Orders for Life-Sustaining Treatment Registry: A Study of Two Decedent Cohorts. Journal of Palliative Medicine, 22(5), 500–507. <a href="https://doi.org.ezproxy.liberty.edu/10.1089/jpm.2018.0446">https://doi.org.ezproxy.liberty.edu/10.1089/jpm.2018.0446</a></td>
<td>Comparison and description of POLST forms and demographics among two cohorts (Zive et al., 2019). Sample characteristics involved two cohorts of decreased individuals having registered POLST forms (Zive et al., 2019). Cohort #1 involved deceased in Methods involved matching of death records with POLST forms and performance of analysis to identify differences between each cohort (Zive et al., 2019). A 46.6% increase in POLST form utilization and registry was noted in cohort #2 with enhanced utilization among the very elderly observed (Zive et al., 2019).</td>
<td>Level 4: Correlational design, retrospective cohort study (University of Michigan Library, 2019).</td>
<td>Study Limitations include retrospective nature and deceased status of sample (Zive et al., 2019).</td>
<td>Yes, this study promotes the need for utilization of POLST forms and the need for further education among the elderly (Zive et al., 2019).</td>
<td></td>
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<td>Study Limitations</td>
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<td><strong>Article 13</strong> Brian Cassel, J., Kerr, K. M., McClish, D. K., Skoro, N., Johnson, S., Wanke, C., &amp; Hoefer, D. (2016). Effect of a home-based palliative care program on healthcare use and costs. <em>Journal of the American Geriatrics Society, 64(11)</em>, 2288–2295. <a href="https://doi.org/ezproxy.liberty.edu/10.1111/jgs.14354">https://doi.org/ezproxy.liberty.edu/10.1111/jgs.14354</a></td>
<td>Study purpose was evaluation of non-clinical benefits related to community palliative care programs (Brian et al., 2016). A retrospective study of 368 individuals having received community based palliative care were compared to 1,075 individuals who had not received the stated</td>
<td>Oregon from 2010-2011, and cohort #2 reviewed deaths from 2015-2016 (Zive et al., 2019).</td>
<td>Study method involved that of a retrospective, observational, case control design (Brian et al., 2016)</td>
<td>Results of the study revealed decreased hospitalization and health care related costs at the end of life in the group having received community based palliative care (Brian et al., 2016).</td>
<td>Level 4: Correlational design, retrospective case control study (University of Michigan Library, 2019).</td>
<td>Study limitations include small interventional sample size and level 4 evidence (Brian et al., 2016).</td>
<td>Yes, study results present data supporting interventions to decrease hospice revocations in order to promote community based palliative care services and decrease hospital readmissions (Brian et al., 2016).</td>
</tr>
<tr>
<td>Article Title, Author, etc. (Current APA Format)</td>
<td>Study Purpose</td>
<td>Sample (Characteristics of the Sample: Demographics, etc.)</td>
<td>Methods</td>
<td>Study Results</td>
<td>Level of Evidence (Use Melnyk Framework)</td>
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<td>Article 14 Treece, J., Ghouse, M., Rashid, S., Arikapudi, S., Sankhyan, P., Kohli, V., ... Baumrucker, S. J. (2018). The effect of hospice on hospital admission and readmission rates: A review. Home Health Care Management &amp; Practice, 30(3), 140–146. <a href="https://doi.org/ezproxy.library.edu/10.1177/1084822318761105">https://doi.org/ezproxy.library.edu/10.1177/1084822318761105</a></td>
<td>Study purpose involved identifying cost effectiveness of community-based hospice programs (Treece et al., 2018).</td>
<td>Sample included 36 research articles (Treece et al., 2018).</td>
<td>Study method involved a systematic article review (Treece et al., 2018).</td>
<td>Results presented evidence that symptom management is provided with enhanced fiscal responsibility within a community hospice program setting (Treece et al., 2018).</td>
<td>Level 5: Systematic article review (University of Michigan Library, 2019).</td>
<td>Study limitations include that of being level 5 evidence and small sample size (Treece et al., 2018).</td>
<td>Yes, presented data promotes community-based hospice programs and the need to decrease revocations (Treece et al., 2018).</td>
</tr>
<tr>
<td>Article 15 Walczak, A., Butow, P. N., Tattersall, M. H. N., Davidson, P. M., Young, J., Epstein, R. M., ... Clayton, J. M. (2017).</td>
<td>Study purpose involved evaluation of nurse-led support programs to aid</td>
<td>Sample size included 110 individuals having a terminal cancer</td>
<td>Study method involved that of a randomized control trial</td>
<td>Results failed to reveal improvement in quality of life or eliciting of patient</td>
<td>Level 2: Randomized control trial (University of Michigan Library, 2019).</td>
<td>Limitations include sample size and inability to identify why further patient</td>
<td>Yes, this study presented information capable of enhancing patient/provider</td>
</tr>
<tr>
<td>Article Title, Author, etc. (Current APA Format)</td>
<td>Study Purpose</td>
<td>Sample (Characteristics of the Sample: Demographics, etc.)</td>
<td>Methods</td>
<td>Study Results</td>
<td>Level of Evidence (Use Melnyk Framework)</td>
<td>Study Limitations</td>
<td>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</td>
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<tr>
<td>Article 16</td>
<td>Study method involved identification of care wishes among the CHF population being admitted to long-term care facilities utilizing POLST</td>
<td>Study sample included 370 patients in 35 long-term care facilities with a diagnosis of CHF and order (Lum et al., 2017).</td>
<td>Methodology of presented study is that of a retrospective randomized control trial analyzing disease management</td>
<td>Utilization of POLST/MOST forms resulted in compliance with end-of-life wishes in 95% of cases when accurately completed</td>
<td>Level 2: Randomized control trial</td>
<td>Study limitation included numerous POLST/MOST forms inaccurately completed (Lum et al., 2017).</td>
<td>Yes, results support utilization of POLST forms to potentiate desired interventions at end of life (Lum et al., 2017).</td>
</tr>
<tr>
<td>Article Title, Author, etc. (Current APA Format)</td>
<td>Study Purpose</td>
<td>Sample (Characteristics of the Sample: Demographics, etc.)</td>
<td>Methods</td>
<td>Study Results</td>
<td>Level of Evidence (Use Melnyk Framework)</td>
<td>Study Limitations</td>
<td>Would Use as Evidence to Support a Change? (Yes or No) Provide Rationale.</td>
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<td>Medical Directors Association, 18(10), 885–890. <a href="https://doi.org/ezproxy.liberty.edu/10.1016/j.jamda.2017.05.021">https://doi.org/ezproxy.liberty.edu/10.1016/j.jamda.2017.05.021</a></td>
<td>or MOST forms (Lum et al., 2017).</td>
<td>as opposed to usual care in the CHF population (Lum et al., 2017).</td>
<td>(Lum et al., 2017).</td>
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<tr>
<td>Article 17 Constantine, L. A., Dichiavcchio, T., Falkentine, E. C., &amp; Moss, A. H. (2018). Nurse</td>
<td>Investigation of Nurse Practitioner POLST form signing authority and the</td>
<td>Sample involved 45 nurse practitioner and the submission of 450 POLST</td>
<td>A retrospective correlational design</td>
<td>POLST forms completed by nurse practitioners</td>
<td>Level four case control study</td>
<td>Sample size was identified as being small</td>
<td>Yes, this study provided vital data</td>
</tr>
<tr>
<td>Article</td>
<td>Authors</td>
<td>Description</td>
<td>Results</td>
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<td>(Pedraza et al., 2017; University of Michigan, 2019).</td>
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<td>Level 4 evidence: This was a level 4, case control study (University of Michigan, 2019).</td>
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<td>(Pedraza et al., 2017).</td>
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<td>Yes, this level 4 case control study provided strong evidence supporting further use of POSLT forms in the terminally ill population (Pedraza et al., 2017).</td>
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**Summary**

1. The completion of Physician Orders for Scope of Treatment forms in West Virginia was analyzed in a secondary analysis of 12 months of data from the state registry. 
2. The forms had a higher probability of DNR, comfort measures, and absence of errors when compared to those without DNR or comfort measures. 
3. The completion of POLST forms was associated with an increased chance of being admitted to hospice care. 
4. A cross-sectional correlation design was used, which lacked a controlled aspect and risk for bias. 
5. Yes, this level 4 case control study provided strong evidence supporting further use of POSLT forms in the terminally ill population.
<table>
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<tr>
<td><strong>Form utilization (Fromme et al., 2014).</strong> Causes of live hospice discharges with associated risk factors and frequencies (Russell et al., 2017). A sample of 9,190 hospice patients were evaluated for live discharge through an electronic medical record from 2013-2015 (Russell et al., 2017). A retrospective cohort design was utilized (Russell et al., 2017). One in five patients were identified as a live discharge with number one cause being hospital admission (Russell et al., 2017). This was more common in those lacking advance directives (Russell et al., 2017).</td>
<td><strong>Implemented (Fromme et al., 2014; University of Michigan, 2019).</strong> Documented in POLST forms were found to be fulfilled (Fromme et al., 2014). Case control study (University of Michigan, 2019). Adequate clinical information (Fromme et al., 2014). Strong evidence promoting implementation of POLST forms with end-of-life care (Fromme et al., 2014).</td>
</tr>
<tr>
<td><strong>Level 4:</strong> A level four retrospective cohort study was implemented (Russell et al., 2017). Limitations included study performance at one hospice agency and all collected data was retrospective (Russell et al., 2017).</td>
<td>Yes, this study provided evidence of top hospice revocation causes and identified areas needed for further research (Russell et al., 2017).</td>
</tr>
</tbody>
</table>
| Article 21 | Zalenski, R. J., Jones, S. S., Courage, C., Waselewsky, D. R., Kostaroff, A. S., Kaufman, Identification of outcomes seen through implementation of Sample size involved 649 hospitalized intensive care A quasi-experimental design was implemented Implementatio
 of early palliative care screening A level three controlled trial The trial was not randomized with a | Yes, this trial provided solid results |
| **Sample size** involved 649 hospitalized intensive care A quasi-experimental design was implemented Implementatio
 of early palliative care screening A level three controlled trial The trial was not randomized with a  | |
<table>
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<tr>
<th>Article 22</th>
<th>Examination of care transitions occurring six months after hospice admission and associated factors (Wang et al., 2016).</th>
<th>Sample size included evaluation of 311,090 hospice patients (Wang et al., 2016).</th>
<th>Design was that of a cross-sectional retrospective cohort study (Wang et al., 2016).</th>
<th>Approximately 10.2% of patients within the sample experienced at least one transition post hospice admission (Wang et al., 2016). Hospital admissions made up 53.4% of the transitions.</th>
<th>A level four cohort study was utilized for this project (University of Michigan, 2019).</th>
<th>Identified limitations involve inability to determine causal inferences secondary to cross-sectional study design (Wang et al., 2016).</th>
<th>Yes, this research project supports the need for intervention to decrease hospice revocation resulting in secondary hospital re-admissions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 23</td>
<td>Exploration of perceived patient and family needs among hospice admission staff (Hyunjin et al., 2017).</td>
<td>Sample size included 16 hospice admission employees among four different hospices (Hyunjin et al., 2017).</td>
<td>A qualitative study design was implemented (Hyunjin et al., 2017).</td>
<td>Results revealed lack of knowledge regarding disease process, alterations in hydration and nutritional needs, risks of life-sustaining measures, and being misinformed regarding comfort measures among patient’s and family members (Hyunjin et al., 2017).</td>
<td>Level 6: This study was identified as a level six with qualitative design (Hyunjin et al., 2017; University of Michigan, 2019).</td>
<td>Limitation included small sample size (Hyunjin et al., 2017).</td>
<td>Yes, while this was only a level six level of evidence, data supports the need to provide specific education regarding hospice services and plan of care which can be further focused through utilization of POST forms (Hyunjin et al., 2017).</td>
</tr>
<tr>
<td>Article 24</td>
<td>Synthetization of data revealing the effect of interdisciplinary collaboration among home hospice patients and how this affects hospital re-</td>
<td>The presented study implemented a qualitative literature review with randomized, controlled trial, and quasi-experimental literature review</td>
<td>The presented study implemented a qualitative literature review</td>
<td>Literature search resulted in the absence of any research articles meeting</td>
<td>Level 6 evidence: This study was identified as level 6 evidence</td>
<td>Identified limitations include absence of a randomized control trial and absence</td>
<td>This level 6 evidence literature review does not provide evidence supporting</td>
</tr>
</tbody>
</table>
| Article 25 | Riolfi, M., Buja, A., Zanardo, C., Marangon, C. F., Manno, P., & Baldo, V. (2014). Effectiveness of palliative home-care services in reducing hospital admissions and determinants of hospitalization for terminally ill patients followed up by a palliative home-care team: A Study purpose was to identify if hospice/palliative care services within the home decrease hospital re-admissions in addition to predicting factors increasing the likelihood of hospital re-admission among Sample size included 402 home hospice patients (Riolfi et al., 2014). Project design was that of a retrospective cohort study (Riolfi et al., 2014). In-home palliative care and hospice services were identified in reduction of hospital re-admissions (Riolfi et al., 2014). Those with specified Evidence Level 4: This project was identified as a level 4 cohort study (Universit y of Evidence Level 4: This project was identified as a level 4 cohort study (Universit y of Limitations include bias risk and lack of randomization (Riolfi et al., 2014). Results of this research study support the need for further analysis and intervention to decrease hospice change as no research articles were identified as fitting inclusion criteria (Joseph et al., 2016). However, need for further research and intervention to decrease hospital re-admissions is affirmed (Joseph et al., 2017). |}

satisfaction and hospital admissions and re-admissions: a systematic review. *JBI Database of Systematic Reviews & Implementation Reports, 14*(1), 108–139. https://doi.org/10.11124/jbisrir-2016-2254

Admissions and patient satisfaction (Joseph et al., 2016). Study studies were included in the search utilizing numerous search engines (Joseph et al., 2016). (Joseph et al., 2016). Inclusion criteria (Joseph et al., 2016). Involving a qualitative literature review (Joseph et al., 2016). Involving research articles meeting inclusion criteria (Joseph et al., 2016).

this population (Riolfi et al., 2014).

 oncological diagnosis were found to have a greater risk of hospital re-admission for symptom management (Riolfi et al., 2014).

Michigan, 2019.

revocation and hospital re-admissions (Riolfi et al., 2014).

**Article 22**


Study purpose is to reveal use of POLST forms resulting in increased utilization of hospice services and advanced directive discussions (Patrick et al, 2019).

Sample size involves a control group of 466 and implementation group of 487 (Patrick et al., 2019).

A retrospective quality improvement project involving three hospitals was conducted (Patrick et al., 2019).

Results indicate significant increase in utilization of hospice and palliative care services with implementation of POLST forms in place of DNR (Patrick et al, 2019).

Level 2: RTC experimental design was conducted (University of Michigan, 2019).

Absence of separation regarding education between pre-POLST and POLST implementation (Patrick et al., 2019).

Yes, results of the presented research provide evidence supporting implementation of POLST forms in practice (Patrick et al., 2019).
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<tr>
<td><strong>Study purpose</strong> includes assessment of medical order reliability documented within POLST forms (Lovadini et al., 2019).</td>
<td><strong>Sample of 64 patients or surrogates/power of attorney</strong> (Lovadini et al., 2019).</td>
</tr>
<tr>
<td>Small sample size was identified as a study limitation (Lovadini et al., 2019).</td>
<td>Yes, despite limitations in sample size, the presented article supports utilization of POLST forms at end of life (Lovadini et al., 2019).</td>
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<tr>
<td><strong>Study purpose</strong> was to assess POLST form quality when prepared for residents within a long-term care facility</td>
<td><strong>Sample size</strong> involved 938 residents within three different long-term care facilities (Rahman et al., 2019).</td>
</tr>
<tr>
<td><strong>Level 6: Descriptive qualitative design study</strong> (University of Michigan, 2019).</td>
<td><strong>Limitations</strong> including data being obtained only from a convenience sample (Rahman et al., 2019).</td>
</tr>
<tr>
<td>Yes, findings reveal a need for further education and close follow-up regarding POLST form utilization in hospice patients residing in long-term care facilities (Rahman et al., 2019).</td>
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<tr>
<td>Study purpose is to identify the percentage of specialty providers completing POLST forms (Lammers et al., 2019).</td>
<td>A sample size of 14,979 were reviewed. (Lammers et al., 2019).</td>
</tr>
<tr>
<td>Methodology involved a retrospective cohort study in which all Oregon deaths from January 1st, 2010 to December 31st, 2011 with a malignant etiology were reviewed (Lammers et al., 2019).</td>
<td>Out of 14,979 deaths, 6,145 were found to have a completed POLST form on file (Lammers et al., 2019). Only 15.3% were signed by hospice/palliative care, and 14.9% by oncology (Lammers et al., 2019).</td>
</tr>
<tr>
<td>Level 4: A level four correlation design cohort study was performed (Lammers et al., 2019; University of Michigan, 2019).</td>
<td>Identified limitations include data pertaining to only one state (Lammers et al., 2019).</td>
</tr>
<tr>
<td>Yes, this article created awareness of the intense need for POLST form among specialty providers specifically hospice/palliative care and oncology (Lammers et al., 2019).</td>
<td>care facilities (Rahman et al., 2019).</td>
</tr>
<tr>
<td>Article 26</td>
<td>Study purpose: to identify how cause of death influences timing of POLST form implementation (Zive et al., 2015).</td>
</tr>
</tbody>
</table>
CITI Training Certificate

This is to certify that:

**Joanna Asselin**

Has completed the following CITI Program course:

- **Social & Behavioral Research - Basic/Refresher** (Curriculum Group)
- **Social & Behavioral Researchers** (Course Learner Group)
- **1 - Basic Course** (Stage)

Under requirements set by:

- **Liberty University**

Verify at [www.citiprogram.org/verify/?w8bf9c7fe-b05e-4e32-9e85-9707bdb3dd89-22482782](http://www.citiprogram.org/verify/?w8bf9c7fe-b05e-4e32-9e85-9707bdb3dd89-22482782)
Appendix C
Organization Letter of Support

October 28, 2019

To Whom It May Concern
The board of directors, administration and staff of [Organization Name] are pleased to honor the
request of [Requard Last Name] to serve as the site for her [Project Name]. [Organization Name] has been
committed to nursing education since its inception in 1994, serving as clinical rotation elective for the
baccalaureate and masters nursing programs in our region. We are pleased to endorse research that
advances knowledge and honors the wishes of the terminally ill patient.

Sincerely,

[Signature]

Vice President of Patient Care Services
Appendix D

Approval for Iowa Model Utilization

You have permission, as requested today, to review and/or reproduce *The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care*. Click the link below to open.

**The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care**

Copyright is retained by University of Iowa Hospitals and Clinics. **Permission is not granted for placing on the internet.**


In written material, please add the following statement:

*Used/reprinted with permission from the University of Iowa Hospitals and Clinics, copyright 2015. For permission to use or reproduce, please contact the University of Iowa Hospitals and Clinics at 319-384-9098.*

Please contact UIHCNursingResearchandEBP@uiowa.edu or 319-384-9098 with questions.
# Appendix E

## POST Form Example

![POST Form Example](https://example.com/post-form-image.png)

---

© 2017 Virginia POST Collaborative. Unauthorized alteration of this form is prohibited.

www.virginia-post.org
HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

NAME: ___________________________ Date of Birth: ______________________________

CARE SETTING WHERE POST WAS COMPLETED
☐ Long-Term Care ☐ Hospital ☐ Home ☐ Hospice Facility ☐ Outpatient Practice ☐ Other _________

Name of Care Setting:

Name of Healthcare Professional Preparing Form:
Print Name: ___________________________ Date: ___________________________ Organization: ___________________________

This form is meant to reflect decisions for treatment based on the patient’s current medical condition. It should be reviewed periodically and updated as needed with changes in condition, patient preferences, or setting.

Instructions for Use of This Form

Completing POST
• POST is not valid until signed by a physician, nurse practitioner or physician assistant who has a bone fide relationship with the patient. Nurse practitioners and physician assistants are authorized to sign POST forms under the Code of Virginia §54.1-2987.2 and §54.1-2987.22 respectively. Health care organizations may have policies that impose limitations on this authority based on the provider’s individual scope of practice.
• Use of the original form is encouraged. A photocopy, fax or electronic version should be honored as if it were an original.

Using POST
• Patients may choose Full Interventions to authorize ventilation/Intubation as a treatment for respiratory distress and still choose Do Not Attempt Resuscitation in the event of a full cardio-pulmonary arrest.
• When comfort cannot be achieved in the current setting, the patient, including someone who has chosen “Comfort Measures,” should be transferred to a setting able to provide comfort (e.g. treatment of a hip fracture).
• Review POST periodically and update if needed with changes in condition, patient preferences or setting.

Revisions/Making Changes to Section A
• Administrative Code of Virginia §12VAC5-66-10 states “Durable DNR order shall also include a Physician Orders for Scope of Treatment (POST) form.” Therefore, provisions under Code of Virginia §54.1-2987.1 apply to POST Section A.
• If “Do Not Attempt Resuscitation” is checked in Section A, and Section D is completed, and the patient has signed this form, no one has the authority to revoke consent for the DNR order other than the patient as stated in the Code of Virginia §54.1-2987.1.
• If “Attempt Resuscitation” is checked in Section A, a legally authorized decision maker may make changes to carry out the patient’s preferences in light of the patient’s changing condition.

Making Changes to Sections B and C
• To change any orders in these sections, the current POST form must be voided and a new POST form completed.
• If the POST is revoked and no new POST form is completed, full treatment and resuscitation may be initiated.
• If a patient tells a healthcare professional that they wish to revoke their consent to POST or change POST, the healthcare professional caring for the patient should draw a line through the front of the form and write “VOID” on the original, date and sign, and notify the patient’s physician. A new POST form may then be completed if desired by the patient.
• If a patient lives in a healthcare facility, the patient (or person authorized to make decisions on the patient’s behalf, in keeping with the patient’s goals for treatment) may revoke consent for POST orders by voiding the form as described above and informing a healthcare professional. The healthcare professional must then notify the patient’s physician so that appropriate orders may be written and a new POST form created if desired by the patient.
• If the patient signs this form and becomes unable to make healthcare decisions, a legally authorized decision maker may continue carrying out the patient’s preferences in light of the patient’s changing condition, and in consultation with the treating physician, may sign, revoke consent to, or request changes to the POST orders (except in Section A as noted above).

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST forms are available to medical providers and organizations that have agreed to the standards set forth by the Virginia POST Collaborative. Contact www.post.va.gov or (877) 477-POST for more information.
Appendix F

Permission to utilize POST form tool

Thank you Joanna for including your background information, your abstract and your advisor’s contact information.

Dr. Kestenbaum has reviewed everything and he said your abstract looks good and he thinks it is a very worthwhile project. He also states, “The only caveat I have is that she must clarify within her methods section that completion of the form is voluntary. It should be ok to offer the POST form to all new hospice patients, since they clearly meet the intended population, but she has to clarify the voluntary nature of completion.”

I have also forwarded your email below to one of the instructors you will meet at the POST Facilitator class, [Instructor Name].

Thanks again and we wish you much success in your future endeavors!

Capital Caring Health

Our Mission

Provide Patients and Their Families with Advanced Illness Care of the Highest Quality.