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Improving POLST/Advanced Directive Completion in the Primary Care Setting

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Improving POLST/Advanced Directive Completion in the Primary Care Setting

Keywords: POLST, Advanced Directive, End-of-life care planning, primary care, practice improvement project

Highlights:

- Successful provider-medical assistant communication enhances patient outcomes
- With attention, numbers of completed Physician Orders for Life-Sustaining Treatment (POLST)/Advanced Directive (AD) can be increased
- Providers need proper training in end-of-life care planning options available to patients

Abstract:

A need for change was identified by clinic management, as Physician Orders for Life-Sustaining Treatment (POLST)/Advanced Directive (AD) completion rates at the primary care center were low. Participants in the study were selected by clinic management and included primary care providers and certified medical assistants (CMA) of two primary care teams within the clinic. For two months, the selected teams participated in the project, which included having CMAs check if patients 65 and older on any given day had POLST or Advanced directives on file. For those without completed forms on file, a POLST was put in the treatment room as a visual cue for the provider to initiate the conversation. Completion rates were tracked over two months with a completion rate of 50% set as significant. An increase in completion rates was seen over a 2-month period, except for the last 2 weeks when a provider returned from leave and had issue with the project, which may have led to skewed data. Prompting providers to have conversations in regards to POLST/Advanced directives was shown to improve completion rates, but proper communication amongst all providers is key to success.

Research Question

The goal of this practice change was to increase the number of POLST/Advanced Directives completed for patients older than or equal to age 65. This practice change sought to achieve this goal through identification of patients age 65 and older with no completed POLST or Advanced Directive, and through the communication of this need across care levels. The practice change implemented the identification of POLST/Advanced Directive status as a medical assistant responsibility, and emphasized and strengthened the communication process that takes place between a medical assistant and a provider to communicate this need during the

existing morning “scrubs”. The ultimate goals/aims of the project were to increase the rates from an average of 20% to at least 50% at the end of two months.

Considering the ultimate goals/aims of the project, the research question to be answered by this project was: “Will identifying patients 65 (and older) without POLST/Advanced Directives and discussing the need for having these forms completed, during their visits in a primary care setting, increase rates of completion?”.

Literature Review

The POLST is a medical order when completed with a patient’s and primary care provider’s (physician, nurse practitioner, or physician assistant) signatures (Washington State Hospital Association, 2015). Originally developed in Oregon, it communicates the end-of-life desires of a person during life-threatening events (Washington State Hospital Association, 2015). It assists medical care providers, patients, and their family members understand and explore these desires before these life-threatening events occur. The POLST is portable, may be changed at any time, and should be reviewed between patient and primary care provider at periodic intervals (Washington State Hospital Association, 2015). It covers areas including antibiotic use, artificial nutrition, intravenous fluids, mechanical ventilation, cardiopulmonary resuscitation, and substitute medical decision makers (POLST.org, 2015).

Completing the POLST has many advantages. A POLST is more readily available and likely to be followed by first responders and other medical personnel than living wills or Advanced Directives (Buck and Fahlberg, 2014). Likewise, a person with a POLST is 59% more likely to have their end-of-life wishes followed than a person with a Do Not Resuscitate (DNR) order alone (Coalition for Compassionate Care of California, 2015). The POLST/Advanced

Directive assists a person in taking personal responsibility for these hard decisions rather than displacing them to a family member or caregiver (Nairn, 2013).

Discussing the POLST allows an opportunity to address spiritual needs; when an individual's spiritual needs are addressed they are likely to die with less depressive symptoms, experience fewer in-hospital deaths, and utilize hospice more frequently (Nairn, 2013). The POLST also allows for an opportunity to speak frankly about the expected trajectory of a person's illness (Nairn, 2013). When speaking about the trajectory, patients' treatment goals and goals for quality of life can be captured (Nisco, Mittelberger, and Citko, 2011). When the personal goals and wishes for end-of-life care are captured, unnecessary pain and suffering, as well as costs and procedures, are avoided (Nisco, Mittelberger, and Citko, 2011).

The POLST was designed for use in persons with chronic illnesses, deteriorating conditions, and medical frailty (Nisco, Mittelberger, and Citko, 2011). The majority of people living with chronic, progressive conditions are age 65 and older (Coalition for Compassionate Care of California, 2015). The number of adults age 65 years and older will double between 2010 and 2050 (Coalition for Compassionate Care of California, 2015). The number of those over age 85 years will increase fourfold during this same timeframe (Coalition for Compassionate Care of California, 2015). Not only does this population need effective advanced care planning, but they expect it from their primary care providers. An exponentially growing elderly population inevitably results in a shortage of geriatric and palliative care specialists; the primary care provider will need to fill this void (Coalition for Compassionate Care of California, 2015). Indeed, the primary care provider is uniquely suited to breach the conversation of end-of-life care as they are the medical provider the patient is likely to have had the longest relationship with and trust the most (Tolle, 2015).

Methods

One month prior to this practice improvement project's start date, a written information sheet was provided via electronic mail to all sample participants. This statement announced the project and gave all participants the option to opt out anonymously. Two weeks prior to the start date, a presentation was made to the project participants making individual roles in the practice change clear, providing information as to why the practice change was important, and allowing for participant questions/concerns to be addressed. The practice change ran for two months.

Prior to daily business operations, the CMA was responsible for performing chart reviews on each patient age 65 and older appearing on the daily docket. During the morning huddle between CMA and provider, the CMA was responsible for sharing the names of patients age 65 and older on the daily docket that did not have a POLST or AD on file. Both the CMA and the provider were accountable for the success of this communication. Later during the business day when these patients arrived for their appointments, the CMA placed a blank POLST form in the room of the patient as a visual cue/reminder that end-of-life care planning was needed for this patient. The expectation was that the provider would start the end-of-life care discussion with the patient, with the goal of having a completed POLST or AD on file in this office visit or the next.

Participants were kept aware of progress toward the 50% goal at the mid-point of the project, at its conclusion, and one month post-project completion. Accompanying these progress reports were reminders for why the practice change was important. Process outcome data was collected via anonymous survey twice during the project: once at the mid-point, and once at its conclusion.

Sample

A total of 9 participants over age 18-years-old participated in the practice improvement project. All participants were female. Project participants consisted of two teams of medical providers and medical assistants. Team one contained two providers and two CMAs. Team two contained three medical providers and two CMAs. These two teams represented one-third of the clinic's total medical staff members. Teams chosen to participate were identified and assigned by clinic management. Permission to opt out anonymously was given via a written information sheet one month prior to project commencement. The sheet stated that participants could discontinue involvement in the project at any time should a participant wish to do so. In addition, approval to work with human participants was attained from the Institutional Review Board of the University of Portland prior to project commencement.

Data Analysis

Pre-project measures were gathered for the cumulative year prior to project implementation. Data continued to be gathered at one-month intervals during the two-month project, as well as for one-month post-project completion to check for sustainability. Data was reported in percentages and gathered from monthly reports. A simple data analysis was performed comparing mid-point percentages, conclusion percentages, and post-conclusion percentages to one another as well as data from the previous year (see figure 1). Pre-implementation and post-implementation percentages were compared to determine if an increase in compliance rate had been achieved.

Results

The objective of the project was to obtain completed POLST forms/Advanced Directives for 50% of patients age 65 and greater. The objective was met during the first six weeks of the project at 52.3%. Two weeks after the conclusion of the project, the objective was no longer met:

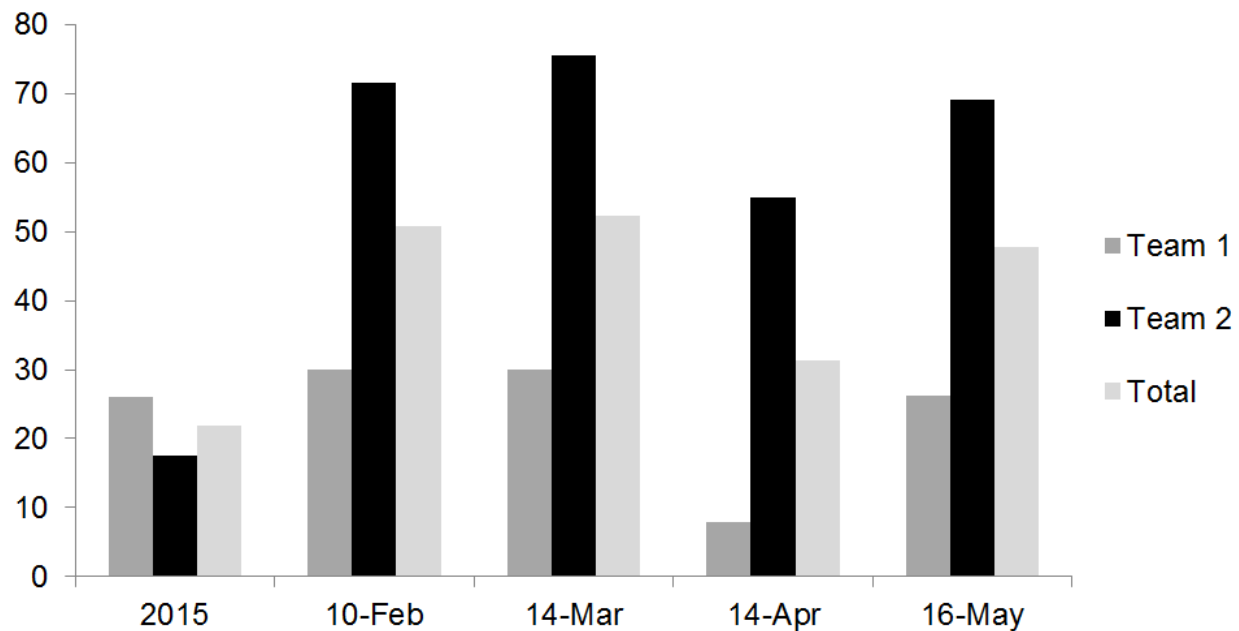
31% of patients age 65 and greater had a POLST/Advanced Directive on file. The final percentage was a 10% increase over the numbers the clinic reported prior to implementing this practice improvement project, with sustainability rates coming in at a 16% increase over pre-implementation rates.

Table 1

Practice Improvement Project Data

	2015 (pre- implementation)	February 10 (Project commences)	March 14	April 14 (Project ends)	May 16 (sustainability)
Team 1	26%	30%	30%	8%	26.3%
Team 2	17.6%	71.5%	75.5%	54.9%	69%
Total	21.8%	50.8%	52.3%	31.4%	47.7%

Table 2

Graphical Representation of Data**Process Outcome Data**

Surveys were distributed to all participants at the mid-point of the project as well as at its conclusion. Mid-point, three surveys were returned (two by nurses and one by a medical doctor). Both nurses reported that patients age 65 and greater were identified in daily huddles and the POLST's were being discussed as well. The medical doctor concurred that POLST/Advanced Directive status for patients age 65 and older were being regularly discussed in morning huddles and that it was “easy” to incorporate this into workflow. The medical doctor further stated: “When [patients] are approached as — We just want to be sure we know what your wishes are — [patients] seem quite open.”

At the conclusion of the project, five surveys were returned (two by nurse practitioners, two by unidentified personnel, and one by a medical doctor). Both nurse practitioners returned unfavorable results stating “review of POLST guidelines did not align with the project’s goals to offer POLST to a percentage of patients age 65+” and “The practice change leaders seemed to

have poor knowledge of the POLST form — why it exists and how to use it appropriately, and for whom it is intended — they drew conclusions like: many people have a chronic illness so therefore if people die of chronic illness all of those with a chronic illness disease should have a POLST!” It is important to know that one of these nurse practitioners returned to work mid-project and was therefore not included in the written information statement and pre-project participant and project leader meetings. Both unidentified personnel as well as the medical doctor reported they were regularly updated on the successes/failures of the project, the importance of the practice change was satisfactorily explained to them, the practice change leaders were readily available to them, and they were clear on their role in increasing the number of patients age 65 and greater with completed POLSTs/Advanced Directives.

Recommendations

- Obtain a representative from the POLST registry and/or end-of-life care expert to lead grand rounds to clarify clinician knowledge and increase the frequency this service is offered to appropriate clientele.
- Review/revise the Advanced Directive policy and procedure at the clinic to make it a user-friendly option to both clinician and clientele.
- Include information on end-of-life planning options available at the clinic in new patient paperwork.
- Provide area-specific cultural guidance to clinicians to enhance cultural competence when speaking about end-of-life planning.

Conclusions

The objective was met during the first six weeks of the project at 52.3%. Two weeks after the conclusion of the project, the objective was no longer met: 31% of patients age 65 and greater had a POLST/Advanced Directive on file. The final percentage was a 10% increase over the numbers the clinic was reporting prior to implementing this practice improvement project, so the project had some success, but not without problems. To avoid problems in future projects it is important to ensure that all possible project participants are notified of the project in advance. Specifically, it is recommended to inquire if anyone is on leave who may be returning during the project and ensure that they are included in pre-project discussions and education.

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