End of Life Care Planning for People with Advanced Dementia

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Medical Director, Health Information & Training, Capital Caring
Associate Medical Director, Virginia POST Collaborative
Co-coordinator, Virginia POST Collaborative, NoVA Region
After this session, you will be able to:

• Describe how the POST form can be used as a medical order set to communicate patient’s end of life care wishes within and across health care settings

• Describe the elements of the POST Advance Care Planning discussion with patients with serious advanced illness, including patients living with Dementia

• Describe the status of POST Regional Initiatives throughout VA, including the Greater Richmond Area

• Describe the process for becoming a POST Advance Care Planning Facilitator (MD/DO/NP/PA/SW/RN/Chaplain)

• Recognize how to make a referral to POST Advance Care Planning Facilitators
Spoiler Alert

SPOILER ALERT: EVERYBODY DIES

from Second City
Death is an inevitable aspect of the human condition.

Dying badly is not.
Let’s Begin With a Story
Let’s Begin With a Story
Have You Been in a Similar Situation?

• A person with dementia was transferred to the hospital but you later found out their advance directive stated they didn’t want to go?

• One of your long-term patients died in the intensive care unit of a hospital rather than surrounded by friends and family?

• A person you are caring for might have benefitted from an inpatient stay because of symptoms that are not under good control at home, but their advance directive stated they would prefer Do Not Resuscitate (“DNR”) status?
Role of POST Within the Continuum of Advance Care Planning (ACP)
An Advance Care Plan is a document or collection of documents that defines:

- The kind of care you would like to receive in particular medical situations
- The person you would like to make medical decisions for you if you become unable to do so (your Agent, or Healthcare Surrogate Decision Maker); this is typically shortened to your “surrogate”

The Advance Directive (AD) is a core component (often the only component) of the Advance Care Plan.
Advance Care Planning:
Conversations That Change Over Time

Healthy Adults: Emergency Planning

People with Progressive Illness: guided planning

Advanced Illness: Physician Orders for Scope of Treatment (POST)

Source: Carol Wilson, Riverside Health System; Used with permission
Advance Care Planning: Conversations That Change Over Time

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The Advance Directive

• Sometimes referred to as the Advance Health Care Directive, Advance Medical Directive, or Living Will
• Should include the appointment a person to act as your agent in making health care decisions for you, if it is determined that you are unable to make health care decisions for yourself (Durable Power of Attorney for Health Care, or DPOA-HC). This includes the decision to make anatomical gifts of a specific part or parts of your body via organ and tissue donation, or of all of your body

For additional information:
http://www.vda.virginia.gov/advmedir.asp
Advance Care Planning

• The process of advance care planning (ACP) is critically important, yet many people procrastinate.

• Typical reasons people procrastinate include:
  – Denial
  – Sense of immortality

• Typical reasons family members procrastinate include:
  – I’m concerned my mother will be depressed and just whither away and die if we talk about how sick she is
  – I know my dad -- He’ll lose all hope if we talk about this
  – And other myths…
Advance care planning does not adversely affect hope or anxiety among patients with advanced cancer.

- 200 individuals completed the study.
- Conclusion: “Engaging in ACP with online planning tools increases knowledge without diminishing hope, increasing hopelessness, or inducing anxiety in patients with advanced cancer. Physicians need not avoid ACP out of concern for adversely affecting patients’ psychological well-being.”

Advance Care Planning

The impact of advance care planning on end of life care in elderly patients: randomised controlled trial

• Conclusions:
  - ACP improves patient and family satisfaction
  - Reduces stress, anxiety and depression in surviving relatives

Advance Care Planning

• It appears that Advance Care Planning is beneficial to both patients and their families/caregivers.

BUT

• Neither study was specific to those people living with Dementia

• There are specific challenges in the typical model of ACP in our situation
Procrastination is clearly the enemy for people living with Dementia who wish to engage in ACP
  – They are often unable to do so by the time people living with other illnesses are “ready” to talk about the future
An Advance Directive may not cover every eventuality
Research has suggested that Advance Directives alone may not be enough to ensure wishes are met
And what are those wishes?

- Gjerdingen DK. Older persons’ opinions about life-sustaining procedures in the face of dementia
- Arch Fam Med 1999; 8:421-425
  - 96% do not want CPR
  - 95% do not want ventilator
  - 96% do not want artificial nutrition
  - 67% do not want hospitalization
  - 75% do not want antibiotics
“...clinical experience and research demonstrate that these advance directives are not sufficient alone to assure that those who suffer from serious, advanced, progressive chronic illnesses will have their preferences for treatment honored unless a POLST form is also completed.”

http://www.polst.org/about-the-national-polst-paradigm/what-is-polst/
Last accessed May 16, 2014
Correspondence between patients’ preferences and surrogates’ understandings for dying and death

- 92 pairs of patients/family members
- Families accurately stated what was important to their loved one who had a terminal illness only 50% of the time

Preferences for end-of-life care: A nominal group study of people with dementia and their family carers

- Wishes and preferences may differ between persons with dementia and their caregivers.
- Conclusion: “To ensure the wishes of people with dementia are respected, their views should be ascertained early in the disease before their ability to consider the future is compromised.”

Dening KH, Jones L, Sampson EL. Preferences for end-of-life care: A nominal group study of people with dementia and their family carers, *Palliative Medicine*. 27(5) 409–417
Aren’t Advance Directives Enough?

A Decade of Change

- 6,000 people over age 60 who died between 2000 – 2010
- 47% had ADs at the beginning of the study
- 72% had ADs by the end of the study
- After adjusting for confounders, “the trend in declining hospital death over the decade [45% to 35%] was negligibly associated with the greater use of ADs.”

Aren’t Advance Directives Enough?

Most people, even those who are older and have serious illnesses, do not complete advance directives, and even when these documents are completed, they rarely affect treatment decisions. They often are unavailable or difficult to interpret, and they may contradict the preferences of the family or clinicians.

Aren’t Advance Directives Enough?

On the other hand, people who have had conversations about end-of-life care values, goals, and preferences (although they may not have completed formal advance directive documents) are less likely to receive unwanted treatment. Advance care planning should be considered a lifelong process.

A question for you

Why is this topic more important than ever before?
### Century of Change

<table>
<thead>
<tr>
<th></th>
<th>“Then” 1900</th>
<th>“Now” 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average age of death</strong></td>
<td>47 years of age</td>
<td>78 years of age</td>
</tr>
<tr>
<td><strong>Causes of death</strong></td>
<td>Infection (34%)</td>
<td>Heart Disease (25%)</td>
</tr>
<tr>
<td></td>
<td>Heart Disease (9%)</td>
<td>Cancer (23%)</td>
</tr>
<tr>
<td></td>
<td>CVA (7%)</td>
<td>COPD (6%)</td>
</tr>
<tr>
<td></td>
<td>Accidents (5%)</td>
<td>CVA (5%)</td>
</tr>
<tr>
<td><strong>Time of disability before death</strong></td>
<td>Days, weeks</td>
<td>2 Years average</td>
</tr>
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</table>
Trajectory of the Dying Process (Then)

- Acute Process
- Little time to think about treatment preferences
- Almost no time spent with a disability

![Graph showing the trajectory of the dying process with a sharp drop in function after an acute event leading to death.]
Trajectories of the Dying Process (Now)

- The reality of the last years of life: death is not predictable

- Peaks in the mid-60s, mid-70s, and mid-80s respectively

<table>
<thead>
<tr>
<th>Stage</th>
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</thead>
<tbody>
<tr>
<td>1 No difficulties</td>
<td>6d Urinary incontinence</td>
</tr>
<tr>
<td>2 Forgets objects, subjective work problems</td>
<td>6e Fecal incontinence</td>
</tr>
<tr>
<td>3 Others notice problems, difficulty traveling</td>
<td>7a Speaks about 6 words</td>
</tr>
<tr>
<td>4 Problems planning dinner, finances</td>
<td>7b Single words</td>
</tr>
<tr>
<td>5 Assist with clothes for season</td>
<td>7c Nonambulatory</td>
</tr>
<tr>
<td>6a Difficulty dressing</td>
<td>7d Unable to sit independently</td>
</tr>
<tr>
<td>6b Difficulty bathing</td>
<td>7e Unable to smile</td>
</tr>
<tr>
<td>6c Difficulty toileting</td>
<td>7f Unable to hold up head</td>
</tr>
</tbody>
</table>
ACP Challenges in People with Dementia

**Possible Approach:**

- Brumley: The Role of POLST in the care of people with Dementia. National POLST Webinar, October 2014

- Engage all patients with the diagnosis of early dementia in an ACP discussion (“routine”)
- Elicit goals of care
- Complete an Advance Directive
- Name a Health Care Surrogate
- Discuss future use of POST
Questions for you

Is there hope?

Is our society ready to have these conversations?

Are we ready to have them early enough to make a difference in AD?
Of Course There’s Hope…

- Changes in the typical model of health care in the US
  - Significant Increases in use of Palliative Care and Hospice

Of Course There’s Hope…

- Culturally, we are starting to talk more openly about death and dying.

After losing someone she loved and experiencing deep depression, artist Candy Chang created an interactive wall on an abandoned house in her neighborhood to create an anonymous place to help restore perspective and share intimately with neighbors while remaining an introvert. After receiving permission, she painted the side of an abandoned house in her neighborhood in New Orleans with chalkboard paint and stenciled it with a grid of the sentence, “Before I die I want to ________.” Anyone walking by could pick up a piece of chalk, reflect on their lives, and share their personal aspirations in public space. It was all an experiment and she didn’t know what to expect. By the next day, the wall was full of responses and it kept growing…
Of Course There’s Hope…

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http://beforeidie.cc/site/

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Of Course There’s Hope…

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http://beforeidie.cc/site/
Of Course There's Hope…

Before I die I want to

find peace

travel the world

watch the Broncos win.

LIVE!

Be prosperous, live a long happy life.

Swim with sharks.
Of Course There’s Hope…

- Death Over Dinner

http://deathoverdinner.org/
Of Course There’s Hope…

- The Conversation Project

http://theconversationproject.org/
Of Course There’s Hope

• While we have shown you research that shows that the use of Advance Directives ALONE has failed to change care at the bedside, they remain an important part of the advance care planning process
• The Virginia POST Collaborative Supports the use of Advance Directives
• In combination with POST, the Advance Directive is an important piece of the Advance Care Plan – and research shows that it does make a difference!
Advance Care Planning: Conversations That Change Over Time

- Healthy Adults: Emergency Planning
- People with Progressive Illness: guided planning
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# Differences Between POST and Advance Directives

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<tr>
<th>Characteristics</th>
<th>POST</th>
<th>Advance Directives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>For the seriously ill</td>
<td>All adults</td>
</tr>
<tr>
<td>Timeframe</td>
<td>Current care</td>
<td>Future care</td>
</tr>
<tr>
<td>Who completes the form</td>
<td>Health Care Professionals</td>
<td>Patients</td>
</tr>
<tr>
<td>Resulting form</td>
<td>Medical Orders (POST)</td>
<td>Advance Directives</td>
</tr>
<tr>
<td>Health Care Agent or Surrogate role</td>
<td>Can engage in discussion if patient lacks capacity</td>
<td>Cannot complete</td>
</tr>
<tr>
<td>Portability</td>
<td>Provider responsibility</td>
<td>Patient/family responsibility</td>
</tr>
<tr>
<td>Periodic review</td>
<td>Provider responsibility</td>
<td>Patient/family responsibility</td>
</tr>
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</table>

Virginia’s Physician Orders for Scope of Treatment (POST) Program
Virginia’s POST Program

- We are part of the POLST movement, which “began in Oregon in the early 1990s to overcome the limitations of CPR Orders” (Hickman, et al. 2009)
- POLST: “Physician Orders for Life Sustaining Treatment”
- POST: “Physician Orders for Scope of Treatment”
- POST is the acronym chosen by the Virginia POST Collaborative as most representative of our statewide program
Examples of POLST Paradigm Programs

Graphic shown by Amy Vandenbroucke, JD, Executive Director of the National POLST Paradigm at the Honoring Choices Virginia Ensuring Access to Advance Care Plans Across Settings and Providers Workshop.
Washington, DC, June 2016
Common to All POLST Paradigm Programs

- Approach to EOL planning that emphasizes
  - Advance care planning conversations between patients, health care professionals, and loved ones
  - Shared decision-making between a patient and a health care professional
  - Ensuring that patient’s wishes are honored
- As a result of these conversations, patient wishes may be documented on a PO(L)ST form
  - Translates the shared decisions into actionable medical orders

http://www.polst.org/about-the-national-polst-paradigm/
Full text available at above site. Last accessed May 19, 2014
Components of POLST Paradigm Programs

- Standardized practices and policies
- Trained advance care planning facilitators
- Timely discussions prompted by prognosis
- End-user training for Providers and EMTs
- Clear, specific language on an actionable form
- Bright form easily found among paperwork
- Orders honored throughout the system
- QI activities for continual refinement
What POST is **NOT**

- POST is **NOT** affiliated with “Death with Dignity” Programs that deliberately end life
- Position Statement from National POLST released September 18, 2015
What POST is NOT

The National Physician Orders for Life-Sustaining Treatment Paradigm recognizes that allowing natural death to occur is not the same as providing a lethal prescription to intentionally cause death. Neither the POLST Paradigm nor any POLST Form allows for PAS or PAD, nor does either authorize a health care professional to prescribe medication that would intentionally shorten life.

POLST originated in Oregon in 1991. The Death with Dignity Act passed as a ballot initiative in 1994. The programs developed completely independently of each other by different groups with different goals.
What POST is

The POST Form
**Section A: Patient Info & CPR Decision**

<table>
<thead>
<tr>
<th><strong>Name Last / First / M.I.</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address</strong></td>
<td></td>
</tr>
<tr>
<td><strong>City / State / Zip</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Birth (mm/dd/yyyy)</strong></td>
<td><strong>Last 4 Digits of SSN</strong></td>
</tr>
</tbody>
</table>

**CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.

- [ ] Attempt Resuscitation
- [ ] Do Not Attempt Resuscitation (DNR/No CPR)

*When Do Not Attempt Resuscitation is checked, qualified healthcare personnel are authorized to honor this order as if it were a Durable DNR Order.*

*When not in cardiopulmonary arrest, follow orders in B & C*
**The POST Form**

- **Section A: Patient Info & CPR Decision**

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*When not in cardiopulmonary arrest, follow orders in B & C*
### The POST Form

- **Section B: Medical Interventions**

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<th>Medical Interventions: Patient has pulse and / or is breathing.</th>
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<tbody>
<tr>
<td></td>
<td>Comfort Measures: Treat with dignity and respect. Keep warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital <em>only</em> if comfort needs cannot be met in current location. Also see “Other Instructions” if indicated below.</td>
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<td>Limited Additional Interventions: Includes comfort measures described above. Do not use intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP or BiPAP). Use additional medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. Transfer to hospital if indicated. Avoid intensive care unit. Also see “Other Instructions” if indicated below.</td>
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<td>Full Interventions: In addition to Comfort Measures above, use intubation, mechanical ventilation, cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit. Also see “Other Instructions” if indicated below.</td>
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Other Instructions: __________________
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**When Do Not Attempt Resuscitation:**

- [ ] Authorized to honor this

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**Other Instructions:** 

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*POST* 
Physicians Orders for Scope of Treatment: A POST Paradigm Program
Section C: Artificial Nutrition

- ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluids by mouth if feasible.
  - □ NO feeding tube (Not consistent with patient’s goals given current medical condition)
  - □ Feeding tube for a defined trial period (specific goal to be determined in consultation with treating physician)
  - □ Feeding tube long-term if indicated

Other Instructions: ___
Section C: Artificial Nutrition

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*Other Instructions:__*
The POST Form

- Discussion & Signatures

DISCUSSED WITH:
- Patient
- Agent under Advance Medical Directive
- Court Appointed Guardian
- Other person legally authorized

PHYSICIAN: My signature below indicates that I have discussed the decisions documented herein with the patient or the person legally authorized to consent on the patient’s behalf and have considered the patient’s goals for treatment, to the best of my knowledge.

Physician Name (Print) (Mandatory)  Physician Phone (Mandatory)

Physician Signature (Mandatory)  Date (Mandatory)

Signature of the Patient OR the Person Legally Authorized to Consent on Patient’s Behalf (Mandatory)

Patient’s Signature  Patient’s Name (Print)

Signature of Person Signing on Behalf of the Patient  Name of Person Signing on Behalf of the Patient

Describe Authority to Sign for Patient (Medical Power of Attorney, Guardian, Spouse, Adult Child, Parent, Sibling, Other Blood Relative)

Phone  Address

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

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Do not alter this form.
Rev. 2/2014

www.virginiapost.org
### The POST Form

- **Discussion & Signatures**

---

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[www.virginiaPOST.org](http://www.virginiaPOST.org)
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Signature of Person Signing on Behalf of the Patient  Name of Person Signing on Behalf of the Patient

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Rev. 2/2014

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Page 1 of 2
The POST Form

- Care Setting/Facilitator Signature

HIPAA permits disclosure to health care professionals and authorized decision makers for treatment

<table>
<thead>
<tr>
<th>NAME</th>
<th>LAST 4 SSN</th>
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CARE SETTING OF ORIGIN

- Long-Term Care
- Hospital
- Home
- Hospice facility
- Outpatient Practice
- Other

Name of Care Setting:

Name of Healthcare Professional Preparing Form: ________________________________

Signature of Healthcare Professional Preparing Form: __________________________

Name of Healthcare Professional Preparing Form (Print): _________________________

Date Prepared: _________________________

The intent of this form is to reflect decisions for life-sustaining treatment based on the patient’s current medical condition. This form should be reviewed with a treating physician and updated when the patient’s medical condition changes, when the patient moves to a new facility or when the patient’s preferences change. If a patient is unable to make decisions and is therefore unable to sign this form, the directions on this form should reflect the patient’s preferences as best understood by the person authorized to consent under Virginia Law. HIPAA permits disclosure to health care professionals and electronic registry as necessary for treatment.
The POST Form

- Care Setting/Facilitator Signature

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NAME __________________________ LAST 4 SSN __________________________

CARE SETTING OF ORIGIN

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Name of Care Setting: __________________________

Signature of Healthcare Professional Preparing Form: __________________________

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The POST Form

• Helpful Instructions

Directions for Healthcare Professionals

Completing POST
• The orders should reflect patient’s current preferences.
• A physician, nurse practitioner or physician assistant who has a bona fide physician/patient relationship with the patient must sign POST. Nurse practitioners and physician assistants are authorized to sign POST forms under the Code of Virginia Sections §64.1-2957.02 and §54.1-2952.2. Health care organizations may have policies that impose limitations on this authority based on their individual scope of practice.
• Use of original form is encouraged. A photocopy, fax or electronic version may be honored as if it were an original.

Using POST
• 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).
• IV medication to enhance comfort may be appropriate for a patient who has chosen “Comfort Measures.”
• Always offer food and fluids by mouth if medically feasible.
The POST Form

• Helpful Instructions (continued)

Revoking/Making Changes to POST
• To change POST, the current POST form must be voided and a new POST form completed. If no new form is completed, full treatment and resuscitation may be provided.
• As long as the patient can make his/her own decisions, the patient may revoke consent for POST and may request changes to POST. If a patient tells a healthcare professional that he/she wishes to revoke his/her 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” in large letters on the original, with the date and the professional’s signature, and notify the patient’s physician. A new POST form may then be completed if desired by the patient.
• If not in a healthcare facility, the patient who can make his/her own decisions 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, the patient’s treatment goals should be honored if the patient becomes unable to make decisions, as provided in the Code of Virginia § 54.1-2986.1.
• If the patient is unable to make healthcare decisions, a legally authorized medical decision maker, in consultation with the treating physician, may sign this form, revoke consent to, or request changes to the POST orders to continue carrying out the patient’s own preferences in light of changes in the patient’s condition.

Persons Legally Authorized to Consent for Patient Incapable of Making an Informed Decision:
An agent named in an Advance Directive (§54.1-2983) may consent for the patient under the terms of the Advance Directive. If the patient has no Advance Directive, the following persons may consent for the patient in this order: guardian, spouse, adult child, parent, adult sibling, other relative in descending order of blood relationship (§54.1-2986)

FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST forms are available to medical care providers and organizations that have agreed to the standards set forth by the Virginia POST Collaborative. Contact: inquiry@virginia-post.org
It is gaining traction across the United States
National POLST Paradigm Programs, 2006

Endorsed Programs
Developing Programs
No Program (Contacts)
VA is the 19th Endorsed State!
A Brief History
History of POST in Virginia

Idea 1 Local Pilot Project
State Stakeholders Group formed Virginia POST Collaborative + 13 Regional Programs
Capital Caring chosen as the Home for the VPC

Grant and In-Kind Support
POST in the Richmond Area

- The Richmond Academy of Medicine: First Steps Program
- Setting the stage for EOL conversations

- VCU, Bon Secours, Capital Caring all actively involved in the Richmond area and within the VPC
- HCA, VCU, Bon Secours have all updated their policies and procedures to recognize POST within their health systems
POST in the Richmond Area

- Presentation made to Henrico EMS 8/2016
- Subsequent sessions requested – monthly for the next year!

- 20 – 30 Richmond area physicians trained earlier this year
- Need to “connect” pink areas…
Does it Work?
Does it Work?

Journal of the American Geriatrics Society, June 2014

- 58,000 decedents in Oregon
- 17,902 (30.9%) had a POLST form
- 11,836 (66.1%) desired comfort measures
- 1,153 (6.4%) desired full treatment option
- 34.2% of patients without a POLST form died in the hospital

Fromme EK, Zive D, Schmidt TA, Cook JNB, Tolle SW. Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon. JAGS. 62(7):1246-1251.
Does it Work?

Journal of the American Geriatrics Society, June 2014

- 6.4% of patients with comfort measures died in the hospital
- 22.4% of patients with limited additional interventions option died in the hospital
- 44.2% of patients with full treatment option selected died in the hospital

Fromme EK, Zive D, Schmidt TA, Cook JNB, Tolle SW. Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon. JAGS. 62(7):1246-1251.
Does it Work in States other than Oregon?


Patient’s preferences recorded as medical orders on a POLST Form and how those orders match with death in the hospital.

Research Letter
Comparable Pattern for POLST Registry Decedents:
Oregon vs West Virginia
2012-2013

<table>
<thead>
<tr>
<th>Treatment Level</th>
<th>% of Decedents dying in hospital</th>
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<tbody>
<tr>
<td>Comfort Measures Only (n=11,816)</td>
<td>6.4%</td>
</tr>
<tr>
<td>Limited Treatment (n=4,787)</td>
<td>22.4%</td>
</tr>
<tr>
<td>Full Treatment (n=1,153)</td>
<td>44.2%</td>
</tr>
<tr>
<td>No POLST in Registry (n=40,098)</td>
<td>34.2%</td>
</tr>
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Slide courtesy of Alvin Moss, MD
From a presentation at the National POLST Paradigm Meeting
Chicago, IL. February 2016.
Conclusion

- The association with numbers of deaths in the hospital suggests that end-of-life preferences of people who wish to avoid hospitalization as documented in POLST orders are honored.

Fromme EK, Zive D, Schmidt TA, Cook JNB, Tolle SW. Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon. JAGS. 62(7):1246-1251.
Reviews transfer statistics and place of death in patients with POST forms from December 2009 – May 2011

- N = 100 residents at 2 nursing care facilities
- 9 transfers
  - 1 to ALF
  - 4 to ED (2 for foley catheter insertion; 1 for GI bleed; other is unknown)
  - 2 admitted to a hospital (1 returned to facility; 1 died)
  - 2 transferred to VAMC Palliative Care Unit

Only 1 patient (1%) with a POST form died in a hospital
- 25% of residents without a POST form in those 2 facilities died in a hospital
Studies in Virginia: Riverside Health System

- 9 nursing facilities in southeast VA with an average daily census of 718 residents; 86 NF residents had POST orders
Important Considerations

Virginia Regulatory Language

&

State and National Endorsements
Durable Do Not Resuscitate (DDNR) FACT SHEET
Virginia Department of Health
Office of Emergency Medical Services

Information for the public related to obtaining a DDNR order form:

- Who Can Obtain a Durable Do Not Resuscitate (DNR) Order?
  Persons desiring to have a DDNR order in place need to speak with a physician that they have a "bonafide" patient-physician relationship with, such as your primary care physician. A nurse practitioner (NP) or a physician assistant (PA) may also write a DDNR order following the same rules that apply when prescribing other treatments.

- Information and Responsibilities for Health Care Personnel Issuing (DNR) orders:
  - The use of the State’s DDNR form is encouraged for uniformity throughout the health care continuum.
  - The State’s DDNR form can be honored by qualified health care providers in any setting.
  - Patient’s that will not be within a qualified health care facility, receiving hospice or health care services at home must have an authorized State DDNR form in order for the DDNR to be honored.
  - “Other DDNR” orders can be honored anytime that a person is within a qualified health care facility or during transport between health care facilities when attended by a qualified health care provider (i.e. by ambulance).
  - If the scope of a DDNR is agreed upon, the physician shall have the following responsibilities:
    - Explain to the patient and his/her family the DDNR order is valid;
    - Explain to the patient how to and who may invoke the DDNR;
    - Document the patient’s full legal names;
    - Document the date the DDNR was assigned;
    - Obtain the patient’s signature or the person who is authorized to consent on behalf of the patient;
    - The physician’s printed name and signature must be included;
    - Note a valid contact number for the physician signing the DDNR order.

Information for Virginia Certified Emergency Medical Service (EMS) Providers:

- Do EMS Providers need to see an original DNR or Other DNR Order?
  No; as of July 1, 2011, legible copies of a DDNR order may be accepted by qualified health care providers.

- What types of DDNR forms or orders can be honored by EMS providers?
  - The VDH/OEMS “State” DDNR form (old or new) can be honored at any time;

- How to Download the DDNR and the Revised State DDNR form to the DDNR program:
  As of July 1, 2011, the State DDNR form has been changed to a downloadable document that can be found online at the VDH/OEMS website at http://www.vdh.state.va.us/OEMS/Files_Page/DDNR/DDNRFactSheet.pdf
  - The new downloadable DDNR form:
    - The revised DDNR form can be printed on any color paper (white paper printed on a color printer is recommended);
    - Health care providers may honor a legible copy of any of the three pages revised DDNR form;
    - The patient copy, medical record copy, or DDNR, jewelry, copy all may be honored;
    - It is recommended that all photocopies of DDNR forms, of any type, be of actual size;
    - The previous golden rod colored State DDNR form:
      - May still be honored no matter when it was dated;
      - Physicians may still complete the golden rod State DDNR forms until supply are exhausted;
      - Photocopies of completed golden rod colored State DDNR form may be honored indefinitely.

This Web site includes:
- The downloadable DDNR form
- DDNR, Fact Sheet
- How to Purchase DDNR Bracelets and Necklaces
- The applicable Virginia laws (Code of Virginia) related to DDNR
- Virginia Durable DNR Regulations

For technical assistance downloading the form you may contact Mr. Russ Stamm at the Office of Emergency Medical Services at (804) 898-9140 or Russ.Stamm@vdh.virginia.gov or write 1041 Technology Park Drive, Glen Allen, Virginia 23060.

(last accessed July 26, 2013).
“Other” DNR Orders: this is the term used to define a physician’s written DNR order when it is in a format other than the State form. “Other” DNR Orders should be honored by EMS providers’ when the patient is within a license health care facility, being transported between health care facilities, or receiving hospice or health care services at home. Examples of “Other” DNR orders include facility developed DNR forms, POST forms, or other documents that contain the equivalent information as the State form.
In November 2012, the VPC saw one of its major advocacy goals accomplished: The Medical Society of Virginia unanimously passed a resolution in support of POST in Virginia: “The Medical Society of Virginia supports the Physician Orders for Scope of Treatment (POST) form as a uniform, portable and legal document in the Commonwealth of Virginia.”

This is an important step in POST becoming the standard of care for Advance Care Planning for Virginians with advanced serious illness, terminal illness or medical frailty.

It is well established that there are significant deficits in the current system of care transitions, but there is limited evidence as to which interventions will most positively affect outcomes. We welcome additional data and new models of care that will help us create and evolve optimal processes for transitions between care settings. In the meantime, we propose some basic tenets that we believe, at least intuitively, will serve as underpinnings to enhance safe and efficient transitions:

Consistent discussion and documentation of advance directives and end-of-life care preferences, with up-to-date POLST (Physician Orders for Life Sustaining Treatment)/POST (Physician Orders for Scope of Treatment)/MOLST (Medical Orders for Life Sustaining Treatment)/MOST (Medical Orders for Scope of Treatment) forms or, in states where these are not available, with other appropriately executed advance directive forms.*
Improving Advanced Illness Care: The Evolution of State POLST Programs

Physician Orders for Life-Sustaining Treatment (POLST) is a promising program to elicit and honor the treatment goals of people with advanced progressive illness or frailty. Research shows that POLST effectively communicates patient treatment choices, whatever they may be, without sacrificing comfort care. This In Brief documents the evolution of POLST in 12 states and highlights lessons learned for states developing and implementing new programs.
Requirements

Education & Training
Required to Participate in the Virginia POST Initiative
“There's no easy way I can tell you this, so I'm sending you to someone who can.”
Types of Education & Training

- Advance Care Planning (ACP) Facilitator Training
  - 2 Pathways
- Primary Care Provider (PCP) Training
- End-User Training
- Public Education

- All educational programs send a clear, consistent message:
  - The program/form is voluntary
  - Prognostic eligibility considerations
ACP Facilitator Training

• Careful discussions designed to elicit care preferences are the most important part of the process
• MD/DO/NP/PA: not required to complete ACP facilitator training prior to engaging in this conversation and subsequently completing/signing a POST form
• Other health care professionals must be certified in order to have these conversations and assist in POST form completion
ACP Facilitator Training

- Respecting Choices™ Pathway
- Respecting Choices is owned and operated by Gundersen Health System, a not-for-profit 501(c)(3) corporation located in La Crosse, WI
- Pre-workshop online learning modules + all-day workshop
VPC ACP Facilitator Training

• Virginia POST Collaborative Pathway
• Developed by the VPC after feedback from across the State
• Flexible, cost-effective, and easily modifiable
• Proceeds return to the administration of the VPC
It’s not about the form.

It’s about the conversation.
It’s About the Conversation

- The POST form documents the outcome (though it can be revised as the patient’s condition warrants) of a thorough discussion
- Conducted by a certified facilitator (usually SW/RN/Chaplain/Bereavement Counselor) OR a trained provider (PA/NP/DO/MD)
- Family/Legal Surrogate should participate
• Overarching theme of this training

  – The POST conversation/Goals of Care (GOC) conversation is a fluid, organic process – but a skilled facilitator can guide this process in an organized, meaningful, and productive manner
  – Proceeding through the form in a step-by-step manner at the beginning of this process is mechanistic and can be off-putting
  – Learn who the *person* (not the *patient*) is and what matters most to them
To Make a Referral to an ACP Facilitator

• Contact one of your local POST Regional Coordinators
  – Richmond: Ken Faulkner (VCU)
  – Richmond: Rebecca Gruszkos (Bon Secours)
  – NoVA: Matt Kestenbaum (Capital Caring)

• Visit the POST website
  – www.virginiapost.org
  – Email Karen Dotson, our statewide program coordinator
Concluding Remarks

- The POLST Paradigm is achieving its goal of honoring treatment preferences of those with advanced illness or frailty.
- POLST/POST serves as catalyst for conversations in which patients talk with their loved ones and their health care professionals about what they really want.

Alvin Moss, MD
Medical Director, Center for Health Ethics and Law
West Virginia University
The Elevator Speech

• The POLST Paradigm is a clinical process designed to facilitate communication between health care professionals and patients with serious progressive illness.

• Its purpose is to ensure that critical medical decisions are informed and consistent with the individual’s values, goals of care, and preferences.

• The product of the process is a set of portable medical orders (consistent with the individual’s values, goals of care, and preferences) that addresses the use of cardiopulmonary resuscitation and other medical interventions; is applicable across health care settings; and which is reviewed and revised as needed.

Charlie Sabatino, JD
Director, American Bar Association Commission on Law and Aging