Agenda

• Welcome and Introductions
• Educational Session: “Implementing a POLST-type Advance Care Planning Model: One Rural Community’s Journey”
• Round-robin sharing/discussion
• Wrap-up and next steps
Implementing a POLST-type Advance Care Planning Model
One Rural Community’s Journey

Mark Papke-Larson, MDiv, BCC
Sanford Health of Northern MN
Nancy Hall, DNP, RN
Bemidji State University
Wednesday, January 27, 2016
After completing this session, the learner will be able to:

- Describe the advantages of a facilitated conversation in generating a POLST document
- Identify some barriers & facilitators to implementation of POLST type advance care planning.
Who is here?

- What professions or roles are represented?
- Experience with POLST paradigm?
- Currently work with POLST documents?
- Experienced POLST facilitators?

Have you ever been present during, or participated in, a medical procedure and wondered:
- “would this person really want to have this done?”
More people in America are dying of a progressive illness

>70% of deaths are likely to occur in hospitals and nursing homes (Meier, 2010)

>70.3% of adults over 60 who needed treatment decisions made at the end of life were unable to make those decisions (Silveira, Kim, & Langa, 2010)

When uncertainty about end-of-life decisions exists, health care professionals default to aggressive treatment approaches
More aggressive care results in...

- Poorer quality of life for the patient
- Higher incidence of regret, poorer quality of life, and major depressive disorder for bereaved caregiver following death

Decisions made in advance of the end of life & communicated to health care agents & health care providers can improve the likelihood that end-of-life care will be consistent with the patient’s preferences

- Wright et al., 2008
“If health professionals or loved ones have not spoken with a patient about end-of-life issues, they cannot reliably predict what the patient would have chosen and they find the decision-making responsibility burdensome and stressful.”

Briggs & Hammes, 2007, Chapter 1, p. 3
In the event of decisional incapacity:

- maximize the likelihood that medical care serves the patients goals,
- minimize the likelihood of over- or undertreatment,
- reduce the likelihood of conflicts between family members (and close friends) and health care providers, and
- minimize the burden of decision making on family members or close friends.
Advance directives (AD)
Low completion rate
If completed, often not available when needed
If available, often didn’t influence care given or cost of care
Others agree AD not working
- Collins, Winter, & Parks, 2006
- Faegerlin & Schneider, 2004
- Messinger-Rapport, Baum, & Smith, 2009

Some recent studies demonstrate more optimistic findings
- Silveira, Kim, & Langa, 2010
What does PC-ACP add to the picture?
Patient centered advance care planning (PC-ACP)

- Involves a trained facilitator and a standard discussion guide addressing beliefs, values, experiences and understanding of treatments
- Includes patient and health care agent (HCA)
- Recommended as a part of good health care
- Plan developed to reflect an individual's current health status
The conversation

- Facilitator trained using RC® class
- Includes patient, HCA, and facilitator
- Standard discussion guide explores
  - Patient’s experiences
  - What brings quality to the patient’s life
  - Patient’s understanding of each treatment
- Provides context for decision-making
- Values, beliefs, experiences, knowledge
What POLST adds to the picture...
One patient’s story

Lee's story, Lifting the Burden

https://www.youtube.com/watch?v=0WKK0BlXtfo&feature=player_embedded
POLST is about....

- For those with life-limiting illnesses like heart, lung, or kidney failure, advanced cancer, progressive neurological disorders & people in long term care facilities or possibly within the last year of life.
- Letting us know what people want done...
- Communicating the preferences across settings
- In a way that works in the health care system (provider’s orders)
- A health care community’s agreement to honor one common document
Approaches POLST as Patient Centered ACP
- evidence-supported process

Provides for a facilitated conversation that includes, at least, the individual and his or her health care agent (HCA)

Facilitated by a health care professional trained in the Respecting Choices model
Follows a standard discussion guide with focus on patient’s experiences, values, knowledge, and ideas about quality of life

Includes decision making matrix when deciding specific procedures
  * well-informed & carefully considered preferences

Products include the POLST document and an associated narrative
Evidence base for POLST

- Results in:
  - Health care workers impression that it is useful
    - In initiating conversation about end-of-life care
    - In making treatment decisions
  - Decreased frequency of unwanted resuscitation attempts
  - Increased number of providers’ orders addressing life-sustaining treatment (beyond resuscitation)
  - Increased incidence of care at the end of life that is consistent with stated preferences
Hall & Jenson, 2014
Hammes, Rooney, Gundrum, Hickman, & Hager, 2012
Hickman, Nelson, Moss, Hammes, Terwilleger, Jackson, & Tolle, 2009.
POLST: Provider Orders for Life Sustaining Treatment

**Provider Orders for Life-Sustaining Treatment (POLST)**

FIRST follow these orders, THEN contact the patient's provider. This is a provider order sheet based on the patient's medical condition and wishes. POLST translates an advance directive into provider orders. Any section not completed implies the most aggressive treatment for that section. Patients should always be treated with dignity and respect.

**Last Name**

**First/Middle Initial**

**Date of Birth**

**Primary Care Provider/Phone**

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**A CARDIOPULMONARY RESUSCITATION (CPR):**

Patient has no pulse and is not breathing.

- [ ] CPR/ATTEMPT RESUSCITATION
- [X] DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

When not in cardiopulmonary arrest, follow orders in B and C.

---

**B GOALS OF TREATMENT:**

Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

- [ ] COMFORT CARE — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.

  **Check all that apply:**
  - [ ] in an emergency, call ____________________________ (e.g. hospice)
  - [ ] if possible, do not transport to ER (when patient can be made comfortable at residence)
  - [ ] if possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

- [ ] LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS — Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)

  **Check one:**
  - [ ] Do not intubate
  - [ ] Trial of intubation (e.g. ______ days) or other instructions: ____________________________

- [ ] PROVIDE LIFE SUSTAINING TREATMENT

  Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)

---

**C INTERVENTIONS AND TREATMENT**

**ANTIBIOTICS (check one):**

- [ ] No Antibiotics (Use other methods to relieve symptoms whenever possible.)
- [ ] Oral Antibiotics Only (No IV/IM)
- [ ] Use IV/IM Antibiotic Treatment

**NUTRITION/HYDRATION (check all that apply):**

- [ ] Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)
- [ ] Tube feeding through mouth or nose
- [ ] Tube feeding directly into GI tract
- [ ] IV fluid administration
- [ ] Other: ____________________________

**Additional Orders:**

---

Provider Name (MD/DO/APRN/PA when delegated, are acceptable)

Provider Signature

Date

**FAXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID. TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE “VOID” IN LARGE LETTERS.**
Provider orders for life-sustaining treatment (POLST)

- Documents patient preferences
- Addresses
  - resuscitation status,
  - goals of care comfort care only, limited intervention, or aggressive treatment,
  - medical interventions i.e. intubation, dialysis
  - antibiotics
  - artificially administered fluids and nutrition
- When signed by provider, functions as an order across settings
POLST: Provider Orders for Life Sustaining Treatment

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, THEN contact the patient’s provider. This is a provider order sheet based on the patient’s medical condition and wishes. POLST translates an advance directive into provider orders. Any section not completed implies the most aggressive treatment for that section. Patients should always be treated with dignity and respect.

Last Name

First/Middle Initial

Date of Birth

Primary Care Provider/Phone

CARDIOPULMONARY RESUSCITATION (CPR):

Patient has no pulse and is not breathing.

☐ CPR/ATTEMPT RESUSCITATION  ☐ DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

An automatic external defibrillator (AED) should not be used for a patient who has chosen “Do Not Attempt Resuscitation.”
### GOALS OF TREATMENT:

Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

- **COMFORT CARE** — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.
  - **Check all that apply:**
    - [ ] In an emergency, call ______________________ (e.g. hospice)
    - [ ] If possible, do not transport to ER (when patient can be made comfortable at residence)
    - [ ] If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

- **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS** — Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)
  - **Check one:**
    - [ ] Do not intubate
    - [ ] Trial of intubation (e.g. _______ days) or other instructions: ____________________________

- **PROVIDE LIFE SUSTAINING TREATMENT**
  Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)

**Additional Orders (e.g. dialysis, etc.):**

- ____________________________
- ____________________________
- ____________________________
## INTERVENTIONS AND TREATMENT

**ANTIBIOTICS (check one):**
- [ ] No Antibiotics (Use other methods to relieve symptoms whenever possible.)
- [ ] Oral Antibiotics Only (No IV/IM)
- [ ] Use IV/IM Antibiotic Treatment

**NUTRITION/HYDRATION (check all that apply):**
- [ ] Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)
- [ ] Tube feeding through mouth or nose
- [ ] Tube feeding directly into GI tract
- [ ] IV fluid administration
- [ ] Other:

**Additional Orders:**

---

**Provider Name (MD/DO/APRN/PA when delegated, are acceptable):**

**Provider Signature:**

**Date:**

_Faxed copies and photocopies of this form are valid._

_TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE “VOID” IN LARGE LETTERS._
POLST Advance Care Planning Session Summary
(name – E #)

Overview:

Understanding of Illness and Disease Burden:

Goals of Care & Quality of Life:

Treatment and Care Preferences:

Summary Treatment Preferences as outlined in the POLST:
  a.) Code Status:
  b.) Goals of Treatment:
  c.) Interventions and Treatments:

Recommendations; Follow Up Plan; Documents addressed:

Thank you for the opportunity to meet with. It was a privilege to assist in advance care planning.

Mark Papke-Larson, MDiv. BBC
Sanford Health Advance Care Planning (ACP) Coordinator
(o) 218 333-5990 © 218 556-2834
A ‘Little’ Demo
Mrs. Samantha Short
- 80 year old
- 6 year resident/LTC
  - Really slowed down last 6 months
- PCP wouldn’t be surprised if Mrs. Short died in the next 12 months
  - 3 recent hospitalization
    - Intubated for 4 days
- COPD
- Heart failure
- Diabetes

Assessed and affirmed dtr. Sylvia’s understanding role as agent

Explored
- Understanding of medical conditions
- Understanding of potential complications
- Experiences of EOL decision making
- Living well

Decided against CPR
Section B – Goals of Care for Medical interventions

GOALS OF TREATMENT:
Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

☐ COMFORT CARE — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.

Check all that apply:
☐ In an emergency, call ______________________ (e.g. hospice)
☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
☐ If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

Additional Orders (e.g. dialysis, etc.)

☐ LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS — Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)

Check one:
☐ Do not intubate
☐ Trial of intubation (e.g. ______ days) or other instructions: ____________________________________________

☐ PROVIDE LIFE SUSTAINING TREATMENT
Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)
Section B – Goals of Care for Medical interventions

- Introducing goals of care for interventions
- Starting with patients preference based last 45 minutes.
- Discuss all 3 options
- Teach back technique
The Bemidji Story
### Bemidji Area Palliative Care Team Activity

**Supporters:** Stratis Health, Sanford Bemidji, Northwest Minnesota Foundation (NMF), GoldPine Home, Bemidji State University, Area Agency on Aging, MN DHS

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<td>• Participation in MN Rural Palliative Care Initiative through Stratis Health grant&lt;br&gt;• Team forms to improve palliative care options in Bemidji</td>
<td>• Focus of activity on POLST &amp; advance care planning&lt;br&gt;• First team members trained through Respecting Choices ® (RC)</td>
<td>• Awarded grant through NMF to pilot POLST&lt;br&gt;• More facilitators trained by RC&lt;br&gt;• POLST coordinator hired through Sanford Bemidji</td>
<td>• POLST facilitator training held in Bemidji&lt;br&gt;• POLST Pilot began at Sanford Home Care, Havenwood &amp; expanded to GoldPine&lt;br&gt;• Stakeholder groups trained (EMS, ED, clinic, etc.)&lt;br&gt;• Community education &amp; financial committees formed&lt;br&gt;• RARE</td>
<td>• POLST pilot expands to Sanford dialysis &amp; oncology, Neilson Place&lt;br&gt;• Grant from CSSD with match from Sanford and other key stakeholders&lt;br&gt;• Replace POLST coordinator position with Advance Care Planning (ACP) coordinator&lt;br&gt;• Plan for First Steps&lt;br&gt;• Quality improvement in place for all stages of ACP</td>
<td>• POLST expands to more appropriate Bemidji residents&lt;br&gt;• First Steps community action team begins, facilitators trained&lt;br&gt;• Ongoing facilitator training to support POLST &amp; First steps&lt;br&gt;• Quality improvement processes in place</td>
<td>• First Steps opportunities expanding to multiple sites&lt;br&gt;• POLST slowly expands to more Bemidji residents&lt;br&gt;• Continue to increase rates of AD completion</td>
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2016 Goals for Bemidji ACP

- Continue to expand ACP initiative into Sanford Bemidji Clinics
  - Internal Medicine Clinic
  - Family Practice Clinic
  - POLST expansion to Sanford Dialysis
- Offer support to current POLST sites
  - education to POLST Facilitators
- Increase rates of ACP plans in COPD population
  - Advance Directives and POLST
Major activities to implement....

- Leadership team engagement
- Key stakeholders
- Pilot agencies, providers
- Venue meetings
- Facilitator training and ongoing support
- Quality activities
- Financing the operation
Challenges to implementation

- Culture change
  - “love the idea” vs “making it happen with what you have”
- Competing priorities for resources
  - Facilitator Agreement of Understanding
- Productivity requirements
- CMS Reimbursement
  - Systems are not in place yet and complexity of rule
  - Insurance not much yet
- Sustaining interest and investment over time
More challenges...

- Leadership engagement
- Logistics of changing practice patterns...
  - Pilot MD issue
  - Mechanics, document flow,
  - POLST travel with patient
  - Providers looking for POLST, aware of its presence and how to use
Challenges for Facilitators...

- How to decide who & when to train
- Keeping them energized engaged
- Getting over the “hump”, inviting and first conversations
- Ongoing support
- Keeping up to date
- Turnover in critical positions
Change processes in multiple organizations....

- Communication
- Quality monitoring
- Changes in key personnel
Questions
References


Hammes, B.J., Rooney, B.L., Gundrum, J.D., Hickman, S.E., Hager, N. (2012). The POLST program: A retrospective review of the demographics of use and outcomes in one community where advance directives are prevalent. *Journal of Palliative Medicine, 15*(1), 77-85.


Contact information

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- Nancy Hall
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Round-Robin Discussion

Sharing about use of POLST or POLST-type Advance Care Planning tools/processes

Current palliative care efforts
Wrap-Up and Next Steps

Next meeting

- May 17, 2016, 10 – 11:30 a.m.
- Educational Session: “Upstream Adventures: Initial results from a clinical trial of community based palliative care, delivered by trained lay persons”
  — Presented by Sandy Schellinger, Allina Health Clinical Co-Investigator Late Life Supportive Care LifeCourse
Questions?

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This material was prepared by the Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy.
11SOW-MN-C3-15-197 091815