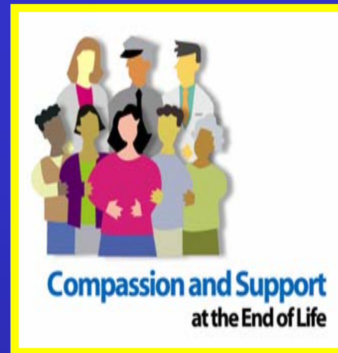

Quality Improvement, Monitoring to Achieve Success

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Objectives

- Explain how the MOLST and similar forms can be used to improve the quality of end-of-life care when compared to traditional advance directives;
- Describe how one state (West Virginia) has implemented a statewide monitoring and education system to improve dissemination and utilization of a MOLST-type program; and
- Give an overview of research that has validated the use of MOLST-type forms as well as the direction of future research including the practical importance of this research

The aim of a POLST paradigm program is not eliminating the use of other advance care planning tools. They are meant to supplement traditional advance directives.

Two types of advance directives

- Traditional – *Have little or no impact on immediate*
- *care*
  - Living will
  - MPOA Form
  - Combined Living Will/MPOA Form
- Actionable or progressive – *direct and relatively immediate impact on course of care – Often are physician's orders*
  - POST form
  - Do Not Resuscitate

What is a staged approach to advance care planning?

At different points in one's life, different types of advance directives are appropriate. A staged approach to advance care planning recognizes that traditional advance directives are appropriate for most adults, and actionable advance directives should be utilized for patients with progressive illness.

During the first stage of planning an individual should:

- Explore and share general values
- Decide in which health states he/she would not want life support
- Identify the person they would like to make decisions for them when they can no longer make decisions for themselves
- Decide how much leeway they want to give this individual
- Complete an MPOA form, Living Will, or combined form

However, these traditional advance directives have limitations

- They may not be available when needed
  - Most adults don’t complete them
  - Not transferred with the patient
- Completing a form may have been limited to a signature without discussion
- Instructions may not be specific enough or address the issue at hand
- Treating physician must interpret traditional AD – may override patient wishes
- Traditional AD does not immediately translate into physician orders

When is it time for a patient to progress to the second stage of advance care planning (an actionable advance directive)?

Physicians should transition to the second stage for patients with life-limiting illnesses if they answer no to the following question:

Would you be surprised if the patient died in the next year?

In West Virginia the Physician Orders for Scope of Treatment (POST) Form is a standard actionable advance directive used across care settings.

POST is for…

- Seriously ill patients*
- Terminally ill patients

* chronic, progressive disease/s

POST improves patient care in two ways at the end of life compared to traditional advance directives

- Provides a means of discussing goals of care concerning the most common medical decisions at the end of life
- Provides a means of transferring physician's orders across care setting that are respected throughout the transfer process

“Just in Time Planning”

- When completing traditional advance directives most individuals have a difficult time envisioning themselves in a terminal condition
- POST forms are completed with a patient or surrogate when their point of view has already been altered by disease and/or frailty
- Patients look to providers to initiate conversations and it makes more sense to discuss these treatment in the context of a limited prognosis
- Trained facilitators can help guide patients and surrogates in completing forms based on their experiences, values, goals, health status, culture, and relationships

Vehicle for Transferring Orders

How do you achieve this goal?

- A standardized form recognized and honored throughout the system
- No organizational logos
- Clear language – actionable in all settings
- Distinctive, bright color
- Institutions/providers recognize the form and are required to follow orders

Living Will* compared to POST

Living Will

- For every adult
- Requires decisions about myriad of future treatments
- Clear statement of preferences
- Needs to be retrieved
- Requires interpretation

POST

- For the seriously ill
- Decisions among presented options
- Checking of preferred boxes
- Stays with the patient
- A physician's order to be followed

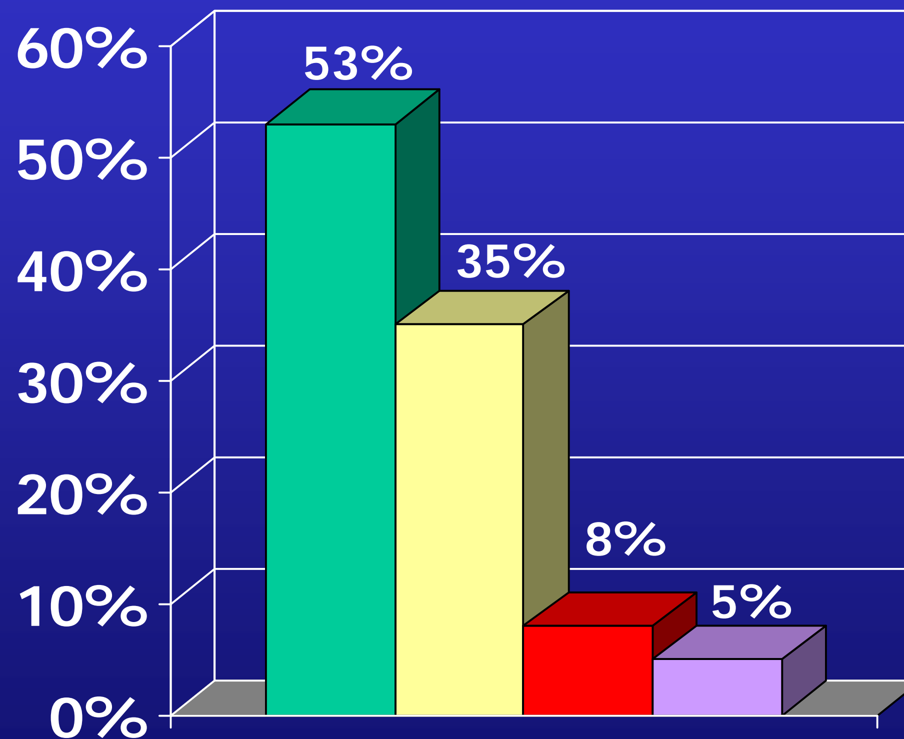
*Fagerlin & Schneider. Enough: The Failure of the Living Will. Hastings Center Report 2004;34:30-42.

Development of the POST

- Oregon experience
- Collaborative effort through the West Virginia Initiative to Improve End-of-Life Care
- Voluntary process
- Codified by West Virginia Legislature

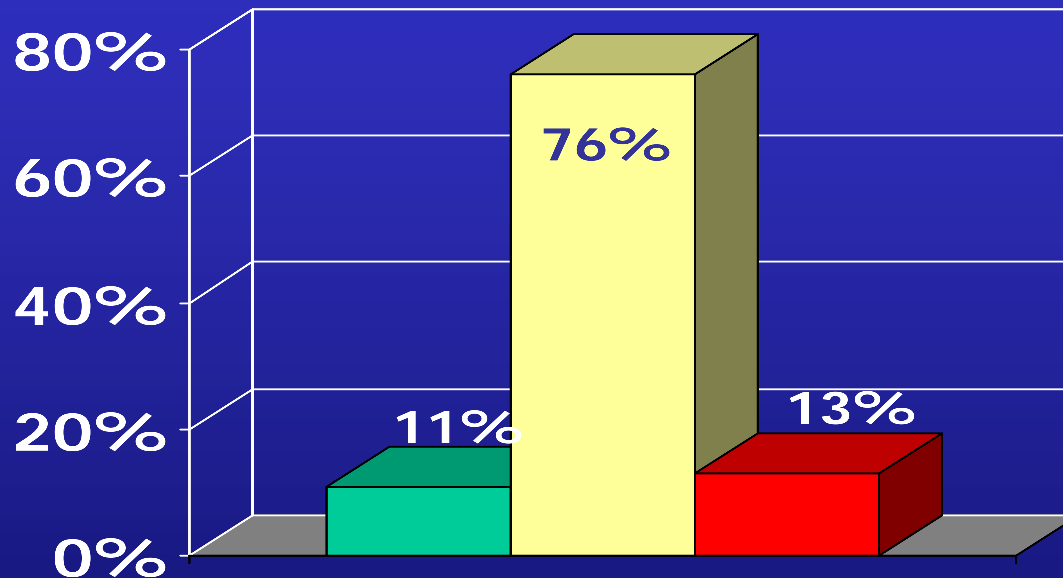
Interest in Dying at Home

How interested would you be in a comprehensive program of care…kept you comfortable at home while providing emotional & other support services to you & your family?



End-of-Life Choice

If you had to choose between being kept alive as long as possible even if you were experiencing pain & suffering or living a shorter time to avoid pain… and being put on machines, which would you pick?



Pilot Project

- Social Workers were completing majority of forms
- Forms were being completed correctly
- Completion rated varied widely between facilities
- Problems with forms being lost upon transfer
- Section D (feeding tubes) most difficult to discuss

Strategies for Implementation, I

- Completion of POST is part of disposition planning
- Think POST at time of transfer or discharge
  - Add POST to discharge checklist
- Complete POST when discharging to a NH or home with home care or hospice
- Educate NHs and EDs to send POST and look for POST respectively
- Educate EMS

Strategies for Implementation, II

- Work with NH social workers and nurses
- Encourage them to complete POST form on admission for residents
- Encourage them to complete/update POST at time of quarterly care planning
- Encourage them to always send POST to hospital on transfer
- Be sure to send POST back with patients!

“Where is the POST form?”

Other Strategies

- Health Care Provider Brochures
- Patient and Family Brochures
- POST Education Section including a PowerPoint Presentation on our website
- Several statewide conferences featuring POST
- Regional training for social workers
- In 2003 and 2004 statewide training via MDTV, a satellite broadcast network
- In services will be provided to facilities that ask for one either by a staff member or a Center affiliate

Tracking System

- All forms are printed and paid for by the Center for End-of-Life Care
- Each form has a serial number at the bottom of the form
- Only Healthcare providers and healthcare agencies/institutions can order POST forms
- They can order forms in one of two ways;
  - By calling our toll free number 1-877-209-8086
  - By online order form on www.wvendoflife.org

Tracking continued

- If our office staff would happen to be suspicious that it is not a legitimate order, they will check the name of the facility or call
- Each order is recorded in the data base along with the facility name, contact info, and type
- This information allows the Center to keep track of the percentage of facilities that are using the form and target facilities that are not using the form for intervention

So What? Do POLST paradigm forms really work to improve care at the end of life? Do patients receive better comfort care and have their wishes respected more often than with traditional advance directives?

Validation of POST

- Dunn PM, Schmidt TA, Carley MM et al: A method to communicate patient preferences about medically indicated life sustaining treatment JAGS 1996;44:785
- Tolle SW, Tilden VP, Nelson CA, Dunn PM: A Prospective study of the efficacy of the POLST JAGS 1998;46:1097
- Lee MA, Brummel-Smith K, Meyer J et al: Physician orders for life-sustaining treatment (POLST): Outcomes in a PACE program JAGS 2000; 48:1-6.

Method to Communicate Patient Preferences Study

- Precursor to the POLST form
- How would providers respond to given situations with and without a *Medical Treatment Coversheet (MTC)*
- Focus groups believed the MTC would be useful for their patients
- When given hypothetical situations, 37% would change decisions with an MTC in acute care and 26% would change decisions in long-term care
- Most changes were due to withholding treatment consistent with patient wishes
- For all scenarios combined, appropriateness scores increased significantly for both acute care (16.4 to 22.3, P<.0001) and long-term care (8.8 to 12.2, P,.0001)

Prospective study of the efficacy of the POLST

- Used chart data to follow prospectively a sample of nursing home residents with POLST forms
- 180 residents who had DNR orders and indicated that they did not want to be transferred to the hospital unless comfort measures failed in the nursing home – followed for one year
- No study subject received CPR, ICU care, or ventilator support. Only 2% were hospitalized for life-extending interventions.
- Of 38 subjects that died in the study year, 63% had an order for opioids. Only 2 died in an acute care hospital.
- In 85% of hospitalizations patients were transferred because nursing home could not control suffering
- In only 4 cases the transfer to a hospital was to extend life, overriding POLST orders

Physician orders for life-sustaining treatment (POLST): Outcomes in a PACE program

- Retrospective chart review
- POLST instructions for PACE participants were identified and whether or not they were followed in the last two weeks of life
- DNR orders were respected 91% of the time
- Level of care was given at the requested level in 46% of cases, at a less invasive level in 33% of cases, and at a more intensive level in 20% of cases
- Antibiotic administration was consistent with wishes in 86% of cases
- Care matched POLST instructions in 84% of cases for IV fluids and 94% for feeding tubes
- POLST completion exceeded that of traditional advance directives, and the care matched wishes more consistently than previously reported with traditional advance directives.

Upcoming Study: Multi-State Study Funded by NIH

- "Converting Treatment Wishes into Orders at End of Life"
- Retrospective longitudinal chart review of 1800 charts in nursing homes in Oregon, Wisconsin, and West Virginia
- Will compare the effectiveness of POLST with traditional advance directives in turning resident and surrogate treatment preferences into medical orders that are resident specific and have an immediate impact on care

Multi-State Study will assess:

- The extent of use of the program in states where it has been implemented;
- How POLST compares to traditional end-of-life care planning such as advance directives;
- How POLST affects symptom management;
- How the care of patients with POLST forms differs from patients who do not take part in the program. For instance, are their preferences for life-sustaining treatments honored more frequently?
- How the POLST form is related to national end-of-life care statistics. For example, in the state of Oregon researchers hope to determine whether POLST usage is related to the state's low rate of in-hospital deaths.

The Big Picture

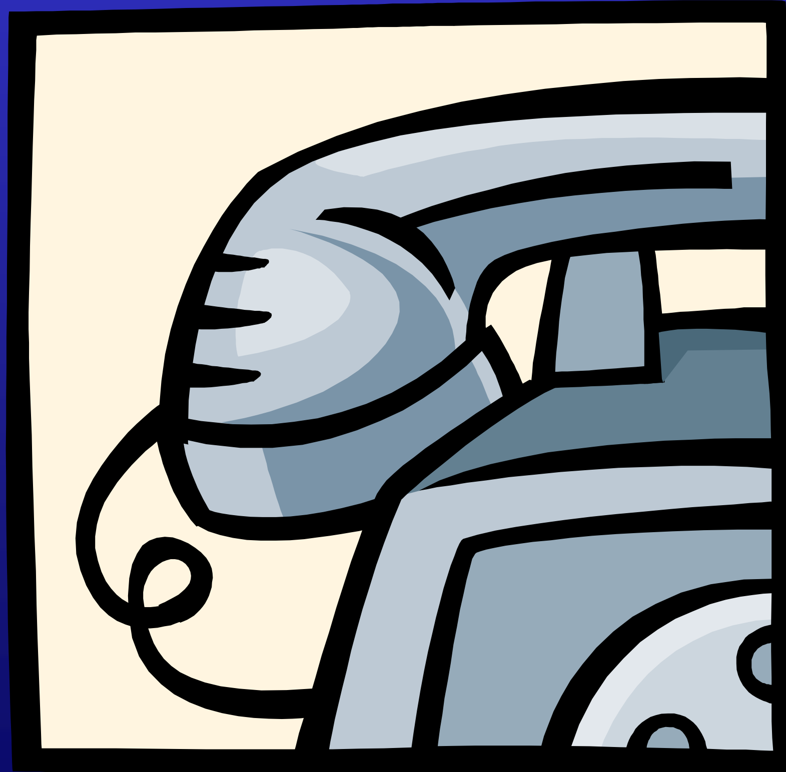
- Limited research does show that POLST, POST, MOLST, and similar forms may be an improvement over traditional advance directives
- More research is needed
- Continued validation of the form will mean more use of the form and possibly a national standard form

What it means for patients and providers

- Patients’ wishes will be respected at the end of life especially in crisis and emergency situations
- Providers will have a standardized form to follow and will know they are following patients’ wishes
- More patients will be in comfort in the setting of their choice in the most vulnerable time of their lives

Call Us!

1-877-209-8086



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