VCU Palliative Care ECHO*

May 9, 2019

The Virginia Physician Orders for Scope of Treatment (POST)

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

April 11, 2019| 12:00 PM | teleECHO Conference

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Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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April 11, 2019| 12:00 PM | teleECHO Conference

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Danielle Noreika, MD

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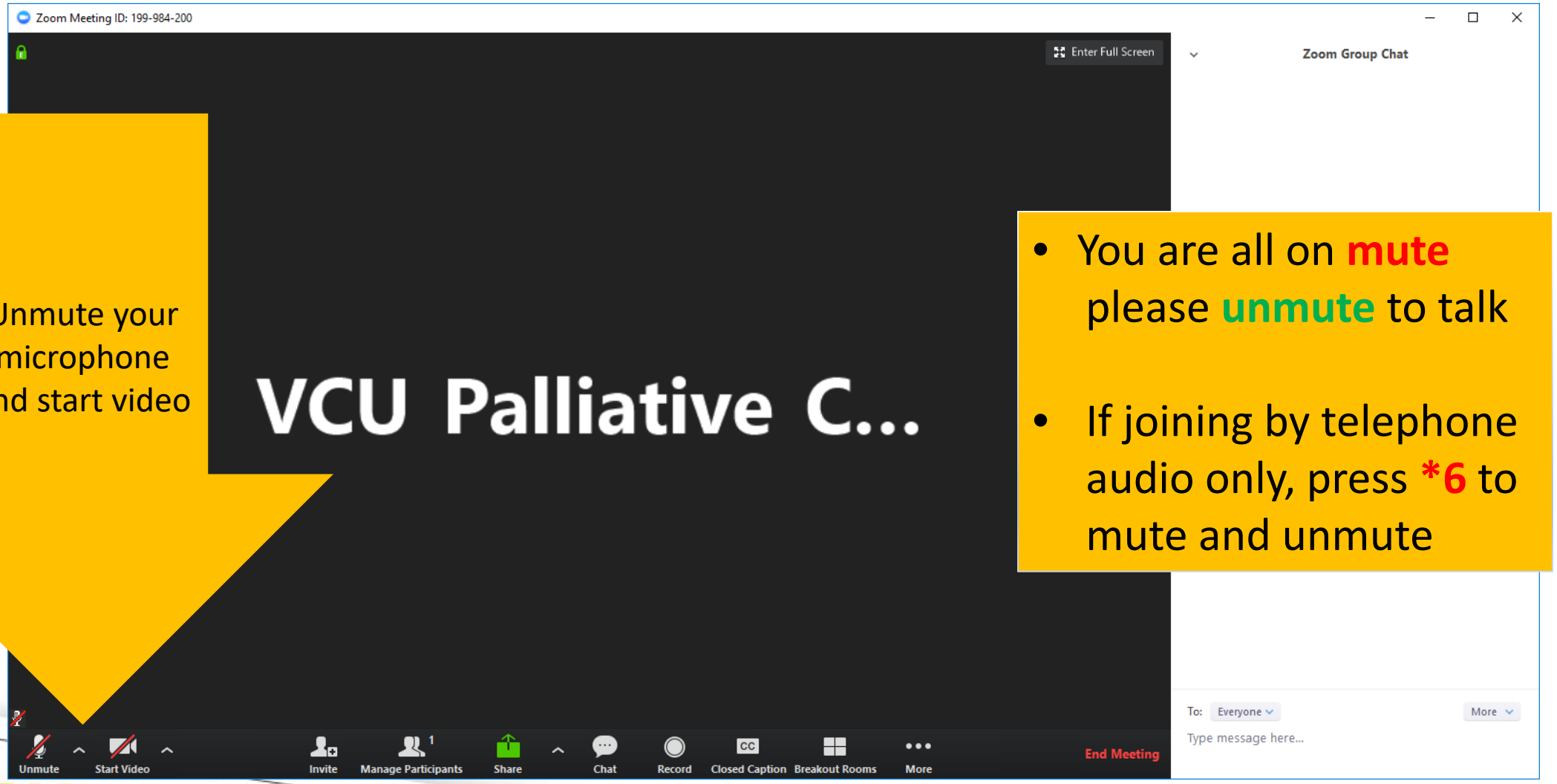
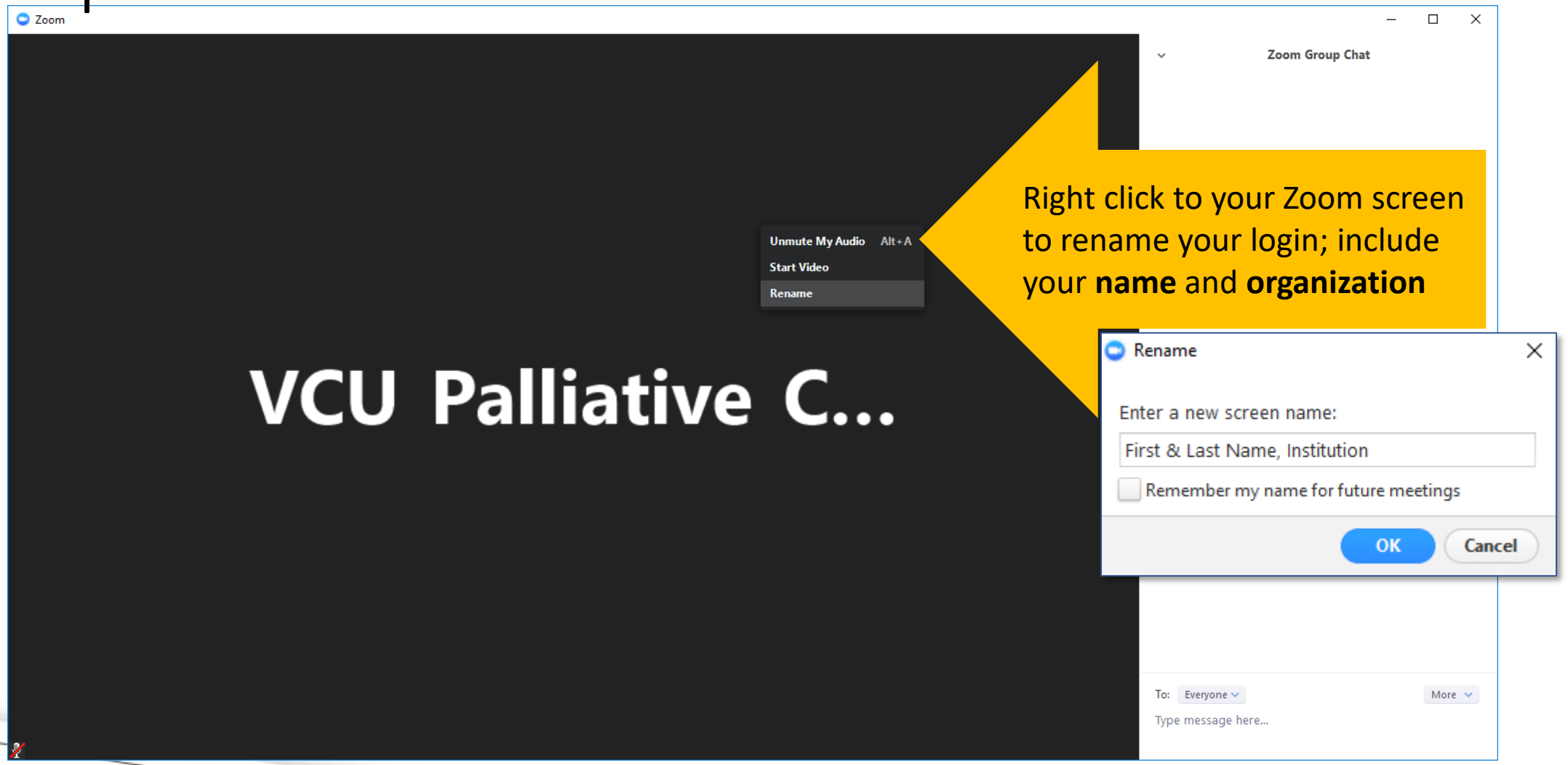
Helpful Reminders



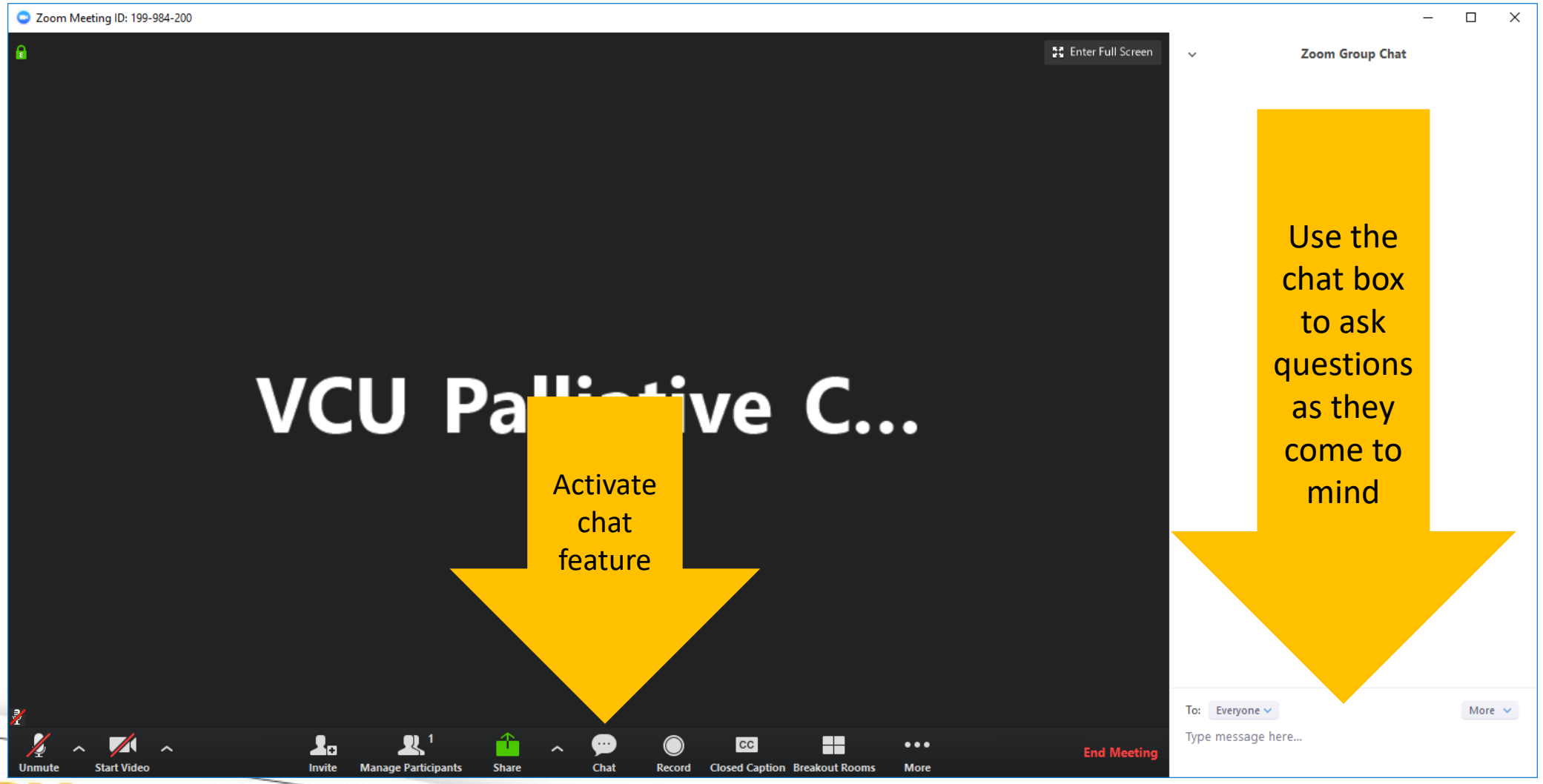
Unmute your microphone and start video

- You are all on **mute** please **unmute** to talk
- If joining by telephone audio only, press ***6** to mute and unmute

Helpful Reminders



Helpful Reminders



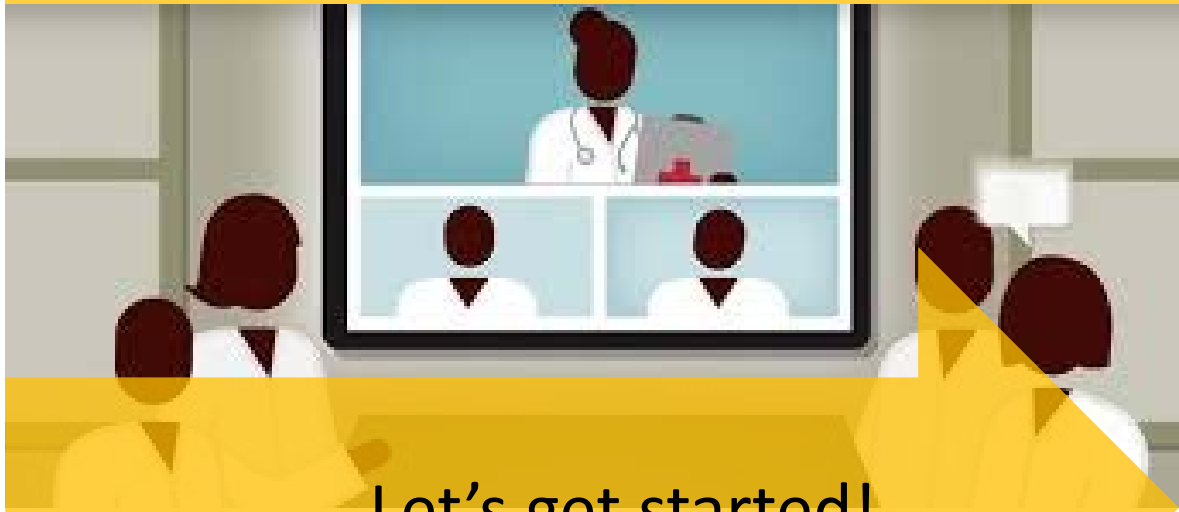
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions
   - Case Presentation
     5 min.
   - Clarifying questions from spokes, then hub
     2 min. each
   - Recommendations from spokes, then hub
     2 min. each
   - Summary (hub)
     5 min.

III. Closing and Questions

- Bi-weekly tele-ECHO sessions (1.5 hours)
- Didactic presentations developed by inter-professional experts in palliative care
- Website: www.vcuhealth.org/pcecho
- Email: pcecho@vcuhealth.org



Let's get started!

Hub Introductions

VCU Team	
Clinical Director	Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Egidio Del Fabbro, MD – VCU Palliative Care Chair Jason Callahan, MDiv – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist Diane Kane, LCSW – Palliative Care Specialty Certified Felicia Hope Coley – RN Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Researcher
Support Staff Program Manager Telemedicine Practice Administrator IT Support	 Teri Dulong-Rae / Bhakti Dave, MPH David Collins, MHA Frank Green

Spoke Participant Introductions

Name and Institution

The Virginia Physician Orders for Scope of Treatment (POST)

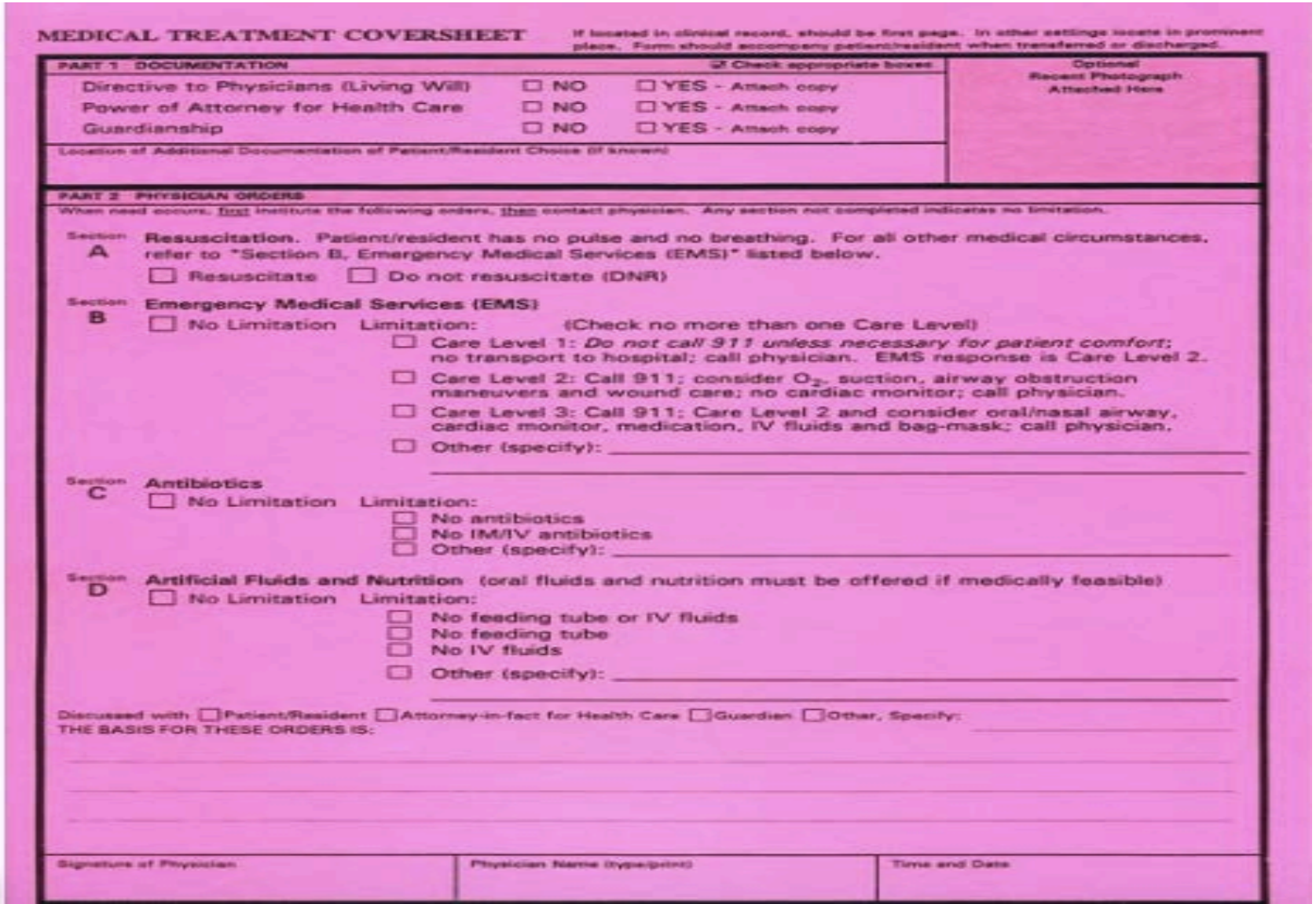
Danielle Noreika, MD, FACP, FAAHPM

A Bit of History……..

- Oregon, *1991*
- Developed a new tool recognizing that AD's were inadequate for patients with serious illness or frailty
- Task force originated from the Center for Ethics in Health Care at Oregon Health & Science University (OHSU) with representatives of stakeholder health care organizations

https://oregonpolst.org/history

Oregon, 1993



MEDICAL TREATMENT COVERSHEET

If located in clinical record, should be first page. In other settings locate in prominent place. Form should accompany patient/resident when transferred or discharged.

PART 1 DOCUMENTATION — ☑ Check appropriate boxes

Directive to Physicians (Living Will)	☐ NO	☐ YES - Attach copy
Power of Attorney for Health Care	☐ NO	☐ YES - Attach copy
Guardianship	☐ NO	☐ YES - Attach copy

Optional Recent Photograph Attached Here

Location of Additional Documentation of Patient/Resident Choice (if known)

PART 2 PHYSICIAN ORDERS

When need occurs, first institute the following orders, then contact physician. Any section not completed indicates no limitation.

Section A — **Resuscitation.** Patient/resident has no pulse and no breathing. For all other medical circumstances, refer to "Section B, Emergency Medical Services (EMS)" listed below.

☐ Resuscitate ☐ Do not resuscitate (DNR)

Section B — **Emergency Medical Services (EMS)**

☐ No Limitation Limitation: (Check no more than one Care Level)

- ☐ Care Level 1: *Do not call 911 unless necessary for patient comfort;* no transport to hospital; call physician. EMS response is Care Level 2.
- ☐ Care Level 2: Call 911; consider O_2, suction, airway obstruction maneuvers and wound care; no cardiac monitor; call physician.
- ☐ Care Level 3: Call 911; Care Level 2 and consider oral/nasal airway, cardiac monitor, medication, IV fluids and bag-mask; call physician.
- ☐ Other (specify): _____

Section C — **Antibiotics**

☐ No Limitation Limitation:

- ☐ No antibiotics
- ☐ No IM/IV antibiotics
- ☐ Other (specify): _____

Section D — **Artificial Fluids and Nutrition** (oral fluids and nutrition must be offered if medically feasible)

☐ No Limitation Limitation:

- ☐ No feeding tube or IV fluids
- ☐ No feeding tube
- ☐ No IV fluids
- ☐ Other (specify): _____

Discussed with ☐ Patient/Resident ☐ Attorney-in-fact for Health Care ☐ Guardian ☐ Other, Specify: _____

THE BASIS FOR THESE ORDERS IS:

Signature of Physician	Physician Name (type/print)	Time and Date

A Vision

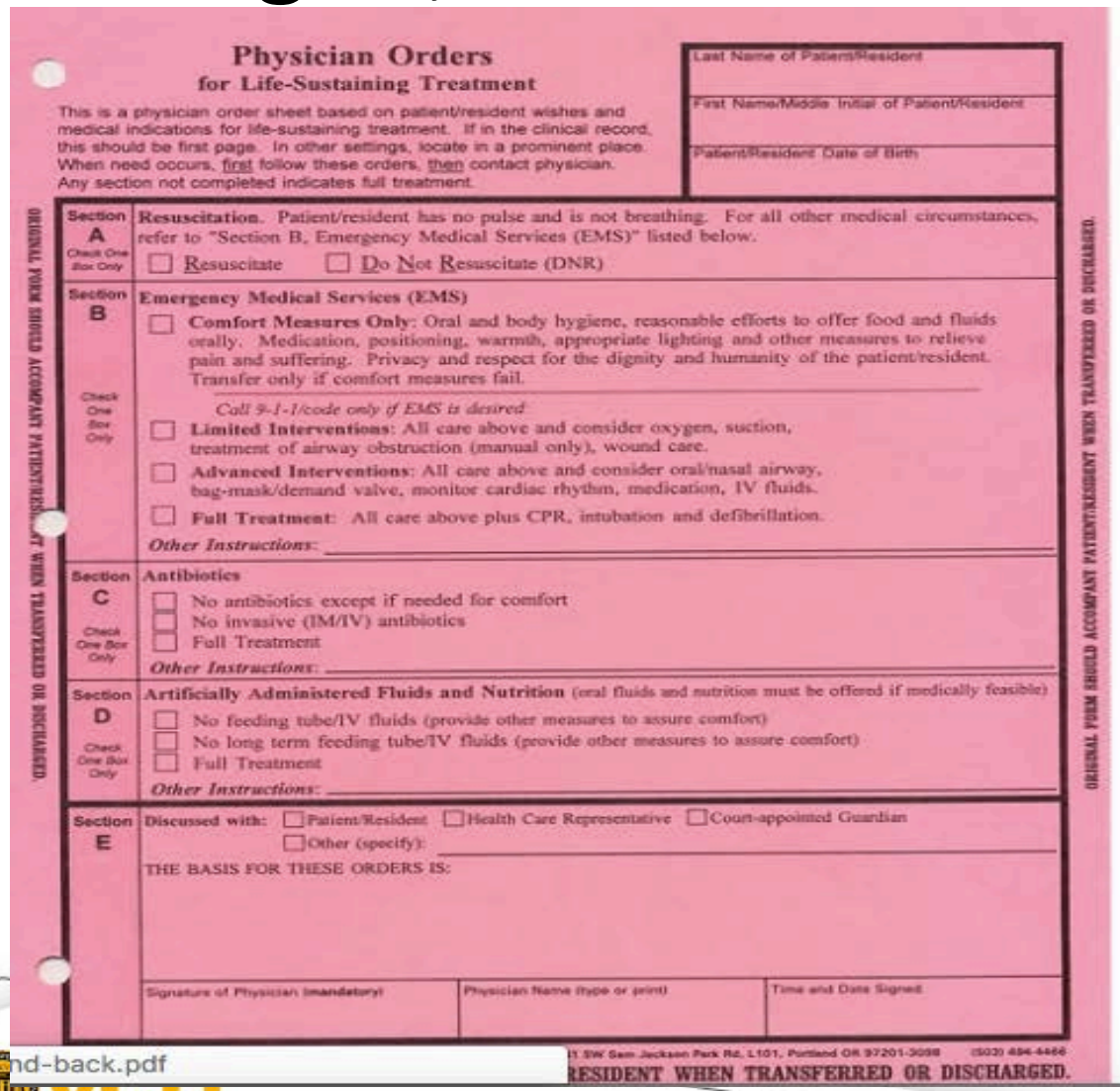
1993: The Vital Role of Statewide Education

The Task Force recognized early on that education is the key to effective use of the Medical Treatment Coversheet (MTC, and later POLST) form. For the program to succeed statewide, health care professionals received updates on form use, newly developed policies and advances in research. The Task Force developed numerous educational resources and relied on member organizations to develop effective on going learning for their constituents. In essence, the group became a clearinghouse of information and the sharing of ideas, catalyzing resource development, all to help health care organizations educate their member health care professionals. Here are some examples of these early educational tools:

- Pamphlets including the MTC form and a step by step implementation process
- Videotape explaining how the MTC is used and implemented
- Consultation with health care professionals skilled in the use of the form
- Executive summary of the MTC evaluation project
- Initial "Train the Trainer" conference providing education about Oregon's new advance directive statute (including decisions for a patient to have or forego permanent feeding tube placement)

The Task Force recognized that education is a cornerstone of the POLST Program. Click here for a more extensive archive of early educational resources for health care professionals, health care systems and patients and families.

Oregon, 1995



Physician Orders
for Life-Sustaining Treatment

This is a physician order sheet based on patient/resident wishes and medical indications for life-sustaining treatment. If in the clinical record, this should be first page. In other settings, locate in a prominent place. When need occurs, first follow these orders, then contact physician. Any section not completed indicates full treatment.

Last Name of Patient/Resident

First Name/Middle Initial of Patient/Resident

Patient/Resident Date of Birth

ORIGINAL FORM SHOULD ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED.

Section A (Check One Box Only)

Resuscitation. Patient/resident has no pulse and is not breathing. For all other medical circumstances, refer to "Section B, Emergency Medical Services (EMS)" listed below.

☐ Resuscitate ☐ Do Not Resuscitate (DNR)

Section B (Check One Box Only)

Emergency Medical Services (EMS)

☐ **Comfort Measures Only**: Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, warmth, appropriate lighting and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. Transfer only if comfort measures fail.

Call 9-1-1/code only if EMS is desired

☐ **Limited Interventions**: All care above and consider oxygen, suction, treatment of airway obstruction (manual only), wound care.

☐ **Advanced Interventions**: All care above and consider oral/nasal airway, bag-mask/demand valve, monitor cardiac rhythm, medication, IV fluids.

☐ **Full Treatment**: All care above plus CPR, intubation and defibrillation.

Other Instructions: _____

Section C (Check One Box Only)

Antibiotics

☐ No antibiotics except if needed for comfort
☐ No invasive (IM/IV) antibiotics
☐ Full Treatment

Other Instructions: _____

Section D (Check One Box Only)

Artificially Administered Fluids and Nutrition (oral fluids and nutrition must be offered if medically feasible)

☐ No feeding tube/IV fluids (provide other measures to assure comfort)
☐ No long term feeding tube/IV fluids (provide other measures to assure comfort)
☐ Full Treatment

Other Instructions: _____

Section E

Discussed with: ☐ Patient/Resident ☐ Health Care Representative ☐ Court-appointed Guardian
☐ Other (specify): _____

THE BASIS FOR THESE ORDERS IS:

Signature of Physician (mandatory)	Physician Name (type or print)	Time and Date Signed

ORIGINAL FORM SHOULD ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED.

nd-back.pdf

How to Change "Physician Orders for Life-Sustaining Treatment"

This form, "Physician Orders for Life-Sustaining Treatment," should be reviewed if:

(1) The patient/resident is transferred from one care setting to another, or
(2) There is substantial permanent change in patient/resident health status, or
(3) The patient/resident treatment preferences change.

First, review "Patient/Resident Preferences as a Guide for Physician Orders for Life-Sustaining Treatment" (Section F). Second, record the review in "Review of Physician Orders for Life-Sustaining Treatment" (Section G).

Finally, if this form is to be voided, draw a line through the "Physician Orders" and/or write the word "VOID" in large letters, then sign or initial the form. After voiding the form, a new form may be completed. *If no new form is completed, full treatment may be provided.*

Section F

Patient/Resident Preferences as a Guide for Physician Orders for Life-Sustaining Treatment

I have given significant thought to life-sustaining treatment. The following have further information regarding my preferences:

Advance Directive	☐ NO	☐ YES - Attach copy
Court-appointed Guardian	☐ NO	☐ YES - Attach copy of documentation

I expressed my preferences to my physician and/or health care provider(s) and agree with the treatment orders on this document. Please review these orders if there is a substantial permanent change in my health status such as:

Close to death
Permanently unconscious
Advanced progressive illness
Extraordinary suffering

Signature of Patient/Resident or Guardian/Health Care Representative (optional)		
Signature of Person Preparing Form (optional)	Preparer Name (type or print)	Time and Date Prepared

Section G

Review of Physician Orders for Life-Sustaining Treatment

Date of Review	Reviewer	Location of Review	Outcome of Review
			☐ No change ☐ Changed, FORM VOIDED, new form completed ☐ Changed, FORM VOIDED, *no* new form
			☐ No change ☐ Changed, FORM VOIDED, new form completed ☐ Changed, FORM VOIDED, *no* new form
			☐ No change ☐ Changed, FORM VOIDED, new form completed ☐ Changed, FORM VOIDED, *no* new form

© CENTER FOR ETHICS IN HEALTH CARE, Oregon Health Sciences University, 3181 SW Sam Jackson Park Rd, L101, Portland OR 97201-3098 August 1998

Then What Happened?

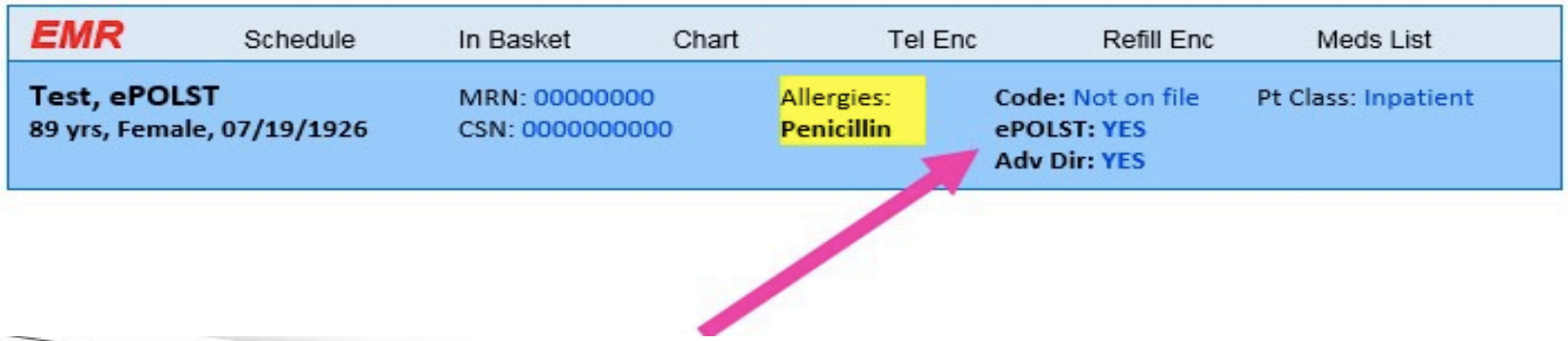
- Emphasized over time continued feedback, research, and changes to form and process
- 2004: National POLST Paradigm Taskforce convened
- 2009: Oregon POLST registry
- 2010: Trademark registration

2015, Seriously

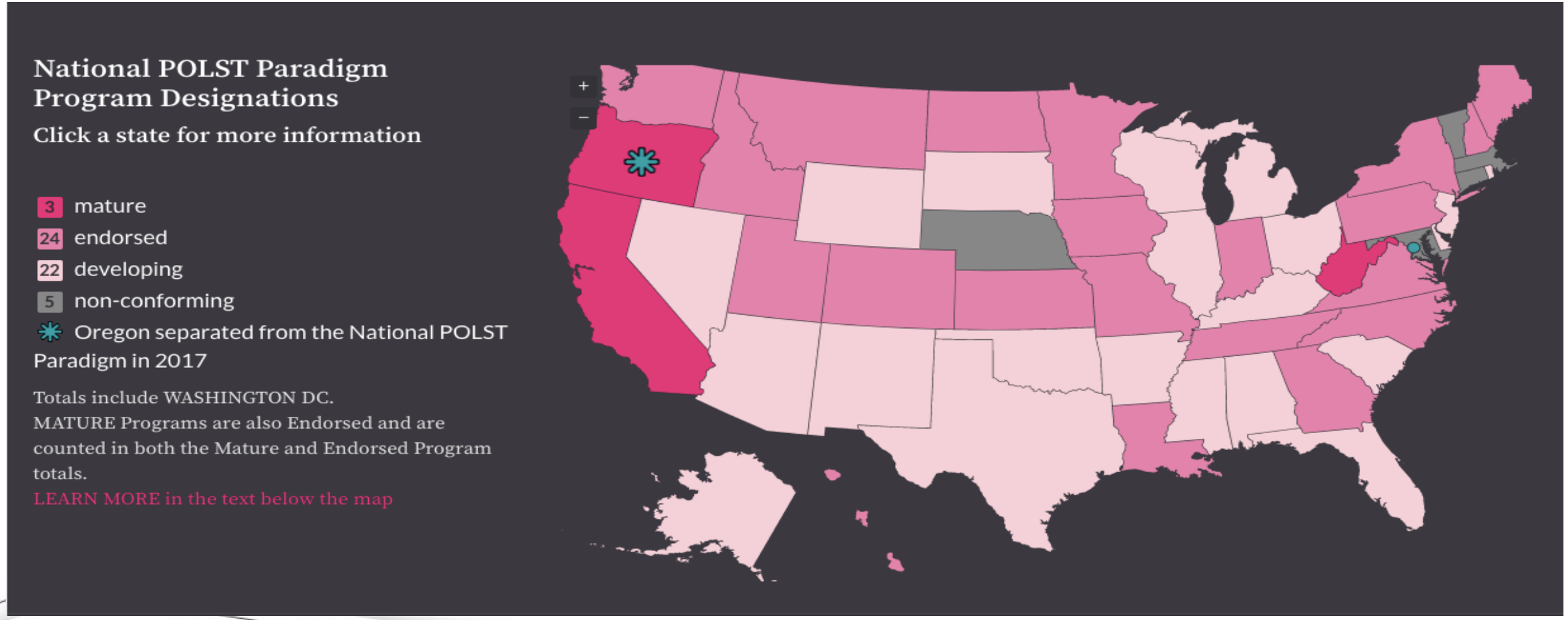
2015: ePOLST Technology

As electronic medical records became the norm, many groups expressed interest in developing electronic versions of POLST. Providence Health and Services in Oregon worked with the POLST Task Force to create a pilot and was the first to develop an electronic POLST completion system. They used an EPIC Smart Form. Providence worked closely with the Oregon POLST Registry to create a secure electronic submission system.

In April of 2015, OHSU developed a partnership with the Vynca ePOLST system which provides an electronic completion system accessed within Epic with direct submission to the Oregon POLST Registry. To ensure that POLST orders can be accessed with a single click, the "ePOLST Yes/No" tab was included on the patient header (Oregon POLST policy recommendation). The system was designed to facilitate bidirectional communication with the Oregon POLST Registry.



https://www.polst.org



OREGON POLST™

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Statement on Oregon POLST Separation from National POLST

Over the past 25 years, the Physician Orders for Life-Sustaining Treatment, or POLST, program has grown out of concern of honoring patient preferences about care at the close of life (Oregon POLST History). The goal of the Oregon POLST program is to provide a mechanism to ensure that seriously ill persons and their family are able to make informed choices about their care. To preserve public trust, it is important that POLST programs are beyond reproach by not taking money from health care related industries that potentially would suggest a conflict between the goals of the POLST program of promoting patient choice and a focus on cost saving that would benefit industry.

Oregon's POLST program grew into a national model for end-of-life care and many states began seeking assistance in implementing POLST programs in their states. Eventually a national office was formed at OHSU, and then expanded and began operating independently from OHSU in January of 2017.

Oregon POLST learned in early 2017 that National POLST accepted industry funding. This poses an inherent conflict of interest. POLST has never been about cost savings. It has been about allowing patients to choose and document what kind of care they wish to receive when nearing the end of life. This conflict of interest does not reflect our values and compromises the goals of the founders of POLST.

We are saddened to see the direction in which the National POLST program is headed and believe

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National POLST Paradigm
www.polst.org

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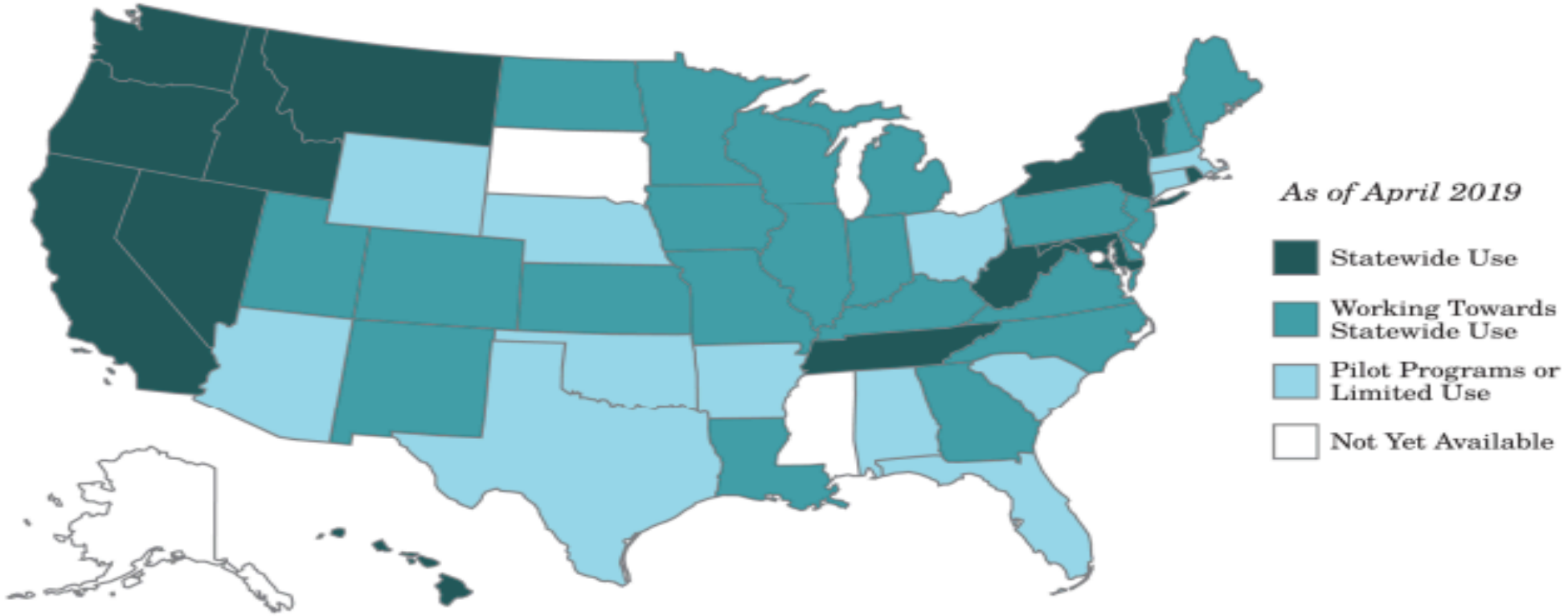
National POLST Paradigm: POLST Use by State

As of April 2019



This map shows the general availability regarding the use of the POLST Paradigm within a state. For this map, POLST Program leaders were asked to use the following definitions and provide their assessment about the level of use of the POLST Paradigm within their state:

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Tark et al, JPM, 2019

POLST maturity status	*Antibiotics* N (%)	*IV fluids* N (%)	*Transfer to hospital* N (%)	*Medication by any route* N (%)	*Oxygen* N (%)	*BiPAP/ CPAP* N (%)	*Intubation/ ventilation* N (%)
POLST maturity status							
Mature	2 (66.67)	3 (100)	3 (100)	3 (100)	3 (100)	3 (100)	3 (100)
Endorsed	14 (73.68)	13 (68.42)	19 (100)	19 (100)	19 (100)	18 (94.74)	18 (94.74)
Developing	14 (70.00)	16 (80.00)	20 (100)	20 (100)	20 (100)	18 (90)	17 (85)
Nonconforming	2 (66.67)	1 (33.33)	3 (100)	3 (100)	3 (100)	3 (100)	3 (100)
Frequency mentioned and locations							
Mentioned once							
Comfort Measures	13 (28.89)	0	0	45 (100)	45 (100)	0	0
Limited treatment	0	28 (62.22)	0	0	0	1 (2.22)	0
Full treatment	15 (33.33)	0	0	0	0	10 (22.22)	36 (80)
Separate section	0	0	4 (8.89)	0	0	0	5 (11.11)
Mentioned twice							
Comfort + limited treatment	3 (6.67)	0	7 (15.56)	0	0	0	0
Limited + full treatment	0	5 (11.11)	0	0	0	26 (57.78)	0
Limited + separate section	1 (2.22)	0	0	0	0	0	0
Full + separate section	0	0	0	0	0	0	0
Mentioned three time							
Comfort + limited + full treatment	0	0	34 (75.56)	0	0	0	0
Limited + full + separate section	0	0	0	0	0	0	0
Total mentioned	32 (71.11)	33 (73.33)	45 (100)	45 (100)	45 (100)	42 (93.33)	41 (91.11)
Not mentioned at all	13 (28.89)	12 (26.67)	0	0	0	3 (6.67)	4 (8.89)
Total	45 (100)	45 (100)	45 (100)	45 (100)	45 (100)	45 (100)	45 (100)

Nugent et al, Amer J Hosp Palliat Med, 2018

Table 3. Logistic Regression Examining Variables Associated With Hospice Enrollment and Location of Death.[a]

Regression Models	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Hospice enrollment		
Stage IV	1.08 (0.45-2.58)	1.01 (0.41-2.49)
Income	2.00 (1.34-2.97)[b]	1.90 (1.27-2.82)[b]
Medical comorbidity	0.99 (0.93-1.07)	0.81 (0.61-1.09)
Functional comorbidity	1.06 (0.94-1.19)	1.26 (0.98-1.62)
POLST registration	2.57 (1.12-5.90)[c]	2.37 (1.01-5.54)[c]
Death inside a VA facility		
Stage IV	1.09 (0.49-2.40)	1.12 (0.50-2.52)
Income	1.03 (0.76-1.42)	1.11 (0.80-1.53)
Medical comorbidity	1.04 (0.98-1.10)	1.03 (0.80-1.33)
Functional comorbidity	1.08 (0.98-1.20)	1.11 (0.89-1.38)
POLST registration	0.27 (0.12-0.59)[b]	0.27 (0.12-0.59)[b]

Abbreviations: CI, confidence interval; OR, odds ratio; POLST, Physician Orders for Life-Sustaining Treatment.

[a] Adjusted models controlled for tumor stage, income, medical comorbidity, and functional comorbidity. Reference group is those without a registered POLST.

Harrison et al, Amer J Emerg Med, 2019

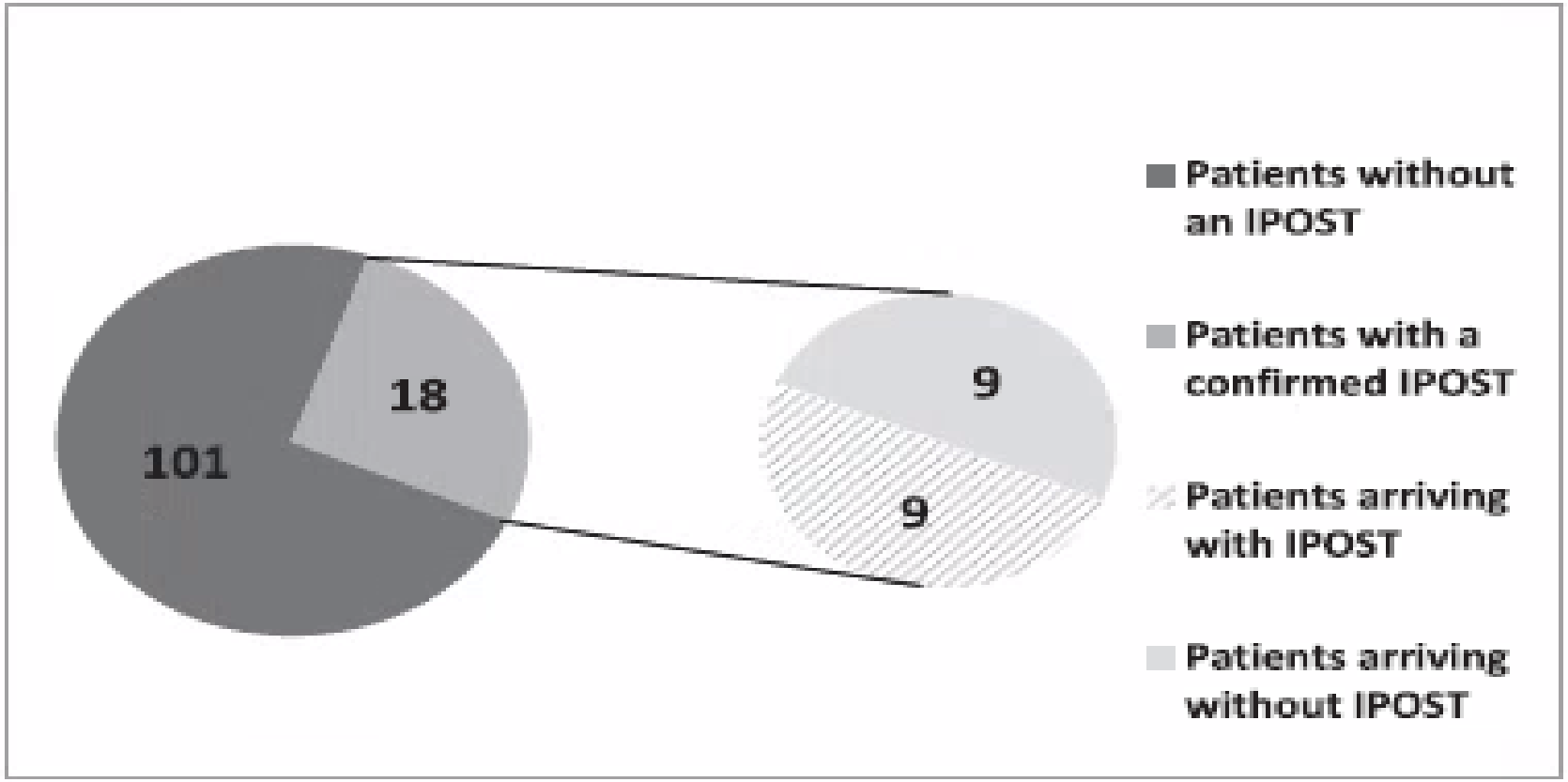
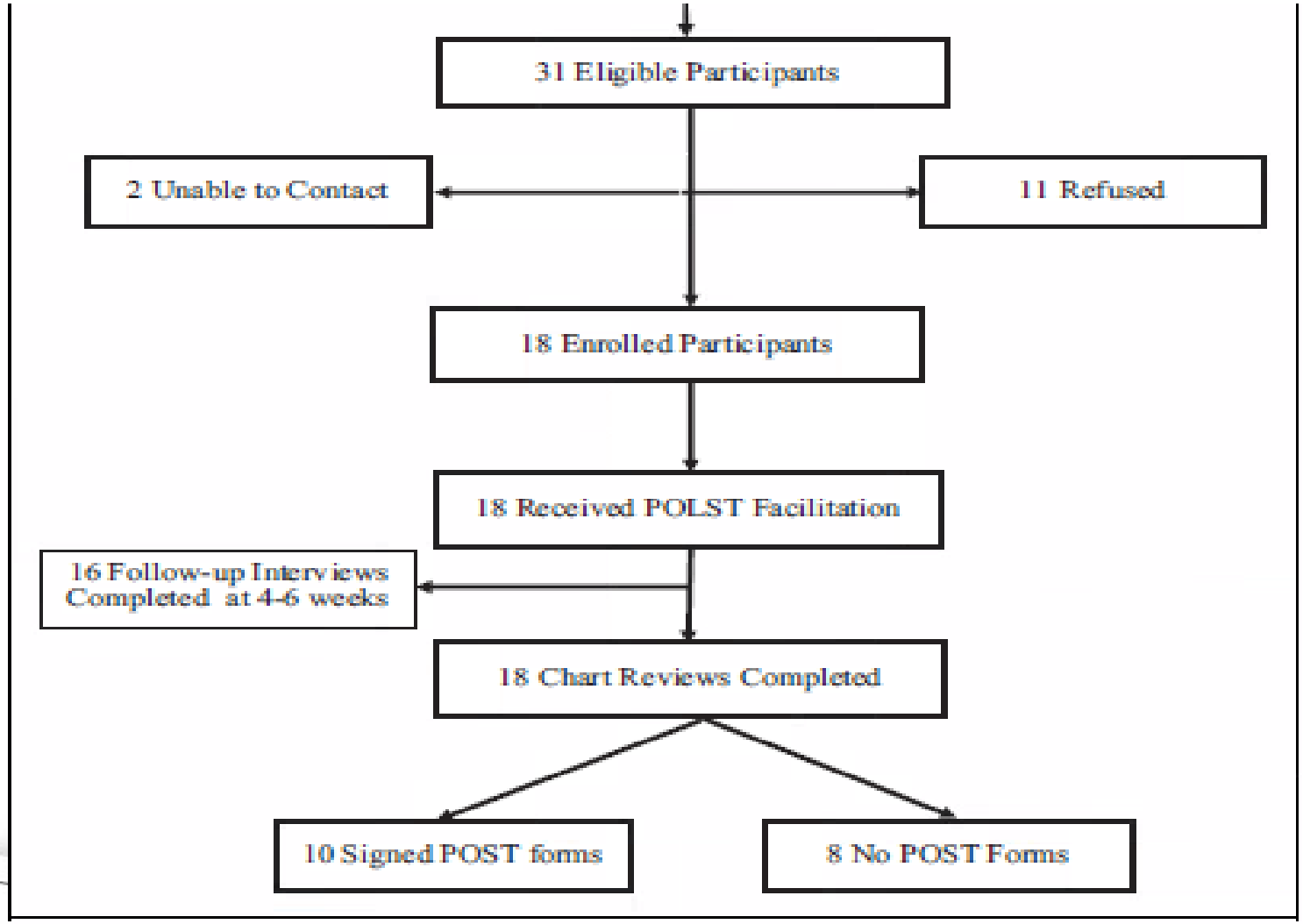


Fig. 1. Incidence of transported IPOSTs. Of the 119 patients included in the prospective arm of the study, 18 patients had a confirmed IPOST and 9 of those patients arrived with a physical IPOST in-hand.

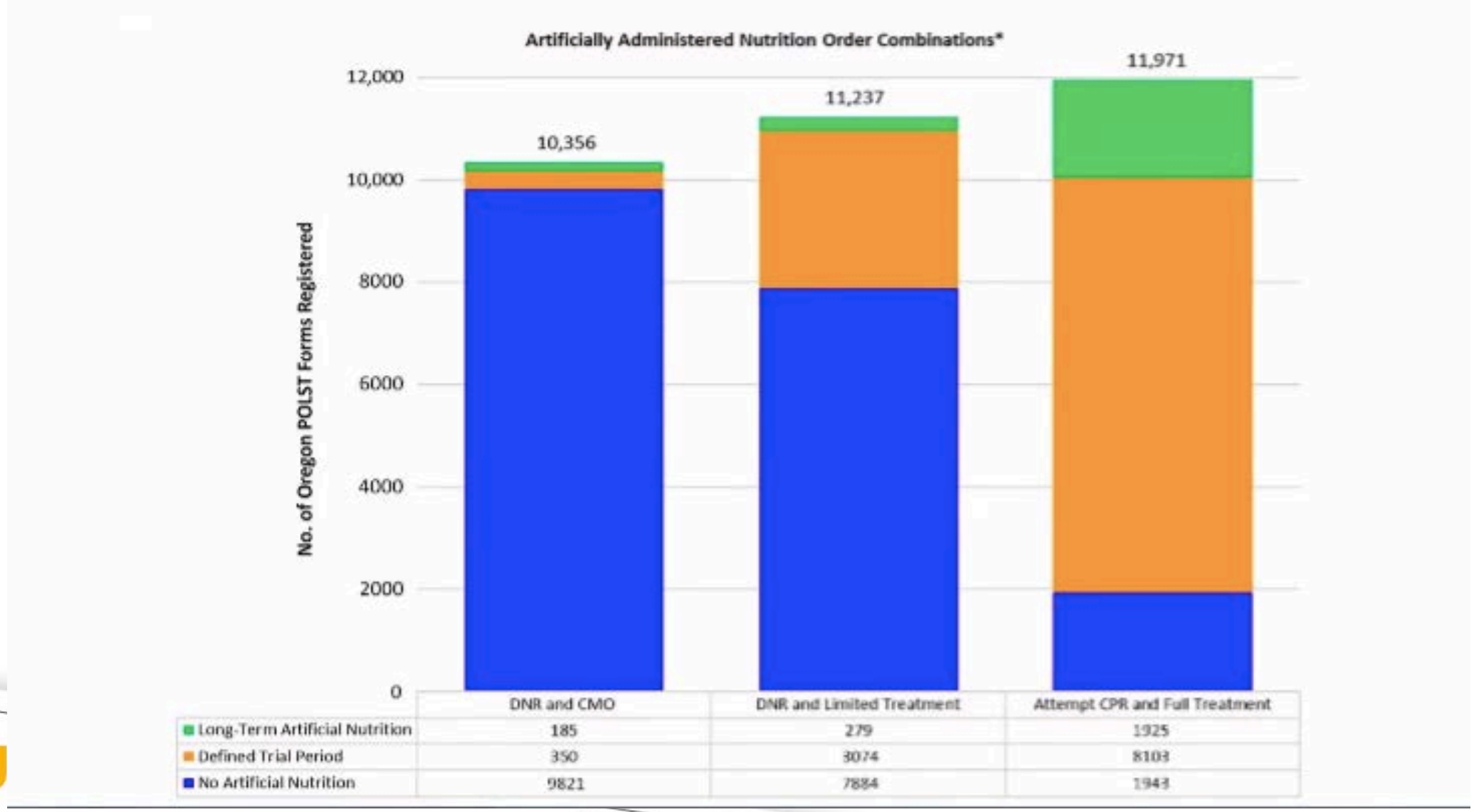
ACEP Ethics Committee, 2018

sures (12). Similarly, patients with cardiac disease admitted for acute coronary syndrome are less aggressively treated and more likely to die (13). Williams et al. report that in the setting of septic shock, patients with DNR documents received lower volumes of fluid resuscitation, were less likely to be intubated, and were less likely to receive a central venous line or early vasopressor therapy (14). Mortality among patients with a DNR document was 65.6%, compared with 6.1% for those without (14). It is not clear to what extent these differences in care and outcome were the result of physicians treating patients in accordance with the patients' wishes, vs. restricting care based on extrapolation of what the patients' wishes might be from a DNR order (for instance, making the decision that because the patient did not want vasopressor support in the context of CPR, assuming the patient would also not want it as a targeted therapy for septic shock). Even decisions concerning patient disposition are influenced by a patient's DNR status, with lower rates of admission to an ICU regardless of a patient's age, Acute Physiology and Chronic Health Evaluation II score, or functional status (15).

Torke et al, Amer J Hosp and Palliat Med, 2018



Tolle et al, JAGS, 2019



Circulation

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ON MY MIND

Extracorporeal Membrane Oxygenation Bridge to No Recovery

Pushing the Limits of Patient and Family Autonomy: When Is Enough Enough?

The concept of mechanical circulatory support has its origins in cardiopulmonary bypass, which allows us to transiently assume the functions of both heart and lungs as we repair critical valves and vessels. It is an elegant sequence of events intended to improve quality of life for our patients.

Teresa A. Mulaikal, MD
Shunichi Nakagawa, MD
Kenneth M. Prager, MD

Treatment limitations in the era of ECMO

Once relegated to the fringes of medicine, the use of extracorporeal membrane oxygenation (ECMO) in adults with severe respiratory or cardiac failure is now increasing at an extraordinary pace.[1] ECMO is perceived by many as life-saving, and this growth is continuing despite a paucity of widely accepted evidence demonstrating benefit.[2] Without such evidence, our obligation to carefully assess the place of this technology in patient care is heightened.[3] In this rapidly evolving area, how do we decide when to offer such high-risk, resource-intensive interventions, and when to withhold or withdraw them?

When making complex medical decisions, we should first decide what our interventions might offer in terms of survival and quality of life. We should then engage with our patients and their surrogates, providing them options within a clinical context while, in turn, they provide us with guidance on their values and goals. Together, we decide which life-sustaining options have the potential to achieve these goals.

On the other hand, CPR could be considered in some patients in whom ECMO would not. The clearest example is the use of ECMO to support the circulation during cardiac arrest, so-called extracorporeal CPR. Circulatory arrest—and therefore circulatory death—might be suspended by the initiation of extracorporeal CPR in an attempt to buy time to reverse the culpable pathology. The provision of conventional CPR, and withholding of extracorporeal CPR, in centres that offer it, is a reasonable approach.

Could a patient have a DNI order but accept extracorporeal CO_2 removal? A scenario we are very likely to confront—one that has already played out in medical literature[8]—is the use of extracorporeal CO_2 removal in patients with acute respiratory failure, in lieu of invasive mechanical ventilation, precisely because the patient has chosen to forgo invasive mechanical ventilation. The promise of extracorporeal CO_2 removal is that it is potentially less invasive and lower risk than ECMO. Yet it is not without risks.[2]

So long as the patient or surrogate decision makers are

Dr Barry Slaboy/Science Photo Library

Published Online
July 10, 2017
http://dx.doi.org/10.1016/S2213-2600(17)30263-1

†Participants listed in the appendix

See Online for appendix

VCU

Let's Discuss!

- We are committed to representing and respecting patient/family wishes—but it's complicated ;)
- Growing body of research around this topic but gaps remain
- Education is a cornerstone—but must be a community effort!
- Access to completed forms across health systems would be ideal…..

Spoke Programs

Survey of POST implementation
in our ECHO Community

Reported Barriers: Education

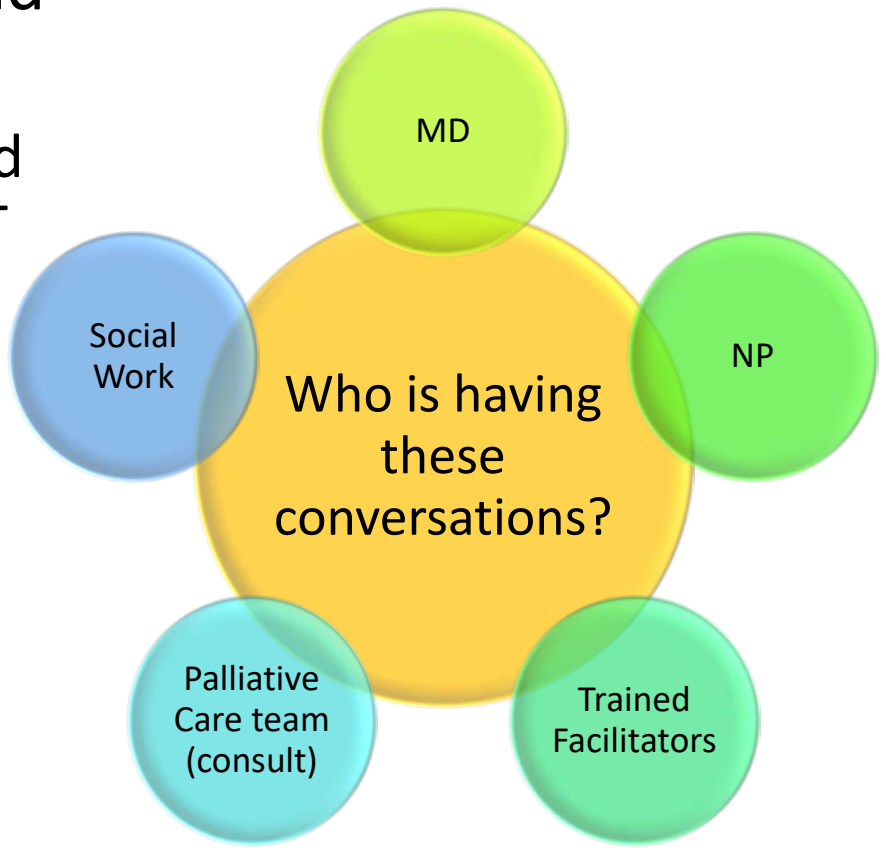
Reported Barriers

"…trying to keep accurate data on how the POST form can help provide goal-concordant care, e.g. for patients who wish to limit future hospitalizations, so that administration can see why the time for these conversations and form completion is important"

"…helped a patient complete a POST, sent him back to the SNF where he resides, I KNOW a copy went with him, however, when he was re-admitted yesterday, the SNF had him listed as FULL CODE (POST indicates DNR) the RN did not know what a POST form was and denied that they had a copy at the SNF."

Conversations, Referrals

- It varies!
- Providers have conversations with patients, and
  - Some providers complete POST forms
  - Some “don’t have time” to complete the forms and request a consult from Palliative to complete POST
- Refer to non-provider
  - POST forms initiated by ACP conversation with facilitators
  - Contact provider to review and sign form

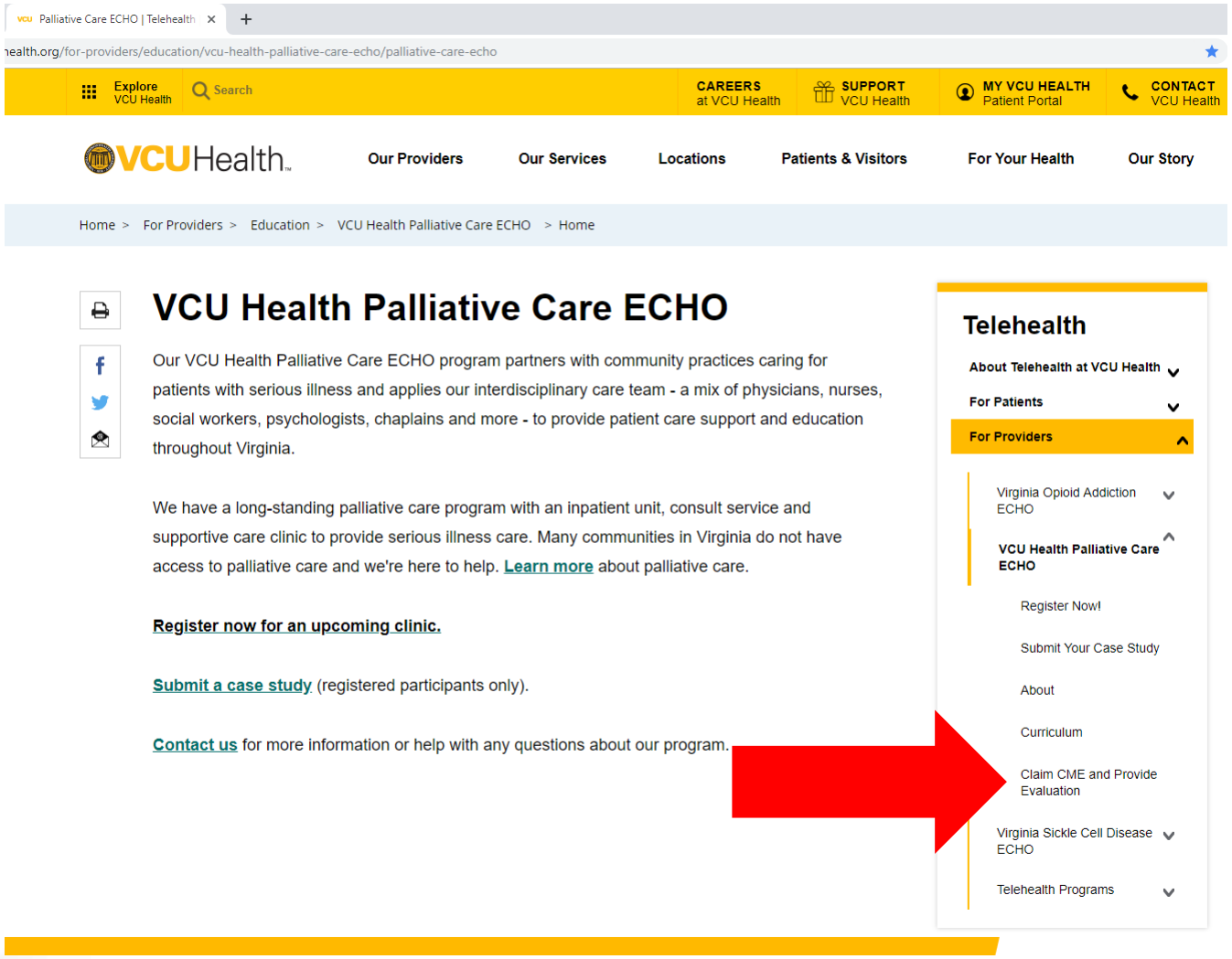


Accessing CME credit

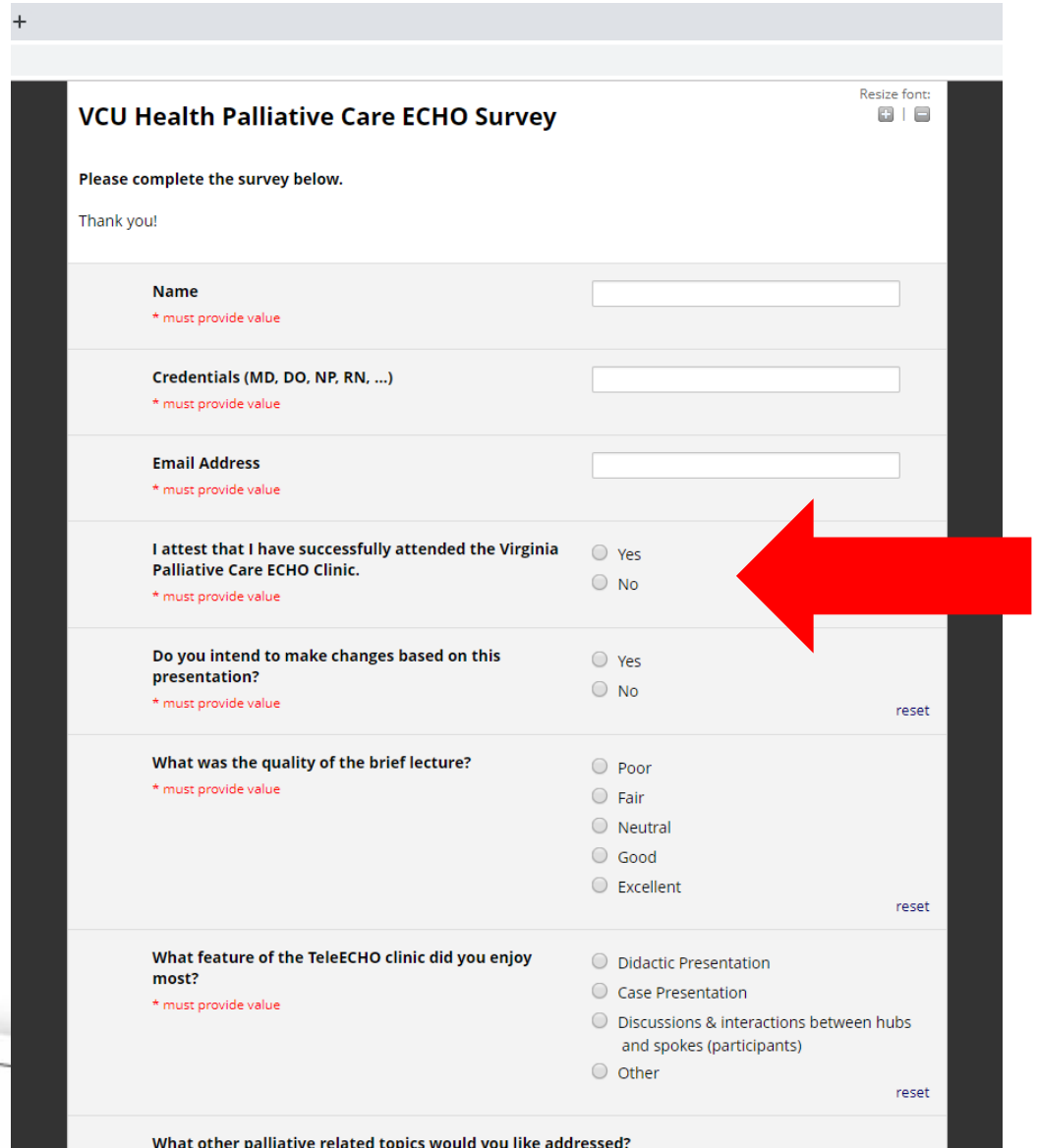
Submit your evaluation to claim your CME

After our live ECHO session, visit www.vcuhealth.org/pcecho

Click “Claim CME and Provide Evaluation”



Submit your evaluation to claim your CME



VCU Health Palliative Care ECHO Survey

Resize font:

Please complete the survey below.

Thank you!

Name
* must provide value

Credentials (MD, DO, NP, RN, ...)
* must provide value

Email Address
* must provide value

I attest that I have successfully attended the Virginia Palliative Care ECHO Clinic.
* must provide value
- Yes
- No

Do you intend to make changes based on this presentation?
* must provide value
- Yes
- No

reset

What was the quality of the brief lecture?
* must provide value
- Poor
- Fair
- Neutral
- Good
- Excellent

reset

What feature of the TeleECHO clinic did you enjoy most?
* must provide value
- Didactic Presentation
- Case Presentation
- Discussions & interactions between hubs and spokes (participants)
- Other

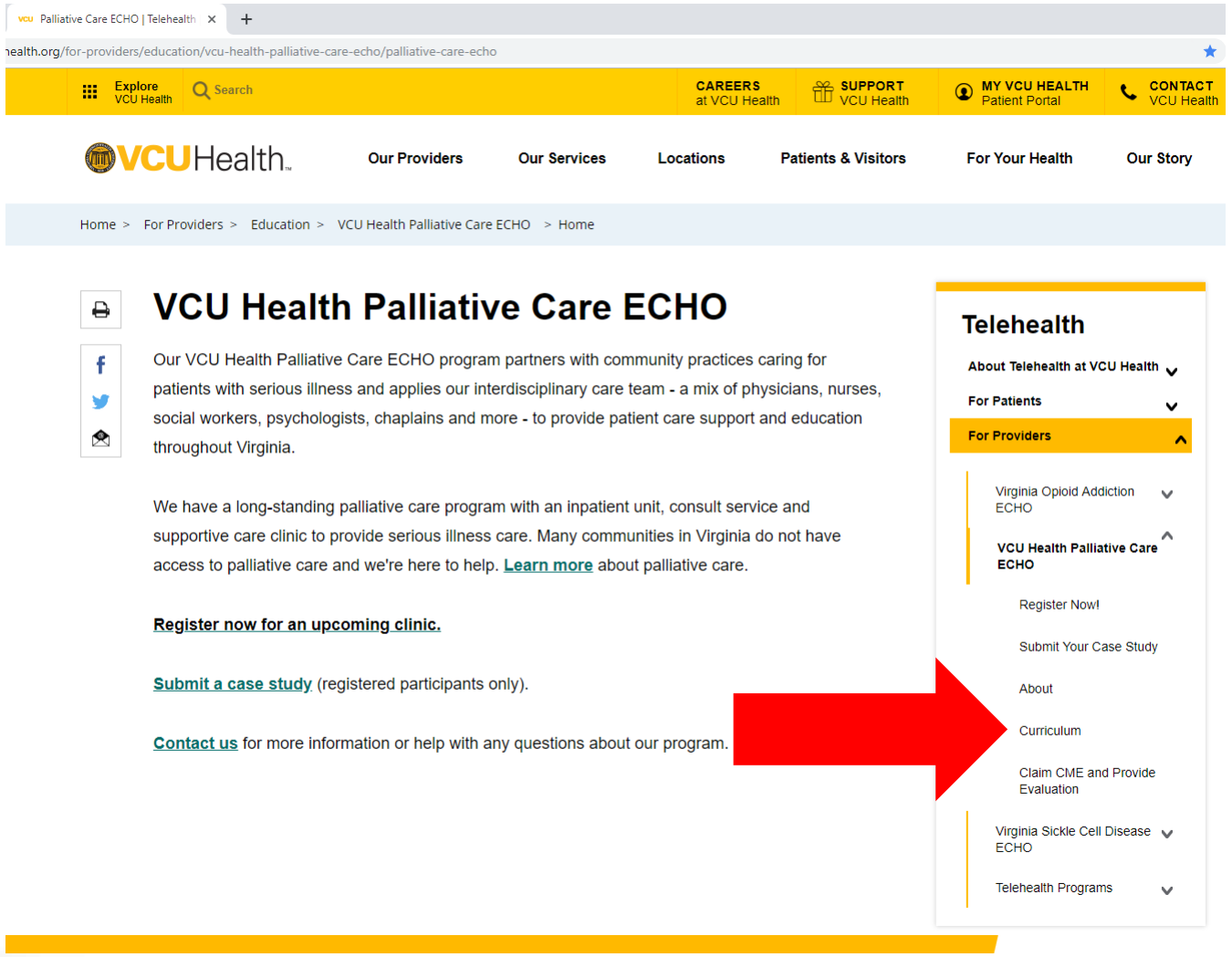
reset

What other palliative related topics would you like addressed?

View previously recorded ECHOs for CME

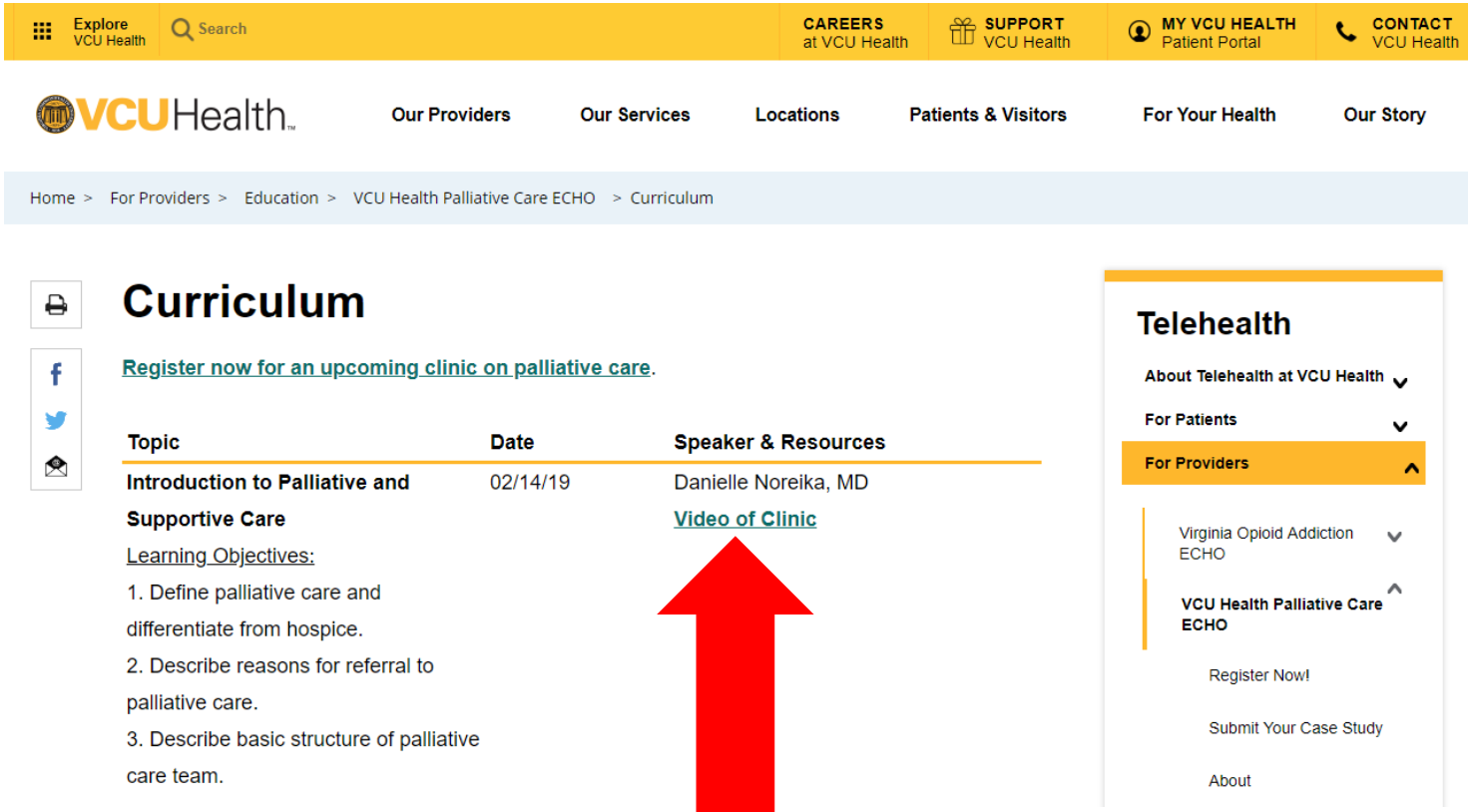
To view previously recorded sessions and claim credit, visit www.vcuhealth.org/pcecho

Click “Curriculum”



View previously recorded ECHOs for CME

Select the session you would like to view



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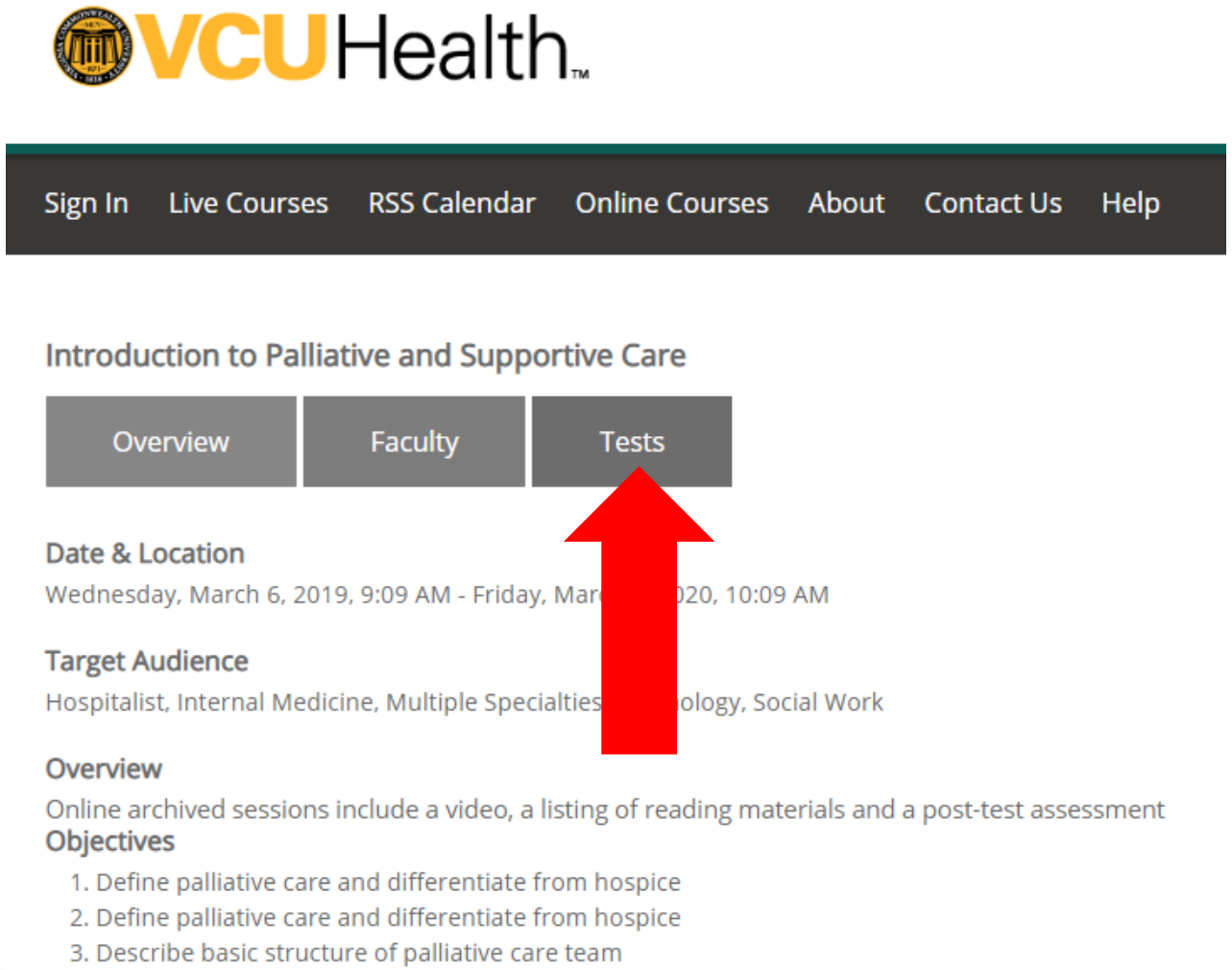
Click “Tests” to view video of the session and take a short quiz for continuing education credit



THANK YOU!

We hope to see you at our next ECHO