Arizona Provider Orders for Life Sustaining Treatment Overview

Provided by:
Arizona Hospital & Healthcare Association
Disclosures

• I have no financial relationships to disclose.
Goals

• Provide an introduction on the National POLST Paradigm and Arizona Provider Orders for Life Sustaining Treatment (AzPOLST)
• Describe how AzPOLST works with current Arizona statutes and documents for advance care planning
• Define the population for AzPOLST and review the form elements and process
• Discuss POLST/AzPOLST resources
The National POLST Paradigm
Federal Law
What is Arizona Provider Orders for Life Sustaining Treatment (AzPOLST)?

• A medical order that is recognized throughout the medical system
• Portable document that transfers with the patient
• Brightly colored, standardized form for the entire state of Arizona
Fundamentals of POLST

• A process designed to improve patient care by creating a system using a portable medical order form (aka “AzPOLST” form) that records patients’ wishes.

• Used across settings of care

• Only used by individuals with a serious illness or frailty toward the end of life

• Always voluntary

• Starts with a conversation
  – Values, beliefs, goals of care, diagnosis, prognosis, treatment options (benefits and burdens)

• National POLST Paradigm

• Each state develops their own program
POLST in Arizona

- Arizona Hospital & Healthcare Association is the lead agency
- Grassroots efforts of local clinicians via task force since 2005
- Started with pilot project in Flagstaff (Phase I from 2015-2016, Phase II from Jan 2017-June 2018)
Barriers & Pathways to Implementation

**Barriers**

- **Standard of Care Approach**
  - No legislation
- **Current Law**
  - **ARS 36-3209B**, Notwithstanding any other law, if there is a conflict between a provision of a valid health care directive, the decision of a patient's agent pursuant to a valid health care power of attorney or the decision of a surrogate decision maker pursuant to section 36-3231 and a health care provider's order, including an order regarding life-sustaining treatment or a similar document, the health care directive, the decision of the patient's agent or the decision of the surrogate decision maker is presumed to represent the decision of the patient.

**Pathways**

- Plans for AzPOLST legislation in 2019
- Education on AzPOLST across the continuum of care for all healthcare providers
- Update Advance Directive at the same time POLST form completed
  - Add statement requesting AzPOLST form be attached and honored
- AzPOLST Memo to Pilots providing guidance.
AzPOLST Pilot: Flagstaff Medical Center

Phase I: 2015 - 2016

• Hospitalized patients with CHF, stage C or D
• Of 82 patients discussed with, 66 completed (80%)
• 65% of patients with POLST received a palliative care consult at the time of POLST initiation
• Communication follow up via phone
  – 89 f/u phone calls
  – 15% felt it helped communication
• No difference in POLST with Native American Indians; all ethnicities have high conversion
  – 28% Navajo

Phase II: 1/1/17 – 6/30/18

• All hospitalized patients meeting criteria
• 72 AzPOLST completed
  – 35% of those eligible
  – Declinations due to patient incapable of signing, surrogate not available
  – 34% chose not to participate
• American Native Indian
  • 32% of AzPOLST completed
• Code Status
  – 60% changed their code status
    • Some decreased and some increased interventions
• Learning: The conversation is important and helps people get the care they want.
Why do we need POLST?
# GAPS

## Advance Directives
- Can be vague, open to interpretation
- Can be completed...
  - Long ago, before illness
  - Without considering goals of care
  - Without discussion about risk and benefits of specific treatments
- Not orders

## Surrogates
- Often don’t know patient’s preferences
- May not agree
- Find life sustaining treatment decisions emotionally difficult
A key recommendation is to “encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements.”
Max’s Story
POLST Program Names

In Arizona we chose AzPOLST (Arizona Provider Orders for Life Sustaining Treatment) to align with National POLST Paradigm.
Arizona is a “Developing” Program

Current Status of POLST in the US
- 3 states deemed “mature”
- 23 states are deemed “endorsed”
- 24 states are deemed “developing”
  - Arizona is a developing state
- 4 states are non-conforming
  - Maryland mandates completion of POLST forms for certain patients
  - Massachusetts & Vermont – form does not follow standards, lack structure, clarity and is confusing
  - Nebraska has no single form

*Oregon has separated from National POLST due to operational differences
## How is AzPOLST Different than an Advanced Directive?

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>POLST</th>
<th>Advance Directives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>For the seriously ill</td>
<td>All adults (18+)</td>
</tr>
<tr>
<td>Time frame</td>
<td>Current care</td>
<td>Future care</td>
</tr>
<tr>
<td>Who completes the form</td>
<td>Healthcare professionals with patient</td>
<td>Patients</td>
</tr>
<tr>
<td>Resulting form</td>
<td>Medical orders (AzPOLST)</td>
<td>Advance directive (Legal)</td>
</tr>
<tr>
<td>HC Agent or Surrogate Role</td>
<td>Can engage in discussion if patient lacks capacity</td>
<td>Cannot complete</td>
</tr>
<tr>
<td>Appoints surrogate</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Portability</td>
<td>Provider responsibility</td>
<td>Patient/family responsibility</td>
</tr>
<tr>
<td>Periodic Review &amp; Updating</td>
<td>Provider responsibility: periodically and when there is a change in the patient’s condition</td>
<td>Patient/family responsibility</td>
</tr>
<tr>
<td>Who Signs</td>
<td>Patient &amp; Provider</td>
<td>Living Will – patient MPOA-pt;witness/notary</td>
</tr>
</tbody>
</table>
### How is POLST Different than Pre-Hospital Medical Care Directive?

<table>
<thead>
<tr>
<th>AzPOLST</th>
<th>Pre-Hospital Medical Care Directive</th>
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<tbody>
<tr>
<td>Allows for choosing resuscitation</td>
<td>Can only use if choosing DNR</td>
</tr>
<tr>
<td>Allows for other medical treatments</td>
<td>Only applies to resuscitation (in the event of cardiac or respiratory arrest)</td>
</tr>
<tr>
<td>• Full treatment</td>
<td></td>
</tr>
<tr>
<td>• Selective Additional Interventions</td>
<td></td>
</tr>
<tr>
<td>• Comfort Measures (AND)</td>
<td></td>
</tr>
<tr>
<td>• Medically Assisted Nutrition</td>
<td></td>
</tr>
<tr>
<td>Honored across all healthcare settings</td>
<td>Only honored outside the hospital (EMS focus)</td>
</tr>
<tr>
<td>Not currently in legislation in Arizona</td>
<td>Currently in Legislation</td>
</tr>
<tr>
<td>• Must be on orange form</td>
<td></td>
</tr>
<tr>
<td>Requires conversation on prognosis, treatment goals of care with provider and patient</td>
<td>Completed by physician, patient and witness</td>
</tr>
<tr>
<td>Signed by patient and provider</td>
<td>Signed by patient, witness &amp; provider</td>
</tr>
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How An Advance Directive and AzPOLST Form Work Together

- All Adults
  - Complete an Advance Directive
    - Update Advance Directive Periodically
      - Diagnosed with Advanced Illness or Frailty (at any age)
        - Complete AzPOLST FORM
          - Update AzPOLST as Health Status Changes
            - Treatment Wishes Honored

Thoughtful Life Conversations

Arizona Provider Orders for Life-Sustaining Treatment (AzPOLST)
Advance Care Planning Process

18+, Healthy
- Identify Health Care Proxy (HCP)
- Conversation about care preferences

Seriously Ill
- Diagnosis of Serious or Chronic Illness(es)
- Progression of Serious or Chronic Illness(es)
- Have Serious Illness Conversation
- Begin MOST / POLST Conversations

Crises & Decline
- Condition worsening
- Revisit Serious Illness Conversation (POLST)
- Goals of Care Discussion (If clinical decision)

End of Life
- Poor Prognosis
- Revisit Serious Illness Conversation / Goals of Care Discussion
- Revisit POLST

Advance Directive
- Planning for future care

POLST
Serious Illness Conversations begin - planning in the context of progression of serious illness
Goals of Care Discussion = Decision making in context of clinical progression/crisis/poor prognosis

Thoughtful Life Conversations
Serious Illness Care Program, Ariadne Labs

AzPOLST
Arizona Provider Orders for the Seriously Ill or Dying

Prognosis:
- 1-2 Years
- Weeks to Months
Intended AzPOLST Population

Would I be surprised if this patient died within the next year?
Population Questions

• Not just if a patient turns 65 or enters into a facility
• Can be used in pediatric populations (unless specified in statute, CO)
• For patients with significant disabilities, need to ask:
  – Does this person have a disease process (not just their stable disability) that is terminal?
  – Is the person experiencing a significant decline in health (such as frequent aspiration pneumonias)?
  – Is the person in a palliative care or hospice program?
  – Is the disease at a point where intervention will not significantly impact the process of decline?
AzPOLST Form Elements
HIPAA PERMITS DISCLOSURE TO HEALTHCARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Arizona Provider Orders for Life-Sustaining Treatment (AzPOLST)

Follow these orders until orders change. These medical orders are based on the patient’s current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name:  Patient First Name:  Middle Int.:  
Date of Birth: (mm/dd/yyyy)  Gender:  M  F  Last 4 of SS#:  
Address: (street / city / state / zip)

A
CAR Di O MARY RESUSCITATION (CPR): Patient is not breathing and has no pulse.

☐ Attempt Resuscitation/CPR
☐ Do Not Attempt Resuscitation (DNR/Allow Natural Death) Provide physical comfort, emotional and respectful spiritual support to patient and family.
☐ Pre-Hospital Medical Care Directive Form completed (Orange form)
When not in cardiopulmonary arrest, follow orders in B and C.

B
MEDICAL INTERVENTIONS: Patient is breathing and has a pulse.

☐ Full Treatment: In addition to treatment described in Comfort Measures Treatment and Selective Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: Full treatment, including life support measures.
☐ Selective Additional Interventions: In addition to treatment described in Comfort Measures Treatment, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Treatment Plan: Provide basic medical treatments.

C
MEDICALLY ASSISTED NUTRITION: Offer food and fluid by mouth if feasible.

☐ Medically assisted nutrition  Specify type and duration:  
☐ No medically assisted nutrition

D
DOCUMENTATION OF DISCUSSION:

☐ Patient (Patient has capacity)  ☐ Surrogate under Healthcare Power of Attorney
☐ Parent of minor  ☐ A legally recognized surrogate under A.R.S. §36-3231.
☐ Court-appointed guardian  ☐ Others in attendance

E
SIGNATURE OF PATIENT/SURROGATES AND HEALTHCARE PROVIDERS

Signature of Patient or Surrogate required: By signing below, I agree that this form accurately reflects my personal treatment preferences, or if surrogate, the patient’s personal preferences, for medical treatment and life-prolonging measures. This form hereby revokes any prior or inconsistent wishes regarding future treatment and advance directives.

Patient or Surrogate Signature (signature required):

Name (Print):  Relationship:  Phone Number:  
Signature of Healthcare Providers: By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient’s current medical condition and preferences.

Physician/NP/PA Signature (required):  Phone Number:  Date/Time (required):  
Physician/NP/PA Name (Print):  Signer License Number:  
PA’s Supervising Physician Signature (if applicable)

Preparer Signature (required if not signing MD/NP/PA):  Preparer Name and Title (Print):  Phone Number:  

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED.
**CARDIOPULMONARY RESUSCITATION (CPR):** Patient is not breathing and has no pulse.

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- **Attempt Resuscitation/CPR**
- **Do Not Attempt Resuscitation (DNR/Allow Natural Death)** Provide physical comfort, emotional and respectful spiritual support to patient and family.
- Pre-Hospital Medical Care Directive Form completed (Orange form)

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<td>☐ <strong>Comfort Measures Treatment (Allow Natural Death):</strong> Relieve pain and suffering through the use of any medication by any route, positioning, -and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. <em>Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.</em> <strong>Treatment Plan:</strong> Maximize comfort through symptom management.</td>
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**Additional Orders:**
How Does AzPOLST Work?
How Does AzPOLST Work?

Conversation with the patient’s health care professional (HCP)

• Diagnosis
• Prognosis
• Available treatment options
  – Benefits and burdens of each
• Patient goals of care, values
AzPOLST Forms are Dynamic
Review of AzPOLST Forms

- AzPOLST Forms should be reviewed:
  - During appointment with health care professionals
  - During changes in level of care
  - Changes in location of care (upon admission and discharge)
  - Changes in patient’s goals of care, treatment preferences or what constitutes a acceptable quality of life
CHANGING HEALTH STATUS

- Full Treatment
- Selected Additional Interventions
- Comfort Measures Only

VOID
Flow of Emergency Care
Standard of Care
Flow of Emergency Care
AzPOLST Form
Things to Remember

• AzPOLST Form completion is **VOLUNTARY**!
• AzPOLST Forms can be changed or revoked at **ANYTIME**
• AzPOLST Forms are about **TREATMENT** wishes
  – Comfort Measures are **ALWAYS** provided
    (treatments aren’t patient wishes honored)
• AzPOLST Forms are signed by health care professionals after a conversation
Value of AzPOLST
Lee’s Story
Patient’s preferences as medical orders on a POLST form and how those orders match with death in the hospital

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JAGS: Fromme et al 2014 62L1246-1251
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JAGS: Fromme et al 2014 6211246
Vision and Mission

Our vision is for all states to have adopted the POLST Paradigm, resulting in consistency of process, improved patient care and greater patient control and direction over medical treatment. Our mission is to advance the POLST Paradigm through stewardship, education, advocacy, support for POLST Paradigm program efforts and national leadership.
Arizona Provider Orders for Life-Sustaining Treatment

Arizona Provider Orders for Life-Sustaining Treatment (AzPOLST) is part of The National POLST Paradigm that helps patients get the medical treatments they want, and avoid medical treatments they do not want, when they are seriously ill or frail. It’s about helping people live the way they want until they die.

AzPOLST encourages patients and their healthcare professionals to talk about what patients want at the end of life. The conversation should include:

- Diagnosis: The disease(s) or medical conditions the patient has.
- Prognosis: What is the likely course of the disease or condition? What will happen to the patient over time.
- Treatment Options: What treatments are available to the patient? How do they help? What are the side effects?
- Goals of Care: What is important to the patient? What gives their life meaning and what makes for a good quality of life?

After talking, the patient and healthcare provider may be able to make informed shared...
Care Continuum Toolkit

• Goal: help facilities implement appropriate POLST processes that support the patient through transitions of care

• Comprehensive Overview of POLST
• 5 chapters focused on these different health care settings
• Resources for implementation (Example policies, FAQ’s, best practices)
Using the Care Continuum Toolkit

• Developed by National POLST Paradigm
• Read the overview first
• Chapters
  – Written by and focused on professionals in those facilities and areas of specialty
• Tailor your facilities work with AzPOLST
  – Connect with Arizona specific resources you can use/incorporate
  – Understand Arizona laws relative to surrogate/proxies and AzPOLST
Resources:

https://www.AzPOLST.org

www.thoughtfullifeconversations.org

www.polst.org
Thank You!

If you have any questions or comments, please contact Sandy Severson sseverson@azhha.org