January 2010

IPOST

The report of the Patient Autonomy in Health Care Decisions Pilot Project

Iowa Physician Orders for Scope of Treatment (IPOST) pilot project began in Cedar Rapids in late 2008 as a result of legislative language included in HF 2539. This is a report of the Cedar Rapids pilot and of the deliberations of the State Advisory Council convened to hear the pilot report and deliberate directions for Iowa.

Abstract

In modern health care systems it is difficult to ensure that a patient's end-of-life treatment choices are communicated and honored from one health care setting to another. To address this complex issue, Mercy Medical Center and St. Luke's Hospital in Cedar Rapids have collaborated to improve system-wide communication for both chronically ill and frail elderly populations. As a result of their three-year initiative, a communication tool called the Iowa Physician Orders for Scope of Treatment (IPOST) was developed based on the National Physician Order for Life-Sustaining Treatment (POLST) Paradigm. This tool facilitates a consistent process in which treatment choices are based on patient/family discussions and are documented, communicated and honored across different health care settings. The standardized form acknowledges a patient's advance directives and creates a portable and actionable set of medical treatment orders. In collaboration with a physician/nurse practitioner, a trained health care professional may assist the patient/family in conversations that build an understanding of a patient's values and goals of care. Their IPOST form is then completed which will help ensure the patients' treatment wishes are met across all of their health care settings

A 2008 Iowa Legislative House File (# 2539) authorized a Cedar Rapids IPOST pilot project to run from May 2008 through December 2009. The legislation also called for a report to the Governor and the Iowa Legislature in January 2010. The Cedar Rapids pilot continues though delayed in starting because of the June 2008 flooding. This report captures the last 10 months of the pilot and the recommendations of the local committee in fulfilling the legislative requirement.

The legislation directed the Iowa Department of Public Health to convene an advisory council to hear the results of the local pilot and to make recommendations to the governor and Iowa Legislature. The IPOST Advisory Committee was created, convened, and discussed the issues and the Cedar Rapids Pilot Project. **Their recommendations are:**

1. Continue the current pilot for another two years.
2. Expand the pilot project into a rural county.
3. Continue data analysis including pilot medical chart reviews and expand analysis to include health care providers, patient, and family surveys.
4. Provide assistance for the community pilot in the statewide education and outreach activities from The Iowa Department of Public Health.
5. Affiliate with organizations (including but not limited to local public health departments) to establish partnerships and enhance funding opportunities for replication of the IPOST pilot.

(Complete recommendation statements are found on page 13.)

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Iowa Physician Orders for Scope of Treatment

Background

The IPOST is based on the national POLST (Physician Order for Life-Sustaining Treatment) paradigm program. The National POLST paradigm's foundation is a tool that facilitates a consistent process in which treatment choices are based on patient/family discussions and are documented, communicated and honored across different health care settings.

The POLST Movement began in Oregon in 1991 as a mechanism to assure that patient end-of-life health care wishes were being honored from one health care setting to another. Medical ethics leaders initially recognized that patient choices regarding life sustaining treatments were not being honored. Patients were subject to treatment they did not want, or, conversely, they did not get the treatment they did want – the decisions were not theirs. Through ongoing education, research and a state-wide experience-based quality improvement process, the POLST form was released for use in 1995. The program is now widely used in several states, and the name varies by state, but all programs share the following key POLST concepts:

- Ensures that treatment choices are honored in the event that a patient/resident is unable to speak for him or herself.
- Converts treatment choices into medical orders with a standardized, clearly identifiable form.
- Designed for individuals with serious or life threatening illness, including the frail and elderly.
- Portable across treatment settings.

The POLST form is recognized as a set of medical orders, to be implemented with the same procedures as all medical orders (www.POLST.org). The form transfers with the patient and clearly identifies the level of treatment the patient wants to receive.

There are four POLST categories that all forms share in order to follow and be consistent with national task force recommendations.

- Section A indicates whether the patient desires resuscitation or a "do not-resuscitate" (DNR) order.
- Section B reflects the degree of aggressiveness with regard to medical intervention that is desired by the patient (full treatment to comfort measures).

- Section C documents whether antibiotics are wanted either for comfort or aggressive treatment (differs state to state).
- Section D shares the wishes regarding artificial nutrition and hydration (differs state to state).

IPOST differs slightly from the POLST form: Antibiotics and hydration are included in section B of IPOST form (see IPOST form in appendix).

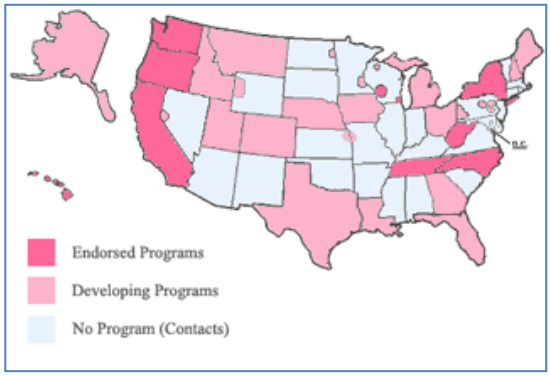
POLST Outcomes

Review of the original research suggests POLST was successful in ensuring that nursing facility residents do not receive unwanted life-sustaining treatments. Oregon was a leader in conducting research in nursing facilities. In one study in which 50% of the residents had a POLST form, 90% of physician orders were followed, and thus patient choices were honored. A second study showed Oregon-care matched POLST order instructions in 91% of those reviewed. POLST research data proves POLST is not just another form documenting a DNR order[i].

- Many patients endorsed different combinations of treatment choices (not just the minimum or maximum level of care)
- The majority of patients in the two studies (77% and 78% respectively) who chose DNR also documented a preference for life sustaining treatment in at least one other category such as antibiotics or hospitalization.
- Of the patients who chose resuscitation, 47% documented preferences for less than the highest level of treatment in at least one other category.

A three-state study published in *Caring for the Ages*: April 2009[ii] provided the following data on the efficacy of the POLST form as a tool to communicate a patient's advance directives in an actionable medical order. The POLST program:

- Boosts advance directive (AD) compliance.
- Creates significantly more medical orders about life sustaining treatment than with traditional AD's.
- Documents treatment orders after a wide range of treatment options are discussed.
- Overcomes vagueness often associated with advance directives: ("Do not resuscitate" does not equate "do not treat")



The National Movement

In May 2008, Iowa was recognized as a developing program by the National POLST Paradigm. This is the important first step in

becoming an endorsed program. The POLST National Task Force has assisted seven (7) states in the United States with full endorsement and there are currently 15 states (including Iowa) in the developmental phases. Thirty-three states currently work on the POLST form at some level.

At the national level, Congressman Earl Blumenauer introduced a bill in the 111th Congress first session; 110H7187 – Amends Title XVIII of Social Security Act. The act is cited as the "Life Sustaining Treatment Preferences Act of 2009". This act serves as a complement to advance directives and provides a process to communicate individual preferences. It also incorporates the key elements of POLST. (See the appendix for a copy of this act) This act is significant because:

- It avoids poor communication about preferences for care at the end of life that can cause distress for both patients and their families.
- It supports compliance with patient wishes because without this medical order, emergency personnel may be required to provide treatments that may not be consistent with the individual's preferences.

Benefit Analysis

A Dartmouth Atlas Project has shown that Medicare spends significantly more in some geographic regions than in others on dying patients – sometimes almost twice as much. Medicare beneficiaries account for about 70% of all deaths each year. While only 5% of Medicare patients die each year, the program spends nearly 30% of its annual budget ($143 Billion in 2009) on providing care for this population. On average, Medicare spends $25,000 per patient in his or her last year of life as compared to an average of $4,000 per enrollees who do not die. The utilization of high levels of health care resources for a person in their last year of life is warranted, especially if it results in an increased chance of survival and positive outcomes. The challenge is trying to estimate the point at which further treatment simply will not make a difference. There is evidence that as a society we tend to over-treat individuals at the end of their lives, in part, due to lack of advance care planning.

Geographic Disparity

The documented geographic differences in end-of-life care speak to the community culture and resources that are most important for support of patient's wishes -- and family support for care given in their homes. For example, in LaCrosse, Wisconsin where a strong advance care planning program has been in place for almost fifteen years and 90% percent of those who die have end-of-life documents, the extraordinary end of life treatment is minimized. Measuring the cost of care at the end of life is one

mechanism to compare communities and cultures. In La Crosse, the Medicare average cost for the last two years of life is $18,359 as compared with a national average of $25,860. The end-of-life decision-making program's purpose is not to save money; it is to make sure doctors and families know how people want to be treated. The program saves money because most people, when their goals are clarified, may choose less aggressive treatment in their last year of life.

IPOST

The Iowa Pilot was envisioned by a core group of Cedar Rapids professionals who developed a local coalition to implement their Iowa Physician Orders for Scope of Treatment (IPOST) project. They developed and piloted the use of their form based on the Oregon POLST form which is similar to those used across the country. The IPOST project has been successful though delayed in its initiation. House File 2539 was passed on May 13, 2008 for a two year time frame, and, in June, the flood hit and devastated a large part of the city. The coalition implemented the pilot on February 23, 2009 and so this report represents a ten-month time frame. The IPOST is the first such project nationally to be authorized legislatively.

Formation of IPOST Idea

Initially, a focus group of health care providers including physicians, palliative care and hospice teams, social work, spiritual care, hospital administration, emergency management and nursing care facility administration was formed. The goal of this group was to evaluate the need in Linn County for a communication system that is both portable across health care settings and more accurately reflects patients' health care treatment choices. From that group, a community advisory board was formed to guide the process. The advisory board evolved and grew into the Linn County IPOST Community Coalition for the implementation phase of the project.

The community coalition drew its membership from a broad array of disciplines including physicians, attorneys, ethicists, evaluation experts, institutional administrators, public health and community members. This diverse membership allowed comprehensive, in-depth conversations about not just the processes to be employed in implementation, but also about the impact on people and families and the community as a result of the work. Through complex challenges, strong collaboration promoted the creation and development of effective processes and procedures. This broadly skilled set of professionals was able to develop a replicatable program to guide future community projects.

The mission of the Linn County IPOST Coalition is to create a system to honor the healthcare treatment choices of individuals through improved communication across the healthcare continuum and to promote community engagement in advance care planning.

A gap analysis identified the following critical gaps in the Out of Hospital "Do Not Resuscitate" process.

- The Out Of Hospital Do Not Resuscitate (OOH-DNR) order applies only to individuals who have a terminal condition (one year or less of life if the disease runs its normal course).
- The OOH-DNR order cannot be used in facilities.
- The OOH-DNR does not meet the needs of the frail and elderly that are not terminal.
- Medical orders do not cross the health care continuum. If a person requests a DNR status while living in a long term care facility, this order must be replicated in acute care facilities when the person transfers to that setting.
- Advance directives lack specificity to direct the health care providers regarding patient's treatment choices.

These gaps result in fragmented communication systems related to a person's treatment choices.

Respecting Choices

Consultation, training and support came from Respecting Choices in La Crosse, Wisconsin. Respecting Choices is an internationally recognized clinical approach to advanced care planning which, where effectively implemented, results in a person's treatment choices being known and honored. It brings to POLST a training approach that prepares a health care professional to have compassionate, effective interactions with patients and their families, so that when they complete the POLST form, they do so with full understanding and informed consent.

Respecting Choices is the second oldest POLST program in the country (first implemented in the region in early 1990s). It is used in over 80 communities or

regions in the US, is the standard of care in Australia, and is being used in several parts of Canada, as well as being implemented in Singapore, Germany and Spain. The Respecting Choices program has a curriculum which trains and certifies other health care professionals to assist the physicians in having these vital conversations with persons about their preferences for treatment. The physicians and other health care professionals are taught how to "facilitate" the conversation rather than to give advice on options. This systematic training allows a consistent, quality approach to end-of-life care planning.

The IPOST pilot project engaged Respecting Choices for the following services:

- a one-day consultation in October 2009 for $1,300.00 to provide guidance in establishing the pilot,
- a two-day POLST facilitator and instructor (train the trainer format) certification course was purchased for $9,250.00 + travel expenses. This training occurred January 20 - 21, 2009 and included a total of 35 persons.
- Ongoing feedback in collaboration with the National POLST task force.

Development of IPOST Form

Individual states are allowed to alter Oregon's POLST form to meet the needs of their state/communities as long as it contains the core components. The community coalition members worked to adapt the form for the unique needs of Iowans. The form was named the Iowa Physician's Order for Scope of Treatment to reflect its function and the mission of the coalition. The group used evidence-based practice models through the national recommendations on issues applicable to a physician's order. For example, the national organization recommends that choices regarding antibiotic treatment be excluded from the form; therefore, this section is not on the IPOST. The group also modified the form to reflect the legislative language by including a check on whether an advance directives document had also been completed.

Engagement and Training

Under the direction of the legislative language, contact was made with all entities that were included in the pilot project. These entities included:

- residential and long term care facilities
- hospice programs
- emergency medical systems (EMS)
- acute care hospitals

A specific training curriculum, based on the Respecting Choices resources, is used to prepare the people who facilitate these conversations and complete the form. Respecting Choices is used as the community model for the training because of its quality and consistency. This allows for the possibility of replication to other communities in Iowa. Total staff training is 12 hours, including 4 hours of online training and 8 hours of classroom training. All five EMS systems that provide care to Linn County were trained. All appropriate departments of both acute care hospitals (St. Luke's Hospital and Mercy Medical Center) in Linn County were trained along with community physicians. Thirty-one total facilities were identified in Linn County as appropriate to participate in the pilot. At least one certified facilitator has been trained in 25 of these facilities (appendix # 5).

IPOST Process

The process for using the IPOST form was developed. Documentation and education systems were created for each acute care hospital, physician community, emergency medical systems and residential/long term care facilities. The implementation process includes steps to:

- Maintain the completed IPOST at the front of the patient's medical chart
- Transfer the IPOST with the patient from one health care setting to another
- Update or void the IPOST when the patient's treatment choices change
- Collect data on each IPOST for analysis to determine implementation rate and effectiveness
- Regularly review IPOST at quarterly care conferences.

The IPOST form is unique because it is *owned* by the patient.

Results of Medical Record Reviews

The local IPOST Coalition received Institutional Review Board (IRB) approval and approximately 400 IPOST forms have been completed. Traci Ripperda, a doctoral candidate in the Community and Behavioral Health program, College of Public Health at the University of Iowa, is the project evaluator and assisted the coalition with data analysis. A total of seventy-one medical charts have been randomly audited, and the information has been collected in a password protected database.

IPOST forms were reviewed for completeness, and the life-sustaining treatment preferences were entered into the database. In addition, the reviewers documented the presence/absence of advance directives in the medical charts. Almost half of the charts had both advance directives and IPOST forms -- there was 100% consistency between living wills found in patient's charts (N=33) and IPOST wishes.

Preferences for treatment limitations were respected in 100% of the cases (N=33). Nearly half (47%) of the IPOST patients with DNR orders wanted more than the lowest level of care in at least one other category, medical intervention and/or artificially administered nutrition. Of the nine IPOST patients that selected CPR, seven of them indicated limited intervention in at least one other category.

In general, early findings indicate IPOST is effective at ensuring that patient preferences are honored. Similar to POLST findings, when given a choice, many IPOST patients want the option for more aggressive treatment in selected situations.

Project Challenges

There are significant challenges encountered with any important project. Though challenges were identified, none was enough to impede the coalition's passion to move this project forward. The following challenges and barriers were identified and worked through during the Cedar Rapids IPOST Pilot Project:

- Time and People- all work has been in kind. The time to do the training was extensive and not reimbursed.
- Lack of a dedicated coordinator for the pilot program.
- The time commitment for facility staff (4-hour online course plus 8-hour classroom session), was a time cost to the facility.
- Funding- no funding from the state, though local donations allowed the start of the initial groundwork.
- Continued material and training costs as training is an ongoing process.
- Transferability- ensuring the form transferred with each person (unable to determine with current pilot due to lack of documentation).
- Accurate and consistent documentation of the community system.
- A break in the communication system is created by the IPOST form not transferring to the home environment.
- Process issues and resistance to change focused in two areas;
  - The document belongs to the patient -- Reframing the understanding of who owns medical documentations
  - Resistance to change
- Timing issues;
  - Some facilities not ready for education
  - Delayed startup resulting from the flood
  - Time for training demonstrated the need for educational staff
- Education for such a large number of people and a variety of providers.

Project Successes

The Cedar Rapids IPOST Pilot Project has much to celebrate. With determination, commitment and perseverance, the following pilot successes have been achieved:

- Community Engagement
- Financial Support
  - Foundations of both St. Luke's Hospital & Mercy Medical Center
  - Private donor
  - St. Luke's Palliative Care & Hospice/Hospice of Mercy/Palliative Care of Mercy's operational budgets support for medical record review, database entry, and tabulation
- Person support
  - Clerical staff
  - Graduate student support for data collection and analysis
  - Facility staff time
  - Mercy and St. Luke's Palliative Care Teams
  - Coalition members
- Community Champions
  - Physicians
  - Facility Administrators
  - Palliative Care Teams
  - St. Luke's & Mercy Administrative support
- Sustainability
  - Iowa Department of Public Health
  - Linn County Public Health
  - Gunderson Lutheran – Respecting Choices
  - 10 local facilitators trained as trainers
  - 25 facilities trained at least one staff member
  - Receipt of the first grant of $13,000 in November 2009, and the second for $5,000 in December 2009.

Coalition Recommendations to the Advisory Council

Recommendations from the Cedar Rapids local coalition:

1. Request additional time for pilot – let pilot continue for a complete two year implementation cycle – through February 2011. This additional timeline allows the opportunity to do satisfaction surveys, gather data and evaluate the impact of the initiative in the community.

2. Expand the pilot to implement IPOST for the home cohort of community patients. This would address a service gap that is evident right now and offers the same planning support for those families that elect to provide

direct care and keep their loved ones at home.

3. Determine feasibility of extending the pilot into an adjacent rural community. Since adoption of this model will likely expand regionally as opposed to a statewide adoption, the transfer of knowledge and assumption of practice has to be as part of outreach from a center that employs the IPOST model and forms. Extending this pilot offers the expansion learning opportunity.

***The Ultimate Goal of the Pilot*:**

The ultimate vision of the pilot is widespread, effective education and statewide implementation of IPOST. This envisions a state where patient treatment choices are honored across health care settings.

Report of the Advisory Council Meeting

On November 6, 2009 the advisory council met to hear the pilot outcomes, deliberate and develop recommendations for Governor Culver and the Iowa Legislature. In a facilitated process under the direction of the IDPH, the council heard the results of the Cedar Rapids pilot, accepted the pilot recommendations and discussed the issues and concerns regarding a statewide Iowa initiative. The minutes of this meeting are available upon request to Jane Schadle: telephone: 515-281-0917 or email: jschadle@idph.state.ia.us . In a consensus process, the council identified a number of actions or activities that would be necessary including pilot extension and expansion, research, education of stakeholders, resources, and outreach extension of the current pilot. Their recommendations, in no specific order, are:

1. Continue Pilot Project Recommendation: **Continue the current pilot for another two years**. Additionally, charge the pilot with providing outreach education statewide to achieve culture change. Collect data on the need for IPOST in all settings and do a needs assessment exploring regional and/or statewide future expansion. Identify sustainability issues including funding.

Comments: Implementation will take a funding source and the pilot and the council should explore funding mechanisms for their expansion.

2. Pilot Expansion Recommendation: In support of the ultimate goal of statewide implementation of IPOST: **expand the pilot project into a rural county**. The expansion should be a contiguous rural county that has a referral relationship with the pilot county. Additionally, the project should assess the feasibility for future expansion to a local community-based setting and a county with a state owned tertiary care hospital.

Comments: The pilot needs to establish both local and out of county partnerships and enhance grant opportunities.

3. Research Recommendation: **Continue data analysis including pilot medical chart reviews. Expand analysis to include health care providers, patient, and family surveys.** Analyze the need for extension into various health care settings (home/hospital/rural/urban) and continue the literature review and content analysis for current best practice.

Comments: The physicians across the nation are doing this analysis also. The group should explore research grants to help fund implementation.

4. Educate and Outreach Recommendations**: The Iowa Department of Public Health shall assist the community pilot in the following education and outreach activities**: 1) Continue education of pilot county providers and promote change in all involved facilities; 2) Develop a plan for statewide outreach and education about the pilot program; 3) Identify statewide stakeholders to increase their knowledge of the pilot program; and 4) Determine if additional stakeholders should be included in the pilot program.

Comments: The advisory council should continue if the pilot continues.

5. Resources Recommendation**: Affiliate with organizations (including but not limited to local public health departments) to establish partnerships and enhance funding opportunities for replication of the IPOST pilot.**

Comments: The underlying justification is that this work could improve the quality of health care for all Iowans. At the community level, this work leads to integration of community care-giving resources for patients and families. This initiative compliments the DNR processes and advance care planning systems in acute care and long-term care facilities.

[1] Hickman SE, Tolle SW, Brummel-Smith K, Carley MM. (2004). Use of the POLST (Physician Orders for Life-Sustaining Treatment) Program in Oregon Nursing Facilities: Beyond Resuscitation Status. Journal of the American Geriatrics Society, 52, 1424-1429.

[1] Tucker, M. (2009). Study finds that POLST programs boost advance directive compliance, *Caring for the Ages,* April; pg. 16.

Appendix

1. State Advisory Council
2. Local Committee
3. National POLST Forms
4. Iowa Form
5. List of Participating Facilities
6. Life Sustaining Treatment Bill 2009

State Advisory Council # 1

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Oregon's Form #3

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders
for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. These medical orders are based on the person's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name/ First/ Middle Initial

Address

City / State / Zip

Date of Birth (mm/dd/yyyy) ____/____/____ | Last 4 SSN ☐☐☐☐ | Gender ☐ M ☐ F

A *Check One*

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

☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

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

B *Check One*

MEDICAL INTERVENTIONS: **Person has pulse and/or is breathing.**

☐ **Comfort Measures Only** 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. ***Patient prefers no transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

C *Check One*

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics when infection occurs.

☐ Use antibiotics if medically indicated.

Additional Orders: _____

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: **Always offer food by mouth if feasible.**

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E

REASON FOR ORDERS AND SIGNATURES

My signature below indicates to the best of my knowledge that these orders are consistent with the person's **current** medical condition and preferences as indicated by **discussion with**:

☐ Patient ☐ Health Care Representative ☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)

☐ Parent of Minor ☐ Court-Appointed Guardian

☐ Other _____

Print Primary Care Professional Name

Print Signing Physician / NP / PA Name and Phone Number ( )

Physician / NP / PA Signature (mandatory) | Date

Office Use Only

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

Oregon's Form Reverse

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Information for Person Named on this Form Person's Name (print) _____

This voluntary form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Signature of Person or Surrogate

Signature	Name (print)	Relationship (write "self" if patient)

Opt Out ☐ **Check box if you do not want this form included in the electronic POLST registry.**

Contact Information

Surrogate (optional)	Relationship	Phone Number	Address

Health Care Professional Preparing Form (optional)	Preparer Title	Phone Number	Date Prepared

PA's Supervising Physician	Phone Number

Directions for Health Care Professionals

Completing POLST

- Should reflect current preferences of persons with advanced illness or frailty. Encourage completion of an Advance Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies, faxes, and electronic registry forms are also legal and valid.
- A person with developmental disabilities or significant mental health condition requires additional consideration before completing the POLST form, refer to *Guidance for Health Care Professionals* at http://www.ohsu.edu/polst/programs/docs/guidance.pdf.

Sending to POLST Registry (Required unless "Opt Out" box is checked)

- For the POLST Registry, the following information on the other side of the form must be completed:
  - Person's full name
  - Date of birth
  - Section A
  - Physician / NP / PA Signature and date signed
- Send a copy of both sides of this POLST form to the POLST Registry.
  - FAX or eFAX: (503) 418-2161 **Date**____/____/____
  - or
  - Mail: Oregon POLST Registry **Date**____/____/____
    Mail Code: CDW-EM
    3181 SW Sam Jackson Park Road
    Portland, OR 97239

Reviewing POLST

This POLST should be reviewed periodically and if:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

PUT REGISTRY ID STICKER HERE:

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- Send a copy of the voided form to the POLST Registry as above (Required).
- If included in an electronic medical record, follow voiding procedures of facility/community.

For permission to use the copyrighted form contact the OHSU Center for Ethics in Health Care. Information on the POLST program is available online at **www.polst.org** or at **polst@ohsu.edu**.

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

Iowa's IPOST Form Side 1 #4

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

Iowa Physician Orders for Scope of Treatment (IPOST)

First follow these orders, THEN contact physician or nurse practitioner. This is a Physician order sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name

First/Middle Name

Date of Birth

A Check one

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

☐ CPR/Attempt Resuscitation

☐ DNR/Do Not Attempt Resuscitation

B Check one

MEDICAL INTERVENTIONS: Person has a pulse AND/OR is breathing.

☐ **COMFORT MEASURES ONLY** 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. ***Patient prefers no transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, cardiac monitor, oral/IV fluids and medications as indicated. **Do not** use intubation, or mechanical ventilation. May consider less invasive airway support (BiPAP, CPAP). May use vasopressors. ***Transfer*** *to hospital if indicated, may include critical care.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes critical care.*

Additional Orders: _____

C Check one

ARTIFICIALLY ADMINISTERED NUTRITION Always offer food by mouth if feasible.

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

D

MEDICAL DECISION MAKING

Directed by: (listed in order of Iowa Code/Statute for Priority of Surrogates; check only one)

☐ Patient

☐ Durable Power of Attorney for Health Care

☐ Spouse

☐ Majority of Adult Children

☐ Parents

☐ Majority rule for nearest relative

☐ Other: _____

Rationale for these orders: (check all that apply)

☐ Advance Directives
Year AD completed: _____

☐ Patient's known preference

☐ Limited treatment options

☐ Poor prognosis

☐ Other: _____

Physician/ARNP/signature (mandatory)	Print Physician/ARNP/ Name	Date	Phone Number

Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)	Date

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Iowa's IPOST Form Side 2

Use of original form is strongly encouraged. Photocopies and Faxes of signed IPOST forms are legal and valid

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

Information for Person named on this Form. Person's Name (print) _____

This form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Contact Information

Surrogate (optional)	Relationship	Phone Number	Address

Directions For Health Care Professionals

Completing IPOST

- Must be completed by a health care professional based on patient preferences and medical indications.
- IPOST must be signed by a physician or nurse practitioner to be valid. Verbal orders are acceptable with follow-up signature by physician or nurse practitioner in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed IPOST forms are legal and valid.

Using IPOST

- Any section of IPOST not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Deactivate internal defibrillators if comfort measures only are in effect.
- Medications by alternative routes of administration to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Reviewing IPOST

- This IPOST should be reviewed periodically and a new IPOST completed when the person's treatment preferences change. Review may also occur when the person is transferred from one care setting or care level to another.

Voiding IPOST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through C and write "VOID" in large letters if IPOST is replaced or becomes invalid.

Prepared by:

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED

Revised 01/21/09, 1/30/09, 07/6/09

Participating Facilities
Linn County #5

Facilities with trained Facilitators	Facilities without trained Facilitators
Abbe Center	Crestview
Bickford Cottage	Garnett Place
Cottage Grove Place	Hallmark Care Center
Evergreen Estates I	Northbrook Manor
Evergreen Estates II	West Ridge
Evergreen Estates III	Willow Gardens
Hallmar – Mercy	
Heritage Nursing and Rehab	
Hiawatha Care Center	
Higley Mansion	
Keystone Cedars	
Linn Manor	
Living Center East	
Living Center West	
Manor Care	
Meth-Wick Community	
Promise House	
The Views – Ridgeview, Brookview and Meadowview	
Silver Pines	
Summit Pointe Senior Living Community	
The Villages – Village Place and Village Ridge	
Winslow House	

Life Sustaining Treatment Bill 2009 # 6

[110H7181]

.....

(Original Signature of Member)

111TH CONGRESS
1ST SESSION

H. R. _____

To amend title XVIII of the Social Security Act to provide for coverage under the Medicare Program for consultations regarding orders for life sustaining treatment and to provide grants for the development and expansion of programs for such orders.

IN THE HOUSE OF REPRESENTATIVES

Mr. BLUMENAUER introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to provide for coverage under the Medicare Program for consultations regarding orders for life sustaining treatment and to provide grants for the development and expansion of programs for such orders.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Life Sustaining Treatment Preferences Act of 2009".

SEC. 2. FINDINGS.

Congress finds as follows:

(1) Serious illness, death, and dying are often difficult subjects to talk about for individuals, their families, and health care professionals.

(2) Poor communication about preferences for care at the end of life can cause distress for both patients and their families.

(3) As individuals approach the last chapter of their life, more can and should be done to educate them about treatment choices and help individuals communicate to health providers what care they want or do not want to receive.

(4) A decade of research has demonstrated that orders for life sustaining treatment effectively convey treatment preferences, guiding medical personnel in providing or withholding interventions.

(5) Orders for life sustaining treatment differ from advance directives. Advance directives (including living wills and durable powers of attorney for health care) must be completed while individuals have the capacity to complete them and generally apply to future, hypothetical medical circumstances when decisionmaking capacity is lost. Patients' values, goals, and preferences, as expressed in advance directives, require a thoughtful interpretive process

to apply to specific medical circumstances in real time. Yet, patients and proxy decisionmakers are often uncertain how to apply and implement patients' values and goals in unfamiliar health care settings when real treatment plans and complicated decisions need to be made.

(6) Orders for life sustaining treatment complement advances directives by providing a process to focus patients' values, goals, and preferences on current medical circumstances and to translate them into visible and portable medical orders applicable across care settings, including home, long-term care, emergency medical services, and hospitals. Without such medical orders emergency medical personnel may be required to provide treatments that may not be consistent with the individual's preferences. Completion of such an order is equally valuable to patients who have not executed advance directives.

(7) The following states have implemented or are developing orders for life sustaining treatment programs at the local or statewide level: Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North

Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin and Wyoming.

(8) Programs for orders for life sustaining treatment provide valuable services to individuals, their families, and health care providers through educational materials, professional training on advance care planning, coordinating and collaborating with hospitals, skilled nursing facilities, hospice programs, home health agencies, and emergency medical services to implement such orders across the continuum of care, and monitoring the success of the program.

(9) Medicare pays for acute care services provided to beneficiaries, but generally does not pay for informed discussions between beneficiaries and health providers to allow beneficiaries the opportunity to determine if they desire such acute care in the last months and years of life.

SEC. 3. MEDICARE COVERAGE OF CONSULTATION REGARDING ORDERS FOR LIFE SUSTAINING TREATMENT.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 101(a), 144(a), and 152(b) of the Medicare Improvements

for Patients and Providers Act of 2008 (Public Law 110–275), is amended—

(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraph (DD);

(B) by adding "and" at the end of subparagraph (EE); and

(C) by adding at the end the following new subparagraph:

"(FF) consultations regarding an order for life sustaining treatment (as defined in subsection (hhh)(1)) for qualified individuals (as defined in subsection (hhh)(3));"; and

(2) by adding at the end the following new subsection:

"Consultation Regarding an Order for Life Sustaining Treatment

"(hhh)(1) The term 'consultation regarding an order for life sustaining treatment' means, with respect to a qualified individual, consultations between the individual and the individual's physician (as defined in subsection (r)(1)) (or other health care professional described in paragraph (2)(A)) and, to the extent applicable, registered nurses, nurse practitioners, physicians' assistants, and social workers, regarding the establishment, implementation,

and changes in an order regarding life sustaining treatment (as defined in paragraph (2)) for that individual. Such a consultation may include a consultation regarding—

"(A) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

"(B) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

"(C) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

The Secretary may limit consultations regarding an order regarding life sustaining treatment to consultations furnished in States, localities, or other ge-

ographic areas in which such orders have been widely adopted.

"(2) The terms 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

"(A) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order) and is in a form that permits it to stay with the patient and be followed by health care professionals and providers across the continuum of care, including home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services;

"(B) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

"(C) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary);

"(D) is portable across care settings; and

"(E) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

"(3) The term 'qualified individual' means an individual who a physician (as defined in subsection (r)(1)) (or other health care professional described in paragraph (2)(A)) determines has a chronic, progressive illness and, as a consequence of such illness, is as likely as not to die within 1 year.

"(4) The level of treatment indicated under paragraph (2)(B) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

"(A) the intensity of medical intervention if the patient is pulseless, apneic, or, has serious cardiac or pulmonary problems;

"(B) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

"(C) the use of antibiotics; and

"(D) the use of artificially administered nutrition and hydration.".

(b) PAYMENT.—

(1) IN GENERAL.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3)), as amended by sections 144(a)(2) and 152(b)(1)(C) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), by inserting "(2)(FF)," after "(2)(EE),".

(2) CONSTRUCTION.—Nothing in this section shall be construed as preventing the payment for a consultation regarding an order regarding life sustaining treatment to be made to multiple health care providers if they are providing such consultation as a team, so long as the total amount of payment is not increased by reason of the payment to multiple providers.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to consultations furnished on or after January 1, 2010.

SEC. 4. GRANTS FOR PROGRAMS FOR ORDERS REGARDING LIFE SUSTAINING TREATMENT.

(a) IN GENERAL.—The Secretary of Health and Human Services shall make grants to eligible entities for the purpose of—

(1) establishing new programs for orders regarding life sustaining treatment in a States or localities;

(2) expanding or enhancing an existing program for orders regarding life sustaining treatment in States or localities; or

(3) providing a clearinghouse of information on programs for orders for life sustaining treatment and consultative services for the development or enhancement of such programs.

(b) AUTHORIZED ACTIVITIES.—Activities funded through a grant under this section for an area may include—

(1) developing such a program for the area that includes home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services within the area;

(2) securing consultative services and advice from institutions with experience in developing and managing such programs; and

(3) expanding an existing program for orders regarding life sustaining treatment to serve more patients or enhance the quality of services, including educational services for patients and patients' families or training of health care professionals.

(c) DISTRIBUTION OF FUNDS.—In funding grants under this section, the Secretary shall ensure that, of the

funds appropriated to carry out this section for each fiscal year—

(1) at least two-thirds are used for establishing or developing new programs for orders regarding life sustaining treatment; and

(2) one-third is used for expanding or enhancing existing programs for orders regarding life sustaining treatment.

(d) DEFINITIONS.—In this section:

(1) The term ''eligible entity'' includes—

(A) an academic medical center, a medical school, a State health department, a State medical association, a multi-State taskforce, a hospital, or a health system capable of administering a program for orders regarding life sustaining treatment for a State or locality; or

(B) any other health care agency or entity as the Secretary determines appropriate.

(2) The term ''order regarding life sustaining treatment'' has the meaning given such term in section 1861(hhh)(2) of the Social Security Act, as added by section 3.

(3) The term ''program for orders regarding life sustaining treatment'' means, with respect to an

area, a program that supports the active use of orders regarding life sustaining treatment in the area.

(4) The term ''Secretary'' means the Secretary of Health and Human Services.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2009 through 2014.