

An Update on the Indiana POST Program

An OPTIMISTIC Educational Webinar

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CME Learner Information

OPTIMISTIC Providers Learning Community Webinar

February 21, 2017

Learning Objectives

At the conclusion of this activity, participants should be able to:

- Identify key elements of the Indiana POST Form and Program;
- Discuss potential legislative changes to the Indiana POST Act and Health Care Consent Act; and
- Apply knowledge about POST to patient/resident care.

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Advance Care Planning

- A process
 - Revisit periodically and when condition changes
 - Individualized
 - Family involvement
 - Outcomes may include documentation
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Traditional Advance Directives

- Advance Directives
 - Appointment of proxy
 - Power of Attorney for Health Care
 - Health Care representative

 - Statement of Preferences
 - Indiana Life-Prolonging Procedures Declaration
 - Indiana Living Will
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Resuscitation Code Status

- DNR vs. Full Code
 - Addresses resuscitation only
 - Simplification
 - Over-generalized to reflect preferences for other treatments
 - Indiana Out of Hospital DNR
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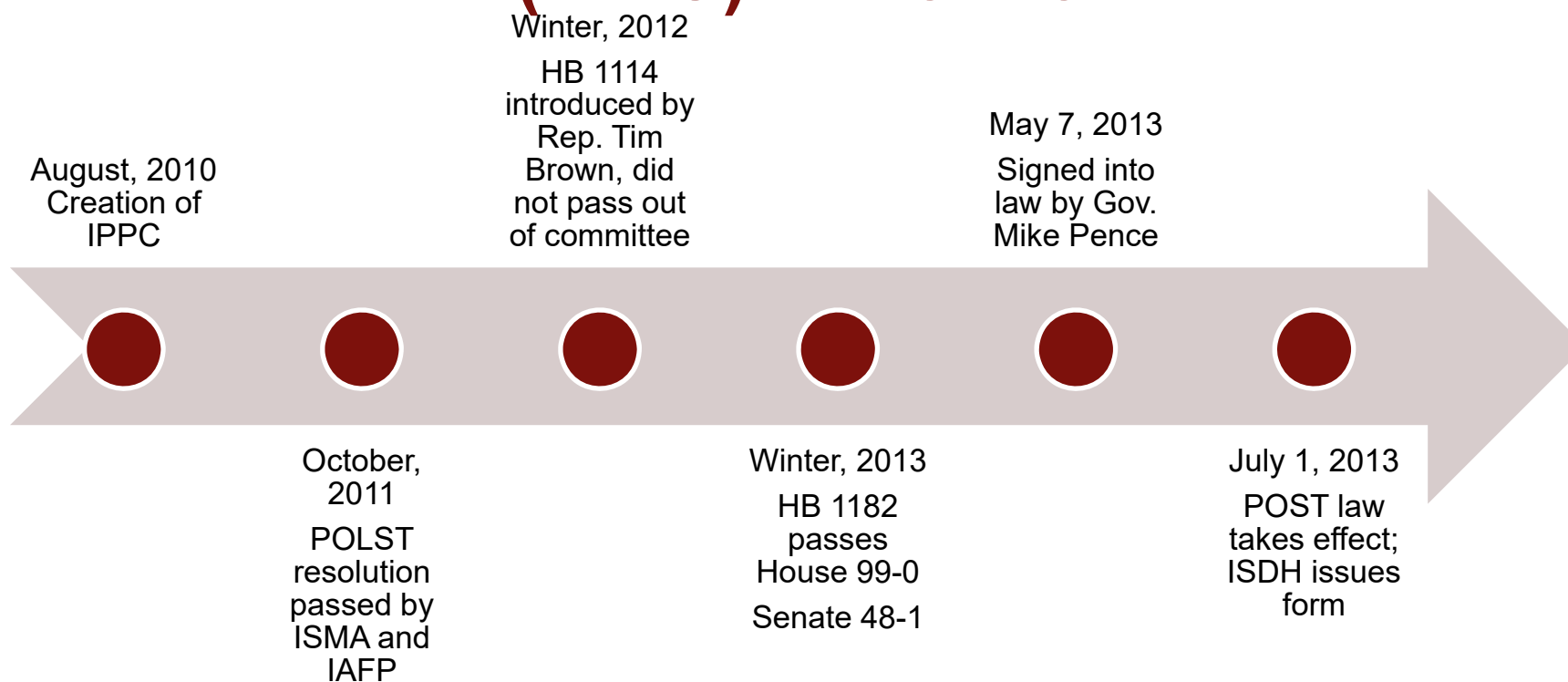
The POST Program

- POST = Physician Orders for Scope of Treatment
 - Converts treatment preferences into actionable medical orders
 - Advanced chronic progressive disease and frailty; terminal illness
 - Preferences to have or decline treatments
 - Transfers across treatment settings with patient
 - Recognizable, standardized form
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Indiana Patient Preferences Coalition (IPPC) Timeline





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POST Form Updates

- Indiana State Department of Health (2016)
 - IPPC workgroup
 - Form revisions and feedback process
- Changes
 - Concerns about HCR appointment/dual form
 - Removed & new form created
 - Readability and spacing
 - Space for additional orders

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INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 53317 (R2 / 12-16)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name		Patient First Name		Middle Initial
Birth Date (mm/dd/yyyy)		Medical Record Number	Date Prepared (mm/dd/yyyy)	
DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.				
A Check One	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing <input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR When not in cardiopulmonary arrest, follow orders in B, C and D			
B Check One	MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing <input type="checkbox"/> Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location. <input type="checkbox"/> Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible. <input type="checkbox"/> Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.			
C Check One	ANTIBIOTICS: <input type="checkbox"/> Use antibiotics for infection only if comfort cannot be achieved fully through other means. <input type="checkbox"/> Use antibiotics consistent with treatment goals.			
D Check One	ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible. <input type="checkbox"/> No artificial nutrition. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____) <input type="checkbox"/> Long-term artificial nutrition.			
OPTIONAL ADDITIONAL ORDERS:				
SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.				

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.		
E SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.		
Signature (required by statute)	Print Name (required by statute)	Date (required by statute) (mm/dd/yyyy)
F CONTACT INFORMATION FOR LEGALLY APPOINTED REPRESENTATIVE IN SECTION E (IF APPLICABLE): If the signature above is other than patient's, add contact information for the representative.		
Relationship of representative identified in Section E if patient does not have capacity (required by statute)	Address (number and street, city, state, and ZIP code)	Telephone Number
PHYSICIAN ORDER: A POST form may be executed only by an individual's treating physician and only if: (1) the treating physician has determined that: (A) the individual is a qualified person; and (B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and (2) the qualified person or representative has signed and dated the POST form A qualified person is an individual who has at least one (1) of the following: (1) An advanced chronic progressive illness. (2) An advanced chronic progressive frailty. (3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty: (A) there can be no recovery; and (B) death will occur from the condition within a short period without the provision of life prolonging procures. (4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.		
G DOCUMENTATION OF DISCUSSION: Orders discussed with (check one): <input type="checkbox"/> Patient (patient has capacity) <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Power of Attorney		
H SIGNATURE OF TREATING PHYSICIAN My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.		
Signature of Treating Physician (required by statute)	Print Treating Physician Name (required by statute)	Date (required by statute) (mm/dd/yyyy)
Physician Office Telephone Number (required by statute)	Physician License Number (required by statute)	Health Care Professional preparing form if other than the physician
I APPOINTMENT OF HEALTH CARE REPRESENTATIVE: As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the ISDH web site at http://www.in.gov/isdh/25880.htm .		



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Use of POST in Indiana Nursing Homes

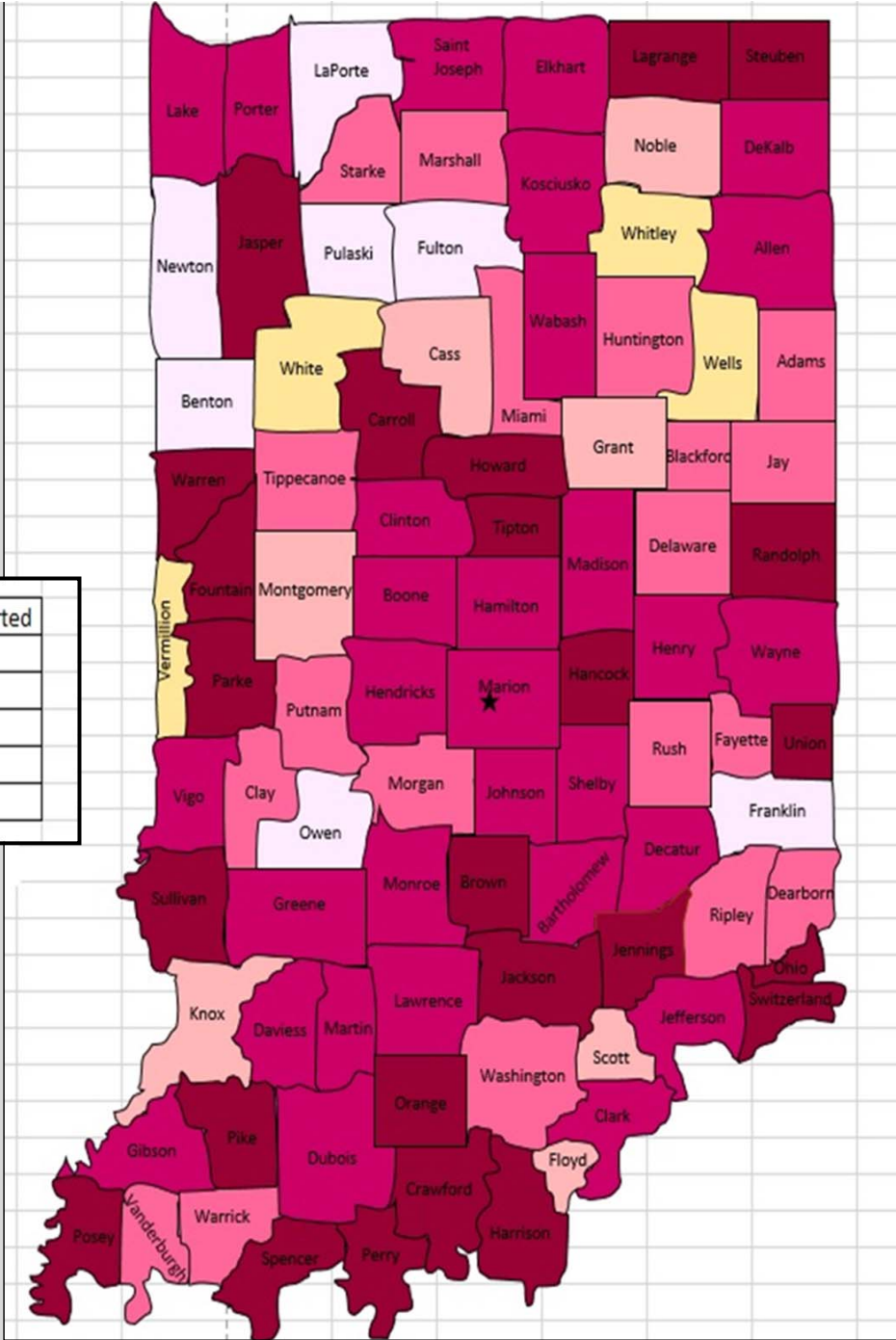
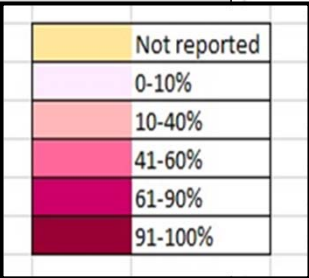
- A statewide survey of Indiana nursing homes (n=486) was conducted in Spring 2016.
 - Phone, email, and postcard surveys
 - 91% participation
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Results

Overall POST Use (n = 486)	n (%)
NF admitted a resident with a POST form	247 (50.9)
NF completed a POST form for resident after admission	315 (64.8)
NF has no experience with POST	101 (20.8)
NF reported staff received education about POST*	272 (80.2)

Indiana POST Use in 2016



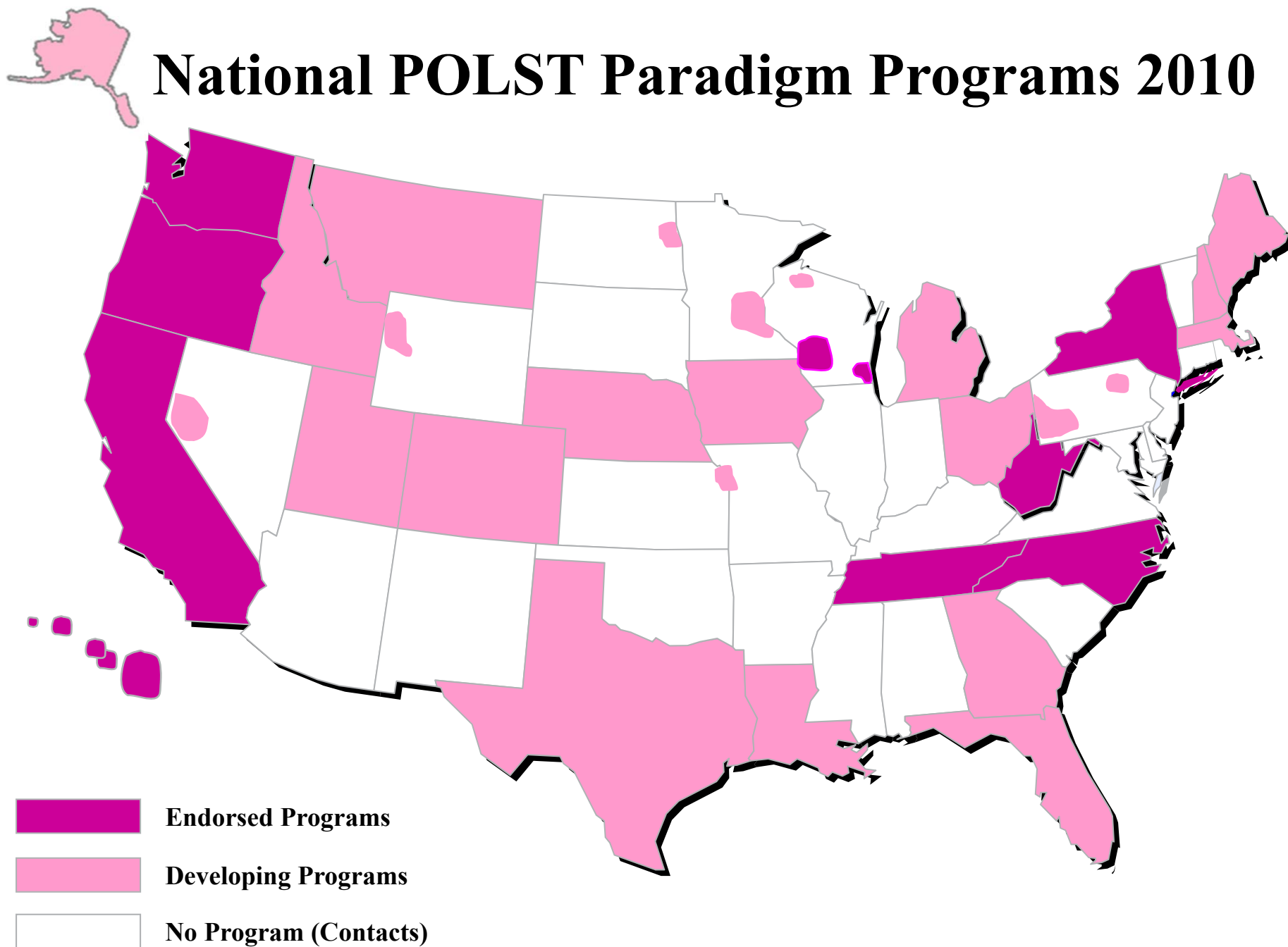


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Indiana Endorsement

- National POLST Paradigm Review
 - Endorsement = meet national standards
 - Program requirements
 - Form requirements
 - Approved in May 2017!
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National POLST Paradigm Programs 2010





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Work is On-Going!

- Indiana Patient Preferences Coalition
 - Walther Cancer Foundation Grant
 - Honoring Choices Indiana
 - The New Harmony Conversation Project
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Indiana POST Refinements

- Issues identified in practice
 - Who is allowed/required to follow?
 - What is a valid POST form?
 - What if unable?
 - Out-of-state forms?
 - HCR revocations – when okay?
 - Who can sign?
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Updates Requiring Legislative Action

- Author
 - Representative Cindy Kirchhofer (R), District 89
 - Summer Working Groups
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House Bill 1119

- Changes
 - Indiana POST Act
 - Health Care Consent Act
 - Co-Authors
 - Representatives Patrick Bauer (D), Ronald Bacon (R), Tim Brown (R), Charlie Brown (D)
 - Senate Sponsor
 - Senator Michael Crider (R)
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Proposed Changes to the Indiana POST Act

- Expand who is required to honor/no duty to perform if not listed
 - English only is only valid version
 - Elements required to be valid
 - Physically unable
 - Out-of-state forms
 - Conditions under which HCR can override
 - NP/PA as authorized signers
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Health Care Consent Act

- Current statute
 - Default surrogate = who makes health care decisions when a patient loses decisional capacity
 - Committee approach
 - spouse, adult children, adult siblings, parents, grandparents, grandchildren



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Proposed Changes to Health Care Consent Act

- Adds a hierarchy/priority list
 - Adds nearest adult relative; close friend
 - Procedure for disagreements
 - Circumstances when someone is disqualified
 - Defines reasonable efforts
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Supporting Organizations

- Indiana Health Care Association
 - LeadingAge Indiana
 - Indiana Hospital Association
 - Indiana State Medical Association
 - Indiana State Nurses Association
 - Coalition of Advance Practice Nurses of Indiana
 - Indiana Medical Directors Association
 - Indiana Chapter of the American College of Emergency Physicians
 - AARP
 - Elder Law Section, Indiana State Bar Association
 - National Academy of Elder Law Attorneys – Indiana Chapter
 - Indiana Rural Health Association
 - Health & Hospital Corporation
 - Honoring Choices Indiana
 - Q-Source
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Legislative Process

➤ House

- Public Health Committee 12-0 (1/12/18)
- House vote 95-0 (1/22/18)

➤ Senate

- Health & Provider Services Committee 8-0 (2/14/18)
- Minor amendment
- Senate Vote

➤ Next Steps

- House
 - Governor
 - Effective date – stay tuned! Likely July 1.
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Using POST with Residents



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How do you talk about POST?

- Do's –
 - Make time
 - Involve resident (if able) & family members
 - Explore
 - Provide information
 - <http://www.optimistic-care.org/about/facility-provider-resources/palliative-care-education-sheets>
 - Schedule follow-up as needed
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How don't you talk about POST?

- Don'ts –
 - Hand form to resident/family and ask to bring back
 - Rush through the discussion
 - Make decisions for resident
 - Judge or impose your values
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The POST Conversation

- Exploring understanding
 - What is understanding of disease and what will happen?
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The POST Conversation

- Exploring Values
 - What gives life meaning?
 - How does their illness impact their quality of life?
 - What does a good day look like?
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The POST Conversation

- What are their goals for treatment?
 - Are they interested primarily in comfort?
 - Or in doing everything we can to live longer?



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The POST Conversation

- Preparing POST
 - Do they understand the treatments described on POST and how applies to them?
 - Do they know the risks and benefits of each decision? Alternatives?
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Conclusion

- POST is an ACP tool to document treatment preferences as orders
 - Updates are in process
 - Process over form - its all about the conversation!
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For more information...

- Web
 - <http://optimistic-care.org/>
 - www.polst.org
 - www.indianapost.org
 - <https://www.in.gov/isdh/25880.htm>
 - Email
 - hickman@iu.edu
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