Advance Care Planning and a proposal for Medical Orders for Scope of Treatment (MOST) in Texas

- Kendra J. Belfi, MD, FACP
  - THMHO
  - March, 2015

Objectives

- Explain the POLST paradigm and MOST (a Texas specific POLST form)
- Identify skills to initiate advance care planning conversations with persons with serious life-limiting illness, designated healthcare agents and loved ones.
- Identify skills to assist in making informed end-of-life treatment decisions, to include CPR, limitations on treatment, time-limited trials and comfort care.

Purpose of POLST Paradigm

- To provide a mechanism to communicate seriously ill patients’ preferences for end-of-life treatment across care settings
- To improve implementation of advance care planning by providing more specific instructions for seriously ill patients

A Patient’s Story

- 71-year-old man with severe chronic obstructive pulmonary disease and mild dementia is admitted to a nursing home after a hospital stay for pneumonia
- He develops increasing shortness of breath and decreasing responsiveness over 24 hours
- The nursing staff calls the emergency medical service, who find the patient unresponsive, with a respiratory rate of 12 breaths per min. and oxygen saturation at 85% on room air

A Patient’s Story

- The patient had discussed his desire to forgo aggressive, life-sustaining measures with his family and nursing personnel, and completed a POAHC
- Although a Do Not Resuscitate (DNR) order was written, the emergency team was not informed, and there were no orders for respiratory failure

©Copyright 2008-2013—All Rights Reserved. Gundersen Medical Foundation
A Patient’s Story

• The emergency team inserts a nasal pharyngeal airway, administers supplemental oxygen, and transports the patient to the ED of a local hospital
• The patient remains unresponsive and his chest X-ray shows large lung volumes with consolidation. Arterial blood gases show marked respiratory acidosis

The emergency department physician writes, “Full code for now, status unclear.” The patient is intubated, sedated, and transferred to the intensive care unit


What Went Wrong?

• DNR order not communicated within healthcare facility
• Lack of clarification of meaning of “no aggressive” treatment with patient
• Lack of eliciting patient wishes for all relevant treatment decisions (e.g., airway management, hospitalization, comfort care)

• Patient received unwanted care?
• System-wide failure to respect wishes
  – Failure to plan ahead for relevant treatment decisions
  – No system for transfer of plan of care between healthcare facilities

The Rationale for Last Steps: Limitations of Advance Directives (Directive to Physician, Family and Surrogates)

• AD may not be available when needed
  – Person did not complete an AD
  – AD not transferred with patient
• Most ADs do not prompt discussion of relevant decisions and are not specific
  – No provision for treatment in the nursing home or home
  – May not cover topics of most immediate need
• AD may be difficult to apply to emergent situation
• AD does not immediately translate into medical orders
  (AD—i.e. Directive to Physicians, Family and Surrogates)

MPOA vs. MOST

Medical Power of Attorney
• Completed in advance by adult with decision-making capacity
• Implemented when capacity is lost
• Often not available
• Designates surrogate(s) for future decision making

MOST (Medical Orders for Scope of Treatment)
• Completed at any point in time by decisional person or designated surrogate
• Implemented immediately as medical orders
• Stays with patient
What is MOST?

- **Medical Orders for Scope of Treatment**
  - Based upon POLST: Physician Orders for Life-Sustaining Treatment
  - www.chsu.edu/polist
- A physician order set and care planning tool based upon patient treatment preferences that travels with the patient from one site of treatment to another regarding
  - CPR status: Attempt or Do Not Attempt Resuscitation
  - General intensity of treatment (intensive treatment, intermediate treatment, comfort only treatment); and
  - Artificial nutrition and hydration.

What do patients want near life’s end?

- Not what they are getting!
- Faced with a terminal illness:
  - 86% prefer last days at home
  - 87% would not want ventilator to gain 1 week of life
  - 77% would not want ventilator to gain 1 month of life
- **Note bene:** 40% fear too little and 45% fear too much treatment

340 seriously ill patients ranked 44 attributes of quality care near the end of life:

1. Freedom from pain
2. Peace with God
3. Other top preferences: presence of family, mental awareness, treatment choices followed, finances in order, feel life was meaningful, resolve conflicts, die at home.

How does MOST compare to OOH-DNR?

<table>
<thead>
<tr>
<th>MOST</th>
<th>OOH-DNR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| MOST Advantages
- Ability to use the document to affirmatively request intensive interventions
  - Remember some persons fear too little Rx
- Guidance for change in condition short of death
  - Information about more than CPR
- One signature rather than 8
  - No “signature burden”
- Font large enough for most middle-aged or older persons

©Copyright 2008-2013—All Rights Reserved. Gundersen Medical Foundation
Why MOST?

- To improve communication and care plans, thus helping deliver the treatment patients need and want.
  - The vast majority of patients with advanced illness want freedom from pain, control, peace with family and God, avoidance of prolonged dying.

Is a MOST form the same as an advance directive?

- No, it is a physician order set that can be used to turn the preferences expressed in an advance directive into medical orders.
  - One need not have an advance directive to complete a MOST form.

Medical Orders for Scope of Treatment (MOST) Screening Criteria

- > Adults for whom it would not be a surprise to you if they died in the next 12 months
- > Individuals with one or more complex chronic illnesses
- > Individuals with advanced frailty, elderly (80+yrs)
- > Individuals living in long-term care facilities
- > Individuals with a terminal or end-stage diagnosis, (cancer, CHF, COPD, renal disease, stroke with residual deficits, or advanced dementia)

Would I be surprised if this patient died in the next year?


Chronic Illness Trajectory Slow, Steady Decline to Death

Field & Cassel, 1997
**First Steps**

Create POAHC and consider when a serious neurological injury would change goals of treatment

**Next Steps**

Determine what goals of treatment should be followed if complications result in "bad" outcomes

**Last Steps**

Establish a specific plan of care expressed in medical orders using the POLST paradigm

---

**National Quality Forum Preferred Practice**

“Compared with other advance directive programs, POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals.”


---

**What does the literature show?**

- POLST significantly increases the likelihood that a patient’s treatment preferences will be honored as evidenced by a review of 18000 death records comparing POLST/MOST preferences and place of death:
  - 6.4% of patients with a POLST/MOST specifying a preference for comfort measures only died in the hospital (i.e. 93.6% died at home or nursing home as preferred by the patient).
  - 22.4% of patients with POLST/MOST specifying intermediate or limited interventions died in the hospital.
  - 44.2% of patients with POLST/MOST specifying intensive interventions died in a hospital. This is significantly higher than the 34.2% of patients with no POLST/MOST who died in a hospital, strongly suggesting that POLST/MOST increases the likelihood of a patient who wishes to have aggressive interventions at life’s end making it to the hospital for treatment.


---

**Where is MOST/POLST used?**

- State law endorsed, 16
- POLST in development, 27
- No program, 7

---

**THE LA CROSSE ADVANCE DIRECTIVE STUDIES**

(LADS I & II)

The Prevalence, Availability, and Consistency of Advance Directives over a 10-year period after implementation of the RC ACP Program

---

©Copyright 2008-2013—All Rights Reserved. Gundersen Medical Foundation
**Prevalence, Availability, and Consistency of Advance Directives in La Crosse County after the creation of an ACP System from 1991 to 1993**

<table>
<thead>
<tr>
<th></th>
<th>LADS I * Data collected in '95/'96 N=540</th>
<th>LADS II** Data collected in '07/'08 N=400</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decedents with Ads (%)</td>
<td>459 (85.0)</td>
<td>360 (90.0)</td>
<td>.023</td>
</tr>
<tr>
<td>ADs found in the medical record where the person died</td>
<td>437 (95.2)</td>
<td>358 (99.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Treatment decisions found consistent with instructions</td>
<td>98%</td>
<td>99.5%</td>
<td>0.13</td>
</tr>
</tbody>
</table>


**LADS II Additional Data**
- 67% of decedents had a POLST document
- 98.5% of POLST forms were in the medical record of the health organization where the person died
- The most recent POLST form was completed 4.5 months prior to death
- 96% of all decedents (n=400) had either an AD or a POLST form at the time of death

**Does POLST work in La Crosse?**
- **POLST has great flexibility:** Of 268 deaths where patient had a POLST, there were 35 different combinations of orders from the 4 sections.
- **POLST is highly prevalent:** 67% of all deaths from all setting has a POLST.
- **POLST is available:** The POLST form was available to the health professional where the patient died.
- **POLST is honored:** If patients wanted treatment, they always received it. If they did not want it, they almost never received it. There were only 2 cases where patients' desire not to be hospitalized was not honored.

**ACP is a Process of**

*Understanding, reflection, and discussion*

**The Role of the ACP Facilitator**
- to promote
  - to expedite
  - to assist
  - to advance
ACP Facilitation Skills

• General interview skills
• Interview skills for POLST-type discussions with adults likely to die within 12 months or those in long-term care

Interview Checklist

1. Introduce the Last Steps program
2. Explore understanding of medical condition
3. Explore understanding of potential complications
4. Explore experiences of
   — Decision making with family or friends
   — Recent hospitalizations
5. Explore concept of living well
6. Help make informed decisions

Choices About Life-sustaining Treatments

• When to start
• When to forgo or withhold
• When a trial of intervention may be an option
• How and when to maintain comfort

#6: Help Make Informed Decisions

#6a: Explore understanding of treatment decision to uncover gaps in information
#6b: Explore understanding of benefits and burdens and provide information as appropriate
#6c: Explore goals for treatment: What would person expect to happen? What would an unacceptable outcome be?
#6d: Explore fears and concerns

Encourage Reflection

“Once you understand how attempting CPR may or may not help you, it is important to think about whether or not CPR would help you meet your goals for living well.”

CPR Video

©Copyright 2008-2013—All Rights Reserved. Gundersen Medical Foundation
MEDICAL ORDERS FOR SCOPES OF TREATMENT (MOST)

Follow this MOST and patient preferences first, then contact a physician. This MOST may only be changed by a physician or revoked by the patient or surrogate/proxy below. Send this MOST with patient for all transfers between treatment sites. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name: ___________________ First Name ___________________ DOB: ___________________

Primary Care Provider: ___________________ Provider Phone: ___________________

PHYSICIAN RESUSCITATION ORDER: No pulse and not breathing

☐ Attempt Resuscitation (CPR) Tube in the windpipe, electrical shocks to the chest, chest compression, and IV tubes for fluids/medications.

☐ Do Not Attempt Resuscitation/ Allow Natural death (DNAR/AND) Provide physical comfort, emotional, and respectful spiritual support to patient and family.

☐ OOH DNR completed

Consider “Trial of Intervention”

• Case examples
  – “I want to try the ventilator once more”
  – “I know the odds may be bad, but I am not ready to just give up”

• Assist in defining goals and unacceptable outcomes

• Develop a follow-up plan to discuss this option with physician or other qualified resource

MEDICAL INTERVENTION SCOPE: Unstable, has pulse and is breathing

Per physician order, use appropriate interventions for the scope of treatment preferences noted below. If this section is not completed, then provide full treatment for this section.

☐ COMFORT INTERVENTIONS ONLY: Avoid hospitalization unless needed to provide comfort care, focus on symptom control, dignity, and allowing gentle, natural death should it occur. Use comfort interventions like oral, subcutaneous, or intravenous medications (e.g., opioids), comfort foods/liquids, oxygen, and emotional/spiritual support.

☐ INTERMEDIATE INTERVENTIONS: If necessary, transfer to a hospital. In addition to comfort measures, may add interventions like intravenous antibiotics, non-invasive breathing support (BiPAP/CPAP), and fluid resuscitation.

☐ FULL INTERVENTIONS: Transfer to a hospital, and if necessary to ICU. Use comfort and intermediate measures, and may add medically appropriate ICU interventions such as, but not limited to, intubation/ventilator support, ICU-only medications, and dialysis.

ADDITIONAL ORDERS:__________________________________________________________

Out-of-Hospital Do-Not-Resuscitate Order

• Order that allows a physician to direct health care professionals in the out of hospital environment to withhold or withdraw certain life sustaining treatments in the event of respiratory or cardiac arrest.

• Health care professionals are defined as physicians, nurses, emergency medical personnel and physician assistants

• Statute can be found at http://www.dshs.state.tx.us/emstraumasystems/ruladopt.shtm

#7: Introduce POLST Section B

• Introduce the purpose of Section B

• Explain each option in Section B
  – Comfort care
  – Limited treatment
  – Full treatment

• Assist in making informed choices based on medical condition and goals for living well

#8: Introduce Section on Artificial Nutrition and Hydration

• Introduce the purpose of this decision as it relates to the person’s medical condition

• Explore understanding, goals, and fears

• Involve other qualified resources as needed
MEDICALLY ASSISTED NUTRITION

Offer nutrition and hydration by mouth at all intervention levels if feasible. Per physician order, use additional interventions noted below. If this section is not completed, then provide full treatment for this section.

☐ No medically assisted nutrition.

☐ Unless medically contra-indicated*, defined trial of medically assisted nutrition. ☐ Length of trial ________ ☐ Goal ______________ 

☐ Long-term medically assisted nutrition.

*In some circumstances including, but not limited to, heart, lung, liver or kidney failure, assisted nutrition or hydration may increase suffering or hasten death, and is therefore medically contraindicated.

This MOST is based upon the patient’s medical condition and preferences expressed in:

☐ OOH-DNR; ☐ Living Will (Directive to Physicians and Family or Surrogates); ☐ MPOA;

☐ Direct conversation with patient with decision-making capacity

☐ Direct conversation with surrogate decision-maker/proxy for incapacitated patient

Surrogate/Proxy designated in: ☐ MPOA ☐ Living Will ☐ Texas Statutory

Surrogate Attached: ☐ OOH-DNR ☐ MPOA ☐ Living Will

Surrogate/Proxy name and contact number: ________________________________

Relationship to patient: ________________________________

Name of NTRC Facilitator: ________________________________

DOCUMENTATION OF DISCUSSION:

☐ Patient (Patient has capacity)

☐ Parent of minor

☐ Court-Appointed Guardian

☐ Health Care Representative or legally recognized surrogate

☐ Surrogate for patient with developmental disabilities or significant mental health condition

(Note: Special requirements for completion. See reverse side.)

☐ Other ________________________________

Patient or Patient’s Designee Signature: ________________________________

Patient or Patient’s Designee Name: (Print) ________________________________

Date/Time Completed: ________________________________

Physician Signature: My signature certifies both the order and preferences above and the basis for them.

Print Name and License Number: ________________________________

Date/Time Completed: ________________________________

QUESTIONS?

#5: Explore Concept of Living Well

“What activities or experiences are most important for you to live well?”

• “In what way do you feel you could make this time especially meaningful to you?”
#5: Explore Concept of Living Well

“What fears or worries do you have about your illness or medical care?”
- “For example, do you feel that there are needs or services that you need to discuss?”

“Who or what helps you when you face serious challenges in life?”
- “Do you have any religious or spiritual beliefs that help you deal with difficult times?”

Example:
Strategies to Discuss Section A (CPR)

Validate the importance of the decision:
- “CPR is an important decision for you to understand. People often make this decision without full understanding or time to reflect. I have a few questions that may help”

Encourage understanding:
#6a: “What is your understanding of CPR? What has your physician discussed?”
#6b: “CPR is not as successful as most people think. What do you know about the success of CPR?”
#6c: “What outcome would you expect from CPR? What would be an unacceptable outcome?”
#6d: “Do you have any fears or concerns about making this decision?”

Provide Information or Make a Referral

CPR outcomes in hospitalized patients
- Fewer than 1 in 5 (17%) patients for whom CPR is attempted will leave the hospital alive after an average hospital stay of 2 weeks
- Over 30% of these survivors will go to nursing facility or rehab center

CPR outcomes in long-term care facilities
- Less than 3% survive the CPR attempt
- Requires transfer to hospital for mechanical ventilation and ICU support for complications of CPR
- May result in a decline in mental function


Encourage Discussion
- “It seems like you have questions for your physician about CPR. Let’s write them down so that you can have a helpful discussion with your doctor.”
- “How would you like to involve your loved ones in this decision? How could I help you talk to them?”
Why MOST?

• To help lessen the three major deficits in treatment near the end of life.
  – High (3 - 6 fold) variability in intensity of treatment without improved outcome – i.e. non-beneficial intervention
  – www.dartmouthatlas.org
  – High amounts of unacceptable suffering with 50% of patients having severe pain at the end of life.
  – High costs in the last year of life with 28% of Medicare dollars spent in the last year and 14% in the last 2 months of life.
  – Last Year of Life study at www.michhs.gov

Lessen the use of non-beneficial CPR treatment

• CPR (advanced age/illness/expected death) = non-beneficial treatment, suffering, and costs.
  • Nursing home initiated CPR (117 patients):
    – 102 (89%) were pronounced dead in the ED.
    – 2 died within 24 hours, 11 died after an average hospital stay of 5 days.
    – 1 returned to nursing home with advanced dementia, died 8 months later.
    – 1 returned to nursing home in pre-arrest condition.
  • CPR is not benign!
    – Survivors with recall report serious pain.
    – Appear unresponsive but may have enough consciousness for pain.

• Cost-effectiveness of CPR for all 6 month survivors is $406,605 per life saved (range $344,314 to 966,759).

  • Dialysis $140,000/year of life, mammography $50,000/year of life, colonoscopy $11,000/year of life