



Honoring Healthcare  
Choices M I C H I G A N

## Honoring Residents' Choices

### Advance Care Planning and MI-POST

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Michigan

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### Disclaimers

- Presenter does not have a financial relationship to disclose which would cause a conflict of interest.
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### Importance of Advance Care Planning

- End-of-life decisions are complex
  - Trajectory of chronic condition
  - Cultural or religious beliefs
  - Family
  - Healthcare professionals
  - Media attention
  - Tools
  - Legal/regulatory

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## The Gap

- 60% of people say that making sure their family is not burdened by tough decisions is "extremely important"
- 80% say that if seriously ill, they would want to talk to their doctor about end-of-life care
- 82% say it's important to put their wishes in writing
- 70% say they prefer to die at home
- 56% have not communicated their end-of-life wishes
- 7% report having had an end-of-life conversation with their doctor
- 23% have actually done it
- 70% die in a hospital, nursing home, or long-term care facility

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## The Honoring Residents' Choices program

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## Honoring Residents' Choices

- 3 year program, from Oct 2012-Sept 2015
- Funded through CMP
- Open to healthcare setting in the tri-county area (preference to CDMC members)
- First steps phase 1 launched in February
  - 5-7 pilot teams
  - Phase 2 launches in November
    - New pilot teams
- Last steps launches April 2014

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## Expected Outcomes

- Increase the % of written advance directives at the time of death; availability; appointment of agent
- Reduce hospital deaths by 10% over baseline
- Increase hospice admissions by 10% over baseline
- Increase median hospice length of stay by 10% over baseline
- Increase transfer of patient preferences to medical orders
- Increase family reports of discussion
- High rate of satisfaction with facilitation
- High rate of satisfaction with healthcare services
- Reduced re-admissions to acute care settings
- Decrease in utilization of unwanted healthcare services, particularly in the last 6 months of life.
- And most importantly, patient wishes honored!

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## What are the desired outcomes of Advance Care Planning?

Ideally to “know” and to “honor” a patient’s informed plans, by...

1. **Creating an effective plan, including:**
  - a) selecting a well prepared health care agent or proxy when possible, and
  - b) creating specific instructions that reflect informed decisions that are geared to the person’s state of health.
2. Having these plans available to the treating physician.
3. Incorporating plans into medical decisions when needed, wherever needed.

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## The Five Promises Of An Advance Care Planning System

<b>PROMISE #1</b> We will initiate the conversation	<b>PROMISE #2</b> We will provide assistance with advance care planning
<b>PROMISE #3</b> We will make sure plans are clear	<b>PROMISE #4</b> We will maintain and retrieve plans
<b>PROMISE #5</b> We will appropriately follow plans	

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## Definition: Advance Directive (AD)

- A plan, made by a capable person or their surrogate, for future medical care regarding treatments or goals of care for a possible or probable event.
- This plan could be expressed:
  - Orally or in writing
  - If written, it could be in strict accord with specific state statutes or simply a documentation of the plan, e.g., a physician's note.

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## Definition: Advance Care Planning (ACP)

- A process of planning for future medical decisions. This process, to be effective, needs to meet similar standards as the process of informed consent, i.e., the person planning needs to...
- Understand selected possible future situations and choices;
  - Reason and reflect about what is best; and
  - Discuss these choices and plans with those who might need to carry out the plan

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## Relationship of ACP to ADs

- ADs are only as good as the process of planning:
- If the person planning does not understand, reflect on, or discuss their choices/options adequately, the plan has a high probability of failure.
  - ADs success is directly tied to the quality of the planning process or ACP.
  - ADs are limiting in use: need for POST

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To be successful...  
...it is essential to build an  
advance care planning system.

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What Might a  
Comprehensive  
Advance Care Planning  
System Look Like?

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Four Key Elements in Designing  
an Effective ACP Program

- #1 Systems Design
- #2 ACP Facilitation Skills Training
- #3 Community Education and Engagement
- #4 Continuous Quality Improvement

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**#1 Key Element:  
Systems Design**

**Building an infrastructure that  
assists in hardwiring excellence**

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- Effective, standardized document(s)
- Reliable medical record storage and retrieval
- ACP team and referral mechanism

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- Effective AD documents**
- Written for what level of understanding
  - Ease of use
    - Intuitive vs easy to follow instructions vs need an advanced degree to complete
  - White space
  - Assists in understanding role of healthcare agent

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## #2 Key Element: ACP Facilitation Skills Education and Training

### Building Competence and Creating an Effective ACP Team

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## ACP Facilitation Skills Training...A Necessary Element for Success

- ACP is a process of communication...of understanding, reflection, and discussion
- Requires clinicians gain patient-centered communication skills and defined roles
- History of incomplete skills training for professionals
- Many clinicians remain uncomfortable, unprepared, and lack time and reimbursement

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## Planning is best done in stages

- Attempting to plan for ALL possibilities in a single document is both impossible and unnecessary.
- Planning has three distinguishable, focused stages:
  1. Basic planning...this type of planning is useful for all adults, but should start by ages 55 to 65 for healthy adults.
  2. Planning for those with life-limiting, progressive illness where complications are evident.
  3. End-stage disease where it would not be surprising if the patient died in the next 12 months.

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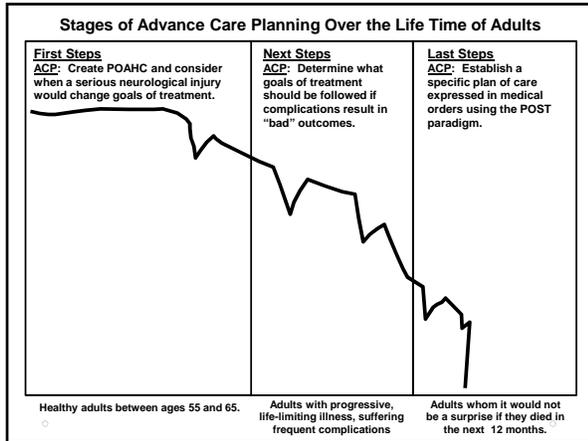
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When these stages of planning are defined, then it becomes possible to...

- Know when to start planning with different populations and to test and refine the planning process,
- Competently train health professionals to facilitate the planning at each stage,
- Develop tools to document the plans at each stage,
- Be better prepared to review and up date plans over time,
- Train physicians to know how to understand and incorporate plans into medical decisions

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**#3 Key Element: Community Education and Engagement**

Reaching out to Communities with Consistent, Common, and Repetitive Messages

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## Components of a Community Engagement Campaign

- Materials
- Partnerships
- Targeted Education
- Strategies to Meet the Needs of Diverse Communities

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## Partnerships

- Faith Communities
- Senior Service Agencies
- Support Groups
- Diverse Communities
- Book Stores
- Coffee Houses

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## Targeted Education Opportunities

- National Health Care Decisions Day
  - <http://www.nhdd.org/>
- Let's Talk Turkey
  - <http://www.munsonhealthcare.org/?id=784&sid=5>



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## #4 Key Element: Continuous Quality Improvement

If you don't measure it, you can't improve it

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## Rapid Testing

- Sample size minimum of 30
- CQI components:
  - Survey monkeys
  - Evaluations
  - Assessments
  - Anecdotal reporting
- Every failure = opportunity to measure

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Respecting Choices® First Steps™ Pre-Testing Workbook

POST-DEATH CHART AUDIT FORM FOR  
BASELINE DATA OF TARGET PILOT POPULATION

**A. Demographics**

1. Date: \_\_\_/\_\_\_/\_\_\_

2. Name of organization: \_\_\_\_\_

3. Type of organization  
 Hospital  Clinic  Nursing Home/Long-term care  Other \_\_\_\_\_

4. Chart number/ID: \_\_\_\_\_ 5. Telephone: \_\_\_\_\_

6. Gender:  Male  Female

7. Religion:  
 Jewish  Protestant  Roman Catholic  Other \_\_\_\_\_

8. Marital status:  
 Never  Married  Widowed  Divorced/Separated

9. Marital status: \_\_\_\_\_

10. Date of birth: \_\_\_/\_\_\_/\_\_\_

11. Date of admission: \_\_\_/\_\_\_/\_\_\_

12. Primary diagnosis, ICD-9 Code: \_\_\_\_\_

13. Secondary diagnosis, ICD-9 Code: \_\_\_\_\_

**B. Advance Care Planning Data**

1. Does the chart indicate the patient has an advance directive?  
 Yes \_\_\_\_\_ Date completed: \_\_\_/\_\_\_/\_\_\_  
 No (please specify) \_\_\_\_\_  
 Unknown (please specify) \_\_\_\_\_

2. What type of advance directive is indicated in the chart?  
 Living Will  
 Durable Power of Attorney  
 Combined Document (Living will & durable power of attorney)

3. Is the advance directive in the medical chart?  
 Yes  
 No

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## So what does a community that does it well look like?

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### ACP System ...

- ▶ We need to devote the same organizational effort to ACP as we do for ACLS/CPR
- ▶ This means we need sustained institutional resources
- ▶ In particular it means we need to:
  - ▶ Have an ACP coordinator and oversight committee;
  - ▶ We need to design processes, select tools and materials, define roles and responsibilities; and provide the needed training as a on-going effort;
  - ▶ We need to measure both the effectiveness of the processes as well as the outcomes of the system

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### Prevalence, Availability, and Consistency of Advance Directives in La Crosse, County after the creation of an ACP system in '91-'93

	LADS I* Data collected in '95/'96 N=540	LADS II** Data collected in '07/'08 N=400	P value
Decedents with ADs No (%)	459 (85.0)	360 (90.0)	.023
ADs found in the medical record where the person died	437 (95.2)	358 (99.4)	<.001
Treatment decisions found consistent with instructions	98%	99.5%	0.13

\*Hammes BJ, Rooney BL. Death and end-of-life planning in one Midwestern community. *Arch Intern Med.* 1998;158:383-390.

\*\*Hammes BJ, Rooney BL, Gundrum JD. A comparative, retrospective, observational study of the prevalence, availability, and utility of advance care planning in a county that implemented an advance care planning microsystem. *JAGS.* 2010;58:1249-1255.

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### Additional Data Regarding Use of POLST... '07-'08 (N=400)

- 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 had either an AD or a POLST form at the time of death.

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### Comparison of POLST vs AD Only

- | POLST (N= 268)   | AD only (N= 116)  |
|--|---|
| • Older: Mean age 83   | • Younger: Mean age 77  |
| • More likely to die of chronic or terminal illness (97%)                      | • More deaths from sudden or traumatic causes (18%)                   |
| • More likely to die in LTC or at home (84%)                                   | • More likely to die in the hospital (59%) or inpatient hospice (23%) |
| • 30% of POLST forms were completed with assistance of health care agents only |   |

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### First Steps

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## First Steps

- Intended for healthcare providers, clergy, and others involved in providing ACP Assistance.
- Purpose: to assist participants in learning the communication and interview skills.
- Normalizes the concept of planning, and orient individuals to the importance of regular review and update of written plans as necessary.
- Appropriate for all adults, but should be initiated as a component of routine healthcare for those over the age of 55-65.
- Goals : to motivate individuals to learn more about the importance of ACP, select a healthcare decision maker, and complete a basic written advance directive.

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## Michigan Physician Orders for Scope of Treatment (MI-POST)

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## What is POST

- A physician order designed to improve end of life care by converting patients' treatment decisions into medical orders that are transferable throughout the healthcare system
- Advisory within the acute care setting
- Binding in nursing facilities with support of policies
- Always voluntary

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## Purpose of POST

“...to improve end-of-life care by converting patients’ preferences into **medical orders** that are transferable throughout the healthcare system.”

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## Who Needs POST?

- Chronic, progressive illness
- Serious health condition
- Medically frail
- Tool for determination:  
“You wouldn’t be surprised if this patient died within the next year”  
NOTE: terminal diagnosis is not required for POST

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## Elements of the National POLST Paradigm

- Medical order form
- Accompanies patient
- Bright, unique color (Pink in OR, Green in WA)
- Training of professionals
- DNR orders
- Limit or provide other interventions
- Decisions about transport, ICU, nutrition, antibiotics

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## Why POST is Needed

- Patient preferences for life-sustaining treatment are frequently unknown at critical moments.
- Clinicians provide treatment that is not medically indicated and/or may inconsistent with patient desires.
- Emergency Medical Services' (EMS) responders are required by law to take heroic measures unless otherwise directed by physician orders.
- Allows healthcare professionals to know and honor patient wishes.

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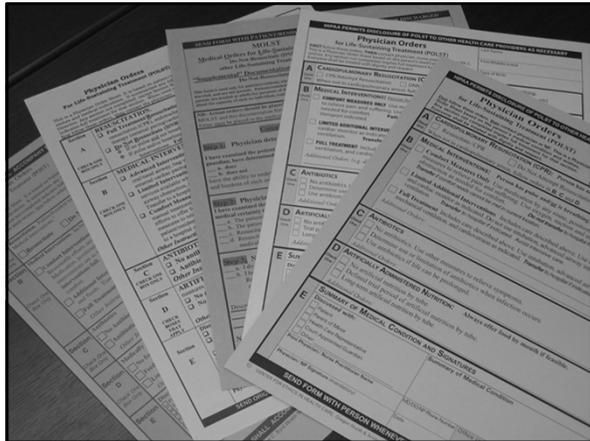
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## The MI-POST form

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# General

Michigan Physician Orders for Scope of Treatment (MI-POST)			
First follow these orders, then contact physician. This is a Medical Order Sheet based on the person's medical condition and treatment decisions. Any section not completed <u>does not</u> invalidate the form and implies full treatment for that section.		Last Name	
		First Name/Middle Initial	
Date of Birth: (mm/dd/yyyy)	Gender: (circle) <b>M</b> <b>F</b>	Last 4 SSN:	

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# Section A – CPR (No pulse AND is not breathing)

A	
<b>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse AND is not breathing.</b>	
<input type="checkbox"/> Attempt Resuscitation/CPR	<input type="checkbox"/> DO NOT Attempt Resuscitation/CPR (DNR/No CPR)

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# Section B – Medical Interventions (has pulse and/or is breathing)

B	
<b>MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.</b>	
ALL patients will receive comfort measures.	
<input type="checkbox"/> <b>Advanced Interventions:</b> Use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advance interventions as medically indicated. <i>Transfer to hospital if indicated; includes intensive care.</i>	
<input type="checkbox"/> <b>Limited Interventions:</b> DO NOT use intubation, advanced invasive airway interventions, or mechanical ventilation. Use medical treatment, IV fluids and cardiac monitor as indicated. <i>Transfer to hospital if indicated. Avoid intensive care.</i>	
<input type="checkbox"/> <b>Comfort Measures Only:</b> Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction manual treatment of airway obstruction and non-invasive respiratory assistance as needed for comfort. <i>Only transfer to hospital if comfort needs cannot be met in current location.</i>	
Additional orders: _____	

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## Section C – Artificially Administered Nutrition

<b>C</b> Check one	<b>ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.</b>	
	<input type="checkbox"/> Long-term artificial nutrition <input type="checkbox"/> Defined trial period of artificial nutrition <input type="checkbox"/> No artificial nutrition Additional orders: _____	

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## Section D – Documentation of Discussion

<b>D</b>	<b>DOCUMENTATION OF DISCUSSION</b>	
	Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Patient Advocate (DPOAH) <input type="checkbox"/> Court-appointed Guardian <input type="checkbox"/> Other Authorized Representative (specify): _____	Patient Goals:
<b>SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT</b>		
My signature below indicates to the best of my knowledge that the orders are consistent with the patient's medical condition and goals of care.		
Signature (print/typed)	Phone Number	
Name (print/type)	Date (mm/dd/yyyy)	
<b>COMPLETE BELOW IF SIGNED BY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT</b>		
Name of Physician of contract:	Physician Phone Number:	
SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY		

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## Section E - Signatures

<b>HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY</b>		
<b>E</b>	<b>SIGNATURES</b>	
	<input type="checkbox"/> Patient <input type="checkbox"/> Patient Advocate (DPOAH) <input type="checkbox"/> Court-appointed Guardian <input type="checkbox"/> Other Authorized Representative (specify): _____	
Print Name	Signature	Date (mm/dd/yyyy)
Address	Phone Number	Alternate Phone Number
The patient and/or the patient's authorized representative may revoke these directions at any time.		
Witness (1) Signature:	Print Name	
Witness (2) Signature:	Print Name	

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## Section F – Healthcare Provider Assisting with Completion of POST

HEALTHCARE PROVIDERS ASSISTING WITH COMPLETION OF POST FORM			
<b>F</b>	Preparer's Name (print)	Preparer's Signature	Date (mm/dd/yyyy)

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## How to Change the POST Form

HOW TO CHANGE THIS FORM
<p>The POST form should be reviewed periodically and if:</p> <ul style="list-style-type: none"> <li>The patient/resident is transferred from one care setting or care level to another;</li> <li>There is a substantial change in patient/resident health status such as:               <ul style="list-style-type: none"> <li>Improved Condition</li> <li>Advanced Progressive Illness</li> <li>Extraordinary Suffering</li> <li>Permanent Unconsciousness</li> <li>Close to death</li> </ul> </li> <li>The patient's/resident's treatment decisions change.</li> </ul> <p>If this form is revoked, write "VOID" on both sides in large letters, then sign and initial the form. After voiding the form, a new form may be completed. <i>If no new form is completed, full treatment and resuscitation shall be provided.</i></p>

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## Section G: Review of the POST

REVIEW OF THIS POST FORM			
Date	Reviewer Name	Location of Review	Outcome of Review
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New Form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New Form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New Form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New Form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New Form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New Form completed
			<input type="checkbox"/> No change <input type="checkbox"/> Form voided <input type="checkbox"/> New Form completed

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# Directions for Healthcare Professionals

**DIRECTIONS FOR HEALTH CARE PROFESSIONALS**

- POST must be completed by a healthcare professional based on patient decisions and medical indications.
- POST must be signed by a Physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility policy.
- A Physician's Assistant or Nurse Practitioner may sign the POST if working under the direction of a physician.
- Use of original forms is strongly encouraged. Photocopies, electronic forms, and faxes of signed POST form are valid. Healthcare providers should maintain a copy of the POST in the patient's chart.

**SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

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Form	Advantages	Limitations
<b>An Out-of-Hospital Do Not Resuscitate Form</b> (also known as the Community DNR)	<ul style="list-style-type: none"> <li>• Statutory protection for emergency personnel</li> <li>• Must be signed by a physician</li> </ul>	<ul style="list-style-type: none"> <li>• Deals only with CPR in event of absence of heartbeat and breathing.</li> <li>• Only applicable to persons in a setting outside of a hospital, a nursing home, or a mental health facility owned or operated by the Department of Community Health</li> <li>• Can only be executed by the individual or his/her legally designated patient advocate</li> <li>• Minimal use due to its limitations</li> <li>• DNR bracelet has only been implemented on a limited basis</li> </ul>
<b>Designation of Patient Advocate Form</b>	<ul style="list-style-type: none"> <li>• Designates a Patient Advocate</li> <li>• Identify individuals treatment wishes in the event he/she becomes incapacitated</li> </ul>	<ul style="list-style-type: none"> <li>• Does not direct EMS</li> <li>• Hypothetical</li> <li>• Only active when patient is incapacitated</li> <li>• Documents not always available/difficult to locate</li> <li>• Not required to be completed with a healthcare provider</li> </ul>
<b>Living Will</b>	<ul style="list-style-type: none"> <li>• Allows individuals to make several wishes known, including for assets and treatment wishes the event he/she becomes incapacitated</li> </ul>	<ul style="list-style-type: none"> <li>• Not recognized in Michigan statutes regarding healthcare decisions</li> </ul>
<b>MI-POST</b>	<ul style="list-style-type: none"> <li>• Not limited to CPR. Deals with a range of treatments that can direct care in emergent and non-emergent situations</li> <li>• Created as a <b>medical standard of care</b>, representing the standard of shared medical decisions and substantially inclusive of MI statutory language</li> <li>• Easy to maintain across settings</li> <li>• Must be signed by a physician or NP/PA who has a contractual relationship with a Physician</li> <li>• Directs EMS in approved Pilot areas</li> <li>• Does protect emergency personnel in limiting treatment beyond DNR pre-radio</li> </ul>	<ul style="list-style-type: none"> <li>• Does not protect emergency personnel in limiting treatment beyond DNR pre-radio*</li> <li>• Advisory in acute care settings to establish resuscitation status (not a medical order)</li> <li>• To sign a MI-POST, a probate judge must grant a court-appointed guardian of a legally incapacitated person the ability to sign a DNR and withhold treatments.</li> </ul>

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## Important Distinction

POST  $\neq$  Advance Directive

- **A current, active physician order**
- **Stands outside of the hospital setting**
- **Can be acted upon by EMS**
- **Hypothetical**
- **Active under certain circumstances**
  - Only when pt is incapacitated
  - Only when someone wonders if the document should be addressed
- **Can NOT be acted upon by EMS**

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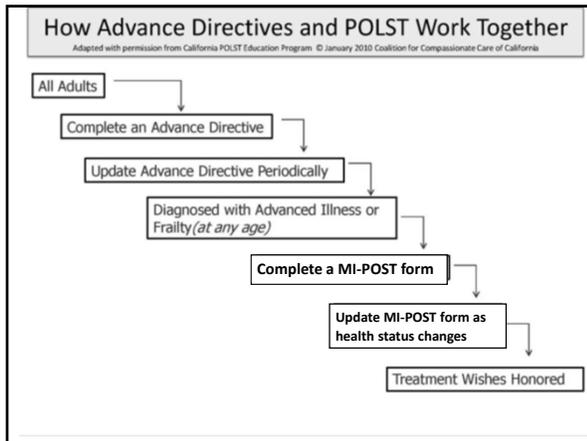
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## Using the POST to Record Decisions

- The MI-POST form should be completed after careful discussion with the MI-POST facilitator and the patient or the patient's authorized surrogate decision-maker, based on the patient's current treatment preferences.
- The discussion may include:
  - Patient (when the patient has capacity)
  - Patient Advocate
  - Court-appointed Guardian with Probate Court approval to make healthcare decisions
  - Other Authorized Representative

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## An example...

An elderly male is becoming frail and wants a MI-POST order to state he does not want resuscitation. At the present time his health and quality of life are such that he would want aggressive treatment, including ventilation, for reversible conditions such as pneumonia. So his current wishes on the MI-POST would be "DNR" and "Advanced Interventions." However, he is afraid of becoming incapacitated and kept alive on tubes and would not want aggressive therapy if he would not recover to good quality of life. The advance directive (with designated representative and specific instructions) is the appropriate way to document wishes to forgo in the future treatments that he would not want in a more incapacitated state. With updated goals of care, a new MI-POST could be created with the representative and health care team to represent the current wishes when his health status and prognosis change.

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## A note about POST in Michigan..

- EMS and Trauma Services Section has defined the EMS Scope of Practice
  - a Michigan-certified First Responder or EMT shall comply with life-sustaining treatment orders
  - three pilot areas : Delta, Northwest Regional, and Jackson Medical Control Authorities' geographical areas. Currently
  - only these Medical Control Authorities participating in the Michigan POST Pilot with explicit permission and approval by the EMS & Trauma Section of the Michigan Department of Community Health may implement the EMS POST Protocol
    - Others must attach the out-of-hospital DNT form to the POST

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## Bringing ACP to life in your organization

- Forms relationships with providers in your community
- Leadership engagement and commitment
  - human and financial resources
- Find the people with the passion
- Develop systems: tools, processes and protocols in your organization
- Training and Education
- Telling stories

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## Some last comments on POST

- It is a current Medical Order, NOT an advance directive
- The completion of the form is based on a skilled conversation with a trained facilitator
  - Based on the individual's values, goals, understanding and experiences
  - NOT a form to be checked: do not start conversation with the medical decision
- Verbal orders are acceptable in transitions
- Form MUST be visible/available to be honored
- It is meant to be changed as a patients' condition or decisions change
- Organizational policies must support
- Important part of a comprehensive ACP system

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## Resources

- California Coalition for Compassionate Care <http://coalitionccc.org/>
- INTERACT <http://interact2.net/>
- POLST <http://www.ohsu.edu/polst/>
- Respecting Choices <http://respectingchoices.org/>

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## Questions?

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