



physician orders for life-sustaining treatment paradigm

## Developing Program Request

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**Date Completed:** July 7, 2011  
**Program Name:** Maine POLST Coalition  
**State or Region:** Maine  
**Area of Use:** Throughout Maine, but as of now, only in a selection of facilities/hospitals and not yet consistently state-wide

**Date Updated:**

**Program Status Requested:**

No Program (possibly state contacts)  
 Developing Program  
 Date Developing Program listed on [www.polst.org](http://www.polst.org) \_\_\_\_\_

Office Use

**Name of Program:** **Maine POLST Coalition**

### Form Information

Yes	No	Optional	POSSIBLE POLST PARADIGM COMPONENTS
x			1. Form has a uniform, standardized color
x			2. Decisions reflected in the form are medical orders that must be followed by emergency personnel in the field and emergency rooms.
x			3. The form accompanies the patient across care settings
x			4. CPR / DNR section
x			5. Levels of interventions for #3
x			6. Levels of interventions for #4
x			7. Feeding Tube
x			8. Antibiotics
x			9. Basis for orders
x			10. Person completing form
x			11. Physician / NP / PA signature
x			12. Physician / NP / PA name & office number
x			13. Patient / Legal agent signature
x			14. Designation of legal agent name and number
x			15. Statement about leeway ( <i>is the patient's surrogate provided authority to interpret the goals and preference at the time decisions are made?</i> )

### Program Information

**EXTENT OF USE:**

**Start year:** 2009

<b>Settings of skills:</b>	Long-term care, some hospitals, not yet well-established in primary care/community settings		
<b>Range of use:</b>	Sporadic over a wide geographic area, only well-established and extensive in limited region of the state		
<b>Use by those under 18yrs:</b>	Would be allowed, but has not yet been addressed in detail		
<b>Distributed per month:</b>	Not able to track yet	<b>Distributed per year:</b>	Not able to track yet

**HISTORY:**

Prior to 2008 POLST was used in isolated silos with various forms and no systems for transfer across settings. In 2008 Maine Hospice Council convened a small POLST work group in partnership with Maine Health Care Association (LTC Assoc) . The core group also included a representative of the Attorney General’s office, an attorney from Office of Elder Services at Department of Health and Human Services (DHHS), and interested clinicians. In April 2009, consensus was reached on the form to be adopted for state-wide use in Maine. Since then our coalition has grown and has extensive involvement from healthcare systems representing most geographic areas of the state. First Maine Health Care Association and then MaineHealth (a large healthcare network) served as POLST “homes” during development . In January 2011, The Maine Hospice Council received a small grant as seed money to develop a state-wide advance care planning initiative to include becoming the administrative POLST home. Emphasis during this year has been on long-term care and hospital outreach and education, and EMS outreach. The Maine Medical Association passed a resolution endorsing POLST and providing seed money for future physician education. The Maine DHHS has included POLST as a best practice model in their annual long-term care educational conference. A current top priority is to broaden our coalition to include more consumer and public representation as current coalition has strong representation primarily from clinical entities, and will benefit from more diverse organizational partners.

**BARRIERS OVERCOME:**

1.) Previous use of various forms in isolated silos, now with one universal form. 2.) Initial concerns raised by Maine EMS as they had recently participated in lengthy process of developing revised Maine Advance Directive Form, including an out-of-hospital DNR order, and had questions about redundancy. They are now supportive and receptive to our efforts to address education and protocols. 3.) Lack of familiarity in medical community. 4.) Large rural state with challenges in coordination of isolated efforts. (#2, #3 and #4 are barriers we are continuing to address.)

**STATE LAW AND REGULATIONS:**

No barriers identified. Currently recognized as voluntary best practice model without regulations or legislation; we received extensive guidance from Office of Attorney General and Dept of Health and Human Services in developing form.

**POLST IN THE HEALTH CARE SETTING:**

**Policies (hospitals, nursing homes, EMS, etc.):**

Developed in a few settings; high priority for development in settings implementing POLST,, yet not well-established in most.

**Registry for POLST Paradigm Forms:**

Not yet, but high priority for future

**MANAGEMENT:**

**Describe program management:**

Newly developed position for Medical Director to lead initiative at Maine Hospice council with funding for position for six hours/week. Maine Hospice Council Administrative Assistant as primary contact and administrative support

**Who will distribute forms:** Currently, pdf available for individual printing by institutions, facilities and practices. Considering moving to distribution by POLST administrative home. Form is printed on lime green #24 paper and this guidance is given to those printing from pdf.

**How will oversight of the program ensure quality:**

Dynamic coalition with strong leadership to emphasize importance of quality, especially the quality of conversations prior to completing forms. Current focus is on oversight in long-term care facilities and working with individual hospitals to monitor quality of their programs. This is one of top priorities for future efforts as do not yet have centralized monitoring capacity. We are developing state-wide quality monitoring plan.

**TRAINING:****Training for health care professionals:**

Extensive outreach in facilities and hospitals in early implementation phases, primarily by POLST Coalition clinical leaders, (several physicians -geriatricians and hospice and palliative medicine physicians, hospice and palliative nurses and a palliative care social worker.) Extensive initial and ongoing repeated opportunities through Maine Health Care Association including webinars, workshops and planned more comprehensive trainings.

**Training for the public and patients:**

In early development. We have been cautious in this area out of concern that premature public outreach could outpace readiness of systems to respond to public interest. This has been a challenge already in some communities where we have had enthusiasm for the POLST model outpace EMS and provider recognition. Strong future focus as discussed below in partner project concerning community engagement in advance care planning.

**EVALUATION:****CQI projects and research:**

Early adapters and pilot sites have done internal CQI projects. Future plans for state-wide quality monitoring strategy and partnership with research projects through MaineHealth. Plan for this to be a core component of multi-year grant project for which Maine Hospice Council is pursuing funding sources. (Council has strong track record of receiving grants for and coordinating similar state-wide comprehensive initiatives.)

**ADDITIONAL INFORMATION:**

- 1.) Lynne Ponto started new position as administrative assistant at Maine Hospice Council in late June 2011. After her orientation period, she will become primary POLST contact. Elizabeth Hart is serving in that capacity until after Ms. Ponto's orientation and then will continue as clinical leadership for POLST efforts in Maine.
- 2.) POLST initiative has been, and will continue to be, a core element of a broader state-wide initiative coordinated by Dr. Hart and the Maine Hospice Council which is entitled "Cultivating Meaningful Conversations to Guide Care." This advance care planning effort focuses on developing community conversations about importance of goals of care discussions and training healthcare professionals in skills for facilitating conversations.
- 3.) Additional information concerning form questions above: Question #2- EMS outreach for recognition is top priority and focus of POLST leadership at present. Currently recognized under existing EMS protocols for out of hospital orders, but no POLST specific requirements. Question #3- Developing policies for inter-institutional transfers. Question #15 – Please see page 2 of POLST form instructions concerning "authorized representative."