

Endorsed Program Description for:		PENNSYLVANIA	
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Date Completed:	10/25/05	Date Updated:	1/08/07, 11/13/08, 4/28/10, 11/1/10
Program Name:	Pennsylvania Orders for Life-Sustaining Treatment (POLST)		
State or Region:	Pennsylvania		
Area of Use:	Statewide		
Program Status Requested:	<input type="checkbox"/>	No Program (possibly state contacts)	
	<input type="checkbox"/>	Developing Program	
	<input checked="" type="checkbox"/>	Endorsed by National POLST Paradigm Initiative Task Force	
Name of Program:	Pennsylvania Orders for Life-Sustaining Treatment (POLST)		
Program Requirements			
Does the program meet the following requirements?			
Yes	No	POLST PARADIGM COMPONENTS	
X		1. The form constitutes a set of current (also known as standing) medical orders.	
X		2. The process includes ongoing training of health care professionals across the continuum of care about the goals of the program as well as the creation and use of the form.	
X		3. Use of the form is recommended for persons who have advanced chronic progressive illness and/or frailty, those who might die or lose decision-making capacity in the next year or anyone wishing to further define their preferences of care.	
X		4. As allowed by statute and regulations, the National POLST Paradigm Task Force strongly recommends that all POLST Paradigm programs require the signature of either the patient or the patient's legal representative (or witnessed verbal consent as allowed by state law) to make the form valid. The signature of the patient (or the patient's legal representative if the patient lacks decision-making capacity) provides evidence that patients or their legal representatives agree with the orders on the form. In this respect, the requirement that patients or their legal representatives review and sign the form provides a safeguard for patients that the orders on the form accurately convey their preferences.	

X		5. Completion of a POLST Paradigm form is a recommended preferred practice for advance care planning in multiple health care settings (e.g., emergency medical services, long-term care, hospice, and hospice), but the completion of the form and the decisions recorded on it should always be a matter of voluntary, informed consent. The completion of a POLST Paradigm form should be based on the patient's goals for care to ensure that the patient receives the care he or she desires.
X		6. There is a plan for ongoing evaluation of the program and its implementation.
X		7. There is a single strong entity within the region or state that is willing to accept ownership for the program (e.g., hospital association, state dept of health, hospice and palliative care association, university-affiliated ethics center, etc) and has the resources to implement it.
Form Requirements		
Does the form meet the following requirements?		
Yes	No	Optional
POLST PARADIGM COMPONENTS		
X		1. The treatment being considered requires a medical order that needs signature by a health care professional.
X		2. The medical order is based on medical indication and a person's preferences for treatment (e.g. as expressed in an oral statement or written advance directive). a) The treatment is a "comfort measure"; or b) The order is an instruction regarding hospital transfer; or c) The medical order is a life-sustaining treatment that is being considered for use in a person with advanced progressive illness and/or frailty and has these characteristics: <ul style="list-style-type: none"> • is <i>frequently</i> needed by health care professionals (e.g. EMS protocol, emergency department and ICU care, long-term care or hospice); and/or • is <i>urgently</i> needed by health care professionals (e.g. EMS protocol, emergency department and ICU care; long-term care or hospice); and/or • requires an <i>informed consent process that is complex</i> (e.g. tube feeding treatment); and/or is <i>not effectively specified as "Additional orders"</i>.
X		3. In addition to orders with regard to CPR, the POLST Paradigm form must indicate the level of medical intervention for the patient: comfort measures only; limited additional interventions; or full treatment. The level of intervention shall contain a description of the services to be provided and the site in which they will be provided. For example, a comfort measures order may indicate that the patient is not to be transferred unless comfort needs cannot be met in the person's current setting.
X		4. The form requires a valid clinician (Physician, Nurse Practitioner or Physician Assistant depending upon POLST paradigm program) signature and a date of signature. Either the date or some other element on the form describes the effective date and there is a clear way to show which are the current orders and

		which are outdated or voided orders.
X		5. The form provides explicit direction about resuscitation (CPR) status if the patient is pulseless and apneic.
X		6. The form also includes directions about other types of intervention that the patient may or may not want. For example, decisions about transport, ICU care, artificial nutrition, etc. Space is provided for additional orders.
X		7. The form accompanies the patient, and is transferable and applicable across all care settings (i.e. home, long-term care, hospice, EMS, hospital).
X		8. The form is uniquely identifiable and standardized within a state/region.
X		9. The form indicates with whom the orders were discussed.
		10. The form indicates a transfer option if the patient's comfort needs cannot be met in the current setting of care.

OPTIONAL ELEMENTS

The following issues may be handled by programs in different ways depending on state law and local preferences. Does the program include the following components?

Yes	No	POSSIBLE POLST PARADIGM COMPONENTS
X		1. Ideally, a legal surrogate should be able to make decisions about treatment choices and complete a POLST Paradigm form for a patient without decision-making capacity, but states have varying laws regarding surrogates and decision-making.
X		2. Some states may recognize the form as the only out-of-hospital DNR form; in others there may be other means of DNR ID as well. Use of the form is always voluntary.
X		3. Ideally, states would accept forms completed in other states (reciprocity).
X		4. Medical orders may address antibiotics and artificially administered nutrition and hydration. This may vary based on medical practice standards, regulations or laws of that state.
X		5. The National POLST Paradigm Task Force strongly recommends that all original, paper POLST Paradigm forms have a bright, easily seen uniform color but recognizes that FAXED or electronic representations of the POLST Paradigm form on white paper are valid.

EXTENT OF USE

Start year:	2000
Settings of skills:	Hospitals, skilled nursing facilities, long-term care, retirement communities, hospices
Range of use:	Varies within communities. Used has expanded so that POLST has been implemented statewide.

Use by those under 18yrs:	Yes
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Distributed per month:	3,000	Distributed per year:	35,000
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HISTORY:

In 2000, Highmark Inc., under the direction of Dr. Judith Black, established its Advance Care Planning/End-of-Life Initiative and began to work internally and collaboratively with community groups such as the Providers’ Task Force, to improve care at the end of life. One of the earliest endorsed initiatives was POLST and a large nursing facility began to use the POLST that year. In 2002, in conjunction with a nursing home quality improvement initiative funded by the Jewish Healthcare Foundation and called the Pittsburgh End of Life Collaborative (PELC), more nursing facilities began to use the form.

The Pennsylvania Geriatrics Society – Western Division, an affiliate of the American Geriatrics Society, endorsed the POLST concept and in April 2004 invited Dr. Susan Tolle to be a presenter at the annual Clinical Update in Geriatric Medicine. During that visit she met and presented POLST to a group of community leaders and then to physician, nursing and social worker attendees of the Clinical Update. Those presentations energized the community and led to a group of leaders coming together and forming the Coalition for Quality at the End of Life (CQEL). Its mission is to improve end of life care for people in western Pennsylvania by identifying and collaborating with key stakeholder groups.

A CQEL subgroup was charged with the task to develop the plan to implement POLST throughout the region. The specific aspects of the plan included identifying the relevant stakeholders throughout the system who could help make POLST happen, having a “POLST Repository” for providers and consumers to use for information, developing a “train the trainer” model for education and enlisting the support of those who can facilitate the use of POLST in various settings (i.e., hospice, nursing homes, hospitals, emergency services). The Aging Institute of UPMC Senior Services and the University of Pittsburgh is an example of an organization that is making POLST happen through its educational effort, development of communication and support to facilities. The University’s Institute to Enhance Palliative Care lends professional support to the project.

In January 2005, Governor Rendell appointed a statewide Task Force for Quality at the End of Life, which issued its Final Report in August 2006. The Task Force report included the following recommendation to the Governor: “The Department of Health should adopt a portable form like the Physician Orders for Life-Sustaining Treatment (POLST) to augment the transferability of advance care plans. The form accompanies patients across health care settings to ensure that their wishes are honored throughout the health care system”.

In November 2006, Governor Rendell signed into law Act 169, which provides a comprehensive statutory framework governing advance health care directives and health care decision-making for incompetent patients. The act mandated the formation of a statewide advisory committee, the Pennsylvania Life-Sustaining Wishes (PLSW) Committee, to examine the advisability and possible adoption of a standardized form of physician’s order for patient’s life sustaining treatment instructions, such as POLST. The PLSW committee formally recommended that Pennsylvania adopt the statewide POLST form in its Report to the Secretary of the Department of Health in November 2008. On October 24, 2010, the secretary approved a standard form called Pennsylvania Orders for Life-Sustaining Treatment for use in Pennsylvania.

BARRIERS OVERCOME:

As described above, although the Pennsylvania OOH-DNR Order is the only document that may be followed by emergency medical services (EMS) in regard to withholding of CPR, the past few years have seen increasing momentum toward formal state recognition. The recommendation of the legislatively mandated Pennsylvania Life Sustaining Wishes Committee to the Secretary of Health has stimulated active discussion of the strategies needed for a statewide rollout of an official Pennsylvania POLST form. Since there is no barrier to the use of POLST (except by EMS personnel), communities across the state have been implementing the POLST and collecting data on its acceptance. The early and still most common use of the POLST has been primarily within skilled nursing facilities. The next steps have been to use POLST among facilities that commonly shared patients who transition between care settings.

Another barrier over the years has been the lack of infrastructure to support efforts to increase awareness of POLST. The support provided by health plans and the medical, nursing and social service staffs of institutions have overcome this.

STATE LAW AND REGULATIONS:

As described above, Act 169 mandated the Pennsylvania Life Sustaining Wishes Committee. Its recommendation for the statewide adoption of a standard form for Pennsylvania was approved by the DOH. The OOH-DNR order is the only form that EMS personnel are authorized to follow, and until legislative action is taken to change this, EMS personnel are instructed to contact their medical command officer whenever they encounter a POLST in the field, and to follow the command officer's directions. There us no regulatory or legislative barrier to the use of the POLST in any other context.

POLST IN THE HEALTH CARE SETTING

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

Actions to facilitate POLST integration in health care settings, as well as for broad-based public education programming, were included in the Final Reports of both the governor's Task Force (2006) and the Patient Life-Sustaining Wishes Committee (2008). As the state's POLST program was being developed interventions were incorporated to facilitate the implementation of POLST within all healthcare settings.

Facilities are encouraged to develop policies related to the completion of POLST forms, and the acceptance/recognition of POLST forms from other institutions.

Registry for POLST Paradigm Forms:

None at this time

MANAGEMENT

Describe program management:

Currently, the Highmark Health Plan as a representative of the Coalition for Quality at the End of Life (CQEL) coordinates the management of the program in close collaboration with consortia and professional organizations across the state. As a broad-based regional collaborative, CQEL has credibility and good communication with health providers across the spectrum of tertiary care hospitals to long-term care, hospice, EMS, and personal care facilities. Regional and statewide organizations such as PANPHA, Pennsylvania's Association for Long Term Care Medicine (PMDA), **Pennsylvania Geriatrics Society – Western** Division and the Hospital & Healthsystem Association of Pennsylvania (HAP) are examples of collaborating groups that support CQEL's efforts and helped it achieve its statewide reach. Examples of management policies are available within the POLST Training Manual.

Who will distribute forms:

Forms are available from the Pennsylvania Department of Health web site. Entities without the ability to download and copy forms may notify the Pennsylvania POLST Contact and forms will be provided.

How will oversight of the program ensure quality:

As the program focus moves from creating awareness and receiving statewide approval, ensuring quality is the primary objective with processes for statewide quality improvement underway.

TRAINING

Training for health care professionals:

Through the collaboration of three health plans, a training manual has been developed and representatives have presented "train the trainer" sessions at large group meetings and individual facilities. The Aging Institute of UPMC Senior Services and the University of Pittsburgh website is the primary source of educational material at <http://www.aging.pitt.edu/professionals/resources-polst.htm>.

Currently, HAP is engaged in rolling out a statewide education plan. Through a coalition of interested long-term

and palliative care physicians, insurers, health care providers, and professional and trade associations, a collectively planned series of introductory educational webinars will be launched in January 2011. The webinars will provide a foundational understanding of Pennsylvania's advance directive law and how physician orders for life-sustaining treatment can support care decisions at the end-of-life. Health care providers will also have an opportunity to hear how hospitals, nursing homes, and communities have come together to implement physician orders for life-sustaining treatment in their facilities. Following these introductory webinars, expert faculty will conduct regional face-to-face sessions to assist those interested in implementing the Pennsylvania Orders for Life-Sustaining Treatment in their communities.

Email requests for training or materials can be sent to marian.kemp@highmark.com.

Professionals are also encouraged to go to the Oregon POLST website at www.ohsu.edu/polst/ for information and materials, including two POLST videos.

Training to assure that health care professionals who discuss the choices offered on the POLST Paradigm form are competent to conduct and facilitate these discussions and decisions with their patients or surrogates:

Training for the public and patients:

Educational programming takes place through local activities of CQEL and its affiliated member organizations. With support from the PA Department of Aging, one of CQEL's members, the Take Charge Campaign has produced a series of public service TV spots, currently available on the web, that encourage advance care planning and raise awareness of the importance of documents such as the POLST

<http://www.takechargeofyourlife.org>.

Specific POLST-related educational campaigns are outlined in the Final Report of the Patient Life-Sustaining Wishes Committee. The public and patients may access POLST information at

<http://www.aging.pitt.edu/professionals/resources-polst.htm>.

EVALUATION

CQI projects and research:

Some facilities have independently undertaken POLST related quality improvement projects. An example is a project that followed assessment of the number of completed POLST forms within the medical record. Another project was initiated to assure individuals' wishes, as documented on the POLST form, are respected.

Additionally there is a plan for ongoing annual evaluation of the program and its implementation.

ADDITIONAL INFORMATION