VCU Palliative Care ECHO*

May 9, 2019
The Virginia Physician Orders for Scope of Treatment (POST)
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Physicians should claim only the credit commensurate with the extent of their participation in the activity.
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The following Planning Committee and Presenting Faculty Members report relevant financial relationships to disclose:

The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

Danielle Noreika, MD

*No commercial or in-kind support was provided for this activity*
Helpful Reminders

- You are all on mute please unmute to talk
- If joining by telephone audio only, press *6 to mute and unmute

Unmute your microphone and start video
Helpful Reminders

Right click to your Zoom screen to rename your login; include your name and organization.
Helpful Reminders

Activate chat feature

Use the chat box to ask questions as they come to mind
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions
   • Case Presentation
     5 min.
   • Clarifying questions from spokes, then hub
     2 min. each
   • Recommendations from spokes, then hub
     2 min. each
   • Summary (hub)
     5 min.

III. Closing and Questions

• Bi-weekly tele-ECHO sessions (1.5 hours)
• Didactic presentations developed by inter-professional experts in palliative care
• Website: www.vcuhealth.org/pcecho
• Email: pcecho@vcuhealth.org

Let’s get started!
# Hub Introductions

## VCU Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Director</strong></td>
<td>Danielle Noreika, MD, FACP, FAAHPM</td>
</tr>
<tr>
<td></td>
<td>Medical Director/Fellowship Director VCU Palliative Care</td>
</tr>
<tr>
<td><strong>Clinical Experts</strong></td>
<td>Egidio Del Fabbro, MD – VCU Palliative Care Chair</td>
</tr>
<tr>
<td></td>
<td>Jason Callahan, MDiv – Palliative Care Specialty Certified</td>
</tr>
<tr>
<td></td>
<td>Tamara Orr, PhD, LCP – Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td>Diane Kane, LCSW – Palliative Care Specialty Certified</td>
</tr>
<tr>
<td></td>
<td>Felicia Hope Coley – RN</td>
</tr>
<tr>
<td></td>
<td>Candace Blades, JD, RN – Advance Care Planning Coordinator</td>
</tr>
<tr>
<td></td>
<td>Brian Cassel, PhD – Palliative Care Outcomes Researcher</td>
</tr>
<tr>
<td><strong>Support Staff</strong></td>
<td>Teri Dulong-Rae / Bhakti Dave, MPH</td>
</tr>
<tr>
<td></td>
<td>David Collins, MHA</td>
</tr>
<tr>
<td></td>
<td>Frank Green</td>
</tr>
<tr>
<td>Program Manager</td>
<td></td>
</tr>
<tr>
<td>Telemedicine Practice Administrator</td>
<td></td>
</tr>
<tr>
<td>IT Support</td>
<td></td>
</tr>
</tbody>
</table>
Spoke Participant Introductions
Name and Institution
The Virginia Physician Orders for Scope of Treatment (POST)

Danielle Noreika, MD, FACP, FAAHPM
A Bit of History........

• Oregon, 1991

• Developed a new tool recognizing that AD’s were inadequate for patients with serious illness or frailty

• Task force originated from the Center for Ethics in Health Care at Oregon Health & Science University (OHSU) with representatives of stakeholder health care organizations

https://oregonpolst.org/history
Oregon, 1993
A Vision

1993: The Vital Role of Statewide Education

The Task Force recognized early on that education is the key to effective use of the Medical Treatment Coversheet (MTC, and later POLST) form. For the program to succeed statewide, health care professionals received updates on form use, newly developed policies and advances in research. The Task Force developed numerous educational resources and relied on member organizations to develop effective on-going learning for their constituents. In essence, the group became a clearinghouse of information and the sharing of ideas, catalyzing resource development, all to help health care organizations educate their member health care professionals. Here are some examples of these early educational tools:

- Pamphlets including the MTC form and a step by step implementation process
- Video tape explaining how the MTC is used and implemented
- Consultation with health care professionals skilled in the use of the form
- Executive summary of the MTC evaluation project
- Initial “Train the Trainer” conference providing education about Oregon’s new advance directive statute (including decisions for a patient to have or forego permanent feeding tube placement)

The Task Force recognized that education is a cornerstone of the POLST Program. Click here for a more extensive archive of early educational resources for health care professionals, health care systems and patients and families.
Oregon, 1995

**Physician Orders for Life-Sustaining Treatment**

This is a physician order sheet based on patient/resident wishes and medical indications for life-sustaining treatment. If in the clinical record, this should be first page. In other settings, locate in a prominent place. When made occurs, first follow these orders, then contact physician. Any section not completed indicates full treatment.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Resuscitation: Patient/resident has no pulse and is not breathing. For all other medical circumstances, refer to “Section B, Emergency Medical Services (EMS)” listed below.</td>
</tr>
<tr>
<td>B</td>
<td>Emergency Medical Services (EMS)</td>
</tr>
<tr>
<td>C</td>
<td>Antibiotics: No antibiotics except if needed for comfort</td>
</tr>
<tr>
<td>D</td>
<td>Artificially Administered Fluids and Nutrition: No feeding tube/IV fluids provide other measures to assure comfort</td>
</tr>
<tr>
<td>E</td>
<td>Discussed with: Patient/Resident, Health Care Representative, Court-appointed Guardian</td>
</tr>
</tbody>
</table>

**How to Change 'Physician Orders for Life-Sustaining Treatment’**

This form, “Physician Orders for Life-Sustaining Treatment,” should be reviewed if:
1. The patient/resident is transferred from one care setting to another, or
2. There is substantial permanent change in patient/resident health status, or
3. The patient/resident treatment preferences change.

First, review ‘Patient/Resident Preferences as a Guide for Physician Orders for Life-Sustaining Treatment’ (Section F). Second, record the review in “Review of Physician Orders for Life-Sustaining Treatment” (Section G). Finally, if this form is to be voided, draw a line through the “Physician Orders” and/or write the word “VOID” in large letters, then sign or initial the form. After voiding the form, a new form may be completed. If no new form is completed, full treatment may be provided.
Then What Happened?

• Emphasized over time continued feedback, research, and changes to form and process

• 2004: National POLST Paradigm Taskforce convened

• 2009: Oregon POLST registry

• 2010: Trademark registration
2015, Seriously

2015: ePOLST Technology

As electronic medical records became the norm, many groups expressed interest in developing electronic versions of POLST. Providence Health and Services in Oregon worked with the POLST Task Force to create a pilot and was the first to develop an electronic POLST completion system. They used an EPIC Smart Form. Providence worked closely with the Oregon POLST Registry to create a secure electronic submission system.

In April of 2015, OHSU developed a partnership with the Vynca ePOLST system which provides an electronic completion system accessed within Epic with direct submission to the Oregon POLST Registry. To ensure that POLST orders can be accessed with a single click, the “ePOLST Yes/No” tab was included on the patient header (Oregon POLST policy recommendation). The system was designed to facilitate bidirectional communication with the Oregon POLST Registry.

<table>
<thead>
<tr>
<th>EMR</th>
<th>Schedule</th>
<th>In Basket</th>
<th>Chart</th>
<th>Tel Enc</th>
<th>Refill Enc</th>
<th>Meds List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test, ePOLST</td>
<td>89 yrs, Female, 07/19/1926</td>
<td>MRN: 000000000</td>
<td>CSN: 0000000000</td>
<td>Allergies: Penicillin</td>
<td>Code: Not on file</td>
<td>Pt Class: Inpatient</td>
</tr>
</tbody>
</table>

Adv Dir: YES
National POLST Paradigm Program Designations
Click a state for more information

- 3 mature
- 24 endorsed
- 2 developing
- 5 non-conforming
- Oregon separated from the National POLST Paradigm in 2017

Totals include Washington DC. MATURE Programs are also Endorsed and are counted in both the Mature and Endorsed Program totals.

LEARN MORE in the text below the map
Statement on Oregon POLST Separation from National POLST

Over the past 25 years, the Physician Orders for Life-Sustaining Treatment, or POLST, program has grown out of concern of honoring patient preferences about care at the close of life (Oregon POLST History). The goal of the Oregon POLST program is to provide a mechanism to ensure that seriously ill persons and their family are able to make informed choices about their care. To preserve public trust, it is important that POLST programs are beyond reproach by not taking money from health care related industries that potentially would suggest a conflict between the goals of the POLST program of promoting patient choice and a focus on cost saving that would benefit industry.

Oregon’s POLST program grew into a national model for end-of-life care and many states began seeking assistance in implementing POLST programs in their states. Eventually a national office was formed at OHSU, and then expanded and began operating independently from OHSU in January of 2017.

Oregon POLST learned in early 2017 that National POLST accepted industry funding. This poses an inherent conflict of interest. POLST has never been about cost savings. It has been about allowing patients to choose and document what kind of care they wish to receive when nearing the end of life. This conflict of interest does not reflect our values and compromises the goals of the founders of POLST.

We are saddened to see the direction in which the National POLST program is headed and believe...
National POLST Paradigm: POLST Use by State
As of April 2019

This map shows the general availability regarding the use of the POLST Paradigm within a state. For this map, POLST Program leaders were asked to use the following definitions and provide their assessment about the level of use of the POLST Paradigm within their state:
<table>
<thead>
<tr>
<th>POLST maturity status</th>
<th>Antibiotics N (%)</th>
<th>IV fluids N (%)</th>
<th>Transfer to hospital N (%)</th>
<th>Medication by any route N (%)</th>
<th>Oxygen N (%)</th>
<th>BiPAP/CPAP N (%)</th>
<th>Intubation/ventilation N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mature</td>
<td>2 (66.67)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>3 (100)</td>
</tr>
<tr>
<td>Endorsed</td>
<td>14 (73.68)</td>
<td>13 (68.42)</td>
<td>19 (100)</td>
<td>19 (100)</td>
<td>19 (100)</td>
<td>18 (94.74)</td>
<td>18 (94.74)</td>
</tr>
<tr>
<td>Developing</td>
<td>14 (70.00)</td>
<td>16 (80.00)</td>
<td>20 (100)</td>
<td>20 (100)</td>
<td>20 (100)</td>
<td>18 (90)</td>
<td>17 (85)</td>
</tr>
<tr>
<td>Nonconforming</td>
<td>2 (66.67)</td>
<td>1 (33.33)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>3 (100)</td>
<td>3 (100)</td>
</tr>
<tr>
<td>Frequency mentioned and locations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentioned once</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfort Measures</td>
<td>13 (28.89)</td>
<td>0</td>
<td>0</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Limited treatment</td>
<td>0</td>
<td>28 (62.22)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (2.22)</td>
<td>0</td>
</tr>
<tr>
<td>Full treatment</td>
<td>15 (33.33)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10 (22.22)</td>
<td>36 (80)</td>
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<td>Separate section</td>
<td>0</td>
<td>0</td>
<td>4 (8.89)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5 (11.11)</td>
</tr>
<tr>
<td>Mentioned twice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfort + limited treatment</td>
<td>3 (6.67)</td>
<td>0</td>
<td>7 (15.56)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Limited + full treatment</td>
<td>0</td>
<td>5 (11.11)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>26 (57.78)</td>
<td>0</td>
</tr>
<tr>
<td>Limited + separate section</td>
<td>1 (2.22)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Full + separate section</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mentioned three times</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Comfort + limited + full treatment</td>
<td>0</td>
<td>0</td>
<td>34 (75.56)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Limited + full + separate section</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total mentioned</td>
<td>32 (71.11)</td>
<td>33 (73.33)</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>42 (93.33)</td>
<td>41 (91.11)</td>
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<tr>
<td>Not mentioned at all</td>
<td>13 (28.89)</td>
<td>12 (26.67)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3 (6.67)</td>
<td>4 (8.89)</td>
</tr>
<tr>
<td>Total</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>45 (100)</td>
<td>45 (100)</td>
</tr>
</tbody>
</table>
Table 3. Logistic Regression Examining Variables Associated With Hospice Enrollment and Location of Death.

<table>
<thead>
<tr>
<th>Regression Models</th>
<th>Unadjusted OR (95% CI)</th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice enrollment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IV</td>
<td>1.08 (0.45-2.58)</td>
<td>1.01 (0.41-2.49)</td>
</tr>
<tr>
<td>Income</td>
<td>2.00 (1.34-2.97)^b</td>
<td>1.90 (1.27-2.82)^b</td>
</tr>
<tr>
<td>Medical comorbidity</td>
<td>0.99 (0.93-1.07)</td>
<td>0.81 (0.61-1.09)</td>
</tr>
<tr>
<td>Functional comorbidity</td>
<td>1.06 (0.94-1.19)</td>
<td>1.26 (0.98-1.62)</td>
</tr>
<tr>
<td>POLST registration</td>
<td>2.57 (1.12-5.90)^c</td>
<td>2.37 (1.01-5.54)^c</td>
</tr>
<tr>
<td><strong>Death inside a VA facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IV</td>
<td>1.09 (0.49-2.40)</td>
<td>1.12 (0.50-2.52)</td>
</tr>
<tr>
<td>Income</td>
<td>1.03 (0.76-1.42)</td>
<td>1.11 (0.80-1.53)</td>
</tr>
<tr>
<td>Medical comorbidity</td>
<td>1.04 (0.98-1.10)</td>
<td>1.03 (0.80-1.33)</td>
</tr>
<tr>
<td>Functional comorbidity</td>
<td>1.08 (0.98-1.20)</td>
<td>1.11 (0.89-1.38)</td>
</tr>
<tr>
<td>POLST registration</td>
<td>0.27 (0.12-0.59)^b</td>
<td>0.27 (0.12-0.59)^b</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; OR, odds ratio; POLST, Physician Orders for Life-Sustaining Treatment.

^a Adjusted models controlled for tumor stage, income, medical comorbidity, and functional comorbidity. Reference group is those without a registered POLST.
Harrison et al, Amer J Emerg Med, 2019

**Fig. 1.** Incidence of transported IPOSTs. Of the 119 patients included in the prospective arm of the study, 18 patients had a confirmed IPOST and 9 of those patients arrived with a physical IPOST in-hand.
sures (12). Similarly, patients with cardiac disease admitted for acute coronary syndrome are less aggressively treated and more likely to die (13). Williams et al. report that in the setting of septic shock, patients with DNR documents received lower volumes of fluid resuscitation, were less likely to be intubated, and were less likely to receive a central venous line or early vasopressor therapy (14). Mortality among patients with a DNR document was 65.6%, compared with 6.1% for those without (14). It is not clear to what extent these differences in care and outcome were the result of physicians treating patients in accordance with the patients’ wishes, vs. restricting care based on extrapolation of what the patients’ wishes might be from a DNR order (for instance, making the decision that because the patient did not want vasopressor support in the context of CPR, assuming the patient would also not want it as a targeted therapy for septic shock). Even decisions concerning patient disposition are influenced by a patient’s DNR status, with lower rates of admission to an ICU regardless of a patient’s age, Acute Physiology and Chronic Health Evaluation II score, or functional status (15).
Torke et al, Amer J Hosp and Palliat Med, 2018

31 Eligible Participants

2 Unable to Contact
11 Refused

18 Enrolled Participants

18 Received POLST Facilitation

16 Follow-up Interviews Completed at 4-6 weeks

18 Chart Reviews Completed

10 Signed POST forms
8 No POST Forms
Tolle et al, JAGS, 2019
ON MY MIND

Extracorporeal Membrane Oxygenation Bridge to No Recovery

Pushing the Limits of Patient and Family Autonomy: When Is Enough Enough?

The concept of mechanical circulatory support has its origins in cardiopulmonary bypass, which allows us to transiently assume the functions of both heart and lungs as we repair critical valves and vessels. It is an elegant sequence of events intended to improve quality of life for our patients.

Teresa A. Mulaikal, MD
Shunichi Nakagawa, MD
Kenneth M. Prager, MD

Treatment limitations in the era of ECMO

Once relegated to the fringes of medicine, the use of extracorporeal membrane oxygenation (ECMO) in adults with severe respiratory or cardiac failure is now increasing at an extraordinary pace. ECMO is perceived by many as life-saving, and this growth is continuing despite a paucity of widely accepted evidence demonstrating benefit. Without such evidence, our obligation to carefully assess the place of this technology in patient care is heightened.

In this rapidly evolving area, how do we decide when to offer such high-risk, resource-intensive interventions, and when to withhold or withdraw them?

When making complex medical decisions, we should first decide what our interventions might offer in terms of survival and quality of life. We should then engage with our patients and their surrogates, providing them options within a clinical context while, in turn, they provide us with guidance on their values and goals. Together, we decide which life-sustaining options have the potential to achieve these goals.

On the other hand, CPR could be considered in some patients in whom ECMO would not. The clearest example is the use of ECMO to support the circulation during cardiac arrest, so-called extracorporeal CPR. Circulatory arrest—and therefore circulatory death—might be suspended by the initiation of extracorporeal CPR in an attempt to buy time to reverse the culpable pathology. The provision of conventional CPR and withholding of extracorporeal CPR, in centres that offer it, is a reasonable approach.

Could a patient have a DNR order but accept extracorporeal CO2 removal? A scenario we are very likely to confront—one that has already played out in medical literature—is the use of extracorporeal CO2 removal in patients with acute respiratory failure, in lieu of invasive mechanical ventilation, precisely because the patient has chosen to forgo invasive mechanical ventilation. The promise of extracorporeal CO2 removal is that it is potentially less invasive and lower risk than ECMO. Yet it is not without risk.

So long as the patient or surrogate decision makers are
Let’s Discuss!

• We are committed to representing and respecting patient/family wishes—but it’s complicated ;)

• Growing body of research around this topic but gaps remain

• Education is a cornerstone—but must be a community effort!

• Access to completed forms across health systems would be ideal.....
Spoke Programs
Survey of POST implementation in our ECHO Community
Respecting Choices
Honoring Choices
Virginia POST Collaborative
Reported Barriers: Education

- Lack of time for education
- Not everyone knows what the form is
- Keeping staff trained (turnover)
Reported Barriers

“...trying to keep accurate data on how the POST form can help provide goal-concordant care, e.g. for patients who wish to limit future hospitalizations, so that administration can see why the time for these conversations and form completion is important”

“...helped a patient complete a POST, sent him back to the SNF where he resides, I KNOW a copy went with him, however, when he was re-admitted yesterday, the SNF had him listed as FULL CODE (POST indicates DNR) the RN did not know what a POST form was and denied that they had a copy at the SNF.”
Conversations, Referrals

• It varies!

• Providers have conversations with patients, and
  • Some providers complete POST forms
  • Some “don’t have time” to complete the forms and request a consult from Palliative to complete POST

• Refer to non-provider
  • POST forms initiated by ACP conversation with facilitators
  • Contact provider to review and sign form
Accessing CME credit
Submit your evaluation to claim your CME

After our live ECHO session, visit www.vcuhealth.org/pcecho

Click “Claim CME and Provide Evaluation”
Submit your evaluation to claim your CME
View previously recorded ECHOs for CME

To view previously recorded sessions and claim credit, visit
www.vcuhealth.org/pcecho

Click “Curriculum”
View previously recorded ECHOs for CME

Select the session you would like to view
View previously recorded ECHOs for CME

Click “Tests” to view video of the session and take a short quiz for continuing education credit.
THANK YOU!

We hope to see you at our next ECHO