POLST, A Community Grassroots Initiative

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ARIZONA

BACKGROUND:

- Strong patient autonomy climate
- Interagency desire for collaboration to improve end of life care and promote informed patient decision making

GRASSROOTS EFFORTS

Pilot POLST in several communities first to show safety/efficacy.

Educate health care providers & legislators about POLST.

Participate in the local and statewide conversations on POLST, including EMS, hospitals, home health, hospice, legislators, patient advocates, religious leaders, and payer groups.

RESOURCES:

Statewide Champions

- Arizona POLST Task Force
- Arizona Hospital and Healthcare Association
- Arizona Thoughtful Life Conversations

Regional Community Champions

- Northern Arizona Healthcare
- Flagstaff Emergency Physicians
- Pre-hospital Program Coordinator & EMS Medical Directors
- Northern Arizona University—School of Nursing

UNIQUE BARRIERS:

- Current legislation regarding DNR (orange PMCD), artificial nutrition, and surrogacy
- Lack of knowledge and misinformation
- Communication infrastructure
- Rural population
- Cultural taboos on discussing end of life decisions

Provider Orders for Life-Sustaining Treatment (POLST)

DEFINITION:

- A medical order set describing patients' wishes regarding medical treatments
- Follows the patient across healthcare settings
- Directed towards patients with serious life limiting illnesses with a life expectancy of 12 months or less
- Focuses on
  - Cardiopulmonary resuscitation
  - Respiratory interventions
  - Use of antibiotics
  - Medically assisted nutrition

NATIONAL TRENDS:

- Currently, 46 states have POLST programs, from developing to mature.
- Arizona is "in development" for POLST.

EXPECTED OUTCOMES AND BENEFITS OF PILOT:

Patient

- Support informed patient choice
- Improve end of life care and quality of life
- Improve communication of patient and healthcare providers about end of life treatments and goals of care

Community

- Promote continuity of care and end of life conversations
- Improve education and preparedness of health care providers
- Identify barriers to state-wide use

State

- Provide Arizona an example on how to implement POLST within a community
- Provide evidence to support potential legislative changes

NORTHERN ARIZONA

Phase One: Initial Activity (2015-2016, funded by NAH)

Study Protocol

- All Stage C or D Congestive Heart Failure patients admitted to FMC screened for inclusion.
- Patient or surrogate introduced to POLST during hospitalization culminating in POLST form completion.
- Followed every 3 months by phone & chart review.

Institutional Support

- Education of Palliative Care, Case Management, ED, EMS
- Addressing policies via EMS and Flagstaff Medical Center

Study Results

- Of 82 patients approached, 66 completed a POLST (80%).
- Population: 65% seen by PC, 28% Navajo
- Communication: 89 follow up phone calls (incomplete)
  - 15% felt it helped communication
  - 75% had contact with healthcare, 15% shared POLST
  - 36% lost or forgot form

Phase Two: THRIVE GRANT (NAH and NAU collaboration)

- Address opportunity to improve communication via education & exposure.
- Increase the sample size with more diverse hospitalized patient population.
- Include any individual with medical/physical frailty PLUS positive surprise question.
- Screening order under nursing & social work scope of practice.

EDUCATE COMMUNITY HEALTH CARE PROVIDERS

- Educate staff nurses & physicians about the POLST study and encouraging them to refer patients to the POLST team.
- Sponsor a regional Palliative Care conference for health care providers, including POLST information.
- Educate lay community.

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