MiCMRC Educational Webinar

Michigan Physician Orders for Scope of Treatment (MI-POST) 101

June 13, 2018

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The Michigan Care Management Resource Center

MiCMRC Educational Webinar

Michigan Physician Orders for Scope of Treatment 101

Expert Presenter:

Carolyn Stramecki, MHSA, CPHQ

ACP Michigan


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PAIN MANAGEMENT
Pain Assessment in Ambulatory Care - Time to Repeal and Replace the Pain Score
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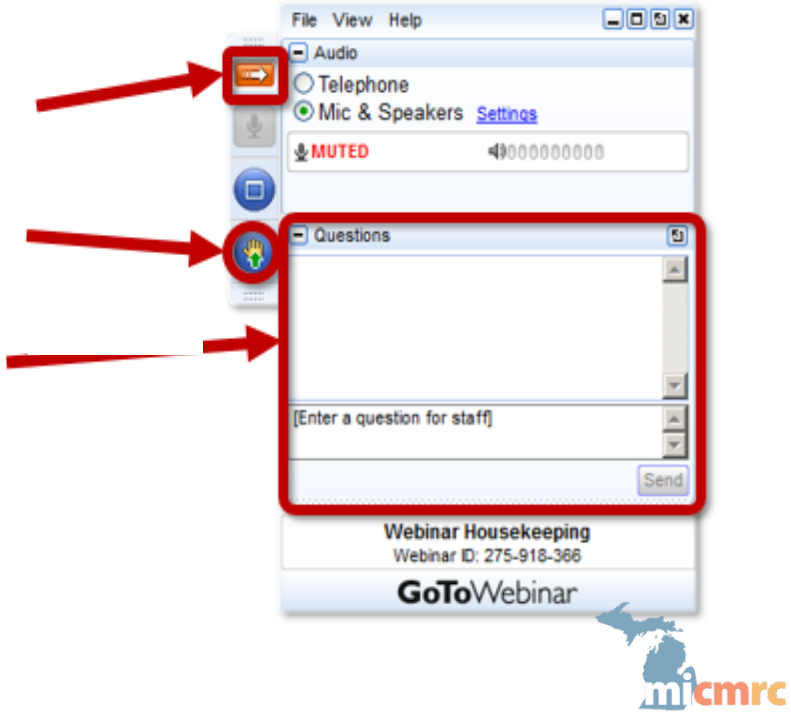

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- There is no conflict of interest for anyone with the ability to control content for this activity.
- This webinar is available for CE credit until June 4, 2020 .
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To receive Nursing, CCMC, or Social Work 1.0 continuing education contact hour for "Michigan Physician Orders for Scope of Treatment (MI-POST) 101" for Today's Live Webinar 6/13/2018 2:00 – 3:00 PM

- Attend the entire webinar

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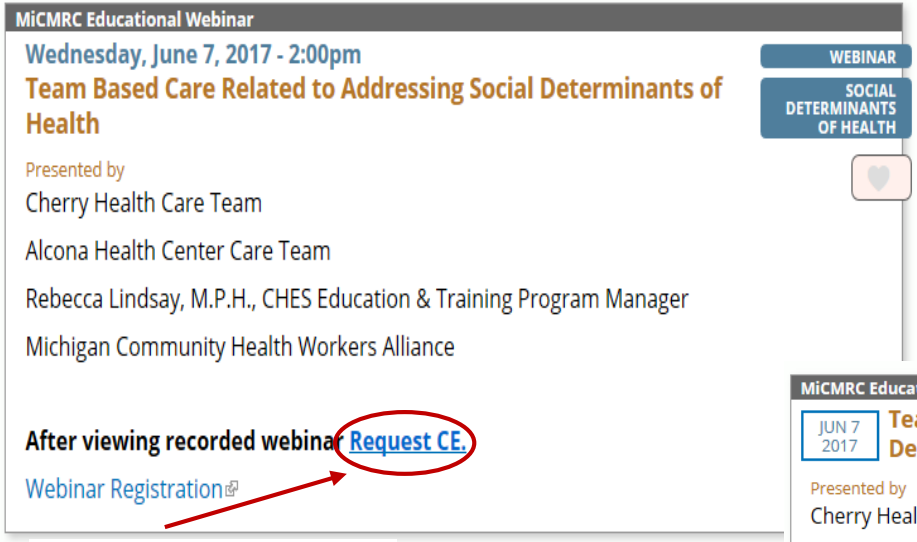

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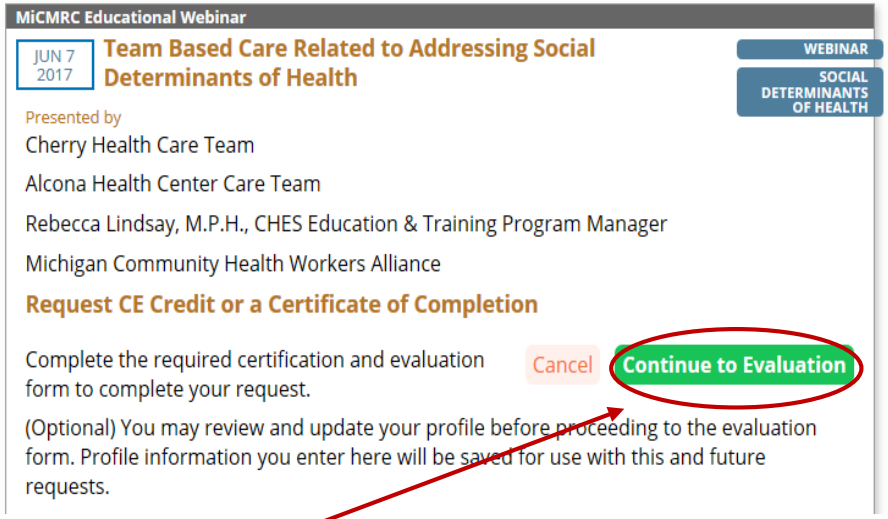

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MI – POST 101

Carolyn Stramecki, MHSA CPHQ

Objectives

- Define MI-POST
- Explain appropriate use of the MI-POST tool
- Explain how MI-POST is supported by ACP processes

Reviewing ACP

Advance Care Planning

- ACP is a *process of communication* that helps individuals
  - understand their choices for future healthcare
  - reflect on personal goals, values, religious, or cultural beliefs
  - talk to physicians, healthcare agents, and other loved ones

- Built upon a shared decision-making approach

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 Patient Advocate 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.

For ACP to Be Successful…

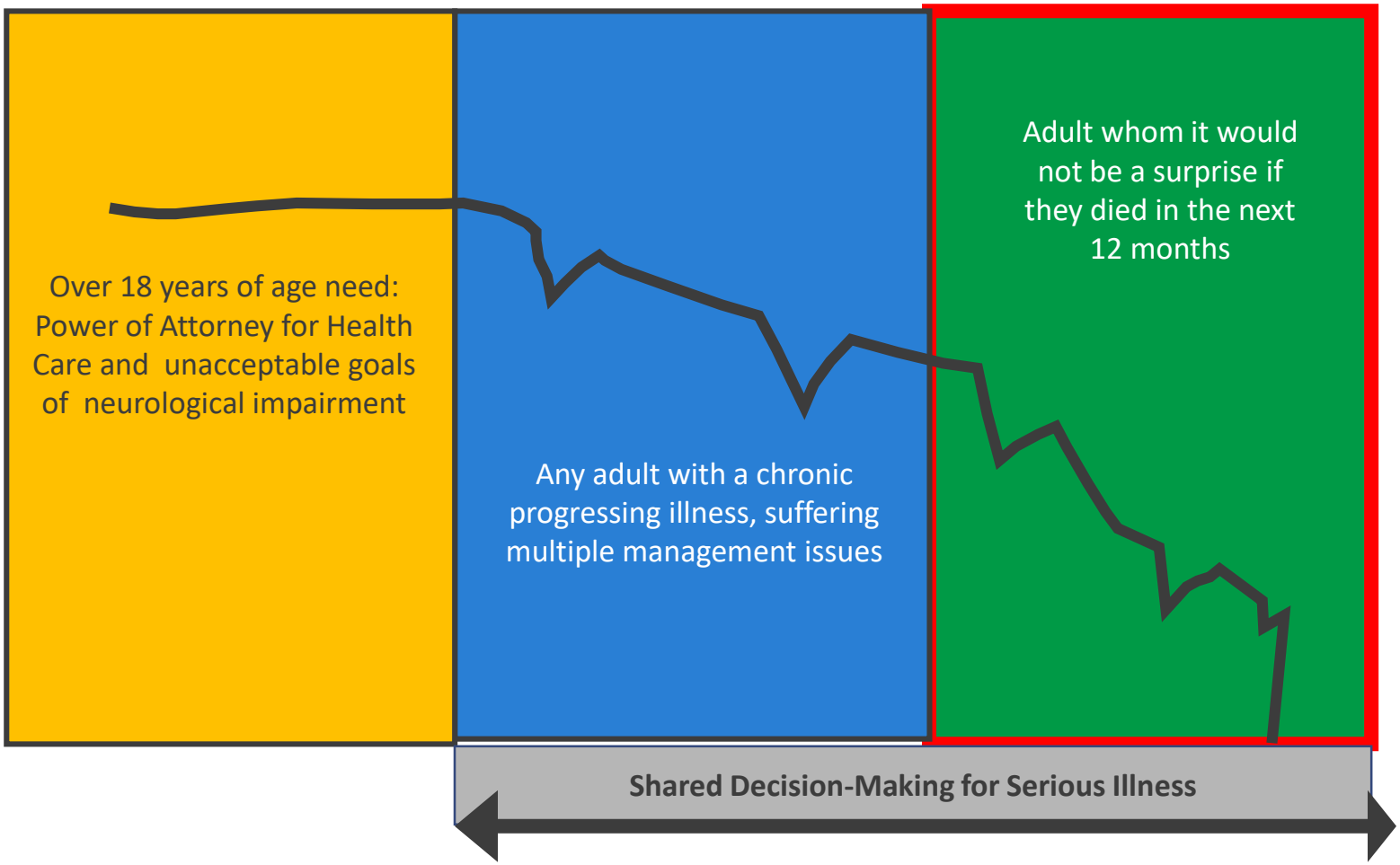
Plans must be

- **Created**—high prevalence is essential
- **Specific** enough for the clinical situation
- **Accurately** reflect the individual's preferences
- **Understandable** to those making decisions
- **Available** to the decision makers
- **Incorporated** into decisions, as needed

(Fagerlin and Schneider, 2004)

MI-POST

Advance Care Planning For Most Adults



Last Steps/MI-POST

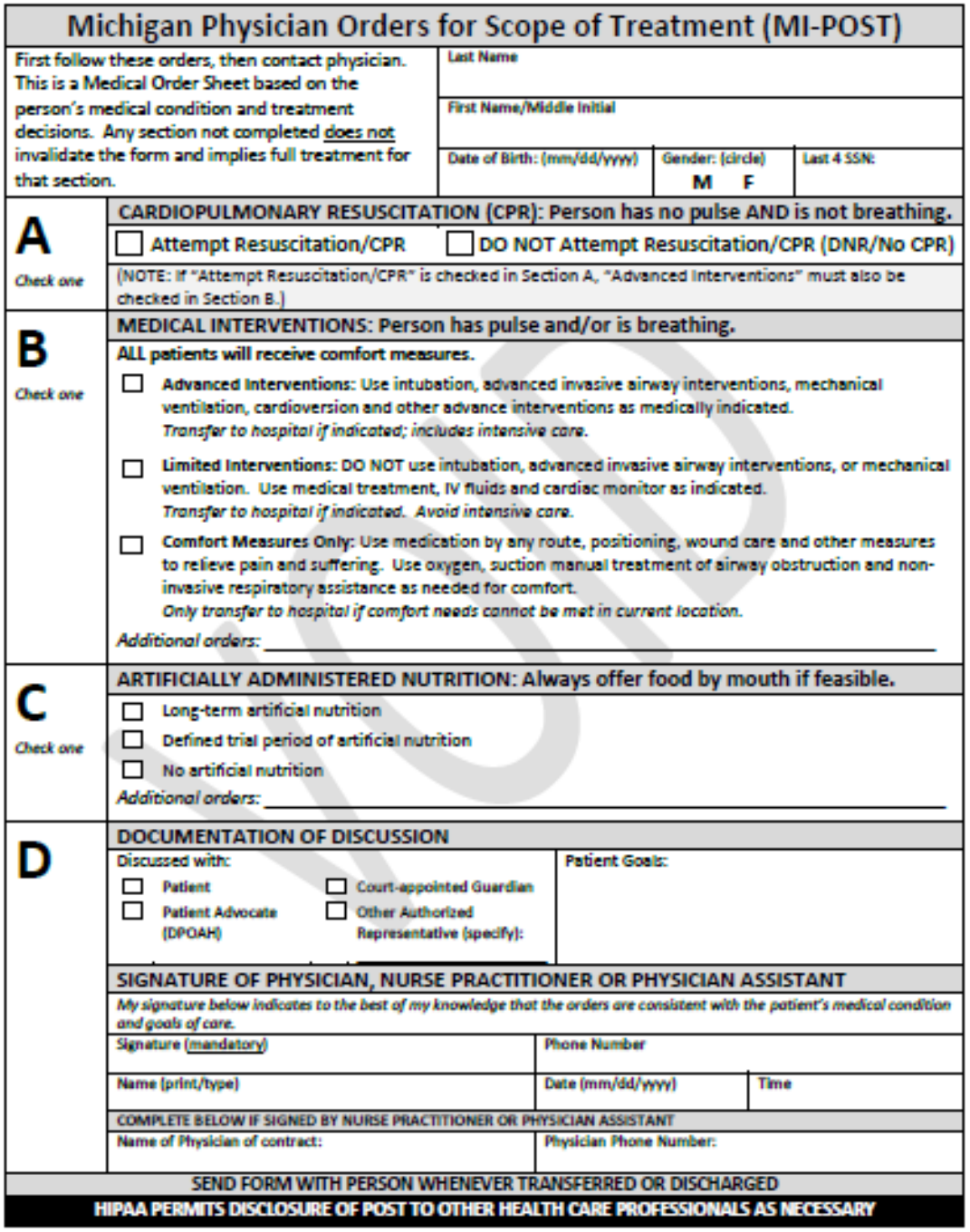
- Goals: to create a specific written plan to document medical treatment decisions and ensure they are honored by healthcare providers throughout the continuum of care.
- Discussions are focused on assisting the individual, or the designated healthcare agent(s), in making the following healthcare decisions:
  - CPR
  - goals of care for cardiopulmonary failure, including hospitalization
  - artificial nutrition and hydration
  - comfort care options

MI-POST

- A **medical order** designed to improve end of life care by converting patients' treatment decisions into medical orders that are transferable throughout the healthcare system
- Is a standard of care for communicating the scope of treatment decisions
- For frail elders or others whose death in the next 12 months would not be surprising.
- Is always voluntary
- Form follows the patient

Medical order components

- Resuscitation
- Medical Interventions
  - Comfort Care
  - Limited Treatment
  - Full Treatment
- Additional orders



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 does not invalidate the form and implies full treatment for that section.

Last Name

First Name/Middle Initial

Date of Birth: (mm/dd/yyyy) | Gender: (circle) M F | Last 4 SSN:

A *Check one*

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse AND is not breathing.

☐ Attempt Resuscitation/CPR ☐ DO NOT Attempt Resuscitation/CPR (DNR/No CPR)

(NOTE: If "Attempt Resuscitation/CPR" is checked in Section A, "Advanced Interventions" must also be checked in Section B.)

B *Check one*

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

ALL patients will receive comfort measures.

☐ **Advanced Interventions:** Use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advance interventions as medically indicated.
Transfer to hospital if indicated; includes intensive care.

☐ **Limited Interventions:** DO NOT use intubation, advanced invasive airway interventions, or mechanical ventilation. Use medical treatment, IV fluids and cardiac monitor as indicated.
Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort Measures Only:** 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.
Only transfer to hospital if comfort needs cannot be met in current location.

Additional orders: _____

C *Check one*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.

☐ Long-term artificial nutrition

☐ Defined trial period of artificial nutrition

☐ No artificial nutrition

Additional orders: _____

D

DOCUMENTATION OF DISCUSSION

Discussed with:

☐ Patient ☐ Court-appointed Guardian

☐ Patient Advocate (DPOAH) ☐ Other Authorized Representative (specify):

Patient Goals:

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

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 (mandatory) | Phone Number

Name (print/type) | Date (mm/dd/yyyy) | Time

COMPLETE BELOW IF SIGNED BY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

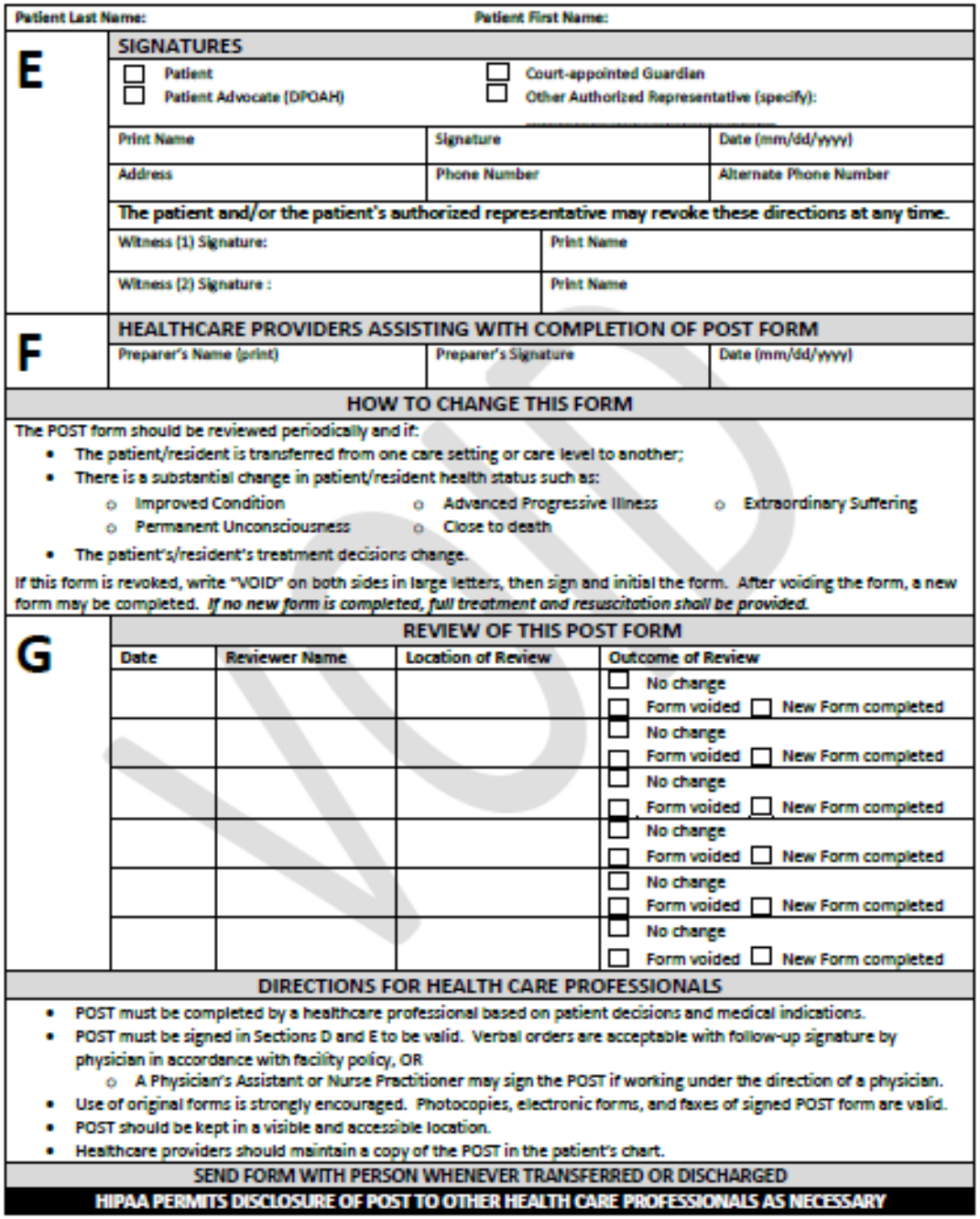
Name of Physician of contract: | Physician Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

V. 7.16.13

Pilot Form



Patient Last Name: Patient First Name:

E SIGNATURES

☐ Patient ☐ Court-appointed Guardian
☐ Patient Advocate (DPOAH) ☐ 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

F HEALTHCARE PROVIDERS ASSISTING WITH COMPLETION OF POST FORM

Preparer's Name (print)	Preparer's Signature	Date (mm/dd/yyyy)

HOW TO CHANGE THIS FORM

The POST form should be reviewed periodically and if:

- The patient/resident is transferred from one care setting or care level to another;
- There is a substantial change in patient/resident health status such as:
  - Improved Condition
  - Advanced Progressive Illness
  - Extraordinary Suffering
  - Permanent Unconsciousness
  - Close to death
- The patient's/resident's treatment decisions change.

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. ***If no new form is completed, full treatment and resuscitation shall be provided.***

G REVIEW OF THIS POST FORM

Date	Reviewer Name	Location of Review	Outcome of Review
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed
			☐ No change ☐ Form voided ☐ New Form completed

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

- POST must be completed by a healthcare professional based on patient decisions and medical indications.
- POST must be signed in Sections D and E to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility policy, OR
  - 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.
- POST should be kept in a visible and accessible location.
- Healthcare providers should maintain a copy of the POST in the patient's chart.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

V. 7.16.13

Pilot Form

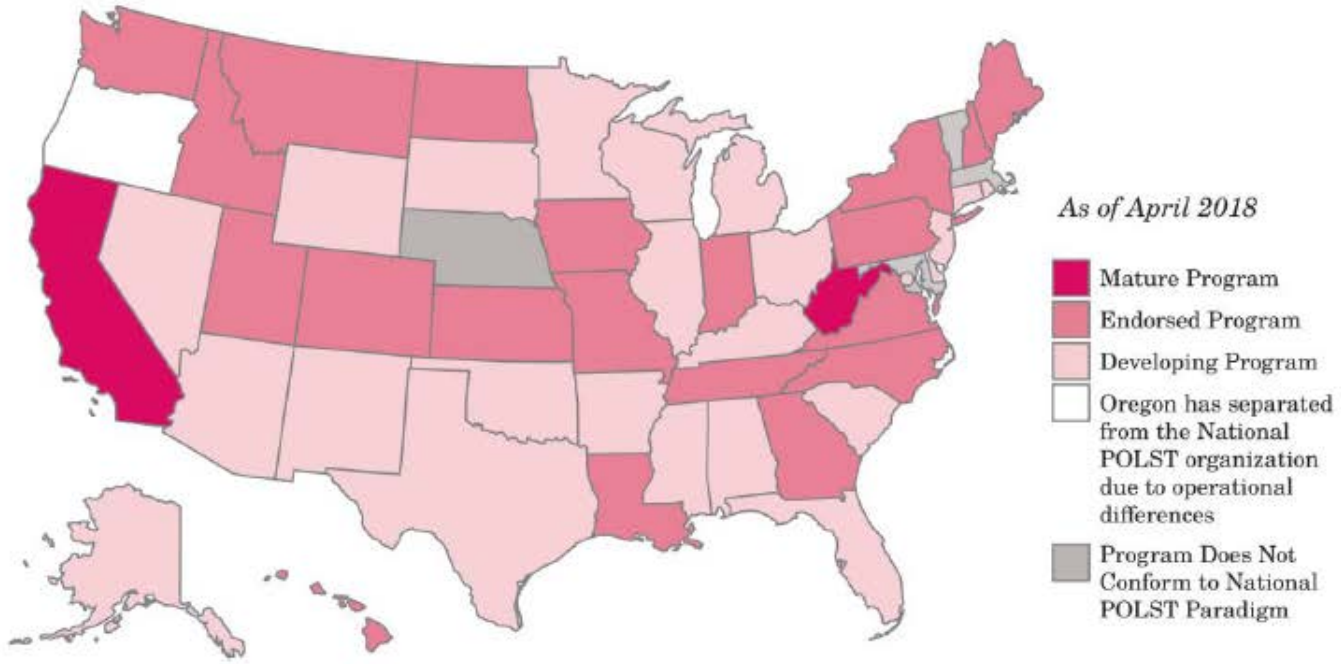
POST and Advance Directives

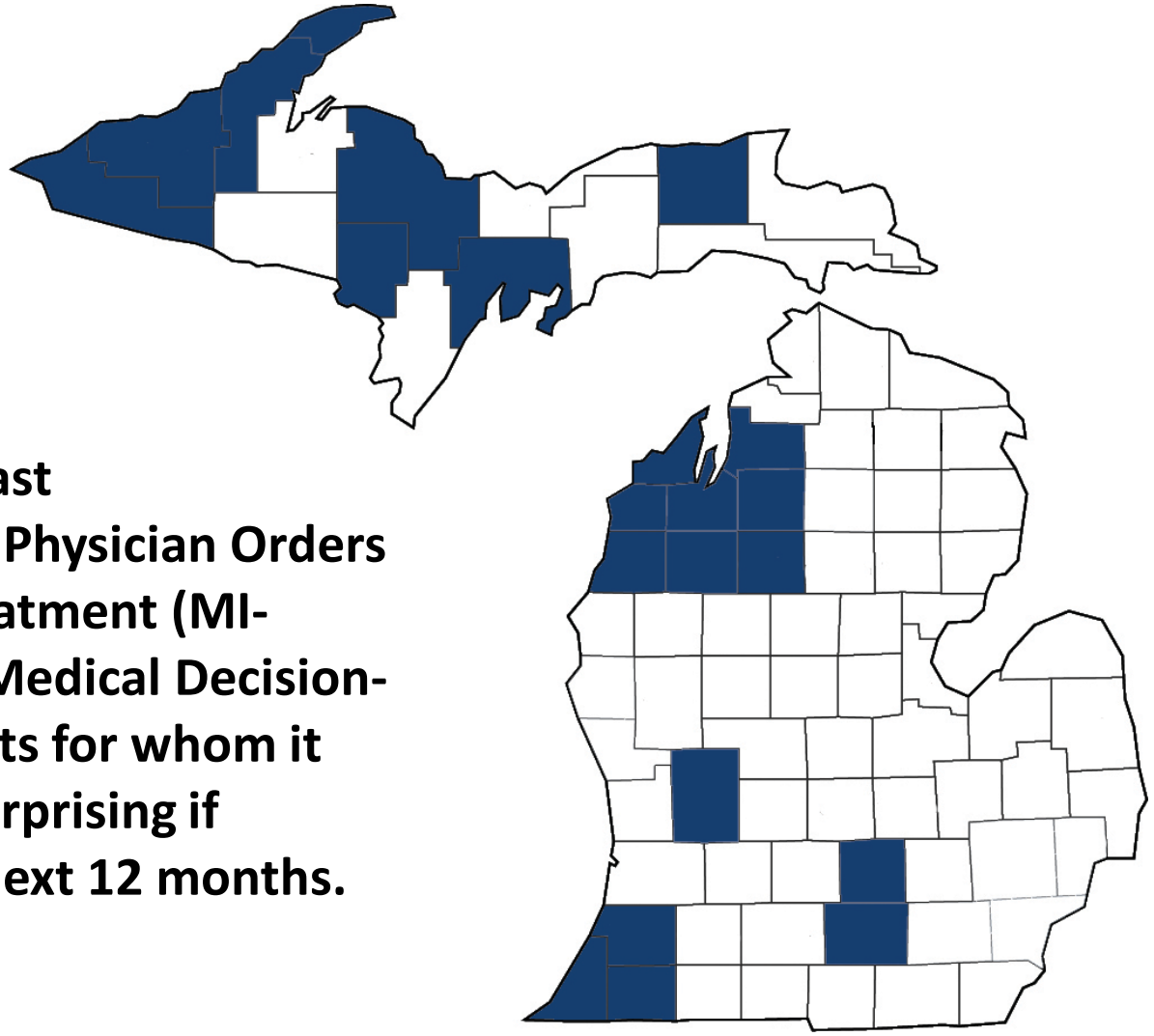
Characteristics	Advance Directive (healthcare wishes + DPOAH)	POST
Type of Document	Legal Document; highly variable	Medical Order; standard
Intended Population	Recommended for all competent adults	Serious advanced illness or facility; not surprising if died within 12 months
Who Completes	individual	Healthcare professional
Required signatures to be valid	Signed by an individual, DPOAH (acceptance), 2 witnesses	Provider(MD/DO, NP, PA) and individual/DPOAH/Guardian
Communication about medical treatments	General wishes about medical treatments the individual does/does not want; hypothetical	Specific medical treatments the individual does/does not want, based on the individual's current state of health
Ability for EMS to honor	Emergency personnel cannot follow, not a medical order. AD's are later reviewed by hospital staff.	Directs emergency personnel
Appointment of Surrogate	Appoints a DPOAH	Does not appoint a decision-maker
Location	Generally not immediately available.	Is a medical order in the medical record, travels with patient
Ease of Interpretation	May be vague and need interpretation	Easy interpretation

National POLST Paradigm
www.polst.org

National POLST Program Designations

As of April 2018





Counties with Last Steps/Michigan Physician Orders for Scope of Treatment (MI-POST) activity: Medical Decision-making for Adults for whom it would not be surprising if he/she died in next 12 months.

HONORING
Healthcare Choices

MI-POST Pilot Results: Quality Chart Review N=196

Respondents:

41% SNFs; 14% Hospital; 25% Adult Foster Care; 19% Hospice; 1% Home

Section A/B:

- CPR/Advanced 19%
- DNR/Advanced 4%
- DNR/Limited 18%
- DNR/Comfort 64%

Section C: 11% Long-term Artificial Nutrition;

14% outcome- defined trial; 69% no artificial nutrition; 7% no orders-assume full treatment

Public Act 154 2017

- Enacts Michigan Post
- Liability protection
- Advisory in acute care
- Medical Orders for individuals for whom it wouldn't be surprising if…
- Signed by Patient, Patient Advocate or Guardian; and Physician, Physician Assistant or Nurse Practitioner
- Revised/Revoked or changed at any time
  - Still creating rules around this process
- Valid for 1 year, must be reviewed at least annually and with specific changes

- Rules for digital copies, faxes, paper copies, etc to be decided
- Recommended certified facilitator is preparer
- Rules for use in “various residential settings”
- Encourages individuals to also designate a Patient Advocate

Suggested Rules for Completion of POST

- Exploration of the patient's goals of care, medical condition and potential complications
- Creation of questions to ask the attending health professional regarding his/her current medical condition
- Explanation of the POST form
- Use of decision-making aides and educational materials
- Designation of a Patient Advocate on the Designation of Patient Advocate form
- Best practice supports the conversation includes the Patient Advocate or potential patient advocate, or others as the patient wishes.

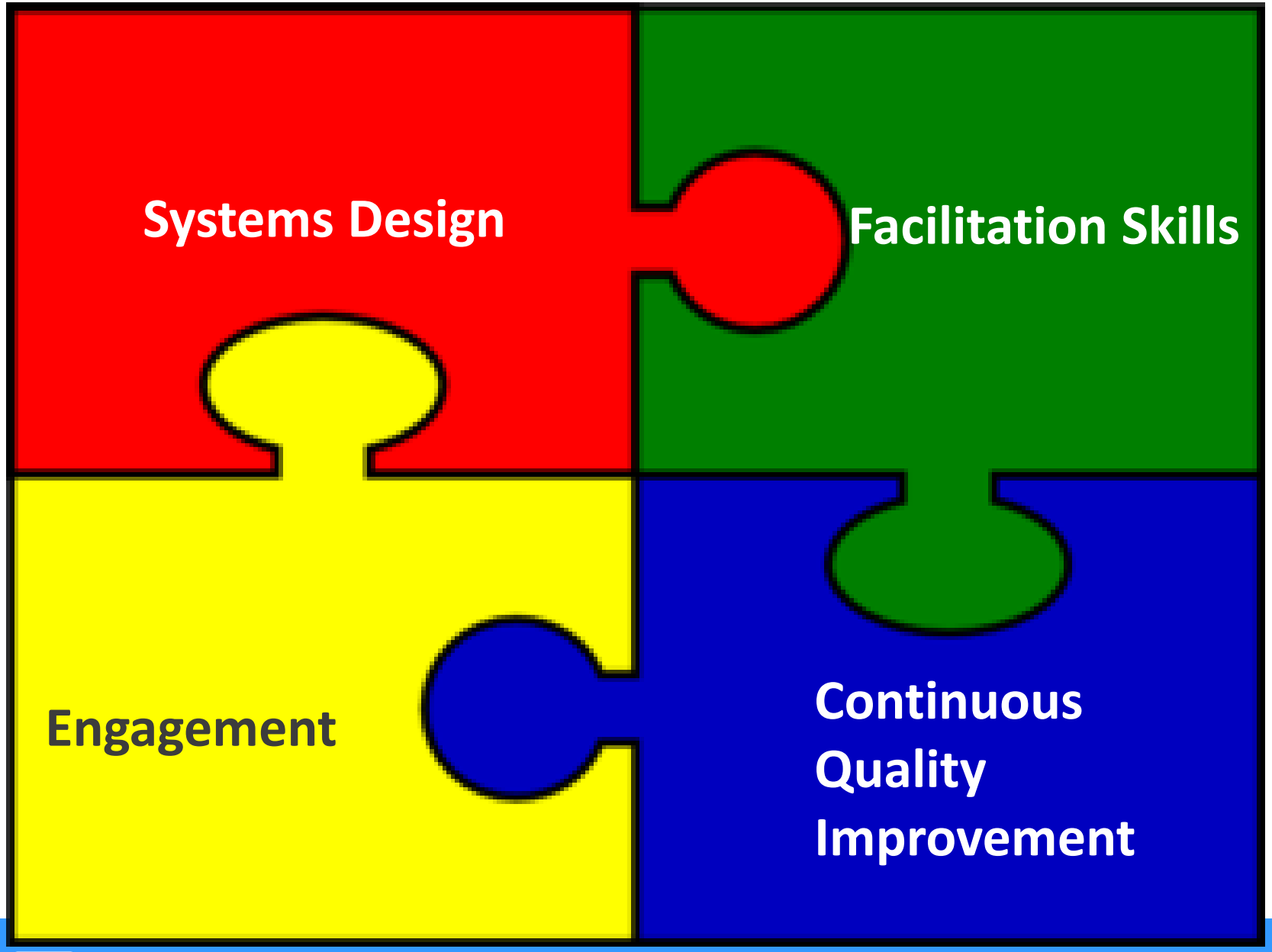
Signing the POST

- The POST must be signed by both:
  - The Individual, or the Individual's activated Patient Advocate or Court-appointed Guardian; and
  - The Attending Health Professional: the Physician, Physician Assistant or Nurse Practitioner that has the primary responsibility for the patient's medical treatment and is authorized as per licensure and organizational policy to sign such orders.
- The POST is valid for 1 year from the date it is signed

Rules for Reaffirming and Revoking

- The POST may be reaffirmed or revoked by the Patient or the Patient's Patient Representative (an activated Patient Advocate or Court-appointed Guardian) at any time and in any manner that the patient or Patient Representative is able to communicate.
- The Attending Health Professional may revoke the POST form if the patient's medical condition makes the current medical orders on the POST form contrary to generally accepted health care standards.
- The POST form must be Reaffirmed or Revoked under the following circumstances:
  - **One year** from the date since the form was last signed or reaffirmed
  - **30 days** from a change in the patient's attending health care provider
  - **1 week** from a change in the patient's place of care, level of care, or care setting, or unexpected change in the patient's medical condition or
  - **1 day** for a change in the patient's treatment decisions.

Getting Ready!


Systems Design
Facilitation Skills
Engagement
Continuous
Quality
Improvement

ACP processes

- Assess….what do you do? Where are the gaps?
  - Who is responsible for ACP
  - When does it happen?
  - How often?
  - How it ACP defined in your facility?

- ACP tools – what is used in your facility? Community?
  - Scope of treatment forms
  - Medical orders
  - Advance directives
  - DNR forms
  - other

Processes…

- The conversation
  - What triggers the process?
  - Is it focused on document completion?
  - Who is involved?
  - How is information documented and shared?
  - How does follow-up occur?
- Storage and retrieval system
  - Standard location for documentation of the ACP conversation
  - Standard location for medical orders
  - Process to transfer this information.

- Staff roles
  - Are they clear?
  - What are the expectations? How are they measured?
  - How are staff educated?
- What materials do you provide to the Patient or family regarding their right to refuse medical care and to complete an advance directive?
  - Health literacy and language considerations
- How do you inform patients/families of health status, treatment options, and outcomes in language they understand?

Communication

- Staff is aware of documents existing
- Staff is aware of who the appropriate decision-maker is
- Information is visible and accessible.
- Staff are appropriately trained to follow the orders
  - Standard orientation and onboarding
  - Expectations are clear
  - Performance is assessed
- Everyone is on the same page!

Basic Facilitation Skills

- Understanding of current condition and potential complications
- Identification of goals and treatment options
- Verification of alignment of chosen options and stated goals
- Supporting persons and families through strong emotions and difficult language
- Identification of follow up issues and resource needs

Quality Improvement: How are you doing?

- If you looked at a chart of the last person who died in your facility:
  - Would the care provided be described in the care plan, the physician orders?
  - Would staff and family describe the care the same?
  - What is documented, and where?
- Do you know:
  - How many have advance directives
  - What type of advance directive is it?

Quality Measures

- Patient Advocate/family presence
- Type of ACP documents used, completeness
- Capacity assessment and presence of appropriate documentation
- Review all return to hospital and ED visits
  - Consistent with Residents' expressed wishes? Rationale?
- Matching orders

A note about processes…

- Research an sustainability and innovation shows, success is higher when changes are built in to existing systems
  - Does not mean you shouldn't change what you need to
  - It does mean you have to understand your own processes well
- Recommended exercise: map your workflow!
  - Be specific with decision points
  - Who is responsible for each step
  - Verify for accuracy (and variation)

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Q&A

What questions do you have?

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