

POLST in California Communities First-Year Experience and Lessons Learned March 2009

Executive Summary

In late 2007, the California Coalition for Compassionate Care (CCCC), with support from the California HealthCare Foundation (CHCF), launched a project to improve medical care for patients with advanced illness or frailty. The project consisted of local and statewide strategies to establish Physician Orders for Life Sustaining Treatment (POLST) as a community standard of care. Originated in Oregon in 1991 and used in a number of other states, the POLST medical order has been especially helpful in communicating and documenting a patient's treatment preferences across care settings.

A feature unique to California's POLST implementation is the use of a strategy that encourages communities to work in a multi-faceted fashion. The approach leverages community leadership in developing collaborative, multi-organizational POLST coalitions. In November 2007, CHCF awarded grants to community POLST projects in Alameda, Humboldt, Mendocino, Riverside, Santa Clara, Ventura and Yolo counties (a similar project already was underway in Sacramento). This paper provides an overview of the eight communities' yearlong efforts to begin POLST implementation and offers ideas for others in California interested in bringing POLST to their locale.

While each community has its own distinct culture and experience, there are commonalities in some of the challenges they faced along the way and the lessons they learned.

Common Challenges:

- Difficulty in getting the attention of stakeholders. Prior to adoption of AB 3000, some community coalitions found it challenging to garner full attention and support from key stakeholders. Much of this resistance lessened once Governor Schwarzenegger signed the legislation that requires health care facilities to honor POLST forms as of January 1, 2009.
- Lack of end-of-life care education among providers. For many providers, there is no common vision for quality end-of-life care nor an awareness of how care could be improved. This is especially true in skilled nursing facilities challenged by thinly-stretched staffing levels, high staff turnover and limited physician presence.
- Limited time and resources of coalition leaders. Implementing POLST in a community is a larger undertaking than it first appears. With many competing demands on POLST coalition members, an ongoing challenge is keeping participants actively involved without being overwhelmed.

Lessons learned:

- Identify a physician champion. Since POLST is a physician order, it is important to have strong proponents from the medical community. Look for leaders with passion for improving end-of-life care, credibility with other physicians and an understanding of the healthcare system.
- Build a POLST coalition of key stakeholders. Essential members include emergency medical services, physicians, acute care and skilled nursing facility representation, all of whom have a role in POLST implementation. Communities that were able to implement POLST right away had in place a coalition that had previously worked together successfully.
- Identify community strengths and resources. To generate continued interest, buy-in and support, coalitions focused initial efforts on aspects of implementation most likely to be successful in their communities and will build on their accomplishments.

- Recognize the need for ongoing education. Especially in skilled nursing facility settings, staff at all levels need to understand basic information about advance directives and POLST, as well as their role in helping ensure good advance care planning.
- Be patient and persistent. Effective roll-out of POLST requires coordination and collaboration among a variety of stakeholders—a time-consuming but necessary process.

Background on POLST

Description

The Physician Orders for Life-Sustaining Treatment (POLST) program is designed to improve the quality of care for people with advanced illness and frailty. It is based on effective communication of patient wishes, documentation of medical orders on a brightly colored form and the assurances of health care professionals to honor these wishes.

Hallmarks of POLST are (1) immediately actionable signed medical orders on a standardized form (2) orders that address a range of life-sustaining interventions as well as the patient's preferred intensity of treatment for each intervention; (3) a brightly colored, clearly identifiable form (4) that is recognized, adopted, and honored across treatment settings. Completion of the form is recommended for patients with a serious illness and life expectancy of a year or less.

Research shows that POLST accurately conveys treatment preferences, POLST instructions are followed the majority of the time, and healthcare professionals find POLST useful.¹ The National Quality Forum recommends using POLST as a preferred practice for quality palliative care.²

History

POLST began in Oregon in 1991, when medical ethics leaders recognized that patient wishes for life-sustaining treatments were not being honored consistently despite the availability of advance directives. The Center for Ethics in Health Care at Oregon Health & Science University worked with stakeholder healthcare organizations to develop POLST. Released for use in Oregon in 1995, the POLST program includes ongoing education, research and a statewide experience-based continuous quality improvement process.

With over one million forms distributed, the use of POLST in Oregon is now the accepted medical standard of care. The form is used by all hospices and over 95% of nursing homes in the state. Other states (New York, Pennsylvania, Washington, West Virginia, and Wisconsin) were early to develop programs similar to Oregon's POLST program and have extensive experience and resources. In 2004, these program leaders became the original members of the National POLST Paradigm Initiative Task Force, which aims to facilitate the development of other programs, help develop policy and conduct research. The task force coined the term "POLST Paradigm" to describe these programs. Today, POLST also is being used in Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Iowa, Louisiana, Maine, Michigan, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Tennessee, Texas and Utah states, as well as parts of Minnesota, Nevada, North Dakota and Wyoming. For more information, visit: www.polst.org.

¹ Meyers JL, Moore C, McGrory A, Sparr J, Ahern M. (2004). Use of the Physician Orders for Life-Sustaining Treatment (POLST) form to honor the wishes of Nursing Home Residents for End of Life Care: Preliminary Results of a Washington State Pilot Project. *Journal of Gerontological Nursing*, 30, (9), 37-46.

² A National Framework and Preferred Practices for Palliative and Hospice Care Quality (2006). Available at: <http://www.qualityforum.org/pdf/reports/palliative/txPHreportPUBLIC01-29-07.pdf>, viii.

POLST in California

The California Coalition for Compassionate Care (CCCC) is a statewide partnership of more than 60 regional and statewide organizations dedicated to the advancement of palliative medicine and end-of-life care in California. In 2007, with support from the California HealthCare Foundation (CHCF), CCCC began working with key stakeholders in California to establish POLST as a recognized and widely-used tool throughout the state. Due to the size and complexity of the state, CCCC chose to tackle implementation with a two-pronged approach. Combining statewide efforts to develop supportive public policy and standardized tools with local grassroots partnerships has helped California move forward quickly. These parallel statewide and local strategies are needed to ensure the broadest, most effective implementation of POLST in a state as large and diverse as California.

Statewide strategies:

- Passage of legislation. To establish POLST as a new mechanism by which patients can provide specific instructions for their end-of-life care, AB 3000 (Statutes 2008, Chapter 266) was introduced by then Assembly member, now Senator Lois Wolk. Signed into law by Governor Schwarzenegger, the law amended the California Probate Code to recognize the validity of the POLST form. Effective January 1, 2009, the new law requires all healthcare professionals and providers, including hospitals, nursing facilities and first responders, to honor POLST orders.
- Establishment of POLST Task Force. The statewide task force provides guidance on issues with statewide implication, including public policy, form content, communication and dissemination. Comprised of more than 20 stakeholder groups, the task force is chaired by Yolo County Supervisor (and former Assembly member) Helen Thomson.
- Standardized approach to implementation. CCCC has developed a number of tools, including a single California POLST form and process for its regular review and update; model policies and procedures for operationalizing POLST in hospital, nursing facility, and hospice settings; and educational curricula for physicians, other health professionals and emergency responders.

Local strategy:

- Community partnerships. CCCC and CHCF provide support for communities to develop and maximize multi-organizational stakeholder coalitions to ensure implementation of POLST across settings of care. This approach recognizes that community-based coalitions: 1) have a broader reach than a single health care organization, 2) help build credibility among stakeholders and the community at large, 3) raise visibility around the issue, and 4) bring expertise, resources and energy. A major component of the POLST spread strategy, these grassroots coalitions serve as the laboratories for putting POLST into action.
 - In 2007, seven communities received CHCF funding support to establish POLST as a recognized and commonly used tool in their local area; their work has been extended through 2010. A separate CHCF pilot project (PREPARED) to improve palliative care and advance care planning in nursing homes in the Sacramento area also was using the POLST form, making a total of eight initial POLST communities (Alameda, Humboldt, Mendocino, Riverside, Santa Clara, Ventura, Yolo and Sacramento).
 - In November 2008, ten additional communities received two-year CHCF grants to support new POLST efforts: Bakersfield, San Fernando Valley, West Los Angeles, Monterey, Napa, Orange, San Bernardino, San Diego, Santa Cruz and Sonoma.

The following section describes the first-year experience of the eight initial POLST communities.

Alameda POLST Project

Snapshot:

Occupying most of the East Bay region of the San Francisco Bay Area, Alameda County is the 7th largest county in the state, with nearly 1.5 million people. The county has 14 hospitals and more than 70 skilled nursing facilities. Initial focus for the Alameda County POLST Project is on Castro Valley, Hayward, San Leandro and Oakland.

Community readiness:

Several favorable conditions set the stage for the Alameda County POLST Project. The county is one of the few in California where nursing facilities had already agreed to use a standardized Physician Intensity of Treatment (PIT) form – primarily due to multi-organizational cooperation through the Long Term Care Bioethics Consortium of the East Bay. Additionally, the physician community, including hospital medical staffs and the local medical association, had worked together successfully on several endeavors, including passage of a sales tax measure to support hospitals and providers caring for indigent patients. Dr. James Mittelberger, lead physician for initial POLST efforts, saw the project as an opportunity to change the long-term care continuum and produce a system of continuous care. He formed the Alameda County POLST Coalition, which includes representatives from the area medical society, hospital ethics committees, county emergency medical services agency, hospice and nursing facilities. The group meets quarterly and is led by a core executive team.

Approach:

The POLST Coalition decided on a two-step approach: first, obtaining support from large healthcare organizations that serve the entire county, and then, developing several implementation sites within specific hospital communities. The Coalition began by securing support from key county-wide stakeholders, e.g., the Alameda Contra Costa Medical Association, Alameda County EMS Agency, hospital ethics committees, the California Association of Long Term Care Medicine, multiple hospices and leaders from several large hospital systems (Kaiser, Sutter Health and Alameda County Medical Center). Because patients in this dense urban area often go from one hospital system to the Emergency Department of another, the Coalition believed that it was important to build a foundation for EMS and the entire county before focusing on implementation. The Alameda leaders also felt it would be most effective to coordinate local activities with implementation of the state law.

Highlights:

- In coordination with CCCC, obtained formal endorsement of POLST from the California Association of Long Term Care Medicine, which helped engage the interest of local nursing facilities in POLST.
- Received support from Alameda Contra Costa Medical Association, whose governing Council then recommended POLST to the California Medical Association for statewide adoption.
- Secured formal support of Alameda County EMS Agency, which implemented policies respecting POLST in September 08.
- Obtained support from more than a dozen Alameda County hospitals' Emergency Department directors, who received training and materials for educating their staff.
- Developed model POLST hospital policy and procedures, which to date have been adopted by Alameda County Medical Center and Eden Medical Center.
- Implemented POLST training sessions for medical staffs at Kaiser, Alameda County Medical Center, Alameda Hospital and Eden Hospital. Trained and tested all paramedics on POLST guidelines.
- POLST is being used in 9 skilled nursing facilities, 2 hospitals and 3 hospices.

Next steps:

- Plan further roll-out of POLST in early 2009 to coincide with enactment of legislation; anticipate growth of POLST in Alameda County and Eden Medical Centers; and expansion into Alameda, Kaiser and Sutter Hospitals as well as 5 hospice agencies and 15-20 skilled nursing facilities.

- Will expand to parts of Contra Costa County in 2009-10, in part due to the reach of the medical association, which serves both counties.

Physician leader (2007-08): James Mittelberger, MD, MPH, Evercare
Project director: Sharon Fernekees-Jeans, LCSW, Eden Medical Center;
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Humboldt POLST Project

Snapshot:

Located on the far north coast of California, Humboldt County is a densely forested, rural community with a population of nearly 129,000 people, most living in or near Eureka, Arcata and Fortuna. The Humboldt County End of Life Project's initial focus is on these relatively populated areas of the county. The county has 4 hospitals and 5 skilled nursing facilities.

Community readiness:

Humboldt County has a well-established end-of-life coalition that started in 2006 as part of a quality initiative of the Humboldt-Del Norte Independent Physicians Association. (The IPA has 250 physicians and advance practice clinicians—95% of the county's healthcare professionals.) The Humboldt County End-of-Life Committee includes 15 stakeholders that meet monthly. As part of an annual physician survey and follow-up interviews conducted by St. Joseph's Hospital (provider of 80% of inpatient care in the county), a need was identified for improving physician communication around end-of-life issues. A series of small group dinners were sponsored by the hospital, hospice and IPA to give physicians a forum for discussion. Attracting 78 physicians during 2007, the dinners engaged colleagues in personal and professional conversations about death and dying, and were critical in setting the stage for future work. This included the coalition's decision to initiate a POLST project because of its effectiveness as a communication vehicle. They also had significant knowledge about the form since patients from Oregon have presented with POLST forms in nearby Del Norte County, where Humboldt physicians also practice.

Approach:

Due to the multi-setting impact of POLST, an initial challenge was determining the appropriate sequence of information-sharing and education. The coalition sought out arenas where they felt they could be the most successful. They brought emergency medical services into the coalition and worked with them to help revise EMS policies and training. They focused on implementation in skilled nursing facilities since all 5 SNFs have the same medical director, who is a coalition member. Since he also oversees SNFs in Del Norte County, he was familiar with POLST and able to implement fairly quickly after educating staff, residents and families. The coalition also has begun implementing POLST in residential care facilities, one by one. Another emphasis has been on physician education, which the coalition sees as an ongoing effort. A 2008 IPA conference focused on communication skill-building as a follow-up to the dinner meetings. A number of physicians and advanced practice clinicians are actively involved in the project, using POLST to document their own patients' care preferences and promoting use of POLST by other physicians. The hardest group to access has been hospital-based clinicians, as most of the inpatient care is provided by out-of-area hospitalists supplied through a staffing agency.

Highlights/outcomes:

- Approximately 700 POLST forms have been distributed to facilities and provider offices.
- Estimate that 20% of patients in SNFs have a POLST form.
- Hospice of Humboldt has had 53% of its patients complete POLST forms. The efforts to improve physician communication have also contributed to a 25% increase in hospice early referrals.
- Regional EMS leadership incorporated POLST training and form into their system.
- Held conference for 70 physicians/advance practice clinicians with keynote speaker Michael Rabow, MD, UCSF Palliative Care Leadership Center on "Communicating in the Last Stage of Life."

- POLST curriculum was added into community college nursing program.
- Have maintained level of commitment and passion of coalition members, most without compensation, throughout 2-year effort.

Next steps:

- Will focus on education of hospital-based clinicians and targeted public education.
- Plan to introduce and implement POLST in SNFs and RCFEs, and the hospital in Del Norte County.
- Will sponsor May 09 IPA conference with sessions for clinicians and the public featuring palliative care expert Ira Byock, MD from Dartmouth Medical Center.

Project leaders: Tim Haskett, GNP; Ken Meece, St. Joseph Hospital System-Humboldt Co; Gay Miller, MSW, Dept. of Social Services Community Care Licensing

Project director: Linda D'Agati, Humboldt-Del Norte IPA

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Mendocino POLST Project

Snapshot:

Mendocino County covers a large rural area of the north coast of California. Communities are located in valleys ringed by coastal and inland mountain ranges or on the Pacific coast. The POLST project concentrated initially on the 3 largest cities (Mendocino, Fort Bragg and Ukiah), in which there are 3 hospitals and 4 nursing facilities).

Community readiness:

Due to its geography and size, Mendocino County has isolated pockets of medical communities which have little interaction. Dr. Mark Apfel, long-time local primary care physician, initiated the Mendocino County POLST project in part to help unite these providers – including private practitioners, non-profit sector, community health clinics, hospitals and public agencies – around a common issue. During the past year, he has helped build support for the project from leaders in acute care, EMS, hospice, and community organizations, as well as local physicians and elected officials. While Mendocino County does not yet have a formal coalition to oversee its POLST education and implementation, this is expected to occur early in 2009. In the meantime, several other community leaders joined Dr. Apfel in spearheading outreach and education efforts.

Approach:

Project leaders began by conducting a number of one-on-one meetings and presentations to a variety of healthcare providers. Administration and medical staff from all 3 area hospitals pledged their support for the project. Ukiah Valley Medical Center emergency room director Mark Luoto, who also serves as the regional EMS director, has been especially enthusiastic, and was instrumental in training volunteer ambulance staff. A key element has been to elicit support from primary care physicians, who provide the majority of patient care in the county. Since most PCPs are in solo practices, this education required labor-intensive, one-on-one outreach. Bringing the PCPs on board is particularly important since Mendocino County has few specialists, including only one oncologist and no palliative care physicians. An additional challenge is that due to the size and terrain of the county, medical providers are isolated with rare opportunities to interact with each other.

Introducing POLST to administration and staff of community clinics, SNFs and hospice organizations is also underway. Project leaders have found the Oregon POLST video to be a powerful teaching tool. They supplied portable DVD players to the local hospice and each SNF for in-service and new employee training, as well as for patient education. Linkages also are being made with county Health and Human Services Department staff who work with the elderly and can encourage appropriate patients to talk with

their physician about the POLST form (or, with training, introduce the form and recommend taking to the doctor for discussion).

Highlights/outcomes:

- Implementation has begun in about 10% of doctors' offices, 2 of the 3 hospitals, and 1 SNF.
- Local EMS is very supportive; EMTs and Paramedics like the clarity of the POLST form and process. EMS director presented POLST at statewide directors meeting, and will be conferring with the area helicopter service, which is greatly utilized in this remote county.
- Are translating the POLST form content into Spanish to use as a discussion guide with Spanish-language patients
- Dr. Apfel represents POLST grantees on the statewide POLST task force and serves on its Documentation Committee.

Next steps:

- Will formally establish a county POLST coalition.
- Will begin implementation in SNFs, residential care facilities, home health and hospice.
- Have approached Napa and Sonoma counties (new POLST grantees) to work together, since Coastal Valleys EMS Agency covers Mendocino, Napa and Sonoma counties.
- Have been approached by Lake County to bring POLST there; hope to expand there in next 2 years.

Physician leader: Mark Apfel, MD; Anderson Valley Health Center

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Riverside POLST Project

Snapshot:

Located in the southeastern part of the state, Riverside County stretches from Orange County to the Arizona border. It is the fastest-growing part of a region known as the Inland Empire. With a population of approximately 1.4 million, Riverside County has 16 hospitals, 50+ nursing facilities and 1700+ practicing physicians. The POLST project began by targeting the City of Riverside (250,000 residents) and then expanding to Corona and Moreno Valley areas.

Community readiness:

Activities related to POLST in Riverside County grew out of previous work of the Inland Empire Palliative Care Coalition (IEPCC), a project of the Riverside County Physicians Memorial Fund begun in 2005 to promote high-quality end-of-life care. The IEPCC was interested in developing a standardized form to guide improved advance care planning and palliative care services. They liked the neutrality of the POLST form (not "owned" by any local hospital), agreed with its emphasis on discussion, and decided to take on POLST as their education project. The IEPCC meets monthly and has a membership of 29 individuals and organizations, e.g., physicians, hospitals, EMS, hospices, nursing facilities. An Executive Committee chaired by POLST physician leader Tarek Mahdi, MD, oversees IEPCC projects, including an annual palliative care conference that attracts 75-100 attendees. IEPCC receives in-kind support from the medical association and also has secured several small grants.

Approach:

Riverside was the first community in California to pilot POLST, beginning early in 2007 with a program in the City of Riverside involving five nursing facilities, one Alzheimer's facility, two community hospitals and the EMS organization. The project focused on educating healthcare providers and patients at all points of the continuum of care. To ensure uniformity of messaging, education and discussion, IEPCC used the Oregon materials as the basis for their outreach. They compiled SNF training packets that included an introductory letter, PowerPoint CD, 10-minute Oregon POLST DVD and POLST form. Presentations were scheduled with key SNF staff, usually during their monthly meetings. The training packet was left for them

to use as in-service for other staff. Key to the educational component was the utilization of champions, well-regarded volunteer IEPCC members who had existing relationships with SNFs. They helped both by providing initial entrée to facilities, as well as presenting educational programs in the SNFs.

After nearly two years of experience, IEPCC determined that its expansion was limited by the volunteer nature of the group. Most work full time in their medical field, making it difficult to conduct daytime educational programs. To address this issue, IEPCC will hire a POLST liaison/trainer to support and provide follow-up to facilities where POLST is being implemented. IEPCC is also working to refine its educational materials and share their experiences with other communities and providers interested in utilizing POLST. Due to the participation of several IEPCC champions from neighboring San Bernardino County, the project expanded into a portion of that county in Sept. 08; IEPCC will be assisting the new San Bernardino community project in 2009-10.

Highlights/outcomes:

- Currently EMS agency, 3 hospitals, 8 SNFs, 2 RCFEs and 2 hospices are implementing POLST; estimates of completed POLST forms in facilities: SNFs (70%), RCFEs (100%), hospices (100%).
- Estimate 10,000 forms have been distributed throughout the county to physicians, SNFs, hospitals and IEPCC members.
- Developed IEPCC website (www.iepcc.org) which includes POLST materials.
- Presented annual conference on palliative care in April 2008 with focus on POLST.
- Took lead in working with California Medical Association to support POLST legislation.
- Serve as advisor/mentor to other communities/providers interested in starting POLST programs.
- Presented poster session at national Center to Advance Palliative Care conference and talk for national Supportive Care Coalition (palliative care organization).

Next steps:

- Hire a POLST liaison (20 hours a month) for training and follow-up.
- Continued expansion in Riverside County hospitals, nursing homes and hospices.
- Training and implementation with EMS agency professionals serving Corona and Moreno Valleys.
- Development of IEPCC as resource center for palliative care and POLST services and education.

Physician leader/project dir: Tarek Mahdi, MD, Inland Empire Palliative Care Coalition

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Santa Clara POLST Project

Snapshot:

Santa Clara County is located in the south San Francisco Bay Area and is the primary site of Silicon Valley. This large county has 15 cities; the county seat is San Jose. With a population of nearly 1.8 million, Santa Clara County has 6 acute care hospitals and more than 50 skilled nursing facilities.

Community readiness:

The Santa Clara County POLST Project grew out of concerns from geriatricians and palliative care physicians at the Santa Clara Valley Medical Center. They were concerned about the number of inappropriate transfers of patients from SNFs and “coding” of patients who had previously stated that they did not wish extraordinary measures. Interested in working with other providers to develop best practices for the area, physician leader Steven Lai began the Santa Clara County POLST Coalition in early 2008 with hospital, SNF and hospice representation. During the next year the coalition, which meets monthly, grew to 30 members with the addition of EMS providers, county counsel, physicians from multiple specialties, and representatives from nursing, case management and social work.

Approach:

Due to the size of the county, the coalition directed its energies to building the foundation for POLST implementation at two hospitals (total of 800 beds) and 3 large SNFs (10% of total patient beds in Santa Clara County). They plan to establish successful POLST programs in these facilities before expanding throughout the larger community. While there was initial resistance to the POLST form by county counsel regarding liability issues, this was addressed with some language changes in the form and by the passage of AB 3000. The coalition began by securing the support of EMS and helping with development of the county's EMS policy. They also started educational outreach, providing trainings for local EMS trainers and hospice staff. Coalition leaders developed a three-part workshop for SNF staff that includes an introduction to POLST; tools to discuss ACP aimed at admissions coordinators, nursing staff and social services staff; and review of implementation policies.

Highlights:

- Participating facilities include 2 hospitals, 3 SNFs, one hospice and an outpatient geriatrics clinic.
- Primary county EMS provider has incorporated POLST training into its curriculum. Their county medical administrator presented POLST to the California association of emergency medical directors.
- Developed and conducted a short survey for SNF staff from several disciplines to give feedback on POLST process. Issues that have arisen include: challenge with physician ownership; form not returned to SNF with patient and need for further education about the POLST paradigm. Staff from nursing facilities also emphasized that they felt the form was more clear and understandable to use with patients and families than the PIT forms.
- Based on Oregon's quality improvement process, Dr. Lai is beginning to collect data on POLST forms completed by geriatrics clinic patients. Since Santa Clara Valley Medical Center is a teaching hospital, he plans to involve geriatric residents in this project.
- Major contributor to development of California's POLST educational materials, including guidebook for health professionals and FAQs.

Next steps:

- Hire part-time POLST Coordinator position to assist with outreach and education and administrative duties; prepare several additional POLST trainers to assist with education at local sites.
- Broaden radius of project to include more SNFs in the western part of the county (Saratoga and West San Jose) and county-wide in hospices and EMS; explore expansion into Kaiser system.
- Consider partnering with community based organizations to raise awareness within Spanish and Chinese-speaking communities.
- Look at POLST as part of an effort to improve chronic care disease management by targeting high-risk groups in clinic setting and getting ACP underway earlier.

Physician leader/project dir: Steve Lai, MD, Santa Clara Valley Medical Center

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Ventura POLST Project

Snapshot:

Located north of the Greater Los Angeles area, Ventura County has a population of 813,000. The county has 8 cities, including Ventura (coastal city and county seat) and Oxnard (largest city, with a population of 200,000). There are eight hospitals and 21 nursing facilities within Ventura County.

Community readiness:

Ventura County's interest in POLST began when Dr. James Hornstein, Community Memorial Hospital ethics committee chair, learned about Oregon's POLST program through his participation in the Southern California Bioethics Consortium. His hospital ethics committee conducted a retrospective review of its clinical ethics consultations, which revealed a number of cases where improved clarity of patient treatment wishes could have significantly aided clinical decision-making. The committee decided to institute a

POLST project. Coincidentally at the same facility, a number of hospitalists who were trained in Oregon and familiar with POLST, called on hospital leadership to build community support for a countywide POLST standard. Interest spread to all 8 hospitals in the county. Dr. Hornstein established the Channel Islands POLST Project; its Executive Team includes representation from physician groups, hospitals, EMS, legal, senior and religious community.

Approach:

The coalition's first year was devoted to coalition-building and laying the groundwork for implementation countywide. Coalition leaders began by educating key stakeholders, meeting with many physicians and community leaders, including elected officials. The ethics committees were the initial point of contact in all 8 hospitals; they have been very supportive, with a number of members actively involved in the project. Coalition leaders made multiple presentations at hospitals (including 3 grand rounds presentations), SNFs, home care and hospice agencies. The county EMS administrator and medical director were enthusiastic supporters and are training EMTs throughout the county. After some initial resistance due to a lack of familiarity with end-of-life treatment concerns and the POLST coalition, the Ventura Medical Society endorsed the POLST project and appointed a liaison to the coalition. The Coalition found that due to the size of the county and the fact that the bulk of coalition leadership is located in the western half of the county, they will concentrate their initial implementation efforts there.

Highlights:

- Presented POLST to Ventura Council of Government (mayors and aides from all 8 cities), which endorsed the project; this has helped emphasize the broad countywide effort and added credibility.
- Received media coverage, including several articles in local newspapers and interviews on local public TV shown widely throughout the community.
- Are partnering with area community college to develop an educational DVD that shows POLST in action locally.
- Coalition member from the legal community is helping set up workshops for estate planning and family law attorneys.
- Due to large penetration of managed care in Ventura, coalition is exploring with area health plans the potential for providing incentives to primary care physicians to encourage POLST process.

Next steps:

- Provide education to staff from SNFs, hospitals, hospice and home health within Western Ventura County and begin implementation in 2009.
- Expand education and implementation into Eastern Ventura County in 2010.

Physician leader (2007-08): Jim Hornstein, MD, Channel Island POLST Coalition

Project leader: Sonya Thomas, RN, MBA, Valley Care IPA

For more info: Mary Carr, (805) 484-6822, marycarr@venturamedical.org

Yolo POLST Project

Snapshot:

Located in northern California adjacent to Sacramento, Yolo County has a population of 150,000 – 85% urban and 15% rural. The county is served by two community hospitals and seven skilled nursing facilities. The POLST project is focused primarily on the cities of Woodland (county seat) and Davis (home to the University of California, Davis).

Community readiness:

Yolo County was well primed for initiating a POLST project in 2008. A Skilled Nursing Coalition has been in existence for a dozen years, with representation from Woodland Memorial Hospital, medical staff and SNFs. Meeting several times per year, the group has worked together to develop forms and processes to

improve the delivery of care for frail elders. They developed a standardized version of the PIC form—used by all 7 SNFs—as well as extensive education programs for staff. The Coalition felt that POLST was a natural transition from their work with the PIC process. They saw an opportunity to expand, involving hospice, the other local acute care hospital (Sutter Davis Hospital) and county’s Emergency Medical Services provider.

Approach:

The Coalition began immediately to gear up for POLST implementation by educating its existing and new members and introducing POLST to other stakeholders (e.g., physicians, EMS). Sutter Davis Hospital, hospice and EMS representatives joined the Coalition, which has also seen increased participation from health professionals working in home health, social work and chaplaincy programs. A major Coalition priority was the education of as many staff as possible from acute, SNF, hospice and home health settings. After developing educational tools, the Coalition conducted nearly 20 trainings with mixed groups of staff in the winter of 2008; implementation started in March. The Coalition learned quickly that staff need more than one education session to develop the knowledge, skill and comfort level of discussing POLST with patients. They found that after an original orientation, it was helpful to return within 3-4 weeks to address specific issues that have arisen. They also focused more on interactive learning, e.g., case studies.

As one of the first communities to implement POLST, the Yolo County Coalition is helping identify and work out some of the challenges in operationalizing POLST, e.g., inter-facility transfers, communication issues. (An example: To address some difficulty in getting POLST forms completed before hospital discharge, they are piloting a worksheet that clarifies diagnosis and prognosis to accompany the patient to the nursing home, where the POLST form can be discussed more fully and completed.) With strengths in education and training, Coalition leaders have helped adapt some of Oregon’s materials for other community coalitions to use, as well as developed new supplemental resources (e.g., course objectives and evaluation tools, SNF implementation checklist).

Highlights:

- 5 of Yolo County’s 7 SNFs currently using POLST.
- Yolo Hospice using POLST with 100% of its patients.
- Facilitated expansion into adjacent Solano County, in part because Yolo Hospice serves patients in both counties. Yolo Co EMS conferred with Solano Co EMS, which approved POLST usage.
- Leading statewide efforts to develop California’s standardized POLST educational curriculum for non-physician staff (multiple modules, teaching methods, tools).
- Provided testimony at several California State Assembly and Senate committee meetings during AB 3000 legislative approval process.
- Presentations made to Catholic Healthcare West palliative care coordinators meeting and national Supportive Care Coalition (palliative care organization).

Next steps:

- Expand use of POLST more intensively in the county, both at Sutter Davis and remaining SNFs.
- Spread POLST discussion into community through collaboration with area clergy.
- Increase POLST usage in Solano County and introduction in Colusa County.

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Sacramento Area PREPARED Project

Although not one of the seven POLST community projects, the PREPARED project is included in this paper because of its use of the POLST tool in a number of Sacramento area skilled nursing facilities.

Snapshot:

Located in the middle of the Central Valley, Sacramento is home to the state capital. Placer is adjacent to Sacramento and is one of the fastest growing counties in the state. Together, they include more than 1.6 million people and are served by 13 hospitals and 50 nursing facilities. The PREPARED project includes portions of Placer and Sacramento counties.

Community readiness:

The project was undertaken to test the replicability of an advance care planning and palliative care pilot conducted in Roseville (Placer County) in 2003. The pilot used the Washington POLST form to document patients' treatment choices. Within 6 months of implementation, transfers from the skilled nursing facility to the hospital decreased by 56%, and patient satisfaction measures improved. The pilot was expanded in 2004 to nearby Auburn, with similar results. A subsequent 18-month PREPARED project grant was awarded by the California HealthCare Foundation in 2007 to improve advance care planning and palliative care in three cohorts of Sacramento area nursing facilities. The project is an inter-organization collaborative involving four hospital systems (Catholic Healthcare West, Kaiser Permanente, Sutter Health System and UC Davis Health System) and 18 skilled nursing facilities in the Sacramento area.

Approach:

Each of the participating hospital systems provided in-kind staff (RN or social worker) for 4-8 hours per week; the grant funded a coordinator at 20 hours per week. The 18 participating SNFs came into the program in three cohorts of six facilities. Each was assigned a nurse educator, who provided intensive training to the administrator, nursing director and clinical staff during the initial six months of their participation, with continued follow-up and support through the remainder of the project. The nurse educator also visited the facility weekly to mentor, teach and role model how to facilitate advance care planning discussions with residents and families.

Highlights:

- 15 of the 18 project SNFs are or will be using POLST.
- Conducted 6-hour class modeled after *Respecting Choices* training for 30 SNF staff (social services designees and admissions coordinators) from 6 different SNFs.
- Provided POLST education in several acute care facilities, with particular attention paid to emergency department staff (including physicians and other licensed professionals).
- A formal evaluation of the project is being conducted by staff from the Center for Gerontology and Health Care Research at the Brown Medical School. Preliminary evaluation of deaths that occurred in the nursing home show a reduction in transfers to acute care facilities in the last 90 days of life and increased use of order to "Do Not Hospitalize."
- Project staff are helping develop California's standardized POLST educational curriculum on facilitating POLST conversations.

Next steps:

- The project will end in June 2009; collaborating hospitals are exploring options for continuation.
- There is interest in the establishment of a Sacramento-area POLST coalition to ensure support for continued use of POLST throughout the area.

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Bringing POLST to Your Community

Steps for Getting Started

1. Identify a physician champion.
2. Establish a coalition of key stakeholders.
3. Develop a workplan with attainable goals that build on coalition strengths
4. Educate providers across the continuum of care about POLST and how to use it properly.
 - standardized materials, curricula, model policies available at: www.finalchoices.org
5. Initiate POLST within a few organizations, e.g., 1-2 hospitals, several SNFs, EMS, hospice.

Learning from Others

The first POLST communities serve as on-the-ground laboratories for launching POLST in eight different areas of the state. Their grassroots experience in building coalitions, developing and testing educational materials and addressing systems issues will continue to be helpful to future local efforts. Following are their key lessons learned thus far:

1. Identify a physician champion.

Successful POLST campaigns require active involvement of physician leaders. While there are essential roles for other health and social service professionals in ensuring successful POLST implementation, POLST is a physician order and needs visible physician proponents. Nearly all of the POLST communities include such leadership. Look for leaders with passion for improving end-of-life care, credibility with other physicians and an understanding of the healthcare system.

Several community projects (**Alameda, Humboldt, Riverside**) are based in their local medical society or IPA, which has provided them access to physician leaders, as well as in-kind support and neutrality. Hospital ethics committees also can offer strong physician support. When approaching a medical society or ethics committee, recruit a member physician to provide entrée.

Do not presume that all physicians will be supportive of POLST. The benefits of POLST may not be obvious to physicians less familiar with or interested in end-of-life issues. Some may see POLST as just another form requiring time and attention that is already limited.

2. Build a POLST coalition of stakeholders.

One of the most valuable attributes of POLST is its use across care settings; therefore, a coalition approach can help ensure effective implementation. The communities that were able to implement POLST within a few months each had in place a coalition of key players with a history of working together. If a group is starting from scratch, devote the time necessary for development; select a name and hold regular meetings to help establish the coalition. Designating a person to take care of administrative tasks is also useful.

The passage of POLST legislation and an All Facilities Letter distributed by the California Department of Public Health announcing the new law have helped bring attention to POLST. Build on this new awareness and interest to recruit coalition members from the community. In addition to physician leadership, involve key stakeholders from emergency medical services, acute care hospitals and skilled nursing facilities.

Emergency Medical Services: The state EMS Agency strongly supports POLST and is responsible for developing guidelines to assist EMS providers with implementation. Be aware that local EMS providers operate autonomously with strong local control; therefore, it is important to meet directly with community providers. POLST coalitions that have begun implementation all have established strong relationships with their local EMS providers.

Acute care: Since hospitals are multi-faceted organizations, look for buy-in from department leaders that should be most receptive: Emergency room staff will be receiving patients with POLST forms. Palliative care leaders care for seriously ill patients and may be quite skilled in having conversations about end-of-life treatment decisions. Some hospitalists or ethics committee members may be interested. Seek out the acute care champions that see value in POLST.

Skilled nursing facilities: Since most SNF residents would benefit from POLST, involvement of SNF leadership is imperative. Examples of how coalitions have recruited SNF participation include: **Riverside** asked coalition members who had relationships with area SNFs to provide initial entrée to the facilities. **Alameda** created an inviting atmosphere by bringing SNF leaders together for a POLST introductory lunch. **Humboldt** recruited the medical director who oversees care at all seven SNFs in the county; he was able to secure administrative buy-in. **Sacramento** found it helpful to meet at the SNF with the entire leadership team from a variety of disciplines. At the state level, CCCC is working with SNF trade associations and SNF corporate leaders – across local communities – to provide support and encourage participation in local POLST implementation efforts.

POLST coalitions also have found it beneficial to have coalition participation from hospice, nursing, social work, chaplaincy and legal arenas.

For information about what makes effective coalitions (e.g., qualities, benefits, recruiting tips), visit: www.finalchoices.org.

3. Identify community strengths and resources.

Each community has its own personality and culture that shape the best approach for making change. Develop POLST project strategies that fit the community and have the best chance for success. Some examples from the POLST coalitions:

- **Alameda** opted to build broad county-wide support first before implementing POLST because in this dense urban area patients often go from one hospital system to the emergency department of another. While this approach delayed implementation at local sites, Alameda County is well positioned for rolling out POLST in 2009.
- Due to the size of the county and modest resources, **Santa Clara** focused implementation on a small number of hospitals and nursing facilities. Once they have a tested program working successfully, they will seek additional partners to expand to other parts of the county.
- **Humboldt** used a more diffuse leadership model than other communities. Instead of a single physician champion, leadership is shared among a geriatric nurse practitioner, chaplain, social worker and IPA director. With nearly one third of the care in Humboldt County provided by advance practice clinicians, there is widespread understanding that health care is delivered by a team, not only physicians.
- **Riverside** leveraged its relationship with the Riverside County Medical Association to garner support of POLST from other medical societies in the state and to help generate backing from the California Medical Association for POLST legislation.
- **Mendocino** – where physicians and patients are likely to know one another personally – found it helpful to get the word out to primary care physicians who provide the bulk of outpatient care and often have longstanding relationships with their patients.
- **Ventura** reached beyond healthcare stakeholders, gaining support from several elected officials to help raise visibility and involving the local community college in their efforts.
- **Yolo** utilized a long-standing committee with representation from all seven skilled nursing facilities as the nucleus for its POLST coalition.

4. Recognize the need for ongoing education, especially in skilled nursing facility settings.

While SNFs provide staff in-service on a variety of topics, end-of-life care is rarely included. For POLST to be implemented successfully in the SNF, staff at all levels (including nurses, certified nursing assistants, admissions coordinators and social service designees) need to understand the importance of establishing goals of care and be well versed in advance care planning, including advance directives and POLST. CCCC has developed a multi-module curriculum to help address this need (www.finalchoices.org).

Education in SNFs can be especially challenging due to thinly-stretched staffing levels and high staff turnover. Therefore, repeated and ongoing education is critical to the success of POLST. Two coalitions (**Riverside** and **Santa Clara**) are adding paid positions during their second phase of implementation to broaden educational efforts.

Some of the educational methods POLST coalitions are employing include:

- Involving staff from a variety of settings (ICU, SNF, hospice, ER) in the same educational session; this adds to the richness of discussion and understanding about how to use POLST (**Yolo**).
- Supplying portable DVD players (for showing POLST video) to each participating SNF for ongoing in-service, new employee training and patient education (**Mendocino**).
- Supplementing POLST education with EPEC (Educating Physicians about End-of-Life Care) modules on communication and pain and symptom management to reinforce key messages (**Riverside**).
- Developed a 3-part workshop presented by a physician and social worker that includes: introduction to POLST; role play and feedback session specifically for staff using POLST regularly (admission coordinators, nursing and social services); and implementation policy review (**Santa Clara**).
- Including CNAs in basic education classes to help them understand a larger view of patient needs. Also allows for peer support and discussion of implementation concerns and issues (**Yolo**).
- Along with role play, using SNF cases from facility to discuss appropriate use of POLST. (**Riverside**).
- In addition to group presentations on facilitating POLST conversations, following up through one-on-one discussions with individual staff members (**Sacramento, Yolo, Santa Clara**).
- Providing mentoring, a contact person for support, and inter-disciplinary in-service, which results in richer case conferences and better patient advocates (**Sacramento**).
- Holding an education follow-up luncheon targeted to discharge planners, case managers and social workers to discuss issues of concern, e.g., how to talk with doctors about POLST (**Yolo**).

5. Be patient and persistent.

While the value of POLST may be clear, getting it established as a standard of practice across the entire continuum of care is not an easy task. Implementing POLST entails coordination of many activities and collaboration among a variety of stakeholders. New relationships often need to be established with organizations that may be unfamiliar. The need for good communication is heightened. There is much to be done. POLST coalition members advise others interested in bringing POLST to their communities to be patient, stay flexible and take advantage of the lessons learned from the first year of POLST in California.