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The Indiana POST Program A New Approach to Honoring Patient Treatment Preferences

Susan Hickman, PhD, Associate Professor, School of Nursing, IU

I admitted yet another terminally ill patient who had definite no code orders written during previous admissions which were to have been continued at the nursing home. Somehow those orders were changed to full code and the patient was intubated and delivered to the emergency room for more "life saving heroics." I was able to discuss this recurring problem with Dr. Dale Theobald (Medical Director of Palliative Care at Community Hospital) and Stacey Sharp (Director, Life's Journey Integration Services at Community Hospital) who referred me to Susan Hickman, PhD, Associate Professor, School of Nursing, IU. As it turns out there is a program developed to ensure that patients' end of life wishes are carried out. Dr. Hickman is nationally recognized for her work with the POLST (Physician Orders for Life-Sustaining Treatment) paradigm. Please enjoy the following information about the Indiana POST Program.

What is POST?

Living wills are largely ineffective at ensuring patient treatment preferences are honored at the end of life for a variety of reasons.¹ The POST (Physician Orders for Scope of Treatment) Program is designed to overcome the limitations of living wills to help ensure that patient preferences for life-sustaining treatments are communicated and honored. The centerpiece of the POST Program is a form that contains immediately actionable medical orders addressing resuscitation, medical interventions (e.g., hospitalization), antibiotics, and artificial nutrition. These orders are based on patient preferences to have or decline interventions and direct care provided by nursing and emergency medical personnel. POST forms transfer with patients across care settings to ensure preferences are honored throughout the healthcare system.

The POST form is specifically intended for seriously ill patients with advanced chronic progressive illness, advanced frailty, or terminal illness. It is frequently used in the skilled nursing facility and hospice setting. The voluntary form is completed based on a conversation between the patient and/or his designated surrogate and a health care provider, which could be either the patient's physician or a physician designee. The form requires a physician signature and a patient or surrogate signature in order to be activated.

In a large, federally-funded multi-state study of POST form use in nursing facilities, residents with POST form orders were significantly more likely to have treatment preferences documented as orders in their medical records than residents without the form.² The orders on POST also successfully directed treatment decisions. Treatments provided were highly consistent with POST form orders for resuscitation (98%), medical interventions (92%), and antibiotic use (93%).³

POST in Indiana

Since it was created in the early 1990s, the POST Program has spread to 14 states. An additional 20 states are in the

process of developing programs (www.POLST.org). The Indiana Patient Preferences Coalition (IPPC), co-chaired by Gerald Walthall, MD, FACS (Franciscan Alliance) and Susan Hickman, PhD (IU School of Nursing) formed in 2010 with the goal of developing an Indiana version of the POST Program. It has quickly grown to include over 45 members representing key stakeholder groups including the Indiana State Medical Association (ISMA), the Indiana Academy of Family Physicians (IAFP), the Indiana Medical Directors Association, and the Indiana Hospital Association. Both the ISMA and the IAFP passed resolutions in 2011 in support of POST implementation. POST legislation was introduced in the 2012 legislative session by Representative Tim Brown, MD, but the bill did not make it out of committee due to a lack of quorum.

Barriers to POST Legislation in Indiana

A primary barrier to POST legislation is the existence of the current DNR statute (IC 16-36-5), which contains statutorily specified language that is incompatible with POST and limits its usefulness. The current DNR statute requires that patients either be unable to survive CPR or be "terminal," a label that excludes a large population of patients with advanced chronic progressive disease or advanced frailty. These patients may wish to limit treatments when the burdens of medical interventions begin to outweigh the benefits, but are unlikely to be identified as "terminal." Additionally, the existing out-of-hospital DNR order form requires two unrelated witnesses. This requirement creates barriers to patients receiving care in the community setting such as those enrolled in hospice care and represents a challenge in nursing facilities, as many prohibit employees from witnessing.

Another key barrier to Indiana POST legislation is determining who is authorized to execute a POST form on behalf of an incapacitated patient. Indiana statutes recognize the need for default surrogate decision-makers in the event that a person loses decisional capacity without formally appointing a health care representative. In these situations, decisions can be made by a spouse, a parent, an adult child, or an adult sibling. However, Indiana's statutes are unique in that they do not specify a hierarchy. Instead, each family member has an equal right to make decisions on behalf of the incapacitated patient, which could be problematic if there are disagreements about what is best for the patient in the process of completing a POST form. Additional issues requiring further study include how the POST program is used within the hospital and whether nurse practitioners should be permitted to sign, as is the practice in several other states.

Benefits to POST Legislation

If POST legislation were passed in Indiana, eligible patients would be able to document their preferences in a format that is easily understandable to clinicians. Hoosiers would be able to benefit from an evidence-based intervention that successfully

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alters the kinds of treatments patients receive near the end of life. Moreover, the POST could be used as a tool in the advance care planning process to facilitate conversations about a wider range of treatment decisions likely to arise in the final months of life, rather than narrowly focusing on resuscitation preferences at the time of death.

Next Steps

The IPPC is working to find legislative solutions to these barriers and others and will provide suggestions for revised legislation with the goal of seeing a new POST bill successfully introduced in the 2013 legislative session. In anticipation of achieving this goal, the IPPC is busy creating educational materials and developing a coordinated implementation plan to help ensure a smooth and successful roll-out of the Indiana POST program.

For more information, contact Susan Hickman at hickman@iupui.edu or Jerry Walthall at gerald.walthall@franciscanalliance.org.

References

¹Hickman SE, Hammes BJ, Moss AH, Tolle SW. Hope for the future: Achieving the original intent of advance directives. *Hastings Center Rep* 2005;35(6):S26-S30.

²Hickman SE, Nelson CA, Moss A, et al. Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting. *J Pall Med* 2009;12: 133-141.

³Hickman SE, Nelson CA, Perrin A, et al. A comparison of methods to communicate treatment preferences in nursing facilities: traditional practices versus the Physician Orders for Life-Sustaining Treatment (POLST) Program. *J Amer Geri Soc* 2010; 58: 1241-1248.

⁴Hickman SE, Nelson CA, Moss A, et al. The consistency between treatments provided to nursing facility residents and orders on the Physician Orders for Life-Sustaining Treatment (POLST) Form. *J Amer Geri Soc* 2011;59: 2091-2099.

On a Personal Note:

I want to thank the members and leadership of the Indianapolis Medical Society for the honor of serving as your President. I have enjoyed the experience immensely and have tried to bring honesty, integrity and energy to this great organization.

I want to acknowledge, too, the many perspectives I have been able to share with you on the pages of the *Bulletin* from medical leaders throughout our community. The diversity, I hope, has proven to be thought-provoking.

Thanks to Beverly Hurt, EVP, and the staff of the IMS for keeping our organization moving forward.



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