

# Understanding POST

## Physician Orders for Scope of Treatment

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### POST protects patients' choices at the end of life.

Indiana supports the right of patients to make their own health care decisions. However, the tools created by the Indiana Living Will Act are often insufficient to ensure that patients receive treatment consistent with their preferences. The general and vague language of a living will is difficult to interpret and apply in most clinical settings. Furthermore, living wills only apply to the very end of life, whereas many individuals with life-limiting conditions experience an extended period of decline and may want to start setting limits on the kinds of treatments they receive prior to a catastrophic event. Out of Hospital Do Not Resuscitate Orders only direct care in a narrow set of circumstances. **Under current law, Hoosiers with advanced progressive illness or frailty do not have a clear and effective method for communicating their treatment preferences to health care providers.** These patients may be unable to exercise their rights as intended by the Indiana Living Will Act.

The Physician Orders for Scope of Treatment (POST) bill would address this gap in the current law by establishing a process for the execution of a POST form, a tool for communicating patient preferences within the real-life clinical settings where patients receive care.

## What is POST?

- ❖ POST is Indiana's unique approach to the POLST (Physician Orders for Life-Sustaining Treatment) Paradigm Program. Like the POLST Paradigm, POST is a coordinated care model centered on a standardized medical order form that communicates patient preferences using medical language that all health care providers can understand. **The POST form would supply health care providers across health care systems with clear information to direct treatment based on the patient's wishes.**
- ❖ Unlike an advance directive, POST forms contain medical orders that must be followed by health care providers, including nurses and emergency medical personnel. In contrast, advance directives (such as living wills) express an individual's general preferences regarding medical decisions made on his/her behalf that require interpretation. **The POST form augments a current living will by translating patient preferences into immediately actionable medical orders that can be easily followed by health care providers.**
- ❖ Unlike an advance directive, which is appropriate for all adults, **the POST form is specifically intended for seriously ill persons with advanced progressive illness or frailty.** Use of the POST form is typically not appropriate for persons with early stage progressive illness or functionally disabling problems who have many years of life expectancy.
- ❖ Unlike a Do Not Resuscitate (DNR) order, **the POST form allows for documentation of preferences to have or decline medical interventions such as hospitalization, antibiotics, and feeding tubes in addition to resuscitation.** In contrast, a DNR order only directs health care providers to withhold resuscitation in the event of a cardiac or respiratory arrest (i.e., at the time of death).
- ❖ A POST form does not eliminate the need for a health care representative or diminish the value of a living will.

### When and how should a POST form be completed and executed?

- ❖ **Individuals are encouraged to complete a POST form when their clinician would not be surprised if the patient died within a year.** Completion of POST forms is highly recommended for hospitalized patients being discharged to nursing homes or to their own home with hospice or home health care. Completion of POST forms is also highly recommended for nursing home residents either at the time of admission to nursing homes or during quarterly care planning. **However, the use of a POST form is always voluntary.**
- ❖ Physicians, nurses, social workers, or other designated health care professions fill out the POST form based on a meaningful discussion with the patient or, if the patient lacks capacity, the patient's health care representative. **The POST form orders take effect only after the patient's treating physician reviews and signs the form.**
- ❖ If a patient's condition changes, it may be appropriate to reconsider the treatment plan. However, the POST form should not be modified or voided unless there is a conversation with the patient or, when appropriate, his/her health care representative. Modifications must be noted and signed by the patient's treating physician, and a new POST form should be completed as soon as possible.
- ❖ An executed POST form is valid unless it is in conflict with a more recently executed advance directive. In that case, the most recently completed form takes precedence, but only to the extent necessary to resolve the inconsistency.

### How is a POST form used?

- ❖ **The POST form travels with the patient to all settings, including home, hospitals, nursing facilities, and other health care settings.** When a patient is being transferred, the facility initiating the transfer will communicate the existence of the POST form to the receiving facility prior to the transfer and send the original with the patient. The order set remains in effect at the receiving facility, and should be honored by all providers across the state. In the event that the patient is transferred to an acute care hospital, the POST form should be used by the admitting physician to guide the treatment plan for that admission. The physician should re-evaluate a patient's POST form if the patient has experienced a change in health status.
- ❖ For patients who reside at home, the POST form is kept on the refrigerator where emergency responders can find it. Family members and caregivers should also know where the form is located.
- ❖ For patients who reside in a long-term care facility, the POST form must generally be kept as the first page in a person's medical record.
- ❖ **The POST form may be used to guide daily care decisions.** Because the POST form documents patients' preferences to receive or forego a variety of interventions, it can be used to guide decisions such as the placement of feeding tubes, the use of antibiotics to treat pneumonia, and the provision of other treatments.
- ❖ **Health care professionals, including emergency medical personnel, are required to follow the orders on a patient's POST form.** The POST bill provides legal protection for health care providers who comply in good faith with the orders on POST forms.

### Will POST *really* make a difference?

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#### Yes! Consider a common clinical scenario:

**Mrs. Smith is an 87-year old woman with diabetes and stable congestive heart failure.** She lives alone, drives to play cards three times weekly, and values her independence. Mrs. Smith understands that her advanced age and medical problems may at some point limit her ability to live independently. **She has discussed this fact with her 3 children; she has specifically stated that she wants “no heroic measures” and would never want to be placed on a ventilator. She has executed an Indiana Living Will declaration.**

One Friday, Mrs. Smith’s neighbor came by to check on her, as she does three times weekly. She let herself in the back door, and there was no answer to her calls. She found Mrs. Smith in her bedroom on the floor, unconscious. Her lips appeared blue and she was breathing only occasionally. Her neighbor immediately called 911.

#### How would POST differ from the current living will statute in Mrs. Smith’s situation?

##### With *only* an Indiana Living Will:

- ❖ The ambulance arrives and Mrs. Smith’s neighbor informs the EMTs of her living will.
- ❖ **Per protocol, the EMTs immediately place Mrs. Smith on a ventilator and transport her to the hospital.** She is transferred to the ICU, where she is found to have pneumonia and a myocardial infarction.
- ❖ Her family members are contacted and they inform the physicians about her wishes regarding the ventilator. Her children are given the option to continue aggressive treatment in the ICU (which is already being provided) or discontinue the ventilator and instead start comfort measures.
- ❖ **The family is not in agreement about whether her illness is incurable and the living will conditions have been met, so treatment is continued for several days.** Mrs. Smith does not improve. After many difficult discussions, the family finally decides to discontinue the ventilator.
- ❖ **Mrs. Smith expires in the ICU in the presence of her family several days after her admission.**

##### With a POST form:

- ❖ The ambulance arrives and Mrs. Smith’s neighbor points out Mrs. Smith’s POST form, posted on her refrigerator. The form indicates that she does not wish to be intubated (placed on a ventilator), but that she does wish to be transferred to the hospital for management of her medical needs and receive antibiotics.
- ❖ **The EMTs give Mrs. Smith oxygen, start an IV, and administer a bit of morphine for her breathlessness. Mrs. Smith is transported to the emergency department of the local hospital,** where her family is notified.
- ❖ Mrs. Smith’s family arrives soon thereafter and spends several hours with Mrs. Smith as she is treated with antibiotics for her pneumonia and IV fluids, but she continues to deteriorate.
- ❖ **She is admitted to hospice and transferred back home, where she dies several days later in the company of her family.**

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With a POST form, Mrs. Smith’s treatment preferences were honored from the start. Mrs. Smith’s family did not have to struggle to decide whether she was receiving the care that she wanted.