SUMMARY POLST Illinois Project

August 23, 2011

Background:
The original Illinois Department of Public Health (IDPH) orange DNR form was initiated by Illinois Emergency Medical Services (EMS) leadership in order to allow for a uniform and understandable instruction to first responders to cardiac arrests in the field. The "orange form", as it came to be known, was introduced for use in Illinois in 2000. Following its release, it became clear that the form would impact providers at other sites along the healthcare continuum, e.g. hospital emergency rooms, hospices, nursing homes. Subsequent legislation instructed IDPH to develop an "IDPH Uniform DNR Order Form" which would account for use by other providers and replace the original "orange form". IDPH convened an interdisciplinary task force that developed the "IDPH Uniform DNR Order Form" which was released for use in June, 2005. Subsequent legislative changes have included a title change, to "IDPH Uniform DNR Advance Directive" (2006), as well as a decrease of the witnessing requirement from two individuals to one (2010).

Since its release in 2005, experience with the IDPH Uniform DNR form has generated recognition that it could be improved upon and that it includes some confusing and incomplete aspects. Feedback from users of the form from throughout the state was plentiful. In 2007, Metropolitan Chicago Healthcare Council (MCHC) sponsored a taskforce to draft a revision of the form based on that feedback, which was to be presented to IDPH for consideration as a replacement of the current form. The taskforce included representatives from the IDPH, EMS, Illinois State Medical Society (ISMS), Illinois Hospital Association (IHA), Chicago End-of-Life Care Coalition (CECC), Chicago Region Advance Care Planning Coalition, several hospital ethicists, chaplains, and practicing physicians and nurses. After numerous meetings and revised drafts, the group was unable to reach consensus on a draft that addressed the concerns of multiple parties, and the process was paused.

In the meantime, a paradigm for documentation of patient wishes and physician orders for end-of-life treatment wishes called POLST (Physician Orders for Life-Sustaining Treatments) has gained the attention of providers and citizens throughout the country and is evolving as a national best practice. Originally developed in Oregon in the 1990's, POLST has been adopted in twelve states including California and New York and is under consideration in an additional 22 states. The POLST form differs from a DNR form in that it addresses more life-sustaining treatment options than CPR and is recognized and honored by all institutions along the healthcare continuum in the states where it is utilized. More information is available at www.polst.org.

POLST in Illinois:
In November 2010, participants from the prior DNR form workgroups and other stakeholders were invited to a local meeting with Susan Tolle, MD, the developer of the original POLST program in Oregon as well as a founder of the National POLST Initiative. In February 2011, in an effort to facilitate the POLST process, HB3134 was brought to the state legislature by Rep. Sarah Feigenholz, and co-sponsored by Rep. Robyn Gabel, who had attended the November meeting. The bill stipulates that the IDPH Uniform DNR Advance Directive form "shall meet the minimum requirements to nationally be considered a physician orders for life-sustaining treatment [POLST] form". It passed through both chambers unanimously and was signed in to law in mid-August.

Anticipating the passage of HB3134, a small interdisciplinary writing group has been working tirelessly to draft a "DNR/POLST" form that meets current Illinois state regulations and also complies with the national POLST paradigm. With the fine-tuning of the draft this month, the writing group is now sharing the document with a broader group of interested parties to invite feedback and further suggestions for improvement.

CHICAGO
END-OF-LIFE CARE
COALITION

Common Questions about the POLST Illinois Draft:

1. **Has IDPH approved this draft?** No. IDPH has not yet begun work on the draft in response to the newly signed legislation. We are hoping that, by requesting broad input from multiple clinical disciplines across the state, we will be able to supply the department with useful form proposal(s) for consideration.
2. **Is it necessary for this document to be signed and witnessed?** Yes. These requirements are legislated and remain unchanged from the current IDPH Uniform DNR Advance Directive form. Not everyone agrees with these requirements, and any changes to these parts of the form would require separate legislation.
3. **Does the provider who signs the document have to be an attending physician?** Yes. The physician signature requirement is legislated, and the determination that the physician must be an attending was made previously by IDPH legal counsel.
4. **How will this document interact with the POAHC form?** Ideally, the Power of Attorney for Health Care form should be completed by all adults. The DNR/POLST form is meant to be completed by anyone who is frail, has a chronic, progressive medical condition, or is terminally ill. The former is primarily a proxy document (identifying a substitute decision-maker if required in the future), whereas the POLST form allows specific patient wishes to be translated into physician orders. Although the legislation is silent regarding the interaction between these two documents, the attached draft includes this wording: "The instructions in this document take precedence over any other advance directive document I have completed in the past." Whether an agent with POAHC can override a patient's previously-expressed wishes as written on the DNR/POLST form is not clear and is not a new issue, as it applies to the current IDPH DNR Advance Directive as well. This issue requires further discussion with IDPH and may require separate legislation.
5. **Is this document an advance directive or a physician's order?** Both. These are statements made by a person, or, if nondecisional, his/her substitute decision-maker, that reflect the individual's specific wishes for care. These directives are then translated into physician orders. Practitioners across the spectrum of care can activate these orders immediately in cases of emergency or when the person is unable to directly communicate wishes.

Next Steps:

Assuming that some version of the new "IDPH Uniform DNR Advance Directives/ Physician Orders for Life-Sustaining Treatment" form is adopted as is instructed by the legislation, there are other critical needs to consider, including:

- Need for **extensive** outreach and education for clinicians regarding how to conduct a conversation about code status with patients in a manner appropriate to their levels of understanding.
- Education of EMS first responders regarding the patient-centered interpretation of the form in the field.
- Education of the public regarding advance care planning, the availability and use of the POLST form, and its interface with other available advance directives such as the healthcare power of attorney.
- Development of a secure storage and retrieval system for the document, such that patient changes can be updated and that providers in the field and at hospitals and nursing homes may have access in order to properly deliver care to patients.
- Recognition of a single entity within the state that is willing to accept primary ownership for the ongoing evaluation of the POLST form and its use, as is standard practice of other states and regions with endorsed National POLST Initiative programs.

We invite continuous and broad participation in this project. Our goal is to maximize patients' control of their medical care by helping them to establish a care plan in which their own wishes are aligned with what is medically possible, and to document those wishes in a uniform, secure and retrievable document that can be used to direct medical care in a variety of settings.