Pennsylvania Orders for Life-Sustaining Treatment (POLST)
Respecting Wishes Across Care Settings
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Agenda

• Role of POLST in Advance Care Planning
• POLST Conversation
• POLST Case Studies
• Key Points and Sharing POLST Experience
PART 1

ROLE of POLST in ADVANCE CARE PLANNING

Two Types of Advance Planning Tools

Traditional - little or no impact on immediate care
• Health Care Proxy or Health Care Power of Attorney
• Living Will

Actionable Medical Orders - direct and relatively immediate impact on course of care
• POLST Paradigm form (POST, MOLST, etc.)
• Do not resuscitate order
• Do not hospitalize, no feeding tube, etc.

The Rationale for POLST:
AD Limitations

AD may not be available when needed
• Not completed by most adults
• Not transferred with patient

AD may not have prompted needed discussion and/or may not be specific enough
• No provision for treatment in the nursing home or home
• May not cover topics of most immediate need

AD may potentially be overridden by a treating MD

AD does not immediately translate into MD order
Purpose of POLST

To provide a mechanism to communicate patient preferences for end-of-life treatment across treatment settings.

POLST Paradigm

- Developed in Oregon by POLST Task Force, early 1990s
- Brightly colored medical order form for seriously ill patients (surprise question)
- Signed by physician, CRNP or PA (requirements vary by state)
- Turns patient treatment preferences and advance directives into medical orders
- Goal is to ensure wishes for treatment are honored

POLST Programs

Paradigm of communication, documentation, and system responsiveness

- July 2006
- January 2014
What is the POLST Program?

POLST is a voluntary process that:

• Translates a patient’s goals for care at the end of life into medical orders that follow the patient across care settings.

• Consists of physician orders that are based on a patient’s medical condition and his/her treatment choices as established in communication between the patient or the legal medical decision-maker and a health care professional.

• Is designed to improve the quality of care people receive at the end of life by turning patient goals and preferences for care into medical orders.

Providing a Uniform Message

POLST is designed to honor the freedom of persons with advanced illness or frailty to have or to limit treatment across settings of care.
Who Would Benefit From a POLST?

There are no age specifications. Anyone with:

• Advanced illness
• A serious health condition
• Medical frailty
• Advanced age and wishing to further define their preferences for care

Tool for determination

• Ask yourself "would I be surprised if this patient died within the next year".

Unless it is the patient's preference, use of the POLST form is not appropriate for persons with stable medical or functionality problems who have many years of life expectancy.

Differences Between a POLST and Advance Directive

<table>
<thead>
<tr>
<th></th>
<th>Advance Directive</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>All Adults</td>
<td>Serious illness or frailty</td>
</tr>
<tr>
<td>Timeline</td>
<td>Future care/future conditions</td>
<td>Current care/current condition</td>
</tr>
<tr>
<td>Who completes form</td>
<td>Individuals/Patients</td>
<td>Health Care Professional</td>
</tr>
<tr>
<td>Where completed</td>
<td>Any setting, not necessarily medical</td>
<td>Medical setting</td>
</tr>
<tr>
<td>Resulting product</td>
<td>Surrogate appointment and statement of preferences</td>
<td>Medical orders based on shared decision-making</td>
</tr>
<tr>
<td>Surrogate role</td>
<td>Cannot do</td>
<td>Can consent if patient lacks capacity*</td>
</tr>
<tr>
<td>Portability</td>
<td>Patient/family responsibility</td>
<td>Health Care Professional responsibility</td>
</tr>
<tr>
<td>Periodic Review</td>
<td>Patient/family responsibility</td>
<td>Provider responsibility to initiate</td>
</tr>
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* Authority for surrogates to consent to POLST form vary by state.

PART 2

The POLST CONVERSATION
Document is **NOT** the Main Thing!

- The POLST form is an essential element of a system to document and transmit patient care preferences, but is NOT the main thing.
- Careful facilitated discussions that elicit care preferences ARE the main thing!

Tools for POLST Conversations

- Diagram of POLST Medical Interventions
- POLST Conversation Points: Key Information
- Helpful phrases for a POLST Conversation

Comprehensive training on the conversation with access to additional tools is available in the Train-the-Trainer Course. Contact the POLST Coordinator for information.

8-STEP Protocol for Discussing POLST

1. Prepare for the discussion
2. Begin with what the patient or family knows
3. Provide any new information about the patient’s condition and values from medical team perspective
4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations
5. Respond empathetically
6. Use POLST to guide choices and finalize resident/family wishes
7. Complete and sign POLST
8. Review and revise periodically

This 8-Step Protocol was originally developed by Dr. Pat Bombo for the MOLST Program of New York State. Program information is found at www.compassionandsupport.org
**POLST Script - Conversation Introduction**

Normalize the conversation
- We talk about this with everyone
- We want to know what you would want if you got sick again

If questions remain:
- Your doctor will talk with you

**POLST Form - Section A, CPR or DNR**

- Section A of the form only applies if resident has no pulse and no respirations;
- If patient has any pulse or any respirations, Section B gives direction;
- In discussing this section, use an easily understood medical situation;
- You can say, “pretend you had a heart attack, your heart is not beating and you are not breathing......you have died a natural death”.

**Section A, Cardiopulmonary Resuscitation**

In choosing CPR or DNR, patients need understanding of the benefits/burdens

Television portrayal of CPR unrealistic with 66% surviving. In real life for elderly patients
- 22% may survive initial resuscitation
- 10-17% may survive to discharge, most with impaired function

Chronic illness, more than age, determines prognosis in the elderly
- With chronic illness, average survival rate less than 5%
- With advanced illness, survival rates are often less than 1%
POLST Form
Section B, Medical Interventions

This section is particularly helpful to teams in nursing homes. It can guide how residents are to be treated when in the facility.

- **COMFORT MEASURES**
  - Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, sedation, and manual treatment of airway obstruction as needed for comfort. Do not provide advanced life support treatment. Transfer to hospital for life-sustaining treatment is appropriate. Do not resuscitate. Do not continue on prolonged life support.

- **LIMITED ADDITIONAL INTERVENTIONS**
  - Includes care described above. Use medical treatment, IV fluids, and suction as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.

- **Full Treatment**
  - Includes intensive care, including resuscitation.

**Transfer to hospital if indicated.**

**Additional Orders**

**POLST, Who Fills it Out?**

- Physician or physician designee facilitator (RN, NP, PA, Social Worker)

- Facilitators need to be skilled, knowledgeable and credible to physicians/providers as well as patients and families

- Verbal orders are acceptable with follow-up signature in Pennsylvania in accordance with facility/community policy
Review of POLST Form

The form should be reviewed periodically and when:
- Patient is transferred from one care setting to another
- There is a substantial change in the person’s health status
- When treatment preferences change

PART 3

Case Studies

Case 1
80 year women admitted for rehab following a total knee replacement
Has living will and has indicated a desire for comfort care
How would you complete her POLST?
Case 2
You are reviewing the POLST of a newly admitted patient. The POLST states:
• Section A: Attempt Resuscitation
• Section B: Comfort Measures Only
• Section C: Use Antibiotics if life can be prolonged
• Section D: Long-term artificial nutrition, including feeding tube

Is anything wrong with this? What would you do next?

Case 3
89 year old male with advanced emphysema, peripheral vascular disease and other chronic conditions, but not imminently terminal

Had two short intubations in past; survived to go to nursing home for possible long term care

Does not want CPR, but would like a trial of intubation, would try up to a week

How would you complete POLST?

Case 3 (CONT'D)
If he develops an acute condition that cannot be managed at the skilled facility should he be transferred?

If admitted to the hospital and has acute cardiac arrest, should he be intubated but no shock?

If he develops pneumonia, and goes into respiratory failure over several days, should he be intubated?

Should he go to the ICU?
Case 4

You are working at a skilled nursing facility and have a POLST signed by the patient, but not signed by the physician. The resident requests:

- Do Not Attempt Resuscitation
- Limited Additional Interventions
- No Artificial Nutrition

The patient complained of chest pain this morning, relieved by two nitroglycerin pills.

What actions can you take?

Case 5

Your patient is 86 years old with moderate to severe dementia, mild hypertension, and a history of osteoarthritis with hip and knee pain. The patient does not have decision making capacity. You are introducing the patient’s daughter to POLST. The daughter states, “I know that she would not want any of this, but I feel like I have to do this.”

What can you say to the daughter?

What questions can you ask her?

Case 6

You are preparing for a family meeting of Mr. Jong, a newly admitted 92 year old male with Alzheimer’s Disease. He has severe contractures and is bedridden. He was admitted yesterday for aspiration pneumonia. His POLST states:

- Section A, Attempt Resuscitation Section
- Section B, Full Treatment

How will you address his POLST during the family meeting?
Case 7

A patient in a skilled nursing facility choked on a piece of toast, has turned blue and stopped breathing. The patient’s POLST states:

• Section A: Do Not Attempt Resuscitation/DNR
• Section B: Comfort Measures Only

What should the staff do?

PART 4

Key Points and Sharing POLST Experiences

Attendee Participation

Keys for Successful Implementation

• A physician champion;
• Staff who understands advance care planning and have comfort level in discussing advance care planning;
• Procedures and policies;
• Involvement and support from EMS and emergency medicine;
• Broadly representative coalition;
• Robust Quality Improvement Monitoring Process across facilities.
Educate, Educate, Educate

- Providers (physician, CRNP, PA) SNF and hospital
- Nursing staff, skilled nursing units and hospital (especially ER and ICU)
- Social work, administration, others
- Patients, families, community
- Importance of having respected physician champion(s), as well as nursing champion(s) and administrative support in facilities

Key Take Away Points

- The form is not the main thing. Careful facilitated discussions that elicit care preferences are the main thing!
- POLST does not replace an advance directive;
- Choosing “CPR” in Section A requires choosing “Full Treatment” in Section B;
- A successful program requires a broadly based implementation plan.
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