Pennsylvania Orders for Life-Sustaining Treatment
POLST

Honoring Patient Treatment Wishes at the End of Life

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March 2012
Agenda

• The POLST Form
• The POLST Discussion
• Implementing POLST
• Quality Improvement
• Resources and References
The POLST Form
Rationale for POLST
Advance Directive Limitations

• Advance Directive (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 NH or home
  – May not cover topics of most immediate need

• AD does not immediately translate into MD order
POLST and Advance Directives

- The POLST is not intended to replace an advance health care directive document or other medical orders.

- The POLST process and health care decision-making works best when the person has appointed a health care agent to speak for them when they become unable to speak for themselves.

- A health care agent can only be appointed through an advance health care directive called a health care power of attorney.
The POLST is not intended to replace an advance health care directive document or other medical orders.

The POLST process and health care decision-making works best when the person has appointed a health care agent to speak for them when they become unable to speak for themselves.

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Where Does POLST Fit In?

**Advance Care Planning Continuum**

- **Age 18**
  - Complete an Advance Directive
  - Update Advance Directive Periodically
  - Diagnosed with Serious or Chronic, Progressive Illness (*at any age*)
  - Complete a POLST Form
  - Treatment Wishes Honored

California POLST Education Program
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# Differences between POLST and Advance Directive

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>POLST</th>
<th>Advance Directive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>For the seriously ill</td>
<td>All adults</td>
</tr>
<tr>
<td>Timeframe</td>
<td>Current care</td>
<td>Future care</td>
</tr>
<tr>
<td>Who completes the form</td>
<td>Health Care Professionals</td>
<td>Patients</td>
</tr>
<tr>
<td>Resulting form</td>
<td>Medical Orders (POLST)</td>
<td>Advance Directives</td>
</tr>
<tr>
<td>Health Care Agent or Surrogate role</td>
<td>Can engage in discussion if patient lacks capacity</td>
<td>Cannot complete</td>
</tr>
<tr>
<td>Portability</td>
<td>Provider responsibility</td>
<td>Patient/family responsibility</td>
</tr>
<tr>
<td>Periodic review</td>
<td>Provider responsibility</td>
<td>Patient/family responsibility</td>
</tr>
</tbody>
</table>

Cardiopulmonary clarifies type of resuscitation. Do Not Attempt Resuscitation assists clinicians in communicating odds about success.

Options give people the choice to decide later since issue of when to use antibiotics is complex.

Discussion about treatment preferences is required.

Clear instruction on when to transfer to hospital and use of intensive care.

IV fluids in Limited Additional Interventions section.

Artificial hydration and artificial nutrition both found here.

If any section left unmarked, the highest level of treatment must be provided.
Pennsylvania Form 2nd Side

Directions for Healthcare Professionals

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care directive that provides instructions for the individual’s health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section “A”, the physician/PA/CRNP should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the Pennsylvania Department of Health, Bureau of EMS, for information about Out-of-Hospital Do-Not-Resuscitate orders, bracelets and necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health. www.health.state.pa.us

Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications or decisions by the patient or a surrogate. This document refers to the person for whom the orders are issued as the “individual” or “patient” and refers to any other person authorized to make healthcare decisions for the patient covered by this document as the “surrogate.”

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician/PA/CRNP in accordance with facility/community policy. A person designated by the patient or surrogate may document the patient’s or surrogate’s agreement. Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms should be respected where necessary.

Using POLST

If a person’s condition changes and time permits, the patient or surrogate must be contacted to assure that the POLST is updated as appropriate.

If any section is not completed, then the healthcare provider should follow other appropriate methods to determine treatment.

An automated external defibrillator (AED) should not be used on a person who has chosen “Do Not Attempt Resuscitation”.

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with “comfort measures only,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

A person who chooses either “comfort measures only” or “limited additional interventions” may not require transfer or referral to a facility with a higher level of care.

An IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”

Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate “Limited Additional Interventions” or “Full Treatment.”

A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-sustaining treatment, at any time, and request alternative treatment.

Review

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person’s health status, or
(3) The person’s treatment preferences change.

Revoking POLST

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the invalid POLST, write “VOID” in large letters across the form, and sign and date the form.
POLST Form Highlights

- Physician, physician assistant or CRNP medical order
- Standardized form, bright distinct color
- Based on conversations for goals of care
- May be used to limit medical interventions or clarify a request for all medically indicated treatments including resuscitation
- Transferrable across care settings
## For Whom is a POLST Form Recommended?

- Persons who have advanced chronic progressive illness and/or frailty
- Those who might die in the next year
- Anyone of advanced age with a strong desire to further define their preferences of care in their present state of health
- To determine whether a POLST conversation is indicated, clinicians should ask themselves, "Would I be surprised if this person died in the next year". If the answer is "No, I would not be surprised", then a POLST form is appropriate.
Diagram of POLST Medical Interventions

- **CPR**
  - **Comfort Measures**
  - **Limited Interventions**
  - **Full Treatment***

- **DNR**

*Consider time/prognosis factors under “Full Treatment”
“Defined trial period. Do not keep on prolonged life support.”

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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 by physician in Pennsylvania in accordance with facility/community policy
Requirements to Make the Form Valid

- Patient name (date of birth recommended)
- Completion of Section A, resuscitation orders
- Physician/PA/CRNP signature*
- Patient or surrogate signature

- All other information is optional

*In Pennsylvania, a physician assistant signature requires a physician co-signature within ten days.
Revocation of POLST Form

- May be revoked by patient at any time
- If patient lacks decision-making capacity, a legal decision-maker may revoke
- Revocation can be a verbal statement
- Draw a line through all orders on form
- Write “VOID” across form, sign and date
Transfer

• Original pink form
  – Transferred with individual (*Use of original form is highly encouraged*)
  – Photocopies and FAXes of signed POLST forms are valid
  – It is recommended that copies be made on pulsar pink paper

• Health care institutions
  – Keep duplicate copy in permanent medical record upon discharge
  – Also make copy prior to inter-facility transports
A patient transitioning between care settings with a completed POLST form.
The POLST Discussion
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 patient/family wishes
7. Complete and sign POLST
8. Review and revise periodically

This 8-Step Protocol was originally developed for the MOLST Program of New York State. Program information is found at www.compassionandsupport.org
Framing Discussion

• Based discussion on patient-centered goals for care (e.g. quantity vs. quality of life)
• Includes likely contingencies for future medical treatment
  - Example: Patient with advanced COPD
    • BiPAP ok?
    • Intubation and mechanical ventilation in ICU ok?
    • Feeding tube ok?
    • Long-term mechanical ventilation if resident cannot be weaned ok?
    • Would hospice be preferred to above?
• Ensure sound informed medical decision-making
• Conversation with HCPOA and “family” as defined by patient
CPR and Elderly

• CPR is intended to prevent sudden, unexpected death and is generally not indicated in cases of irreversible illness where death is expected

• Actual in-hospital survival rates for CPR:
  – All hospital patients, > 15%
  – Frail elders, <5%
  – Individuals with advanced chronic illness, <1%

• Chronic illness, more than age, determines prognosis

(Annals Int Med 1989; 111:199-205)
(JAMA 1990; 264:2109-2110)
(EPEC Project RWJ Foundation, 1999)
Implementing POLST
Keys to Successful Implementation

- Ideally a facility champion
- Wide range of staff who understands advance care planning and have comfort level in discussing advance care planning and end of life treatment options
- Ongoing education of staff and families
- Collaboration with institutions that accept facilities’ patients
- Involvement and support from EMS and emergency medicine

Procedures and policies must be in place!
Standardized Policies and Procedures

- Accepting forms from other institutions
- Training requirements
- Timeline for completion and sign off by doctor/CRNP
- Internal review process. On review:
  - Document that form contains current wishes OR
  - Complete new form
- At time of transfer both the POLST and Living Will to be sent with the resident
Collaborative Process Model

- Teams meet and review pertinent topic information
- Assess performance
- Identify areas for improvement
  - Set goals
  - Determine means of measuring progress
  - Set a deadline for reassessment
  - Anticipate barriers to improvement
Barriers to Implementation

- Failure to develop POLST policies/procedures
- Inability of staff to conduct effective POLST discussion
- Belief that POLST must match advance directive
- Hospitals and transferring facilities lack of awareness of the tool
Quality Improvement
<table>
<thead>
<tr>
<th>Quality Improvement Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is POLST form present? If not, why not?</td>
</tr>
<tr>
<td>Is there assurance that form contains current choices?</td>
</tr>
<tr>
<td>Length of time to complete form</td>
</tr>
<tr>
<td>• From date of admission</td>
</tr>
<tr>
<td>• Date signed by physician</td>
</tr>
<tr>
<td>• Date signed by surrogate</td>
</tr>
<tr>
<td>Is resuscitation order complete (Section A)</td>
</tr>
<tr>
<td>Are Sections B-D complete?</td>
</tr>
<tr>
<td>Section E</td>
</tr>
<tr>
<td>• Is the patient or surrogate with whom the POLST was discussed identified?</td>
</tr>
<tr>
<td>• Is a physician/PA/CRNP signature found?</td>
</tr>
<tr>
<td>• Is a patient/surrogate found</td>
</tr>
<tr>
<td>Is the name of the health care professional who facilitated the POLST discussion found on side two of the form? Is that signature dated?</td>
</tr>
<tr>
<td>Is there a process to evaluate if patient treatment choices were honored?</td>
</tr>
</tbody>
</table>
# Quality Improvement Measurement of a Skilled Nursing Facility

## Medical Record Review

<table>
<thead>
<tr>
<th></th>
<th>Completed</th>
<th>Incomplete</th>
<th>No POLST on Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quarter</td>
<td>181 (91.8%)</td>
<td>13 (6.6%)</td>
<td>3 (1.5%)</td>
</tr>
</tbody>
</table>

## Honoring Treatment Choices

<table>
<thead>
<tr>
<th>Quarter</th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
<th>3rd Quarter</th>
<th>SNF Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90%</td>
<td>90%</td>
<td>89.3%</td>
<td>90.5%</td>
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</tbody>
</table>
Resources and References
Pennsylvania POLST Tools

http://aging.upmc.com/professionals/resources-polst.htm

Resources:
Pennsylvania Orders for Life-Sustaining Treatment (POLST)
The goal of the POLST paradigm is to effectively communicate the wishes of seriously ill patients to have or to limit medical treatment as they move from one care setting to another.

- POLST: Respecting Patient Wishes Near the End of Life
- POLST Paradigm Core Elements
- PA Department of Health Out-of-Hospital Do-Not-Resuscitate (DNR) Orders
- PA Department of Health POLST Form
- Guidance for Health Care Professionals in Completing the POLST Form
- Information for Patients and Families
- Frequently Asked Questions
- Steps to Implement POLST
- POLST Brochure
- Resources
## Advance Care Planning
### Web Site Resources

<table>
<thead>
<tr>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
</table>
| [www.pamedsoc.org](http://www.pamedsoc.org) | Pennsylvania Medical Society  
A guide to Act 169 of 2006                                                   |
| [www.acba.org](http://www.acba.org) | Allegheny County Bar Association/Allegheny County Medical Society  
Health Care Power of Attorney and Living Will Forms  |
| [www.caringinfo.org](http://www.caringinfo.org) | Download state specific Advance Directives                                  |
| [www.hardchoices.com](http://www.hardchoices.com) | “Hard Choices for Loving People“:  
A resource for professionals, patients and their families regarding end-of-life decisions |
| [www.eperc.mcw.edu](http://www.eperc.mcw.edu) | End of life and palliative care education resource center                   |
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<tr>
<td><a href="http://www.polst.org">www.polst.org</a></td>
<td>Center for Ethics in Health Care Oregon Health &amp; Science University</td>
</tr>
<tr>
<td><a href="http://www.aging.pitt.edu/professionals/resources.htm">http://www.aging.pitt.edu/professionals/resources.htm</a></td>
<td>Aging Institute of UPMC Senior Services and the University of Pittsburgh</td>
</tr>
<tr>
<td><a href="http://www.dom.pitt.edu/dgim/IEPC/">http://www.dom.pitt.edu/dgim/IEPC/</a></td>
<td>University of Pittsburgh Institute to Enhance Palliative Care</td>
</tr>
<tr>
<td><a href="http://www.wvendoflife.org">www.wvendoflife.org</a></td>
<td>West Virginia Center for End-of-Life Care POST</td>
</tr>
<tr>
<td><a href="http://www.compassionandsupport.org/">www.compassionandsupport.org/</a></td>
<td>Excellus Blue Cross Blue Shield MOLST</td>
</tr>
</tbody>
</table>
References


Bomba PA, Discussing Patient Preferences and End of life Care, Journal of the Monroe County Medical Society, 7th District Branch, MSSNY. 2011; April 2011: 12-15,. http://www.compassionandsupport.org/index.php/research_references/references

Kirchhoff, Karin T, PhD, RN, Hammes, B J, PhD, Kehl, Karen A, Phd, RN Briggs, Linda A, MA, MS, RN & Brown, Roger L, PhD. Effect of a Disease-Specific Planning Intervention on Surrogate Understanding of Patient Goals for Future Medical Treatment, J AM Geriatric Society 2010; 2760;1233-1240.


References

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Emmanuel EJ, et. al. Managed Care, Hospice Use, Site of Death, and Medical Expenditures in the Last Year of Life. *Arch Intern Med*. 2002;162: 1722-1728.


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