Pennsylvania Orders for Life-Sustaining Treatment POLST

Honoring Patient Treatment Wishes at the End of Life

Revised July 2019
Note to Readers

- It is hoped that information presented in this module will introduce you to the POLST program and provide a basic understanding of requirements to establish and maintain an effective POLST program within your health care institution.

- Further information on POLST is found throughout the POLST website. Other info is provided within facility training programs across Pennsylvania and through the Coalition for Quality at the End of Life (CQEL).

- For further information contact the POLST coordinator at PAPOLST at papolst@verizon.net.
Background on POLST

- POLST was originally developed in Oregon in the 1990s
- Since then use of POLST has spread across the country.
- As of November 2018, POLST programs are found at some level in all states and the District of Columbia.
- In Pennsylvania, POLST began as a grass roots effort in Western Pennsylvania in 2000. Now widely used across the state.
- In October 2010 POLST was approved by the Pennsylvania Secretary of Health.
- PA program was endorsed the National POLST Paradigm Task Force the same year.
National POLST Program Designations

As of March 2019

- Mature Program
- Endorsed Program
- Developing Program
- Program Does Not Conform to National POLST Paradigm

Oregon separated from the National POLST Paradigm in 2017
Agenda

• The POLST Form
• The POLST Conversation
• Implementing POLST Program
• Policy and Procedure Guidelines
• Quality Improvement
THE POLST FORM
Rationale for POLST
Advance Directive Limitations

- Advance Health Care 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 may/or may not be specific enough
  - No provision for treatment in a SNF or home
  - May not cover topics of most immediate need

- AD does not immediately translate into medical order
Rationale for POLST
Advance Directive Limitations (Continued)

• The POLST is not intended to replace an AD document

• 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 are directive called a health care power of attorney
Purpose of POLST

To provide a mechanism to define patients’ preferences for end-of-life treatment and to communicate them across care settings.

Turns treatment preferences and advance directives into medical orders.
Where Does POLST Fit In?

Advance Care Planning Continuum

Age 18

Complete an Advance Directive

Update Advance Directive Periodically

Diagnosed with Advanced Illness or a Serious Health Condition (at any age) or Medical Frailty*

Complete a POLST Form

Treatment Wishes Honored

*Someone for whom you would not be surprised if they died within a year

Materials adapted and used with permission from the Coalition for Compassionate Care of California, www.coalitionCCC.org
## Differences between POLST and AD

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Advance Directive</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>All adults</td>
<td>For the seriously ill</td>
</tr>
<tr>
<td>Timeframe</td>
<td>Future care</td>
<td>Current care</td>
</tr>
<tr>
<td>Who completes the form</td>
<td>Patients</td>
<td>Health care professionals</td>
</tr>
<tr>
<td>Where completed</td>
<td>Any setting, not necessarily medical</td>
<td>Medical setting</td>
</tr>
<tr>
<td>Resulting form</td>
<td>Health Care Power of Attorney, Living Will</td>
<td>Medical Orders based on shared decision-making</td>
</tr>
<tr>
<td>Becomes effective</td>
<td>Patient is incompetent, and; permanently unconscious or has end-stage medical condition</td>
<td>When signed and dated by doctor, CRNP or PA and by patient or medical decision maker</td>
</tr>
<tr>
<td>Health Care Agent or surrogate role</td>
<td>Cannot complete</td>
<td>Can engage in discussion if patient lacks capacity</td>
</tr>
<tr>
<td>Portability responsibility</td>
<td>Patient/family</td>
<td>Provider</td>
</tr>
<tr>
<td>Periodic review</td>
<td>Patient/family responsibility</td>
<td>Provider responsibility</td>
</tr>
</tbody>
</table>

HIPAA Compliant

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.
Currently, the POLST form is not available on the Pennsylvania Department of Health website. It is found at: www.papolst.org

This side includes:

Surrogate Contact Information

A line for the signature of a POLST Facilitator who completes the form
POLST Form Highlights

• Physician, physician assistant or CRNP medical order

• Standardized form, bright distinct color

• Based on conversation for goals of care and is only as good as the conversation preceding it

• 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 POLST Form Intended?

- Patients with serious life-limiting medical condition or advanced frailty
  - Whose health care professional would not be surprised if they died within 1-2 years; or
  - Who are at an increased risk of experiencing a medical emergency based on their current medical condition and who wish to make clear their treatment preferences, including about CPR, mechanical ventilation, ICU;
  - Who have had multiple unplanned hospital admissions in the last 12 months, typically coupled with increasing frailty, decreasing function, and/or progressive weight loss
Diagram of 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.”
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
What Makes the POLST Form Valid?

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

*In Pennsylvania, a physician assistant signature requires a physician co-signature within ten days.
Can a POLST Form be Revoked?

- 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 sections A through E of the invalid POLST

- 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 CONVERSATION
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.
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 developed by Dr. Pat Bomba 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)
- Include likely contingencies for future medical treatment
  - Example: Patient with advanced COPD
    - BiPap okay?
    - Intubation and mechanical ventilation in ICU okay?
    - Long-term mechanical ventilation if resident cannot be weaned okay?
    - Feeding tube okay?
    - Would hospice be preferred to above?
- Ensure sound shared decision making
- Include medical decision-maker and “family” as defined by resident
Providing Real Facts about CPR in the Elderly

- The portrayal of CPR on TV may lead the viewing public to have an unrealistic impression of the chances of success of CPR
  - On one TV series, 75% of patients survive CPR with 67% appearing to survive to discharge

- 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 (<5% survival)

4. EPEC Project RWJ Foundation, 1999
IMPLEMENTING A POLST PROGRAM
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

• Include Legal team, IT and pastoral care

• Utilizing outside expertise can move program along and minimize barriers

• Procedures and policies in place

• Ongoing education of staff and families

• Involvement and support from EMS and emergency medicine
First Steps

• Complete a needs assessment
• Assemble a work group with broad representation,
• Develop program components
• Educate and train professionals and health professionals
• Program coordination
• Monitor program
Collaborative Process Model

- Teams met and reviewed pertinent topic information
- Assessed their performance
- Identified areas for improvement
  - Set goals
  - Means of measuring progress
  - Set a deadline for reassessment
  - Anticipate barriers to improvement
**POLST Checklist**

As your plan is developed, you can use this checklist as a guide.

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies developed</td>
<td></td>
</tr>
<tr>
<td>a. Advance Directive</td>
<td></td>
</tr>
<tr>
<td>b. POLST</td>
<td></td>
</tr>
<tr>
<td>c. Process established for review of both documents</td>
<td></td>
</tr>
<tr>
<td>d. Procedure established to address conflicts</td>
<td></td>
</tr>
<tr>
<td>e. Policy To Accept POLST Forms From Transferring Facilities &amp; Providers</td>
<td></td>
</tr>
<tr>
<td>Education Plan</td>
<td></td>
</tr>
<tr>
<td>a. Staff</td>
<td></td>
</tr>
<tr>
<td>b. Physicians</td>
<td></td>
</tr>
<tr>
<td>c. Patients/families</td>
<td></td>
</tr>
<tr>
<td>Notification of key contacts</td>
<td></td>
</tr>
<tr>
<td>a. Emergency Medical Services</td>
<td></td>
</tr>
<tr>
<td>b. Hospitals</td>
<td></td>
</tr>
<tr>
<td>Program Implementation Status</td>
<td></td>
</tr>
<tr>
<td>a. New patients</td>
<td></td>
</tr>
<tr>
<td>b. Partial facility use</td>
<td></td>
</tr>
<tr>
<td>c. Entire facility</td>
<td></td>
</tr>
<tr>
<td>Quality Improvement</td>
<td></td>
</tr>
<tr>
<td>a. Audit plan in place to track compliance</td>
<td></td>
</tr>
<tr>
<td>b. Process established to obtain feedback</td>
<td></td>
</tr>
</tbody>
</table>
Barriers to Successful Implementation

- Failure to develop POLST policies/procedures
- Lack of ongoing staff training
- Inability of staff to conduct effective POLST discussions
- Belief that POLST must match AD
- Unawareness of POLST among hospitals and transferring facilities in community
POLICIES AND PROCEDURES
Standardized Policy and Procedures
A Policy describing the use of POLST is required

- As a facility plans for implementation, it is essential that a policy be developed for its use

- It is recommended that facilities incorporate a statement into its policy and include in each training situation a statement that POLST is always voluntary

- Detailed information on Model Policies and Recommended Elements for Inclusion in a Facilities’ POLST Policy are found at on this website at:
  - https://www.papolst.org/pa-polst-forms/policy-examples/33-model-policies-introduction/file
  - https://www.papolst.org/pa-polst-forms/policy-examples/34-recommended-policy-elements/file
QUALITY IMPROVEMENT
7 Deadly Sins of POLST

All health care providers should be aware of and conscientiously avoid the seven deadly sins of POLST.

1. Using POLST with people who are too healthy.
2. Signing a POLST form without a meaningful discussion.
3. Having patients complete their own POLST form.
4. Providing incentives for completing more POLST forms.
5. Failing to review POLST forms.
7. Failing to evaluate your use of the POLST Paradigm.

Quality Indicators

- All residents or their surrogates are informed about the use and value of the POLST form
- All residents who do not want CPR attempted in the event of a cardiopulmonary arrest have at least Section A completed and the POLST form appropriately signed within 24 hours of admission
- The POLST form is completed within 14 days of admission for residents that choose to have a form
- POLST forms are kept in a specific location and are easy to find in an emergency
- POLST forms or a copy of the form always travel with a resident when the resident leaves the facility
- When transported via EMS, the POLST form must be visible on the top of transfer papers
- POLST forms are reviewed with the resident or surrogate as part of regular care planning
- POLST forms are revisited when there is a change in the resident’s health status
Ongoing Program Review

• Review within institution the extent of use, appropriateness of discussions, success of process of transfer of form with patient

• Outcome assessment, especially care discordant from POLST preferences

• Importance of hospital-long-term care facilities sharing of information about form transfer and discordant care cases
Selected Challenges

- Measuring the quality of the conversation underlying ACP and POLST
- Training health care providers (Facilitators)
- Decision-making for those who have no appointed proxy
- Educating health care agents/proxies
- Evaluating protections for vulnerable population