POLST IN LONG-TERM CARE

RESPECTING TREATMENT PREFERENCES AT THE END-OF-LIFE

Pennsylvania Health Care Association

July 19, 2017
Objective

1. Provide an understanding of the POLST Paradigm Program specific to long-term care

2. Outline significant elements of implementation

3. Describe a strategy to assure support of emergency medical services and compliance with resident’s care preferences across care settings

4. Discuss options for individuals living in the community
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.
What is POLST

• 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 medical 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
  
  – Allows health care providers to know a patient’s wishes in the event of a serious illness and to honor them
POLST Form Highlights

- Physician, physician assistant or CRNP medical order, transferrable across care settings

- Standardized form, bright distinct color

- Consists of medical 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

- May be used to limit medical interventions or clarify a request for all medically indicated treatments including resuscitation
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 a person has appointed a health care agent to speak for them if they become unable to speak for themselves.

A health care agent can only be appointed through a health care power of attorney.
For Whom is POLST Form Intended

- The POLST form is intended for:
  - Patients who are seriously ill or frail
  - Patients whose health care professionals wouldn’t be surprised if they died within a year—regardless of patient age or what facility a patient is in

- Most 65-year-olds are too healthy to have POLST orders

- Not all residents in a nursing home may be appropriate for a POLST form
For Whom is a POLST Form Intended

NOTE

• In some care settings, POLST forms are being offered to all individuals to establish and document goals of care

• This could include residents for whom you would be surprised if they died within a year

• This is because it a requirement to document CPR status and facilities prefer to use one consistent form as using different forms could lead to confusion
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
Cardiopulmonary clarifies type of resuscitation. Do Not Attempt Resuscitation assists clinicians in communicating odds about success.

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.

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

Discussion about treatment preferences is required.
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

*In Pennsylvania, a physician assistant signature requires a physician co-signature within ten days.
Completing Section B

- Section A provides direction on CPR/DNR

- Not Completing Section B, the heart of the form, is a disservice to patients
  - It provides necessary direction about treatment preferences to emergency personnel and other professionals in situations other than full cardiac and respiratory arrest
Medical Interventions and Comfort Care

**MEDICAL INTERVENTIONS:** Person has pulse *and/or* is breathing.

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. *Do not transfer* to hospital for life-sustaining treatment. *Transfer* if comfort needs cannot be met in current location.

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. *Transfer* to hospital if indicated. *Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer* to hospital if indicated. *Includes intensive care.*

*Additional Orders* ____________________________________________________________

Comfort care focuses on the dignity and quality of remaining life.
POLST and Long Term Care

- Offer/complete POLST soon after admission; for current residents, at quarterly conference
- Include resident, Healthcare Agent, other family in conversations
- Incorporate prior advance directives; attention to artificial nutrition and hydration provisions
- Assure POLST is kept in location for easy access
- If resident transferred, send original POLST with patient
- Review/update as condition changes; at least quarterly
## Differences Between Ads and POLST

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

• 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
# POLST Checklist

<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>
Recommended Policy Elements

1. Statement that completion of POLST is voluntary

2. Recognition that POLST form is a set of medical orders

3. What patients will be offered the POLST form

4. Who will engage patients/residents or their surrogate in the goals of care conversation

5. If the resident/patient is unable to be engaged, a plan exists to assure that the conversation occurs with the appropriate decision-maker

Above information from the California POLST Program. ©March 2012 Coalition for Compassionate Care of California.
POLST and EMS
POLST and EMS

At top of form it states:

To follow these orders, an EMS provider must have an order from his/her medical command physician.
Out-of-Hospital DNR

EMS providers may only follow a PA OOH-DNR order, bracelet, or necklace or Orders from a medical command physician
The standardized POLST allows for faster and more efficient discussion between EMS and the medical command physician.
Need for Legislation

Issues to be addressed by legislation.

• Provider who signed form not on staff of facility that receives patient
• Liability protection for providers acting in good faith
• Reciprocity with other state forms
• Signature requirements – who can sign the form
• Dismissal of Out-of-Hospital portions of Act 169
• Role of EMS in following POLST orders
• Process for systematic review and update of form
• Establishment of a home for the POLST Program in the DOH
Pennsylvania POLST Website:

To access most quickly, google “POLST in Pennsylvania”
Fast Facts and Concepts
- #16 Moderating an End-of-Life Family Conference
- #23 Discussing DNR Orders—Part I
- #24 Discussing DNR Orders—Part II
- #65 Establishing End-of-Life Goals: The Living Well Interview
- #162 Advance Care Planning in Chronic Illness
- #178 The National POLST Paradigm Initiative

Steps to Implement POLST
- Advance Care Planning & POLST Process
- Implementation Checklist

Policy Examples
- Model Policies’ Introduction
- Recommended Policy Elements
- Transition from Hospital to Skilled Nursing Facility
- Long-term-care: Administrative
- Long-term-care: Resident Rights
- Senior living: Accepting forms from other providers
- Hospital Policy
- Comprehensive Hospital Policy

Resources
- ARP Public Policy Institute: Improving Advanced Illness Care: The Evolution of State POLST Programs
- Oregon POLST
- West Virginia POLST
- National POLST Paradigm website
- Recommended Book: Hard Choices for Loving People
- POLST Program Research and Resources
- End of Life/Palliative Education Resource Center of the Medical College of Wisconsin
- POLST Nursing Home Survey Summary

Useful Tools
- Letter Templates to Inform Family Members of Durable Power of Attorney
## General POLST Web Site Resources

<table>
<thead>
<tr>
<th>Website</th>
<th>Description</th>
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</thead>
<tbody>
<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>
Contact Information

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Coalition for Quality at the End of Life

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