Physician Orders for Life Sustaining Treatment

Cultivating Meaningful Conversations and Documenting Patients' Wishes

Elizabeth Balsam Hart, MD
Elizabeth Hart has no relevant financial relationships to disclose that would present a conflict of interest.

This presentation is intended as an overview of POLST. While it will be relevant to both those new to and those already using POLST, it is not intended to be a full foundation for developing a POLST program in your organization. Further training is important for successful POLST implementation.
• This presentation is modified from the Maine POLST Coalition’s Train-the-Trainer Curriculum, with additional slides and edits by E.B. Hart, MD
Why POLST?

1. Patient wishes often are not known when most relevant.
   - An advance directive may not be accessible.
   - Specific preferences for care may not be clearly defined in an advance directive.
   - ADs may not address issues of most immediate concern (e.g. transfer to hospital vs care at home or in nursing home, immediate medical interventions)

2. POLST allows healthcare providers to know and honor wishes during serious illness.
What is POLST?

- A physician, NP, PA-C order set recognized throughout the medical system.
- Portable document that transfers with the patient.
- Brightly colored, lime green standardized form for entire state of Maine.
Maine’s POLST Form
Single page, double-sided, standardized color paper #24 lime green
What is POLST?

- An order set that allows individuals to choose medical treatments they want to receive, and identify those they do not want.

- Provides direction for healthcare providers during serious illness.

- Complements, but does not replace, advance directives
Who Would Benefit from Having a POLST Form?

- Chronic, progressive illness
- Serious health condition
- Medically frail

Tool for determining: **Surprise Question**
- “Would you be surprised if your patient with advanced _______ died in the next year?”
POLST History

- Expanded across the United States.
National POLST Paradigm Programs

www.polst.org

*As of May 2016

- Mature Programs
- Endorsed Programs
- Regionally Endorsed Program
- Developing Programs
- No Program (Contacts)
- Programs That Do Not Conform to POLST Requirements
Compelling Strength of POLST Evidence
JAMA. 2016; 315(22):2471-2472

- Oregon study of 58,000 deaths found strong association between POLST treatment orders and location of death (reflecting patients’ goals)

- 3-state study of 1711 residents in 90 nursing homes—significant associations between POLST use, scope of treatment orders and level of treatment received.

- Evidence-based tool, as cited in this recent JAMA article, Recommended by the Institute of Medicine

- More research available at www.polst.org
POLST in Maine

- The Maine Hospice Council is the administrative home for POLST implementation efforts.
- Supported by the Maine POLST Coalition
- Coalition members from across health systems and across disciplines.
- Many health systems are active in education and policy-making
POLST in Maine

• In 2009 the Maine Medical Association endorsed POLST and supported physician education. Many other groups have endorsed the POLST Program in Maine.

• In 2012, Maine was selected as one of five states to receive a competitive 3 year POLST advancement grant from the Retirement Research Foundation, coordinated by the National POLST Paradigm
POLST in Maine

- One form for entire state
- First state-wide Maine POLST form adopted in 2009 with form most recently revised in March 2015 (important to update to current form if you have a POLST program in place)
- Use is voluntary - not mandated
- Honoring the executed POLST form is strongly encouraged across care settings
- POLST use in transitions of care still evolving in Maine. Essential to know policies of your institution
POLST in Action Video

http://www.youtube.com/watch?v=IxT4XKP__7c
## POLST VS. ADVANCE DIRECTIVE

<table>
<thead>
<tr>
<th>POLST</th>
<th>AD</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consistent form for Maine</td>
<td>• ADs can be varied in form</td>
</tr>
<tr>
<td></td>
<td>• Is not a medical order</td>
</tr>
<tr>
<td>• Is a medical order</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• May only be honored as information to be</td>
</tr>
<tr>
<td></td>
<td>interpreted and when readily available</td>
</tr>
<tr>
<td>• Honored across all healthcare settings</td>
<td></td>
</tr>
</tbody>
</table>
DIFFERENCES BETWEEN POLST AND ADVANCE DIRECTIVES

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>POLST</th>
<th>Advance Directives</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>

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
POLST and EMS

- Maine Emergency Medical Service protocols updated in December, 2011 to recognize the POLST form as an actionable medical order
- Must be signed and dated within one (1) year
- “Understandable to the crew”
- Protocol revision added recognition of NP and PA signatures for out of hospital DNRs
## POLST VS. PRE-HOSPITAL DNR

*(DO NOT RESUSCITATE)*

<table>
<thead>
<tr>
<th><strong>POLST</strong></th>
<th><strong>DNR</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Allows for choosing resuscitation</td>
<td>● Can only use if choosing DNR</td>
</tr>
<tr>
<td>● Allows for other medical treatments</td>
<td>● Only applies to resuscitation</td>
</tr>
<tr>
<td>● Honored across all healthcare settings</td>
<td>● Only honored outside the hospital</td>
</tr>
</tbody>
</table>
“No form or checkbox will ever eliminate the uncertainty and the complexity of the human condition.”

-Rebecca Sudore-
California Coalition for Compassionate Care Conference. February 2012

A brief detour summarizing important approach before we look at the POLST form in detail
Redefining the “Planning” in Advance Care Planning


• Prepare patients and surrogates to:
  work with clinicians to make the best possible “in-the-moment” decisions
  consider complex decisions based on clinical context, evolving goals & needs

• Step 1: Choose appropriate surrogate
• Step 2: Clarify values over time
• Step 3: Establish leeway in decision making

http://coalitionccc.org/documents/Rebecca_Sudore_Presentation.pdf
Maine’s POLST Form

Single page, double-sided, standardized color paper #24 lime green

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. These medical orders are based on the patient’s current medical condition and preferences. Any section not completed will invalidate the form and implies full treatment for flat section.

A. Check One

Resuscitation CPR
Crib Resuscitation CPR
Do Not Attempt Resuscitation

Patient has no pulse and is not breathing.

B. Check One

If Not Transferred to Hospital for Life-Sustaining Treatment:
Transfer if comfort needs cannot be met in current setting.

Limited Additional Interventions: Includes all case described above. Use medical treatment and monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). Transfer to hospice if indicated. Avoid intensive care.

Full Treatment: Includes all care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospice if indicated. Include intensive care.

Additional Orders:

C. Check One

Artificially Administered Nutrition
Hydration: Offer food / liquids by mouth if feasible.

Part 1 - Nutrition

No artificial nutrition by tube
Total amount of artificial nutrition by tube
Long-term artificial nutrition by tube

Part 2 - Hydration

No artificially administered fluids
Total period of artificial hydration
Full treatment with artificially administered fluids

Additional Orders:

D. Basis for Orders

My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s current medical condition and preferences as indicated by:

Basis for determining patient’s preferences (check all that apply)

Advance Directive (in file)
Patient’s current statement to Physicians / NP / PA or Other Health Care Professional
Patient’s statement to authorized representative

Discussion with (check all that apply)

Patient Parent of a minor Guardian Health Care Agent Other

Signature of Physician / PA / NP: [Signature]

Patient Last Name: [Last Name]
First Name: [First Name]
DOB: [DOB]

Signature of Authorized Representative: [Signature]
Relationship: [Relationship]
Address & Phone: [Address & Phone]

Health Care Professional Preparing Form

Tips: Phone: [Phone]

Directions for Health Care Professionals

Completing POLST

- This is a voluntary order.
- Should reflect patient’s preferences based on current medical condition. Encourage completion of an advanced directive.
- POLST must be signed by a physician, nurse practitioner or physician assistant to be valid. Verbal orders are acceptable only if followed by a written POLST signed by the physician/NP/PA in accordance with facility policy.
- Use of original form is strongly encouraged. Photocopies and faxes are legal and valid.
- Patient should sign this form if able to make his or her own health care decisions. If unable to sign, an authorized representative should sign.
- In the event of an emergency, changes may be made to this form by an Authorized Representative via telephone.
- An Authorized Representative includes an order of priority: a health care agent (same as durable health care power of attorney or agent named in advance directive), court-appointed guardian, parent of minor, or surrogate as defined in 18-A M.R.S. § 3-501.

Using POLST

- Section A
- No defibrillator (including AED’s) should be used on a person who has chosen “Do Not Attempt Resuscitation.”
- Section B
- When comfort cannot be achieved in the current setting, the patient, including someone with “Comfort Measures Only”, should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medications to enhance comfort may be appropriate for a patient who has chosen “Comfort Measures Only.”

Reviewing POLST

This POLST should be reviewed periodically and if:
- The patient is transferred to an acute care setting or care level to another or
- There is a substantial change in the patient’s health status, or
- The patient’s treatment preferences change.
- Discuss a list through sections A through D and write “VOID” as large letters if POLST is implausible or becomes invalid.

Obtaining Additional POLST Form:

Additional POLST forms may be obtained by contacting the Maine POLST Coalition, online at www.polstmaine.org

Send form with Patient Whenever Transferred or Discharged
Section A: Must be completed

HIPAA Compliant

If any other section is not completed it implies full treatment for that section.

Only applies if no pulse and not breathing.

“Do Not Attempt Resuscitation” facilitates discussion about limited potential for success.

<table>
<thead>
<tr>
<th>HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT 03/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Orders for Life-Sustaining Treatment (POLST)</strong> 03/2015</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City / State / Zip:</td>
</tr>
<tr>
<td>Date of Birth:          Gender: M F</td>
</tr>
<tr>
<td>A Check One</td>
</tr>
<tr>
<td>__ CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.</td>
</tr>
<tr>
<td>__ Attempt Resuscitation/CPR  __ Do Not Attempt Resuscitation/DNR (Allow Natural Death)</td>
</tr>
<tr>
<td>When not in cardiopulmonary arrest, follow orders in B and C.</td>
</tr>
</tbody>
</table>
Section B: Medical Interventions

<table>
<thead>
<tr>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing</td>
</tr>
<tr>
<td>Comfort Measures Only: Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort.</td>
</tr>
<tr>
<td>Do Not Transfer to Hospital for life sustaining treatment.</td>
</tr>
<tr>
<td>Transfer if comfort needs cannot be met in current setting.</td>
</tr>
<tr>
<td>Limited Additional Interventions: Includes all care described above. Use medical treatment and monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). Transfer to hospital if indicated. Avoid intensive care.</td>
</tr>
<tr>
<td>Full Treatment: Includes all care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.</td>
</tr>
</tbody>
</table>

Additional Orders:

This section most directly influences place of care at time of death.
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.”
Section C: Nutrition and Hydration

<table>
<thead>
<tr>
<th>Check One for part 1</th>
<th>ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION: Offer food/liquids by mouth if feasible.</th>
</tr>
</thead>
</table>
| __No artificial nutrition by tube | Part 1 – Nutrition:  
| __Trial period of artificial nutrition by tube. | Part 2 – Hydration:  
| Goal: __________________________  
| __Long-term artificial nutrition by tube. | __No artificially administered fluids  
| | __Trial period of artificial hydration.  
| | Goal: __________________________  
| | __Full treatment with artificially administered fluids.  

Additional Orders:
### Section D: Basis for Orders

**Basis for Orders**

My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s current medical condition and preferences as indicated by:

<table>
<thead>
<tr>
<th>Basis for determining patient’s preferences (check all that apply)</th>
<th>Discussion with: (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directive (on file)</td>
<td>Patient</td>
</tr>
<tr>
<td>Patient’s current statement to Physician / NP / PA / or</td>
<td>Parent of a minor</td>
</tr>
<tr>
<td>Other Health Care Professional</td>
<td>Guardian</td>
</tr>
<tr>
<td>Patient’s statement to authorized representative</td>
<td>Health Care Agent</td>
</tr>
<tr>
<td>Best interest determined by authorized representative (no</td>
<td>Other</td>
</tr>
<tr>
<td>advance directive / preferences unknown)</td>
<td></td>
</tr>
</tbody>
</table>

**Print Name of Primary Care Professional**

**Print Name of Signing Physician / PA / NP**

**Signature of Physician / PA / NP (required)**

**Date**

**Phone:**

**Phone:**

**Phone:**

---

*Must be signed*

*Basis for orders clearly identified*
**Side 2: Section F - Instructions for use**

**Instructions for Use**

**Patient Last Name:**

**First Name:**

**DOB:**

**Signature of Patient or Authorized Representative**

This form records your preferences for life-sustaining treatment in your current state of health. It can be reviewed and updated by your healthcare professional at any time if your preferences or condition change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by the authorized representative named below.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name (print)</th>
<th>Relationship (write &quot;self&quot; if patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name of Authorized Representative**

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Address &amp; Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Health Care Professional Preparing Form**

<table>
<thead>
<tr>
<th>Title</th>
<th>Phone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Directions for Health Care Professionals**

**Completing POLST**

- This is a voluntary order.
- Should reflect patient’s preferences based on current medical condition. Encourage completion of an advance directive.
- POLST must be signed by a physician, nurse practitioner or physician assistant to be valid. Verbal orders are acceptable with follow-up signature by the physician/NP/PA in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and facsimiles are legal and valid.
- Patient should sign this form if (s)he is able to make his/her own health care decisions. If unable to sign, an authorized representative should sign.
- In the event of an emergency, changes may be made to the form by an Authorized Representative via telephone.
- An Authorized Representative includes, in order of priority, a health care agent (same as durable health care power of attorney or agent named in advance directive), court appointed guardian, parent or minor, or surrogate as defined in 18-A MRS § 5-801.

**Using POLST**

- Section A
  - No defibrillator (including AED’s) should be used on a person who has chosen “Do Not Attempt Reanimation.”
- Section B
  - When comfort cannot be achieved in the current setting, the patient, including someone with “Comfort Measures Only,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
  - IV medication to enhance comfort may be appropriate for a patient who has chosen “Comfort Measures Only.”

**Reviewing POLST**

This POLST should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient’s health status, or
- The patient’s treatment preferences change.

Draw a line through sections A through D and write “VOID” in large letters if POLST is replaced or becomes invalid.

**Obtaining Additional POLST forms**

- Additional POLST forms may be obtained by contacting the Maine POLST Coalition, online at www.polstmaine.org

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**
Who Can Help Complete POLST?

- “Healthcare providers”
- Best practice - those specifically trained in the POLST Conversation:
  - Nurse Practitioners
  - Physician Assistants
  - Physicians
  - Nurses
  - Social Workers
  - Chaplains
The POLST Conversation

- A POLST form is only as good as the underlying conversation on which it is based.

- Advance care planning, including POLST, is *a process not an event*. Often requires several conversations and evolves over time.

- The POLST conversation provides context for patients/families to:
  - Make informed choices.
  - Identify goals of treatment.
The Conversation is Essential
Steps for Discussing POLST

1. Prepare for the discussion
2. Begin with assessing patient and family understanding
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. Focus on achieving overall goals, not just on specific interventions
6. Use POLST to guide choices and finalize patient/family wishes
7. Complete and sign POLST
8. Review and revise periodically (at least yearly and with change in care setting or goals)
Establish Realistic, Attainable Goals

• Help facilitate an understanding of the scope of illness and likely progression

• Identify relevant values and goals

• Define “acceptable” and “unacceptable” quality of life

• Encourage consideration of goals of treatment in context of non-illness related priorities. “What matters most?”
If we understand the patient’s goals, we can better recommend care that achieves those goals

“You don’t ask ‘What do you want when you are dying?’

You ask, ‘If time becomes short, what is most important to you?’

Susan Block’s Approach to Goals of Care
Conversations Summarized in *Being Mortal*

• “What do they understand their prognosis to be”
• “What are their concerns about what lies ahead”
• “What kind of trade-offs are they willing to make”
• "How do they want to spend their time if their health worsens”

For more on specifics of this model:
“Serious Illness Conversation Guide” “provides an evidence-based framework for serious illness conversations, consisting of prompts for the conversation flow and patient-tested, open-ended language”

https://www.youtube.com/watch?feature=player_detailpage&v=45b2QZxDd_o
Care Across Settings

- The POLST form is always voluntary
- Goal: A completed Maine POLST form would be honored by healthcare providers
- In a hospital setting, a patient should be assessed by an MD, PA, or NP who will issue appropriate orders
- Verbal orders are valid with follow up signature by the physician in accordance with hospital/health system policy. But EMS requires signed orders.
- Provider engagement in the POLST conversation is essential
- Faxes and photocopies of POLST forms are valid
- When the provider does not have admitting privileges, there are various practices currently in place across the state
When Should POLST be Reviewed?

- Transfer from one care setting to another.
- A substantial change in patient’s health status.
- Patient’s treatment preferences change.
- Patient Care Conference.
- At least annually for EMS recognition.
Can POLST be Changed?

- Individual with capacity can request alternative treatment or revoke a POLST at anytime. (See page 2 of form for process.)

- Legally recognized decision maker may request change based on condition change or new information regarding patient wishes.
Where Should We Keep POLST?

Original lime green POLST stays with patient

- At SNF/Hospital:
  - File in medical chart (with Advance Directive).
  - Send original with patient upon return to home/SNF/hospital.
  - Keep copy if resident transferred; review POLST upon resident’s return.
Where Should We Keep POLST?

- At home:
  - Accessible in easy-to-find location (with AD).
  - Give to EMS to transport with patient.
Current POLST Challenges

- POLST forms completed without conversation with patient or authorized representative
- POLST forms given or mailed to patients or families to complete on their own, or faxed to DHHS to sign, without conversation
- POLST forms filled out for all patients in a facility, whether appropriate or not
- POLST not appropriately signed
- POLST forms not transferred with resident/or not easily found in transfer paper work
- Enthusiasm for convenience of form outpacing conversations / process training/systems
Maine POLST Form

- Available at [www.POLSTmaine.org](http://www.POLSTmaine.org)
POLST Resources

- POLST Forms - Distribution of Maine POLST pdf through Maine POLST Coalition to ensure institutions print in standardized format/color and use of current form

- Patient and Family Brochure

- Standardized educational curriculum

- www.POLSTmaine.org

- info@mainehospicecouncil.org

- 207-626-0651
Upcoming POLST Train-the-Trainer Workshops:

Strongly encourage formal training if starting a POLST roll-out in your organization or community.

- October 6, 2016
  The Aroostook Medical Center, Presque Isle

- October 7, 2016
  Northern Maine Medical Center, Fort Kent

- December 9, 2016
  Maine General Health, Augusta

- Others TBA

- For more information - Contact Sarah Swift at Maine Hospice Council at 207-626-0651
  sswift@mainehospicecouncil.org