The Role of POLST in Advance Care Planning

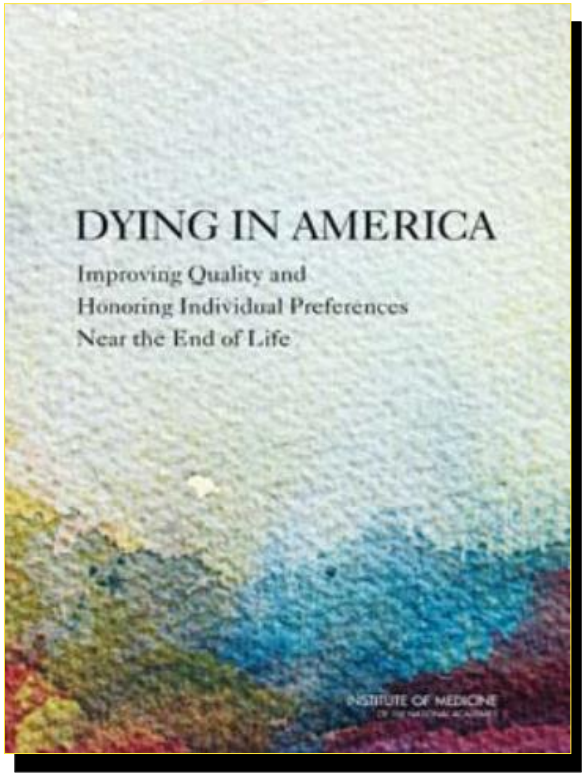
Richard W. Cohen, MD

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

Financial Disclosure

The presenters have no financial interests or relationships to disclose

Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life



"The IOM committee believes a person-centered, family-oriented approach that honors individual preferences and promotes quality of life through the end of life should be a national priority."

SEPTEMBER 2015

http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx

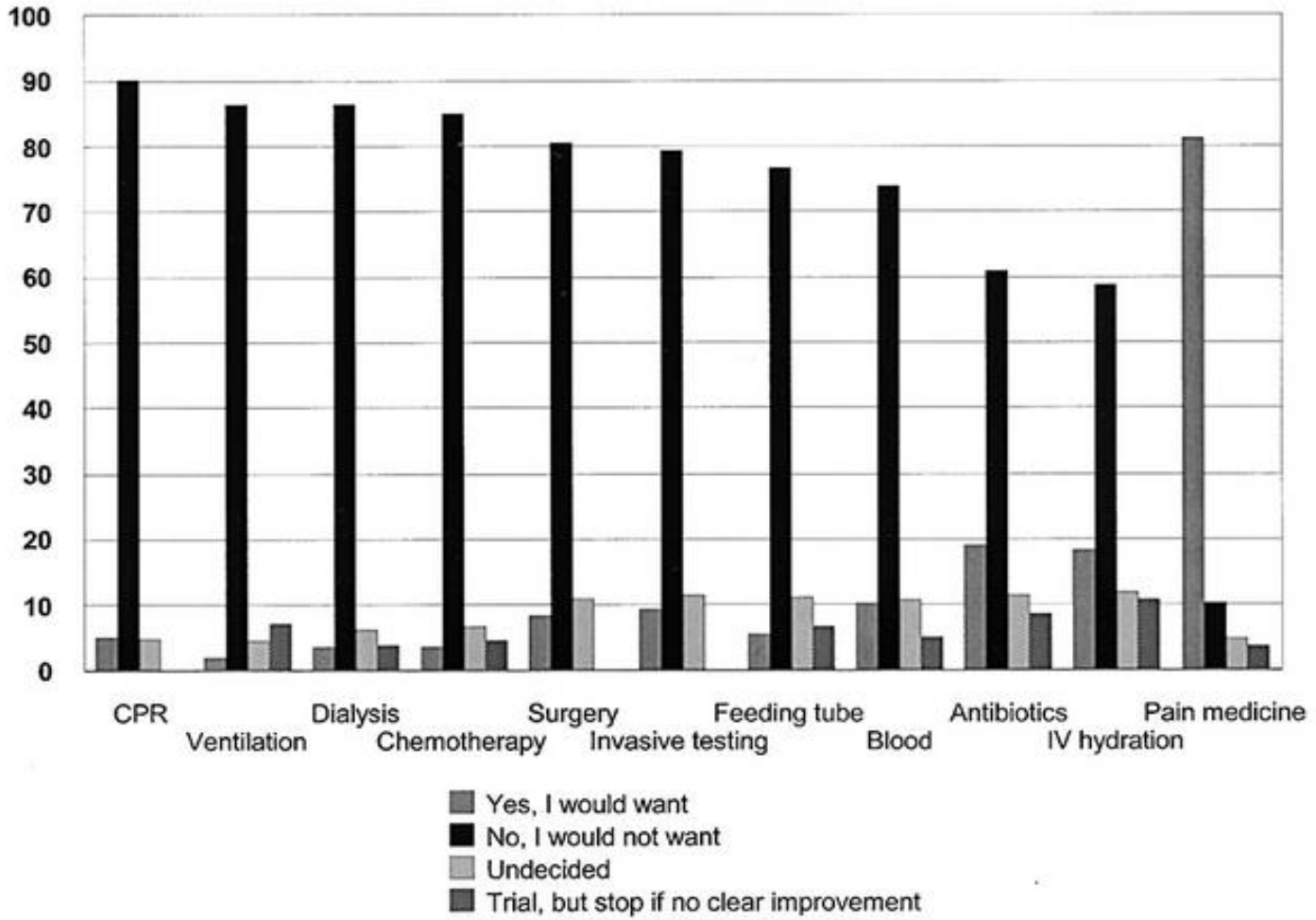
END-OF-LIFE DEMOGRAPHICS IN THE U.S.

- The majority of deaths occur in elderly adults
- Seriously ill patients spend most of their final months at home, but most deaths occur in the hospital or nursing home
- Location of death varies regionally:
    - Portland: 35% in hospitals
    - New York City: >70% in hospitals

One conversation can make all the difference

- **70%** of people say they prefer to die at home yet **70%** die in a hospital, nursing home, or long-term-care facility *(Centers for Disease Control, 2005)*
- **82%** of people say it's important to put their wishes in writing ; **23%** have actually done it *(Survey of Californians by the California HealthCare Foundation, 2012)*
- **80%** of people say that if seriously ill, they would want to talk to their doctor about end-of-life care; **7%** report having had an end-of-life conversation with their doctor *(Survey of Californians by the California HealthCare Foundation, 2012)*

How Physicians want to die



http://thesocietypages.org/socimages/2013/12/31/how-do-physicians-and-non-physicians-want-to-die/

Physician VS Patient End of Life

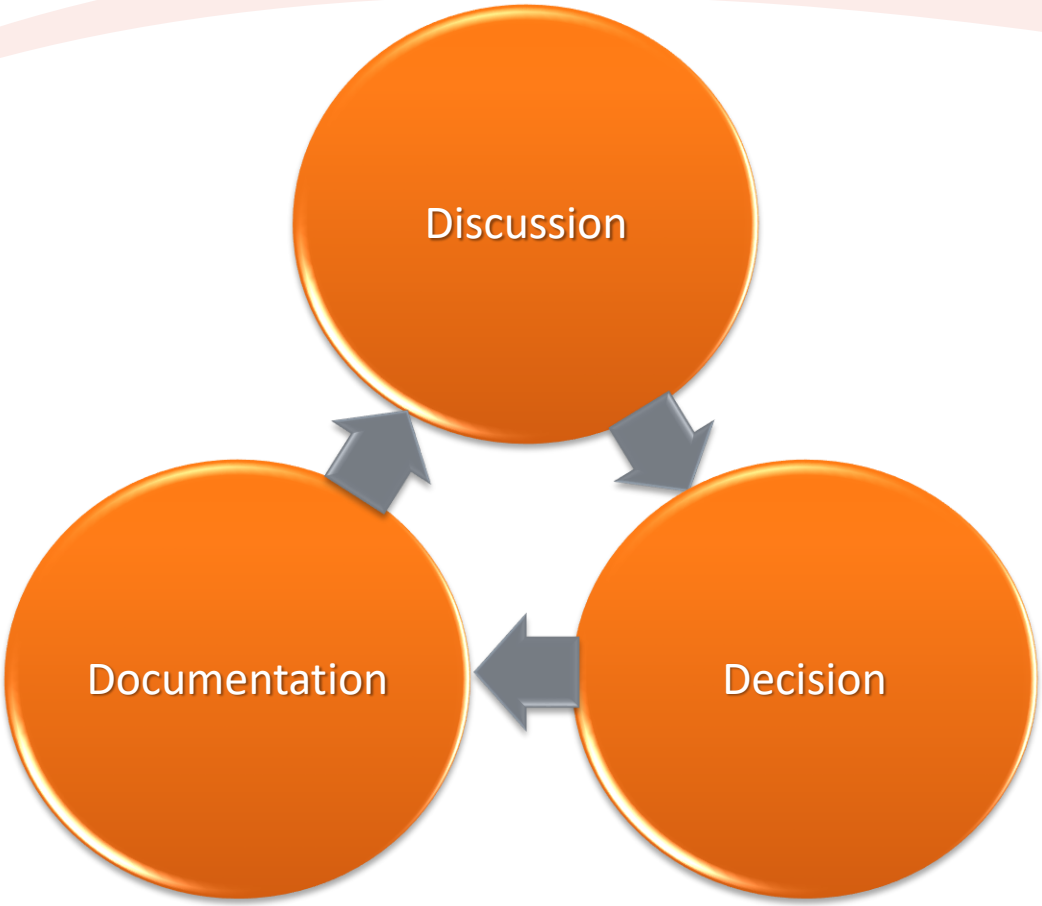
- The POLST breaks down interventions, to a greater degree, into how physicians and people in the medical field think about interventions.

Advance Care Planning

"Advance Care Planning Is Not An Event, It's A Process."

- Susan Tolle, Director of the Center for Ethics in Health Care at Oregon Health & Science University

Advance Care Planning



When Should Advance Care Planning Happen?

While individuals are still actively able to participate in the conversation prior to a crisis

"Planning is important! It wasn't raining when Noah started the ark."

~ Richard Cushing

Gold Standard

Discussing and following a patient's preferences for end-of-life care should be as routine as asking about and responding to a patient's allergies to medicines

Right to Refuse Medical Treatments

- In Georgia, a competent adult has the right to refuse any unwanted medical treatment for any reason
- Right to refuse medical treatments includes life support and other life-sustaining treatments
- The right to refuse or terminate treatments may be exercised by family members or loved ones

History

- **It is a National movement**
  - Advance Directive
  - POLST
  - The Conversation
- **It is a State movement**
  - Georgia Health Decisions
  - Georgia POLST Collaborative

Georgia Advance Directive for Health Care

In 2007, Georgia Law combined all three advance care planning tools into one document:

- Naming a **health care agent**
- Stating **treatment preferences**
- Nominating a guardian (if a court rules that a guardian is necessary)

Also includes:

- Authorizing organ donation, autopsy, burial

Legal with:

- **Patient signature & 2 witnesses**

http://ngoc.com/wp-content/uploads/ELAP-GEORGIA-ADVANCE-DIRECTIVE-2012.pdf

POLST
Physician Orders for Life Sustaining Treatment

- **Medical order** completed by a health care provider
  - Requires signatures by the patient or patient's authorized representative AND a physician
- **Activates** a patient's Advance directive
- Mechanism to **communicate** a patient's wishes for their care at the end of their life
- Designed **to travel** with patient from one care setting to another
- Must be **honored** by all health care professionals

Physician Order for Life Sustaining Treatment (POLST)

POLST in action:

- Oregon deaths 2011-2012; 17,902 (30.9%) had a POLST form in the registry
- **Comfort measure only** (CMO) 11,836 **(66.1%) -** avoiding hospitalization unless comfort cannot be achieved in the current setting
- Only **6.4%** of participants with **POLST CMO orders died in the hospital**
- **Full treatment requested - 44.2% died in the hospital** *~ J Am Geriatr Soc 62:1246–1251, 2014.*

Who Should Have a POLST?

- Anyone who wants their end-of-life decisions honored
- Anyone choosing “Allow Natural Death” or DNR
- Anyone choosing to limit or not limit medical interventions
- Anyone residing in a long term care facility
- Anyone who might die or lose decision-making capacity within the next year

Difference Between Advance Directives and POLST

Advance Directive	POLST
For anyone over 18	For seriously ill/frail at any age
Completed by an individual	Completed by a physician and patient or authorized patient representative
General instructions for future treatment	Specific orders for current treatment
Signed by individual and two witnesses (neither an attorney nor notary is needed in GA)	Signed by physician and patient or authorized patient representative

Georgia Legal Foundations

- GA Advance Directive
  - Ga. AD Law - 2007 HB 24
  - Ga. Dept. Of Human Resources (2007 HB 24 Rules And Regulations)
  - Ga. Code 31-39 DNR/AND & Cardiopulmonary Resuscitation Laws
- GA Physician Order For Life Sustaining Treatment (POLST)
  - Ga. DPH, POLST Form, 2012
  - ***SB 109 2015***

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

SB109

- **A Legally Sufficient Order In**
  - **All Settings**
  - **Valid Consent**
  - **Unless Revoked**
  - **From Another State**
    - If substantially similar & with the same signatures
  - **A Copy**

SB109

- **Portable Across Care Settings**
  - Review of form recommended as care transitions
- **Immunity For All**, including guardian actions
  - **Protections for treating pain**
  - **Except if violates Code Section 16-5-5**
    - Physician Assisted Death

SB109

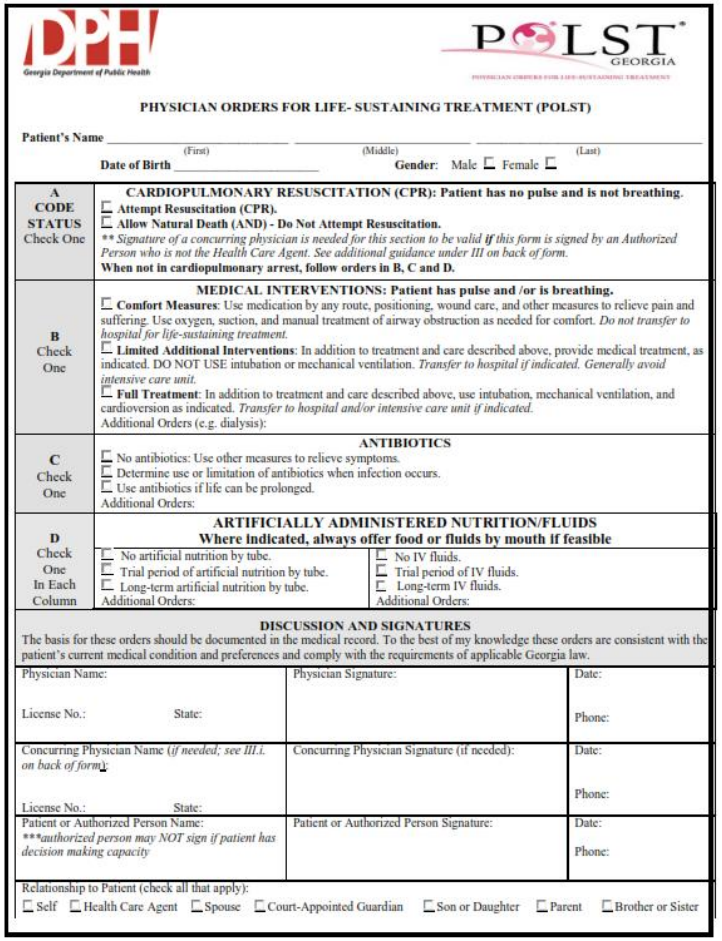
- Equates Terms **DNR=AND** etc.
- All **conflicting laws** or parts are repealed
- **Most recent document** is the valid one

Georgia POLST Form

- Developed by the Georgia Department of Public Health in 2012 **updated 2015** after SB109
- Available at: https://dph.georgia.gov/POLST
- Use and compliance with POLST form provides immunity to any “person” acting in good faith (2015)

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

Georgia POLST Form



PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ (First) _____ (Middle) _____ (Last)

Date of Birth _____ Gender: Male ☐ Female ☐

A CODE STATUS Check One

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR).**

☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.**

*** Signature of a concurring physician is needed for this section to be valid if this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.*

When not in cardiopulmonary arrest, follow orders in B, C and D.

B Check One

MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.

☐ **Comfort Measures**: 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. *Do not transfer to hospital for life-sustaining treatment.*

☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.*

☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

Additional Orders (e.g. dialysis):

C Check One

ANTIBIOTICS

☐ No antibiotics: Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics when infection occurs.

☐ Use antibiotics if life can be prolonged.

Additional Orders:

D Check One In Each Column

ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS

Where indicated, always offer food or fluids by mouth if feasible

☐ No artificial nutrition by tube.	☐ No IV fluids.
☐ Trial period of artificial nutrition by tube.	☐ Trial period of IV fluids.
☐ Long-term artificial nutrition by tube.	☐ Long-term IV fluids.
Additional Orders:	Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed; see III.i. on back of form*): License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ****authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to Patient (check all that apply):

☐ Self ☐ Health Care Agent ☐ Spouse ☐ Court-Appointed Guardian ☐ Son or Daughter ☐ Parent ☐ Brother or Sister

Five Sections

- Cardiopulmonary Resuscitation (CPR)
- Medical Interventions
- Antibiotics
- Artificially Administered Nutrition/Fluids
- Signatures

https://dph.georgia.gov/POLST

Signatures

- **Two Required**
  - Patient **&** Physician **OR**
  - Authorized Person / Medical Power of Attorney **&** Physician **OR**
  - Two physicians (specific situations, see back of POLST, Section III)
- **Remember**
  - Physician must be on the staff of the institution honoring the POLST

POLST Conversation

- POLST is not just a check-box form
- The POLST conversation provides context for patients/families to:
  - Make informed decisions
  - Identify goals of treatment
- A patient or their Health Care Agent can request alternative treatment or revoke a POLST at any time

POLST Implementation/Use in Hospital Setting

Medicare Conditions of Participation: Hospital orders may only be written by MD with staff privileges; this does not mean a POLST signed by a non-privileged physician should be ignored.

POLST Process when Patient Arrives at Hospital with POLST signed by non-privileged physician:

- Physician should review the document(s) and either
  - Sign POLST form as the "Concuring Physician"
  - Rewrite orders into hospital system
- Hospital policies should be written to govern this process

David W. Eddinger, RN, MPH
Captain US Public Health Service, Retired
Technical Director Hospital Survey and Certification
CMS/CCSQ/Survey & Certification Group/Division of Acute Care Services

Admission to Long-Term Care (LTC) Facility

Identify or determine:

- Health Care Advocate's name
- Patient's medical state
- Code status based on:
  - Patient's wishes and/or
  - When, in the judgment of a physician, **Either:**
    - **A patient is in a terminal condition**
    - **A patient is in a permanent state of unconsciousness**
    - **In medical judgment CPR would be medically inappropriate**

O.C.G.A. 31-39-4 (2010)

Healthcare Agent / Authorized Person

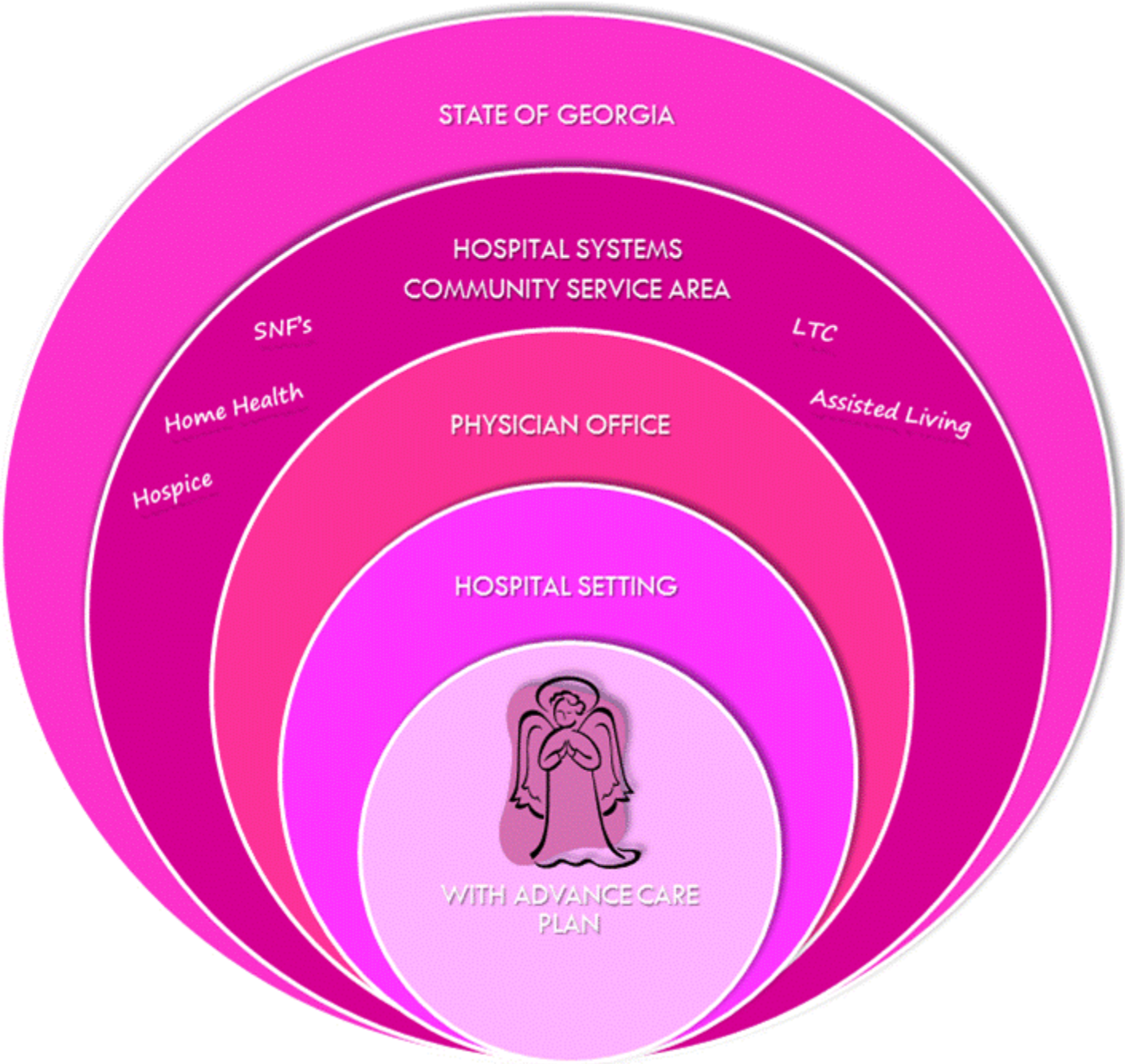
Must be named in either

- **Advance Directive**
- **POA**

Responsibilities:

- **To follow the patient's known preferences**
- **To honor the patient's Advance Directive and POLST**
- **To act in the best interest of the patient**

My Vision


STATE OF GEORGIA
HOSPITAL SYSTEMS
COMMUNITY SERVICE AREA
SNF's
Home Health
Hospice
LTC
Assisted Living
PHYSICIAN OFFICE
HOSPITAL SETTING
WITH ADVANCE CARE PLAN

Georgia POLST Collaborative

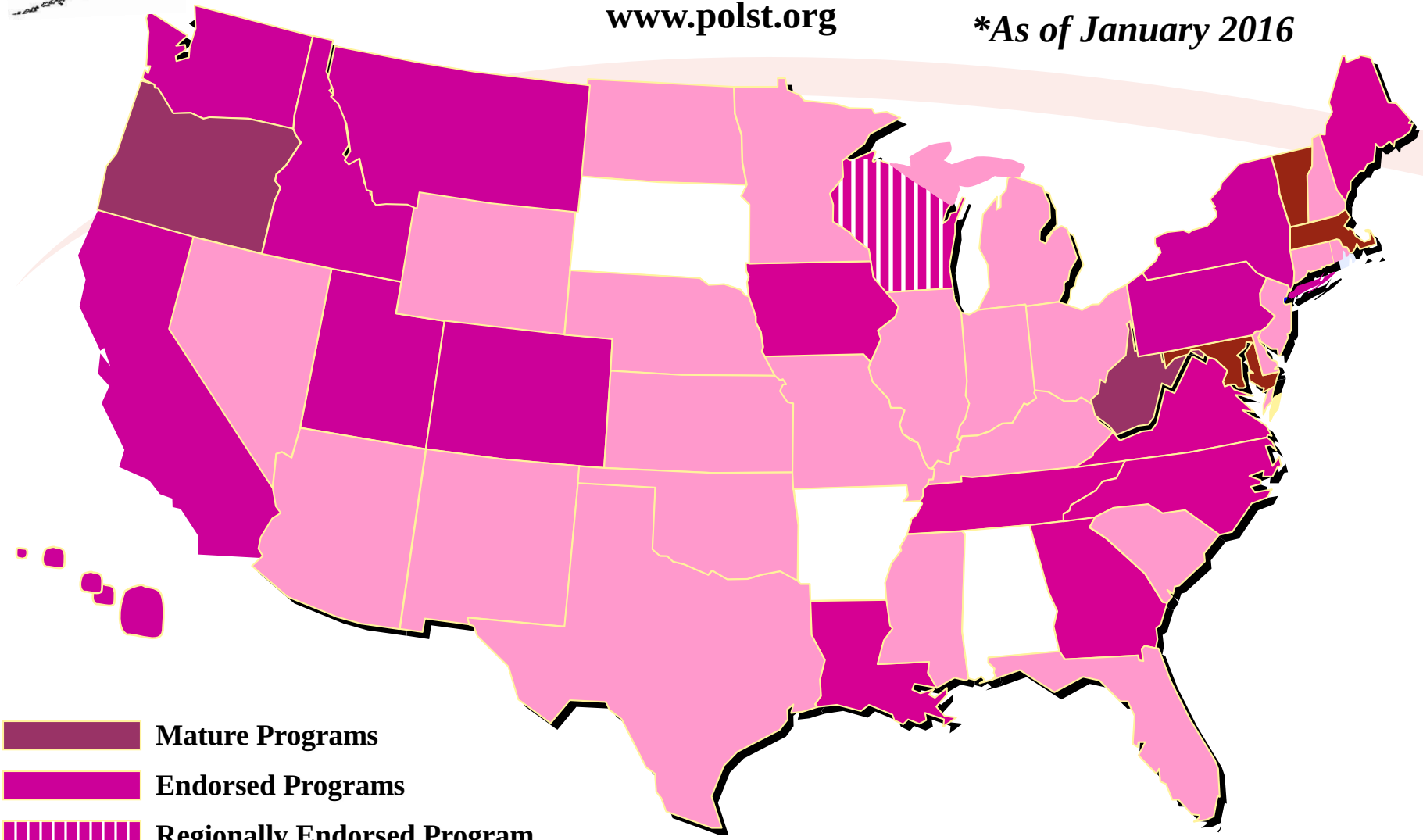
- 40+ Statewide Organizations
- Part of a national movement to promote POLST
- Endorsed by the National POLST Paradigm Taskforce
- **Vision:** All Georgians will have their health care preferences known and honored

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

National POLST Paradigm Programs

www.polst.org

***As of January 2016**



- **Mature Programs**
- **Endorsed Programs**
- **Regionally Endorsed Program**
- **Developing Programs**
- **No Program (Contacts)**
- **Programs That Do Not Conform to POLST Requirements**

Georgia POLST Collaborative *(cont'd)*

- **Mission**: To improve health care at the end-of-life through
  - **Promoting the utilization of the Physician Orders for Life Sustaining Treatment form** by health care professionals and institutions across the state
  - **Educating Georgians** about advance care planning and the role of POLST in having their wishes honored

‘Getting it Right’

- Honor all patients wishes
- Encourage all patients to have an Advance Care Plan
- Consider POLST when the answer to the question,“Would You Be Surprised If Patient Was Alive in one year” is ‘yes’
- Apply reasonable medical judgment

CASES: HOW DO YOU USE POLST?

?

Anna Skold, MD, MPH

Let’s start out easy

- Start with someone who already understands CPR and what it does and does not do

Case 1

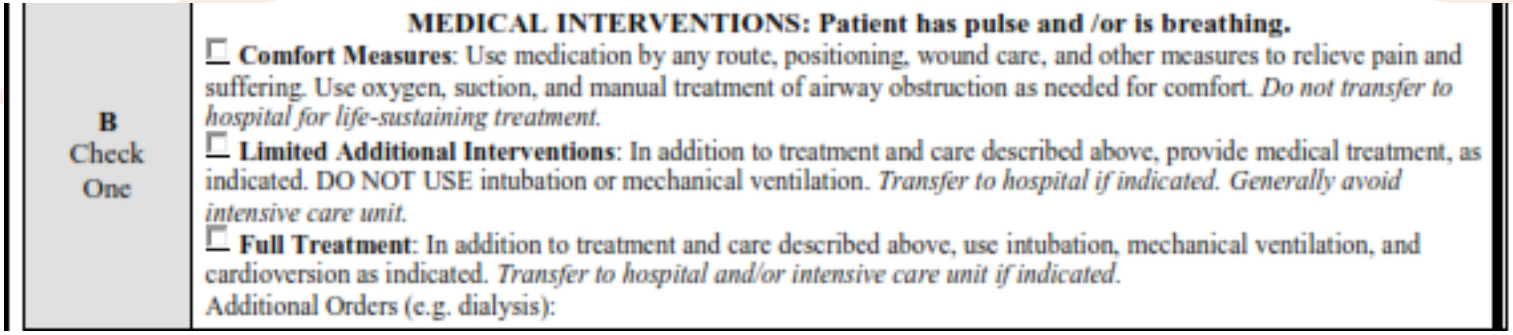
50 yo male, former firefighter, has a diagnosis of end stage heart failure with his second Left Ventricular Assist Device (LVAD) with repeat line infection and recurrent positive blood cultures. He understands he is not a transplant candidate and cannot receive a repeat LVAD. You have met a couple of times and worked on symptoms and resources. He comes to you and states, “Doc, how do I get one of those DNR orders?”

Section A

A CODE STATUS Check One	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** ** *Signature of a concurring physician is needed for this section to be valid* ***if*** *this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* **When not in cardiopulmonary arrest, follow orders in B, C and D.**

Start talking in “POLST terms” when doing advance care planning with anyone. We need to start saying “When your heart and lungs stop and you die…” **NOT** “Do you want us to do everything if you die?”

Section B



B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: 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. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.* Additional Orders (e.g. dialysis):

Use it to start disease appropriate conversations. This patient wished to be DNR/AND but still wanted IV diuretics and IV antibiotics for recurrent infections. We had a good conversation about at what point to stop antibiotics and what that would look like. He chose “limited additional interventions” and we wrote in under additional orders when to stop.

Section C

C Check One	ANTIBIOTICS ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. Additional Orders:

Who may want to limit antibiotics?

- Our patient with recurrent line infections and worsening heart failure wanted to discontinue using antibiotics when he was fully bed bound
- Data shows that antibiotics may prolong life but decreases quality of life significantly in end stage dementia patients with pneumonia (CASCADE 2010)

Case 2

- 45 yo male with ALS and dysphagia, no longer able to speak, motorized wheelchair bound, full assist.
- He is Catholic and questions if he stops something, will God consider that suicide?
- He and his family go on trips and enjoy life.

Section D

D Check One In Each Column	ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS Where indicated, always offer food or fluids by mouth if feasible	
	☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders:	☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

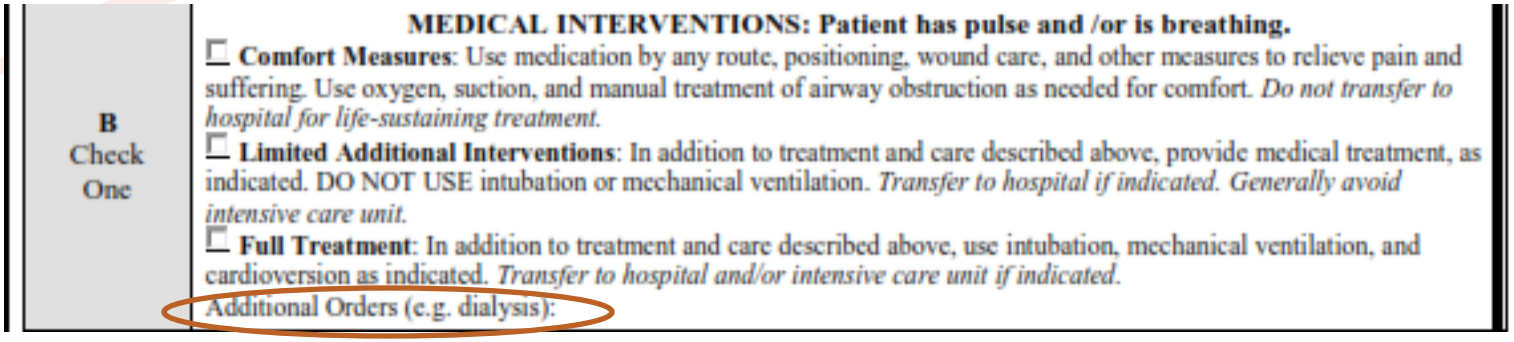
At first he did not want a feeding tube. We had lots of conversations about this, which led to conversations about other interventions. It also led to conversations about how artificial nutrition and fluids can cause discomfort at end of life.

He refused intubation and trach and wished to have a code status of DNR/AND. However, he received a PEG tube and lived nearly two more years. He had a very rich life and went on trips, including going to Disney multiple times with his family.

Case 3

- 80 yo female with end stage renal disease who does not want dialysis and does not have significant family nearby. She has clear wishes to Allow Natural Death and never be on any machines, especially dialysis. “And no nursing home ever!” She does designate a distant relative as Medical Power of Attorney but does not trust them to complete her wishes even though she has spoken to them about her wishes.

Additional Orders



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	☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
	Additional Orders (e.g. dialysis):

The additional orders section can be useful for things such as dialysis, po versus IV antibiotics, BiPap versus intubation, time-limited trail. Write things in to clarify.

Case 4

- 90 yo patient with multiple co-morbidities and frailty who will be discharged tomorrow to LTC. He states “If I told you once, I told you a hundred times, I am DNR!!! Can’t you see my wrist band? Don’t you guys look at the chart?”

But my hospital won't let me use POLST?

- This does not stop you from discharging a patient with a POLST form. Georgia law protects and honors the POLST across all healthcare settings.
  - Remember: How much time does the physician at LTC have before seeing the patient?
- I send patients to the hospital in an ambulance from the clinic I work at every once in awhile. I always complete a POLST even if the patient is full code. I then educate the EMS crew about POLST when I hand it to them. I also call ahead and educate the ER physician. This way, a patient is protected while the EMS crew and ER physician are educated and know what to do.

Case 5

- 87 year old male with metastatic slowly progressive small bowel cancer. He has been clear from first meeting that he wishes to Allow Natural Death, “never” wishes to be on any “machines”, and does not want to die in a hospital. He lives alone. A POLST is created and he wears it around his neck.

Make patients POLST advocates

- I explain to every patient how new the POLST is in the state of Georgia. I empower them to be their own advocate for POLST.
  - Put it on or in the fridge
  - Carry copies because they are valid – have one in your wallet, have one in your spouses wallet, give copies to your kids, have one in the glove box, take it with you when you travel

Make patients POLST advocates

- Tell loved ones what it is and why you have it
- Explain to doctors and nurses when you see them what it is and turn it over and point to the GA policy that protects them
  - I also empower them to explain they can rip it up

Practical Lessons Learned

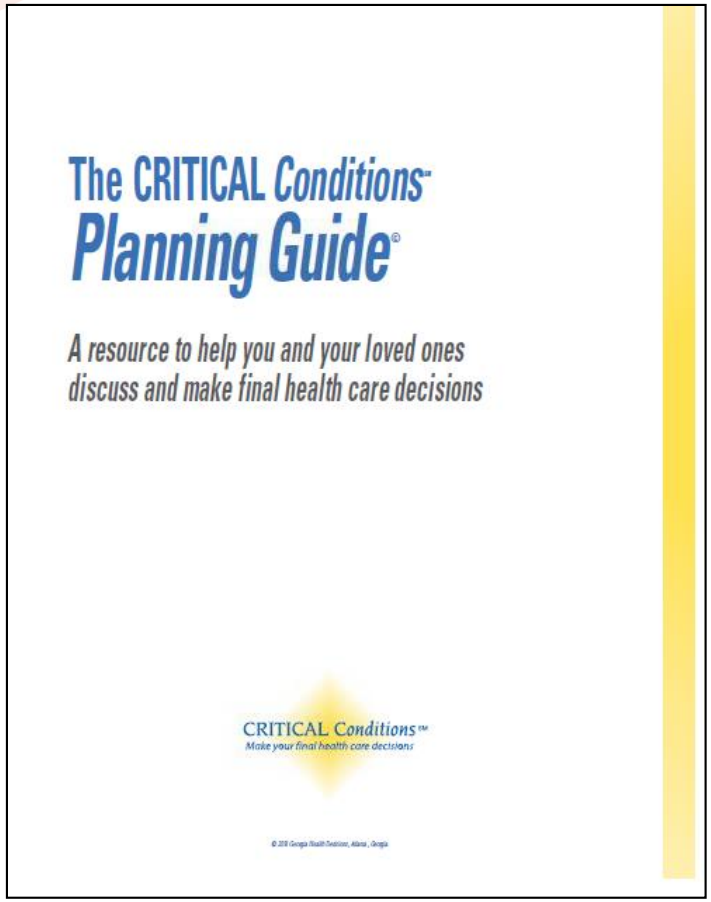
- Have the form handy.
- Let people look at it and then come back to it later.
- Use it with patients who have already had clear discussions.
- Start using the language of POLST when talking about advance care planning and code status.

Practical Lessons Learned

- Have a white and pink copy and complete both with patient – the pink is for the fridge but it does not copy/fax well – use the white copy for this.
- Use it for patients you know will lose capacity due to their disease process– i.e. dementia, cirrhosis, end stage renal disease.
- Figure out where to put the copy – scan into chart/front of paper chart? Put it on the problem list.

Additional Resources

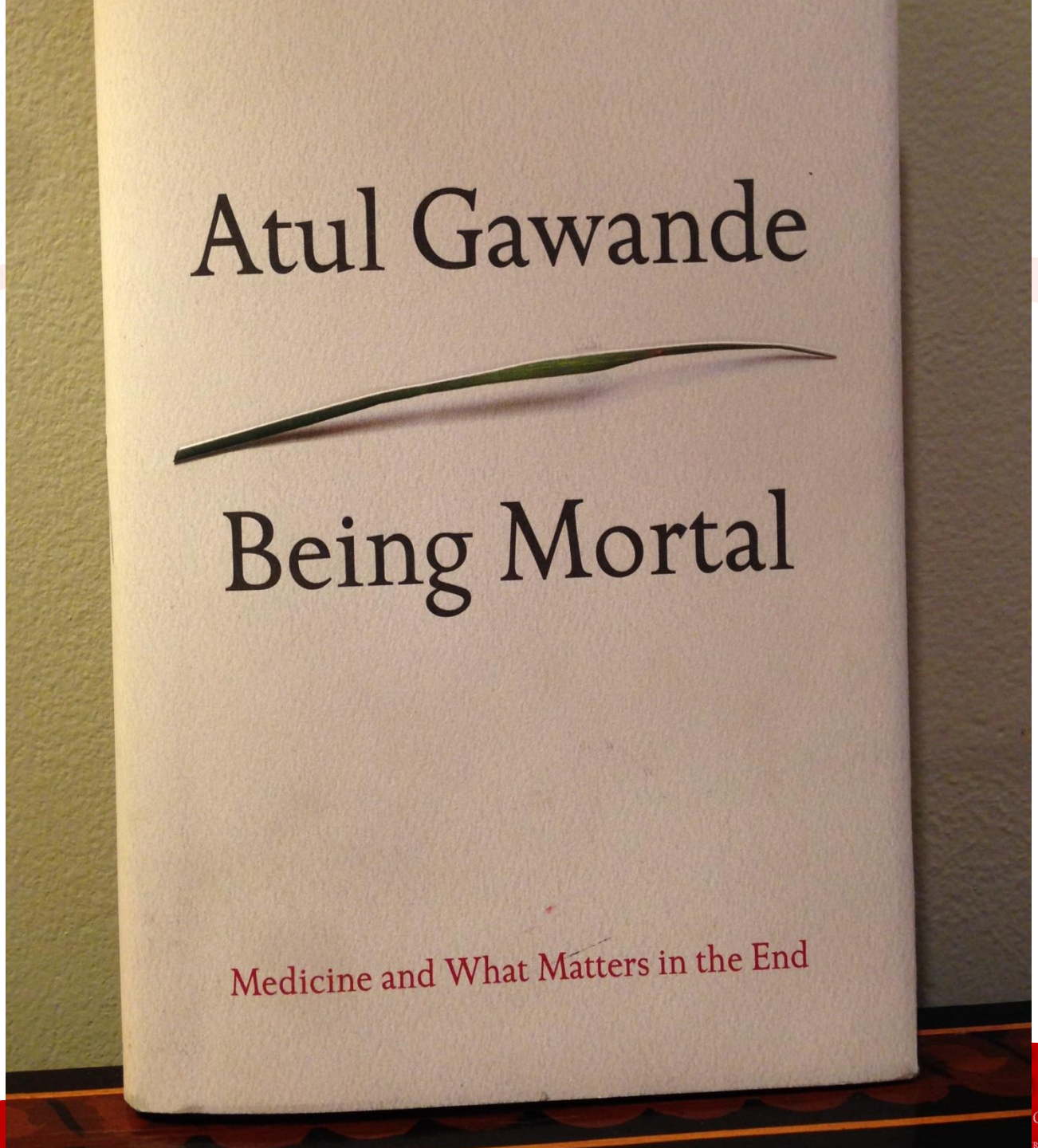
Critical Conditions Guide



http://georgiahealthdecisions.org/store.html

“Being Mortal”

- It is a book, 2015 and a very good one!
  - Atul Gawande
- It is an educational program / video
  - A local application of the PBS Frontline program


Atul Gawande
Being Mortal
Medicine and What Matters in the End

Partner Organizations

- Healthcare Ethics Consortium (Emory Univ.)
- Conversation Project
- Death Over Dinner
- Nation POLST organization
- CAPC (Center to Advance Palliative Care)

POLST Websites

- Critical Conditions Planning Guide
  - www.critical-conditions.org
- www.gapolst.org
- www.dph.ga.gov/POLST
- www.polst.org
- www.capolst.org/documents/POLSTFAQ

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American Geriatric Society Geriatric Review Syllabus Teaching Slide-set

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