The Role of POLST in Advance Care Planning

Richard W. Cohen, MD
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

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

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

- Discussion
- Documentation
- Decision
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

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
  
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

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

- GA Advance Directive
  - Ga. AD Law - 2007 HB 24
- GA Physician Order For Life Sustaining Treatment (POLST)
  - Ga. DPH, POLST Form, 2012
  - **SB 109 2015**
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)
Georgia POLST Form

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 “Concurring 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

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

LTC

Assisted Living

HOSPITAL SETTING

Physician Office

Hospice

WASHINGTON

WITH ADVANCE CARE PLAN

WITH ADVANCE CARE PLAN

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
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
CASSE: 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

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?”
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

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

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

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
References


American Geriatric Society Geriatric Review Syllabus Teaching Slide-set
