Overview of POLST and Where We Are in Pennsylvania

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OBJECTIVES

• Define the role of POLST in advance care planning
• Recognize the value of POLST in helping assure patients’ health-care treatment choices are respected
• Address religious and cultural concerns in end-of-life decisions

PURPOSE OF POLST

To provide a mechanism to communicate patient preferences for end-of-life treatment across treatment settings.
POLST PARADIGM
Developed in Oregon by POLST Task Force, early 1990s
Brightly colored medical order form for seriously ill patients (surprise question)
Signed by physician (requirements vary by state)
Turns patient treatment preferences and Advance Directives into medical orders
Goal is to ensure wishes for treatment are honored

WHAT IS POLST?
• A medical order
• Can be completed by any healthcare professional
• Signed by a physician, nurse practitioner or physician assistant in Pennsylvania*
• Complements, but does not replace, advance directives
• Voluntary use, but provides consistent recognized document

* A physician assistant signature requires a physician to co-sign within ten days.

POLST IS FOR...
• Seriously ill patients
• Terminally ill patients
• Patients with advanced frailty
• Anyone with advanced age wishing to further define their preferences for care

Unless it is the patient's preference, use of the POLST form is not appropriate for persons with stable medical or functionality problems who have many years of life expectancy.
DIFFERENCES BETWEEN POLST AND ADVANCE CARE DIRECTIVES

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>POLST</th>
<th>Advance Directives</th>
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<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>
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WHERE DOES POLST FIT IN?

Advance Care Planning Continuum

Age 18

Complete an Advance Directive

Complete a POLST Form

Diagnosed with Serious or Chronic, Progressive Illness (at any age)

Update Advance Directive Periodically

Treatment Wishes Honored

Pennsylvania Form

HIPAA Compliant

Clear instruction on what to do if patient is unconscious or unable to communicate

Options give people the chance to decide what interventions they want or do not want

Discussion about treatment preferences is required

Artificial hydration and artificial nutrition both found here

If any section is left unmarked, the highest level of treatment must be provided

Clear instruction on when to transfer to hospital and use of intensive care
CASE STUDY: END STAGE DEMENTIA AND FEEDING TUBE

Case History: 95 year old with dementia and recently admitted from SNF to hospital with aspiration pneumonia. The speech therapist recommended a feeding tube. On return to the nursing home the question about a feeding tube was posed.

What are the next steps? Would having a POLST help?
CASE STUDY: END STAGE DEMENTIA AND FEEDING TUBE APPROACH

- What are the patient’s goals of care?
- Does the patient and or family understand the prognosis?
- What are the risk and benefits of treatment?
- Does the patient and or family understand the risks and benefits of treatments?

CASE STUDY: END STAGE DEMENTIA AND FEEDING TUBE FACTS

- What are the patient’s goals of care?
  - Three living wills and wanted comfort measures
  - Outlined HCPPOA and step sister appointed HCPPOA with a good friend alternative HCPPOA
- What are the risk and benefits of treatment?
  - Risks outweigh benefits
  - Attending doctor offers hospice care to alternative HCPPOA and patient placed on hospice
- Does the patient and or family understand the prognosis and risk and benefits of treatment?
  - Good friend and alternative HCPPOA does
  - Half-sister HCPPOA who has not seen patient in two years does not
- Care team perspective:
  - Believe hospice appropriate but when the living will is discovered it only had one witness consult nursing home attorney
  - Half-sister calls nursing home administrator and pleads “I just want my sister to live”
  - Half-sister says she talked to a doctor friend and told feeding tube would help her sister

How do you start the conversations about feeding tubes and POLST?

ADDRESS THE UNSPOKEN CONCERNS IN END-OF-LIFE CARE

- "My mother will starve to death without food or nutrition"
- "My husband will die of thirst"
- Opportunity to explain that their loved one is dying of the underlying illness and that stopping eating and drinking is a natural part of the dying process
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 originally developed by Dr. Pat Bomba for the MOLST Program of New York State. Program information is found at www.compassionandsupport.org

POLST PROGRAMS

July 2006
National POLST Paradigm Programs

September 2012
National POLST Paradigm Programs

Paradigm of communication, documentation, and system responsiveness

NATIONAL POLST PARADIGM TASK FORCE

- One representative from each state that has met the requirement to be an endorsed POLST Paradigm program
- Establish quality standards for the POLST Paradigm programs
- Conducts POLST Research
  - Recent study found POLST use provides treatment consistent with patients' wishes more than 90% of the time, reduces unwanted hospitalizations and decreases medical errors in their care
  - Developing quality measures to assess impact of the POLST Paradigm Program on patient outcomes
### POLST AND RECIPROCITY

<table>
<thead>
<tr>
<th>States</th>
<th>Placement in the State Code</th>
<th>Regulations/Guidelines</th>
<th>Out of State POLST Recognized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>Approved for use given by the Department of Health in October 2010.</td>
<td>Under the leadership of the PLSW, guidelines for use have been established.</td>
<td>Not addressed</td>
</tr>
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### QUESTIONS AND CONCERNS VOICED WITHIN THE CATHOLIC COMMUNITY

- Gives too much importance to patient autonomy
- Can be used to hasten the death of patients who are chronically but not terminally ill
- Is not a good tool for end-of-life discussions
- Can be used as a mechanism for cost containment in health care rather than welfare of patients
- Is a step on the way to allowing euthanasia

_Courtesy of Janie Marie Idziak, Ph.D. (Director, Bioethics Resource Center, Loras College and Consultant for Health Care Ethics and Life Issues, Archdiocese of Dubuque), Christine Harlander, BSN (Palliative Care Coordinator and Co-director, IPOST pilot project, Mercy Medical Center, Cedar Rapids, IA), members of the Medical-Moral Commission of the Archdiocese of Dubuque, Iowa, and the IPOST Linn County Committee._

### POLST GIVES TOO MUCH IMPORTANCE TO PATIENT AUTONOMY

**Autonomy - Making decisions about using or forgoing medical treatment**

<table>
<thead>
<tr>
<th>POLST Concern</th>
<th>Response</th>
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<tbody>
<tr>
<td>Focusses too much on patient autonomy, elevating it to a level of an enforceable, legal right</td>
<td>Free and informed health care decisions should be followed as long as not contradicting Catholic principles*</td>
</tr>
<tr>
<td>Allows autonomy to become the legal mandated standard for medical care</td>
<td>Autonomy a factor, but no more so than any other physician order requiring patient consent</td>
</tr>
<tr>
<td>Requires compliance by health care workers</td>
<td>Medical orders are generally to be followed from the moment they are written *No set of medical orders should be blindly followed</td>
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*As stated in the Ethical and Religious Directives for Catholic Healthcare Services*
# POLST Can Be Used to Hasten the Death of Patients Who Are Chronically But Not Terminally Ill

<table>
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<tbody>
<tr>
<td>POLST not appropriate for those who are not terminally ill</td>
<td>POLST conversation can give insight into medical events that might happen in the course of illness. This permits planning in advance for interventions, for example in advanced COPD.</td>
</tr>
<tr>
<td>Death hastened by the forgoing of ordinary and proportionate means of preserving life (routine means)</td>
<td>Patient’s may forgo any treatment which in the patient’s judgment do not offer reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or community.</td>
</tr>
<tr>
<td>The POLST Form is a tool in which aggressive treatment choices for care, such as long term artificial nutrition or mechanical ventilation can be indicated, according to the patient’s wishes.</td>
<td></td>
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# POLST Is Not a Good Tool for End-of-Life Discussions

<table>
<thead>
<tr>
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<th>Response</th>
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</thead>
<tbody>
<tr>
<td>POLST tool can be used as a boiler plate check-off list</td>
<td>POLST is not a check-list, but a program in which qualified trained health care professionals engage in.</td>
</tr>
<tr>
<td>Patients can be encouraged to sign away care years before they face a health care crisis</td>
<td>• The POLST form is intended for use by a limited population who are terminally ill, have a chronic serious condition and/or are elderly and frail. “Those whom you wouldn’t be surprised if they died within a year”. • The POLST form is to be reviewed periodically to assure it reflects a patient current choices for care.</td>
</tr>
<tr>
<td>An effective POLST discussion is the key element to assure patient treatment choices are respected at the end of life.</td>
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# POLST Can Be Used as a Mechanism for Cost Containment in Health Care Rather Than Welfare of Patients

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</thead>
<tbody>
<tr>
<td>Widespread use of POLST is a cost-containment measure</td>
<td>• Cost containment may or may not be the result of POLST. • Patients have a right to choose their own treatments, including those treatments which might increase the cost of care. • There is no requirement or suggestion that the least expensive option be chosen.</td>
</tr>
<tr>
<td>Cost containment is not the intent of the POLST.</td>
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POLST IS A STEP ON THE WAY TO ALLOWING EUTHANASIA

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<tbody>
<tr>
<td>• Condones or approves of mercy killing or euthanasia</td>
<td>• The POLST program never condones euthanasia</td>
</tr>
<tr>
<td>• Grants approval to remove life-sustaining treatments when the burden imposed by them would be offset by a reasonable hope for recovery</td>
<td>• Does not provide permission for any affirmative or deliberative act or omission to end life</td>
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POLST allows the natural process of dying to progress

POLST IN PENNSYLVANIA COUNTY MAP

HISTORY OF POLST IN PA

2000 - Provider Task Force to Improve Care at the End-of-Life convened

2002 - Pittsburgh End of Life Collaborative, a quality improvement initiative within fourteen nursing homes. Funded by Highmark, UPMC and the Jewish Healthcare Foundation

2004 - Susan Tolle, MD, of the Oregon Health Sciences University Department of Ethics and a leader in the launching of POLST, spoke to group of community leaders

2004 - Coalition for Quality at the End of Life (CQEL) established

2007 - As mandated by Act 169, the Pennsylvania Department of Health Patient Life-Sustaining Wishes Committee convened

October 2010 - POLST approved by Pennsylvania Secretary of Health

January 2011 - Endorsed by the National POLST Paradigm Task Force
ACT 169 OF 2006
November 30, 2006

Comprehensive statute governing advance health care directives and health care decision-making for Incompetent patients.

PATIENT LIFE-SUSTAINING WISHES COMMITTEE

Committee established by the Department of Health to assist in determining the advisability of using a standardized form containing orders by qualified physicians that detail the scope of medical treatment based upon the patient’s life sustaining wishes.

The committee included representatives of:
- Pennsylvania Medical Society
- Hospital and Health System Association
- Joint State Government Commission’s Advisory Committee on Decedents’ Estate Law
- Pennsylvania Bar Association
- Departments of Aging and Public Welfare
- Other interested persons to represent geographical, religious and cultural diversity
PATIENT LIFE-SUSTAINING WISHES COMMITTEE

The committee’s charter was to include the examination of:

• The need to adopt a standardized form in view of the existing use of the do-not-resuscitate orders

• The use and evaluation of such forms in other states

• Any other matters determined by the Department of Health to be relevant to its determination

PATIENT LIFE-SUSTAINING WISHES COMMITTEE RECOMMENDATIONS

• Adopt a POLST form specific to Pennsylvania and includes an associated out-of-hospital (OOH-DNR) to assure that those completing POLST have access to the separate OOH-DNR order

• Require all licensed facilities in Pennsylvania accept and honor the POLST form as an acceptable medical order form

• DOH and other stakeholders explore potential regulatory or legislative actions to permit a single POLST form to serve as an Out-of-Hospital DNR order for the purpose of providing guidance to EMS personnel

• Convene at regular intervals the PLSWC to serve as an advisory board to those implementing and using POLST

OUT-OF-HOSPITAL DNR

EMS providers may only follow a PA OOH-DNR order, bracelet, or necklace.
POLST AND EMS

The standardized POLST allows for faster and more efficient discussion between EMS and the medical command physician.

RECENT POLST ACTIVITIES

- HAP series
- Funding of POLST Coordinator
- Statewide Closure meeting and POLST
- Transition of POLST form to the Institute of Aging website
- POLST grant
- Update on POLST tools
- DOH approached PMS to house POLST and convene stakeholders

PENNSYLVANIA POLST TOOLS

http://aging.upmc.com/professionals/resources-polst.htm

Resources:
- Pennsylvania Orders for Life-Sustaining Treatment (POLST)
- The goal of the POLST paradigm is to effectively communicate the wishes of seriously ill patients to have or to limit medical treatment as they move from one care setting to another.
- POLST: Respecting Patient Wishes Near the End of Life
- POLST Paradigm Care Elements
- PA Department of Health Out-of-Hospital Do-Not-Resuscitate (DNR) Orders
- PA Department of Health POLST Form
- Guidance for Health Care Professionals in Completing the POLST Form
- Information for Patients and Families
- Steps to Implement POLST
- POLST Brochure
- Resources
KEY POLICY ELEMENTS

- For newly admitted patients with a POLST form, acceptance of POLST forms signed by physicians or nurse practitioners not on staff
- Statement that completion of the POLST form is voluntary
- Recognition of the POLST form as a set of medical orders
- Who among staff will engage patients/resident's or their legal decision-makers in the POLST conversation
- If the resident/patient is unable to be engaged in the POLST conversation, a plan exists to assure that the conversation occurs with the appropriate decision-maker

KEY POLICY ELEMENTS

- Identify any limitations in the authority of the legal decision-maker contained in a health care power of attorney, and clearly identify the statutory limitations of authority for health care representatives and guardians under Pennsylvania law
- POLST forms are signed by either the patient or the legal decision-maker
- Guidelines on timeframes for:
  - The initial conversation
  - Obtaining a Physician / NP/ PA signature
  - Review and updating of form
- Accessing, placement and maintenance of residents’ POLST forms
- Assurance that the POLST form accompanies transferring or discharged patients across care settings

NURSING HOME SURVEY

- SurveyMonkey assessing POLST use and non-use in LTC conducted July 2012
- Long-term care facilities informed of survey through communication of in newsletters/bulletins
  - HAP – Hospital Affiliated Long-Term Care
  - LeadingAge PA
  - Pennsylvania Association of County Affiliated Homes
  - Pennsylvania Health Care Association
- Elements assessed include:
  - Reason for non-use
  - Who is having the POLST conversation
  - Is POLST being offered to all residents in a facility
  - Are patients transitioning in and out with POLST forms
  - Have facilities developed POLST policies
POLST NURSING HOME SURVEY

- Survey and other experience indicate only 10-20% of facilities use POLST
- Reasons for not using POLST
  - Area hospitals not using
  - No community initiative
  - Waiting corporate or administrative approval
  - No implementation plan or awaiting further information on plan
- NHs report the following levels of staff engage residents in conversation
  - Social workers (86%), Nurses (81%), Physicians (71%) CRNPs (33%)
- 94% of facilities using POLST have formal policies
- In NHs using POLST, needs exist for education on process, including
  - Quality improvement programs
  - POLST policies
  - Understanding of who can/should engage patients in POLST discussions
  - Awareness of authority differences of a competent patient, an agent, and representative

NEWS FROM SEPT PENNSYLVANIA MEDICAL SOCIETY (PAMED) BOARD MEETING

- Standardized POLST form would help improve care for seriously ill
- PAMED strongly supports the existence of a POLST program
- Will work vigorously during the next legislative session to pursue legislation for a standardized POLST program with oversight within state government

http://www.pamedsoc.org/

PMS RESOLUTION: PROVIDING A “HOME” FOR THE PA POLST PROGRAM

- Resolve that the Pennsylvania Medical Society expeditiously convene stakeholders with an interest in promoting the PA POLST program
- Goal of developing a “home” for the PA POLST program
- Include the maintenance of a website with appropriate educational materials
- Develop a steering committee responsible for the ongoing development, maintenance and quality assurance assessments necessary to maintain a quality POLST program
- Assess the need for legislative or regulatory initiatives to resolve the inability of EMS personnel to follow orders on a properly executed PA POLST form
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

TAKE HOME MESSAGES

• Have the conversation and ask the Surprise Question:
  – “Would you be surprised if your patient with advanced _____ died in the next year”? If the answer is “No”, likely appropriate for POLST
• Identify and utilize the resources available to train healthcare professionals to have effective POLST conversations
• Establish and apply POLST policies within your institutions
• Establish formal monitoring and evaluation processes

ADVANCE CARE PLANNING WEBSITE RESOURCES

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<thead>
<tr>
<th>Resource</th>
<th>Description</th>
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<tbody>
<tr>
<td><a href="http://www.pamedsoc.org">www.pamedsoc.org</a></td>
<td>Pennsylvania Medical Society A guide to Act 169 of 2006</td>
</tr>
<tr>
<td><a href="http://www.agingwithdignity.org">www.agingwithdignity.org</a></td>
<td>Five Wishes</td>
</tr>
<tr>
<td><a href="http://www.acba.org">www.acba.org</a></td>
<td>Allegheny County Bar Association/Allegheny County Medical Society Health Care Power of Attorney and Living Will Forms</td>
</tr>
<tr>
<td><a href="http://www.caringinfo.org">www.caringinfo.org</a></td>
<td>Download state specific Advance Directives</td>
</tr>
<tr>
<td><a href="http://www.hardchoices.com">www.hardchoices.com</a></td>
<td>“Hard Choices for Loving People”: A resource for professionals, patients and their families regarding end-of-life decisions</td>
</tr>
<tr>
<td><a href="http://www.eperc.mcu.edu">www.eperc.mcu.edu</a></td>
<td>End of life and palliative care education resource center</td>
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</table>
POLST WEB SITE RESOURCES

www.aging.pitt.edu/professionals/resources.htm Aging Institute of UPMC Senior Services and the University of Pittsburgh
www.polst.org Center for Ethics in Health Care Oregon Health & Science University
www.aarp.org AARP Public Policy Institute
www.ventusdfh.org West Virginia Center for End-of-Life Care POST
www.compassionandsupport.org Excellus Blue Cross Blue Shield MOLST

REFERENCES

Dunn, Patrick M, MD; Tolle, Susan W. MD; Moss, Alvin H. MD; Black, Judith S. MD, MHA. The Polst Paradigm: Respecting the Wishes of Patients and Families. Annals of Long-Term Care/Volume 15, Number 9/September 2007: 33-40.
Bomba, Patricia, MD., Kemp, Marian, Black Judith S., MD., POLST: An improvement over traditional advance directives, Cleveland Clinic Journal Of Medicine 79:4, July 2012
Bomba PA, Discussing Patient Preferences and End of Life Care, Journal of the Monroe County Medical Society, 7th District Branch, MSS91. 2011, April 11-15, http://www.compassionandsupport.org/docs/research/researches/monroecounty
Emmanuel, EJ, et. al. Managed Care, Hospice Use, Site of Death, and Medical Expenditures in the Last Year of Life. Arch Intern Med. 2002;162: 1722-1728.
REFERENCES


Questions?

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