Objectives

1. Define POLST and how it complements the health care directive.
2. Identify how POLST benefits both patients and healthcare professionals.
3. Describe the status of POLST in North Dakota.

What is POLST

Physician Orders for Life Sustaining Treatment (POLST) Paradigm

1991 - Originated in Oregon
- End of Life care not consistently honored.
- Advance Directives inadequate or did not exist
- Addresses needs of serious ill and frail
- Addresses medical emergency - life sustaining needs
- Spread to other states - NY, PA, WA, WV, WI
- Unique legal, medical, cultural, and environment contexts

Philosophy of POLST Paradigm

- Individuals have the right to make their own health care decisions
- These rights include:
  - Making decisions about life-sustaining treatment
  - Describing desires for life-sustaining treatment to health care providers
  - Receiving comfort care while having wishes honored

POLST...

- Provides thoughtful, facilitated advance care planning conversations
- Occurs between health care professionals and patients and those close to them
- Determines what treatments patients do and do not want
- Based on their personal beliefs and current state of health.
**POLST Outcomes**
- Improves the quality of patient care
- Reduces medical risks
- Identifies patients’ values and wishes regarding medical treatment
- Communicates and respects patient’s wishes by creating portable medical orders.

**2007 POLST Map**

**Who Should Have a POLST**
- Not for everyone
- Patients with serious illness, frailty
- The Surprise question:
  “Would you be surprised if this patient died in the next 12 months?”
How Does POLST Work?

- A set of medical orders
- Completed as a result of the process of shared decision-making facilitated conversations
- Values, beliefs, including spiritual and religious and goals for care (can be both realistic and more hopeful)
- The health care professional presents the patient’s diagnosis, prognosis, and treatment alternatives
- Reach an informed decision about desired treatment
- Follows patient across treatment settings

The POLST Conversation

- POLST is not just a check-box form.
- The POLST conversation provides context for patients/families to:
  - Make informed choices.
  - Identify goals of treatment.

Key Components of the POLST Form (cont)

- Form allows for clear directions about other life-sustaining treatment
- Form transfers with the patient
- Health professionals are trained to use the form and to have discussion to complete the form.
- Measures are made to monitor the success of the program and its implementation

Key Components of POLST Paradigm

1. Standardized practices, policies and form - Coalition
2. Education and Training
   a) Advance care planning facilitators
   b) System implementation
3. Timely discussions along continuum prompted by:
   a) Identification of appropriate cohort
   b) Prognosis
4. Medical orders honored throughout the system
5. Quality improvement process for form and system

(Hammes, 2010)

Advance Care Planning

Compassion, Support and Education along the Health-Illness Continuum

Chronic disease or functional decline
Advancing chronic illness
Multiple co-morbidities with increasing frailty
Allowing Natural Death
Maintain and maximize health and independence
Healthy and independent

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Key Components of the POLST Form

- Complete and Health Care Directive
- Update Health Care Directive Periodically
- Diagnosed with Advanced Illness or Frailty (at any age or last year of life)
- Complete a POLST Form
- Change in health status
- May Complete a new POLST Form
- Treatment Wishes Honored

How POLST Fit In?

Adapted with permission from California POLST Educates Program © January 2010 Coalition for Compassionate Care of California, with Permission

Age 18
Complete a Health Care Directive
Update Health Care Directive Periodically
Diagnosed with Advanced Illness or Frailty (at any age or last year of life)
Complete a POLST Form
Change in health status
May Complete a New POLST Form
Treatment Wishes Honored
How POLST and HCD Work Together?

- Complement each other
- Not intended to replace each other
- A Health Care Directive is necessary to appoint a legal health care representative and provide instructions for future life-sustaining treatments.
- The Advance Directive is recommended for all adults over 18, regardless of their health status
- POLST is recommended for elderly, seriously ill.
  “I wouldn’t be surprised if the person died in the next year”

Limitations of Healthcare Directives / Advance Directives (AD)

- Not available or known
- Not completed by most adults
- Not transferred
- Not specific enough
- May be overridden by a provider
- Do not translate into medical order
- Used only when patient/resident unable
- Used only under certain delineations

Comparing POLST Form to Healthcare Directive

<table>
<thead>
<tr>
<th></th>
<th>Healthcare Directive</th>
<th>POLST Paradigm Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>All adults &gt;18 y.o.</td>
<td>Any age, serious illness, at end of life or frailty</td>
</tr>
<tr>
<td>Time Frame</td>
<td>Future care/future conditions</td>
<td>Current care/current conditions</td>
</tr>
<tr>
<td>Where Completed</td>
<td>Any setting, not necessarily medical</td>
<td>Medical setting</td>
</tr>
<tr>
<td>Resulting Product</td>
<td>Healthcare agent appointed and/or statement of preferences</td>
<td>Medical orders based on shared decision making</td>
</tr>
<tr>
<td>Healthcare Agent Role</td>
<td>Cannot complete</td>
<td>Can consent if patient lacks capacity</td>
</tr>
<tr>
<td>EMS Role</td>
<td>Does not guide EMS</td>
<td>Guides EMS as a medical order</td>
</tr>
<tr>
<td>Portability</td>
<td>Patient/Family Responsibility</td>
<td>Healthcare Professional Responsibility</td>
</tr>
<tr>
<td>Periodic Review</td>
<td>Patient/Family Responsibility</td>
<td>Healthcare Professional Responsibility</td>
</tr>
</tbody>
</table>

Limitations of Healthcare Directives (cont)

- Not available or known
- Not completed by most adults
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Evidence of POLST Success

- Patient wishes recorded on a POLST form are honored 94% of the time in nursing homes (Hickman et al, 2010)
- POLST is an important evidence-based tool that helps ensure that patient wishes are honored and that unnecessary pain and suffering are avoided (Nisco et al, 2011)
- POLST program serve as an effective approach to both document a patient’s treatment plan and to honor this plan in several settings (Hammes et al, 2012)
- Electronic registry of POLST forms can be used by EMTs to enhance their ability to locate and honor patient preferences regarding life-sustaining treatments (Schmidt et al, 2014).
- POLST form use is supported by the American Hospital Association, AARP, the National Hospice and Palliative Care Organization (IOM, 2014)
Current Research

- POLST studies reflect development and validation of best practices to ensure the integrity of these program models as they are diffused to other settings (IOM, 2014)
- Better use of technology to ensure patient preferences are honored with inclusion of POLST (NPPTF, 2016)
- 20 years of documented benefits of the POLST paradigm supports it nationwide implementation (Tolle et al., 2016)
- The POLST paradigm is an effective means to assure that resuscitation orders are consistent with medical indications and patient preference (Derse, 2017)
- With POLST, patient’s preference are documented in a manner that assure implementation (Pope, 2017).

Development of POLST in ND

- 2005- Interest in Grand Forks
- 2007-2010 Grand Forks Pilot Program
- 2010- Endorsed by the ND Medical Association
- Under the NDMA Ethics Committee
- 2013- Assigned to ND Healthcare Review (Minot)
- Sally May, RN, BSN, Quality Improvement Specialist
- Invited interested parties throughout the state
- Grew from 10 to 40 members

Development of ND POLST (cont)

- 2013- current: POLST workgroup formed, including representation from:
  - EMT, RN, APRN, SW, Chaplain, MD, JD
  - Fargo, Bismarck, Minot, Grand Forks
- 2014-2016:original 2007 Altru POLST form updated
- 2016- POLST provider feedback survey sent out
- 25 completed responses
- 24 accepted the entire form
Who Can Help Complete POLST?

- Healthcare providers – “licensed, certified, or otherwise authorized to provide healthcare in the normal course of business.”
- Best practice suggests use of those trained in the POLST Conversation:
  - Physicians
  - Nurses, Nurse Practitioners, Physician Assistants
  - Social Workers
  - Chaplains
  - Social Service Designees
  - (with permission, Coalition for Compassionate Care of California, 2016)

Diagram of POLST Medical Interventions

*CPR

Full Treatment*

Selective Treatment

Comfort-Focused Treatment

*Consider time/prognosis factors under “Full Treatment”
"Trial Period of Full Treatment" may be checked if prolonged life support is not desired.
(with permission, Coalition for Compassionate Care of California, 2016)
When Should POLST be Reviewed?

- Transfer from one care setting to another.
- Change in patient’s health condition.
- Patient’s treatment preferences change.
- Patient Care Conference.

Recommendation: Update POLST forms to the 2016 version when reviewing 2007 POLST forms.

Where Should We Keep POLST?

Original ND POLST with green trim stays with patient

At SNF/Hospital:
- File in medical chart (with HCD)
- Send original with patient upon return to home/SNF/hospital.
- Keep copy if patient transferred; review POLST upon patient’s return.

Where Should We Keep POLST at Home?

At home:
- Post in easy-to-find location (AHCD).
- Examples (On Refrigerator, on the wall, by their bed or with medications)
- Give to EMS to transport with patient.
2014 American Medical Directors Association (AMDA) Statement

AMDA’s House of Delegates Reinforces
Mission of Quality Care

**D14: Physician Orders for Life-Sustaining Treatments (POLST):** AMDA will promote the POLST paradigm by supporting education about, dissemination and appropriate use of, and resident access to the POLST Paradigm and other advance care planning materials and collaborate with the National POLST Task Force in order to improve advance care planning for the post-acute and long-term care population.

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**Current Status**
- Website presence: [www.honoringchoicesnd.org/polst](http://www.honoringchoicesnd.org/polst)
- CME being developed for website
- Policies for hospital, nursing home, EMS through National POLST toolkit

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**Conclusion**
- The POLST paradigm is generally being accepted as the standard of care
- The POLST programs are implemented in most states of the U.S.
- The POLST conversation and forms help translate a patient’s wishes for medical treatment into medical orders, benefiting both patients and healthcare professionals.
- The POLST complements the Health Care Directive.
- The POLST is being accepted statewide in North Dakota.

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**For more Information of ND POLST**
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**References 1 of 4**
- Coalition for Compassionate Care of California (CCCC). (2016). California POLST National Training slides. (With permission)
References 2 of 4


References 3 of 4


References 4 of 4

- POLST Toolkit- www.polst.org/toolkit