POLST in ND

Physician Orders for Life Sustaining Treatment

2017 Dakota Conference

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Honoring Choices® NORTH DAKOTA

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.

Physician Orders For Life Sustaining Treatment (POLST) Paradigm

What is POLST

Physician **O**rders for **L**ife **S**ustaining **T**reatment

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…

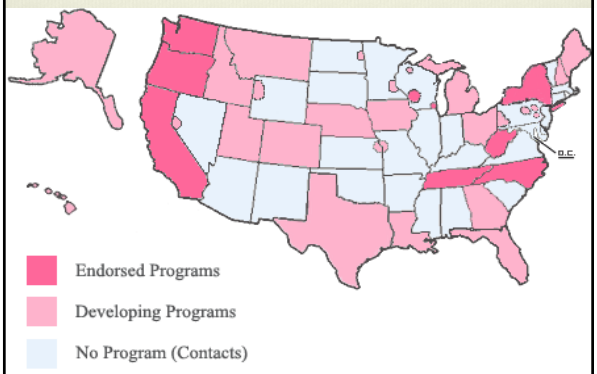
- Provides thoughtful, facilitated advance care planning conversations
- Occurs between health care professionals and patients and those close to them
- Determines what treatments patients **do and do not want**
- Based on their personal beliefs and current state of health.

POLST Outcomes

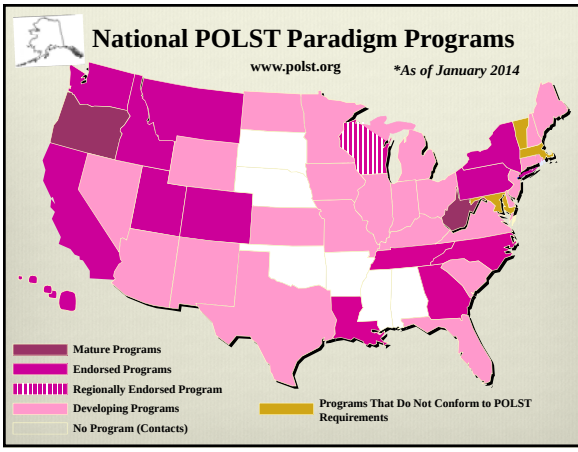
- Improves the quality of patient care
- Reduces medical risks
- Identifies patients' values and wishes regarding medical treatment
- Communicates and respects patient's wishes by creating portable medical orders.

2007 POLST Map

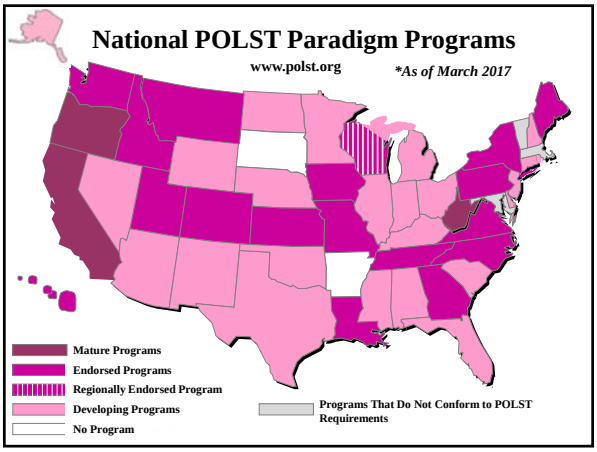
2009- 34 states



National POLST Paradigm Programs



National POLST Paradigm Programs



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
- The benefits and burdens of life-sustaining treatment.
- 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 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

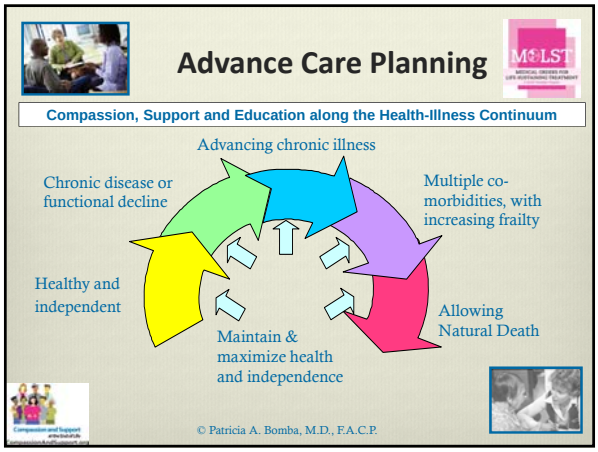
(Hammes, 2010)

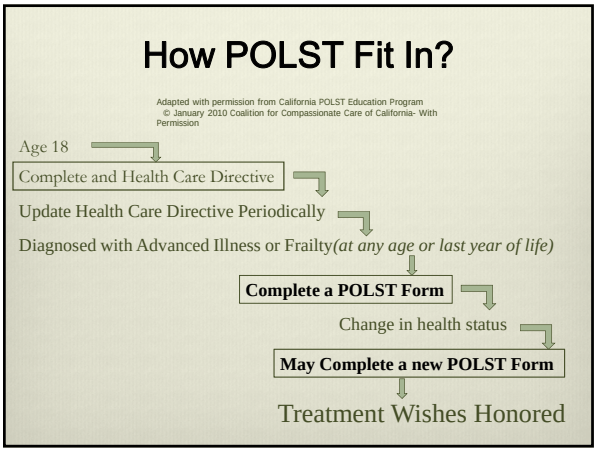
Key Components of the POLST Form

(cont)

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

(Hammes, 2010)





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"

Comparing POLST Form to Healthcare Directive

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

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

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Limitations of Healthcare Directives (cont)

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POLST: Doing It Better

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 servse 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).

ND POLST Program

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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

North Dakota POLST Form- Completion & Implementation

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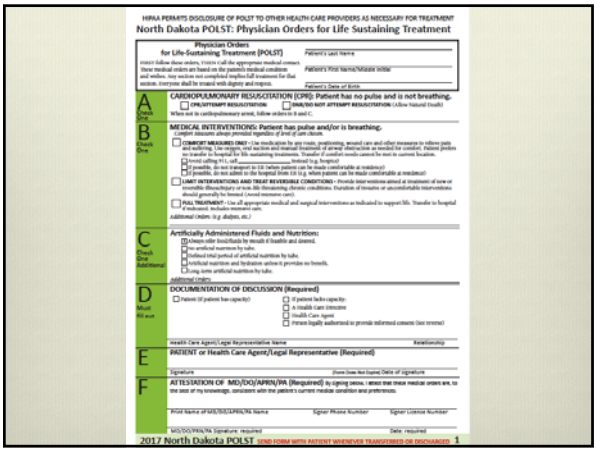

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth

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

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

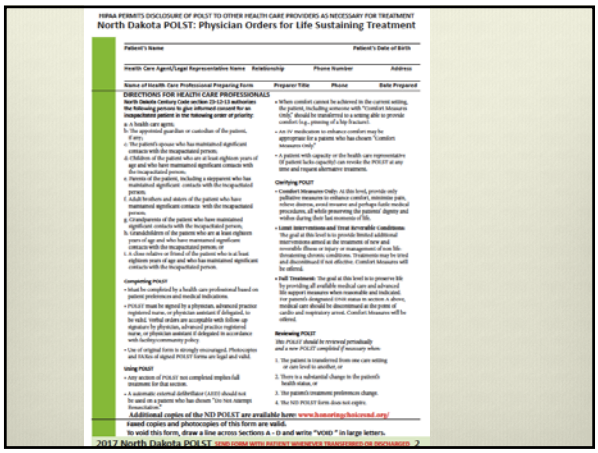
C — Artificially Administered Fluids and Nutrition:

D — DOCUMENTATION OF DISCUSSION (Required)

E — PATIENT or Health Care Agent/Legal Representative (Required)

F — ATTESTATION OF MD/DO/APRN/PA (Required)

2017 North Dakota POLST SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED 1


HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Patient's Name | Patient's Date of Birth

Health Care Agent/Legal Representative Name | Relationship | Phone Number | Address

Name of Health Care Professional Preparing Form | Preparer Title | Phone | Date Prepared

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

North Dakota Century Code section 23-12-13 authorizes the following persons to give informed consent for an incapacitated patient in the following order of priority:

a. A health care agent.
b. The appointed guardian or custodian of the patient, if any.
c. The patient's spouse who has maintained significant contacts with the incapacitated person.
d. Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person.
e. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person.
f. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person.
g. Grandparents of the patient who have maintained significant contacts with the incapacitated person.
h. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person, or
i. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Competing POLST
- Must be completed by a health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician, advanced practice registered nurse, or physician assistant if delegated, to be valid. Verbal orders are acceptable with follow up signature by physician, advanced practice registered nurse, or physician assistant if delegated in accordance with facility/community policy.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST
- Any section of POLST not completed implies full treatment for that section.
- A automatic external defibrillator (AED) should not be used on a patient who has chosen "Do Not Attempt Resuscitation."

Additional copies of the ND POLST are available here: www.honoringchoicesnd.org/

Faxed copies and photocopies of this form are valid.

To void this form, draw a line across Sections A - D and write "VOID" in large letters.

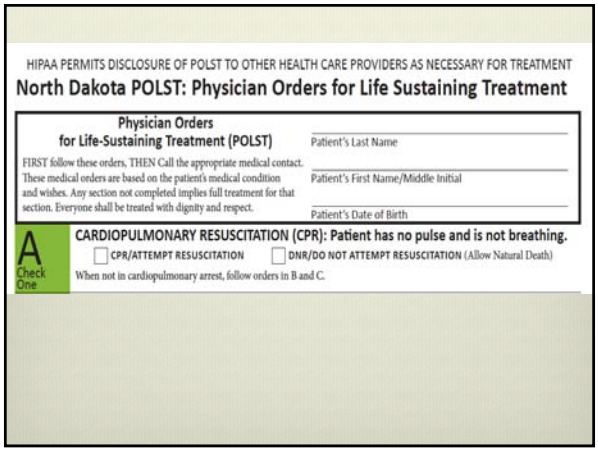
Clarifying POLST
- Comfort Measures Only: At this level, provide only palliative measures to enhance comfort, minimize pain, relieve distress, avoid invasive and perhaps futile medical procedures, all while preserving the patients' dignity and wishes during their last moments of life.
- Limit Interventions and Treat Reversible Conditions: The goal at this level is to provide limited additional interventions aimed at the treatment of new and reversible illness or injury or management of non life-threatening chronic conditions. Treatments may be tried and discontinued if not effective. Comfort Measures will be offered.
- Full Treatment: The goal at this level is to preserve life by providing all available medical care and advanced life support measures when reasonable and indicated. For patients designated DNR status in section A above, medical care should be discontinued at the point of cardio and respiratory arrest. Comfort Measures will be offered.

Reviewing POLST
The POLST should be reviewed periodically and a new POLST completed if necessary when:
1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change.
4. The ND POLST form does not expire.

2017 North Dakota POLST SEND DOWN WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED 2

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)


HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth

A Check One

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

☐ CPR/ATTEMPT RESUSCITATION ☐ DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

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

Diagram of POLST Medical Interventions

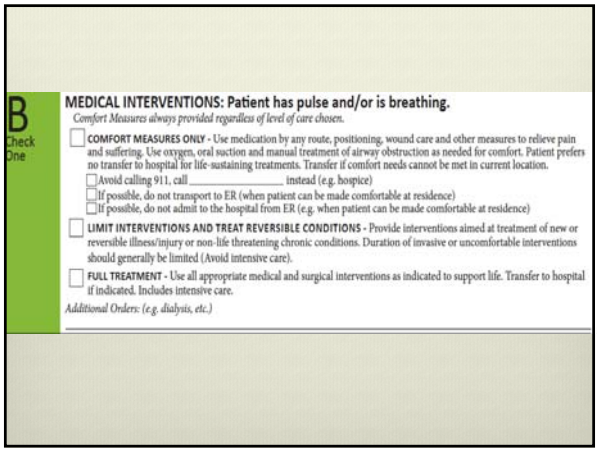
CPR

→ 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)


B Check One

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

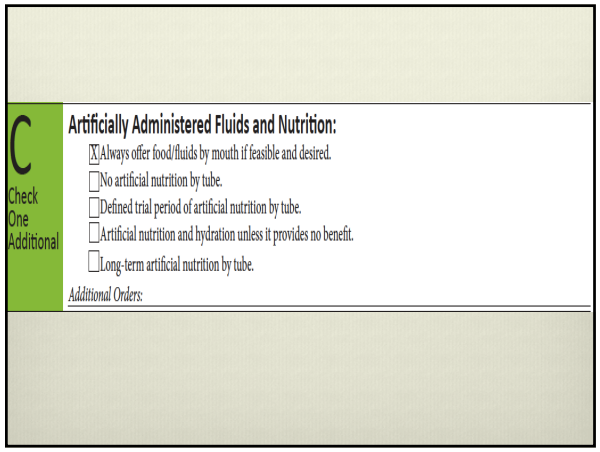
Comfort Measures always provided regardless of level of care chosen.

☐ COMFORT MEASURES ONLY - Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.
- ☐ Avoid calling 911, call _____ instead (e.g. hospice)
- ☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
- ☐ If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

☐ LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS - Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited (Avoid intensive care).

☐ FULL TREATMENT - Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

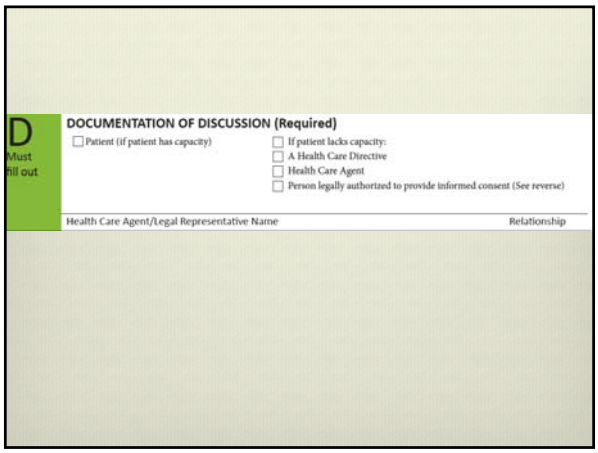
Additional Orders: (e.g. dialysis, etc.)

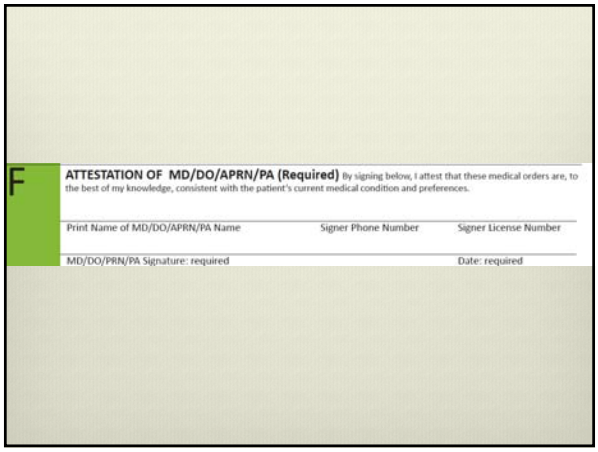

C Check One Additional

Artificially Administered Fluids and Nutrition:

- ☒ Always offer food/fluids by mouth if feasible and desired.
- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Artificial nutrition and hydration unless it provides no benefit.
- ☐ Long-term artificial nutrition by tube.

Additional Orders:





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?

<u>Original ND POLST with green trim stays with patient</u>

- 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
- CME being developed for website
- Policies for hospital, nursing home, EMS through

National POLSTtoolkit

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, benefitting both patients and healthcare professionals.
- The POLST complements the Health Care Directive.
- The POLST is being accepted statewide in North Dakota.

For more Information of ND POLST

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POLST

physician orders for life-sustaining treatment paradigm

www.POLST.org

References 1 of 4

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