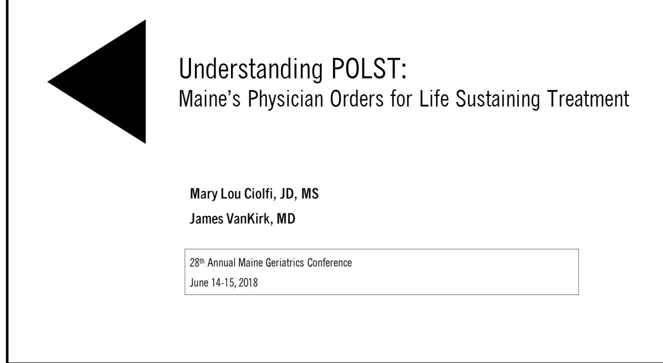
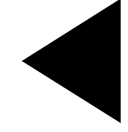




Agenda

- What is POLST?
- Advance Care Planning
- History of POLST
- Use of POLST
- POLST in the Research
- POLST Forms and Training
- POLST Resources

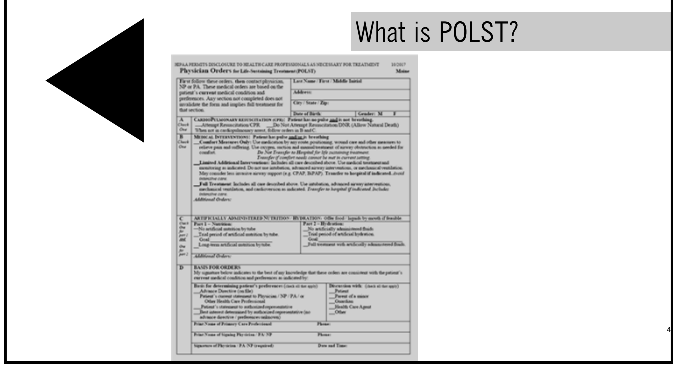
2

Experience with POLST?

- Never heard of it
- Heard of it, but don't really know what it is
- Heard of it and want to use it, but don't know how
- Heard of it, use it, and want to know more

3

What is POLST?


HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT 10/2017

Physician Orders for Life-Sustaining Treatment (POLST) **Maine**

First follow these orders, then contact physician, NP or PA. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.	Last Name / First / Middle Initial Address: City / State / Zip: Date of Birth: Gender: M F

A (Check One) CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse **and** is not breathing.
___Attempt Resuscitation/CPR ___Do Not Attempt Resuscitation/DNR (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in B and C.

B (Check One) MEDICAL INTERVENTIONS: Patient has pulse **and/or** is breathing
___**Comfort Measures Only:** 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. Transfer if comfort needs cannot be met in current setting.*
___**Limited Additional Interventions:** Includes all care described above. Use medical treatment and monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated.** *Avoid intensive care.*
___**Full Treatment:** Includes all care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*
Additional Orders:

C ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION: Offer food / liquids by mouth if feasible.

Part 1 – Nutrition:	Part 2 – Hydration:
___No artificial nutrition by tube	___No artificially administered fluids
___Trial period of artificial nutrition by tube. Goal:___	___Trial period of artificial hydration. Goal:___
___Long-term artificial nutrition by tube.	___Full treatment with artificially administered fluids.

Additional Orders:

D BASIS FOR ORDERS
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences as indicated by:

Basis for determining patient's preferences (check all that apply)	Discussion with: (check all that apply)
___Advance Directive (on file)	___Patient
Patient's current statement to Physician / NP / PA / or Other Health Care Professional	___Parent of a minor
___Patient's statement to authorized representative	___Guardian
___Best interest determined by authorized representative (no advance directive / preferences unknown)	___Health Care Agent
	___Other

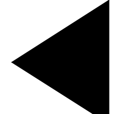
Print Name of Primary Care Professional: Phone:
Print Name of Signing Physician / PA/ NP Phone:
Signature of Physician / PA /NP (required) Date and Time:

4

Advance Care Planning

5

Advance Care Planning



What is Advance Care Planning
(and why don't we have Advance Directives)

- Directing our care in advance
- Contemplation of treatment wishes
- Discussion with family/friends
- Discussion with medical providers
- Documentation
- Older person patients self-perceived barriers:
  - Irrelevant ◆ Don't want to burden others ◆ Don't have family

Schickedanz, A. D., Schillinger, D., Landefeld, C. S., Knight, S. J., Williams, B. A., & Sudore, R. L. (2009). A Clinical Framework for Improving the Advance Care Planning Process: Start with Patients' Self-identified Barriers. *Journal of the American Geriatrics Society, 57*(1), 31–39.

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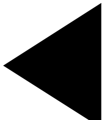


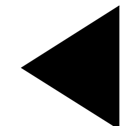
Advance Care Planning

NOT just forms

Advance Care Planning is a process

Conversations are a key part of ACP

7

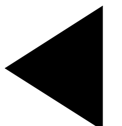


Advance Care Planning

Advance Directives vs POLST

Advance Directive (in the future)	POLST (in the near term)
• Everyone 18 and older	• People with advanced frailty/ illness
• Assignment of HPOA	• No HPOA Assignment
• Not a Physician Order Set	• Physician Order Set
• Other Planning Pieces (organ donation, funeral plan)	• No other planning pieces

8



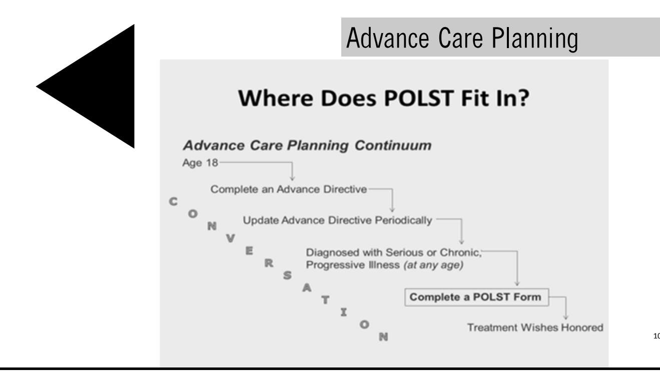
Advance Care Planning

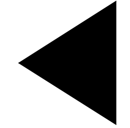
Maine Health Care
Advance Directive Form

You may use this form now to tell your physician and others what medical care you want to receive if you become too sick in the future to tell them what you want. **You may choose to fill out the whole form or any part of the form and then sign and date the form in Part 6.** These are the parts:

Part 1	Fill this out if you want to choose someone to make all your health care decisions for you, either right away or if you become too sick to tell others what you want. This person is called your agent.
Part 2	Fill this out if: (1) you did not name an agent in Part 1 and now want to choose whether you want certain treatments or, (2) you did name an agent in Part 1 and want to tell your agent your wishes about certain treatments, knowing that your agent must follow your directions.
Part 3	Fill this out if you want to give the name of your primary physician, physician assistant or nurse practitioner.
Part 4	Fill this out if you want to make decisions about donating your organs, body or tissues after your death.
Part 5	Fill this out if you want: (1) to choose someone to make all funeral and burial decisions after your death, **or** (2) to tell your family any wishes you have about funeral and burial decisions.
Part 6	You must sign and date your Advance Directive form on this page. Have two witnesses sign the form at the same time you sign it. Tell others about your decisions and give copies to your physician, other health care providers, family and hospital.
Part 7	If you do not wish to be revived by ambulance crews should your heart or breathing stop, then you **and** your physician (or nurse practitioner or physician assistant) need to sign this Do Not Resuscitate (DNR) form.

9



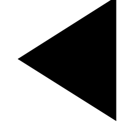


Advance Care Planning

Conversations: What is a Life Worth Living?

- Goals
- Fears/Worries
- Sources of Strength
- Critical Abilities
- Tradeoffs
- Family (as defined by person)

11



Advance Care Planning

Goals of Care Conversations

- Let go of trying to say the "perfect" thing
- People will forget what you said but they won't forget how you made them **feel**. (Paraphrase of Maya Angelou)
- As much as possible, use POSITIVE language
- Do NOT be afraid to guide
- Provide support
- Put away forms (AD / POLST) if resistance is present

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History of POLST

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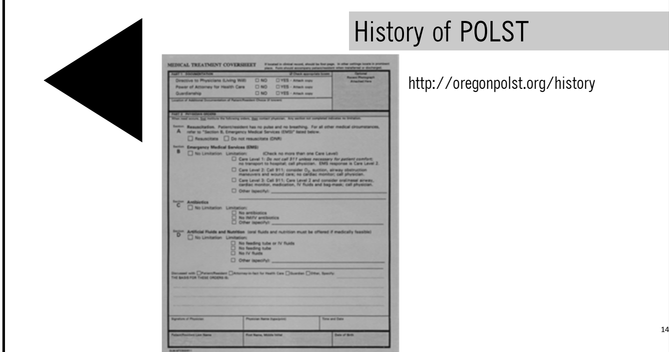

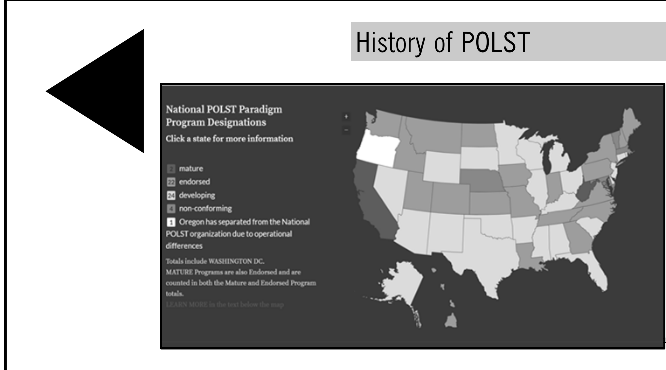

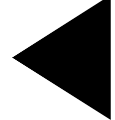

History of POLST

https://youtu.be/IxT4XKP__7c

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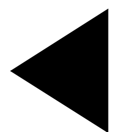
Use of POLST

17



Use of POLST

Who Can Help Complete POLST?

- Healthcare providers
- Best practice: those trained in the POLST Conversation:
  - Physicians
  - Nurses
  - Social Workers
  - Chaplains
  - Social Service designees (e.g. Hospice volunteer)
- POLST in Maine video
  https://www.youtube.com/watch?v=IxT4XKP__7c

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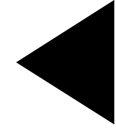

Use of POLST

Maine's POLST Form

- Updated 2017
- Single page, double-sided
- Standardized color paper #24 lime green

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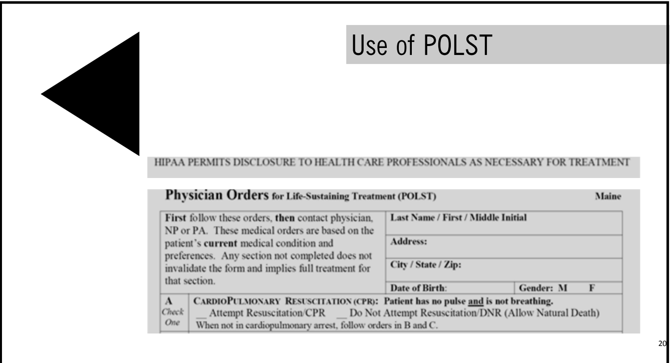
Use of POLST



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

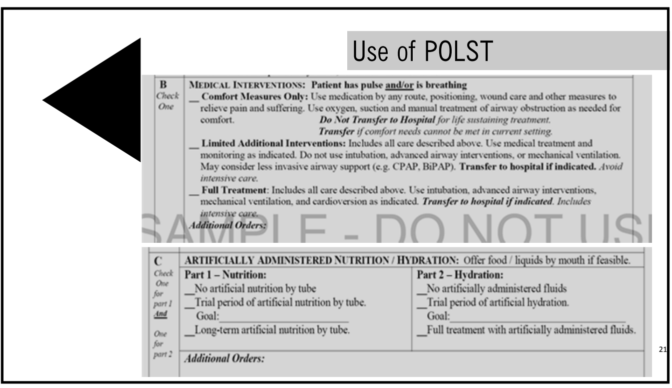
Physician Orders for Life-Sustaining Treatment (POLST) **Maine**

First follow these orders, **then** contact physician, NP or PA. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.	**Last Name / First / Middle Initial**	
	Address:	
	City / State / Zip:	
	Date of Birth:	**Gender: M F**

A *Check One*	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** __ Attempt Resuscitation/CPR __ Do Not Attempt Resuscitation/DNR (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in B and C.

20

Use of POLST



B *Check One*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing

__ **Comfort Measures Only:** 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.* ***Transfer*** *if comfort needs cannot be met in current setting.*

__ **Limited Additional Interventions:** Includes all care described above. Use medical treatment and monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated.** *Avoid intensive care.*

__ **Full Treatment**: Includes all care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer to hospital if indicated***. *Includes intensive care.*

Additional Orders:

SAMPLE - DO NOT USE

C *Check One for part 1 And One for part 2*

ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION: Offer food / liquids by mouth if feasible.

Part 1 – Nutrition:	**Part 2 – Hydration:**
__No artificial nutrition by tube	__No artificially administered fluids
__Trial period of artificial nutrition by tube.	__Trial period of artificial hydration.
Goal:______________	Goal:______________
__Long-term artificial nutrition by tube.	__Full treatment with artificially administered fluids.

Additional Orders:

21

Use of POLST

D	BASIS FOR ORDERS My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences as indicated by:	
	Basis for determining patient's preferences (check all that apply) __ Advance Directive (on file) __ Patient's current statement to Physician / NP / PA / or Other Health Care Professional __ Patient's statement to authorized representative __ Best interest determined by authorized representative (no advance directive / preferences unknown)	**Discussion with:** (check all that apply) __ Patient __ Parent of a minor __ Guardian __ Health Care Agent __ Other
	Print Name of Primary Care Professional	**Phone:**
	Print Name of Signing Physician / PA/ NP	**Phone:**
	Signature of Physician / PA /NP (required)	**Date and Time:**

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Use of POLST

E	**Signature of Patient or Authorized Representative** This form records your preferences for life-sustaining treatment in your **current** state of health. It can be reviewed and updated by your health care professional at any time if your preferences or condition change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by the authorized representative named below.		
	Signature	**Name (print)**	**Relationship (write 'self' if patient)**
	Name of Authorized Representative	**Relationship**	**Address & Phone**

Health Care Professional Preparing Form	Title	Phone	Date

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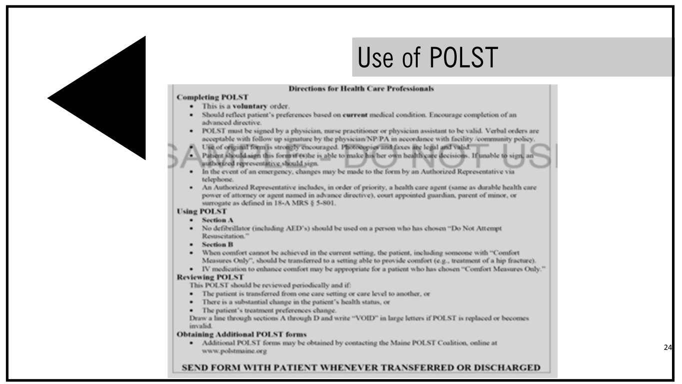
Use of POLST



Directions for Health Care Professionals

Completing POLST

- This is a **voluntary** order.
- Should reflect patient's preferences based on **current** medical condition. Encourage completion of an advanced directive.
- POLST must be signed by a physician, nurse practitioner or physician assistant to be valid. Verbal orders are acceptable with follow up signature by the physician/NP/PA in accordance with facility /community policy.
- Use of original form is strongly encouraged. Photocopies and faxes are legal and valid.
- Patient should sign this form if (s)he is able to make his/her own health care decisions. If unable to sign, an authorized representative should sign.
- In the event of an emergency, changes may be made to the form by an Authorized Representative via telephone.
- An Authorized Representative includes, in order of priority, a health care agent (same as durable health care power of attorney or agent named in advance directive), court appointed guardian, parent of minor, or surrogate as defined in 18-A MRS § 5-801.

Using POLST

- **Section A**
- No defibrillator (including AED's) should be used on a person who has chosen "Do Not Attempt Resuscitation."
- **Section B**
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only."

Reviewing POLST

This POLST should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Draw a line through sections A through D and write "VOID" in large letters if POLST is replaced or becomes invalid.

Obtaining Additional POLST forms

- Additional POLST forms may be obtained by contacting the Maine POLST Coalition, online at www.polstmaine.org

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

SAMPLE - DO NOT USE

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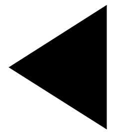

Use of POLST

Reviewing POLST

- Transfer from one care setting to another
- A substantial change in patient's health status
- Patient's treatment preferences change
- Patient care conference
- Annually (for EMS)

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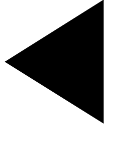

Use of POLST

Intervention Efficacy for Advanced Frailty or Illness

- Hospitalization
- Cardiopulmonary Resuscitation
- Surgical procedures
- Dialysis
- Artificial Nutrition and Hydration
- Time limited trails
- Tying "quality of life" to interventions

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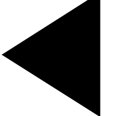

Current Successes & Challenges

Successes

- Patients and families are relieved
- EMHS has adopted a system-wide policy

Challenges

- Improper use
- Modification of form
- System-level adoption

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POLST Research

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POLST in the Research

What is the Evidence base for POLST?

Mixed

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POLST in the Research

The Good News - Consistency between treatments and orders

98% Consistency with CPR orders

91% Consistency with medical orders

93% Consistency with antibiotic orders

Hickman, S. E., Keevern, E., & Hammes, B. J. (2015). Use of the physician orders for life-sustaining treatment program in the clinical setting: a systematic review of the literature. *Journal of the American Geriatrics Society, 63*(2), 341-35.

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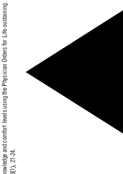

POLST in the Research

Mandatory POLST training:

- Increased POLST completion
- Improved clinician comfort with conversations
- Did not change EOL attitudes

McGough, N. N., Hauschildt, B., Mollon, D., & Fields, W. (2015). Nurses' knowledge and comfort levels using the Physician Orders for Life-sustaining Treatment (POLST) form in the progressive care unit. *Geriatric Nursing*, 36(1), 21-24.

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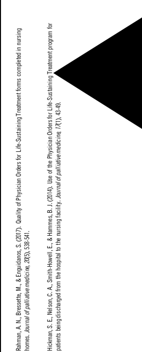

POLST in the Research

The Not-So-Great News

At hospital discharge to nursing facility:

- Poor quality of POLST orders at nursing facility
- Physicians are using "advisory POLST" (which is not a best practice)
- Still confusion in the ED

Rahman, A. N., Bressette, M., & Enguidanos, S. (2017). Quality of Physician Orders for Life-Sustaining Treatment forms completed in nursing homes. *Journal of palliative medicine*, 20(5), 538-541.

Hickman, S. E., Nelson, C. A., Smith-Howell, E., & Hammes, B. J. (2014). Use of the Physician Orders for Life-Sustaining Treatment program for patients being discharged from the hospital to the nursing facility. *Journal of palliative medicine*, 17(1), 43-49.

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POLST in the Research

Some Interesting Evidence

- POLST forms signed by surrogates
- Timing of POLST by cause of death
- No sense of too early or too late, just patterns
- But over 90% were completed in the last year of life

Zive, D. M., Fromme, E. K., Schmidt, T. A., Cook, J. N., & Tolle, S. W. (2015). Timing of POLST form completion by cause of death. *Journal of pain and symptom management*, 50(5), 650-658.

Hammes, B. J., Rooney, B. L., Gundrum, J. D., Hickman, S. E., & Hager, N. (2012). The POLST program: a retrospective review of the demographics of use and outcomes in one community where advance directives are prevalent. *Journal of palliative medicine*, 15(1), 77-85.

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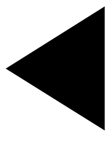

POLST in the Research

The Direction of Future Research

National Academy of Medicine (IOM) *Dying in America* (2014)

- http://www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx
- Research Needs

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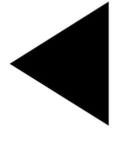

POLST Forms & Training

- POLST forms – updated in 2017
- Train-the-trainer sessions – next August 3, 2018 - Gorham House
- Individual training sessions – Contact Maine Hospice Council
- POLST monthly phone calls
- Individual health system efforts and policies

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POLST Resources

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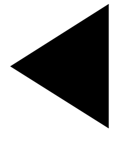

Resources

- National POLST Paradigm
  - http://polst.org/
  - Professional and Patient Resources
- National Healthcare Decision Day – April 16th
  - https://www.nhdd.org/
- The Conversation Project
  - https://theconversationproject.org/
- National Institutes of Health
  - https://www.nia.nih.gov/health/advance-care-planning-healthcare-directives

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QUESTIONS?

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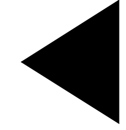

Contact Information

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marylou.ciolfi@maine.edu

Maine Hospice Council and Center for End-of-Life Care
http://mainehospicecouncil.org/
Kandyce Powell, RN

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