Understanding POLST:
Maine’s Physician Orders for Life Sustaining Treatment

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Agenda

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

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
What is POLST?

Advance Care Planning

- 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

Advance Care Planning

**NOT just forms**

Advance Care Planning is a process

Conversations are a key part of ACP

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**Advance Care Planning**

**Advance Directives vs POLST**

<table>
<thead>
<tr>
<th>Advance Directive (in the future)</th>
<th>POLST (in the near term)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyone 18 and older</td>
<td>People with advanced frailty/illness</td>
</tr>
<tr>
<td>Assignment of HPOA</td>
<td>No HPOA Assignment</td>
</tr>
<tr>
<td>Not a Physician Order Set</td>
<td>Physician Order Set</td>
</tr>
<tr>
<td>Other Planning Pieces (organ donation, funeral plans)</td>
<td>No other planning pieces</td>
</tr>
</tbody>
</table>

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**Advance Care Planning**

**Maine Health Care Advance Directive Form**

- Part 1: Your name, date of birth, as well as any legal names you have ever used.
- Part 2: Your description of a medical condition or treatment for which you would want life-sustaining treatment to be stopped.
- Part 3: Your instructions for when a medical condition or treatment is considered to be life-sustaining or non-life-sustaining.
- Part 4: Your instructions for when a medical condition or treatment is considered to be life-sustaining or non-life-sustaining.
- Part 5: Your instructions for when a medical condition or treatment is considered to be life-sustaining or non-life-sustaining.
- Part 6: Your instructions for when a medical condition or treatment is considered to be life-sustaining or non-life-sustaining.
- Part 7: Your instructions for when a medical condition or treatment is considered to be life-sustaining or non-life-sustaining.

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**Advance Care Planning**

- Great.
Advance Care Planning

Where Does POLST Fit In?

Advance Care Planning Continuum

- Complete an Advance Directive
- Update Advance Directive Periodically
- Diagnosed with Serious or Chronic, Progressive Illness at any age

Complete a POLST Form

Treatment Wishes Honored

Advance Care Planning

Conversations: What is a Life Worth Living?

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

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
History of POLST

http://oregonpolst.org/history
History of POLST

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
Use of POLST

Maine’s POLST Form

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

[Image of Maine’s POLST Form]

Use of POLST

[Image of POLST form with instructions and options]
Use of POLST

**BASIC END OF LIFE 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:

- **Indicate advance directive (not for CRF):**
  - Patient
  - Parent of a minor
  - Guardian
  - Health Care Agent
  - Other

- **Specify to advance directive representative (not for CRF):**

**Print Name of Primary Care Provider:**
Phone:

**Signature of Physician/PA/NP:**
Date and Time:

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**Use of POLST**

**Signature of Patient or Authorized Representative:**
This form must be completed by the patient’s current provider. It can be reviewed and updated by both healthcare providers and patients at any time if preferences or conditions change. It is highly recommended to make your own health care decisions, but the orders should reflect your preferences as best professional judgment allows.

<table>
<thead>
<tr>
<th>Name of Authorized Representative</th>
<th>Relationship (term “off” if patient)</th>
<th>Health Care Professional Preparing Form</th>
</tr>
</thead>
</table>

**Use of POLST**

**Indications for Health Care Professionals:**
- Use if patient is not competent to make end-of-life decisions.
- Provide patient with patient’s current medical condition. Ensure completion of the POLST form by the patient’s current provider.
- Use the form as an aid in making end-of-life decisions. Use it to help facilitate conversations between family members, patients, and health care providers.
- Complete the form as a guide to end-of-life decisions. Use it to help patients and families make informed decisions about end-of-life care.

**Patients’ Rights:**
- I hereby authorize the attending physician to administer all necessary medical and/or surgical procedures which may be required to maintain life in cases of acute, chronic, or terminal illness.
- I hereby authorize the attending physician to discontinue all life-sustaining treatment which I may receive.

**Choosing While Dying:**
- The attending physician or the attending physician’s delegated provider shall have the authority to advise the patient, family, or legal representative of the patient’s death and the necessity to take action to ensure that the patient’s death occurs as the attending physician or the attending physician’s delegated provider directs.

**Obtaining Additional POLST Forms:**
- The patient is free to obtain additional copies of the POLST form at any time, as necessary or desired.

**SEND FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED:**

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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)

Use of POLST

Intervention Efficacy for Advanced Frailty or Illness
- Hospitalization
- Cardiopulmonary Resuscitation
- Surgical procedures
- Dialysis
- Artificial Nutrition and Hydration
- Time limited trials
- Tying “quality of life” to interventions

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
What is the Evidence base for POLST?

**The Good News** - Consistency between treatments and orders

- 98% Consistency with CPR orders
- 91% Consistency with medical orders
- 93% Consistency with antibiotic orders

### Mandatory POLST training:
- Increased POLST completion
- Improved clinician comfort with conversations
- Did not change EOL attitudes

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### 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

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### 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
The Direction of Future Research

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

- Research Needs

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

POLST Resources
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

QUESTIONS?

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