2014 POLST: A Training for Health Care Professionals

Disclosure Information
Continuing Medical Education committee members and those involved in the planning of this CME Event have no financial relationships to disclose.

Richard J. Moore, MD
I have no financial relationships to disclose.
I will not discuss off label use/or investigational use in my presentation.

Objectives
- Describe the purpose of the Physician Orders for Life-Sustaining Treatment (POLST)
- Differentiate between the POLST, DNR, and Advance Directive forms
- Understand the legal implications of the POLST
- Identify the effect of age and other risk factors as outcome predictors for patients who experience cardiac arrest in various settings
**CPR That People Know**

- CPR on TV shows
- 1 year of medical TV series
- SUCCESS 75% OF THE TIME!
- Leads the viewing public to have an unrealistic impression of CPR and its chances for success.


---

**CPR in the Real World**

- 2010 study of 95,000+ cases
- 8% survived more than 1 month
  - About 3% could lead a mostly normal life
  - A little more than 3% in vegetative state
  - About 2% were alive but had a “poor” outcome

*Crit Care* 2010; 14(6)

---

**CPR in the Real World**

- 2000 study of 2,600 out-of-hospital cases
- 40s and 50s = highest rate of success = 10%
- 60s = 8.1%
- 70s = 7.1%
- After 80 = 3.3% survived to hospital discharge

*Acad Emergency Med* 2000; 7(7) 762-768
CPR in the Real World

- 69 patients in cardiac arrest
- Paramedics and emergency physicians
- 10 regained a pulse
- At 48 hours … none survived

"L'inconnue de la Seine"

The Most Kissed Face of All Time

- 1960
- Peter Safar, Austrian physician
- Asmund Laerdahl, Norwegian toymaker
Resusci Anne

Practitioners

• They’ve changed!

Marcus Welby, M.D.

Dr. House
Medical Care at the End of Life

• 25% of Medicare spending each year on 5% of people who die
• 50% cost on last 2 months of life
• Despite high spending, quality of care is poor
• People receive care
  – They do not want
  – From which they cannot benefit
• People fail to receive care
  – They do want
  – From which they will benefit

Physician Orders for Life-Sustaining Treatment

• POLST is effective in reducing unwanted hospitalization & medical intervention

Evidence-Based Potential Harms of Hospitalization

• Especially in the late stage populations
• Thirteen (13) evidenced based reasons hospitalization harms these demographics: the “iatrogenic consequences of hospitalization.”
  1. Physical trauma of transfer
  2. High rates of delirium – delirium is NOT necessarily reversible
Evidence-Based Potential Harms of Hospitalization

3. High rates of hospitalization induced functional decline - frequently permanent
4. Inability to address the patient’s special needs
5. Lack of communication of goals of care
6. Falls
7. Medication Errors
8. Adverse Drug Events
9. Polypharmacy

Evidence-Based Potential Harms of Hospitalization

10. Adverse Procedures – e.g. catheters, feeding tubes, CTs/MRIs, “stroke code” on a patient with delirium
11. Burdensome cost to patient/family.
12. Anxiety for Loved Ones

Advance Care Planning

1. Improved Quality of Care
2. Less in Hospital Death
3. Increased Use of Hospice with less stays < 3 days
4. Less likely to be admitted to the ICU
5. Less likely to visit the ED more than once in their last month
6. Fewer stays > 2 weeks, if admitted
Hospice Increases Length of Life

- Increased by 29 days for patients who chose hospice over non-hospice care:
  - CHF = + 81 days
  - Lung Cancer = + 39 days
  - Pancreatic Cancer = + 21 days
  - Colon Cancer = + 33 days
  - Breast Cancer = + 12 days
  - Prostate Cancer = + 4 days

Palliative Care - The Current Definition

- Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness whatever the diagnosis.
- The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
Palliative Care - Prolonged Survival

- 151 patients with NSCLC at Mass General
- Immediate vs. delayed palliative care along with usual oncologic care
- Early palliative care patients results in:
  - Improved Quality of Life
  - Less depression
  - Less chemo in last 2 weeks
  - Fewer hospitalizations in the last month
- Nearly 3 months longer survival (11.6 mos. vs. 8.9 mos., p<0.02)

What do patients want?

- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

Patients Admitted to ICU/CCU During the Hospitalization in Which Death Occurred, California vs. United States, 1999 to 2007
What is the POLST?

Physician
Orders for Life
Sustaining Treatment

The POLST

“The main point of POLST is to encourage communication between providers, patients, and their loved ones, so patients can make more informed decisions and clearly communicate these decisions to their health care providers.”

Kate O’Malley, senior program officer, CHCF’s Better Chronic Disease Care Program

The Conversation

WHY IT’S IMPORTANT

• 60% of people say that making sure their family is not burdened by tough decisions is “extremely important”
• 56% have not communicated their end-of-life wishes
• One conversation can make all the difference.

Survey of Californians by the California HealthCare Foundation (2012)
**Why POLST?**

- Patient wishes often are not known
  - The Advance Health Care Directive (AHCD) may not be accessible
  - Wishes may not be clearly defined in AHCD
  - The AHCD is not a physician order
- Allows healthcare providers to know and honor wishes during serious illness

**What is POLST?**

- A physician order recognized throughout the medical system
- Portable document that transfers with the patient
- Brightly colored, standardized form for entire state of CA

**What is the POLST?**

- Allows individuals to choose medical treatments they want to receive, and identify those they do not want
- Provides direction for healthcare providers during serious illness
**Reality**

- Current survival to hospital discharge from out-of-hospital cardiac arrest is 5% or less.
- Many cardiac arrests are in patients with terminal illness.
- EMS does not want to attempt resuscitation when it is not wanted but they need documentation.
- EMS is often faced with decisions about how to proceed for patients with serious illness who are not in cardiac arrest.

**Who Would Benefit from Having a POLST Form?**

- Whether you seem sick or well right now
- Chronic, progressive illness
- Serious health condition
- Medically frail
- Tool for determination
  - “You wouldn’t be surprised if this patient died within the next year.”

**History of the POLST**

- POLST development began in Oregon in 1991
- Expanded to more than half of the United States
The POLST in California

- The Coalition for Compassionate Care of California (CCCC) is lead agency
- Support from California HealthCare Foundation
- Grassroots efforts of local POLST coalitions and communities
The POLST in California

One form for entire state
Use not mandated
Honoring form is mandated
Provides immunity from civil or criminal liability

Does the POLST Replace the Advance Health Care Directive?
- The POLST complements the Advance Health Care Directive (AHCD)
- POLST is not intended to replace the AHCD
- AHCD allows you to:
  - Name a health care decisionmaker
  - Make general statements about health care wishes
- Both are legal documents

AB 3000, Part 4, Sec 7, Probate Code Section 478
**Cardiopulmonary Resuscitation (CPR)**

**What does it involve?**

A person whose heart has stopped, and who has stopped breathing, undergoes interventions to restart the heart and the breathing.

- repetitive mechanical chest compressions (a person or machine pressing down hard on the chest wall) are carried out to squeeze blood out of the heart and into the circulation
- mechanical ventilation (forcefully blowing air into the patient’s lungs by a person or by using a mask) is carried out to inflate the lungs and deliver oxygen to the bloodstream

- cardioversion (passing an electrical current through the heart to restart it or convert the heart rhythm) may be done
- injection of cardiac (heart) medications of various types into the bloodstream or directly into the heart may be necessary
Cardiopulmonary Resuscitation (CPR)

- The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death.
- Cardiopulmonary resuscitation is not indicated in...cases of terminal irreversible illness where death is expected or where prolonged cardiac arrest dictates the futility of resuscitation efforts.

ACLS Provider Manual, American Heart Association, 2001

Cardiopulmonary Resuscitation (CPR)

- For many people the last beat of their heart should be the last beat of their heart.
- These people simply have reached the end of their life. A disease process reaches the end of its clinical course and a human life stops.

ACLS Provider Manual, American Heart Association, 2001

Cardiopulmonary Resuscitation (CPR)

- In these circumstances resuscitation is unwanted, unneeded and impossible. If started, resuscitative efforts for those people are inappropriate, futile and undignified.
- They are demeaning to both the patient and rescuers.

ACLS Provider Manual, American Heart Association, 2001
**Cardiopulmonary Resuscitation (CPR)**

- Good ACLS requires careful thought about when to stop resuscitative efforts and - even more important - when not to start.

*ACLS Provider Manual, American Heart Association, 2001*

**Cardiopulmonary Resuscitation (CPR)**

- Without oxygen, the human brain begins to suffer irreversible brain damage after about 5 minutes. The heart loses the ability to maintain a normal rhythm.
- Current standards reflect a more conservative view of the success of potential bystander CPR and stress the importance of rapid defibrillation.

*Standards, American Heart Association, 2000*

**CPR: In-Hospital**

- 1960-introduction of closed cardiac massage
- Steady increase in application of technology and techniques
- However, no improvement in hospital survival rates of CPR in the past 40 years

*Anesthesiology 2003 Aug; 99(2): 248 -50
CMAJ/2002 Aug 20; 167(4):343-8*
**CPR: In-Hospital Arrests**

- Physicians overestimate the likelihood of survival to hospital discharge
- Literature
  - Survival 6.5%-32% - Average 15%
  - At least 44% of survivors have significant decline in functional status


**CPR: Good Outcomes: In-Hospital**

- Improved survival rates with good functional recovery
  - Duration of CPR shorter than 5 minutes
  - CPR in the ICU


**CPR: Poor Outcomes: All Sites**

- Unwitnessed Arrest
- Asystole
- Electrical-Mechanical Dissociation
- >15 minutes resuscitation
- Metastatic Cancer
- Multiple Chronic Diseases
- Sepsis
CPR and the Elderly

- 22% may survive initial resuscitation
- 10-17% may survive to discharge, most with impaired function
- Chronic illness, more than age, determines prognosis (<5% survival)

CPR Outcomes

1. Average rate of success (overall) 15%
2. Ventricular fibrillation after myocardial infarction 26-46%
3. Drug reaction or overdose 22-28%
4. Acute stroke 0-3%
5. Bedfast patients with metastatic cancer who are spending fifty percent of their time in bed 0-3%
6. End stage liver disease 0-3%
7. Dementia requiring long-term care 0-3%
8. Coma (traumatic or non-traumatic) 0-3%
9. Multiple (2 or more) organ system failure with no improvement after 3 consecutive days in the ICU 0-3%
10. Unsuccessful out-of-hospital CPR 0-3%
11. Acute and chronic renal failure Same as general population 0-10%
12. Elderly patients Same as general population 0-5%
13. Chronically ill elderly 0-5%
**Cardiopulmonary Resuscitation (CPR)**

**When is CPR likely to be helpful?**

- CPR was originally developed for persons who are otherwise healthy who suffer a sudden arrhythmia or develop a clot blocking an artery in the heart.
- In this situation, restarting the heart enables the person to reach the hospital for definitive treatment.
- The outcome of a return to normal function is attainable.

**Cardiopulmonary Resuscitation (CPR)**

**Now the Default Response**

- CPR evolved from a specific intervention applied in limited clinical situations to the default response to cardiac arrest in or out of the hospital, an evolution accompanied by a dramatic decline in survival rates after CPR.

**Cardiopulmonary Resuscitation (CPR)**

**When is CPR not likely to be helpful?**

- If the person is very ill with end stage cancer or end stage chronic illness, CPR is unlikely to help.
  - the likelihood of a successful resuscitation is very low
  - the likelihood that those resuscitated will survive to be discharged from the hospital is minimal
  - the likelihood that the few discharged from the hospital will return to previous functioning is nil.
Public Perceptions

- 75% of resuscitations are successful on TV
- Educating patients
  - 371 patients, age > 60 yrs
  - 41% wanted CPR
  - After learning the probability of survival only 22% wanted CPR

NEJM 1996; 334:1578-1582
NEJM 1994; 330:545-549

DNR Discussions

- Physicians speak 75% of the time and use medical jargon
- After discussions
  - 66% did not know that many patients need mechanical ventilation after resuscitation
  - 37% thought ventilated patients could talk
  - 20% thought ventilators were O2 tanks

JGIM 1995; 10:436-442
JGIM 1998; 13:447-454

Cardiopulmonary Resuscitation (CPR)
What are the burdens and side effects of CPR?

- It is not unusual, particularly for a frail elderly person, for rib fractures to occur
- Vomiting with aspiration of the vomit into the lung and subsequent pneumonia are a possibility
- Brain injury due to prolonged absence of oxygen to the brain is also fairly common
- The person frequently requires placement on a ventilator to be able to breathe subsequent to the resuscitation.
**Reality**

- DNR orders are very helpful to EMS when the person is in cardiac arrest
- DNR orders are inadequate because they do not provide direction for patients in extremis but not yet in arrest

**Barriers to DNR Discussion**

- Personal discomfort with confronting mortality
- Fear of damaging the doctor-patient relationship
- Fear of harming the patient by raising the topic of death
- Limited time to establish trust
- Difficulty in managing complex family dynamics

**POLST vs. Advance Healthcare Directive**

<table>
<thead>
<tr>
<th>POLST</th>
<th>AHCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For seriously ill/frail, at any age</td>
<td>• For anyone 18 and older</td>
</tr>
<tr>
<td>• Physician orders for medical treatment</td>
<td>• General instructions for treatment</td>
</tr>
<tr>
<td>• Can be signed by decisionmaker</td>
<td>• Appoints decisionmaker</td>
</tr>
</tbody>
</table>
What AHCD form is “required?”

- No “official” form is required in California.
- Old “DPAHC” can still be valid unless it says it has expired.
- The only requirements are:
  - The date of execution
  - The signature of the principal (or at the principal’s direction)
  - Properly witnessed (some requirements exist) or notarized
- Capacity to complete the AHCD is PRESUMED
  - unless MD has found incapacity
How is the California AHCD “legal” to appoint agent?

- Notarized OR witnessed correctly:
  - TWO adult witnesses, ONE of whom will not inherit from patient
  - NEITHER are employees of health care provider
- In a SNF, must include the facility LTC Ombudsman

When no Agent is named

- ORAL Directive: A person with “capacity” may appoint a surrogate by telling the primary physician.
  - The physician documents:
    - That the patient has capacity
    - Who the surrogate is to be
- This appointment:
  - Lasts the duration of hospitalization or 60 days - whichever is shorter
  - Supersedes any prior directive, oral or written
POLST vs. Pre-Hospital DNR (Do Not Resuscitate)

- Similarities:
  - Physician orders
  - Address Do Not Resuscitate
  - Intended for medically frail or those with chronic or serious illness

POLST vs. Pre-Hospital DNR (Do Not Resuscitate)

<table>
<thead>
<tr>
<th>POLST</th>
<th>Pre-Hospital DNR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows for choosing resuscitation</td>
<td>Can only use if choosing DNR</td>
</tr>
<tr>
<td>Allows for other medical treatments</td>
<td>Only applies to resuscitation</td>
</tr>
<tr>
<td>Honored across all health care settings</td>
<td>Only honored outside the hospital</td>
</tr>
</tbody>
</table>
Translations of the POLST Form

- Translations of the POLST form are available to assist healthcare providers in explaining the form to patients and loved ones.
- However, an English version of the POLST form must be completed and signed so that emergency medical personnel and healthcare providers can follow the orders.

Available Languages

- English
- Armenian
- Farsi
- Japanese
- Pashto
- Spanish
- Vietnamese
- Chinese (Traditional)
- Chinese (Simplified)
- Hmong
- Korean
- Russian
- Tagalog
CA POLST Form – Front Side

Emergency Medical Services Authority
Logo

CA POLST Form – Front Side

Physician Orders for Life-Sustaining Treatment (POLST)

Section A: CPR

A. Autocpr: Attempted Resuscitation (CPR), if patient is not in cardiac arrest, no breathing. If patient is in cardiac arrest, no breathing, follow orders in Sections B and C.

A. Attempt Resuscitation CPR (sec 4 A(E)(4)) 1. Attempted CPR in Section A, 2. Attempted CPR in Section B.

A. Do Not Attempt Resuscitation CPR (sec 4 A((4)) 1. Do not attempt CPR in Section A.

Section A: CPR

Emergency Medical Services Authority
Logo
Section B: Medical Interventions

Diagram of the POLST Medical Interventions

- CPR
- Full Treatment*
- Selective Treatment
- Comfort-Focused Treatment
- DNR

*Consider time/prognosis factors under "Full Treatment"
"Trial Period of Full Treatment" may be checked if prolonged life support is not desired.

Section C: Artificial Administered Nutrition

Artificially Administered Nutrition:
- Oral food by mouth if feasible and desired
- Long-term artificial nutrition, including feeding tubes
- Total parenteral artificial nutrition, including feeding tubes
- No artificial means of nutrition, including feeding tubes

Additional Orders:
The POLST Conversation

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

Section D: Information & Signatures

Who Can Speak for the Patient?

- Surrogate decisionmaker / agent
- Parent, registered domestic partner, guardian, conservator
- Closest available relative
Directions – Completing POLST

Directions for Healthcare Provider

Completing POLST
- Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, but patients may refuse to adhere to any portion of it. In the hospital setting, a patient will be assessed by a provider who will ensure appropriate access that is consistent with the patient’s preferences.
- POLST does not replace the Advance Directive. When available, enter the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally represented decision-maker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, legally designated trusted family member, registered health care proxy, or parent of a minor child.

- If the patient lacks legal capacity, documentation of all interactions will be documented, and the decision will be made in accordance with the patient’s previously established values and beliefs that the patient has known.
- A legally represented decision-maker may execute the POLST form only if the patient lacks legal capacity, or has designated the decision-maker’s authority as effective immediately.
- POLST must be signed by a physician and the patient or decision-maker to be valid. Verbal orders are acceptable with follow-up documented in the patient’s medical record.
- If a teledoc form is used with patient or decision-maker, attach it to the signed Digital POLST form.
- Use of original form is strongly encouraged. Microscope and POLST forms are legal and valid. A copy should be retained in patients’ medical records on Ultra thin paper when possible.

Directions – Using POLST

Using POLST:
- At the beginning of Section B, the section of POLST is required for full treatment for that section.

Section A:
- Cardiac arrests and not resuscitating, no defibrillator (including automated external defibrillator) or chest compressions
- Anticipate blood loss per protocol

Section B:
- When normal cannot be achieved in the current setting, the patient, including someone with “Comfort-Focused Treatment,” should be transferred to a setting plane to achieve comfort (i.e., management of a hip fracture).
- Medical treatment includes intubation and mechanical ventilation to achieve comfort (i.e., management of a hip fracture).
- Medical treatment includes intubation and mechanical ventilation to achieve comfort (i.e., management of a hip fracture).
- Treatment of complications (i.e., when a patient receives IV fluids, indicate “Selective Treatment” or “Full Treatment.”
- Depending on local EMS protocol, “Additional Orders” within in Section B may not be implemented by EMS personnel.
Directions – Reviewing/Modifying/Voiding POLST

When Should the POLST be Reviewed?

• Recommended that the POLST be reviewed periodically.
• Review is recommended when:
  – 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 2014 version when reviewing 2009 or 2011 POLST forms.

Can the POLST be Changed?

• Patient with capacity can request alternative treatment or revoke a POLST at anytime
• Legally recognized decisionmaker may request change based on condition change or new information regarding patient wishes
**Where Should We Keep the POLST?**

Original pink POLST stays with patient

- At SNF/Hospital:
  - File in medical chart (with AHCD).
  - 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 the POLST?**

- At home:
  - Post in easy-to-find location (with AHCD)
  - Give to EMS to transport with patient

---

**POLST: Depth of the Process**

- POLST is more than a form.
- POLST:
  - Facilitates rich conversations with patients/families
  - Complements the AHCD
  - Incorporates the importance of comfort
**Care vs. Treatment**

- Care is never futile.
- Certain treatments, under specific circumstances, may be inappropriate and futile.

---

**Shared Medical Decision Making**

- Will treatment make a difference?
- Do burdens of treatment outweigh benefits?
- Is there hope of recovery?
  - If so, what will life be like afterward?
- What does the patient value?
  - What is the goal of care?

---

**Patient Care Categories: Rationales for Decision-Making**

- Poor chance CPR will be successful (no medical benefit)
- Poor outcome expected following CPR
- Poor quality of life currently, according to the patient/surrogate

*NEJM 1988*
Language Issues

- How we talk about DNR orders is important
  - “The message behind the term ‘do not resuscitate’ is predominantly negative, suggesting an absence of treatment and care. The reality is that comfort care and palliative care are affirmative and, for these patients, more appropriate interventions”.
- “Do Not Resuscitate” means “Allow Natural Death”
- “Do Not Resuscitate” does NOT mean “Do Not Treat”

Charlie Sabatino, American Bar Association Commission on Law and Aging

Vial of Life Project

What goes in the plastic baggie on the front of your refrigerator door?

- A completed Vial of Life form (Answer the questions you want, don’t answer questions you don’t want)
- Providing a picture of yourself would be helpful.
- A copy of the last EKG will greatly assist the emergency personnel (The doctor should provide you with a copy)
**Vial of Life Project**

What goes in the plastic baggie on the front of your refrigerator door? (cont'd)

- Place your Advance Health Care Directive or equivalent in your baggie, if you have one
- Place any POLST or Do Not Resuscitate (DNR) documentation in the baggie
- Place any other documentation you feel important in the baggie.

---

**Voiding a POLST Form**

- A person with capacity can at any time void the POLST form or change his/her mind about treatment.
- To void a POLST form, draw a line through Sections A through D and write “VOID” in large letters.
- Then sign and date this line.

---

**Voiding a POLST Form**

- If a health care decisionmaker wishes to change the POLST form based on the known desires of the individual or the individual’s best interests, the decisionmaker may request that the physician modify the orders.
California POLST Form

- Print on Ultra Pink, 65# card stock paper
- Copies/faxes on any color paper are acceptable

Focus on the conversation

POLST Resources

- Provider and Consumer Brochures
- Provider Manual
- FAQs

POLST Resources

- Frequently Asked Questions (FAQs)
- Standardized educational curriculum
- Local POLST coalitions
- www.caPOLST.org
Questions?