2014 POLST: A Training for Health Care Professionals

Shared Decision Making with Diverse Patients Concerning Dialysis and Palliative Care Resources:

A Skill-Based Learning Conference

Stanford Geriatric Education Center | The Hospital Consortium of San Mateo County | Latino End of Life Initiative | HealthPlan of San Mateo

January 9, 2015

Richard J. Moore, M.D.

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.

N Engl J Med 1996; 334:1578-82

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

SCC 2010; 18(10) 1287-1292

"L'inconnue de la Seine"

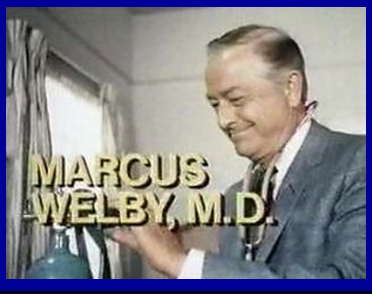
The Most Kissed Face of All Time

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

Resusci Anne

Practitioners

- They've changed!



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

Journal of the American Geriatrics Society 2010; 58(7):1241–1248

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

11. Infections
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

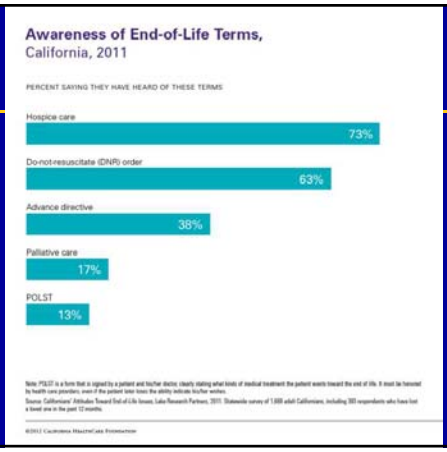
Advance Care Planning

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

JAGS 2013: Advance Care Planning and the Quality of End-of-Life Care in Older Adults

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

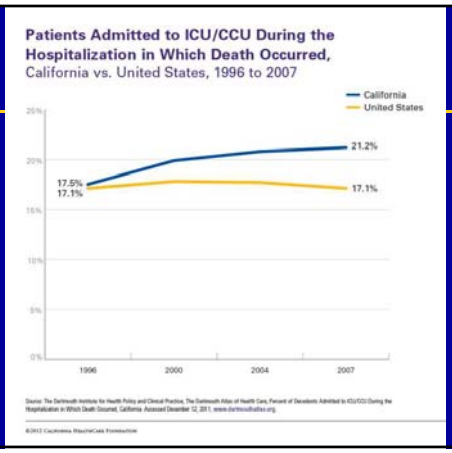
- 151 patients with NSCLC at Mass General
- Immediate vs. delayed palliative care along with usual oncologic care
- Early palliative care patients results in:
  - Improved Quality of Life
  - Less depression
  - Less chemo in last 2 weeks
  - Fewer hospitalizations in the last month
- Nearly 3 months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

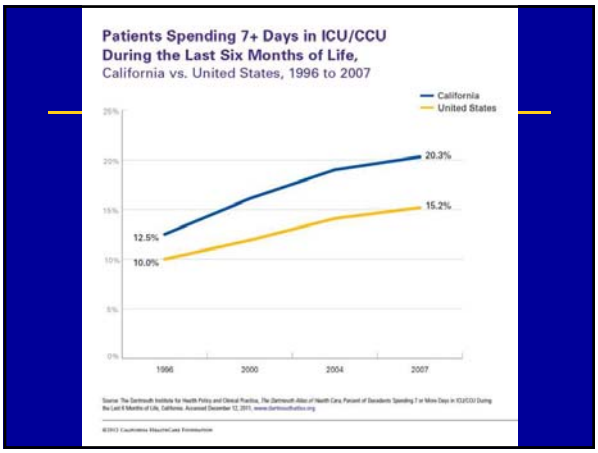
NEJM 2010

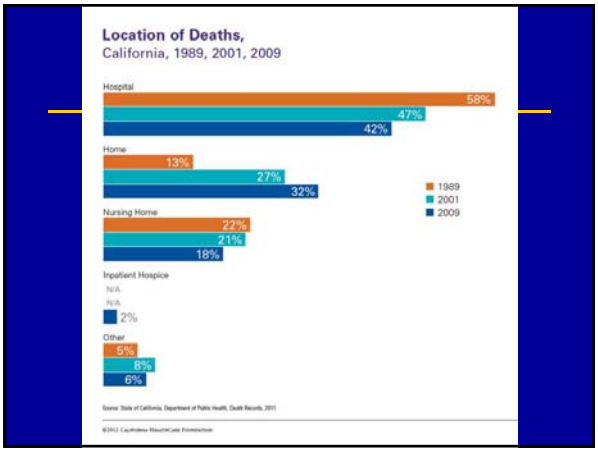
What do patients want?

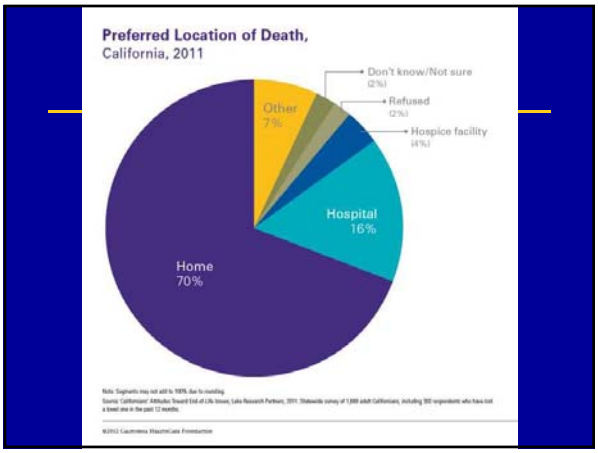
- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

JAMA 1999; 281(2):163-168




Patients Spending 7+ Days in ICU/CCU
During the Last Six Months of Life,
California vs. United States, 1996 to 2007
California
United States
20.3%
15.2%
12.5%
10.0%
1996
2000
2004
2007


Location of Deaths,
California, 1989, 2001, 2009
Hospital
58%
47%
42%
Home
13%
27%
32%
Nursing Home
22%
21%
18%
Inpatient Hospice
N/A
N/A
2%
Other
5%
8%
6%
1989
2001
2009


Preferred Location of Death,
California, 2011
Other
7%
Don't know/Not sure
(2%)
Refused
(2%)
Hospice facility
(4%)
Hospital
16%
Home
70%

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

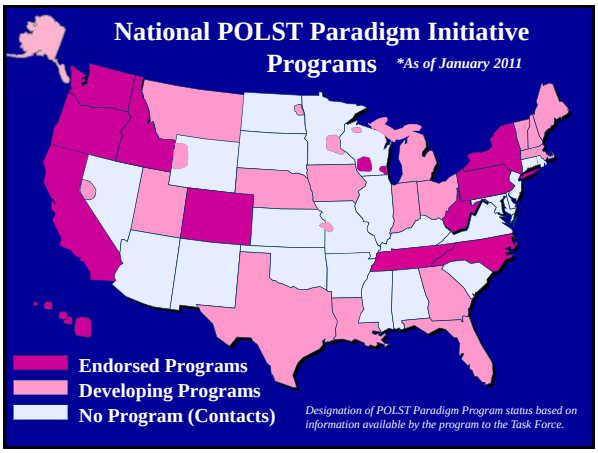
- Current survival to hospital discharge from out-of-hospital cardiac arrest is 5% or less.
- Many cardiac arrests are in patients with terminal illness.
- EMS does not want to attempt resuscitation when it is not wanted but they need documentation.
- EMS is often faced with decisions about how to proceed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

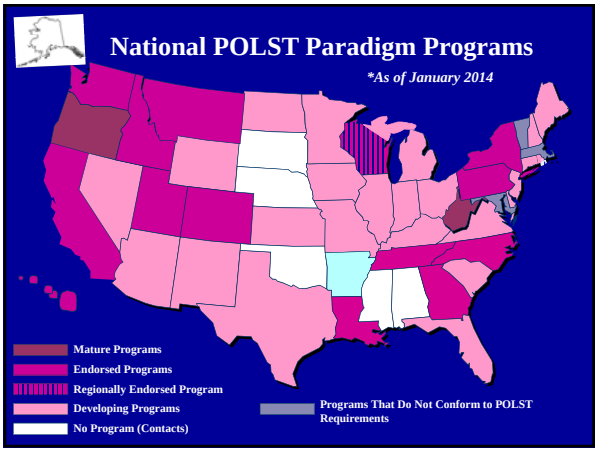
Who Would Benefit from Having a POLST Form?

- 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

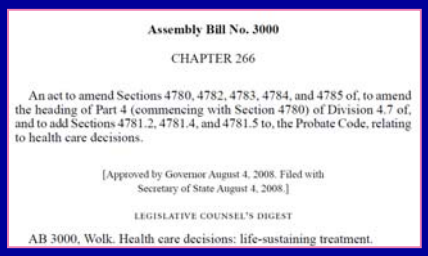




The POLST in California

- 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



Assembly Bill No. 3000

CHAPTER 266

An act to amend Sections 4780, 4782, 4783, 4784, and 4785 of, to amend the heading of Part 4 (commencing with Section 4780) of Division 4.7 of, and to add Sections 4781.2, 4781.4, and 4781.5 to, the Probate Code, relating to health care decisions.

[Approved by Governor August 4, 2008. Filed with Secretary of State August 4, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 3000, Wolk. Health care decisions: life-sustaining treatment.

Effective January 1, 2009

The POLST in California

- One form for entire state
- Use not mandated
- **Honoring form is mandated**
- Provides immunity from civil or criminal liability AB 3000, Wolk. Part 4, Sec 7, Probate Code Section 478

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 3, Probate Code 4780 (3) (c)

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.

Cardiopulmonary Resuscitation (CPR)
What does it involve?

- 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

Cardiopulmonary Resuscitation (CPR)
What does it involve?

- 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.

JAMA 1974; 227 (7): Standards for CPR and ECC

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

Arch Intern Med 1993; 153:1999-2003
Arch Intern Med 2000; 160:1969-1973

CPR: Good Outcomes: In-Hospital

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

Mayo Clin Proc 2004 Nov; 79(11): 1391-5

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)

Annals Int Med 1989; 111:199-205
JAMA 1990; 264:2109-2110
EPEC Project RWJ Foundation, 1999

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%

CPR Outcomes

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	0-10%
12. Elderly patients	Same as general population
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

NEJM 2009; 361:22-31

Cardiopulmonary Resuscitation (CPR)
When is CPR <u>not</u> 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
Acad Emer Med 2000:7(1):48-53

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 O_2 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

CMAJ 2000; 163(10)

POLST vs. Advance Healthcare Directive

POLST	AHCD
• For seriously ill/frail, at any age	• For anyone 18 and older
• Physician orders for medical treatment	• General instructions for treatment
• Can be signed by decisionmaker	• Appoints decisionmaker

Advance Health Care Directive

FORM 3-1

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Advance Health Care Directive

ADVANCE HEALTH CARE DIRECTIVE

Including Power of Attorney for Health Care Decisions

California Probate Code Sections 4600-4805

MY HEALTH CARE WISHES

1. APPOINTMENT OF HEALTH CARE AGENT

SAMPLE

What AHCD form is "required?"

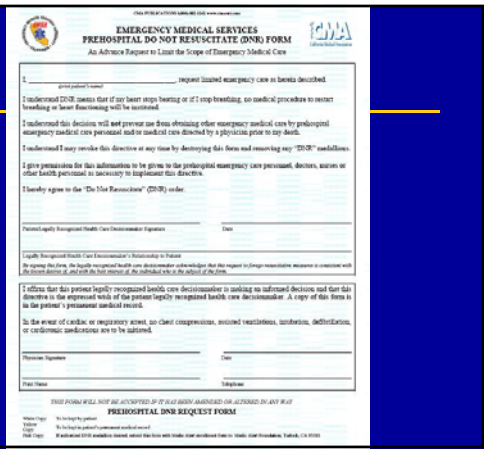
- No "official" form is required in California.
- Old "DPAHC" can still be valid unless it says it has expired.
- The only requirements are:
  - The date of execution
  - The signature of the principal (or at the principal's direction)
  - Properly witnessed (some requirements exist) or notarized
- Capacity 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



EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM
An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Legally Recognized Health Care Decisionmaker Signature _____ Date _____

Legally Recognized Health Care Decisionmaker's Relationship to Patient _____

By signing this form, the legally recognized health care decisionmaker acknowledges that this request is foregoe resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

I affirm that this person legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the person legally recognized health care decisionmaker. A copy of this form is in the patient's prehospital medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

Physician Signature _____ Date _____

Print Name _____ Telephone _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

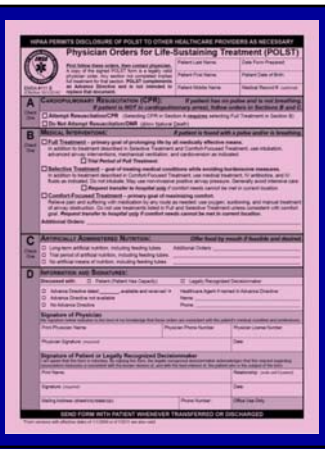
White Copy: To be kept by patient
Yellow Copy: To be kept in patient's permanent medical record
Pink Copy: If authorized EMS medallion issued, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381

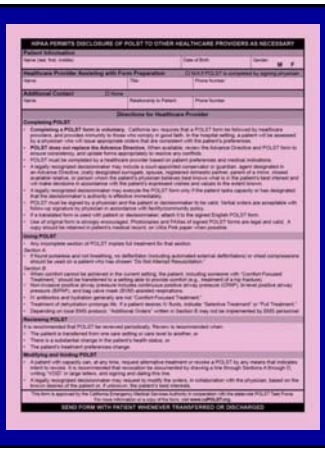
POLST vs. Pre-Hospital DNR (Do Not Resuscitate)

- 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)

POLST	Pre-Hospital DNR
• Allows for choosing resuscitation	• Can only use if choosing DNR
• Allows for other medical treatments	• Only applies to resuscitation
• Honored across all health care settings	• Only honored outside the hospital


Physician Orders for Life-Sustaining Treatment (POLST)



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

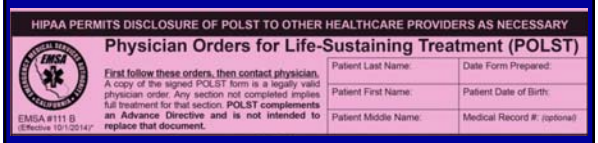
Available Languages

- 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



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

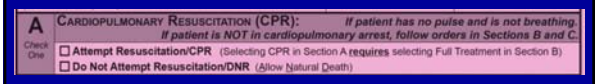
Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

EMSA #111 B (Effective 10/1/2014)*

Section A: CPR

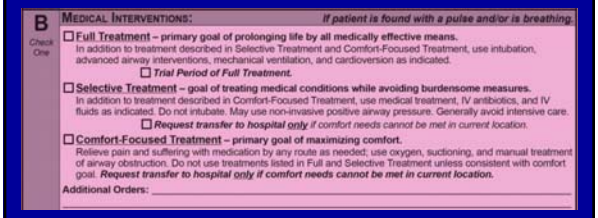


A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

Section B: Medical Interventions



B Check One — **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

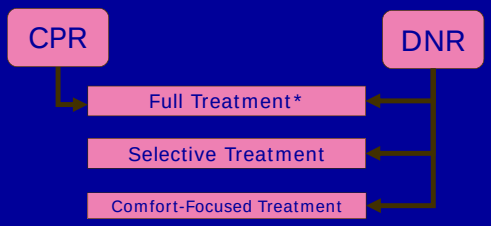
☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

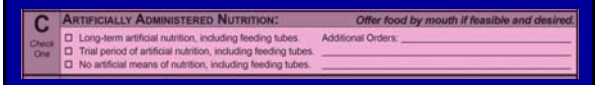
Additional Orders: _____

Diagram of the POLST Medical Interventions



*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



C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

The POLST Conversation

- The POLST is <u>not</u> 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

D **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Healthcare Agent if named in Advance Directive:
☐ Advance Directive not available Name: _____
☐ No Advance Directive Phone: _____

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: (required)		Date:
Mailing Address (street/city/state/zip):	Phone Number:	Office Use Only:

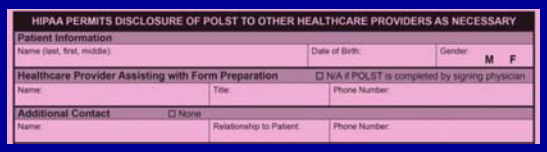
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

Who Can Speak for the Patient?

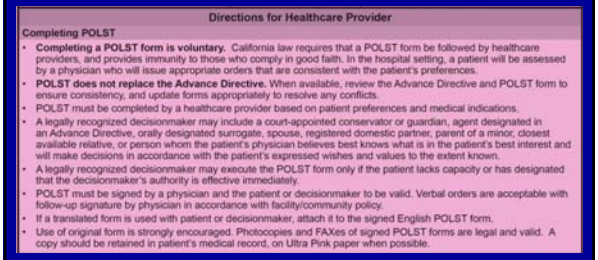
- Surrogate decisionmaker / agent
- Parent, registered domestic partner, guardian, conservator
- Closest available relative

CA POLST Form – Back Side



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY		
Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F
Healthcare Provider Assisting with Form Preparation	☐ N/A if POLST is completed by signing physician	
Name:	Title:	Phone Number:
Additional Contact ☐ None		
Name:	Relationship to Patient:	Phone Number:

Directions – Completing POLST

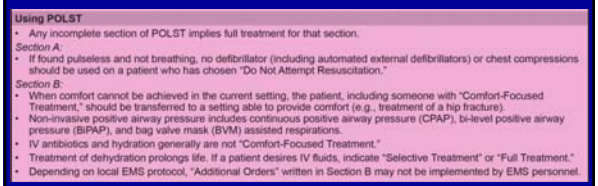


Directions for Healthcare Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review 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 recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Directions – Using POLST



Using POLST

- Any incomplete section of POLST implies full treatment for that section.

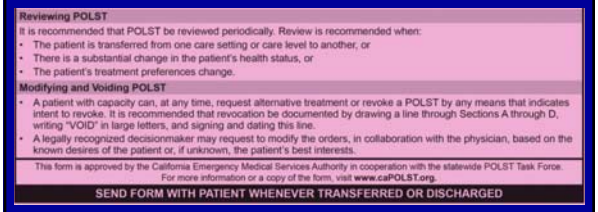
Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Directions – Reviewing/Modifying/Voiding POLST



Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- 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.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org.**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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

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?