Andrew Rosenzweig, MD, CMD, FACP
March 30, 2012
Objectives

- Review basic elements of the POLST program
- Review basic elements of POLST form
- Describe integration of POLST at long term care facility
- Describe integration of POLST at hospital
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Physician Orders for Life-Sustaining Treatment (POLST) Paradigm

- National initiative designed to improve the quality of care people receive at the end of life.
- Brightly colored, portable medical order form
- Actionable set of medical orders.
- Not a guideline.
- Based on effective communication of patient wishes.
History of POLST

- Center for Ethics in Health Care at Oregon Health & Science University
- POLST initiative begun in Oregon in 1991
- Form was released for use in Oregon in 1995
- In 2004, National POLST Paradigm Initiative Task Force formed
- In Oregon the POLST form is used by all hospices and over 95% of nursing homes in the state.
Key POLST Paradigm Public Policy Principles

• Principle A. Health care professionals should encourage and offer assistance to all adults to designate a decision-maker and document their care goals and preferences.

• Principle B. Health care professionals should have a process to convert treatment goals and preferences of persons with life-limiting illness into medical orders (e.g. the POLST Paradigm Initiative) to ensure that the information is transferable and applicable across all care settings.

• Principle C. In the absence of a validly executed advance directive, any authentic expression of an individual’s goals, values, or wishes with respect to health care shall be honored.

• Principle D. Universal implementation of electronic medical records and internet based personal health records shall prominently include and integrate timely information about patient proxy designations, care goals and preferences, and medical orders for life-sustaining treatment.

• Principle E. The federal government should support research, education, and development of best practices relating to the quality and continuity of care planning and care implementation for persons with life-limiting illnesses across care settings.
On November 16, 2010, the PA Dept of Health posted on its website a new standard form for Orders for Life Sustaining Treatment (POLST).

Pennsylvania - Orders for Life-Sustaining Treatment (POLST)

POLST is a medical order that gives patients more control over their end-of-life care. The POLST form specifies the types of medical treatment that a patient wishes to receive towards the end of life. These medical orders are signed by both a patient’s physician, physician’s assistant, or certified registered nurse practitioner and the patient or the patient’s surrogate.

Completion of a POLST form is only a small step in the process of a patient’s decision-making, and it is critical that this form be used as part of a program for end of life decisions that includes educational support and other aspects of planning for providers and patients.

This form was developed by the Pa Department of Health’s Patient Life Sustaining Wishes Committee and was designed to be consistent with Pennsylvania law. There are significant advantages to using a form that contains standardized language and is produced in a distinctive and easily recognizable format. In order to maintain continuity throughout Pennsylvania, please follow these printing instructions:

*** Print POLST Form on Pulsar Pink Card Stock (65#)***

Click on the links below to download:

- [POLST FORM](http://www.portal.state.pa.us/portal/)
- [POLST FORM - Espanol](http://www.portal.state.pa.us/portal/)

See additional instructions on the POLST form related to completing and using the form.

Note: The files listed above are in PDF format and require the free Adobe Acrobat Reader to be installed on your computer in order to access, view the file, and print copies. Please click here to learn more about Adobe Acrobat Reader.
State Program Requirements

• Form constitutes a set of current medical orders.
• Ongoing training.
• Recommendations for who should have form completed.
• As allowed by state regulations, require the signature of patient/legal representative.
• Inclusion in advance care planning across settings.
• Completion of the form is voluntary, includes informed consent and shared medical decision making.
• Ongoing evaluation of the program and its implementation.
• Single entity within the state willing to accept ownership for the program and has the resources to implement it.
The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation

Susan E. Hickman, Charles P. Sabatino, Alvin H. Moss, and Jessica Wehrle Nester

The Physician Orders for Life-Sustaining Treatment (POLST) Paradigm is designed to improve end-of-life care by converting patients’ treatment preferences into medical orders that are transferrable throughout the health care system. It was initially developed in Oregon, but is now implemented in multiple states with many others considering its use. Accordingly, an observational study was conducted in order to identify potential legal barriers to the implementation of a POLST Paradigm. Information was obtained from experts at state emergency medical services and long-term care organizations/agencies in combination with a review of relevant state law. Legal analysis of survey responses and existing laws identified several potential state legal barriers to a POLST Paradigm implementation. The most potently problematic barriers are detailed statutory specifications for out-of-hospital DNR (do not resuscitate) protocols (n = 9 states). Other potential barriers include limitations on the authority to consent to forgo life-sustaining treatments (n = 23 states), medical preconditions (n = 15), and witnessing requirements (n = 12) for out-of-hospital DNR protocols. State leaders interested in the development of a POLST Paradigm Program are advised to work with legal counsel to address the potential legal barriers identified in this study.

It is widely agreed that advance directives have failed to achieve their “admirable purpose” of helping patients retain control over end-of-life treatment, and researchers have identified numerous reasons for this failure. Most people do not complete advance directives, and when they do, they often fail to understand the form’s language and the implications of their decisions. Patients’ goals and preferences for care may change over time, but their advance directives are rarely revisited, and proxy decision makers, appointed by patients to make decisions on their behalf upon incapacitation, often do not understand the patients’ wishes. Furthermore, advance directives are frequently unavailable when needed, or health care providers may not know about the directives or may not think they apply to the patient’s situation. Even when they are available, the language is often too vague to provide helpful guidance. As a result, advance directives typically do not affect patient care.

The POLST (Physician Orders for Life-Sustaining Treatment) Program was originally developed in Oregon to improve end-of-life care by overcoming many of the advance directives’ limitations. It is designed to convert patient preferences for life-sustaining treatments into immediately actionable medical orders. The centerpiece of the program is a standardized, brightly colored form that provides specific treatment orders for cardiopulmonary resuscitation, medical interventions, artificial nutrition, and antibiotics. It is completed based on conversations among health care professionals with the patient and/or the appropriate proxy decision makers, in conjunction with any existing advance directive for incapacitated patients. The POLST form is recommended for persons who have
### Potential Statutory Barriers

<table>
<thead>
<tr>
<th>STATE</th>
<th>Lack Default Surrogate Provisions</th>
<th>Default Surrogate</th>
<th>Witnessing Required to Forgo LST</th>
<th>Detailed statutory out-of-hospital DNR form or identifier</th>
<th>Medical Preconditions for out-of-hospital DNR</th>
<th>Witnessing Requirements for out-of-hospital DNR</th>
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</thead>
<tbody>
<tr>
<td>Pennsylvania**</td>
<td></td>
<td>Agent</td>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

### OHDNR Order Statutory and Regulatory Provisions

<table>
<thead>
<tr>
<th>State &amp; Citation Key</th>
<th>Who may consent to forgoing LST including DNR</th>
<th>Statute Expressly non-exclusive</th>
<th>OHDNR Order Provisions</th>
<th>Out-of-Hospital DNR Provision Barriers to POLST</th>
<th>Statutory OHDNR Form Requirements</th>
<th>Medical Preconditions for OHDNR Orders¹</th>
<th>Witnessing Reg's for OHDNR Consents</th>
<th>Substituted Consent Limitations/Barriers to POLST</th>
<th>Consent Limits on Forgoing Life-Sustaining Treatment</th>
<th>Consent Limits Specific to Forgoing ANH</th>
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</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>Patient, Agent, Guardian</td>
<td>(1) OHDNR PCS 5421</td>
<td></td>
<td></td>
<td>Statutory form – Detailed 20 PCS 5484</td>
<td>Yes “Terminal condition” or “permanently unconscious” PCS 5484 PAC 1051 11(a) and 1051.22(a)</td>
<td>None listed</td>
<td>Pregnancy limitation. 20 PCS 5429 PAC1051.61</td>
<td>None listed</td>
<td></td>
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<tr>
<td>Pa. Cons. Stat. (PCS)</td>
<td>20 PCS 5456, 5460, 5461, PAC1051.11 &amp; 1051.12</td>
<td>(2) AD PCS 5421 &amp; 5423 [combined act];</td>
<td></td>
<td></td>
<td>Regulations/Guidelines: 20 PAC 1051.1 to 1051.101</td>
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</table>
OOH DNR vs POLST

- The DNR Act of 2007 which provides for out-of-hospital DNR order remains effective.
- POLST form is NOT a replacement
- "End-stage medical condition" must be documented
- OOH DNR order is officially the only document first responders can follow to withhold CPR in the event of cardiac or respiratory arrest
- POLST - More comprehensive than CPR alone and expands qualifiers - "terminal illness" not required
- EMS provider must have an order from his/her medical command physician.
- PA POLST form simplifies any discussion related to termination of resuscitation efforts that an EMS provider might have with a medical command.
PENNSYLVANIA OUT-OF-HOSPITAL DNR

Patient’s Name: Jane Doe

Attending Physician: John Smith, MD

Date: March 1, 2003

STOP
DO NOT RESUSCITATE
Limitations on Consent to Forgo Life-Sustaining Treatment

- Only a competent patient or a health care agent authorized by a health care power of attorney may decline such care.
- Neither a health care representative nor a guardian of the person may decline care necessary to preserve life unless the patient is in an end-stage medical condition or is permanently unconscious.
- If the health care decision-maker is a court appointed guardian, a court order granting the guardian the specific authority to decline such care or authorizing such a decision in a specific situation may be required.
Objectives

- Review basic elements of the POLST program
- **Review basic elements of POLST form**
- Describe integration of POLST at long term care facility
- Describe integration of POLST at hospital
POLST FORM
POLST Form Basics

- Can be completed by any health care practitioner or social worker after discussion with the patient or surrogate regarding goals of care
- Must be signed by MD, DO, NP or PA*
- Focuses on IMMEDIATE potential decisions and not on distant goal-based planning
- VOLUNTARY use, but provides a consistent recognized document
- PORTABLE- accompanies patient from one setting to another across the health care continuum (home care, long-term care, hospice, acute care and during transports).
- COMPLEMENTS, but does not replace, advance directives

*A physician countersignature is required for PA signed forms within 10 days
Barriers of Traditional AD

- Little or no impact on immediate care
- Does not immediately translate into MD order
- May not be available when needed
- May not be specific enough
- No provisions for treatment in the NH or home
- May not cover topics of most immediate need
- May be overridden by a treating MD
Where POLST fits

• Use of the form is recommended for persons who have **chronic progressive illness** or anyone wishing to further define their preferences of care.

• The form may be used either to limit medical interventions or to clarify a request for all medically indicated treatments including resuscitation.

• Goal is consistency between AD and POLST.
Chronic Progressive Illness*

- POLST paradigm uses broader phraseology replacing “end-stage (terminal) medical condition” or “permanently unconscious”
  - Chronic progressive illness
  - Advanced frailty
  - Life expectancy less than one year
  - End stage or life-limiting medical condition
- “incurable and irreversible medical condition in an advanced state caused by injury, disease or physical illness that will, in the opinion of the attending physician to a reasonable degree of medical certainty, result in death, despite the introduction or continuation of medical treatment.”
Components of POLST Form

- A* – Cardiopulmonary Resuscitation
- B – Medical Interventions
- C – Antibiotics
- D – Artificially Administered Nutrition
- E* – Reason for Orders and Signatures
- MOST IMPORTANT PART IS THE CONVERSATION

*REQUIRED
Cardiopulmonary Resuscitation

Check One

☐ Resuscitate/CPR  ☐ Do Not Attempt Resuscitation (DNR/no CPR)

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

• This applies ONLY when the person has no pulse and is not breathing

• EMS- PA law requires that they contact Medical Command if pt wishes to forego life sustaining measures

• Does not apply to:
  – respiratory distress
  – irregular pulse and low blood pressure

• For these situations, the first responder should refer to B, C and D
Medical Interventions: Person has pulse and/or is breathing.

Box to check:

- 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 location.

- Limited Additional Interventions: Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.

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

Additional Orders: ____________________________
______________________________
Medical Interventions

• "Full Treatment"
  – In medical emergencies, 9-1-1 is called
  – Includes use of intubation, advanced airway intervention, mechanical ventilation, cardioversion
  – Includes transfer to hospital and use of intensive care, as indicated
Medical Interventions

• “Comfort Measures Only”
  – Treatment of symptoms, not underlying illness
  – Do not transfer to a hospital unless comfort needs cannot be met in the current location
  – Sometimes it is necessary to transfer patients to the hospital to control their suffering.
  – This gives authority to EMS and LTC staff to use medications to treat symptoms
Medical Interventions

• “Limited Additional Interventions”
  – Gray area
  – May depend on issue at hand
  – Most important section to document well
  – Avoid a la carte menu
  – Usually avoids use of intensive care
  – Includes listed comfort interventions and avoids heroic or invasive measures
Antibiotics

Check One

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.

Additional Orders:
Antibiotics

• May depend on illness at hand
• Questions to consider:
  – Will treatment of infection prolong/relieve suffering?
  – Will treatment of infection require a higher or same level of care?
  – Is this a reversible condition?
Artificially Administered Nutrition

- Always offer food by mouth if feasible.
- No artificial nutrition by tube.
- Defined trial period of artificial nutrition by tube.
- Long-term artificial nutrition by tube.

Additional Orders: ____________________
Artificially Administered Nutrition

• PA law contains a presumption in favor of a patient wanting artificial hydration and nutrition unless:
  – The individual has expressed wishes to the contrary
  – It is clear from the patient’s preferences and values that he/she would not want artificial hydration and nutrition under the circumstances.
Artificially Administered Nutrition

• Consider
  – Timeline
  – Trial
  – Type
    • Peripheral
    • Enteral
    • IV hydration
Reason for Orders and Signatures

SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

SEND FORM WITH PERSON WHenever TRANSFERRED OR DISCHARGED

Required Section
Signing of POLST

- Required that pt or legal decision maker sign
- Form must be signed by NP, PA, or MD within 10 days or less as established by facility
- NP signatures do not require co-signature of MD, PA signatures do
- Important to know who participated in conversation
- Without this signature the orders are not valid.
- In PA, MD/PA/CRNP must sign the form assuming full responsibility for the medical indications of the orders and assuring that they accurately reflect the person’s values.
The “other” side

• This space allows for documentation of the name and contact information for the patient’s surrogate and practitioner completing form.

• Also provides instructions for completing document.

• Encourage review of the other side.
Storing and transfer of POLST

• POLST should be the first document in the clinical record.
• PULSAR PINK card stock (65#) for easy retrieval.
• Should accompany AD (HCPOA or LW) if they exist
  – The POLST is not intended to replace an advance health care directive document or other medical orders
  – Copy is acceptable
Changing a POLST

• NEW POLST
  – For large changes in goals of care
  – Put large black X across old document and write void with date
  – Keep in medical records
  – Complete a new POLST form

• CHANGES
  – For minor changes
  – Cross out with one line and write new info
  – Date and sign change
  – Should be updated whenever there is a change in the person’s condition or values
Objectives

• Review basic elements of the POLST program
• Review basic elements of POLST form
• Describe integration of POLST at long term care facility
• Describe integration of POLST at hospital
Stakeholders must collaborate

Abington Health System
- Emergency Departments
- Emergency Medical Services
- Area Hospitals
- Home Care
- Long Term Care

OBJECTIVES: To assess statewide nursing facility use of the POLST and to identify the patterns of orders documented on residents' POLST forms.

DESIGN: Telephone survey; on-site POLST form review.

SETTING: Oregon nursing facilities.

PARTICIPANTS: 146 nursing facilities in the telephone survey; 356 nursing facility residents aged 65 and older at 7 nursing facilities in the POLST form review.

MEASUREMENTS: A telephone survey; onsite POLST form reviews.

RESULTS: In the telephone survey, 71% of facilities reported using the POLST program for at least half of their residents. In the POLST form review, DNR orders were present on 88% of POLST forms. On forms indicating DNR, 77% reflected preferences for more than the lowest level of treatment in at least one other category. On POLST forms indicating orders to resuscitate, 47% reflected preferences for less than the highest level of treatment in at least one other category.

CONCLUSION: The POLST program is widely used in Oregon nursing facilities. A majority of individuals with DNR orders requested some other form of life-extending treatment, and advanced age was associated with orders to limit treatments.
OBJECTIVES: To evaluate the relationship between POLST program vs traditional practices and documentation of life-sustaining treatment orders, symptom assessment and management, and use of life-sustaining treatments.


SETTING: Stratified, random sample of 90 Medicaid-eligible facilities in OR, WI, and WV.

PARTICIPANTS: 1711 living and deceased residents ≥ 65 with a minimum 60-day stay.

MEASUREMENTS: Life-sustaining treatment orders; pain, shortness of breath, and related treatments over 7-day period; and use of life-sustaining treatments over 60-day period.

RESULTS: Residents with POLST forms were more likely to have orders about life-sustaining treatment preferences beyond cardiopulmonary resuscitation than residents without (98.0% vs 16.1%, P<.001).

CONCLUSION: Residents with POLST forms were more likely to have treatment preferences documented as medical orders than those who did not, but there were no differences in symptom management or assessment. POLST orders restricting medical interventions were associated with less use of life-sustaining treatments. Findings suggest that the POLST program offers significant advantages over traditional methods to communicate preferences about life-sustaining treatments.

Hickman SE et al. The consistency between treatments provided to nursing facility residents and orders on the physician orders for life-sustaining treatment form. JAGS Nov 2011; 59 (11); 2091-9.

OBJECTIVES: To evaluate the consistency between treatments provided and POLST orders.

DESIGN: Retrospective chart abstraction.

SETTING: Stratified, random sample of 90 nursing facilities in OR, WI, and WV.

PARTICIPANTS: 870 living and deceased nursing facility residents aged 65 and older with a minimum 60-day stay.

MEASUREMENTS: Chart data about POLST form orders and related treatments over a 60-day period were abstracted. Determine whether the rationale for each treatment was consistent with POLST orders.

RESULTS: Overall consistency rates between treatments and POLST orders were high for resuscitation (98%), medical interventions (91.1%), and antibiotics (92.9%) and modest for feeding tubes (63.6%). In all, POLST orders were consistent with treatments provided 94.0% of the time.

CONCLUSION: The use of medical treatments was nearly always consistent with POLST orders to provide or withhold life-sustaining interventions. The POLST program is a useful tool for ensuring that the treatment preferences of nursing facility residents are honored.
POLST and LTC

• Pilot site for LTC launch of POLST
• Large percentage of individuals in one place with chronic progressive illnesses
• Key area for completion of POLST
• Opportunity to develop best practices to then disseminate to surrounding community and facilities
LTC Implementation - Checklist

• Partnership Engagement
• Policy Review and Development
• Facility Education Plan
• POLST Implementation
• Quality Improvement
• Whole process is possible in 6-12 months
DEPARTMENT: Resident Rights

SUBJECT: Physician’s Orders for Life-Sustaining Treatment (POLST)

POLICY: It is the policy of Artman Lutheran Home to support the rights of residents in making decisions regarding their care and treatment.

Advance Directives are defined as written instructions to express a person’s choice on treatments or to designate someone else to make healthcare decisions when the person is unable. An Advance Directive can take the form of a living will or a durable power of attorney for healthcare.

POLST is the Physician’s Orders for Life-Sustaining Treatment. The POLST form is used by the healthcare practitioner (MD, DO, CRNP, PA) to write orders that indicate what types of life-sustaining treatment the resident wants or does not want during their stay at the facility. This form was developed by the PA Department of Health’s Patient Life Sustaining Wishes Committee and was designed to be consistent with Pennsylvania law. A completed POLST form constitutes an actionable set of orders.

In accordance with federal and state law, Artman Lutheran Home will provide each resident with written information regarding his/her right to make and participate in treatment decisions concerning the medical care to be provided to him/her including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

Each resident will be strongly encouraged to complete an Advance Directive as well as a POLST form at the time of admission to the Artman Lutheran Home. The Advance Directive and POLST will be reviewed annually or when a significant change in a resident’s health condition occurs, when resident transitions to different levels of care, or when a change in a resident’s beliefs or treatment wishes occurs.

It is the policy of the Artman Lutheran Home to honor previously completed Advance Directives within the parameters established by Artman Lutheran Home philosophy.

Resident/family requests for discontinuation or refusal of treatment will be addressed on an individual basis and may be referred to the resident’s physician or the Ethic’s Committee for input. In the event that Artman Lutheran Home is unable to comply with the resident’s/family’s wishes, assistance in seeking alternative placement will be provided.

PROCEDURE: On admission to the Artman Lutheran Home, the admission coordinator and/or...
Facility Education Plan

• Facility wide in-service- general background
• 3 part series for implementation team
  – Overview
  – Integration
  – Role play
• “Train the Trainer” model
  – Implementation team goes on to instruct point people on other units
1. In what scenario does cardiopulmonary resuscitation apply as it relates to the POLST?
   a. A person is in respiratory distress (0%)
   b. A person is pulseless (33.3%)
   c. A person has no movement (0%)
   d. A person is pulseless and apneic (66.7%)

2. Please choose the statement below which is FALSE:
   a. The POLST must be signed by the patient or surrogate (0%)
   b. All sections A through E must be completed for the POLST to be valid (100%)
   c. The POLST must be signed by the MD, CRNP, or physician’s assistant (0%)
   d. The POLST may be voided or changed (0%)

3. For which individuals would a POLST form be appropriate to complete?
   a. Someone with an advanced directive (0%)
   b. Someone who wishes to further clarify their end of life wishes (0%)
   c. Someone with a chronic progressive illness (0%)
   d. Someone who you would not be surprised if they died in the next year (0%)
   e. All of the above (100%)
4. Give an example of an opening question or phrase that could be used to assess a person’s beliefs as they pertain to end of life wishes: (examples below)
   - “You have the opportunity to provide all who care for you with your wishes. What would you like them to know?”
   - “Have you ever discussed with your family your wishes, should become more ill?”
   - “Have you ever given much thought regarding what you would like done for your medical care interventions in the future.”

5. Describe the difference between an advanced directive or living will and a POLST. (examples below)
   - “The advanced directive/living will is the patient's wishes. POLST is a written MD order and expressed directive of the patient or family with more clarity”
   - “POLST is clear, and applies as an order without confusing language of AD”
   - “POLST is a set of orders to carry out what advance directive sets in motion.”
6. The educational program adequately prepared me to implement the POLST program at Artman

| Strongly Disagree (0%) | Disagree (0%) | Neutral (33.3%) | Agree (0%) | Strongly Agree (66.7%) |

7. The three sessions were adequate to achieve the goals of proficiency in facilitating form completion and implementing the program at my facility

| Strongly Disagree (0%) | Disagree (0%) | Neutral (33.3%) | Agree (33.3%) | Strongly Agree (66.7%) |

8. I feel confident in facilitating a POLST conversation with a resident

| Strongly Disagree (0%) | Disagree (0%) | Neutral (0%) | Agree (100%) | Strongly Agree (0%) |

10. I understand the purpose of the POLST and how it complements advanced care planning in nursing homes.

| Strongly Disagree (0%) | Disagree (0%) | Neutral (0%) | Agree (100%) | Strongly Agree (0%) |

11. Based on the educational series, I believe POLST will help me provide better end of life care for our patients at Artman

| Strongly Disagree (0%) | Disagree (0%) | Neutral (0%) | Agree (100%) | Strongly Agree (0%) |
POLST Implementation In a Community Hospital

Diane Dietzen MD, Susan Kristiniak DHA, MSN, RN, Ashley Zampini, MSN, CRNP, Andrew Romano, MD, CMD, FACP

Abington Memorial Hospital, Abington, PA

INTRODUCTION

The POLST- Physician Orders for Life Sustaining Treatment-Paradigm program is designed to improve the quality of care people receive at the end of life. It is based on effective communication of patient wishes, documentation of medical orders on a brightly colored form and a promise by health care professionals to honor these wishes. POLST is expanding in use and recognition across the US. Currently it is used in over 25 states.

In 2010, The Pennsylvania DOH approved the POLST form and The Hospital Association of PA has held education and strategy sessions about implementation.

After participating in these teleconferences, the Geriatrics and Palliative Care staff at Abington Memorial Hospital embarked on an effort to bring POLST to our community.

Abington Memorial Hospital is a 665 bed community hospital located in suburban Philadelphia. It shares patients with the suburban and urban communities surrounding the hospital, with multiple Skilled Nursing facilities. A variety of primary care and specialty practices, many not affiliated with the hospital and several other hospitals are also a part of this community.

BACKGROUND

Key Components at AMH

•Regular group meetings
•Focus on specific goals
•Hospital and NH policy
•Education: Visiting professor day and to local groups
•Pilot involving a single NH to begin robust

OUTCOMES

Half day seminar using prepared sessions from Artman Pilot designed for training and implementation model, •Two- thirds felt well prepared to discuss POLST after training
•100% agreed they understood the purpose of POLST and that they would be valid

•100% could identify parts of form that were required for the POLST to be complete

•100% could recognize multiple patient scenarios in which a POLST form would be appropriate to complete

•“The advanced directive/living will is the patient’s wishes. POLST is clear, and applies carry out what advance directive sets in motion.”

Education and Outreach

•Initial pilot has led to creation of training and implementation model, that other regional NH are interested in using
•Half day seminar using prepared sessions from Artman Pilot designed to educate stakeholders at other area long term care facilities in development
•Efforts continue to educate the ER staff as well as other areas of the hospital
•EMS staff have been very welcoming of this model

Policy

•Official policy recognizing POLST written into nursing home policy
•Hospital policy recognizing POLST has been formally adopted, but process for completing these documents in the hospital has not been created.

Obstacles

•In a region with so many different providers, dissemination of information about POLST in multiple venues will continue to be needed

REFERENCES

• POLST.org website
• HAPonline.org – HAP website

AMH PROGRAM PLANNING

Core Working Group

•Our core working group was formed in late 2010.
•All were invited participants and were selected due to their areas of expertise, looking across the areas POLST would be used in the community.

•This interdisciplinary core group
– 2 physicians
– 1 palliative care, 1 geriatrician
– Nurse manager
– Nurse coordinator
– Hospice RN
– Social Worker
– Nurse manager – leader from one of the ambulance services in the community

AMH PILOT PROJECT

Pilot Project AMH

A single nursing home where POLST core group members work was chosen for initial pilot. Artman Lutheran Home

•”Stakeholders” on one unit identified

•Program Implementation
– Facility-based
– Physician practice – opportunity for process improvement
– not merely the form

•Education and Training AMH

Dr. Judith Black, a well known PA speaker on POLST, was invited to AMH.

•POLST Kickoff at AMH, with keynote Judith Black
– Invited representative for both Nursing and Extended care facility

•Presentations were given by members of the core working group to regional EMS meetings, house staff, other NH staff and regional geriatricians groups.

POLST PILOT PROJECT GUIDELINES

•Training
•Distribution & fulfillment of materials
•Establish key outcomes
•Measure regularly
•Share results with key stakeholders

In first month of pilot, 6 POLST forms completed

•One issue of note, which arose after first month trial from which all other data derived, resident with POLST form transferred to hospital but form had not been signed by MD so could not be honored.

References

• HAPonline.org – HAP website

VALIDATION OF PILOT EDUCATION PROGRAM

“Train the Trainer” Model

•66.7 % of respondents could identify correctly in what scenario the canputomy measures question apply as it relates to the POLST?
•100% could identify parts of form that were required for the POLST to be valid
•100% could recognize multiple patient scenarios in which a POLST form would be appropriate to complete

•Two-thirds felt well prepared to discuss POLST after training
•100% agreed they understood the purpose of POLST and that they felt confident about discussing its contents with a resident at the facility

100% agreed this would improve care of resident at the nursing facility.

•POLST is a set of orders to be addressed by professional

MOVING FORWARD: OBSTACLES AND NEXT STEPS

•Needs Assessment
•Core Working Group
•Task Force – Collaborative Model
•Program Coordination
•Key Components
•Legal Issues
•Pilot Project
•Education and Training
•Distribution and Fulfillment
•Program Requirements
•Relationship to Media
•Available Resources
•Standardized practices, policies and form
•Education and Training

•Timely discussions along spectrum prompted by:
– Identification of appropriate cohort
– Voluntary
– Timely discussion along continuum prompted by:
– Data was collected on process and forms completed
– Measure regularly
– Share results with key stakeholders

•Program Implementation
– Facility-based
– Physician practice – opportunity for process improvement
– not merely the form

•Education and Training AMH

Dr. Judith Black, a well known PA speaker on POLST, was invited to AMH.

•POLST Kickoff at AMH, with keynote Judith Black
– Invited representative for both Nursing and Extended care facility

•Presentations were given by members of the core working group to regional EMS meetings, house staff, other NH staff and regional geriatricians groups.

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Implementation in Abington

Community Dissemination and Implementation

Pilot Program in LTC

Dissemination of education within AMH

Education of Steering Committee

Development of Steering Committee

IN-PATIENT CARE

HOME

LTC

ER
Steering Committee

- Geriatrics - MD and NP
- Long Term Care Administrator
- Palliative Care Nursing Coordinator
- ETC administrator
- EMS personnel
- Legal
- Pastoral
OBJECTIVES: To evaluate emergency medical technicians' (EMTs) experiences with the POLST program and learn about attitudes regarding its effectiveness.

DESIGN: Anonymous survey mailed to a stratified random sample.

SETTING: Tri-County Portland, Oregon, area.

PARTICIPANTS: A total of 572 Oregon EMT respondents (out of 1,048 surveys) were included in the analysis. Respondents were mostly male (76%) and paramedics (66%).

MEASUREMENTS: Survey questions about experiences with the POLST form and opinions about POLST.

RESULTS: 73% had treated a patient with a POLST, and 74% reported receiving education about POLST. When present, POLST form changed treatment in 45% of cases. 75% of the respondents agreed that the POLST form provides clear instructions about patient preferences, and 93% agreed that the POLST form is useful in determining which treatments to provide when the patient is in cardiopulmonary arrest. 63% agreed that the form is useful in determining treatments when the patient has a pulse and is breathing.

CONCLUSION: Most respondents have experience with the POLST program. EMTs find the POLST form useful and often use it to change treatment decisions for patients.
Hospital Efforts

- Dept Medicine Grand Rounds- Judith Black
- Chief of Staff Mailings x2
- LTC Quarterly Admin Meetings
- Interdisciplinary Geriatric Grand Rounds
- Education- ETC, EMS, Nursing, Housestaff, Hospice, Homecare- anyone who will listen!
- Healthstream Mandatory Module
- Advanced Directives Day
PURPOSE: To provide a process for identifying and recognizing a POLST so that definitive patient preferences as expressed through a current POLST are considered when developing goals of care and physician orders within all Abington Health settings.

POLICY: It is the intent of AH to comply with all current POLST forms that express definitive patient preferences upon presentation to the Emergency Department or inpatient admission, and to document definitive patient preferences for treatment via POLST forms.

DEFINITION: Pennsylvania Physician Orders for Life Sustaining Treatment (POLST)

1. A highly visible, portable, written medical order completed by a physician, nurse practitioner, or physician assistant after learning the patient’s wishes about end of life health care for a chronic, debilitating condition. It goes beyond the Advance Directive by turning the patient’s wishes concerning life-sustaining treatment into specific written medical orders. It is based on the patient’s wishes which can be understood and followed by other physicians, nurses, emergency medical services personnel, and health care facilities and should be considered when developing goals of care and physician orders. The physician’s orders in the POLST form covers:
   a. Resuscitation,
   b. Medical interventions if the patient has pulse and/or is breathing,
   c. Use of antibiotics, and
   d. Artificially administered nutrition through a feeding tube.

2. The form can be reviewed and changed over time. The POLST is not meant to replace an Advance Directive, but to complement it.

3. POLST was developed by the PA Department of Health’s Patient Life Sustaining Wishes Committee and was designed to be consistent with Pennsylvania law. Patients
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<th><strong>POLST Resources</strong></th>
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<td><strong><a href="http://www.ohsu.edu/polst/index.htm">http://www.ohsu.edu/polst/index.htm</a> or <a href="http://www.polst.org">www.polst.org</a></strong></td>
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<td><strong><a href="mailto:PAPOLST@verizon.net">PAPOLST@verizon.net</a>.</strong></td>
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Questions?