Coleman Supportive Oncology Initiative

Palliative Training Module

Topic: **POLST Paradigm – Physician Orders for Life-Sustaining Treatment Paradigm**

Presenters: Catherine Deamant, MD and Amy Scheu, MSH CHPCA

Version: 08072017

Learning Objectives

By the end of this module you should be able to:

1. **Distinguish the relationship between an advance directive and the POLST (Physician Orders for Life-Sustaining Treatment) Form**
2. **Identify patients who are appropriate to initiate a discussion about POLST**
3. **Use the POLST form for creating actionable medical orders for ensuring seriously ill patient's decisions about life-sustaining treatments are respected across settings of care (outpatient to hospital; hospital to home or nursing home)**

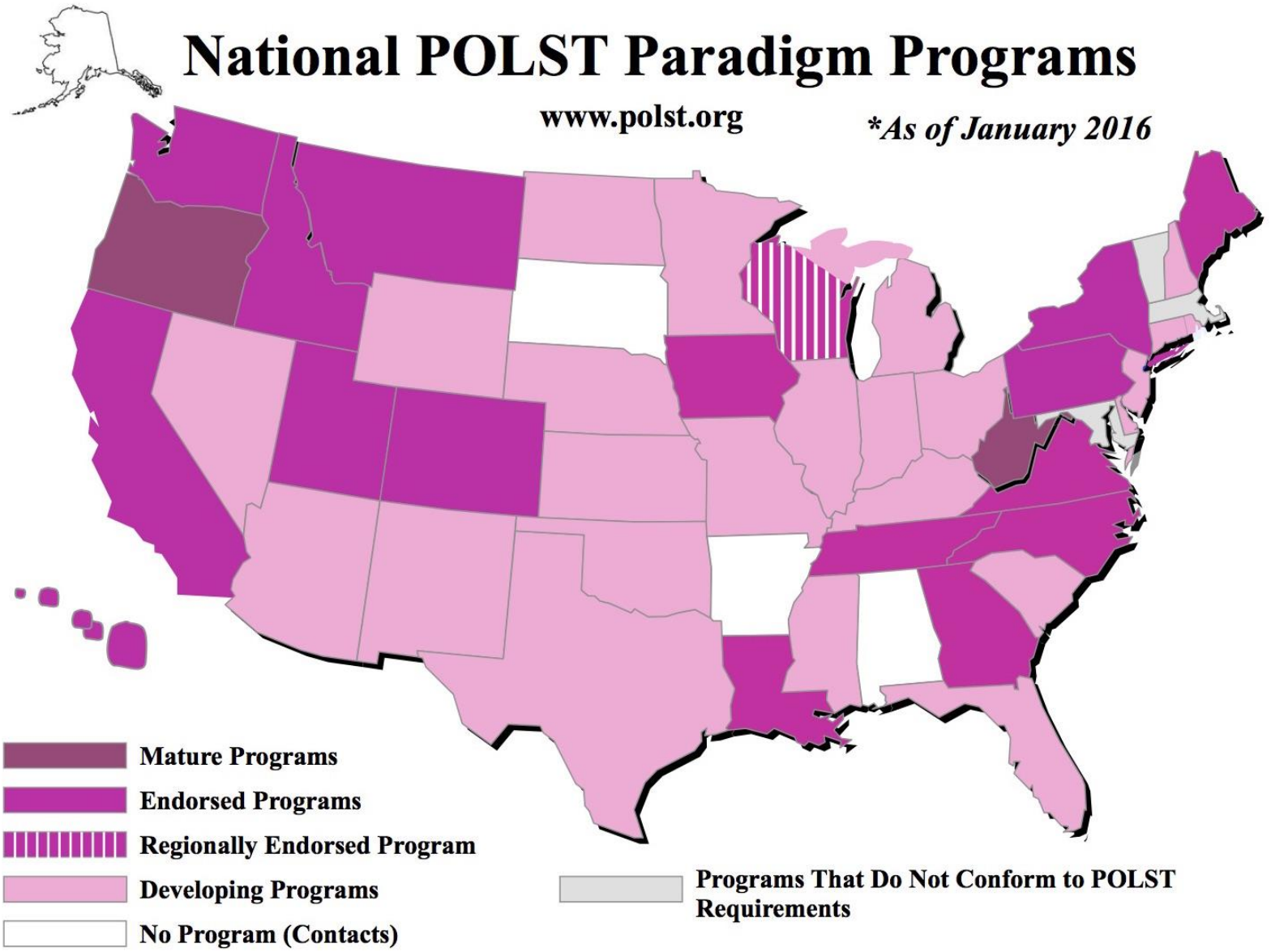
POLST Background and Key Components

- **Began in Oregon in 1991**
- **National POLST Paradigm, an approach to end-of-life planning, emphasizes patients' wishes about the care they receive**
- **Key elements of POLST Paradigm:**
  - An advance care planning discussion between the patient, health care provider (HCP) and loved ones
  - Shares decision-making between patient and HCP
  - Allows individuals to choose medical treatments they *want* and identify those they *do not want*
  - Ensures patient wishes are honored across settings using documented, actionable medical orders on POLST form

POLST Background and Key Components (con't.)

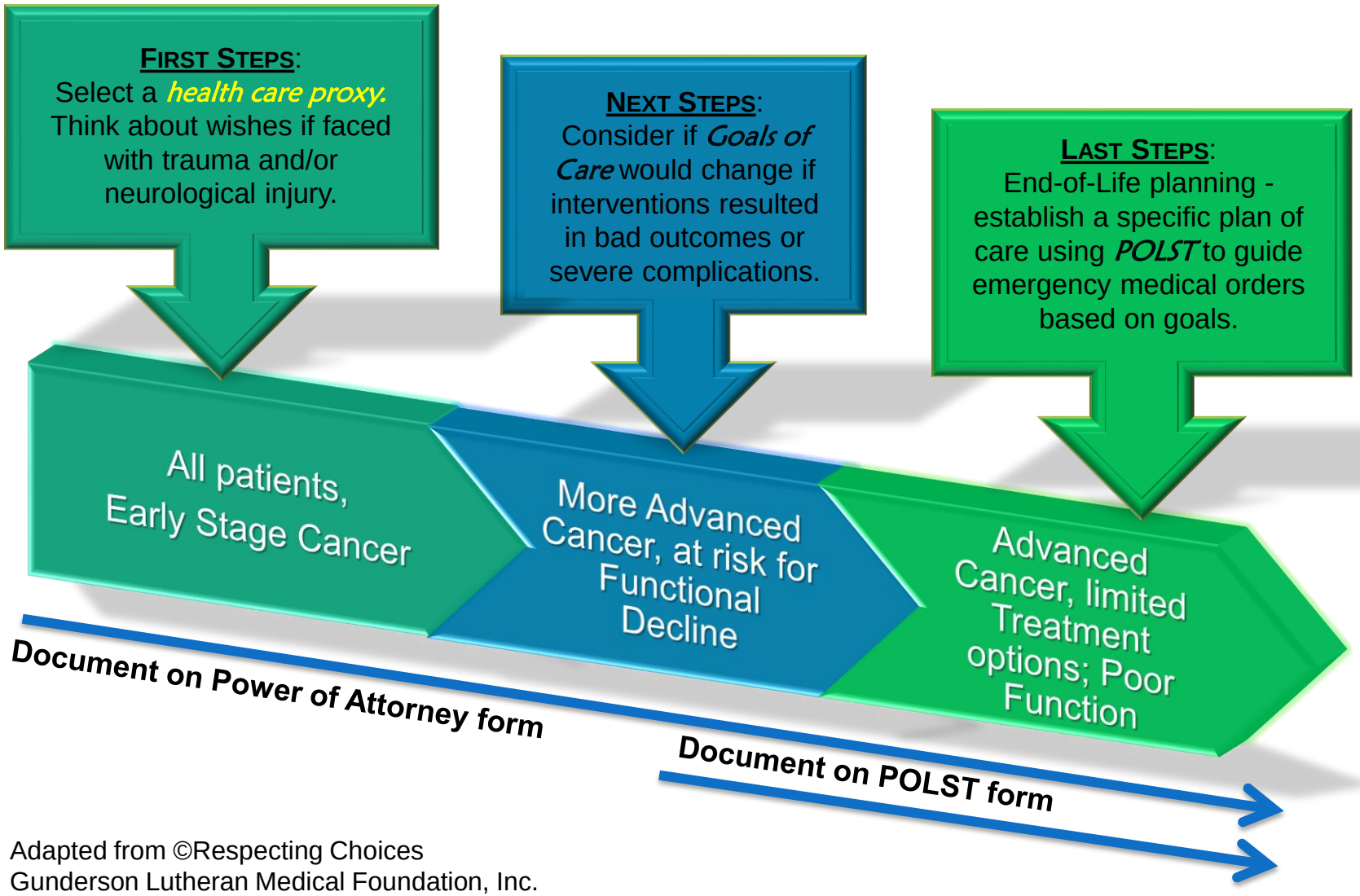
- **POLST forms have different titles per state, examples:**
  - Physician Orders For Life Sustaining Treatment
  - Provider Orders for Life Sustaining Treatment
  - Medical Orders for Life Sustaining Treatment
  - Medical Orders for Scope of Treatment
- **Most state's form includes the following elements:**
  - Decisions about resuscitation in cardiac arrest
  - Decisions about life-sustaining treatments prior to death
  - Decisions about artificial nutrition

POLST Use in the United States



POLST, physician orders for life-sustaining treatment paradigm®, http://www.polst.org/programs-in-your-state/. Used with permission.

Advance Care Planning Over Time



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Who is Appropriate for Implementing POLST Discussion?

- **Patients who should have a POLST discussion:**
  - Can be of any age
  - Have a serious illness, such as advanced cancer with limited treatment options, and/or are medically frail
- **A quick assessment can be made by asking yourself:**

"Would I be surprised if this patient died in the next year?"

Moss AH, Jour Pall Med 2010; 13(7):837-840.

Differences Between POLST and Advance Directives

Characteristics	POLST	Advance directives
Appropriate Population	Seriously ill; not surprised if die in 12 months	All adults
Time frame of care	Current care	Future care
Who completes the form	Health care professionals	Patients
Resulting form	Medical orders (POLST)	Advance Directive
Health care agent or surrogate role	Can engage in discussion if patient lacks capacity	Cannot complete
Portability	Provider responsibility	Patient / family responsibility
Periodic review	Provider responsibility	Patient / family responsibility

Adapted from Bomba P, Cleveland Clinic Jour Med 2012;79(7):457-464.

Rationale for POLST: Limitations of Advance Directives (AD)

- **Advance directives (AD) are preferences for care at end-of-life:**
  - "Living will" of wishes about future medical treatment, if patient can't make their own medical decisions
  - Durable power of attorney for healthcare
- **AD may not be *available* when needed**
  - May not have completed one
  - Often not transferred with patient
- **ADs may not have prompted relevant decisions and/or may not be *specific* enough**
  - No provision for treatment in nursing home or home
  - May not cover topic of immediate need or guide actions by emergency personnel
  - AD does not immediately or easily ***translate*** into medical order

Adapted from Bomba P, Cleveland Clinic Jour Med 2012;79(7):457-464.

Elements of a POLST Form (variable by state)

Primary Medical Order Sections

- **Cardiopulmonary resuscitation (CPR) for full arrest**
  - ❑ Yes, Attempt CPR
  - ❑ No, Do Not Attempt CPR (DNR)
- **Patient has a pulse and/or is breathing**
  - ❑ Comfort Care
  - ❑ Limited or Selective Treatments (iv fluids; antibiotics; hospitalization)
  - ❑ Full Treatment (intubation & ventilation)
- **Medical interventions including hospitalization, antibiotics, and artificial nutrition**
  - ❑ None
  - ❑ Trial period
  - ❑ Acceptable

Signatures needed:

- ❑ Patient or health care proxy if not decisional
- ❑ Provider varies by state (e.g., physician, advanced practice nurse, physician assistant or acceptance of verbal order)

Hickman SE, et al. JAGS. 2010;58:1241-1248

Who Can Assist in Preparing the POLST Form?

Best practice suggests use of those trained in the POLST Conversation such as:

- Physicians
- Advanced Practice Nurses
- Physician Assistants
- Social Workers
- Nurses
- Chaplains
- Care Managers
- Ethicists
- Among others

POLST versus Traditional Care Practices

- **The POLST process offers significant advantages over traditional methods of care in communicating and documenting preferences about life-sustaining treatment**
- **Patients with POLST forms are more likely to have treatment preferences documented as medical orders**
- **For patients with POLST forms indicating orders for comfort measures only, were less likely to receive unwanted medical interventions**

Hickman SE, et al. 2010; Tolle SW, Tilden VT, Nelson CA, Dunn PM. 1998.

POLST versus Traditional Care Practices

- **There have been several studies showing how well POLST works in allowing providers to honor patient wishes.**
- **One study of 180 Skilled Nursing Facility residents in Oregon showed some excellent results.**
  - Only the residents whose charts contained POLST forms documenting “Do Not Resuscitate” and “Comfort Measures Only” were surveyed.
  - The study found that none of these residents received unwanted CPR, care in the intensive care unit or ventilator support.
  - Their wishes were honored.

[*REFERENCE*: Tolle SW, Tilden VT, Nelson CA, Dunn PM: A prospective study of the efficacy of the PO(L)ST: Physician Order Form for Life-Sustaining Treatment. J.Am Geriatr Soc 1998;46:1097-1102.]

POLST versus Traditional Care Practices

Medical Order	N	Received LST (%)	Odds Ratio	p-value
POLST comfort only	300	13.7	1.00 (reference)	----
POLST limited interventions	335	18.8	1.73 (10.6-2.83)	.03
POLST full treatment	83	22.9	3.03 (1.45-6.34)	<.01
Traditional DNR order	626	25.9	2.44 (1.56-3.79)	<.001
Traditional full code	262	24.4	3.40 (1.98-5.85)	<.001

POLST (n=817) vs. Non-POLST (n=894)

[1]Life sustaining treatments (LST) included: hospitalization or emergency department visits, intravenous fluids, dialysis, transfusion, surgery or invasive diagnostic tests, chemotherapy, radiation, and intubation or ventilator support.

Data from: Hickman SE, et al. JAGS. 2010;58:1241-1248

Conclusion

- **POLST is a process**
  - should not be used as a check-box form, or as a replacement for an informed conversation between the patient, their families and providers
- **A POLST conversation should promote informed quality care through end-of-life and include shared decision-making**
  - Identify goals of treatment made with informed choices
  - Be documented in the medical record, along with a copy of the completed POLST form, reducing chance of medical error and improving guidance during life-threatening situations

Summary of Points Covered

In this training module we addressed:

1. **The relationship between advance directives and the POLST (Physician Orders for Life-Sustaining Treatment) Form**
2. **Identifying patients who are appropriate to initiate a discussion about POLST**
3. **Creating actionable medical orders for ensuring seriously ill patient's decisions about life-sustaining treatments are honored across settings of care (outpatient to hospital; hospital to home or nursing home) by having a POLST conversation and completing a POLST form.**

Next Steps

For more detailed training on this topic you can go to the following resources:

National Comprehensive Cancer Network® (NCCN®)

- **NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Palliative Care, Version 2.2017**
  http://www.nccn.org/professionals/physician_gls/pdf/palliative.pdf

POLST

- **POLST, physician orders for life-sustaining treatment paradigm®**
  http://www.polst.org/educational-resources/videos/www.yyy.edu
- **Polst: Doing it Better**
  http://www.polst.org/polst-doing-it-better/

Find an example of a POLST conversation at:
http://www.uctv.tv/search-details.aspx?showID=18360

Faculty Bio for Catherine Deamant, MD

Catherine Deamant , MD, graduated from Rush Medical College and completed her internal medicine residency at Michael Reese Hospital in Chicago, IL. From 1990-2014, she worked as a general internist in the Division of General Internal Medicine at Cook County Health and Hospitals System (CCHHS), with a focus on HIV care and homeless healthcare. In 2001, she established the Palliative Care Program for CCHHS.

From 2012-2014, she served as the Program Director for the Hospice and Palliative Medicine Fellowship, in collaboration with Rush University Medical Center and Horizon Hospice. She was an assistant professor at Rush Medical College.

She is board certified in hospice and palliative medicine. Currently, she is an associate hospice medical director for JourneyCare.

Faculty Bio for Amy Scheu, MSH, CHPCA

Brief bio of faculty Member

Amy Scheu, MSH, CHPCA, joined Advocate at Home, the home care division of Advocate Health Care, in 2007 and currently serves as Administrator of Advocate Hospice and System Palliative Care. In this role, she has led implementation and operations of hospice programs across the Chicago area and central Illinois that serve more than 2,200 patients annually. In 2010, Amy was asked to lead efforts to further assure care across the continuum by designing and implementing a system wide palliative care program for Advocate Health Care. Through her efforts, Advocate has launched successful home- and skilled nursing facility-based programs; established four outpatient clinics serving patients in the south, west and north areas of the city and suburbs; and expanded inpatient palliative care services at several hospitals. Amy has also been instrumental in initiating physician palliative medicine education efforts through Advocate Physician Partners, Advocate Health Care's PHO. She has also worked with Advocate Medical Group to secure funding and implement a palliative care pilot serving Medicare Advantage patients on Chicago's south side.

Amy has been certified as a hospice and palliative care administrator by the National Hospice and Palliative Care Organization. She received her bachelor of arts degree from Marquette University and a master's degree in health services administration from Cardinal Stritch University, Milwaukee. She also has a certificate from Harvard School of Public Health in Healthcare Project Management.

References

Bomba P, et al. POLST: an improvement over traditional advance directives. Cleveland Clinic Jour Med. 2012;79(7):457-464.

Hickman SE, et al. A comparison of methods to communicate treatment preferences in nursing facilities: traditional practices versus the physician orders for life-sustaining treatment program. J Am Geriatr Soc. 2010;58:1241-1248.

Moss AH, Lunney JR, et al. Prognostic significance of the “surprise” question in cancer patients. Jour Pall Med 2010;13(7):837-840.

POLST, physician orders for life-sustaining treatment paradigm®. http://www.polst.org/. Accessed January 21, 2016.

POLST Illinois, Practitioner Orders for Life-Sustaining Treatment. http://www.polstil.org/. Accessed January 21, 2016.

University of California Television, UCTV. POLST: Having the POLST Conversation. http://www.uctv.tv/search-details.aspx?showID=18360. Accessed January 21, 2016.