USING PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) IN PLANNING RESIDENT CARE

James McCracken, New Jersey Long-Term Care Ombudsman
Elizabeth Speidel, Director, Policy and Legislative Affairs

Objectives

- Describe and why of effective advance care planning
- Describe what advance care planning currently looks like in New Jersey
- Describe why POLST is needed
- Describe what POLST is

ACP = Good Care

- ACP is an ongoing process of communication and negotiation that focuses on goals and likely outcomes
- Person-centered care
  - “Person before the task”
  - Resident choice
- No one communication strategy
  - Tailor to the disease trajectory
  - Tailor to needs/communication style of individual and family
- MUST COMMIT to ensure preferences are honored
Components of Successful ACP

Health Care Proxy – AD
- How to Pick a Proxy
  - Is the person willing to take on the role?
  - Is the person willing to listen to and understand individuals’ goals, values, and beliefs for future health care decisions?
  - Can the person follow your wishes even if they are different than their own?
  - Can the person make decisions under difficult and stressful situations?
  - Will the person be available?
- Back-Up
- Covenant v. Contract
  - Flexibility?

Need for Advance Care Planning
- Need to honor patient wishes, values, and preferences for care
- Life expectancy increased to 78 with many reaching 90’s +
- Increased prevalence of chronic diseases and varying degree of disability and dependence
- Regional variations in use of intensive care, artificial life supports, hospital care, utilization of hospice, location of death,
- Lack of good communication skills for HC professionals about prognosis and EOL options
- Death denying society
- Once patients reach ED via 9-1-1 call, NO GOALS OF CARE identified
Current World & Need to Improve

Advance Directives

- Proper writing
- Proper signed/directed by person
- Witnessed by 2 adults or a notary

Lack Capacity
- 2 doctors say
- Individual is unable to understand/appreciate the nature and consequences of health care decisions

Given to Health Care Provider
- Medical providers have to have the document

Limitations
- Can be confusing to providers
- Not operational in the field

DNRs/DNHs/DNIs

- DNRs/DNHs/DNIs are orders written by doctors or advanced practice nurses (in collaboration with doctors) that are made part of a resident's medical record
- Do not travel across medical settings and only address particular component of care (resuscitation, intubation, hospitalization)
- One trick ponies
ACP in Today’s World

- Many people think it’s important but few have done it: ADs in NJ ~ 16%
- Focus on forms and NOT on communication
  - Forms vague/difficult to understand when filling out
  - Forms are not written in a way that is useful to HCP
  - Surrogates are poorly prepared to act
  - People change but forms haven’t been updated
  - Forms aren’t accessible (not with HCP, even given to HCP not accessible when needed)

The Dartmouth Atlas of Health Care

- Dying New Jerseyans receive the most excessive care in the nation without any evidence of benefits to this care (e.g., living longer or higher quality of life)
- NJ has the nation’s highest Hospital Care Index Score – dying patients see the most doctors, get the most tests and spend the most time in hospitals and ICUs WITH NO EVIDENCE OF BENEFIT TO PATIENT

What is POLST?
Philosophy of POLST

- Creates structure for talk with medical and long-term care providers
- Focus on individuals’ goals of care not just code status
- Aligning care and treatment with goals of care
- Individuals have right to make own health care decisions
- Respect for wishes across the continuum regardless of setting and provider! (Same form in ALL settings)

IT IS NOT A PANACEA.

POLST

- Actionable Medical Orders:
  - Brightly colored format uniform form
  - Portable from one setting to another – ALL SETTINGS!
  - Does not require interpretation or evaluation of patient so can be honored at point of contact with POLST by LTCF, EMS, ED, hospital
  - Represents previous discussions with health care provider about residents’ goals of care and decisions regarding desired medical interventions
  - Promise by HC professionals to honor
  - Complements Advance Directives

POLST

- ABOUT NOW
- Voluntary
- Modification/Revocation
  - Individual with DMC can change/revoke POLST at any time or request alternative treatment to what is on POLST
- Surrogates
  - Can sign based on known preferences or, if they are unknown, best interest
  - May modify/revoke if patient authorized
- Most recent verbal or written medical directive of patient governs
- Will work if copy or not on green paper (Hammerhill 103366)
What Does POLST Address?

- Goals of Care
- Medical Interventions
- Artificially Administered Fluids and Nutrition
- CPR
- Airway Management

Possible Candidates for POLST

- Anyone expected to die or lose DMC within next year
- Frail elderly and terminally ill
- Long-term residents in LTC facility
- People who are chronically ill and have multiple contacts with health care system
- Anyone choosing Do Not Resuscitate and Allow Natural Death
  
  *Not indicated for healthy person for “what if”*

POLST v. DNR

- POLST is portable!
- POLST includes choices about other life-sustaining treatments such as intubation for respiratory distress while DNR only applies to CPR
Differences Between AD & POLST

<table>
<thead>
<tr>
<th>Advance Directive</th>
<th>POLST</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Adults</td>
<td>People w/Advanced Illness</td>
</tr>
<tr>
<td>Future Care/Condition - IF THEN</td>
<td>Current care/condition - NOW</td>
</tr>
<tr>
<td>Individual &amp; Witnesses/Notary</td>
<td>Individual/Surrogate &amp; Doctor/APN</td>
</tr>
<tr>
<td>Names surrogate</td>
<td>Doesn't name surrogate</td>
</tr>
<tr>
<td>Legal Document - Requires Interpretation</td>
<td>Medical Order - Immediately Actionable</td>
</tr>
<tr>
<td>Any Setting</td>
<td>Medical Setting</td>
</tr>
<tr>
<td>Individual/Med. Records</td>
<td>Original w/ Individual/Copy in Medical Records</td>
</tr>
<tr>
<td>Not operational in field (EMS)</td>
<td>Operational in field (EMS)</td>
</tr>
<tr>
<td>Transportable</td>
<td>Transportable</td>
</tr>
<tr>
<td>Limited to certain situations</td>
<td>Not limited by situation or place</td>
</tr>
<tr>
<td>Loss of capacity</td>
<td>No loss of capacity</td>
</tr>
</tbody>
</table>

POLST Form

The Conversations

- Prepare
  - Review resident’s goals & values, medical condition & prognosis, any ACP docs, resident’s capacity, identify key family members and/or health care proxy if necessary
  - Create the space: private, enough time, turn off cell – give full attention
  - Be mindful to use simple language and respond empathetically
  - Have tissues
The Conversations
- Discussion
  - Describe purpose of meeting
  - Identify spokesman if not resident and there is one
  - Assess resident’s current state of mind, comfort level
  - Ask what resident/family understand of condition and prognosis
  - Talk about ACP/POLST – what resident has, what ACP is
  - Ask about resident’s goals of care, values, wishes

Communication: Goals & Concerns
- What an individual hopes for, what he or she fears, what makes life worth living
  - Activities (listening to music, engaging with people)
  - Milestones
  - Fears/concerns (breathing, pain, family strife)
  - Specific to condition: Cure, improving function
  - Where individuals want to be
- Every person is different and that must be valued
- Goals and values change

The Conversations
- Go more in-depth about condition and prognosis and clarify any areas of confusion
- Discuss possible interventions (use of antibiotics, CPR, ANH) and palliative care or hospice
- Discuss/fill-out any medical orders; encourage filling out advance directive
- Ending the Discussion
  - Ask: What do you understand about what we’ve talked about? (Not do you have any questions.)
  - Explain will always have provide comfort
  - Offer to have a follow-up meeting if necessary and explain will revisit whenever needed
**Keys To Success**

- Trust, communication & relationships
- Individual understands health care status, diagnosis, prognosis, possible care/treatment options.
- Opportunity to reflect on goals/values in conjunction with health status
- Opportunity to clearly articulate goals/values/wishes
- Individuals know they have choices/understand ALL the choices/treatment options and burdens/benefits
- Involvement of IDT and all relevant facility/care provider knows who the proxy is and what articulated wishes are and all are ready to advocate

---

**Positive Facility ACP Process**

- Staff are trained and supported about ACP/GOC; how to deal ethics dilemmas, with death/dying of residents.
- Team approach
- Ensure resident and family are fully informed of (1) resident’s medical condition, (2) prognosis and range of possible outcomes (hope for best, prepare for rest) and (3) common medical interventions (CPR, ANH, palliative care)
- Residents have the opportunity to express wishes about GOC and desired medical interventions clearly.
- Connect /collaborate with network (provider-level, community-level) to ensure success of implementation
- Facility has policies/procedures in place to document, communicate, and honor wishes of residents.

---

**Important Aspects of NJ POLST**

- Should be reviewed or renewed ONLY when:
  - Individual preferences change
  - Individual’s health status changes warranting change in preferences
  - Patient transferred to another care setting (review only to verify)
  - Focus on goals of care
  - Includes education and training for MD
  - Requires "process" - a discussion with doc or APN (not just filling out a check-box form)
  - Individual or surrogate signs the form too
  - Surrogate may complete POLST but cannot modify or rescind POLST unless specifically authorized to do so by patient when signed.
A Decade of Research
Oregon POLST Program

2004:
- 96% Oregon NH's report POLST used to guide decisions and evolved to care standard
- Oregon EMS indicate POLST changes treatment in 45% of patients

Outcomes

Benefits of ACP
- Reinforces to residents that health care needs will be met
- If critical event happens, won’t be first time thinking about issues
- Avoid conflict among family/staff
- Strengthen relationships
- Reduced stress and anxiety for proxies and staff
- Reduce unnecessary hospital transfers
- Improved quality of care
- Increased satisfaction with care

Consequences of No ACP
- More aggressive intervention (feeding tube) or insufficient intervention (pain)
- Imposes stress on staff b/c of inability to constructively deal with grief/loss and time to sort through ethical complexities
- No matter what decision made, family/HCP live with uncertainty, resulting in lasting distress

Resources

Tools for Developing a Facility Plan
- POLST
  - njha.com/polst
- Coalition for Compassionate Care of California
- Advancing Excellence in America's Nursing Homes
  - Goal 6 – Advance Care Planning
    http://www.nhqualitycampaign.org/star_index.aspx?controls=realGoal

By Goal
Resources
Tools that May Help Have the Conversation

- INTERACT II
  http://www.interact2.net/tools.html
- Hospice & Palliative Nurses Association TIPS Sheets
- American Hospice Foundation: Medical Issues to be Considered in Advance Care Planning

Resources
Advance Care Planning Tools

- The Conversation Project
  http://theconversationproject.org/
- Engage with Grace
  http://www.engagewithgrace.org/
- 5 Wishes
  http://www.agingwithdignity.org/five-wishes.php
- Caring Conversations
  http://practicalbioethics.org/resources/caring-conversations.html
- American Bar Association
  http://www.americanbar.org/groups/law_aging/publications.html
- Your Life Your Choices
  http://www.rihlp.org/pubs/Your_life_your_choices.pdf

New Jersey Long-Term Care Ombudsman

James W. McCracken, M.H.A., Ombudsman
240 West State Street
Post Office Box 852
Trenton, NJ 08625-0852
Toll Free: 1-877-582-6995
FAX: 609-943-3479
Elizabeth Speidel
609-826-5025