Using Physician Orders for Life-Sustaining Treatment (POLST) in Planning Resident Care

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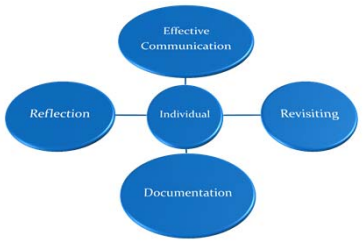
Objectives

- Descrhat 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

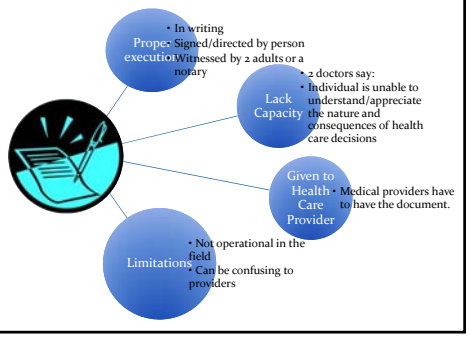
- How to Pick a Proxy
  - Is the person willing to take on the role?
  - Is the person willing to listen to and understand individuals' goals, values, and beliefs for future health care decisions?
  - Can the person follow your wishes even if they are different than their own?
  - Can the person make 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



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

Advance Directive	POLST
All Adults	People w/Advanced Illness
Future Care/Condition – IF, THEN	Current care/condition - NOW
Individual & 2Witnesses/1 Notary	Individual/Surrogate & Doctor/APN
Names surrogate	Doesn't name surrogate
Legal Document – Requires Interpretation	Medical Order – Immediately Actionable
Any Setting	Medical Setting
Individual/Med. Records	Original w. Individual/Copy in Medical Records
Not operational in field (EMS)	Operational in field (EMS)
Transportable	Transportable
Limited to certain situations	Not limited by situation or place
Loss of capacity	No loss of capacity

POLST Form

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

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
  - http://coalitionccc.org/nursing-homes.php
- Advancing Excellence in America's Nursing Homes
  - Goal 6 – Advance Care Planning http://www.nhqualitycampaign.org/star_index.aspx?controls=resByGoal

Resources

Tools that May Help Have the Conversation

- INTERACT II
  - http://www.interact2.net/tools.html
- Hospice & Palliative Nurses Association TIPS Sheets
  - http://www.hpna.org/DisplayPage.aspx?Title=TIPS
- American Hospice Foundation: Medical Issues to be Considered in Advance Care Planning
  - http://www.americanhospice.org/articles-mainmenu-8/advance-care-planning-mainmenu-9/46-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

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