

POLST

physician orders for life-sustaining treatment paradigm

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FROM THE EXECUTIVE DIRECTOR

Dear Friends,

Too often I hear stories of how completion of a POLST Form is just an item checked off during a process. It is important to remember - and educate our communities - that the National POLST Paradigm is not just a form, but a conversation between patients and health care professionals. The stronger this conversation is, the stronger the National POLST Paradigm becomes. Our challenge is to ensure that mutual, detailed conversations about treatment options, goals of care, and values underlie every POLST process.



While fostering good conversations is harder than filling out a form, it is a task we are up to. National POLST is always looking for new opportunities to encourage conversations, like National Healthcare Decisions Day (see News), and we are interested in finding other ideas, like Advanced Illness Systems (see News), that can encourage real discussions of end-of-life goals. We hope that all of you will continue to share your ideas and resources for improving conversations so that we can continue to strengthen the National POLST Paradigm and improve the lives of those with serious illness and frailty.

Best wishes,

Amy Vandenbroucke, JD
Executive Director

News

Rhode Island Implements MOLST

In 2012, Rhode Island passed a law creating a MOLST program. The law was finally implemented last fall and, as of January 1st, hospitals and long-term care facilities must offer MOLST forms to admitted patients with serious

FEATURED NEWS

Deactivation of Cardiac Devices

A recent post on the New York Times New Old Age blog explored the issue of deactivation of pacemakers and defibrillators. As the author emphasizes, there are hundreds of thousands of these devices implanted each year, but many patients have not thought about whether they want their implants to remain active as they approach the end of life.

A recent study from a Mayo Clinic researcher showed that many

illness.

Congratulations to the leaders in Rhode Island who have worked to bring MOLST from the legislature to patients in need.

To read an article on MOLST from the Providence Journal, [click here](#).

To learn more about MOLST from the Rhode Island Department of Health, [click here](#).

Teamwork at the End of Life

NPPTF Executive Committee member Judy Black was recently recognized for her team's contributions to a new end-of-life care initiative. Highmark Inc., where Black is Medical Director for Senior Markets, won the Gold Medal from the Jewish Healthcare Foundation's Fine Awards for Teamwork Excellence in Healthcare for its Advanced Illness Services (AIS). AIS is an initiative to provide multidisciplinary consultations to individuals in their health plans.

To watch a video about Advanced Illness Services, [click here](#).

Start Planning for National Healthcare Decisions Day

National Healthcare Decisions Day (NHDD) is April 16th, a date that is quickly approaching. NHDD is a national day that encourages awareness of advance care planning. It is also an ideal time for POLST Programs to educate the public about the importance of POLST and how to have the conversation.

Start thinking about how your organization can create a campaign around NHDD to help people better understand their end-of-life options.

To learn more about NHDD, [click here](#).

patients who ultimately had their devices deactivated had not recorded this wish in an advance directive or POLST form. Furthermore, the blog's author notes that many patients with implants do not know that the devices can be disabled.

The research on cardiac device deactivation reveals that this is an area of advance care planning that needs additional attention. Advance care planning initiatives need to better educate patients about their options and incorporate decisions about cardiac devices into conversations about treatment wishes.

To read the blog post, [click here](#).

FEATURED RESOURCE

Kansas-Missouri TPOPP Video

Kansas and Missouri's POLST Program - called **Transportable Physician Orders for Patient Preferences** or TPOPP - recently released a new video clearly explaining the role of TPOPP in advance care planning, the importance of the conversation, and the perspectives of health care professionals.

The video not only makes a clear and persuasive case for the value of TPOPP, it also serves as a guide for other POLST programs considering producing a video. Watch the video and think about how the POLST Paradigm can best be explained to people in your state.

To watch the video, [click here](#).

To watch other POLST Program videos, [click here](#).

FEATURED RESEARCH

Efficacy of a POLST-Like Program in Singapore

A 2013 article in **Palliative Medicine** explored the effect of a standing, end-of-life care medical order form on the provision of treatment in Singapore's National University Hospital. Although the document is not a POLST form, it is modeled on POLST and has many similarities. The authors reviewed charts of patients who died in 2007 - before the intervention was implemented - and patients who died in 2010 - after implementation.

The study found that the use of the medical order form significantly increased the likelihood of a DNR order (from 66% to 80%). The use of the form also increased the proportion of patients who refused other life-sustaining treatment, including IV hydration, antibiotics, and tube feeding. Notably, the care provided in the last 24 hours of life reflected the treatment wishes. For example, 9% of patients received CPR prior to the intervention while 5% received CPR after the intervention. Similarly, 45% received antibiotics before the intervention and 25% of patients received antibiotics after the intervention.

An important additional finding was the relationship of the order form to conversations between patients and health care professionals. Prior to the intervention only 5% of patients had discussions with their health care professionals about CPR use, while after the intervention 10% discussed CPR orders with health care professionals. Even more dramatic, the proportion who spoke to family members about about CPR orders increased from 57% to 80%.

The authors conclude that the form is effective in fostering end of life conversations and allowing patients the option to decline some life-sustaining treatments. Although the study is not about POLST forms, this research supports the idea that POLST Programs foster advance care planning and offer patients a means to avoid unwanted treatment.

To access the full article, click the citation below:

Tan, A, A Seah, G Chua, TW Lim, and J Phua. (2013). "Impact of Palliative Care Initiative on End-of-Life Care in the General Wards: A Before-and-After Study" Palliative Medicine 28(1): 34-41.

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