

POLST Legislative Guide

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National POLST Paradigm Task Force

Introduction

The development of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm has generated a range of legal/regulatory questions that have been answered in a variety of ways by states— by clinical consensus, sometimes by legislation or regulation, and sometimes by guidance. Drawing upon the experience of the states that have implemented POLST Paradigm by 2013, the National POLST Paradigm Task Force (NPPTF), with assistance from two individual members of the American College of Trust and Estate Counsel (ACTEC), convened a legislative working group¹ to review the recurring policy, legislative and regulatory issues and the responses of states developing POLST Programs to those issues. The result of that process is this POLST Legislative Guide which we hope will facilitate a better understanding of the issues, options available, and best practices.

An underlying principle reflected in this review is that the development of a POLST Program should be driven by clinical consensus with broad input from the field. The discussion under *Issue 2* below suggests examining whether legislation is really needed to create a POLST Program. The article, *The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation*, identifies some of the circumstances and issues that have presented barriers to POLST and that have prompted legislative solutions.² To whatever extent legislative and/or regulatory changes are sought, it is important to build in flexibility in the program so that it can be sensitive to innovations in clinical practice and continuous quality improvement with broad-based input from the field.

The Guide is organized around twelve legal/regulatory questions and issues that have been most recurrent across the states implementing POLST Programs. It suggests a preferred outcome to each issue, based upon the collective learned experience of states with POLST Programs endorsed by the NPPTF. The Guide provides a description and analysis of each issue -- and sub-issues where indicated -- and offers options to guide response strategies that may range from clinical practice consensus to legislation. The NPPTF has not attempted to provide a model POLST act because experience to date has demonstrated that the frameworks and complexities of each state's existing state health care decisions laws are unique. Every legislative approach requires substantial customization to work within any particular state. It is expected that any of the options described here will need some degree of adjustment to fit with or modify state law.

¹ Margaret Carley, Marilyn J. Maag, Thaddeus M. Pope, Charles P. Sabatino, Amy Vandenbroucke, and Robert B. Wolf.

² Susan E. Hickman et al., "The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation," 36 *J. L. Med. & Ethics* 119-40 (2008), available at http://www.polst.org/educational_resource/the-polst-paradigm-to-improve-end-of-life-care-potential-state-legal-barriers-to-implementation.

While the above authorities are consistent with POLST's validity at the time of admission to a hospital or emergency department, the implementation of POLST also involves the concurrent clinical obligation to reassess the patient's condition and the medical plan of care whenever the patient's condition changes. This includes reassessment of POLST and its possible modification.

Issue 9B. When is POLST review and possible modification necessary or advisable?

Review of POLST follows fairly clear clinical norms and is best not fixed by a statutory schedule. In practice, in states with POLST Programs most hospitals honor the POLST form that accompanies a patient until the patient is reassessed, treatment choices are discussed, and new orders are written. In emergency circumstances there may be no time to do a reassessment, in which case POLST should dictate care.

As a clinical matter, the NPPTF recommends that POLST be reviewed periodically and specifically when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's goals of care and/or treatment preferences change.

Review of the patient's POLST form upon discharge or transfer for one care setting to another, is critical. When a patient is leaving a care setting, health care professionals should review the POLST form with the patient to: (i) confirm the orders are still accurate; (ii) update the POLST form to reflect new preferences or (iii) void the POLST form if the patient is not within the appropriate POLST population.

Health care professionals should also be sure to review POLST as part of other scheduled care plan reviews. It is clinically appropriate to review POLST orders at least once a year even if none of the other triggering events listed above have occurred. For example, in nursing homes, there is already a federal requirement for review of care plans every three months and states may have additional care plan review requirements.³¹ POLST should be made an express part of care plan review.

If a patient presents with a POLST form at a hospital, an appropriate practice is for the admitting physician to discuss the POLST orders with the patient, acknowledging that a physician or other health professional has previously spoken to the patient about his or her wishes. The admitting physician then can reissue the orders, or change them if the patient indicates such a change is now desired.

The practical challenge occurs when the patient is not capable of having this conversation with the admitting physician or circumstances otherwise prohibit the conversation. In this

[Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-47.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-47.pdf); and F tag 309 (Quality of Care), available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-48.pdf>.

³¹ 42 C.F.R. 483.20(c).

circumstance, if the patient has an authorized surrogate available and time permits, the physician should discuss the patient's condition and wishes with the surrogate, and POLST can likewise be reissued or changed.

If the medical situation is an emergency that precludes the attending physician from discussing the POLST orders with the patient, the orders expressed on the POLST form are valid and should be followed. If, thereafter, the patient stabilizes, POLST should be reviewed and adjusted accordingly according to hospital protocols. This review is done by a physician who has facility privileges. In all cases, the attending physician should ensure that the orders on the POLST form, as revised if necessary, become active hospital chart orders, and that a new POLST is done prior to discharge.

Issue 10: Does POLST raise liability or immunity concerns?

Preferred Outcome: Establishment of POLST as a clear standard of practice. Health care professionals are protected under common law by compliance with generally accepted standards of practice in their area.

Some states, like Oregon, have been able to implement POLST solely through clinical consensus. In 1991, Oregon clinicians implemented POLST on the basis of clinical consensus and without any explicit grant of immunity. Only subsequently, in 2007, did the Oregon Medical Board promulgate a regulation confirming that “a physician or physician assistant shall not be subject to criminal prosecution, civil liability or professional discipline” for honoring a POLST.³²

Issue 10A. Is legislative immunity preferable, analogizing to advance directives?

Many health care professionals across the country want more explicit reassurance. While they may not need it, they prefer statutory immunity. When they follow the orders in a POLST in good faith, they want protection from criminal prosecution, civil liability, and disciplinary sanctions. Since health care professionals already have this immunity for following advance directives and surrogates, some argue that it is anomalous not to have equivalent immunity language in a POLST statute or regulation.

Washington is illustrative. Currently Washington law affords immunity only to EMTs. But legislative testimony, in early 2013, demonstrated that emergency room and long-term care providers are reluctant to comply with POLST forms that decline treatment.³³ These clinicians and facilities want to carry out patient wishes. But, they are fearful of legal risk. Whether or not this fear is grounded, it is real to them. And it leads some providers to disregard patient wishes. Consequently, depending on the medical culture in one's state, statutory immunity may be a critical factor to assuring that POLSTs are carried out.

³² Ore. Admin. R §§847-010-0110 & 847-035-0030(6).

³³ Wash. S.B. 5562 (2013); Wash. H.B. 1000 (2013).

Issue 10B. Can health care professionals presume validity of a POLST form presented to them?

Parallel to the general rule for advance directives, health care professionals should be able to presume the validity of a POLST. A health care professional who honors a POLST should not be subject to any sanctions, as a result of his or her reliance on the POLST, so long as the health care professional believes “in good faith” both that the POLST is valid and that it has not been revoked. In this regard, reliance on a POLST is equivalent to reliance on any other medical order.

Issue 11: Administration, monitoring, and evaluation – what infrastructure and process should be in place for POLST Programs?

Preferred Outcome: A clear lead entity or agency exists to administer the POLST Program, with three essential functions: ongoing education, research and monitoring, and quality improvement.

Issue 11A: What is an appropriate administrative structure needed to establish a POLST Program?

It is possible in theory to establish a POLST Program with no administrative entity responsible for any of the functions above. Legislation can legitimize any program meeting the minimum legislative criteria for POLST, or meeting criteria established by a designated state regulatory agency such as the department of health. However, research examining twelve states with POLST Programs as of 2010 found that one of the key lessons of success from those states is that POLST is neither a static program nor self-implementing. It requires a continuous process of professional education, evaluation, and quality improvement. Oregon, which has the longest history of using POLST, continues to evaluate the operation of the program and continues to make changes in the form or procedures every few years to respond to problems identified. POLST Programs must also adapt to continuing improvements in medical treatment, technology, and health delivery.

States have chosen quite different lead agencies with quite differing resources.

- In New York, the State Health Department exercises regulatory jurisdiction over POLST (called MOLST), setting basic guidelines and having authority to enforce them, but a statewide non-profit group (Compassion and Support) actually distributes the form and provides an array of educational resources and research.
- In Oregon and West Virginia, the lead entity is a University.

Issue 11B. How do we best evaluate whether the POLST Program is genuinely determining patients' values, priorities, and goals of care and translating them into accurate orders?

Because POLST is neither a static program nor self-implementing, an inclusive oversight group, consisting of representatives of the various organizations that contribute to advanced care and end-of-life health care must provide input, over time, on how to make the POLST form and

program more effective in the state. As explained under *Issue 4C* above, the coalition ideally includes the state medical association, the state bar association, EMS providers, hospitals, long-term care providers, nurses' associations, hospice associations, the disability community, and other consumer groups, including faith-based organizations that are particularly concerned about patient protections. This coalition will make suggested improvements to the POLST form and program based on the experiences and input of its various members.

Educating everyone involved in advanced care planning on the availability and proper use of POLST is key to its widespread and effective implementation. Accordingly, the working group should develop and implement a specific plan for initial and ongoing education in the use of POLST and effective counseling of patients and families. Large organizations, such as hospitals and nursing homes, may create their own training programs. Public education is also a necessity to better equip the public to participate effectively in decisions about advanced care.

The coalition implementing the POLST Program should implement a system for evaluating their POLST form and the POLST program, and for implementing changes and updates to both. To the extent that a data collection and monitoring system can be established to track usage of POLST, evaluation will be more effective.

From time to time there may be a need to propose changes or updates to the rules in the state administrative code or the state's statutes, if applicable. If the coalition is meeting regularly and has a plan for monitoring and evaluating the POLST program, then the coalition will be in a position to garner the evidence needed to bring about changes in the administrative rules or the state's statutes.

The coalition will have assistance and resources available to it through the NPPTF. The NPPTF is engaged in education, advocacy, and research, with regard to end-of-life health care, on a nationwide basis. Thus, each state's working group can learn from the experiences and insights of other working groups, and from the research done at the national level by the NPPTF.

Issue 12: Are POLST forms portable across jurisdictions?

Preferred Outcome: Explicit reciprocity recognized in protocols, regulations, or law.

Issue 12A. What is the source of authority for recognition across jurisdictions and applicability of immunity?

Only a minority of states have a statute or regulation explicitly recognizing POLST forms from other states.³⁴ Therefore, the only “authority” for recognition across jurisdictions emanates from generally accepted medical practice, to the extent it acknowledges and respects existing medical

³⁴ See e.g., Colo. Rev. Stat. Ann. § 15-18.7-104 (1)(a) (“Except as provided in [this statute], emergency medical service personnel, a health care provider, or a health care facility shall comply with an adult's executed medical orders for scope of treatment form that: (I) Has been executed in this state or another state; (II) Is apparent and immediately available; and (III) Reasonably satisfies the requirements of a medical orders for scope of treatment form....”).

orders. POLST is a written medical order, which is followed by the medical community to whatever extent that all medical orders are generally followed and implemented. When a patient moves from a hospital to a nursing home, or across state lines – from one jurisdiction to another, typically a physician will review the patient's history and existing orders, and update those orders. When a patient with a POLST form moves into a jurisdiction that does not utilize POLST forms, it becomes unclear whether the new physician is required to recognize the POLST orders and will be protected from liability for doing so. Legislation specifically mandating recognition of the other state's POLST form, and granting immunity from liability for doing so, is a helpful solution.

Issue 12B. Where there is variation of substantive POLST provisions or health decisions laws, which law applies (originating state or receiving state)?

As explained in other portions of this Legislative Guide, a POLST Program may be created and implemented without legislation. Portability of POLST forms, however, is an area where legislation is helpful, because it can establish explicit reciprocity and recognition. See additional discussion under *Issue 4A*.

Most states already recognize the face validity of an out-of-state advance directive, but implementation of such a directive may be impaired or its interpretation altered by the implementing state. Reciprocity is similarly developing with regard to POLST, but whether it will be hampered by implementation or interpretation differences is still largely untested.

The states have taken four main approaches to POLST portability. First, some states will honor the originating state's POLST so long as it complies with the law of the *receiving* state (e.g. Iowa,³⁵ New Jersey³⁶). Second, some states will honor the originating state's POLST so long as it just *reasonably or substantially* complies with the law of the receiving state (e.g. Colorado,³⁷ Idaho,³⁸ Utah³⁹). Third, some states honor the originating state's POLST so long as it complies with the law of the *originating* state (e.g. Rhode Island⁴⁰). Fourth, some states will honor the originating state's POLST so long as it complies with *either* the law of the receiving state *or* the law of the originating state (e.g. West Virginia⁴¹). We do not yet have enough experience to say which approach is the best solution.

Whichever approach is taken, POLST will be undermined if clinicians have to refer all questions about legal compliance to counsel. One way to avoid that is to build in a presumption of validity for POLST forms, regardless of origin. California has such a presumption for DNR requests,⁴² but so far, only Maryland has legislated such a presumption in their POLST law:

³⁵ Iowa Code § 39-4514.

³⁶ N.J. Stat. Ann. § 26:2H-134(c).

³⁷ Colo. Rev. Stat. Ann. § 15-18.7-104.

³⁸ Idaho Code § 39-4514.

³⁹ Utah Admin. Code R. 432-31-11.

⁴⁰ R.I. Gen. Laws 1956, §§ 23-4.11-2 & 23-4.11-12.

⁴¹ W. Va. Code § 16-30C-15.

⁴² Cal. Probate Code § 4784.

A health care provider may rely in good faith on the presumed validity of a “Medical Orders for Life-Sustaining Treatment” form.⁴³

This kind of resumption is more common in state advance directive laws. For example California’s advance directive law provides:

In the absence of knowledge to the contrary, a physician or other health care provider may presume that a written advance health care directive or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.⁴⁴

In light of the variation in portability provisions, this is clearly an area where *federal* law could be very effective. For example, the recently introduced *Personalize Your Care Act of 2013*⁴⁵ provides that an advance directive validly executed outside the State in which such directive is presented “must be given effect by a provider of services or organization to the same extent as an advance directive validly executed under the law of the State in which it is presented.”⁴⁶ The bill has an express preemption clause that would preempt any state law with inconsistent portability provisions. Legislation could apply this same kind of mandate to POLST.

Alternatively, a *uniform* law, adopted by most or all states implementing the POLST Paradigm, could also be very effective. While it is still under revision and not directly applicable to POLST, one potential source of guidance is the draft Inter-jurisdictional Recognition of Substitute Decision-Making Documents Act from the National Conference of Commissioners on Uniform States Laws. If adapted to POLST, the reciprocity provisions in this Act would deem a POLST form valid if, when completed, it complied with the law of the jurisdiction where it was completed. Because a clinician in the receiving state may not know the legal status of the originating state POLST, the clinician may accept the POLST as valid so long as she has a good faith belief it is valid and has not been revoked. The weakness of uniform laws is that states do not have to adopt them. Nevertheless, they serve as influential benchmarks that states pay attention to.

Without a federal or uniform law, there will likely be some obstacles to implementing portability. States vary not only in their requirements regarding the formalities of execution but also in their substantive rights regarding health care decisions. But portability and reciprocity produce a net benefit. Portability and reciprocity better assure the honoring of patient wishes.

⁴³ Md. Health Decisions Code §5-608.1(h).

⁴⁴ Cal. Probate Code §4676(b).

⁴⁵ H.R. 1173, 113th Cong., 1st Sess. (2013) (Blumenauer, Ore.).

⁴⁶ *Id.*, at § 5.