

POLST: Avoid the Seven Deadly Sins

By Charlie Sabatino

The POLST — or Physician Orders for Life-Sustaining Treatment — Paradigm is a valuable person-centered clinical process designed to facilitate communication between health care professionals and patients with serious illness or frailty or with the patient's authorized surrogate.¹ The process is intended to encourage shared, informed medical decision-making leading to a set of portable medical orders that respects the patient's goals for care in regard to the use of cardiopulmonary resuscitation, the level of treatment aggressiveness desired, and other medical interventions. Portability of POLST is a key feature; it is applicable across health care providers and settings, and should be reviewed and revised as needed.

The effectiveness of POLST in increasing documentation of patient preferences and in delivering end-of-life treatment concordant with those preferences has been convincingly demonstrated.²

1) The terminology of POLST varies across jurisdictions. Examples include *Medical Orders for Scope of Treatment (MOLST)*, *Provider Orders for Scope of Treatment (POST)*, *Medical Orders for Scope of Treatment (MOST)*, and even *Transportable Physician Orders for Patient Preferences (TPOPP)*. A full list of terms may be found at www.polst.org/map.

2) Hickman SE, E Keevern, and BJ Hammes (2015). "Use of the Physician Orders for Life-Sustaining Treatment Program in the Clinical Setting: A Systematic Review of the Literature." *Journal of the American Geriatrics Society*, 63(2):341-350; Hickman SE, CA

However, because the POLST form is such a powerful tool in directing care and treatment, its improper use poses an equally powerful risk of undermining person-centered, informed decision-making at the end of life if the form does not truly reflect the informed preferences of the patients.

I have had the opportunity to observe the development of the National POLST Paradigm and to have some small hand in its development as a legal advisor to the National POLST Paradigm Task Force since it was established in 2004. At that time only six states had POLST Paradigm Programs: New York, Oregon, Pennsylvania, Washington, West Virginia and Wisconsin. Today, virtually every state (and Washington D.C.) has a POLST program under some stage of development and 22 of them have programs that meet the voluntary endorsement standards of the Task Force for programs and forms.

The growth of POLST programs has benefited countless individuals and families facing advanced illness. But it has also brought many challenges in education, quality assurance, and monitoring. The

Nelson, AH Moss, SW Tolle, NA Perrin, and BJ Hammes (2011). "Consistency between treatment provided to nursing facility residents and orders on the physician orders for life-sustaining treatment form." *Journal of the American Geriatrics Society*, 59(11):2091-2099.

National POLST Paradigm Task Force has set a high bar for meeting those challenges in its standards, guidance and educational efforts.³ Yet, as one observer of its growth, I think certain errors are serious enough to call out more clearly and target for careful avoidance. These are all missteps that undermine patients' informed decision-making. Health care providers should be aware of and conscientiously avoid the following seven deadly sins of POLST:

1) Using POLST with people who are too healthy.

POLST is for individuals with a serious illness or frailty whose health care providers would not be surprised if they died within the next year or so. It is also an entirely voluntary option for patients. The specificity of the medical orders contained in a POLST order set are justified by the proximity between the patient's current condition and the critical care decisions likely to be faced by patients in the here and now. Using the form further "upstream," such as for patients who reach a specific age or for all patients who enter a nursing home, eliminates the connection between the orders and immediate medical circumstances and forces patients to address increasingly hypothetical rather than known circumstances.

One illustration of the immediacy of POLST comes from a study of advance care planning in LaCrosse, Wisconsin, which found that among a sample of 400 decedents, advance directives were completed an average of 3.8 years before death versus an average of 4.3 months for POLST forms.⁴ In another study, death certificates of 18,285 Oregon decedents were matched to the state's POLST registry. The study

3) For example, see the Task Force's guidance titled, POLST Paradigm Fundamentals, available at <http://polst.org/wp-content/uploads/2016/09/POLST-Paradigm-Fundamentals.pdf> and Appropriate POLST Paradigm Form Use Policy, available at <http://polst.org/wp-content/uploads/2017/05/2017.05.18-Appropriate-POLST-Paradigm-Form-Use-Policy.pdf>.

4) Hammes BJ, BL Rooney, and JD Gundrum (2010). "A Comparative, Retrospective, Observational Study of the Prevalence, Availability, and Specificity of Advance Care Plans in a County that Implemented an Advance Care Planning Microsystem." *Journal of the American Geriatrics Society*, 58(7):1249-55.

found that the median interval between POLST completion and death was just 6.4 weeks.⁵

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The error that some nursing homes have fallen into is that of using POLST forms for all or most residents, possibly because they are required to document the code status of all residents. The POLST Paradigm is far more than a documentation of code status. Its misuse with residents who enter a nursing home for short-term rehabilitation puts them in the position of having to make decisions about a range of premature and out-of-context interventions inappropriate to their situation. Moreover, the expectation that all residents should have a POLST form undermines its voluntary nature.

For these "healthier" residents, nursing homes need to find a distinct way to document code status.

2) Signing a POLST form without meaningful discussion.

Completion of a POLST form requires discussion of: (1) the status of individual's medical condition; (2) the choices or trade-offs faced in the person's care and treatment; (3) the individual's goals and priorities given their current diagnosis and prognosis; and (4) the effect of each of the choices offered on the POLST form.

The discussion is the heart of the POLST process and also its Achilles heel if done poorly. Sometime the compact nature of the POLST form is misperceived as a shortcut advance planning tool. Nothing could be further from the truth. As a medical order, it is short and succinct. But getting to that end product requires skillful communication, time, and attention, often

5) Zive DM, EK Fromme, TA Schmidt, JNB Cook, and SW Tolle (2015). "Timing of POLST Form Completion by Cause of Death." *Journal of Pain and Symptom Management*, 50(5):650-58.

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from a team of providers. We have few good quality measures for these discussions, so professional and ethical diligence of providers is imperative.

3) Having patients complete their own POLST form.

Yes, this does happen, and it illustrates a grave misperception that a POLST form is a type of advance directive. The two are complimentary but quite distinct creatures. Among their differences are the following:

- A POLST form is a medical order set for immediate circumstances; an advance directive appoints a surrogate decision-maker and/or provides general decision-making guidance for hypothetical future circumstances.
- A POLST form is completed by medical professionals in a health care setting for seriously ill or frail patients; an advance directive is completed by an adult at any stage of health in any setting.
- Review and portability of POLST forms across care settings is the responsibility of health care providers; for advance directives, it is the responsibility of the individual.

4) Providing incentives for completing more POLST forms.

Health system experts have long recognized that incentives profoundly affect the delivery of health care, causing both intended and unintended

consequences.⁶ Most often incentives are financial. The most popularly cited examples are fee for service payment systems that tend to incentivize more medical procedures, versus capitated payments in managed care systems that may incentivize reduced numbers of services. Paying “bonuses” for certain behaviors, such as completing POLST forms will increase the number of POLST forms, but that’s likely to happen at the cost of the quality, appropriateness, and voluntariness, where those variables are not incentivized. Paying for the time it takes to have advance care planning discussions is understandably important, but if that is measured simply by the number of advance directives or the number of POLST forms, the same unintended consequences are likely.

Incentives can be non-monetary, too, such as in the use of “report cards” comparing performance, or even simply counting certain behaviors such as in the above example of POLST form completion. These can indirectly incentivize behaviors in, subtle, unanticipated ways. It is a complicated stew of variables. Avoid financial incentives for form completion rate goals and be wary of all behavioral incentives.

5) Failing to review POLST forms.

Patients experiencing advanced illness are not a stable lot. In their weakened states, they are highly vulnerable to change. Because POLST prescribes a critical care plan for the person’s *immediate* condition, it needs to be reviewed whenever there is a substantial change in the person’s health care status, or when the person is transferred from one care setting or care level to another, or when the patient goals of care or treatment preferences change. A POLST form provides clear medical orders when critical care decisions must be made during a medical emergency, but when the time for review is available, review is essential.

6) Letting POLST disappear.

Perhaps the most innovative, systemic impact of POLST is its portability across care settings, a characteristic that enhances continuity of care across settings, from hospital to nursing home to community setting and during transport in between. Bringing this about has required unprecedented coordination across care settings, and increasingly, the creation of quick

6) See e.g., Hillman AL (1991). “Managing the Physician: Rules Versus Incentives.” *Health Affairs*, 10(4): 138-146.

access registries such as Oregon's. Implementation depends on the diligence of institutions to ensure the current POLST form is visibly present and immediately accessible in the record and promptly transfers to the next institution or setting to which the individual is taken. If that doesn't happen, its value is entirely undermined. Failure to transfer or forward a patient's POLST form is a medical error.

7) Failing to evaluate your use of the POLST Paradigm.

Ever since its inception in the early 1990's, the POLST process has undergone changes and improvements in form and procedure, as technology has changed, as lessons are learned, and as health organizations evolve. To some extent, the POLST Paradigm will always be a work in progress, but it will only be progress if monitoring and evaluation are integral to state POLST programs. Skimping on that process threatens its quality and its legitimacy as a tool for person-centered care. As already counseled above, just counting numbers is risky. The kind of outcomes that reflect the person-centered quality of the POLST process include questions such as:

- Do providers utilize clear triggers and communication skills for POLST discussions and completion of POLST forms?
- Do patients or their surrogates remember a discussion about POLST?
- How do patients and their surrogates perceive the timing and value of the POLST discussions?
- Do patients and their surrogates feel they had adequate opportunity to reflect and talk to family members to be sure they understood how POLST would be used?
- Do they feel POLST accurately reflected their values and goals of care?
- Do patients or their surrogates feel the orders in a POLST form were known by their health care providers and honored?
- When and how were POLST form orders reviewed with the patient or surrogate?

The POLST Paradigm has become a powerful tool for identifying and honoring the goals of care of seriously ill or frail individuals. But that power can be turned against patients if health care providers misunderstand

or misuse it. Each of these seven deadly sins require resolute reconsideration for redemption.

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