POLST
physician orders for life-sustaining treatment paradigm

August 27, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
P.O. Box 8013
Baltimore, MD 21244-8013

Strong Support for CMS-1631-P, Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

The National POLST (Physician Orders for Life Sustaining Treatment) Paradigm Task Force strongly supports the reimbursement to health care professionals for providing advanced care planning services to Medicare and Medicaid patients through two new codes (CPT codes 99497 and 99498) proposed by the Center for Medicare & Medicaid Services (CMS). Compensating health care professionals for time spent in valuable conversations with their patients to discuss goals of care and treatment wishes is a critical step forward to honoring patient treatment preferences, particularly those nearing the end of life.

Proposal CMS-1631-P is Vital!

We appreciate the Center for Medicare & Medicaid Services' recognizing the vital importance of advance care planning conversations between patients and health care professionals. According to the Institute of Medicine's (IOM) report, *Dying in America*, advance care planning is the start of an ongoing dialogue between patients, family members, and health care providers about end-of-life care. This on-going dialogue requires health care providers to revisit patients' goals and preferences as their needs and intensity of service change over time. These crucial advance care planning conversations should:

- encourage thoughtful decisions about who the patient's surrogate/decision maker should be in the event a patient lacks decision-making capacity;
- facilitate the patient's sharing their personal values and beliefs and goals for care, key quality of life elements with their surrogate/decision maker, family and health care professionals;
- create documentation about patient treatment wishes, through both the patient's medical record as well as by encouraging completion of an advance directive;

- help ensure patients understand their options, including benefits and burdens of treatment options considering their current health condition and prognosis, particularly for those individuals who might die in the next year; and
- offer the opportunity for appropriate populations complete medical orders for life-sustaining treatment.

Medical orders helps health care professionals provide treatment the patient wants and not provide treatment the patient does not want in the event of an emergency. In short, these conversations allow patients to provide guidance about what treatments they would like to receive- and which treatments they do not want to receive- when they can no longer speak for themselves. This critical information helps health care professionals avoid providing treatments unwanted by the patient.

CMS's proposal eliminates two key barriers mentioned in the Institute of Medicine's *Dying in America* report. First, health care professionals say that "lack of time and lack of payment" is a significant barrier to initiating these vital conversations. In providing two CPT codes to allow payment for time spent having advance care planning conversations, this proposal eliminates the barrier of lack of payment and likely lack of time. Second, "many people do not make their wishes known." The report indicates "efforts are needed to normalize conversations about death and dying." (Key Findings, p.2). Through eliminating barriers of time and payment, CMS is encouraging on-going conversations about advance care planning- helping normalize discussion about death and dying. CMS is also helping health care professionals spend time educating their patients about how to document their wishes so that loved ones and health care professionals know them and can provide the treatments the patient wants.

The IOM report also recognized that advance care planning occurs over a lifetime and changes as one's life milestones occur and health events develop. When one reaches a stage of advanced progressive illness, the conversation about care plans becomes more specific and medical orders for life-sustaining treatment become important. The IOM report "encourages states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements."

Conversation is the essential element of the National POLST Paradigm. The Paradigm is an approach to end-of-life planning emphasizing eliciting, documenting and honoring patients' wishes about the treatment they receive- ***quality*** conversation is essential for achieve this goal. Advance care planning conversations between patients and health care professionals are essential for informed shared decision-making between a patient and his/her health care professional about the treatment the patient would like to receive at the end of his/her life and to help ensure those wishes are honored.

As a result of these conversations, patient wishes may be documented in a POLST Form, which translates the informed shared treatment decisions into actionable medical orders. The POLST

form assures patients that health care professionals will provide only the treatments that patients themselves wish to receive, and decreases the frequency of medical errors.

The value of these conversations is evident in a 2014 the Journal of American Geriatrics Society study, *Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon* showing the strong connection between POLST Form orders and where people die. The data demonstrates that POLST orders for those with serious illness or frailty are honored, but creation of these orders requires time for meaningful conversation. While the results cannot be generalized to all POLST Programs at various stages of development, the study conclusively demonstrates the promise of the POLST Paradigm- and the conversation fundamental to it- for patients approaching the end of life.

Advance care planning conversations are not just vital for POLST discussions but for every adult. We should encourage advance care planning at all ages and when individuals are healthy- this is a time when individuals can have thoughtful conversations and time to consider who should be their surrogate/decision maker and make medical decisions on their behalf when they no longer can speak to themselves. When POLST is appropriate, it is often a time of stress because of an illness or frailty; this is not an ideal time for a first foray into advance care planning. CMS' proposal encourages early discussions about advance care planning that likely increases the value of a conversation leading to a POLST Form later in a patient's life.

Not only is time for the conversation important but so is the quality of the conversation. Quality conversation is essential for thoughtful advance care planning and we support the IOM's recommendation that professional societies and other organizations should develop quality measures for advance care planning conversations that payers, such as CMS, should tie to reimbursement.

The CMS's proposal to reimburse health care professionals for providing advanced care planning services to Medicare and Medicaid patients through two new codes (CPT codes 99497 and 99498) reflects the recognition that advance care planning is an integral component of the practice of medicine and changing values for those services. For these reasons, the National POLST Paradigm Task Force strongly supports CMS's efforts.

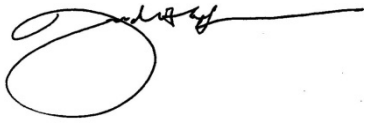
Creation of the POLST Paradigm Initiative

The POLST Paradigm Initiative began in Oregon in 1991 in response to individuals with serious illness indicating that their preferences regarding life-sustaining treatment were frequently not being respected, even if individuals had executed an advance directive. Since emergency personnel require medical orders to do anything other than make all attempts possible to save someone's life, advance directives were not even looked at during a medical crisis until the patient arrived at a hospital.

A Task Force convened by Oregon Health & Science University with broad representation of stakeholder organizations developed the brightly colored Physician Orders for Life-Sustaining Treatment (POLST) medical order form to put an individual's treatment preferences into action. The order set compliments an advance directive and is widely recognized by emergency medical services and other health care professionals. The POLST Paradigm Initiative is a program not just a form, including extensive ongoing education, policy development and research.

National Adoption
With success of Oregon's model, many states and localities have adopted a similar program including: Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. The National Task Force with representation from experienced programs was created in 2004 to provide education and consultation to new and developing programs and to conduct research on the effectiveness of existing programs (see www.polst.org).

Sincerely,



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