POLST
physician orders for life-sustaining treatment paradigm

September 14, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3260-P
P.O. Box 8010
Baltimore, MD 21244

Re: CMS-3260-P, Reform of Requirements For Long-Term Care Facilities

The National POLST (Physician Orders for Life Sustaining Treatment) Paradigm Task Force (Task Force) recommends incorporating the recognition of Physician Orders for Life Sustaining Treatment into the proposed regulation CMS-3260-P, Reform of Requirements for Long-Term Care Facilities in each paragraph in which advance directives are referred to or in which care planning or discharge planning is addressed, as follows:

1. In §483.5 Definitions, include a definition of "Physician Orders for Life Sustaining Treatment" as follows:
   A "Physician Orders for Life Sustaining Treatment" means a set of medical orders in standardized format consistent with state practice and nationally recognized core requirements that address key medical decisions consistent with the patient's goals of care and results from a clinical process, voluntarily agreed to by residents or patients, designed to facilitate shared, informed medical decision making and communication between health care professionals and patients with serious, progressive illness or frailty.
2. In §483.10 Resident Rights, at subsection (b)(4), modify the language to read: The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive, and if applicable, an Physician Orders for Life Sustaining Treatment, as specified in § 483.11(e)(5).
3. In §483.11 Facility Responsibilities, at subsection (e)(5), modify the language to read: The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
   (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive, and if applicable, a Physician Orders for Life Sustaining Treatment.
   (ii) This includes a written description of the facility's policies and procedures to implement advance care planning, advance directives, implement and honor Physician Orders for Life Sustaining Treatment in accordance with applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive or has a Physician Orders for Life Sustaining Treatment, the facility may give advance directive information, or if applicable, information on Physician Orders for Life Sustaining Treatment, to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

4. In §483.15 Transitions of Care, at subsection (b)(2), documentation in the resident's medical record should include, if applicable, updated Physician Orders for Life Sustaining Treatment. This can be accomplished by modifying the language of (b)(2)(iii)(C) to read: Advance Directive information, and if applicable, updated Physician Orders for Life Sustaining Treatment.
5. In §483.21(a)(1)(ii), the requirements for Baseline Care Plans should add the following component as section (G): Include, if applicable, review and update Physician Orders for Life Sustaining Treatment and a palliative order set that addresses symptoms to support Physician Orders for Life Sustaining Treatment orders.
6. In §483.21(b)(1)(iv), Comprehensive Care Plans should have the following component added: If applicable, a review and update of the resident's Physician Orders for Life Sustaining Treatment and a palliative order set that addresses symptoms to support Physician Orders for Life Sustaining Treatment orders.
7. In §483.21(c)(1), the Discharge Planning Process should add the following component as section (x): Include, if applicable, a review and update of the resident's Physician Orders for Life Sustaining Treatment and a palliative order set that addresses symptoms to support Physician Orders for Life Sustaining Treatment orders.
8. In §483.21(c)(2), the Discharge Planning Process should add the following component as section (v): Include, if applicable, the resident's Physician Orders for Life Sustaining Treatment and a palliative order set that addresses symptoms to support Physician Orders for Life Sustaining Treatment orders.

Including these recommendations incorporates the current clinical and legal advances in advance care planning reflected in the Institute of Medicine's recent report, Dying in America: Improving Quality and Honoring Preferences Near the End of Life[1]. That report recognizes advance directives as just one component in a life-long process of advance care planning that changes according to the stage of life and stage of illness or frailty of the individual. The later stages of life fall into the period of advanced and eventually fatal illness, a stage experienced by most nursing home residents. Advance care planning at that stage necessarily becomes more specific, especially with regard to addressing critical treatment decisions that may have to be made during medical crisis situations and addressing both management of chronic diseases and palliative treatments. The IOM Committee recognized that for

[1] Institute of Medicine, DYING IN AMERICAN: IMPROVING QUALITY AND HONORING PREFERENCES NEAR THE END OF LIFE (National Academies of Science, 2014).

individuals in an advanced stage of illness, the POLST process has become an important clinical procedure for eliciting and honoring individual treatment wishes. POLST complements, rather than replaces, advance directives for individuals with advance illness or frailty.

According to the IOM:

> The POLST paradigm is an approach to advance care planning designed to ensure that seriously ill or frail patients can choose the treatments they want or do not want and that their wishes are documented and will be honored in an emergency. POLST is a clinical process designed to facilitate communication between health care professionals and patients, their families, their health care agents, or their designated surrogates. The process encourages shared, informed medical decision making. The result is a set of portable medical orders, POLST forms, that respects the patient's goals for care with regard to the use of cardiopulmonary resuscitation; artificially administered nutrition; and other medical interventions, such as intubation and future hospitalization. Medical intervention options generally are described as "comfort measures only," "limited additional interventions," and "full treatment" and align with the intensity of the desired interventions. (*references not included*)[2]

A national voluntary certification of POLST programs is overseen by the Task Force (see www.POLST.org). The Task Force endorses POLST Programs when they have proven they have developed and implemented a POLST Program and form meeting the Task Force endorsement standards. Endorsed programs are POLST Programs that have become standard components of advance care planning in their location and are moving toward statewide implementation and consistency (if not already there). As of this writing, 18 POLST Programs currently have achieved the status of "endorsed" and most of the remaining states are in various stages of developing their POLST programs. At this rate of development, virtually every state will have a POLST program within the next five years. Therefore, it is important for CMS to recognize and incorporate this model clinical practice into its regulation. POLST plays a key role in comprehensive care planning and discharge planning.

While the POLST Paradigm model is called various names in states that have adopted it[3], they may all be described generically as portable medical orders. POLST is neither an advance directive nor a replacement for advance directives but a timely complement; both advance directives and POLST are helpful advance care planning documents for communicating resident wishes when appropriately used. The differences are important to understand. An advance directive is a form in which an individual: (1) appoints a person or persons to make health care decisions for the individual if and when the individual loses the capacity to make health care decision (typically called a "health care power of attorney"); and/or (2) provides guidance or instructions for making health care decisions, typically in end-of-life care situations (often called a "living will"). An advance directive is a direction from the resident, not a medical order. In contrast, POLST consists of a set of medical orders that applies to a limited population of residents and addresses a limited number of critical medical decisions. POLST is

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[2] *Id.* at 173.

[3] POLST is known by different names in different states, including MOLST (Medical Orders for Life-Sustaining Treatment), MOST (Medical Orders for Scope of Treatment), POST (Physician Orders for Scope of Treatment), LaPOST (Louisiana Physician Order for Scope of Treatment), COLST (Clinician Orders for Life-Sustaining Treatment), IPOST (Iowa Physicians Orders for Scope of Treatment), SMOST (Summary of Physician Orders for Scope of Treatment), TPOPP (Transportable Physician Order for Patient Preference), and WyoPOLST (Wyoming Provider Orders for Life-Sustaining Treatment). For simplicity, the term POLST is used when referring to POLST forms or programs.

intended as a complement to advance directives in that it serves as a translational tool and a continuity of care assurance.

The wishes of residents as expressed in an advance directive often prove ineffective in directing care because: (1) they do not address the specific here-and-now medical circumstances of the resident; (2) they often do not get recorded in the medical record; (3) they do not necessarily follow residents across care settings; and (4) they do not dictate a care plan through medical orders and clinical protocols. POLST does all these things.

Regardless of label, POLST Programs include the following key components:

(1) a conversation between the health care professional (HCP) and resident (or resident's surrogate) to ensure that the resident's condition and treatment options are known and that the HCP understands the resident's goals of care, preferences, and values with respect to treatment;
(2) the completion of a POLST form, with the resident's consent, that translates his/her goals of care and treatment preferences into standardized medical orders;
(3) an obligation of the HCP to ensure portability of the medical orders across medical settings;
(4) review of the medical orders whenever the resident's condition or wishes change or the resident is transferred; and
(5) while offering a POLST Form may be mandatory, completion of a POLST is always voluntary.

We want to emphasize the voluntary nature critical for POLST success, as it is consistent with resident choice. The Task Force recommends against automatically assuming all residents in any facility be deemed an appropriate candidate for POLST. Facilities may have a policy to *offer* POLST to all residents admitted. This may result in offering a POLST discussion to a relatively healthy adult with acute convalescence who needs to be placed in a nursing home for a limited period of therapy before returning to the community for a substantially full recovery. If facilities are using the POLST in this way, they should be sure to have a clear process to review and, if appropriate, void POLST forms during the discharge process so that only those residents who are appropriate for POLST leave with a valid POLST Form. Review of the resident's POLST form upon discharge or transfer for one care setting to another, is critical. When a resident is leaving a care setting, health care professionals should review the POLST form with the resident 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 resident is not within the appropriate POLST population.[4]

The Task Force recognizes that federal nursing facility regulations require a "comprehensive assessment" upon resident admission. While this assessment should include consideration of the appropriateness of POLST as part of advance care planning, caution should be exercised to make sure POLST is not reduced to a checklist as part of the admissions process. It is critical that facilities offering POLST to all residents implement policies and procedures to ensure that quality POLST conversations are occurring whenever a POLST form is offered.

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 residents' wishes about the

[4] The Task Force defines the "appropriate POLST population" as those individuals who are seriously ill or frail for whom their health care professional would not be surprised if they died within a year.

treatment they receive- ***quality*** conversation is essential for achieve this goal. Advance care planning conversations between residents and health care professionals are essential for informed shared decision-making between a resident and his/her health care professional about the treatment the resident would like to receive at the end of his/her life and to help ensure those wishes are honored.

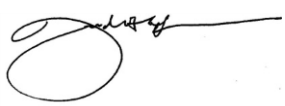
Including POLST as described in the beginning of this letter will help honor individual choices about treatment; POLST forms can help prevent the initiation of treatments the resident does not want and finds disproportionately burdensome. Given the rapid adoption of the POLST Paradigm throughout the country, POLST should be included in these proposed regulations to ensure it is appropriately used.

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 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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