Table of Contents

Overview **4**

Why does the POLST Paradigm exist? **4**
The Value of the POLST Paradigm **4**
How the POLST Paradigm Fits within Advance Care Planning **6**
» POLST and Advance Directives 7
» Key Differences Between Advance Directives and POLST forms 7
» How POLST Forms and Advance Directives Work Together 8
» Surrogate Role 8
» POLST Form Value in the Absence of an Advance Directive 9
How the POLST Paradigm Works **9**
» The POLST Paradigm Population: Who Should Have a POLST Form? 9
» The POLST Paradigm in Unique Populations 10
The POLST Paradigm Conversation **11**
» Medicare Reimbursement for the Conversation 11
» Hospice Reimbursement 12
The POLST Paradigm Form **13**
» Form Sections 13
» Completing a POLST Form 15
» Revising or Voiding a POLST Form 16
Education and Training About the POLST Paradigm **16**
» Health Care Professional Education & Training 17
» Community Education 17
» POLST Program Quality Assurance and Assessment 17
Accessing POLST Forms Electronically **17**
» POLST Forms in EMRs 18
» POLST Form Registries 20
POLST Paradigm and the Law **20**
Frequently Asked Questions **21**
Introduction to Toolkit Chapters **21**
Why Was this Toolkit Created? **21**
How Should You Use this Toolkit? **21**
Getting Started with Implementing the POLST Paradigm **22**
Glossary **24**

Primary Care **26**

Benefits of Adopting POLST Paradigm for Primary Care **26**
Advance Care Planning (ACP) **26**
» Advance Directives 27
Effective Implementation and Sustainability Requires a Multidimensional Approach **27**
» Dedicated System and Physician Champion 28
» Culture Change 28
Public Advance Care Planning Education, Engagement and Empowerment **29**
System Implementation, Policies and Procedures, Workflow, Quality Improvement **30**
Policies and Procedures (Appendix H) 30
» Identification of Eligible Patients Pre-Visit 30
» Staffing Considerations 30
» Operational Considerations for Population Health Approach 30
» Documentation of the POLST Conversation 30

» Quality Improvement 31
Advance Care Planning CPT Codes 99497 and 99498 31
» ACP CPT Codes 99497 and 99498 Frequently Asked Questions 32

Inpatient Hospital Setting 33

Benefits of Adopting the POLST Paradigm for Hospitals 33
Identifying Appropriate Patients 33
» Not All Patients are Medically Appropriate for a POLST Form 34
A Goals of Care Conversation Should Come First 34
» Beginning the POLST Conversation with Inpatients 34
» Having the POLST Conversation with the Inpatient 35
» Documenting POLST in the Medical Record 35
Integrating POLST form Orders into Hospital Order Sets 35
» Notes on Code Status 35
» Admission & Discharge Policies/Procedures 36
How to Start Integrating the POLST Paradigm into a Hospital Setting 36
Tracking POLST form Orders 37
Hospital Staff Education on POLST 38
POLST Forms in the Emergency Department 38
Frequently Asked Questions 39
1. Must hospital staff follow POLST form orders? 39
2. What if a POLST form conflicts with another advance care planning document? 39
3. What if my patient's POLST document is not fully completed? 40
4. Can a POLST form be temporarily suspended for surgery or other procedures? 40

Emergency Medical Services 41

Benefits of Adopting POLST Paradigm for Emergency Medical Services 41
A Note on Terminology and EMS Structure 42
EMS Critical to Development of the POLST Paradigm 42
Case Study: Value Proposition of POLST to EMS 43
POLST Implementation in the EMS Setting 44
Frequently Asked Questions 47
1. What should EMS providers do when a family says the POLST isn't accurate or disagrees with it? 47
2. How do EMS providers decide when to transport a patient with Comfort Measures Only (CMO) orders? 47
3. Do EMS providers need legislative authority or protection for honoring POLST? 47
4. Can a POLST form be followed if it is not the original? 48
5. What do EMS providers do in states where there is a state law requiring the most recently signed document, between an advance directive and POLST form, be followed? 48

Nursing Homes 49

Setting the Stage for Using the POLST Paradigm in Your Nursing Home 49
Steps to Engage Residents with the POLST Paradigm 50
» Not All Nursing Home Residents are Medically Appropriate for a POLST Form 50
» POLST Form Completion is Always Voluntary 51
» A Goals of Care Conversation Should Come First 51
» Beginning the POLST Conversation with Nursing Home Residents 52
» Having the POLST Conversation with the Nursing Home Resident 52
» Documenting POLST Conversations and Resident Preference in the Medical Record 54
» When a Resident Lacks Decision-Making Capacity 54
Signing the POLST Form and Verbal Orders 55
» A Completed POLST Form is an Actionable Medical Order 55

» POLST Forms Should be Reviewed on a Regular Basis 55
» Revising a POLST Form 56
Training Staff on the POLST Paradigm 56
Evaluating Your Nursing Home's Implementation of POLST 57
Nursing Homes: Frequently Asked Questions 58
References 61

Hospice 62

Benefits of Adopting POLST Paradigm for Hospice 62
Setting the Stage for Using the POLST Paradigm in Your Hospice 63
The Integration of the POLST Paradigm and Hospice 64
» Utilizing the POLST Paradigm as a Communication Tool with Hospice Patients 64
» Incorporating POLST into Care Across Systems Utilizing the Hospice Benefit 65
» POLST and Bereavement Implications 65
» Training Interdisciplinary Health Care Team Members 66
POLST is an Opportunity for Community Engagement, Education, and Coordination of Care 66
» Community Engagement 66
» Coordination of Care 66
» Quality Assessment and Improvement 67
Frequently Asked Questions 67
1. What are hospice policies regarding CPR and DNR? 67
2. When should the POLST conversation begin with hospice patients? 67
3. Should a POLST form be offered at admission? 67
4. When should a POLST form be reviewed? 68
5. Which member of the hospice team should guide POLST conversations? 68
6. How does the team ensure that the POLST form becomes a valid medical order? 68
References 69

Authors 70

Acknowledgements 70

Reviewers 70

Appendix 1: About the POLST Paradigm 71

National POLST Paradigm 71
POLST Programs (State Programs) 71

Overview

An introductory chapter explaining basics about the POLST Paradigm
by Amy Vandenbroucke

Why does the POLST Paradigm exist?

In 1991, leading medical ethicists in Oregon discovered that patient preferences for end-of-life care were not consistently honored. Recognizing that advance directives were inadequate for the patients with serious illness or frailty—who frequently require emergency medical care—a group of stakeholders developed a new tool for honoring patients' wishes for end-of-life treatment. After several years of evaluation, the program became known as Physician Orders for Life-Sustaining Treatment, or POLST.

Since the first POLST form use in 1994 in Oregon, the POLST Paradigm has grown exponentially and now exists, at some level, in 49 states, creating an intense need for education and resources to help facilities and professionals appropriately use POLST forms. Used as intended, these actionable medical order forms potentially avoid unwanted hospitalizations and emergency department visits. Patients have peace of mind that their wishes are known and will be honored during a medical emergency.

The Value of the POLST Paradigm

The POLST Paradigm's purpose is to improve the quality of care for patients who are seriously ill or frail whose health care professionals wouldn't be surprised if they died within a year by creating a voluntary system that elicits, documents and honors patient medical treatment wishes using an actionable, portable medical order. This population includes individuals who are at the greatest risk of having a medical emergency and who can have specific conversations about what different treatment options mean for them, given their specific medical situation.

The POLST Paradigm improves patients' ability to communicate treatment wishes and, as a result, receive the type of treatment they want according to their wishes. It also helps avoid receiving unwanted treatments that are the standard of care. It is part of advance care planning, a process that includes conversations between patients and health care professionals about goals of care and quality of life[1]. Everyone is encouraged to complete an advance directive but also to recognize its limitation: advance directives are not medical orders so emergency personnel cannot follow guidance provided in an advance directive during a medical emergency. Instead, once a patient is in the hospital and stabilized, the health care team works with the surrogate identified in the advance directive and reviews the patient's wishes to develop a treatment plan.

The current standard of care is to do everything possible in an attempt to save someone's life unless there are medical orders stating otherwise. During a medical crisis, emergency personnel provide the standard of care *regardless of the patient preferences stated in an advance directive.* This means a patient may receive unwanted treatment during the medical crisis, unwanted transportation to the hospital, and unwanted treatment in the emergency department before their advance directive is even reviewed.

[1] We encourage involving a patient's surrogate in the conversation as well as any family, loved ones, friends and faith leaders as may be appropriate for the specific patient.

The POLST Paradigm uses an out-of-hospital/facility medical order that follows patients as they transition across care settings (***POLST form***). With a POLST form, the current treatment plan is developed in advance producing medical orders. The POLST form gives the medical orders that either confirms the standard of care is what the patient wants or provides other orders emergency personnel can follow—this helps ensure patients receive the care and treatment they want during the medical crisis right from the start.

Prior to the POLST Paradigm, only two documents were used for advance care planning:

1) **Advance Directives**. An advance directive is a legal document and personal tool for exercising one's autonomy in the indeterminate future. It enables the individual to name a surrogate of his/her choice and give some degree of guidance for future medical decisions.
2) **Do-Not-Resuscitate (DNR) Orders and Out-of-Hospital DNR Orders (OHDNR)**. A medical order that instructs health care professionals not to provide cardiopulmonary resuscitation (CPR) if a patient does not have a pulse, is not breathing and is non-responsive.

Since it is a medical order, emergency personnel and other health care professionals can immediately treat a patient using POLST form orders. This differs from advance directives, which generally aren't even looked at or acted upon until a patient has been taken to the hospital and stabilized.

As compared to DNR orders, the POLST form provides emergency personnel with more information critical during a medical crisis. DNR orders only apply when a person does not have a pulse, is not breathing and is unresponsive. In most medical emergencies, this isn't the case, rendering the DNR order useless as emergency personnel are aware only that the patient did not want CPR. They are unaware about what other treatments the patient may have wanted in that emergency situation. A POLST form answers that vital question. In its *Medical Intervention* section, POLST forms inform emergency personnel of what treatment the patient wanted by picking one of three options:

1) **Full Treatment**: The patient wants to go to the hospital and all treatment options should be considered, including intubation and use of a breathing machine;
2) **Limited Treatment** or **Selective Treatment**: The patient wants basic medical treatments but wishes to avoid the intensive care unit (ICU); or
3) **Comfort Measures Only**: The patient does not wish to go to the hospital but wants to be made comfortable wherever they are living.

Having patient treatment wishes beyond CPR is incredibly important: DNR status does not indicate what treatments patients want if they are not in cardiac arrest. Research shows that when a patient has a DNR order, health care professionals assume the patient wants less treatment.[2] However, research looking at POLST forms in Oregon shows that is not the case: approximately half of patients with a POLST form in Oregon indicating that they do not want CPR show that they want full treatment or limited/selective treatment.[3]

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[2] Hickman SE, CA Nelson, NA Perrin, AH Moss, BJ Hammes, and SW Tolle (2010). A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the POLST Program. *Journal of the American Geriatrics Society* 58: 1241-1248. doi:10.1111/j.1532-5415.2010.02955.x

[3] Fromme EK, D Zive, TA Schmidt, E Olszewki, SW Tolle (2012). POLST Registry Do-Not-Resuscitate Orders and Other Patient Treatment Preferences. *Journal of the American Medical Association* 307:34-35. doi:10.1001/jama.2011.1956

The POLST form orders benefit patients by reducing unwanted medical interventions and changing where they die:

- A 2010 study showed a 67 percent reduction in unwanted medical interventions (mainly emergency room visits and hospitalizations) for patients with POLST forms that had orders for comfort measures only as compared to POLST orders for full treatment, and a 59 percent reduction as compared to traditional DNR orders. In short, POLST orders for comfort measures only reduce hospitalization, readmissions and emergency room visits, and unwanted interventions.[4]
- A 2014 study of Oregon's POLST population showed that patients with POLST forms indicating comfort measures only or limited additional interventions are significantly less likely to die in a hospital than individuals without a POLST form.[5] Equally important, the research revealed that patients with POLST forms indicating full treatment are significantly more likely to die in a hospital than individuals without a POLST form. A similar study published in 2016 showed the same results in both Oregon and West Virginia.[6]

The National POLST Paradigm Task Force (National Task Force) supports the completion of advance directives but recognizes their limitation and the value a POLST form can add in ensuring patient treatment wishes may be honored.

In short, the POLST Paradigm honors patient autonomy. It emphasizes the need for ongoing conversations between health care professionals and patients to ensure the treatments they receive during an unexpected medical crisis are what they want given their current medical status. It also can change the treatments emergency personnel provide to patients in the field, from automatically providing the standard of care to providing the treatments patients want to receive in the setting they prefer.

How the POLST Paradigm Fits within Advance Care Planning

Advance care planning means taking steps to identify and discuss the patient's personal goals, values, religious, spiritual, and cultural beliefs and what matters for the patient's quality of life. Having this discussion and documenting treatment wishes that reflect what is important, helps the surrogate and health care professionals make treatment decisions that reflect the patient's wishes (or what likely would have been the patient's decision if the patient had capacity) during a medical crisis. There are two key elements to advance care planning:

1) Conversations with health care professionals; and
2) Documenting treatment wishes or preferences.

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[4] Hickman, *Id.*

[5] Fromme EK, D Zive, TA Schmidt, JNB Cook, and SW Tolle (2014). Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon. *Journal of the American Geriatrics Society* 62(7):1246-1251. doi:10.1111/jgs.12889.

[6] Moss AH, DM Zive, EC Falkenstine, EK Fromme, and SW Tolle. (2016). Physician Orders for Life-Sustaining Treatment Medical Intervention Orders and In-Hospital Death Rates: Comparable Patterns in Two State Registries. *Journal of the American Geriatrics Society* 64(8):1739-1741. doi:10.1111/jgs.14273.

» POLST and Advance Directives

The POLST form should be included in advance care planning conversations, but it is not an advance directive and should not be referred to as such to avoid confusion.

An advance directive is an appropriate tool for identifying a surrogate and making future end-of-life treatment wishes known. An individual completes this legal document to: (1) appoint a surrogate and/or (2) provide guidance or instructions for making health care decisions, typically in end-of-life situations. An advance directive is guidance from the patient, not a medical order; it does not give medical orders to emergency personnel to follow during a medical crisis.

Conversely, a POLST form is a medical order addressing a limited number of critical medical decisions. It is effective as soon as it is signed by the health care professional (and patient or surrogate where required by law)[7] and gives medical orders to other professionals, including emergency service personnel, for what treatments to provide to a patient during a medical emergency. This also helps alleviate any moral distress by emergency personnel since they can be assured the treatment they are providing is what the patient wanted.

» Key Differences Between Advance Directives and POLST forms

While all competent adults—regardless of health status—should have an advance directive, not everyone should have a POLST form. Key differences are best presented in a chart:

	POLST Paradigm Form	Advance Directive
Type of Document	Medical Order.	Legal Document.
Who Completes	Health Care Professional.	Individual.
Who Needs One	Seriously ill or frail (any age) for whom health care professional wouldn't be surprised if died within 1 year.	All competent adults.
Appoints a Surrogate	No.	Yes.
What is Communicated	Specific medical orders for treatment wishes during a medical emergency.	General wishes about treatment wishes. May help guide treatment plan after a medical emergency.
Can EMS Use	Yes.	No.
Ease in locating	Very easy to find. Patient has original. Copy is in medical record. Copy may be in a Registry (if your state has a Registry).	Not very easy to find. Depends on where patient keeps it and if they have told someone where it is, given a copy to surrogate or to health care professional to put in his/her medical record.

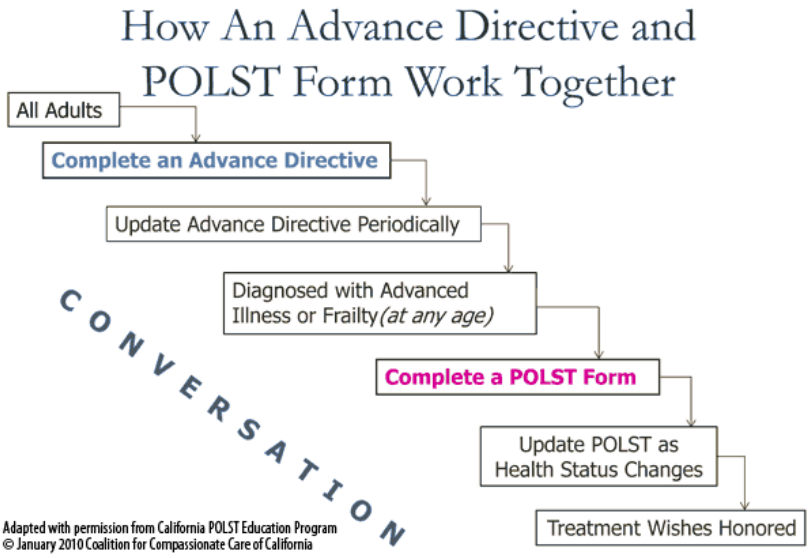
[7] Not all states require the patient or surrogate to sign the POLST form for it to be valid. The National Task Force encourages patients or surrogates to sign, providing an indication the patient or surrogate is aware of the form and the orders in it. This is especially important for reciprocity reasons: if a patient travels from a state where patient signature is not required to a state where patient signature is, there may be questions raised about the validity of the form.

» How POLST Forms and Advance Directives Work Together

Advance directives and POLST forms help patients in different ways. Both:

- Offer a way to document and communicate patient treatment wishes when appropriately used;
- Provide information about patient treatment wishes; and
- Serve to support continuity of care for a patient.

Advance directives remain critically important, from when someone turns 18 years old until death, by providing guidance on health care decision-making. When the use of a POLST form becomes appropriate, an existing advance directive may help shape the patient's treatment choices when discussing POLST form treatment options with their health care professional. The thoughtful appointment of a surrogate in an advance directive is the most valuable function of an advance directive since it gives someone clear legal authority to speak for the person who no longer has decision-making capacity.



» Surrogate Role

Because the POLST form orders direct a patient's medical treatments, the patient must have sufficient decision-making capacity to give consent, meaning that the patient has the mental capacity to understand his or her condition, the benefits and burdens of the proposed course of treatment; and any possible alternative treatments. The preferred outcome is for the patient to consent to the POLST form, but sometimes the patient's lack of capacity results in an inability to engage in the shared decision-making process.

Once an individual loses decision-making capacity[8], the responsibility for making treatment decisions falls to their surrogate who is expected to consent or refuse consent to medical

[8] It is beyond the scope of this toolkit to discuss determining capacity yet this is fundamental to respecting the patient's autonomy; the authors assume facilities have policies and procedures in place relative to decisional capacity assessment. State statutes determine who can make decisions for incapacitated patients and what decisions they can make. It is recommended to know state law regarding surrogate decision-making.

decisions consistent with the values and wishes of the individual as best they can, based on the patient's advance directive or as otherwise known to the surrogate.[9] Critical care decisions are highly likely and often imminent for individuals with serious illness or frailty.

In most states, when the patient becomes incapacitated, the surrogate can participate in either initiating a new POLST form or updating previous POLST form orders in a manner consistent with the patient's preferences as the patient's health status changes.[10]

Some states have limitations on what surrogates are permitted to do relative to a POLST form. For example, in Virginia if a patient has completed a POLST form marked DNR the surrogate cannot change that section of the form to require CPR but the surrogate can change the form from CPR to DNR. The surrogate can also complete and change the rest of the form as appropriate. In contrast, on the West Virginia POLST form the patient must check a box on the POLST form for the surrogate to make changes to the form at all.

» POLST Form Value in the Absence of an Advance Directive

When no advance directive exists, as is the case for most adults, POLST forms can still be used. If the patient is capable of participating and completing a POLST conversation, the patient is also likely capable of appointing a surrogate and should be encouraged to do so in an advance directive. The ability to have a continuing discussion around the review of a POLST form is best assured if there is a surrogate to continue that conversation when the patient is no longer able to participate.

How the POLST Paradigm Works

Ideally patients and their health care professionals discuss advance care planning topics throughout their relationship and the patient has an advance directive. It is only when a patient is diagnosed with a serious illness or frailty that his/her health care professional should suggest completing a POLST form.

» The POLST Paradigm Population: Who Should Have a POLST Form?

The POLST Paradigm is not for everyone. POLST is appropriate for patients with serious illness or frailty for whom their health care professional would not be surprised if they died within a year. For patients where a POLST form is appropriate, their current health status indicates the need for standing medical orders for emergent or future medical treatment.

For healthy patients, and even for many patients who have recently been diagnosed with a serious illness, an advance directive is an appropriate tool for making future end-of-life treatment wishes known to family, friends and health care professionals.

However, just because a person's prognosis indicates he or she is POLST appropriate, does not mean that person must have a POLST form. POLST forms are completely voluntary and should never be used as a criterion for admission to a long-term care, nursing home, assisted living or hospice facility. The choice to have a POLST is always up to the resident (or the surrogate decision maker).

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[9] An advance directive is a personal tool for exercising one's autonomy in the indeterminate future. It enables the individual to name a surrogate of his/her choice and give some degree of guidance for future medical decisions. If the individual does not have an advance directive, most states provide authorization to a surrogate via statute.

[10] A couple of states where surrogates have limited ability to update a POLST Form based on state law.

POLST Paradigm screening questions identify patients appropriate for thoughtful POLST conversations:

1) Does this person have one or more advanced chronic conditions or a serious illness with a poor prognosis or advanced frailty?
2) Would you be surprised if the person dies in the next year?
3) Does the person express a desire to receive or avoid any or all life-sustaining treatment?
4) Does the person live in a nursing home or receive long term care services at home or in an assisted living facility?
5) Does this patient have decreased function, frailty, progressive weight loss, >= 2 unplanned admissions in last 12 months, have inadequate social supports, or need more help at home?

Both Virginia and New York have created useful guides for helping health care professionals determine which of their patients may be appropriate for the POLST Paradigm.

A facility should never mandate the completion of a POLST form for all patients in a facility—in fact, it should raise a red flag if a facility has 100% POLST form completion rates and trigger a review of how staff discusses the POLST Paradigm with patients or residents. Instead, a facility can—and should!—have a policy to offer a POLST form to all appropriate patients, provided that the facility appropriately implement the POLST Paradigm, which includes appropriate staff training and education on the POLST Paradigm.

» The POLST Paradigm in Unique Populations

Certain populations require greater thought and consideration to determine if the POLST Paradigm is appropriate.

Minors

The POLST Paradigm covers pediatric populations except in Colorado, which has prohibited the use of POLST forms for patients under 18 years of age. For all other states the same standard applies: POLST appropriate patient should be seriously ill or frail and their health care professional should not be surprised if the patient died within a year. A good guide to use is New York's MOLST Program's Guidelines for Types of Minor Patients Appropriate for POLST.

Disability Community

The intended population for whom the POLST Paradigm may be appropriate does not include individuals with significant physical or developmental disabilities and/or significant mental health conditions that, while chronic, are not life-limiting. The Oregon POLST Program developed this helpful guidebook for using the POLST Paradigm in this population: Physician Orders for Life-Sustaining Treatment (POLST) Use for Persons with Significant Physical Disabilities, Development Disabilities and/or Significant Mental Health Condition who are Now Near the End of Life.

The POLST Paradigm Conversation

A key component to advance care planning is thoughtful, facilitated conversations between health care professionals and patients and those close to the patients, particularly the individual the patient has identified as his/her surrogate. Patients should be encouraged to both (a) let the individual the surrogate know they have been named and (b) include the potential future surrogate in the advance care planning conversations so the surrogate is aware of the patient's values and beliefs. Including the surrogate in these conversations will help the surrogate feel more comfortable making person-centered goals of care treatment decisions when necessary.

The POLST form is completed as a result of the process of shared decision-making. During the conversation, the patient shares his or her values, beliefs, and goals for care, and the health care professional explains the patient's diagnosis, prognosis, and treatment alternatives, including the benefits and burdens of life-sustaining treatment. Together they reach an informed decision about desired treatment, based on the person's values, beliefs and goals for care. These conversations should be documented in the patient's medical record, irrespective of whether a POLST form is completed.

Regardless of setting, a POLST form should never be completed without a conversation between a trained health care professional and the patient or his/her surrogate. Tips for how different facilities should handle these conversations are found within this toolkit. The POLST Paradigm encourages health care professionals be trained to conduct shared decision-making discussions with patients and families so that POLST forms are completed properly.

» Medicare Reimbursement for the Conversation

In 2016, two Current Procedural Terminology (CPT) code sets were established to reimburse certain clinicians for advance care planning conversations under Medicare Part B. These discussions may include a Part B cost sharing deductible (e.g., a co-payment) to be paid by the Medicare beneficiary. If the advance care planning discussion is completed with the Annual Medicare Wellness visit, then there is no cost-sharing for the Medicare beneficiary. Advance care planning conversations are voluntary and patients should be informed if they will be billed.

The codes with short descriptions are:

- **CPT Code 99497**: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **CPT Code 99498**: Each additional 30 minutes (List separately in addition to code for primary procedure).

These codes can be used by physicians and other qualified health care professionals who are authorized to independently bill Medicare; authorized clinicians are subject to federal regulation and vary by state. This must be face-to-face advance care planning conversations with the patient and/or surrogate—and can take place in any setting, but exclusions do exist for some critical care settings, including neonatal and pediatric critical care. There are no specific training, specialty restrictions, or quality measures a provider must satisfy to perform and bill using these codes; however, the National POLST Paradigm encourages health care

professionals to obtain training in conducting shared decision-making discussions with patients and families so that they understand the forms and their options.

These are time-based codes used to report face-to-face service between a physician or other qualified health care professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing legal forms. No active management of the problem(s) is undertaken during the time-period reported.

The two CPT codes may be used together if applicable, and there is no limit to the number of times these codes can be used or the number of physicians who can use them. The first code, 99497, covers the first 30 minutes of face-to-face conversation and documentation by the health care professional with the patient, family member(s) and/or surrogate. In order to qualify, at least 16 minutes must be performed and documented. If the conversation exceeds 30 minutes, the second code, 99498, provides each additional 30-minute increments of service.

For multiple bills for a given beneficiary, CMS expects to see a documented change in the patient's health status or wishes regarding his or her end-of-life care.[11] Documentation in the medical record should include:

1) An account of the discussion with the beneficiary (or family members/surrogate) regarding the voluntary nature of the encounter;
2) Documentation indicating the explanation of advance directives (along with completion of those forms, when performed);
3) Who was present; and
4) The time spent in the face-to-face encounter.[12]

Although CMS has given specific guidelines for time components for billing and direction that the time must be separate from time spent in medical management, they have not provided specifications on documentation. In short, whatever is discussed is what should be documented. View the CMS Advance Care Planning publication (describes how to code, eligibility, how to bill, and more) and CMS FAQs about Advance Care Planning CPT codes. Another resource is the FAQs: Advance Care Planning Under Medicare by the Coalition for Compassionate Care of California.

» Hospice Reimbursement

Hospice is an underutilized service that has demonstrated effectiveness in improving people's end-of-life experience. People are often referred too late to benefit from the comprehensive services offered. When discussing goals of care and supportive services for individuals and families, it is important to understand different hospice options that are available.

The Medicare Hospice Benefit is intended for people who have a projected life expectancy of approximately six months or less if the disease runs its normal course; the primary focus is comfort care and helping people have the highest quality of life possible. The Medicare Care

[11] Frequently Asked Questions about the Billing Physician Fee Schedule for Advance Care Planning Services (Question 6), July 14, 2016. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf Last accessed September 9, 2017.
[12] *Id.* (Question 2)

Choices model, as well as some private insurance companies, allow payment for curative treatment as well as hospice care if patients meet criteria for these programs.

All health care professionals can help to identify when hospice is an appropriate option for a patient facing advanced illness. When discussing goals of care, ask the patient what is important to them, what their values and beliefs are, and how that relates to their health care preferences. If, for example, the patient states that they would like to remain in their home and not go to the hospital, hospice should be explored as an option for care and support.

- Ask the patient and family if they have heard of hospice. Do they have personal experiences with, or have they heard stories about, hospice? Has a family or friend received hospice care? If they say yes, ask them to tell you about their experiences. Today, unlike thirty years ago, many people have stories about hospice. Stories are a valuable segue into a more in-depth conversation about goals, preferences and options.
- Describe the interdisciplinary approach to care and the variety of supports that hospice provides. People may not be aware of the comprehensive services that hospice offers. Core members of an interdisciplinary team include a physician (medical director) who partners with a personal physician, a nurse, a social worker and a spiritual or other counselor. Additional team members may include nurse practitioners, pharmacists, hospice aides, music therapists, volunteers, bereavement counselors, and other disciplines. Inquire if hospice might be a resource they are interested in for themselves and their family. If so, an appointment with hospice staff can be scheduled. Hospice staff will provide information about services, assess if the patient meets guidelines for admission, and determine next steps.

Offering hospice as a choice if it aligns with a patient's goals of care assists the individual and family in making an informed choice.

The POLST Paradigm Form

The POLST form reflects patient treatment decisions made as part of an advance care planning conversation; it is a tool for translating patient's current goals of care (or what is an acceptable quality of life) and treatment wishes into medical orders so that they are easily located and portable across care settings. The POLST form varies among states but states endorsed by the National Task Force have all met the same standards found on the Endorsement Application.

Since these are medical orders that are followed by emergency personnel, the POLST form orders should reflect what the patient would want if they had an emergency tonight. The POLST form is not meant to reflect future wishes when the patient may be sicker or frailer, instead, the POLST form is designed to be updated as treatment wishes change over time.

» Form Sections

All POLST forms are divided into three key sections, although the order of the sections varies by state. Requirements about what POLST forms must contain can be found on the Endorsement Application.

Section A: Cardiopulmonary Resuscitation (CPR)

A *Check One*	**CARDIOPULMONARY RESUSCITATION (CPR):** ***Unresponsive, pulseless, & not breathing.***	
	☐ **Attempt Resuscitation/CPR**	If patient is not in cardiopulmonary arrest, follow orders in **B** and **C**.
	☐ **Do Not Attempt Resuscitation/DNR**	

This section only applies when the patient is unresponsive, has no pulse and is not breathing; this section does not apply to any other medical circumstance. If the patient wants CPR, the box should be checked and full CPR measures should be performed. If the patient does not want CPR, the box should be checked and CPR should not be performed by emergency personnel. Some forms use the term ***allow natural death*** instead of *DNR*.

This section of the POLST form is similar to a DNR order, except that it allows patients to clearly indicate they want CPR. A DNR order only indicates the patient doesn't want CPR attempted; a DNR order does not allow a patient to clearly state they want CPR. The POLST form allows a patient to clearly say either that they don't want CPR attempted or that they do.

If this is left blank, emergency personnel will attempt CPR if medically necessary.

Section B: Medical Interventions

B *Check One*	**MEDICAL INTERVENTIONS:** ***If patient has pulse and is breathing.***
	☐ **Comfort Measures Only**. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.* **Treatment Plan: Provide treatments for comfort through symptom management.**
	☐ **Limited Treatment**. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer*** *to hospital if indicated. Generally avoid the intensive care unit.* **Treatment Plan: Provide basic medical treatments.**
	☐ **Full Treatment**. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: All treatments including breathing machine.**
	Additional Orders: _____

This section gives medical orders when CPR is not required but the patient still has a medical emergency and cannot communicate. There are three options and a space for a health care professional to write in orders specific for the patient. Care is always provided to patients. This section is specifically for informing emergency personnel what treatments the patient wants to have.

1) **Comfort Measures Only/Allow Natural Death**. The treatment plan is to maximize comfort through symptom management. This should be ordered if a patient's goal is to maximize comfort and avoid hospitalizations unless necessary to ensure comfort needs are met. For example, antibiotics may be used as a comfort measure.
2) **Limited Treatment/Selective Treatment**. The goal of this option is to provide basic medical treatments. The treatment plan is to hospitalize if needed but to avoid mechanical ventilation and generally avoid ICU care. This should be ordered if a patient's goal is to obtain treatments for reversible conditions or exacerbations of his/her underlying disease with the goal of restoring the patient to his/her current state of health.

3) **Full Treatment**. The goal of this option is to provide all treatments necessary (and medically appropriate) to keep the patient alive. The treatment plan should include all life-sustaining treatments possible, including intubation, advanced airway intervention, mechanical ventilation, cardioversion, transfer to hospital and use of intensive care as indicated with no limitation of treatment.

In many states, in Section A, if a patient chooses CPR or leaves it blank, **Full Treatment** is required in this Section B. This is because CPR usually requires intubation and a breathing machine, and **Full Treatment** is the only medical intervention providing these options.

Section C: Artificially Administered Nutrition

C Check One	ARTIFICIALLY ADMINISTERED NUTRITION:	*Offer food by mouth if feasible.*
	☐ Long-term artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ No artificial nutrition by tube.	***Additional Orders (e.g., defining the length of a trial period):***_____ _____

This section provides orders about artificial nutrition (and in some states artificial hydration) when the patient cannot eat. All POLST forms clearly state that nutrition will be provided if medically feasible; if forms address artificial hydration, they also say fluids will be provided if medically feasible.

Other POLST Form Sections

Health care professional: Since this form is a medical order a health care professional is required to sign it for it to be valid, although what health care professionals have the authority to sign (nurse practitioner, physician, physician assistant) varies by state. POLST forms have a statement by the signature saying that, by signing the form, the health care professional agrees that the orders on the form match what treatments the patient said he/she wanted during a medical emergency based on his/her medical condition today.

Patient or Surrogate: Most states require the patient or his/her surrogate to sign this form. This helps show the patient or surrogate was part of the conversation and agrees with the orders chosen on the form.

Backside of Form: Most backsides of POLST forms have directions and information, usually for health care professionals, including:

- Information on how to void a POLST form;
- Contact information for surrogates; and
- Information on which health care professional completed the POLST form.

» Completing a POLST Form

The health care professional completes the POLST form; it should never be completed by an administrator, patient, surrogate or family member. The health care professional gives the patient or surrogate the original copy (generally a brightly colored form) to keep in a place where emergency personnel are trained to look (e.g., the refrigerator or medicine cabinet). A copy is also kept in the patient's medical record. Conversation and discussion notes should also be documented in the medical record. If applicable, a copy may also be sent to a POLST Registry (currently only available in certain states).

State laws authorize certain health care professionals to sign medical orders; the POLST form is signed by those health care professionals who are accountable for the medical orders.

The POLST form may be signed by a patient with capacity or a patient's surrogate when the patient lacks decisional capacity, but such a signature is not required in all states. The National Task Force encourages POLST Programs to require a patient or surrogate's signature on the POLST form; having a signature may help alleviate concerns or questions later about whether the patient or surrogate knew about the POLST form. However, since traditional medical orders are not signed by patients or surrogates, the Task Force's focus is on encouraging state POLST Programs to design systems to ensure the conversation about patient's treatment options and goals has taken place.

» Revising or Voiding a POLST Form

As a patient's disease progresses his/her goals of care may change, it is therefore important that the POLST form be easily amended or voided. For example, when treatment has been initiated and more medical information becomes available regarding diagnosis, prognosis, or potential outcomes, the patient's goals and preferences may change which may necessitate updates to the medical orders on the POLST form. The reverse side of all POLST forms have information on how to revise and void forms.

Revising a POLST Form

The patient's primary care professional should review and update the POLST form, with the patient or the patient's surrogate, as needed based on the patient's medical condition and treatment preferences. At a minimum, a POLST form should be reviewed (and updated, if appropriate) in the following circumstances:

- When the patient is transferred from one care setting or care level to another;
- When there is a substantial change in the patient's health status; and
- When the patient's primary care professional changes.

A patient with capacity, or the patient's surrogate when the patient lacks capacity, may also initiate a revision of a POLST form at any time.

Revisions of a POLST form generally require voiding the current POLST form and writing and signing a new form, as well as giving the patient the updated form with instructions to destroy all older versions. The health care professional should put the most current form in the patient's medical record and archive the old POLST form.

Voiding a POLST Form

A patient with capacity, or the patient's surrogate when the patient lacks capacity, can void the form and request alternative treatment at any time. Writing "VOID" in large letters across the form generally voids a POLST form, but the process varies by state, particularly if there is a state registry to be notified.

Education and Training About the POLST Paradigm

Education about the POLST Paradigm is a vital part of the work of the National POLST Paradigm and state POLST Programs. The National POLST Paradigm collects various education materials and makes them available in its library and video page, and also hosts and makes available its recorded webinars. It also has provided guidance for state POLST Programs regarding educating health care professionals and the public.

» Health Care Professional Education & Training

Training for health care professionals is primarily done at the state level—contact your state POLST Program for information about health care professional education and training.

» Community Education

It takes a collaborative effort in any community to make the POLST Paradigm work effectively. *Train the trainer* workshops are effective ways to disseminate information about POLST and are used in many states. These opportunities may be offered locally, regionally or statewide, facilitated by core faculty as well faculty from each venue/region where the training is held. Contact your state POLST Program for information about training or educational opportunities.

The following is a list of examples of community health care partners who may benefit from POLST Paradigm training:

- Health clinics
- Hospitals
- City, county, and private ambulance providers
- First responders/EMS/community paramedicine programs
- Public health departments
- Home health organizations
- Senior centers
- Religious leaders
- Independent and assisted living centers
- Adult day health centers
- Nursing homes
- Lawyers
- Private caregivers
- Prisons
- Veteran's Administration Medical Centers

Higher education centers also can incorporate POLST Paradigm education into their curriculum. This may include but is not limited to medical, nursing, social work, pharmacy, public health, and administrative health care students. University Centers on Aging and Interprofessional Education (IPE) programs could be additional partners in learning about and providing POLST Paradigm education.

» POLST Program Quality Assurance and Assessment

A variety of quality assessment and improvement projects can be developed and implemented (e.g., to assess, *Are forms signed correctly and in a timely manner?*). Many instruments have been developed already and are available for download. One comprehensive resource is the POLST Quality and Research Toolkit (PQRsT).

Accessing POLST Forms Electronically

There are two ways technology can be used to support the POLST Paradigm, making POLST forms more widely available and useful to health care professionals and patients.

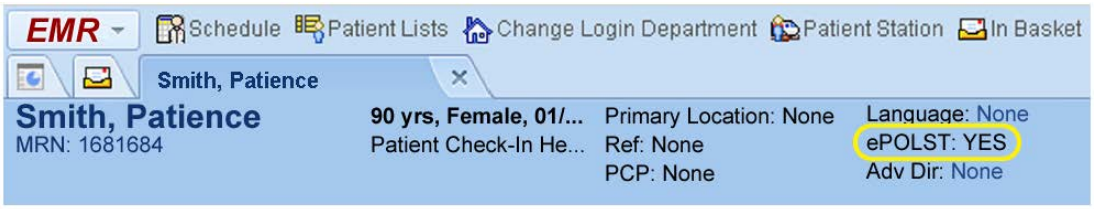
» POLST Forms in EMRs

Electronic Medical Records (EMR) systems are the systems used to collect patient health information in a digital format that is electronically-stored and available across different health care settings. EMRs provide opportunities to make a patient's POLST form more widely available than just having the paper form.

There are two ways POLST forms can be integrated into EMRs:

1) **EMR systems can scan and store a POLST form as a PDF**. This is not considered an *ePOLST*, although it is a POLST form electronically stored.
2) **A POLST form can be completed electronically within an EMR system**. This is an *ePOLST* because it was created without the need to scan and upload a PDF.

Unfortunately, no requirement currently exists for EMR systems to provide easy access to a POLST form or any advance care plan or advance care planning conversation notes. This is problematic for documents that may be urgently needed such as the POLST form because, although a document may be "in the record" (meaning in the EMR) it may not be easily located by health care professionals. The National Task Force strongly recommends EMRs be designed to include a unique field/tab for POLST forms that can be accessed instantly in a single click (see policy). An example is shown below:



However, facilities investing in ePOLST technology may see a return on investment, upgrading from paper to electronic completion, in the following ways:

- **Work Flow Improvements:**
  - **Time saved and errors reduced** with auto-completion of POLST form fields, such as patient demographic information and health care professional information (name, license number, date of signature);
  - **Standardized location for POLST forms**. Eliminates/reduces improper scanning into unknown areas of EMR and inability to locate POLST forms during a medical emergency.
  - **Avoiding critical and potentially dangerous delay** of when POLST form orders are unavailable, eliminating the inability of a health care professional to know and honor a patient's wishes.
- **POLST Form Quality Improvements:**
  - **Eliminates invalid POLST forms**. Oregon POLST Registry data showed approximately 12-15 percent of all POLST forms received each month are not registry ready, meaning that the POLST form is invalid for some reason. This means administrative time is spent notifying the patient and health care professional to correct the problem before a valid POLST form can be entered into

the registry. ePOLST eliminates this problem by ensuring POLST forms cannot be signed (electronically) until all information is completed.

    - The Oregon POLST Registry showed approximately 36 percent of all not registry ready POLST forms are missing a health care professional signature and 40 percent are missing a signature date. ePOLST prevents not registry ready POLST forms by pre-populating fields with information already in an EMR and using an individual authentication process to validate the health care professional's signature and date.

  - **Eliminates incompatible orders**, such as *CPR* and *Comfort Measures Only*, which are incompatible because comfort measure only orders indicate the patient does not want to be in the ICU or to use a breathing machine, both of which are likely required after providing CPR.

- **Other Value:**
  - **Increased reimbursement opportunities**. ePOLST provides a framework and materials for an advance care planning conversation (as well as an audit trail) that can support billing for advance care planning time.
  - **Quality assurance opportunities**. ePOLST can lead to improved processes by reviewing several metrics, including: time spent on a POLST conversation, how often educational materials are accessed and how long is spent reviewing them, who is involved with completing a POLST form and how long is spent on that process, who is initiating POLST conversations, who is signing POLST forms and who is not but perhaps should be, how often POLST forms are reviewed as part of an exam, etc.
    - Health care professionals may also find they can improve patient care with increased access to historical information such as previous POLST form orders, revision dates, changes and who/what entity was involved with each version.
    - Ability to track operational efficiency and conduct quality assurance activities, including audit tracking, reports of ePOLST utilization, and identifying what department(s) or individual(s) may need more support or education.
    - Opportunities for "just in time" education, for health care professionals and patients. This means education materials, such as videos or handouts, are available with a single click from the screen. For example, when the ePOLST is on the CPR/DNR section, there may be a video about CPR the health care professional can click on and show the patient available in a single click.
  - **Avoiding medical errors**. The provision of unwanted treatment to a patient with a POLST form can be very expensive in treatment costs and legal fees (such as in-house and external counsel, and settlement, mediation or litigation expenses).
  - **Supply chain savings**. Cost-savings in eliminating paper forms and eliminating supply chain management for ordering or printing, distributing and conducting inventory checks.

» POLST Form Registries

Currently, POLST Registries are developed and supported at the state level. Several states, including Oregon, West Virginia, Idaho, and Utah, have registries for POLST forms, ensuring emergency personnel and health care professionals can find out the treatment wishes of their patients during an emergency. Depending the on the state, registries can be accessed either electronically or by calling a 24/7 registry line to get POLST form information.

For example, in an emergency in Oregon, when EMTs are called to a scene they are trained to look at/in the refrigerator for a bright pink form; patients and families are told that this is where the form should be kept. Emergency personnel are trained to call the Oregon POLST Registry anytime: (1) they suspect a patient has a POLST form; (2) they are told a patient has a POLST form but are unable to locate it; (3) the patient has a chronic, progressive illness; (4) the patient is a frail or elderly patient; and (5) if a POLST form is produced on the scene but there is a problem or question as to the orders selected, or validity of the form.

Registries have the potential to be a single source of truth for POLST forms. A patient may have multiple POLST forms if they receive care in multiple systems—this means a single person can have multiple versions of a POLST form. If those forms provide different orders, it means the patient's care may change depending on what facility they go to during an emergency (and the treatment provided may match the POLST form that facility has on file but not be the most recent version and—therefore—not what the patient wanted). Having a "single source of truth"—such as a registry—helps ensure facilities know what the current version of a patient's POLST form orders, no matter where they go during an emergency.

POLST Paradigm and the Law

Currently, no federal rules or regulations explicitly mention POLST and the Centers for Medicare & Medicaid Services (CMS) has never discussed POLST explicitly in its regulations. CMS has, however, recently acknowledged POLST (referred by CMS as *MOLST*) as a positive example in recent changes to its Guidelines to Surveyors for Federal nursing home regulations (aka F-tag) 309 ("Quality of Care") and F-tag 155 ("Advance Directives").[13]

Not all states have laws or regulations regarding POLST. Each state coalition must evaluate both legislative and non-legislative approaches considering the culture of a state in order to determine the best course of action. Some states have found establishing their program through clinical consensus is the preferred approach. In those states, since the POLST Paradigm is a clinical program implemented by means of medical orders, health care professionals view it like other medical orders, for which there is normally no need for authorizing legislation. Instead, broad clinical consensus establishes a generally accepted medical practice standard.

In other states, legislation passed to address either specific impediments in state law that posed legal barriers to POLST Paradigm implementation or political or health practice realities that posed serious barriers to implementation.

Contact your state POLST Program to make sure your facility understands the legal requirements relative to the POLST Paradigm in your state.

[13] CMS Manual System Pub. 100-07, State Operations, Provider Certification. Transmittal-ADVANCE COPY (September 27, 2012). SUBJECT: Revisions to Appendix PP—Interpretive Guidelines for Long-Term Care Facilities—F tag 155 (Advance Directives), available at: 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.

Frequently Asked Questions

Each chapter includes FAQs specific to that setting. Additionally, the National POLST Paradigm's website has FAQs in a number of places:

- For patients/caregivers
- For professionals
- Specific to advance directives (go to bottom of linked page)

Introduction to Toolkit Chapters

A key recommendation from the Institute of Medicine's (IOM) *Dying in America* report is to *"encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements."* The National Task Force is the nonprofit entity that sets those core requirements and works to ensure that individuals with serious illness or frailty not only have access to POLST forms but also to professionals who understand the value of the POLST Paradigm and are trained to have meaningful goals of care conversations to elicit, document and honor patient treatment wishes properly through a POLST form.

Why Was this Toolkit Created?

This toolkit will help facilities implement the POLST Paradigm by addressing the needs of specific patient populations and professionals in primary care offices, hospitals, nursing homes, hospices, and EMS settings. In addition to educating about the benefits and value of the POLST Paradigm, this toolkit provides setting-specific resources for POLST Paradigm implementation to address the specialized needs of implementing POLST in different types of care facilities.

The goal of this toolkit is to provide the necessary information and resources for facilities, organizations and systems to implement a quality POLST Paradigm process that supports patients and families who want to access or currently use the POLST Paradigm. The National POLST Paradigm encourages all staff to:

- Review this material;
- Look at the information on www.polst.org;
- Sign up for our eNewsletter (www.polst.org/subscribe); and
- Connect with your state POLST Program.

How Should You Use this Toolkit?

This overview provides information that is common across all care settings; the chapters build upon this introduction to provide specific details in five different settings. This overview should be read first before going to the specific chapter.

A caveat: you need to understand your state laws (this comparison chart may be helpful) and adapt these resources to your care setting. The information provided in this toolkit should be helpful for you and feedback is always welcome. You can share feedback at toolkit@polst.org. This document will be updated as feedback and additional questions are received. Please share what worked, provide sample policies, or any remaining questions.

If you have questions not answered by this toolkit, or are concerned about misuse of POLST forms or implementation of the POLST Paradigm, please contact the National POLST Paradigm at toolkit@polst.org.

Getting Started with Implementing the POLST Paradigm

Implementing the POLST Paradigm in your facility, organization or setting is not a "one and done" process—or even a linear one—but requires continual training, evaluation and improvement. Each chapter provides information specific to the setting. For state POLST Program leaders, this will provide general knowledge on the challenges a facility, organization or system faces. For facility, organization or system leaders, this will hopefully provide guidance on what needs to be considered to successfully implement the POLST Paradigm in a way that supports your patient population.

On the next page is an example of a general process for implementing the POLST Paradigm—there is no one right way and both your state POLST Program and the National POLST Paradigm (email: info@polst.org) are happy to provide technical assistance if needed.

Step 1. Committing to honoring patient treatment wishes at the end of life.

- Get familiar with the difference advance care planning documents available, particularly the differences between POLST medical orders and advance directives.
- Watch the POLST Toolkit Overview webinar and read the Overview chapter.
- Learn about the different sections of a POLST form.
- Understand the POLST Paradigm fundamentals.
- Review the FAQs about the POLST Paradigm.

Step 2. Learning local laws around the POLST Paradigm.

- Connect with your state POLST Program and the National POLST Paradigm
- Read the Overview section *POLST Paradigm & the Law*
- Check if your state has legislation using our Legislative and Regulatory Chart.
- Read the facility chapters to appreciate laws applicable to those facilities.

Step 3. Implementing the POLST Paradigm.

The Overview provided the POLST Paradigm basics; the chapters provide information specific to that setting. We encourage everyone to read all chapters and become familiar with the challenges of each setting: by appreciating the care continuum, we can better support patients using the POLST Paradigm transitioning among these care settings. The steps for implementing a POLST Program are not linear but key elements include:

1. **Training staff and articulating roles/responsibilities.**
    a. Consider what suggestions on training and identifying roles within each care setting work for your facility. Connect with your state POLST Program for what training materials exist in your state (and, if applicable, ask for permission to tailor them to your setting).
    b. Review the national website's webinars, educational videos, and other resources for what may be useful for your trainings.
    c. Sign up for the POLST eNewsletter to learn about new webinars and conferences.

2. **Engaging with the community.**
    a. Connect with your state POLST Program for what community outreach materials exist in your state that you can tailor for your community.
    b. Participate in National Healthcare Decisions Day (NHDD).
    c. Explore advance care planning resources and help patients appreciate the difference between the POLST Paradigm and advance directives.

3. **Developing a process for identifying patients who are appropriate to be approached about the POLST Paradigm.**
    a. Read The POLST Paradigm Population: Who Should Have a POLST Form?

4. **Conducting Quality** Improvement.
    a. Review chapter suggestions for quality improvement activities within each care setting.
    b. Consider strategies and documents in the POLST Quality and Research Toolkit.

Glossary

The Toolkit uses the following language conventions throughout:

advance care planning refers to a person-centered, ongoing process of communication that facilitates individuals' understanding, reflection and conversations of their goals, values and preferences for future health treatment decisions. Advance care planning includes documenting discussions health care treatment decisions in medical records, advance directives and POLST forms.

advance directive refers to any legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves and/or may authorize a surrogate for when the person loses their decision-making capacity. This term encompasses living wills, power of attorney for health care, personal directives, health care directives, durable powers of attorney for health care, medical powers of attorney, and health care proxies.

health care professional means any health care professional involved in the POLST process acting with their scope of practice. These guidelines most frequently focus on health care professionals who have authority to sign POLST forms. In addition to licensed physicians, professionals with signing authority may include, nurse practitioners, and physician assistants, depending on state scope of practice laws. However, other health care professionals, including nurses and social workers, are typically part of the care team that supports the POLST Paradigm, even though they have no authority to sign POLST forms.

POLST is the generic identifier for all programs fitting its definition regardless of the actual term used in a state. Terms for states can be found on the POLST Paradigm Map. Since the term "POLST" can mean many things we tried to make sure we were clear in this document (e.g., POLST form, POLST conversation, POLST program).

POLST Paradigm means the ideal *process* of eliciting, completing, documenting and honoring a POLST form. This includes appropriate conversations and completion of the form, as well as use of the form across care settings in honoring patient treatment wishes. It is the ideal the National Task Force promotes and what state POLST Programs should implement.

National POLST Paradigm is the nonprofit entity that, through its governance body (National POLST Paradigm Task Force) standardizes the core requirements for the POLST Paradigm and works to ensure that individuals with serious advanced illness or frailty not only have access to POLST forms but to professionals who understand the value of the POLST Paradigm and are trained to have meaningful goals of care conversations to elicit, document and honor patient treatment wishes properly through a POLST form. The National POLST Paradigm promotes and educates on those standards nationally, as well as reviews state POLST Programs for compliance with those standards.

Surrogate is a substitute health-care decision-maker. A surrogate consents or refuses to consent to some or all medical treatments for the patient who lacks decision-making capacity. We include the following in this definition:

1. an agent under a health care power of attorney or health care proxy;
2. a guardian or conservator of the person with health care decision-making powers, a court-appointed surrogate;
3. a surrogate recognized under state law;
4. any other similarly authorized decision-maker, regardless of the terminology used in a particular state; and
5. in the absence of anyone legally appointed, the individual identified by the facility to make decisions on behalf of the incapacitated patient.

Even when the patient appoints the surrogate, questions can still arise as to the extent of the surrogate's authority. For more information about surrogates, please see Issue 7 of our Legislative Guide. Read more about the Role of the Surrogate in the Overview.

Common abbreviations include:

AD—advance directive
ACP—advance care planning
AED—automated external defibrillators
ALF—assisted living facility
ALS—amyotrophic lateral sclerosis
AND—allow natural death
CCCC—Coalition of Compassionate Care of California
CEU—continuing education courses/units
CME/CE—continuing medical education; continuing education
CMS—Centers for Medicare & Medicaid Services
CPR—cardiopulmonary resuscitation
CPT—current procedural terminology, as in CPT code
DNAR—do not attempt to resuscitate
DNR—do not resuscitate
DPOA-H—durable power-of-attorney for healthcare
ED—emergency department
EMS—emergency medical services (see the EMS chapter for more detail)
EMR—electronic medical record
ePOLST—electronic POLST form
FAQ/FAQs—frequently asked question(s)
HIPAA—Health Insurance Portability and Accountability Act
ICU—intensive care unit
IOM—the Institute of Medicine (now NASEM)
IPE—Interprofessional Education
IPOST—Iowa Physician Orders for Scope of Treatment
LTC—long term care
LTAC—long term acute care
MOLST—alternative term for POLST
NASEMSO—National Association of State EMS Officials
NASEM—National Academies of Sciences, Engineering, and Medicine (formerly the IOM)
NHDD—National Healthcare Decisions Day
OHDNR/OOHDNR—out-of-hospital do-not-resuscitate
PCP—Primary care physician (sometimes provider or practitioner)
POLST—Physician (Provider) Orders for Life-Sustaining Treatment (see above)
PQRI—Physician Quality Reporting Initiative (from the CMS)
PVS—persistent vegetative state
QAPI—quality assurance and performance improvement
SNF—skilled nursing facility
TPOPP— Transportable Physician Orders for Patient Preferences

Primary Care

A chapter discussing the POLST Paradigm for Inpatient Hospital settings
by Patricia Bomba, MD, MACP & Kathryn Borgenicht, MD, CHMD

Note: ***Please read the Overview prior to reading this chapter.***
This chapter was written by and for professionals in a primary care practice setting and builds on the basic information contained in the Overview.

Note on Primary Care Practices*: Primary care practices provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.) The primary care office practice setting may be in a private practice, a hospital owned primary care practice or clinic, a federally qualified health center (FQHC), or part of a larger multispecialty group. The type of primary care office setting may also vary in urban and rural regions. Regardless of the type of practice setting, the primary care office setting is the ideal setting to initiate the advance care planning process.*

Benefits of Adopting POLST Paradigm for Primary Care

The POLST Paradigm allows patients and their surrogates to document their medical decisions based on their individual goals of care. Clearly establishing a patient's wishes for the level of medical intervention they are willing to accept helps the primary care professionals develop an individualized plan of care that can follow the patient as they go across the care continuum: hospital, long term care, and hospice. Most importantly, the POLST form is a medical order that emergency personnel must follow.

Having a POLST form can improve patient and surrogate experiences and level of satisfaction with the treatments they receive. The primary care professionals benefit from a POLST form by having previous conversations on goals of care documented as a medical order. Finally, in introducing the POLST Paradigm, having a POLST conversation and having a POLST Form, patients and surrogates will feel more comfortable with reviewing and updating the form later or having additional conversations. It will also help professionals in hospitals, long term care facilities and hospice; when patients are admitted to these facilities there is significant stress and uncertainty which makes them less than ideal places to initiate advance care planning conversations. These conversations should start with primary care professionals, when the patient and surrogate have more time to understand and consider their options before making a decision about what treatments are wanted right now.

The POLST Paradigm and form may also contribute to decreasing inappropriate hospital readmissions if patients/surrogates elect comfort care that would not return them to the hospital for care.

Advance Care Planning (ACP)

While this toolkit is focused on the POLST Paradigm, advance care planning discussions should begin in the primary care practice by physicians and other clinicians who know the patient and family, long before the patient is appropriate for a POLST Form. This section of the Toolkit aims to help clinicians transform their practices and incorporate a systematic

approach to advance care planning, including the POLST Paradigm, into their current office workflow. For guidance in implementing the POLST Paradigm in other health care settings, see the pertinent sections of the toolkit that address the needs of specific patient populations and professionals in those settings and read the Overview. Click on a state on the POLST Program map to access state-specific tools and resources.

Advance care planning is:

1) A key pillar of palliative care and an integral component of the practice of medicine.

With the changing healthcare landscape, a seriously ill or frail person who might die in the next year is unlikely to see the same health care professional or health care team members in all care settings. The health care professional who primarily provides care for the patient is most likely to know the person best and have a discussion before a crisis occurs.

2) A process of planning for future medical care in the event the person lacks capacity to make medical decisions.

It is a continual process along the life cycle and not merely a document or isolated event. ACP assists in preparing for a sudden unexpected illness, from which a person is expected to recover, as well as the dying process and ultimately death. The advance care planning process focuses on the clarification of values, beliefs and goals, choosing the right person to make decisions if the individual loses the ability to make decisions, discussion with family and close friends and embodiment of preferences through written documents called advance directives and medical orders.

» Advance Directives

It is critical to appreciate the differences between advance directives and the POLST Paradigm; please review the *Overview*.

Early ACP discussion and completion of advance directives is recommended for all patients 18 years of age and older. Ideally, advance care planning conversations occur with a patient, along with family member(s) or the patient's surrogate and the primary health care professional (physician, nurse practitioner, physician assistant), along with other members of the health care team. Discussions are recorded and updated as needed and allow for flexible decision making in the context of the patient's current medical situation. Discussions between the patient's health care professional(s) and the patient along with family member(s) or surrogate(s) ahead of time, regarding these decisions and preferences, and preparation of an advance directive, increases the likelihood a patient will receive the care and treatment he or she prefers at the end of life.

Decisions are revisited periodically, as values, beliefs and goals, as well as who we trust to make decisions changes with time. Conversations become more focused as health status changes.

Effective Implementation and Sustainability Requires a Multidimensional Approach

Experience has shown effective implementation of a systematic approach to advance care planning and the POLST Paradigm in a primary care practice setting, as well as other care settings, requires a multidimensional approach to ensure quality and sustainability. Several of these key elements (*) are recommended in the IOM Dying in America. These key elements will be addressed:

1) Culture change*****

2) Professional training of physicians, clinicians & other professionals*
3) Public advance care planning education, engagement and empowerment*
4) Thoughtful discussions*
5) Shared, informed medical decision-making*
6) Care planning that supports POLST
7) System implementation, policies and procedures, workflow, quality improvement
8) Dedicated system and physician champion
9) Leverage existing payment stream (CPT codes 99497 and 99498) to encourage upstream shared, informed, decision making*
10) Utilize a state registry, if one is available, to ensure accessibility to advance directives and/or medical orders*

» Dedicated System and Physician Champion

To achieve successful implementation and sustainability, experience has shown it is helpful to:

1) Establish an advance care planning team; create a work plan and timeline.
2) Identify a physician leader and system leader.
3) Establish a POLST Team: physician leader, system leader, office manager, practice IT lead, staff responsible for quality and staff education.
4) Assign a project manager.
5) Review progress via weekly or bi-weekly meetings.

» Culture Change

Before embarking on transforming the approach to advance care planning, establish buy-in from the practice leadership team. Review potential challenges and opportunities:

1) Physician buy-in
2) Staff buy-in
3) Staff availability, including turnover and capacity (current workload)
4) Staff discomfort with starting the conversation
5) Communication within practice
6) Patient follow-up
7) Documentation of discussion
8) Scanning and retrieval of AD's, POLST Paradigm form

It is useful to recognize advance care planning and the POLST Paradigm are an integral component of the practice of medicine that aims to improve the quality of care of seriously ill patients with advanced illness. It is helpful to leverage the existing payment stream for advance care planning discussions (new CPT codes for Advance Care Planning) and point out where advance care planning aligns with current practice priorities and projects; for example:

1) Palliative Care
2) Quality, Patient Safety & Risk Management
3) Compliance with Public Health Law that govern end-of-life decisions with or without the POLST.
4) Care Transitions
5) Reducing Readmissions and Unwanted Hospitalizations, Life-Sustaining Treatment
6) Accountable Care Organizations and Innovative Payment Models
7) IOM Dying in America Recommendations

Once buy-in is confirmed by aligning mutual priorities, review operational and staffing considerations, identify and remove barriers. Most importantly, assess the readiness of the staff and the practice for change.

Staff Readiness

Begin by assessing the advance care planning readiness of all staff members in the practice. If staff members have not engaged themselves personally in advance care planning, had a family discussion and completed their own advance directives, it will be difficult to educate, actively engage and empower patients in the practice about advance care planning, advance directives and the POLST Paradigm. You can use the following questions to begin a dialogue:

1. Are you uncomfortable discussing death?
2. Do you believe that "accepting mortality" is "giving up hope"?
3. Are you afraid that a discussion about death will "make it happen"?
4. Are you unwilling and/or unsure how to broach the topic?
5. Do you understand the benefits of advance directives and advance care planning?
6. Are you able to find reliable resources related to advance directives and advance care planning?
7. Have you completed advance directives, identified your surrogate, and shared your wishes with your family, your physician and trusted individuals?

While an open discussion with all staff members is essential, it is also helpful to collect data to track progress. This simple survey includes four questions taken from the Excellus BlueCross BlueShield (EBCBS) employee and community surveys. EBCBS has surveyed employees since 2002; this has resulted in significant culture change and support for MOLST, New York's POLST Paradigm Program. These survey questions can be made available in Survey Monkey format. Results can track changes in employee behavioral readiness for personal advance care planning, a prerequisite to a team-based approach to advance care planning, within scope of practice. The survey and staff education that will be outlined in the section on professional training of physicians, clinicians and other professionals below can be used as part of new employee orientation as part of the sustainability plan.

Practice Readiness

There is significant variation in primary practices in the systematic approach to advance care planning. This survey that assesses the practice's readiness for transformation and implementation of advance care planning and the POLST Paradigm Program.

Public Advance Care Planning Education, Engagement and Empowerment

Individuals can, and should, take control for quality of their life throughout their lives, including at the end of life. They should choose how they want to live at the end of their life, who they trust to make decisions if they lose the ability to do so, and doctors should help initiate discussions with their patients about such decisions.

All staff members can educate, engage and empower patients, families and surrogates to participate in the ACP process. Individuals receive and use information in different ways. se educational resources (videos, websites, booklets, etc.) based on what works best for the individual. The National POLST Paradigm has information for patients and families.

The POLST Paradigm is intended for people who have serious illnesses or frailty for whom health care professionals would not be surprised if they died within a year. When a patient is

appropriate for the POLST Paradigm, share "Questions to Help an Individual Prepare for A POLST Discussion—See Advance Care Planning Workflow Tool for PCPs.

April 16 is National Healthcare Decisions Day and is an opportunity to join other clinicians across the country in raising awareness of the value of advance care planning for office staff and family. For specific ideas, view NHDD.org.

System Implementation, Policies and Procedures, Workflow, Quality Improvement

Policies and Procedures (Appendix H)

Each practice is different and will need to develop the best process for implementing ACP, based on clinical and administrative staffing. Practice leaders will need to develop and implement a process that works best. A sample policy and procedure template is included. Roles and responsibilities will need to be assigned within scope of practice for available staff.

» Identification of Eligible Patients Pre-Visit

Consider a population health approach in identifying eligible patients as part of the pre-visit preparation process. See the Advance Care Planning Workflow Tool for PCPs

Early ACP discussion and completion of an advance directive is recommended for all patients 18 years of age and older. Using *Medicare Wellness Visit Screening Questions* is appropriate for all patients:

1. Does my patient have a surrogate?
2. Do I have a copy of the advance directive authorizing the surrogate?
3. Has the patient shared their values, beliefs and goals for their care?
4. Has the person spoken with their family?
5. Is my patient appropriate for a POLST Form?

Depending on the response, use the Advance Care Planning Clinical Pathway: Life Expectancy Greater Than One Year to discuss ACP based on yes/no response. The clinical pathway will focus discussion based on the behavioral readiness for ACP.

Please also review Who Should Have a POLST Form?

» Staffing Considerations

1. Clinical roles within scope of practice, as outlined in the sample policies and procedures, for thoughtful POLST Paradigm discussions.
2. Administrative roles, as outlined in the sample policies and procedures. For example, at each encounter, a staff member (**designated staff member**) will ask each adult patient 18 years of age and older (or the patient's family, or surrogate): "Do you have an Advance Directive?"

» Operational Considerations for Population Health Approach

If you are using pre-visit planning, use this 10 Steps to Pre-Visit Planning sheet to identify ways to integrate ACP from a population health perspective.

» Documentation of the POLST Conversation

Documentation of the POLST conversation in the patient's medical record is critical. Please review *POLST Conversations & Documentation* in the Overview.

» Quality Improvement

Once the practice has begun implementing ACP with patients, it is important to review the process to identify opportunities for improvement. The Institute for Healthcare Improvement uses the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.

Advance Care Planning CPT Codes 99497 and 99498

Key barriers for physician engagement in thoughtful POLST discussions include, lack of time, lack of reimbursement for time and the need for ACP training to improve knowledge, attitudes and communication skills. Leverage existing payment stream (CPT codes 99497 and 99498) to encourage upstream shared, informed, decision making.

Please review *Reimbursing for the POLST Conversation*.

The ACP Section from Final Rule, AMA CPT Codes Manual affirms advance care planning involves learning about and considering the types of decisions that will need to be made at the time of an eventual life-ending situation and what the patient's preferences would be regarding those decisions.

The clinical example in the AMA CPT Codes Manual is a 68-year-old male with heart failure and diabetes on multiple medications who is seen with his wife to discuss ACP.

Consistent with the 8-Step POLST protocol, additional time may be needed to discuss:

- the patient's condition, prognosis, options and resolve conflicts due to the presence of a new, unexpected, or sudden illness
- a complicated family dynamic
- disagreement or controversy over advance directive or shared decision making for adult not able to make their own decision.

Individuals who may need additional time are patients who may be appropriate for a POLST Form: those patients with a serious advanced illness or frailty whose health care professional wouldn't be surprised if they died within a year. This includes:

- Individuals with end-stage chronic illness (e.g. CHF, COPD, renal disease, HIV/AIDS);
- Individuals facing emergent and high-risk surgery, or those who experience a sudden event (e.g. TIA) and are at risk of repeated episodes;

Some individuals may need additional time and may or may not be appropriate for a POLST Form:

- Individuals with early dementia; for example, an 80-year-old whose goals focus on longevity but would prefer a natural death and definitely does not want a feeding tube placed.
- Individuals with mental illness
- Individuals who rely on guardians or parents to make decisions; for example, persons with developmental disabilities who lack capacity and minor patients

The clinical example in the AMA CPT Codes Manual is a 68-year-old male with heart failure and diabetes on multiple medications. The patient was recently discharged from the intensive care unit, is seen with his wife to discuss advance care planning. During the hospitalization, he had difficulty weaning from the ventilator, his renal function declined, and he has become increasingly frail. He does not to be a burden on his family and does not want to be dependent on a ventilator.

CPT codes 99497 and 99498 cannot be reported on the same day of service as critical care codes: 99291, 99292; neonatal/pediatric critical care: 99468-99476; and initial & continuing intensive care: 99477-99480.

» ACP CPT Codes 99497 and 99498 Frequently Asked Questions

The CMS Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning answers many questions. Other FAQs are:

1. Who can receive and where can ACP service be rendered?

CMS: All Medicare and Medicare Advantage plan beneficiaries can receive ACP services in all settings.
Commercial: check with your carrier.

2. Can ACP be part of a regular office visit?

Yes, if active management of the clinical problem(s) and ACP both occur on the same day. Active management and ACP cannot occur during the same time-period reported. For ACP, additional CPT codes can be reported, if the service is provided; the provider must add modifier 25. Documentation of the content of the ACP discussion is critical, including amount of time spent for each service.

3. Can ACP be Part of the CMS Annual Wellness Visit (AWV)?

Yes, ACP is an optional element, at the beneficiary's discretion. The AWV provides an opportunity to access ACP services should the beneficiary elect to do so. The code for an initial AWV is G0438; for a subsequent visit, the code is G0439. Part B cost sharing does not apply when ACP is part of the AWV.

4. Can ACP be part of Preventive Medicine Visits?

Yes. Codes for Preventive Medicine Visits are 99381-99397. For ACP, additional CPT codes can be reported if service is provided; the provider must add modifier 25. Documentation of the content of the ACP discussion is critical, including amount of time spent.

5. What are the cost sharing requirements for beneficiaries?

CMS: Part B cost sharing will apply, as it does for other physician services; the ***exception*** is the Annual Wellness Visit.
Commercial Carriers: Check with Provider Services.

6. Can Telemedicine be used to provide and bill for services?

CMS: **Yes**. It is included in the 2017 CMS Physician Fee Schedule, effective 1/1/2017. In 2016, the service must be face-to-face with the patient, family member(s) or surrogate(s).

Inpatient Hospital Setting

A chapter discussing the POLST Paradigm for Inpatient Hospital settings
by Suzanne Labriola, DO

Note: ***Please read the Overview prior to reading this chapter.***
This chapter was written by and for professionals in a hospital setting and builds on the basic information contained in the Overview.

The POLST Paradigm is an approach to end-of-life planning based on conversations between patients, their network of support (generally family or close friends), and health care professionals. The POLST Paradigm's purpose is to improve the quality of care for patients who are seriously ill or frail whose health care professionals wouldn't be surprised if they died within a year by creating a voluntary system that elicits, documents and honors patient medical treatment wishes using an actionable, portable medical order.

Patients who meet the recommended guidelines for the POLST Paradigm may be admitted from the emergency department (ED), be receiving inpatient care, or be transferred to the hospital from another care facility.

Benefits of Adopting the POLST Paradigm for Hospitals

The POLST Paradigm allows patients and their surrogates to document their medical decisions based on their individual goals of care. Clearly establishing a patient's wishes for the level of medical intervention they are willing to accept helps the hospital team develop an individualized plan of care. This can improve patient and surrogate experiences and level of satisfaction with their care. The hospital health care professionals benefit from a POLST form by having previous conversations on goals of care documented as a medical order. Finally, in introducing the POLST Paradigm, having a POLST conversation and having a POLST form, patients and surrogates will feel more comfortable with reviewing and updating the form later or having additional conversations.

Adopting the POLST Paradigm prepares the hospital health care professionals to become comfortable having difficult conversations about the level of inpatient hospital care that patients/surrogates want to receive. As mentioned in the Emergency Medical Services (EMS) chapter, an early conversation documenting less aggressive care at the end of life can also decrease moral distress of staff members who must perform Cardiopulmonary Resuscitation (CPR) on patients who did not want and would not benefit from such action.

The POLST Paradigm and form may also contribute to decreasing inappropriate hospital readmissions if patients/surrogates elect comfort care that would not return them to the hospital for care.

Identifying Appropriate Patients

Hospitals must have established policies about who is responsible for engaging patients about advance care planning and introducing the POLST Paradigm when appropriate.

» Not All Patients are Medically Appropriate for a POLST Form

The general rule that applies to other settings also applies in the hospital setting: if the health care professional would not be surprised if the person were to die within the next 12 months, then the person is appropriate for POLST. However, just because a person's prognosis indicates he or she is POLST appropriate, does not mean that person must have a POLST form. Just as patients may choose to refuse treatment or not to have an advance directive, patients may refuse to have a POLST form completed on their behalf. It is inappropriate to force a patient to make decisions that they may not be ready to make or participate in advance care planning, which they may not want to do. POLST forms are completely voluntary. The choice to have a POLST is always up to the patient (or the surrogate decision maker).

Review: The POLST Paradigm Population—Who Should have a POLST Form?

A Goals of Care Conversation Should Come First

Ideally, numerous advance care planning conversations would have taken place with the patient's primary care professional. Unfortunately, the reality is that sometimes no advance care planning conversations have taken place.

The value of the POLST Paradigm is the process of engaging the patient, the surrogate, the family (as appropriate), and the health care professional in a conversation of the patient's values, beliefs, and goals of care in light of their health status and treatment preferences.

If the surrogate and/or family were not included in the conversation, encourage the patient to inform the surrogate and family members about what was decided and documented on the POLST form. This shared understanding can be especially critical at the time of a medical emergency.

The POLST form should not be completed until after one more conversations occur. Completion of the POLST form after these conversations increases the likelihood that a seriously ill or frail person will get the treatments he or she wants during a medical crisis, and avoid treatments he or she does not want.

» Beginning the POLST Conversation with Inpatients

Below are three categories of patients:

1) **Patient already has a completed POLST form**. Upon admission, the POLST form should be translated into in-hospital order sets. Upon discharge, the POLST form orders should be discussed with the patient or surrogate to confirm they are still accurate or a new POLST should be completed or the POLST form should be voided. If the patient has an advance directive, a copy should be included in the medical records. Ideally, staff will confirm the decisions expressed on the POLST form are consistent with the wishes expressed in the advance directive. If the documents are not in agreement the health care professionals should discuss the discrepancy with the patient (and/or surrogate), and work toward a solution to make the documents consistent and in alignment.
2) **Patient does not have a POLST form but appears to be POLST appropriate based on prognosis**. If there is time, the patient or surrogate should start or have the conversation prior to discharge. The critical piece is having enough time to have a meaningful conversation about goals of care and treatment wishes. If this is not possible, the patient or surrogate should be encouraged to set up an appointment to have this conversation with their primary care professional.

3) **Person does not have a POLST form and does not meet the POLST criteria**. If the patient has a life expectancy longer than 12 months, they are not medically appropriate for the POLST Paradigm. There is no need to mention the POLST Paradigm.

» Having the POLST Conversation with the Inpatient

Hospitals are interdisciplinary settings. The primary care professional should engage in and document POLST conversations as early as possible to strengthen the interdisciplinary approach to this important process. Although conversations about goals and treatment options may be initiated by any qualified and trained health care professional, a licensed physician or other state-authorized health care professional must always, at a minimum:

1) Confer with the patient and/or the patient's surrogate about the patient's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker; and,
2) Sign the POLST form that reflects the patient's preferences.

» Documenting POLST in the Medical Record

The goal of the POLST Paradigm is to help ensure that people's wishes are elicited, documented, and honored. A patient's goals of care should determine the type of treatment they initially receive in a hospital. The hospital should have a policy for transferring the contents of the POLST form into in-hospital order sets, for putting a copy of the POLST form into the patient's medical record, and for providing the original POLST form (or an updated POLST form) to the patient upon discharge.

Review: POLST Conversations & Documentation.

Integrating POLST form Orders into Hospital Order Sets

Unlike an Advance Directive (AD), the POLST form provides medical orders for the patient's treatment preferences and should direct the treatment plan the patient has within the hospital. (See the *POLST and Advance Directives* section in the Overview). A POLST form will most likely need to be translated into the hospital's order set for Life Sustaining Treatment, whether it is a Code Status or a CPR Status order set.

» Notes on Code Status

All POLST forms very clearly separate the option to accept or decline CPR from additional medical interventions. If a hospital's current orders for Life Sustaining Treatment cannot accommodate this separation, then those orders may need to be updated or changed.

For example, the concept of a *Code Status* can present options that allow patients and their surrogates to select parts of CPR that should not be separated. This historical practice and term allowed for the concept of a *Chemical Code*, where a patient would receive intravenous medications in the CPR algorithm that had no medical efficacy since concurrent compressions were not performed and the airway was not secured. Adopting a new practice of designating Life Sustaining Treatment order sets that mirror the POLST paradigm (with *CPR Status* connected to *Additional Medical Interventions*) can eliminate this ineffective option.

This very clear separation of CPR Status also eliminates the possibility that a patient's decision to forego attempted resuscitation during a cardiac arrest (DNR) is not interpreted as an order to forego intubation outside of cardiopulmonary arrest. DNR is useless in an

emergency situation when a patient is responsive, has a pulse or is breathing. A review of POLST forms from the first year of the Oregon POLST Registry shows that only a 50 percent of patients with a DNR order also want to go to the hospital; the other 50 percent want comfort measures only and chose not to return to the hospital.[14] Without POLST, EMS would bring anyone not requiring CPR to the hospital– something half of these patients do not want.

In addition to updating the order set for Life Sustaining Treatment, each hospital may also consider implementing the National Colors of Safety armbands to clearly delineate patients who have a Do Not Resuscitate (DNR) status. Purple armbands with or without the lettering DNR can be used in combination with the written/ electronic medical record (EMR) order for DNR to further substantiate the wishes of these patients.

» Admission & Discharge Policies/Procedures

The hospital admission process should include not only asking whether the patient has an advance directive (AD), but also whether the patient has a POLST form—and put copies of both in the patient's medical record. (See Sample Hospital Policy for Advance Care Planning and Sample Policy for Writing Orders for Life-Sustaining Treatment from Allegheny Health Network) This is especially true for patients being transferred from a skilled nursing facility / long-term acute care (SNF/LTAC) or enrolled in a home care program due to advanced illness.

Likewise, hospital discharge processes should include time to talk to the patient to confirm if POLST form orders are still accurate and, if not, to update and revise an existing POLST form, or to see if the patient would like to complete a POLST form.

The admission and discharge process may involve multiple members of the hospital health care professional team. For example, a nurse in the ED or on the hospital ward may inquire about an AD or POLST and inform the patient's physician or advanced practitioner of an existing POLST form. Then the physician or their representative would translate the POLST form into the hospital order set. It is imperative that the physician participates in the conformation of the POLST form with the patient/surrogate.

Another example would involve a palliative medicine physician/advanced practitioner, advance care planning (ACP) facilitator, case manager or social worker holding a discussion on goals of care with a patient and surrogate at time of discharge. Following this discussion, a POLST form may then be offered and completed. Once again, the treating physician should be notified about the completed POLST form and about any decisions made that would change the course of treatment. Then the treating physician must confirm the completed POLST form.

Physicians who have participated in such discussions on goals of care, at admission or discharge, have addressed Advanced Care Planning and, therefore, the Centers for Medicare & Medicaid Services (CMS) now allows those physicians to bill for time spent in such face-to-face counseling. (For more, review the Medicare Reimbursement section from the Overview.)

How to Start Integrating the POLST Paradigm into a Hospital Setting

Review the Getting Started with Implementing the POLST Paradigm section of the Overview.

The preparation necessary to support patients using the POLST Paradigm by accepting POLST forms from the outpatient community and starting to offer POLST forms on discharge first requires establishment of a core working group with a Physician Champion, Nursing Leader,

[14] Hickman, SE, SW Tolle, K Brummel-Smith, and MM Carley. (2004), Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status. *Journal of the American Geriatrics Society*, 52:1424–1429. doi:10.1111/j.1532-5415.2004.52402.x.

Quality & Safety Officer and broad representation (consider including Legal, Ethics, Director of Case Management/Social Services, Palliative Medicine).

It is also critical to have senior leadership buy-in on the process and policies.

Hospital policies on Advance Care Planning and Writing Orders for Life Sustaining Treatments will need to be updated to include language to support finding, completing and honoring POLST forms. These policies will have to:

- Define what the POLST Paradigm is and how to interpret, complete and honor the POLST form;
- Determine procedures for finding and honoring POLST forms from out-of-network physicians/extenders;
- Establish personnel who can translate POLST form orders into hospital orders and set a time frame for completion;
- Establish who will have POLST conversations and, if appropriate, complete POLST form with a patient or his/her surrogate; and
- Determine where POLST forms will be filed in chart/EMR so that there is consistency.

It may also be necessary to add to the hospital policies and guidelines a provision that states that the POLST Paradigm process become a core or yearly competency for all staff as well as mandatory ACP education. Education should include: Who Should have a POLST Form?, Elements of a POLST Form and How to have a POLST conversation.

Conversations can be reimbursed; review Reimbursing for the POLST Conversation.

Tracking POLST form Orders

The original POLST form travels with the patient. But a copy of the POLST form should always be kept in the hospital record.

- **For hospitals using paper charts**: POLST documentation should be placed in an ACP section, but if not available, although it is not an AD, it should be placed in the Advance Directives section.
- **For hospitals with an EMR**: The EMR presents additional opportunities to enhance POLST Paradigm implementation across the care continuum.

EMR systems are complicated and while a document may be "in the record" it may not be easily located. Unfortunately, no requirement exists for EMR systems to provide easy access to a POLST form—or any advance care plan or advance care planning conversation notes. This is problematic for documents that may be urgently needed. For example, the POLST form is needed during a medical crisis so that health care professionals can locate patient wishes instantly in order to avoid providing unwanted treatment. The National POLST Paradigm Task Force strongly recommends that EMRs be designed so that POLST forms are located in a unique field/tab that can be accessed instantly in a single click (see *Recommendations for integrating POLST forms with EMR*). Ideally, the EMR should link inpatient and outpatient ACP documents. If a patient has a POLST form on file with the system, it should be readily accessible and known to all health care professionals. With POLST on the banner bar of EMR, the orders can be available with a single click (see *example from the Overview*).

If electronic POLST (ePOLST) is utilized and the state's standard color and paper weight is not available, an envelope of the same color may be used to store the ePOLST for transfer and to highlight it as an important document in the patient's chart or for easy location at home. Depending on local protocol, EMS may be trained to look for the POLST form in the state's

standard colored paper in the following locations: posted on the refrigerator, as the first page of a hospice chart, or with other specific items for medical orders applicable during a medical emergency. Regardless of how it is implemented, it is important to ensure all POLST education accurately reflects what EMS is trained to do.

Hospital Staff Education on POLST

The POLST Paradigm and any changes or updates to hospital policies and order sets related to POLST forms should be offered to all staff who have direct patient contact responsibilities. This education should be standardized into a format that is easily accessed so staff can complete it independently within defined timeframes (e.g., online or computer-based learning modules).

More intensive education including how to engage patients and families in discussions on ACP and the POLST Paradigm (with practice scenarios) should be targeted towards hospital health care professionals tasked with having these difficult conversations. Staff members who engage patients and their families will vary from hospital to hospital. Some facilities will have ACP facilitators, others may rely on palliative medicine consultants, while smaller facilities may use case managers, social workers or chaplains. The National POLST Paradigm website as well as the state's POLST Program website (find state information on the *State POLST Programs* web page) is available for educational materials.

POLST education should be mandatory for all staff. Having CME/CEU available will also assist in completion. Some hospitals have yearly CME/CEU in ACP requirements to remain on staff. If a hospital has graduate medical education, engaging interns and residents in addition to medical students and fellows in POLST education and policies can help.

Part of the POLST Paradigm education should include how a POLST form is reviewed on admission and discharge, as well as with a change in patient condition, and defining responsibilities in this process. Demonstrating how a POLST form follows a patient from outpatient to inpatient and back to the community is important in education.

Education on the POLST Paradigm does not stop with the introduction of a POLST form. Ongoing education should be focused on each hospital's need. Participation in a POLST Paradigm Knowledge Assessment will help identify areas that need to be reviewed at each hospital (view sample POLST quiz and answer key). The POLST Knowledge Assessment tool can also be used to engage and extend education to EMS as well as SNF/LTAC partners.

As a hospital prepares for the POLST Paradigm, a tracking system for compliance and quality control needs to be established. A hospital may select the CMS Physician Quality Reporting Initiative (PQRI) POLST CPT II codes which are available to facilitate reporting of quality data. These codes can be added to physician/extender billing with no increased cost to the patient:

- **1123F** denotes that a POLST form was completed.
- **1124F** denotes that a POLST form was reviewed or that education on the POLST form was presented to patient/surrogate but a decision to not complete one was made.

Maximizing the EMR potential with the use of smart phrases, ePOLST or an ACP folder may also help in tracking and quality control.

POLST Forms in the Emergency Department

POLST forms are intended to be out of hospital medical orders and guide treatment provided during a medical emergency. Once EMS has transported patients to the ED, there needs to be a process in place to hand-off POLST form orders (from EMS to the ED) so the patient continues

to receive the treatments they want and avoid the treatments they don't want. Patients with POLST forms may be coming into the ED with:

- **An order for full treatment**: this patient wants the standard of care.
- **An order for limited or selective treatment**: this patient does not want to be in the intensive care unit (ICU) or hooked up to a breathing machine, but would like more than just comfort measure treatments.
- **An order for comfort measures only**: this patient does not want to be in the ED or hospital but was transported because their comfort was unmanageable wherever they were located. For these patients, the focus should be on providing the treatments necessary to be able to transport the patient back to where they were previously.

If any of these patients need to be admitted, the ED and hospital need to have a policy and process in place for translating the POLST medical orders into in-hospital orders.

If the patient can be discharged from the ED, there should be a process by which their POLST form orders are confirmed as still accurate.

And there should be a policy to ensure that a copy of the POLST form is put within the patient's facility medical record (so health care professionals can ask about the POLST form in the future).

Frequently Asked Questions

1. Must hospital staff follow POLST form orders?

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

An exception is if there is an intervening cause (e.g., the patient arrives because of a suicide attempt or a car crash instead of an emergency related to his/her medical condition). In that instance, the information should be used in conjunction with the best clinical judgment in formulating the plan of care.

2. What if a POLST form conflicts with another advance care planning document?

Ideally, this should not happen if health care professionals are asking to review advance directives when creating or reviewing a patient's POLST form. The purpose in asking is to confirm the documents do not conflict.

Some states have expressly stated the most recent document controls. This shows a misunderstanding of POLST forms versus advance directives but nevertheless binds health care professionals in those states.

If this is not expressly stated, as a medical order, the POLST form should control treatments provided.

3. What if my patient's POLST document is not fully completed?

State laws dictate what needs to be completed on the POLST form in order for it to be a valid medical order. All states require the signature of a licensed independent practitioner (although what Licensed Independent Practitioners can sign varies by states) and most require the signature of the patient or surrogate. Some states require specific sections be completed at a minimum (this should be obvious on the face of the form).

If something is missing that means the form is not valid and, if the patient has an advance directive, that document should be used in formulating the plan of care.

4. Can a POLST form be temporarily suspended for surgery or other procedures?

A POLST form is an out of hospital document to be used for emergencies outside the hospital and transition-of-care setting such as the emergency department. When a patient is admitted, the POLST form orders should be translated into in-hospital order sets and hospital policy then applies.

Emergency Medical Services

A chapter discussing the POLST Paradigm and the EMS Healthcare Professional
by Angela Fera, NREMT-Paramedic, Captain, and Katrina Altenhofen

Note: ***Please read the Overview prior to reading this chapter.***
This chapter was written by and for professionals in the Emergency Medical Services setting and builds on the basic information contained in the Overview.

The POLST Paradigm is an approach to end-of-life planning based on conversations between patients, their network of support (generally family or close friends), and health care professionals. The POLST Paradigm's purpose is to improve the quality of care for patients who are seriously ill or frail whose health care professionals wouldn't be surprised if they died within a year by creating a voluntary system that elicits, documents and honors patient medical treatment wishes using an actionable, portable medical order.

These individuals are at the greatest risk of having a medical emergency. Our current default standard of care is to do everything medically possible in an attempt to save someone's life. A person within this population may use the POLST form either to confirm they want our standard of care or clarify they want to receive care more directed towards comfort rather than aggressive treatment during a medical crisis.

Benefits of Adopting POLST Paradigm for Emergency Medical Services

Within today's healthcare system many patients choose to approach their end of life in a home environment rather than a clinical setting. Therefore, many patients are not in a healthcare facility at the time their end-of-life wishes need to be acknowledged and honored. Often during the final moments of life, Emergency Medical Services (EMS) providers are called to the scene and required to implement medical decisions. EMS providers are licensed or certified out-of-hospital clinicians who deliver care under the orders of a physician. Standing orders can be applied without direct contact with the physician. Certain documents, such as advance directives, are legal documents but **not** medical orders that the out-of-hospital health care professional can honor (*see differences between POLST form medical orders and advance directives* in the Overview).

While EMS providers are already familiar with Out of Hospital Do Not Resuscitate (OHDNR) orders, POLST forms are particularly helpful to EMS crews in the moments prior to cardiac arrest when decisions must be made quickly and the OHDNR is not yet applicable. While Section A of the POLST form guides EMS providers in the "resuscitate" or "do not attempt resuscitation" decision (as with OHDNRs), it also guides EMS providers to make treatment and transport decisions consistent with the patient's goals of care through Section B. (View section from the Overview on *POLST Form Elements*.)

EMS response is fundamental to the portability and success of a state's POLST Program. EMS providers may encounter patients with a POLST form in a variety of settings. Family members or staff may call 911 during a crisis or change in patient status. Facilities may also need EMS in a non-emergent situation to transfer a patient from a facility (long term care, acute care, hospice, etc.) to home or to another facility. Emerging community paramedicine programs that are serving as extensions of various community healthcare agencies could also encounter patients with POLST forms. In any situation, EMS providers will need to recognize, interpret and apply the POLST form to the patient's current circumstance. EMS providers could also

serve as advocates for patients that do not understand the differences between the various end-of-life documents that are available to them.

A Note on Terminology and EMS Structure

As set forth in the 1966 "Accidental Death and Disability" whitepaper and 1966 Highway Safety Act, EMS standards are determined by the Department of Transportation via the National Highway Traffic Safety Administration. Standards may be modified by each state and states are responsible for determining scope of practice and licensure requirements for EMS providers. *EMS Medical Directors* are board certified physicians who oversee the protocols of an EMS system or organization. *EMS providers* (volunteer and paid *First Responders*, *Emergency Medical Technicians* and *Paramedics*) operate under standing protocols with an option to call Medical Control for additional physician orders when needed.

Currently in the United States there are 46 levels of EMS and confusion in terminology. The public commonly uses the following terms to describe emergency providers: *paramedics*, *first responders*, and *ambulance drivers*. It is important for POLST leaders to know the correct terminology when working with EMS personnel. *EMS* is an umbrella term for all EMS providers that includes: *Emergency Medical Responder (EMR)*; *Emergency Medical Technician (EMT)*; *Advanced Emergency Medical Technician (AEMT)*.

EMTs can function at various levels of care based on their certification. An *EMT-Basic* performs care at the basic life support level while an *EMT-Paramedic* performs care at the advanced life support level. Some states have levels in between such as *EMT-Advanced* who can perform some but not all advance life support care. The National Registry of EMTs recognizes four levels of certification. *EMR-emergency medical responder*, *EMT-emergency medical technician*, *AEMT-advanced emergency medical technician* and *paramedic*.

Medical control (also known as medical direction) is an umbrella term that refers to any physician designated to give online medical direction (orders) by the medical director. Every EMS agency has a medical director, the physician whose license under which they practice. That medical director can designate additional physicians to provide online (via radio) medical direction. So EMTs function as an "extension" of the physician while caring for patients in the field and provide high level medical care in remote locations.

EMS Critical to Development of the POLST Paradigm

The POLST Paradigm was started in Oregon by health care professionals, which included EMS stakeholders, who recognized that patient preferences for end-of-life treatment were not being consistently honored during emergencies, particularly those outside healthcare facilities. In the absence of medical orders like POLST forms or an Out of Hospital Do Not Resuscitate (OHDNR) order, EMS providers defaulted to full treatment: attempting resuscitation and transporting to the nearest emergency department. This default may create significant moral distress for EMS providers who are made aware that a patient's wishes for only limited additional interventions or comfort measures but does not have the appropriate medical orders to support those wishes. POLST forms were specifically created to alleviate this issue by being portable and honored by EMS providers.

To ensure the POLST Paradigm can be implemented, it is important that POLST advocates seek to become engaged with the state office of EMS to ensure that appropriate individual(s) effectively advocate for changes to EMS legislation, protocols, policies and practices to support a POLST program. The state office of EMS should be able to identify those subject matter experts. EMS legislation changes may need to be facilitated by an EMS lobbyist, if

available. Protocols would be changed through the EMS agency's medical director and possibly an overarching medical society. Policies and practices are adapted/created by each EMS agency, so the Director or Chief of the agency would need to agree. Effective advocacy ensures obstacles to implementation have been identified and are being addressed.

The National POLST Paradigm recognizes the vital importance of having EMS providers' advice on these activities. In addition to encouraging all state POLST Programs to include EMS providers on POLST Program coalitions, the National POLST Paradigm has an Emergency Medicine physician advisor and an EMS advisor on the National POLST Paradigm Task Force, which is the body advising on the quality of the POLST Paradigm.

Case Study: Value Proposition of POLST to EMS

Presenting the POLST Paradigm to EMS providers in the form of a case study communicates how the POLST Paradigm improves effectiveness in honoring patient treatment wishes and reducing moral distress. The following is an example of a case study that can be used for training purposes:

> *EMS providers are dispatched high priority (all units using lights and sirens) to a residence for a patient with difficulty breathing. The fire department's first response team and EMS ambulance unit arrives on scene to find the patient's husband at the front door. Upon entry, the patient's husband reports the patient is his 62-year-old wife who has been diagnosed with end-stage cancer and is receiving care in the home via hospice.*
>
> *The patient is found in her bedroom, unresponsive with agonal respirations and a palpable carotid pulse. Many EMS agencies would identify this patient's condition as respiratory failure and protocols would require them to treat the patient and transport her to the nearest Emergency Department.*
>
> *The patient's husband reports she has a valid OHDNR, but she is not yet in cardiac arrest, so the directive does not apply at this time. The directive also does not address her goals of care prior to cardiac arrest, so EMS providers cannot make any assumptions about the level of care the patient would prefer. Without a medical order, EMS providers must default to full treatment and transport. However, the patient's husband discloses that she "would not want to go to the hospital."*
>
> *At this point, the EMS providers may be wondering why they were summoned and are now faced with a moral dilemma regarding the level of care to provide and whether to transport the patient. Even though the patient's husband has shared her wishes, she does not meet policy or protocol requirements for a refusal of transport and any interpretation of his statement would be considered an assumption and could be applied incorrectly. He also states the patient has three adult children from a previous marriage, without which he doesn't feel comfortable making decisions.*
>
> *The EMS providers ask the patient's husband if she has appointed a durable power of attorney for healthcare (DPOA-H) or completed any other advance care planning documentation such as an advance directive or living will. He states she has not yet, her diagnosis was recent and they were not expecting such a sudden decline in her condition. The EMS providers recognize that even if they were available, those documents would be difficult to discern and apply to this emergency setting. However, if the patient had already named a DPOA-H, EMS providers would have a decision maker to consult for treatment and transport decisions.*

EMS providers might consider contacting hospice but would have to get any orders for comfort care approved by medical control and may not have the operational capacity to stay on scene long enough for hospice to arrive. Without POLST form medical orders, EMS providers would be unable to honor this patient's wishes. Too often, this patient would be treated and transported per protocol. Subsequently, the patient would likely be intubated in the field or ED, placed on a ventilator and admitted to the intensive care unit.

The value of Section B (*Medical Interventions*) becomes very apparent in this case study. With a POLST form, the patient would have been able to select *Full Treatment*, *Limited Additional Interventions* or *Comfort Measures Only* and EMS providers would have been able to provide treatment and make a transport decision in accordance with the patient's choice and the medical order. See *Differences between POLST and DNR orders* in the Overview.

POLST Implementation in the EMS Setting

Most states have several laws regarding end-of-life medical care documents that includes various administrative rules, therefore education should highlight the difference between an advance directive and POLST form. The former states patient preferences expressed in advance of the patient's incapacity in a legal document. The latter is a doctor's order that incorporates patient preferences. While both play an important part in advance care planning, they play different—but complementary—roles. Read more in *POLST and Advance Directives* section of the Overview.

Successful implementation will require the addition of key EMS stakeholders in the state POLST Program. For state leaders wanting to include EMS providers but not sure how to start, consider meeting with personnel from the state's Office, Bureau, or Board of EMS, talking with the National Association of State EMS Officials (NASEMSO), and connecting with the National POLST Paradigm leaders and advisors in order to identify key contacts within a state. EMS representatives should be able to:

1) Analyze state legislation, rules, regulations, and protocols to determine what updates are required to support the POLST Paradigm;
2) Identify pathways and appropriate stakeholders to support and make those changes;
3) Develop and provide initial training and continuing education that can be utilized for the renewal of EMS certification; and
4) Recommend policies that support appropriate implementation and practice.

EMS implementation must ensure medical protocols are aligned with the goals of the paradigm. While patient autonomy is a widely-recognized principle of medical ethics, the EMS profession does not formally recognize patient autonomy in its EMS Oath or Code of Ethics (despite revision in 2013). EMS providers can recognize patient refusal of treatment, but EMS providers rely heavily on medical direction and protocol to do so. POLST form medical orders support the ability of EMS providers to honor patient wishes.

Because of the time-critical nature of EMS response and implementation of proper treatment, whether aggressive treatment or comfort measures, the best practice is that POLST protocols are written as standing orders that do not require special approval by medical control at the time of patient contact. An EMS provider does not have an independent license to practice; instead, an EMS provider practices under the direct supervision of a physician. Every EMS agency has a medical director, which is required by state statue or legislative code, although

medical direction can differ from state to state on what discipline can assume that role. A medical director provides medical oversite to the EMS agency and can provide medical orders to EMS providers on what treatments to provide in the field.

Currently the national trend for EMS protocols is that they are written as evidence-based guidelines, procedural guidelines, or educational/coaching guidelines. Protocols maybe written by the State Office of EMS or from local medical control. State Offices of EMS can develop state level protocols that are either mandatory or just minimum guidelines for local EMS agencies.

- In states where the Office of EMS does not issue protocols, they may provide a resolution in support of a POLST specific protocol. View *Kansas Board of EMS Resolution* in support of TPOPP.
- Many state EMS offices have a medical advisory board that could issue a position statement in support of the POLST Paradigm. View *Kansas Board of EMS Medical Advisory Committee position* in support of TPOPP.

In a decentralized structure individual implementation by many EMS services may be necessary. In this case, several agencies may want to work together to develop a regional approach in coordination with the hospitals and long-term care facilities served by multiple agencies. For example, in Kansas and Missouri the Mid-America Regional Council Emergency Rescue Committee (MARCER) facilitated a workgroup composed of EMS professionals (field personnel and medical directors) to develop an approach to implementing Transportable Physician Orders for Patient Preferences (TPOPP). This ensured consistent patient experiences across the nine-county region served by the committee. This approach allowed the group to identify additional protocols needed to honor patient wishes. For example, most EMS services do not have comfort care protocols and EMS providers receive little, if any, training on providing comfort care. This group developed the comfort measures protocol that was necessary to support TPOPP and patients who may have treatment goals other than full treatment and transport.

Agencies that have developed comfort measures protocols tend to take one of three approaches:

1) A generic, non-specific protocol that directs EMS providers to consult with medical control. View *Utah EMS Protocol General Guidelines* PDF.
2) General guideline more than a specific protocol. View *Ohio EMS Guidelines for Emergency Medical Responders* PDF.
3) A specific standing orders for comfort measures View *Kansas/Missouri Comfort Measures Protocol* PDF.

Successful EMS implementation of the POLST Paradigm also requires identification of operational champions such as EMS directors. These service directors are responsible for determining how EMS will be delivered (service models vary by state, region and geographic/demographic area) and for developing policies that support the medical protocols. These policies may also be created in response to statutory rules and regulations developed by the state government and EMS governing agency. For example, many states have laws regarding the OHDNR Orders and how they can be honored by EMS providers. These laws have the potential to impact how EMS providers can also honor POLST. A law passed prior to POLST implementation that states EMS providers can only recognize a particular form such as an OHDNR Order could create a legislative barrier to honoring a

POLST form. Therefore, it is also beneficial to have an advisor on the implementation team who is comfortable interpreting EMS related law and regulation. Some agencies have policies that require EMS providers to start resuscitation if requested by family even in the presence of an OHDNR order. Some laws are very narrow in scope and only allow for no resuscitation if, and only if, the patient needs resuscitation due to the terminal illness by which an OHDNR order was granted. For example, Iowa has an OHDNR and the law requires it be ordered by a physician, only for a terminally ill person over the age of 18 who is dying of the terminal illness. If an Iowa patient has an OHDNR is driving by private vehicle to his/her oncologist appointment and is involved in a crash and presents to EMS providers as a "trauma code", EMS providers must initiate a full resuscitation attempt despite the patient has the OHDNR. The EMS providers must initiate resuscitation for the patient due to the nature of the arrest: the arrest status is from the trauma and not a result of her terminal illness. This does not conform to the POLST Paradigm goal of physician orders that honor patient wishes and is the type of policy that may need to be updated for optimal POLST implementation. Patient refusal policies are another area that may need to be updated to align with the POLST Paradigm. These policies often require a patient to be alert and oriented in order to refuse treatment and/or transport.

In addition to physician and administrative champions, it is helpful to involve field technicians and EMS educators in the implementation strategy. This can be accomplished by convening a task force or workgroup to assess system readiness for the POLST Paradigm. This group can identify potential barriers, involve subject matter experts as needed, and make recommendations regarding policy/process/protocol changes that may be needed to support the goals of the POLST paradigm. These are the leaders that will translate protocol and policy into practice. Educating and training EMS providers in POLST practice should also involve all potential first responders, which may include volunteers and law enforcement that have Automated External Defibrillators (AEDs) on site. (**Note**: AEDs are in many locations, including schools, churches, gyms, and airports. They are designed to provide electric shocks to the heart with the goal of bringing the heart back into a viable rhythm. While training is available, it is designed so that *anyone* can use an AED. The reality is that a person with a POLST form stating DNR may have a cardiac arrest at a public location and a good Samaritan places the AED on, it says to shock so they shock. The general public is not trained to look for a POLST or any DNR order so having someone shocked who didn't want it is a potential consequence with the proliferation of AEDs.)

EMS professionals are required to obtain continuing education to renew their certification/ licensure. Education requirements are determined by the state EMS agency and may follow the National Registry for EMTs renewal criteria. Offering EMS continuing education will encourage participation in POLST Paradigm education/training. Presenting the reasons EMS providers need to support the POLST Paradigm and vice versa is done most effectively via case study. Utilizing actual case studies enables the EMS provider a better understanding of the applicability of the POLST Paradigm within their purview of providing healthcare. The POLST Paradigm can also be presented as a tool to assist EMS providers in resolving ethical dilemmas on scene and supporting patient autonomy.

Key points to emphasize to EMS providers include the following:

- A POLST form is NOT the same as an OHDNR form. Patients with a POLST form may have chosen "attempt resuscitation" so the presence of a POLST form does not automatically mean the patient has an OHDNR order. Review Overview section on *How POLST forms differ from DNR orders*.

- The presence of a POLST form does not mean "do not treat." All options in Section B (*Medical Interventions*) indicate a treatment preference and what should be provided if the patient is having a medical emergency but has a pulse, is breathing, or is responsive.
- The presence of a POLST form does not mean "do not transport." Any patient whose treatment goals (Section B- Medical Interventions) cannot be met on scene should be transported to an appropriate facility.

Finally, it is important EMS providers have relationships with admitting emergency departments; typically EMS providers have established emergency departments they go to and many states dictate via accreditation recognition of various systems (e.g., stroke, trauma) where a patient is to be transported. As recipients of patients transported by EMS providers, emergency department physicians who are well versed about the POLST Paradigm and support its implementation are critical to successful implementation by EMS agencies. If there is not a clear understanding of a POLST form by the emergency department physicians, then there is a potential for a patient to receive treatment not conforming to their wishes as detailed on their POLST form. For more information, see the Hospital Chapter.

Frequently Asked Questions

1. What should EMS providers do when a family says the POLST isn't accurate or disagrees with it?

The POLST form represents the most complete and current description of the patient's treatment goals. It should be honored under the principle of patient autonomy even if family members disagree with the patient's goals. If family members insist on a level of care that is not consistent with the orders reflected on the POLST form, the patient's physician or medical control could be contacted from the scene. It is strongly recommended that EMS providers be familiar with their respective administrative rules and laws governing their state's advance care planning forms as that may also guide the response in this situation.

2. How do EMS providers decide when to transport a patient with Comfort Measures Only (CMO) orders?

The POLST form indicates that if a patient cannot be kept comfortable in the current setting, they should be transported to the hospital where appropriate comfort care measures can be provided. EMS providers should follow medical direction and/or standing orders.

3. Do EMS providers need legislative authority or protection for honoring POLST?

No. POLST can be implemented using a Standard of Care approach. Oregon, Kansas/Missouri, and Ohio are all examples of states that have implemented without legislation. This physician order can be viewed the same as any other medical protocol written by an EMS Medical Director. For example, there isn't legislation which dictates how a patient suffering from abdominal pain or shortness of breath should be treated. The Medical Director has the authority to create standing orders for EMS providers to follow and the same can be done for POLST. Even in states like Montana and West Virginia with statewide EMS protocols, the protocols aren't approved by the legislature. Some states may choose to pursue legislation that provides explicit protection (immunity) for honoring POLST like has been done for the Out of Hospital DNR forms in the past, but it is not necessary.

4. Can a POLST form be followed if it is not the original?

The National POLST Paradigm encourages all states to clearly state on their POLST forms that the original form does not need to be present to be followed, that faxes, copies and electronic versions of the form are legal and valid. This information is either on the footer of the POLST form or included in the instructions on page 2 of the form.

5. What do EMS providers do in states where there is a state law requiring the most recently signed document, between an advance directive and POLST form, be followed?

First, these laws are challenging because they conflate legal documents (advance directives) with medical orders (POLST forms) and disregard the real-world impact of these documents on patient treatment during a medical emergency. These laws also ignore that these documents do not cover the same information: with respect to patient treatment wishes, an advance directive is vague and requires interpretation to develop a treatment plan. A POLST form, however, gives immediately actionable, specific medical orders emergency providers can follow.

Second, these laws can cause confusion that emergency providers must deal with. When a patient leaves an appointment with a POLST form, they are told it is actionable and something emergency providers will honor. If the patient then creates or updates an advance directive, they have voided their POLST form. It is likely neither the patient nor his/her surrogate are aware the POLST form is voided and, therefore, confused when emergency providers aren't following those orders. It is critical for emergency providers to know their state law and be able to explain to those around the patient why they cannot follow the POLST form orders, if that is the case.

In states where this is the law, when emergency providers are presented with two documents (an advance directive and a POLST form), they must look at the date to determine which was more recently signed. If the POLST form was more recently signed, emergency providers should follow those orders. If the advance directive was more recently signed, emergency providers should call medical control to determine what to do.

Nursing Homes

A chapter discussing POLST Paradigm implementation in Nursing Home facilities
by Mercedes Bern-Klug, PhD, MSW, MA; Nicole Peterson, DNP, ARNP; Jane Dohrmann, MSW, LISW ACHP-SW; and Kandyce Powell, RN, MSN

Note: ***Please read the Overview prior to reading this chapter.***
This chapter was written by and for professionals in a nursing home setting and builds on the basic information contained in the Overview.

The POLST Paradigm is an approach to end-of-life planning based on conversations between patients, their network of support (generally family or close friends), and health care professionals. The POLST Paradigm's purpose is to improve the quality of care for patients who are seriously ill or frail whose health care professionals wouldn't be surprised if they died within a year by creating a voluntary system that elicits, documents and honors patient medical treatment wishes using an actionable, portable medical order. Since a fairly high percentage of nursing home residents meet this definition, it is particularly important for nursing home staff to be well acquainted with the POLST Paradigm and how it can be used to support resident autonomy and promote communication about their treatment preferences.

There are no federal POLST rules or regulations. Laws or regulations relating to the POLST exist at the state level, if they exist—not all states with POLST Programs have laws and regulations (read more in the Overview section on *The POLST Paradigm and the Law*). In order to make sure the nursing home complies with your state's POLST laws, regulations, and best practice recommendations, please connect with your state POLST Program, check your state's law, or the National POLST Paradigm.

In this section, the term ***nursing home*** refers to both skilled nursing facilities that provide post-acute skilled care and nursing facilities that provide long-term custodial care. People who are receiving care in nursing homes are referred to as ***residents***. People who are authorized to make medical decisions on behalf of a resident who lacks decisional capacity, are called *surrogates*. In recognition that not all surrogates are family members, and not all family members are surrogates, in this section both terms are used.

Setting the Stage for Using the POLST Paradigm in Your Nursing Home

As you introduce the POLST Paradigm into your nursing home, recognize that you are implementing a systems change within your organization. The systems change makes it easier for staff to know what is expected of them and why. It can improve the care provided to residents. Many of the changes will involve policies and procedures and may ultimately involve a variety of persons and committees who are responsible or affected by the policy changes. Because many people will need to be consulted and educated, the change process may take months. In their *Implementation Guide for Long-Term Care Facilities*, Louisiana POLST community leaders recommend the following three initial steps:

1) Establish within the facility a multidisciplinary team (e.g., a representative from nursing and one from social work) responsible for planning the adoption of the POLST Paradigm in the facility.
2) Designate physician (or other primary care professional) and facility champions. The medical director of the facility should be involved if at all possible.

3) Develop a plan to implement the POLST Paradigm including how and where the POLST form will be placed in the resident chart, including the electronic health record if one exists.

There are other more generic but critical decisions about processes and protocols that will need to be decided, based in part on your state law, and your organizational structure. For example, nursing homes need to decide:

- Who screens residents (and how) for POLST appropriateness;
- Where to keep the original form and when (if ever) to use a copy of the form;
- Who is responsible for educating residents and families about the POLST Paradigm;
- Expectations about documenting the contents of the POLST conversation and POLST form orders in the residents' health record;
- When and how to work with the state POLST electronic registry (if the state has one);
- How to void a POLST form; and
- Whether the voided forms are kept in the medical chart, and if so, where.

Once your facility is ready to begin involving residents, consider starting with current residents who are medically appropriate for POLST and who have already had goals of care conversations with health care professional. For residents who do not have decision-making capacity, you may invite their designated surrogate decision maker. The goal is to help build consensus and understanding, both of which can benefit residents by helping to provide them the care they want, in the event of a medical crisis.

Steps to Engage Residents with the POLST Paradigm

Each nursing home should have established policies about who is responsible for engaging residents about advance care planning and introducing the POLST Paradigm when appropriate.

Leaders in New York (Bomba & Vermilyea, 2006) developed an 8-step protocol for health care professionals when engaging a person in a POLST conversation. (Please note, the protocol is applicable for various settings; it is not specific to the nursing home setting.)

» Not All Nursing Home Residents are Medically Appropriate for a POLST Form

While a POLST form is appropriate for many nursing home residents, it is not appropriate for all nursing home residents. The table below lists six categories of potentially POLST appropriate nursing home residents. The table is offered as a starting point; POLST appropriateness should be considered on a case-by-case basis.

The general rule that applies to other settings also applies in the nursing home setting: if the health care professional would not be surprised if the person were to die within the next 12 months, then the person is appropriate for POLST. However, just because a person's prognosis indicates he or she is POLST appropriate, does not mean that person must have a POLST form. POLST forms are completely voluntary and should never be used as a criterion for admission. The choice to have a POLST is always up to the resident (or the surrogate decision maker).

Review: *The POLST Paradigm Population—Who Should have a POLST Form?*

Table 1. Categories of Nursing Home Residents and Appropriateness for a POLST Form

Category of Nursing Home Resident	POLST Appropriate? (in general)	Explanation
Persons recuperating from acute care episodes	No	Not generally appropriate if they are expected to recover and are not at significant risk of death within the next year.
Persons with a chronic, stable physical disability who are alert and oriented	No	Not generally appropriate if their condition is stable and they are not at significant risk of death within the next year.
Persons who are experiencing the final stages of advanced medical illness	Yes	Appropriate due to limited life expectancy.
Persons experiencing advanced stages of Alzheimer's Disease or other forms of progressive and irreversible dementia or cognitive impairment	Yes	People in advanced stages are considered to be seriously ill, and/or frail, and the disease will lead to death.
Persons with a diagnosis of persistent vegetative state (PVS)	Yes	Persistent vegetative state is a life-limiting irreversible condition.
Minors/children with advanced medical illness or advanced medical frailty	Yes except in Colorado	If the minor is seriously ill or frail and their health care professional wouldn't be surprised if they died within a year, a POLST form should be offered.

» POLST Form Completion is Always Voluntary

Nursing homes should not require all residents to have a completed POLST form. Completion of such forms must always be voluntary. Although nursing homes can recommend POLST forms to all residents, such forms should never be a criterion for admission or mandatory. Just as residents may choose to refuse treatment or not to have an advance directive, residents may refuse to have a POLST form completed on their behalf. It is inappropriate to force a patient to make decisions that they may not be ready to make or participate in advance care planning, which they may not want to do. A facility may have a policy to offer a POLST form to all appropriate residents but should never mandate completion.

» A Goals of Care Conversation Should Come First

Ideally, numerous advance care planning conversations would have taken place prior to transfer to a nursing home. Unfortunately, the reality is that sometimes no advance care planning conversations have taken place before admission.

The value of the POLST Paradigm is the process of engaging the resident, the surrogate, the family (as appropriate), and the health care professional in a conversation of the resident's values, beliefs, and goals of care in light of their health status and treatment preferences.

If the surrogate and/or family were not included in the conversation, encourage the resident to inform the surrogate and family members about what was decided and documented on the POLST form. This shared understanding can be especially critical at the time of a medical emergency.

The POLST form should not be completed until after a conversation(s) occurs. Completion of the POLST form after these conversations increases the likelihood that a seriously ill or frail

person will get the treatments he or she wants during a medical crisis, and avoid treatments he or she does not want.

Review: *POLST Conversation & Documentation*

» Beginning the POLST Conversation with Nursing Home Residents

Upon admission, the nursing home staff is required to document code status and determine if the new resident has appointed a surrogate decision maker and/or developed an advance directive. If the resident does not have an advance directive and would like one, the staff should set up a separate meeting devoted to an advance care planning conversation.

In regard to the POLST form, below are three categories of newly admitted nursing home residents:

1) **Person already has a completed POLST form before admission** to the nursing home. A newly admitted resident may already have had a POLST conversation and may already have a completed POLST form. If so, the nursing home staff member (usually a nurse or social worker trained in POLST) who discovers this should review the form for completeness (for example: make sure the required signatures are included and it is dated) and confirm verbally with the new resident or their surrogate that the stated preferences are still an accurate reflection of the resident's wishes. If yes, the presence of the POLST form should be noted during the admissions process and documented in the resident's medical chart and included in the care plan. If the resident does not have the cognitive capacity to confirm wishes expressed in the POLST form, the surrogate should be consulted. The primary care professional should engage in a POLST conversation with the resident (or surrogate) to verify or up-date the preferences expressed in the POLST form. In most cases, it is neither necessary nor appropriate to complete a new POLST form.

   Some newly admitted residents may have an advance directive, as well as a completed POLST form. The decisions expressed on the POLST form should be compared with the advance directives to ensure consistency. If the documents are not in agreement the health care professionals should discuss the discrepancy with the resident (and/or surrogate), and work toward a solution to make the documents consistent and in alignment.

2) **Person does not have a POLST form but appears to be POLST appropriate** based on prognosis. Such individuals should be encouraged to set up an appointment to have this conversation with a health care professional. If the resident has decisional capacity, staff should consider recommending that the resident include the surrogate in the conversation. The day of admission is generally not a good day to engage in a POLST conversation because of the stress of the admissions process on the new resident and family, and the amount of time a thorough conversation can require. However, it is an ideal time to mention the opportunity for a separate appointment with the resident, their family/surrogate, and health care professional.

3) **Person does not have a POLST form and does not meet the POLST criteria**. If the newly admitted person has a life expectancy longer than 12 months, they are not medically appropriate for the POLST Paradigm. There is no need to mention the POLST Paradigm.

» Having the POLST Conversation with the Nursing Home Resident

Nursing homes are interdisciplinary settings. The medical director or other primary care professional and nursing home staff work together to plan and provide care. In some nursing homes, a registered nurse or a licensed social worker trained in the POLST Paradigm (see your state POLST Program for training opportunities) may initiate the POLST conversation within their scope of professional practice.

The primary care professional should engage in and document POLST conversations early in the resident's stay to strengthen the interdisciplinary approach to this important process. Although the conversation(s) about goals and treatment options may be initiated by any qualified and trained health care professional, a licensed physician or other state-authorized health care professional must always, at a minimum: 1) confer with the resident and/or the resident's surrogate about the resident's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker; and, 2) sign the POLST form that reflects the resident's preferences. Please note: primary care professional may submit Advance Care Planning current procedural terminology (CPT) codes to Medicare if a face-to-face conversation lasting 16 minutes or more took place (see *Overview section on Medicare Reimbursement for the Conversation*).

Below are two examples of how the nursing home staff and the primary care professional authorized to sign the completed form may interact regarding POLST:

Scenario A. Nursing home staff member (usually a registered nurse or a licensed social worker working within their scope of practice) *trained in the POLST Paradigm* engages the resident and the family or surrogate in a POLST conversation and helps them organize their questions to be asked of the primary care professional who will have the conversation (physician, physician's assistant or advanced practice nurse, depending on the state). The primary care professional then meets with the resident and/or surrogate who reviews and re-engages the POLST conversation. If the treatment wishes are clear, the primary care professional completes and signs the POLST form.

Scenario B. A nursing home staff member (usually a registered nurse or a licensed social worker working within their scope of practice) *who is trained in the POLST Paradigm* facilitates the POLST conversation, and if there are no unanswered questions, completes the form with the resident/family, documents the conversation in the medical chart, contacts the primary care professional and shares the result of the conversation. If this is consistent with the primary care professional's existing understanding of the resident's preferences based on previous conversations, then the primary care professional may choose to sign the form completed by the staff member—or may choose to contact the resident and/or surrogate to follow-up. Working this closely with the staff regarding a particular nursing home resident may be considered when the primary care professional knows the resident well, had prior goals of care conversations with the resident with consistent results, the resident has not experienced major changes since the goals of care conversations, and the primary care professional trusts the fidelity of the conversation because he or she is familiar with the nurse or social worker. The primary care professional who signs the POLST form is responsible for making sure that the treatment choices expressed in the POLST form reflect the resident's current preferences.

Licensed or specially trained staff (generally a registered nurse or a licensed social worker) who educate residents and surrogates about the POLST Paradigm should have clear understanding of advance care planning, the POLST Paradigm, and

knowledge of the scope of their practice pertaining to the POLST process. Due to the high staff turnover in long-term care, frequent POLST Paradigm education is necessary (refer to your state POLST Programs for recommended training).

» Documenting POLST Conversations and Resident Preference in the Medical Record

The goal of the POLST Paradigm is to help ensure that people's wishes are elicited, documented, and honored. A resident's goals of care should determine the type of treatment they receive in a facility. After the POLST conversation(s), the nursing home should have a policy for transferring the contents of the POLST form into the resident's medical record. The resident's individualized care plan should be consistent with the POLST form so that the residents' preferences for treatment in a medical crisis are clear.

View a sample West Virginia Nursing Home Model POLST Policy for a state that utilizes an electronic registry, and a sample Maine Long-Term-Care facility policy for paper POLST form.

The information below is an example policy of POLST in the medical record, and is from the California 2014 Model Policy for Skilled Nursing Facilities. (**Note**: POLST forms may be different colors in different states. #4 below indicates that in California, the POLST form is pink.)

POLST and the Medical Record

1. The most current POLST in its original format should be the first page of the medical record.
2. If the resident has an advance directive, copies of it should be attached to the current original POLST in the front of the chart.
3. If the resident is transferred or discharged from the facility, the current original POLST must accompany the resident.
4. A fully executed, dated copy of the POLST, marked "COPY," should be retained in the medical record in the advance directive or legal section of the medical record. This copy should be on Ultra Pink paper stock so it is readily recognizable when and if the current original is transferred with the resident.
5. All voided versions of the POLST, clearly marked "VOID," will be retained in the medical record.
6. Whenever the POLST is reviewed, revised, and/or revoked, this will be documented in the medical record by the physician and/or the healthcare provider(s) involved.
7. For facilities with electronic health records, the POLST should be scanned in and placed in the appropriate section of the healthcare record per facility policy.

Review: *POLST Conversation & Documentation*

» When a Resident Lacks Decision-Making Capacity

If the nursing home resident does not have decisional capacity, it falls to the surrogate to communicate decisions that the nursing home resident would communicate if he or she were able.

The surrogate should be included in all the advance care planning processes and POLST conversations. If the resident did not appoint a surrogate and can no longer appoint one because the resident lacks decisional capacity, staff should follow state law to determine who is authorized to speak on behalf of the resident. Most, but not all, states have a hierarchy listing who is authorized to speak on behalf of a person who lacks decisional capacity.

It is important to recognize the authority of a surrogate if/when a nursing home resident loses the capacity to make medical decisions. If a resident is incapacitated and cannot weigh in on treatment options, the surrogate may complete the POLST form on the resident's behalf. However, the choices made should be what the resident would want, according to the resident's known values and preferences. Likewise, if a resident becomes incapacitated after completing a POLST form, a surrogate should enforce the choices made by the resident and reflect the resident's core values in subsequent updates to the form, as the resident's conditions and circumstances change. The role of the surrogate is to make decisions for the resident in the context of the current circumstances.

If it is a matter of updating the POLST form, in most states, the surrogate has the right to do that. However, surrogates do not have the authority to change an advance directive.

If there is no surrogate, then consider contacting an attorney to see what other options might be available in your state. According to the American Bar Association Commission on Law and Aging, *guardianship* should be viewed as a last resort after fully considering options. It is hoped that advance care planning conversations early in the disease process will avoid the need for a court-appointed guardian. (View American Bar Association Commission on Law and Aging website on guardianship).

For more information about surrogates, please see **Issue 7** of our *Legislative Guide* and consult your state POLST Program.

Signing the POLST Form and Verbal Orders

Each state has laws and/or regulations regarding which health care professionals are authorized to sign a POLST form. Physicians are authorized to sign in all states. In some states physician assistants and/or advance practice nurses are authorized signers. In most states, the patient or his/her surrogate is also required to sign. Once the completed form is signed by an authorized health care professional, it is an actionable medical order.

Sometimes, the authorizing health care professional is not immediately physically present to sign the POLST form. Over the phone, they can provide a verbal order to the nurse indicating their intent to sign the POLST form. In these cases, nurses accepting a verbal order should follow their respective state board of nursing regulations as well as the nursing home policies and protocols.

» A Completed POLST Form is an Actionable Medical Order

The POLST form, signed by an authorized health care professional (including a verbal order—see above), is an actionable medical order. An actionable medical order means that all health care personnel are to treat a POLST form as they would any other medical order.

» POLST Forms Should be Reviewed on a Regular Basis

POLST forms reflect a nursing home resident's current wishes about medical treatments. Thus, a POLST form should be reviewed whenever the resident experiences a change in health status, a change in health care setting, or a change in goals of care. A resident with decision-making capacity, or the surrogate when the resident lacks capacity, may also initiate a review, revision, or revocation of a POLST form at any time. A resident's surrogate makes decisions for the resident in the context of the current diagnosis, health status and prognosis. If a resident is incapacitated the surrogate may complete the POLST form on the resident's behalf.

Regardless of whether the surrogate is completing an original form or a revision, their role is to reflect the resident's known values and preferences. If these are not known, the surrogate considers the resident's best interest, given their current health status and prognosis.

All federally-certified nursing homes are required to conduct regular individual assessments with all residents and use the information to develop an individualized care plan. For long-stay residents, these care plan meetings are to be held at least quarterly (more often if the resident experiences a health change). Although residents and family members are expected to be invited to attend these quarterly care plan meetings (in-person, by phone or by internet video), primary care professionals are not required to attend, and in most facilities, rarely attend. The POLST form should be reviewed at every care plan meeting to ensure that it is understood by the resident and reflects their current goals of care and related wishes. If the residents' preferences have changed, they should re-engage in a new POLST conversation with health care professionals.

» Revising a POLST Form

If treatment preferences change, it is important to engage in new conversations. After engaging in a conversation, the health care professional should begin a new POLST form and void the former one. Instructions for voiding the POLST form are on the back of the document. Follow your policies and procedures about what to do with the voided form. Document in the medical chart and communicate to staff that the resident has a new POLST form.

Training Staff on the POLST Paradigm

For the POLST Paradigm to be as effective as possible in communicating nursing home resident preferences, the following five groups of people need to be trained in the POLST Paradigm.

1. **General staff training**. All nursing home direct care staff and temporary staff need to understand the POLST Paradigm process, the meaning of the terms used in the POLST forms, how to carry-out the wishes expressed in a POLST form, and their own specific responsibility with respect to honoring this medical order. Staff also need to know which residents have a POLST form, where it is located and what it says. Staff should also be clear about organizational procedures for residents to take POLST forms on outings, as well as during physical therapy, occupational therapy, and recreational activities. Staff should be clear about organizational protocols for calling 911, including who makes the call.
2. **Staff responsible for engaging residents and surrogates in POLST conversations**. There should be clear organizational policies about which staff members hold responsibility for engaging residents and their surrogates in conversations related to the POLST Paradigm. Policies should identify roles of team members and their scope of practice; this includes nurses, social workers, physicians, physician's assistants, and nurse practitioners. Policies should clarify who should be leading conversations, who should be reviewing goals of care and when, and whose responsibility it is to review the POLST form (at the quarterly care plan meetings or when there is a change in resident's health status or a change in their preferences or setting of care). Staff members should receive POLST Paradigm training commensurate with their responsibilities (see your state POLST Program for more information on who can sign forms).

In addition to receiving training, staff should be provided other support in carrying out their POLST-related duties. Examples of support include: opportunities to debrief, appropriate professional supervision, and time and guidance in discussing ethical issues that may arise from issues such as capacity determination or conflict resolution.

3. **Primary care professionals authorized to sign the POLST form**. Some nursing home residents receive their medical care from the nursing home's medical director. Others continue to be seen by their community primary care physician who cared for them before they were admitted to the nursing home. Nursing home medical directors should participate in developing organizational protocol related to the POLST Paradigm, so they are prepared to follow the protocol on behalf of the residents for whom they provide direct medical services. Additionally, primary care professionals can help communicate these protocols to other primary care professionals who may be responsible for individual residents.
4. **Education of residents, surrogates and family members**. Nursing homes should offer information about the POLST Paradigm to residents, their surrogates, and to other family members. Information can be provided through newsletter articles, the organizational website, resident council meetings, family council meetings, and general education meetings. This not only educates people about the POLST Paradigm it also sends a message that staff are available as a resource.
5. **Community partners**. One of the strengths of the POLST Paradigm is that the form is designed to work across care settings. For this to happen, all links in the health care chain need to be aware of the POLST Paradigm, as well as understand and support its use. For most nursing homes, the most common POLST community partners will be the EMS, ambulance service, and hospitals.

Evaluating Your Nursing Home's Implementation of POLST

Evaluating your organization's experience with the POLST Paradigm is necessary to ensure you are providing the best care possible. That means care consistent with resident wishes. A retrospective chart review can be an important component of an evaluation. It is an audit of a small number of residents who have died in the past six months to compare the treatment provided to the residents with their treatment preferences documented on the POLST form. The *Honoring Your Wishes* Advance Care Planning program in Iowa City, Iowa has developed simple audit tools that nursing homes can use to assess their POLST program (view example).

The most important evaluation question is, "Are residents' POLST forms followed during care and until they die or are discharged?" If residents' wishes were not honored, it is important to understand why and to determine if there are policy and procedure changes that are required to enhance the nursing home's ability to comply with future POLST forms.

For example:

- Does the nursing home have a clear policy about how the POLST Paradigm is to be introduced and implemented with residents? An example of skilled nursing facility model policies can be found on the Coalition for Compassionate Care of California (CCCC) website.
- What are the procedures when inconsistencies are encountered between a POLST form and an advance directive?

- Does the facility have a policy about where in the medical chart the POLST form is kept?
- Is the POLST form sent with resident on every outing? Is a copy or the original sent? Is a copy placed in medical chart and clearly marked as a copy? Is the POLST form returned with the resident from every outing?

Other approaches to evaluation, including root cause analysis, five whys, fishbone diagram (see the CMS link to *QAPI Tools* below for details) can be particularly useful to nursing homes. Some nursing homes may wish to develop a quality assurance and performance improvement (QAPI) project related to POLST; one example comes from California. For more information about QAPI in general, in the nursing home setting, please see:

- QAPI Description and Background: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition.html
- QAPI Five Elements: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/qapifiveelements.pdf
- QAPI Tools: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.html
- QAPI Resources: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html

Regardless of how many years a nursing home has been engaged with the POLST Paradigm, a review of a sample of POLST forms should occur at least annually. Ongoing POLST program evaluation is important to ensure that residents' wishes are being regularly solicited, accurately recorded, and appropriately followed.

Nursing Homes: Frequently Asked Questions

The overview provides links to general POLST FAQs but the following FAQs are specific to nursing homes.

1. Should nursing home staff give a blank POLST form to residents, surrogates, or family members as part of the admissions packet?

No. Residents and surrogates should not be left with the impression that they can or should complete the POLST form themselves or that it is a required part of the admissions process. Although it may be appropriate to provide a sample POLST form (with the word SAMPLE clearly written across the front and back) or an educational handout about the POLST Paradigm, we strongly recommend against including a blank form in the admission packet. The POLST form is to be completed by a health care professional only after advance care planning conversation(s) between a heath care professional and the resident and/or the surrogate. These conversations should focus on the resident's current health status, prognosis, and goals of care. Examples of advance care planning educational resources include The Conversation Project, Prepare For Your Care, and Fives Wishes (requires a nominal fee).

Please also review the Appropriate POLST Paradigm Form Use Policy.

2. Can a nursing home resident have both a POLST form and an advance directive?

Yes. It is recommended that all adults with decision-making capacity complete an advance directive to appoint a surrogate. Not all residents are medically appropriate for a POLST form. If the resident has appointed a surrogate and then later loses decisional capacity, most states allow surrogates to complete a POLST form with a health care professional[15] on the resident's behalf. It is important for staff to remember that completing a POLST or an advance directive is completely voluntary. A POLST form does not replace an advance directive (review the Overview section *POLST and Advance Directives* for more information).

3. Does a nursing home resident with a POLST form also need a DNR/CPR order?

To learn about the sections of a POLST form, read *POLST Form Sections* from the Overview.

Limited information about resident treatment preferences is provided if a resident has a Do Not Resuscitate (DNR) order—also known as a Do Not Attempt Resuscitation (DNAR) order, or an order to Allow Natural Death (AND)—or only Section A on a POLST form completed. A DNR order does not apply if a resident is responsive, has a pulse, or is breathing. In those circumstances, the question becomes what level of treatment and what other medical interventions the resident wants—or does not want—in that medical crisis. Neither a DNR order nor a POLST form with only Section A completed provides that time-sensitive, critical information.

A POLST form communicates more than preferred code status and the form is not appropriate for all residents. A POLST form should not be used as a code status form only. The POLST form is intended to provide emergency personnel more than just code status information:

- **Section A (Cardiopulmonary Resuscitation options)** allows a resident either to confirm they actually do want CPR attempted or that they want to refuse attempted resuscitation, in the event of cardiac and/or respiratory arrest.
- **Section B (Medical Interventions or Treatments)** provides direction about treatment preferences to emergency personnel and other health care professionals in situations other than full cardiac and respiratory arrest.

Understanding the importance of Section B on a POLST form is very important. It is the heart of the POLST Paradigm. The literature indicates not all people who complete a DNR order want the same level of treatment. Half of people with only Section A of a POLST form completed or only a DNR order may receive treatment they did not want.[16] If a resident wants to have a POLST form, both Sections A and B should be completed in order to fully document and protect residents' treatment wishes. If Section B is not complete the default is the most aggressive treatment option, which may include intubation and mechanical ventilation.

When CPR is selected in Section A, states have different rules about what is allowed in Section B. In some states if CPR is selected for Section A, then Section B must be Full Treatment. In other states, if CPR is selected in Section A, Section B can be Full Treatment or Limited

[15] Very few states restrict a surrogate's ability to initiate or revise a POLST form.

[16] A majority of individuals with DNR orders requested some other form of life-extending treatment. Hickman, SE, SW Tolle, K Brummel-Smith, and MM Carley. (2004), Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status. *Journal of the American Geriatrics Society*, 52:1424–1429. doi:10.1111/j.1532-5415.2004.52402.x.

Treatment. However, please note that no states allow CPR in Section A and Comfort Measures Only in Section B. CPR and Comfort Measures Only are considered incompatible.

Additionally, if a resident is appropriate for a POLST form and chooses to have resuscitation attempted, there is value in completing the POLST form. In completing a POLST form residents have the option to clarify they do want resuscitation attempted. This clarification can alleviate moral distress for emergency personnel who provide CPR, as well as reduce surrogate burden in making the decision to support resuscitation attempts.

The POLST form should be easily accessible in a medical emergency. Staff should be able to quickly identify which residents have a POLST form. Each nursing home should follow their facility protocol if a separate Do Not Resuscitate (DNR) order is required in addition to the presence of the POLST form.

4. What if the resident and health care professional disagree?

The health care professional and resident should discuss the resident's medical prognosis, the resident's preferences for medical interventions, and his or her values, beliefs, and goals of care during the POLST conversation. If after a conversation, there is disagreement about what the POLST form should indicate, the resident (or surrogate, if applicable) has the right to choose a different physician (or other state authorized health care professional). If the health care professional is uncomfortable with the resident's preferences expressed on the POLST form, care of that resident can be transferred to another health care professional.

5. What if a resident requests a POLST form but it is not medically appropriate?

The POLST Paradigm is intended to be used by individuals who are seriously ill or frail. The question, "Would I be surprised if this person were to die in the next 12 months?" is the standard. If a medical professional can answer this question "No, I would not be surprised," then the person is appropriate for a POLST form regardless of patient age or what facility a patient is in. Generally, individuals who do not meet these criteria are not appropriate to have a POLST form. If the resident is not medically appropriate for a POLST form, explain this and find out what the resident (or surrogate) is trying to accomplish with a POLST form. Consider other options to achieve those goals. While a POLST form is not always medically appropriate, it is always appropriate to offer an advance directive. An advance directive guides future care decisions. A POLST form provides direction for current care because, when completed, it creates an actionable medical order.

6. If a resident enrolls in hospice, who should approach him or her about POLST?

If the person is a nursing home resident and POLST appropriate before being admitted to hospice, the nursing home staff should have already introduced the POLST Paradigm and have followed through by facilitating one or more POLST conversations leading to a completed POLST form, if the resident wanted a POLST form. If the resident was receiving hospice benefits before being admitted to the nursing home, hospice should have educated the person about POLST and followed through with completion, if the resident so desired. Regardless, nursing home and hospice staff should be offering POLST when it is appropriate.

7. How does HIPAA affect communication about the POLST form?

The Health Insurance Portability and Accountability Act (HIPAA) permits the disclosure of a POLST form and its orders between health care professionals across health care settings because doing so is necessary for the appropriate treatment of the resident. This is also stated on POLST forms either the top or bottom of page one.

8. What can I learn from POLST experiences of nursing homes in other states?

The National POLST Paradigm keeps a repository of educational information in its library. You may also find additional information on state pages, including:

- **California**—The Coalition for Compassionate Care in California developed many useful tools for educating staff, residents and families about advance care planning and about the POLST Paradigm.
- **Indiana**—The Indiana Patient Preferences Coalition – Long Term Care Policy subcommittee has developed a model policy for long term care facilities in Indiana.
- **Louisiana**—Louisiana Health Care Quality Forum has developed resources and factsheets.

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Hospice

A chapter discussing implementation of the POLST Paradigm in the hospice setting,
by Jane Dohrmann, MSW, LISW, Kandyce Powell, MSN, RN, Mercedes Bern-Klug, PhD, MSW, MA and Nicole Peterson, DNP, MSN, ARNP

Notes: ***Please read the Overview prior to reading this chapter.***
This chapter was written by and for professionals in a hospice setting and builds on the basic information contained in the Overview.

The authors hope this chapter will provide state POLST Paradigm leaders with general knowledge about the challenges and unique environment of the hospice setting. For hospice leaders, the authors hope this chapter helps them start (or improve) their implementation of the POLST Paradigm. Not all hospices are the same, so this chapter contains information that should be useful as a starting point within all organizations. We welcome feedback or questions to improve this chapter (email us at toolkit@polst.org).

***Note on terminology**: it is important to use "**organizations**" rather than "**facilities**" since most hospice patients are seen in their home or home-like environments.*

The POLST Paradigm is an approach to end-of-life planning based on conversations between patients, their network of support (generally family or close friends), and health care professionals. The POLST Paradigm's purpose is to improve the quality of care for patients who are seriously ill or frail whose health care professionals wouldn't be surprised if they died within a year by creating a voluntary system that elicits, documents and honors patient medical treatment wishes using an actionable, portable medical order.

Hospice is a philosophy of care that focuses on providing comprehensive, person-centered, family-oriented care, specializing in pain and symptom management. People who meet the recommended guidelines for the POLST Paradigm may also qualify for hospice care.

Benefits of Adopting POLST Paradigm for Hospice

The POLST Paradigm allows patients and their surrogates to document their medical decisions based on their individual goals of care. Clearly establishing a patient's wishes for the level of medical intervention they are willing to accept helps the hospice team develop an individualized plan of care. This can improve patient and surrogate experiences and level of satisfaction with their care. The hospice health care professionals benefit from a POLST form by having previous conversations on goals of care documented as a medical order. Finally, in introducing the POLST Paradigm, having a POLST conversation and having a POLST form, patients and surrogates will feel more comfortable with reviewing and updating the form later or having additional conversations.

When discussing goals of care and supportive services for individuals and families, it is important to understand different hospice options that are available. The Medicare Hospice Benefit is intended for people who have a projected life expectancy of approximately six months or less if the disease runs its normal course; the primary focus is comfort care and helping people have the highest quality of life possible. The Medicare Care Choices model, as well as some private insurance companies (e.g., Aetna), allow payment for curative treatment as well as hospice care if patients meet criteria for these programs.

All health care professionals can help to identify when hospice is an appropriate option for a patient facing advanced illness. When discussing goals of care, ask the patient what is important to them, what their values and beliefs are, and how that relates to their health care preferences. If, for example, the patient states that they would like to remain in their home and not go to the hospital, hospice should be explored as an option for care and support.

- Ask the patient and family if they have heard of hospice. Do they have personal experiences with, or have they heard stories about, hospice? Has a family or friend received hospice care? If they say yes, ask them to tell you about their experiences. Today, unlike thirty years ago, many people have stories about hospice. Stories are a valuable segue into a more in-depth conversation about goals, preferences and options.
- Describe the interdisciplinary approach to care and the variety of supports that hospice provides. People may not be aware of the comprehensive services that hospice offers. Core members of an interdisciplinary team include a physician (medical director) who partners with a personal physician, a nurse, a social worker and a spiritual or other counselor. Additional team members may include nurse practitioners, pharmacists, hospice aides, music therapists, volunteers, bereavement counselors, and other disciplines. Inquire if hospice might be a resource they are interested in for themselves and their family. If so, an appointment with hospice staff can be scheduled. Hospice staff will provide information about services, assess if the patient meets guidelines for admission, and determine next steps.

Offering hospice as a choice if it aligns with a patient's goals of care assists the individual and family in making an informed choice.

Setting the Stage for Using the POLST Paradigm in Your Hospice

As you introduce the POLST Paradigm into your hospice, recognize that you are implementing a systems change within your organization. This systems change makes it easier for staff to know what is expected of them and why. It can improve the care provided to patients. Many of the changes will involve policies and procedures and may ultimately involve a variety of persons and committees who are responsible or affected by the policy changes. Because many people will need to be consulted and educated, the change process may take months. The following initial steps are recommended:

1) **Establish within the organization an interdisciplinary team** (e.g., a representative from each discipline including the medical director or nurse practitioner) responsible for planning the adoption of the POLST Paradigm.
2) **Develop a plan to implement the POLST Paradigm**. Include in plans how and where the POLST form will be stored (following state guidelines), and how the orders will be documented in the medical record.

Additional considerations include:

- When (if ever) to use a copy of the form;
- Who is responsible for educating patients and families about the POLST Paradigm;
- Expectations about documenting the contents of the POLST conversation and POLST form orders in the patient's health record;
- When and how to work with the state POLST electronic registry (if the state has one);
- How to void a POLST form; and
- Whether the voided forms are kept in the medical chart, and if so, where.

Once your organization is ready to begin to implement the POLST Paradigm, ensure that your care partners (e.g., referring health care professionals, nursing homes, etc.) understand their role in POLST implementation. Educate patients, families and their designated surrogate decision maker about POLST and include everyone in conversations as much as possible. The intent is to help build consensus and understanding in the event of a medical crisis, as a patient's health care condition changes, or if goals of care change.

The Integration of the POLST Paradigm and Hospice

All hospice patients should have the opportunity to have a POLST conversation and a POLST form as a part of their plan of care. A 2009 study in three states found that hospice personnel believe the POLST form to be a helpful, reliable tool to use with hospice patients. The study also showed that the majority of hospice patients with DNR orders requested more than the lowest level of treatment in at least one other category of the POLST form (Hickman et al., 2009).

This means that a Do Not Resuscitate (DNR) order alone does not tell the full story about patient treatment wishes. Instead, completing a POLST form allows a patient (or their surrogate if the patient does not have decision-making capacity) to document preferences if their heart and breathing stop.

If they have a pulse, and/or are breathing or are responsive, the POLST form delineates the patient's goals of care and current treatment wishes, as well as their preferences if they have a medical crisis. In-depth conversations utilizing a POLST form can assist hospice patients in receiving more personalized treatment and care than the required Cardiopulmonary Resuscitation (CPR)/Do Not Resuscitate (DNR) orders.

» Utilizing the POLST Paradigm as a Communication Tool with Hospice Patients

The POLST Paradigm can be a very helpful communication tool to assist professional and personal caregivers in understanding the wishes of the patient and determining the appropriate care and treatment to provide.

> **Case #1:** Molly was diagnosed with ALS (Amyotrophic Lateral Sclerosis) and was receiving hospice care. Her primary goal was to live with the assistance of a respirator in order to finish her degree. Because she was unable to communicate verbally, a communication board was used by family, friends and health care staff. However, not everyone was comfortable with this method, including some of the physicians who assisted in her care. The communication board required concentration, patience, and time. One day a physician demanded the hospice nurse tell Molly she was dying. He thought she was denying her prognosis and did not want to communicate with her using the board. The nurse respectfully shared that she and Molly had discussed this issue many times. Molly simply wanted to complete her degree before she died. If a POLST form had been available for Molly and the physician would have reviewed conversations documented in the chart, he would have better understood Molly's choices.
>
> **Case #2:** A daughter, Elena, flew across the country to be with her mother, Maria. Her sister, Flora, had been caring for Maria with the support of hospice care. Upon Elena's arrival, Flora told Elena that she needed a break and that Elena could provide care for the next day. Flora reviewed her mother's medications and the POLST form and told Elena that their mother's wish was to stay at home and not return to the hospital. The POLST form proved to be a helpful tool for Elena to understand her mother's wishes more

concretely. If Elena had questions about caring for their mother, she was instructed to call hospice, not 911.

» Incorporating POLST into Care Across Systems Utilizing the Hospice Benefit

Goals of care conversations and the POLST Paradigm help elicit treatment preferences and treatment interventions that the individual may wish to avoid. The POLST Paradigm can be introduced during informational visits or as a part of the initial visit. Educational materials for patients, family members, and caregivers should include information about the POLST Paradigm. Specific instructions about what to do with the form in case of a medical emergency or if the patient is transferred from one care setting to another should be reviewed.

Case example: Joseph, age 80, was being cared for by his spouse, Julia. Julia stated that their granddaughter would be married in May and that she hoped to attend but was not sure that Joseph would be able to travel. The social worker described the hospice caregiver respite benefit and services provided at the local hospice unit in the hospital. She also explained that Joseph's POLST form would go with him to help ensure that his health care preferences would be honored. Joseph stated that he was comfortable with this plan.

Spring came and it was time for Julia to attend their granddaughter's wedding. Joseph was admitted to the hospice unit at the local hospital for caregiver respite. The hospice team and Joseph reviewed the POLST form with hospital staff. They agreed to follow his wishes if there were a medical crisis or if his heart and breathing stopped. The hospital staff placed Joseph's POLST medical orders into their Electronic Medical Records as actionable medical orders.

Julia was able to see their granddaughter marry, and hospice volunteers and Joseph watched the wedding via FaceTime on the hospice unit. Upon Julia's return, Joseph's POLST form was reviewed with hospital and hospice staff. His goals of care remained the same and he was discharged to his home with his brightly colored POLST form. Joseph had his POLST form placed at the foot of his bed so that everyone would know his choices regarding care and treatment.

The hospice and hospital teams communicated Joseph's treatment choices to one another and were able to honor his wishes across health care systems.

» POLST and Bereavement Implications

"*Shared decision-making about care during the end stage of a serious illness has significant potential to improve the quality of the dying process and to help families cope in bereavement."*
—*Deborah Waldrop and Mary Ann Meeker*

Grief support is an integral part of hospice care. The POLST Paradigm may bring additional comfort to the hospice patient and their family by clarifying health care choices and incorporating them into the plan of care. Following the death of the individual, it may also assist family members in the grieving process, knowing that their family members' health care preferences were discussed and honored. The POLST Paradigm aligns with the hospice philosophy of providing person-centered and family-oriented care and assists with enhancing care at the end of life.

» Training Interdisciplinary Health Care Team Members

After organizational policies and protocols are developed, it is important to offer in-services and training to all staff and volunteers and to check-in with them regarding implementation, especially the first several months. Every health care team member should have an understanding of his or her respective role related to the POLST Paradigm. For example, a nurse may start a POLST conversation upon admission. If there is family conflict about preferences and care, a social worker may be asked to assist. A spiritual counselor may be contacted to explore spiritual beliefs and values as they relate to health care preferences.

The nurse care manager should review goals of care at every visit that may include discussions about the POLST form. However, for example, a patient may ask additional questions about the POLST Paradigm or POLST form while receiving personal care from a home health aide. If so, it would then be the responsibility of the home health aide to inform the nurse and other clinical team members of the discussion to help address any questions or concerns.

POLST is an Opportunity for Community Engagement, Education, and Coordination of Care

» Community Engagement

Hospice staff and volunteers often provide education about end-of-life and hospice care in community settings. They have the opportunity to incorporate information about the POLST Paradigm into presentations, helping individuals and families understand for whom the POLST Paradigm is appropriate and when hospice services could be utilized. Community outreach helps consumers be more informed about options for themselves, and their friends and family.

Hospices also have the opportunity to take a leadership role in educating health care professionals on who is appropriate for a POLST conversation, how to coordinate care utilizing the POLST Paradigm (including the use of the POLST form), and how it can enhance person-centered care. Providing POLST Paradigm training may also be an opportunity to review hospice admission criteria and when it is appropriate to refer patients based on their goals of care.

Studies show that 70 to 80 percent of people state that they would prefer to die in their home or home-like environment. A retrospective study in Oregon showed that over half of the people who had a POLST died within two months (Zive et al., 2015). POLST Paradigm education by hospice providers may increase earlier access to hospice care.

Hospices may also choose to put information regarding the POLST Paradigm on their website to educate their community/region/state (note sample).

» Coordination of Care

Community health care providers may or may not be aware of the POLST Paradigm depending on the relationship they have with local hospices, hospitals and other health care entities. Therefore, it is important to notify community health providers if your hospice is utilizing the POLST Paradigm and to determine their preferences related to completing a new POLST form (e.g., who will sign the order—the medical director, the attending physician, or the nurse practitioner). If the attending physician or nurse practitioner in the community prefers to sign the order, administrative staff should be aware that the signed form should be returned promptly so that hospice team members can return it to the patient.

» Quality Assessment and Improvement

Once the POLST Paradigm is effectively implemented, an overarching question for hospice providers is: Are people's POLST orders followed during care and until they die? Retrospective chart reviews utilizing the various sections of the POLST form is one way to answer this question.

> **Case example**: A hospice in Iowa decided to perform a retrospective audit of ten charts of people who died while receiving care. Each chart was reviewed to determine if the Iowa POLST (IPOST) medical orders were followed throughout their care. The audit showed that 100 percent of IPOST orders were followed and the individuals received the care they wanted until they died (view the Honoring Your Wishes Care Center IPOST Audit Tool).

More information about quality improvement and assessment is addressed in the Overview chapter.

Frequently Asked Questions

1. What are hospice policies regarding CPR and DNR?

Some hospices allow patients the choice to have CPR attempted, while others only accept patients who request DNR or AND (Allow Natural Death). It is imperative to make referrals consistent with patients' treatment preferences.

For health care professionals referring patients to hospice, please check with local hospice providers about their organizational policies regarding CPR and DNR to ensure organizational alignment with treatment choices.

It is recommended that hospices clearly state their policies regarding CPR/DNR on their website, in printed materials for professionals making referrals, and during initial inquiries.

2. When should the POLST conversation begin with hospice patients?

Ideally, people are admitted to hospice with a thorough understanding of their options for treatment and care. In addition, they would be offered an opportunity to engage in a conversation about the POLST Paradigm and be offered assistance with completing a POLST form should they choose.

While POLST forms can be offered to all individuals admitted to hospice, they should ***never*** be required. POLST forms should only be completed after one or more conversations with a health care professional, the patient, and/or the patient's surrogate. Shared decision-making is a key component of the POLST Paradigm.

3. Should a POLST form be offered at admission?

Yes, but only if there is time for a POLST conversation. Sometimes, hospice patients are admitted emergently with acute symptoms to manage. It is important to address pain and symptoms first. In addition, it may take a great deal of time to complete admission paperwork, address immediate questions and concerns, and provide care.

Some hospices require a CPR/DNR order at time of admission, while others may require it anytime within 48 hours. Some hospices utilize a POLST form as a CPR/DNR order, while others may utilize both a CPR/DNR/ order and a POLST form. If a POLST form is utilized as a CPR/DNR order and time does not permit the completion of the entire form, patients and

families need to understand that leaving sections blank implies full treatment if there is a medical emergency.

Goals-of-care discussions begin at admission and a POLST form may be mentioned during initial conversations. However, the POLST form may need to be discussed in more detail during subsequent visits. All sections of the POLST form should be clearly and thoughtfully considered by the patient or, if the patient lacks capacity, his/her surrogate. In either case, it is important to include the surrogate in the conversations as much as possible. By including the surrogate, it is more likely that the patient's wishes will be honored throughout care.

4. When should a POLST form be reviewed?

If a patient has a POLST form, it should be reviewed upon admission.

POLST medical orders should also be reviewed at other times:

- Upon the patient's or surrogate's request,
- When goals of care are reviewed (e.g., interdisciplinary team meetings),
- Upon transfer to another level or setting of care (e.g., inpatient care for pain and symptom management, caregiver respite, or final days), and
- Upon recertification or revocation of the hospice benefit

View workflow samples: Iowa City Hospice IPOST Flow Chart and Detailed Process and Model Policy for Hospice from California.

Staff should document the outcome of POLST conversations and change POLST form medical orders as needed to reflect the treatment wishes of the patient. If a POLST form is changed or voided, refer to your state or organization's protocols for voiding the form (generally on the back of a POLST form).

Document all POLST conversations in the patient's medical record; work with the patient and surrogate to create a new POLST form, if desired; and update the plan of care as appropriate.

5. Which member of the hospice team should guide POLST conversations?

It is important to consider who on the interdisciplinary team will be best to introduce the POLST Paradigm, and how the team will work together. The person guiding the POLST conversation should be knowledgeable about the POLST Paradigm and comfortable leading goals of care discussions. It could be a nurse, social worker, spiritual counselor, medical director, attending physician, or nurse practitioner, depending on the availability of staff and needs of the individual and family. Completion of the POLST form should be done in accordance with state regulations regarding the scope of practice for each licensed discipline. Licensed health care professionals are responsible for signing the medical order (e.g., the attending physician, the hospice medical director, or the nurse practitioner).

6. How does the team ensure that the POLST form becomes a valid medical order?

Licensed health care professionals are responsible for signing the medical order (e.g., the attending physician, the hospice medical director, or the nurse practitioner). The patient or surrogate decision maker must also sign the form. Organizational policies on ensuring that the POLST form becomes a valid medical order may vary depending on the location of the hospice patient (e.g., nursing home, private home, or assisted living). Organizational policies and protocols regarding verbal orders should be followed if an RN is taking a verbal order from a licensed provider (view sample policy from Maine). With the exception of a few states, faxed and or photocopies of the form are considered valid.

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Appendix 1: About the POLST Paradigm

National POLST Paradigm

In September 2004, the National POLST Advisory Panel, later known as the National POLST Paradigm Task Force convened to establish quality standards for POLST forms and Programs and to assist states in developing the POLST Paradigm, which it still does today. The National Task Force is comprised of one representative chosen by each state that has an endorsed program, as well as advisors (legal, technology, EMS, Emergency Department, and long term care).

The National Task Force and Executive Director oversee the National POLST Paradigm. In addition to this national leadership, each state participating has its own coalition that implements the state's POLST Program. All participants in the National POLST Paradigm have a shared vision for change and work to build consensus on strategies. The National Task Force and the National POLST Office serve as the backbone of the initiative and coordinate guidance, research, education, policy and quality assurance for all POLST Programs to follow.

POLST Programs (State Programs)

Each state builds its own coalition to implement the POLST Paradigm by developing their own POLST Program, either through a grassroots approach or through legislation or regulation. All states considering or actively developing a POLST Program are encouraged to participate in the National POLST Paradigm. POLST Programs that have submitted their state POLST form and required documentation to the National Task Force, proving their POLST Program meets National Task Force standards, can be endorsed and participate on the National Task Force.

This grid, created by the American Bar Association Commission on Law & Aging, shows the current laws and regulations in states related to the POLST Paradigm. Another resource the AARP Public Policy Institute Research Report entitled Improving Advanced Illness Care: The Evolution of State POLST Programs that looked at how the first twelve states with POLST Programs developed.