POLST Program in New Jersey
(Practitioner Orders for Life Sustaining Treatments)
for EMS Providers

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Why do we Need Advance Care Planning?

- Need to honor *patient preferences* for End-Of-Life (EOL) care and to know what those preferences are
- Life expectancy increased to 78 with many reaching 90’s +
- Increased prevalence of chronic diseases and varying degree of disability and dependence
- Increased use of intensive care, artificial life supports, hospitalizations, and under utilization of palliative care and hospice for patients at the end of life
- Patient/family dissatisfaction with EOL care
- Lack of comprehensive conversations about EOL options, prognosis and **Goals of Care**
When and where should Advance Care Planning Start?

- Doctor’s visit
- Healthy and independent
- Chronic illness
- Diagnosis of serious illness
- When “nothing more can be done”
- When you do not know your loved ones’ wishes
Review of NJ Advance Directives for Health Care Act
1992 Law

- 18 years old +
- Living Will Instruction directive
- Proxy Directive
- Becomes operative only:
  - When patient determined to lose Decision-Making capacity; and
  - When received by doctor or hospital; and
  - When adequate time for diagnosis and prognosis; and
  - When adequate time for evaluation and interpretation of Advance Directive document

*Is not operational in the field for EMS*
Review of Out-of-Hospital DNR Orders in NJ

- Statewide protocol developed – 1997
- Honored by EMS statewide
- *Should be* utilized when discharging patients who have DNR orders from hospital or transferring by ambulance from facilities
- Protects patients at home, or during EMS transport who do not want resuscitation at the time of death
So why do we need POLST in NJ?
What happens when you call 9-1-1 for emergency help?

- No time for evaluation of diagnosis/prognosis
- No time for evaluation of patient preferences
- No Goals of Care identified
- All medical interventions provided
- High speed train!
Why do patients call 9-1-1?

- Accident/injury

- **Symptoms!**
  - Pain
  - Shortness of breath
  - Bleeding
  - Weakness
  - Nausea/vomiting
  - Unconscious/syncope

*We don’t know overall goals of care.*
Shortcomings of Advance Directives

- Not “operational” in emergency settings
- Language often ambiguous, unclear …”if I have a terminal condition” or “If there is no reasonable hope of recovery”
- Family members over-ride written wishes, “that is not what my mother meant” “she would want to live”, etc.
- >80% of patients do not have Advance Directive
- Does not contain “actionable” orders to stop unwanted medical interventions like CPR, intubation
- Requires evaluation, prognosis and takes time – not a tool for use in EMS!
Shortcomings of OOH DNR orders

- Not portable (only applicable in home, EMS, ED)
- Only addresses orders for resuscitation if patient has cardiopulmonary arrest
- Does not address need for intubation for respiratory distress or other interventions
- Poorly utilized throughout New Jersey (many facilities do not know about it...even though operational since 1997)
POLST: What is it?
(Practitioners Orders for Life Sustaining Treatments)

- **Actionable Medical Orders:**
  - Set of physician or APN Orders to be followed at point of contact (EMS, ED, Hospital, Nursing Home, Home)
  - Represents previous EOL discussion and decisions made concerning limitation/choices of medical interventions
  - Brightly colored green format – universally recognized among all health care professions
  - Mandated by law that all HC professionals honor in good faith

- **Portable from one setting to another – Honored in ALL SETTINGS!**
POLST target population

- **Who should have POLST?**
  - **Target population:** those with terminal progressive illness and limited life expectancy who have preferences about their EOL care
  - Anyone choosing to limit medical interventions (CPR, intubation, feeding tubes, dialysis, antibiotics, surgery) – **POLST is Voluntary!**
  - Adults or children with terminal illness
  - Those residing in LTC facility nearing EOL
  - Anyone expected to die within next year

*Not indicated for healthy person for “what if”*
How is POLST different than AD?

- Does **not** require loss of decision-making capacity
- Can be created by HC practitioner in NJ (physician or nurse practitioner) and **patient (or surrogate if patient lacks decision-making capacity)**
- Applies immediately – no interpretation/evaluation
- Set of actionable medical orders operational at point of contact.
How is POLST different than OOH DNR?

- OOH DNR – is not portable! (Only applicable to EMS/ED)- must be re-written in other HC facility settings (hospitals/nursing homes)
- OOH DNR – only applies to resuscitation in event of CP arrest; POLST includes choices about other life-sustaining treatments such as intubation for respiratory distress
- POLST = Travels across all settings to accept and follow
Philosophy of POLST

- Individuals have right to make their own health care decisions
- Rights include:
  - Deciding about life-sustaining interventions (surgery, PEG tube feeding, antibiotics, ventilators, dialysis, etc.)
  - Provision of comfort care always
  - Choosing preferred location of dying
  - Respect for wishes across the continuum regardless of setting and provider! (Same form in ALL settings)
- **POLST form belongs to patient!** (original should go with patient – copies can be made by HC)
Examples where POLST could have made a difference?
A Decade of Research
Oregon POLST Program

• 2004:

  • 96% Oregon nursing homes report POLST used to guide decisions and evolved to a care standard

  • Oregon EMS indicate POLST changes treatment in 45% of patients
Core Elements of POLST

- **Actionable** medical orders
- Recommended for persons who have advanced chronic progressive illness and interested in further defining their end of life care wishes *(voluntary)*
- May be used either to limit medical interventions or to clarify a request for all medically indicated treatments *(examples)*
- Provides explicit direction about resuscitation
- Includes directions about other types of LST (intubation, dialysis, antibiotics, tube feeding, etc.)
Core Elements of POLST

- Should be **reviewed and renewed** when:
  - Individual preferences change
  - Individual’s health status changes
  - Patient transferred to another care setting
- Includes **education and training**
- Requires “**process**” for comprehensive discussion about end-of-life preferences… by a clinician that understands the prognosis and appropriate options for care
POLST is *not* a check list menu!

- It is a tool used to implement Goals of Care
- Requires a *comprehensive conversation* with patient’s *clinical caregivers* about their goals of care and medical conditions
- Should *not* be used for *DNR status*
Benefits of EOL Care Discussions (recent studies)

- Improve quality; reduce unnecessary and unwanted medical interventions;
- Only 31% of patients with advanced cancer at EOL had discussions with physicians about EOL care;
- Patients who had EOL conversations had better quality of life at end of life;
- Lung cancer patients (published study) who chose palliative care instead of continued aggressive treatments lived longer!
- POLST is “trigger” for conversations!
ROLE OF EMS in POLST

- Review POLST for completeness/validity:
  - Physician/APN signature
  - Patient or Surrogate signature
  - Review content of Orders prior to initiating treatment
  - Clarify with patient (if alert with capacity) or surrogate
  - Notify EMS physician control of POLST
  - Bring POLST form with patient to hospital (make copy of POLST and attach to EMS patient report)

- Follow EMS procedures for documentation of POLST form on your EMS call sheet.
Role of EMS in POLST

- Follow orders for:
  - **Box D:** Do or Do Not Attempt Resuscitation (DNAR) – same as Out of Hospital DNR
  - **Box D:** New – Do or Do Not Intubate for respiratory distress (when patient is not in cardiopulmonary arrest): provide other means of respiratory relief – Oxygen, medications, manual relief of airway obstruction (applies to ALS units for intubation, medications and/or c-pap)
  - **Box B:** “Full Treatment” – all appropriate interventions (Resuscitation Status – See Section D)
  - **Box B:** “Limited Treatment” with “Transfer to hospital only if comfort needs cannot be met in current location” – transport for comfort/symptom relief.
Special EMS issues...

- If a box is left “**blank**” on POLST form: Assumption is that **treatment will be provided** for that category.

- If Box B is marked either Limited Treatment or Symptom Treatment Only with indication that **transport to hospital should only take place if comfort needs cannot be met in current location**: Follow instructions of sending facility after verifying that patient is indeed to be transported.

- **Validity of POLST**: Required MD or APN signature and signature of patient or surrogate.
Box B. What does Symptom Treatment Only mean? How should EMS treat?

- Comfort is primary intention
  - Use of medications appropriate (morphine, lasix, oxygen, anti-seizure meds, nitro, etc.) – whatever provides relief of symptoms
  - Request for no artificial life supports (intubation, CPR, dialysis, etc.)
  - Provide psychological, emotional and spiritual support as needed…
POLST is Law in New Jersey as of December, 2011

- Signed into law by Governor
- Steering Committee on POLST – NJHA Quality Institute authorized to develop statewide data and educational requirements
- HC Professionals are protected from liability when honoring POLST in good faith
- Implementation in February 2013
- Need widespread education in EMS
Concerns/Questions ?