POLST Program in New Jersey

(Practitioner Orders for Life Sustaining Treatments)

for EMS Providers

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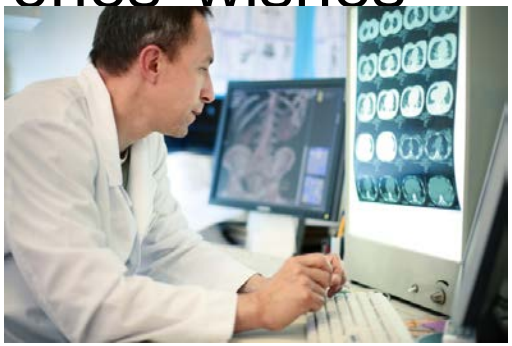
Why do we Need Advance Care Planning?

- 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 ca

Shortcomings of Advance Directives

- **Not "operational" in emergency settings**
- **Language often ambiguous, unclear …"<u>if</u> I have a terminal condition" or "<u>If</u> 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 – <u>not a tool for use in EMS!</u>**

Short comings of OOH DNR orders

- **Not portable (only applicable in home, EMS, ED)**
- **Only addresses orders for resuscitation <u>if patient has cardiopulmonary arrest</u>**
- **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 sin**

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

- **<u>Who</u> should have POLST ?**
  - **<u>Target population</u>: 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) – <u>*POLST is Voluntary!*</u>**
  - **Adults or children with terminal illnes**
  - **Those residing in LTC facility nearing**
  - **Anyone expected to die within next ye**

<u>Not indicated for healthy person for "what if</u>

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 acti medical order rational at point of co

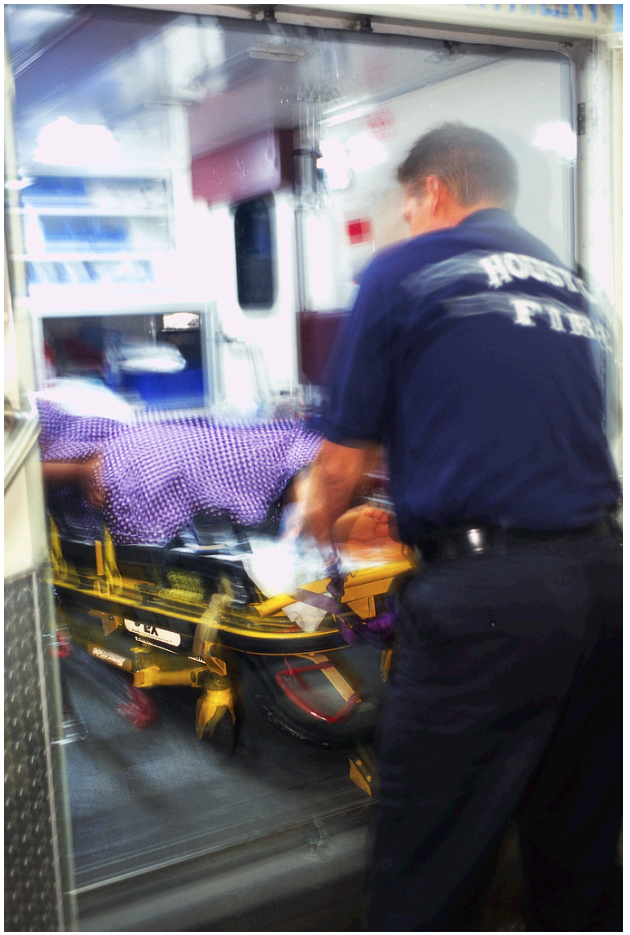
How is POLST different than OOH DNR?

- 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 **<u>all settings</u>** 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

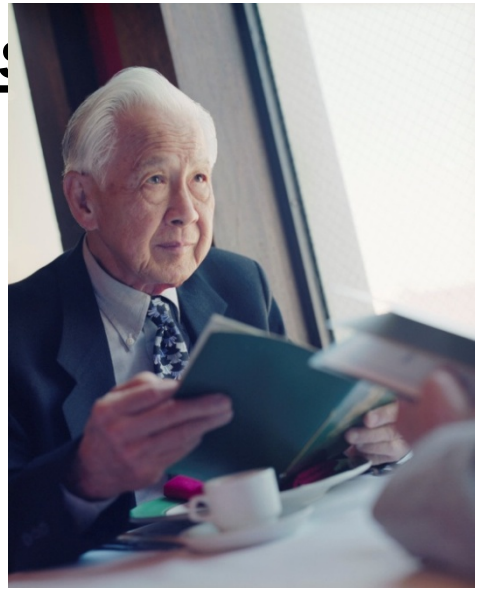
- **Actionable medical orders**
- **Recommended for persons who have advanced chronic progressive illness and interested in further defining their end of life care wishes (*voluntary*)**
- **May be used either to limit medical interventions or to clarify a request for all medically indicated treatments (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

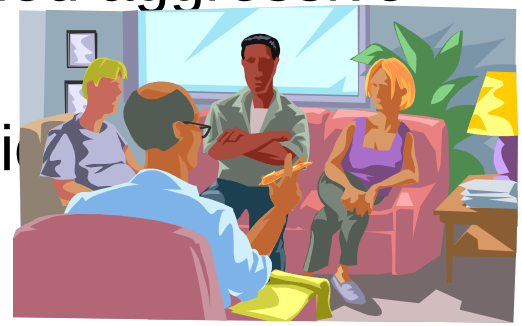
POLST is *not* a check list menu !

- 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 conversati



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

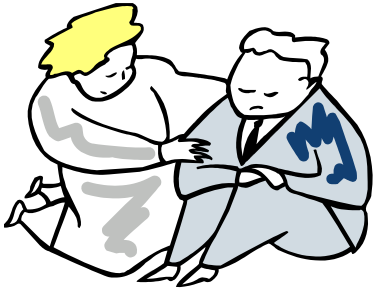
- Follow orders for:
  - **Box D: Do or Do Not Attempt Resuscitation** (DNAR)– same as Out of Hospital DNR
  - **Box D: *New* – Do or Do Not Intubate for respiratory distress** (when patient is not in cardiopulmonary arrest): provide other means of respiratory relief – Oxygen, medications, manual relief 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.

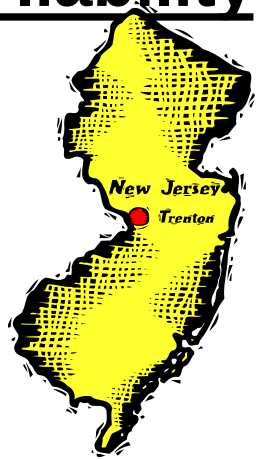
Box B: What does Symptom Treatment Only mean ? ***How should EMS treat?***

- 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 ?