Better Advance Care Planning: Advance Directives and POLST

Thaddeus Mason Pope, J.D., Ph.D.
For Bayada Nurses and
Widener University School of Nursing
Camden, NJ • June 7, 2011

Delaware law professor

New Jersey APNs

"NJSNA supports education of nurses which enables them to:"

"Understand the **Federal and State requirements** for Advance Directives"

"Be prepared to talk to the client and family about **advance directives**"

NJSNA NEW JERSEY STATE NURSES ASSOCIATION

N.J. S.B. 2197

"Board of Nursing shall require that a person certified as an advanced practice nurse . . . complete **two credits** of educational programs . . . related to **end-of-life care"**

Passed out of committee May 12

Must still go to Senate, House, Governor

Prudent

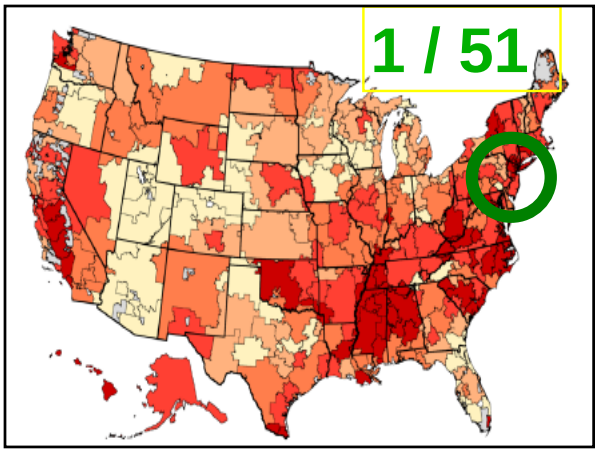
Required?

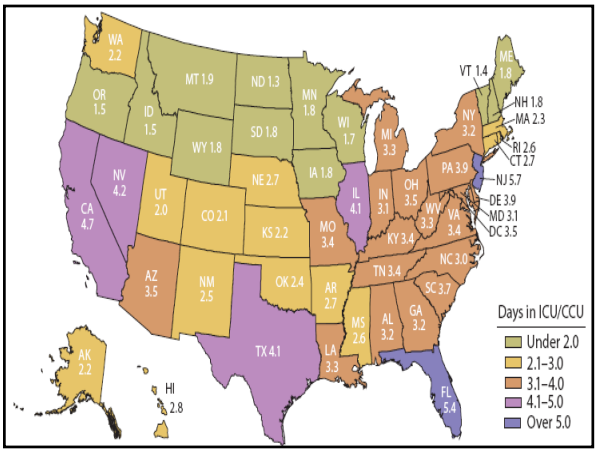
Not all law

End-of-Life Care in New Jersey

45 min
15 min Q&A
-- Break --
45 min
15 min Q&A

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change
A Report of the Dartmouth Atlas Project





Total physician visits* per decedent during the last 2 years of life	75.9 visits	1 of 51
Medical specialist visits* per decedent during the last 2 years of life	42.7 visits	1 of 51
Total physician visits* per decedent during last 6 months of life	41.5 visits	1 of 51
Medical Specialist visits* per decedent during the last 6 months of life	25.0 visits	1 of 51
Percent of decedents seeing 10 or more different physicians* during the last 6 months of life	38.7%	1 of 51

Compared to the average American

In last 6 months, NJ

30% more days in hospital

43% more physician visits

44% more days in the ICU

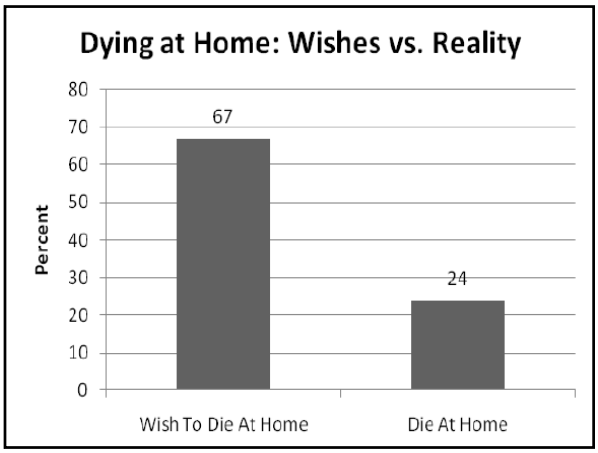
Value = Quality / Cost

Treatment is **un**wanted

71%: "More important to enhance the **quality** of life for seriously ill patients, even if it means a **shorter life.**"

National Journal (Mar. 2011)

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
If doctors believe there is no hope of recovery, which would you prefer?		
Life-sustaining treatments should be stopped and should focus on comfort	72.8	92.6
All efforts should continue indefinitely	20.6	2.5



84% would trade
length of life
for
quality of life

N.J. S.B. 2199

The current health care system in New Jersey often **fails** to meet the special needs of persons who are approaching the end of life

by depriving them of the opportunity that they earnestly desire to spend their final months free of pain, in familiar surroundings, together with their friends and families,

instead of being tethered to tubes and other medical apparatus in an intensive care unit or other acute care hospital setting

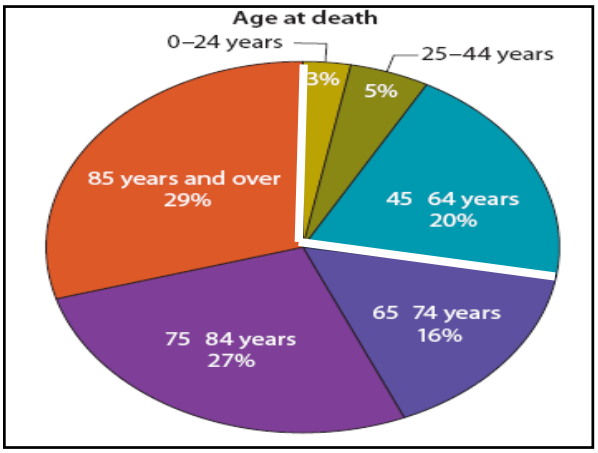
Harm to family

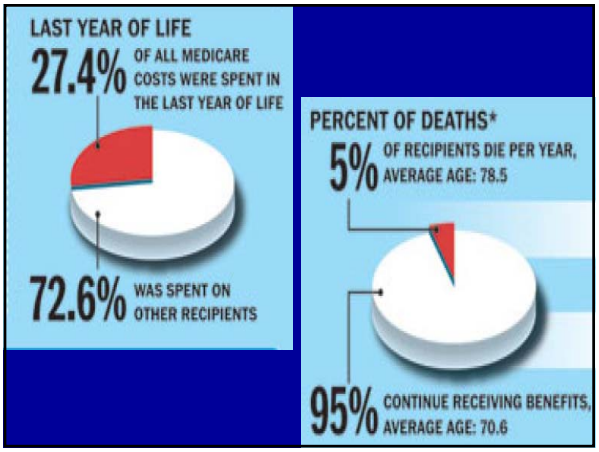
Emotional

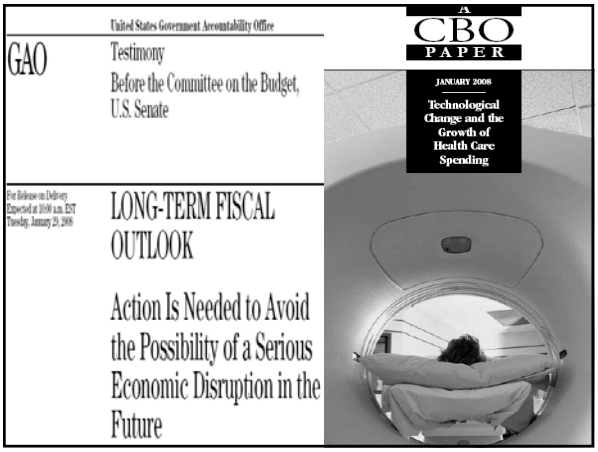
Economic

Harm to others

- Limited ICU beds
- ER boarding
- Antibiotic resistance
- Moral distress







Not public policy

Not rationing

Rights patients have regarding their medical treatment

- under New Jersey law
- under federal law

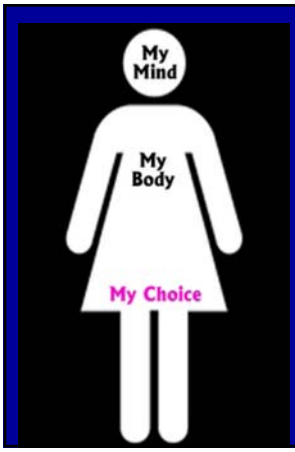
Rise of Bioethics

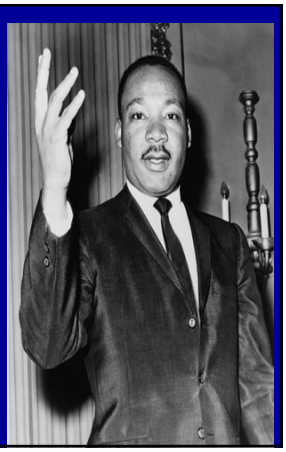
1960s

CPR

Dialysis

Mechanical ventilators





Salgo v. Stanford
(Cal. App. 1957)

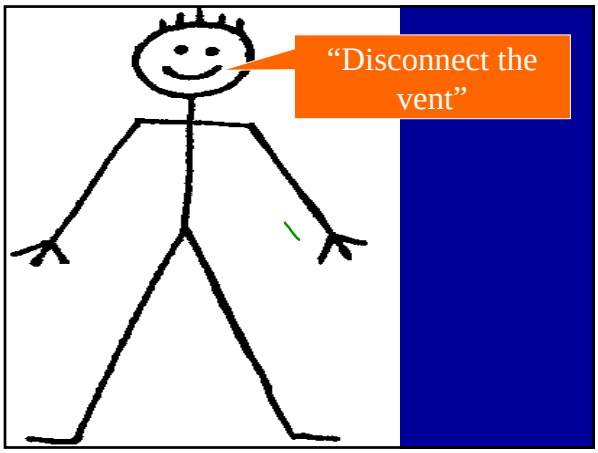
Natanson v. Kline
(Kan. 1960)

"At common law, ...the logical corollary of the doctrine of informed consent is that the patient generally possesses the **right not to consent**, that is, to refuse treatment."

- *Cruzan v. Missouri DOH* (1990)
(Rehnquist, C.J.)

Easier situation

Contemporaneous patient refusal



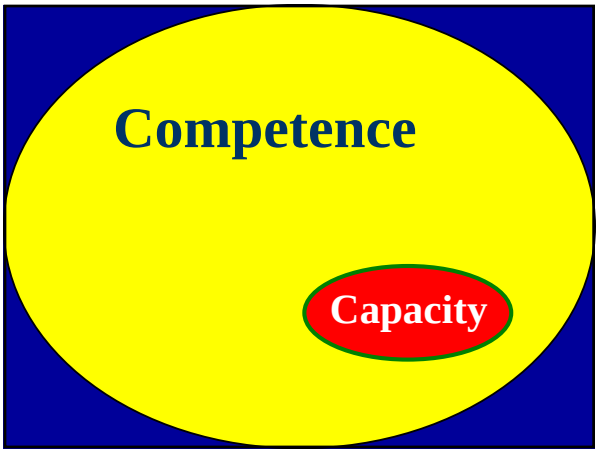
More common, more complicated

Patients lack capacity

Capacity

Ability to **understand** the significant benefits, risks and alternatives to proposed health care

Ability to **make and communicate** a decision.



Task specific

Fluctuates over time

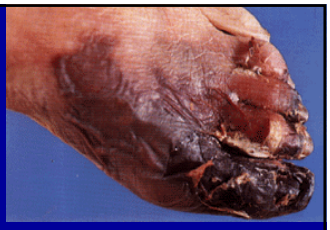
Lane v. Candura

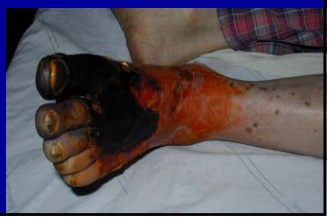
(Mass. 1978)

77yo Rosaria Candura

Gangrenous right foot and leg

Refuse consent for amputation





In re Maynes-Turner (Fla. App. 1999)

Doc: "Cognitively she does reasonably well. She would seem to possess the necessary knowledge that would be required for restoration."

Doc: "She might pose significant risks for herself on the basis of those decisions that she would make."

DHS v. Northern

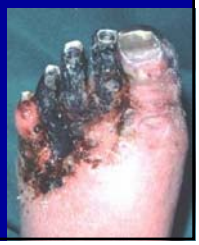
(Tenn. 1978)

Mary Northern 72yo

Admitted Nashville Gen.

Gangrene both feet

Amputation required to save life



Soft paternalism

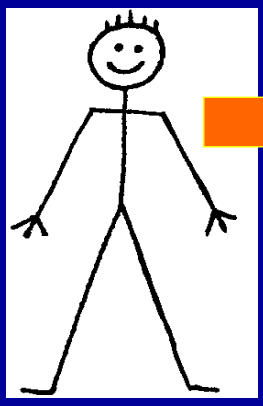
Cognitive or volitional defect

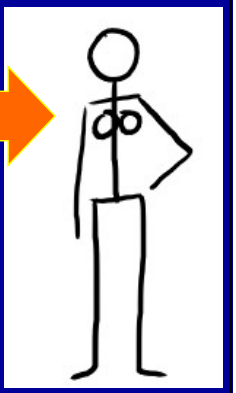
Hard paternalism

No cognitive or volitional defect
Restrict autonomy because values

Patient not lose autonomy right

- Who decides
- What standards

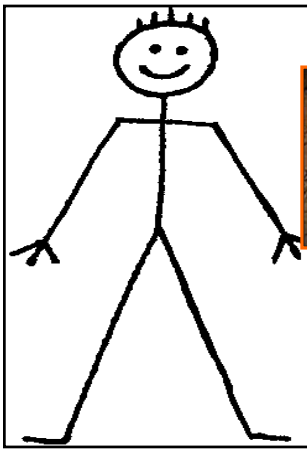


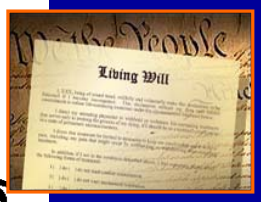


Court-appointed “guardian”

Patient-designated “agent”

Default “proxy” “surrogate”





Advance Directives

Advance directive

Document that instructs health care providers about your care when you cannot

"Springing"

Only effective when you lack capacity

New Jersey Advance Directive for Health Care Act (1991)

Type 1 of 3

Proxy directive

"health care representative"

"durable power of attorney for health care"

"agent"

A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I, _____, hereby designate _____,
of _____

_____,
(home address and telephone number of health care representative)

as my health care representative to make any and all health care decisions for me, including decisions to accept or

B) ALTERNATE REPRESENTATIVES: If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the order of priority stated:

1. *name* _____
   address _____
   city _____ *state* ____
   telephone _____

2. *name* _____
   address _____
   city _____ *state* ____
   telephone _____

C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.

___ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

___ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

_____

_____

_____

A proxy shall act in accord

"directive . . . decisions"

"the maker's . . . wishes"

"maker's best interests"

Type 2 of 3

Instructional directive

"living will"

Initial ONE of the following two statements with which you agree:

1. ___ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition

2. ___ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

Type 3 of 3

Combined directive

Both proxy
And instructional

Review

Decade

Death (family member)

Divorce

Diagnosis (new)

Decline (ADL)

Compliance: Key sources

TJC Accreditation standards

Medicare COPs

NJ Advance Directives for Health Care Act

TJC

Patient Rights

RI.01.01.05

Patient Self-Determination Act (PSDA)

When

After *Cruzan* (June 1990)

Sen. John Danforth (Mo.)

What

Agnostic as to substantive rights

Assure compliance with state law

Promote ACP

Who

Facilities receiving Medicare reimbursement

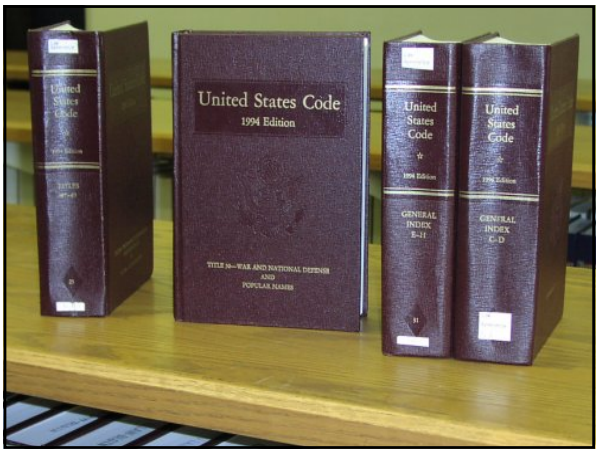
Centers for Medicare & Medicare Services

Agency (inside DHHS)

Implements PSDA with conditions of participation (COP)

COPs apply to **all** patients in facility

Not just the Medicare patients



Title 42--Public Health

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS

emergencies and referral when appropriate.

[51 FR 22042, June 17, 1986; 51 FR 27847, Aug. 4, 1986, as amended at 53 FR 6549, Mar. 1, 1988; 53 FR 18987, May 26, 1988; 56 FR 8852, Mar. 1, 1991; 56 FR 23022, May 20, 1991; 59 FR 46514, Sept. 8, 1994; 63 FR 20130, Apr. 23, 1998; 63 FR 33874, June 22, 1998; 68 FR 53262, Sept. 9, 2003]

§ 482.13 Condition of participation: Patient's rights.

A hospital must protect and promote each patient's rights.

(a) *Standard: Notice of rights*—(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.

decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates).

(4) The patient has the right to have

CMS Manual System
Pub. 100-07 State Operations
Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 37 **Date: October 17, 2008**

SUBJECT: Revise Appendix A, "Interpretive Guidelines for Hospitals"

I. SUMMARY OF CHANGES: Appendix A is being revised to reflect amended regulations and survey and certification policy issuances concerning the Conditions of Participation for Hospitals, 42 CFR Part 482. It also contains new guidance related to the Patients' Rights Final Rule, 42 CFR 482.13(e), (f), and (g), published in the Federal Register December 8, 2006 (71 FR 71378). In addition, Regulatory text that appears in brackets was included in a previous tag, but is repeated for clarity and accuracy in representing the regulatory citation.

HOSPITAL INTERPRETIVE GUIDELINES--PATIENTS' RIGHTS

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A 750	§482.13 Condition of participation: Patients' rights. A hospital must protect and promote each patient's rights.	Interpretive Guidelines: §482.13. These requirements apply to all Medicare or Medicaid-participating hospitals including short-term, psychiatric, rehabilitation, long-term, children's and alcohol-drug, whether or not they are accredited. This rule does not apply to psychiatric facilities for individuals under age 21, to residential treatment centers (unless these services are provided in a hospital setting); nor to Critical Access Hospitals (See Social Security Act (the Act) §1861(e)).
A 751	(a) Standard: Notice of rights. (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.	This regulation requires that whenever possible, the hospital informs each patient of his or her rights in language that the patient understands. The hospital has the responsibility to establish policies and procedures that effectively ensure that patients and/or their representatives have the information necessary to exercise their rights under the Act. This responsibility includes and is not limited to providing all notices required by statute and regulation regarding patients' rights. For example, the patient must be given notice of the rights afforded to him/her by the provider agreement, including the right to an advance directive and notice of non-coverage (see 42 CFR part 489), as well as the rights listed in this CoP. Depending on other factors, the hospital may have existing mechanisms for notifying patients of their rights. The hospital may decide it is most effective to bundle the patients' rights and advance directives notice with these existing notices.

New Jersey Advance Directive for Health Care Act (1991)

Assure New Jerseyans gets rights **under New Jersey law**

- Notify / inform
- Document
- Respect
- Education

Mirrored in licensure code

e.g. home health
N.J.A.C. 8:42-6.3

On admission

Determine if patient has AD

If yes →

Get it

Place in chart

If no →

Give assistance on request

Give information about right to accept, refuse

Give information

- In way patient understand
- Account for age, vision, literacy

Documentation

- P sign & acknowledge

After admission

- Give option to review, revise AD
- Honor AD
  - Unless conscience objection per state law
  - Unless other exception per state law
- Do not make access to care **depend** on whether have AD

Respect AD – or else

- TJC
- CMS
- State discipline
- Battery
- Informed consent
- IIED

Education

Staff

- To ensure compliance

Community

- To ensure reflection
- To ensure documentation

Policies & procedures

Verbal AD

When operative

Objections

Revocation

The way things are **supposed** to work

Too limited EOL care discussion

JAMA

Online article and related content current as of October 8, 2008.

Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment

Alexi A. Wright; Baohui Zhang; Alaka Ray; et al.

JAMA. 2008;300(14):1665-1673 (doi:10.1001/jama.300.14.1665)

EOL discussion less aggressive medicine

Arch Intern Med. 2009;169(5):480-488

Variable	Discussed EOL Care Preferences With Physician: Yes (n=75)	No (n=70)
Medical care received during the last week of life, No. (%)		
Intensive care unit stay	2 (2.7)	10 (14.3)
Ventilator use	1 (1.3)	10 (14.3)
Resuscitation	1 (1.3)	6 (8.6)
Chemotherapy	4 (5.3)	7 (10.0)
Inpatient hospice used	8 (10.7)	5 (7.1)
Inpatient hospice stay ≥1 wk	4 (5.3)	2 (2.9)
Outpatient hospice used	58 (77.3)	40 (57.1)
Outpatient hospice stay ≥1 wk	52 (69.3)	34 (48.6)
Place of death, No. (%)[b]		
Intensive care unit	2 (2.9)	9 (13.2)
Hospital	15 (21.7)	18 (26.5)
Inpatient hospice	5 (7.2)	3 (4.4)
Home	47 (68.1)	38 (55.9)

JAMA

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EOL discussion

- Earlier hospice referral
- Better patient QOL
- Better family bereavement

Not happening

ELNEC — CONNECTIONS - WINTER 2011
Advancing End-of-Life Nursing Care

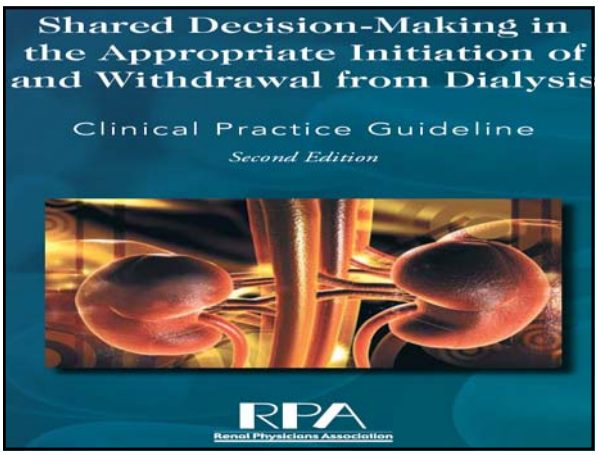
END-OF-LIFE NURSING EDUCATION CONSORTIUM

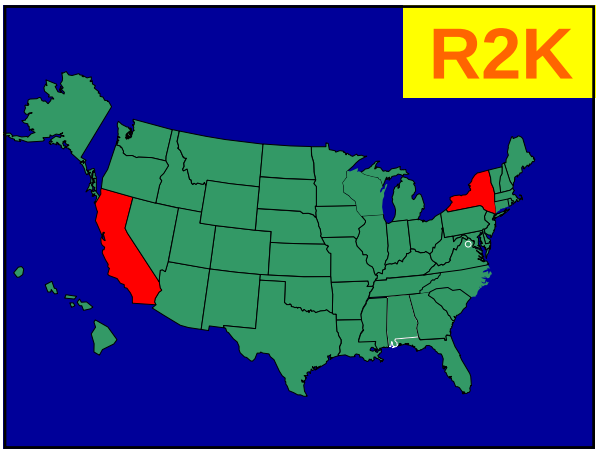
EPEC®
Education in Palliative and End-of-life Care

EPERC — End of Life / Palliative Education Resource Center

ASCO® American Society of Clinical Oncology
Making a world of difference in cancer care

- Limited effectiveness
- Side effects
- Options





Benefits
Risks
Alternatives
Financial

Largey v. Rothman

Before 1988
Professional standard

After 1988
Material risk standard

Hargett
v.
Vitas

Lack of
awareness

Limits of Advance Directives

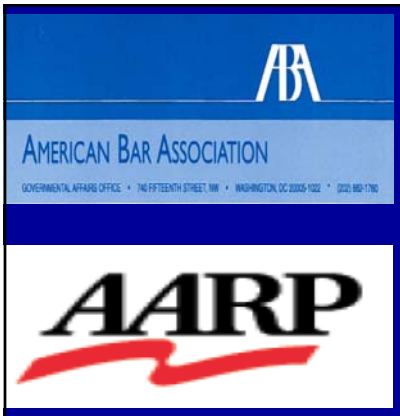
Not completed

Not found

Not informed

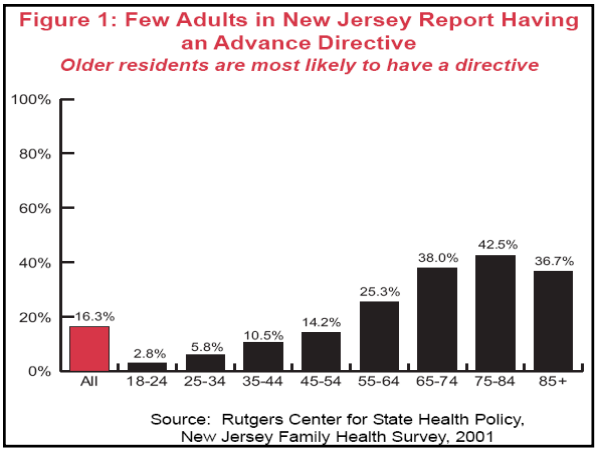
Not clear

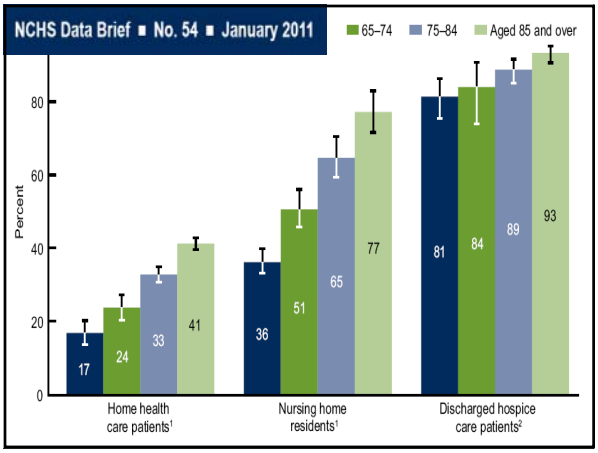
Not completed



30%

28%





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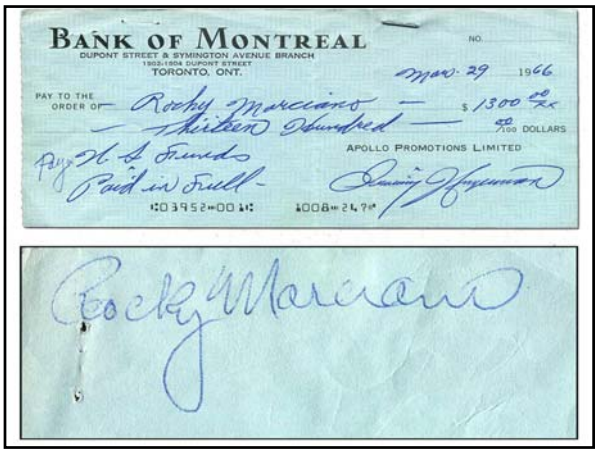

BANK OF MONTREAL
DUPONT STREET & SYMINGTON AVENUE BRANCH
TORONTO, ONT.
May 29 1966
PAY TO THE ORDER OF Rocky Marciano
Thirteen Hundred
$1300.00
APOLLO PROMOTIONS LIMITED
Rocky Marciano

65-76% of physicians whose patients have advance directives do not know they exist

U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Individuals fail to make & distribute copies

- Primary agent
- Alternate agents
- Family members
- PCP
- Specialists
- Attorney
- Clergy
- Online registry

Not informed

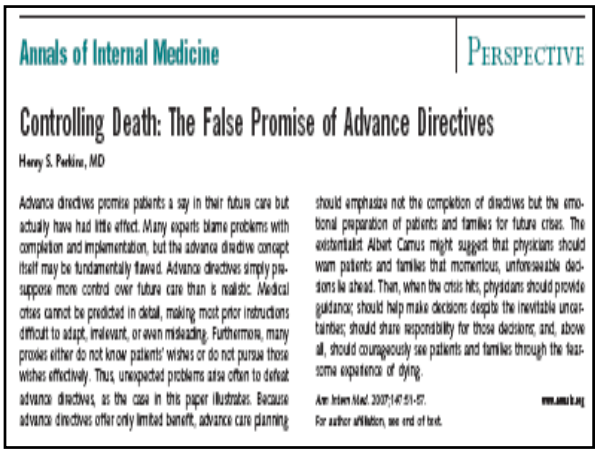
Enough

The Failure of the Living Will

by Angela Fagerlin and Carl E. Schneider

In pursuit of the dream that patients' exercise of autonomy could extend beyond their span of competence, living wills have passed from controversy to conventional wisdom, to widely promoted policy. But the policy has not produced results, and should be abandoned.

HASTINGS CENTER REPORT March–April 2004



Annals of Internal Medicine | PERSPECTIVE

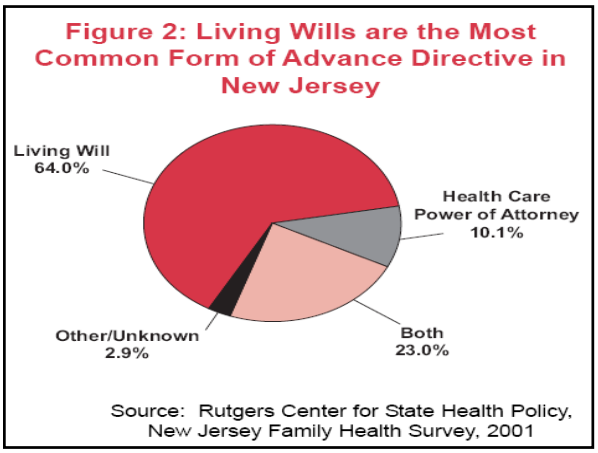
Controlling Death: The False Promise of Advance Directives

Henry S. Perkins, MD

Advance directives promise patients a say in their future care but actually have had little effect. Many experts blame problems with completion and implementation, but the advance directive concept itself may be fundamentally flawed. Advance directives simply presuppose more control over future care than is realistic. Medical crises cannot be predicted in detail, making most prior instructions difficult to adapt, irrelevant, or even misleading. Furthermore, many proxies either do not know patients' wishes or do not pursue those wishes effectively. Thus, unexpected problems arise often to defeat advance directives, as the case in this paper illustrates. Because advance directives offer only limited benefit, advance care planning should emphasize not the completion of directives but the emotional preparation of patients and families for future crises. The existentialist Albert Camus might suggest that physicians should warn patients and families that momentous, unforeseeable decisions lie ahead. Then, when the crisis hits, physicians should provide guidance; should help make decisions despite the inevitable uncertainties; should share responsibility for those decisions; and, above all, should courageously see patients and families through the fearsome experience of dying.

Ann Intern Med. 2007;147:51-57. www.annals.org

For author affiliation, see end of text.



Not clear

If _____, then _____

Trigger terms vague

"Reasonable expectation of recovery"

75% 51%

25% 10%

Plus: prognosis uncertain

Preferences vague

"No ventilator"

Ever

Even if temporary

SITUATION A

If I am in a coma or a persistent vegetative state and, in the opinion of my physician and two consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my goals and specific wishes — if medically reasonable — for this and any additional illness would be:

Please check appropriate boxes:	I want	I want treatment tried. If no clear improvement, stop.	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).		*Not applicable*		
2. Major surgery (for example, removing the gallbladder or part of the colon).		*Not applicable*		
3. Mechanical breathing (respiration by machine, through a tube in the throat).				
4. Dialysis (cleaning the blood by machine or by fluid passed through the belly).				
5. Blood transfusions or blood products.		*Not applicable*		
6. Artificial nutrition and hydration (given through a tube in a vein or in the stomach).				
7. Simple diagnostic tests (for example, blood tests or x-rays).		*Not applicable*		
8. Antibiotics (drugs used to fight infection).		*Not applicable*		
9. Pain medications, even if they dull consciousness and indirectly shorten my life.		*Not applicable*		

Less transactional

More discussion

Goals

Values

QOL

Priorities

What makes your life worth living?

How would you like to spend your last days?

What are your spiritual beliefs that might affect treatment choices?

More technology is the **default**

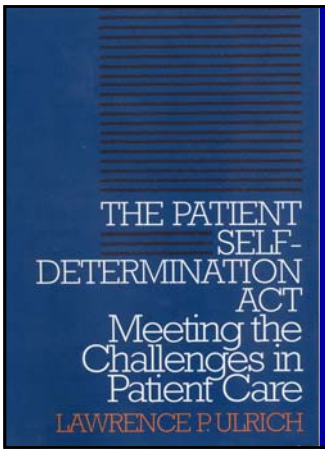
Patient must **opt out**

Improving advance directives

More ACP

Better documentation

Prompt Providers



1991

Enforce PSDA

Voluntary Advance Care Planning

Blumenauer
H.R. 3200
Sec. 1233

One 90-minute ACP

Nine 10-minute patient visits

PPACA silent on ACP. But does cover **annual wellness visits**.

Section 4103

DHHS: "Notice of Proposed Rulemaking: Physician Fee Schedule" (July 2010)

Final Rule (Nov. 2010)

Defined "VACP" as element of annual wellness visit

PolitiFact.com
Sorting out the truth in politics

Lie of the Year:

"Death Panels"

A "**quiet**" victory

"The longer this goes **unnoticed**, the better our chances of keeping it."

Jan. 2011: Rescind VACP

"We did not have an opportunity to consider . . . the wide range of views . . . held by a broad range of stakeholders"

H. R. 6331

One Hundred Tenth Congress
of the
United States of America

AT THE SECOND SESSION

(1) IN GENERAL.—Section 1861(ww) of the Social Security Act (42 U.S.C. 1395x(ww)) is amended—

"(3) For purposes of paragraph (1), the term 'end-of-life planning' means verbal or written information regarding—

"(A) an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions; and

"(B) whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.".

112TH CONGRESS
1ST SESSION

H. R. 1589

To amend the Social Security Act to provide for coverage of voluntary advance care planning consultation under Medicare and Medicaid, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 15, 2011

SECTION 1. SHORT TITLE; FINDINGS; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Personalize Your Care Act of 2011".

SENATE, No. 2199

STATE OF NEW JERSEY

214th LEGISLATURE

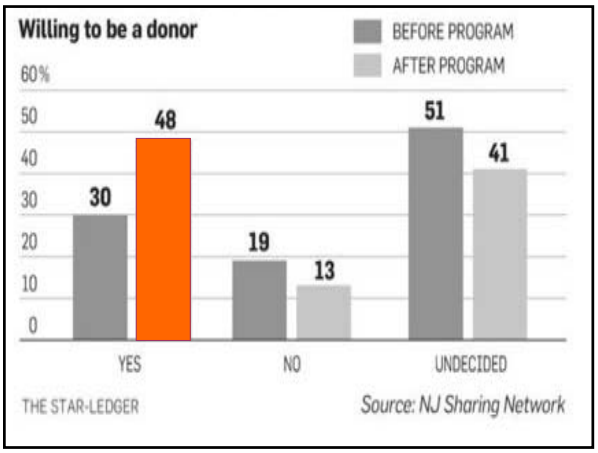
INTRODUCED JULY 19, 2010

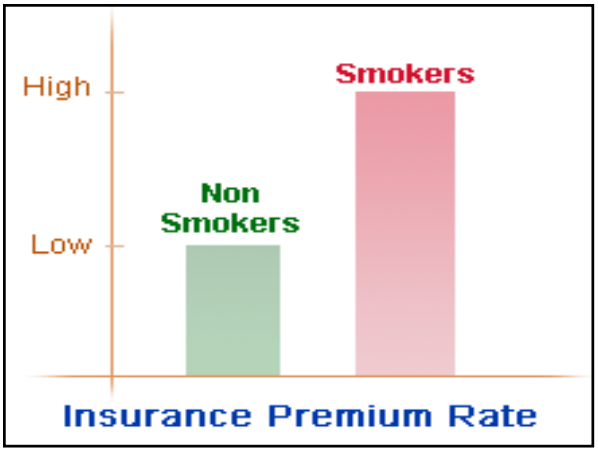
New Jersey Advisory Council on
22 End-of-Life Care

Sponsored by:

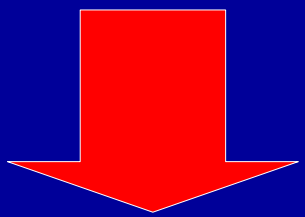
Senator M. TERESA RUIZ

Prompt Patients





Advance directive



Lower premiums

Content agnostic

Make AD available

Registries

Organ donation

Sara's Law

April 2011

Effective late 2012

NOKR

POLST

POLST

Physician

Order

Life

Sustaining

Treatment

POLST

Practitioner

Order

Life

Sustaining

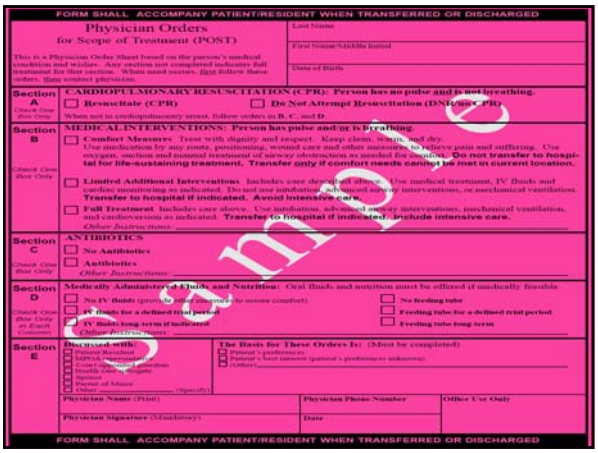
Treatment

POST Physician Order for Scope of Treatment

MOST Medical . . .

COLST Clinician . . .

MOLST Medical . . .


FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)

Last Name

First Name/Middle Initial

Date of Birth

Section A — CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitation (DNAR/No CPR)

Section B — MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
☐ Comfort Measures. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.
☐ Limited Additional Interventions. Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.
☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.
Other Instructions:

Section C — ANTIBIOTICS
☐ No Antibiotics
☐ Antibiotics
Other Instructions:

Section D — Medically Administered Fluids and Nutrition: Oral fluids and nutrition must be offered if medically feasible.
☐ No IV fluids (provide IV fluids for symptom management to assess comfort)
☐ IV fluids for a defined trial period
☐ IV fluids long-term if indicated
Other Instructions:
☐ No feeding tube
☐ Feeding tube for a defined trial period
☐ Feeding tube long-term

Section E — Discussed with:
☐ Patient Resident
☐ Surrogate (Health Care Agent)
☐ Health Care Agent
☐ Spouse
☐ Parent of Minor
☐ Other (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient's preferences unknown)
☐ Other

Physician Name (Print)
Physician Phone Number
Office Use Only
Physician Signature (Mandatory)
Date

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

What is POLST

POLST **supplements** AD

It does not replace it

Terminally ill

Chronic progressive illness

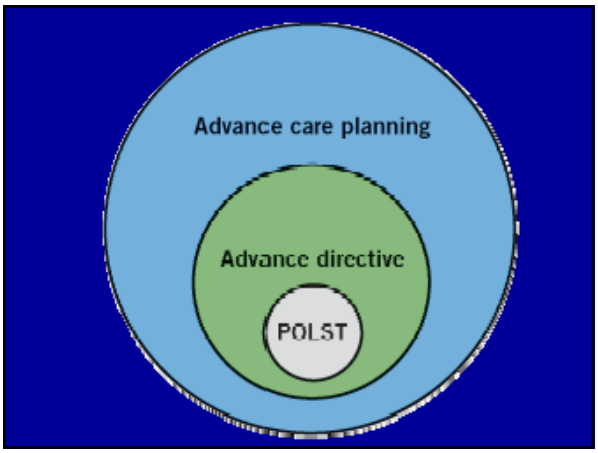
Frailty

For those in last year of life

NJ < 5 year

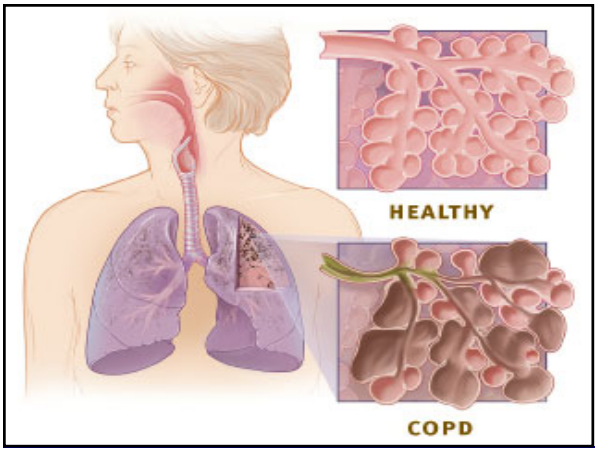
Others who want to define care

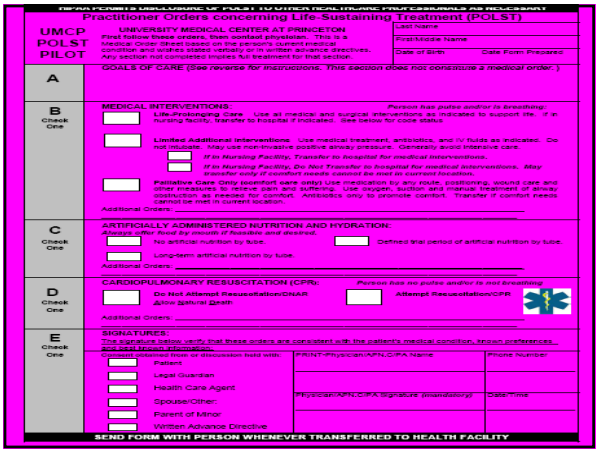
Differences between POLST and Advance Directives		
Characteristics	**POLST Paradigm**	**Advance Directive**
Population	Advanced progressive chronic conditions	All adults
Timeframe	Current care	Future care
Where completed	In medical setting	In any setting
Resulting product	Medical orders (POLST)	Advance directive
Surrogate role	Can do if patient lacks capacity	Cannot do
Portability	Provider responsibility	Patient/family responsibility
Periodic review	Provider responsibility	Patient/family responsibility



About the present

Here and now




Practitioner Orders concerning Life-Sustaining Treatment (POLST)

UMCP POLST PILOT

UNIVERSITY MEDICAL CENTER AT PRINCETON

A

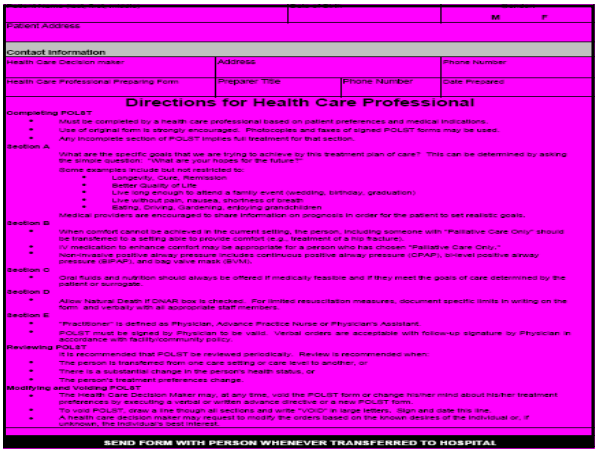
B

C

D

E

SEND FORM WITH PERSON WHENEVER TRANSFERRED TO HEALTH FACILITY


Directions for Health Care Professional

SEND FORM WITH PERSON WHENEVER TRANSFERRED TO HOSPITAL

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Practitioner Orders concerning Life-Sustaining Treatment (POLST)

UMCP POLST PILOT

UNIVERSITY MEDICAL CENTER AT PRINCETON

First follow these orders, then contact physician. This is a Medical Order Sheet based on the person's current medical condition and wishes stated verbally or in written advance directives. Any section not completed implies full treatment for that section.

Last Name

First/Middle Name

Date of Birth Date Form Prepared

A

GOALS OF CARE *(See reverse for instructions. This section does not constitute a medical order.)*

B Check One

MEDICAL INTERVENTIONS: *Person has pulse and/or is breathing:*

☐ **Life-Prolonging Care** Use all medical and surgical interventions as indicated to support life. If in nursing facility, transfer to hospital if indicated. See below for code status

☐ **Limited Additional Interventions** Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

- ☐ *If in Nursing Facility, Transfer to hospital for medical interventions.*
- ☐ *If in Nursing Facility, Do Not Transfer to hospital for medical interventions. May transfer only if comfort needs cannot be met in current location.*

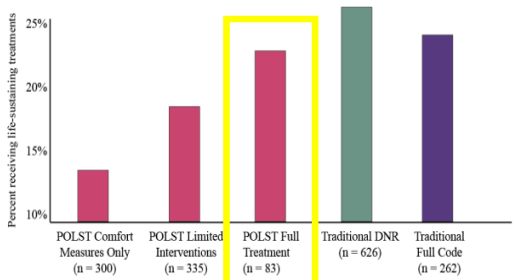
☐ **Palliative Care Only (comfort care only)** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. Transfer if comfort needs cannot be met in current location.

Additional Orders: _____

Order **for** LST

Order **about** LST

Life-Sustaining Treatments Received (n = 1,606)*†



* Analyses performed with subset of residents having the same orders in place for at least 60 days. For residents with POLST forms, only those with orders for medical interventions (Section B) were included.

† Life-sustaining treatments in Section B included hospitalization/ED visits, IV fluids, dialysis, transfusion, surgery/invasive diagnostic tests, chemotherapy/ radiation, and intubation/ ventilator support.

JAGS 58: 1241-1248, 2010 . A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices versus the Physicians Orders for Life-Sustaining Treatment (POLST) Program.
Susan E. Hickman, PhD, Christine A. Nelson, PhD, RN, Nancy A Perrin, PhD, Alvin H Moss, MD, Bernard J Hammes, PhD, and Susan W. Tolle, MD.

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION:

Always offer food by mouth if feasible and desired.

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

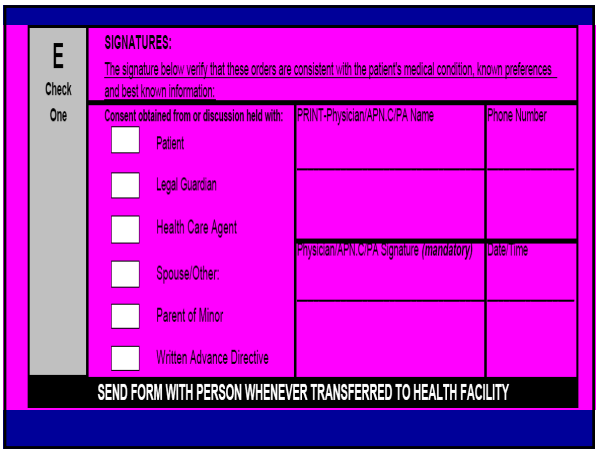
D Check One

CARDIOPULMONARY RESUSCITATION (CPR): *Person has no pulse and/or is not breathing*

☐ Do Not Attempt Resuscitation/DNAR
Allow Natural Death

☐ Attempt Resuscitation/CPR

Additional Orders: _____



70% - patient

30% - surrogate

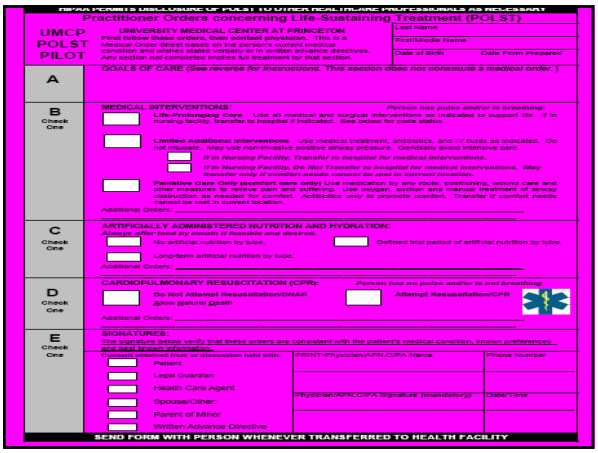
POLST does not expire

But should be reviewed with change in patient's condition or location

POLST can be revised or revoked at any time

POLST benefits

Closes gap between what people **want** and what they **get**


Practitioner Orders Concerning Life-Sustaining Treatment (POLST)

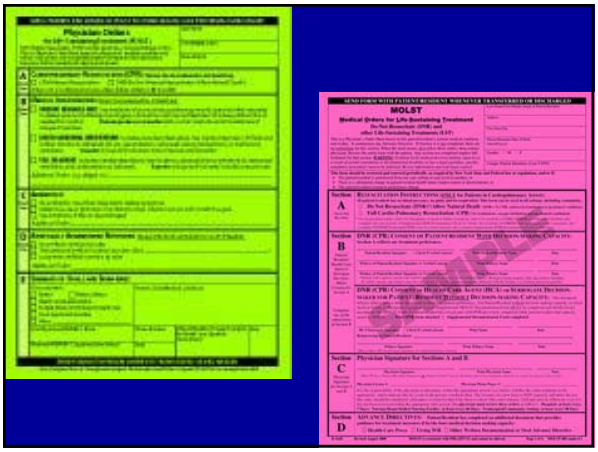
UMCP POLST PILOT

UNIVERSITY MEDICAL CENTER AT PRINCETON

SEND FORM WITH PERSON WHENEVER TRANSFERRED TO HEALTH FACILITY

Brightly colored

Easily identified



Original MOLST is printed on **lilac** heavy card stock paper

But a **copy** has the same force as the original form

Specific detailed instructions

Easy to follow

No need to “interpret”

Actionable orders

More likely honored

No need to "translate"

Portable

Travels with the patient in **all** treatment settings

Home LTC
Hospital EMS

Medical Society of New Jersey
MSNJ

DO NOT RESUSCITATE

ALL FIRST RESPONDERS AND EMERGENCY MEDICAL SERVICES PERSONNEL ARE AUTHORIZED TO COMPLY WITH THIS OUT-OF-HOSPITAL DNR ORDER.

This request for no resuscitative attempts in the event of a cardiac and/or respiratory arrest for: _____ (PLEASE PRINT NAME) has been ordered by the physician whose signature appears below. This order is in compliance with the patient's/surrogate's wishes and it has been determined and documented by the physician below that resuscitation attempts for this patient would be medically inappropriate.

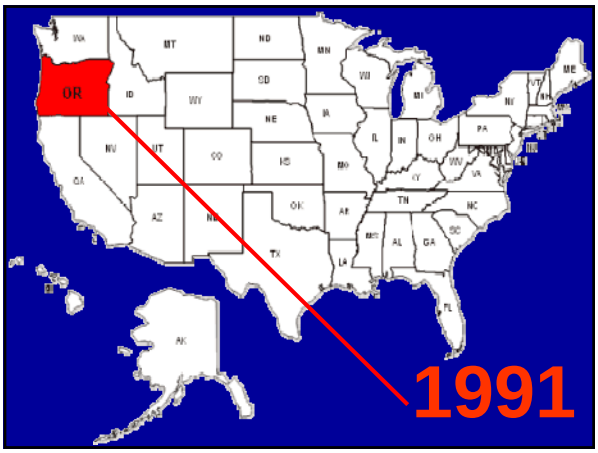
POLST	Pre-Hospital DNR
• Allows for choosing resuscitation	• Can only use if choosing DNR
• Allows for other medical treatments	• Only applies to resuscitation
• Honored across all healthcare settings	• Only honored outside the hospital

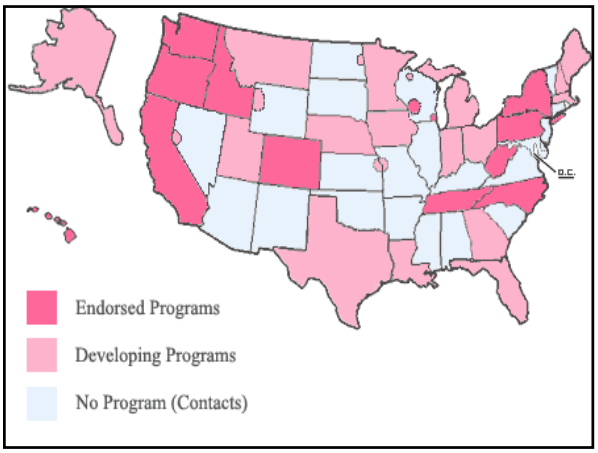
POLST is Evidence Based

- Major academic research in 3 POLST states: strong evidence base of efficacy of POLST in ensuring preferences are elicited, documented, honored, w/ pain and symptom management equivalent to those without POLST order

Hickman et al. "A Comparison of Methods to Communicate Treatment Preferences: Traditional Practices versus the Physician Orders for Life-Sustaining Treatment Program" J Am Geriatr Soc 58:1241–1248, 2010.

POLST status





PA - implementing 2011

DE - implementing 2011

MD - implementing 2011

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 2197

STATE OF NEW JERSEY

214th LEGISLATURE

ADOPTED MAY 12, 2011

Sponsored by:
Senator M. TERESA RUIZ
District 29 (Essex and Union)
Senator LORETTA WEINBERG
District 37 (Bergen)

7/19/2010 Introduced in Senate

5/12/2011 Reported from Senate HHS Committee

5/12/2011 Referred to Senate Budget and Appropriations Committee

PSO

Form

Public awareness

Training professionals

Patient Safety & Quality Act of 2005

Patient Safety and Quality Improvement Final Rule (2008)

NJHA Institute for Quality and Patient Safety

Princeton HealthCare System

Redefining Care.

Thank you

Widener University

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