THE PERIL OF POLST: LESSONS FROM THE USA

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Objectives:

- Review rationale for POLST development in USA
- Discuss lessons learned
- Challenge of POLST as “solution” to EOL care
- Reflect on the continued need for conversation to understand intent and values

“Now when I go abroad I tell everyone I’m a Canadian goose.”

A case:

- 68 year old man is transferred from a rehab facility, one week after admission, following 1 month acute ICU stay for multi-organ failure from progressive rheumatoid disease, pneumonia and heart failure.
- Presents to another ED obtunded with hypercarbia, RR 6, being bagged by paramedics.
- He has a POLST form with him dated from 1st day at rehab after discharge.
  - Form filled out by nurse, cosigned.
  - The form states:
    - No CPR
    - "Limited" treatment, which includes: No Intubation
- His family has no knowledge of the POLST. They say "intubate" – they aren't ready for him to "go."

US Advance Care Planning History:

- Patient Self-Determination Act in US, 1991
- Development of Written Advance Directives:
  - Living Will
    - "Terminal State"
    - "Persistent Vegetative State"
  - CPR Directive
  - Medical Durable Power of Attorney (MDPOA)
- POLST-Paradigm Form, 1990s
  - Translation of wishes to physician ORDERS
  - Honored across settings
  - State-based, nationally authorized

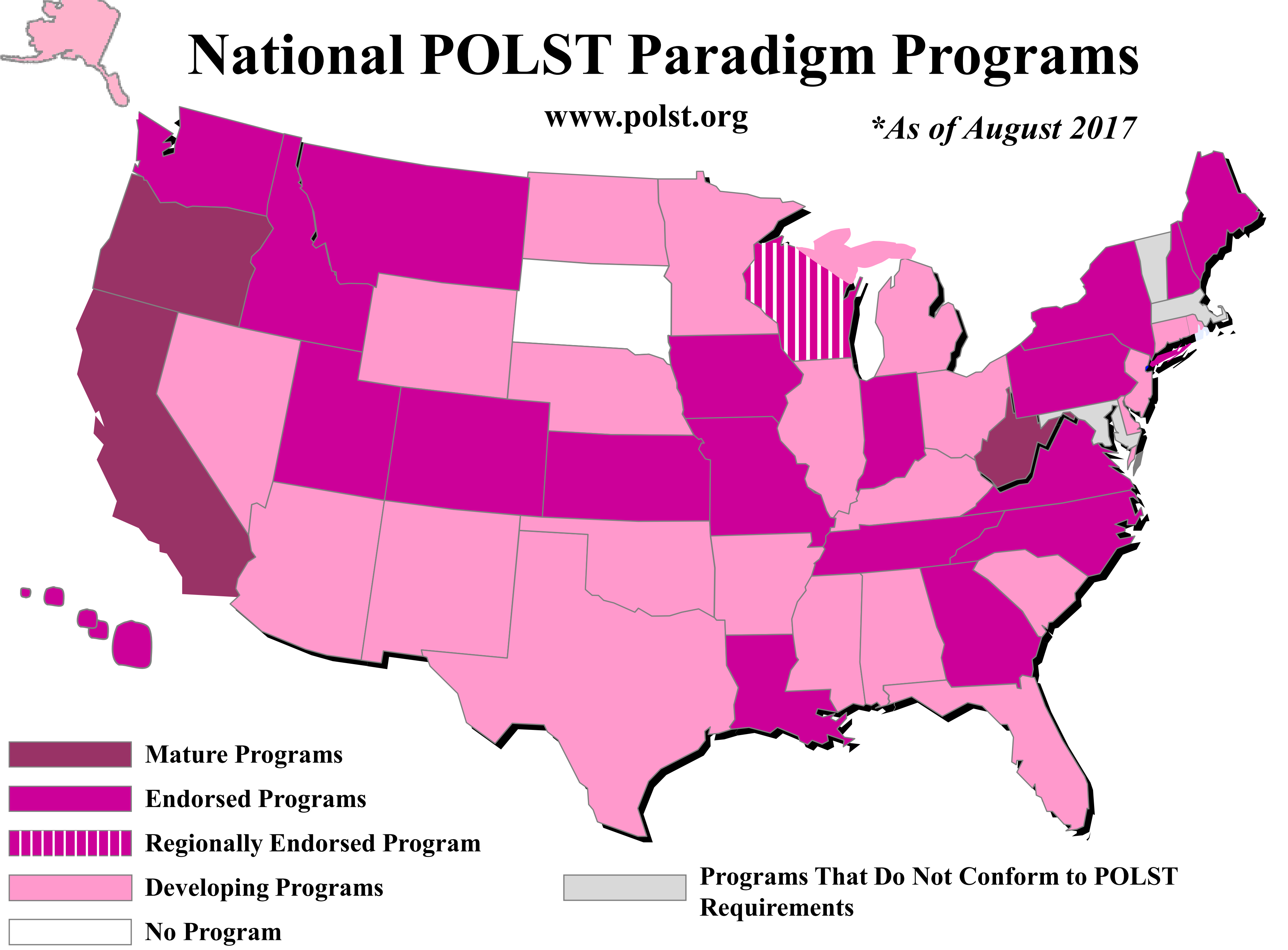
POLST Purpose:

- Corrective near the end of life to abstract, procedure-based written ADs due to inability to:

  - Recognize <u>adaptation</u> to evolving limitations
  - <u>Predict</u> life circumstances or type of medical downturn
  - <u>Extrapolate</u> basic DNR/DNI wishes to other “peri-death” interventions

Sudore R, et al

- ***Directions for Current Care***
  - Terminal trajectory, frailty, incurable end-stage diseases, last year of life


National POLST Paradigm Programs
www.polst.org
*As of August 2017
Mature Programs
Endorsed Programs
Regionally Endorsed Program
Developing Programs
No Program
Programs That Do Not Conform to POLST Requirements

MOST Form: British Columbia

Section 1: Code Status

Section 2: Most Designation based on document conversations. (Initial appropriate level.)

Medical Treatments Excluding Critical Care Intervention and Resuscitation	
M1: ________	**Supportive care, symptom management and comfort measures. Allow natural death.** Transfer to higher level of care only if patient's comfort needs not met in current location.
M2: ________	**Medical treatments available within location of care. Current location:** ________ Transfer to a higher level of care only if patient's comfort needs not met in current location.
M3: ________	**Full medical treatments excluding critical care.**
Critical Care Interventions Requested. Note: consultation will be required prior to admission.	
C1: ________	**Critical Care Interventions excluding intubation.**
C2: ________	**Critical Care Interventions including intubation.**

Section 3: Specific Interventions (Optional. Complete consent forms as appropriate)

Blood Products: ☐ Yes ☐ No　　Dialysis: ☐ Yes ☐ No

Enteral Nutrition: ☐ Yes ☐ No　　Non-invasive Ventilation: ☐ Yes ☐ No

Other Directions: ________________________________

Surgical Resuscitation Order

☐ WAIVE DNR for duration of procedure and per-operative period. Attempt CPR as indicated.

☐ **Do not attempt resuscitation** during procedure.

POLST Positives:

- Translation of wishes into orders:
  - To avoid transport to hospital from residential living site
  - To avoid admission to hospital/ICU when not aligned with wishes
  - To limit interventions not aligned with patient’s wish for arc of end of their life
  - To affirm aggressive treatment desires
  - To support family by making treatment choices clear
- Should be honored by EMS, Nursing Home, ED, Hospital
- Provider protection from liability

POLST: “Lessons Learned”

Oregon 2012: 31,000 forms

CPR ?	Comfort	Limited	Full
YES	0.04%	7.3%	23.9%
No (68%)	34.4%	29.7%	3.9%

Schmidt, et al. Resuscitation, 2014

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POLST: What Effect Does it Have?

- Most consistent effect: CPR directives (Part A) honored
- 31% of patients dying in Oregon had POLST
  - (2010-11)
- Death in hospital
  - 6.4%: if “Comfort care” with POLST
    - (hospitalize only for comfort management)
  - 44.2%: if “full treatment” with POLST
  - 34.2%: no POLST

POLSTs in the Emergent Situations:

Clemency, et al; JAMDA 2017

- ED Study of 100 POLST forms in Buffalo, NY
- ½ by patient, ½ by surrogate
- 100% had resuscitation instructions
- 82% had intubation instructions

- *66 forms – at least one blank section*
- *Only 56 forms had treatment guidelines (Part B)*
- *14% had "contradictory" treatment orders*

Other Concerning Challenges about POLST

- ¾ of forms are filled out by nurses, other non-physicians.
- Few studies on quality
- Mandated in some assisted living, NHs (???)
- EMS sometimes says “we will never honor”

Concerns in Acute Setting:

- Not accessible
- Unclear what people intend
- Unclear if people understand the meaning

- "I am here to save lives. If I do save them, they can sort it out in the ICU!" *Anon ED physician*
- "Decisions by default: incomplete and contradictory….." *Clemency, et al*

A better way to think about POLST:

- *This is a step forward….*
  - For EMS, ED, nursing homes…..
- *Good to know whether patients want CPR*
- *Good to know intubation status*
- *Helpful for disposition*
- ***The rest requires a conversation***

National POLST Paradigm Organization: "Appropriate Use Policy" April 2017

- POLST use should always be voluntary
- Completion must include patient/surrogate
- "Only as good as the conversations preceding it."
- Intended population
  - Seriously ill
  - Frail
  - Death within a year expected
- Don't just hand to the patient
- Current – patient wishes are dynamic, therefore revisit.
- Importance of Section B (treatment preferences)

Questions?

"Because of your age, I'm going to recommend doing nothing."