Advance Care Planning

- 80 to 85 percent of people who die in the United States are 65 or older
- Most die from chronic conditions
- Only 22 percent die from cancer
- Medical treatment does not cure the underlying disease
- Medical treatment can resolve the crisis and may extend life
Introduction

- Often there is no clearly recognizable threshold between being very ill and dying
- Patients become too incapacitated to speak for themselves
- Decision making is usually made jointly by the physician and family or surrogate
The problem

• Less than 50 percent of severely or terminally ill patients had an advance directive (AD) in their medical chart
• Only 12 percent with an AD had received input from their physician
• 65 to 76 percent of physicians whose patients had an AD were not aware it existed
• Having an AD did not increase documentation of the patients wishes
The problem

- AD helped make end-of-life decisions in less than half of cases where a directive existed
- AD were not applied until the patient became incapacitated and "absolutely hopelessly ill"
- Providers and patient surrogates had difficulty knowing when to stop treatment and often waited until the patient was actively dying before the directive was invoked
The problem

• Language in AD was nonspecific and general to provide clear instructions
• Surrogates named in the AD were often not present or too overwhelmed to offer guidance
• Physicians were only about 65% accurate in predicting patient preferences and tended to make errors of under treatment
• Family members tended to make errors of over treatment, even if they discussed the AD with the patient
The problem

- Two studies done by the Agency for Healthcare Research and Quality (AHRQ)
  - Patient preference to decline CPR was not translated into DNR orders
  - Patients received life-sustaining treatments at the same rate regardless of their desire to limit treatment
The Problem

- Doctors are poor prognosticators and tend to avoid this subject
- Disease trajectory:
  - Cancer- expected course
  - Chronic illness- slowly declining health marked by sudden severe episodes requiring hospitalizations with improvement
  - Dementia or Frailty- progressive decline in both physical and mental health
The Problem

• Patients are not told that their chronic disease is terminal
• Lack of communication leads to confusion about the diagnosis, the prognosis, and the decisions that patients and their family need to make
The Solution

- Advance care planning is a structured provider guided discussion with the patient and family whose goal is to define the patient's preferences for treatments at end of life, prepare and complete the supporting documentation, and update the patient's preferences and documentation on a regular basis.
Definitions
Advances Directive (living will)

- Formal legal documents specifically authorized by states that allow patients to continue their personal autonomy.
- Provide instructions for care in case they become incapacitated and cannot make decisions.
- May also be a durable power of attorney.
Durable power of attorney (health care proxy)

- Allows the patient to designate a surrogate, a person who will make treatment decisions for the patient if the patient becomes too incapacitated to make such decisions
The structured process

• Initiate a guided discussion
• Introduce the subject of advance care planning and offer information
• Complete advance care planning documents
  • Be specific
• Review preferences on a regular basis and update
• Apply the patient's desires to actual circumstances
Physician Orders for Life-Sustaining Treatment (POLST) - the Future

- Details one’s end-of-life GOALS and wishes in writing
- Actual order from the physician or NP
- Follows the patient through all parts of the health-care system
- The version in New Jersey differs from other states in that it places the goals of care first and the DNR order last
What Does POLST stand for

Practitioner Orders for Life-Sustaining Treatment
Introduction to POLST

- Legislation was signed by Governor Christie in December 2011 and officially released by the Department of Health on February 22, 2013.
- NJ’s POLST form is bright green in color, however it can be photocopied.
- Travels with the patient.
- Must be honored in all settings: hospitals, clinics, ambulatory surgery centers, long-term care, rehab facilities, long-term care hospitals, assisted living, hospice, during transit by pre-hospital providers or home.
Goals of POLST Legislation

- Promotes an adult’s right to self-determination and autonomy with respect to goals of care, treatment preferences and choices.
- Clarify treatment choices and goals.
- Reduce repetitive actions and inappropriate hospitalization/transfer.
Does it Replace an Advance Directive?

- Does not replace an Advance Directive, living will, medical POAs.
- It is used to compliment those documents.
- POLST can overrule any previous instructions if they are in conflict.
- Completion of a POLST, however, does invalidate all previous POLST documents.

- Must by signed by MD or APN and voluntarily signed by the patient, if able to make such a decision or by a designated individual who knows what the patient wants.
The portability of the form allows for seamless documentation of treatment goals and preferences and closes the gaps as individuals transfer across healthcare settings.
Who is it Appropriate for?

- Seriously ill with life-limiting advance illness
- Advanced frailty with significant weakness and difficulty with ADLs.
- May lose the capacity to make their own healthcare decisions within the year.
- Hold strong preferences about EOL care.
- Chronically ill with frequent contact with the healthcare system.
- Long-term care residents
When would it not be appropriate?

Unless it is the individual’s preference, the use of the POLST form to limit treatment is not appropriate for patient’s who are medically stable or who have functionally disabling problems but have many years to live.
Where should it be kept?

- In a healthcare facility, it should be the first document on the chart and implemented like all other MD orders.
- At home, the form should be placed in a location that is easily accessible and likely to be seen by first responders and EMS personnel.
Sections of the N. J. POLST Form

- Section A- Goal of Care
- Section B- Medical Interventions
- Section C- Artificially Administered Fluids and Nutrition
- Section D- Cardiopulmonary Resuscitation (CPR) and Airway Management
- Section E- Identification and authorization of a surrogate decision maker in the event that the individual loses decision making capacity, and who is the only person who is able to modify or revoke the N.J. POLST orders in consultation with the patient’s treatment physician or APN.
- Section F- Signature of the practitioner (MD/DO/APN) and the patient or surrogate
- Any section not completed indicates that full treatment should be provided for that type of treatment until clarification can be obtained.
Goals of Care

Even though this section does not constitute a medical order, it does prompt the medical provider to have a meaningful discussion with the patient about prognosis.
Medical Intervention

These orders apply to an individual who is breathing and/or has a pulse. Choose:

- **Full Treatment**: all life sustaining tx.
- **Limited Treatment**: hospitalized for medical tx but no invasive mechanical ventilation and ICU care. Some individuals may only want to be hospitalized for comfort care that can not be met at their current location.
- **Symptom Treatment**: goals are to maximize comfort and avoid hospitalization unless it is necessary to ensure comfort.

Additional orders: to clarify the individual’s preferences.
• Artificially Administered Fluids and Nutrition: these orders allow the individual to state whether they want artificial fluids or nutrition if they are unable to take food and fluids orally. Oral fluid and food must always be offered to the individual if medically feasible and desired.

• Cardiopulmonary Resuscitation (CPR) & Airway Management: orders only apply for cardiac arrest and/or respiratory arrest/distress.
  
  CPR: There are 2 boxes to check: Attempt Resuscitation/CPR or Do Not Attempt Resuscitation/DNAR. If neither box is checked then CPR is to be administered.
  
  Airway: Respiratory distress with a pulse. Intubate or Do Not Intubate
- Surrogate Designation: Can only be completed if the patient has decision making capacity. Under this section the individual can appoint someone to modify/revoke the POLST document.

- Signatures: Must be dated and signed by the physician (MD/DO) or the APN. Without their signatures of the MD/DO/APN the form is not valid.

- Anatomical gift: If checked on the POLST form only records an existing gift. The POLST form can not be used to make, or refuse to make an anatomical gift and will not change the terms of an existing anatomical gift.
Healthcare professionals should first follow the orders on the POLST form and then contact the physician/APN for further directions.
Frequently Asked Questions:
Why Was POLST developed?

- It was developed in response to seriously ill patients receiving medical treatments that were not consistent with their wishes.
- The goal is provide a framework in which medical professionals can provide care in accordance with the patient’s wishes.
Can it be changed?

- It can be modified or rescinded by a patient with decision-making capacity, verbally or in writing at any time. Changes can also be made by the patient’s legally recognized surrogate, if the patient has designed a surrogate via POLST, to make such modifications. Any changes should be made in collaboration with the patient’s physician or APN.
When should it be Reviewed?

When the following occurs:

- Transferred from one medical or residential setting to another.
- Significant changes in the patient’s health status or there is a new diagnosis
- If the patient’s treatment preferences change.
What happens if a POLST form is willfully ignored?

- Healthcare professionals who intentionally ignore a POLST form will be subject to discipline for professional misconduct.
- Hospitals and healthcare facilities will be subject to fines.
- Family members who willfully conceal, ignore, hide, forge, falsify or fail to disclose a valid POLST form are guilty of a crime in the fourth degree. If it leads to an earlier death of the patient then it is crime in the first degree.
POLST & Hospice

- Ask the patient if they have a POLST form. If so request a copy and read it over to learn the patient’s wishes.
- If the POLST form conflicts with Hospice philosophy or procedures, the hospice personnel should explain what the philosophy and procedures are.
- If the patient wishes to abide by his/her choices on the POLST form that conflict with Hospice then the patient should not be admitted.
- If the patient decides to change his/her choices then the hospice team should communicate those changes with the patient’s physician.
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

<table>
<thead>
<tr>
<th>Person Name (last, first, middle)</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>A</th>
<th>MEDICAL INTERVENTIONS: Person is breathing and/or has a pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Full Treatment. Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.</td>
</tr>
<tr>
<td></td>
<td>• Limited Treatment. Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.</td>
</tr>
<tr>
<td></td>
<td>• Transfer to hospital for medical intervention.</td>
</tr>
<tr>
<td></td>
<td>• Transfer to hospital only if comfort needs cannot be met in current location.</td>
</tr>
<tr>
<td></td>
<td>• Symptom Treatment Only. Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use Antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.</td>
</tr>
<tr>
<td></td>
<td>Additional Orders: ________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Defined trial period of artificial nutrition.</td>
</tr>
<tr>
<td></td>
<td>• Long-term artificial nutrition.</td>
</tr>
<tr>
<td></td>
<td>• No artificial nutrition.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>CARDIOPULMONARY RESUSCITATION (CPR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Person has no pulse and/or is not breathing</td>
</tr>
<tr>
<td></td>
<td>• Attempt resuscitation/CPR</td>
</tr>
<tr>
<td></td>
<td>• Do not attempt resuscitation/DNAR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>AIRWAY MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Person is in respiratory distress with a pulse</td>
</tr>
<tr>
<td></td>
<td>• Intubate/use artificial ventilation as needed</td>
</tr>
<tr>
<td></td>
<td>• Do not intubate - Use O₂, manual treatment to relieve airway obstruction, medications for comfort.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>If I lose my decision-making capacity, I authorize my surrogate decision maker. Listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No</td>
</tr>
</tbody>
</table>

Print Name of Surrogate (address on reverse)

<table>
<thead>
<tr>
<th>Phone Number</th>
</tr>
</thead>
</table>

### SIGNATURES:
I have discussed this information with my physician/APN.

<table>
<thead>
<tr>
<th>F</th>
<th>Signature.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Person Named Above</td>
</tr>
<tr>
<td></td>
<td>• Health Care Representative/Legal Guardian</td>
</tr>
<tr>
<td></td>
<td>• Spouse/Civil Union Partner</td>
</tr>
<tr>
<td></td>
<td>• Parent of Minor</td>
</tr>
<tr>
<td></td>
<td>• Other Surrogate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has the person named above made an anatomical gift.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Yes</td>
</tr>
<tr>
<td>• No</td>
</tr>
<tr>
<td>• Unknown</td>
</tr>
</tbody>
</table>

These orders are consistent with the person’s medical condition, known preferences and best known information.

PRINT - Physician/APN Name
Phone Number

Physician/APN Signature (Mandatory)
Date/Time

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED
References:
N.J. POLST : www.goalsofcare.org
National POLST  www.ohsu.edu/polst