

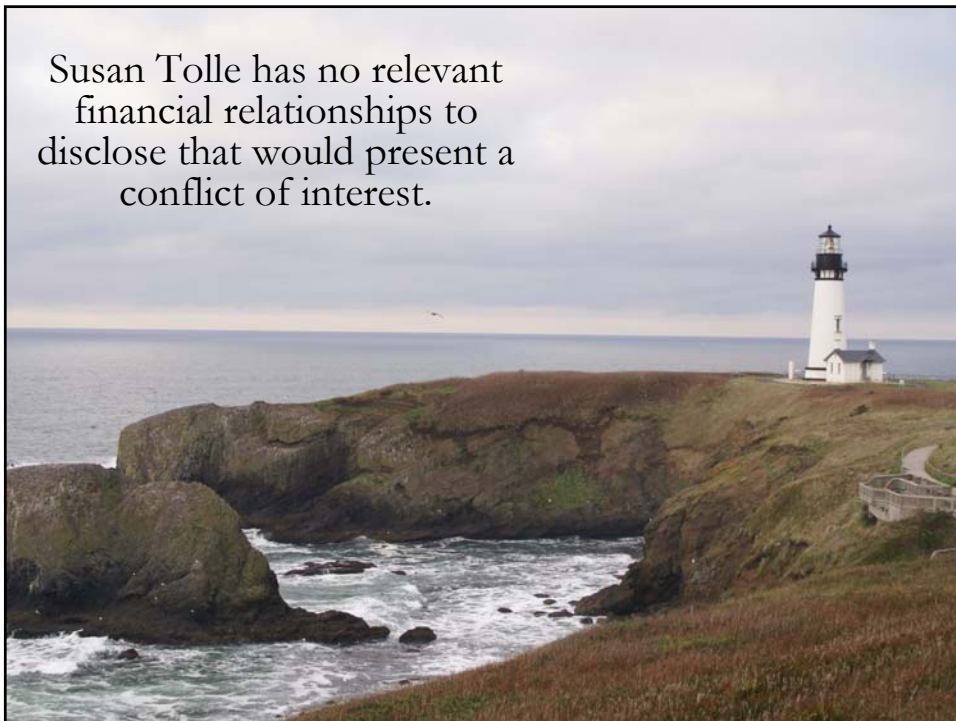
POLST:
Physician Orders for Life-Sustaining Treatment

Honoring Treatment Preferences Across Settings of Care

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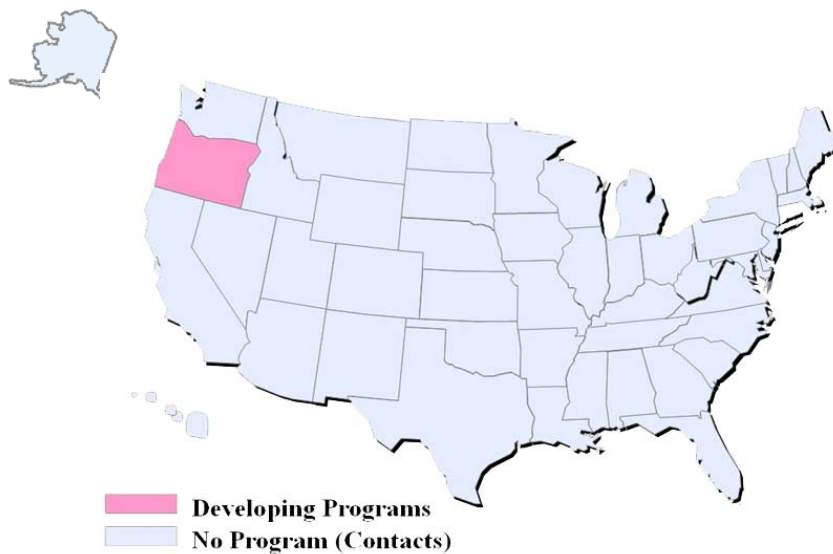
Susan Tolle has no relevant
financial relationships to
disclose that would present a
conflict of interest.

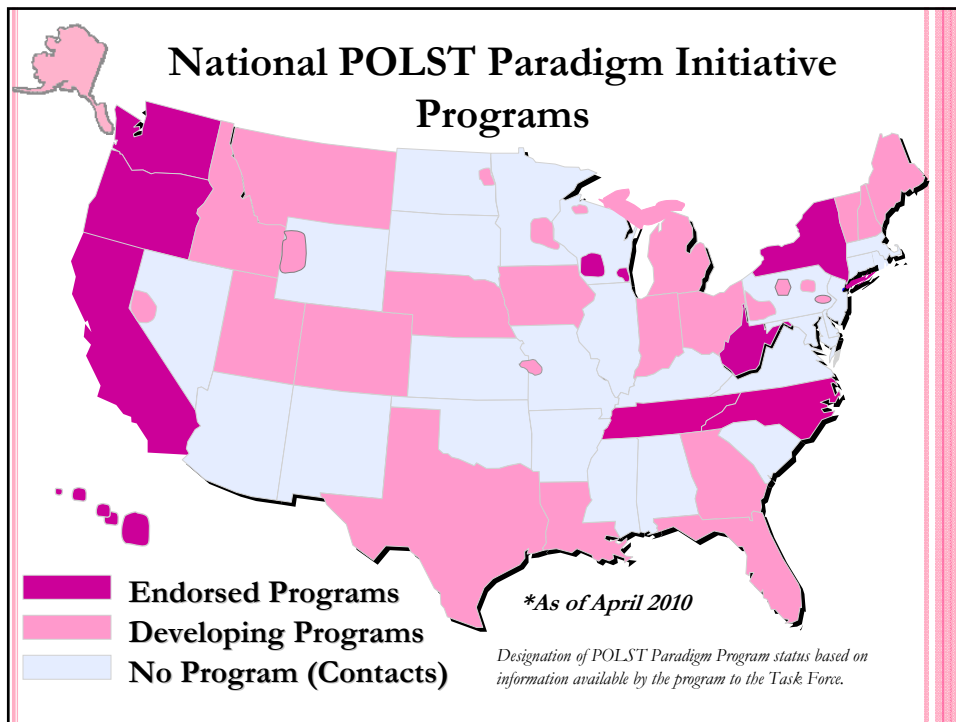


DIFFERENCE BETWEEN POLST & ADVANCE DIRECTIVE

	Advance Directive	POLST
For whom	For all adults to express preferences for <u>future</u> treatment	For persons of any age with advanced illness to guide <u>current</u> treatment
Purpose	To express values and to appoint a surrogate	Medical orders that turn a patient's values into action
Guide actions by emergency medical personnel	Usually not	Yes

POLST PARADIGM INITIATIVE 1990





EFFECTIVENESS DATA

POLST USE IN SNF 1996

0/180 NH residents with POLST orders of DNR/comfort measures only received CPR/ICU

5% died in acute care hospital

JAGS 46:1097-1102, 1998

EFFECTIVENESS DATA

OHSU PALLIATIVE CARE CONSULTATIONS 2004

- 183 discharged alive
- 5% died in an acute care hospital

Journal of Palliative Medicine, Volume 9, Number 4, 2006

EFFECTIVENESS DATA

DATA FROM MULTISTATE POLST NURSING FACILITY STUDY

Susan Hickman PI

90 facilities

3 states OR, WI, WV

1711 subject

In Press: 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

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)

Fill out these orders, then contact physician, NP, or PA. These medical orders are based on the person's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name / First / Middle Initial _____
Address _____
City / State / Zip _____
Date of Birth (mm/dd/yyyy) _____ **Last 4 SSN** _____ **Gender** M F

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
 Attempt Resuscitation CPR Do Not Attempt Resuscitation DNR (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in B, C and D.

B MEDICAL INTERVENTIONS: Person has pulse and is breathing.
 Comfort Measures 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. *Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if needed/possible cannot be met in current location.*
 Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital if indicated. Avoid intensive care.*
 Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*
 Additional Orders: _____

C ANTIBIOTICS
 No antibiotics. Use other measures to relieve symptoms.
 Determine use or limitation of antibiotics when infection occurs.
 Use antibiotics if medically indicated.
 Additional Orders: _____

D ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.
 No artificial nutrition by tube.
 Defined trial period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.
 Additional Orders: _____

E REASON FOR ORDERS AND SIGNATURES
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences as indicated by the discussion with:
 Patient Health Care Representative Surrogate for patient with developmental disabilities or significant mental health conditions (Note: Special requirements for completion. See reverse side.)
 Parent of Minor Court-Appointed Guardian
 Other _____

Print Primary Care Professional Name _____ **Office Use Only**
Print Signing Physician / NP / PA Name and Phone Number _____
 _____ () _____
Physician / NP / PA Signature (mandatory) _____ **Date** _____

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

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POLST IS ENTIRELY VOLUNTARY

- No one has to complete a POLST
- Choice to **have** or **limit** treatments
- Revoke or change at anytime
- Comfort measures are always provided

CULTURE CHANGE IN END OF LIFE

- Takes time
- Public education
- Health care professional education
- Policy & systems reform

NEW STANDARD OF END OF LIFE CARE

- Advanced care planning becomes the
norm
- Health professionals outraged when
system fails



POLST.org