

Background

POLST is an acronym that stands for Physician Orders for Life-Sustaining Treatment. POLST helps give seriously-ill patients more control over the medical treatment they receive. The POLST form guides discussions between patients, their families, their physician, and their healthcare team about treatment wishes in instances of serious illness. POLST transforms those wishes into physician orders, which are actionable and to be respected across the continuum of healthcare settings. Research shows that POLST helps to ensure that patients receive the treatments that they want, and do not receive treatments that they do not want.

POLST should not be introduced as a discussion about end-of-life care. POLST should be introduced as a discussion about possible serious illness.

POLST is voluntary for patients, but must be honored by healthcare providers

Filling out a POLST form is completely voluntary for patients and physicians. However, California law requires that the medical orders in a valid, completed POLST form be honored by healthcare professionals, and provides immunity from civil or criminal liability to those who comply in good faith with a patient's POLST requests.

POLST and the Advance HealthCare Directive

The POLST form complements an Advance Directive and is not intended to replace that document. An Advance Directive is still necessary to appoint a legal healthcare decisionmaker, and is recommended for all adults, regardless of their health status.

Completing and signing the POLST form

A POLST form can be completed and signed by any physician, nurse practitioner or physician assistant that has a treating relationship with the patient. This includes the Primary Care Physician, but could also include consulting physicians, hospitalists, physicians caring for the patient in a nursing home, and Emergency Department physicians. Knowledge of the patient's medical condition, prognosis, and capacity to make decisions is required, as well as a willingness to have an informed, collaborative discussion with the patient and/or decisionmaker.

Billing for completing a POLST form

Medicare and Medi-Cal now pay healthcare providers for advance care planning (ACP) discussions with beneficiaries under CPT codes 99497 and 99498. Authorization for Medicare payment is set forth in the November 2015 Final Rule, published by the Centers for Medicare and Medicaid Services (CMS). Information on Medi-Cal rates is published by the California Department of Health Care Services.

In order to be billable under Medicare, advance care planning discussions must be face-to-face conversations with Medicare patients and/or their surrogates (the patient does not need be present), and cover the patient's specific health conditions, their options for care and what care best fits their personal wishes, and the importance of sharing those wishes in the form of a written document.

The CPT manual defines an advance directive as a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Relevant legal forms include, but are not limited to, a Health Care Proxy, Durable Power of Attorney for Health Care, a Living Will and/or completion of a Medical Order for Life Sustaining Treatment (MOLST). The POLST form qualifies as a relevant legal form under this definition.

POLST for patients lacking capacity

A healthcare professional can complete the POLST form based on family members' understanding of their loved one's wishes. The appointed decisionmaker can then sign the POLST form on behalf of their loved one.

Modifying a POLST form

The POLST can be modified or revoked by a patient, verbally or in writing, at any time. Changes may also be made by a physician/NP/PA, or requested by a patient's decisionmaker, based on new information or changes in the patient's condition, and should be consistent with the patient's goals of care.

CPR/Full Treatment requirement

Cardiopulmonary resuscitation (CPR) is defined to include chest compressions **and** Advanced Cardiac Life Support Procedures, including intubation. If CPR is desired, then the full array of CPR procedures should be expected to be implemented. So if CPR is successful initially and the heart is revived, then it is highly likely that the patient will end up on a ventilator. A patient not willing to accept Full Treatment/ventilator treatment should not have CPR performed. The patient can choose

Full Treatment as a “Trial Period” not to be kept on life support if not expected to recover; then, if not recovering, ventilator treatment could be withdrawn in accordance with his/her wishes.

No CPR and Full Treatment rationale

“No CPR” represents a treatment decision that applies only to the specific situation of a complete cardiac arrest, where the patient is unconscious, has stopped breathing and has no heartbeat. CPR only applies when a patient has died. “Full Treatment,” in comparison, describes treatment that is rendered, if indicated, when patient is still alive and has a heartbeat. “Full Treatment” would be given when in respiratory arrest, where breathing has failed but the patient still has a heartbeat. The prognosis for cardiac arrest is significantly different than the prognosis for respiratory arrest, and it is essential to delineate these differences. “No CPR” and “Full Treatment” is a legitimate combination of Section A and B choices on the POLST form.

Full Treatment: Primary goal of prolonging life by all medically effective means

This is the appropriate selection for patients who wish to receive all available treatments designed to prolong life, including invasive medical procedures such as ICU care or major surgery. As noted above, a patient may choose “Full Treatment” AND “No CPR”.

Selective Treatment: Goal of treating medical conditions while avoiding burdensome measures

This medical intervention is the most complex category of treatment choices to understand. Patients choosing this treatment category generally are asking not to be treated with invasive medical procedures such as mechanical ventilators and major surgery, such as open-heart surgery. However, ICU care is not strictly prohibited. For instance, a patient who has chosen “Selective Treatment” could conceivably be treated in the ICU with intravenous vasopressors if transiently hypotensive, or with bi-level positive airway pressure (BiPAP) or similar respiratory interventions short of intubation, if such treatment is consistent with the patient’s goals of care. Similarly, surgery is not prohibited. Consider the case of acute cholecystitis – cholecystectomy may be an option if it can be performed with relative ease and low risk.

Based on empiric experience, the common thread as to what is considered “Selective Treatment” is based upon the risk of the proposed treatment and the predicted course. Patients who choose “Selective Treatment” are often communicating that they do not want treatment that will result in prolonged, difficult, uncertain recovery phases.

Comfort- Focused Treatment: Primary goal of maximizing comfort

This is an appropriate selection when patients wish to defer treatments for acute, potentially treatable illnesses (i.e., pneumonia) in favor of treatments focused on relieving discomfort and providing comfort. Comfort measures may include treatment other than pain medication. For example, in the case of a hip fracture, an operation is often performed in order to relieve pain. Without an operation, the patient with a fractured hip would likely have to endure prolonged and inadequately treated pain. Spiritual and psychosocial issues are important to be addressed.

Artificially Administered Nutrition

Feeding tubes and enteral nutrition are best discussed with patients using the terminology of "medically prescribed nutrition" or "artificial nutrition." This terminology emphasizes that enteral feeding is a medical treatment that has potential benefits and potential risks.

Medically prescribed nutrition has been shown to be beneficial in some very well defined situations, including head and neck cancers, and also in neurologic syndromes that disproportionately cause dysphagia. There are other situations where no benefit has been shown to providing medically prescribed nutrition. These include advanced dementia patients, or terminally-ill patients who are expected to die within days. There are definite risks associated with enteral feedings in these situations, including aspiration and fluid overload. Artificial nutrition does not generally add comfort to a terminally-ill patient.

The studies that are available suggest that most dying patients do not experience hunger pains. In the last days to weeks of life, many patients may force themselves to eat just to please family members. Their bodies and intestinal system cannot accept usual amounts of food and water. Artificial nutrition or fluids given by feeding tubes or intravenous lines often cause discomfort in dying patients, including nausea or abdominal pain. In the last days and hours of life, as the body is shutting down, food and fluids are not absorbed or metabolized. Administering fluids by tube or IV at this time may increase swelling and lung congestion, and cause additional discomfort to the patient.