FREQUENTLY ASKED CLINICAL QUESTIONS FOR PROVIDERS

Section 1: General Questions

- Why is it important that I help patients complete a POLST form?
- Does the POLST form replace traditional Advance Health Care Directives?
- Who can sign a POLST form as a legally recognized decision-maker?
- Are patients required to complete a POLST form?
- Who would benefit from having a POLST form?
- POLST Conversations
- Can the new Medicare ACP Codes be used for discussions about POLST?
- When is a good time to talk to patients about POLST?
- Can non-physicians help patients complete a POLST form?
- Is a POLST form only to be completed and signed by a patient's Primary Care Physician?
- What if a POLST form is not signed?
- Is a physician, NP or PA obligated to sign off on all POLST forms presented for signature?
- What happens when a patient completes a POLST, but then becomes incapacitated?
- Can you make changes to a POLST?
- What if more than one copy of POLST is found?
- I think my patients will think I've given up on them if I have this conversation. What can I do?

Section 2: Treatment Questions

- Why does choosing "Attempt Resuscitation/CPR" in Section A require "Full Treatment" in Section B to be selected?
- What does "No Code" mean? Is this the same as "No CPR" and "Do Not Attempt Resuscitation?"
- Why would someone choose "No CPR" in Section A and "Full Treatment" in Section B?
- Do people choose "Do Not Attempt Resuscitation" or "No CPR" only when they give up?
- If a patient chooses "No CPR" in Section A, does that mean they must also choose "Comfort-Focused Treatment" in Section B?
- Does "Comfort-Focused Treatment" mean that a patient must stop all other treatments and medications?
- Does "Comfort-Focused Treatment" include any medical treatments other than pain medications?

©2018 Coalition for Compassionate Care of California

- How does POLST help me understand what to do in situations other than a full cardiac and respiratory arrest?
- How long should "Full Treatment" be continued?
- How do we decide what "Selective Treatment" includes?
- My patient is dying, but the family thinks that the patient is "starving to death" unless a feeding tube is put in. What can I tell them?
- Do feeding tubes help advanced dementia patients?
- Are there any situations in which feeding tubes are effective?

Section 3: POLST in Different Settings

- To whom does "Request transfer to hospital only if comfort needs cannot be met in current location" in Section B apply?
- Is using POLST different in a SNF as compared to Assisted Living Facilities (ALFs) or Residential Care Facilities for the Elderly (RCFEs)?

©2018 Coalition for Compassionate Care of California

Section 1: General Questions

Why is it important that I help patients complete a POLST form?

POLST helps give seriously-ill patients more control over the medical treatment they receive. The POLST form guides discussions between patients, their families, and their healthcare team about treatment wishes in instances of serious illness. POLST is a tool to document those wishes as medical orders, which are actionable and respected across the continuum of healthcare settings. Research shows that POLST helps to ensure that patients receive the treatments they want, and avoid receiving treatments they do not want.

Does the POLST form replace traditional Advance Health Care Directives?

The POLST form complements an Advance Directive and is not intended to replace that document. An Advance Directive is still necessary to legally appoint a healthcare decision-maker, and is recommended for all adults, regardless of age or health status.

Who can sign a POLST form as a legally recognized decision-maker?

If a patient lacks decision-making capacity, a legally recognized decision-maker may sign the POLST form on behalf of the patient. The decision-maker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.

In the case of a patient who does not have a legally recognized decision-maker, the provider should comply with their facility's internal policies.

Are patients required to complete a POLST form?

POLST is a voluntary form. No one is required to complete a POLST form. A skilled nursing facility may use POLST as a part of their routine admission process; however, a resident cannot be required to complete a POLST form as a condition of admission to the facility. The facility may use an analogous form to document the residents' wishes. If the patient or family does not wish to sign such forms, it is assumed that they want the most aggressive measures to prolong or sustain life.

©2018 Coalition for Compassionate Care of California

Who would benefit from having a POLST form?

POLST is designed for seriously-ill patients, or those who are medically frail, regardless of age. A helpful tool for determining who would benefit from POLST is if you would not be surprised if they were to die within the next year. These patients are often in a state of irreversible decline. Medical treatment and interventions have only a very limited effect on extending life expectancy in this population, and some of these treatments and procedures may decrease quality of life and be considered by some to be medically futile. Helping these patients and their families anticipate future serious illness and understand and choose appropriate medical treatments is an important clinical responsibility when working with this patient population.

POLST Conversations

Having a conversation with a seriously ill patient about end-of-life issues is an important and necessary part of good medical care. Most patients are willing to discuss these issues – their healthcare providers simply have failed to ask them previously. POLST provides an excellent framework for guiding the conversation, making it easier to have the discussion, and therefore making it more likely that a patient will express his or her wishes.

The POLST conversation is a rich and meaningful discussion between a patient, their family, their physician, nurse practitioner (NP) or physician assistant (PA), and other members of their care team regarding specific treatment options and the patient's values and goals of care. A completed POLST form may be the outcome of the conversation, or it may be completed at a later time if there are still questions about the patient's treatment preferences.

POLST conversations occur in a variety of settings, including in the physician's office, during a family meeting at the acute care hospital, upon admission to a skilled nursing facility, or at home with hospice or home health. Some of these conversations are relatively brief, as many people know what they do or do not want. Other conversations may require more time or additional meetings.

The goal of having good POLST conversations with patients and families is to promote well-informed, collaborative decision-making.

©2018 Coalition for Compassionate Care of California

Can the new Medicare ACP Codes be used for discussions about POLST?

Yes. As of January 1, 2016, CPT codes 99497 and 99498 can be used to bill for advance care planning conversations between a physician or other qualified health care professional and a patient, family member, or surrogate, with or without completing relevant legal forms. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Physician Orders for Life-Sustaining Treatment (POLST).

When is a good time to talk to patients about POLST?

Patients are often more open to discussing their treatment wishes during serious illness than healthcare providers may think. Conversations about POLST can be incorporated into a number of situations.

Some opportunities to introduce POLST include:

- At the time a patient has been newly diagnosed with a serious or life-limiting illness
- As part of an annual examination
- When a family member accompanies a patient to an appointment
- After a patient has experienced a family member or close friend become seriously ill
- When a patient is transferred between care settings, including upon admission to and discharges from the hospital, admission to a skilled nursing facility and quarterly care conferences there, admission to an assisted living facility/residential care facility for the elderly, or an office follow-up visit after discharge from the hospital

Can non-physicians help patients complete a POLST form?

A POLST form is not valid until it is signed by a physician, nurse practitioner (NP) or physician assistant (PA) *AND* the patient (or decision-maker). Other healthcare providers, including nurses, social workers, and chaplains, may help explain the POLST form and guide patients in making treatment decisions, and then document those wishes on the POLST form. These providers should receive proper training in explaining the treatment decisions on the POLST form and communicating with patients and families about goals of care. It is important that the provider helping to complete the document with the patient or decision-maker write his/her name and work contact information on the back of the POLST form so that the physician/NP/PA may contact the provider if he/she has questions regarding the content of the completed POLST form before signing it.

If the POLST form is being completed by a healthcare provider other than the signing physician/NP/PA, the physician/NP/PA should sign only when he or she is confident that the

©2018 Coalition for Compassionate Care of California

form expresses an informed decision by the patient (or decision-maker). This process may be facilitated if the healthcare provider assisting the patient also provides documentation to the physician/NP/PA regarding details of their conversation with the patient (or decision-maker).

Is a POLST form only to be completed and signed by a patient's Primary Care Physician?

A POLST form can be completed and signed by any physician, NP, or PA that has a treating relationship with the patient. This includes the Primary Care Physician, NP or PA, 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 decision-maker.

What if a POLST form is not signed?

A POLST form requires the signature of a physician, NP or PA, *AND* the patient or their decision-maker in order for it to be valid. If either of these signatures is missing, then the legal protections afforded in AB 3000 are negated. If the patient signature is missing, then instructions on the POLST form do not have to be honored by Emergency Medical Services, or any other healthcare provider. If the physician/NP/PA signature is missing, the patient wishes expressed on the POLST form could be accepted as a statement of desired treatment.

Is a physician/NP/PA obligated to sign off on all POLST forms presented for signature?

A physician/NP/PA should not sign a POLST form if there is any concern that the form may not represent the informed choices of the patient or decision-maker, or if the physician/NP/PA feels the patient lacks capacity. It is the obligation of the physician/NP/PA to confirm or rectify the treatment wishes listed on the POLST form before signing. If the form does in fact represent the informed wishes of the patient or decision-maker, but the physician/NP/PA feels strongly that those wishes are medically inappropriate, the physician/NP/PA may also choose not to sign the form. It would be appropriate in this situation for the physician/NP/PA to discuss with the involved parties why he/she is choosing not to sign the POLST.

©2018 Coalition for Compassionate Care of California

What happens when a patient completes a POLST, but then becomes incapacitated?

The decision-maker for the patient and the treating physician/NP/PA should honor the patient's previously expressed wishes unless there is new information that the patient's wishes have changed. If the patient's condition changes, then a re-evaluation of POLST orders may be appropriate, taking into account the patient's previously expressed wishes.

Can a POLST form be changed?

A patient with decision-making capacity can request alternative treatment at any time. If a patient lacks capacity, his/her decision-maker can request to modify the orders, in collaboration with the patient's physician/NP/PA, based on the known desires of the patient, or if unknown, the patient's best wishes. In considering changes, the treating physician/NP/PA should evaluate the patient's current condition, the patient's previously stated wishes, and the likely medical outcomes. If a new POLST is created, the old POLST should be marked "VOID," signed and dated.

What if more than one copy of POLST is found?

The most recently dated POLST is considered to be the valid POLST.

I think my patients will think I've given up on them if I have this conversation. What can I do?

POLST should not be introduced as a discussion about end-of-life care, but instead about possible serious illness and a way to identify what treatments a patient wants or doesn't want. Sometimes, stating that this is a topic you discuss with all patients with medical conditions similar to theirs can make it seem less threatening. POLST is a tool that enables patients to be informed about treatment choices available to them and provides a way to direct their healthcare providers.

©2018 Coalition for Compassionate Care of California

Section 2: Treatment Questions

Why does choosing "Attempt Resuscitation/CPR" in Section A require "Full Treatment" in Section B to be selected?

Cardiopulmonary resuscitation 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 primary goal of full treatment is prolonging life by all medically effective means. The patient can choose to have Full Treatment as a "Trial Period," and if not doing well, then ventilator treatments could be withdrawn.

What does "No Code" mean? Is this the same as "No CPR" and "Do Not Resuscitate?"

This is a subject that is frequently confused because in many institutions the phrases "No code," "No CPR," and "DNR" are used differently by different staff.

"No CPR" and "DN(A)R" are terms that should be used specifically in the case of full cardiac arrest in which there is no circulation (i.e., ventricular fibrillation, asystole, pulseless electrical activity). "No code" can be ambiguous. In many hospitals, the phrase "call a code" is used in any situation in which a patient requires immediate, emergent attention. This includes cardiac resuscitation as described above, but in these institutions, "call a code" may also refer to other situations such as sudden respiratory distress, hypotension, cardiovascular instability, or syncope.

Case example: a patient is admitted to the hospital and has completed a POLST which indicates "DNR" in Section A (no resuscitation in case of cardiac arrest) and "Full Treatment" in Section B (meaning, employ aggressive treatment measures, including intubation and mechanical ventilation if necessary, in all situations other than cardiac arrest). A nurse comes upon this patient who is now suddenly in extreme respiratory distress. In this hospital, "call a code" would bring immediate help. However if the nurse assumes that the POLST "DNR" means "no code," and does not call for help, then the patient will not receive the treatment that was desired and specified in POLST Section B.

The prognosis for cardiac arrest (addressed in Section A of POLST) is significantly different than the prognosis for respiratory arrest (addressed in Section B of POLST), and it is essential to delineate these two scenarios. Usage of the term "Code/No Code" should be discouraged

©2018 Coalition for Compassionate Care of California

because of the potential for misinterpretation, and distinct and separate orders regarding "CPR" and "Intubation" should be made on the physicians orders form. Appropriate examples may be: "DNR/DNI", or "DNR/Intubation OK".

Why would someone choose "No CPR" in Section A and "Full Treatment" in Section B?

"No CPR" represents a treatment decision that applies only to the specific situation where the patient is unconscious, has stopped breathing and has no heartbeat – i.e., a complete cardiac arrest, or a natural death. "Full Treatment," in comparison, describes treatment that is rendered, if indicated, when a 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.

Do people choose "Do Not Attempt Resuscitation" or "No CPR" only when they give up?

A "Do Not Attempt Resuscitation" choice in Section A indicates specifically not to institute CPR measures in the case of cardiac and respiratory arrest (patient has no pulse and is not breathing). It is not pertinent to any other situation, and does not indicate treatment wishes for any other situation. Patients need to be reassured that choosing "Do Not Attempt Resuscitation" in Section A does not mean "No Treatment."

If a patient chooses "No CPR" in Section A, does that mean they must also choose "Comfort-Focused Treatment" in Section B?

A patient who chooses "Do Not Attempt Resuscitation" in Section A of the POLST form can choose "Comfort-Focused Treatment," "Selective Treatment," or "Full Treatment" in Section B. DNAR represents a treatment decision that applies only to the specific situation where the patient has no heartbeat and has stopped breathing – i.e., a complete cardiac and respiratory arrest, or a natural death. The "No CPR/DN(A)R "designation in Section A does not specify what treatment should be rendered in situations in which the patient still has a heartbeat. A person who chooses "Comfort-Focused Treatment" with the primary goal of maximizing comfort is generally refusing curative treatment when new, life-threatening, serious problems arise.

Does "Comfort-Focused Treatment" mean that a patient must stop all other treatments and medications?

©2018 Coalition for Compassionate Care of California

A patient who has indicated "Comfort-Focused Treatment" should not necessarily have all other treatments and medications stopped. Treatments and medications that are currently being given to the patient should be re-evaluated to determine whether they are creating an undue burden on the patient or otherwise no longer fit in with the overall goals of care. If so, consideration can be given to stopping these treatments or medications.

Does "Comfort-Focused Treatment" include any medical treatments other than pain medications?

Comfort 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. So, invasive treatments can be looked upon as being a part of a treatment plan that is focused upon providing comfort for a patient. Continuing routine medications, unless they are burdensome to the patient, is often appropriate. Periodic re-evaluation of routine medications and discussion with the patient and family is important.

How does POLST help me understand what to do in situations other than a full cardiac and respiratory arrest?

The POLST form, completed properly, contains a wealth of information regarding patient wishes for treatment. Every potential medical treatment cannot be listed on a POLST form for a patient to accept or decline, and nuances of every complex clinical scenario cannot be captured on the form, but POLST can help identify desired treatments by clarifying what is desired, and what is not. Patients who do not want artificial nutrition may be telling us that they do not want treatments that keep them alive in a debilitated, dependent condition. Patients who choose "Selective Treatment" may be indicating that they are fearful of treatments that are painful or invasive, may cause further debility and involve long recovery times, and that have a low chance of success. Patients who choose "Full Treatment" should be informed about trial periods – if the treatment does not result in a good recovery, should it be continued? Another example of when a person might want a trial period of Full Treatment is a person in renal failure who wants to try dialysis for a period of time. POLST helps to understand patients goals of care – then decisions can be made if particular treatments will help achieve those goals of care or not.

How long should "Full Treatment" be continued?

If a patient chooses "Full Treatment" in Section B, consider asking the patient, "What should be done if those treatments are not working after a period of time? If you are on life support, not getting better, and the doctor believes that you will not make a good recovery, should invasive

©2018 Coalition for Compassionate Care of California

treatments be continued? Continued treatment often means more complications, a longer stay in the intensive care unit, and any recovery is looking less certain and more difficult."

Patients may want invasive treatments to be initiated, but may not want treatment continued if the chances of recovery are uncertain and difficult. A patient that expresses this concern can check the box, "Trial Period of Full Treatment" in Section B to specify that these treatments should be undertaken as a "Trial Period" so that their progress can be assessed and decisions be made in view of their progress.

How do we decide what "Selective Treatment" is?

Section B "Selective Treatment" is the most complex category of treatment choices to understand. The goal statement for "Selective Treatment" is the goal of treating medical conditions while avoiding burdensome measures. 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/ventilation. 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 surgery and the predicted postoperative course.

Patients who choose "Selective Treatment" are often communicating that they do not want treatment that will result in prolonged, difficult and uncertain recovery phases.

My patient is dying, but the family thinks that the patient is "starving to death" unless a feeding tube is put in. What can I tell them?

Some people fear that not providing a feeding tube at the end of life means they are letting their loved one "starve to death." This is not true. When a dying person's body begins to shut down, the body may be unable to adequately use nutrients that artificially administered nutrition would provide, and the chance for bloating and discomfort increases. 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 increases edema and pulmonary congestion, causing additional discomfort to the patient. Death related to dehydration with progressive hypovolemia and hypotension is generally considered (and clinically observed) to be a peaceful and natural way to die. In the last days to weeks of life, many patients may force themselves to eat just to please

©2018 Coalition for Compassionate Care of California

family members. Helping families understand these facts may help them come to terms with a decision not to use artificial means of nutrition, including feeding tubes.

Do feeding tubes help advanced dementia patients?

Studies suggest that when patients are no longer able to eat adequate amounts of food and water because of dementia, artificial nutrition through feeding tubes may not be an effective treatment. In these studies, patients lived equally long whether they were continued to be assisted by hand feeding or if a feeding tube was inserted. Patients who have feeding tubes inserted may continue to suffer from aspiration pneumonia. Recent studies have demonstrated an increased risk of pressure ulcers in patients who are fed via gastrostomy tubes. Though there may not be a difference in medical outcomes between artificial nutrition through feeding tubes and assisted feeding techniques, many feel that the social interaction and touch that occurs with hand feeding leads to a higher quality of life. These situations can be difficult and are best approached individually as a patient-centered decision that addresses patient values, religious values, and family concerns.

Are there any situations in which feeding tubes are effective?

There are medical situations in which feeding tubes are a useful part of a medical treatment plan. Feeding tubes may be useful after otolaryngology procedures that cause temporary swallowing disability. Some patients with amyotrophic lateral sclerosis (ALS) elect feeding tubes and it does extend their life. A patient who has suffered a stroke, in which the main deficit is dysphagia where recovery seems possible, may be helped with artificial nutrition by tube. In the population for which POLST is designed though, a severe stroke usually has a poorer chance of recovery.

©2018 Coalition for Compassionate Care of California

Section 3: POLST in Different Settings

To whom does "Request transfer to hospital only if..." in Section B apply?

"Request transfer to hospital only if comfort needs cannot be met in current location" in Section B was instituted as an acknowledgement of patients being cared for in the skilled nursing facility (SNF) setting who may want Selective Treatment at the facility, but do not want to be transferred to the acute care hospital. An example would be a resident of a SNF where IV treatments are available who wants treatment for a severe infection to be given there in the facility, rather than undergoing the burden of being transported, evaluated, and treated in the emergency department and acute care hospital.

Is using a POLST different in a SNF as compared to assisted living facilities (ALFs) or residential care facilities for the elderly (RCFEs)?

The main difference arises in emergency situations in which POLST-directed treatment may need to be implemented. ALFs/RCFEs are not healthcare facilities and as such generally don't have licensed healthcare providers on staff, and do not have emergency pharmaceuticals available. For example, a patient who has chosen "Comfort-Focused Treatment" with a sudden change in condition may require morphine. If that patient is a resident of a SNF, the patient will likely be able to have treatment instituted without having to go to the emergency room. If the same situation develops with a resident in an ALF/RCFE who is not under hospice care, it is unlikely that morphine can be obtained immediately. The patient may need to be transferred in order to be evaluated, and have appropriate comfort treatments coordinated and instituted.

The Coalition for Compassionate Care of California wishes to thank Jeffrey Yee, MD, of Woodland Healthcare, for helping to develop the content for this document.

©2018 Coalition for Compassionate Care of California