University of Minnesota
Center on Aging

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Minnesota’s Physician Order for Life Sustaining Treatment in Rural Minnesota
http://www.polstmn.org

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Learning Objectives

To be able to:

- Describe the purpose of the POLST

- Identify infrastructure considerations and training issues in implementing the POLST

- Discuss how to effectively work with EMS in utilizing the POSLT

National POLST Effort

- Led by Oregon

- The National POLST Paradigm Initiative Task Force

- Endorses State initiatives
**MN POLST History**

- Considered since 1990’s
- MMA Ethics Comm. Considered ~ 2006
- POLST Task Force – 2007-09
- Implemented by MN health systems - 2010
- Endorsed by EMSRB, MMA, and others

**POLST Task Force**

- Sponsored by MMA
- Open to anyone interested
- Invites to those participating in national POLST teleconferences
- Representatives from:
  - Medical, nursing, health law, hospice, EMS
  - Metro and outstate
- Started from tools used by Allina and Echo
**Purpose of POLST in MN**

- Substitutes for consent when patient unable to communicate preferences
- Communicates from medical provider to EMS, ER, nursing and other doctors
- Allows RNs, EMS, & doctors to act on patient preferences
- Informs until AD or agent can be consulted

**In Minnesota, POLST Is NOT**

- A contract
- Defined in statute
- Binding from one doctor to another
- Unchangeable
- An order of a legal court
Target for POLST

- For those in last 1 - 2 years of life
  - all hospice enrollees
  - long-term nursing residents
  - assisted living facility residents
  - other high-risk institutionalized populations

MN POLST Tool

Section A:

- Only applies if no pulse
- DNR/Allow Natural Death includes withholding external defibrillator
**MN POLST Tool**

Section B: Goals of care statements

- Who to call if avoiding 911 (or transport)
- Allows preference to remain at home if comfortable, including unresponsive
- Allows transport, but preference to return home if can be comfortable
  - Non-surgical trauma
  - W/U for stroke, MI without plan for hospital treatment
- Allows preference for intubation or not

**MN POLST Form**

- Section C: not relevant for EMS
  - Antibiotics
  - Hydration
  - Nutrition

If plan includes transport, would always use IV per protocols for management of BP and med administration
**MN POLST Form**

**Authorized Signatures:**

- MD/DO
- Nurse Practitioner
- Physician Assistant

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**MN POLST Form**

**Section D:**

- Discussed with:
- The basis for these orders is:

Allows assessment of validity and legal implications

If named legal proxy present, appropriate to allow him/her to change preferences / revoke POLST
Reverse Side Signatures

• Required:
  – Person completing (e.g. MD/RN/SW/Chaplain)

• Optional:
  – Patient/Surrogate
    • Ethically and legally not required
    • Some institutions (e.g. hospitals do require, however)

USING POLST in Minnesota
Location of Death Among Minn. Residents – 1999 – 2009
Decline in NH, increase at home

Health Care Directive

- Minnesota Statute 145C.11

- Combines Durable Power of Attorney for Health Care and “Living Will”

- Communicates preferences from patient to health care provider

In MN, HCD is any paper, signed and witnessed X 2 or notarized
**Health Care Directives (HCD) and POLST**

- If POLST completed based upon HCD, medical provider has legal protection when preferences honored.

- If patient “competent”, do both (esp. if L.E. < 2 yrs)

- Without HCD, POLST clarifies and communicates – but not legally protective

**Before ACP discussion**

- Decide when to have discussion
- Review copy of HCD
  - Determine if a health care agent has been appointed with authority to make health care decisions, and if there are any limits to that authority
- Assess patient decisional capacity
  - Assess ability to express preferences
  - If can only express preferences but not make complex decisions, complete HCD for naming of surrogate decision maker
**What is CPR**

- Cardio-pulmonary resuscitation
- Includes defibrillation (shock to heart)
- Outside of drowning, term used for response to absent pulse
- Intermittent pressure on chest to distribute blood to brain
- Requires defibrillation or drugs to be effective
- Usually requires intubation
- Always requires ER evaluation

**CPR - Prognosis**

- NH patients (114) vs. Community (228), matched
- Survival to hospital discharge ~10% each group
- Asystole or electromechanical dissociation as an initial rhythm – survival 2%

In NH- Post CPR Survival*
- Witnessed 3/24 (13%)
- Un-witnessed 0/13 (0%)

Ghahri, J AGS. 1995 May;43(5):587-8

* Only 33% of charts had witness status
Hospitalization

- What can be done at hospital that can’t be done at nursing home:
  - Urgent MD evaluation
  - Surgery
  - CT / MRI scan
  - Suture, casting for fracture
  - ICU care
  - Self-harm prevention (psychiatric)
  - ? IV, Nasogastric

- ? Survival benefit to hospitalization if none of the above

- Hospital increases risk of falls, agitation, loss of function

Other Issues in ACP / POLST

- True indications for hospitalization

- Varied circumstances related to intubation

- Survival with feeding tubes
**Descriptive Language for Intubation**

Insertion of plastic tube through mouth into windpipe (trachea)

Attachment of bag or breathing machine (respirator) to tube to push air into lungs

Tube can stay in throat for weeks

Patient usually requires sedation

If long-term support for breathing, can use tube directly into neck (tracheostomy), which does allow talking and eating.

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**Prognosis with Intubation**

• Depends on underlying disease

• Good - If acute underlying illness treatable, good

• Poor - If respiratory failure due to progression of chronic illness (e.g. COPD, ALS)
Feeding Tubes

- **Nasogastric**
  - Can be inserted at NH
  - Short term use only in non-agitated patient (e.g. acute stroke)

- **Percutaneous gastrostomy**
  - Radiology (change q 3 months)
  - Gastroenterology (change prn only)
  - Well tolerated

Feeding Tubes in Swallowing Disorders (S.D.)

- MDS files
- Patients who lost ability to feed self and S.D.
- 3 states, 1 year survival
  - Without feeding tubes: 39%
  - With feeding tubes: 50%
- Multivariate results feeding tubes reduced risk of death by 29%
  (risk ratio, 0.71; 95% confidence interval, 0.59, 0.86)

Feeding Tubes Use and Prognosis in Advanced Dementia

- MDS and Medicare file review
- Patients with Advanced Dementia dx
- The incidence of feeding-tube insertion was 53.6/1000 residents/year
  - (Between 2 and 11/1000 in MN)
- 68% feeding-tube insertions at hospital
- One year post-insertion mortality was 64.1%.
- Median survival of 56 days.
- No evidence of benefit to nutrition, reduced aspiration or survival


145C.11 IMMUNITIES.

Subdivision 1. Health care agent.

- A health care agent is not subject to criminal prosecution or civil liability if the health care agent acts in good faith.
**Competency Assessment Process**

- Principal of See one, Do one
- Careful observation is part of training
- Being observed is assurance to facility and to POLST prescriber/signer
- Passing score up to program recommend no more than one item “Partial or Not Done” per category

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**POLST Competency Assessment Tool**

**Communication**
- Private space for discussion
- Seated
- Eye contact made
- Communication of empathy (e.g., understanding difficulty of issue or situation)
- Non-verbal empathy (e.g., leaning forward, touching, nodding)

**Content**
- Explains POLST purpose
- Explains CPR options
- Explains hospitalization issue
- Explains feeding issues
- Non-judgmental and unbiased
- Assures NH will address comfort, regardless of plan

**Procedure**
- Reviews EOL or advance decisional capacity
- Checks boxes for POLST process appropriately
- Writes name, facility, and date

**Other Comments**

Employee Name: 

Date: 

Observer Name: 

MAGEC
Message, Assist, Educate, Guide
145C.11 IMMUNITIES.
Subd. 2. Health care provider

(a) With respect to health care provided to a patient with a health care directive, a health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider acts in good faith and in accordance with applicable standards of care.

[POLST can summarize a health care directive]

145C.11 IMMUNITIES.
Subd. 2. Health care provider

(b) A health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider relies on a health care decision made by the health care agent and the following requirements are satisfied:

[POLST can summarize agent’s decision]
145C.11 IMMUNITIES.
Subd. 2. Health care provider

- (1) the health care provider believes in good faith that the decision was made by a health care agent appointed to make the decision and has no actual knowledge that the health care directive has been revoked; and
- (2) the health care provider believes in good faith that the health care agent is acting in good faith.

[POLST documents agent’s role]

145C.11 IMMUNITIES.
Subd. 2. Health care provider

- (c) A health care provider who administers health care necessary to keep the principal alive, despite a health care decision of the health care agent to withhold or withdraw that treatment, is not subject to criminal prosecution, civil liability, or professional disciplinary action if that health care provider promptly took all reasonable steps to:

[POLST doesn’t exclude life sustaining Rx, when any doubt about appropriateness]
145C.11 IMMUNITIES.

Subd. 2. Health care provider

• (1) notify the health care agent of the health care provider's unwillingness to comply;
• (2) document the notification in the principal's medical record; and
• (3) permit the health care agent to arrange to transfer care of the principal to another health care provider willing to comply with the decision of the health care agent.

[EMS notification of agent likely deferred to ER staff]

Implementing POLST in Non-urban Communities

Barriers:
• Limited palliative care expertise
• Limited financial incentives for POLST program development
• Lack of history in POLST development
• Multi-level EMS response teams
• Out-of-state health system ownership (e.g., Sanford)
Implementing POLST in Non-urban Communities

Success Factors:

- Limited number of organizations
- Trusting relationships relatively likely
  - Provider-provider
  - Provider-patient/family
- Motivation
  - Aging population
  - Distances to hospitalization

Promoting POLST with Health Care Providers

- Hospice
- Nursing home(s)
- Assisted Living
- Emergency medicine
- Primary Care providers
- Hospital(s)

Often key is having physician champions
**Working with EMS**

- Start with EMS medical director
- Use endorsement of EMSRB
- Justify with measurable outcomes
  - Reduced calls to NH and ALF
  - Reduced non-beneficial transports
- Request policy and procedure update related to POLST
- Training for first responders, ambulance services and ER staff

**Summary of Law for EMS**

- EMS staff must follow its medical director’s and organization’s policies and protocols
- If local EMS policy allows acceptance of orders on a POLST:
  - responder can withhold life-sustaining Rx, if so ordered
  - responder can defer transport if patient comfortable, if so ordered
  - responder can override POLST to save life, if there is doubt about POLST or preferences
Summary

• After long wait, MN has POLST

• POLST complements HCD near the end of life to help honor patient preferences

• Barriers to implementation can be overcome

• More info available at http://www.polstmn.org and www.coa.umn.edu/magec/polst