Advance Care Planning and POLST for our ACOs

“A Team Approach to End-of-Life Care Conversations”

Jim Barr, MD
Peter Bolo, MD
Tom Kloos, MD

If not using the Zoom meeting audio, please connect via 877-860-3058 and code 9739717499#
ACO ACP/POLST Learning Module Objectives

- For PIIP-eligible practices, part of the 3rd Qtr, 2016 PIIP application (submit the module quiz with your PIIP application)

- Important for all providers and clinical staff to learn!!
  - Learn how to incorporate Advanced Care Plans (ACP) and Practitioner Orders for Life Sustaining Treatments (POLST) into your office workflows

- Future ACO reports to include a “POLST Patient List” (similar to the ACO High Risk Patient List)

- The module will be recorded. All documents, the powerpoint and recording will be available on the ACO website www.atlanticaco.org > Provider Login > Resources > scroll down toward bottom

NAME OF PRESENTATION IN ALL CAPS (INSERT IN FOOTER)
WHY End-of-Life Care Planning Conversations?

BECAUSE:

This is a critical Population Health initiative which meets the Triple Aim:

- Improving QUALITY thru better understanding of patient preferences
- Increasing SATISFACTION thru patient input into dying process…also helps families to mourn better
- Decreasing COST thru reduction of potentially excessive, futile, or traumatizing medical interventions
WHY End-of-Life Care Planning Conversations?

BECAUSE:
There is growing public interest in End-of-Life Care Planning:

- Atul Gwande’s book *Being Mortal* was on the NY Times Best-seller list throughout 2015
- 90% say it’s important to discuss their end-of-life preferences with family…but only 30% actually do
- 82% say it’s important to put their end-of-life preferences in writing…but only 23% actually do
- 80% say they should speak with their doctor about their end-of-life preferences…but only 7% actually do
- 70% say they wish to die at home…but 70% actually die in a healthcare facility
Why End-of Life Care Planning Conversations?

BECAUSE:
Life expectancy has increased steadily such that many of us live into our 90s and beyond:

- For some, the burden of poor quality of life, chronic pain, and/or multiple losses are undesirable
- Advancing medical technology prolongs the dying process when preference may actually be to allow natural progression of illness, if this option were offered
WHY End-of-Life Care Planning Conversations?

BECAUSE:

The Institute of Medicine identified planning for End-of-Life Care as one of the most pressing areas needing improvement in healthcare in their 2014 report, *Dying in America*
WHY End-of-Life Care Planning Conversations?

BECAUSE:

**CMS** (Center for Medicare and Medicaid Services) recognizes the importance of Advance Care Planning and has begun **reimbursing** doctors for these conversations in 2016.
WHY End-of-Life Care Planning Conversations?

BECAUSE:

New Jersey ranks #1 (worst) in the Dartmouth Atlas for healthcare spending in the last 6 months of life amongst all 50 states…with evidence suggesting that higher spending is not translating to better quality of care or clinical outcomes.
WHY End-of-Life Care Planning Conversations?

BECAUSE:

- Over 60% of patients who die at an AHS hospital spent time in ICU during their last admission, compared to 30-40% nationally

- Many patients may have opted out of some aggressive treatments if choices had been presented earlier
GOALS

**Identify** appropriate patients for Advanced Care Plans and POLST planning;

Use a **team** approach to engage patients in the process;

Team includes: ACO Practice Clinical Coordinator, PCP or Specialist, Patient/Family/Caregiver, others;

**Incorporate** patient preferences in End-of-Life Care Planning;

This becomes part of the High Quality **routine care** we provide.
APPROACH: 4 Steps

Step 1
- Identify the patient population for ACP and POLST

Step 2
- Clinical Coordinator completes Advance Care Planning (ACP) Worksheet with patient/family and schedules provider follow-up appointment/discussion for the conversation

Step 3
- Patient completes homework (“End-of-Life letter”)

Step 4
- PCP and patient/family meet, review homework, discuss and complete ACP and POLST form if indicated
Step 1 (Identify)

Patient Selection Criteria

- Consider patients on the ACO High Risk Patient List (*Practice Clinical Coordinators*)
- ACO will provide “POLST Patient List” in future
- Advanced Care Plans
  - All patients over age 18 a health care proxy discussion
  - Consider Living Will and Proxy for all annual wellness visits
- POLST for …

Identify who within your practice workflows will initiate and manage the process
Step 2 (Worksheet)

ACP Worksheet Completed by practice Clinical Coordinator or other practice clinical staff with Patient/Surrogate

- **Question #1**
  *Do you have an Advance Care Plan that helps us know what your preferences are for medical treatments should you become very sick? CHECK ONE: YES___ NO___*

- If “YES” please indicate *which type of document* (may have more than one):
  ___Living Will (Instructional Directive)
  ___Durable Power of Attorney for Healthcare (Proxy Directive)
  ___POLST Form

  Ask: *Do we have a copy in your chart here? CHECK ONE: YES___ NO___*
  If “NO” please request a copy for the chart
  If “YES” proceed to Question #2

- If “NO” proceed to Question #2
Step 2 (Worksheet)

- **Question #2**
  Many people find it helpful to discuss their overall goals and preferences with their doctor—even if already written down—to clarify specific wishes and to discuss the benefits versus burdens of certain medical treatments that may be automatically-provided should you become very sick. We recommend that you have this type of conversation with your doctor. Are you willing? CHECK ONE: YES____ NO____

- If “YES” then:
  Let me arrange a time to discuss this further with your doctor. I will give you some material to help you prepare for this meeting (educational information given)

- If “NO” proceed to Question #3
Step 2 (Worksheet)

- **Question #3**

I would like to give you some information about Advance Care Planning and how it can help your medical team, family, and caregivers insure you get the kind of medical care you prefer should you become very sick. Okay? CHECK ONE: YES___ NO___

- **If “YES” then**

After you read this, I strongly recommend you speak with your doctor and family. I will call in a few days to see if I can help schedule an appointment for you or help with any questions.

- **If “NO” then**

Thank you for your time. Please contact me if you wish to discuss this in the future.
End of Step 2

- Worksheet completed. Existing ACP documents are placed in the patients chart.

- Patient given “Prepare For Your Care” or “Your Life Your Wishes” or other educational information on advanced care planning. Those willing to discuss/review with their provider are scheduled for an appointment.

- Patients appropriate for POLST also given the “End of Life Letter” (this name will be revised) to complete and bring back to discuss at a visit with their provider (Step 3).
Step 3 (POLST Homework)

- Patient/surrogate completes “End-of-Life Letter” at home

- PCP (APN) reviews letter with the patient/surrogate in the follow-up appointment…

  “I’d like to spend a few minutes speaking with you (and your family member/surrogate) about your medical condition and what your preferences are for your care going forward. Many people appreciate being able to talk about medical procedures they would or would not like done for them should they become very ill, as well as what their priorities in life are at this point. I appreciate your taking the time to write an “End-of-Life” Letter. By law in NJ, if we write your wishes down on a POLST form they must be honored. If not, and you are brought to an ER or hospital very ill and—in many cases—confused and not able to communicate, then procedures can be performed whether you would have preferred them or not. Is it okay for us to continue and write a POLST form together?”
POLST: The “Green Form”

- POLST is a set of medical orders that help give seriously ill or frail patients more control over their end-of-life care. It is recommended for those patients who are thought to have a prognosis of 1 year or less.

- Produced on a distinctive green form and signed by both the doctor/APN and patient/surrogate, POLST specifies the types of medical treatment that a patient wishes to receive toward the end of life. As a result, POLST can prevent unwanted or medically ineffective treatment, reduce patient and family suffering and help ensure that patients’ wishes are honored.

- New Jersey law requires that medical orders contained in a POLST be followed by healthcare professionals and provides immunity from civil or criminal liability to those who comply in good faith with a patient’s POLST.
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.

Person Name (last, first, middle) ______________________________ Date of Birth ________

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

B MEDICAL INTERVENTIONS: Person is breathing and/or has a pulse
- 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.
- 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.
  - Transfer to hospital for medical interventions.
  - Transfer to hospital only if comfort needs cannot be met in current location.
- 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.

Additional Orders: ________________________________

C ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:
- Always offer food/liquids by mouth if feasible and desired.
- No artificial nutrition.
- Defined trial period of artificial nutrition.
- Long-term artificial nutrition.

D CARDIOPULMONARY RESUSCITATION (CPR)
- Person has no pulse and/or is not breathing
  - Attempt resuscitation/CPR
  - Do not attempt resuscitation/DNAR
  - Allow Natural Death

E If I lose my decision-making capacity, I authorize my surrogate decision maker noted below to modify or revoke these NJ POLST orders in consultation with my treating physician/APN:
- Health care representative identified in an advance directive
- Other surrogate decision maker

Print Name of Surrogate (address as on reverse) __________________________ Phone Number ________

F SIGNATURES:
- I have discussed this information with my physician/APN.
  Signature __________________________
- Has the person named above made an anatomical gift:
  - Yes
  - No
  - Unknown

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

PRINT - Physician/APN Name __________________________ Phone Number ________

1/17/14

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

1  2
Step 4 (POLST)

PCP (APN) discusses and completes a POLST form with Patient (or surrogate)

- **Section A, Goals of Care:**
  Ask: “What is most important for you to achieve from your medical treatment at this point in life?”

  Paraphrase or quote the patient/surrogate, writing a brief **narrative** on the POLST form
  These generally involve prioritizing: **function, comfort** or **longevity**
Step 4 (POLST)

- Section B, Medical Interventions
  Indicate one:

  “Symptom Treatment Only” = Comfort care
  Goal: Promote comfort

  “Limited Treatment” = Treat reversible conditions
  Goal: Preserve function
  (Avoid ICU; Indicate if may hospitalize for care)

  “Full Treatment” = Care as usual
  Goal: Prolong life
Step 4 (POLST)

- **Section C, Artificially Administered Fluids and Nutrition**
  Indicate:
  - [ ] None
  - [ ] Limited time period
  - [ ] Long-term

- **Section D, Cardiopulmonary Resuscitation / Airway Management**
  Indicate:
  - [ ] CPR or [ ] DNR (Allow Natural Death)
  - [ ] Intubate or [ ] Do Not Intubate (DNI)

(consider discussing the likely prognostic outcome if resuscitated/intubated)
Step 4 (POLST)

- Section E, Option for Surrogate to modify or void POLST

Offer patient the option to list a surrogate who they grant permission to change this POLST form in any way should the Patient be too incapacitated to participate in their own medical decisions

If Patient is not completing their own POLST with physician, leave this section blank
Step 4 (POLST)

- **Section F, Signatures**
  
  Patient (or Surrogate) **MUST** sign and date  
  Physician (or APN) **MUST** sign, date, list license #, and phone #  
  If *either* party fails to sign then POLST is not valid

- **Back of POLST form**
  
  Patient name and DOB  
  Surrogate (if any) name, and contact info
Step 4 (POLST)

- **Additional POLST tips**
  - Complete all Sections routinely (aside from Section E)
    - Sections left blank default to the highest level of care
  - Patient (or Surrogate) keeps the original (green) POLST
  - Make multiple 2-sided (white) copies of POLST form
    - Place one in the patient chart
    - Give copies to the patient, advising they provide a copy to all healthcare providers they see
Practice Tools and Resources

- Recording of this Module and Powerpoint – make sure all clinical practice staff view and consider discussing at a practice meeting
- Living Will document
- Healthcare Proxy document
- POLST document
- ACP/POLST Worksheet
- End of Life Letter
- Prepare for Your Care brochure
Resources

- http://yourlifeyourwishes.com
- Prepare for Your Care www.prepareforyourcare.org
- http://www.nj.gov/health/advancedirective/polst/
Atlantic Health System Services:

- Atlantic Home Care & **Hospice**
  - 973-379-8472 (Morris, Somerset, Union, Essex)
- **Atlantic Supportive Care** (home-based palliative care)
  - 973-379-8472 (Morris, Somerset, Union, Essex)
  - Staffed by Hospice nurses
- **Atlantic Palliative Care** 908-522-5329
  - Dr Rashmi Kaura
- **ACO Complex Care Coordinators** 855-226-7171
<table>
<thead>
<tr>
<th>2016 Advance Care Planning/POLST Quiz</th>
<th>Put your answer in the shaded areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Select the one best answer: NJ POLST stands for:</strong></td>
<td></td>
</tr>
<tr>
<td>a. New Jersey Physicians Orders for Life-Supporting Treatment</td>
<td></td>
</tr>
<tr>
<td>b. New Jersey Providers Orders for Life-Stopping Treatments</td>
<td></td>
</tr>
<tr>
<td>c. New Jersey Practitioner Orders for Life-Sustaining Treatment</td>
<td></td>
</tr>
<tr>
<td>d. New Jersey Physicians Orders for Life-Stopping Treatments</td>
<td></td>
</tr>
<tr>
<td><strong>2. Select the one best answer: Which of these statements is true?</strong></td>
<td></td>
</tr>
<tr>
<td>a. An Advance Directive is a physician order and goes into effect upon admission</td>
<td></td>
</tr>
<tr>
<td>b. A NJ POLST may be completed by a physician or APN and is an enduring medical order</td>
<td></td>
</tr>
<tr>
<td>c. A DNR remains in effect after discharge from hospital</td>
<td></td>
</tr>
<tr>
<td>d. An Out-of-Hospital DNR goes into effect upon admission to a nursing home</td>
<td></td>
</tr>
<tr>
<td><strong>Select the one best answer: NJ POLST is unique nationally in that it begins with a patient's goals of care.</strong></td>
<td></td>
</tr>
<tr>
<td>3. These may include:</td>
<td></td>
</tr>
<tr>
<td>a. Preserve Function</td>
<td></td>
</tr>
<tr>
<td>b. Promote Comfort</td>
<td></td>
</tr>
<tr>
<td>c. Prolong Life</td>
<td></td>
</tr>
<tr>
<td>d. Any of the above</td>
<td></td>
</tr>
<tr>
<td><strong>4. Select the one best answer: Which one of these statements about NJ POLST is false?</strong></td>
<td></td>
</tr>
<tr>
<td>a. The patient keeps the original bright green POLST form</td>
<td></td>
</tr>
<tr>
<td>b. Copies of the NJ POLST on white paper are valid and patients should provide them to all their providers</td>
<td></td>
</tr>
<tr>
<td>c. If the CPR and Airway Management section are not completed, then the assumption is Do Not Resuscitate and Do Not Intubate</td>
<td></td>
</tr>
<tr>
<td><strong>5. Select the one best answer: Which of these statements is most accurate about Comfort Care?</strong></td>
<td></td>
</tr>
<tr>
<td>a. The goal is controlling distressing symptoms while providing support</td>
<td></td>
</tr>
<tr>
<td>b. The focus shifts from monitoring and diagnosing to treatments for comfort</td>
<td></td>
</tr>
<tr>
<td>c. The Comfort Care order set is for all DNR-a and POLST &quot;Symptom Treatment Only&quot;</td>
<td></td>
</tr>
<tr>
<td>d. All of the above</td>
<td></td>
</tr>
</tbody>
</table>
6. Select the one best answer: Hospice care:
   a. Does not require a physician order or referral
   b. Applies to patients whose prognosis for life is less than 6 months
   c. Is always provided in a hospital or institution
   d. Is available only to those over age 64

7. Select the one best answer: Consider completing an NJ POLST for all except:
   a. Those for whom you would not be surprised if they were to die this year
   b. The frail elderly with impairments in several ADLs
   c. All individuals 18 years of age and older
   d. Patients with advanced, life-limiting illnesses like COPD, CHF, or renal failure

8. True or False: An attorney must write an Advance Directive and witness signatures
   a. True
   b. False

   True or False: A Living Will and Durable Power of Attorney only take effect when the patient lacks medical decision-making capacity
   a. True
   b. False

   True or False: Prior to hospital discharge is a good time to complete a NJ POLST with a patient with an advanced, life-limiting illness since likelihood of re-hospitalization is high
   a. True
   b. False

11. True or False: Unlike an Advance Directive, a patient cannot write their own NJ POLST
   a. True
   b. False

12. True or False: The Hospice Team provides needed medications, supplies, and durable medical equipment
   a. True
   b. False

Print Name of Person Completing the Quiz and Sign:

Print Name of Practice ACO Provider Champion and Sign:

Date:
Summary: Sample Patient

- CABG age 66
- Dementia onset age 76
- Moved to a memory unit in Sept, 2015 at age 81
- Hospitalized after a fall in November, 2015
- Transferred to rehab/skilled nursing facility
- Has an advanced directive and health care proxy
- Should you do anything else for this patient?
APPENDIX

ACP Reimbursement

“AHS Advance Care Planning Tools, End-of-Life Care, and Palliative Care" course slides
Advanced Care Planning Reimbursement

- CPT 99497- First 30 minutes (payment $93.61)
- CPT 99498-Additional 30 minutes (payment $81.00)
- 2016 AWV G0438 $191.14
  plus ACP 99497-33 $93.61 = $284.75
- 99214 = $119.85 and 99215= $161.02
- Medicare beneficiaries will have not have any cost sharing liability for advance care planning if provided in conjunction with their annual wellness visits.
- Transitional Care Visits – can now be billed at time of first visit
  - 99495 = $184.37 (moderate intensity)
  - 99496 = $259.37 (high intensity)
Advance Care Planning Tools, End-of-Life Care, and Palliative Care
Advance Care Planning Tools, End-of-life Care, and Palliative Care

Welcome to the "Advance Care Planning Tools, End-of-Life Care, and Palliative Care" course.

In this course, you will learn about the various Advance Care Planning tools: Advance Directives, DNR, and NJ POLST. In addition, Comfort Care, Hospice Care, and Palliative Care will be discussed. Please note that there are a total of 8 interspersed pages assigned to Physicians and APNs ONLY, marked: THIS PAGE FOR PHYSICIANS & APNs ONLY. If you are not a Physician or APN, please skip only these 8 pages.

At the completion of this course, you should be able to:

- Define the three major types of Advance Care Planning tools and their distinguishing features.
- Recognize the appropriate clinical setting for POLST planning. Physicians and APNs will learn how to complete this document.
- Understand the purpose of Comfort Care and how it reflects a transition in the focus of treatment.
- Identify the population for whom Hospice Care is indicated and its potential benefits.
- Describe the potential benefits of Palliative Care and its place in overall treatment planning.
Advance Care Planning Tools

Definitions:

- **Advance Directive**
  - A legal document which allows one to direct those making the medical decisions should one lose decision-making capacity.
  - It may be used to name a Health Care Proxy and to specify any particular medical treatments be accepted or declined.

- **DNR** - "Do Not Resuscitate".
  - A medical order written by a physician reflecting the decision not to resuscitate in the event of a cardiopulmonary arrest.

- **NJ POLST** – “New Jersey Practitioner Orders for Life-Sustaining Treatment”.
  - A medical order written by a physician or an advance practice nurse (APN) which specifies pertinent patient Goals of Care and any desired limitation on medical interventions.
Advance Directives

There are three types of Advance Directives:

- **Instructional Directive:** A “Living Will” outlines what types of treatment one would accept or decline depending upon specified circumstances

- **Proxy Directive:** A “Durable Power of Attorney for Healthcare” allows one to name a healthcare representative to make healthcare decisions on one's behalf when decision-making capacity is lost

- **Combined Directive:** Includes both a “Living Will” and a “Durable Power of Attorney for Healthcare”; this type of Advance Directive is recommended at Atlantic Health.
Advance Directives

To be valid, an Advance Directive must be:

- Executed by an adult at least 18 years of age
- Signed and dated in the presence of a notary public, an attorney-at-law, OR two adult witnesses (neither of which is the healthcare representative/proxy)
- Must be witnessed -- any health professional not caring for the patient may serve as a witness

It is the policy of Atlantic Health System to inquire of every patient 18 and older as to whether they have an Advance Directive (including a NJ POLST form).

- This occurs during the Nursing Assessment.
- If the patient has one, it is the responsibility of the nurse to request a copy and place it on the chart.
  - At OMC, NMC, and CMC, if the patient lacks an Advance Directive, it is the responsibility of the social worker to provide information to the patient and opportunity for the patient to complete one.
  - At MMC, this is a nursing responsibility.
DNR (Do Not Resuscitate)

DNR is:

- A medical order written by a physician with a patient (or their surrogate) reflecting the decision not to resuscitate the patient in the event of a cardiopulmonary arrest in a facility.
- Defined as either DNR-a or DNR-b.
  - DNR-a status indicates Comfort Care only; the Comfort Care order set should be completed routinely for all DNR-a patients.
  - DNR-b status implies some active medical care is being continued.
- A hand-written physician order which should be accompanied routinely by an electronic medical order of DNR status.

An Out-of-Hospital DNR may be written which applies to times of transport

NJ POLST may include a DNR order and replace both an in- and out-of-hospital DNR; AHS encourages use of NJ POLST
NJ POLST
(Practitioner Orders for Life-Sustaining Treatment)

NJ POLST:

- Was signed into law by Governor Christie in 2011 in New Jersey. Similar laws exist in many states.
- May be completed by a physician or an APN with a patient or their surrogate, should the patient lack decision-making capacity.
- An enduring medical order set requiring no interpretation or evaluation of the patient to be acted upon by any healthcare professional in any setting—hospital, ED, EMS, residential facility, home, etc.
- Applies whether the patient has intact medical decision-making capacity at the time or not.
- Differs from an Advance Directive since it requires no interpretation or comprehensive assessment of the patient's clinical status to be implemented, and since it applies even if the patient has intact decision-making capacity.
- Applies in all settings including during medical transport.
- Appropriate for a patient of any age if there is limited life expectancy of generally less than one year.
Understanding the POLST is important for the entire treatment team in design of the patient’s plan of care.

- **NJ POLST** is unique as it starts with a Goals of Care discussion between patient and physician/APN (Section A).

- “Goals of Care” are the patient’s overarching wishes for their medical treatment and outcome.

- POLST forms include specific preferences for treatment intensity and interventions including CPR, artificial ventilation, and nutrition.
Goals of Care statements generally fall into three broad categories:

1) **Prolong Life** (example: “I want to live as long as possible, even in pain and disability.”)

2) **Preserve Function** (example: “I don't want to be kept alive if I can't see to my basic needs...eating, walking, getting myself dressed.” or “I want to try treatments for a period of time but stop if I am suffering or becoming incapacitated.”)

3) **Promote Comfort** (“Being pain free is most important to me right now.”)

These categories should guide recommendations for completing the remainder of the POLST document.
NJ POLST

For whom should we consider completing a POLST document?

- Any patient for whom you would answer "No" to the “Surprise Question”: “Would you be surprised if this patient were to die in the upcoming year?”

- Patients with advanced, life-limiting illnesses, including: locally-advanced or metastatic cancer; chronic obstructive pulmonary disease (COPD); congestive heart failure (CHF); end stage renal disease on dialysis (ESRD); cirrhosis; neurodegenerative disorders, such as Alzheimer's dementia

- The frail elderly with impairments in several activities of daily living (ADLs)--walking, feeding, grooming, toileting, etc.

- Patients with life-limiting illness and frequent re-hospitalizations

- Anyone choosing a Do Not Resuscitate and Allow Natural Death status for themselves
NJ POLST

When to consider completing a POLST document:

- At an Annual Wellness or post-hospitalization visit with a primary care physician/APN or pertinent specialist
- When there has been a significant change or worsening of a patient's condition or prognosis
- Prior to hospital discharge for an appropriate patient in anticipation of potential future medical crises
- When the Practitioner has adequate time and skill to focus on this matter with a patient/surrogate willing to engage in this conversation
NJ POLST

What to do with the form:
- Patient keeps the bright green original POLST form
- Patient should keep green POLST form in a place where easily found at home
- Kept temporarily in the chart while in-hospital in a specially-marked sleeve
- Make some 2-sided copies and provide to the patient/family
- Patient should take a copy to any medical appointment and give to provider
- A white copy of the original green POLST is considered valid in all settings

If patient wants to change the form:
- A patient or designated surrogate may amend or revoke a POLST form
- To void an existing POLST form, draw a line diagonally through all sections and write “VOID” along the line, sign and date it

To interpret the form:
- Any treatment section left blank implies full treatment in that area
- To help avoid confusion, generally complete all sections

To see the form:
- Found in ChartMaxx (View: “Universal” section) at MMC, OMC, NMC
- Found in Alpha Imageworks (“Advance Directives” tab) at CMC
Completing NJ POLST

To begin POLST documentation, enter the patient’s name and DOB at the top:

Section A:
Next, open a Goals of Care (GOC) conversation with the patient or their surrogate with a question such as: “What do you hope to achieve from your medical care at this point in your life?” This may require providing some further information to the patient/surrogate about their diagnosis, prognosis, and the benefits and trade-offs of treatment options under consideration.
Section B:
Indicate the intensity level of medical intervention elected by the patient/surrogate. The three levels of treatment generally align with one of the three categories of Goals of Care outlined above:

*Full Treatment = Prolong Life, including ICU level of care*  
*Limited Treatment = Preserve Function, and avoiding ICU level of care*  
*Symptom Treatment Only = Promote Comfort, likely appropriate for hospice level of care*

If electing "Limited Treatment," indicate under which circumstances transfer to hospital is desired.

Additional Orders of any type desired by the patient/surrogate may also be entered (for example: "no dialysis").
Section C:
Indicate the patient/surrogate choice for artificial fluids and nutrition (TPN, IV fluids, NG tube, PEG tube) and, if relevant, for what period of time.

Section D:
Indicate the decision of the patient/surrogate with their physician/APN as to whether CPR should be performed if the patient has no pulse and/or is not breathing, and as to whether to intubate if the patient is in respiratory distress with a pulse. If an inpatient has a POLST indicating “Do not attempt resuscitation,” an electronic DNR order should be entered by the physician also.

It is important to ensure that the recommendations and selected choices for Sections C and D are consistent with the Goals of Care listed in Section A, and levels of hospital intervention in Section B.
Applicable only if the patient is completing the POLST themselves:

Section E:

This section should be completed only if the patient has decision-making capacity. If completed by a surrogate, this section should be left blank.

A patient completing their own POLST may list a surrogate here who - in the event that the patient subsequently loses decision making capacity - may amend or void the POLST document in keeping with the patient's goals.

Enter the name of the surrogate and their phone number. This surrogate may or may not be the healthcare representative or proxy identified in an existing Advance Directive, which is to be indicated in the check box. The address of this surrogate should be entered on the reverse side of the POLST document (see below).
Section F:

This section is for signatures and information about those who completed the POLST document; it is critical that it be accurate and legible.

The patient should print and sign their name, and mark the “person named above” checkbox. If a surrogate is completing the POLST document, then the surrogate should print and sign their name and mark the checkbox which indicates the nature of their relationship.

The physician or APN should print and sign their name, and enter their phone number and date/time of signature. Professional license number must be included.

There are also checkboxes to indicate whether the patient has made an anatomical gift.

To be valid, every POLST requires a patient/surrogate signature AND a physician/APN signature.
- Print the patient's name and DOB, then their address on the line below.
- Below this, print the surrogate's name (if a surrogate is completing this document or one is named in Section E) with their address and phone number.

**NOTE:**
Starting in 2016, physicians and APNs may bill for advance care planning conversations with patients/surrogates using CPT codes 99497 (first 30 minutes) and 99498 (each additional 30 minutes)
Comfort Care

- The goal of Comfort Care is to control pain, dyspnea, and other distressing physical symptoms while providing social, emotional, and spiritual support to patients approaching end-of-life and their families.

- In a Comfort Care mode, the focus of treatment shifts away from non-beneficial monitoring and diagnostic tests, and refocuses on providing treatment interventions that ensure comfort.

- It is important to note that comfort care does not preclude the use of antibiotics, diuretics, steroids, or nebulizers. These can be ordered along with opiates to treat symptoms such as pain and dyspnea.

- Assistance in completing the Comfort Care order set can be provided by the Palliative Care Team.

- **The Comfort Care Order set should be used for all inpatients designated DNR-a or who have a POLST document indicating "symptom treatment only" in Section B.**

- It is strongly recommended that patients and families are counseled about the benefits of enrolling in hospice, which include expert symptom management and bereavement counseling for up to 13 months.
It is strongly recommended that practitioners completing the comfort care order set consider the following:

- Referral to hospice care, pastoral care & integrative therapy

- Review and discontinue any medications, monitoring and diagnostics that are not in keeping with comfort focused care

- Write for opiates “as needed” i.e. PRN for intermittent moderate to severe pain/dyspnea
Comfort Care Order Set

Write for a continuous opiate infusion with breakthrough doses for **constant moderate to severe** pain/dyspnea

Choose a bowel regimen and measures to provide mouth and eye care

Choose at least one medication “as needed” for other symptoms including diarrhea, nausea/vomiting, agitation, delirium, respiratory secretions, cough, hiccups, pruritus, fever and insomnia

Add other orders that may provide comfort (e.g., steroids)
Hospice Care

How does Hospice Care work?

- Hospice focuses on caring while allowing the natural progression of a life-limiting illness.

- In most cases, hospice care is provided in the patient's home, however, it is available in free-standing hospice centers, hospitals, nursing homes, and other long-term care facilities for patients who meet criteria.

- Hospice services are available to patients of any age, religion, race, or illness.

How is Hospice Care Accessed?

- Requires a physician's order/referral.

- The patient is assessed by the hospice organization as to:
  - Whether their prognosis is of 6 months or less;
  - Whether their health insurance covers hospice services;
  - At which care setting hospice services can be provided.
Hospice Care

How is Hospice Care delivered?

- Typically, family members or residential/nursing home staff serve as the primary caregivers.

- Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff are on-call 24 hours a day, seven days a week.

- The hospice team develops a care plan in collaboration with patients and their caregivers that meets their needs.

The inter-disciplinary Hospice Team:

- Manages the patient's pain and symptoms.

- Provides patient and families emotional, psychosocial, and spiritual support.

- Provides needed drugs, medical supplies, and durable medical equipment.

- Coaches caregivers on how to care for the patient.

- Delivers special services like speech and physical therapy, when needed.

- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home.

- Arranges for respite care of up to 5 days for caregivers.
Palliative Care

- **Palliative Care** is specialized medical care delivered by an interdisciplinary team of professionals for patients with serious, life-limiting illness and their families.

- It is suitable from the time of diagnosis of an incurable serious illness, and has been shown to be beneficial while patients are receiving concurrent life-prolonging treatment such as chemotherapy.

- **Goals include:**
  - Relief of suffering through expert symptom management;
  - Helping with the psychological, social, and spiritual concerns which inevitably arise when serious illness occurs;
  - Providing medical and prognostic information in a supportive fashion;
  - Aligning medical care with patient and family values and preferences; and
  - Coordinating and accessing care across various specialties and health care disciplines.

- **Palliative Care differs from Hospice:**
  - Palliative care provides symptomatic support **at any stage** of a life-limiting illness, whereas Hospice applies to the last 6 months.
  - Palliative providers specialize in communication skills that help patients, families, and their healthcare teams determine the best plan of care going forward.