Integrating Palliative Care into Our Community

A Palliative Care Professional Conference

SHARP HEALTHCARE’S TRANSITION PROGRAM: A NEW MODEL FOR LATE STAGE DISEASE MANAGEMENT

Friday, November 22, 2013
8:00 AM – 9:00 AM

Esteemed Faculty

Daniel Hoefer, MD
Chief Medical Officer, Outpatient Palliative Care and Hospice
Sharp HealthCare Hospice and Palliative Care

Objective(s):

1. Describe the historical model for healthcare and reimbursement
2. Discuss how proactive versus reactive care can transform the healthcare industry
Sharp HospiceCare's Transitions Program
A New Model for Late Stage Disease Management
CMMI 2013

Daniel R. Hoeffel, MD
CMO, Outpatient Palliative Care and Hospice
Suzi K. Johnson, MPH, RN
Vice President
Sharp HealthCare Hospice and Palliative Care

• First generation outpatient palliative care
• Second generation outpatient palliative care
  1. UCSF
  2. Kaiser
  3. Sutter (AlM)
  4. VA
  5. Care More
  6. Health Care Partners
  7. Partners Medical Group (Boston)
  8. University of Pittsburgh
  9. Long Island Jewish
  10. Hospice of the Valley
  11. Sharp HealthCare

Goals
CMS Goals:
1. Better individual patient care
2. Better population care
3. Lower growth in health care expenditures
4. Prevent readmissions

Sharp Transitions Goals:
1. Better individual patient care
2. Better population care
3. Reverse the growth in health care expenditures
4. Better professional caregiver support
5. Better professional family support and conflict resolution
6. Prevent any admissions including primary admissions

Principles of Transitions
• Proactive In home Disease Management
• Proactive Psychosocial Management
• Accurate description of what the health care industry can and cannot provide

Cultural Mind Shift
"The continued application of traditional treatment strategies which are valuable to the patient at an earlier time in their health experience has the opposite effect on patients at end of life resulting in inferior outcomes."

Daniel Hoeffel, MD
CMO, Outpatient Palliative Care and Hospice
Sharp HealthCare

Up to Date: Physiology and Goals of Care for the Pre-terminal Populations are Not the Same as a Younger and Healthier Geriatric Patient
"Standard of Care" versus "Evidence Based Medicine"

1. Pressure Ulcers
   - Evidence Based Medicine: The development of a pressure ulcer is not necessarily a sign of bad care but a sign that the patient is terminal. Healthcare providers need to acknowledge this issue.

2. Weight loss
   - Evidence Based Medicine: there is a point in the 3rd cycle when efforts to feed the patient are actually associated with increased morbidity and mortality.

(continued)

3. Delirium
   - Associated with statistically significant decreases in mental and physical decline, and higher mortality rates.
   - Evidence Based Medicine: The induction of delirium by an elective procedure is associated with significant long term health consequences.

(continued)

4. Infections
   - Immune Senescence Mandates an updated standard of care. Givens, MD 2016, Arch Intern Med
   - "We have treated your loved one's infection. However, the issues which permitted your loved one's infection to occur in the first place have not gone away. So the issue isn't your loved one going to develop the same infection but what do you want us to do about it when it occurs?" D. Hoeser, MD

"Standard of Care" versus "Evidence Based Medicine"

Evidence Based Potential Harms of Hospitalization: Especially in the Late Stage populations

More Conflict:
1. Physical trauma of transfer
2. High rates of delirium - delirium is NOT necessarily reversible
3. High rates of hospitalization induced functional decline - frequently permanent
4. Inability to address the patient's special needs
5. Lack of communication of goals of care
6. Falls
13. Medication Errors
14. Adverse Drug Events (ADEs)
15. Polypharmacy
16. Infections
17. Adverse Procedures - e.g., catheters, feeding tubes, CT/ MRI
e. "strobe code" on a patient with delirium
18. Burdensome cost to patient/family
19. Anxiety for Loved Ones

ACP is associated with:
1. Improved Quality of Care
2. Less in Hospital Death
3. Increased Use of Hospice with less stays < 3 days
4. Less likely to be admitted to the ICU
5. Less likely to visit the ED more than once in their last month
6. Fewer stays > 2 weeks if admitted

B. McShane, K. McD. Jr, et al. Advance Care Planning and the Quality of End-of-Life Care in Older Adults, 2013, AGS

Patient Goals of Care Who Completed an Advance Directive:
- 92% requested to prioritize comfort and forgo extensive measures to prolong life
- 5% expressed a desire to limit care in certain situations
- 3% requested all care possible

Current Culture of Health Care
- Reactive versus Proactive
- Paternalistic vs. Shared decision making
- Dependent vs. Self-reliant

Medicare Cost in Matched Hospice and Non-Hospice Cohorts

Comparing Hospice and Non-Hospice Patient Survival Among Patients Who Die Within a Three Year Window

### Mean Survival
Increased by 29 days for patients who chose hospice over non-hospice care:
- CHF: +81 days
- Lung Cancer: +39 days
- Pancreatic Cancer: +21 days
- Colon Cancer: +33 days
- Breast Cancer: +12 days
- Prostate Cancer: +4 days

### The Traditional Medical Model
"This Disease Can Be Cured"

27% of patients with incurable terminal disease believed they could have been cured.

<table>
<thead>
<tr>
<th>Unresectable non-small-cell lung cancer</th>
<th>54%</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>32%</td>
</tr>
<tr>
<td>CHF</td>
<td>22%</td>
</tr>
<tr>
<td>ALS</td>
<td>16%</td>
</tr>
<tr>
<td>COPD</td>
<td>12%</td>
</tr>
</tbody>
</table>


### Hospitalizations last year of life - CHF
Acceptable or Not?

- **Historical average hospitalizations for CHF during the last year of life**: 3.5

### Where Patients with CHF Die
Acceptable or Not?

- **Historically 63% of CHF patients died in the hospital**: (2005)

### Expanding the Care Continuum

- **Home Setting**
- **Focus on high risk late stage chronic illnesses**
- **Skilled Clinicians**
- **Flexible Models**
- **Cost efficient**
Four Pillars of Transitions
Extending the evidence based benefits of In-Home Care patients at an earlier point in their healthcare.

1. Comprehensive in-home patient and family education about their disease process; proactive medical management
2. Evidence-based Prognostication
3. Professional Proactive Management of the Patient
4. Advance Health Care Planning

Pillar One
In Home Proactive Disease Management
Registered Nurse
Medical Social Worker
Spiritual Care
Primary Care MD
Palliative Care MD

Decrease Primary Admissions & Re-admissions

Improved Compliance
Improved Symptom Management
Improved Disease Management

The best medication reconciliation occurs in the home

Pillar Two
Evidenced-Based Medical Prognostication
1. 343 doctors
2. Estimates on 468 terminally ill patients
3. Mean patient survival – 24 days
4. Considered accurate if estimate within 33% for each patient
5. 20% of the time accurate
   a) 80% of the time inaccurate
   b) 83% over-optimistic

The Clinical Consequences of Institutionalized Over-optimism
(Pillar two continued)
6. The average over-optimistic estimate was 24 days
   a) Increases the risk that treatment decisions for patients, families and healthcare providers are NOT consistent with reality
   b) Leaves patients and families emotionally unready for inevitable outcomes
   c) Increase risk that providers will lose or deny

Diagnosis and Treatment vs. Diagnosis, Treatment and Prognosis
The only group more overly optimistic than healthcare providers are patient and families.

General Prognostic Data
1. Age
2. Male
3. BMI
4. Weight Loss
5. Depression
6. Geriatric Frailty Syndrome

Biometric models + functional decline patterns + specific biological data + general biological data + adjusting for your personal tendencies = accurate, effective, professional and compassionate information.

Event Prognostication – Prognostication which guides the patient in an expected series of events.

Anticipatory Guidance

<table>
<thead>
<tr>
<th>Ind</th>
<th>Race</th>
<th>Age</th>
<th>Sex</th>
<th>Height</th>
<th>Weight</th>
<th>BP</th>
<th>Heart Rate</th>
<th>Respiratory Rate</th>
<th>Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>65</td>
<td></td>
<td>180 cm</td>
<td>80 kg</td>
<td>120</td>
<td>70 bpm</td>
<td>18</td>
<td>37.5°C</td>
</tr>
</tbody>
</table>

Note: 85-year-old male
Diagnosis: Frailty
Progression of decline: BOB
Signs of frailty: decline
Pillar Three
Professional Evidence-Based Care for the Caregiver

Evidence-based medicine - Hospice care is associated with an absolute reduction in death rates of the caregiver at 16 months post death of the patient by 0.5% (1 in 200)


Pillar Four
Advance Health Care Planning

Evidence-based medicine shows that AHCDs, which would include POLST, do not consistently match the health care desired by the patient with the care received by the patient.

Problems with Advance Health Care Directives

- They are not disease specific
- They are too vague or contradictory to be interpreted in the context of the care which is being provided

Resolve Morale Conflict Proactively
Create Disease Specific Directives
Issues Important in the Management of a Pre-terminal Aging Population:

- Mobility Deficit
- Transportation Deficit
- Financial Restraint
- Social Support/Family Deficit
- Cognitive Deficit
- Compliance Deficit
- Change in Goals of Care

It is better to bring healthcare to patients at this time, than to bring patients to healthcare.

What Transitions does not do ...

- We do not prevent or discourage the patient from seeing their cardiologists or PCPs
- We do not prevent or discourage state-of-the-art cardiology therapies or interventions
- We do not discourage hospitalizations
- We do not "take over" the medical management of the patient

Key Performance Indicators

- Reduction of hospitalizations/ED visits
- Completion of advance healthcare plan
- Timely referral to hospice
- System cost savings
- Patient/family satisfaction

Transitions Case Management Design

- Active Phase
- Maintenance Phase
- Role of Hospice
  - 24 hour call availability
  - Full integration and hand offs between programs

Hospitalization ER Utilization: All cause

It's not about the hospital... it's about the "non-event"
**Current Programs**

- CHF
- COPD
- Dementia
- Cancer
- Geriatric Frailty Syndrome
- ACP
- Nursing Home Care

Coming soon... Renal Failure, other neurodegenerative disorders

**Hospice Admissions - Heart Failure**

```
<table>
<thead>
<tr>
<th>Year</th>
<th>FY'07</th>
<th>FY'08</th>
<th>FY'09</th>
<th>FY'10</th>
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<tbody>
<tr>
<td>200</td>
<td>143</td>
<td>142</td>
<td>143</td>
<td>145</td>
</tr>
</tbody>
</table>
```

**Patient Family Satisfaction Transitions FY2011**

<table>
<thead>
<tr>
<th>Transition Factor</th>
<th>FY2011</th>
<th>FY2012</th>
<th>Average % Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Control</td>
<td>98%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Communication</td>
<td>97%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Overall Experience</td>
<td>93%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Symptom Management</td>
<td>92%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>91%</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Cost of Care**

Average total cost of care

- Pre-Transitions
- During Transitions

- 43% reduction

**Thank You**
OPIOID ANALGESICS FOR CANCER PAIN

Friday, November 22, 2013
9:00 AM – 10:00 AM

Esteemed Faculty

Mary Lynn McPherson, Pharm D, BCPS
CPE Professor and Vice Chair
Department of Pharmacy Practice and Science
University of Maryland School of Pharmacy

Objective(s):

1. Summarize evidence-based recommendations on the use of opioid analgesics in the treatment of cancer pain
Opioid Analgesics for Cancer Pain

Mary Lynn McPherson, PharmD, BCPS, CPE
Professor and Vice Chair
University of Maryland School of Pharmacy
mcmpherson@umm.edu

Objectives

- At the conclusion of this presentation the learner will be able to summarize 16 evidence-based recommendations on the use of opioid analgesics in the treatment of cancer pain by the European Palliative Care Research Collaborative.

Prevalence of Cancer

- Cancer is a leading cause of death worldwide, accounting for 7.6 million deaths (around 13% of all deaths) in 2008
- Deaths from cancer worldwide are projected to continue rising, with an estimated 13.1 million deaths in 2030
- Risk factors: high body mass index, low fruit and vegetable intake, lack of physical activity, tobacco use, alcohol use.

Pain in Cancer

- Cancer patients who experience pain and require treatment with analgesic drugs:
  - 33% of cancer patients in active therapy
  - 66-100% of advanced cancer patients
  - Pain generally worsens as disease progresses
- Pain may be acute and/or chronic
- Various pathologies (disease, treatments)
  - Bone metastases (breast, prostate, lung, etc.)
- Cancer pain is undertreated - up to 80%

Management of Cancer Pain

- Pharmacologic and non-pharmacologic interventions
- Patient, family, caregiver education
- Ongoing evaluation and modification of the treatment plan
- WHO 3-step ladder

WHO Step II Opioids

- For patients with mild to moderate pain, or pain is not adequately controlled by acetaminophen or an NSAID given regularly:
  - Addition of a step II opioid recommended (codeine, tramadol)
  - Consider use of a lower-dose step III opioid (morphine, oxycodone)

WHO Step III Opioids

- The data show no importance differences between morphine, oxycodone and hydromorphone given by the oral route of administration.
- Any can be used as the first choice step III opioid for moderate to severe cancer pain.

Opioid Effectiveness in Cancer Pain

- Opioids are considered the gold standard for treatment of moderate to severe cancer pain.
- Literature search 1996-2010
  - Observational studies for chronic cancer pain treated with opioids
  - 18 studies reviewed; 7 met inclusion criteria
- Result was a 1C/strong recommendation with benefits clearly outweighing risks and burdens.

Which Opioid?

- Eenie-Meenie Miney Mo'phine: Why morphine isn't ALWAYS the answer to cancer pain.

First Line Opioids

- Morphine
- Oxycodone
- Hydromorphone
- Methadone
- Buprenorphine
- Fentanyl

Considerations in Opioid Selection?

- Patient-related variables
  - Assessment information about patient's pain complaint
  - Specific information about the patient's pre-existing conditions that may alter the expected dosing and effects (both therapeutic and toxic) prior to selection of pharmacotherapy
- Agent/Drug-related variables
  - Characteristic properties of a medication that affects it use in a given situation, including pharmacodynamic and pharmacokinetic parameters, dosage formulations or routes of administration, adverse effects, and costs (cost of medication, administration and monitoring).

Patient Related Variables

- History of opioid-use
  - Opioid-naive or tolerant
- Opioids that gave positive response in the past
- History of opioid allergy or intolerance
- Differentiate between opioid adverse effects and allergy
  - Codeine "allergy"; opioid-induced sedation/depression
  - Opioid-Induced pruritus vs. true allergic reaction
Chemical Classes of Opioids

<table>
<thead>
<tr>
<th>Chemical Class</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenanthrenes</td>
<td>Morphine, codeine, hydromorphone, levorphanol, oxycodone, hydrocodone, oxymorphone, buprenorphine, nalbuphine, butorphanol</td>
</tr>
<tr>
<td>Benzomorphans</td>
<td>Pentazocine</td>
</tr>
<tr>
<td>Phenylpiperidines</td>
<td>Fentanyl, alfentanil, sufentanil, meperidine</td>
</tr>
<tr>
<td>Diaphenylpiperidines</td>
<td>Methadone, (propyphonene)</td>
</tr>
<tr>
<td>Other</td>
<td>Tramadol, tapentadol</td>
</tr>
</tbody>
</table>


Patient Related Variables

- Age, race, body habitus
- Health care beliefs
  - Regarding the management of pain and addiction
  - Beliefs regarding specific opioids
- Renal and hepatic function
  - Morphine, hydromorphone, oxycodone — caution with patients and chronic kidney disease
  - All opioids — caution with hepatic impairment

Patient Related Variables

- History of substance abuse
  - Patient
  - Home environment
- Ability to manipulate or tolerate dosage formulations
  - Transdermal, transmucosal
  - Ability to swallow solid dosage formulations
- Febrile, pregnant, breast-feeding
- Financial resources

Agent/Drug-Related Variables

- Defined as those properties of any agent which are characteristic of that agent and effect its use in a given situation:
  - Mechanism of action
  - Available dosage forms, bioavailability of various formulations, distribution in the body, onset, peak, duration of action, serum half-life, method of elimination from the body
  - Side effects and toxicities
  - Cost (drug, administration, monitoring)

First Line Opioids

- Morphine
- Oxycodone
- Hydromorphone
- Methadone
- Buprenorphine
- Fentanyl

continued statement


Morphine

- Mu agonist; kappa agonist (negligible activity)
- Metabolized in liver to active metabolites
  - Morphine-3-glucuronide (neurotoxicity)
  - Morphine-6-glucuronide (analgesia)
- Accumulates in renal impairment
- Increased BAB with hepatic impairment
- LA and SA tablets, capsules, oral solution/intensol
- Rectal suppositories, injectable formulation
### Hydromorphone
- Mu agonist; kappa agonist (negligible activity)
- Metabolized in the liver to active metabolites
  - Hydromorphone-3-glucuronide
  - Accumulates in renal impairment (neurotoxicity)
  - Increased B+AB with hepatic impairment
- LA and SA tablets, oral solution
- Rectal suppositories, injectable formulation

### Oycodone
- Mu opioid agonist
- Metabolized in liver to noroxycodone via 3A4
  - 3x affinity for mu receptor but poor CNS penetration
- Also metabolized to oxymorphone via 2D6
- Caution with renal disease and hepatic disease
- SA and LA tablets, capsules, oral solution/intensol
- Often in combination with acetaminophen

### Role of Acetaminophen and NSAIDS in addition to Step III Opioids
- Adding NSAIDs to step III opioids may improve analgesia or reduce opioid dose required to achieve analgesia
- Restrict NSAID use due to series adverse effects
  - Elderly, renal/hepatic/cardiac failure
- Acetaminophen may be preferred to NSAID, particularly regarding AE, but efficacy questionable

### The Role of Transdermal Opioids
- Transdermal fentanyl and buprenorphine are alternatives to oral opioids.
- Either TDF or TDB may be the preferred step III opioid for some patients.
  - For patients unable to swallow they are an effective, non-invasive means of opioid delivery

### Fentanyl
- Mu opioid agonist
- Metabolized by the liver to inactive metabolites
  - Despite this, consider dosage adjustment in continuous infusion or transdermal fentanyl with severe renal impairment
  - Avoid TDF in severe hepatic disease
- 100 times the potency of morphine
- Transmucosal formulations (OTFC, effervescent tablet, sublingual tablet, sublingual spray, mucosal film, intranasal spray)
- Transdermal, transmucosal, parenteral

### Buprenorphine
- Partial agonist at the mu opioid receptor, antagonist at the kappa receptor
- Metabolized to norbuprenorphine (weak mu agonist) and buprenorphine-3-glucuronide
- No dosage adjust needed in renal impairment/failure or mild to moderate hepatic impairment
- 75 times more potent than morphine
- Approximately equipotent with fentanyl
- SL tablets (with and without naloxone)
- Transdermal patch, parenteral
The Role of Methadone

- Methadone has a complex pharmacokinetic profile with an unpredictably long half-life.
- Methadone can be used as a step III opioid of first or later choice for moderate to severe cancer pain.
- Methadone should only be used by experienced professionals.

Methadone

- Mu opioid agonist, NMDA receptor antagonist
- Metabolized to inactive metabolites
  - No dosage adjustment with renal impairment; caution with ESRD
  - Prolonged half life with hepatic impairment
- Tablets, oral solution/intensol, parenteral
- Caution with switching from other opioids
  - Do not adjust dose before 4-7 days

Use of Opioids in Patients with Renal Failure

- For patients with severe renal impairment (GFR < 30 ml/min), opioids should be used with caution
- First choices include fentanyl or buprenorphine
- Alternative strategies include reduction in dose or frequency of administration of morphine

Opioids in Renal Failure

<table>
<thead>
<tr>
<th>Not recommended</th>
<th>Use with caution</th>
<th>Avoid if possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Hydromorphone</td>
<td>Fentanyl</td>
</tr>
<tr>
<td>Codeine</td>
<td>Oxycodone</td>
<td>Methadone</td>
</tr>
<tr>
<td>Meperidine</td>
<td>Oxymorphone</td>
<td></td>
</tr>
<tr>
<td>(Propoxyphene)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Opioid Titration

- Both immediate-release and slow-release oral formulations of morphine, oxycodone and hydromorphone can be used for dose titration
- Supplement with oral immediate-release opioids as needed

Opioid Switching

- Patients receiving step III opioids who do not achieve adequate analgesia and have side-effects that are severe, unmanageable, or both, might benefit from switching to an alternative opioid.
Relative Opioid Analgesic Properties

- When switching from one opioid drug to another, dose conversion ratios can be recommended with different levels of confidence.
- These conversion ratios are specific for patients in whom analgesia from the first opioid is satisfactory.
  - When switching due to unsatisfactory analgesia, excessive adverse effects or both, starting dose should be lower than that calculated.

Reasons for Changing Opioids

- Lack of therapeutic response
- Development of adverse effects
- Change in patient status
- Other considerations
  - Opioid/formulation availability
  - Formulary issues
  - Patient/family health care beliefs

Evidence for Opioid Switching

- Search from 2004-2010
  - Adult cancer patients
- 11 publications met inclusion criteria
- Studies compared 280 patients
  - Variety of opioids and switching strategies used
- Pain intensity was significantly reduced in the majority of studies
- Serious adverse effects were improved

Equianalgesic Opioid Dosing

<table>
<thead>
<tr>
<th>Drug</th>
<th>Equianalgesic Doses (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Parenteral</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>0.3</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxycodeone</td>
<td>15*</td>
</tr>
<tr>
<td>Tramadol</td>
<td>100*</td>
</tr>
</tbody>
</table>

The Problem with "Those Charts"

- Source of equianalgesic data
- Patient-specific variables
- Unidirectional vs. bidirectional equivalencies

5-Step OCC Process

1. Globally assess pain complaint (PQRSTU)
2. Determine TDD current opioid (LA and SA)
3. Decide which opioid analgesic will be used for the new agent and consult established conversion tables to determine new dose
4. Individualize dosage based on assessment information gathered in Step 1
5. Patient follow-up and continual reassessment (7-14 days)
### Additional Caveats

- When switching from one route of administration or dosage formulation to another of the SAME opioid consider:
  - Bioavailability (e.g., first pass effect, absorption)
  - Morphine 30-40% (range 16-68%)
  - Hydromorphone 50% (29-95%)
  - Oxycodone 80%
  - Oxymorphone 10%

- When switching from one route of administration or dosage formulation to a DIFFERENT opioid consider:
  - Bioavailability (e.g., first pass effect, absorption)
  - Potency
  - If pain controlled, do ratio and reduce by about one third
  - If patient in pain, do ratio and use calculated dose

### Additional Caveats

- Methadone has unique pharmacokinetic properties
  - Not a linear conversion from other opioids
  - Wait 5-7 days before adjusting dose, due to long terminal half-life

### Alternative Systemic ROA

- The SQ ROA is simple and effective for the administration of morphine, hydromorphone
  - Should be first choice after oral or ID
- IV ROA should be considered when SQ contraindicated
  - Peripheral edema, coagulation disorder, poor peripheral circulation, need for high volumes and doses
- IV ROA appropriate for opioid titration when rapid pain control is needed

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### Opioid for Breakthrough Pain

- Pain exacerbations resulting from uncontrolled background pain should be treated with additional doses of immediate-release oral opioids, and that an appropriate titration of around-the-clock opioid therapy should always precede the recourse to potent rescue opioid analgesics.

### Opioid for Breakthrough Pain

- Breakthrough pain can be effectively managed with oral IR opioids, or with buccal or intranasal fentanyl preparations
  - May be used pre-emptively for predictable episodic breakthrough pain
- In some cases buccal or intranasal fentanyl preparations are preferable to IR oral opioids due to more rapid onset of action and shorter duration of effect
Cost Benefits to TM Fentanyl

- RCT compared fentanyl pectin nasal spray with IR morphine tablets for breakthrough pain
  - 33% response rate at 10 minutes
    - 33.9% INF; 28.3% IR morphine
  - 33% response rate at 15 minutes
    - 55.4% with INF; 37.4% with IR morphine
- NNT to benefit one patient with INF
  - 10 minutes = 18; 15 minutes = 12 patients

- AWP IR morphine 30 mg = $0.30/dose
- AWP intranasal fentanyl 400 mcg = $60/dose
- Two breakthrough pain episodes/day x 1 year
- Cost to benefit one patient with INF = $777,600/year at 10 minutes
- Cost to benefit one patient with INF = $518,000/year at 15 minutes
- More adverse effects with INF than IR morphine

Treatment of Opioid-Related Emesis

- Some antidopaminergic agents (e.g., haloperidol) and other drugs with antidopaminergic and additional modes of action (e.g., metoclopramide) should be used in patients with opioid-induced emesis.

Treatment of Opioid-Related CNS Symptoms

- Methyldiphenidate can be used to improve opioid-induced sedation
  - The threshold between desirable and undesirable effects is narrow
- Opioid-related neurotoxic effects (delirium, hallucination, myoclonus, hyperalgesia) may be treated with opioid dosage reduction or opioid switching

Role of Adjuvant Drugs for Neuropathic Pain

- Amitriptyline or gabapentin should be considered for patients with neuropathic cancer pain that is only partially responsive to opioid analgesia
- Combination with an opioid may cause more CNS adverse events unless careful titration of both drugs is undertaken
Spinal route of opioid administration

- Spinal (epidural or intrathecal) administration of opioid analgesics in combination with local anesthetics or clonidine should be considered for patients in whom analgesia is inadequate or who have intolerable adverse effects despite the optimal use of oral and parenteral opioids and non-opioid agents.

Pennsylvania Orders for Life-Sustaining Treatment: Who Should Have a POLST? Why? - How Do We Best Facilitate the Conversation?

Friday, November 22, 2013
10:20 AM – 11:35 AM

Esteemed Faculty

Judith S. Black, MD, MHA
Medical Director, Senior Markets, Highmark, Inc.
National POLST Paradigm Task Force Member

Objective(s):

1. Define the role of POLST in Advance Care Planning
2. Describe the target population for POLST completion
3. Facilitate the POLST conversation
Pennsylvania Orders for Life-Sustaining Treatment
Who Should Have a POLST? Why?
How Do We Best Facilitate the Conversation?

York Hospital
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FACULTY DISCLOSURE

Dr. Black has disclosed that she is employed by
Highmark Inc. and is an executive committee
member of the National POLST Paradigm Task
Force.

OBJECTIVES

- Define the role of POLST in Advance Care Planning
- Describe the target population for POLST completion
- Facilitate the POLST conversation

PART 1

ROLE of POLST and ADVANCE CARE PLANNING

TWO TYPES OF ADVANCE PLANNING TOOLS

Traditional - little or no impact on immediate care
- Health Care Proxy or Health Care Power of Attorney
- Living Will

Actionable Medical Orders - direct and relatively immediate impact on course of care
- POLST Prenursing Form (POST, POLST, etc.)
- Do not resuscitate order
- Do not hospitalize, no feeding tube, etc.

THE RATIONALE FOR POLST: AD LIMITATIONS

AD may not be available when needed
- Not completed by most adults
- Not transferred with patient

AD may not have prompted needed discussion and/or may not be specific enough
- No provision for treatment in the nursing home or home
- May not cover types of most immediate need

AD may potentially be overridden by a treating MD
AD does not immediately translate into MD order
PURPOSE OF POLST
To provide a mechanism to communicate patient preferences for end-of-life treatment across treatment settings.

DIFFERENCES BETWEEN POLST AND ADVANCE DIRECTIVES

WHAT IS THE POLST PROGRAM?
POLST is a voluntary process that:
- Translates a patient's goals for care at the end of life into medical orders that follow the patient across care settings
- Consists of physician orders that are based on a patient's medical condition and higher treatment choices as established in communication between the patient or the legal medical decision-maker and a health care professional
- Is designed to improve the quality of care people receive at the end of life by turning patient goals and preferences for care into medical orders

POLST IN PENNSYLVANIA
What is POLST?

PROVIDING A UNIFORM MESSAGE
POLST is designed to honor the freedom of persons with advanced illness or frailty to have or to limit treatment across settings of care.

POLST IN PENNSYLVANIA
Who should have a POLST form?
POLST IS FOR...

- Seriously ill patients
- Terminally ill patients
- Patients with advanced frailty
- Anyone with advanced age wishing to further define their preferences for care

Unless it is the patient's preference, one of the POLST forms is not appropriate for persons with stable medical or functional problems who have many years of life expectancy.

POLST IN PENNSYLVANIA

Why complete a POLST form?

DOING THIS REALLY DOES HELP PATIENTS AND FAMILIES!

- Proven benefits
- System to understand, document and then be sure to HONOR patients wishes
- Communicate patient preferences across sites of care and across time

POLST

JAGS* Article Findings

- Compared effectiveness of POLST to Advance Directives in nursing homes
  - Those with POLST, more likely to have wishes documented as medical orders
  - Fewer hospitalizations for residents with POLST restricting medical intervention

PART II

The POLST CONVERSATION
**WHERE DOES POLST FIT IN?**

Advance Care Planning Continuum

- Age 18
- Complete an Advance Directive
- Update Advance Directive Periodically
- Diagnosed with Serious or Chronic, Progressive Illness (at any age)
- Complete a POLST Form
- Treatment Wishes Honored

**5-STEP PROTOCOL FOR DISCUSSING POLST**

1. Prepare for the discussion
2. Begin with what the patient or family knows
3. Provide any new information about the patient's condition and values from medical team perspective
4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations
5. Respond empathetically
6. Use POLST to guide choices and finalize resident/family desires
7. Complete and sign POLST
8. Revise and revise periodically

**POLST SCRIPT - CONVERSATION INTRODUCTION**

Normalize the conversation

- We talk about this with everyone
- We want to know what you would want if you got sick again

If questions remain:

- Your doctor will talk with you

**POLST SCRIPT - SECTION A**

Use an easily understood medical situation

- Begin Section A by saying, "Pretend you had a heart attack, your heart is not beating and you are not breathing... you have died a natural death"
PROVIDING REAL FACTS ABOUT CPR IN THE ELDERLY

The portrayal of CPR on TV may lead the viewing public to have an unrealistic impression of the chances of success of CPR:

- On one TV series, 75% of patients survive CPR with 67% appearing to survive to discharge.

In reality, for elderly patients:

- 12% may survive initial resuscitation
- 10-33% may survive to discharge, meet with impaired function

Chronic illness, more than age, determines prognosis (<5% survival)

POLST Script - Section B Medical Interventions

"Consider time/prognosis factors under "Full Treatment", "defined trial period. Do not keep on prolonged life support."

POLST Script - Section C Antibiotics

Use an easily understood medical situation:

- If the patient has selected Full Treatment in Section B then guide choice for use of antibiotics if life can be prolonged
- For patients with end stage dementia who are asymptol each, discuss goals of care with appropriate decision maker. No antibiotics maybe an appropriate choice

POLST Script - Section D Artificial Administered Hydration/Nutrition

- Would you want hand feeding to allow you to eat as the best you can? Or would want artificial nutrition by tube?
- It is important to clarify the benefits and burdens of medically prescribed artificial hydration and nutrition by tube

POLST Form Requirements

The minimum requirements for completion and acceptance as a medical order are:

- Patient name
- Completion of Section A - Resuscitation orders
- Completion of Section E
  - Decision signature - A physician, CRNP or physician assistant
  - Patient or legal decision maker signature

All other information is optional

(" Must be co-signed by a physician within 10 days")
WHO IS THE PENNSYLVANIA DECISION-MAKER

Quick Start Guide Health Care Decision-Making

If the patient is unable to engage in the POLST discussion, it is critical that the conversation occurs with the correct legal decision-maker.

Power to Sign POLST or Agree to DNR
- Competent Patient - Yes
- Health Care Agent - Yes
- Guardian - Yes, but...
- Health Care Representative - Yes, but...
- Incompetent Patient - No

WHO IS THE PENNSYLVANIA DECISION-MAKER

Quick Start Guide Health Care Decision-Making

Power to Revoke a POLST or DNR Order
- Competent Patient - Yes
- Health Care Agent - Yes if signed by Agent - Otherwise maybe
- Guardian - Yes, if signed by Guardian
- Health Care Representative - Yes, if signed by Health Care Representative
- Incompetent Patient - Yes if for revoking withholding or withdrawing life sustaining

WHO IS THE PENNSYLVANIA DECISION-MAKER

Quick Start Guide Health Care Decision-Making

Power to Decline Care Needed to Preserve Life
- Competent Patient - Yes
- Health Care Agent - Yes
- Guardian - Yes, if End Stage Medical Condition (ESMC) or Permanently Unconscious (PU)
- Health Care Representative - Yes, if ESMC or PU
- Incompetent Patient - No

PART III

POLST CASE DISCUSSIONS

CASE 1

The patient, a 94 year old, has requested in Section B, Comfort Measures Only. He has had a significant stroke and now cannot make his own decisions. His son says, "I don't care, do everything."

What can you do or say?
CASE 2
An 88 year old female, living at a skilled nursing facility has a POLST; Section B is Comfort Measures Only. She is having abdominal pain and vomiting.

What should you do and why?

CASE 3
Sue is a new staff nurse caring for a patient who is dying of Hepatitis C with end-stage liver disease, who is having progressive pain, shortness of breath and increased difficulty breathing. Sue has expressed her discomfort with giving more medications, as the patient's blood pressure is 98/58.

How can you help mentor Sue in caring for the dying patient?

CASE 4
You are working at a skilled nursing facility and have a POLST signed by the patient, but not signed by the physician. The resident requests:
- Do Not Attempt Resuscitation
- Limited Additional Interventions
- No Artificial Nutrition
The patient complained of chest pain this morning, relieved by two nitroglycerin pills.

What actions can you take?

CASE 5
You are asked to begin the POLST Conversation with a 72 year old, diagnosed with stage 3 lung cancer three months ago, now with metastases to liver and bones despite chemotherapy. The patient has lost 29 pounds, now weighs 115 pounds and has significant bone pain.

What aspects of the POLST Conversation are important to this person?

How can you describe comfort care?

CASE 6
Your patient is 86 years old with moderate to severe dementia, mild hypertension, and a history of osteoarthritis with hip and knee pain. The patient does not have decision making capacity. You are introducing the patient's daughter to POLST. The daughter states, "I know that she would not want any of this, but I feel like I have to do this."

What can you say to the daughter?
What questions can you ask her?

CASE 7
You are reviewing the POLST of a newly admitted patient. The POLST states:
- Section A: Attempt Resuscitation
- Section B: Comfort Measures Only
- Section C: Use Antibiotics if life can be prolonged
- Section D: Long-term artificial nutrition, including feeding tube

Is anything wrong with this? What would you do next?
CASE 8
You overhear a staff member telling the daughter of a patient with advanced dementia, “Your Mom is such a sweet lady, of course you would want us to give her antibiotics if she got pneumonia.” Her POLST states:
- Section A: Do Not Attempt Resuscitation
- Section B: Comfort Measures Only
- Section C: No antibiotics, use other measures to relieve symptoms
- Section D: No Artificial Means of Nutrition
Do you have any concerns about this statement? If so list your concerns. What could you say to this staff member?

CASE 9
A staff person tells the family of an elderly man who has end-stage COPD (chronic obstructive pulmonary disease) and is no longer eating that their dad is “starving” to death. The patient’s POLST indicates: No artificial means of nutrition, including feeding tubes.

Does this staff member seem to understand comfort and the dying process? How might you mentor this staff person?

CASE 10
In a POLST conversation, the patient says: “I want everything done - CPR, breathing tube, ICU, but the most important thing to me is I just want to be comfortable when I die.”

Does this patient’s statement concern you? How might you continue the conversation with the patient?

CASE 11
You are the primary care physician for Mrs. Fong, an 81 year old female, and you introduce the POLST conversation. The oldest son interrupts you and says, “Do not speak to my mother about this”.

What can you do?

CASE 12
You are preparing for a family meeting of Mr. Jong, a newly admitted 92 year old male with Alzheimer’s Disease. He has severe contractures and is bedridden. He was admitted yesterday for aspiration pneumonia. His POLST states:
- Section A, Attempt Resuscitation Section
- Section B, Full Treatment

How will you address his POLST during the family meeting?

CASE 13
A 34 year old female is critically ill, comatose and needs consent for a surgical procedure. Her partner visits on a daily basis. The patient has no AHCDO. The surgeon asks the nurse to call the patient’s parents to sign the consent. The RN is aware that her partner is dedicated and visits each day.

What can the RN do?
CASE 14

A patient in a skilled nursing facility choked on a piece of toast, has turned blue and stopped breathing. The patient's POLST states:

- Section A: Do Not Attempt Reasseslation/DNR
- Section B: Comfort Measures Only

What should the staff do?

PENNSYLVANIA POLST TOOLS

http://aging.psu.edu/professional/resources-polst.htm

Resources:
Pennsylvania Orders for Life-Sustaining Treatment (POLST)

The goal of the POLST process is to effectively communicate the wishes of seriously Ill patients to their or their family members as they move through the care setting to another.

PA POLST Form: Pennsylvania Orders for Life-Sustaining Treatment (NILST) Orders
Department of Health POLST Form
Guidelines for Health Care Professionals in Completing the POLST Form
Interventions for Professionals and Patients
Stages in Implementing POLST
POLST Brochure

POLST WEBSITE RESOURCES

www.aging.psu.edu/professional/resources-polst.htm

Aging Institute of UPenn: Senior Services and the University of Pittsburgh
www.polst.state.pa.us/ Hospedeianr/po mmy/geriatric_emergency_medical_standards/14138
www.polst.state.pa.us/ Hospedeianr/geriatric_emergency_medical_standards/14138

www.aging.psu.edu/professional/resources-polst.htm

Pennsylvania Orders for Life-Sustaining Treatment (POLST)

www.polst.org
Center for Excellence in Health Care Oregon
Health & Science University
www.nasw.org
Coalition for Compassionate Care of California

www.compassionatenurses.org/ Reeds/Blue_Roses_Bio_750_MOLST
www.aarp.org/pie
AARP POLST Policy Institute

REFERENCES


REFERENCES

Materials used with permission from the Coalition for Compassionate Care of California, www.CC.org

QUESTIONS?

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POLST Training

Overview
POLST or Pennsylvania Orders for Life Sustaining Treatment is a standardized medical form that became recognized in Pennsylvania by the Department of Health in November 2010. POLST complements but does not replace an Advance Directive, and aims to give seriously-ill patients more control over their medical treatment.

The bright pink form is signed by both the physician and patient, or the patient’s decision maker, and specifies the types of medical treatment that a patient wants to receive should they become unable to speak for him or herself. POLST encourages communication between providers and patients. It enables patients to make more informed decisions and clearly communicate those decisions to providers. As a result, POLST reduces patient and family suffering by aligning the care that the patient wants with the care that they receive, and helps to ensure that patients’ wishes are honored.

A POLST form is only as good as the conversation on which it is based. While having conversations about treatment options is an important and necessary part of good medical care, often it’s a skill overlooked in the education of healthcare professionals. POLST provides a framework for guiding conversations with patients and families, as well as a mechanism for documenting those conversations and communicating the patient’s wishes to others who are caring for the patient.

Though POLST is a physician order, the discussion of patient wishes and goals of care may also include other members of the patient’s care team and family. Depending on the setting, other trained healthcare providers – such as nurses, social workers, or chaplains – may be involved in introducing and explaining the POLST form and helping to address the physical, psychosocial and spiritual issues that often arise during these discussions. Physician participation and oversight of the process is absolutely critical because POLST is a physician order.

How Can I Obtain Further Information on POLST?
The POLST Form and educational materials are available through the website of The Aging Institute of UPMC Senior Services and the University of Pittsburgh, www.aging.pitt.edu/professionals/resources.htm. Users should download and print the form on Pulsar Pink stock (#65). A further resource is the POLST coordinator of the Coalition for Quality at the End of Life (CQEL), Marian Kemp at papolst@verizon.net.

- POLST Form
- Frequently Asked Questions
- Guidance for Health Care Professionals
- POLST Brochure - Information for Patients and Families
- Improving Advanced Illness Care: The Evolution of State POLST Program
- Web Site Resources

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Pennsylvania Orders for Life-Sustaining Treatment (POLST)

**Cardiopulmonary Resuscitation (CPR):** Person has no pulse and is not breathing.
- [ ] CPR / Attempt Resuscitation
- [ ] DNR / Do Not Attempt Resuscitation (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in B, C and D.

**Medical Interventions:** Person has pulse and/or is breathing.
- [ ] Comfort Measures Only: Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs 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.
- [ ] Full Treatment: Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

**Additional Orders:**

**Antibiotics:**
- [ ] No antibiotics. Use other measures to relieve symptoms.
- [ ] Determine use or limitation of antibiotics when infection occurs, with comfort as goal.
- [ ] Use antibiotics if life can be prolonged.

**Artificially Administered Hydration / Nutrition:**
- [ ] No hydration and artificial nutrition by tube.
- [ ] Trial period of artificial hydration and nutrition by tube.
- [ ] Long-term artificial hydration and nutrition by tube.

**Summary of Goals, Medical Condition and Signatures:**

**Patient Goals / Medical Condition:**

**Additional Orders:**

**By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.**

**Physician / PACRN / Provider Name:**

**Physician / PACRN / Phone Number:**

**Physician / PACRN / Signature (required):**

**Signature of Patient or Surrogate:**

**Name (print):**

**Relationship (write "Self" if patient):**

**Date:**
### Directions for Healthcare Professionals

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care directive that provides instructions for the individual's health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section "A", the physician/PA/CRNP should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the Pennsylvania Department of Health, Bureau of EMS, for information about Out-of-Hospital Do-Not-Resuscitate orders, bracelets and necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health. [www.health.state.pa.us](http://www.health.state.pa.us)

### Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications or decisions by the patient or a surrogate. This document refers to the person for whom the orders are issued as the "individual" or "patient" and refers to any other person authorized to make healthcare decisions for the patient covered by this document as the "surrogate."

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician/PA/CRNP. A person designated by the patient or surrogate may document the patient's or surrogate's agreement. Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms should be respected where necessary.

### Using POLST

- If a person's condition changes and time permits, the patient or surrogate must be contacted to assure that the POLST is updated as appropriate.
- If any section is not completed, then the Healthcare provider should follow other appropriate methods to determine treatment.
- An automated external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- A person who chooses either "comfort measures only" or "limited additional interventions" may not require transfer or referral to a facility with a higher level of care.
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."
- A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-sustaining treatment, at any time, and request alternative treatment.

### Review

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:

1. The person is transferred from one care setting or care level to another, or
2. There is a substantial change in the person's health status, or
3. The person's treatment preferences change

### Revoking POLST

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the Invalid POLST; write "VOID" in large letters across the form, and sign and date the form.
Information on POLST
If you think a POLST is right for you or your loved one, talk to your health care provider. Your doctor, nurse, social worker or other health care professional is the best resource for information about POLST.

Additional information about POLST can be found at:
- http://www.aging.pitt.edu/professionals/resources-polst.htm
- www.polst.org

You may also contact:
Marian Kemp, RN
POLST Coordinator
Coalition for Quality at the End of Life (CQEL)
E-mail: papolst@verizon.net

Coalition for Quality at the End of Life (CQEL)
650 Smithfield St # 2400
Pittsburgh, PA 15222-3922

January 2012
in the windpipe to assist breathing.

Electric shock or a plastic tube being placed electric shock or a plastic tube being placed

pressure on the chest. May also involve pressure on the chest. May also involve
nose-to-mouth and mouth-to-mouth and mouth-to-mouth and mouth-to-mouth and
resuscitation. Typically includes resuscitation. Typically includes
and who has no heartbeat. Typically includes and who has no heartbeat. Typically includes
resuscitation of a person who is not breathing resuscitation of a person who is not breathing
and the attempt to restart breathing and the attempt to restart breathing
Cardiopulmonary Resuscitation (CPR)
Cardiopulmonary Resuscitation (CPR)

Trachea.

Surgical procedure directly into the the windpipe to assist breathing.

Long-term basics: a tube inserted through a tube inserted through a
nose into the throat. Can be given through a tube in the nose

Short-term basics: fluids and liquids

The patient can no longer eat or drink

Artificial Nutrition
Artificial Nutrition

What are some of the terms used when...what are some of the terms used when...

POPLST is discussed?
POPLST is discussed?

The form is kept in the medical chart.
The form is kept in the medical chart.

POPLST is completed by a physician.
POPLST is completed by a physician.

Nutrition
Nutrition

Artificially administered fluids and
Artificially administered fluids and

The use of antibiotics
The use of antibiotics

medical conditions
medical conditions

The POPLST form includes information
The POPLST form includes information

Even for those who have an advance directive, a POPLST form is recommended.
Even for those who have an advance directive, a POPLST form is recommended.

Care in the Patient's State of Health.
Care in the Patient's State of Health.

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Emergency Situations
Emergency Situations

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Reaching the patient's state of

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Pennsylvania Orders for Life-Sustaining Treatment (POLST)
Frequently Asked Questions

- **What is the POLST Program?**
  POLST is a voluntary process that:
  - Translates a patient's goals for care at the end of life into medical orders that follow the patient across care settings;
  - Consists of physician orders that are based on a patient's medical condition and his/her treatment choices as established in communication between the patient or the legal medical decision-maker and a health care professional;
  - Is designed to improve the quality of care people receive at the end of life by turning patient goals and preferences for care into medical orders.

  While the program is known by different names elsewhere, in our state POLST stands for "Pennsylvania Orders for Life-Sustaining Treatment".

- **For whom is a POLST form appropriate?**
  Use of the POLST form is recommended for persons who have advanced chronic progressive illness and/or frailty, those who might die in the next year or anyone of advanced age with a strong desire to further define their preferences of care in their present state of health. To determine whether a POLST form should be encouraged, clinicians should ask themselves, "Would I be surprised if this person died in the next year". If the answer is "No, I would not be surprised", then a POLST form is appropriate. Unless it is the patient's preference, use of the POLST form is not appropriate for persons with stable medical or functionality problems who have many years of life expectancy.

- **May a health care provider (hospital, nursing home, hospice, other) require completion of a POLST form for all patients?**
  No. As stated above, use of the POLST form is completely voluntary and completed only after a discussion of choices between a patient or his/her legal decision-maker and physician. However, facilities may choose to use the POLST form to document Do-not-Resuscitate vs. full code status for all patients, including those less seriously ill.

- **Is POLST an advance directive?**
  No, the POLST form is NOT an advance directive (i.e., living will or health care power of attorney). A POLST form represents and summarizes a patient's wishes in the form of medical orders for end-of-life care. The POLST form is designed to be most effective in emergency medical situations.

- **Is an advance directive required in order to have a POLST?**
  No, an advance directive is not required for the completion of POLST. The POLST is an instrument that complements an advance directive. An advance directive, in which a healthcare agent is appointed, allows for the designated agent to be engaged in care planning and healthcare decision-making even when a patient is no longer able to be involved in his/her treatment choices. It is recommended that people with advanced illness and/or advanced frailty have both an Advance Directive and a POLST form.

- **Can a POLST form be completed following discussion with someone other than the patient?**
  Yes, a POLST form can be completed based on a patient's treatment choices as expressed by a health care agent, guardian, health care representative or parent of a minor (legal decision-maker).

- **Are there any limitations on a POLST form completed by someone other than the patient?**
  Yes. Neither a health care representative nor a guardian of the person may decline care necessary to preserve life unless the patient is in an end-stage medical condition or is permanently unconscious. Only a competent patient or a health care agent authorized by a health care power of attorney may decline such care. In addition, if the health care decision-maker is a court-appointed guardian of the person, the court order should be examined to determine whether the order of appointment specifically deals with health care decision-making. If it does not specify powers regarding health care, particular care should be exercised to discuss the completion of the POLST with any other available family members, and if there is disagreement, a court order may be advisable.
Pennsylvania Orders for Life-Sustaining Treatment (POLST)
Frequently Asked Questions

- **What are the requirements for a POLST form?**
The POLST form at a minimum must include the patient name, resuscitation orders (Section A) and signature of a physician, physician assistant or certified registered nurse practitioner (Section E). A physician countersignature is required for physician assistant signed forms within ten days or less as established by facility policy and procedure. Sections B, C and D are optional.

- **How and when does one review and update a POLST Form?**
The POLST form should be reviewed if (1) the patient is transferred from one care setting or care level to another, (2) there is a substantial change in patient health status, or (3) the patient's treatment preferences change. The patient (or person completing the form on behalf of the patient) can also identify when to review the POLST form: closeness to death, extraordinary suffering, improved condition, advanced progressive illness, and/or permanent unconsciousness. An emergency room visit or inpatient hospitalization calls for a review. A person with capacity or the legal decision-maker of a person without capacity can always ask for review or alternate treatment.

- **Can a patient revoke a POLST?**
Yes. Should a patient revoke a POLST, "VOID" should be written on the front side of the form. A new form can then be completed, but a new POLST is not required.

- **Can a copy of the POLST form, rather than the original, accompany a transferring patient?**
Yes, a copy of the POLST form should be accepted when it is sent with the patient. It is recommended that the copy be made on pulsar pink paper.

- **If a nursing home patient with a POLST and an advance directive is being transferred, is the advance directive also sent along with the POLST?**
Yes, it is important that the treating facility have all available information including the POLST and advance directive.

- **Does one document, the advance directive or POLST, supersede the other?**
No, ideally the values expressed on the advance directive do not conflict with the medical orders on the POLST. One document does not necessarily supersede the other. If there is conflict between the two instruments, then it is best to amend the one that is not representative of the patient’s values and choices for medically indicated treatments.

- **What is recommended if the advance directive and the POLST conflict?**
The usual process is to carefully elicit patient values from the patient or legal decision-maker, and making sure the POLST is consistent with these values. If in crisis and goals of care are not clear, then provide a higher level of care until more information is known.

- **Who is responsible to assure the POLST and advance directive are not in conflict?**
Ultimately it is the attending physician. It would also be the responsibility of the physician's agent who is helping to complete the document (Nurse or social worker at nursing home, for example).

- **Does a DNR order imply that a patient does not want treatment?**
No, a DNR order is only a decision about CPR and does not relate to any other treatment. An informed patient may recognize the futility of CPR in the presence of advanced or serious illness and may request a DNR order. However, based on their goals for care, the patient may wish to receive further treatment.

- **How does the POLST program ensure incapacitated individuals are not harmed by the POLST?**
The POLST is specifically designed to assure that an individual's treatment choices for end-of-life care are respected whether the choices are full or limited treatment or comfort measures only. The orders on the form are based on a patient's medical condition and his/her treatment choices. Use of the POLST form is completely voluntary. A POLST form is completed only after a discussion of end-of-life choices between a patient or his/her legal decision-maker and physician.

More information is available through the POLST coordinator at polst@verizon.net or online at: www.aging.pitt.edu/professionals/resources-polst.htm or www.polst.org.

8_29_12
POLST: An improvement over traditional advance directives

ABSTRACT

Physician Orders for Life-Sustaining Treatment (POLST) is a process that translates a patient’s goals for care at the end of life into medical orders that follow the patient across care settings. POLST overcomes the limitations of traditional advance directives. It enables physicians and other health care professionals, through a conversation with a patient or surrogate, to assess and convey the wishes of patients with serious life-limiting illness who may have a life expectancy of less than 1 year, or of anyone of advanced age interested in defining his or her wishes for end-of-life care.

KEY POINTS

Failures and opportunities for improvement in current advance care planning processes highlight the need for change.

Advances exist between traditional advance directives and actionable medical orders.

Advance care planning discussions can be initiated by physicians as a wellness initiative for everyone 18 years of age and older and can help patients and families understand advance care planning.

POLST is outcome-neutral and may be used either to limit medical interventions or to clarify a request for any or all medically indicated treatments.

Shared, informed medical decision-making is an essential element of the POLST process.

A 90-year-old woman with advanced dementia is living in a nursing home and is fully dependent in all aspects of personal care, including feeding. She has a health care proxy and a living will.

Her husband is her health care agent and has established that the primary goal of her care should be to keep her comfortable. He has repeatedly discussed this goal with her attending physician and the nursing-home staff and has reiterated that when his wife had capacity, she wanted “no heroics,” “no feeding tube,” and no life-sustaining treatment that would prolong her dying. He has requested that she not be transferred to the hospital and that she receive all further care at the nursing home. These preferences are consistent with her living will.

One evening, she becomes somnolent and febrile, with rapid breathing. The physician covering for the attending physician does not know the patient, cannot reach her husband, and sends her to the hospital, where she is admitted with aspiration pneumonia.

Her level of alertness improves with hydration. However, the hospital nurses have a difficult time feeding her. She does not seem to want to eat, “pockets” food in her cheeks, is slow to swallow, and sometimes coughs during feeding. This is nothing new—at the nursing home, her feeding pattern had been the same for nearly 6 months. During this time she always had a cough; fevers came and went. She has slowly lost weight; she now weighs 100 lb (45 kg), down 30 lb (14 kg) in 3 years.

With treatment, her respiratory distress and fever resolve. The physician orders a swallowing evaluation by a speech therapist, who determines that she needs a feeding tube. After that, a meeting is scheduled with her husband
and physician to discuss the speech therapist's assessment. The patient's husband emphatically refuses the feeding tube and is upset that she was transferred to the hospital against his expressed wishes.

Why did this happen?

TRADITIONAL ADVANCE DIRECTIVES ARE OFTEN NOT ENOUGH

Even when patients fill out advance directives in accordance with state law, their preferences for care at the end of life are not consistently followed.

Problems with living wills

Living wills state patients' wishes about medical care in the event that they develop an irreversible condition that prevents them from making their own medical decisions. The living will becomes effective if they become terminally ill, permanently unconscious, or minimally conscious due to brain damage and will never regain the ability to make decisions. People who want to indicate under what set of circumstances they favor or object to receiving any specific treatments use a living will.

The Patient Self-Determination Act of 1990 states that on admission to a hospital or nursing home, patients have to be informed of their rights, including the right to accept or refuse treatment. However, the current system of communicating wishes about end-of-life care using solely traditional advance directives such as the living will has proven insufficient. This is because traditional advance directives, being general statements of patients' preferences, need to be carried out through specifications in medical orders when the need arises.

Further, traditional advance directives require patients to recognize the importance of advance care planning, understand medical interventions, evaluate their own personal values and beliefs, and communicate their wishes to their agents, loved ones, physicians, and health care providers. Moreover, these documents apply to future circumstances, require further interpretation by the agent and health care professionals, and do not result in actionable medical orders. Decisions about care depend on interpreting earlier conversations, the physician's estimates of prognosis, and, possibly, the personal convictions of the physician, agent, and loved ones, even though ethically, all involved need to focus on the patient's stated wishes or best interest. A living will does not help clarify the patient's wishes in the absence of antecedent conversation with the family, close friends, and the patient's personal physician. And living wills cannot be read and interpreted in an emergency.

The situation is further complicated by difficulty in defining "terminal" or "irreversible" conditions and accounting for the different perspective that physicians, agents, and loved
ones bring to the situation. For example, imagine a patient with dementia nearing the end of life who eats less, has difficulty managing secretions, aspirates, and develops pneumonia. While end-stage dementia is terminal, pneumonia may be reversible.

Increasingly, therefore, people are being counseled to appoint a health care agent (see below).³

**The importance of a health care proxy**

(durable power of attorney for health care)

In a health care proxy document (also known as durable power of attorney for health care), the patient names a health care agent. This person has authority to make decisions about the patient's medical care, including life-sustaining treatment. In other words, you the patient appoint someone to speak for you in the event you are unable to make your own medical decisions (not only at the end of life).

Since anyone may face a sudden and unexpected acute illness or injury with the risk of becoming incapacitated and unable to make medical decisions, everyone age 18 and older should be encouraged to complete a health care proxy document and to engage in advance care planning discussions with family and loved ones. Physicians can initiate this process as a wellness initiative and can help patients and families understand advance care planning. In all health care settings, trained and qualified health care professionals can provide education on advance care planning to patients, families, and loved ones.

A key issue when naming a health care agent is choosing the right one, someone who will make decisions in accordance with the person's current values and beliefs and who can separate his or her personal values from the patient's values. Another key issue: people need to have proactive discussions about their personal values, beliefs, and goals of care, which many are reluctant to do, and the health care agent must be willing to talk about sensitive issues ahead of time. Even when a health care agent is available in an emergency, emergency medical services personnel cannot follow directions from a health care agent. Most importantly, a health care agent must be able to handle potential conflicts between family and providers.

**TABLE 2**

Four questions about treatment at the end of life

Will treatment make a difference?
Do the burdens of treatment outweigh its benefits?
Is there hope of recovery? If so, what will life be like afterward?
What does the patient value? What is the patient's goal for his or her care?

**POLST ENSURES PATIENT PREFERENCES ARE HONORED AT THE END OF LIFE**

Approximately 20 years ago, a team of health care professionals at the University of Oregon recognized these problems and realized that physicians needed to be more involved in discussions with patients about end-of-life care and in translating the patient's preferences and values into concrete medical orders. The result was the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program.⁴

**What is POLST?**

POLST is an end-of-life care transitions program that focuses on patient-centered goals for care and shared informed medical decision-making.⁵ It offers a mechanism to communicate the wishes of seriously ill patients to have or to limited medical treatment as they move from one care setting to another. TABLE 1 lists the differences between traditional advance directives and POLST.

The aim is to improve the quality of care that seriously ill patients receive at the end of life. POLST is based on effective communication of the patient's wishes, with actionable medical orders documented on a brightly colored form (www.ohsu.edu/polst/programs/sample-forms.htm; **FIGURE 1**) and a promise by health care professionals to honor these wishes.⁶ Key features of the program include education, training, and a quality-improvement process.

**Who is POLST for?**

POLST is for patients with serious life-limiting illness who have a life expectancy of less
PHYSICIAN ORDERS

Physician Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition, new orders may need to be written.

For more information: www.polst.org

FIGURE 1. Oregon’s Physician Orders for Life-Sustaining Treatment (POLST) form.

The key element of the POLST process:
Shared, informed medical decision-making
Health care professionals working as an interdisciplinary team play a key role in educating patients and their families about advance care planning and shared, informed medical decision-making, as well as in resolving conflict. To be effective, shared medical decision-making must be well-informed. The decision-maker
Most hospice patients choose at least one life-sustaining treatment on POLST

(patient, health care agent, or surrogate) must weigh the following questions (Table 2):

- Will treatment make a difference?
- Do the burdens of treatment outweigh its benefits?
- Is there hope of recovery? If so, what will life be like afterward?
- What does the patient value? What is the patient's goal for his or her care?

In-depth discussions with patients, family members, and surrogates are needed, and these people are often reluctant to ask these questions and afraid to discuss the dying process. Even if they are informed of their diagnosis and prognosis, they may not know what they mean in terms of their everyday experience and future.

Health care professionals engaging in these conversations can use the eight-step POLST...
TABLE 3

POLST eight-step protocol

Prepare for discussion
- Review what is known about patient and family goals and values
- Understand the facts about the patient’s medical condition and prognosis
- Review what is known about the patient’s capacity to consent
- Retrieve and review completed advance directives and prior do-not-resuscitate documents
- Determine who key family members are, and if the patient does not have the capacity, see if there is an identified health care agent, guardian or health care representative
- Find uninterrupted time for the discussion

Begin with what the patient and family know
- Determine what the patient and family know about the patient’s condition and prognosis
- Determine what is known about the patient’s views and values in light of the medical condition

Provide any new information about the patient’s medical condition and values from the medical team’s perspective
- Provide information in small amounts, giving time for response
- Seek a common understanding; understand areas of agreement and disagreement
- Make recommendations based on clinical experience in light of the patient’s condition

Try to reconcile differences in terms of prognosis, goals, hopes, and expectations
- Negotiate and try to reconcile differences; seek common ground; be creative
- Use conflict resolution when necessary

Respond empathetically
- Acknowledge
- Legitimize
- Explore (rather than prematurely reassure)
- Empathize
- Reinforce commitment and nonabandonment

Use POLST to guide choices and finalize patient and family wishes
- Review the key elements with the patient and family
- Apply shared medical decision-making
- Manage conflict resolution

Complete and sign POLST
- Get verbal or written consent from the patient or health care agent, guardian, health care representative
- Get written order from the treating physician and witnesses
- Document conversation

Review and revise periodically

*POLST (Physician Orders for Life-Sustaining Treatment) is a medical order form designed to provide a single, community-wide document that would be easily recognizable and would enable the patient’s wishes for life-sustaining treatment to be honored. This eight-step protocol was originally developed by Dr. Patricia Bomba for the POLST Program of New York State. Program Information is found at www.CompassionAndSupport.org.

Protocol (Table 3) to elicit their preferences at the end of life. Table 4 lists tools and resources to enhance the understanding of advance care planning and POLST.

What does the POLST form cover?
The POLST form (Figure 1) provides instructions about resuscitation if the patient has no pulse and is not breathing. Additionally, the medical orders indicate decisions about the level of medical intervention that the patient wants or does not want, eg, intubation, mechanical ventilation, transport to the hospital, intensive care, artificial nutrition and hydration, and antibiotics.

Thus, POLST is outcome-neutral and can
be used either to limit medical interventions or to clarify a request for any or all medically indicated treatments.

Both the practitioner and the patient or patient's surrogate sign the form. The original goes into the patient's chart, and a copy should accompany the patient if he or she is transferred or discharged. Additionally, if the state has a POLST registry, the POLST information should be entered into the registry.

**POLST is expanding across the country**
The use of POLST has been expanding across the United States, with POLST programs now implemented in all or part of at least 30 states. There are endorsed programs in 14 states, and programs are being developed in 26 more. Requirements for endorsement are found at www.polst.org. **Figure 2** shows the status of POLST in the 50 states.

Oregon's POLST form is the original model for other forms designed to meet specific legislative or regulatory requirements in other states. POLST-like programs are known by different names in different states: eg, New York's Medical Orders for Life-Sustaining Treatment (MOLST) and West Virginia's Physicians Orders for Scope of Treatment (POST), but all endorsed programs share common core elements.

**POLST research**
A number of studies in the past 10 years have shown that POLST improves the documentation and honoring of patient preferences, whatever they may be.4-8,15

Emergency medical technicians in Oregon reported that the POLST form provides clear instructions about patient preferences and is useful when deciding which treatments to provide. In contrast to the single-intervention focus of out-of-hospital do-not-resuscitate orders, the POLST form provides patients the opportunity to document treatment goals and preferences for interventions across a range of treatment options, thus permitting greater individualization.15

Comfort care is not sacrificed if a POLST document is in place. Most hospice patients choose at least one life-sustaining treatment on their POLST form.14

In a multistate study published in 2010, the medical records of residents in 90 randomly chosen Medicaid-eligible nursing homes were reviewed.15 POLST was compared with traditional advance care planning in terms of the effect on the presence of medical orders reflecting treatment preferences, symptom management, and use of life-sustaining treatments. The study found that residents with POLST forms had significantly more medical orders about life-sustaining treatments than

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**TABLE 4**
Tools and resources to enhance the understanding of advance care planning and POLST

| Center for Ethics in Health Care and National POLST Paradigm Program | www.polst.org |
| Community-wide End-of-life/Palliative Care Initiative and New York State's MOLST | www.CompassionAndSupport.org |
| Aging Institute of UPMC Senior Services and the University of Pittsburgh Website | www.aging.pitt.edu/professionals/resources.htm |
| West Virginia Center for End-of-Life Care POST | www.wvendolife.org |
| End-of-Life and Palliative Care Education Resource Center | www.eperc.mcw.edu |

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**FIGURE 2.** Status of POLST programs, by state, as of May 2012. SOURCE: www.ohsu.edu/polst.
residents with traditional advance directives. There were no differences between residents with or without POLST forms on symptom assessment or management measures. POLST was more effective than traditional advance planning at limiting unwanted life-sustaining treatments. The study suggests that POLST offers significant advantages over traditional advance directives in nursing facilities.\(^\text{15, 16}\)

In summary, more than a decade of research has shown that the POLST Paradigm Program serves as an emerging national model for implementing shared, informed medical decision-making. Furthermore, POLST more accurately conveys end-of-life care preferences for patients with advanced chronic illness and for dying patients than traditional advance directives and yields higher adherence by medical professionals.

**REFERENCES**


**CORRECTION**

In the June 2012 issue, on page 384 of the Clinical Picture article by Álvarez-Twose et al (Álvarez-Twose I, Vafio-Galván S, Sanchex-Munoz L, Fernandez-Zapardiel S, Escribano L. The Clinical Picture: anemia, leukocytosis, abdominal pain, flushing, and bone and skin lesions. Cleve Clin J Med 2012; 79:384-386), Dr. Álvarez-Twose's first name was spelled incorrectly. The correct spelling is Iván. This error has been corrected in the online version.
Helpful Phrases for POLST Conversations

Introduction – Finding Out What the Patient/Family Understands

- Who would you like to be with you as we talk about your health and treatments?
- How have the last 3 months /6 months been for you/your family member?
- How have things been going for you at home? (In the past days, weeks, last few months)
- When you think about what lies ahead what worries you the most?
- What is bothering you the most?
- When you think about the future, what do you hope for?
- What has your doctor told you about your illness/medical condition?
- What do you think is happening with your health?
- What brings you the greatest comfort right now?
- Can you share with me more about what you are thinking so we can work together?
- Many patients with your condition (COPD, cancer, etc.) think about the possibility of dying and have questions about this. Have you thought about this?
- What does a “good death” look like to you?
- I have information about your condition. Some patients want to know the details and others prefer to have me talk to someone else. What are your thoughts/preferences?
- What would you like us know about your cultural/spiritual beliefs to best take care of you?

Introducing POLST

- We want to document your treatment wishes should you become seriously ill.
- It’s important to talk about your health and your wishes for medical care if you got really sick. We talk about this with everyone with serious illness. Your doctor will review what we talk about and answer your questions.
- You look really concerned. How are you doing?
- Refer to The POLST Conversation and The POLST Cue Card for more detailed information.
Discussing Bad News or Difficult Situations

- Use warning words such as, “I am sorry…”, “I wish…”, “I had also hoped for…”, If what we hoped for does not happen... we also need to be prepared…”, “If your time were limited…”, “If your Dad could see his life now, what would he tell us?... What would he want?”
- Focus on what we can and will do: “Do everything possible to meet your needs…” “Concentrate on maximizing comfort.”

Concluding Discussion

- I can appreciate that this has been a difficult discussion.
- I can tell that this has been really hard for you. What can we do now that would be of help to you?

Phrases to Avoid

- There is nothing more we can do for you.
  - Patients and families may feel abandoned. Rather focus on what medical treatment can be provided. For example: “We are going to aggressively treat your pain and other symptoms. Our goal is for you to be as comfortable as possible.”
- Would you like us to do everything possible? or Do you want us to do everything?
  - It is difficult to answer “no” to these questions for fear of not getting good care. Instead, it is important for the physician to make care recommendations to the patient and family. For example: “Based on your prognosis and your goal to be comfortable, I recommend we don’t do things that might cause you discomfort such as chest compressions or being put on a breathing machine. Instead, we will give you medicines to aggressively treat your pain and other symptoms.”
- Should we withdraw care? or It is time to think about withdrawal of care?
  - These words lead to fear of abandonment. Instead, talk about a transition in the types of treatments that will best meet your goals of care. Talk about the burdens and benefits of different treatments.

- Avoid talking in absolutes.
  - Instead, refer to hours to days; days to weeks; weeks to months. No one knows the exact moment that death will occur.
POLST Cue Card

It’s important to talk about your health and your wishes for medical care if you got really sick. We talk about this with everyone with serious illness. Your doctor will review what we talk about and answer questions. (If appropriate, encourage patient to complete an advance directive and to designate a health care agent if not previously done.)

Take time to ask... How do you feel things are going? Have you noticed any changes in the past weeks, months? What has your doctor told you about your medical condition? What do you hope for with your care? What do you enjoy doing? What is important to you? What gives your life meaning?

POLST records your wishes for medical care if you are seriously ill; becomes medical orders after you and your doctor sign. Form goes with you to hospital. POLST can be changed if your condition changes or your treatment wishes change.

Section A: Cardiopulmonary Resuscitation/CPR - Introduce with, “If you had a bad heart attack...” CPR is attempted only if the heart has stopped beating; you are not breathing, not awake and have died a natural death. Unfortunately, CPR almost never works on older people. Of the rare times people live thru CPR, most will be on ventilator (life support) for a period of time and may still die. For those who survive, many have worse disability and brain damage. CPR never cures the original medical problem.

If you die a natural death, would you want us to try CPR?
- If “yes” – Requires Full Treatment in Section B. (Ask about Ventilator Trial)

Section B: Medical Interventions - Introduce with, “If you got really sick, for example, you had a bad pneumonia...” There are different treatment options for serious illness. We always take care of comfort needs. With aggressive medical care, say you needed a ventilator to help you breathe, the machine is not comfortable and pain and sedating/calming medicines are needed. Recovery time after intensive treatments is often long and difficult.
- Full Treatment: All medical treatment options. You can ask to stop if doctor thinks you are not going to make good recovery and treatments are just keeping you alive. We can write “Full treatment for trial period” on Additional Orders.
- Limited Additional Interventions: Hospital care, but no ventilator, no intubation. May use non-invasive positive pressure breathing mask. Patients often choose not to have major surgery or treatments with long, difficult recoveries.
- Comfort Measures Only: Some patients with illness we cannot cure want us to care for them by treating all symptoms and pain, focusing on comfort. The patient chooses not to start treatments to try and cure medical problems because they do not want to prolong their life. Medicines to promote comfort, like antibiotics for bladder infection, can be given.

What do you think is best for you? For SNF patients, Limited Interventions, ask if they want hospital transfer or treatment at SNF with transfer to hospital only if required to meet comfort needs.

7/29/2013
Section C: Antibiotics - Introduce with, “Antibiotics may require a conversation on how they may be used to treat a specific condition”.
You can choose “no antibiotics” or “use if life can be prolonged”. You also may want to determine use or limitation when an infection occurs.

What do you think is best for you?

Section D: Artificially Administered Hydration / Nutrition - Introduce with, “If you had brain damage from a bad stroke or severe dementia or Alzheimer’s and you cannot speak for yourself, cannot swallow food or fluids and are not expected to recover (or may take months to recover).
Food is offered by mouth if possible and desired. We will continue to hand feed you with the best texture of food and help you eat as best you can. Or a feeding tube can be placed to give artificial nutrition with medically prescribed formula. Careful feeding by hand can be just as effective for most people and some believe the human touch is better. There is little evidence that artificial tube feeding helps people with advanced dementia. Artificial tube feeding can be helpful in specific situations like cancer of the mouth or throat, and some may choose a trial period, in hopes that their ability to swallow may get better.

If patient desires further information you can add, artificial tube feeding may be uncomfortable, does not prevent pneumonia, and can cause swelling and infections.

Would you want hand feeding to allow you to eat as best you can, or would you want long-term artificial nutrition by tube?

Next steps:

- Review POLST choices.
- Prepare any questions and coordinate time with doctor if follow up would be helpful or wanted by patient.
- Complete signatures
- Document the conversation.

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7/29/2013
August 1, 2013

Judith Black, MD, MHA
Medical Director, Senior Market
Highmark, Inc.
120 5th Avenue
Pittsburgh, PA 15222

Re: Authorization to use copyrighted materials *

The Coalition for Compassionate Care of California (CCCC) hereby grants Highmark, Inc. permission to use the following resources:

- POLST Education Curriculum – Module 4 and Module 5, including Role Plays, Case Studies and Cue Cards

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Judy Citko
Executive Director

Date

8/1/13

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August 1, 2013

Marian Kemp
POLST Coordinator
Coalition for Quality at the End of Life (CQEL)

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Judy Citko
Executive Director

8/1/13

Date

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Dear Dr. Bomba,

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Let us know if we can be of help in any other way.

Best regards,
Peter

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PAIN MANAGEMENT FOR THE DELIRIOUS AND NON-VERBAL PATIENT

Friday, November 22, 2013
1:45 PM – 3:00 PM

Esteemed Faculty

Sandra P. Gomez, MD, FAAHPM
President, Symptom Management Consultants P.A.
Physician Director, Hermann Medical Hospital System Palliative Care
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Objective(s):

1. Describe common opioids used for pain management in delirious or non-verbal patients
2. Identify new onset delirium and the patient’s response to pain
3. Provide adequate/appropriate pain management in a non-verbal/unresponsive patient
Pain Management for the Delirious and Non-Verbal Patient

Sandra P. Gomez, MD FAAHPM
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Objectives
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Definition of Pain
- "An unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage".
  - International Association for the Study of Pain.
- The American Academy of Pain Medicine defines pain as - "An unpleasant sensation and emotional response to that sensation".

Types of pain
- Acute pain is pain of sudden onset, lasting for hours to days and disappears once the underlying cause is treated. Acute pain has a clear cause.
- Chronic pain is the pain that starts as an acute pain and continues beyond the normal time expected for resolution of the problem or persists or recurs for various other reasons.

Chronic pain
- Chronic pain is further divided into
  - Nociceptive pain
    - Pain arising from damage to tissues other than nerve fibers.
  - Neuropathic pain
    - Pain caused by the lesion in the nervous system.

Cancer Pain
- Malignant pain is the pain suffered by the patients with cancer.
- The pain can be either due to the disease or treatment.
- It can be nociceptive or neuropathic or both.
Prevalence of Pain

- 25-50% of community-dwelling aging individuals experience significant pain.
- 50% of critically ill patients.
- Older patients (>65 years) had similar level of pain intensity but required lower amount of opioid analgesia than younger adults.
- Age >85 & low cognitive performance are predictors of failure to receive analgesics.

Systemic Management of Nociceptive Pain in Delirious or Unresponsive Patients

- Same as standard pain management +
- Go low, Go Slow, but Go!
- Start with acetaminophen (unless severe)
- Routine dosing - avoid prn
- Avoid orders that use ranges
- Monitor poly-pharmacy

Opioids

- Opioids are effective pain relievers for all types of pain including neuropathic pain.
- The analgesic effects of opioids are due to decreased perception of pain by binding to opioid receptors.
- Weak Opioids like codeine and hydrocodone are dose limited by the acetaminophen in combined agents.

Strong Opioids

- Morphine
- Hydromorphone (Dilaudid)
- Oxycodone (Oxycontin)
- Methadone
- Fentanyl (Duragesic)
- Oxymorphone (Opana)

Opioid Management

- Around the clock dosing
- Dosing for breakthrough pain
- Long acting opioids
- Short acting opioids

Opioid Management in Delirium

- IV/SC administration preferred to oral
- Intermittent IV opioids vs. continuous infusion
- Frequent assessment
- Nursing bolus vs. demand via PCA
Side effects of opioids

- Sedation, usually temporary
- Nausea, can be temporary also
- Constipation

Opioid Induced Neurotoxicity (OIN)

- Caused by accumulation of the parent opioid and its metabolites
- Excessive sedation
- Hallucination
- Confusion (Deltium)
- Myoclonus
- Seizures

Treatment of OIN

- Opioid rotation
- Dose reduction or discontinuation
- Hydration
- Discontinuation of other contributing drugs

Opioid Rotation (OR)

- Substituting one opioid with another using equianalgesic ratios
- Indications
  - Uncontrolled pain
  - Opioid induced neurotoxicity
  - Common side effects
  - Route of administration
  - Opioid availability

Opioid Rotation for uncontrolled pain

- Balance between analgesia and side effects to allow dose escalation
- Large individual variation in response to different mu-agonists
- Incomplete cross tolerance between opioids
- Higher cross tolerance to adverse effects than to analgesic effects

Barriers in Assessment of Pain

- Patients with impaired ability to communicate: rely on non-verbal pain behaviors
- Delirium - great barrier to pain assessment
THE ELEPHANT IN THE ROOM: LET'S TALK ABOUT LESBIAN, GAY, BISEXUAL AND TRANSGENDER RELATIONSHIPS

Friday, November 22, 2013
3:15 PM – 4:15 PM

Esteemed Faculty

Crystal Stiffler, BSW
Social Worker, Orthopedics and Spine Specialists

Objective(s):

1. Describe the impact of lesbian, gay, bisexual and transgender relationships on health care delivery
2. Describe the struggles of LGBT in seeking health care in a timely manner
The Elephant in the room: Let's talk......
Lesbian, Gay, Bisexual and Transgender Discussions

By: Crystal Smith, MSW
Social worker, OSS Hospital

Why are we talking about this?

- According to a 2009 Lambda Legal survey, more than half of the LGBT population reported experiencing at least one of the following types of healthcare discrimination:

Why are we talking about this continues:

- Being refused needed care
- Healthcare professionals refusing to touch them or using excessive precautions
- Healthcare professionals using harsh or abusive language
- LGBT being blamed for their health status
- Healthcare professionals being physically rough or abusive

Lets talk history

- Discrimination
- Social stigma
- Prejudice
- History of being labeled as criminals, sinners, and mentally ill.

Movie Time

What is the impact?

- Life disruption
- Disrupted family connections
- Lifetime earnings
- Access to healthcare
- Apprehensive of healthcare professionals
Even bigger impact

- LGBT are at great risk for:
  - Social isolation
  - Depression and anxiety
  - Poverty
  - Chronic illness
  - Delayed care seeking
  - Poor nutrition
  - Premature mortality

- Less access to insurance and health care services
- Increased incidence of some cancers
- Inequitable policies and practices
- Little or no inclusion in health outreach or education
- Inappropriate restrictions or limits on visitation

Fear...

- LGBT also experience a number of health disparities related to higher rates of mental health issues, cancer, physical and emotional violence, obesity, substance abuse and HIV and/or other sexually transmitted diseases

Movie Time

Lets define LGBT:

- The acronym LGBT stands for lesbian, gay, bisexual, and transgender and is an umbrella term that generally refers to a group of people who are diverse with regard to their gender identity and sexual orientation

Sexual Orientation

- The preferred term used when referring to an individuals' physical and/or emotional attraction to the same and/or opposite gender. Sexual orientation describes how people locate themselves on the spectrum of attraction.
Sexual orientation continued:

- Someone who feels a significant attraction to both sexes is said to be bisexual.
- A man entirely or primarily attracted to men is said to be gay
- A woman entirely or primarily attracted to women is said to be lesbian

Transgender:

- People whose gender identity or gender expression differ from their birth sex or prevailing ideas of masculinity and femininity are often called transgender.
- Although transgender is an umbrella term that includes people who cross-dress and people who otherwise express themselves in unconventional ways from their birth sex, it is often used to refer to transsexuals—people who live as a sex not associated with their birth sex after a process known as "transitioning." Although some transsexuals describe themselves as "trans," others simply say they are male or female, depending on the sex to which they have transitioned.

Gender Identity

- The gender you feel you are inside (man, woman, neither or both). Gender identity and sexual orientation are NOT the same. Transgender people may be heterosexual, lesbian, gay or bisexual. Example: transgender woman who was assigned a male gender at birth and is attracted to other women may see her identity as lesbian.

Gender Expression

- Characteristics in appearance, personality, and behavior, culturally defined as masculine or feminine.

What is Homophobia

- Homophobia is a range of negative attitudes and feelings towards homosexuality and people who are identified or perceived as being homosexual. Also an antipathy, prejudice, contempt, and aversion, as well as irrational fear.

How do we make changes?

- Create a welcoming environment that is inclusive of LGBT patients.
- Prominently post the hospital's nondiscrimination policy or patient bill of rights.
- Waiting rooms and other common areas should reflect and be inclusive of LGBT patients and families.
Changes...

- Create or designate unisex or single stall restrooms.
- Ensure that visitation policies are implemented in a fair and nondiscriminatory manner.
- Foster an environment that supports and nurtures all patients and families.

Changes....

- Avoid assumptions about sexual orientation and gender identity.
- Refrain from making assumptions about a person’s sexual orientation or gender identity based on appearance.
- Be aware of misconceptions, bias, stereotypes, and other communication barriers.

Change the forms:

- All forms should contain inclusive, gender-neutral language that allows for self-identification.
- Patient forms should provide options that are inclusive of LGBT patients and families and should allow LGBT patients to self-identify if they choose to do so. For example, provide options such as “partnered” under “relationship status.” For parents, use terminology such as parent/guardian, which is inclusive of same-sex parents who may or may not be biologically related to the child.

- Open dialogue with a patient about their gender identity/expression, sexual orientation, and/or sexual practices means more relevant and effective care.

Transgender thoughts

- As with all patient contacts, approach the interview showing empathy, open-mindedness, and without rendering judgment.

- Prepare now to treat a transgender patient someday. Health care providers’ ignorance, surprise, or discomfort as they treat transgender people may alienate patients and result in lower quality or inappropriate care, as well as deter them from seeking future medical care.
Transgender thoughts continued

- Transgender individuals may have had traumatic past experiences with the healthcare team may cause fear or mistrust. Therefore, developing rapport and trust with transgender patients may take longer and require added sensitivity from the provider.

Transgender thoughts continued

- When talking with transgender people, ask questions necessary to assess the issue, but avoid unrelated probing. Explaining why you need information can help avoid the perception of intrusion, for example: “To help assess your health risks, can you tell me about any history you have had with hormone use?”

Taking a good history

- Explore the degree to which LGBT patients are “out” to their employers, family, and friends, and/or the extent of social support or participation in community. One’s level of identification with community in many cases strongly correlates with decreased risk for STDs (including HIV) and improved mental health.

Taking a good history, continued

- Understand that LGBT people are particularly vulnerable to social stresses that lead to increased tobacco and substance use. A recent large study showed GB men smoked 50% more than other men, and LGBT women smoked almost 200% more than other women. Emphasis on other health issues may leave many people unaware of the disproportionate impact of tobacco in this population. Be prepared to intervene and provide treatment options. Likewise, explore whether LGBT patients are dealing with social stress through alcohol or drug use and be prepared to present treatment options. Social stress may also contribute to body image, exercise, and eating habits.

Taking a good history, continued

- Conduct violence screening: LGBT people are often targets of harassment and violence, and LGBT people are not exempt from intimate partner/domestic violence. Individuals being battered may fear being “outed,” i.e., that if they report the violence to providers or authorities, their batterer could retaliate by telling employers, family, or others that they are gay. Assure the patient of confidentiality to the extent possible depending on your state laws regarding mandatory reporting.

Taking a good history, continued

- Ask all patients—men and women—violence screening questions in a gender neutral way:
- Have you ever been hurt (physically or sexually) by someone you are close to or involved with, or by a stranger?
- Are you currently being hurt by someone you are close to or involved with?
Taking a good History continued:
- Are you sexually active with men, women or both or neither?
- What was your sex assigned at birth? What's your gender identity now?
- Do you currently have a partner? Is your partner male, female or transgender?
- Is there anything related to your sexuality or gender that might be relevant to your healthcare at this time?

Language
- Listen to your patients and how they describe their own sexual orientation, partner(s) and relationship(s), and reflect their choice of language.

Language continued
- Respect transgender patients by making sure all office staff is trained to use their preferred pronoun and name. Clearly indicate this information on their medical record in a manner that allows you to easily reference it for future visits.

Movie Time

What does it boil down to?
- Respect

Thank you!
Questions?