Nevada POLST Post

Fall 2019

Incentivizing Providers to Complete a POLST

It is always a good idea to have Advance Care Planning with all patients. Everyone over 18 should be aware of and have an option to complete an advance directive and designate a DPOA-HC.

However, the Nevada POLST is *only* appropriate for those near the end of life. If the provider would not be surprised if the patient was not alive within a year, is frail and elderly or is near the end of a life-limiting illness, Nevada Law (NRS 449A.551.2) requires that the patient be told of:

(a) the existence and availability of the POLST form;
(b) the features and procedures offered by the POLST form; and,
(c) the differences between a POLST form and the other types of advance directives.

Generally, **patients who do not meet the criteria of approaching the end of life are not appropriate to have a POLST Form**. Most 65-year-olds, for example, are too healthy to have POLST orders and not all residents in a nursing home may be appropriate for a POLST form.

Although we like to think we know what we would want if we were near the end of a serious illness, just like other life crises, we often don't behave or make the choices we expect we might until confronted with the reality. If completed too far in advance, we may not have the hard experience needed to make a decision regarding end-of-life treatment. This also explains the recommendation to review the POLST if there is a change of health status or transfer to another facility; our realities may change! "*The intended population are the individuals with whom health care professionals can initiate specific and detailed conversations about current diagnosis, prognosis, treatment options, the likely effect those treatments will have on that patient* (e.g., what will most likely happen if CPR is attempted) and identify the patient's goals of care. For example, the POLST form provides medical orders for what happens tonight if a medical crisis occurs given the patient's current medical condition. If conversations with this level of specificity cannot happen, or if the patient is not appropriate for a POLST form based on their clinical status and prognosis, then a POLST form should not be offered to, or completed for, that patient (and an advance directive should be offered instead).[1]"

To broadly incentivize providers to complete POLST forms for inappropriate patients is a misuse of the POLST, confusing for patients and a violation of Nevada law.

In addition, inappropriate use presents legal jeopardy for providers receiving these patients. By law, providers are to follow POLST orders, but if a POLST has been completed for a patient who has chosen Comfort Focused Treatment, and they suffer a serious but treatable and reversible condition and would be expected to have a meaningful survival, the provider is confronted with a legal conundrum of whether to provide the standard of care treatment or follow a POLST that may have been completed without the patient's full understanding of the ramifications of their decision.

As an example, an otherwise healthy 40+-year-old is brought to the emergency department with a CVA. The patient temporarily lacks capacity. He has a POLST specifying Comfort Focused Treatment, but no DPOA or Surrogate. Normally, in this situation, if within the treatment window for TPA, TPA would be administered. This can be very successful, with patients able to eventually resume normal life activities. But, according to Nevada POLST legislation, the physician should only provide comfort measures in this case, although the standard of care would be to provide TPA. Because the POLST was completed inappropriately, the provider is put in a VERY challenging position. Many people change their minds about the level of care they want once they are confronted with the reality of nearing the end of life. In this case, the patient did not have an end-of-life realization upon which make an informed decision.

In addition, for those providers who *are* completing the POLST appropriately, it is confusing for their patients if they speak to other patients who have had a POLST completed inappropriately.

Incentives are a strong enticement to action. Applied judiciously and wisely, they can help encourage good medical practice. But, if providers have been misinformed regarding appropriate use of the POLST by the organization for which they work, they may unwittingly be using the POLST inappropriately and be skirting Nevada law.

Our organization, Nevada POLST, is the primary source of information regarding the Nevada POLST program. Be sure you receive accurate information so your patients are well served and you are not put in legal jeopardy. To learn more, you may register for one of our webinars or review the following:

- Appropriate Use Policy
- Quick Reference Guide
- Step-by-Step form completion
- Need to Know (patient brochure)

And, of course, should you have any questions or concerns we are always available at info@nevadapolst.org.

1. National POLST Paradigm Appropriate POLST Paradigm Form Use Policy, https://docs.wixstatic.com/ugd/5be8ad_5f1322c78b494e1e83e3baa965340d60.pdf.

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Please Our website provides:

- **Sample POLST forms**
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POLST: The 7 Deadly Sins - Part II of VII: Sin #2 Signing a POLST Form Without a Meaningful Discussion

In the last issue, Summer 2019, we began a series on the 7 Deadly Sins of POLST with excerpts presented in *Bifocal, the Journal of the ABA Commission on Law and Aging*[1]. We now continue with the 2nd Deadly Sin: Signing a POLST Form Without Meaningful Discussion. (Click here to view the 1st Deadly Sin article).

The POLST is a medical order and like all medical orders, requires knowledge of the patient to determine the appropriate corse of action. In addition, like any treatment that may involve invasive or aggressive measures, completion of the POLST involves an informed consent. That is, the patient should be told what the possible treatment choices involve, what the alternatives are, what the risks and benefits are and the likelihood of success might be.

In his discussion of the 2nd Deadly Sin, Mr. Sabatino clarifies this further stating:

> Completion of a POLST form requires discussion of: (1) the status of individual's medical condition; (2) the choices or trade-offs faced in the person's care and treatment; (3) the individual's goals and priorities given their current diagnosis and prognosis; and (4) the effect of each of the choices offered on the POLST form.
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> The discussion is the heart of the POLST process and also its Achilles heel if done poorly. Sometimes the compact nature of the POLST form is misperceived as a shortcut advance planning tool. Nothing could be further from the truth. As a medical order, it is short and succinct. But getting to that end product requires skillful communication, time, and attention, often from a team of providers. We have few good quality measures for these discussions, so professional and ethical diligence of providers is imperative.

The discussion with the patient or their representative or surrogate is known to be difficult for many providers. (By the way, do you know the legal difference between a healthcare representative and healthcare surrogate?)

There are legitimate reasons for this. As Mr. Sabatino acknowledges, the discussion takes time, a shortage of which is common to medical practice these days. However, the provider who signs the POLST (physician, APRN or PA) need not have the discussion with the patient. This may be done by auxiliary staff. Trained and experienced social workers, medical assistants or chaplains may be able to have the conversation. This person having the conversation needs to understand the patient's diagnosis and how the treatments offered on a POLST may impact the patient and how they relate to a patient's goals. In addition, they need to be able to explain the different options and what they entail.

For example, when discussing whether a patient would like to be resuscitated, we need to consider their particular health status. A frail, elderly patient is more likely to have broken ribs after CPR; the patient needs to know this and that there are medications to help relieve the pain, but there will be discomfort for several weeks. In addition, CPR will require that the patient be intubated. In the case of the frail, elderly patient, they are more likely have a difficult time being weaned from, or not be able to have an endotracheal tube removed. In other words, it is imperative that an informed consent is provided.

1. Sabatino, C (2018). "*POLST:Avoid the Seven Deadly Sins.*" *Bifocal, the Journal of the ABA Commission on Law and Aging.Mar/Apr 2018; 39 (4), 55 - 58.*