



COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Resources in California: POLST & PCAP

Judy Thomas, JD

Coalition for Compassionate Care of California

- Collaboration of healthcare providers, consumers and regulatory agencies
- Working together to improve care for seriously ill, and foster change in the areas of public, professional and system readiness
- 501(c)(3) nonprofit, founded in 1998



COALITION FOR
COMPASSIONATE CARE
OF CALIFORNIA

Tools, Publications and Research



NEW WHITEPAPER

Thinking Ahead Matters: Supporting and Improving Healthcare Decision-Making and End-of-Life Planning for People with Intellectual and Developmental Disabilities



Lead agency for POLST in California



- Support from California HealthCare Foundation
- Worked to pass AB 3000 that authorized the use of POLST throughout California
- Leads 25+ local POLST coalitions
- Developed California POLST education curriculum

caPOLST.org



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What is POLST?

- A physician order recognized throughout the medical system.
- Portable document that transfers with the patient.
- Brightly colored, standardized form for entire state of CA.





Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

EMSA #111 B
(Effective 10/1/2014)*

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #:

A **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing, follow orders in Section A. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B or C.*

Check One

Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B.)

Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing, follow orders in Section B or C.*

Check One

Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubated advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, a fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intubation.

Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: _____

C **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and patient is able to swallow.*

Check One

Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

Trial period of artificial nutrition, including feeding tubes. _____

No artificial means of nutrition, including feeding tubes. _____

D **INFORMATION AND SIGNATURES:**

Discussed with: Patient (Patient Has Capacity) Legally Recognized Decisionmaker

Advance Directive dated _____, available and reviewed → Healthcare Agent if named in Advance Directive

Advance Directive not available Name: _____

No Advance Directive Phone: _____

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: (required)	Date:	

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request for resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:	Relationship: (write self)
Signature: (required)	Date:
Mailing Address (street/city/state/zip):	Phone Number: Office Use Only:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F
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Healthcare Provider Assisting with Form Preparation N/A if POLST is completed by signing physician

Name:	Title:	Phone Number:
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Additional Contact None

Name:	Relationship to Patient:	Phone Number:
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Directions for Healthcare Provider

Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

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

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

What is POLST?



- Allows individuals to choose medical treatments they **want** to receive, and identify those they **do not want**.
- Provides direction for healthcare providers during serious illness.



Who benefits from having a POLST form?

- Chronic, progressive illness
- Serious health condition
- Medically frail
- Tool for determination

“You wouldn’t be surprised if this patient died within the next year.”



POLST vs. Advance HealthCare Directive

POLST

- For seriously ill/frail, at any age
- Physician orders for ***medical*** treatment
- Can be signed by decisionmaker

AHCD

- For anyone 18 and older
- General instructions for treatment
- Appoints decisionmaker



The POLST conversation

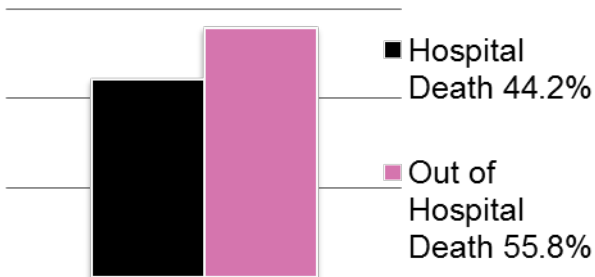
- POLST is **not** just a check-box form.
- The POLST conversation provides context for patients/families to:
 - Make informed choices.
 - Identify goals of treatment.

POLST success

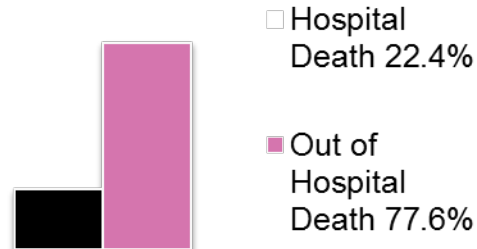
Oregon Study: Location of Death and POLST Orders

- 58,000 deaths reviewed, 31% had POLST in Oregon Registry
- Patient treatment choices honored, including avoiding dying in hospital

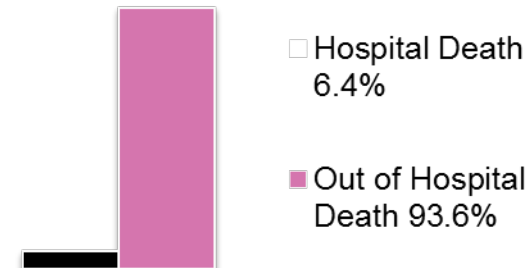
Full Treatment
1,153



Limited Interventions
4,787



Comfort Measures Only
11,836



Palliative Care Access Project (PCAP)

- Voice of palliative care in California
- Incubates and disseminates models and ideas to improve access to community-based palliative care
- Working to ensure organizations and communities have the information, knowledge and tools to create the future of palliative care



"Open source" palliative care

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Thinking Ahead Matters
Helping and Improving Healthcare Decision-Making of Older Adults with Physical and Developmental Disabilities

New whitepaper see how to understand conservatorship of people with developmental disabilities

Whitepaper published: Thinking Ahead Matters
The Coalition for Compassionate Care of California undertakes effort to understand conservatorship of people with developmental disabilities. [Learn more and download the report](#)

FOR HEALTHCARE PROVIDERS
Resources for healthcare professionals on informed decision-making, palliative medicine and end-of-life care

FOR PATIENTS & LOVED ONES
Helping patients and loved ones discuss and document wishes for medical care

Impact Summary (Net Margin for Target Population)	Number of Patients	Value
Expected Clinical Revenues	1,000	\$1,000,000
Net margin impact per pt. from avoided hospitalizations at CCU	1,000	\$1,000,000
Avoided 30-day readmissions	1,000	\$1,000,000
Avoided 90-day readmissions	1,000	\$1,000,000
Avoided 180-day readmissions	1,000	\$1,000,000
Avoided 365-day readmissions	1,000	\$1,000,000
Impact Summary (Avoided Direct Costs)	1,000	\$1,000,000

VALUE SNAPSHOT | Palliative Care Clinics

Clinic-based palliative care decreases symptoms and improves patient satisfaction

Palliative care (PC) clinics apply a critical, extra layer of support to patients with complex conditions or uncertain prognoses. By providing early access to expert assistance with symptom management and medical decision-making, and by attending to the social, emotional and spiritual issues that often arise in the setting of serious illness, PC clinics positively affect patient health, wellbeing and satisfaction. In a review of the literature addressing the impact of outpatient palliative care, including results from four controlled trials, Rigor and colleagues noted evidence of **improved symptoms, improved quality of life, and greater satisfaction** among patients who used such services.¹

For example, in a prospective study of patients with metastatic cancer cared for in an oncology PC clinic, Fellner et al. found statistically significant improvements for **pain, fatigue, nausea, depression, anxiety, drowsiness, appetite, dyspnea, insomnia, and constipation** at 1 week (all p<0.005) and 1 month (all p<0.05) following initial consultation.² The investigators also found **significant improvement in patient satisfaction with multiple aspects of care following initial PC consultation**, that also showed the greatest

improvement were "information given about how to manage pain," "doctor's attention to symptoms," "how thoroughly the doctor assesses symptoms," and "speed with which symptoms are treated" (all p<0.005).

Patient Report of PC Effect on Communication, Coordination and Satisfaction

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Home-based palliative care increases satisfaction, reduces symptoms

Homebased palliative care (PC) fills a critical gap in the health care system, bringing expert, medication-free care to individuals with advanced or chronic illness who would otherwise face obstacles in accessing services. HomePC supports patients and caregivers by addressing pain and other symptoms, providing psychosocial support, reconciling medications, offering information about disease and prognosis, and engaging in and documenting goals of care discussions. With these supports and services patients can often take to receive care in their homes, even in the setting of advanced disease. Common measures of the ways homePC benefits patients and families include assessments of symptom burden, evidence of advance care planning, frequency and duration of hospice enrollment, proportion of patients who are able to die at home, and patient, family and referring provider satisfaction.

The Palo Alto Medical Foundation Palliative Care Service, which sees patients with advanced illness across multiple settings—including private residences and skilled nursing facilities—has documented and program impact across multiple domains.³ The program reports that **96% of enrolled patients have documented goals of care, and 94% have been called about advance care planning**. Further, **71% of enrolled patients who die do so while receiving hospice care, with a median hospice length of service of 40 days**—far longer than the national figure of 18.5 days reported by the National Hospice and Palliative Care Organization. These contributions have been appreciated by referring providers, 100% of whom report that they would use the service again.

Bunley and colleagues also documented positive results in a randomized controlled trial of homePC vs. usual care delivered to

VALUE SNAPSHOT | Inpatient Palliative Care

Inpatient palliative care improves care quality and family satisfaction

Hospitalized patients with serious illness, and their families, commonly have a wide range of needs, including management of pain and other symptoms, assistance with emotional and spiritual distress, help understanding complex medical information, addressing disease processes, prognosis and the benefits and burdens of various treatment options, and assistance in developing and ensuring adherence to care plans that reflect patient and family goals.¹

Families of patients who received palliative care also reported higher satisfaction with multiple elements of care compared to families of patients who received usual care.

Family Rating of Care Quality Following Care Compared to Usual Care

Inpatient PC can also help with symptom management. In a retrospective analysis of the impact of a PC service at a large urban hospital, Carones et al. found that **PC consultation had an impressive impact on clinical outcomes, with an observed reduction in pain, dyspnea, and secretion scores of 84%, 64%, and 87%, respectively, among consultation patients.**²

Change in Pain Scores Following PC Consultation

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Factsheets, reports, calculators and presentations

CoalitionCCC.org/PCAP

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7th ANNUAL SUMMIT

APRIL 14-15, 2015

SACRAMENTO, CALIFORNIA

COALITIONCCC.ORG/SUMMIT



Robert M. Arnold, MD



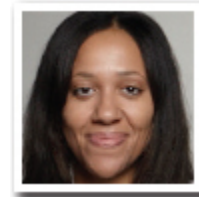
Diana Dooley



Shirley Otis-Green, MSW,
ACSW, LCSW, OSW-C



Christine, Ritchie, MD, MSPH,
FACP, FAAHPM



Cardinale Smith, MD, MSCR

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Judy Thomas, JD

Email: jthomas@CoalitionCCC.org

Twitter: [@JudyThomasJD](https://twitter.com/JudyThomasJD)

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COMPASSIONATE CARE
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CoalitionCCC.org

(916) 489-2222 // info@coalitionccc.org