

FAQ: CHANGES TO POLST UNDER AB 637

Will the new law (AB 637) only affect California, or is this reflective nation-wide?

[Assembly Bill 637](#) is a California law, and as such, only affects California's POLST program.

Is the POLST form now required in California?

Completing a POLST has always been voluntary and will remain so. A patient cannot be required to complete a POLST.

Will the name *Physician Orders for Life-Sustaining Treatment (POLST)* change under the new law?

No. The California program and form will continue to be called Physician Orders for Life-Sustaining Treatment (POLST).

When will the 2016 POLST forms be available?

The 2016 POLST form is available for download from www.caPOLST.org and for bulk orders through [Med-Pass](#).

Are Medical Interns allowed to sign the POLST as well?

No. Under AB 637, physicians, nurse practitioners (NPs) and physician assistants (PAs) will be authorized to sign POLST. In order to hold oneself out as a "physician", an individual must have a current license that allows them to practice medicine. California law currently requires that an individual complete one year of residency training to be eligible for licensure. The internship year is generally the first year of residency and residents are unlicensed during this time. Therefore, they would not be qualified to sign POLST forms.

QUESTIONS RELATING TO NPS AND PAS

Can you respond to suggestions made by representatives from the California Association for Nurse Practitioners (CANP) that NPs should NOT sign POLSTs with DNR optioned?

The Coalition for Compassionate Care of California (CCCC) can find no valid basis for the opinion that NPs should not sign POLSTs with DNR orders. The Board of Registered Nursing (BRN) reviewed AB 637 during their annual Board meeting on Nov. 4-5, 2015. The Board voted unanimously, and without comment or question, to post the AB 637 language to the Nurse Practitioner Practice Information section of the BRN website. CCCC staff has also spoken directly with a representative from the BRN regarding the concerns expressed in an article in the California Association of Nurse Practitioners' newsletter. The BRN representative reiterated that that POLST is an important document for expressing and honoring patient wishes, and that AB 637 clearly creates a law which allows NPs and PAs to sign POLST forms to create actionable medical orders, regardless of whether DNR is one of the selections in Section A.

If the older (2011 and 2014) POLST forms are still valid, does that mean that an NP or PA can sign a 2014 form, if that is the only one the patient or facility has available at the time?

AB 637 makes it legal for NPs and PAs to sign POLST forms. The primary goal of POLST is to ensure that patients' treatment wishes are known and honored. We want to avoid any situation where a valid POLST might look questionable. Therefore, best practice is for NPs and PAs to use only the 2016 form because it contains the correct signature line and instructions.

Nurse practitioners have a RN license number and a NP certificate number. Which number should be listed on the POLST form when signing?

Nurse practitioners should use their California NP certificate number.

Is the physician who is listed in our protocols considered the "supervising physician" for the purposes of POLST?

Yes.

Do the NP and PA need to be under the physician that is supervising the care of the patient?

No. The NP and PA need to be acting under the supervision of a physician, but the supervising physician does not have to be the patient's attending physician of record.

What language should PAs add to their Delegation of Services Agreement (DSA)?

Something like, "(PA Name) is authorized to discuss with patients or their designated healthcare decisionmaker treatment options for serious illness and to sign Physician Orders for Life-Sustaining Treatment (POLST) forms which are consistent with the patient's medical condition and preferences."

What if the physician assistant works at several different clinics or facilities?

A separate DSA should be made for each clinic or facility, regardless of how many supervising physicians the physician assistant works with. Alternatively, a physician assistant may have a DSA that specifies what services can be provided at a specific site.¹

What language should NPs use when updating their standardized procedures?

Something like: "Educates/counsels patients on treatment options related to advanced illness and/or end-of-life care. Assists patients in completing Physician Orders for Life-Sustaining Treatment (POLST) forms and signs POLST forms which are consistent with the patient's medical condition and preferences."

I am a geriatric nurse practitioner and work with a physician who has patients in a number of nursing homes. Do the revisions to the standardized procedures have to be approved by each facility?

Yes. Standardized procedures are agency/facility specific and must be approved by nursing, administration and medicine in the agency/facility in which they are used.

¹ "Delegation of Services Agreements – Change in Regulations," California Department of Consumer Affairs, Physician Assistant Board. http://www.pac.ca.gov/forms_pubs/delegation.doc

INFORMED CONSENT

Can NPs and PAs obtain informed consent?

AB 637 allows nurse practitioners and physician assistants, under the supervision of a physician and within their scope of practice, to sign POLST forms. AB 637 does not change the law regarding the role of NPs and PAs with respect to informed consent. Some institutions/organizations may have specific policies regarding informed consent, so NPs and PAs are advised to check with their employer.

BILLING

Can NPs and PAs bill the new advance care planning (ACP) codes for POLST discussions?

The new codes (99497 and 99498) can be billed by physicians and other non-physician practitioners (NPPs), such as nurse practitioners and physician assistants, whose scope of practice and Medicare benefit category include the services described in the CPT codes and who are authorized to independently bill Medicare using the physician fee schedule. Check with your facility/agency billing department for details.

GENERAL POLST QUESTIONS

Can a POLST document be honored if it was signed by a patient but not discussed with family members and mental status of patient suddenly declines?

Yes. If the patient was competent to make decisions at the time the POLST was completed, and signed by the patient and physician, the POLST is valid. There is no requirement to consult the patient's family.

My coworkers are confused by patients who check "DNR" in Section A of the POLST, and "Full Treatment" in Section B. How can I explain this?

The options in Section A and Section B of the POLST deal with two different situations.

Section A applies only if the patient's heart has stopped and he/she is not breathing, i.e., the patient died a natural death. We look to Section A to determine whether the patient wants CPR attempted or not.

Section B applies to patients who are in a medical crisis, but still have a heartbeat.

So, for example, a patient with advanced COPD may choose DNR in Section A because they know that if even if they survive resuscitation, they will likely suffer brain damage and other complications. The same patient might choose "Full Treatment" in Section B because they believe their chances of surviving something like pneumonia with minimal complications would be better with full treatment.

Where can I find more resources or training on the POLST conversation?

The Coalition for Compassionate Care of California has developed several resources to aid providers in improving skills around “the conversation,” including a POLST script, cue cards, case studies and videos. CCCC’s [Decision Guides](#) can be used to help explain the complex topics of artificial hydration, cardiopulmonary resuscitation (CPR), mechanical ventilation, and tube feeding. CCCC offers a [two-day POLST training program](#) which includes an in-depth review of the POLST conversation, as well as classes on advance care planning and cultural competency, which also cover conversational elements. More information is available on our websites at www.caPOLST.org and www.CoalitionCCC.org.

Other web-based resources include [ACP Decisions](#), which offers video support tools for clinicians and families on their website, and the [PREPARE](#) website, which is designed to help people and their loved ones prepare for medical decision making.

Are there good layman's terms that you use to introduce different sections of the POLST? For example, is there another term you might use instead of "artificial nutrition and hydration"?

It is recommended that each section of the POLST be introduced with an example of a future medical event.

For example, Section A might be introduced with, “If, in the future, you were to have a heart attack and your heart stopped beating...”

Section B could be introduced with, “Now imagine that one day you have a serious case of pneumonia and it became difficult for you to breath on your own...”

For Section C, you could say, “What if one day you became too ill to eat on your own or swallow? A tube can be used to deliver medically-prescribed formula directly into the stomach...”

What is the responsibility and liability of the person who helps prepare a POLST?

A healthcare provider who assists in the preparation of a POLST should be someone with the knowledge to explain the treatment options and what they mean in context of the patient’s current medical condition. It is very beneficial to have specific training on the POLST conversation. The person who assists in preparing a POLST should ensure that the completed form is consistent with the patient’s medical condition and personal preferences. California law requires that healthcare providers honor the wishes contained in a valid POLST form, and the same law provides immunity to those who comply in good faith with a POLST which appears to be valid.

Where would a "modified code" belong in the POLST form? I see hospitals do this a lot. Would it be in the trial of full treatment?

The California POLST does not provide a “modified code” option because Emergency Medical Technicians in the field are required to follow Advance Cardiac Life Support guidelines, which includes CPR and intubation. EMTs are not trained or authorized to provide modified code in the field. When an acute hospital receives a patient with a POLST, the standard procedure is to translate the POLST orders into in-patient hospital orders.

Who can serve as a “legally recognized decisionmaker?”

A court-appointed conservator or guardian, agent designated in an advance directive, an orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative or a 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.

If an individual does not have capacity to make decisions and has no known family, can a close friend make a decision and sign the POLST?

Yes. If an advance directive does not exist and reasonable attempts to identify a family member have failed, the physician, NP or PA can – in accordance with community standard of practice – turn to a close friend of the patient to serve as the legally recognized decisionmaker .

Can a decisionmaker change a POLST?

A legally recognized decisionmaker may request to modify POLST orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient’s best interests. For example, a decisionmaker could request to change a POLST from “Full Treatment” to “Selective Treatment” or “Comfort-Focused Treatment” if the patient’s medical condition had deteriorated significantly and the physician agree that doing so is in accordance with the patient’s known desires or, if unknown, best interests.

Would an advance directive take legal precedence over a duly signed POLST if the decision-maker so decided?

No. If an advance directive and POLST conflict, the most recent document is the one which takes legal precedence.

Imagine a patient, upon admission to a hospital, forgets his advance directive and orally designates a close friend to act as his medical decisionmaker. The patient subsequently loses capacity during the hospital stay and the friend, as the patient’s decisionmaker, creates and signs a POLST for the patient. Could a family member challenge the POLST if they have a copy of the patient’s previously completed advance directive, which names the family member as a decisionmaker?

(1) The patient executed a verbal advance directive, (2) that is in effect for the hospital stay or 30 days. (3) During that time the friend is the surrogate and executes POLST. (4) The POLST is valid because the friend was the legally recognized decisionmaker at the time it was executed.

Can a POLST be created for someone who is under conservatorship or do they need a special declaration for DNR/hospice?

A court-appointed conservator or guardian can initiate a POLST on behalf of a conserved individual. A special declaration for DNR is not required.

Will a translated POLST form (i.e., non-English form) be valid in the medical setting, or are these used to facilitate understanding?

The translated versions of POLST are used only to facilitate understanding and provide education. POLST must be completed using the English version so that it can be easily understood by any emergency medical personnel.

Under "Additional Orders," on the POLST, can patients indicate other treatments they ABSOLUTELY DO NOT WANT, including family members not permitted at patient bedside, or pets they DO want present.

The "Additional Orders" section is for additional medical orders. An advance directive is the document for patients to provide more detail on such things as pets, family members or disposition of their remains.

Does a pediatric patient require an advance directive to be in place prior to a POLST taking effect or is it implied that all minors have an advance directive in place defaulting to parent or legal guardian?

Children under 18 are not legally competent; as such they cannot complete a legal advance directive. The law generally authorizes parents to serve as the legal decisionmaker for their children. A parent or legal guardian can initiate a POLST for a minor child.

What about the [Five Wishes document](#)? Does that work with POLST or does it replace it?

The Five Wishes document is an advance directive document. POLST and advance directives should work together.

What should be done if a patient refuses to involve their family in the POLST discussion?

Patients should be counseled that talking with their family about their treatment wishes is a gift because it can reduce future conflict and alleviate stress during a health crisis. However, some people may prefer to not involve their family members in the decision-making process. You can only remind them of the benefits and importance of good communication.

How can I help a patient who wants a POLST but has family members that are not knowledgeable or supportive?

Communication is important. If time allows, you can suggest a group meeting with the patient and family, where you can share information about POLST and why it is important for patients and their families. There are also brochures and consumer-friendly materials on POLST which can be downloaded from www.caPOLST.org and shared with patients and their families. Ultimately, a patient has a right to complete a POLST regardless of whether their family is supportive.

POLST & THE DEVELOPMENTALLY DISABLED**Are there activities/programs from CCCC in educating clinicians and Regional Centers regarding POLST and sensitivity to "Quality of Life" identifiers for elder individuals who are diagnosed with profound intellectual, developmental and physical disabilities?**

CCCC developed a whitepaper on this topic: [Thinking Ahead Matters: Supporting and Improving Healthcare Decision-Making and End-of-Life Planning for People with Intellectual and Developmental](#)

[Disabilities](#). The document explores the concepts around conservatorship and self-determination in healthcare decision-making for this population.

In addition, CCCC has an advance care planning workbook and video, [Thinking Ahead: My Life at the End](#), which contain words, symbols and pictures that facilitate discussion with and decision-making by persons with developmental disabilities regarding their values, goals and treatment preferences at the end of life.

AB 637 WEBINAR SLIDES

Can we print the AB 637 webinar slides for use with other staff?

Yes. The AB 637 webinar slides can be shared for use with other staff. The slides can be downloaded from http://coalitionccc.org/wp-content/uploads/2015/11/111915_changes_to_polst_2015.pdf.