POLST CALIFORNIA

A program of the Coalition for Compassionate Care of California

POLST (Physician Orders for Life-Sustaining Treatment) Frequently Asked Clinical Questions for Providers

This Frequently Asked Questions list focuses on the medical/clinical details of completing the POLST for seriously ill patients. For general questions about the POLST and the POLST Program, please see the POLST FAQs for Healthcare Providers. Questions are hotlinked to their answers for easy access.

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- To whom does “Request transfer to hospital only if comfort needs cannot be met in current location” in Section B apply?
- Is using POLST different in a SNF as compared to assisted living facilities (ALFs) or residential care facilities for the elderly (RCFEs)?

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Section 1: General Questions

Why is it important that I help patients complete a POLST form?

POLST allows seriously ill patients an opportunity to clearly state their choices regarding the medical treatment they receive. The POLST form guides discussions between patients, their surrogate decision maker, their families, and their healthcare team about treatment wishes in the setting of serious illness. POLST translates those wishes into actionable medical orders, which must be respected across the continuum of healthcare settings. Research shows that a completed POLST helps patients receive the treatments they want and avoid receiving treatments they do not want.

Who would benefit from having a POLST form?

POLST is designed specifically for patients of any age who have serious, chronic, progressive, or terminal illness, or those who are medically frail, and are likely to require medical treatment and may not be able to express their choices themselves due to incapacity. A helpful tool for determining who would benefit from POLST is the question, “Would you be surprised if this patient were to die within the next year or two?” These patients are often in a state of irreversible decline. Medical treatment and interventions have only a very limited effect on extending life in this population, and some of these treatments and procedures may decrease quality of life and are considered by some to be medically ineffective. Helping these patients and their families anticipate future serious illness and understand and choose appropriate medical treatments is an important clinical responsibility when working with this patient population.

What is a “POLST conversation”?

Having a conversation with a seriously ill patient about the approaching end of their life is an important and necessary part of good health care. Most patients are willing to discuss their wishes, concerns, fears, and questions – their healthcare providers simply have failed to ask them previously. POLST provides an excellent framework for guiding the conversation, making it easier to have the discussion and, therefore, making it more likely that a patient will express their wishes.

The POLST conversation is a rich and meaningful discussion between a patient, their family, their physician, nurse practitioner (NP), or physician assistant (PA), and other members of their care team regarding specific treatment options and the patient’s values and goals for their care. A completed POLST form may be the outcome of the conversation, or it may be completed at a later time if there are still questions about the patient’s treatment preferences.

POLST conversations occur in a variety of settings, including the physician’s office, during a family meeting at the acute care hospital, upon admission to a skilled nursing facility, or at home with hospice or home health. Some of these conversations are relatively brief, as many people know what they do or do not want. Other conversations may require more time or additional meetings.

The goal of having good POLST conversations with patients and families Is to promote well-informed, collaborative decision making.

Can the Medicare CPT codes for advance care planning be used for discussions about POLST?

YES. As of January 1, 2016, CPT codes 99497 and 99498 can be used to bill for advance care planning conversations between a physician or other qualified healthcare professional and a patient, family member, or surrogate, with or without completing relevant legal forms. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, living will, advance healthcare directive, and POLST.

When is a good time to talk to patients about POLST?

Patients are often more open to discussing their treatment wishes during serious illness than healthcare providers may think. Conversations about POLST can be incorporated into a number of different situations.

Some opportunities to introduce POLST include:

- When a patient has been newly diagnosed with a serious or life-limiting illness,
- As part of an annual examination,
- When a family member accompanies a patient to an appointment,
- After a patient has experienced a family member or close friend becoming seriously ill,
- When a patient is transferred between care settings, including upon admission to and discharge from the hospital; admission to a skilled nursing facility and quarterly care conferences there; admission to an assisted living, facility/residential care facility for the elderly; or an office follow-up visit after discharge from the hospital.

Can clinicians other than physicians help patients complete a POLST?

YES. Healthcare professionals, including nurses, social workers, and chaplains, may help explain the POLST, guide patients in making treatment decisions, and then document those wishes on the POLST. These clinicians should receive proper training in explaining the treatment decisions on the POLST and communicating with patients and families about treatment choices and goals of care. It is important that the professional helping to complete the document with the patient or decision maker write their name and work contact information on the back of the POLST so that the physician/NP/PA may contact the professional if they have questions regarding the content of the completed POLST before signing it. A POLST is not valid until it is signed by a physician, NP, or PA and the patient or the patient’s legally recognized decision maker.

If the POLST is being completed by a healthcare professional other than the signing physician/NP/PA, the physician/NP/PA should sign only when they are confident that the form expresses an informed decision by the patient or their decision maker. This process may be facilitated if the healthcare professional assisting the patient also provides documentation to the physician/NP/PA regarding details of their conversation with the patient or decision maker.

Is a patient's primary care physician the only one who can complete and sign the patient's POLST?

NO. A POLST can be completed and signed by any physician, nurse practitioner (NP), or physician assistant (PA) who has a treating relationship with the patient. This includes the primary care physician, NP, or PA, but could also include consulting physicians, specialists, hospitalists, physicians caring for the patient in a nursing home, and Emergency Department physicians. Knowledge of the patient's medical condition, prognosis, and capacity to make decisions is required, as well as a willingness to have an informed, collaborative discussion with the patient and/or their legally recognized decision maker.

What if a POLST form is not signed?

A POLST requires the signature of a physician, NP, or PA, and the patient or their legally recognized decision maker, and the date of signature, for it to be valid.

Is a physician, NP, or PA obligated to sign off on any POLST form presented for signature?

It is the obligation of the physician/NP/PA signing the POLST to confirm the treatment wishes before signing. A physician/NP/PA should not sign a POLST if they have any concern that the form may not represent the informed choices of the patient or legally recognized decision maker or that the patient lacks capacity and is not represented by a surrogate decision maker. If the form does represent the informed wishes of the patient or decision maker but the physician/NP/PA feels strongly that those wishes are medically inappropriate, the physician/NP/PA may also choose not to sign the form. It would be appropriate in this situation for the physician/NP/PA to discuss their concerns with the involved parties and make an effort to agree on a more appropriate set of choices. If the patient or decision maker insists, the physician/NP/PA may still decline to sign and suggest the patient or decision maker transfer care to another provider. POLST forms should never be pre-signed.

What happens when a patient completes a POLST, but then becomes incapacitated?

POLST is designed to speak for patients when they can't speak for themselves. The decision maker for the patient and the treating physician/NP/PA should honor the patient's POLST unless there is new information that the patient's wishes have changed. If the patient's condition changes, then a re-evaluation of POLST orders may be appropriate, taking into account the patient's previously expressed wishes.

Can a POLST be changed?

A patient with decision-making capacity can request alternative treatment at any time. If a patient lacks capacity, their legally recognized decision maker can request to modify POLST orders, in collaboration with the patient's physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests. In considering changes, the treating physician/NP/PA should evaluate the patient's current condition, the patient's previously stated wishes, and the likely medical outcomes. If a new POLST is created, the old POLST should be marked "VOID," signed, and dated.

What if more than one version of POLST is found?

The most recently dated POLST is the valid POLST.

I think my patients will think I've given up on them if I have this conversation. What can I do?

POLST should not be introduced as a discussion about end-of-life care, but instead about possible serious illness treatment approaches and a way to identify what treatments a patient wants or doesn't want. Sometimes stating that this is a topic you discuss with all patients with medical conditions similar to theirs can make it seem less threatening. POLST is a tool that enables patients to be informed about treatment choices available to them and provides a way to provide instructions for their healthcare providers.

Section 2: Treatment Questions

Why does choosing "Attempt Resuscitation/CPR" in Section A require selecting "Full Treatment" in Section B?

Cardiopulmonary resuscitation (CPR) is defined to include chest compressions and advanced cardiac life support procedures, including intubation. If CPR is desired, then the full array of CPR procedures should be expected to be implemented. If CPR is successful initially and the heart is revived, then it is highly likely that the patient will require ventilation and other intensive care. A patient not willing to accept Full Treatment/ventilator treatment should not have CPR performed. The primary goal of full treatment is prolonging life by all medically effective means. The patient can choose to have Full Treatment as a "Trial Period," and if not doing well, then the ventilator treatments could be withdrawn.

What does "No code" mean? Is this the same as "No CPR" and "Do Not Resuscitate"?

This is a subject that is frequently confused because in many institutions the phrases "No code," "No CPR," and "DNR" are used differently by different staff.

"No CPR" and "DNR" (or "DNAR" for "Do Not Attempt Resuscitation") are terms that should be used specifically in the case of full cardiac arrest in which there is no circulation (i.e., ventricular fibrillation, asystole, pulseless electrical activity). "No code" can be ambiguous. In many hospitals, the phrase "call a code" is used in any situation in which a patient requires immediate, emergent attention. This includes cardiac resuscitation as described above, but in these institutions, “call a code” may also refer to other situations such as sudden respiratory distress, hypotension, cardiovascular instability, or syncope.

Case example: A patient is admitted to the hospital and has completed a POLST that indicates “Do Not Attempt Resuscitation/DNR” in Section A (no resuscitation in case of cardiac arrest) and “Full Treatment” in Section B (meaning, employ aggressive treatment measures, including intubation and mechanical ventilation, if necessary, in all situations other than cardiac arrest). A nurse comes upon this patient who is now suddenly in extreme respiratory distress. In this hospital, “call a code” would bring immediate help. However, if the nurse assumes that the POLST “DNR” means “No code” and does not call for help, then the patient will not receive the treatment that was desired and specified in POLST Section B.

The prognosis for cardiac arrest (addressed in Section A of POLST) is significantly different from the prognosis for respiratory arrest (addressed in Section B of POLST), and it is essential to delineate these two scenarios. Usage of the term “Code/No code” should be discouraged because of the potential for misinterpretation, and distinct and separate orders regarding “CPR” and “intubation” should be made on the physician’s orders form. Appropriate examples may be: “DNR/DNI” or “DNR/Intubation OK.”

Why would someone choose “Do Not Attempt Resuscitation/DNR” in Section A and “Full Treatment” in Section B?

“Do Not Attempt Resuscitation/DNR” represents a treatment decision that applies only to the specific situation where the patient is unconscious, has stopped breathing, and has no heartbeat – i.e., a complete cardiac arrest or a natural death. “Full Treatment,” in comparison, describes treatment that is rendered, if indicated, when a patient is still alive and has a heartbeat. “Full Treatment” would be given to a patient when in respiratory arrest, where breathing has failed but the patient still has a heartbeat. The prognosis for cardiac arrest is significantly different from the prognosis for respiratory arrest, and it is essential to delineate these differences.

Does choosing “Do Not Attempt Resuscitation/DNR” mean “No Treatment” or “Do Not Treat”?

NO. A “Do Not Attempt Resuscitation” choice in Section A indicates specifically not to institute CPR measures in the case of cardiac and respiratory arrest (patient has no pulse and is not breathing). It is not pertinent to any other situation and does not indicate treatment wishes for any other situation. Patients need to be reassured that choosing “Do Not Attempt Resuscitation” in Section A does not mean “No Treatment.”

If a patient chooses "Do Not Attempt Resuscitation/DNR" in Section A, does that mean they must also choose "Comfort-Focused Treatment" in Section B?

NO. A patient who chooses "Do Not Attempt Resuscitation/DNR" in Section A of the POLST can choose "Comfort-Focused Treatment," "Selective Treatment," or "Full Treatment" in Section B. DNR represents a treatment decision that applies only to the specific situation where the patient has no heartbeat and has stopped breathing – i.e., a complete cardiac and respiratory arrest or a natural death. The "Do Not Attempt Resuscitation/DNR" selection in Section A does not specify what treatment should be rendered in situations in which the patient still has a heartbeat or is still breathing. A person who chooses "Comfort-Focused Treatment" with the primary goal of maximizing comfort is generally refusing curative treatment when new, life-threatening, serious problems arise.

Does "Comfort-Focused Treatment" mean that a patient must stop all other treatments and medications?

NO. A patient who has indicated "Comfort-Focused Treatment" should not necessarily have all other treatments and medications stopped. Treatments and medications that are currently being given to the patient should be re-evaluated to determine whether they are creating an undue burden on the patient or otherwise no longer fit in with the overall goals of care. If so, consideration can be given to stopping these treatments or medications.

Does "Comfort-Focused Treatment" include any medical treatments other than pain medications?

YES. Comfort may include treatment other than pain medication. It could include antibiotics to clear up a painful urinary tract infection or diuretics to reduce painful edema. In the case of a bone fracture, surgery may be performed in order to relieve pain and preserve mobility or function. In some cases, even radiation might be considered "palliative." So many treatments can be looked upon as being part of a comfort-focused treatment plan. Continuing routine medications, unless they are burdensome to the patient, is often appropriate, with periodic re-evaluation and discussion with the patient and family.

How does POLST help me understand what to do in situations other than a full cardiac and respiratory arrest?

The POLST form, completed properly, contains a wealth of information regarding patient wishes for treatment. Not every potential medical treatment can be listed on a POLST form for a patient to accept or decline, and nuances of every complex clinical scenario cannot be captured on the form, but POLST can help identify desired treatments by clarifying fundamental goals. Patients who do not want artificial nutrition may be telling us that they do not want treatments that keep them alive in a debilitated, dependent condition. Patients who choose "Selective Treatment" may be indicating that they are fearful of treatments that are painful or invasive, may cause further debility and involve long recovery times, and have a low chance of success. Patients who choose “Full Treatment” should be informed about trial periods – if the treatment does not result in a good recovery, should it be continued? Another example of when a person might want a trial period of "Full Treatment” is a person in renal failure who wants to try dialysis for a period of time. POLST helps to understand patients’ goals of care – then decisions can be made if particular treatments will help achieve those goals of care or not.

How long should “Full Treatment” be continued?

If a patient chooses “Full Treatment” in Section B, consider asking the patient, “What should be done if those treatments are not working after a period of time? If you are on life support, not getting better, and the doctor believes that you will not make a good recovery, should invasive treatments be continued? Continued treatment often means more complications, a longer stay in the intensive care unit, and any recovery looking less certain and more difficult.”

Patients may want invasive treatments to be initiated but may not want treatment continued if the chances of recovery are uncertain and difficult. A patient who expresses this concern can check the box “Trial Period of Full Treatment” in Section B to specify that these treatments should be undertaken for a defined time so that their progress can be assessed, and decisions be made based on their progress.

How do we decide what “Selective Treatment” includes?

Section B “Selective Treatment” is the most complex category of treatment choices to understand. The goal statement for “Selective Treatment” is the goal of treating medical conditions while avoiding burdensome measures. Patients choosing this treatment category generally are asking not to be treated with invasive medical procedures, such as mechanical ventilators, or major surgery, such as open-heart surgery. However, ICU care is not strictly prohibited. For instance, a patient who has chosen “Selective Treatment” could conceivably be treated in the ICU with intravenous vasopressors if transiently hypotensive, or with bi-level positive airway pressure (BiPAP) or similar respiratory interventions short of intubation/ventilation. Similarly, surgery is not altogether prohibited. Consider the case of acute cholecystitis – cholecystectomy may be an option if it can be performed with relative ease and low risk.

The common thread as to what is considered “Selective Treatment” is based upon an assessment of the balance between risks, benefits, and burdens. Patients who choose “Selective Treatment” are often communicating that they do not want treatment that has a low chance of success or will result in prolonged, difficult, and uncertain recovery phases.

What would I write for “Additional Orders” at the end of Section B?

This is where you could address any treatments, medications, or procedures not specifically mentioned in the provided options. For instance, some patients might wish to refuse blood products or limit antibiotics in certain circumstances. Some patients might have strong feelings about other invasive procedures such as dialysis, surgeries, ECMO, etc. This section can be used to detail such instructions.

My patient is dying, but the family thinks that the patient is “starving to death” unless a feeding tube is put in. What can I tell the patient and family to help guide their decisions?

Some people fear that not providing a feeding tube at the end of life means they are letting their loved one “starve to death.” This is not true. When a dying person’s body begins to shut down, the body may be unable to adequately use nutrients that artificially administered nutrition would provide, and the chance of bloating and discomfort increases. In the last days and hours of life, as the body is shutting down, food and fluids are not absorbed or metabolized; administering fluids by tube or IV at this time increases edema and pulmonary congestion, causing additional discomfort to the patient. Death related to dehydration with progressive hypovolemia and hypotension is generally considered (and clinically observed) to be a peaceful and natural way to die. In the last days to weeks of life, many patients may force themselves to eat just to please family members. Helping families understand these facts may help them come to terms with a decision not to use artificial means of nutrition, including feeding tubes. A patient-friendly way to put this might be,

“Your mom is reaching the end of her life, and her body is letting go. You’ve noticed her sleeping more, interacting less, eating and drinking less. This is all part of the process of dying. If we give her more water and liquid food than her body can handle, the fluid will leak out of her blood vessels and into her tissues, including her lungs. She’ll be more uncomfortable and more at risk of pneumonia and other painful conditions. From everything we know about living and dying, the body knows what it needs and what it can’t handle. She isn’t starving, and she isn’t thirsty. But you can help her stay comfortable by swabbing her mouth and rubbing lotion on her feet and hands.”

Do feeding tubes help patients with advanced dementia?

For similar reasons, artificial nutrition through feeding tubes may not be an effective treatment when patients are no longer able to eat adequate amounts of food and water because of dementia. Studies have shown that patients lived equally long whether they were fed by hand or a feeding tube was inserted. Patients who have feeding tubes inserted may continue to suffer from aspiration pneumonia. Recent studies have demonstrated an increased risk of pressure ulcers in patients who are fed via gastrostomy tubes. Though there may not be a difference in medical outcomes between artificial nutrition through feeding tubes and hand feeding, many feel that the social interaction and touch that occurs with hand feeding leads to a higher quality of life. These situations can be difficult and are best approached individually as a patient-centered decision that addresses patient values, religious values, and family concerns.

Are there any situations in which feeding tubes are effective?

There are medical situations in which feeding tubes are a useful part of a medical treatment plan. Feeding tubes may be useful after otolaryngology procedures that cause temporary swallowing disability. Some patients with amyotrophic lateral sclerosis (ALS) elect feeding tubes, and it does extend their life. A patient who has suffered a stroke in which the main deficit is dysphagia, where recovery seems possible, may benefit from artificial nutrition by tube. In the population for which POLST is designed though, a severe stroke usually has a poorer chance of recovery.

My patient is not ready to make a decision about tube feeding, because a lot might depend on the circumstances or indications. Can I leave this section blank?

YES. You can leave any section blank, but according to the protocols in place for POLST, any section left blank implies that the patient desires full treatment for that section. If you leave Section A blank, first responders will assume the patient wants CPR; if you leave Section B blank, first responders and other treating clinicians will assume the patient wants Full Treatment; if you leave Section C blank, they will assume the patient desires to have tube feeding if it is indicated.

Section 3: POLST in Different Settings

To whom does "Request transfer to hospital only if comfort needs cannot be met in current location" in Section B apply?

"Request transfer to hospital only if comfort needs cannot be met in current location" in Section B was instituted for patients being cared for in the skilled nursing facility (SNF) setting who may want Selective Treatment at the facility, but do not want to be transferred to the acute care hospital. An example would be a resident of a SNF where IV treatments are available who wants treatment for a severe infection to be given in the nursing facility rather than undergoing the burden of being transported, evaluated, and treated in the emergency department and acute care hospital.

Is using a POLST different in a SNF as compared to assisted living facilities (ALFs) or residential care facilities for the elderly (RCFEs)?

The main difference arises in emergency situations in which POLST-directed treatment may need to be implemented. ALFs/RCFEs are not healthcare facilities and, as such, generally don't have licensed healthcare providers on staff and do not have emergency pharmaceuticals available. For example, a patient who has chosen “Comfort-Focused Treatment” with a sudden change in condition may require morphine. If that patient is a resident of a SNF, the patient will likely be able to have treatment instituted without having to go to the emergency room. If the same situation develops with a resident in an ALF/RCFE who is not under hospice care, it is unlikely that morphine can be obtained immediately. The patient may need to be transferred to be evaluated and have appropriate comfort treatments coordinated and instituted.

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