Frequently Asked Clinical Questions for Providers

GENERAL QUESTIONS

Why is it important that I help patients complete a POLST form?
POLST helps give seriously-ill patients more control over the medical treatment they receive. The POLST form guides discussions between patients, their physician, and their health care team about treatment wishes in instances of serious illness. POLST is a tool to document those wishes as physician orders, which are actionable and respected across the continuum of healthcare settings. Research shows that POLST helps to ensure that patients receive the treatments they do want, and do not receive treatments they do not want.

Does the POLST form replace traditional Advance Health Care Directives?
The POLST form complements an Advance Directive and is not intended to replace that document. An Advance Directive is still necessary to appoint a legal healthcare decisionmaker, and is recommended for all adults, regardless of health status.

Are patients required to complete a POLST form?
POLST is a voluntary form. No one is required to complete a POLST form. A Skilled Nursing Facility may use POLST as a part of their routine care and documentation; however, a resident cannot be required to complete a POLST form as a condition of admission to the facility. The facility may use an analogous form to document the resident’s wishes.

Can non-physicians help patients complete a POLST form?
Though POLST is a physician order, other healthcare providers, including nurses, nurse practitioners, physician assistants, social workers, and chaplains, may help explain the POLST form and guide patients in making treatment decisions, and then document those wishes on the POLST form. These providers should receive proper training in explaining the treatment decisions on the POLST form and communicating with patients and families about goals of care. It is important that the provider helping to complete the document with the patient or decisionmaker write their name and contact information on the back of the POLST form so that the physician may contact the provider if the physician has questions regarding the content of the completed POLST form before signing it.

A POLST form is not valid until it is signed by both the patient (or decisionmaker) and a physician. If the POLST form is being completed by a healthcare provider other than the signing physician, the physician should sign only when assured that the form expresses an informed decision by the patient (or decisionmaker). This process may be facilitated if the health provider assisting the patient also provides documentation to the physician regarding details of their conversation with the patient (or decisionmaker).
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 and a way to identify what treatments a patient wants or doesn’t want. POLST is a tool that enables patients to be informed about treatment choices available to them and provides a way to direct their healthcare providers.

TREATMENT QUESTIONS

Why does choosing “Attempt Resuscitation/CPR” in Section A require “Full Treatment” in Section B to be selected?

Cardiopulmonary resuscitation 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. So if CPR is successful initially and the heart is revived, then it is highly likely that the patient will end up on a ventilator. A patient not willing to accept Full Treatment/ventilator treatment should not have CPR performed. The patient can choose to have Full Treatment as a “Trial Period,” and if not doing well, then ventilator treatments could be withdrawn.

Why would someone choose “No CPR” in Section A and “Full Treatment” in Section B?

“No CPR” represents a treatment decision that applies only to the specific situation where the patient is unconscious, has stopped breathing and has no heart beat – i.e. a complete cardiac arrest, or a natural death. “Full Treatment,” in comparison, describes treatment that is rendered, if indicated, when patient is still alive and has a heartbeat. “Full Treatment” would be given when in respiratory arrest, where breathing has failed but the patient still has a heartbeat. The prognosis for cardiac arrest is significantly different than the prognosis for respiratory arrest, and it is essential to delineate these differences.

How do we decide what “Limited Additional Interventions” are?

Section B “Limited Additional Interventions” is the most complex category of treatment choices to understand. Patients choosing this treatment category generally are asking not to be treated with invasive medical procedures, such as mechanical ventilators and major surgery, such as open-heart surgery. However, ICU care is not strictly prohibited. For instance, a patient who has chosen “Limited Additional Interventions” could conceivably be treated in the ICU with intravenous vasopressors if transiently hypotensive. Similarly, surgery is not absolutely prohibited. Consider the case of acute cholecystitis - if a laparoscopic cholecystectomy may be an option if it can be performed with relative ease.

Based on empiric experience, the common thread as to what is considered “Limited Additional Interventions” is based upon the risk of the surgery and the predicted postoperative course. Patients who choose “Limited Additional Interventions” are often communicating that they do not want treatment that will result in prolonged, difficult and uncertain recovery phases.
To whom does “Do Not Transfer” in Section B apply?
“Do Not Transfer” in Section B was instituted as an acknowledgement of patients being cared for in the Skilled Nursing Facility (SNF) setting who may want limited 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 there in the 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 health care providers on staff, and do not have emergency pharmaceuticals available. For example, a patient who has chosen “Comfort Measures Only” 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 doom. If the same situation develops with a resident in an ALF/RCFE who is not under hospice care after hours, it is unlikely that morphine can be obtained immediately. The patient may need to be transferred in order to be evaluated, and have appropriate comfort measures coordinated and instituted.