

Improving Advanced Illness Care: The Evolution of State POLST Programs

Physician Orders for Life-Sustaining Treatment (POLST) is a promising program to elicit and honor the treatment goals of people with advanced progressive illness or frailty. Research shows that POLST effectively communicates patient treatment choices, whatever they may be, without sacrificing comfort care. This In Brief documents the evolution of POLST in 12 states and highlights lessons learned for states developing and implementing new programs.

The Physician Orders for Life-Sustaining Treatment (POLST) protocol to improve advanced illness care began in Oregon in the early 1990s, and by 2010 at least 12 states had programs. Most other states are developing POLST programs and can learn from the experiences of the pioneer states.

What Is POLST?

POLST is a tool for translating patients' goals of care into medical orders in a highly visible, portable way. Following the protocol, health care professionals must discuss with seriously ill patients (or their surrogates) the available treatment options in light of their current condition—and help clarify the patients' preferences. Then clinicians must document those preferences on a standardized medical order form and ensure that it travels with the individual if he or she changes settings of care. POLST differs from an advance directive (living will or health care power of attorney) in that it is an actionable medical order dealing with the here-and-now needs of patients—it builds on an advance directive but can be created for patients without an advance directive.

POLST enables patients to choose among a full range of care options, from aggressive treatment to limited interventions to comfort care. Recent academic research documents POLST's success in improving the documentation and honoring of patient preferences, whatever they may be.

The State POLST Experience: Challenges and Successes

While issues and barriers have challenged stakeholders in the 12 states with POLST programs, POLST programs have grown and enriched care for seriously ill individuals.

Legislative and regulatory approaches vary, with many common features.

- States have used differing terminology, including POST, MOLST, and MOST.
- Two states (OR, MN) used clinical consensus rather than legislation.
- POLST universally requires an authorized clinician's signature—and six states expand this authority to nurse practitioners and/or physician assistants.
- None of the states mandate completion of POLST forms, but two

states (TN, UT) require health care facilities to offer POLST to certain patients and residents.

Key facilitators of POLST development are effective organizing and incremental strategies.

- Well-established statewide end-of-life coalitions or palliative care organizations helped jump-start POLST development.
- A core of “physician champions” was a key component to achieving POLST awareness and acceptance in major health care institutions.
- Many proponents used a deliberately incremental strategy, starting with a pilot program and then expanding statewide.
- Advocates should expect a multiyear implementation process. Programs in operation for 10 or more years show high rates of POLST use in nursing homes and hospitals.

Barriers and issues include these.

- Whether patient consent must be documented on the form by signature
- What elements and options the form should include
- How to correct the misperception that POLST is a health care advance directive
- The extent of surrogates’ authority to consent to POLST on behalf of a patient lacking decisional capacity
- Integrating POLST into electronic health records.

Training and education, especially for physicians, posed the greatest implementation challenge.

- Physicians and other clinicians need education in communication skills for facilitating conversations with patients and families, and knowledge of therapeutic impact of

interventions such as CPR and tube feeding in older ill patients.

- Funding for a sustained training and education effort is critical.

Formal monitoring and evaluation processes are lacking.

- The majority of existing state POLST programs have none. Periodic review of POLST by stakeholders is critical.
- Electronic POLST registries such as Oregon’s provide promising opportunities to use data for assessment and quality improvement.

POLST rests on meaningful discussion of options and preferences between patients and clinicians.

- Professional education is the primary strategy to ensure the quality of these conversations.
- Quality measurement tools and payment incentives for advance care planning are needed.

Advice for states working to adopt POLST includes the following.

- Don’t reinvent the wheel—consult the National POLST Paradigm Task Force and other POLST leaders.
- Know your state—all politics is local. Be inclusive.
- Allow flexibility for form design.

In Brief 189, April, 2011

This In Brief is a synopsis of the AARP Public Policy Institute Research Report of the same title, 2011-01, by Charles P. Sabatino and Naomi Karp. AARP Public Policy Institute, 601 E Street, NW, Washington, DC 20049 www.aarp.org/ppi. 202-434-3924, ppi@aarp.org © 2011, AARP. Reprinting with permission only.