

POLST Legislative Guide

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National POLST Paradigm Task Force

Introduction

The development of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm has generated a range of legal/regulatory questions that have been answered in a variety of ways by states— by clinical consensus, sometimes by legislation or regulation, and sometimes by guidance. Drawing upon the experience of the states that have implemented POLST Paradigm by 2013, the National POLST Paradigm Task Force (NPPTF), with assistance from two individual members of the American College of Trust and Estate Counsel (ACTEC), convened a legislative working group¹ to review the recurring policy, legislative and regulatory issues and the responses of states developing POLST Programs to those issues. The result of that process is this POLST Legislative Guide which we hope will facilitate a better understanding of the issues, options available, and best practices.

An underlying principle reflected in this review is that the development of a POLST Program should be driven by clinical consensus with broad input from the field. The discussion under *Issue 2* below suggests examining whether legislation is really needed to create a POLST Program. The article, *The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation*, identifies some of the circumstances and issues that have presented barriers to POLST and that have prompted legislative solutions.² To whatever extent legislative and/or regulatory changes are sought, it is important to build in flexibility in the program so that it can be sensitive to innovations in clinical practice and continuous quality improvement with broad-based input from the field.

The Guide is organized around twelve legal/regulatory questions and issues that have been most recurrent across the states implementing POLST Programs. It suggests a preferred outcome to each issue, based upon the collective learned experience of states with POLST Programs endorsed by the NPPTF. The Guide provides a description and analysis of each issue -- and sub-issues where indicated -- and offers options to guide response strategies that may range from clinical practice consensus to legislation. The NPPTF has not attempted to provide a model POLST act because experience to date has demonstrated that the frameworks and complexities of each state's existing state health care decisions laws are unique. Every legislative approach requires substantial customization to work within any particular state. It is expected that any of the options described here will need some degree of adjustment to fit with or modify state law.

¹ Margaret Carley, Marilyn J. Maag, Thaddeus M. Pope, Charles P. Sabatino, Amy Vandenbroucke, and Robert B. Wolf.

² Susan E. Hickman et al., "The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation," 36 *J. L. Med. & Ethics* 119-40 (2008), available at http://www.polst.org/educational_resource/the-polst-paradigm-to-improve-end-of-life-care-potential-state-legal-barriers-to-implementation.

The Guide uses three language conventions throughout:

One is the use of the term “POLST” as the generic identifier for all programs fitting its definition (spelled out under *Issue 1* below), regardless of the actual term used in a state.

The second is the use of the term “surrogate” for any authorized substitute health-care decision-maker. The term “authorized surrogate” or simply “surrogate” encompasses the following:

- an agent under a health care power of attorney (also referred to in this guide as an appointed or named surrogate or health care agent)
- a guardian or conservator of the person with health care decision-making powers (also called a court-appointed surrogate)
- a default family surrogate recognized under state law (or simply a default surrogate) and any other similarly authorized decision-maker, regardless of the terminology used in a particular state.

See *Issue 7* for more information about Surrogates.

The third is the use of the term “health care professional” which means any health care professional involved in the POLST process acting within their scope of practice. These guidelines most frequently focus on health care professionals who have authority to sign POLST. In addition to licensed physicians, professionals with signing authority may include, nurse practitioners, and physician assistants, depending on state scope of practice laws. However, other health care professionals, including nurses and social workers and chaplains, are typically part of the care team that supports the POLST program, even though they have no authority to sign POLST.

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Issue 1: What is the definition of POLST?

The Physician Orders for Life-Sustaining Treatment (POLST) Paradigm is a clinical process designed to facilitate communication between health care professionals and patients with serious illness or frailty (or their authorized surrogate) where the health care professional would not be surprised if the patient died within the next year. The process encourages shared, informed medical decision-making leading to a set of portable medical orders that respects the patient's goals for care in regard to the use of cardiopulmonary resuscitation (CPR) and other medical interventions, is applicable across health care settings, and can be reviewed and revised as needed.

Conversation about the patient's goals is a fundamental to the POLST Paradigm. Ideally, a patient and his/her health care professional have been talking about the patient's values and about advance care planning throughout their relationship. When a patient is diagnosed with a serious illness or has frailty, the health care professional and patient can talk about the specifics of the patient's diagnosis, prognosis, and the patient's goals of care. Using that information, the health care professional and patient work together to make decisions about what medical treatments the patient would like to receive or avoid. The health care professional documents those decisions as medical orders when he/she fills out the POLST Form. For more information see *Issue 6A*.

The POLST Paradigm promotes use of a highly visible, portable medical form that transfers from one setting to another with the patient. It functions as a do-not-resuscitate (DNR) order and provides treatment direction for multiple situations. The form itself is outcome neutral. Its options range from full treatment to comfort care only.

The POLST Paradigm recognizes state-specific variations in form and procedures as long as they meet the essential elements contained in the endorsement standards of the National POLST Paradigm Task Force (NPPTF). The "POLST Paradigm" refers to the essential elements that all POLST Programs, as implemented by state coalitions, should incorporate into their programs and forms; the NPPTF recognizes there may be variations among coalitions, but for a POLST Program to be endorsed by the NPPTF, the program must conform to fundamental POLST Paradigm principles.

One of the variations among POLST Programs is the program name. Some of the variations have included:

- Physician Orders for Scope of Treatment (POST)
- Medical Orders for Life-Sustaining Treatment (MOLST)
- Medical Orders for Scope of Treatment (MOST)

As already noted, the term "POLST" will be used throughout this guide. The term "POLST Paradigm" is intended to reflect the full process of communication and decision-making, while the term "POLST" by itself is intended to refer to the set of medical orders embodied in a POLST form. The term "POLST Program" refers to how the POLST Paradigm is being implemented in a specific state.

Issue 1A: Is POLST Another Form of Advance Directive?

POLST is neither an advance directive nor a replacement for advance directives. However, both advance directives and POLST are helpful advance care planning documents for communicating patient wishes when appropriately used.

An advance directive is a form in which an individual: (1) appoints a person or persons to make health care decisions for the individual if and when the individual loses the capacity to make health care decision (typically called a “health care power of attorney”); and/or (2) provides guidance or instructions for making health care decisions, typically in end-of-life care situations (often called a “living will”). An advance directive is a direction from the patient, not a medical order.

In contrast, POLST consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. POLST is intended as a complement to advance directives in that it serves as a translational tool and a continuity of care assurance.

The wishes of patients as expressed in an advance directive often prove ineffective in directing care because: (1) they do not address the specific here-and-now medical circumstances of the patient; (2) they often do not get recorded in the medical record; (3) they do not necessarily follow patients across care settings; and (4) they do not dictate a care plan through medical orders and clinical protocols.

This is especially problematic in situations where emergency medical services (EMS) personnel are called to the aid of an individual. EMS personnel are obligated to utilize all available life-sustaining procedures absent a countervailing order by medical control or protocols honoring out-of-hospital DNR orders or POLST. POLST expands out-of-hospital DNR orders which only apply when the patient is in cardiopulmonary arrest, covering a range of medical interventions for patients with serious illness or frailty for whom death within the next year would not be surprising. This step beyond DNR is the crux of the POLST Paradigm. While the POLST has a section on whether the patient wants CPR, it is not the most clinically useful section of a POLST form. The section of a POLST form detailing the patient’s goals of care, or what level of medical intervention he/she wants, is the most important for ensuring the patient’s end of life care goals are communicated and honored. POLST requires in-depth in counseling and communicating with patients to ensure that they understand their medical condition and that their goals of care are authentically reflected in a completed POLST form.

Advance directives remain critically important for adults from the age of majority until death to provide guidance to health care decision-making. When the use of POLST becomes appropriate, an existing advance directive will help shape the patient’s choices when discussing POLST with a health care professional. And, the thoughtful appointment of a surrogate in an advance directive is the most valuable function of an advance directive, ensuring that someone with clear legal authority can speak for the person who no longer has decision-making capacity, at the time a POLST is completed, at the time a POLST is reviewed, and at the time it is implemented.

A key component to advance care planning is thoughtful, facilitated advance care planning conversations between health care professionals and patients and those close to them, particularly the individual the patient has identified as his/her surrogate. Patients should be encouraged to both (a) let the individual he/she has identified as his/her surrogate know they have been named and (b) include the potential future surrogate in the advance care planning conversations so the surrogate is aware of the patient's values and beliefs; this will help the surrogate feel more comfortable making person-centered goals of care when necessary.

Additionally, as a clinical matter it is recommended that a POLST be reviewed by the patient and his/her health care professional periodically and if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status; or
- (3) The patient's goals of care and/or treatment preferences change.

Periodic reviews ensure the POLST form accurately documents the patient's wishes for treatments as his/her disease progresses. In contrast, advance directives are not periodically reviewed—in fact, health care professionals may not be aware a patient has one unless it is part of a process to ask for a copy (and, even then, it is hard to confirm the copy is the most recent version). See *Issue 9B* for additional information.

The kinds of legal protections legislators have imposed on advance directives, including witnessing requirements, capacity assessment procedures and documentation, all serve to ensure the authenticity of advance planning decisions often made years before their implementation and generally without the benefit of medical counsel. Advance directive laws draw heavily from a legal transactional model that ties validity to formalities similar to those for creating wills, trusts, and other legal instruments.

POLST, in contrast, is appropriate in the later stages when serious illness or frailty where the health care professional would not be surprised if the patient died within the next year and the decisions to be made are concrete, clear, and concern the here-and-now. The model for decision-making for POLST is one of shared decision-making via direct engagement with health care professionals. Most formalities required of advance directives hinder rather than help such a model, because they cast the process into an implicitly adversarial context with an emphasis on legal formalities rather than good communication. Here is a comparison of advance directives and POLST:

Key Comparison of Advance Directives and POLST Paradigm Forms³

	Advance Directives	POLST Paradigm Forms
Population:	All adults	Serious illness or frailty
Timeframe:	Future care/ future conditions	Current care/current condition
Where completed:	Any setting, not necessarily medical	Medical setting
Resulting product:	Surrogate appointment & statement of preferences	Medical orders based on shared decision-making
Surrogate role:	Cannot Complete	Can consent if patient lacks capacity ⁴
Portability:	Patient/family responsibility	Health Care Professional responsibility
Periodic review:	Patient/family responsibility	Provider responsibility to initiate

When no advance directive exists, as is the case for the majority of adults, POLST forms are still available as an essential health care decision-making tool for patients now facing serious illness or frailty where the health care professional would not be surprised if the patient died within the next year. If the patient is capable of a POLST discussion, the patient is also likely capable of appointing a surrogate and should be encouraged to do so. The ability to have a continuing discussion around the review of a POLST is best assured if there is a surrogate to continue that conversation when the patient is no longer able to participate. (For discussion on whether a surrogate should be allowed to change a POLST, see *Issue 7(B)*)

Issue 2: Is Legislation Needed to Establish POLST?

Preferred Outcome. There is no preferred approach; each coalition must evaluate both legislative and non-legislative approaches in light of the particular culture of an individual state and determine what the best course of action is. The NPPTF cautions coalitions to avoid assuming legislation will help ensure their POLST Program’s success. The NPPTF advises that coalitions carefully consider all elements of their program and the benefits legislation may offer before going the legislative route (once legislation or regulations are enacted, they are difficult or impossible to remove).

Even if legislation may be the best approach, not all elements of a POLST Program need to be included in the legislation. The NPPTF strongly recommends that exact POLST form language not be included in any statute or regulation. Forms need to be updated on a routine basis to

³ Adapted from: Bomba, P.A., Kemp, M. and Black, J.S. POLST: An improvement over traditional advance directives. [Cleveland Clinic Journal of Medicine](#). July 2012, Vol. 79, Issue 7, p. 457-64.

⁴ Authority for surrogates to consent to a POLST form varies by state. See *Issues 6 and 7*.

incorporate new research or improved practices. If forms need to go through the legislative process for a statutory change, or even through a regulatory agency review to be changed, then updating the forms will be lengthy process. See *Issue 4* for additional information about POLST Forms.

Some states have found establishing their POLST Program through clinical consensus is the preferred approach. In those states, since POLST is a clinical program implemented by means of medical orders, health care professionals view it like other medical orders, for which there is normally no need for authorizing legislation.

Non-legislative approaches through clinical consensus have been successfully used in some states (e.g., Oregon and Pennsylvania) and have the advantage of greater flexibility in shaping and implementing a POLST Program. Broad clinical consensus establishes a generally accepted medical practice standard. However, to enable meaningful implementation, it is necessary to get recognition from the state department of health or a healthcare licensing board.

For example, Oregon originally adopted the POLST Paradigm through health care professional consensus. It was later supported by targeted changes in the Oregon Medical Board (OMB) rules as well modification of the emergency medical technician (EMT) Scope of Practice, which was changed to require EMTs to comply with life-sustaining treatment orders executed by a physician, nurse practitioner, or physician assistant,⁵ In addition, the OMB provided rules allowing physicians in emergency departments and hospitals to honor a POLST form regardless of whether or not the person signing the form has admitting privileges at that hospital. This incremental approach has enabled the Oregon POLST Task Force to modify the POLST form and make changes to the Oregon POLST Program periodically as lessons are learned without having to re-navigate the complexities and politics of the legislative process. Recently, Oregon enacted a statute to create the Oregon POLST Registry. The legislation provides funding and mandates the health care professional signing the form to submit the form to the Registry unless the patient specifically opts-out. Whether created by consensus, law or regulation, POLST programs need the flexibility to evolve over time through a process of evidence-based research, quality improvement processes, and clinical experience.

Issue 2A: When is Legislation Needed?

Legislation is needed if: (1) there are specific impediments existing in state law that pose legal barriers to POLST program implementation; or (2) there are political or health practice realities that pose serious barriers to implementation.

A 2008 article by Hickman *et al.* identifies state law barriers that exist in some states.⁶ For example, some states have legislated detailed state requirements for out-of-hospital DNR orders that do not permit other orders to be combined with a DNR order. Such a provision is a clear barrier to POLST. Some states restrict the use of out-of-hospital DNR protocols to certain medical diagnoses that are more restrictive than suggested by the POLST paradigm, and some

⁵ See Ore. Admin. Reg. §§ 847-010-0110 & 847-035-0030(6).

⁶ See *supra* note 2.

states impose such significant limitations on surrogate consent to forgo life-sustaining treatments that the use of POLST for patients relying on surrogates will be challenging but not impossible. See *Issue 7* for more discussion on surrogate authority.

Political and health practice barriers are more difficult to assess and quantify objectively. They often require a judgment about the efficacy or consequences of proceeding with a legislative initiative versus non-legislative. For example, uniformity of a POLST Program statewide is important for its success. Can that be achieved by clinical consensus among multiple health care facilities and systems? Proceeding in that manner avoids the danger of heavy handed, impractical, or inflexible legislation. On the other hand, legislation that directs a uniform system may avoid inconsistency of practice across the state and enhance its acceptance. Similarly, health care professional confidence in using POLST is important. If health care professionals are overly fearful of malpractice liability or disciplinary sanction for implementing POLST, then legislative immunity may become a priority among clinicians. See *Issue 10* for more discussion on legislative immunity provisions.

New York illustrates one example of targeting a narrow legislative barrier. The state's DNR law had prohibited any deviation from the state's prescribed DNR form. Legislation in 2005 allowed a community pilot to test an alternative form, approved by the State Health Department, and permitted EMS to follow "do not intubate" orders. A successful three-year community pilot in two counties changed legislation to allow statewide community use of an alternative form. The legislation was further refined in the state's 2010 Family Health Care Decisions Act⁷ to address procedures for surrogate consent and decision-making based on explicit clinical and surrogate standards, which had been lacking. Thus, legislation targeted specific barriers narrowly and deferred to the State Health Department to approve the details of a form and procedure. The only approved alternate form is New York Department of Health's MOLST form.

Issue 3: Who should have a POLST Form?

This is a medical and personal decision. It becomes a legal issue only if state law imposes medical preconditions applicable to certain health care decisions or out-of-hospital DNR orders that implicate the POLST.

Preferred outcome: The POLST Paradigm is for individuals with serious illness or frailty whose health care professionals would not be surprised if they died within the next year. The form is a set of current (or standing) medical orders that reflect the *current* goals of care of the patient. At least two studies have shown that, while not perfect, this clinical rule of thumb (i.e., I would not be surprised of death occurring within the next year) can be reasonably applied by health care professionals. In a study of cancer patients, 41% of the "death would be no surprise" patients died compared to 3% of the "death would be a surprise" patients.⁸ Similarly, in a study of dialysis patients, 29% of the "no surprise" patients died within a year compared to 11% of the

⁷ N.Y. Pub. Health Law §2994-dd(6).

⁸ Alvin H. Moss, et al., "Prognostic Significance of the "Surprise" Question in Cancer Patients," 13(7) *J. Palliative Med.* 837-40 (2010).

“death would be a surprise” patients.⁹ The differences in both studies were statistically significant. Given the difficulty with prognosis and determining the rate of disease progression, the NPPTF discourages states from legislating timeframes for POLST use. Examples of inappropriate timeframes include requiring a determination that the patient is terminally ill or statutorily allowing a prognosis of up to 5 years prior to death, both of which are strongly discouraged by the NPPTF.

Issue 3A. Should specific medical preconditions in state advance directive laws be required for POLST?

The preferred approach is for POLST to be available to anyone meeting the above clinical description. Where state law limits the freedom of individuals and their health care professionals under a state’s health care advance directive laws, the policy makers need to understand how advance directives and POLST differ in nature and function.

State advance directive laws may impose medical preconditions on advance health care directives that may cause confusion relative to the POLST Program but should not fundamentally interfere with the functioning of POLST. For example, in order for a living will to be operational in Pennsylvania, the patient must be incompetent and either must be permanently unconscious or be suffering from an end-stage medical condition, a term very similar to “terminal condition”, but without any express or implied reference to a time frame for life expectancy. A POLST, however, is not a living will, nor an advance health care directive. It is a medical order that is effective immediately, taking into account the patient’s current condition. A living will, in contrast, is a direction to health care professionals that provides guidance to decisions about future end-stage medical conditions or permanent unconsciousness. Restrictions on when an advance directive such as a living will becomes effective have been justified because of the danger of unintended consequences of medical instructions given by lay persons long before life threatening circumstances are known.

The POLST Form documents shared, informed health care decision-making in the here-and-now. Where the POLST is completed with the health care professional while the patient is able to participate in the health care decision-making process (aka has “decisional capacity”), there really is no compelling reason to limit the patient’s right to consent to or refuse any available medical intervention. The execution of a POLST is thus an effectuation of the patient’s constitutional, common law and statutory rights reflecting informed consent.

Limitations in state law applicable to living wills should not be applied to a POLST Program, and these limitations on advance health care directives should also be re-evaluated over time in light of the fundamental liberty interests of the patient to receive care and treatment that is consistent with their goals and values, honors their dignity, and avoids unwanted, intrusive and burdensome care.

⁹ Alvin H. Moss, et al., “Utility of the “Surprise” Question to Identify Dialysis Patients with High Mortality,” 3 *Clinical J. Am. Soc’y. Nephrol.* 1379–84 (2008).

Issue 3B. Should medical preconditions in state out-of-hospital DNR order statutes be applied to POLST?

State out-of-hospital DNR order statutes may contain medical preconditions for the issuance of out-of-hospital DNR orders.¹⁰ Since POLST forms include an order to either attempt CPR or not attempt CPR, the presence of specific medical preconditions for such DNR orders under state law may create a barrier or inconsistency with respect to the POLST. Further, in some states, state law dictates the details of out-of-hospital DNR orders and precludes adding additional orders.¹¹

DNR orders in a hospital setting have been available as a matter of clinical practice for virtually as long as cardiopulmonary resuscitation. The use of a DNR order in the hospital setting is based upon proper clinical judgment and, normally, the informed consent of the patient. Out-of-hospital DNR order statutes grew out of the need for EMS to have clear direction and protection where their resuscitation protocols would be inappropriate. An out-of-hospital DNR order, necklace or bracelet provides communication and authority to the EMS providers.

Example: Pennsylvania has an out-of-hospital DNR statute making an order, bracelet or necklace available to patients through their attending physician where the patient (1) has an end-stage medical condition or (2) is permanently unconscious with a living will directing non-resuscitation. A statewide advisory committee tasked by statute to study the need and advisability of a POLST form was faced with the alternatives of limiting the POLST form to patients with end-stage medical conditions or leaving the existing out-of-hospital DNR order form as a parallel stand-alone form. The advisory committee chose the latter approach while recommending as its first preference legislative change if such change would allow the POLST and the out-of-hospital DNR order to be combined without the medical preconditions.

A patient with serious illness or frailty whose health care professional would not be surprised if the patient died within the next year and who has decision-making capacity should be able to refuse CPR even if the patient does not have an end-stage medical condition. For right of surrogates to make this decision see *Issue 7*.

Issue 4: Who has responsibility for the language of a state's POLST form?

Preferred Outcome: POLST procedures and form details should not be dictated by statute or regulations. They should be delegated to a broad-based, inclusive working group, whose members provide input based on their experience, current research, and areas of expertise. The authority of such a coalition or oversight committee could be established by statute where necessary, with authority to convene and approve the POLST form and procedures through

¹⁰ Do Not Attempt Resuscitation (DNAR) and Allow Natural Death (AND) have emerged as preferred alternative terms to DNR, but the majority of state laws still use the term DNR.

¹¹ See *supra* note 2.

collaboration with the appropriate state agency (e.g., department of health, department of aging, or medical licensing body).

Issue 4A. Must one uniform POLST form be used throughout the state?

It is important that the health care professionals use a uniform POLST form so that the document becomes easily recognized, understood, and implemented. Variations by region or health system cause confusion, misinterpretation, and undermine clinical and political acceptance of the form. The POLST form should also be readily available, for example, by download from a website.

The goal of the POLST Paradigm is to have greater uniformity in information and appearances of all POLST forms to facilitate reciprocity among the states; this is why there is such emphasis on compliance with form element requirements and recommendations during the NPPTF endorsement process. While variation is currently unavoidable, it is in the interest of all POLST Programs to be as consistent as possible to assure patients their wishes are truly portable across not only care setting but state lines.

Issue 4B. Should we include the POLST form within a statute?

Any POLST Program is best viewed as a work in process. The POLST form that is implemented initially is not going to be the most appropriate form in the future because of changing medical science, changing health delivery systems, new research, and feedback from the field. Some states, such as Louisiana, have adopted a POLST form, word for word, in a statute in order to create uniformity throughout the state, and to provide immunity from liability for following the orders documented in the POLST form. Louisiana has been an exception to the norm and not a pathway recommended by the NPPTF.

Issue 4C. What is the most successful method for creating a uniform process and POLST form?

A study of established POLST Programs found that among the most important factors facilitating successful creation of a POLST Program was a core group of “physician champions” working with a broadly inclusive task force or coalition.¹² The coalition should include representatives of the various organizations that contribute to end-of-life health care, including the state medical association, the state bar association, EMS providers, hospitals, long-term care providers, nurses' associations, hospice associations, the disability community, and other consumer groups, including faith-based organizations that are particularly concerned about patient protections.

Such a coalition also needs a statewide organization to serve as the "home" for POLST in that state. A viable organization is needed to provide the administrative and organizational support to the coalition. The organization could be a medical or hospital association, a university or other educational facility, a hospice association, the state bar association, a governmental agency such

¹² Charles P. Sabatino & Naomi Karp, *Improving Advanced Illness Care: The Evolution of State POLST Programs*, (AARP Public Policy Institute, April 2011), available at: <http://www.aarp.org/health/doctors-hospitals/info-04-2011/polst-04-11.html> (accessed Jan. 24, 2013).

as the state health department, or a non-profit whose mission is focused on advanced care or end-of-life care issues. Ultimately, when the POLST Program is implemented, this organization or some other agency or entity is necessary to provide ongoing management and oversight of the POLST program. Ongoing management is addressed in *Issue 11*.

The coalition should make use of the assistance and resources available to it through the NPPTF. The NPPTF is engaged in education, advocacy, and research, with regard to end-of-life health care, on a nationwide basis. Thus, each state's working group can learn from the experiences and insights of other working groups, and from the research done at the national level by the NPPTF.

Issue 5: Which health care professionals can execute a POLST form?

Preferred Outcome: To maximize patient access to POLST, physicians, nurse practitioners, and physician assistants, consistent with state law, should be able to execute a POLST form.

Issue 5A. How should scope of practice regulatory issues be handled with respect to authority to execute POLST?

This is an issue that will play out uniquely in each state. Authorization to execute POLST forms must fit within state regulations and scope of practice rules. If there are serious objections to authorizing anyone other than physicians, then it may be advisable to start only with physician authorization. When the program is more established and comfort levels within the medical profession more secure, the option of expanding authority to execute a POLST may become easier to address. Idaho used this incremental approach and secured approval for nurse practitioners to sign the form in 2012, five years after the initial POLST legislation.¹³

Issue 5B. Can POLST counseling and preparation be delegated in part to health care professionals not authorized to sign a POLST?

POLST is not an end in itself but the end of a process. Many people may be involved in the process of helping a patient to clarify goals of care. A physician, NP, or PA has the ultimate responsibility to confirm that the patient (or surrogate) understands his or her condition, available choices, and is making an informed choice before signing the form. Other professionals, such as chaplains, social workers may help the patient explore and understand their values and goals of care (see *Issue 6A* for more on conversation). The process takes time and requires skills at facilitating a discussion. The quality of a POLST Program is enhanced by a team approach.

California has developed a two day training program on how to have the conversation. There are a number of medical and nursing journal articles and curricula on this topic.¹⁴ Many states have

¹³ See Idaho Code. § 39-4512A (2007). Idaho Session Laws 2012, ch. 302, § 11, eff. July 1, 2012, amended this provision to authorize advanced practice professional nurses and physician assistants, defined in §39-4502, to sign POLST orders.

¹⁴ See, e.g., End-of-Life Nursing Education Consortium (ELNEC) project, a national education initiative to improve palliative and end-of-life care, <http://www.aacn.nche.edu/ELNEC>.

also used the “Respecting Choices” program developed by Gundersen Lutheran Health System in La Crosse, Wisconsin.¹⁵ Additional educational resources can be found at www.polst.org.

Most state POLST forms provide a field for identifying the person who assists with completion of the POLST form, ensuring accountability of the team responsible for the POLST process. The most important element is the quality of the conversation, and the capability of the preparer to engage in and facilitate that conversation. In some states, like Utah, the statute indicates the credentials of the persons who can have the conversations with the patient.¹⁶ Regardless of who has or documents the conversation, when the physician or other authorized clinician signs the orders, he or she has the responsibility to confirm that the treatment orders are consistent with the patient’s goals.

Issue 6: How should patient preference be elicited and documented on a POLST form?

Preferred Outcome: A shared decision-making process engaged in by a patient and the health care professional leads to consent that is well-informed, collaborative and thoughtful. The patient’s goals of care and preferences for treatment are explored through this shared decision-making process. The process results in informed consent to medical orders, as documented by signature, attestation or through witnessed verbal consent.

The term “shared decision-making” denotes more nuanced process than that of “informed consent”. While the POLST conversation between a patient and the health care professional should include all elements of informed consent (information about diagnosis and prognosis; information about treatment options, including risks and benefits of each; and an opportunity to ask questions), the conversation includes more nuanced discussion that includes a deeper discussion of the patient’s goals of care for the end of their life. The POLST Form not only documents treatment decisions (such as CPR or DNR) but also conveys the level of medical interventions the patient wants to receive and the patient’s goal of care. Informed consent is generally used in the context of a specific procedure or course of treatment for a specific condition; the resulting document is a consent form the patient or his/her surrogate signs consenting to that specific procedure or course of treatment. The shared decision-making model used in POLST encompasses a larger discussion than just a specific procedure or course of treatment, but an entire goal of care discussion that may encompass multiple procedures or course of care decisions- all of which ultimately are respecting the overarching patient goal at the end of his/her life. The conversation for a POLST form should be more comprehensive than a typical informed consent discussion. Like informed consent, the shared decision-making discussion should be with a patient with capacity; if the patient lacks capacity, the conversation should be with the patient’s surrogate.

¹⁵ http://respectingchoices.org/about_us.

¹⁶ Utah Code Ann. §75-2a-106(2).

Issue 6A. Is a patient or surrogate signature or attestation necessary on a POLST?

The NPPTF strongly recommends that, as allowed by state statute and regulation, POLST forms require evidence that the patient or his/her surrogate has reviewed the form, agreed with the orders on the form, and agree that the orders accurately convey the patient's preferences. This should be done via signature, attestation or through witnessed verbal consent.

POLST is based on the premise that the patient or surrogate has engaged in a shared decision-making process with the health care professional, and that process has resulted in informed consent to a care plan. The POLST form documents that plan as medical orders that reflect the patient's wishes and goals of care with regard to the patient's immediate medical condition.

There is no doubt that either the patient's consent or that of the patient's authorized surrogate is needed. The practice and policy issue is how to document that consent. Obtaining the patient's signature is a common practice for documenting informed consent for major medical decisions, although a signature does not guarantee informed consent. On the other hand, most medical orders normally include only the health care professional's signature and not the patient's, and the POLST form is a set of medical orders. Circumstances may also make a signature impractical where, for example, the patient is physically but not mentally impaired, or the surrogate's discussion of POLST with the health care professional unavoidably takes place by phone. Thus, states currently using POLST have taken differing approaches to this issue.¹⁷

Of nineteen states with legislation or statewide POLST programs in January of 2013, thirteen required the patient's or the patient's surrogate's signature. In the other six, signature is optional but recommended. New York is unique in that, while signature of the patient is optional, two witnesses to the POLST form are recommended.

The NPPTF recommends against additional legal formalities such as witnessing or notarization as this extra step: (i) is not needed for other medical orders; (ii) may be burdensome, depending on who may serve as a witness and how convenient a notary is to the location; and (iii) causes confusion between POLST and advance directives.

Issue 7: What authority should surrogates have?

Preferred Outcome: Any surrogate recognized under state law to make other health care decisions, including a health care agent or proxy, a guardian, or a default surrogate, is authorized to consent to POLST when the patient lacks capacity to make health care decisions.

Issue 7A. Surrogates cannot sign an advance directive. Why should they sign a POLST?

The difference is in the nature of the act of POLST versus an advance directive. An advance directive is a personal tool for exercising one's autonomy in the indeterminate future. It enables

¹⁷ Exceptions should be made for these circumstances or where the POLST is being completed to effectuate a living will that has become operational and a surrogate is unavailable.

the individual to name a surrogate of his/her choice and give some degree of guidance for future medical decisions. Once the individual loses decisional capacity, a further direct expression of the patient's intent is no longer possible. Instead, the responsibility falls on the shoulders of an authorized surrogate under state law to consent to or refuse consent to medical decisions consistent with the values and wishes of the individual as best they can be discerned by the patient's advance directive or as otherwise known to the surrogate. For individuals with serious illness or frailty, several critical care decisions are highly likely and fairly imminent.

In a La Crosse, Wisconsin health system with widespread use of POLST, a study found that 67 percent of deceased patients had a POLST form, and the average time that the last POLST form was completed was only 4.3 months before death.¹⁸ These are patients for whom a clear care plan is needed right now in the form of medical orders, so that there are no unwanted surprises in care delivery. Someone to participate in and consent to a care plan and orders is needed. State surrogacy law normally applies to such decisions.

Of course, the preferred outcome is for the patient herself to consent to the POLST, but sometimes the patient's lack of mental capacity results in the patient lacking the ability to engage in the shared decision-making process. Because the POLST orders direct the patient's medical care, the patient must have sufficient capacity to give consent. That in turn, requires the patient to have the mental capacity to understand his or her condition, understand the benefits and burdens of the proposed course of treatment, and understand any possible alternative treatments. Not all patients have that degree of mental capacity.

A surrogate consents to or refuses to consent to some or all medical treatments for the patient when the patient lacks capacity. The preferred surrogate is one designated by the patient to make health care decisions for the patient in the event that the patient is mentally incapacitated. In most states, if the patient has not designated a surrogate, a state statute automatically appoints the patient's spouse as the surrogate, sometimes referred to as a "default surrogate." If there is no spouse, or if the spouse is not capable of acting as a surrogate, most statutes have a list of alternative possible surrogates, beginning with an adult child, a parent, a sibling and so forth, similar to the laws disposing of a person's property where they have not signed a will. State law varies about when an individual is authorized to consent to or refuse to consent to some or all medical treatments and even who that individual is or can be; it is important to review all statutes related to surrogacy when implementing a POLST Program.

A surrogate appointed by a state statute has, in some states, the same authority to make health care decisions as one appointed by the individual, but in other states, that may not be the case. The state law may limit a default surrogate's authority to refuse or terminate life sustaining treatment for the patient. Those limitations may affect the nature of a POLST that the surrogate can agree to. For example, Arizona's default surrogate law does not permit a default surrogate to consent to or approve the permanent withdrawal of the artificial administration of food or fluid.¹⁹

¹⁸ Bernard J. Hammes, et. al., "A Comparative, Retrospective, Observational Study of the Prevalence, Availability, and Specificity of Advance Care Plans in a County that Implemented an Advance Care Planning Microsystem," 58 *J. Amer. Geriatrics Soc'y*. 1249, 1252 (2010).

¹⁹ Ariz..Rev. Stat. § 36-3203(E).

If Arizona were to adopt POLST, a default surrogate could consent to a DNR option provided in POLST but may not be able to consent to the withholding of nutrition and hydration. POLST may still be utilized in that state but with a more limited scope when default surrogates are involved.

Even when the patient appoints the surrogate, questions can still arise as to the extent of the surrogate's authority. Some states limit the right of an individual to delegate termination of life sustaining treatment to a surrogate. For example, in Ohio, the attorney-in-fact acting under a power of attorney for health care may refuse or withdraw informed consent to life-sustaining treatment only if the principal is in a terminal condition or a permanently unconscious state. Additionally, there must be no reasonable possibility of the principal regaining the capacity to make informed health care decisions.²⁰ The POLST Program may be utilized in states with statutory limitations such as these. Physicians and other health care professionals are familiar with the limitations currently in place. The entire process does not have to be changed; rather, the POLST Program may be added to the picture, with surrogate decision-makers participating to the extent permitted under state law.

In addition to statutory limitations on a surrogate's decision-making authority, a surrogate's authority also may be limited by the patient's own directions. A living will declaration may provide several specific choices by the declarant with regard to his or her end-of-life medical care. A surrogate is expected to follow and implement those directives to the extent they apply to a particular decision, unless the advance directive and state law give authority to the surrogate to override the general directions in a living will.²¹ A durable power of attorney for health care also may include limitations, put in place by the patient, on the surrogate's authority to make medical decisions. The surrogate must be aware of and act within the limitations established by the patient.

Issue 7B. If a patient agreed to a particular care plan set forth in POLST, should a surrogate be allowed to change the plan later when the patient no longer has decisional capacity?

This question reflects a concern that a surrogate could undermine the previously expressed wishes of the patient. The same question arises if the surrogate makes a decision regarding POLST that appears inconsistent with an advance directive executed by the patient. It is a concern that deserves thoughtful consideration, but a rule to outright prohibit the surrogate from changing the POLST could clash directly with good clinical practice, and ultimately fail to fulfill the patient's wishes, had the patient been able to participate in the decision-making process at a later time when the circumstances are better known. Patients with serious illness or frailty whose health care professional would not be surprised if they died within a year are certain to face changes in medical condition and functioning. Good medical care and treatment has to adapt to changing circumstance. If done properly, a POLST provides "clear and convincing" evidence of the patient's wishes. However, new circumstances require evaluation and consideration.

²⁰ Ohio Rev. Code § 1337.13.

²¹ See e.g. 20. Pa.C.S.A §5471.

Scenario 1: An 80 year old woman with moderately severe heart failure works with her clinician to complete a POLST. She is awaiting the birth of her first great-grandchild and is hoping to enjoy quality time with the baby before she died. She requests CPR in the event her heart and breathing stopped; she has capacity to make such a medical decision. Subsequently, she suffers a severe cerebrovascular accident (a stroke) that causes her to lose her ability to make POLST decisions and from which she is not expected to recover; prognosis is less than 6 months. A palliative approach is recommended by the health care team.

Review of POLST: The patient's health care professionals and surrogate are aware that she will not attain her previously expressed goal for care and the focus of care shifts from longevity to comfort. Given the new medical condition, maintaining the previous medical order would be inappropriate. Her clinician and her surrogate can revise her POLST to reflect her new health condition, including DNR and comfort measures only.

Scenario 2: An 85 year old woman with moderately severe heart failure works with her clinician to complete a POLST. She indicates she lived a good life and prefers to allow a natural death at home; she has capacity to make such a medical decision. She requests a DNR order in the event her heart and breathing stopped, and limited interventions in the event her heart failure decompensates so she can age in place at home. Subsequently, she suffers a severe cerebrovascular accident (a stroke) that causes her to lose her ability to make POLST decisions and from which she is not expected to recover; prognosis is less than 6 months. A palliative approach is recommended by the health care team.

Review of POLST: The patient's health care professionals and surrogate are aware that she will not attain her previously expressed goal for care and the focus of care shifts from functionality to comfort. Given the new medical condition, her clinician and her surrogate can revise her POLST to reflect her new health condition, retaining DNR and changing to comfort measures only. Her surrogate cannot request an order for CPR and full treatment in this clinical scenario.

Each state can establish reasonable safeguards to make certain that the surrogate is, at all times, acting to carry out the patient's wishes. Examples of safeguards are:

- (1) a requirement that a surrogate engage in further consultation with the treating physician before authorizing a change to the patient's POLST;
- (2) a requirement that the patient's advance directive be consulted, if available;
- (3) a requirement that good faith efforts be made to act consistently, at all times, with the patient's known wishes; and
- (4) a requirement that the reasons for any change in the patient's POLST be documented.

Issue 8: Is offering and completion of a POLST mandatory?

Preferred Outcome: The NPPTF's position is that a POLST should never be mandatory, but health care professionals should be encouraged to offer POLST to appropriate patients.

Requiring healthcare facilities to offer POLST to appropriate patients encourages widespread clinical implementation of POLST. A number of states require that hospitals or long term care facilities offer POLST to certain groups of patients. This requirement parallels the long-standing duty under the Patient Self Determination Act to “provide written information . . . concerning . . . right to formulate advance directives.”²² For example, Utah requires that hospitals, hospices, nursing, assisted living, and other facilities determine, on admission, whether each individual has a POLST.²³ These facilities must establish a process to determine which of those individuals without a POLST should be offered the opportunity to complete one. POLST Programs should be targeted to patients with serious illness or frailty for whom death within the next year would not be a surprise.

Issue 8A. Should every nursing home resident be deemed within the appropriate group to whom POLST is offered?

No. The NPPTF recommends against automatically assuming all patients in any facility be deemed an appropriate candidate for POLST. Facilities may have a policy to *offer* POLST to all residents admitted. This may result in offering a POLST discussion to a relatively healthy adult with acute convalescence who needs to be placed in a nursing home for a limited period of therapy before returning to the community for a substantially full recovery. If facilities are using the POLST in this way, they should be sure to have a clear process to review and, if appropriate, void POLST forms during the discharge process so that only those patients who are appropriate for POLST leave with a valid POLST Form. See *Issue 9B* for further discussion.

Federal nursing facility regulations require that nursing home facilities conduct a “comprehensive assessment” upon resident admission. This assessment should include consideration of the appropriateness of POLST as part of advance care planning. But caution should be exercised to make sure POLST is not reduced to a checklist as part of the admissions process. It is critical that facilities offering POLST to all residents implement policies and procedures to ensure that the POLST conversations (see *Issue 6A*) are occurring whenever a POLST form is offered.

Issue 8B. Is completion of POLST mandatory?

The NPPTF will not endorse any POLST Program that requires completion of a POLST, regardless of the patient population. It is fundamental to the POLST Paradigm that completion of a POLST form always be voluntary.

The law in Maryland (which is not a POLST endorsed state) requires healthcare facilities to offer POLST to *all* their admitted patients. Furthermore, Maryland requires healthcare facilities actually to *complete* a POLST for all admitted individuals who do not have a POLST. This is over-inclusive on two levels. First, as described above, this categorical approach results in POLST being offered to patients and residents for whom it is not indicated. Second, Maryland mandates not only the *offering* but also the *completion* of POLST. State regulations require the

²² 42 U.S.C. §§ 1395cc(f) & 1396a(w).

²³ Utah Admin. R. 432-31 (Oct. 1, 2011).

health care professional to note in the medical record when a patient or an authorized decision maker declines to participate in completing or updating the MOLST form.²⁴

To be sure, the mere completion of POLST is not the same as dictating particular treatment plans. POLST accommodates varying treatment preferences. So, even if actual completion were required, patients and residents could complete POLST in any way that they want. Indeed, nearly one-quarter of patients completing POLSTs choose “full treatment.” And many of those choosing DNR on their POLST still want other kinds of treatment like hospitalization and artificial nutrition and hydration.²⁵ Still, requiring completion arguably undermines the premise that a POLST is based on the voluntary, informed consent of the patient.

Issue 9: Is health care professional compliance with POLST mandatory?

Preferred Outcome: Health care professionals must comply with POLST unless changed circumstances or new information dictate otherwise.

Review and possible modification of POLST is indicated in non-emergency circumstances when: (1) there is substantial change in patient/resident health status, (2) the patient/resident is transferred from one health care setting to another, or (3) the patient/resident treatment preferences change. Periodic review with the passage of time is also highly advisable as an additional safeguard.

Issue 9A. Is compliance with POLST required or prohibited in the emergency department or at hospital admission when the prescribing health care professional is not credentialed at the receiving hospital?

When POLST has been introduced in states, questions have arisen about the obligation of hospital physicians in the Emergency Department (ED) or at admission when receiving a patient with a POLST form that is signed by a health professional who is not credentialed by the hospital or does not have admitting privileges at the hospital. Sometimes the admitting physician or physician treating the patient at the hospital is reluctant to honor the orders contained in the form. This reluctance often arises from a belief that an order signed by a physician or other qualified signor without admitting privileges is not valid at the hospital under federal Medicare law.

An examination of federal law and regulations provides no basis for that belief. Federal regulations provide only that the hospital’s governing body must:

Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff; ... and

²⁴ COMAR (Code of Maryland Regulations) § 10.01.21.04(B) (eff. January 1, 2013).

²⁵ See, e.g., Erik K. Fromme *et al.*, “POLST Registry Do-Not-Resuscitate Orders and Other Patient Treatment Preferences,” 307 *JAMA* 134-35 (2012).

Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;²⁶

Furthermore,

In accordance with hospital policy, the governing body must ensure that the following requirements are met:

... (4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that--

(i) Is present on admission or develops during hospitalization;²⁷

Neither of these provisions precludes recognition of a POLST form, any more than it precludes recognition of a state-recognized DNR order or prescription orders that accompany an arriving patient.

At the same time, federal law is very strong with respect to the hospital's obligation to honor patient direction of health decisions.

Standard: Exercise of rights.

(1) The patient has the right to participate in the development and implementation of his or her plan of care.

(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.²⁸

Finally, federal regulations require hospitals and medical personnel to comply with state law:

The hospital must be--

(1) Licensed; or

(2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.

(3) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.²⁹

CMS has never discussed POLST explicitly in its regulations, manuals, or transmittals. Therefore, where POLST is permissible under state law as an appropriate clinical procedure for honoring patients' goals of care, it is fully consistent with federal rules. Perhaps more significantly CMS has recently acknowledged POLST (referring to "MOLST") as a positive example in recent changes to its Guidelines to Surveyors at F tag 309 ("Quality of Care") and F tag 155 ("Advance Directives") for nursing homes.³⁰

²⁶ 42 C.F.R. §§ 482.12(a) (1) & (a) (5).

²⁷ 42 C.F.R. § 482.12 (c).

²⁸ 42 C.F.R. § 482.13(b).

²⁹ 42 C.F.R. §§ 482.11(b) & (c).

³⁰ CMS Manual System Pub. 100-07, State Operations, Provider Certification. Transmittal-ADVANCE COPY (September 27, 2012). SUBJECT: Revisions to Appendix PP – "Interpretive Guidelines for Long-Term Care Facilities -- F tag 155 (Advance Directives)," available at: <http://www.cms.gov/Medicare/Provider-Enrollment-and->

While the above authorities are consistent with POLST's validity at the time of admission to a hospital or emergency department, the implementation of POLST also involves the concurrent clinical obligation to reassess the patient's condition and the medical plan of care whenever the patient's condition changes. This includes reassessment of POLST and its possible modification.

Issue 9B. When is POLST review and possible modification necessary or advisable?

Review of POLST follows fairly clear clinical norms and is best not fixed by a statutory schedule. In practice, in states with POLST Programs most hospitals honor the POLST form that accompanies a patient until the patient is reassessed, treatment choices are discussed, and new orders are written. In emergency circumstances there may be no time to do a reassessment, in which case POLST should dictate care.

As a clinical matter, the NPPTF recommends that POLST be reviewed periodically and specifically 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 goals of care and/or treatment preferences change.

Review of the patient's POLST form upon discharge or transfer for one care setting to another, is critical. When a patient is leaving a care setting, health care professionals should review the POLST form with the patient to: (i) confirm the orders are still accurate; (ii) update the POLST form to reflect new preferences or (iii) void the POLST form if the patient is not within the appropriate POLST population.

Health care professionals should also be sure to review POLST as part of other scheduled care plan reviews. It is clinically appropriate to review POLST orders at least once a year even if none of the other triggering events listed above have occurred. For example, in nursing homes, there is already a federal requirement for review of care plans every three months and states may have additional care plan review requirements.³¹ POLST should be made an express part of care plan review.

If a patient presents with a POLST form at a hospital, an appropriate practice is for the admitting physician to discuss the POLST orders with the patient, acknowledging that a physician or other health professional has previously spoken to the patient about his or her wishes. The admitting physician then can reissue the orders, or change them if the patient indicates such a change is now desired.

The practical challenge occurs when the patient is not capable of having this conversation with the admitting physician or circumstances otherwise prohibit the conversation. In this

[Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-47.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-47.pdf); and F tag 309 (Quality of Care), available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-48.pdf>.

³¹ 42 C.F.R. 483.20(c).

circumstance, if the patient has an authorized surrogate available and time permits, the physician should discuss the patient's condition and wishes with the surrogate, and POLST can likewise be reissued or changed.

If the medical situation is an emergency that precludes the attending physician from discussing the POLST orders with the patient, the orders expressed on the POLST form are valid and should be followed. If, thereafter, the patient stabilizes, POLST should be reviewed and adjusted accordingly according to hospital protocols. This review is done by a physician who has facility privileges. In all cases, the attending physician should ensure that the orders on the POLST form, as revised if necessary, become active hospital chart orders, and that a new POLST is done prior to discharge.

Issue 10: Does POLST raise liability or immunity concerns?

Preferred Outcome: Establishment of POLST as a clear standard of practice. Health care professionals are protected under common law by compliance with generally accepted standards of practice in their area.

Some states, like Oregon, have been able to implement POLST solely through clinical consensus. In 1991, Oregon clinicians implemented POLST on the basis of clinical consensus and without any explicit grant of immunity. Only subsequently, in 2007, did the Oregon Medical Board promulgate a regulation confirming that “a physician or physician assistant shall not be subject to criminal prosecution, civil liability or professional discipline” for honoring a POLST.³²

Issue 10A. Is legislative immunity preferable, analogizing to advance directives?

Many health care professionals across the country want more explicit reassurance. While they may not need it, they prefer statutory immunity. When they follow the orders in a POLST in good faith, they want protection from criminal prosecution, civil liability, and disciplinary sanctions. Since health care professionals already have this immunity for following advance directives and surrogates, some argue that it is anomalous not to have equivalent immunity language in a POLST statute or regulation.

Washington is illustrative. Currently Washington law affords immunity only to EMTs. But legislative testimony, in early 2013, demonstrated that emergency room and long-term care providers are reluctant to comply with POLST forms that decline treatment.³³ These clinicians and facilities want to carry out patient wishes. But, they are fearful of legal risk. Whether or not this fear is grounded, it is real to them. And it leads some providers to disregard patient wishes. Consequently, depending on the medical culture in one's state, statutory immunity may be a critical factor to assuring that POLSTs are carried out.

³² Ore. Admin. R §§847-010-0110 & 847-035-0030(6).

³³ Wash. S.B. 5562 (2013); Wash. H.B. 1000 (2013).

Issue 10B. Can health care professionals presume validity of a POLST form presented to them?

Parallel to the general rule for advance directives, health care professionals should be able to presume the validity of a POLST. A health care professional who honors a POLST should not be subject to any sanctions, as a result of his or her reliance on the POLST, so long as the health care professional believes “in good faith” both that the POLST is valid and that it has not been revoked. In this regard, reliance on a POLST is equivalent to reliance on any other medical order.

Issue 11: Administration, monitoring, and evaluation – what infrastructure and process should be in place for POLST Programs?

Preferred Outcome: A clear lead entity or agency exists to administer the POLST Program, with three essential functions: ongoing education, research and monitoring, and quality improvement.

Issue 11A: What is an appropriate administrative structure needed to establish a POLST Program?

It is possible in theory to establish a POLST Program with no administrative entity responsible for any of the functions above. Legislation can legitimize any program meeting the minimum legislative criteria for POLST, or meeting criteria established by a designated state regulatory agency such as the department of health. However, research examining twelve states with POLST Programs as of 2010 found that one of the key lessons of success from those states is that POLST is neither a static program nor self-implementing. It requires a continuous process of professional education, evaluation, and quality improvement. Oregon, which has the longest history of using POLST, continues to evaluate the operation of the program and continues to make changes in the form or procedures every few years to respond to problems identified. POLST Programs must also adapt to continuing improvements in medical treatment, technology, and health delivery.

States have chosen quite different lead agencies with quite differing resources.

- In New York, the State Health Department exercises regulatory jurisdiction over POLST (called MOLST), setting basic guidelines and having authority to enforce them, but a statewide non-profit group (Compassion and Support) actually distributes the form and provides an array of educational resources and research.
- In Oregon and West Virginia, the lead entity is a University.

Issue 11B. How do we best evaluate whether the POLST Program is genuinely determining patients' values, priorities, and goals of care and translating them into accurate orders?

Because POLST is neither a static program nor self-implementing, an inclusive oversight group, consisting of representatives of the various organizations that contribute to advanced care and end-of-life health care must provide input, over time, on how to make the POLST form and

program more effective in the state. As explained under *Issue 4C* above, the coalition ideally includes the state medical association, the state bar association, EMS providers, hospitals, long-term care providers, nurses' associations, hospice associations, the disability community, and other consumer groups, including faith-based organizations that are particularly concerned about patient protections. This coalition will make suggested improvements to the POLST form and program based on the experiences and input of its various members.

Educating everyone involved in advanced care planning on the availability and proper use of POLST is key to its widespread and effective implementation. Accordingly, the working group should develop and implement a specific plan for initial and ongoing education in the use of POLST and effective counseling of patients and families. Large organizations, such as hospitals and nursing homes, may create their own training programs. Public education is also a necessity to better equip the public to participate effectively in decisions about advanced care.

The coalition implementing the POLST Program should implement a system for evaluating their POLST form and the POLST program, and for implementing changes and updates to both. To the extent that a data collection and monitoring system can be established to track usage of POLST, evaluation will be more effective.

From time to time there may be a need to propose changes or updates to the rules in the state administrative code or the state's statutes, if applicable. If the coalition is meeting regularly and has a plan for monitoring and evaluating the POLST program, then the coalition will be in a position to garner the evidence needed to bring about changes in the administrative rules or the state's statutes.

The coalition will have assistance and resources available to it through the NPPTF. The NPPTF is engaged in education, advocacy, and research, with regard to end-of-life health care, on a nationwide basis. Thus, each state's working group can learn from the experiences and insights of other working groups, and from the research done at the national level by the NPPTF.

Issue 12: Are POLST forms portable across jurisdictions?

Preferred Outcome: Explicit reciprocity recognized in protocols, regulations, or law.

Issue 12A. What is the source of authority for recognition across jurisdictions and applicability of immunity?

Only a minority of states have a statute or regulation explicitly recognizing POLST forms from other states.³⁴ Therefore, the only “authority” for recognition across jurisdictions emanates from generally accepted medical practice, to the extent it acknowledges and respects existing medical

³⁴ See e.g., Colo. Rev. Stat. Ann. § 15-18.7-104 (1)(a) (“Except as provided in [this statute], emergency medical service personnel, a health care provider, or a health care facility shall comply with an adult's executed medical orders for scope of treatment form that: (I) Has been executed in this state or another state; (II) Is apparent and immediately available; and (III) Reasonably satisfies the requirements of a medical orders for scope of treatment form....”).

orders. POLST is a written medical order, which is followed by the medical community to whatever extent that all medical orders are generally followed and implemented. When a patient moves from a hospital to a nursing home, or across state lines – from one jurisdiction to another, typically a physician will review the patient's history and existing orders, and update those orders. When a patient with a POLST form moves into a jurisdiction that does not utilize POLST forms, it becomes unclear whether the new physician is required to recognize the POLST orders and will be protected from liability for doing so. Legislation specifically mandating recognition of the other state's POLST form, and granting immunity from liability for doing so, is a helpful solution.

Issue 12B. Where there is variation of substantive POLST provisions or health decisions laws, which law applies (originating state or receiving state)?

As explained in other portions of this Legislative Guide, a POLST Program may be created and implemented without legislation. Portability of POLST forms, however, is an area where legislation is helpful, because it can establish explicit reciprocity and recognition. See additional discussion under *Issue 4A*.

Most states already recognize the face validity of an out-of-state advance directive, but implementation of such a directive may be impaired or its interpretation altered by the implementing state. Reciprocity is similarly developing with regard to POLST, but whether it will be hampered by implementation or interpretation differences is still largely untested.

The states have taken four main approaches to POLST portability. First, some states will honor the originating state's POLST so long as it complies with the law of the *receiving* state (e.g. Iowa,³⁵ New Jersey³⁶). Second, some states will honor the originating state's POLST so long as it just *reasonably or substantially* complies with the law of the receiving state (e.g. Colorado,³⁷ Idaho,³⁸ Utah³⁹). Third, some states honor the originating state's POLST so long as it complies with the law of the *originating* state (e.g. Rhode Island⁴⁰). Fourth, some states will honor the originating state's POLST so long as it complies with *either* the law of the receiving state *or* the law of the originating state (e.g. West Virginia⁴¹). We do not yet have enough experience to say which approach is the best solution.

Whichever approach is taken, POLST will be undermined if clinicians have to refer all questions about legal compliance to counsel. One way to avoid that is to build in a presumption of validity for POLST forms, regardless of origin. California has such a presumption for DNR requests,⁴² but so far, only Maryland has legislated such a presumption in their POLST law:

³⁵ Iowa Code § 39-4514.

³⁶ N.J. Stat. Ann. § 26:2H-134(c).

³⁷ Colo. Rev. Stat. Ann. § 15-18.7-104.

³⁸ Idaho Code § 39-4514.

³⁹ Utah Admin. Code R. 432-31-11.

⁴⁰ R.I. Gen. Laws 1956, §§ 23-4.11-2 & 23-4.11-12.

⁴¹ W. Va. Code § 16-30C-15.

⁴² Cal. Probate Code § 4784.

A health care provider may rely in good faith on the presumed validity of a “Medical Orders for Life-Sustaining Treatment” form.⁴³

This kind of resumption is more common in state advance directive laws. For example California’s advance directive law provides:

In the absence of knowledge to the contrary, a physician or other health care provider may presume that a written advance health care directive or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.⁴⁴

In light of the variation in portability provisions, this is clearly an area where *federal* law could be very effective. For example, the recently introduced *Personalize Your Care Act of 2013*⁴⁵ provides that an advance directive validly executed outside the State in which such directive is presented “must be given effect by a provider of services or organization to the same extent as an advance directive validly executed under the law of the State in which it is presented.”⁴⁶ The bill has an express preemption clause that would preempt any state law with inconsistent portability provisions. Legislation could apply this same kind of mandate to POLST.

Alternatively, a *uniform* law, adopted by most or all states implementing the POLST Paradigm, could also be very effective. While it is still under revision and not directly applicable to POLST, one potential source of guidance is the draft Inter-jurisdictional Recognition of Substitute Decision-Making Documents Act from the National Conference of Commissioners on Uniform States Laws. If adapted to POLST, the reciprocity provisions in this Act would deem a POLST form valid if, when completed, it complied with the law of the jurisdiction where it was completed. Because a clinician in the receiving state may not know the legal status of the originating state POLST, the clinician may accept the POLST as valid so long as she has a good faith belief it is valid and has not been revoked. The weakness of uniform laws is that states do not have to adopt them. Nevertheless, they serve as influential benchmarks that states pay attention to.

Without a federal or uniform law, there will likely be some obstacles to implementing portability. States vary not only in their requirements regarding the formalities of execution but also in their substantive rights regarding health care decisions. But portability and reciprocity produce a net benefit. Portability and reciprocity better assure the honoring of patient wishes.

⁴³ Md. Health Decisions Code §5-608.1(h).

⁴⁴ Cal. Probate Code §4676(b).

⁴⁵ H.R. 1173, 113th Cong., 1st Sess. (2013) (Blumenauer, Ore.).

⁴⁶ *Id.*, at § 5.