National POLST Paradigm (NPP)

Institutes of Medicine: Dying in America Report

Talking Points

September 2014

The Institute of Medicine’s (IOM) Report Dying in America is a comprehensive review of the end-of-life care in this country. The IOM Report found that the U.S. health care system is poorly designed to meet the needs of patients near the end of life, and because of this, patients and families are suffering. Major changes to the health care system are needed to meet patients’ end-of-life care needs and informed preferences in a high-quality, affordable, and sustainable manner.

The value of POLST is found throughout the Institute of Medicines’ Dying in America Report. The focus on the need for advance care planning, conversations between patients and health care professionals, shared medical decision-making that is informed, documenting wishes for EOL care, providing education to health care professionals, and encouraging accessibility to advance care planning opportunities to all are themes throughout this report. These talking points pull out specific items that may be helpful in advocating for POLST.

IOM Report Overview

The IOM Report is divided into five key areas:

- Delivery of person-centered, family-oriented care
- Clinician-patient communication and advance care planning
- Professional education and development
- Policies and payment systems
- Public education and engagement

Key recommendations include:

- Quality standards should be developed for clinician-patient communication and advance care planning
- Appropriate provider training, certification and licensure should be developed to strengthen palliative care knowledge and skills of all clinicians; this includes advance care planning
- Fact-based public education that encourages advance care planning and shared, informed medical decision-making; the “life-cycle” model for advance care planning
- All insurers should cover comprehensive care for individuals with advanced serious illness who are near the end of life; a care plan is needed to support POLST orders
- All insurers should integrate the financing of medical and social services to support quality care consistent with patients’ values and preferences
IOM Key Findings & Recommendations that Align with POLST

- "For patients and their loved ones, no care decisions are more profound than those made near the end of life." (Introduction)
- "A committee of experts finds that improving the quality and availability of medical and social services for patients and their families could not only enhance quality of life through the end of life, but may also contribute to a more sustainable care system." (Introduction)
- "The IOM committee believes a person-centered family-oriented approach that honors individual preferences and promotes quality of life through the end of life should be a national priority.”
  - The NPP has been advocating for this approach for over 10 years.
- **Recommendation 1 (Delivery of Care):** A comprehensive care plan is needed to support POLST. Comprehensive care should be seamless, high-quality, integrated, patient-centered, family-oriented, and consistently accessible around the clock.
- **Recommendation 2 (Clinician-Patient Communication and Advance Care Planning):** Professional societies and other organizations that establish quality standards should develop standards for clinician–patient communication and advance care planning that are measurable, actionable, and evidence based.
  - The NPP has established quality standards – we advocate for shared decision making between patients, families and health care professionals. This is a requirement for endorsement. (See Item 5 on endorsement application).
- **Recommendation 2 (Clinician-Patient Communication and Advance Care Planning):** Payers should tie such standards to reimbursement, and professional societies should adopt policies that facilitate tying the standards to reimbursement, licensing, and credentialing to encourage high-quality conversations about advance care planning and encourage clinicians to continue to revisit advance care planning discussions with their patients because individuals’ preferences and circumstances may change over time.
  - Highlights the importance of clinician-patient communication and ACP
- **Recommendation 3 (Professional Education and Development):** all clinicians across disciplines and specialties who care for people with advanced serious illness should be competent in basic palliative care, including communication skills, interprofessional collaboration, and symptom management. (See Item 7 on endorsement application)
- **Recommendation 4 (Policies & Payments):** encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements.
- **Recommendation 4 (Policies & Payments):** require the use of interoperable electronic health records that incorporate advance care planning to improve communication of individuals’ wishes across time, settings, and providers, documenting (1) the designation of a surrogate/decision maker, (2) patient values and beliefs and goals for care, (3) the presence of an advance directive, and (4) the presence of medical orders for life-sustaining treatment for appropriate populations
- **Recommendation 4 (Policies & Payments):** provide financial incentives for improved shared decision making and advance care planning that reduces the utilization of unnecessary medical services and those not consistent with a patient’s goals for care;
- **Recommendation 5 (Public Education and Engagement):** Civic leaders, public health and other governmental agencies, community-based organizations, faith-based organizations, consumer groups, health care delivery organizations, payers, employers, and professional societies
should engage their constituents and provide fact-based information about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.

- See IOM Key Findings and Recommendations 8 page booklet.

**Specific POLST References within IOM Report**

- Lists POLST as one of seven practices related to ACP identified by the 2006 National Quality Forum’s National Framework and Preferred Practices for Palliative and Hospice Care Quality. (3-42)
- Provides overview of POLST (3-43 to 48)
  - Identifies that POLST form use is supported by the American Hospital Association, AARP, the National Hospice and Palliative Care Organization (3-44)
  - Outlines the effects of POLST on Patient Care (research summary) (3-45)
- Defines appropriate population for POLST: POLST are not intended for everyone; they are for people with serious illnesses or frailty whose health care professionals would not be surprised if they died within the next year, based on their current health status and prognosis. POLST also are appropriate for patients who reside in a long-term care facility or receive long-term services at home as a result of frailty, and for persons of advanced age who want to avoid or receive any or all life-sustaining treatment. Among vulnerable populations, including persons with disabilities, POLST are intended only for seriously ill or frail patients facing end of life, not the entire population.
- Emphasizes the need for electronic storage of POLST and other ACP documents in EHRs. (3-49 to 52):
  - Easily located when critical decisions must be made
  - Reminder to HCPs to ask whether patient’s care preferences have changed and whether they want to update surrogate information
  - New York State’s eMOLST program is an example of well-coordinated electronic documentation of advance care choices.
- Provides “A Proposed Life-Cycle Model of Advanced Care Planning” (3-52 to 54)
  - Final Year of Expected Life – provides "the opportunity for thoughtful POLST discussions...to increase the likelihood that preferences for care and treatment are accessible and honored." (3-54)
  - Model has implications for quality improvement programs, clinician training, public and patient education, and payment systems. (3-52)
- “Advance care planning should be considered a lifelong process. Health care agents should be identified early in this process, and for people with advanced serious illness, POLST Forms should be used." (3-56)
- Research Needs
  - With respect to the POLST paradigm and other community-wide efforts to encourage advance care planning, the research challenge is one of developing and validating best practices to ensure the integrity of these program models as they are diffused to other settings.
  - Investigations should be initiated to determine the most effective ways in which electronic health records can support advance care planning.

**IOM Resources**

- [IOM Report Dying in America](#)
General: National POLST Paradigm & POLST Talking Points

- POLST is a process.
  - In any response, we want to emphasize that the POLST Paradigm is not just a form but a conversation that includes shared decision making by health care professionals and their patients.
    - Watch for how “POLST” is used – is the word being used interchangeably with the form and the program? You’ll want to be sure people are clear POLST is more than a form. States will not get the same results as what is in the research manuscript unless they implement the full process of conversation with the form. (A POLST form alone is not enough!!)

- POLST is not for everyone.
  - POLST is not for everyone; only patients with serious illnesses or frailty (for whom their health care professional would not be surprised if they died within a year) should have a POLST form. For these patients, their current health status indicates the need for standing medical orders for emergent or future medical care.
    - For healthy patients, an advance directive, particularly a health care proxy or durable power of attorney for healthcare, is an appropriate tool. More important is starting family discussions earlier and emphasizing the importance of choosing the right health care agent in case the individual loses the ability to make medical decisions. This may be due to acute illness or injury with the possibility of recovery, or a life-threatening condition where death may occur.

- Completion of a POLST Form should always be voluntary.
  - A health care facility may have a policy that offering the POLST form is mandatory, but completion should always be voluntary.

National POLST Paradigm Resources

- About the National POLST Paradigm
- What is POLST?
- Key POLST Paradigm Public Policy Principles
- NPPTF Goals
- POLST Legislative Guide
- History of the POLST Paradigm
- POLST Endorsement Application