Nevada POLST Proposed Statutory Revisions

I. Proposal 1

A. Change Out-of-hospital DNR section (449.6946.2) of statute.

- *Problem:* Currently, if a patient carries an out-of-hospital Do Not Resuscitate (DNR) card issued by the State (often referred to as "the salmon-colored card") that differs from a more recent POLST directing resuscitation be provided, the patient is *not* to be resuscitated.
- *Revision*: The most recent document (POLST or out-of-hospital DNR) should be honored.
- *Rationale:* Current law is very confusing and disturbing to health care providers. If a patient's desires are not clear (the POLST and DNR resuscitation orders do not agree) and no one is able to speak for the patient, the provider will normally err on the side of life (attempt resuscitation). The statute currently states the opposite; even if a more recent document declares that the patient wants resuscitation, providers are NOT to resuscitate. The most recent document should guide treatment. Patients may change their mind about treatment decisions and these changes should be honored. We have heard that the rationale for the original policy of not resuscitating was that patients may have changed their minds after completing a POLST and decided again to be DNR. However, more likely is that a patient has forgotten that they are carrying the DNR card; it probably has never been used and for the population for whom the POLST is intended, forgetting that they have such a card would be understandable. Even if a provider asked specifically if the patient already has such a card, because it is known variously as a "DNR", "out-of-hospital DNR" or "salmon-colored" card, the patient may not recognize what is being requested.

B. **Change "incompetence" or "incompetent" to "lacking decisional capacity**". Refer to suggested insertion definition at **NRS 449.6923**.

- *Problem:* Competence is widely understood to be a judicial determination; it is a legal term. A significant number of patients near the end of life lose decisional capacity and that number will grow as baby boomers develop infirmities.
- *Revision:* Add a definition for "lacking decisional capacity". All references to "incompetence" or "competency" should be changed to "lacking decisional capacity".
- *Rationale:* Requiring all patients who lose decisional capacity to be determined incompetent by a judge before their legal representative (patient's DPOA-HC or guardian) may assume decision-making authority is neither a reasonable nor realistic requirement for those near the end of life. "Capacity" is a medical term reflecting a patient's ability to manage different aspects of their lives. It is determined by their health care provider. In a review of states with POLST programs established in statute, only one, Iowa, requires "competence" rather than "capacity" as a determination for when a patient's representative may assume decision-making authority for the patient. The patient's representative should be able to make decisions for the patient when the patient is deemed to lack decisional capacity and not require a court hearing to be determined incompetent. Changing to "capacity" from "competency" would also allow for the

patient to regain decisional authority if their mental status changed, as happens frequently with the POLST population (earlier stages of Alzheimer's, sundowner syndrome, etc.). Currently, incompetency reversal would require another adjudication.

C. APRNs and PAs as authorized provider signers of the Nevada POLST

- *Problem:* Rural areas often do not have physician coverage or access. Hospice, skilled nursing, rehab patients and home-bound patients may not have a physician available to consult and sign a POLST form.
- *Revision:* Allow APRNs and PAs to sign and validate a POLST with the same statutory requirements as currently apply to physicians and under the same supervisory requirements as currently exist for their licensing. Change the name of the program to Provider Order for Life-Sustaining Treatment (POLST).
- *Rationale*: Many patients are currently unable to complete a POLST form because a physician is unable to visit them due to distance, or availability. Currently, 30 of the 45 states with a POLST program allow for APRNs and PAs to sign a POLST form. This number increases each year as states revise their programs. Much of the opposition in those states still opposing this change is from physicians with general arguments about expanded roles of physician extenders; however, our Nevada State Medical Association has endorsed this proposal.

Please note: With acceptance/passage of this revision, the Nevada POLST form would be revised to include identification of the APRN or PA completing the POLST form.

D. **Surrogate Health Care Decision-Making regarding POLST**.

- *Problem*: Many patients who are candidates for the Nevada POLST program lack decisional capacity. Some have a Durable Power of Attorney for Health Care (DPOA-HC) or a legal guardian, but many do not. If they already lack decisional capacity, they are unable to complete a POLST, which currently requires the authorization of the patient's, DPOA-HC or legal guardian. Families of and others with established relationships with these patients, even when they are aware of the desires of their loved one, are unable to complete a POLST which may result in poorer health outcomes, poor resource allocation and unwanted care.
- *Revision*: Allow health care surrogates as describe in **NRS TBA** (see attached) to complete and sign a POLST for a patient lacking decisional capacity if the patient does not already have a POLST or designated agent (DPOA-HC or legal guardian). Health care surrogates may not revoke the POLST completed by the patient or their DPOA. The patient's lack of decisional capacity to complete a POLST shall be determined by their physician, APRN or PA. The patient's physician, APRN or PA shall retain the right to determine fitness of a surrogate pursuant to federal Privacy Act, 45 CFR 164.502(g). Attestation will be required of single third party witness.
- *Rationale*: Family members as described in **NRS 449.626** may currently make decisions regarding withdrawal of life support or refusal of life support for a patient determined by the physician to be terminal. Family members and others who have exhibited special care and concern for the patient are not, however, able

to authorize other treatments such as admission to hospice, a Long-Term Acute Care facility (LTAC), or other treatment that may actually extend life and lower end-of-life cost of care. Care provided at an acute care facility vs. a long-term facility for similar care is significantly more expensive; for those on respirators, there is about a $20,000 difference[1]. But, more importantly, admission to a long-term care facility is associated with a longer survival rate[2]. It seems counter-intuitive that family members may make decisions to refuse or withdraw life support, but not to authorize treatment that may extend life, provide comfort care at the end of life and other treatments that align with a patient's values.

Another concern is that a DNR order written by a physician is not valid outside a facility. Currently, NRS 449.626 allows family members to refuse resuscitation and life-sustaining treatment decisions for the patient, but once outside a facility (during transport or at home) the hospital DNR is *not* valid because the out-of-hospital DNR requires the signature of the patient. For patients who lack decisional capacity, the location of the patient should not preclude completion of a POLST by a family member or, if no family member is available, an "adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is willing and able to make a health-care decision for the patient" as approved and recommended by the National Conference of Commissioners on Uniform State Laws (1993),[3]

In addition, many believe if their advance directive is completed stipulating refusal of resuscitation or life-sustaining measures, they will not be resuscitated. However, should a life-threatening incident (for example, cardiac arrest) occur, emergency medical services are required to attempt resuscitation regardless of declarations on their advance directive. A patient's health care surrogate should be able to complete a POLST to align with the patient's wishes and values.

For those not wishing resuscitation (approximately 66% of POLST patients choose not to be resuscitated and to receive only comfort measures[4]), such unwanted treatment is extremely burdensome and a misguided use of resources. "In patients who are initially resuscitated, hypoxic–ischemic brain damage is the leading cause of morbidity and mortality. Almost 80% of patients who initially survive a cardiac arrest remain in a coma for varying lengths of time,

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[1] Connor, SR, et al. (March 2007) *Comparing hospice and non-hospice patient survival among patients who die within a three-year window*. Journal of Pain and Symptom Management, 33(3): 238-246. Found at http://www.ncbi.nlm.nih.gov/pubmed/17349493

[2] Seneff, Michael G. MD; Wagner, et al (2000). *The impact of long-term acute-care facilities on the outcome and cost of care for patients undergoing prolonged mechanical ventilation.* Critical Care Medicine. 28(2): 342-350. Found at http://www.ncbi.nlm.nih.gov/pubmed/10708164

[3] Uniform Health-Care Decision Act, 1993, Section 5.4.c.

[4] Fromme EK, Zive D, Schmidt TA, Cook JNB, Tolle SW (2014). "Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon" Journal of the American Geriatric Association 62(7): 1246-1251. Found at: http://online.liebertpub.com/doi/abs/10.1089/jpm.2013.0097

approximately 40% enter a persistent vegetative state" [5], and the overall 1-year-survival rate is 4%-20[6,7,8]. In the absence of any other agent (DPOA-HC or guardian), health care surrogates should be able authorize and support the wishes and values of their loved for the care they desire at the end of life.

It should be noted that 24 States have surrogacy laws governing health care decisions for patients who lack decisional capacity that include family and "close friends". "Good friends" is the collective term used in the American Bar Association's research regarding these types of surrogates.[9]

Please note: With acceptance/passage of this revision, the Nevada POLST form would be revised to include an optional authorization and identification of the health care surrogate completing the POLST form, their signature and a line for witness attestation.

E. Remove POLST as a form of Advance Directive

- *Problem:* There is a conflict in statute. NRS 449.6928 states a POLST is not another type of advance directive, while NRS 449.905.4 includes the POLST as an advance directive.
- *Proposal:* Remove POLST from NRS 449.905.4
- *Rationale:* The POLST is not an advance directive. An advance directive, as the name indicates, is in advance of an illness or injury. Anyone over the age of 18 in any health status may complete an advance directive. The POLST is specifically for those we would expect not to survive another year, the very frail elderly or those near the end of a life-limiting illness. If such a patient is completing a POLST, their health care provider can anticipate what types of treatment options are likely in the near future so the patient can make an informed decision concerning them. Furthermore, the national POLST organization, POLST Paradigm, does not recognize the POLST as an advance directive, for these same reasons. Because the legislation specifically excludes POLST from "other advance directives" (NRS 449.6928), NRS 449.905.4 should be struck from statute to eliminate confusion.

F. Sustainability of the Nevada POLST program

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[5] Connor, SR, et al. (March 2007) *Comparing hospice and non-hospice patient survival among patients who die within a three-year window*. Journal of Pain and Symptom Management, 33(3): 238-246.

[6] Seneff, Michael G. MD; Wagner, et al (2000). *The impact of long-term acute-care facilities on the outcome and cost of care for patients undergoing prolonged mechanical ventilation.* Critical Care Medicine. 28(2): 342-350.

[7] Swedish study: Libungan B, Lindqvist J, Strömsöe A, et al (2015). *Out-of-hospital cardiac arrest in the elderly: A large-scale population-based study*. Resuscitation. Sep(94):28-32. Found at: http://www.ncbi.nlm.nih.gov/pubmed/26073274

[8] Bonnin MJ, Pepe PE, Clark PS et al (1993). *Survival in the elderly after out-of-hospital cardiac arrest*. Crit Care Med. 1993 Nov 21(11):1645-51. Found at http://www.ncbi.nlm.nih.gov/pubmed/8222679

[9] Default Surrogate Consent Statutes as of June 2014. American Bar Association. Found online at: http://www.americanbar.org/content/dam/aba/administrative/law_aging/2014_default_surrogate_consent_statutes.authcheckdam.pdf

- Nevada POLST is the only organization in the State of Nevada to provide the POLST forms, education and training.
- Nevada POLST has processed POLST orders for 169 facilities throughout Nevada for a total of more than 50,000 POLST forms.
- We have provided training to thousands of health care professionals in most all counties of Nevada.
- Our website provides extensive education and resources for patient's, families and health care providers, receiving an average of 4,000 unique visits per month.
- We produce a newsletter with a health care subscriber base of over 300.
- Nevada POLST is an entirely volunteer organization with a single volunteer performing 98% of the operation.
- Suggestions and recommendations for the sustainability of Nevada POLST will be gratefully and seriously considered.
- An estimated annual budget would be as follows:

Executive Director – .75 FTE:		$45,000.00
Quality Assurance Investigator: .75 FTE		$33,750.00
Executive Asst. – .5 FTE:		$22,500.00
Taxes & Benefits		$25,312.50
Rent ($400/mo – 300 sq ft)		$4,800.00
General Operations		
▪ Postage, Mailing Service	1,300.00	
▪ Printing and Copying	5,500.00	
▪ Supplies	300.00	
▪ Telephone	1,800.00	
▪ Telecommunications	600.00	
General Operations		$9,500.00
Technology (computers, presentation equip., etc.)		$2,500.00
Travel		$3,500.00
TOTAL		**$142,062.50**